

Guidelines for Communications and Information Sharing Between Family Physicians and Community Partners for Children and Youth



Prepared by:

Geri McGrath Executive Director

Diane Burton Project Manager, Delta Division A GP for Me

David Flaherty Privacy and Information Policy Consultant, and first Information and Privacy
Commissioner for BC

July 7 2016

Background and Purpose

With the implementation of the “A GP for Me” initiative for the Delta Division of Family Practice, one of the primary goals was to improve communications processes to enable Family physicians to identify and rapidly refer to targeted Mental Health and Substance Use (MHSU) and allied health care resources, and to receive timely feedback, which would enable a smoother journey for the MHSU patient and his/her family. Guidelines for communication were developed for adult MHSU patients, and have been adapted here for the child/youth MHSU patient and his/her family.

The care of mental health and substance use patients typically involves sensitive personal information, and these guidelines are intended to offer clarity about information sharing between Family physicians and community partners for **MHSU child/youth patients and their families (non-urgent care)**.

These guidelines have been prepared to exist within the context of current legislation, including two privacy laws:

- *The BC Personal Information Protection Act (PIPA)*, which is the ‘private sector’ privacy law that covers the Delta Division of Family Practice, Doctors of BC, A GP for Me, health clinics, psychologists, Family physicians, counselors, and not-for-profit organizations, etc., and
- *The BC Freedom of Information and Protection of Privacy Act (FIPPA)*, the ‘public sector’ law, which applies to the Ministry of Health and Health Authorities.

Recent guidance has been prepared by the BC division of the Canadian Mental Health Association¹ to support patients, families and service providers with understanding information sharing and consent. Information sharing references that specifically address children and youth are:

- *Information sharing for Young People – Fact sheet*
- *Privacy for Parents and Caregivers – Fact sheet*
- *Information Sharing in the Context of Child and Youth Mental Health and Substance Use in BC*

Definitions

- **Personal information:** Information about an identifiable individual.
- **Patient:** Refers to Child and or Youth.
- **Infant:** Legally, anyone under the age of 19 in BC is an infant.
- **Family:** The full range of relationships of importance to individuals, including significant others who provide support and/or care on a regular basis (includes biological family, a legal guardian, foster parents, or any other adult that helps out).

¹ Resources can be found at: <http://www.cmha.bc.ca/get-informed/public-issues>

- **Mental Health Care Team (care team):** The group of people who are working together to provide the child / youth with care and support, e.g., family doctor, psychiatrist, school counselor, therapist, social worker, other allied health community partners, family members, and other important adults.
- **Community partners:** Ministry of Child and Family Development (MCFD), Fraser Health MHSU, school counselors, private counselors, and community service organizations (e.g., Canadian Mental Health Association, Schizophrenia Society, *Deltassist*) that provide mental health and substance use services to patients/clients in our community.
- **MHSU Local Action Team:** The team of Family physicians, MCFD, schools (e.g., principals, teachers, counselors), parents and youth, medical office assistants, Fraser Health MHSU, community partners, and emergency services (police, fire, and ambulance) working collaboratively to provide care for MHSU patients/clients and their families in the community.

Guiding Principles

Principles underlying the MHSU Local Action Team communications and information processes:

- a. Relevant personal information should be shared on a ‘need to know’ basis among authorized participants in the ‘circle of care’ for the child / youth patient or client.
- b. Always state that you are collecting, using, and disclosing personal information under controlled conditions, and in compliance with the applicable law(s) and best practices.
- c. The delivery of healthcare in BC functions on the basis of an implied consent model. Implied consent is given, for example, when the child/youth patient goes to the Family Physician or the community partner for care. However, express consent is advisable in the special circumstances of children and youth (e.g., considering their broad views and sensitivities with mental health stigmatism).
 - When the child/youth patient or client provides sensitive information that is not relevant to a referral, such information should not be disclosed to another care provider. (Note: Practically speaking, the provider must use clinical judgment, and the standard of reasonableness when deciding how much of “a record” to send, for example if the information is not easily partitioned or severed.)
 - While consent may be implied, some care providers may prefer a stronger standard. For example, when there is sensitive personal information, the care provider and/or community partner may choose to explicitly request permission to disclose. (Note that perceptions of sensitivity of personal information may vary from one child / youth to another.)
 - It is understood that health care providers have to assess their various legal obligations and potential liability with respect to the collection, use and disclosure of personal information, and may want to engage in risk mitigation by obtaining more express forms of consent.

