DECLARATION OF PATRICIA CHAMBERLAIN, Ph.D

I, Patricia Chamberlain, declare that, if called as a witness, I could and would competently testify as follows:

A. Summary of Observations and Opinions

1. I am a psychologist, a children's mental health researcher, and the Executive Director of the Social Learning Center, Community Programs. I developed a therapeutic foster care program—known as Multidimensional Treatment Foster Care—which is one of the most studied foster care programs in the country. After developing this program in 1983, I conducted eight randomized clinical trials, which demonstrate the effectiveness of Multidimensional Treatment Foster Care ("MTFC").

2. The federal government has repeatedly lauded Multidimensional Treatment Foster Care ("MTFC"). The U.S. Department of Health and Human Services selected MTFC as a model program for children's mental health care (see Mental Health: A Report of the Surgeon General (2000)). Based on scientific evidence of the program's effectiveness, the U.S. Office of Juvenile Justice and Delinquency Prevention and the Center for Substance Abuse Prevention selected MTFC as one of seven Exemplary I Programs (the highest rating category) in the Strengthening America's Families series. The U.S. Department of Health and Human Services identified MTFC as a model program for violence prevention (see Youth Violence: A Report of the Surgeon General). MTFC was selected as one of the original 10 national Blueprints for Violence Prevention programs by the Office of Juvenile Justice Delinquency Prevention. Additionally, the U.S. Department of Education praised MTFC as one of nine Exemplary Programs for Safe, Disciplined, and Drug-free Schools. In addition, our program has been replicated—nationally and internationally. Several of these sites are in California: with implementations being conducted in collaboration with the California Institute for

Mental Health (in Orange, San Diego, Kern, San Luis Obispo, and Fresno Counties) and with Walden Family Services (in San Diego).

3. It is my opinion that a children's mental health system that does not include Therapeutic Foster Care ("TFC") as an available intervention is incomplete and inadequate because intense mental health inventions, provided in home-like settings are necessary for many children with serious behavioral or mental health needs. Our experience shows that most foster children with the most serious and chronic emotional or behavioral impairments often can best have their needs met in therapeutic foster homes. Further, the failure to provide TFC can result in the over-reliance on more restrictive (and more expensive) out-of-home placements including residential treatment centers and in-patient hospitalization, for which there is no proven effectiveness.

B. <u>My Qualifications</u>

4. I received a Master's Degree in Special Education in 1972 from Northeastern Illinois University. I earned my Ph.D in Educational Psychology from the University of Oregon, Eugene, in 1980. After I completed my Ph.D, I began working as a research scientist at the Social Learning Center in Eugene, Oregon. I received funding from the MacArthur Foundation from 1981-1983 and was a co-investigator on a grant from the National Institute of Mental Health (on Treatment Process) from 1984-1987. I have been a licensed psychologist in the State of Oregon since 1982.

5. I became the Executive Director of Social Learning Center Community Programs ("OCP") in 1986. Oregon Social Learning Center is a private non-profit organization that designs and delivers evidence-based mental health treatment services in Oregon. OCP, which is affiliated with the Oregon Social Learning Center, is a collaborative, multidisciplinary center dedicated to increasing the scientific understanding of social and psychological processes related to healthy development and

family functioning. We apply that understanding to the design and evaluation of interventions that strengthen children, adolescents, families, and communities. In 1990, OCP was designated as a Prevention Research Center funded by the National Institute of Mental Health. The theme of the Oregon Prevention Research Center is the prevention of antisocial behavior problems and delinquency during childhood, called the "conduct disorders" by the American Psychiatric Association.

6. Since the early 1980s, a major area of focus of the work at OCP has been refining and researching Multidimensional Treatment Foster Care. Since the development of MTFC, I, along with other researchers at OCP, have conducted eight randomized clinical trials on MTFC with youth and families referred from the juvenile justice, mental health, and child welfare systems.

