Local Interagency Planning Teams

Collaborating for Successful Communities

Team Handbook

GEORGIA DEPARTMENT OF HUMAN RESOURCES

Table of Contents

Overview

Goals of the LIPT

A Local Interagency Planning Team (LIPT) must be established on behalf of children in each community. The team may be single or multi-county teams dependent upon the size of the community and the geographic availability of needed resources. The underlying purpose for the development of the LIPT is to improve and facilitate the coordination of services to children with severe emotional disorders (SEDs) and addictive disease. LIPTs have the following goals:

- To assure that children with severe emotional disorders (SEDs) and addictive disease (ADs) and their families have access to a system of care in their geographic areas;
- To assure the provision of an array of community therapeutic and placement services;
- To decrease fragmentation and duplication of services and maximize the utilization of all available resources in providing needed services;
- To facilitate effective referral and screening systems that will assure that children have access to the services they need to lead productive lives.

Goals of This Guide

This guide is intended to be a resource for teams to assist them as they determine membership, set their meeting agendas, and complete case planning and resource development.

This guide contains templates and guidelines for the following team tasks:

- Determining team composition and leadership structure
- Building a logic model for the team
- Creating agendas and minutes for team meetings
- Facilitating LIPT meetings
- Creating plans for youth and their families
- Maintaining LIPT/case documentation

Basic Underpinnings: The System of Care Philosophy

Core Values

- The system of care should be child centered and family focused, with the needs of the child and family dictating the types and mix of services provided.
- The system of care should be community based, with the focus of services as well as management and decision making responsibility resting at the community level.
- The system of care should be culturally competent, with agencies, programs, and services that are responsive to the cultural, racial, and ethnic differences of the populations they serve.

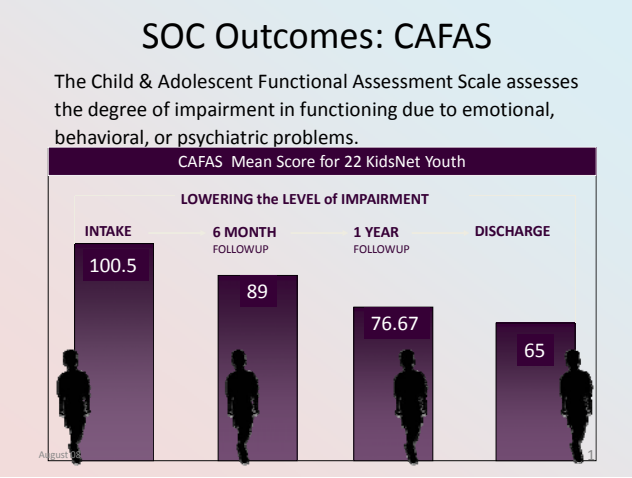
Guiding Principles

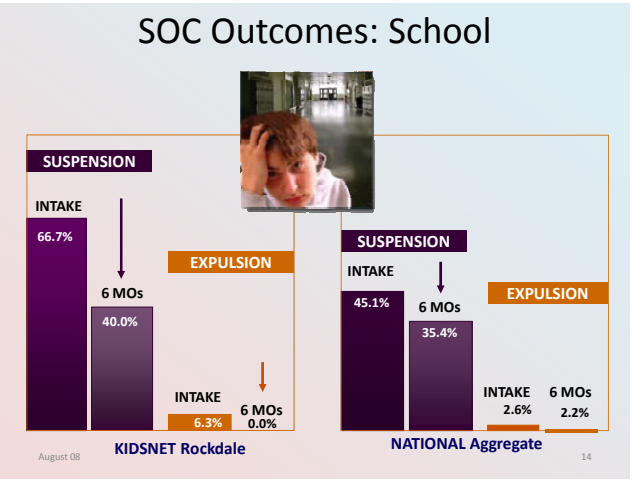
1. Children with emotional disturbances should have access to a comprehensive array of services that address the child's physical, emotional, social and educational needs.
2. Children with emotional disturbances should receive individualized services in accordance with the unique needs and potentials of each child and guided by an individualized service plan.
3. Children with emotional disturbances should receive within the least restrictive, most normative environment that is clinically appropriate.
4. The families and surrogate families of children with emotional disturbances should be full participants in all aspects of the planning and delivery of services.
5. Children with emotional disturbances should receive services that are integrated with linkages between child-serving agencies and programs and mechanisms for planning, developing, and coordinating services.
6. Children with emotional disturbances should be provided with case management or similar mechanism to ensure that multiple services are delivered in a coordinated and therapeutic manner and that they can move through the system of services in accordance with their changing needs
7. Early identification and intervention for children with emotional disturbances should be promoted by the system of care in order to enhance the likelihood of positive outcome.
8. Children with emotional disturbances should be ensured smooth transitions to the adult service system as they reach maturity.
9. The rights of children with emotional disturbances should be protected, and effective advocacy efforts for children and youth with emotional disturbances should be promoted.
10. Children with emotional disturbances should receive services without regard to race, religion, national origin, sex, physical disability or other characteristics, and services should be sensitive and responsive to cultural differences and special needs.

