Enhanced Care Programs Guide

Serving Foster Youth with Unmet Complex Needs

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Overview

The Enhanced Care Programs Guide serves as a manual to assist counties and providers with the development and implementation of individualized programs serving foster youth with unmet complex needs to safely and successfully thrive in family and community-based settings. This guide includes information about program design, eligibility, staffing models, clinical practices, and funding. This guide is not a "how to," but instead offers an approach that can be adapted on a case-by-case basis to the individual youth's developmental and behavioral needs and cultural background.

The first part of this guide provides an overview of the experience, principles, and philosophies underpinning the Enhanced Care Program (ECP) model and outlines the core elements of ECPs. The key takeaway from this part of the guide is that ECPs build on many of the best practices and strength of the existing continuum of care, but have been designed to support the distinct needs of youth with unmet complex needs that have not been adequately or safely addressed in existing systems or programs. The services that must be provided involve more individualized, intensive services to support transition to less intensive services and placement settings within the existing continuum of care, ideally with family or other natural supports.

The second part of this guide focuses more on operations, providing practical guidance for how to implement ECPs. It touches upon a number of areas, including staffing, funding, training, community partnerships, and designing successful, individualized and solution focused services. It is intended for service providers, counties, and community partners who may be interested in the operational aspects of ECPs. The guide includes a case example of a successful adaptation of the model distributed in parts throughout.

The Enhanced Care Programs Guide is a living document that will be periodically updated as we learn more and as we gather additional resources to assist providers and counties across California. To access the guide in its entirety, please visit https://www.catalyst-center.org/ecp-guide

Unmet Complex Needs

The phrase "Unmet Complex Needs" is intended to highlight that youth engaged in ECPs have a variety of identified needs across multiple domains that have been unmet, often over long periods of time, by behavioral health, child welfare, probation, education, regional center and/or other systems. These systemic shortfalls have resulted in youth needing a high intensity individualized treatment option to better resolve challenges and address their needs.

Foreword to the program model

The community has expressed concerns about a lack of adequate, effective placement resources and services within the current continuum of care to serve the highest needs, most vulnerable population of youth. The process of identifying an appropriate placement and services can be lengthy and ineffective, often with a deleterious effect on youth. The Catalyst Center's California Provider Helpline's data indicates that providers and counties are struggling to find appropriate, effective placements for youth exhibiting multiple high-risk behaviors, especially assaultive and aggressive behavior, runaway behavior, substance use, and property destruction. Transgender and nonbinary youth and survivors of commercial sexual exploitation are

disproportionately represented in high intensity services. In response, The Catalyst Center and Casey Family Programs have partnered to support counties and providers in developing trauma-informed, permanency-focused individualized interventions for youth whose needs have not been met by current system resources. This collaboration has involved extensive community consultation with individuals with lived expertise, existing providers, and county partners. The Enhanced Care Program framework is a result of this collaborative effort. Individuals with lived experience in the child welfare system have and will continue to provide necessary and valuable input and are an integral part of this initiative.

Part 1: What is an Enhanced Care Program?

Enhanced Care Programs (ECPs) are an adaptation of existing program models, but are based on the understanding that youth may require treatment interventions and placement settings distinct from existing models, and therefore the solutions must be individualized. The development of these programs reflects the gap in the current continuum of services available, and are designed to be youth and family-centered. The ECP model is assessment-driven and highly individualized, using a variety of interventions and modalities adapted to meet the particular needs of individual youth with multiple identified needs across various domains, including any mix of the following: multiple mental health and/or substance abuse diagnoses, severe challenges in family, social and/or school functioning, neuropsychological difficulties, and/or developmental delays (referred to throughout this document as “unmet complex needs”).

Many of these “complex” behaviors are rooted in histories of severe, chronic trauma and insecure or disrupted attachment/caregiving experiences. As a result of these early and/or ongoing unmet needs for relational and environmental safety, youth may have adapted behaviors that ensure access to these needs for safety and survival. Many of these youth also have histories of involvement with systems of care (e.g., child welfare, behavioral health, probation, education) that, paralleling their earlier experiences, have been unsuccessful in accurately understanding or appropriately meeting their needs. It follows that, rather than being described as “complex care” youth, these youth may be better understood as youth with *unmet* complex needs. Although this difference in language is subtle, the invitation is profound: to promote trauma-responsive care and emphasize systemic responsibility to address unmet needs, rather than situating problems within youth and families by describing them as “complex”.

ECPs, including **Enhanced Short-Term Residential Therapeutic Program (E-STRTP, also known as “STRTP of 1”) or Enhanced Intensive Services Foster Care (E-ISFC, also known as “Enhanced ISFC” or “ISFC Plus”)**, provide an alternative to group residential treatment through the provision of care, treatment and services in an individually-based, intensive and structured environment. These short-term programs are intended to stabilize youth, develop clarity about youth treatment needs, create and support legal and/or emotional/relational permanency plans and enable youth to transition to less intensive services and placements within the current continuum of care, ideally with family, natural supports, or to other community-based settings. ECPs utilize a no reject, no eject model to serve California’s highest need and most vulnerable youth, including minor children and nonminor dependents. A no reject, no eject model is a commitment on the part of the provider, in collaboration with the county Child Welfare, Probation and Behavioral Health departments, to accept all youth referred, and to adjust and change interventions as needed while ensuring that the youth continues to be served by the provider.

Permanency Defined

Legal Permanency: A youth's relationship with a parenting adult is recognized by law – the adult is the child's birth, kin, foster, guardianship or adoptive parent. Legal status confers emotional, social, financial and other status.

Emotional/Relational Permanency: Connection to family, community and culture creates emotional and relational permanency that ensures there are adults who are reliable and committed to the youth throughout their life. Emotional/Relational permanency includes recognizing and supporting many types of important long-term relationships that help a child or young person feel loved and connected. Examples may include relationships with parents, siblings, family friends, extended family and former foster family members.

In an ECP, youth receive comprehensive assessment, planning, therapy, rehabilitation, collateral and case management services, as well as medication and nursing support as needed. Interventions are culturally-responsive, trauma-informed, highly individualized, creative and designed to target the behaviors or symptoms that most significantly inhibit the youth's ability to be safely and successfully served within the existing continuum of care, in family, or in other community-based placements. In collaboration with the placing county and the Child and Family Team, ECPs support the youth's permanency planning process, including family search, engagement and permanency support activities as appropriate and necessary. For detailed descriptions of the E-STRTP and E-ISFC models, please see the complete guide here.

What Enhanced Care Programs Are Not

ECPs differ from other programs and placements available to youth in the existing continuum of care. ECPs are intended to give youth the individualized services they need to address immediate issues preventing safe and successful family and community-based living, including those issues impacting the efficacy of placements in the existing continuum of care. Providing individualized services and placement for youth does not in and of itself make a program an ECP, which must align with the core principles of the model (discussed in the next section).

A broad range of placement and program options within the existing continuum of care may be beneficial for youth and support their goals related to safety, well-being, and permanency. However, not all of these placements are able to effectively support and treat youth's unmet complex needs. These placements may include congregate care settings, placement with individuals, including family or kin, who are not uniquely trained to support the needs and address the unique needs and risk factors, and placements that require youth to move if they engage in high-risk behaviors.

ECPs operate with the overarching goal of promoting legal and/or emotional/relational permanency for the youth and the belief that youth should not be denied access to thrive in family settings due to their unmet complex needs necessitating this level of treatment. ECP providers and partners simultaneously recognize that legal permanency may not be a realistic short-term goal for the youth in these placements, but the goal of youth being connected to family is consistently embedded in their treatment and long-term plans. ECPs

support skill development for youth and families, and relationships that can eventually lead to permanency and connection to extended family.

The Core Principles of Enhanced Care Programs

The core principles of ECPs are designed to meet the distinct needs of youth with unmet complex needs. This is based on an understanding that these youth have treatment needs distinct from youth effectively served in the existing continuum of care. The model and its principles are embedded in an anti-racist framework that values permanency and embraces positive youth development.

No reject, no eject

Evidence suggests that youth who do not receive appropriate services experience increased instability, which can be unhealthy, unsafe, traumatizing, and stressful. These programs must therefore focus on preventing youth from experiencing disruptions. ECPs operate with a “no reject, no eject” policy, meaning that any youth who meets eligibility criteria and parameters for placement will be neither denied admission to the program nor be discharged from the program, regardless of the severity or complexity of their behaviors.

Programs serving youth with unmet complex needs understand that youth will exhibit the behaviors, symptoms and impairments that contributed to their referral to the program and will not pursue a youth’s discharge or removal from the program due to these behaviors. Enhanced Care Program providers work diligently within the Child and Family Team (CFT) context to design solutions to challenging issues so that youth can stay in their placement and program, even when doing so requires extraordinary interventions developed by and with the CFT members. Successful implementation of no reject, no eject practices require strong community partnerships, adequate resources, and an assumption of shared risk.

In order for youth to receive the treatment they need using a “whatever it takes” approach, county partners, state agencies and Community Care Licensing must partner with providers to ensure that youth needs are met and that all necessary resources are brought to bear to ensure youth success. The entire treatment team, both within and outside of the provider agency, must be willing to share the risk and engage in problem solving in order to maintain youth safety such that providers are not shouldering the burden and risk of this approach alone.

Adaptable, individualized, youth-driven supports

The youth are at the center of every aspect of ECP planning and delivery. Youth vary in their presenting expressions, symptoms, and experience with previous placements and providers. ECPs must be adaptable and tailored to the specific needs and characteristics of youth and families, providing carefully selected, assessment-driven support and services to effectively support both short- and long- term safety, stabilization, skill building, recovery, and permanency. ECPs employ multiple treatment modalities and culturally-responsive interventions. Program adaptations are based on the availability of local supports, the needs and capacities of the individual youth, and cultural and developmental needs of the youth.

As part of an equity-based approach, ECPs should meet the needs of sub-populations, including LGBTQ2S youth, BIPOC, and others. Program design must account for individual experiences not only because of

cultural differences and the experience of racism and discrimination but also because laws and rights may be applied differently.

Permanency-focused Wraparound

ECPs value connection and recognize the youth in the context of their families, caregivers, and other natural supports. Youth placed in ECPs typically have histories of fractured or unknown family connections leading to intensive externalized and/or internalized behaviors and regular placement disruptions. These youth have experienced profound disconnection from the people in their natural ecology. An important antidote to this lack of connection is the intentional and focused integration of family members, caring adults and natural supporters into the youth's mental health treatment, CFT processes, and stable placement. The continuous identification and engagement of a youth's relatives, fictive kin, natural support people, educational supports, and community members can greatly enhance the positive effects of mental health treatment interventions, support better team decision-making, reduce racial disparities in foster care, improve culturally responsive treatment, reduce placement disruptions and support the sustainment of progress over time. Promoting permanence and community integration acknowledges "family" (however defined by a youth) as an asset that should be strengthened through intentional activities that broaden a youth's network of support.

ECPs must value the strength of families and communities. ECPs work with public systems and within the CFT context to ensure that families have access to all available safety net programs. Providers must hold the shared goal of reducing time in intensive and/or congregate care settings and fully engage in efforts to transition the youth to family-based settings wherever possible, which includes strengthening the capacity of family members to safely respond to these unmet complex needs.

County partners should have engaged in intensive family finding efforts, ideally aimed at identifying family and/or other natural supports who may be willing to become an E-ISFC provider for youth in need of an ECP or who are open to welcoming the youth into their homes following treatment in an ECP. During transition from an ECP, counties should work to ensure that permanency-focused wraparound and other needed transition services are fully supported. These services should allow providers to support families in preparing them for the youth's transition and for the achievement of legal permanency in all possible situations. Wraparound services should be thoughtfully planned and skillfully executed to ensure stability after treatment in an ECP.