7. I have authored three books and over sixty journal articles and book chapters on evidence-based treatment approaches, treatment process, outcome research, methodology, foster care, and related topics. I am currently the Principal Investigator on three grants, two of which are funded by the National Institutes of Health and one by the National Institute on Drug Abuse. See, Curriculum Vita, attached as Exhibit 1.

8. In addition to my work at OCP , I am also a senior research scientist at the Center for Research to Practice. I am a Fellow in the Academy of Experimental Criminology, a consultant to the Andrus Family Foundation, and a grant reviewer for the National Institute of Mental Health. Further, I am a member of the Child and Adolescent Research Intervention Network, a group of researchers examining methods for strengthening services in child welfare system.

C. The SLC's Model of Treatment Foster Care: Multidimensional Treatment Foster Care

9. Multidimensional Treatment Foster Care provides intensive, individualized mental health care in home-like settings to youth who face severe emotional and behavioral challenges. It is an alternative to group and residential care, institutionalization, and incarceration. Therapeutic foster care is widely considered to be the least restrictive and most integrating form of out-of-home placement for children with severe emotional and behavioral disorders. (Mental Health: A Report of the Surgeon General (2000)).

10. In MTFC programs, the program staff recruit, train, and support foster families who provide therapeutic placements for children participating in the program. Usually only one foster child will be placed in any foster family, though often the family has biological or adopted children who also live in the home. Intensive services are provided both to the youth and to members of their family (biological, adoptive, relative) so that after the youth completes the foster care portion of the MTFC program he or she can return home, or to an alternative home setting, and continue to be successful.

11. Under my direction, OCP first developed the MTFC model as an alternative to residential and group care for serious and chronic juvenile offenders. In 1986, MTFC was adapted to youth with severe emotional and behavioral problems who were leaving the State of Oregon psychiatric hospital. These children were 9 to 18 years old and had been hospitalized for most of the year prior to placement. OCP began treating youth ages 4 to 18 who were referred from the mental health and child welfare systems, were eligible for Medicaid services, and had previously had a number of out-of-home placements.

12. The model of MTFC that I developed and research is composed of seven elements:

a) *Recruitment and Matching*: Local families are recruited to serve as therapeutic foster parents and matched with children in need of therapeutic foster placements. We have found excellent therapeutic foster homes in both two parent and one-parent families, both female and male headed families, and in families with a wide range of social, ethnic, educational, and economic backgrounds. We attempt to recruit stable families who have some experience with children, and who are willing to support a child during his or her entire time in a therapeutic foster environment (generally, six to twelve months). Because we use a team approach, where the team includes working with the program supervisor, family and individual therapists, the schools, biological families (if reunification is the goal), caseworkers, and, possibly parole and probation officers, we ensure that the foster family is open to working within this approach. If a potential therapeutic foster family meets these criteria, successfully completes criminal screening and certification criteria, and completes pre-service training, then we attempt to match them with an appropriate child.

b) *Pre-service Training*: Before a child enters into the home of a therapeutic foster parent, we require that the foster parent undergo a 20-hour pre-service training. During the training, we teach the foster parents to use behavior management strategies, including techniques on how to avoid escalating conflicts with kids (a very common issue for the populations we serve), specific methods of encouragement and limit setting, techniques for identifying and tracking positive and negative behaviors and for responding to them in a systemic way. We then use various role-playing techniques to allow the foster parents to "road test" the behavioral management techniques before a child is placed in their care.

c) *Daily Management of the Child in the Home or Community.* Each child has a treatment plan that is both standardized and individualized. We insist upon age-appropriate limits for all of the children placed in therapeutic foster care settings, but we also focus on building on the individualized strengths and responding to needs of the child. Each individualized program is structured to give the youth a clear picture of what is expected of him or her throughout the day and evening, giving the participating youth a concrete way to measure his or her success. Adolescents—especially those with serious mental health needs—require close supervision including monitoring of peer relationships. The amount of freedom allowed would vary depending on how long the child has been in the program and his or her level of adjustment. Consequently, the individualized program helps guide the foster parents to be specific in the way they reinforce progress and to be consistent in setting limits and consequences. The plans are also individualized because we engage the children differently in their treatment to build on their strengths. For example, with a child who was interested in art or in soccer, we would use these specific interests to create a treatment plan for the youngster.

