



REPORT / CHILDREN'S MENTAL HEALTH

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The Residential Treatment Initiative to Prevent Parental Relinquishment: 2019 Evaluation Report

Submitted to the Texas Health and Human Services Commission



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Contents

Introduction	1
Background	1
Quality Improvement Support.....	2
Communication Activities	2
Policy and Procedure Refinement	2
Database and Tracking Document.....	2
Evaluation Study	3
Evaluation Design.....	3
2018 Evaluation Progress.....	3
2019 Evaluation Progress.....	3
Evaluation Results	5
2019 Evaluation Summary	5
Referrals to the RTC Project.....	5
Community-based Coordination.....	7
Looking Forward: Challenges and Opportunities.....	10
Challenges/Opportunities for the RTC Project	10
Recommendations and Next Steps	11
Next Steps for Evaluation.....	Error! Bookmark not defined.

Introduction

Background

Texas has documented a significant problem with mental health access, where families of children and youth with severe emotional disturbances are unable to access intensive mental health services (Child & Family Research Institute, 2014). To access these services when private health insurance is not available or mental health benefit limits have been exceeded, families turn to the child welfare system to take conservatorship of the child or youth to access a placement within a residential treatment facility. In these circumstances, caregivers are faced with the heartbreaking choice of refusing to care for their youth and relinquishing their parental rights through a judicial process or failing to get their youth needed care. In the 83rd Texas Legislative Session, the Department of State Health Services (moved to the Health and Human Services Commission, HHSC) was provided with \$2 million for the biennium to implement a program in partnership with the Department of Family and Protective Services (DFPS). Within this program, families referred to child welfare in which investigations find no evidence of abuse, but rather caregivers are solely referred due to a lack of access to intensive mental health services, are offered placement in contracted residential treatment centers (RTC) across the state. Caregivers retain their parental rights and services are focused on supporting families in reunification following treatment. The program began placing youth in need of residential treatment in January 2014 with funding to serve up to 10 youth at a time in residential treatment. The program has received additional funding in the 84th, 85th and 86th Legislative Sessions to increase program capacity. This capacity increase has allowed funding for additional youth to be placed, but has not provided additional funding for program management or increases in reimbursement rates for treatment centers.

The Texas Health and Human Services Commission contracts with the Texas Institute for Excellence in Mental Health (TIEMH) to conduct an evaluation of the program. In previous years, TIEMH has conducted a qualitative study of project implementation and documented the number of children served in the program and their reasons for exiting the program. Additionally, the evaluation has examined the services and outcomes of the supports provided by Local Mental Health Authorities both during and following residential placement of children. This report updates those findings with additional activities. TIEMH staff have also offered to provide support to program staff, as needed, with addressing previous evaluation recommendations.

Quality Improvement Support

Communication Activities

In 2018, TIEMH worked with HHSC and DFPS project staff to develop recorded webinars to increase understanding of the RTC initiative, outline the roles and responsibilities of key partners, and provide a summary of contractual expectations for LMHAs and RTCs. This was a recommendation from staff representing RTCs and LMHAs, who noted that increased communication would enhance their ability to serve families when referred to the program. While a number of webinars were developed and recorded, there have been challenges with identifying the best platform for posting these resources and the best methods for disseminating this information. Towards the end of FY 2019, HHSC and DFPS staff agreed that there have been enough significant changes in policies and procedures that re-recording some webinars is warranted. These webinars are currently under review for approval by DFPS.

In FY 2019, HHSC developed a webpage with information on the RTC initiative, primarily targeting caregivers of children. This webpage provides information on the purpose of the initiative, characteristics of eligible children, services and supports offered in the program, and how to access the services. This communication tool provides some basic information for parents or other caregivers, and is available in an easy to access format. Clear communication about the program continues to be a need, especially for mental health and child welfare staff who may encounter families appropriate for the services or have a role in the programs success.