Trauma-informed and recovery-oriented care

ECPs are trauma-responsive and seek to help youth heal. The complex care model serves youth who have experienced profound trauma resulting in multiple identified needs across various domains, including any mix of the following: multiple mental health and/or substance abuse diagnoses, severe challenges in family, social and/or school functioning, neuropsychological difficulties, complex trauma and/or developmental delays. ECPs are grounded in the belief that all young people have a right to the services and settings they need to build and sustain the skills and relationships necessary to thrive in family and community-based settings. Youth with profound trauma histories can recover and do well if they have access to the safe, comprehensive, and culturally and developmentally appropriate services they need to address their needs. Facilitating connection and reconnection to families and others is a therapeutic intervention in and of itself, contributing to a sense of belonging and cultural connection that can greatly benefit the youth in their recovery. ECPs will operate with a high degree of attunement to issues related to trauma-informed care and cultural responsiveness, including the impact of racial trauma. Therapeutic relationships are rooted in connection and hope. Because they are

individualized, adaptable, and operate using a “no reject, no eject” framework, ECPs seek to address the potential for re-traumatization and exacerbation of mental health and trauma-related issues that occur when youth receive inadequate care to meet their needs, often resulting in increased instability and vulnerability.

Mitigation of Inequities including Racial Bias

ECPs will work to mitigate the disparities in service and the impact of racial bias and racism on youth in treatment. Child maltreatment is experienced across races at roughly the same rates; however, youth of color enter the system at much higher rates and are less likely to receive the necessary appropriate and culturally responsive services. This inequitable access to services often perpetuates systemic biases wherein symptoms worsen, thereby leading to the need for more intensive services that may not appropriately address youth’s cultural and other needs. It is important to note that these disparities exist in part due to both implicit racial bias and explicit discrimination by individuals (e.g., caseworkers, supervisors, educators, mandated reporters, other professionals and by institutional structures (e.g., policies and practices that create advantages for white people and discrimination, oppression and disadvantage for youth and families of color).

While the ECP model is highly attuned to the role of systemic bias and the presence of racial disparities in the lives of youth and families involved in the child welfare system, the model cannot eradicate these disparities but can only seek to address them at various points of contact throughout the placement.

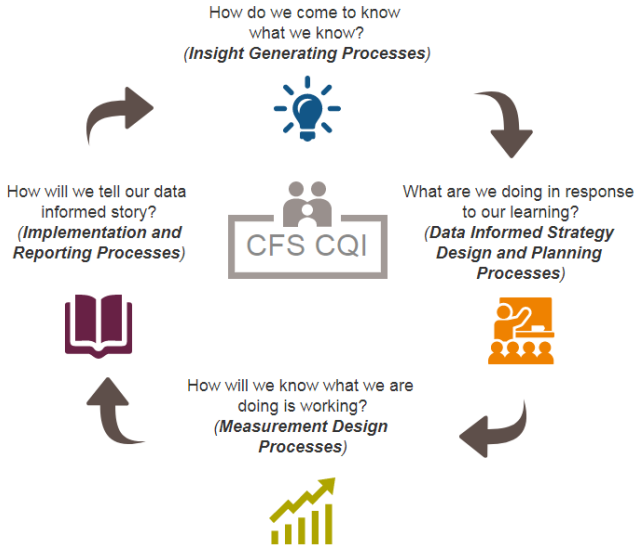
To act preventively and correctively, service providers must intentionally hold an authentic and deep commitment to counter white supremacy culture, including in youth systems of care. It is critical that providers and county partners examine their own implicit and explicit biases that may have contributed to labeling youth as more “dangerous” or “untreatable” or to referring them for enhanced services. When reviewing youth for service within an Enhanced Care Program, providers and counties must ask themselves if implicit bias or explicit discrimination are playing any role in the determination that a youth cannot be served within a less intensive setting and/or placed within a traditional family-based setting. Enhanced Care Providers will assess and understand the unique needs of youth and families of diverse racial and ethnic backgrounds and employ practices that will better serve them.

Continuous Quality Improvement

In order to adjust and change interventions to meet individual needs, it is important to build upon an established continuous quality improvement (CQI) framework. Bickman and Nosser (2009) describe CQI as involving the use of assessment, feedback and application of information to improve services in a proactive manner by continuously evaluating processes and outcomes and the link between them to change services. This interplay of processes and outcomes has a specific focus within child welfare as the outcomes of safety, permanency and well-being are paramount. An integrated CQI process is guided by the same values and approach that guide direct practice with youth and families. Each CQI process must be family centered, relationship-based, participatory and culturally responsive. Effective models are firmly based on a learning approach that is urgent, relentless, trauma-informed, innovative and evidence informed. Perhaps most importantly, CQI is dependent upon the active inclusion and participation of staff at all levels of an organization, and other key stakeholders (youth, families and caregivers in particular) throughout the process.

Although the CQI activities vary from organization to organization, there are various ways to learn from those we serve including surveys, interviews, focus groups and continually monitoring identified outcomes by way of

data. A high-level framework should include considerations as noted in the diagram below. This cycle does not represent a discrete process; instead, it is a way to describe the thinking that underlies a full suite of CQI activities. Within that suite, specific activities may focus on a single phase of the cycle or cross two or three; a few could make up complete cycles in and of themselves. The principal tenets of this approach include staying curious, always asking questions and thinking critically about what is learned or not learned.



Who are Enhanced Care Programs designed for?

ECPs provide treatment for youth, including both minor children and non-minor dependents (NMDs), with a history of profound trauma resulting in behavioral health needs that have not been successfully ameliorated in other community settings within the existing continuum of care, but who do not require acute inpatient stabilization. ECPs serve youth who typically have multiple identified needs across various domains, including any mix of the following: multiple mental health and/or substance abuse diagnoses, severe challenges in family, social and/or school functioning, neuropsychological difficulties, and/ developmental delays.

Celia's Case

Celia, a 16-year-old Hispanic youth, became a pressing concern for her county as the fear for her safety escalated and placement options all began turning her down one-by-one. The county Deputy Director of Child Welfare reached out to the Caring Change (CC) agency with a plea for help. The request was to see if CC would be able to develop and deliver an individualized care plan for Celia that encompassed placement, wraparound, intensive and integrated behavioral health and permanency support. CC's leadership team immediately began holding meetings with the county team to learn more about Celia's strengths and needs to determine whether CC could keep Celia safe and offer the kind of care and treatment that would allow Celia to successfully step-down to a lower level of care.

*** Note: this vignette is aggregated from examples provided by agencies currently serving youth through Enhanced Care Programs. Specific client and agency information was adjusted to protect anonymity.***

Due to chronic and acute risks including potential for aggression, self-injury or suicidality, and/or absence from care or runaway behaviors, youth with unmet complex needs require substantial supervision and may be appropriate for an ECP. While ECPs may be appropriate for youth experiencing substance use issues, specialized drug treatment settings may be more appropriate when substance use is severe or is the primary presenting problem.

Most youth with unmet complex needs have endured both severe, chronic trauma and an absence of protective parent or caregiver relationships. Their histories may include multiple types of abuse, in utero exposure to drugs or alcohol, history of significant head trauma and/or neuropsychological difficulties, all of which complicate health and wellbeing. A precise primary diagnosis is blurred by complex comorbidity. The etiology of symptoms is often obscured by a plethora of early chemical, physical and emotional insults.

Youth who have experienced severe trauma routinely struggle in three domains: emotional regulation, behavioral impulsivity and interpersonal disturbance. Among youth served in these programs, it is common to see extreme impairments in some or all of these domains. Many youth have a low threshold for feeling threatened and struggle to regulate their impulses, leading to fight or flight behaviors including aggression, fleeing from placement and other high-risk behaviors. Youth may also present with hypersexual behavior or develop maladaptive preoccupations with staff members. These youth are often unpredictable and may be dangerous to themselves or others.

Celia entered the foster care system at the age of 4. By the time she was a teenager, she had stayed with multiple care providers (including foster homes, residential treatment and other types of placements). Her mother was unavailable due to drug use, her younger brother was in another home, she did not know who her father was and she grew up detached from her one other known family connection, her grandmother. Celia also has Type 1 Diabetes and experienced challenges with managing her insulin dependency. On two occasions while Celia was absent from the home or facility she was formally placed in, she went into diabetic shock and was hospitalized.

Celia has a history of physical abuse, frequent psychiatric hospitalizations and sexual exploitation by older men. Celia was first sexually assaulted at 8 years old. At 14 years old she was raped by a 30-year-old man, resulting in a pregnancy and miscarriage. Soon after miscarrying, she attempted suicide. In another episode, she eloped from a residential care facility to stay with a 25-year-old man who sexually abused her after giving her drugs and alcohol and who attempted to sexually traffic her. Celia began self-harming and suicidal behavior as a pre-adolescent and frequently eloped from residential placements. She had been diagnosed with multiple severe mental health disorders, including Major Depressive Disorder and PTSD. Each of her 7 psychiatric inpatient hospitalizations was prompted by serious self-harm or suicide attempts.

Celia grew up believing that she needed to be self-reliant and "tough" - she convinced herself that she only needed to care for herself and her younger brother to survive. This belief pushed her towards making unhealthy choices such as engaging with negative peers and drug use. While Celia was moving from placement to placement, her brother was adopted by a former foster mom. This led to increased feelings of being unwanted and a corresponding uptick in substance use.

Often, youth who are most appropriate for an ECP are already receiving, but not successfully treated by, intensive community services including wraparound, crisis response, STRTPs, TBS and others. Existing services may continue within the context of the ECP with a further coordinated and targeted focus on the areas that inhibit the youth from being successful without the ECP structure. Service providers may not have the engagement strategies and, consequently, struggle to engage youth and they often have placement gaps or absences from care that inhibit their ability to receive consistent intensive treatment services. Youth may struggle in congregate care settings, spend periods of time staying in county offices or in the community and may even refuse to go into placement. Youth are often engaging in high-risk behaviors that require intensive individualized support to stabilize and step down to a lower level of care.

Intended Outcomes

Core client outcomes for youth served in ECPs center on a few core areas: permanency, behavioral stability, symptom reduction living situation stability, strengths development, and educational stability. Client outcomes vary based on their individual needs and challenges faced by the specific youth and their treatment plans; however, common quantifiable outcomes at the program level include:

- 100% of the youth accepted to the program are placed and receive intensive services and support.
- 90% of youth shall have a reduction in action items in the Behavioral/Emotional Needs Domain, Risk Behaviors Domain and the Family Functioning and Living Situation items in the Life Functioning Domain from the initial Child and Adolescent Needs and Strengths (CANS) Assessment to the discharge CANS Assessment.
- 80% of youth shall have improved scores in the Strengths domain from the initial Child and Adolescent Needs and Strengths (CANS) Assessment to the discharge CANS Assessment.
- 100% of youth will have documented efforts during placement to identify and achieve legal or emotional/relational permanency.
- 90% of youth will have an increase in the number of natural support people represented within the Child and Family Team at discharge as compared to their team composition at intake.
- 90% of youth shall have improved scores in the Permanency module from the initial Child and Adolescent Needs and Strengths (CANS) Assessment to the discharge CANS Assessment, demonstrating increased family and natural support connection and/or achievement of permanency.
- 85% of the youth accepted to the program will be transitioned to less restrictive placements to include but not limited to legal or emotional/relational permanency.
- 75% of youth shall report a positive experience of service and perceived symptom/behavior improvement as evidenced by client surveys.
- Based on longitudinal review, 75% of youth served by the program will experience stability in future placements, as evidenced by two or fewer placement changes following their transition from the program.
- 80% of youth served in the program will require fewer emergency or crisis interventions (defined as psychiatric hospitalizations/5150s and use of manual restraints) in the two years following treatment, based on longitudinal review.

