Local Interagency Planning Team Manual

Collaborating for Healthy Communities

Team Guidebook

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Overview

Goals of the LIPT:

A Local Interagency Planning Team (LIPT) must[1] be established on behalf of youth and their families 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 purpose for the development of the LIPT is to improve and facilitate the coordination of services for children with behavioral health challenges. The term behavioral health is inclusive of mental health (also known as severe emotional disturbance) and substance use disorders. LIPTs have the following goals:

- To ensure that youth with behavioral health challenges and their families have access to a system of care in their geographic areas;
- To ensure the provision of an array of community therapeutic services;
- To decrease fragmentation and duplication of services, and maximize the utilization of all available resources in providing needed services and supports;
- To facilitate effective referral processes that will ensure that children have access to the services and supports they need to lead productive lives.

Goals of this guide:

This guide is intended to be a resource for LIPTs to provide information about the System of Care (SOC) infrastructure, assist LIPTs as they determine membership, set meeting agendas, and complete case planning and resource development.

This guide contains templates and guidelines for the following LIPT tasks and responsibilities:

- Using the SOC approach in service delivery
- Determining team composition and leadership structure
- Creating agendas and minutes for LIPT meetings
- Effectively facilitating LIPT meetings
- Creating plans with youth and their families

[1] OCGA § 49-5-225

Basic Underpinnings: The System of Care Philosophy

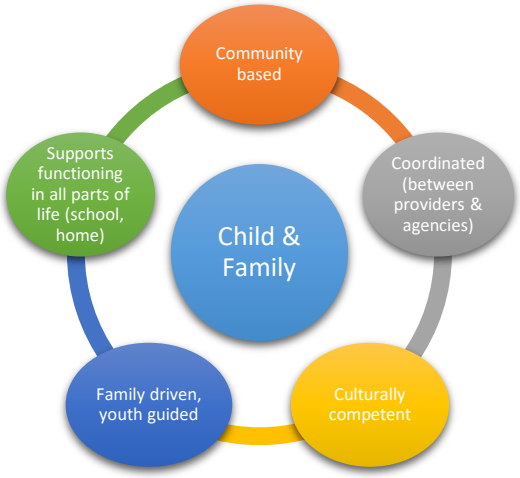
*A **system of care** (SOC) is a spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families, that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them to function better at home, in school, in the community, and throughout life.*

(https://gucchd.georgetown.edu/products/Toolkit_SOC_Resource1.pdf).

Core Values

- The system of care should be **family driven and youth guided,** with the strengths and needs of the child and family determining the types and mix of services and supports provided.
- The system of care should be **community based**, with the focus of services as well as system management resting within a supportive, adaptive infrastructure of structures, processes, and relationships at the community level.
- The system of care should be **culturally and linguistically competent**, with agencies, programs, and services that reflect the cultural, racial, ethnic, and linguistic differences of the populations they serve to facilitate access to and utilization of appropriate services and supports and to eliminate disparities in care.

Figure 1. SOC Approach to Service and Support Delivery



Guiding Principles

1. Ensure *availability and access* to a broad, flexible array of effective, community-based services and supports for children and their families that address their emotional, social, educational, and physical needs, including traditional and nontraditional services as well as natural and informal supports.
2. Provide *individualized* services in accordance with the unique potentials and needs of each child and family, guided by a strengths-based, wraparound service planning process and an individualized service plan developed in true partnership with the child and family.
3. Ensure that services and supports include *evidence-informed and promising practices*, as well as interventions supported by practice-based evidence, to ensure the effectiveness of services and improve outcomes for children and their families.
4. Deliver services and supports within the *least restrictive, most normative environments* that are clinically appropriate.
5. Ensure that *families, other caregivers, and youth are full partners* in all aspects of the planning and delivery of their own services and in the policies and procedures that govern care for all children and youth in their community, state, territory, tribe, and nation.
6. Ensure that services are *integrated* at the system level, with linkages between child-serving agencies and programs across administrative and funding boundaries and mechanisms for system-level management, coordination, and integrated care management.
7. Provide *care management* or similar mechanisms at the practice level to ensure that multiple services are delivered in a coordinated and therapeutic manner and that children and their families can move through the system of services in accordance with their changing needs.
8. Provide *developmentally appropriate* mental health services and supports that promote optimal social-emotional outcomes for young children and their families in their homes and community settings.
9. Provide developmentally appropriate services and supports to facilitate the *transition of youth* to adulthood and to the adult service system as needed.
10. Incorporate or link with *mental health promotion, prevention, and early identification and intervention* in order to improve long-term outcomes, including mechanisms to identify problems at an earlier stage and mental health promotion and prevention activities directed at all children and adolescents.
11. Incorporate *continuous accountability and quality improvement* mechanisms to track, monitor, and manage the achievement of system of care goals; fidelity to the system of care philosophy; and quality, effectiveness, and outcomes at the system level, practice level, and child and family level.
12. *Protect the rights* of children and families and promote effective advocacy efforts.
13. Provide *services and supports without regard* to race, religion, national origin, gender, gender expression, sexual orientation, physical disability, socio-economic status, geography, language, immigration status, or other characteristics, and ensure that services are sensitive and responsive to these differences.

