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.

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.

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[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

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 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.

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.

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.