We use a behavioral point system and level system. Each day, the child earns "points" for participating in expected activities and loses points if he or she engages in a problematic behavior, such as arguing or being destructive. Each child's point program is individually tailored to be responsive to his or her treatment needs and to the circumstances in the home. The points affect the level of supervision, of which there are three. Level one is the lowest level and requires that the youth be within adult supervision at all times (they are driven to and from school and are not allowed out of the eyesight of supervising adults, except when they are sleeping). On level two, the youth can earn some limited free time in the community but the setting is controlled

(i.e., sports activities and other supervised activities are sanctioned, "hanging out" is not). At level three the structure is lifted somewhat and peer activities that require less structure are encouraged.

d) *Ongoing Supervision and Support for Foster Parents.* The therapeutic foster parent is the center or key agent in implementing the child's treatment plan. Because of that central role, there is ongoing supervision and support that is similar to that given to therapist trainees. This supervision and support takes many forms. First, the foster parents communicate with the treatment team every weekday during a 10 to 15 minute telephone call during which we collect data on the youth's adjustment during the past 24 hours using the parent daily report checklist, which has been validated in several research studies. During this call, the foster parents provide data on how the youngster is behaving (i.e., what problem behaviors have occurred/not occurred), they also report on the child's daily point numbers and on their own stress. MTFC staff members are on-call 24 hours a day, 7 days a week for crisis management. Foster parents participate in a weekly training and support meeting with MTFC program staff and other foster parents. We also provide respite, though this is not scheduled at a set time, but is provided when the foster parents are in need of it.

e) *Individual Child Treatment*: Individual mental health treatment is provided for all children in therapeutic foster homes. This is done in three different ways. First, the children in care undergo therapy with an MSW-level therapist. Much of this therapy occurs in natural environments, rather than in in-office sessions. These therapists have a caseload of twenty children. The therapy they provide is present-focused, aimed at helping the child understand the challenges that they are currently facing. Second, many of the children in our program require individualized, one-on-one behavioral interventions. For these children, a bachelor's degree-level, trained mental

health aide generally works with him or her in a natural setting (e.g., in the community or at school). In our program, these aides are called "skill trainers." In other programs, they are often referred to as therapeutic behavioral aides or community support personnel. These skill trainers focus on the child's strengths and needs, and teach skills in an integrated setting. For example, if the team wants to provide the child with the opportunity to learn skills to better relate to peers, and the child is a basketball fan, we might enroll the child on a basketball team, which would give the skill trainer a natural forum in which to work with the child on developing peer relationships. Children with serious emotional or behavioral impairments are often repeatedly kicked off of such teams, but with the aid of the skill trainer, they are able to get involved in this normative activity and develop skills that are necessary for their success. Third, managing some children's mental health needs requires psychotropic medication. For those children, appointments with a psychiatrist, where medication is prescribed and monitored, are provided.

f) Family Treatment: The ultimate goal of a therapeutic foster placement depends on the permanency plan. If reunification were the goal, we work to prepare the family for when the child returns home and we strive to involve the parents (or guardians) with the child, while he or she is in care. To this end, we provide therapy to the child's family and we work with the parent to learn and practice behavioral management techniques. We also encourage frequent contact between the youngster in care and his or her family. We start out with many short visits where the parent focuses on setting limits and appropriately reinforcing positive behavior. Many of our children spend weekends at home with their families. When the child leaves foster care, we continue to be involved in the family's life. Usually the family therapy continues and the biological family is encouraged to call if there is a crisis.

