SUPPLEMENTAL DECLARATION OF TIMOTHY PENROD

I, Timothy Penrod, hereby declare and affirm as follows:

A. Summary of Qualifications and Opinions

1. I am the co-founder, President and Chief Executive Officer of a behavioral health clinic in Arizona, which provides families with flexible, individually-tailored support services to children with emotional, behavioral, and mental health impairments, known in Arizona as direct support services. My organization, like all of the publicly-funded behavioral health providers in Arizona, provides services that are developed in wraparound teams. Some of the children whom my organization serves are in therapeutic foster care, and we participate as part of the child's treatment team. In addition, my organization is in the process of becoming a therapeutic foster care provider. Prior to founding my organization, I worked for ValueOptions, the private company that managed the behavioral health system in Maricopa County, on the development and delivery of community-based mental health services for children. In this position, I was directly involved with the development of the array of community-based, Medicaid-covered services for children in Arizona.

2. In addition to my direct work, I have been heavily involved in implementing the efforts to reform the children's behavioral health system as a result of the lawsuit in J.K. v. Eden. Most recently, the State has hired me as a consultant to assist with the development of community-based services statewide. I also have provided training, coaching, consulting and technical assistance to thousands of individuals and dozens of agencies seeking to improve their approach to community-based care, largely as a result of the J.K. litigation.

3. I am Licensed Marriage and Family Therapist, and also have my Masters in Business Administration. I have written multiple articles and done many presentations on providing community-based care to children with complex needs. 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.

4. In Arizona, wraparound services and therapeutic foster care are funded through Medicaid, as I discussed in my prior declaration. All of the components of wraparound services and therapeutic foster care, as defined by plaintiffs in Appendix A and B respectively, are covered by Medicaid in Arizona.

5. Wraparound services and therapeutic foster care are essential mental health services for children with significant behavioral, emotional and mental health impairments. Wraparound services and therapeutic foster care have been found to be clinically effective, and, for large numbers of children, are the only services that lead to positive outcomes.

6. All of the components of wraparound services and therapeutic foster care must be provided and be provided in a coordinated fashion for these services to be effective in meeting the mental health needs of children.

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. Arizona Uses Medicaid to Fund the Components of Wraparound Services and Therapeutic Foster Care

8. Wraparound services are funded by Medicaid in Arizona. As I discussed in my prior declaration, Arizona's Medicaid agency funds the work of the wraparound team (known in Arizona as the child and family team) and pays for the behavioral health services the child and family team identifies as necessary in the child's wraparound services plan. Exh. 1 at ¶¶ 3, 19-20.

9. I have been involved in developing the array of community-based, Medicaid-funded services for children at several levels. When I worked for ValueOptions, I was part of a group that worked with Arizona's Medicaid agency to develop the mechanisms to fund the work of the wraparound team and to develop a wide array of Medicaid-funded community-based services for children, including therapeutic foster care. I am continuing to work with the state on expanding necessary Medicaid-funded services for children. Further, as a provider, I now am intimately familiar with how to bill Medicaid for providing wraparound services and therapeutic foster care in Arizona.

10. The Arizona Department of Health Services has issued a Technical Assistance Document setting forth and describing the "essential steps" of the Child and Family Team Process and providing guidance to providers on how to bill Medicaid for each of these steps. A true copy of this document is attached as Exhibit 3 and is incorporated herein by reference. The essential steps of the Child and Family Team Process are engagement of the child and family; immediate crisis stabilization; strength, needs and culture discovery; child and family team formation; behavioral health service plan development; behavioral health service plan implementation; ongoing crisis and safety planning; tracking and adapting;

and transition. The activities included in each of these steps can be billed to Medicaid, and this Technical Assistance Document identifies billing codes that can be used to reimburse qualified providers for carrying out these steps and their included activities. Exh. 3, Attachment 1.

11. I have reviewed the definition of wraparound services in Appendix A, and I agree with it. The activities that are the components of wraparound services in Appendix A are the same as the activities in the essential steps of the Child and Family Team Process in Arizona. My use of the term wraparound services in this declaration and in my prior declaration is the same as the definition in Appendix A and as plaintiffs' use of the term in this litigation.

12. Therapeutic foster care, recently renamed Home Care Training to Home Care Client Services for Children or HCTC[1], is also funded by Medicaid in Arizona. Arizona's Department of Mental Health has issued a Practice Protocol regarding HCTC, a true copy of which is attached as Exhibit 4 and incorporated herein by referencd. This Practice Protocol defines HCTC and describes the activities that comprise the service. I have reviewed the definition of therapeutic foster care in Appendix B, and I agree with it. The definition of HCTC is the same as therapeutic foster care in Appendix B, and the activities described in the HCTC

---

[1] I understand that name change of therapeutic foster care to Home Care Training to Home Care Client Services for Children was to reflect that the service is not simply a foster care placement but is a mental health intervention available to all children in the behavioral health system (whether or not in foster care) and that the goal of the service is to train the child to live in a home environment in the community.

