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UNITED STATES DISTRICT COURT

DISTRICT OF ARIZONA

J.K., a minor by and through R.K., *et al.*, on behalf of themselves and all others similarly situated,

Plaintiffs,

vs.

WILL HUMBLE, in his official capacity as Interim Director of the Arizona Department of Health Services; DR. LAURA NELSON, in her official capacity as Director, Division of Behavioral Health Services, Arizona, Department of Health Services; THOMAS J. BETLACH, in his official capacity as Director, Arizona Health Care Cost Containment System,

Defendants.

No. CIV 91-261 TUC JMR

PLAINTIFFS' MOTION FOR ENFORCEMENT OF SETTLEMENT AGREEMENT

(Honorable John M. Roll)

I. INTRODUCTION

Eight years ago, this Court adopted a judicially enforceable Settlement Agreement to protect the right of Arizona's Medicaid-eligible children to receive necessary mental health and substance abuse services ("behavioral health services"). Settlement Agreement ("Agreement") at 1 (Agreement "legally binding and enforceable by the Court"); Order June 26, 2001 (Agreement "approved and adopted in its entirety").

Federal law requires States to provide Medicaid-eligible children "necessary … services, treatment and other measures … to correct or ameliorate … physical and mental illnesses and conditions." 42 U.S.C. § 1396(d)(a)(4)(B); [1] *Katie A. v. Los Angeles County*, 481 F.3d 1150, 1154 (9th Cir. 2007). In the Settlement Agreement, the Defendants – the directors of the Arizona Department of Health Services ("ADHS"), the Department's Division of Behavioral Health Services ("DBHS"), and the Arizona Health Care Cost Containment System ("AHCCCS") – agreed to meet this obligation by developing and maintaining a service system that meets nationally accepted standards, which are spelled out in what are known as the "*J.K.* Principles." The Agreement also includes specific actions Defendants must take to develop and maintain this system, including: developing the array of intensive community-based services that children with serious conditions need, Agreement at ¶ 23; expanding substance abuse services, *id.* at ¶ 52; developing

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[1] The cited statute is commonly referred to as the "EPSDT" program of the Medicaid Act. It requires the State to deliver "early and periodic screening, diagnostic, and treatment services," known as "EPSDT" services, to Medicaid-eligible children and youth under 21. 42 U.S.C. § 1396(d)(a)(4)(B). These services include "necessary health care, diagnostic services, treatment and other measures . . . to correct or ameliorate … physical and mental illnesses and conditions." 42 U.S.C. § 3396d(r). States must provide these services regardless of whether they are specifically covered in the State's Medicaid plan. *Id.*

training program that ensures that staff have necessary knowledge and skills, *id.* at ¶¶ 32-39; and changing the state's quality management ("QM") system so that it measures whether class members are receiving the services required by the Agreement, *id.* at ¶ 55.

When it became clear three years ago that Defendants were not meeting their obligations, the parties agreed to and the Court approved a three-year extension to July 2010 of the term of the Settlement Agreement. Order, January 10, 2007. With this date fast approaching, and Defendants' compliance still incomplete and inadequate, Plaintiffs seek another extension of the term of the Agreement, as well as other relief needed to protect Plaintiffs' federal law entitlement.

A. Supporting Declarations

In support of this Motion, Plaintiffs submit ten Declarations detailing Defendants' non-compliance and its tragic consequences for children and families. The declarants include: two national experts who have examined Defendants' compliance, *see* Declaration of Knute Rotto ("Rotto Dec."), attached as Ex. 1, and Declaration of Bruce Kamradt ("Kamradt Dec."), attached as Ex. 2; a former clinical director of a network of providers serving over 8,000 class members, *see* Declaration of Matthew Pierce ("Pierce Dec."), attached as Ex. 3; a former director of children's behavioral health services for the Maricopa County Regional Behavioral Health Authority, *see* Declaration of Michael Terkeltaub ("Terkeltaub Dec."), attached as Ex. 4; a former deputy director of Arizona's Medicaid program, *see* Declaration of Linda Huff Redman ("Redman Dec."), attached as Ex. 5; an expert whom Defendants consulted concerning their quality management system, *see* Declaration of Eric Bruns ("Bruns Dec."), attached as Ex. 6; and parents of class members, *see* Declaration of Krista Long ("Long Dec."), attached as Ex. 7; Declaration of Carol McDermott ("McDermott Dec."), attached as Ex. 8; Declaration of

Donna Ifill ("Ifill Dec."), attached as Ex. 9; Declaration of Lee Bieber ("Bieber Dec."), attached as Ex. 10.

As these declarations show, Defendants have failed to comply with the Agreement. *See, e.g.*, Rotto Dec. at ¶ 46 ("Arizona is not operating a children's behavioral health system that meets the needs of *J.K.* class members, as required by the Settlement Agreement and Medicaid law"); Kamradt Dec. at ¶ 4; Pierce Dec. at ¶ 3; Terkeltaub Dec. at ¶ 4. Defendants have not created the intensive community-based services that class members with serious conditions require, and as a result, children are being needlessly removed from their homes and placed in out-of-home care. *See infra* at Section III.B.1. Defendants have not ensured that class members get the substance abuse services they need; the behavioral health system fails to identify substance abuse treatment needs and lacks sufficient substance abuse services. *See infra* at Section III.B.2. Defendants have not developed the training program required by the Settlement Agreement, that is, one that ensures that behavioral health staff have the knowledge and skills to provide necessary services and that measures the competencies of staff. *See infra* at Section III.B.3. Class members age 18 to 21 have been denied the benefits of the Settlement Agreement; upon their 18th birthday, they are disenrolled from the children's behavioral health system and enrolled in the adult system, where they are denied medically necessary services to which they are entitled under the Settlement Agreement and federal law. *See infra* at Section III.B.4. Furthermore, Defendants have failed to develop a quality management system that monitors compliance with the Settlement Agreement and that takes corrective action when deficiencies are found. *See* infra at Section III.B.5.

The declarations also show the tragic consequences of Defendants' noncompliance for Arizona's vulnerable children and struggling families. *See, e.g.*, Pierce Dec. at ¶¶ 36-

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56 (describing cases of four representative children); *id.* at ¶ 35 ("failures … occur repeatedly in our system, to the great detriment of children and their families"); McDermott Dec. at ¶ 3 (" Families like mine, whose children need, but do not receive, intensive services hang on by our fingernails."); Long Dec. at ¶ 6 ("constant struggle"); Bieber Dec. at ¶ 5 ("behavioral health system not helping [her daughter] get better").

The story of "Brittany" is a case in point. Brittany, now 18 years old, entered foster care at an early age. Although a longtime client of the behavioral health system, she has never received the treatment she needs. By age 12, she had taken more than 50 different medications and been hospitalized on several occasions. Her foster parents were told that intensive community-based services were not available; they felt they had no choice but to place her in out-of home care. She ran away from a group home in an effort to return to her foster family and was moved to a residential treatment center where she stayed for the next two years. She returned home and her foster family and again requested intensive community-based services, but again was told these services were not available. Over the next several years, she had more than a dozen different placements. When Brittany was close to turning 18, she was assigned a case manager to plan for her adulthood. The clinician who evaluated whether she qualified for adult services never met Brittany and refused information from the foster parents. Recently, her foster family was informed that no adult services were available for Brittany. Pierce Dec. at ¶¶ 36-42.

B. Relief

With this Motion, Plaintiffs seek to require Defendants to develop and implement a plan that ensures the commitments Defendants made in the Agreement are met and class members receive the services to which they are entitled under federal law. The last eight years have shown that if Defendants are to comply with the Agreement, they must have a

written plan that reflects a strong commitment, provides meaningful accountability for key participants in the system, and resolves the specific deficiencies described in this Motion. Moreover, Defendants must be accountable to the Court for the plan's implementation.

To ensure that Defendants meet their obligations, Plaintiffs respectfully move the Court to:

- Direct Defendants to develop, and secure the Court's approval, for a plan with specific actions and deadlines for correcting the deficiencies described in this Motion,
- direct Defendants to implement the plan, and
- extend the term of the Settlement Agreement, and the Court's jurisdiction, for the period required to implement the plan, including the resolution of any disputes over implementation.

The parties' Agreement provides that, when a party by motion asserts a breach of the Agreement, the Court "will … as appropriate, receive evidence" and "resolve the matter in a manner consistent with the purposes and goals of the Settlement Agreement."[2] Agreement at ¶¶ 69, 70. Plaintiffs are prepared to prove each of the factual assertions in this Motion. Plaintiffs note, however, that in some instances, proof may require testimony

[2] Under the Agreement, either Plaintiffs or Defendants may complain of a breach. Agreement at ¶ 56. "If mediation does not produce a resolution…, the party may file an appropriate motion with the Court. *Id*. at ¶ 68. Earlier this year, Plaintiffs invoked these provisions. *See* March 6, 2009 Letter from Plaintiffs to Defendants, attached as Ex. 11. Mediation failed to produce a resolution. *See* Report of Mediator to the Court, August 13, 2009.

or information from state officials, Regional Behavioral Health Authorities (known as "RBHAs"),[3] networks, or providers that can be obtained only through the Court's compulsory process.

II. FACTUAL BACKGROUND

A. Pre-Settlement Litigation

Plaintiffs, Medicaid-eligible children with emotional and behavioral disorders, filed this class action lawsuit on May 8, 1991. *See* Complaint, May 8, 1991. Plaintiffs sought to compel Defendants to provide them medically necessary mental health and substance abuse services ("behavioral health services") in compliance with the Medicaid Act, 42 U.S.C. § 1396d(r), *et seq*. *See* Second Amended Complaint, April 26, 1993. The certified Plaintiff class includes "all persons, under the age of twenty-one, who are eligible for Title XIX behavioral health services in the State of Arizona and have been identified as needing behavioral health services."[4] Order at 7-8, June 24, 1993.

The litigation proceeded from 1991 through 1997.[5] In October 1997, the litigation was stayed, following the State's declaration of an emergency in the provision of children's behavioral health services, to allow an independent expert to conduct a

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[3] RBHAs are the managed care entities with whom Defendants contract and who actually operate the system. RBHAs in turn contract with networks of providers ("networks") and/or individual provider agencies ("providers").

[4] "Title XIX" refers to the Medicaid Act. *See infra* at n. 10.

[5] Several cross-motions for summary judgment were resolved in Plaintiffs' favor. *See J.K. v. Dillenger*, 836 F. Supp. 694 (D. Ariz. 1993) (finding Defendants responsible for alleged failures to provide medically necessary services); Order, May 13, 1996 (finding violations of the notice and fair hearing provisions of the Medicaid Act).

comprehensive study. *See* Order Approving Parties' Agreement and Staying Litigation, October 23, 1997. In 1998, the independent expert, Dr. Ivor Groves, submitted his first report, focusing on Maricopa County, which found, *inter alia*, that more than half of class members were receiving inadequate behavioral health services and that the system's performance was not acceptable for any age group. June 1998 Report, filed with Pls' Response to Defs' Motion to Extend Stay, August 21, 2000. Dr. Groves' reviews of services in the rest of the state confirmed that behavioral services were inadequate statewide, and a follow-up review of Maricopa County in April 2000 found that little had changed in two years.[6] June 2000 Report, attached to Pls' Response to Defs' Motion for Extension of Stay, August 21, 2000. Soon thereafter, newly appointed directors of ADHS and AHCCCS announced their intention to settle the case.

B. The Settlement Agreement

The *J.K.* Principles are the foundation of the Settlement Agreement, which was signed in March 2001. Agreement at ¶ 19 ("The Principles … are the foundation of this Settlement Agreement ….). The Principles both reflect and articulate a professional consensus concerning the medically necessary treatment of children with behavioral health disorders, including "partnering with families and children, interagency collaboration, and individualized services aimed at achieving meaningful outcomes for families and

[6] After Dr. Groves filed his first report, Plaintiffs agreed to continue the stay of litigation, provided that Dr. Groves would evaluate behavioral health services in the rest of the state and that Defendants would work with Dr. Groves to address the deficiencies identified in his report. Order at ¶¶ 1-4, 8, 8/10/98.

1 children." *Id*. at ¶ 1;[7] *see also, e.g.,* Rotto Dec. at ¶ 18 ("the services required by the *J.K.*
2 Settlement Agreement are medically necessary to treat class members"); Kamradt ¶¶ 14-
3 17 (same).
4 The Principles were designed to address the deficiencies identified by Dr. Groves.
5 Individual clinicians, due to excessive caseloads and other reasons, worked in isolation
6 from the child's family and other service providers addressing the child's condition,
7 including the foster care and juvenile probation systems. Service plans were "cookie-
8 cutter," with too heavy a reliance on office-based counseling. What are referred to as
9 "intensive" community-based services – services provided outside the office and in
10 families' homes and other natural settings – were largely unavailable. As a result, it was
11 common that children, especially children with serious conditions, did not get better.
12 The Principles required the State to make a "fundamental shift" in the way it
13 treated children and families. *See* Gov. Hull Press Release, March 20, 2001, Ex. F to Pls'
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18 [7] A psychiatric expert urged that the Settlement Agreement "provides the basis for
19 developing and implementing a children's mental health system that provides care at a
20 level at least equivalent to national standards." Affidavit of Dr. John Scialli at ¶ 3, May
21 29, 2001, Ex. L. to Pls' Pre-Hearing Mem. In Support of Approval of Settlement
22 Agreement (hereinafter "Pls' Pre-Hearing Mem"). The Children's Action Alliance -- a
23 non-profit research, education, and advocacy organization -- wrote that the "*J.K.*
24 Principles are widely accepted principles of good practice." Statement of the Children's
25 Action Alliance at ¶ ¶ 3, 7, 6/4/01, Ex. N. to Pls' Pre-Hearing Mem. Dr. Robert L.
Klaehn, a member of the American Academy of Child and Adolescent Psychiatry's Work
Group on Community-Based Systems of Care, endorsed the *J.K.* Principles as necessary
to the provision of community-based services. Statement of Dr. Robert L. Klaehn at ¶ 5,
6/13/01, Ex. P. to Pls' Pre-Hearing Mem.
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Pre-Hearing Mem.[8] The Principles committed the State to delivering treatment through "child and family teams" whose membership included the responsible clinician, other involved providers, other systems serving the child, the child's family, and members of the family's natural support system. Agreement at ¶¶ 20, 22, 27, 29-31. The Principles also required the State to expand services so that behavioral service plans could be tailored to the individualized needs of the child. *Id.* at ¶¶ 23-25, 27-31. Of particular importance was the development of intensive community-based services, including intensive case management, direct supports, and therapeutic foster care, which are medically necessary services for children with serious behavioral health conditions. *See, e.g.,* Pierce Dec. at ¶¶ 4-8; Rotto Dec. at ¶ 27; *Katie A. v. Bonta*, 433 F. Supp. 2d 1065 (C.D. Cal. 2006), *rev'd on other grounds*, *Katie A. ex rel Ludin v. Los Angeles County*, 481 F.3d 1150 (9th Cir. 2007); *Rosie D. v. Romney*, 410 F. Supp.2d 18 (D. Mass. 2006). Without such services, children with serious conditions are unlikely to "achieve success in school, live with their families, avoid delinquency, and become stable and productive adults," the outcomes sought by the Agreement, Agreement at ¶ 21.[9] *Id.*

The Agreement requires Defendants to "move as quickly as is practicable to develop a Title XIX behavioral health system that delivers services according to the *J.K.*

[8] "If everything in this agreement is implemented, this will be a total system change." Statement of Maria Hoffman, former executive director of the Arizona Council of Human Service Providers, at ¶ 3, Ex. O. to Pls' Pre-Hearing Mem.

[9] *See also* Agreement at ¶¶ 24-25, 28.

Principles"[10] and, "[o]nce developed, … [to] maintain the system in accordance with the Principles for the term of this Agreement." *Id.* Additionally, the Settlement obliged Defendants to "conform all contracts, decisions, practice guidelines and policies related to the delivery of Title XIX behavioral health services to be consistent with and designed to achieve the Principles for class members." *Id.* at ¶ 16. To this end, the Settlement required Defendants, among other things, to implement a statewide training program to "provide front-line staff and supervisors sufficient knowledge and skills to enable them to plan and provide services consistent with the Principles," *id.* at ¶ 35; "develop a plan for the expansion of substance abuse treatment services," *id.* at ¶ 52, and change "the quality management and improvement system" (the system Defendants use to monitor service planning and delivery) so that it "measures" whether services are being provided as required by the Agreement, *id.* at ¶ 55.

Defendants' obligations under the Agreement were to end on July 1, 2007. *Id.* at ¶¶ 79-83. By this time, the required system of services was to have been developed. *Id.* at ¶ 15 ("Once developed, Defendants will maintain the system in accordance with the Principles for the term of this Agreement."). Additional time was provided for resolving disputes concerning implementation. *Id.* at ¶ 80 (through February 1, 2008). [11]

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[10] "Title XIX," as used in the Agreement, refers to the Medicaid Act. Agreement at ¶ 12. The term "Title XIX behavioral health system," as used in the Agreement, refers to the behavioral health system "supervised and administered by Defendants for delivering Title XIX behavioral health services to class members." *Id*. at ¶5.

[11] In 2006, the date was extended to July 1, 2010. Order, January 10, 2007. The date for resolving disputes concerning implementation was extended to February 1, 2011. *Id.*

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C. Implementation 2001-2006

Plaintiffs were intimately involved in the implementation of the Settlement Agreement. *See* Pls' Pre-Hearing Memo at 10 (referencing parties' "joint commitment to collaborative action"). Plaintiffs' counsel participated in numerous meetings and working committees with State officials, representatives of the RBHAs, private providers, and parents of class members, as well as official reviews of compliance with the Settlement Agreement.[12] Plaintiffs regularly raised issues of concern with Defendants and met with Defendants to attempt to resolve these issues.[13] However, these efforts by Plaintiffs were unavailing in securing compliance.

In January 2006, Plaintiffs invoked the dispute resolution procedures in the Agreement. Based on an interim agreement reached in mediation, the parties tried to reach agreement on a plan for securing compliance with the Agreement. A team of Defendants' staff met with Plaintiffs and family organizations and agreed on the outline of a plan. *See* June 6, 2006 Planning Meeting, Combined Issues, attached as Ex. 12. Unfortunately, Defendants rejected the plan. Ultimately, the parties agreed on a three-year extension of the Settlement Agreement. *See* Stipulation to Amend the Settlement Agreement, November 21, 2006. The Court ordered the extension on January 10, 2007. Order, January 10, 2007.

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[12] Plaintiffs' counsel also regularly advocated on behalf of individual class members denied needed services.

[13] In all these efforts, Plaintiffs collaborated with two major family advocacy organizations.

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D. Events Following the Extension

Although the parties had not reached agreement on a written implementation plan, Defendants began to address some of the deficiencies Plaintiffs had identified as top concerns. These were that:

- Defendants had not created adequate performance expectations for RBHAs or held RBHAs accountable for poor performance.
- Intensive community-based services – required by the 25-35% of class with serious conditions – were in short supply, including intensive case management, direct supports, respite, and therapeutic foster care.
- Substance abuse services were inadequate.
- There was no effective training program.
- Youth 18-21 were systematically denied the benefits of the Agreement. When children turned 18, they were transferred to providers in the adult system unable to meet their needs or, worse, denied services altogether.
- Defendants lacked a reliable method for determining whether RBHAs and providers were delivering services according to the Agreement.

The parties met on a regular basis. Of significant concern during this time was a finding in the third quarter of Fiscal Year 2008 that only 33% of the children in Maricopa County were receiving appropriate services. *Cf.* Redman Dec. at ¶ 18. Plaintiffs wrote a series of letters setting forth their views and confirming their understanding of actions that Defendants planned to take. *See* letters from Plaintiffs to Defendants, attached as Ex. 13.

Ultimately, the parties were unable to resolve their differences. Defendants asserted that they would be in full compliance with the Settlement Agreement by July 2010, and that no actions in addition to those already planned and being implemented

were necessary for Defendants to meet their obligations. In March 2009, Plaintiffs invoked the dispute resolution provisions of the Settlement Agreement. *See* March 6, 2009 Letter from Plaintiffs to Defendants, attached as Ex. 10.

III. ARGUMENT

A. This Court Has the Power to Enforce the Settlement Agreement and Grant the Relief Requested

The Settlement Agreement, by its terms, is judicially enforceable. *See* Agreement at 1 ("legally binding and enforceable by the Court."). The Court approved and adopted the Agreement in its entirety, maintaining jurisdiction for enforcement purposes. Order, July 5, 2001. Plainly, this Court has the authority, as well as the obligation, to enforce the Agreement. *Frew v. Hawkins*, 540 U.S. 431 (2004); *Rufo v. Inmates of Suffolk County Jail*, 502 U.S. 367 (1992); *cf. Spallone v.United States*, 493 U.S. 265, 276 (1990) (referencing courts' inherent powers).

A court may use its enforcement powers even absent a finding of contempt. *Holland v. N.J. Dept. of Corrections*, 246 F.3d 267, 283 n. 14 (3rd Cir. 2001); *Berger v. Heckler*, 771 F.2d 1556, 1569 (2nd Cir. 1985). A district court "is invested with broad equitable powers and simply should not be compelled to operate in a punishment or nothing atmosphere. Alleviation rather than sanction [is] properly the goal on which the district court concentrate[s] its attention." *Alexander v. Hill*, 707 F.2d 780, 783 (4th Cir. 1983).

A Court may require Defendants to undertake specific corrective actions required for compliance. *See, e.g.*, *David C. v. Leavitt*, 242 F.3d 1206, 1209 (10th Cir. 2001) (affirming order for defendants to implement a detailed remedial plan to remedy non-compliance); *Alexander v. Hill*, 707 F.2d 780, 783 (4th Cir. 1983) (affirming order

directing remedial actions to address defendants non-compliance). Moreover, where as here the Defendants' obligations are time-limited, the Court may extend the term of the obligations to remedy non-compliance. *See, e.g.*, *Thompson v. U.S. Dept. of Housing and Urban Dev.*, 404 F.3d 821, 831 (4th Cir. 2005) (extending term of consent decree to address defendants' non-compliance). This Court has already done so by agreement of the parties. *See* Order, January 10, 2007. It may take the same action upon motion of Plaintiffs when such an extension is required to secure the benefit of the bargain struck with Defendants. "[T]he power to modify in appropriate circumstances is inherent in the equity jurisdiction of the court." *Keith v. Volpe*, 784 F.2d 1457, 1461 (9th Cir. 1986); *accord SEC v. Worthen*, 98 F.3d 480, 482 (9th Cir. 1996) ("inherent power of a court sitting in equity to modify its decrees prospectively to achieve equity"). A failure of compliance with a judicial decree "would justify the decree's extension." *Labor/Community Strategy Center v. Los Angeles Metropolitan Transportation Authority*, 564 F.3d 1115, 1120-21 (9th Cir. 2009).

B. Defendants Are Violating the Settlement Agreement and the Medicaid Act

As demonstrated below, Defendants have not moved "as quickly as practicable" to develop the system of services required by the Agreement. *See e.g.*, Rotto Dec., at ¶ 7 ("Defendants have not … moved as quickly as practicable to develop a behavioral health system that provides services according to the *J.K.* Principles."); Kamradt Dec. at ¶ 4; Pierce Dec. at ¶ 57; Terkeltaub Dec. at ¶ 27. That system is not yet developed and, given what remains to be done, Defendants cannot finish the job by the July 2010 deadline. *See, e.g.*, Rotto Dec. at ¶ 4 (Arizona's behavioral health system "is not operating as required by the *J.K.* Settlement Agreement and thus is not providing the medically necessary services

that class members require."); *id.* at ¶ 45, 46 ("If the State were to develop a good remedial plan and implement it with focused and sustained effort, I expect that the State could address the deficiencies in its current system in three years."); Pierce Dec. at ¶ 3; Terkeltaub Dec. at ¶ 4 Kamradt Dec. at ¶¶ 42, 43; Long Dec. at ¶ 11.

Among other problems, Defendants have never developed a comprehensive plan to implement the Agreement. S*ee, e.g.,* Kamradt Dec. at ¶ 43 (Arizona lacks "the clear implementation plan … necessary for a large system-reform effort…."). Nor have Defendants held the key participants in the system – RBHAs, provider networks, and provider agencies accountable for delivering services according to the Principles. *See, e.g.,* Kamradt Dec. at ¶ 29 ("The State does not have clear expectations for performance and meaningful benchmarks related to the Settlement Agreement…"); Rotto Dec. at ¶ 32 ("There are no consequences for poor practice…"); Pierce Dec. at ¶ 29 ("The State continues to distribute money to the same providers, in the same way, no matter how providers have performed…."). These failures are significant causes of Defendants' non-compliance. *See, e.g.,* Rotto Dec.at ¶ 7.

1. *There are too Few Intensive Community Services for Children with Complex Needs*

Due to poverty, life circumstances, and other causes, a significant proportion of the children in the Plaintiff class have serious conditions and hence complex needs.[14] Defendants have estimated that number to be in the range of 25%. Based on their experience nationally, Plaintiffs' experts believe the number to be in the range of 25%-

[14] As is common in the field of children's mental health, Plaintiffs and their declarants use interchangeably the terms "serious conditions," "complex needs," and "high needs."

35%. *See, e.g.,* Rotto Dec. at ¶ 24. These children require intensive community services for their conditions to improve, especially the intensive community services known as "intensive case management" and "direct supports."[15] *See, e.g.*, Rotto Dec. at ¶ 27 ("essential to serving high needs children"); Pierce Dec. at ¶¶ 5, 8 (same); Kamradt ¶ 19 ("I am not aware of any effective children's mental health system that does not provide intensive case management and an array of intensive community-based services and supports to its high needs children."); DBHS Protocol, *Child and Adolescent Service Intensity Instrument (CASII)* ("CASII Protocol"), at 9, available at www.azdhs.gov/bhs.guidance.casii.pdf; DBHS Practice Protocol, *Support and Rehabilitation Services for Children Adolescents and Young Adults* ("Direct Supports Protocol") at 7, available at www.azdhs.gov/bhs/guidance/ supportrehab.pdf. *Accord Katie A. v. Bonta*, 433 F. Supp. 2d 1065 (C.D. Cal. 2006), *rev'd on other grounds*, *Katie A. ex rel Ludin v. Los Angeles County*, 481 F.3d 1150 (9th Cir. 2007); *Rosie D. v. Romney*, 410 F. Supp.2d 18 (D. Mass. 2006). Other needed services include respite care for their parents and, for those children who cannot be supported in their own homes, therapeutic foster care. *See, e.g.,* Rotto Dec. at ¶ 27; Kamradt Dec. at ¶ 21; Pierce Dec. at ¶ 7 ("Home-based respite is another service that is essential for meeting the needs of complex children and keeping them at home or in family settings. They often need a place to go for a few days to help de-escalate crisis situations that otherwise might lead to their removal from their home."); *id* at ¶ 6 ("Children with high needs who cannot be served in their own home or a regular

[15] In Arizona, direct supports are sometimes referred to as "direct support services" or "support and rehabilitation services," *see* Direct Supports Protocol at 2. Nationally, they are part of what is often called "intensive community-based services."

foster home need therapeutic foster care to avoid institutional out-of-home care."); DBHS Practice Protocol, *Home Care Training to Home Care Client Services for Children* ("TFC Protocol"),[16] at 3, available at http://azdhs.gov/bhs/guidance/hctc.pdf ("in the absence of such services the child or youth would be at risk of placement into a restrictive residential setting such as a hospital, psychiatric center, correctional facility, residential treatment program …"). *Accord Katie A. v. Bonta*, 433 F. Supp. 2d 1065 (C.D. Cal. 2006), *rev'd on other grounds*, *Katie A. ex rel Ludin v. Los Angeles County*, 481 F.3d 1150 (9th Cir. 2007) (therapeutic foster care).

If these services are not available, effective treatment plans for these children cannot be designed or implemented, and children will not improve their functioning and "achieve success at school, live with their families, avoid delinquency, and become stable and productive adults," that is, they will not achieve the outcomes sought in the Agreement, Agreement at ¶ 21. *See, e.g.,* Rotto Dec. at ¶ 27; Kamradt Dec. at ¶ 19 Pierce Dec. at ¶¶ 5-6, 8; *cf.* Direct Supports Protocol at 7; TFC Protocol at 11. Additionally, without these services, children cannot be maintained "in the home or community" or in the "most-integrated and home-like setting appropriate to their needs" as required by the Agreement, Agreement at ¶ 25. *See, e.g.,* Terkeltaub Dec. at ¶ 17 ("Many children are still ending up in out-of-home care because there is a lack of intensive community-based services to meet their needs."); Rotto Dec. at ¶ 19 ("the services required by the *J.K.* Settlement Agreement . . . prevent the over-reliance on restrictive placements"); Kamradt Dec. at ¶¶ 15, 21; Direct Supports Protocol at 7 (direct supports "increase [the] number of

[16] In Arizona, the official Medicaid title for the service of therapeutic foster care was recently changed to "Home Care Training to Home Care Client Services for Children."

children …living successfully at home with their families or in the community"); TFC Protocol at 12 (TFC allows "home-based" and "community-based" care).

The need for these services was understood when the Agreement was entered into and implementation began. However, Defendants have failed to develop them. Before the 2006 dispute resolution process, intensive case management, direct supports, and therapeutic foster care were essentially unavailable outside Maricopa County. In Maricopa County, intensive case management that had been developed in early implementation efforts had withered away, and direct supports were unavailable to most children who required them. After the 2006 dispute resolution, Defendants began to address these problems. However, Defendants failed to move with dispatch. *See, e.g.,* Kamradt Dec. at ¶ 20-22; Rotto Dec. at ¶ 27. The result is that intensive case management, direct supports, and respite continue to be in short supply.[17] Rotto Dec. at ¶ 27 ("not enough intensive services for high needs children, and this lack of services continues to stymie the ability of child and family teams to develop and implement effective plans"); Pierce Dec. at ¶ 4; Terkeltaub Dec. at ¶ 17; Kamradt Dec. at ¶ 21. Long Dec. at ¶¶ 12-13; Ifill Dec. at ¶¶ 5-6; McDermott Dec. at ¶ 12, 14-15; Bieber Dec. at

[17] In addition, there are not "enough quality services, including psychiatric and clinical services, for children with less complex needs, with the result that many needlessly become children with high needs." Pierce Dec. at ¶ 4.

¶ 5.[18] There is little therapeutic foster care outside Maricopa County, and much of the therapeutic foster care in Maricopa County is of poor quality, Terkeltaub Dec. at ¶ 18 ("quality of TFC is uneven and services are often not delivered consistent with the *J.K.* Principles"); Pierce Dec. at ¶ 6 (TFC providers lack ability to support children with high needs and manage crisis situations); Ifill Dec. at ¶ 8. This is the case despite Defendants' commitment that "[c]hildren have access to a comprehensive array of behavioral health services" sufficient to ensure needed treatment and that services be adapted or created when they are needed but not available." Agreement at ¶ 23.

It was not until 2007 that Defendants set as a goal that every child with complex needs would have an intensive case manager. It took another year for Defendants to settle on a process for identifying these children and a plan for expanding intensive case management. Defendants have not yet met their goal. Defendants have no plan for developing the requisite amount of direct supports, respite, or therapeutic foster care.

With too few intensive community services for children with complex needs, Defendants continue to needlessly institutionalize children, serving far too many in

[18] *See* McDermott Dec. at ¶ 12 ("Although my [child and family team] agreed that other direct supports … were needed, and those supports were included in my treatment plan…, I was not referred for such services. The case manager could not find a service provider. Instead…we were given catalogues identifying parks and recreation programs in the area and told to try different sports. My grandson tried 5 different sports, but, without needed support from the behavioral health system, he failed at each. In fact, the situation became worse. My grandson was disliked by other kids and parents, was excluded and isolated, and was even bullied.")

expensive and ineffective residential centers.[19] Rotto Dec. at ¶ 28 (State "has not made sufficient efforts to keep high needs children from going into out-of-home care"); Terkeltaub Dec. at ¶ 17 ("The State has never made a serious commitment to move money from congregate care to intensive community based services."); Ifill Dec. at ¶¶ 5-6. ("They did not … provide intensive supports. … It was recommended that we place [my stepson] at Canyon State Academy, a residential school. Because we cannot afford it, Cenpatico suggested that we terminate our parental rights and turn our son over to the state so that they can send him to Canyon State."); Bieber Dec. at ¶ 5 (Daughter was not receiving "adequate services for a high needs child" and was "languishing in group homes").

Although a stated goal of the Agreement is to avoid needless institutionalization, Agreement at ¶¶ 21, 25, the State consistently spends too much money on ineffective institutional care. *See, e.g.,* Terkeltaub Dec. at ¶ 15 ("State still spends an inordinate percentage of its children's mental health budget on these congregate placements"). In addition to the harm done children and their families, this has impeded the behavioral health system's ability to make necessary financial investments in intensive community services.

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[19] "Currently, the State still spends more than $20 million dollars on out-of-home placements. The State could easily set a goal to reduce the number of children in out-of-home placements or to reduce their lengths of stay and reallocate the savings to an expansion of needed community based services." Rotto Dec. at ¶ 28. To do so, the State must address "the financial incentives that lead to many children needlessly ending up in congregate care: that providers are not responsible for congregate care costs, so they have no real financial incentive to serve children with complex needs in the community." Terkletaub Dec. at ¶ 17.

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2. *Substance Abuse Services are Inadequate*

Substance abuse services in Arizona have long been inadequate. The Agreement required that, early on, Defendants "develop a plan for the expansion of substance abuse services." Agreement at ¶52; *see also id*. at ¶ 23 ("comprehensive array of behavioral health services").

Defendants have convened committees to conduct research and identify best practices. But little has actually been done to ensure that children get the substance abuse services they need. Substance abuse problems are not identified, there are not enough substance abuse services, and the services that do exist are often inadequate and fail to comply with the *J.K.* Principles. *See, e.g.,* Rotto Dec. at ¶¶ 41-43 ("The substance abuse issues of class members are often not identified, and substance abuse services are inadequate to meet children's needs when issues are identified…. The substance abuse programs that exist are full and have waiting lists, and there are very few aftercare programs. … Also, many of the substance abuse services that exist are not sound…."); Pierce Dec. at ¶¶ 18-19 ("The number of children in the system with substance abuse issues is high, but very few providers have received training or technical assistance in how to identify and address those needs. … [T]here is rarely an appropriate response when children have significant substance abuse needs. … There are very few substance abuse services available to children, and virtually no community-based programs focused on substance abuse."); Kamradt Dec. at ¶¶39-41; Terkeltaub Dec. at ¶ 22.

3. *Training is Inadequate*

The Agreement reflects the importance the parties placed on having a sound training program in order to secure compliance. It includes detailed requirements for the training program that Defendants must design and implement statewide. Agreement ¶¶

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32-39. The training program must be designed to provide front-line staff … and supervisors sufficient knowledge and skills to enable them to plan and provide services consistent with the Principles." *Id*. at ¶ 35. It must have a "sufficient number of qualified trainers," *id*. at ¶ 39, and a "hands-on" component in which "trainers … coach and mentor front-line staff and supervisors in effective techniques and approaches," *id*. at ¶ 36. Moreover, Defendants are required to have "[t]ools to evaluate the ongoing effectiveness of the training program" and a "methodology for measuring core-competencies of front-line staff." *Id.* at ¶ 38. Defendants' training program meets none of these standards.

There are too few qualified trainers, inadequate hands-on training opportunities, and there is no methodology for evaluating either the effectiveness of training or the competencies of staff. *See, e.g.*, Rotto Dec. at ¶¶ 34-37 ("Arizona has not developed a training system that ensures that behavioral health staff practice according to the *J.K.* Principles. … [M]ost of the system's training efforts have focused on classroom training instead of the hands-on coaching and mentoring that is necessary for good practice. … [W]hile there has been extensive training on the *J.K.* Principles themselves, there has been inadequate training for staff on developing the skills necessary to deliver services according to the Principles, as required by the Settlement Agreement. Moreover, the State has failed to develop measures to assess the effectiveness of training. "); Pierce Dec. at ¶¶ 30-32 ("The State has spent a lot of time and money on training but the training has not been effective. Most of the training has been in the classroom and focused on values and a theoretical orientation to the system. Practitioners often leave these trainings excited but they are not subsequently given the hands-on coaching and mentoring they need to learn necessary skills. There has not been enough training for supervisors and agency

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leadership, which is essential to ensuring that front-line practitioners deliver services as required by the Principles."); Terkeltaub Dec. at ¶¶ 23-25; Kamradt Dec. at ¶¶ 31-35 .[20]

Given the central role of training, it is not surprising that Defendants have been unable to come into compliance with the Agreement.

4. *Youth Aged 18 to 21 Have Been Denied the Benefits of the Agreement*

Youth aged 18 to 21 are class members, entitled to needed services under both the Agreement and the EPSDT program of Medicaid.[21] Defendants have estimated that there are more than 6,000 class members in this age group. Until recently, Defendants largely ignored their obligations to these class members. The result is that these youth are very poorly served by Defendants.

In most instances, when a youth turns 18, the youth is dismissed, or "disenrolled," from the children's behavioral health system and, if the youth wants to continue to receive mental health or substance abuse services, he or she must enroll in the adult behavioral health system. If the youth has a well-functioning child and family team supervising and planning his care, that team is disbanded. If the youth has been receiving intensive services, such as direct supports or therapeutic foster care, from the children's system, those services are typically discontinued. *See, e.g.,* Rotto Dec. at ¶ 38 ("When class

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[20] The training program is also "hampered by the lack of a working QM [quality management] system on which they can rely for data regarding performance." Terkletaub Dec. at ¶ 25.

[21] *See supra* at note 1. A youth exits the plaintiff class when he or she reaches the age of 21. The parties have consistently referred to the older youth in the plaintiff class as "aged 18 to 21." For this reason, Plaintiffs use the term here.

members turn 18, they are being disenrolled from the children's mental health system. As a result, they lose their child and family teams and whatever intensive community-based services and supports they may be receiving from children's providers. Moreover, when the youth reaches out to the adult system, he or she is likely to find that system ill-equipped to meet his needs.); Terkeltaub Dec. at ¶ 26 ("In my experience, serving 18 to 21 year olds has never been a priority or focus for the State. When class members enter the adult system, they are served badly. … [T]hey are denied needed services by the adult system."); Long Dec. at ¶ 14.

