DECLARATION OF ROBERT FRIEDMAN, Ph.D.

I, Dr. Robert Friedman, declare that, if called as a witness, I could and would competently testify as follows:

I. Summary of Qualifications and Opinions

1. I am the chair of the Department of Child and Family Studies within the Florida Mental Health Institute ("FMHI") of the University of South Florida. I also served as Director of the Research and Training Center for Children's Mental Health, one of two such research centers in the United States.

2. I am the co-author along with Beth Stroul of, "*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. Since the publication of the monograph in 1986, the federal government adopted the system of care model as a way to organize and deliver mental health services, by awarding grants to states to develop systems of care sites. Ninety-two systems of care sites have been funded by the Substance Abuse and Mental Health Services Administration ("SAMHSA"), a division of the U.S. Department of Health and Human Services.

3. I have served on many national committees including the Planning Board for the Surgeon General's Report on Mental Health. I have provided Congressional testimony on several occasions, including a recent address to the President's New Freedom Commission on Mental Health.

4. During the past seven to ten years, the field of children's mental health has put greater emphasis on promoting services for which there is a proven track record of success, or so called "research validated evidence-based practices" or simply "evidence-based practices." Therapeutic foster care is an evidence-based

practice, the gold standard in mental health interventions for youth. For years, wraparound has been considered a "promising practice," a considerable recognition of the effectiveness of a mental health intervention. In recent months, additional research, has lead some (including myself) to conclude that there are sufficient research findings to consider wraparound services a research validated evidence-based practice. Many children's mental health interventions that receive Medicaid funding—chief among these services are in-patient hospitalization and residential treatment centers—are neither evidence-based nor promising practices.

5. Through my work, I have come to the conclusion that a functioning children's mental health system would include both therapeutic foster and wraparound care services. Both services are necessary for some children with serious emotional disturbance, many of whom are in the foster care system.

II. Qualifications

6. I received my Ph.D. in 1970 from Florida State University. After I was awarded my Ph.D., I provided direct clinical services to children and adolescents with emotional and behavioral problems and directed several clinical programs. Starting in 1984, my professional focus has been primarily in research and program/systems design. I have written extensively and consult on mental health systems of care for children and adolescents, including evaluating community-based interventions for children and families. See Curriculum Vitae at pp. 9-12 (listing recent book and professional presentations).

7. From 1984 until 1991, I was chair of the Epidemiology and Policy Analysis Department at the Florida Mental Health Institute ("FMHI") located at the University of South Florida, and the Director of FMHI's Research and Training Center for Children's Mental Health.

8. Since 1991, I have been a professor and chair of the FMHI's Department of Child and Family Studies, a multi-disciplinary department that strives to improve the well-being of families and children through applied research, training and education, evaluation, and dissemination of information. In this capacity, it is one of my responsibilities to keep up-to-date on the research in the field of children's mental health, either in the context of my own research or in reviewing the work of others.

9. Of particular relevance here, my research has included not only the evaluation of the foster care system in Florida, but a national survey on public sector financing of community based services, a study of alternatives to residential treatment, research on substance abuse treatment for adolescents, studies of school functioning of children in residential treatment programs, and studies of the prevalence of psychiatric disorders in children. Additionally, from 1987 until 1993, I directed a child welfare / mental health training project at FMHI and in the early 1980's, I directed a technical assistance project and was the principal investigator for an assessment of foster care in Florida.

10.I have published over 40 articles and over 30 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*." A full list of my publications is found on my Curriculum Vitae, attached at Ex. 1.

11.My research is funded by numerous federal, state and local agencies and foundations. Among the grants I have received for my work are the following:

(a) Evaluation of the Comprehensive Center for Mental Health Services for Children and Their Families Program, 1994 to present, ($3,000,000);

(b) Research and Training Center for Children's Mental Health, National Institute on Disability and Rehabilitation Research (1994-1999) ($5,000,000); 1999-2004 ($4,500,000);

(c) Preparation for Responsive Educational Program, National Institute of Mental Health (NIMH), 1975-1976 ($800,000) (co-principal investigator).

12.I was a consultant to the Children's Subcommittee of the President's New Freedom Commission on Mental Health from 2002-2003. I am currently a member of the Professional Advisory Board, Children and Adults with Attention-Deficit Hyperactivity Disorder (CHADD); a member of the Executive Committee, James and Jennifer Harrell Center for the Study of Domestic Violence; a member of the Policy Group for Florida's Children and Families; and a grant reviewer, National Institute of Mental Health/Center for Mental Health Services.

