

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 a paginated hard copy of the CON application including a completed affidavit, signed and notarized by the appropriate individuals.
 - (*New*). A completed supplemental application specific to the proposal type, available on OHCA's website under "[OHCA Forms](#)." A list of supplemental forms can be found on page 2.
 - 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.
 - 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 completed Financial Attachment
 - Submission includes one (1) original hardcopy in a 3-ring binder and a USB flash drive containing:
 1. A scanned copy of each submission in its entirety, including all attachments in Adobe (.pdf) format.
 2. An electronic copy of the applicant's responses in MS Word (the applications) and MS Excel (the financial attachment).

For OHCA Use Only:

Docket No.: 16-32043 - cov Check No.: 2113
OHCA Verified by: SW Date: 4/21/16

**GROWING POTENTIAL SERVICES: THERAPEUTIC
AND BEHAVIORAL SOLUTIONS, P.C.**

139 HAZARD AVE
ENFIELD, CT 06082-6109

2113

51-57/119 CT
18615

DATE 4/18/16

PAY
TO THE
ORDER OF

Treasurer State of CT

\$ 500.⁰⁰

five hundred

DOLLARS

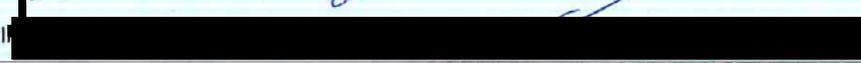
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Bank of America 

ACH R/T 011900571

FOR con application fee

MP





**State of Connecticut
Department of Public Health
Office of Health Care Access**

**Certificate of Need Application
Main Form**
Required for all CON applications

Contents:

- Checklist
- List of Supplemental Forms
- General Information
- Affidavit
- Abbreviated Executive Summary
- Project Description
- Public Need and Access to Health Care
- Financial Information
- Utilization

General Information

Name of Applicant:

Name of Co-Applicant:

Growing Potential Services:Therapeutic and Behavioral Solutions, PC	
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Connecticut Statute Reference:

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Main Site	MAIN SITE	MEDICAID PROVIDER ID	TYPE OF FACILITY	MAIN SITE NAME
				Program Building
	STREET & NUMBER			
	141 Hazard Ave			
	TOWN			ZIP CODE
	Enfield			06082

Project Site	PROJECT SITE	MEDICAID PROVIDER ID	TYPE OF FACILITY	PROJECT SITE NAME
				Program Building
	STREET & NUMBER			
	141 Hazard Ave			
	TOWN			ZIP CODE
	Enfield			06082

Operator	OPERATING CERTIFICATE NUMBER	TYPE OF FACILITY	LEGAL ENTITY THAT WILL OPERATE OF THE FACILITY (or proposed operator)	
			Growing Potential Services:Therapeutic and Behavioral Solutions, PC	
	STREET & NUMBER			
	141 Hazard Ave			
	TOWN			ZIP CODE
	Enfield			06082

Chief Executive	NAME	TITLE		
	Marcy Taliceo	CEO		
	STREET & NUMBER			
	141 Hazard Ave			
	TOWN		STATE	ZIP CODE
	Enfield		CT	06082

TELEPHONE	FAX	E-MAIL ADDRESS
860-698-6077	860-698-6631	growingpotentialservices@gmail.com

Title of Attachment:

Is the applicant an existing facility? If yes, attach a copy of the resolution of partners, corporate directors, or LLC managers, as the case may be, authorizing the project.	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Does the Applicant have non-profit status? If yes, attach documentation.	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Identify the Applicant's ownership type.	PC <input type="checkbox"/> LLC <input type="checkbox"/> Corporation <input checked="" type="checkbox"/>	Other: _____
Applicant's Fiscal Year (mm/dd)	Start <u>01/01/2016</u> End <u>12/31/2016</u>	

Contact:

Identify a single person that will act as the contact between OHCA and the Applicant.

Contact Information	NAME		TITLE
	Marcy Taliceo		CEO
	STREET & NUMBER		
	141 Hazard Ave		
	TOWN	STATE	ZIP CODE
	Enfield	CT	06082
	TELEPHONE	FAX	E-MAIL ADDRESS
	860-698-6077	860-698-6631	growingpotentialservices@gmail.com
RELATIONSHIP TO APPLICANT	Owner		

Identify the person primarily responsible for preparation of the application (optional):

Prepared by	NAME		TITLE
	Marcy Taliceo		CEO
	STREET & NUMBER		
	7 Quaker Lane		
	TOWN	STATE	ZIP CODE
	Enfield	CT	06082
	TELEPHONE	FAX	E-MAIL ADDRESS
	860-698-6077	860-698-6631	growingpotentialservices@gmail.com
RELATIONSHIP TO APPLICANT	self		

Affidavit

Applicant: Growing Potential Services: Therapeutic and Behavioral Solutions, PC

Project Title: Freestanding Psychiatric Outpatient Day Treatment Clinic

I, Marcy Taliceo, CEO
(Name) (Position – CEO or CFO)

of Growing Potential Services: Therapeutic and Behavioral Solutions, PC being duly sworn, depose and state that the (Facility Name) said facility complies with the appropriate and applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 and/or 4-181 of the Connecticut General Statutes.

[Signature]
Signature

4-14-16
Date

Subscribed and sworn to before me on 4/14/16

[Signature]

LISA A. STROM
NOTARY PUBLIC
MY COMMISSION EXPIRES 9/30/2020

Notary Public/Commissioner of Superior Court

My commission expires: 9/30/2020

Executive Summary

The purpose of the Executive Summary is to give the reviewer a conceptual understanding of the proposal. In the space below, provide a succinct overview of your proposal (this may be done in bullet format). Summarize the key elements of the proposed project. Details should be provided in the appropriate sections of the application that follow.