Stroul, B., Blau, G., & Friedman, R. (2010). Updating the system of care concept and philosophy. Washington, DC: Georgetown University Center for Child and Human Development, National Technical Assistance Center for Children's Mental Health.

SOC Infrastructure in Georgia

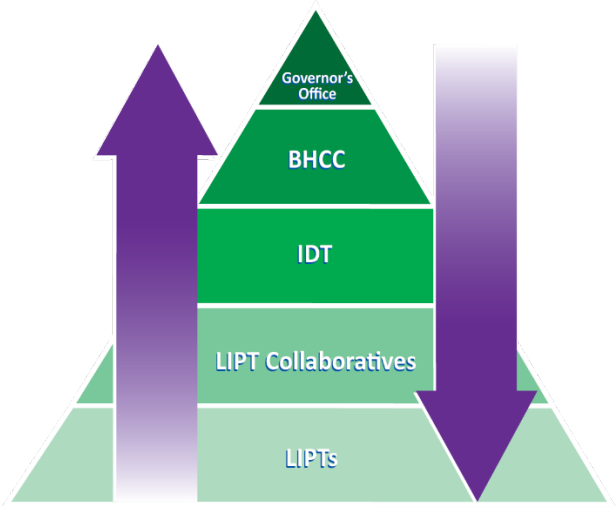
Behavioral Health Coordinating Council (BHCC): the BHCC was created (O.C.G.A. § 37-2-4), to promote child and adult behavioral health coordination among state agencies at the commissioner level. The BHCC identifies and ensures the coordination of overlapping behavioral health services, funding, and policy within the state and among state agencies. The BHCC is chaired by the commissioner of the Department of Behavioral Health and Developmental Disabilities (DBHDD) and is composed of Commissioners from agencies that interact with the behavioral health and criminal justice systems, as well as legislators, consumers, consumer family members, and the state ombudsman. The BHCC chair collaborates directly with the Governor's office, and the BHCC provides high-level support for and guidance to the Interagency Directors Team (IDT).

Interagency Director's Team (IDT): The IDT is a multi-agency, public-private collaborative created to design, manage, facilitate, and implement an integrated approach to SOC that informs policy and practice, and shares resources and funding. The IDT functions as a workgroup of the BHCC and currently consists of representatives from state agencies and nongovernmental organizations that serve children with behavioral health needs. The IDT leads the implementation of Georgia's SOC State Plan.

LIPT Collaboratives (LCs): LCs have two main functions: to create a feedback loop between IDT and LIPTs to address regional issues, and to provide a regional opportunity for collaborative learning and service coordination. LCs align with the six DBHDD regions and are comprised of LIPT chairs in the respective region.

Local Interagency Planning Teams (LIPTs): LIPTs are comprised of legislatively mandated local or county-level child-serving agencies and partner participants that work with families to improve and coordinate services for youth with a mental health diagnosis. The approach, based on the SOC framework, is child centered, and highlights family strengths and supports by providing needed care and resources in the home and community. LIPTs are spearheaded by a volunteer chairperson and are present in almost every county in Georgia; however, some LIPTs serve multiple counties depending on the size of the community and the geographic availability of needed resources.

Figure 2. Feedback Framework



Better Outcomes: The SOC Philosophy

Examples of systems working together to improve mental health services:

Infrastructure: Examples of SOC infrastructure in Georgia are demonstrated through the BHCC, IDT at the state level, LIPT Collaboratives at the regional level, and LIPTs located across the state at the local/county level.

Philosophy: The DBHDD Office of Children, Young Adults, and Families (CYF) and IDT sponsor a SOC Academy for child-serving stakeholders, youth, and families annually in Georgia. The SOC Academy is a children's behavioral health conference offering Certified Education Unit approved workshops focused on prevention, wellness, education, and recovery, and features keynote speakers. The academy serves to expand awareness of and education about the SOC philosophy across the state.

