

1 **SECOND SUPPLEMENTAL DECLARATION OF**
2 **PATRICIA CHAMBERLAIN, Ph.D.**

3 I, Patricia Chamberlain, Ph.D., hereby declare and affirm as follows:

4 **A. Summary of Qualifications and Opinions**

5 1. I am a licensed psychologist and a children’s mental health researcher. I
6 am the founder of the Oregon Social Learning Center, Community Programs, and
7 was the Executive Director from 1983 until 2006. The Oregon Social Learning
8 Center Community Programs is a private non-profit organization that designs and
9 delivers evidence-based mental health treatment services and is dedicated to
10 increasing the scientific understanding of social and psychological processes
11 related to health development of children and their families.

12 2. For the last 25 years, the focus of my work has been developing and
13 studying the effectiveness of Multidimensional Treatment Foster Care (MTFC), a
14 therapeutic foster care program which has been repeatedly lauded by the federal
15 government as a model program for treating children with significant emotional,
16 behavioral, and mental health needs.

17 3. I am currently the Principal Investigator on three grants related to MTFC,
18 one of which is funded by the National Institutes of Health and two by the National
19 Institute on Drug Abuse, and am a co-investigator on two other grants from these
20 organizations. I also am a Senior Research Scientist at the Center for Research to
21 Practice, an organization that works to translate advances in research to changes in
22 public child-serving systems’ practices to improve outcomes for children and
23 families, and a member of the Child and Adolescent Research Intervention
24 Network, a group that focuses on implementing evidence-based practices for
25 children with behavioral, emotional and mental health needs in the child welfare

1 system. I have authored three books and over seventy journal articles and book
2 chapters on evidence-based treatment approaches, outcome research, methodology,
3 foster care, and related topics. I have done more than 100 presentations on these
4 topics.

5 4. For many years, I have helped federal, state and local governments
6 develop and implement therapeutic foster care programs. Since 2003, I have been
7 working with communities in California to develop MTFC programs. For the last
8 several years, the California Institute for Mental Health (CIMH) and I, with a grant
9 from the National Institute of Mental Health, have been working to assist counties
10 in California in implementing MTFC.

11 5. My qualifications are set forth in more detail in my earlier declarations
12 submitted in support of Plaintiffs' Motion for Preliminary Injunction, true copies
13 of which are attached as Exhibits 1 and 2, respectively, and are incorporated herein
14 by reference. My most recent curriculum vitae details my education, professional
15 experience, organizational affiliations, publications and awards, a true copy of
16 which is attached as Exhibit 3 and is incorporated herein by reference.

17 6. Therapeutic foster care is an essential mental health service for youth
18 with significant emotional, behavioral, and mental health needs. A children's
19 mental health system that does not include therapeutic foster care as an available
20 intervention is incomplete and inadequate.

21 7. MTFC has been evaluated extensively, including in nine randomized
22 experimental clinical trials, and has been found to be an effective treatment for
23 children with significant emotional, behavioral, and mental health needs. MTFC
24 leads to consistent and sustained positive outcomes for children with emotional,
25 behavioral and mental health challenges and prevents the over-reliance on

1 restrictive out-of-home placements, like residential treatment centers and in-patient
2 hospitalization, for which there is no proven effectiveness.

3 8. To meet the mental health needs of children for whom therapeutic foster
4 care is necessary, all of the components of therapeutic foster care must be provided
5 and they must be provided in a coordinated fashion as they are with MTFC.

6 9. In my expert opinion, California cannot adequately provide the
7 components of therapeutic foster care unless it provides all of the components of
8 this service and does so in a coordinated fashion.

9 **B. Therapeutic Foster Care Is An Essential Children's Mental**
10 **Health Service**

11 10. In my prior declaration, I described MTFC. MTFC provides intensive,
12 individualized mental health care in a home-like setting to youth who face severe
13 emotional, behavioral, and mental health challenges. MTFC is an alternative to
14 group and residential care, institutionalization, and incarceration for these youth.
15 Exh. 1 at ¶ 9. In MTFC programs, specially trained foster parents provide a
16 therapeutic placement and act as the key implementing agents of an individualized
17 treatment plan. A variety of intensive services are provided to the child. In
18 addition, the child's family participates in therapy and receives education and
19 training regarding the child's disorder and how to manage the child's behaviors
20 and meet the child's needs so that after the child completes the foster care portion
21 of the MTFC program, he or she can return home, or to an alternative family
22 setting. Exh. 1 at ¶ 10. I also discussed the elements of the MTFC in my prior
23 declaration. These elements include recruitment and matching; pre-service
24 training; daily management of the child in the home or community; ongoing
25

1 supervision and support for foster parents; individual child treatment; family
2 treatment; and program supervision. Exh. 1 at ¶ 12.