- Autism service
- Social skills training
- Community mentor support
- ADL skill assessment and training

- Life skills training
- Medication Management
- Case Management
- Substance Abuse Consultation
- Outreach Services
- Adult Day Treatment Programs
- Adult Outpatient Psychiatric Services
- Psychological Testing
- Occupational Therapy
- Physical Therapy
- Speech and Language Therapy
- Psychiatric Testing for Diagnostic Clarification
- Day treatment groups
- Partial hospitalization program

PROJECT DESCRIPTION

- 1. Provide a detailed narrative describing the proposal. Explain how the Applicant(s) determined the necessity for the proposal and discuss the benefits for each Applicant separately (if multiple Applicants). Include all key elements, including the parties involved, what the proposal will entail, the equipment/service location(s), the geographic area the proposal will serve, the implementation timeline and why the proposal is needed in the community.**

GPS was established on June 13, 2013 with the following mission statement in mind:

Growing Potential Services: Therapeutic and Behavioral Solutions, PC was founded on the belief that all individuals benefit from guidance and direction to help maximize their unique potentials and achieve growth in all aspects of their lives. Growing Potential Services assists individuals in navigating their internal GPS on the road toward healthy growth and change.

At that time only outpatient services were being offered in our original location in Windsor Locks. By November of 2013 GPS expanded into a larger office space located at 139 Hazard Ave, Enfield and started to offer Therapeutic Services for Kids in an individual and group setting. Over the next year and half we continued to grow to add a Behavior Analyst, and other Licensed Clinicians to offer outpatient services to children and adults. We've obtained a second service location located at 141 Hazard Ave, Enfield in order to offer even more services. Since June of 2013, we have added the following services:

Therapeutic Afterschool Program through ABH/DCF (DCF)
Clinical Assessments through ABH/DCF (Insurance and DCF)
Child and Adult Medication Management (Insurance)
DDS Autism Services (Contracted)
Extended Day Treatment licensed through DCF (Insurance)
Independent Behavioral Consultations for DDS residential and day treatment programs (Contracted)
In Home Behavioral Services for children with and without Autism (Insurance and DCF)

GPS is paneled to provide services to the following insurance companies: Husky, United Behavioral Health, Connecticare, Tufts, BCBS, Cigna, Aetna, Oxford, TriCare, Beacon Health, Magellan

Although GPS currently serves adults in its outpatient group and has a clinic license for children, we would like to expand adult services to include

- Day treatment
- Testing for diagnostic clarity
- Case management, individual and group therapies
- Outreach services
- Internships for qualified students.

GPS would like to start providing Adult Clinic Services as of May 1, 2016.

We have found that the population in Enfield and surrounding towns is seeking a comfortable, multifaceted, holistic clinic to attend as opposed to “people mills, drs offices” as clients have expressed. The setting at GPS can be described as a more relaxing and private setting that feels more like being at home. GPS is also the only mental health group in this area that provides a large number of services to a large demographic needing more than just a “cookie cutter” treatment plan. Our current population is: Ages 4-73, Commercial and State Plan insured, primarily low income families with an average of 5 individuals in the family. Our individuals have diagnosis of Autism, ADHD, Mood Disorders, Anxiety Disorders, Adjustment Disorders, etc... Over the next few months, we will be adding Developmental Testing, Physical Therapy, Speech Therapy and other services needed for children in the community so that parents with limited mobility and/or availability can have their child receive all of the services they need under one roof.

2. Provide the history and timeline of the proposal (i.e., When did discussions begin internally or between Applicant(s)? What have the Applicant(s) accomplished so far?).

After obtaining the second space in September of 2015, we applied for and received DCF licensing for Extended Day Treatment. We are now considered a Child/Adolescent Clinic through Value Options and Husky. Since our 141 Hazard Ave location is primarily used for children in the afternoons, I realized that the space is severely underutilized while the community at large is in need of more Day Treatment options for adults. Since February 2016, I have been discussing this option with others on my team and we all feel as though this is a great step forward for the community.

3. Provide the following information:

- a. utilizing **OHCA Table 1**, list all services to be added, terminated or modified, their physical location (street address, town and zip code), the population to be served and the existing/proposed days/hours of operation;

identify in **OHCA Table 2** the service area towns and the reason for their inclusion (e.g., provider availability, increased/decreased patient demand for service, market share

Table 1 and 2 attached

4. List the health care facility license(s) that will be needed to implement the proposal;

Private Freestanding Mental Health Day Treatment Facility CT 19a-491 and/or 19a-506 ,

Private Freestanding Facilities for the Care or Treatment of Substance Abuse or Dependence Connecticut General Statutes Section 19a-491 and/or 19a-506

5. **Submit the following information as attachments to the application:**

- a. **a copy of all State of Connecticut, Department of Public Health license(s) currently held by the Applicant(s);**

see attached

- b. **a list of all key professional, administrative, clinical and direct service personnel related to the proposal and attach a copy of their Curriculum Vitae;**

see attached resumes

Clinic Personnel

<u>Licensed Clinicians :</u>	<u>Date of Hire</u>
Marcy Taliceo, LPC	6/13/13
Yvonne Kintgios, LPC	12/14/15

Behavior Analyst:

Kaitlin Grout, BCBA 12/20/14

Psychiatry:

Dr Amit Rathi, Psychiatrist 1/26/16

Direct Care Staff:

- Jamal Williams	10/21/15
- Corey Overstreet	2/29/16
- Kristen Pomeroy	2/26/16
-Marquis Taliceo	1/14/14
- Mark Nassau	11/12/13
- Shanna Hebert	1/9/15
- Cynthia Ortiz	7/8/15
- Jessica Hickey	6/11/15
- Kelley Phelan	11/3/15
- Helena Rosario	9/24/15
- Michael Fitch	4/2/16

- c. **copies of any scholarly articles, studies or reports that support the need to establish the proposed service, along with a brief explanation regarding the relevance of the selected articles;**

see attached article entitled Engaging Families into Child Mental Health

Treatment: Updates and Special Considerations.