Interventions Peer Support and School-Based Mental Health are important supports implemented through various agencies across the state, including Georgia Apex.[2]

Highlight of SOC in GA: Peer Support

Parent and Youth Certified Peer Specialists (CPSs-P & -Y) are responsible for the implementation of peer support services, which are Medicaid reimbursable under Georgia's Rehabilitation Option. Peer support is a SOC informed, recovery-oriented peer certification; continued education training; and workforce development, for parents and youth with lived experience.

CPSs provide hope and model that possibility to every peer they are partnered with. As paid employees of our public and private behavioral health providers, CPSs neatly transition ownership of the program into the hands of their peers. Through their lived experience with recovery, they lend unique insight into behavioral health and what makes recovery possible.

CPSs are part of the shift that is taking place in the Georgia Behavioral Health System from one that focuses on the individual's *illness* to one that focuses on the individual's *strength*.

[2] Georgia Apex Program began in 2015 and is implemented through DBHDD.

Culturally and Linguistically Competent Service Delivery

The SOC philosophy includes addressing the cultural and linguistic needs of youth and families. In LIPT meetings, it is important that a culturally appropriate approach is used among team members for meeting with, and on behalf of families.

Culturally and linguistically appropriate services (CLAS) are respectful of and responsive to the health beliefs, practices, and needs of diverse individuals.

The National Standards for CLAS in Health and Health Care

Principal Standard

(1) Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

Governance, Leadership, and Workforce

(2) Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.
(3) Recruit, promote, and support a culturally and linguistically diverse governance, leadership and workforce that are responsive to the population in the service area.
(4) Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Communication and Language Assistance

(5) Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
(6) Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
(7) Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
(8) Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Engagement, Continuous Improvement, and Accountability

(9) Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organizations' planning and operations.
(10) Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into assessment measurement and continuous quality improvement activities.

(11) Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
(12) Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
(13) Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
(14) Create conflict- and grievance-resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
(15) Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents and the general public.

The National CLAS Standards. (2018, May 22). Retrieved from Office of Minority Health, https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=53

Legislation supporting Georgia's SOC

Georgia 49-5-220: SOC State Plan

(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 use of public funds are inappropriately placed out of state; and

(6) Develop a coordinated SOC 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 General Assembly intends that the DBHDDs shall have the primary responsibility for planning, developing, and implementing the coordinated SOC for severely 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 (DOE) provide appropriate education in accordance with P.L. 94-142 and that the DBHDDs provide mental health treatment.

(c) Further, in recognition that only a portion of the children needing services are receiving them and in recognition that not all of the services that comprise a coordinated SOC are currently in existence or do not exist in adequate numbers, the General Assembly intends that the DBHDDs and the DOE jointly develop and implement a State Plan for the Coordinated SOC for severely or emotionally disturbed children or adolescents as defined in paragraph (10) of Code Section 49-5-221.

(d) The commissioner of behavioral health and developmental disabilities and the State School Superintendent shall be responsible for the development and implementation of the state plan.

(e) The commissioner of behavioral health and developmental disabilities shall be responsible for preparing this jointly developed state plan for print or electronic publication and dissemination. The commissioner of behavioral health and developmental disabilities shall also be responsible for preparing for print or electronic publication and dissemination the annual report.

(f) The receipt of services under this article is not intended to be conditioned upon placement of a child in the legal custody, protective supervision, or protection of the Department of Human Services.

Georgia 37-2-4: BHCC; membership; meetings; obligations

(a) There is created the BHCC. The council shall consist of the commissioner of behavioral health and developmental disabilities; the commissioner of community health; the commissioner of human services; the commissioner of juvenile justice; the commissioner of corrections; the commissioner of community affairs; the Commissioner of Labor; the State School Superintendent; the chairperson of the State Board of Pardons and Paroles; the ombudsman appointed pursuant to Code Section 37-2-32; an adult consumer of public behavioral health services, appointed by the Governor; a family member of a consumer of public behavioral health services, appointed by the Governor; a parent of a child receiving public behavioral health services, appointed by the Governor; a member of the House of Representatives, appointed by the Speaker of the House of Representatives; and a member of the Senate, appointed by the Lieutenant Governor.

(b) The commissioner of behavioral health and developmental disabilities shall be the chairperson of the council. A vice chairperson and a secretary shall be selected by the members of the council as prescribed in the council's bylaws.