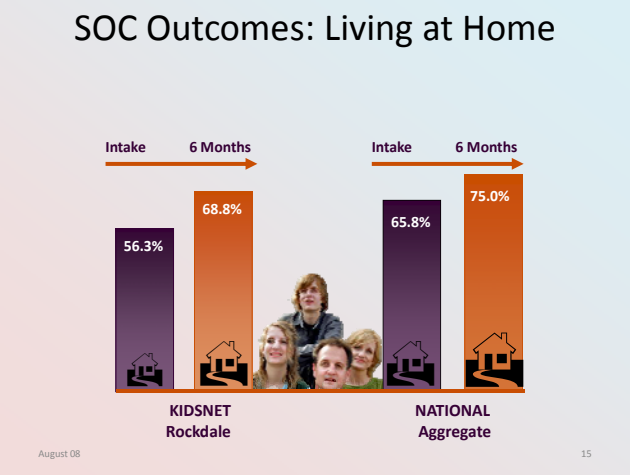
Source: Stroul, B. & Friedman, R. (1986). A System of Care for Children & Youth With Severe Emotional Disturbances. Washington, DC: Georgetown University Child Development Center, National Technical Assistance Center for Children's Mental Health.

Better Outcomes: The System of Care Philosophy

In Georgia and Nationwide...







And in a study from Maine…

Reduced costs due to fewer days in inpatient care. The average reduction in per-child inpatient hospital days from entry into services to 12 months translated into an average per-child cost savings of $2,776.85.

Decreased utilization of inpatient facilities. The percentage of children who used inpatient facilities within the previous 6 months decreased 54 percent from entry into systems of care to 18 months after systems of care.

Reduced arrest results in per-child cost savings. From entry into systems of care to 12 months after entry, the average reduction in number of arrests per child within the prior 6 months translated into an average per-child cost savings of $784.16.

Mental health improvements sustained. Emotional and behavioral problems were reduced significantly or remained stable for nearly 90 percent of children after 18 months in systems of care.

Suicide-related behaviors were significantly reduced. The percentage of children and youth who had deliberately harmed themselves or had attempted suicide decreased 32 percent after 12 months in systems of care.

School attendance improved. The percentage of children with regular school attendance (i.e., 75 percent of the time or more) during the previous 6 months increased nearly 10 percent with 84 percent attending school regularly after 18 months in systems of care.

School achievement improved. The percentage of children with a passing performance (i.e., C or better) during the previous 6 months increased 21 percent with 75 percent of children passing after 18 months in systems of care.

Significant reductions in placements in juvenile detention and other secure facilities. Children and youth who were placed in juvenile detention or other secure facilities within the previous 6 months decreased 43 percent from entry into services to 18 months after entering systems of care.

Source: Tri-County Mental Health Services, Lewiston, Maine: Comprehensive Community Mental Health Services Program for Children and Their Families. http://www.thriveinitiative.org/

Legal Mandate: Georgia 49-5-220 and 49-5-225

49-5-220 Legislative findings and intent; State Plan for the Coordinated System of Care for the severely emotionally disturbed children or adolescents

(a) the General Assembly declares its intention and desire to:

1) Ensure a comprehensive mental health program consisting of early identification, prevention, and early intervention for every child in Georgia:
2) Preserve the sanctity of the family unit;
3) Prevent the unnecessary removal of children and adolescents with a severe emotional disturbance from their homes;
4) Prevent the unnecessary placement of these children out of state;
5) Bring those children home who through the use of public funds are inappropriately placed out of state; and
6) Develop a coordinated system of care so that children and adolescents with a severe emotional disturbance and their families will receive appropriate educational, nonresidential and residential mental health services, and support services, as prescribed in an individualized plan.

(b) In recognition of the fact that services to these children are provided by several different agencies, each having a different philosophy, a different mandate, and a different source of funding, the Division of Mental Health, Developmental Disabilities, and Addictive Diseases of the Department of Human Resources shall have the primary responsibility for planning, developing, and implementing the coordinated system of care for severally emotionally disturbed children. Further, it recognizes that to enable severely emotionally disturbed children to develop appropriate behaviors and demonstrate academic and vocational skills, it is necessary that the Department of Education provide appropriate education in accordance with P.L. 94-142 and the Division of Mental Health, Developmental Disabilities, and Addictive Disease of the Department of Human Resources provide mental health treatment.