I chose this article for several reasons. What stands out to me most about this article is the need for family services. This article outlines the need for entire families to engage in services whether for themselves or the child. Without family involvement the rates of attendance and compliance with treatment decreases significantly. Our clinic will provide a menu of services for child and their parents so that we can help the family as a whole in one setting. Potentially, children may attend a group while parents attend an individual session and visa versa or parents may attend couples therapy while the child is with a mentor working on skill building and positive relationships. The need for a holistic and family oriented clinic is a great one and it is something that the Town of Enfield and surrounding towns will benefit tremendously from.

- d. **letters of support for the proposal;**
see attached

- e. **the protocols or the Standard of Practice Guidelines that will be utilized in relation to the proposal. Attach copies of relevant sections and briefly describe how the Applicant proposes to meet the protocols or guidelines.**
See attached

- f. **copies of agreements (e.g., memorandum of understanding, transfer agreement, operating agreement) related to the proposal. If a final signed version is not available, provide a draft with an estimated date by which the final agreement will be available.**

There are no agreements in place related to this proposal.

PUBLIC NEED AND ACCESS TO CARE

6. **Describe how the proposed project is consistent with any applicable policies and standards in regulations adopted by the Connecticut Department of Public Health.**

A Certificate of Need in accordance to CT Gen Statute 19a-639a is being applied for at this time. GPS is attaching evidence of a 3 consecutive day publication and appropriate application fee.

7. **Describe how the proposed project aligns with the Connecticut Department of Public Health Statewide Health Care Facilities and Services Plan, available [on OHCA's website](#).**

GPS Day Treatment and Psychiatric Clinic Services will align with CT DPH Health Care Facilities and Services Plan by offering a menu of therapeutic services available to

Individuals of all age, race, gender, religion, culture and their families. GPS is committed to a family model of services when appropriate to maximum success for the Individual and community at large.

8. With respect to the proposal, provide evidence and documentation to support clear public need:

a. identify the target patient population to be served;

Target Population: Ages 4-73, Commercial and State Plan insured.
Qualifying DSM V diagnosis. Individual and Family Focused Treatment Model

b. discuss how the target patient population is currently being served

Currently the target population is being served either in a private individual clinicians office in conjunction with other community service providers if there is a need for care in other areas eg. Physical therapy, Occupational Therapy, Medication Management. There is 1 other Community Based center in Enfield however they do not have the array of services that GPS currently offers and proposes to offer such as intensive Autism services, Speech Therapy, Developmental screenings.

c. document the need for the equipment and/or service in the community;

Community need: Multiple community services organizations have been developed in an effort to help with the growing need of the mental health and substance abuse crisis in Enfield and Hartford County. The following is an example of the community's efforts in providing resources to the Enfield population.

- Wrapct
- North Central Community Collaborative
- Enfield Special Education Resource Group
- Enfield Together Coalition

d. explain why the location of the facility or service was chosen

GPS has 2 buildings in this medical office park. There is also access to a chiropractor, general practitioner and Obgyn. We are also on a public transportation line and handicapped accessible.

e. provide incidence, prevalence or other demographic data that demonstrates community need;

According to Suicide Prevention CT Connecticut Data From 2001 through 2014, 114 of Connecticut's youth have died by suicide. Connecticut's statistics closely follow the national statistics (above) for suicidal ideation or planning, having trended down from 2001- 2009 and increasing since 2009 (graph). Equally concerning is the downward trend in the average age of a youth who die by suicide, from 17 in 2007 to just over 14 years of age in 2013. Although the numbers are small relative to the total population, each

youth suicide has a devastating impact to the youth's family, school, and community, and the ripple effect of each tragedy cannot be overstated.

According to samhsa.gov, there are only 2 Clinic and Day Treatment Facilities in Enfield, CT

- f. discuss how low income persons, racial and ethnic minorities, disabled persons and other underserved groups will benefit from this proposal;**

GPS is seeking to increase the level of services that we can offer to the community.

- g. list any changes to the clinical services offered by the Applicant(s) and explain why the change was necessary;**

Increase in patient care will include medication management, outpatient therapy, day treatment, partial hospitalization programs, case management.

- h. explain how access to care will be affected;**

Offering these services will be a large benefit to the community for individuals of all ages.

- i. discuss any alternative proposals that were considered.**

no other proposals were considered

9. Describe how the proposal will:

- a. This proposal will:**

Improve the quality of health care in Enfield and surrounding towns by offering a variety of services under one roof for ease and convenience for individuals and their families.

- b. improve accessibility of health care in the region; and**

GPS is fully accessible by public transportation and in a known medical park on a main road.

- c. improve the cost effectiveness of health care delivery in the region.**

Service costs of inpatient stays will decrease due to the increase of services that GPS will be able to offer to Enfield and surrounding towns.

10. How will this proposal help improve the coordination of patient care (explain in detail regardless of whether your answer is in the negative or affirmative)?

GPS employs a large variety of qualified individuals to provide the needed services in one setting. There is almost no need to go elsewhere for behavioral health treatment.

11. Describe how this proposal will impact access to care for Medicaid recipients and indigent persons.

GPS will not turn any person away for inability to pay for services. GPS will continue to accept Medicaid.

12. Provide a copy of the Applicant's charity care policy and sliding fee scale applicable

to the proposal.

Financial Assistance is the cost of providing free or discounted care to individuals who cannot afford to pay, and for which GPS ultimately does not expect payment. GPS may determine inability to pay before or after medically necessary services are provided. This is also referred to as Charity Care

- 13. If the proposal fails to provide or reduces access to services by Medicaid recipients or indigent persons, provide explanation of good cause for doing so.**

Not Applicable. This proposal will not reduce services to Medicaid recipients; it will increase services and care.

