RECEIVED
NOV 12 2014
Office of
HEALTHCARE ACCESS

Application Checklist

Instructions:

1. **Please check each box below, as appropriate; and**
2. **The completed checklist *must* be submitted as the first page of the CON application.**

☑ **Attached is the CON application filing fee in the form of a certified, cashier or business check made out to the "Treasurer State of Connecticut" in the amount of $500.**

For OHCA Use Only:

Docket No.: 14-31964-CON **Check No.:** 51-116/211 7561
OHCA Verified by: **Date:** _____

☑ **Attached is evidence demonstrating that public notice has been published in a suitable newspaper that relates to the location of the proposal, 3 days in a row, at least 20 days prior to the submission of the CON application to OHCA. (*OHCA requests that the Applicant fax a courtesy copy to OHCA (860) 418-7053, at the time of the publication)***

☑ **Attached is a paginated hard copy of the CON application including a completed affidavit, signed and notarized by the appropriate individuals.**

☑ **Attached are completed Financial Attachments I and II.**

☑ **Submission includes one (1) original and four (4) hard copies with each set placed in 3-ring binders.**

Note: A CON application may be filed with OHCA electronically through email, if the total number of pages submitted is 50 pages or less. In this case, the CON Application must be emailed to ohca@ct.gov.

Important: For CON applications(less than 50 pages) filed electronically through email, the singed affidavit and the check in the amount of $500 must be delivered to OHCA in hardcopy.

☑ **The following have been submitted on a CD**

1. **A scanned copy of each submission in its entirety, including all attachments in Adobe (.pdf) format.**
2. **An electronic copy of the documents in MS Word and MS Excel as appropriate.**

Shoreline Wellness Behavioral Health Clinic
415 Main Street
West Haven, CT 06516

51-110/211 7561

Date 10/1/2014

PAY to the order of Treasurer State of Connecticut $ 500.00

five hundred dollars and 00/100 Dollars

Security Features Details on Back.

WELLS FARGO Wells Fargo Bank, N.A. Connecticut wellsfargo.com

For CON application

Cara Pavia

MP

⑆021101108⑆ 8354926878⑈

CITY OF WEST HAVEN, CONNECTICUT
Planning and Zoning Commission
City Hall | 355 Main Street | 1st Floor | West Haven, Connecticut 06516-0812
Phone 203.937.3580 Fax 203.937.3742
CITY HALL 1898-1967

CERTIFICATE OF DECISION

July 17, 2014

Cara Powers
Shoreline Wellness Center
415 Main St.
West Haven CT 06516

RE: **415 Main St.** - Special Permit Application to allow applicant to change existing business to mental health clinic in the Central Business District (CBD). Under Section 85 Table 39.2 of the West Haven Zoning Regulations

File: SP 14-077
Meeting: July 8, 2014
Action: Approved with Conditions
Owner: West Haven Professional Services
Applicant: Cara Powers, Shoreline Wellness Center
Effective Date: August 3, 2014

Conditions: No medications be dispensed on site

The above referenced matter was approved on the date stated above and a Notice of Decision was published in the New Haven Register on July 19, 2014.

You must file this decision with the City clerk before the effective date listed above.

Sincerely,

Robert Librandi
Assistant City Planner

NEW HAVEN REGISTER THE REGISTER CITIZEN The Middletown Press Farmington Valley Times CONNECTICUT
SHORELINE TIMES The Foothills Trader WEST HARTFORD NEWS MINUTEMAN
Bulletin THE GRANBY NEWS the Dolphin THE LITCHFIELD COUNTY TIMES Post-Chronicle

Proof of Ad 07/17/14

Account:	134091
Name:	
Company:	WEST HAVEN PLANNING & ZONING
Address:	355 MAIN ST WEST HAVEN, CT 06516
Telephone:	(203) 937-3580
Ad ID:	330100
Description:	LEGAL NOTICE The West Haven Planning
Run Dates:	07/19/14 to 07/19/14
Class:	1201
Orig User:	CRCGILSON
Words:	134
Lines:	43
Agate Lines:	45
Column width:	1
Depth:	4.972
Blind Box:	

LEGAL NOTICE

The West Haven Planning and Zoning Commission made the following decisions Tuesday, July 8, 2014 in the Harriet North Room, 2nd Floor, City Hall, 355 Main Street, West Haven, CT at 6:30 P.M.

Amend Table 39.2, Section E of the Regulations Zoning text amendment to permit a Regional Shopping Center in a Waterfront Design District as of right. Under sections 86, Table 39.2.E Applicant: City of West Haven File# ZR 14-076 **CONTINUED**

415 Main St. -Special Permit Application to allow applicant to change existing business to mental health clinic in the Central Business District (CBD). Under Section 85 Table 39.2 of the West Haven Zoning Regulations. Applicant Cara Powers, Shoreline Wellness Center, Owner. West Haven Professional Services. File #SP 14-077 **APPROVED WITH CONDTIONS**

100 Calligeri Dr. Bond Release APPROVED

Gene Sullivan
Chairman

We Appreciate Your Business!
Thank You!

NEW HAVEN REGISTER THE REGISTER CITIZEN The Middletown Press Farmington Valley Times CONNECTICUT
SHORELINE The Foothills Trader WEST HARTFORD NEWS MINUTEMAN
Bulletin THE GRANBY NEWS the Dolphin THE LITCHFIELD COUNTY TIMES Post-Chronicle

RECEIPT

New Haven Register
40 Sargent Drive
New Haven, CT 06511

Phone: **1-203-789-5200**

10/17/14

Account:	145594
Name:	
Company:	CARA POWERS
Address:	415 MAIN ST. SHORELINE WELLNESS CENTER WEST HAVEN, CT 06516
Telephone:	(203) 931-1184 Legal Notice Shoreline Wellness

Gross:	$526.51
Paid Amount:	- $526.51
Amount Due:	$0.00

Date:	10/17/14
Ad Date:	10/20/14
Class:	1201
Ad ID:	411612
Ad Taker:	CRCGILSON
Sales Person:	Chris Gilson- Legals
Words:	137
Lines:	37
Agate Lines:	39
Column width:	1
Depth:	4.306
Inserts:	6
Blind Box:	

Publication

New Haven Register, nhregister.com

Ad sample

Legal Notice

Shoreline Wellness Behavioral Health Clinic, LLC an affiliate of Shoreline Wellness Center, LLC, is applying for a certificate of need pursuant to Connecticut General Statute Section 19a-638. Shoreline Wellness Behavioral Health Clinic, LLC is seeking Licensure as a free standing behavioral health clinic that will continue to provide mental health services to children, adults and families. Shoreline wellness Behavioral Health Clinic, LLC will not dispense any medications on site as agreed upon with the city of West Haven variance approval. There will be no changes in any of our current day to day operations that will affect the city, the general population, or the clients that we currently provide services for. Shoreline Wellness Behavioral Health Clinic, LLC is located at 415 Main Street, West Haven, CT. The total capital expenditure for the project is 35,000.

We Appreciate Your Business!
Thank You

21ST CENTURY media

Shoreline Wellness
Behavioral Health Clinic, LLC
415 Main Street, Lower Suite
West Haven, CT 06516
203-687-5580

November 12, 2014

Re: Certificate of Need (CON) Application
New Service (Behavioral Health/Substance Abuse)

To Whom It May Concern:

Enclosed is our application for a certificate of need (CON) to start the process of becoming credentialed as a free-standing mental health clinic with the Department of Public Health (DPH).

We appreciate your time and attention to this matter and if you should require any additional information or have any questions please do not hesitate to contact us.

Thank you.

Sincerely,

Cara M. Powers, LPC
Founder & Clinical Director

Robert J. Powers
Executive Director

AFFIDAVIT

Applicant: Shoreline Wellness Behavioral Health Clinic, LLC

Project Title: Mental Health & Substance Abuse Clinic Application

I, Cara Powers, Founder & CFO
(Individual's Name) (Position Title – CEO or CFO)

of Shoreline Wellness Behavioral Health Clinic being duly sworn, depose and state that
(Hospital or Facility Name)

Shoreline Wellness Behavioral Health Clinic's information submitted in this Certificate of
(Hospital or Facility Name)

Need Application is accurate and correct to the best of my knowledge.

Signature

10-7-14
Date

Subscribed and sworn to before me on October 7th, 2014

Notary Public/Commissioner of Superior Court

My commission expires: 11/30/2018

State of Connecticut
Office of Health Care Access
Certificate of Need Application

Instructions: Please complete all sections of the Certificate of Need ("CON") application. If any section or question is not relevant to your project, a response of "Not Applicable" may be deemed an acceptable answer. If there is more than one applicant, identify the name and all contact information for each applicant. OHCA will assign a Docket Number to the CON application once the application is received by OHCA.

Docket Number:

Applicant: Shoreline Wellness Behavioral Health Clinic

Contact Person: Cara Powers

Contact Person's Title: Founder & Clinical Director

Contact Person's Address: 415 Main Street
West Haven, CT 06516

Contact Person's Phone Number: (203) 931-1184 x 116

Contact Person's Fax Number: (203) 931-0063

Contact Person's Email Address: cara.shorelinewellnesscenter@gmail.com

Project Town: West Haven

Project Name: Mental Health & Substance Abuse Clinic Application

Statute Reference: Section 19a-638, C.G.S.

Estimated Total Capital Expenditure: 40,000.00

Table of Contents

Section 1 Project Development..... 9

Section 2 Clear Public Need..... 9-14

Section 3 Projected Volume 15-18

Section 4 Quality Measures 18-20

Section 5 Organizational and Financial Information 20-21

Section 6 Patient Population Mix: Current and Projected 21

Section 7 Financial Attachment I & II 22-23

References.....24

Appendices.....25

1. Project Description

Shoreline Wellness Behavioral Health Clinic, LLC (SWBHC) is submitting this application as part of a proposal to be credentialed by the State of Connecticut Department of Public Health as a free-standing mental health clinic. If granted this credential, SWBHC will be able to continue to provide, high quality, graduate student internship placements for practicums and internships in the fields of Counseling, Social Work, Marriage and Family Therapy, Advanced Nurse Practitioners, and Psychologists. Additionally, the Center will be able to provide employment opportunities for post- graduate, Master's Level Clinicians that are seeking to obtain State of CT licensure in their specific, specialty areas.

All of these specialties require a minimum of 1500 internship/practicum hours and an additional 3000 post-graduate hours of direct client/patient care under the supervision of a licensed professional. Each clinician and graduate student obtaining said hours is required to receive a minimum of one hour of direct supervision per week which includes, but is not limited to; signing and reviewing progress notes, signing and reviewing treatment plans, signing and reviewing treatment plan reviews and discussing and presenting cases on an on- going basis throughout their placement at the Clinic.

2. Clear Public Need

a. The proposal's location is located at the same location as its affiliate company, Shoreline Wellness Center (SWC), LLC. The proposed clinic will also be located at 415 Main Street, West Haven, CT 06516 in the lower level. This address is where SWC currently operates as an independent, multi-specialty group,

behavioral health practice. This will not change if permission is granted to credential a clinic at this site.

i. The rationale for choosing the proposed service location is that SWBHC's affiliate company, SWC, is already fully operational at this site as a behavioral health practice and currently serves as a collaborating learning facility with many Colleges and Universities nearby.

ii. The service area towns that surround SWC are; West Haven, New Haven, Milford, Orange and Woodbridge. However, SWC currently services clients from all areas of CT and will continue to do so as need allows and appropriate referrals to SWBHC will be made from these areas as well.

iii. The population and communities that SWC currently serves is predominantly Caucasian, followed by African American, then Hispanics/Latino. The communities are made up of a small percentage of Asian, Native American, Pacific Islander and multi-racial individuals as well. Additionally, the individuals are predominantly lower- middle to lower income families. SWC is currently averaging at least 5-6 new patient calls per day for individual, group, couples/family services as well as medication management and the current demand cannot be met. The need for this additional service is dire and we expect to serve the same population and communities that we currently serve except we will have an increase in lower income individuals and families being seen at the clinic due to billing restrictions imposed by the State of CT.

Our current facility SWC, continues to expand at a steady pace and it is our hope that through the addition of a new behavioral health clinic we will be able to provide even more comprehensive programs and services that will benefit the clients and patients we serve as well as the communities we serve, the

universities we work with, and that through this additional program we will set the gold standard for mental health professionals entering this field.

Due to the overwhelming need of mental health services in this specific area of West Haven, Connecticut and in the nation as a whole, the need for quality professionals entering the field of Mental Health is quite evident. Current statistics show that 1 in 4 adults and 1 in 10 children suffer from a mental illness which equates to approximately 60 million Americans affected by a mental illness (National Institute of Mental Health, 2008). Without placement opportunities that can provide quality training and supervision of these incoming behavioral health professionals the overwhelming need for quality and cost effective mental health services will not be met. Current statistics further show that when individuals receive quality and appropriate mental health care their use of other medical services declines (Rhode Island Psychological Association, 2009). A previous study conducted on individuals diagnosed with anxiety disorders demonstrated that after successful, psychological treatment, the number of medical visits decreased by 90%, laboratory costs decreased by 50%, and overall treatment costs dropped by 35% (Rhode Island Psychological Association, 2009). Research has also shown that individuals with untreated mental health problems visit a medical doctor twice as much as individuals who receive mental health treatment (Rhode Island Psychological Association, 2009).

Additionally, people with good mental health also are better employees as good mental health is associated with higher productivity, better performance, more consistent work attendance, and fewer workplace accidents which are all extremely important benefits in this struggling economy (Rhode Island Psychological Association, 2009).

Unfortunately, when individuals are unable to obtain quality mental health care due to long waiting lists, lack of quality providers, lack of insurance benefits, etc. it is detrimental for the individual as well as society as a whole. Previous research has further indicated that excessive anxiety and stress when left untreated, can contribute to numerous physical problems such as; heart disease, ulcers, and colitis just to name a few (Rhode Island Psychological Association, 2009). Untreated anxiety and stress can also reduce the strength of the immune system, making people more vulnerable to conditions ranging from the common cold to cancer (Rhode Island Psychological Association, 2009). Furthermore, untreated psychological problems also increase the likelihood that people will make poor behavioral choices which then contributes to more medical problems and legal problems. Smoking, excessive alcohol or drug use, poor eating habits, and reckless behaviors can all result in severe physical problems and an increased need for other types of medical services. These poor behavioral choices also contribute to increased levels of crime and deviant behaviors (Rhode Island Psychological Association, 2009).

Research has shown that half of all lifetime mental illnesses begin by age 14 (Kessler, Chiu, Demler, & Walters, 2005). Children that have undiagnosed and untreated mental health problems will generally go on to have many problems as an adult. Also, children with untreated mental illnesses often do poorly in school, get in trouble with the law, have poor peer relationships and are at risk for a host of other negative and potentially dangerous behaviors. Successful treatment in childhood can often help children lead happy and productive lives and will provide children and their parents the tools to control or possibly help rid the child of the disorder (Tep, 2010).

The need for mental health services as current research has clearly shown is increasing with an overwhelming demand. SWC has been offering graduate

student placements on site for the past several years. However, due to the growth and expansion of people seeking mental health services and the number of people entering into the Mental Health profession the Center can no longer meet the demand for the graduate student services without being able to bill out for the graduate student intern services. Through the inclusion of these additional services by allowing SWBHC to credential as a free-standing mental health clinic we will be able to meet these demands and offer more comprehensive services with the inclusion of two extremely reputable Medical Directors. Furthermore, with continued mutual collaboration with local Universities and State licensing boards the Clinic will help guide the future of quality mental health care through the continued and ongoing placement of incoming graduate students and post-graduate students. Without quality, internship sites, willing to host graduate student interns, the colleges and universities would not be able to place their students effectively and students will not graduate. This would be extremely detrimental to the mental health field where there is already a dire need for more counselors and which is a trend that is only expected to increase over the next coming years (Hamby, McDonald, Grych, 2014).

iv. The proposed patient population is currently being served at our current location at 415 Main Street. Licensure as a free- standing mental health clinic will not change this except for the location in the physical building where the clinic will be held.

v. Please see SWBHC Flow Chart in Appendix A

vi. There will be no significant effect of the proposal on the Center's existing staff and/or providers with the exception of the Center's licensed staff possibly seeing

more commercially insured clients as many of the Medicaid clients will be seen at the clinic.

3. Projected Volume

a. Table I. Projected Volume

	Projected Volume (First 3 full operational Fiscal Years and Partial FY)			
Service Type	**2015[1]**	**2016[2]**	**2017[3]**	**2018[4]**
Individual Counseling Sessions	2774	3640	4160	4680
Group Counseling Sessions	26	104	104	156
Family/Couples Counseling Sessions	180	260	325	406
Medication Management/Psychiatric Evaluations	1800	5200	2600	5200
Total	**4780**	**9204**	**7189**	**10442**

b. The projected volume was calculated by including billable services for interns and unlicensed post Master's Level Clinicians' if licensed as a free-standing mental health clinic by March 2015. Individual Counseling Sessions for PFY 2015 were calculated using approximately 70-75 patient/clients per week seen at the clinic for individual counseling. FY2016 keeps this same ratio of 70 patients/clients per week but utilizes a full year of 52 weeks. For FY 2016

[1] March 1- December 31, 2015
[2] Full Calendar Year
[3] Full Calendar Year
[4] Full Calendar Year

this number increases by 10 additional patient/client sessions per week due to success of the previous 2FYs. For FY 2017 and FY 2018 the patient/client ratio per week increases by 10 each week, for each year, respectively. Group counseling sessions were calculated for PFY 2015 starting in March 2015-Dec. 2015 as 1 group session per week. In FY 2016 and FY 2017 this number is increased by 2 group sessions per week. In FY 2018 the number is increased to 3 group sessions per week based on the successful outcomes of FYs 2015-2017.

For Family/Couples counseling sessions this number was calculated for PFY 2015 by using 5 sessions per week for 36 weeks. FY 2016 kept the same number of 5 sessions per week for the full 52 weeks. For FYs 2017 and 2018 the numbers were increased by 25% which seems like a reasonable growth trend as evidenced by the data from our parent company Shoreline Wellness Center, LLC.

Medication Management and evaluations for PFY 2015 were calculated by 50 patients per week being seen at the clinic for medication management and/or evaluations from our graduate student Nurse Practitioners (NP) and/or Psychiatric residents. This number doubles for FY 2016 as our NPs enter their second year of internship and are comfortable taking more patients. For FY 2017 the number decreases again as the new NPs interns begin their internships. The number will increase again in FY 2018 as the NP students become more comfortable with increased caseloads.

c. Due to this being a newly established company we do not have three full years of data to support the need to implement the proposed services under this company Shoreline Wellness Behavioral Health Clinic, LLC. However, SWBHCs' parent company, Shoreline Wellness Center, (SWC) has gone

from taking one student intern in 2011, to 3 interns in 2012, 5 in 2013, and 9 graduate student interns in 2014 and were forced to turn away several Universities and Colleges that asked us to take additional students. As our relationship with the local colleges and universities continues to thrive the need for placements for students is continuing to grow. As previously mentioned, this year we had to turn away numerous interns looking for placement because we were unable to accommodate them based on financial restraints from not being able to bill out for their services as we are not licensed as a clinic. By being able to bill out for their services we will be able to hire more supervisors, more administrative staff, and provide more services for graduate students and for those seeking mental health services. Which as previously discussed and documented through ongoing research is very much needed.

d. Currently in the United States as stated above, mental illness affects 1 in 4 adults, and 1 in 10 children which equates to approximately 60 million Americans affected (National Institute of Mental Health, 2008). In CT there are approximately 400,000 children and families receiving Husky A Medicaid coverage which is up at a 3% increase from 2010 (CT Department of Social Services, 2011). In 2014 the poverty level increased by a 138% which will now allow for a substantially larger amount of individuals and families to qualify for Husky /Medicaid insurance. At SWC and SWBHC we want to be proactive in meeting the mental health needs of all of these newly eligible Medicaid individuals and families. By allowing us to expand and increase our services we will be able to accomplish this goal.

In a 2006 study conducted by the National Alliance for Mental Illness (NAMI) the researchers found that no states were focusing on wellness and/or

survival for people with mental illnesses. The researchers for this NAMI study stated that "In no state was NAMI able to find comprehensive, integrated, and preventive action, or outcome measurement related to wellness and survival. Most states do not even study causes of death among people with serious mental illnesses (instead they tend to track only suicides or hospital-based deaths)." (NAMI, 2009).

Due to the increases in mental illness in the United States as a whole and the increases in CT Medicaid recipients over the past few year the statistics support the need for more behavioral health clinicians and more behavioral health clinics that can and will accept Medicaid clients.

4. Quality Measures

a. Cara Powers, Founder & Clinical Director
Robert Powers, Executive Director
Samya Hashem- Hawley, Medical Director
Mark Rego, Medical Director
Lisa Biagioni, Assistant Clinical Director
Ashley Toffey, Clinical Coordinator
New Administrative Assistant Position will be created
New Billing Assistant Position will be created

Please see Appendix B for current staff resumes & CVs

b. The proposal to become a free-standing mental health clinic contributes to the quality of health care delivery in the region because the need for qualified mental health providers is more important than ever and helping people obtain quality mental health care is and definitely should be a priority. Also,

the focus on illness needs to be shifted to a focus on wellness which is the goal of SWC and SWBHC. Our philosophy is centered around treating the whole person which includes the mind, body and spirit and the Clinic's mission is founded on the premise of guiding clients to obtain optimal wellness. As more and more empirical data emerges to support this notion of wellness it becomes clearer than ever to see the link between a person's thoughts and actions, thoughts and feelings and how these impact a person's overall health.

c. SWBHC is committed to the following guiding principles within all of its services and programs and will most certainly be utilized in our proposed expansion; cultural competence, strengths-based approaches, person centered services, and safety and gender responsiveness. These same tenets will be the guiding principles of the free-standing mental health clinic if licensure is obtained. Additionally, the clinic will adhere to the following:

- Actively developing and practicing appropriate, relevant, and sensitive strategies and skills in interacting with culturally different persons;
- Assessing the inherent strengths in a person or family and use them as a foundation for growth and change;
- Creating an environment based on physical and emotional safety, respect and dignity.

All clinicians that work at the clinic both licensed and non-licensed will uphold the following standards of practice:

- Practitioners are alert for identifying and addressing co-occurring conditions;
- Practitioners employ the best interventions currently available;

- Practitioners are attentive to medical issues and the impact of psychiatric medications on the person's overall health and well-being (Connecticut Department of Mental Health and Addiction Services (DHMAS), 2006).

All patient care will be recovery-oriented and consistent management by SWBHC Clinical Director(s)/supervisors will ensure that all patient care provided will be efficient, equitable, and effective.

5. Organizational and Financial Information

a. SWBHC is a Limited Liability Company

Please see Appendix C for SWBHC articles of organization.

b. SWBHC is not a non-profit organization.

c. Currently SWBHC the primary applicant does not hold any Connecticut, Department of Public Health Licenses. The Founder of SWBHC holds a Licensed Professional Counselor License from the State of Connecticut. See appendix D for copy. This proposal is seeking to obtain licensure from the State of Connecticut as a free-standing, mental health, and substance abuse clinic.

d. Not Applicable at this time

e. Submit a final version of all capital expenditures/costs as follows:

Table 2: Proposed Capital Expenditures/Costs

Medical Equipment Purchase	$20000.00
Imaging Equipment Purchase	$0
Non-Medical Equipment Purchase	$5000.00
Land/Building Purchase *	$0
Construction/Renovation **	$15000.00
Other Non-Construction (Specify)	$0

Total Capital Expenditure (TCE)	**$40,000.00**
Medical Equipment Lease (Fair Market Value) ***	$0
Imaging Equipment Lease (Fair Market Value) ***	$0
Non-Medical Equipment Lease (Fair Market Value) ***	$0
Fair Market Value of Space ***	$0
Total Capital Cost (TCC)	**$0**
Total Project Cost (TCE + TCC)	**$40,000.00**
Capitalized Financing Costs (Informational Purpose Only)	$0
Total Capital Expenditure with Cap. Fin. Costs	**$40,000.00**

f. The funding will be paid through CT Department of Economic Community Development (DECD) small business loan.

6. Patient Population Mix: Current and Projected

a. Table 3: Patient Population Mix

	Partial FY 2015	Year 1 FY 2016	Year 2 FY2017	Year 3 FY 2018
Medicare*	0	0	0	0
Medicaid*	133	191	173	226
Champus & TriCare	0	0	0	0
Total Government				
Commercial Insurers*	0	0	0	0
Uninsured	0	0	0	0
Worker's Compensation	0	0	0	0
Total Non-Government	**0**	**0**	**0**	**0**
Total Payer Mix	**133**	**191**	**173**	**226**

b. The basis for our assumptions in Table 3 Patient Population Mix were calculated utilizing the proposed data we provided in Section 3a.

7. Financial Attachments I & II

a. Please see Appendix E

b. Please see Appendix F

c. The assumptions that were utilized in developing financial attachments I and II were calculated as follows;
If SWBHC is credentialed as a free-standing mental health clinic SWC will be able to provide internship and licensure hour placement for at least 15 interns per year seeing a minimum of 133 patients per year.

In regards to expenses the numbers are based on the increase in patient volume which then creates a higher demand for office supplies and an increase in administrative and managerial staff required

d. Please see Appendix G- Husky/Medicaid fee schedule

e. The minimum number of units required to show an incremental gain for SWC operations for each year are as follows;

- Partial Fiscal Year 2015 is projected to have a gain in revenue of $56,190.00 with approval to become a clinic. 133 minimum units broken down by individual counseling, group counseling, family/marriage, medication management as shown in section 6a.
- Fiscal year 2016 is projected to have a gain in revenue of $176,450.00 with approval to become a clinic. 191 minimum units broken down by individual counseling, group counseling, family/marriage, medication management as shown in section 6a.

- Fiscal year 2017 is projected to have a gain in revenue of $427,800.00 173 minimum units broken down by individual counseling, group counseling, family/marriage, medication management as shown in section 6a.

f. This is not applicable due to the fact that if SWCBH is approved to become a clinic financially it would only impact the company in a positive way.

g. As the numbers from the tables, charts, and financial worksheets indicate without the approval to become a clinic SWC with its current interns operates at a loss as no revenue is generated for their current services and money is paid out in supervision wages and administrative costs. In being able to utilize and bill for the services of interns more clients will be serviced and more jobs will be created. Through the continued and increased opportunity for intern placement at the Clinic, the Clinic will be instrumental in the training and licensing of qualified behavioral health professionals, where the demand for these individuals and services is continuously growing and is extremely vital (Hambry, McDonald, & Grych, 2014).

References

Connecticut Department of Mental Health and Addiction Services (DHMAS). (2006). *Practice guidelines for recovery-oriented behavioral health care.* Retrieved from http://www.ct.gov/dmhas/lib/dmhas/publications/practiceguidelines.pdf

Connecticut Department of Social Services. (2011). *State fiscal year report 2011.* Retrieved from http://www.ct.gov/dss/lib/dss/pdfs/reports/annualreportsfy2011.pdf

National Alliance Mental Health (NAMI). (2009). *Grading the states.* Retrieved from http://citationmachine.net/index2.php?reqstyleid=2&mode=form&rsid=5&reqsrcid=APAWebPage&more=yes&nameCnt=1

National Institute of Mental Health. (2008, June 26). *The numbers count: mental disorders in America.* Retrieved from http://wwwapps.nimh.nih.gov/health/publications/the-numbers-count-mental-disorders-in-america.shtml

Hambry, S., McDonald, R., Grych, J. (2014). Trends in Violence Research: An Update through 2013. *Psychology of Violence, 4, (1),* 1-7.

Kessler R.C., Chiu, W.T., Demler, O., Walters, E.E. (2005). Prevalence, severity, and comorbidity of twelve-month DSM-IV disorders in the National Comorbidity Survey Replication (NCS-R). *Archives of General Psychiatry, 6,* 617-27.

Rhode Island Psychological Association. (2009). *Importance of mental health.* Retrieved from http://www.ripsych.org/importance-of-mental-health

Tep, J. (2010, March 10). *Mental illness in children: Understanding and diagnosing the problem. .* Retrieved from http://voices.yahoo.com/mental-illness-children-understanding-diagnosing-5664080.html?cat=5

Appendices

A – Shoreline Wellness Center, LLC Flow Chart

B – Current Staff Resumes and Curriculum Vitae

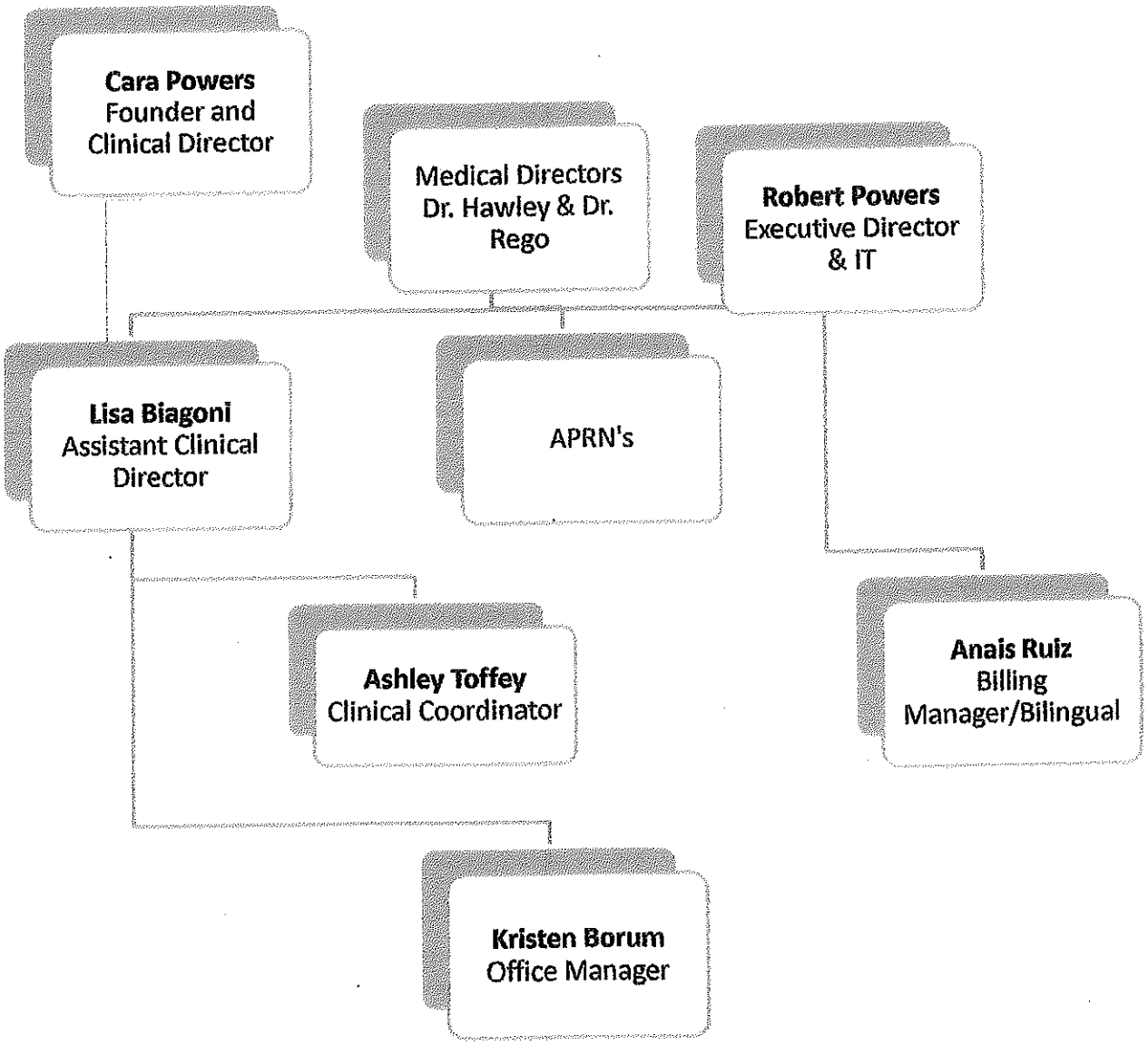
C – Shoreline Wellness Center Articles of Organization

D – Copy of Current CT License

E – Financial Attachment I

F – Financial Attachment II

G – Current Provider Fee Schedules


Cara Powers
Founder and
Clinical Director
Medical Directors
Dr. Hawley & Dr.
Rego
Robert Powers
Executive Director
& IT
Lisa Biagoni
Assistant Clinical
Director
APRN's
Ashley Toffey
Clinical Coordinator
Anais Ruiz
Billing
Manager/Bilingual
Kristen Borum
Office Manager

CARA M. POWERS

21 Phipps Drive
West Haven, CT 06516
E-Mail Carampowers@yahoo.com
(203) 931-1724

OBJECTIVE: To continue to maintain a rewarding career as a Counselor and a Counselor Educator

EDUCATION: **Central Connecticut State University**, New Britain, CT

- Bachelor of Arts, Psychology (May 1997)
- Master of Science, Counseling (May 2001)

Southern Connecticut State University, New Haven, CT

- Sixth Year Certificate of Advanced Graduate Studies, Mental Health Counseling (May 2003)

North Central University, Prescott, Arizonia

- Doctor of Philosophy, Health Psychology (anticipated completion May 2017)

CERTIFICATION: State of Connecticut School Counselor K-12 Certification
LICENSURE: State of Connecticut Licensed Professional Counselor

EXPERIENCE:

7/06-Present **Shoreline Wellness Center, West Haven, CT**
Owner/Clinical Director
Licensed Professional Counselor

- Created and established a successful mental health counseling agency which offers individual, group, marriage and family counseling to clients in the surrounding area
- Manage a staff of 21 mental health professionals
- Maintain a caseload of 30 clients

8/01-6/05 **Ansonia Middle School,** Ansonia, CT
School Counselor

- Created and established first time School Counselor position for Ansonia Middle School and conducted personal, social, and academic counseling with a caseload of 662 middle school students
- Student Assistance Team coordinator for sixth, seventh and eighth grade as well as case manager for students
- Participated on district wide crisis team and one of the leaders of the school crisis team
- Nominated as chair for the district attendance committee and created and implemented two attendance in-service presentations for Ansonia Personnel
- Assisted with supervision of seven social work interns from SCSU
- Created and taught developmental guidance curriculum for sixth grade

Robert J. Powers Jr.

Summary

Versatile, results oriented leader with proven ability to develop and implement program goals and curriculum in various different settings. Effective communicator capable of navigating interpersonal dynamics. Capable change agent proficient at integrating business processes, systems, and personnel.

Education

MS-Educational Technology — May (2006)
Eastern CT State University — Williamantic, CT

BS- Physical Education & Health Education — May (2004)
Southern CT State University — New Haven, CT

Experience

Shoreline Wellness Center, LLC — **West Haven, CT**
Co-Founder & Executive Director — **2006- Present**

Developed and executed Shoreline Wellness Center's initial business plan and assisted in creating and establishing the agency. Responsible for technology at the center, management of core administrative staff and billing staff.

Ansonia Board of Education — **Ansonia, CT**
Physical Education and Health Teacher — **2004 - Present**

Physical Education and Health educator to students in grades K-12. Responsible for teaching State approved health and physical education curriculum to K-12 students.

21st Century Boys and Girls Club — **Ansonia, CT**
Mentor/Educator/Director — **2001-2010**

Developed and executed 21st Century program grant designed to help keep pre—identified, at-risk students from dropping out of high school. Emphasis on cultural awareness and how different cultures view education while respecting their views but stressing and guiding parents to see the importance of education..

United States Army Infantry — **1995–2000**
CT National Guard

Received numerous awards and accolades for army achievement as well as recipient of several army achievement medals. Selected as a unit trainer for incoming soldiers and taught several skills training missions.

Awards

2010 Teacher of the Year Nominee

Professional Associations

American Federation of Teachers
Greater New Haven Health Care Chamber of Commerce
Our Lady of Victory Church –Eucharistic Minister and Youth Development Committee

PERSONAL

Samya Hashem Hawley, MD
Birth Place: San Diego, CA
SS#:
Citizenship: American

ADDRESS

12 Clear Brook
Farmington, CT 06032
(h)860-284-1104
(c)215-527-3313
samyahawley@comcast.net

LICENSE AND CREDENTIALS

Board Certified in Psychiatry, 2006 (expires 12/31/2016)
Board Certified in Child and Adolescent Psychiatry, 2007 (expires 12/31/2017)
Licensed in Connecticut (CT #040650)

EDUCATION/WORK

Bishop Neumann H.S.
Williamsport, PA

New York University-Early Admission
Major: Biochemistry
Graduated Magna Cum Laude, 1995

MCP/Hahnemann School of Medicine
Philadelphia, PA
M.D. 2000
Graduated AOA

MCP/Hahnemann Internal Medicine Internship
2001

Yale University Psychiatry Resident
2001-2003

Institute of Living/Hartford Hospital: Child Psychiatry Fellow
2003-2006

Village for Families and Children: Psychiatric Consultant (Subacute/Outpatient)
2006- Current

Shoreline Wellness Center, LLC: Child & Adolescent Psychiatrist/Medical Director
2013-Present

NYU: Organic Chemistry Department
Analogs of Tamoxifen

NIH Award Grant in Neuroscience
Effects of Cocaine on Fetal Circadian Rhythm

MCP/Hahnemann Research Grant Summer 1997
Spinal Cord Injuries

MCP/Hahnemann Clinical Research: Tomoxetine (now called Atomoxetine) in ADHD
1999-2000

PROFESSIONAL SOCIETIES AND ORGANIZATIONS

Catholic Medical Society
APA member
AACAP member
CT Psychiatric Society member

EXTRACURRICULAR ACTIVITIES

Danced with Joffrey Ballet 1991-1992
Worked for ANAD 1991-1994
Worked for CF Foundation 1991-1994
Organized local hospital mammography screening 1992-1994
Tutoring, Reading, Yoga, and Travel
Regional and National Member of Legion of Mary
Religious Education Teacher for troubled Ninth Graders—2002
St. Joseph School (Bristol, CT) HSA Member 2006-current
Christian Fellowship Center soup kitchen volunteer (monthly) 2008-current
Work for St. Gregory Church Christmas Drive 2006-current
Featured guest on Sirius Radio
Volunteer in Newtown, CT

Village for Families and Children: Psychiatric Consultant for Family Based Recovery Program—current

Crisis Team Responding to Newtown, CT Tragedy- December 2012-current

TRAININGS/AREAS OF INTEREST

Substance abuse training—VA West Haven July 2002-June 2003
Alcohol and Polysubstance Abuse Clinic—VA West Haven July 2002-June 2003
Disaster Psychiatry Training—Yale New Haven Hospital, 2001
Grief and Loss Training—Yale New Haven Hospital, 2001
Transcranial Magnetic Stimulation Training—in progress
Consultation Liaison Psychiatry—Yale New Haven Hospital and VA West Haven, 2002
Pediatric Consultation Liaison Psyciatry training—Connecticut Childrens Medical Center, 2004-2006

STAFF APPOINTMENTS

Hartford Hospital/IOL: March 2011-current
CCMC: March 2011-current
Contemporary Care- Greenwich, CT

HONORS AND ACADEMIC AWARDS

Phi Beta Kappa 1994
Magna Cum Laude 1995
University Scholar Award 1995
Alumni Scholar Award 1991-1995
Deans List-Four Years
George Granger Brown National Award for Chemistry and Physics 1995
National Merit Scholar 1988-1991
Who's Who in American Schools 1988-1991
The Arthur and Bertha Weisman Award for Excellence in Child Psychiatry 2000
Award for Excellence in General Psychiatry 2000
MCP/Hahnemann Residency Excellence Award 2001
Award for Excellence in Cardiology 2001
Award for Excellence in Endocrinology 2001
Yale University Award for Excellence in Consultation-Liaison Psychiatry 2003

RESEARCH EXPERIENCE

CURRICULUM VITAE

Name: Mark D. Rego, M.D.

Born: April 21, 1959 Yonkers, NY

Education: Fordham University 1977-1981. B.A. Biology Honors; Summa Cum Laude, Phi Beta Kappa.
New York Medical College 1981-1985. Medical Doctor

Career: Westchester County Medical Center 7/85-6/87 Medical Intern
Yale University, School of Medicine Department of Psychiatry 7/87-6/89. Resident in Psychiatry.
Chief Resident of Adult Psychiatric In-Patient Service, Yale New Haven Hospital 6/88-1/89.
Bridgeport Community Mental Health Center. Medical and Psychiatric Consultant (7/87-6/88)
Milford Mental Health Center. Psychiatric Consultant (7/88-11/89)
Consulting Psychiatrist, Golden Hill Nursing Home, Milford, CT (long-term care, traumatic brain injury unit) (7/89-12/92).
Attending Psychiatrist for Consultation-Liason Service. West Haven VA Medical Center.(7/88-6/90)
Private Psychiatric Practice. Milford, CT (7/89-11/12).
Attending Psychiatrist, Milford Hospital, Milford, CT. (7/89-11/00)
Chief of Psychiatry Section, Milford Hospital, Milford, CT (1/98-11/00).
Attending Psychiatrist, Yale New Haven Hospital. (7/90-present).
Consulting Psychiatrist, Milford HealthCare Center (long term care, subacute care, rehabilitation) (2/92-9/05).
Consulting Psychiatrist, Mediplex Health Center, Milford, CT (subacute care, rehabilitation, long term care) (4/93-11/95).

Attending Psychiatrist, Hospital of Saint Raphael. (1/94-present).

Consulting Psychiatrist, Silver Springs Nursing Home, Meriden, CT (long term Care, care of neuropsychiatric and chronic mentally ill) (11/95-7/02).
Co-Medical Director, Silver Springs Nursing Center, Meriden, CT (7/97-7/02).
Consulting Psychiatrist, Regency House, Wallingford, CT(long term care Alzheimer's unit, rehabilitation) (2/97-12/03)
Consulting Psychiatrist, Marrakech, Inc., New Haven, CT(residential, vocational and supportive care for psychiatricly and developmentally disabled adults (3/96-9/07).
Consulting Psychiatrist, Benhaven, Inc (residential, educational and treatment services for children and adults with Autistic range disorders) (4/05-present).
Consulting Psychiatrist Connecticut Department of Developmental Services (9/07-).
Consulting Psychiatrist Shoreline Wellness Center 9/13- present).

Professional Honors: Member Alpha Omega Alpha

Board Certification:

Diplomat, American Board of Psychiatry and Neurology, Adult Psychiatry (4/91)
Diplomat, American Board of Psychiatry and Neurology, Added qualifications in Geriatric Psychiatry (4/94-4/05; renewed 5/05-5/15).

Lectures, Courses:

Faculty member of "Doctor to Doctor" delegation to Viet-Nam, July 2001, presented "The Treatment of Bipolar Depression" and conducted small groups with Vietnamese physicians.
Paper presentation annual meeting of the American Association for the Advancement of Philosopy and Psychiatry, 2001. "Externality and the Paradox of Agency in Psychiatry."
Paper presentation annual meeting of the American Association for the Advancement of Philosopy and Psychiatry, 2005. "Frontal Fatigue. How Technology May Contribute to Mental Illness."
Paper presentation 2009 meeting American Psychiatric Association: "How To Construct a Third World Forumlary." Part of symposium: "The Ayacucho Mental Health Project."

Professional Service:

Active member of Association for the Advancement of Philosophy and Psychiatry

Member of Peruvian American Medical Society:Presently active in the development and support of a free-standing mental health clinic in rural Peru

Board Member COSMA (Comisión de Salud Mental de Ayacucho)-a free standing mental health clinic in Ayacucho, Peru.

Bibliography: Peer-reviewed papers

Rego, M, Giller E: Mania Secondary to Amantadine Treatment of Neuroleptic-Induced Hyperprolactinemia. J Clin Psychiatry, 50; 143-144

Rego, MD, Powsner SM, Byck R: Graphic Display of Psychiatric History and Treatment. Annual Meeting of the American Psychiatric Association, 1989. Abstract 424.

Rego M, "Externlality and the Paradox of Agency in Psychiatry" in *Philosophy, Psychiatry, and Psychology.* December 2004 Vol 11 # 4. pp313-322.

Rego M. "In, Out. Me, You. Mental, Moral. Where Do I Begin?" in *Philosophy, Psychiatry and Psychology.* December 2004 Vol 11 # 4 pp 331-334.

Rego, M. "What Are (and what are not) the Existernial Implications of Antidepressant Use?" in *Philosophy, Psychiatry, and Psychology.* June 2005 Vol 12 # 2 pp119-128.

Rego M. "Surrender Versus Control: How Best Not To Drink." Philosophy, Psychiatry & Psychology. Sept 2006 Vol13 # 3 pp 223-226.

Case Reports, Letters

Rego, M: Neuroendocrine Side Effects of Neuroleptics: Comment (letter). J Clin Psychopharmacol, Vol 8/No.5, Oct 88.

Rego, M: Sexual Abuse and the Seduction Theory(letter). American Journal of Psychiatry. 1989; 146: 1082.

Rego M. "Philosophy and Psychiatry: Making Use of Ignorance," in symposium on Kenneth S. Kendler's "Toward a Philosophical Structure for Psychiatry," in AJP, March, 2005, Vol 162, #3. In the AAPP Bulletin, Vol 13, #1, 2005

Rego M "Empiricism and the Craft Nature of Science" AAPP Bulletin Vol 14 # 1

Reviews, Chapters

Rego, M. Book Review of "When Consciousness Breaks: Alien Voices and Inserted Thoughts", by G. Lynn Stevens and George Graham, Cambridge, MA: MIT Press. In the AAPP Bulletin, Vol 9, #1, 2001

Rego, M. Book Review; "The Contour of Agency. Essays on Themes from Harry Frankfurt." American Journal of Psychiatry 2003 160 p. 1196-1197.

Rego, M. Book Review; "Agency and Responsibility. A Common-Sense Moral Psychology" By Jeanette Kennett. On-Line a Metapsychology Online Reviews. November 25, 2002.

Rego M. "From Lab Bench to Bedside...to Nowhere. Premises, Problems and Paths. *Philosophy, Psychiatry, and Psychology.* June 2005 Vol 12 # 2 pp137-142.

Rego M. Book Review; "Getting Old Without Getting Anxious." American Journal of Psychiatry 2006 163 p. 1457.

Rego, M. "Frontal Fatigue. How Technology May Contribute to Mental Illness." In "Technology and Psychiatry." Ed. James Phillips. Oxford University Press. 2008.

LISA G. BIAGIONI, LCSW
73 Sentinel Hill Road Milford, CT 06460 rambill14@att.net (203) 877-2466

PROFESSIONAL EXPERIENCE

SHORELINE WELLNESS CENTER West Haven, CT
Assistant Clinical Director- October 2012-Present
Conduct bio-psychosocial assessments and diagnosis of adults
Develop and apply comprehensive treatment plans and goals for clients
Provide individual, couple, and family therapy, maintain cultural competence and confidentiality
Facilitator of Parent Education Program for court mandated families in custody transition
Oversee supervision for clinical staff
Field Supervisor for Master of Social Work student interns

BRIDGES... A COMMUNITY SUPPORT SYSTEM, INC. Milford, CT
Children and Family Services
Clinical Social Worker - May 2012-Present
Formulate bio-psychosocial intake assessments and diagnosis for children and adolescents
Develop and apply comprehensive treatment plans and goals for clients
Provide individual and family therapy, maintain cultural competence and confidentiality
Ensure accurate documentation, participate in supervision and team case assessments

Youth Prevention Services
West Shore Achieves Visionary Education – Project Supervisor September 2011- September 2012
Responsible for a middle school after-school program by supervising the on-site coordinator and ensuring accurate records for data collection and program evaluation
Facilitated Positive Parenting Program for parents, guardians and their children to promote family skill building designed to prevent teen substance abuse and other problem behaviors

West Shore Middle School Substance Abuse Prevention Program – Prevention Specialist
September 2011-June 2012
Recruited middle school students for group participation designed to provide prevention and early intervention of alcohol, tobacco, and other substance use for students who are at-risk of using, or currently using, or are children of substance abusers
Taught problem solving and coping skills
Examined peer pressure influences and develop refusal skills
Educated students to the physical, emotional, and social consequences of using substances
Taught Toward No Tobacco Use Curriculum for tobacco prevention in after-school program

Across Ages Mentoring Program - Project Specialist February 2005- August 2011
Recruited, screened, interviewed, and processed perspective mentors and mentees
Assessed, matched, and trained adult mentors and middle school student mentees
Provided ongoing supervision to mentors, mentees, and school liaisons
Conducted monthly in-service meetings for mentors for ongoing support
Taught Positive Youth Development Curriculum to mentees in school weekly
Planned and facilitated monthly family activities and community service events

LISA G. BIAGIONI, LCSW
73 Sentinel Hill Road Milford, CT 06460 rambill14@att.net (203) 877-2466

BRIDGES... A COMMUNITY SUPPORT SYSTEM, INC. Milford, CT
Adolescent Addiction Services
Adolescent Intensive Outpatient Program – Group Facilitator Per Diem March 2004- June 2007
Provided group therapy for adolescents with addiction diagnosis
Participated in weekly supervision and team case assessments

Children and Family Services
Clinical Social Worker – Contractor Per Diem May 2003- February 2005
Conducted intakes and bio-psychosocial assessments of children and adolescents
Provided individual, group, and family therapy
Evaluated diagnostic criteria and applied comprehensive treatment plans
Performed assessment, treatment goals, and case planning services for adolescent students at Foran High School in Milford, CT as a substitute school social worker

EDUCATION

SOUTHERN CONNECTICUT STATE UNIVERSITY New Haven, CT
Master of Social Work - May 2003
Specialization: Children and Families Direct Service
Bachelor of Arts in Economics – minor in psychology - May 1980

ASHLEY J. TOFFEY
108 Poplar Drive • Shelton, CT 06484 • (203) 513-0708 • toffeya1@gmail.com

EMPLOYMENT HISTORY:

Shoreline Wellness Center-West Haven, CT October 2013- Present
Clinical Coordinator

- To assess, interview, and hire potential clinical, administrative and medical staff members as the human resource manager.
- To coordinate all meetings and trainings with employees.
- Assisting in the development of an effective Electronic Healthcare Records system and to collaborate with staff on the training and use of the system.
- To manage and oversee the client intake process and coordinate the appropriate scheduling of clients with providers.
- To work with supervisors and colleagues in implementing interventions and collaborating on treatments.
- To be familiar with relevant literature pertaining to psychological theory and treatment methods and implement effective. treatment plans for clients.

Connecticut Center for Child Development-Milford, CT May 2011-September 2013
Senior Instructional Assistant

- Direct 1:1 teaching of a diverse population of children and young adults who have various developmental disorders including limited verbal skills and intellectual disabilities.
- Utilizing Applied Behavior Analysis principles and techniques and operating Behavior Intervention Plans and implementing each child's Behavioral Intervention Plan.
- To independently and collaboratively provide behavioral intervention and educational instruction with students 1:1 at CCCD, public school inclusion, job training sites and community settings.
- To work with a special education teacher/supervisor in developing curriculum for students that reflects the goals of each student's Individualized Education Plan (IEP) and Behavioral Intervention Plan.
- To identify, record, graph and interpret/report behavioral and educational data consistently and accurately.
- To individualize training for new staff on: Applied Behavior Analysis principles, graphing, data sheet development, specific teaching and behavior intervention procedures for all students, and policies and procedures.
- To supervise Instructional Assistants when Special Education Teachers/ Behavior Analysts are unavailable as well as encourage professionalism and model positive productive work habits.
- To participate in staff development that included workshops on ABA techniques and theories.

EDUCATION:

B.A. Psychology, Graduated May 2011, Cum Laude
Southern Connecticut State University - New Haven, CT

M.A. Community Psychology, Graduated May 2014
University of New Haven- West Haven, CT

SKILLS: Program Evaluation, Applied Behavior Analysis, Physical Management Training (PMT) Certified, Microsoft Word & PowerPoint, Mac & PC computers, SPSS data analysis, CATAYLST data programs, Data interpretation, Curriculum Development, Cognitive Behavioral Therapy

SECRETARY OF THE STATE OF CONNECTICUT

MAILING ADDRESS: COMMERCIAL RECORDING DIVISION, CONNECTICUT SECRETARY OF THE STATE, P.O. BOX 150470, HARTFORD, CT 06115-0470
DELIVERY ADDRESS: COMMERCIAL RECORDING DIVISION, CONNECTICUT SECRETARY OF THE STATE, 30 TRINITY STREET, HARTFORD, CT 06106
PHONE: 860-509-6003 WEBSITE: www.concord-sots.ct.gov

ARTICLES OF ORGANIZATION

LIMITED LIABILITY COMPANY - DOMESTIC

C.G.S. §§34-120; 34-121

USE INK. COMPLETE ALL SECTIONS. PRINT OR TYPE. ATTACH 81/2 X 11 SHEETS IF NECESSARY.

FILING PARTY *(CONFIRMATION WILL BE SENT TO THIS ADDRESS)*:
NAME: **Law Offices of Jerome A. Lacobelle, LLC**
ADDRESS: **537 Washington Avenue**
CITY: **West Haven**
STATE: **CT** ZIP: **06516**

FILING FEE: $120
MAKE CHECKS PAYABLE TO "SECRETARY OF THE STATE"

1. NAME OF LIMITED LIABILITY COMPANY - REQUIRED: (MUST INCLUDE BUSINESS DESIGNATION I.E. LLC, L.L.C., ETC.)
Shoreline Wellness Behavioral Health Clinic, LLC

2. DESCRIPTION OF BUSINESS TO BE TRANSACTED OR PURPOSE TO BE PROMOTED - REQUIRED:
ATTACH 81/2 X 11 SHEETS IF NECESSARY.
TO ENGAGE IN ANY LAWFUL ACTIVITY FOR WHICH LIMITED LIABILITY COMPANIES MAY BE FORMED UNDER THE CONNECTICUT LIMITED LIABILITY ACT.

3. LLC'S PRINCIPAL OFFICE ADDRESS - REQUIRED: *(NO P.O. BOX)* PROVIDE FULL ADDRESS. "SAME AS ABOVE" NOT ACCEPTABLE.
ADDRESS: **415 Main Street**
CITY: **West Haven**
STATE: **CT** ZIP: **06516**

4. MAILING ADDRESS, IF DIFFERENT THAN #3: PROVIDE FULL ADDRESS. "SAME AS ABOVE" NOT ACCEPTABLE.
ADDRESS:
CITY:
STATE: ZIP:

5. APPOINTMENT OF STATUTORY AGENT FOR SERVICE OF PROCESS - REQUIRED: *(COMPLETE A OR B NOT BOTH)*
☒ **A. IF AGENT IS AN INDIVIDUAL.**
PRINT OR TYPE FULL LEGAL NAME:
Cara Powers

BUSINESS ADDRESS *(P.O. BOX NOT ACCEPTABLE) IF NONE, MUST STATE "NONE"*	**CONNECTICUT RESIDENCE ADDRESS** *(P.O. BOX NOT ACCEPTABLE)*
ADDRESS: **415 Main Street**	ADDRESS: **21 Phipps Drive**
CITY: **West Haven**	CITY: **West Haven**
STATE: **CT**	STATE: **CT**
ZIP: **06516**	ZIP: **06516**

SIGNATURE ACCEPTING APPOINTMENT:

☐ **B. IF AGENT IS A BUSINESS:**
PRINT OR TYPE NAME OF BUSINESS AS IT APPEARS ON OUR RECORDS:

CT BUSINESS ADDRESS *(P.O.BOX UNACCEPTABLE)*

ADDRESS:

CITY:

STATE: ZIP:

SIGNATURE ACCEPTING APPOINTMENT ON BEHALF OF AGENT:

PRINT NAME & TITLE OF PERSON SIGNING:

6. MANAGER OR MEMBER INFORMATION-*REQUIRED:* *(MUST LIST AT LEAST ONE MANAGER OR MEMBER OF THE LLC.)*
ATTACH 81/2 X 11 SHEETS IF NECESSARY.

NAME	TITLE	BUSINESS ADDRESS (No. P.O Box) *IF NONE, MUST STATE "NONE"*	RESIDENCE ADDRESS: (No. P.O Box)
Cara Powers	**Member**	**415 Main Street West Haven, CT 06516**	**21 Phipps Drive West Haven, CT 06516**

7. MANAGEMENT - PLACE A CHECK NEXT TO THE FOLLOWING STATEMENT ONLY IF IT APPLIES

☐ MANAGEMENT OF THE LIMITED LIABILITY COMPANY SHALL BE VESTED IN A MANAGER OR MANAGERS

8. EXECUTION: *(SUBJECT TO PENALTY OF FALSE STATEMENT)*

DATED THIS 28th **DAY OF** August , 2014

NAME OF ORGANIZER (PRINT OR TYPE)	SIGNATURE
Cara Powers	

AN ANNUAL REPORT WILL BE DUE YEARLY IN THE ANNIVERSARY MONTH THAT THE ENTITY WAS FORMED/REGISTERED AND CAN BE EASILY FILED ONLINE @ www.concord-sots.ct.gov
CONTACT YOUR TAX ADVISOR OR THE TAXPAYER SERVICE CENTER AT THE DEPARTMENT OF REVENUE SERVICES AS TO ANY POTENTIAL TAX LIABILITY RELATING TO YOUR BUSINESS, INCLUDING QUESTIONS ABOUT THE BUSINESS ENTITY TAX.
TAX PAYER SERVICE CENTER: (800) 382-9463 OR (860) 297-5962 OR GO TO www.ct.gov/drs

Member	Percentage Interest	Capitol Contribution
CARA POWERS	100%	

OPERATING AGREEMENT

OF

SHORELINE WELLNESS BEHAVIORAL HEALTH CLINIC, LLC

Prepared for:

CARA POWERS

By

Law Offices of Jerome A. Lacobelle, LLC
537 Washington Avenue
West Haven, CT 06516

(IRS USE ONLY) 575A 08-04-2014 SHOR B 9999999999 SS-4

The IRS is committed to helping all taxpayers comply with their tax filing obligations. If you need help completing your returns or meeting your tax obligations, Authorized e-file Providers, such as Reporting Agents (payroll service providers) are available to assist you. Visit the IRS Web site at www.irs.gov for a list of companies that offer IRS e-file for business products and services. The list provides addresses, telephone numbers, and links to their Web sites.

To obtain tax forms and publications, including those referenced in this notice, visit our Web site at www.irs.gov. If you do not have access to the Internet, call 1-800-829-3676 (TTY/TDD 1-800-829-4059) or visit your local IRS office.

IMPORTANT REMINDERS:

* Keep a copy of this notice in your permanent records. **This notice is issued only one time and the IRS will not be able to generate a duplicate copy for you.** You may give a copy of this document to anyone asking for proof of your EIN.
* Use this EIN and your name exactly as they appear at the top of this notice on all your federal tax forms.
* Refer to this EIN on your tax-related correspondence and documents.

If you have questions about your EIN, you can call us at the phone number or write to us at the address shown at the top of this notice. If you write, please tear off the stub at the bottom of this notice and send it along with your letter. If you do not need to write us, do not complete and return the stub.

Your name control associated with this EIN is SHOR. You will need to provide this information, along with your EIN, if you file your returns electronically.

Thank you for your cooperation.

Keep this part for your records. CP 575 A (Rev. 7-2007)

Return this part with any correspondence so we may identify your account. Please correct any errors in your name or address.

CP 575 A

9999999999

Your Telephone Number ( ) -

Best Time to Call

DATE OF THIS NOTICE: 08-04-2014
EMPLOYER IDENTIFICATION NUMBER: 47-1491174
FORM: SS-4 NOBOD

INTERNAL REVENUE SERVICE
CINCINNATI OH 45999-0023

SHORELINE WELLNESS BEHAVIORAL HEALTH CLINIC
CARA POWERS SOLE MBR
415 MAIN ST
WEST HAVEN, CT 06516

IRS DEPARTMENT OF THE TREASURY
INTERNAL REVENUE SERVICE
CINCINNATI OH 45999-0023

Date of this notice: 08-04-2014

Employer Identification Number:
47-1491174

Form: SS-4

Number of this notice: CP 575 A

SHORELINE WELLNESS BEHAVIORAL
HEALTH CLINIC
CARA POWERS SOLE MBR
415 MAIN ST
WEST HAVEN, CT 06516

For assistance you may call us at:
1-800-829-4933

IF YOU WRITE, ATTACH THE
STUB AT THE END OF THIS NOTICE.

WE ASSIGNED YOU AN EMPLOYER IDENTIFICATION NUMBER

Thank you for applying for an Employer Identification Number (EIN). We assigned you EIN 47-1491174. This EIN will identify you, your business accounts, tax returns, and documents, even if you have no employees. Please keep this notice in your permanent records.

When filing tax documents, payments, and related correspondence, it is very important that you use your EIN and complete name and address exactly as shown above. Any variation may cause a delay in processing, result in incorrect information in your account, or even cause you to be assigned more than one EIN. If the information is not correct as shown above, please make the correction using the attached tear off stub and return it to us.

Based on the information received from you or your representative, you must file the following form(s) by the date(s) shown.

Form 941	07/31/2015
Form 940	01/31/2016

If you have questions about the form(s) or the due date(s) shown, you can call us at the phone number or write to us at the address shown at the top of this notice. If you need help in determining your annual accounting period (tax year), see Publication 538, *Accounting Periods and Methods*.

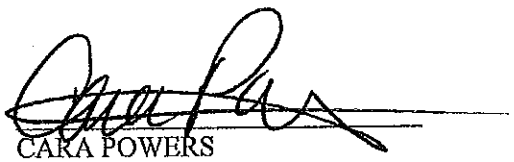
We assigned you a tax classification based on information obtained from you or your representative. It is not a legal determination of your tax classification, and is not binding on the IRS. If you want a legal determination of your tax classification, you may request a private letter ruling from the IRS under the guidelines in Revenue Procedure 2004-1, 2004-1 I.R.B. 1 (or superseding Revenue Procedure for the year at issue). Note: Certain tax classification elections can be requested by filing Form 8832, *Entity Classification Election*. See Form 8832 and its instructions for additional information.

If you are required to deposit for employment taxes (Forms 941, 943, 940, 944, 945, CT-1, or 1042), excise taxes (Form 720), or income taxes (Form 1120), you will receive a Welcome Package shortly, which includes instructions for making your deposits electronically through the Electronic Federal Tax Payment System (EFTPS). A Personal Identification Number (PIN) for EFTPS will also be sent to you under separate cover. Please activate the PIN once you receive it, even if you have requested the services of a tax professional or representative. For more information about EFTPS, refer to Publication 966, *Electronic Choices to Pay All Your Federal Taxes*. If you need to make a deposit immediately, you will need to make arrangements with your Financial Institution to complete a wire transfer.

EXHIBIT A

provision referred to as the same may be amended from time to time, as well as any substitute or successor provisions.

IN WITNESS WHEREOF, the parties have duly executed this Agreement as of the date first above written.



CARA POWERS

(h) Construction. This Agreement shall be governed by and construed in accordance with the laws of the State of Connecticut applicable to contracts made and to be wholly performed within this State.

(i) Binding Nature. This Agreement shall be binding upon and inure to the benefit of the Members and heir successors, personal representatives, heirs, devisees, guardians and assigns.

(j) Arbitration. Any dispute, difference, disagreement or controversy among the Members arising out of or in connection with the Company or the interpretation of the meaning or construction of the Agreement shall be settled by arbitration in New Haven, Connecticut before the American Arbitration Association in accordance with its rules then obtaining. There shall be no appeal from such award or determination and judgment thereon may be entered in any court of competent jurisdiction.

(k) Counterparts. This Agreement may be executed in any number of counterparts and all of such counterparts taken together shall for all purposes constitute one agreement binding upon all the Members.

(l) Headings. The headings contained in this Agreement are for reference purposes only and shall not affect the meaning or interpretation of this Agreement.

(m) Usage. In construing this Agreement, feminine or neuter pronouns shall be substituted for those of the masculine form, and the plural for the singular, and vice versa, in any case in which the context may require. The capitalized terms used in this Agreement shall have the meaning first applied to their first usage in the Agreement unless otherwise indicated.

(n) References to Code or Regulations. Any references in the Agreement to the Internal Revenue Code or to a Treasury Regulation shall be interpreted to include the specific

members may be admitted without the written consent of all Members.

(b) Notices. Any notice, consent or other communication which any party hereto is required or permitted to give to another party shall be deemed duly given if in writing and if delivered personally or sent by registered mail, return receipt requested, to the recipient at his or its address first stated above, or in the case of the Company, at its principal office as set forth in Section 1(c) above, or at such other address of which he or it shall have given the other party or parties due notice hereunder. All notices duly given hereunder shall be deemed effective (a) upon delivery, if delivered personally, or (b) forty-eight (48) hours after posting, if mailed.

(c) Waiver. The failure of any party to insist in any one or more instances upon the performance of any of the terms and conditions of this Agreement shall not be construed as a waiver or relinquishment of any right granted hereunder, or the future performance of any such term or condition.

(d) Entire Agreement. This agreement sets forth the entire understanding of the parties hereto with respect to the subject matter hereof.

(e) Further Acts. Each of the parties hereto shall execute and deliver all such additional documents or legal instruments, and shall perform or cause to be performed all such further acts and things, as may be necessary or desirable to carry out the purposes and intent of this Agreement.

(f) Amendment. This Agreement may not be amended, modified or altered in any manner, except pursuant to the terms of a written instrument signed by each of the parties hereto.

(g) Invalid Provision. The invalidity or unenforceability or any particular provision of this Agreement shall not affect the other provisions hereof, and this Agreement shall thereafter be construed in all respects as if such invalid or unenforceable provisions are omitted.

(3) To the Members in accordance with their positive Capital Account balances, as determined after taking into account all Capital account adjustments for the Company taxable year during which the liquidation of the Company occurs.

(d) Distribution in Kind. If the Members shall determine that an immediate sale of part or all of the Company's assets would be inadvisable, the Company may distribute to the Members, in lieu of cash, interests in any Company assets, liquidating only such assets as are necessary in order to pay the debts and liabilities of the Company. Such distribution shall be made in such proportions as cash would have been distributed, if available for distribution, under Subsection (c) above and such distribution shall, in any event, be based on the fair market value of such distributed property at the time of distribution.

(e) Timing of Distributions. Liquidating distributions shall be made by the end of the taxable year during which the liquidation (as defined in Treasury Regulation Section 1.704-1(b)(2)(ii)(g)(a "Liquidation") of the company occurs, or if later, within ninety (90) days of such Liquidation, except to the extent of any reserves established pursuant to Subsection (c) (2) above. In the event that such reserves have been established, liquidation proceeds (other than any such withheld amounts) shall be distributed in proportion to the Members positive Capital Accounts, and any withheld amounts shall be distributed as soon as practicable in proportion to the Members positive Capital Accounts.

(f) Capital Account Deficits. No Member shall be required to make any contribution to the Company to eliminate any deficit balance in his Capital Account following the Liquidation of the Company (or any other time).

10. MISCELLANEOUS

(a) Additional Members. Except as otherwise provided herein, no additional

(1) The sale or other disposition of all or substantially all of the Company's property;

(2) The expiration of the term of the Company;

(3) The determination by the Members to dissolve the Company;

(4) An event of dissociation of a Member, unless there are at least two remaining Members and within ninety (90) days following the occurrence of such event, all of the remaining Members agree in writing to continue the business of the Company; or

(5) The entry of a decree of judicial dissolution under Section 43 of the Act.

The Members hereby agree that, notwithstanding any provision of the Act, the Company shall not dissolve prior to the occurrence of a Liquidating Event. If it is determined that the Company has dissolved prior to the occurrence of a Liquidating Event, the Members hereby agree to continue the business of the Company without a winding up or liquidation.

(b) Winding up. Upon the winding up of the Company, the assets of the Company shall be liquidated as promptly as possible in an orderly and businesslike manner so as not to involve undue sacrifice.

(c) Priority of Distributions. Liquidation proceeds shall be distributed and applied in the following order of priority:

(1) To the payment of debts and liabilities (including those owed to Members who are creditors) of the Company and expenses of liquidation;

(2) To the setting up of any reserves which the Members may deed necessary for any contingent or unforeseen liability of obligation of the Company, which reserves shall be maintained for such period as the Members deem advisable; and

and conditions may include, without limitation the following:

(1) the transferee executes and delivers to the other members an undertaking of the transferee to be bound by all the terms and provisions of this Agreement, and such other instruments as may be required by the other Members, and a completed counterpart signature page of this Agreement; and

(2) the transferee pays or reimburses the Company for all expenses incurred by the Company in connection with the admission of the transferee as a Member.

(d) Effective Date of Transfer. Any Transfer that is permitted hereunder shall be effective (i) in the case of a Transfer by reason of death, as of the date of death, and (ii) in the case of a Transfer other than by reason of death, as of the first day of the first month following the month during which the other Members have consented, in writing, to the Transfer or at such later date as is specified in the Transfer documents.

(e) Indemnity. Each Member hereby indemnifies the Company and each other Member against any and all loss, damage or expense (including without limitation, tax liabilities or loss of tax benefits) arising, directly or indirectly, as a result of any Transfer or purported Transfer by that Member in violation of any provision contained in this section.

(f) Partition. No Member shall have the right to bring an action for partition against he Company.

(g) Withdrawal. No Member shall have the right to withdraw from the Company without the prior written consent of each of the other Members.

9. DISSOLUTION AND WINDING UP

(a) Events of Dissolution. Upon the happening of any of the following events (a "Liquidation Event"), the company shall be dissolved and its affairs would upon:

other Members to such Transfer, which consent may be withheld in the complete discretion of each such other Member and (ii) satisfied all requirements and conditions established by the other Members for such Transfer, which requirements and conditions may include, without limitation, the following:

(A) the transferor has executed and delivered to the other Members an assignment and such other documents as are required by, and in form satisfactory to, the other Members.

(B) the other Members have determined that the Transfer will not result in a termination of the Company pursuant to Section 708 of the Internal Revenue Code or otherwise for federal income tax purposes;

(C) the other Members have determined that the Transfer will not be in violation of any applicable federal or state securities laws; and

(D) the transferor and/or transferee pay or reimburse the Company for all expenses incurred by the Company in connection with the transfer.

Any Transfer pursuant to this Subsection (b) shall not entitle the Transferee to be admitted as, or to exercise any of the rights of, a Member, but shall hereby entitle the Transferee to receive and be allocated, to the extent assigned, distributions and Income and Loss to which the Transferor would otherwise be entitled.

(c) Admission of Transferee as Additional Member. In the event any Transfer permitted pursuant to Subsection (b) above, the transferee shall be admitted as a Member upon (i) obtaining the written consent of each of the other Members to the admission of such transferee as a Member, which consent may be withheld in the complete discretion of each such other Member, and (ii) satisfying all requirements and conditions established by the other Members, which requirements

(c) Financial Statements. As soon as practicable after the end of each fiscal year, each Member shall be furnished with a copy of the financial statements of the company for such year and a statement of distributions and allocations during or in respect of such year, and the amount thereof reportable for state and federal income tax purposes.

(d) Other Reports. The Company shall furnish such other reports as shall be appropriate to advise the Members as to the operations of the Company.

(e) Rights of Examination. Any Member may examine, inspect, and audit, at his own expense, the Company's books, records, accounts and assets (including bank balances and physical properties), either in person or through a certified public accountant, engineer, appraiser, or other qualified professional, provided that any such inspection shall be conducted at such time and in such manner as not to interfere with the conduct of the business of the Company.

8. TRANSFER OF INTERESTS

(a) Transferability. A Member may not sell, assign, give, encumber or otherwise transfer (directly or indirectly, conditionally or collaterally) ("Transfer" or a "Transfer") his Membership Interest or any part thereof except as specifically permitted in this Agreement, and any act in violation of this Subsection (a) shall be null and void and have no effect and shall not be binding upon or recognized by the Company regardless of whether any other Member shall have knowledge thereof.

(b) Permitted Transfer.

(1) Transfer by Reason of Death. A Member may Transfer his Membership upon his death, by will or intestacy.

(2) Transfer Other than by Reason of Death. A Member may transfer all or any part of his Membership Interest after he has (i) first obtained the written consent of each of the

of this Subsection (c) shall be taken into account in making subsequent allocations of Income and Loss so that, to the extent possible, the net aggregate amounts of Income and Loss allocated to each member shall be equal to the net aggregate amounts that would have been allocated to each such Member is such Subsection (c) never existed.

5. DISTRIBUTION OF CASH.

The Members shall determine the amount and frequency of distributions of cash which the Company shall make. Any such distributions (other than distributions in connection with the dissolution and liquidation of the Company) shall be distributed to the Members in accordance with their Percentage Interests.

6. ADMINISTRATION.

The business, property and affairs of the Company shall be managed by the Members. The affirmative vote, approval, or consent of Members owning in the aggregate more then 65% of all of the Percentage Interests then owned by Members shall be required to decide any matter connected with the business or affairs of the Company.

7. BOOKS AND RECORDS AND ACCOUNTING.

(a) Books and Records. The Company shall keep proper and complete books and records in accordance with good accounting practice. The Company may adopt the cash receipts and disbursements method or the accrual method as its method of accounting, as the Members shall determine. The fiscal year of the Company (for federal income tax purposes and financial statement purposes) shall be the calendar year, unless the Members determine otherwise.

(b) Tax Returns. The Company shall, for each fiscal year, file a timely United States Partnership income tax return and any state and local partnership income tax returns as may be required by law.

(d) Capital Accounts. A separate "Capital Account" for each Member shall be maintained as part of the books of the Company. Each Member's Capital Account shall be maintained in accordance with the provisions of Treasury Regulation Section 1.704-1(b).

4. INCOME AND LOSS

(a) Definition of Income and Loss. "Income" and "Loss" means, for each taxable year or other period, an amount equal to the Company's taxable income or taxable loss for such year or period, determined in accordance with Section 703(a) of the Internal Revenue Code (for this purpose, all items of income, gain, loss or deduction required to be stated separately pursuant to Section 703(a)(1) of the Internal Revenue Code shall be included in taxable income or loss, as the case may be) with such adjustments as are consistent with the provisions of Treasury Regulation Section 1.704-1(b).

(b) Allocation of Income and Loss. Except as otherwise provided in Subsection (c) below, Income and Loss shall be allocated among the Members in accordance with their Percentage Interests.

(c) Special Allocation Rules. The allocation of Income and Loss otherwise provided for in Subsection (b) above shall be adjusted to the extent necessary to cause the allocation to have substantial economic effect under Treasury Regulation Sections 1.704-1(b) and 1.704-2. Furthermore, and in addition to the foregoing, (i) Income and Loss shall be allocated pursuant to a so-called minimum gain chargeback as described in Treasury Regulations Section 1.704-2(f), (ii) Income and Loss shall be allocated pursuant to a so-called partner nonrecourse debt minimum chargeback as described in Treasury Regulation Section 1.704-2(i)(4), and (iii) Income and Loss shall be allocated pursuant to a so-called qualified income offset as described in Treasury Regulation Section 1.704-1(b)(2)(ii)(d). Any variations to allocations made pursuant to the preceding sentences

and shall continue until terminated in accordance with this Agreement.

(e) Purpose. The purpose of the Company is to engage in any lawful activity for which limited liability companies may be formed under the Connecticut L.L.C. Act.

2. MEMBERSHIP INTERESTS

Each Member's share of the rights and obligations of the Members may be referred to herein as his "Membership Interest". The Percentage Interest of the Members shall be as follows:

Member	Percentage Interest
CARA POWERS	100%

3. CAPITALIZATION AND CONTRIBUTIONS

(a) Capital Contributions. The original capital contributions of the Members shall be as follows, all of which shall be contributed contemporaneously with the execution of this Agreement. See "Exhibit B" attached hereto and made a part hereof.

(b) Additional Contributions. No Member shall be required to make additional contributions to the capital of the company, except as specifically provided in this Agreement.

(c) Withdrawal of Contributions. Except as otherwise specifically provided in this Agreement, no Member shall be permitted to withdraw any contributions made to the Company or otherwise receive any payments or distributions from the Company. Furthermore, no Member shall be entitled to receive any distribution of money or other property in excess of $1.00 by reason of such person ceasing to be a Member, except if (i) upon dissolution of the Company, or (ii) upon the written consent of each of the other Members. Rather, such former Member shall remain entitled to allocations of Income and Loss (as those terms are hereinafter defined) and distributions in the same manner as if such Member had not withdrawn, but shall thereafter have no rights to exercise any of the rights of a Member.

THIS OPERATING AGREEMENT made and entered into as of this 29th day of August, 2014 by and between:

Cara Powers

The parties identified above may also be referred to individually as a "Member" and collectively as the "Members".

WITNESSETH:

WHEREAS, the Members desire to form a limited liability company for the purposes set forth below; and

WHEREAS, the Members deem it desirable to define the terms of their association, and to commit their agreement in writing.

NOW, THEREFORE, intending to be legally bound hereby, the Members do hereby agree to form a limited liability company under the laws of the State of Connecticut upon the following terms and conditions:

1. ORGANIZATION

(a) Formation. The Members hereby form a limited liability company (the "Company") pursuant to the Connecticut Limited Liability Company Act (the "Act").

(b) Name. The name of the company shall be:

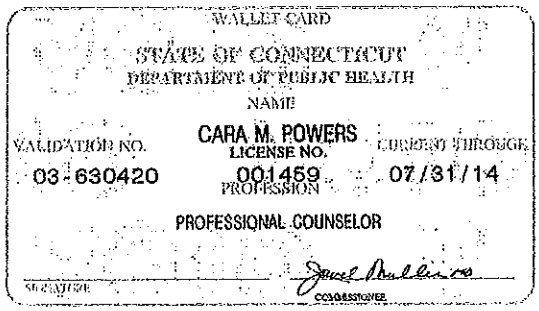
Shoreline Wellness Behavioral Health Clinic, LLC

(c) Location. The principal office of the company shall be 260 Main Street, New Britain, CT 06051 or such address as the Members shall designate.

(d) Term. The term of the company began on the date first above written

TABLE OF CONTENTS

Paragraphs 1	-	ORGANIZATION
Paragraph 2	-	MEMBERSHIP INTERESTS
Paragraph 3	-	CAPITALIZATION AND CONTRIBUTIONS
Paragraph 4	-	INCOME AND LOSS
Paragraph 5	-	DISTRIBUTION OF CASH
Paragraph 6	-	ADMINISTRATION
Paragraph 7	-	BOOKS AND RECORDS AND ACCOUNTING
Paragraph 8	-	TRANSFER OF INTERESTS
Paragraph 9	-	DISSOLUTION AND WINDING UP
Paragraph 10	-	MISCELLANEOUS
EXHIBIT A	-	ARTICLES OF ORGANIZATION
EXHIBIT B	-	MEMBERS



WALLET CARD

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

NAME
CARA M. POWERS

VALIDATION NO.
03-630420

LICENSE NO.
001459

CURRENT THROUGH
07/31/14

PROFESSION
PROFESSIONAL COUNSELOR

SIGNATURE

COMMISSIONER

13. B i. Please provide one year of actual results and three years of projections of **Total Facility** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

Total Facility: Description	PFY 2014 Actual Results	PFY 2015 Projected W/out CON	PFY 2015 Projected Incremental	PFY 2015 Projected With CON	FY 2016 Projected W/out CON	FY2016 Projected Incremental	FY2016 Projected With CON	FY 2017 Projected W/out CON	FY 2017 Projected Incremental	FY 2017 Projected With CON
NET PATIENT REVENUE	Not Applicable									
Non-Government		$0			$0	$0		$0	$0	$0
Medicare		$0		$0	$0	$0	$0	$0	$0	$0
Medicaid and Other Medical Assistance		$0		$380,190	$0	$236,450	$616,640	$0	$0	$614,640
Other Government		$0		$0	$0	$0	$0	$0	$0	$0
Total Net Patient Patient Revenue		$0		$380,190	$0	$236,450	$616,640	$0	$0	$614,640
								$0	$0	
Other Operating Revenue		$0		$0	$0	$0	$0	$0	$0	
Revenue from Operations		$0		$380,190	$0	$236,450	$616,640	$0	$0	$614,640
								$0	$0	
OPERATING EXPENSES								$0	$0	
Salaries and Fringe Benefits		$0		$284,000	$0	$60,000	$344,400	$0	$0	$344,400
Professional / Contracted Services		$0		$0	$0	$0	$0	$0	$0	$0
Supplies and Drugs		$0		$12,000	$0	$0	$12,000	$0	$0	$14,000
Bad Debts		$0		$0	$0	$0	$0	$0	$0	$0
Other Operating Expense		$0		$0	$0	$0	$0	$0	$0	$0
Subtotal		$0		$296,000	$0	$60,000	$356,400	$0	$0	$358,400
Depreciation/Amortization		$0		$0	$0	$0	$0	$0	$0	$0
Interest Expense		$0		$0	$0	$0	$0	$0	$0	$0
Lease Expense		$0		$9,000	$0	$0	$9,000	$0	$0	$12,000
Total Operating Expenses		$0		$305,000	$0	$60,000	$365,400	$0	$0	$370,400
								$0	$0	
Income (Loss) from Operations		$0		$75,190	$0	$176,450	$251,240	$0	$0	$244,240
								$0	$0	
Non-Operating Income				$0			$0	$0	$0	$0
Income before provision for income taxes		$0		$75,190	$0	$176,450	$251,240	$0	$0	$244,240
								$0	$0	
Provision for income taxes				$19,000			$62,810	$0	$0	$61,060
Net Income		$0	$0	$56,190	$0	$176,450	$188,430	$0	$0	$183,180
								$0	$0	
Retained earnings, beginning of year		$0	$0	$0	$0	$0	$56,190	$0	$0	$244,620
Retained earnings, end of year		$0	$0	$56,190	$0	$176,450	$244,620	$0	$0	$427,800
FTEs				0			0			0

*Volume Statistics:
Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

12.C(ii). Please provide **three** years of projections of <u>incremental</u> revenue, expense and volume statistics **attributable to the proposal** in the following reporting format:

Type of Service Description: Mental Health Services
Type of Unit Description: Client/Patient
# of Months in Operation: 6

FY ___2015-2017_____	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
FY Projected Incremental		Rate	Units	Gross Revenue Col. 2 * Col. 3	Allowances/ Deductions	Charity Care	Bad Debt	Net Revenue Col.4 - Col.5 -Col.6 - Col.7	Operating Expenses Col. 1 Total * Col. 4 / Col. 4 Total	Gain/(Loss) from Operations Col. 8 - Col. 9
Total Incremental Expenses:	**$370,400**									
Total Facility by Payer Category:										
Medicare		$0				$0	$0			
Medicaid		$60	10,442	$614,640.00	$61,060	$0	$0	$565,460	$370,400	$195,060
Total Governmental		$60	10,442	$614,640	$61,060	$0	$0	$565,460	$370,400	$195,060
Commericial Insurers		N/A								
Uninsured		N/A								
Total NonGovernment		$0								
Total All Payers		$60	10,442	$614,640	$61,060	$0	$0	$565,460	$370,400	$195,060

Exhibit D - Covered Services Table
Revised May 26, 2011

Coverage Responsibility Legend:	1= HUSKY MCO – All diagnoses 2= BHP - All diagnoses 3= BHP for Primary Diagnoses 291-316, HUSKY MCO all other diagnoses 4= Not covered Note: PSR = Provider Specific Rate		
90887	Interpretation or explanation of results of psychiatric or other medical examinations and procedures or other accumulated data to family or other responsible persons.	2	$ 84.10
96101	Psychological testing, per hour	2	$ 88.47
96110	Developmental testing with report	2	$ 14.75
96111	Developmental testing, extended	2	$ 133.69
96118	Neuropsychological testing battery, per hour	2	$ 120.90
99201	Office or other outpatient visit, 10 minutes, new patient	2	$ 40.22
99202	Office or other outpatient visit, 20 minutes, new patient	2	$ 64.88
99203	Office or other outpatient visit, 30 minutes, new patient	2	$ 95.77
99204	Office or other outpatient visit, 45 minutes, new patient	2	$ 144.48
99205	Office or other outpatient visit, 60 minutes, new patient	2	$ 180.79
99211	Office or other outpatient visit, 5 minutes, established patient	2	$ 21.54
99212	Office or other outpatient visit, 10 minutes, established patient	2	$ 38.69
99213	Office or other outpatient visit, 15 minutes, established patient	2	$ 61.93
99214	Office or other outpatient visit, 25 minutes, established patient	2	$ 93.74
99215	Office or other outpatient visit, 40 minutes, established patient	2	$ 126.36
99217	Observation care discharge	2	$ 67.25
99218	Initial observation care, low severity	2	$ 63.03
99219	Initial observation care, moderate severity	2	$ 104.05
99220	Initial observation care, high severity	2	$ 146.77
99221	Inpatient hospital care, 30 minutes	2	$ 85.64
99222	Inpatient hospital care, 50 minutes	2	$ 120.37
99223	Inpatient hospital care, 70 minutes	2	$ 175.51
99231	Subsequent hospital care, 15 minutes	2	$ 56.59
99232	Subsequent hospital care, 25 minutes	2	$ 64.45
99233	Subsequent hospital care, 35 minutes	2	$ 91.97
99234	Observation of inpatient hospital care, low severity	2	$ 126.81
99235	Observation of inpatient hospital care, moderate severity	2	$ 167.09
99236	Observation of inpatient hospital care, high severity	2	$ 208.26
99238	Hospital discharge day management 30 minutes or less	2	$ 66.94
99239	Hospital discharge day management more than 30 minutes	2	$ 96.52
99241	Office consultation for a new or established patient, approximately 15 minutes	2	$ 50.69
99242	Office consultation for a new or established patient, approximately 30 minutes	2	$ 92.71
99243	Office consultation for a new or established patient, approximately 40 minutes	2	$ 126.80
99244	Office consultation for a new or established patient, approximately 60 minutes	2	$ 185.23
99245	Office consultation for a new or established patient, approximately 80 minutes	2	$ 229.59
99251	Initial inpatient consultation, 20 minutes	2	$ 46.20
99252	Initial inpatient consultation, 40 minutes	2	$ 74.42
99253	Initial inpatient consultation, 55 minutes	2	$ 110.12
99254	Initial inpatient consultation, 80 minutes	2	$ 158.65
99255	Initial inpatient consultation, 110 minutes	2	$ 198.08
99271	Confirmatory consultation, limited or minor	2	$ 37.94
99272	Confirmatory consultation, low severity	2	$ 62.77

Exhibit D - Covered Services Table
Revised May 26, 2011

Coverage Responsibility Legend:	1= HUSKY MCO – All diagnoses 2= BHP - All diagnoses 3= BHP for Primary Diagnoses 291-316, HUSKY MCO all other diagnoses 4= Not covered Note: PSR = Provider Specific Rate		
90801	Diagnostic Interview	2	$ 156.67
90802	Interactive Diagnostic Interview	2	$ 157.52
90804	Individual Psychotherapy-Office or other Outpatient (20-30 min)	2	$ 63.21
90805	Individual Psychotherapy-Office or other Outpatient (20-30 min) with medical evaluation and management services	2	$ 69.28
90806	Individual Psychotherapy-Office or other Outpatient (45-50 min)	2	$ 91.53
90807	Individual Psychotherapy-Office or other Outpatient (45-50 min) with medical evaluation and management services	2	$ 99.14
90808	Individual Psychotherapy-Office or other Outpatient (75-80 min)	2	$ 135.38
90809	Individual Psychotherapy-Office or other Outpatient (75-80 min) with medical evaluation and management services	2	$ 142.20
90810	Interactive Individual Psychotherapy-Office or other Outpatient (20-30 min)	2	$ 67.27
90811	Interactive Individual Psychotherapy-Office or other Outpatient (20-30 min) with medical evaluation and management services	2	$ 76.72
90812	Interactive Individual Psychotherapy-Office or other Outpatient (45-50 min)	2	$ 99.07
90813	Interactive Individual Psychotherapy-Office or other Outpatient (45-50 min) with medical evaluation and management services	2	$ 106.69
90814	Interactive Individual Psychotherapy-Office or other Outpatient (75-80 min)	2	$ 142.49
90815	Interactive Individual Psychotherapy-Office or other Outpatient (75-80 min) with medical evaluation and management services	2	$ 148.88
90816	Individual Psychotherapy-Facility Based (20-30 min)	2	$ 60.95
90817	90816 with medical evaluation and management	2	$ 67.60
90818	Individual psychotherapy, insight oriented 45-50 minutes	2	$ 91.97
90819	90818 with medical evaluation and management	2	$ 96.18
90821	Individual Psychotherapy-Facility Based (75-80 min)	2	$ 135.60
90822	Individual Psychotherapy-Facility Based (75-80 min) with med management	2	$ 139.79
90823	Interactive Individual Psychotherapy-Facility Based (20-30 min)	2	$ 65.54
90824	Interactive Individual Psychotherapy-Facility Based (20-30 min) med management	2	$ 71.89
90826	Interactive Individual Psychotherapy-Facility Based (45-50 min)	2	$ 97.08
90827	Interactive Individual Psychotherapy-Facility Based (45-50 min) med management	2	$ 100.68
90828	Interactive Individual Psychotherapy-Facility Based (75-80 min)	2	$ 140.66
90829	Interactive Individual Psychotherapy-Facility Based (75-80 min) med management	2	$ 144.48
90846	Family Psychotherapy (without the patient present)	2	$ 89.10
90847	Family Psychotherapy (conjoint)	2	$ 109.72
90849	Multi-group family psychotherapy	2	$ 32.26
90853	Group Psychotherapy	2	$ 36.64
90857	Interactive Group psychotherapy	2	$ 41.93
90862	Pharmacological management, including prescription, use, and review of medication with no more than minimal medical psychotherapy	2	$ 54.54
90865	Narcosynthesis for Psychiatric Diagnostic and Therapeutic purposes	2	$ 154.82
90870	Electroconvulsive therapy (including necessary monitoring); single seizure	2	$ 145.87
90875	Individual psychophysiological therapy incorporating biofeedback training (20-30 min)	2	$ 77.43
90876	Individual psychophysiological therapy incorporating biofeedback training (45-50 min)	2	$ 112.04
90880	Hypnotherapy	2	$ 114.04

Exhibit D - Covered Services Table
Revised May 26, 2011

Coverage Responsibility Legend:	1= HUSKY MCO – All diagnoses 2= BHP - All diagnoses 3= BHP for Primary Diagnoses 291-316, HUSKY MCO all other diagnoses 4= Not covered Note: PSR = Provider Specific Rate		
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three components: comprehensive history; comprehensive examination; medical decision making of high complexity (Typically 40 minutes face-to-face)	1	N/A
All others		1	N/A

Code	FQHC Medical Clinics (including those operating as School-Based Health Centers)	Coverage	BHP Fee
90782	Therapeutic or diagnostic injection; subcutaneous or intramuscular	1	N/A
90783	Therapeutic or diagnostic injection; intra-arterial	1	N/A
90784	Therapeutic or diagnostic injection; intravenous	1	N/A
90801	Psychiatric Diagnostic Interview	3	$ -
90804	Individual psychotherapy (20-30 min)	3	$ -
90805	Individual Psychotherapy-Office or other Outpatient (20-30 min) with medical evaluation and management services	2	$ -
90806	Individual Psychotherapy-Office or other Outpatient (45-50 min)	2	$ -
90807	Individual Psychotherapy-Office or other Outpatient (45-50 min) with medical evaluation and management services	2	$ -
90808	Individual Psychotherapy-Office or other Outpatient (75-80 min)	2	$ -
90846	Family psychotherapy (without the patient present)	3	$ -
90847	Family psychotherapy (conjoint psychotherapy w/patient present)	3	$ -
90853	Group psychotherapy (other than of a multiple-family group)	3	$ -
90862	Pharmacologic management	2	$ -
99211	Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. (Typically 5 minutes)	1	N/A
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three components: problem focused history; problem focused examination; straightforward medical decision-making. (Typically 10 minutes face-to-face)	1	N/A
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three components: expanded problem focused history; expanded problem focused examination; medical decision making of low complexity. (Typically 15 minutes face-to-face)	1	N/A
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three components: detailed history; detailed examination; medical decision making of moderate complexity (Typically 25 minutes face-to-face)	1	N/A
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three components: comprehensive history; comprehensive examination; medical decision making of high complexity (Typically 40 minutes face-to-face)	1	N/A

Exhibit D - Covered Services Table
Revised May 26, 2011

Coverage Responsibility Legend:	1= HUSKY MCO – All diagnoses 2= BHP - All diagnoses 3= BHP for Primary Diagnoses 291-316, HUSKY MCO all other diagnoses 4= Not covered Note: PSR = Provider Specific Rate		
90806	Individual Psychotherapy-Office or other Outpatient (45-50 min)	3	$ 66.17
90807	Individual Psychotherapy-Office or other Outpatient (45-50 min) with medical evaluation and management services	3	$ 74.65
90808	Individual Psychotherapy-Office or other Outpatient (75-80 min)	3	$ 97.87
90809	Individual Psychotherapy-Office or other Outpatient (75-80 min) with medical evaluation and management services	3	$ 102.80
90846	Family psychotherapy (without the patient present)	3	$ 64.41
90847	Family psychotherapy (conjoint)	3	$ 79.32
90853	Group psychotherapy	3	$ 31.22
90857	Interactive Group therapy	3	$ 34.13
96118	Neuropsychological testing battery, per hour	3	$ 116.94
All others		1	N/A

Code	Freestanding Medical Clinic (including non-FQHC School-Based Health Centers)	Coverage	BHP Fee
90782	Therapeutic or diagnostic injection; subcutaneous or intramuscular	1	N/A
90783	Therapeutic or diagnostic injection; intra-arterial	1	N/A
90784	Therapeutic or diagnostic injection; intravenous	1	N/A
90801	Psychiatric Diagnostic Interview	3	$ 96.84
90804	Individual psychotherapy (20-30 min)	3	$ 41.13
90805	Individual Psychotherapy-Office or other Outpatient (20-30 min) with medical evaluation and management services	2	$ 45.89
90806	Individual Psychotherapy-Office or other Outpatient (45-50 min)	2	$ 59.56
90807	Individual Psychotherapy-Office or other Outpatient (45-50 min) with medical evaluation and management services	2	$ 67.19
90808	Individual Psychotherapy-Office or other Outpatient (75-80 min)	2	$ 88.08
90846	Family psychotherapy (without the patient present)	3	$ 57.97
90847	Family psychotherapy (conjoint psychotherapy w/patient present)	3	$ 71.39
90853	Group psychotherapy (other than of a multiple-family group)	3	$ 28.09
90862	Pharmacologic management	2	$ 40.74
99211	Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. (Typically 5 minutes)	1	N/A
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three components: problem focused history; problem focused examination; straightforward medical decision-making. (Typically 10 minutes face-to-face)	1	N/A
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three components: expanded problem focused history; expanded problem focused examination; medical decision making of low complexity. (Typically 15 minutes face-to-face)	1	N/A
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three components: detailed history; detailed examination; medical decision making of moderate complexity (Typically 25 minutes face-to-face)	1	N/A

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

December 10, 2014 VIA FAX ONLY

Ms. Cara M. Powers, LPC
Clincal Director
Shoreline Wellness Behavioral Health Clinic, LLC
415 Main Street
West Haven, CT 06516

RE: Certificate of Need Application; Docket Number: 14-31964-CON
Shoreline Wellness Behavioral Health Clinic, LLC
Proposal to Establish a Free-Standing Behavioral Health Clinic

Dear Ms. Powers:

On November 12, 2012, the Office of Health Care Access ("OHCA") received your initial Certificate of Need ("CON") application filing on behalf of Shoreline Wellness Behavioral Health Clinic, LLC ("SWBHC" or "Applicant"), proposing to establish a free-standing behavioral health clinic in West Haven, Connecticut, with an associated total capital expenditure of $40,000.

OHCA has reviewed the CON application and requests the following additional information pursuant to General Statutes §19a-639a(c):

1. Provide a detailed explanation of the operations of Shoreline Wellness Center (SWC), including the services provided, the state-issued licenses that allow the provision of services and how those services are paid.

2. Explain how proposed Shoreline Wellness Behavioral Health Clinic (SWBHC) will operate, including the services to be provided, who will provide the counseling sessions and how those services will be paid.

3. How does the proposed clinic differ from the existing SWC and why do those differences necessitate a separate facility to serve the same population and at the same location?

4. Provide a detailed explanation of the following statement found on page 10 of the application:

   "The need for this additional service is dire and we expect to serve the same population and communities that we currently serve except we will have an increase in lower income individuals and families being seen at the clinic due to billing restrictions imposed by the State of CT."

5. Explain the roles of the mental health students and professionals in the proposal. Explain the proposed interaction among the students, clinicians and clients.

6. On page 5 of the application, the Applicant proposes establishing a free-standing "mental health clinic." On page 7 the project name includes substance abuse as well as mental health. Definitively list the services to be offered under the proposal.

7. Identify the proposed client population and explain how and where this proposed client population is currently being served.

8. How does the proposed client population differ from the Applicant's current client population?

9. Support the need for the proposed service. Include specific evidence, such as incidence, prevalence or other data from the Substance Abuse and Mental Health Administration ("SAMSHA"), or a similar organization. that demonstrates a need for the proposed services. Apply the specific evidence to Applicant's target populations (e.g., the prevalence of juvenile females in need of mental health services).

10. For each proposed service listed in your response to Question 6 above, identify all existing providers (name, address, services provided, hours and days of operation) of those services in West Haven, New Haven, Milford, Orange and Woodbridge.

    Note: The Department of Mental Health and Addiction Services ("DMHAS") collects capacity and actual population statistics on existing providers by town/city, and service/program.

11. What will be the effect of the proposal on these providers? How will current referral patterns be affected by the proposal?

12. Provide copies of the references cited on page 24 of the application. For larger documents or websites you may provide the pages that are relevant to the topic discussed.

13. What are the beginning and end dates of the Applicant's fiscal year?

14. Identify the specific population groups that will be served by the proposal. For example, men, women, specific age groups or persons with a specific condition or disorder.

15. For each of the specific population groups to be served, report the following by service level (include all assumptions):

    a. An estimate of the number of persons within the population group by town that need the proposed service;
    b. The number of persons in need of the service that will be served by the proposal (estimated client volume).

16. For the Medicaid population, provide the assumptions and actual calculation used to determine the projected client volume.

17. On page 21 of the application, the Applicant projects that 100% of its payers will be Medicaid. How do you intend to reach this population to offer your services?

18. For all services the Applicant currently offers that it will continue to offer in the new facility (i.e., areas of service overlap between SWC and SBHC), provide the number of clients treated for the past three full fiscal years and the current fiscal year-to-date.

TABLE A
HISTORICAL UTILIZATION BY SERVICE/PROGRAM

	Fiscal Years			Current
Service/Program	**FY***	**FY***	**FY***	**FY****
Service/Program Name and Location***				
Total				

*Fill in years. In a footnote, identify the period covered by the Applicant's FY (e.g. July 1-June 30, calendar year, etc.).
**For periods greater than 6 months, report annualized volume, identifying the number of actual months covered and the method of annualizing. For periods less than six months, report actual volume and identify the period covered.
***List each service type and location provided by the Applicant. Provide number of visits and/or number of admissions for each service listed, as appropriate.

19. Explain any increases and/or decreases in volume reported in Table A.

20. Provide the current population payer mix for services reported in Table A.

21. Please list the towns from which most of your clients originate and indicate how many clients received services from each town for the past three full fiscal years and the current fiscal year-to-date.

22. Identify the Standard of Practice Guidelines that will be used at the proposed facility. Attach copies of relevant sections and briefly describe how the Applicant proposes to meet each of the guidelines.

23. Provide the policies and procedures that will be used at the proposed facility. Explain the quality assurance program. What level of staff will be responsible for quality assurance on-site?

24. Explain how the proposal will improve quality, accessibility and cost effectiveness of health care delivery in the region, including but not limited to, (1) provision of or any change in the access to services for Medicaid recipients and indigent persons, and (2) the impact upon the cost effectiveness of providing access to services provided under the Medicaid program.

25. Provide a copy of the State of Connecticut, Department of Public Health license(s) currently held by the Applicant.

26. List the licenses that the SWBHC will be seeking in relation to the proposal. Information concerning DPH licensure may be obtained by calling DPH Facility Licensing at (860) 509-8023. (Please note that the State's Department of Children and Families is the agency responsible for licensing facilities that provide services to children. The agency's main number is (860)-550-6300.)

27. Please provide a copy of the Operating Agreement for SWBHC that was included in the initial application, as the document provided was not in appropriate page order.

28. Please provide audited financial statements for the most recently completed fiscal year or other financial documentation (e.g., unaudited balance sheet, statement of operations, federal tax return or other similar documents).

29. Provide a short description of the medical equipment to be obtained and the required renovations proposed on page 20 of your application.

30. Demonstrate how this proposal will impact the financial strength of the health care system in the state or that the proposal is financially feasible for the Applicant.

In responding to the questions contained in this letter, please repeat each question before providing your response. Information filed after the initial CON application submission (e.g., completeness response letter, prefiled testimony, late file submissions and the like) must be numbered sequentially from the Applicant's document preceding it. **Paginate and date** your response (i.e., each page in its entirety) beginning with Page Number 66. Please reference

"Docket Number: 14-31964-CON." Submit one (1) original and four (4) hard copies of your response. Fully paginate each copy. In addition, please submit a scanned copy of your paginated response, including all attachments, on CD in Adobe format (.pdf) and in MS Word format (.docx).

Pursuant to Section 19a-639a(c) you must submit your response to this request for additional information no later than sixty days after the date that this request was transmitted. Therefore, please provide your written responses to OHCA no later than January 31, 2014, otherwise your application will be automatically considered withdrawn. If you have any questions concerning this letter, please feel free to contact me at (860) 418-7032.

Sincerely,

Laurie Greci

Laurie K. Greci
Associate Research Analyst

* * * COMMUNICATION RESULT REPORT (DEC. 10. 2014 11:21AM) * * *

FAX HEADER:

TRANSMITTED/STORED : DEC. 10. 2014 11:19AM FILE MODE	OPTION	ADDRESS	RESULT	PAGE
803 MEMORY TX		912039310063	OK	6/6

REASON FOR ERROR
E-1) HANG UP OR LINE FAIL
E-2) BUSY
E-3) NO ANSWER
E-4) NO FACSIMILE CONNECTION

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: Cara Powers

FAX: (203) 931-0063

AGENCY: Shoreline Wellness Behavioral Health Clinic

FROM: Laurie Greci

DATE: 12/10/2014

NUMBER OF PAGES: 6
(including transmittal sheet

Comment

RE: Certificate of Need Application, Docket Number 14-31964-CON Proposal to Establish a Free-Standing Behavioral Health Clinic in West Haven, CT

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

Phone: (860) 418-7001 Fax: (860) 418-7053
410 Capitol Ave., MS#13HCA
P.O.Box 340308Hartford, CT 06134

415 Main Street
West Haven, CT 06516
(203) 931-1184
ww.shorelinewellnesscenter.com

January 25, 2015

Re: Certificate of Need (CON) Application Additional Information

CON Docket # 14-31964-CON

Dear Ms. Greci:

Thank you for your consideration of our certificate of need application (CON) to become licensed as a free-standing, mental health clinic. I have reviewed the letter you sent via fax on December 10, 2014 and have attached my responses to your questions with this letter. I look forward to hearing from you.

Sincerely,

Cara M. Powers, LPC
Clinical Director

RECEIVED
JAN 30 2015
Office of
HEALTHCARE ACCESS

1. ***Provide a detailed explanation of the operations of Shoreline Wellness Center (SWC) including the services provided, the state-issued licenses that allow the provision of services and how those services are paid.***

Shoreline Wellness Center (SWC) is an independent, multi-specialty, group, behavioral health practice. The services that are provided are individual, family, couples/marriage, medication management, and group counseling. The state-issued licenses of the various members of our group are as follows; Licensed Professional Counselor (LPC), Licensed Clinical Social Worker (LCSW), Licensed Marriage and Family Therapist (LMFT), Licensed Alcohol and Drug Counselor (LADC), Advanced Practice Registered Nurse (APRN), and Psychiatrist (MD). These services are paid through reimbursement of each individual, patient's insurance either private/commercial insurance, or state/federal Medicare and/or Medicaid insurance.

2. ***Explain how proposed Shoreline Wellness Behavioral Health Clinic (SWBHC) will operate including the services to be provided, who will provide the counseling sessions and how those services will be paid.***

Shoreline Wellness Behavioral Health Clinic (SWBHC) will offer individual, couples, group, family/marriage counseling and medication management and psychiatric evaluation services. The services will be provided by graduate student counseling and/or

nurse practitioner students, master's level clinicians seeking licensure hours, and licensed clinicians and Psychiatrists as needed. All students will be supervised by both the licensed professional for their specific discipline as well as by the Medical and Clinical Director(s). These services will be paid through Medicaid reimbursement

3. How does the proposed clinic differ from the existing SWC and why do those difference necessitate a separate facility to serve the same population at the same location?

The proposed clinic differs from the existing SWC as it will utilize intern services for the majority of its clinical, counseling sessions and these services will be billable due to the clinic license. The clinic will also differ as it will be governed by two medical directors, one for children, and one for adults as per the State of CT clinic requirements which are not requirements for an independent, group, practice. Both Medical Directors are board certified Psychiatrists. The proposed clinic will also be located in a fully handicap accessible and compliant part of the building whereas the other practice is not.

Furthermore, due to financial constraints the independent, group, practice Shoreline Wellness Center, LLC is not governed by nor is it required to be governed by a full-time, on-call, medical directors as the clinic will be. SWC is a large practice and to change this protocol would greatly exceed the budget whereas the clinic will be much smaller in size.

The SWBHC will also be set up to take walk- in appointments where SWC is not and will not have the capability to do so.

Lastly, one of the main differences will be that we envision SWBHC to be a learning center. One that will be closely run by the Clinical and Medical Directors as well as the faculty and staff from the local Universities that we collaborate with. SWC is currently run as an independent, multi-specialty, group practice, and many of the practitioners currently working at SWC prefer to be managed and work in this independent manner. Whereas if they were to work in the clinic they would be subject to requirements that they are currently not subject to in an independent setting such as; treatment plan signing by the Medical Directors, mandatory meetings, etc. This would impose different mandates for many of our staff and would violate current contract requirements for SWC existing staff.

4. Provide a detailed explanation of the following statement found on page 10 of the application: "The need for this additional service is dire and we expect to serve the same population and communities that we currently serve except we will have an increase in lower income individuals and families being seen at the clinic due to billing restrictions imposed by the State of CT."

The need for quality mental health services is dire in that access to mental health care is worse than other types of medical services. The Bureau of Labor Statistics estimated in 2010 that the country had 156,300 mental health counselors. Access to mental health professionals is worse than for other types of doctors: 89.3 million Americans live in

federally-designated Mental Health Professional Shortage Areas, compared to 55.3 million Americans living in similarly-designated primary-care shortage areas and 44.6 million in dental health shortage areas, (Kliff, 2012). In the two years since the Sandy Hook massacre school shootings have occurred once every five weeks on average since Sandy Hook (Follman, 2014). Clearly, these statistics show why the need for quality mental health services is dire. There is a need to expand providers for those who have insurance (all types) but are facing a shortage of providers who accept it. There is also billing restrictions on license types for example only Licensed Clinical Social Workers can accept Medicare insurance and without being able to be reimbursed for intern services it will make training programs hard to maintain.

Medicaid allows services to be reimbursed for paraprofessionals which includes; graduate students, nursing students, and post-master's degree clinicians that are accumulating licensure hours for their specific license i.e, LCSW, LPC, LMFT. Each of these disciplines are required to complete an in-school internship or residency, and then additional post- degree hours and supervision to become licensed. Without being able to be reimbursed for these services conducted by the paraprofessionals it makes it very difficult and now impossible to offer high, quality training programs. The clinic would provide professional training, development, and education.

5. Explain the roles of the mental health students and professionals in the proposal. Explain the proposed interaction among the students, clinicians, and clients.

The roles of the mental health students are to develop and learn principles and practices and skills in the helping profession as well as facilitate the growth and workability of Shoreline Wellness Behavioral Health Clinic. Students include medical office professionals, medical assistants, graduate level counseling and social work students, and nursing students.

Medical office professional students assist in facilitating client appointments, coordinating clinician and client schedules, answering phone calls, and maintaining the cleanliness of the office while maintaining HIPPA compliance and confidentiality.

Medical assistants assist the medical staff directly with client charting, performing client blood pressure measurements and weight measurements, and assisting in the handling of medication and prescription matters while maintaining HIPPA compliance and confidentiality.

Graduate level counseling and social work under supervision of one of the following: a licensed professional counselor, licensed marriage and family therapist, licensed clinical social worker, or licensed alcohol and drug counselor. These students are required to meet with their licensed supervisor for one hour of supervision per week and are required to have all counseling related paperwork reviewed and signed by their assigned

supervisor. Supervisors are all required to be available for consultation as needed. Graduate counseling and social work students assist in performing intake assessments for new clients, co-facilitate various counseling groups, and perform assessments and counseling with individuals, couples and families. Graduate students also have the ability to sit in on counseling sessions with licensed professionals in order to obtain direct and non-direct hours required for their graduate programs.

Nursing students work under an Advanced Practice Registered Nurse or a Psychiatrist. Nursing students assist in performing vital signs, gather patient health histories, update allergies, reconcile medication lists, and perform some patient education all under supervision of APRN.

6. On page 5 of the application, the Applicant proposes establishing a free-standing "mental health clinic." On page 7 the project name includes substance abuse as well as mental health. Definitively list the services to be offered under the proposal.

The services that will be provided are individual, family, couples, and group counseling. The clinic will also offer medication management services under our Student Nurse Practitioners and the Medical Directors. In regards to substance abuse counseling we will offer counseling for individuals that are diagnosed with a substance abuse disorder and/or individuals that have been diagnosed in the past with a substance abuse disorder. The counseling services for these individuals will be limited to our clinic's scope of practice

meaning that we will not offer methadone maintenance, SUBOXONE®, or drug and alcohol withdrawal and/or detoxification services.