Practice Protocol are the same activities that are the components of therapeutic foster care set forth in Appendix B. My use of the terms "therapeutic foster care" and "Home Care Training to Home Care Client Services for Children" in this declaration and in my prior declaration are the same as the definition in Appendix B and as plaintiffs' use of the term therapeutic foster care in this litigation.

13. The Arizona Department of Health Services has recently updated its Covered Behavioral Health Services Guide to describe Medicaid coverage and billing of HCTC, a true copy of which is attached as Exhibit 5 and incorporated herein by reference. HCTC is paid through a case rate. This case rate includes implementation of the treatment plan by the therapeutic foster parents (including personal care, psychosocial rehabilitation, skills training and development, transportation to activities such as therapy and visitations, and participation in treatment and discharge planning), as well as administrative expenses such as recruitment, pre-service training and supervision of therapeutic foster parents. Exh. 5 at 92. Children receiving HCTC can receive other covered behavioral health services, such as professional services like counseling, day program services or prescription drugs, which are billed separately to Medicaid. Medicaid does not pay for HCTC room and board costs. Exh. 5 at 94.

C. Wraparound Services and Therapeutic Foster Care Are Essential Children's Mental Health Services

14. Wraparound services are essential mental health services for children with significant behavioral, emotional and mental impairments and are at the core of Arizonas's children's mental health system, as I discussed in my prior declaration. Exh. 1 at ¶¶ 15-18. Extensive and system wide use of wraparound services for these children is cost-effective and beneficial to children and their

families. Wraparound services are widely considered to be clinically effective for children with mental health needs, and in my experience, enable children with significant behavioral, emotional, and mental impairments to function in their homes, communities, and schools.

15. In my own experience at my agency, I have seen the following outcomes from providing wraparound services: children are able to live at home and in the community successfully instead of in institutional settings like residential treatment centers or psychiatric hospitals; the troubling behavior that led to the referral to my agency decreases in frequency and intensity; children and families become more independent; and children have more success in school and avoid delinquency. My agency also conducts family/youth surveys every six months, where we ask ten questions of families regarding their satisfaction with the outcomes and services they are experiencing (on a five point scale). There is a correlation between success in these ten areas and positive outcomes for youth. Some of the questions we ask include whether families feel their life is better as a result of the services they are receiving and whether they are seeing positive results as a result of these services. The data shows that as the child and family team practice and the associated community-based services improve, the scores families report in these areas improve.

16. The availability of therapeutic foster care (now called HCTC) is another crucial part of Arizona's children's mental health system, as I discussed in my prior declaration. Exh. 1 at ¶ 25. Therapeutic foster care is widely considered to be clinically effective, and in my experience, enables children with significant behavioral, emotional and mental impairments who cannot be served in their own home to function in a home-like environment and in the community. HCTC is

provided to children whose behavioral health needs are severe enough that they are at risk of placement into a restrictive residential setting such as hospital, group home, correctional facility, or residential treatment program. Exh. 4 at 3. In Arizona, HCTC is typically only provided after an attempt to deliver sufficient behavioral health services to the child and family in the family-home setting has failed and the child and family team has determined that HCTC is medically necessary. *Id.* at 4. Arizona has given priority to recruiting and matching therapeutic foster parents who have a current connection to the child who is in need of HCTC. *Id.*

17. My organization has served many children for whom the child and family team, of which we were part, determined that HCTC was medically necessary. For these children, HCTC was often the only alternative to placing the child in an institutional setting like a residential treatment center or a psychiatric hospital. In my experience, HCTC has been extremely beneficial to these children and has led to such improved functioning that we were able to return the children to their own homes or another permanent family environment. Because of the benefit of and need for this service, my organization is in the process of becoming a HCTC provider.

D. The Effectiveness of Wraparound Services and Therapeutic Foster Care Requires the Provision of All of the Components of these Services and that the Components Be Provided in a Coordinated Fashion

18. As a general proposition, a mental health intervention must be provided as it has been designed for its benefits to be realized. As a provider, I believe it would be unethical not to provide all of the pieces of an intervention or to fail to

coordinate the pieces as required by the intervention. There must be adherence to the practice to experience the full benefits of a mental health intervention.