- 14. Will the proposal adversely affect patient health care costs in any way? Quantify and provide the rationale for any changes in price structure that will result from this proposal, including, but not limited to, the addition of any imposed facility fees.**

These services will not negatively impact any current or future Individuals who are accepting into GPS programs

FINANCIAL INFORMATION

- 15. Describe the impact of this proposal on the financial strength of the state's health care system or demonstrate that the proposal is financially feasible for the applicant.**

GPS is currently providing services for multiple commercial and state funded plans and we are maintained financially by such. We have been in business for almost 3 year and have never needed a line of credit to sustain our operations. We will continue to provide services and help reduce the cost of inpatient hospital stays that are being funded by the state or other resources.

- 16. Provide a final version of all capital expenditure/costs for the proposal using [OHCA Table 3](#).**

see attached table 3

- 17. List all funding or financing sources for the proposal and the dollar amount of each. Provide applicable details such as interest rate; term; monthly payment; pledges and funds received to date; letter of interest or approval from a lending institution.**

GPS is currently providing services for multiple commercial and state funded plans and we are maintained financially by such.

- 18. Include as an attachment**

a. audited financial statements for the most recently completed fiscal year. If audited financial statements do not exist, provide other financial documentation (e.g., unaudited balance sheet, statement of operations, tax return, or other set of books). Connecticut hospitals required to submit annual audited financial statements may reference that filing, if current;

see attached tax returns for 2014. 2015 have not been completed and an extension has been filed after beginning services with a new accountant this year.

b. completed Financial Worksheet A (non-profit entity), B (for-profit entity) or C (§19a-486a sale), available on [OHCA's website under OHCA Forms](#), providing a summary of revenue, expense, and volume statistics, "without the CON project," "incremental to the CON project," and "with the CON project." Note: the actual results reported in the Financial Worksheet must match the audited financial statement that was submitted or referenced.

see attached financial worksheet

19. Complete [OHCA Table 4](#) utilizing the information reported in the attached Financial Worksheet.

see attached table 4

20. Explain all assumptions used in developing the financial projections reported in the Financial Worksheet.

Financial assumptions are based on the increase in patient care and billing practices that will be available if license is obtained. This will include an increase in groups therapies, day treatment programs and other needed community services. This will increase the revenue of the company based on increased client visits.

21 Explain any projected incremental losses from operations resulting from the implementation of the CON proposal.

There are no projected financial losses at this time.

22. Indicate the minimum number of units required to show an incremental gain from operations for each projected fiscal year.

The minimal amount of unit gains needed are projected to be 50% in 2 years and 75% within 3 years.

UTILIZATION

23. Complete [OHCA Table 5](#) and [OHCA Table 6](#) for the past three fiscal years (“FY”), current fiscal year (“CFY”) and first three projected FYs of the proposal, for each of the Applicant’s existing and/or proposed services. Report the units by service, service type or service level.

see attached table 5 and 6

24. Provide a detailed explanation of all assumptions used in the derivation/ calculation of the projected service volume; explain any increases and/or decreases in volume reported in OHCA Table 5 and 6.

Medicaid volume is expected to increase therefore the potential for discharged numbers in Medicaid may rise. As Medicaid volume rises, there is a potential that commercial plan volume will decrease.

25. Provide the current and projected patient population mix (number and percentage of patients by payer) for the proposal using [OHCA Table 7](#) and provide **all assumptions**. Note: payer mix should be calculated from patient volumes, not patient revenues.

see table 7

26. Describe the population (as identified in question 8(a)) by gender, age groups or persons with a specific condition or disorder and provide evidence (i.e., incidence, prevalence or other demographic data) that demonstrates a need for the proposed service or proposal. Please note: if population estimates or other demographic data are submitted, provide only publicly available and verifiable information (e.g., U.S. Census Bureau, Department of Public Health, CT State Data Center) and document the source.

see attached data regarding the need for services for families struggling with mental health and/or substance use/abuse.

27. Using [OHCA Table 8](#), provide a breakdown of utilization by town for the most recently completed fiscal year. Utilization may be reported as number of persons, visits, scans or other unit appropriate for the information being reported.

see attached table 8

28. Using [OHCA Table 9](#), identify all existing providers in the service area and, as available, list the services provided, population served, facility ID (see table footnote), address, hours/days of operation and current utilization of the facility. Include providers in the towns served or proposed to be served by the Applicant, as well as providers in towns contiguous to the service area.

see attached table 9

29. Describe the effect of the proposal on these existing providers.

It is the understanding as reported by Individuals served, that the waitlist for the above mentioned local providers is months long. It has also been reported that they are unhappy with the "feel" of the other settings and feel more "comfortable" at GPS which is reflective of our retention and minimal no show rate. Being afforded quality care in a comfortable and reinforcing environment will hopefully have long term and lasting effects of treatment.

30 and 31.

Describe the existing referral patterns in the area served by the proposal.

Explain how current referral patterns will be affected by the proposal.

Referrals are currently provided by schools, Pediatricians, families and other community providers. Our referral process is easy and informative, providing information about services to the caller and Individual upon scheduling. Referrals are made on an average of 4 calls per day however our waitlist for some services is growing due to community recognition and service demands. It is necessary to be able to employ more clinicians and offer more services at the Individuals convenience so that we can continue to serve all our referrals in a timely manner. Our average referral to appt time frame is 3 days.

32. If applicable, explain why approval of the proposal will not result in an unnecessary duplication of services.

By providing more clinicians and case coordination and a variety of needed services, we will be able to ensure timely and efficient care.

33. Explain in detail how the proposal will impact (i.e., positive, negative or no impact) the diversity of health care providers and patient choice in the geographic region.