13.I have given over 130 papers or presentations in professional meetings, including numerous national conferences. These are listed in Exh. 1 hereto.

14.I am currently the editor of the book series Systems of Care for Children's Mental Health, a guest reviewer for Health Affairs, and a consulting editor (member of the editorial board) for three other journals related to children's mental health.

15.I have presented numerous policy reports to public agencies, also listed in Exhibit 1 hereto.

III. Systems of Care for Youth with Mental Health Needs

16.The term "systems of care" was first defined by a monograph, which I co-authored, in 1986. This monograph has been widely cited as defining the core values and guiding principles essential in building a comprehensive system for

children with serious emotional disturbance, as a solution to the problems associated with haphazardly developed, non-collaborative services. In 1992, led by the efforts of Dr. Ira Lourie, the Comprehensive Community Mental Health Services Program ("CCMHSP") for Children and Their Families, run by the federal government's Center for Mental Health Services ("CMHS"), adopted the system of care model as a way to organize, coordinate, and deliver mental health services and supports for children, adolescents and their families, by giving grants to states to develop systems of care. Between 4.5-6.3 million children with serious emotional disturbances and their families are eligible for the grant program. The program has funded 92 grantees across the country; there are currently 61 grant communities and 31 former grant programs.

17. Systems of care are guided by a core set of principles. First, systems of care should be child-centered and family-focused, with the needs of the child and family dictating the types and mix of services provided. Systems of care should be community-based, with the focus of services as well as management and decision making responsibility resting at the community level. The system of care should be culturally competent, with agencies, programs, and services that are responsive to the cultural, racial, and ethnic differences of the populations they serve.

The federal government, and most in the children's mental health field, have adopted or supported the systems of care approach for serving children with serious emotional disturbance many of whom are touched by many child-serving agencies. Systems of care are widely thought of as a core component of any modern children's mental health system. Increasingly, systems outside of the mental health system, such as the Administration for Children and Families and Divisions of child welfare are incorporating the systems of care model.

IV. Evidence Base for Children's Mental Health Interventions

19. The process of identifying and incorporating best practices was first utilized extensively in the business sector. Over the past seven to ten years, increasing efforts have been made to encourage the adoption and funding of best practice methodologies within the field of children's mental health. Evidence-based practices refer to the body of scientific knowledge about different service interventions, describing the strength of the scientific knowledge about the effectiveness of an intervention.

20. Methodologically sound practices are typically divided into different categories (i.e., "research validated evidence-based practices" or "promising practices"), recognizing the varying strength of the scientific knowledge known about the intervention.

21. For example, for a treatment to be classified as "research validated evidence-based practice," at least two between-group design studies must be conducted across studies representing the same age group and receiving the same treatment for the same target problem, at least two within-group or single case design studies with the same parameters must be conducted, or there must be a combination of these. Further, a majority of the applicable studies must support the treatment, and the protocol must show acceptable adherence to the treatment manual.

22. Promising practices are those that have worked within organizations and show promise for becoming an evidence-based practice with long term sustainable impact. A promising practice must have an objective basis for claiming effectiveness and must have the potential for replication among other organizations.

23.Few children's mental health interventions are considered either research-validated evidence-based practices or promising practices, and as such classification as either has considerable weight.

24.Examining the classification of three mental health interventions that are often provided to children with serious mental health needs—therapeutic foster care, wraparound services, and institutional care—is revealing. A comparison of the first two—therapeutic foster care and wraparound—reveals how the history of different mental health interventions colors their classification. A comparison of therapeutic foster care and wraparound with institutional care reveals that the movement toward funding evidence-based practices is not fully effectuated, as the former two both have considerable research demonstrating their effectiveness, whereas the latter does not, despite the wide use and Medi-Cal funding of institutional care.

25.To address the first of these—how history influences outcome—one needs to look no further than two of the mental health interventions at issue in this lawsuit: therapeutic foster care and wraparound. The historical development of these two services could not be more dissimilar.

26. Therapeutic foster care was developed in research and academic settings, lead by the efforts of Patti Chamberlain at the Oregon Social Learning Center and leaders in the Pride program in Pittsburgh. Therapeutic foster care is a service for children with serious behavioral and emotional needs who cannot be cared for in their own homes. Like wraparound services, therapeutic foster care is a flexible intervention approach that emphasizes building upon positive family strengths, and provides crisis intervention, family counseling, assistance with child management and skills to enhance family functioning, and provides access to other community

support programs. Building positive expectations and maintaining a strength-based orientation are essential to therapeutic foster care. These programs produced good long-term outcomes for children and families, a result which is not surprising given that the intervention recognizes the heterogeneity of the children who are served by mental health clinics and responds to each child's unique situation (in adherence to the "systems of care" principles).