(c) Meetings of the council shall be held quarterly, or more frequently, on the call of the chairperson. Meetings of the council shall be held with no less than five days' public notice for regular meetings and with such notice as the bylaws may prescribe for special meetings. Each member shall be given written notice of all meetings. All meetings of the council shall be subject to the provisions of Chapter 14 of Title 50. Minutes or transcripts shall be kept of all meetings of the council and shall include a record of the votes of each member, specifying the yea or nay vote or absence of each member, on all questions and matters coming before the council. No member may abstain from a vote other than for reasons constituting disqualification to the satisfaction of a majority of a quorum of the council on a recorded vote. No member of the council shall be represented by a delegate or agent.

(d) Except as otherwise provided in this Code section, a majority of the members of the council then in office shall constitute a quorum for the transaction of business. No vacancy on the council shall impair the right of the quorum to exercise the powers and perform the duties of the council. The vote of a majority of the members of the council present at the time of the vote, if a quorum is present at such time, shall be the act of the council unless the vote of a greater number is required by law or by the bylaws of the council.

(e) The council shall:

(1) Develop solutions to the systemic barriers or problems to the delivery of behavioral health services by making recommendations that implement funding, policy changes, practice changes, and evaluation of specific goals designed to improve services delivery and outcome for individuals served by the various departments;

(2) Focus on specific goals designed to resolve issues for provision of behavioral health services that negatively impact individuals serviced by at least two departments;

(3) Monitor and evaluate the implementation of established goals; and

(4) Establish common outcome measures.

(f)

(1) The council may consult with various entities, including state agencies, councils, and advisory committees and other advisory groups as deemed appropriate by the council.

(2) All state departments, agencies, boards, bureaus, commissions, and authorities are authorized and required to make available to the council access to records or data, which are available in electronic format or, if electronic format is unavailable, in whatever format is available. The judicial and legislative branches are authorized to likewise provide such access to the council.

(g) The council shall be attached to the DBHDDs for administrative purposes only as provided by Code Section 50-4-3.

(h)

(1) The council shall submit annual reports of its recommendations and evaluation of their implementation to the Governor and the General Assembly.

(2) The recommendations developed by the council shall be presented to the board of each member department for approval or review at least annually.

(i) For purposes of this Code section, the term "behavioral health services" has the same meaning as "disability services" as defined in Code Section 37-1-1.

Georgia 49-5-225 [excerpt]: LIPTs

(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 General Assembly intends that the DBHDDs shall have the primary responsibility for planning, developing, and implementing the coordinated SOC for severely 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 DOE provide appropriate education in accordance with P.L. 94-142 and that the DBHDDs provide mental health treatment.*

In regard 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 DBHDDs 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 Services;

(3) The Department of Juvenile Justice;

(4) The Department of Public Health;

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

(6) The Georgia Vocational Rehabilitation Agency.

(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.

LIPT Basics: Forming and Organizing the Team

1 Identify and recruit members on an ongoing basis. The size of the LIPT may vary; however, the following agencies must be represented in the LIPT:

- ✓ DFCS representative
- ✓ DJJ representative
- ✓ Georgia Vocational Rehabilitation Agency representative
- ✓ Public health representative
- ✓ Local Education Agency (LEA)
- ✓ Local mental health service providers

In addition, it is strongly recommended that at least one parent or legal guardian be present during discussions about a youth. While parents/guardians are not permanent members of the team in the sense that they are not required to be present when youth are 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/guardian team members:

- ✓ It is strongly recommended and encouraged that the parent/guardian be present during the entire time their child is discussed, with the exception of the initial short presentation by the lead case manager.
- ✓ Always keep the parent/guardian involved, as indicated in the agenda guidelines on page 22.
- ✓ If a parent/guardian is unable to make a meeting, try to reschedule at a time that is convenient for them.
- ✓ Avoid "no shows" by discussing challenges such as transportation and childcare ahead of time.
- ✓ If necessary, the parent/guardian can participate remotely (e.g., phone, video conference).
- ✓ Include the parent/guardian in the follow-up meetings (participation can be done remotely), especially during a transition period.
- ✓ Include the youth where possible and appropriate.

Roles of mandated LIPT agencies (not limited to roles listed):

1. Department of Juvenile Justice (DJJ) – to identify community-based services and supports to prevent youth from entering the legal system as well as support youth in custody upon re-entry into their communities.

1) Department of Family and Children Services (DFCS) – to refer children considered for residential treatment to LIPT for staffing, review decisions about placement of children and adolescents in out-of-home treatment or placement, and monitor youth's progress.

2) Local Education Agency/Schools/Special Education – to work with families and youth in the adherence to an educational plan and ensure continuity of services in the school setting.

3) Department of Public Health (DPH) – to address health needs (physical exams, health education in schools, and family health support) to all youth as appropriate.