7. Identify the proposed client population and explain how and where this proposed client population is currently being served.

The proposed client population is residents of the community of West Haven as well as the surrounding communities. Currently, these clients are being served at various agencies, private practices, hospitals, and inpatient facilities. However, the demand continues to grow and in order to meet this need and improve the state of mental health care additional services are needed such as the clinic we are proposing which will both help meet the needs of the ever growing mental health population as well as be able to provide excellent training that will be able to successfully prepare professionals entering the field of mental health.

8. How does the proposed client population differ from the Applicant's current client population?

The proposed client population will not differ from the applicant's current client population with the exception that the proposed clinic client population will not accept commercial insurance plans.

9. Support the need for the proposed service. Include specific evidence, such as incidence, prevalence or other data from the Substance Abuse and Mental Health Administration (SAMSHA), or a similar organization that demonstrates a need for the proposed services. Apply the specific evidence to the Applicant's target populations (e.g., the prevalence of juvenile females in need of mental health services).

"In 2014, 32 million more Americans will be covered by health insurance because of changes under the Affordable Care Act. Between 20 to 30 percent of these people (6 to 10 million) will have a mental or substance use disorder.97, 98

The Affordable Care Act will increase the number of people who are insured. Currently, individuals with a mental disorder are twice as likely to be uninsured than those without a mental disorder.99

Among the currently uninsured aged 22 to 64 with family income of less than 150 percent of the Federal poverty level (FPL), 32.4 percent had illicit drug or alcohol dependence/abuse or mental illness.100

As of 2005, Medicaid paid for 28 percent of all spending on mental health services and 21 percent of substance abuse treatment in the United States.101

As of 2005, Medicare paid for 8 percent of all spending on mental health services and 7 percent of substance abuse treatment in the United States.102

Medicaid is a primary source of support for mental health services at the State level—44 percent of mental health funding managed by State Mental Health Authorities comes from Medicaid.103

In 2006, nearly 7.5 million individuals were dually eligible for both Medicare and Medicaid at a cost of approximately $200 billion.104, 105 Fifty-two percent of these people have a psychiatric illness.106

Many individuals with mental and substance use disorders will no longer pay significant out-of-pocket expenses for medication due to the closing of the "doughnut hole" in Medicare Part D.107

States spend as much as 75 percent of their Medicaid mental health funds for children on residential treatment and inpatient hospital services.108

The Mental Health Parity and Addiction Equity Act (MHPAEA) affects 140 million individuals participating in group health plans.109

Lesbian, gay, bisexual, transgender, and questioning (LGBTQ); racial; and ethnic populations are disproportionately represented in the ranks of the uninsured. In 2008, 22 percent of gay and lesbians reported having no health insurance,110 and in 2009, 34 percent of Hispanics, 28 percent of American Indians and Alaska Natives, 23 percent of African Americans, and 18 percent of Asian Americans, compared with 14 percent of white Americans, were uninsured"

10. For each proposed service listed in your response to Question 6 above, identify all existing providers (name, address, services provided, hours and days of operation) of those services in West Haven, Milford, Orange, and Woodbridge.

Note: The Department of Mental Health and Addiction Services (DMHAS) collects capacity and actual population statistics on existing providers by town/city, and service/program.

Name	The West Haven Mental Health Clinic
Address	270 Center Street West Haven, CT 06516
Services Provided	• Walk-In Services • Evaluation • Individual and Group Therapy • Crisis Intervention • Psychological Testing • Community Support Services Community support services are provided through the collaboration with the Milford Mental Health Clinic. They are as follows: • Case Management • Supportive employment • Social rehabilitation • Supervised apartment program CHILDREN • Evaluation • Individual, Group & Family Therapy • Psychological Testing • Crisis Intervention • Parenting Education Groups FAMILIES • Evaluation • Couples/Family Therapy

	• Crisis / Brief Treatment West Haven Mental Health Clinic also receives referrals from DCF and probation court. There is also a DBT program and a dual diagnosis program available. Services available in Spanish. Support and Education for Families of the Mentally Ill (CT.gov, 2015)
Hours and Days of Operation	Hours: Mon.- Wed. & Fri. 9 AM to 5 PM, Thurs. 11 AM to 7 PM Walk In Hours: Mon.-Wed. & Fri. 9AM-3PM, Thurs. 11AM-3PM
Name	The Connecticut Mental Health Center
Address	34 Park Street New Haven, CT 06508
Services Provided	"CMHC treats individuals suffering from severe and persistent psychosis, depression, anxiety, addictions (including alcoholism, cocaine, and gambling) and those with co-existing mental health and addiction problems. CMHC also operates outreach programs for individuals who are homeless, who are at serious risk for mental illness, or involved with the criminal justice system. CMHC is also responsible for a specialized clinical service for people whose primary language is Spanish. Clinical services are complemented by a range of rehabilitation programs designed to improve functioning and quality of life. CMHC is nationally recognized for its research into the causes and treatment of mental illness and addiction. Research components include the Ribicoff Research facilities, Treatment Research Program (Treatment Research Project), Substance Abuse Treatment Unit, Tobacco Cessation Project, Women's Health Clinics, Prevention, and Service Utilization. CMHC is also a major training site for all of the professional specialties

	involved in treating mental illness and addictions: Psychiatry, Neuropharmacology, Psychology, Psychiatric Nursing, Social Work and Pastoral" (CT.gov, 2015).
Hours and Days of Operation	M-F 9am-4pm
Name	Bridges A Community Support System, Inc
Address	949 Bridgeport Ave Milford CT 06460
Services Provided	Comprehensive Services For Adults and Children At Bridges, we strive to treat the whole person by offering a comprehensive range behavioral health, substance abuse and primary care services in a single, centralized location Services: 24-hour Mobile Crisis Outpatient Mental Health and Addiction Recovery Community Support Services Primary Health Care and Wellness Tobacco Cessation Employment Services Jail Diversion Services Bereavement Support Young Adult Services Bridges provides a full range of services for children and families. Outpatient Psychiatric Clinic for Children Intensive Family Preservation & Family Reunification Intensive In-home Child and Adolescent Psychiatric Services (IICAPS) Care Coordination Prevention Services
Hours of Operation	Mon. – Thurs. 8 a.m. – 7 p.m., Friday 8 a.m. – 5 p.m.

Name	Clifford Beers Clinic
Address	93 Edwards Street, New Haven, CT 06511 5 Science Park, New Haven, CT 06511 377 Main Street, West Haven, CT 06516 652 Boston Post Road Ste. #3, Guilford, CT 06437 11 Meetinghouse Lane, Woodbridge, CT 06525 374 Grand Ave, New Haven, CT 06513
Services Provided	Clifford Beers offers a range of outpatient programs and services to meet the mental health needs of children and families in the community. • EMPS Crisis Services: A mobile response program for children and families available 24 hours a day, 7 days a week by dialing 2-1-1. • Outpatient Services: individual, family and group services • Specialized Services: children are treated for a wide variety of problem sexual behaviors. • School Based Health Clinics: Clifford Beers offers services to children in need in a school based setting. The schools are: Clinton Avenue School, Fair Haven School, Lincoln Bassett School, and Wilbur Cross High School all located in New Haven. Clifford Beers has treated children and families with and not limited to: anxiety, domestic violence, community violence, depression, divorce, emotional abuse, incarceration, loss of a loved one, military deployment, neglect, peer issues, physical abuse, risky sexual behaviors, school behavior problems, and sexual abuse. New programs include the Strong Families Program which is for children of incarcerated parents and where they can attend groups to help work through feelings of abandonment and showing children they do not need to follow in the footsteps of the incarcerated parent. There is also the Child FIRST program which is a birth to five home based program aiming at preventative care.

	July 1 2012 to June 30, 2013, Clifford Beers was able to serve 1,947 children through their outpatient services and 991 through their EMPS program. There were also a total of 4887 family members served through their outpatient services and 2487 through their EMPS program. In their annual report, there were around 185 names listed for staff, interns, and volunteers. http://www.cliffordbeers.org/12-13-annualrpt/
Hours of Operation	
Name	Dixwell Newhallville Community Mental Health Services, Inc.
Address	660 Winchester Ave, New Haven, CT 06511
Services Provided	Services • Individual Therapy • Group Therapy • Family Therapy • Couples Therapy • Psychiatric Evaluation • Psychiatric Medications • Trauma Treatment with EMDR We are Here for... • Adults • Families • Couples • The Elderly We extend our professional expertise and community centered commitment to the delivery of services of the highest quality to community members coping with chronic mental illness, alcohol and

	drug addictions, and psychological trauma. Neighborhood Services • Referral Services • Hope Group • Summer Youth Camp • Summer Youth Employment • Food Pantry • Energy Assistance
Hours of Operation	Monday 9am-4pm, Tuesday 9am-7pm, Wednesday 9am-5pm, Thursday 9am-7pm, Friday 9am-4pm
Name	APT Foundation
Address	One Long Wharf Drive, Suite 321 New Haven, CT 06511
Services	Our outpatient psychiatric (mental health services) program offers a milieu of behavioral health services. Clients are seen for individual psychotherapy by onsite psychiatrists, psychologist s or by any of our licensed clinicians. Treatment includes therapy emphasizing individualized treatment planning, long and short term goal setting, couples/family therapy, and crisis intervention. Clients with psychiatric conditions that may benefit from medications are treated with appropriate pharmacological agents. Medications are prescribed and monitored by the Medical Director as well as the on-site licensed staff psychiatrists. (aptfoundation.org)
Hours of Operation	Mon 8:00AM-12:00PM | Tue 7:30AM-8:30AM | Wed 8:00AM-12:00PM Thu 7:30AM-8:30AM | Fri 8:00AM-11:00AM

Name	The Consultation Center
Address	389 Whitney Avenue, New Haven, CT 06511
	Adolescent Programs: Adult and Workplace Programs Child Development & Epidemiological Research Culture and Diversity Training Elder Programs Evaluation Research Family Violence Education Family Violence Research Prevention Training Program Male Development Program & Service System Evaluation Stress & Coping Urban Education
Hours of Operation	Monday - Friday 8am-5pm
Name	Family Centered Services of Connecticut
Address	235 Nicoll Street, New Haven, CT 06511
Services	Care Coordination for Children and Youth with Special Health Needs (South Central Medical Home Initiative) Caregiver Support Team Empowerment and Literacy Groups Family-Based Recovery Integrated Family Violence Services Multisystemic Therapy-Building Stronger Families Neighborhood Victim Advocacy Program New Haven Family Partnership Nurturing Families Network Parenting Support and Parental Rights Initiative

	Positive Parenting Program (Triple P) Wyman Teen Outreach Program
Hours of Operation	Monday - Friday 8:30am-4:30pm
Name	Fellowship Place
Address	441 Elm Street, New Haven, CT 06511
Services	Fellowship Place offers an eclectic group of programs and services that emphasize wellness, creative expression, giving back to the community and the importance of social relationships. Programs include: Psycho Social Rehab Services Career Development Homeless Engagement Supportive Housing Community Reporting Engagement Support and Treatment (CREST) which is partnered with The Connection Inc. and the Connecticut Mental Health Center Art Ship http://fellowshipplace.org/category/services/
Hours of Operation	Hours Vary by Program
Name	Yale -New Haven Psychiatric Hospital
Address	425 George Street, New Haven,

Services	• Comprehensive and multidisciplinary biopsychosocial evaluations • Cognitive-behavioral group therapy focusing on effective management of behavioral, emotional and/or substance-abuse problems; and learning skills to increase tolerance and regulation of feelings and interpersonal effectiveness • Intensive family therapy • Discharge planning and collaboration with the adolescent's school, outpatient clinicians, family and other community agencies to facilitate an integrated approach, to establish comprehensive transition plans and to promote the adolescent's optimal functioning • **General Adult Track (for patients with general mood or anxiety disorders)** • **Dual Diagnosis Track (for patients with both psychiatric and substance-abuse diagnoses)** • **Dialectical Behavioral Track (primarily for patients with borderline personality disorder and other severe personality disorders** • Comprehensive and multidisciplinary biopsychosocial evaluation • Crisis intervention and case management to help patients safely manage their psychiatric or co-occurring disorders on an ambulatory basis with increasing self- and community-support reliance • Cognitive-behavioral groups that focus on continued development of coping and problem-solving skills and relapse prevention • Group therapy that actively addresses interpersonal problems which may contribute to the patient's ongoing psychiatric problems or co-occurring disorders • Psychoeducational groups that strengthen the patient's commitment to change problematic behaviors • Specialized groups are provided targeting bipolar disorder, anxiety disorder, family issues, loss and trauma

- Medication consultation to community psychiatrists and other physicians prescribing pharmacologic treatments for patients and promotion of medication compliance; if there is no prescriber in place, this component of treatment is provided by psychiatrists at IOP
- Discharge planning and collaboration with patients' outpatient treaters, family and community agencies to facilitate an integrated approach and to establish comprehensive transition plans that promote patients' optimal functioning.

Hours	Monday- Friday 9:00 am-1:00 pm.

-

11. What will be the effect of the proposal on these providers? How will current referral patterns be affected by the proposal?

Shoreline Behavioral Health Clinic called each provider listed in question 10 and inquired about services and wait lists. This was done to show how Shoreline Behavioral Health Clinic could address the deficits currently in behavioral health services provided to the community. Overall it was found that Shoreline Behavioral Health Clinic could help improve in terms of offering services to Medicaid subscribers, children, individuals with developmental disabilities, and offering a more abundant and flexible time frame for clients to receive services, particularly on nights and weekends.

West Haven Mental Health Clinic stated that Adults with Medicaid insurance are currently being place on a wait list for 2-3 months for counseling services and medication management services. Children are on a wait list for approximately 3 weeks for medication management services and counseling services. Shoreline Wellness Center is not currently placing adults or children on a wait list for counseling or medication management. Therefore, Shoreline Behavioral Health Clinic would be able to provide clients on this facilities wait list with immediate care in terms of counseling services and medication management services. Shoreline Wellness Center is also open on days and hours that West Haven Mental Health Clinic is not. Therefore, Shoreline Behavioral Health Clinic could see clients on Monday - Thursday up until 8:00 pm and Fridays 9-6 and Saturdays 9-4, all of these hours WHMHC is not open.

The Connecticut Mental Health Center reported that they are unable to service individuals who reside in West Haven as this is not in their catchment area. CMHC also does not provide services to children. CMHC is referring callers/clients from West Haven to WHMHC, which as stated above is reporting as having a 2-3 month wait list. Shoreline Behavioral Health Clinic is not limited to serving clients within a particular catchment area and therefore could provide services to client unrelated to their residence location.

At Bridges, the counseling and medication management wait list for adults and children with Medicaid is currently up to 5 weeks. According to the intake department Bridges is also unable to accept clients who are non-verbal and extremely developmentally disabled. Shoreline Behavioral Health Clinic is not currently placing adults or children on a wait list for counseling or medication management. Therefore, Shoreline Behavioral Health Clinic would be able to provide clients on this facilities' wait list with immediate care in terms of counseling services and medication management services. SWC is also open Saturdays 9:00am-4:00 pm to see clients, where Bridges is not.

Clifford Beers Clinic does not accept adult clients. Clifford Beers also is unable to accept clients with severe developmental disabilities as client who are non-verbal are "Out of their scope of practice". Shoreline Behavioral Health Clinic is not currently placing adults or children on a wait list for counseling or medication management. Therefore, Shoreline Behavioral Health Clinic would be able to provide clients on this facilities' wait list with immediate care in terms of counseling services and medication management

services. Shoreline Behavioral Health Clinic will also accept client's with severe intellectual disabilities and adults and would be able to provide services to the individuals that Clifford Beers Clinic cannot. Dixwell Newhallville Community Mental Health Services, Inc. is not currently taking any new clients and the wait-list is also reported as being closed. They also reported that there is not a projected time frame as to when the agency will taking new clients or opening the wait list.

Shoreline Behavioral Health Clinic will not place adults or children on a wait list for counseling or medication management. Therefore, Shoreline Behavioral Health Clinic would be able to provide clients on this facilities' wait list with immediate care in terms of counseling services and medication management services. Shoreline Behavioral Health Clinic will also be open Saturdays 9:00am-4:00 pm to see clients, where Dixwell Newhallville Community Mental Health Services, Inc.

The APT Foundation is currently only accepting adult clients who are available during their walk-in hours listed above in response 10, and only accept adult clients on a walk-in "first come first serve basis". APT foundation is also not currently open on Saturdays. Shoreline Behavioral Health Clinic will be open Monday-Thursday 8:30am to 8:00 pm, Friday 8:30am to 6:00 pm , and Saturdays 8:30am -4:00pm and accepts clients through phone intakes, not just in-person or walk-in appointments. Shoreline Behavioral Health Clinic will also accept children in addition to adults, where the APT foundation does not.

The Consultation Center reported that the agency's individual providers are unable to accept Medicaid clients. Shoreline Behavioral Health Clinic will accept all Medicaid insurances and could therefore potentially serve Medicaid clients for their behavioral health needs.

Cornell Scott Hill Health Center stated that the wait list for adults with Medicare insurance to receive counseling services the wait list is about 2-3 weeks and medication management services are at a wait list of about a month. Cornell Scott Hill Health Center did confirm that there is a wait list for children to receive services and could not give an approximate time frame as to how long one could be placed on the wait list for. Shoreline Behavioral Health Clinic will be open Monday-Thursday 8:30am to 8:00 pm, Friday 8:30am to 6:00 pm, and Saturdays 8:30am -4:00pm which offers a more flexible time frame and hours that Cornell Scott Hill Health Center does not offer.

Yale -New Haven Psychiatric Hospital outpatient services currently does not provide medication management services or individual therapy for clients. Yale also stated that non-verbal clients would not be able to be seen. Shoreline Behavioral Health Clinic provides medication management, individual and group counseling services, and provides services for individuals with individuals with developmental disabilities, even those who are non-verbal.

Family Centered Services of Connecticut and Fellowship Place were unable to be reached for information.

Lastly, another example of how the proposed clinic could be beneficial to the current area clinics are that there will be certain mental health areas that neither SWC nor SBHC will be able to treat. One example would be difficult psychosis cases or severe schizophrenia. Yale University School of Medicine currently has a Early Intervention STEP program that specializes in early identification and treatment of Adults with psychotic disorders (Bruce, 2014). Shoreline Behavioral Health Clinic could refer individuals with schizophrenia to the STEP program at Yale. Since the STEP program at Yale only works with a specific population of 18-35 year olds with psychotic disorders (Bruce, 2014), Shoreline Behavioral Health Clinic could receive referrals from the STEP program at Yale.

12. Provide copies of the references cited on page 24 of the application. For larger documents or websites you may provide the pages that are relevant to the topic discussed.

Please see Appendix A

13. What are the beginning and the end dates of the Applicant's fiscal year?

The beginning date of our fiscal year will be October 1 2015- September 30, 2016.

14. Identify the specific population groups that will be served by the proposal. For example, men, women, specific age groups or persons with a specific condition or disorder.

Populations that will be served include all ages, men, women, and those with intellectual disabilities.

15. For each of the specific population groups to be served, report the following by service level (include all assumptions):

a. An estimate of the number of persons within the population group by town that need the proposed service;

The three main towns where most of our clients come from are West Haven, New Haven, and Milford. As of October 2014 in Connecticut 767,157 individuals receive Medicaid services. Unfortunately, we were not able to find a break-down of this by town so we cannot break it down with actual statistics. However, two of the three main areas our clients currently come from are considered low-income, large cities so based on this information we assumed that at least 20% of this number would come from the main three towns we service so approximately 153,451 people in these three areas receive Medicaid benefits given this large number of people on Medicaid if we can further assume that 40% of this group of people will seek some sort of behavioral health services that would be approximately 61,400 individuals that would need or utilize behavioral health services. Since we currently serve about 3500 individuals and 67% of our volume is Medicaid we currently serve 2100 individuals on Medicaid per year. We assume that

this number will continue to increase as the number of individuals eligible to receive Medicaid services also has increased.

b. The number of persons in need of the service that will be served by the proposal (estimated client volume).

The estimated client volume that we anticipate to be seen at the clinic will be 150 clients per week.

16. For the Medicaid population, provide the assumptions and actual calculation used to determine the projected client volume.

The assumptions were based on taking the current volume of Medicaid enrollees in the three main towns our patients/clients come from which is West Haven, New Haven, and Milford and calculating 20% of the total Medicaid recipients from CT. The projected client volume is based on 10 interns per week seeing a minimum of 15 Medicaid clients per week.

17. On page 21 of the application, the Applicant projects that 100% of its payers will be Medicaid. How do you intend to reach this population to offer your services?

We will take intake calls through both the clinic phone number and SWC. All calls that come into SWC that we feel are appropriate for the clinic we will put through to the clinic so that appropriate appointments can be made. We will also enroll with Medicaid under the clinic name and take referrals from there.

We currently receive a very large number of Medicaid calls in 2014 our records show that out of 962 intakes 482 alone were clients with Medicaid insurance making up 50% of our intake volume for the year. This makes up an average of 16 intakes per week, 8 per week being Medicaid clients. In 2013 we received 1,006 intakes which averages 19 intakes per week.

18. For all services the Applicant currently offers that it will continue to offer in the new facility (i.e., areas of service overlap between SWC and SBHC), provide the number of clients treated for the past three full fiscal years and the current fiscal year to date.

Table A

HISTORICAL UTILIZATION BY SERVICE/PROGRAM

Service Program	FY 2011	FY 2012	FY 2013	Current FY (10/1-Present)
Counseling/Med Management West Haven	205	319	497	1061

*FY October 1- September 30.

19. Explain any increases and/or decreases in volume reported in Table A.

Shoreline Wellness Center, LLC (SWC) began in September 2011. We did not have medication management services at all during this fiscal year as you will see from 2012 fiscal year we began to grow and hired our first Nurse Practitioners for medication

management. In Fiscal year 2013 we continued to increase in services and as you will see from our Current FY we have doubled in 3 months the number of patients we saw for the entire year in 2013.

20. Provide the current population payer mix for services reported in Table A.

Our numbers have consistently been between 49%-67% Medicaid payers. Currently, are payer mix is 61% Medicaid as of 12/31/2014 with the remainder of our payers being commercial/private insurance companies.

21. Please list the towns from which most of your clients originate and indicate how many clients received services from each town for the past three full fiscal years and the current fiscal year-to-date.

From the current data that we have compiled from the past 3 years Shoreline Wellness Center (SWC) now services close to 3000 adults and children annually at its West Haven location, 415 Main Street between our counseling and medication management services, fundraiser/community events, and Parenting Education Programs. Currently, Shoreline Wellness Center's services are predominantly used by West Haven residents making up 62% of our client/patient population. New Haven and Milford residents make up the next largest majority of our client/patient population at 27%. East Haven residents make up 6% of our patient population with the remaining percentage of our clients/patients from the following cities and towns: Ansonia, Beacon Falls, Bethany, Branford, Bridgeport,

Cheshire, Derby, East Hampton, Guilford, Hamden, Madison, Meriden, Middletown, Monroe, Newington, North Branford, Northford, Norwalk, Old Saybrook, Orange, Prospect, Sandy Hook, Seymour, Shelton, Stratford, Trumbull, Wallingford, Waterbury, Westbrook and Woodbridge. The majority of our client/patient population is for the past 3 fiscal years was made up of 67% Medicaid we anticipate this fiscal year's Medicaid number to increase even more due to HUSKY D patients now being allowed to see private practitioners as of July 1, 2014.

22. Identify the Standard of Practice Guidelines that will be used at the proposed facility. Attach copies of relevant sections and briefly describe how the Applicant proposes to meet each of the guidelines.

Our facility will follow the Standard Practice Guidelines for each of our allied professions professional organization guidelines which are based off of the American Psychiatric Evaluation Guidelines which we have included in Appendix B for your review. We will meet these guidelines through program evaluations, employee evaluations, and supervision of all staff. The Clinical and Medical Director(s) will be responsible for conducting these evaluations.

23. Provide the policies and procedures the will be used at the proposed facility. Explain the quality assurance program. What level of staff will be responsible for quality assurance on-site? See article for implementation

For policies and procedures please go to Appendix C

SBHC will follow a quality assurance program that instills the highest and most effective ways of providing services to consumers. This includes but is not limited to:

1. All staff and providers will utilize the most effective and clinical based practices for consumers. This means that all providers and staff will follow their perspective ethics and codes as well as focusing on evidence-based practices to provide change for consumers. SBHC will allow providers to attend evidence based workshops and other sessions to continue their education in the field to be able to adapt into the setting at SLBHC. The Clinical and Medical directors will be responsible for quality assurance on site. The process will run as follows:

   - Medical Directors will sign off on all staff's treatment plans and attend bi-weekly all staff meetings.

   - Clinical Directors will have designated interns that they supervise on a weekly basis and will sign off on all notes for all clients that the interns see as well as attending ongoing meetings with University supervisors and directors.

   - Two post-master degree Counseling and/or Social Work employees that are working towards licensure will be on premise during all hours of the clinic's operation to triage and route emergency call procedures as well as handle routine matters.

2. SBHC will use certain program evaluation to make sure that we are meaningfully and effectively addressing our consumer's needs. SLBHC measurement tools would be client intakes, monthly client data reports that indicate volume, demographics, case notes, and

contract standards. SLBHC will also utilize client satisfaction surveys for both adults and children.

3. Using client treatment plans as progress benchmarks (such as initial, 3 month follow up review, 6 month follow up review, etc.) This would then require treatment plan reviews to happen at those benchmark times.

4. Directors and senior coordinators/staff will meet quarterly to discuss and review program quality and to ensure compliance with evaluation. Monthly meetings will also be held to make sure all contracts and policies are being followed to ensure quality programs are being followed

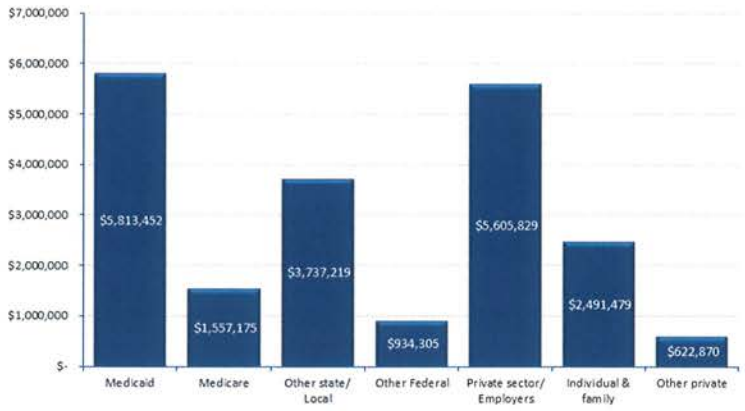
24. Explain how the proposal will improve quality, accessibility and cost effectiveness of health care delivery in the region, including but not limited to, (1) provision of or any change in the access to services for Medicaid recipients and indigent persons, and (2) the impact upon the cost effectiveness of providing access to services provided under the Medicaid program.

SWC already provides quality, affordable services to its Medicaid clients. This proposal, if approved, will not change this for either site. The proposal will make mental health services more accessible because there is currently a very high demand from graduate students looking for placement as well as Master's level clinicians looking for sites to

obtain their post- master's degree hours for licensure. Due to this demand if approved we will have more appointments available to meet the growing demand for mental health services which is evidenced by the very long and extensive waiting lists that the majority of the service providers in our area as we have cited in this CON currently have as well as our own growing waiting list for services. As previously stated quality mental health care can significantly reduce unnecessary medical care so this will improve the effectiveness of health care delivery in the region. I approved as a clinic this will not change the access to services for Medicaid recipients and/or indigent persons as they will always have the option to not receive services at the clinic but with a licensed staff member at SWC and will need to consent to see a student and/or a master's level clinician. This will, however, increase access to services as we will have more appointments available. We will also very carefully screen our students and will look for students that plan to continue their work with us once they graduate so that there will be steady, continuity of care for our clients.

The impact upon cost effectiveness of providing additional mental health services under the Medicaid program will be positive in that if people are effectively treating their mental health needs there will be a decrease in unnecessary medical visits and/or medical illnesses (Healthcare Foundation of Greater Kansas, 2013). Furthermore, when individuals are not treated for mental illness appropriately they are often unable to work. If they are unable to work they will most likely need some sort of financial assistance

such as Medicaid. If we reduce the number of individuals that are unable to work due to untreated mental illnesses this too would also have a positive impact on cost effectiveness for the Medicaid population. Research that was conducted recently in Kansas showed that when mental illness was left untreated the costs were astronomical for those on Medicaid. Here is a sample of their research findings:



What the research demonstrated was that when people are not treated for mental health issues it costs above and beyond what "normal" medical costs would be as the individuals need more crisis interventions and they have a higher rate of comorbid conditions (Healthcare Foundation of Greater Kansas, 2013).

25. Provide a copy of the State of Connecticut, Department of Public Health license(s) currently held by the applicant.

This was submitted with the initial CON application submitted. An additional copy can be found on page, Appendix E. I apologize if you are looking for something additional but this is the only license that the applicant currently holds.

26. List the licenses that the SBHC will be seeking in relation to the proposal. Information concerning the DPH licensure may be obtained by calling the DPH Facility Licensing at (860) 509-8023. (Please note that the State's Department of Children and Families is the agency responsible for licensing facilities that provide services to children. The agencies main number is (860-550-6300.)

We are applying for the following licensed from the CT Department of Public Health (DPH): Psychiatric Outpatient Clinic for Adults and Facility for the Care or Treatment of Substance Abusive or Dependent Persons.

We are applying for the following licenses from the Department of Children and Families: Outpatient Psychiatric Clinic for Children

27. Please provide a copy of the Operating Agreement for SBHC that was included in the initial application, as the document provided was not in appropriate page order.

My apologies for this error we have resubmitted the required documentation please see Appendix D.

28. Please provide audited financial statements for the most recently completed fiscal year or other financial documentation (e.g. unaudited balance sheet, statement of operations, federal tax return or other similar documents).

SBHC is currently in its first year of operations and has no financial documents at this point. Please see Appendix F which includes current ninety day bank statements for the company.

29. Provide a short description of the medical equipment to be obtained and the required renovations proposed on page 20 of your application.

Medical Equipment Purchase	$20000.00
Imaging Equipment Purchase	$0
Non-Medical Equipment Purchase	$5000.00
Land/Building Purchase *	$0

Construction/Renovation **	$15000.00
Other Non-Construction (Specify)	$0
Total Capital Expenditure (TCE)	**$40,000.00**
Medical Equipment Lease (Fair Market Value) ***	$0
Imaging Equipment Lease (Fair Market Value) ***	$0
Non-Medical Equipment Lease (Fair Market Value) ***	$0
Fair Market Value of Space ***	$0
Total Capital Cost (TCC)	**$0**
Total Project Cost (TCE + TCC)	**$40,000.00**
Capitalized Financing Costs (Informational Purpose Only)	$0
Total Capital Expenditure with Cap. Fin. Costs	**$40,000.00**

The medical purchases of $20,000.00 will include the purchase and installation of a handicap ramp, door, and bathroom. The construction cost of $15000.00 will include the remodeling of all of the offices in the clinic to be handicap complaint and have handicap

accessible doors and hallways. The $5000.00 non-medical purchases will include computers, desks, and office furniture for the new spaces.

30. Demonstrate how this proposal will impact the financial strength of the health care system in the state or that the proposal is financially feasible for the Applicant.

This program will impact the financial strength of the health care system in the State of CT because mental health significantly impacts physical health. There is a lot of research emerging that indicates that appropriate, affordable, and accessible, mental health care will strengthen the financial health care system of the state by reducing the cost of unnecessary medical visits often made by individuals suffering from a mental illness. "Patients diagnosed with psychological problems are typically heavy users of medical services. If mental health services were made available to these patients, medical utilization would decrease resulting in potentially large savings to health care programs" (Rhode Island Psychological Association, 2014).

This proposal is financially feasible because we have just been renewed for another two year grant from the Department of Disability Services (DDS) and we feel it is beneficial to make these renovations to accommodate our DDS patients regardless of the clinic status at this time. The State of Connecticut Department of Economic Development (DECD) has also given us a $15000.00 grant to assist with the renovation. Furthermore,

we have successfully maintained and provided excellent quality training for the past two years to several Universities and colleges that have placed their interns with us. However, as our reputation continues to grow in a positive way the demand for more interns to be placed with us also continues to grow.

Unfortunately, if we are not granted this license we will be extremely limited in how many interns we can place each year and will have to end some of our collaborative agreements with some of the Universities and Colleges we currently work with as their training guidelines have changed significantly due to their new accreditation standards and guidelines and we will not be able to accommodate their new required hours (all Counseling graduate students will be required to see 20 patients per week) without being able to bill for these services.

References

About us (2015). In APT foundation. Retrieved January 20, 2015.

About Us (2015). In BH Care. Retrieved January 20, 2015.

Bruce, L. (2014, February 19). STEP reopens, offering early intervention for psychosis. In Yale School of Public Health. Retrieved January 28, 2015.

Department of Public Health (2006). Licensure of private freestanding mental health day treatment facilities, intermediate treatment facilities and psychiatric outpatient clinics for adults. Department of Public Health – Public Health Code, 19a-495-550.

Health Care Foundation of Greater Kansas City (HCF) (2014). The Costs of Untreated Mental Illness. http://hcfgkc.org/costs-untreated-mental-illness

Health Insurance Portability and Accountability Act. "State HIPPA Security Policy." 2.0 CT (Nov. 3, 2004).

O'Brien, J. (n.d.). Leading Change: A Plan for SAMHSA's Roles and Actions. Retrieved January 14, 2015.

Our Work (2014). In The Consultation Center. Retrieved January 28, 2015.

Rhode Island Psychological Association (2014) Importance of mental health. Retrieved from http://rippsych.org

Services (2013). In DN Community Mental Health Services. Retrieved January 20, 2015.

The Connecticut Mental Health Center about CMHC (2013). In DHMAS. Retrieved January 20, 2015.

US Department of Homeland Security (2008). Active shooter how to respond. October 2008.

Who we are (2015). In bridges a community support system. Retrieved January 20, 2015.

Appendices

A – Previous CON References- Full Articles

B – Standard Practice Guidelines

C – Policies and Procedures

D – Shoreline Wellness Center Articles of Organization

E. Copy of CT license

F – SBHC Bank Statements

G- Letter from Dr. Morris

Connecticut

State of Connecticut Website (http://www.huskyhealth.com/)

(/medicaid-chip-program-information/by-state/by-state.html)

Medicaid-Marketplace Overview

Connecticut is operating a State-based Marketplace, known as Access Health CT. The state has expanded Medicaid coverage to low-income adults.

Medicaid and CHIP Eligibility Levels

To view the modified adjusted gross income (MAGI) (/medicaid-chip-program-information/program-information/downloads/modified-adjusted-gross-income-and-medicaid-chip.pdf) -based eligibility levels, expressed as a percentage of the federal poverty level (FPL) and by monthly dollar amount and family size for Medicaid and CHIP, visit the National Medicaid and CHIP Eligibility Levels page (/medicaid-chip-program-information/program-information/medicaid-and-chip-eligibility-levels/medicaid-chip-eligibility-levels.html) for more information.

State	Medicaid Expansion	Children - Medicaid			Separate CHIP	Pregnant Women		Parents[3]	Other Adults
		Ages 0-11	Ages 1-52	Ages 6-182		Medicaid	CHIP		
Connecticut	Y	196%	196%	196%	318%	258%	N/A	196%	133%

1. These eligibility standards include CHIP-funded Medicaid expansions.

2. Children in separate CHIP programs are typically charged premiums. This table does not include notations of states that have elected to provide CHIP coverage from conception to birth.

3. In states that use dollar amounts rather than percentages of the federal poverty level (FPL) for 2013 to determine eligibility for parents, we converted those amounts to a percent of the FPL and selected the highest percentage to reflect eligibility level for the group. In addition, in states that are adopting the Medicaid expansion, we have indicated the upper income limit for parents to also be 133% of the FPL, since parents can be eligible for coverage under the new adult group. The actual dollar standards that states will use to determine eligibility are quoted in the monthly income tables.

Monthly Medicaid and CHIP Enrollments Data

Each month, CMS releases state-reported data on State Medicaid and CHIP program Enrollment. The enrollment data for each month is a point-in-time count of total Medicaid and CHIP enrollment on the last day of the month, and is not solely a count of those newly enrolled during the reporting period. Below, this data is compared to average enrollment from July-September 2013, the period before the initial open enrollment period of the Health Insurance Marketplaces. Additional information and enrollment data is available on the Medicaid and CHIP Application, Eligibility Determination, and Enrollment Data page (/medicaid-chip-program-information/program-information/medicaid-and-chip-enrollment-data/medicaid-and-chip-application-eligibility-determination-and-enrollment-data.html).

State	State Medicaid & CHIP Enrollment			National		
	Total Medicaid & CHIP Enrollment (October 2014) (Preliminary)	Comparison of October 2014 data to July-September 2013 Average Enrollment		Total Medicaid & CHIP Enrollment, all States (October 2014) (Preliminary)	Comparison of October 2014 data to July-September 2013 Average Enrollment	
		Net Change	% Change		Net Change	% Change
Connecticut	767,157	Not Available	Not Available	68,529,576	9,683,006	16.76%

Medicaid and CHIP Applications

The Affordable Care Act established a streamlined enrollment process through which individuals can gain access to affordable insurance coverage for which they are eligible. The law directed the Secretary of Health and Human Services (HHS) to develop a model application that will be used to apply for coverage through the Marketplace, Medicaid and CHIP (http://www.healthcare.gov/get-coverage/). States have the option to adopt the Secretary of HHS's model application form for affordable insurance programs or to adopt an alternative application that meets federal requirements.

- Connecticut Medicaid/CHIP Application (http://www.connect.ct.gov)

Targeted Enrollment Strategies

42

response to CMS guidance provided on May 17, 2013 (/federal-policy-guidance/downloads/sho-13-003.pdf) , many states have adopted

one or more "targeted enrollment strategies" designed to facilitate enrollment and retain coverage for eligible individuals in Medicaid/CHIP. The states that have adopted one or more targeted enrollment strategies are listed here (/medicaid-chip-program-information/program-information/targeted-enrollment-strategies/targeted-enrollment-strategies.html).

Medicaid and CHIP State Plan Amendments

The state Medicaid and CHIP plans spell out how each state has chosen to design its program within the broad requirements for federal funding. As always, states amend their Medicaid and CHIP state plans in order to inform CMS of programmatic and financing changes and to secure legal authority for those changes. The Affordable Care Act included many new opportunities for states to augment and improve their Medicaid and CHIP programs. As a result there has been a great deal of state plan amendment activity over the past several years in the areas of eligibility, benefits design and financing, as well as new approaches to providing health homes, long-term services and supports, and enrollment strategies like hospital presumptive eligibility. See below for a state-specific list of approved Medicaid and CHIP SPAs.

- Connecticut Medicaid SPAs (http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Plan-Amendments/Medicaid-State-Plan-Amendments.html?filterBy=Connecticut)
- Connecticut CHIP SPAs (http://www.medicaid.gov/chip/state-program-information/chip-state-program-information.html?filterBy=Connecticut)

Demonstrations and Waivers

Demonstrations and waivers are vehicles states can use to test new or existing ways to deliver and pay for health care services in Medicaid and CHIP. The primary types of waivers and demonstration projects include section 1115 demonstrations, section 1915(b) managed care waivers, and section 1915(c) home and community-based services waivers. More information about waivers is available here (/medicaid-chip-program-information/by-topics/waivers/waivers.html).

- State of Connecticut Approved Waivers (http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers_faceted.html?filterBy=Connecticut)

Medicaid Delivery System

States have choices in their approach to delivery system design under the Medicaid and CHIP programs. States are increasingly moving to the use of managed care (/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/managed-care-site.html) and other integrated care models (/medicaid-chip-program-information/by-topics/long-term-services-and-supports/integrating-care/integrating-care.html) in serving their Medicaid beneficiaries. On average, more than 70 percent of the Medicaid population is enrolled in some form of managed care.

CHIP Program Information

The Children's Health Insurance Program (/chip/chip-program-information.html) was established in 1997 to provide new coverage opportunities for children in families with incomes too high to qualify for Medicaid, but who cannot afford private coverage. Like Medicaid, CHIP is administered by the states, but is jointly funded by the federal government and states. States had the opportunity to design their CHIP programs (/chip/downloads/chip-map.pdf) as an expansion of Medicaid, as a stand-alone program or through a combined approach.

Medicaid/CHIP Participation Rates

The participation rate is the percentage of eligible children enrolled in Medicaid and CHIP in the state. Data from 2012 show 88.1 percent of the eligible children in the United States are enrolled in Medicaid and CHIP programs. Click here (http://www.insurekidsnow.gov/professionals/reports/index.html) and scroll over your state to see the participation rate among children in Connecticut.

State	Participation
Connecticut	94.70%

Medicaid/CHIP Eligibility Verification Plans

Medicaid and CHIP agencies now rely primarily on information available through data sources (e.g., the Social Security Administration, the Departments of Homeland Security and Labor) rather than paper documentation from families for purposes of verifying eligibility for Medicaid and CHIP.

- Connecticut's Medicaid and CHIP Verification Plan is currently in progress

MAGI Conversion Plans

CMS provided states with a template for completing their "MAGI Conversion Plans" that are designed to reflect the MAGI-based eligibility standards that are used to determine Medicaid and CHIP eligibility. The MAGI-conversion process involved a translation of pre-2014 net income eligibility standards into MAGI-based eligibility standards. Moving to MAGI replaced income disregards with simpler, more universal income eligibility rules that are generally aligned with the rules that are used to determine eligibility for the premium tax credits in the Marketplace. To complete the transformation to MAGI, states needed to "convert" their net-income based eligibility standards to MAGI-based standards.

- Connecticut MAGI Conversion Plan (/medicaid-chip-program-information/program-information/medicaid-and-chip-and-the-marketplace/downloads/connecticut-magi-conversion-plan-template-051013.pdf)
- Connecticut SIPP-Based MAGI Conversion Results (/medicaid-chip-program-information/program-information/medicaid-and-chip-and-the-marketplace/downloads/ct-converted-thresholds-21jun2013.pdf)

NIH Public Access
Author Manuscript
Arch Gen Psychiatry. Author manuscript; available in PMC 2010 March 30.

Published in final edited form as:
Arch Gen Psychiatry. 2005 June ; 62(6): 617–627. doi:10.1001/archpsyc.62.6.617.

Prevalence, Severity, and Comorbidity of Twelve-month DSM-IV Disorders in the National Comorbidity Survey Replication (NCS-R)

Ronald C. Kessler, PhD, **Wai Tat Chiu, AM**, **Olga Demler, MA, MS**, and **Ellen E. Walters, M.S.**
Department of Health Care Policy, Harvard Medical School

Abstract

Context—Little is known about the general population prevalence or severity of DSM-IV mental disorders.

Objective—To estimate 12-month prevalence, severity, and comorbidity of DSM-IV anxiety, mood, impulse-control, and substance disorders in the recently completed US National Comorbidity Survey Replication (NCS-R).

Design and Setting—Nationally representative face-to-face household survey conducted between February 2001 and April 2003 using a fully structured diagnostic interview, WHO World Mental Health (WMH) Survey version of the Composite International Diagnostic Interview (WMH-CIDI).

Participants—9282 English-speaking respondents ages 18 and older.

Main Outcome Measures—Twelve-month DSM-IV disorders.

Results—Twelve-month prevalence estimates are anxiety 18.1%, mood 9.5%, impulse-control 8.9%, substance 3.8%, and any disorder 26.2%. 22.3% of 12-month cases are classified serious, 37.3% moderate, and 40.4% mild. 55% carry only a single diagnosis, 22% two, and 23% three or more. Latent class analysis detects seven multivariate disorder classes, including three highly comorbid classes representing 7% of the population.

Conclusions—Although mental disorders are widespread, serious cases are concentrated among a relatively small proportion of cases with high comorbidity.

Community epidemiological surveys estimate that as many as 30% of the adult population in the US meet criteria for a 12-month DSM mental disorder.[1, 2] Clinical reappraisal studies confirm these estimates.[3] Although fewer than half these people receive treatment,[4, 5] unmet need for treatment may not be a major problem, as a high proportion of untreated cases might be mild or self-limiting. No definitive epidemiological data exist on this possibility, though, as severity has not been a focus of previous psychiatric epidemiological surveys. Although secondary analysis of surveys in the US[6] and other countries[7, 8] suggests that many 12-month cases are mild, this conclusion is based on crude post hoc severity indicators.

Corresponding author and reprints: RC Kessler, PhD, Department of Health Care Policy, Harvard Medical School, 180 Longwood Avenue, Boston, MA, USA 02115. Voice: 617-432-3587; Fax: 617-432-3588; kessler@hcp.med.harvard.edu.

The authors appreciate the helpful comments on earlier drafts of William Eaton, Kathleen Merikangas, and Michael Von Korff, and Hans-Ulrich Wittchen.

NIH-PA Author Manuscript
NIH-PA Author Manuscript
NIH-PA Author Manuscript

NIH-PA Author Manuscript

NIH-PA Author Manuscript

NIH-PA Author Manuscript

Recognizing the importance of obtaining more refined disorder severity data as well as of updating available data on the epidemiology of mental disorders in a number of other ways, the World Health Organization recently expanded its Composite International Diagnostic Interview (CIDI),[9] the interview used in almost all major psychiatric epidemiological surveys in the world over the past decade, to include detailed questions about severity.[10] This expanded CIDI was used in a coordinated series of epidemiological surveys carried out under WHO auspices known as the World Mental Health (WMH) Survey Initiative.[8] The current report presents WMH-CIDI data on prevalence, comorbidity, and severity of 12-month DSM-IV disorders from the US National Comorbidity Survey Replication (NCS-R),[11, 12] the WMH survey carried out in the US.

METHODS

Sample

As described in more detail elsewhere,[12, 13] the NCS-R is a nationally representative household survey of English speakers ages 18+ in the coterminous United States. Respondents were confined to English-speakers because two parallel surveys are currently underway in nationally representative samples of Hispanics (in Spanish or English, depending on the preference of the respondent) and Asian Americans (in a number of Asian languages or English, again depending on the preference of the respondent). These surveys are using the same diagnostic instrument as the NCS-R and are covering the major groups of non-English speakers in the US population. NCS-R respondents were selected from a multi-stage clustered area probability sample of households. Face-to-face interviews were carried out between February 2001 and April 2003 by professional interviewers from the Institute for Social Research at the University of Michigan. The response rate was 70.9%. The survey was administered in two parts. Part I included a core diagnostic assessment (n = 9282). Part II included questions about risk factors, consequences, and other correlates along with assessments of additional disorders that were administered to all Part I respondents who met lifetime criteria for any disorder plus a probability sub-sample of other respondents (n = 5692). Interviewers explained the study and obtained verbal informed consent prior to beginning each interview. The NCS-R recruitment, consent, and field procedures were approved by the Human Subjects Committees of both Harvard Medical School and the University of Michigan.

Measures

Diagnostic assessment—DSM-IV diagnoses were based on the WMH-CIDI,[10] a fully structured lay interview that generates diagnoses according to ICD-10[14] and DSM-IV[15] criteria. DSM-IV criteria are used here. Twelve-month disorders considered here include anxiety disorders (panic disorder, generalized anxiety disorder, agoraphobia without panic disorder, specific phobia, social phobia, post-traumatic stress disorder, obsessive-compulsive disorder, separation anxiety disorder), mood disorders (major depressive disorder, dysthymia, bipolar disorder I or II), impulse-control disorders (oppositional-defiant disorder, conduct disorder, attention-deficit/hyperactivity disorder, intermittent explosive disorder), and substance use disorders (alcohol and drug abuse and dependence). Minor corrections to diagnostic algorithms were made subsequent to previously reported aggregate analyses, leading to small differences in aggregate prevalence estimates.[8] The disorders assessed in Part II include the four childhood disorders (separation anxiety disorder, oppositional-defiant disorder, conduct disorder, and attention-deficit/hyperactivity disorder), post-traumatic stress disorder, obsessive-compulsive disorder, and the substance use disorders. Assessment of the childhood disorders in Part II was limited to respondents in the age range 18–44 based on concerns about recall bias among older respondents. As all but one of the impulse-control disorders were assessed only among respondents in the age range

NIH-PA Author Manuscript NIH-PA Author Manuscript NIH-PA Author Manuscript

18–44, overall prevalence of any impulse-control disorder was limited to that age range, leading to a much higher prevalence estimate than in a previously reported aggregate analysis (where prevalence was reported for the total sample).[8] DSM-IV organic exclusion rules were used in making diagnoses. Diagnostic hierarchy rules were also used in making all diagnoses other than substance use disorders, where abuse was defined with or without dependence in recognition of abuse often being a stage in the progression to dependence. Hierarchy-free diagnoses were consistently used in analyses of comorbidity. As described elsewhere,[12] blind clinical re-interviews using the Structured Clinical Interview for DSM-IV (SCID)[16] with a probability sub-sample of NCS-R respondents found generally good concordance between WMH-CIDI diagnoses and SCID diagnoses.

Severity—Twelve-month cases were classified serious if they had any of the following: a 12-month suicide attempt with serious lethality intent; work disability or substantial limitation due to a mental or substance disorder; a positive screen for non-affective psychosis; bipolar I or II disorder; substance dependence with serious role impairment (as defined by disorder-specific impairment questions); an impulse-control disorder with repeated serious violence; or any disorder that resulted in 30+ days out of role in the year. Cases not defined serious were defined moderate if they had any of the following: suicide gesture, plan or ideation; substance dependence without serious role impairment; at least moderate work limitation due to a mental or substance disorder; or any disorder with at least moderate role impairment in two or more domains of the Sheehan Disability Scales (SDS).[17] (The SDS assessed disability in work role performance, household maintenance, social life, and intimate relationships on 0–10 visual analogue scales with verbal descriptors, and associated scale scores, of: none 0; mild 1–3; moderate 4–6; severe 7–9; and very severe 10.) All other cases were classified mild. This classification scheme is somewhat more refined than the one used in comparative analyses of all WMH surveys[8] due to the NCS-R having more detailed information than the other WMH surveys. To assess the meaning of the severity ratings, we compared number of days in the past 12 months respondents were totally unable to carry out their normal daily activities because of mental or substance problems. The mean of this variable was significantly higher ($F_{2,5689} = 17.7$, $p < .001$) among respondents classified serious (88.3) than those classified moderate (4.7) or mild (1.9).

Socio-demographic correlates—Socio-demographic correlates include cohort (defined by age at interview in categories 18–29, 30–44, 45–59, 60+), gender, race-ethnicity (Non-Hispanic White, Non-Hispanic Black, Hispanic, Other), completed years of education (0–11, 12, 13–15, 16+ years), marital status (married-cohabitating, previously married, never married), family income, and urbanicity. Family income was defined in relation to the federal poverty line.[18] Low income was less than or equal to 1.5 times the poverty line, low-average was 1.5–3 times the poverty line, high-average as 3–6 times the poverty line, and high was greater than 6 times the poverty line. Urbanicity was coded according to 2000 Census definitions[19] and distinguished large (at least 2 million residents) vs. smaller Metropolitan Statistical Areas (MSAs) by central cities, suburbs, adjacent areas (areas outside the suburban belt, but within 50 miles of the central business district of a central city), and rural areas (more than 50 miles from the central business district of a central city).

Analysis methods

Weights were used to adjust for differences in within-household probability of selection, non-response, and differences between the sample and 2000 Census on socio-demographic variables. As described in more detail elsewhere, [13] socio-demographic matching was based on the full 2000 Census (which includes non-English speakers and non-household residents, who were excluded from the NCS-R sample) because it was impractical to refine the 2000

NIH-PA Author Manuscript

NIH-PA Author Manuscript

NIH-PA Author Manuscript

Census data to have the same restrictions as the NCS-R while still using tract-level Census geo-code data to adjust for geographic variation in non-response. This failure to make exclusions from the Census data comparable to those in the NCS-R introduced a small bias into the last part of the weight adjustment.

Prevalence and severity were estimated by calculating means for dichotomous variables. Standard errors were obtained using the Taylor series linearization method[20] implemented in the SUDAAN software system to adjust for the effects of weighting and clustering on the precision of estimates.[21] Comorbidity was studied initially by calculating tetrachoric correlations of disorders among Part II respondents ages 18–44. The restriction to Part II was because some disorders were only assessed in Part II, while the restriction to ages 18–44 was because childhood disorders were assessed only in that age range. Exploratory factor analysis, implemented in SAS v8.2,[22] was used to reduce the dimensionality of the correlation matrix.

The additivity of associations among the 19 WMH-CIDI disorders was investigated by using log-linear analysis to evaluate the fit of a saturated two-way marginal model to the 2^{19} logically possible multivariate profiles of disorders.[23] As described below, this analysis documented significant higher-order interactions among the disorders. Based on this result, latent class analysis (LCA),[24, 25] a data reduction method that allows for non-additive associations among comorbid conditions, was used to study multivariate comorbidity among the NCS-R disorders.. LCA postulates a discrete latent variable defining class membership that explains covariance among observed disorders. When this model holds, the observed cell probabilities in the cross-classification among disorders will equal the product of the within-class marginal disorder probabilities multiplied by the class prevalence and summed across classes. This model contains one parameter for the probability of each disorder in each of k classes of the latent variable in addition to k parameters for class prevalence. The latent class model was fit for values of k between one and eight using the iterative-fitting NAG FORTRAN library routine E04UCF[26] and the method of maximum likelihood.[27] The comparative fit of LCA models with successively higher values of k was assessed by evaluating the Bayes Information Criterion.[28]

Socio-demographic correlates were examined by transforming the seven predicted probabilities of class membership from the LCA solution into logits, the natural logarithm of the odds $p_{ic}/(1-p_{ic})$, where p_{ic} is the probability that respondent i is in class c, that were then used as dependent variables in linear regression equations for effects of socio-demographic variables on the odds of class membership. The Taylor series method was used to estimate standard errors. Regression coefficients were exponentiated and interpreted as odds-ratios (OR's) with design-based 95% confidence intervals. Multivariate significance was evaluated with Wald χ^2 tests using Taylor series design-based coefficient variance – covariance matricies. Statistical significance was evaluated using two-sided design-based .05-level tests.

RESULTS

Prevalence and severity

The more prevalent 12-month disorders (Table 1) are specific phobia (8.7%), social phobia (6.8%), and major depressive disorder (6.7%). Anxiety disorders are the most prevalent class (18.1%), followed by mood disorders (9.5%), impulse-control disorders (8.9%), and substance disorders (3.8%). Twelve-month prevalence of any disorder is 26.2%, with more than half of cases (14.4% of the total sample) meeting criteria for only one disorder and smaller proportions for two (5.8%) or more (6.0%) disorders.

NIH-PA Author Manuscript

NIH-PA Author Manuscript

NIH-PA Author Manuscript

Among respondents with a disorder, 22.3% were classified serious, 37.3% moderate, and 40.4% mild. Severity is strongly related to comorbidity: 9.6% of respondents with one diagnosis, 25.5% with two, and 49.9% with three or more diagnoses classified serious. The distribution of severity is quite different from the distribution of prevalence across classes of disorder: mood disorders have the highest percent serious (45.0%) and anxiety disorders the lowest (22.8%). The anxiety disorder with the highest percent serious is obsessive-compulsive disorder (50.6%), while bipolar disorder has the highest percent serious (82.9%) among mood disorders, oppositional-defiant disorder the highest (49.6%) among impulse-control disorders, and drug dependence the highest (56.5%) among substance disorders.

Bivariate comorbidity

Tetrachoric correlations between hierarchy-free 12-month disorders (Table 2) are almost all positive (98%) and statistically significant (72%). Of only four negative correlations, all involve either OCD or separation anxiety disorder (SAD), both of which are very uncommon. The twelve highest correlations, each exceeding .60, represent well-known syndromes: bipolar disorder (major depressive episode with mania-hypomania), double-depression (major depressive episode with dysthymia), anxious-depression (major depressive episode with generalized anxiety disorder), comorbid mania-hypomania and attention-deficit/hyperactivity disorder, panic disorder with agoraphobia, comorbid social phobia with agoraphobia, and comorbid substance disorders (both alcohol abuse and dependence with drug abuse and dependence).

Exploratory factor analysis of the correlation matrix was carried out after excluding the disorders associated with negative correlations (OCD and SAD). Two factors had eigenvalues greater than one (7.3, 2.3), while the eigenvalue of the third factor (0.8) was substantially smaller. Both rigid and oblique rotations of the two-factor solution yielded similar patterns, with high factor loadings on the first factor (Table 2) for internalizing disorders (anxiety disorders, major depressive episode) and on the second factor for externalizing disorders (conduct disorder, substance disorders). Five disorders have factor loadings of .30 or higher on both factors (dysthymia, mania-hypomania, ODD, ADHD, and IED), although all five have higher loadings on the internalizing than externalizing factor.

Multivariate comorbidity

Of the 524,288 (2^{19}) logically possible multivariate disorder profiles among the 19 NCS-R disorders, 433 were observed. Nearly 80% involve highly comorbid cases (three or more disorders) (Table 3), accounting for 27.0% of all respondents with a disorder and 55.9% of all instances of these disorders. Importantly, the distribution of comorbidity is significantly different ($\chi^2_3 = 110.2$, $p < .001$) from the distribution we would expect to find if the multivariate structure among the disorders was due entirely to the two-way associations that are the focus of factor analysis. This finding led us to reject the use of confirmatory factor analysis to carry out more in-depth exploration of comorbid profiles. Instead, LCA was used to study non-additive comorbid profiles. Alcohol abuse and dependence were collapsed into a single category for purposes of this analysis because their separation violates the LCA assumption of conditional independence within classes. Similarly for drug abuse and dependence. Major depressive episode and dysthymia were collapsed based on their extremely high tetrachoric correlation.

A seven-class LCA model provided the best fit to the data. The seven classes differ greatly in prevalence (Table 4, Part I), from 68.5% in Class I to 0.7% in Class VII. Prevalence is inversely related both to number of disorders (Table 4, Part III) and severity (Table 4, Part IV), although there are meaningful inversions between Classes IV and V. Although subsets of the classes form a general hierarchy (e.g., Classes II, IV, and VI represent profiles of

NIH-PA Author Manuscript

NIH-PA Author Manuscript

NIH-PA Author Manuscript

increasingly comorbid internalizing disorders), some disorders are more prevalent in the lower than higher classes (e.g., oppositional-defiant disorder and conduct disorder are more prevalent in Class II than Class IV, while panic disorder and all three types of phobia are more prevalent in Class IV than Class VI). These inversions show that the classes are not merely points of density on the two factor analysis dimensions.

The seven LCA classes can be interpreted by examining the mean number ($\bar{x}_d$) and content of within-class disorders. Class I represents unaffected respondents ($\bar{x}_d = 0.1$). Class II represents pure ($\bar{x}_d = 1.2$) internalizing disorders. Class III represents pure ($\bar{x}_d = 1.2$) externalizing disorders. Class IV represents comorbid ($\bar{x}_d = 2.9$) internalizing disorders. Class V represents comorbid ($\bar{x}_d = 2.0$) internalizing-externalizing disorders dominated by comorbid social phobia and attention-deficit/hyperactivity disorder. Class VI represents highly comorbid ($\bar{x}_d = 4.9$) major depressive episodes. Class VII represents highly comorbid ($\bar{x}_d = 7.5$) bipolar disorder. Although the classes with high comorbidity (Classes IV, VI, and VII) include only about 7% of the sample, 43.6% of serious cases are in these classes.

Socio-demographic correlates

Using the predicted probabilities of LCA class membership as outcomes, correlates of being largely unaffected (Class I) include male, Non-Hispanic Black or Hispanic, married, college education, high income, and residing in a rural area. (Table 5) Correlates of pure internalizing disorders (Class II) include female, married, high education, and residing in the suburbs of small metropolitan areas. Correlates of pure externalizing disorders (Class III) include young, male, Hispanic, not low income, and residing in a rural area. Correlates of comorbid internalizing disorders (Class IV) include female, previously married, and residing either in suburbia or in an outlying non-rural area. Correlates of comorbid internalizing-externalizing disorders (Class V) include young, male, married, and residing in a non-rural area. Correlates of highly comorbid major depression (Class VI) include female, Non-Hispanic White or other Non-Hispanic/Non-Black race-ethnicity, unmarried, low education, less than high income, and residing in a non-rural area. Correlates of highly comorbid bipolar disorder (Class VII) include termination of schooling with the completion of high school and residing in cities or suburbs. Socio-demographic variation is strongest and most diverse in predicting either being unaffected (Class I) or having highly comorbid major depression (Class VI). Socio-demographic variation is weakest in predicting pure internalizing disorders (Class II) and highly comorbid bipolar disorder (Class VII).

COMMENT

Four limitations of the NCS-R are relevant to the analyses reported here. First, the sample under-represents several important population segments, including the homeless, those in institutions, and those who cannot speak English. The first two of these exclusions reduce prevalence estimates. In addition, mentally ill people might be more reluctant than others to participate in a mental health survey. This is relevant because the 70.9% response rate means that nearly 30% of eligible respondents are not represented in the sample. Evidence for selection bias related to mental illness has been reported in other community surveys,[29–31] although no evidence for it was found in an NCS-R non-response survey.[13] To the extent that this bias exists, it will make NCS-R estimates conservative.

Second, participants might have under-reported 12-month prevalence. This possibility is consistent with evidence in the methodology evidence that embarrassing behaviors are often under-reported.[32] Experimental studies show that this under-reporting bias can be reduced by using strategies aimed at decreasing embarrassment[3, 33] a number of which were used in the NCS-R.[10] To the extent these strategies were unsuccessful, the NCS-R estimates are likely to be conservative.

NIH-PA Author Manuscript

NIH-PA Author Manuscript

NIH-PA Author Manuscript

Third, the WMH-CIDI is a lay-administered interview. As reported elsewhere,[34] though, a clinical reappraisal study using the Structured Clinical Interview for DSM-IV (SCID)[16] found generally good individual-level concordance between the WMH-CIDI and SCID and conservative estimates of prevalence compared to the SCID.

Fourth, the NCS-R did not include all DSM-IV diagnoses. Schizophrenia and other non-affective psychoses (NAP) are notably missing. NAP was excluded from the NCS-R core because previous studies have shown it is dramatically over-estimated in lay-administered interviews.[35–39] These same studies showed that the vast majority of respondents with NAP meet criteria for CIDI anxiety, mood, or substance disorders and are consequently captured as cases. If severity is under-estimated in the WMH-CIDI, though results will be conservative.

Within the context of these limitations, NCS-R results are generally consistent with the earlier Epidemiologic Catchment Area (ECA) Study and National Comorbidity Survey (NCS)[1] in finding 12-month mental disorders to be highly prevalent. The 26.2% estimate of any disorder in the NCS-R is very close to estimates of 28.1% in the ECA[2] and 29.5% in the NCS.[1] This great similarity should not be over-interpreted, though, as the three surveys differed greatly in sampling frames, age ranges, diagnostic systems used to define disorders, and measures that it is impossible to draw firm conclusions about time trends in prevalence from these comparisons. It is nonetheless noteworthy, in light of these different design elements, that the three most prevalent NCS-R disorders (specific phobia, social phobia, and major depressive disorder) are identical to the three most prevalent disorders in the NCS and to two of the three in the ECA. The exception is social phobia, which was not comprehensively assessed in the ECA.

The NCS-R findings that anxiety disorders are more prevalent than mood disorders and that mood disorders are more prevalent that substance disorders are also consistent with both ECA and NCS findings. The NCS-R prevalence estimates can also be directly compared to those in over a dozen countries that participated in the WHO World Mental Health (WMH) Survey Initiative.[8] NCS-R prevalence estimates are consistently higher than in these other countries. However, as with the ECA and NCS, within-country differences in disorder prevalence in the NCS-R are quite similar to those reported so far in other WMH countries.[40, 41]

The externalizing disorders in NCS-R have been much less well studied than anxiety, mood, and substance disorders in previous adult surveys. The limited evidence on intermittent explosive disorder[42] is consistent with the NCS-R prevalence estimate of 2.6%, but we are aware of no comparable information on other impulse-control disorders among adults. These disorders are routinely assessed in surveys of children.[43–45] NCS-R 12-month prevalence estimates of all but one of the childhood-onset impulse disorders are much smaller than in surveys of youth. The exception is ADHD, with 12-month NCS-R prevalence approximately 50% as high as the estimates in surveys of youth. This is consistent with independent evidence that as many as half of children with ADHD continue to have symptoms as adults.[46]

The NCS-R results regarding severity support the secondary analyses in showing that many mental disorders are mild. Indeed, nearly twice as high a proportion of NCS-R cases are mild (40.4%) as serious (22.3%). Nonetheless, the 14.0% of respondents with serious or moderate disorder is substantial. The 5.7% with a serious disorder (22.3% of the 26.2% overall prevalence) is almost identical to the estimated prevalence of Serious Mental Illness (SMI), using the SAMHSA definition of that term, in the baseline NCS.[47] The finding that mood disorders are more likely than anxiety disorders to be classified serious is consistent

NIH-PA Author Manuscript

NIH-PA Author Manuscript

NIH-PA Author Manuscript

with a cross-national comparative analysis of five earlier CIDI surveys that used a less precise measure of severity[7] as well as with the results of the more recent WMH Surveys.[8]

Patterns of bivariate comorbidity are broadly consistent with the ECA and NCS in showing the vast majority of disorders positively correlated. Relative magnitudes of associations are also quite similar across the three surveys, with high rank-order correlations of odds-ratios among comorbid pairs in the NCS versus published odds-ratios[48] in both the NCS (.79) and the ECA (.57). Major internal patterns of comorbidity are also quite consistent across surveys, such as the stronger odds-ratios within the mood disorders than the anxiety disorders, very high odds-ratios between anxiety and mood disorders, and odds-ratios between anxiety and mood disorders generally being higher than between pairs of anxiety disorders.

The factor analysis found a very similar two-dimensional solution as in the NCS.[49] A similar structure was found in a stud of comorbidity among primary care patients.[50] The log-linear analysis showed clearly, though, that powerful interactions exist among NCS-R disorders that are not captured by the additive model on which factor analysis is based. LCA was used to study these profiles. This is a departure from the confirmatory factor analysis approach used in other recent studies of comorbidity (CITES: Kreuger papers #1–2 that are already in the bib; Vollebergh WA et al. Arch Gen Psych 2001). The LCA results documented progression within and overlap between internalizing and externalizing disorders, with a clear divergence from a simple two-dimensional progression due to panic and phobia being considerably more prevalent in the comorbid internalizing class than in the highly comorbid internalizing and externalizing classes. This is an intriguing specification that was also found a decade ago in an LCA analysis of the NCS data.[51] It is conceivable that this pattern reflects a protective effect of comorbid panic and phobias against externalizing disorders, possibly through risk aversion.

The NCS-R LCA results share several other features with the earlier NCS LCA results. Both include separate classes of pure and comorbid internalizing disorders with low prevalence of bipolarity. Both have highly comorbid classes with a small proportion of the sample (4.9% in NCS and 7.3% in NCS-R) having a high concentration of severe cases. The implicit progression among these classes warrants a more fine-grained investigation of transitions in lifetime comorbidity. Such an investigation goes beyond the scope of the current report.

The results regarding socio-demographic correlates are broadly consistent with previous surveys in finding that mental disorders (i.e., low probability of membership in Latent Class I) are associated with a general pattern of disadvantaged social status, including being female, unmarried, and having low socioeconomic status.[8, 52–59] The finding that Non-Hispanic Blacks and Hispanics have significantly lower risk of disorders is inconsistent with this general pattern, but the same relationship was found in the baseline NCS.[1] It is not clear whether the associations of achieved social statuses (i.e., marital status, socioeconomic status) with prevalence are due to effects of environmental experiences on mental disorders, to effects of mental disorders on achieved social status, to unmeasured common biological causes, or to some combination. In the case of the ascribed social statuses (i.e., sex and race-ethnicity), the causal effects clearly flow from the statuses and their correlates to the disorders, although the relative importance of environmental and biological mediators is unclear. The significant associations of race-ethnicity, marital status, education, and income with positive disorder classes are largely confined to predicting highly comorbid major depression (Class VI). This means the associations of these important socio-demographic variables with 12-month DSM-IV disorders are due largely to effects on a comparatively rare (16% of the population) profile of highly comorbidity.

NIH-PA Author Manuscript

NIH-PA Author Manuscript

NIH-PA Author Manuscript

CONCLUSION

The NCS-R results show 12-month DSM-IV disorders to be highly prevalent in the US. Although over one-third of cases are mild, the prevalence of moderate and serious cases is substantial (14.0% of the population). Although anxiety disorders are by far the most common mental disorders, the proportion serious is lower than for other classes of disorder. Mood disorders are next most common and have the highest proportion serious. Impulse-control disorders, which have been neglected in previous epidemiological studies of adult mental disorders, are found in over one-third of cases and have a higher proportion serious than either anxiety or substance disorders. More than 40% of 12-month cases are comorbid. Multivariate comorbidity profiles generally conform to a two-dimensional model of progression and overlap between internalizing and externalizing disorders, but with notable exceptions that are masked in conventional additive analysis. Severity is strongly related to comorbidity. Many of the most consistently documented socio-demographic correlates of disorder are related largely to a relatively small proportion of the population made up of people with highly comorbid major depression. Clarification of the implications of these results for public health interventions requires more dynamic analysis of the lifetime onset and cumulation of comorbid disorders.

Acknowledgments

The National Comorbidity Survey was supported by the National Institute of Mental Health (NIMH; R01 MH46376, R01 MH49098, and RO1 MH52861) with supplemental support from the National Institute of Drug Abuse (NIDA; through a supplement to MH46376) and the W.T. Grant Foundation (90135190). The National Comorbidity Survey Replication (NCS-R) is supported by NIMH (U01-MH60220) with supplemental support from NIDA, the Substance Abuse and Mental Health Services Administration (SAMHSA), the Robert Wood Johnson Foundation (RWJF; Grant 044708), and the John W. Alden Trust. Collaborating investigators include Ronald C. Kessler (Principal Investigator, Harvard Medical School), Kathleen Merikangas (Co-Principal Investigator, NIMH), James Anthony (Michigan State University), William Eaton (The Johns Hopkins University), Meyer Glantz (NIDA), Doreen Koretz (Harvard University), Jane McLeod (Indiana University), Mark Olfson (Columbia University College of Physicians and Surgeons), Harold Pincus (University of Pittsburgh), Greg Simon (Group Health Cooperative), Michael Von Korff (Group Health Cooperative), Philip Wang (Harvard Medical School), Kenneth Wells (UCLA), Elaine Wethington (Cornell University), and Hans-Ulrich Wittchen (Max Planck Institute of Psychiatry). The views and opinions expressed in this report are those of the authors and should not be construed to represent the views of any of the sponsoring organizations, agencies, or U.S. Government. A complete list of NCS publications and the full text of all NCS-R instruments can be found at http://www.hcp.med.harvard.edu/ncs. Send correspondence to NCS@hcp.med.harvard.edu. The NCS-R is carried out in conjunction with the World Health Organization World Mental Health (WMH) Survey Initiative. We thank the staff of the WMH Data Collection and Data Analysis Coordination Centres for assistance with instrumentation, fieldwork, and consultation on data analysis. These activities were supported by the John D. and Catherine T. MacArthur Foundation, the Pfizer Foundation, the US Public Health Service (R13-MH066849, R01-MH069864, and R01 DA016558), the Pan American Health Organization, Eli Lilly and Company, and GlaxoSmithKline. A complete list of WMH publications can be found at http://www.hcp.med.harvard.edu/wmh/.

References

1. Kessler RC, McGonagle KA, Zhao S, et al. Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the United States. Results from the National Comorbidity Survey. Arch Gen Psychiatry 1994;51:8–19. [PubMed: 8279933]
2. Regier DA, Kaelber CT, Rae DS, et al. Limitations of diagnostic criteria and assessment instruments for mental disorders. Implications for research and policy. Arch Gen Psychiatry 1998;55:109–115. [PubMed: 9477922]
3. Kessler RC, Wittchen H-U, Abelson JM, et al. Methodological studies of the Composite International Diagnostic Interview (CIDI) in the US National Comorbidity Survey. Int J Methods Psychiatr Res 1998;7:33–55.
4. Kessler RC, Berglund PA, Bruce ML, et al. The prevalence and correlates of untreated serious mental illness. Health Serv Res 2001;36:987–1007. [PubMed: 11775672]

NIH-PA Author Manuscript NIH-PA Author Manuscript NIH-PA Author Manuscript

5. Kessler RC, Zhao S, Katz SJ, et al. Past-year use of outpatient services for psychiatric problems in the National Comorbidity Survey. Am J Psychiatry 1999;156:115–123. [PubMed: 9892306]
6. Narrow WE, Rae DS, Robins LN, Regier DA. Revised prevalence estimates of mental disorders in the United States: using a clinical significance criterion to reconcile 2 surveys' estimates. Arch Gen Psychiatry 2002;59:115–123. [PubMed: 11825131]
7. Bijl RV, de Graaf R, Hiripi E, et al. The prevalence of treated and untreated mental disorders in five countries. Health Aff (Millwood) 2003;22:122–133. [PubMed: 12757277]
8. Demyttenaere K, Bruffaerts R, Posada-Villa J, et al. Prevalence, severity and unmet need for treatment of mental disorders in the World Health Organization World Mental Health surveys. JAMA 2004;291:2581–2590. [PubMed: 15173149]
9. Robins LN, Wing J, Wittchen H-U, Helzer JE. An epidemiologic instrument suitable for use in conjunction with different diagnostic systems and in different cultures. Arch Gen Psychiatry 1988;45:1069–1077. [PubMed: 2848472]
10. Kessler RC, Ustun TB. The World Mental Health (WMH) survey initiative version of the World Health Organization (WHO) Composite International Diagnostic Interview (CIDI). Int J Methods Psychiatr Res 2004;13:93–121. [PubMed: 15297906]
11. Kessler RC, Merikangas KR. The National Comorbidity Survey Replication (NCS-R): background and aims. Int J Methods Psychiatr Res 2004;13:60–68. [PubMed: 15297904]
12. Kessler RC, Berglund PA, Demler O, Jin R, Walters EE. Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication (NCS-R). under review.
13. Kessler RC, Berglund P, Chiu W-T, et al. The US National Comorbidity Survey Replication (NCS-R): design and field procedures. Int J Methods Psychiatr Res 2004;13:69–92. [PubMed: 15297905]
14. World Health Organization. International Classification of Diseases (ICD-10). Geneva, Switzerland: World Health Organization; 1991.
15. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, (DSM-IV). 4. Washington, DC: American Psychiatric Association; 1994.
16. First, MB.; Spitzer, RL.; Gibbon, M.; Williams, JBW. Structured Clinical Interview for DSM-IV Axis I Disorders, Research Version, Non-patient Edition (SCID-I/NP). New York: Biometrics Research, New York State Psychiatric Institute; 2002.
17. Leon AC, Olfson M, Portera L, Farber L, Sheehan DV. Assessing psychiatric impairment in primary care with the Sheehan Disability Scale. Int J Psychiatry Med 1997;27:93–105. [PubMed: 9565717]
18. Proctor, BD.; Dalaker, J. Poverty in the United States: 2001. Washington, DC: U.S. Government Printing Office; 2002. Current population reports.
19. US Census Bureau. County and City Databook, 2000. Washington, DC: US Government Printing Office; 2000.
20. Wolter, KM. Introduction to Variance Estimation. New York: Springer-Verlag; 1985.
21. SUDAAN: Professional Software for Survey Data Analysis [computer program] [computer program]. Version 8.0.1. Research Triangle Park, NC: Research Triangle Institute; 2002.
22. SAS Institute I. SAS/STAT Software: Changes and Enhancements, Release 8.2. Cary, NC: SAS Publishing; 2001.
23. McCutcheon, AL.; Mills, C. Categorical Data Analysis: Log-linear and Latent Class Models. In: Scarbrough, E.; Tanenbaum, E., editors. Research Strategies in the Social Sciences: a Guide to New Approaches. New York: Oxford University Press; 1998. p. 71-94.
24. Lazarsfeld, PR.; Henry, NW. Latent Structure Analysis. Boston, MA: Houghton-Mifflin; 1968.
25. Hagenaars, JA.; McCutcheon, AL. Applied Latent Class Analysis. New York: Cambridge University Press; 2002.
26. Numerical Approximation Group. Nag FORTRAN Library Introductory Guide. Downers Grove, Illinois: Nag Inc; 1990.
27. Eaves LJ, Silberg JL, Hewitt JK, et al. Analyzing twin resemblance in multisymptom data: genetic applications of a latent class model for symptoms of conduct disorder in juvenile boys. Behav Genet 1993;23:5–19. [PubMed: 8476390]

NIH-PA Author Manuscript NIH-PA Author Manuscript NIH-PA Author Manuscript

28. Lewis SM, Raftery AE. Estimating Bayes factors via posterior simulation with the LaPlace-Metropolis estimator. Journal of the American Statistical Association 1997;92:648–655.
29. Eaton WW, Anthony JC, Tepper S, Dryman A. Psychopathology and attrition in the Epidemiologic Catchment Area Study. Am J Epidemiol 1992;135:1051–1059. [PubMed: 1595691]
30. Allgulander C. Psychoactive drug use in a general population sample, Sweden: correlates with perceived health, psychiatric diagnoses, and mortality in an automated record-linkage study. Am J Public Health 1989;79:1006–1010. [PubMed: 2751014]
31. Kessler RC, Little RJA, Groves RM. Advances in strategies for minimizing and adjusting for survey nonresponse. Epidemiol Rev 1995;17:192–204. [PubMed: 8521937]
32. Cannell, CF.; Marquis, KH.; Laurent, A. Vital Health Stat 2. Series 2. 69. Rockville, MD: US Department of Health, Education and Welfare, National Centre for Health Statistics; 1977. A summary of studies of interviewing methodology: 1959–1970.
33. Turner CF, Ku L, Rogers SM, Lindberg LD, Pleck JH, Sonenstein FL. Adolescent sexual behavior, drug use, and violence: increased reporting with computer survey technology. Science 1998;280:867–873. [PubMed: 9572724]
34. Kessler RC, Berglund PA, Demler O, et al. The National Comorbidity Survey Replication (NCS-R): An Overview of Methods. Arch Gen Psychiatry. in press.
35. Bebbington PE, Nayani T. The psychosis screening questionnaire. Int J Methods Psychiatr Res 1995;5:11–19.
36. Eaton WW, Romanoski A, Anthony JC, Nestadt G. Screening for psychosis in the general population with a self-report interview. J Nerv Ment Dis 1991;179:689–693. [PubMed: 1940893]
37. Spengler PA, Wittchen H-U. Procedural validity of standardized symptom questions for the assessment of psychotic symptoms: a comparison of the DIS with two clinical methods. Compr Psychiatry 1988;29:309–322. [PubMed: 3378418]
38. Keith, SJ.; Regier, DA.; Rae, DS. Psychiatric Disorders in America: The Epidemiologic Catchment Area Study. New York, NY: Free Press; 1991. Schizophrenic disorders; p. 33-52.
39. Kendler KS, Gallagher TJ, Abelson JM, Kessler RC. Lifetime prevalence, demographic risk factors, and diagnostic validity of nonaffective psychosis as assessed in a US community sample. The National Comorbidity Survey. Arch Gen Psychiatry 1996;53:1022–1031. [PubMed: 8911225]
40. Alonso J, Angermeyer MC, Bernert S, et al. Prevalence of mental disorders in Europe: results from the European Study of the Epidemiology of Mental Disorders (ESEMeD) project. Acta Psychiatr Scand Suppl 2004:21–27. [PubMed: 15128384]
41. Posada Villa JA, Aguilar-Gaxiola S, Magana C, Gomez LC. Prevalencia de Trastornos Mentales u Uso de Servicios: Resultados Preliminares del Estudio Nacional de Salud Mental, Colombia, 2003. Revista Colombiana de Psiquiatria. in press.
42. Olvera RL. Intermittent explosive disorder: epidemiology, diagnosis and management. CNS Drugs 2002;16:517–526. [PubMed: 12096933]
43. Costello EJ, Mustillo S, Erkanli A, Keeler G, Angold A. Prevalence and development of psychiatric disorders in childhood and adolescence. Arch Gen Psychiatry 2003;60:837–844. [PubMed: 12912767]
44. Lahey BB, Schwab-Stone M, Goodman SH, et al. Age and gender differences in oppositional behavior and conduct problems: a cross-sectional household study of middle childhood and adolescence. J Abnorm Psychol 2000;109:488–503. [PubMed: 11016118]
45. Scahill L, Schwab-Stone M. Epidemiology of ADHD in school-age children. Child Adolesc Psychiatr Clin N Am 2000;9:541–555. vii. [PubMed: 10944656]
46. Pary R, Lewis S, Matuschka PR, Rudzinskiy P, Safi M, Lippmann S. Attention deficit disorder in adults. Ann Clin Psychiatry 2002;14:105–111. [PubMed: 12238735]
47. Kessler, RC.; Berglund, PA.; Zhao, S., et al. The 12-month prevalence and correlates of serious mental illness (SMI). In: Manderscheid, RW.; Sonnenschein, MA., editors. Mental Health, United States, 1996. Washington, D.C: U.S. Government Printing Office; 1996. p. 59-70.
48. Kessler, RC. Epidemiology of psychiatric comorbidity. In: Tsuang, MT.; Tohen, M.; Zahner, GEP., editors. Textbook in Psychiatric Epidemiology. New York: John Wiley & Sons; 1995. p. 179-197.

NIH-PA Author Manuscript

NIH-PA Author Manuscript

NIH-PA Author Manuscript

49. Krueger RF. The structure of common mental disorders. Arch Gen Psychiatry 1999;56:921–926. [PubMed: 10530634]
50. Krueger RF, Chentsova-Dutton YE, Markon KE, Goldberg D, Ormel J. A cross-cultural study of the structure of comorbidity among common psychopathological syndromes in the general health care setting. J Abnorm Psychol 2003;112:437–447. [PubMed: 12943022]
51. Kessler, RC. The prevalence of psychiatric comorbidity. In: Wetzler, S.; Sanderson, WC., editors. Treatment Strategies for Patients with Psychiatric Comorbidity. New York, NY: John Wiley & Sons; 1997.
52. Bland RC, Orn H, Newman SC. Lifetime prevalence of psychiatric disorders in Edmonton. Acta Psychiatr Scand 1988;77:24–32.
53. Canino GJ, Bird HR, Shrout PE, et al. The prevalence of specific psychiatric disorders in Puerto Rico. Arch Gen Psychiatry 1987;44:727–735. [PubMed: 3498456]
54. Hwu HG, Yeh EK, Cheng LY. Prevalence of psychiatric disorders in Taiwan defined by the Chinese diagnostic interview schedule. Acta Psychiatr Scand 1989;79:136–147. [PubMed: 2923007]
55. Lee CK, Kwak YS, Yamamoto J, et al. Psychiatric epidemiology in Korea: part I. gender and age differences in Seoul. J Nerv Ment Dis 1990;178:242–246. [PubMed: 2319232]
56. Lépine JP, Lellouch J, Lovell A, et al. Anxiety and depressive disorders in a French population: methodology and preliminary results. Psychiatric Psychobiology 1989;4:267–274.
57. Wittchen H-U, Essau CA, von Zerssen D, Krieg CJ, Zaudig M. Lifetime and six-month prevalence of mental disorders in the Munich Follow-up Study. Eur Arch Psychiatry Clin Neurosci 1992;241:247–258. [PubMed: 1576182]
58. Wells JE, Bushnell JA, Hornblow AR, Joyce PR, Oakley-Browne MA. Christchurch Psychiatric Epidemiology Study, part I: methodology and lifetime prevalence for specific psychiatric disorders. Aust N Z J Psychiatry 1989;23:315–326. [PubMed: 2803144]
59. WHO International Consortium in Psychiatric Epidemiology. Cross-national comparisons of the prevalences and correlates of mental disorders. Bull World Health Organ 2000;78:413–426. [PubMed: 10885160]

NIH-PA Author Manuscript
NIH-PA Author Manuscript
NIH-PA Author Manuscript

Table 1

Twelve-month prevalence and severity of DSM-IV/WMH-CIDI disorders (n=9282)

		Severity[1]		
	Total	Serious	Moderate	Mild
	% (se)	% (se)	% (se)	% (se)
I. Anxiety Disorders				
Panic disorder	2.7 (0.2)	44.8 (3.2)	29.5 (2.7)	25.7 (2.5)
Agoraphobia without panic	0.8 (0.1)	40.6 (7.2)	30.7 (6.4)	28.7 (8.4)
Specific phobia	8.7 (0.4)	21.9 (2.0)	30.0 (2.0)	48.1 (2.1)
Social phobia	6.8 (0.3)	29.9 (2.0)	38.8 (2.5)	31.3 (2.4)
Generalized anxiety disorder	3.1 (0.2)	32.3 (2.9)	44.6 (4.0)	23.1 (2.9)
Post-traumatic stress disorder[2]	3.5 (0.3)	36.6 (3.5)	33.1 (2.2)	30.2 (3.4)
Obsessive-compulsive disorder[3]	1.0 (0.3)	50.6 (12.4)	34.8 (14.1)	14.6 (5.7)
Separation anxiety disorder[4]	0.9 (0.2)	43.3 (9.2)	24.8 (7.5)	31.9 (12.2)
Any anxiety disorder[5]	18.1 (0.7)	22.8 (1.5)	33.7 (1.4)	43.5 (2.1)
II. Mood Disorders				
Major depressive disorder	6.7 (0.3)	30.4 (1.7)	50.1 (2.1)	19.5 (2.1)
Dysthymia	1.5 (0.1)	49.7 (3.9)	32.1 (4.0)	18.2 (3.4)
Bipolar I-II disorders	2.6 (0.2)	82.9 (3.2)	17.1 (3.2)	0.0 (0.0)
Any mood disorder	9.5 (0.4)	45.0 (1.9)	40.0 (1.7)	15.0 (1.6)
III. Impulse-control Disorders				
Oppositional-defiant disorder[4]	1.0 (0.2)	49.6 (8.0)	40.3 (8.7)	10.1 (4.8)
Conduct disorder[4]	1.0 (0.2)	40.5 (11.1)	31.6 (7.5)	28.0 (9.1)
Attention-deficit/hyperactivity disorder[4]	4.1 (0.3)	41.3 (4.3)	35.2 (3.5)	23.5 (4.5)
Intermittent explosive disorder	2.6 (0.2)	23.3 (3.3)	74.4 (3.5)	1.7 (0.9)
Any impulse-control disorder[4, 6]	8.9 (0.5)	32.9 (2.9)	52.4 (3.0)	14.7 (2.3)
IV. Substance Disorders				
Alcohol abuse[2]	3.1 (0.3)	28.9 (2.6)	39.7 (3.7)	31.5 (3.3)
Alcohol dependence[2]	1.3 (0.2)	34.3 (4.5)	65.7 (4.5)	0.0 (0.0)

Arch Gen Psychiatry. Author manuscript; available in PMC 2010 March 30.

NIH-PA Author Manuscript NIH-PA Author Manuscript NIH-PA Author Manuscript

		Severity[1]		
	Total	Serious	Moderate	Mild
	% (se)	% (se)	% (se)	% (se)
Drug abuse[2]	1.4 (0.1)	36.6 (5.0)	30.4 (5.8)	33.0 (6.8)
Drug dependence[2]	0.4 (0.1)	56.5 (8.2)	43.5 (8.2)	0.0 (0.0)
Any substance disorder[2]	3.8 (0.3)	29.6 (2.8)	37.1 (3.5)	33.4 (3.2)
V. Any Disorder				
Any[5]	26.2 (0.8)	22.3 (1.3)	37.3 (1.3)	40.4 (1.6)
One disorder[5]	14.4 (0.6)	9.6 (1.3)	31.2 (1.9)	59.2 (2.3)
Two disorders[5]	5.8 (0.3)	25.5 (2.1)	46.4 (2.6)	28.2 (2.0)
Three or more disorders[5]	6.0 (0.3)	49.9 (2.3)	43.1 (2.1)	7.0 (1.3)

[1] Percentages in the three severity columns are repeated as proportions of all cases and sum to 100% across each row.

[2] Assessed in the Part II sample (n = 5692).

[3] Assessed in a random one-third of the Part II sample (n = 1808).

[4] Assessed in the Part II sample among respondents in the age range 18–44 (n = 3199).

[5] Estimated in the Part II sample. No adjustment is made for the fact that one or more disorders in the category were not assessed for all Part II respondents.

[6] The estimated prevalence of any impulse-control disorder is larger than the sum of the individual disorders because the prevalence of intermittent explosive disorder, the only impulse-control disorder that was assessed in the total sample, is reported here for the total sample rather than for the sub-sample of respondents among whom the other impulse-control disorders were assessed (Part II respondents in the age range 18–44). The estimated prevalence of any impulse-control disorder, in comparison, is estimated in the latter sub-sample. Intermittent explosive disorder has a considerably higher estimated prevalence in this sub-sample than in the total sample.

Arch Gen Psychiatry. Author manuscript; available in PMC 2010 March 30.

NIH-PA Author Manuscript NIH-PA Author Manuscript NIH-PA Author Manuscript

Table 2

Tetrachoric correlations among hierarchy-free 12-month DSM-IV/WMH-CIDI disorders and factor loadings from a principal axis factor analysis of the correlation matrix (n=3199)[1]

	PD	AG	SP	SoP	GAD	PTSD	OCD	SAD	MDE	DYS	MHE	ODD	CD	ADHD	IED	AA	AD	DA	DD
I. Anxiety Disorders																			
Panic disorder (PD)	1.0																		
Agoraphobia (AG)	.64*	1.0																	
Specific phobia (SP)	.49*	.57*	1.0																
Social phobia (SoP)	.48*	.68*	.50*	1.0															
Generalized anxiety disorder (GAD)	.46*	.45*	.35*	.47*	1.0														
Post-traumatic stress disorder (PTSD)	.49*	.47*	.44*	.43*	.44*	1.0													
Obsessive-compulsive disorder (OCD)[2]	.42	.44	.21	.16	.33	.57*	1.0												
Separation anxiety disorder (SAD)	.39*	.31	.32*	.34*	.36*	.49*	−.79	1.0											
II. Mood Disorders																			
Major depressive episode (MDE)	.48*	.52*	.43*	.52*	.62*	.50*	.42*	.37*	1.0										
Dysthymia (DYS)	.54*	.44*	.44*	.55*	.55*	.50*	.36	.41*	.88*	1.0									
Manic-hypomanic episode (MHE)	.51*	.52*	.39*	.46*	.49*	.44*	.40	.40*	.63*	.56*	1.0								
III. Impulse-control Disorders																			
Oppositional-defiant disorder (ODD)	.40*	.48*	.45*	.47*	.27*	.53*	.52	.46*	.48*	.48*	.55*	1.0							
Conduct disorder (CD)	.26	.24	.17	.28*	.07	.27	−.81	−.07	.12	.31	.32*	.50*	1.0						
Attention-deficit/hyperactivity disorder[3]	.38*	.42*	.34*	.51*	.46*	.43*	.26	.37*	.50*	.51*	.60*	.58*	.39*	1.0					
Intermittent explosive disorder (IED)	.32*	.35*	.27*	.30*	.31*	.21*	.25	.29	.39*	.36*	.43*	.37*	.42*	.38*	1.0				
IV. Substance Disorders																			
Alcohol abuse (AA)	.27*	.22	.10	.22*	.25*	.27*	.31*	.09	.24*	.33*	.37*	.29	.40*	.27*	.41*	1.0			
Alcohol dependence (AD)	.25	.33	.21*	.31*	.31*	.34*	.25	.10	.37*	.38*	.41*	.36	.39	.30	.37*	1.0*	1.0		
Drug abuse (DA)	.16	.08	.07	.22*	.24*	.14	.32	.06	.25*	.42*	.43*	.40	.41	.36*	.30*	.67*	.63*	1.0	
Drug dependence (DD)	.27	.29	.26	.44*	.35*	.25	.36	−.81*	.40*	.56*	.38*	.43	.44	.55*	.38*	.63*	.71*	1.0*	1.0
Prevalence	3.4	1.6	10.1	8.8	4.4	3.7	1.3	0.9	10.3	2.4	3.8	1.1	1.0	4.1	6.6	5.0	2.2	2.4	0.7

NIH-PA Author Manuscript NIH-PA Author Manuscript NIH-PA Author Manuscript

	PD	AG	SP	SoP	GAD	PTSD	OCD	SAD	MDE	DYS	MHE	ODD	CD	ADHD	IED	AA	AD	DA	DD
Percent comorbid	80	97	62	74	85	75	65	71	76	99	87	93	70	78	70	77	100	79	100
Factor 1[4]	.70	.76	.65	.71	.63	.64	--	--	.80	.74	.66	.60	.26	.60	.39	.11	.21	.08	.29
Factor 2[4]	.12	.09	.03	.18	.17	.16	--	--	.19	.33	.34	.34	.47	.34	.37	.89	.86	.92	.88

*Significant at the .05 level, two-sided test.

[1]Part II respondents in the age range 18–44 (n=3199).

[2]Assessed in a random one-third of the Part II sample among respondents in the age range 18–44 (n = 1025).

[3](ADHD)

[4]Varimax rotation

Arch Gen Psychiatry. Author manuscript; available in PMC 2010 March 30.

NIH-PA Author Manuscript NIH-PA Author Manuscript NIH-PA Author Manuscript

Table 3

The distribution of hierarchy-free 12-month DSM-IV/WMH-CIDI disorders (n=3199)[1]

	Respondents	Cases	Diagnoses[2]	Profiles[3]
	% (se)	% (se)	% (se)	%
Disorders				
0	66.4 (0.9)	--	--	-
1	16.9 (0.7)	50.3 (1.5)	23.2 (1.4)	3.9
2	7.6 (0.4)	22.7 (1.2)	20.9 (1.4)	17.1
3+	9.1 (0.6)	27.0 (1.8)	55.9 (2.4)	79.0

[1] Part II NCS-R respondents in the age range 18–44.

[2] The proportion of respondents with more than two diagnoses ranged from 3.8% with exactly three to 0.03% with 15 and averaged 4.5 diagnoses per respondent with more than two. When the diagnosis is taken as the unit of analysis, the results in this column show that more than half of all 12-month diagnoses occurred to respondents with three or more disorders.

[3] The 19 disorders generate 2^{19} (524,288) logically possible multivariate disorder profiles, of which 433 are observed in the sample of Part II respondents in the age range 18–44.

NIH-PA Author Manuscript NIH-PA Author Manuscript NIH-PA Author Manuscript

Table 4

Conditional probabilities and distributions of hierarchy-free 12-month DSM-IV/WMH-CIDI disorders based on a seven-class Latent Class Analysis (n=3199)[1]

	Class 1	Class 2	Class 3	Class 4	Class 5	Class 6	Class 7
	%	%	%	%	%	%	%
I. Within-class disorder prevalences							
Panic disorder	0.9	1.5	2.5	32.8	0.0	10.9	73.0
Agoraphobia	0.0	0.0	0.0	23.7	1.5	3.0	45.8
Specific phobia	4.8	15.6	2.0	53.0	25.4	36.0	83.9
Social phobia	2.1	15.9	3.6	51.3	40.2	41.0	88.4
Generalized anxiety disorder	0.1	13.2	3.5	23.2	0.0	38.6	50.5
Post-traumatic stress disorder	1.0	5.8	1.5	19.5	14.1	22.8	54.8
Major depressive episode/dysthymia	0.0	40.7	5.3	40.7	0.0	94.6	89.3
Manic-hypomanic episode	0.0	6.5	11.1	10.2	0.0	54.1	93.8
Oppositional-defiant disorder	0.0	1.1	1.3	0.7	15.9	11.7	39.3
Conduct disorder	0.3	0.3	3.0	0.0	15.0	6.7	11.9
Attention-deficit/hyperactivity disorder	0.9	5.9	0.0	7.7	39.0	56.2	64.0
Intermittent explosive disorder	1.4	12.7	22.1	14.6	21.8	40.5	45.1
Alcohol abuse or dependence	0.2	0.0	43.6	13.2	14.4	42.5	5.6
Drug abuse or dependence	0.0	0.0	21.5	0.0	11.9	31.2	5.2
II. Class prevalence	68.5	14.5	7.4	5.0	2.3	1.6	0.7
III. Within-class disorder distributions							
0	88.9	25.7	24.4	2.6	9.7	0.0	0.9
1	10.5	40.1	40.9	12.2	26.1	0.8	0.2
2	0.6	25.4	25.6	27.0	35.2	4.2	0.0
3+	0.0	8.9	9.1	58.2	29.0	95.0	98.8
IV. Within-class severity distributions							
None	86.8	25.1	23.8	2.6	9.5	0.0	0.9
Mild	7.6	22.7	28.5	23.2	30.7	1.3	0.2
Moderate	4.5	37.3	30.7	40.0	44.5	28.1	5.2
Serious	1.1	14.9	17.0	34.2	15.2	70.5	93.8

[1] Part II respondents in the age range 18–44.

NIH-PA Author Manuscript NIH-PA Author Manuscript NIH-PA Author Manuscript

Table 5

Socio-demographic correlates (Odds-ratios) of Latent Class Analysis class membership probabilities (n=3199)[1]

	Class 1	Class 2	Class 3	Class 4	Class 5	Class 6	Class 7
	OR (95% CI)	OR (95% CI)	OR (95% CI)	OR (95% CI)	OR (95% CI)	OR (95% CI)	OR (95% CI)
I. Age							
18–29	0.9 (0.7–1.1)	0.9 (0.7–1.0)	1.4*(1.2–1.6)	0.8 (0.7–1.0)	1.4*(1.2–1.7)	1.1 (0.8–1.4)	1.0 (0.9–1.1)
30–44	1.0 --	1.0 --	1.0 --	1.0 --	1.0 --	1.0 --	1.0 --
χ^2_1	1.9	2.4	15.5*	3.1	14.2*	0.3	0.4
II. Sex							
Female	0.7*(0.6–0.9)	1.6*(1.4–1.8)	0.6*(0.5–0.7)	1.9*(1.7–2.2)	0.6*(0.6–0.7)	1.4*(1.1–1.7)	1.1 (0.9–1.2)
Male	1.0 --	1.0 --	1.0 --	1.0 --	1.0 --	1.0 --	1.0 --
χ^2_1	9.3*	52.2*	51.3*	87.0*	46.1*	9.5*	1.0
III. Race-Ethnicity							
Non-Hispanic White	1.0 --	1.0 --	1.0 --	1.0 --	1.0 --	1.0 --	1.0 --
Non-Hispanic Black	2.1*(1.4–3.0)	1.2 (1.0–1.4)	0.9 (0.8–1.1)	0.9 (0.7–1.0)	1.2 (1.0–1.4)	0.5*(0.4–0.7)	1.1 (0.9–1.2)
Hispanic	2.0*(1.3–3.0)	1.0 (0.8–1.2)	1.3*(1.0–1.7)	0.9 (0.7–1.1)	1.1 (0.9–1.3)	0.5*(0.4–0.8)	0.9 (0.8–1.0)
Other	0.9 (0.4–1.8)	1.0 (0.7–1.3)	0.8 (0.6–1.1)	0.9 (0.7–1.3)	1.4 (0.9–2.0)	1.1 (0.6–2.1)	1.2 (0.9–1.5)
χ^2_3	23.4*	4.4	7.8*	3.3	6.2	32.7*	5.9
IV. Education							
0–11	0.3*(0.2–0.5)	0.7*(0.5–1.0)	1.0 (0.7–1.3)	1.2 (1.0–1.6)	1.0 (0.7–1.3)	2.6*(1.7–4.0)	1.1 (0.9–1.4)
12	0.5*(0.4–0.8)	0.8*(0.7–0.9)	1.0 (0.8–1.3)	1.0 (0.8–1.3)	1.0 (0.8–1.2)	1.6*(1.2–2.2)	1.2*(1.0–1.3)
13–15	0.6*(0.4–0.9)	0.9 (0.8–1.1)	1.0 (0.9–1.2)	1.2 (1.0–1.5)	1.0 (0.8–1.2)	1.4*(1.1–1.9)	1.0 (0.9–1.1)
16+	1.0 --	1.0 --	1.0 --	1.0 --	1.0 --	1.0 --	1.0 --
χ^2_3	25.2*	18.5*	0.4	5.9	0.2	21.2*	7.8
V. Marital Status							
Married-cohabitating	1.0 --	1.0 --	1.0 --	1.0 --	1.0 --	1.0 --	1.0 --
Previously married	0.2*(0.1–0.4)	0.9 (0.7–1.1)	0.8 (0.6–1.2)	1.7*(1.2–2.3)	0.6*(0.5–0.9)	3.0*(1.9–4.8)	1.2 (0.9–1.6)
Never married	0.6*(0.4–0.8)	0.8*(0.7–0.9)	1.2 (1.0–1.5)	1.1 (0.9–1.3)	0.7*(0.6–0.9)	1.5*(1.1–2.0)	1.0 (0.8–1.2)
χ^2_2	32.5*	9.1*	6.1*	8.8*	13.3*	28.0*	1.7

62

NIH-PA Author Manuscript
NIH-PA Author Manuscript
NIH-PA Author Manuscript

	Class 1	Class 2	Class 3	Class 4	Class 5	Class 6	Class 7
	OR (95% CI)	OR (95% CI)	OR (95% CI)	OR (95% CI)	OR (95% CI)	OR (95% CI)	OR (95% CI)
VI. Family Income[2]							
Low	0.7 (0.4–1.2)	1.0 (0.7–1.3)	0.7*(0.6–0.9)	1.2 (0.9–1.6)	1.0 (0.8–1.2)	1.4 (0.9–2.1)	1.2 (1.0–1.5)
Low average	0.6*(0.4–1.0)	1.0 (0.8–1.3)	0.9 (0.7–1.1)	1.2 (0.9–1.6)	0.9 (0.7–1.2)	1.4 (1.0–2.0)	1.1 (0.9–1.3)
High average	0.7*(0.5–1.0)	1.0 (0.8–1.2)	1.0 (0.8–1.3)	1.2 (0.9–1.5)	1.0 (0.8–1.3)	1.4*(1.0–1.8)	1.0 (0.9–1.1)
High	1.0 --	1.0 --	1.0 --	1.0 --	1.0 --	1.0 --	1.0 --
χ^2_3	6.4	0.2	9.4*	2.7	1.7	7.3	3.5
VII. County Urbanicity[3]							
Central City (CC) 2M+	0.6*(0.4–0.8)	1.0 (0.8–1.3)	0.7*(0.6–0.9)	1.0 (0.8–1.3)	1.6*(1.3–2.0)	2.0*(1.4–2.8)	1.2*(1.1–1.4)
Central City (CC) <2M	0.6*(0.4–1.0)	1.1 (1.0–1.4)	0.7*(0.6–0.9)	1.1 (0.9–1.3)	1.6*(1.4–1.8)	1.6*(1.2–2.2)	1.3*(1.1–1.4)
Suburbs of CC 2M+	0.6*(0.4–0.8)	1.1 (0.8–1.5)	0.7*(0.6–0.9)	1.3*(1.1–1.6)	1.6*(1.3–1.9)	1.7*(1.3–2.3)	1.2*(1.0–1.5)
Suburbs of CC <2M	0.5*(0.3–0.8)	1.3*(1.1–1.6)	0.6*(0.5–0.8)	1.4*(1.1–1.7)	1.6*(1.4–1.9)	2.1*(1.5–2.9)	1.2* (1.0–1.4)
Adjacent Area	0.6*(0.4–0.8)	1.1 (1.0–1.4)	0.7*(0.6–0.8)	1.2*(1.0–1.5)	1.6*(1.2–2.0)	1.7*(1.3–2.1)	1.1 (1.0–1.3)
Rural Area	1.0 --	1.0 --	1.0 --	1.0 --	1.0 --	1.0 --	1.0 --
χ^2_5	19.6*	9.0	40.2*	12.6*	74.4*	41.6*	23.0*

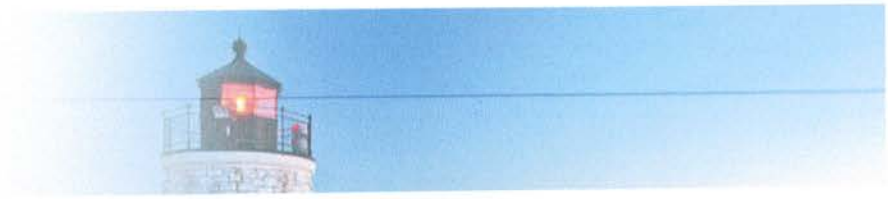
*Significant at the .05 level, two-sided test.

[1]Part II respondents in the age range 18–44.

[2]Family income is defined in relation to the official federal poverty line for families of the size and composition of the respondent's family.[18] Low income is defined as less than or equal to 1.5 times the poverty line, low-average as 1.5+ to 3 times the poverty line, high-average as 3+ to 6 times the poverty line, and high as greater than 6 times the poverty line.

[3]Coded according to the 2000 Census definitions.[19] Central Cities and Suburbs are defined by the Census Bureau for each consolidated Metropolitan Statistical Area and Metropolitan Statistical Area in the US. Adjacent Areas are defined as all area beyond the outer boundary of the suburban belt, but within fifty miles of the central business district of a Central City. Rural Areas include all territory more than fifty miles from the central business district of a Central City.

Arch Gen Psychiatry. Author manuscript; available in PMC 2010 March 30.



Useful Psychology Information: *Importance of Mental Health*

Mental Health Improves the Quality of Life

When we are free of depression, anxiety, excessive stress and worry, addictions, and other psychological problems, we are more able to live our lives to the fullest.

Peace of mind is a natural condition, and is available to everyone.

Mental health strengthens and supports our ability to:

- have healthy relationships
- make good life choices
- maintain physical health and well-being
- handle the natural ups and downs of life
- discover and grow toward our potential

Mental Health Treatment Reduces Medical Costs

Many research studies have shown that when people receive appropriate mental health care, their use of medical services declines. For example, one study of people with anxiety disorders showed that after psychological treatment, the number of medical visits decreased by 90%, laboratory costs decreased by 50%, and overall treatment costs dropped by 35%.

Other studies have shown that people with untreated mental health problems visit a medical doctor twice as often as people who receive mental health care.

Excessive anxiety and stress can contribute to physical problems such as heart disease, ulcers, and colitis. Anxiety and stress can also reduce the strength of the immune system, making people more vulnerable to conditions ranging from the common cold to cancer.

Psychological problems also increase the likelihood that people will make poor behavioral choices which can contribute to medical problems. Smoking, excessive alcohol or drug use, poor eating habits, and reckless behavior can all result in severe physical problems and the need for medical services.

Click here for research findings on medical cost offset of mental health treatment.

Mental Health is Good for Businesses

Businesses benefit when employees have good mental health. Mental health is associated with higher productivity, better performance, more consistent work attendance, and fewer workplace accidents.

Employers can strengthen and safeguard their businesses by choosing employee health plans with strong mental health benefits.

By eliminating the causes of productivity loss, absenteeism, and worker accidents, mental health services increase a company's efficiency, productive capacity, and quality of goods and services.

Click here for research findings on the effects of psychological problems in the workplace.

Peace of Mind: Buying Mental Health Insurance for Your Company -- An informational brochure for employers, produced by the Rhode Island Psychological Association.