Communications and Information Sharing Processes for Child/Youth MHSU Patients and Their Families

Processes for communications and information sharing between Family physicians and community partners are presented below with use of scenarios and supplementary questions.

Children and Youth

Mental Health Care Team and Consent for Information Sharing

It is imperative to recognize that children / youth and family need to be aware of the options that are available for sharing information with their mental health care team and that the child / youth is able to identify with whom information can be shared (or not shared).

To provide reassurance and to respect the child / youth patient's rights, a suggested approach would be:

“To ensure the best care is provided for you, who would you like to be on your care team? Your care team (or support team) is the group of people who are working together to provide you with care and support and may include, for example, your family doctor, psychiatrist, school counselor, therapist, social worker, family members, or a trusted adult.

I'm requesting your consent to provide information to your full team of care. Who supports you?

You can also tell me if there is information that you don't want shared with a specific person.

The only time I must share information, by law, is when there is imminent risk of harm to yourself or to others, abuse or neglect of a child, or if I am subpoenaed by a court of law.

Then assist the child/youth to complete a consent form (see sample in Appendix 2 – Sample Consent Form), which prompts for care team members and type of information to be shared.

Note: the CMHA guide, *Information Sharing in the Context of Child and Youth Mental Health and Substance Use in BC* offers further direction regarding communication and responsibilities regarding consent (refer to section *Best Practices: Privacy and Information Sharing*, p. 15-16)

Scenario A: Child/youth patient visits a Family Physician who then refers to a community partner.

When the Family Physician refers or recommends a child/youth patient to a community partner, the Family Physician may provide a note for the child/youth or family to bring to the provider, or the Family Physician may want to send information directly to the community partner.

The Family Physician arranges to have the information faxed to the community partner. Obviously, if the child/youth patient expressly refuses further disclosure, then the information is not shared unless there is a duty to report (due to serious risk of harm to self or harm to others, for example).

Question: Express consent with children/youth is advised, but in a situation where consent is implied is there a need to communicate anything further to the child/youth patient about the proposed information transfer?

- Answer: Yes, the Family Physician must inform the child/youth patient about what is being sent.

Question: Why would the Family Physician provide a note to the child/youth patient instead of faxing information to the community partner directly?

- Answer: When the Family Physician is assessing whether the child/youth patient will take more responsibility for his or her own health, the Family Physician may direct the child/youth to take information to a counselor.

Scenario B: Child/youth patient visits a community partner*, and the community partner becomes aware of information that should be shared with the child/youth's Family Physician.

* In this scenario, either the child/youth patient was referred by the Family Physician, or the child/youth patient has self-referred.

Sometimes the community partner may know more than the Family Physician about the child/youth patient, particularly if he/she spends more time with the child/youth. The community partner may become aware of information that the Family Physician might need.

The community partner must inform the child / youth why it is important to contact his/her Family Physician and then support him/her to find a way to communicate with the Family Physician.

The community partner would ask the child/youth, "Have you told your Family Physician?", "Do I have your permission to contact your Family Physician / share this information with your Family Physician?", and "Do you need assistance with providing this information to your Family Physician?". If the child/youth expressly refuses, then the information is not shared unless there is a duty to report (due to risk of serious harm to self or harm to others, for example).

The community partner arranges to have the following information faxed to the Family Physician:

- **The child/youth patient was seen on (*date*), by whom (*name of community partner*), and community partner’s credentials**

 - This information is required because patients don’t always remember whom they have seen.

- **Brief summary** (not detailed unless necessary)
 - E.g., “Annette was scheduled to be seen 6 times for anxiety, and showed up twice.”
- **Any relevant context** - Exercise clinical judgment to determine what to send.
 - E.g., “abuse happening”
 - E.g., behaviours that the Family Physician should know about

Question: What if the Family Physician requested feedback from the community partner on something specific, and the child/youth patient tells the community partner that they don’t want that information shared?

- Answer: Most of the time the GP wants to know that the child/youth patient has been seen and there is a plan in place. The community partner should ask the child/youth patient for the reason why he/she does not want to share the information, inform them why it would be important to share the information, and help them find a way to communicate.

The child/youth patient’s rights must be considered and respected, and the community partner must rely on his/her professional assessment of whether the child/youth has capacity to give consent.

The community partner can relay that the “patient would not consent”. In a serious matter, a community partner could make the clinical judgment that the Family Physician has a need to know.

Scenario C: Child/youth patient visits the community partner, and the community partner has a question for the Family Physician.