In regards to the local interagency committees, the law states as follows:

49-5-225. Local interagency committees; membership; function of committees

(a) At least one local interagency committee shall be established for each region of the Division of Mental Health, Developmental Disabilities and Addictive Diseases of the Department of Human Resources whose permanent membership shall include a local representative from each of the following:

(1) The community mental health agency responsible for coordinating children's services;

(2) The Division of Family and Children Services of the Department of Human Resources;

(3) The Department of Juvenile Justice:

(4) The Division of Public Health of the Department of Human Resources:

(5) A member of the special education staff of the local education agency;

(6) The Division of Rehabilitation Services of the Department of Labor

(b) In addition to the permanent members, the local interagency committee reviewing the case of a child or adolescent may include as ad hoc members the special education administrator of the school district serving the child or adolescent, the parents of the child or adolescent, and caseworkers from any involved agencies

(c) The local interagency committees shall:

(1) Staff cases and review and modify as needed decisions about placement of children and adolescents in out-of-home treatment or placement, monitor each child's progress, facilitate prompt return to the child's home when possible, develop a reintegration plan shortly after a child's admission to a treatment program, review the individual plan for the child or adolescent and amend the plan if necessary, and ensure that services are provided in the least restrictive setting consistent with the effective series; and

(2) Be the focal point for the regional plan, if any.

The Fentons: An Illustration of Different Approaches

David and Jeannette Fenton have three children. Louis, the oldest, has a learning disability and is in special education classes at his high school. Maria, the middle child, has just started high school and is subject to wild mood swings which cause trouble for the whole family. Rick, the youngest, is a bright, active middle schooler involved in many extra-curricular activities and sports. Because David is a long-haul truck driver, he is gone a lot of the time, leaving Jeannette, a stay-at-home mom, with the task of juggling many teacher meetings for Louis and driving Rick to and from his numerous activities.

Mrs. Fenton has her hands full, and feels she is near a breaking point when Maria's behavior starts to become very troublesome. First, she has been getting in fights at school and has had many school detentions. Then, she is arrested for shoplifting and given probation. Then, Jeannette is visited by a DFCS investigator after the school reports suspected child abuse when Maria shows up at school with bleeding cuts on her hands and legs. The DFCS case is closed after it is determined that Maria cut herself. The DFCS case worker encourages Mrs. Fenton to get a psychological evaluation for Maria. Mrs. Fenton follows up with Maria's pediatrician, who suspects bipolar disorder and prescribes medication for Maria. Mrs. Fenton also follows up with the school, and the school creates an IEP for Maria and puts her in a psycho-educational program. The school and the pediatrician both recommend therapy for Maria, but Mr. and Mrs. Fenton feel they cannot afford it and want to manage things on their own.

Mrs. Fenton continues to try to carry on, but she is becoming depressed herself. She cannot seem to control or console Maria, who, depending on whether she is in a high or low mood, threatens herself or others, talks about suicide, or becomes erratic in her thoughts and actions. Several times, Mrs. Fenton has had to admit her to a Crisis Stabilization Program (their minimal insurance does not cover a private facility) for emergency stays of five to seven days. Currently, Maria is in the Crisis Stabilization Program again after another cutting incident. The Fentons need help.

Let's look at possible courses of action in three different communities.

Eastville Community: The school social worker talks to Mrs. Fenton about getting assistance with Maria from the LIPT and takes the lead in making the referral. Mrs. Fenton tells the committee she cannot handle her daughter any more and that Maria is in a Crisis Stabilization Program at the present time. She wants the committee to place her daughter in a residential program where she can also receive treatment. The committee determines that they can offer support to the family while maintaining Maria in the home and that all community resources have not been exhausted to justify placement outside of the home. Mrs. Fenton becomes very angry and refuses to pick up Maria from the Crisis Stabilization Program. DFCS ends up with custody of Maria and places the youth in a group home (RBWO) in the community where she can still have contact with her family and be reunited with them in the near future. The Fentons agree to participate in family therapy and have Maria for home visits every other weekend. Within six months, Maria is returned home. Maria is supported with a number of

resources in the community, is stable on her medications, and attending school with only minor incidents. She has fewer mood swings, allowing the family to rebuild their relationships.

Westfield Community: Mrs. Fenton reaches out to a behavioral health provider in the community, and they refer her to the LIPT, which is staffed by representatives from Maria's school, her probation officer at DJJ, representatives from Mental Health, and a number of other community resources. The LIPT reviews the background information provided by the behavioral health provider and hears from Mrs. Fenton about Maria. The mental health provider explains that the child's CAFAS (Child and Adolescent Functioning Score) is very high (160) and indicates a possible need for residential treatment in a PRTF (Psychiatric Residential Treatment Facility). They explain their hesitancy in making that referral without seeing what other community support may be available; thus the referral to the LIPT. The LIPT listens to the challenges and strengths of the child and family and decides Maria's behaviors are too risky at this time to support in the community. The behavioral health provider agrees to refer Maria to a PRTF. Maria is sent to a PRTF across the state from her home, as there were no openings in a facility close to home. Her placement is authorized for a total of 90 days. The family only came to visit two times due to the distance, the father's work, and the obligations regarding the other children. Maria returns home at the end of the 90 days but has significant problems again and is placed in a Crisis Stabilization Program. The LIPT decides a referral to a RBWO placement is in order to allow for a smoother transition home. A referral is made, she is accepted, and placed in a group home over 100 miles from home. The family continues to have problems in visiting and arranging home visits, resulting in the placement lasting a year. Upon return home, Maria has problems adjusting and misses a lot of days of school. The school counselor feels Maria is in danger of dropping out of school.