The Staff at GPS are very diverse in many ways. We come from all walks of life, have different life experiences, vary in age from 19-67, are of a variety of races and cultural backgrounds, some with children/some without, some with family members living with mental illness or substance addiction and some without. We are a group of clinicians that cares and relates to the Individuals we serve. We are a judge free environment and that remains a priority first and foremost. It is important that our Individuals feel that as soon as they enter our office.

#5 A

HEALTH INSPECTION
CERTIFICATION
8-1-08

RESIDENTIAL AND DAY FACILITIES

STATE OF CONNECTICUT
DEPARTMENT OF CHILDREN AND FAMILIES
DIVISION OF ADMINISTRATIVE LAW AND POLICY
505 Hudson Street, Hartford, Connecticut 06106

Unit or Cottage Name: _____

Facility Name: Growing Potential Services

Address: 141 Hazard Ave
Enfield, CT 06082

WATER SUPPLY:

1. Description of drinking water source: Public Well
2. If supplied by well water, has the supply been analyzed and found safe? _____
If so, When? _____ Please attach lab results to this form.

SEWAGE DISPOSAL:

1. Private on-site septic system _____ Public Sewers
2. Date system was last serviced/pumped _____

TOILET FACILITIES:

- Hot water @ 125.9°F @ 1:21 pm - dropped to 92°F*
1. Number of toilets for ^{children} females 1 for ^{staff} males 1 Urinals N/A Sinks 2
 2. Toilets clean in good working order in good repair
 3. Adequate lighting Ventilation Screening N/A
wall mounted paper towel dispenser covered waste

SLEEPING QUARTERS (N/A for Day Programs and Clinics): N/A

1. Is distance between beds proper? (3 ft. For single, 4 1/2 for double deck beds)? _____
Check for cleanliness: walls _____ floor _____ mattresses _____ bedding _____

KITCHEN AND DINING ROOM:

1. Are dishes, silverware, etc. in good condition and clean? Plastic ware - wash/rinse/sanitize
2. Is there sufficient hot water available for washing dishes? yes
3. Is the home equipped with a dishwasher? NO If so is it functioning properly? _____
4. Check for cleanliness: floors walls tables counters sinks
ventilation and air conditioning systems appliances Ref. / toaster oven / microwave
5. Is refrigerator clean? Is food adequately refrigerated and properly stored? 44°F air temp
6. Is food protected from dust? yes flies? yes vermin? yes
7. Is kitchen screened? N/A Is dining room screened? N/A
8. Are covered containers provided for garbage? yes
9. Are food preparation & serving areas in compliance with Health Department requirements? Snacks only

Notes: Packaged juice and packaged snacks are served to children

GENERAL:

1. Are all stairways free from obstruction? N/A
2. Is the building apparently in good repair? yes

- 3. Are surrounding grounds kept clean? yes
- 4. Is housekeeping satisfactory? yes
- 5. Are floor coverings safe and clean? tile and carpet - yes
- 6. Are laundry facilities adequate? N/A Clean? In good repair?

LEAD INSPECTION (Child Caring Facilities Only): ⓧ Building built in 1972 - Bldg #1 - Bldg #2
 Has the facility had a comprehensive lead inspection? NO (ATTACH RESULTS) built in 1995
 Date of Inspection: Not applicable if house built since 1978:

Note: Children ⓐ the age of 8⁺ use facility per owner

FLOOR PLANS:

Please attach floor plans for all buildings used for sleeping or treatment purposes.

The attached floor plans have been reviewed and the maximum number of beds for children in each area meets with my approval. The maximum capacity for sleeping or treatment purposes by floor is :

1st: 2nd: 3rd:

THIS FACILITY HAS BEEN INSPECTED BY ME AND
 DOES DOES NOT
 MEET ALL APPLICABLE HEALTH DEPARTMENT REQUIREMENTS

HEALTH INSPECTOR (Print or type name) Deborah A. Carouso
 Signature: Deborah A. Carouso - North Central District H.D.
 Address: 31 North Main St, Enfield, CT 06082 Date: 1/19/2016

Comments and Recommendations (use separate sheet if necessary)

Note - check with DCF regarding Comprehensive lead inspection as building was built in 1972

2nd Provisional License

STATE OF CONNECTICUT
DEPARTMENT OF CHILDREN AND
FAMILIES

This is to certify that, in accordance with the provisions of Sections 17a-147 of the General Statutes of the State of Connecticut as amended, **GROWING POTENTIAL SERVICES, INC.**, located at 141 HAZARD AVENUE in the Town of ENFIELD, CT is hereby licensed as an **EXTENDED DAY PROGRAM** for children at the location listed below.*

This license is issued effective April 24, 2016 for a period of 60 DAYS and is conditional upon compliance with all regulations of the Department of Children and Families and may be revoked for cause at any time.

License No. EDT-31

Signed at Hartford, CT this 12th day of April 2016

James McPherson
James McPherson, Program Manager
Office of Legal Affairs

* 141 Hazard Ave., Enfield, CT.....6 (M/F; ages 8-17)

5B

Marcy L. Taliceo M.A., LPC
Enfield, CT

413-235-3450
mtaliceo@msn.com

Professional Summary

Compassionate, solutions-oriented mental health professional dedicated to providing exceptional care and devising creative treatment plans for children, adolescents and adults diagnosed with a mental health disorder.

Work History

06/2013 to present

Owner/ President, Clinical Director, Clinician
Growing Potential Services: Therapeutic and Behavioral Solutions, PC

Owner/President:

- Duties include the day to day business and professional profile of the organization
- Responsible for maintaining and strengthening our business strategies and utilizing effective and appropriate marketing techniques for growth and development.
- Attend all meeting with regards to the business planning and decision of execution.