Range of Services and Supports

Though the specific interventions vary by program and by each youth, the individualized treatment approaches used by ECPs allow providers to treat children and adolescents with high-risk behaviors and complex clinical issues so that they can transition to less intensive services and placements within the existing continuum of care, ideally to family or other community-based settings. The major work, particularly early in treatment, is containing the most unsafe behaviors (aggression, flight, self-harm) and allowing the youth the experience of a safe, nurturing relationship that can serve as a base for disrupting maladaptive patterns and ways of relating. The primary goals of treatment are to stabilize the youth, diminish symptoms that are barriers to lower levels of care and/or a return to family/community. Though the program is not designed to treat physical health conditions directly, coordination with medical providers and individualized training on youth medical needs for staff and specialized parents is an important part of the services provided.

Intensive, Individualized Treatment Approaches

The approach to support youth experiencing complex challenges must be intensive and individualized. At the same time, some common principles guide work across youth. The initial therapeutic focus is to identify what traumatic cues or triggers are most likely to lead the youth towards dysregulation – typically expressed in aggressive, escape and/or inexplicable behavior. Additionally, providers seek to identify cues that are reassuring to the youth and encourage feelings of safety. While providers continually assess and reassess trauma and safety triggers as they better know a youth, they also work to contain maladaptive behaviors: often expressed through aggression or fleeing/withdrawal behaviors. Providers work both to communicate safety and provide protection to the youth, even while intervening to stop aggressive expressions.

In Celia's case, the Caring Change (CC) team quickly determined that Celia would benefit from more individualized attention, which had largely been missing in her life and experiences to date. In addition, CC offered a different perspective: instead of trying to contain Celia and stop her from leaving placement without permission, the CC team sought to identify what would support Celia in choosing to stay. Building an individualized Enhanced ISFC program around Celia's preferences, interests, hobbies and natural supports was a significant paradigm shift. CC had a new Specialized Parent *(Laurel) available who was excited to care for Celia. Laurel has a background as a healthcare assistant and was prepared to manage Celia's medical needs.*

During the early phases of treatment, the CC team worked to engage Celia in treatment by providing her with unconditional positive regard and a genuine interest in Celia's perspective. The team, including Laurel, incorporated aspects of Celia's culture that she identified as important to her within her daily life, such as serving sopa de res and pupusas that she named as her favorites and playing popular music from El Salvador. Laurel offered to let Celia teach them how to dance to this music, which created bonding opportunities and much laughter.

This approach tends to reduce violent behavior, absences from care and unregulated and misplaced behavior over time. As intervention begins, it becomes possible to use specialized approaches such as play therapy, cognitive-behavioral approaches, relational work, rehabilitative skill building and other techniques to address the youth's needs. When youth sense that staff are working to help and protect them, they are not required to maintain the same hypervigilance and can allocate the mental space previously needed to detect threats towards curiosity, accurate appraisals of social interactions and learning new behaviors. Clients learn how to manage the normal cycle of rupture and repair that occurs during relationships, which creates healing and enhances social and emotional development as staff support them through escalations and dysregulation. These gains extend to relationship-building with other natural supports, peers and extended family. Additional step-down treatment and placement options often include these improved relationships and natural supports.

Assessment Process

Assessment involves both initial efforts towards diagnostic formulation and case coordination and ongoing determination of changing needs, triggers that lead to overwhelming emotions and maladaptive behaviors and the ways in which the youth copes in interpersonal and environmental contexts that contribute to high-risk behaviors. The assessment process informs treatment and helps the youth develop greater awareness of themselves. All assessments should include attention to complex trauma issues, trauma triggers and reactions, attachment disturbance, behavioral and affect dysregulation, medical needs, substance use, educational needs, interpersonal difficulties, and identity-related issues.

The assessment process begins the positive, collaborative working relationship between the youth and their providers, which is crucial to building trust and to the success of the program. The assessment typically includes information from several sources, including:

- the youth
- family reports about their history and functioning
- collateral reports from caregivers, teachers, cross-system partner agencies and other providers, and
- administration of standardized assessment tools, e.g., CANS, PSC 35

The primary focus of assessment is the youth's safety level, trauma exposure history, and current psychological symptoms or problems. In order to ensure appropriate services driven by the assessment, they should all include a comprehensive review of the youth's strengths, history, symptoms, behaviors and family connections.

Clinical Services

Treatment approaches vary among providers and are tailored to individual youth needs. Programs may use evidence-based and promising practice models including Attachment, Regulation and Competency (ARC), which emphasizes the need to help caregivers (including residential staff) develop an attuned, sensitive and responsive stance in order to help youth improve emotional and behavioral regulation, Integrated Treatment of Complex Trauma (ITCT), Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), Dialectical Behavior Therapy (DBT), Multidimensional Family Therapy (MDFT), and others. Additionally, treatment should include training for family members that are engaged with youth or are developing relationships with them. Such family training will ensure that caregivers are prepared to work with youth after discharge from the ECP in a continuous way that reinforces the skills learned by youth while engaged in the program.

Treatment targets the key behaviors and their intensity levels that inhibit the youth's ability to succeed in traditional treatment settings. These behaviors are typically identified by the CFT and referring party. Treatment focuses on both the reduction of maladaptive behaviors and enhancement of existing or learned strengths and skills that a youth can leverage to mitigate behaviors and improve functioning in the community. Staff and caregivers will consistently provide youth with experiences that run contrary to the majority of their interpersonal history. The role of staff and caregivers is to defy negative expectations, while also actively working to contradict the expectation of an ideal provider. Staff and caregivers should model with youth that they too can make mistakes; staff and caregivers reflect curiously upon mistakes, are comfortable with the idea that they can make errors, seek feedback from others and wonder openly about how they could improve in the future.

In treatment, Celia was initially ambivalent about accepting help. Receiving multiple modalities of service while residing with Laurel, she would oscillate between strong engagement and avoidance of sessions with providers. Throughout treatment, Caring Change (CC) provided therapy using a Dialectical Behavior Therapy ("DBT") approach, which focused on decreasing suicidality and emotional instability. CC staff identified that Celia was most motivated by the goals of achieving independence and connecting with her family. Using these goals as motivation, CC's team was able to establish strong engagement and collaboration with Celia. In addition, she capitalized on her intelligence, strong relationship skills and frequent journaling to achieve greater emotional stability during her placement with CC.

When youth are dysregulated, staff and caregivers work to remain calm and maintain clear thinking, seeking to interact with the youth in a positive, concerned manner. Staff and caregivers utilize many of the same skills

they teach and reinforce with youth, including distress tolerance, interpersonal effectiveness, mindfulness and reflective curiosity about their emotions and behaviors.

Assessment-driven, creative, and individualized treatment requires highly skilled, experienced, and technically eclectic clinicians. For an example of matching identified issues to treatment components that may be useful, please see Appendix A.

Education Supports

Youth placed in ECPs often have exceptional educational needs requiring high levels of partnership and commitment from the local educational entities, providers and the county departments. Adequate services require educational support and cooperation from the educational rights holder, the school district where the program is located and the school district from which the youth is transitioning. Considerable attention should be paid to how a youth's education can be supported during their time in placement, after care, and transition to their next placement [1]. Counties working to develop ECPs should work proactively with provider partners to anticipate and plan for educational needs common among youth requiring this intensity of treatment. Counties that are exploring this option should follow the best guidelines put forth by the county's AB 2083 MOU and collaborate with the county Interagency Leadership Team, the Special Education Local Plan Area(s) in the county, the school district of the neighborhood school, the county Foster Youth Services Coordinating Program (FYSCP), and the FYSCP Executive Advisory Committee. All educational partners should be alerted to the Enhanced Care Program to ensure clarification around roles and responsibilities and to ensure the development of the best possible education plans for each youth in placement.

Providers of ECPs must also develop internal expertise within the organization to ensure appropriate advocacy in meeting youth's educational needs. Staff and Specialized Parents receive additional training on educational system interventions, securing educational entitlements for students in foster care, section 504 plans and process, the Individualized Education Program (IEP) process and how to identify special education service options that are most appropriate to each specific youth's needs. Additionally, some ECPs develop expertise within family partner or youth advocate roles to specifically address educational needs for youth served by the program.

Through the IEP team, services are determined based on identified needs in the least restrictive environment. Services are designed specific to the needs identified in order to be successful in the school setting and not all recommendations made to the IEP team will be granted. However, in general, education options in the ECPs may include the school of origin, local school placement near the program or Nonpublic School placement. The precise educational option for each youth is determined through the Best Interest Determination (BID). This decision is made by the Educational Rights Holder and is informed through the BID process which is a shared responsibility between the school of origin and the placing agency. Use of a Non-Public School for an educational placement is a decision of the IEP team and cannot be predetermined by the Enhanced Care Program.

[1] For information on school of origin and other foster youth specifics in regards to School of Origin and best interest determinations please see: Best Interest Determination Joint Letter (Revised Mar-10-2021; PDF). This joint letter between the CDE and California Department of Social Services details the Best Interest Determination process, including recommendations from the State. Also see section II of this publication: http://www.cfyetf.org/uploads/AB%20490%20FAQs06.pdf

Youth with IEPs should have their plan reviewed and updated based on the current status of their needs. In many situations, these youth have been referred for educational assessments in the past and may have changed school districts due to placement disruption before assessments could be completed. Therefore, it is recommended that IEP teams initiate new assessments for youth as they are transitioned into an Enhanced Care Program. An IEP team may approve any educational support or services determined to be necessary during the time of treatment. Should a youth have no IEP, the team and the child's educational rights holder should consider requesting an evaluation to determine if there is an educational disability. There is no exhaustive list of allowable services; this is an open entitlement based upon individual needs and agreement of the team. However, there are structures within the federal regulations and California educational codes, as well as rules that prohibit duplication of services. Individual determinations about how to ensure appropriate educational opportunities for youth are dependent on the particular educational needs of the youth, location of the program, anticipated living arrangement of the youth upon discharge and the available educational options. These factors should be discussed by the IEP team and the CFT as part of determining appropriateness for enrollment in an Enhanced Care Program.

Family Finding and Engagement

The aim of Family Finding is to engage individuals who can provide legal or emotional/relational permanency for youth. The Family Finding model activates around a series of stages where staff: locate and engage at least 40 family members; plan and make decisions with youth and families; determine if plans are meeting the family's needs; and provide supports to maintain permanency. Overall, findings from studies indicate that familial connections increase and the time to identify placements decreases.

Youth placed in ECPs typically have histories of fractured or unknown family connections, intensive externalized and/or internalized behaviors and regular placement disruptions. These youth have experienced profound disconnection from the people in their natural ecology. An important antidote to this lack of

With the help of her Caring Change (CC) team, Celia's substance use decreased, she began developing healthier coping skills and improved emotion regulation. These gains allowed the team to focus more on permanency and connections. Family searches identified family members in other states. Family Finding trips to Texas and Arizona occurred and Celia fostered those relationships to build her circle of natural supports which will continue to support her in her transition into adulthood. Celia also reconnected with her grandmother, who was unable to have Celia live with her due to grandmother's medical issues, but was able to have Celia visit monthly (Celia's transportation was provided by her Wraparound team) and speak regularly on the phone. Celia also reconnected with her brother, with whom she began texting frequently and made plans to visit. Bilingual staff were used to support these connections, as several members of Celia's family preferred to communicate in Spanish.