Youth must be determined by the adult system to be "seriously mentally ill" (SMI) in order to get access to meaningful services from the adult system. *See, e.g.,* Rotto Dec. at ¶ 17 (those not found SMI "get few if any of the services they require"); Pierce Dec. at ¶ 15 (those not SMI "get little to no services from the adult system"); Long Dec. at ¶ 14; Bieber Dec. at ¶¶ 9-10. However, a substantial number of class members do not obtain SMI status. Pierce Dec. at ¶ 15 ("The majority of the children in the *J.K.* class do not meet the eligibility criteria for 'seriously mentally ill' in the adult system."). Even youth with serious conditions may be denied an "SMI" determination. *See id*. at ¶ 40-42. Hence, a large number of class members are denied needed services. *See, e.g.,* Rotto Dec. at ¶ 17; Pierce Dec. at ¶ 15; Terkeltaub Dec. at ¶ 26 (describing situation of foster children not deemed SMI). For these class members, reaching the age of majority is tantamount to losing an entitlement to services, despite the contrary mandate in the Settlement Agreement and under federal law. Furthermore, even if a youth obtains an SMI determination, he or she may not receive needed services. Given the focus and history of the adult system, it lacks many of the services required by transition age youth. *See, e.g.,* Rotto Dec. at ¶ 17 ("The 18 year olds who are determined to be "seriously mentally ill"

are enrolled in the adult system but cannot access many of the services they need."); Pierce Dec. at ¶ 15 ("The children who are determined to be SMI get some services from the adult system, but these children are routinely denied services required by the *J.K.* Principles.").

In 2006, Defendants developed policy guidance ("Transition to Adulthood Protocol") to address youth transitioning to the adult system. More recently, Defendants have initiated some pilot projects to address the problems described above. However, these pilots have as of yet had only a small impact. Overall, Defendants have made little progress overall in ensuring that youth aged 18 to 21 are served according to the Principles. *See, e.g.,* Rotto Dec. at ¶ 40 (the State has made "little progress" in serving 18-21 year olds); Kamradt Dec. at ¶ 38 ("Children age 18 to 21 continue to be denied medically necessary services."); Pierce Dec. at ¶ 17 (State's "policy document is good, but the State has done little to ensure that the policy is followed and, for the most part, it is not being followed ….").

5. *Defendants Lack a System for Determining Whether Children are Being Served According to the Settlement Agreement*

Paragraph 55 of the Agreement requires changes to Defendants' "quality management and improvement system." Agreement at ¶ 55. Far from being a technical requirement, this provision goes to the heart of Defendants' responsibilities. The job of a "quality management and improvement system" ("QM system") is to inform leaders how well a behavioral health the system is functioning. *See, e.g.,* Redman Dec. at ¶ 9; Bruns Dec. at ¶ 8; Rotto Dec. at ¶ 30. Information from the QM system is used to correct deficiencies that may be found. *Id*. A sound QM system is essential to the system's developing and maintaining the capacity to meet its clients' needs. *See, e.g.*, Redman

Dec. at ¶ 9 ("A functioning QM system is essential for ensuring that Medicaid-eligible children receive medically necessary behavioral health services."); Rotto Dec. at ¶ 30 ("An effective quality management system is essential to a children's mental health system. A QM system must be able to identify whether good practice and outcomes are being achieved and to collect and analyze data to identify problems and areas of needed improvement. … Successful communities establish their QM systems early in their implementation process and use information from their QM system to drive their decision-making.").[22]

The Agreement requires Defendants to "change their quality management and improvement system so that it measures whether services to class members are consistent with and designed to achieve the Principles." Agreement at ¶ 55. The purpose, understood by all parties, is to ensure that Defendants' QM system generates the information that Defendants need to monitor compliance with the Agreement and to take corrective action when required. To ensure that Defendants have rich information, the Agreement requires that Defendants conduct "an in depth case review of a sample of individual children's cases that includes interviews of relevant individuals in the child's

[22] "To work effectively, a QM system must identify measurements that reflect desired program outcomes and goals. It then must collect and analyze data to identify where established program outcomes and goals are being met and where there are areas of needed improvement. Finally, it must ensure that identified problems are addressed and that improvements are sustained over time." Redman Dec. at ¶ 9. "A QM system must be able to identify whether good practice and outcomes are being achieved and to collect and analyze data to identify problems and areas of needed improvement. Information from the QM system must be used to make informed decisions, including to incentivize good practice and consequence poor practice." Rotto Dec. at ¶ 30; *accord* Terkeltaub Dec. at ¶ 6.

life," *id*., a process that the independent expert Dr. Groves used and on which he had trained stakeholders in the State.

Defendants have not complied with Paragraph 55 of the Agreement. *See, e.g.*, Redman Dec. at ¶ 7 ("[T]there are significant deficiencies in DBHS' QM system, including in monitoring and measuring implementation of the *J.K.* Settlement Agreement. DBHS' lack of leadership, lack of staff with QM expertise, and lack of a culture focused on improvement are serious weaknesses in its QM system.");[23] Terkeltaub Dec. at ¶ 5 ("the State's QM system is one of the biggest failures in its implementation of the Settlement Agreement"); Kamradt Dec. at ¶ 27 ("Arizona has not implemented key components of an effective QM system."). Defendants did not even begin to turn their attention to making changes to their QM system until after the 2006 dispute resolution process.

In 2007, Defendants added to their QM system a review process known as the Wraparound Fidelity Index ("WFI"). Plaintiffs, family organizations, and many in the provider community voiced concerns about the WFI, including questioning whether it measured service delivery according to the Principles.[24] The Maricopa County RBHA

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[23] Dr. Redman notes that "DBHS has not prioritized or assured the reliability of measures it claims evaluate compliance with the Settlement Agreement. …DBHS has not used the data it collects to improve practice. …DBHS is unable to examine data trends over time to identify problems because it has repeatedly changed the measures it collects, the intervals for which it reports the measures, and the QM tools it employs." Redman Dec. at ¶ 7.

[24] The WFI lacks measures of, among other things, whether services are designed and implemented to achieve desired outcomes, Agreement at ¶ 21, whether children have access to a comprehensive array of services, *id.* at ¶ 23, and whether services are provided in the most integrated setting, *id* at. ¶ 25.

had developed its own process for implementing Paragraph 55, known as the "Maricopa County review process." Unlike the WFI, it was specifically designed to focus on service delivery according to the *J.K.* Principles, it included mental health professionals in the review process, and it included an in-depth review of cases. *See* Terkeltaub Dec. at ¶ 8; Pierce Dec. at ¶ 24. Plaintiffs and many stakeholders urged Defendants to adopt a review process similar to the Maricopa County process instead of the WFI; however, Defendants rejected this advice. Terkeltaub Dec. at ¶ 10; Pierce Dec. at ¶ 25. Disturbingly, there is significant evidence that Defendants did so specifically to avoid meaningful reviews of their performance in implementing the Agreement. *See* Terkletaub Dec. at ¶ 10 ("What became clear to me at that time is that leadership in the State was not committed to a meaningful review process. At one point, I was specifically told by the State to stop developing and implementing the Maricopa County practice review. I understand that soon after I had left my job as Director of Children's Behavioral Health Services at [the Maricopa County RBHA], a wide range of stakeholders, including family organizations, Plaintiffs' counsel, and providers, tried to encourage the State to adopt the Maricopa County practice review statewide. Not only did the State refuse to expand this review practice statewide, but it stopped the review process in Maricopa County."); *cf.* Bruns Dec. at ¶ 8 ("The WFI is not designed to measure the adequacy of the behavioral health services in a children's behavioral health system or outcomes for children receiving those services."); Pierce Dec. at ¶ 25 (WFI does not measure "whether children's needs are being adequately identified and met. Providers who went through the 'ritual' of the child and family team process but who nonetheless failed to deliver needed services could do well on the WFI.").

The reviews using the WFI were poorly implemented and, hence, there was little confidence in the results. *See* Pierce Dec. at ¶¶ 25-27. To the extent the reviews generated reliable information, the information was not used for its intended purpose, namely, to identify and correct system deficiencies. *Id.* Moreover, Defendants did not apply the WFI to the class as a whole. Instead, the WFI reviews were limited to "high needs" children. As a result, Defendants lacked a QM process for determining whether the approximately two-thirds of class members identified by Defendants as having "moderate" or "low" needs were receiving services according to the Principles.[25] Recently, the Defendants announced they were abandoning the WFI. Their new review process is not yet being implemented.

Defendants' failure to implement the QM process required by Paragraph 55 has severely limited their ability to monitor and ensure compliance with the Agreement. *See, e.g.*, Rotto Dec. at ¶ 7 (lack of effective QM process has contributed to "Arizona's failures"); Kamradt Dec. at ¶ 27 ("The State … does not appear to have an adequate understanding of the outcomes being achieved or whether services are being delivered according to the *J.K.* Principles."); Terkeltaub Dec. at ¶ 5 ("[T]he State's QM system … is a major barrier to its ability to provide children with the services they need for their mental health conditions to improve."). Defendants lack reliable data on whether children are being served according to the Principles, as well as the rich information that in-depth reviews would provide on root causes of deficiencies in the system. *Id.*

[25] Moreover, it is uncertain whether Defendants' QM system can reliably distinguish between children with "high needs" and those with lower needs.

Defendants themselves appear to recognize these deficiencies. They have never used QM data to hold RBHAs, provider networks, or provider agencies accountable for their performance in serving children according to the Principles. *See* Pierce Dec. at ¶ 29; Terkeltaub Dec. at ¶ 13. It is unlikely that the deficiencies described in this motion will be corrected without Defendants using QM data to promote improved performance and to establish accountability when expectations are not met. *See, e.g.*, Kamradt Dec. at ¶ 44 (To remedy the deficiencies, State must "create accountability, including by using its QM system to drive changes"); Rotto Dec. at ¶ 7 (State must address "lack of accountability and lack of data decision-making" to remedy the failures in its implementation of the Agreement). Terkeltaub Dec. at ¶ 5 ("State's QM system is … a major barrier…")

C. This Court Should Order Defendants to Correct Their Non-Compliance and Extend the Term of the Settlement Agreement

This Court has broad discretion to fashion a remedy for Defendants' non-compliance, including ordering specific remedial steps and extending the term of the Agreement. *See, e.g., Horne v. Flores*, 129 S. Ct. 2579, 2594 (2009) ("It goes without saying that federal courts must vigilantly enforce federal law and must not hesitate in awarding necessary relief."). "Deference to the district court's use of discretion is heightened in a case, like this one, when "complex institutional reform" is at issue. *Jeff D. v. Kempthorne*, 365 F.3d 844, 850 (9th Cir. 2004); *accord Labor/Community Strategy Center*, 564 F.3d at 1121.

Plaintiffs hereby request that the Court:

- Direct Defendants to develop, and secure the Court's approval, for a plan with specific actions and deadlines for correcting the deficiencies described in this motion,

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- direct Defendants to implement the plan, and
- extend the term of the Settlement Agreement, and the Court's jurisdiction, for the period required to implement the plan, including the resolution of any disputes over implementation.

Plaintiffs' requested remedy is carefully tailored to bring Defendants into compliance. S*ee Labor/Community Strategy Center*, 564 F.3d at 1120. Moreover, it gives Defendants broad latitude in fashioning a plan, so long as the plan is reasonably calculated to secure compliance. It extends the Settlement Agreement only so long as is required to secure class members the services to which they are entitled under the Agreement and federal law.

This Court has ample power to require and direct Defendants to implement a remedial pan. *See David C.*, 242 F.3d at 1209 (requiring defendants to implement a detailed remedial plan to correct non-compliance with a settlement agreement); *Alexander,* 707 F.2d at 783 (imposing additional obligations on defendants to secure compliance with judicial decree). Moreover, extending the Settlement Agreement is well within the Court's power. Such an extension is "not itself an imposition of additional, material obligations on [the state]," but rather a device "to allow … [the state] to fulfill the very obligations it voluntarily undertook when it entered into the Agreement." *David C.,* 242 F.3d at 1211-12; *see also id*. at 1213 ("it would defy logic for [plaintiffs] to agree to include the four-year Termination Provision in the Agreement if they actually foresaw that [Defendants] would not be in substantial compliance with the terms of the Agreement at the end of the four-year period"); *Thompson*, 404 F.3d at 832 (extension of term of consent decree was "necessary to approximate the positions the parties would have occupied had the Defendants lived up to their obligations); *id.* at 828 ("If the parties had

1 actually anticipated that the Defendants would be so far behind on their obligations at this
2 stage in the proceedings, the Consent Decree would never have been executed.")
3 Plaintiffs respectfully submit that the Court should exercise its broad powers to
4 ensure that Defendants live up to the commitments they made in the Settlement
5 Agreement and to their commitments under federal law.

6 **IV. CONCLUSION**

7 For the foregoing reasons, Plaintiffs respectfully request that the Court grant their
8 Motion for Enforcement of the Settlement Agreement and order the relief requested
9 herein.

10 **RESPECTFULLY SUBMITTED** this 13th day of November, 2009.

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12 s/Anne C. Ronan

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CERTIFICATE OF SERVICE

I hereby certify that on November 13, 2009, I electronically transmitted the attached Plaintiffs' Motion for Enforcement of Settlement Agreement to the Clerk's Office using the CM/ECF System for filing and transmittal of a Notice of Electronic Filing to the following CM/ECF registrants:

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s/ Anne C. Ronan

EXHIBIT LIST

Ex. 1	Declaration of Knute Rotto
Ex. 2	Declaration of Bruce Kamradt
Ex. 3	Declaration of Matthew Pierce
Ex. 4	Declaration of Michael Terkeltaub
Ex. 5	Declaration of Linda Huff Redman
Ex. 6	Declaration of Eric Bruns
Ex. 7	Declaration of Krista Long
Ex. 8	Declaration of Carol McDermott
Ex. 9	Declaration of Donna Ifill
Ex. 10	Declaration of Lee Bieber
Ex. 11	March 6, 2009 Letter from Plaintiffs to Defendants
Ex. 12	June 6, 2006 Planning Meeting, Combined Issues
Ex. 13	Letters from Plaintiffs to Defendants

EXHIBIT 1

DECLARATION OF KNUTE ROTTO

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

A. Summary of Qualifications and Opinions

1. I have almost twenty years experience working with children with mental health needs. Since 1997, I have been the Chief Executive Officer for Choices, Inc., a non-profit care management organization that provides intensive community-based services to children with mental health needs. I currently oversee a variety of programs in four states – Indiana, Ohio, Maryland, and Washington, D.C. – serving approximately 5,000 children and their families annually. Choices, Inc. has received numerous awards and recognition for its programs, including recognition by the President's New Freedom Commission.

2. I am an expert on developing community-based services for children with mental health needs. I have consulted with and provided technical assistance to approximately twenty-five different communities over the last ten years. I have published numerous articles and presented at dozens of national conferences on community-based services for children with mental health needs. I also run the statewide technical assistance center on children's mental health for Indiana.

3. I was asked by Plaintiffs to review Arizona's children's mental health system[1] and opine as to whether the State has developed a system that meets class members' mental health needs, as required by the Settlement Agreement. In forming my opinion, I traveled to Arizona five times since August 2007. On each of these several-day visits, I met with a wide range of individuals knowledgeable about the system, including parents with children with mental health needs, staff and leadership from family organizations, private providers, staff and leadership from the Regional Behavioral Health Authorities ("RBHAs"), and staff and leadership from the State. I also reviewed information and data about Arizona's implementation of the *J.K.* Settlement Agreement, including correspondence between Plaintiffs and Defendants; relevant policy guidance documents developed by the State; quality management data, evaluations, and plans; and the State's recently developed logic model and documents cited in the model.

4. The services required by the *J.K.* settlement agreement are medically necessary. That is, class members require these services to have their needs met and for their mental health conditions to improve. The system required by the *J.K.* settlement agreement constitutes the professional standard for an adequate children's mental health system.

5. Arizona's children's mental health system ("system") is not operating as required by the *J.K.* Settlement Agreement and thus is not providing the medically necessary services that class members require.

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[1] Throughout this declaration, I use "mental health system" (the more common national term) and "behavioral health system" (the term most commonly used in Arizona) interchangeably.

a. First, the system does not have the necessary services to meet the needs of children with high or complex needs ("high needs children"). There is not enough intensive case management and not enough community-based services and supports, including direct supports, therapeutic foster care, and home-based respite. In addition, the State has not focused its efforts on avoiding unnecessary out-of-home placements for these high needs children.

b. Second, the State does not have a system that effectively reviews whether services are being provided as required by the Settlement Agreement. The Settlement Agreement requires the State to "change their quality management and improvement system so that it measures whether services to class members are consistent with and designed to achieve the Principles" in the Settlement Agreement. *J.K.* Settlement Agreement at ¶ 55. Such a system has not been developed and implemented. Moreover, the State has failed to use effectively the data it does collect to improve practice.

c. Third, the State has not developed a training system that ensures that behavioral health staff provide medically necessary services as required by the Settlement Agreement. For example, most of the system's training efforts have focused on classroom training instead of the hands-on coaching and mentoring that is necessary for effective training. Moreover, the State has failed to develop measures to assess the effectiveness of training and the competencies of behavioral health staff to deliver services according to the *J.K.* Principles.

d. Fourth, the system is not serving 18 to 21 year olds as required by the Settlement Agreement, despite their being members of the *J.K.* class. When class members turn 18, they are being disenrolled from the children's mental health system, causing them to lose their child and family teams and whatever intensive community-based services they may have been receiving from the children's mental health system. They are being enrolled in the adult system, where they are not receiving the medically necessary services required by the Settlement Agreement. In addition, the State has failed to develop the array of specialized services that this group of class members need, including services to promote independent living and employment.

e. Finally, the State has failed to address the substance abuse needs of class members. The substance abuse issues of class members are often not identified. Moreover, there are inadequate substance abuse services to meet the needs that have been identified.

6. Arizona needs to develop and implement a meaningful plan to address these deficiencies. In my expert opinion, the plan must include:

- Expanding intensive case management for high needs children;
- Expanding intensive community-based services, including direct supports, therapeutic foster care, and home-based respite;
- Increasing efforts to reduce out-of-home care, including reallocating funds to expand community-based services;

- Implementing a system for reviewing whether services are being provided as required by the Settlement Agreement and using data from that system to make needed improvements;
- Developing a training curriculum;
- Increasing hands-on training opportunities, including coaching and mentoring;
- Examining the effectiveness of the training system and the competencies of behavioral health staff to practice according to the *J.K.* Principles;
- Expanding specialized services targeted to 18 to 21 year olds;
- Training staff on identification of substance abuse issues; and
- Expanding substance abuse services.

7. Based on my professional experience, Arizona should have been able to fully develop its children's behavioral health system required by the *J.K.* Settlement Agreement within the last eight years. Defendants have not moved as quickly as practicable to develop the system of services required by the Settlement Agreement; nor have they moved as quickly as practicable to develop a behavioral health system that provides services according to the *J.K.* Principles. Based on my knowledge of the implementation efforts in Arizona, I believe that the lack of leadership, lack of accountability, and lack of data-driven decision-making are to blame in large part for Arizona's failures. If Arizona can address these issues and develop a good implementation plan, I estimate that with sustained effort Arizona could remedy the

deficiencies and bring its system into compliance with the *J.K.* Settlement Agreement in three years.

B. Qualifications

8. I have been the Chief Executive Officer of Choices Inc., since its inception in 1997. I developed and currently oversee a variety of programs in four states serving over 5,000 youth with mental health needs annually, including: the Dawn Project (providing behavioral health services to children with a range of mental health needs), Youth Emergency Services (serving children with suspected abuse and neglect), Back to Home (serving run-away youth), and Community Reintegration Initiative (serving individuals re-entering the community from corrections) in Marion County, Indiana; Hamilton Choices in Cincinnati Ohio (providing behavioral health services to high needs children); Maryland Choices in Rockville, Baltimore, and St. Mary's, Maryland (same); and DC Choices in Washington DC (same). In each of these programs, we provide children with intensive community-based services, developed through child and family teams, with intensive case management. Among other things, we facilitate child and family team meetings to develop and implement treatment plans, provide clinical coordination and intensive case management, and oversee and manage a broad-range of providers of community-based services and supports. The children and families are partners in our efforts.

9. Choices, Inc. is a leader nationwide in developing community-based mental health services for children. In 2001, Choices, Inc. began to offer technical assistance to other communities interested in developing intensive community-based services for children.

Over the past decade, Choices, Inc. has received local and national recognition for our work. The Dawn Project has been recognized by the President's New Freedom Commission for its services to children with serious emotional disorders and their families. The Dawn Project has also been highlighted by the Health Care Reform Tracking Project's Promising Approaches Series and recognized by the National Policy Center for Children with Special Health Care Needs. Choices, Inc. received the 2002 Indiana Achievement Award for its clinical outcomes and for efficiency in the use of public funds. Choices, Inc. also received the *Outcomes Champion at the Agency Level Award* from the Praed Foundation.

10. Prior to my work with Choices, I was the Director of Mental Health Services at Cedars Youth Services in Nebraska from 1995 to 1997. Cedars Youth Services is a 24-hour, ten bed residential treatment center for youth ages 13 to 18. I developed and directed the Crisis Intervention, Day Treatment, Mentoring for At-Risk Youth, Intensive Family Preservation, In-Home Therapy, Juvenile Justice Supervision Mentors, Mobile Crisis System for Child Welfare Families, and Family Visitation Center clinical services. I improved children's outcomes by shortening length of stay, involving families in planning and treatment, and accessing community-based resources for efficient aftercare planning. My experience with Cedars Youth Services made me realize that most of the youth with whom I worked ended up in our facility because they and their families did not receive the services and supports they needed in the community. I saw that with appropriate services and supports, these children could successfully be served in the community.

11. From 1989 to 1995, I was the Coordinator/Clinical Director for the Mental Health Center of Dane County COMPASS Unit (Communities Organized to Maintain Parents and Adolescents in Safe/Secure Surroundings) in Wisconsin. I oversaw a $2.5 million Robert Woods Johnson grant to develop and implement an intensive community-based mental health system for youth with serious emotional disabilities. I directed Clinical Coordination, Crisis Intervention, Youth Mentoring, and Transitional Living Initiative services.

12. From 1985 to 1989, I was a Family-Based Case Manager for the Dane County Child Welfare Department. In this role, I investigated allegations of abuse and neglect and provided on-going case management to children adjudicated a "Child In Need of Protection" and in need of services.

13. I have had an active consulting practice around developing community-based children's mental health services for the last fifteen years. I have consulted with more than 25 different communities interested in developing community-based services for children with mental health needs. Several of these consultations have involved statewide system reform. For example, from 1999 to 2002, I helped the State of New Jersey design and implement a statewide community-based children's mental health system that was guided by principles nearly identical to the *J.K.* Principles. From 1994 to 1997, I consulted with the State of Nebraska, Office of Community Mental Health, Children Mental Health Division to develop, implement and evaluate a statewide case management system for at-risk youth in the juvenile justice, mental health and child

welfare systems. I also have consulted on data collection and evaluation for children's mental health systems.

14. I have served as an expert consultant on children's mental health issues in several cases. I consulted with Plaintiffs' counsel about designing intensive community-based services for a class of Medicaid-eligible children with serious emotional disturbances ("SED") in *Rosie D. v. Romney* in federal court in Massachusetts and for a class of Medicaid-eligible children with mental health needs in the foster care system in *Katie A. v. Bonta* in federal court in California.

15. I have published numerous articles, including a recent book chapter, and have presented at dozens of national conferences on community-based services for children with mental health needs.

16. I received my Bachelor's degree in Social Work with a minor in Psychology from Luther College in 1984. In 1985, I received my Master's in Social Work from the University of Wisconsin-Madison, Graduate School of Social Work. I am a licensed Certified Social Worker (ACSW) and have completed more than 3000 post-masters' degree supervised clinical hours. I also have supervised graduate students in Social Work from the University of Wisconsin-Madison, University of Nebraska-Omaha, and Indiana University-Perdue University Indianapolis.

17. My curriculum vitae is attached as Exhibit 1.

C. The Services Required by the *J.K.* Settlement Agreement Are Medically Necessary to Treat Class Members

18. In my expert opinion, the services required by the *J.K.* Settlement Agreement are medically necessary to treat class members. That is, children with mental health needs require these services to have their needs met and for their mental health conditions to improve. The system required by the *J.K.* Settlement Agreement constitutes the professional standard for an adequate children's mental health system.

19. There is now consensus in the children's mental health field that children with significant mental health needs require intensive community-based services provided through child and family teams – the services required by the *J.K.* Settlement Agreement – to improve. These services have been shown to result in sustained improvements in social, emotional and behavioral functioning; decreased use of psychiatric hospitals and residential treatment centers; and improved outcomes in school. They 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, and they are far more effective than other mental health services, such as office-based therapy. *See generally* Mental Health: A Report of the Surgeon General, Chapter 3 (1999), available at http://www.surgeongeneral.gov/library/mentalhealth/toc.html#chapter3. For services to be effective, families must be an integral part of treatments and providers must do intensive work with children in their homes and in other natural settings.

20. Choices, Inc. provides the intensive community-based services and case management required by the *J.K.* Settlement Agreement. We have found that our services lead to significantly improved outcomes for children and their families. Specifically, children in our programs:

- Experience significant improvements in their mental health status and day-to-day functioning;
- Successfully live in the community;
- Achieve stable reunification with their families when reunification is part of their treatment plan;
- Remain in stable living environments;
- Have substantially decreased involvement with the criminal justice system and, for those children currently involved, do not violate their probation;
- Are enrolled in school and attend; and
- Have success in school, including earning their diploma and graduating for eligible youth.

See External Evaluations and Internal Outcome Reports, available at http://www.choicesteam.org/choicesreports.

21. We also collect data on family's perspectives on the services we provide. We have found nearly all families participating in our programs report that t their ideas are valued and that they are satisfied with the mental health services their children are

receiving. *Id.* Moreover, the programs run by Choices, Inc. not only achieve better outcomes but actually save money. *Id.*

22. In sum, the *J.K.* class members need the services required by the *J.K.* Settlement Agreement for their mental health needs to be met and for their conditions to improve.

D. Defendants Are Not Providing Services as Required by the Settlement Agreement

23. The *J.K.* Settlement Agreement requires Arizona to develop and operate a children's behavioral health system that provides class members with medically necessary services. The State has failed to develop such a system.

i. Failure to Serve High Needs Children

24. First, the system is not adequately serving its most needy children – its high needs children. In my opinion, about 30 to 40 percent of the children in Arizona's mental health system are high needs. Many are in or at risk of placement in institutional care. These children require intensive case management and an array of intensive community-based services. The State has not yet developed the services necessary to meet the needs of these children.

25. Most communities developing their children's mental health system focus first on developing services for their highest needs children. These children are often in expensive institutional settings, like residential treatment centers and psychiatric hospitals. Communities can reallocate money to develop community-based services by moving these children to less-expensive, but more effective, community-based services. Focusing on serving high needs children also facilitates the development of intensive

community-based services and the infrastructure for collaboration across public systems (collaboration with child welfare, juvenile justice, and education systems). Once a community has developed a system that serves its high needs children well, it is much easier to expand the system to serve moderate and lower needs children well too.

26. Arizona did not effectively implement this strategy of focusing efforts first on high needs children. The State has failed to develop the services that complex children need most, namely intensive case management and an array of intensive community-based services and supports, including especially what is known as direct supports.

27. The State has just recently begun to re-focus its efforts on serving high needs children. The system's recent initiative to expand intensive case management to all high needs children is a good start, but this should have been done early in the implementation effort, as intensive case management is essential to serving high needs children. And while this effort is a good start, many high needs children still are not receiving intensive case management. Similarly, until recently, there was not a focus on ensuring that the array of intensive community-based services that high needs children require – such as direct supports, therapeutic foster care, and home-based respite – were available in the system. The State's recent efforts, including its "Meet Me Where I Am Campaign" to expand direct supports, is another good start, but this expansion should have been done in the first year or two of the implementation effort, not the seventh or eighth. Moreover, there still is not enough intensive services for high needs children, and this lack of services continues to stymie the ability of child and family teams to develop and implement effective plans for high needs children. The system has recently implemented

an initiative to try to better identify high needs children. However, even if the system improves at identifying high needs children, it will be unable to serve them adequately if there is not immediately available intensive case management and community-based services and supports.

28. The State also has not made sufficient efforts to keep high needs children from going into out-of-home care. The number of children in out-of-home care has not decreased over several years, and in fact has increased in some years, including the last contract year (FY 2007-08). Currently, the State still spends more than $20 million dollars on out-of-home placements. The State could easily set a goal to reduce the number of children in out-of-home placements or to reduce their lengths of stay and reallocate the savings to an expansion of needed community based services. Moreover, the provider network organizations ("PNOs") are not responsible for out-of-home placement costs, so there is no financial incentive for them to serve the highest needs children in the community.

ii. Failure to Develop a Quality Management System That Measures Compliance With the Settlement Agreement

29. Second, the system has not developed a quality management system that measures whether services are being provided as required by the Settlement Agreement.

30. An effective quality management ("QM") system is essential to a children's mental health system. A QM system must be able to identify whether good practice and outcomes are being achieved and to collect and analyze data to identify problems and areas of needed improvement. Information from the QM system must be used to make

informed decisions, including to incentivize good practice and consequence poor practice. Successful communities establish their QM systems early in their implementation process and use information from their QM system to drive their decision-making.

31. In my review of the State's QM documents and data, it appears that the State is collecting a lot of data. But I do not see that they are using the data to improve outcomes or practice. It does not appear that the State is making decisions based on data. Nor do they have a meaningful process for using the data to identify and address problems and monitor improvements. This is particularly important in system like the one required by the *J.K.* Settlement Agreement, as a wide range of skills are required of practitioners and many of the skills necessary to such practice, such as facilitation of child and family teams and intensive case management, are often new to them.

32. A functioning QM system is essential to accountability, but I do not see that the State is using its QM system for this purpose. The State has developed a lot of expectations on paper but does not enforce them. There are no consequences for poor practice, and no reward for good practice.

33. Several times over the last few years, the State has expended substantial efforts in implementing a tool to review whether services are being provided according to the *J.K.* Principles to later abandon that tool for another one. One of the tools that the State implemented, and now, as I understand, plans to abandon, is the Wraparound Fidelity Index ("WFI"). I am familiar with the WFI, as Choices, Inc. uses the WFI as one of several tools to evaluate our programs. The WFI is a tool that measures if front-line staff

are faithful to a defined model of service provision. It can be used to identify problems, such as failure to partner meaningfully with families or individualize services. The WFI is not an outcome tool, however, and it was never intended to measure the outcomes of practice. In my experience, a provider could score well on the WFI yet still be getting poor outcomes for the children it serves.

iii. Failure to Develop the Required Training System

34. Third, the State has not developed a training system that ensures that behavioral health staff serve children according to the *J.K.* Principles, as required by the Settlement Agreement.

35. I have found that state leadership is essential to effective statewide training efforts. Choices, Inc. runs the statewide training center in Indiana, and I have worked with Maryland to build their statewide training institute. These statewide training centers develop a statewide training curriculum, do initial and continuing training of behavioral health staff, help providers develop their own coaches, and do problem-solving for issues that arise.

36. Arizona has not developed a training system that ensures that behavioral health staff practice according to the *J.K.* Principles. Arizona has not built training expertise within the State. Moreover, most of the system's training efforts have focused on classroom training instead of the hands-on coaching and mentoring that is necessary for good practice. Studies have shown that hands-on learning opportunities are essential to mastering front-line practice, and my experience as a trainer has supported this. In addition, while there has been extensive training on the *J.K.* Principles themselves, there

has been inadequate training for staff on developing the skills necessary to deliver services according to the Principles, as required by the Settlement Agreement.

37. Moreover, the State has failed to develop measures to assess the effectiveness of training. It does not, for example, examine the competencies and skills of behavioral health staff to practice according to the *J.K.* Principles, as many other systems do. As a result, there is no process for giving feedback to supervisors and front-line staff about areas where additional training, coaching and mentoring is needed.

iv. Failure to Meet the Needs of 18 to 21 Year olds.

38. Fourth, the system is not serving 18 to 21 year olds as required by the Settlement Agreement. When class members turn 18, they are being disenrolled from the children's mental health system. As a result, they lose their child and family teams and whatever intensive community-based services and supports they may be receiving from children's providers. The 18 year olds who are determined to be "seriously mentally ill" are enrolled in the adult system but cannot access many of the services they need. The 18 year olds who are determined to have mental health service needs but who are not "seriously mentally ill" get few if any of the services they require.

39. The 18 to 21 year old age group has special needs, and the State has not developed the services they require. These youth need intensive support as they are leaving the children's system and transitioning to independence or to the adult system. They also need an array of services to help them transition to adulthood, including services to promote independent living and employment and to assist with accessing housing.

40. The State recently developed a policy document for serving 18 to 21 year olds. However, the State has made little progress in actually implementing this policy. Children age 18 to 21 continue to be denied medically necessary services.

v. Failure to Develop Substance Abuse Services

41. Finally, the State has failed to develop adequate substance abuse services for class members. The substance abuse issues of class members are often not identified, and substance abuse services are inadequate to meet children's needs when issues are identified.

42. I would expect that approximately 40 to 50 percent of class members have some type of substance abuse issue, but very few class members are receiving substance abuse services. Identification of substance abuse needs is not part of the training for many behavioral health staff.

43. There also is a lack of substance abuse services to meet class members' needs. The substance abuse programs that exist are full and have waiting lists, and there are very few aftercare programs. While direct support programs could be deployed to meet some of this need, the State has made no effort to push this approach. Also, many of the substance abuse services that exist are not sound; they do not deliver services according to the *J.K.* Principles.

E. Correcting the System's Deficiencies

45. Arizona needs to develop and implement an effective plan to address the deficiencies in its children's mental health system. In my expert opinion, the plan should describe how Defendants will:

High needs children:

- Expand intensive case management until there is enough capacity for all high needs children.
- Ensure the adequacy of intensive case management by setting expectations, monitoring, and holding providers accountable.
- Expand intensive community-based services, particularly direct supports, therapeutic foster care, and home-based respite.
- Reduce the number of children in out-of-home care and their lengths of stay, and reallocate savings to expand community-based services.

Quality Management System

- Create an effective system for reviewing compliance with the Settlement Agreement, including whether services are being provided according to the *J.K.* Principles.
- Use data from its QM system to identify and address problems, including by incentivizing good performance and consequencing poor performance.
- Develop meaningful corrective action plans, monitor whether the plans are working, and if not, take remedial action.

Training

- Develop a statewide training curriculum.
- Expand hands-on training opportunities, including coaching and mentoring, particularly at the supervisor level.

- Implement a process to examine the effectiveness of training and ensure the competencies of behavioral health staff.

18 to 21 Year Olds

- Expand services for this population, especially intensive case management, direct supports, and specialized services designed to promote independent living and employment.
- Ensure that youth, particularly those who have not been identified as "seriously mentally ill" by the adult behavioral health system, have access to medically necessary mental health services.

Substance Abuse

- Ensure that behavioral health staff are trained to identify substance abuse issues.
- Ensure that substance abuse services are adequate – in quality and quantity – to meet class members' needs.

F. Conclusion

46. In my expert opinion, Arizona is not operating a children's behavioral health system that meets the needs of *J.K.* class members, as required by the Settlement Agreement and by Medicaid law. Moreover, Arizona has not moved as quickly as practicable to develop and maintain a behavioral health system that delivers services according to the Principles, as required by the Settlement Agreement. If the State were to develop a good remedial plan and implement it with focused and sustained effort, I expect that the State could address the deficiencies in its current system in three years.

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 Arizona that the foregoing is true and correct. Executed this 17 day of SEPTEMBER 2009 in INDIANAPOLIS, IN.

Knute Rotto

EXHIBIT 1

Knute I. Rotto

317.205.8202 (O); 317.202.4202 (fax)
email: krotto@ChoicesTeam.org

Administration

Chief Executive Officer, Choices Inc., Indianapolis, Indiana

- Developed Choices into a $40 million non profit care management organization.
- Oversees nine services across 4 states: Marion County, Indiana; Dawn Project, Youth Emergency Services, Back to Home, ACES; Hamilton Choices, Cincinnati Ohio, Maryland Choices, Rockville & Baltimore City, Maryland, and DC Choices, Washington DC.
- Project Director for the $8 million, 6 year Comprehensive Community Mental Health Services Grant received by the Dawn Project.
- Integrated behavioral health with state-of-the-art technology making staff effective & efficient
- Received national recognition for Dawn in the President's New Freedom Commission Report and ACES as exemplary program with SAMSHA and Lilly.

Director of Mental Health Services, Cedars Youth Services, Lincoln, Nebraska

- Directed clinical services including Crisis Intervention, Community Service Mentoring, Day Treatment, Intensive Family Preservation, Juvenile Justice Supervision Mentor System, and Family Visitation Center.
- Managed the Residential Treatment Center (24 hour, 10 bed facility for male and female youth ages 13-18 years).

COMPASS Manager, Mental Health Center of Dane County, Madison, Wisconsin

- Directed four services: Clinical Coordination, Crisis Intervention, Mentoring, and Transitional Living Initiative while overseeing the Robert Wood Johnson Initiative.
- Hired and supervised 35 full-time employees and a total of 60 employees.
- Completed performance evaluations for employees and clinical staff.
- Increased revenue from $1.2 to $1.7 million.

Program Development

- Developed Choices Inc. from its inception with approval by a board of directors. Choices has grown to over 200 employees, 9 programs, 4 states and $40 million annual budget.
- Developed and implemented six services: Crisis Intervention, Day Treatment, Mentoring for At-Risk Youth, Family Preservation, In-Home Therapy, and Juvenile Justice Supervision Mentors, Mobile Crisis System for Child Welfare Families
- Initiated outcome based evaluation procedures and documented improvement in Residential Treatment Center client outcomes by shortening length of stay, involving families in planning and treatment, and accessing community-based resources for efficient aftercare planning.
- Assisted in development, implementation, and evaluation of a statewide case management system for at-risk youth in Nebraska.
- Assisted in developing The Clinical Manager, a computerized client information system that incorporates managed care principles in the design of treatment plans, program outcomes, billing, and contact notes.

Clinical Experience

- Provided intensive community-based case management services through clinical coordination, treatment planning, and service provision while developing a plan of care to support seriously emotionally disturbed youth.
- Implemented individualized, strength-based wraparound plans for youth with serious emotional disabilities and their families.
- Provided crisis intervention services for Dane County residents, setting up crisis plans and using in-home, brief therapy techniques while offering 24 hour services.
- Provided child protection services, including child protection investigations, ongoing family based services, and juvenile court intake and supervision.
- Completed 3000+ post masters' supervised clinical hours.
- Supervised graduate students in Social Work from the University of Wisconsin-Madison University of Nebraska-Omaha, and IUPUI.
- Sought continuing education and training experiences at over 40 national conferences and seminars.