Southtown Community: Mrs. Fenton reaches out to a behavioral health provider in the community, and they refer her to the LIPT, which is staffed by representatives from Maria's school, her probation officer at DJJ, representatives from Mental Health, and a number of other community resources. The LIPT reviews the background information provided by the behavioral health provider and hears from Mrs. Fenton about Maria. The mental health provider explains that the child's CAFAS (Child and Adolescent Functioning Score) is very high (160) and indicates a possible need for residential treatment in a PRTF (Psychiatric Residential Treatment Facility). They explain their hesitancy in making that referral without seeing what other community support may be available; thus the referral to the LIPT. The LIPT listens to the challenges and strengths of the child and family and determines that despite Maria's risky behaviors, they will try to support the child and family in the community at this time. The family is very open to assistance from the LIPT and takes the lead in identifying what resources are a good match for their needs. Together, they develop a Community Care Plan which includes the Probation Officer seeing Maria at home, rather than in the office. The school offers to enroll Maria in an after-school program to help her catch up on her academics. ICSP (Intensive Community Support Program) services are made available to help with transportation, a Behavioral Aide in the home, music lessons for Maria, and respite. At first, Maria becomes even more aggressive and threatening, and the Core provider recommends IFI (Intensive Family Intervention) services for the family. After 90 days, Maria is much more stable. She avoids hospitalization, is succeeding in school, and lives with her parents in relative stability.

Team Survey: The System of Care Philosophy

Core Values

- The system of care should be child centered and family focused, with the needs of the child and family dictating the types and mix of services provided.
- The system of care should be community based, with the focus of services as well as management and decision making responsibility resting at the community level.
- The system of care should be culturally competent, with agencies, programs, and services that are responsive to the cultural, racial, and ethnic differences of the populations they serve.

Guiding Principles	Consistently	Sometimes	Seldom	Don't Know
1. Children with emotional disturbances should have access to a comprehensive array of services that address the child's physical, emotional, social and educational needs.				
2. Children with emotional disturbances should receive individualized services in accordance with the unique needs and potentials of each child and guided by an individualized service plan.				
3. Children with emotional disturbances should receive within the least restrictive, most normative environment that is clinically appropriate.				
4. The families and surrogate families of children with emotional disturbances should be full participants in all aspects of the planning and delivery of services.				
5. Children with emotional disturbances should receive services that are integrated with linkages between child-serving agencies and programs and mechanisms for planning, developing, and coordinating services.				
6. Children with emotional disturbances should be provided with case management or similar mechanism to ensure that multiple services are delivered in a coordinated and therapeutic manner and that they can move through the system of services in accordance with their changing needs				
7. Early identification and intervention for children with emotional disturbances should be promoted by the system of care in order to enhance the likelihood of positive outcome.				
8. Children with emotional disturbances should be ensured smooth transitions to the adult service system as they reach maturity.				
9. The rights of children with emotional disturbances should be protected, and effective advocacy efforts for children and youth with emotional disturbances should be promoted.				
10. Children with emotional disturbances should receive services without regard to race, religion, national origin, sex, physical disability or other characteristics, and services should be sensitive and responsive to cultural differences and special needs.				

Source: Stroul, B. & Friedman, R. (1986). A System of Care for Children & Youth With Severe Emotional Disturbances. Washington, DC: Georgetown University Child Development Center, National Technical Assistance Center for Children's Mental Health.

Discussion Questions

What patterns do you see in your ratings? What do they mean?

What can you do to resolve “I don’t know” items? (For example, is there data you should collect?)

Do you believe in these principles? What can you do to build a consensus on shared beliefs?

In which areas do we have the greatest gaps between beliefs and actions?

What can you do to make sure your actions reflect your beliefs?

Logic Model

A logic model is useful for framing the overall work of the team, getting consensus on "big picture" decisions, explaining what the LIPT is all about, providing information for program evaluation, and seeking grants or other monies.

The logic model generally has the categories listed below, but you can add categories if you like. Also, a logic model most often is a table, as shown below, but may also be constructed as a different type of graphic, as shown in one of your samples.

Mission and Vision	Conditions and Assumptions	Inputs (resources)	Activities and Services	Short-term Outcomes	Long-term Outcomes

Making Decisions for the Logic Model. Complete each of the sections below, in the order indicated. Each section includes some thought jogging questions to get your discussion going and to maintain focus.

Mission and Vision

Tip: You may also want to look at the "Goals of the LIPT" section on page 3 of this handbook.

- Why do we exist as an LIPT?
- What is our mission as a team?
- What sort of future do we envision for our community?

Outcomes

- What do we hope to accomplish in the next three to five years? (long-term outcomes)? *Example: Keeping youth safely at home, in school, and out of trouble.*
- What do we hope to accomplish in the next 12 to 24 months (short-term outcomes) in order to reach our long-term outcomes? *Example: Implement LIPT as a vehicle for improving the system of care available to youth with SED/AD.*

- What outcomes do we envision for youth? Families? Our service system? The community as a whole?
- If we were to gather data on whether we had made an impact after some time had passed, what sorts of things would we measure?