4) Georgia Vocational Rehabilitation Agency (GVRA) – to provide job assistance, training, and placement for eligible youth with a physical and/or mental disability and their families.

2 Set up a structure to facilitate the work of the team. Review and discussion of operating guidelines between partners will strengthen the accountability processes for outcomes.

Team Leadership: An LIPT should have a chairperson responsible for calling and presiding over all meetings. Each chairperson should receive training from the previous chairperson and/or the DBHDD CYF Program Specialist (see onboarding process on page 17). It is suggested that the chair serve for a term of one to two years. Other leadership tasks on the team—such as providing an agenda, taking and distributing minutes, and other 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 operating guidelines. The co-chair fulfills the role of the chairperson in his/her absence. The secretary should be the recorder for all meeting documents and discussions. The secretary provides meeting minutes and completed forms to the chairperson at the conclusion of all meetings. The onboarding process is detailed on page 17.

It is advised that a team approach (chair, co-chair, secretary) be used to ensure appropriate team support. Prior to appointment, each team should develop a plan of succession for the chairperson role after the term of service. Examples can be automatic succession from co-chair to chair, agency rotation (each agency representative rotates the role), or longest tenured LIPT member assumes the chair position.

Team Member Role: as an LIPT member, it is important to be present and engaged in the planning process. This includes identifying youth in need of service and making referrals to LIPT, helping to identify services at your agency and/or in the community, and ensuring youth are connected to and followed in appropriate services. Each team member should be given an overview of the LIPT functions and processes when joining the team.

3 Discuss the criteria for youth to be served by the team. Generally, most LIPTs discuss youth whose service needs exceed those that a 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 youth with BH needs an LIPT can serve are:

1. Transition from inpatient facility to the community

2. Psychiatric Residential Treatment Facility (PRTF)/Intensive Customized Care Coordination transition

3. Crisis Stabilization Program transition

4. Other youth at risk of out-of-home placement or treatment, including the following:

   a. Frequent use of psychiatric hospitals or crisis/emergency services, including mobile crisis, in-clinic, or crisis stabilization units (e.g., two or more admissions per year)
   b. Use of high-end substance use services, including Intensive Residential Treatment (IRT) and group home discharges
   c. Involvement with the juvenile justice system
   d. Harm to self or others or clinical evidence of threats of harm to self or others within last three months

Other considerations around case management include:

- **How often** will we review each case? Guidelines: Weekly if youth is in crisis, bi-weekly if the youth has continued challenging behaviors, monthly if there has been a recent or upcoming change, and bi-monthly if youth is stable. If the child is in residential services, then follow up at least monthly and bring a sense of urgency about planning and preparing for the child's return home. In follow-up meetings, make sure 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?" Hold monthly meetings for discussing youth and follow-up as needed and/or recommended by team.
- **How long** should youth remain on the discussion docket? Youth can be removed from the main docket once they are showing maintenance in care and services, as determined by the family and team. However, youth and families with previous LIPT involvement can be added back to the docket and be reviewed whenever needed, at any time.
- How will we **complete reviews**/follow up? (Some might be in meetings; others in conference calls).
- How will we **involve family members/youth** in follow up? Family and youth involvement are strongly encouraged throughout the LIPT process. Youth and families can attend in person or call in to the meeting. The referring agency can receive updates from the families and report back to the team on progress, and challenges, if approved by the family.

4 Decide on meeting management guidelines.

- The **length of meetings**. (Not more than two or three hours.)
- The **number of youths** to review during a single meeting. (For an initial meeting, plan on 30-45 minutes for planning). This will also be determined by the capacity and participation of team members.
- Basic approach to **meeting management**. What is the best way to

facilitate meetings to ensure the best outcomes for youth and community? (See guidelines on the following pages.)

- Disagreement or dispute resolution guidance.