The community partner follows the same procedure as outlined above in Scenario B.

Question: Wouldn’t the community partner need a Release of Information form, signed by the client/patient?

- Answer: A Release of Information form can be used, if preferred, but it is not necessary in these circumstances involving members of the ‘circle of care’.

Scenario D: The community partner becomes aware that the child/youth patient had presented at the Emergency or was admitted to the hospital because he/she was suicidal.

Question: Does the community partner need to communicate that information to the Family Physician?

- Answer:
 - When a child/youth is admitted to the hospital, the hospital will communicate with the Family Physician.
 - When the child/youth presents at the hospital and is seen by an Emergency doctor and discharged (i.e. not admitted), communication is usually timely from the hospital to the family physician. While unusual, it is possible that communication from the ER could be delayed, so it would be advisable to make the Family Physician aware (and others on the child/youth's care team, according to the child/youth's consent - please follow the consent process as outlined in this document).

Scenario E: The child/youth visits the community partner (self-referral), but has no Family Physician. The community partner becomes aware of information that should be shared with a Family Physician and recommends that the client sees a Family Physician.

The community partner recommends that the child/youth go to a walk-in clinic and may provide the child/youth with information to take with him/her. If the South Delta child/youth doesn't have a doctor and wants a doctor, the community partner will assist him/her with registering for a doctor in South Delta.

The community partner, using the Patient Registry function on the FETCH (For Everything That's Community Health) website for South Delta residents, enters:

- The child/youth's name, address, and phone number
- Community partner's name and organization should the Family Physician need to contact him or her.
- Verbal or written consent, so that you can print and retain on file.

Additional Questions:

1. **Question: When would a Family Physician communicate the child/youth patient's physical/medical issues (e.g., endocrine, poly-pharmacy, anemia, auto-immune) to the child/youth's care team?**

Answer: While this may occur infrequently, the family physician would assess, on a need to know basis, whether information needs to be shared with members of the child/youth's care team and will communicate medical / physical issues accordingly. Generally speaking, a Family Physician will transfer information (e.g., a letter) to another care provider via the child/youth patient or family.

2. **When would there be a need for the community partner to call the Family Physician, and not just fax information?**

Answer: The Family Physician expects, and wants, a call when the child/youth is a danger to self or to others.

3. What about a situation where the child/youth client is with a community partner and is experiencing an incident / crisis (non-urgent)?

Answer: The community partner should exercise professional judgment regarding when to call the Family Physician and/or members of the mental health care team or send relevant information, and in accordance with the child/youth's consent.

4. If a Family Physician makes a referral to a community partner and information is shared (either with a Family Physician or with a community partner) and the child/ youth and family doesn't show up, what do we need to consider from a privacy perspective?

Answer:

- Usually in the case of children/youth and family there is a follow up phone call to find out whether the appointment can be rescheduled and to understand whether there are any barriers from the child/youth or family perspective

5. What if the child/youth client provides consent to a Family Physician or community partner, but in retrospect doesn't feel comfortable or confident to refuse? (I.e. there was no duress, but the client was not personally comfortable.)

Answer:

- The child/youth patient can inform the caregiver that he or she is withdrawing his or her consent, and the caregiver can explain the implications of this decision for the child / youth patient.

6. What if the child/youth is not capable of providing consent and there is no family/guardian present? (E.g., a community service worker may be present to assist the client.)

Answer:

- The legal representative of the client is responsible in such circumstances. The MCFD's *A Guide to the Privacy Charter* provides direction regarding who may act on behalf of these individuals, and states, "Service partners, including ministry staff, may also wish to refer to their program specific policy manuals It is important to note that the Young Offenders Act does not allow either young offenders or their parents to consent to the release of their personal information".

Refer to Appendix 1 – "Decision Makers for Children and Youth Who are Unable to Provide Informed Consent" – for specific references to the *Child, Family and Community Service Act* (CFCSA) and the *Infants Act*.

7. As a community partner, I have sent recommendations to the Family Physician, and the Family Physician changes a course of action and/or doesn't agree with my recommendations. Why would this happen? What can I do?

Answer:

- The Family Physician may determine that it would be inappropriate to proceed with the community partner's recommendations; for example, medical complications might alter recommendations.
- Even if the community partner was expecting to hear back from the Family Physician on a specific concern, the Family Physician may not be able to communicate this related information due to other complications.
- If the community partner has remaining questions/concerns regarding recommendations, he/she should follow up with the Family Physician before dismissing concerns.