P 401-736-2900
F 888-809-8191
E ripsych@ripsych.org

Rhode Island Psychological Association
1643 Warwick Avenue
PMB 103
Warwick, RI 02889

© Copyright 2014 Rhode Island Psychological Association

Numbers of Americans Affected by Mental Illness

- One in four adults–approximately 61.5 million Americans–experiences mental illness in a given year. One in 17–about 13.6 million–live with a serious mental illness such as schizophrenia, major depression or bipolar disorder.[1]
- Approximately 20 percent of youth ages 13 to 18 experience severe mental disorders in a given year. For ages 8 to 15, the estimate is 13 percent.[2]
- Approximately 1.1 percent of American adults—about 2.4 million people—live with schizophrenia.[3,4]
- Approximately 2.6 percent of American adults–6.1 million people–live with bipolar disorder.[4,5]
- Approximately 6.7 percent of American adults–about 14.8 million people–live with major depression.[4,6]
- Approximately 18.1 percent of American adults–about 42 million people–live with anxiety disorders, such as panic disorder, obsessive-compulsive disorder (OCD), posttraumatic stress disorder (PTSD), generalized anxiety disorder and phobias.[4,7]
- About 9.2 million adults have co-occurring mental health and addiction disorders.[8]
- Approximately 26 percent of homeless adults staying in shelters live with serious mental illness and an estimated 46 percent live with severe mental illness and/or substance use disorders.[9]
- Approximately 20 percent of state prisoners and 21 percent of local jail prisoners have "a recent history" of a mental health condition.[10]
- Seventy percent of youth in juvenile justice systems have at least one mental health condition and at least 20 percent live with a severe mental illness.[11]

Getting Mental Health Treatment in America

- Approximately 60 percent of adults[12], and almost one-half of youth ages 8 to 15 with a mental illness received no mental health services in the previous year.[13]
- African American and Hispanic Americans used mental health services at about one-half the rate of whites in the past year and Asian Americans at about one-third the rate.[14]
- One-half of all chronic mental illness begins by the age of 14; three-quarters by age 24.[15] Despite effective treatment, there are long delays–sometimes decades–between the first appearance of symptoms and when people get help.[16]

The Impact of Mental Illness in America

- Serious mental illness costs America $193.2 billion in lost earnings per year.[17]
- Mood disorders such as depression are the third most common cause of hospitalization in the U.S. for both youth and adults ages 18 to 44.[18]
- Individuals living with serious mental illness face an increased risk of having chronic medical conditions.[19] Adults living with serious mental illness die on average 25 years earlier than other Americans, largely due to treatable medical conditions.[20]
- Over 50 percent of students with a mental health condition age 14 and older who are served by special education drop out–the highest dropout rate of any disability group.[21]
- Suicide is the tenth leading cause of death in the U.S. (more common than homicide) and the third leading cause of death for ages 15 to 24 years.[22] More than 90 percent of those who die by suicide had one or more mental disorders.[23]
- Although military members comprise less than 1 percent of the U.S. population[24], veterans represent 20 percent of suicides nationally. Each day, about 22 veterans die from suicide.[25]

References

1 National Institutes of Health, National Institute of Mental Health. (n.d.). *Statistics: Any Disorder Among Adults.* Retrieved March 5, 2013, from http://www.nimh.nih.gov/statistics/1ANYDIS_ADULT.shtml
2 National Institutes of Health, National Institute of Mental Health. (n.d.). *Any Disorder Among Children*. Retrieved March 5, 2013, from http://www.nimh.nih.gov/statistics/1ANYDIS_CHILD.shtml
3 National Institutes of Health, National Institute of Mental Health. (n.d.) *The Numbers Count: Mental Disorders in America.* Retrieved March 5, 2013, from http://www.nimh.nih.gov/health/publications/the-numbers-count-mental-disorders-in-america/index.shtml
4 Prevalence numbers were calculated using NIMH percentages (cited) and 2010 Census data. Census data is available at: United States Census Bureau. (revised 2011). "USA [State & County QuickFacts]." Retrieved March 5, 2013, from http://quickfacts.census.gov/qfd/states/00000.html
5 National Institutes of Health, National Institute of Mental Health. (n.d.). *The Numbers Count: Mental Disorders in America.* Retrieved March 5, 2013, from http://www.nimh.nih.gov/health/publications/the-numbers-count-mental-disorders-in-america/index.shtml
6 *Ibid.*
7 National Institutes of Health, National Institute of Mental Health. (n.d.). *Statistics: Any Anxiety Disorder Among Adults.* Retrieved March 5, 2013, from http://www.nimh.nih.gov/statistics/1anyanx_adult.shtml
8 Substance Abuse and Mental Health Services Administration. (2012). *Results from the 2010 National Survey on Drug Use and Health: Mental Health Findings* NSDUH Series H-42, HHS Publication No. (SMA) 11-4667). Rockville, Md.: Substance Abuse and Mental Health Services Administration, 2012.
9 U.S. Department of Housing and Urban Development, Office of Community Planning and Development. (2011). *The 2010 Annual Homeless Assessment Report to Congress.* Retrieved March 5, 2013, from http://www.hudhre.info/documents/2010HomelessAssessmentReport.pdf
10 Glaze, L.E. & James, D.J. (2006, updated December). Mental Health Problems of Prison and Jail Inmates. *Bureau of Justice Statistics Special Report.* U.S. Department of Justice, Office of Justice Programs Washington, D.C. Retrieved March 5, 2013, from http://bjs.ojp.usdoj.gov/content/pub/pdf/mhppji.pdf
11 Skowyra, K.R. & Cocozza, J.J. (2007) Blueprint for Change: A Comprehensive Model for the Identification and Treatment of Youth with Mental Health Needs in Contact with the Juvenile Justice System. The National Center for Mental Health and Juvenile Justice; Policy Research Associates, Inc. The Office of Juvenile Justice and Delinquency Prevention. Delmar, N.Y: The National Center for Mental Health and Juvenile Justice; Policy Research Associates, Inc.
12Substance Abuse and Mental Health Services Administration. (2012). *Results from the 2010 National Survey on Drug Use and Health: Mental Health Findings* NSDUH Series H-42, HHS Publication No. (SMA) 11-4667). Rockville, Md.; Substance Abuse and Mental Health Services Administration, 2012.
13 National Institute of Mental Health. (n.d.). *Use of Mental Health Services and Treatment Among Children*. Retrieved March 5, 2013, from http://www.nimh.nih.gov/statistics/1NHANES.shtml
14 Agency for Healthcare Research and Quality. (2010). *2010 National Healthcare Disparities Report.* Agency for Healthcare Research and Quality, Rockville, MD. Retrieved January 2013, from http://www.ahrq.gov/research/findings/nhqrdr/nhdr10/index.html.
15 Kessler, R.C, et al. (2005). Lifetime prevalence and age-of-onset distributions of *DSM-IV* disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry*, 62(6), 593-602.
16 National Institutes of Health, National Institute of Mental Health. (2005). *Mental Illness Exacts Heavy Toll, Beginning in Youth.* Retrieved March 5, 2013, from http://www.nih.gov/news/pr/jun2005/nimh-06.htm
17 Insel, T.R. (2008). Assessing the Economic Costs of Serious Mental Illness. *The American Journal of Psychiatry.* 165(6), 663-665.
18 Wier, LM (Thompson Reuters), et al. *HCUP facts and figures: statistics on hospital-based care in the United States, 2009.* Web.. Rockville, Md. Agency for Healthcare Research and Quality, 2011. Retrieved March 5, 2013, from http://www.hcup-us.ahrq.gov/reports.jsp.
19 Colton, C.W. & Manderscheid, R.W. (2006). Congruencies in increased mortality rates, years of potential life lost, and causes of death among public mental health clients in eight states. *Preventing Chronic Disease: Public Health Research, Practice and Policy,* 3(2), 1-14.
20 Parks, J.,et al. (2006). *Morbidity and Mortality in People with Serious Mental Illness.* Alexandria, VA: National Association of State Mental Health Program Directors (NASMHPD) Medical Directors Council.
21 U.S. Department of Education. (2006). *Twenty-eighth annual report to Congress on the implementation of the Individuals with Disabilities Education Act, 2006, Vol. 2.* Washington, D.C.: U.S. Department of Education.
22 McIntosh, J.L.. & Drapeau, C.W. (for the American Association of Suicidology). (2012). *U.S.A. suicide: 2010 official final data.* Washington, D.C: American Association of Suicidology.
23 American Association of Suicidology. (2012). *Suicide in the USA Based on 2010 Data.* Washington, DC: American Association of Suicidology.
24 Martinez, L. & Bingham, A. (2011). U.S. Veterans: by the Numbers. Retrieved March 5, 2013, from http://abcnews.go.com/Politics/us-veterans-numbers/story?id=14928136
25 U.S. Department of Veterans Affairs, Mental Health Services, Suicide Prevention Program. (2013). *Suicide Data Report, 2012.* Retrieved March 5, 2013, from http://www.va.gov/opa/docs/Suicide-Data-Report-2012-final.pdf

Reviewed by Ken Duckworth, M.D., March 2013

Connecticut

Connecticut is a state of paradoxes. It strives to provide an excellent mental health care system and boasts many good conceptual ideas and interagency collaboration with the criminal justice system. However, the state's Department of Mental Health and Addiction Services (DMHAS) uses the word "gridlock" to describe its own system capacity failures. Mental health gridlock leaves people stuck in places they do not need to be, which is expensive and disruptive.

In 2006, the state received a grade of B. Three years later, its grade has stayed the same.

DMHAS is attempting to address many issues, but the state's budget shortfalls parallel the collapse of Wall Street. The state's challenge is to improve during a recession what it could not achieve in better times. Overuse of nursing homes and correctional settings and a U.S. Department of Justice (DOJ) report in 2007 documenting problems at Connecticut Valley Hospital (CVH) highlight the system's capacity failures. An Olmstead lawsuit is pending over the nursing home issue because of the failure to provide the least restrictive, appropriate treatment environments in communities for people with mental illnesses.

DMHAS is ahead of the curve in framing the system's mission based on recovery and co-occurring disorder treatment strategies. Historically, the state has been successful at obtaining federal grants to improve the system. Yale University is an academic partner that informs DMHAS vision and programming. Evidence-based practices are a priority for the state.

DMHAS has made great strides in collaborating with the state's law enforcement and correctional agencies. Court support services, supervised diversionary programs, and probation officer training are concrete examples of this important collaboration.

DMHAS has also recently developed a Military Support Program, a creative and comprehensive approach to aid military personnel and their families.

Innovations

- Military Support Program
- Collaboration with Department of Corrections
- Emerging electronic records capacity

Urgent Needs

- Increase community-based services
- Housing as an alternative to more restrictive placements
- End nursing home warehousing

Consumer and Family Comments

- *"Good services are available but not nearly enough, and many are languishing in prison or on the streets."*
- *"Trying to find a psychiatrist after being released from a hospital was nearly impossible and remains a crisis."*
- *"My family member was dumped in a nursing home where, in spite of my efforts, he eventually died."*

CVH is also moving forward. In anticipation of the harsh DOJ report in 2007, key CVH staff were fired and replaced. CVH is piloting a promising electronic information Recovery Management System. Although CVH had four suicides in four years, improvements in staffing, training, and monitoring appear likely to reduce this risk going forward. Connecticut also plans to reduce the overuse of nursing homes for people with serious mental illnesses. During 2006-2007, more than $7 million was lost in federal payments to state nursing homes because too many people with serious mental illnesses were being inappropriately warehoused there.

Connecticut's paradoxes do not inspire confidence among consumers and family members. The fact that the state receives a B reflects its sophisticated vision and willingness to address problems. However, for a person with schizophrenia stuck in a nursing home, or a family who loses a loved one to suicide inside a state facility, the system is failing.

Connecticut's citizens deserve far better.

Practice Guidelines for Recovery-Oriented Behavioral Health Care

Connecticut Department of Mental Health and Addiction Services

"No right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his[/her] own person, free from all restraint or interference of others, unless by clear and unquestioned authority of law."

— United States Supreme Court

(Union Pacific Railway Co. v. Botsford)

Prepared for the Connecticut Department of Mental Health and Addiction Services by the Yale University Program for Recovery and Community Health (Tondora & Davidson, 2006).

Forward by Commissioner Thomas A. Kirk, Jr., Ph.D.

The document that you are about to read is an extraordinary one in its origins, its content, and its value as another step toward achieving and maintaining a recovery-oriented health care service system in Connecticut.

In my view, if not *the* most important, the following document is one of the most significant products to result within the last five years from the public/private partnership composed of persons in recovery, families, staff and leadership of DMHAS, prevention specialists, private nonprofit service providers, the academic community, and other advocates and stakeholders. This collective group has focused on assessing and improving the quality of services available for persons with mental illness and/or substance use disorders in the State of Connecticut.

Consider a few of its origins. Listening to the suggestions and continuing guidance of those who need or use our services is one of the most basic and essential characteristics of a recovery-oriented service system. Thus, beginning in 1999 we asked Advocacy Unlimited, Inc. and the Connecticut Community for Addiction Recovery, Inc. to work together to develop a set of **Recovery Core Values** that could serve as guideposts for DMHAS as it began the journey of restructuring its service system. The result was 27 principles divided into four categories: **Direction, Participation, Programming and Funding/Operations.** Go to www.dmhas.state.ct.us, click on major Initiatives, then "Recovery Initiative" for further information about the Recovery Core Values.

Well before 1999, there had been "champions" of recovery in any number of state and private service sectors who understood the meaning of "recovery" and the importance of it in the lives and care of the people receiving services. They now had the opportunity to speak in a louder voice and educate the rest of us. We all stand on the shoulders of those who came before us.

DMHAS later hosted a few statewide Recovery Conferences, established a Recovery Institute and Centers of Excellence, and conducted a series of consensus-building retreats for executive directors, medical and clinical leadership, and several other stakeholder groups within the mental health and addiction service communities and elicited their views about the concept of recovery, what it would mean for their activities, and what gaps needed to be addressed and barriers removed for us to achieve a recovery-oriented system.

All of the above, and other work, led to the signing in September 2002 of **Commissioner's Policy Statement No. 83 on "Promoting a Recovery-Oriented Service System."** This landmark policy designated the concept of recovery as the overarching goal, guiding principle, and operational framework for the system of care supported by the DMHAS. It incorporated the Recovery Core Values. It stated that:

> ***"We shall firmly embed the language, spirit, and culture of recovery throughout the system of services, in our interactions with one another and with those persons and families who trust us with their care."***

In addition, this policy envisioned and mandated services characterized by:

"...a high degree of accessibility, effectiveness in engaging and retaining persons in care

...effects shall be sustained rather than solely crisis-oriented or short-lived

...age and gender appropriate, culturally competent, and attend to trauma and other factors know to impact on one's recovery

...whenever possible, shall be provided within the person's home community, using the person's natural supports."

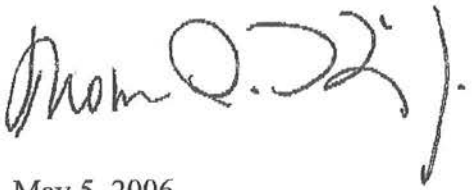
But how do you actually do a recovery-oriented service system? This key question remained after all of the above work and many current activities—too numerous to mention. Absent answers to this question, one may think "all this recovery stuff is conceptual ... it has no real meaning or practical reality. The focus will not really change our system."

The following document answers this question by identifying eight domains of a recovery-oriented service system ranging from degree of participation of persons in recovery in the recovery planning and system development process to "Identifying and Addressing Barriers to Recovery." It then lists a dozen or so concrete, practical and well-researched action steps or guidelines in each domain. It answers questions like: **"You will know when you are placing primacy on the participation of people in recovery when..."**

The document gives examples, identifies potential barriers, and uses the words of people in recovery to explain what each domain means and what they can expect in that domain. It includes a glossary and distinguishes a **Deficit-based Perspective** from a **Recovery-oriented, Asset-based Perspective**. As service providers review their Agency Recovery Assessment Plans and as DMHAS fiscal, service, and quality staff go about their business, they now will have a roadmap to inform policy, develop outcomes and funding strategies, and a framework to monitor our fidelity with the guidelines of a recovery-oriented health care system. Persons in recovery and other recipients of services will know what to expect, what they need to be educated about, and what they have a right to demand in their interactions with the system.

It is said that successful initiatives have a thousand fathers and mothers and failed initiatives are orphans. I believe our journey to a recovery-oriented and transformed service system has many parents. I hope this document will help those who either cannot understand or who have not yet embraced a recovery-oriented service system to become another parent of this journey.

I would welcome any comments about the above or your opinion of this document at Thomas.Kirk@po.state.ct.us.



May 5, 2006

Table of Contents

Executive Summary

Introduction

Defining Our Terms

Recovery

From Recovery to Recovery-Oriented Care

Practice Guidelines

A. Primacy of Participation

B. Promoting Access and Engagement

C. Ensuring Continuity of Care

D. Employing Strengths-Based Assessment

E. Offering Individualized Recovery Planning

F. Functioning as a Recovery Guide

G. Community Mapping, Development, and Inclusion

H. Identifying and Addressing Barriers to Recovery

Recommended Resources for Further Reading

Appendix

Glossary of Recovery-Oriented Language

Examples of Strengths-Based Conceptualizations

Executive Summary

The notion of recovery has become the focus of a considerable amount of dialogue and debate between and among various constituencies within the mental health and addiction communities. Following a brief introduction to the topic, in which we clarify various sources of confusion about the term, these practice guidelines begin to operationalize the various components of DMHAS' vision of a recovery-oriented system of behavioral health care. This vision was first put forth in Commissioner's Policy #83, "Promoting a Recovery-Oriented Service System," and has since been embodied in various DMHAS education, training, and program development initiatives. These guidelines represent the first systematic effort to bring recovery into the concrete everyday practice of DMHAS-funded providers.

Defining our Terms

One major source of the confusion surrounding use of the term in recovery in behavioral health derives from a lack of clarity about the respective roles of behavioral health practitioners and those of people with behavioral health disorders themselves. For the purposes of this document, we offer the following two definitions which we have found to distinguish usefully between the process of recovery (in which the person him or herself is engaged) and the provision of recovery-oriented care (in which the practitioner is engaged).

> ***Recovery*** *refers to the ways in which a person with a mental illness and/or addiction* ***experiences*** *and* ***manages*** *his or her disorder in the process of reclaiming his or her life in the community.*

> ***Recovery-oriented care*** *is what psychiatric and addiction treatment and rehabilitation practitioners* ***offer*** *in support of the person's recovery.*

Practice Guidelines

A. Primacy of Participation

An essential characteristic of recovery-oriented behavioral health care is the primacy it places on the participation of people in recovery and their loved ones in all aspects and phases of the care delivery process. Participation ranges from the initial framing of questions or problems to be addressed and design of the capacity and needs assessments to be conducted, to the delivery, evaluation, and monitoring of care, to the design and development of new services, interventions, and supports.

Practice guidelines to be included in this domain:

A.1. People in recovery are routinely invited to share their stories with current service recipients and/or to provide training to staff.

A.2. People in recovery comprise a significant proportion of representatives to an agency's board of directors, advisory board, or other steering committees and work groups.

A.3. Agencies reimburse people for the time they spend providing input into services, providing peer support and mentoring, and/or providing educational and training sessions for clients or staff.

A.4. Each person served is provided with an initial orientation to agency practices.

A.5. Initial orientation is supplemented by the routine availability of information and agency updates to people in recovery and their loved ones.

A.6. Policies are established and maintained that allow people in recovery maximum opportunity for choice and control in their own care.

A.7. Measures of satisfaction are collected routinely and in a timely fashion from people in recovery and their loved ones.

A.8. Formal grievance procedures are established and made readily available to people in recovery and their loved ones to address their dissatisfaction with services.

A.9. Administration enforces ethical practice (e.g., "first, do no harm") through proactive human resource oversight.

A.10. Assertive efforts are made to recruit people in recovery for a variety of staff positions for which they are qualified.

A.11. Active recruitment of people in recovery for existing staff positions is coupled with ongoing support for the development of a range of peer-operated services that function independent of, but in collaboration with, professional agencies.

A.12. Self-disclosure by employed persons in recovery is respected as a personal decision and is not prohibited by agency policy or practice.

A.13. Staff encourage individuals to claim their rights and to make meaningful contributions to their own care and to the system as a whole.

A.14. The agency offers to host local, regional, state, and/or national events and advocacy activities for people in recovery and their loved ones.

B. Promoting Access and Engagement

For every one person who seeks and/or receives behavioral health care for a diagnosable psychiatric disorder or addiction there are from two (in mental health) to six (in addiction) individuals, with similar conditions, who will neither gain access to nor receive such care. Recovery-oriented practitioners promote access to care by facilitating swift and uncomplicated entry and by removing barriers to receiving care. Engagement involves making contact with the person rather than with the diagnosis or disability, building trust over time, attending to the person's stated goals and needs and, directly or indirectly, providing a range of services in addition to clinical care.

Practice guidelines to be included in this domain:

B.1. The service system has the capacity to go where the potential client is, rather than always insisting that the client come to the service.

B.2. People can access a wide range of services from many different points.

B.3. There is not a strict separation between clinical and case management functions.

B.4. Assessment of motivation is based on a stages of change model, and interventions incorporate motivational enhancement strategies which assist providers in meeting each person where he or she is.

B.5. Staff look for signs of organizational barriers or other obstacles to care before concluding that a client is non-compliant or unmotivated.

B.6. Agencies have "zero reject" policies that do not exclude people from care based on symptomatology, substance use, or unwillingness to participate in prerequisite clinical or program activities.

B.7. Agencies have an "open case" policy which dictates that a person's refusal of services, despite intensive and long-term engagement efforts, does not require that he or she be dropped from the "outreach" list.

B.8. The system builds on a commitment to and practice of motivational enhancement, with reimbursement for pre-treatment and recovery management supports.

B.9. Outpatient addiction treatment clinicians are paired with outreach workers to capitalize on the moment of crisis that can lead people to accept treatment, and to gain access to their appropriate level of care.

B.10. Mental health and addiction practitioners, including people in recovery, are placed in critical locales to assist in the early stages of engagement.

B.11. The agency employs staff with first hand experience of recovery who have a special ability to make contact with and engage people into care.

B.12. Housing and support options are available for people who are not yet interested in, or ready for, detoxification, but who may begin to engage in their own recovery if housing and support are available to them.

B.13. The availability of sober housing is expanded to make it possible for people to go immediately from residential or intensive outpatient treatment programs into housing that supports their recovery.

C. Ensuring Continuity of Care

Recovery is seldom achieved from a single episode of care, so practitioners, as well as people in recovery, families, and policy makers, need to recognize that there are no quick fixes in behavioral health. Similar to other chronic illnesses, previous treatment of a person's condition also should not be taken to be indicative of a poor prognosis, non-compliance, or the person's not trying hard enough to recover. Relapses in substance use and exacerbations of psychiatric symptoms are to be viewed as further evidence of the severity of the person's condition rather than as causes for discharge. All of these principles suggest that treatment, rehabilitation, and support are not to be offered through serial episodes of disconnected care offered by different providers, but through a carefully crafted system that ensures continuity of the person's most significant healing relationships and supports over time and across episodes and agencies.

Practice guidelines to be included in this domain:

C.1. The central concern of engagement shifts from: "How do we get the client into treatment?" to: "How do we nest the process of recovery within the person's natural environment?"

C.2. Services are designed to be welcoming to all individuals and there is a low threshold (i.e., minimal requirements) for entry into care.

C.3. Eligibility and reimbursement strategies for outreach and engagement strategies are established and refined by administrative leadership.

C.4. People have a flexible array of options from which to choose and options are not limited to what "programs" are available.

C.5. Individuals are not expected or required to progress through a pre-determined continuum of care in a linear or sequential manner.

C.6. In a Recovery Management Model, an individual's stage of change is considered at all points in time, with the focus of care on enhancing existing strengths and recovery capital.

C.7. Goals and objectives in the recovery plan are not defined by staff based on clinically-valued outcomes (e.g., reducing symptoms, increasing adherence), but rather are defined by the person with a focus on building recovery capital and pursuing a life in the community.

C.8. The focus of care shifts from preventing relapse to promoting recovery.

C.9. Valued outcomes are influenced by a commitment to ensuring continuity of care and generating long-term effects in the lives of people in recovery.

C.10. The range of valued expertise is expanded beyond specialized clinical and rehabilitative professionals and technical experts to include the contributions of multiple individuals and services. These individuals may include peers in paid or volunteer positions, mutual aid groups, indigenous healers, faith community leaders, primary care providers, and other natural supports.

C.11. Individuals are seen as capable of illness self-management and interventions support this as a valued goal of recovery-oriented services.

C.12. New technologies (e.g., tele-medicine and web-based applications and self-help resources) are incorporated as service options to enhance illness self-management treatment relationships.

C.13. Access is enhanced to housing, employment, and other supports that make recovery sustainable.

C.14. Policy formulation and legislative advocacy at the administrative level is coupled with on-going efforts to work collaboratively with a variety of state systems to ensure continuity of care.

C.15. To facilitate sustained recovery and community inclusion, advocacy efforts are extended beyond institutional policies and procedures to the larger community, including stigma-busting, community education, and community resource development activities.

D. Employing Strengths-Based Assessment

Focusing solely on deficits in the absence of a thoughtful analysis of strengths disregards the most critical resources an individual has on which to build in his or her efforts to adapt to stressful situations, confront environmental challenges, improve his or her quality of life, and advance in his or her recovery. Strengths-based approaches allow providers to balance critical needs that must be met with the resources and strengths that people possess to assist them in this process.

Practice guidelines to be included in this domain:

D.1. A discussion of strengths is a central focus of every assessment, care plan, and case summary.

D.2. Initial assessments recognize the power of simple, yet powerful, questions such as "What happened? And what do you think would be helpful? And what are your goals in life?"

D.3. Staff interpret perceived deficits within a strengths and resilience framework, as this will allow the individual to identify less with the limitations of their disorder.

D.4. While strengths of the individual are a focus of the assessment, thoughtful consideration also is given to potential strengths and resources within the individual's family, natural support network, service system, and community at large.

D.5. The diversity of strengths that can serve as resources for the person and his or her recovery planning team is respected.

D.6. In addition to the assessment of individual capacities, it is beneficial to explore other areas not traditionally considered "strengths," e.g., the individual's most significant or most valued accomplishments, ways of relaxing and having fun, ways of calming down when upset, personal heroes, educational achievements, etc.

D.7. Assessments explore the whole of people's lives while ensuring emphasis is given to the individual's expressed and pressing priorities.

D.8. Assessments ask people what has worked for them in the past and incorporate these ideas in the recovery plan.

D.9. Guidance for completing the assessment may be derived from interviewing strategies used within solution-focused approaches to care.

D.10. Illness self-management strategies and daily wellness approaches such as WRAP are respected as highly effective, person-directed, recovery tools, and are fully explored in the assessment process.

D.11. Cause-and-effect explanations are offered with caution, as such thinking can lead to simplistic resolutions that fail to address the person's situation. In addition, simplistic solutions may inappropriately assign blame for the problem to the individual, with blame being described as "the first cousin" of deficit-based models of practice.

D.12. Assessments are developed through in-depth discussion with the person as well as attempts to solicit collateral information regarding strengths from the person's family and natural supports.

D.13. Efforts are made to record the individual's responses verbatim rather than translating the information into professional language.

D.14. Staff are mindful of the power of language and carefully avoid the subtle messages that professional language has historically conveyed to people with psychiatric disorders, addictions, and their loved ones.

D.15. Practitioners avoid using diagnostic labels as a means of describing an individual, as such labels often yield minimal information regarding the person's experience or manifestation of the illness or addiction.

D.16. Language used is neither stigmatizing nor objectifying. "Person first" language is used to acknowledge that the disability is not as important as the person's individuality and humanity.

D.17. Exceptions to person-first and empowering language that are preferred by some persons in recovery are respected.

E. Offering Individualized Recovery Planning

All treatment and rehabilitative services and supports to be provided shall be based on an individualized, multi-disciplinary recovery plan developed in partnership with the person receiving these services and any others that he or she identifies as supportive of this process. While based on a model of collaboration, significant effort is taken to ensure that individuals' rights to self-determination are respected and that all individuals are afforded maximum opportunity to exercise choice in the full range of treatment and life decisions. The individualized recovery plan will satisfy the criteria of treatment, service, or care plans required by other bodies (e.g., CMS) and will include a comprehensive and culturally sensitive assessment of the person's hopes, assets, strengths, interests, and goals and will reflect a holistic understanding of his or her behavioral health conditions, general medical concerns, and desires to build or maintain a meaningful life in the community

Practice guidelines to be included in this domain:

E.1. Core principles of "person-centered" planning are followed in the process of building individualized recovery plans. For example:

E.1.1. Consistent with the "nothing about us, without us" dictum, staff actively partner with the individual in all planning meetings and/or case conferences regarding his or her recovery services and supports.

E.1.2. The individual has reasonable control as to the location and time of planning meetings, as well as to who is involved.

E.1.3. The language of the plan is understandable to all participants, including the focus person and his or her non-professional, natural supports. Where technical or professional terminology is necessary, this is explained to all participants in the planning process.

E.1.4. When individuals are engaged in rehabilitation services (e.g., housing social, or educational/employment areas), rehabilitation practitioners are involved in all planning meetings (at the discretion of the individual) and are given copies of the resulting plan.

E.1.5. Within the planning process, a diverse, flexible range of options must be available so that people can access and choose those supports that will best assist them in their recovery.

E.1.6. Goals are based on the individual's unique interests, preferences, and strengths, and objectives and interventions are clearly related to the attainment of these stated goals.

E.1.7. Planning focuses on the identification of concrete next steps, along with specific timelines, that will allow the person to draw upon existing strengths to move toward recovery and his or her vision for the future.

E.1.8. Assessments begin with the assumption that individuals are the experts on their own recovery, and that they have learned much in the process of living with and working through their struggles.

E.1.9. Information on rights and responsibilities of receiving services is provided at all recovery planning meetings.

E.1.10. The individual has the ability to select or change his or her service providers within relevant guidelines and is made aware of the procedures for doing so.

E.1.11. In the spirit of true partnership and transparency, all parties must have access to the same information if people are to embrace and effectively carry out responsibilities associated with the recovery plan.

E.1.12. The team reconvenes as necessary to address life goals, accomplishments, and barriers.

E.2. A wide range of interventions and contributors to the planning and care process are recognized and respected. For example:

E.2.1. Practitioners acknowledge the value of the person's existing relationships and connections.

E.2.2. The plan identifies a wide range of both professional supports and alternative strategies to support the person's recovery, particularly those which have been helpful to others with similar struggles.

E.2.3. Individuals are not required to attain, or maintain, clinical stability or abstinence before they are supported by the planning team in pursuing such goals as employment.

E.2.4. Goals and objectives are driven by a person's current values and needs and not solely by commonly desired clinical/professional outcomes.

E.3. Community inclusion is valued as a commonly identified and desired outcome. For example:

E.3.1. The focus of planning and care is on how to create pathways to meaningful and successful community life and not just on how to maintain clinical stability or abstinence.

E.3.2. Recovery plans respect the fact that services and practitioners should not remain central to a person's life over time, and exit criteria from formal services are clearly defined.

E.3.3. Recovery plans consider not only how the individual can access and receive needed supports from the behavioral health system and the community, but how the individual can, in turn, give back to others.

E.3.4. Practitioners are mindful of the limited resources available for specialized services and focus on community solutions and resources first by asking "Am I about to recommend or replicate a service or support that is already available in the broader community?"

E.4. The planning process honors the "dignity of risk" and "right to fail" as evidenced by the following:

E.4.1. Prior to appealing to coercive measures, practitioners relentlessly try different ways of engaging and persuading individuals in ways which respect their ability to make choices on their own behalf.

E.4.2. Unless determined to require conservatorship by a judge, individuals are presumed competent and entitled to make their own decisions.

E.4.3. Practitioners are encouraged to offer their expertise and suggestions respectfully within the context of a collaborative relationship, outlining for the person the range of options and their possible consequences.

E.4.5. In keeping with this stance, practitioners encourage individuals to write their own crisis and contingency plans.

E.5. Administrative leadership demonstrate a commitment to both outcomes and process evaluation. For example:

E.5.1. Outcomes evaluation is a continuous process involving expectations for successful outcomes in a broad range of life domains.

E.5.2. There is a flexible application of process tools, such as fidelity scales, to promote quality service delivery.

F. Functioning as a Recovery Guide

The sentiment that "we're not cases, and you're not our managers" has been accepted increasingly as a fundamental challenge to the ways in which behavioral health care is conceptualized within a recovery-oriented system. Rather than replacing any of the skills or clinical and rehabilitative expertise that practitioners have obtained through their training and experience, the recovery guide model offers a useful framework in which these interventions and strategies can be framed as tools that the person can use in his or her own recovery.

Practice guidelines to be included in this domain:

F.1. The primary vehicle for the delivery of most behavioral health interventions is the relationship between the practitioner and the person in recovery. The care provided must be grounded in an appreciation of the possibility of improvement in the person's condition, offering people hope and/or faith that recovery is "possible for me."

F.2. Providers assess where each person is in relation to the various stages of change with respect to the various dimensions of his or her recovery.

F.3. Care is based on the assumption that as a person recovers from his or her condition, the addiction or psychiatric disorder then becomes less of a defining characteristic and more simply one part of a multi-dimensional sense of identity that also contains strengths and competencies.

F.4. Interventions are aimed at assisting people in gaining autonomy, power, and connections with others.

F.5. Opportunities and supports are provided for the person to enhance his or her own sense of personal and social agency.

F.6. Individuals are allowed the right to make mistakes, and this is valued as an opportunity for them to learn.

F.7. People are allowed to express their feelings, including anger and dissatisfaction, without having these reactions attributed to the illness.

F.8. Care is not only attentive to cultural differences across race, ethnicity, and other distinctions of difference (e.g., sexual orientation), but incorporates this sensitivity at the level of the individual.

F.9. Rather than dwelling on the person's distant past or worrying about the person's long-term future, practitioners focus on preparing people for the next one or two steps of the recovery process by anticipating what lies immediately ahead, by focusing on the challenges of the present situation, and by identifying and helping the person avoid or move around potential obstacles in the road ahead.

F.10. Interventions are oriented toward increasing the person's recovery capital as well as decreasing his or her distress and dysfunction.

F.11. Practitioners are willing to offer practical assistance in the community contexts in which their clients live, work, learn, and play.

F.12. Care is not only provided in the community but is also oriented toward increasing the quality of a person's involvement in community life.

F.13. Efforts are made to identify sources of incongruence between the person and his or her environment and to increase person-environment fit.

F.14. In order to counteract the often hidden effects of stigma, practitioners explicitly draw upon their own personal experiences when considering the critical nature of various social roles in the lives of all individuals, continuing to view people in recovery squarely within the context of their daily lives.

F.15. Rather than devaluing professional knowledge, the "recovery guide" approach moves behavioral health much closer to other medical specialties in which it is the health care specialist's role to assess the person, diagnose his or her condition, educate the person about the costs and benefits of the most effective interventions available to treat his or her condition, and then provide the appropriate interventions.

F.16. Recovery is viewed as a fundamentally social process, involving supportive relationships with family, friends, peers, community members, and practitioners

G. Community Mapping and Development

Given its focus on life context, one tool required for effective recovery planning and the provision of recovery-oriented care is adequate knowledge of the person's local community, including its opportunities, resources, and potential barriers. Community mapping and development are participatory processes that involves persons in mapping the resources and capacities of a community's individuals, its informal associations, and its structured institutions, as a means of identifying existing, but untapped or overlooked, resources and other potentially hospitable places in which the contributions of people with disabilities and/or addiction will be welcomed and valued.

Practice guidelines to be included in this domain:

G.1. People in recovery are viewed primarily as citizens and not as clients and are recognized for the gifts, strengths, skills, interests, and resources they have to contribute to community life.

G.2. Community leaders representing a range of community associations and institutions work together with people in recovery to carry out the process of community development.

G.3. Opportunities for employment, education, recreation, social and civic involvement, and religious participation are regularly identified and are compiled in asset maps, capacity inventories, and community guides.

G.4. Asset maps and capacity inventories created collaboratively by actively involved community stakeholders reflect a wide range of *natural* gifts, strengths, skills, knowledge, values, interests, and resources available to a community through its individuals, associations, and institutions.

G.5. Value is placed on the less formal aspects of associational life that take place in neighborhood gatherings, block watch meetings, salons, coffee clatches, barbershops, book groups, etc.

G.6. Institutions do not duplicate services that are widely available in the community through individuals and associations.

G.7. Community development is driven by a creative, capacity-focused vision identified and shared by community stakeholders.

G.8. The relational process of gathering information about community assets and capacities through personal interviews and sharing of stories is recognized as being as important as the information that is collected.

H. Identifying and Addressing Barriers to Recovery

There currently are elements and characteristics of the service delivery system and the broader community that unwittingly contribute to the creation and perpetuation of chronicity and dependency in individuals with behavioral health disorders. There also are several aspects of behavioral health disorders and their place within contemporary society that complicate the person's efforts toward recovery. The competent behavioral health care practitioner will have tools and strategies for identifying and addressing these barriers to recovery.

Practice guidelines to be included in this domain:

H.1. **There is a commitment at the local level to embrace the values and principles of recovery-oriented care and to move away from the dominant illness-based paradigm. Systemic changes that reflect this paradigm shift include the following:**

H.1.1. Stakeholders understand the need for recovery-oriented system change as a civil rights issue which aims to restore certain elementary freedoms to American citizens with psychiatric disorders and/or addictions.

H.1.2. Stakeholders work together to move away from the criteria of "medical necessity" toward "human need," from managing illness to promoting recovery, from deficit-oriented to strengths-based, and from symptom relief to personally-defined quality of life.

H.1.3. The possibility of recovery, and responsibility for delivering recovery-oriented care, are embraced by stakeholders at all levels of the system.

H.2. Systemic structures and practices which impede the adoption of recovery-oriented practices are identified and addressed. Representative change strategies in this area include the following:

H.2.1. Sequential movement through a pre-existing continuum of care is no longer required, as it is inconsistent with a civil rights perspective and contradicts current knowledge suggesting that recovery is neither a linear process nor a static end product or result.

H.2.2. Agencies need to have coordinating structures to attend to both the prioritization and integration of the range of new initiatives, policies, and procedures they are attempting to implement at any given time.

H.2.3. Performance and outcome indicators need to reflect the fact that the desired goal of recovery-oriented care is to promote growth, independence, and wellness; goals which sometimes involve the taking of reasonable risks that may result in interim setbacks.

H.2.4. Continual quality assurance and independent audits are conducted by people in recovery and families trained in recovery-oriented care.

H.2.5. Initial placement and service design are driven as much by the person's perception of what services and supports would be most helpful as by the staff's assessments of what the individual seeking services needs.

H.2.6. Recovery plans respect the fact that services and practitioners should not remain central to a person's life over time.

H.2.7. To integrate employment within the larger system, the task of assisting people in entering employment and education is made inherent to the responsibilities of the entire practitioner network, including those not specifically charged with supported employment or education tasks.

H.3. Implementation of recovery-oriented care needs to be facilitated, rather than impeded, by funding, reimbursement, and accrediting structures. Change strategies to address this issue include:

H.3.1. Even though Medicaid is funded by federal dollars, it remains primarily a state-administered program, and considerable flexibility exists in using these dollars to support innovative, community-based, supports.

H.3.2. Within existing funding structures, training and technical assistance can be provided to practitioners attempting to implement recovery-oriented practices to assist them in learning how to translate the wishes of people in recovery into reimbursable service goals and to describe their interventions in a manner that will generate payment.

H.3.3. Rather than being an add-on to existing services, transformation to recovery-oriented care begins with discovering ways to be creative and flexible within the constraints of existing resources.

H.3.4. Self-directed funding opportunities should be considered both on a collective basis and through individualized budget programs.

H.4. Training and staff development is prioritized as an essential function to increase individual practitioners' competencies in providing recovery-oriented care. Necessary change strategies to address this issue include the following:

H.4.1. As consensus emerges regarding the knowledge and skills needed to implement recovery-oriented care, this information must lead to the development of competency models, and these models must be disseminated broadly as guidance for training programs and licensing bodies which prepare and accredit providers of behavioral health care.

H.4.2. Once established, competency models should be incorporated in all human resource activities as a means of promoting accountability and quality improvement.

H.4.3. An analysis of staff's current competencies and self-perceived training needs should guide the development of on-going skill-building activities at the agency level.

H.4.4. Competency-based training must be coupled with on-going mentorship, enhanced supervision, recovery-oriented case conferences, and opportunities for peer consultation.

H.4.5. Clinical directors and agency leaders should be involved in ongoing training initiatives so that there is consistency between proposed recovery-oriented practices and the system's administrative structures.

H.4.6. Recovery-oriented care does ***not*** imply that there is no longer any role for the practitioner to play. Rather, the provider's role has changed from that of all-knowing, all-doing caretaker to that of coach, architect, cheerleader, facilitator, mentor, or shepherd—roles that are not always consistent with one's clinical training or experiences.

H.4.7. Training initiatives need to support people in recovery and families to develop their own capacity to self-direct their care and life decisions.

H.5. Forces at the societal level which undermine recovery and community inclusion are identified and addressed. Necessary change strategies to address this issue include the following:

H.5.1. Behavioral health practitioners have significant expertise to address the lack of basic resources and opportunities in the broader community, and are prepared to offer supportive guidance and feedback at both the individual and community level.

H.5.2. Community collaborations and education must be coupled with efforts on the part of behavioral health practitioners to recognize instances of discrimination, to understand relevant disability legislation, and to effectively utilize state and local resources.

H.5.3. Agencies are cautioned to avoid the establishment of 'one stop shopping' service programs which may inadvertently contribute to the perpetuation of discriminatory and unethical practices on the part of community members. We must continue to work with community partners to uphold their obligation to respect people with behavioral health disorders as citizens who have the right to be treated according to the principles of law that apply to all other individuals

H.5.4. Professionals and service recipients should be mindful of the limited resources available for specialized services and should focus on community solutions and resources first by asking "Am I about to recommend or replicate a service or support that is already available in the broader community?"

H.6. Certain internal barriers unique to behavioral health disorders are identified and addressed. Necessary change strategies to address these barriers include the following:

H.6.1. Staff appreciate the fact that, based on a complex interaction of the person's conditions and his or her past experiences in the behavioral health care system, people with behavioral health disorders may be reluctant to assume some of the rights and responsibilities promoted in recovery-oriented systems. They may initially express reluctance, fears, mistrust, and even disinterest when afforded the right to take control of their treatment and life decisions. Exploring and addressing the many factors influencing such responses is an important component of care.

H.6.2. Research indicates that many individuals with behavioral health disorders also have histories of trauma. Failure to attend to such histories may seriously undermine the treatment and rehabilitation enterprises, and further complicate the person's own efforts toward recovery.

H.6.3. Certain symptoms of illnesses may also pose direct impediments to the recovery process. In certain conditions, the elimination or reduction of symptoms may also come with great ambivalence, e.g., while episodes of mania can be destructive, they may include a heightened sense of creativity, self importance, and productivity that are difficult to give up. Being able to identify and address these and other sequelae requires knowledge and skill on the part of the clinical practitioner.

In each of the following sections, practitioners are given examples of what they are likely to hear from people in recovery when these guidelines have been implemented successfully. In addition, there is a list of recommended resources for further reading on transformation to recovery-oriented care, as well as a glossary of recovery-oriented language and examples of strengths-based conceptualizations that are proposed as alternatives to current deficit-based ones.

Introduction

The notion of recovery has become the focus of a considerable amount of dialogue and debate between and among various constituencies within the mental health and addiction communities. Prior to attempting to operationalize the various components of DMHAS' vision of a recovery-oriented system of care, we thought it important to clarify these confusions, some of which are due to the fact that the notion of recovery is in transition, moving gradually from a well-established vision among people with addictions or mental illnesses to exerting more influence on the practice of behavioral health care providers.

For example, being "in recovery" has long been the guiding vision and goal of self-help[1] within the addiction community. Primarily a force within self-help, however, this notion has not played as much of a role historically within the addiction service provider community, where concepts of treatment and relapse prevention have been more central. Having a fifty-year history of peaceful, if benign, co-existence, these two complementary approaches have recently entered into a period of partnership in which there is now considerable potential for them to build dynamically on each others' strengths to promote a unified and coherent vision of recovery among people with addictions.

Despite being a long-standing core value in addiction, the notion of "recovery" has emerged as a dominant force within mental health just within the last decade. Most recently, it has taken center stage through its prominent role in both the Surgeon General's *Report on Mental Health*[2] and the President's New Freedom Commission on Mental Health. In its influential *Final Report*, the Commission strongly recommended "fundamentally reforming" all of mental health care to be based on the goal of recovery[3]. In both of these reports, however—as well as in clinical and rehabilitative practice—there is considerable ambiguity and a tangible lack of clarity about what precisely is meant by recovery in mental health. As in addiction, much work remains to be done in mental health in developing a coherent and unified vision of recovery that can prove to be acceptable (as well as useful) to all involved parties.

---

[1] Derived from Alcoholics Anonymous, these so-called "12-step" groups have expanded to include many other addictions and life conditions, and have consistently been shown to help promote and maintain abstinence.

[2] Department of Health and Human Services. (1999). *Mental health: A report of the Surgeon General.* Rockville, MD: Substance Abuse and Mental Health Services Administration.

[3] Department of Health and Human Services. (2003). *Achieving the promise: Transforming mental health care in America.* Rockville, MD: Substance Abuse and Mental Health Services Administration, p. 4

Given its multiple and complicated parentage and the diverse constituencies involved, it is not surprising that it has been difficult to reach consensus on any one definition, or even on any one list of essential aspects, of the concept of recovery in behavioral health. For the sake of clarity—as well as to facilitate future discussions as these concepts continue to evolve—we propose the following distinction as a prelude to articulating the Guidelines that will be used to guide the development, monitoring, and evaluation of clinical and rehabilitative services and supports offered within a recovery-oriented system of behavioral health care. Rather than mutually exclusive, these two concepts are intended to be somewhat overlapping and complementary, with the eventual goal of being brought together into a unified vision that can be promoted equally by people in recovery, their loved ones, behavioral health care providers, and the community at large.

Defining our Terms

One major source of the confusion surrounding use of the term in recovery in behavioral health derives from a lack of clarity about the respective roles of behavioral health practitioners and those of people with behavioral health disorders themselves. For the purposes of this document, we offer the following two definitions which we have found to distinguish usefully between the process of recovery (in which the person him or herself is engaged) and the provision of recovery-oriented care (in which the practitioner is engaged).

- ***Recovery*** *refers to the ways in which a person with a mental illness and/or addiction* ***experiences*** *and* ***manages*** *his or her disorder in the process of reclaiming his or her life in the community.*

- ***Recovery-oriented care*** *is what psychiatric and addiction treatment and rehabilitation practitioners* ***offer*** *in support of the person's own recovery efforts.*

Recovery

Given that the notion of recovery derives from the self-help and self-advocacy communities in both addictions and mental health, the first definition of recovery refers to ***what people who have these conditions do to manage their mental illness and/or addiction and to claim or reclaim their lives in the community.*** In addition to managing the condition, this sense of recovery therefore also involves ***what people do to overcome the effects of being perceived as an addict or a mental patient***—including rejection from society, alienation from one's loved ones, poverty, substandard housing or homelessness, social isolation, unemployment, loss of valued social roles and identity, and loss of sense of self and purpose in life—in order to regain some degree of control over their own lives.

As experiences of being discriminated against are viewed as traumatic and irreversible, advocates also argue that a return to a pre-existing state of health (as another alternative definition of recovery) is not only impossible, but also would diminish the gains the person has had to make to overcome the disorder and its effects. Overcoming the scars of stigma requires the development and use of new muscles, often leaving people feeling stronger than prior to the onset of their illness.

Beginning with a common foundation, recovery in addiction and in mental health can then be seen to divide into two distinct, but at times parallel and at other times overlapping, paths. Before turning to the characteristics of recovery-oriented care, we provide a brief overview of the similarities and differences between these two paths to recovery. Given the high rate at which addiction and mental illness co-occur in the same person, we understand that any given individual may be involved in either, or both, of these paths at the same time. For the sake of clarity, it still may be useful to highlight a few of the salient differences between them prior to turning to their implications for care.

Addiction Recovery. Derived from the self-help community, people who are achieving or maintaining abstinence from drug or alcohol use following a period of addiction have described themselves as being "in" this form of recovery for over half a century. Being "in recovery" in this sense is meant to signify that the person is no longer actively using substances but, due to the long-term nature of addiction, continues to be vulnerable to relapses and therefore has to remain vigilant in

protecting his or her sobriety. In this tradition—in which continued vulnerability to relapse is seen as inherent to addiction—recovery does not connote cure, nor does it entail remission of the signs, symptoms, or other deficits of a disorder as is common to recovery in other medical illnesses. Unlike in most physical illnesses, people may consider themselves to be in recovery while continuing to be affected by their addiction.

People who are achieving or maintaining abstinence . . . have described themselves as being . . . in recovery for over half a century.

Based on this definition, it is possible that many people who have used substances to an extent that would have met current diagnostic criteria for an addition at one point earlier in their lives, but who are no longer actively using or having to focus on protecting their sobriety, would not consider themselves to be "in recovery." While for some people it may apply to the remainder of their lives, being in recovery from addiction appears to pertain more specifically to the period following active use in which the person is consciously and actively involved in remaining abstinent and in which there continues to be a sense of vulnerability to relapse. In this sense, recovery in addiction is not only hard-won but often has to be protected and reinforced through persistent vigilance and adherence to the self-help and other principles that made it possible in the first place.

In addition to being in recovery from the addiction, this process involves addressing the effects and side effects of the addiction as well. The self-help tradition recognizes that living life with an addiction generates many negative effects on one's life beyond the addiction *per se*, including detrimental effects on one's relationships, on one's ability to learn or work, and on one's self-esteem, identity, and confidence. With the toxic effects of addiction spreading to the person's life as a whole, this sense of being in recovery involves the person's efforts to abstain from substance use while also resuming increasing responsibility for his or her life. It thus often involves returning to school or work, making amends to others who have been hurt, repairing damaged relationships, and, in general, learning how to live a clean and sober life.

Recovery involves the person's efforts to abstain from substance use while resuming increasing responsibility for his or her overall life.

It also is true that for many people, achieving recovery may be the first time they have known how to live without their addiction, tracing its origins back to their earlier lives even prior to actual substance use. For these people, a clean and sober life is not so much restored by abstinence as it is created for the first time; a gain which they credit to their recovery above and beyond sobriety. It is not unusual in

such cases for people in recovery to believe they are now a better person for having gone through the addiction and recovery process than if they had never become addicted in the first place.

Mental Health Recovery. It was this same sense of being "in recovery" that was first introduced into the mental health community approximately thirty years ago through the self-help/consumer movement. In the process of its introduction into mental health, this sense of recovery took on a few characteristics specific to the history of the perception and treatment of mental illness in society. Being associated initially with being liberated from mental hospitals (many, if not all, of the first self-advocates were former inpatients), the mental health self-help community viewed itself first and foremost as a civil rights movement rather than as part of any treatment or rehabilitative enterprise.

For people with mental illnesses, prior to denoting anything like a cure or improvement in their psychiatric condition, recovery meant having one's civil rights restored as a full and contributing member of society. It meant no longer being defined entirely by one's mental illness (i.e., as a mental patient) and having, as a result, one's major life decisions—as well as one's day-to-day life activities—determined by others. In addition to advocating for the radical reform of involuntary commitment laws and inpatient care, advocates have since been active in identifying ways in which community services also have unwittingly perpetuated many of the discriminatory practices historically seen in institutional settings.

. . . prior to denoting anything like a cure or improvement in [one's] psychiatric condition, recovery meant having one's civil rights restored as a full and contributing member of society.

Within mental health, then, two related but distinct uses of the term recovery have emerged. While not inconsistent with use of the term within addiction, the first of these two senses acquires a different emphasis as an advocacy issue. This sense of recovery is proposed as a fundamental challenge to the "mentalism" which advocates see as continuing to permeate health and human services and to influence the ways in which people with psychiatric disabilities are treated both inside and outside of

mental health[4]. Similar to racism, sexism, and other forms of prejudice, a set of attitudes and mentalism involves that have the effect of associated behaviors of the general population to confining a segment ship. In this case, the discrimination is based on the belief that people with mental illness are more like children than adults, unable to make their own decisions, to function independently, or to take care of themselves. They thereby require the care and direction of well-intended others in order to meet their basic needs—whether this care and direction be provided, as earlier, in hospital settings or, as is now more common, through community services.

. . . recovery [poses] a fundamental challenge to . . . "mentalism"

Within this historical context, recovery has come to be a powerful rallying cry and tool in the advocacy movement's efforts to counteract mentalism and its legacy in the lives of people with mental illnesses. It has been fueled both by the personal conviction of people in recovery and by over thirty years of clinical research findings which consistently have demonstrated a broad heterogeneity in outcome over time and across domains of functioning in serious mental illness. Research has shown that mental illness not only comes and goes over time and varies significantly in severity and duration, but that even when a person is actively experiencing psychosis, it most often affects only some of the person's abilities, leaving other abilities intact.

Rather than subsuming the entirety of the person, mental illnesses are better understood—even in their most severe form—as disabilities that co-exist with other areas of competence within the context of the person's life.

Rather than subsuming the entirety of the person, mental illnesses are better understood—even in their most severe form—as disabilities that co-exist with other areas of competence within the context of the person's life.[5] Just as we would not assume that someone with a visual, auditory, or mobility impairment was unable to take care of him or herself because he or she could not see, hear, or ambulate unassisted, we need not assume that a person's mental illness renders him or her unable or

[4] Chamberlin, J. (1984). Speaking for ourselves: An overview of the Ex-Psychiatric Inmates' Movement. *Psychosocial Rehabilitation Journal, 2*, 56-63.

[5] Beginning with the World Health Organization's International Pilot Study of Schizophrenia launched in 1967, there have been a series of long-term, longitudinal studies conducted around the world that have produced a consistent picture of a broad heterogeneity in outcome for severe psychiatric disorders. With respect to schizophrenia, this line of research has documented partial to full recovery in between 45-65% of each sample. In this context, recovery has been defined narrowly as amelioration of symptoms and other deficits associated with the disorder and a return to a pre-existing healthy state. We now know that up to two thirds of people achieve even this narrowly-defined form of recovery from psychosis, with many others able to function independently despite continued symptoms. For more on this research, see Davidson, L., Harding, C.M. & Spaniol, L. (2005). *Recovery from severe mental illnesses: Research evidence and implications for practice.* Boston, MA: Center for Psychiatric Rehabilitation of Boston University.

incompetent to be in control of his or her life. As other people with disabilities may require Braille signs, visual indicators of doorbells or ringing telephones, or wheelchairs, people with mental illness may require similar social and environmental supports in order to function optimally in community settings. While we have just begun to learn to identify and offer such supports, this represents a very promising, and important, area for future growth and development.

It is at this juncture that the civil rights movement in mental health meets up with the sense of recovery used in addiction in order to promote an alternative vision of mental health recovery. This second sense of recovery involves viewing psychiatric disorder as only one aspect of a person who otherwise has assets, interests, aspirations, and the desire and ability to continue to be in control of his or her own life. Paralleling in some ways addiction recovery, this sense of recovery involves the person's assuming increasing control over his or her illness while reclaiming responsibility for his or her life; a life that previously had been subsumed by the disorder.

Recovery involves viewing psychiatric disorder as only one aspect of a person who otherwise has assets, strengths, interests, aspirations, and the desire and ability to continue to be in control of his or her own life.

In other respects, however, this sense of recovery differs from recovery in addiction. For example, being in recovery from an addiction invariably involves some degree of abstinence; it requires a change in the person's condition from being controlled by the addiction to the addiction being under at least some degree of the person's control. While vulnerability to relapse remains a core element of addiction recovery, a person who continues to use cannot be viewed as in recovery; i.e., active substance use in the context of a lack of awareness of the addiction, or in the lack of any progress made toward decreasing use, precludes recovery.

The same cannot be said, however, for mental illness. In this respect, mental health recovery borrows from the disability rights movement in arguing that recovery remains possible even while a person's condition may not change. A person with paraplegia does not have to regain his or her mobility in order to have a satisfying life in the community. Being in recovery similarly cannot require a cure or remission of one's psychiatric disorder or a return to a pre-existing state of health. Rather, it involves a redefinition of one's illness as only one aspect of a multi-dimensional person who is capable of identifying, choosing, and pursuing personally meaningful aspirations despite continuing to suffer the effects and side effects of the illness.

With recovery in both addiction and mental health now defined, it becomes more evident why we have said that recovery is ***what the person does***. Addiction treatment providers are well aware that they have not been able to make a person stop using drugs or alcohol. In this sense, addiction recovery has always been in the hands of the person with the addiction. What may be different about recovery-oriented care in the addiction field are the number of things practitioners can now do over time to increase a person's desire to choose abstinence through the use of motivational enhancement strategies. In mental health, however, the idea that recovery is what the person with the mental illness does is a less commonly accepted notion. With the assumption that mental illness incapacitates the person in his or her entirety, more of the focus has been on what practitioners can do to and for the person to alleviate his or her symptoms and suffering and enhance his or her functioning.

It is important to note that defining recovery in mental health as pertaining to what the person with the mental illness does in no way diminishes the importance of professional competence or the role of mental health care practitioners. What it does, instead, is to shift the responsibility for deriving maximum benefit from health care services from the educated and caring people who provide them to the person him or herself who needs to use them. Rather than devaluing professional knowledge and experience, this approach moves psychiatry much closer to other medical specialties in which it is the health care specialist's role to assess the person, diagnose his or her condition, educate the person about the costs and benefits of the most effective interventions available to treat his or her condition, and then provide the appropriate interventions. No matter how expert or experienced the practitioner, it is then ideally left up to the person and his or her loved ones to make decisions about his or her own care. It is not the practitioner's role or responsibility to make such health care decisions ***for*** the person.[6] The idea of recovery extends this conventional model of care to behavioral health as well.

This definition of . . . recovery in no way diminishes the importance of professional competence or the role of . . . health care practitioners.

[6] Emergency medicine provides another exception in cases in which the issue of informed consent/permission to treat is suspended temporarily in order to perform life-saving measures. Such situations certainly occur in behavioral health as well, in which practitioners must take action to protect an individual or the public in the event of emergency or crisis situations as narrowly defined by statutory laws (e.g., suicidality, homicidality, and grave disability). In these cases, practitioners have solid legal ground on which to stand in making decisions for the person (i.e., against his or her will). As in medicine, however, this transfer of authority can only be a temporary measure, in effect only for as long as an acute episode takes to resolve. In all other cases, the decision of a judge is required in the state of Connecticut in order to terminate or otherwise place limits on a person's autonomy through the appointment of a conservator of person or other means.

From Recovery to Recovery-Oriented Care

In suggesting how behavioral health might come to resemble more closely other forms of medical care, we have arrived at the point where recovery—i.e., what the person with a behavioral health condition does—comes into contact with recovery-oriented care—i.e., what practitioners of mental health and substance abuse treatment and rehabilitation offer in support of the person's recovery. As we have suggested above, our focus on the process of recovery as the unique journey of each individual should not be taken to suggest that there is no longer an integral role for services and supports.

This is no more true in behavioral health than in other forms of medicine. When we suggest that someone who has been in an accident follow a graduated plan of convalescence and exercise in order to regain his or her physical functioning, for example, we do not thereby diminish the importance of the orthopedist's role in assessing the impact of the trauma, setting the broken bones, and prescribing an exercise plan, which may then need to be implemented with the assistance of a physical therapist and the support of the person's family.

We know that while broken bones may heal of their own accord—with or without detriment to the person's functioning—they are more likely to heal completely with timely and effective care. Similarly, while the person might eventually regain his or her functioning following an accident without a graduated exercise plan or physical therapy, he or she is more likely to do so in an expedient and uncomplicated fashion, and is less likely to suffer unexpected setbacks, with the guidance of competent and experienced experts. Based on these considerations, we reject both assertions, either that: 1) the person will not benefit from professional intervention or 2) the orthopedist is responsible for the person's recovery. Although it is unquestionably each person's own recovery, this recovery can be substantially supported and facilitated by the assistance of competent and experienced practitioners. The fact that we find it necessary to make this point, perhaps repeatedly, derives mostly from the history of stigma, discrimination, and prejudice against people with behavioral health conditions rather than from any wish to devalue or diminish the role of behavioral health practitioners.

What, then, is the most appropriate role for the behavioral health care provider in relation to recovery? Similar to the example provided above, what the person in recovery is most in need of is information about the nature of his or her difficulties, education about the range of effective interventions available to overcome or compensate for these difficulties, access to opportunities to utilize these interventions in regaining functioning, and the supports required in order to be successful in doing so.

. . . what the person in recovery is most in need of is information about the nature of his or her difficulties, education about the range of effective interventions available to overcome or compensate for these difficulties, access to opportunities to utilize these interventions in regaining functioning, and the supports required in order to be successful in doing so.

Drawing from the orthopedic analogy, the person will need to exercise and resume use of those faculties most directly affected by his or her trauma. In the case of behavioral health conditions, these faculties include the person's cognitive, social, and emotional life as well as his or her sense of self, personal and social identity, and belonging within his or her community. If a person with a broken leg does not try to walk again, he or she will not regain the use of the leg that was broken. If a person with a psychiatric or substance use disorder does not try to reclaim responsibility for his of her life, he or she will be unable to regain his or her functioning. This fact poses a fundamental challenge to the provision of recovery-oriented care.

Like the proverbial horse that cannot be made to drink, recovery-oriented practitioners can create or enhance access for people in recovery to a variety of educational, vocational, social, recreational, and affiliational activities in the community. They cannot, however, make the decisions ***for*** the person as to which, if any, of these activities he or she will participate in and find enjoyable or meaningful. The challenge confronting recovery-oriented practitioners may not, in this way, be unique to behavioral health. Cardiologists, for example, cannot make their patients stick to a heart-healthy diet any more than oncologists can keep some of their patients from smoking. What complicates the picture in the case of behavioral health is the perception that the person's decision-making capacity is itself among the faculties most directly affected by the illness.

As both psychiatric and substance use disorders are currently viewed primarily to be diseases of the brain, such a concern is understandable. In and of itself, however, this concern cannot be taken to lead inevitably to the conclusion that other, well-intentioned, people must therefore step in and make decisions for the person. In certain, limited, circumstances practitioners are legally authorized, if not also obligated, to do so. These circumstances include imminent risk of harm to the person and/or others (i.e., homicidality, suicidality, grave disability). In most other circumstances, however, practitioners are left in the difficult position of having to honor—if not actively support—the person's decisions, even in cases in which the practitioner is persuaded that it is the illness, rather than the person's best judgment, which is driving the decision-making process.

In the absence of conservatorship, guardianship, or other legal mechanisms, practitioners can educate, inform, discuss, debate, and attempt to persuade the person to embrace some options rather than others. If the person is ever to regain his or her functioning, however, in the end she or he will have to be accorded, in Pat Deegan's terms, the "dignity of risk" and the "right to failure."[7] As is true in most components of recovery-oriented care, it requires concerted effort and reflection—and perhaps supervision—as well as compassion, for behavioral health practitioners to continue to view and treat the person as sitting in the driver's seat of his or her own life. Given the damage that these disorders can do to the person's self-esteem and confidence, though, it is difficult to imagine how recovery can be achieved through other means.

As suggested in the definition above, recovery-oriented care takes as its primary aim offering people with psychiatric and/or addictive disorders a range of effective and culturally-responsive interventions from which they may choose those services and supports which they find useful in promoting or protecting their own recovery. As further defined in Commissioner's Policy #83 on Recovery:

> *A recovery-oriented system of care identifies and builds upon each person's assets, strengths, and areas of health and competence to support the person in achieving a sense of mastery over mental illness and/or addiction while regaining his or her life and a meaningful, constructive sense of membership in the broader community.*

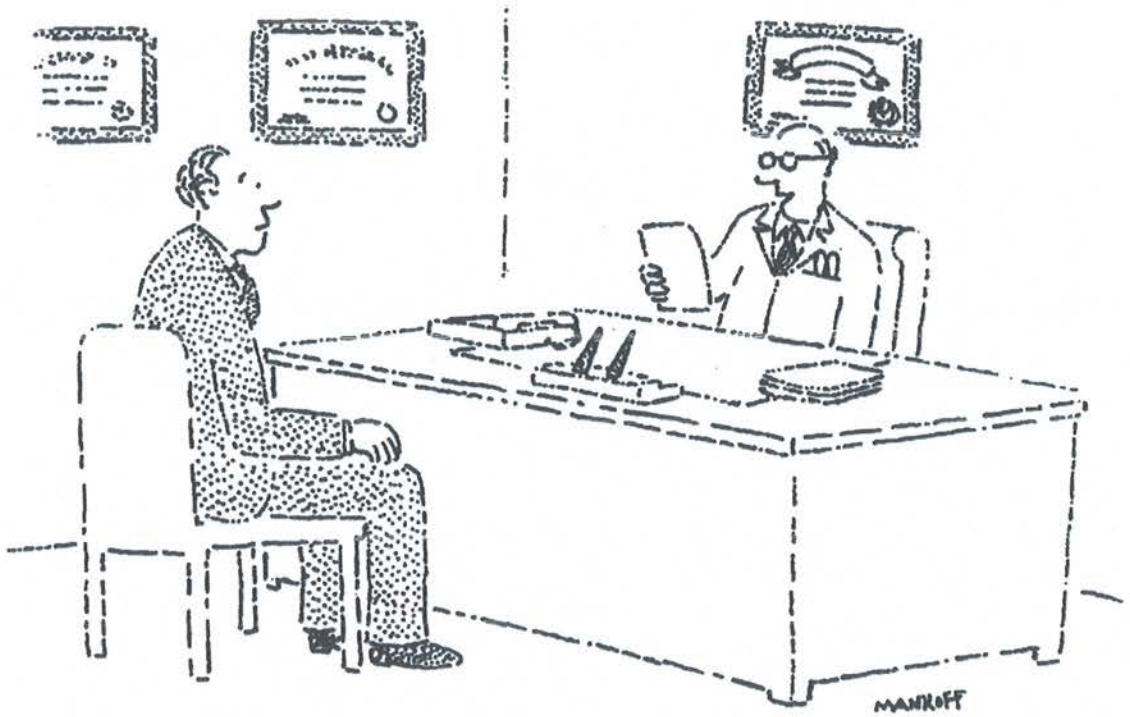
While the goal of recovery-oriented care may appear, in this way, to be relatively clear and straightforward, the ways in which care can be used to promote recovery are neither so clear nor so straightforward—neither, unfortunately, are the ways in which care, as currently configured, may impede or undermine recovery. The following guidelines are offered as a beginning roadmap of this territory, bringing together what we think we know at this point about how care can best promote and sustain recovery, and how care may need to be transformed to no longer impede it. These guidelines are drawn from over two years of conversations with practitioners, people in recovery, families, and program managers, and are informed by the current professional literature on recovery and recovery-oriented practice.

These guidelines focus primarily on the concrete work of practitioners and provider agencies so as to provide practical and useful direction to individuals and collectives that are committed to implementing recovery-oriented care. We recog-

---

[7]Deegan, P.E. (1992). The Independent Living Movement and people with psychiatric disabilities: Taking back control over our own lives. *Psychosocial Rehabilitation Journal, 15*, 3-19.

nize, however, that many of the practices described will require a broader commitment of agency leadership to significant and on-going administrative restructuring. We offer these guidelines as only one piece of a much larger whole, but as an important step forward in the overall process of system transformation. Equally important steps were taken in the past through the development of practice standards for culturally competent care[8] (which therefore are not duplicated here), and future efforts are planned to address the crucial roles of prevention and early intervention and the need for ongoing evaluation and monitoring of the outcomes of care.



"Well, this is a very impressive résumé, young man. I think you're going to make a fine patient."

[8] State of Connecticut Department of Mental Health and Addiction Services Office of Multicultural Affairs. (2001). *Multicultural behavioral healthcare: Best practice standards and implementation guidelines*. Hartford, CT: State of Connecticut Department of Mental Health and Addiction Services

Practice Guidelines for

Recovery-Oriented Behavioral Health Care

A. Primacy of Participation

B. Promoting Access and Engagement

C. Ensuring Continuity of Care

D. Employing Strengths-Based Assessment

E. Offering Individualized Recovery Planning

F. Functioning as a Recovery Guide

G. Community Mapping, Development, and Inclusion

H. Identifying and Addressing Barriers to Recovery

A. The Primacy of Participation

An essential characteristic of recovery-oriented behavioral health care is the primacy it places on the participation of people in recovery and their loved ones in all aspects and phases of the care delivery process. Beginning with the Federal Rehabilitation Act of 1973 and reaffirmed in 1990 in Public Law 99-660, federal and state governments have mandated the involvement of people with behavioral health disorders in all components of designing and implementing systems of community-based behavioral health care. This mandate has been confirmed consistently in numerous federal and state statutes and regulations issued since, and forms the foundation of CT DMHAS's Recovery and System Transformation Initiative.

For the involvement of people in recovery and their families to be meaningful and substantive, it must go well beyond asking them to sign off on provider-driven treatment plans or to endorse the adoption or replication of practitioner-driven models of care. Recovery-oriented care requires that people in recovery be involved in all aspects and phases of the care delivery process, from the initial framing of questions or problems to be addressed and design of the capacity and needs assessments to be conducted, to the delivery, evaluation, and ongoing monitoring of care, to the design and development of new services, interventions, and supports.

As recovery is what the person with the behavioral health condition ***does***, rather than something that can be done ***to*** or ***for*** the person by a care provider, people in recovery, by definition, are understood to be the foremost experts on their own needs and preferences for assistance in managing their condition and reconstructing their lives. As a result, recovery-oriented care consistently elicits and is substantially informed by the input and involvement of people in recovery across all levels, from recovery planning led by individual clients (see Section E, Individualized Recovery Planning), to program development and evaluation, to policy formulation.

You will know that you are placing primacy on the participation of people in recovery when:

A.1.	People in recovery are routinely invited to share their stories with current service recipients and/or to provide training to staff.
A.2.	People in recovery comprise a significant proportion of representatives to an agency's board of directors, advisory board, or other steering committees and work groups. Persons in recovery are provided orientation to their committee role by the chair, and actively contribute to the group process. Their involvement in these groups is reflected in meeting minutes and in decision-making processes.

A.3. The input of people in recovery is valued, as embodied in the fact that the agency reimburses people for the time they spend participating in service planning, implementation, or evaluation activities, providing peer support and mentoring, and/or providing educational and training sessions for clients or staff. Where system involvement is a mutually negotiated volunteer activity, people in recovery are reimbursed for out of pocket expenses that may be associated with their participation.

A.4. Each person served is provided with an initial orientation to agency practices regarding client rights, complaint procedures, treatment options, advance directives, access to their records, advocacy organizations (e.g., PAMI, Human Rights Commission), rehabilitation and community resources, and spiritual/chaplaincy services. Contact information on program staff and agency leaders is made available. Provision of orientation is documented in the person's record.

A.5. Initial orientation is supplemented by the routine availability of information and agency updates to people in recovery and their loved ones. This information is provided in a variety of formats (e.g., information tables, service directories, educational programs, newsletters, web postings, etc.) to enable people in recovery and their loved ones to make informed choices about treatments, rehabilitation, and supports and to provide meaningful input about program and agency performance. Feedback is regularly solicited from people in recovery and their loved ones regarding their informational needs.

A.6. Policies are established and maintained that allow people in recovery maximum opportunity for choice and control in their own care. For example, people in recovery are able to a) access their records with minimal barriers, b) incorporate psychiatric advance directives in their recovery and crisis plans, c) secure the services of local or state advocacy services as necessary, d) request transfer to an alternative provider within agency guidelines, and e) participate actively in agency planning activities. These policies and procedures are highlighted on agency admission and are routinely publicized throughout the agency through newsletters, educational postings, Consumer Empowerment Councils, etc. This process is particularly crucial within services such as "money management" where the line between providing a service and infringing on people's rights can easily be blurred in the absence of clear programmatic guidelines and safeguards.

A.7. Measures of satisfaction with services and supports are collected

routinely and in a timely fashion from people in recovery and their loved ones. These data are used in strategic planning and quality improvement initiatives to evaluate and make meaningful changes in programs, policies, procedures, and interventions. Feedback mechanisms are in place to inform people in recovery and their loved ones of changes and actions taken based on their input.

A.8. Formal grievance procedures are established and made readily available to people in recovery and their loved ones to address their dissatisfactions with services. People in recovery and their loved ones are fully informed about these procedures on a regular basis, and the frequency and focus of grievances are tracked to inform agency or program quality improvement processes.

A.9. Administration enforces ethical practice through proactive human resource oversight. This oversight prohibits the use of coercive practices, and holds all staff accountable for affording people in recovery maximum control over their own treatment and rehabilitation.

A.10. Assertive efforts are made to recruit people in recovery for a variety of staff positions for which they are qualified. These include positions for which their personal experience of disability and recovery make them uniquely qualified (e.g., peer support), as well as positions for which they are qualified by virtue of licensure (e.g., nursing, psychiatry) or other training or work experience (clerical, administrative, medical records, etc.). Assertive efforts include establishing mentoring programs for employees in recovery so they can advance in their skills and attain the necessary credentialing that will allow them to occupy a more diverse range of agency positions.

A.11. Active recruitment of people in recovery for existing staff positions is coupled with ongoing support for the development of a range of peer-operated services that function independent of, but in collaboration with, the professional agency. This will help to ensure that the recovery community's role is supported, while avoiding co-opting by transforming it into an adjunct service provider. As one example, recovery community centers operated by people in recovery should be available in all areas. Such recovery centers are neither treatment centers nor social clubs. They are places where people who are interested in learning about recovery can meet with other non-professionals to get support, learn about recovery and treatment resources, and simply find people to talk to. Agencies can demonstrate their support for peer-operated services by offering material and supervisory support to

emerging programs. For example, technical assistance or mentoring regarding business management, attainment of 501(c)3 status, human resource practices, etc., can greatly facilitate the establishment and long-term viability of emerging peer-operated services. Care should be taken to ensure capacity-building and enhanced independence in the peer-operated program over time. As with all community support programs, peer-operated services should be well integrated with the agency at large in terms of committee membership and with recovery planning at the individual level.

A.12. Self-disclosure by employed persons in recovery is respected as a personal decision and is not prohibited by agency policy or practice. Supervision is available to discuss the complex issues which can arise with self-disclosure.

A.13. Staff appreciate that many people in recovery may not, at first, share the understanding that they are the foremost experts on the management of their own condition. Persons who have come to depend upon services and professionals to alleviate their distress may neither believe themselves capable of being the expert nor recognize that they are entitled to occupy this role. Therefore, staff encourage individuals to claim their rights and to make meaningful contributions to their own care and to the system as a whole. For example, individuals are encouraged to become involved in local and state advocacy as a means of developing their confidence and skills in self-determination and collective action, agency efforts to enhance the participation of service users are widely publicized to the recovery community, and general education is offered regarding the necessity of active service-user involvement to achieve recovery outcomes. While people are to be encouraged to become involved at all levels of the system, not everyone will want to participate beyond the primary level of involvement, i.e., their personal recovery plan. As in other areas of self-determination, this too is respected as a valid choice.

A.14. The agency offers to host local, regional, and/or state events and advocacy activities for people in recovery and their loved ones, e.g., meetings of 12-step fellowships, Connecticut Community for Addiction Recovery, Advocacy Unlimited, and Focus on Recovery-United.

What you will hear from people in recovery when you are placing primacy on their participation:

- *You know, at first I thought, "What do I know or what could I possibly say at this meeting?" But then, I could tell that what I had to say made a difference. People were really listening to me. I finally got a place at the table!*

- *I knew I was in recovery when I could help somebody else that was in the same awful place I used to be. But I think about where I am today: healthy, and drug free, and being a real Grandma. And getting back in the work field as a peer provider makes me feel good; makes me understand that I can do this. I can really do this. And if I could do this, anybody can do this. Folks get hope when they look at me.*

- *I don't have to hide who I am–even the part of me that isn't well. Because it's that part of me and all the things I've experienced as a client here -- good and bad -- that gives me ideas for how things could change.*

- *I just didn't think my program was a good fit for me. I was sticking it out, but lots of other folks stopped showing up. But then, somebody came in and we had a great talk about what was working and what wasn't in the program. And some changes actually got made. Things are a lot better now. The group is packed every week!*

B. Promoting Access and Engagement

A core principle of the deinstitutionalization movement of the 1950s and beyond was that persons with psychiatric disabilities should receive mental health services in the least restrictive setting possible within their home communities. Community mental health centers and clinics were developed in large part in response to this principle. Unfortunately, many persons with psychiatric disabilities did not receive care due to a variety of factors such as: inadequate funding for community-based services, administrative and bureaucratic barriers that discouraged people from seeking care, expectations of motivation for treatment that did not take into account internal (to the clinic) or external (in the person's environment) barriers to care, a lack of knowledge of ways to engage people living in the community into mental health treatment, clients' avoidance of the mental health system because of previous negative experiences, and persons' inability to meet the requirements of treatment (e.g. appointment times, etc.) due to the exigencies of their lives of poverty and/or homelessness, or due to their psychiatric symptoms. Thus, many people who were eligible for services did not receive them, and suffered impoverished lives without adequate treatment, social support, or material resources in the community.

For these, and additional, reasons, the recent U.S. Surgeon General's *Report on Mental Health*[9] suggested that for every one person who seeks and receives specialty mental health care for a diagnosable psychiatric disorder, there remain two individuals, with similar conditions, who will neither gain access to nor receive such care. This report was followed by a supplement on culture, race, and ethnicity, which further identified lack of access to care as an even more formidable obstacle to recovery among people of color[10].

While this situation may seem dire, the proportion of people who access and receive care to those who are in need of such care is even worse in the case of addiction, with approximately 1 out of 7 people with an addiction actually receiving active behavioral health treatment. These facts clearly warrant the attention of the behavioral health system, including a greater focus on efforts to enhance access and engage people in care.

Access to care involves facilitating swift and uncomplicated entry into care, and can be increased through a variety of means. These include: 1) conducting outreach to persons who may not otherwise receive information about services or who may avoid institutional settings where services are provided; 2) establishing numerous points of entry into a wide range of treatment, rehabilitative, social, and

---

[9]Department of Health and Human Services. (1999). *Mental health: A report of the Surgeon General.* Rockville, MD: Substance Abuse and Mental Health Services Administration.

[10]Department of Health and Human Services. (2001). *Mental health: Culture, race, and ethnicity.* Rockville, MD: Substance Abuse and Mental Health Services Administration.

other support services. For example, a public health nurse working with a homeless outreach team facilitates a person's entry into behavioral health care, a clinician might help the person gain access to vocational services and entitlement income support, and, with the client's permission, all of these service providers meet with or talk to each other regularly to coordinate their work with the person; and 3) ensuring that information about services is made readily available and understandable to people through public education and information, liaison with other agencies, links to self-help groups, and other venues.

Access to care also involves removing barriers to receiving care, including bureaucratic red tape, intimidating or unwelcoming physical environments and program procedures, schedule conflicts, and modes of service provision that conflict with the life situations and demands of persons with psychiatric disabilities or addiction. It also means that access to care goes far beyond mere eligibility to receive services. Finally, access to care involves moving away from traditional philosophies of treatment—including hitting bottom (e.g., "Addicts can't be helped until they hit bottom and have lost everything") and incrementalism (e.g., "We can't house people with addictions until they've been in recovery for 6 months")—and toward stages of change approaches, recognizing that addressing basic needs, employment, and housing can enhance motivation for treatment and recovery.

Engagement into services is closely tied to access to care. Engagement involves making contact with the person rather than with the diagnosis or disability, building trust over time, attending to the person's stated needs and, directly or indirectly, providing a range of services in addition to clinical care. The process of engagement benefits from new understandings of motivational enhancement, which sees people standing at various points on a continuum from pre-readiness for treatment to being in recovery, rather than being either motivated or unmotivated.

Engagement involves sensitivity to the thin line between persuasion and coercion and attention to the power differential between the service provider and the client or potential client, and the ways in which these factors can undermine personal choice. Finally, methods of ensuring access and engagement are integrated within and are part of providing good clinical and rehabilitative care, not adjuncts or qualifications to them.

You will know that you are promoting access and engagement when:

B.1.	The service system has the capacity to go where the potential client is, rather than always insisting that the client come to the service. Services and structures (e.g., hours of operation and locations of services) are designed around client needs, characteristics, and preferences.

B.2. The team provides, or can help the person gain swift access to, a wide range of services. People can access these services from many different points. In a "no wrong door" approach to providing an array of services, individuals can also self-refer to a range of service options (e.g., specialized rehabilitation supports) without the need for referral from a primary clinical provider. In addition, individuals can access DMHAS-funded rehabilitation programs without being mandated to participate in clinical care. However, self referrals will be subject to admission and oversight and need approval by a licensed entity to satisfy reimbursement and accreditation needs.

B.3. There is not a strict separation between clinical and case management functions, though there may be differences in expertise and training of the people providing these services. Services and supports address presenting clinical issues, but are also responsive to pressing social, housing, employment, and spiritual needs. For example, employment is valued as an important element of recovery. Skill building and finding employment are competencies included in all staff job descriptions, including clinical providers, with only the most difficult-to-place clients being referred to specialized programs.

B.4. The assessment of motivation is based on a stages of change model, and services and supports incorporate motivational enhancement strategies which assist providers in meeting each person at his or her own level. Training in these strategies is required for all staff who work with people with addictions in order to help move people toward recovery.

B.5. Staff and agencies look for signs of organizational barriers or other obstacles to care before concluding that a client is non-compliant with treatment or unmotivated for care, e.g., meeting the needs of women with children for daycare.

B.6. Agencies have "zero reject" policies that do not exclude people from care based on symptomatology, substance use, or unwillingness to participate in prerequisite clinical or program activities. For example, vocational rehabilitation agencies do not employ screening procedures based on arbitrary "work readiness" criteria, as such criteria have limited predictive validity regarding employment outcomes. In addition, such procedures suggest that individuals must attain, and maintain, clinical stability or abstinence before they can pursue a life in the community, when, in fact, employment and other meaningful activities are often a path through which people become stable in the first place.

B.7. Staff have an "open case" policy which dictates that a person's refusal of services, even despite intensive and long-term outreach and engagement, does not require that he or she be dropped from the "outreach" list. This person may still accept services at another time. Committee structures and supervision are in place to evaluate the fine line between assertive outreach versus potential harassment or coercion. In addition, the agency establishes guidelines regarding what defines an "active" versus an "outreach" client, and considers how such definitions impact program enrollment, documentation standards, 30 day drop out lists, case load definitions, and reimbursement strategies.

B.8. From an administrative perspective, the system builds on a commitment to and practice of motivational enhancement, with reimbursement for pre-treatment and recovery management supports. This includes flexibility in outpatient care, including low-intensity care for those who do not presently benefit from high-intensity treatment.

B.9. Outpatient substance abuse treatment clinicians are paired with outreach workers to capitalize on the moment of crisis that can lead people to accept treatment, and to gain access to their appropriate level of care.

B.10. Mental health professionals, addictions specialists, and people in recovery are placed in critical locales to assist in the early stages of engagement, e.g., in shelters, in courts, in hospital emergency rooms, and in community health centers. The agency develops and establishes the necessary memoranda of agreement and protocols to facilitate this co-location of services.

B.11. The team or agency employs staff with first person experience of recovery who have a special ability to make contact with and engage people into services and treatment.

B.12. Housing and support options are available for those who are not interested in, or ready for, detoxification, but who may begin to engage in their own recovery if housing and support are available to them. Provider ambivalence regarding harm reduction approaches and the issue of public support for persons who are actively using must be addressed in regard to this point.

B.13. The availability of sober housing is expanded to make it possible for people to go immediately from residential or intensive outpatient treatment programs into housing that supports their recovery.

What you will hear from people in recovery when you are promoting access and engagement:

- *I didn't want nothing to do with them at first. But, folks from the Center just kept showing up . . . they didn't drop me or let me get off on the wrong track... they didn't give up, they just stuck by me. It was like a velvet bulldozer.*

- *I hated going to their building. Everybody looked at me as I was walking up the block like "Oh, I wonder if he's a patient there – crazy and on dope." So, I just never went. But, they came to me on my own turn and my own terms. Today, I think my case manager is the reason I'm still alive.*

- *I got help with the kinds of things that were most important to me – like getting my daughter back, and putting food on the table for her. Since they were willing to help me with that stuff, I figured "Hey, maybe I should listen to what they are telling me and try out that program they keep talking about." Today I've been clean for 9 months...*

- *Nobody wanted anything to do with me before. It was always "Come back and see us when you get serious about your recovery... when you've got some clean urines." But, then, this program tried to help me out with getting this job I had wanted for a really long time. Now, I am working part time and I've finally got a reason to be sober every day.*

- *They knew when to take "no" for an answer. They didn't stay on my back all the time, but I knew they were always there for me if I needed them. Now I don't say "no" so often.*

C. Ensuring Continuity of Care

Recovery in both addiction and in mental health, in the sense in which we are using it in this document, refers to a prolonged or long-term process. It does not refer, that is, to an acute phenomenon such as recovery from the flu or from a broken bone. This is not to say that substance use or mental illness cannot also be acute in nature. Many people do, in fact, experience one episode of mental illness or a short-lived period of substance use and do not develop prolonged conditions to begin with.

For such people experiencing only one acute and delimited episode of either substance use or mental illness, however, the notion of recovery is unlikely to have much relevance. Such individuals are unlikely to consider themselves, or to refer to themselves, for example, as being "in recovery" from psychiatric or substance use disorders. In the face of the significant stigma and discrimination which continue to accrue to psychiatric and substance use disorders in the general public, these persons seldom disclose their psychiatric or addiction history or define themselves in terms of this isolated episode of illness, preferring to return quietly to the normal lives they led previously. Without giving much thought to the repercussions of their condition for their social role or sense of identity, such individuals are unlikely to describe themselves as being "in recovery" from anything.

For those individuals for whom being in recovery is a meaningful goal, the nature of their struggle with mental illness and/or addiction is likely to be sustained. In such cases—which, it should be acknowledged, comprise a significant segment of Connecticut citizens receiving care from DMHAS—an acute model of care is not the most useful or appropriate. Particularly in terms of system design, prolonged conditions call for longitudinal models that emphasize continuity of care over time and across programs. Consistent with the principles undergirding the "new recovery movement" in addictions, the long-term nature of addiction and mental illness suggests a number of parameters for developing new models of care that go beyond loosely linked acute episodes[11].

These models are based on the belief that full recovery is seldom achieved from a single episode of treatment, and that providers, as well as clients, families, and policy makers, should not be disappointed or discouraged by the fact that there are no quick fixes. Similar to (other) chronic medical illnesses, previous treatment of a person's condition also should not be taken to be indicative of a poor prognosis, of non-compliance, or of the person's not trying hard enough to recover. Relapses in substance use and exacerbations of psychiatric symptoms are to be viewed as further evidence of the severity of the person's condition rather than as causes for discharge (e.g., we do not discharge a person from the care of a cardiologist for having a

[11] White, W. (2001). The new recovery advocacy movement: A call to service. *Counselor, 2*(6), 64-67.

second or third heart attack). All of these principles suggest that treatment, rehabilitation, and support are not to be offered through serial episodes of disconnected care offered by different providers, but through a carefully crafted system of care that ensures continuity of the person's most significant healing relationships and supports over time and across episodes, programs, and agencies.

You will know that you are ensuring continuity of care when:

C.1. The central concern of engagement shifts from: "How do we get the client into treatment?" to: "How do we nest the process of recovery within the person's natural environment?" For example, people have often asked for meeting places and activities to be available on weekends, especially for those individuals who are in the early stages of their recovery.

C.2. Services are designed to be welcoming to all individuals and there is a low threshold (i.e., minimal requirements) for entry into care. There also is an emphasis on outreach and pre-treatment recovery support services that can ensure that individuals are not unnecessarily excluded from care. If a person is denied care, they receive written explanations as to why and are connected to appropriate alternatives including appointment and transportation.

C.3. Eligibility and reimbursement strategies for this group of individuals (i.e., outreach and pre-engagement) are established and refined as necessary over time by administrative leadership.

C.4. People have a flexible array of options from which to choose, and options are not limited to what "programs" are available. These options allow for a high degree of individualization and a greater emphasis on the physical/social ecology (i.e., context) of recovery.

C.5. Individuals are not expected or required to progress through a continuum of care in a linear or sequential manner. For example, individuals are not required to enroll in a group home as a condition of hospital discharge when this is determined solely by professionals to be the most appropriate level of care. Rather, within the context of a responsive continuum of care, individuals work in collaboration with their recovery team to select those services from within the array that meet their particular needs and preferences at a given point in time.

C.6. In a Recovery Management Model, an individual's stage of change is considered at all points in time and the focus of care is on enhancing existing strengths and recovery capital. The assessment of problems and needs is consistently coupled with an assessment of resources and strengths both in initial and in on-going recovery planning. This is best achieved by including the person's family/kinship network and/or any natural supports she or he believes would be supportive of recovery.

C.7. Goals and objectives in the recovery plan are not defined by practitioners based on clinically-valued outcomes (e.g., reducing symptoms, increasing adherence), but rather are defined by the person with a focus on building recovery capital and pursuing a life in the community.

C.8. The overall focus of care shifts from preventing relapse to promoting recovery. Services are not primarily oriented toward crisis or problem resolution, e.g., detoxification and stabilization. There is a full array of recovery support services, including proactive, preventive supports and post-crisis, community-based resources such as adequate safe housing, recovery community centers operated by people in recovery, sustained recovery coaching, monitoring with feedback, and early re-intervention if necessary. The concept of "aftercare" is irrelevant as all care is conceptualized as continuing care and there is a commitment to provide ongoing, flexible supports as necessary.

C.9. Valued outcomes are influenced by the system's commitment to ensuring continuity of care. For example, less emphasis is placed on a professional review of the short-term outcomes of single episodes of care (e.g., readmission or incarceration rates) and more emphasis is placed on the long-term effects of service combinations and sequences on those outcomes valued by the person such as quality of life domains including satisfaction with housing, relationships, and employment.

C.10. The range of valued expertise is expanded beyond specialized clinical and rehabilitative professionals and technical experts to include the contributions of multiple individuals and services. These individuals may include peers in paid or volunteer positions, mutual aid groups, indigenous healers, faith community leaders, primary care providers, and other natural supports. Valuing and incorporating such community resources in ongoing care planning is viewed as essential to decreasing dependence on formal behavioral health care and assisting the person to develop a more natural recovery network. In this spirit, the community, rather than the clinic, agency, or program, is viewed as the ultimate context for sustained recovery.

C.11. Individuals are seen as capable of illness self-management and interventions support this as a valued goal of recovery-oriented services. People are actively involved in all aspects of their care including policy development, assessment, goal setting, and evaluation. These different forms of involvement build capacity for independent community living and are powerful antidotes to the passivity and dependence that may have resulted from years of being a recipient of professionally-prescribed and delivered care. In the process of decreasing the power differential that traditionally has characterized relationships between clients and providers, care is conceptualized within a partnership or consultant framework in which services—while available over the long-term—may be time-limited and accessed by the person when and as she or he deems necessary.

C.12. New technologies (e.g., tele-medicine and web-based applications and self-help resources) are incorporated as service options to enhance illness self-management collaborative treatment relationships.

C.13. Access to housing, employment, and other supports that make recovery sustainable is enhanced. This includes changing policies and laws that restrict people's access to employment and home ownership, such having a criminal record for non-violent, one-time, drug-dealing offenses or offenses related to psychiatric disability.

C.14. Policy formulation and legislative advocacy at the administrative level is coupled with on-going efforts to work collaboratively with a variety of state systems to ensure continuity of care, e.g., with the Department of Corrections to put into place plans for re-entry, with resources such as Oxford Houses and rental assistance for people with substance use disorders coming out of jails and prisons.

C.15. In order to facilitate sustained recovery and community inclusion, advocacy efforts are extended beyond institutional policies and procedures to the larger community, including stigma-busting, community education, and community resource development activities.

What you will hear from people in recovery when you are ensuring continuity of care:

- *They were there for me – no strings attached. I didn't walk through the door and get a whole bunch of expectations dumped on me.*

- *People respected that I was doing the best I could. It was two steps forward one step back for a long time, but overall, I was moving in the right direction for the first time in as long as I could remember. But they stuck with me for the long haul. Now, I've been clean for 18 months, and someone still calls me everyday to check in–even if its just to day "Hi, How ya' doin'?"*

- *I didn't get kicked out of the program because I had a dirty urine–it used to be that happened every week. This time, I had been clean for two months. My case manager reminded of how good it was in those two months and I wanted to get back there.*

- *It used to be I was terrified of leaving detox. I'd go back to the same crappy environment and be back out on the streets in a matter of days. But, I got into some sober housing and it changed my life.*

- *They knew I needed to work on my recovery AND my life at the same time. That meant getting a part-time job, paying off my debts, working on my marriage, and learning how to enjoy myself again and to do it all drug-free.*

D. Employing Strengths-Based Assessment

As described above, traditional behavioral health services have been based on a narrow and acute medical model that perceives mental illnesses and addictions as diseases that can be treated and cured. While this approach works effectively for many people, for many others it primarily serves to add additional weight to their already heavy burdens. In this case, providers have had an unfortunate tendency to overlook the remaining and co-existing areas of health, assets, strengths, and competencies that the person continues to have at his or her disposal—what remains "right" with people—by focusing on the assessment and treatment of their deficits, aberrations, and symptoms—what is "wrong" with people. Emphasizing the negative in this way has led to a tremendous sense of hopelessness and despair among both clients and the behavioral health practitioners who serve them.

In addition, whether one has a psychiatric disability or an addiction, focusing solely on deficits in the absence of a thoughtful analysis of strengths disregards the most critical resources an individual has on which to build in his or her efforts to adapt to stressful situations, confront environmental challenges, improve his or her quality of life, and advance in his or her unique recovery journey. As the process of improvement depends, in the end, on the resources, reserves, efforts, and assets of and around the individual, family, or community, a recovery orientation thus encourages providers to view the glass as half full rather than half empty[12].

Following principles that have been articulated at length by Rapp and others[13], strengths-based approaches allow professionals to balance critical needs that must be met with the resources and strengths that individuals and families possess to assist them in this process. This perspective encourages providers to recognize that no matter how disabled, every person continues to have strengths and capabilities as well as the capacity to continue to learn and develop. The failure of an individual to display competencies or strengths is therefore not necessarily attributed to deficits within the person, but may rather, or in addition, be due to the failure of the service system and broader community to adequately elicit information in this area or to create the opportunities and supports needed for these strengths to displayed.

While system and assessment procedures have made strides in recent years regarding inquiry into the area of individual resources and capacities, simply *asking* an individual what strengths they possess or what things they think they are "good at" may not be sufficient to solicit the information that is critical to the recovery planning process. For example, many people who have prolonged conditions will at first report

---

[12]Saleeby, D. (2001). The diagnostics strengths manual. *Social Work, 46,* (2), 183-187.

[13]Rapp, C.A. (1998). *The Strengths Model: Case management with people suffering from Severe and Persistent Mental Illness*. New York: Oxford University Press.

that they have no strengths. Such a response should not be taken at face value, but rather to represent the years of difficulties and failures they may have endured and the degree of demoralization which has resulted. Over time, it is not uncommon for such individuals to lose touch with the healthier and more positive aspects of themselves and become unable to see beyond the "patient" or "addict" role.

When facing such circumstances, providers need to conceptualize one of their first steps as assisting this person to get back in touch with his or her previous interests, talents, and gifts. The guidelines below are intended to assist providers in conducting a comprehensive, strengths-based assessment that can help people to rediscover themselves as capable persons with a history, a future, and with strengths and interests beyond their symptoms, deficits, or functional impairments.

You will know that you are providing strengths-based assessment when:

D.1. A discussion of strengths is a central focus of every assessment, care plan, and case summary. Assessments begin with the assumption that individuals are the experts on their own recovery, and that they have learned much in the process of living with and working through their struggles. This strengths-based assessment is conducted as a collaborative process and all assessments in written form are shared with the individual.

D.2. Initial assessments recognize the power of simple, yet powerful, questions such as "What happened? And what do you think would be helpful? And what are your goals in life?" Self-assessment tools rating level of satisfaction in various life areas can be useful ways to identify diverse goal areas around which supports can then be designed.

D.3. Practitioners attempt to interpret perceived deficits within a strengths and resilience framework, as this will allow the individual to identify less with the limitations of their disorder. For example, an individual who takes their medication irregularly may automatically be perceived as "non-compliant," "lacking insight," or "requiring monitoring to take meds as prescribed." This same individual, however, could also be seen as "making use of alternative coping strategies such as exercise and relaxation to reduce reliance on medications" or could be praised for "working collaboratively to develop a contingency plan for when medications are to be used on an 'as-needed' basis."

D.4. While strengths of the individual are a focus of the assessment procedure, thoughtful consideration also is given to potential strengths and resources within the individual's family, natural support network, service system, and community at large. This is consistent with the view that recovery is not a solitary process but rather a journey toward interdependence within one's community of choice.

D.5. The diversity of strengths that can serve as resources for the person and his or her recovery planning team is respected. Saleeby, for example, has recommended conceptualizing strengths broadly to include the following dimensions: skills (e.g., gardening, caring for children, speaking Spanish, doing budgets); talents (e.g., playing the bagpipes, cooking); personal virtues and traits (e.g., insight, patience, sense of humor, self-discipline); interpersonal skills (e.g., comforting the sick, giving advice, mediating conflicts); interpersonal and environmental resources (e.g., extended family, good neighbors); cultural knowledge and lore (e.g., healing ceremonies and rituals, stories of cultural perseverance); family stories and narratives (e.g., migration and settlement, falls from grace and redemption); knowledge gained from struggling with adversity (e.g., how one came to survive past events, how one maintains hope and faith); knowledge gained from occupational or parental roles (e.g., caring for others, planning events); spirituality and faith (e.g., a system of meaning to rely on, a declaration of purpose beyond self); and hopes and dreams (e.g., personal goals and vision, positive expectations about a better future)[14].

D.6. In addition to the assessment of individual capacities, it is beneficial to explore other areas not traditionally considered "strengths," e.g., the individual's most significant or most valued accomplishments, ways of relaxing and having fun, ways of calming down when upset, preferred living environment, educational achievements, personal heroes, most meaningful compliment ever received, etc.

D.7. Assessment explores the whole of people's lives while ensuring emphasis is given to the individual's expressed and pressing priorities. For example, people experiencing problems with mental illness or addiction often place less emphasis on symptom reduction and abstinence than on desired improvements in other areas of life such as work, financial security, safe housing, or relationships. For this reason, it is beneficial to explore in detail each individuals' needs and resources in these areas.

[14]Saleeby, D. (2001). The diagnostics strengths manual. *Social Work, 46*(2), 183-187.

D.8. Strengths-based assessments ask people what has worked for them in the past and incorporate these ideas in the recovery plan. People are more likely to use strategies that they have personally identified or developed rather than those that have been prescribed for them by others.

D.9. Guidance for completing a strengths-based assessment may be derived from certain interviewing strategies employed within solution-focused approaches to treatment. For example, DeJong and Miller recommend the following types of inquiry: exploring for exceptions (occasions when the problem could have occurred but did not), imagining a future when the problem has been solved and exploring, in detail, how life would then be different; assessing coping strategies, i.e., asking how an individual is able to cope despite the presence of such problems; and using scaling questions (where the individual rates his or her current experience of the problem) to elucidate what might be subtle signs of progress[15].

D.10. Illness self-management strategies and daily wellness approaches such as WRAP[16] are respected as highly effective, person-directed, recovery tools, and are fully explored in the strengths-based assessment process.

D.11. Cause-and-effect explanations are offered with caution in strengths-based assessment as such thinking can lead to simplistic resolutions that fail to address the person's situation. In addition, simplistic solutions may inappropriately assign blame for the problem to the individual, with blame being described as "the first cousin" of deficit-based models of practice[17]. For example, to conclude that an individual did not pay his or her rent as a direct consequence of his or her "non-compliance" with medications could lead to an intrusive intervention to exert control over the individual's finances or medication. Strengths-based assessments respect that problem situations are usually the result of complex, multi-dimensional influences, and explore with the person in more detail the various factors that led to his or her decisions and behavior (e.g., expressing displeasure with a negligent landlord).

---

[15]DeJong, G. & Miller, S. (1995) How to interview for client strengths, *Social Work, (40),* 729-736.

[16]Copeland, M. (2002). *The depression workbook: A guide for living with depression and manic depression. Wellness Recovery Action Plan.* Oakland, CA: New Harbinger Publications.

[17]Cowger, C.D. (1994). Assessing client strengths: Clinical assessment for client empowerment. *Social Work 39*(3), 262-268.

D.12. Strengths-based assessments are developed through in-depth discussion with the individual as well as attempts to solicit collateral information regarding strengths from the individual's family and natural supports. Since obtaining all of the necessary information requires time and a trusting relationship with the person, a strengths-based assessment may need to be completed (or expanded upon) after the initial contact as treatment and rehabilitation unfold. While each situation may vary, the assessment is written up as soon as possible in order to help guide the work and interventions of the Recovery Planning Team. Modular approaches to service delivery, billing, and reimbursement are considered by local and state administrative leadership, e.g., certain information is gathered in the first 24 hours with additional areas being assessed by the end of one week, one month, etc.

D.13. Efforts are made to record the individual's responses verbatim rather than translating the information into professional language. This helps to ensure that the assessment remains narrative-based and person-centered. If technical language must be used, it is translated appropriately and presented in a person-first, non-offensive manner, e.g., avoiding the language of "dysfunction, disorder."

D.14. Practitioners are mindful of the power of language and carefully avoid the subtle messages that professional language has historically conveyed to people with psychiatric diagnoses, addictions, and their loved ones. Language is used that is empowering, avoiding the eliciting of pity or sympathy, as this can cast people with disabilities in a passive, "victim" role and reinforce negative stereotypes. For example, just as we have learned to refer to "people who use wheelchairs" as opposed to "the wheelchair bound" we should refer to "individuals who use medication as a recovery tool" as opposed to people who are "dependent on medication for clinical stability." In particular, words such as "hope" and "recovery" are used frequently in documentation and delivery of services.

D.15. Practitioners avoid using diagnostic labels as "catch-all" means of describing an individual (e.g., "she's a borderline"), as such labels yield minimal information regarding the person's actual experience or manifestation of their illness or addiction. Alternatively, a person's needs are not well captured by a label, but by an accurate description of his or her functional strengths and limitations. While diagnostic profiles may be required for other purposes (e.g., decisions regarding medication, justification of level of care), asset-based assessment places limited value on diagnosis per se. In addition, acknowledging

limitations and areas of need are not viewed as accepting one's fate as a mentally ill person or an addict. Rather, identifying and accepting one's current limitations is seen as a constructive step in the process of recovery. Gaining a sense of perspective on both strengths and weaknesses is critical in this process as it allows the person to identify, pursue, and achieve life goals despite the lingering presence of disability.

D.16. Language used is neither stigmatizing nor objectifying. At all times "person first" language is used to acknowledge that the disability is not as important as the person's individuality and humanity, e.g., "a person with schizophrenia" versus "a schizophrenic" or a "person with an addiction" versus "an addict." Employing person-first language does not mean that a person's disability is hidden or seen as irrelevant; however, it also is not to be the sole focus of any description about that person. To make it the sole focus is depersonalizing, and is no longer considered an acceptable practice.

D.17. Exceptions to person-first and empowering language that are preferred by some persons in recovery are respected. For instance, the personal preferences of some individuals with substance use disorders, particularly those who work the 12-Steps as a primary tool of their recovery, may at times be inconsistent with person-first language. Within the 12-Step Fellowship, early steps in the recovery process involve admitting one's powerlessness over a substance and acknowledging how one's life has become unmanageable. It is also common for such individuals to introduce themselves as: "My name is X and I am an alcoholic." This preference is respected as a part of the person's unique recovery process, and it is understood that it would be contrary to recovery principles to pressure the person to identify as "a person with alcoholism" in the name of person-first language or principles. Use of person-first language is in the service of the person's recovery; it is not a super-ordinate principle to which the person must conform. While the majority of people with disabilities prefer to be referred to in first-person language, when in doubt ask the person what he or she prefers.

What you will hear from people in recovery when you are employing strengths-based assessment:

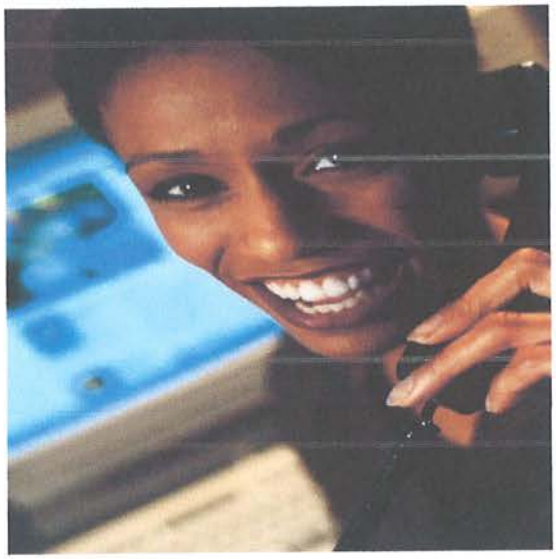
- *I used to think my life was over, but my illness isn't a death sentence. Its just one small part of who I am. Sometimes I forget about those other parts – the healthy parts of me. But my counselor always reminds me. You really need someone like that in your life.*

- *Being in recovery means that I know I have certain limitations and things I can't do. But rather than letting these limitations be an occasion for despair and giving up, I have learned that in knowing what I can't do, I also open up the possibilities of all I can do.*[18]

- *I thought I was so alone in my problems. I may not feel as though I have much strength right now, but I realize I can draw strength from all the people around me... my friends, my neighbors, my pastor, and my counselors here at the Center.*

- *When they asked me about what I was good at and what sorts of things in my life made me happy, at first I didn't know who they were talking to. Nobody ever asked me those kinds of questions before. Just sitting through that interview, I felt better than before I had walked through the door!*

- *No one here treats me like a label. Just because I have schizophrenia, that doesn't tell you a whole lot. My roommate does too, but we couldn't be more different. Folks here take the time to get to know lots of things about me, not just the things that go along with my diagnosis.*



[18]Deegan,, P.E. (1993). Recovering our sense of value after being labeled mentally ill. *Journal of Psychosocial Nursing, 31*(4), 7-11.

E. Offering Individualized Recovery Planning

In accordance with the Connecticut General Statutes, as well as Federal and JCAHO guidelines regarding the need for individualized care, all treatment and rehabilitative services and supports to be provided shall be based on an individualized, multidisciplinary recovery plan developed in collaboration with the person receiving these services and any others that he or she identifies as supportive of this process. While based on a model of collaboration and partnership, significant effort will be taken to ensure that individuals' rights to self-determination are respected and that all individuals are afforded maximum opportunity to exercise choice in the full range of treatment and life decisions. The individualized recovery plan will satisfy the criteria of treatment, service, or care plans required by other bodies (e.g., CMS) and will include a comprehensive and culturally sensitive assessment of the person's hopes, assets, strengths, interests, and goals in addition to a holistic understanding of his or her behavioral health conditions and other medical concerns within the context of his or her ongoing life.

Typical examples of such life context issues include employment, education, housing, spirituality, social and sexual relationships, and involvement in meaningful and pleasurable activities. In order to ensure competence in these respective areas, including competence in addressing the person's cultural background and affiliations, the multi-disciplinary team will not be limited to physician/psychiatrists, nurses, psychologists, and social workers, but may also include rehabilitative and peer staff, and wherever possible, relevant community representatives and/or others identified by the person.

Building on the strengths-based assessment process, individualized recovery planning both encourages and expects the person to draw upon his or her strengths to participate actively in the recovery process. It is imperative throughout this process that providers maintain a belief in the individual's potential for growth and development, up to, and including, the ability to exit successfully from services. Providers also solicit the person's own hopes, dreams, and aspirations, encouraging individuals to pursue their preferred goals even if doing so presents potential risks or challenges.

For example, many people identify returning to work as a primary recovery goal. It is not uncommon for practitioners to advise against this step based on an assumption that an individual either is not "work ready" or that employment will be detrimental to his or her recovery (e.g., by endangering his or her disability benefits). While such advice is based on good intentions, it sends a powerful message to the individual and can reinforce self-doubts and feelings of inadequacy. Rather than discouraging the person from pursuing this goal, the practitioner can have a frank discussion with the person about his or her concerns while simultaneously

highlighting the strengths that the individual can draw upon to take the first step toward achieving this goal.

In this vein, individualized recovery planning explicitly acknowledges that recovery entails the person's taking risks to try new things, and is enhanced by the person having opportunities to learn from his or her own mistakes and their natural consequences. This represents an important source of progress in the person's efforts to rebuild his or her life in the community that—similar to exercising one's muscles—cannot proceed without an exertion of the person's own faculties.

You will know that you are offering Individualized Recovery Planning when:

E.1. **Core principles of "person-centered" planning are followed in the process of building individualized recovery plans. For example:**

E.1.1. Consistent with the "nothing about us, without us" dictum, providers actively partner with the individual in all planning meetings and/or case conferences regarding his or her recovery services and supports.

E.1.2. The individual has reasonable control as to the location and time of planning meetings, as well as to who is involved, including conserved persons who wish to have an advocate or peer support worker present. Planning meetings are conducted and services are delivered at a time that does not conflict with other activities that support recovery such as employment. The individual can extend invitations to any person she or he believes will be supportive of his or her efforts toward recovery. Invitations extended are documented in the recovery plan. If necessary, the person (and family as relevant) are provided with support before the meeting so that they can be prepared and participate as equals[19].

E.1.3. The language of the plan is understandable to all participants, including the focus person and his or her non-professional, natural supports. Where technical or professional terminology is necessary, this is explained to all participants in the planning process.

---

[19] Osher, D. & Keenan, S. (2001). From professional bureaucracy to partner with families. *Reaching Today's Youth, 5(3),* 9–15.

E.1.4. When individuals are engaged in rehabilitation services, the rehab practitioners are involved in all planning meetings (at the discretion of the individual) and are given copies of the resulting plan.

E.1.5. Within the planning process, a diverse, flexible range of options must be available so that people can access and choose those supports that will best assist them in their recovery. These choices and service options are clearly explained to the individual, and documentation reflects the options considered.

E.1.6. Goals are based on the individual's unique interests, preferences, and strengths, and objectives, and interventions are clearly related to the attainment of these stated goals. In the case of children and youth, the unique goals of the family are also considered, with the youth increasingly driving the process as he or she approaches the age of maturity. In cases in which preferred supports do not exist, the recovery team works collaboratively with the individual to develop the support or to secure an acceptable alternative.

E.1.7. Planning focuses on the identification of concrete next steps, along with specific timelines, that will allow the person to draw upon existing areas of strength to move toward recovery and his or her vision for the future. Individuals, including non-paid, natural supports who are part of the planning process, commit to assist the individual in taking those next steps. The person takes responsibility for his or her part in making the plan work. Effective recovery plans help people rise to this challenge regardless of their disability status.

E.1.8. A discussion of strengths is a central focus of all recovery plans (See Section #D). Assessments begin with the assumption that individuals are the experts on their own recovery, and that they have learned much in the process of living with and working through their struggles.

E.1.9. Information on rights and responsibilities of receiving services is provided at all recovery planning meetings. This information should include a copy of the mechanisms through which the individual can provide feedback to the practitioner and/or agency, e.g., protocol for filing a complaint or compliments regarding the provision of services.

E.1.10. The individual has the ability to select or change his or her service providers within eligible guidelines and is made aware of the procedures for doing so.

E.1.11. In the spirit of true partnership and transparency, all parties must have access to the same information if people are to embrace and effectively carry out responsibilities associated with the recovery plan[20]. Clients are automatically offered a copy of their written plans, assessments, and progress notes. Knowing ahead of time that a copy will be shared is a simple but powerful strategy that can dramatically impact both the language of the plan and the content of its goals and objectives.