Conditions and Assumptions

- What population are we serving? What do we know about this population—numbers, locations, services currently receiving, attitudes, strengths, needs?
- What are some of the challenges we face? *Example: History of sending kids away from home and the community.*
- What guiding principles do we want to follow? *Example: Kids who get community-based treatment while remaining at home have better outcomes.*

Activities and Services

- What activities must be carried out to achieve the intermediate outcomes?
- Given our mission and mission and our outcomes, what services must we offer?
- What are the steps that will serve as a bridge between where we are not

Inputs

- What resources exist within our community and its citizens to help this population? Examples:
  - Churches
  - Scout leaders
  - Self help groups (AA, Al-anon, etc.)
  - Civic groups
  - Ethnic-based organizations
  - Neighborhood organizations
  - Parks and recreations departments
  - After school programs and summer programs
  - Employment counselors
  - Teachers
  - School nurses
  - Graduation coaches
- What are the resources needed to carry out the activities?
- What are the strengths and needs of our service system? *Examples: Existing service providers, research on what works, greater understanding of the potential for these youth*
- What are the strengths and needs of our service providers?

Completing the Logic Model. Put together your ideas in some sort of framework, using either a table such as the one on the previous page or another type of organizer.

LIPT Basics: Forming and Organizing the Team

1 Identify and recruit members. In total, an LIPT *may* have a total of 17-20 people, or it could be as few as 7-10 people. The following agencies must be represented in the LIPT:

- DFCS representative
- DJJ representative
- MHDDAD representative
- DOL Rehabilitative Services representative
- Public health representative
- GNET/local public schools representative
- Local mental health service providers

In addition, it is strongly recommended that at least one parent (or, if not possible, an advocate for the parent) be present during case planning for a youth. While parents are not permanent members of the team in the sense that they are not present when every youth is discussed, they are important team members when the team discusses their children. The youth should be included where possible and appropriate. Special notes on parent members:

- It is strongly recommended that the parent (or advocate) be present during the entire time their child is discussed, with the exception of the initial short presentation by the lead case manager.
- Keep parent involved at all times, as indicated in the agenda guidelines on page 21.
- If a parent is unable to make a meeting, reschedule at a time and place that is convenient for them.
- Avoid "no shows" by discussing issues like transportation and child care ahead of time.
- If necessary, the parent/advocate can participate by phone.
- As possible, include the parent in at least some of the follow-up meetings, especially during transition times.
- Include the youth where possible and appropriate.

2 Set up a structure to facilitate the work of the team and document it in a memorandum of understanding.

Leadership: An LIPT should have a chair responsible for calling and presiding over all meetings. This chair should serve a term of one to two years. Other leadership tasks on the team—such as providing an agenda, taking and distributing minutes, and other keeping documentation—should be shared and/or rotated among LIPT members to make sure no single member has an undue amount of responsibility. Other formal leadership roles should be identified in the Memorandum of Agreement (MOA). A Results-based Facilitator is recommended, but not required.

Memorandum of Agreement: Each LIPT should develop and maintain an MOA. See page 17 for a sample.

3 Discuss the criteria for youth to be served by the committee. Generally, most LIPTs look at a case when the services needed exceed those which core provider or child-serving agency can provide, especially when the child is at risk for out-of-home placement.

Tip: The criteria for which SED/AD youth an LIPT should serve are:

1. *Hospital discharges (working with MHDDAD case expeditors)*
2. *PRTF discharges/step downs*
3. *Crisis Stabilization Program discharges*
4. *Youth in MRBWO with SED or AD*
5. *Youth needing specialized sex offender treatment*
6. *Other youth at risk of out-of-home placement, including following:*
   a. *High use of psychiatric hospitals or crisis/emergency services including mobile, in-clinic, or crisis residential (e.g. 2 or more admissions per year)*
   b. *Use of high end substance abuse services including IRT's and group home discharges*
   c. *Involvement w/ juvenile court system*
   d. *Harm to self or others or clinical evidence of threats of harm to self or others within last 3 months*

<u>Other decisions around case management include:</u>

- **How often** will we review each case? (Guidelines: Weekly if youth is in crisis, bi-weekly if the youth has continuing significant issues, monthly if there has been a recent or upcoming change, bimonthly if youth is stable. If the child is in residential services, then follow up at least monthly and bring a sense of urgency about preparing for the child's return home. In follow-up meetings, make sure that there is a transition plan and that it is being executed. Always ask, "What is being done to bring this child home? What is being done to pave the way for a successful homecoming?")
- How will we **complete reviews**/follow ups? (Some might be in meetings; others in conference calls)
- How will we **involve family members/youth** in follow ups?

4 Determine who should keep records, what records should be kept, and how long they should be kept.

- For each active case, maintain a 3-ring binder with youth's Community Care Plan, Safety Plan, Crisis Plan, Unified Release of Information, and agendas and minutes related to that youth.
- Keep case records for three years after a case closes.
- Maintain meeting agendas and minutes for two years.
- Make sure record keeping procedures are HIPAA compliant.