Wraparound Services

19. In order to be effective, all of the components of wraparound services must be provided and be provided in a coordinated fashion. Researchers in the field of mental health have shown that wraparound programs that faithfully provide all of the components of wraparound services in a coordinated fashion produce excellent outcomes for children with significant behavioral, emotional and mental health impairments. This research and my experience show that in order to be clinically effective, wraparound programs must contain all the essential elements of wraparound services, which are the same as the activities that are the essential steps of the Child and Family Team Process in Arizona and the components of wraparound services in Appendix A.

20. Based on my experience designing a wraparound program, as well as facilitating and participating in wraparound teams, all of the components of wraparound services are essential. One could not adequately provide wraparound services, for example, without engaging the family, forming the wraparound team, and having the team develop and implement the treatment plan. One could not provide wraparound services adequately without addressing and planning for crisis situations. And one could not provide wraparound services adequately without focusing on transitioning the child away from formal behavioral health services to the child's natural and family-based support system as the child's condition improves. I would not consider a service to be wraparound services if any of the components were missing. But, wraparound services must be individualized to each child and family. While every child who needs wraparound services must

receive every component, it is up to the child and family team to decide how to best implement each component for that particular child and family.

21. One reason it is critical that all of the elements of wraparound services be provided is that they interact with another through the service process, as I discuss below. The components are not linear steps that are completed only once. For example, engagement occurs not only before the wraparound team forms, but through the provision of wraparound services. If one took away the element of engagement, the entire wraparound service delivery would suffer, not just the upfront coordination.

22. A key to the effectiveness of wraparound services is the provision of all of the components in a coordinated fashion. By coordinated, I mean that the components of wraparound services are interrelated and interconnected. For example, the child and family must be engaged through the child's treatment and involved in forming the child and family team; the child and family team must be involved in developing and implementing the treatment and crisis plans; and the goals determined by the child and family team must drive the treatment and ultimately the transition from wraparound services.

23. The child and family team acts as the "glue" to coordinating the implementation of all of the components of wraparound services, and the team itself functions as a mode of treatment. Individual approaches by treatment providers are not, in my experience, effective unless pulled together and coordinated into a single strategy by the team as a whole, as illustrated in the example given below. This is particularly true for children with more complex needs, such as children who are involved in multiple systems.

24. Arizona's statewide implementation of wraparound services has shown the necessity of providing wraparound services in a coordinated fashion. During the early stages of implementation of wraparound services, many service providers tried to provide wraparound services separate from the child and family team process. The team would decide that a child needed services from a service provider. The provider then would independently decide which specific services the child needed and how best to serve the child without input from the child and family team. The provider would independently decide when the child no longer needed the services and then return the child to the team. The state quickly found that receiving services in this manner did not improve the outcomes for children and their families, or that any improvements that were made were often not sustained.[2] Disconnected efforts often led to less-effective outcomes. Instead, the state found that the best way to ensure that the services a child received from a provider were effective was to have the child and family team work together with the provider and coordinate the child's care from the provider. The team must identify the need for the services and find a provider that would be a good fit for the child. The team then must commission the provider to do certain tasks based on the needs of the child and family. Similarly, the team must monitor progress and communicate with the provider on a regular basis, and when necessary, adjust

---

[2] By analogy, this is similar to the reasoning behind providing family therapy for children, versus providing only individual therapy to the child. One cannot improve a child's condition through individual therapy, return the child to a home and family environment where the same challenging interaction patterns occur and expect the outcomes to be sustained.

the plan based on the results. The team, in conjunction with the provider, must decide how and when to transition the child and family away from paid services when goals have been met. In my experience, when this type of coordination between the child and family team and provider is missing, good outcomes are not obtained. For example, a worker from an individual agency may discovery a way to help a child interact more successfully with peers, but unless that learning is transferred to others who work with that child, the gains are less likely to be sustained.

25. For many children, wraparound services, provided with all of its components in a coordinated fashion, can mean the difference between long-term institutionalization and a fulfilling life in the community. My interactions as a wraparound facilitator with a child named "Tom" provide an illustration of the necessity for this type of coordination.

a. Tom had complex mental health needs and was involved with multiple systems. When I first met Tom, then age eleven, he was on the verge of being placed in a full-time, out-of-state residential facility at huge cost to the state. Tom had been placed in several residential treatment centers in-state and had failed at these placements due to his challenging behaviors. Tom was exhibiting self-abuse behavior such as head banging, had delusions, and was thought by his psychiatrist to be showing signs of schizophrenia. Tom was on large doses of medication; he was drooling and sedated. Tom had been in the custody of the state since his mother, who suffered from schizophrenia, died. Tom's father wanted Tom to live with him, but the father too had serious mental illness.

