SUPPLEMENTAL DECLARATION OF

ROBERT FRIEDMAN, Ph.D.

I, Dr. Robert Friedman, hereby declare and affirm as follows:

A. Summary of Qualifications and Opinions

1. For the last thirty-seven years, I have worked in the area of children's mental health. My professional focus has been on research in mental health interventions for children and the design of children's mental health programs and systems. I am currently a professor in the Department of Child and Family Studies within the Florida Mental Health Institute at the University of South Florida, a multi-disciplinary department that conducts applied research, provides training and education, and evaluates programs and interventions for children with mental health needs. From 1991 until 2006, I served as the Chair of the Department of Child and Family Studies. I also am the Director of the Research and Training Center at the University of South Florida, one of two federally-funded research and training centers on children's mental health. I have been the Director of this center since 1984. My research has been funded by numerous federal, state and local agencies and foundations, including by the National Institute of Mental Health, Center for Mental Health Services, and National Institute on Disability and Rehabilitation Research.

2. I have published 47 articles and 31 books or book chapters in the area of children's mental health, including "*A System of Care for Children and Youth with Severe Emotional Disturbances,*" the monograph that introduced the concept of a "system of care" for children with mental health needs. I have presented more than 140 papers in professional meetings and have presented numerous policy reports to public agencies on children's mental health topics.

3. I served on the Planning Board for the Surgeon General's Report on Mental Health and have provided Congressional testimony on several occasions. In 2002, I gave invited testimony to the President's New Freedom Commission on Mental Health. I have leadership roles in several organizations related to children's mental health, and I have served as a reviewer for several journals related to children's mental health.

4. My qualifications are set forth in more detail in my earlier declaration submitted in support of Plaintiffs' Motion for Preliminary Injunction, a true copy of which is attached as Exhibit 1 and incorporated herein by reference. My most recent curriculum vitae details my education, professional experience, organizational affiliations, publications and awards, a true copy of which is attached as Exhibit 2 and incorporated herein by reference.

5. Wraparound services and therapeutic foster care are medically necessary services for children with mental health needs and are widely considered essential services to any modern children's mental health systems. There is a strong evidence base that wraparound services and therapeutic foster care are clinically effective and lead to positive outcomes for children with mental health needs. Wraparound services and therapeutic foster care allow many children to live and function in the community, instead of being placed in restrictive institutional settings.

6. In order to meet the mental health needs of children for whom wraparound services or therapeutic foster care are medically necessary, all of the components of these services must be provided and they must be provided in a coordinated fashion. There is no evidence to suggest, and no reason to believe, that wraparound services or therapeutic foster care will have the positive outcomes

expected without providing all of the components and doing so in a coordinated fashion as they have been designed, developed and researched.

7. In my expert opinion, California cannot adequately provide the components of wraparound services or therapeutic foster care unless it provides all of the components of these services and does so in a coordinated fashion.

B. Wraparound Services and Therapeutic Foster Care Are Essential Mental Health Services and Lead to Positive Outcomes for Children

8. Wraparound services and therapeutic foster care are necessary for children with significant emotional, behavioral, or mental health needs, as I discussed in my prior declaration. Exh. 1 at ¶¶ 4, 5, 26-32. Wraparound services and therapeutic foster care are necessary components of a modern children's mental health system. Wraparound services and therapeutic foster care lead to long-term benefits for children with mental health needs, including sustained improvements in social, emotional, and behavioral functioning, decreased use of psychiatric hospitals and residential treatment centers, and improved outcomes in school.

9. In 2006, the Substance Abuse and Mental Health Services Administration (SAMHSA) of the U.S. Department of Health and Human Services released a study on the provision of community-based services provided through the systems of care grants.[1] System of care services are intensive home- and community-based

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[1] I described systems of care in my prior declaration. Exh. 1 at ¶¶ 2, 16-18. Like wraparound services, the principles guiding systems of care are that they must be child-centered and family-focused, community-based, and culturally competent.

mental health services and include wraparound services and therapeutic foster care. SAMSHA concluded that these services lead to meaningful improvements for children at a significant cost savings, including:

a. Reduced need for inpatient hospitalization, leading to an average per-child cost savings of $2,776;

b. Decreased utilization of inpatient facilities;

c. Reduced arrests, leading to an average per-child cost savings of $784;

d. Significantly reduced emotional and behavioral health problems and improvements sustained;

e. Significantly reduced suicide-related behaviors;

f. Improved school attendance and achievement; and

g. Significantly reduced placements in juvenile detention and other secure facilities.