5 Decide on meeting management guidelines.

- How **long** should our **meetings** be? (not more than two or three hours)
- **How many cases** should we discuss in a single meeting? (For new cases, plan on about 30 minutes for case planning)
- What should our basic approach to **meeting management** be? What is the best way to facilitate meetings to ensure the best outcomes for youth and our community? (See guidelines on the following pages.)

Template for Memorandum of Agreement

Section	Recommendations
Title	LOCAL INTERAGENCY PLANNING TEAM of _____ County(ies) MEMORANDUM OF AGREEMENT
Purpose of Agreement	May include something like the following: *The purpose of this agreement is to establish a cooperative partnership among the parties for the purpose of operating a Local Interagency Planning Team (LIPT). This LIPT will develop a coordinated system of care for youth with severe emotional disturbance (SED) or substance abuse (SA).*
Parties to the Agreement A. Mandated Agency Representatives B. Other members C. Representation agreement	Mandated Agency Representatives a. DFCS b. DJJ c. MHDDAD (Regional Program Specialists) d. Dept. of Labor, Rehab. Services e. Public Health f. GNET/local public schools g. Local mental health/substance abuse provider Other members h. Parents i. Family Advocate/Parent Partner j. Family Connections member k. Representatives of other local resources Representation agreement—include the following: l. *Agencies represented herein agree to send qualified staff as active, consistent participants*.

Section	Recommendations
Items of Agreement A. Referral a. Children to be referred b. Referral Sources B. Meetings a. Frequency b. Record Keeping c. Leadership d. Decision-Making e. Information-Sharing f. Preparation	Referral a. Children to be referred: See Handbook page 17 to insert criteria for youth served. b. Referral Sources: Youth may be referred from any of the participating agencies. Meetings a. Frequency: Include here the frequency and conditions under which meetings will be held. See Handbook, page 16 for guidance. b. Record Keeping: Include information on who will keep records, where they will be kept, for how long, etc. See Handbook, page 16 for guidance. c. Leadership: Decide and include how the Chair will be selected, how long they will serve, leadership tasks, etc. See Handbook page 16, section 2 for guidance) d. Decision-Making: Decide and include how your LIPT will made decisions. It is preferable that decisions be made by consensus, with voting to occur only when there is an inability to come to agreement. i. Information-Sharing: All parties should agree to share pertinent information with the Team. Include your policies on Confidentiality, and reference the “Unified Release of information) e. Preparation: Include the agreement of all parties, (the Leadership, the Case Manager, and other agency representatives), to come prepared to each meeting. See Handbook page 16 for guidance.

Section	Recommendations
Responsibilities of the Agencies A. Shared responsibility for case planning B. Responsibilities of Presenting Case Manager	Shared responsibility for case planning. Include: a. Community Care Plan b. Safety Plans c. Crisis Plan d. Transition Plans e. Confidentiality and Unified Release of Information Responsibilities of Presenting Case Manager: See Handbook page 20 for guidance.
Process for responding to Crises	Each LIPT should decide on how they will respond to a crisis with a youth within their system of care. This should include additional staffing meetings, contacts with families, crisis response resources, following through with Crisis Plan, etc.
Summary	Include language such as the following: *This agreement will be reviewed annually and revised as necessary.* *This agreement is entered into in good faith by all parties in the spirit of mutual support and partnership.* *Names, Agencies, and Signatures with dates listed below)*

Meeting Preparation

Much of the important work of the LIPT occurs during regular meetings, when members work on case planning and case follow up. Effective LIPT meeting facilitators keep the meetings efficient and well-run by taking the following preparation steps.

Prior to the Meeting:

Case manager:

- Ensure that Unified Release of Information Form is signed.
- Send a request to the chair to get on the meeting agenda.
- Work with the family to complete the *Community Care Plan Background Information* form. Email this to the LIPT chair.
- Make sure the family is prepared for the meeting. Give an overview of the agenda, what they should expect, and what their role will be. If needed, assist them with transportation.
- Work with the family to complete the information on the first page of the *Community Care Plan.* Explain that they will lead off the discussion with this information.
- Prepare a five-minute or less oral presentation of family information for the LIPT. Focus on the most significant information in the Community Care Plan Background Information. This presentation is just to give the LIPT some background information before they are introduced to the family.

LIPT Chair:

- Prepare and distribute agenda to all team members.
- Ensure you have the completed "Background Information" section of Community Care Plan from the case manager and that the case manager has secured a Unified Release of Information and will bring that to the meeting.
- Gather files needed for the meeting.

Meeting Agenda

Having a set format for each meeting and sticking to it will help the team work efficiently and focus on facilitating better outcomes for the community. The suggested agenda below is embedded with system of care principles, legal mandates, and good case planning guidelines.

Chair (Note: You may have a designated meeting facilitator who may complete some of the agenda items designated for the chair):

- Welcome participants and, if needed, introductions.
- Reiterate purpose and goals of LIPT.
- Ask someone to take minutes.
- Verify the list of active cases/status check (Case becomes inactive once youth is no longer receiving services)
- Records should be kept for three years from the date the case is designated "inactive."
- State names of youth being discussed; go over agenda.
- Follow up on all action items from previous meeting.