E.1.12. The team reconvenes as necessary to address life goals, accomplishments, and barriers. Planning is characterized by celebrations of successes, and meetings can occur beyond regular, established parameters (e.g., 6-month reviews) and crises (e.g., "all-treaters" meetings to address hospitalization or relapse).

E.2. **A wide range of interventions and contributors to the planning and care process are recognized and respected. For example:**

E.2.1. Practitioners acknowledge the value of the person's existing relationships and connections. If it is the person's preference, significant effort is made to include these "natural supports" and unpaid participants as they often have critical input and support to offer to the team. Interventions should complement, not interfere with, what people are already doing to keep themselves well, e.g., drawing support from friends and loved ones[21].

E.2.2. The plan identifies a wide range of both professional supports and alternative strategies to support the person's recovery, particularly those which have been helpful to others with similar struggles. Information about medications and other treatments are combined with information about self-help, peer support, exercise, nutrition, daily maintenance activities, spiritual practices and affiliations, homeopathic and naturopathic remedies, etc.

E.2.3. Individuals are not required to attain, or maintain, clinical stability or abstinence before they are supported by the planning team in pursuing such goals as employment. For example, in some systems access and

[20] Osher, T., & Osher, D. (2001). The paradigm shift to true collaboration with families. *The Journal of Child and Family Studies, 10*(3), 47-60.

[21] Osher, D. and Webb, L. (1994). *Adult Literacy, Learning Disabilities, and Social Context: Conceptual Foundations for a Learner-Centered Approach.* Washington, DC, U.S. Department of Education.

referral to vocational rehabilitation programs may be controlled by a clinical practitioner, and people are often required to demonstrate "work readiness" or "symptomatic stability" as a prerequisite to entry. In addition to an abundant literature which has shown that screening procedures and criteria have limited predictive validity, this structure also neglects that fact that activities such as working are often the path through which people become clinically stable in the first place.

E.2.4. Goals and objectives are driven by the person's current values and needs and not solely by commonly desired clinical/professional outcomes, e.g., recovery is a process that may or may not begin with the individual understanding or appreciating the value of abstinence or of taking medications.

E.3. **Community inclusion is valued as a commonly identified and desired outcome. For example:**

E.3.1. The focus of planning and care is on how to create pathways to meaningful and successful community life and not just on how to maintain clinical stability or abstinence. Person-centered plans document areas as physical health, family and social relationships, employment/education, spirituality, housing, social relations, recreation, community service and civic participation, etc., unless such areas are designated by the person as not-of-interest. For example, traditional planning has often neglected the spiritual and sexual aspects of peoples' lives. Achieving interdependence with natural community supports is a valued goal for many people in recovery who express a strong preference to live in typical housing, to have friendships and intimate relationships with a wide range of people, to work in regular employment settings, and to participate in school, worship, recreation, and other pursuits alongside other community members[22]. Such preferences often speak to the need to reduce time spent in segregated settings designed solely to support people labeled with a behavioral health disorder.

E.3.2. Recovery plans respect the fact that services and practitioners should not remain central to a person's life over time, and exit criteria from formal services are clearly defined. Given the unpredictability of illness, and life more generally, however, readmission also remains uncomplicated, with avenues clearly defined for people on discharge.

[22]Reidy, D. (1992). Shattering illusions of difference. *Resources, 4*(2), 3-6.

E.3.3. Recovery plans consider not only how the individual can access and receive needed supports from the behavioral health system and the community, but how the individual can, in turn, give back to others. People have identified this type of reciprocity in relationships as being critical to building recovery capital and to the recovery process as a whole. Therefore, individuals should be encouraged to explore how they can make meaningful contributions in the system or in the community, e.g., through advocacy, employment, or volunteering.

E.3.4. A focus on community is consistent not only with person-centered care principles but with the need for fiscal efficiency. Practitioners and people in recovery should be mindful of the limited resources available for specialized services and should focus on community solutions and resources first by asking "Am I about to recommend or replicate a service or support that is already available in the broader community?" At times this has direct implications for the development of service interventions within recovery plans, e.g., creating on-site health and fitness opportunities such as exercise classes without first exploring to what extent that same opportunity might be available in the broader community through public recreational departments, YMCAs, etc. If natural alternatives are available in the community, individuals should be informed of these opportunities and to the extent to which what is offered is culturally responsive and accessible, they should be supported in pursuing activities of choice in integrated settings.

E.4. **The planning process honors the "dignity of risk" and "right to fail" as evidenced by the following:**

E.4.1. Prior to appealing to coercive measures, practitioners try different ways of engaging and persuading individuals in ways which respect their ability to make choices on their own behalf.

E.4.2. Unless determined to require conservatorship by a judge, individuals are presumed competent and entitled to make their own decisions. As part of their recovery, they are encouraged and supported by practitioners to take risks and try new things. Only in cases involving imminent risk of harm to self or others is a practitioner authorized to override the decisions of the individual. Person-centered care does not take away a practitioner's obligation to take action to protect the person or the public in the event of emergent or crisis situations, but limits the authority of practitioners to specifically delimited circumstances involving imminent risk as defined by relevant statutes.

E.4.3. In all other cases, practitioners are encouraged to offer their expertise and suggestions respectfully within the context of a collaborative relationship, clearly outlining for the person his or her range of options and possible consequences. Practitioners support the dignity of risk and sit with their own discomfort as the person tries out new choices and experiences that are necessary for recovery.

E.4.5. In keeping with this stance, practitioners encourage individuals to write their own crisis and contingency plans (such as psychiatric advanced directives or the crisis plans of the WRAP model). Ideally, such plans are directed by the individual but developed in collaboration with the entire team so as to share responsibility and resources in preventing or addressing crises[23]. Such plans provide detailed instructions regarding preferred interventions and responses in the event of crisis, and maximize an individual's ability to retain some degree of autonomy and self-determination at a time when he or she is most likely to have these rights taken away. This plan is kept in an accessible location and can be made available for staff providing emergency care.

E.5. **Administrative leadership demonstrate a commitment to both outcomes and process evaluation. For example:**

E.5.1. Outcomes evaluation in a provider-driven paradigm is typically limited to change in specific agency functions (e.g., length of hospital stays) as well as by the need to protect the image of the agency (e.g., consumer satisfaction)[24]. In a consumer or family-driven paradigm, in contrast,

evaluation is a continuous process and expectations for successful outcomes in a broad range of quality of life dimensions (e.g., in areas such as employment, social relationships, community membership, etc.) are high. The maintenance of clinical stability alone is not accepted as a treatment outcome as the experience of recovery is about much more than the absence of symptoms or distress.

---

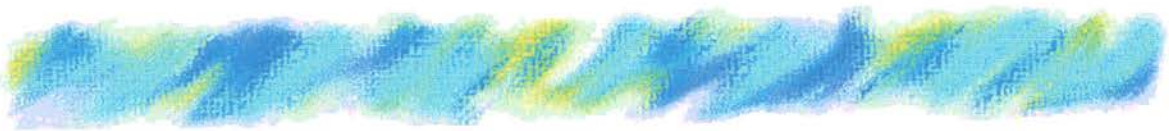
[23]Kendziora, K. T., Bruns, E., Osher, D., Pacchiano, D., & Mejia, B. (2001). *Wraparound: Stories from the Field.* Washington, DC: Center for Effective Collaboration and Practice, American Institutes for Research.

[24]Osher, T. & Osher, D. (2001). The paradigm shift to true collaboration with families. *The Journal of Child and Family Studies, 10*(3), 47-60.

E.5.2. There is a flexible application of process tools, such as the Assessment of Person-Centered Planning Facilitation Integrity Questionnaire[25], to promote quality service delivery. Assuming attention is paid to the larger organizational culture, process tools can be helpful in defining the practice and then monitoring its effective implementation[26].

What you will hear from people in recovery when you are offering individualized recovery planning:

- *It's amazing what you can do when you set your mind to it ... especially when you're no longer supposed to have one!*
- *It made such a huge difference to have my pastor there with me at my planning meeting. He may not be my father, but he is the closest thing I've got. He knows me better than anyone else in the world and he had some great ideas for me.*
- *I had been working on my recovery for years. Finally, it felt like I was also working on my LIFE!*
- *Not everybody thought it was a good idea for me to try to get my daughter back. But they realized that without her, I didn't have a reason to be well. So, we figured out a plan for what to do if I couldn't handle the stress, and my whole team has stood beside me every step of the way. Was it "too stressful" at times? You bet! But every day is a blessing now that I wake up and see her smiling face!*



[25] Holburn, S. (2001). How science can evaluate and enhance person-centered planning. *Research and Practice for Persons with Severe Disabilities, 27*(4), 250-260.

[26] Osher, T., Osher, D. & Blau, G. (2005a). Family-driven Care: A working definition. Alexandria, VA: Federation of Families for Children's Mental Health. http://ffcmh.org/systems_whatis.htm.

F. Functioning as a Recovery Guide

The sentiment that "we're not cases, and you're not managers"[27] has been accepted increasingly as a fundamental challenge to the ways in which behavioral health care is conceptualized within a recovery-oriented system. During this time, the predominant vehicle for offering services to many adults with serious disabilities has evolved from the team-based and *in vivo* approach of intensive case management to the introduction of strengths-based and rehabilitative forms of case management that attempt to shift the goals of care from stabilization and maintenance to enhanced functioning and community integration.

From the perspective of recovery, however, even these inherited models of case management limit the progress that otherwise could be made in actualizing the shift from a deficit- and institution-based framework to a recovery paradigm. This paradigm calls for innovative models of community-based practice that move beyond the management of cases, and beyond merely semantic changes that introduce new terms for old practices, to the creation of a more collaborative model which respects the person's own role in directing his or her life and, within that context, his or her own treatment (in much the same way that people, in collaboration with their health care professionals, make decisions about their own medical care for other conditions such as hypertension). One such model that is emerging within DMHAS is that of the community or recovery guide.

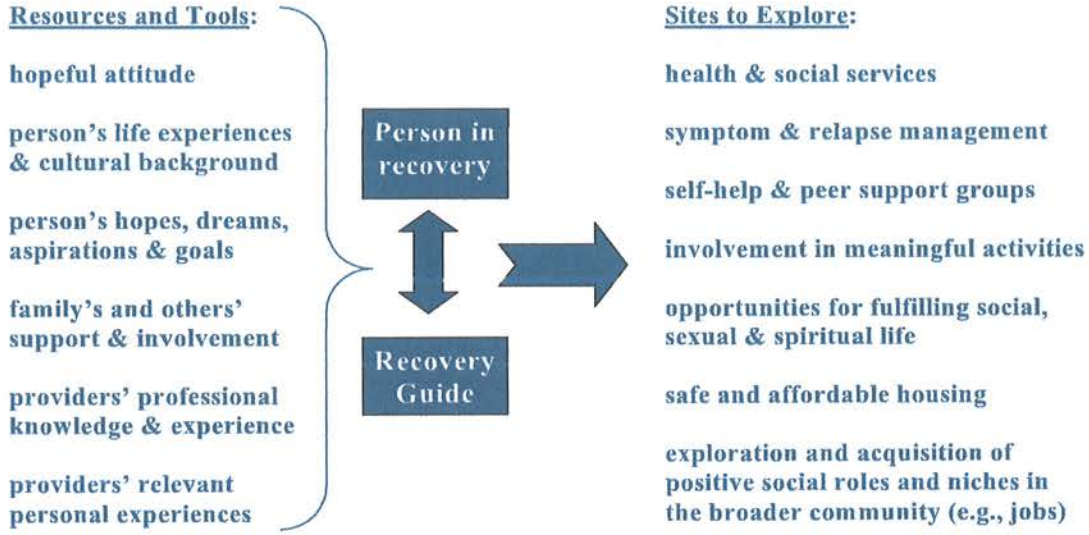
Rather than replacing any of the skills or clinical and rehabilitative expertise that practitioners have obtained through their training and experience, the recovery guide model offers a useful framework in which these interventions and strategies can be framed as tools that the person can use in his or her own recovery. In addition, the recovery guide model, as depicted on the following page, offers both providers and people in recovery a map of the territory they will be exploring together.

Prior to attempting to embark with a client on his or her journey of recovery, however, practitioners appreciate that the first step in the process of treatment, rehabilitation, or recovery is often to engage in a relationship a reluctant, disbelieving, but nonetheless suffering, person. In this sense, practitioners accept that most people with behavioral health disorders will not know that they have an addiction or psychiatric disorder at first, and therefore will frequently not seek help on their own. The initial focus of care is thus on the person's own understanding of his or her predicament (i.e., not necessarily the events or difficulties which brought him or her into contact with care providers), and on the ways in which the practitioner can be of assistance in addressing this predicament, regardless of how the person understands it at the time.

---

[27]Everett, B. & Nelson, A. (1992). We're not cases and you're not managers. *Psychosocial Rehabilitation Journal, 15(4),* 49-60.

Figure 1. Conceptual Model for the Recovery Guide



It also is important to note that within this model, care incorporates the fact that the lives of people in recovery did not begin with the onset of their disorders, just as their lives are not encompassed totally by substance abuse or psychiatric treatment and rehabilitation. Based on recognition of the fact that people were already on a journey prior to the onset of their disorders, and therefore prior to coming into contact with care, the focus of care shifts to the ways in which this journey was impacted or disrupted by each person's disorder(s).

For example, practitioners strive to identify and understand how the person's substance use or psychiatric disorder has impacted on or changed the person's aspirations, hopes, and dreams. If the person appears to be sticking resolutely to the hopes and dreams he or she had prior to onset of the disorder, and despite of or without apparent awareness of the disorder and its disabling effects, then what steps need to be taken for him or her to get back on track or to take the next step or two along this track? Rather than the reduction of symptoms or the remediation of deficits—goals that we assume the person will share with care providers—it is the person's own goals for his or her life beyond or despite his or her disability that drive the treatment, rehabilitation, and recovery planning and efforts.

You will know that you are functioning as a Recovery Guide when:

F.1. The primary vehicle for the delivery of most behavioral health interventions is the relationship between the practitioner and the person in recovery. The care provided must be grounded in an appreciation of the possibility of improvement in the person's condition, offering people hope and/or faith that recovery is "possible for me." Practitioners convey belief in the person even when he or she cannot believe in him or herself and serve as a gentle reminder of his or her potential. In this sense, staff envision a future for the person beyond the role of "mental patient" or "addict" based on the person's own desires and values and share this vision with the person through the communication of positive expectations and hope.

F.2. Providers assess where each person is in relation to the various stages of change (e.g., pre-contemplation, preparation, etc.) with respect to the various dimensions of his or her recovery. Interventions are appropriate to the stages of change relevant to each focus of treatment and rehabilitation (e.g., a person may be in an action phase related to his or her substance use disorder but be in pre-contemplation related to his or her psychiatric disorder).

F.3. Care is based on the assumption that as a person recovers from his or her condition, the addiction or psychiatric disorder then becomes less of a defining characteristic of self and more simply one part of a multi-dimensional sense of identity that also contains strengths, skills, and competencies. Services elicit, flesh out, and cultivate these positive elements at least as much as, if not more than, assessing and ameliorating difficulties. This process is driven by the person in recovery through inquiries about his or her hopes, dreams, talents, and skills, as well as perhaps the most important question of "How can I be of help?"

F.4. Interventions are aimed at assisting people in gaining autonomy, power, and connections with others. Practitioners regularly assess the services they are providing by asking themselves: "Does this person gain power, purpose (valued roles), competence (skills), and/or connections (to others) as a result of this interaction?" and, equally important: "Does this interaction interfere with the acquisition of power, purpose, competence, or connections to others?"

F.5. Opportunities and supports are provided for the person to enhance his or her own sense of personal and social agency. For example, practitioners understand that medication is only one tool in a person's "recovery tool box" and learn about alternative methods and self-management strategies in which people use their own experiences and

knowledge to apply wellness tools that work best for them. Sense of agency involves not only feeling effective and able to help oneself but also being able to positively impact the lives of others. Providers can achieve this by thoughtfully balancing when to do for someone, do with someone, or when to let someone do for him or herself. Knowing when to hold close and support and protect, when to encourage someone while offering support, when to let someone try alone and perhaps stumble, and when to encourage a person strongly to push themselves is an advanced, but essential, skill for practitioners to develop. While these are intuitive skills that all practitioners must struggle to refine over time, prior to taking action it is always beneficial for practitioners to ask the question: "Am I about to do for this person something she or he could manage to do more independently." Strong messages of low expectations and incapability are given, and reinforced, every time unnecessary action is undertaken for a person, instead of with them.

F.6. Individuals are allowed the right to make mistakes, and this is valued as an opportunity for them to learn. People in recovery report that they have found meaning in adverse events and failures and that these have subsequently helped them to advance in their recovery. In accordance with this, practitioners recognize that their role is not necessarily to help people avoid adversity or to protect them from failure. For example, the re-experiencing of symptoms can be viewed as a part of the recovery process and not necessarily a failure or setback. The "dignity of risk" ensues following a thoughtful and proactive planning process in which practitioners work collaboratively with individuals to develop relapse prevention plans, including advance directives which specify personal and treatment preferences in the event of future crises.

F.7. People are allowed to express their feelings, including anger and dissatisfaction, without having these reactions attributed to symptoms or relapse.

F.8. Care is not only attentive to cultural differences across race, ethnicity, and other distinctions of difference (e.g., sexual orientation), but incorporates this sensitivity at the level of the individual. Only an individual-level process can ensure that practitioners avoid stereotyping people based on broad or inaccurate generalizations (e.g., what all lesbians want or need), and enable them instead to tailor services to the specific needs, values, and preferences of each person, taking into account each individual's ethnic, racial, and cultural affiliations.

F.9. Rather than dwelling on the person's distant past or worrying about the person's long-term future, practitioners focus on preparing people for the next one or two steps of the recovery process by anticipating what lies immediately ahead, by focusing on the challenges of the present situation, and by identifying and helping the person avoid or move around potential obstacles in the road ahead. Although the practitioner deemphasizes the person's early personal history (because it may not be relevant) and long-term outcome (because it cannot be predicted), either of these perspectives may be invoked should they prove useful in the current situation. Especially as these issues pose barriers to recovery, practitioners utilize appropriate clinical skills within the context of a trusting relationship in order to enhance the person's capacity to overcome, compensate for, or bypass these barriers (see section #H below).

F.10. Interventions are oriented toward increasing the person's recovery capital as well as decreasing his or her distress and dysfunction (see Sections #C and #H). Grounded in a person's "life-context," interventions take into account each person's unique history, experiences, situations, developmental trajectory, and aspirations. In addition to culture, race, and ethnicity, this includes less visible but equally important influences on each person's development, including both the traditional concerns of behavioral health practitioners (e.g., family composition and background, history of substance use and relapse triggers) as well as less common factors such as personal interests, hobbies, and role models that help to define who each person is as an individual and as a member of his or her network.

F.11. Practitioners are willing to offer practical assistance in the community contexts in which their clients live, work, and play. In order to effectively address "individuals' basic human needs for decent housing, food, work, and 'connection' with the community," practitioners are willing to go where the action is, i.e., they get out of their offices and out into the community[28]. They are prepared to go out to meet people on their own turf and on their own terms, and to "offer assistance which they might consider immediately relevant to their lives"[29].

---

[28] Curtis, L.& Hodge, M. (1994). Old standards, new dilemmas: Ethics and boundaries in community support services. *Psychosocial Rehabilitation Journal, 18(2),* 13-33.

[29] Rosen, A. (1994). Case management: The cornerstone of comprehensive local mental health services. *Australian Hospital Association, Management Issues* Paper No. 4. April, 47-63.

F.12. Care is not only provided in the community but is also oriented toward increasing the quality of a person's involvement in community life. Thus, the focus of care is considered more important than locus of where it is provided. The focus of care includes the process of overcoming the social and personal consequences of living with psychiatric and/or substance use disorders. These include gaining an enhanced sense of identity and meaning and purpose in life and developing valued social roles and community connections despite a person's continued symptoms or disability. Supporting these goals requires that practitioners have an intimate knowledge of the communities in which their clients live, the community's available resources, and the people who are important to them, whether it is a friend, parent, employer, landlord, or grocer. Practitioners also are knowledgeable about informal support systems that are in communities such as support groups, singles clubs, and other special interest groups, and actively pursue learning more about other possibilities that exist to help people connect.

F.13. Efforts are made to identify sources of incongruence between the person and his or her environment and to increase person-environment fit. This is done both by helping the person assimilate into his or her environment (through symptom management, skill acquisition, etc.) and by helping the community to better accommodate people with disabilities (through education, stigma reduction, the creation of niches, etc.), with the common goal being to develop "multiple pathways" into and between members of communities.

F.14. In order to counteract the often hidden effects of stigma, practitioners explicitly draw upon their own personal experiences when considering the critical nature of various social roles in the lives of all individuals (e.g., being a parent, a worker, a friend, etc), continuing to view people in recovery squarely within the context of their daily lives (i.e., as opposed to within institutional settings).

F.15. Community-focused care supplements, and is not meant to be a substitute for, the practitioner's existing expertise and services. Rather than devaluing professional knowledge and experience, the "recovery guide" approach moves psychiatry much closer to other medical specialties in which it is the health care specialist's role to assess the person, diagnose his or her condition, educate the person about the costs and benefits of the most effective interventions available to treat his or her condition, and then provide the appropriate interventions. There is an expectation that practitioners engage in on-going professional education so that they are aware of, and can deliver, a wide range

of evidence-based and emerging practices. But no matter how expert or experienced the practitioner, it is then ideally left up to the person and his or her loved ones to make decisions about his or her own care.

F.16. Recovery is viewed as a fundamentally social process, involving supportive relationships with family, friends, peers, community members, and practitioners. Interventions serve to minimize the role that professionals play in people's lives over time and maximize the role of natural supports. While the provider-person relationship can be a powerful component of the healing and recovery process, individuals must also develop and mobilize their own natural support networks to promote sustained recovery and independent community life.

What you will hear from people in recovery when you are functioning as a recovery guide:

- *She believed in me, even when I didn't believe in myself. Hope was the biggest gift she could have given me... and it saved my life.*
- *When he asked me, "So how can I best be of help!" I thought, "Oh great, I've really got a green one. You are supposed to be the professional–you tell me!" But I get it now. I need to decide what I need to move ahead in my recovery. And I needed to know it was OK to ask people for that. That was the key.*
- *When she ever showed up on my doorstep with a bag of clothes so my baby could start kindergarten, I knew this one was different. I couldn't care about myself or my recovery until I knew my kids were OK. She didn't pity me, or look for a pat on the back. She just knew, this was what I needed and it made all the difference in my recovery.*
- *I was terrified of going back to that hospital. My case manager couldn't guarantee me that it wouldn't happen again. But we sat down together and did a plan for how to make things different if there ever was a "next time." Knowing my dog would get fed, making sure somebody talked to my landlord so I wouldn't get evicted, and being able to write down how the staff could help me if I lost control... All those things made the idea of going back less scary.*

G. Community Mapping and Development

Given its focus on life context, one tool required for effective recovery planning is adequate knowledge of the person's local community, including its opportunities, resources, and potential barriers. This knowledge is to be obtained and updated regularly at a community-wide level for the areas in which a program's service recipients live, but also is to be generated on an individual basis contingent on each person's interests, talents, and needs.

Historically falling under the purview of social work and rehabilitation staff, the function of identifying, cataloguing, and being familiar with community resources both within and beyond the formal behavioral health system can be carried out by staff from any discipline with adequate training and supervision. In most cases, however, this expertise will reside with local community-based providers rather than with inpatient or residential staff located at a distance from the person's community of origin. In such cases, close coordination between inpatient/residential and outpatient staff will be required to obtain and integrate this information into the individualized recovery plan. Regardless of how it is provided, a comprehensive understanding of the community resources and supports that are available to address the range of a person's needs as he or she identifies them is essential to the recovery planning process across the continuum of care.

Asset-based community development is one essential strategy for developing this comprehensive understanding of local resources and supports. Based on the pioneering work of Kretzmann and McKnight ("Building Communities from the Inside Out"), asset-based community development (ABCD) is a widely recognized capacity-focused approach to community development that can help open doors into communities for persons who have been labeled or otherwise marginalized, and through which people in recovery can build social capital and participate in community life as citizens rather than clients.

Through the cultivation of mutually beneficial relationships, ABCD has been shown to be an effective technology for capitalizing upon the internal capacities of low-income urban neighborhoods and rural communities, particularly as the depth and extent of associational life in these communities is often vastly underestimated[30]. Whereas community development has historically been deficit- or problem-based and fueled by "needs assessments" and "needs maps," ABCD operates on the premise that every person in a community has gifts, strengths, skills, and resources to be contributed to the community and that community life is shaped, driven, and

---

[30]Kretzmann, J.P. &, McKnight, J.L. (1993). Building Communities from the Inside Out. Chicago, IL. ACTA Publications.

sustained by the contributions of an involved and interdependent citizenry. Capacity, strength, and resources are also derived from community associations (religious, civic, recreational, political, social, etc.) and from community institutions (schools, police, libraries, parks, human services, etc.).

Asset-based community development is a fully participatory process that involves all persons in mapping the resources and capacities of a community's individuals, its informal associations, and its structured institutions, as a means of identifying existing, but untapped or overlooked, resources and other potentially hospitable places in which the contributions of people with disabilities will be welcomed and valued[31]. Information about individuals, community associations, and institutions is collected through the sharing of stories and in one-on-one interviews that foster the development of personal relationships.

The relationships, resource maps, and capacity inventories that result from this process serve to guide on-going community development and provide a means by which people can expand their existing social networks and involvement in community activities. Pride in past achievements is strengthened, new opportunities for creative endeavor are discovered, resiliency is experienced, and hope is sustained. It is important to note that the primary producers of outcomes in this process are not institutions but individuals strengthened by enhanced community relationships. ABCD ultimately helps people in recovery derive great benefit from access to a range of naturally occurring social, educational, vocational, spiritual, and civic activities involved in their return to valued roles in the life of their community.

You will know you are engaged in community mapping and development when:

G.1. People in recovery and other labeled and/or marginalized persons are viewed primarily as citizens and not as clients and are recognized for the gifts, strengths, skills, interests, and resources they have to contribute to community life.

G.2. Community leaders representing a range of community associations and institutions work together with people in recovery to carry out the process of community development.

[31] McKnight, J. (1992). Redefining community. *Journal of Social Policy, Fall/Winter,* 56-62.

G.3. People in recovery and other community members experience a renewed sense of empowerment and social connectedness through voluntary participation in civic, social, recreational, vocational, religious, and educational activities in the community. Therefore, opportunities for employment, education, recreation, social involvement, civic engagement, and religious participation are regularly identified and are compiled in asset maps, capacity inventories, and community resource guides. These informational resources are made available to individuals on their initial agency orientation and are updated over time as knowledge about the local community grows.

G.4. Asset maps and capacity inventories created collaboratively by actively involved community stakeholders reflect a wide range of *natural* gifts, strengths, skills, knowledge, values, interests, and resources available to a community through its individuals, associations, and institutions. In other words, they are not limited to social and human services or professional crisis or emergency services.

G.5. High value is placed on the less formal aspects of associational life that take place, for instance, in neighborhood gatherings, block watch meetings, coffee clatches, salons, barbershops, book groups, knitting and craft circles, restaurants, pubs, diners, etc.

G.6. Institutions do not duplicate services that are widely available in the community through individuals and associations.

G.7. Community development is driven by a creative, capacity-focused vision identified and shared by community stakeholders. It is neither deficit-oriented nor driven by needs assessments and needs maps.

G.8. The relational process of gathering information about community assets and capacities through personal interviews and sharing of stories is recognized as being as important as the information that is collected.

What you will hear from people in recovery when you are engaged in community mapping and development:

- *I just wanted to get back to my life: my friends, and my job, and my church activities. My recovery was important, but it didn't matter so long as I didn't have those things in my life to look forward to. It was those things that kept me going in my darkest days.*

- *Just having a place to hang out, where I blend in with the crowd... where no one knows me as a patient on the ACT team. That is when I am most peaceful.*

- *It wasn't enough for me to just get better. I appreciated everyone's help, but I felt like such a charity case all the time. What really made a difference was when my counselor helped me to get a volunteer position at the local nursing home. Sometimes I read to the folks, or we play cards. It may not be fancy, but it feels right to me. I don't just have to take help from everybody else, I have valuable things to give back in return.*

- *I knew all about the places where folks could go to get help if you had a problem with drugs or mental illness. What I had forgotten about was how to have FUN! My case manager gave me this terrific list of low-cost activities that happen right around the corner from my apartment, and I never even knew this stuff was right under my nose. It's opened up a whole new world for me. I made some great friends, and one of them is even looking for some part-time help in her art store--so I'm gonna get a job out of it too! Things happen in the strangest ways sometimes...*

- *My yoga class at the mental health center got cancelled, and instead, they gave us a coupon to try out some free lessons at the city Rec Department. At first I was so disappointed. But once I tried it out, I loved it. I now take pilates in addition to yoga and I also joined a hiking club. I feel healthier physically and mentally...*

H. Identifying and Addressing Barriers to Recovery

To this point, our guiding assumption has been that behavioral health disorders are illnesses like any others and that, with few exceptions, seeking and receiving care for these disorders should resemble care provided for other medical conditions. Although we have made a point of stressing the need for outreach and engagement to ensure access to care, we otherwise may have given the reader the impression that people with behavioral health disorders are educated consumers of health care and that they will naturally act on their own behalf in making appropriate choices in this and other domains.

Experienced providers will no doubt consider such a perspective simplistic and naïve, and will suggest that up to 80% of the work entailed in treating behavioral health disorders is devoted to helping people to arrive at such a position of being willing to receive care for their conditions. Once a person accepts that he or she has a behavioral health disorder and agrees to participate in treatment and/or rehabilitation, the bulk of the more difficult work may appear to be done. We appreciate this sentiment, and agree that it may take a generation or more before many more people experiencing these conditions will be able to access and benefit from care in such a straightforward and uncomplicated manner.

For the foreseeable future, there will continue to be two major sources of complications—and of considerable suffering—that make accessing and benefiting from care a labor intensive and difficult process. These two types of barriers to recovery reside both external to the person, in societal stigma and discrimination and in the ways in which care has historically been structured and provided, and internal to the person, intrinsic to the nature of the illnesses themselves. In order to promote recovery, providers must be able to identify and address the variety of barriers encountered in each of these domains.

In terms of external barriers, there currently are elements and characteristics of the service delivery system and the broader community that unwittingly contribute to the exacerbation of symptoms and the creation and perpetuation of chronicity and dependency in individuals with behavioral health disorders. Foremost among these is the discrimination that continues to affect people with mental illnesses and/or addictions in society at large and, even more importantly, within the behavioral health system itself.

This discrimination results in people with behavioral health disorders being viewed and treated as second-class citizens in a variety of life domains. One byproduct of repeated discrimination is that people come to view and treat themselves as second-class citizens as well. What advocates within the mental health community have come to call "internalized stigma" presents a significant obstacle to

recovery, undermining the self-confidence and self-esteem required for the person to take steps toward improving his or her life. The demoralization and despair that are associated with internalized stigma and feelings of inferiority also tap the person's sense of hope and initiative, adding further weight to the illness and its effects.

Beyond the impact of stigma and discrimination, there are a variety of ways in which the health care system and the broader community make recovery more difficult. These range from the lack of affordable housing and accessible, high quality medical care to the employment disincentives built in to entitlement programs, to the punitive aspects of some care settings and programs (e.g., in which people are discharged for manifesting the symptoms of their illness). Identifying and assisting the person to overcome these barriers to the degree that is possible is an important component of the work of the recovery-oriented behavioral health care practitioner.

In terms of internal barriers, there are several aspects of behavioral health disorders and their place within contemporary society that complicate and undermine the person's efforts. For example, while trauma may not be intrinsic to behavioral health per se, there is considerable evidence that suggests that people experiencing behavioral health disorders at the present time have a greatly increased chance of having experienced a history of trauma earlier in their lives, as well as being at increased risk for exposure to trauma and victimization currently.

Perhaps more directly as a consequence of the illness itself, there also are symptoms of behavioral health disorders that pose their own barriers. The hallucinations and delusions often found in psychotic illnesses, for example, may compete as a source of information with that being offered to the person by health care practitioners, thereby discouraging the person from taking prescribed medications or otherwise participating in treatment or rehabilitation. The heightened sense of creativity and self-importance that often accompanies episodes of mania similarly may lead a person down a path that diverges from the one preferred by his or her loved ones and care providers. As destructive as they may appear to the person's loved ones or care providers, giving up delusions or mania often comes with its own costs. As a young man with a psychotic disorder once poignantly asked: "If you had the choice between being a CIA operative or a mental patient, which would you choose?"

Accepting that these and other elements associated with the disorders themselves undermine a person's efforts to cope with his or her illness, recovery-oriented practitioners become familiar with these issues and adept in working proactively with the person to overcome or bypass their destructive impact. Many of the skills and techniques traditionally utilized by clinicians within the context of office-based practice find their greatest utility and effectiveness in this domain, whether offered inside, or outside, of the office.

You will know you are addressing external and internal barriers to recovery when:

H.1. **There is a commitment at the local level to embrace the values and principles of recovery-oriented care and to move away from the dominant illness-based paradigm. The practices identified throughout this document can only grow in a culture that fully embraces recovery principles and values. Systemic changes that reflect this paradigm shift include the following:**

H.1.1. Stakeholders understand the need for recovery-oriented system change as a civil rights issue which aims to restore certain elementary freedoms (e.g., self-determination, community inclusion, etc.) to American citizens with psychiatric diagnoses and/or addictions.

H.1.2. Stakeholders work together to move away from the criteria of "medical necessity" toward "human need,"[35] from managing illness to promoting recovery, from deficit-oriented to strengths-based, and from symptom relief to personally-defined quality of life. Perhaps most critical is the fundamental shift in power involved in realigning systems to promote recovery-oriented care—the shift away from prioritizing expert knowledge over respect for personal autonomy and self-determination[32].

H.1.3. The possibility of recovery, and the responsibility to deliver recovery-oriented care, must be embraced by all stakeholders at all levels of the system. While many exciting things are occurring in agencies across the country, recovery-oriented change tends to occur in a fairly fragmented manner with a relatively small number of progressive practitioners or advocates taking on a large amount of responsibility for carrying out the recovery mission. For example, certain programs and staff in behavioral health systems (e.g., peer staff, rehabilitation providers, community-based case managers, etc.) are uniquely positioned to be leaders in the mission to provide recovery-oriented care, and the contributions of these programs should be respected and capitalized upon. Taking a lead in the recovery mission is a natural fit for such programs for a variety of reasons including their structure as private-

---

[35] Tondora, J., Pocklington, S., Gorges, A., Osher, D. & Davidson, L. (2005). *Implementation of person-centered care and planning: From policy to practice to evaluation.* Washington D.C.: Substance Abuse and Mental Health Services Administration.

[36] Osher, T. & Osher, D. (2001). The paradigm shift to true collaboration with families. *The Journal of Child and Family Studies, 10*(3), 47-60; WNYCCP. (2005). *Foundations of person-centeredness. Training curriculum,* Western New York Care Coordination Program. Rochester, NY: Coordinated Care Services.

non profit entities, their rehabilitation expertise, lower pressure and demands to deliver only medically necessary care, and their direct affiliations with the state or national consumer/recovery movement. However, agencies and systems must guard against the complacency which results when recovery is seen as being a "nice add-on," but "not part of my job" or as being manifest only in "special" (sometimes "token") programs that are split off from the functioning of the agency as a whole. Recovery-oriented system change will only take hold and thrive if it is understood that it is the shared mission of all stakeholders and that the task of promoting recovery—as the overarching aim of all behavioral health services—is a part of everyone's job. Resources and guidelines are emerging which define exactly what that job is depending on what one's role is as a practitioner (e.g., primary clinician, peer specialist, supported employment specialist) within the system.

H.2. **Systemic structures and practices which inhibit the adoption of recovery-oriented practices are identified and addressed. Representative change strategies in this area include the following:**

H.2.1. Well intentioned efforts to provide a full "continuum" of care have led to a system in which people are sometimes expected to enter in, and progress through, a range of services in a sequential fashion as they "stabilize" and move toward enhanced functioning and greater independence. The misapplication of this model has led to systems of care in which individuals are then expected to jump through hoops in order to earn their way into less restrictive settings (e.g., an expectation that they prove they can prepare three meals a day or keep their living space clean before they can move out of a group home) or to earn the right to participate in preferred services (e.g., an expectation that they comply with medication or outpatient psychotherapy groups before they will be referred to a supported employment program).

In addition to there being an accumulating body of evidence which demonstrates the failure of such a continuum approach, this sequential movement through a pre-existing continuum of supports is inconsistent with the civil rights perspective noted above and it contradicts current knowledge suggesting that recovery is neither a linear process or a static end product or result. Rather, it is for many a life-long experience that involves an indefinite number of incremental steps in various life domains, with people moving fluidly between the various domains over time (as opposed to moving through these dimensions in a systematic, linear process). Rather than a pre-established continuum of services,

what is necessary is a flexible array of supports that each person can choose from at different points in time depending upon his or her phase of recovery and unique needs and preferences. This array should be constantly evolving based on the input of persons in recovery, the experience of practitioners, and the research literature.

H.2.2. There is often a lack of clarity regarding system priorities when agencies attempt to implement numerous initiatives simultaneously, e.g., evidence-based practice versus recovery-oriented programming. While such initiatives may not be incompatible, competing demands–even complementary ones–can diffuse the effort and resources of the agency and inhibit the adoption of any new practices. It is critical that there are coordinating structures to attend to both the prioritization and integration of new initiatives, policies, and procedures.

H.2.3. The structure of certain outcome indicators places significant pressures on agency staff to operate in a manner that they see as inconsistent with recovery-oriented care. For example, staff might like to support persons in making choices regarding their housing preferences, such as moving to a less intensive level of supported housing. They may legitimately be concerned; however, that they will be held accountable should the result of such an individual's choice ultimately be a negative one. This accountability is not limited to the potential adverse events themselves, but is further accentuated through the agency's collection of mandatory performance data, such as statistics regarding the number of individuals who move from "housed" to "homeless." The resulting need to portray the agency's performance on such indicators as positive creates a strong incentive for the maintenance of stability as a desired outcome in and of itself. In contrast, a desired goal of recovery-oriented care is to promote growth, independence, and wellness; goals which sometimes involve the taking of reasonable risks that may result in interim set-backs. At both the agency and system level, quality management tools and outcome indicators should be examined and mechanisms should be built in to track the trade-off which sometimes exists as we support individuals in taking risks to grow and advance in their recovery.

H.2.4. Processes for continual quality assurance and independent audits by people in recovery and families trained in recovery-oriented care need to be funded and coordinated. Outcomes and assessment of quality should not focus solely on the rating of services/supports, but on whether the choices people make are personally meaningful and whether recovery-oriented care leads to a valued community life.

H.2.5. Initial placement and service design currently is driven by practitioners' assessments of what the individual seeking services needs. While this assessment should remain a critical element of the referral process, it should be coupled with questions, directed to the person and answered in his or her own words, which solicit the individual's perception of what services and supports would be most helpful. Individuals must be engaged as active partners in their care from the outset of treatment. This can only be achieved with greater transparency in the system of care as a whole and with greater involvement of the person and family in all important, decision-making processes, including the decision of initial level of care and team/program assignment.

H.2.6. Recovery plans respect the fact that services and practitioners should not remain central to a person's life over time. Currently, many behavioral health systems lack clearly defined exit criteria and it is not uncommon for individuals to feel as if they will be attached to the formal system for life following their entry into care. This perpetuates a sense of chronicity through which individuals lose hope that they will be able to resume a meaningful and productive daily life beyond treatment. In contrast, exit criteria should be established and used to engage people in a collaborative decision-making process regarding the potential advantages and risks of moving to a lower level of care, with effort being made to respect the individual's desire to "graduate" whenever possible. When an individual is strongly advised by the recovery team against "graduation," there should be evidence in the recovery plan of concrete steps being taken by the individual and the team to reach this ultimate goal. In establishing exit criteria, agencies must take caution to avoid punitive measures by which individuals are discharged from services for displaying symptoms of their illness or addition.

H.2.7. Despite legislative advances in the past decade, the structure of federal and state disability, benefits, and vocational programs continue to impede the wish of many individuals of entering, or reentering, the workforce, thereby excluding them from an activity which many have described as a cornerstone of recovery. Rigid definitions of disability, earnings limits which perpetuate poverty, a lack of supported employment programs, and complex referral procedures drastically reduce the likelihood that individuals will access necessary services and return to meaningful employment. To integrate employment within the larger system of care, the task of assisting people in entering employment and education must be inherent in the responsibilities of the entire practitioner network, including those not specifically charged with work service or supported education activities.

H.3. **The implementation of recovery-oriented care is facilitated, rather than impeded, by funding, reimbursement, and accreditation structures. Intrinsic to any dialogue regarding systemic barriers to recovery-oriented care is the need to address funding structures that recognize a limited range of clinical interactions as reimbursable services, and documentation requirements that hinder creative formulation of recovery-oriented goals and objectives. Necessary change strategies to address these barriers include the following:**

H.3.1. Rules and regulations dictating eligibility and reimbursement for Medicaid and other public supports must be adapted at the federal and state level over time for greater relevance to innovative, recovery-oriented approaches. Even though Medicaid is funded by federal dollars, it remains primarily a state-administered program, and considerable flexibility exists already in using these dollars to support innovative, community-based, recovery-oriented services and supports.

H.3.2. Within existing funding structures, training and technical assistance can be provided to practitioners attempting to implement recovery-oriented practices to assist them in learning how to translate the wishes of people in recovery into reimbursable service goals and to describe their interventions in a manner that will generate payment.

H.3.3. Operating in this manner is consistent with the growing understanding that recovery-oriented practices cannot be an add-on to existing care for which additional funding must always be secured. Rather, recovery-oriented care begins with discovering ways to be creative and flexible within the constraints of existing resources. In some cases, for example, braiding funds may enable collaborations to move beyond funding silos to provide people with flexible, highly individualized services[33]. Programs that successfully utilize such alternatives must be explored for expansion[34].

H.3.4. Self-directed funding opportunities should be considered both on a collective basis and through individualized budget programs. The Florida "Self-Directed Care" initiative is an example of such a program

---

[33]Osher, D., Dwyer, K. & Jackson, S. (2004). *Safe, supportive, and successful schools step by step.* Longmont, CO: Sopris West; Poirier, J., Osher, D. & Tierney, M. (in press). Understanding the new environment of public school funding: How pupil services are funded. In C. Franklin, M.B. Harris & C. Allen- Meares (Eds.) *School social work and mental health workers training and resource manual.* New York: Oxford University Press.

[34]Blessing, Tierney, Osher, Allegretti-Freeman, & Abrey. (2005). *Person-centered planning: Learning from other communities,* Washington D.C.: Substance Abuse and Mental Health Services Administration. .

which shifts fiscal control from the hands of service providers to the hands of service users. Within this program, participants are given control of their service dollars and then are free to shop around to weave together the type and frequencies of services that may best respond to their individual interests and preferences. While this approach has proponents, there is also an inherent tension and uncertainty about whether there is any guarantee that high quality services will be available to purchase if there are no consistent funding underpinnings. A robust practitioner network is needed and it must be easily accessible[35].

H.4. Training and staff development is prioritized as an essential function to increase individual practitioners' competency in providing recovery-oriented care. Necessary change strategies to address this issue include the following:

H.4.1. As consensus emerges regarding the knowledge and skills needed to implement recovery-oriented care, this information must lead to the development of competency models, and these models must be disseminated broadly as guidance for training programs and licensing bodies which prepare and accredit future and current providers of mental health care. For example, competency models regarding the delivery of recovery-oriented care should be used to address training gaps in pre-certification curriculum as well as ongoing professional development activities.

H.4.2. Once established, competency models—which are largely under-utilized in general in behavioral health—should be incorporated in all human resource activities (e.g., hiring, routine performance evaluation, promotion decisions, staff development targets, etc.) as a means of promoting accountability and quality improvement.

H.4.3. An analysis of staff's current competencies and self-perceived training needs should guide the development of on-going skill-building activities at the agency level. For example, practitioners are frustrated by the fact that they are overwhelmed by a constant stream of change mandates for which they receive little or no training or support. There

[35] Jonikas, J., Cook, J., Fudge, C., Hiebechuk, F. & Fricks, L. (2005). *Charting a meaningful life: Planning ownership in person/family-centered planning.* Washington D.C.: Substance Abuse and Mental Health Services Administration.

are beneficial, self-reflective tools (e.g., the CAI, RSA, RKI, etc.[36]) that can be used to conduct a training needs analysis which identifies both strengths and areas in need of improvement as it relates to the provision of recovery-oriented care. Gaps in skill sets can be identified and prioritized for development by training administrators.

H.4.4. Training in and of itself will not allow providers to develop the enhanced skill set and the increased sense of efficacy that will allow them to carry out the complex responsibilities and roles of the recovery-oriented practitioner. Competency-based training must be coupled with on-going mentor support, enhanced supervision, recovery-oriented case conferences, and opportunities for peer consultation.

H.4.5. Directors of clinical services and agency leaders should be involved in ongoing training initiatives so that there is consistency in proposed recovery-oriented practices and the system's administrative structures. This allows direct care staff to feel supported and respected and it allows agency leadership the opportunity to proactively identify, and address, any systemic barriers that prohibit the adoption of recovery-oriented practices.

H.4.6. Training and staff development activities must be sensitive to the role confusion which can result with the adoption of recovery-oriented practice. Recovery-oriented care does ***not*** imply that there is no longer any role for the practitioner to play in the treatment and recovery process. Rather, the provider's role has changed from that of all-knowing, all-doing caretaker to that of coach, architect, cheerleader, facilitator, mentor, or shepherd[37]–roles that are not always consistent with one's clinical training or experiences. One effective educational strategy may be using a combination of literature, outcomes/efficacy data, and personal accounts such as recovery dialogues to help practitioners learn the new roles of advisor, mentor, or supports broker[38].

---

[36]Campbell-Orde, T., Chamberlin, J., Carpenter, S. & Leff, S. (2005). *Measuring the promise: A compendium of recovery measures, Volume II.* Boston: Human Services Research Institute.

[37]Adams, N. & Grieder, D. (2005). *Treatment planning for person-centered care: The road to mental health and addiction recovery*. San Diego, CA, US: Elsevier Academic Press; Davidson, L., Tondora, J., Staeheli, M., O'Connell, M.J., Frey, J. & Chinman, M.J. (2006). Recovery guides: An emerging model of community-based care for adults with psychiatric disabilities. In A. Lightburn & P. Sessions (Eds.), *Community-based clinical practice*. Oxford University Press, New York.

[38]Jonikas, Cook, Fudge, Hiebechuk & Fricks. (2005). *op cit.*

Further, those involved in educating providers about self-determination and recovery-oriented care have found that acknowledging staff's fears and doubts, rather than dismissing or shaming them, is more likely to lead them to accept a new role in their clients' lives[39]. The application of sophisticated and effective clinical practices in the larger context of collaborative partnerships and self-determination is a training area that requires ongoing attention.

H.4.7. No matter how competent the workforce, no matter how ripe the culture, and no matter how compatible the funding mechanisms, recovery-oriented care will not become a reality unless people in recovery and their families understand it, are supported in using it, and come to demand it as a basic expectation of quality care. It is imperative that training initiatives regarding recovery-oriented care not neglect the needs of people in recovery and families to develop their own capacity to self-direct their treatment and life decisions. Some may already do this with great skill and acumen. Others may be reluctant to assume the seat of power, having been socialized by their culture[40] or taught by professionals and agencies that their preferred role is one of deferential compliance[41]. Ideally, training initiatives put all stakeholders, including people in recovery, families, and practitioners, at the same table.

H.5. **Forces at the societal level (e.g., stigma, discrimination, lack of basic resources, etc.) which undermine recovery and community inclusion are identified and addressed. Necessary change strategies to address this issue include the following:**

H.5.1. A lack of basic resources and opportunities (e.g., jobs, affordable housing, primary medical care, educational activities) in the broader community significantly complicates the task of recovery for persons with behavioral health disorders. This lack of resources and opportunities often stems from inadequate knowledge and skills on the part of community organizations regarding how to create welcoming and accessible environments for all people. Behavioral health practitioners have significant expertise to address this skill and knowledge gap, and should be prepared to offer supportive guidance and feedback at both

---

[39]Holburn, S. & Vietze, P. (2002). *Person-centered planning: Research, practice, and future directions.* Baltimore: Paul Brookes Publishing.

[40]Harry, B., Kalyanpur, M. & Day, M. (1999). *Building cultural reciprocity with families.* Baltimore, MD: Paul Brooks.

[41]Katz, E. & Danet, B. (1973). *Bureaucracy and the public.* New York: Basic Books.

the individual and community level. For example, consultation with a community employer regarding the impact of a certain medication on an individual's stamina can lead to a reasonable accommodation in the work place which allows greater productivity and success on the job– an outcome which is ultimately beneficial to both the individual and the employer. Provided appropriate support and consultation, many community members are excellent collaborators and can become facilitators of the recovery and community inclusion process.

H.5.2. Despite the promise of such collaborations, discrimination against people with behavioral health disorders will most likely continue for the foreseeable future. Community collaborations and education must therefore be coupled with efforts on the part of behavioral health practitioners to recognize instances of discrimination, to understand relevant disability legislation (e.g., the Americans with Disabilities Act), and to effectively utilize state and local resources (e.g., the Connecticut Legal Rights Project, the Office of Protection and Advocacy, the Equal Opportunity Employment Commission, advocacy organizations, etc.). This type of knowledge also must be built within the consumer community so that people in recovery can protect themselves by recognizing and rectifying experiences of discrimination.

H.5.3. Agencies are cautioned to avoid the establishment of 'one stop shopping' service programs. In an effort to respond simultaneously to individuals' multi-dimensional needs while also protecting them from the experience of stigma and discrimination, there is a tendency for agencies to develop "in-house" alternatives to community activities based on concern that the community will never accept or welcome individuals with behavioral health disorders. As a result, agencies often create in artificial settings, activities that already exist in the natural community. For example, developing in house medical clinics, movie nights, GED classes, social events, etc. Agencies which fall into this trap of providing a one stop shop for the needs of people with mental illness or addiction inadvertently contribute to the development of chronic "patient hood" as well as the perpetuation of discriminatory and unethical practices on the part of community members. We must continue to work with community partners to uphold their obligation to respect people with behavioral health disorders as citizens who have the right to be treated according to the principles of law that apply to all other individuals[42].

[42]National Council on Disability. (2000). *From privileges to rights: People labeled with psychiatric disabilities speak for themselves*. Downloaded from http://www.ncd.gov/newsroom/publications/privileges.html

address this internal barrier and to support people in embracing expanded roles and responsibilities. Education and ongoing support and mentoring is perhaps best offered through mental health advocacy organizations and peer-run programs.

H.6.2. Individuals with serious behavioral health disorders often have histories of trauma which impact on treatment and recovery. For example, while trauma may not be intrinsic to behavioral health per se, there is considerable evidence that suggests that people living with behavioral health disorders at the present time have a greatly increased chance of having experienced a history of trauma earlier in their lives as well as being at increased risk for future victimization[44]. Evidence also suggests that the failure to attend to a person's history of sexual and/or physical abuse will seriously undermine the treatment and rehabilitation enterprise, leading to a poor prognosis, while approaches that are responsive to trauma significantly improve treatment effectiveness and outcomes. Similar processes resulting from patterns of relating in a person's family context or immediate social environment may pose additional barriers to the person's recovery. Within the context of urban poverty and violence, e.g., the only incentive offered by abstinence may be a decreased immunity to the horrors that a person faces on a daily basis.

H.6.3. The above barriers represent more of an interaction between a person's condition and his or her experiences in the behavioral health system and the community at large. In addition, the symptoms of certain illnesses themselves may also pose direct impediments to the recovery process. As we described above, for example, hallucinations and delusions may compete with the information a person is receiving from health care professionals, thereby discouraging the person from taking prescribed medications or participating in other treatment or rehabilitation. Similarly, impairments in such areas as working memory, executive processes, language, attention and concentration, and problem solving[45] can undermine a person's abilities to articulate and assert his

[44]Sells, D., Rowe, M., Fisk, D. & Davidson, L. (2003). Violent victimization of persons with co-occurring psychiatric and substance use disorders. *Psychiatric Services*, *54*(9), 1253-1257.

[45]Saykin, A., Gur, R.C., Gur, R.E., Mozley, D., Mozley, R.H., Resnick, S., Kester, B. & Stafinick, P. (1991). Neuropsychological function in schizophrenia: Selective impairment in memory and learning. *Archives of General Psychiatry, 48,* 618-624.; Bell, M. & Lysaker, P. (1995). Psychiatric symptoms and work performance among people with severe mental illness, *Psychiatric Services,* 46(5), 508-510; Westermeyer, J. & Harrow, M. (1987). Factors associated with work impairments in schizophrenic and nonschizophrenic patients. In R. Grinker & M. Harrow (Eds.), *Clinical research in schizophrenia: A multidimensional approach.* p. 280-299. Springfield: Charles Thomas Books; Cornblatt, B. & Erlenmeyer-Kimling, L. (1984). Early attentional predictors of adolescent behavioral disturbances in children at risk for schizophrenia. In Watt, N.F., James, A.E. (eds.). (1984). *Children at risk for schizophrenia: A longitudinal perspective.* (pp. 198-211). New York,

important. My new doctor explained to me how the insurance and billing things work. And then we worked on the plan together. It still wasn't perfect, but at least I kind of knew where he was coming from and that he really HAD heard what I was trying to say.

- *All those years I spent in Social Skills groups, I met the same 20 people I knew from Clozaril Clinic and the Clubhouse. It didn't exactly expand my social horizons! Now I am playing basketball in one of the city leagues and there is this girl I've got my eye on who comes to the games. My therapist and I have been talking a lot about how I could strike up a conversation with her.*

- *The thought of getting discharged was so terrifying to me I almost didn't want to get well. But my case manager and I made sure that I had people and places I could go to for support when I needed it–and these folks had been involved in our work all along. It made a huge difference in my feeling good about taking the next step.*

- *I just didn't buy it when my clinician started talking to me about this thing called "consumer-driven care"... But she proved to me that she was for real in terms of making some changes in how we worked together— even referred me to a local self-advocacy center. I had been sitting back letting other folks call the shots, and then complaining when things got messed up. A Peer Specialist at the advocacy center called me out on it. I realized that I had gotten real comfortable letting other folks make decisions for me, and I know now that I gotta take charge of my own recovery and the Peers at the Center are helping me to do that...*

Recommended Resources for Further Reading

Adams, N. & Grieder, D. (2005). *Treatment planning for person-centered care: The road to mental health and addiction recovery.* San Diego, CA, US: Elsevier Academic Press.

Copeland, M. (2002). *The depression workbook: A guide for living with depression and manic depression. Wellness Recovery Action Plan.* Oakland, CA: New Harbinger Publications.

Davidson, L., Harding, C.M. & Spaniol, L. (2005). *Recovery from severe mental illnesses: Research evidence and implications for practice.* Boston, MA: Center for Psychiatric Rehabilitation of Boston University.

Davidson, L., Kirk, T., Rockholz, P., Tondora, J., O'Connell, M.J. & Evans, A.C. (in press). Creating a recovery-oriented system of behavioral health care: Moving from concept to reality. *Psychiatric Rehabilitation Journal*

Davidson, L., O'Connell, M., Tondora, J., Staeheli, M.R. & Evans, A.C. (2005). Recovery in serious mental illness: A new wine or just a new bottle? *Professional Psychology: Research and Practice,* 36(5), 480-487.

Davidson, L., O'Connell, M.J., Tondora, J., Styron, T. & Kangas, K. (in press). The top ten concerns about recovery encountered in mental health system transformation. *Psychiatric Services.*

Davidson, L., Stayner, D. A., Nickou, C., Styron, T. H., Rowe, M. & Chinman, M. L. (2001). "Simply to be let in": Inclusion as a basis for recovery. *Psychiatric Rehabilitation Journal, 24,* 375-388.

Davidson, L., Tondora, J., Staeheli, M., O'Connell, M., Frey, J. & Chinman, M. (2006). Recovery Guides: An emerging model of community-based care for adults with psychiatric disabilities. In A. Lightburn & P. Sessions (Eds.), *Community based clinical practice.* London: Oxford University Press.

Deegan, P.E. (1992). The independent living movement and people with psychiatric disabilities: Taking back control over our own lives. *Psychosocial Rehabilitation Journal, 15*(3), 3-19.

Deegan, P.E. (1993). Recovering our sense of value after being labeled mentally ill. *Journal of Psychosocial Nursing, 31*(4), 7-11.

Deegan, P.E. (1996). Recovery as a journey of the heart. *Psychiatric Rehabilitation Journal, 19*, 91-97.

Department of Health and Human Services. (2003). *Achieving the promise: Transforming mental health care in America.* President's New Freedom Commission on Mental Health. Final Report. Rockville, MD: Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

Department of Health and Human Services. (2005). *Transforming mental health care in America: Federal action agenda, first steps*. Rockville, MD: Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

Department of Health and Human Services. (2005). *Free to choose: Transforming behavioral health care to self-direction*. Report of the 2004 Consumer Direction Initiative Summit. Rockville, MD: Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

Department of Health and Human Services. (2006). *National Consensus Statement on Mental Health Recovery.* Rockville, MD: Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

Fisher, D. (1994). Hope, humanity, and voice in recovery from psychiatric disability. *The Journal, 5,* 13-15.

Frese, F. J. III, Stanley, J., Kress, K. & Vogel-Scibilia, S. (2001). Integrating evidence-based practices and the recovery model. *Psychiatric Services, 52*(11), 1462-1468.

Harry, B., Kalyanpur, M. & Day, M. (1999). *Building cultural reciprocity with families*. Baltimore, MD: Paul Brooks.

Jacobson, N. (2004). *In recovery: The making of mental health policy*. Nashville, TN: Vanderbilt University Press.

Jacobson, N. & Curtis, L. (2000). Recovery as policy in mental health services: Strategies emerging from the states. *Psychiatric Rehabilitation Journal, 23,* 333-341.

Jacobson, N. & Greenley, J.R. (2001). What is recovery? A conceptual model and explication. *Psychiatric Services*, 52(4), 482-485.

Kretzmann, J.P. & McKnight, J.L. (1993). *Building communities from the inside out.* Chicago, IL. ACTA Publications.

Marrone, J., Gandolfo, C., Gold, M. & Hoff, D. (1998). Just doing it: Helping people with mental illness get good jobs. *Journal of Applied Rehabilitation Counseling, 29*(1), 37-48.

Mead, S. & Copeland, M. E. (2000). What recovery means to us: Consumers' perspectives. *Community Mental Health Journal, 36*(3), 315-328.

National Council on Disability. (2000). *From Privileges to Rights: People Labeled with Psychiatric Disabilities Speak for Themselves.* Downloaded from http://www.ncd.gov/newsroom/publications/privileges.html [August 20, 2003]

Nerney, T. (2005) Quality issues in consumer/family direction. Downloaded from http://www.mentalhealth.samhsa.gov/publications/allpubs/NMH05-0194/default.asp [July 13, 2005].

O'Brien, J. (1987). A guide to life-style planning: Using the activities catalog to integrate services and natural support systems. In B. Wilcox & G.T. Bellamy (Eds.), *A comprehensive guide to the activities catalog.* Paul Brookes, Baltimore, MD.

O'Brien, C. & O'Brien, J. (2000*). The origins of person-centered planning: A community of practice perspective.* Syracuse, NY: Responsive Systems Associates.

O'Connell, M.J., Tondora, J., Evans, A.C., Croog, G. & Davidson, L. (2005). From rhetoric to routine: Assessing recovery-oriented practices in a state mental health and addiction system. *Psychiatric Rehabilitation Journal, 28*(4), 378-386.

Onken, S.J., Dumont, J.M., Ridgway, P., Dornan, D.H. & Ralph, R.O. (2002). *Mental health recovery: What helps and what hinders? A National research project for the development of recovery facilitating system performance indicators. Phase One research report.* Alexandria, VA: National Association of State Mental Health Program Directors (NASMHPD) National Technical Assistance Center (NTAC).

Osher, T., Osher, D. & Blau, G. (2005a). *Family-driven care: A working definition.* Alexandria, VA: Federation of Families for Children's Mental Health.

Osher, T. & Osher, D. (2001). The paradigm shift to true collaboration with families. *The Journal of Child and Family Studies, 10*(3), 47-60.

Ralph, R.O. & Corrigan, P. (eds.). (2005). *Recovery in mental illness: Broadening our understanding of wellness*. Washington, D.C.: American Psychological Association.

Reidy, D. (1992). Shattering illusions of difference. *Resources, 4*(2), 3-6.

Ridgway, P., McDiarmid, D., Davidson, L., Bayes, J. & other Kansas Consumers. (2002). *Pathways to recovery: A strengths self-help workbook.* Lawrence, KS: University of Kansas, School of Social Welfare, Office of Mental Health Research and Training.

Ridgway, P. & Rapp, C. A. (1997). *The active ingredients of effective supported housing: A research synthesis*. Lawrence, KS: University of Kansas, School of Social Welfare, Office of Mental Health Research and Training.

Ridgway, P., Press, A., Ratzlaff, S., Davidson, L. & Rapp, C. (2003). *Report on field testing the Recovery Enhancing Environment Measure (REE)*. Unpublished report. Lawrence, KS: University of Kansas, School of Social Welfare, Office of Mental Health Research and Training.

Roberts, G. & Wolfson, P. (2004). The rediscovery of recovery: open to all. *Advances in Psychiatric Treatment*, 10:37-49.

Saleeby, D. (2001). The diagnostics strengths manual. *Social Work, 46,* (2), 183-187.

Stefan, S. (2001). *Unequal rights: discrimination against people with mental disabilities and the Americans with Disabilities Act.* Washington, D.C.: American Psychological Association.

Tondora, J., Pocklington, S., Gorges, A., Osher, D. & Davidson, L. (2005). *Implementation of person-centered care and planning: From policy to practice to evaluation.* Washington, D.C.: Substance Abuse and Mental Health Services Administration. See http://www.psych.uic.edu/uicnrtc/cmhs/pfcppapers.htm for additional resources from the National Consensus Initiative on Person-Family Centered care.

UIC National Research and Training Center on Psychiatric Disability and the Self-Determination Knowledge Development Workgroup. (2002). *Self determination for people with psychiatric disabilities: An annotated bibliography of resources.* Chicago, IL: Author. http://www.cmhsrp.uic.edu/download/uicnrtc-sdbib.pdf

Vandercook, T., York, J. & Forest, M. (1989). The McGill Action Planning System (MAPS): A strategy for building the future. *Journal of the Association of Persons with Severe Handicaps, 14*(3), 205-215.

White, W. (2004). Addiction recovery mutual aid groups: An enduring international phenomenon. *Addiction, 99*, 532-538.

White, W. (2005). A question of justice: Recovery and civil rights. *Recovery Rising: Quarterly Journal of the Faces and Voices of Recovery*, Summer, p.6.

White, W. (2005). Recovery: Its history and renaissance as an organizing construct concerning alcohol and other drug problems. *Alcoholism Treatment Quarterly, 23*(1), 3-15.

White, W. (2005). The voice of history: The evolution of recovery celebrations. *Quarterly Journal of the Faces and Voices of Recovery*.

APPENDIX

Glossary of Recovery-Oriented Language

Examples of Strength-Based Conceptualizations

Glossary of Recovery-Oriented Language

Creation of a recovery-oriented system of care requires behavioral health care practitioners to alter the way they look at mental illness and addiction, their own roles in facilitating recovery from these conditions, and the language they use in referring to the people they serve. The following glossary and associated tables are intended as tools for providers to use as they go about making these changes in practice.[47] Not meant to be exhaustive, this material will be further enhanced in the process of implementing recovery-oriented practices across the state.

Given its central role in the remaining definitions, we will start with the term "recovery" itself, followed by a list, in alphabetical order, of other key terms.

Recovery: there are several different definitions and uses of this term in behavioral health. In the addiction recovery community, for example, this term refers to the achievement and maintenance of abstinence from alcohol, illicit drugs, and other substances (e.g., tobacco) or activities (e.g., gambling) to which the person has become addicted, vigilance and resolve in the face of an ongoing vulnerability to relapse, and pursuit of a clean and sober lifestyle.

In mental health there are several other forms of recovery. For those fortunate people, for example, who have only one episode of mental illness and then return to their previous functioning with little, if any, residual impairment, the usual sense of recovery used in primary care is probably the most relevant. That is, such people recover from an episode of psychosis or depression in ways that are more similar to, rather than different from, recovery from other acute conditions.

Persons who recover from an episode of major affective disorder or psychosis, but who continue to view themselves as vulnerable to future episodes, may instead consider themselves to be "in recovery" in ways that are more similar to, than different from, being in recovery from a heart attack or chronic medical condition. Many others will recover from serious mental illness over a longer period of time, after perhaps 15 or more years of disability, constituting an additional sense of recovery found in some other medical conditions such as asthma. More extended periods of disability are often associated with concerns about the effects and side effects of having been labeled with a mental illness as well as with the illness itself, leading some people to consider themselves to be in recovery also from the trauma of having been treated as mental patients.

---

[47] Credit for many of the addiction entries goes to William White, with text appreciatively borrowed and adapted from his unpublished manuscript *The Language of Addiction Recovery: An Annotated Glossary.*

Finally, those people who view taking control of their illness and minimizing its disruptive impact on their lives as the major focus of their efforts might find the sense of recovery used in the addiction self-help community to be most compatible with their own experiences. Such a sense of recovery has been embraced, for instance, among some people who suffer from co-occurring psychiatric and addictive disorders who consider themselves to be in "dual recovery."

For purposes of simplicity and clarity, the Connecticut Department of Mental Health and Addiction Services has adopted the following single definition to capture the common elements of these various forms of recovery:

> ***"Recovery involves a process of restoring or developing a meaningful sense of belonging and positive sense of identity apart from one's condition while rebuilding a life despite or within the limitations imposed by that condition."***

Other Key Terms

Abstinence-Based Recovery: is the resolution of alcohol- and other drug-related problems through the strategy of complete and enduring cessation of the non-medical use of alcohol and other drugs. The achievement of this strategy remains the most common definition of recovery in addiction, but the necessity to include it in this glossary signals new conceptualizations of recovery that are pushing the boundaries of this definition (see partial recovery, moderated recovery, and serial recovery).

Affirmative Business: see Social Cooperative/Entrepreneurialism

Asset-Based Community Development: a technology for identifying and charting the pathways and destinations in the local community most likely to be welcoming and supportive of the person's efforts at community inclusion. A first step is the development of local resource maps (see below). A strategy of community preparation is then used to address gaps identified in the resource maps through educational and other community building activities aimed at decreasing stigma and creating a more welcoming environment in partnership with local communities.

Asset Mapping: part of asset-based community development (above) referring to the process of identifying opportunities in local communities for people in recovery to take up and occupy valued social roles in educational, vocational, social, recreational, and affiliational (e.g., civic, spiritual) life. Although not a literal "map" (i.e., as in contained on a piece of paper), asset mapping involves developing and utilizing virtual or mental landscapes of community life that highlight resources, assets, and opportunities that already exist in the person's local community.

Choice: a key concept in recovery-oriented care, choice refers to the central role people with psychiatric disabilities and/or addictions play in their own treatment, rehabilitation, recovery, and life. Within the behavioral health system, people in recovery need to be able to select services and supports from among an array of meaningful options (see menu below) based on what they will find most responsive to their condition and effective in promoting their recovery. Both inside and outside of the behavioral health system, people in recovery have the right and responsibility for self-determination and making their own decisions, except for those rare circumstances in which the impact of the illness or addition contributes to their posing imminent risks to others or to themselves.

Citizenship: a strong connection to the rights, resources, roles, and responsibilities that society offers people through public institutions and associational life.

Community Supports: material and instrumental resources (including other people), and various forms of prostheses that enable people to compensate for enduring disabilities in the process of pursuing and being actively involved in naturally-occurring community activities of their choice.

Consumer: literally means someone who purchases services or goods from others. Historically has been used in mental health advocacy to offer a more active and empowered status to people who otherwise were being described as "clients" or "mental patients." Given the fact that people in recovery have not really viewed themselves as consumers in the traditional sense (ala Ralph Nader), this term has never really generated or been met with wide-spread use.

Continuity of Care/Contact: is a phrase used to underscore the importance of sustained, consistent support over the course of recovery. Such support can come from living within a community of shared experience and hope, but also can refer to the reliable and enduring relationship between the individual in recovery and his or her recovery coach. Such sustained continuity is in marked contrast to the transience of relationships experienced by those who have moved through multiple levels of care or undergone multiple treatment relationships.

Disparities in Healthcare: differences in access, quality, and/or outcomes of health care based on such issues as race, ethnicity, culture, gender, sexual or religious orientation, social class, or geographic region.

Empowerment: is the experience of acquiring power and control over one's own life decisions and destiny. Within the addiction recovery context, there are two different relationships to power. Among the culturally empowered (those to whom value is ascribed as a birthright), addiction-related erosion of competence is often countered by a preoccupation with power and control. It is not surprising then that

the transformative breakthrough of recovery is marked by a deep experience of surrender and an acceptance of powerlessness. In contrast, the culturally disempowered (those from whom value has been systematically withheld) are often attracted to psychoactive drugs in their desire for power, only to discover over time that their power has been further diminished. Under these conditions, the initiation of recovery is often marked by the assumption of power and control rather than an abdication or surrender of power.

Within the mental health context, empowerment typically refers to a person first taking back control of his or her own health care decisions prior to regaining control of his or her major life decisions and destiny. As such, "empowerment" has been used most by advocacy groups in their lobbying efforts to make mental healthcare more responsive and person-centered. In either community, empowerment is meant to be inspiring, horizon-raising, energizing, and galvanizing. The concept of empowerment applies to communities as well as individuals. It posits that the only solution to the problems of addiction and/or mental health in disempowered communities lies within those very communities. It is important to note that, by definition, one person cannot "empower" another, as to do so undermines the very premise of the term, which attributes power over the person's decisions, recovery journey, and life to the person him or herself.

Evidence-Based Practices: are clinical, rehabilitative, and supportive practices that have scientific support for their efficacy (under ideal conditions) and effectiveness (in real world settings). Advocacy of evidence-based practice is a commitment to use those approaches that have the best scientific support, and, in areas where research is lacking, a commitment to measure and use outcomes to elevate those practices that have the greatest impact on the quality of life of individuals, families and communities.

Faith-Based Recovery: is the resolution of alcohol and other drug problems within the framework of religious experience, beliefs, and rituals and/or within the mutual support of a faith community. Faith-based recovery frameworks may serve as adjuncts to traditional recovery support programs or serve as alternatives to them.

Harm Reduction (as a stage of recovery): is most often viewed as an alternative to, and even antagonistic to, recovery, but can also be viewed as a strategy of initiating or enhancing early recovery. The mechanisms through which this can occur include preventing the further depletion of recovery capital, increasing recovery capital when it does not exist, and enhancing the person's readiness for recovery via the change-encouraging relationships through which harm reduction approaches are delivered.

Inclusion: refers to a person's right to be afforded access to, and to participate in, naturally occurring community activities of his or her choice.

Illness Self-management: is the mastery of knowledge about one's own illness and assumption of primary responsibility for alleviating or managing the symptoms and limitations that result from it. Such self-education and self-management shifts the focal point in disease management from the expert caregiver to the person with the illness.

Individualized Care: see Person-Centered Care.

Indigenous Healers and Institutions: are people and organizations in the natural environment of the recovering person who offer words, ideas, rituals, relationships, and other resources that help initiate and/or sustain the recovery process. They are distinguished from professional healers and institutions not only by training and purpose, but through relationships that are culturally-grounded, enduring, and often reciprocal and/or non-commercialized.

Initiating Factors: are those factors that spark a commitment to recovery and an entry into the personal experience of recovery. Factors which serve this recovery priming function are often quite different than those factors that later serve to sustain recovery. Recovery-initiating factors can exist within the person and/or within the person's family and social environment as well as in the behavioral health system. These factors can include pain-based experiences, e.g., anguish, exhaustion, and boredom with addictive lifestyle; death of someone close; external pressure to stop using; experiences of feeling humiliated; increased health problems; failures or rejections; or suicidal thoughts. Less well-recognized, however, are the hope- and pleasure-based experiences: pursuing interests and experiencing enjoyment and success; exposure to recovery role models; new intimate relationships; marriage, parenthood, or other major positive life change; a religious experience; or new opportunities.

Jump Starts: see Initiating Factors.

Menu (of services and/or supports): an array of options from which people can then choose to utilize those services and/or supports they expect will be most effective in assisting them to achieve their goals and most responsive to their individual, familial, and socio-cultural values, needs, and preferences.

Micro Enterprise: see Social Cooperative/Entrepreneurialism.

Moderated Recovery: is the resolution of alcohol or other drug problems through reduction of alcohol or other drug consumption to a sub-clinical level (shifting the

frequency, dosage, method of administration, and contexts of drug use) that no longer produces harm to the individual or society. The concept takes on added utility within the understanding that alcohol and other drug problems exist on a wide continuum of severity and widely varying patterns of acceleration and deceleration. The prospects of achieving moderated recovery diminish in the presence of lower age of onset, heightened problem severity, the presence of co-occurring psychiatric illness, and low social support. The most common example of moderated resolution can be found in studies of people who develop alcohol and other drug-related problems during their transition from youth to adulthood. Most of these individuals do not go on to develop enduring substance-related problems, but instead moderate their use through the process of maturation.

Motivational Interventions: is a non-confrontational approach to eliciting recovery-seeking behaviors that was developed by Miller and Rollnick. This approach emphasizes relationship-building (expressions of empathy), heightening discrepancy between an individual's personal goals and present circumstances, avoiding argumentation (activation of problem-sustaining defense structure), rolling with resistance (emphasizing respect for the person experiencing the problem and his or her sense of necessity and confidence to solve the problem), and supporting self-efficacy (expressing confidence in the individual's ability to recovery and expressing confidence that they will recovery). As a technique of preparing people to change, motivational interviewing is an alternative to waiting for an individual to "hit bottom" and an alternative to confrontation-oriented intervention strategies.

Multiple Pathways of Recovery: reflects the diversity of how people enter into and pursue their recovery journey. Multiple pathway models contend that there are multiple pathways into psychiatric disorder and addiction that unfold in highly variable patterns, courses and outcomes; that respond to quite different treatment approaches; and that are resolved through a wide variety of recovery styles and support structures. This is particularly true among ethnic minority and religious communities, but diversity is to be found wherever there are people of different backgrounds.

Mutual Support/Aid Groups: are groups of individuals who share their own life experiences, strengths, strategies for coping and hope about recovery. Often called "self-help" groups, they more technically involve an admission that efforts at self-help have failed and that the help and support of others is needed. Mutual aid groups are based on relationships that are personal rather than professional, reciprocal rather than fiduciary, free rather than fee-based, and enduring rather than transient (see also Indigenous Healers and Institutions).

Natural Recovery: is a term used to describe those who have initiated and sustained recovery from a behavioral health disorder without professional intervention or

involvement in a formal mutual aid group. Since people in this form of recovery neither access nor utilize behavioral health services, it is difficult to establish the prevalence or nature of this process, but it is believed to be common.

New Recovery Advocacy Movement: depicts the collective efforts of grassroots recovery advocacy organizations whose goals are to: 1) provide an unequivocal message of hope about the potential of long term recovery from behavioral health disorders, and 2) to advocate for public policies and programs that help initiate and sustain such recoveries. The core strategies of the New Recovery Advocacy Movement are: 1) recovery representation, 2) recovery needs assessment, 3) recovery education, 4) recovery resource development, 5) policy (rights) advocacy, 6) recovery celebration, and 7) recovery research.

Natural Support: technical term used to refer to people in a variety of roles who are engaged in supportive relationships with people in recovery outside of behavioral health settings. Examples of natural supports include family, friends, and other loved ones, landlords, employers, neighbors, or any other person who plays a positive, but non-professional, role in someone's recovery.

Partial Recovery: is 1) the failure to achieve full symptom remission (abstinence or the reduction of alcohol/drug use below problematic levels), but the achievement of a reduced frequency, duration, and intensity of use and reduction of personal and social costs associated with alcohol/drug use, or 2) the achievement of complete abstinence from alcohol and other drugs but a failure to achieve parallel gains in physical, emotional, relational, and spiritual health. Partial recovery may precede full recovery or constitute a sustained outcome.

Peer: within behavioral health, this term is used to refer to someone else who has experienced first-hand, and is now in recovery from, a mental illness and/or addiction.

Peer-Delivered Services: any behavioral health services or supports provided by a person in recovery from a mental illness and/or addiction. This includes, but is not limited to, the activities of peer specialists or peer support providers (see below), encompassing also any conventional behavioral health intervention which a person in recovery is qualified to provide. Examples of these activities range from medication assessment and administration by psychiatrists and nurses who disclose that they are in recovery to illness management and recovery education by peers trained in providing this evidence-based psychosocial intervention. An underlying assumption here is that there is "value added" to any service or support provided by someone who discloses his or her own recovery journey, as such disclosure serves to combat stigma and inspire hope.

Peer-Operated or Peer-Run Programs: a behavioral health program that is developed, staffed, and/or managed by people in recovery. In contrast to peer-run businesses (described below) which are self-sustaining and able to generate profits, peer-run programs are typically private-non-profit and oriented to providing behavioral health services and supports such as respite care, transportation to and from healthcare appointments, recovery education, and advocacy.

Peer-Run Businesses: see Social Cooperative/Entrepreneurialism

Peer Specialist: a peer (see above) who has been trained and employed to offer peer support to people with behavioral health conditions in any of a variety of settings. These settings may range from assertive or homeless outreach in shelters, soup kitchens, or on the streets, to part of a multi-disciplinary inpatient, intensive outpatient, or ambulatory team, to roles within peer-run or peer-operated programs (see below).

Peer Support: while falling along a theoretical continuum, peer support differs both from traditional mutual support groups as well as from consumer-run drop-in centers or businesses. In both mutual support groups and consumer-run programs, the relationships peers have with each other are thought to be reciprocal in nature; even though some peers may be viewed as more skilled or experienced than others, all participants are expected to benefit. Peer support, in contrast, is conceptualized as *involving one or more persons who have a history of significant improvement in either a mental illness and/or addiction and who offers services and/or supports to other people with mental illnesses or addictions who are considered to be not as far along in their own recovery process.*

Person-Centered Care: behavioral health care that is based on the person's and/or family's self-identified hopes, aspirations, and goals, which build on the person's and/or family's own assets, interests, and strengths, and which is carried out collaboratively with a broadly-defined recovery management team that includes formal care providers as well as others who support the person's or family's own recovery efforts and processes, such as employers, landlords, teachers, and neighbors.

Person in Recovery: a person who has experienced a mental illness and/or addiction and who has made progress in learning about and managing his or her behavioral health condition and in developing a life outside of, or in addition to, this condition.

Recovery Capital: is the quantity and quality of internal and external resources that one can bring to bear on the initiation and maintenance of recovery from a life-changing disorder. In contrast to those achieving natural recovery, most people with

psychiatric or addictive disorders entering treatment have never had much recovery capital or have dramatically depleted such capital by the time they seek help.

Recovery Celebration: is an event in which recovered and recovering people assemble to honor the achievement of recovery. Such celebrations serve both healing and mutual support functions but also (to the extent that such celebrations are public) serve to combat social stigma attached to addiction or mental illness by putting a human face on behavioral health disorders and by conveying living proof of the possibility and enduring nature of recovery from these disorders.

Recovery Coach/Guide (Recovery Support Specialist): is a person who helps remove personal and environmental obstacles to recovery, links the newly recovering person to the recovery community and his or her broader local community, and, where not available in the natural community, serves as a personal guide and mentor in the management of personal and family recovery.

Recovery Community (Communities of Recovery): is a term used to convey the sense of shared identity and mutual support of those persons who are part of the social world of recovering people. The recovery community includes individuals in recovery, their family and friends, and a larger circle of "friends of recovery" that include both practitioners working in the behavioral health fields as well as recovery supporters within the wider community. Recovery management is based on the assumption that there is a well-spring of untapped hospitality and service within this community that can be mobilized to aid those seeking recovery for themselves and their families. "Communities of recovery" is a phrase coined by Kurtz to convey the notion that there is not one but multiple recovery communities and that people in recovery may need to be introduced into those communities where the individual and the group will experience a goodness of "fit." The growth of these divergent communities reflects the growing varieties of recovery experiences.

Recovery Management: is the provision of engagement, education, monitoring, mentoring, support, and intervention technologies to maximize the health, quality of life, and level of productivity of persons with severe behavioral health disorders. Within the framework of recovery management, the "management" of the disorder is the responsibility of the person with the disorder. The primary role of the professional is that of the recovery consultant, guide, or coach.

Recovery-Oriented Practice: a practice oriented toward promoting and sustaining a person's recovery from a behavioral health condition. DMHAS policy defines recovery-oriented practice as one that "*identifies and builds upon each individual's assets, strengths, and areas of health and competence to support the person in managing his or her condition while regaining a meaningful, constructive, sense of membership in the broader community.*"

Recovery-Oriented Systems of Care: are systems of health and human services that affirm hope for recovery, exemplify a strengths-based orientation, and offer a wide spectrum of services and supports aimed at promoting resilience and long term recovery from behavioral health disorders.

Recovery Planning and Recovery Plans: in contrast to a treatment or service plan, is developed, implemented, revised, and regularly evaluated by the client. Consisting of a master recovery plan and regular implementation/action plans, the recovery plan covers life domains in addition to behavioral health issues (e.g., physical, finances, employment, legal, family, social life, personal, education, and spiritual). In mental health settings, recovery planning follows the principles described above under person-centered care.

Recovery Priming: see Initiating Factors.

Recovery Support Services: are designed to 1) remove personal and environmental obstacles to recovery, 2) enhance identification and participation in the recovery community, and 3) enhance the quality of life of the person in recovery. Such services include outreach, engagement and intervention services; recovery guiding or coaching, post-treatment monitoring and support; sober or supported housing; transportation; child care; legal services; educational/vocational supports; and linkage to leisure activities.

Serial Recovery: is the process through which individuals with multiple concurrent or sequential problems resolve these problems and move toward optimum level of functioning and quality of life. Serial recovery refers to the process of sequentially shedding two or more drugs, or to the overlapping processes involved in recovering from addiction and co-occurring psychiatric or other physical disorders.

Social Cooperative/Entrepreneurialism: the development and operation of small businesses ("micro enterprises") by people in recovery based on their talents and interests and in partnership with their local community. The resulting businesses offer goods and services to the general public and may be either for profit or not for profit, but should be at least financially self-sustaining, although perhaps subsidized through tax breaks or other government means.

Spirituality: refers to a system of religious beliefs and/or a heightened sense of perception, awareness, performance, or being that informs, heals, connects, or liberates. For people in recovery, it is a connection with hidden resources within and outside of the self. There is a spirituality that derives from pain, a spirituality that springs from joy or pleasure, and a spirituality that can flow from the simplicity of daily life. For many people, the spiritual has the power to sustain them through adversity and inspire them to make efforts toward recovery. For some, this is part of

belonging to a faith community, while for others is may be the spirituality of fully experiencing the subtlety and depth of the ordinary as depicted in such terms as harmony, balance, centeredness, or serenity. All of these can be part of the many facets of recovery.

Triggering Mechanisms: see Initiating Factors.

User/Service Recipient: a person who receives or uses behavioral health services and/or supports, preferred by some people as an alternative to "consumer" or "person in recovery."

Valued-Based Practice: a practice which has not yet accrued a base of evidence demonstrating its effectiveness in promoting recovery, but for which there are other persuasive reasons to view it as having been a helpful resource, and as being a helpful resource in the future, for people with behavioral health conditions. Examples of value-based practices include peer-based services that offer hope, role modeling, and mentoring and culturally-specific programs oriented toward cultural subgroups.

WRAP (Wellness Recovery Action Planning): a self-help approach to illness management and wellness promotion developed by Mary Ellen Copeland.

Moving from a Deficit-Based to a Strengths-Based Approach to Care

The following are examples of how language, thinking, and practice shift in the evolution of a recovery-oriented system of care

Presenting Situation	Deficit-based Perspective		Recovery-oriented, Asset-based Perspective	
	Perceived Deficit	Intervention	Perceived Asset	Intervention
Person re-experiences symptoms	Decompensation, exacerbation, or relapse	Involuntary hospitalization; warning or moralizing about "high risk" behavior (e.g., substance use or "non-compliance")	Re-experiencing symptoms as a normal part of the recovery journey; an opportunity to develop, implement, and/or apply coping skills and to draw meaning from managing an adverse event	Express empathy and help person avoid sense of demoralization; highlight how long it may have been since symptoms had reappeared; provide feedback about the length of time it takes to achieve sustained change; offer advice on strategies to cope; reinforce sense of self-efficacy
Person demonstrates potential for self-harm	Increased risk of suicide	Potentially intrusive efforts to "prevent suicide"	Indicators of potential for self-harm are important signals to respond differently. The person is likely to have a weakened sense of efficacy and feel demoralized, and thus may require additional support. On the other hand, the person has already survived tragic circumstances and extremely difficult ordeals, and should be praised for his or her prior resilience and perseverance.	Rather than reducing risk, the focus is on promoting safety. Supportive, ongoing efforts are oriented to "promote life," e.g., enabling people to write their own safety/ prevention plans and advance directives. Express empathy; reinforce efficacy and autonomy; enhance desire to live by eliciting positive reasons and motivations, with the person, not the provider, being the source of this information.
Person takes medication irregularly	Person lacks insight regarding his or her need for meds; is in denial of illness; is non-compliant with treatment; and needs monitoring to take meds as prescribed.	Medication may be administered, or at least monitored, by staff; staff may use cigarettes, money, or access to resources as incentives to take meds; person is told to take the meds or else he or she will be at risk of relapse or decompensation, and therefore may need to be hospitalized.	Prefers alternative coping strategies (e.g., exercise, structures time, spends time with family) to reduce reliance on medication; has a crisis plan for when meds should be used. Alternatively, behavior may reflect ambivalence regarding medication use which is understandable and normal, as approximately half of people with any chronic health condition (e.g., diabetes, asthma) will not take their medication as prescribed.	Individual is educated about the risks and benefits of medication; offered options based on symptom profile and side effects; and is encouraged to consider using meds as one tool in the recovery process. In style and tone, individual autonomy is respected and decisions are ultimately the person and his or her loves one's to make. Explore person's own perspective on symptoms, illness, and medication and invite him or her to consider other perspectives. Person is resource for important ideas and insights into the problem and is invited to take an active role in problem solving process.

Presenting Situation	Deficit-based Perspective		Recovery-oriented, Asset-based Perspective	
	Perceived Deficit	Intervention	Perceived Asset	Intervention
Person makes poor decisions	Person's judgment is impaired by illness or addiction; is non-compliant with directives of staff; is unable to learn from experience	Potentially invasive and controlling efforts to "minimize risk" and to protect the person from failure, rejection, or the other negative consequences of his or her decisions	Person has the right and capacity for self-direction (i.e., Deegan's "dignity of risk" and the "right to fail"), and is capable of learning from his or her own mistakes. Decisions and taking risks are viewed as essential to the recovery process, as is making mistakes and experiencing disappointments and set backs. People are not abandoned to the negative consequences of their own actions, however, as staff stand ready to assist the person in picking up the pieces and trying again.	Discuss with the person the pros, cons, and potential consequences of taking risks in the attempt to maximize his or her opportunities for further growth and development. This dialogue respects the fact that all people exercise poor judgment at times, and that making mistakes is a normal part of the process of pursuing a gratifying and meaningful life. Positive risk taking and working through adversity are valued as means of learning and development. Identify discrepancies between person's goals and decisions. Avoid arguing or coercion, as decisions made for others against their will potentially increase their learned helplessness and dependence on professionals.
Person stays inside most of the day	Person is withdrawing and becoming isolative; probably a sign of the illness; can only tolerate low social demands and needs help to socialize	Present the benefits of spending time outside of the house; offer the person additional services to get the person out of the house to a clubhouse, drop-in center, day program, etc.	Person prefers to stay at home; is very computer savvy; and has developed skills in designing web pages; frequently trades e-mails with a good network of NET friends; plays postal chess or belongs to collectors clubs; is a movie buff or enjoys religious programs on television. Person's reasons for staying home are seen as valid.	Explore benefits and drawbacks of staying home, person's motivation to change, and his or her degree of confidence. If staying home is discordant with the person's goals, begin to motivate for change by developing discrepancies. If leaving the house is important but the person lacks confidence, support self-efficacy, provide empathy, offer information/advice, respond to confidence talk, explore hypothetical change, and offer to accompany him or her to initial activities.
Person denies that he or she has a mental illness and/or addiction	Person is unable to accept illness or lacks insight	Educate and help the person accept diagnoses of mental illness and/or addiction; facilitate grieving loss of previous self	Acceptance of a diagnostic label is not necessary and is not always helpful. Reluctance to acknowledge stigmatizing designations is normal. It is more useful to explore the person's understanding of his or her predicament and recognize and explore areas for potential growth.	In addition to exploring person's own understanding of his or her predicament, explore symptoms and ways of reducing, coping with, or eliminating distress while eliciting ways to live a more productive, satisfying life.

Presenting Situation	Deficit-based Perspective		Recovery-oriented, Asset-based Perspective	
	Perceived Deficit	Intervention	Perceived Asset	Intervention
Person sleeps during the day	Person's sleep cycle is reversed, probably due to illness; needs help to readjust sleep pattern, to get out during the day and sleep at night.	Educate the person about the importance of sleep hygiene and the sleep cycle; offer advice, encouragement, and interventions to reverse sleep cycle	Person likes watching late-night TV; is used to sleeping during the day because he or she has always worked the night shift; has friends who work the night shift so prefers to stay awake so she or he can meet them after their shift for breakfast. Person's reasons for sleeping through the day are viewed as valid.	Explore benefits and drawbacks of sleeping through the day, the person's motivation to change, the importance of the issue and his or her degree of confidence. If sleeping through the day is discordant with the person's goals, begin to motivate change by developing discrepancy, as above.
Person will not engage in treatment	Person is non-compliant, lacks insight, or is in denial	Subtle or overt coercion to make person take his or her medications, attend 12-step or other groups, and participate in other treatments; alternatively, discharge person from care for non-compliance	Consider range of possible reasons why person may not be finding available treatments useful or worthy of his or her time. It is possible that he or she has ambivalence about treatment, has not found treatment useful in the past, did not find treatment responsive to his or her needs, goals, or cultural values and preferences. Also consider factors outside of treatment, like transportation, child care, etc. Finally, appreciate the person's assertiveness about his or her preferences and choices of alternative coping and survival strategies	Compliance, and even positive behaviors that result from compliance, do not equate, or lead directly, to recovery. Attempts are made to understand and support differences in opinion so long as they cause no critical harm to the person or others. Providers value the "spirit of noncompliance" and see it as sign of the person's lingering energy and vitality. In other words, he or she has not yet given up. Demonstrate the ways in which treatment could be useful to the person in achieving his or her own goals, beginning with addressing basic needs or person's expressed needs and desires; earn trust.
Person reports hearing voices	Person needs to take medication to reduce voices; if person takes meds, he or she needs to identify and avoid sources of stress that exacerbate symptoms	Schedule appointment with nurse or psychiatrist for med evaluation; make sure person is taking meds as prescribed; help person identify and avoid stressors	Person says voices have always been there and views them as a source of company, and is not afraid of them; looks to voices for guidance. Alternatively, voices are critical and disruptive, but person has been able to reduce their impact by listening to walkman, giving them stern orders to leave him or her alone, or confines them to certain parts of the day then they pose least interference. Recognize that many people hear voices that are not distressing.	Explore with person the content, tone, and function of his or her voices. If the voices are disruptive or distressing, educate person about possible strategies for reducing or containing voices, including but not limited to medication. Ask person what has helped him or her to manage voices in the past. Identify the events or factors that make the voices worse and those that seem to make the voices better or less distressing. Plan with the person to maximize the time he or she is able to manage or contain the voices.

CONNECTICUT DEPARTMENT OF SOCIAL SERVICES

State Fiscal Year 2011
(July 2010-June 2011)

Roderick L. Bremby, Commissioner (effective April 4, 2011)
Claudette J. Beaulieu, *Deputy Commissioner, Programs*
***Established* - 1993**
***Statutory Authority* - Title 17b**
***Central Office* - 25 Sigourney Street, Hartford, CT 06106**
***Number of Employees* - 1,935**
***Operating Expenses* - $ 191,759,299**
***Program Expenses* - $ 5,195,775,795**
***Structure* - Commissioner's Office, Regional Administration, Administrative Operations, Program Operations**

MISSION

The Department of Social Services provides a continuum of services to meet the basic needs of food, shelter, economic support, and health care; to promote and support the choice to live with dignity in one's own home and community; and to promote and support the achievement of economic viability in the workforce. The department gains strength from a diverse environment to promote equal access to all agency programs and services.

STATUTORY RESPONSIBILITY

The Department of Social Services is designated as the state agency for the administration of 1.) the Child Care Development Block Grant, pursuant to the Child Care and Development Block Grant Act of 1990; 2.) the Connecticut Energy Assistance Program, pursuant to the Low Income Home Energy Assistance Act of 1981; 3.) programs for the elderly, pursuant to the Older Americans Act; 4.) the state plan for Vocational Rehabilitation Services; 5.) the Refugee Assistance Program, pursuant to the Refugee Act of 1980; 6.) the Legalization Impact Assistance Grant Program, pursuant to the Immigration Reform and Control Act of 1986; 7.) the Temporary Assistance for Needy Families program, pursuant to the Personal Responsibility and Work Opportunity Reconciliation Act of 1996; 8.) the Medicaid program, pursuant to Title XIX of the Social Security Act; 9.) the Supplemental Nutrition Assistance Program (Food Stamp), pursuant to the Food Stamp Act of 1977; 10.) the State Supplement to the Supplemental Security Income Program, pursuant to the Social Security Act; 11.) the state Child Support Enforcement Plan, pursuant to Title IV-D of the Social Security Act; 12.) the state Social Services Plan for the implementation of the Social Services and Community Services Block Grants, pursuant to the Social Security Act; 13.) the Section 8 existing certificate program and the housing voucher program, pursuant to the Housing Act of 1937; 14.) the state plan for the Title XXI State Children's Health Insurance Program; 15.) Disability Determination Services and 16) State plan for the U.S. Department of Energy – Weatherization Assistance Program for Low-Income Persons – Title 10, Part 440, Direct Final Rule – Federal Register, June 22, 2006.

DEPARTMENT OVERVIEW

The Department of Social Services provides a wide range of services to the elderly, persons with disabilities, children, families, and individuals who need assistance in maintaining or achieving their full potential for self-direction, self-reliance and independent living. Services to families, children, elders, adults and persons with disabilities include medical coverage, food and nutrition assistance, housing and energy assistance, independent living, social work and protective services, vocational rehabilitation, and financial subsistence. The Department of Social Services was established on July 1, 1993, through a merger of the Departments of Income Maintenance, Human Resources, and Aging. The merger resulted from legislation based on recommendations by the Harper-Hull Commission report in 1992.

PUBLIC CONTACT POINTS

Websites and web pages:

- DSS general: www.ct.gov/dss
- Aging Services: www.ct.gov/agingservices
- Bureau of Rehabilitation Services: www.ct.gov/brs
    - Connecticut Tech Act Project: www.CTtechact.com
    - Connecticut Tech Act AT Recycling Program: www.getATstuff.com
    - Connect-Ability: www.Connect-Ability.com
    - Connect-to-Work Center: www.connecttoworkcenter.state.ct.us
- Charter Oak Health Plan: www.charteroakhealthplan.com
- Child Care Services (including Care4Kids): www.ct.gov/dss, search on "Care4Kids"; also www.ctcare4kids.com
- Child Support Enforcement: www.ct.gov/dss and follow the link for "Families with Children"
- Connecticut Pharmaceutical Contract for the Elderly and the Disabled (ConnPACE): www.connpace.com
- HUSKY Plan: www.huskyhealth.com
- Connecticut Behavioral Health Partnership: www.ctbhp.com
- Connecticut Medical Assistance Program: www.ctdssmap.com
- Winter heating assistance: www.ct.gov/staywarm
- John S. Martinez Fatherhood Initiative of Connecticut: www.fatherhoodinitiative.state.ct.us
- Long-Term Care Ombudsman: www.ct.gov/ltcop
- Supplemental Nutrition Assistance Program (formerly food stamps): www.ct.gov/snap

Toll-free information:

- General public information: 1-800-842-1508
- TDD/TTY for persons with hearing impairment: 1-800-842-4524
- Aging services: 1-866-218-6631
- Bureau of Rehabilitation Services: 1-800-537-2549 (TTY: 860-424-4839)
    - Connect-Ability: 866-844-1903

  - Connect-to-Work Center: 1-800-773-4636 (TTY: 860-424-4839)
- Child care services: 2-1-1 or 1-800-811-6141
- Care4Kids child care subsidy program: 1-888-214-5437
- Charter Oak Health Plan: 1-877-77-CTOAK (1-877-772-8625)
- Child support enforcement: 1-888-233-7223
- CHOICES (Connecticut Health Insurance Assistance, Outreach, Information and Referral, Counseling and Eligibility Screening): 1-800-994-9422
- Connecticut Aids Drug Assistance Program (CADAP): 1-800-233-2503
- Connecticut Home Care Program for Elders: 1-800-445-5394
- Connecticut Pharmaceutical Contract to the Elderly and the Disabled (ConnPACE): 1-800-423-5026
- Connecticut Behavioral Health Partnership: 1-877-552-8247
- Connecticut Medical Assistance Program Client Assistance Center (Medicaid Fee-for-Service Program): 866-409-8430
- Connecticut Dental Health Partnership: 1-866-420-2924 or 1-855-CTDental (1-855-283-3682)
- Fraud and recoveries (including lien matters): 1-800-842-2155
- HUSKY Plan (information and referral, applications, accessing healthcare services for children, parents, relative caregivers and pregnant women): 1-877-CT-HUSKY (1-877-284-8759)
- Long-Term Care Ombudsman: 1-866-388-1888
- Winter heating/Weatherization assistance: 2-1-1 or 1-800-842-1132
- 2-1-1 Infoline: dial 2-1-1. Available 24/7. Information and referral, crisis intervention services. Operated by United Way of Connecticut with DSS funding.

DSS CENTRAL ADMINISTRATION

25 Sigourney Street, Hartford, CT 06106-5033

Department Chief of Staff and Directors:
Chief of Staff and Affirmative Action Director: Astread Ferron-Poole; Communications Director: David Dearborn; Human Resources Director: Jeanne Anderson; Legal Counsel, Regulations, Administrative Hearings Director: Brenda Parrella; Strategic Planning Manager: Anthony Judkins; Medical Care Administration Director: Mark Schaefer, Ph.D.; Certificate-of-Need and Rate-Setting Director: Christopher Lavigne; Medical Director: Robert Zavoski, M.D.; Bureau of Aging (State Unit on Aging), Community and Social Work Services Director: Pamela Giannini; Child Support Director: David Mulligan; Bureau of Rehabilitation Services Director: Amy Porter, Ph.D.; Contracts Administration Director: Kathleen Brennan; Information Technology Services Director: Louis Polzella; Quality Assurance Director: John McCormick; Financial Management and Analysis Director: Lee Voghel; Long-Term Care Ombudsman: Nancy Shaffer; Organizational and Skill Development Director: Darleen Klase

News media/public information/client information and referral:

- David Dearborn, 860-424-5024
  Email: david.dearborn@ct.gov
- Kathleen Kabara, 860-424-5068
  Email: kathleen.kabara@ct.gov

Legislative/intergovernmental relations:

- Carolyn Treiss, 860-424-5538
  Email: carolyn.treiss@ct.gov
- Heather Rossi, 860-424-5646
  Email: heather.rossi@ct.gov

Freedom of Information Act document request contact point:

- Email to: david.dearborn@ct.gov and sallie.kolreg@ct.gov

DSS Regional Office Information

Services provided through DSS Regional Offices include Temporary Family Assistance; Supplemental Nutrition Assistance Program (formerly food stamps); Medical Assistance (HUSKY Plan for children, eligible parents/caregivers, pregnant women; Medicaid for elders and adults with disabilities; Medicaid for Low-Income Adults; Medicare premium affordability assistance; State-Administered General Assistance; State Supplement Program; Social Work Services; Child Support Enforcement Services; Rehabilitation Services; Housing Assistance. For highlights of SFY 2011, please see page 38.

DSS Northern Region - Silvana M. Flattery, Regional Administrator
Serving: Andover, Avon, Ashford, Berlin, Bloomfield, Bolton, Bristol, Brooklyn, Burlington, Canterbury, Canton, Chaplin, Columbia, Coventry, Eastford, East Granby, East Hartford, East Windsor, Ellington, Enfield, Farmington, Glastonbury, Granby, Hampton, Hartford, Hebron, Killingly, Manchester, Mansfield, Marlborough, New Britain, Newington, Plainfield, Plainville, Plymouth, Pomfret, Putnam, Rocky Hill, Scotland, Simsbury, Somers, Southington, South Windsor, Stafford, Sterling, Suffield, Thompson, Tolland, West Hartford, Union, Vernon, Wethersfield, Willington, Windham, Windsor, Windsor Locks and Woodstock.

- **Hartford**—3580 Main Street 06120; 860-723-1000, or 1-800-566-2244. TDD/TYY: 860-566-7913. Silvana M. Flattery, Regional Administrator. Alejandro Arbelaez and John Hesterberg, Social Services Operations Managers.
- **Manchester**—699 East Middle Turnpike 06040; 860-647-1441, or 1-800-859-6646. TDD/TYY: 860-647-5821. Linda Roache, Social Services Operations Manager.
- **New Britain**—30 Christian Lane, New Britain 06051; 860-612-3400, or 1-866-723-2591. TDD/TYY: 860-827-7151. George Chamberlin, Social Services Operations Manager.
- **Willimantic**—676 Main Street 06226; 860-465-3500, or 1-866-327-7700. Albert Williams, Social Services Operations Manager.

DSS Western Region - Frances A. Freer, Regional Administrator
Serving: Barkhamsted, Beacon Falls, Bethel, Bethlehem, Bridgeport, Bridgewater, Brookfield, Canaan, Cheshire, Colebrook, Cornwall, Danbury, Easton, Fairfield, Goshen, Hartland, Harwinton, Kent, Litchfield, Middlebury, Monroe, Morris, Naugatuck, New Fairfield, New Hartford, New Milford, Newtown, Norfolk, Norwalk, North Canaan, Oxford, Prospect, Redding, Ridgefield, Roxbury, Salisbury, Sharon, Sherman, Southbury, Stratford, Thomaston, Torrington, Trumbull, Warren, Washington, Waterbury, Watertown, Weston, Westport, Winchester, Wolcott and Woodbury.

- **Bridgeport**—925 Housatonic Avenue 06604; 203-551-2700, or 1-877-551-2700. TDD/TYY: 203-579-6821. Frances A. Freer, Regional Administrator. Phil Ober and Alexis Kiss, Social Services Operations Managers. Regional Processing Unit for HUSKY applications, Poonam Sharma, Manager.

- **Danbury**—342 Main Street 06810; 203-207-8900. TDD/TYY: 203-797-4032. Patrick Hearn, Social Services Operations Manager.
- **Stamford**—1642 Bedford Street 06905; 203-251-9300, or 1-866-663-9300. TDD/TYY: 203-251-9304. Evelyn Balamaci, Social Services Operations Manager.
- **Waterbury**—249 Thomaston Avenue 06702; 203-597-4000, or 1-866-454-1108. TDD/TYY: 203-597-4175. Marva Perrin, Social Services Operations Manager.
- **Torrington**—62 Commercial Boulevard 06790; 860-496-9600, or 1-800-742-6906. TDD/TYY: 860-482-5719. John Souchuns, Social Services Operations Manager.

DSS Southern Region - Ronald Roberts, Regional Administrator
Serving: Ansonia, Bethany, Branford, Bozrah, Chester, Clinton, Colchester, Cromwell, Deep River, Derby, Durham, East Haddam, East Hampton, East Haven, East Lyme, Essex, Franklin, Griswold, Groton, Guilford, Haddam, Hamden, Killingworth, Lebanon, Ledyard, Lisbon, Lyme, Madison, Meriden, Middlefield, Middletown, Milford, Montville, New Haven, New London, North Branford, North Haven, North Stonington, Norwich, Old Lyme, Old Saybrook, Orange, Portland, Preston, Salem, Seymour, Shelton, Sprague, Stonington, Voluntown, Wallingford, Waterford, Westbrook , West Haven and Woodbridge.

- **New Haven**—194 Bassett Street 06511; 203-974-8000. TDD/TYY: 203-974-8394. Ronald Roberts, Regional Administrator. Cathy Patton and Frederic Presnick, Social Services Operations Managers.
- **Middletown**—117 Main Street Extension 06457; 860-704-3100. TDD/TYY: 860-704-3100. Peter Bucknall, Social Services Operations Manager.
- **Norwich**—401 West Thames Street 06360; 860-823-5000. TDD/TYY: 860-892-1429. Cheryl Parsons, Social Services Operations Manager.

BUREAU OF REHABILITATION SERVICES (BRS) OFFICE INFORMATION:

BRS provides vocational rehabilitation services to assist Connecticut residents with significant disabilities to find and keep employment.

Note: Legislation that took effect July 1, 2011 (the beginning of State Fiscal Year 2012) placed the DSS Bureau of Rehabilitation Services into a new state Bureau of Rehabilitative Services. The new bureau also includes the Board of Education Services for the Blind, the Commission on Deaf and Hearing Impaired and portions of the Workers' Compensation Commission and Department of Motor Vehicles. The Bureau of Rehabilitative Services is attached to DSS for administrative purposes only. Pending the appointment of a bureau director, DSS Commissioner Roderick L. Bremby was serving as acting director.

Central administrative office - Amy Porter, Director

25 Sigourney Street, 11th Floor, Hartford 06106; 860-424-4844 or 800-537-2549 (toll-free in Connecticut). TDD/TYY: 860-424-4839.

BRS Northern Region – Lynn Frith, District Director

- **Hartford**—3580 Main Street 06120; 860-723-1400 (TDD/TTY: 860-723-1430/860-723-1453)
- **Danielson**—95 Wescott Road, 06239; 860-412-7070 (voice); 860412-7034 (TDD/TYY).
- **Enfield**—Office temporarily closed; staff working out of Hartford office.
- **Manchester**—699 East Middle Turnpike 06040; 860-647-5960 (voice); 860-647-5968 (TDD/TYY).
- **New Britain**—30 Christian Lane 06051; 860-612-3569 (voice).

BRS Southern Region – Iris Mellow-Barnes, District Director

- **New Haven**—Suite 301, 414 Chapel Street 06511; 203-974-3000 (TDD/TYY: 203-974-3013).
- **Middletown**—117 Main Street Extension 06457; 860-704-3070 (voice).
- **New London**—Shaws Cove Six 06320; 860-439-7686 (voice and TDD/TYY).
- **Norwich**—c/o Future Works, Suite 200, North Building, 113 Salem Turnpike 06360; 860-859-5720 (voice and TDD/TYY).

BRS Western Region – Kathleen Marchione, District Director

- **Bridgeport**—1057 Broad Street 06604; 203-551-5550 (voice and TDD/TYY).
- **Danbury**—342 Main Street 06810; 203-207-8990 (voice and TDD/YTY).
- **Stamford**—1642 Bedford Street 06905; 203-251-9430 (voice and TDD/TYY).
- **Torrington**—62 Commercial Boulevard, Suite One 06790; 860-496-6990 (voice and TDD/TYY).
- **Waterbury**—249 Thomaston Avenue 06702; 203-578-4550 (voice and TDD/TYY).

SIGNIFICANT ACCOMPLISHMENTS/HIGHLIGHTS OF SFY 2011

Overview

The Department of Social Services continued to deliver critical assistance to an increasing number of Connecticut residents during fiscal 2011. As the need for public entitlement programs like Medicaid coverage and food assistance remained on an upward trend, DSS staff sustained heavy workloads of application processing, eligibility determination and case maintenance.

On April 4, 2011, Roderick L. Bremby took office as DSS Commissioner after appointment by Governor Dannel P. Malloy. Commissioner Bremby, a former seven-year Secretary of the Kansas Department of Health and Environment, was unanimously confirmed for a four-year term by the Connecticut Senate.

"DSS is an agency with a critical mission—having Rod's leadership and experience will help us streamline the agency and provide services to the people who are depending on them the most," Governor Malloy said in his appointment announcement.

Bringing public-sector management experience at the municipal and state level in Texas and Kansas, Commissioner Bremby began his term by emphasizing the themes of service, communication and accountability in visits with DSS staff throughout the state. The Commissioner also began a comprehensive evaluation of the agency, while taking immediate steps to accelerate a sweeping initiative to modernize client service delivery through technological upgrades.

Taking the helm of an agency charged with overhauling the administration of several major public health coverage programs, Commissioner Bremby oversaw preparations to transform the system from managed health care to an 'administrative services organization' structure. The initiative was scheduled to take effect January 1, 2012, expanding care coordination and support for the first time to Medicaid beneficiaries who are elderly or with disabling conditions and representing other improvements such as enhanced medical data collection and budget savings.

Commissioner Bremby succeeded Michael P. Starkowski, who served as agency head from 2007 through March 2011.

Serving nearly 700,000 individual Connecticut residents and managing over $5.1 billion in public expenditures, DSS continued to play an indispensable role in the human services safety net, especially in light of the sustained economic downturn.

