1
DECLARATION OF ERIC BRUNS, PhD

2 I, Eric Bruns, declare that, if called as a witness, I could and would competently
3 testify as follows:

4 ## A. Summary of Observations and Opinions

5 1. I am a researcher, a psychologist, and Assistant Professor at the
6 University of Washington School of Medicine, in the Department of Psychiatry
7 and Behavioral Sciences. The focus of my research is on evaluating community-
8 based services and supports for families with children with complex mental health
9 needs, and in particular, on methods or administering care management, including
10 developing wraparound standards, evaluating wraparound process, and researching
11 the fidelity of wraparound programs to the national wraparound standards.

12 2. I, along with my colleague John Burchard, developed the Wraparound
13 Fidelity Index ("WFI"), a measure designed to assess adherence to wraparound's
14 essential elements during service delivery. Nationwide, over 100 communities
15 have used this fidelity tool to access the fidelity of their wraparound model.

16 3. Along with therapeutic foster care, and a small number of other mental
17 health interventions, wraparound is generally cited among the most effective
18 integrated community-based interventions for children with emotional, behavioral,
19 and mental health disorders. As such, both therapeutic foster care and wraparound
20 are integral parts of any modern children's mental health system.

21 4. The vast majority of federally funded "Systems of Care" programs use
22 wraparound process to implement systems of care values for individual families.
23 A recent survey revealed that 42 of 46 State Mental Health liaisons reported that
24 some version of the wraparound process was being used in their state (Burchard,
25 2002). It is clear that many recognize wraparound as the right kind of service to

1 meet the needs of children with significant mental health needs. My research and
2 the research of several colleagues on fidelity show that it is not enough to provide
3 wraparound services to children with serious mental health needs—better
4 outcomes are associated with conducting the process consistent with the core
5 phases and activities that constitute the wraparound process. Programs that
6 comply are considered "high fidelity" wraparound programs.

7 5. Wraparound principles should be adhered to for all children with
8 behavioral health needs. Full-scale, high-fidelity wraparound should be provided
9 to children with the serious emotional disturbance, i.e. those with the most
10 significant needs.

11 **B. <u>My Qualifications</u>**

12 6. I received my doctorate in Clinical Psychology from the University of
13 Vermont in 1997.

14 7. I completed a Clinical Internship at the Georgetown University Child
15 Development Center in 1997. While there, I conducted developmental,
16 psychoeducational, and neuropsychological assessments of infants, children, and
17 adolescents. I was also a psychology intern at the Behavior Therapy and Psychotherapy
18 Center, at the University of Vermont Department of Psychology from 1995-1996. I
19 provided individual, family, and group psychotherapy to children and adolescents in a
20 university-based outpatient setting.

21 8. After completing my doctorate, I joined the faculty at the University of
22 Maryland School of Medicine, as an Assistant Professor in the Department of
23 Psychiatry. In 2005, I left the University of Maryland School of Medicine to join the
24 faculty at the University of Washington. I am now an Assistant Professor at the
25

University of Washington School of Medicine, in the Department of Psychiatry and Behavioral Sciences.

9. Throughout my academic tenure, my research has focused on developing and evaluating processes for delivering community-based services and supports for families with children with complex mental health needs. I have centered this research on the wraparound process and in particular on the fidelity measures of the wraparound process.

10. I, along with my colleague John Burchard, Ph.D., of the University of Vermont, developed the Wraparound Fidelity Index ("WFI"), which is a measure designed to assess adherence to wraparound's essential elements during service delivery.

11. I am currently the Principal Investigator on six grants, including one that is funded by the National Institute of Mental Health, one from the Center for Medicare and Medicaid Services (CMS), and two funded by the SAMHSA Center for Mental Health Services. In addition to the current projects I am working on, I was the Principal Investigator on ten other grants, including ones funded by the Center for Mental Health Services, the Robert Wood Johnson Foundation, and the Annie E. Casey Foundation. I have a pending application with the National Institute of Health ("NIH") to conduct the first NIH funded randomized clinical trial on the wraparound process. (See Curriculum Vitae, attached hereto)

12. I have authored twelve books, monographs, and book chapters, and have published over fifteen articles in refereed journals. I am on the editorial boards of the Journal of Child and Family Studies, the Journal of Emotional and Behavioral Disorders. I was on the editorial board of the Children's Services: Public Policy, Research, and Practice.