Case manager from presenting agency (five minutes or less):

- Give an overview of youth's history and current status:
  - Current level of functioning in home, school, and community.
  - Placement history
  - Involvement with DJJ, DFCS, Mental Health, education, and other providers.
  - Family composition and relationship status
  - Youth and family strengths
  - Diagnoses and assessment data
  - Financial resources
- Ensure Confidentiality Form is signed by all attending. If needed, excuse any LIPT members whom the family excluded on the Unified Release of Information Form.
- Introduce family members and sit by them.

Chair:

- Welcome the family and ask members of the LIPT to introduce themselves.
- Ask the family, "Mr./Ms. _____, please share with us your reasons for being here today and describe your family situation.

Parent/guardian:

- Allow parent ample time to discuss the child's life, issues, family situation, and family/child strengths (the information on page one of the plan, which they should have completed with the case manager prior to coming to the meeting). Elicit strengths and interests. Ask parent: *What do you want to see for your child?*

- Note: If parent does not show up for the meeting, reschedule at the family's convenience. (Note that no shows can be dramatically reduced by talking with the parent ahead of time to identify transportation, child care, or other issues. Parents may also participate by phone.)

Chair:

- Ask other LIPT members for additional information about the family/youth's strengths and needs.
- Ask parent/guardian, "What resources would be helpful for your child?" Consider Natural Supports:

  - Neighbors
  - Friends
  - Church
  - Relatives
  - Scout leaders
  - Self help groups (AA, Al-anon, etc.)
  - Civic groups
  - Ethnic-based organizations
  - Neighborhood organizations
  - Parks and recreations departments
  - After school programs and summer programs
  - Mentor
  - Employment counselors
  - Teachers
  - School nurses
  - Graduation coaches
  - Anyone else willing to lend support and help out

Entire LIPT and parent/guardian:

  - Identify needed services for the family and the child. This should be holistic, including such things as budget management and other supports to help the family cope.
  - Do identify one agency/ provider as accountable for overall case management, but DO *not* identify individual service providers at this time.
  - Create a Community Care Plan, Safety Plan, and Crisis Plan for the youth. (Note: These plans will not be finalized at this meeting, but the team should agree on overall approach. The case manager will follow up later with the family to produce final documents.)
  - Identify and document follow-up actions (who, what, when). Include that the case manager will follow up with the parent and present an array of service options for the parent to consider.
  - Identify when the LIPT will follow up with this child. At the second meeting, help family decide among options and create the CCC.
- Thank family.
- Continue to next youth and repeat above steps.

Chair:

- Conclude the session:
  - Confirm all action items.
  - Confirm date and location of next meeting or conference call.
  - Thank LIPT members.
  - Gather all forms required for the Chair to keep.

Agenda Template

Use the information below as a guide when creating forms or templates for meeting agendas.

(Name) Local Interagency Planning Team Meeting

Date and Time:

Location:

Introduction

- 1:00 – 1:05: Welcome and restatement of purpose and goals.
- 1:05 – 1:10: Verify the list of active cases (status check).
- 1:10 – 1:15: State names of youth being discussed; go over agenda.
- 1:15 – 1:30: Follow up on all action items from previous meeting.

New Cases

- 1:30 – 2:00: E'vonte Diamond
- 2:00 – 2:30: Devante Wolerine
- 2:30 – 3:00: Nickolas Desreti

Ongoing Cases (3:00 -3:25)

- Lamond Smithson
- Vika Goring

Wrap Up (3:25 -3:30)

- Action items
- Next meeting

Meeting Minutes Template

Use the information below as a guide when creating forms or templates to use to keep meeting minutes.

Name of LIPT

Date:

Attendees:

Meeting called to order by:

Notes:

Youth's name: (Include a description of the youth's situation.)

Action items: Include follow-up items, along with person responsible and date.

Closing Comments:

Recorder's Name

Meeting Minutes Sample Notes

The notes below are samples of what one LIPT wrote to summarize the current situation and action items of the youth discussed at one meeting.

Vika G. – Vika is having difficulties at home and at school. She has a seriously strained relationship with her mother. She needs help with coping and social skills. Amber is booked until the end of February, and an assessment needs to be done sooner than that because of time constraints. The next court date for her is set for January 29 with Judge Beam.
Action Items: A referral has been made to the Big Sister program, and Ms. Wright will go out to see Vika. Felicia, Shontyre, and Dawn will continue to work closely with the family. Jamie will go out and do a re-enrollment for IFI services.

Marvin D. – Marvin has ADHD and is still not taking his meds. He is acting out at home and at school. Amber stated that the counseling worked out for about two weeks, and then he stopped attending. He did however come back for a session on January 23, 2008. He is scheduled for counseling at ABC Counseling with Amber every Wednesday and Thursday. Laura wants to do a DFCS referral because the mother's alleged crack usage. Mr. El-Amin didn't feel it was necessary because the mother is not using in the home, and the grandmother is Marvin's caretaker.
Action Items: Laurel will give DFCS a call and report the mother's drug usage.