After 6 months in CC's Enhanced Care Program, Celia graduated from CC's Enhanced ISFC and continued with Wraparound services in one of CC's non-Enhanced ISFC homes. At 17, Celia found a job, learned to budget and made plans to access Transitional Housing upon her 18th birthday, while also maintaining her rekindled family connections. Celia recently graduated from high school and intends to enroll herself in community college. She plans to transfer to a four-year university to major in pre-law in order to pursue her dream of becoming a public defender and give back to her community.

connection is the intentional and focused integration of caring adults and unpaid supporters into the youth's mental health treatment, CFT processes and placement setting.

ECPs operate from the fundamental perspective that every youth has a family (note: the definition of family should be seen in the broader sense, beyond only traditional biological connections). The continuous identification and engagement of a youth's relatives, fictive kin, natural support people and community members can greatly enhance the positive effects of mental health treatment interventions, support better team decision-making, reduce racial disparities in foster care, improve culturally responsive treatment, reduce placement disruptions and support the sustainment of progress over time. Placement within an Enhanced Care Program should prompt vigorous family finding and engagement activities with a focus on identifying a family-based placement that can adequately meet the youth's specific needs. When a family-based placement is identified as a viable option for the youth, the family can be trained in the same treatment approach as that used by the ECP staff.

Collaborating with families on a consistent basis to identify natural support systems is another method of actively combating racial disparities in child welfare. While prioritizing the needs, dignity and humanity of families, ECPs should work with the youth's extended family and friends to mitigate crises and emergencies. Service providers collaborate with the youth's parents, grandparents, aunts and/or uncles to facilitate achievement of legal or emotional/relational permanency. Additionally, Enhanced Care Program principles and procedures must be transformed such that client and family self-determination are central to the vital family engagement and permanency work. Enhanced Care Program staff work to build and transferable skills and support success in current and future placements, including family placements, by ensuring that families have access to concrete support in response to economic needs and providing intensive family services, including visitation, throughout treatment.

While some ECPs include specialized staff, such as a Permanency or Connections Specialist, to focus on network building, others embed this work in the responsibilities of other staff roles. Regardless of the person's title, it is important that someone on the team primarily focuses on building a youth's natural support network and creating a robust CFT to develop sustainable solutions for the legal and emotional/relational permanency of the youth. Legitimizing and protecting this work through the use of a designated staff person allows for its continuation in the midst of potential crises that can result in it being deprioritized.

Staff who focus on family finding and engagement work utilize a variety of tools to creatively assess each youth's existing network of support, identify potential network members and skillfully engage them in the youth's treatment. They complete logs or other tracking tools to assess and evaluate progress related to the quantity and quality of a youth's connections and may also use the CANS Permanency Module as a way to assess and inform their work. These staff will also use their knowledge of the youth's connections to schedule and facilitate regular CFT meetings with as many natural supports as possible.

For more information, on family finding and the impact of family finding on youth outcomes, please see: https://www.childtrends.org/project/evaluating-family-finding and https://www.casey.org/family-search-engagement/.

Wraparound Principles

Child and Family Team (CFT) members of youth in ECPs should be educated on the structure and framework of ECPs and the treatment team should communicate with those team members frequently to share progress data, insights regarding triggers and/or safety cues, plans for placement/permanency options and to discuss any other helpful information. For more information on wraparound principles, please see Appendix B.

To prepare for Celia's arrival, Caring Change's (CC) health services team worked with Celia's pediatric social worker and medical team at the hospital where she had been treated to make sure all of Celia's medical needs would be well attended to during her placement. The hospital staff even trained Laurel and CC's health services team on how to manage insulin dependency.

Even if a youth and family has not formally participated in the Wraparound process, the focused work of building and engaging a network of unpaid natural support people around a youth and their family within a CFT process should begin prior to and continue during enrollment in an Enhanced Care Program. In order to fully align with the Wraparound Principles of Family Voice and Choice, Natural Supports, Team Based and Cultural Competence, natural support people and family members must be effectively identified and engaged throughout placement and woven into the mental health and/or substance use treatment being provided by the program.

To maintain the spirit of the Integrated Core Practice Model, Wraparound, Continuum of Care Reform and AB 2083, CFT engagement should be a seamless part of treatment and all key stakeholders should work collaboratively to ensure the continuity of the CFT's work before, during and after any individualized placement. Doing this well takes intentional partnership, information-sharing and focus. CFTs should prioritize inclusion of the youth, family members, identified kin and as many natural supports as possible. CFTs should also include all involved parties and systems, including but not limited to CASA workers, child welfare/probation system staff, educational partners, regional center staff, service providers and others involved in the youth's holistic care plan.

Discharge

Youth are ready for discharge from an Enhanced Care Program when their targeted behaviors sustain diminishment to a level that will allow for transition to a lower level of care. Discharge planning should begin from the moment the youth enters the Enhanced Care Program, and the youth and family need to be an active part of this planning. Barrier behaviors should drop below a level necessary for a return to community-based/family-based outpatient treatment, anticipating that such transitions often exacerbate symptoms. Symptom severity should decrease from severe to moderate on most indicators. Key challenges such as suicidality, self-harm, aggression, psychotic symptoms and social withdrawal should ideally decrease to moderate levels. High risk behaviors and symptoms will likely be more critical to transition than other individualized goals. If the youth is being discharged from an E-STRTP, six months of aftercare must be offered.

Part II: Developing Enhanced Care Programs

ECP Program Models and Eligibility

In the **E-STRTP model**, agencies utilize a staff-based placement and service model under an STRTP license. These programs provide intensive behavioral health services, funded by EPSDT contracts, while engaging in care and supervision activities funded by an enhanced STRTP placement rate established collaboratively by the county and provider. Youth are placed alone or with one other youth in a licensed STRTP facility operating with a significantly higher staff to client ratio than standard STRTPs. All E-STRTP placements must be approved by the county Interagency Placement Committee and recommended by the Qualified Individual (QI), unless the youth is placed on an emergency basis.

Program	Description	License	Primary Funding Options	Staffing
Enhanced ISFC	Foster home with a Specialized Resource Parent (including qualified family members, kin, or natural supports), that also includes intensive staffing to focus on stabilization and permanency needs	FFA, RFA home with ISFC levels of training	- Funded up to traditional STRTP rate - Wrap w/ reinvestment - Specialty Mental Health Services - TFC	- Resource parent (with no other job or competing responsibility) - Intensive staffing individualized to meet the most urgent needs

Enhanced STRTP	STRTP level placement with 24/7 staffing to serve one to two youth at a time, with the whole program customized to that/those youth	STRTP	- Enhanced STRTP rate - Wrap w/ reinvestment - Specialty Mental Health Services	- 24/7 staffing, flexibly designed to offer the individualized structure - Mental health services provided multiple hours per day

In the **E-ISFC model**, youth are placed in a family setting with a Specialized Resource Parent who has received the additional training, coaching, and supervision that enables them to respond in a therapeutic manner to very challenging behaviors The Specialized Resource Parent is funded by an enhanced payment rate for both the agency and the resource parent, which must be negotiated and may not exceed the standard STRTP placement rate. Youth are typically placed alone in an E-ISFC family and program staff are available to support the youth and family in the home 24 hours per day/7 days per week. Youth also receive intensive behavioral health services funded through EPSDT contracts. E-ISFC placements may be with a family member or other natural support whenever possible, provided that all preconditions of the ISFC license are met and the family member or natural support is approved as a Resource Parent through a Foster Family Agency (FFA) that is able to administer an E-ISFC program. ISFC families can be relatives or fictive kin of the youth identified by the provider and county partners.

While enrolled in either an E-STRTP or E-ISFC program, youth receive comprehensive assessment, treatment planning, therapy, rehabilitation, collateral, intensive home-based services, intensive care coordination and case management services from registered or licensed clinicians and experienced skills counselors. Medication and nursing support will be provided or arranged for, as needed. Interventions are trauma-informed, highly innovative and individually designed to target the behaviors or symptoms that most significantly inhibit the youth's ability to progress in traditional behavioral health and/or placement programs. In collaboration with the placing county and the Child and Family Team (CFT), ECPs also provide guidance and/or support to the youth's permanency planning process, including family search, engagement and permanency support activities as appropriate and necessary.

ECPs serve minor children and nonminor dependents. Programs accepting youth with unmet complex needs will review youth symptoms, risks and behaviors, fit with any other individuals in the home/program, available staff resources and the ability of less restrictive or intensive settings to serve the youth. If the program is utilizing an STRTP license model, state requirements regarding alignment with the Qualified Individual Assessment justifying the need for an STRTP level of care would be considered.

Eligibility Criteria

CANS reflects significant needs across a variety of domains, particularly related to Behavioral/Emotional Needs, Life Functioning and Risk Behaviors

And two or more of the following:

- Self-harm with or without imminent risk of suicide
- Aggression with or without imminent risk of homicide
- Fire setting with or without imminent risk of arson
- Psychosis that is dangerous or disabling; places youth or others at risk of harm
- Risk of wandering or absences from care arising from a mental health condition
- Significant sexualized behaviors putting youth or others at risk, including commercial sexualized exploitation
- Substance use or abuse
- Frequent impulsive, high-risk behaviors
- Psychotic episodes that are not presenting in an acute stage
- Serious deterioration in ability to manage activities of daily living
- Repeated removal from placements and/or a history of placement instability
- Challenges with engagement in mental health services
- Co-occurring Mental Health, Substance Use and/or Developmental Delay diagnoses
- Delinquent behaviors resulting from behavioral health challenges
- History of psychiatric hospitalizations/5150s with continued significant safety concerns
- Serious physical health concerns with or without imminent risk of hospitalization
- Other behavioral problems that are not able to be treated in other treatment settings

County Partnerships

ECPs are focused on the provision of services to treat youth's behavioral and emotional health needs and not on trying to match a youth without placement to an open bed. This focus requires partnerships between providers and county agencies to ensure agencies have the resources necessary to meet the needs of the most complex youth in the county. All relevant county agencies and associated system partners should be included in these partnerships, including but not limited to child welfare, probation, behavioral health, education and regional centers.

Critical features of partnership for ECPs include building strong team communication between the provider and all involved county departments, intense coordination of care, integrated funding models utilizing Behavioral Health and Child Welfare/Probation funds, inclusion of educational system and regional center partners and development of shared risk structures. Counties should work toward alignment with AB 2083 and Children and

Youth System of Care memorandums of understanding. State agency partnership is necessary for counties with providers to navigate the licensing standards as programs launch.

In Celia's case, the placing county's social services agency was ready and willing to pay for the entire cost of the placement and therapeutic supports, even without the involvement of behavioral health.

Recognizing the importance of leveraging Medi-Cal EPSDT to access federal revenue and support the provision of mental health services to which youth are entitled, Caring Change(CC) began persistently reaching out, including sending emails every day to the placing county's behavioral health department to reiterate that CC could not move forward with the placement without a behavioral health contract in place. The social services department began doing the same, reiterating the importance of establishing a behavioral health contract with CC that addressed the myriad needs Celia had, including provisions for Specialty Mental Health Services, Therapeutic Behavioral Services, Therapeutic Foster Care, Medication Management and step-down Wraparound services.

Within two weeks, there was an agreement that a behavioral health contract was possible and CC was able to begin providing all the required documentation to establish a contract. As a result, CC was able to provide a comprehensive array of behavioral health services to support Celia's transition to a lower level of home-based care.