10. I have reviewed the definitions of wraparound services and therapeutic foster care in Appendices A and B, respectively, and I agree with those definitions. My use of the terms wraparound services and therapeutic foster care in this declaration and in my prior declaration is the same as the definitions in Appendices A and B and as plaintiffs' use of those terms in this litigation.

11. As I discussed in my prior declaration, children's mental health systems have increasingly focused on incorporating interventions with proven success in treating children, or best practices. Exh. 1 at ¶¶ 19-22. These interventions are typically divided into different categories (i.e., "research-validated evidence-based

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This SAMSHA study is available on-line at http://www.systemsofcare.samhsa.gov/news/datafactsheet.aspx.

practices" and "promising practices") based on the strength of scientific knowledge about the effectiveness of the intervention. Although there are a variety of definitions of "evidence-based," basically for a treatment to be classified as a research validated evidence-based practice – the gold standard in mental health interventions for children, at least two studies by different investigators that examine the same population and use the same treatment must be conducted and must yield positive results.[2] In addition, the majority of studies on the intervention must support a finding that the intervention is effective. Promising practices are those that have worked within organizations in the field, have an objective basis for claiming effectiveness, and have the potential for replication among other organizations but have not yet been validated through research as conclusive (as they are with evidence-based practices). Promising practices must show potential for becoming an evidence-based practice with long-term sustainable impact. An intervention's classification as an evidence-based practice or promising practice has considerable weight, as many widely used children's mental health interventions are neither. As I discussed in my prior declaration, whether an intervention is considered an evidence-based or promising practice has more to do with whether the intervention was developed in an academic setting and quickly subjected to study (as most interventions that are first designated as research-

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[2] The studies can either be designed as a between-group study, where the experimental intervention is provided to one group of children and is not provided to a comparable control group, or as a within-group study, where the experimental intervention is given to one group of children for a period of time and then is no longer given to the same group of children.

validated evidence-based practices are) or is developed in the field (as most interventions that are first designed as promising practices are). Exh. 1 at ¶¶ 25-28.

12. Both wraparound services and therapeutic foster care have been proven to be clinically effective and to have positive outcomes for children with significant emotional, behavioral, and mental health needs. Therapeutic foster care is recognized as a research-validated evidence-based practice. Wraparound services have long been considered a promising practice, and, at the time of my last declaration, recent research had led many in the field of children's mental health to conclude it was a research-validated evidence-based practice. Exh. 1 at ¶¶ 23-30. Based on additional research that has been published since my last declaration (in particular, research by Dr. Eric Bruns and his colleagues, see, e.g. Bruns, Suter et al. 2005 and Bruns, et al. 2006), wraparound services are now generally considered to be an evidence-based practice. Wraparound services and therapeutic foster care are far more effective interventions for children and youth with serious emotional, behavioral and mental health challenges than traditional mental health services, such as in-office therapy. They also prevent the over-reliance on restrictive placements such as in-patient hospitalization and residential treatment centers, neither of which have been shown to have long-term benefits for children.

C. All of the Components Wraparound Services and Therapeutic Foster Care Must Be Provided In a Coordinated Fashion To Achieve the Expected Positive Outcomes From These Services

13. As a general proposition regarding evidenced-based practices, there is no evidence, and no reason to believe, that the intervention will lead to the positive

results that have been proven if you vary the method of providing it from the way it was designed, developed, and researched. There must be adherence to the evidence-based practice to obtain the results that are possible from the intervention.

14. All of the components of wraparound services and therapeutic foster care must be provided and be provided in a coordinated fashion, as required by these interventions' designs, to achieve the expected positive outcomes from these services.

15. As I discussed in my prior declaration, wraparound programs must contain the essential elements of the service to achieve the expected positive outcomes from wraparound services. Exh. 1 at ¶ 28. These essential elements are the same as the components in Appendix A. Researchers in the field of mental health, including Eric Bruns and others with the National Wraparound Initiative, have developed "fidelity measures" to test whether wraparound programs have these essential elements. They have proven that wraparound programs that faithfully provide all of the components of wraparound services in a coordinated fashion produce excellent results for children with emotional, behavioral, and mental health challenges.

16. Similarly, all of the elements of therapeutic foster care are essential to achieving the expected positive outcomes from this intervention. The essential elements of therapeutic foster care are the same as the components in Appendix B. Researchers, including Patricia Chamberlain, have concluded that therapeutic foster care programs that faithfully provide all of the components of therapeutic foster care in a coordinated fashion, as required by the intervention's design, are very effective in addressing children's mental health needs. Exh. 1 at ¶ 26.