g) *Program Supervision.* Each child in care is assigned a program supervisor. The program supervisors provide daily monitoring, review the daily data about the child, coordinate the efforts of the foster parents and the individual therapists, and oversee the development of a plan to avoid crises (and to address them, when they arise). They also maintain contact with the child's biological parents, teachers, psychiatrist (if any), employers (if any), and other important members of the child's community. Through these contacts, they are able to marshal community and natural supports. Each week, there is a clinical meeting staffed by the child's program supervisor, therapist, skill aide (if any), and psychiatrist (if any), where the overall integrity of the child's treatment plan is monitored and re-evaluated, and the sequencing and timing of interventions is planned. Because of the intensity their supervision, the program supervisors have a caseload of only ten children.

D. <u>Clinical Effectiveness of Therapeutic Foster Care</u>

13. Experts in the mental health field strive to utilize mental health interventions that had a positive effect on the lives of children and their families. As the Surgeon General noted, since the 1980s, the field of children's mental health has shifted from institution-based care to community-based interventions. (Mental Health: A Report of the Surgeon General (2000)). As the field has moved in this direction, researchers began assessing these new community-based programs.

14. Researchers and clinicians in the mental health field endeavor to assess the level of effectiveness in a given area through clinical trials, review articles, and other methods. The strength of the evidence amassed for any conclusion is referred to as the "evidence base." The most powerful research method used in the mental health field is the randomized clinical trial. Randomized clinical trials are considered to be the "gold standard" method for assessing program efficacy. Other quasi-experimental designs are

often used to evaluate programs because they tend to be less expensive and may be easier to conduct than randomized trials, but the conclusions that can be drawn from quasi-experimental studies are more tentative.

15. Multidimensional Therapeutic Foster Care has been evaluated extensively, including in eight randomized experimental clinical trials. These evaluations show that MTFC provides consistent and sustained positive outcomes for youth.

16. Based on research and program evaluation, MTFC is widely accepted as an evidence-based practice for controlling and allaying delinquency and anti-social behavior caused by psychological, behavioral, or emotional impairments. (See, for example, Mental Health: A Report of the Surgeon General (2000)).

17. MTFC first underwent a quasi-experimental study in 1990. The study examined the use of MTFC for adolescents referred for delinquency (Chamberlain, 1990). This was followed by a randomized trial with youngsters leaving the state mental hospital (Chamberlain & Reid, 1994). These early studies showed that in comparison to alternative residential treatment models, MFTC resulted in better outcomes for children and families and did so at far less expense. For example, in the study that examined outcomes for children and adolescents leaving the Oregon State Hospital, those of children served in the MTFC program were placed in the community more quickly and, upon follow-up, had fewer behavior problems. Further, the early studies showed the cost of serving children in MTFC was significantly lower because they returned to more restrictive placement (institutions) less often than in comparison conditions.

18. These two studies led to larger investigations of MTFC. The first of these involved boys with serious mental health needs who had chronic problems with delinquency (Chamberlain & Reid, 1994). The boys in the study had spent an average

of 75 days during the previous year in locked detention settings. Boys were randomly assigned to placement in MTFC or Group Care and assessed one year after their placements ended. Compared to boys in Group Care:

- MTFC boys spent 60% fewer days incarcerated in follow-up;
- Had fewer than half the number of subsequent arrests;
- Ran away from programs 3 times less often;
- Returned to live with parents/relatives twice as many days; and
- Had significantly less hard drug use in follow-up.
- Had significantly fewer violent offenses at 2 year follow-up.

19. In the second study, we conducted a randomized trial with Oregon State foster parents in three counties (Chamberlain, Moreland, & Reid, 1992). Foster families were randomly assigned to one of three groups: (1) enhanced services plus a monthly stipend, (2) a monthly stipend only, and (3) a foster-care-as-usual control group.