Consultation

- Consulted with the State of New Jersey as they developed a statewide system of care; involved since the inception of the Children's Initiative.
- Provide clinical consultation to Clinical Data Solutions, a software development firm which developed *The Clinical Manager (TCM)* customized client information systems for human service providers nationwide.
- Consulted with the State of Nebraska Children Mental Health Division to develop and implement a statewide system of care for juvenile justice, mental health and child welfare clients.
- Consultation services provided to over 25 different locales in the past 10 years.

Employment History

3/97-present	**Chief Executive Officer**, Choices Inc. Indianapolis, Indiana
7/95-3/97	**Director of Mental Health Services**, Cedars Youth Services, Lincoln, NE
7/94-3/97	**Consultant**, State of Nebraska, Office of Community Mental Health, Lincoln, Nebraska
7/94-present	**Clinical Consultant**, Clinical Data Solutions, Madison, Wisconsin
8/89-6/95	**Coordinator/Clinical Director**, COMPASS Unit, Mental Health Center of Dane County, Madison, Wisconsin

Education

1985	Master of Science in Social Work, University of Wisconsin-Madison Graduate School of Social Work, Madison, Wisconsin.
1984	Bachelor of Arts in Social Work, Minor in Psychology, Luther College Decorah, Iowa.

Licensure

- Academy of Certified Social Workers (ACSW)

EXHIBIT 2

DECLARATION OF BRUCE KAMRADT

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

A. Summary of Qualifications and Opinions

1. I have over thirty-five years' experience working in the mental health field, the last thirty of which I have worked with children with mental health needs. Since its inception in 1995, I have been director of Wraparound Milwaukee, a government agency that serves children with significant emotional, behavioral and mental health needs. We provide intensive community-based services to approximately 1,300 children with complex mental health needs annually. Wraparound Milwaukee has been repeatedly lauded as a national model for serving children with mental health needs, including in the Surgeon General's Report on Mental Health and the Presidential New Freedom Commission's Report on Mental Health.

2. I am an expert on developing community-based services for children with mental health needs. I have consulted with and provided technical assistance to nearly fifty communities over the last twenty years. In the last two years alone, I have worked with more than six states interested in reforming their children's mental health systems statewide. I have published numerous articles and presented at dozens of national conferences on community-based services for children with mental health needs.

3. I was asked by Plaintiffs to review Arizona's children's mental health system[1] to determine whether the State has developed a system that meets class members' mental health needs, as required by the Settlement Agreement. In forming my opinion, I have reviewed information and data about Arizona's children's mental health system and implementation of the *J.K.* Settlement Agreement, including correspondence between Plaintiffs and Defendants regarding implementation; relevant policy guidance documents developed by the State; quality management data, evaluations, and plans; and the State's recently developed logic model and documents cited in the model. I also spent several days in Arizona in July 2009 meeting with a wide range of individuals knowledgeable about the system, including parents with children with mental health needs, staff and leadership from family organizations, private providers, staff and leadership from the Regional Behavioral Health Authorities ("RHHAs"), and staff from other child-serving agencies (such as juvenile justice).

4. In my expert opinion, Arizona is not operating a children's mental health system that meets the needs of the *J.K.* class members, as required by the Settlement Agreement. The State has not moved as quickly as practicable to develop the system of services required by the Settlement Agreement, namely, one that provides services according to the *J.K.* Principles. To bring the system into compliance with the Settlement Agreement,

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[1] Throughout this declaration, I use the terms "mental health system" (the more common national term) and "behavioral health system" (the term most commonly used in Arizona) interchangeably.

the State must develop and implement with sustained effort a remedial plan to address the deficiencies in its system, which I discuss in detail below.

B. Qualifications

5. I have been the Director of Wraparound Milwaukee since its inception in 1995. Wraparound Milwaukee is a government agency that provides a coordinated system of intensive community-based care to children with severe emotional, behavioral and mental health needs. Among other things, we facilitate child and family team meetings to develop and implement treatment plans, provide clinical coordination and intensive case management, and manage a provider network of community-based services and supports. We provide individualized services that build on youth and family strengths. The services we provide are determined by children's needs, not availability. We fully engage families in the planning and delivery of services.

6. Wraparound Milwaukee has been repeatedly lauded as a national model on how to provide services to children with severe mental and emotional disorders. In 2009, Harvard University-Kennedy School of Government recognized Wraparound Milwaukee for being the best innovation in American government. In 2008, the National Gains Center, part of the Center for Mental Health Services in the U.S. Department Health and Human Services, presented Wraparound Milwaukee with the National Impact Award for outstanding work meeting the needs of youth with mental health needs in the delinquency system. The President's New Freedom Commission on Mental Health named Wraparound Milwaukee an exemplary program in its July 2003 report. In 2002, the Center for Mental Health Services selected Wraparound Milwaukee to serve as one of

two national host-learning centers for the more than sixty children's mental health programs funded by HHS' Substance Abuse Mental Health Services Administration ("SAMHSA") throughout the United States. In 1999, the U.S. Surgeon General's Report on Mental Health recognized Wraparound Milwaukee as exemplary. That same year I was invited to participate and present at the White House Conference on Mental Health chaired by Al and Tipper Gore.

7. Prior to my work with Wraparound Milwaukee, from 1986 to 1995, I was the Director of Milwaukee's Child and Adolescent Treatment Center, where I was responsible for the management and administration of a psychiatric hospital and outpatient services for children and adolescents. From 1982 to 1986, I was a Juvenile Court Administrator for the Human Services Department of Waukesha County (a suburb of Milwaukee and the State's largest county), where I was responsible for administration of all Juvenile Court Services including operation of the 32-bed secure and non-secure Children's Detention Center.

8. From 1976 to 1978, I was an Adult Services and Adult Protective Services Supervisor for the Waukesha County Social Services Department. I was responsible for supervising two units providing adult protective services to mentally ill and elderly clients. In 1978, I was promoted to Senior Social Work Supervisor, responsible for supervision of a staff of 30 providing child protective services, family services, court custody studies, and adult protective services. I previously worked from 1973 to 1976 as the Director of Deaconess Hospital, Social Work Services, providing direct services to patients.

9. I have had an active consulting practice related to developing community-based children's mental health services for the last fifteen years. I have consulted with more than fifty different communities on developing community-based services for children with mental health needs. In the last two years alone, I have consulted with several states interested in statewide reform of their children's mental health systems, including New Hampshire, Oregon, Maryland, Georgia, Utah and South Carolina.

10. I regularly participate in national and local conferences on children's mental health, and I have published over half a dozen articles on children's mental health issues, including:

- B. Kamradt and Mary Jo Meyers, "Curbing Violence in Juvenile Offenders with Serious Emotional and Mental Health Disturbance – The Effective Utilization of Wraparound Approaches in an American Urban Setting," International Journal of Adolescent Medicine and Health, Selected papers, November 1999, Jerusalem, Israel.
- B. Kamradt, "Utilizing Programs, Fiscal and Clinical Outcomes Data to Build and Sustain a System of Care," 14th Annual Research Conference Proceedings, The Research and Training Center for Children's Mental Health, Feb. 2002.
- Bruce Kamradt, MSW, Larry Marx, M.D., and Marilyn Benoit, M.D., Foster Children in the Child Welfare System, Chapter in the Handbook of Child and Adolescent Systems of Care, edited by Andres J. Pumariega and Nancy C. Winters, published by Jossey-Bass, 2003.
- Bruce Kamradt, MSW, Stephen A.Gilbertson, MS, and Nancy Lynn, MS, Wraparound Milwaukee Program Description and Evaluation in Outcomes for

Children and Youth with Emotional and Behavioral Disorders and Their Families, Edited by Michael H. Epstein, Krista Kutash, and Albert Duchnowski, published by Pro-Ed, Austin, Texas, 2004.

11. I have served as an expert on children's mental health issues in several cases. From 2006 to 2009, I was an expert witness for Plaintiffs in *Rosie D. v.* Romey, a class action lawsuit in federal court in Massachusetts challenging the State's failure to provide intensive community-based services to Medicaid-eligible children with serious emotional disturbances. In 2005, I served as an expert witness for Plaintiffs in *Katie A. v. Bonta*, a class action lawsuit in federal court in California challenging the State's failure to provide intensive community-based mental health services for Medicaid-eligible children in, or at risk of entering, California's foster care system.

12. I received my Bachelor's degree in Psychology and History from the University of Wisconsin Oshkosh in 1970. In 1973, I received a Masters of Social Work from the University of Wisconsin Milwaukee.

13. My curriculum vitae is attached as Exhibit 1.

C. The Services Required by the *J.K.* Settlement Agreement Are Medically Necessary to Treat Class Members

14. In my expert opinion, the services required by the *J.K.* Settlement Agreement are medically necessary to treat class members. By that, I mean that children with mental health needs require these services to have their needs met and for the mental health conditions to improve. The system required by the *J.K.* Settlement Agreement is the professional standard for an adequate children's mental health system.

15. It is generally accepted in the mental health field that children with significant mental health needs require intensive community-based services provided through child and family teams – the services required by the *J.K.* Settlement Agreement – to improve. These services have been shown to have 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. They 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, and they are far more effective than other traditional mental health services, such as office-based therapy. *See generally* Mental Health: A Report of the Surgeon General, Chapter 3 (1999), available at http://www.surgeongeneral.gov/library/mentalhealth/toc.html#chapter3.

16. Wraparound Milwaukee is a nationally-recognized program for providing the intensive community-based services and case management required by the *J.K.* Settlement Agreement. We have found that our services lead to significantly improved outcomes for children and their families. Wraparound Milwaukee's outcomes include:

- Sustained improvements in children's functioning and mental health status;
- Successful diversion from residential treatment placements;
- Reduced use of in-patient psychiatric hospital services;
- Placement stability;
- Increased school attendance and success, including graduation;

- Successful community living; and
- Reduced recidivism rates for children involved in the juvenile justice system.

See, e.g. publications *supra* in ¶ 10.

17. We have found that families participating in Wraparound Milwaukee report that they are satisfied with the mental health services their children receive and think our program has empowered them to handle challenges in the future. *Id.*

D. Defendants Are Not Providing Services As Required by the Settlement Agreement

18. The *J.K.* Settlement Agreement requires Arizona to develop and operate a children's behavioral health system that delivers services according to the *J.K.* Principles. The State has failed to develop such a system.

i. Failure to Serve High Needs Children

19. First, the system is not meeting the needs of its high needs children. The needs of these children and their families are complex. These children are almost always involved another child-serving system other than children's mental health, such as child welfare, juvenile justice, or special education. They require intensive community-based services, available 24 hours a day, seven days a week, to stabilize them, help them avoid crises, and improve their functioning. Intensive case management, which assists these children and families in accessing needed services and in coordinating among involved child-serving agencies, is essential. I am not aware of any effective children's mental health system that does not provide intensive case management and an array of intensive community-based services and supports to its high needs children.

20. I am aware that Arizona has recently focused on developing intensive case management for its high needs children. Arizona should have focused on developing this service much earlier in the implementation process, as it is absolutely essential to meeting the needs of high needs children. Moreover, while this recent initiative is a good start, it appears that Arizona still has a lot more work to do. There still are not enough intensive case managers to serve all high needs children in the system. In addition, the State needs to ensure the quality of its intensive case management services. Many of the case managers in the system are new; they need additional training, especially coaching and strong supervision, to do their job adequately. Moreover, the State has not yet clearly defined the roles and responsibilities of intensive case managers, and as a result, intensive case management is inconsistent in quality.

21. There also are not enough intensive community-based services to meet the needs of high needs children, particularly direct supports, therapeutic foster care, and home-based respite. As a result, providers are still heavily relying on office-based counseling and residential treatment, in violation of the Settlement Agreement. It also appears that providers are not utilizing informal supports as required by the Settlement Agreement.

22. I am aware of the State's recent efforts to expand direct supports and, as with intensive case management, I believe this focus should have come earlier in the implementation. The State should have focused on expanding intensive community-based services simultaneously with focusing on developing child and family teams. Without needed intensive services and supports, child and family teams cannot implement the plans they develop.

23. For the services that do exist, they do not appear to be properly integrated through child and family teams. Direct supports, clinical services, and crisis services are seen as separate services, rather than as a single, integrated package of services for an individual child. In addition, there does not appear to be a sufficient emphasis on crisis services for high needs children. In my experience serving high needs children, sound up-front planning for crises helps avoid unnecessary removals from home, interactions with the criminal justice system, and admissions to restrictive and expensive placements like psychiatric hospitals and residential treatment centers. The lack of sufficient planning and services for crises undoubtedly leads to many class members being needlessly confined in segregated settings. Cross-system collaboration is also critical for serving high needs children. In Wraparound Milwaukee, representatives from all systems in which the child is involved are part of the child and family team. We also have developed formal mechanisms for the child-serving systems together to address systemic problems and barriers. Meaningful cross-system collaboration seems lacking in Arizona.

ii. Failure to Develop a Quality Management System That Measures Compliance With the Settlement Agreement

24. Second, the system has not developed a quality management system that measures whether services are being provided as required by the *J.K.* Settlement Agreement. A good quality management ("QM") system is essential to a working children's mental health system. A QM system must be able to identify core measures of practice and outcomes; collect and trend data to identify problems and areas of needed improvement; and then take action to address problems and ensure improvements are sustained. A QM

system in which stakeholders have confidence is essential to accountability. Information from the system should be used to make data-driven decisions, incentivize good practice, and consequence poor practice.

25. Wraparound Milwaukee has developed its QM system with one end-goal – to improve practice. In developing our QM system, we identified what we desired from our children's mental health system, both in terms of child outcomes and the process of service delivery, and developed measures of each. The child outcome data Wraparound Milwaukee collects includes children's functional performance, living situation/place of residence, school participation and performance, juvenile justice involvement, utilization of informal supports, successful disenrollment and/or transition to adulthood, and family satisfaction. We collect process indicators such as timely and appropriate development of a plan of care, collaboration among the child and family team, appropriate authorization for services, and appropriate documentation and progress notes in clients' records. We also collect data through review of individual cases, including a chart review, team facilitator observation tool, and interviews.

26. Wraparound Milwaukee uses the information it collects to ensure sound practice. We have set benchmarks for performance, and we contractually require our provider agencies to meet these benchmarks. For example, every six months, we review the performance of our care management agencies. If they are not meeting the benchmarks, we work with them to develop corrective action plans to improve their performance. We monitor the agency's implementation of the corrective action plan and evaluate whether its performance is improving. We consequence agencies who cannot improve their

performance after repeated assistance from us. In egregious circumstances, we will end a contract with a provider. Because the agencies that contract with Wraparound Milwaukee know that we are serious about their performance, they work extremely hard to meet the benchmarks and improve their performance if they fall below them.

27. Arizona has not implemented key components of an effective QM system. The State is collecting a lot of data, but does not appear to have an adequate understanding of the outcomes being achieved or whether services are being delivered according to the *J.K.* Principles. For the data it does collect, there are concerns about reliability. Reliable data is obviously essential to a working QM system.

28. The State has failed to implement a review tool that effectively measures whether services are being provided according to the *J.K.* Principles, as required by the Settlement Agreement. I understand that the State has used and abandoned several tools and is beginning to implement another (the System of Care Practice Review). The State's failure to implement and stick with an effective tool has impeded its ability to create a sustainable QM system, as it takes several years for a system to implement a review tool that can gather useful data and be used to improve practice.

29. The State also is failing to hold providers accountable. The State does not have clear expectations for performance and meaningful benchmarks related to the Settlement Agreement to which providers are being held accountable. While the State appears to be developing corrective action plans when problems are identified, it does not appear to be seriously monitoring the plans and ensuring that they are having the desired impact.

30. The lack of accountability is a problem throughout the system. Part of the difficulty is the many layers of administration and delegation. The State delegates responsibility to the RBHAs; the RBHAs delegate to the provider networks; and the provider networks believe the responsibility belongs to the RBHAs or the State. A QM system with clear expectations and consequences for poor performance would cut through a lot of these issues.

iii. Failure to Develop the Required Training Program

31. Third, the State has not developed a training program that ensures that behavioral health staff serve children as required by the *J.K.* Settlement Agreement.

32. Arizona has not developed a statewide training curriculum and instead has delegated that responsibility to the RHBAs, which in some cases have delegated it to the provider networks. As a result, the content, quality and focus of training varies across the system, which has led to inconsistent service delivery. I saw this clearly, for example, when speaking with individuals about intensive case management. The roles, responsibilities, and expectations for intensive case managers were different from one provider to the next. In my opinion, the quality and effectiveness of case management is suffering as a result.

33. Arizona has not developed a sustainable training program that ensures that behavioral health staff practice as required by the Settlement Agreement. The State has done a lot of training and spent a lot of money on training its behavioral health staff, but the vast majority of that training has focused on the *J.K.* Principles themselves. The State has not done enough training to ensure that behavioral health staff actually developed the

skills necessary to deliver services according to the *J.K.* Principles. In addition, there is too heavy a reliance on outside trainers rather than building internal expertise. This appears to be a major impediment to the development of a sustainable training system.

34. Most of the system's training efforts have focused on classroom training instead of the hands-on coaching and mentoring that is essential to learning good service delivery. In Wraparound Milwaukee, the vast majority of our training efforts focus on providing behavioral health staff the opportunity to see good service delivery and to get feedback on their own practice. Also unlike Wraparound Milwaukee, Arizona does not appear to be providing sufficient training on an on-going basis to existing staff.

35. Moreover, the State has failed to develop measures to assess the effectiveness of training. It does not, for example, examine the competencies and skills of behavioral health staff. As a result, there is no regular process of giving feedback to supervisors and front-line staff about areas where additional training, coaching and mentoring is needed. In Wraparound Milwaukee, we employ tools to assess the competencies of our staff. For example, we use a coaching observation tool to rate our care coordinators (the equivalent of intensive case managers in Arizona). We use this tool to measure their skills in engagement, child and family team facilitation, and case management. We use this tool to provide feedback to the individual, his or her supervisor and the provider organization on strengths and areas of needed improvement.

iv. Failure to Meet the Needs of 18 to 21 Year Olds

36. Fourth, the system is not serving 18 to 21 year olds as required by the Settlement Agreement, despite their being members of the *J.K.* class. When class members turn 18,

they are being disenrolled from the children's mental health system and as a result, lose their child and family teams and whatever intensive community-based services and supports they receive from children's providers. For 18 year olds who are determined to be seriously mentally ill, they are enrolled in the adult system but cannot access many of the services they need. The 18 year olds who are determined to have mental health needs but who are not seriously mentally ill get few, if any, of the services they require.

37. Wraparound Milwaukee has developed services to address the unique needs of this age group. We provide these transition-age youth with intensive case management by case managers who are knowledgeable about both the children's and adult mental health systems and have expertise in accessing the resources necessary for this group. We ensure that the child and family teams for transition-age youth include representatives and providers from both the children's and adult mental health systems. And we have expanded Wraparound Milwaukee's provider network to include providers of services that are necessary for this age group, including job coaches, housing providers, and providers who teach independent living and life skills. I do not see that Arizona has implemented these necessary actions to meet the needs of 18 to 21 year olds.

38. I have reviewed Arizona's policy on serving 18 to 21 year olds. While it is a good start, the State has made little progress in actually implementing this policy. Children age 18 to 21 continue to be denied medically necessary services.

v. Failure to Develop Substance Abuse Services

39. Finally, the State has failed to develop adequate substance abuse services for class members. The substance abuse issues of class members are often unidentified, and

substance abuse services are inadequate to meet children's needs when issues are identified.

40. About one-third of the children served by Wraparound Milwaukee have substance abuse issues. In my review of information regarding the identification and utilization of substance abuse services and based on my conversations with stakeholders, I believe substance abuse issues are seriously under-identified in Arizona. In Wraparound Milwaukee, our behavioral health staff are trained to identify substance abuse issues during intake and initial assessment. I did not see that Arizona's behavioral health professionals receive this same type of training.

41. Even when children's substance abuse needs are identified, there is a lack of services to meet the need. In Wraparound Milwaukee, our child and family teams specifically address substance abuse needs in the child's plan of care. To address this need, the team utilizes a combination of formal substance abuse services, direct supports to engage the child in meaningful activities (such as a mentoring and therapeutic recreation), and informal supports. The team also refers any substance-abusing family-members to services. In Arizona, I understand that the substance abuse programs have waiting lists and that there are few aftercare programs. Of the substance abuse programs that do exist, many are not of good quality and do not conform to the *J.K.* Principles. In addition, I did not see that child and family teams were marshalling direct supports and informal supports to address substance abuse needs.

E. Correcting the System's Deficiencies

42. Arizona needs to develop an implementation plan to address the deficiencies in its children's mental health system. In my expert opinion, I believe an implementation plan should include the following:

- High needs children: The State should continue its expansion of intensive case management until there is enough capacity for all high needs children. It must ensure the quality of intensive case management by setting clear expectations, monitoring them, and providing strong supervision, mentoring and coaching to case managers. There also must be an expansion of intensive community-based services, particularly direct supports, therapeutic foster care, and home-based respite, and better use of informal supports. Services, including in particular clinical services, direct supports, and crisis services, need to be better integrated through child and family teams. The State must also improve its infrastructure for cross-system collaboration. It also should set goals to reduce the number of children in out-of-home care and their lengths of stay, and reallocate savings to expand community-based services.
- Quality Management System: The State must develop a process for using reliable data for decision-making. The State should develop and prioritize core measures of compliance with the *J.K.* Settlement Agreement and ensure the reliability of the data. The State must implement a practice review process that measures the practice and outcomes required by the Settlement Agreement.

The State must address the lack of accountability in the system. It should set performance expectations and monitor compliance with its policy directives. When problems are identified, it must work with providers to develop and implement corrective action plans, monitor implementation, and if necessary, consequence continued poor performance. In short, the State must use the data from its QM system and practice reviews to improve service delivery and secure compliance with the Settlement Agreement.

- Training: The State should develop a statewide training curriculum. The State should ensure the sustainability of its training program by developing internal expertise within the State rather than relying on outside consultants. It must expand coaching, mentoring and other hands-on training opportunities, particularly at the supervisor level. The State also must implement a process to examine the effectiveness of its training program and to ensure the competencies of behavioral health staff.
- 18 to 21 Year Olds: The State must implement and monitor its policy document on serving 18 to 21 year olds. It must develop the intensive case management and other specialty services, including independent living skills training, necessary to meet the needs of this population. The State should develop better collaboration between the children's and adult mental health systems.
- Substance Abuse: The State must ensure that behavioral health staff are trained in identifying substance abuse issues and marshalling specialized

substance abuse services, as well as direct supports and informal services, to address those needs. Child and family team facilitators, case managers, and direct support workers all should receive this training. The State should expand the capacity of substance abuse services and ensure that they are of good quality and are being provided according to the *J.K.* Principles.

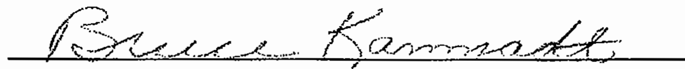
43. I do not believe that Arizona has developed the children's behavioral health system required by the *J.K.* Settlement Agreement. Arizona should have been able to fully develop the system required by the Settlement Agreement within eight years. In less than half that time, Wraparound Milwaukee was making minor adjustments to our system, and I have seen the same timeframe for development in other communities. Wraparound Milwaukee and these communities were able to do this by having a clear implementation plan: first developing the service capacity required by high needs children, developing a sound QM system upfront, and providing extensive hands-on training opportunities. It does not appear that Arizona has had the clear implementation plan or the strong leadership necessary for a large system-reform effort, and I believe this is one of the major reasons why Arizona has struggled in its implementation efforts.

44. In order to develop the system required by the *J.K.* Settlement Agreement, the State must develop and implement a sound remedial plan to address the deficiencies I described above. It must also provide leadership and create accountability, including by using its QM system to drive changes. If this is done, it is my expert opinion that Arizona could develop the system required by the *J.K.* Settlement Agreement in three years.

F. Conclusion

45. In my expert opinion, Arizona is not operating a children's mental health system that meets the needs of the *J.K.* class members, as required by the Settlement Agreement. The State has not moved as quickly as practicable to develop the system of services required by the Settlement Agreement, namely, one that provides services according to the *J.K.* Principles. If the State were to develop a good remedial plan and implement it with sustained effort, I expect that the State could address the deficiencies in its current system in three years.

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 Arizona that the foregoing is true and correct. Executed this 25th day of September 2009 in Milwaukee, Wisconsin



Bruce Kamradt

EXHIBIT 1

RESUME

BRUCE J. KAMRADT

Milwaukee County
Behavioral Health Division
Children's Mental Health Services – Wraparound Milwaukee Program
9201 Watertown Plank Road
Milwaukee, WI 53226
(414) 257-7611

1995-Present - Director of Wraparound Milwaukee

- Responsibility for Administration and Management of the integrated services system for children and adolescents in Milwaukee County with an annual operating budget of over $43 million per year. Wraparound Milwaukee is currently the largest integrated services system and a national model as cited in the 1999 U.S. Surgeon General's Report and the President's New Freedom Commission Report on Mental Health (2004). Wraparound Milwaukee is set up as a unique publicly operated care management organization that blends funds from Child Welfare, Mental Health, Medicaid, and Juvenile Justice to care for children with complex mental health and social service needs. System of care components include case management, mobile crisis, and comprehensive Provider Network. There are 41 county staff and 100 contracted case management staff associated with this program.

- Responsibility for the Family Intervention Support Services Program (FISS) for all Child Welfare sites. The FISS program provides early intervention services to youth who have runaway histories, truancy, or uncontrollability at home who would otherwise enter the court system. There are two county staff and six contracted FISS managers in this program.

- Oversees the Operation of the Mobile Urgent Treatment Team for foster families under a $700,000 grant with the Bureau of Milwaukee Child Welfare and Mobile Urgent Treatment Team for Milwaukee Public Schools under a $500,000 contract. This team of 24 clinical staff provides 24 hours mental health crisis intervention to improve placement stability of youth in foster care and in the public school system.

- Currently involved in design and development of an integrated health care system for children in foster care, specifically developing the mental health component of the "medical home" model.

1986 - 1995- Director, Child and Adolescent Treatment Center
Milwaukee County Mental Health Division
Wauwatosa (Milwaukee County), Wisconsin 53226

Responsible for administration and management of a psychiatric hospital and outpatient services for children and adolescents with an annual operating budget

of $12 million.

1982 - 1986 - Juvenile Court Administrator
Waukesha County Human Services Department
500 Riverview Drive
Waukesha, Wisconsin

Responsible for administration of all Juvenile Court Services including operation of the 32-bed secure and non-secure Children's Detention Center, management and supervision of staff providing juvenile court intake and disposition services.

Responsible for development and management of all purchase of service programs including in-home, mediation, day treatment, volunteer and restitution programs. There were about 60 staff in these programs with a budget of $3.5 million per year.

Responsible for the operation of the County's Criminal Justice office which provided training and grants to various community agencies and law enforcement agencies.

1978 - 1982 - Senior Social Work Supervisor
Waukesha County Social Services Department
500 Riverview Drive
Waukesha, Wisconsin

Responsible for supervision of staff providing child protective services, family services, court custody studies, adult and adult protective services. This included approximately 30 staff with a budget of over $1 million.

Managed purchase of service contracts for Child Welfare Services, including in-home and group home resources.

1976 - 1978 - Adult Services and Adult Protective Services Supervisor
Waukesha County Social Services Department
500 Riverview Drive
Waukesha, Wisconsin

Responsible for supervising two units of 11 staff providing adult protective services to mentally ill and elderly clients.

Responsible for development and management of several purchase of service group homes for chronically mentally ill adults and family foster homes for elderly clients.

1973 - 1976 - Director of Deaconess Hospital - Social Work Services
(No longer in existence)
Milwaukee, Wisconsin

Responsible for direct services to patients in a medical setting and supervision of

two B.A. social workers.

EDUCATION

1973 - University of Wisconsin - Milwaukee
Masters of Social Work (MSW)

1970 - University of Wisconsin - Oshkosh
Bachelor's Degree - Major: History and Psychology

PUBLICATIONS AND ARTICLES

- E. Michael Foster, Christopher C. Kelsek, Bruce Kamradt, Zijin Yang in Journal of Emotional and Behavioral Disorders, "Expenditures and Sustainability in Systems of Care, Vol. 9, Number 1, Spring 2001

- B. Kamradt and Mary Jo Meyers, "Curbing Violence in Juvenile Offenders with Serious Emotional and Mental Health Disturbance – The Effective Utilization of Wraparound Approaches in an American Urban Setting," International Journal of Adolescent Medicine and Health, Selected papers, November 1999, Jerusalem, Israel.

- Bruce Kamradt, "Wraparound Milwaukee: Aiding Youth With Mental Health Needs," Juvenile Justice, Vol. VIII, Number 1, April 2000

- Bruce Kamradt, "Funding Mental Health Services for Youth in the Juvenile Justice System: Challenges and Opportunities, Monograph prepared for the National Center for Mental Health and Juvenile Justice, December 2002.

- Bruce Kamradt, MSW, Larry Marx, M.D., and Marilyn Benoit, M.D., Foster Children in the Child Welfare System, Chapter in the Handbook of Child and Adolescent Systems of Care, edited by Andres J. Pumariega and Nancy C. Winters, published by Jossey-Bass, 2003

- Bruce Kamradt, MSW, Stephen A.Gilbertson, MS, and Nancy Lynn, MS, Wraparound Milwaukee Program Description and Evaluation in Outcomes for Children and Youth with Emotional and Behavioral Disorders and Their Families, Edited by Michael H. Epstein, Krista Kutash, and Albert Duchnowski, published by Pro-Ed, Austin, Texas, 2004

AWARDS AND RECOGNITION FOR WRAPAROUND MILWAUKEE

- Bruce Kamradt, Wraparound Milwaukee's Director, was invited to participate and present our model at the White House Conference on Mental Health chaired by Al and Tipper Gore and held on June 7, 1999.
- Cited in the US Surgeon General's Report on Mental Health (November 1999-Page 185) as an outstanding and unique managed care model in children's mental health.
- Recipient of the Lincoln Gaines Award presented by the Milwaukee Area YMCA honoring the

work of Martin Luther King. The award was for outstanding leadership in building strong families-January 2008.

- Center for Mental Health Services, National Gains Center presented the Wraparound Milwaukee Program with the 2008 National Impact Award for outstanding work meeting the needs of justice-involved people with mental illness.
- Wisconsin Family Based Services Association presented its 2008 "In Search of Excellence Award" to the Wraparound Program for its work strengthening and supporting families of youth with mental illness.
- The President's New Freedom Commission on Mental Health named Wraparound Milwaukee as an exemplary program in children's mental health (p. 35-36) in its final report in July 2003. Our program was one of only four programs mentioned in the entire report.
- Harvard University-Kennedy School of Government – Best Innovation in American Government Award for 2009.

PRESS AND MEDIA RECOGNITION OF WRAPAROUND MILWAUKEE

The Wraparound Milwaukee Program has received considerable press and media coverage and has been written about in various national publications. Some of these include:

- Milwaukee Journal Sentinel, "Wraparound Program" touted in US Report December 25, 2000
- Behavioral Health Care Tomorrow – December 1999, vol. 8, no. 6 "Wraparound Milwaukee cited as model of Managed Care success"
- Claiming Children "Wraparound Milwaukee: Effectively Working with Delinquent Youth & Their Families", November 2000, publication of the Federation of Families
- "Children with Special Needs Through Medicaid Managed Care, Two Programs Rise to the Challenge (Wraparound Milwaukee)", Healthplan Magazine, May/June 2001
- "Wraparound A Model for Children's Mental Health", The Brown University Child & Adolescent Letter, 2002 Manissess Communication Group
- Juvenile Justice Magazine, "Wraparound Milwaukee: Aiding Youth with Mental Health Needs, vol. VII, no. 1 April 2000
- American Youth Policy Forum, "Less Cost, More Safety: Guiding Lights for Reform in Juvenile Justice, Richard Mendel, 2001
- Omaha World Herald, January 21, 2002 "Home-Based Therapy Catching on: Milwaukee Program Treats Youth Where They Live"
- Open Minds "Reaching Mentally Ill Youth Offenders", September/October 2003, Wraparound Milwaukee cited as effective program helping children
- Outcomes for Children and Youth with Emotional and Behavioral Disorders- Programs and Evaluation Best Practice, Epstein, Michael; Kutach, Krista; Duchnoruski, Albert; p. 307-328, Pro-Ed, Inc. 2005
- Pittsburgh Post-Gazette "Wrapping Troubled Teens in a Blanket of Support" by Steve Tweedt. Article on Wraparound Milwaukee's effective model for treating youth, July 18, 2001
- Promising Approaches for Behavioral Health Services to Children in Managed Care Systems, Health Care Reform and Tracking Project, Sheila Pires, University of South Florida, November 2002
- National Conference of State Legislatures, State Health Notes "Wraparound Milwaukee" gives kids with serious mental health problems community services in place of costly residential

care", vol. 22, no. 353, July 16, 2001

Recent Consulting and Technical Assistance Provided to Other Communities 2007-2009

2009 - - New Hampshire Endowment For Health Grant Initiative, Developing Care Coordination Pilot

2008-09 - - Oregon's Governor's Office and Care Oregon Inc. Developing Model for Statewide Implementation of Wraparound System of Care for Children with Serious Mental Health Needs

2008-09 - - Innovations Institute-University of Maryland – Developing Model and Implementation Plan for Maryland Case Management Program

2008 - - Policy Research and Associates, Inc., Del Mar NY; Consultation and training for "Models For Change Initiative", Chicago, Austin, Texas and Washington D.C.

2006-09 - - Technical Assistance Collaborative, Consulting with Massachusetts State Medicaid Agency and Center For Public Representation on Rosie D. lawsuit and Implementation of Remedy. Initially wrote Program Report and testified in lawsuit for the Center For Public Rep.

2007-09 BCAP Project on integrating primary care with Child Welfare, Center For Health Care Strategies in Philadelphia

2008 - - Center For Juvenile Justice, Wingspread Conference on Child Welfare/Juvenile Justice Youth who cross child service systems

2007 - - Georgia Association of Homes and Services – Developing and Financing Wraparound Model of Care

2007 - - Utah Dept. of Human Services – Facilitation of Statewide Strategies Planning for developing wraparound system of care

2007 - - South Carolina Department of Disabilities – consultation and TA on developing and financing Wraparound model for State

EXHIBIT 3

DECLARATION OF MATTHEW PIERCE

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

1. I am currently the clinical director of Child and Family Support Services (CFSS), a leading provider of direct support services,[1] and have held that position since 2007. In this position, I oversee all clinical operations of CFSS' programs within Maricopa County, provide training and coaching to staff at all levels, and develop and oversee CFSS' quality performance activities. I also provide consultation, training, coaching and technical assistance to other providers of children's behavioral health services through my own consulting agency. I am currently consulting with Touchstone, a large provider in Maricopa County, regarding the development of direct support services, and have consulted with several other communities nationally regarding the development of community-based services for children.

2. From 2005 to 2007, I was the clinical director at the Southwest Network, the largest network of providers in Maricopa County, serving over 8000 children. I oversaw all clinical operations within Southwest Network and our contracted agencies. I designed and implemented a range of community-based services and provided quality management, technical assistance, and training to contracted agencies within the network. From 2003 to 2005, I was the Director of Outpatient Services at Youth Evaluations and

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[1] Direct support services are intensive, individualized services to support children with significant behavioral health needs in their own homes, schools, and communities.

Treatment Centers (Youth ETC), where I was responsible for developing and maintaining all clinical operations for outpatient services, providing on-going supervision and training to all clinical and support staff, and designing, implementing and overseeing innovative community-based programs. From 2001 to 2003, I worked at Southwest Network, first as a senior team leader, where I was responsible for supervision of case managers, and then as a child and family team coach, where I was responsible for helping the network's contracted agencies to implement the child and family team process through coaching, training and supervision. From 1999 to 2001, I was the program coordinator for the Hozhoni Foundation, where I oversaw programs for individuals with developmental disabilities, and from 1998 to 1999, I was the Youth Coordinator for the City of Flagstaff.

3. The *J.K.* Settlement Agreement requires Arizona to develop and operate a children's behavioral health system that delivers medically necessary services according to the *J.K.* Principles. Such a system would ensure that children get the services they need, when they need them, where the need them, and how they need them and would monitor to ensure that those services are having the desired positive impact. I do not believe that the State has yet developed such a system. Moreover, I do not believe the State has "moved as quickly as practicable" to develop a behavioral health system that delivers needed services according to the *J.K.* Principles.

Children with High Needs

4. First, the *J.K.* system is not meeting the needs of its most complex children – children with high needs. Children with high needs include those in or at risk of out-of-home care, as well as children who are involved in other systems, such as child welfare,

juvenile justice, or special education. I would expect that after eight years, the system would have developed the services necessary to meet the needs of *J.K.* class members, particularly those with the highest needs. But in my experience, there are not enough intensive and individualized services to meet the needs of children, particularly children in or at risk of out-of-home care. We do not have sufficient direct support services, therapeutic foster care, and home-based respite. Nor do we have enough quality services, including psychiatric and clinical services, for children with less complex needs, with the result that many needlessly become children with high needs.

5. While there has been an increase in the number of direct support providers as a result of the recent Meet Me Where I Am Campaign, many of these providers limit the services they offer and fail to offer particular needed services, such as crisis services. They also limit the intensity, frequency and duration of necessary services. This makes it impossible for them to serve the highest needs children. This problem has been created in large part by the system's failure – and particularly the State's failure – to monitor and enforce the standards the State has developed regarding direct support services.

6. Children with high needs who cannot be served in their own home or a regular foster home need therapeutic foster care (TFC) to avoid institutional out-of-home care. TFC providers should have the ability to support children with high needs and manage crisis situations. But in our system, children with high needs repeatedly get kicked out of TFC placements for displaying the same behaviors that prompted the placement in the first place.

7. Home-based respite is another service that is essential for meeting the needs of complex children and keeping them at home or in family settings. They often need a place to go for a few days to help de-escalate crisis situations that otherwise might lead to their removal from their home. There is not enough home-based respite. One reason: as with TFC, some of the providers of the service are not equipped to serve children with high needs.