Policy and Procedure Refinement

TIEMH staff have participated in monthly meetings with HHSC and DFPS project staff to continue exploring methods for refining available policies and procedures. These meetings have allowed for the identification of areas where DFPS and HHSC policies may not align, to coordinate strategies for supporting individuals with unique circumstances, and to brainstorm pathways for continued improvement across the RTC initiative. TIEMH staff play a facilitative role, supporting processes for decisions to be made and documented.

Database and Tracking Document

In 2017 and 2018, TIEMH recommended that HHSC consider enhancing the tracking database, used to document referrals to the program and subsequent activities, to allow for increased efficiencies and data quality. Since these recommendations, there have been a number of changes made to the existing tracking documents. While these newer documents allow for more effective tracking of individuals in the initiative, the absence of a comprehensive tracking tool continues to be a challenge. Current processes may require updates to be entered into multiple places. While the system has been improved through clearer documentation processes, concerns remain that the multi-step procedure may be prone to inaccuracies and inefficient. The system may also be challenging to manage during times of staff turnover or absences. Collaborative meetings each month have allowed for easier sharing of tracking data between TIEMH and HHSC project staff.

Evaluation Study

Evaluation Design

Aim of Evaluation. The goal of the overall evaluation is to document the impact of the RTC initiative on children and families in Texas and identify potential opportunities to strengthen the program. Over the course of the evaluation, the evaluators aim to address the following questions:

- What are the characteristics of the youth and families served in the RTC initiative? Are there characteristics of families or placements that predict successful outcomes (e.g., reunification with family)?
- Do caregivers find the treatment provided through the program acceptable? Do they report perceptions that the child has improved following treatment?
- What percentage of youth placed on the waiting list for RTC placement are successfully served without an out-of-home placement? What are the characteristics of the family and service system that may be related to successful intervention without a RTC placement?
- What strengths and barriers do caregivers report to accessing effective mental health care within the RTC initiative?
- What strengths and barriers do center administrators report related to referral processes, treatment planning, continuity with community providers, and coordination with state agencies?
- What strengths and barriers do local mental health providers report related to eligibility assessment processes, maintenance of families on the wait list, coordination of care during placement, and continuity planning?

2018 Evaluation Progress

The goal of the second year of the evaluation was to develop an evaluation plan to gather longitudinal data on child and family outcomes following participation in the RTC initiative, obtain any required approvals, and begin data collection. The evaluation team held two initial meetings with HHSC program staff to review the results of the evaluation, discuss recommendations, and identify priorities for the year. Some of the priorities identified included examining the process through which children and youth are placed within a residential center, creating a series of webinar for additional outreach and communication about the project, and exploring how data can best be captured to track individuals in the project. There were also a strong recommendation to train LMHAs and RTCs on the consent process for recruiting families to participate in evaluation.

2019 Evaluation Progress

Revising the Consent Process. The goal of the third year of the evaluation was to revise the plan for obtaining informed consents from families enrolled in the RTC Project to participate in evaluation surveys and implement the revised plan. Prior to this year, there were hopes that HHSC would be able to send letters directly to the youth and families involved in the RTC initiative to introduce the evaluation and begin the consent process. Receiving approval from HHSC for this approach proved to be challenging. A change was made to the process so that LMHAs are responsible for obtaining the informed consent form at the same time the family completes the common application. The LMHAs were provided with a link to a secure, password-protected folder where informed consents can be uploaded. TIEMH staff also recently worked with HHSC program staff to ensure that a copy of the

tracking document can be uploaded more easily and more often, which is thought to improve the rate at which TIEMH staff are aware of new referrals.

Training the LMHAs. With the help of HHSC project staff, TIEMH staff sent an email to each of the LMHA's RTC liaisons with a copy of the informed consent and instructions for how to access the folder for uploading informed consent forms. During this time, TIEMH staff identified at least seven LMHAs (Betty Hardwick, Center for Life Resources, Central Plains, Pecan Valley, StarCare, Texana Center, and West Texas Centers) who have not accessed their individualized link. It is interesting to note that two of these LMHAs (Central Plains and StarCare) have not had a referral to the RTC project since August 1, 2017. TIEMH also provided a presentation to the Children's Mental Health Director's monthly call with information on evaluation of the RTC project and instructions for how to upload informed consent forms. There were several LMHAs who reached out after the webinar with additional questions and requests for clarification. TIEMH staff also provided a follow-up email to each of the LMHA's RTC liaisons that contained a copy of the presentation.