20. Foster parents in the enhanced services group participated in a weekly group that focused on the use of practical behavior management skills, such as the ones used in MTFC. Each enhancement group was conducted by an experienced foster parent who was well versed in the MTFC model, and foster parents in the groups were telephoned weekly to obtain behavioral data on their child's adjustment and to troubleshoot any problems that were occurring. Compared to those receiving only a stipend, or those in the control group, foster families who received enhanced services plus a stipend demonstrated significantly greater decreases in child symptoms, fewer failed placements due to the child's behavioral/emotional problems, and significantly less attrition (i.e., fewer in the enhanced group subsequently discontinued to provide services as foster parents). Thus, not only did the enhanced services lead to better child

outcomes, but the retention rates of foster parents were higher for those who participated in enhanced services.

21. This study is currently being replicated on a large scale with over 700 foster families in San Diego County in collaboration with the Child and Adolescent Services Research Center affiliated with the Children's Hospital and San Diego State University.

22. In addition to studying outcomes, we were interested in identifying the "active" ingredients of MTFC. We wanted to know what is it about the MTFC model that makes it work? To study this, we asked boys and their caretakers in MTFC or in Group Care ("GC") about specific parenting practices that we hypothesized would explain our positive outcomes. These practices included: consistent discipline, close supervision, and positive encouragement and engagement with adult caretakers. We also asked about the amount of time youth spent with delinquent peers. Significant differences were observed between MTFC and GC boys in several areas. Most notably, MTFC participants spent more time with their adult caretakers and less overall time without adult supervision; they were disciplined in a more consistent manner for rule violations and misbehavior; they spent less time unsupervised with delinquent peers; and reported less influence by delinquent peers (Chamberlain, Ray, & Moore, 1996).

23. In a later study replicating these effects, we used a data analysis method called structural equation modeling ("SEM") to see if these practices explained the differential outcomes for boys in MTFC and GC. The answer to the question was essentially "yes" (Eddy & Chamberlain, 2000). We are currently conducting a parallel study for girls referred from juvenile justice system.

24. The research shows that MTFC is both appropriate and necessary for many children who are eligible for substitute care (i.e., kids being sent to residential or group homes) because of severe emotional, behavioral, or psychiatric impairments.

E. Cost

25. The OCP receives funding for its program for behaviorally and emotionally disturbed children through a partnership with the local child welfare and mental health divisions and from the state and county juvenile justice systems. MTFC foster parents are paid from $1,200 to $1,500 per month, depending on their experience level with MTFC or, in some cases, on an assessment of the difficulty of the case. In addition, other costs including family and individual therapy services, skills training, program supervision, psychiatry, review of daily points, recruitment, training, and case consultation average $2,000 to $3,000 per month per child, and the average length of stay for these children is 9 months.

26. MTFC was recently evaluated by the Washington State Public Policy Group (Aos, Phipps, Barnoski, & Lieb, 2001: www.wa.gov/wsipp; document # 01-05-1201). Of all of the juvenile justice programs evaluated, MTFC was shown to result in the largest cost saving to the taxpayer. The report found that "Overall taxpayers gain approximately $21,836 in subsequent criminal justice cost savings for each program participant. Adding the benefits that accrue to crime victim increases the expected net present value to $87,622 per participant, which is equivalent to a benefit-to-cost ratio of $43.70 for every dollar spent."

27. The best way to fund TFC is on a per diem basis. Funding TFC on other than a per diem basis is much harder because it is administratively quite expensive to bill Medicaid for each of the components of a program that is, in reality, an integrated service. Our experience of funding TFC on per diem and non-per diem dollars leads us to the conclusion that it is, ultimately, easier and less expensive to fund TFC on a per diem basis.

H. Conclusion

28. In my opinion MTFC is a unique service that is necessary to appropriately serve many children with emotional, behavioral, and mental health needs, so as to promote their healthy development and, when they have been removed from their homes, to foster reunification with birth parents, where possible.

I declare under penalty of perjury under the law of the United States of America and the State of California that the foregoing is true and correct. Executed on 10/5/05, in [illegible], Oregon.

Patricia Chamberlain, Ph.D