8. Another service that is in short supply but is essential to meeting the needs of complex children is intensive case management. Until recently, there has not been sufficient focus on ensuring that children with high needs get intensive case management. Until recently, children with high needs were being served by case managers with caseloads three to four times what is clinically appropriate, who often did not have the skills necessary to do their job. In the last year, the State has began to focus on intensive case management, primarily by moving the responsibility for intensive case management of children with high needs from individual provider organizations to the networks that are supposed to manage the providers. I do not think that shifting responsibility is enough to address existing problems, and more needs to be done to ensure adequate case management. There still are not enough intensive case managers at the networks. Many of the intensive case managers are new and are not getting the hands-on coaching, mentoring, and supervision they need to develop necessary skills. As a result, many children with high needs continue to be served by caseworkers with poor skills and high caseloads. Moreover, the State is not reviewing the competency of case managers or the quality of case management; instead it is examining only whether the networks have

hired a specific number of case managers. This focus solely on quantity, with no focus on quality, is perpetuating the problem our system has long had with poor case management.

9. Another problem is that intensive services are being misdirected. In other states, children's mental health systems identify their children with high needs and ensure that they are provided the most intensive, individualized services the system has to offer. Unfortunately, that has not happened in Arizona. The State does not have a mechanism for ensuring that the most intensive services are directed to the children with the most significant needs. In my experience, much of the intensive services in the system, like direct supports, are not being deployed to children with high needs. All too often providers choose to serve "easier" low to moderate needs children instead of the highest needs children, like children at risk of out-of-home care or children returning from residential treatment centers. This problem of failing to direct intensive services to children with high needs has in large part been created by the State, which has not set appropriate expectations. The emphasis is on providing units of service instead of ensuring that children are actually getting the services they need and that positive outcomes are being produced.

10. Instead of creating mechanisms to ensure that the needs of complex children are met, the State has spent a lot of energy on developing processes for identifying children with high needs. But, in my experience, our system has always had consensus on identifying our highest needs children; they are easily identified by providers and other child-serving systems like school, juvenile justice, and child welfare. What our system

has struggled with – and what the State has not adequately addressed – is how to competently serve these children once we identify them.

11. Finally, I do not believe that the State has engaged in sufficient efforts to keep children with high needs from entering out-of-home care. Early in the *J.K.* implementation effort, the system worked hard on returning children home from restrictive, congregate settings to the community. But the work was not sustained, and the number of children in out-of-home care increased after those initial efforts. There have been other initiatives over the years, but there has been no sustained effort to return children from out-of home care, and more importantly, to keep children from going into out-of-home care in the first place. When I left Southwest Network about 18 months ago, the State had more children system-wide in out-of-home care than it did in the early years of the *J.K.* implementation effort. This could have been prevented with appropriate, timely interventions.

12. The system does a poor job in providing services where and when families need them. Due to the inflexibility of providers and the lack of capacity of individualized direct supports, oftentimes families' situations deteriorate while waiting for services. By the time a plan and services are in place, the child has already entered out-of-home care.

13. Another problem is that the networks and private providers have never been financially at risk for the cost of out-of-home care. As a result, community-based providers have no financial incentive to keep children in the community. Money does not follow the child in the system. The provider is not required to pay for the out-of-home care, and the provider keeps the money it had been spending to serve the child.

Moreover, if a provider returns a child from residential care to the child's home, the provider does not get additional money. Because of the financial incentives in our system, and the fact that out-of-home care providers have not been required to abide by the *J.K.* Principles,[2] too many children are placed in expensive institutional care and children stay in such care longer than necessary.

Children Age 18-21 Years Old

14. Second, the system is not serving class members who are 18 to 21 years old according to the *J.K.* Principles. Children age 18 to 21 continue to be denied medically necessary services.

15. When children turn 18, they lose their child and family teams and services provided by the children's system. The majority of the children in the *J.K.* class do not meet the eligibility criteria for "seriously mentally ill" (SMI) in the adult system and hence get little to no services from the adult system. The children who are determined to be SMI get some services from the adult system, but these children are routinely denied services required by the *J.K.* Principles. There is no process that allows children's providers to stay involved once the child turns 18 years old, and there is no meaningful collaboration between the adult and children's systems.

16. The issues with this population have been raised again and again over the last eight years, but it is only in the last year that the State has focused any attention on this

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[2] The State has not taken leadership in training out-of-home providers or holding them accountable for practicing according to the Principles.

population. The State has a few small contracts focused on allowing children's providers to continue serving 18 to 21 year olds. But this work is in its infancy, and the necessary structural changes to support this system-wide have not been made.

17. The State has developed a policy document on serving children 18 to 21 years old. The policy document is good, but the State has done little to ensure that the policy is followed and, for the most part, it is not being followed because of a variety of structural and other barriers that the State needs to address.

Substance Abuse Services

18. Third, the State is not meeting the substance abuse needs of class members. The number of children in the system with substance abuse issues is high, but very few providers have received training or technical assistance in how to identify and address those needs. My experience is that when substance abuse issues are raised for children with mental health needs, providers focus exclusively on the behavioral health problem rather than also addressing substance abuse needs directly. As a result, there is rarely an appropriate response when children have significant substance abuse needs. Among other things, the State must set appropriate expectations in this area and there must be more training for providers on substance abuse issues in children.

19. There are very few substance abuse services available to children, and virtually no community-based programs focused on substance abuse. In the first few years of *J.K.* implementation, a couple of small community-based substance abuse programs were developed and implemented, and they led to very good outcomes for the children they served. But those programs had very limited capacity, and I am not aware of any other

more recent development of similar community-based substance abuse programs. The limited substance abuse programs that do exist do not provide services according to the Principles. Moreover, because the State does not have a working QM system, *see infra* at ¶¶ 20-28, it is unable to collect and analyze data about how the system is doing in meeting the substance abuse needs of class members.

Quality Management System

20. Fourth, Defendants have not developed a QM system that can measure whether services are provided to class members consistent with the *J.K.* Principles. *See* Settlement Agreement ¶ 55. Nor has the State yet implemented an adequate in-depth case review process. *Id.*

21. An effective QM system must be able to measure whether children are receiving the services they need, whether services are timely provided, and whether services are having the desired impact. In addition, an effective QM system must be able to identify providers' strengths and weaknesses and address identified problems, resulting in improved performance when interventions are put into place. Finally, an effective QM system should be used to reward providers who meet expectations and penalize those who, despite receiving technical assistance, continue to fall short of expectations.

22. The State lacks an effective QM system. First, the State's QM system does not focus on whether services are adequate to meet children's needs or whether services are achieving desired outcomes for children. The State primarily monitors units of services – for example, whether a prescribed percentage of children have child and family teams. Even in this realm, it does a poor job. When I was the clinical director at Southwest

Network, the State's QM reviews would show that the vast majority of children served by some providers in our network had child and family teams. But subsequent reviews found that many of those "child and family teams" lacked necessary team members and that the teams were not achieving positive outcomes. Understandably, families were dissatisfied. Similarly, the State's monitoring of intensive case management has focused primarily on whether the networks have a designated number of case managers, not on the adequacy of the case management services being provided. Moreover, although the State has created policy documents that address the adequacy or quality of services, such as the State's policy document on therapeutic foster care, the State has never monitored whether providers are following these policies. The focus on quantity has undermined the purpose of QM reviews, which is to improve the quality and effectiveness of services.

23. Second, the State lacks an in-depth case review process that measures whether providers are practicing according to the *J.K.* Principles. Among other things, the State's review processes have not adequately examined whether providers are meeting the obligation to design and implement services to achieve the *J.K.* functional outcomes. Moreover, the State has not utilized the data from reviews to improve practice.

24. Early in the implementation of the Settlement Agreement, the community in Maricopa County came together to design and implement an in-depth case review process, known as the "Maricopa County review process." The review included interviews of key individuals, including the family, case manager, and individuals from other involved agencies (e.g., probation officer or child welfare workers), and a paper review of the child's file. The review focused on whether the child and family team had

adequately identified the child's strengths and needs, had developed a treatment plan that built on strengths and adequately addressed the needs, and whether the plan was leading to positive outcomes for the child.

25. In 2007, the State mandated that a new review tool, the Wraparound Fidelity Index (WFI), be implemented statewide, and the Maricopa County review tool was abandoned. In my opinion, the State's implementation of the WFI moved us away from focusing on quality and outcomes. The WFI measures fidelity to a process, not whether children's needs are being adequately identified and met. Providers who went through the "ritual" of the child and family team process but who nonetheless failed to deliver needed services could do well on the WFI. Moreover, the State did not utilize the results to improve performance.

26. In both of the review processes that have been implemented thus far, there has been no standardization about how the review scores would be used to improve providers' quality of services. In most cases, the State or the Regional Behavioral Health Authority (RBHA) would communicate a score to a provider without explaining what that score meant or how the provider could use the information from the review to improve their services. Also, in both review processes, there was low inter-rater reliability among reviewers and minimal technical assistance and coaching given to providers between the reviews.

27. I understand that the State has recently decided to abandon the WFI and move to yet another practice review approach. It will take time, and sustained effort, for the State to design and implement another practice review – including training reviewers,

determining how many cases to review and at what providers, and developing a process for using the reviews to assist providers in improving their services. The State never made a sustained effort to train and coach reviewers when implementing the previous review processes. Doing so will be essential to ensuring confidence in the new review process. Moreover, the State must use the data generated by the process to improve the system's performance. The State's failure to use data to improve performance has been a disappointing part of all the previous review processes. I believe that using data to improve performance is key to the success of whatever review process the State uses.

28. QM reviews are a means to an end – better practice – not an end in and of themselves. In many of the agencies at which I have worked, we analyze and synthesize data we collect from qualitative reviews. We use the data to identify where our staff are performing well and areas where they need additional training, support, and supervision to deliver services according to the Principles. We utilize the data to ensure that the measures we take to improve performance are having the desired effect. The State should similarly be using data from its QM reviews to improve performance and ensure that services are being delivered according to the Principles.

29. The State does not use its QM system to incentivize good performance. The State continues to distribute money to the same providers, in the same way, no matter how providers have performed on reviews. Eight years into implementation, I would have expected the State to have implemented a meaningful system for ensuring that providers are held accountable for delivering services according to the Principles.

Training

30. Finally, Defendants have not developed the training system required by the Settlement Agreement – that is, one that ensures that front-line staff and supervisors have sufficient skills to provide services according to the Principles. Settlement at ¶ 34.

31. The State has spent a lot of time and money on training but the training has not been effective. Most of the training has been in the classroom and focused on values and a theoretical orientation to the system. Practitioners often leave these trainings excited but they are not subsequently given the hands-on coaching and mentoring they need to learn necessary skills. There has not been enough training for supervisors and agency leadership, which is essential to ensuring that front-line practitioners deliver services as required by the Principles. Moreover, the State has never developed a system for measuring the competencies of practitioners. As a result, the quality of practice has become uneven at best, and gotten worse in many circumstances, as capacity has grown.

32. Adding to the problem is that the State has not developed a statewide training curriculum. Currently, each RBHA and, in Maricopa County, each network of providers within the RBHA, has developed its own training. Some agency's trainings are quite good. Others are extremely poor; for example, some agencies provide new case managers with only a minimal number of hours of training and coaching, which is plainly insufficient. (In contrast, Southwest Network during my tenure had an expansive training curriculum for case managers that included several days of classroom training, in the field coaching, and continuing supervision when they needed it, where they needed it.) I believe that if the State set clear expectations for training, it would go a long way to ensuring that services are provided according to the Principles.

33. Another problem with the State's training is that there are not enough qualified trainers and coaches in the system. Initially, the State relied heavily on outside trainers and coaches. It did not focus on building expertise within the State, and still has not devoted sufficient efforts to develop internal expertise. Now that the outsiders have left, many of the trainers and coaches lack adequate experience and expertise. With that being said, there are good practitioners in the system, and with sustained support and guidance from the State, I believe an adequate training program could be developed.

Impact on Children

34. The State's failure to comply with the *J.K.* Settlement Agreement is having a significant impact on children and their families. It is disappointing that eight years into implementation, many class members are being denied the services they need for their conditions to improve. And in many of the instances where I have seen children, particularly children with high needs, served well, it is because individual practitioners have made extraordinary efforts to overcome the barriers in our system to good care.

35. Sadly, I can think of many children with whom I have worked whose needs have not been met. They have not been served as required by the Settlement Agreement. The cases I describe below are representative of these children and of the all too many children who today are served badly by the behavioral health system.[3] Unfortunately, the failures that are reflected in these cases, including obvious departures from the *J.K.*

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[3] I have changed the names of the individual children described below to protect their privacy.

Principles and State policies meant to implement them, are failures that occur repeatedly in our system, to the great detriment of children and their families.

PARAGRAPHS 36 THROUGH 56 FILED UNDER SEAL

Conclusion

57. In my opinion, Arizona's behavioral health system fails to deliver medically necessary services to *J.K.* class members, with tragic consequences like those I describe for the children above. I do not believe that the State has moved "as quickly as practicable to develop a Title XIX behavioral health system that delivers services according the Principles." Settlement Agreement ¶ 15.

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 Arizona that the foregoing is true and correct.

Executed this ______day of ___________, 2009 in ______________________________.

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MATTHEW PIERCE

EXHIBIT 4

DECLARATION OF MICHAEL TERKELTAUB

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

1. I have more than twenty years experience developing, implementing and operating systems that provide community-based services to children with mental health, emotional and behavioral needs. Since 2002, I have been the Executive Director of Triad Training and Consulting Services, where I have worked with more than a dozen communities in developing and implementing community-based services for children with mental health needs. Much of my work focuses on developing community-based alternatives to out-of-home care – including direct supports, therapeutic foster care, and respite – as well as system approaches to reducing the need for out-of-home care. I also train behavioral health staff on the provision of community-based services for children with mental health, emotional and behavioral health needs.

2. Since 1999, I have consulted with Arizona's children's mental health system in a variety of capacities. In 1999, I was part of the implementation team for Value Options (VO), a private managed care organization, when it took over as the Regional Behavioral Health Authority (RBHA) for Maricopa County. In 2001 and 2002, I consulted on initial implementation work around the *J.K.* Settlement Agreement, focusing on increasing community-based services. From 2004 to 2006, I served as the Executive Director of Children's Behavioral Health Services for Value Options. In this position, I oversaw all of VO's children's services, including implementation of the *J.K.* Settlement Agreement at VO. A major focus on my work was to increase community-based services and reduce

the need for out-of-home placements. Since 2007, I have worked as a consultant on a variety of matters with Child and Family Support Services (CFSS), a well-respected provider of direct support services. In 2007 and 2008, I worked with CFSS on the Meet Me Where I am Campaign, which focused on expanding direct support services, and on the Bring Our Children Home Campaign, where Southwest Network and CFSS brought back to the community several of the system's highest needs children who had been placed long-term in psychiatric hospitals. For the last two years, I have consulted with CFSS in developing plans for children with particularly complex needs, and for the last eight months, I have served as the leader of a team from CFSS developing community mental health clinics in Flagstaff and Prescott Valley, Arizona.

3. From 1998 to 2002, I worked as the Administrator and Director of Program Development at First Home Care/Alternative Behavioral Services, a national community-based organization providing services in eight states, Puerto Rico, and Washington, D.C. In this position, I developed a range of community-based services (including therapeutic foster care, direct support services, mentoring services and after school programs) and managed all operational aspects of our programs. From 1995 to 1998, I served as the Comprehensive Services Act Coordinator for the City of Hampton, Virginia, where I directed a multi-agency collaborative that included social services, juvenile justice, mental health, schools, health, private agencies and family representatives. The system created through this project is considered a model for serving complex children and has resulted in the City of Hampton having no children in residential treatment centers or group homes. From 1991 to 1995, I was the Director of Home-Based Services at the

Barry Robinson Center in Norfolk, Virginia, and from 1987 to 1991, I was the Child Care Coordinator and Recreational Director at the Jewish Child Care Association/Youth Resident Center in New York, New York.

4. The *J.K.* Settlement Agreement requires Arizona to develop and operate a children's behavioral health system that delivers medically necessary services according to the *J.K.* Principles. I do not believe that the State has yet developed a system that delivers services according to the Principles. In addition, the State has not "moved as quickly as practicable" to develop such a system.

Quality Management System

5. First, Defendants have not developed a QM system that can measure whether services are provided to class members consistent with the Principles. *See* Settlement Agreement ¶ 55. In my opinion, the State's QM system is one of the biggest failures in its implementation of the Settlement Agreement and is a major barrier to its ability to provide children with the services they need for their mental health conditions to improve.

6. A working QM system must be able to measure that services are delivered according to the Principles, including whether services are leading to the functional outcomes identified in the Settlement Agreement, such as achieving success in school, living with their families, avoiding delinquency, and becoming stable and productive adults. In addition, a working QM system identifies problems, puts in place interventions, and measures whether the interventions are leading to sustained improvements. Finally, a working QM system must be transparent. Information from it

must be accessible to the entire community so families can make informed choices about which agencies serve their children. It is surprising, and disappointing, that eight years after the *J.K.* Settlement Agreement, the State does not have a QM system that can measure whether services are delivered according to the Principles, evaluate whether services are having the desired impact on children in terms of functional outcomes, or drive sustained improvement in the delivery of services.

7. The Settlement Agreement specifically requires the State to develop and implement, as an integral part of its QM system, an in-depth review of a sample of individual children's cases, including interviews with key individuals such as the family and child, case manager, foster family, and child welfare worker. Settlement Agreement at ¶ 55. When I first began working in Arizona, the State was relying on a review process that did not meet the requirements of the Agreement and that was consistently giving providers positive results that were not supported by outcome data. Only paper was reviewed; no interviews were conducted, and no outcome data was collected. In my opinion, that process did not produce useful information that could be used to improve services.

8. When I became Director of Children's Services at VO in 2004, my staff and I, in collaboration with stakeholders, focused on developing the in-depth review process required by the Settlement Agreement. The review process which we developed, known as the "Maricopa County practice review," gathered information through interviews of the child, family, case managers, and staff from other child-serving systems such as child welfare, juvenile justice, and education, as well as through a review of case files. The

interview team included one clinical professional and an individual whose child had received services from the system. Also, in implementing the Maricopa County practice reviews, we worked hard to ensure that the review process was transparent to the community and was not just an internal process for VO.

9. During the 18 months or so that we were allowed to implement this practice review process, we collected a lot of useful data, which we used to give immediate feedback to providers to improve their services. While some providers got low scores on this review, it was my opinion, and the opinion of many other stakeholders, that those scores were an accurate reflection of the quality of those providers' service delivery. We were able to use the information from the reviews to identify providers' strengths and weaknesses, develop strategies together with the provider to address weaknesses, and then monitor to ensure sustained improvement. There was huge buy-in to this review process in the community, including by families and providers. The reviews were seen as a collective effort, and they gathered momentum around Maricopa County.

10. During the initial stages of development and implementation of the Maricopa County review, the State gave me a huge amount of pushback. What became clear to me at that time is that leadership in the State was not committed to a meaningful review process. At one point, I was specifically told by the State to stop developing and implementing the Maricopa County practice review. I understand that soon after I had left my job as Director of Children's Behavioral Health Services at VO, a wide range of stakeholders, including family organizations, plaintiffs' counsel, and providers, tried to encourage the State to adopt the Maricopa County practice review statewide. Not only

did the State refuse to expand this review practice statewide, but it stopped the review process in Maricopa County.

11. I continue to believe in effectiveness of the Maricopa County practice review. It is an extremely useful tool for measuring fidelity to the Principles and whether services are leading to positive outcomes for children. It also is a review process that is effective because it facilitates community participation. Several other communities in which I have consulted have adopted and use this review process with great success.

12. After the Maricopa County Review process was abandoned, the State began to use the Wraparound Fidelity Index (WFI). As I understand, the WFI has now been abandoned for yet another review tool – the System of Care Practice Review (SOCPR). Because the State has repeatedly changed the review tools it employs and the data it collects, it is hamstrung in evaluating how much and in what ways the behavioral health system has improved over time.

13. Another deficiency in the State's QM system is that it is not used to hold providers accountable for their performance. The State does not use data from the QM system to incentivize good performance or consequence bad performance. Moreover, the State does not even evaluate whether providers are complying with many of the expectations that the State has developed. For example, the State has developed a series of policy documents that set forth expectations on a variety of issues, including serving transition age youth, youth with substance abuse issues, and youth who have experienced trauma or abuse. The State does not monitor whether the expectations in these policy documents are being followed, and as a result, practice in these areas has not significantly changed.

Children with High Needs

14. Second, the State is failing to meet the needs of the children in the *J.K.* class with the highest and most complex needs. Eight years into implementation of the Settlement Agreement, I would expect very few kids to be in out-of-home care, particularly residential treatment centers, group homes, and other congregate care. I would expect to see a very strong community-based system of care, where virtually all children are served in their own homes or other permanent family environments. Unfortunately, this is not what Arizona's system looks like today.

15. In the early years of *J.K.* implementation, the State and Regional Behavioral Health Authorities (RBHAs) implemented a few initiatives aimed at getting children out of congregate care and back into the community. While these initiatives were successful in the short term, there was no sustained effort to keep children in the community and out of congregate care. As a result, after each of these initiatives ended, the number of children in congregate care crept up again. According to the State's most recent publicly available data, the State still spends an inordinate percentage of its children's mental health budget on these congregate placements.

16. In Arizona, I have seen excellent services provided to some high needs children, including those children who were returned to the community from congregate care through the Meet Me Where I am Campaign. But the behavioral health system does not have the infrastructure in place to consistently deliver medically necessary services to high needs children.

17. Many children are still ending up in out-of-home care because there is a lack of intensive community-based services to meet their needs. In 2004, I was part of an effort to significantly expand case management, direct supports, and therapeutic foster care. While we made some good progress in expanding services, the rest of the job has not been done. Among other things, the State has never made a serious commitment to move money from congregate care to intensive community based services. And the State has not addressed the financial incentives that lead to many children needlessly ending up in congregate care: that providers are not responsible for congregate care costs, so they have no real financial incentive to serve children with complex needs in the community.

18. Over the last several years, I have seen therapeutic foster care (TFC) become another form of unnecessary out-of-home care for many children. TFC is designed as a short-term intervention for high needs children who cannot be served in their own homes, even with intensive community-based services. But in Arizona, children are oftentimes placed in TFC in lieu of providing them intensive community-based services. There are many children currently in TFC who could be living with their own families if they received intensive community-based services. Other children currently in TFC do not currently have high needs, and TFC is used as "supersized" foster care for these children. Some TFC providers will not work with children with the highest needs who require TFC to avoid entering congregate care. Adding to the problem is that the quality of TFC is uneven and services are often not delivered consistent with the *J.K.* Principles.

19. Case management is essential to serving children with high needs. The lack of quality case management in the system is another major reason why the system continues to fail to meet these children's needs.

20. When I first came to Arizona, its case management system was far weaker than that of any other system that I had seen. Case managers had high caseloads – about three or four times what is clinically acceptable – and the skill sets of its case managers were very weak. While there certainly has been some improvement in case management, there has not been enough improvement. After eight years of implementation, I would expect case managers to be well-trained and to have clear expectations for their work. I would also expect there to be enough case managers to adequately serve children with high needs. This not yet the case in Arizona, unfortunately.

21. The State's recent focus on intensive case management for high needs children is a good start, but there still are not enough intensive case managers in the state. Also, in my experience, the quality of the intensive case management is uneven and, in many areas, downright poor. Many of the intensive case managers are new, and they are not being given enough training, especially hands-on training and supervision, to learn the skills necessary for their work. They are not adept at working across systems, which is essential to serving high needs children. Moreover, the State has not yet set clear expectations for intensive case managers and has not yet developed a process to evaluate their competencies.

22. The under-identification of substance abuse issues and the lack of substance abuse services in general is another barrier to adequately serving children with high needs.

Practitioners in the system are not trained to identify and address substance abuse issues, and as a result, children's substance abuse needs are often unidentified. Even when needs are identified, they are not met. There is not enough substance abuse services in the system, and the services that do exist are not consistently providing services according to the *J.K.* Principles.

Training

23. Third, Defendants have not developed the training system required by the Settlement Agreement – that is, one that ensures that front-line staff and supervisors have sufficient skills to provide services according to the Principles. Settlement at ¶ 34.

24. The State has spent a lot of money on training, but not to good effect. The State's training curriculum has focused on teaching "values," rather than necessary skills. It has primarily been classroom training and there has not been enough hands-on opportunities to learn skills through coaching, mentoring, and supervision. And often the classroom training that does exist goes awry. When I recently trained to be a clinical liaison, for example, the curriculum used language that was not respectful of families and did not encourage practice according to the *J.K.* Principles.

25. The State's training has not addressed all levels within the system. There has not been enough training for supervisors, who must have the skills and knowledge to help support front-line staff. There has been virtually no training for clinical management and executive leadership of the provider agencies. The State also has not created a sustainable training system. It has relied heavily on outside trainers and has created very little internal expertise within the system. The few good internal coaches within the

system are often marginalized because the lack of buy-in from agency leadership. They also are hampered by the lack of a working QM system on which they can rely for data regarding performance.

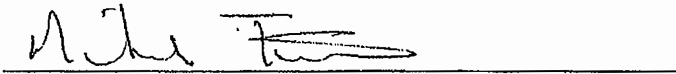
Children Aged 18-21

26. Finally, the system is not serving class members who are 18 to 21 years old according to the Principles. In my experience, serving 18 to 21 year olds has never been a priority or focus for the State. When class members enter the adult system, they are served badly. They lose their child and family teams and the services being provided by the children's mental health system, and they are denied needed services by the adult system. Of particular concern to me are some vulnerable subsets, including foster children with mental health needs who are not considered "seriously mentally ill" by the adult system and children with mental health needs aging out of the juvenile justice system. In part because it does not have a working QM system, the State has not focused on how badly it is serving this vulnerable population of transition-age youth.

Conclusion

27. In my opinion, Arizona's behavioral health system fails to deliver medically necessary services to *J.K.* class members. I do not believe that the State has moved "as quickly as practicable to develop a Title XIX behavioral health system that delivers services according the Principles," as required by Paragraph 15 of the Settlement Agreement.

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 Arizona that the foregoing is true and correct. Executed this 14th day of October 2009 in Phoenix Arizona.



Michael Terkeltaub

EXHIBIT 5

DECLARATION OF LINDA HUFF REDMAN, Ph.D.

I, Linda Huff Redman, Ph.D., declare that, if called as a witness, I could and would competently testify as follows:

A. Qualifications and Summary of Opinions

1. I have over twenty years experience in Medicaid and healthcare policy, and a substantial portion of my work has involved reforming Arizona's behavioral health system.

2. From 1984 to 1988, I served as a special assistant to the Arizona State Senate President and as a research analyst for the Senate Health and Welfare Committee, where I helped establish the Division of Behavioral Health Services ("DBHS") within the Arizona Department of Health Services. From 1988 to 1993, I was the Executive Administrator of the Office of Policy and Intergovernmental Relations in Arizona's Medicaid Agency, the Arizona Health Care Cost Containment System Administration ("AHCCCS"), and from 1993 to 1996, I served as the Deputy Director of AHCCCS. While at AHCCCS, and later as a consultant to the State of Arizona, I directed the implementation of Arizona's Medicaid managed care behavioral health program, including integrating the children's behavioral health program into a managed care model. Since 1996, I have been a consultant, advising public and private agencies on a broad range of healthcare related issues.

3. I have a particular expertise in healthcare quality management ("QM"). As the Deputy Director of AHCCCS, I oversaw the statewide Medicaid managed care operations, including QM, and I helped the agency develop its QM performance

measures. As a consultant, I worked with the State of Arizona on QM matters. In 2006, I conducted an assessment of DBHS' QM system, including a paper review of all QM documents and interviews with key QM personnel and leadership, and provided DBHS with recommendations for improving their QM system. I also have worked for several years with a private Medicaid HMO company in Arizona in the design and implementation of their QM systems for different state Medicaid programs, and I have consulted with external quality review organizations that conduct independent assessments of state Medicaid managed care contractors, including their QM systems.

4. I also have served as an expert witness in several cases. I filed an expert declaration in *Katie A. v. Bonta* in federal court in California about Medicaid coverage for intensive community-based services for children with mental health needs. I served as an expert witness for the State of California in *CalOptima v. Molina Medical Center*. I testified in a Medicare Appeal (Arizona Medicare DSH Group Appeal) before the Provider Reimbursement Review Board as an expert on AHCCCS Administration.

5. My curriculum vita is attached as Exhibit 1.

6. I was asked by Plaintiffs to review DBHS' QM system. In forming my opinion, I reviewed QM materials available on DBHS' and AHCCCS' websites, including DBHS' recent QM Plans, QM Evaluations, federally-mandated External Quality Review ("EQR") reports, System of Care Plans, Children's System of Care Performance Improvement Reports, Structural Elements and Functional Outcomes reports, member satisfaction survey results, Performance Improvement Specifications Manual, DBHS' logic model, and the QM sections of DBHS' contract with several RBHAs. I also

reviewed a recent external independent assessment of DBHS' QM system conducted by the Health Services Advisory Group ("HSAG") in February 2009, a recent performance audit of DBHS' substance abuse programs by the Arizona Office of the Auditor General in July 2009, and correspondence over the last several years between Plaintiffs and Defendants regarding their QM system. In addition, I have prior familiarity with DBHS' QM system from my 2006 evaluation of the QM system as a consultant to the State, my tenure at AHCCCS, and my five years' consulting with DBHS.

7. In my expert opinion, there are significant deficiencies in DBHS' QM system, including in monitoring and measuring implementation of the *J.K.* Settlement Agreement. First, DBHS has not prioritized or assured the reliability of measures it claims evaluate compliance with the Settlement Agreement. Second, DBHS has not used the data it collects to improve practice. Third, DBHS is unable to examine data trends over time to identify problems because it has repeatedly changed the measures it collects, the intervals for which it reports the measures, and the QM tools it employs. Finally, DBHS' lack of leadership, lack of staff with QM expertise, and lack of a culture focused on improvement are serious weaknesses in its QM system. In addition to my own review identifying these deficiencies, they also have been identified in two recent independent evaluations of DBHS.

8. In my opinion, DBHS has failed to "change their quality management and improvement system so that it measures whether services to class members are consistent with and designed to achieve the Principles" in the Settlement Agreement. *J.K.* Settlement Agreement, at ¶ 55

B. Critical Components of a QM System

9. A functioning QM system is essential for ensuring that Medicaid-eligible children receive medically necessary behavioral health services. To work effectively, a QM system must identify measurements that reflect desired program outcomes and goals. It then must collect and analyze data to identify where established program outcomes and goals are being met and where there are areas of needed improvement. Finally, it must ensure that identified problems are addressed and that improvements are sustained over time.

10. To be successful, a QM system must have effective leadership; an organizational culture focused on quality improvement; data integrity; the ability to collect and analyze individual client-level and aggregate data; user-friendly reports; consumer, family and other advocate involvement; and provider collaboration. It must also incentivize good performance, for example, by public recognition of good providers and/or financial rewards, and consequence poor performance, such as considering performance in renewing contracts. See Feb. 2009 *Arizona Department of Health Services, Division of Behavioral Health Services: Independent Assessment* by Health Services Advisory Group ("HSAG Report") at 3-1; March 2007 *Promising Practices in Behavioral Health Quality Improvement: Summary of Key Findings and Lessons Learned* by Center for Health Policy and Research ("CHPR Report") at 37.

C. Deficiencies in DBHS' QM System

11. I have reviewed DBHS' QM system, and in my expert opinion, it has significant deficiencies, particularly when it comes to reviewing and measuring compliance with the

Settlement Agreement. DBHS has created a lot of QM policies, plans, and reports, and based on this, one might be left with the misimpression that DBHS has an adequate QM system in place. However, when I looked behind the paper and examined DBHS' actual practices, I found significant deficiencies in the QM system. My findings are confirmed by two recent independent evaluations of DBHS – a February 2007 independent assessment of DBHS' QM system by HSAG ("HSAG Report") and a July 2009 performance audit of DBHS' Substance Abuse Treatment Program by the Arizona Office of the Auditor General ("Auditor General's Report"), as well as federally-mandated external quality annual reviews of DBHS' QM system, ("EQR reports") in 2004 and 2007.

i. Failure to Measure Compliance with the Settlement Agreement

12. DBHS collects a lot of information about its service delivery system, in fact, too much. But it does not collect the information it needs to evaluate compliance with the *J.K.* Settlement Agreement or to effectively identify actions needed to improve compliance.

13. Two recent independent assessments criticize DBHS for failing to identify data needed to advance agency goals and to use that data to improve performance. The HSAG Report states:

> By its own admission, ADHS/DBHS has an enormous amount of data, but not what it considers useful information. Leaders do not feel they have the "dashboard-type" of information needed on a real time basis to use in decision-making or to look for answers/explanations regarding the system's performance

> and outcomes. The data are not readily organized and routinely analyzed, and DBHS does not have "critical indicators," or an early warning system, to identify the need for rapid or timely improvement interventions.

HSAG Report at 3-4. Similarly, the Auditor General's Report recommends that DBHS reconfigure the data on substance abuse that it collects. Auditor General's Report at 32. . HSAG specifically recommended to DBHS that it identify and use a set of core set of performance measures to support the Division's goals and priorities. *Id.* at 4-4. In my 2006 review of DBHS' QM system, I similarly recommended to DBHS that it create and use a set of core data to monitor and improve performance. It does not appear that DBHS has implemented these recommendations, including with respect to compliance with the *J.K.* Settlement Agreement.

14. DBHS does not have a QM system that measures whether services to class members are consistent with and designed to achieve the Settlement Agreement. A key aspect of the Settlement Agreement is that services be designed to achieve specific outcomes for children, such as succeeding in school, staying out of trouble with the law, and maintaining stable living situations. However, the QM system does not collect information that allows it to adequately monitor and evaluate these *J.K.* outcomes. Most measures that the QM system uses relate to process, not outcomes. The Auditor General's Report made a similar observation:

> [The] Division monitors process, not treatment outcomes—The Division's oversight of the behavioral health treatment system is limited to a number of process measures and is not focused on treatment results. . . . [The QM] measures

> . . . provide information that is relevant to assessing whether consumers receive services, but they do not provide meaningful insight as to whether consumers are reducing their dependence on drugs and alcohol.

Auditor General's Report at 32.

15. While DBHS does use some measures that are related to the Settlement Agreement, those measures are often incomplete or inadequate. For example, one of the outcomes in the *J.K.* Settlement Agreement is that children will achieve success in school. DBHS contends that it is measuring this outcome by collecting data regarding whether a child is enrolled in school, instead they should be using data to measure how the child is doing in school. For *J.K.* outcomes regarding stability and avoiding crises, DBHS appears to be relying on measures that merely examine where the child is residing. DBHS is not using more meaningful measures of stability and avoiding crises, such as whether the child has visited the emergency room, needed psychiatric hospitalization, or used crisis services.

16. I also have concerns about the reliability of data that DBHS collects, including with respect to the Settlement Agreement. Reliability of data is obviously essential to a working QM system. The recent independent evaluation of DBHS' QM system by HSAG identified as significant problems: unreliable data, a failure to ensure the accuracy of data it collects from RBHAs, and a lack of stakeholder confidence in the data. HSAG Report at 3-8, 3-9, and 3-12. I similarly raised concerns about the reliability of data with DBHS in my 2006 review of its QM system.

ii. DHBS Does Not Use the Data It Collects to Improve Performance

17. Another major deficiency in DBHS' QM system is that it does not effectively use the data it collects to improve performance. Such improvement occurs when data collected is analyzed, problems are identified, interventions are put in place to address those problems, interventions are monitored for their effectiveness, and further action is taken if interventions are not working.

18. DBHS' QM system collects data but does not effectively use data to improve performance. While DBHS has sometimes imposed corrective action plans when problems are identified, it does not appear to be monitoring implementation of those plans and ensuring that they are having the desired impact. For example, RBHAs have been repeatedly performing poorly on the measure "appropriateness of services." The minimum performance standard for this measure was not met for children in FY 2007-08; DBHS claims that it provided technical assistance to RBHAs and began measuring quarterly to address this problem. Quality Management Plan Annual Evaluation, Oct. 1, 2007 – Sept. 30, 2008 at page 1of 10. But the RBHAs' performance on this measure decreased for five of the next six quarters. Quarterly Performance Improvement Report, Children's System of Care, Quarter 3 Fiscal Year 2009 ("Q3 2009 SOC Report"), at 18. It does not appear that DBHS has taken any additional action to address this continuing poor performance.

19. DBHS' failure to effectively use data to improve performance was noted in my 2006 evaluation of DBHS' QM system. I noted that DBHS did not have a process in place to identify areas where improvement was needed, to implement interventions, and

to monitor their impact. Recent evaluations of DBHS have made similar criticisms. A recent federally-mandated external evaluation of DBHS' QM system found that DBHS was not adequately overseeing implementation of corrective action plans to ensure improvement and that it was not using data to make decisions. 2004 EQR Report at IV-10; see also 2007 EQR Report at V-10. Similarly, the Auditor General's Report found that DBHS was not using data to evaluate provider performance, had no established benchmarks for clinical performance or outcome goals, and did not incentivize good performance or penalize poor performance. Auditor's Report at 33-34.

20. DBHS has delegated most of the responsibility for collecting data and monitoring compliance, including implementation of corrective action plans, to RBHAs. DBHS does not appear to be giving adequate guidance to RBHAs on QM matters, nor is DBHS ensuring that RBHAs are actually following through on implementation of corrective action plans. This is, in my opinion, a major reason why DBHS' QM system is so ineffective. Throughout the Auditor General's Report, it notes the need for DBHS to give additional guidance to RBHAs and to monitor RBHAs' compliance with their QM obligations. AG's Report, at 32, 41-42. In my review of hundreds of pages of DBHS' QM documents, I found little to no mention of what monitoring DBHS is actually doing of RBHAs' QM systems, including RBHAs' implementation of corrective action plans, or what guidance DBHS is giving to RBHAs about their QM obligations. And although RHBAs' contracts with DBHS require RBHAs to report QM activities and data on their website, I was unable to find any substantive information on their websites.

iii. DBHS Is Unable To Trend Data to Identify Problems Because It Has Repeatedly Changed Performance Measures, Measurement Intervals, and QM Tools

21. Another problem with respect to DBHS' evaluation of its compliance with the Settlement Agreement is that DBHS has repeatedly changed performance measures, measurement intervals, and QM tools. While these changes may have been aimed at improving the QM system, they are nonetheless a problem. In order to identify problems and to ensure continuing improvements in performance, QM systems must use data to establish a baseline and evaluate whether performance is increasing or decreasing over time. To do this, the system must be able to compare data from year to year. DBHS' repeated changes in the performance measures it uses, its measurement reporting intervals, and the QM tools it employs have made trending data reflective of system performance over time very challenging.