Training the RTCs. Similar to the work that has been done with the LMHAs, TIEMH also reached out to four of the RTCs with current residents (Krause Children's Residential, Roy Mass Youth Alternatives, Unity Children's Home, and Willow Bend Center) to obtain informed consent. Each RTC has received instructions for how to upload informed consent forms and a link to their secure, password-protected folder. While each of these RTCs were responsive to multiple emails and phone calls, only one of the RTCs (Krause Children's Residential) has provided an informed consent form. At the time of evaluation, only two of the four RTCs have accessed their folder for uploading informed consent forms.

Current Status of the Evaluation. At this time, only one informed consent form has been obtained from the LMHAs and RTCs. One of the residential centers attempted to reach out to one of the youth but the caseworker was unable to reach the guardian after numerous attempts. Getting buy-in from LMHAs and RTCs continues to serve as a large barrier to the evaluation. This lack of engagement is complicated by a lack of awareness of the purpose RTC Project and by the fact that many of the LMHAs and RTCs are not accustomed to working with youth who are part of the RTC Project. As a result, LMHAs and RTCs must re-familiarize themselves with their role and procedures for working with youth who are referred to the RTC initiative following each referral.

Plans for Next Year. The evaluation team would like to continue to work towards the evaluation consent being a standard part of the enrollment process. With more timely information on referrals to the program, TIEMH staff can reach out to LMHAs to remind them of the consent process and methods for submission. Similarly, staff will focus on engaging RTCs to connect with families of youth currently residing in the RTC. Since both LMHAs and RTCs are strongly encouraged to engage caregivers throughout the time following referral to transition to the community, there should be opportunities to engage families in a brief discussion of a phone interview and gather their consent to be contacted. If these tactics are not successful, TIEMH staff will engage liaisons from both groups for further discussion on ways to improve the recruitment process.

Evaluation Results

2019 Evaluation Summary

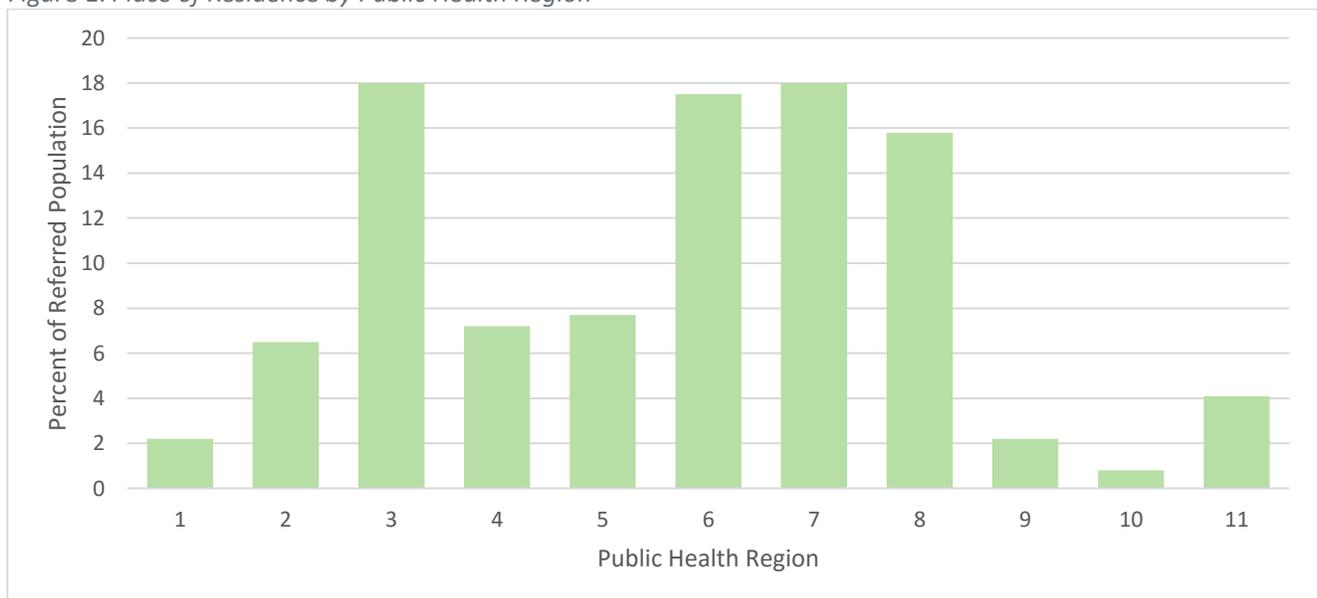
To provide additional information to HHSC and DFPS, a review of the administrative participant tracking tool was conducted, analyzing information on the children referred to the RTC project in the past two years. Additionally, administrative data in the HHSC electronic data system was analyzed to provide information on the children and families served through the initiative, the community-based services received, and the youth accessing community-based services following transition from the residential setting.