3 11. I have reviewed plaintiffs' definition of therapeutic foster care and its
4 components in Appendix B. The activities described in the components of
5 therapeutic foster care in Appendix B contain a general description of the activities
6 that comprise the elements of MTFC.¹ My use of the term therapeutic foster care
7 in this declaration and in my prior declarations is consistent with the general
8 definition used in Appendix B and with plaintiffs' use of this term in this litigation.

9 12. As I discussed in my prior declaration, therapeutic foster care is an
10 essential mental health service for children with significant emotional, behavioral
11 and mental health needs. Exh. 1 at ¶¶ 3, 13-24. Children with the most serious and
12 chronic emotional, behavioral and mental health impairments often can have their
13 needs met by the intensive mental health interventions, provided in a home-like
14 setting, through therapeutic foster care. Failure to provide therapeutic foster care
15 can result in the over-reliance on more restrictive (and more expensive) out-of-

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17 ¹ For example, the specific "intensive oversight of the child's treatment," "ongoing
18 supervision and support [of therapeutic foster parents]," and "coordinat[ion] [of]
19 the efforts of the [therapeutic] foster parents," see Appendix B at 1, 3, 4, required
20 by MTFC is daily contact and at least weekly meetings with therapeutic foster
21 parents to monitor case progress. Some formal services that must be provided to
22 children receiving MTFC, see Appendix B at 5, include behavioral support
23 services for the child, crisis planning and intervention, education of the therapeutic
24 foster parents and child's family about the child's disorder and how to manage it,
25 mobile therapy, and medication monitoring.

1 home placements, including residential treatment centers and in patient
2 hospitalization, for which there is no proven effectiveness. A children's mental
3 health system that does not include therapeutic foster care as an available
4 intervention is incomplete and inadequate.

5 13. MTFC has been evaluated extensively, including in nine randomized
6 experimental clinical trials, and has repeatedly found to be clinically effective.
7 These evaluations show that MTFC provides consistent and sustained positive
8 outcomes for children, including decreased mental health symptoms, decreased
9 behavior problems, decreased delinquency, arrests and violent behavior, and more
10 successful and quick placement in the community. MTFC is not only clinically
11 effective, but is cost effective. As I discussed in my prior declarations, MTFC is a
12 fraction of the cost of alternative placements like group care or in-patient
13 hospitalization and leads to cost savings in other systems, such as the criminal
14 justice system. Exh. 1 at ¶¶ 17, 25-26; Exh. 2 at ¶ 6.

15 14. In my prior declaration, I discussed the eight randomized clinical trials of
16 MTFC that had been conducted at that time. Exh. 1 at ¶¶ 15-23. Since my prior
17 declaration, one additional study has been completed and, like the prior trials, has
18 concluded that MTFC is clinically effective.

19 a. My colleagues and I recently completed a two year follow-up
20 on a randomized clinical trial of girls referred to MTFC from the juvenile justice
21 system (Chamberlain, Leve, DeGarmo 2007). As with the results I previously
22 discussed from our study of boys referred to MTFC from the juvenile justice
23 system, Exh 1 at ¶¶ 18, 22-23, this study found that MTFC is a more effective
24 treatment approach than group care for these girls and leads improved outcomes,
25 including a significant reduction in number of referrals to the criminal justice

1 system and more than 100 fewer days in locked settings such as detention,
2 correctional facilities, jail or prison. The cost-implications of our findings are
3 significant. Estimates are that placement in MTFC costs about one-half less on a
4 daily basis than placement in group care. Additional cost were saved by the MTFC
5 group's more than 100 fewer days in locked settings when compared with the
6 control group in group care and by the MTFC participants' attendance at public
7 schools rather than the specialized institutional schools that most girls in the
8 control group attended.