22. In my review of Arizona's QM documents related to *J.K.*, I do not see that DBHS is trending data in a meaningful way to identify areas for needed improvement and examine if improvements are being sustained. For example, I reviewed DBHS' data on children in out-of-home placements. The most recent data shows that there was a decrease and then a sharp increase in utilization of out-of-home care over the year. But there is no accompanying analysis that compares utilization to prior years, examines whether these changes in utilization are statistically significant, and determines whether the recent increase in utilization is an area that needs intervention.

iv. DBHS Lacks Leadership, Expertise, and a Data-Driven Culture

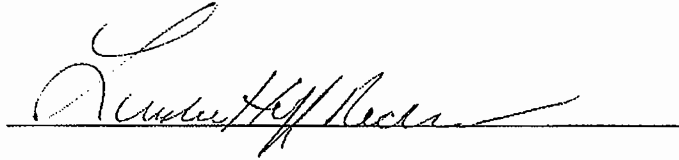
23. Finally, DBHS' lack of leadership, expertise, and data-driven culture impedes it from developing a functioning QM system. A recent evaluation of DBHS' QM system identified the lack of leadership and lack of staff with expertise as serious problems. HSAG Report at 3-2. It found that current QM staff do not have the necessary expertise in research and analysis skills. *Id.* at 3-6. It also found that DBHS lacked the data-driven culture necessary for managing and improving performance; instead, DBHS had a "'crisis of the day' management style." *Id.* at 3-2 – 3-3. When I evaluated DBHS' QM system in 2006, I similarly found a lack of clarity regarding the roles and responsibilities of QM staff and lack of a culture focused on quality improvement. These factors are absolutely necessary to a working QM system.

D. Conclusion

24. In my expert opinion, DBHS has failed to develop a working QM system that can evaluate compliance with the *J.K.* Settlement Agreement. DBHS has failed to "change their quality management and improvement system so that it measures whether services to class members are consistent with and designed to achieve" the Settlement Agreement. *J.K.* Settlement Agreement, *at* ¶ 55. While DBHS has developed a lot of QM policies, plans and reports, when I looked behind the paper, I found significant deficiencies. DBHS's QM system does not adequately collect and use data to evaluate and improve performance, including compliance with the *J.K.* Settlement Agreement.

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 Arizona that the foregoing is true and correct.

Executed this 17 day of Sept, 2009 in Tempe, AZ.



Linda Huff Redman

EXHIBIT 1

Linda Huff Redman, Ph.D.
Management Consultant

Representative Accomplishments

- As a management consultant (1996 to present), Dr. Redman has advised public and private agencies on a broad range of health-care related issues including:
  - Assisting numerous Medicaid programs in the redesign/improvement of their health care delivery systems in the area(s) of physical health, behavioral health and long-term care (including special need populations with physical, mental health or developmental disabilities). Project activities included the evaluation of current delivery systems and operations, focus group facilitations, design of managed care/participant driven systems, analysis of policy issues, development of federal waivers and RFPs, implementation of new programs and development of strategic plans.
  - Working on other Medicaid related-projects such as behavioral health program redesigns as it relates to covered services, intake/assessment processes, reimbursement strategies and data collection and reporting; analysis of delivering non-emergency medical transportation services; implementation of Medicaid reimbursement for school based health-related services; privatization of state eligibility functions; performance reviews of Medicaid health plans; assessment of behavioral health services for juveniles in detention; and development of waiver evaluation plan, behavioral health plan review tool, and administrative program-related rules, policies and intergovernmental agreements.
  - Working with private sector groups on projects such as, developing a new integrated behavioral health provider organization; preparing EQRO plan review reports; resolving issues related to use of seclusion and restraint; designing health care delivery systems for the uninsured population and children eligible under S-CHIP; expanding Medicaid coverage through the use of tobacco settlement dollar; developing a universal health care plan for Arizona; and analyzing eligibility system barriers.
  - Serving as project director for Arizona's $1.16 million dollar federal State Planning Grant (SPG) to develop a plan for providing Arizonans with affordable, accessible health insurance. Included analyzing rural health care infrastructure issues and strategies; conducting a feasibility study and designing a pilot for an employer sponsored insurance program. Also assisted Arizona with submittal of several SPG supplementary grants and Louisiana with submittal of their initial $801,319 SPG grant.

- Assisting health plans in numerous states in development of responses to Medicaid RFPs (including physical health, behavioral health and long term care; managed care, care/disease management and ASO models); implementation of new health plan contracts, preparation of Medicare Special Need Plan applications; and development of health plan documents, e.g., provider manuals (behavioral health and physical), medical management policies, quality management plans and commercial member handbook.

- Serving as an expert witness for CalOptima as it related to its start-up as a Medicaid managed care program (deposition taken but case settled prior to the trial.); the Bazelon Center for Law as it related to behavioral health services for children; a group of Arizona hospitals as it related to a Medicare disproportionate share dispute; and a physician group as it related to a managed care service delivery dispute.

- Conducting an analysis on maximization and effective utilization of key funding sources related to preparing young children for school and a statewide assessment of existing early childhood development and health programs in Arizona.

- Serving as a representative of CMS on the Competitive Pricing Demonstration Project for Medicare; providing technical assistance to the members of the Phoenix Area Advisory Committee.

- Assisting in the Arizona Works RFP process (i.e., privatization of welfare); developing the evaluation manual, evaluating the proposals and participating in contract development.

■ As Deputy Director of the Arizona Health Care Cost Containment System Administration (1993 to 1996) and initially as Executive Administrator for the Office of Policy and Intergovernmental Relations (1988 to 1993), Dr. Redman managed a variety of operations, including:

- Overseeing statewide Medicaid managed care operations including areas of policy development and implementation, strategic planning, intergovernmental relations, fraud and abuse, grievance and appeal, legal analysis, human relations, Indian affairs, the agency's quality management initiative, program budget preparation and monitoring, and capitation and fee-for-service rate setting.

- Directing special projects such as implementation of a Medicaid managed care behavioral health program, competitive bid process for and operational and financial reviews of health plans and long-term care program contractors, member satisfaction survey, hospital reimbursement system and disproportionate share distribution, HCFA waiver submittals

or Medicare/Medicaid dual eligibles, and maximization of federal funds through changes in eligibility determination.

- Providing guidance in the implementation of the following programs/initiatives: streamlining of eligibility process, clinical quality indicators for health plan performance, integration of foster care and children rehabilitative programs into a managed care model, medical policy manual, family planning services expansion, home and community-based transitional program, emergency service program for undocumented aliens, early entry prenatal care initiative, establishment of member fraud unit, and expansion of long term care alternative residential settings.

- As Special Assistant to Senate President, Arizona State Senate (1987 to 1988), and Senate Health and Welfare Committee Research Analyst (1984 to 1987), Dr. Redman was responsible for a wide range of tasks, including:

  - Researching, analyzing and drafting health and social services legislation; and preparing speeches and major issue briefing packets.

  - Serving as lead staff for several significant state initiatives: development of a Title XIX managed care long-term care program; establishment of a behavioral health division as well as a capitated pilot program for persons with serious mental illnesses; and a deinstitutionalization initiative for the developmental disabled.

- As Project Coordinator, Center for Social Analysis, SUNY-Binghamton (1979 to 1981), Dr. Redman conducted two studies - one a needs assessment of aged and the other analyzing the nutritional impact of the Title IIIC nutrition program for the aged. Telephone and face-to-face interviews with seniors were used as the primary data source.

- Dr. Redman also served as College Instructor in Anthropology/Gerontology, SUNY-Binghamton and Broome Community College - 1979 to 1981

Education & Academic Qualifications

SUNY-Binghamton, Binghamton, New York
Doctorate of Philosophy in Anthropology/Human Biology - 1981

SUNY-Binghamton, Binghamton, New York
Master of Arts in Anthropology/Human Biology - 1976

University of Utah, Salt Lake City, Utah
Bachelor of Arts in Anthropology – 1974

Community Activities

- All-Star Kids Tutoring (2008 to present): Tutoring and mentoring of 2nd and 3rd grade students struggling to master basic reading skills.

- QUEST (2004 to present): Serving as mentor for two minority students from a low-income environment to provide support in achieving goal of going to college.

- Board of Trustees of Tempe St Luke's Hospital (2006 - 2008): Serving as a community representative on the Board of Trustees, which is the governing body of the Tempe St. Luke's Hospital.

- Tempe Community Council Board Member (1995 - 2004): This non-profit organization oversees the planning and delivery of health and human services for the City of Tempe. Dr. Redman served on the executive board in the positions of President, Past Board President Member-at-Large, Secretary and Treasurer. Also served as the Co-Chair for the City of Tempe Homeless Study Committee and the Open Horizons Task Force (i.e., day care program for parenting teens).

- Maricopa Association of Governments – Human Services Coordinating Committee Member (2001 - 2004): Served as representative for the City of Tempe on this policy level committee which defines local community problems, including allocation of the federal social service block grant funds.

- The Tempe Governors Board Member (2001 - 2003): A non-profit organization supports agencies delivering health care services to Tempe residents through an annual fundraising event. Dr. Redman served for one year as Treasurer.

- City of Tempe Commission on Disability Concerns Board Member (2000 - 2002): Dr. Redman was appointed by the City of Tempe to serve on this commission whose purpose is to advocate for disability issues and to seek and resolve concerns of persons with disabilities.

Contact Information

Linda Huff Redman, Ph.D.

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E-mail: sashaaaron@aol.com

EXHIBIT 6

DECLARATION OF ERIC BRUNS, Ph.D.

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

Background and Qualifications

1. I am a researcher, a psychologist, and an Associate Professor at the University of Washington School of Medicine, in the Department of Psychiatry and Behavioral Sciences. I am also the Chair of the Board of Advisors for the Research and Training Center on Children's Mental Health at the Florida Mental Health Institute at the University of South Florida.

2. The focus of my research is on evaluating community-based services and supports for children with complex mental health needs and their families, and in particular, the administration of care management through the wraparound process.[1] My research has been funded by, among others, the National Institute of Mental Health (NIMH), the Center for Medicare and Medicaid Services (CMS), and the Substance Abuse Mental Health Services Administration (SAMHSA).

3. I am a founder and the co-coordinator of the National Wraparound Initiative (NWI).

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[1] The behavioral health system in Arizona uses the term "child and family team process" to refer to the process of planning and delivering services through a child and family team. This is the process to which I refer when I use the term "wraparound process."

4. I, along with my colleague John Burchard, developed the Wraparound Fidelity Index (WFI), a measure designed to assess adherence to the wraparound process.

5. I have published more than a dozen books, book chapters, and monographs, and have published over twenty articles in refereed journals. I am regularly asked to make presentations on children's mental health issues. I am on the editorial board or serve as a reviewer for several children's and/or mental health journals. My curriculum vitae, which is attached as Exhibit 1, details my education, professional experience, organizational affiliations, publications and awards.

The Wraparound Fidelity Index (WFI)

6. The Wraparound Fidelity Index (WFI) is a tool designed to measure fidelity to the wraparound process. It is intended to measure, for example, whether families are an active part of planning, whether a strengths and needs assessment was completed, whether natural supports are part of the wraparound team, and whether collaboration between involved agencies (e.g., mental health, child welfare, and juvenile justice) is occurring. It is not a tool designed to measure the adequacy of the behavioral health services provided by the system or the outcomes experienced by children in the system. The WFI was not designed to be applied to all children in the behavioral health system but only to those with complex needs.

7. An effective children's mental health system must provide quality behavioral health services, including good care management (e.g., through a child and family team and intensive case management). It must also have a method for ensuring that interventions are leading to improved outcomes for children.

8. An adequate quality management system must be able to measure, among other things:

a. Fidelity to prescribed processes, such as the wraparound process ;

b. The adequacy of the behavioral health services available in the system; and

c. Outcomes for children receiving services from the system.

It must use this data to improve performance and ensure that children are receiving medically necessary services.

9. The WFI focuses on fidelity to the wraparound process. The WFI is not designed to measure the adequacy of the behavioral health services in a children's behavioral health system or outcomes for children receiving those services.

Work in Arizona

10. In late 2006, I was contacted by Michael Shafer, a professor at Arizona State University. Dr. Shafer told me that as a consultant to the State, he had conducted a review of potential quality management (QM) instruments and was advising use of the WFI as part of their QM system. I was not involved in the State's decision to choose this tool; the State had already made its decision by the time it contacted me.

11. I was retained by the State to train QM staff on administering the WFI. I engaged in approximately six days of training in Arizona.

12. During my visits to Arizona, I raised a number of questions with the State about its implementation of the WFI. When the State informed me that it planned to use the WFI for all children in the behavioral health system, I told them that the WFI was not

originally designed for this purpose and expressed concern about applying the WFI to children with less complex needs. I also raised questions with the State about who would be reviewing the results from the WFI and how the State planned to use the results to help providers improve their performance. My consultation with the State never formally addressed issues of how results would be used to improve services. I did review for the State a version of the WFI for moderate needs youth; however I was not part of implementing this version of the WFI and never saw any data collected from it.

13. In 2007, after initial training of reviewers, the State implemented a small pilot using the WFI, reviewing 29 cases statewide. The State sent me this data. The WFI scores were extremely low, with total scores averaging 61 percent of the total possible score. This score is far below average when compared to a national sample of sites implementing the WFI. The State did not provide any additional data to me after this initial pilot. I was not involved in the State's implementation of the WFI other than the limited role I described above.

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 Arizona that the foregoing is true and correct. Executed this 30 day of October, 2009 in Seattle, Washington.

Eric Bruns, Ph.D.

EXHIBIT 1

Curriculum Vitae
Eric J. Bruns, Ph.D.
University of Washington School of Medicine

Date July 1, 2009

Personal Information

Associate Professor
University of Washington School of Medicine
Department of Psychiatry and Behavioral Sciences
Division of Public Behavioral Health and Justice Policy
2815 Eastlake Ave E, Suite 200
Seattle, WA 98102
206-685-2477 (phone)
206-685-3430 (fax)
ebruns@u.washington.edu

Born: Frankfurt, Germany; March 6, 1968
Citizenship: United States

Education

UNIVERSITY OF VERMONT, Burlington, 1992-1997
Ph.D., Clinical Psychology, 1997
Major areas: Child Clinical/Community Psychology
GEORGETOWN UNIVERSITY Child Development Center, Washington, DC, 1996-97
(Clinical internship)
UNIVERSITY OF VIRGINIA, Charlottesville, 1986-1990
B.A., with high honors, Psychology

Faculty Positions Held

2008-pres.	Associate Professor, Dept. of Psychiatry and Behavioral Sciences Division of Public Behavioral Health and Justice Policy University of Washington School of Medicine, Seattle
2005-2008	Assistant Professor, University of Washington School of Medicine, Seattle
2002-2005	Assistant Professor (tenure track), Department of Psychiatry Division of Child and Adolescent Psychiatry University of Maryland School of Medicine, Baltimore

Other Academic Affiliations

2006-present	Instructor, Certificate Program in Systems of Care and Child Mental Health, Florida Mental Health Institute, University of South Florida, Tampa
2002-2005	Clinical Assistant Professor, Department of Psychology University of Vermont, Burlington
1999-2002	Research Associate, Department of Population and Family Health Sciences, Johns Hopkins University Bloomberg School of Public Health
1999-2001	Instructor, Program in Community Mental Health Trinity College of Vermont/Southern New Hampshire University

Other Employment

1998-2002	Director of Research and Evaluation, Family League of Baltimore City

Fellowships and Honors

Phi Beta Kappa, Beta of Virginia. University of Virginia, 1990.
Ronald Suiter Award for Graduate Research, University of Vermont Graduate College, 1994.
Annual Student Research Award from Division 37 of the American Psychological Association (Child, Youth, and Family Services), 1995.
National Institutes of Health Loan Repayment Fellowship for Clinical Researchers, 2003
Keys for Networking Annual "Kansas Oscar" for work with children and families, 2004
Washington State Department of Health and Human Services (DSHS) Research and Data Analysis Division (RDA) Teamwork Award, 2006

Certifications and Professional Licenses

Psychologist, State of Washington, Number PY00003285, September 2, 2005

Professional Organizations

American Evaluation Association (AEA)
American Psychological Association (APA)
Divisions 37 (Children, Youth, & Family Services) and 53 (Society for Clinical Child and Adolescent Psychology)
Society for Community Research and Action (SCRA)
Society for Prevention Research (SPR)

National/International Service

Editorships

Editor, *Report on Emotional and Behavioral Disorders in Youth,* 2008 – present
Associate Editor, *Journal of Child and Family Studies,* 2008 – present.
Associate Editor, *Journal of Emotional and Behavioral Disorders*, 2000 – present.

Editorial Boards

Editorial Board, Brookes Publishing Co., *Series on Children's Mental Health*, 2008 - present

Regular Reviewer for

Psychiatric Services, Children and Youth Services Review, Journal of School Health, Clinical Psychology Review, Journal of Behavioral Health Services & Research, Health Affairs, many others

National Task Forces and Committees

National Implementation Research Network, Florida Mental Health Institute National Research and Training Center on Children's Mental Health, 2004 – present.
National Child and Family Evidence-Based Practices Consortium (Research Co-Chair), 2004 – present.
National Wraparound Initiative (Co-Director), Research and Training Center for Family Support and Children's Mental Health, Portland State University, 2003 – present.
SAMHSA Center for Mental Health Services National Services Evaluation Committee, 2002 – 2007.
American Public Health Association, Community-Based Public Health Caucus Policy/Advocacy Committee, 2002 – 2006.
Certified expert witness, Federal Court of Maryland, 2004; 9th Circuit Court (California); State Court of Idaho, 2006.

Board Memberships

Florida Mental Health Institute National Research and Training Center on Children's Mental Health, 2004 – present (Board Chair).
National Advisory Board on Parent Empowerment and Family Support (Columbia University, State of New York Office of Mental Health), 2006 – present.
Research Advisory Board for Eastfield Ming Quong, Inc. (Campbell, California), 2007 – present
Baltimore Neighborhood Indicators Alliance, 2000 – 2005.

Research Grants and Contracts (current)

Outcomes of the Wraparound Service Model (Bruns, PI). National Institute of Mental Health (1 R34 MH072759-01A1), 2006 – 2009, $450,000.

Evaluation of the Washington State Mental Health Transformation State Infrastructure Grant (Bruns, PI). Washington State Department of Social and Health Services, 2006 – 2010; $381,000.

Children's Mental Health Evidence-Based Practices Institute (Trupin, PI, Bruns, Co-PI). Washington State Department of Social and Health Services, 2009-2011; $210,000.

Long-Term Outcome Evaluation of King County (WA) Family Treatment Court (Bruns, PI). King County Juvenile Court Services, 2007 – 2010, $129,000.

Project FOCUS: Effective Mental Health Practices for Washington's Foster Children (Trupin, PI). Paul G. Allen Foundation, 2007 – 2009, $420,000.

Research Grants and Contracts (completed)

Wraparound Fidelity Assessment System (Bruns, PI, Rast, Co-I). National Institutes for Mental Health Phase I STTR (1 R41 MH077356-01), 2007-2009, $145,000.

National Wraparound Initiative Planning Grant / Development of Wraparound Process Implementation Guide (Bruns, PI; Walker, Co-PI). American Institutes for Research / SAMHSA Center for Mental Health Services, Child, Adolescent, and Family Branch, 2005 – 2009; $390,000.

National Wraparound Comparison Study (Bruns, PI; Burchard, original PI). ORC Macro, Inc./ SAMHSA Center for Mental Health Services Child, Adolescent, and Family Branch, 2002-2006, $245,000.

Process Evaluation of King County (WA) Family Treatment Court (Bruns and Trupin, Co-PIs). King County Juvenile Court Services, 2005-2006, $43,000.

Maryland Child and Adolescent Community Innovations Institute (Bruns and Pruitt, Co-PIs). Maryland Governor's Office for Children, 2005 – 2007; $497,000.

Community Treatment Alternatives for Children (Zachik, PI; Bruns, Co-PI). Center for Medicare and Medicaid Services (award no. 11-P-92001/3-01), 2003-2006, $100,000.

Maryland Science to Service for Children's Mental Health (Zachik, PI; Bruns, Co-PI). National Institutes for Mental Health/SAMHSA (award no. 1-R24-MH068773-01), 2004-2005, $100,000.

Maryland Single Point of Access Implementation and Evaluation (Bruns, P.I.; Pruitt, Schaeffer, Co-PIs). Maryland Governor's Office of Children, Youth and Families, 2004-2005, $142,000.

Sexual Assault in Maryland: The African American Experience (Weist, PI; Bruns, Co-PI). National Institutes of Justice; 2003-2005, $550,000.

Impact of Wraparound Baltimore (Bruns, PI). Maryland Governor's Office of Children, Youth, and Families and Family League of Baltimore City, 2003-2004, $21,000.

Baltimore After-School Strategy Evaluation (Bruns, PI; Marzke, Co-PI). Baltimore Safe and Sound Campaign, 2002-2004, $154,820.

Baltimore City Data Collaborative (Bruns, PI). Family League of Baltimore City, 2002-2004, $44,300.

Implementation of Evidence-Based Mental Health Treatments in Baltimore Public Schools (Bruns, PI, Weist, Co-PI). Maryland Department of Health and Mental Hygiene/Center for School Mental Health Assistance, 2003, $32,000.

Sexual Assault Needs Assessment Project. (Weist, PI, Bruns, Kinney, Co-PIs). Maryland Department of Health and Mental Hygiene, 2002-2003, $284,000.

Baltimore City Data Collaborative (Bruns, PI). Robert Wood Johnson Foundation/Baltimore Safe and Sound Campaign to Family League of Baltimore City, 2001-2002, $71,800.

Compilation of Geocodable Health and Mental Health Indicators Data (Bruns, PI). Johns Hopkins Urban Health Institute to Family League of Baltimore City, 2001-2002, $25,000.

Youth Resource Mapping Project (Bruns, PI, Whitt, Co-PI). Annie E. Casey Foundation to Family League of Baltimore City, 2001-2002 $81,000.

Longitudinal and geospatial analysis of mental health service utilization patterns in Baltimore (Bruns, PI; McCann, Quiambao, Co-PIs). Baltimore Mental Health Systems, Inc., 2001, $25,000.

Impact of Expanded School Mental Health Centers on School Outcomes and Climate (Bruns, PI). Maryland Department of Health and Mental Hygiene, 2000-2002, three annual subcontracts to Family League of Baltimore City, $37,000 total.

Promising Practices Monograph on Wraparound Services (Kendziora, Bruns, Osher, Co-PIs). Center for Mental Health Services to National TA Partnership for Children's Mental Health/American Institutes of Research, 1998-1999, $82,000 total (Bruns subcontract)

Evaluation of statewide respite care program for children with EBD and their families (Bruns, PI, Burchard, Co-PI). CMHS/Vermont Department of Developmental and Mental Health Services, 1995-1996, $8,000.

Professional Publications

Refereed Journals

1. Bruns, E.J. Burchard, J.D. & Yoe, J.T. (1995). Evaluating the Vermont System of Care: Outcomes associated with community-based wraparound services for children and adolescents. *Journal of Child & Family Studies, 4,* 321-339.

2. Bruns, E.J., Burchard, J.D., Froelich, P., Yoe, J.T., & Tighe, T. (1998). Tracking behavioral progress within a children's mental health system: The Vermont Community Adjustment Tracking System. *Journal of Emotional and Behavioral Disorders, 6*, 19-32.

3. Bruns, E.J. & Burchard, J.D. (2000). Impact of respite care services for families with children experiencing emotional and behavioral problems and their families. *Children's Services: Public Policy, Research and Practice, 3,* 39-61.

4. Bruns, E.J., Suter, J.C., Burchard, J.D., Leverentz-Brady, K. & Force, M. (2004). Assessing fidelity to a community-based treatment for youth: the Wraparound Fidelity Index. *Journal of Emotional and Behavioral Disorders, 12,* 69-79.

5. Walrath, C., Bruns, E.J., Anderson, K., Glass-Siegel, M., & Weist, M. (2004). Understanding Expanded School Mental Health Services in Baltimore City. *Behavior Modification, 28*, 472-490.

6. Bruns, E.J., Walrath, C., Glass, M., Anderson, K., Spriggs, D., and Weist, M. (2004). School-Based Mental Health Services in Baltimore: Association with School Climate and Special Education Referrals. *Behavior Modification, 28,* 491-512.

7. Bruns, E J; Moore, E; Stephan, SH; Pruitt, D; Weist, MD. (2005). Impact of School Mental Health Services on Out-of-School Suspension Rates. *Journal of Youth & Adolescence, 34,* 23-30.

8. Schaefer, C., Bruns, E.J., Goldstein, J., Hoover, S., Simpson, Y., & Weist, M. (2005). Overcoming challenges to using manualized interventions in schools. *Journal of Youth & Adolescence, 31*, 15-22.

9. Bruns, E.J., Suter, J.S., Force, M.D., & Burchard, J.D. (2005). Adherence to wraparound principles and association with outcomes. *Journal of Child and Family Studies, 14,* 521-534.

10. Bruns, E.J., Lewis, C.P., Kinney, L.M., Weist, M.D., & Dantzler, J. (2005). Clergy members as responders to victims of sexual abuse and assault. *Social Thought: Journal of Religion and Spirituality in Social Work, 24,* 3-19

11. Bruns, E.J., Rast, J., Walker, J.S., Peterson, C.R., & Bosworth, J. (2006). Spreadsheets, service providers, and the statehouse: Using data and the wraparound process to reform systems for children and families. *American Journal of Community Psychology, 38,* 201-212.

12. Bruns, E.J., Suter, J.S, & Leverentz-Brady, K. (2006). Relations between program and system variables and fidelity to the wraparound process for children and families. *Psychiatric Services, 57,* 1586-1593.

13. Walker, J.S. & Bruns, E.J. (2006). Building on practice-based evidence: Using expert perspectives to define the wraparound process. *Psychiatric Services, 57,* 1579-1585.

14. Kerns, S.E. & Bruns, E.J. (2007). Treating and preventing adolescent mental health disorders. *Clinical Psychology Review, 27,* 676-678.

15. Bruns, E.J., Walrath, C.M., & Sheehan, A. (2007). Implementing wraparound within the Context of Evidence-Based Practices for Children and Families: A Survey of Providers. *Journal of Emotional and Behavioral Disorders, 15*(3), 156-168.

16. Kinney, L.M., Bruns, E.J., Bradley, P., Dantzler, J., Weist, M.D. (2007). Sexual assault training of law enforcement officers: Results of a statewide survey. *Women and Criminal Justice, 18*, 81-100.

17. Bruns, E.J. & Hoagwood, K.E. (2008). State Implementation of Evidence-Based Practice for Youth, part 1: Responses to the state of the evidence. *Journal of the American Academy of Child and Adolescent Psychiatry, 47*, 369-373.

18. Bruns, E.J., Hoagwood, K.E., Rivard, J.C., Wotring, J., Marsenich, L., & Carter, B. (2008). State implementation of evidence-based practice for youth: Recommendations for research and policy. *Journal of the American Academy of Child and Adolescent Psychiatry, 47,* 499-504.

19. Bruns, E.J., Leverentz-Brady, K.M., & Suter, J.C. (2008). Is it wraparound yet? Setting fidelity standards for the wraparound process. *Journal of Behavioral Health Services and Research, 35,* 240-252.

20. Holleman, M., Sundius, J., & Bruns, E.J. (in press). Bringing opportunity to scale: Systems building in Baltimore's citywide after school strategy. *American Journal of Community Psychology.*

21. Suter, J.C. & Bruns, E.J. (in press). Effects of wraparound from a meta-analysis of controlled studies. *Clinical Child and Family Psychology Review.*

22. Walker, J.W., Bruns, E.J. (in press). The National Wraparound Initiative: A Community-of-Practice Approach to Building Knowledge in the Field of Children's Mental Health. *Best Practices in Mental Health.*

23. Bruns, E.J. & Walker, J.S. (in press). Defining practice: Flexibility, legitimacy, and the nature of systems of care and wraparound. *Evaluation and Program Planning.*

24. Bertram, R.M., Suter, J.C., Bruns, E.J., & O'Rourke, K. (in press). Implementation research in the wraparound literature: Building a research agenda. *Journal of Child and Family Studies.*

25. Walker, J.S., Koroloff, N., & Bruns, E.J. (in press). Defining "Necessary" Services and Supports: Why Systems of Care Must Take Direction from Service-Level Processes. *Evaluation and Program Planning.*

26. Walker, J.S., Kerns, S.E., Lyon, A. & Bruns, E.J. (in press). Impact of School-Based Health Center Use on Academic Outcomes. *Journal of School Health.*

27. Walker, S.E.C., Bruns, E.J., & Leverentz-Brady, K.M. (in press). Wraparound fidelity and association with outcomes: Results from a multi-site study. *Journal of Child and Family Studies.*

28. Bruns, E.J., Walker, J.S., Zabel, M., Estep, K., Matarese, M., & Pires, S.A. (under review). The wraparound process as a model for intervening with youth with complex needs and their families. *American Journal of Community Psychology.*

29. Rast, J., Bruns, E.J., Brown, E.C., Mears, S., & Peterson, C.R. (under review). Outcomes of the wraparound process compared to services as usual in a child welfare system. *Journal of Emotional and Behavioral Disorders.*

Book chapters

1. Burchard, J.D., Hinden, B., Carro, M., Schaefer, M., Bruns, E. & Pandina, N. (1994). Using Case Level Data to Monitor a Case Management System. In Friesen, B. & J. Poertner (Eds.) *Building on Family Strengths: Case Management for Children with Emotional, Behavioral, or Mental Disorders* (pp. 169-187). Baltimore: Brookes.

2. Bruns, E.J. (1996). Making evaluation happen. In Schoenberg, S. (Ed.) *Making it happen: A guide to developing programs that provide services to children and adolescents experiencing a severe emotional experience and their families.* Rockville, MD: SAMHSA Center for Mental Health Services.

3. Burchard, J.D. & Bruns, E.J. (1998). The role of the case study in the evaluation of individualized services. In Epstein, M., Duchnowski, A., & K. Kutash (Eds.) *Outcomes for Children and Youth with Emotional and Behavioral Disorders and their Families* (pp. 363-383). Austin, TX: Pro-ED.

4. Bruns, E.J., Santarcangelo, S. & Yoe, J.T. (1998). New Directions: Evaluating Vermont's system of individualized care for children and adolescents. In Epstein, M., Duchnowski, A., & K. Kutash (Eds.) *Outcomes for Children and Youth with Emotional and Behavioral Disorders and their Families* (pp. 117-139). Austin, TX: Pro-ED.

5. Burchard, J. D., Bruns, E.J., & Burchard, S.N. (2002). The Wraparound Process. In B. J. Burns, K. Hoagwood, & M. English. *Community-based interventions for youth* (pp. 69-90). New York: Oxford University Press.

6. Bruns, E.J., Walrath, C., & Glass, M. (2003). Mobilizing research to inform a school mental health initiative: Baltimore's School Mental Health Outcomes Group. In Weist, M.D., Evans, S., & Lever, N. (Eds.) *The School Mental Health Handbook* (pp. 61-71). New York: Kluwer Academic/Plenum.

7. Bruns, E.J., Burchard, J.D., Suter, J.C., & Force, M.D. (2005). Measuring fidelity within community treatments for children and families. In Epstein, M., Kutash, K., & Duchnowski, A. (Eds.) *Outcomes for Children and Youth with Emotional and Behavioral Disorders and their Families, vol. 2* (pp. 175-197). Austin, TX: Pro-ED.

8. Walker, J.S. & Bruns, E.J. (2006). The wraparound process: Individualized care planning and management for children and families. In S. Rosenberg & J. Rosenberg (Eds.) *Community Mental Health Reader: Current Perspectives* (pp. 44-54). New York: Routledge.

9. Walker, J.S., Bruns, E.J., & Penn, M. (2008). Individualized services in systems of care: The wraparound process. In B. Stroul & G. Blau (Eds.). *The System of Care Handbook: Transforming Mental Health Services for Children, Youth, and Families.* Baltimore: Brookes.

10. VanDenBerg, J., Bruns, E.J., & Burchard, J. (2008). History of the wraparound process. In E.J. Bruns & J.S. Walker (Eds.), *Resource guide to wraparound.* Portland, OR: National Wraparound Initiative, Research and Training Center for Family Support and Children's Mental Health.

11. Bruns, E.J., Walker, J.S., & The National Wraparound Initiative Advisory Group. (2008). Ten principles of the wraparound process. In E.J. Bruns & J.S. Walker (Eds.), *Resource guide to wraparound.* Portland, OR: National Wraparound Initiative, Research and Training Center for Family Support and Children's Mental Health.

12. Bruns, E.J. (2008). The evidence base and wraparound. In E.J. Bruns & J.S. Walker (Eds.), *Resource guide to wraparound.* Portland, OR: National Wraparound Initiative, Research and Training Center for Family Support and Children's Mental Health.

13. Suter, J., & Bruns, E.J. (2008). A narrative review of wraparound outcome studies. In E.J. Bruns & J.S. Walker (Eds.), *Resource guide to wraparound.* Portland, OR: National Wraparound Initiative, Research and Training Center for Family Support and Children's Mental Health.

14. Bruns, E.J., Sather, A., & Stambaugh, L. (2008). National trends in implementing wraparound: Results from the state wraparound survey, 2007. In E.J. Bruns & J.S. Walker (Eds.), *Resource guide to wraparound.* Portland, OR: National Wraparound Initiative, Research and Training Center for Family Support and Children's Mental Health.

15. Walker, J.S., Bruns, E.J., & National Wraparound Initiative Advisory Group. (2008). Phases and activities of the wraparound process. In E.J. Bruns & J.S. Walker (Eds.), *Resource guide to wraparound.* Portland, OR: National Wraparound Initiative, Research and Training Center for Family Support and Children's Mental Health.

Published Books, Monographs, and Manuals

1. Burchard, J.D. & Bruns, E.J. (1993). *User's Guide to the Weekly Adjustment Indicator Checklist.* Burlington, VT: University of Vermont Department of Psychology.

2. Bruns, E., McCarthy, J., & Dodge, J. (1998). *Training for Effective Child Welfare Services: Results of a National "Information Needs Sensing Survey" for Child Welfare Professionals Who Work with Children Experiencing Emotional and Behavioral Disturbances, and Their Families*. Washington, DC: Georgetown University Technical Assistance Center for Children's Mental Health.

3. Kendziora, K., Bruns, E., Osher, D., Pacchiano, D., & Mejia, B. (2001). *Wraparound: Stories from the field.* Systems of Care: Promising Practices in Children's Mental Health, 2001

Series, Volume 1. Washington, DC: Center for Effective Collaboration and Practice, American Institutes for Research.

4. Suter, J.C., Burchard, J.D., Bruns, E.J., Force, M.D., & Mehrtens, K. (2002). *User's Manual to the Wraparound Fidelity Index 3.0.* Burlington, VT: University of Vermont Department of Psychology.

5. Reynolds, J., McCann, J., & Bruns, E.J., (2003). *Baltimore's Communities: A Statistical Profile of Child and Family Well-Being.* Baltimore: Maryland KidsCount/Advocates for Children and Youth.

6. Walker, J.S. & Bruns, E.J., Editors (2003). *Focal Point: Research, Policy, and Practice in Children's Mental Health, issue 17: Quality and Fidelity in Wraparound.* Portland, OR: Research and Training Center on Family Support and Children's Mental Health, Portland State University.

7. Walker, J.S., Bruns, E.J., Adams, J., Miles, P., Osher, T.W., Rast, J., VanDenBerg, J.D. & National Wraparound Initiative Advisory Group (2004). *Ten principles of the wraparound process.* Portland, OR: National Wraparound Initiative, Research and Training Center on Family Support and Children's Mental Health, Portland State University.

8. Bruns, E.J., Walker, J.S., VanDenBerg, J.D., Rast, J., Osher, T.W., Miles, P., Adams, J., & National Wraparound Initiative Advisory Group (2004). *Phases and activities of the wraparound process.* Portland, OR: National Wraparound Initiative, Research and Training Center on Family Support and Children's Mental Health, Portland State University.

9. Walker, J.S., Koroloff, N., Schutte, K. & Bruns, E.J. (2004). *Organizational and system support for wraparound: An introduction.* Portland, OR: National Wraparound Initiative, Research and Training Center on Family Support and Children's Mental Health, Portland State University.

10. Miles, P., Bruns, E.J., & Walker, J.S. (2005). *The Wraparound Process: A User's Manual for Family Members.* Portland, OR: National Wraparound Initiative, Research and Training Center on Family Support and Children's Mental Health, Portland State University.

11. Bruns, E.J., Suter, J.C., Force, M.D., Sather, A., & Leverentz-Brady, K.M. (2006). *User's Manual to the Wraparound Fidelity Index, version 4.* Seattle, WA: Wraparound Evaluation and Research Team, University of Washington, Division of Public Behavioral Health and Justice Policy.

12. Miller, B., Bruns, E.J., Willey, C., Mulligan, P., & Sather, A. (2006). Washington State Mental Health Transformation: Results of the In-Depth Youth, Family Member, and Consumer Interview Project. Olympia, WA: Washington State Department of Social and Health Services.

13. Walker, J.W. & Bruns, E.J. (2007). *A theory of change for wraparound.* Portland, OR: National Wraparound Initiative, Research and Training Center on Family Support and Children's Mental Health, Portland State University.

14. Bruns, E.J. & Sather, A. (2007). *User's Manual to the Wraparound Team Observation Measure*. Seattle, WA: University of Washington, Wraparound Evaluation and Research Team, Division of Public Behavioral Health and Justice Policy.

15. Bruns, E.J. & Walker, J.S. (Eds.) (2008). *A Resource Guide to Wraparound.* Portland, OR: National Wraparound Initiative, Research and Training Center on Family Support and Children's Mental Health, Portland State University.

Newsletters and Other Publications

1. Bruns, E.J. (1995). Comparing interventions for children experiencing severe emotional disturbance. *Division of Child, Youth & Family Services Quarterly*, Fall 1995.