1 13. I am involved both nationally and locally in the implementation and
2 evaluation of wraparound programs. I am on the SAMHSA Center for Mental Health
3 Services National Services Evaluation Work Group, the Maryland Governor's Office of
4 Children, Youth and Families Evaluation and Monitoring Task Force, the Baltimore
5 City Mayor's Office: *CitiStat* and *KidStat.*
6 14. Further, when I was at the University of Maryland, I coordinated the
7 evaluation of Baltimore's After-School Strategy, a $28 million initiative aimed at
8 improving youth outcomes through delivery of high-quality youth development
9 services. I also directed the Baltimore City Data Collaborative, a project that compiles
10 citywide risk and resource data on all aspects of child and family well-being.
11 **C. Wraparound Services were a Response to Failures in the**
12 **Children's Mental Health System.**
13 15. Over the past two decades, the children's services field has focused on
14 the inadequacies of outdated service systems for children experiencing mental
15 health problems. One notorious example of the outdated mode of service delivery
16 is the allocation of vast amounts of public mental health dollars to restrictive
17 service options such as residential treatment and psychiatric hospitalization,
18 despite a near absence of outcome data in support of such treatment options
19 (Burns, Hoagwood, & Maultsby, 1998).
20 16. These inadequacies led to a response within the children's mental health
21 field. The responses included a shift from institutional to less restrictive care
22 settings, significant improvements to the research base on interventions for youth,
23 and the development of integrated systems of care that are individualized, family-
24 centered, and community-based. (Duchnowski, Kutash, & Friedman, 2002). In
25 tandem, these responses help to ensure that many more children receive medically

appropriate and clinically effective mental health services in their own homes, or in home-like settings.

17. Wraparound developed out of this shift in focus of children's mental health, becoming one among a handful of prominent services to provide clinically-sound mental health interventions that are individualized, family-centered, and community-based for children with significant emotional, behavioral, and mental health needs and their families.

18. The initial wraparound programs—like the Kaleidoscope program in Chicago, founded by Karl Dennis, the Alaska Youth Initiative program developed by John VanDenBerg, and Project Wraparound, Vermont, developed by John Burchard and Richard Clarke—developed out of the "System of Care" movement, which emerged in the mid-1980s as an attempt to overcome fragmented systems and over reliance on restrictive treatments, like psychiatric hospitalizations and care provided in residential treatment centers.

19. Wraparound has become one of the most influential strategies for implementing the System of Care philosophy for children with serious emotional or behavioral disorders. It has even been described as *the* primary vehicle for applying the System of Care philosophy to individual families (Stroul, 2002) and a recent survey revealed that 42 of 46 State Mental Health liaisons reported that some version of the wraparound approach was being used in their state (Burchard, 2002). It has been estimated that over 200,000 youth have received some form of wraparound services (Faw, 1999).

D. <u>Clinical Effectiveness of Wraparound Services</u>

20. As noted above, one of the responses to the shortcomings of the children's mental health system has focused on the expansion of the research base, which in turn

facilitated an emphasis on evidence-based practices, allowing knowledge about the dynamics of service delivery, and their effects on outcomes, to help guide selection and implementation of services and supports (Hoagwood, Schoenwald, Kiser, Ringeisen, & Burns, 2001).

21. The research base on the wraparound model is still emerging; there have been a number of extremely encouraging evaluation results. Wraparound, like therapeutic foster care, is generally cited as among the promising community-based interventions for children with mental health needs and their families. For example, Surgeon General's Report on Mental Health (1999) and the Surgeon General's Report on Youth Violence (2000) both cite wraparound as a promising practice.

22. Among the studies that are most encouraging include the following:

a) Randomized clinical trials of wraparound have found greater declines in behavioral problems, greater increases in functioning, greater stability in residential placements, and greater likelihood of placement permanence than foster care or treatment-as-usual conditions. (Clark, H.B., Lee, B., Prange, M.E., & McDonald, B.A. (1996) and Evans, M. . Children lost within the foster care system: can Wraparound service strategies improve placement outcomes? Journal of Child and Family Studies, 5(1), 39-54; Burchard, Bruns, & Burchard (2002)).

b) Since implementation of the highly successful Wraparound Milwaukee project—which has grown to serve over 700 youth involved in juvenile justice—use of residential treatment has declined 60 percent, use of psychiatric hospitalization has fallen 80 percent, and average overall care costs for target youth has dropped by one-third, from over $5000 per month to less than $3300. Meanwhile, rates of offending behaviors for these youth have been cut by from one-half to one-third from pre-

treatment levels. (Kamradt, B. (2000). Wraparound Milwaukee: Aiding youth with mental health needs. Juvenile Justice Bulletin, 7(1), 14-23).

c) In Califorinia, the adoption of a system of care approach in Santa Cruz County, which employed the wraparound model reduced special education and out-of-home care expenditures dramatically after implementation started in 1986. (Jacobson, D. & Cervine, D. (1998). *Santa Cruz County ninth annual report on comprehensive interagency system of care for children and youth* (p.3). Santa Cruz, CA: Santa Cruz County Children's Mental Health).