9 b. My colleagues at the Oregon Social Learning Center have also
10 just completed a randomized trial of MTFC for preschoolers in the foster care
11 system (Fisher, Kim 2007). They focused on this group because studies have
12 consistently indicated that young foster children experience developmental and
13 mental health problems at extremely high rates. When compared to a control
14 group in regular foster care, the preschoolers who had received MTFC exhibited
15 positive changes in attachment-related behaviors and decreased avoidant behavior
16 as measured by the Parent Attachment Diary (PAD)², and had a decreased risk of
17 negative placement disruption³. Again, MTFC was found to have cost-savings
18 implications for this group.

20 ² PAD measures secure, resistant and avoidant attachment behaviors by asking
21 caregivers to indicate how their child responds to situation in which he/she was
22 frightened, hurt, or separated from the caregiver.

23 ³ Lower rates of negative placement disruption means that children are not being
24 expelled from foster homes because the foster parents are unable to deal with the
25 children's behavioral and emotional problems.

1 15. Based on research and program evaluation, MTFC is widely accepted as
2 an evidence-based practice for children with emotional, behavioral, and mental
3 health impairments. (See, for example, Mental Health: A Report of the Surgeon
4 General (2000). In general terms, an evidence-based practice is an intervention
5 that has been shown through rigorous scientific research to be an effective
6 treatment. Being deemed an evidence-based practice is the “gold standard” for a
7 mental health treatment.

8 **C. The Effectiveness Therapeutic Foster Care Requires the Provision**
9 **of All of the Components of this Service and that the Components**
10 **Be Provided in a Coordinated Fashion**

11 16. As a general proposition regarding evidenced-based practices of any
12 type, there is no evidence, and no reason to believe, that the intervention will be
13 effective if you vary the method of providing it from the way it was designed,
14 developed, and tested in research studies. There must be adherence to the practice
15 of an intervention to claim the evidence of its effectiveness.

16 17. Based on my research of therapeutic foster care and working with
17 programs providing MTFC, all of the components are essential. A therapeutic
18 foster care program must, for example, have an individualized treatment plan that
19 addresses the specific needs of the child and focuses on the skills a child needs to
20 gain to function. This individualized treatment plan helps ensure that there is a
21 single plan guiding all therapeutic interactions with the child, be it from the
22 therapeutic foster parents or other treating professionals. Therapeutic foster care
23 must also have trained therapeutic foster parents, who receive ongoing supervision
24 and support from the team, as the key implementers of the treatment plan. This
25 training is necessary to enable therapeutic foster parents to work on a day-to-day

1 basis with the child, implementing the behavioral plan and working towards the
2 goals identified in the treatment plan. A therapeutic foster care program must
3 involve the biological family (or other identified permanent placement) in the
4 treatment and plan for and transition the child from therapeutic foster care to a
5 permanent placement, be it the child's biological home or other family
6 environment in the community. These components are essential to ensuring that
7 any gains experienced by the child in therapeutic foster care are sustained when he
8 or she is placed in a permanent home, as research has consistently shown that
9 returning a "fixed" child to an unchanged environment is useless. Therefore, it is
10 essential to simultaneously work on the child and his environment. In my
11 experience, so-called therapeutic foster care programs that do not provide all of the
12 components do not get the positive results that have been shown from therapeutic
13 foster care, see *supra* at ¶ 13-14 and *infra* ¶ 19, and therefore cannot adequately
14 meet the mental health needs of the children they are serving.

15 18. Therapeutic foster care must be provided as an integrated service to be
16 effective, as I mentioned in my earlier declaration. Exh. 1 at ¶ 27. By integrated
17 service, I mean that the components are interrelated and must be coordinated. For
18 example, the therapeutic foster care team is involved in the development and
19 implementation of the child's treatment plan and in providing ongoing support and
20 supervision to the therapeutic foster parents. The therapeutic foster parents
21 participate as part of the team and then become the key agents in implementing the
22 child's treatment plan. When reunification with the child's family is a goal of
23 therapeutic foster care, the child's family participates in family therapy, receives
24 education to prepare them for the child's transition home, and is part of the child's
25 transition out of therapeutic foster care. The coordination of the components is a

1 key to the success of therapeutic foster care. With children with significant
2 behavioral, emotional and mental health needs, consistency across settings is
3 essential. Coordination of the components of therapeutic foster care ensures for
4 example, that the therapeutic foster parents, biological parents, treating
5 professionals, and teachers all use the same strategies and treatments when dealing
6 with the child and have the same expectations. I have seen situations where a
7 child's teacher, for example, does not follow the plan. Not only does it send a very
8 confusing message to the child, but the child copes by acting out and starting to
9 exhibit significant mental health, emotional or behavioral problems. Effective
10 therapeutic foster care programs must be coordinated to ensure that everyone is
11 working on the same plan, towards the same goals. Coordination avoids having
12 the child and family feeling pulled in multiple directions. In my experience,
13 without this coordination, children do not experience the positive results that are
14 possible from therapeutic foster care, see *supra* at ¶ 13-14 and *infra* ¶ 19.