2. Rast, J.D. & Bruns, E.J. (2003). Ensuring fidelity to the wraparound process. *Focal Point: Research, Policy, and Practice in Children's Mental Health, 17.*

3. VanDenBerg, J., Bruns, E.J., & Burchard, J.D. (2003). History of the wraparound process. *Focal Point: Research, Policy, and Practice in Children's Mental Health, 17.*

4. Bruns, E.J. (2004). The evidence base and wraparound. *The Wraparound Solutions Newsletter, 4.*

5. Bruns, E.J. (2004). John D. Burchard: In Memoriam. *Journal of Emotional and Behavioral Disorders, 12,* 128.

6. Bruns, E.J. & Willey, C. (2007). Partnering with Consumers and Family Members in Evaluation Research Experiences from Washington State's Mental Health Transformation Project. *Data Matters: An Evaluation Newsletter.* Washington, DC: Georgetown University Technical Assistance Center for Children's Mental Health.

National Keynotes and Invited Lectures and Addresses[1]

Bruns, E.J. (December 2008). *Using the Wraparound Fidelity Assessment System to support implementation of high quality wraparound: Lessons learned from California Development Teams.* Keynote delivered at California Wraparound Symposium, Sacramento.

Bruns, E.J. (November 2008). *Wraparound: Principles, practice, and research.* Keynote delivered at Massachusetts Children's Behavioral Health Initiative Academic Retreat, Shrewsbury, MA.

Bruns, E.J. (October 2008). *The wraparound care coordination process: Recent and ongoing research on the model.* Grand Rounds, University of Washington School of Medicine Division of Public Behavioral Health and Justice Policy.

Bruns, E.J. (September 2008). *The Washington State Children's Mental Health Needs Assessment: Results from four sources of stakeholder input.* Presentation at Washington State Children's Mental Health Forum, Sea-Tac, WA.

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[1] List of competitive review conference presentations and additional invited addresses is available upon request. In general, I co-author 3-4 additional competitive conference presentations a year with students and colleagues.

Bruns, E.J. (April 2008). *Researching Wraparound: Fidelity, Outcomes, and putting it all together.* Research keynote delivered at the Wrap Maine Statewide Training Symposium, Freeport, ME.

Bruns, E.J. (February 2008). *Evidence-Based Practices and Systems of care: Elevating the Discussion.* Keynote delivered at 21st Annual Research Conference on Systems of Care and Children's Mental Health, Tampa, FL

Bruns. E.J., Jemelka, R., Monroe-DeVita, M., Cuddeback, G., & Voss, B. (February 2008). *Using data, transforming practice: Evaluating Mental Health Transformation.* Invited address at Annual NASMHPD National Research Institute Conference, Arlington, VA.

Bruns, E.J. (February 2008). *Better together? Research on teamwork in children's mental health.* Invited keynote at Catholic Community Services Annual Training Day, Tacoma, WA

Bruns, E.J., Walker, J.S., Rast, J., & Sather, A. (March 2007). *Using Evaluation to Implement Community Treatments and Sustain Fidelity.* Invited Intensive Methodological Workshop, Florida Mental Health Institute Research and Training Center on Children's Mental Health 20th Annual Conference, Tampa.

Bruns, E.J., & Willey, C. (September 2006). *Using Evaluation to Support Consumer Delivered Services.* Invited address at First Annual Washington State Consumer Mental Health Conference, Kennewick, WA.

Walker, J.W., Bruns, E.J., Rodriguez, G., Norman, B., Penn, M., & El-Amin, R. (July 2006). *Using tools and other resources from the National Wraparound Initiative to support community implementation of wraparound.* Training workshop at 10th Training Institutes for Children's Mental Health, Orlando, FL.

Bruns, E.J. (April 2006). *Specifying and Evaluating an Individualized Care Management Model for Youth with Serious Mental Health Disorders.* Invited lecture, University of Washington Psychiatry Health Services Seminar, Seattle.

Bruns, E.J. (April 2006). *First Steps on a Long Journey: Research on Wraparound and Family Support.* Invited keynote: First Annual California Wraparound Institute, Universal City, CA.

Bruns, E.J., Kerns, S.E., & Smith, J.D. (April 2006). *Results of public testimony for the Washington State Mental Health Transformation Project.* Presentation to statewide transformation advisory team, SeaTac, WA.

Bruns, E.J. (February 2006). *Children's Mental Health: Priorities for the Next Five Years.* Invited plenary address, Florida Mental Health Institute Research and Training Center on Children's Mental Health 19th Annual Conference, Tampa.

Bruns, E.J. (December 2005). *The Wraparound Process and children's mental health: Current research and new directions.* Invited address, Washington Health Foundation Annual Conference, SeaTac, WA.

Bruns, E.J. (October 2005). *Applying individualized care planning and the wraparound process within juvenile justice initiatives.* Invited presentation, King County Reclaiming Futures Probation Day, Seattle.

Bruns, E.J. & Brylske, P. (July 2005). *Maryland Science to Service for Children's Mental Health: A Statewide Study of Treatment Foster Care.* Invited address, Foster Family Treatment Association of America Annual Conference, Atlanta.

Walker, J.S. & Bruns, E.J. (June 2005). *The National Wraparound Initiative: What can our work offer families and family organizations?* Invited keynote address, Conference of Statewide Family Organizations, Portland OR.

Bruns, E.J., Holleman, M.H., & Ferebee, H. (May 2005). *Evaluating comprehensive community-based initiatives: Lessons learned from Baltimore City.* Invited address, Eighth Annual Urban Health Seminar, Harvard University Kennedy School of Government, Boston.

Bruns, E.J. (February 2005). *The Wraparound Process and its current place within the research base on treatments for children, youth, and families.* Grand Rounds, University of Washington Division of Child and Adolescent Psychiatry, Seattle.

Bruns, E.J. & Osher, T.W. (December 2004). *What families should know about high-quality wraparound.* Invited address, 16th Annual Federation of Families for Children's Mental Health Conference, Washington, DC.

Bruns, E.J. (August 2004) *Ensuring High-Quality Wraparound.* Invited webinar, National Technical Assistance Partnership for Children's Mental Health.

Bruns, E.J. & Eber, L.E. (June 2004) *Developing and implementing comprehensive plans for students with intensive needs as a component of a school-wide system of PBIS.* Invited presentation, Maryland Positive Behavioral Supports Conference, Timonium, MD.

Bruns, E.J. (June 2004). *The importance of high-quality individualized care management for children with EBD and their families.* Invited keynote address, Circle Around Families Evaluation Conference, Merrillville, IN.

Bruns, E.J. (June 2004). *The Evidence Base and Wraparound.* Invited plenary address, 11th Annual Building on Family Strengths Conference, Research and Training Center for Children's Mental Health, Portland, OR.

Bruns, E.J., & Weist, M. (May 2004). *The Promise to Practice Gap in Children's Mental Health and Examples of Projects to Overcome It.* Invited address to the MacArthur Foundation Policy Work Group on Mental Health, Washington, DC.

Bruns, E.J. (March 2004). *The Wraparound Comparison Study and National Wraparound Initiative.* Invited presentation to annual CMHS Services Evaluation Committee meeting, Bethesda, MD.

Bruns, E.J. (February 2004). *John Burchard: In Memoriam.* Plenary address, Florida Mental Health Institute Research and Training Center on Children's Mental Health 17th Annual Conference, Tampa.

Blasé, K., Bruns, E.J., Isaacs, M. (February 2004). *Cultural Competence and Evidence-Based Practices.* Invited keynote, Annual research conference of the National Association of State Mental Health Program Directors (NASMHPD), Arlington, VA.

Bruns, E.J. (November 2003). *Mobilizing Research to Improve School Mental Health Services.* Inservice given at Baltimore School Mental Health Partnership bi-annual staff development day, Baltimore, MD.

Bruns, E.J., & Marzke, C. (August 2003). *Evaluating After School Programs.* Invited workshop, 3rd Annual After School Institute Conference, Ellicott City, MD.

Bruns, E.J. (July 2003). *The Wraparound Process.* Invited address, Maryland Summit on School-Based Mental Health and Violence Prevention, Linthicum, MD.

Bruns, E.J., (June 2003). *The Wraparound Approach: Gaining Understanding, Maintaining Fidelity.* Invited workshop, National Children's Mental Health Conference, University of Maryland School of Nursing, Baltimore, MD.

Bruns, E.J. (June 2003). *Fidelity and Effectiveness in Wraparound.* Invited keynote at 10th Annual Building on Family Strengths Conference, Research and Training Center for Children's Mental Health, Portland, OR.

Bruns, E.J. (March 2003). *Current Directions in Wraparound Research.* Invited address at annual CMHS Services Evaluation Committee meeting, Bethesda, MD.

Weist, M.D., Schaeffer, C. Goldstein, J., & Bruns, E. (March 2003). *Effectiveness and school mental health.* Plenary Presentation, Moving research into practice in public children's mental health services. Texas Department of Mental Health and Mental Retardation, Austin.

Bruns, E.J. (October 2002). *Mobilizing Data and Information to Plan Youth Strategies.* Invited lecture, Maryland Governor's Office of Crime Control and Prevention, Symposium on Disproportionate Minority Representation, Baltimore, Maryland.

Bruns, E.J. (September 2002). *Mobilizing Data and Information for Children: Mapping Community Indicators in Baltimore City.* Invited workshop, National KidsCount Annual Meeting, Bethesda, Maryland

Bruns, E.J. (July 2002). *Understanding and Improving Baltimore's After School Strategy from Evaluation Results.* Invited workshop, The After School Institute 2nd Annual Conference, Hunt Valley, MD

Bruns, E.J., Acosta, O., Taylor, L., & Weist, M.D. (May 2002). *Mobilizing Research (and Researchers) to Improve School Mental Health Programs.* Invited presentation, National Assembly of School-Based Health Care Annual Conference, Denver.

Bruns, E.J. (April 2002). *Demonstrating Impact, Championing for Children: The Challenge of Measuring Community Outcomes.* Invited keynote, United Way Community Leaders' Conference, Indianapolis.

Bruns, E.J. (March 2002). *Wraparound for Children with Severe Emotional Disturbances: The Research Agenda.* Invited address at the Center for Mental Health Services Evaluation Committee Meeting, Bethesda, MD.

Bruns, E.J. (October 2001). *Community-level predictors of Youth Violence.* Invited pre-conference institute, American Public Health Association Annual Convention, Atlanta.

Bruns, E.J. (October 2001). *Geocodable health, safety, and service data for children and adolescents: Preliminary analyses and future directions.* Invited lecture, Department of Mental Hygiene Seminar Series, Johns Hopkins School of Public Health, Baltimore, MD.

Bruns, E.J. (September 2001). *Mobilizing Data and Information to Help Champion for Children.* Invited workshop, Maryland Children's Action Network Convention, Linthicum, MD.

Bruns, E.J. (April 2001). *The Baltimore City Data Collaborative: Philosophy, Methods, and Findings.* Invited address, Johns Hopkins University Urban Health Institute, Baltimore, MD.

Bruns, E.J. (March 2001). *Baltimore City KidStat: An overview of the well-being of Baltimore's young people.* Baltimore City Mayor's Office, City Hall, Baltimore, MD.

Bruns, E.J. & Vaughn, D. (February 2001). *Using the Survey of Adults and Youth data to inform Baltimore's action plan.* Invited address, Annual Urban Health Initiative Research Conference, Wagner School Center for Health and Policy Research, New York University, Miami, FL.

Bruns, E.J. (December 2000). *The role of Geographic Information Systems and Global Positioning Systems in community-level strategizing.* Invited workshop, Casey Foundation Making Connections Initiative Peer-to-Peer Technical Assistance Conference, San Diego, CA.

Bruns, E.J., Wheitner, D., & Parks, J.S. (November 2000). *The role of geographic information systems in child and family human services research.* Invited workshop, Annual conference of the Maryland Association of Resources for Families and Youth (MARFY), Cumberland, MD

Bruns, E.J. (October, 2000). *Big thinking from small science: Balancing complex system evaluations with the need for data-driven decision-making.* Invited keynote, Applied Evaluation Workshops for the Human Services, Santa Fe, NM.

Bruns, E.J. (April 2000). *Evaluating Service Variables in Children's Mental Health Initiatives: Measurement of Availability, Quality, and Satisfaction Indicators.* Invited Workshop, Center for Mental Health Services Children's Mental Health Evaluation Conference, Baltimore, MD.

Bruns, E.J. (March, 2000). *Theory-driven evaluation of the Baltimore Safe and Sound Campaign.* Invited address, Annual Urban Health Initiative Research Conference, Wagner School Center for Health and Policy Research, New York University, New York, NY.

Bruns, E.J. (January 2000). *Profile of Child and Family Well-Being in Baltimore.* Annual briefing of the Baltimore City Council, Baltimore, MD.

Teaching and Mentoring Responsibilities

Graduate Courses and Residency Didactics

Applied Evaluation Seminar (Johns Hopkins University Institute for Policy Studies) – 1999-2000
Community Systems and Research Methods in Community Mental Health (Program in Community Mental Health, Trinity/SNHU) – 2000-2001
Family Therapy (University of Maryland School of Medicine) – 2003-2004
Mental Health Services Research (Johns Hopkins School of Public Health) – 2002-2004
Care Coordination and Wraparound: Principles and Practice (Univ. So. Florida) – 2007 - present

Supervision and Mentoring (since 2002)

New Faculty mentoring
Maria Monroe-DeVita, Ph.D., Acting Assistant Professor, UW PBSCI, 2006-2007
Suzanne Kerns, Ph.D., Acting Assistant Professor, UW PBSCI, 2007-2008
Shannon Dorsey, Ph.D., Acting Assistant Professor, UW PBSCI, 2007-2008

Post-Doctoral Fellow Supervision: 4 (all UW)
Aaron Lyon, Ph.D., Michael Pullmann, PhD, Sarah Walker, PhD, Suzanne Kerns, PhD, Michiko Iwazaki, PhD

Pre-Doctoral Clinical Internship Resident Supervision: 4 (2 UMB, 2 UW)
Charla Lewis, Shawn Costello, My Banh, Tracy Johnson

Research Coordinator and Research Assistant Supervision: 6 (3 UMB, 5 UW)
Ericka Wiggins, Cathy Schaefer; Kate Conover, April Sather, MSW, Erik Janson, MSW (UW); Steve Petrica, M.Div., Kristy Tomlin, Cristin Murtaugh (UMB)

Master's and Doctoral Student Supervision: 5 (2 Univ. Vermont, 3 UMB)
Jesse Suter, Kristen Leverentz-Brady, Walter Fitz-William, Shawn Costello, Liz Clever

Doctoral Dissertation Committees: 4 (1 UW, 2 Univ. Vermont, 1 UMB)
Cory Sechrist, Jesse Suter, Kristen Leverentz-Brady, Cynthia Fontanella

Other Teaching and Mentoring Responsibilities

UW PBSCI Resident (R03) Didactics, 2005-2008
UW pre-doctoral internship in clinical psychology, Policy Track Journal Club and mock grant reviews, 2005-2007
UW Undergraduate Research Interns, 2006 – 2007

Local Service

School of Medicine and Departmental Service

Admissions Committee, University of Washington School of Medicine, (2007 – present)
Washington State Mental Health Transformation Research Advisory Team (2006 – present)
Mental Health Services Task Force, University of Washington Dept of Psychiatry and Behavioral Science (2005 – present)
Jansen Child and Adolescent Psychiatry Visiting Scholars Series, University of Maryland, Baltimore (Co-Coordinator, 2003 – 2005)
School Mental Health Outcomes Group, University of Maryland, Baltimore (Chair, 2002 – 2005)
Division of Child and Adolescent Psychiatry Research Committee, University of Maryland, Baltimore (Chair, 2002 – 2005)
Pre-Doctoral Clinical Internship Selection Committee, University of Maryland (2003 – 2005)

Other Local Responsibilities

Washington State Children's Mental Health Evidence Based Practices Institute (Co-Director), 2008 – present
King County Youth Violence Prevention Initiative Evaluation workgroup, 2009 – present
Washington State DSHS, Division of Substance Abuse and Mental Health, Children's Leadership Team, 2009 – present
Foster Care Assessment Project (FCAP), Washington State Department of Social and Health Services, Children's Administration, Region 4 (2006 – present).
Washington State Mental Health Transformation project, Evaluation Team (Coordinator), 2005 – present
Mockingbird Society, Research Advisory Board, 2006 – 2008
Washington State Mental Health Transformation project, Evidence Based Practices committee (Chair), 2006 – 2007
Annie E. Casey Baltimore Local Learning Partnership, 2001-2003.
Johns Hopkins University Center for Prevention of Youth Violence (Core faculty member), 2001 – 2005.
Baltimore City Mayor's Office: *CitiStat* and *KidStat* Committees, 2001 – 2004.
Baltimore Dept. of Juvenile Justice Comprehensive Strategy for Serious, Violent, and Chronic Juvenile Offenders (Research Committee chair), 1997 – 1999.
Maryland Governor's Office of Children, Youth and Families Evaluation and Monitoring Task Force, 1999 – 2004.
Baltimore City Council Advisory Panel on Human Resources, 1999 – 2002.

EXHIBIT 7

Declaration of Krista Long

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

1. I am 35 years old. I was a family support partner in the behavioral health system for two years, from 2002 to 2004. I went back to school in 2004 and, in 2008, I received a degree in Social Work. I am now employed by EMPACT, a behavioral health service provider which has a contract with Magellan.

2. I have served on the board of directors for the Family Involvement Center, a family run organization, since 2005. I have been a family representative of the Meet Me Where I Am Steering Committee for Maricopa County for the past three years. Since July 2009, I have been co-chair of that committee, and a member of the Statewide Meet Me Where I Am Steering Committee. I was a parent reviewer for the Maricopa County review process from 2004 through 2006. I often provide training on the JK Principles as a parent co-trainer.

3. I am the single parent of two boys, ages 15 and 11. My 11 year is very creative and enjoys dance, drawing and music. He receives behavioral health services but does not have high needs.

4. My 15 year old son is currently in his first year of high school, and is mainstreamed in all but one of his classes. He loves cars and hopes to be an automobile designer. Our goal is for him to attend college and receive an engineering degree. However, he has some extreme behaviors. He has been delusional, aggressive and out of control. Unlike my 11 year old, he has high needs.

5. From 2000 to 2002, our service provider in Maricopa County was Westside Social Services. My son saw a therapist once every two weeks and received medication. We were told that there weren't any other services available.

6. In 2002, we transferred to Devereux and began receiving case management. Even with case management, it was a constant struggle to receive services that met my family's needs. This was true even though I was trained and working as a family support partner in the system and knew how things were supposed to work.

7. The behavioral health staff on my Child and Family Team (CFT) were not supportive and did not deliver services according to the JK Principles. There was high case manager turnover. I requested a crisis plan but did not get one. I requested a strengths and needs assessment, which every CFT is supposed to do, and did not get one. The CFT did not brainstorm about services that might help my family. The CFT offered us a succession of ineffective therapists and did not listen to input from me or others.

8. In 2004, I was finally able to get direct supports for my son through Child and Family Support Service (CFSS). Without them, I would have had to place my son in 24 hour residential care. For the past few years, even though we have not had a well-functioning CFT, the direct supports kept us going.

9. In 2005, I complained to the network about the CFT. After my complaint, Devereux was very defensive and retaliated against us. Devereux dropped my son to medication only status

and took away our CFT. However, CFSS continued to provide us direct supports from CFSS. The network eventually required Devereux to provide us a case manager. After that, Devereux became even harder to work with. For example, the case manager would often threaten that "you may not have direct supports next month."

10. In 2008, we transferred to the Southwest Network, of which Devereux is not a part. I feel actively supported in the CFT team. My son just graduated from CFSS direct services. He can now control his aggression. This would not have been possible without the direct supports. Without the direct supports, he would have been removed from the house by behavioral health services or the juvenile justice system.

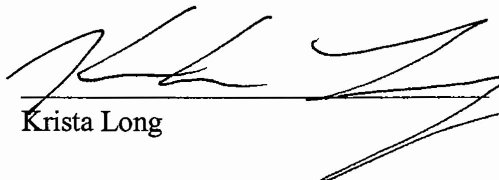
11. Because I have held various responsible positions in the behavioral health system, I have seen how many other families, besides my own, are treated. It is pretty clear to me that the State has not lived up to the J.K. Settlement Agreement.

12. There are not enough services for children. High needs kids often wait for services, even when a juvenile court has ordered the State to provide behavioral health services. Low and medium needs kids get pushed aside until they are in crisis and become high needs. Therapists are the gateway to services for low and medium needs children, but there are not enough therapists.

13. Providers move from crisis to crisis. The system lacks experienced case managers. It also lacks respite care. There is a shortage of specialty services, for example, for children with low level sexual acting-out. There are some sexual offender services, but these are not appropriate for children with boundary issues but who are not sex offenders.

14. Youth aged 18-21 have special problems. They can't continue to have their CFT. They lose their services. Upon turning 18, they are not determined to have a serious mental illness, there are not many services out there for them.

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 Arizona that the foregoing is true and correct. Executed this 2 day of November, 2009 in Phoenix, AZ.



Krista Long

EXHIBIT 8

Declaration of Carol McDermott

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

1. My husband and I are in our 60's and are both retired. I first became involved with the behavioral health system 23 years ago. Both of my children are adopted and have received services from the public health system. My daughter, who is 28 years old and has a mental health diagnosis, lives with us along with her son. My grandson is currently 9 years old. He has received mental health services since he was approximately 3 years old.

2. My grandson is very bright and reads well. He wants to be a police officer or work in the military. He enjoys riding his bike and playing with other children. However, he has ADHD, can be intrusive and defiant, and has emotional outbursts/meltdowns in which he has public crying fits. He is immature for his age, and over the past few years it has been very painful for him to have other children distance themselves due to his emotional issues.

3. My grandson was served from 2004 to 2008 by Southwest Behavioral Health Services (Southwest Behavioral). His services were grossly inadequate. At the time, I did not think anything could be done for my grandson other than what Southwest Behavioral was providing. Now I know that Southwest could have provided my grandson a well-functioning child and family team, intensive case management and direct supports, all of which would have made a world of difference in his life and ours. Families like mine, whose children need, but do not receive, intensive services hang on by our fingernails.

4. In 2004, while a client of Southwest Behavioral, my grandson began receiving medication. He met with a psychiatrist once a month for 15 minutes.

5. Despite taking medication, my grandson continued to be defiant and out of control. I told Southwest Behavioral that we were struggling, but my grandson was not provided any additional services.

6. In 2007, I became a member of the Magellan Child and Adolescent Advisory Committee. I also became involved with the Family Involvement Center. I learned for the first time about Child and Family Teams (CFTs). This was after three years in the system, and six years after the JK settlement was signed. I asked Southwest Behavioral for a CFT.

7. My CFT started in approximately October 2007. It did not go well. At first it included only a clinician (a "clinical liaison"). I then got a case manager, but lost the clinical liaison. In the spring and summer of 2008, our case manager changed four times. In addition, our medication prescriber (we were assigned first to a psychiatrist, then a nurse practitioner), changed three times. I was given no choice of meeting sites.

8. The CFT meetings were held sporadically and lasted only 45 minutes. I was treated disrespectfully, like I was an antagonist.

9. I learned through the Family Involvement Center that I could have a say in the makeup of the CFT and in where it met. In approximately January 2008, I had the CFT moved to my grandson's school so that the school principal and his teacher could provide input.

10. Although we had a CFT, we were not offered meaningful services. Southwest Behavioral offered us anger management. My grandson took the class although he did not really need it, because it was the only skill building service we were offered. He took the class three times – at age 5, age 7, and approximately one year ago. It did not help.

11. In early 2008, I learned that there were behavioral coaches available in the system and asked Southwest Behavioral for one. Had I never asked specifically for a coach, we would never have got one. You had to know just what to ask for; Southwest Behavioral never suggested or recommended direct supports. I was told that I could have a coach to work on one identified goal. My grandson made progress and met that goal. Although my grandson still needed a behavioral coach, the coach was taken away. I had to request a coach again and wait for one to become available. After at least six weeks, the same coach became available, and we were again allowed to work toward only one identified goal. Given my grandson's significant needs, working on one goal at a time made no sense and would never adequately meet his needs.

12. Although my CFT agreed that other direct supports, such as a youth mentor and social skills training were needed, and those supports were included in my treatment plan since August 2008, I was not referred for such services. The case manager could not find a service provider. Instead she told me that if I put my son in social situations he would develop social skills. Instead of a youth mentor or social skills training, we were given catalogues identifying parks and recreation programs in the area and told to try different sports. My grandson tried 5 different sports, but, without needed support from the behavioral health system, he failed at each. In fact, the situation became worse. My grandson was disliked by other kids and parents, was excluded and isolated, and was even bullied.

13. In August 2008 I also requested a child therapist for my grandson. Although my CFT agreed that a therapist was needed and included a therapist in our treatment plan, it took months to get a child therapist on a trial basis. After only 4 meetings, the therapist stopped seeing my grandson because she could not connect with him. We were not offered a different therapist.

14. In early 2009, I asked for youth mentor/social skills services from two specific providers that I understood had openings. In late February 2009, the request was denied because the providers were out of network. I was told that these services were available in my network, but was not told where. I appealed the denial in March 2009. In April 2009, the denial was upheld and two specific in-network providers were identified for me. However, when my case manager called them, she was told that there was no space available. I was told by the provider that every youth mentor/social skills provider was at capacity.

15. I then requested a Medicaid fair hearing, which was scheduled for June. About two or three days after my request, our case was transferred to Southwest Network. Southwest Network approved our request for an after-school social skills program, however, so much time had passed since my request that when our case manager called the program, she learned that the program had changed the eligible age group and my grandson no longer qualified. I did not proceed with the fair hearing.

16. After our case was transferred to Southwest Network, I finally began to receive quality services that were intensive enough to address my grandson's needs. The new case manager began updating our behavioral plan, and strengths and needs assessment, because they were all out of date. The CFT meetings are not limited to 45 minutes; they last for as long as they need to. I am treated respectfully and my input is valued. The CFT evaluates objectives, and brainstorms about helpful services. We have a case manager and a parent partner. Initially, the case manager came to see us several times a week and, to get to better know my grandson, spent time with him in a variety of settings. The CFT developed a comprehensive behavioral services plan.

17. My grandson began a social skills class in June 2009. He recently started with a new family/individual therapist, who sees him at our home. We also have respite services at Devereaux for 16 hours each week.

18. Even in the short time my grandson has received intensive services, I have seen an improvement in my grandson's behavior and in our relationship. He is calmer and more manageable. He feels more secure, is doing better with other children, and is less isolated. I am hopeful about his future.

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 Arizona that the foregoing is true and correct. Executed this 31st day of October, 2009 in Phoenix, Arizona.

Carol McDermott

EXHIBIT 9

Declaration of Donna Ifill

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

1. I am 36 years old. My husband and I have been married for 4 years. We live in Pinal County, Arizona. We have two children who live with us, my husband's son and my son, both 15 years old.

2. My husband's son, my step-son, came to live with us in October 2008, when he was 14 years old. His mother sent him to live with us because she was unable to control him.

3. But my stepson has extreme behaviors. He destroys things, hurts animals, starts fires, and is truant. He has been assaultive in the past. My stepson has been hospitalized several times, usually for no more than one week. He participated in a partial hospitalization program in 2006 in New York, which was not effective.

4. My stepson became a client of the Arizona behavioral health system in 2008. Our Regional Behavioral Health Authority is Cenpatico, and our provider is Superstition Mountain. We have repeatedly asked for intensive services but my stepson has not been provided the intensive services necessary to meet his needs. Instead, he gets crisis services when things hit bottom.

5. In November 2008 my stepson was hospitalized for seven days at Banner Hospital. Then in March 2009 he was hospitalized again at Aurora hospital. The hospital suggested placing him in a group home. However, that did not happen. Three days after his discharge from the hospital he assaulted my husband and was arrested. From detention he was placed in the group home for 90 days, from March through June 2009. At the end of 90 days he was discharged with no improvement in his condition. They did not extend treatment or provide intensive supports.

6. The judge dismissed the charges since he had no prior criminal record, and ordered mental health treatment. It was recommended that we place him at Canyon State Academy, a residential school. Because we cannot afford it, Cenpatico suggested that we terminate our parental rights and turn our son over to the state so that they can send him to Canyon State. The director from Superstition recommended that we send him to Boys Town in Nebraska, which we cannot afford.

7. After the group home our son continued to live at home. We had a sensor on his door to know when he left his room; I carried mace in my pocketbook. CPS threatened to remove our other son if we could not protect him from his step-brother.

8. When I requested therapeutic foster care, I have been told that it is hard to get good therapeutic foster care and it can only be used for 30 days.

9. We will try anything, including services in another state. But the Director of Superstition Mountain has told us that we have already received all the services they have to offer. Our

case manager also says that her hands are tied because there are no services other than what we have already been offered.

10. In August 2009, he ran away for 24 hours. After he was picked up, and was charged with disorderly conduct and incarcerated. He also has charges pending for truancy. A few days prior to being arrested he wiped feces on the bathroom shower curtain. The behavioral health system sent a letter to the Judge telling him he needed long term care, but didn't offer to provide it. However, the Judge sent him home pending disposition of his charges.

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 Arizona that the foregoing is true and correct. Executed this 31 day of October, 2009 in ______________________________.

T

Donna Ifill

EXHIBIT 10

Declaration of Lee Bieber

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

1. I am currently 60 years old, my husband is 61. We have been married for 33 years. My husband has worked as a data engineer manager for Wells Fargo Bank for 30 years. I am a stay-at-home parent. We have two biological children who are grown and two adopted children who are 13 and 19.

2. I have been a foster parent for 33 years. My husband and I have fostered over 180 children. We currently have three foster children in our home, ages 12, 12 and 17.

3. My 17 year old foster child has been treated by Devereaux for about 5 years. She has extreme difficulties. She is almost 18 and up until last month ago her case manager continued to tell us that she would receive no services once she turned 18.

4. She engages in disruptive, oppositional behavior and has been hospitalized numerous times in psychiatric wards. She has gone into rages for hours, destroyed property, cut her clothes, threatened to hurt herself, and run away. Five years ago, when she was 12 years old, we did not feel that we could keep her safe in our home and she went to Devereaux's residential treatment center until she was 15. After that, she cycled in and out of group homes, the hospital and our home. She would return home and then ran away, get hospitalized, and be placed in a group home. When she would have trouble in a group home, the system would move her instead of providing services. They put her wherever there was a bed. The police would be called when she became upset and she was detained several times at the request of group home staff.

5. Throughout these years, she received medication, saw a psychiatrist every 3-4 months, and had in-office counseling once a week. These are not adequate services for a high needs child. The behavioral health system was not helping her get better. They were letting her languish in group homes until she turned 18.

6. Earlier this year, I contacted Anne Ronan, an attorney with the Arizona Center for Law in the Public Interest, for assistance. Ms. Ronan succeeded in getting our child identified as a high needs child in January of this year. As a result, our foster daughter began to receive intensive case management services from her network, Quality Care. Our new case manager was not very responsive. Our foster child began to receive direct support services from Child and Family Support Services (CFSS) to assist her with social skills.

7. Once she received direct support services, I could immediately see improvement. My foster child is now able to determine which people are not good for her and can chose to have better relationships. She is learning how to be in a family – cleaning her room, taking responsibility, following rules, learning budgeting. There has been no drug use. Our relationship has improved.

8. While we have been happy with CFSS staff, there have been problems with the Child and Family Team (CFT). The CFT did not brainstorm about services that might help my family. It has been necessary to keep constant pressure on Quality Care Network to prevent services from being discontinued. Ms. Ronan remained involved in the CFT to ensure that Quality Care addressed transition services. Our foster daughter's probation officer has not attended CFT meetings.

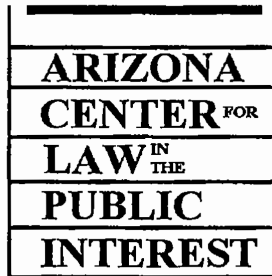
9. Last month, Quality Care confirmed that they would not provide services once our foster daughter turns 18. We then switched providers and went to Southwest Network. The Southwest case manager is very involved. Changing service providers has been difficult and upsetting for our foster daughter. She has lost her therapist of 2and 1/2 years.

10. Since switching to Southwest, the case worker has meet with us several times to complete paperwork to have our foster daughter determined to be "seriously mentally ill" (SMI) to get access to services as an adult. Southwest has also helped complete paperwork for the Arizona Department of Rehabilitation for vocational rehabilitation and job training. Southwest has stated that they will continue to work with her after she turns 18.

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 Arizona that the foregoing is true and correct. Executed this 5th day of ~~October~~ Nov., 2009 in ______________________________.

Lee Bieber

EXHIBIT 11



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March 6, 2009

VIA EMAIL AND U.S. MAIL

Gregory Honig Arizona Attorney General's Office 1275 West Washington Phoenix, Arizona 85007-2926	Logan T. Johnston Johnston Law Offices, PLC 1402 East Mescal Street Phoenix, Arizona 85020

Re: *JK v. Gerard*

Dear Greg and Logan:

Plaintiffs hereby invoke the dispute resolution provisions of Section IX of the Settlement Agreement ("Disputes Regarding Implementation"). We have been unsuccessful in securing needed relief through other avenues.

As required by Paragraph 59 of the Settlement Agreement ("Written Statement of Issues in Dispute"), which we now specifically invoke, we describe our concerns, which we have also detailed in prior correspondence and meetings. We hope we can resolve these issues through collaborative negotiation with the aid of a mediator.

As you know, Plaintiffs have carefully followed Defendants' implementation activities. In addition to periodic meetings with Defendants, we stay in close touch with knowledgeable individuals at all levels of the behavioral health system. We also participate in key meetings and processes in Maricopa County where the majority of class members reside.

We recognize Defendants have taken important steps toward implementation, including in areas we highlighted during the 2006 dispute resolution process. We also acknowledge the many individuals who have worked hard to implement the Settlement Agreement. While progress has been made, key parts of the behavioral

health service system required by the Settlement Agreement remain underdeveloped and, in some areas, there has been little forward movement until recently. In addition, in many areas of the state outside of Maricopa County, efforts to implement the Settlement Agreement began in earnest only recently.

Setting appropriate expectations for the Regional Behavioral Health Authorities (RBHAs) and timely and effectively intervening when expectations are not being met remains a problem. While the Defendants have recently set and held RBHAs accountable for expectations regarding direct supports and case management, Defendants have not yet set appropriate expectations for RBHAs with respect to the fundamental obligation in the Settlement Agreement that services be delivered according to the Principles.

The situation in Maricopa County is a case in point. Magellan has performed poorly in implementing *J.K.* For well over a year, Magellan showed little leadership, and there was backsliding in the children's behavioral health system. Defendants did not effectively intervene. Magellan has now hired an excellent director of children's services, but she has uncertain authority and virtually no staff.

Slow and Uneven Progress

Under the Settlement Agreement, the state must "move as quickly as is practicable" to develop a functioning children's behavioral system that meets its clients' needs. Once that system is developed, it must be maintained. Settlement Agreement, Par. 15. The Settlement requires the children's behavioral health system to:

- Focus on keeping children at home, doing well in school, and staying out of trouble with the law.

- Ensure that children with complex needs have case managers and receive needed therapeutic foster care, respite, and community based direct supports.

- Use child and family teams to secure family input and cross-system coordination.

- Regularly review the adequacy of services, including whether they met children's needs.

- Provide needed services to youth aged 18 to 21.

- Provide needed substance abuse services.

Moving "as quickly as practicable," Defendants should have put these key elements in place before the original termination date of the Settlement Agreement. As detailed during the 2006 dispute resolution process, Defendants did not take the required actions to make this happen. As a compromise measure, Plaintiffs agreed in late 2006 to extend the term of the Settlement Agreement an additional three years. Since that compromise, Defendants have continued to move too slowly on these same key elements. For example, Defendants still do not have a functioning system, as required by the Settlement Agreement, for measuring whether services are provided according to the *J.K.* Principles. Consistently, relevant time lines in the *J.K.* Annual Plan are not met.

As a result of Defendants' slow and uneven implementation, including since the 2006 compromise, the following serious issues remain.

ISSUES IN DISPUTE

1. Delivering Services According to the *J.K.* Principles

Defendants have failed to meet their core obligation under the Settlement Agreement to develop (at first by July 2007, but now by July 2010); a Title XIX behavioral health system that delivers services according to the *J.K.* Principles. Defendants have not made changes to "contracts, decisions, practice guidelines and other policies" needed to achieve the Principles for class members. Major failings are described below.

2. Measuring Whether Services are Delivered According to the Principles

Defendants have repeatedly advised that they are using multiple sources of information to measure whether services are being delivered according to the Principles. However, no actual effort was being made along these lines until recently.

In July 2008, Defendants implemented a process for using multiple sources of information to measure whether services are being delivered according to the Principles. However, the information required to make such judgments does not exist. For example, there is not yet data from a functioning process for reviewing practice in

individual cases. In addition, the process is not informed by information on implementation of required *J.K.* practice protocols. Specifically, the system does not generate information on whether services are designed and implemented to achieve the *J.K.* functional outcomes, including stability, for example, minimizing multiple placements, avoiding removal in crises. In addition, the system does not generate information on whether services are provided in the most integrated setting, or on the sufficiency of interagency collaboration.

Defendants' use of the "WAFAS" to review practice in individual cases has long been problematic. There have been problems with the competence of reviewers, inappropriate constraints on what reviewers could report, inadequate guidance to reviewers including on scoring, and serious sampling issues. Furthermore, the WAFAS is focused on only a fraction of the children – those currently identified as having high needs. This limitation is especially concerning since the number of children so identified is very low, contributing to the problems discussed in other sections below. While Defendants have agreed to implement a revised process for reviewing practice in individual cases that should provide better information, this process is still in the pilot stage.

3. High Needs Children

Defendants still lack a functioning system for identifying enrolled children who have high needs. The last information we received was that only 6% of the enrolled children have been so identified, although there is a virtual consensus that 15 to 25% of enrolled children have high needs.

High needs children need ready access to direct supports, home-based respite, and therapeutic foster care. The 2006 dispute resolution process was initiated in large part because Defendants had failed to adequately develop these services. To their credit, Defendants have now made the development of these services a priority. However, expansion of these services has been slow and the need for such services far exceeds the system's capacity. This has hobbled the efforts of child and family teams to deliver services according to the Principles.

We have confidence in the team at ADHS that is nurturing the expansion of these services. However, they do not make the decisions regarding the scope and pace of expansion, or the funding to be devoted to this effort, which has been too little too late. We are unsure whether Defendants are planning any significant expansion of these services next fiscal year. Additionally, Defendants have failed to fully explore

expanding these services by reallocating money from costly and unnecessary (if direct supports, respite and therapeutic foster care were available) residential care.