8. What consent is required when police/fire need to contact the Family Physician when a non-urgent incident arises?

Answer:

- Police have a duty to disclose that overrides privacy requirements; they would not need consent to disclose personal information to a Family Physician, e.g. for law enforcement purposes.
- The Family Physician should exercise clinical judgment regarding disclosing information. A formal Release of Information request may be required.

Acknowledgement

The Delta Division of Family Practice is grateful to the members of the Delta Child Youth Mental Health and Substance Use Local Action Team for providing their input to the development of these guidelines.

Appendix 1: Decision Makers for Children and Youth Who are Unable to Provide Informed Consent

Child, Family and Community Service Act (B.C. Reg. 527/95):

Part 5 – Freedom of Information and Protection of Privacy

Who can act for a child

- 76 (1) A person, other than a director [a person designated by the minister under section 91], who has legal care of a child under 12 years of age may, on behalf of the child, exercise the child's rights under the [Freedom of Information and Protection of Privacy Act](#)
- (a) to be given access to information about the child in a record,
 - (b) to consent to the disclosure of that information, and
 - (c) to request the correction of that information.
- (2) A person, other than a director, who has legal care of a child 12 years of age or older may, on behalf of the child, exercise the child's rights under the [Freedom of Information and Protection of Privacy Act](#)
- (a) to be given access to information about the child in a record,
 - (b) to consent to the disclosure of that information, and
 - (c) to request correction of that information
- if the child is incapable of exercising those rights.

BC Infants Act

Part 2 - Medical Treatment

Consent of infant to medical treatment

- 17 (1) In this section:
- "**health care**" means anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other health related purpose, and includes a course of health care;
- "**health care provider**" includes a person licensed, certified or registered in British Columbia to provide health care.
- (2) Subject to subsection (3), an infant may consent to health care whether or not that health care would, in the absence of consent, constitute a trespass to the infant's person, and if an infant provides that consent, the consent is effective and it is not necessary to obtain a consent to the health care from the infant's parent or guardian.
- (3) A request for or consent, agreement or acquiescence to health care by an infant does not constitute consent to the health care for the purposes of subsection (2) unless the health care provider providing the health care

- (a) has explained to the infant and has been satisfied that the infant understands the nature and consequences and the reasonably foreseeable benefits and risks of the health care, and
- (b) has made reasonable efforts to determine and has concluded that the health care is in the infant's best interests.

Appendix 2: Sample Consent Form for Children and Youth

COMMUNITY COMMON CONSENT FORM		
For the purposes of planning, providing, and/or coordinating services: for me or for my child/youth (circle one).		
I, _____, consent that the following agencies/organizations may collect, use, and disclose only relevant personal information among themselves about me/my child/youth. This applies to both verbal and written/recorded information.		
Please check and complete as applicable	Individual and program name	
<input type="checkbox"/>	Child and Youth Mental Health (MCFD)	(individual)
<input type="checkbox"/>	School	(name an individual)
<input type="checkbox"/>	Family Doctor	
<input type="checkbox"/>	Specialists- Pediatrician/Psychiatrist	
<input type="checkbox"/>	Parent / family / trusted adult	
<input type="checkbox"/>	Other (e.g., Community Agency, Police)	
Your care/support team could include, for example: School counselor, teacher, principal, vice-principal; place of worship / pastor; sibling, friend, aunt/uncle, grandparent; youth/school police liaison officer; community counselor: START team, Deltassist, private counselor.		
Do not share the following information: _____		
with the following people / programs: _____		

AUTHORIZATION		
<p>I understand that the professionals/organizations involved are required to protect my personal information; and use and disclose it only with my consent or as permitted/required by law including the Youth Criminal Justice Act (YCJA). Personal information that is collected, used, and/or disclosed among the professionals involved will be maintained and kept confidential by each professional in accordance with privacy laws, and their organization’s standards and regulations.</p> <p>I understand there is a legal obligation on the professionals/organizations involved to report certain information (i.e.: abuse, information about imminent harm to self and others, etc.) and that such information cannot be held in confidence.</p> <p>I understand that I may revoke this consent at any time and that revoking my consent will not affect any action already taken by professionals/organizations or recipients of the personal information, before they received written notice of my revocation, or affect future service.</p>		
Child/Youth , or Parent/Guardian/Substitute Decision Maker	Witness	Date
This consent is effective until (limit two years)	Name of organization	Organization representative