As a team, all involved partners should not only have a voice in the considerations of the youth's needs, but also have a responsibility to help fully fund those services in an integrated way within their scope and regulations. For example, if a youth is in an individualized placement setting, requiring 24/7 staffing, the design needs to ensure that this level of service is supported in the staffing and budget within the program, rather than relying on a variety of outside providers to push services into the program. Certainly, if the youth is already connected to and has a relationship with another provider, that partner should become part of the broader team, but behavioral health services provided by the staff in the program must be fully funded and flexibly applied. This means that funding for ECPs must be a braid of both placement rates and behavioral health funding. Not only is this the best scenario for youth, but this ensures programs are leveraging as much Federal Financial Participation as possible, bringing down the overall cost to the county. Additionally, funding for family finding and engagement activities must be part of the menu of services provided through an ECP.

It can take quite some time to create the kind of placement that will help youth stabilize when time is of the essence. Providers need time to secure a site, hire the staff, recruit Specialized Parents if home-based placement will be utilized, train and on-board staff and ensure they are working as a strong and integrated team. This takes time and resources – resources that agencies aren't able to invest without a partnership with a county and a commitment to fully fund and support the program during start-up and over time.

Shared Risk

Protecting and preserving the safety of youth with unmet complex needs is the highest priority of providers and creating programs that promise a no eject/no reject approach can present significant risk that was historically assumed to be held 100% by the provider. Thus, when critical incidents or high-profile accidents occurred, blame was often placed wholly on the provider. Yet it is known that no incident or program challenge occurs in a vacuum, without other driving factors. Sometimes those factors can look like pressure to take a youth quickly, with inadequate funding and siloed, uncoordinated services. In each of these situations, responsibility – and thus risk – is shared not only with the provider, but also the placing agency and entire system of care.

ECPs will operate with a high degree of attunement to issues related to trauma-informed care and cultural responsiveness, mitigating the disparities in service and the impact of racial bias and racism on youth in treatment. Program staff and county partners are expected to reflect both internally and as a team to ensure that concerns about youth admissions to the program and/or remaining in treatment are discussed in ways that address the systemic challenges that youth of color face and the frequency with which they are deemed "too challenging" or "unsuccessful" due to behaviors that white youth could exhibit without fear of losing placement.

Enhanced Care Program providers and their county partners work diligently within the CFT context to design solutions to challenging issues so that youth can stay in their placement and program, even when doing so requires extraordinary interventions developed by and with the CFT members. All treatment discussion and decisions will occur within the Child and Family Team context, ensuring that all efforts are made to identify areas of challenge or concern and to preserve placement. Removal from an Enhanced Care Program occurs as a result of a CFT decision that a placement change is in the youth's best interest or that a youth no longer needs enhanced services. If disruption does occur, youth should be given immediate access to support to help them exit in order to mitigate potentially devastating effects on their' well-being.

Licensing

In order to provide services within an Enhanced Care Program, agencies operating under an STRTP framework will need to update and/or create a new Plan of Operations and Program Statements for Community Care Licensing (CCL) review and approval. Depending on the content of their existing Plan of Operations, FFA based programs may need to update these documents for CCL as well to achieve the flexibility needed for this program. These updates will enable programs to operate under adjusted structures and providing clarity to licensing departments about the ways in which the structure, services and supports available within ECPs are distinctly different from "standard" ISFC or STRTP programming. If not already in place, ECPs using an STRTP licensure model will also need to work with the Department of Health Care Services (DHCS) to ensure Mental Health Program Approval of any new program sites. Providers can anticipate the need to work with the local CCL liaison, as well as CDSS leadership and state-level CCL staff in order to address barriers within existing STRTP or ISFC regulations and to discuss area where exceptions may be necessary in order to best serve the youth identified for treatment within an ECP.

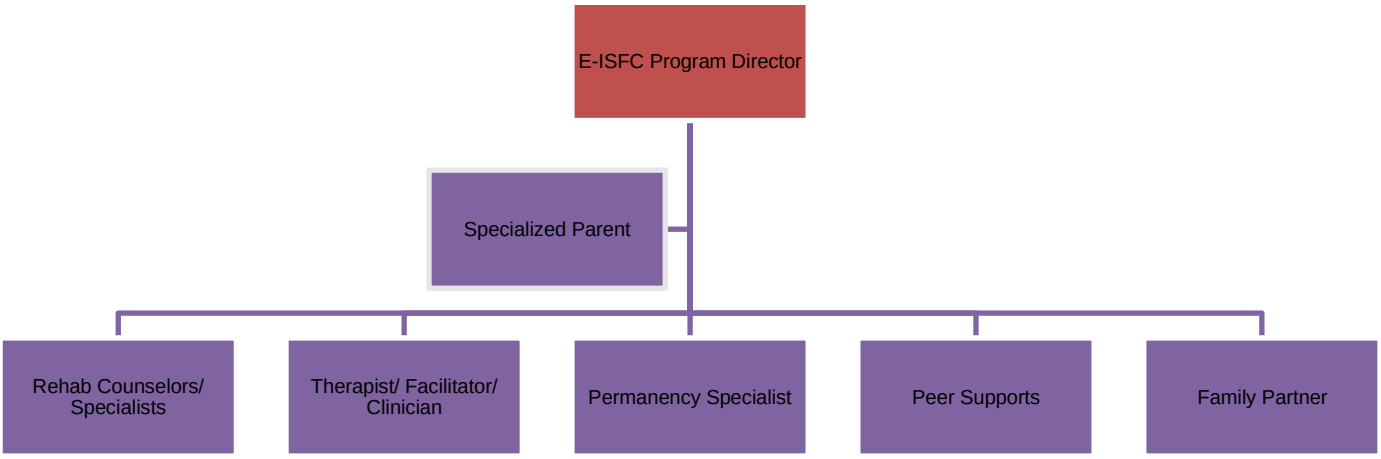
Staffing Models

E-ISFC Staffing

Enhanced Care Program staffing is determined by the license under which the program will be operating. The Enhanced ISFC model builds on a traditional ISFC home through the addition of a dedicated Specialized Parent. Specialized Parents differ from traditional ISFC resource parents in several key ways, including:

- experience in a helping profession, or prior experience working with youth with unmet complex needs;
- capacity for 24/7 availability to respond to youth needs, with at least one parent acting full-time as a Specialized Parent and not working outside the home;
- a commitment to providing unconditional care for the youth regardless of any behavioral challenges that emerge, with a no eject, no reject policy; and
- successful completion of rigorous supplemental training and continuing education.

Enhanced Care Program staff are available to provide in-person support in the home 24 hours per day, seven days per week, further enhancing the level of support and therapeutic intervention available. This support, provided by therapists, rehab counselors and permanency specialists, may include scheduled meetings, additional check-ins during challenging periods or responding to crises in the home as they arise. In some programs, family partners and/or peer support also provide key services to increase engagement and the therapeutic impact of services. Designed to be short-term treatment options, Specialized Parent homes support youth stabilization and the creation of a sustainable legal and/or emotional/relational permanency plans. ECPs are intended to be linked directly with supportive community-based services such as Wraparound and Mobile Crisis Response to support placement preservation. Wraparound services can also assist with family finding and support step-down into traditional ISFC or Foster Family Agency (FFA) homes or with natural supports.



E-ISFC Staff Training

Because the E-ISFC program serves youth with highly complex behavioral health needs, the staff training plan is more comprehensive than traditional ISFC staff training and is aligned with training provided for staff working in an STRTP. In some cases, E-ISFC staff training meets or exceeds the licensing regulations for STRTPs. Training for E-ISFC staff ranges from 80-120 hours of initial training that includes both new hire orientation and in-program training. Additionally, E-ISFC staff also complete ongoing annual training commensurate with agency and Interim Licensing Standards. Please see Appendix C for an example staff training plans.

Enhanced Care Program staff will receive training and technical assistance to increase cultural responsiveness.

Specialized Parent Training

At the core of the E-ISFC model are the Specialized Parents, who are specifically recruited, assessed, trained and approved by the FFA to meet the individualized needs of youth with unmet complex needs. Specialized Parents often have previous professional experience in the helping professions and/or in working with high needs youth. Regardless of prior experience, all caregivers are highly trained to the E-ISFC model and receive additional training as compared to standard ISFC resource parent training.

To ensure that all caregivers are prepared to meet the unique challenges of the youth in their home, the FFA provides at least 40 hours of intensive pre-approval training, in alignment with both Intensive Services Foster Care (ISFC) standards and TFC requirements, followed by additional training and coaching specific to the youth they will care for. Please see Appendix C for an example list of Specialized Parent trainings.

In addition to the intensive pre-approval training, Celia's identified Specialized Parent, Laurel, received training in managing insulin dependency from Celia's hospital staff. Laurel was also trained in Medication Policies and Procedures, as well as multiple trainings on building resilience and supporting attachment with foster youth who have experienced complex trauma.

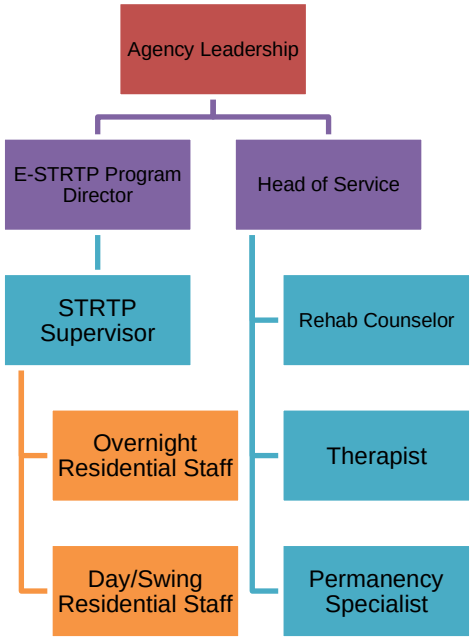
To best support Celia with her history of trauma and substance use disorder, Celia's staff team received additional training on the Seeking Safety model of treatment. Once Celia began to feel a sense of safety with Laurel and her Caring Change (CC) team, she was able to participate in CC's weekly Seeking Safety group therapy sessions, which also provided her with an opportunity to build some relationships with her peers, outside of situations involving her substance use. Finally, Celia's team was trained in DBT training and DBT skills groups, to support Celia's healing.

The FFA conducts a thorough assessment of the parents' skills, experience and capacity to be trauma-informed and develops goals with caregivers for continuous learning. Each caregiver receives youth-specific support from the treatment team, families are invited to attend monthly caregiver group meetings offering support and training. Caregivers must also engage in ongoing training tailored to their specific needs and the population of youth for whom they are caring. This training is offered in group classes, as deemed appropriate, and in the private weekly coaching meetings component of the support they receive while providing Therapeutic Foster Care.

Enhanced-STRTP Staffing

E-STRTP staffing structures are more robust than the minimum direct care and mental health program staff to youth ratios outlined by licensing and DHCS regulations for licensed STRTPs. E-STRTP programs must be able to increase staffing to address any anticipated high needs and to responsively meet such needs when they arise. E-STRTPs should typically assume at least a 1:1 milieu staff to client ratio 24 hours a day; however, it is not uncommon, particularly early in treatment, to have two milieu staff available on site at all times.

Additionally, a rehab counselor and therapist are available and participating in the milieu to enhance therapeutic activities on a daily basis. This staffing model allows for the 1:1 support of youth while balancing care and supervision with therapeutic interventions. Therapeutic supports are provided by staff on the floor throughout the day through planned skill-building interventions and ready response to crisis behavioral needs. For youth with substance use issues, staff will be trained in interventions to address substance use.



E-STRTP Staff Training

E-STRTP staff have access to a dedicated training team to support the rigorous and comprehensive field, classroom and experiential learning required to serve their target population. The team should have considerable experience with residential treatment and developing relevant curriculum and course work. This is particularly critical in assisting staff in balancing their responsibility to act in a trauma-informed manner, while intervening on challenging behaviors.