High needs children also require case managers with low case loads. Too few such case managers exist. In fact, there are fewer intensive case managers in Maricopa County today (or there were until very recently) than when the state first required ValueOptions to hire such case managers. Fortunately, Defendants have made an impressive commitment to secure an adequate number of case managers. However, there seems little chance that a fully staffed case management system will be in place by July 2010.

4. Substance Abuse Treatment Services

Services to address substance abuse among high needs children remain inadequate. This is despite the fact that the Settlement Agreement required Defendants to begin addressing this issue in the first year of the Agreement. While the state has recently reviewed substance abuse services, there is no plan for expansion. The state continues to have little information on unmet needs.

5. 18-21 Year Olds

This is an area to which Defendants had paid virtually no attention until the 2006 dispute resolution process. Defendants have since made efforts to identify both the contours of the problem and possible solutions. However, because of the slow pace of the effort, and the relatively small investment that Defendants have made, there has been little change in how 18-21 year olds are treated by the behavioral health system. For the most part, these youth continue to be served by the adult behavioral health system, not the children's system, and services are not delivered according to the *J.K.* Principles. Children with high needs who are not identified as "SMI" (serious mental illness) have limited access to services, including case management and direct supports.

6. Training

The Settlement Agreement requires a training program to ensure that services are provided according to the Principles. A program meeting the specifications in the Settlement Agreement does not exist. Among other things, there are not qualified trainers in sufficient numbers, and the program fails to impart sufficient knowledge and skills to enable staff to provide services according to the Principles. We believe

that the RBHAs would implement such training programs if they faced meaningful consequences for their current failure to provide services according to the Principles.

Unfortunately, we believe another extension of the term of the Settlement Agreement is necessary. Additionally, the parties must agree on a plan for Defendants resolving the issues identified above. As we have mentioned, we are open to paring down the Settlement Agreement to focus only on these issues.

Thank you for your attention to these matters. We have confidence that, if Plaintiffs and Defendants approach these matters with an open mind and in good faith, we can negotiate a collaborative resolution of them.

Sincerely,

Anne Ronan
Ira A. Burnim

cc: Joe Kanefield
Laura Nelson
Michael Fronske
Robert Sorce
Brian Lensink

EXHIBIT 12

JK Planning Meeting
Combined Issues
6/2/06

1. Process for reviewing fidelity of practice to JK principles.

There should be a mutually agreed process, presumably as part of the quality management system, that: comprehensively reviews fidelity to the *JK* Principles, is implemented by individuals who can competently assess fidelity to the Principles, and uses as an integral source of information an in-depth review of a sample of individual children's cases including interviews with key individuals such as the family and child, case manager, foster family, child welfare worker, and JPO.

There should be agreed consultants who assist the parties in the development of this process.

Planning Discussion
(The discussion was a brainstorming process to get all of the expectations and ideas on the table so as to understand the expectations for the JK Plan. Specific planning will include the ADHS/DBHS Bureaus and Divisions to review ideas and develop specific plan goals and tasks over a multi-year basis.)

A. mutually agreed process

- There should be one ADHS review tool with well developed, helpful instructions. The questions should be the same or very similar for the record review and the interviews.

- The reviews should answer the four (4) primary practice questions on some type of scale, which results in an acceptable or unacceptable level of practice in accordance with the 12 Principles. The four practice principles are:
  - Engagement as determined through establishing of a trusting relationship with the child and family.
  - Clearly knows the family and has identified the strengths, needs and culture of the child and family.
  - Create an individualized service plan that meets the needs of the child and family.
  - Implements monitor and modify the service plan toward a successful outcome for the child and family.

- Specific guidelines for the reviews are developed and furnished by ADHS including:
  - How reviews are to be conducted - methodology.
  - Debriefing processes.
  - Process improvement and or corrective action plan development.
  - Method for looking at work done in the first 45 days after intake including assessment, planning, crisis stabilization and CFT development.
  - The same reviewers who do the chart review should do the interviews.

- Reviews can be reduced to two or three per year from the current four to make the process less costly and time consuming. This will give RBHAs more time to make improvements between reviews.

- The current ICR process should be discontinued and those AHCCCS/CMS required elements should be incorporated into more valuable review processes.

- ADHS needs to insure the integrity of the process. ADHS should validate the reviews or should contract for the validation from an outside organization that knows and understands the CFT practice and 12 principles. This process should be a replacement for the ICR process for children for it was not seen as informative or valuable as a method to ensure fidelity to the JK Principles.

- The results of the reviews should be made widely available so that consumers can make informed decisions on what services are best for their child and family.

- ADHS may want to develop a PIP on the practice improvement review including reasons for the reviews, how the reviews can be used for quality improvement and the implementation details for the review process. Adherence to this PIP should be contractually required.

- It should be indicated that if a Provider agency, or a RBHA, feels that the results of the review are inaccurate or do not represent the agencies real level of proficiency an additional review could immediately take place focused on another randomly selected number of cases to see if the results are different.

- Add a section into future contracts or through a contract amendment stating that the RBHA agrees to be judged by the ADHS CFT measurement process and cooperation and practice improvement as indicated through the process is a responsibility.

B. part of the quality management system

- ADHS needs to have the internal QM capacity to manage the CFT review process at the state level, require the RBHAs to have the QM capacity at their level and insure the family entities have the capacity to manage their involvement in the process as supported by ADHS or the RBHAs. QM activities are Medicaid refundable and are included in the Administrative funding for the RBHAs.

- Family participation (including involvement in reviews, planning reviews, analyzing and preparing results and involvement in practice improvement activities after the reviews) is required and must have a stable infrastructure and clear budget. The family's core functions should be in line with the white paper developed by FIC/MIKID.

- The CFT Practice Measurement Process is a QM function and other QM activity should be supportive to the core activity of judging the quality of practice.

- ADHS should consider reviewing and then changing or eliminating QM Processes that do not focus attention on the implementation of the CFT practice and the 12 Principles.

- The aspects of the CFT Practice Measurement System includes; 1. Organization of the review process, 2. Finding and training reviewers, 3. Preparing the data from the review, and 4. Analyzing and interpreting the data and preparing the report. It was felt that QM should be responsible for areas 1 and 3, clinical could work on area 2 and QM and clinical could complete area 4.

C. comprehensively reviews fidelity to the *JK* Principles

- ADHS needs to have a qualitative review process that looks at the quality of the practice according to the CFT Process and the Arizona 12 Principles.

- The outcome measures should be better integrated into the review questions.

- A stratified random sample should be used to insure representation from the provider including age, sex, nationality, CMDP status and other meaningful criteria.

D. implemented by individuals who can competently assess fidelity to the Principles

- The CFT Practice reviews need to have trained certified professional and family member reviewers (non-family members and family members) who make a judgment on a case jointly as a team as to overall acceptability of practice as represented by the CFT Practice and 12 Principles.

- The core group of reviewers must be approved at the beginning phase of implementation by ADHS or their representatives i.e. Mike Shafer/CWG

- Family members must be independent of the RBHA – use existing family organizations for assistance in recruiting family member reviewers.

- A process needs to be developed for growing or building a stable cadre of reviewers from the RBHA or provider agencies, so they are a regular and sustainable resource to the review process.

- Encounter Relief could be provided for RBHA and provider staff that are trained as the cadre of reviewers.

- The reviewer process should be used as a teaching tool for the system by using agency personnel in the review process.

E. in-depth review

- There can be a smaller number of reviews than there are presently but then there needs to be more depth by including sound qualitative questions and broader interviews with all people involved with the case including family, child, foster family, CPS worker, JPO etc.

- Reviews should produce practice data to the provider level in GSA 6 (Maricopa County) and GSA 5 (Pima County). Reviews in more rural RBHAs can produce practice data to the RBHA level or have RBHA level plans for providing data to their providers.

- Develop agreements with system partners to support the involvement of their staff in the CFT review process.

F. interviews with key individuals

- In person interviews of children and families will be required. Other interviews may be by telephone, as necessary.

- Families should be informed that they may be asked to participate in review process to help improve services. They should also get helpful information telling them the value of their participation.

G. agreed consultants who assist the parties in the development of this process

- It has been agreed that Mike Shafer will work with the Child Welfare Group (CWG) to develop the combined tool and process (State process and VO process) for the CFT practice measurement reviews

2. Method for holding RBHAs and providers accountable.

There should be a method for holding RBHAs and providers accountable for their performance as measured by practice reviews, including a method for rewarding and "consequencing" providers based on their success in delivering services according to the Principles. The State should establish an enforceable expectation that RBHAs and providers will serve all children according to the Principles. This expectation could be phased in over a period of years. For example, in year one, 50% of children would be so served. In year two, 75% of children would be so served.

The State has issued a number of documents setting forth standards for complying with some of the *JK* Principles, for example, the practice improvement protocol and technical assistance document for child and family team practice. RBHAs and providers should be held accountable for meeting the standards in these documents.

Planning Discussion
(The discussion was a brainstorming process to get all of the expectations and ideas on the table so as to understand the expectations for the JK Plan. Specific planning will include the ADHS/DBHS Bureaus and Divisions to review ideas and develop specific plan goals and tasks over a multi-year basis.)

A. Method for holding RBHAs and providers accountable for their performance as measured by practice reviews, including a graduated method for rewarding and "consequencing" providers based on their success in delivering services according to the Principles and CFT Practice. The State should establish an enforceable expectation that RBHAs and providers will serve all children according to the Principles.

- A strong, consistent and clear message from ADHS would greatly assist in this area.

- ADHS should strengthen their commitment to requiring targeted and specific changes needed to support the CFT practice and 12 principles.

- Recognize and reward movement toward acceptable practice.

- Review the 5th annual plan and insure that all goals and tasks support this implementation plan being developed. RBHAs and Providers should be required to have plans that are consistent with this JK Implementation plan so these areas are addressed at all levels.

- ADHS needs to determine a graduated response for continual non-performance in practice improvement, development of direct services, development of Team Coordination, and competent clinical services, which could include:
    - The social pressure that naturally occurs through the publication of review results and other QM data can assist in holding providers accountable. A strong CFT Practice measurement system that judges quality through a strong measuring tool and broad professional and consumer input can back up this approach.
    - Require specific performance improvement plans in areas of deficiency as informed by the Practice Improvement Review and other system data.
    - ADHS should identify the problems needing resolution and assist in a resolution process by directly attending to the problem or issue.
    - Have ADHS personnel work directly with the RBHA in the development of a solution to a problem and provide technical assistance and direct oversight of the effort until it is resolved.
    - Require the use of state approved consultants to assist in areas that cause poor performance
    - Develop an institute for development and training in CFT practice, to send poor performing providers. This would increase ADHS' ability to sustain this practice over time.
    - Limit a provider's ability to bid on new contracts based on previous lack of performance.
    - Contractually required corrective action plans should be used as a higher level approach, if other methods have not been effective to obtain desired results. Use the contract deliverables and notice to cure methods for getting the RBHAs focused on developing capacity, performance, and outcome thresholds, established by ADHS.

- If there is lack of performance take away specific targeted functions and corresponding resources from the RBHA and contract with another provider to get those specific services delivered in the desired manner (i.e. case management, QM processes, residential authorizations/concurrent reviews, crisis services, etc.). This same process can be used by the RBHA to hold Providers accountable.

B. The State has issued a number of documents setting forth standards for complying with some of the *JK* Principles, for example, the practice improvement protocol and technical assistance document for child and family team practice. RBHAs and providers should be held accountable for meeting the standards in these documents.

ADHS needs to require some PIP's and TAD's as part of the contract and other PIP's and TAD's are clinical guidance documents or best practice documents that do not need to be required. Below are the PIP's and TAD's and how they might be separated to support CFT practice.

Practice Improvement Protocols (PIPs):

Required of RBHAs contractually

Transitioning to Adult Services
The Adult Clinical Team
The Child and Family Team
Therapeutic Foster Care Services for Children
Out of Home Care Services
Pervasive Developmental Disorders and Developmental Disabilities

Clinical or System Guidance

The Use of Psychotropic Medication in Children and Adolescents
Attention Deficit Hyperactivity Disorder
Substance Use, Abuse and/or Dependence in Pregnant and
Postpartum Women
Co-Occurring Psychiatric and Substance Disorders
Substance Abuse Treatment in Children
Best Practices
Children and Adolescents Who Act Out Sexually
The Unique Behavioral Health Service Needs of Children Involved with CPS

Technical Assistance Documents (TADs)

Required of RBHAs contractually

Requests for Neuropsychological Evaluations from Arizona Health Care Cost Containment System (AHCCCS) Health Plans and Tribal/Regional Behavioral Health Authorities (T/RBHA) and Providers
Informed Consent for Psychotropic Medication Treatment
The Child and Family Team Process
Information Sharing with Family Members of Adult Behavioral Health Recipients
Informed Consent for Psychotropic Medication Treatment

Clinical or System Guidance

Disorders of Attachment
Providing Services to Children in Detention
Polypharmacy Use: Assessment of Appropriateness and Importance of Documentation

3. Development of direct supports, home-based respite, and therapeutic foster care.

There should be more direct supports, home-based respite, and therapeutic foster care. These need to be immediately available in crisis situations (e.g., where there is an imminent risk of placement in out- of-home or congregate care). The State should establish enforceable performance expectations for the development of direct supports, home-based respite, and therapeutic foster care. The plan would spell out measurable increases in capacity and a process for ensuring needed funding. Capacity should be consistently increased until reviews of the fidelity of practice to *JK* Principles show that all children are receiving the community-based services they need

Special attention should be paid to tailoring these services to the needs of children who abuse alcohol and drugs. It might be useful to have a practice improvement protocol on using community supports.

Planning Discussion
(The discussion was a brainstorming process to get all of the expectations and ideas on the table so as to understand the expectations for the JK Plan. Specific planning will include the ADHS/DBHS Bureaus and Divisions to review ideas and develop specific plan goals and tasks over a multi-year basis.)

- Increase Direct Supports, Home-Based Respite, Therapeutic Foster Care, Flex Funds, and Family Support Partner Services in a continuum: 1st year based on raw data, 2nd - 3rd based on more sophisticated data

- There will be an expectation to increase Direct Supports, Home-Based Respite, Therapeutic Foster Care, Flex Funds, and Family Support Partner Services regardless of money increase.

- DHS will need to develop a system to measure the increase in Direct Supports, Home-Based Respite, Therapeutic Foster Care, Flex Funds, and Family Support Partner Services from the identified baseline.

- ADHS will review licensing for foster care homes and TFC homes to ensure, homes will be in compliance for serving children up to the age of 21. TFC provider contracts need to be expanded to including serving youth, until the age of 21.

- It needs to be clear that the meaning of direct services encompass five primary service areas that include:
  - Direct support (as defined below and described as discrete services in the covered services manual),
  - Home based respite,
  - Therapeutic foster care (TFC)
  - Flex Funds
  - Family Support Partner Services

- Direct supports are those services provided to a family that are not provided in the office but in the home and community. Direct supports do not include counseling in or out of the office for this is seen as a clinical service irrespective of where it is provided. Direct supports include:
  - family support,
  - living skills training,
  - health promotion,
  - personal care services,
  - positive behavioral support (note: need to define)
  - other services that fit within these headings.

- ADHS needs to determine how much of the services described above are currently being provided within each RBHA. Encounter data is not accurate in determining this baseline. Only people who provide direct supports full or part time as their only job will be counted in the inventory. This should be the baseline used to determine how much direct support is in the system. This inventory should be done in 30 days and the results are the basis for the plan. A different counting approach will be used in the rural GSA's to accommodate the differences in methods for providing direct supports.

- ADHS Network Development will work to implement the inventory of direct support, by pursuing the use of a consultant with CA-SIG funding. Network Development will monitor the RBHAs to ensure the base is maintained, expected increases in direct supports are achieved.

- Provide training for direct support providers whether developed by the RBHA or by the Provider.

- A PIP, TAD or other guidance document should be developed on how to use direct supports effectively in; responding to immediate needs, the development of the full behavioral health service plan, the development of the crisis plan, identifying and providing mentoring, and as interventions/preventions for crisis. This document will also, set the expectation there will be no arbitrary reduction of direct services unrelated to need, including Direct Supports, Home-Based Respite, Therapeutic Foster Care, Flex Funds, and Family Support Partner Services.

- Network Development Plan- Is a disincentive. If RBHAs identify a need they are then contractually obligated to develop the services. A logic model is utilized to collect several different data points.

- A formula may be useful for creating an incremental plan by asking a variety of national experts their view of the quantity of direct support generally needed in an effective system. One such formula was developed by John VanDenBerg is 1/3 direct supports, 1/3 case management, 1/3 clinical services. Establish capacity thresholds in the contract for direct services, case management services, and clinical expertise (perhaps to the 1/3, 1/3, 1/3 approach) to encourage development in those areas.

- It is important to get a fix on what service level exists today so you know what you are building from when resources are added.

- In Volume 3, Service Delivery System, Schedule H: a grid was developed by all RBHAs detailing their plans for developing capacity.

- Funding: utilizing recoupment monies, grants, capitation increases, RSA establishment grant, capitalize on 4-E waiver use and these should be directed to the development of direct supports whenever possible.

- When funds are recouped ADHS must redirect them to services and functions that support CFT practice and the 12 Principles.

- ADHS needs to negotiate with the RBHAs on redistribution of funds to those services and functions that support CFT process, including direct supports and shift them out of areas of less value (i.e. out of home services, professionalized intake/assessment, counseling not recommended by a team process) to implementation of the CFT practice and meeting the needs of children and their families. (Current contract supports this concept)

- Specific areas of need can be targeted periodically by ADHS for development by the RBHA (i.e. Crisis system).

- Have rates been distributed for next year? Need to distribute any new money based on targeted areas of concern and needed development. Has there been a decrease in AHCCCS eligible kids? Will this create no increase, flat money? Assumptions should be updated and then actuaries should crunch the dollars.

- Family focus groups could provide feedback on the value of different services.

- The RBHA should maintain a list of all the possible direct supports identified so they can be used as educational and resource information for families and agency staff.

- An “Unmet Need” system could be developed similar to the adult system.

- In the first year the plan will identify an increase in direct supports with the 1/3, 1/3, 1/3 principle as the target. In future years the expansion will be based on a review of:
  - Focused reviews of children and families in out of home placements, cross system teams and those with high needs.
  - Needs identified in CFT Practice Reviews
  - Family focus groups
  - Systematic unmet needs process

- An end quantity of direct support is needed and the plan should allow for periodic review of that number.

- ADHS will review rate and compensation for direct support to ensure there are no barriers to implementation.

- Family member, system involvement is prioritized as the following:
  - Fidelity Measurement/Review
  - Direct Support
  - Family Support Partner services - including supporting families of high needs children
  - Intake processes

- ADHS will define the specific role of the family support partner and publish this as a mandatory system guidance document. Family support partners, to qualify for ADHS funding, will need to provide only the services described in this guidance.

- Family Support Partner services will be increased by 20% from the current base. All new capacity will be provided by family based agencies outside the provider networks. This will provide a choice for families in who provides their family support, and will provide an option for providers who may choose to use these agencies to obtain their FSP's.

4. Development of case management.

There should be performance expectations for case managers and/or case management. The State should clearly articulate: the functions of case management and a process for identifying the intensity of case management needed for a child including whether the child should have a dedicated case manager to provide needed case management services. The plan should include caseload criteria for those performing case management services, including case managers, clinical liaisons, therapists, and family support partners.

The plan should require measurable increases in case management capacity and a process for ensuring needed funding. Capacity should be consistently increased until reviews of the fidelity of practice to *JK* Principles show that all children are receiving adequate case management services.

Planning Discussion
(The discussion was a brainstorming process to get all of the expectations and ideas on the table so as to understand the expectations for the JK Plan. Specific planning will include the ADHS/DBHS Bureaus and Divisions to review ideas and develop specific plan goals and tasks over a multi-year basis.)

- Develop a clear and detailed description of Case Management so activities are clear. The description of case management functions should be included in the covered services manual or some other place so that encountering for this service would be clear and better and more accurate data would be available in the future.

- ADHS needs to do an inventory of all full time case managers currently in the system and their current case loads. The inventory was to be of case managers and not case management services. This needs to be done in the next 30 days. The case manager is to be the person who provides the services defined above.

- ADHS Network Development will work to implement the inventory of case managers, clinical liaisons and clinicians, by pursuing the use of a consultant with CA-SIG funding. Network Development will then monitor the RBHAs to ensure the base is maintained, expected increases in direct supports are achieved. Inventory of Clinical Liaisons and Clinicians would include their self-prescribed areas of expertise and average percentage of time spent performing case management functions.

- 35% of all children should be assigned a case manager in the first year of the plan and those children assigned a case manager should be the highest needs children.

- A case manager for 25% of the highest needs children should have an average caseload of 1:15 and 10% shall have caseloads not to exceed 1:30, both combined equal the 35% requirement.

- A set of criteria for determining high need should be established and disseminated. The criteria should include at a minimum:
  - Multiple system involvement (CPS, juvenile justice, DDD)
  - Children at risk of out of home placement
  - Children returning to their community from an out of home placement
  - Children with complicated behavioral health needs
  - Risk due to youth having children or having a parent in the adult behavioral health system

- The goal for the second year is to have children entering the system assigned a case manager who would follow them through the intake process and become their case manager on an ongoing basis unless they were high needs, and they would then be assigned to the high needs caseloads.

- During the first year of the plan there would be a pilot established to assign case managers at intake to prepare the system for the second year initiative.

- The state would establish reasonable case load ratios for non high needs children and would continue to increase the availability of case management services for all children over the next 3 years of a five year plan cycle.

- ADHS should contract with a non-traditional behavioral health pilot project in GSA 5 and 6 that would demonstrate the establishment of at least one free standing case management agency whose sole function is to provide case management. All other services would be provided through contracted services when the team determined they were needed. This pilot may consist of the 50 children who have the highest use of behavioral health services. This approach will be expanded each year for the next 4 years by focusing these services on the new people coming into the system and not by moving people from their existing agencies. The behavioral health case management agency pilot could be developed using some of the providers who have demonstrated a real ability to implement the CFT Practice or agencies that do both activities could be encouraged to separate their operations (completely or organizationally) toward the areas of greater interest and/or demonstrated expertise. The move would send a message to other providers that they need to develop in this direction more quickly or be left behind as the system develops in the future. It also provides more competition, greater selection for consumers and quicker movement toward overall implementation of the CFT Practice and 12 Principles. This case management pilot would provide:
  - Intake
  - Assessment
  - Crisis stabilization
  - Family support
  - Formation of the Child and Family Team
  - Service planning
  - Direct Support
  - All other services would be received from separate agencies or separate subsidiaries that could provide psychiatric services, counseling, TFC and residential placements needed by the child and family.

  Additionally, the state will work in partnership with the RBHAs to jointly establish the principles of the Piolot, maintain state involvement in the implementation, utilize different approaches to meet the desired outcome, and develop outcome standards.

- ADHS should evolve the clinical liaison into a behavioral health case manager position.

- ADHS should work to replace the Clinical Liaison system with Team Coordinators, who can focus on proper implementation of the CFT practice with fidelity to the 12 Principles and the CFT PIP and a clinical consultant network, which can focus on providing clinical support to teams addressing the specific needs identified by the team. ADHS will develop an approach where current non-credentialed and privileged staff can be promoted to Team Coordinator with proper training and experience.

- The ladder system should include opportunities for entry level case manager to develop into clinical liaison case manager. These opportunities could include a method to convert Continuing Education Units (CEUs) into semester hours and relationships with Universities to provide semester hour programs that are accessible to staff.

- ADHS should not have two people responsible for one child (i.e. case manager and clinical liaison) and should settle on the behavioral health case manager with appropriate clinical support available to the team when needed.

- ADHS should strive to ensure where there is CPS involvement; the families are driving the CFT, unless there is a court order baring involvement. Foster families must also be active participants in the CFT. This can be monitored through the CFT Practice Measurement Process.

5. Training

There should be an effective training program that: identifies staff who need training and the training they need, includes as the primary training method hands-on coaching and mentoring, and has a sufficient number of qualified trainers, coaches and mentors. The training should be competency-based and provided before employment or within 30 days of staring work. Class room training should be immediately connected to coaching and mentoring

The plan should create an expectation of measurable increases in the number of staff with the competence to serve children according to the Principles. The number of trainers, coaches and mentors should be increased until reviews of fidelity to *JK* practice show that all children are receiving services from staff competent to deliver service according to the Principles.

Planning Discussion

(The discussion was a brainstorming process to get all of the expectations and ideas on the table so as to understand the expectations for the JK Plan. Specific planning will include the ADHS/DBHS Bureaus and Divisions to review ideas and develop specific plan goals and tasks over a multi-year basis.)

- A PIP, TAD or other type of guidance needs to be developed on training and coaching explaining what ADHS expects from training and how it is to be delivered.
- Training is needed on how to use direct support services in service planning. This training would be for professionals and families.
- Training needs to be hands on training. Adult learning principles suggest that people don't learn well in the classroom and on the job training and coaching with good knowledgeable supervision is the best method for training.
- Training needs to focus heavily on supervision and management.
- Trainers and coaches need to go out to and be with the workers and supervisors and do on the job work.
- The classroom-to-coaching shift needs to be implemented within the first two years of the plan. The dollars would also need to shift.
- Build the proper amount of money for training into the CAP rate or covered service rate. Make sure that that amount of money in the CAP rate is in fact being spent within the RBHA system. (travel costs also needed to reflect real costs).
- Require RBHAs to identify their training budget and where the funds are being spent.
- Require RBHAs to spend their training funds for classroom and on the job coaching/training based on a percent required ____% in the plan.
- Use trainers who have practiced according to the principles.
- All levels of supervision and internal coaching personnel need to be experienced in successful implementation of the CFT practice and be able to supervise staff in this practice.
- Develop minimum core training requirements for case managers and facilitators focused on the CFT practice and case management fundamentals.
- Funds will be made available for the training of families to better advocate for themselves and navigate the system.

- Enforce current requirements around the supervision tool developed and required by ADHS.

6. Clinical expertise.

There should be strategies to increase the number of clinicians with appropriate expertise. The State should establish a performance expectation that RBHAs and providers will have a sufficient number of clinicians with appropriate expertise. The plan should require measurable increases in the number of clinicians with appropriate expertise and a process for ensuring needed funding. RBHAs and providers should recruit clinicians with appropriate expertise or find ways to develop appropriate expertise in their current workforce, or both. Capacity should be consistently increased until reviews of fidelity to *JK* practice show that all children are receiving adequate clinical services.

Planning Discussion
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- ADHS needs to require some PIP's and TAD's as part of the contract and other PIP's and TAD's are clinical guidance documents or best practice documents that do not need to be required. Below are the PIP's and TAD's and how they might be separated to support CFT practice.

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Informed Consent for Psychotropic Medication Treatment
The Child and Family Team Process
Information Sharing with Family Members of Adult Behavioral Health Recipients
Informed Consent for Psychotropic Medication Treatment

Clinical or System Guidance
Disorders of Attachment
Providing Services to Children in Detention
Polypharmacy Use: Assessment of Appropriateness and Importance of Documentation

- Clinicians should be licensed experts with a high competence and skill level performing:

  - Clinical assessments.
  - Clinical supervision,
  - Clinical interventions
  - Positive behavioral support including functional analysis of behavior

- ADHS should name a consultant, in the JK Plan, to perform the following:
  - Improve general clinical expertise for address areas, such as trauma and running away.
    - Identify good practicing clinicians, in state, to form a cadre of experts for mentoring and
      coaching other clinicians.
  - Develop a plan to improve clinical competency in meeting the needs of children with: Developmental Disabilities, Substance Abuse, and sexual related issues.
    - The plan will include the identification of programs to implement in Arizona and the identification of experts to consult directly with CFTs.
  - Connecticut Model for building clinical expertise
- ADHS will provide guidance on how needed clinical activities can be encountered.

- ADHS will identify the clinical expertise available in important key specialty areas including:
  - Sexual issues
  - Trauma
  - DD
  - Birth to five
  - Substance Abuse

- ADHS will shift funding supporting, ineffective clinical services to those most needed by children and families to effectively meet desired outcomes.

7. Avoid congregate facilities.

There should be a targeted effort avoid placement of class members in congregate facilities and to facilitate the discharge of class members in congregate facilities. Additional PIPs and TADs may be needed.

Planning Discussion
(The discussion was a brainstorming process to get all of the expectations and ideas on the table so as to understand the expectations for the JK Plan. Specific planning will include the ADHS/DBHS Bureaus and Divisions to review ideas and develop specific plan goals and tasks over a multi-year basis.)

- Develop targets for decreased length of stay and reduced number of youth in care of behavioral health Out-of-Home placements.
- Tighten the authorization process for Out-of-Home placements. Children under the age of 12, should not be authorized for these placements.
- Increase capacity for RBHAs to provided rapid intervention for teams requesting OOH. These interventions would work with the CFT to develop alternatives to residential.
- Increase capacity of crisis stabilization teams, similar to Maricopa County's CPS Stabilization Teams and Special Assistance Teams. Children who have requests for OOH, users of the crisis system, and who's team has identified as a risk for OOH should be targeted.
- Establish very short term residential to provide reprieve for CFT's to reinvigorate and develop supportive plans for children to remain in the community. This can be fashioned after the Group Home Without Walls or Tucson's Sendaro.
- Crisis planning is a skill that needs to be developed as a clinical consultation specialty.

8. Substance abuse treatment.

There should be an aggressive effort to reach, assess, and treat children with substance abuse issues. A more thoughtful approach to treatment of children with substance abuse issues needs to be developed and implemented. Additional PIPs and TADs may be needed.

Planning Discussion
(The discussion was a brainstorming process to get all of the expectations and ideas on the table so as to understand the expectations for the JK Plan. Specific planning will include the ADHS/DBHS Bureaus and Divisions to review ideas and develop specific plan goals and tasks over a multi-year basis.)

- In addition to current grant directed activity, survey existing Intensive Out-Patient Substance Abuse programs and the base of current clinical activity in the substance abuse area, to determine quantity of service dollars currently supporting these activities.
- Review current activities to determine which programs or individuals are practicing according to the Substance Abuse PIP and current best practice approaches. Redirect funds supporting poorly performing programs to those desired by AHDS.
- ADHS will turn training opportunities for Substance Abuse competence, into expectations for practice.
- RBHAs will increase capacity for providing substance abuse services by ___%, with training provided by ____expert and by the end of the year will have _____ approved trainees designated by the expert.
- Substance Abuse PIP should emphasize the Support Paradigm and focus on using mentors.

9. Intake.

Intake policies should be revised to ensure that the initial assessment is performed by the team and is of quality.

Planning Discussion
(The discussion was a brainstorming process to get all of the expectations and ideas on the table so as to understand the expectations for the JK Plan. Specific planning will include the ADHS/DBHS Bureaus and Divisions to review ideas and develop specific plan goals and tasks over a multi-year basis.)

- It was felt that the current intake/assessment process was a continuation of the old way of doing business and was not thought valuable by the agencies. This would be an important change and support the better CFT practice and 12 principles.

- The intake process should start with an effort to identify any crisis or urgent needs that must be addressed immediately, establishing some family support, completing any intake paperwork that was needed to start services and beginning team formation. The next step would then involve getting to know the family, understanding their current situation, identifying their longer term goals and starting to form the child and family team. The assessment should be done later but within the 45 day requirement.

- Utilize Family Support Partners, in the intake to facilitate initial engagement and triage activities.

- The intake process should be the starting point for case management and the case manager would coordinate the next steps of forming the team, arranging for the assessment, facilitating the team process, completing the strengths, needs and culture discovery, and developing the service plan, all with full team involvement.

- The intake/assessment process relies on high paid clinical people to do a process not supportive of CFT practice. There may be a savings found if this intake/assessment process was redesigned to be more effective and supportive as suggested above.

10. 18 to 21 year olds.

There should be an enforceable performance expectation, in both the children's system and the adult system, that youth aged 18 to 21 will be served according to the Principles. Compliance with this expectation should be assessed by the quality management system, using the review process referenced in #1 above. Additional PIPs and TADs may be needed.

Planning Discussion

- ADHS should create a structure to allow for young adults to keep their CFT, case managed/facilitated by the children system after the age of 18.

- Case loads for staff working with this age group need to be low, for there is a high probability that transition activity including housing, employment, benefits, continuing education and interfacing with the adult system will become a more intensive process.

- Transition into the adult system should occur as determined by the CFT between the ages of 18-21.

- The adult system should have designated, trained case managers to coordinate services for young adults as they transition into the adult system.

- Children's and adult services should be available for young adults ages 18-21.

- Transition planning for young adults involved with CPS, should include a family finding focus.

- RBHAs need to develop housing options, appropriate for this age group.
- ADHS will develop a process for identifying youth 16-17 years of age, to notify Team Coordinators and/or supervisors to develop transition plans, as required by ADHS.
- Update and improve the Transition PIP to include emphasis on continuing education, housing, and continuity in TFC.

11. Financial incentives.

Financial incentives need to be aligned to encourage practice according to the Principles.

Planning Discussion
(The discussion was a brainstorming process to get all of the expectations and ideas on the table so as to understand the expectations for the JK Plan. Specific planning will include the ADHS/DBHS Bureaus and Divisions to review ideas and develop specific plan goals and tasks over a multi-year basis.)

- ADHS should require the RBHAs to reduce in-office services provided. A baseline needs to be determined by encounter data and a percentage reduction will be developed, to be included in the JK Plan.
- ADHS should meet with RBHA CFO's, or other designated positions, to determine what financial disincentive exists to implementing JK.

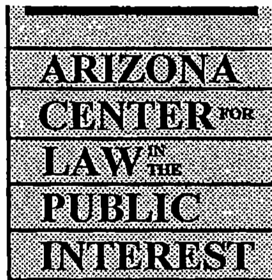
12. Low intensity children.

The plan should include a clear vision for serving children with less complex needs. Much, if not all, of the problem would be solved by ensuring that these children receive adequate case management services from a variety of provider staff. The plan should describe how the child and family team process works, and the Principles are implemented, for children with varying degrees of need.

Planning Discussion
(The discussion was a brainstorming process to get all of the expectations and ideas on the table so as to understand the expectations for the JK Plan. Specific planning will include the ADHS/DBHS Bureaus and Divisions to review ideas and develop specific plan goals and tasks over a multi-year basis.)

- ADHS should develop a protocol for checking in with families, whose children have less complex needs. The protocol should include methods for elevating services when needs increase.
- ADHS should determine case load requirements for case managers who service children and families with less complex needs.

EXHIBIT 13



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March 31, 2008

VIA U.S. MAIL

Kevin Ray
Attorney General's Office
1275 West Washington
Phoenix, Arizona 85007-2926

Mr. Logan T. Johnston
Johnston Law Offices, PLC
One North First Street, Suite 250
Phoenix, Arizona 85004-2359

Re: JK v. Gerard

Dear Kevin and Logan:

Plaintiffs have serious concerns about implementation of the Settlement Agreement. We have raised these concerns with Defendants, most recently when we described our conversation with Magellan's CEO. We hope to resolve them through collaborative negotiations so that we can avoid formally invoking the dispute resolution provisions of Settlement Agreement.

We acknowledge that progress has been made in implementing the Agreement. We also recognize that defendants have been responsive to the priorities plaintiffs identified during the previous dispute resolution process. Significantly, defendants launched a process for measuring the fidelity of services to the J.K. Principles. Defendants also made significant commitments to creating case management and direct support capacity. These efforts hold great promise. The case management and direct support initiatives, in particular, will move the system forward in critical areas.

Nevertheless, significant barriers remain. Below, we briefly describe our concerns.

First, progress has not been adequate in serving increasing numbers children according to the J.K. Principles. The RBHA reports on how many children are being served in child and family teams are inflated since those reports do not adequately take into account whether the team is practicing according to the principles. We had hoped that the practice review would provide more reliable information on whether and to what extent children are being served according to the principles, but it has been so poorly implemented that it is unclear whether one can trust the assessments it yields. Other information available to us, including reports from individuals well-positioned in the system, suggests that progress in serving children according to the Principles has stalled.

One reason for this, we think, is the continuing failure to articulate and enforce expectations that speak directly to serving children according to the Principles. The expectations emphasized and enforced by the state remain focused on quantity, not quality, for example, hiring particular kinds of staff or spending a particular amount of money on particular services. While we agree that quantitative indicators are important, they are no substitute for performance expectations that speak directly to the core requirement of the Settlement Agreement, namely, that children receive services according to the Principles.

Another reason for the lack of progress, we think, is the lack of an implementation plan developed collaboratively with RHBA's, providers, and champions of J.K. such as family organizations.

Second, as mentioned above, the practice review has been poorly implemented. When the review was being planned, we expressed our concern that the WAFAS was inadequate for evaluating whether services were being delivered according to the Principles. We appreciate that the state responded to our concern by assuring us that the WAFAS would be adapted, including, for example, by having reviewers as a team give comprehensive and meaningful feedback to providers they reviewed. However, the state has failed to implement the WAFAS as advertised. Not only has the state failed to implement modifications discussed by the parties, but the state has even failed to implement the WASFAS in the way it is designed. For example, neither qualified reviewers nor reasonable samples are being used. As a result, the WAFAS cannot meaningfully guide practice improvement. Providers have no faith in the process.

Third, little progress has been made in ensuring that 18-21 year olds are served according to the J.K. Principles. While the state has adopted some relevant policies, there has been little change since we raised this issue in 2006 in how youth 18-21 are served. These youth continue to be denied the benefits of the Settlement Agreement.

Fourth, there still is no functioning system for identifying children with high needs in the system, a first step to ensuring they get needed services. This is especially perplexing because the state in 2006 developed a reasonable and simple approach for identifying these children. We are unsure why this approach was abandoned.

Fifth, little progress has been made in ensuring that class members receive needed substance abuse services consistent with the J.K. Principles. There has been much talk and study, but we are unable to discern any significant progress in this area.

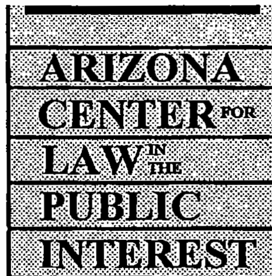
Sixth, training remains inadequate. There are not qualified trainers in sufficient numbers to train front-line staff and supervisors, and the training program does not provide front-line staff and supervisors with sufficient knowledge and skills to enable them to plan and provide services consistent with the *JK* Principles.