Rick D.- There are concerns that Rick is being verbally abused by Mrs. B. She does not have anything positive to say about him, and she's stated that she wants him out of the home. There was an incident where the police were called because Rick and Mrs. B. got physical. There was no arrest. Dawn expressed concern about Rick meeting his biological mother without having a counselor present. Amber shared the same concern, and stated that Mrs. B. is not consistent with Rick's appointments. Shantyre would like to see Mrs. B. get into some anger management counseling. Mr. Cooper from Greenbriar is concerned about the extent that Mrs. B. will go to get Rick out of the home.
Action Items: KidsNet team will continue to work closely with the family.

Chris W.-Chris was on the run, and was locked up once he was found. Mr. Alvin is his PO, and he offered insight into Chris's criminal background. Right now Chris has pending burglary charges. Mr. Alvin stated that Chris is very creative, and before he was locked up Mr. Roberts had referred him to a creative cultural program. Chris has been referred to Savannah Impact. Kalvin also referred him and his mother to Gateway to see what services would be beneficial to them.
Action Items: Shontyre will check and see if the Medicaid number is valid. A psychological also needs to be done.

Chanda B.- Chanda is being disruptive in class. Mrs. Jackson, her school counselor, is concerned because Chanda has seven unexcused absences. This is the reason that she was retained last year. Mrs. Jackson did a referral to the school social worker to see if the mother would be able to provide the school with the excuses. Ten unexcused absences will cause Chanda to be retained again. Mrs. Jackson also expressed concern about Chanda being jumped on by one of the girls from the neighborhood and that child's mother. Mr. El-Amin made the suggestion that they should try to get out of that environment. Felicia was able to get Chanda into an afterschool tutoring program to help with her grades. Shontyre expressed concern that Chanda's behavior stemmed from the mother's actions, and that the family needed counseling to help with coping and social skills.
Action Items: Shantyre will make the suggestion to mom about changing their environment. A referral to IFI was made.

Team Application: Case Planning

Directions: You've read about Maria Fenton and the Fenton family, and you've seen what members of the hypothetical LIPTs from Eastville, Westfield, and Southtown did to help Maria and her family. Now, it is your turn.

Imagine that Maria is a youth whose family has come to your LIPT for help. As a team, you are going to complete her case planning, imaging that she is a member of *your* community.

To complete this activity, you will need:

- This handbook, especially the Fenton story (page 9), the meeting preparation guidelines (page 20),and the meeting agenda guidelines (page 21).
- A blank crisis plan
- A blank safety plan
- The background information form for the Fentons (already completed for you, as though the case manager had done so before coming to the meeting)
- A community care plan with page one completed by the family

Complete each of these steps:

- Determine roles for the LIPT meeting: Chair, presenting case manager, parent, recorder, agency and provider representatives.
- Complete all preparation steps (page 20).
- Conduct the meeting (page 21).
- Create crisis plan, safety plan, and community care plan.
- Write minutes for Maria's portion of the meeting.

You'll have 1 hour to complete this activity. (It is enough time, but barely, so you'll have to be efficient.)

Team Resources

Family Connection. In some communities, Family Connection staff may be available to serve as the "coordinating body" to ensure LIPT meeting consistency across the state. State Family Connection staff along with the MHDDAD regional staff will partner as the point of contact for state wide planning teams, as explained in the chart below.

Expectations	Optional	Disclaimers	Assurances
•Schedule local planning committee meetings •Contact local agencies •Convene local planning committe meetings •Facilitate local planning committee meetings (i.e., introductions, sign-in sheets)	•Chair local planning committee •Provide facility for meetings •Record the minutes of the meeting	•Not responsible for case management •Not accountable for implementation of case plan •Not responsible for maintaining confidential records of agencies	•MHDDAD and other agencies will provide training and on-going technical assistance •Other state agencies will be available for technical assistance and resource development

Family Connection Partnership, found at www.gafcp.org , also invites all LIPTs to participate in a training on *Results Based Facilitation (RBF)* ™ This two-day training was designed to help you get results through conversation with one person or fifty people. The term facilitation in this training means: "The process of leading participatory discussions on decision making through group engagement and neutral leadership." Maintaining the facilitator role while not being obtrusive to the individual or group and getting results is the focus of a Results Based Faciltatior. Because, in the end, getting people to take ownership, action and get results is what facilitation is all about. *For more information, contact John Bringuel at brin6963@bellsouth.net or 678-245-2740.*

Other resources for LIPT teams include:

- MHDDAD Program Specialist
- DFCS Provider Relations
- DJJ Regional Treatment Service Specialists and Residential Placement Specialists
- KIDSNet (where available)
- Governor's Office for Children and Families
- Regional Action Teams

Learning Journal

Learning Journal

Reflections on the Day

Please take a few minutes and share your thoughts on the following four areas.

Important things I've learned or had reaffirmed. . .	Today's experiences have left me feeling. . .
Questions I want answered now. . .	What I will do when I return to my workplace. . .