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.