Referrals to the RTC Project

Home Community. Between August 1, 2017 and August 1, 2019, the RTC Project had 157 referrals for 168 different youth. Individuals ranged from 5 to 17 years of age at the time of referral, with 13 years of age representing the average age at the time of referral. A greater proportion of the individuals referred to the initiative were male (59.7%). Referred youth resided in all of the public health regions; however, most of the referrals came from Regions 3, 6, 7, and 8 (Figure 1). Region 3 is in Northeast Texas, and includes the Dallas/Fort Worth Metroplex area. Region 6 includes Houston and surrounding communities. Region 7 represents Austin and Central Texas, and Region 8 includes San Antonio and South Central Texas.

Across FY 2017 and 2018, 31 of the 37 LMHAs (86.5%) had contact with a child or youth who was involved in the RTC Project. The list of LMHAs that have not had contact with a child or youth who was involved in the RTC Project in the last two years include Betty Hardwick, Central Plains Center, Coastal Plains, Starcare, and MHMR for the Concho Valley. The four LMHAs with the most referred youth included Community Health Core, the Center for Health Care Services, The Harris Center for IDD and BH, and MHMR of Tarrant County. One-third of the referred youth lived within the catchment area of these four LMHAs. These findings are similar to those documented in the [2017 Report](#).

Figure 1. *Place of Residence by Public Health Region*



Placement of Youth in Residential Care. Forty-one youth were placed in a contracted residential treatment provider between August 1, 2017 and August 1, 2019. Table 1 identifies the contracted providers and the number of children served over the 24-month period. Some children were served within two residential providers over the course of care and are reflected in the chart more than once. HHSC worked with 12 contracted providers over the two year period, with the greatest number of youth placed in Unity Children’s Home (48.8%) followed by Houston Serenity Place (14.6%). Both of these programs are located in Harris County.

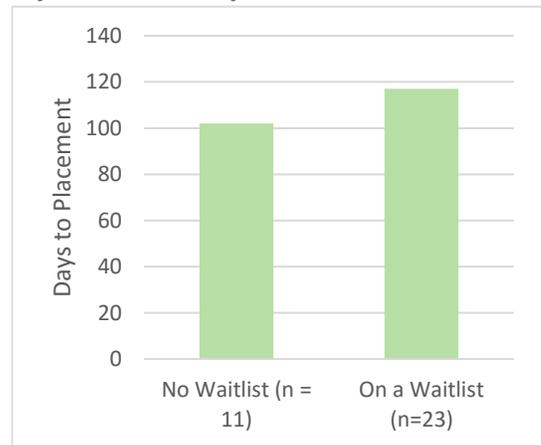
It is important to note that some of the youth who are captured in the placement table were referred to the project before August 1, 2017, but placed after this date. Available data suggests that 30 of the 157 children (19.1%) referred to the RTC Project between August 1, 2017 and August 1, 2019 have been placed within a contracted residential center. An additional 14 referred children (8.91%) are active and awaiting placement.