b. Before I became involved in Tom's case, a number of different professionals had regular contact with Tom. In addition to his psychiatrist, Tom

was being seen by a caseworker from the child welfare agency, a therapist associated with his residential placement, special education staff at his school, and a caseworker from the adult mental health system concerned with his father's care. Tom also had his own case manager from the behavioral health system. Despite the intensity of these interactions, there had been little coordination among these professionals, and no progress was being made.

c. I became involved in the case when Tom began receiving wraparound services from my organization. We immediately put together a child and family team comprised of Tom's father, several neighbors that were close with Tom's family, Tom's father's caseworker from the mental health system, and all of the professionals that had regular contact with Tom. The team did an assessment and decided that Tom's complex behavior was likely not schizophrenia but rather was a form of grieving for his mother through imitation of her symptoms. Together we developed a plan, after trying several different interventions for this behavior, to help him work though his bereavement and learn to control his behavior. At the same time, the team worked to have Tom and his father spend more time together, with the goal that Tom one day could be returned to his own home. The team facilitated regular visits between Tom and his father. The team arranged for transportation to and from the residential treatment center where Tom was living, which was several hours away from Tom's father's home, and created opportunities for Tom and his father to interact in a natural setting (as opposed to the grounds of the treatment center) by enlisting the help of a local church group to supervise visits between father and son. We began providing Tom's father with education about Tom's disorder and how to manage Tom's behavior, with the end goal of returning Tom home in mind.

d. The improvements in Tom's behavior were quick and dramatic. Within a couple months, Tom's self-abuse behavior decreased from several times a day to almost stopping entirely. His medication was decreased dramatically, and he no longer was reporting hallucinations and delusional beliefs.

e. Approximately nine months after the child and family team first convened, Tom returned home to live with his father. The team's involvement in planning for this transition, as well as developing a crisis plan, were crucial. For example, the team developed a series of interventions to help with the transition, including providing in-home therapy to Tom and his father, having a therapeutic behavioral services (TBS)-type provider help Tom learn how to interact appropriately with his peers at school, and educating Tom's extended family, neighbors, and friends on how to handle Tom's behaviors so they would feel comfortable interacting with him. The team developed a crisis plan that anyone involved in Tom's life could follow. When Tom banged his head at school one of his first days there, his teacher followed the plan and was able to keep him calm, rather than escalating the situation. Tom never engaged in self-abusive behavior at school after this one occasion, and I attribute this in large part to the teacher's ability to seamlessly implement the team's strategy. Tom eventually became more and more comfortable in the community and with his peers. When Tom expressed a wish to join the Boy Scouts, the team was able to ensure his success in this activity by training the Scout leader about Tom's needs and to respond to him.

f. Although Tom was once viewed as incapable of living at home and in his community, Tom has been able to adjust to teenage life, living at home, engaging in community activities just like any "typical" teenager, and even earning money mowing lawns in the neighborhood. But for the provision of wraparound

services in a coordinated manner, I believe Tom would be living the rest of his life in an institutional setting at a huge cost to the state of Arizona.

Therapeutic Foster Care

26. In order to be effective, all of the components of therapeutic foster care must be provided and be provided in a coordinated fashion. Researchers have shown that therapeutic foster care programs that faithfully provide the components in a coordinated manner are effective and produce good results for children with significant emotional, behavioral, and mental health impairments.

27. In my experience developing a therapeutic foster program, as well as working with children receiving therapeutic foster care, all of the components of therapeutic foster care are essential. One could not adequately provide therapeutic foster care, for example, without having a treatment plan developed by the therapeutic foster team for the child and for the family (when reunification is a goal). Therapeutic foster care must have trained therapeutic foster parents as the primary implementers of the treatment plan. And one could not adequately provide therapeutic foster care without planning for and transitioning the child from therapeutic foster care to a permanent placement, be it the child's biological home or alternative home in the community.

28. As with wraparound services, coordination of the components is key to the success of the intervention. For example, the therapeutic foster care team is involved in the development and implementation of the treatment plan, as well as transitioning the child out of therapeutic foster care when appropriate. The therapeutic foster parents are the primary agents in implementing, tracking and adapting the child's treatment plan. And when reunification with the child's family is a goal of therapeutic foster care, the child's family is involved in

development of the treatment plan and receiving education to prepare them for the child's transition home. There is no way to provide therapeutic foster care successfully without this type of coordination of the components.

California

29. In my professional opinion, California cannot meet the mental health needs of children for whom wraparound services or therapeutic foster care is necessary unless it provides all of the components of wraparound service and therapeutic foster care 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 27 day of NOV, 2007 in Temple, AZ.

Timothy Penrod