E-STRTP training is centered on the premise that everything we do and how we do it has the potential to either cue safety and stability or contribute to further dysregulation, disengagement and unsafe coping mechanisms that may compromise safety and security. E-STRTPs must make every effort to translate trauma-informed research into practical and realistic practice for youth and staff.

Training experiences should emphasize the essential elements on trauma-informed care within each training provided to staff:

- Explaining the benefits of trauma-informed approaches
    - Promoting healing and resilience, increasing youth functioning and overall well-being
    - Minimizing retraumatization, reducing the number of critical incidents and crisis services, fewer placement changes
    - Management: enhancing staff resilience and improving job satisfaction, reducing turnover and burnout
- Presenting basic information on trauma
    - What trauma is and how it affects the brain and body
    - Trauma related adaptations, symptoms and behaviors
    - Gender and culturally specific issues, including coping mechanisms,
    - Facilitating youth safety and stability
- Demonstrating effective skills
    - Effective response to youth experiencing challenges with program expectations
    - Responding to youth disclosures of trauma respectfully and effectively
- Sufficient skill practice and rehearsal
    - Using role plays
    - Practicing de-escalation techniques
    - Practicing how to identify boundary issues and maintain professional boundaries
- Reinforcing and building upon strategies that have been used successfully in the past

E-STRTP staff are required to complete orientation training, including up to 80 hours of in-person and online training and at least 8 hours of field training/job shadowing, prior to any work directly with youth. Additionally, E-STRTP staff are required to receive at least 52 hours of training annually. Please see Appendix C for an example list of E-STRTP trainings.

ECP Funding

Designing an effective and individualized program is dependent on integrated funding from child welfare and behavioral health to provide all the necessary services and supports. Delivering the individualized services needed to effectively meet the needs of youth who require complex care necessitates creativity, collaboration, partnership and an unconditional commitment to do whatever it takes to achieve success. These innovative services can be funded through a comprehensive mix of placement and service dollars, utilizing state investments in complex care funding made available through AB153 as outlined in the existing All County Letter (ACL-21-119) with available county allocations described in the recent County Fiscal Letter (CFL 21-22-35) and forthcoming guidance from CDSS. Further detail on each of the below funding streams, as well as additional funding information, can be found in Appendix E.

Complex Care Funding		
Behavioral Health		
Medi-Cal: Specialty Mental Health services	Leverage federal, state EPSDT and local funding. Per-minute reimbursement for services documented in progress notes including	Provisional service rates determined based on provider costs and projected units of services during contract negotiation with county MHP

	assessment, plan development, rehabilitation, IHBS, collateral, therapy, case management, ICC, crisis, medication management	
Medi-Cal Therapeutic Foster Care	Leverage federal, state and local funding to reimburse resource parent therapeutic work. Daily rate based on services and a progress note	Provisional service rate determined based on provider costs and projected units of services during contract negotiation with county MHP
MHSA	Programmatic funding based on county MHSA plan	Based on MHSA fund availability
AB153 Child Specific Funding	Option to apply for child specific AB153 funding for increased anticipated EPSDT local match costs.	Amount based on proposal/request submitted to CDSS. See ACL 21-119 for submission details.
DMC-ODS	Substance Use funding may be available through the Behavioral Health Department	Provisional service rate determined based on provider costs and projected units of services during contract negotiation with county MHP
General Fund	Additional funding needed for cost reimbursement or other expenses that may not be covered through Medi-Cal, social services or other payers.	Reimbursement of costs
Social Services		
Enhanced STRTP or Enhanced ISFC rate individualized rate (through AB2944)	Monthly rate, prorated, for the provision of intensive services negotiated with CDSS	ISFC rate up to $14,035/mo. STRTP rate at least $14,035 per month. Rates set in collaboration with CDSS.
AB153 Child Specific Funding	Option to apply for child specific AB153 funding for increased anticipated county costs.	Amount based on proposal/request submitted to CDSS. See ACL 21-119 for submission details.
Wraparound	Monthly rate, prorated, for the provision of intensive services	Up to $14,035/mo., prorated. For lower rates, funding may be available in reinvestment options
Wraparound reinvestment	County-allocated funds for foster youth via Wraparound and County funding allocations; unused funding received for eligible Wraparound services and funding can be used for alternative approaches	Range of adjunct funding
Grants and Allocations, Community funds; 2011 realignment	Block Grants and other county-specific dollars may be used for pro-social services and activities	Range of adjunct funding
Juvenile Probation		
Enhanced STRTP or Enhanced ISFC rate	Monthly rate, prorated, for the provision of intensive services negotiated with CDSS	ISFC rate up to $14,035/mo. STRTP rate at least $14,035 per month.

individualized rate (through AB2944)		Rates set in collaboration with CDSS.
AB153 Child Specific Funding	Option to apply for child specific AB153 funding for increased anticipated county costs.	Amount based on proposal/request submitted to CDSS. See ACL 21-119 for submission details.
Wraparound	Monthly rate, prorated, for the provision of intensive services	Up to $14,035/mo., prorated. For lower rates, funding may be available in reinvestment options
Wraparound reinvestment	Similar to social services, probation may share the oversight of these funds	Range of adjunct funding
Grants and Allocations	Block Grants and other county-specific awards may be used for pro-social services and activities	Range of adjunct funding
Regional Center		
Individual Program Plan (IPP)	Services are determined by the Individualized Program Plan (IPP) team to support persons with developmental disabilities and their families to build their capacities and capabilities. Services are coordinated and provided for by the regional center through generic resource coordination or the regional center network of providers or vendors. Services coordinated by the regional center may not fund ECPs, unless the provider is vendored by their local regional center to provide specific services according to their vendorization. Regional center services designated by the IPP can be layered and integrated into the ECP programing, per the IPP.	"Vendor" and "provider" are the words used to describe the community of professionals who provide direct services to people with developmental disabilities through contracts with California's network of 21 community-based, non-profit regional centers. Before providers can provide and be reimbursed for services, they must go through an approval and contracting process with their local regional center(s). Vendorization is the process for identification, selection, and utilization of service providers based on the qualifications and other requirements necessary in order to provide services to consumers. The vendorization process allows regional centers to verify, prior to the provision of services to consumers, that an applicant meets all of the requirements and standards specified in regulations. Applicants who meet the specified requirements and standards are assigned a unique vendor identification number and service code.
Education		
Individualized Education Plan (IEP)	Through the IEP, services may be approved and paid for by the education system for special education and related services. Special Education Dept has to review and the IEP must include specific language about how services are related to youth obtaining a	Funding determined by IEP team

	Free Appropriate Public Education. Funds will not be used for programs, but may fund specific services provided by programs.	
Local Control Funding Formula (LCFF)	District funds are available to provide some direct services, including academic instruction, to students who are in foster care that meet the LCFF definition.	Funding determined by School District
Foster Youth Services Coordinating Program	Can provide direct services to foster youth through AB 130 at the COE level. This requires that the COE FYSCP apply for funds. See this link for more information https://fyscptap.scoe.net/resources/additional-direct-service-funds-ab-130	Funding determined by FYSCP

Start-up and operational costs are part of funding considerations. Start-up costs may be inclusive of funding for recruitment of Specialized Parents (E-ISFC); hiring, training/ramp up for staff; and facilities costs (rental, purchase, renovation or other for offices and/or facility for E-STRTP). Because of these complexities and to guarantee availability of the program as urgent youth needs arise, it is strongly recommended that counties develop cost-reimbursement contracts that fully fund both start-up and operational costs in an ongoing manner. AB 153 provides for funding for these costs through a proposal process to build capacity within counties, though precise guidance on applying for these funds is forthcoming. Please see Appendix D for example Enhanced Care Program budgets.

Funding can also be viewed through the lens of the core program elements. The example below reflects the potential costs of each element of service within an E-ISFC model. The blended funding can cover all or portions of each service, such as social services funding paying for the Specialized Parent, flex funds paying for some of the family finding and stabilization and behavioral health paying for some of the family engagement activities and all of the behavioral health services.

E-ISFC Cost Breakdown Example			
Service	**Rationale**	**Example Monthly Cost per Youth**	**Example Annual Cost**
Specialized Parent	To support high cost of living and incentivize giving their time and energy to the youth: ● Tiered payment approach ● Stipend/housing as available ● Medical benefits ● Matrix of specialty homes ● Type of household/personality for the different youth personalities/behaviors	$ 8000	$96,000
Family Engagement/ Finding	● Family Finding staff time ● Rapid Response Family Finding for youth with no permanency plan	$5000	$60,000

	• Rapid engagement for families + youth with a plan. Involves resourcing, parent prep/training, time together with coaching • 16 hours/week of family search/finding • Flex funds; travel costs		

Clinical Care Team (stabilization, service provision and oversight/ supervision)	• Child and Family Team (CFT)
	• Therapeutic Interventions and EBPs
	• Community linkage
	• Independent Living Skills
	• 24/7 Rapid Response
	• Flex funds
	• Program Staffing (portion of FTE funded per youth):
	  ○ 1 Clinical Program Manager
	  ○ 1 CADAC
	  ○ 2 Clinician II
	  ○ 1 Family Finding Supervisor
	  ○ 6 Family Specialists
	  ○ 1 Family Partner
	  ○ 1 Family Finding Specialist
	  ○ 1 Administrative Assistant
	• Stabilization up to 24/7, titrating down to 10 hrs./wk.; 40 hrs./wk. average; 10 staff
		$12,000	$144,000

	Total	**$25,000**	**$300,000**

Enhanced programs provide significant long-term fiscal savings to future health systems by comprehensively addressing unmet complex needs to reduce crisis and urgent medical services. This link describes these benefits in more detail.

Questions to Consider for Counties

1. What is the current continuum of care in the county and what might be missing?
2. What are the highest levels of care available in your county (Wraparound, Emergency Response, STRTP, Other)?
3. Does the county regularly have placement gaps, frequent placement changes or absences from care with some youth with complex unmet needs in the foster care or probation system?
4. Are there youth that have intensive needs that require more services than Wraparound or currently available community-based services?
5. Are there youth that struggle in congregate care, regularly leave placement without permission or refuse to go to identified placements?
6. Are there periods of time youth in the foster care system with complex unmet needs are at higher risk of engaging in higher risk behaviors and need more intensive individualized supports than can be offered?
7. Approximately how many youth in the county require more intensive, individualized and time-limited programs to stabilize and step down to a lower level of care?