Table 1. *Placement of Youth in Residential Care*

Residential Provider	Number of Youth	Residential Provider	Number of Youth
Embracing Destiny	2	Pegasus Schools, Inc.	1
Everyday Life, Inc.	1	Renewed Strength, Inc.	1
Helping Hands Home for Children	1	Roy Mass Youth Alternatives	2
Houston Serenity Place (Crockett)	1	The Center for Success and Independence	1
Houston Serenity Place (Houston)	6	Unity Children’s Home	20
Krause Children’s Residential (Upbring)	2	Willow Bend Center	3

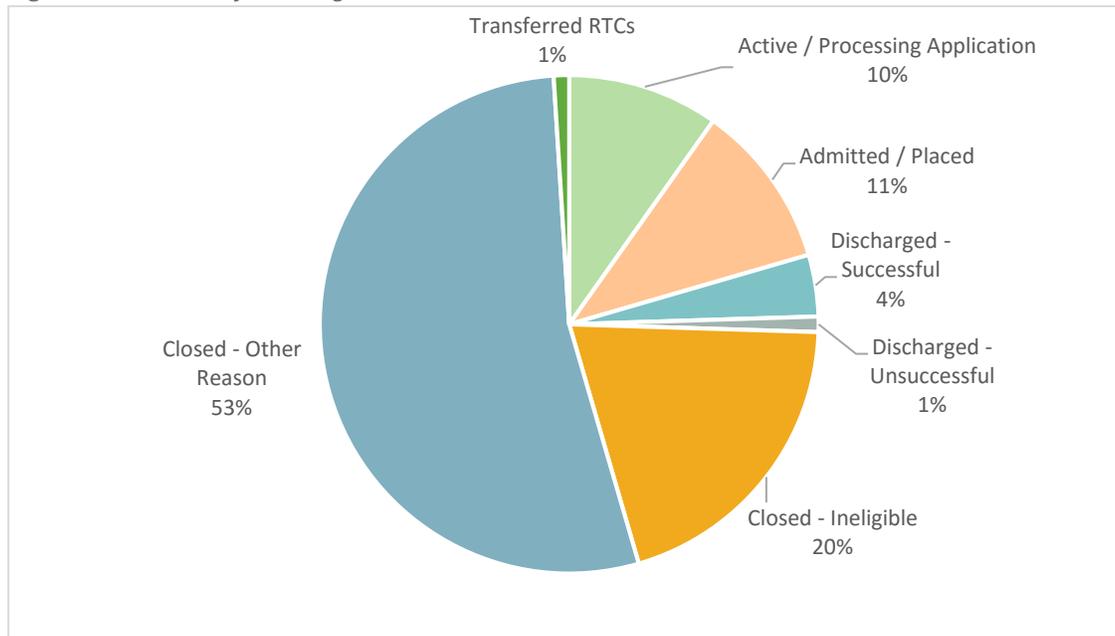
Time between Referral and Placement. Data suggests that placement in a contracted residential provider may take a significant amount of time and energy. The available data shows that, from the point of referral, placement in a residential center ranged from 8 to 347 days in length, with a median length of 77 days (2-1/2 months). When the RTC project has reached capacity, children may be placed on a waiting list. While this may be one explanation for time between referral and placement, it does not appear to be a significant factor. Figure 2 shows a comparison of the time to placement for individuals who have been placed in a residential center who were on a waitlist and those who were not on a waitlist. It is important to note that this figure does not include everyone who has been in a RTC, as data on initial referral date was not always available. This data also only includes individuals who were eventually placed in a residential center.

Figure 2. *Average Number of Days between Referral and Time of Placement*



Results of Children Placed on Waitlist. Between August 1, 2017 and August 1, 2019, there were 117 individuals placed on the RTC waitlist. At the time of this evaluation, the majority of those individuals (84.6%) had not been placed in a residential center. Figure 3 provides a summary of the status of youth who were placed on the waitlist during this time. A small portion of these youth had been placed and discharged from the program. About 13% were currently in a placement and 10% are in the process of being admitted and/or placed. The majority of youth (73.5%) were closed either because they were ineligible or for other reason.