Clinical Director:

- Responsible for program planning and implementation. Part of that planning is to provide in house trainings as well as locate off site training and development seminars for our staff in an effort to retain a high quality team of professionals.
- Manage all intake operations to ensure comprehensive, timely and appropriate case assignment.
- Providing professional supervision, case consultations, conducting risk assessments and grievance response.
- Build and maintain professional relationships within the community in an effort to strengthen collaborations.

Clinician:

- Develop and implement treatment plans and modify when needed.
- Direct family-centered, strengths-based, culturally competent and individualized intakes and assessments
- Display sensitivity to the cultural needs of the clients and families served
- Guide clients in effective therapeutic exercises integrated from Cognitive Behavior Therapy (CBT), Applied Behavior Therapy (ABA) and Dialectical Behavior Therapy (DBT)
- Document responses to treatment in clients' case file.
- Facilitate a smooth discharge by encouraging and reassuring clients throughout their transitions.

03/2010 to 03/2013

**Assistant Program Director In Home Behavioral Services , Clinical Supervisor, Outpatient Clinician, In Home Behavior Specialist, In Home Therapist
Valley Psychiatric Services
Springfield, MA**

Assistant Program Director:

- Responsible for the daily tracking of referrals and case assignments as the primary program contact
- Ran weekly team meetings, supervision of clinicians, case consultations and collaborations.
- Served the role of liaison between clinicians, clients and insurance companies regarding treatment prior authorizations and renewals.

Clinical Supervisor for Outpatient Services and the In Home Behavioral Services:

- Managed 12 supervisees, their cases and their documentation
- Work to resolve any client concerns
- Provided weekly and bi weekly supervision to Masters level clinicians as well as Bachelor level case monitors.

Clinician/In Home Therapist:

- Developed and implemented treatment plans and modified when needed
- Directed family-centered, strengths-based, culturally competent and individualized intakes and assessments
- Conducted risk assessments and crisis evaluation referrals
- Displayed sensitivity to the cultural needs of the clients and families served
- Guided clients in effective therapeutic exercises integrated from Cognitive Behavior Therapy (CBT), Applied Behavior Therapy (ABA) and Dialectical Behavior Therapy (DBT)
- Documented responses to treatment in clients' case file.
- Facilitated a smooth discharge by encouraging and reassuring clients throughout their transitions.

In Home Behavior Specialist:

- Worked to identify and distinguish problem behaviors for the identified child
- Developed Functional Behavior Assessments as well as Behavior Intervention Plans in an effort to bring clarity and structure to the child and their behaviors
- Employed methods of Applied Behavior Analysis in my work with these clients to include reinforcement, extinction, shaping, data collection and graphing, functional analysis if needed, direct assessments, indirect assessments, structured interviews, identification of functional relations and more

01/2009 to 03/2010

**Clinician/Parent Educator/After School Program
Clinical Support
Eastern Services of CT
East Windsor, CT**

| *Clinician/Parent Educator:*

- Developed and implemented treatment plans and modified when needed
- Directed family-centered, strengths-based, culturally competent and individualized intakes and assessments
- Conducted risk assessments and crisis evaluation referrals
- Displayed sensitivity to the cultural needs of the clients and families served
- Facilitated a smooth discharge by encouraging and reassuring clients throughout their transitions. Provided structured parent education/training in both a group and individual setting.
- Provided clinical support for after school program.

03/2008-03/2009

**Employment Specialist
Community Health Resources
North Central Counseling
Enfield, CT**

Employment Specialist:

- Guided young adults with mental illness in their journey to employment
- Worked one on one with clients in their home and in the office
- Served to be a support to clients while completing employment applications and helping to prepare them for employment interviews.
- As many of my clients were still pursuing educations simultaneously, I also attended school team meeting in an effort to collaborate for success

Education

10/2011 to 06/2013

Florida Institute of Technology: Online

Applied Behavior Analysis Certification

Coursework: Concepts and Principles of Behavior Analysis, Behavior Assessment and Program Evaluation, Behavior Change and Procedures

09/2006 to 05/2009

**American International College
Springfield, MA**

Masters of Art: Clinical Psychology with a concentration in Forensic Psychology

Coursework: Counseling Psychology, Psychology of Cultural Diversity, Diagnostic Assessment I and II, Forensic Psychology, Advanced Abnormal Psychology, Adolescent Psychology, Child Development, Psychopharmacology, Family Counseling, Interpersonal Violence, Ethics in Criminal Justice

09/2003 to 05/2006

Bay Path College: Longmeadow, MA
Bachelors of Art: Psychology

Coursework: Communicating in Psychology, Psychology of Cultural Diversity, Theories of Personality, Counseling Psychology

Skills

- Skilled in intake interviewing
- Adept at treatment and discharge planning
- Strong public speaker
- Case management proficiency
- Learning disability awareness
- Culturally sensitive
- Licensed as a mental health professional in both Mass and CT
- CPR and First Aid certified
- Trained in Crisis Prevention Interventions
- Trained in data collection and interpretation

CT Licensed Professional Counselor

MA Licensed Mental Health Counselor

References

Kaitlin Grout, BCBA	GPS	860-214-3626
Crystal Henry	State of CT-Probation	860-241-2312
Karen Lapienski, EdD	Elegant Clinical	860-413-9509

Michael Fitch M.Ed.CAGS

26 Saybrook Circle
South Hadley, MA
01075
413-885-1921
mike_f761@netzero.com

HIGHLIGHTS OF QUALIFICATIONS

- *Skilled at working collaboratively with multidisciplinary teams
- *Extensive background working in hospital and outpatient settings
- *Knowledge of mental health, substance abuse, and trauma related issues
- *Experience performing psychological and educational evaluations

EDUCATION

American International College
2003 Certificate of Advanced Graduate Studies
1998 Master of Arts in Educational Psychology
1994 Bachelor of Science in Psychology