While these are not an exhaustive list of concerns, they are the concerns of most immediate importance. We have confidence that, if Plaintiffs and Defendants approach these matters with an open mind and in good faith, we can negotiate a collaborative resolution of them.

Sincerely,

Anne Ronan
Ira A. Burnim

cc: Michael Fronske
Brian Lensink
Leezie Kim



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May 21, 2008

Mr. Kevin D. Ray
Arizona Attorney General's Office
1275 West Washington
Phoenix, Arizona 85007-2926

Re: Settlement Agreement, Paragraph 55

Dear Kevin:

When we met last week in Phoenix, Plaintiffs said they would identify by letter the issues to be addressed at our June 3, 2008 meeting which will focus on Paragraph 55 of the Agreement. We propose the meeting be a working meeting where we try to reach agreement on (a) whether and how the WAFAS process will be improved and (b) additional sources of information the State will use to measure "whether services to class members are consistent with and designed to achieve the Principles." We propose the meeting focus on the following matters:

- Collecting richer information on fidelity to the JK Principles. We think that refining the guidance given to interviewers and record reviewers would allow the State, without changing the questions asked, to collect richer information and provide more meaningful feedback to providers. This could be accomplished, for example, by ensuring that reviewers take full advantage of opportunities to explore the adequacy of the CFT's assessment and service planning. Reviewers could be asked to explore and perhaps determine whether the services in the plan are likely to be effective in meeting a child's needs.

- Integrating the information from the family interviews and the record review. We propose that the same individual score both the interviews

and the record review or that the family interviewer and the record reviewer jointly score both the WFI and the record review instrument.

- Ensure that reviewers are competent to make the judgments required by the WAFAS. We think the WAFAS would be a more effective vehicle for improving practice if the standards for reviewers were raised, and if the necessary infrastructure was in place at the RBHA and at the family organization to ensure proper training, oversight and competence.

- Ensure that systemic issues that emerge from the review process are identified and communicated, for example, issues of working with CPS.

- Ensure an appropriate number of cases from a provider are actually reviewed. In some cases there were as few as three cases in which the caregiver and the facilitator were interviewed.

- Ensure caregivers and family members are interviewed in person, and increase the number of other team members interviewed to gather a clear picture of the case.

Additional Measures

Attached for your review is a comparison of the JK Principles and the questions in the WAFAS. We welcome your comments on whether we have omitted relevant WAFAS questions and whether our comments in the third column are accurate.

The SOC Plan says that the State is using information from the WAFAS and other sources of information (referred to as children's performance measures) to evaluate fidelity to the Principles. We asked for a description of the additional sources of information. We propose that at the meeting the parties attempt to reach agreement on the additional measures that will be used, including:

- Measures of compliance with required practice protocols.

- Measures of whether services are designed and implemented to achieve the JK functional outcomes. These measures may include both outcome measures and measures that look at the adequacy of assessment and

service planning. The CASII may provide information relevant in this regard.

- Measures of whether services are provided in the most integrated setting.
- Measures of the sufficiency of interagency collaboration.
- Measures of stability and the sufficiency of efforts to achieve stability (e.g., minimize multiple placements, avoid removal in crises).
- Measures of the adequacy of the array of services offered by the RHBA, including direct supports, case management, and substance abuse services. We understand that the State can quantify these services and is developing methods for evaluating whether they are of acceptable quality.

Please let us know if you have questions concerning the above. Thank you.

Sincerely,

Anne Ronan
Ira A. Burnim

cc: Dr. Laura Nelson
Brian Lensink
Michael Fronske
Logan T. Johnston
Leezie Kim

JK Principles & WAFAS Questions

Principle	Content	WFI interviews	File review	Comments
Collaboration with the child and family	* Parents treated as partners in assessment, planning, delivery and evaluation; * Parent preferences taken seriously	1.1, Y1.1 (family/youth given time to talk about strengths beliefs and traditions and for youth, things like and good at; shared with team) 1.2, Y1.2 (explaining wraparound process and family's choices) 1.3, Y1.3 (family/youth given opportunity to tell things have worked in past) 1.4, Y1.4 (family/youth select who on team) Y1.6 (youth happy with the members of the team) 2.1, Y2.1 (family/youth and team created plan describing how team will meet needs) 2.10 (family makes final decision in designing wraparound plan) 2.11, Y2.5 (team took time to understand family's/youth's values and beliefs and plan is in tune with them) Y2.3 (team knows what youth likes and things do	1 (family and youth's needs/concerns are documented) 2 (documentation that identifies and prioritizes needs for child and family) [scoring appears to give consideration to whether documentation reflects family's view] 6 (child and family team is doing the planning and implementation) 7 (service plan specifies family's goals/objectives) 8 (clearly articulated long range vision of the future for youth and family) [scoring indicates this should be family's articulation] 10 (goals and objectives of service plan relate to needs family has prioritized) 25 (evidence that family and/or youth making decisions about direction and method of team)	

		well) 3.1, Y3.1 (important decisions made with child and family) 3.6, Y1.5 (friend or advocate of the family/youth actively participates on team) 3.10, Y3.8 (team uses language the family can understand) 3.12, Y3.10 (all team members, including friends, family and natural supports, participate in meetings) 3.14, Y3.12 (all members demonstrate respect for the family) 3.15 (youth has opportunity to communicate views when time to make decision) Y3.13 (youth has chance to give ideas during meetings) 4.5 (after formal wraparound has ended, there is a process to re-start it if youth/family needs it)		

Functional outcomes	Services designed and implemented to achieve: * Success in school * Children live with families * Avoid delinquency * Become stable and productive adults * Stabilize child's condition * Minimize safety risks	1.6 (process of identifying what leads to crises/dangerous situations) 2.8, Y2.7 (crisis/safety plan specifies what everyone must do to respond to crises and how to prevent crises) 2.9 (confidence that team can keep child in community in event of crisis)	16 (service plan developed in the LRE and if in a more restrictive environment includes strategies to move to a LRE) 21 (crisis plan based on comprehensive functional assessment on predicted crises and includes strategies to prevent crises) 22 (crisis plan identifies signs/behaviors of impending crisis and ways to deescalate crises) 23 (crisis plan includes specific steps to be taken if crisis occurs and assigns responsibilities for steps)	* There are questions (not catalogued here) that look at whether the team has set goals and whether progress is being made toward goals. However, the questions do not look at whether services are designed and implemented to achieve the outcomes specified in JK * Information relevant to whether services are designed and implemented to achieve the outcomes specified in JK may be available via CASII * Some information relevant to whether services are designed and implemented to achieve JK outcomes may be available from questions on LRE and crisis planning
Collaboration with others	* Joint assessment, joint plan, and joint implementation for multi-system involved kids	1.5 (if difficult to get members to attend team meetings) [reviewer probes issues related to getting participation by others including other agencies]	11 (services/activities coordinated through integrated service plan) [grading tool says reviewer is looking for collaboration between system partners in	* No question directly asks whether there is a joint assessment or plan for multi-system kids * No question on whether team includes representa-

	* Team includes representatives from other agencies needed to develop an effective plan including teacher, Child Protective Service and/or Division of Developmental Disabilities case worker, and probation office * Team includes any foster parents	2.6 (whether member of team do not have a role in implementing the plan) [example in grading: if school rep comes b/c "has to be there" but doesn't participate] 3.12, Y3.10 (all team members, including friends, family and natural supports, participate in meetings)	the development of service plan] 27 (evidence that individuals on CFT working together to provide coordinated services/supports)	tives from other systems (e.g., education, child welfare, juvenile probation, DD) when needed to develop an effective plan * No question on whether teacher included if needed to develop an effective plan * No question on whether foster parent is on team *How is the concept of wraparound ending or finishing (see 4.5, 4.8) harmonized with the idea that all children have CFTs?
Accessible services	* Comprehensive array of behavioral health services, sufficient to ensure children receive the treatment they need * Case management as	3.2, Y3.2 (when team has good idea for support/service, it finds the resources/figures out some way to make it happen) 3.8, Y3.7 (whether services/supports are hard to access b/c they are far away or b/c transportation issues)	13 (services/supports based on needs, not on availability of services/supports)	* No question on whether services on plan are likely to be effective in meeting child's needs * No questions about case management * No question on whether plan identifies and addresses transportation needs

	needed * Plans identify transportation needs to access services * Services adapted/created when needed but not available			
Best practices	* Services provided by competent individuals who are adequately trained * Services delivered in accordance with ADHS guidelines that incorporate evidence-based Abest practice@ * Plans identify and appropriately address behavioral symptoms that are reactions to death, abuse/neglect, LDs, trauma,	3.7, Y3.6 (team comes up with new idea for plan when family's needs change or something isn't working)	28 (documentation that progress towards goals and action steps has been monitored) 29 (child and family are making progress towards their goals)	* No questions looking at competence of individuals providing service * No questions re: whether services incorporate evidence-based practice * No questions on whether teams/plans identify and address behavioral symptoms that are reactions to death, abuse, neglect, substance abuse, DD, maladaptive sexual behavior, etc. * Questions on service modification do not reference JK functional outcomes

	substance abuse, DD, maladaptive sexual behavior, and need for stability and permanency (esp for kids in foster care) * Services continuously evaluated and modified if not meeting desired outcomes			
Most appropriate setting	* Services in child's home and community to extent possible * Services in most integrated setting appropriate * If residential necessary, most integrated and home-like setting	2.5, Y2.4 (plan includes strategies to get youth involved in community activities)	16 (service plan developed in the LRE and if in a more restrictive environment includes strategies to move to a LRE) 19 (service plan includes opportunities for youth to engage in community activities)	* There does not appear to be a direct look at whether child is being served in most integrated setting. The focus is on "LRE," which while related to integration, is different. * Interview does not include questions on LRE. * No inquiry into whether residential program is most integrated and home-like residential program possible

Timeliness	* Children assessed and served promptly			*Measures other than WAFAS address timeliness. Do these other measures look at whether (a) urgent matters are appropriately identified and (b) if identified, get immediate attention?
Services tailored to child and family	* Strength and needs dictate type, mix and intensity of services * Parents and children encouraged and assisted to articulate own strength and needs, goals, and service preferences	1.1, Y1.1 (family/youth given time to talk about strengths beliefs and traditions and for youth, things like and good at; shared with team) 1.2, Y1.2 (explaining wraparound process and family's choices) 1.3, Y1.3 (family/youth given opportunity to tell things have worked in past) 2.1, Y2.1 (family/youth and team created plan describing how team will meet needs) 2.4 (supports/services in plan connected to strengths and abilities of child and family) 2.10 (family makes final decision in designing wraparound plan) 2.11, Y.2.5 (team took time to understand	1 (family and youth's needs/concerns are documented) 3 (examples of strengths, assets, resources and cultural considerations are included for areas of priority need) 7 (service plan specifies family's goals/objectives) 13 (services/supports based on needs, not on availability of services/supports) 16 (services/supports based on strength of youth/family) 25 (evidence that family and/or youth making decisions about direction and method of team)	

		family's/youth's values and beliefs and plan is in tune with them) Y2.3 (team knows what youth likes and things do well) Y2.8 (youth feels like he and his family gets the help they need) 3.3, Y3.3 (youth involved in activities that builds on strengths)		
Stability	* Plans strive to minimize multiple placements * Plans identify if child at risk of placement disruption and steps to take to minimize/eliminate the risk * Plan anticipate and plan for crisis * In responding to crisis, use all service possible to help child	1.6 (process of identifying what leads to crises/dangerous situations) 2.8, Y2.7 (crisis/safety plan specifies what everyone must do to respond to crises and how to prevent crises) 2.9 (confidence that team can keep child in community in event of crisis) 4.4, Y4.4 (team helped child prepare for major transitions through planning) 4.6, Y4.2 (wraparound has helped the family develop/strengthen relationships that will support them when	20 (transition planning documentation identifies needs, services and supports that will continue to need attention after formal supports discontinued or when transitioning to adult service system) 21 (crisis plan based on comprehensive functional assessment on predicted crises and includes strategies to prevent crises) 22 (crisis plan identifies signs/behaviors of impending crisis and ways to deescalate crises)	* Questions don't examine efforts to minimize multiple placements, minimize placement disruptions * Questions don't examine efforts, in crises, to avoid removal from home and inappropriate use of police/criminal justice system

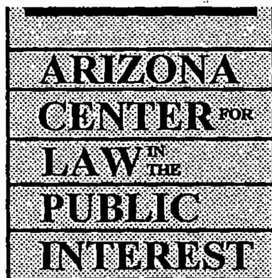
	remain at home, minimize placement disruptions, and avoid inappropriate use of police/crim justice system * Service plans anticipate and appropriately plan for transitions in children's lives, including transitions to new schools and new placements, and transitions to adult services	wraparound finished)	23 (crisis plan includes specific steps to be taken if crisis occurs and assigns responsibilities for steps)	

Respect for child and family's cultural heritage	* Services provided in manner that respects cultural traditions and heritage * Services provided in Spanish when that is family's primary language	1.1 (family given time to talk about strengths beliefs and traditions; shared with team) 2.11, Y2.5 (team took time to understand family's/youth's values and beliefs and plan is in tune with them) 3.10, Y3.8 (team uses language the family can understand) [scoring refers to needing to address language barriers for non-English speakers] 3,14, Y3.12 (members show respect for youth and family)	3 (examples of strengths, assets, resources and cultural considerations are included for areas of priority need) 4 (examples of family and youth culture, values and beliefs are included for areas of priority need) 18 (services/supports based on culture of youth/family)	* No inquiry into whether services delivered in Spanish as required
Independence	* Services include support and training to parents to meet child's need * Services include support and training for children in self-management * Plan identify and provide training and support to parents and children to	1.2 (explaining wraparound process and family's choices) 4.3 (wraparound has helped child solve own problems)		* No questions on whether parents are given training and support to meet their child's needs themselves * No questions on whether child is given training and support in self-management (although is question on whether wraparound has helped the child solve his own problems) * No inquiry into supportive services to

	help them participate as partners (including transportation assistance, advance discussions, and help with understanding written materials)			parents and children to help them participate in process
Connection to natural supports	* System identifies and appropriately utilizes natural supports	1.5 (if difficult to get natural supports to attend team meetings, reviewer explores issue) 2.3, Y2.6 (services, supports, and strategies in family's plan) [more informal/natural supports, higher score] 2.5, Y2.4 (plan includes strategies to get youth involved in community activities) 3.4, Y3.4 (team finds ways to increase natural supports) 3.6, Y1.5 (friend or advocate of the family/youth actively participates on team) 3.12, Y3.10 (all team members, including friends, family and natural supports,	5 (documentation of natural supports) 8 (natural support actively involved or ongoing efforts to identify and engage natural supports) 19 (service plan includes opportunities for youth to engage in community activities) 25 (service plan at least partially implemented by natural supports)	

		participate in meetings) Y3.5 (team helps youth talk with friends and other natural supports when things aren't going right) 4.2, Y4.3 (wraparound has helped child develop friendships with other positive youth) 4.6, Y4.2 (wraparound has helped family develop/strengthen relationships that will support them when wraparound finished) 4.7 (family can succeed on own with help from natural supports)		

The WFI interview questions in the chart with no lettered prefixes are from the Caregiver, Facilitator and Team Member Forms. The questions on these forms are identical. Questions from the youth form contain the prefix Y and then the question number.



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June 19, 2008

Kevin Ray
Office of the Arizona Attorney General
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Phoenix, Arizona 85007

Re: JK v. Gerard Settlement Agreement; Paragraph 55

Dear Kevin:

Thank you for the productive discussion of June 3, 2008 concerning methods the State might use to determine "whether services to class members are consistent with and designed to achieve the Principles." Below we highlight what were for us some of the important elements and "take-aways" of the discussion.

We reviewed a list of Quality Management and Practice Improvement System Processes. The processes represent multiple sources of information available to the Department on how the system is performing. We discussed, among other things, the extent to which the processes evaluate whether services are designed and implemented to achieve J.K. outcomes: success in school, living with family, avoiding delinquency, and becoming stable and productive adults. We discussed the possibility of the DHS refining existing processes to better view the system through a "J.K. lens."

Of the sources of information reviewed, the following seemed to hold the most promise for evaluating fidelity to the Arizona vision and J.K.:

Practice Reviews[1]	QM
Assessment and CFT Practice Review using Chart Reviews	QM
Practice Protocol Monitoring	QM and Clinical
Program Area Monitoring	SOC
Structural Elements Reports	QM

[1] We discussed the Department's commitment to improving the WFI and DWP.

Quarterly SOC Network Dev. Plan Review	SOC
Quality of Care Reviews	QM
Out of State Placement case reviews	QM
Title XIX Utilization Report	QM
RTC Review	QM
Monitoring by Children's SOC Planning and Development	SOC

Also, to the extent they use a "J.K. lens:"

Performance Measures	QM
Administrative Review Process	Compliance

The Department indicated its intention to periodically review all the information garnered from these various sources to determine the extent to which services are being provided according to the Principles. The Statewide Quality Management Committee, which includes family representation from all regions of the state, could be a forum for such activity.

It may make sense to reduce the number of review processes. In addition to being less burdensome on the system, it would make easier the task of refining the processes to take a better "J.K. look," as well as the task of implementing processes in a quality way. Also, it might allow staff to devote more time and energy to understanding what the data teaches and reveals.

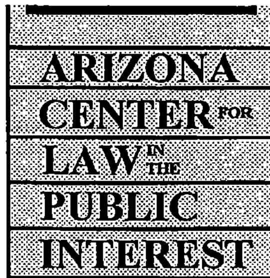
It may also make sense to give the Division's children's staff a greater role in overseeing processes for collecting information, synthesizing it, and making decisions regarding corrective action. Currently, much of the information collected – including nearly all information from large scale reviews – is generated exclusively by the Quality Management Division. Indeed, a case can be made that the Division's children's staff should take the lead in refining current QA processes, and in synthesizing and acting on the information regarding the children's system that these processes generate.

Again, thank you for meeting with us.

Sincerely,

Anne Ronan
Ira Burnim

cc: Dr. Laura Nelson
Brian Lensink
Michael Fronske
Logan T. Johnston
Leezie Kim



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June 20, 2008

Kevin Ray
Office of the Arizona Attorney General
1275 West Washington
Phoenix, Arizona 85007

Re: JK v. Gerard

Dear Kevin:

We look forward to meeting on July 26, 2008, and propose focusing on two topics: serving 18-21 year olds according to the J.K. Principles, and substance abuse services. Let us know if that is agreeable to the Department.

18-21 Year Olds

We appreciate the Department sending us a list of challenges and barriers in serving 18-21 year olds, and we look forward to a discussion of the approaches the Department is considering to resolve these matters. Items 1(a), 1(b), 2, 3, and 6 (fingerprinting, payment, multiple agencies and data tracking) strike us as matters amenable to administrative fixes, and we would appreciate an opportunity to better understand the strategies the Department is pursuing. It would help to have sense of the number of youth involved, even in approximate terms. For example, how many youth turn 18 while enrolled in the behavioral health system in Maricopa County? In other RBHAs? Of these, how many remain enrolled after their 18th birthday? How many are determined to be SMI? How many youth who were not enrolled when they turned 18 later enroll while aged 18-21? How many are determined to be SMI?

Regarding item 4 (statutory issue), has the Legislature been asked to enact a fix specific to the 18-21 year old issue? Does item 5 (transition to adulthood but not the adult system) have significance independent of items 1-4? Regarding the question in

item 6, what are the special challenges being referenced? Regarding item 1(c), is there a plan to provide all youth aged 18-21 needed behavioral health services, including case management and direct support, even if not SMI?

Substance Abuse

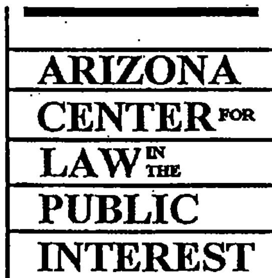
Thank you for the extensive and thoughtful materials the Department provided us. We think additional work may need to be done to ensure the evaluation tool better reflects the Adolescent Substance Abuse PIP (incorporating the JK Principles). Also, we are interested in learning more about: when the Department expects to begin aggressively expanding substance abuse services, whether the Department is committed to implementing the recommendations in the Issues and Needs Document, and how it plans to implement these recommendations.

Thank you.

Sincerely,

Anne Ronan
Ira Burnim

cc: Dr. Laura Nelson
Brian Lensink
Michael Fronske
Logan Johnston
Leezie Kim



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July 8, 2008

Kevin Ray
Office of the Arizona Attorney General
1275 West Washington
Phoenix, Arizona 85007

Dear Kevin:

We write to recap elements of our productive discussion on June 26, 2008.

<u>Settlement Agreement, Paragraph 55</u>

We appreciate the Department's clarifying some of the items discussed in the previous meeting, as well as the draft revisions to the Individual Service Plan format designed to underscore that service plans should be designed to achieve the "J.K. outcomes." We would like to hear more at our next meeting on how this may allow outcomes to be tracked systemically.

One of the items of clarification concerned the finding by one of the quality management processes that in only 33% of the cases were persons receiving appropriate services. At the meeting it was reported that when the encounter information was factored in the results were different. Please let us know if the Department plans to conduct further inquiries concerning the meaning of the 33% rating that the Maricopa County RBHA received for appropriateness of service plans. It seems to us unlikely that the low score is explained entirely by incomplete records.

Additionally, we would like further clarification as to whether the quarterly charts reviews assess whether the services provided are appropriate to meet the identified needs of the child.

We discussed our mutual concern with the poor performance by Touchtone Behavioral Health, one of the largest children's providers, in the most recent review of practice. It was particularly concerning in that this was the second review within six months showing poor performance. We urged the Department to begin immediately to engage Magellan and Southwest PNO to ensure that appropriate actions are timely taken if Touchstone's performance does not improve, and we urged a similar early planning approach for other providers with disappointing performance.

In response to our concerns with the current process for implementing the WAFAS and the evaluation of the results, including the development of necessary practice improvement strategies suggested by those results, the Department acknowledged similar concerns. We would appreciate an update at our July meeting of the progress made to include the children's staff at the Department in a more central figure in this effort.

We proposed that at our July meeting, the Department update us on its efforts to assess fidelity to the J.K. principles. Brian indicated his staff was preparing a cross walk of all the Principles with the current quality management processes. We are particularly interested in when the Department expects the desired system will be operational – that is, multiple sources of information reflecting the quality of practice will be reviewed together, and these assessments will drive practice improvement. We would appreciate Anne Ronan being invited to participate in the QA committee that will review relevant information.

18-21 Year Olds

The parties agreed that additional data is needed on how many children are in this group; how many continue to need mental health services after age 18 and of those how many are seriously mentally ill. The Department plans to collect this data. We also discussed possible fixes for identified barriers, including: creating a cadre of transition specialists in the adult system, who would meet the fingerprint clearance requirement for the children's system; changing the law to allow adult system staff to participate in Child and Family Teams and related activities for 16-17 year olds without getting fingerprint clearance; having the transition from the children's to the adult system occur at a later age, for example, 18½ or 19; and changing the law to allow both children and adult systems to pay for services for transitioning youth. The Department had concerns about some of these approaches.

The Department plans to explore strategies used by those RBHAs who have been successful in serving children in transition and consider requiring similar processes statewide.

We urged the Department to take steps to ensure that Title XIX youth aged 18-21 receive the case management, direct support, and other services they need, even if not seriously mentally ill.

We proposed that the Department update us at July's meeting. We are especially anxious to know when planned changes will be implemented.

Substance Abuse

Regarding possible under-identification, Plaintiffs proposed that there many be a number of explanations for the very low number of children receiving substance abuse services. Children and their family don't access the behavioral health system and instead end up in the Juvenile Justice system. Additionally, children who do enroll are not properly assessed for substance abuse and therefore go untreated. Plaintiffs suggested that the Department should develop a close relationship with the Juvenile Justice system to identify eligible children in need of substance abuse services. Once in the system, the best way to determine whether a problem exists -- and to resolve it – is by improving the quality of the Child and Family Teams. We agreed that a new screening approach may be warranted.

It is our understanding the Department intends to revise the Substance Abuse practice improvement protocol to create an expectation that all substance abuse services incorporate the core elements of the Department's new evaluation tool. In addition, the protocol will address collaboration with the court system and the use of direct supports. It is also our understanding that the Department intends to require the RBHAs to expand substance abuse services.

We proposed that the Department update us on these efforts at the July meeting, including projected implementation dates.

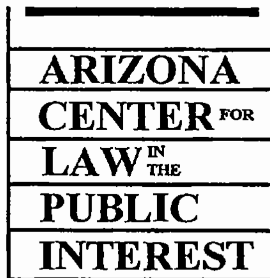
Thank you.

Sincerely,

Anne Ronan
Ira Burnim

cc: Dr. Laura Nelson
Brian Lensink

Michael Fronske
Logan Johnston
Leezie Kim



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September 18, 2008

Mr. Kevin D. Ray
Arizona Attorney General's Office
1275 West Washington
Phoenix, Arizona 85007-2926

Re: *J.K. v. Gerard*

Dear Kevin:

On March 31, 2008, we wrote to you of our serious concerns with the implementation of the Settlement Agreement. We hope to resolve our concerns through collaborative negotiations so that we can avoid formally invoking the dispute resolution provisions of the Settlement Agreement. Over the course of the ensuing months, we have had informative conversations on each of the identified concerns. However, we are concerned that the changes the parties discussed will not materialize for months or even years. We do not believe we can allow the Court's jurisdiction to end until the key elements of the children's behavioral health system are actually in place and working, including: a quality assurance process that measures whether children are receiving services according to the J.K. Principles, well-functioning child and family teams for most children, case managers and direct supports for high-needs children, the capacity to consistently improve the delivery of case management and direct support to other children, and ensuring that youth 18-21 years old enjoy the benefits of the system.

Delivering Services According to the J.K. Principles

As we have pointed out, the data on the number of well-functioning child and family teams is inadequate. Some of the reasons are: the State still lacks an adequate system for measuring whether child and family teams deliver services according to the Principles. Furthermore, the State's current process is focused on only 6% of the

children, those who are currently identified as having high needs. The process for reviewing moderate needs children is currently scheduled to start in January 2009, and it is unknown when reviews of low needs children will occur, although the J.K. Annual plan calls for this to be initiated September 1, 2008.

Previously, we asked what the sample size would be for these additional populations. Also, we asked for the specific plan for transfer of the review process to the RBHAs, the expectations to be placed on the RBHAs, and the funding they would have to implement the review process. We understand that funding has been transferred to the RBHAs, but the amount transferred is only what is currently needed to review 6% of the population. What is the plan for operationalizing and funding the full process? The J.K. Annual Plan indicates this task was to be completed by July 1, 2008.

The current process for evaluating whether children are being served according to the Principles remains problematic. Consistently, relevant timelines in the J.K. Annual Plan are not met. We were encouraged in our conversations by the State's commitment to finally get the quality assurance review process on track by both improving implementation of the WAFAS and having State leadership use multiple sources of information to evaluate whether expectations were being met regarding the delivery of services according to the Principles.

Regarding the WAFAS, we discussed: refining the guidance given to interviewers and record reviewers so that richer information is collected, integrating information from interviews and the record review through joint scoring, ensuring that reviewers are competent to make the judgments including by having an adequate infrastructure at RBHA's and family organizations for oversight and training, ensuring that any systemic issues are identified and communicated (e.g., issues of working with CPS), reviewing an adequate number of cases from each provider, interviewing caregivers and family members in person, and increasing the number of interviews per case. It does not appear that any of these improvements are progressing, based on what we see and hear as participants on the state oversight committee, the Maricopa County oversight committee, and as observers at debriefings.[1] Have the activities regarding data validation and inter-rater reliability begun as scheduled in August? If so, please provide any information they have generated.

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[1] We regularly receive the Practice Improvement scores from Magellan and CPS but not from the other RBHAs. Please provide the most current WAFAS reports from the other RBHAs.

Also, we had understood that the responsibility for generating analysis, feedback and practice improvement based on the WAFAS was going to be handled by the Clinical Department. We are unclear whether this transition has occurred. The new Annual Plan appears to assign most of these tasks to the Quality Management Department.

Regarding the use of multiple sources of information, our conversation began with an examination of the ways in which the WAFAS did not measure important elements of delivering services according to the Principles. We provided a comparison of the JK Principles and the questions in the WAFAS. We then discussed other sources of data regularly collected by the State that might fill in the gaps.[2] The conversation ended with the State's commitment to use the State's quality management committee to regularly review multiple sources of information to evaluate the extent to which services were being delivered according to the Principles.

We must rely on indirect evidence of whether the process is working adequately including whether the information upon which the State relies is adequate to allow the committee to make the required judgments. What we have been able to glean so far fails to demonstrate that the committee process is evaluating sufficient sources of information to assess whether the system is serving children according to the Principles.

We had understood that the Department created a matrix analyzing whether the information considered by the quality assurance committee was sufficient to allow judgments about the extent to which services are being delivered according to the Principles. If you did, please provide the matrix. Also please explain how the quality assurance committees review the following: measures compliance with required practice protocols, measures whether services are designed and implemented to achieve the J.K. functional outcomes, measures whether services are provided in the most integrated setting, measures the sufficiency of interagency collaboration, measures stability and the sufficiency of efforts to achieve stability (*e.g.*, minimize

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[2] Of the sources of information reviewed, the following seemed to hold the most promise for evaluating fidelity to the J.K. Principles: Practice Reviews, Assessment and CFT Practice Review using Chart Reviews, Practice Protocol Monitoring, Program Area Monitoring, Structural Elements Reports, Quarterly SOC Network Dev. Plan Reviews, Quality of Care Reviews, Out of State Placement case reviews, Title XIX Utilization Reports, RTC Reviews, Monitoring by Children's SOC Planning and Development, and to the extent they use a "J.K. lens," Performance Measures and Administrative Review Process.

multiple placements, avoid removal in crises), and measures the adequacy of the array of services offered by the RHBAs, including direct supports, case management, and substance abuse services. It is our understanding that the Department will submit a comprehensive quality management plan to AHCCCS by October 1, 2008. Please provide us the plan, especially if it answers the above questions.

Thank you for the notes we received from a July 2008 Quality Management Committee meeting. Data from some but not all of the sources we discussed were reviewed at that meeting. Have there been subsequent meetings? If so, could we receive the minutes? In addition, what actions were taken in response to any findings of the Committee regarding delivery of services according to the J.K. Principles?

High Needs Children

We are uncertain why after so many years the State cannot identify enrolled children who have high needs. At present, only 6% of the enrolled children have been so identified, and the two largest RBHA's are reporting that fewer than 5% of their children have been identified as high need. The State has chosen to use the CASII to identify such children. Is there data on the number of CASII's that have been completed in each RBHA and whether the CASII process is correctly identifying high need children?

It is our understanding that by December 2008 a CASII will have been done on all children and reported in the CIS system. What is the plan for validating RBHA's identification of children as *not* having high needs?

We have requested and would appreciate a report on the status of the expansion of direct supports by RBHA. We would also appreciate a copy of the inventory of case managers, with case load information, that we were informed the Department has been updating. What is the Department's expectation for each RBHA for further expanding direct supports and the number of case managers? While we realize this is a tight budget year, we do not believe the system can afford a year without significant increases in both these key services. As we stated in our meetings, we believe it is critical that the State consider requiring some shift from expenditures on residential to direct supports.

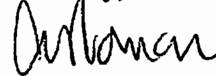
The Department stated it had completed an inventory of the substance abuse treatment currently available in the State and was in the process of evaluating whether these services contained certain core elements. What are the findings to date? What action if any does the Department intend to take based on the findings?

18-21 Year Olds

We have been encouraged by the State's attention to this long neglected issue and that it is considering seeking legislation. We would appreciate an update, including the State's plan to provide youth aged 18-21 needed behavioral health services, including case management and direct support, even if they are not SMI.

We look forward to discussing these issues at our meeting later this month.

Sincerely,



Anne Ronan
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cc: Dr. Laura Nelson
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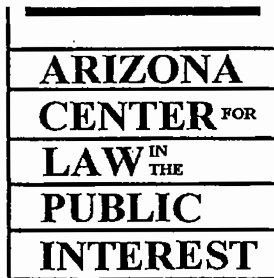

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October 8, 2008

Mr. Kevin D. Ray
Arizona Attorney General's Office
1275 West Washington
Phoenix, Arizona 85007-2926

Re: *J.K. v. Gerard*: Quality Management and Improvement System

Dear Kevin:

In our March 31, 2008 correspondence, we wrote of our concerns that the WAFAS process, as it had been implemented, did not adequately measure whether children were being served according to the Principles as required by the Settlement Agreement. In our follow up correspondence of May 21, 2008, we made several specific suggestions for improving the process. We enclosed a comparison from our view of the *JK* Principles and the WAFAS questions which identified those Principles which are not covered by the WAFAS. In addition, we asked for a description of the additional sources the State is using to assess whether the services are consistent with and designed to achieve the Principles.

In a subsequent meeting we discussed other sources of data regularly collected by the State that might fill in the gaps, and we listed those we thought might address the issue.[1]

We were told the Department had created a matrix analyzing whether the current sources of information available to the quality assurance committee were

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[1] Practice Reviews, Assessment and CFT Practice Review using Chart Reviews, Practice Protocol Monitoring, Program Area Monitoring, Structural Elements Reports, Quarterly SOC Network Dev. Plan Reviews, Quality of Care Reviews, Out of State Placement case reviews, Title XIX Utilization Reports, RTC Reviews, Monitoring by Children's SOC Planning and Development, and Performance Measures and Administrative Review Process.

sufficient to allow judgments about the extent to which services are being delivered according to the Principles. We have asked on more than one occasion for that analysis and we have not received it. This information is critical to our assessment of whether the processes used by the Department will meet the obligations in the Settlement Agreement.

Given all of our extensive discussions on this topic we were quite alarmed to hear Bob Source assert that the Department does currently have a Quality Management System that meets the requirements of the Settlement Agreement. This would suggest that no improvements are needed and that in fact all of the sources of information currently used are sufficient for the Department to assess whether the system is serving children according to the Principles. Is this the position of the Department?

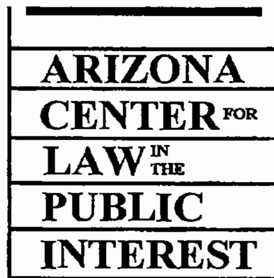
It was equally concerning to hear that the Department believes it "has 22 months" to develop the required Quality Management System. The Agreement, signed in 2001, requires the Department to move as quickly as practicable to develop a system that delivers services according to the Principles and to maintain that system once developed. The Department has not complied with this obligation in its development of a QM system. As a result, and to avoid formal dispute resolution, we have been urging speedy and decisive action in building the required system. The notion that the Department "has 22 months" will land us back in formal dispute resolution. The Department cannot meet its obligation to "develop" and "maintain" the required system if it does not soon have a QM process that regularly measures whether the system is serving children according to the Principles.

We look forward to hearing from you soon about the above matters.

Sincerely,

Anne Ronan
Ira A. Burnim

cc: Dr. Laura Nelson
Brian Lensink
Michael Fronske
Logan T. Johnston
Leezie Kim
Robert Sorce



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February 24, 2009

Joe Kanefield
General Counsel
Office of Governor Jan Brewer
1700 West Washington
9th Floor
Phoenix, Arizona 85007

Re: *JK v. Gerard*

Dear Joe:

Thank you for your assistance with *Arnold*. I will call soon to discuss how best to meet the Court's instructions to the parties in the Minute Entry of February 19, 2009. As I mentioned in an earlier email, we also have concerns with the Stipulation in *JK. v. Gerard*.

We had proposed to the Department that we extend the Agreement on limited terms for three more years to address the development of several remaining critical components of the system. The Agreement will expire on July 1, 2010 provided there are no issues in dispute. We were told that until a new Director was appointed, the Department could not discuss this with us.

We are writing to ask that the Governor's Office assist the parties in *J.K.* avoid an abrupt break in our working relationship and a return to adversarial litigation before the U.S. District Court. When the parties reached an impasse of this sort in 2006, the Governor's Office was helpful in crafting a solution that avoided litigation.

We reported on the status of the *J.K.* case to Ted Williams, a member of the Governor's transition team, in early January, 2009. In brief, our view is that: While progress is presently being made, the State has not yet met its obligations under the *J.K.* Settlement Agreement, our extended efforts to resolve key concerns have not been

successful, and we believed that we would have to seek relief from the Federal court if we could not resolve our concerns.

Under the Settlement, the State must "move as quickly as is practicable" to develop a functioning children's behavioral system that meets its clients' needs. Once that system is developed, it must be maintained for the term of the Agreement. Settlement Agreement, Par. 15. The Settlement requires the children's behavioral health system to:

- Focus on keeping children at home, doing well in school, and staying out of trouble with the law.

- Ensure that children with complex needs have case managers and receive needed therapeutic foster care, respite, and community based direct supports.

- Use child and family teams to secure family input and cross-system coordination.

- Regularly review the adequacy of services, including whether they meet children's needs.

- Provide needed services to youth aged 18 to 21.

- Provide needed substance abuse services.

With the help of a mediator and the intervention of the Governor's Office, the parties in *J.K.* resolved the 2006 impasse in the case by agreeing to a three year extension of the Settlement Agreement. In addition, the State began to address some of our key concerns. Progress has been made, but key parts of the required system remain underdeveloped and, in some important areas, there has been little forward movement.

Our understanding is that the Defendants have advised the Governor's office that Plaintiffs lack a basis for obtaining relief from the U.S. District Court. In assessing this advice, we ask that the Governor's staff consider our letter to the Department of September 18, 2008. Note that in most communities outside Maricopa County, the children's behavioral system is even less developed than in Maricopa County, mainly because the State's *J.K.* implementation efforts outside Maricopa County began in earnest only recently.

The Settlement Agreement lays out a process the Plaintiffs must follow before returning to Court. The process is initiated by the Plaintiffs writing a formal letter. If the issues are not resolved within 30 days, a mediator is appointed. Unsuccessful mediation is followed by litigation in the Federal court. Settlement Agreement, Section IX.

We plan to write a letter invoking this process before our next meeting with Defendants on March 9. We would welcome any opportunity to work with the Governor's staff to arrive at a mutually agreeable resolution with the Defendants.

Please let us know if the Governor's Office would like us to provide any additional information. Also, please feel free to call us with any questions or comments you may have. We look forward to any suggestions you may have for resolving the present impasse.

Sincerely,

Anne Ronan
Ira A. Burnim

cc: Gregory Honig
Ira A. Burnim