Figure 3. Outcome after Being Placed on a Waitlist



Since “Other Reasons” represented the largest proportion of youth, additional analyses were conducted to identify and code these reasons for closure after being placed on the waitlist. Some of the most common reasons that individuals were removed from the waitlist include:

- Parent or guardian requesting to be taken off of the waitlist (45%)
- Placement in another residential center outside of the RTC initiative (20%)
- Inability to contact the family or the family not wanting to be contacted (18%)
- Relinquishment to custody of child welfare (9%)
- Multiple unsuccessful attempts at placement (4%)
- Placement in Waco Center for Youth (3%)
- Moved out of state (1%)

Families who wished to be taken off the waitlist frequently reported that community-based services, such as those provided through the YES Waiver, had been effective and that there was no longer a need for residential services.

Provision of Referrals from DFPS. Available records also indicate large variability in the amount of time that it takes from the initial date of referral to DFPS until the date that HHSC receives the referral. While there were 78 instances (53.4%) in which DFPS provided a rapid referral to HHSC (within 2 days), 29 referrals from DFPS (19.9%) took 10 days or more. In nine instances (6.2%), individuals were reviewed by DFPS for 30 days or more before the referral was made to HHSC.

Length of Stay in Residential Placement. Analyses examined the number of days children were placed in a residential center. For youth who were discharged from a residential center between August 1, 2017 and August 1, 2019 (n=48), the length of stay in the ranged from 11 to 885 days, with a median length of stay of 232 days (about 7-1/2 months). This number is consistent with the length of stay documented in the [2017 Report](#).

Community-based Coordination

Upon referral to the RTC initiative, children and families are linked with the LMHA within their catchment area. The LMHA is responsible for assessing clinical eligibility for RTC care and providing crisis or other mental health services until the youth is placed. After placement in a residential setting, LMHA staff provide care coordination

services and family supports to ensure that family reunification goals are met and that appropriate community-based services are available upon the child's return to their home. Analyses from HHSC's administrative data system were conducted to understand the extent to which these goals were met. The residential treatment level of care has been documented since September 1, 2017

Participant Sample. Ninety-three children were authorized for the residential treatment level of care between August 1, 2017 and July 1, 2019. A subset of these youth reflected a pilot project in two communities (Burke Center and LifePath Systems) in which wraparound planning and non-traditional supports are provided to families in residential treatment. As these youth were generally in residential programs external to the RTC project and LMHAs received additional funding for these services, these children were removed from the analyses. The resulting sample included 50 youth served over the almost two-year period.

As shown in the referred sample, there were slightly more males (52.0%) than females represented. The average age at admission was 12.7 years old ($sd=2.6$), with the youngest participants age 6. Participants were predominantly White, non-Hispanic/Latino (58.0%), followed by White, Hispanic/Latino (20.0%), Black or African American (12.0%), and more than one race or other (10.0%). This is a larger proportion of White, non-Hispanic youth and a lower proportion of White, Hispanic youth than is generally seen in the public mental health population. Youth were engaged with a variety of LMHAs, based on their home residence, with the highest number from Integral Care, Community Healthcore, and Tri-County Behavioral Healthcare. With the exception of Integral Care in Travis County, the other two LMHAs serve rural areas in Eastern Texas.

Services Provided During Residential Care. Most families (80.0%) received mental health services from the LMHA while the youth was receiving residential treatment (see Table 2). On average, families received 2.6 service encounters per month for about two and one-half hours each month. Generally, services were provided during most of the residential stay, reflected by services lasting for an average of seven months, while the youth were enrolled in the residential level of care for about one year. This small difference may be explained by time needed to engage families in services, as well as differences that occur due to the level of care authorization periods. For example, a youth may remain in the residential level of care for a short time as the youth is transitioned to community-based services and authorized for an appropriate service level.