LICENSURE

2009 Licensed Educational Psychologist
2004 Licensed School Psychologist

WORK HISTORY

10/09-present

Clinician/Psychologist Pathways Clinical Services Springfield, MA
Individual therapy for children, teens, and adults with varied diagnoses autism consultant
with training received from Yale Provide consultation and multifaceted psycho-
educational evaluations

11/01-present

School Psychologist Holyoke Public Schools Holyoke, MA
psycho-educational assessments for kindergarten through twelfth grade
Assist multidisciplinary teams with developing/implementing IEP process

9/04 to 12/09

Consulting Psychologist Brightside West Springfield, MA
psycho-educational and Psychiatric related assessments for middle school through
twelfth grade. Assist multidisciplinary team with implementing behavior plans

Further work experience available upon request

YVONNE J. KINTGIOS, LPC, ATR
54 Atwater Terrace
Springfield, MA 01107
(413) 348-0952/c.i.t.e.studio@comcast.net

OBJECTIVE: Obtain a position as a Licensed Professional Counselor and Art Therapist

LICENSURE: LPC #2784-State of Connecticut, Registered Art Therapist #15-115, Application for LMHC Licensure-State of Massachusetts is pending

EDUCATION

Springfield College, Springfield, MA – *Master of Science/Art Therapy/Counseling*,
December 2012, GPA 3.989 – May 2013-successfully completed National LMHC Exam,
Recipient of Distinguished Graduate Student Award Representing the School of Arts, Sciences
and Professional Studies
California State University, Fullerton, CA – *Bachelor of Fine Arts/Environmental Design*,
June 1991, Dean's List with Honors
Orange Coast College, Costa Mesa, CA – *Associate of Arts Degree*,
June 1987

SUMMARY OF QUALIFICATIONS:

- First-hand knowledge in the curative properties of verbal/art therapy
- Empathy for and desire to assist clients in enhancing life opportunities through therapeutic processes
- Applied broad theory and therapeutic skill-set in therapy/counseling sessions
- Ability to integrate the use of art as an alternative therapeutic modality with clinical theories of child development, family dynamics, pathology, and health issues
- Understand ethical matters, multi-cultural concerns, and development of therapeutic alliances and relationships regarding therapeutic treatment
- Capability to observe, depict, and record both verbal and non-verbal communication
- Knowledge of issues and stages of substance abuse, clinical interventions, and rehabilitation process
- Use of client interview and Mental Status Exam for crisis evaluation
- Fundamental skill level of various hypnotic change techniques used in brief therapy
- Additional strengths include the ability to carry out the following:
 - Individual and Group Verbal Therapy
 - Intakes/Discharges
 - Progress Notes
 - Aftercare and Community Based Support Systems
 - Collaborative Documentation
 - Individual and Group Art Therapy
 - Diagnosis and Assessments
 - Treatment Planning
 - Crisis Intervention and Trauma-Related Safety Plans
 - Collateral Contact
- Professional verbal and written communication skills honed through years as a legal assistant employed by primary partners of nationally recognized law firms

COUNSELING/ART THERAPY EXPERIENCE

River Valley Counseling Center – Adult Day Treatment Program July 2015 to present

- Clinical Staff Therapist & Art Therapist in a group setting carrying a caseload of 15 adult clients seen on a daily basis. Management of treatment and providing art therapy groups throughout the day.
- Complete all clinical documentation for assessment, diagnosis, treatment planning, aftercare and termination.

South Bay Mental Health June, 2013 to July 2015

- Clinical Staff Therapist & Art Therapist performing out-patient therapy with caseload of 35 clients consisting of children, adolescents and adults seen weekly and bi-weekly
- Complete all clinical documentation for assessment, diagnosis, treatment planning, aftercare and termination. Comply with state, federal and private insurance requirements

Baystate Medical Center-Child & Adult Partial Hospital Program (Internship) Springfield, MA 2011-2012

- Identified biological, psychology, and social components of client health to establish treatment modalities from intake through discharge
- Implemented crisis intervention and stabilization components
- Employed *Collaborative Problem Solving Approach* with clients to gain emotional regulation and cognitive flexibility
- As client liaison, interfaced with families and personnel of medical, state, and educational institutions
- Observed and participated in group psychotherapy sessions
- Conducted family meetings; identified and recommended additional community-based resources based on client needs
- Contributed to psycho-educational groups
- Designed and carried-out art directives and creative activities for individual and group sessions based on age, diagnosis, and cognitive abilities increasing life skills and self-reflection
- Managed and organized creative arts facility and art materials
- Taught clients basic skills and nomenclature necessary to engage in art directives and creative art activities
- Worked individually and in groups to encourage client self-expression
- Applied computer medically-based system to complete all case management documentation

Northeast Center for Youth & Families -Residential Adolescents (Practicum) East Hampton January-May 2011

- Conducted individual verbal and art therapy sessions
- Designed and operated group verbal and art therapy sessions
- Established group's level of functioning; identified treatment goals
- Assessed initial and changes in affect, thought processes, behaviors, during sessions pertaining to:
 - verbal content and art images produced
 - suicidal or homicidal intent or ideation
 - summarization of group dynamic and progress
- Attended corporate and residential team meetings
- Prepared client progress notes
- Appraised client art projections and recovery progress
- Reported findings to members of the treatment team

RESEARCH EXPERIENCE

Designed Master's level research study to address the Effect of Art Therapy in the Reduction of Symptoms of PTSD in War Veterans; surveyed, selected, and performed detailed review of scholarly literature; completed college prescribed sections for research proposal; adhered to APA format; established mode of data collection, submitted proposal to Institutional Review Board for approval; located study participants; conducted a six-week bi-weekly study; executed data analysis; synthesized findings and procured results; proposed suggestions for future research; assembled scientific poster; and performed oral presentation of study to faculty and peers