27. The development of this intervention was very "top down." This intervention was lead by researchers and academics who were quick to run in-group and between-group design studies, and publish the results of those studies in peer reviewed journals. They were also quick to create "model" therapeutic foster care programs, all of which were requirements for an intervention to be considered a research-validated evidence-based practice. As a result, therapeutic foster care was relatively quickly recognized as an evidence-based practice. This was good for children with mental health needs because the success of these programs spread quickly, and the therapeutic foster care programs were replicated, providing access to these services. A review of effective children's mental health programs reveals that therapeutic foster care is one the most effective programs for addressing children's mental health needs (home-based services, therapeutic foster care, some forms of case management, and both pharmaceutical and psychosocial treatments for specific syndromes). Burns, B. J., Hoagwood, K., & Mrazek, P. J. (1999). Effective treatment for mental disorders in children and adolescents. Clinical Child and Family Psychology Review 2(4), 199-254.

28. The development of wraparound service programs was quite different. These programs were driven from the "bottom up." The intervention was not designed in a university setting, or a research center, it was started by front-line

children's mental health clinics that saw a more effective way to treat children and families, based on the same strength-based principles of systems of care and therapeutic foster care. These programs developed in the 1970s and 1980s, the first program being the Kaleidoscope Program, headed by Karl Dennis in Chicago. Wraparound services are mental health interventions that are child-centered, family-focused, community-based services, which utilize community and natural supports, and are provided pursuant to an assessment, decision making, and ongoing coordination and evaluation by a child, family and multi-agency team. Wraparound services are individualized and unconditional and the focus of the team is on marshalling the strengths of the child and family. Wraparound teams use a broad array of therapeutic interventions.

29.Even before researchers were able to document the effectiveness of wraparound services, and indeed even before the term "systems of care" was in active use, families of children with mental health needs understood the importance of family voice and family choice and considered these services important and essential interventions for certain children with serious mental health needs. As a result, there were many years where wraparound services were provided to children but in which there was no active effort to systematically document the success of the program for children, beyond the obvious attention to the individual outcomes for individual children. Research studies of wraparound services have therefore tended to focus on "before/after" studies rather the between-group designs critical for classifying a practice as evidence-based. Further, wraparound services generally come from public, not private systems, and it is more difficult to do "gold standard" research in public systems than in the private sector. One additional obstacle to conducting research on wraparound

services was that, until recently there were not standardized measures for evaluating wraparound care programs. Hence, it was difficult to determine if programs labeled as wraparound programs were consistently operating as intended, including consistently convening the right type of child and family team. Recently researchers (including Eric Bruns) have developed "fidelity measures," which test whether a wraparound program includes the essential elements of the service.

30. Nonetheless, as a growing number of wraparound programs touted their successes, there has been an increasing interest in research into the effectiveness of wraparound services and the most effective components of those services. The outcome of these studies was that wraparound services have long been considered "promising practices," a strong indication of their effectiveness. More recently, the weight of the research of the effectiveness of wraparound services have lead some, including myself, to conclude that wraparound services have enough research heft behind them to be considered "research validated evidence-based practices."

31. The provision of both wraparound services and therapeutic foster care are widely thought of as essential to any modern children's mental health system and as a way of effectuating the goals of "systems of care."

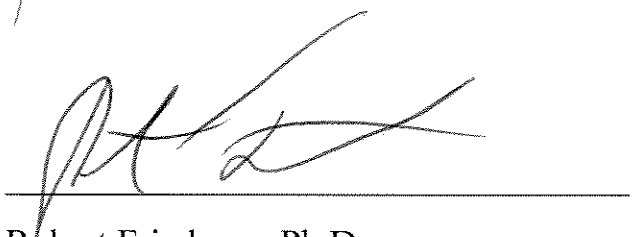
32. Other treatments provided to children with mental health needs—and funded by Medicaid—are neither research validated evidence-based practices nor promising practices. These treatments include in-patient hospitalization and residential treatment centers, both of which have few proven long-term benefits to children and adolescents.

V. Conclusions

33. A functioning children's mental health system would include both therapeutic foster and wraparound care services. Both services are necessary for some children with serious emotional disturbance, many of whom are in the foster care system.

34. Both therapeutic foster care and wraparound services are a research validated evidence-based practices, the gold standard in mental health interventions for youth.

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 August 29, 2005, in Tampa, Florida.



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