There was no clear pattern for the ten families who did not receive services during the residential stay; they represented seven different LMHAs, all but one of whom provided services to other families involved in the RTC initiative. The youth who did not receive services from the LMHA while in residential treatment stayed in the level of care slightly longer than the group average (406 days versus 385 days), so limited lengths of stay does not explain the finding. Other explanations may include the family declining services, not responding to outreach, or accessing mental health services through another community provider.

The most frequently provided services were routine case management, intensive case management, and family partner services. Intensive case management reflected the service with the greatest number of encounters each month. Although provided less frequently, crisis services and parent skills training with provided to more than 20% of the families. While family partner services were provided to over one-third of families, those receiving it received only about 37 minutes per month. This was the least time intensive service, other than continuity of services (engagement).

Table 2. *Number of Youth Receiving Services while in RTC Level of Care*

Service	Number (n=50)	%	Average Number of Encounters per Month for Families Served	Average Total Time (in hours) per Month for Families Served
Any Service	40	80.0%	2.59	2.52
Intensive Case Management	18	36.0%	1.36	1.27
Routine Case Management	23	57.5%	1.06	1.14
Continuity of Service/Engagement	9	22.5%	0.46	0.25
Family Case Management	2	4.0%	0.92	1.24
Crisis Rehabilitation	12	24.0%	0.75	0.81
Skills Training	11	22.0%	0.92	1.00
Family Partner	18	36.0%	0.61	0.65
		Mean		
Length of Stay in RTC Level of Care	385 days	1 year, 20 days		
Length of Time in LMHA Services	224 days	7 months, 11 days		

Services Provided following Residential Treatment. LMHAs are available to provide intensive community-based services to support children and families as they transition from residential care. Table 3 presents an analysis of the data suggesting that more than one-third of children receive services through the LMHA in the year following their involvement in the RTC initiative. For those that do seek services, families generally receive intensive services, averaging 5.88 encounters per month and six and three-quarter hours of intervention per month. The most common services are routine case management, medication management, and skills training. Only 16% of families “step down” into services using a wraparound approach.

Table 3. *Number of Youth Receiving Services in 12 Months Following RTC Level of Care*

Service	Number (n=50)	%	Average Number of Encounters per Month for Families Served	Average Total Time in Service per Month for Families Served
Any Service	19	38.0%	5.88	6.75
Intensive Case Management	8	16.0%	3.62	3.92
Routine Case Management	13	26.0%	1.15	1.03
Continuity of Service/Engagement	2	4.0%	0.61	0.19
Family Case Management	0	0%	N/A	N/A
Crisis Rehabilitation	6	12.0%	1.67	2.06
Skills Training	9	20.8%	1.82	2.09
Family Partner	7	14.0%	0.87	1.49
Medication Management	12	24.0%	0.80	0.41
Medication Training & support	0	0%	N/A	N/A
Counseling	5	10.0%	0.95	0.85

Looking Forward: Challenges and Opportunities

Challenges/Opportunities for the RTC Project

Staffing Barriers. Over the last year, HHSC and DFPS project staff have continued to navigate how to coordinate efforts across agencies and worked collaboratively to best support children and youth who are referred to the RTC project. As in previous years, there have been changes in project staff, which can slow progress as new staff become familiar with procedures and documentation and make modifications as needed. Program management involves minimal state-level staffing, which can result in difficulties when staff are on leave, traveling, or responding to agency priorities. Maintaining communication with LMHAs, RTCs, and family members to ensure efficient placement and high quality care is time intensive and challenging, especially as the program grows to meet its full capacity. While each agency has identified additional staff to support the project when needed, an increase in dedicated FTEs could strengthen oversight, create efficiencies, and enhance continuity following staff changes.

Communication Challenges. There remains a general lack of awareness of or confusion about the purpose of the RTC project across DFPS, the LMHAs, and the RTCs. HHSC made significant progress in this area by developing a project webpage for caregivers interested in residential treatment options. This resource is likely not sufficient, however, for the various professional stakeholders who may be involved in project in some way. Since the initiative involves a modest number of families across all of Texas, DFPS casemanagers may have never seen a child who should be referred for the program prior to encountering a family in crisis. Similarly, LMHAs are unlikely to see more than a few eligible children in a year. Without readily available resource materials for stakeholders to understand their role and the procedures they should follow, confusion is likely to continue.