Healthcare Initiatives: Covering Our Uninsured

- As fiscal 2011 began, Connecticut was becoming the first state to capitalize on the federal Patient Protection and Affordable Care Act by expanding Medicaid coverage to a new segment of the single adult population. With federal approval, DSS transferred its State-Administered General Assistance medical coverage beneficiaries to the new

Medicaid for Low-Income Adults program, retroactive to April 2010. The move provided more extensive health benefits package and first-time federal revenue for clients previously funded by solely by state expenditures. The program serves very low-income, single, childless adults who do not qualify for Medicaid because they are under age 65, do not have a permanent qualifying disability, are not pregnant, or do not have a child under age 19. Further information: www.ct.gov/dss/cwp/view.asp?Q=461916&A=2345.

- A second initiative to expand health care options was specifically designed for individuals with pre-existing conditions that prevented them from getting coverage in the past. Beginning August 1, 2011, he **Connecticut Pre-Existing Condition Insurance Plan** utilized federal funds to offer coverage regardless of income or age. The new program joined the state-sponsored Charter Oak Health Plan -- opened in July 2008 and also covering people with pre-existing conditions – to give Connecticut residents a wider range of coverage and benefit level options. Further information: www.ctpreexistingconditionplan.com; www.charteroakhealthplan.com.

- Meanwhile, the **HUSKY Plan** (Healthcare for UninSured Kids & Youth) provided extensive health coverage to nearly 400,000 children, teenagers, parents, relative caregivers and pregnant women. HUSKY A (Medicaid) serves children under 19, parents and relative caregivers in households earning at or below 185% of the federal poverty level and pregnant women earning at or below 250% of the federal poverty level while HUSKY B (Children's Health Insurance Program) offers coverage to children under 19 in households of any income above 185% of FPL. Further information: www.huskyhealth.com.

- A change in state law made it possible to make changes in the **Medicare Savings Programs**, which help many eligible Connecticut residents pay Medicare Part B premiums, deductibles and co-insurance. Specifically, the state raised the income-eligibility limits and eliminated the asset reporting requirement. Beneficiaries could earn up to $2,091.67 for a single person and $2,816.67 for a couple to qualify for one of the Medicare Savings Programs, or MSP: www.ct.gov/dss, search term "Medicare Savings Programs." In July 2011, legislation deemed Connecticut residents eligible for Medicare as no longer eligible for ConnPACE. However, with the changes in eligibility for MSP, most no longer eligible for ConnPACE would be eligible for MSP. Once enrolled, Medicare Part D co-pays actually went down to $6.30 or less; through Medicaid-funded MSP, DSS pays for Medicare Part B premiums ($96.40-$115.40 per month), and some individuals who are eligible for the MSP may even qualify to have their 20% co-insurance and Medicare deductibles covered by the state.

Serving More Connecticut Residents: Critical DSS Programs

- Nine key DSS programs showed total enrollment of more than one million at the end of SFY 2011 (duplicative number of clients, meaning a person enrolled in more than one program, such as medical coverage and food aid, is counted twice). To track this caseload level, DSS listed client participation across nine selected entitlement programs – Temporary Family Assistance; Medicaid (including HUSKY Part A and Medicaid for

Low-Income Adults); state-funded medical assistance, including home care services; Connecticut AIDS Drug Assistance Program; State-Administered General Assistance (SAGA) cash assistance; Qualified Medicare Beneficiary Program; Supplemental Nutrition Assistance Program (food stamps); and the Charter Oak Health Plan.

Individual program growth highlights included:

- 356,750 Connecticut residents receiving federally-funded SNAP/Food Stamp benefits, up 8% from the end of SFY 2010;
- 393,111 individuals receiving HUSKY A/Medicaid coverage, up 3% from the end of SFY 2010.

'Money Follows the Person' and Long-Term Support and Service System

The **Money Follows the Person Program** (MFP), a Medicaid 'rebalancing demonstration' initiative, makes services available to transition Medicaid-eligible clients back to the community. Eligible individuals must have resided in nursing homes or other institutions for a period of no less than 90 qualified days. This program receives an enhanced federal match based on a grant application that the state was awarded in 2007. Since the program was opened in 2008, DSS and service partners have transitioned 832 people to the community.

In addition to transition services, the demonstration provides long-term supports and services to participants for the first 365 days in the community. Services range from personal care assistance and/or nursing to transportation and/or housing. The unique service mix provided to each participant is studied to determine impact on quality of life, cost and health outcomes. Data collected informs additional MFP initiatives designed to increase options for community long-term care as an alternative to institutionalization.

On February 8, 2011, Lieutenant Governor Nancy Wyman and Office of Policy and Management Secretary Ben Barnes announced a new initiative combining Money Follows the Person and a long-term support and service system 'right-sizing' initiative to assist nursing facilities in adapting to changing needs of the aging population. At the same time, a long-term expansion of MFP to 5,200 transitions by 2016 was announced.

Funded by the federal Centers for Medicare and Medicaid Services, the long-term support and service initiative aims to balance Connecticut's system and provide individuals participating in the Medicaid program with a choice regarding where they receive their care and support. The initiative is being guided by a strategic plan developed in partnership with stakeholders. The plan will address removal of barriers or challenges within Medicaid that prevent choice in the system. Targeted focus areas for change include home- and community-based services, including waivers, hospital care transitions, workforce development, nursing home modernization/diversification, and housing and transportation. Strategies and tactics will be funded by the MFP demonstration. As barriers that prevent persons participating in the Medicaid program from having a choice regarding where they receive care and services, demand for

institutional care is expected to decrease. MFP competitive grants will be awarded to nursing facilities that align business practices with the strategic plan and seek to redefine and diversity their business model within the new long-term support and service continuum.

Child Support

Connecticut's **child support enforcement program** collected nearly $310.8 million in court-ordered child support during SFY 2011. The program sent $209 million in parental support to children whose families are not receiving state cash assistance benefits. Another $17.8 million went to children living out of state.

At the same time, state taxpayers benefited from approximately $16.4 million in child support collected from parents of Connecticut children receiving Temporary Family Assistance. Most of this amount goes back to the state as reimbursement for public assistance benefits. Another $22.5 million was collected on past-due amounts and kept by the state in lieu of current or past public assistance benefits.

Consumer information: 1-800-228-KIDS or on-line at www.ct.gov/dss and click on Families with Children and Child Support Resource Center; or www.jud.ct.gov/childsupport.com.

As of June 30, 2011, the program provides services on 195,899 cases. 10% of these cases are Current Assistance (active cash assistance – support assigned to the State), 53% are Former Assistance (payments to the family), and 37% are Never Assistance cases (payments to the family). 74% of the caseload have a court order for support and/or health care coverage in place.

Aging Services

CHOICES (**C**onnecticut's program for **H**ealth insurance assistance, **O**utreach, **I**nformation and referral, **C**ounseling, and **E**ligibility **S**creening), was ranked second out of 54 such programs nationally by the U.S. Centers for Medicare and Medicaid Services, the program's highest performance ranking to date. CHOICES continued to use a statewide network of community-based paid staff as well as 629 volunteers to provide older adults and adults with disabilities with health insurance assistance, outreach, information and referral counseling, and eligibility screening. In SFY 2011, CHOICES assisted more than 73,900 people.

In June 2011, the CT CHOICES program was awarded a national Certificate of Appreciation from the Centers for Medicare and Medicaid Services "in appreciation of State Health Assistance Program Services to Medicare Beneficiaries who are potentially eligible for the low income subsidy."

American Recovery and Reinvestment Act (ARRA)

DSS played a central role in Connecticut's implementation of the American Recovery and Reinvestment Act, also known as the federal stimulus bill. While the majority of projects were completed in SFY 2010, the following outlines key activities in SFY 2011:

- **Weatherization:** ARRA Supplemental Funding for the Weatherization Assistance Program is designed to reduce energy costs for low-income families, particularly for the elderly, people with disabilities, and children, by improving the energy efficiency of their homes while ensuring their health and safety.
    - 5,076 units were weatherized in SFY 2011. This number includes 206 state-financed elderly housing units weatherized through the Department of Economic and Community Development pilot project in northwestern Connecticut. Included also are 19 DSS-funded homeless and domestic violence shelters for the equivalent of 273 units.

- **Homelessness Prevention and Rapid Rehousing:** The goal of the Homelessness Prevention and Rapid Rehousing Program is to provide financial assistance and services to prevent individuals and families from becoming homeless or to re-house/stabilize those who have already become homeless.
    - 8,287 clients were served through the Homelessness Prevention and Rapid Rehousing Program --6,818 through prevention and 2,195 through rapid re-housing.
    - 2-1-1 Infoline made 81,947 referrals to housing / shelter services.

- **Child Care and Development Fund:** ARRA Supplemental Funding for the Child Care and Development Fund provides child care financial assistance to low-income working families and funds activities to improve the quality of child care. In addition, approval has been made to support one-time funding of programs in the child-care system. During SFY 2011, ARRA quality funding was distributed among four vendors for child care quality activities. Some of the quality projects funded by ARRA include development of curriculum for administration of medication in day care settings, workshops on playground safety, web-based data reporting systems (to reduce errors and increase speed of federal reimbursement claims) and computer system enhancements for child care management information systems.

- **Vocational Rehabilitation Program:** With American Recovery and Reinvestment Act (ARRA) funding, the Bureau of Rehabilitation Services (BRS) created an **Employment Division** to enhance statewide employer development. The Employment Consultants are responsible for local and regional job development efforts. The Employment Division has developed 179 work outcomes for consumers, with 89 of those outcomes taking the form of On-the-Job Trainings with local employers. Connect-Ability partnered with the Employment Division and created and developed employer-focused materials.

- **Chronic Disease Management:** ARRA provided funding for the statewide expansion of the Chronic Disease Self-Management Program. This program teaches older adults with chronic diseases practical skills to manage chronic health problems and the program gives the older adult the confidence and motivation they need to

manage challenges of living with a chronic health condition. In SFY 2011, the program was offered at 54 sites to 612 people with a variety of chronic diseases.

- **Connecticut Child Support Enforcement System:** Throughout SFY 2011, the Connecticut child support program continued development and implementation of major programming enhancements to the Connecticut Child Support Enforcement System (CCSES). The CCSES enhancements, or 'ACE' project (ARRA-funded CCSES Enhancements) consists of two programming efforts: 1) simplification of CCSES case status and case type, and 2) installation of all current updates from the Federal Parent Locator System and Federal Case Registry.

    - **Simplification of CCSES Case Status and Case Type** - Since CCSES was brought online in 1987, many system status and case type codes were added as required by federal and state law, and programmatic changes. The addition of each code however, created a more complex web of programming. In recent years, more than 500 case type/case status combinations evolved into a major problem, making child support case processing more difficult and programming more costly.

    - **Updates to Federal Case Registry and Federal Parent Locator System** - The Federal Parent Locator System is an assembly of systems operated by the federal Office of Child Support Enforcement, designed to assist states in locating putative fathers, noncustodial parents, and custodial parties for the establishment of paternity and child support obligations, and the enforcement and modification of orders for child support, custody and visitation. It also identifies support orders or support cases involving same parties in different states. Developed in cooperation with states, employers, federal agencies, and the judiciary, the Federal Parent Locator System was expanded by welfare reform to include other child support information and collection resources such as the Federal Case Registry: a national database that contains information on individuals in child support cases and child support orders. Connecticut's ongoing interface with many Federal Parent Locator System programs had been highly successful.

    - It is anticipated that the ACE project enhancements will:
        - Improve services to families by increasing available time for staff to manage child support caseloads
        - Save time and effort through increased automation.
        - Increase federal child support performance ranking and associated incentive funding
        - Help to avoid federal non-performance sanctions
        - Increase productivity to offset staff shortages
        - Reduce costs by making future system programming simpler and less costly
        - Make CCSES a viable, long-term solution to total system replacement

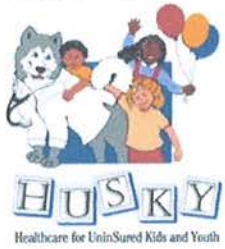
MAJOR PROGRAM AND SERVICE AREAS

Medical and Health Care Services

The Division of Medical Care Administration and Regional Offices ensure that eligible children, youth, adults, and seniors are able to access needed medical and/or prescription medication coverage through Medicaid, the State Children's Health Insurance Program, the Charter Oak Health Plan, ConnPACE, and other health coverage programs. Connecticut's HUSKY Plan (Healthcare for UninSured Kids and Youth) combines services under Medicaid and the State Children's Health Insurance Program for children, teenagers, pregnant women, and parents/caregivers. Medicaid fee-for-service coverage is provided to eligible elders, adults with disabilities and other low-income adults, while Charter Oak offers coverage to uninsured adults of all incomes.

Supporting Regional Offices and the Division of Medical Care Assistance in the delivery of medical services to DSS clients are the Bureau of Assistance Programs; the Bureau of Aging, Community and Social Work Services; and Office of Communications/Public and Government Relations.

HUSKY (Healthcare for UninSured Kids and Youth; www.huskyhealth.com or 1-877-CT-HUSKY) offers health coverage to Connecticut children and families. The program has two parts, HUSKY A (Medicaid) and HUSKY B (Children's Health Insurance Program).



In SFY 2011, Connecticut continued to operate HUSKY as one of the leading public health care programs in the nation. Over 396,900 individuals were enrolled in HUSKY A, and over 15,270 in HUSKY B, as the fiscal year ended.

Children under 19 are eligible without regard to their family income level, since HUSKY B coverage includes an unsubsidized coverage option (same benefits but higher family cost-sharing). The HUSKY A income-eligibility ceiling of 185% of the federal poverty level applies to parents and relative caregivers, while an income limit of 250% of the federal poverty level applies to pregnant women.

HUSKY has a toll-free customer hotline (1-877-CT-HUSKY), apply-by-phone option, and informative website (www.huskyhealth.com).

In SFY 2011, DSS continued successful 'carve-out' services from the general managed health care services in the HUSKY and Medicaid fee-for-service environments. Mental health and substance abuse services are provided through the Connecticut Behavioral Health Partnership, an

integrated system of behavioral health services jointly administered by the Departments of Social Services and Children and Families since January 2006. DSS assumed management of pharmacy benefits in February 2008, with providers and HUSKY members now utilizing one, rather than multiple, preferred drug list. The Connecticut Dental Health Partnership oversees all dental benefits afforded to HUSKY A, HUSKY B and Medicaid fee-for-service programs through an administrative services organization arrangement.

The department's primary care case management pilot program, named HUSKY Primary Care, offered HUSKY A-eligible families in certain areas an alternative enrollment choice to the traditional managed health care plan options. In SFY 2011, HUSKY Primary Care was available in the New Haven, Hartford, Putnam, Waterbury and Windham areas. For more information, please visit www.huskyhealth.com and click on 'Enrollment'; or www.huskyhealth.com/hh/cwp/view.asp?a=3573&q=457384.

The Charter Oak Health Plan

Charter Oak is a state-sponsored health coverage program designed for uninsured residents aged 19 through 64. Charter Oak, like HUSKY B, has no upper income limit for service eligibility.

Charter Oak offers a comprehensive benefits package that includes preventive care, primary care and specialist office visits, emergency room and inpatient hospital coverage, outpatient surgery, maternity, behavioral health, skilled nursing, durable medical equipment and prescriptions. As SFY 2011 ended, 9,446 previously uninsured Connecticut residents were enrolled in Charter Oak coverage. For a full list of benefits and their co-pays/deductibles, visit www.charteroakhealthplan.com.

At the end of SFY 2011, Charter Oak offered a flat monthly premium of $307 to new enrollees, regardless of income, and annual deductibles and co-insurance ranging from $150 to $900, depending on income.

Enrollee costs were scheduled to rise on September 1, 2011, as a result of budget legislation reducing subsidy levels for those still eligible for subsidies; and as a result of overall higher medical costs incurred by the program. The monthly premium for all enrollees who joined the program on or after June 1, 2010, was scheduled to rise from $307 to $446 per month (all income levels).

The monthly premium for enrollees who joined before June 1, 2010, was scheduled to increase (based on income levels). Before September 1, 2011, the range for this group was $129 to $296, depending on specific income. Beginning September 1, the range was to become $215 to $446.

Since its inception in 2008, Charter Oak has generally attracted an older population with more chronic health care conditions than originally anticipated, leading to higher-than-anticipated costs. Consequently, premiums were adjusted for the higher program costs after actuarial analysis of claims utilization data. The state legislation that created the program – and new 2011

state budget legislation – govern the extent of available state subsidies to enrollees. This accounts for the higher cost, beginning September 1, 2011

In addition, the annual benefit cap of $100,000 was scheduled to be rescinded (there is still lifetime $1 million benefit cap). The $7,500 annual prescription medication benefit cap, and the $4,000 cap on durable medical equipment, were to be rescinded.

ConnPACE (Connecticut Pharmaceutical Assistance Contract to the Elderly and Disabled; www.connpace.com) helps eligible senior citizens and people with disabilities afford the cost of most prescription medicines. During the fiscal year, ConnPACE continued to coordinated benefits with Medicare Part D and the department's Medicare Savings Programs.

The Connecticut AIDS Drug Assistance Program (www.ct.gov/dss - DSS search term "cadap") pays for drugs determined by the U.S. Food and Drug Administration to support individuals with AIDS/HIV. To be eligible for the program in Connecticut, an applicant must have a physician certification, must not be a recipient of Medicaid, and must have net countable income within 400% of the federal poverty level. In addition, the individual must apply for Medicaid within two weeks of approval for this program. CADAP coordinates benefits with Medicare Part D and other third party coverage. There are approximately 1,900 individuals enrolled in the program during this fiscal year.

Med-Connect, Medicaid for the Employed Disabled: (www.ct.gov/dss - DSS Search Term "Med-Connect") allows people with disabilities to become and stay employed without risking eligibility for medical coverage.

Approximately 5,000 residents with disabilities receive Medicaid coverage through this program. Individuals may have incomes up to $75,000 per year. Some participants are charged a premium (10% of their income in excess of 200 percent of the federal poverty level). Liquid assets may not exceed $10,000 for a single person or $15,000 for a couple.

With federal approval in SFY 2010, DSS transferred its State-Administered General Assistance medical coverage beneficiaries to the **Medicaid for Low-Income Adults** program. Connecticut was the first state in the nation to receive federal approval to expand Medicaid under the Patient Protection and Affordable Care Act. This program continued in SFY 2011 to serve very low-income, single, childless adults who do not qualify for Medicaid because they are under age 65, do not have a permanent qualifying disability, are not pregnant, or do not have a child under age 19. Over 75,000 Connecticut residents were being served under the Medicaid for Low-Income Adults Program at the end of SFY 2011. Further information: www.ct.gov/dss/cwp/view.asp?Q=461916&A=2345.

The **Medicaid for Aged/Blind/Disabled** program continued to serve approximately 60,442 low-income elders and adults with disabilities, including about 18,427 residents in long-term care facilities.

The Connecticut Home Care Program for Elders (CHCPE; www.ct.gov/dss, click on "Elders" under Programs and Services) is a comprehensive home care program designed to enable older persons at risk of institutionalization to receive the support services they need to remain living at their home.

The CHCPE provides a wide range of home health and non-medical services to persons age 65 and older who are institutionalized or at risk of institutionalization. The program serves approximately 15,000 frail elders statewide. Available services include adult day health, homemaker, companion, chore, home delivered meals, emergency response systems, care management, home health, assisted living, personal care assistant, assistive technology, mental health counseling and minor home modification services. The individual must meet the income and asset limits to be eligible for the program.

The program has a three-tiered structure through which individuals can receive home care services in amounts corresponding to their financial eligibility and functional dependence. Two categories within the program are funded primarily with state funds; the third category is funded under a Medicaid waiver. Persons receiving services under the state funded portion of the program are required to pay a co-pay for the services they receive.

Prospective clients are referred by community home-health agencies, hospitals and nursing facilities. Interested people can call the program directly at 1-800-445-5394. Individuals who meet both the financial and functional criteria are referred for an independent, comprehensive assessment. This assessment determines the prospective client's needs and whether a plan of care can be developed which will safely and cost-effectively meet those needs in the community.

Medicare Savings Programs, such as such as the Qualified Medicare Beneficiary and Specified Low-Income Medicare Beneficiary programs, are available to help eligible residents pay for Medicare coverage. A change in state law made it possible to make changes to help many eligible Connecticut residents pay Medicare Part B premiums, deductibles and co-insurance. Specifically, the state raised the income-eligibility limits and eliminated the asset reporting requirement. Beneficiaries can now earn up to $2,260.92 for a single person and $3,052.74 for a couple to qualify for one of the Medicare Savings Programs: www.ct.gov/dss, search term "Medicare Savings Programs." In SFY 2011, the department served approximately 112,655 individuals through the Qualified Medicare Beneficiary program and another 4,481 individuals through the Specified Low-Income Medicare Beneficiary and Additional Low-Income Medicare Beneficiary programs. Application is made at DSS regional offices.

ConnTRANS (Connecticut Organ Transplant Fund; www.ct.gov/dss, follow the link for Publications, and scroll down to the Brochures list), supported by donations from taxpayers who earmark a part of their state tax refund, helps those who need or have received an organ transplant when their expenses are not covered by another source.

Medical Coverage for Children at DCF (www.ct.gov/dss, search term "Family Services")
The Family Support Unit provides medical benefits for children cared for by the Department of Children and Families (DCF). During SFY 2011, HUSKY A coverage was provided to 1,453 children in DCF foster care and 172 children in subsidized adoption care. An additional 350 youths, transitioning from DCF care on their 18th birthday, were granted medical coverage until the age of 21. Medical benefits were also granted for 176 children in subsidized guardianship. The Bureau of Assistance Programs also helps provide Medicaid-funded services to Temporary Family Assistance recipients and eligible breast and cervical cancer patients.

Services for Families and Children

The department operates **Jobs First**, Connecticut's welfare reform program, providing **Temporary Family Assistance** (TFA) to families in need of and eligible for cash assistance. Jobs First has been successful in helping thousands of parents move into the workforce and off welfare rolls. At the end of SFY 2011, the department's TFA caseload was 18,150 households.

Jobs First is a time-limited program that emphasizes early case-management intervention and participation in the labor market. Jobs First establishes a time limit of 21 months for families that contain an adult who is able to work. Extensions beyond 21 months may be available if the adult cannot find a job that makes the family financially independent. Able-bodied adults are referred to Jobs First Employment Services, administered by the Department of Labor and regional Workforce Investment Boards, for help in finding work. During the 21 months, and during extensions, recipients must cooperate with the Jobs First Employment Services program and make a good-faith effort to find a job and keep working. Among the beneficiaries of TFA are children who are living with their grandparents.

Safety Net services are provided to families who have exhausted their 21 months of benefits, have an eligible child in the home, have income below the TFA benefit level for their family size, and do not qualify for an extension due to the exhaustion of the time limits. Help with meeting basic needs is available, along with case management and service coordination. The Safety Net program served 832 families in SFY 2011.

The **Employment Success Program** (ESP) provides early intervention, in-depth assessment and intensive case management services to TFA recipients who are mandatory participants in Jobs First Employment Services. This program seeks to address client barriers that prevent successful participation in the TFA program. ESP served 791 families in SFY 2011.

The Individual Performance Contract Program (IPC) provides case management services to families who have been penalized for non-compliance with **Jobs First** Employment Services and are at risk of being ineligible for an extension of benefits. The IPC is an opportunity for the adults in the household to restore a good faith effort by removing barriers to employment in order to qualify for an extension of benefits. IPC served 232 families in SFY 2011.

The department funds **Transportation to Work (TTW)** programs for TFA and low-income working clients. The funding assists clients in overcoming their transportation barrier to employment. There are five DSS contractors administering the TTW program statewide. The

Department of Transportation is a partner and offers insight and complementary funding through its Jobs Access Reverse Commute program and the Federal Transportation Administration. The TTW program served 42,808 individuals in SFY 2011.

Transitionary Rental Assistance (T-RAP) is available for some families if an adult member is employed at the time the family leaves the TFA and either (1) has income which exceeds the TFA payment standard; or (2) is employed for a minimum of 12 hours per week. There is an income limit of 50% of the state median income level. Rental assistance is available for up to 12 months. Approximately 150 families, on average, receive a housing subsidy. Due to limited funding, a lottery system is used to select eligible recipients.

The Supplemental Nutrition Assistance Program (or SNAP), formerly called Food Stamps, provides monthly benefits to help eligible families and individuals afford food purchases. Benefits are provided electronically, enabling clients to use a debit-type swipe card at food markets. Income and asset eligibility guidelines apply. The general income limit is 185% of the federal poverty level. Maximum monthly food benefit examples are $200 for a single person and $668 for a four-person household. At the end of SFY 2011, 356,750 Connecticut residents were receiving SNAP benefits in 195,028 households, a significant increase over previous years.

The SNAP Nutrition Education Plan provides nutrition education intervention to SNAP recipients and applicants. For SFY 2011, the department received $2,990,876 in federal funds to partner with the University of Connecticut, Hispanic Health Council, Inc. and the Department of Public Health to provide these nutrition education activities

The SNAP Outreach program provides activities such as SNAP benefit pre-screening, group presentations and public awareness campaigns to potential SNAP eligible individuals. The department received $1,029,353 in federal funds for SNAP Outreach for SFY 2011. Connecticut Association for Human Services, End Hunger Connecticut! and the Hispanic Health Council have contracted with the department to provide outreach services. For more information on SNAP, visit www.ct.gov/snap.

Child Care Services

As lead agency for child care services, DSS continued administration of a range of programs and activities, in collaboration with partner agencies and providers.

- The Care 4 Kids program, operated with the United Way of Connecticut, provided subsidies for the care of approximately 30,000 children. About 12,000 families received an average of $602 in child care benefits each month. For more information on Care 4 Kids, visit www.ctcare4kids.com.

- The state-supported Child Day Care contract program provides child care opportunities to help low-income families begin and retain employment. The program served 4,590 children.
- Nearly 2,700 children of school age participated monthly in the department's Before- and After- School program through seven contractors.
- Connecticut Charts-A-Course, the state's single early care and education professional development program, through a combination of state General Fund appropriations and federal ARRA funds provided scholarships benefiting more than 1,860 early care and education caregivers.
- As of June 2011, there were 443 centers accredited by the National Association for the Education of Young Children a 2% increase over the prior year.

The department's Child Care Unit and the Fraud and Recoveries Unit continued two **fraud prevention and detection initiatives** in SFY 2011. The Fraud Early Detection Program and the Active Case Assessment Program were developed to ensure that those parents and/or providers receiving benefits from the Care 4 Kids Program were truly entitled to those funds. The department continued efforts to reduce administrative errors, improper payments and detect, prevent and recover fraudulent overpayment claims through an array of administrative controls. Strategies included active monitoring of business functions processes, data integrity reporting and production and performance measurement. Corrective action initiatives focused on areas determined to be error-prone and included staff training initiatives and collaboration with the Departments of Public Health, Public Safety, Children and Families, Education and Labor, Criminal Justice and the Office of the Attorney General.

Quality Enhancement Grants, at a funding level of $1.16 million, helped 19 priority school districts develop local quality initiatives that support the communities' family and caregiver needs. Local School Readiness Councils in the designated communities used the funds to serve 2,800 child care providers, including relatives, caring for more than 4,500 children in various ways: direct services to children and families, consultation services to child care centers and family providers, training and staff development, instructional materials and equipment, and public education campaigns. The department also provided funds to the Departments of Children and Families and Public Safety to support background checks in the areas of child abuse and criminal records.

2-1-1 Child Care, supported by department funds and United Way of Connecticut, received over 35,000 phone calls from parents seeking child care information and referrals to child care centers and homes in their area, and from child care providers interested in information and referral services. They also have an interactive childcare search tool available online at http://search.211childcare.org/.

The Training Program in Child Development helped nearly 146 caregivers receive training in the **Connecticut Charts-A-Course** curriculum. The statewide Accreditation Facilitation Project provided support and technical assistance to 282 childcare center sites. Of these, 151 achieved NAEYC accreditation. The Connecticut Charts-a-Course Scholarship Fund provided almost

1,860 individuals with financial assistance to support their attendance at training seminars for college credits.

The department also is a member and participant on the State Child Day Care Council, Head Start Advisory Council, Head Start Statewide Collaboration Project, Commission on Children, Early Childhood Partners, Early Childhood Alliance, Early Childhood Education Cabinet and its committees.

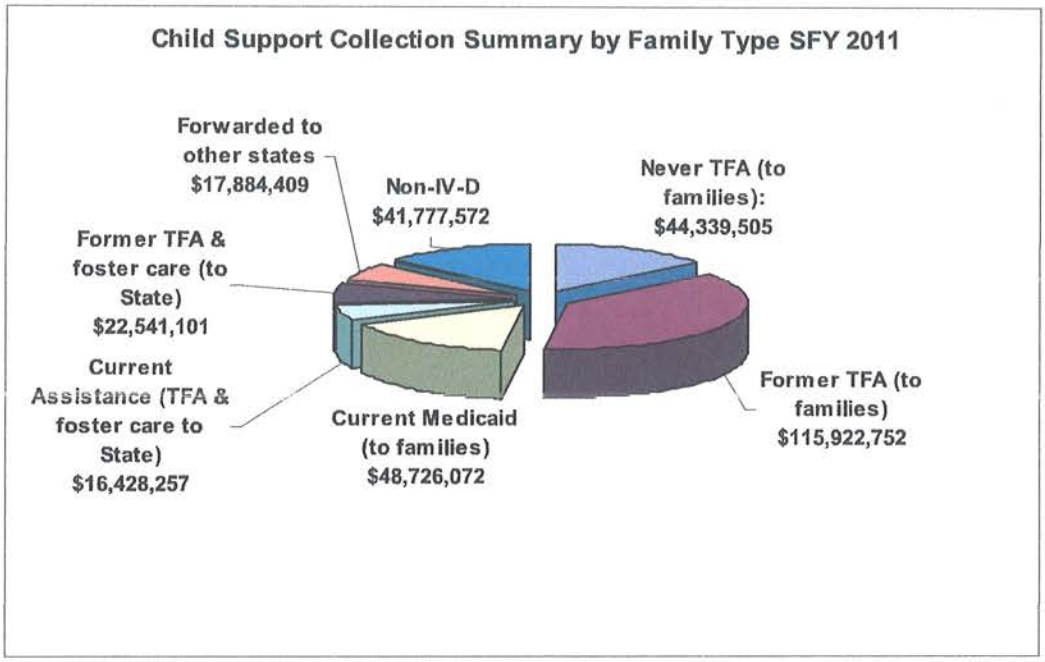
Readers can learn more about these and other child care activities in the state in the Child Care Annual Report. Visit the DSS website at www.ct.gov/dss, follow the link for Publications and scroll down to Annual Reports.

Child Support Enforcement Services

Child support enforcement services are available to all families in Connecticut. A need for assistance in establishing and maintaining financial support from both parents is the only criterion for service eligibility, regardless of a family's income.
DSS is the lead agency for Title IV-D child support enforcement activity, working closely with the Judicial Branch's Support Enforcement Services, and the Office of the Attorney General to establish and enforce paternity, financial, and medical orders.

The child support enforcement program collected nearly $310.8 million in court-ordered child support during SFY 2011. The program sent $209 million in parental support to children whose families are not receiving state cash assistance benefits. Another $17.8 million went to children living out of state.

State taxpayers benefited from approximately $16.4 million in current child support collected from parents of Connecticut children receiving Temporary Family Assistance. Another $22.5 million was collected on past-due amounts and kept by the state in lieu of current or past public assistance benefits. Fifty percent of this support is retained by the state as a general fund deposit; fifty percent is the federal share as reimbursement for public assistance benefits.
Consumer information: 1-800-228-KIDS or on-line at www.ct.gov/dss and click on Families with Children and Child Support Resource Center; or www.jud.ct.gov/childsupport.com.



The DSS Bureau of Child Support Enforcement is committed to assisting families in reaching independence through increased financial and medical support, establishment of paternity for children born out outside of marriage, and integration of the principles of the Fatherhood Initiative.

Child support efforts that involve other state and local agencies include: the Paternity Registry and Voluntary Paternity Establishment Outreach program, which works with the Department of Public Health and hospitals; employer reporting via the Department of Labor of all newly-hired employees; the Arrears Adjustment Program, which works with the Fatherhood Initiative sites; and the Partners Executive Council, which includes representatives from all child support cooperating agencies (Attorney General, Judicial) and works to improve the child support program.

While core functions remain a major focus for the Bureau of Child Support Enforcement, as the lead Title IV-D agency, a number of initiatives are in place to improve the quality of customer service, program performance, and service delivery. The bureau continued participation in longstanding collaborative efforts such as Access and Visitation, providing supervised visitation and other parental counseling services to never-married couples; and the Voluntary Paternity Establishment Program, providing services in 29 area hospitals and six Fatherhood Initiative program sites.

Two bills proposed for improvement of the child support program passed the legislature in the 2011 session. The first, P.A. 11-219, *AAC Child Support Enforcement and Expedited Establishment of Paternity and Support in Title IV-D Cases*:

- Authorizes immediate redirection of support payments to the state when a child begins receiving temporary family assistance or Title IV-E foster care payments, provided subsequent notice is given to the obligee of the support order, if other than the present custodial party
- Limits retroactive arrears chargeable to the noncustodial mother or father in establishment cases to the three years preceding the filing of the petition or agreement to support
- Eliminates a $50 processing fee for the amending of a birth record by the Department of Public Health (DPH) based on receipt of an acknowledgment of paternity
- Authorizes the IV-D agency to disclose information in the paternity registry maintained by the Department of Public Health (DPH) with agencies under cooperative agreement with the IV-D agency for child support enforcement purposes
- Establishes a procedure for notifying the parties and docketing disapproved agreements to support for a hearing on support
- Authorizes electronic service of income withholding orders
- Authorizes information sharing in IV-D cases with the Department of Correction and the Judicial Branch
- Authorizes the state Treasurer to review a list of IV-D obligors before paying out unclaimed property to claimant, and withhold payout until DSS notifies the IV-D obligor of child support arrearage and right to hearing
- Expands the authority of judicial marshals to execute capias mittimus orders in court facilities
- Amends direct income withholding due process provisions under the Uniform Interstate Family Support Act (UIFSA)
- Authorizes support enforcement officers to acknowledge legal instruments necessary for review and adjustment of IV-D support orders

The second, P.A. 11-214, *AAC Minor and Technical Changes to the Child Support Statutes;*

- Provides that a submittal in electronic format is sufficient for meeting the requirement for an annual child support program self-assessment report
- (A) Adopts consistent usage of the terms "Bureau of Child Support Enforcement," "temporary family assistance" or "TFA," and "Temporary Assistance for Needy Families" or "TANF" throughout the various statutes relating to the Title IV-D program; and (B) corrects various references to sections of UIFSA that were amended in the 2007 legislative session; and make other minor corrective and clarifying language changes
- Makes various technical amendments to the statutes concerning the Commission for Child Support Guidelines
- Amends the definition of "IV-D support cases" in the Family Support Magistrate's Act to include TFA and HUSKY A cases.

In August 2010, the Connecticut child support program also initiated an innovative and money-saving partnership with the state of Rhode Island. Child support payment processing for the two states is now co-housed at the Connecticut State Disbursement Unit (SDU) facility in Windsor. Both states realize savings associated with payment processing functions performed by the CT SDU contractor, Systems and Methods, Inc. Connecticut savings under the SDU contract totaled in excess of $121,000 for SFY 2011.

John S. Martinez Fatherhood Initiative of Connecticut

teach · love · inspire
JOHN S. MARTINEZ FATHERHOOD INITIATIVE OF CONNECTICUT

During SFY 2011, the Department continued to administer a five-year, $5 million grant from the Department of Health and Human Services, Administration for Children and Families (ACF), to implement a *Promoting Responsible Fatherhood* demonstration project.

The grant incorporates strategies encompassing all three of the ACF-established activity areas: Healthy Marriage, Responsible Parenting and Economic Stability. Each of the six state-certified fatherhood programs (Career Resources, Inc., Bridgeport; Families In Crisis, Inc. (serving incarcerated fathers); Family Strides, Inc., Torrington; New Haven Family Alliance, Inc.; New Opportunities, Inc., Waterbury and Madonna Place, Inc., Norwich) target primarily low-income fathers, new fathers, fathers-to-be, and young fathers who may be single, unmarried, non-custodial or cohabitating and couples who identify themselves as engaged or in a committed relationship, or who are interested in marriage.

Each program site is targeted to serve a minimum 100 fathers and eight couples for a total of 500 fathers and 40 couples served annually. Services offer enhanced prevention and intervention strategies to promote healthy marriage, responsible parenting and economic stability.

In addition, in December 2010, the six above programs and four new programs (Community Renewal Team, Inc., Hartford; CT Department of Correction; Greater Bridgeport Area Prevention Program, Inc. (serving teen fathers); and Village for Families and Children, Inc., Hartford) successfully completed the ***Connecticut Fatherhood Program Certification Project.*** State-certified fatherhood programs are recognized for the provision of quality services to fathers and ultimately benefit the children who live in low-income families. For more information, visit www.ct.gov/fatherhood.

The Children's Trust Fund

The Children's Trust Fund is responsible for the administration of several major state and federally funded initiatives that that prevent child abuse and neglect by helping families and communities be responsive to children, ensuring their positive growth and development. These efforts include funding a broad range of organizations to implement evidenced-based programs, testing innovations in the field and conducting research to assess the effectiveness of programs and developing strategies for improvement.

The Trust Fund's major programs are researched and evaluated by the University of Hartford Center for Social research. The evaluation is a vital ingredient in the development of the Trust Fund programs and has consistently shown that the programs are making a positive difference in the lives of the children and families that participate.

In addition, the Trust Fund is responsible for the administration of the Community-Based Program to Prevent Child Abuse (CBCAP), a federal program to support innovative community-based prevention efforts. As a part of the CBCAP program the Trust Fund has launched several important initiatives.

The Children's Trust Fund has been working on a number of groundbreaking projects that will benefit families and children throughout the state and make a significant contribute to the prevention field.

In-Home Treatment for Maternal Depression: The Children's Trust Fund launched a randomized control trial to study in-home cognitive behavioral therapy offered in tandem with Nurturing Families Network (NFN) home visiting services. Preliminary results of study show a statistically significant improvement within the experimental group from the baseline to the follow-up assessment and a statistically significant improvement in the experimental group when compared to the control group.

Home visiting program for new fathers and men: Ten NFN sites have hired male home visitors to provide home visiting services to fathers and men. The program is among the first of its kind in the country. The fathering home visitors have made a few adjustments to the program including meeting with fathers and men not living with their baby, more evening visits, and a stronger emphasis on employment.

Preventing Shaken Baby Syndrome within high risk populations: The Children's Trust Fund initiated a randomized control group study to test the two shaken baby prevention models with the high risk mothers participating in the Nurturing Families Network. The two–year study determined that one model, the *Period of Purple Crying,* was significantly more effective than the other. The Children's Trust Fund has trained all of the Nurturing Families Network home visitors in the more effective model.

In addition, the Trust Fund staff trained the prison system re-entry counselors to provide the *Period of Purple Crying* shaken baby syndrome prevention program to men leaving prison.

Financial Assistance for Adults

Through the **State-Administered General Assistance (SAGA)** program, the department provides cash assistance to eligible individuals who are unable to work for medical or other prescribed reasons, and to families that do not meet the blood-relationship requirements of the Temporary Family Assistance program. Approximately 4,759 individuals were receiving SAGA cash assistance at the end of SFY 2011.

Employable individuals are not eligible for SAGA cash assistance. However, employable individuals with drug and/or alcohol abuse problems may be eligible to receive treatment and some financial support through the Department of Mental Health and Addiction Services' Basic Needs Program.

General application for SAGA services is made at local DSS offices. Further information: www.ct.gov/dss, search on "financial" and scroll down.

The **State Supplement Program** provides cash assistance to the elders, people with disabilities, and people who are blind, to supplement their income and help maintain them at a standard of living established by the General Assembly. To receive benefits, individuals must have another source of income such as Social Security, Supplemental Security Income, or veteran's benefits.

To qualify as aged, an individual must be 65 years of age or older; to qualify as disabled, an individual must be between the ages of 18 and 65 and meet the disability criteria of the federal Social Security Disability Insurance program; and to qualify as blind, an individual must meet the criteria of the Social Security Disability program, or the state Board of Education and Services for the Blind. The program is funded entirely by state funds, but operates under both state and federal law and regulation. Incentives are available to encourage recipients to become as self-supporting as their ages or abilities will allow. State Supplement Program payments also promote a higher degree of self-sufficiency by enabling recipients to remain in non-institutional living arrangements.

People eligible for State Supplement are automatically eligible for Medicaid. At the end of SFY 2011, 15,396 people (4,576 aged, 86 blind, and 10,734 with other disability) were receiving State Supplement benefits. Further information: www.ct.gov/dss, search for "financial" and scroll down.

Services for Older Adults, People with Disabilities & Social Work Services

See also: (Medical and Health Care Services and Financial Assistance for Adults)

As part of the DSS Bureau of Aging, Community and Social Work Services, the DSS Aging Services Division (also known as the State Unit on Aging) administered approximately $26 million from the federal Older Americans Act and other federal and state funds to provide a wide range of services to nearly 87,000 older adults in Connecticut. In addition, nearly 62,116 consumers received counseling regarding health insurance issues.

Older Americans Act-funded services are provided to adults age 60 and older. These services include home care, transportation, housekeeping, respite for caregivers, nutritional services (meals served in a group environment and meals-on-wheels, also known as home-delivered meals, as well as nutrition education and nutrition counseling as appropriate), legal assistance, adult day care, senior center operation, employment, and education and counseling.

Highlights of Older Americans Act Program for the year:

- 1,280,793 home-delivered meals were served statewide;
- 946,301 meals were served in group settings to older adults;
- 190,038 trips were provided for older adults to doctor appointments, shopping and recreational activities;
- 68,379 hours of homemaker services were provided; and
- 116,240 adult day care hours for personal care were funded.

Nursing Home Diversion
Connecticut's nursing home diversion initiative, titled, "Choices At Home," is a two-part project in the south central and western regions of the state:

Part 1: Development and implementation of a 'cash and counseling' option of service delivery. This option takes existing program dollars available through the federal Title III-E, National Family Caregiver Support and CT Statewide Respite Care programs and transforms them into flexible funds that allowed 39 consumers to hire and receive care from a caregiver of their choice. Additionally, the option expands the supplemental services benefit of the National Family Caregiver Support program from $750 to $4,000 for 112 consumers under this initiative. Selected consumers received supplemental services such as home modifications and other critical items that allowed them to remain at home and deter or significantly delay nursing home placement.

Part 2: Development and implementation of pilot Aging and Disability Resource Centers (ADRC), known as "Community Choices" in south central (operated by the Agency on Aging of South Central CT & the Center for Disability Rights) and western regions (operated by Western

CT Area Agency on Aging and Independence Northwest). These two regional ADRCs provide consumers with long-term care information, assistance and support (more below).

The Nursing Home Diversion grant concluded on Thursday, September 30, 2010. Since that time, the consumer directed service option piloted through the CT Statewide Alzheimer's Respite Care Program (CSRCP) as part of this grant has been adapted and permanently implemented as a service option available through the CSRCP. Plans to permanently incorporate a consumer directed service option into the National Family Caregiver Support Program are ongoing as well.

Aging and Disability Resource Center (ADRC)
The Aging Services Division began implementation of Aging and Disability Resource Centers (ADRCs), also known as "Community Choices," in Connecticut. An ADRC is envisioned to assist individuals 18 and older who are seeking services and support, regardless of disability, through a coordinated system of information and access. ADRCs are resource hubs of information and assistance, including completing benefits applications and planning for long-term care option supports and services. Connecticut's third ADRC, North Central Community Choices, began in the north central region in May 2010 and is operated by the North Central Area Agency on Aging, Independence Unlimited and Connecticut Community Care, Inc. Community Choices may be reached by calling 1-800-994-9422.

Veterans' Directed Home- and Community-Based Services Program
The Aging Services Division's successful application for a joint funding opportunity offered by the federal Veterans Administration and the Administration on Aging has created a Veterans' Directed Home- and Community-Based Services option in the south central region of the state. This partnership with the Agency of Aging of South Central CT and the VA CT Healthcare system is designed to keep veterans in the community by self-directing their own care and receiving services in their home by the caregiver of their choice. The program is a new VA service option that has the potential to be integrated into the permanent menu of VA service offerings nationwide. Connecticut launched this new option in SFY 2010 and has enrolled 30 veterans, the maximum number allowable at this time. As of June 2011, the program expanded into Fairfield County in partnership with the Southwestern CT Area Agency on Aging. In the first month, 10 veterans in Fairfield County were enrolled onto the program.

Senior Medicare Patrol (SMP)
The Senior Medicare Patrol Program empowers seniors to prevent becoming victims of health care fraud. This program helps Medicare and Medicaid beneficiaries, family members, caregivers and others on identifying health care fraud. SMP staff and volunteers educate Medicare beneficiaries on the steps to protect their personal information and detect potential errors, fraud and abuse on their health care bills and Medicare Summary Notices. SMP staff and volunteers also educate seniors on identifying deceptive health care practices, such as illegal marketing, and reporting errors and suspected fraudulent activities. The SMP program is funded by the U.S. Administration on Aging, Department of Health and Human Services. To learn more about the program, become a SMP volunteer or arrange for a presentation, the public may

contact any one of the five Area Agencies on Aging at 1-800-994-9422 or the statewide SMP Coordinator at (860) 424-5293.

Elder Rights

Under the Older Americans Act, the Aging Services Division is tasked with providing state leadership in securing and maintaining the legal rights of older individuals, coordinating the provision of legal assistance, providing technical assistance, training, and other supportive functions to the aging network, legal assistance providers, ombudsmen, and other persons, as appropriate, and assisting older individuals in understanding their rights, exercising choices, benefiting from services and opportunities authorized by law.

Legal Assistance for Older Americans

Through the Older Americans Act, Title IIIB funding is provided to the five Area Agencies on Aging to contract with legal services organizations to provide free counseling and representation on many elder law issues. Due to limited funding, the following categories have priority for representation: access to health care; federal and state benefit and support programs; rights of nursing home residents; and legal issues which are a direct result of a client's poverty.

Health Care Planning and Advanced Directives

Through the Aging Services Division, DSS publishes and distributes *Advanced Directives: Planning for Future Health Care Decisions* – for Connecticut consumers. During SFY 2011, Aging Services Division distributed over 1,200 Advanced Directive packets and the division's Legal Services Developer made presentations concerning advanced directives for consumers and health care and aging services providers at conferences and community meetings
The Aging Services Division, one of the founders of the Connecticut Coalition to Improve End-of-Life Care, represents DSS on the coalition's executive board. DSS co-sponsored the coalition's annual meeting, "Life Support Interventions: Fact vs. Fiction" on October 20, 2010. The keynote speaker was Dr. Gerard J. Kerins, MD, FACP, Section Chief of Geriatrics, Hospital of St. Raphael, Associate Clinical Professor at Yale School of Medicine and member of the CT Commission on Aging

Through the advisory board of the Connecticut Triad, the Aging Services Division continued to strengthen community partnerships that help reduce crime and the fear of crime of the state's older residents in SFY 2011. On September 17, 2010, the Board sponsored the 9th annual conference, "Responding to Elder Abuse – Preventing Victims from Falling Through the Cracks," including keynote speaker Manhattan Assistant U.S. Attorney Elizabeth Loewy, a nationally recognized expert on prosecuting elder abuse cases. In May 2011, the board published its first Program Information Guide to assist communities in forming and operating their own Triad programs to promote senior safety. A copy of the publication can be found on the Division's website - http://www.ct.gov/agingservices

Elderly Nutrition Services

The department provides funding under Title IIIC of the Older Americans Act, as well as state appropriations, to serve nutritionally balanced meals and provide nutrition education and counseling to individuals 60 years and older and their spouses at 200 Senior Community Cafés statewide. Meals, nutrition education and counseling are also delivered in homes to frail, homebound or otherwise isolated persons. (Meals and these nutrition services may also be

provided to persons with disabilities living in senior housing facilities that have Senior Community Cafes.)

Elderly Health Screening Program
This program provides health screening services oral health, geriatric assessments, follow-up care and programs related to health promotion and wellness to persons age 60 and over at various sites throughout Connecticut in SFY 2011, funding of $361,683 made it possible for 2,943 older adults to benefit from the services provided through this program.

Connecticut Statewide Respite Care
This state-funded program offers case management and short-term respite to individuals with Alzheimer's disease and related disorders. In SFY 2011, the services of 389 consumers were recertified, and a total of 611 individuals received direct services such as adult day care and home health services.

The New England Cognitive Center's Brain Get Your Mind Moving (G.Y.M.M.) Program
Working with the New England Cognitive Center, this program utilizes a two-tiered non-pharmaceutical approach to address the needs of individuals with Alzheimer's disease. The two primary interventions target specific areas of cognition and hands-on cognitive training in a small group or workshop environment. In SFY 2011, 40 consumers participated in the program, approximately 27,360 hours of cognitive training were performed and 228 sessions were conducted.

CT Statewide Fall Prevention Initiative
The overall objective of the Connecticut Collaboration for Fall Prevention (CCFP) is to decrease the rate of falls among community's dwelling older adults by embedding an evidence-based, multidisciplinary, multi-factorial fall risk assessment and intervention strategy throughout Connecticut. The intervention consists of changing prevailing knowledge, attitudes, skills, and behaviors related to fall risk factor assessment and prevention among relevant care providers and ultimately among older adults. This initiative provided interventions at 334 facilities and reached 8,250 individuals.

Senior Community Service Employment Program
Funded under Title V of the Older Americans Act, this is a training and employment program for low-income adults aged 55 and older. The program offers part-time community service training in non-profit organizations to enhance skills and provide on-the-job work experience. During SFY 2011, this program served 262 older adults through the Title V program. A total of $1.84 million in funding from Title V and the 2010 Appropriations Act for SFY 2011.

The Connecticut Partnership for Long-Term Care
The Partnership provides education and outreach and offers, through private insurers, special long-term care insurance to help individuals increase their options and avoid impoverishing themselves when paying for their long-term care.

Coordinated by the Office of Policy and Management, the Partnership has an information and education program managed by DSS. This education program offers one-on-one counseling, distributes materials, and conducts regional public forums and other presentations.

During SFY 2011, the Partnership responded to 523 requests for information, counseled 309 people and reached 463 people through its five regional public forums and other presentations. To date, over 52,000 Connecticut residents have purchased Partnership-approved long-term care policies.

Retired and Senior Volunteer Program (RSVP)
This program recruits individuals age 55 and older for meaningful and challenging volunteer opportunities to benefit communities and non-profit organizations throughout the state. Eleven programs across the state had 3,487 participating volunteers in SFY 2011.

Volunteers from the Heart
Using a volunteer service credit program, volunteers age 55 and older provide support such as transportation to medical appointments and grocery shopping for other individuals 55 and older who are frail or homebound. In return, the volunteers receive one credit hour for each hour volunteered, with credits redeemed at any time during the life of the program to be used for similar services for themselves and their family members. During SFY 2011, 58 new consumers received services.

Project Home Share
Two home-share programs in the state facilitate arrangements to enable two adults to share a home in exchange for a financial contribution to household expenses, services, companionship, or some combination. The service matches single adults, one of whom must be age 60 or over, who are having difficulty maintaining their homes because of financial, social, or physical needs, with other adults who need decent, affordable housing and/or do not want to live alone. During SFY 2011, the program counseled 247, enrolled 45 adults and matched six adults over age 60 with other adults.

Congregate Housing Services
Through funding from the Department of Housing and Urban Development, the Area Agencies on Aging provide services such as case management, personal assistance, housekeeper/chore, companion and transportation to older adults residing in rural elderly housing, with eight sites in eastern Connecticut and ten sites in western Connecticut. In SFY 2011, 309 consumers were served through this program.

The **Connecticut National Family Caregiver Support** Program, funded under Title IIIE of the Older Americans Act, is operated in partnership with the DSS Aging Services Division and the state's Area Agencies on Aging. The program provides services to caregivers, including family members caring for relatives age 60 and older, grandparents or older relatives caring for children 18 years of age or under, and those caring for adult children with disabilities.

During federal fiscal year 2011, the program provided information and assistance to 6,238 individuals. Caregiver training, counseling and support group services were provided to 1,008 consumers. Respite care services were provided to 425 caregivers and supplemental services such as home safety devices, medical supplies and medical-related equipment were provided to 649 consumers.

The **DSS Rx-Xpress** serves as a mobile public assistance center that works with CHOICES to provide older adults and other eligible persons with Medicare Part D prescription drug benefit information and enrollment assistance. In addition, the DSS Rx-Express service conducts outreach in rural, suburban and urban communities, where DSS regional staff provide eligibility screening for various public assistance programs, including Medicaid, Charter Oak Health Plan, HUSKY, SAGA, Medicare Savings and SNAP (Food Stamps.) During SFY 2011, DSS participated in 94 events and provided information and eligibility screening to 1,905 people through this mobile service option.

Protective Services for the Elderly assists persons age 60 and older who have been identified as needing protection from abuse, neglect and/or exploitation. During SFY 2011, agency social workers provided services to 3,481 persons living in the community. The Department also received 211 report forms regarding residents of long-term care facilities. The Conservator of Person program, for indigent individuals 60-and-over who require life management oversight, helped 353 individuals; and the Conservator of Estate program provided financial management services to 107 people in the same age group.

The federal Supplemental Security Income Program serves people who are elderly, disabled, or blind. In Connecticut, the State Supplement Program augments the federal program. As the state fiscal year ended, the State Supplement Program was serving 17,882 persons (5,447 aged, 104 blind, and 12,331 with other disability).

During the fiscal year, the **Community Based/ Essential Services Program** provided services designed to prevent institutionalization to 843 persons with disabilities. There were 848 persons who received help through the **Personal Care Assistance Program** (people with disabilities between age 18 and 64); and 386 individuals were provided assistance under the **Acquired Brain Injury** Program. Both programs operate under Medicaid waivers.

The **Family Support Grant Program** helped 25 families with children with developmental disabilities other than mental retardation in meeting extraordinary expenses of respite care, health care, special equipment, medical transportation and special clothing.

Family and Individual Social Work Services
Regional and Central Office social work staff provided brief interventions for 3,229 families and individuals, including counseling, case management, advocacy, information and referral, housing and homelessness assistance and consultation, through Family and Individual Social Work Services.

The **Teenage Pregnancy Prevention Initiative**, designed to prevent first-time pregnancies in at-risk teenagers, continued to target the urban areas of Hartford, New Haven, New Britain, Waterbury, Meriden, Norwich, New London, Torrington, West Haven and Willimantic, as well as Bridgeport, East Hartford and Killingly re-opening. The programs served 540 individuals.

In addition to the above services, Social Work Services staff provided more than 100 educational and training sessions to community members, professional associations, agency and institutional staff on DSS social work programs and services. Staff continued to develop practice standards for the agency social work programs; program databases to track client services and outcomes; and revised regulations to comply with recent statutory changes.

The **Long-Term Care Ombudsman Program** (LTCOP) serves residents of long-term care facilities, including nursing homes, assisted living facilities and residential care homes. Regional Ombudsmen investigate and work to resolve complaints made by or on behalf of residents. Additionally, Ombudsman staff educates long-term care consumers and the general public about long-term care issues and concerns. The State Ombudsman monitors and advocates at the state and national levels the policies and laws affecting quality care and services for long-term care residents. Nine Regional Ombudsman advocate for change at the facility level, as well as in regard to public policy and law. In addition to the Regional Ombudsman, there are three intake counselors.

Information and outreach are important aspects of Ombudsman work. Regional Ombudsman and Volunteer Resident Advocates of the program provide complaint and non-complaint visits to long-term care facilities and work with administration at these homes to make improvements in the quality of care and services for the residents. Essential to the Ombudsman role and responsibility is facilitating self-advocacy amongst residents. The State Ombudsman and Regional Ombudsmen educate and empower residents individually through casework, with groups of residents through the facility Resident Council and with families through the care planning process and Family Council activities. The LTCOP works with other state agencies, advocacy organizations and a wide variety of stakeholders and organizations. Ombudsman work is always directed by the resident him/herself and the effectiveness of Ombudsman work is largely based on identifying and resolving issues and customer satisfaction of outcomes.

In SFY 2011, there were approximately 35,000 skilled nursing facility, assisted living facility and residential care home beds in Connecticut. The Long-Term Care Ombudsman Program served these long-term care residents and received 2,078 complaints. The preponderance of complaints was in regard to care issues and residents' rights related to autonomy and choice as well as admission, transfer, discharge and eviction issues. The Regional Ombudsmen provided 1,666 individual consultations, attended 299 Resident Council meetings and provided 254 consultations to facilities. The State Ombudsman was the federally-appointed Patient Care Ombudsman for each of the nursing homes in bankruptcy in Connecticut during SFY 2011. It was her responsibility to oversee the well-being of the hundreds of residents in these bankrupt facilities, as well as those residents in closing nursing homes during this time period. For further information: www.ct.gov/ltcop or 1-866-388-1888.

Housing Assistance

Through various **homeless assistance** programs, DSS supported 44 emergency shelters with a total of 1,349 beds, and 112 family units serving more than 11,675 adults and children, plus six programs that provide advocacy, housing, and health services.

The **Transitional Living Program** served more than 2,248 individuals, and helped families and adults move from shelters into independent living. The **AIDS Residence Program** provided housing and support services to approximately 900 people. In addition, funding was provided to 14 **CT Beyond Shelter Programs**. These programs improve housing retention by providing coordinated services to landlords and households leaving homeless shelters or transitional living programs into independent housing.

Also, during SFY 2011, the department's new **"Housing First for Families"** program became fully operational, as five regional providers to families in emergency shelters. The program will assist households in obtaining permanent affordable housing or stable shared housing. The family will be engaged with the HFF coordinator for 30 days to transition them out of the shelter and into housing. Follow-up will also be provided to ensure that households are stably housed. During the first year of the program, 194 families were served with HFF services.

The department contractually requires its emergency shelter, transitional living, AIDS residential, CT Beyond Shelter, Housing First for Families and Homelessness Prevention and Rapid Re-housing providers to enter data into CT Homeless Management Information System in efforts to begin to capture unduplicated client level and service data on the populations that we serve.

The department was also awarded $10.8 million in American Recovery and Reinvestment Act funds for the **Homelessness Prevention and Rapid Rehousing Program (HPRP)**. The department contracted with six regional agencies – CTE, Inc., Columbus House, Mercy House & Shelter Corp, Inc., Thames Valley Council for Community Action, Inc., Journey Home, Inc., and New Opportunities, Inc. - to provide services to services to prevent individuals and families from becoming homeless, or to re-house/stabilize those who have become homeless. The program provides funding to assist both families and individuals who are at imminent risk of homelessness, or who are literally homeless. Examples of assistance provided include:

- Financial assistance
  - Temporary rental assistance for a maximum of 18 months, including shallow (partial) subsidies, declining subsidies, and subsidies deeper than Section 8 subsidies
  - Up to 6 months of back rent, which counts against the 18 month maximum
  - Security and utility deposits
  - Up to 18 months of utility payments, including up to 6 months of back utility payments
  - Moving cost assistance (not furnishings)
  - Motel and hotel vouchers up to 30 days

- Outreach and other services
  - Housing search and placement services, such as tenant counseling, representative payee services with respect to housing costs, and mediation and outreach to landlords
  - Case management services
  - Service coordination
  - Legal services to help people stay in their housing (not assistance with mortgages)
  - Credit repair, including money management and resolving personal credit issues

2-1-1 Infoline of Connecticut provided eligibility screening and referrals for all HPRP programs in the state. For individuals and families who were not eligible for HPRP services, 2-1-1 made referrals to other appropriate services. During SFY 2011:

- 4,185 unduplicated clients were served through the Homelessness Prevention and Rapid Rehousing Program; 3,049 through prevention and 1,176 served through rapid re-housing.
- 2-1-1 Infoline made 71,409 referrals to housing / shelter services.

The **Security Deposit Assistance Program** provided help to more than 2,542 individuals and families in obtaining permanent housing. These services are provided through DSS regional offices.

Under the **Rental Assistance Program (RAP)**, DSS provided rental subsidies to 2,691 families and adults living in privately-owned rental housing and supportive housing projects. One-year rental subsidies were provided under the Transitionary Rental Assistance Program to an average of 60 former Temporary Family Assistance-recipient families per month.

Under the federal **Section 8 Housing Choice Voucher Program** and **Section 8 Moderate Rehabilitation Program**, DSS provided 6,496 rental vouchers so families and adults could move into and afford safe and sanitary housing. A special program category under Section 8 includes the Mainstream Housing Opportunities for Persons with Disabilities Program. Competitive HUD funding awarded to DSS is used to provide housing subsidies to eligible individuals with disabilities who often face difficulties in locating suitable and accessible housing. The department currently receives funding for 150 households. There is a waiting list, which is currently closed to new applicants. When the list is about to be opened, a notice and pre-application form is placed in local newspapers and media outlets, as well as on the DSS website.

The HUD-Veterans' Affairs Supportive Housing (HUD-VASH) program combines Housing Choice Voucher rental assistance for homeless veterans with case management and clinical services provided by the US Department of Veterans' Affairs (VA). VA provides these services for participating veterans at VA medical centers and community-based outreach clinics. The department was awarded 90 of these special vouchers.

DSS works closely with the Department of Children and Families in the **Family Unification Program**, promoting family unity by providing both Section 8 and RAP housing assistance to families for whom the lack of adequate housing is a primary factor in the separation, or the threat of imminent separation, of children from their families. The housing component of the **Money Follows the Person Program** enables eligible nursing home residents to safely return to the community and a more self-sufficient lifestyle through a rental subsidy provided by the department. Once the necessary community support systems have been identified and put in place, transition coordinators make referrals to DSS for a Rental Assistance Program certificate. There have been 318 rental subsidies provided since the program began in 2009.

DSS has a memorandum of understanding with the Department of Mental Health and Addiction Services, the Office of Policy and Management, the Department of Economic and Community Development, the Department of Children and Families and the Connecticut Housing Finance Authority in support of the **Supportive Housing Pilots/Next Steps Initiative**. This is designed to create service-supported, affordable housing opportunities for homeless families, homeless youth aging out of the child welfare system and people affected by mental illness or chemical dependency who are facing homelessness. The department has devoted Section 8 and state Rental Assistance Program rental subsidies as part of this initiative.

Energy and Food Assistance, Community Programs

The **Connecticut Energy Assistance Program** (CEAP) is administered by DSS and coordinated by regional Community Action Agencies, in cooperation with municipal and other non-profit human service agencies. Families or individuals may obtain help with their winter heating bills, whether the primary heating source is a utility (natural gas or electricity) or a deliverable heating fuel (oil, kerosene, wood, and propane).

During SFY 2011, DSS and its service partners assisted 117,876 CEAP/CHAP-eligible households, distributing $108 million in federally funded energy assistance through CEAP and Contingency Heating Assistance Program (CHAP).

- CEAP is available to households with incomes up to 150% of the federal poverty guidelines. Households with even higher incomes, up to 200% of the federal poverty guidelines, are eligible for CEAP if they include a person who is at least 60 years of age or a person with disabilities. Efforts are made to accommodate homebound applicants.

- CEAP-eligible households with incomes up to 150% of the federal poverty guidelines, whose heat is included in their rent, and who pay more than 30% of their gross income toward their rent, are eligible for renter benefits.

- CEAP includes liquid assets eligibility requirements.

The **Contingency Heating Assistance Program** is also administered by DSS and coordinated by the regional Community Action Agencies.

- CHAP is available to households who are ineligible for CEAP assistance, but whose incomes are less than 60% of the state median income guidelines.
- CHAP benefits are not available to households whose heat is included in their rent.
- CHAP includes liquid assets eligibility requirements.

For additional information regarding CEAP and CHAP, households can refer to: www.ct.gov/staywarm or dial 2-1-1.

DSS also administered federal funds for a **Weatherization Assistance** program, providing energy-efficient measures to approximately 250 households with incomes up to 60% of the federal poverty level. (See also, weatherization section under the American Recovery and Reinvestment Act section on page 11.) Further information: 1-800-842-1132 and http://www.ct.gov/dss/weatherize.

The department provides federal funding to agencies that assist in the **resettlement of refugees,** including Catholic Charities, Episcopal Social Services, International Institute of Connecticut, and Jewish Federation Association of Connecticut. Besides funding for employment assistance to refugees, DSS directly assists refugees through cash, medical and Supplemental Nutrition Assistance Program assistance.

Through the **Neighborhood Facilities Program,** DSS provides grants for planning, site preparation, construction, renovation, and acquisition of facilities for child care centers, senior centers, multi-purpose centers, domestic violence programs, emergency shelters and shelters for the homeless, food distribution facilities, and accommodations for people with HIV and AIDS. During SFY 2010, DSS received approval from the state Bond Commission for four projects with a value of $1,475,000. These various projects included a roof replace for Jubilee House, an educational tutorial facility in Hartford, roof and drainage improvements at the Prudence Crandall facility, a women's housing facility in New Britain and construction assistance for a new health facility in Middletown operated by the Middletown Community Health Center, Inc. as well as renovations to the social services agency TVVCCA in Norwich which is the primary provider of social services in that town.

In addition, DSS was given the responsibility for nine projects funded with OPM Urban Act funds in the amount of $10,345,000; and four Small Town Economic Assistance Program projects in the amount of $670,000. These various renovation projects are located in Somers, Thompson and Warren.

The **Emergency Food Assistance Program** distributes available food from the U.S. Department of Agriculture to soup kitchens, food pantries, and shelters that serve people in need. The program distributed approximately 8.2 million pounds of food in SFY 2011. The **Supplemental Nutrition Program** purchases high-protein foods for distribution to food pantries, soup kitchens, and shelters through a statewide network of 448 agencies. Approximately 562,261 pounds of food, with a value of $604,422.00 were distributed through this program.

Connecticut Human Services Infrastructure Initiative and Strategic Planning

HSI

During SFY 2011, the department and its Division of Strategic Planning oversaw further services under the Connecticut Human Services Infrastructure (HSI) initiative, in collaboration with 2-1-1 Infoline and the state's 12 Community Action Agencies (CAAs). The initiative seeks to streamline customer access to services within and between CAAs, DSS and other human service partners by better use of existing resources, and by connecting clients to community resources before, during and after DSS intervention. This enables DSS clients to be better prepared to use services efficiently, coordinating all "helping" services within the HSI initiative and identifying client barriers early in the process.

The CAAs and their statewide organization, the Connecticut Association for Community Action (CAFCA), have launched an automated benefits enrollment calculator. The calculator was created to help residents easily find out what state and federal programs they may be eligible for. By taking a few minutes and answering some anonymous questions about themselves, their family and others who may live in their home, the calculator is to determine what programs and benefits people are potentially eligible for and how they can go about applying for those programs. Funding was provided through the Community Services Block Grant and the American Reinvestment and Recovery Act. CAA staff can help customers with this tool and individuals can also access the calculator on the CAFCA website at http://cafcacalculator.cafca.org/.

During SFY 2011, automated benefits calculator clinics were held on-site for 120 staff at all 12 CAAs. Desk aids for using the calculator were developed and distributed to case managers. These were specifically tailored to the needs of each agency, based on the type of case management software in use.

The "Using ABC: Case Management and the Program Policies Behind ABC" training has been provided to over 218 case managers at all 12 CAAs. Training needs assessment continued, incorporating feedback from training participants, in addition to utilizing an online survey tool. A 38-page manual for CAA case managers on the automatic benefits calculator and DSS programs was completed and distributed to agencies.

As of this November 2011, over 2,236 members of the public have accessed the automated benefits calculator via the CAFCA website. Besides ease to the public, CAA case managers have saved time and resources in connecting clients to programs (the calculator has been integrated into CAAs' energy and case management software).

DSS Regional Offices

The Department's Regional Offices provide direct services to eligible clients in the areas of Supplemental Nutrition Assistance Program (formally food stamps), Temporary Financial Assistance, State Supplement, Medical Assistance and State-Administered General Assistance. In addition, Regional Offices provide on-site Child Support Services, Social Work Services, as well as Fraud Investigations, and Resources Investigations (public assistance recovery) services. Regional Offices also include staff of the Bureau of Rehabilitation Services.

Northern Region

The DSS Northern Region is comprised of a regional office (Hartford) with three sub-offices (Manchester, New Britain, Willimantic), serving 59 cities and towns with a total of 131,172 unduplicated active 'assistance units' (technical term for households, whether a family or single individual), for a total of 223,684 active recipients. The Northern Region is the largest of the department's three regions, serving approximately 37% of the statewide active caseload.

Regional Processing Unit is a centralized unit in the Hartford office that handles all presumptive eligibility for HUSKY, as well as expedited eligibility for pregnant women; newborns; children who are transitioning from HUSKY B to HUSKY A; and HUSKY applications received directly in the region. In this manner, the Northern Region can expedite service delivery for this critical medical eligibility piece and reduce gaps in client medical coverage.

Outstationed Staff at Acute-Care and Long-Term Care Facilities -- The Northern Region's collaboration with area hospitals expanded with the development of out-stationed eligibility workers in long-term care facilities and the expansion to community health care clinics. In this way, DSS is able to support health care coverage and services needed both in acute-care and long-term care settings, as well as in communities.

Mobile Office Eligibility Services -- The Northern Region continues to expand client access and services through the DSS Rx-Xpress Bus at regional events, such as the Veterans' Stand Down, SNAP/Food Stamp outreach, farmers' markets and other venues. Not only does this initiative offer enhanced service to connect clients with the agency, the mobile office has been extremely helpful in providing continuity in services during times when additional office space is needed.

Hartford Community Court – The DSS Hartford office has a successful cooperative relationship at the Hartford Community Court with several community partners, including the City of Hartford, the Department of Mental Health and Addiction Services and the state Judicial Branch. The court attends to "quality of life" and misdemeanor crimes in Hartford, with defendants willing to enter a conditional plea of guilty to avoid or receive a shortened prison time by performing community service. The DSS representative facilitates the transition of detainees to the community by granting applications for DSS programs, responding to client

inquiries, performing interim eligibility changes, and providing technical assistance to participating partner agencies regarding DSS programs and procedures.

SNAP E-Faxing -- All Northern Region offices collaborate with End Hunger CT! (EHC) and its partners to facilitate submission of Supplemental Nutrition Assistance Program applications, electronically, via 'E-Fax.' The collaboration and technology has proven effective and advantageous to SNAP applicants/recipients and the partners who take part in the initiative. Each month EHC submits applications electronically to a designated DSS contact person, who distributes for processing.

Service Delivery Enhancements:

Hartford Office

SNAP Team -- From team of nine eligibility services staff, one worker is assigned on a rotating basis to screen mail-in applications and assign the applications to another member of the team. The screener also identifies potential expedited applications and these are immediately handed off to one worker assigned to process them. The third member on the rotation interviews and processes applications for 'walk-in' clients. In addition, staff specialize in SNAP Redetermination and Periodic Review Form processing and are responsible for all case updates within the assigned functional area.

Manchester sub-office
Family SNAP/HUSKY -- This unit is divided between Intake and Case Maintenance, with all HUSKY redeterminations are initiated by clerical staff and then processed by a designated worker. The SNAP redeterminations go to a group of designated workers, who process SNAP redeterminations.

TFA Family -- Two workers are now assigned to screening activities for all applications to determine if they qualify for cash assistance and scheduling required appointments with a TFA worker. If there is no cash assistance eligibility but expedited SNAP eligibility, applications are processed and moved to the Family Intake Unit or Regional Processing Unit.

Adult/Community Elderly -- This unit is divided between Intake, SNAP redet/PRF processing and Case Maintenance, with every application logged into a database and assigned to an intake worker. They are responsible for processing the case and then turning it over to Case Maintenance staff. Staff are assigned to one of the three functions. Staff members are not assigned a caseload and are responsible for all case updates and redeterminations within the assigned functional area.

Long-Term Care The Long-Term Care unit is also divided between Intake and Case Maintenance. Additionally, the two staff members assigned to Case Maintenance work together with Intake on a combined caseload.

Enfield Outposting – In an effort to expand client services to the Northern most portion of our service area, Enfield, we have collaborated with the Mary Lou Strom Community Health Center, and have out stationed a worker on a regular basis, in order to bring services into the community and reduce the number of times residents may have to drive a considerable distance to avail themselves of our services.

New Britain sub-office
Client Benefit Center -- The office operates a fully-functioning, bilingual-capacity Benefit Center that features four dedicated staff who respond to client inquiries concerning application and redetermination status, updates or clarifications on requested information to be submitted, and deadlines for submission. Another 20 staff rotate through the Benefit Center during the workday and respond to nine voice mailboxes carefully scripted to explain and request information on the common client changes that impact SNAP (and related program) eligibility and/or benefit amount.

Structured Processing -- Eligibility units have been reconfigured to focus on SNAP program maintenance and support other core programs. Certain staff specialize in and concentrate on SNAP applications and redeterminations, with the goal of addressing the dramatic increase in program participation, reducing processing times, and reducing program errors. Other staff maintain emphasis on related programs to ensure timely benefit issuance and customer service.

Express SNAP Grants -- The office maintains a special focus on SNAP applications via a dedicated service-window that fields client inquiries, assists with program applications, updates client information and tags completed applications. A dedicate team of eligibility services workers (co-located in the office's reception area) receives such applications and ensures expedited processing.

Community Outreach-- New Britain staff volunteer to work aboard the DSS Bus (a fully equipped and retro-fitted RV) in service to clients living in outlying areas. As a result of these outreach events, clients and staff have the opportunity to share important case information, document and update program data, and establish connections with community partners.

Willimantic sub-office
Call Center - Adult Cases
The Adult Unit implemented two teams with dedicated telephone lines, providing clients with greater efficiency by assigning cases to a customer service team rather than specific workers. The new format allows staff to be assigned where the need is greatest at any given time, such as telephone calls, redeterminations and interim changes.

Structured Processing
For each of the following areas -- TFA/Family Support, SNAP, SAGA Cash, State Supplement, HUSKY and Medicaid for Aged, Blind and Disabled/Low-Income Adults -- an assigned worker coordinates all new applications.

Community Involvement, Collaborations and Initiatives

The Northern Region participates in a wide range of community-based efforts to improve the coordination of services and develop prevention and early intervention services to address the needs of high-risk populations. In addition, the Region maintains an active Speaker's Bureau of trained volunteer staff who provide information and workshops on DSS programs to community-based agencies, consumer groups and statewide organizations. Following is a list of some of the committees and organizations which the Northern region participates in.

Hartford Area Child Care Collaborative, a project of the Hartford Foundation for Public Giving. The Northern Region participates on the steering committee, supporting the collaborative's work on such priorities as the education and credentialing of early childhood teachers, promotion of researched-based curriculum, building leadership and advocating for high quality child care at the local, state and national level. The collaborative also piloted the **Safe Families, Safe Homes** training model for early childhood programs, addressing issues of domestic violence affecting young children.

Hartford/West Hartford System of Care an interagency/community group originally supported by the Department of Children and Families to address the needs of families with children with behavioral health needs. The DSS Northern region participates on both the steering committee and monthly membership meetings.

Greater Hartford Children and Domestic Violence Collaborative, addressing issues of domestic violence and the effect on children and families in the Greater Hartford and Manchester areas by bringing together domestic violence services, court officials, DCF, DSS, domestic violence consultants, city services, police, and local agencies to coordinate and improve services. It is facilitated by Interval House.

Department of Public Health's Injury Community Planning Group, multi-disciplinary interagency group charged with developing a comprehensive state injury prevention plan as part of a federal Centers for Disease Control five-year grant. The Northern Region also participates in the intentional injury workgroup, the community assessment workgroup and peer violence workgroup.

Community Health Center of New Britain Advisory Board, a leader in the development of electronic medical records, autism screening, dental services provided on-site in New Britain schools. The board developed a public benefit website at Qualify4care.com, where people can learn if they qualify for public health insurance.

The Bristol Continuum of Care, addressing issues of homelessness in Bristol and responsible for the design and oversight of the HUD grant for the homeless, including the St. Vincent DePaul shelter programs, supportive housing programs, and homeless outreach and services.

Windham County Re-entry Council, addressing issues affecting people who are returning to the community from prison. The council meets regularly to facilitate coordination of services.

Generations Family Health Center, with DSS meeting regularly with staff of the Willimantic-based provider to help coordinate services and share information on public benefits.

Eastern Workforce Investment Board, addressing employment issues, including transportation to work for Temporary Family Assistance clients for work, which is especially challenging in this area of the state.

Southern Region

The Southern Region is comprised of a regional office (New Haven) and two sub-offices (Middletown and Norwich), serving 55 cities and towns across south central and southeastern Connecticut. The Region has a total of 312 staff, including 185eligibility staff, 27 social workers and 31 child support investigators. The Southern Region serves approximately 30% of the agency's active caseload, which includes 119,860 unduplicated households and 207,524 active recipients.

Regional Processing Unit -- To improve eligibility processing, a centralized unit located in the Middletown office handles all presumptive eligibility for HUSKY, as well as expedited eligibility for pregnant women and Newborn Initiative cases for the entire Southern Region. This unit works closely with 22 'Medicaid Certified entities' (hospitals and health clinics) in the region to expedite over 200 applications a month.

CT Works Partners -- Southern Region staff from the TFA units meets quarterly with their CT Works partners to coordinate all employment service activities for 2,253 time-limited TFA clients, including referrals to orientations and sanctioning of noncompliant clients.

Regional Client Fraud and Investigations Unit -- Based in New Haven, this unit now completes investigations formerly handled by Resources Investigations staff. Separate training and focus support more comprehensive investigations.

Outstationed Staff at Hospitals and Service Providers -- A total of five New Haven regional office eligibility staff is out-stationed at the Hospital of St. Raphael, Yale New Haven Hospital, and the Cornell Scott Hill Health Center. Two Middletown regional office eligibility staff are outstationed at the Connecticut Valley Hospital.

Two DSS workers are out-stationed at New Opportunities, Inc. in Meriden one day a week. This benefits those who need and/or want to be seen by a DSS worker and may have transportation issues when traveling to Middletown.

Income Verification Pilot

An electronic data exchange Income Verification pilot was developed, with the assistance of the DSS Information Technology Services Division and the Housing Authority of New Haven's IT division. The New Haven Regional Office was the original pilot of a process that eliminated the need for faxing budget/income information to the New Haven Housing Authority. This process does away with client office visits and delays associated with over 1,000 New Haven clients who

need to meet HUD income verification requirements. This pilot is now being offered to other housing authorities in an effort to eliminate an archaic income verification practice for all housing authorities and DSS.

Mobile Office Eligibility Services Regional office eligibility staff are deployed on an ongoing basis to all Southern Region city/town locations where the DSS Rx-Xpress Bus is stationed. Such efforts have increased availability and access of DSS programs to the general public.

Community Partnerships during SFY 2010 included:

New Haven

- Participate in advisory meetings for SNAP (formerly Food Stamp) and HUSKY outreach.
- Represent DSS on DCF Advisory Council, New Haven's Re-entry Roundtable, Greater New Haven Regional Alliance to End Homelessness, Job Corps Advisory Council, System of Care Collaboration and the Male Involvement Network.
- Participate in program planning/development —DCF's Differential Response System Regional Plan; New Haven Early Childhood Plan; Child First and Project Soar.
- Member of the New Haven Early Childhood Council and Early Head Start Policy Council.
- Through Help Me Grow Community Networking Breakfast meetings and Speakers' Bureau, provide programmatic information to other service providers and neighborhood groups.

Norwich

- Meet monthly with TVCCA's Care Team.
- Participate in the annual Homeless Connect Event, a collaborative event of all the region's social services agencies to reach out to the homeless population in the area.
- Staff a table at two events with the Department of Correction each year for inmates who are close to being released.

Middletown/Meriden

- Member of Middletown's School Readiness Council and Middletown's Children's Coalition.
- End Hunger Collaborative
- Member of Meriden Children First

Western Region

The DSS Western Region is comprised of a regional office (Bridgeport) with four sub-offices (Danbury, Stamford, Waterbury and Torrington), serving 57 cities and towns in Litchfield and Fairfield County. The Western Region serves over 200,000 recipients, representing nearly one-third of the department's total clientele statewide.

Regional Processing Unit, a specialized regional unit in the Bridgeport office, handles all presumptive eligibility for HUSKY, expedited eligibility for pregnant women, interim changes for HUSKY, Newborn Initiative applications, and Charter Oak-to-Medicaid for Low-Income Adults cases for the Western Region. In addition, there are 62 qualified entities, direct providers of medical services in the community and DSS partners in the facilitation of access to medical benefits. This unit has 12 dedicated staff and screens over 1,000 applications per month.

Community Partnerships and Modernization Initiatives in SFY 2011 included:

- Workload management and time study of all eligibility staff functions.
- Staff automated reception log and redetermination log, tracking and identifying timeliness of staff seeing clients.
- Phone survey done manually by staff to identify call volume, reasons for call and disposition times, in preparation for the department's Modernization of Client Service Delivery initiative.
- Waterbury Call Center, moving all eligibility services workers into a virtual call center to prepare and determine lessons learned for Modernization of Client Service Delivery. Eligibility staff work in teams to answer calls and process work.
- Long-Term Care Workgroup developed to identify standard practices in each office and identify system delays for payments to nursing homes and delays in application processing. This Western Region pilot has resulted in a statewide group meeting with nursing home association members to create statewide system improvements.
- Newborn Initiative –working with the Office of Skill Development, staff created statewide system used by 32 state hospitals to expedite enrollment of all uninsured newborns. Created computer-based tracking system and moved enrollment from 53-day average to three days.
- Info Desk Pilot –Triage style reception area service model that began in Bridgeport office and is now statewide customer service representative model used statewide.
- Leadership 2000- diversity model that brings together vertical slice of all staff functions to improve relationships and communication within Western region.
- HUSKY Community Forums- staff hold quarterly meeting with community partners to update on all current medical and benefit changes.
- Long-Term Care Community Forums – nursing home staff invited to regional offices to update on current info and improve relationships and timeliness of applications and payments.

OTHER DIVISIONS WITHIN DSS

Communications/Public and Government Relations

The **Office of Communications/Public & Government Relations** provides public information, legislative, news media, information/referral, and client services in support of the department's mission and statutory mandates. The office works closely with DSS divisions and regional offices, serving as direct contact point for media, legislators, applicants and clients, and the general public.

Staff assists applicants and clients who call or email for information, referral and assistance with food, medical, housing, subsistence, and related needs. The office researches and helps resolve client service issues, including referrals from the Governor's Office and members of the General Assembly.

Support functions include: advising on and coordinating legislative proposals; providing advocacy and representation at the General Assembly; serving as press secretary, departmental spokesperson and media contact point; preparing public information materials and news releases in support of agency services and initiatives; coordinating public relations with community organizations, grantees and individual clients and complainants; serving as Freedom of Information Act contact point and response coordination; conducting website development, maintenance and content management; program management of $3.7 million contract with United Way of Connecticut/2-1-1/HUSKY Infoline.

The office also provides verification of client information for state Office of Victim Services; verification of Temporary Assistance to Needy Families client information for other states for purposes of federal time-limit tracking; and client verification with Office of Policy and Management and municipalities for Renters' Tax Relief Program for elderly and individuals with disabilities; and Verification of Medicaid eligibility and resolution of medical services for clients in liaison with legal entity representing Connecticut hospitals.

The Communications/Public & Government Relations Office is on call for Governor's emergency response communications team, in conjunction with Department of Emergency Management and Homeland Security; and participates in agency's continuity of operations plan (including 'web EOC,' a state emergency operations communications site).

During SFY 2011 the office continued communications support to departmental program initiatives, while assisting applicants, clients and members of the general public by phone, email and outside referrals. A special highlight in customer service was establishment of a 'client information tracking system,' in conjunction with Regional Offices and the Division of Information Technology Services. The new system facilitates communication and problem resolution on behalf of clients; improves efficiency when clients contact multiple offices; and provides a central clearinghouse of information about client inquiries, complaints and service

resolutions. Over 1,800 client inquiries were routed through the client information tracking system for investigation/resolution during SFY 2011.

Legal Services

The **Office of Legal Counsel, Regulations and Administrative Hearings** provides in-house legal counsel to the agency, oversees the regulation promulgation process and provides administrative hearings in accordance with the Uniform Administrative Procedure Act for applicants and recipients of DSS programs who wish to contest actions taken by the department, including:

- Denial of applications for and discontinuance of SNAP, cash benefits, medical benefits, Child Care Assistance program benefits;
- Reduction of amount of SNAP, cash benefits, Child Care Assistance program benefits;
- Administrative Disqualification Hearings for the Temporary Family Assistance and Food Stamp programs. (Follow this link for the Administrative Disqualification Hearings Homepage - http://www.ct.gov/dss/cwp/view.asp?a=2349&q=304650)
- Recoupment of benefits, including liens placed by the DSS;
- Child support hearings pertaining to administrative actions including, state and federal income tax offset, credit bureau reporting and property liens;
- Nursing facility transfer and discharge hearings.

Quality Assurance

The Office of Quality Assurance is responsible for ensuring the fiscal and programmatic integrity of all programs administered by the Department of Social Services. In addition, QA is responsible for ensuring the integrity of all administrative functions of the Department. The office has four separate divisions, each with unique program integrity functions: Audit, Fraud & Recoveries, Quality Control, and Special Investigations. During SFY 2011, QA identified over $370 million in overpayments, third-party recoveries, and cost avoidance.

The **Audit Division** is responsible for the federally mandated audits of medical and health care providers that are paid through the various medical assistance programs administered by the department. The Audit Division's Grants & Contracts Unit is responsible for reviewing federal and state single audit reports. The unit is additionally responsible for reviewing financial reporting of activity for various DSS grants and contracts with non-profit agencies and municipalities. The Audit Division's Internal Audit Unit performs audits of the department's operations, involving review of administrative and programmatic functions and the electronic data processing systems used in their support.

The **Fraud & Recoveries Division** ensures that the department is the payor of last resort for the cost of a client's care by detecting, verifying, and utilizing third-party resources; establishing monetary recoveries realized from liens, mortgages, and property sales; identifying and deterring recipient fraud; and establishing recoveries for miscellaneous overpayments. The division's Central Processing Unit is responsible for the day-to-day operations of the Electronic Benefits Transfer (EBT) program. The EBT program distributes Supplemental Nutrition Assistance Program and cash assistance benefits to qualifying agency clients.

The Fraud & Recoveries Division's Client Fraud Unit includes investigation staff located at both Central and Regional Office locations. This unit performs investigations through the use of its pre-eligibility Fraud Early Detection Program and other fraud investigation measures. The Real Property Unit recovers monies owed to the department through liens and mortgages on real estate. The Third-Party Liability Unit is responsible for identifying and recovering the cost of health care from third parties, including insurance companies and Medicare, when responsible for payment of the health care services.

The **Quality Control Division** is responsible for the federally-mandated reviews of child care, Medicaid, and the SNAP programs. A newly-established set of federally-required Medicaid reviews has been implemented under the Payment Error Rate Measurement program. Reviews of Temporary Assistance for Needy Families cases and special projects may also be performed by this unit.

The **Special Investigations Unit** is charged with the responsibility of coordinating and conducting activities to prevent, detect, and investigate fraud, waste, abuse, and overpayments in the programs administered by the department. The unit uses data analysis of payments to identify aberrant billing activity and pursues collection of such overpayments. In addition, specialized investigations are performed on suspect providers to determine if a fraud referral is

appropriate. Fraud referrals are pursuant to a memorandum of understanding with the following agencies: the Office of the Chief State's Attorney, the Office of the Attorney General and the U.S. Department of Health and Human Services' Office of the Inspector General. Once referred, each entity independently determines if a criminal or civil investigation is appropriate. The Special Investigations Unit is also responsible for the review and approval of all provider enrollment applications.

Affirmative Action

The Department of Social Services is strongly committed to the concepts, principles, and goals of affirmative action and equal employment opportunity. These objectives are commensurate with the state's policy of compliance with all federal and state constitutional provisions, laws, regulations, guidelines, and executive orders that prohibit discrimination. The **Affirmative Action Plan**, submitted on March 30, 2011 was approved and granted continued annual filing status by the Connecticut Commission on Human Right and Opportunities. DSS administers its programs, services, and contracts in a fair and impartial manner.

During SFY 2011, the Department of Social Services continued to monitor and improve its practices in employment and contracting, giving special consideration to affirmative action goal attainment, diversity training for all employees, and contract compliance. At the close of the November 30, 2010, affirmative action reporting period, 41.3% of DSS employees were minorities, 70.4% were women, and 1.2% was self-identified as having a disability. During the plan year, the department hired 113 new employees: 52 (46%) were minorities and 79 (69.9%) were women.

The department's affirmative action posture is reflected in the established, Department of Administrative Services-approved goals for small-, women-, and minority-owned business enterprises. The agency actively solicits participation from these categories in its selection of contractors.

Division of Financial Management and Analysis

The Division of Financial Management and Analysis supports the department through a full range of financial oversight and operational functions. These financial management activities are provided through four key service centers outlined below.

The Budget and Payroll Group is responsible for budgeting for well over $5 billion in state and federal funds and over 50 distinct budgeted accounts. Ongoing functions of this group include developing estimates of agency spending, producing or reviewing detailed spending plans, monitoring against these plans and estimates, facilitating the development of agency budget options, and providing updates on the status of the budget process for the agency. In addition to operational expenses, the Budget Unit develops forecasts and expenditure reports for the many complex health and cash assistance services DSS provides to eligible state residents.

During SFY 2011, this group has been involved in providing fiscal analyses on several major department initiatives. These include implementation of Medicaid for Low-Income Adults, prior authorization for specified dental procedures, increased utilization review, and many others.

Within this group, the Payroll Unit is responsible for management and oversight of payroll and benefit services to nearly 2,000 employees of the department.

The Federal Reporting and Accounting Services Group includes the Federal Reporting, General Accounting, Accounts Payable and Convalescent Accounting functions. The Federal Reporting unit is responsible for the financial reporting of federal grants and for the department's public assistance cost allocation plan. The General Accounting unit coordinates the fund postings to the state accounting system, in addition to the maintenance of the Chart of Accounts and the Random Moment Sample System, which supports the cost allocation process. This unit is also responsible for the Department's American Recovery and Reinvestment Act (ARRA) reporting. The Accounts Payable unit is responsible for all vendor payments issued through the state accounting system. The Convalescent Accounting unit is responsible for accounting activities related to the long-term care portion of the Medicaid program.

During the past year, this group allocated over $371.8 million in Department administrative costs for the purpose of accessing federal reimbursement, reported on over 135 federal grants, processed over 25,000 CORE-CT payment vouchers and successfully assisted in Medicaid payment starts for reimbursement of care provided in skilled nursing facilities.

The Fund Management and Reporting (FMR) Group is charged with meeting the department's fund management and reporting requirements. This area is responsible for the calculation and filing of the federal award requests and claiming for Connecticut's Medicaid, Children's Health Insurance and Money Follows the Person programs. In SFY 2011, funding from revenue generating programs resulted in approximately over $3.82 billion in federal revenue for the state. FMR is also responsible for cash management for all federal accounts. The Cash Management area oversees the drawdown and reconciliation of 200+ grants contained on five different federal draw systems. In SFY 2011, this area drew down over $4.12 billion for the state.

FMR also contains the Benefit Accounting Unit (BA), which is responsible for the management of funds associated with over 30 DSS benefit entitlement programs utilizing state and federal funds, such as Medicaid and Temporary Family Assistance. Other programs include ConnPACE, Charter Oak, Husky B, Supplemental Security Interim Assistance, State Supplemental Benefits, State-Administered General Assistance, along with several other benefit programs, with an annual total of over $5.5 billion.

The Accounts Receivable unit, responsible for a significant level of receivables related to the Medicaid program, as well as those of other agency programs, is located within this service center. During SFY 2011, the department successfully collected over $300 million in receivables.

The Actuarial Research and Analytical Support Unit supports the department by providing an in-house analytical capability. This unit is responsible for the development of capitation rates for the department's managed care services, developing estimates for complex medical program changes, and providing the analytical support for state Medicaid waivers and state Medicaid plan amendments. The unit also is available to provide actuarial and analytical support to other program areas within the department as needed. This unit works with staff from program areas to research and analyze issues, recommending changes to policy and procedures, as warranted.

Contract Administration

The Division of Contract Administration is comprised of four separate functional units: Contracts; Facilities Management and Support Services; Procurement and Purchasing. Collectively, the division is charged with the oversight and administration of all contract, procurement and purchasing functions for the department, including the development and approval of purchase orders to process contract payments and payments for the purchase of commodities and services for the Department. In addition, the Facilities Management Unit is responsible for the management of building facilities and intra-agency operations.

Contract Administration staff provide direction and support in all administrative contract activities for the purchase of training, technical assistance and other services. The staff work with DSS program divisions to contract for the delivery of client services through the development and execution of 'purchase of service' contracts with non-profit, community-based human service agencies and other governmental agencies. In addition, contract staff work with other department staff to arrange for the delivery of services to the department through development and execution of 'personal services agreements.' Unit staff also work with sister state agencies to develop Memoranda of Agreement and Understanding to ensure that the transfer of funding between agencies is properly expended and monitored and that the needs of both DSS and the sister agencies are met in terms of their inter-dependence on one another.

Contract Administration staff ensure that the Department complies with policies and procedures pertaining to contracting promulgated by the Office of Policy and Management (OPM) and that all contracts contain the requisite contract provisions, as directed by the OPM and the Attorney General's Office. Annually, staff process over 1,000 contracts and amendments with over 350 contractors.

Staff members work directly with OPM and the Attorney General's Office to assist in the development and dissemination of policies and procedures for the development and execution of Purchase of Services contracts for the provision of direct-client services and Personal Services Agreements for the purchase of services for the Department. They also implement and participate in the training of department staff on new or revised contractual requirements or processes and ensure that state contract compliance rules for all contract and procurement activities conducted by the department are followed in the areas of contract development, processing and administration.

In addition to the development of contracts to support the programs within the Bureau of Assistance Programs and the Bureau of Aging, Community and Social Work Services, the Contract Administration staff, primarily through its director and the staff attorney dedicated to the unit, work closely with Medical Care Administration staff and the Division of Financial Management and Analysis to maintain current contracts and to implement new initiatives through contracts and memoranda of understanding. The recent paradigm shift toward value-based purchasing, through the implementation of Affordable Care Act provisions to ensure the purchase of quality medical services, is helping DSS better negotiate and monitor its medical care administration contracts.

Contract Administration's role in SFY 2011 was especially important as the first elements of the federal Affordable Care Act were unfurled, particularly in extending the Medicaid benefit to the State-Administered General Assistance (SAGA) medical beneficiary population (effective 7/1/10) and in initiating the Connecticut Pre-Existing Condition Insurance Plan. The SAGA-to-Medicaid for Low-Income Adults roll-out required amending seven existing contracts and the addition of a sub-contractual relationship through a managed care organization. Additionally, procurements for a Non-Emergency Medical Transportation broker, a statewide behavioral health program contractor, and an administrative services organization for medical care management were all released.

Contract Procurement staff are responsible for managing the department's procurement process for purchase of service and personal services agreement contracts, and for ensuring that every procurement is conducted in full compliance with applicable laws, rules and regulations. The unit is responsible for ensuring a fair, open and competitive selection process and to select the best candidate(s), based on ability and cost, to negotiate a contract with the department. Contract Procurement staff maintain the legal procurement file and, once the procurement activity is complete, work with contract administration and program staff on the development and implementation of the resulting contract(s).

Purchasing Staff are responsible for the purchase, receipt and delivery of all commodities, supplies, and services for the department. Staff ensure that purchases are conducted in accordance with state guidelines and state statutes that may include the solicitation and review of multiple bids. Staff serve as liaison and facilitator of purchases from contract awards that originate with the Departments of Administrative Services and/or Information Technology. Purchasing Staff also initiate the payment process following the receipt of the purchased items through the initiation and the development of the purchase orders used to process the payments.

Purchasing staff are the primary contact for all vendors of services and supplies; and is the agency's surplus coordinator. They also participate in facilitation of asset management through the identification of equipment purchased to be entered in the state's CORE-CT asset management system; the review of new office equipment; and the review and continuation of lease and maintenance agreements for all office equipment throughout the agency.

The supervisor of the Purchasing Staff is the designated coordinator for the agency credit card (P-Card) used by department staff specifically authorized for certain purchase transactions,

including but not limited to charges associated with travel needs. Travel arrangements are handled by the travel coordinator and are charged to the P-card. This includes booking airline, train or bus reservations and making hotel or motel reservations. The travel coordinator also handles employee reimbursements including mileage, meals, registrations, licenses, etc

.

Purchasing staff also arrange for vehicle rental for Central Office staff through DAS Fleet Services and Enterprise Rental Car.

The **Payment Processing and Fiscal Support Services Staff** initiate and amend purchase orders in the CORE-CT system to facilitate payments to a contracted vendor for services provided on behalf of or for the department. In addition, this staff is responsible for the development and submission of the department's annual Small Business & Minority goals and the ongoing quarterly reporting on efforts to comply with the goals, as approved by the Department of Administrative Services.

The **Facilities Management and Support Services Staff** provide support services to all DSS offices, including the 12 Regional Office locations, Central Office, and several Bureau of Rehabilitation Services locations throughout the state, including Disability Determination Services. Support services address building and maintenance matters, including security, health, safety and environmental issues, emergency requirements and compliance with all federal, state and local building code regulations. Facilities Management coordinates the development of the statewide facilities plan to maintain and secure office space and manages the state's process to request and obtain leased space necessary for department operations. Facilities Management is the department's primary liaison with the state's leasing group, now functionally part of the Department of Administrative Services, and manages the DSS fleet of 82 vehicles.

Information Technology Services

The Information Technology Services Division encompasses several sections, including Technical Services, Support Services, the Data Warehouse, and the Document Center/Mailroom. These sections have provided extensive technical support to both the program and administrative areas of the agency.

The **Technical Services Section** is responsible for the technical computer systems changes, maintenance and administration. This includes Operations (batch and on-line processing), Help Desk Support and Communications, LAN/WAN Administration, Microsystems, Applications Development (including programming and systems analysis) and Data Base Administration units.

Operations, Helpdesk, LAN/WAN and Communications Support Units
With a staff of 21 in the Operations, Helpdesk area and supporting the LAN/WAN areas, overall support is provided in the following areas:

Operations:

- Computer operations / maintenance

- PC/Mainframe networking
- Batch schedules / processing
- Library functions
- Data transmission / receipt
- Data control functions
- Report distribution
- Disaster recovery
- Equipment installation
- Field Relocation
- Telephone Support (including cell and BlackBerry devices)

LAN Support:

- LAN/WAN Technical support
- Active Directory Administration
- Citrix Terminal Servers and Applications
- Email Administration
- Data Backup / recovery
- Virus protection / Operating System Patch Management
- Capacity Planning and Performance
- Security
- Internet Access
- Technical Standards
- New product evaluation

Coordination of effort among the staff of these two areas is critical and is essential to the successful maintenance of the mainframe and LAN/WAN environments. The functioning of the data center is a 24 hour a day and six day a week process with two staff assigned to each of the second and third shifts, primarily for the processing of both the production and test Eligibility Management System cycles along with generation of daily notices, checks, and the communicating of various data files to the appropriate entities via file transfer protocol or various other types of media.

Supporting over 3,000 PCs and 50+ servers utilizing the DSS infrastructure, the staff maintains all the hardware and is responsible for troubleshooting and problem resolution in an effort to support agency staff in performing their daily activities and ability to provide the necessary services to the customers.

The **PC Microsystems - Applications Unit** provides a variety of computer-based system and application support services to support the operation of the department's program and support divisions. The unit develops/documents software for office automation applications, evaluates new hardware/software to improve program effectiveness, procurement of hardware and software systems, and manages/maintains data management systems.

In addition to providing client/server application support and development services to the department, the unit is also responsible for designing, maintaining and determining the technical path of internet and intranet-based web sites associated with the department. The unit provides a structured approach for maintaining content on these sites as well as following state design guidelines, accessibility mandates and interoperability practices.

The unit maintains eleven primary agency websites and two intranet sites. Maintenance of these sites includes content management, change management and design modifications. New web sites are added at a rate of approximately two per year.

The **Application Development and Data Base Administration Unit** provides the core IT support for the agency, including application requirements, analysis, development, implementation and maintenance to the mainframe environment. The main application this unit provides the application support for is the Eligibility Management System. This mainframe system provides fully integrated data processing support for the determination of client eligibility, benefit calculation and issuance, financial accounting, and management reporting. EMS supports many of the agency's major programs such as Temporary Family Assistance, Medical Assistance (HUSKY and Medicaid), Supplemental Nutrition Assistance Program, State Supplement to the Aged, Blind, and Disabled, the State Administered General Assistance, and the Refugee Cash and Medical assistance programs.

The **Support Services Section** provides support to the Technical Services Section, as well as supplying other services to the department, the legislature, other state agencies, and the general public. Within ITS Support Services are the User Support Group (EMS and CCSES Help Desks), the Systems Planning Unit, and the Information Services Unit.

EMS User Support Group - the 'Help Desk' for EMS users -- responds to questions ranging from password resets to system functionality problems.

CCSES User Support Group - provides testing of changes to the Child Support/CCSES computer systems tests new computer software from a user's perspective before the changes are moved into the production region of the system. The group also handles project management of CCSES systems changes, and provides 'help desk' service.

The **Systems Planning Unit** is responsible for providing overall ITS project management, EMS project management, EMS business and systems functional requirements definition and various other planning activities for EMS, CCSES, and PC projects. In addition, it is responsible for ITS budget and spending plan completion; departmental forms and forms transmittal development (hard copy and intranet), and records (including DSS client case record information) retention

and management. Systems Planning also acts as a liaison for Department of Information Technology/DSS interactions and is responsible for the Information Technology Agency Review and Planning Group.

The **Information Services Unit** is responsible for creating and modifying EMS management reports; performing analysis and documenting and defining the methodology for quality control selection criteria and outcomes and reporting the results to federal and state entities; compiling data and reporting on the Temporary Assistance to Needy Families high-performance bonus and TANF participation rates; creating and modifying regional 'download' files; analyzing and writing requirements for reports, as well as validating the report results; responding to outside queries for information; and performing general data analysis.

The **Data Warehouse Administration Unit** manages a system that provides users access to Connecticut Medical Assistance Program data for the creation of ad hoc queries and reports, as well as for producing regularly scheduled reports. The data warehouse system operates the Management and Administrative Reporting and Surveillance and Utilization Review subsystems for the Medicaid Management Information System. It also has fraud/abuse and overpayment functionality. It serves as a decision support system for program and financial analysis and the ability to respond to information requests.

The Document Center/Mailroom/Archiving Services Unit provides departmental printing and mail insertion services, including more than 4.4 million notices to clients per year. The automated inserting equipment can process 2,000-4,000 items per hour and can affix the proper discounted postage rate in one process. By presorting the mail, the department saves approximately $30,000 a month on postage.

The Archiving Services Unit provides the department with support relative to document storage. The unit handles all archiving services including, retrieval, re-file, and the ordering of supplies.

Office of Organizational & Skill Development *"Building Skills, Developing Success"*

The Office of Organizational & Skill Development provides the department, its staff, and partners with training and organizational development services that enhance staff skills and support the DSS mission.

Core services include - training and staff development, organizational development, media, web-based training, systems and graphic support in programs, computer systems, leadership and professional development. The Office of Organizational & Skill Development supports organizational development initiatives such as the John S. Martinez Fatherhood Initiative, Traumatic Brain Injury, Modernization of Client Service Delivery and others.

The mission of the Office of Organizational & Skill Development is the provision of timely, relevant and effective organizational and staff development activities to: enhance knowledge, skills and abilities of the staff to ensure Department of Social Services customers receive effective services; ensure a culturally responsive delivery of services that recognizes and affirms

diversity; improve job performance through the institution of measures of accountability to inspire public confidence; provide employees with opportunities to develop their potential within the context of the organization and overall career development; facilitate compliance with DSS policies; institute systemic interventions that support organizational operations in the area of communication, project management, access, and service.

The Office of Organizational & Skill Development is deployed in four service areas – Programs; Leadership and Professional Development; Administrative; and the MultiSystems Service Areas. OSD accomplishments include focus groups with clients and providers in preparation for the Modernization of Client Service Delivery Initiative, training and organizational development for the implementation of universal design standards in service; skill building in DSS programs like the Supplemental Nutrition Assistance Program, Temporary Assistance to Needy Families, Child Support, Social Work and Medicaid; supervision; and technology training.

OSD continues to partner with staff in training for DSS partners (other state agencies, Community Action Agencies, and hospitals) in topics like the Voluntary Paternity Establishment program, the use of the Eligibility Management System, programmatic overviews, and others.

OSD is established through a collaborative agreement with the University of Connecticut School of Social Work and DSS. This unique agreement provides for federal reimbursement to the state General Fund.

Human Resources Division

The Human Resources Division is responsible for providing technical guidance and support to the employees of the central and regional offices. Staff are involved in addressing issues which impact human resource management for the agency as a whole, through coordination of policy issues, involvement in labor relations activity and, in general, with the objective of ensuring that the quality of human resource service throughout the department remains consistent.

Functions of the Human Resource Division include: providing general personnel services to all staff; coordination and administration of information related to personnel data collection; decentralized examination and the development and dissemination of agency policies and procedures; participation in labor relations activities with respect to contract administration and negotiation, staff training and the grievance process; administration of medical and other benefits; and implementation of health and safety programs, including employee wellness education and workers' compensation.

Bureau of Rehabilitation Services

Note: Legislation that took effect July 1, 2011 (the beginning of State Fiscal Year 2012) placed the DSS Bureau of Rehabilitation Services into a new state Bureau of Rehabilitative Services. The new bureau also includes the Board of Education Services for the Blind, the Commission on Deaf and Hearing Impaired and portions of the Workers' Compensation Commission and

Department of Motor Vehicles. The Bureau of Rehabilitative Services is attached to DSS for administrative purposes only. Pending the appointment of a bureau director, DSS Commissioner Roderick Bremby is serving as acting director. The following section covers the Bureau of Rehabilitation Services during SFY 2011, before the reorganization.]

The mission of the Bureau of Rehabilitation Services (www.ct.gov/brs) is to create opportunities that enable individuals with significant disabilities to work competitively and live independently. Staff strive to provide appropriate, individualized services, develop effective partnerships, and share sufficient information so that consumers and their families may make informed choices about the rehabilitation process and employment options.

BRS administers the Title I Vocational Rehabilitation (VR) and Title VI Supported Employment (SE) programs of the Rehabilitation Act of 1973, as amended. Consumers who have significant disabilities receive individual assistance in preparing for, finding or keeping a job. BRS receives this federal funding from the Rehabilitation Services Administration, Office of Special Education and Rehabilitative Services, at the U.S. Department of Education.

BRS assisted 8,441 consumers in Federal Fiscal Year (FFY) 2011. BRS assistance in the amount of approximately $9.2 million helped these consumers to prepare for employment opportunities. The expenditures covered a broad range of services including community rehabilitation providers; adaptive technology like home and vehicle modifications; devices to replace limbs or assist with hearing; training programs and supplies to complete training; tuition, fees, and books needed for college education; evaluations and treatments for physical, psychological, and psychiatric conditions; and other services needed to maintain consumers as they progress along in their individual plans. BRS successfully rehabilitated 1,171 consumers to enter or maintain competitive employment.

In addition to assisting consumers to prepare for, acquire and maintain employment, BRS also assists employers seeking qualified candidates for employment. BRS led several efforts to improve the process of helping consumers find work or to improve the climate in which consumers interacted with employers and community rehabilitation providers, while seeking training and employment. Several projects and programs used in that effort are described below.

Connect-Ability, a technical assistance center funded by the Medicaid Infrastructure Grant, strives to reduce barriers to employment by creating a strong competitive employment infrastructure. Staff assists key stakeholders (job-seekers, employers, state agencies, and disability advocates) in navigating Connecticut's employment system for job-seekers and employees with disabilities.

Through a marketing campaign, Connect-Ability:

- Strengthened capacity to assist state agencies by providing technical assistance to the populations they support to enhance the employment of people with disabilities.

- Created three new television and radio spots, print ads, and internet banner ads and also redesigned its website: www.connect-ability.com. The ads featured actual BRS service consumers and the Connect-Ability tag line, "See the ability. See how we can work together." Staff responded to 300 calls for technical assistance; 25,000 unique visitors sought information from the website. Brochures and other materials were also created for job seekers and employers.

- Recognized top employers at the June 2011 **Employment Summit** for their commitment to employing people with disabilities.

- Collaborated with 50 employers to participate in **National Disability Mentoring Day**, an initiative that provides workplace skills and experiences to students and jobseekers with disabilities. Over 175 "mentorees" participated in activities from mock interviews, company tours, and company overviews.

- Helped launch the national marketing campaign **"Think Beyond the Label,"** a collaboration of states to enhance systems that provide opportunities for people with disabilities to enter the workforce. The goals of this campaign are to change attitudes about hiring people with disabilities, raise awareness of the need for diversity in the workplace, and counter stereotypes.

Under the Connect-Ability **Transportation** activities, BRS engaged in the following:

- Developed a web-based trip planner in partnership with CT TRANSIT and the Connecticut Department of Transportation to help individuals plan their bus trips. The trip planner is available at www.cttransist.com.

- Hosted over 250 individuals at six transportation workshops co-sponsored with the Connecticut Association for Community Transportation (CACT) and the Kennedy Center. These workshops helped to increase awareness of existing transportation options, networking, advocacy, and exposure to Connect-Ability and CACT.

- Provided new public transportation services and alternatives beyond those required by the Americans with Disabilities Act of 1990 (42 U.S.C. 12101 et. Seq.) with New Freedom Initiative (NFI) grants from the federal Department of Transportation. This funding assists individuals with disabilities with transportation to and from jobs and employment support services. The NFI provided funding for four wheelchair accessible taxis, two new taxi voucher programs, and two Mobility Ombudsman positions.