Onboarding process for LIPT Chairperson

- The role of the LIPT chairperson is to provide leadership for the team and facilitate meetings for youth with or at risk for behavioral health challenges and their families.
- The chairperson can be a member of a mandated agency or a community organization working with children.
- The LIPT chairperson should review the mission and vision of LIPT in addition to the SOC principles.
- When a person is interested in LIPT, they are to contact their respective DBHDD CYF Program Specialist listed on page 27-28.
    - The specialist provides necessary documents to conduct the meetings and an overview of LIPT. Meeting documents include the unified Release of Information, background information form, community care plan, safety plan, crisis plan, and SOC confidentiality agreement.
    - LIPT information to be given to the chairperson is the LIPT manual, LIPT brochure, and LIPT meeting forms.
    - Every LIPT chairperson should be provided training about both the LIPT and the chairperson role. This includes:
        - Contact information for LIPT participants
        - Electronic contact information (i.e., email and list servs)
        - Access to previous client data/files
        - Overview of SOC state plan and connection with regional and state level stakeholders (SOC Program Manager will provide resources/support)
        - The chairperson should extensively review the LIPT manual to understand the guidelines and requirements for the chairperson role.
- It is strongly recommended that the LIPT chairperson attend and observe a nearby LIPT meeting and/or review the two-part LIPT YouTube video https://youtu.be/MvA_ikqSKk8 and https://youtu.be/uR0V35IHY7w.
- The first 1-2 meetings should be monitored and supported by the respective CYF Program Specialist.
- The program specialist should contact the SOC Program Manager to update the county chairperson information in the LIPT Master Chair contact directory when needed.
- The program specialists serve to provide ongoing technical assistance to the LIPTs located in his/her region.

Resignation/Dismissal of LIPT Chairperson

- When an LIPT chair decides to vacate the position, he/she is asked to give 30 days' advanced notice to team members and the CYF Program Specialist.
    - If a co-chair is in place, it is expected they will step into the chair role permanently or on an interim basis.
- The chair contact information should be removed from the chair list, email correspondence, and listservs. No LIPT emails should be sent from an inactive chairperson.
    - If the chair continues participation as a team member, they will be added to email correspondence in that role.
- In the event there are challenges with filling the chair role, it is recommended that a representative from a mandated agency be appointed to temporarily fill the role until a permanent chair can be assigned for the team.
- Once a new chair is identified, he/she will go through the onboarding process with the CYF Program Specialist.

LIPT and CHINS Youth

With service planning, there is sometimes overlap and confusion with appropriate referrals being made to the LIPT versus Children in Need of Services (CHINS)[3] planning meeting. The chart below has been developed as a resource to use when deciding on next steps/referral recommendations for a child.

Tips for combining LIPT and CHINS meetings:

1. Meetings should not be blended. The meetings are separate and have different purposes, therefore, a meeting should be officially adjourned before beginning the next meeting.
2. All necessary forms still need to be signed at the *beginning* of the LIPT meeting.
3. Essential participants should be present for each meeting. Some individuals may need to leave based on the family's decision and/or legislation.

LIPT and CHINS Comparison Chart

	Local Interagency Planning Team (LIPT)	Children in Need of Services (CHINS)
Purpose	To improve and facilitate the coordination of services to youth with behavioral health challenges.	Separate status offenders from delinquent offenders; resolve case before formal court hearing is needed; provide youth with multi-agency approach.
Family driven	Yes, families are central to LIPT; meetings should not be held without them present.	Families are strongly encouraged to participate in CHINS.
Mandated agencies' participation	Local mental health agency, DJJ, DFCS, LEA/special education, Vocational Rehab, DPH.	DJJ, DFCS, involvement from independent courts, schools.
Court-mandated	No, LIPT participation is voluntary for families. Service recommendations are made but participation is not mandatory.	CHINS is not court mandated but is a precursor to court. A case should only be petitioned to court if there is a charge or severe MH issue. Court intervention is used to receive support/help.

[3] OCGA 15-11-2: (11) "Child in need of services" means: (A) a child adjudicated to be in need of care, guidance, counseling, structure, supervision, treatment, or rehabilitation and who is adjudicated to be: truant, a runaway, stubborn child, and habitual school offender.

Eligibility	Youth with behavioral health challenges and/or substance use disorder.	Status offenders under age 17 including truant, runaways, child offenders; needs supervision but not treatment or rehabilitation

Meeting Preparation

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

Referral Process for Staffing:

- Anyone can refer a child to LIPT (including family members).
  - Child-serving agencies and/or LIPT members are asked to identify and refer eligible youth to LIPT.
- The chairperson will send forms to referring agency to have signed by the family prior to the meeting.
- The referring agency is responsible for explaining the LIPT process to family members and maintaining communication with the family.
- The referring agency should also be sure the LIPT process is explained to the youth in a way that is developmentally appropriate.
- Meeting attendance is to be coordinated and confirmed with the family by the referring agency and communicated to the chairperson.

Pre-Meeting:

Presenter/individual discussing the youth:

- 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 *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 the importance of their role on the team. If available, assist them with transportation coordination.
- Work with the family to complete the information on the first page of the *Community Care Plan*. Explain discussion will begin with this information.
- Prepare a three-minute or less oral presentation of family information for the LIPT. Focus on the most significant information in the *Community Care Plan* form.
  - This presentation is only to give the LIPT some **background** information before they are introduced to the family.