23. In addition to the rapidly emerging evidence-base, through the efforts of leaders in the field—such as John VanDenBerg—the "core" elements of the wraparound approach have been identified and defined. Wraparound services are family-driven, team-based, collaborative, community-based, culturally competent, individualized, strength based, natural support focused, unconditional, and outcome based.

24. In turn, each of the elements of wraparound have their own evidence base, which predicts why wraparound has been such an effective intervention.

25. By way of example, being "community-based" is a core value of wraparound. Research has shown that serving children in the community is far superior to serving children in out-of-home (or home-like) settings. Indeed, the best predictor of future out-of-home placement utilization is past utilization. (Pfeiffer et al, 1990) Other studies have shown that placement stability and youth perception of placement stability both predict future outcomes. (Dubovitz et al., 1993, Horvitz et al., 1994) Further, there is no research base on effectiveness of residential treatment/psychiatric hospitalization, for example in one study the researchers found that 33% of youth in RTCs returned to a restrictive placement

within one year and 75% returned to a restrictive placement within six years. (NACTS study). Further, there is lots of evidence of superior outcomes of community-based treatment .

26. Another core element of wraparound is "family voice and choice." From a clinically therapeutic standpoint, the research shows that voice and choice matters. One study showed that when therapists direct treatment, without family alliance, the results are poorer than where there is family buy-in on the treatment goals. Further, the lack of family member engagement found to be major impediment to treatment implementation. For example, one study showed that family members' belief in effectiveness of treatment influences engagement and outcomes. (Spoth & Redmond, 2000)

27. Being "team-based" is also important. For example, one study indicated positive child outcomes result from foster parents who viewed themselves as part of a team with goal of positive outcomes. (Stone & Stone, 1983) Team-based care for adults with serious mental illness found to be superior than "brokered" case management models. (Burns & Santos, 1995) Team process literature suggests that effective teams succeed in producing more options which leads to better plans.

28. Lastly, it is extremely important that the mental health services are "individualized." Families with (unmet) complex needs likely to experience poorer outcomes. For example, social-ecological theory demands a "fit" between family/child and their environment.

29. Further, case management literature reveals that more intensive and early tailoring of community supports to client needs results in superior outcomes (Ryan, Sherman, & Bogart, 1997)

E. Wraparound Fidelity

30. Another major focus of my research has been on "fidelity measures." Fidelity is may be defined as conformity with prescribed elements and the absence of non-prescribed elements, which is to say adherence to the core elements. The research I have conducted leads me to conclude that it is not enough to just do wraparound. You must do it well. "High-fidelity" to the wraparound model is associated with better outcomes.

31. The fidelity tool that I developed, the Wraparound Fidelity Index (or "WFI") was developed out of concerns about misapplication of the term "wraparound" by providers who did not have adequate understanding of the full set of required service strategies or did not possess the resources to implement them.

32. The results of my studies indicate that outcomes such as child behavior may be predicted by how well providers adhere to the core principles of wraparound. These studies have found that (1) administrative and system characteristics of programs can explain much of the variation in sites' adherence to wraparound's philosophical principles (Bruns, Burchard, Suter, & Leverentz-Brady, 2003), and that (2) in turn, adherence to these principles predict future child and family service and functioning outcomes (Bruns, Suter, Force, Burchard, & Dakan, 2003).

33. As a result of my research on fidelity, I have been involved with the work of the National Wraparound Initiative, which created a set of national principles, which guide wraparound programs, as well as a document that describes the phases, and activities of the wraparound services. I consider programs to be "high fidelity" if they follow the phases and activities described in those national

standards. The most recent set of "Wraparound Principles" and "Phases and Activities" are attached to this declaration as Exhibits 2 and 3, respectively.

F. Targeting Wraparound

34. All children with a mental health diagnosis should receive services that consistent with the core values of wraparound. Just as we would require that a pediatrician would follow core values in her field, so too must mental health professionals. However, because children with mental health needs require varying levels of mental health intervention, there is a continuum of behavioral health levels. For example, some children require only medication monitoring, others require medication monitoring and therapy, and yet other children require more intensive interventions like wraparound and therapeutic foster care.

35. Children who have been identified as seriously emotionally disturbed (or SED) require the individualized services that are consistent with wraparound planning. This is in harmony with the President Bush's New Freedom Commission on Mental Health, which includes as one of its major recommendations that every child with a serious emotional disturbance should have a family-driven, individualized plan of care. There are up to about 20% of the general population of children have mental health needs that warrant professional intervention, though for children in foster care this number is likely to be much higher. For these children, an approach that adheres to the basic wraparound principles would be appropriate and necessary.

36. For children with the most serious mental health needs—approximately 3-5% of all children, though again a higher percentage of children in the foster care system would fall into this category—full team-based high-fidelity wraparound teams would be appropriate and necessary to achieve the most positive outcomes.

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 on August 30, 2005, in Seattle, Washington.

Eric Bruns, PhD