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The Catalyst Center engages stakeholders at each level of the advocacy process to promote the health, well-being and safety of children, youth and families in California as a collective voice impacting policy and best practices to strengthen the systems that serve them.

https://www.catalyst-center.org

Cardenas Consulting Group improves the capacities of the behavioral health system and works at the provider, county and state levels to ensure provision of high-quality services.

https://cardenasgroup.org

Redwood Community Services offers a continuum of care built to empower, encourage, and sustain success while providing unconditional care and positive connections.

https://redwoodcommunityservices.org

Seneca Family of Agencies provides a broad continuum of permanency, mental health, education, and juvenile justice services to over 18,000 youth and families throughout California and Washington State each year.

https://senecafoa.org

Pacific Clinics is California's largest community-based nonprofit provider of behavioral and mental health services and supports. Its team of more than 2,000 employees speak 22 languages and are dedicated to offering hope and unlocking the full potential of individuals and families through culturally-responsive, trauma-informed, research-based services for individuals and families from birth to older adults. The agency offers services in 18 counties including Alameda, Contra Costa, Fresno, Kings, Los Angeles, Madera, Orange, Placer, Riverside, Sacramento, San Bernardino, San Francisco, Santa Clara, Solano, Stanislaus, Stockton, Tulare and Ventura.

https://www.pacificclinics.org/

Appendix A: Problems-to-components grid

Problem	Treatment components that may be useful
1. Safety (environmental)	Safety training, system interventions, psychoeducation
2. Caretaker support	Family therapy, intervention with caretakers
3. Anxiety	Distress reduction/affect regulation training, titrated exposure, cognitive processing
4. Depression	Relationship building and support, cognitive processing, group therapy
5. Anger/aggression	Distress reduction/affect regulation training, trigger identification/intervention, cognitive processing
6. Low self-esteem	Cognitive processing, relational processing, group therapy, relationship building and support
7. Posttraumatic stress	Distress reduction/affect regulation training, titrated exposure, cognitive processing, psychoeducation, relationship building and support, trigger identification/intervention
8. Attachment insecurity	Relationship building and support, relational processing, group therapy, intervention with caretakers
9. Identity issues	Relationship building and support, relational processing
10. Relationship problems	Relationship building and support, relational processing cognitive processing, group therapy
11. Suicidality	Safety training, distress reduction/affect regulation training, cognitive processing, systems intervention
12. Risky behaviors and tension-reduction behaviors	Psychoeducation, safety training, cognitive processing, trigger identification/intervention
13. Dissociation	Distress reduction/affect regulation training, affect regulation training, emotional processing, trigger identification/intervention
14. Substance abuse	Psychoeducation, trigger identification/intervention, titrated exposure, distress reduction/affect regulation training
15. Grief	Psychoeducation, cognitive processing, relationship building and support
16. Sexual concerns and/or dysfunctional behaviors	Psychoeducation, trigger identification/intervention, titrated exposure, distress reduction/affect regulation training
17. Self-mutilation	Trigger identification/intervention, distress reduction/affect regulation training

Source: University of Southern California Keck School of Medicine, Adolescent Trauma Training Center

Integrative Treatment of Complex Trauma for Adolescents (ITCT-A; Briere & Lanktree, 2013).

Appendix B: Wraparound Principles in Enhanced Care Programs

Wraparound is a supportive and effective model of delivering services to families and is currently being analyzed for inclusion in the federal clearinghouse of evidence-based practices. The Wraparound process (as outlined in ACIN I-52-15) is consistently woven through the fabric of statewide efforts to fully implement the Continuum of Care Reform, Family First Prevention Services Act (FFPSA), System of Care coordination (AB 2083) and other initiatives.

Wraparound implemented with high fidelity is required as a part of California's operationalization of FFPSA's 6-month aftercare service requirement for all youth transitioning from an STRTP to a family-based setting. It is also very possible that a youth or family would have participated in Wraparound prior to their placement in an STRTP or individualized placement as an effort to prevent that need.

Given the demonstrated effectiveness of the Wraparound process and the likelihood that it is both familiar to a family and has/will bookend an STRTP or individualized placement for a youth, it is strongly recommended that all individualized placement and treatment models embrace and align with the 10 Wraparound principles listed below (and fully outlined by the National Wraparound Institute here).

- Family Voice and Choice
- Natural Supports
- Team Based
- Collaboration
- Community Based
- Culturally Competent
- Individualized
- Strengths Based
- Persistence
- Outcome Based

For more information on wraparound, please visit the UC Davis Wraparound site here or CDSS' information here.

Appendix C: Staff Training Topics

E-ISFC Staff Training

With recognition that the needs of all youth and families are different, Enhanced ISFC staff are provided with extensive training. Examples of trainings include:

- New Employee/Hire Orientation
- Child Development and Relational Treatment
- Impact of Trauma on Child Development
- Crisis Intervention
- Comprehensive Assessment and Planning (i.e., documentation training)
- CANS
- Working with Resource Parents
- Promoting Permanency
- Agency policies and procedures
- Mandated Child Abuse Reporting
- Adoption Competency Training (ACT)
- Trauma-informed Service Delivery
- Substance Use
- Educational Disabilities
- Working with commercially Sexually Exploited Youth
- Cultural Proficiency Trainings
- Sexual Orientation, Gender Identity and Expression and serving LGBTQ+ Youth
- Pathways to Permanence I or II
- Foster Youth Rights
- Symptoms and Impact of Child Abuse
- Foster Youth and the Educational System (includes content in IEPs and managing educational needs)

Specialized Parent Training

To ensure that all caregivers are prepared to meet the unique challenges of the youth in their home, the FFA provides at least 40 hours of intensive pre-approval training in alignment with both Intensive Services Foster Care (ISFC) standards and requirements, followed by additional training and coaching specific to the youth they will care for. Below is a list of possible topics for trainings that a Specialized Parent may receive:

- Introduction to Child Welfare (and its goals of safety, permanency and wellbeing)
- Introduction to Trauma-Informed Foster Parenting
- Foster Youth and the Education System (includes content in IEPs and managing educational needs)
- Foster Parenting and Unconditional Care (for the highest-need youth)
- Substance Use
- Educational Disabilities
- Working with Commercially Sexually Exploited Youth

- Sexual Orientation, Gender Identity and Expression and serving LGBTQ+ Youth
- Suicide Risk and Prevention with Children, Adolescents, and Nonminor Dependents
- Foster Care Medication Policies and Procedures
- Implicit Bias in the Foster Care System
- Culturally Responsive Caregiving
- Building Resiliency in Youth Impacted by Trauma and Loss
- CPR and First Aid
- CCL Regulations While Caring for Foster Youth
- Understanding Child Abuse and Caregiving Reporting Requirements
- Understanding Attachment When Caring for Foster Youth
- Creating a Safe Caregiving Environment
- Progressive Crisis Intervention
- Pathways to Permanence

SAMPLE SPECIALIZED RESOURCE PARENT TRAINING	
Topic	**Example Training Titles**
Introduction to E-ISFC and the Mental Health Service System	*E-ISFC Logic Model Training: Supports the Specialized Parent with understanding the target population, the specific interventions, the requirements of the parent and the agency and the intended overall program outcomes of E-ISFC.*
Understanding Child and Adolescent Development and Age-appropriate Interventions for Positive Behavior Management	*Wisdom Path Way (WPW) Reparative Parenting model- Level I: 3 day/18-hour course on the overview of child development and the impacts of trauma and attachment.*
Working with Abused, Neglected, and/or Delinquent Children/Youth Using a Trauma-Informed Approach and Understanding Youth Attachment Challenges	*WPW- Level II: 4 day/24 hours teaching and coaching on the WPW approach and development of coaching plans, limit setting, and the impacts of trauma and attachment.*
Preventing and Managing a Crisis	*Crisis Training for Foster Families (a derivative of Therapeutic Crisis Intervention)*
Communication and Relationship Building with Children/Youth and Families	*WPW- Level II: 4 day/24 hours teaching and coaching on the WPW approach and development of coaching plans, limit setting, and the impacts of trauma and attachment.*
Cultural Humility & Awareness	*Embedded in WPW Level I and II. Supports the Specialized Parent with understanding the impacts of historical and systemic trauma in various cultures. Additional training on SOGIE.*
Teaming	*Training of the CFT process and CFT meeting roles and responsibilities. On-going coaching is provided to support the Specialized Parent on their role within the CFT.*
Parent Self-Care, Loss and Vicarious Trauma	*E-ISFC Staff will use the Taking Care of Yourself checklist from the National Child Traumatic Stress Network with resource parent. Discussion will also include the program respite care program.*
Others	*HIPAA, Progress Note Documentation -The Daily Life of a Chart/Medi-Cal note writing, Computer Intro-Parents will be loaned an Agency laptop to use while providing E-ISFC services, Motivational Interviewing, Specialty Training such as CSEC, SUD and other individual youth needs.*

E-STRTP Staff Training

STRTP regulations outline the primary requirements for staff training; however, E-STRTP programs provide additional trainings that are relevant for the program's target population. Examples of additional trainings include:

- New Employee Onboarding
    - Introduction to Trauma-Informed Care
    - Collaborative Problem Solving
    - Motivational Interviewing
    - System of Care
    - PRO-ACT (Crisis Communication Day 1 & 2 and Restraint)
    - Vicarious/Secondary Trauma
- Additional Training:
    - Employee Wellness – Emotional Intelligence: Awareness
    - Question, Persuade, Refer (QPR)
    - Boundaries and Dual Relationships for Paraprofessionals
    - Identifying and Preventing Child Abuse and Neglect
    - Medication Management for Children's Services Paraprofessionals
    - Overview of Psychiatric Medications for Paraprofessionals
    - Traumatic Stress Disorders in Children, Adolescents, and Nonminor Dependents
    - Critical and Unusual Incidents
    - Behavioral Support and Management
    - Foster Youth and the Educational System (includes content in IEPs and managing educational needs)

Appendix D: Budget Samples

E-ISFC Sample Budget #1

Specialty Mental Health	Rate Per Minute	Total Unit of Service per Month	Cost Per Client per Month	Total Annual Cost per Client
Case Management	$2.41	357	$860	**$10,320**
MH Services	$3.14	1638	$5,143	**$61,716**
Medication Support	$5.79	42	$243	**$2,916**
Crisis Intervention	$4.51	63	$284	**$3,408**
			$6,530	**$78,360**

TFC	Rate Per Day	Service Days per Client per Month (average)	Cost Per Client per Month	Total Annual Cost per Client
TFC	$398	15	$5,970	**$71,640**

Enhanced ISFC Plus (Pilot Program)			Cost Per Client per Month	Total Annual Cost per Client
ISFC Plus (Pilot)			$11,355	**$91,236**
Grand Total			**$23,855**	**$286,263**

Direct Costs

Personnel Costs	**Contract Amount**
Salaries	$97,850
Payroll Taxes	$7,486
Employee Benefits	$28,132
Subtotal Personnel Costs	$**133,468**
Operating Expenses	
Equip/Parts/IT networks	$8,000
General Supplies	$500
Postage/Shipping/Printing	$300
Foster Parent Fees	$8,550
Foster Parent Recruitment	$6,000
Audit fee	$700
Travel	$3000
Training & Conference	$5300
Client Program Costs	$10,000
Contract Psychiatrists	$17,920
Insurance Liability	$17,169
Occupancy Cost	$22,313
Other Regional support Cost	$ 11,000
Subtotal Operating Expenses	**$110,752**
Indirect Costs *	
Administrative Overhead	$42,043
Subtotal Indirect Costs	**$42,043**
GRAND TOTAL*	**$286,263**

E-ISFC Sample Budget #2

		E-ISFC (4 homes)	
PROJECTED CLIENT CAPACITY			
Max Program Capacity			4.0
Projected Social Services Revenue			
Social Services Wraparound Revenue			240,000
Social Services Placement Revenue			240,000
Total Social Services Revenue			$480,000
Projected Behavioral Health Revenue			
Projected EPSDT Specialty Mental Health Services Revenue			253,440
Projected Therapeutic Foster Care Revenue			208,704
Total Behavioral Health Revenue			$462,144
Other Revenue			
Wraparound Reinvestment, MHSA, General Fund, AB153, etc.			$553,500
TOTAL PROJECTED REVENUE			$1,495,644
Projected Expenses			
PERSONNEL			
		Total	
Subtotal Salary			$563,219
	Benefits		152,069
TOTAL PERSONNEL			$715,288
OPERATIONS			
Contract Services			$38,538
Program Support			$57,121
Occupancy			$246,285
Child and Family Related			$254,582
TOTAL OPERATIONS			$596,526
TOTAL DIRECT EXPENSE			$1,311,814
	Allocable Overhead		183,654
TOTAL EXPENSE			$1,495,468
Net Position			$176
Average Cost Per Child Per Month		$31,156	