LIPT Chair:

- Prepare and email the agenda to all team members.
  - Make sure youth information is private.

- Check completion of the "Background Information" section of *Community Care Plan* from the case manager and that the referring party has secured a *Unified Release of Information* and will bring that to the meeting.
- Gather documents needed for the meeting.
- When sending meeting notifications out to team, be mindful of privacy. Do not include any confidential information in unsecured communication (e.g., email, fax, etc.). Be sure to send confidential information in a password protected file or only use de-identified information, for example, E. Jones.

Sample Email Correspondence with Team Members

> Greetings team members!
>
> Here is the calendar invite for the next _(county name)_ County LIPT meeting. It will take place on the __(date)_____ of the month from _(time)___ at _(location)__. Your participation and youth referrals are requested.
>
> The mandated partners include:
>
> - **Department of Behavioral Health and Developmental Disabilities (DBHDD)**
> - **Department of Juvenile Justice (DJJ)**
> - **Public Education/Special Education**
> - **Department of Public Health**
> - **Division of Family and Children Services (DFCS)**
> - **Georgia Vocational Rehabilitation Agency (Voc Rehab)**
> - **Behavioral Health Providers and Facilities**
>
> Your participation is needed so that we can collectively best serve the youth and families in _____ County. Please join us!
>
> Signed, LIPT Chair

Post-Meeting:

- After the meeting, the chairperson is responsible for gathering meeting data and appropriately storing documents.
  - The secretary is responsible for providing the appropriate documents to the chair following each meeting.
  - Monitoring agencies should be prepared to report/give an update on youth at the next meeting.
- Any recommendations or referrals should be followed up with by the responsible party.

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 (next) is embedded with SOC principles, legal mandates, and good case planning guidelines.

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

1. Welcome participants and make introductions.
2. Reiterate purpose and goals of LIPT.
    a. Review SOC guiding principles.
    b. Emphasize importance of the meeting being driven by the family.
3. Ask someone to take minutes.
4. Verify the list of active youth/status check. (Youth becomes inactive once they are no longer receiving services)
5. State name(s) of youth being discussed; review agenda.
6. Follow up on all action items from previous meeting.

Representative from referral agency (three minutes or less):

1. 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.
2. Give a brief overview of youth's history and current status.
3. Introduce family members and sit by them.

Chair:

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

Parent/guardian:

1. Allow parent/guardian 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 prior to attending the meeting).
    a. Current level of functioning in home, school, and community.
    b. Placement and treatment history.
    c. Involvement with DJJ, DFCS, mental health, education, and other providers.
    d. Family composition and relationship status.
    e. Youth and family strengths and interests.
    f. Diagnoses and assessment data.
    g. Financial resources.
2. Ask parent/guardian: "What are your goals or what would you like to see for your child?

Note: If parent/guardian does not show up for the meeting, reschedule at the family's convenience. (Note: no-shows can be dramatically reduced by talking with family members

ahead of time to identify transportation, childcare, or potential barriers to attending. Parent/guardians may also participate by phone.)

Chair:

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

Natural Supports

- Neighbors
- Friends
- Church/faith-based organizations
- Relatives
- Scout leaders
- Self-help groups (i.e., AA, Al-anon
- Civic groups
- Ethnic-based organizations
- Neighborhood organizations
- Parks and recreation 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:

1. Identify needed services and supports for the family and the youth. This should be holistic, including such things as budget management and other supports to help the family succeed.
2. Identify one agency/provider as accountable for overall management, but do not identify individual service providers at this time.
3. Create a *Community Care Plan (CCP), Safety Plan,* and *Crisis Plan* for the youth. Plans will not be finalized at this meeting, but the team should agree on overall approach. The referring agency provides family with final documents.
4. Identify and document follow-up actions (who, what, when). Include that the presenter will follow up with the parent/guardian and present an array of service options for their consideration.
5. Identify when the LIPT will follow up with this child. At the second meeting, help family decide among options and create the CCP.
6. Thank family.
7. Continue to next youth and repeat above steps.

Chair:

1. Conclude the session.
2. Confirm all action items.
3. Confirm date and location of next meeting or conference call.
4. Thank LIPT members.
5. 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. Include brief overview of SOC guiding principles.
1:05 – 1:10: After having all participants sign the confidentiality agreement, verify the list of active youth to discuss (status update).
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 Referrals

1:30 – 2:00: E. Diamond
2:15 – 2:45: D. Wolerine
2:45 – 3:15: N. Desreti

Follow-up Referrals (3:15 -3:35)

L. Smithson
V. Goring

Wrap Up (3:35 -3:40)

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:

Secretary/Recorder's Name

Meeting Minutes Sample Notes

The following notes 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, Shantyre, 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, 2020. 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 drug 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 use.