15 19. My research and research of others has shown that to achieve therapeutic
16 foster care's shown positive results, therapeutic foster care programs must provide
17 all of the components in a coordinated fashion. This is what distinguishes MTFC
18 from other so-called therapeutic foster care programs. For example, a recent study
19 examined several therapeutic foster care programs nationally (Dore and Mullin,
20 2006). The authors found significant variation in the components of the programs
21 they examined. Other than MTFC, the therapeutic foster care programs they
22 studied only provided some of the components of therapeutic foster care as set
23 forth in Appendix B, and/or did not provide the components in a coordinated
24 fashion. These other programs, for example, had significant variations in their
25 clinical models, structure and intensity of services, and foster parent characteristics

1 and training requirements. The authors determined that only MTFC was a proven
2 effective mental health intervention for children. Among other things, the authors
3 found the following characteristics distinguished MTFC from the other programs
4 they studied: MTFC foster parents received intensive pre-service training on
5 therapeutic interventions, as well as close ongoing support and supervision from
6 program staff; MTFC used therapeutic foster parents as the primary treating agents
7 and had the youth's own biological family participate in family therapy and home
8 visits; and individualized programs were developed for each child using a
9 treatment team. The authors stated that "MTFC is one of the few mental health
10 interventions for children and youth that has been accorded the imprimatur of
11 'evidence-based treatment,'" and noted that randomized studies had found positive
12 outcomes for children receiving MTFC, including fewer arrests, fewer delinquent
13 activities, less time spent in incarceration, and decreased behavioral problems. The
14 authors concluded that following a program design like MTFC is essential to
15 improving outcomes in terms of child functioning, safety, and stability.

16 California

17 20. Since 2003, I have been working with communities in California to
18 develop MTFC programs. For the last several years, the California Institute for
19 Mental Health (CIMH) and I, with a grant from the National Institute of Mental
20 Health , have been working to get counties in California interested in implementing
21 MTFC. Through this project, we have helped several counties design and
22 implement MTFC programs, provided counties technical assistance, and helped
23 monitor practice. Through my work with CIMH, several counties have started
24 MTFC programs, including Orange, Fresno, San Diego, Kern, and Los Angeles.

1 21. One major barrier we have encountered is figuring out and getting Medi-
2 Cal to cover the component services of MTFC – services that are commonly paid
3 for by Medicaid in other states. Counties are having difficulty determining which
4 services are covered by Medi-Cal and how to bill for these covered services. I also
5 understand that there are some components that are difficult or impossible to get
6 covered by Medi-Cal.

7 22. In my work in California, and across the United States, I have
8 encountered so-called therapeutic foster care programs that do not provide all of
9 the components and/or do not coordinate the components. For example, I have
10 encountered programs that provide only higher payments to foster parents but that
11 do not have the therapeutic foster parents as part of the treatment team. I have seen
12 programs that send the therapeutic foster child to get professional services, such as
13 therapy, without coordinating the professional services with the strategies, goals
14 and interventions identified in the treatment plan. I have also seen programs that
15 do not develop and implement a plan to transition the child to a permanent home.
16 In my opinion, these programs do not lead to the positive outcomes for children
17 that are possible through therapeutic foster care programs that provide all of the
18 components in a coordinated fashion like MTFC. In contrast, the therapeutic foster
19 care programs that CIMH and I have helped develop in California provide all of
20 the components and do so in a coordinated fashion and are meeting the mental
21 health needs of the children they serve.

22 23. Based on my research and my considerable experience developing and
23 implementing therapeutic foster care programs, California cannot meet the mental
24 health needs of children for whom therapeutic foster care is necessary unless it
25 provides all the components and does so in a coordinated fashion.

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Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury under the laws of the United States of America and the State of California that the foregoing is true and correct. Executed this 29th day of November 2007 in Seaside, Oregon.



Patricia Chamberlain