17. Wraparound services and therapeutic foster care are adapted to the needs of the child. While every child who needs wraparound services or therapeutic foster care must receive every component of the service, the wraparound team or therapeutic foster care team individualizes the service by deciding how best to implement each component for a particular child and family.

18. As a general principle, children with complex mental health needs -- who are often involved in multiple systems -- need coordination and integration of services for their mental health needs to be met. The design of wraparound services and therapeutic foster care incorporates this principle and requires coordination of the components. Research has shown that achieving the positive outcomes from wraparound services requires that all of the components be provided in a coordinated fashion. In contrast, no research has found wraparound services to have these positive outcomes when any of the components are missing or when the components are not coordinated.

a. Two studies of wraparound programs exemplify the need for implementation of wraparound services with all of the components in a coordinated fashion in order to achieve positive results for children for whom the service is necessary. A recent study compared children in Nevada in the child welfare system receiving wraparound services to those receiving traditional mental health and child welfare services. (Rast, Bruns, et al., 2007). The researchers were careful to ensure that the wraparound program was being provided as it was intended to be provided. They examined the wraparound program and determined that it was providing wraparound services that had all of the essential elements and that the elements were being provided in a coordinated fashion. The study found that the group of children receiving wraparound services had positive outcomes,

including decreased behavioral problems and functional impairment as measured by the Child Behavior Checklist (CBCL)[3] and the Child and Adolescent Functional Assessment Scale (CAFAS)[4], decreased restrictiveness of residential placement as measured by the Restrictiveness of Living Environment Scale (ROLES)[5], more placement stability, and better grades in school.

b. In contrast, a study of a multi-site Department of Defense demonstration wraparound project did not find any statistically significant differences between children receiving this program's wraparound services and children receiving traditional mental health services (Bickman et al 2003). This wraparound program did not provide all of the components of wraparound services, nor did it coordinate the components that were provided. The authors

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[3] The CBCL assesses a child's emotional/behavioral problems through questions in a variety of areas, including the child's activities, social relations, and school performance. Standardized scores have been developed to distinguish levels of behavioral problems (i.e., clinical, borderline, and subclinical).

[4] The CAFAS assess a child's impairment in day-to-day functioning due to emotional, behavioral, psychological, psychiatric, or substance abuse problems. The CAFAS examines a variety of areas, including school/work, home, community, behavior towards others, self-harmful behavior, and substance abuse. Each of these areas is grouped into four levels of impairment, and a total score is generated by summing the scores in all areas.

[5] The ROLES assesses residential settings through a tiered level system, ranging from a child is living independently or with a family to where a child is living in a psychiatric hospital or in juvenile detention.

pointed out that they "did not determine whether services were delivered in a culturally-competent manner, that the plan was team-driven, that agencies had unconditional commitment to serve the children, or that families were full and active partners," all of which the authors stated had been "identified as important defining elements of an effective . . . program." For example, in this so-called wraparound program, the case managers, and not the wraparound team, developed the child's wraparound plan, and families were not actively involved in the implementation of the wraparound plan. This study supports the position that when wraparound services are not provided in the manner in which they have been designed, that is with all of the components provided in a coordinated fashion, they are not effective.

c. One state's recent experience implementing wraparound services provides another example of the need to provide all of the components in a coordinated fashion in order to be clinically effective. One region in Nebraska has a wraparound program. The local agency running the program was interested in adding multi-systemic therapy (MST), an evidence-based practice for children with anti-social behavior, to its array of community-based services. The MST providers first insisted on providing services independent of the wraparound team. The MST providers, not the wraparound team, would decide when a child needed MST, how often the child needed MST, and when the child no longer needed MST. The local agency quickly found that children receiving MST were not having the sustained positive outcomes that they expected (i.e., improved child functioning as measured by the CAFAS)[6]. The agency eventually integrated the MST providers into the

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[6] See n. 4 for description of CAFAS.

wraparound team. Now it is the wraparound team that decides what services and supports a child needs, and MST is one of many interventions available to the team. The wraparound team (of which the MST provider is a member) together decides when the child needs MST and how to use MST to meet the child's goals in the treatment plan. When the team selects MST as an intervention, the MST provider joins the team. The team together decides how often the child needs MST, monitors the child's progress, and decides when the child no longer needs MST. Other services, as determined by the team, are also provided. By coordinating wraparound services in this manner, Nebraska is finding that children's mental health is improving, as measured by the CAFAS.

19. In my professional opinion, California cannot meet the mental health needs of children for whom wraparound services or therapeutic foster care is medically necessary unless it provides all of the components of these services and does so in a coordinated fashion.

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 28th day of November, 2007 in Tampa, Florida.

Robert Friedman, Ph.D.