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: The Keys Family Support team will continue to work closely with the family.

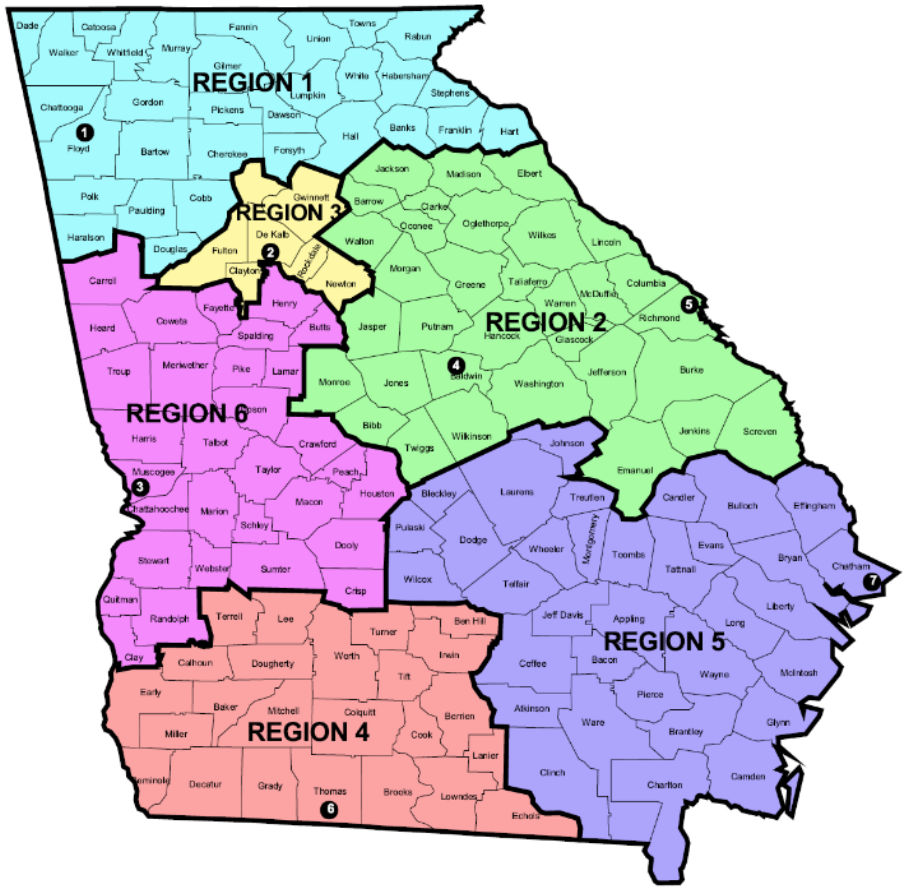
Chris W. – Chris was on the run and was locked up once he was found. Mr. Alvin is his PO, and he offered insight into Chris's criminal background. Right now, Chris has pending burglary charges. Mr. Alvin stated that Chris is very creative, and before he was locked up Mr. Roberts had referred him to a 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: Shantyre 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 suggested 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. Shantyre 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 suggest to mom about changing their environment. A referral to IFI was made.

Team Resources

Ongoing SOC related training such as SOC leadership, cultural, and linguistic competence, and LIPT training are available to LIPT chairpersons and team members as needed. Refresher trainings and additional supportive workshops are also available. For more information, please contact the SOC Program Manager, La'Keidra Mitchell, lmitchelll@gsu.edu.

DBHDD regional staff serve as the point of contact for local and regional planning teams. Please see contact information (below).



- DBHDD Children, Young Adults, and Families (CYF) Program Specialists
  - Region 1: Eileen Murphy
    - Email: eileen.murphy@dbhdd.ga.gov
    - Phone: 470-379-5937
  - Region 2: Kimberly Dempsey
    - Email: Kimberly.dempsey@dbhdd.ga.gov
    - Phone: 706-792-7663
  - Region 3: Olga Pittman
    - Email: olga.pittman@dbhdd.ga.gov

        - Phone: 404-244-5045
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        - Email: todd.jones@dbhdd.ga.gov
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        - Phone: 912-303-1670
    - Region 6: Jackie Ezell
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➢ Additional resources can be found at www.gacoeonline.gsu.edu/soc.

➢ Learning Journal