- Collaborated with the Connecticut Department of Transportation (DOT) and the Kennedy Center to standardize the ADA paratransit applications. The goal was to have one application that can be used statewide by all paratransit providers.

Pre-employment Skills for Consumers

In May 2011, BRS hosted the latest **Consumer Prep Rallies,** a series of day-long events geared to prepare consumers to successfully navigate a job fair and converse in on-the-spot interviews.

Small group instruction and individual readiness preparation were provided. Consumers participated in a mock job fair, practiced skills presented in the training, and received feedback on their efforts. Consumers received copies of their resumes that had been reviewed and revised as a part of the training. Prep rallies were held in Bridgeport, Hartford, Middletown, New Haven, Norwich, and Waterbury, enabling hundreds of consumers to attend. This innovative approach prepared consumers to participate in jobs fairs around the state. Connect-Ability partnered with BRS to help promote the prep rallies and develop materials for the events.

Wages and Public Benefits

The **Connect-to-Work Center** within BRS provides a single access point for information about the impact of wages on federal and state benefits. Community Work Incentive Coordinators provide comprehensive benefits analysis summaries to help people with disabilities maximize income by working and using federal, state and community resources appropriately to enable sustained employment and increased self-sufficiency. The project hosted 62 workshops during the federal fiscal year.

The Center, selected to participate in a national Individual Development Account (IDA) Pilot Project, has been designated as an **"Innovation Champion" for 2010** by Corporation for Enterprise Development, a national organization. IDA accounts assist low- and moderate-income people to save money and receive significant matching funds that will help them increase their assets and financial stability. The IDAs began enrollment in Connecticut in July 2011. Participants in IDAs must be employed or must plan on becoming employed, and receive a Social Security benefit due to disability.

These IDA accounts will enable BRS consumers to buy a vehicle needed for work. IDA consumers will receive financial literacy training and budget mentoring. This program will be self-sustaining, based on its tie-in with Social Security's Ticket to Work program and may be replicated around the country. The Connect to Work Center Work Incentives Planning and Assistance Project staff collaborated with BRS and Connect-Ability staff, Co-opportunity, Inc. (a community non-profit agency that provides financial education), and the Social Security Administration.

Business Updates

Business Leadership Network: The Connecticut Business Leadership Network (BLN), a coalition of employers working to increase employment opportunities for people with disabilities, continued to grow. The BLN has a total of 190 members representing 93 companies, one federal agency, nine state agencies, 23 non-profit organizations, five municipalities, four higher education institutions, four public schools, and 61 individuals.

Employer Engagement: Connecticut employers were surveyed to determine the best practices in recruitment, hiring and retention of people with disabilities and six were selected as top employers for people with disabilities in Connecticut. Nineteen companies have signed a pledge to proactively recruit people with disabilities by placing their company logo with a link to their job openings on the Connect-Ability website.

BRS continued its **Employment Partnerships** with **Walgreens** by referring consumers for training and employment. Approximately 46% of the more than 550 workers at the distribution center in Connecticut are employees with a disability. Walgreens is planning to expand training for consumers with disabilities to its retail business nationally, and BRS is ready to partner with the pharmacy on this new initiative.

Through the Arc of Quinebaug Valley, **Lowe's** has established a training program at its distribution center in Plainfield. This business partnership, similar to the Walgreens model, has received positive feedback from Lowe's and BRS consumers who have participated in this partnership. While the initial class included five consumers, many more have participated in the training beyond this reporting period.

Employment Division
With American Recovery and Reinvestment Act (ARRA) funding from 2009, BRS developed three program areas in 2010. In some cases, this funding was blended with state or federal dollars from the vocational rehabilitation program.

- BRS created an **Employment Division** to enhance statewide employer development. The Employment Division developed 179 work outcomes for consumers, with 89 of those outcomes taking the form of on-the-job trainings with local employers. Connect-Ability partnered with the Employment Division and created and developed employer-focused materials.

- BRS partnered with the state Department of Education, the Regional Educational Service Centers (RESC), the Connecticut Parent Advocacy Center, and the State Education Resource Center (SERC) to develop the **Regional Education Service Center /State Education Resource Center Transition Resource Counselor Initiative**. This initiative will help develop effective working partnerships between BRS and local education agencies; coordinate services for students and families regarding employment; increase capacity for of the organizations to collaborate on vocational rehabilitation services; and develop a plan to sustain this collaboration. Each RESC and SERC hired a transition resource counselor to identify supports and services available through BRS and other state adult service agencies.

- ARRA funds helped to improve **Client Services** for BRS consumers with community rehabilitation providers in the areas of job placement, interview preparedness, and employment readiness.

Consumer Services
The **Connecticut Tech Act Project** strives to increase independence and improve the lives of individuals with disabilities through increased access to and acquisition of Assistive Technology (AT) devices for work, school, and community living.

The Tech Act added a new AT Device Loan Program. BRS consumers may borrow from a new inventory of devices while they engage in working evaluations, on-the-job training, or work. This loan program allows the consumer, VR counselor, and employer to determine if the AT

device will remove barriers and increase independence for consumers as they perform their job duties.

Individuals using Public Assistance
BRS collaborated with DSS Bureau of Assistance Programs and the Temporary Assistance for Needy Families (TANF) Program to hire four state-funded **TANF/VR Counselors**. These counselors screen TANF consumers subject to sanctions for not complying with their employment plans. Screenings occur at the conciliation interview. As part of that process, consumers are offered the opportunity to be screened in one or more of these three areas: mental health, substance abuse and/or learning disabilities.

Services for Individuals Who are Deaf
Through the **CRP Differential Rate Pilot Program**, community rehabilitation providers increased their knowledge of the deaf culture and increased their ability to provide services in American Sign Language so deaf consumers can better access suitable services.

BRS is moving closer to installing 20 **video phones** to provide better access to consumers who are deaf and hearing-impaired. The plan includes installing one video phone in each regional and field office and two video phones in the bureau's central office.

The rehabilitation counselors for the deaf are currently working with community work incentive coordinators to develop a series of **benefit counseling workshops for deaf consumers.**

Independent Living
Through the five **Centers for Independent Living (CIL)** --the Center for Disability Rights, West Haven; Disabilities Network of Eastern Connecticut, Norwich; Disability Resource Center of Fairfield County, Stratford; Independence Northwest, Naugatuck; and Independence Unlimited, Hartford -- individuals with disabilities received four core independent living services: advocacy, information & referral, peer counseling, and independent living skills training. BRS also received ARRA funding for the independent living programs under Title VII, Chapter 1, Part B, to augment independent living services. Four of the centers used this funding to increase the independent living and pre-vocational skills for consumers with vocational goals; the fifth center used the funding for students with disabilities who are transitioning from school to independent living to employment.

Four of the CILs were approved by the Social Security Administration to become Employment Networks: Disabilities Network of Eastern CT, Independence Unlimited, Independence Northwest, and the Disability Resource Center of Fairfield County.

Disability Determination Services (DDS), located within BRS, is responsible for deciding eligibility for the Social Security Disability Insurance (SSDI) and Supplemental Security Insurance (SSI) programs. These programs provide cash benefits to individuals who are unable to maintain employment due to the severity of their disabilities. DDS processed 40,000 client applications (filed at local Social Security Administration field offices or online at www.ssa.gov) for SSDI and SSSI during SFY 2011. The Connecticut DDS remains ranked as one of the top in

the nation in productivity, effectiveness, and public service and continues to achieve a low cost-per-case rate in the nation.

Board of Education and Services for the Blind

Note: Legislation that took effect July 1, 2011 (the beginning of State Fiscal Year 2012) placed the Board of Education and Services for the Blind into a new state Bureau of Rehabilitative Services. The new bureau also includes the Bureau of Rehabilitation Services, the Commission on Deaf and Hearing Impaired and portions of the Workers' Compensation Commission and Department of Motor Vehicles. The Bureau of Rehabilitative Services is attached to DSS for administrative purposes only. Pending the appointment of a bureau director, DSS Commissioner Roderick Bremby is serving as acting director. The following section covers the Board of Education and Services to the Blind during SFY 2011, before the reorganization.]

Brian G. Sigman, Executive Director
Keith L. Maynard, Deputy Executive Director
Established – 1893
Statutory authority – CGS Sec. 10-293 through 10-311(a)
Central office - 184 Windsor Avenue, Windsor, Connecticut, 06095
Web address - www.ct.gov/besb

Total employees – 113
Recurring operating expenses- $17.9 million

Organizational Structure

The BESB Program contains four separate service units which provide a full range of services to clients of all ages: an Adult Services Unit that serves as the central intake for clients and provides independent living training services to adults; a Children's Services Unit that provides Braille instruction and support to children who are blind or visually impaired and professional and technical assistance to school districts; a Vocational Rehabilitation Unit that helps adults who are legally blind obtain and retain employment; and a Business Enterprises Unit that offers entrepreneurial opportunities to people who are blind.

Mission

The Board of Education and Services for the Blind Program is responsible for initiating, coordinating and implementing the education and training of Connecticut's children with blindness and visual impairment in order to maintain their academic, physical, emotional and social progress at age level, grade level or diagnosed ability level. The BESB Program also serves Connecticut's adults with blindness through ongoing educational, vocational and living skills programs in order to empower them to achieve employment success in their chosen profession and to enhance their independence and self-sufficiency.

Statutory Responsibility

The Board of Education and Services for the Blind (BESB) Program operates under the authority of Chapter 174 of the Connecticut General Statutes and maintains a confidential registry of people who are blind in Connecticut as required by statute. The BESB Program provides

comprehensive independent living services, adaptive aids and devices and volunteer supports, among other rehabilitative services, to adults who are legally blind or deafblind and children who are visually impaired, legally blind or deafblind, with a goal of maximizing independence and community inclusion. Under the provisions of Connecticut General Statutes Section 10-295, the Program provides to any school district upon written request the services of Teachers of the Visually Impaired to address the vision-related developmental needs of students who are blind, deafblind or visually impaired. Services to students often include the provision of large print or Braille textbooks, adaptive note taking devices and low vision magnifying aids to facilitate participation in classroom learning. The Program also provides reimbursement to school districts for the costs of hiring Teachers of the Visually Impaired on their own.

For adults who are legally blind or deafblind, services include independent living instruction such as training in safe cooking techniques or community travel using a long white cane or white support cane. Vocational rehabilitation services, including the sponsoring of post-secondary education and training where applicable, are available to enable eligible clients to achieve gainful employment. The Program works with employers in job placement activities and also to implement strategies that result in the retention of employment for clients who are experiencing vision-related impediments on the job.

Entrepreneurial opportunities are available through the Business Enterprise Program, providing eligible clients who are blind with the ability to operate businesses in the food services industry and at newsstands and gift stores at government locations throughout the state.

Public education activities on topics related to blindness are offered on an ongoing basis to senior centers, local education agencies, nursing homes, community rehabilitation providers, civic groups, service provider networks and employers.

The BESB Program is advised by a Board appointed by the Governor and the leaders of the General Assembly. Its members are Alan Sylvestre (Chair), Eileen Akers, Christine Boisvert, Carol Gillispie, Patrick Johnson, Jay Kronfeld, Dr. Chris Kuell, Stephen Thal, Randa Utter, Betty Woodward and Roderick L. Bremby who, as the Commissioner of the Department of Social Services, serves ex-officio.

Public Service

The Board of Education and Services for the Blind Program is the state's lead program for the coordination and provision of services to Connecticut residents who are legally blind. Founded in 1893, BESB was among the first state programs in the nation for people who are blind and that proud heritage is reflected in an unsurpassed dedication to public service.

For fiscal year 2011, the client registry for the Program contained 10,942 Connecticut residents. A total of 643 newly blind individuals were added to the registry, 447 of whom, or nearly 70 percent, were age 65 or older. Of that total number of new clients, 94 were children, bringing the total number of children on the registry to 1,074.

The Program primarily delivers services through itinerant means, going into the homes, schools and places of employment of BESB clients to deliver rehabilitative evaluations and training. In fiscal year 2011, the Program increased the total number of hours of direct rehabilitative services provided to clients by 5 percent to over 27,000 hours, providing crucial educational assistance to children, career assistance to adults and transition-age youth, and improvements in independent living to clients of all ages. Additionally, over 6,500 hours of outreach, consultation and public education services were provided to educators, community providers, employers and vending locations in fiscal year 2011, an increase of nearly 10 percent over fiscal year 2010.

In fiscal year 2011, the Program provided nearly 4,000 hours of direct Orientation and Mobility services - an increase of over 11 percent from the previous year - to teach safe travel techniques to children and adults, enabling clients to access their communities and participate in education and employment. In addition, the Program provided over 2,100 hours of Rehabilitation Teaching services to increase safety and independence in daily living tasks, representing an increase of nearly 50 percent. BESB Program Social Workers provided more than 2,100 hours of independent living services – an increase of over 9 percent- including adjustment to blindness counseling and referrals to community providers. Last year, in collaboration with the National Federation of the Blind of Connecticut (NFB-CT) and the Connecticut Radio Information System (CRIS), services through NFB Newsline grew to 1,016 subscribers who gained access to state and national newspapers through touchtone telephones. Subscribers accessed NFB Newsline more than 23,000 times during the year, with a total of almost 7,200 hours of news information delivered. Nearly 5,000 electronic newsletters were also sent to Connecticut subscribers during the year.

Opportunities for entrepreneurial employment in food service and retail operations at locations such as courthouses, government office buildings, community colleges, postal facilities and such popular tourist locations as Hammonasset Beach, Rocky Neck Beach and Gillette's Castle are provided through the Business Enterprise Program. This program is administered under both the federal Randolph-Sheppard Act and Connecticut General Statutes Section 10-303. The Business Enterprise Program is completely self-funded, with income derived from commissions on vending machine sales at federal, state, and municipal buildings and properties throughout Connecticut. Through these commissions, the program funds the opening of new locations and renovations to existing locations. In addition, funding from vending machine commissions is utilized to cover the cost of medical benefits for these entrepreneurs who are blind. Participants of the program receive training and support services through field representatives from the agency. In total, 7,000 hours of training and support were provided during fiscal year 2011, a nearly 3 percent increase over 2010. There were 48 entrepreneurs who participated in the program during the past federal fiscal year, up from the previous year. These entrepreneurs increased the number of employees to 70 workers within their operations, 15 percent of whom also had disabilities. Combined gross sales for these business ventures exceeded $4.6 million. Despite the challenging economy, the combined total net income of these 48 entrepreneurs exceeded $1.2 million.

The BESB Program provided the services of its own Teachers of the Visually Impaired to 113 school districts across the state, at no cost to cities and towns, for direct instruction and

consultation services to maximize the participation of children who are blind or visually impaired in public education. Over 7,600 hours of educational assistance, with just over half of those hours in Braille assessment and training, were provided to students served by the agency in fiscal year 2011. For the 20 school districts that directly hired or contracted for their own Teachers of the Visually Impaired, the program provided over $1.3 million in funding reimbursements. Statewide, the BESB Program served a total of 912 school-age students across Connecticut, 91 of whom use Braille as a primary or secondary reading mode. In addition, the BESB Program served 72 children who are under the age of three and therefore not yet served by any school district.

Through the provision of Vocational Rehabilitation (VR) services, authorized under Title I and Title 6, Part B of the federal Rehabilitation Act, as amended, for the past federal fiscal year ending September 30, 2010, 99 individuals achieved successful employment outcomes. Cumulative annualized earnings for all vocational rehabilitation clients exceeded $2.5 million. The Vocational Rehabilitation unit served 969 participants and increased the number of new applicants over the previous year by 40 percent to 173. Vocational Rehabilitation staff delivered over 1,300 hours of employer outreach services in state fiscal year 2011. In addition, the VR unit provided over 2,000 hours of direct vocational counseling services to clients served in the program. Transition school-to-work initiatives to prepare high school students for employment and post-secondary education included 13 summer programs in state fiscal year 2011, providing 111 opportunities in activities such as career exposure, mentoring, independent living skill development and leadership training.

Improvements and Achievements 2010-11

- With a goal of providing more timely and cost efficient services to clients, the BESB Program continued to offer a model for centralized service delivery in the Greater Hartford and Bridgeport regions in 2011. Through this one-stop approach, 10 sessions were in held in Bridgeport and one in neighboring Trumbull, serving 52 clients. All of the clients received Rehabilitation Teaching services and 42 of them also received Low Vision services from an optometrist partnering with the Program. Orientation and Mobility services and Social Work services were provided to 38 and 42 clients respectively. Two hundred and forty-two (242) daily living aids and 83 low vision aids were dispensed directly to clients in these sessions. In Hartford, BESB Program staff held 84 one-on-one sessions with clients. Rehabilitation teaching services were provided in all instances with 151 daily-living aids and 111 low-vision aids dispensed. In total, nearly 400 daily living aids and almost 200 low vision aids were provided directly to clients accompanied by personalized, professional instruction in their use. Many clients were also helped with referrals to the Connecticut Library for the Blind and to their telephone carrier for free directory assistance.

- Over 1,000 hours of specialized adaptive technology services were provided to enable children who are blind or visually impaired to access classroom materials through the use of speech, Braille and large font devices.

- Twelve school-age students experienced college life for one week at Wesleyan University through the LIFE Program developed by the Children's Services Unit. The residential program provided these students with an opportunity to live in a dormitory, prepare meals and travel independently on the campus. Students also participated in a community service project at a local soup kitchen.

- The Skills for Life mobility program was expanded to two locations in August 2010 to increase accessibility to the program. This provided the opportunity for 15 students who are blind or visually impaired to receive intensive training in indoor and outdoor travel using white canes. Students utilized public transit and received training in complex street crossings using tactile and auditory techniques.

- BESB's volunteer program participated in the 2010 Summer Youth Employment and Learning Program, opening the door for area at-risk youth to develop job readiness, leadership and decision-making skills while volunteering at BESB. Students received 120 hours of on-the-job training and evaluation in career competency areas such as business math, computer literacy and customer service through BESB's Volunteer Program. New this year, the Volunteer Program also collaborated with L.I.S.A., a community-based program that assists individuals with special needs to develop vocational and social skills.

- Individuals and organizations provided over 14,000 volunteer services hours to the Program and its clients during fiscal year 2011. BESB clients were directly assisted by volunteers with such daily living activities as grocery shopping and reading mail. Volunteers also assisted with transcribing books and materials into Braille. The estimated total value of these volunteer hours to clients and the state approached $310,000.

- The number of vending machine locations which support entrepreneurial employment for clients rose to 893 during fiscal year 2011, with a total of 1,682 vending machines at those locations. Overall customer satisfaction with the level of vending services and support remains high. Over 370 consumer site surveys were conducted and the average customer satisfaction rating grew from 88 to 92 percent.

- Combined efforts from BESB Program volunteers, including the continued collaboration with the Department of Correction for inmate volunteers, resulted in a total of 200 textbooks and novels being transcribed into Braille for use by school children who are blind. These volunteer transcriptionists enabled the Program and the state to save over $115,000 in Braille book purchases, nearly a 9 percent increase in savings over last year.

- Results of an independent client satisfaction survey conducted by the Center for Public Policy and Social Research found that Vocational Rehabilitation (VR) clients remain very satisfied with the unit's services. Ninety-eight percent of respondents reported satisfaction with BESB VR Counselors coordination of services, an increase of 19 percent. Overall satisfaction with the BESB's VR program has increased to its highest recorded level ever with a mean rating of 8.6 out of 10. Finally, the survey also showed

that more than 9 out of 10 (94 percent) of respondents would recommend BESB's Vocational Rehabilitation services to a friend.

- In 2011, the Children's Services Unit purchased 279 Braille books and 875 large print books for school districts to provide to children who are blind or visually impaired to enable their full participation in classroom learning. The Program's Braille library also loaned an additional 113 Braille and 466 large print books to school districts. Over 4,000 volumes were added to the Program's lending library during the year. There are now over 60,000 catalogued volumes in one central location available at no cost to all Connecticut students who are blind or visually impaired. BESB's Braille unit also assisted other state agencies and groups with their Braille needs. The Braille unit transcribed Braille programs and guides for the Connecticut Council on Culture and Tourism to use at an art exhibit that featured the works of artists with disabilities. In addition, the Braille unit transcribed menus and calendars for residents of assisted living centers, manuals for telephones and appliances, and books for use in guide dog training. Several college students who needed Braille materials on short notice were able to use the Braille unit as a helpful and fast-acting resource. A number of municipalities were assisted with converting printed materials into Braille for town residents.

- This year, the BESB Program completed its multi-year Strategic Plan. Through this plan, many innovative proposals were developed and executed to help people with blindness move toward more productive and independent lives. The Strategic Planning team was a collaborative effort that included BESB Program staff and leadership, community partners, Board members and persons with blindness. The final product of the planning process was the creation of goals for timely service provision by all four units of BESB. Over the lifespan of the Strategic Plan, the Program implemented Job Seeking Skills classes for Spanish speaking clients, a Blind Pedestrian Safety Awareness Campaign with public service announcements, collaboration with Department of Transportation on accessible crosswalk design, development of an emergency response information guide for First Responders, a fire safety procedures manual, a transportation resource guide, a functional gains survey to measure the effectiveness of Independent Living services, and implementation of a new cost savings approach for the provision of low vision devices.

- A new initiative for fiscal year 2011 was the Camp Abilities program held in Andover, Connecticut. The 6-day program served 16 students with visual impairments. In addition, 5 students developed leadership skills while serving as Counselors in Training. Students participated in low ropes team-building sessions and a high ropes challenge course. They also received daily instruction in swimming, wrestling, beep baseball, goal ball and archery.

- A second new initiative was the Sports Adventure Weekend, which was held for high school students in December and again for middle school students in March. A total of 33 students participated in general fitness and track and field activities. Students learned adaptations for traditional physical education games to enhance their inclusion in school sports and there were team competitions in beep baseball and goal ball. Eight additional

- Ongoing Braille instruction classes for paraprofessionals serving students who read Braille were provided at no cost to school districts, with 17 paraprofessionals attending throughout the year at four conveniently located sites across the state.

- With the assistance of federal ARRA funding (American Recovery and Reinvestment Act of 2009), the BESB Program had a unique opportunity to create new programs and expand on existing ones for the career development of our clients. BESB's Vocational Rehabilitation (VR) unit has built up its new Internship program which offers financial incentives to employers to provide paid training and durational work opportunities to people who are blind, which in turn provides valuable experience and exposure to a wide range of career possibilities. With the utilization of these ARRA funded initiatives, 27 clients transitioned into jobs at businesses across the state.

- BESB's Board of Directors continued to refine the performance benchmarks set by the former BESB Monitoring Council and has added many new benchmarks in an ongoing continuous improvement initiative for the Program. There were 10 performance benchmarks set for the Program and its four units for the past year. These goals included public outreach, trainings for food service facility operators who are blind, parent education programs and job seeking skills classes. All ten benchmarks were achieved.

- The BESB Program organized and conducted eight full days of training throughout the year for school district classroom teachers, paraprofessionals, Birth-to-Three personnel, preschool teachers and other service providers who work with students who are blind, visually impaired or deafblind. A total of 361 professionals and paraprofessionals – an increase of 20 percent over last year - attended these trainings, increasing their understanding of visual impairments, and learning strategies and techniques for working with children from birth through high school graduation. BESB continues to assess statewide needs in assisting local districts with the challenges of serving children with significant vision loss. One new component to the training schedule this year was a full-day workshop designed specifically for physical education and adaptive physical education teachers working with children with visual impairments. This workshop focused on strategies and accommodations to allow students to more fully participate in active physical education in their schools.

- The BESB Program sponsored a Technology Fair in June, with more than 100 attendees. The Fair featured a wide range of cutting edge services and products for people who are blind. Attendees were also able to sign up for services such as CRIS Radio and the National Federation of the Blind's (NFB) Newsline service.

Information Reported as Required by State Statute

The Board of Education and Services for the Blind remains committed to the achievement of workforce diversity. The Board of Education and Services for the Blind's last Affirmative Action Plan was unanimously approved by the Connecticut Commission on Human Rights and Opportunities (CHRO) in January of 2011. There were two hires this last fiscal year, a Rehabilitation Teacher for adults and an Orientation and Mobility Instructor for children. Both hires met established Affirmative Action goals, achieving 100 percent Goal Attainment. The Program provides a diverse and inclusive work setting. Members of traditional minority groups represent more than one out of every six employees and over 65 percent of all employees are female.

The BESB Program also prides itself as a model of opportunity for persons with disabilities and strives, by example, to eradicate historical and mistaken prejudices. The Program employs 10 persons with blindness, comprising nearly one out of every ten employees. This last year the Program merged its Blindness Matters Committee with its Diversity Committee into one committee to provide a more unified and holistic focus on issues of accommodation, inclusion and respect. The Committee assembles a diverse group of employees from throughout the agency, facilitating a free exchange of ideas and initiatives to educate staff and others on issues of cultural sensitivity and diversity. The BESB Program continues in its strong commitment to equal employment opportunity in contracts, programs and policies, including affirmative action. The Program has developed and implemented hiring and contracting goals to maintain a diversified work and contracting force. All BESB Program policies and procedures are consistent with state and federal reporting procedures.

Commission on the Deaf and Hearing Impaired

Note: Legislation that took effect July 1, 2011 (the beginning of State Fiscal Year 2012) placed the Commission on the Deaf and Hearing Impaired into a new state Bureau of Rehabilitative Services. The new bureau also includes the Bureau of Rehabilitation Services, the Board of Education and Services for the Blind and portions of the Workers' Compensation Commission and Department of Motor Vehicles. The Bureau of Rehabilitative Services is attached to DSS for administrative purposes only. Pending the appointment of a bureau director, DSS Commissioner Roderick Bremby is serving as acting director. The following section covers the Commission on the Deaf and Hearing Impaired during SFY 2011, before the reorganization.]

Executive Director: Stacie J. Mawson
Established: 1974
Statutory authority: Conn. Gen. Statutes Chapter 814 Sec. 46(a)-27 through 46(a) – 33(b)
Office: 67 Prospect Avenue, 3rd Floor, Hartford, CT 06106-2980
Employees: nine full-time employees and one assistant accountant on loan from Department of Administrative Services, 45 part-time employees
Recurring operating expenses 2010-2011:

- **General Fund: $2,837,044.91**
- **Federal Funds: $211,361.54**
- **Reimbursements: $1,883,286.09**
- **Other Funds: $1,618.60**

Organizational Structure:

- Administration, Interpreting Department, Counseling Department
- Fiscal operations managed by the Department of Administrative Services (DAS)
- Human resources/affirmative action functions managed by the DAS SmART Unit

Agency Mission/Statutory Authority

The Commission on the Deaf and Hearing Impaired (CDHI) is a state-wide coordinating agency established to advocate, strengthen and implement state policies affecting deaf and hard-of-hearing individuals and their relationships to the public, industry, healthcare and educational opportunities. Connecticut has approximately 280,000 deaf and hard-of-hearing residents, including 17,000 who are profoundly deaf. CDHI interpreting and counseling services are available to state residents who are deaf or hard of hearing.

CDHI was placed under the Department of Social Services for administrative purposes only per Public Act 93-262, effective July 1, 1993. The agency's business and human resource functions were consolidated into the Department of Administrative Services, effective October 1, 2005.

CDHI is mandated to maintain an updated statewide registry of interpreters for the deaf. This requires CDHI to monitor the education and certification of interpreters working for compensation in the State of Connecticut, as per Conn. Gen. Statute Sec. 46(a)-33(a). There are 175 registered interpreters of which 167 are certified and qualified to work in the State of Connecticut. The names of the interpreters who are qualified to work in the state are posted on the agency's website.

Interpreting Department:
The primary responsibility of the CDHI Interpreting Department is to provide certified interpreting services for individuals who are deaf and hard of hearing in situations involving the person's legal and constitutional rights, health, safety, employment and educational opportunities. Currently, 59 percent of these services support other state agencies and allow for conduction of business with deaf and hard of hearing individuals. Provision of these services also ensures multiple state agencies to be in compliance with the Americans with Disabilities Act, and provides deaf and hard of hearing citizens of Connecticut with equal access to state services. Besides daily requests from the Judicial Department, the Department of Mental Health and Addition Services, Department of Children and Families, to name a few, the Interpreting Department also responds routinely to police and hospital emergencies on nights and weekends. CDHI is also the sole provider of interpreting services for the state university and community college educational systems. All interpreting services rendered by CDHI are reimbursable; those monies supplement the overall agency budget.

Counseling Department:
The Counseling Department provides individual, family and group counseling, consultation services and outreach and advocacy to deaf and hard of hearing consumers. As there are only two full time licensed professional counselors employed by the agency, the counselors have developed collaborations with other state and local community agencies to create a team approach to working with deaf and hard of hearing consumers that includes, but is not limited to employment support, case management, crisis management, and psychiatric and psychological services and those that utilize providers who can or are willing to communicate with the client's preferred mode of communication and have an understanding of deaf culture and hard of hearing norms.

Along with the above-mentioned services, CDHI also serves as an information resource center. When possible, the staff provides training to employers, municipalities and nursing homes, and shares information with those who may need hearing aids, or refers those who may have questions about receiving appropriate services, sign language, or deafness. The agency also spearheads legislation regarding the deaf and hard of hearing, and ensures compliance to such legislation.

Public Service
CDHI continues to collaborate with organizations serving the deaf and hard of hearing communities within Connecticut. These activities enable CDHI to be responsive to the community's needs. Below are brief listings of public service activities undertaken by both departments during fiscal year 2010-2011:

Interpreting Department:

- Coordination of practicum interpreting student placements; provision of experience in interpreting to Northwestern Connecticut Community College interpreting students.
- Representation of agency on DCF Deaf Advisory Group; presentation to DCF staff in Willimantic in April.
- Representation of agency in collaborative work with Connecticut Hospital Association to ensure that hospital emergency interpreting is handled appropriately.
- Engagement in in-service and outreach activities upon request; coordinator participated in one day-long interagency seminar, and in one day-long training of nurses at Hartford Hospital.
- Involvement in Connecticut Department of Emergency Management and Homeland Security Emergency Preparedness training exercises; provision of interpreters for media briefings and other functions as requested by the Office of the Governor.
- Collaboration with Bureau of Rehabilitation Services to coordinate two separate training workshops for CDHI interpreters and BRS interpreter assistants in June.

Counseling Department:

- Both counselors carry caseloads ranging from 55 to 60 active cases on a monthly basis. In addition, special activities included the following:
- A three-hour presentation to providers from the DCF Willimantic office on how to work with deaf and hard of-hearing children and families within the DCF system.
- Collaboration with BRS' Heidi Forrest and Arlene Lugo (CT Tech Act Project) to offer a presentation to high school senior students from the American School for the Deaf and CREC-Soundbridge.
- Collaboration with Cassandra Bjoryslawskyj (Communication Advocacy Network) to present to New Britain CT Works staff and Hartford CT Works staff.
- Facilitation of Deaf Artisans Group in presenting their arts and crafts for sale to the general public; follow-up group will start to meet in the fall to develop marketing strategies, learn how to price their merchandise and how to network with each other.
- Presentation to DCF Commissioner Joette Katz regarding the mission of the DCF Deaf and Hard of Hearing Advisory Council, as well as discussion on addressing the needs of mental health concerns for deaf and hard-of-hearing children and families.
- One counselor served as Co-Project Coordinator for five days for the Youth Leadership Forum Camp at the University of Connecticut.
- Hosting of WISE - Work Incentive Seminars (part of the Ticket to Work program with Social Security) event, along with staff from BRS, with the topic of provision of Social Security funding assistance funds to deaf and hard of hearing community members.
- Planning for monthly orientation outreach sessions to the community to provide information on both BRS and CDHI services at various BRS sites throughout the state.

In addition, the executive director represented the agency on the Connecticut Telecommunications Relay Service advisory board and at the Connecticut Council of Organizations Serving the Deaf meetings. Annual statistical data compiled by both the

interpreting and counseling departments has been a tool used to document and assess services provided to the consumers. In addition to the public service provided by the two departments, members of CDHI's Advisory Board also represent a diverse population within the deaf and hard of hearing communities and provide feedback on how various community needs are being addressed.

Improvements/Achievements

During fiscal year 2010-2011, initiatives and achievements of the Commission on the Deaf and Hearing Impaired included the following:

Interpreting Department:

- Scheduling and delegation of work for 46 part-time field interpreters; approximately 13,600 assignments, equivalent to roughly 26,000 hours of interpreting services statewide.
- Partnership with software developer to complete work on customization of interpreter scheduling system (Avianco). The project, which was implemented in April 2010, is in its final stages; the department is working closely with the developer to ensure the system satisfies the current request for proposals. This software will allow the office to be paper-free and allow vendors to request and confirm interpreting requests online. Interpreting department payroll and billing processes will become automated during fiscal year 2011-2012. A series of software training sessions was provided for all field staff interpreters.
- Creation of a new supplementary website www.ctinterpreter.com; field interpreters may log on from this website and vendors may make interpreting services requests online.
- Daily office operations:
  - Rendering of immediate decisions on day-to-day issues that need to be dealt with when there are barriers to the expected service (i.e., interpreters out ill, highways closed and other events that impact scheduled interpreters from otherwise completing their assignments).
  - Data entry of assignment requests that are called in, faxed, or e-mailed.
  - Data entry of new active contracts from over 700 vendors; contacting vendors for missing billing information; maintenance of business accounts online.
  - Review of non-automated payroll; separate timesheets need to be matched up with assignments and reviewed and calculated each month.
  - High volume of phone calls in which there may be interpreter requests, cancellations or changes to existing assignments. Also handling of phone calls from interpreters with situations currently occurring on the job and resolution.
- Preparation for elimination of executive director position and merger into newly created Bureau of Rehabilitative Services agency; participation in transition leadership meetings.
- Routine handling of labor issues and participation in labor management meetings.
- Continued collection activities to provide increased revenues from severely past due accounts.

Counseling Department:

- Provided a work study internship opportunity to a student from the American School for the Deaf from September to June.

- Created five wellness groups held in Hartford, Middletown and Newington and Norwich, serving approximately 32 deaf and hard of hearing individuals on a weekly basis.
- Hosted Child of Deaf Adults and Hard of Hearing groups that focused on positive behaviors and self-advocacy techniques.
- Collaborated with the Middletown Community Health Center Family Wellness Program to host a play group for families in which there were deaf and/or hard-of-hearing family members to promote positive parenting skills.
- Weekly counseling services in Norwich (housed at Southeastern Mental Health Authority) and New Haven (housed at New Haven BRS) areas to address counseling needs in those parts of the state.
- Counselors represented the agency at the following statewide meetings:
  - DCF Deaf and Hard of Hearing Advisory Council – quarterly
  - Department of Mental Health and Addiction Services Deaf and Hard of Hearing Task Force – quarterly.
  - Deaf Interagency Meeting – hosted a day-long event in April that included agencies and providers who work with individuals and families where there is identified hearing loss
  - Governor's Coalition for Youth with Disabilities – monthly
  - Youth Leadership Project, Inc. Planning Committee – monthly
  - Birth-To-Three Interagency Coordinating Council - quarterly
  - Southeastern Mental Health Agency Providers Network Meeting – every other month

Agency-Wide:

- Community outreach included 100 hours of deaf culture and disability sensitivity training to First Responders statewide.
- CDHI collaborated with multiple state agencies successfully to achieve goals of shared benefit to the consumers that are mutually served.
- Provided extensive information and referral to Connecticut residents seeking information on services available to assist individuals who are deaf and hard of hearing.

PRACTICE GUIDELINE FOR THE
Psychiatric Evaluation of Adults
Second Edition

0158

WORK GROUP ON PSYCHIATRIC EVALUATION

Michael J. Vergare, M.D., Chair
Renée L. Binder, M.D.
Ian A. Cook, M.D.
Marc Galanter, M.D.
Francis G. Lu, M.D.

AMERICAN PSYCHIATRIC ASSOCIATION STEERING COMMITTEE ON PRACTICE GUIDELINES

John S. McIntyre, M.D.,
Chair
Sara C. Charles, M.D.,
Vice-Chair

Daniel J. Anzia, M.D.
Ian A. Cook, M.D.
Molly T. Finnerty, M.D.
Bradley R. Johnson, M.D.
James E. Nininger, M.D.
Paul Summergrad, M.D.
Sherwyn M. Woods, M.D., Ph.D.
Joel Yager, M.D.

AREA AND COMPONENT LIAISONS

Robert Pyles, M.D. (Area I)
C. Deborah Cross, M.D. (Area II)
Roger Peele, M.D. (Area III)
Daniel J. Anzia, M.D. (Area IV)
John P. D. Shemo, M.D. (Area V)
Lawrence Lurie, M.D. (Area VI)
R. Dale Walker, M.D. (Area VII)
Mary Ann Barnovitz, M.D.
Sheila Hafter Gray, M.D.
Sunil Saxena, M.D.
Tina Tonnu, M.D.

STAFF

Robert Kunkle, M.A., *Senior Program Manager*
Amy B. Albert, B.A., *Assistant Project Manager*
Laura J. Fochtmann, M.D., *Medical Editor*
Claudia Hart, *Director, Department of Quality Improvement and Psychiatric Services*
Darrel A. Regier, M.D., M.P.H., *Director, Division of Research*

This practice guideline was approved in December 2005 and published in June 2006.

CONTENTS

Statement of Intent

Development Process

Introduction

I. Purpose of Evaluation
- A. General Psychiatric Evaluation
- B. Emergency Evaluation
- C. Clinical Consultation
- D. Other Consultations

II. Site of the Clinical Evaluation
- A. Inpatient Settings
- B. Outpatient Settings
- C. General Medical Settings
- D. Other Settings

III. Domains of the Clinical Evaluation
- A. Reason for the Evaluation
- B. History of the Present Illness
- C. Past Psychiatric History
- D. History of Substance Use
- E. General Medical History
- F. Developmental, Psychosocial, and Sociocultural History
- G. Occupational and Military History
- H. Legal History
- I. Family History
- J. Review of Systems
- K. Physical Examination
- L. Mental Status Examination

IV. Evaluation Process
- A. Methods of Obtaining Information
- B. The Process of Assessment

V. Special Considerations
- A. Privacy and Confidentiality
- B. Interactions With Third-Party Payers and Their Agents
- C. Legal and Administrative Issues in Institutions
- D. Special Populations

2e0

VI. Future Research Needs .....
A. Interviewing Approaches .....
B. Rating Scales .....
C. Diagnosis and Formulation .....
D. Diagnostic Testing .....

Individuals and Organizations That Submitted Comments .....

References .....

201

STATEMENT OF INTENT

The APA Practice Guidelines are not intended to be construed or to serve as a standard of medical care. Standards of medical care are determined on the basis of all clinical data available for an individual patient and are subject to change as scientific knowledge and technology advance and practice patterns evolve. These parameters of practice should be considered guidelines only. Adherence to them will not ensure a successful outcome for every individual, nor should they be interpreted as including all proper methods of care or excluding other acceptable methods of care aimed at the same results. The ultimate judgment regarding a particular clinical procedure or treatment plan must be made by the psychiatrist in light of the clinical data presented by the patient and the diagnostic and treatment options available.

This practice guideline has been developed by psychiatrists who are in active clinical practice. In addition, some contributors are primarily involved in research or other academic endeavors. It is possible that through such activities some contributors, including work group members and reviewers, have received income related to treatments discussed in this guideline. A number of mechanisms are in place to minimize the potential for producing biased recommendations due to conflicts of interest. Work group members are selected on the basis of their expertise and integrity. Any work group member or reviewer who has a potential conflict of interest that may bias (or appear to bias) his or her work is asked to disclose this to the Steering Committee on Practice Guidelines and the work group. Iterative guideline drafts are reviewed by the Steering Committee, other experts, allied organizations, APA members, and the APA Assembly and Board of Trustees; substantial revisions address or integrate the comments of these multiple reviewers. The development of the APA practice guidelines is not financially supported by any commercial organization.

More detail about mechanisms in place to minimize bias is provided in a document available from the APA Department of Quality Improvement and Psychiatric Services, "APA Guideline Development Process."

This practice guideline was approved in December 2005 and published in May 2006.

262

DEVELOPMENT PROCESS

This practice guideline was developed under the auspices of the Steering Committee on Practice Guidelines. The development process is detailed in a document available from the APA Department of Quality Improvement and Psychiatric Services, the "APA Guideline Development Process." Key features of this process include the following:

- A comprehensive literature review
- Development of evidence tables
- Initial drafting of the guideline by a work group that included psychiatrists with clinical and research expertise in psychiatric evaluation
- Production of multiple revised drafts with widespread review (14 organizations and 64 individuals submitted significant comments)
- Approval by the APA Assembly and Board of Trustees
- Planned revisions at regular intervals

Relevant literature was identified through a computerized search of MEDLINE, using PubMed, for the period from 1994 to 2005. The search strategy (psychiatric assessment OR psychiatric assessments OR psychiatric emergencies OR psychiatric emergency OR psychiatric evaluation OR psychiatric evaluations OR psychiatric histories OR psychiatric history OR psychiatric interview OR psychiatric interviewing OR psychiatric interviews OR psychological assessment OR psychological assessments OR psychological evaluation OR psychological interview OR mental status examination OR mental status examinations OR psychiatric rating) OR (mental disorders/diagnosis AND [laboratory findings OR laboratory techniques OR laboratory test OR laboratory tests OR radiograph OR radiographic OR radiography OR x ray OR imaging OR MRI OR tomography OR physical exam OR physical examination OR interview OR interviewing OR history taking OR evaluation OR assessment]) yielded 19,429 references, of which 7,894 were published between 1994 and 2005 in English and had associated abstracts. An additional search on history taking AND (psychiatric OR sexual OR occupational OR social OR psychosocial) yielded 1,927 references, with 731 of these published with abstracts in English between the years 1994 and 2005.

Additional, more limited searches were conducted by APA staff and individual members of the Work Group on Psychiatric Evaluation to address discrete issues outside of the primary guideline topic.

This document represents a synthesis of current scientific knowledge and rational clinical practice on the psychiatric evaluation of adults. It strives to be as free as possible of bias toward any theoretical approach.

INTRODUCTION

Psychiatric evaluations vary according to their purpose. This guideline is intended primarily for general, emergency, and consultation evaluations for clinical purposes. It is applicable to evaluations conducted by a psychiatrist with adult patients (age 18 or older), although sections may be applicable to younger patients. Other types of psychiatric evaluations (including forensic, child custody, and disability evaluations) are not the focus of this guideline; however, the general recommendations of this guideline may be applicable to other, more specialized evaluations.

The guideline presumes familiarity with basic principles of psychiatric diagnosis and treatment planning as outlined in standard, contemporary psychiatric textbooks (1–6) and taught in psychiatry residency training programs. It was developed following a review of contemporary references, and it emphasizes areas of consensus in the field.

Recommendations of this guideline are intended to be consistent with the care model endorsed in the Institute of Medicine report *Crossing the Quality Chasm* (7). This report notes that with advancements in medical science, the emphasis of health care delivery must shift to ongoing management of chronic conditions. The initial psychiatric evaluation may set the stage for such ongoing care by establishing initial treatment goals, gathering relevant baseline data, establishing a plan for systematic follow-up assessment using formal but practical and relevant measures, and ensuring longitudinal follow-up.

While there is broad agreement that each element of the extensive general evaluation described in this guideline may be relevant or even crucial in a particular patient, the specific emphasis of an evaluation will vary according to its purpose and the patient's presenting problem. Consideration of the domains outlined in this guideline is part of a general psychiatric evaluation, but the content, process, and documentation must be determined by applying the professional skill and judgment of the psychiatrist. The performance of a particular set of clinical procedures does not ensure the adequacy of a psychiatric evaluation, nor does their omission imply that the evaluation is deficient. The particular emphasis or modifications applied by the psychiatrist to the generic evaluation offered in this guideline should be consonant with the aims of the evaluation, the setting of practice, the patient's presenting problem, and the ever-evolving knowledge base concerning clinical assessment and clinical inference. Although documentation is an integral part of an evaluation, it is important to emphasize that the scope and detail of clinically appropriate documentation also will vary with the patient, setting, clinical situation, and confidentiality issues. Because of the wide variation in these factors, this guideline does not include recommendations regarding the content or frequency of documentation. Such determinations must be based on the specific circumstances of the evaluation.

To share feedback on this or other published APA practice guidelines, a form is available at http://www.psych.org/psych_pract/pg/reviewform.cfm.

2e4

I. PURPOSE OF EVALUATION

The purpose and conduct of a psychiatric evaluation depend on who requests the evaluation, why it is requested, and the expected future role of the psychiatrist in the patient's care. The outcome of the evaluation may or may not lead to a specific psychiatric diagnosis. Three types of clinical psychiatric evaluations are discussed: 1) general psychiatric evaluation, 2) emergency evaluation, and 3) clinical consultation. In addition, general principles to guide the conduct of evaluations for administrative or legal purposes are reviewed. At times there may be a conflict between the need to establish an effective working relationship with the patient and the need to obtain comprehensive information efficiently. If the psychiatrist expects to provide care directly to the patient, the establishment of an effective working relationship with the patient may take precedence over the comprehensiveness of the initial interview or interviews (8). In such a case, emphasis may be placed on obtaining information needed for immediate clinical recommendations and decisions (9).

A. GENERAL PSYCHIATRIC EVALUATION

A general psychiatric evaluation has as its central component an interview with the patient. The interview-based data are integrated with information that may be obtained through other components of the evaluation, such as a review of medical records, a physical examination, diagnostic tests, and history from collateral sources. A general evaluation usually is time intensive. The amount of time necessary generally depends on the complexity of the problem and the patient's ability and willingness to work cooperatively with the psychiatrist. Language competence needs to be assessed early in the evaluation so that the need for an interpreter can be determined. Several meetings with the patient, and in many cases appropriate family or relational network members, may be necessary. More focused evaluations of lesser scope may be appropriate when the psychiatrist is called on to address a specific, limited diagnostic or therapeutic issue.

The aims of a general psychiatric evaluation are 1) to establish whether a mental disorder or other condition requiring the attention of a psychiatrist is present; 2) to collect data sufficient to support differential diagnosis and a comprehensive clinical formulation; 3) to collaborate with the patient to develop an initial treatment plan that will foster treatment adherence, with particular consideration of any immediate interventions that may be needed to address the safety of the patient and others—or, if the evaluation is a reassessment of a patient in long-term treatment, to revise the plan of treatment in accordance with new perspectives gained from the evaluation; and 4) to identify longer-term issues (e.g., premorbid personality) that need to be considered in follow-up care.

In the course of any evaluation, it may be necessary to obtain history from other individuals (e.g., family or others with whom the patient resides; individuals referring the patient for assessment, including other clinicians). Although the default position is to maintain confidentiality unless the patient gives consent to a specific intervention or communication, the psychiatrist is justified in attenuating confidentiality to the extent needed to address the safety of the patient and others (10, 11). In addition, the psychiatrist can elicit and listen to information provided by friends or family without disclosing information about the patient to the informant.

More detailed recommendations for performing a general psychiatric evaluation are provided in Section III.

B. EMERGENCY EVALUATION

The emergency psychiatric evaluation generally occurs in response to thoughts, feelings, or urges to act that are intolerable to the patient, or to behavior that prompts urgent action by others, such as violent or self-injurious behavior, threats of harm to self or others, failure to care for oneself, bizarre or confused behavior, or intense expressions of distress. The aims and specific approaches to the emergency evaluation have been reviewed elsewhere in detail (11–15) and include the following:

1. Assess and enhance the safety of the patient and others.
2. Establish a provisional diagnosis (or diagnoses) of the mental disorder(s) most likely to be responsible for the current emergency, including identification of any general medical condition(s) or substance use that is causing or contributing to the patient's mental condition.
3. Identify family or other involved persons who can give information that will help the psychiatrist determine the accuracy of reported history, particularly if the patient is cognitively impaired, agitated, or psychotic and has difficulty communicating a history of events. If the patient is to be discharged back to family members or other caretaking persons, their ability to care for the patient and their understanding of the patient's needs must be addressed.
4. Identify any current treatment providers who can give information relevant to the evaluation.
5. Identify social, environmental, and cultural factors relevant to immediate treatment decisions.
6. Determine whether the patient is able and willing to form an alliance that will support further assessment and treatment, what precautions are needed if there is a substantial risk of harm to self or others, and whether involuntary treatment is necessary.
7. Develop a specific plan for follow-up, including immediate treatment and disposition; determine whether the patient requires treatment in a hospital or other supervised setting and what follow-up will be required if the patient is not placed in a supervised setting.

The emergency evaluation varies greatly in length and may on occasion exceed several hours. Patients who will be discharged to the community after an emergency evaluation may require more extensive evaluation in the emergency setting than those who will be hospitalized. For example, patients who have presented with intoxication or who have received medications in the emergency department may require additional observation to verify their stability for discharge. In other individuals with significant symptoms but without apparent acute risk to self or others, additional time may be needed to obtain more detailed input from family, other involved caretaking persons, and treatment providers; to verify that the proposed plan of follow-up is viable; and to communicate with follow-up caregivers about interventions or recommendations resulting from the emergency assessment.

When patients are agitated, psychotic, or uncooperative with assessment, and when their clinical presentation appears to differ from the stated factors prompting assessment, it may be especially important to obtain history from other individuals (e.g., family members, other professionals, police), keeping in mind principles of confidentiality, as described in Section I.A above and in Section V.A.

Patients presenting for emergency psychiatric evaluation have a high prevalence of combined general medical and psychiatric illness, recent trauma, substance use and substance-related conditions, and cognitive impairment (16–27). These diagnostic possibilities deserve careful consideration. General medical and psychiatric evaluations should be coordinated so that additional medical evaluation can be requested or initiated by the psychiatrist on the basis of diagnostic or therapeutic considerations arising from the psychiatric history and interview. Although issues of confidentiality are sometimes raised, in an emergency situation necessary information about the patient can be communicated with the emergency medicine department

2004

staff. In many emergency settings, patients initially are examined by a nonpsychiatric physician to exclude acute general medical problems. Such examinations usually are limited in scope and rarely are definitive (18, 19, 28–30). Furthermore, psychiatrists and emergency physicians sometimes have different viewpoints on the utility of laboratory screening for substance use or medical disorders in psychiatric emergency department patients (31, 32). Therefore, on the basis of clinical judgment and the specific circumstances of the evaluation, the psychiatrist may need to request or initiate further general medical evaluation to address diagnostic concerns that emerge from the psychiatric evaluation (12, 16, 18–27, 33–35).

C. CLINICAL CONSULTATION

Clinical consultations are evaluations requested by other physicians or health care professionals, patients, families, or others for the purpose of assisting in the diagnosis, treatment, or management of an individual with a suspected mental disorder or behavioral problem. These evaluations may be comprehensive or may be focused on a relatively narrow question, such as the preferred medication for treatment of a known mental disorder in a patient with a particular general medical condition. Psychiatric evaluations for consultative purposes use the same data sources as general evaluations. Consideration is given to information from the referring source on the specific problem leading to the consultation, the referring source's aims for the consultation, information that the psychiatrist may be able to obtain regarding the patient's relationship with the primary clinician, and the resources and constraints of those currently treating the patient. Also, in the case of a consultation regarding a mental or behavioral problem in a patient with a general medical illness, information about that illness, its treatment, and its prognosis is relevant. The patient should be informed that the purpose of the consultation is to advise the party who requested it. Permission to report findings to others, including family, needs to be clarified with the patient and other concerned parties before the evaluation begins.

The aim of the consultative psychiatric evaluation is to provide clear and specific answers to the questions posed by the party requesting the consultation (36, 37). For example, the psychiatrist may be asked to determine the patient's capacity to give consent for treatment decisions. On other occasions, the psychiatrist may be asked to assess a particular sign, symptom, or syndrome; provide a diagnosis; and recommend evaluation, treatment, or disposition at a level of specificity appropriate to the needs of the treating clinician.

In the course of the evaluation, the consultant may also identify a diagnostic or therapeutic issue that was not raised in the request for consultation but that is of concern to the patient or of relevance to treatment outcome. For example, treatment adherence may be affected by personality and countertransference issues that compromise the patient's therapeutic alliance with the referring clinician. If any conflicts between the patient and the primary clinician do emerge as an issue, positive resolution of them should be encouraged in a manner that respects the patient's relationship with the primary clinician.

If agreed to by the patient, discussion of findings and recommendations with the family or involved persons can assist with appropriate follow-up and adherence with recommendations.

D. OTHER CONSULTATIONS

Other psychiatric consultations are directed toward the resolution of specific legal, administrative, or other nonclinical questions. While the details of these evaluations, such as forensic evaluations, child custody evaluations, and disability evaluations, are beyond the scope of this guideline, several general principles apply. First, the evaluee usually is not the psychiatrist's patient, and there are limits to confidentiality implicit in the aims of the evaluation; accordingly, the aims of the evaluation and the scope of disclosure should be addressed with the evaluee at the start of the interview (38, 39). Second, questions about the evaluee's legal status and legal

207

representation should be resolved before the assessment begins, if possible. Third, many such consultations rely heavily, or even entirely, on documentary evidence or data from collateral sources. The quality and potential biases of such data should be taken into account.

The aims of these psychiatric consultations are 1) to answer the requester's question to the extent possible with the data obtainable and 2) to make a psychiatric diagnosis if it is relevant to the question.

II. SITE OF THE CLINICAL EVALUATION

A. INPATIENT SETTINGS

The scope, pace, and depth of inpatient evaluation depend on the patient population served by the inpatient service, the goals of the hospitalization, and the role of the inpatient unit within the overall system of mental health services available to the patient (40, 41).

In addition to providing a highly structured and contained setting in which patient safety can be monitored and optimized, the inpatient setting permits intensive and continuous observation of signs and symptoms while the patient is being treated for psychiatric and general medical conditions through the collaborative efforts of the multidisciplinary treatment team (see also Section IV.A.5). Particularly for individuals with complex psychiatric presentations or multiple co-occurring disorders, the enhanced level of observation in the inpatient environment may facilitate assessment of co-occurring general medical conditions or evaluation for procedures such as electroconvulsive therapy, may aid in resolving diagnostic dilemmas, and may help in determining a patient's ability to function safely and independently in a less restrictive setting (41, 42).

Inpatient settings provide enhanced opportunity to corroborate clinical judgment and decision making, including discharge planning, through access to information from multiple sources. These include the multidisciplinary treatment team, family, friends, and individuals involved in the care of the patient outside the hospital, as well as prior hospitalization records.

From the outset, the inpatient evaluation should include assessment of the patient's access to appropriate treatment following hospitalization. The patient's living arrangements should also be assessed to determine whether they will continue to be suitable after discharge. If the posthospitalization disposition is not apparent, the evaluation should identify both patient factors and community resources that would be relevant to a viable disposition plan and should identify the problems that could impede a suitable disposition. Family involvement, when appropriate, can also be initiated, and goals for inpatient family work can be identified.

B. OUTPATIENT SETTINGS

Outpatient settings differ widely, from office-based practices to community mental health centers to intensive outpatient or partial hospital programs, among others. Nevertheless, evaluation in the outpatient setting usually differs in intensity from inpatient evaluation because of less frequent interviews and less immediate availability of laboratory services and consultants from other medical specialties. Also, the psychiatrist in the outpatient setting has substantially less opportunity to directly observe the patient's behavior and to implement protective interventions when necessary. For this reason, during the period of evaluation it is important for the psychiatrist to reassess whether the patient requires hospitalization or more intensive outpatient care (e.g., greater visit frequency, intensive outpatient or partial hospital programs, programs of assertive community treatment). Unresolved questions about the patient's general medical status

may also require more rapid assessment in a more structured setting. If the patient's presentation is atypical (e.g., with respect to symptoms, symptom severity, or age at onset), a more thorough medical workup may be required or coordinated with the patient's primary care physician. Patients who do not have a primary care physician may need assistance in obtaining appropriate referrals. A decision to change the setting for evaluation will depend on the patient's current mental status and behavior as well as the patient's history of psychiatric symptoms and treatment, the status of co-occurring general medical conditions or substance use, and the availability of diagnostic resources, therapeutic resources, and sociocultural supports.

Advantages of the outpatient setting include greater patient autonomy and the potential for a more longitudinal perspective on the patient's symptoms. However, the lack of continuous direct observation of behavior limits the obtainable data on how the patient's behavior appears to others. Consequently, extended evaluation of the patient in the context of psychoeducational or time-limited groups can complement and augment observations from one-to-one interviews. With the patient's permission, involvement of family or significant others as collateral sources in the evaluation process also deserves consideration. It is also useful to be aware that family and significant others may not be supportive of the patient or of psychiatric treatment. If the patient states that family systems issues, especially marital or partner issues, are a problem, an evaluation session with the partner can provide valuable information and clarify the systems issues. When substance use is suspected, obtaining data from other involved persons (e.g., family, close friends, staff), determining blood alcohol levels, or screening for substances of abuse may be especially important.

C. GENERAL MEDICAL SETTINGS

Evaluations are also conducted in hospital emergency departments (see Section I.B) and general medical (i.e., nonpsychiatric) settings, such as inpatient units. The latter allow for some direct behavioral observation by staff and for some safeguards against self-injurious or other violent behavior by patients. However, the level of behavioral observation and potential intervention against risky behavior in these settings tends to be less than on psychiatric inpatient units. In addition, psychiatric interviews on general medical-surgical units are often compromised by interruptions and lack of privacy. These problems sometimes can be mitigated by using a space on the unit where the patient and the psychiatrist can meet privately.

Developing an ongoing relationship with staff on medical inpatient units will increase the likelihood of obtaining accurate behavioral data as well as of ensuring that staff implement recommendations. If there is prominent hostility or anxiety in interactions between the patient and hospital staff, the evaluating physician must consider interfacing with others in the hospital system to determine its contributors.

If the patient has an unclear sensorium or other cognitive impairments, it is critical to interview people in the patient's relational network to see if these symptoms were present before hospitalization or have developed since treatment was begun. In interviewing family members, it is very useful to discuss their beliefs about the patient's illness and prior treatment, the patient's record of adherence to medication treatment, and concerns about discharge planning. If family members do not perceive themselves as allies in treatment, the patient's treatment is likely to be compromised once he or she leaves the hospital (43).

Documentation of psychiatric evaluations in general medical charts should be sensitive to the standards of confidentiality of the nonpsychiatric medical sector and the possibility that charts may be read by persons who are not well informed about psychiatric issues. Information written in general medical charts should be confined to that necessary for the general medical team and should be conveyed with a level of detail and specificity that will be most helpful to the overall management of the patient. It is also important that documentation be of sufficient detail to establish a diagnosis and treatment plan.

D. OTHER SETTINGS

Evaluations conducted in other settings, such as residential treatment facilities, home care services, nursing homes, long-term care facilities, schools, and prisons, are affected by a number of factors: 1) the level of behavioral observations available and the quality of those observations, 2) the availability of privacy for conducting interviews, 3) the availability of general medical evaluations and diagnostic tests, 4) resources to conduct the evaluation safely, and 5) the degree of likelihood that information written in facility records will be understood and kept confidential.

In light of these factors, it is necessary to consider whether a particular setting permits an evaluation of adequate speed, safety, accuracy, and confidentiality to meet the needs of the patient. Factors of the setting that compromise the evaluation merit documentation.

III. DOMAINS OF THE CLINICAL EVALUATION

General psychiatric evaluations involve a systematic consideration of the broad domains described in this guideline and vary in scope and intensity. Table 1 summarizes the domains. The intensity with which each domain is assessed depends on the purpose of the evaluation and the clinical situation. An evaluation of lesser scope may be appropriate when its purpose is to answer a circumscribed question. Such an evaluation may involve a particularly intense assessment of one or more domains especially relevant to the reason for the evaluation.

Across all domains, evaluations are generally based on three sources of information: 1) observation and interview of the patient; 2) information from others (e.g., family, significant others, case managers, other clinicians [including the patient's primary care physician]) that corroborates, refutes, or elaborates on the patient's report; and 3) medical records. An awareness of how people report current symptoms and events is important to the clinical assessment process. In considering the information obtained, the patient's current mental state is relevant. Mistakes in comprehension, recall, and expression may also lead to erroneous reporting of information (44).

A. REASON FOR THE EVALUATION

The purpose of the evaluation influences the focus of the examination and the form of documentation. The reason for the evaluation usually includes (but may not be limited to) the chief complaint of the patient. It should be elicited in sufficient detail, including the patient's words, to permit an understanding of the duration of the complaint and the patient's specific goals for the evaluation. If the symptoms are of long standing, the reason for seeking treatment at this specific time is relevant; if the evaluation was occasioned by a hospitalization, the reason for the hospitalization is also relevant. If the patient did not initiate the evaluation, the reason another individual or entity may have requested or required it should be noted. The opinions of other parties, including family, can also assist in establishing a reason for evaluation. Under some circumstances (e.g., with psychotic or uncommunicative patients), input from others may be crucial.

B. HISTORY OF THE PRESENT ILLNESS

The history of the present problem or illness is a chronologically organized history of recent exacerbations or remissions and current symptoms or syndromes. These may involve descriptions of worries, changes in mood, suspicions, preoccupations, delusions, or hallucinatory ex-

TABLE 1. Domains of the Clinical Evaluation

Domain	Questions to Consider
Reason for the evaluation	What is the patient's chief complaint and its duration? What reason does the patient give for seeking evaluation at this specific time? What reasons are given by other involved parties (e.g., family, other health professionals) for seeking evaluation at this specific time?
History of the present illness	What symptoms is the patient experiencing (e.g., worries; preoccupations; changes in mood; suspicions; delusions or hallucinatory experiences; recent changes in sleep, appetite, libido, concentration, memory, or behavior, including suicidal or aggressive behaviors)? What is the severity of the patient's symptoms? Over what time course have these symptoms developed or fluctuated? Are associated features of specific psychiatric syndromes (i.e., pertinent positive or negative factors) present or absent during the present illness? What factors does the patient believe are precipitating, aggravating, or otherwise modifying the illness or are temporally related to its course? Did the patient receive prior treatment for this episode of illness? Are other clinicians who care for the patient available to comment?
Past psychiatric history	What is the chronology of past episodes of mental illness, regardless of whether such episodes were diagnosed or treated? What are the patient's previous sources of treatment, and what diagnoses were given? With respect to somatic therapies (e.g., medications, electroconvulsive therapy), what were the dose or treatment parameters, efficacy, side effects, treatment duration, and adherence? With respect to psychotherapy, what were the type, frequency, duration, adherence, and patient's perception of the therapeutic alliance and helpfulness of the psychotherapy? Is there a history of psychiatric hospitalization? Is there a history of suicide attempts or aggressive behaviors? Are past medical records available to consult?
History of alcohol and other substance use	What licit and illicit substances have been used, in what quantity, how frequently, and with what pattern and route of use? What functional, social, occupational, or legal consequences or self-perceived benefits of use have occurred? Has tolerance or withdrawal symptoms been noted? Has substance use been associated with psychiatric symptoms? Are family members available who could provide corroborating information about the patient's substance use and its consequences?

TABLE 1. Domains of the Clinical Evaluation *(continued)*

Domain	Questions to Consider
General medical history	What general medical illnesses are known, including hospitalizations, procedures, treatments, and medications?
	Are undiagnosed illnesses causing major distress or functional impairment?
	Does the patient engage in high-risk behaviors that would predispose him or her to a medical illness?
	Is the patient taking any prescribed or over-the-counter medications, herbal products, supplements, and/or vitamins?
	Has the patient experienced allergic reactions to or severe adverse effects of medications?
Developmental, psychosocial, and sociocultural history	What have been the most important events in the patient's life, and what were the patient's responses to them?
	What is the patient's history of formal education?
	What are the patient's cultural, religious, and spiritual beliefs, and how have these developed or changed over time?
	Is there a history of parental loss or divorce; physical, emotional, or sexual abuse; or exposure to other traumatic experiences?
	What strategies for coping has the patient used successfully during times of stress or adversity?
	During childhood or adolescence, did the patient have risk factors for any mental disorders?
	What has been the patient's capacity to maintain interpersonal relationships, and what is the patient's history of marital and other significant relationships?
	What is the patient's sexual history, including sexual orientation, beliefs, and practices?
	Does the patient have children?
	What past or current psychosocial stressors have affected the patient (including primary support group, social environment, education, occupation, housing, economic status, and access to health care)?
	What is the patient's capacity for self-care?
	What are the patient's sociocultural supports (e.g., family, friends, work, and religious and other community groups)?
	What are the patient's own interests, preferences, and values with respect to health care?
Occupational and military history	What is the patient's occupation, and what jobs has the patient held?
	What is the quality of the patient's work relationships?
	What work skills and strengths does the patient have?
	Is the patient unable to work due to disability?
	Regarding military service, what was the patient's status (volunteer, recruit, or draftee), did the patient experience combat, and did the patient suffer injury or trauma?
	Is the patient preparing for or adjusting to retirement?

TABLE 1. Domains of the Clinical Evaluation *(continued)*

Domain	Questions to Consider
Legal history	Does the patient have any past or current involvement with the legal system (e.g., warrants, arrests, detentions, convictions, probation, parole)?
	Do past or current legal problems relate to aggressive behaviors or substance intoxication?
	Has the patient had other significant interactions with the court system (e.g., family court, workers' compensation dispute, civil litigation, court-ordered psychiatric treatment)?
	Is past or current legal involvement a significant social stressor for the patient?
Family history	What information is available about general medical and psychiatric illnesses, including substance use disorders, in close relatives?
	Is there a family history of suicide or violent behavior?
	Are heritable illnesses present in family members that relate to the patient's presenting symptoms?
Review of systems	Is the patient having difficulty with sleep, appetite, eating patterns, or other vegetative symptoms, or with pain, neurological symptoms, or other systemic symptoms?
	Does the patient have symptoms that suggest an undiagnosed medical illness that may be causing or contributing to psychiatric symptoms?
	Is the patient experiencing side effects from medications or other treatments?
Physical examination	What is the appropriate timing, scope, and intensity of the exam for this patient, and who is the most appropriate examiner?
	Upon examination, are there abnormalities in the patient's general appearance, vital signs, neurological status, skin, or organ systems?
	Is more detailed physical examination necessary to assess the patient for specific diseases?
Mental status examination	What symptoms and signs of a mental disorder is the patient currently exhibiting?
	What are the patient's general appearance and behavior?
	What are the characteristics of the patient's speech?
	What are the patient's mood and affect, including the stability, range, congruence, and appropriateness of affect?
	Are the patient's thought processes coherent?
	Are there recurrent or persistent themes in the patient's thought processes?
	Are there any abnormalities of the patient's thought content (e.g., delusions, ideas of reference, overvalued ideas, ruminations, obsessions, compulsions, phobias)?
	Is the patient having thoughts, plans, or intentions of harming self or others?
	Is the patient experiencing perceptual disturbances (e.g., hallucinations, illusions, derealization, depersonalization)?

TABLE 1. Domains of the Clinical Evaluation *(continued)*

Domain	Questions to Consider
Mental status examination *(continued)*	What are the patient's sensorium and level of cognitive function (e.g., orientation, attention, concentration, registration, short- and long-term memory, fund of knowledge, level of intelligence, drawing, abstract reasoning, language, and executive functions)?
	What are the patient's level of insight, judgment, and capacity for abstract reasoning?
	What is the patient's motivation to change his or her health risk behaviors?
Functional assessment	What are the patient's functional strengths, and what is the disease severity?
	To what degree can the patient perform physical activities of daily living (e.g., eating, toileting, transferring, bathing, dressing)?
	To what degree can the patient perform instrumental activities of daily living (e.g., driving, using public transportation, taking medications as prescribed, shopping, managing finances, keeping house, communicating by mail or telephone, caring for dependents)?
	Would a formal assessment of functioning be useful (e.g., to document deficits or aid continued monitoring)?
Diagnostic tests	What diagnostic tests are necessary to establish or exclude a diagnosis, aid in the choice of treatment, or monitor treatment effects or side effects?
Information derived from the interview process	Are symptoms minimized or exaggerated by the patient or others? Does the patient appear to provide accurate information?
	Do particular questions evoke hesitation or signs of discomfort?
	Is the patient able to communicate about emotional issues?
	How does the patient respond to the psychiatrist's comments and behaviors?

periences as well as recent changes in sleep, appetite, libido, concentration, memory, or behavior, including suicidal or aggressive behaviors. Information gathered on the pertinent positive and pertinent negative features of the history of present illness will vary with the patient's presenting symptoms or syndrome. Temporal features relating to the onset or exacerbation of symptoms may also be relevant (e.g., onset after use of exogenous hormones, herbal products, or licit or illicit substances; variation in symptoms with the menstrual cycle; postpartum onset). Also pertinent are factors that the patient and other informants believe to be precipitating, aggravating, or otherwise modifying the illness. Available details of previous treatments and the patient's response to those treatments will be delineated as part of the history of present illness. If the patient was or is in treatment with another clinician, the effects of that relationship on the current illness, including transference and countertransference issues, are considered. Input from members of a clinical team who care for the patient can be very helpful (Section IV.A.6). For patients seen on medical-surgical units, it is important to consider the history of both the present medical-surgical illness and the present psychiatric illness (45).

C. PAST PSYCHIATRIC HISTORY

The past psychiatric history includes a chronological summary of all past episodes of mental illness, including substance use disorders, and treatment. The summary includes prior hospitalizations; suicide attempts, aborted suicide attempts, or other self-destructive behavior; psychiatric syndromes not formally diagnosed at the time; previously established diagnoses; treatments offered; and responses to and satisfaction with treatment. With respect to psychotherapy, it is important to ascertain the type (e.g., psychodynamic, cognitive, behavioral, supportive), format (e.g., group, individual, couple), frequency, duration, patient's perception of the alliance, and adherence. With respect to medications, the dose, efficacy, side effects, treatment duration, and adherence are important to ascertain while understanding that reporting errors are more likely to occur when treatment involved more than one medication (46). With respect to other somatic therapies such as electroconvulsive therapy, information on the number of treatment sessions, treatment course duration, technical parameters, efficacy, and side effects is similarly useful to obtain. When past medical records are available and readily accessible, it is important that they be consulted for ancillary information.

The chronological summary also delineates the most recent periods of stability as well as episodes when the patient was functionally impaired or seriously distressed by mental or behavioral symptoms, even if no formal treatment occurred. Such episodes frequently can be identified by asking the patient about the past use of psychotropic medications prescribed by other clinicians and otherwise unexplained episodes of social or occupational disability.

D. HISTORY OF SUBSTANCE USE

The psychoactive substance use history includes past and present use of both licit and illicit psychoactive substances, including but not limited to alcohol, caffeine, nicotine, marijuana, cocaine, opiates, sedative-hypnotic agents, stimulants, solvents, MDMA (methylenedioxymethamphetamine), androgenic steroids, and hallucinogens (47). Relevant information includes the quantity and frequency of use and route of administration; the pattern of use (e.g., episodic versus continual, solitary versus social); functional, interpersonal, or legal consequences of use; tolerance and withdrawal phenomena; any temporal association between substance use and other present psychiatric illnesses; and any self-perceived benefits of use. It is also important to inquire about prior treatments for substance use disorders as well as about periods of abstinence, including their duration, recentness, and factors that aided in sobriety or contributed to relapse. Obtaining an accurate substance use history often involves a gradual, nonconfrontational approach to inquiry that involves asking multiple questions to seek the same information in different ways and using slang terms for drugs, patterns of use, and drug effects. Patients are particularly likely to underestimate their level of substance abuse and their related functional impairments; corroboration by other family members is useful when possible. It is also helpful to inquire about patterns of substance use by others within the family or living constellation. For more extensive discussion of the assessment of substance use, abuse, and dependence, the reader is referred to the Center for Substance Abuse Treatment's *Assessment and Treatment of Patients With Coexisting Mental Illness and Alcohol and Other Drug Abuse* (48) and APA's *Practice Guideline for the Treatment of Patients With Substance Use Disorders* (49).

E. GENERAL MEDICAL HISTORY

The general medical history includes available information on known general medical illnesses (e.g., hospitalizations, procedures, treatments, and medications), allergies or drug sensitivities, and undiagnosed health problems that have caused the patient major distress or functional impairment. This includes history of any episodes of important physical injury or trauma; sexual and reproductive history; and any history of endocrinological, infectious (including but not

limited to HIV, tuberculosis, and hepatitis C) (50), neurological disorders, sleep disorders (including sleep apnea), and conditions causing pain and discomfort. Of particular importance is a specific history regarding diseases and symptoms of diseases that have a high prevalence among individuals with the patient's demographic characteristics and background—for example, infectious diseases in users of intravenous drugs or pulmonary and cardiovascular disease in people who smoke. Information regarding all current and recent medications, including hormones (e.g., birth control pills, androgens), over-the-counter medications, herbal supplements, vitamins, complementary and alternative medical treatments, and medication side effects, is part of the general medical history. With all aspects of the general medical history, obtaining corroborating information (e.g., from medical records, treating clinicians, family) can be helpful, since ordinary errors in comprehension, recall, and expression can lead to errors in patient reports (51).

F. DEVELOPMENTAL, PSYCHOSOCIAL, AND SOCIOCULTURAL HISTORY

The personal history reviews the stages of the patient's life, with special attention to perinatal events, delays in physical or psychological development, formal educational history, academic performance, and patterns of response to normal life transitions and major life events, including parental loss or divorce; physical, emotional, or sexual abuse; and other trauma such as exposure to political repression, war, or a natural disaster (52–55). The childhood and adolescent history of risk factors for later psychiatric disorders (Table 2) may also be relevant. History of adaptive skills and strengths to overcome challenges is also relevant.

The patient's capacity to maintain stable and gratifying interpersonal relationships should be noted, including the patient's capacities for attachment, trust, and intimacy. A sexual history is obtained and includes consideration of sexual orientation and practices, past sexual experiences (including unwanted experiences), and cultural beliefs about sex (54). The psychosocial history also determines the patient's past and present levels of interpersonal functioning in family and social roles (e.g., marriage, parenting) (56–58). This includes a delineation of the patient's history of marital and other significant relationships. For patients with children (including biological, foster, adopted, or stepchildren), the psychosocial history will include information about these individuals and their relationship to the patient.

As part of the psychosocial history, past or current stressors are assessed and include the categories on axis IV of DSM-IV-TR: primary support group, social environment (e.g., discrimination and acculturation), education, occupation, housing, economic status, and access to health care. Specific information obtained in evaluating psychosocial stressors may include details about patients' living arrangements, access to transportation, sources of income, insurance or prescription coverage, and past or current involvement with social agencies. Assessment of the patient's self-care functioning may also include consideration of exercise behavior and money management skills, including gambling behavior.

The sociocultural history delineates the patient's migration history and past and current sociocultural context of supports and stressors as well as other important cultural and religious influences on the patient's life (59). Emphasis is given to relationships, both familial and nonfamilial, and to religion and spirituality that may give meaning and purpose to the patient's life and provide support, as described in the DSM-IV-TR Outline for Cultural Formulation (described in more detail in Section IV.B.1.a).

Patients present for a psychiatric evaluation with their own interests, preferences, and value systems pertaining to health care practice, and these are another important part of the sociocultural history. They may involve cultural factors and explanatory models of illness that affect attitudes, expectations, and preferences for professional and popular treatments, as described in the DSM-IV-TR Outline for Cultural Formulation and the 2004 Core Competencies of the American Board of Psychiatry and Neurology (60). Also important to the assessment and treatment process are other domains such as existential, moral, and interpersonal values and social

TABLE 2. Questions About Childhood Developmental History for Which Affirmative Answers May Indicate Increased Risk for Psychiatric Illness

Did the patient lose a parent at an early age?
Was there unusual or excessive separation anxiety during childhood or adolescence?
Were there significant problems with sleep?
Were there eating disturbances?
Were there problems making or keeping friends?
Was severe shyness a problem, including when interacting in peer groups?
Were there problems with being bullied or bullying?
Were there frequent disciplinary problems in school?
Were there serious difficulties with temper?
Were there many school absences for medical problems or any other problems?
Were there any delays in learning to read, write, or do math?
Were there serious problems paying attention, finishing school work, or completing homework?
Did the above problems lead to grade retention or special education intervention?

influences such as school, church, work, and community or other agencies. Attending to these factors plays a crucial role in developing a therapeutic alliance, negotiating a treatment plan, determining the outcome criteria for successful treatment, and enhancing treatment adherence. Belief systems may also influence the handling of privacy and confidentiality during the evaluation as well as influence the type and amount of information disclosed as part of any informed consent process. In addition, patients' value systems are relevant to clinical considerations at important life transitions (e.g., job and career transitions, marital transitions, genetic counseling before or during pregnancy, end-of-life planning).

G. OCCUPATIONAL AND MILITARY HISTORY

The occupational history describes the sequence and duration of jobs held by the patient, reasons for job changes, and the patient's current or most recent employment, including quality of work relationships and whether current or recent jobs have involved shift work, a noxious or perilous environment, exposure to hazardous materials, unusual physical or psychological stress, or injury or exposure to trauma while in the military or hazardous occupations (e.g., fire and rescue, law enforcement). Work skills and strengths are noted, as well as the quality of the patient's relationships with co-workers and work supervisors. Past or current experience with the workers' compensation system and patterns of recovery or disability following episodes of illness are also determined (61–64). When appropriate, a history of preparation for and adjustment to retirement is included.

Relevant data about military experience include volunteer, recruited, or draftee status; reasons for rejection at time of enlistment (if relevant); combat exposure (if any); awards; disciplinary actions; and discharge status.

H. LEGAL HISTORY

The legal history includes a description of past or current involvement with the legal system (65). This may include interactions with the police without formal arrest as well as involvement with the juvenile or criminal justice system (e.g., arrests, detentions including jail or prison confinement). Individuals may be on probation or parole or may have pending court appearances or active warrants for arrest that will influence treatment planning. A history of legal

problems relating to aggressive behaviors or occurring in the context of substance intoxication is similarly relevant. Other past or current interactions with the court system (e.g., family court, workers' compensation, civil litigation, court-ordered psychiatric treatment) may serve as significant stressors for the patient and are also important to address (55, 66).

I. FAMILY HISTORY

The family history includes available information about the patient's family constellation and the strength of relationships with family members. Information obtained about close family members, including parents and, if applicable, siblings, spouse, and children, will include general information (e.g., current age or age at time of death, position in sibship, occupation), quality of relationship to the patient, and health status. General medical and psychiatric illness in close relatives is noted, including disorders that may be familial or may strongly affect the family environment. A history of adoption or foster care or disruptions in the family environment because of divorce, remarriage, prolonged absences of family members (e.g., occupational absences, hospitalization, incarceration), or deaths may be useful to elicit. Family history information will also consist of any history of psychiatric hospitalizations, illness, or significant symptoms, including suicide and attempted suicide in first- and second-degree relatives. More specific questions are important to ask depending on the patient's clinical presentation, given the heritability of psychosis; mood disorders; anxiety disorders; cognitive disorders; learning disabilities; developmental disabilities, including autism, hyperactivity, or attention deficit disorder; substance use disorders; and antisocial behavior. For family members who have experienced psychiatric symptoms, it is helpful to learn the treatment received and their response to treatment. It is also important to determine first- and second-degree relatives' history of medical disorders (67), particularly those with relevance to psychiatric illness and treatment, such as cardiac, neurological, and endocrine disorders. If family health problems are current, this may contribute psychological or financial stresses for the patient.

Construction of a formal pedigree or genogram is often helpful in delineating family relationships and identifying a family history of illness. The web sites of the American Medical Association (68), the American Society of Human Genetics (69), and the March of Dimes (70) provide additional details on the drawing of pedigrees.

J. REVIEW OF SYSTEMS

The review of systems includes current symptoms not already identified in the history of the present illness. If not already addressed in the history of present illness, sleep, appetite, eating patterns, vegetative symptoms of mood disorder, pain and discomfort, systemic symptoms such as fever and fatigue, and neurological symptoms are also relevant. In addition, common symptoms of diseases for which the patient is known to be at particular risk because of historical, genetic, environmental, or demographic factors are an important part of the review of systems. Special attention should be given to typical side effects observed with prescribed or over-the-counter medications and other treatments, including complementary or alternative therapies, that the patient is receiving.

K. PHYSICAL EXAMINATION

Evaluation of the patient's general medical status necessitates that a physical examination be performed. Although the process of the physical examination is described more fully in Section IV.A.5, specific elements assessed as part of the physical examination may include the following:

1. General appearance, height, weight, body mass index (BMI), and nutritional status
2. Vital signs
3. Head and neck, heart, lungs, abdomen, and extremities
4. Neurological status, including cranial nerves, motor and sensory function, gait, coordination, muscle tone, reflexes, and involuntary movements
5. Skin, with special attention to any stigmata of trauma, self-injury, or drug use
6. Any body area or organ system that is specifically mentioned in the history of the present illness or review of systems or that is relevant to determining the current status of problems mentioned in the past medical history

Additional items may be added to the examination to address specific diagnostic concerns or to screen a member of a clinical population at risk for a specific disease. For example, an individual with mental retardation might be assessed for the physical characteristics of a recognized syndrome.

L. MENTAL STATUS EXAMINATION

The purpose of the mental status examination is to obtain evidence of symptoms and signs of mental disorders, including dangerousness to self and others, that are present at the time of the interview. Further, evidence is obtained regarding the patient's insight, judgment, and capacity for abstract reasoning to inform decisions about treatment strategy and the choice of an appropriate treatment setting. Thus, the mental status examination is a systematic collection of data based on observation of the patient's behavior while the patient is in the psychiatrist's view during, before, and after the interview. During the mental status examination, the patient might also mention past symptoms and signs, but these should be recorded under the history of the present illness.

Responses to specific questions are an important part of the mental status examination (71, 72), particularly in the assessment of cognition. Consequently, in recording the findings of the mental status examination, it is useful to include examples that illustrate the clinical observations. For example, it would be preferable to note that the patient exhibited poor judgment in precipitously attempting to remove his intravenous line rather than simply describing the patient's judgment as impaired.

Although its precise organization may vary, the mental status examination typically contains the following elements:

1. *Appearance and general behavior.* In describing the patient's appearance, factors such as approximate age, body habitus, dress, grooming, hygiene, and distinguishing features (e.g., scars, tattoos) may be noted. The patient's general behavior, level of distress, degree of eye contact, and attitude toward the interviewer are also considered.
2. *Motor activity.* The patient's level of psychomotor activity is noted, as is the presence of any gait abnormalities or purposeless, repetitive, or unusual postures or movements (e.g., tremors, dyskinesias, akathisia, mannerisms, tics, stereotypies, catatonic posturing, echopraxia, apparent responses to hallucinations).
3. *Speech.* Characteristics of the patient's speech are described and may include consideration of rate, rhythm, volume, amount, accent, inflection, fluency, and articulation.
4. *Mood and affect.* The patient's expressions of mood and affect are noted. Although the use and definitions of the terms *mood* and *affect* vary, mood is typically viewed as referring to the patient's internal, subjective, and more sustained emotional state, whereas affect relates to the patient's externally observable and more changeable emotional state (71, 73). Affect is often described in terms of its range, intensity, stability, appropriateness, and congruence with the topic being discussed in the interview.

5. *Thought processes.* Features of the patient's associations and flow of ideas are described, such as vagueness, incoherence, circumstantiality, tangentiality, neologisms, perseveration, flight of ideas, loose or idiosyncratic associations, and self-contradictory statements.
6. *Thought content.* The patient's current thought content is assessed by noting the patient's spontaneously expressed worries, concerns, thoughts, and impulses, as well as through specific questioning about commonly observed symptoms of specific mental disorders. These symptoms include delusions (e.g., erotomania or delusions of persecution, passivity, grandeur, infidelity, infestation, poverty, somatic illness, guilt, worthlessness, thought insertion, thought withdrawal, or thought broadcasting), ideas of reference, overvalued ideas, ruminations, obsessions, compulsions, and phobias. Assessment of suicidal, homicidal, aggressive, or self-injurious thoughts, feelings, or impulses is essential for determining the patient's level of risk to self or others as part of the clinical formulation. If such features are present, details are elicited regarding their intensity and specificity, when they occur, and what prevents the patient from acting on them (11, 74–79).
7. *Perceptual disturbances.* Hallucinations (i.e., a perception in the absence of a stimulus) and illusions (i.e., an erroneous perception in the presence of a stimulus) may occur in any sensory modality (e.g., auditory, visual, tactile, olfactory, gustatory). Other perceptual disturbances that patients may experience include depersonalization and derealization.
8. *Sensorium and cognition.* Systematic assessment of cognitive functions is an essential part of the general psychiatric evaluation, although the level of detail necessary and the appropriateness of particular formal tests will depend on the purpose of the evaluation and the psychiatrist's clinical judgment. Evaluation of the patient's sensorium includes a description of the level of consciousness and its stability. Elements of the patient's cognitive status that may be assessed include orientation (e.g., person, place, time, situation), attention and concentration, and memory (e.g., registration, short-term, long-term). Arithmetic calculations may be used to assess concentration or knowledge; other aspects of the patient's fund of knowledge may also be assessed as appropriate to sociocultural and educational background. Additional aspects of the cognitive examination may include assessment of level of intelligence, language functions (e.g., naming, comprehension, repetition, reading, writing), drawing (e.g., copying a figure or drawing a clock face), abstract reasoning (e.g., explaining similarities or interpreting proverbs), and executive functions (e.g., list making, inhibiting impulsive answers, resisting distraction, recognizing contradictions).
9. *Insight.* The patient's insight into his or her current situation is typically assessed by inquiring about the patient's awareness of any problems and their implications. Patients may or may not recognize that psychosis or other symptoms may reflect an underlying illness or that their behavior affects their relationships with other individuals. They also may or may not recognize the potential benefits of treatment.

   Another element of insight involves the patient's motivation to change his or her health risk behaviors. Such motivation often fluctuates over time from denial and resistance to ambivalence to commitment, a sequence that has been referred to as "stages of change" (80–82). The stages, which are not necessarily discrete, have been labeled *precontemplation* (denial, minimization); *contemplation* (musing or thinking about doing something); *preparation* (actually getting ready to do something); *action* (implementing concrete actions to deal with the problem); and *maintenance* (acting to ensure that the changes are maintained) (83). Patients who are not quite ready to change may vacillate about modifying their behaviors before actually committing to change and acting on it. Assessing stages of change as part of the evaluative process leads to stage-appropriate educational and therapeutic interventions that attempt to help patients move to more adaptive stages in a patient-centered manner (84–86).

10. *Judgment.* The quality of the patient's judgment has sometimes been assessed by asking for the patient's responses to hypothetical situations (e.g., smelling smoke in a theater). However, in assessing judgment, it is generally more helpful to learn about the patient's responses and decision making in terms of his or her own self-care, interactions, and other aspects of his or her recent or current situation and behavior. If poor judgment is present, a more detailed explication of the patient's decision-making processes may help differentiate the potential causes of this impairment.

IV. EVALUATION PROCESS

A. METHODS OF OBTAINING INFORMATION

1. Patient interview

The psychiatrist's primary assessment tool is the direct face-to-face interview of the patient. Evaluations based solely on review of records and interviews of persons close to the patient are inherently limited by a lack of the patient's perspective. Furthermore, the clinical interview provides the psychiatrist with a sample of the patient's interpersonal behavior and emotional processes. It can either support or qualify diagnostic inferences from the history and can also aid in prognosis and treatment planning. Important information can be derived by observing the patient's general style of relating, the ways in which the patient minimizes or exaggerates certain aspects of his or her history, and whether particular questions appear to evoke hesitation or signs of discomfort. Additional observations concern the patient's ability to communicate about emotional issues, the defense mechanisms the patient uses when discussing emotionally important topics, and the patient's responses to the psychiatrist's comments and to other behavior, such as the psychiatrist's handling of interruptions or time limits.

The interview should be done in a manner that facilitates the patient's telling of his or her story, while simultaneously obtaining the necessary information. Time constraints need to be considered and adequate time allowed for the interview. High-priority tasks include an assessment of the patient's safety and the identification of signs, symptoms, or disorders requiring urgent treatment.

Opening with a discussion of the purpose of the interview offers the patient an understanding of the process. Empirical studies of the interview process suggest that the most comprehensive and accurate information emerges from a combination of 1) open-ended questioning with empathic listening and 2) structured inquiry about specific events and symptoms (87–92). When the purpose is a general evaluation, beginning with open-ended, empathic inquiry about the patient's concerns usually is best. Attention to the patient's most pressing concerns, whenever possible, will improve the therapeutic alliance and is likely to facilitate increased patient cooperation; other inquiries may be more limited initially in the service of the alliance. Patient satisfaction with open-ended inquiry is greatest when the psychiatrist provides feedback to the patient at multiple points during the interview. Structured, systematic questioning has been shown to be especially helpful in eliciting information about substance use and traumatic life events and in ascertaining the presence or absence of specific symptoms and signs of particular mental disorders (93–102) (Section IV.A.3).

Throughout the interview, useful clinical information is obtained by being sensitive to issues of development, culture, race, ethnicity, primary language, health literacy, disabilities, gender, sexual orientation, familial/genetic patterns, religious and spiritual beliefs, social class, and

physical and social environment influencing the patient's symptoms and behavior. Respectful evaluation involves an empathic, nonjudgmental attitude and appropriate responses concerning the patient's cultural identity, his or her own explanation of illness and treatment pathways, sociocultural stressors and supports, and modes of interpersonal communication, both verbal and nonverbal. An awareness of one's possible biases or prejudices about patients from different subcultures and an understanding of the limitations of one's knowledge and skills in working with such patients may help one determine when it is advisable to consult with a clinician who has expertise concerning a particular subculture (103–105).

a) Use of interpreters in the interview

When available, professionally trained interpreters with mental health experience should be used for encounters involving patients with limited English proficiency and those who are deaf or have severely limited hearing and who prefer to communicate using sign language (106, 107). Bilingual and bicultural staff may also be helpful (108). With cooperative patients, over-the-phone language interpretation services can be used when other professionally trained interpreters are unavailable, although establishing rapport with the patient may be more difficult. Family members, community members, or friends should not be used unless the patient refuses to use the professional interpreter or under emergency circumstances, in which case this should be noted in the patient record. The interpreter should be instructed to translate the patient's own words and to avoid paraphrasing except as needed to translate the correct meaning of idioms and other culture-specific expressions (109–111).

b) Interviews with agitated or aggressive individuals

When evaluating individuals who are agitated or aggressive, the psychiatrist needs to give consideration to the patient interview as well as to his or her own safety (13, 77, 112–116). Establishing the presence of backup personnel and choosing an appropriate space in which to conduct the interview are useful preparations before meeting with an agitated or aggressive patient. Because such individuals may become more agitated if they feel trapped within a small room or are too closely positioned to the interviewer, a distance of several arms' length from the patient, with both psychiatrist and patient having access to the door, is generally optimal. A safe office environment should not contain potentially dangerous objects (e.g., decorative items), and the clinician should avoid clothing that can be used against him or her (e.g., neckties, scarves, prominent dangling earrings). Depending on the configuration of the office or interview room and its proximity to other staff, a mechanism for summoning assistance (e.g., a panic button) may also be indicated.

During the interview, a nonconfrontational and straightforward approach is often most effective. Attending to the patient's comfort, using reflective or active listening techniques, and showing respect for the patient's feelings and stated concerns may aid in establishing rapport. The key to calming an aggressive patient is affect management. Patients who are affectively aroused will need to ventilate their feelings, and the clinician should allow the patient to tell his or her own story. Logical or rational responses to an affectively flooded individual may further inflame the patient. Affect management involves acknowledging the patient's affect, validating the affect when appropriate, and encouraging the patient to talk about his or her feelings (116).

In some circumstances, it may be appropriate to set limits (e.g., noting that aggressive behavior cannot be permitted) while simultaneously emphasizing the need to attend to the safety of the patient and others. Throughout the interview, the clinician needs to be alert for signs that the patient's agitation is escalating (e.g., increased body movements or pacing, clenched fists, verbal threats, or increasing verbal volume); such signs may indicate a need to adjust the interview style or timing. At times, it will be best to postpone in-depth history taking or discussion of distressing topics that are not germane to the patient's current presentation.

In some instances, administration of psychotropic medications or judicious use of seclusion or restraint may be necessary to enhance the safety of the patient and others (114) or to permit essential physical examination, laboratory studies, or other diagnostic assessment. Reliance on such measures should be justified by the urgency of obtaining the diagnostic information and should be in compliance with applicable laws and regulations. The psychiatrist should consider how any special circumstances of the interview or examination may influence clinical findings. When the patient is able to cooperate, parts of the examination that cannot be completed or that are significantly influenced by the use of medication, seclusion, or restraint should be repeated if possible.

Guidelines for reducing the use of seclusion and restraint while at the same time maintaining the safety of patients and staff are available in a report developed by the APA with the American Psychiatric Nurses Association and the National Association of Psychiatric Health Systems (117). Recommendations of the report include assessing for anger management problems, identifying risk factors (e.g., pregnancy, asthma, head or spinal injury) before using restraint, identifying triggers, involving patients in treatment planning, asking patients about past experiences of seclusion and restraint, involving family, and documenting interventions attempted before using seclusion or restraint.

2. Use of collateral sources

Family members, other important people in the patient's life, and records of prior medical and psychiatric treatment are frequently useful sources of information. Collateral information is particularly important when patients have impaired insight, including when patients have substance use disorders or cognitive impairment, and is essential for treatment planning when patients require a high level of assistance or supervision because of impaired function or unstable behavior. Family members and others who know the patient well may provide important information about the patient's personality before the onset of illness, since the patient's own account may be unduly influenced by his or her mental state. Collateral sources of information may also provide essential information about the illness course (Section III.C), the current symptoms and behavior (Section III.B), and the reasons for the evaluation (Section III.A). The extent of the collateral interviews and the extent of prior record review should be commensurate with the purpose of the evaluation, the complexity of the clinical presentation, and the diagnostic and therapeutic goals. For example, in an acute inpatient or emergency setting, collateral information may be crucial to developing an understanding of the patient's clinical condition, whereas in long-term outpatient psychotherapy the impact on the treatment process of obtaining collateral information from family or others needs to be considered. Except when immediate safety concerns are paramount, the confidentiality of the patient should be respected. At the same time, it is permissible for the psychiatrist to listen to information provided by family members and other important people in the patient's life, as long as confidential information is not provided to the informant (Sections I.A, I.B, II.C, and V.A).

3. Use of structured interviews and rating scales, including functional assessments

Structured interviews, standardized data forms, questionnaires, and rating scales can be useful tools for diagnostic assessment and evaluation of treatment outcome. Table 3, while not all-inclusive, lists many of the common structured instruments in use (see also the CD-ROM from APA's *Handbook of Psychiatric Measures* [118]). Such structured instruments may be used as components for establishing a diagnosis, measuring social or occupational function, or monitoring changes in symptom severity or side effects over time during treatment.

Although most commonly used in psychiatric research, rating scales may also help psychiatrists structure a thorough line of questioning. In addition, self-report scales may be valuable in opening communication with patients about their symptoms, feelings, or experiences. At the

TABLE 3. Examples of Clinical Rating Scales

Scale	Administration (Time)	Clinical Use	Reference	Availability
Quality of life				
Quality of Life Enjoyment & Satisfaction Questionnaire (Q-LES-Q)	Self-administered questionnaire; short (16-item; 5 min) or long (60-item; 15 min) format	Assessment of degree of enjoyment and satisfaction in various areas of daily life	Endicott J, Nee J, Harrison W, et al: Quality of Life Enjoyment and Satisfaction Questionnaire: a new scale. Psychopharmacol Bull 29:321–326, 1993	Jean Endicott, Ph.D.; Dept. of Research Assessment and Training, New York State Psychiatric Institute, Unit 123; 1051 Riverside Drive; New York, NY 10032; ph 212-543-5536
Mental health status and functioning				
Clinical Global Impression (CGI) Scale	Clinician-rated scale (1–2 min after clinical information is obtained)	Global assessment of response to medication treatment	Guy W, Bonato RR (eds): Manual for the ECDEU Assessment Battery, revised 2nd ed. Chevy Chase, Md, National Institute of Mental Health, 1970, pp 12.1–12.6	Guy W: ECDEU Assessment Manual for Psychopharmacology, revised ed. Washington, DC, US Department of Health, Education, and Welfare, 1976; APA (2000) *Handbook of Psychiatric Measures*
Global Assessment of Functioning (GAF) Scale	Clinician-rated scale, ranked 0–100 (1–2 min after clinical information is obtained)	Assessment of patient functioning, monitoring of change, and selection of patients suitable for short-term treatment	American Psychiatric Association: DSM-IV-TR	DSM-IV-TR
Social and Occupational Functioning Assessment Scale (SOFAS)	Clinician-rated scale, ranked 0–100 (1–2 min after clinical information is obtained)	Assessment of patient social and occupational functioning and monitoring of change	American Psychiatric Association: DSM-IV-TR	DSM-IV-TR

284

TABLE 3. Examples of Clinical Rating Scales *(continued)*

Scale	Administration (Time)	Clinical Use	Reference	Availability
Adverse effects				
Abnormal Involuntary Movement Scale (AIMS)	Observer-rated 12-item anchored scale (5–10 min)	Assessment of patients who may have involuntary movement disorders (from antipsychotic medications) and may have tardive dyskinesia	Guy W (ed): ECDEU Assessment Manual for Psychopharmacology, revised ed. DHEW Publ No ADM 76-338. Washington, DC, US Department of Health, Education, and Welfare, 1976	Guy 1976; APA (2000) *Handbook of Psychiatric Measures*
Rating Scale for Extrapyramidal Side Effects or Simpson-Angus Extrapyramidal Symptom Rating Scale	Observer-rated 10-item anchored scale (10 min)	Assessment of dose-limiting side effects when antipsychotic medications are initiated, titrated, and monitored and effectiveness of anticholinergic or other agents in the treatment of extrapyramidal side effects	Simpson GM, Angus JWS: A rating scale for extrapyramidal side effects. Acta Psychiatr Scand Suppl 1970; 212:11–19	APA (2000) *Handbook of Psychiatric Measures*
Cognitive disorders				
Delirium Rating Scale Revised–98 (DRS–R98)	Clinician-administered structured exam (15–30 min)	Assessment of a broad range of delirium symptoms: the 16-item scale can be used to diagnose delirium; the 13-item severity subscale can be used to rate symptom severity	Trzepacz PT et al: Validation of the Delirium Rating Scale—Revised–98: comparison with the Delirium Rating Scale and the Cognitive Test for Delirium. J Neuropsychiatry Clin Neurosci 2001; 13:229–242; erratum, 2001; 13:433	© Paula T. Trzepacz, M.D., Lilly Research Laboratories, Indianapolis, IN 46285; PTT@lilly.com
Mini-Mental State Examination (MMSE)	Clinician-administered 30-item structured scale (5–10 min)	Detecting and tracking the progression of cognitive impairment associated with neurogenerative diseases	Folstein MF et al: "Mini-Mental State": a practical method for grading the cognitive state of patients for the clinician. J Psychiatr Res 1975; 12:189–198	Administrator of the Mini-Mental LLC, 31 St. James Avenue, Suite 1, Boston, MA 02116; ph 617-587-4215; APA (2000) *Handbook of Psychiatric Measures*

285

TABLE 3. Examples of Clinical Rating Scales *(continued)*

Scale	Administration (Time)	Clinical Use	Reference	Availability
Alcohol use disorders				
CAGE Questionnaire	Self-report or observer-rated 4-item questionnaire (<1 min)	Screening for alcohol problems	Ewing JA: Detecting alcoholism: The CAGE questionnaire. JAMA 1984; 252: 1905–1907	APA (2000) *Handbook of Psychiatric Measures*
Mood disorders				
Beck Depression Inventory, 2nd Revision (BDI-II)	Self-report or observer-rated 21-item questionnaire, ranked on a 0–3 scale (5–10 min)	Assessment of severity of depressive symptoms in patients with diagnosed depressive illness and monitoring of treatment effects	Beck AT et al: An inventory for measuring depression. Arch Gen Psychiatry 1961; 4:561–571	Harcourt Assessment, Inc., 19500 Bulverde Road, San Antonio, TX 78259; ph 800-211-8378; http://harcourtassessment.com/haiweb/Cultures/en-US/default.htm
Hamilton Depression Rating Scale (Ham-D)	Observer-rated 21- or 17-item checklist, ranked on a 0–4 or 0–2 scale (15–20 min)	Assessment of severity of depressive symptoms in patients with primary depressive illness and monitoring changes with treatment	Hamilton M: A rating scale for depression. J Neurol Neurosurg Psychiatry 1960; 23:56–62	Guy W: ECDEU Assessment Manual for Psychopharmacology, revised ed. DHEW Publ No ADM 76-338. Washington, DC, US Department of Health, Education, and Welfare, 1976
Quick Inventory of Depression Symptomatology—Self-Report (QIDS-SR)	Self-report 16-item scale including the nine domains of major depressive disorder (5–7 min)	Assessment of depressive symptom severity and symptomatic changes in a time efficient manner to gauge effects of treatment	Rush AJ et al: The 16-Item Quick Inventory of Depressive Symptomatology (QIDS), Clinician Rating (QIDS-C), and Self-Report (QIDS-SR): a psychometric evaluation in patients with chronic major depression. Biol Psychiatry 2003; 54:573–583; erratum, 2003; 54:585	Trivedi MH et al: The Inventory of Depressive Symptomatology, Clinician Rating (IDS-C) and Self-Report (IDS-SR), and the Quick Inventory of Depressive Symptomatology, Clinician Rating (QIDS-C) and Self-Report (QIDS-SR) in public sector patients with mood disorders, a psychometric evaluation. Psychol Med 2004; 34:73–82

286

TABLE 3. Examples of Clinical Rating Scales *(continued)*

Scale	Administration (Time)	Clinical Use	Reference	Availability
Mood disorders *(continued)*				
Patient Health Questionnaire (PHQ-9)	Self-report, clinician-scored 9-item questionnaire ranked on 0–3 scale and scored 0–27 (<2 min)	Assessment of DSM-IV depressive disorder diagnoses and grading of depressive symptom severity	http://www.pfizer.com/pfizer/phq-9/index.jsp	Copyright 1999 Pfizer, Inc. http://www.pfizer.com/pfizer/phq-9/index.jsp http://www.depressionprimarycare.org/clinicians/toolkits/materials/
Geriatric Depression Scale (GDS)	Self-report 30-item scale (10–15 min)	Screening for depressive illness in geriatric patients, assessment of severity, and monitoring change with treatment	Yesavage JA et al: Development and validation of a geriatric depression screening scale: a preliminary report. J Psychiatr Res 1982; 17:37–49	Yesavage et al. 1982; APA (2000) *Handbook of Psychiatric Measures*
Young Mania Rating Scale (YMRS)	Clinician-administered 11-item checklist, ranked on a 0–4 or 0–8 scale (15–30 min)	Assessment of the severity of mania and evaluation of changes in manic symptoms with treatment over time	Young RC et al: A rating scale for mania: reliability, validity and sensitivity. Br J Psychiatry 1978; 133:429–435	Young et al 1978; APA (2000) *Handbook of Psychiatric Measures*
Anxiety disorders				
Hamilton Anxiety Rating Scale (HARS)	Clinician-administered 14-item scale, with items ranked 0–5 (15–30 min)	Assessment of the severity of overall anxiety in patients with diagnosed anxiety or depressive disorders and monitoring outcome of treatment	Hamilton M: The assessment of anxiety states by rating. Br J Med Psychol 1959; 32:50–55	Hamilton 1959; Anxiety Disorders Prevention Program, Western Psychiatric Institute and Clinic, 3811 O'Hara Street, Pittsburgh, PA 15213
Yale-Brown Obsessive Compulsive Scale (Y-BOCS)	Clinician-administered semistructured interview (30 min initially)	Assessment of overall obsessive-compulsive disorder severity and monitoring change with treatment	Goodman WK et al: The Yale-Brown Obsessive Compulsive Scale, I: development, use, and reliability. Arch Gen Psychiatry 1989; 46:1006–1011	University of Florida, College of Medicine, Department of Psychiatry, P.O. Box 100256, 1600 SW Archer Road, Gainesville, FL 32610; APA (2000) *Handbook of Psychiatric Measures*

287

TABLE 3. Examples of Clinical Rating Scales *(continued)*

Scale	Administration (Time)	Clinical Use	Reference	Availability
Psychotic disorders				
Brief Psychiatric Rating Scale (BPRS)	Clinician-rated 18-item scale, ranked 1–7 (20–30 min)	Global assessment of response to treatment in patients with moderate to severe psychotic disorders	Overall JE, Gorham DR: The Brief Psychiatric Rating Scale: recent developments in ascertaining and scaling. Psychopharmacol Bull 1988; 24:97–99	Overall and Gorham, http://www.psychrehab.com; APA (2000) *Handbook of Psychiatric Measures*
Positive and Negative Syndrome Scale (PANSS)	Clinician-rated 3-subscale, 5-factor, 30-item scale rated based on information from a structured interview (30–40 min) and informant information	Assessment of severity of common symptoms in patients with schizophrenia and other psychotic disorders, delineation of target symptoms, and monitoring of treatment response	Kay SR et al: Positive and Negative Syndrome Scale (PANSS) Rating Manual. Toronto, ON, Multi-Health Systems, 2000	Multi-Health Systems, Inc., P.O. Box 950, North Tonawanda, NY 14120-0950; ph 800-456-3003; fax 888-540-4484; http://www.mhs. com
Aggression and agitation				
Overt Aggression Scale—Modified (OAS-M)	Clinician-administered 25-item scale with 9 subscales and rating three areas, aggression, irritability, and suicidality (30 min)	Assessment of aggressive behaviors, delineation of target symptoms, and monitoring of change over time	Coccaro E et al: Development of neuropharmacologically based behavioral assessments of impulsive behavior. J Neuropsychiatry Clin Neurosci 1991; 3(suppl): S44–S51	Emil Coccaro, M.D., Department of Psychiatry, Medical College of Pennsylvania, Eastern Pennsylvania Psychiatric Institute, 3200 Henry Avenue, Philadelphia, PA 19129; APA (2000) *Handbook of Psychiatric Measures*

Source. Information in this table was derived from APA's *Handbook of Psychiatric Measures* (118).

same time, these tools vary considerably as to their reliability and validity. Potential cultural, ethnic, gender, social, and age biases are relevant to the selection of standardized interviews and rating scales and the interpretation of their results (119–125). Furthermore, clinical impressions of treatment response should consider the relative importance of specific symptoms to the patient's function and well-being and the relative impact of specific symptoms on the patient's social environment. Consequently, rating scales should never be used alone to establish a diagnosis or clinical treatment plan; they can augment but not supplant the clinician's evaluation, narrative, and clinical judgment (11, 126–129).

For persons with chronic diseases, and particularly those with multiple comorbid conditions, structured assessment of physical and instrumental function may be useful in assessing strengths and disease severity (130). Functional assessments include assessment of physical activities of daily living (e.g., eating, using the toilet, transferring, bathing, and dressing) and instrumental activities of daily living (e.g., driving or using public transportation, taking medication as prescribed, shopping, managing one's own money, keeping house, communicating by mail or telephone, and caring for a child or other dependent) (131, 132). Impairments in these activities can be due to physical or cognitive impairment or to the disruption of purposeful activity by the symptoms of mental illness.

Formal assessment of physical and instrumental activities of daily living may be appropriate for patients who are disabled by old age or by chronic mental illness or general medical conditions. Such assessments facilitate the delineation of the combined effects of multiple illnesses and chronic conditions on patient's lives, and such assessments provide a severity measure that is congruent with patients' and families' experience of disability. In addition, functional assessment facilitates the monitoring of treatment by assessing important beneficial and adverse effects of treatment.

4. Use of diagnostic tests, including psychological and neuropsychological tests

Laboratory tests are included in a psychiatric evaluation when they are necessary to establish or exclude a diagnosis, to aid in the choice of treatment, or to monitor treatment effects or side effects (16, 133–144). When laboratory tests are obtained, relevant test results are documented in the evaluation, with their importance for diagnosis and treatment indicated in the clinical formulation or treatment plan.

Diagnostic tests used during a psychiatric evaluation include those that do the following:

1. Detect or rule out the presence of a disorder or condition that has treatment consequences. Examples include urine screens for substance use disorders, neuropsychological tests to ascertain the presence of a learning disability, and brain imaging tests to ascertain the presence of a structural neurological abnormality.
2. Determine the relative safety and appropriate dose of potential alternative treatments. For example, tests of hematological, thyroid, renal, and cardiac function in a patient with bipolar disorder may be needed to help the clinician choose among available mood-stabilizing medications (145), or evaluation of cardiac or pulmonary function may be important in determining a patient's medical status prior to electroconvulsive therapy (146).
3. Provide baseline measurements before instituting treatment, with subsequent measurements used to assess for effects of treatment. For example, baseline and follow-up electrocardiograms may be required to identify effects of antipsychotic or tricyclic antidepressant medications on cardiac conduction, whereas baseline and follow-up glucose levels and lipid panels may be required to identify effects of second-generation antipsychotic agents.
4. Monitor blood levels of medications when indicated (e.g., for effectiveness, toxicity, or adherence).

Under each of these circumstances, the potential utility of a test will be determined by multiple interrelated factors, including the following:

1. The likelihood that an individual from a population of similar patients (e.g., of similar age, gender, treatment setting) would have the condition. This probability is also referred to as the *prevalence* of the condition in that population. In general, conditions that are more prevalent in the population are more likely to be correctly identified by use of a diagnostic test. In the context of obtaining baseline measurements, the likely prevalence of the condition at a later date may also be relevant.
2. The probabilities that the test will correctly detect a condition that is present (true positive), incorrectly identify a condition as present when it is not (false positive), correctly identify a condition as absent (true negative), or incorrectly identify a condition as absent when it is actually present (false negative). Although information about these probabilities is available for many tests, the key point to consider in clinical practice is that false negative and false positive test results do occur. Furthermore, incorrect identification of a condition can result in unnecessary and potentially detrimental evaluations and interventions; incorrectly viewing a condition as absent can lead to other crucial signs and symptoms of the condition being ignored.
3. The treatment implications of the test results. Obviously, a test will be of benefit if it correctly detects a previously unidentified and treatable condition. However, the treatment implications may be nil if the test correctly detects a condition that is already known to be present on the basis of clinical examination or history or if it correctly detects a benign or incidental condition that leads to further unnecessary testing with no beneficial effect on treatment.