Personnel Line Items	
Position	**FTE**
Regional Executive Director	0.05
Program Director	0.25
Wraparound & Placement Program Supervisor	0.65
Recruitment & Retention Supervisor	0.05
Nurse	0.10
Care Coordinator/Placement Clinician	1.00
Bilingual Care Coordinator/Bilingual Placement Clinician	1.00
Placement Support Counselor	1.00
Bilingual Support Counselor/Bilingual Placement Support Counselor	1.00
Family Partner/Peer Partner	0.50
Permanency Specialist	0.50
Therapist	0.15
Therapeutic Foster Care Clinician	1.00
Resource Family Recruiter and Retention Specialist	0.50
Senior Administrative Assistant	0.05
Program Assistant	0.15
Health Information Specialist	0.15
Facility Manager	0.10
Administrator On-Call	0.50
24/7 Crisis Response On-Call	0.55

Operations Line Items
Contract Services
Psychiatry Services
Contract Nursing Services
Note Approvers
Other Contract Services
Program Support
Office Supplies
Telephone
Staff Training/Professional Development
Subscriptions and Dues
Travel/Mileage Reimbursement
Staff Recruitment Materials
Resource Family Recruitment Materials
Advertising/Marketing- Digital Resource Family Recruitment
Occupancy
Facility Lease
Facility Interest
Facility Depreciation
Utilities
Building Maintenance and Supplies
Equipment (rep, dep, expendable)
Child and Family Related
Treatment and Engagement Supplies
Resource Family Placement Fees
Resource Family Respite Fees

E-STRTP Sample Budget

Staffing		Monthly Expense
Program Director		$400
Program Administrator/Manager		$1,310
Therapeutic Skills Coach		$8,070
TSC Overnight		$1,825
Additional Coverage (holidays/PTO)		$1,400
Records Manager		$700
IT/QA Staff		$250
Maintenance Staff		$272
	Total Wages	$14,227
	Benefits	$3,272
	Total Monthly Staffing Expense	$**17,499**
Client Expense		
Food, Supplies, Clothing, Activities, Allowances		$**1,250**
Operation Expense		
Facility Cost		$900
Facility Maintenance Supplies		$120
Insurance Expense		$200
Mileage/Vehicle Expense		$525
Miscellaneous Admin Expense		$500
Office Supplies		$75
Telephone/Internet		$200
Utilities		$375
	Monthly Operating Expense	$2,895
	Total Monthly Expense	**$21,644**
	Indirect Admin - 12%	**$2,597**
	Total Monthly STRTP Rate Expense	**$24,242**

STRTP Rate per month per youth		$24,242
EPSDT Services - ~18 hours per week per youth		$14,040
	Total Monthly Cost	**$38,282**

Appendix E: Fiscal Sources Detail

No two counties will have the same strategy to fund Enhanced Care Programs. The level of detail provided in the file is intended to lead into county-specific discussions through the tailored TA about how the funding can be braided to support this work. Some counties will have a straight-forward strategy and others will need to plan to create something that works.

County System of Care Funding Sources

	Youth/Family Supports	Pre-Placement Support	ECP Placement	Layered Services^	System of Care
	Transition Services	- Child-Specific Support AB 153 - Wraparound			
	Crisis Services	- Family Urgent Response System FURS AB403 - County BH Mobile Response Team			
	Foster Parent Recruitment	Foster Parent Recruitment, Retention, and Support FPRRS AB403			
Enhanced Care Program	Care and Supervision		**- AFDC-FC Title IV-E** **- Child-Specific Support AB153** **- County Gen. Funds/ Realignment** **- Innovative Model of Care Funds AB2944**		
	Mental Health Services		**- Medi-Cal EPSDT Specialty MH Services**		

			- Medi-Cal TFC		
	Educational Support			- County Office of Education COE º - SELPA - LEA Funding	
	Substance Use			- Drug Medi-Cal º - Medi-Cal EPSDT Specialty MH Servicesº	
	Wraparound			- MHSA FSP Funds º - County Gen Funds/ Realignment - Medi-Cal EPSDT Specialty MH Services	
	Developmental Disabilities			Regional Center º	
	Medical Services			Medi-Cal Title XIX º	
	CSEC			State CSEC Program	
	Vocational/ Life Training			Medi-Cal Title XX º	
	Close SOC Gaps				- County Capacity Building AB153 - FFPSA Part IV *
	Use of Federal Funds				MHP MHSA 3-year plan
	Close Complex Need Gaps				Children's Crisis Continuum Pilot AB153 *

^ These services are encumbered through service contracts, if available. For example, not every county has a Wraparound program.

º An ECP provider would need to secure separate contracts to access these fund sources directly. For example, they would have to become Drug Medi-Cal certified to be able to provide SUD services.

* Funding details/processes not yet published.

In the following tables, "**Current Funding**" is used to identify funding sources or programs commonly used to support the services identified. The term "**Possible Funding**" is used to identify funding sources or programs that may be part of the youth treatment, but will vary based on youth needs and county resources. Many items in the Possible Funding sections depend on each county opting-in or applying for the programs or grants.

In addition to the program activities included in the tables, all counties may have created local programs or services to meet the needs of their communities. Such initiatives vary widely around the state and are dependent on both funding availability and local priorities.

Pre-Placement Support Funding

Pre-Placement Support is provided to youth in the time period before they are admitted into an enhanced care program. This time period varies widely from 1 day to possibly multiple weeks, depending on the specific situation and case history of the youth.

Current Funding	**Info**	**Details**
Active Support Intervention Services (ASIST)	ACL 19-53 AB 403	• Short-term aid to help youth transitioning from residential facilities that are not transitioning to STRTP. • Financial assistance for counties that opted-in only. • TA services available from CDSS to all counties.
Family Urgent Response System FURS	ACL 20-89 AB 403	• Emergency support for youth or families needing crisis and/or de-escalation support. • Limited to 3 hours of support per incident. • State and county funds.
Possible Funding	**Info**	**Details**
MHSA Funds	ACL 20-104	• Programing and funding determined by the county 3-year MHSA plan. • Includes Wraparound coordinated at the county level. • Providers must have a Wraparound Services contract. • Highly flexible based on local plans/priorities.

Complex Care Funding Type I	ACL 21-119 AB 153	• Child-specific funding for individualized services. • Must be consistent with a permanency plan. • Must submit a request form with plan and budget. • Fund allocation by county.
Foster Parent Recruitment, Retention, and Support FPRRS	ACL 20-11 AB 403	• Funding to recruit, retain and support foster caregivers. • Provides staffing, family finding, childcare, exceptional supports. • Must submit yearly program plans & outcomes reports. • Relies on 2011 Realignment funds.
State CSEC Program	ACL 21-142 AB 855	• For minors at risk of commercial sexual exploitation. • Flexible funding covers a wide array of services. • Funding provided directly to counties and through the State CSEC Program.
County General Funds/ Realignment Funds		• Flexible funding from local resources. • Funding determined based on availability of funds and local priorities.

Enhanced Care Program Funding

This funding provides for the core support needed by the youth. The foundation of the ECP is what enables the youth to stabilize and access the other community ("layered") services to meet their needs. For the ECP provider, the braided budget that is created from these sources will determine the financial viability of the program.

Current Funding	**Info**	**Details**
AFDC-FC	ACL 21-76 Title IV-E	• Care and Supervision funding for non-Medi-Cal staff and support services. • Separate rate for STRTP and ISFC programs
Medi-Cal EPSDT SMHS		• Mental Health Services cover an array of MH support. • Service rates negotiated by provider contract.
Medi-Cal TFC		• Therapeutic Foster Care provided by foster parent in an ISFC home. • Requires trained foster parent to act as a Medi-Cal provider, supervised by FFA licensed clinical staff.
County General Funds/ Realignment Funds		• Flexible funding from local resources. • Funding determined based on availability of funds and local priorities.
Possible Funding	**Info**	**Details**

Innovative Model of Care Funds	ACL 22-21 AB 2944	• Updates AFDC-FC rate for children with unmet complex needs • 2 types of funds: Program-specific and Child-specific • Must provide program description for an innovative model or individual youth. • Counties responsible for 100% of non-FFP portion.
Complex Care Funding Type I	ACL 21-119 AB 153	• Child-specific funding for individualized services. • Must be consistent with a permanency plan. • Must submit a request form with plan and budget. • Recurring funding with a yearly allocation by county.
MHSA Funding		• Mental Health services that are covered by the county MHSA plan. • Funding differs based on county allocations and service contracts.

Layered/Community Services Funding

The provider contracted for the Enhanced Care Program may be able to also provide the layered support services, subject to the individual service structure and contracting requirements. In most cases, the ECP staff will work to provide access to these services, aligned with the youth's treatment plan, but not necessarily provide the services directly.

Current Funding	**Info**	**Details**
Regional Center	Title IV-E	• Services for Individuals with Developmental Disabilities. • Services aligned with an Individualized Program Plan (IPP) for each youth. • Providers must be vendorized to bill services.
Drug Medi-Cal		• Services to clients with Substance Use Disorders. • Providers must be Drug Medi-Cal certified in addition to their program license.
State CSEC Program	ACL 21-142 AB 855	• For minors at risk of commercial sexual exploitation. • Flexible funding covers a wide array of services. • Funding provided directly to counties and through the State CSEC Program.
Medi-Cal Title XIX		• Provides access to medical services and supports for foster youth. • Medical services provided by an approved Medi-Cal provider.
Medi-Cal Title XX		• Services for life skills, vocational training, transition support.

		• Services provided under approved contracts.
Possible Funding	**Info**	**Details**
Foster Youth Services Coordinating Program FYSCP	ACL 16-91 SB 860	• Program run by the County Office of Education. • Requires county application for funds. • Education support provided directly to foster youth.
MHSA FSP Funds	ACL 20-104	• Programing and funding determined by county 3-year MHSA plan. • Wraparound services coordinated at the county level. • Providers must have a Wraparound Services contract.
Approved Relative Caregiver Funds	ACL 15-96	• Flexible funds support placement with youth relatives. • Increases payment to relative caregivers to equal AFDC funds. • Funding for counties that opted-in.

System of Care Funding

Recent funding opportunities are designed to identify and fill gaps in the county system of care. These funds or programs require long-term plans rooted in stakeholder engagement and serve to address pressing needs of the community. Some of the activity involved in these initiatives may benefit the youth placed in ECPs eventually, but the funding will not be available in the short-term.

Each county must determine its ability to engage with these programs to promote the need of youth with unmet complex needs. Although the funding possibilities are extensive and flexible, a lot of coordination will be needed across the county system of care.

Possible Funding	**Info**	**Details**
Complex Care County Capacity Building Type II	ACL 21-143 AB 153	• County capacity building activities to expand or create new programs that fill gaps in the system of care. • Must submit self-assessment aligned with AB 2083 requirements. • County plans completed with stakeholder engagement. • Goal to address long-term capacity, not short-term need.
MHP MHSA 3-year plan		• County MHSA plans provide access to flexible funds aligned with Title IV-E guidelines. • Enhanced Care supports may be added to the next version of the MHSA plans.
Children's Crisis Continuum Pilot	AB 153	• Funding to participating counties for specialized supports to meet complex needs. • RFA details expected to be released in April, 2022.

FFPSA Part IV	ACL 21-116 AB 153	• Funding to support the FFPSA Aftercare requirements in the County Wraparound Plan. • EPSDT matches federal funds. • Focus is on creating high-fidelity Wraparound programs consistent with the CA Wraparound Standards. • Providers will have to be certified. • Funding details to be provided.