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

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.

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 when these systems have struggled to work collaboratively or intervene in silos rather than in a coordinated fashion.

The terms “complex care” or “complex needs” have been increasingly used as labels to describe youth; however, these terms more accurately reflect systemic barriers and lack of capacity rather than the individual needs of the youth. Offered as an alternative to the labels of “complex care” or “complex needs”, the phrase “unmet complex needs” is intended to highlight that youth engaged in Enhanced Care Programs have a variety of unaddressed needs across multiple domains. Many of these needs are rooted in histories of severe, chronic trauma, disrupted caregiving experiences, or other adverse life experiences. As a result of these unmet needs for relational and environmental safety, youth may have adapted relational and behavioral expressions that promote self-preservation or increase access to safety and survival. Many of these youth also have histories of involvement with behavioral health, child welfare, education, probation, regional center, and other systems of care that, paralleling their earlier
experiences, have been unable to meet 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 call to action is profound: to reframe a collective tendency to situate problems within youth and families and, instead, promote systemic accountability to accurately understand and address the needs of youth and families. Therefore, this guide will use the phrase “unmet complex needs”.

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. Some ECPs may be designed as specialized programs with expertise in serving particular populations, such as youth who have experienced sexual exploitation or youth with substance abuse concerns. The “no reject, no eject” philosophy should not be seen as inhibiting
programs from developing such specializations and determining that youth who are not aligned with the specialty population would be best served by other, more general ECPs.

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. Facilitating engagement with community-based enrichment activities is an important part of ECP design, as such activities provide youth with individualized opportunities that foster wellbeing, facilitate skill building, promote normalcy and empower youth. 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. Interventions and staffing ratios will change over the course of a youth’s treatment stay and may vary within a day, or even within an hour, based on the youth’s trauma symptoms and behavioral health needs.

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 homophobia, transphobia, racism and other types of bias 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. Many youth in foster care identify as LGBTQIA+ and in some cases a lack of acceptance of these identities has contributed to placement instability and has also inhibited access to services. 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 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, cis-gendered 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 and systems that perpetuate any type of bias or discrimination, 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 identities, including 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.

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’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.**
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.

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.

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. When possible, programs should consider the addition of Occupational Therapy as well. 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

*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.*
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.

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. 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.

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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
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.

**Family Finding and Engagement**

The aim of Family Finding is to engage individuals who can provide legal, physical or emotional/relational permanency for youth. The Family Finding model centers around developing a lifetime support network and is built on four core beliefs:

1. Every young person has an immediate and extended family, and they can be found if we try.
2. Loneliness can be devastating, even dangerous, and is experienced by most children and youth in the care system.
3. A permanent, meaningful connection to family and caring adults helps a youth to develop a sense of belonging and hope.
4. The single factor most closely associated with positive outcomes for young people is a meaningful, life-long connection to a family and community of support.

Staff engage in this framework of beliefs through a series of stages where staff: locate and engage as many family members, fictive kin, and other supportive adults as possible; hold the youth and family’s voice at the heart of the planning and decision-making process; 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, Child & Family Team 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 an immediate and extended family, and they can be found if we try. It is worth noting that 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 and identity-based 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 creating a natural support network that helps identify 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 and identity-based 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, physical 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 Child & Family Team to develop sustainable solutions for the legal, physical and emotional/relational permanency of the youth. While every staff member working with the youth and the family can and should engage in permanency efforts, 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 Child & Family Team 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.