Given the wide range of clinical situations evaluated by psychiatrists, there are no specific guidelines about which tests should be "routinely" done. It is important to have a clear rationale for the ordering of tests (12, 23, 26), and each patient should be considered individually. Nevertheless, some general principles may aid in deciding on particular diagnostic assessments. For example, tests may be ordered on the basis of the setting (e.g., some patients seen in emergency departments may be at increased risk for certain conditions that warrant diagnostic tests), the clinical presentation (e.g., certain tests are warranted for patients with new onset of delirium), or the potential treatments (e.g., patients may need certain tests before initiation of lithium therapy). For tests that require the patient's participation, factors such as language, education level, intelligence, culture, and level of alertness can affect the testing process and may influence the choice of diagnostic approaches. Patient preferences are also important to consider. Furthermore, the potential benefits of identifying and treating a particular condition need to be weighed against the costs (e.g., time, money, physical pain, emotional stress) of indiscriminate testing.

More detail on the use of laboratory testing to aid in diagnosis and to guide treatment is provided in APA practice guidelines for specific disorders. Table 4 provides examples of and general indications for tests that may be indicated depending on the status of the patient.

Neuropsychological testing has a broad range of application, but the decision to order neuropsychological testing for an individual patient remains a matter of clinical judgment (147). Neuropsychological testing may be requested when cognitive deficits are suspected or there is a need to grade for severity or progression of deficits over time. In addition, neuropsychological testing can be helpful in distinguishing between cognitive disorders and malingering or factitious disorders. When patients present later in life with the new onset of psychosis or mood disorder accompanied by cognitive deficits, neuropsychological testing may also be helpful in distinguishing dementia from other psychiatric syndromes. In research studies, typical patterns of cognitive deficits have been identified in a variety of psychiatric disorders, including Alzheimer's disease (148), schizophrenia (149–151), bipolar disorder (152–156), major depressive disorder (157–160), and autism (161, 162). Findings have highlighted the fact that cognitive deficits and associated impairment of social and occupational functioning may persist despite successful treatment of other core symptoms of an illness. For example, executive dysfunction may

TABLE 4. Tests That May Be Indicated as Part of a Psychiatric Evaluation

Test	Notes
Basic laboratory tests (e.g., complete blood count; blood chemistries, including lipid profile, B_{12}, folate; urinalysis)	Used to screen for general medical conditions or provide baseline measures prior to treatment. Recommended frequency of screening may vary with health status and with specific ongoing treatments (e.g., second-generation antipsychotics, lithium).
Medication levels	Used to monitor therapeutic levels of medications.
Pregnancy test	Some psychiatric conditions and treatments may entail risks to a pregnant woman or her fetus.
Fasting blood glucose or hemoglobin A1c	Used to diagnose diabetes or help determine risk. Patients prescribed second-generation antipsychotics may be at increased risk of developing diabetes.
Lyme serology, syphilis serology, HIV test	May assist in evaluation of cognitive and behavioral changes. Individuals with behavioral problems such as impulsivity or drug use may be at increased risk for HIV infection.
Thyroid function tests	May be important for patients with suspected mood disorder, anxiety disorder, or dementia. Used to monitor lithium effects.
Toxicology screen, blood alcohol level	Used to screen for substance use or abuse. Individuals with a mental disorder are at increased risk for substance abuse.
Electrocardiogram	Used to assess effects of medications that may influence cardiac conduction (e.g., tricyclic antidepressants, some antipsychotics). May also be indicated depending on age and health status.
Chest X ray	Used to diagnose cardiopulmonary disorders (e.g., pneumonia, tuberculosis) that may contribute to delirium. May also be part of a pre-ECT evaluation depending on age and health status.
Imaging studies	Structural (e.g., computed tomography [CT], magnetic resonance imaging [MRI]) and functional (e.g., positron emission tomography [PET], single photon emission computed tomography [SPECT], electroencephalogram [EEG], functional magnetic resonance imaging [fMRI]) studies may indicate regional brain abnormalities related to a psychiatric illness and its management.
Lumbar puncture	Used to diagnose central nervous system infection (e.g., meningitis, herpes, toxoplasmosis, syphilis, Lyme disease). May be important for differential diagnosis of delirium.
Polysomnography	Used to diagnose sleep disorders, including sleep apnea. May be important for differential diagnosis of depression, psychosis, or other cognitive or behavioral changes.
Psychological testing	May be requested when cognitive deficits are suspected or there is need to grade for severity or progression of symptoms over time. May also be helpful in establishing a diagnosis (e.g., dementia, mental retardation) or in delineating specific deficits that affect thought processes, treatment, or vocational planning.

persist in otherwise responsive depression (163), and working memory may remain impaired in schizophrenia independent of response of positive and negative symptoms (149, 164). Thus, for some patients, a better understanding of persistent neuropsychological impairments can aid in treatment and vocational planning.

5. Physical examination

An understanding of the patient's general medical condition is important in order to 1) properly assess the patient's psychiatric symptoms and their potential cause, 2) determine the patient's need for general medical care, and 3) choose among psychiatric treatments that can be affected by the patient's general medical status (16, 22, 25, 26, 34, 144, 165, 166). The psychiatrist also ensures that a recent medical workup with appropriate laboratory tests and monitoring is performed. The psychiatrist should be informed about the results of the medical workup and incorporate this information into the evaluation. The psychiatrist's close involvement in the patient's general medical evaluation and ongoing care can also improve the patient's care by promoting cooperation, facilitating follow-up, and permitting prompt reexamination of symptomatic areas when symptoms change.

The physical examination may be performed by the psychiatrist, another physician, or a medically trained clinician. Considerations influencing the decision of whether the psychiatrist will personally perform the physical examination include potential effects on the psychiatrist-patient relationship, the purposes of the evaluation, and the complexity of the medical condition of the patient. The timing, scope, and intensity will vary according to clinical circumstances. For example, the physical examination of an otherwise healthy patient with paranoia, or the genital-rectal examination of a patient with a history of sexual abuse, may be deferred to a more appropriate time and setting.

In most circumstances, the physical examination should be chaperoned. Particular caution is warranted in the physical examination of persons with histories of physical or sexual abuse or with other features that could increase the possibility of the patient's being distressed as a result of the examination (e.g., a patient with an erotic or paranoid transference to the psychiatrist). All but limited examinations of such patients should be chaperoned.

6. Work with multidisciplinary teams

In many settings, it has become commonplace for the care of psychiatric patients to draw on the expertise of multidisciplinary teams. In the evaluation phase of care, other members of the clinical team (e.g., nurses, psychologists, occupational therapists, social workers, case managers, peer counselors, chaplains) may gather data or perform discipline-specific assessments. The psychiatrist responsible for the patient's care reviews and integrates these assessments into the psychiatric evaluation of the patient and works with other members of the multidisciplinary team in developing and implementing a plan of care.

The opportunity to improve systematic observations of patients' behavior by staff is an advantage of controlled settings such as hospitals, partial hospital settings, residential treatment facilities, and other institutions. Several types of observations may be gathered, according to the patient's specific situation:

1. *General observations.* These are relevant to all patients in all settings and include notes on patients' behavior, statements and expressed concerns, cooperativeness with or resistance to staff, sleep/wake patterns, and self-care.
2. *Diagnosis-specific observations.* These are observations relevant to confirming a diagnosis or assessing the severity, complications, or subtype of a disorder. Examples include recording signs of withdrawal in an alcohol-dependent patient and observations during meals for patients with eating disorders.

3. *Patient-specific observations.* These are observations aimed at assessing a clinical hypothesis. An example is observation of behavior following a family meeting for a patient in whom family conflicts are suspected of having contributed to a psychotic relapse.
4. *Observations of response to treatment interventions.* Examples include systematic recording of a target behavior in a trial of behavior therapy, observations of the effects of newly prescribed medications, and nurse-completed rating scales to measure changes after behavioral or psychotherapeutic interventions.

B. THE PROCESS OF ASSESSMENT

The actual assessment process during a psychiatric evaluation usually involves the development of initial impressions and hypotheses during the interview and their continual testing and refinement on the basis of information obtained throughout the interview and from mental status examination, diagnostic testing, and other sources (167).

1. Clinical formulation

The integrative formulation aids in understanding the patient as a unique human being and allows the psychiatrist to appreciate the patient's environment, strengths, challenges, and coping skills. The formulation includes information specific to the patient that goes beyond what is conveyed in the diagnosis; it will vary in scope and depth with the purpose of the evaluation. Components of the formulation include phenomenological, neurobiological, psychological, and sociocultural issues involved in diagnosis and management (60, 168–179). As relevant to each domain, the formulation will typically include a concise synthesis of what is known about the patient (e.g., individual characteristics, genetic predispositions, general medical conditions or laboratory abnormalities, past life experiences and developmental history, extent and quality of interpersonal relationships, central conflicts and defense mechanisms) and the patient's past and current symptomatology (including childhood or subsyndromal illness and predisposing, precipitating, perpetuating, or protecting factors) as well as the responses of symptoms to treatment. Variations in phenomenology with factors such as a patient's age or gender can be relevant in determining whether or not a behavior is indicative of psychopathology (180). Thus, the formulation may also include a discussion of the diagnostic, therapeutic, and prognostic implications of the evaluation findings.

a) Cultural formulation

The DSM-IV-TR Outline for Cultural Formulation (Table 5) provides a systematic method of considering and incorporating sociocultural issues into the clinical formulation (181–185). Depending on the focus and extent of the evaluation, it may not be possible to do a complete cultural formulation based on the findings of the initial interview. However, when cultural issues emerge, they may be explored further during subsequent meetings with the patient. In addition, the information contained within the cultural formulation may be integrated with the other aspects of the clinical formulation or recorded as a separate element.

The cultural formulation begins with a review of the individual's cultural identity and includes the patient's self-construal of identity over time (186). Cultural identity involves not only ethnicity, acculturation/biculturality, and language but also age, gender, socioeconomic status, sexual orientation, religious and spiritual beliefs, disabilities, political orientation, and health literacy, among other factors.

Next, the formulation explores the role of the cultural context in the expression and evaluation of symptoms and dysfunction, including the patient's explanatory models or idioms of distress through which symptoms or needs may be communicated. These are assessed against the norms of the cultural reference group. Treatment experiences and preferences (including complementary and alternative medicine and indigenous approaches) are also identified. Cul-

TABLE 5. Components of a Cultural Formulation

Cultural identity of the individual
Cultural explanations of the individual's illness
Cultural factors related to psychosocial environment and levels of functioning
Cultural elements of the relationship between the individual and the clinician
Overall cultural assessment for diagnosis and care

Source. From DSM-IV-TR, pp. 897–898.

tural factors related to psychosocial stressors, available social supports, and levels of function or disability are also assessed; during this process, the roles of family/kin systems and religion and spirituality in providing emotional, instrumental, and informational support are highlighted.

The cultural formulation also includes specific consideration of cultural elements influencing the relationship between the individual and the clinician. In this regard, it is important for clinicians to cultivate an attitude of "cultural humility" (187) in knowing their limits of knowledge and skills rather than reinforcing potentially damaging stereotypes and overgeneralizations. Differences in language, culture, or social status, as well as difficulties in identifying and understanding the cultural significance of behaviors or symptoms, may add to the complexities of the clinical encounter. Transference and countertransference may also be influenced by cultural considerations and may either aid or interfere with the treatment relationship. Further, the potential effect of the psychiatrist's sociocultural identity on the attitude and behavior of the patient should be taken into account in the subsequent formulation of a diagnostic opinion.

The cultural formulation concludes with an overall assessment of the ways in which these varied cultural considerations will specifically apply to differential diagnosis and treatment planning.

b) Risk assessment

An additional component of the formulation involves an assessment of the patient's risk of harm to self or others. This may include consideration of suicide or homicide risk as well as other forms of self-injury (e.g., cutting behaviors, accidents), aggressive behaviors, neglect of self-care, or neglect of the care of dependents. The risk assessment is intended to identify specific factors that may increase or decrease a patient's degree of risk, thereby suggesting specific interventions that may modify particular risk factors or address the safety of the patient or others. Specific risk factors may include demographic parameters (e.g., age, gender), past behavior (e.g., suicide attempts, self-injury, aggression), psychiatric diagnoses, psychiatric symptoms (e.g., anxiety, hopelessness), co-occurring general medical conditions, sociocultural factors, psychosocial stressors, or individual strengths and vulnerabilities. For patients with suicidal behaviors, this risk assessment process is described in detail in APA's *Practice Guideline for the Assessment and Treatment of Patients With Suicidal Behaviors* (11). Although standardized rating scales of suicidal or aggressive behaviors are often used in research and may suggest helpful lines of clinical inquiry, their utility in clinical risk assessment is limited by their low predictive value (11).

For individuals with dependent children, the risk assessment also includes an evaluation of the patient's capacity to parent. In addition to considering the number and ages of any children, the assessment reviews the patient's capacity to meet the needs of dependent children, both in general and during psychiatric crises if these are likely to occur. The overall health, including mental health, of the children is also relevant, especially when the patient's psychiatric condition is likely to affect the children through genetic or psychosocial mechanisms or to impede the patient's ability to recognize and attend to the needs of a child.

2. Diagnosis

On the basis of information obtained in the evaluation, a differential diagnosis is developed. The differential diagnosis comprises conditions (including personality disorders or personality

traits) described in the *Diagnostic and Statistical Manual of Mental Disorders,* Fourth Edition, Text Revision (DSM-IV-TR) (188), APA's current edition of DSM. A multiaxial system of diagnosis provides a convenient format for organizing and communicating the patient's current clinical status, other factors affecting the clinical situation, the patient's highest level of past functioning, and the patient's quality of life (188, pp. 27–33). General medical conditions are established through history, examination, diagnostic tests, medical records, and consultation.

The DSM classification and the specific diagnostic criteria are meant to serve as guidelines to be informed by clinical judgment in the categorization of the patient's condition(s) and are not meant to be applied in a rote fashion. (Other issues in the use of DSM and its application in developing a psychiatric diagnosis are discussed in DSM-IV-TR, pp. xxiii–xxxv and 1–12.) To augment the DSM multiaxial approach, some clinicians also find it helpful to identify the patient's level of defensive functioning or incorporate dimensional or other approaches into their diagnostic assessments (188, pp. 807–813; 189, 190).

3. Initial treatment plan

The initial treatment plan addresses any specific diagnoses and psychiatric needs of the patient that have been identified during evaluation. If diagnostic or other questions have been posed or additional information is necessary, these issues should be addressed in the treatment plan.

The initial treatment plan begins with a determination of the appropriate treatment setting and includes an explicit statement of the diagnostic, therapeutic, and rehabilitative goals for treatment that includes short-term as well as longer-term goals. In the case of patients who initially will be treated in an inpatient or partial hospital setting, this implies apportioning the therapeutic task between a hospital phase and a posthospital phase. Within the acute care setting, some goals may be targeted for achievement within several days, whereas other goals will be targeted for completion by the time of discharge. On the basis of the goals, the plan specifies further diagnostic tests and procedures, further systematic observations or additional information to be obtained, and specific therapeutic modalities to be applied.

A comprehensive treatment plan addresses biological, psychological, and sociocultural domains. The psychiatrist can select from a range of individual, group, and family therapies to create an integrated multimodal treatment that includes biological and sociocultural interventions (60).

Quality care involves treatment plans that are safe, timely, effective, efficient, equitable (i.e., not influenced in quality by personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status), and person-centered (7). Such treatment plans encourage recovery from illness through community integration and empower patients to make choices that improve their quality of life (191). Thus, the treatment plan is ideally the result of collaboration between the patient, the psychiatrist, and other members of the treatment team as well as the primary care practitioner for patients who have an established source of primary care.

A range of potentially effective treatments is initially considered. More detailed consideration and documentation of the risks and benefits of treatment options may be needed in the following circumstances: when a relatively risky, costly, or unusual treatment is under consideration; when involved parties disagree about the optimal course of treatment; when the patient's motivation or capacity to benefit from potential treatment alternatives is in question; when the treatment would be involuntary or when other legal or administrative issues are involved; or when available treatment options are limited by external constraints (e.g., financial barriers, insurance restrictions, geographic barriers, service availability, the patient's capacity to participate in the proposed treatment). Such considerations are also relevant when considering the level of care needed to provide an individual patient with appropriate treatment. In addition, level-of-care determinations will vary with the diagnosis, the presence of co-occurring general medical or psychiatric disorders (including substance use disorders), the assessment of the patient's risk to self or others, the current severity of symptoms, the patient's prior illness course and complications, his or her psychosocial supports, his or her treatment adherence, and the strength of the thera-

peutic alliance, among other factors. In some circumstances, it is also important for the psychiatrist to be able to recognize the limitation of health care resources and demonstrate the ability to act as an advocate for patients within their sociocultural and financial constraints (60).

4. Decisions regarding treatment-related legal and administrative issues

Although the consideration of forensic evaluations is outside the scope of this practice guideline, there are times when the general psychiatric evaluation may need to address legal or administrative concerns (Section V.C). Examples include deciding between voluntary and involuntary admission, determining whether legally mandated treatment should be pursued in objecting patients, determining whether there is a duty to protect (e.g., by modifying the patient's treatment, increasing outpatient visit frequency, initiating hospitalization, warning the victim) if the patient is deemed a potential risk to others, and deciding on the level of observation needed to address the patient's safety (11). In situations such as these, the psychiatrist's decision making will depend on the risk assessment (Section IV.B.1.b) as well as other relevant aspects of the history, examination, symptoms, diagnosis, and clinical formulation. Assessment of the patient's decision-making capacity may also be needed as part of the informed consent process. When a patient's capacity to consent to treatment is uncertain, questioning to determine mental status should be extended to include items that test the patient's decision-making capacity (192). As with other aspects of the evaluation, it is important to document the rationales for making a particular treatment decision, including a discussion of supporting evidence from the evaluation findings.

5. Systems issues

An assessment of family, peer networks, and other support systems is an important part of the psychiatric evaluation because of the potential role of these systems in ameliorating or augmenting the patient's signs and symptoms of illness. This is particularly true when evaluating individuals with complex biopsychosocial challenges or serious psychiatric or general medical conditions. If the initial evaluation indicates that aspects of the care system have an important role in the patient's illness and treatment, goals are developed in response to these findings. Systems may be more open to considering change at times of crisis. Consequently, as well as generating goals for the patient's diagnosis and individual treatment, the evaluation may lead to goals for intervening with the family, other important people in the patient's life, other professionals (e.g., therapists), general medical providers, and governmental or social agencies (e.g., community mental health centers or family service agencies). Specific plans may be needed for addressing problems in the care system that are seen as important to the patient's illness, symptoms, function, or well-being and that appear amenable to modification. For example, a parent may be unable to attend follow-up appointments unless issues relating to care of dependents are addressed; financial issues or formulary restrictions may preclude patients from obtaining their medications; or geographic constraints may limit access to a full range of treatment options. Plans to address such systems issues should consider feasibility, the patient's wishes, and the willingness of other people to be involved.

V. SPECIAL CONSIDERATIONS

A. PRIVACY AND CONFIDENTIALITY

Considerations of privacy and confidentiality are an integral component of any psychiatric encounter. Aspects of privacy and confidentiality relating to communication with other medical

professionals and with sources of collateral information have been discussed above (Sections I.A, I.B, II.C, and IV.A.2). In general, the default position is to maintain confidentiality unless the patient gives consent to a specific intervention or communication. However, the psychiatrist is justified in attenuating confidentiality to the extent needed to address the safety of the patient and others (10, 11). This includes the ability to communicate necessary information about the patient to medical personnel in the context of an emergency situation. It is also permissible for the psychiatrist to listen to information provided by family members and other important people in the patient's life, as long as confidential information is not provided to the informant.

The Health Insurance Portability and Accountability Act (HIPAA) contains guidelines for release of the results of psychiatric evaluations. State laws may be more restrictive, and if so, state laws take precedence over HIPAA. According to HIPAA, information can be released without a specific consent form for purposes of "treatment, payment, and health care operations." Otherwise, patients must sign an authorization form that indicates the information to be used or disclosed, the purposes to which it will be put, the recipient of the information, and an expiration date. HIPAA gives special protection to psychotherapy notes if they are kept in a separate part of the medical chart (193, 194). The interpretation of HIPAA and other federal and state laws about confidentiality continues to evolve, and legal or risk management consultation should be sought if there are questions about the regulations related to release of information and protection of psychiatric records (195).

For individuals in treatment for substance use disorders, the provisions of 42 CFR §2.11 will apply (196) and will generally be more strict and supersede the provisions of HIPAA (197). As with HIPAA, necessary information may be disclosed to medical personnel in the context of treating a condition that poses an immediate threat to the health of any individual and that requires immediate medical intervention. Under such circumstances, documentation in the medical record needs to include "the name of the medical personnel to whom disclosure was made and their affiliation with any health care facility; the name of the individual making the disclosure; the date and time of the disclosure; and the nature of the emergency" (42 CFR §2.51 [196]).

Medical records may also be viewed by others in addition to the clinician writing the note (198) or other members of an interdisciplinary treatment team. These include third-party payers, quality assurance/peer review evaluators, the patient, and, in certain jurisdictions, the executor of an estate after a patient's death. Furthermore, records may be part of future or current legal or administrative hearings, including disability litigation, divorce and custody adjudication, competency determinations, and actions of medical licensing boards. Such accessing of patient's medical records needs to be taken into consideration when documenting the evaluation, formulation, diagnosis, and plan of treatment.

B. INTERACTIONS WITH THIRD-PARTY PAYERS AND THEIR AGENTS

Third-party payers and their agents frequently request data from psychiatric evaluations to make determinations about whether a hospital admission or a specific treatment modality will be covered by a particular insurance plan. Despite the blanket consents to release information to payers that most patients must sign to obtain insurance benefits, it is useful for the psychiatrist to obtain, whenever feasible, contemporaneous consent for such communications. In some instances, it may be necessary to inform the patient what specific information has been requested and obtain specific consent for the release of that information. With valid consent, the psychiatrist may release information to a third-party reviewer, supplying the third-party reviewer with sufficient information to understand the rationale for the treatment and why it was selected over potential alternatives. However, the psychiatrist may also withhold information about the patient not directly relevant to the utilization review or preauthorization decision (199, 200).

C. LEGAL AND ADMINISTRATIVE ISSUES IN INSTITUTIONS

When a patient is admitted to a hospital or other residential setting, the patient's legal status should be promptly clarified to establish whether the admission is voluntary or involuntary, whether the patient gives or withholds consent to evaluation and recommended treatment, whether the patient appears able to make treatment-related decisions, and whether an advance directive is in place. If there is a potential legal impediment to necessary treatment, action should be taken to resolve the issue.

The decision to hospitalize a patient involuntarily will depend on multiple factors, including the estimated level of risk to the patient and others, the patient's level of insight and willingness to seek care, and the legal criteria in that jurisdiction. In general, patients at risk for causing harm to themselves or others will satisfy the criteria for involuntary admission; however, the specific requirements vary from state to state (201), and in some states, willingness to enter a hospital voluntarily may preclude involuntary admission. To that end, psychiatrists need to be familiar with their specific state statutes regarding involuntary hospitalization.

Advance directives are attempts to ensure that individuals' wishes about treatment will be honored. Such directives may relate to wishes about treatment at the end of life (202) but may also relate to wishes about psychiatric treatment (203) or assignment of a durable power of attorney or health care proxy to make decisions in the event that the individual lacks capacity to do so (204). Although the specifics of advance directive regulations vary by jurisdiction, psychiatrists should include in their evaluation whether the patient has executed an advance directive—and, if so, the nature of the advance directive should be determined.

In every institution, whether public or private, fiscal and administrative considerations limit treatment options. Usually there are constraints on length of stay and on the intensity of services available. Further constraints can arise from the absence or inadequate funding of aftercare services or of a full continuum of care. The initial assessment of treatment needs should not be confounded unduly with concerns about financing or availability of services, although the actual treatment may represent a balancing of optimal treatment and external constraints. A common example is the situation in which a patient's safety requires a level of supervision not available in a given facility. Another example is when a patient requires a general medical evaluation that cannot be carried out in a free-standing psychiatric facility and requires the patient's transfer to a general hospital. If such issues result in a major negative effect on patient care, efforts should be made to find alternatives, and the patient, family, and/or third-party payer should be informed of the limitations of the current treatment setting and/or resources.

D. SPECIAL POPULATIONS

1. Elderly patients and patients with medical conditions

While advanced chronological age alone does not necessitate a change in the approach to the psychiatric evaluation, the strong association of old age with chronic disease and related impairments may increase the need for emphasis on certain aspects of the evaluation. The general medical history and evaluation, cognitive mental status examination, and functional assessment may need to be especially detailed because of the high prevalence of disease-related disability, use of multiple medications, cognitive impairment, and functional impairment in older people. The psychiatrist should attempt to identify all of the general medical and personal care clinicians involved with the patient and to obtain relevant information from them if the patient consents. It is also helpful to obtain information from the family.

The personal and social history includes coverage of common late-life issues, including the loss of a spouse or partner, the loss of friends or close relatives, residential moves, the new onset of disabilities, financial concerns related to illness or disability, and intergenerational issues,

such as informal caregiving or financial transfers between members of different generations. It is important to evaluate intergenerational strains such as midlife couples with young children who cannot care for elderly relatives or, increasingly, patients in their 90s whose children are now in their 70s and ill themselves.

The psychiatrist may need to accommodate the evaluation to patients who cannot hear adequately. Use of sign language interpreters, amplification, a quieter interview room, and enabling lip reading are possible means to do this. When an elderly patient is brought for psychiatric evaluation by a family member, special effort may be necessary to ensure that both patient and family member have an opportunity to talk to the psychiatrist alone.

2. Incarcerated Persons

Increasing numbers of individuals with mental illness are incarcerated in jails, prisons, and other correctional facilities and require psychiatric evaluation (205–208). In addition, suicide is one of the leading causes of death in correctional settings, and urgent suicide assessments may be needed for individuals at risk (11, 209, 210).

The psychiatric evaluation of incarcerated individuals will include the general elements common to any psychiatric evaluation (211–213) but will place additional emphasis on aspects of the individual's alcohol and substance use history and legal history, including previous episodes of incarceration and associated behavioral changes. Psychosocial stressors, including new legal complications (e.g., denial of parole), receiving bad news about loved ones at home, and experiencing sexual assault or other trauma, are also important to assess, as these may increase the likelihood of suicidal behaviors (214). Similarly, the recentness of the incarceration (210, 214, 215) or placement in isolation (216–219) may be relevant to determination of suicide risk. Depending on the likely duration of incarceration, options for care following transfer between correctional institutions or for aftercare following release may also need to be explored as part of the evaluation.

Access to space that allows for auditory privacy and physical safety is necessary to adequately perform psychiatric evaluations in correctional settings (212).

3. Homeless persons

Evaluations of persons who are homeless may require both modifications of the evaluation process and unique interviewing skills. The disengaged lifestyle and mistrust often encountered in homeless persons may make a classically direct approach difficult if not impossible (220). As a result, the first step toward psychiatric evaluation is engagement. This process can take from days to years in nonclinical settings (e.g., on the street, under bridges, in shelters). Evaluation becomes possible when the homeless person believes that engaging with the psychiatrist will not recapitulate previous negative experiences, lost opportunities within the health care system, and encounters in jail and prison that heighten a fear of consequences from talking honestly. By necessity, then, the full psychiatric evaluation of homeless persons typically unfolds over numerous, often brief, and seemingly casual interactions.

4. Persons with mental retardation

The evaluation of individuals with mental retardation presents a number of clinical challenges. Although psychiatric illnesses occur at increased rates in those with mental retardation (221, 222), it is not always possible to establish a definitive axis I diagnosis as a cause for behavioral symptoms (223). Depending on the extent of the patient's intellectual limitations, the diagnosis of mental retardation may have been unrecognized before the behavioral symptoms began.

In interviewing individuals with mental retardation, particular attention needs to be given to the phrasing of questions so that they will be understandable to the patient. The use of general psychiatric self-report scales or other structured interview formats may be problematic in this

regard (221, 224). Behavioral observations or functional measures will often carry a greater weight in the assessment process, and patients with more severe mental retardation may be unable to report on their own mental experiences (225, 226). Thus, obtaining a comprehensive description of symptoms, signs, and aspects of history from family members, caretakers, and other professionals is often crucial. This is particularly true when persons with mental retardation present for evaluation in the context of a behavioral crisis, because otherwise minor events (e.g., changes in routine, upsetting interpersonal interactions) may be quite distressing and result in catastrophic reactions. Similar issues with evaluation may be observed in individuals with other developmental disabilities.

Evaluation for co-occurring general medical conditions is particularly important in adults with mental retardation, given higher rates of undetected medical illnesses (222, 227) as well as the tendency for atypical clinical presentations of medical illnesses (140, 227).

VI. FUTURE RESEARCH NEEDS

Psychiatric evaluation is, by necessity, highly individualized to the patient and to the treatment setting, making the development of rigorous research designs challenging. Nonetheless, a number of aspects of psychiatric interviewing and assessment may lend themselves to formal study and are discussed in further detail below. In addition, the research agenda for DSM-V (228) provides suggestions for research relating to psychiatric diagnosis, which has many areas of overlap with research on psychiatric assessment.

A. INTERVIEWING APPROACHES

Some research, predominantly conducted in primary care settings, has examined the differences between specific interviewing approaches. For example, approaches to enhancing reporting and recall of historical information have been evaluated (229, 230). Additional studies have assessed the effects of communication style and vocabulary on outcomes such as patient satisfaction (231–236). The development of new evaluation strategies could help strengthen psychiatric interviewing approaches. In addition, it will be important to expand such research across different patient subgroups (e.g., according to age, gender, sexual orientation, race, ethnicity, cultural background), to individuals with psychiatric disorders, and to collaborative models of assessment and care. Measures of outcomes will also need to be expanded to include factors such as treatment adherence and the strength of the therapeutic alliance. Furthermore, studies will need to assess whether guideline-concordant approaches to assessment are associated with improved outcomes in community-based patient samples (237).

Research has also focused on the impact of technology on information gathering and the physician-patient encounter. For example, some studies have examined differences in the information elicited by face-to-face interviews as compared with computer-aided assessments or telephone interviews (238, 239). Other studies have assessed computerized documentation by physicians at the time of evaluation and its effect on patient perceptions (240–242). Patients and family members are increasingly learning about possible diagnoses and treatments through direct-to-consumer advertising and through Internet-based educational resources, which they sometimes bring to the evaluation. Systematic study of the influences of these information sources on the assessment and treatment planning processes would be useful. It also remains unclear whether use of template-based electronic health records as compared with narrative-based health records will influence the evaluation process, the physician-patient relationship, or communi-

cation with other members of the health care team. Thus, with the increasing use of technology in medicine, including computer-based interviews and telepsychiatry, the influence of such technologies is worthy of additional study in the full range of psychiatric settings.

B. RATING SCALES

Although rating scales have been widely used in clinical research for assessment by the clinician and self-assessment, they are less often incorporated into psychiatric evaluations in clinical practice. To be most useful, rating scales need to be valid and reliable as well as demonstrate practical utility in typical clinical settings. Further study of clinical rating scales is required in clinical samples including patients with potentially confounding co-occurring disorders (243). Development and testing of rating scales also need to consider the different requirements for rating scales that are used in initial diagnostic assessments as compared with those used in monitoring of signs and symptoms over time or with treatment. The ability to use rating scales to detect prodromal or subsyndromal disorders as part of the psychiatric evaluation would be an important step in the design and testing of preventive approaches to psychiatric disorders. Ideally, research on rating scales could lead to the development of a limited set of formal systematic measures for screening and monitoring, with resulting benefits in identification and treatment of common psychiatric disorders, including substance use disorders.

C. DIAGNOSIS AND FORMULATION

An integral part of the psychiatric evaluation is the process by which the information gathered as part of the psychiatric evaluation is synthesized and integrated into the development of a multiaxial diagnosis and biopsychosocial formulation. In addition to research on the validity and reliability of specific diagnoses, further research is needed on variations in both clinical and community presentations across different patient subgroups (e.g., according to age, gender, sexual orientation, race, ethnicity, cultural background) and in the presence of co-occurring general medical and psychiatric conditions. It is anticipated that the development of DSM-V will stimulate such research across many diagnostic areas, guided by APA's systematic efforts to review existing data and provide agendas for new research (228). With the advent of electronic health records and the increasing availability of decision-support tools, computerized approaches that may permit development of differential diagnoses or formulations will need to be compared to clinician-generated assessments. Longitudinal research on the reliability and validity of approaches to the clinical formulation may aid in fine-tuning this aspect of assessment.

D. DIAGNOSTIC TESTING

With regard to diagnostic testing, neurogenetics and structural and functional neuroimaging techniques are areas of active and promising research. A burgeoning body of literature has reported associations between genetic markers (e.g., apoplipoprotein E ε4 allele, dopamine D_4 allele, catechol-*O*-methyltransferase polymorphisms, promoter polymorphisms of the serotonin transporter gene) and the presence of psychiatric illnesses or symptoms (244–251). Neurogenetic approaches may ultimately be useful in distinguishing between genetic and environmental etiologies of psychiatric disorders as part of the psychiatric evaluation (252), thereby permitting greater specificity in treatment planning and outcome measurement. While some have speculated that characterization of the particular genotype of a patient will lead to "personalized medicine" by guiding treatment choices, significant support for such therapeutic guidance in psychiatric disorders is not yet substantiated by the literature. The potential for progress in this area merits continued vigilance for reports of its impact on the practice of psychiatry.

Neuroimaging techniques are currently used in identifying central nervous system processes such as infection, malformations, cerebrovascular events, and malignancy. Accumulating evidence also suggests other applications of neuroimaging in psychiatric evaluation. In cognitive disorders of late life, such as Alzheimer's disease, neuroimaging techniques have been evaluated for use as surrogate markers for the microscopic neuropathologies that characterize the illness (253–256). Functional neuroimaging with positron emission tomography or single-photon emission computed tomography has demonstrated an association between reduced regional activity (metabolism or perfusion) in temporoparietal regions and the presence and severity of Alzheimer's disease (257–264), whereas other dementing illnesses do not show this temporoparietal feature. The reproducibility of these findings has enhanced the differentiation between Alzheimer's disease and other dementing illnesses (265). Ongoing work aims to confirm the clinical utility of such information.

In patients with schizophrenia and mood and anxiety disorders, structural and functional neuroimaging studies have reported differences between patients and healthy control persons (266–288) as well as differences in some patient subgroups (289–292) and in responders and nonresponders to some treatments (293–302). Nevertheless, the clinical utility of neuroimaging techniques for planning of individualized treatment has not yet been shown. Further research is needed to demonstrate a clinical role for structural and functional neuroimaging in establishing psychiatric diagnoses, monitoring illness progression, and predicting prognoses.

INDIVIDUALS AND ORGANIZATIONS THAT SUBMITTED COMMENTS

Norman Abeles, Ph.D.
Renato D. Alarcon, M.D., M.P.H.
Mark A. Amdur, M.D.
Kamal Artin, M.D.
David Baron, M.S.Ed., D.O.
Carl C. Bell, M.D.
David W. Brook, M.D.
Beth Ann Brooks, M.D.
Karen Broquet, M.D.
R.W. Burgoyne, M.D., Ph.D.
Gabrielle A. Carlson, M.D.
Mitchell J.M. Cohen, M.D.
Paul D. Cox, M.D., C.G.P.
Larry Culpepper, M.D., M.P.H.
Glenn Currier, M.D., M.P.H.
David L. Cutler, M.D.
Sarah DeMichele, M.D.
William R. Dubin, M.D.
Michael A. Fauman, M.D., Ph.D.
Joel Feiner, M.D.
Paul Jay Fink, M.D.
Peter Forster, M.D.
K.W.M. Fulford, D.Phil., F.R.C.P., F.R.C.Psych.
Paulette Marie Gillig, M.D., Ph.D.
Leslie H. Gise, M.D.
Sir David Goldberg, M.D.
Lawrence S. Gross, M.D.
Douglas G. Jacobs, M.D.
Douglas A. Kalunian, M.D.
Elisabeth J.S. Kunkel, M.D.
Ira Lesser, M.D.
James W. Lomax, M.D.
Henry Mallard, M.D.
David Mallott, M.D.
Marlin R. Mattson, M.D.
Peter McGeorge, M.D. M.B.Ch.B., F.R.A.N.Z.C.P.
Hunter L. McQuistion, M.D.
Jeffrey L. Metzner, M.D.
Kenneth Minkoff, M.D.
Mark Munetz, M.D.

Marvin Nierenberg, M.D.
Ann E. Norwood, M.D.
Lewis A. Opler, M.D., Ph.D.
John Peteet, M.D.
Herbert S. Peyser, M.D.
Harold Alan Pincus, M.D.
Henry Pinsker, M.D.
Brian Robertson, M.D.
Barbara R. Rosenfeld, M.D.
Barry W. Rovner, M.D.
M. David Rudd, Ph.D., A.B.P.P.
John Z. Sadler, M.D.
Warren Seides, M.D.
Michael Serby, M.D.
Joel J. Silverman, M.D.
Robert Stern, M.D., Ph.D.
Nada Stotland, M.D., M.P.H.
Jeffrey Stovall, M.D.
Paula T. Trzepacz, M.D.
Mitchell G. Weiss, M.D., Ph.D.
Cindy Wigg, M.D.
Bonnie Zima, M.D., M.P.H.
Mark Zimmerman, M.D.
Sidney Zisook, M.D.

Academy of Psychosomatic Medicine
American Academy of Addiction Psychiatry
American Academy of Clinical Psychiatrists
American Academy of Family Physicians
American Association for Emergency Psychiatry
American Association of Directors of Psychiatric Residency Training
American Association of Suicidology
American Group Psychotherapy Association
Association for Academic Psychiatry
Association for Behavioral and Cognitive Therapies
Group for the Advancement of Psychiatry
National Institute of Mental Health
Royal College of Psychiatrists
World Federation for Mental Health

REFERENCES

The following coding system is used to indicate the nature of the supporting evidence in the summary recommendations and references:

[A] *Double-blind, randomized clinical trial.* A study of an intervention in which subjects are prospectively followed over time; there are treatment and control groups; subjects are randomly assigned to the two groups; both the subjects and the investigators are blind to the assignments.

[A–] *Randomized clinical trial.* Same as above but not double-blind.

[B] *Clinical trial.* A prospective study in which an intervention is made and the results of that intervention are tracked longitudinally; study does not meet standards for a randomized clinical trial.

[C] *Cohort or longitudinal study.* A study in which subjects are prospectively followed over time without any specific intervention.

[D] *Control study.* A study in which a group of patients and a group of control subjects are identified in the present and information about them is pursued retrospectively or backward in time.

[E] *Review with secondary data analysis.* A structured analytic review of existing data, e.g., a meta-analysis or a decision analysis.

[F] *Review.* A qualitative review and discussion of previously published literature without a quantitative synthesis of the data.

[G] *Other.* Textbooks, expert opinion, case reports, and other reports not included above.

1. Othmer E, Othmer SC: The Clinical Interview Using DSM-IV-TR, vol 1: Fundamentals. Washington, DC, American Psychiatric Publishing, 2002 [G]
2. Shea SC: Psychiatric Interviewing, the Art of Understanding: A Practical Guide for Psychiatrists, Psychologists, Counselors, Social Workers, Nurses, and Other Mental Health Professionals, 2nd ed. Philadelphia, WB Saunders, 1998 [G]
3. Carlat DJ: The Psychiatric Interview: A Practical Guide. Philadelphia, Lippincott Williams & Wilkins, 1999 [G]
4. Pridmore S: Psychiatric Interview: A Guide to History Taking and the Mental State Examination. New York, Taylor & Francis, 2000 [G]
5. Hales RE, Yudofsky SC: The American Psychiatric Publishing Textbook of Clinical Psychiatry, 4th ed. Washington, DC, American Psychiatric Publishing, 2005 [G]
6. Sadock BJ, Sadock VA (eds): Kaplan and Sadock's Comprehensive Textbook of Psychiatry, 8th ed, vol 1 and 2. Philadelphia, Lippincott Williams & Wilkins, 2005 [G]
7. Institute of Medicine: Crossing the Quality Chasm: A New Health System for the 21st Century. Washington, DC, National Academy Press, 2001 [G]
8. Margulies A, Havens LL: The initial encounter: what to do first? Am J Psychiatry 1981; 138:421–428 [F]
9. Morrison J: The First Interview: Revised for DSM-IV, revised ed. New York, Guilford, 1994 [G]
10. American Psychiatric Association: The Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry. Washington, DC, American Psychiatric Association, 2001 [G]
11. American Psychiatric Association: Practice guideline for the assessment and treatment of patients with suicidal behaviors. Am J Psychiatry 2003; 160(Nov suppl) [G]
12. Currier GW, Allen MH, Serper MR, Trenton AJ, Copersino ML: Medical, psychiatric, and cognitive assessment in the psychiatric emergency service, in Emergency Psychiatry. Edited by Allen MH. Washington, DC, American Psychiatric Publishing, 2002, pp 35–74 [G]
13. Slaby AE, Dubin WR, Baron DA: Other psychiatric emergencies, in Kaplan and Sadock's Comprehensive Textbook of Psychiatry, 8th ed. Edited by Sadock BJ, Sadock VA. Philadelphia, Lippincott Williams & Wilkins, 2005, pp 2453–2471 [G]
14. Hillard R, Zitek B: Emergency Psychiatry. New York, McGraw-Hill Medical, 2004 [G]
15. Petit JR: Handbook of Emergency Psychiatry. Philadelphia, Lippincott Williams & Wilkins, 2004 [G]
16. Reeves RR, Pendarvis EJ, Kimble R: Unrecognized medical emergencies admitted to psychiatric units. Am J Emerg Med 2000; 18:390–393 [G]
17. White AJ, Barraclough B: Thyroid disease and mental illness: a study of thyroid disease in psychiatric admissions. J Psychosom Res 1988; 32:99–106 [G]
18. Allen MH, Currier GW: Medical assessment in the psychiatric emergency service. New Dir Ment Health Serv 1999; 82:21–28 [G]
19. Williams ER, Shepherd SM: Medical clearance of psychiatric patients. Emerg Med Clin North Am 2000; 18:185–198 [F]
20. Schiller MJ, Shumway M, Batki SL: Utility of routine drug screening in a psychiatric emergency setting. Psychiatr Serv 2000; 51:474–478 [G]
21. Perrone J, De Roos F, Jayaraman S, Hollander JE: Drug screening versus history in detection of substance use in ED psychiatric patients. Am J Emerg Med 2001; 19:49–51 [G]
22. Olshaker JS, Browne B, Jerrard DA, Prendergast H, Stair TO: Medical clearance and screening of psychiatric patients in the emergency department. Acad Emerg Med 1997; 4:124–128 [G]

23. Korn CS, Currier GW, Henderson SO: "Medical clearance" of psychiatric patients without medical complaints in the Emergency Department. J Emerg Med 2000; 18:173–176 [G]
24. Kanich W, Brady WJ, Huff JS, Perron AD, Holstege C, Lindbeck G, Carter CT: Altered mental status: evaluation and etiology in the ED. Am J Emerg Med 2002; 20:613–617 [G]
25. Henneman PL, Mendoza R, Lewis RJ: Prospective evaluation of emergency department medical clearance. Ann Emerg Med 1994; 24:672–677 [G]
26. Gregory RJ, Nihalani ND, Rodriguez E: Medical screening in the emergency department for psychiatric admissions: a procedural analysis. Gen Hosp Psychiatry 2004; 26:405–410 [F]
27. Elie M, Rousseau F, Cole M, Primeau F, McCusker J, Bellavance F: Prevalence and detection of delirium in elderly emergency department patients. CMAJ 2000; 163:977–981 [G]
28. Weissberg MP: Emergency room medical clearance: an educational problem. Am J Psychiatry 1979; 136:787–790 [F]
29. Tintinalli JE, Peacock FW, Wright MA: Emergency medical evaluation of psychiatric patients. Ann Emerg Med 1994; 23:859–862 [G]
30. Riba M, Hale M: Medical clearance: fact or fiction in the hospital emergency room. Psychosomatics 1990; 31:400–404 [G]
31. Zun LS, Hernandez R, Thompson R, Downey L: Comparison of EPs' and psychiatrists' laboratory assessment of psychiatric patients. Am J Emerg Med 2004; 22:175–180 [G]
32. Broderick KB, Lerner EB, McCourt JD, Fraser E, Salerno K: Emergency physician practices and requirements regarding the medical screening examination of psychiatric patients. Acad Emerg Med 2002; 9:88–92 [G]
33. Hall RC, Gardner ER, Popkin MK, Lecann AF, Stickney SK: Unrecognized physical illness prompting psychiatric admission: a prospective study. Am J Psychiatry 1981; 138:629–635 [C]
34. Anfinson TJ, Stoudemire A: Laboratory and neuroendocrine assessment in medical-psychiatric patients, in Psychiatric Care of the Medical Patient, 2nd ed. Edited by Stoudemire A, Fogel BS, Greenberg DB. New York, Oxford University Press, 2000, pp 119–148 [F]
35. Meyers J, Stein S: The psychiatric interview in the emergency department. Emerg Med Clin North Am 2000; 18:173–183 [G]
36. Garrick TR, Stotland NL: How to write a psychiatric consultation. Am J Psychiatry 1982; 139:849–855 [G]
37. Karasu TB, Plutchik R, Conte H, Siegel B, Steinmuller R, Rosenbaum M: What do physicians want from a psychiatric consultation service? Compr Psychiatry 1977; 18:73–81 [C]
38. Group for the Advancement of Psychiatry: The Mental Health Professional and the Legal System: Report 131. New York, Brunner/Mazel, 1991 [F]
39. Gutheil TG, Appelbaum PS: Clinical Handbook of Psychiatry and the Law, 3rd ed. Baltimore, Lippincott Williams & Wilkins, 2000 [G]
40. Sederer LI: Brief hospitalization, in American Psychiatric Press Review of Psychiatry, vol 11. Edited by Tasman A, Riba MB. Washington, DC, American Psychiatric Press, 1992, pp 518–534 [G]
41. Sederer LI, Rothschild AJ (eds): Acute Care Psychiatry: Diagnosis and Treatment. Philadelphia, Lippincott Williams & Wilkins, 1997 [G]
42. George L, Durbin J, Sheldon T, Goering P: Patient and contextual factors related to the decision to hospitalize patients from emergency psychiatric services. Psychiatr Serv 2002; 53:1586–1591 [G]
43. Rolland JS: Families, Illness, and Disability: An Integrative Treatment Model. New York, Basic Books, 1994 [G]
44. Redelmeier DA, Schull MJ, Hux JE, Tu JV, Ferris LE: Problems for clinical judgement, 1: eliciting an insightful history of present illness. CMAJ 2001; 164:647–651 [F]

45. Bronheim HE, Fulop G, Kunkel EJ, Muskin PR, Schindler BA, Yates WR, Shaw R, Steiner H, Stern TA, Stoudemire A (Academy of Psychosomatic Medicine): The Academy of Psychosomatic Medicine practice guidelines for psychiatric consultation in the general medical setting. Psychosomatics 1998; 39(suppl 4):S8–S30 [G]
46. Posternak MA, Zimmerman M: How accurate are patients in reporting their antidepressant treatment history? J Affect Disord 2003; 75:115–124 [G]
47. Greenfield SF, Hennessy G: Assessment of the patient, in Textbook of Substance Abuse Treatment. Edited by Galanter M, Kleber HD. Washington, DC, American Psychiatric Publishing, 2004, pp 101–119 [G]
48. Center for Substance Abuse Treatment: Substance Abuse Treatment for Persons With Co-occurring Disorders. Treatment Improvement Protocol (TIP) Series No 42. DHHS Publ No (SMA) 05-3922. Rockville, Md, Substance Abuse and Mental Health Services Administration, 2005. http://www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat5.chapter.7073 [G]
49. American Psychiatric Association: Practice guideline for the treatment of patients with substance use disorders (second edition). Am J Psychiatry (in press) [G]
50. Yates WR, Gleason O: Hepatitis C and depression. Depress Anxiety 1998; 7:188–193 [G]
51. Redelmeier DA, Tu JV, Schull MJ, Ferris LE, Hux JE: Problems for clinical judgement, 2: obtaining a reliable past medical history. CMAJ 2001; 164:809–813 [F]
52. Loewenstein RJ: An office mental status examination for complex chronic dissociative symptoms and multiple personality disorder. Psychiatr Clin North Am 1991; 14:567–604 [G]
53. Herman JL: Trauma and Recovery. New York, Basic Books, 1992 [G]
54. Group for the Advancement of Psychiatry: A Guide to the Assessment of Sexual Function. Washington, DC, American Psychiatric Press, 2001. http://www.groupadpsych.org/pdf%20files/Gapbook%20April%202001.pdf [G]
55. Ursano RJ, Bell C, Eth S, et al: Practice guideline for the treatment of patients with acute stress disorder and posttraumatic stress disorder. Am J Psychiatry 2004; 161(11 suppl):3–31 [G]
56. Rey JM, Stewart GW, Plapp JM, Bashir MR, Richards IN: Validity of axis V of DSM-III and other measures of adaptive functioning. Acta Psychiatr Scand 1988; 77:535–542 [C]
57. Sohlberg S: There's more in a number than you think: new validity data for the Global Assessment Scale. Psychol Rep 1989; 64:455–461 [F]
58. Harder DW, Strauss JS, Greenwald DF, Kokes RF, Ritzler BA, Gift TE: Predictors of outcome among adult psychiatric first admissions. J Clin Psychol 1992; 46:119–128 [C]
59. Galanter M: Spirituality and the Healthy Mind: Science, Therapy and the Need for Personal Meaning. New York, Oxford University Press, 2005 [G]
60. Scheiber S, Kramer T, Adamowski S (eds): Core Competencies for Psychiatric Practice: What Clinicians Need to Know. A Report of the American Board of Psychiatry and Neurology, Inc. Washington, DC, American Psychiatric Publishing, 2003 [G]
61. Politi BJ, Arena VC, Schwerha J, Sussman N: Occupational medical history taking: how are today's physicians doing? a cross-sectional investigation of the frequency of occupational history taking by physicians in a major US teaching center. J Occup Environ Med 2004; 46:550–555 [G]
62. MacDonald-Wilson K, Rogers ES, Anthony WA: Unique issues in assessing work function among individuals with psychiatric disabilities. J Occup Rehabil 2001; 11:217–232 [F]
63. Anthony WA, Rogers ES, Cohen M, Davies RR: Relationships between psychiatric symptomatology, work skills, and future vocational performance. Psychiatr Serv 1995; 46:353–358 [B]
64. Mueser KT, Becker DR, Torrey WC, Xie H, Bond GR, Drake RE, Dain BJ: Work and nonvocational domains of functioning in persons with severe mental illness: a longitudinal analysis. J Nerv Ment Dis 1997; 185:419–426 [B]

65. Metzner JL: An introduction to correctional psychiatry, part II. J Am Acad Psychiatry Law 1997; 25:571–579 [G]
66. Metzner JL, Buck JB: Psychiatric disability determinations and personal injury litigation, in Principles in Practice of Forensic Psychiatry. Edited by Rosner R. London, Arnold, 2003, pp 260–272 [G]
67. Bennett R: The Practical Guide to the Genetic Family History. New York, Wiley-Liss, 1999 [G]
68. American Medical Association: Family Medical History Pocket Information Card, 2004. http://www.ama-assn.org/ama1/pub/upload/mm/464/family_insert02.pdf [G]
69. American Society of Human Genetics: To Draw Your Family Tree, 2005. http://www.ashg.org/genetics/ashg/educ/007a.shtml [G]
70. March of Dimes: Genetics and Your Practice, 2005. http://www.marchofdimes.com/gyponline/index.bm2 [G]
71. Trzepacz PJ, Baker RW: The Psychiatric Mental Status Examination. New York, Oxford University Press, 1993 [G]
72. Reeves RR, Bullen JA: A standardized form for DSM-IV review of symptoms and mental status examination for students and residents. J Am Osteopath Assoc 1995; 95:381–387 [G]
73. Serby M: Psychiatric resident conceptualizations of mood and affect within the mental status examination. Am J Psychiatry 2003; 160:1527–1529 [G]
74. Tardiff K: The current state of psychiatry in the treatment of violent patients. Arch Gen Psychiatry 1992; 49:493–499 [G]
75. Hughes DH: Suicide and violence assessment in psychiatry. Gen Hosp Psychiatry 1996; 18:416–421 [F]
76. Shea SC: The chronological assessment of suicide events: a practical interviewing strategy for the elicitation of suicidal ideation. J Clin Psychiatry 1998; 59(suppl 20):58–72 [F]
77. Twemlow SW: Interviewing violent patients. Bull Menninger Clin 2001; 65:503–521 [F]
78. Tardiff K: Concise Guide to Assessment and Management of Violent Patients, 2nd ed. Washington, DC, American Psychiatric Press, 1996 [G]
79. Chiles JA, Strosahl KD: Clinical Manual for Assessment and Treatment of Suicidal Patients. Washington, DC, American Psychiatric Publishing, 2005 [G]
80. Prochaska J, DiClemente C: The Transtheoretical Approach: Crossing Traditional Boundaries of Therapy. Homewood, IL, Dow Jones-Irwin, 1984 [G]
81. Prochaska J, DiClemente C: Stages of Change in the Modification of Problem Behaviors. Newbury Park, CA, Sage, 1992 [G]
82. Prochaska JO, Velicer WF: The transtheoretical model of health behavior change. Am J Health Promot 1997; 12:38–48 [F]
83. Littell JH, Girvin H: Stages of change: a critique. Behav Modif 2002; 26:223–273 [E]
84. Miller WR, Rollnick S, Conforti K: Motivational Interviewing: Preparing People for Change, 2nd ed. New York, Guilford, 2002 [G]
85. Finnell DS: Use of the Transtheoretical model for individuals with co-occurring disorders. Community Ment Health J 2003; 39:3–15 [F]
86. Rogers ES, Martin R, Anthony W, Massaro J, Danley K, Crean T, Penk W: Assessing readiness for change among persons with severe mental illness. Community Ment Health J 2001; 37:97–112 [G]
87. Cox A, Hopkinson K, Rutter M: Psychiatric interviewing techniques, II: naturalistic study: eliciting factual information. Br J Psychiatry 1981; 138:283–291 [C]
88. Hopkinson K, Cox A, Rutter M: Psychiatric interviewing techniques, III: naturalistic study: eliciting feelings. Br J Psychiatry 1981; 138:406–415 [C]
89. Cox A, Rutter M, Holbrook D: Psychiatric interviewing techniques, V: experimental study: eliciting factual information. Br J Psychiatry 1981; 139:29–37 [B]
90. Cox A, Holbrook D, Rutter M: Psychiatric interviewing techniques, VI: experimental study: eliciting feelings. Br J Psychiatry 1981; 139:144–152 [B]

91. Cox A, Rutter M, Holbrook D: Psychiatric interviewing techniques: a second experimental study: eliciting feelings. Br J Psychiatry 1988; 152:64–72 [G]
92. Cruz M, Pincus HA: Research on the influence that communication in psychiatric encounters has on treatment. Psychiatr Serv 2002; 53:1253–1265 [E]
93. Maier W, Philipp M, Buller R: The value of structured clinical interviews. Arch Gen Psychiatry 1988; 45:963–964 [C]
94. Robins LN: Diagnostic grammar and assessment: translating criteria into questions. Psychol Med 1989; 19:57–68 [F]
95. Watson CG, Juba MP, Manifold V, Kucala T, Anderson PE: The PTSD interview: rationale, description, reliability, and concurrent validity of a DSM-III-based technique. J Clin Psychol 1991; 47:179–188 [C]
96. First MB (ed): Standardized Evaluation in Clinical Practice (Review of Psychiatry Series, vol 23; Oldham JM and Riba MB, series editors). Washington, DC, American Psychiatric Publishing, 2003 [G]
97. Kashner TM, Rush AJ, Suris A, Biggs MM, Gajewski VL, Hooker DJ, Shoaf T, Altshuler KZ: Impact of structured clinical interviews on physicians' practices in community mental health settings. Psychiatr Serv 2003; 54:712–718 [A–]
98. Miller PR, Dasher R, Collins R, Griffiths P, Brown F: Inpatient diagnostic assessments, 1: accuracy of structured vs unstructured interviews. Psychiatry Res 2001; 105:255–264 [G]
99. Steiner JL, Tebes JK, Sledge WH, Walker ML: A comparison of the structured clinical interview for DSM-III-R and clinical diagnoses. J Nerv Ment Dis 1995; 183:365–369 [G]
100. Ramirez BM, Bostic JQ, Davies D, Rush AJ, Witte B, Hendrickse W, Barnett V: Methods to improve diagnostic accuracy in a community mental health setting. Am J Psychiatry 2000; 157:1599–1605 [G]
101. Shear MK, Greeno C, Kang J, Ludewig D, Frank E, Swartz HA, Hanekamp M: Diagnosis of nonpsychotic patients in community clinics. Am J Psychiatry 2000; 157:581–587 [G]
102. Zimmerman M, Mattia JI: Psychiatric diagnosis in clinical practice: is comorbidity being missed? Compr Psychiatry 1999; 40:182–191 [G]
103. Pinderhughes E: Understanding Race, Ethnicity and Power. New York, Free Press, 1988 [G]
104. American Psychiatric Association: Position statement on bias-related incidents (official actions). Am J Psychiatry 1993; 150:686 [G]
105. American Psychiatric Association: Guidelines regarding possible conflict between psychiatrists' religious commitment and psychiatric practice. Am J Psychiatry 1990; 147:542 [G]
106. US Department of Health and Human Services Office of Minority Health: National standards on culturally and linguistically appropriate services (CLAS) in health care. Federal Register 2000; 65:80865–80879 [G]
107. US Congress: Americans With Disabilities Act of 1990. 42 USC 12101–12213, 1990 [G]
108. Westermeyer JJ: Cross-cultural psychiatric assessment, in Culture, Ethnicity, and Mental Illness. Edited by Gaw AC. Washington, DC, American Psychiatric Press, 1993, pp 125–144 [F]
109. Tribe R, Raval H: Working With Interpreters in Mental Health. London, Brunner-Routledge, 2002 [G]
110. Tribe R, Morrissey J: Using interpreters when working in mental health. Int J Psychol 2004; 35:380 [G]
111. Mailloux SL: Ethics and interpreters: are you practicing ethically? J Psychol Practice 2004; 10:37–44 [G]
112. Fochtmann LJ: Psychiatric assessment and management, in Emergency Toxicology. Edited by Viccellio P, Bania T. Philadelphia, Lippincott-Raven, 1998, pp 41–59 [G]
113. Brasic JR, Fogelman D: Clinician safety. Psychiatr Clin North Am 1999; 22:923–940 [F]
114. Khadivi AN, Patel RC, Atkinson AR, Levine JM: Association between seclusion and restraint and patient-related violence. Psychiatr Serv 2004; 55:1311–1312 [B]

115. Dubin WR, Lion JR (eds): American Psychiatric Association Task Force Report 33: Clinician Safety. Washington, DC, American Psychiatric Association, 1993 [G]
116. Dubin WR: Clinician safety, in Medical Management of the Violent Patient. Edited by Tardiff K. New York, Marcel Dekker, 1999, pp 219–236 [G]
117. American Psychiatric Association, American Psychiatric Nurses Association, National Association of Psychiatric Health Systems: Learning From Each Other: Success Stories and Ideas for Reducing Restraint/Seclusion in Behavioral Health. Arlington, Va, American Psychiatric Association, 2003. http://www.psych.org/psych_pract/treatg/pg/learningfromeachother.cfm [G]
118. American Psychiatric Association: Handbook of Psychiatric Measures. Washington, DC, American Psychiatric Press, 2000 [G]
119. Escobar JI, Burnam A, Karno M, Forsythe A, Landsverk J, Golding JM: Use of the Mini-Mental State Examination (MMSE) in a community population of mixed ethnicity: cultural and linguistic artifacts. J Nerv Ment Dis 1986; 174:607–614 [C]
120. Lopez S, Nunez JA: Cultural factors considered in selected diagnostic criteria and interview schedules. J Abnorm Psychol 1987; 96:270–272 [F]
121. Flaherty JA, Gaviria FM, Pathak D, Mitchell T, Wintrob R, Richman JA, Birz S: Developing instruments for cross-cultural psychiatric research. J Nerv Ment Dis 1988; 176:257–263 [F]
122. Roberts RE, Rhoades HM, Vernon SW: Using the CES-D scale to screen for depression and anxiety: effects of language and ethnic status. Psychiatry Res 1990; 31:69–83 [C]
123. Sandoval J, Geisinger KF, Frisby C: Test Interpretation and Diversity: Achieving Equity in Assessment. Washington, DC, American Psychological Association, 1999 [G]
124. Samuda RJ: Psychological Testing of American Minorities: Issues and Consequences, 2nd ed. Thousand Oaks, Calif, Sage, 1998 [G]
125. Suzuki LA, Ponterotto JG, Meller PJ: The New Handbook of Multicultural Assessment: Clinical, Psychological, and Educational Applications, 2nd ed. San Francisco, Jossey-Bass, 2000 [G]
126. Kovess V, Sylla O, Fournier L, Flavigny V: Why discrepancies exist between structured diagnostic interviews and clinicians' diagnoses. Soc Psychiatry Psychiatr Epidemiol 1992; 27:185–191 [C]
127. Harrington R, Hill J, Rutter M, John K, Fudge H, Zoccolillo M, Weissman M: The assessment of lifetime psychopathology: a comparison of two interviewing styles. Psychol Med 1988; 18:487–493 [C]
128. North CS, Pollio DE, Thompson SJ, Ricci DA, Smith EM, Spitznagel EL: A comparison of clinical and structured interview diagnoses in a homeless mental health clinic. Community Ment Health J 1997; 33:531–543 [G]
129. Blacker D: Psychiatric rating scales, in Kaplan and Sadock's Comprehensive Textbook of Psychiatry, 8th ed. Edited by Sadock BJ, Sadock VA. Philadelphia, Lippincott Williams & Wilkins, 2005, pp 929–955 [G]
130. Applegate WB, Blass JP, Williams TF: Instruments for the functional assessment of older patients. N Engl J Med 1990; 322:1207–1214 [F]
131. Katz S: Assessing self-maintenance: activities of daily living, mobility, and instrumental activities of daily living. J Am Geriatr Soc 1983; 31:721–727 [F]
132. American Psychiatric Association: Position statement on the role of psychiatrists in assessing driving ability (official actions). Am J Psychiatry 1995; 152:819 [G]
133. Anfinson TJ, Kathol RG: Screening laboratory evaluation in psychiatric patients: a review. Gen Hosp Psychiatry 1992; 14:248–257 [G]
134. White AJ, Barraclough B: Benefits and problems of routine laboratory investigations in adult psychiatric admissions. Br J Psychiatry 1989; 155:65–72 [F]
135. Bostwick JM, Philbrick KL: The use of electroencephalography in psychiatry of the medically ill. Psychiatr Clin North Am 2002; 25:17–25 [F]

136. Gomez-Gil E, Trilla A, Corbella B, Fernandez-Egea E, Luburich P, de Pablo J, Ferrer RJ, Valdes M: Lack of clinical relevance of routine chest radiography in acute psychiatric admissions. Gen Hosp Psychiatry 2002; 24:110–113 [G]
137. Knutsen E, DuRand C: Previously unrecognized physical illnesses in psychiatric patients. Hosp Community Psychiatry 1991; 42:182–186 [G]
138. Koran LM, Sheline Y, Imai K, Kelsey TG, Freedland KE, Mathews J, Moore M: Medical disorders among patients admitted to a public-sector psychiatric inpatient unit. Psychiatr Serv 2002; 53:1623–1625 [G]
139. Lyketsos CG, Dunn G, Kaminsky MJ, Breakey WR: Medical comorbidity in psychiatric inpatients: relation to clinical outcomes and hospital length of stay. Psychosomatics 2002; 43:24–30 [G]
140. Ryan R, Sunada K: Medical evaluation of persons with mental retardation referred for psychiatric assessment. Gen Hosp Psychiatry 1997; 19:274–280 [G]
141. Sheline Y, Kehr C: Cost and utility of routine admission laboratory testing for psychiatric inpatients. Gen Hosp Psychiatry 1990; 12:329–334 [G]
142. Warner MD, Boutros NN, Peabody CA: Usefulness of screening EEGs in a psychiatric inpatient population. J Clin Psychiatry 1990; 51:363–364 [G]
143. Yudofsky SC, Kim HF (eds): Neuropsychiatric Assessment (Review of Psychiatry Series, vol 23; Oldham JM and Riba MB, series editors). Washington, DC, American Psychiatric Publishing, 2004 [G]
144. Pomeroy C, Mitchell JE, Roerig J, Crow S: Medical Complications of Psychiatric Illness. Washington, DC, American Psychiatric Publishing, 2002 [G]
145. American Psychiatric Association: Practice guideline for the treatment of patients with bipolar disorder (revision). Am J Psychiatry 2002; 159(April suppl) [G]
146. American Psychiatric Association: The Practice of Electroconvulsive Therapy. Recommendations for Treatment, Training, and Privileging: A Task Force Report of the American Psychiatric Association, 2nd ed. Washington, DC, American Psychiatric Press, 2001 [G]
147. Meyer GJ, Finn SE, Eyde LD, Kay GG, Moreland KL, Dies RR, Eisman EJ, Kubiszyn TW, Reed GM: Psychological testing and psychological assessment: a review of evidence and issues. Am Psychol 2001; 56:128–165 [F]
148. Ercoli LM, Siddarth P, Dunkin JJ, Bramen J, Small GW: MMSE items predict cognitive decline in persons with genetic risk for Alzheimer's disease. J Geriatr Psychiatry Neurol 2003; 16:67–73 [C]
149. Green MF, Kern RS, Braff DL, Mintz J: Neurocognitive deficits and functional outcome in schizophrenia: are we measuring the "right stuff"? Schizophr Bull 2000; 26:119–136 [E]
150. Phillips WA, Silverstein SM: Convergence of biological and psychological perspectives on cognitive coordination in schizophrenia. Behav Brain Sci 2003; 26:65–82 [G]
151. Ragland JD: Profiles of neuropsychologic function in schizophrenia. Curr Psychiatry Rep 2003; 5:299–302 [G]
152. Harrow M, Green KE, Sands JR, Jobe TH, Goldberg JF, Kaplan KJ, Martin EM: Thought disorder in schizophrenia and mania: impaired context. Schizophr Bull 2000; 26:879–891 [G]
153. Rubinsztein JS, Michael A, Paykel ES, Sahakian BJ: Cognitive impairment in remission in bipolar affective disorder. Psychol Med 2000; 30:1025–1036 [D]
154. Quraishi S, Frangou S: Neuropsychology of bipolar disorder: a review. J Affect Disord 2002; 72:209–226 [F]
155. Donaldson S, Goldstein LH, Landau S, Raymont V, Frangou S: The Maudsley Bipolar Disorder Project: the effect of medication, family history, and duration of illness on IQ and memory in bipolar I disorder. J Clin Psychiatry 2003; 64:86–93 [C]
156. Martinez-Aran A, Vieta E, Colom F, Reinares M, Benabarre A, Torrent C, Goikolea JM, Corbella B, Sanchez-Moreno J, Salamero M: Neuropsychological performance in depressed and euthymic bipolar patients. Neuropsychobiology 2002; 46(suppl 1):16–21 [G]

157. Nebes RD, Pollock BG, Houck PR, Butters MA, Mulsant BH, Zmuda MD, Reynolds CF III: Persistence of cognitive impairment in geriatric patients following antidepressant treatment: a randomized, double-blind clinical trial with nortriptyline and paroxetine. J Psychiatr Res 2003; 37:99–108 [A]
158. Alexopoulos GS: Role of executive function in late-life depression. J Clin Psychiatry 2003; 64(suppl 14):18–23 [G]
159. Shenal BV, Harrison DW, Demaree HA: The neuropsychology of depression: a literature review and preliminary model. Neuropsychol Rev 2003; 13:33–42 [F]
160. Wilson RS, Mendes De Leon CF, Bennett DA, Bienias JL, Evans DA: Depressive symptoms and cognitive decline in a community population of older persons. J Neurol Neurosurg Psychiatry 2004; 75:126–129 [G]
161. Gilotty L, Kenworthy L, Sirian L, Black DO, Wagner AE: Adaptive skills and executive function in autism spectrum disorders. Neuropsychol Dev Cogn Sect C Child Neuropsychol 2002; 8:241–248 [G]
162. Tager-Flusberg H, Joseph RM: Identifying neurocognitive phenotypes in autism. Philos Trans R Soc Lond B Biol Sci 2003; 358:303–314 [G]
163. Kaiser S, Unger J, Kiefer M, Markela J, Mundt C, Weisbrod M: Executive control deficit in depression: event-related potentials in a Go/No-go task. Psychiatry Res 2003; 122:169–184 [G]
164. Green MF, Nuechterlein KH: Should schizophrenia be treated as a neurocognitive disorder? Schizophr Bull 1999; 25:309–319 [G]
165. Schiffer RB, Klein RF, Sider RC: The Medical Evaluation of Psychiatric Patients. New York, Plenum, 1988 [G]
166. Talbot-Stern JK, Green T, Royle TJ: Psychiatric manifestations of systemic illness. Emerg Med Clin North Am 2000; 18:199–209 [F]
167. Nurcombe B, Fitzhenry-Coor I: How do psychiatrists think? clinical reasoning in the psychiatric interview: a research and education project. Aust N Z J Psychiatry 1982; 16:13–24 [F]
168. IGDA Workgroup WPA: IGDA, 8: idiographic (personalised) diagnostic formulation. Br J Psychiatry Suppl 2003; 45:S55–S57 [G]
169. Summers RF: The psychodynamic formulation updated. Am J Psychother 2003; 57:39–51 [G]
170. Bergner RM: Characteristics of optimal clinical case formulations: the linchpin concept. Am J Psychother 1998; 52:287–300 [G]
171. Pies RW: Clinical Manual of Psychiatric Diagnosis and Treatment: A Biopsychosocial Approach. Washington, DC, American Psychiatric Press, 1994 [G]
172. Weerasekera P: Formulation: a multiperspective model. Can J Psychiatry 1993; 38:351–358 [G]
173. McDougall GM, Reade B: Teaching biopsychosocial integration and formulation. Can J Psychiatry 1993; 38:359–362 [G]
174. Cleghorn JM, Bellissimo A, Will D: Teaching some principles of individual psychodynamics through an introductory guide to formulations. Can J Psychiatry 1983; 28:162–172 [G]
175. Ross CA, Leichner P, Matas M, Anderson D: A method of teaching and evaluating psychiatric case formulation. Acad Psychiatry 1990; 14:99–105 [G]
176. Perry S, Cooper AM, Michels R: The psychodynamic formulation: its purpose, structure, and clinical application. Am J Psychiatry 1987; 144:543–550 [G]
177. Sadock BJ: Psychiatric report, medical record and medical error, in Kaplan and Sadock's Comprehensive Textbook of Psychiatry, 8th ed. Edited by Sadock BJ, Sadock VA. Philadelphia, Lippincott Williams & Wilkins, 2005, pp 834–847 [G]
178. Engel GL: The need for a new medical model: a challenge for biomedicine. Science 1977; 196:129–136 [G]

179. Eells TD, Kendjelic EM, Lucas CP: What's in a case formulation? development and use of a content coding manual. J Psychother Pract Res 1998; 7:144–153 [G]
180. IGDA Workgroup WPA: IGDA, 4: evaluation of symptoms and mental state. Br J Psychiatry Suppl 2003; 45:S46–S47 [G]
181. Lu F, Lim R, Mezzich J: Issues in the assessment and diagnosis of culturally diverse individuals, in American Psychiatric Press Review of Psychiatry, vol 14. Edited by Oldham JO, Riba M. Washington, DC, American Psychiatric Press, 1995, pp 477–510 [G]
182. Group for the Advancement of Psychiatry: Cultural Assessment in Clinical Psychiatry. Washington, DC, American Psychiatric Publishing, 2002 [G]
183. Koskoff H: The Culture of Emotions (video recording). Boston, Fanlight Productions, 2002 [G]
184. Lim R: Cultural Psychiatry for Clinicians. Baltimore, Johns Hopkins University Press (in press) [G]
185. Hays P: Addressing Cultural Complexities in Practice: A Framework for Clinicians and Counselors. Washington, DC, American Psychological Association, 2001 [G]
186. Weinreich P, Saunderson W: Analyzing Identity: Cross-Cultural, Societal, and Clinical Contexts. New York, Routledge, 2003 [G]
187. Tervalon M, Murray-Garcia J: Cultural humility versus cultural competence: a critical distinction in defining physician training outcomes in multicultural education. J Health Care Poor Underserved 1998; 9:117–125 [G]
188. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision. Washington, DC, American Psychiatric Association, 2000 [G]
189. Phillips KA, First MB, Pincus HA (eds): Advancing DSM Dilemmas in Psychiatric Diagnosis. Washington, DC, American Psychiatric Publishing, 2003 [G]
190. McHugh PR, Slavney PR: The Perspectives of Psychiatry, 2nd ed. Baltimore, Johns Hopkins University Press, 1998 [G]
191. Adams N, Grieder DM: Treatment Planning for Person-Centered Care: The Road to Mental Health and Addiction Recovery. Burlington, Mass, Elsevier, 2005 [G]
192. Grisso T, Appelbaum PS: Assessing Competence to Consent to Treatment: A Guide for Physicians and Other Health Professionals. New York, Oxford University Press, 1998 [G]
193. Maio JE: HIPAA and the special status of psychotherapy notes. Lippincotts Case Manag 2003; 8:24–29 [G]
194. American Psychiatric Association: Psychotherapy notes provision of the Health Insurance Portability and Accountability Act (HIPAA) privacy rule: a resource document. Washington, DC, American Psychiatric Association, 2001 [G]
195. Appelbaum PS: Privacy in psychiatric treatment: threats and responses. Am J Psychiatry 2002; 159:1809–1818 [G]
196. US Public Health Service: Confidentiality of Alcohol and Drug Abuse Patient Records. Code of Federal Regulations, Title 42, Chapter I, Part 2, 2000. http://www.access.gpo.gov/nara/cfr/waisidx_00/42cfr2_00.html [G]
197. Substance Abuse and Mental Health Services Administration: The Confidentiality of Alcohol and Drug Abuse Patient Records Regulation and the HIPAA Privacy Rule: Implications for Alcohol and Substance Abuse Programs, 2004. http://www.hipaa.samhsa.gov/Part2Applicability.htm [G]
198. Gutheil TG: Paranoia and progress notes: a guide to forensically informed psychiatric recordkeeping. Hosp Community Psychiatry 1980; 31:479–482 [G]
199. American Psychiatric Association: Minimum necessary guidelines for third-party payers for psychiatric treatment: a position statement. Washington, DC, American Psychiatric Association, 2002 [G]
200. American Psychiatric Association: Documentation of psychotherapy by psychiatrists: resource document. Washington, DC, American Psychiatric Association, 2002 [G]

201. McCormick JJ, Currier GW: Emergency medicine and mental health law. Top Emerg Med 1999; 21:28–37 [G]
202. Karlawish J, James B: Ethical issues in geriatric medicine: informed consent, surrogate decision making, and advanced care planning, in Principles of Geriatric Medicine and Gerontology, 5th ed. Edited by Hazzard WR, Glass JP, Halter JB, Ouslander JG, Tinetti M. New York, McGraw-Hill, 2003, pp 353–360 [G]
203. Srebnik DS, Rutherford LT, Peto T, Russo J, Zick E, Jaffe C, Holtzheimer P: The content and clinical utility of psychiatric advance directives. Psychiatr Serv 2005; 56:592–598 [G]
204. Simon RI: The law and psychiatry, in The American Psychiatric Publishing Textbook of Clinical Psychiatry, 4th ed. Edited by Hales RE, Yudofsky SC. Washington, DC, American Psychiatric Publishing, 2003, pp 1585–1628 [G]
205. Lamb HR, Weinberger LE: Persons with severe mental illness in jails and prisons: a review. Psychiatr Serv 1998; 49:483–492 [F]
206. National Institute of Corrections: Provision of Mental Health Care in Prisons. Washington, DC, US Department of Justice, 2001 [G]
207. National Commission on Correctional Health Care: Correctional Mental Health Care: Standards and Guidelines for Delivering Services. Chicago, National Commission on Correctional Health Care, 1999 [G]
208. Jones G, Connelly M: Mentally Ill Offenders and Mental Health Care Issues: An Overview of the Research. College Park, Md, Maryland State Commission on Criminal Sentencing Policy, 2002. http://www.msccsp.org/publications/mental.html [G]
209. Metzner JL: An introduction to correctional psychiatry, I. J Am Acad Psychiatry Law 1997; 25:375–381 [F]
210. Hayes LM: Prison Suicide: An Overview and Guide to Prevention. Washington, DC, US Department of Justice, National Institute of Corrections, 1995 [G]
211. Federal Bureau of Prisons: Federal Bureau of Prisons Clinical Practice Guidelines for Psychiatric Evaluations. Federal Bureau of Prisons, 2002. http://www.us.oup.com/us/pdf/pdr/psychEval.pdf [G]
212. American Psychiatric Association: Psychiatric Services in Jails and Prisons, 2nd ed. Washington, DC, American Psychiatric Association, 2000 [G]
213. Metzner JL, Miller RD, Kleinsasser D: Mental health screening and evaluation within prisons. Bull Am Acad Psychiatry Law 1994; 22:451–457 [F]
214. Bell CC: Correctional psychiatry, in Kaplan and Sadock's Comprehensive Textbook of Psychiatry, 8th ed. Edited by Sadock BJ, Sadock VA. Philadelphia, Lippincott Williams & Wilkins, 2005, pp 4002–4012 [G]
215. McKee GR: Lethal vs nonlethal suicide attempts in jail. Psychol Rep 1998; 82:611–614 [G]
216. Marcus P, Alcabes P: Characteristics of suicides by inmates in an urban jail. Hosp Community Psychiatry 1993; 44:256–261 [C]
217. Hayes LM, Kajden B: And Darkness Closes In: A National Study of Jail Suicides: Final Report to the National Institute of Corrections. Washington, DC, National Center on Institutions and Alternatives, 1981 [E]
218. Hayes LM: National study of jail suicides: seven years later. Psychiatr Q 1989; 60:7–29 [F]
219. Bonner RL: Isolation, seclusion, and psychosocial vulnerability as risk factors for suicide behind bars, in Assessment and Prediction of Suicide. Edited by Maris RW, Berman AL, Maltsberger JT, Yufit RI. New York, Guilford, 1992, pp 398–419 [F]
220. McQuistion HL, Felix A, Susser ES: Serving homeless people with mental illness, in Psychiatry, 2nd ed. Edited by Tasman A, Lieberman J, Kay J. London, Wiley, 2003, pp 2314–2321 [G]
221. Rush KS, Bowman LG, Eidman SL, Toole LM, Mortenson BP: Assessing psychopathology in individuals with developmental disabilities. Behav Modif 2004; 28:621–637 [F]

222. King BH, DeAntonio C, McCracken JT, Forness SR, Ackerland V: Psychiatric consultation in severe and profound mental retardation. Am J Psychiatry 1994; 151:1802–1808 [G]
223. Ferrell RB, Wolinsky EJ, Kauffman CI, Flashman LA, McAllister TW: Neuropsychiatric syndromes in adults with intellectual disability: issues in assessment and treatment. Curr Psychiatry Rep 2004; 6:380–390 [F]
224. Finlay WM, Lyons E: Methodological issues in interviewing and using self-report questionnaires with people with mental retardation. Psychol Assess 2001; 13:319–335 [F]
225. Ross E, Oliver C: The assessment of mood in adults who have severe or profound mental retardation. Clin Psychol Rev 2003; 23:225–245 [F]
226. Desrochers MN, Hile MG, Williams-Moseley TL: Survey of functional assessment procedures used with individuals who display mental retardation and severe problem behaviors. Am J Ment Retard 1997; 101:535–546 [G]
227. Beange H, McElduff A, Baker W: Medical disorders of adults with mental retardation: a population study. Am J Ment Retard 1995; 99:595–604 [G]
228. Kupfer DJ, First MB, Regier DA (eds): A Research Agenda for DSM-V. Washington, DC, American Psychiatric Association, 2002 [G]
229. McLean M, Armstrong D: Eliciting patients' concerns: a randomised controlled trial of different approaches by the doctor. Br J Gen Pract 2004; 54:663–666 [A–]
230. Brewer DD, Garrett SB: Evaluation of interviewing techniques to enhance recall of sexual and drug injection partners. Sex Transm Dis 2001; 28:666–677 [A–]
231. Swenson SL, Buell S, Zettler P, White M, Ruston DC, Lo B: Patient-centered communication: do patients really prefer it? J Gen Intern Med 2004; 19:1069–1079 [G]
232. O'Keefe M, Roberton D, Sawyer M, Baghurst P: Medical student interviewing: a randomized trial of patient-centeredness and clinical competence. Fam Pract 2003; 20:213–219 [G]
233. Stewart M, Brown JB, Donner A, McWhinney IR, Oates J, Weston WW, Jordan J: The impact of patient-centered care on outcomes. J Fam Pract 2000; 49:796–804 [G]
234. Dowsett SM, Saul JL, Butow PN, Dunn SM, Boyer MJ, Findlow R, Dunsmore J: Communication styles in the cancer consultation: preferences for a patient-centered approach. Psychooncology 2000; 9:147–156 [A–]
235. Williams N, Ogden J: The impact of matching the patient's vocabulary: a randomized control trial. Fam Pract 2004; 21:630–635 [A–]
236. Razavi D, Delvaux N, Marchal S, Durieux JF, Farvacques C, Dubus L, Hogenraad R: Does training increase the use of more emotionally laden words by nurses when talking with cancer patients? a randomised study. Br J Cancer 2002; 87:1–7 [A–]
237. Wells KB, Sherbourne C, Schoenbaum M, Duan N, Meredith L, Unutzer J, Miranda J, Carney MF, Rubenstein LV: Impact of disseminating quality improvement programs for depression in managed primary care: a randomized controlled trial. JAMA 2000; 283:212–220 [B]
238. Chinman M, Young AS, Schell T, Hassell J, Mintz J: Computer-assisted self-assessment in persons with severe mental illness. J Clin Psychiatry 2004; 65:1343–1351 [A–]
239. Newman JC, Des J, Turner CF, Gribble J, Cooley P, Paone D: The differential effects of face-to-face and computer interview modes. Am J Public Health 2002; 92:294–297 [G]
240. Solomon GL, Dechter M: Are patients pleased with computer use in the examination room? J Fam Pract 1995; 41:241–244 [A–]
241. Garrison GM, Bernard ME, Rasmussen NH: Twenty-first-century health care: the effect of computer use by physicians on patient satisfaction at a family medicine clinic. Fam Med 2002; 34:362–368 [G]
242. Main DS, Quintela J, Araya-Guerra R, Holcomb S, Pace WD: Exploring patient reactions to pen-tablet computers: a report from CaReNet. Ann Fam Med 2004; 2:421–424 [G]
243. Rudd MD, Rajab MH: Specificity of the Beck Depression Inventory and the confounding role of comorbid disorders in a clinical sample. Cognit Ther Res 1995; 19:51–68 [G]

244. Rocchi A, Pellegrini S, Siciliano G, Murri L: Causative and susceptibility genes for Alzheimer's disease: a review. Brain Res Bull 2003; 61:1–24 [F]
245. Egan MF, Goldberg TE, Kolachana BS, Callicott JH, Mazzanti CM, Straub RE, Goldman D, Weinberger DR: Effect of COMT Val108/158Met genotype on frontal lobe function and risk for schizophrenia. Proc Natl Acad Sci U S A 2001; 98:6917–6922 [G]
246. Goldberg TE, Egan MF, Gscheidle T, Coppola R, Weickert T, Kolachana BS, Goldman D, Weinberger DR: Executive subprocesses in working memory: relationship to catechol-*O*-methyltransferase Val158Met genotype and schizophrenia. Arch Gen Psychiatry 2003; 60:889–896 [G]
247. Harrison PJ, Owen MJ: Genes for schizophrenia? recent findings and their pathophysiological implications. Lancet 2003; 361:417–419 [G]
248. Ressler KJ, Nemeroff CB: Role of serotonergic and noradrenergic systems in the pathophysiology of depression and anxiety disorders. Depress Anxiety 2000; 12(suppl 1):2–19 [G]
249. Hariri AR, Weinberger DR: Imaging genomics. Br Med Bull 2003; 65:259–270 [G]
250. Caspi A, Sugden K, Moffitt TE, Taylor A, Craig IW, Harrington H, McClay J, Mill J, Martin J, Braithwaite A, Poulton R: Influence of life stress on depression: moderation by a polymorphism in the 5-HTT gene. Science 2003; 301:386–389 [C]
251. Bookheimer SY, Strojwas MH, Cohen MS, Saunders AM, Pericak-Vance MA, Mazziotta JC, Small GW: Patterns of brain activation in people at risk for Alzheimer's disease. N Engl J Med 2000; 343:450–456 [D]
252. Moffitt TE, Caspi A, Rutter M: Strategy for investigating interactions between measured genes and measured environments. Arch Gen Psychiatry 2005; 62:473–481 [G]
253. Killiany RJ, Gomez-Isla T, Moss M, Kikinis R, Sandor T, Jolesz F, Tanzi R, Jones K, Hyman BT, Albert MS: Use of structural magnetic resonance imaging to predict who will get Alzheimer's disease. Ann Neurol 2000; 47:430–439 [C]
254. Killiany RJ, Hyman BT, Gomez-Isla T, Moss MB, Kikinis R, Jolesz F, Tanzi R, Jones K, Albert MS: MRI measures of entorhinal cortex vs hippocampus in preclinical AD. Neurology 2002; 58:1188–1196 [G]
255. Kaye JA, Swihart T, Howieson D, Dame A, Moore MM, Karnos T, Camicioli R, Ball M, Oken B, Sexton G: Volume loss of the hippocampus and temporal lobe in healthy elderly persons destined to develop dementia. Neurology 1997; 48:1297–1304 [C]
256. Xu Y, Jack CR Jr, O'Brien PC, Kokmen E, Smith GE, Ivnik RJ, Boeve BF, Tangalos RG, Petersen RC: Usefulness of MRI measures of entorhinal cortex versus hippocampus in AD. Neurology 2000; 54:1760–1767 [D]
257. Jagust WJ, Budinger TF, Reed BR: The diagnosis of dementia with single photon emission computed tomography. Arch Neurol 1987; 44:258–262 [G]
258. DeKosky ST, Shih WJ, Schmitt FA, Coupal J, Kirkpatrick C: Assessing utility of single photon emission computed tomography (SPECT) scan in Alzheimer disease: correlation with cognitive severity. Alzheimer Dis Assoc Disord 1990; 4:14–23 [G]
259. Holman BL, Tumeh SS: Single-photon emission computed tomography (SPECT): applications and potential. JAMA 1990; 263:561–564 [G]
260. Silverman DH, Gambhir SS, Huang HW, Schwimmer J, Kim S, Small GW, Chodosh J, Czernin J, Phelps ME: Evaluating early dementia with and without assessment of regional cerebral metabolism by PET: a comparison of predicted costs and benefits. J Nucl Med 2002; 43:253–266 [G]
261. Herholz K, Salmon E, Perani D, Baron JC, Holthoff V, Frolich L, Schonknecht P, Ito K, Mielke R, Kalbe E, Zundorf G, Delbeuck X, Pelati O, Anchisi D, Fazio F, Kerrouche N, Desgranges B, Eustache F, Beuthien-Baumann B, Menzel C, Schroder J, Kato T, Arahata Y, Henze M, Heiss WD: Discrimination between Alzheimer dementia and controls by automated analysis of multicenter FDG PET. Neuroimage 2002; 17:302–316 [D]

262. Gill SS, Rochon PA, Guttman M, Laupacis A: The value of positron emission tomography in the clinical evaluation of dementia. J Am Geriatr Soc 2003; 51:258–264 [F]
263. Kulasingam SL, Samsa GP, Zarin DA, Rutschmann OT, Patwardhan MB, McCrory DC, Schmechel DE, Matchar DB: When should functional neuroimaging techniques be used in the diagnosis and management of Alzheimer's dementia? a decision analysis. Value Health 2003; 6:542–550 [E]
264. Silverman DH, Small GW, Chang CY, Lu CS, Kung De Aburto MA, Chen W, Czernin J, Rapoport SI, Pietrini P, Alexander GE, Schapiro MB, Jagust WJ, Hoffman JM, Welsh-Bohmer KA, Alavi A, Clark CM, Salmon E, de Leon MJ, Mielke R, Cummings JL, Kowell AP, Gambhir SS, Hoh CK, Phelps ME: Positron emission tomography in evaluation of dementia: regional brain metabolism and long-term outcome. JAMA 2001; 286:2120–2127 [C]
265. Hoffman JM, Hanson MW, Welsh KA, Earl N, Paine S, Delong D, Coleman RE: Interpretation variability of 18FDG-positron emission tomography studies in dementia. Invest Radiol 1996; 31:316–322 [G]
266. Drevets WC, Videen TO, Price JL, Preskorn SH, Carmichael ST, Raichle ME: A functional anatomical study of unipolar depression. J Neurosci 1992; 12:3628–3641 [G]
267. Coffey CE, Wilkinson WE, Weiner RD, Parashos IA, Djang WT, Webb MC, Figiel GS, Spritzer CE: Quantitative cerebral anatomy in depression: a controlled magnetic resonance imaging study. Arch Gen Psychiatry 1993; 50:7–16 [D]
268. Steffens DC, Krishnan KR: Structural neuroimaging and mood disorders: recent findings, implications for classification, and future directions. Biol Psychiatry 1998; 43:705–712 [F]
269. Drevets WC: Functional anatomical abnormalities in limbic and prefrontal cortical structures in major depression. Prog Brain Res 2000; 126:413–431 [G]
270. Bearden CE, Hoffman KM, Cannon TD: The neuropsychology and neuroanatomy of bipolar affective disorder: a critical review. Bipolar Disord 2001; 3:106–150 [F]
271. Kumar A, Gupta RC, Albert TM, Alger J, Wyckoff N, Hwang S: Biophysical changes in normal-appearing white matter and subcortical nuclei in late-life major depression detected using magnetization transfer. Psychiatry Res 2004; 130:131–140 [G]
272. Glahn DC, Ragland JD, Abramoff A, Barrett J, Laird AR, Bearden CE, Velligan DI: Beyond hypofrontality: a quantitative meta-analysis of functional neuroimaging studies of working memory in schizophrenia. Hum Brain Mapp 2005; 25:60–69 [E]
273. Meyer-Lindenberg AS, Olsen RK, Kohn PD, Brown T, Egan MF, Weinberger DR, Berman KF: Regionally specific disturbance of dorsolateral prefrontal-hippocampal functional connectivity in schizophrenia. Arch Gen Psychiatry 2005; 62:379–386 [D]
274. Szeszko PR, Ardekani BA, Ashtari M, Kumra S, Robinson DG, Sevy S, Gunduz-Bruce H, Malhotra AK, Kane JM, Bilder RM, Lim KO: White matter abnormalities in first-episode schizophrenia or schizoaffective disorder: a diffusion tensor imaging study. Am J Psychiatry 2005; 162:602–605 [D]
275. MacDonald AW III, Carter CS, Kerns JG, Ursu S, Barch DM, Holmes AJ, Stenger VA, Cohen JD: Specificity of prefrontal dysfunction and context processing deficits to schizophrenia in never-medicated patients with first-episode psychosis. Am J Psychiatry 2005; 162:475–484 [D]
276. Hill K, Mann L, Laws KR, Stephenson CM, Nimmo-Smith I, McKenna PJ: Hypofrontality in schizophrenia: a meta-analysis of functional imaging studies. Acta Psychiatr Scand 2004; 110:243–256 [E]
277. Davidson LL, Heinrichs RW: Quantification of frontal and temporal lobe brain-imaging findings in schizophrenia: a meta-analysis. Psychiatry Res 2003; 122:69–87 [E]
278. Konick LC, Friedman L: Meta-analysis of thalamic size in schizophrenia. Biol Psychiatry 2001; 49:28–38 [E]

279. Zakzanis KK, Poulin P, Hansen KT, Jolic D: Searching the schizophrenic brain for temporal lobe deficits: a systematic review and meta-analysis. Psychol Med 2000; 30:491–504 [E]
280. Wright IC, Rabe-Hesketh S, Woodruff PW, David AS, Murray RM, Bullmore ET: Meta-analysis of regional brain volumes in schizophrenia. Am J Psychiatry 2000; 157:16–25 [E]
281. Riffkin J, Yucel M, Maruff P, Wood SJ, Soulsby B, Olver J, Kyrios M, Velakoulis D, Pantelis C: A manual and automated MRI study of anterior cingulate and orbito-frontal cortices, and caudate nucleus in obsessive-compulsive disorder: comparison with healthy controls and patients with schizophrenia. Psychiatry Res 2005; 138:99–113 [D]
282. van den Heuvel OA, Veltman DJ, Groenewegen HJ, Cath DC, van Balkom AJ, van Hartskamp J, Barkhof F, van Dyck R: Frontal-striatal dysfunction during planning in obsessive-compulsive disorder. Arch Gen Psychiatry 2005; 62:301–309 [D]
283. Pujol J, Soriano-Mas C, Alonso P, Cardoner N, Menchon JM, Deus J, Vallejo J: Mapping structural brain alterations in obsessive-compulsive disorder. Arch Gen Psychiatry 2004; 61:720–730 [D]
284. Kitayama N, Vaccarino V, Kutner M, Weiss P, Bremner JD: Magnetic resonance imaging (MRI) measurement of hippocampal volume in posttraumatic stress disorder: a meta-analysis. J Affect Disord 2005; 88:79–86 [E]
285. Mathew SJ, Mao X, Coplan JD, Smith EL, Sackeim HA, Gorman JM, Shungu DC: Dorsolateral prefrontal cortical pathology in generalized anxiety disorder: a proton magnetic resonance spectroscopic imaging study. Am J Psychiatry 2004; 161:1119–1121 [D]
286. Bremner JD, Vythilingam M, Vermetten E, Southwick SM, McGlashan T, Nazeer A, Khan S, Vaccarino LV, Soufer R, Garg PK, Ng CK, Staib LH, Duncan JS, Charney DS: MRI and PET study of deficits in hippocampal structure and function in women with childhood sexual abuse and posttraumatic stress disorder. Am J Psychiatry 2003; 160:924–932 [D]
287. Massana G, Serra-Grabulosa JM, Salgado-Pineda P, Gasto C, Junque C, Massana J, Mercader JM, Gomez B, Tobena A, Salamero M: Amygdalar atrophy in panic disorder patients detected by volumetric magnetic resonance imaging. Neuroimage 2003; 19:80–90 [D]
288. Massana G, Serra-Grabulosa JM, Salgado-Pineda P, Gasto C, Junque C, Massana J, Mercader JM: Parahippocampal gray matter density in panic disorder: a voxel-based morphometric study. Am J Psychiatry 2003; 160:566–568 [D]
289. Morey RA, Inan S, Mitchell TV, Perkins DO, Lieberman JA, Belger A: Imaging frontostriatal function in ultra-high-risk, early, and chronic schizophrenia during executive processing. Arch Gen Psychiatry 2005; 62:254–262 [D]
290. Woods BT, Ward KE, Johnson EH: Meta-analysis of the time-course of brain volume reduction in schizophrenia: implications for pathogenesis and early treatment. Schizophr Res 2005; 73:221–228 [E]
291. Strasser HC, Lilyestrom J, Ashby ER, Honeycutt NA, Schretlen DJ, Pulver AE, Hopkins RO, Depaulo JR, Potash JB, Schweizer B, Yates KO, Kurian E, Barta PE, Pearlson GD: Hippocampal and ventricular volumes in psychotic and nonpsychotic bipolar patients compared with schizophrenia patients and community control subjects: a pilot study. Biol Psychiatry 2005; 57:633–639 [D]
292. Saxena S, Brody AL, Maidment KM, Smith EC, Zohrabi N, Katz E, Baker SK, Baxter LR Jr: Cerebral glucose metabolism in obsessive-compulsive hoarding. Am J Psychiatry 2004; 161:1038–1048 [D]
293. Kennedy SH, Evans KR, Houle S, Vaccarino FJ: PET analysis of antidepressant effects of paroxetine (abstract #47). Continuing Medical Education Syllabus and Scientific Proceedings of the 151st Annual Meeting of the American Psychiatric Association. Toronto, May 30–June 4, 1998 [G]
294. Sackeim HA, Prohovnik I, Moeller JR, Brown RP, Apter S, Prudic J, Devanand DP, Mukherjee S: Regional cerebral blood flow in mood disorders, I: comparison of major depressives and normal controls at rest. Arch Gen Psychiatry 1990; 47:60–70 [D]

295. Sackeim HA, Prohovnik I: Brain imaging studies of depressive disorders, in The Biology of Depressive Disorders, Part A: A Systems Perspective. Edited by Mann JJ, Kupfer DJ. New York, Plenum, 1993, pp 205–258 [G]
296. Nobler MS, Roose SP, Prohovnik I, Moeller JR, Louie J, Van Heertum RL, Sackeim HA: Regional cerebral blood flow in mood disorders, V: effects of antidepressant medication in late-life depression. Am J Geriatr Psychiatry 2000; 8:289–296 [G]
297. Figiel GS, Krishnan KR, Doraiswamy PM, Rao VP, Nemeroff CB, Boyko OB: Subcortical hyperintensities on brain magnetic resonance imaging: a comparison between late age onset and early onset elderly depressed subjects. Neurobiol Aging 1991; 12:245–247 [G]
298. Hickie I, Scott E, Mitchell P, Wilhelm K, Austin MP, Bennett B: Subcortical hyperintensities on magnetic resonance imaging: clinical correlates and prognostic significance in patients with severe depression. Biol Psychiatry 1995; 37:151–160 [G]
299. Saxena S, Brody AL, Ho ML, Zohrabi N, Maidment KM, Baxter LR Jr: Differential brain metabolic predictors of response to paroxetine in obsessive-compulsive disorder versus major depression. Am J Psychiatry 2003; 160:522–532 [G]
300. Drevets WC, Bogers W, Raichle ME: Functional anatomical correlates of antidepressant drug treatment assessed using PET measures of regional glucose metabolism. Eur Neuropsychopharmacol 2002; 12:527–544 [G]
301. Phan KL, Wager T, Taylor SF, Liberzon I: Functional neuroanatomy of emotion: a meta-analysis of emotion activation studies in PET and fMRI. Neuroimage 2002; 16:331–348 [E]
302. Carey PD, Warwick J, Niehaus DJ, van der Linden G, van Heerden BB, Harvey BH, Seedat S, Stein DJ: Single photon emission computed tomography (SPECT) of anxiety disorders before and after treatment with citalopram. BMC Psychiatry 2004; 4:30 [G]

Shoreline Behavioral Health Clinic Handbook

Prepared By:

Document Owners	Project/Organization Role
Cara M. Powers, LPC	Founder and Executive Director

Shoreline Behavioral Health Clinic Manual

Version	Date	Author	Change/Description
1.0	01/25/2015	Cara M. Powers	Complete Handbook

Note: The content of a manual does not constitute nor should it be construed as a promise of employment/internship or as a contract between Shoreline Behavioral Health Clinic and any of its staff/interns.

Shoreline Behavioral Health Clinic at its option, may change delete, suspend, or discontinue parts or the policy in its entirety at any time without prior notice.

TABLE OF CONTENTS

1.0 Welcome and Mission Statement
2.0 Goals
3.0 General Policies
- 3.1 Dress Code Policy
- 3.2 Attendance and Tardiness
- 3.3 Parking
- 3.4 Smoking
- 3.5 Alcohol & Substance Abuse
- 3.6 Email Practices & Policy
- 3.7 Returning Phone Calls
  - 3.7a. Phone Calls Received During Regular Business Hours
  - 3.7b. After Hour Phone Calls
  - 3.7c. New Client Calls
- 3.8 Cell Phone Policy
- 3.9 Computer Usage

4.0 Principles and Ethical Standards
- 4.1 Gifts

5.0 Staff Communications
- 5.1 Open Communication
- 5.2 Harmful Communications
- 5.3 Harassment Policy
- 5.4 Sexual Harassment Policy
- 5.5 Violence in the Workplace
- 5.6 Crisis Suspension

6.0 Legal Considerations/Accident or Incident Reports
- 6.1 Subpoena Policy
- 6.2 Accident or Incident Reports

7.0 Documentation
- 7.1 Client Records
- 7.2 Child Client Records

8.0 Mandated Reporting
- 8.1 Child Abuse or Neglect
- 8.1a. How To Report

8.2 Abuse of Persons with Disabilities
8.3 Abuse of the Elderly
9.0 Program Evaluation
10.0 Safety, Crisis Intervention and Emergency Procedures
10.1 Safety Procedures
10.2 Crisis Procedures
10.2a.Suicidial and Homicidal Ideation

10.2b.Threats & Violent

11.0 Affirmative Action
12.0 Appendices

1.0 Welcome & Mission Statement

This document has been developed in order to familiarize staff and interns with Shoreline Behavioral Health Clinic (SBHC). This handbook will provide information about working conditions, key policies and procedures, and address other concerns or questions staff and interns may have regarding Shoreline Behavioral Health Clinic.

Welcome

Welcome to Shoreline Behavioral Health Clinic! We look forward to sharing a productive and successful professional experience with you.

This handbook has been written to serve as a guide as you embark on your professional journey with Shoreline Behavioral Health Clinic. It is an introduction what the management and supervisors will expect of you as well as what the staff or intern can expect from Shoreline Behavioral Health Clinic.

Our policies are procedures are adapted from the Department of Public Health as well as the Department of Children and Families. We must follow all policies and procedures from these departments as an outpatient mental health clinic.

We extend to you our wishes of success and happiness while working here at Shoreline Behavioral Health Clinic.

Welcome Aboard!

Cara M. Powers, LPC, NCC
Founder & Clinical Director

Mission Statement

At Shoreline Behavioral Health Clinic, our vision is to create a productive environment where everyone has all of the resources necessary to lead a healthy, safe, and meaningful life. To bring this vision to reality, Shoreline Behavioral Health Clinic is to offer empowering services that are person-centered, strength-based, gender-sensitive and collaborative to all members of West Haven, CT and the surrounding communities.

2.0 Goals

Our goal at Shoreline Behavioral Health Clinic is to:

- Ensure the highest quality service operations in all of the clinic's programs.
- Develop and implement strategies to retain and recruit highly qualified staff and supervisors to enhance leadership and quality.
- Enhance stability of the clinic's programs and services to keep serving those who need and search for mental health treatment.

3.0 General Policies

3.1 Dress Code Policy

All professionals working at Shoreline Behavioral Health Clinic are required to present a neat and organized appearance while on-site. It is expected that all staff and interns will exercise good judgment and dress appropriately to project a professional image.

A business Casual attire is expected. This typically consists of but is not limited to:

- Suits
- Dresses
- Skirts
- Dress Pants
- Dress Shoes
- Blazers
- Dress Shirts
- Polo Shirts

All administrative staff are required to wear solid, neutrally colored "scrubs" at all times.

Jeans of any color, t-shirts, jogging attires, tank/halter tops, shorts, worn are tattered shoes, etc., are not acceptable at any time.

3.2 Attendance and Tardiness

Every staff/intern is expected to report for work regularly and on time. Maintaining good attendance and punctuality are important job requirements and are essential within this

professional environment. Absenteeism and tardiness relays the message that our client's time is not regarded as valuable; this impression carries significant repercussions for Shoreline Behavioral Health Clinic as a whole and for you as a professional service provider.

Shoreline Behavioral Health Clinic's Management staff reserves the right to ask for a Doctor's note after 4 consecutive absences and may ask you to reschedule your own patients regarding your absence. Shoreline Behavioral Health Clinic requires that if you are going to absent to contact management or office manager to confirm your absence.

3.3 Parking

Parking at the facility is for patients and clients **ONLY**.

Staff and interns **MUST** use the commuter parking lot located one block from the facility. The commuter lot is behind the Medical Building at 385 Main Street.

If you are working past 5pm, please use the buddy system or security to walk you to your car.

3.4 Smoking

No smoking of any kind is permitted inside Shoreline Behavioral Health Clinic offices. Smoking may take place in only designated smoking areas outside Shoreline Behavioral Health Clinic.

3.5 Alcohol and Substance Abuse

Shoreline Behavioral Health Clinic should remain free of illicit drugs and alcoholic beverages, and free of their use.

3.6 Email Practices & Policy

All staff, interns, and volunteers will receive a safe and reliable Shoreline Behavioral Health Clinic email. This will be used to communicate with Shoreline Behavioral Health Clinic staff and other professionals.

Email will be the primary communication method amongst all Shoreline Behavioral Health Clinic staff. It is imperative that you check your email frequently. Respond to email in a timely manner. If you are going to be away from the office, we ask that you

please update your outgoing message accordingly to let staff know that you will be away and not checking email for specific period of time.

For personal safety and safety of our patients – this email should not be given to patients.

Email is permanent record and must be treated with professionalism. Please be aware of the legal risks of email:

- If you send or forward emails with any libelous, dilatory, offensive, racist, or obscene remarks, you and/or Shoreline Behavioral Health Clinic may be held liable.
- If you unlawfully forward confidentiality information, you and or Shoreline Behavioral Health Clinic may be held liable.
- If you send emails with negative personal opinions or legal conclusions, such opinions and legal conclusions may be legally used against Shoreline Behavioral Health Clinic.

You should take the same care in drafting an email as you for any other forms of written communication. You should adhere to these guidelines:

- Do not send any personal health information or confidential information via email.
- Write well-structured emails and use short, descriptive subject lines.
- **Word did not find any entries for your table of contents.**check emails prior to transmission.
- Only send emails that you are comfortable with displaying in a public forum, such as a newspaper or in a courtroom. If it can't be displayed in a public manner, consider rephrasing the email or use other means of communication.
- Do not offer your legal option in emails.
- Do not send emails with libelous defamatory, offensive, racist, or obscene remarks.
- Do not use email to discuss or report concerns about improper or illegal conduct. Instead report such conduct directly to Shoreline Behavioral Health Clinic management or Human Resources Department.

3.7 Returning Phone Calls

Al staff and interns of Shoreline Behavioral Health Clinic will designated a voicemail box and extension at the business landline phone number. This will be used in communication for Shoreline Behavioral Health Clinic staff and with patients. Please follow email prompt given to staff at orientation for staff voicemails.

3.7a. Phone Calls Received During Regular Business Hours

All phone called received Monday – Saturday are answered by administrative staff and should be responded to as quickly as possible (within 24 hours).Check your voicemail frequently.

3.7b. After Hour Phone Calls

Calls received after normal business hours should be returned promptly the following work day. Calls received after 5pm on Friday, Saturday and Sunday should be returned promptly on Monday morning.

3.7a. New Client Calls

In the event that you receive a call from a new or potential client, refer this call to intake staff as soon as possible. The intake staff will return the call within 24 hours during regular business hours.

3.8 Cell Phone Policy

All staff is not permitted to give out their personal cell information to patients at any time. Patients should be instructed to call the main line and leave messages there.

Office staff is not permitted to use their personal cell phones or the office phones for personal use during work hours. If you have an emergency when you would need to make a personal call, please inform your supervisor beforehand.

3.9 Computer Usage

There are computers located in each office for staff usage. PLEASE DO NOT REMOVE THESE OR ANY OTHER COMPUTERS FROM SHORELINE BEHAVIORAL HEALTH CLINIC PREMISES. Computers are for office and work use.

4.0 Principles and Ethical Standards

Shoreline Behavioral Health Clinic insists on the highest legal and ethical standards while conducting business. Doing the right thing and acting with integrity are the two driving forces behind Shoreline Behavioral Health Clinic success. When faced with an ethical issue, staff and interns are expected to make the right professional decisions consistent with industry standard ethical principles and guidelines (i.e., ACA, APA, AMHCA, etc.).

Staff should also report any decisions to direct supervisors.

4.1 Gifts

Advance approval from management is required before any staff may accept or solicit a gift of any kind from a client. Staff is not permitted to give or receive unauthorized gifts.

5.0 Staff Communications

5.1 Open Communication

Shoreline Behavioral Health Clinic encourages staff to discuss any issues they may have with a co-worker directly with that person. If a resolution is not reached, staff should arrange a meeting with their direct supervisor. Any information discussed in an Open Communication meeting is considered confidential, to the extent possible while still allowing management to respond to the problem. Retaliation against any staff for appropriate usage of Open Communication channels is unacceptable.

5.2 Harmful Communications

Shoreline Behavioral Health Clinic recognizes that harmful communications can be extremely detrimental to the workplace environment. Such "gossip" can damage reputations, hurt morale, and decrease productivity. Therefore, the spreading of harmful communications (i.e., gossip) that involves sensitive subject matter acting to harm a: colleague, supervisor, client, or any other affiliated individual or group of individuals, is strictly prohibited.

5.3 Harassment Policy

Shoreline Behavioral Health Clinic does not tolerate workplace harassment. Workplace harassment can take many forms. It may be, but is not limited to, words, signs, offensive jokes, cartoons, pictures, posters, e-mail jokes or statements, pranks, intimidation, physical assaults or contact, or violence.