Policies and Documentation. HHSC and DFPS have made significant progress in documenting and coordinating agency policies and procedures related to the RTC initiative. This has laid the groundwork for identifying opportunities to streamline and improve processes and focus on service quality and family outcomes. Additional efforts to improve processes and strengthen tracking tools as the project continues to expand and grow and greater staff efficiencies become crucial for maintaining standards.

Payment Rates for Residential Care. The data demonstrates that most children are served in two residential programs in the Houston area. Although HHSC has developed contracts with many programs, staff may struggle to place children in many of these settings. While the evaluation study did not set out to measure the factors that created barriers to placement, anecdotal evidence suggested that children with comorbid conditions (such as intellectual disabilities or medical comorbidities), aggressive behaviors, or sexual misconduct may be challenging to find an appropriate program willing to take the child. Daily reimbursement rates below the current market rates also present a challenge. The RTC initiative has set high expectations for family engagement and continuity with community providers, but RTC programs may find meeting these expectations challenging without additional resources.

Evaluation Study. Many of the communication challenges noted above have also played a role in the slow progress in the evaluation study. Family referrals to LMHAs occur sporadically and staff are unlikely to remember the need to engage caregivers in the consent for contact. Similarly, RTCs have infrequent personal contact with caregivers and are unlikely to recall the need to engage families in the consent process. TIEMH staff hope to continue to discuss effective and efficient strategies to engage families in providing critical feedback to the program.

Family First Act. The Family First Prevention Services Act is federal legislation that allows state child welfare agencies to be reimbursed for family prevention services provided to families at risk of child removal. States who

choose to accept the funding must limit their use of congregate care for children. These states must limit residential placement to accredited programs that meet certain criteria for staffing, trauma-informed practices, family engagement, and length of stay. This legislation, if Texas DFPS opts to access the funding, is an opportunity to strengthen the residential treatment system in the state and increase the focus on shortened lengths of stay, active transition planning, and close collaboration between residential and community providers.

Recommendations and Next Steps

1. HHSC and DFPS should develop online training, tools and resources and ensure awareness of existing resources through communication strategies. Audiences for these resources include caregivers, CPS case managers and supervisors, RTC administrators and staff, LMHA administrators and staff, and other mental health providers. Suggested areas to be addressed include an overview of the RTC initiative, history of the RTC initiative, roles and responsibilities of DFPS, HHSC, LMHA and RTCs, frequently asked questions, what caregivers should expect when calling CPS, and contractual/role expectations amongst the parties.
2. HHSC should increase collaboration and communication among participating LMHAs and RTCs through quarterly or semi-annual conference calls to discuss what's going well, areas to improve upon, provide an open forum for questions and answers, and opportunities to learn from each other and conduct shared problem-solving.
3. HHSC (with support from TIEMH) should work collaboratively with family members with lived experience to develop a family rights and expectations document that helps parents understand their rights when engaging in services through the RTC project, as well as the expectations that come with involvement.
4. HHSC and DFPS should develop resources to provide clarity and reduce confusion between similar programs such as the RTC Initiative, YES Waiver, and Joint Conservatorship.
5. Additional enhancements to the program's tracking database should be considered to increase efficiencies and allow for ease of reporting. HHSC should consider conducting a use case study to identify the key needs, tasks, and processes necessary to the HHSC project staff and align choices in software to the study results.
6. TIEMH would like to revisit the opportunity to engage caregivers of youth in the RTC project through a letter mailed to the individual. TIEMH staff would then follow-up with any caregiver that does not decline contact to further explain the interview process and obtain consent. This would provide an additional opportunity to engage families who have received services in the past. The initial request for approval of the letter did not reach a leader with decision-making authority.
7. TIEMH will increase efforts to prompt LMHAs to seek consents by striving to contact the local liaison as soon as TIEMH staff are aware of a referral. This feedback system could be strengthened if HHSC also reviewed for the presence of a consent form (either consenting or declining participation) as eligibility documents are submitted.