5.4 Sexual Harassment Policy

Shoreline Behavioral Health Clinic has adopted a "no tolerance" policy and will not tolerate sexual harassment. Sexual harassment may include unwelcome sexual advances, requests for sexual favors, or other unwelcome verbal or physical contact of a sexual nature when such conduct creates an offensive, hostile, and intimidating working environment and prevents an individual from effectively performing the duties of their position.

5.5 Violence in the Workplace

Shoreline Behavioral Health Clinic has adopted a policy prohibiting workplace violence. Consistent with this policy, acts or threats of physical violence, including intimidation, harassment, and/or coercion, which involve or affect SBHC or which occur on SBHC or client property, will not be tolerated.

5.6 Crisis Suspension

Any staff that commits any serious violation of Shoreline Behavioral Health Clinic policies, at minimum will be suspended without pay pending an investigation of the situation. Following the investigation, the staff may be terminated without any previous disciplinary action having been taken.

6.0 Legal Considerations/Accident or Incident Reports

6.1 Subpoena Policy

As a behavioral health care agency, Shoreline Behavioral Health Clinic may be the recipient of subpoenas requiring the timely production of specific information regarding individuals or entities involved in potential or ongoing litigation. This would then call for working with the Department of Public Health.

The purpose of this policy is to provide internal guidelines and procedures for all staff and interns regarding the potential of being served a subpoena while on-site. This policy is intended only as a general guideline – specific or detailed questions should always be referred to Shoreline Behavioral Health Clinic. If your immediate supervisor is not available, please contact the other Clinical Director.

Background and Scope

Definitions

Staff, in the normal course of business, may be the recipient of a subpoena served by a "process server" or, in certain circumstances, by mail.

- Deposition Subpoena is a command to appear at a certain time or place to give testimony upon a certain matter. Staff may receive a subpoena summons to testify in person as a witness in regard to certain legal or civil actions.
- A Subpoena Duces Tecum is an order for a person to produce records or documents under his or her control at a specific time and place in a court hearing or a disposition.

Procedure

A person "accepts" a subpoena by signing an affidavit of service, if the subpoena is served by a process server, or by simply assuming responsibility for a subpoena that arrives by mail.

A. Acceptance of Subpoenas

- Deposition Subpoena: Only the Clinician who is directly involved in the client's case named on the deposition subpoena is able to accept the service of deposition subpoena.
- Subpoena for Records (Duces Tecum): Only the Clinician who is directly involved in the client's case named on the subpoena for records is able to accept the subpoena for records subpoena.
- If you receive a Deposition Subpoena or Subpoena of Records, contact the Assistant or Clinical Director immediately in order to identify how to proceed.

If a process server appears and tries to serve anyone other the clinician involved with the case, you **MAY NOT** accept the subpoena. Do not sign the document for the designee. Immediately contact the Clinical or Assistant Clinical Director to report that an attempt to serve a subpoena has been made.

6.2 Accident or Incident Reports

A. Classification: All accident or incident reports that go to the Department of Public Health shall employ the following classifications of such events:

Class A: One which has resulted or had the potential to result in serious injury or death

Class B: One which has interrupted or has the potential to interrupt the services provided by the facility

Class C: One which results in legal action against the facility

B. Report: The Executive Director shall report any accident or incident to the Department of Public Health as follows

Class A & B: Immediately by telephone to DPH, to be confirmed by written report as provided herein within seventy-two (72) hours of said events.

Class C: Written report to the department as provided herein within seventy-two (72) hours of the initial of legal action.

C. Each written report shall contain the following information:

- Date of report and date of event
- Facility classification

- Identification of the individuals affected by the events, including, where available: client name and age, name of employee, visitor or other, nature of incident, action taken by the facility and disposition.
- If an affected individual is or was at the time of the reported event a client of the facility you would need:
    a. Date of admission
    b. Current diagnosis
    c. Physical and mental status prior to the event
    d. Physical and mental status after the event
- The location nature and brief description of the event
- The name of the physician consulted, if any, and time of notification of the physician and a report summarizing any subsequent physical examination, including finding and orders
- The name of any witnesses to the event
- Any other information deemed relevant by the reporting authority
- The signature of the person who prepared the report and the Executive Director.

D. Numbering: Each report shall be identified on each page with a number as follows: The number appearing on the facility license; the last two digits of the calendar year; the sequential number of the report during the calendar year.

E. The Executive Director shall submit subsequent reports relevant to

any accident or incident.

7.0 Documentation

All Clinical, Medical, and Administrative staff will be trained and expected to utilize our Electronic Health Records website for each and every patient/client that they see or have contact with. A separate training video outlining are forms and EHR procedures will be provided to all new hires.

7.1 Client Records

A. An organized electronic record for each client shall be maintained which contains current information sufficient for identification and assessment for the provision of appropriate care, treatment and other applicable services.
B. Each client record shall contain the following:
    - Documentation of advisement of client rights
    - Social/Family background
    - Emergency contact information
    - Physical exam inclusive of medical history
    - Substance abuse history (if applicable)
    - Education background
    - Employment History
    - Referral source summary

- Legal history
- Releases and notation of release of information

C. Each client record shall contain a comprehensive written assessment which shall be written within fifteen (15) days of admission and include identification of individual needs of the client as well as the approaches to meet each identified need, i.e., psychiatric, psychological, recreational, nursing, and social work as applicable

D. Each client record shall contain an individualized care plan, which must include:

i. Specific objectives, which are related to, stated goals

ii. Name of assigned staff person to develop and monitor the care plan

iii. Description of the type and frequency of services to be provided

iv. Provision for periodic review by designated staff member

v. Description of supportive services determined to be needed

vi. Signatures of the counselor, supervisor, or other staff person formulating the individualized care plan.

E. Each individual client record shall contain progress notes, which document services provided to the client and progress made toward personalized goals and objectives in accordance with their plan. Each note shall be entered electronically by a direct care staff member and should be dated, legible, and signed by the person making the entry with their electronic signature, position title, and supervisor signature (if applicable).

F. Current lists of all medications and instruction for administration

G. Documentation of periodic individualized care plan review. This should include date, person conducting review, and any changes in the care plan as a result of the review

H. A comprehensive individualized care plan based on the assessment shall be developed and reviewed as follows:

aa. Developed no later than thirty (30) calendar days after admission.

bb. Reviewed every ninety (90) calendar days.

I. Discharge Summary, which has been written within fifteen (15) days of the individual's client's discharge date. This summary shall:

i. Indicate the client's progress towards the established individualized care plan goals

ii. Address original reason for referral

iii. Describe the type, frequency, and duration of treatment or services provided

iv. Reasons for discharge

v. Identify expectations for future functioning

J. Client records shall remain secure under the electronic health record system. They should be kept for at least seven (7) years following discharge. (Department of Public Health, 2006)

7.2 Child Client Records

A. Each clinic shall maintain a current confidential case record for each child in treatment including family, social, and health history. The case record shall contain but not be limited to pre-admission data; the reason for admission; results of all diagnostic assessments performs; a summary of admission information; the individual treatment plan; a record of all care and services, including medical services, provided by the clinic; progress notes on the child in treatment; reviews of the treatment plan; the plan for discharge and disposition; a discharge summary and all other documents received and required for the treatment plan of a particular child.

B. The case record shall contain only information pertaining to a particular child.

C. The case record shall include contact summaries where appropriate and copies of special behavior contracts used for a particular child.

8.0 Mandating Reporting

Shoreline Behavioral Health Clinic are in a position to identify potential cases of abuse and neglect of children, the elderly, and individuals with disabilities based on the considerable contact with families, individuals, and couples.

The purpose of these policies is to provide a guideline for understanding mandated reporting requirements for suspected abuse and neglect of children, the elderly, and the disabled. This policy will also provide internal guidelines for initiating a report to state departments.

8.1 Child Abuse or Neglect

CT general statute requires that certain persons in their professional capacity are mandated to report child abuse and neglect when they have reasonable cause or suspicion to believe that a child under the age of 18 years has been abused, neglected, or is placed in imminent risk of serious harm.

Child abuse occurs where a child has had physical injury inflicted upon him or her other than by accidental means, has injuries at variance with history given of them, or is in a condition resulting in maltreatment, such as, but not limited to, malnutrition, sexual molestation or exploitation, deprivation of necessities, emotional maltreatment or cruel punishment. (Connecticut General Statutes §46b-120)

Child neglect occurs where a child has been abandoned, is being denied proper care and attention physically, emotionally, or morally, or is being permitted to live under conditions, circumstances or associations injurious to his well-being. (Connecticut General Statutes §46b-120)

When making a report, a mandated reporter is required to provide the following information, if known:

1. The names and addresses of the child and his parents or other person responsible for his care;
2. The age of the child;
3. The gender of the child;
4. The nature and extent of the child's injury or injuries, maltreatment or neglect;
5. The approximate date and time the injury or injuries, maltreatment or neglect occurred;
6. Information concerning any previous injury or injuries to, or maltreatment or neglect of, the child or his siblings;
7. The circumstances in which the injury or injuries, maltreatment or neglect came to be known to the reporter;
8. The name of the person or persons suspected to be responsible for causing such injury or injuries, maltreatment or neglect;
9. The reasons such person or persons are suspected of causing such injury or injuries, maltreatment or neglect;
10. Any information concerning any prior cases in which such person or persons have been suspected of causing an injury, maltreatment or neglect of a child;
11. Whatever action, if any, was taken to treat, provide shelter or otherwise assist the child (PA 11-93 §15).

8.1a. How To Report

Mandated reporters must report orally to the Department of Children and Families' (DCF) Hotline or a law enforcement agency within 12 hours of suspecting that a child has been abused or neglected and must submit a written report (**DCF-136 form**) to DCF within 48 hours of making the oral report.

When the Mandated reporter is a member of the staff of a public or private institution or facility that provides care for children or a member of a public or private school, they must also provide written notification to the head of the facility or institution where the alleged victim is enrolled or registered. DCF is required to tape record all reports to the Careline.

Special reporting requirements may apply for staff members of a public or private institution or facility that cares for such child, or a public or private school. (See pages 4-5).

Police must report to DCF immediately upon receipt of any oral report of abuse or neglect.

Upon receipt of any oral report alleging sexual abuse or serious physical abuse or serious neglect, DCF must report to the appropriate state or local law enforcement agency within 12 hours.

Mandated reporters are required to make a referral to the DCF Hotline as soon as practical **but no later than 12 hours after the mandated reporter becomes aware of or suspects abuse/neglect or imminent risk of serious harm to a child or children.** Any person required to report who fails to make such report or fails to make such report within the time period prescribed (in sections 17a-101b to 17a-101d), could be fined not less than five hundred dollars ant not more than two thousand five hundred dollars and could be required to participate in an educational and training program (pursuant to subsection (d) of section 17a-101). The Department shall promptly notify the Chief State's Attorney when there is reason to believe that any such person has failed to make a report in accordance with this section.

DCF 136 Form in Appendix A

8.2 Abuse of Persons with Disabilities

Any physician or surgeon licensed under the provisions of chapter 370, any resident physician or intern in any hospital in this state, whether or not so licensed, any registered nurse, any person paid for caring for persons in any facility and any licensed practical nurse, medical examiner, dental hygienist, dentist, occupational therapist, optometrist, chiropractor, psychologist, podiatrist, social worker, school teacher, school principal, school guidance counselor, school paraprofessional, mental health professional, physician assistant, licensed or certified substance abuse counselor, licensed marital and family therapist, speech and language pathologist, clergyman, police officer, pharmacist, physical therapist, licensed professional counselor or sexual assault counselor or battered women's counselor, as defined in section 52-146k.

Report

An oral report must be made as soon as possible within seventy two (72) hours to the office of Protection and Advocacy, Abuse Investigation Division. In cases where the allegation results in death an oral report must be made within twenty-four (24) hours.

A written report must follow within five (5) additional calendar days of the oral report.

All information known must be reported to the Abuse Investigations Division of the Office of Protection and Advocacy for Persons with Disabilities at **(860) 297-4300** or **(800) 842-7303**. This would then be followed by a **PA6** form which can be faxed to **(860) 297-4355**. Please see Appendix A

8.3 Abuse of the Elderly

To report cases of suspected abuse, neglect or exploitation, call the toll-free In State referral line at 1-888-385-4225, Out of State call Infoline at 1-800-203-1234. After Hours Elder Abuse Emergencies, In State call Infoline at 211, Out of State call Infoline at 1-800-203-1234. Please see Appendix A.

9.0 Program Evaluation

A. Measurement tools are client intake reports, monthly client data reports that indicate volume, demographics, case notes and assessment (that are reviewed every 90 calendar days), and contract standards.
B. Client satisfaction surveys for adults and children shall also be given and received.
C. Progress of individualized care plan and reviews
D. Shall be reviewed quarterly (every 90 calendar days) to ensure quality

10.0 Safety, Crisis, and Emergency Procedures

10.1 Safety Procedures

Advise any of the Direct Supervisors of any safety concerns. They are also trained to lead us through any safety procedures and drills.

CODE – ALL CALL

A. Fire Escapes & Exits - TBD
B. Forced Entry Alarms – Alarms will be located on all emergency exit doors. The main door in the front building will also alarm once the master alarm is set.

C. Panic Buttons – There are silent panic buttons in the office. These will be located around the facility. This will automatically silently signal for emergency services.
D. Fire Extinguisher & First Aid Kits – These will be located throughout the clinic, There will be a first aid kit at the reception desk for emergency usage.
E. Fire Alarms – There are fire alarms located throughout the building. If alarms sound please exit through fire escapes or other planned routes for emergency exits. Call 911 to report a fire immediately.

10.2 Crisis Intervention Procedures

Crisis intervention is when a client or others associated with the client (i.e., children) are in serious or immediate emotional distress or at risk for danger.

10.2a.Suicidal and Homicidal Ideation

IF IMMEDIATE DANGER IS PRESNT USE PANICBUTTON OR CALL 911 AND THEN CALL OR SEEK DIRECT SUPERVISOR TO NOTIFY/ASSIST WITH SITUATION

CODE – RED FOLDER

Procedures During Shoreline Behavioral Health Clinic Hours:

- Consult with Direct Supervisor o=in building or on call supervisor
- If hospitalization is recommended, initiate the following procedures:
  a. Contact appropriate family members; **IF MINOR PARENT MUST BE NOTIFIED**
  b. Call local hospital to let staff know client is on their way (Nearest hospitals are Yale and St. Raphael's)
- Give your name, position and Shoreline Behavioral Health Clinic name.
- State that you "want to refer someone whom we consider an emergency"
- Ask to speak to the mental health professional on call
- Have information about client collected.

Procedures For After Hour Emergencies:

- All clinicians and medical staff must have a message on the voicemail box that informs clients "that in case of an emergency do not wait for a return call but to dial 911 or go to their local emergency room."

10.2b.Threats and Violence

An emergency response plan for staff in the events that a threat of violence.

A. Dangerous/Violent Person

CODE – MR WESTIE IN THE BUILDING

- Please try to remain as calm as possible in all emergency situations
- There is a panic button locates in the front office, upstairs in the staff kitchenette, and in the billing office. If you think a client is dangerous or has the potential to become dangerous please bring one with you to session.
- Press 0 at any time from any office landline phone and this will call the front desk. Never yell to the front office that there is an emergency, or yell call and ambulance or call the police unless you or client/patient are in immediate, imminent, danger. Yelling and shouting only escalates anxiety levels of staff and patient. If you have an emergency and need assistance dial 0 form any phone.
- If you have an emergency and are calling the front office but do not wish to alert or anger your patient/ client by explaining the emergency to the front desk tell the front office that you NEED THE RED FOLDER. The office staff will then call 911 immediately.
- The front office can all call every phone in the building by pressing 400. The following codes will be used to signal emergencies:

B. Active Shooter Response

CODE – BLACK HAWK

An active shooter is an individual who engages in killing or attempting to kill people in confined and populated areas. Fire arms are most often used and there is usually no pattern or method to their selection of victims.

Active shooter situations are usually no more than 10 or 15 moments in length, evolve quickly, are unpredictable and when notified, evoke immediate response from local law enforcement, which is the only way to stop the shooting.

PROCEDURE

- The first staff member to identify an active shooting incident should call the front desk and initiate a **CODE BLACK HAWK**. Without placing

themselves or others at risk, the caller should identify where the incident is occurring and any other information on the shooter(s) and weapons.

- The front desk should announce a **CODE BLACK HAWK** over the all call system and then call 911 and provide as much information to police as they have available.

Evacuation

- If there is a safe escapable route, attempt to evacuate the premises taking your clients with you, be sure to:
    - Have an escape route and plan in mind
    - Evacuate regardless of whether others agree to follow or not
    - Leave belongings behind
    - Help others if possible. Keep them from entering an area where the active shooter(s) may be
    - Keep hands visible
    - Follow instructions of the police
    - Do not attempt to move the wounded
    - Call 911 when safe

Hide Out

- If evacuation is not possible, find a place to hide where active shooter is less likely to find you. This hiding place should:
    - Be out of shooter view
    - Provide protection if shots are fires in your directions
    - Prevent a shooter from entering your hiding place by locking door and blocking it with heavy furniture or other objects
- If active shooter is nearby
    - Lock door
    - Silence cell phone, pagers, and turn off any source of noise
    - Extinguish all lights
    - Hide behind large objects
    - Remain silent

If evacuation and hiding out are not possible remain calm. Dial 911 and give location – If unable to speak leave line open for dispatcher to listen.

Take Action Against Shooter

- At a last resort and only when your life is imminent danger, attempt to disrupt or incapacitate the shooter(s) by
    - Acting aggressively as possible against the shooter(s)
    - Throw items and improvise weapons
    - Yell
    - Commit to your actions

How To Respond When Law Enforcement Arrives
The purpose of the police is to stop the shooter as quickly as possible. They will proceed directly to the area in which the last shots were heard. As other officers arrive remain calm and follow police instructions. KEEP HANDS FREE OF ANY OBJECTS AND RAISE HANDS WITH FINGERS SPREAD AND VISIABLE (US Department of Homeland Security, 2008).

11.0 Affirmative Action

At Shoreline Behavioral Health Clinic we are committed to both equal employment opportunities (EEO) and affirmative action (AA).

As the director of SBHC, I firmly support the principles of equal employment opportunity, affirmative action, and equal employment laws.

The goal of affirmative action is equal employment opportunity. Equal employment opportunity is the employment of individuals without regards to race, color, religious creed, age, sex, sexual orientation, marital status, national origin, ancestry, mental disability or history of mental disability, mental retardation, learning disability, physical disability, including but not limited to blindness, pregnancy, previous opposition, genetic information, or workplace hazards to reproductive systems unless there is a bonafide occupational qualification excluding persons in one of these protected classes. Affirmative action means positive, vigorous action taken to achieve equal employment opportunities. Affirmative action does not require that "quotas" or "set asides" be established for minorities or women.

Affirmative action and equal opportunity are immediate and priority objectives. To that end, SBHC has developed an Affirmative Action Plan, which commits the organization to aggressively pursue equal employment opportunities and to provide services and programs to the public in a fair and impartial manner. In order to ensure this policy's dissemination and implementation throughout all levels of the organization.

Affirmative action plays an important and necessary role in all stages of the employment process, such as recruitment, staff orientation, training, upward mobility and employment counseling; as well as implementing the complaint procedure by investigating discrimination allegations. This includes evaluation and monitoring employment applications, job qualifications and specifications, recruitment practices, personnel policies, job restructuring, evaluations, layoffs and terminations.

The employment process consists of recruitment, selection, placement, job training, and counseling, promotion, and transfer, salary and fringe benefit determination, separation and termination. The role of affirmative action is to provide an environment for the application of equal opportunity principles and to monitor the employment process to prevent instance of illegal discrimination from arising or existing.

12.0 HIPPA Policy Information

"**Health Insurance Portability and Accountability**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) was signed into law on August 21, 1996. Among this law's many important protections for millions of working Americans and their families are requirements to protect the privacy of individual's health information through rules which govern health care providers and entities that pay for health care or process health care information. The HIPAA Privacy and Security Rules ensure a national floor of privacy and security protections for patients by limiting the ways that health plans, pharmacies, hospitals and other covered entities can use patients' personal medical information. Starting in September 2009, HIPAA protections now include new rules against disclosure or protected health information including notification of individuals when the privacy of their information is breached" (Health Insurance Portability and Accountability Act, 2004).

Appendices

A. Written DCF 136 Form for Reporting Abuse or Child Neglect, Written PA-6 for Reporting Abuse of Persons with Intellectual Disabilities, Written Form for Abuse of the Elderly

Appendix A

REPORT OF SUSPECTED CHILD ABUSE OR NEGLECT

DCF-136
11/2014 (Rev.)

Careline
1-800-842-2288

Within forty-eight hours of making an oral report, a mandated reporter shall submit this form (DCF-136) to the relevant Area Office listed below
See the reverse side of this form for a summary of Connecticut law concerning the protection of children

Please print or type

Child's Name	☐ M ☐ F	Age Or DOB	Race: ☐ American Indian or Alaskan Native ☐ Asian/Pacific Islander ☐ Black/African American (not of Hispanic Origin)	☐ Hispanic ☐ White (not of Hispanic origin) ☐ Unknown ☐ Other _____
Child's Address				
Name Of Parents Or Other Person Responsible For Child's Care		Address		Phone Number
Name Of Careline Worker To Whom Oral Report Was Made		Date Of Oral Report		Date And Time Of Suspected Abuse/Neglect
Name Of Suspected Perpetrator, If Known		Address And Phone Number, If Known		Relationship To Child
Nature And Extent Of Injury(ies), Maltreatment Or Neglect				
Describe The Circumstances Under Which The Injury(ies), Maltreatment Or Neglect Came To Be Known				
Describe the Reasons Such Persons(s) Are Suspected of Causing Such Injuries, Maltreatment of Neglect				
Information Concerning Any Previous Injury(ies), Maltreatment Or Neglect Of The Child Or His/Her Siblings				
Information Concerning Any Prior Cases(s) In Which The Person(s) Have Been Suspected Of Causing An Injury(ies), Maltreatment Or Neglect Of A Child				
List Names And Ages Of Siblings, If Known				
What Action, If Any, Has Been Taken To Treat, Provide Shelter Or Otherwise Assist The Child?				
Reporter's Name And Agency	☐ American Indian or Alaskan Native ☐ Asian/Pacific Islander ☐ Black/African American (not of Hispanic Origin) ☐ Hispanic ☐ White (not of Hispanic origin) ☐ Prefer Not to Answer ☐ Other _____	Address: City:		Phone Number
Reporter's Signature		Position		Date

WHITE COPY: TO DCF AREA OFFICE (see below) *IF YOU NEED ADDITIONAL SPACE, YOU MAY ATTACH MORE DOCUMENTATION*

Bridgeport 100 Fairfield Avenue Bridgeport, CT 06604 203-384-5300 TDD: 203-384-5399 Fax: 203-384-5307	**Danbury** 151 West Street Danbury, CT 06810 203-207-5100 TDD: 203-748-6325 Fax: 203-207-5170	**Hartford** 250 Hamilton Street Hartford, CT 06106 860-418-8000 TDD: 800-315-4082 Fax: 860-418-8327	**Manchester** 364 West Middle Tpke Manchester, CT 06040 860-533-3600 TDD: 800-315-4415 Fax: 860-533-3750	**Norwalk** 761 Main Ave Norwalk, CT 06851 203-899-1400 TDD: 203-899-1491 Fax: 203-853-3821
Meriden One West Main Street Meriden CT 06451 203-238-6400 TDD: 203-238-6517 Fax: 203-238-6287	**Middletown** 2081 South Main St Middletown, CT 06457 860-638-2100 TDD: 860-638-2195 Fax: 860-346-2585	**Milford** 38 Wellington Road Milford, CT 06461 203-306-5300 TDD: 203-306-5604 Fax: 203-777-4358	**New Britain** One Grove Street, 4th Fl New Britain, CT 06053 860-832-5200 TDD: 860-832-5370 Fax: 860-832-5318	**New Haven** One Long Wharf Drive New Haven, CT 06511 203-786-6500 TDD: 203-786-2959 Fax: 203-786-7457
Norwich Two Courthouse Square Norwich, CT 06360 860-886-2641 TDD: 860-886-2438 Fax: 860-886-1300	**Torrington** 62 Commercial Blvd Torrington, CT 06790 860-496-5700 TDD: 860-496-5798 Fax: 860-496-5746	**Waterbury** 395 West Main Street Waterbury, CT 06702 203-759-7000 TDD: 203-465-7329 Fax: 203-759-7298	**Willimantic** 322 Main Street Willimantic, CT 06226 860-450-2000 TDD: 860-456-6803 Fax: 860-423-5034	

REPORT OF SUSPECTED ABUSE OF AN ADULT WITH INTELLECTUAL DISABILITY

PA-6 Rev. 5/2011

TELEPHONE NUMBERS
297-4355 (Hartford Area)
566-2102 (TDD Only)
1-800-842-7303 (Toll free Voice and TDD)

STATE OF CONNECTICUT
OFFICE OF PROTECTION AND ADVOCACY
FOR PERSONS WITH DISABILITIES
60-B Weston Street
Hartford, CT 06120-1551

See next page for summary of Connecticut law concerning protection of adults with intellectual disability from abuse. In cases of suspected abuse an **ORAL REPORT SHOULD BE MADE IMMEDIATELY TO THE ABUSE INVESTIGATION DIVISION** in the Office of Protection and Advocacy. Written reports must be submitted within (5) calendar days of the oral report.

Reporter: Send original to the above address. You may make a copy for your records

Individual Being Referred (alleged victim of abuse or neglect)

(Last Name)	(First Name)	(M.I.)	Date of Birth Mo./Day/Year	Age
Address (No. & Street)	(City or Town)		Telephone Number	
Parents, Guardian or Caretaker Name (s)	Address (If different)			
Suspected Perpetrator if known Name (s)	Address			
Date (s) of suspected abuse or neglect	Oral report made to (Protection and Advocacy Investigator)		Date of report	

Reasons for Believing Alleged Victim is a person with a intellectual disability

Information supporting alleged victim's inability to substantially protect himself/herself from abuse or neglect

Nature of extent of suspected abuse or neglect and supporting information (attach additional sheets if necessary)

Referral Source	Does reporter wish to be: Notified of Action? Y N	Does reporter wish to Remain Anonymous? Y N
Reporters name/agency	Address	Telephone Number
Reporters Signature	Title, Position or Relationship	Date

W-675
Rev. 12/2006

STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES
25 Sigourney Street, Hartford, CT 06106

To Refer a Connecticut Protective Service Case Call: 1-888-385-4225 Toll Free

REPORT FORM FOR PROTECTIVE SERVICES FOR THE ELDERLY

Call the Protective Services for the Elderly from the Department of Social Services on the toll free line or at the regional numbers listed on back (or Info-line at 211 **after hours**) if you have any reason to believe or suspect that the elderly person cited below is being abused, abandoned, neglected, or exploited. If you choose you may complete this form and forward it to the DSS office covering the elder's town of residence **LISTED ON THE BACK**.

Certain individuals are required by State Statute to report suspected abuse, abandonment, neglect, or exploitation. If you are making the referral, complete this form giving as much information as you have available to you. **RETURN TO APPROPRIATE OFFICE LISTED ON BACK!**

I. INDIVIDUAL BEING REFERRED (Person in need of protection)

(Last Name)	(First)	(M.I.)	Age:	Date of Birth: ____/____/____
ADDRESS	(No. & Street)	(City or Town)		Phone (include area code):
SOCIAL SECURITY NUMBER			LANGUAGE SPOKEN:	

OTHER PERSONS/In-Home -- Not in Home

NAME	RELATIONSHIP	CURRENT ADDRESS

II. REASON FOR REFERRAL (Check all appropriate categories not mutually exclusive) Does Emergency Exist? ____ Yes ____ No

____ Abuse ____ Neglect ____ Abandonment ____ Exploitation

Date of Alleged Incident (If Known): _____

Give Details: _____

If Abused, Name of Suspected Perpetrator (If Known)	Relative (Specify)	Other (Specify)

Are State or local police involved? ____ Yes ____ No	Official's Name, Address, and Phone:
Individual has Physical Problems? ____ Yes ____ No	

Give details of physical problems/limitation:

Is individual on any public assistance programs? ____ Yes ____ No If "Yes" Specify
____ OAA ____ AD-AB ____ Town ____ SSI/SSA ____ Title XIX
Other (Specify) _____

Case Number:

III. REFERRAL SOURCE:

NAME:	ADDRESS:	
Does complainant wish to be: ____ Identified ____ Does Not Want to be Identified ____ Anonymous ____ Notified of Action	Relationship to Elderly Person:	Phone (include area code):

_____ Signature _____ Printed Name _____ Date

References

Health Insurance Portability and Accountability Act. "State HIPPA

Security Policy." 2.0 CT (Nov. 3, 2004).

Department of Public Health (2006). *Licensure of private freestanding mental health day treatment facilities, intermediate treatment facilities and psychiatric outpatient clinics for adults.* Department of Public Health – Public Health Code, 19a-495-550.

US Department of Homeland Security (2008). Active shooter how to respond. October 2008.

OPERATING AGREEMENT

OF

SHORELINE WELLNESS BEHAVIORAL HEALTH CLINIC, LLC

Prepared for:

CARA POWERS

By

Law Offices of Jerome A. Lacobelle, LLC
537 Washington Avenue
West Haven, CT 06516

THIS OPERATING AGREEMENT made and entered into as of this 29th day of August, 2014 by and between:

Cara Powers

The parties identified above may also be referred to individually as a "Member" and collectively as the "Members".

WITNESSETH:

WHEREAS, the Members desire to form a limited liability company for the purposes set forth below; and

WHEREAS, the Members deem it desirable to define the terms of their association, and to commit their agreement in writing.

NOW, THEREFORE, intending to be legally bound hereby, the Members do hereby agree to form a limited liability company under the laws of the State of Connecticut upon the following terms and conditions:

1. ORGANIZATION

(a) Formation. The Members hereby form a limited liability company (the "Company") pursuant to the Connecticut Limited Liability Company Act (the "Act").

(b) Name. The name of the company shall be:

Shoreline Wellness Behavioral Health Clinic, LLC

(c) Location. The principal office of the company shall be 260 Main Street, New Britain, CT 06051 or such address as the Members shall designate.

(d) Term. The term of the company began on the date first above written

and shall continue until terminated in accordance with this Agreement.

(e) Purpose. The purpose of the Company is to engage in any lawful activity for which limited liability companies may be formed under the Connecticut L.L.C. Act.

2. MEMBERSHIP INTERESTS

Each Member's share of the rights and obligations of the Members may be referred to herein as his "Membership Interest". The Percentage Interest of the Members shall be as follows:

Member	Percentage Interest
CARA POWERS	100%

3. CAPITALIZATION AND CONTRIBUTIONS

(a) Capital Contributions. The original capital contributions of the Members shall be as follows, all of which shall be contributed contemporaneously with the execution of this Agreement. See "Exhibit B" attached hereto and made a part hereof.

(b) Additional Contributions. No Member shall be required to make additional contributions to the capital of the company, except as specifically provided in this Agreement.

(c) Withdrawal of Contributions. Except as otherwise specifically provided in this Agreement, no Member shall be permitted to withdraw any contributions made to the Company or otherwise receive any payments or distributions from the Company. Furthermore, no Member shall be entitled to receive any distribution of money or other property in excess of $1.00 by reason of such person ceasing to be a Member, except if (i) upon dissolution of the Company, or (ii) upon the written consent of each of the other Members. Rather, such former Member shall remain entitled to allocations of Income and Loss (as those terms are hereinafter defined) and distributions in the same manner as if such Member had not withdrawn, but shall thereafter have no rights to exercise any of the rights of a Member.

(d) Capital Accounts. A separate "Capital Account" for each Member shall be maintained as part of the books of the Company. Each Member's Capital Account shall be maintained in accordance with the provisions of Treasury Regulation Section 1.704-1(b).

4. INCOME AND LOSS

(a) Definition of Income and Loss. "Income" and "Loss" means, for each taxable year or other period, an amount equal to the Company's taxable income or taxable loss for such year or period, determined in accordance with Section 703(a) of the Internal Revenue Code (for this purpose, all items of income, gain, loss or deduction required to be stated separately pursuant to Section 703(a)(1) of the Internal Revenue Code shall be included in taxable income or loss, as the case may be) with such adjustments as are consistent with the provisions of Treasury Regulation Section 1.704-1(b).

(b) Allocation of Income and Loss. Except as otherwise provided in Subsection (c) below, Income and Loss shall be allocated among the Members in accordance with their Percentage Interests.

(c) Special Allocation Rules. The allocation of Income and Loss otherwise provided for in Subsection (b) above shall be adjusted to the extent necessary to cause the allocation to have substantial economic effect under Treasury Regulation Sections 1.704-1(b) and 1.704-2. Furthermore, and in addition to the foregoing, (i) Income and Loss shall be allocated pursuant to a so-called minimum gain chargeback as described in Treasury Regulations Section 1.704-2(f), (ii) Income and Loss shall be allocated pursuant to a so-called partner nonrecourse debt minimum chargeback as described in Treasury Regulation Section 1.704-2(i)(4), and (iii) Income and Loss shall be allocated pursuant to a so-called qualified income offset as described in Treasury Regulation Section 1.704-1(b)(2)(ii)(d). Any variations to allocations made pursuant to the preceding sentences

of this Subsection (c) shall be taken into account in making subsequent allocations of Income and Loss so that, to the extent possible, the net aggregate amounts of Income and Loss allocated to each member shall be equal to the net aggregate amounts that would have been allocated to each such Member is such Subsection (c) never existed.

5. DISTRIBUTION OF CASH.

The Members shall determine the amount and frequency of distributions of cash which the Company shall make. Any such distributions (other than distributions in connection with the dissolution and liquidation of the Company) shall be distributed to the Members in accordance with their Percentage Interests.

6. ADMINISTRATION.

The business, property and affairs of the Company shall be managed by the Members. The affirmative vote, approval, or consent of Members owning in the aggregate more then 65% of all of the Percentage Interests then owned by Members shall be required to decide any matter connected with the business or affairs of the Company.

7. BOOKS AND RECORDS AND ACCOUNTING.

(a) Books and Records. The Company shall keep proper and complete books and records in accordance with good accounting practice. The Company may adopt the cash receipts and disbursements method or the accrual method as its method of accounting, as the Members shall determine. The fiscal year of the Company (for federal income tax purposes and financial statement purposes) shall be the calendar year, unless the Members determine otherwise.

(b) Tax Returns. The Company shall, for each fiscal year, file a timely United States Partnership income tax return and any state and local partnership income tax returns as may be required by law.

(c) Financial Statements. As soon as practicable after the end of each fiscal year, each Member shall be furnished with a copy of the financial statements of the company for such year and a statement of distributions and allocations during or in respect of such year, and the amount thereof reportable for state and federal income tax purposes.

(d) Other Reports. The Company shall furnish such other reports as shall be appropriate to advise the Members as to the operations of the Company.

(e) Rights of Examination. Any Member may examine, inspect, and audit, at his own expense, the Company's books, records, accounts and assets (including bank balances and physical properties), either in person or through a certified public accountant, engineer, appraiser, or other qualified professional, provided that any such inspection shall be conducted at such time and in such manner as not to interfere with the conduct of the business of the Company.

8. TRANSFER OF INTERESTS

(a) Transferability. A Member may not sell, assign, give, encumber or otherwise transfer (directly or indirectly, conditionally or collaterally) ("Transfer" or a "Transfer") his Membership Interest or any part thereof except as specifically permitted in this Agreement, and any act in violation of this Subsection (a) shall be null and void and have no effect and shall not be binding upon or recognized by the Company regardless of whether any other Member shall have knowledge thereof.

(b) Permitted Transfer.

(1) Transfer by Reason of Death. A Member may Transfer his Membership upon his death, by will or intestacy.

(2) Transfer Other than by Reason of Death. A Member may transfer all or any part of his Membership Interest after he has (i) first obtained the written consent of each of the

other Members to such Transfer, which consent may be withheld in the complete discretion of each such other Member and (ii) satisfied all requirements and conditions established by the other Members for such Transfer, which requirements and conditions may include, without limitation, the following:

(A) the transferor has executed and delivered to the other Members an assignment and such other documents as are required by, and in form satisfactory to, the other Members.

(B) the other Members have determined that the Transfer will not result in a termination of the Company pursuant to Section 708 of the Internal Revenue Code or otherwise for federal income tax purposes;

(C) the other Members have determined that the Transfer will not be in violation of any applicable federal or state securities laws; and

(D) the transferor and/or transferee pay or reimburse the Company for all expenses incurred by the Company in connection with the transfer.

Any Transfer pursuant to this Subsection (b) shall not entitle the Transferee to be admitted as, or to exercise any of the rights of, a Member, but shall hereby entitle the Transferee to receive and be allocated, to the extent assigned, distributions and Income and Loss to which the Transferor would otherwise be entitled.

(c) Admission of Transferee as Additional Member. In the event any Transfer permitted pursuant to Subsection (b) above, the transferee shall be admitted as a Member upon (i) obtaining the written consent of each of the other Members to the admission of such transferee as a Member, which consent may be withheld in the complete discretion of each such other Member, and (ii) satisfying all requirements and conditions established by the other Members, which requirements

and conditions may include, without limitation the following:

(1) the transferee executes and delivers to the other members an undertaking of the transferee to be bound by all the terms and provisions of this Agreement, and such other instruments as may be required by the other Members, and a completed counterpart signature page of this Agreement; and

(2) the transferee pays or reimburses the Company for all expenses incurred by the Company in connection with the admission of the transferee as a Member.

(d) Effective Date of Transfer. Any Transfer that is permitted hereunder shall be effective (i) in the case of a Transfer by reason of death, as of the date of death, and (ii) in the case of a Transfer other than by reason of death, as of the first day of the first month following the month during which the other Members have consented, in writing, to the Transfer or at such later date as is specified in the Transfer documents.

(e) Indemnity. Each Member hereby indemnifies the Company and each other Member against any and all loss, damage or expense (including without limitation, tax liabilities or loss of tax benefits) arising, directly or indirectly, as a result of any Transfer or purported Transfer by that Member in violation of any provision contained in this section.

(f) Partition. No Member shall have the right to bring an action for partition against he Company.

(g) Withdrawal. No Member shall have the right to withdraw from the Company without the prior written consent of each of the other Members.

9. DISSOLUTION AND WINDING UP

(a) Events of Dissolution. Upon the happening of any of the following events (a "Liquidation Event"), the company shall be dissolved and its affairs would upon:

(1) The sale or other disposition of all or substantially all of the Company's property;

(2) The expiration of the term of the Company;

(3) The determination by the Members to dissolve the Company;

(4) An event of dissociation of a Member, unless there are at least two remaining Members and within ninety (90) days following the occurrence of such event, all of the remaining Members agree in writing to continue the business of the Company; or

(5) The entry of a decree of judicial dissolution under Section 43 of the Act.

The Members hereby agree that, notwithstanding any provision of the Act, the Company shall not dissolve prior to the occurrence of a Liquidating Event. If it is determined that the Company has dissolved prior to the occurrence of a Liquidating Event, the Members hereby agree to continue the business of the Company without a winding up or liquidation.

(b) Winding up. Upon the winding up of the Company, the assets of the Company shall be liquidated as promptly as possible in an orderly and businesslike manner so as not to involve undue sacrifice.

(c) Priority of Distributions. Liquidation proceeds shall be distributed and applied in the following order of priority:

(1) To the payment of debts and liabilities (including those owed to Members who are creditors) of the Company and expenses of liquidation;

(2) To the setting up of any reserves which the Members may deed necessary for any contingent or unforeseen liability of obligation of the Company, which reserves shall be maintained for such period as the Members deem advisable; and

(3) To the Members in accordance with their positive Capital Account balances, as determined after taking into account all Capital account adjustments for the Company taxable year during which the liquidation of the Company occurs.

(d) Distribution in Kind. If the Members shall determine that an immediate sale of part or all of the Company's assets would be inadvisable, the Company may distribute to the Members, in lieu of cash, interests in any Company assets, liquidating only such assets as are necessary in order to pay the debts and liabilities of the Company. Such distribution shall be made in such proportions as cash would have been distributed, if available for distribution, under Subsection (c) above and such distribution shall, in any event, be based on the fair market value of such distributed property at the time of distribution.

(e) Timing of Distributions. Liquidating distributions shall be made by the end of the taxable year during which the liquidation (as defined in Treasury Regulation Section 1.704-1(b)(2)(ii)(g)(a "Liquidation") of the company occurs, or if later, within ninety (90) days of such Liquidation, except to the extent of any reserves established pursuant to Subsection (c) (2) above. In the event that such reserves have been established, liquidation proceeds (other than any such withheld amounts) shall be distributed in proportion to the Members positive Capital Accounts, and any withheld amounts shall be distributed as soon as practicable in proportion to the Members positive Capital Accounts.

(f) Capital Account Deficits. No Member shall be required to make any contribution to the Company to eliminate any deficit balance in his Capital Account following the Liquidation of the Company (or any other time).

10. MISCELLANEOUS

(a) Additional Members. Except as otherwise provided herein, no additional

members may be admitted without the written consent of all Members.

(b) Notices. Any notice, consent or other communication which any party hereto is required or permitted to give to another party shall be deemed duly given if in writing and if delivered personally or sent by registered mail, return receipt requested, to the recipient at his or its address first stated above, or in the case of the Company, at its principal office as set forth in Section 1(c) above, or at such other address of which he or it shall have given the other party or parties due notice hereunder. All notices duly given hereunder shall be deemed effective (a) upon delivery, if delivered personally, or (b) forty-eight (48) hours after posting, if mailed.

(c) Waiver. The failure of any party to insist in any one or more instances upon the performance of any of the terms and conditions of this Agreement shall not be construed as a waiver or relinquishment of any right granted hereunder, or the future performance of any such term or condition.

(d) Entire Agreement. This agreement sets forth the entire understanding of the parties hereto with respect to the subject matter hereof.

(e) Further Acts. Each of the parties hereto shall execute and deliver all such additional documents or legal instruments, and shall perform or cause to be performed all such further acts and things, as may be necessary or desirable to carry out the purposes and intent of this Agreement.

(f) Amendment. This Agreement may not be amended, modified or altered in any manner, except pursuant to the terms of a written instrument signed by each of the parties hereto.

(g) Invalid Provision. The invalidity or unenforceability or any particular provision of this Agreement shall not affect the other provisions hereof, and this Agreement shall thereafter be construed in all respects as if such invalid or unenforceable provisions are omitted.

(h) Construction. This Agreement shall be governed by and construed in accordance with the laws of the State of Connecticut applicable to contracts made and to be wholly performed within this State.

(i) Binding Nature. This Agreement shall be binding upon and inure to the benefit of the Members and heir successors, personal representatives, heirs, devisees, guardians and assigns.

(j) Arbitration. Any dispute, difference, disagreement or controversy among the Members arising out of or in connection with the Company or the interpretation of the meaning or construction of the Agreement shall be settled by arbitration in New Haven, Connecticut before the American Arbitration Association in accordance with its rules then obtaining. There shall be no appeal from such award or determination and judgment thereon may be entered in any court of competent jurisdiction.

(k) Counterparts. This Agreement may be executed in any number of counterparts and all of such counterparts taken together shall for all purposes constitute one agreement binding upon all the Members.

(l) Headings. The headings contained in this Agreement are for reference purposes only and shall not affect the meaning or interpretation of this Agreement.

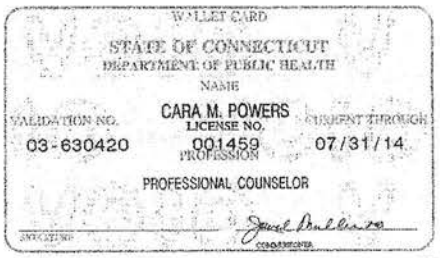
(m) Usage. In construing this Agreement, feminine or neuter pronouns shall be substituted for those of the masculine form, and the plural for the singular, and vice versa, in any case in which the context may require. The capitalized terms used in this Agreement shall have the meaning first applied to their first usage in the Agreement unless otherwise indicated.

(n) References to Code or Regulations. Any references in the Agreement to the Internal Revenue Code or to a Treasury Regulation shall be interpreted to include the specific

provision referred to as the same may be amended from time to time, as well as any substitute or successor provisions.

IN WITNESS WHEREOF, the parties have duly executed this Agreement as of the date first above written.

CARA POWERS



WALLET CARD

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

NAME
CARA M. POWERS

VALIDATION NO.	LICENSE NO.	CURRENT THROUGH
03-630420	001459	07/31/14

PROFESSION
PROFESSIONAL COUNSELOR

SIGNATURE COMMISSIONER

WELLS FARGO

Wells Fargo Business Online®

Account Activity

Business and Personal Accounts

BUSINESS CHECKING XXXXXX6878

Activity Summary

Ending Collected Balance as of 01/28/15	$36.00
Current Posted Balance	$36.00
Pending Withdrawals/ Debits	$0.00
Pending Deposits/ Credits	$0.00
Available Balance	**$36.00**

The Available Balance shown above reflects the most up-to-date information available on your account. The balances shown below next to the last transaction of each day do not reflect any pending withdrawals or holds on deposited funds that may have been outstanding on your account when the transaction posted. If you had insufficient available funds when the transaction posted to your account, fees may have been assessed.

Transactions

Show: for **Last 12 Months**

Date	Description	Deposits / Credits	Withdrawals / Debits	Ending Daily Balance
Pending Transactions	Note: Debit card transaction amounts may change			
No pending transactions meet your criteria above.				
Posted Transactions				
01/15/15	ONLINE TRANSFER TO CARA POWERS BUSINESS CHECKING XXXXXX6623 REF #IBEG9XRHGT ON 01/15/15		$6,000.00	$36.00
01/15/15	ONLINE TRANSFER FROM CARA POWERS BUSINESS CHECKING XXXXXX3019 REF #IBEK6Z9Z9X ON 01/15/15	$6,000.00		
12/31/14	MONTHLY SERVICE FEE		$14.00	$36.00
11/14/14	CHECK		$500.00	$50.00
10/08/14	ONLINE TRANSFER FROM CARA POWERS BUSINESS CHECKING XXXXXX7314 REF #IBEXRB4XL7 ON 10/08/14	$500.00		$550.00
09/17/14	ONLINE TRANSFER FROM CARA POWERS BUSINESS CHECKING XXXXXX6623 REF #IBETV2V9ST ON 09/17/14	$50.00		$50.00
Totals		**$6,550.00**	**$6,514.00**	

Equal Housing Lender

© 1995 – 2015 Wells Fargo. All rights reserved.

362

UNIVERSITY OF
NEW HAVEN

January 19, 2015

NEED FOR COUNSELING INTERNSHIPS

As coordinator of the M.A. Program in Community Psychology at the University of New Haven, I would like to express my support for expanding the number of settings that provide counseling internships. The competition for high-quality counseling internships is great, and over the years I have seen cases where talented and motivated students were not able to obtain internships that provided the level of professional training in counseling that I believed they deserved. The number of graduate programs in Connecticut that prepare students for counseling-related careers has been growing. (For example, Quinnipiac recently started an MSW program.) Such growth only adds to the pressure to enhance training opportunities in counseling and related fields.

Our program has enjoyed a positive internship relationship with Shoreline Wellness Center, and would welcome the chance to increase the number of students we place there. Please feel free to contact me if I can be of further assistance concerning this matter.

Sincerely,

Michael Morris

Michael Morris, Ph.D.
Professor of Psychology

203-932-7289

Greer, Leslie

From: Lazarus, Steven
Sent: Friday, February 13, 2015 9:54 AM
To: Greer, Leslie
Cc: Greci, Laurie
Subject: FW: URGENT PLEASE RESPOND REGARDING LEGAL NOTICE: Ad: 411612
Attachments: shoreline1.PDF; ATT00001.htm; Shoreline2.PDF; ATT00002.htm; shoreline3.PDF; ATT00003.htm

Leslie,

Please place copy of this email and the attachments with the newspaper notice evidence in the original file.

Thank you,

Steve

Steven W. Lazarus
Associate Health Care Analyst
Division of Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue
Hartford, CT 06134
Phone: 860-418-7012
Fax: 860-418-7053

From: cara.shorelinewellnesscenter@gmail.com [mailto:cara.shorelinewellnesscenter@gmail.com]
Sent: Thursday, February 12, 2015 2:13 PM
To: Lazarus, Steven
Subject: Fwd: URGENT PLEASE RESPOND REGARDING LEGAL NOTICE: Ad: 411612

Sent from my iPhone

Begin forwarded message:

> **From:** New Haven Register Legals <legals@nhregister.com>
> **Date:** February 12, 2015 at 1:24:26 PM EST
> **To:** cara.shorelinewellnesscenter@gmail.com
> **Subject: Re: URGENT PLEASE RESPOND REGARDING LEGAL NOTICE: Ad: 411612**
>
> Hello,
>
> 2 legal affidavits (after publication, and in november) were mailed to Cara Powers at 415 Main Street, West Haven, CT, perhaps it got lost in the filing? It should have appeared in a New Haven Register envelope.

As you may remember, we did set this for the 20th, 21st, and 22nd, as that was a monday, tuesday, and wednesday.

A third affidavit won't go out until tomorrow.

Chris.

On Wed, Feb 11, 2015 at 10:54 PM, New Haven Register Legals <legals@nhregister.com> wrote:

We have received your legal notice and will get back to you with a proof and price shortly. Thank you

AUTOMOTIVE

Automotive Technician
Fast paced repair shop looking for A & B techs. Must have foreign and domestic experience. Alignment experience preferred. Must have own tools.
Competitive pay, paid vacation and holiday time. Paid Overtime. State of the art facility and equipment. Spacious work areas. Family owned business with over 25 years in the business. Full or part time position available.
Please send your resume to autorepairsllc@yahoo.com or call 203-735-7553.

BODY SHOP MANAGER
needed for multi point new car dealer.
All inquiries held in confidence. Great comp pkg and benefits.
Please send resume to reggie7857@gmail.com

SKILLED LABOR

Electrician, E-2 - Full Time Permanent Positions. Come join our team, benefits include paid holidays, health insurance, dental insurance, 401K. large Stamford based co. **Call 203-327-6907 email info@camsaninc.com.**

LEGAL NOTICES

CITY NOTICE BOARD OF ZONING APPEALS CITY OF NEW HAVEN

NOTICE is hereby given of the following decisions rendered by the BOARD OF ZONING APPEALS on October 14, 2014. An appeal by any person aggrieved by this decision must be taken to SUPERIOR COURT, JUDICIAL DISTRICT OF NEW HAVEN, within fifteen (l5) days after the date of publication:

GRANTED:
1. 14-61-V. 98 Rock Street. Variances to allow two side yards of 0ft each where 5ft each are required for a detached garage in a Low Medium Density (RM-1) Residence District. Owner /Applicant: Maria Bascom and Sam Varma
2. 14-62-V. 35 Church Street. Variance to allow 0sf of usable open space where a minimum of 450sf is required for 18 residential dwelling units in a BD-1 District. Owner: 35-39 Church Street LLC. Applicant: James Segaloff
3. 14-55-V, 14-56-S. 202 Whalley Avenue. Use Variance to allow retail sales (beauty supplies) in a Business B (Automotive Sales) District and a Special Exception to allow 0 on-site parking spaces where 8 are required. Owner: Mahas Properties. Applicant: 1&1B Beauty Supply Corp.
4. 14-58-S. 887 Grand Avenue. Special Exception to permit 10 on-site parking spaces where 13 spaces are required in a General Business (BA) District. Owner: Edward Roubeni. Applicant: Paula Squillacote.

DENIED
5. 14-67-S. 533 Whalley Avenue. Special Exception to allow a Restaurant Liquor License in a General Business (BA) District. Owner: 533 Whalley Avenue LLC. Applicant: Joseph Cunha
6. 14-54-S. 401 Sherman Avenue. Special Exception to permit a Special Exception for a Convenience Use (Convenience Store) in a High-Middle Density (RM-2) Residence District. Owner: 401 Sherman LLC. Applicant: Maria Vargas

Gaylord Bourne, Secretary

LEGAL NOTICE REQUEST FOR PROPOSALS

Tweed-New Haven Regional Airport New Haven, Connecticut

The Tweed-New Haven Airport Authority will receive sealed proposals for a Taxi Service License on November 12, 2014 at 2:00 p. m.

A copy of the Request for Proposals may be obtained by calling 203-466-8833, x100 between the hours of 9 am and 4 pm Monday through Friday.

The Authority reserves the right to reject any or all taxi service proposals, to waive any informalities in the proposals received, and to accept the proposals deemed in the best interest of the Authority.

CLASSIFIED IS OPEN
8:00 AM – 5:00 PM
MON–FRI
Call **1.877.872.3278**
or email:
CLASIFIEDADS@NHREGISTER.COM

SHOP FROM your easy chair. Shopping the classifieds is easy, relaxing and you don't have to worry about parking.

LEGAL NOTICES

Legal Notice
Shoreline Wellness Behavioral Health Clinic, LLC an affiliate of Shoreline Wellness Center, LLC, is applying for a certificate of need pursuant to Connecticut General Statute Section 19a-638. Shoreline Wellness Behavioral Health Clinic, LLC is seeking Licensure as a free standing behavioral health clinic that will continue to provide mental health services to children, adults and families. Shoreline wellness Behavioral Health Clinic, LLC will not dispense any medications on site as agreed upon with the city of West Haven variance approval. There will be no changes in any of our current day to day operations that will affect the city, the general population, or the clients that we currently provide services for. Shoreline Wellness Behavioral Health Clinic, LLC is located at 415 Main Street, West Haven, CT. The total capital expenditure for the project is 35,000.

POST ROAD ENTERTAINMENT LLC d/b/a HULA HANKS and/or HULA'S NEW HAVEN LLC – NOTICE OF DISCLAIMER
STATE OF CONNECTICUT, NEW HAVEN
SUPERIOR COURT.
NOTICE TO: Post Road Entertainment LLC d/b/a Hula Hanks and/or Hula's New Haven LLC, last known place of business 84 West Park Place, Stamford, CT 06901. On or around May 21, 2009, Post Road Entertainment LLC d/b/a Hula Hanks and/or Hula's New Haven LLC was named a defendant in the matter of Konesky v. Post Road Entertainment LLC, New Haven Superior Court Civil Action No. NNH-CV09-5029249-S (hereinafter, the "suit"). The suit is calendared to proceed to trial on or about October 15, 2014, following a decision by the Supreme Court of Connecticut which was released July 16, 2013. Your failure to appear at trial may result in a default judgment against Post Road Entertainment LLC d/b/a Hula Hanks and/or Hula's New Haven LLC. On or about September 29, 2014, Navigators Insurance Company received its first notice of the suit. On October 14, 2014, Navigators Insurance Company **disclaimed coverage** for any the suit and/or any claims and/or judgments arising therefrom or subject thereto. To date, Navigators Insurance Company has been unable to locate Post Road Entertainment LLC d/b/a Hula Hanks and/or Hula's New Haven LLC, which may be dissolved. To all persons interested in the above-captioned matter, please be advised that Navigators Insurance Company has **disclaimed insurance coverage** for Post Road Entertainment LLC d/b/a Hula Hanks and/or Hula's New Haven LLC. Any interested parties in the suit who are adversely affected by this **disclaimer of insurance coverage** should contact John P. Graceffa, Esq., Morrison Mahoney LLP, 250 Summer St., Boston, MA 02210.

PROBATE NOTICES

NOTICE TO CREDITORS
Estate of
Barbara Ann Robertson Campbell

The Hon. John A. Keyes, Judge of the Court of Probate, District of New Haven Probate District, by decree dated August 14, 2014, ordered that all claims must be presented to the fiduciary at the address below. Failure to promptly present any such claim may result in the loss of rights to recover on such claim.

Edward Cleary,
Assistant Clerk

The fiduciary is:

Michelle Mitchell
390 E. 21st St. Apt 10
Brooklyn, NY 11226

CARPENTERS! PAINTERS! LANDSCAPERS!
Place your ad in our Business Card Section or our Service Directory. Our readers will call you! They trust our advertisers to do the job right!
Call 203-850-6628

A HOME OF YOUR OWN
The Job of Your Dreams
A Pet for the Children
A Second Car for Commuting
A Tag Sale"Buried Treasure"
Find these and more in the ***New Haven Register Classifieds.***

PROBATE NOTICES

NOTICE TO CREDITORS
ESTATE OF
George C. Micklus, Sr.

The Hon. Beverly Streit-Kefalas, Judge of the Court of Probate, Milford - Orange Probate District, by decree dated November 29, 2013, ordered that all claims must be presented to the fiduciary at the address below. Failure to promptly present any such claim may result in the loss of rights to recover on such claim.

Nabil E. Valencia,
Asst Clerk

The fiduciary is

Goerge C. Micklus, Jr.
c/o Barry Knott, Esq.
Knott & Knott
1656 Main Street
Stratford, CT 06615-6559
399583

NOTICE TO CREDITORS
ESTATE OF
George Whitney, AKA George D. Whitney, AKA George Dana Whitney

The Hon. Beverly K. Streit-Kefalas, Judge of the Court of Probate, District of Milford - Orange Probate District, by decree dated October 7, 2014, ordered that all claims must be presented to the fiduciary at the address below. Failure to promptly present any such claim may result in the loss of rights to recover on such claim.

Elizabeth Davis,
Chief Clerk

The fiduciary is:

Lee Ha & Carolyn W. Sabol
c/o John J. Esposito, Jr., Esq.
Law Offices of Esposito & Annunziata,
373 Humphrey Street,
New Haven, CT 06511
405819

NOTICE TO CREDITORS
ESTATE OF
Gwendolyn Buskey

The Hon. John A. Keyes, Judge of the Court of Probate, District of New Haven Probate District, by decree dated September 29, 2014, ordered that all claims must be presented to the fiduciary at the address below. Failure to promptly present any such claim may result in the loss of rights to recover on such claim.

Edward Cleary,
Assistant Clerk

The fiduciary is:

Janie Buskey
c/o John J. Kennedy, Jr., Esq.
555 Long Wharf Drive, 13th floor
New Haven, CT 06511
406139

YOU'LL NEVER KNOW how effective a classified ad is until you use one yourself! Reach the entire area without leaving the comfort of your home. Call and place your classified today to sell those unwanted items.

THE CLASSIFIEDS ... they go where you can't ... into thousands of homes. Andy they do all in one day!

PROBATE NOTICES

NOTICE TO CREDITORS
ESTATE OF Laura Montgomery Gagnon

The Hon. Clifford D. Hoyle, Judge of the Court of Probate, District of Derby Probate District, by decree dated September 10, 2014, ordered that all claims must be presented to the fiduciary at the address below. Failure to promptly present any such claim may result in the loss of rights to recover on such claim.

Kay Jeanette, Chief Clerk

The fiduciary is:

Susan Ellen Gagnon Sparks
c/o Karen A. Fisher, Esq.
Law Office of Karen A. Fisher LLC
19 Bank Street
P.O. Box 439
Seymour, CT 06483
382095

NOTICE TO CREDITORS
ESTATE OF Wayne A. Davis

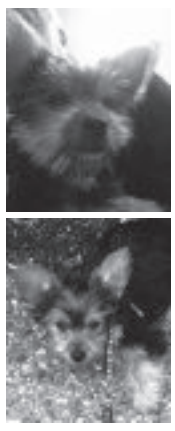
The Hon. Beverly K. Streit-Kefalas, Judge of the Court of Probate, District of Milford - Orange Probate District, by decree dated September 23, 2014, ordered that all claims must be presented to the fiduciary at the address below. Failure to promptly present any such claim may result in the loss of rights to recover on such claim.

Karen Adams,
Assistant Clerk

The fidicuary is:

Kathleen Rudy
c/o Keith Bradoc Gallant, Esq.
Day Pitney LLP
One Audubon Street
6th Floor
New Haven, CT 06511
398302

LOST & FOUND



MISSING TOY YORKIE, Male, Gizmo, black/brown/tan, with white patch on head, $500 reward-missing since July. New Haven Goffe St or E.H. condominium areas. Call 203-508-3634 Jessica Jacobs.

BIRDS

Baby Parrots-Sun Conures -Cockatoos 203-824-1717

CATS

Looking for a good homes for 1 or more of my 6 kittens. 5 mos. old. Blk., Tuxedo, 1 gray calico, Sm fee. Call (203) 850-2479

DOGS

ALL BREEDS PUPPIES KITTENS, KITTENS Statewidepets.com 203-795-9931 ORANGE

November 4, 2014
State Election
The Electors of the City of Milford are hereby warned to meet at their respective polling places in said town on Tuesday, November 4, 2014, for the following purposes:
1. To cast their votes for Governor and Lieutenant Governor, Representative in Congress, State Senator, State Representative, Secretary of the State, Treasurer, Comptroller, Attorney General, Judge of Probate and Registrar of Voters.
2. To vote on the following question for the approval or disapproval of a proposed AMENDMENT to the Constitution of Connecticut, a vote of "YES" being a vote for approval, and a vote of "NO" being a vote for disapproval:
1. Shall the Constitution of the State be amended to remove restrictions concerning absentee ballots and to permit a person to vote without appearing at a polling place on the day of an election?
The full text of such proposed questions with explanatory test, printed in accordance with §2-30a of the General Statutes, is available at the town clerk's office for public distribution.
The vote on the proposed questions is taken pursuant to the Constitution of Connecticut.
Notice is hereby given that the location of the polling places is as follows:

Voting District	Location of Polling Place
117	Joseph Foran High School 80 Foran Road
118-1	JFKennedy School 404 West Avenue
118-2	Meadowside School 80 Seemans Lane
118-3	West Shore Rec. Center 14 Benham Avenue
118-4	Margaret Egan Center 35 Mathew Street
118-5	Harborside Middle School 175 High Street
119-1	Orange Avenue School 260 Orange Avenue
119-2	JFKennedy School 404 West Avenue
119-3	Harborside Middle School 175 High Street

Absentee Ballots will be counted at the following central location: Parsons Municipal Complex, Conference Room "A", 70 West River Street. Optical Scan Ballots will be used. The polls will be opened at six o'clock in the morning (6:00 AM) and will remain open until eight o'clock in the evening (8:00 PM).
Dated at Milford, Connecticut, this 20th day of October 2014.
Attests/Joanne M. Rohrig, City Clerk

DOGS

Border Collie Puppies, 8 wks, black & white & Tri's, $500. Call 860-207-0962

APPLIANCES

4 Burner Maytag gas stove. White. Good condition. $250. 4 window air conditioners $50 each. 5000-1200 BTU's 203-457-0859

Westinghouse washer 3 spd, 9 cycle & GE gas dryer, 6 cycle both heavy duty, large capacity. $250 ea. or both. $450 Like new. 203-457-0849.

FURNITURE

Beautiful matching leather sofa, love seat, oversized chair & ottoman. Cordovan w/nail stud trim, exceptional cond. $850. Also large matching coffee & end tables with stitched leather trim & surfaces, all have storage. $350. Call (203) 248-1836

PASSENGER CARS

CADILLAC DEVILLE 1993 4 dr. sedan, 4.9 V8 mod. 2100. Low mi. $3900, reduced to $2900. Will sell fast! 203-245-4530

OLDSMOBILE AURORA 1998 $3,800, reduced to $3,200! Great car! Sunroof, V8, tan. Will sell fast! 203-245-4530

AUTOS WANTED

NICHOLS Salvage - Will buy your scrap steel, cars, trucks, alum., trailers, copper, batteries, heavy equip. 46 Meadow Rd. Clinton CT. 860-669-2808

CAN'T FIND what you're looking for? Find it the fast & easy, effective way by using the classifieds! Call and place a low cost classified ad under "Wanted To Buy" in next week's paper.

CALL TOLL-FREE
1-877-872-3278
TO PLACE YOUR CLASSIFIED AD

Make a list of those items you're not using anymore, then give us a call. We can help you sell them!

To place your ad, call toll-free
1-800-922-7066

The Classifieds in the
NEW HAVEN REGISTER
NewHavenRegister.com

NOTICE OF TENTATIVE DECISION INTENT TO RENEW FOR ONE YEAR FOUR NATIONAL POLLUTANT DISCHARGE ELIMINATION SYSTEM GENERAL PERMITS INTO THE WATERS OF THE STATE OF CONNECTICUT

TENTATIVE DECISION

The Commissioner of Energy and Environmental Protection ("DEEP") hereby gives notice of a tentative decision to renew for one year: the General Permit for the Discharge of Water Treatment Wastewater, the General Permit for the Discharge of Minor Non-contact Cooling and Heat Pump Water, the General Permit for the Discharge of Hydrostatic Pressure Testing Wastewater, and the General Permit for the Discharge of Groundwater Remediation Wastewater Directly to a Surface Water, under Section 22a-430b of the Connecticut General Statutes for discharges into waters of the state. The current general permits expire on March 29, 2015. The renewed general permits would become effective March 30, 2015 and expire March 29, 2016.

In accordance with applicable federal and state law, the Commissioner has made a tentative decision that continuance of the existing general permits would not cause pollution of the waters of the state. The one year extension allows work to continue on the development of two general permits that will encompass the discharges currently authorized by these four general permits. Renewal registrations for existing registrants under these four general permits would not be required for the one year extensions.

COMMISSIONER'S AUTHORITY

The Commissioner of Energy and Environmental Protection is authorized to approve or deny such general permits pursuant to (1) section 402(b) of the Federal Water Pollution Control Act, as amended, 33 USC 1251, et. seq. and (2) section 22a-430b of the Connecticut General Statutes and the Water Discharge Permit Regulations (section 22a 430 3 and 4 of the Regulations of Connecticut State Agencies).

INFORMATION REQUESTS

Interested persons may obtain a copy of this public notice and the proposed general permits on the DEEP website at www.ct.gov/deep/publicnotices. The general permits are also available for inspection at the DEEP Bureau of Materials Management and Compliance Assurance, 79 Elm Street, Hartford, CT or by calling 860-424-3025 from 8:30 – 4:30, Monday through Friday. Questions may be directed to Kevin Sowa at this phone number or kevin.sowa@ct.gov.

Any interested person may request in writing that his or her name be put on a mailing list to receive notice of intent to issue any permit to discharge to the surface waters of the state. Such request may be for the entire state or any geographic area of the state and shall clearly state in writing the name and mailing address of the interested person and the area for which notices are requested.

PUBLIC COMMENT

Prior to making a final determination to approve or deny the one year extension of these permits, the Commissioner shall consider written comments on the general permits from interested persons that are received within 30 days of this public notice. Written comments should be directed to: James Creighton, Water Permitting and Enforcement Division, BMMCA, DEEP, 79 Elm Street, Hartford, CT 06106 5127 or may be submitted via electronic mail to: james.creighton@ct.gov. The Commissioner may hold a public hearing prior to approving or denying the issuance of a general permit if in the Commissioner's discretion the public interest will be best served thereby, and shall hold a hearing upon receipt of a petition signed by at least twenty-five persons. Notice of any public hearing shall be published at least 30 days prior to the hearing.

Petitions for a hearing should include the name of the general permits noted above and also identify a contact person to receive notifications. Petitions may also identify a person who is authorized to engage in discussions regarding the application and, if resolution is reached, withdraw the petition. Original petitions must be mailed or delivered to: DEEP Office of Adjudications, 79 Elm Street, 3rd floor, Hartford, CT, 06106-5127. Petitions cannot be sent by fax or email. Additional information can be found at www.ct.gov/deep/adjudications.

/s/Macky McCleary
Deputy Commissioner
Dated: 10/16/2014

The Connecticut Department of Energy and Environmental Protection is an Affirmative Action and Equal Opportunity Employer that is committed to complying with the Americans with Disabilities Act. To request an accommodation contact us at (860) 418-5910 or deep.accommodations@ct.gov.

AUTOMOTIVE

Automotive Technician
Fast paced repair shop looking for A & B techs. Must have foreign and domestic experience. Alignment experience preferred. Must have own tools.
Competitive pay, paid vacation and holiday time. Paid Overtime. State of the art facility and equipment. Spacious work areas. Family owned business with over 25 years in the business. Full or part time position available.
Please send your resume to autorepairsllc@yahoo.com or call 203-735-7553.

SKILLED LABOR

Electrician, E-2 - Full Time Permanent Positions. Come join our team, benefits include paid holidays, health insurance, dental insurance, 401K. large Stamford based co. **Call 203-327-6907 email info@camsaninc.com.**

LEGAL NOTICES

CITY OF NEW HAVEN
- BID NOTICE

Sealed bids, to purchase the following, will be accepted by the Bureau of Purchases, Room 301, 200 Orange Street, New Haven, CT 06510 until **3:00 P.M.** local time, on the date shown, at which time they will be publicly opened and read. Bid forms are available online at www.cityofnewhaven.com/purchasingbureau

Pickup Truck
70155004
DPW
November 6, 2014

CLASSIFIED IS OPEN
8:00 AM – 5:00 PM
MON–FRI
Call **1.877.872.3278**
or email:
CLASIFIEDADS@NHREGISTER.COM

LEGAL NOTICES

Legal Notice
Shoreline Wellness Behavioral Health Clinic, LLC an affiliate of Shoreline Wellness Center, LLC, is applying for a certificate of need pursuant to Connecticut General Statute Section 19a-638. Shoreline Wellness Behavioral Health Clinic, LLC is seeking Licensure as a free standing behavioral health clinic that will continue to provide mental health services to children, adults and families. Shoreline wellness Behavioral Health Clinic, LLC will not dispense any medications on site as agreed upon with the city of West Haven variance approval. There will be no changes in any of our current day to day operations that will affect the city, the general population, or the clients that we currently provide services for. Shoreline Wellness Behavioral Health Clinic, LLC is located at 415 Main Street, West Haven, CT. The total capital expenditure for the project is 35,000.

LEGAL NOTICE
The following vehicle will be sold for outstanding towing and storage charges on Oct. 24, 2014 at 10:00am. We reserve the right to puchase. Catapano Bros. Inc., 267 Kimberly Ave., New Haven, Conn.
2008 Honda
IHGCP36848A000632

CARPENTERS!
PAINTERS!
LANDSCAPERS!
Place your ad in our Business Card Section or our Service Directory. Our readers will call you! They trust our advertisers to do the job right!
Call 203-850-6628

YOU GET QUICK action at a low cost when you advertise in the Insider classifieds.

FIND RENTERS
in your community!

CALL US TODAY | 800-922-7066

- Get listed in the latest local property listings, in print, & online
- Be found in home searches with our user-friendly online database.
- We list new construction, resale homes, & apartment rentals.

MEDIAOne MARKETPLACE
We Listen. We Understand. We Get Results.
Promo Code for 10% Off: RECT004

LEGAL NOTICES

LEGAL NOTICE
NEW HAVEN
SELF STORAGE
140 Ferry St.
New Haven, CT 06513
(203) 772-4050
Self-Storage Facility Operator's sale for non-payment of storage charges. To resolve this Claim, property manager is Conducting an auction. The following units will be sold By
PUBLIC AUCTION
Wednesday at 10:00 AM
October 29, 2014
Contents of the following units to be sold in their entirety.

1148 Gina Mitchner
1207 Jose Rosa
1412 Lakesha R Brown
1424 Laquanna Miller
1434 Albert Branch
2136 Tyrone Williams
2168 Jesse Snipes
2185 orge Gonzalez
2230 Michael D Jackson
2231 Susan Williams
2256 Wanda Quiles
2257 Andrew Lee
2336 James Rodriguez
2374 Lachers Reese
3014 Johnisha Allen
3023 Jerald Nelson
3033 Michael Rivera
3045 Terrence Newman
3070 Nicole Thomas
3117 Kiva Stevens
3144 Teofilo Guadalupe
3192 Helen Polanco
3221 Jasmine Reyes
3236 Oshane Dixon
3259 Rhodia Hough
3264 Noreen Corraro
3270 Shelene Wearing
3303 Geraldo Rivera
3337 Luz Navarro
4124 John Figueroa
4185 Curtis Moore
4278 Kowan Terry
4155 and 1262
Nadine Jenkins

Units contain household goods, tools, furniture, tools and electronics, etc...
Auction per order of New Haven Self Storage. Terms are cash. Owner reserves the right to bid @ auction or reject any/all bids. Auction is subject to postponement and/or cancellation by auctioneer, Storage Auction Solutions

Notice of Decision
Woodbridge Inland Wetlands Agency
At its regular meeting on October 15, 2014, the Inland Wetlands Agency of the Town of Woodbridge approved the following application:
Sonila Bakiu and Arthur Killira: 1707 Litchfield Turnpike
Removal of concrete block wall along the West River.
Robert Blythe, Chairman

CALL TOLL-FREE
1-877-872-3278
TO PLACE YOUR CLASSIFIED AD

LEGAL NOTICES

LEGAL NOTICE
TOWN OF GUILFORD
INVITATION TO
RE-BID #11-1415
MOBILE GENERATOR
FOR THE
FIRE DEPARTMENT

The Town of Guilford is seeking competitive bids for a mobile generator for the Fire Department. Sealed Bids will be due on Tuesday November 04, 2014 at 2:00 p.m. at the office of the First Selectman, on the second floor of Town Hall, 31 Park Street, Guilford, CT 06437 at which time they will be opened publicly. Bids received after this date and time will be rejected. Sealed Bid envelopes (including overnight packaging) should be clearly labeled with bid number, bid title and marked "time sensitive". Bid specifications may be obtained at the Office of the First Selectman or may accessed from the Town of Guilford's website at www.ci.guilford.ct.us and the Department of Administrative Services procurement website.

Any questions regarding the specifications may be directed, ***in writing only***, to Fire Chief Charles Herrschaft, Jr. at gfd10@snet.net with a copy to the Purchasing Department at millmanp@ci.guilford.ct.us.

Each bidder will be required to submit to the Office of the First Selectman, their original proposal with one (1) copy and a bid bond or cashier's check in the amount of ten percent (10%) of the base bid. Each bidder shall honor the bid price for ninety (90) business days from the date of the bid opening, without modification. Upon award of the bid, the winning bidder shall be bound by the bid proposal price throughout the contract period.

The Town of Guilford reserves the right to reject any or all bids; or to waive defects in same, if it deems such to be in the best interest of the Town.

Joseph S. Mazza
First Selectman

LEGAL NOTICE: THE PLANNING & ZONING COMMISSION, LEGAL NOTICE: THE PLANNING & ZONING COMMISSION, Town of Hamden, will hold a Public Hearing & Regular Meeting on Tuesday, October 28, 2014 at 7:00 p.m., in the Thornton Wilder Hall, Miller Memorial Library Complex, 2901 Dixwell Ave, Hamden, CT, and the following will be reviewed:
Public Hearing:
1. Special Permit & Site Plan 14-1245/WS
80 Skiff St, T-5 Zone
Used cars/repairs
Robert Melillo, Applicant
Withdrawn at the request of the applicant
2. Special Permit & Site Plan 14-1247/WS
415 Mather St, T-4 zone
Multi-Family/Affordable Housing
Regan Development Corp., Applicant
Regular Meeting:
1. Special Permit & Site Plan 14-1247/WS
415 Mather St, T-4 zone
Multi-Family/Affordable Housing
Regan Development Corp., Applicant
2. Site Plan 14-1491/WS
275 Mt. Carmel Ave, R-2 zone
Telecommunications
Cellco Partnership d/b/a Verizon Wireless
Submitted by: Stacy Shellard, Clerk of the Commission

LEGAL NOTICE: THE PLANNING & ZONING COMMISSION, Town of Hamden, held a Public Hearing & Regular Meeting on Tuesday, October 14, 2014 with the following results:
Public Hearing:
1. Special Permit & Site Plan 14-1243/WS
3594 Whitney Ave, Medical Office
RJT Medical, LLC, Applicant
Approved with conditions
2. Special Permit & Site Plan 14-1244
56 Fairview Ave, Place of Worship
Loyel Sophia Downer, Applicant
Approved with conditions
3. Special Permit & Site Plan 14-1246/WS
1125 Dixwell Ave(aka 1187), Place of Worship
Mt. Calvary Deliverance Tabernacle, Applicant
Postponed at the applicant's request until 11/25/14 meeting
4. Location Approval 14-036
2625 State St,Auto repair
Tracy Kennedy, Applicant
Approved with conditions
Submitted by: Stacy Shellard, Clerk of the Commission

CLASSIFIEDS WORK!
... Call and place yours today!

LEGAL NOTICES

ORANGE ZONING BOARD OF APPEALS
LEGAL NOTICE

Notice is hereby given that the Orange Zoning Board of Appeals will hold a meeting on Monday, November 3, 2014, at 7:00 p.m., at the Orange Town Hall, 617 Orange Center Road, to conduct a publich hearing on the following:

PETITION #1769, APPEAL OF THE ZONING ENFORCEMENT OFFICER, Submitted by Anthony Urbano. For property known as 909 Derby Milford Road. The appeal concerns the denial of an Application for Certificate of Zoning Compliance, 909 Derby Milford Road, to construct a single family dwelling.

Application materials are on file in the Orange Zoning Office. A copy of this notice has been filed with the Orange Town Clerk. Dated in Orange, CT, this 15th day of October, 2014.

Kenneth Gambardella
Secretary
Orange Zoning Board of Appeals

A HOME OF YOUR OWN
The Job of Your Dreams
A Pet for the Children
A Second Car for Commuting
A Tag Sale"Buried Treasure"
Find these and more in the ***New Haven Register Classifieds.***

HOUSE HUNTING?
SHOP CLASSIFIED
FOR THE HOME
OF YOUR DREAMS!

LEGAL NOTICES

STATE OF CONN
Superior Court
Juvenile Matters

NOTICE TO:
Jeremy Yeargan, father of male child born on 01/21/2009 to mother, Jayme B., in the Town of New Haven, CT where said child was born.
OF PARTS UNKNOWN

A petition has been filed seeking commitment of minor child(ren) of the above named or vesting of custody and care of said child(ren) of the above named in a lawful, private or public agency or a suitable and worthy person. The petition, whereby the court's decision can affect your parental rights, if any, regarding minor child(ren) will be heard on: 11/05/2014 at 10:00 a.m. at New Haven Juvenile Court 239 Whalley Ave. New Haven, CT 06511. Therefore, ORDERED, that notice of the hearing of this petition be given by publishing this Order of Notice once, immediately upon receipt, in the: New Haven Register, a newspaper having circulation in the town/city of Derby, CT.
Hon. John Cronan
Judge
Mara Castro-Mesa,
Clerk
10/08/14
Right to Counsel: Upon proof of inability to pay for a lawyer, the court will provide one for you at court expense. Any such request should be made immediately at the court office where your hearing is to be held.

November 4, 2014 State Election

The Electors of the Town of East Haven are hereby warned to meet at their respective polling places in said town on Tuesday, November 4, 2014, for the following purposes:

I. To cast their votes for Governor and Lieutenant Governor, Representative in Congress, State Senator, State Representative, Secretary of the State, Treasurer, Comptroller, Attorney General, Judge of Probate, and Registrar of Voters.
II. To vote on the following question for the approval or disapproval of a proposed AMENDMENT to the Constitution of Connecticut, a vote of "YES" being a vote for approval, and a vote of "NO" being a vote for disapproval:
1. Shall the Constitution of the State be amended to remove restrictions concerning absentee ballots and to permit a person to vote without appearing at a polling place on the day of an election?

The full text of such proposed questions with explanatory test, printed in accordance with §2-30a of the General Statutes, is available at the town clerk's office for public distribution.

The vote on the proposed questions is taken pursuant to the Constitution of Connecticut.

Notice is hereby given that the location of the polling places is as follows:

Voting District	Location of Polling Place
District 01 – Tuttle School	108 Prospect Road
District 1S – East Farm Village	55/65 Messina Drive
District 02 – Momauguin School	93 Cosey Beach Road
District 03 – Deer Run School	Route 80
District 3S – Deer Run School	Route 80
District 04 – Overbrook School	54 Gerrish Avenue
District 05 – Hays School	1 Maple Street
District 5S – Woodview	1270 North High Street

Absentee Ballots will be counted at the following central location: East Haven Town Hall, Mario Giamo Room, Lower Level, 250 Main Street.

Voting tabulators will be used. The polls will be opened at six o'clock in the morning (6:00 a.m.) and will remain open until eight o'clock in the evening (8:00 p.m.).

Dated at East Haven, Connecticut, this 20th day of October, 2014.

Stacy Gravino, CCTC
Town Clerk
Town of East Haven

Legal Notice
Town of Orange
November 4, 2014 State Election

The electors of the Town of Orange are hereby warned to meet at their respective polling places in said town on Tuesday, November 4, 2014, for the following purposes:

I. To cast their votes for:
Governor and Liutenant Governor
Representative in Congress
State Senator
State Representative
Secretary of the State
Treasurer
Comptroller
Attorney General
Judge of Probate
Registrar of Voters

II. To vote on the following question for the approval or disapproval of a proposed AMENDMENT to the Constitution of Connecticut, a vote of "YES" being a vote for approval, and a vote for "NO" being a vote for disapproval:
1. Shall the Constitution of the State be amended to remove restrictions concerning absentee ballots and to permit a person to vote without appearing at a polling place on the day of an election?

The full text of such proposed questions with explanatory text, printed in accordance with section 2-30a of the General Statutes, is available at the town clerk's office for public inspection.

Notice is hereby given that the location of the polling places is as follows:

Voting District		Location of Polling Place
1	State Rep #114	Mary L. Tracy School 650 Schoolhouse Lane
2	State Rep #117	High Plains Community Center 525 Orange Center Road
3	State Rep #119	High Plains Community Center 525 Orange Center Road

Absentee Ballots will be counted at the following central location: Orange Town Hall 617 Orange Center Road

Voting tabulators will be used. The polls will be opened at six o'clock in the morning (6:00 a.m.) and will remain open until eight o'clock in the evening (8:00 p.m.).

Dated at Orange, Connecticut, this 20th day of October, 2014.
Patrick B. O'Sullivan
Town Clerk
Town of Orange

New Haven Register ——— Check rates daily at http://nhregister.interest.com Bankrate.com

MORTGAGE GUIDE

Program	Rate	Points	Fees	% Down	APR
SANTANDER BANK, N.A. http://www.sovereignbank.com					
30 yr fixed	4.250	0.000	$1067	20%	4.305
15 yr fixed	3.250	0.000	$1067	20%	3.344
30 yr jumbo	4.125	0.000	$1067	20%	4.179
(C)					
BANK OF AMERICA					
30 yr fixed	3.875	0.413	$996	20%	3.959
15 yr fixed	3.250	0.278	$996	20%	3.378
30 yr jumbo	3.875	0.025	$1096	20%	3.932
(C) New Haven, CT 06510					

Program	Rate	Points	Fees	% Down	APR
FIRST NIAGARA BANK, NA					
30 yr fixed	4.000	0.000	$653	20%	4.033
15 yr fixed	3.250	0.000	$653	20%	3.307
30 yr jumbo	Call for Rates				
(C) Buffalo, NY 14207					
PEOPLE'S UNITED BANK					
30 yr fixed	3.750	0.000	$748	20%	3.787
15 yr fixed	2.875	0.375	$475	20%	2.970
30 yr jumbo	3.875	0.000	$748	20%	3.912
(C) Hartford, CT 06103					

Calculate Your Mortgage Payment

	30 yr fixed	15 yr fixed	5 yr ARM
This week	4.01	3.23	3.09
Last Week	4.18	3.37	3.27
Last Year	4.42	3.49	3.31

Source: Bankrate.com, for more information visit www.bankrate.com. Bankrate national averages are based on 100 largest institutions in the top 10 markets in the United States.

LENDERS, TO PARTICIPATE IN THIS FEATURE CALL BANKRATE.COM @ 800-509-4636

Legend: The rate and annual percentage rate (APR) are effective as of 10/16/14. © 2014 Bankrate, Inc. http://www.interest.com. The APR may increase after consummation and may vary. Payments do not include amounts for taxes and insurance. The fees set forth for each advertisement above may be charged to open the plan (A) Mortgage Banker, (B) Mortgage Broker, (C) Bank, (D) S & L, (E) Credit Union, (BA) indicates Licensed Mortgage Banker, NYS Banking Dept., (BR) indicates Registered Mortgage Broker, NYS Banking Dept., (loans arranged through third parties). "Call for Rates" means actual rates were not available at press time. All rates are quoted on a minimum FICO score of 740. Conventional loans are based on loan amounts of $165,000. Jumbo loans are based on loan amounts of $435,000. Points quoted include discount and/or origination. Lock Days: 30-60. Annual percentage rates (APRs) are based on fully indexed rates for adjustable rate mortgages (ARMs). The APR on your specific loan may differ from the sample used. Fees reflect charges relative to the APR. If your down payment is less than 20% of the home's value, you will be subject to private mortgage insurance, or PMI. Bankrate, Inc. does not guarantee the accuracy of the information appearing above or the availability of rates and fees in this table. All rates, fees and other information are subject to change without notice. Bankrate, Inc. does not own any financial institutions. Some or all of the companies appearing in this table pay a fee to appear in this table. If you are seeking a mortgage in excess of $417,000, recent legislation may enable lenders in certain locations to provide rates that are different from those shown in the table above. Sample Repayment Terms – ex. 360 monthly payments of $5.29 per $1,000 borrowed ex. 180 monthly payments of $7.56 per $1,000 borrowed. We recommend that you contact your lender directly to determine what rates may be available to you. **TO APPEAR IN THIS TABLE, CALL 800-509-4636. TO REPORT ANY INACCURACIES, CALL 888-509-4636.** • *http://nhregister.interest.com*

HIRE THE MOST QUALIFIED CANDIDATES

Call today to learn about how MediaOne's digital technology targets the perfect candidates saving you time and money!

We Listen.
We Understand.
We Get Results.

MEDIAOne MARKETPLACE

Call us today at 877-872-3278
Promo Code for 10% Off: EMPCT004

"Whenever we use MediaOne to advertise for our open positions, we always see an increase in response from high quality candidates. We definitely consider having MediaOne on our team a solid investment."

Hope Johnson
H.R. Representative
Brunswick at Longstown

ADVERTISEMENT FOR BIDS

Project: Parks Revitalization Program,
Phase 2 –Town Beach Park
460 Candlewood Lake Road,
Brookfield, Connecticut 06804
Owner: Town of Brookfield, Connecticut
100 Pocono Road,
Brookfield, Connecticut 06804
Architect: Doyle Coffin Architecture, LLC,
158 Danbury Road,
Ridgefield, CT 06877

THE TOWN OF BROOKFIELD, CONNECTICUT, will receive bids on a general contract for the Parks Revitalization Program, Phase 2 – Town Beach Park, located at 460 Candlewood Lake Road, Brookfield, Connecticut 06804. The work proposed is for overall site improvements and new building construction.

Bids must be in a lump sum basis and presented as per the bid documents.

Bids will be received until 2:00pm on Tuesday, November 18, 2014, at the BROOKFIELD TOWN HALL, Parks and Recreation Dept., 2nd Floor (left wing),100 Pocono Road, Brookfield, CT 06804. Bids received after this time will not be accepted. Bids will be opened and publically read aloud promptly after 2:00pm. All interested parties are invited to attend the bid opening.

Copies of Bid Documents may be obtained upon deposit of $100 per set (check made payable to the "Town of Brookfield"), at the Brookfield Town Hall, Parks and Recreation Dept., 2nd Floor (left wing),100 Pocono Road, Brookfield, CT, weekdays starting October 23, 2014, between 10:00am-3:00pm. Interested bidders are limited to two sets of documents each. Deposits will only be returned if bid documents are returned to the Parks and Rec Dept., Brookfield Town Hall in good condition within 10 days of the date when bids are due.

There will be a pre-bid site walk on Wednesday, October 29, 2014 from 11:00am-12:00pm. Interested bidders are welcome to review the project site upon purchasing bid documents. The site is also available to review from the Candlewood Lake Road entrance.

The General Conditions for this Project will require Bid, Performance and Payment Bonds. Non-discrimination is required. As this is a partially funded grant project by the State of CT (DECD) all applicable certifications, regulations and CT State Statutes apply.

The Town of Brookfield, CT is an Affirmative Action/Equal Opportunity employer. Minority/Women's business enterprises are encouraged to apply in accordance with CT State Statutes.

Bidders will be required to provide references and evidence of experience in previous, similar work, and must carry appropriate insurance coverages.

The Town of Brookfield, CT in consideration with their Architect, reserve the right to reject any or all bids, and to accept informality in bids, and to award the contract to any one of the bidders regardless of the amount of the bid, if the interest of The Town of Brookfield, be promoted. The Town of Brookfield, CT intends to award the contract to the responsible and qualified bidder who has proposed the lowest Contract Sum and reserves the right to negotiate with said qualified bidder.

No bidder may withdraw his or her bid within ninety (90) days after the actual date of the opening thereof. The Owner reserves the right to reject bids and to waive irregularities.

The Town of Brookfield, Connecticut
Office of the First Selectman and
Department of Parks and Recreation
100 Pocono Road, Brookfield, Connecticut 06804

Solicitation for Section 3 and Small/Minority Business Enterprises

Associated Construction/A.P. Construction, LLC seeks proposals from qualified City of Norwalk HUD Section 3 Businesses and State of Connecticut DAS certified small and minority business enterprises for the following bid packages relating to the construction of Phase I of Washington Village in South Norwalk, CT. The project consists of the new construction of 80 units of housing in two wood-framed buildings totaling approximately 125,000 SF. The work will take place in a 16-18 month timeframe beginning in November of 2014. The participation goals are as follows: 10% Section 3 businesses, 25% CT DAS certified Small Business Enterprises (SBE), 12.5% CT DAS certified Minority Business Enterprises (MBE). Participation is sought in the following trade divisions:

1. DIVISION 1 GENERAL CONDITIONS
Field Office/Trailer; Storage Trailers; Scaffolding; Temporary Electrical; Temporary Toilets; Temporary Fencing; Temporary Building Enclosures; Temporary Heat; Progress Cleaning; Final Cleaning; Window Washing; Trash Chutes; Dumpsters; Pest Control; Progress Photographs; Drawing Reprographics; Surveyor – Building Layout; Security Services/Night Watchman; Material Testing
2. DIVISION 2 SITEWORK & DEMOLITION
Sitework; Landscaping
3. DIVISION 3 CONCRETE
Cast in Place Concrete
4. DIVISION 4 UNIT MASONRY
Masonry
5. DIVISION 5 METALS
Structural Steel
6. DIVISION 6 WOODS & PLASTICS
Rough Carpentry; Finish Carpentry
7. DIVISION 7 THERMAL & MOISTURE PROTECTION
Damproofing; Insulation; Asphalt Shingle Roofing Systems; Fiber-Cement Siding; Applied Fireproofing; Joint Sealers
8. DIVISION 8 DOORS & WINDOWS
Hollow Metal Doors & Frames
9. DIVISION 9 FINISHES
Gypsum Board Assemblies; Tiling; Acoustical Ceilings; Wood Flooring; Resilient Sheet Flooring; Terrazzo Flooring; Carpet; Painting & Wall Covering
10. DIVISION 10 SPECIALTIES
Signage; Screens; Shelving; Toilet Accessories; Fire Protection & Postal Specialties
11. DIVISION 11 EQUIPMENT
Parking Control Equipment; Appliances
12. DIVISION 12 FURNISHINGS
Blinds, Drapes, Shades; Kitchen Casework
13. DIVISION 14 CONVEYING SYSTEMS
Traction Elevators; Trash Chutes
14. DIVISION 15 MECHANICAL
Fire Protection; Plumbing Systems; HVAC Mechanical
15. DIVISION 16 ELECTRICAL
Electrical; Site Lighting; Utility Hookup

Plans and specifications are available and may be viewed at the following location:

Associated Construction/A.P. Construction, LLC
1010 Wethersfield Avenue, Suite 304
Hartford, CT 06114

Associated Construction/A.P. Construction, LLC
707 Summer Street
Stamford, CT 06901

VASE Construction Services, LLC
360 Fairfield Avenue, Suite 200
Bridgeport, CT 06604

Norwalk Housing Authority
24 Monroe Street
Norwalk, CT 06854

Plans and specs are also available for view online at: http://files.accgc.com
Username: **E14-064** Password: **washington**

Bid deadline is October 31, 2014. Interested contractors may inquire by sending a Letter of Interest, Company Profile and HUD Section 3 or State of Connecticut DAS SBE/MBE Certification via email to Kenneth Woodward at kaw@accgc.com.

Associated Construction/A.P. Construction, LLC is an Affirmative Action/Equal Opportunity Employer.

LEGAL NOTICES

Legal Notice

Shoreline Wellness Behavioral Health Clinic, LLC an affiliate of Shoreline Wellness Center, LLC, is applying for a certificate of need pursuant to Connecticut General Statute Section 19a-638. Shoreline Wellness Behavioral Health Clinic, LLC is seeking Licensure as a free standing behavioral health clinic that will continue to provide mental health services to children, adults and families. Shoreline wellness Behavioral Health Clinic, LLC will not dispense any medications on site as agreed upon with the city of West Haven variance approval. There will be no changes in any of our current day to day operations that will affect the city, the general population, or the clients that we currently provide services for. Shoreline Wellness Behavioral Health Clinic, LLC is located at 415 Main Street, West Haven, CT. The total capital expenditure for the project is 35,000.

A HOME OF YOUR OWN
The Job of Your Dreams
A Pet for the Children
A Second Car for Commuting
A Tag Sale"Buried Treasure"
Find these and more in the ***New Haven Register Classifieds.***

LEGAL NOTICES

LEGAL NOTICE

The following vehicle will be sold for outstanding towing and storage charges on Oct. 24, 2014 at 10:00am. We reserve the right to puchase. Catapano Bros. Inc., 267 Kimberly Ave., New Haven, Conn.
2008 Honda
IHGCP36848A000632

LIQUOR PERMIT

Notice of Application

This is to give notice that
I, Kinja S Patel
8 Cheshire Road
Wallingford, CT 06492
Have filed an application placarded 10/22/2014 with the Department of Consumer Protection for a PACKAGE STORE LIQUOR PERMIT for the sale of alcoholic liquor on the premises at
287 Universal Drive
North Haven, CT 06473

The business will be owned by: SURESH LLC
Objections must be filed by: 12/03/2014

REMEMBER - when placing a classified to get fast results be sure to include:
1) all the details
2) include the price
3) be available to callers
As easy as 1 - 2 - 3!

EITHER BUYING, selling, or trading, a classified is a good investment.

LEGAL NOTICES

LIQUOR PERMIT

Notice of Application
This is to give notice that
I, VICENTE N SIGUENZA
26 ADELAIDE ST
FAIRFIELD, CT 06825-7401
Have filed an application placarded 10/15/2014 with the Department of Consumer Protection for a RESTAURANT LIQUOR PERMIT for the sale of alcoholic liquor on the premises at
1104 CHAPEL ST
NEW HAVEN CT
06510-2301
The business will be owned by: 1104 CHAPEL STREET LLC
Entertainment will consist of: Acoustics (Not Amplified) Disc Jockeys
Live Bands

Objections must be filed by 11/26/2014
VICENTE N SIGUENZA

LIQUOR PERMIT

Notice of Application
This is to give notice, I
JUAN L. CARRENO
10 HEATHER LN
NORWALK, CT 06851-5928

Have filed an application placarded 10/08/2014 with the Department of Consumer Protection for a RESTAURANT LIQUOR PERMIT for the sale of alcoholic liquor on the premises at
704 BOSTON POST RD
WESTBROOK CT
06498-1846
The business will be owned by: NARCISA DIVINO NINO LLC
Entertainment will consist of: Live Bands

Objections must be filed by: 11/19/2014
JUAN L CARRENO

NOTICE OF DECISION

BETHANY ZONING BOARD OF APPEALS
REGULAR MEETING OF OCTOBER 14, 2014

Granted the application submitted by MaryAnn & Leonardis Stefanis for property located at 4 Simpson Ct for the following variances to rebuild house:
• A 1% increase in the max building coverage to allow 11% where only 10% is allowed.
• A 2.5% increase in the max ground coverage to allow 17.5% where only 15% is allowed.
• No more than a 12.9' variance of the rear yard setback to allow a 37.1' rear yard setback.
• No more than a 7.8' variance of the front yard setback to allow a 42.2' front yard setback.
• No more than a 3.9' variance of the side yard setback to allow a 46.1' southerly side yard setback.
Antonia Marek, ZBA Clerk

CLASSIFIEDS WIN!!
When it comes to saving time, energy and money, Classifieds are in first place! Place your classified and see how easy it is to be a winner!

LEGAL NOTICES

NOTICE OF DECISION

Notice is hereby given that at its October 16, 2014 meeting, the Representative Policy Board of the South Central Connecticut Regional Water Authority approved the South Central Connecticut Regional Water Authority's Issuance Test Rate Application (#14-03), filed July 22, 2014.
The Final Decision of the Representative Policy Board is on file at its office at the address below.

Kevin J. Curseaden,
Chairperson
REPRESENTATIVE POLICY BOARD
South Central Connecticut Regional Water District
90 Sargent Drive
New Haven, CT 06511
Website:
www.rwater.com

NOTICE OF DECISION

Notice is hereby given that at its October 16, 2014 meeting, the Representative Policy Board of the South Central Connecticut Regional Water Authority approved the South Central Connecticut Regional Water Authority's Application (#14-04) for Approval of a Project to Complete Improvements at the Lake Saltonstall Intake and Raw Water Pump Station, filed July 29, 2014.

The Final Decision of the Representative Policy Board is on file at its office at the address below.

Kevin J. Curseaden, Chairperson
REPRESENTATIVE POLICY BOARD
South Central Connecticut Regional Water District
90 Sargent Drive
New Haven, CT 06511
Website:
www.rwater.com

Request for Bid

Konover Commercial Corporation as Agent for the State of Connecticut Department of Transportation will receive bids for snow and ice removal services at @ the Waterbury Rail Station and the Naugatuck Rail Station.
A mandatory site meeting will be held on Monday, October 27th @ 10am for all interested bidders. Please meet @ the Naugatuck Rail Station @ 195 Water Street, Naugatuck, CT.
Copies of the Bid package can be obtained by contacting Michelle Gaudreault, Assistant Property Manager at 203-624-4499.

CLASSIFIEDS hold many, many opportunities. They give opportunity for you to buy items, meet people, sell unwanted items, find housing, save money, earn a couple bucks, and much, much more.

HOW TO WRITE a classified ad that sells: First - Be complete. Second - Include the price. And third - Be available. Call today and we will be happy to help you write the most effective ad.

Town of Bethany
Warning of State Election
November 4, 2014

The Electors of the Town of Bethany are hereby warned to meet at their respective polling places in said town on Tuesday, November 4, 2014, for the following purposes:

I. To cast their votes for Governor and Lieutenant Governor, Representative in Congress, State Senator, State Representative, Secretary of the State, Treasurer, Comptroller, Attorney General, Judge of Probate and Registrar of Voters.
II. To vote on the following question for the approval or disapproval of a proposed AMENDMENT To the Constitution of Connecticut, a vote of "YES" being a vote for approval, and a vote of "NO" being a vote for disapproval:
1. Shall the Constitution of the State be amended to remove restrictions concerning absentee ballots and to permit a person to vote without appearing at a polling place on the day of an election?

The full text of such proposed question with explanatory text, printed in accordance with Sec. 2-30a of the General Statutes, is available at the Town Clerk's Office for public distribution.

Notice is hereby given that the location of the polling place is as follows:

Voting District	Location of Polling Place
1	40 Peck Road, Bethany, CT 06524

Voting machines will be used. The polls will be opened at six o'clock in the morning (6:00 a.m.) and will remain open until eight o'clock in the evening (8:00 p.m.).

Dated at Bethany, Connecticut, this 22nd day of October 2014.

Nancy A. McCarthy, CMC
Town Clerk
Town of Bethany

NOTICE OF PROPERTY TAX AUCTION

The City of Ansonia, Connecticut has levied upon the following properties and slated them for public auction for delinquent taxes and charges under C.G.S. §12-157. The volume and page numbers below refer to the Ansonia Land Records. Unless paid, these properties will be auctioned in "as is" condition at 7:00 P.M. on November 13, 2014 at the Ansonia Town Hall, 253 Main Street, Ansonia:

PROPERTY #1 TYPE SINGLE FAMILY HOME
#5 Pin Oak Lane owned by Elizabeth Ann Bosses, 5 Pin Oak Lane, Ansonia, Connecticut, 06401 described in Volume 253, Page 0847 owing $39,386.03 through the end of August, 2014. Wells Fargo; Citizens Bank of Rhode Island; Lienfactors, LLC; may claim interests, which will be extinguished by the sale.

PROPERTY #2 TYPE .09 ACRE VACANT LOT:
#11 Hillside Avenue owned by Chase Home Finance, LLC., 11 3145 Vision Dr., Columbus Ohio, 43085 described in Volume 416, Page 657 owing $20,211.96
through the end of August, 2014.

PROPERTY #3 TYPE APPROX 10.3 ACRES VACANT LAND
#135 Hill Street owned by Casimir J. Machowski, deceased, Rev. Francis T. Zlotkowski and Ann Zech, Co-Executors, 921 St. Edwards Drive, Austin, TX, 78704, described in Volume 435, Page 711 owing $30,897.90 through the end of August, 2014.

PROPERTY #4 TYPE SINGLE FAMILY HOME
#24 High Acres Road owned by Raymond N. Ott and Theresa Ott, 24 High Acres Road, Ansonia, Connecticut, 06401 described in Volume 164, Page 80 owing $26,520.39 through the end of August, 2014. Bank of America; Naugatuck Healthcare; Norman Ott; may claim interests which will be extinguished by the sale.

PROPERTY #5 TYPE SINGLE FAMILY HOME
#4 Bartholomew Road owned by Virginia Speciale, 4 Bartholomew Road, Ansonia, Connecticut, 06401 described in Volume 115, Page 426 owing $78,491.10 through the end of August, 2014. Bank of America; may claim interests which will be extinguished by the sale.

PROPERTY #6 TYPE TWO FAMILY HOME
#12 Orchard Street owned by Anthony F. Palumbo, 12 Orchard Street, Ansonia, Connecticut, 06401 described in Volume 291, Page 486 owing $54,745.85 through the end of August, 2014. Wells Fargo; Griffin Hospital; Geraldin El-Zoul; may claim interests which will be extinguished by the sale.

PROPERTY #7 APPROX 32,000 SQ FT LIGHT INDUSTRIAL COMPLEX
#26 Beaver Street owned by Cook Industrial Associates, LLC, 26 Beaver Street, Ansonia, Connecticut, 06401 described in Volume 468, Page 782 owing $134,721.20 through the end of August, 2014. United States of America; Webster Bank; Eddy Block, dba Beaver Street Associates; Valley Council of Governments; Precision Scale; Valley Cab; Dawid Manufacturing, Inc.; American Precision Mfg. LLC; Stars & Stripes Thrift Shoppe; may claim interests which will be extinguished.

Bidders must present Ten Thousand and 00/100 ($10,000.00) Dollars per property in cash or certified check made payable to State Marshal Arthur J. Davies, Trustee, on the day of sale, and the winning bidder must pay the balance of the sale price with ten (10) days or forfeit the deposit. Absent a redemption, the purchaser will take title "free and clear" six months after the auction except for certain specified encumbrances.

The auction will be conducted by
the Ansonia Tax Collector's Agent,
Connecticut State Marshal Arthur J. Davies,
PO BOX #468, ANSONIA, CT 06401
phone (203) 735-6367.

NOW TAKING APPLICATIONS

SEABURY HOUSING COOPERATIVE
400 ELM STREET, NEW HAVEN CT
203-503-0422
AFFORDABLE COOPERATIVE HOUSING
EFFICIENCY AND –1 BEDROOM UNITS
AVAILABLE. UTILITIES INCLUDED
MUST MEET INCOME LIMITS FOR
OCCUPANCY

RETURN DATE: NOVEMBER 18, 2014	:SUPERIOR COURT
OCWEN LOAN SERVICING, LLC	:JD OF NEW HAVEN
VS	:AT NEW HAVEN
COBB, CAROL ET AL	:OCTOBER 1, 2014

STATE OF CONNECTICUT

NOTICE TO CAROL COBB, IF LIVING OR TO HER WIDOWER, HEIRS, BENEFICIARIES, REPRESENTATIVES AND/OR CREDITORS

The Plaintiff has named Carol Cobb, if living, and her Widower, Heirs, Beneficiaries, Representatives and/or Creditors, if not living, as parties defendant in the complaint which it is bringing to the above named court seeking a foreclosure of its mortgage upon premises known as 51 HEMINGWAY AVENUE, EAST HAVEN, CONNECTICUT. This complaint is returnable to court on November 18, 2014 and will be pending therein after that date.

The plaintiff has represented to said court, by means of an affidavit annexed to the said complaint, that despite all reasonable efforts to ascertain such information, it has been unable to determine the residence of the said Carol Cobb, if living, or the identity or residence of her Widower, Heirs, Beneficiaries, Representatives, and/or Creditors, if not living.

Now, therefore, it is hereby ordered under C.G.S. § 52-69 that notice of the institution of this action be given to each such defendant by some proper officer causing a true and attested copy of this order be published in The New Haven Register once a week for two successive weeks, commencing on or before October 29, 2014, and that return of service be made to the Court.

Tara Bartlett
Assistant Clerk, Superior Court
Judicial District of New Haven

A TRUE COPY ATTEST
JOHN T. FIORILLO
CONNECTICUT STATE MARSHAL
HARTFORD COUNTY

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

February 24, 2015

VIA FAX ONLY

Ms. Cara M. Powers, LPC
Clincal Director
Shoreline Wellness Behavioral Health Clinic, LLC
415 Main Street
West Haven, CT 06516

RE: Certificate of Need Application; Docket Number: 14-31964-CON
Shoreline Wellness Behavioral Health Clinic, LLC
Proposal to Establish a Free-Standing Behavioral Health Clinic

Dear Ms. Powers:

On January 30, 2015, the Office of Health Care Access ("OHCA") received your response to the request for additional information concerning the initial Certificate of Need ("CON") application filed on behalf of Shoreline Wellness Behavioral Health Clinic, LLC ("SWBHC" or "Applicant"), proposing to establish a free-standing behavioral health clinic in West Haven, Connecticut, with an associated total capital expenditure of $40,000.

OHCA has reviewed the response and requests the following additional information pursuant to General Statutes §19a-639a(c):

1. The following table reports the project number of sessions as given on page 15 of the initial CON application:

PROJECTED NUMBER OF SESSIONS BY TYPE AND FISCAL YEAR

Service Type	Fiscal Year			
	2015*	2016	2017	2018
Individual	2,774	3,640	4,160	4,680
Group	26	104	104	156
Family/Couples	180	260	325	406
Medication Management and Psychiatric Evaluations	1,800	5,200	2,600	5200
Total	**4,780**	**9,204**	**7,189**	**10,442**

The information in the table was based on calendar year rather than fiscal year. Provide a revised table utilizing the Applicant's fiscal year. Report the number of sessions in the first partial year for services to be provided from March 1, 2015 through September 30, 2015 and for the next three full years from October 1 through September 30.

2. Please resubmit the financial attachment provided on page 60 of the initial CON application. Report each year separately, i.e., do not add values from one year to the following year. As this the CON application is for a new service, the column identified as "ProjectedW/out CON" will always be zero. The amounts reported in the "Projected Incremental" columns should be equal to the amounts reported in the "Project With CON" columns. Report patient revenues on the basis of the total number of sessions reported in Question 1. Prorate operating expenses for the six months reported in Fiscal Year 2015.

3. In response to the Completeness Question 28 concerning financial documentation, please confirm that the bank statement provided is for the Applicant's account.

4. Please provide a description of each of the following, including the name of the grantee, the stipulation conditions and other relevant information:
    a. Grant received from the State of Connecticut Department of Disability Services; and
    b. Grant received from the State of Connecticut Department of Economic Development.

5. Explain how the Applicant will cover the operating expenses of the clinic until reimbursements from Medicaid are received. Include in your explanation all available funding sources.

6. The Applicant intends to only accept Medicaid patients at the clinic. Please provide a discussion as to why other patients, such as uninsured or underinsured, will not be accepted.

In responding to the questions contained in this letter, please repeat each question before providing your response. Information filed after the initial CON application submission (e.g., completeness response letter, prefiled testimony, late file submissions and the like) must be numbered sequentially from the Applicant's document preceding it. **Paginate and date** your response (i.e., each page in its entirety) beginning with **Page Number 364**. Please reference "Docket Number: 14-31964-CON." Submit one (1) original and four (4) hard copies of your response. Fully paginate each copy. In addition, please submit a scanned copy of your paginated response, including all attachments, on CD in Adobe format (.pdf) and in MS Word format (.docx).

Pursuant to Section 19a-639a(c) you must submit your response to this request for additional information no later than sixty days after the date that this request was transmitted. Therefore, please provide your written responses to OHCA no later than **April 24, 2015**, otherwise your application will be automatically considered withdrawn. If you have any questions concerning this letter, please feel free to contact me at (860) 509-8075.

Sincerely,

Jessica Schaeffer-Helmecki
Planning Analyst (CCT)

* * * COMMUNICATION RESULT REPORT (FEB. 24. 2015 2:58PM) * * *

FAX HEADER:

TRANSMITTED/STORED : FEB. 24. 2015 2:57PM FILE MODE	OPTION	ADDRESS	RESULT	PAGE
923 MEMORY TX		912039310063	OK	3/3

REASON FOR ERROR
E-1) HANG UP OR LINE FAIL
E-2) BUSY
E-3) NO ANSWER
E-4) NO FACSIMILE CONNECTION

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: MS. CARA M. POWERS

FAX: (203) 931-0063

APPLICANT: SHORELINE WELLNESS BEHAVIORAL CLINIC

FROM: OHCA

DATE: 2/24/2015 **Time:**

NUMBER OF PAGES: 3
(including transmittal sheet

Comments: 2nd Completeness Letter for Docket Number: 14-31964

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS

Phone: (860) 418-7001
Fax: (860) 418-7053

410 Capitol Ave., MS#13HCA
P.O.Box 340308
Hartford, CT 06134