PROFESSIONAL AFFILIATIONS/DEVELOPMENT

- Massachusetts Mental Health Counselor Association (MaMHCA)
- Connecticut Counseling Association (CCA)
- American Counseling (ACA)
- American Art Therapy Association (AATA)
- New England Art Therapy Association (NEATA)

- Orthodox Christian Mission Center International (OCMC), FL
- Ronald McDonald House, Springfield, MA
- Springfield Rescue Mission, Springfield, MA

CERTIFICATION

American Heart Association BLS (Basic Life Skills) Certification

ART-RELATED EXPERIENCE

c.i.t.e.studio, Art/Interior Design-MA

2001-2008

M-Des, Interior Design-CA

1993-2001

ADDITIONAL EXPERIENCE

Bulkley, Richardson and Gelinas, LLP, Springfield, MA

2006-2011

Allen Matkins, Los Angeles, CA

1999-2001

Bronson, Bronson & McKinnon, Los Angeles, CA & Additional California Law Firms

1995-1998

References Available Upon Request

DR AMIT RATHI

MBBS, MD

Name Amit Rathi
Address 270 Farmington Avenue, Suite 309
Farmington, CT 06032
Phone: Work (860) 677-5570
Cell (860) 810-0593
Fax: (860) 677-9570

Education

Medical School Maulana Azad Medical College, New Delhi, India, 1996-2002
Internship Maulana Azad Medical College, New Delhi, India, 2002-2003
Residency in Psychiatry Saint Louis University School of Medicine, Department of Psychiatry and Neurology, 2006-2009
Fellowship in Child and Adolescent Psychiatry CNMC/ George Washington University, Washington, DC, 2009-2011.

Certification:

ABPN board certified in General Psychiatry, and Child and Adolescent Psychiatry

Present Appointment

Psychiatry private practice. Affiliated with Connecticut Mental health Specialists. Psychiatric evaluation and management of patients in the age group of 3 – 45 years.

Previous Appointments

1. DKH Psychiatrist: 2011- September 2014

Worked as a Staff Psychiatrist in Day Kimball Hospital, Putnam, CT. Evaluating and managing child, adolescent and adult patient population in outpatient, inpatient and emergency setting. Collaborating with PCPs, schools and community providers in ensuring the best care for the patients.

2. Child and Adolescent Psychiatry Fellow, Children's National Medical Center/ George Washington University, Washington DC, 2009-2011.

3. General Adult Psychiatry, Saint Louis University Hospital, 2006-2009

4. Research/ House Officer, Vidya Sagar Institute of Mental Health and Neurosciences, New Delhi, 2005-2006

I was sub investigator in three drug trials.

I was also responsible for inpatient, outpatient and emergency management of psychiatric patients.

5. Junior Residency, Male Family Welfare Center, Lok Nayak Hospital, New Delhi, India, June 2003-June 2004

I evaluated and managed patients, with complaints of sexual dysfunction and infertility. I arranged coordination of care with psychiatry and surgery departments. The position also required me to counsel and prepare cases for Vasectomy and conducting the procedure, under supervision. I was responsible for teaching 2nd year Medical Students. During the one year I coordinated four national and international NSV (No Scalpel Vasectomy) training programs and camps.

6. Internship, Maulana Azad Medical College and Associated Hospitals, March 2002- March 2003

Clinical Experience

During my training in Psychiatry I have worked in a variety of service structures - University hospitals, VA hospitals, NGO clinics, County clinics, County jail, Nursing home and Children's hospital.

I have worked in a number of psychiatric specialties and I have seen patients for individual psychotherapy and pharmacotherapy for a prolonged period of time.

Administrative Experience

I was responsible for setting up the Child and Adolescent Behavioral health program at Day Kimball Hospital, which required policy planning, staff appointment and connecting with local agencies.

Teaching Experience

Clinical instructor at University of Connecticut, School of Medicine, Department of Psychiatry.

I was involved in teaching medical students in small groups as resident and fellow.

While in Saint Louis I gave talks to outreach staff at a NGO clinic and presented Grand rounds at Saint Louis University School of Medicine.

I have jointly conducted Child Fellowship Program at the Baltimore Washington Center for Psychoanalysis.

I am an Associate faculty at Yale University and St. Joseph University, and I have supervised APRN students.

Educational Courses:

Window into the therapy process, Saint Louis Psychoanalytic Institute, January 2008- February 2008

Introduction to Cognitive Behavior Therapy, APA 2008

Trauma focused Cognitive Behavior Therapy

Fellowship in Child and Adolescent Psychoanalysis at Baltimore Washington Institute for Psychoanalysis

Licensure:

Connecticut Medical License.

Volunteer Activity:

Pulse Polio Immunization Program, 1996-2004

I took part in administration of Polio vaccine to all children younger than 5 in Delhi, India.

Blood Donation Camp, 1997-1998

I helped to organize blood donation camps in the medical school.

Other Interests

I have been formally trained in Kriya Meditation technique. My other interests include sports- both playing and watching. I enjoy playing squash, soccer and basketball. I was in my medical school's cricket and badminton team.

Special Interests

I enjoy the flexibility my training provides me to treat patient of all age groups. I enjoy working with young children and transitional age population (18-21) in various settings. Administrative piece of practice is an area of interest for me. I am especially interested in cross - cultural psychiatry and working with individuals with personality disorders, eating disorders and autism.

STATE OF CONNECTICUT ♦ DEPARTMENT OF CONSUMER PROTECTION

Be it known that

AMIT RATHI MD
270 FARMINGTON AVE STE 309
FARMINGTON, CT 06032-1953

has satisfied the qualifications required by law and is hereby issued a

CONTROLLED SUBSTANCE REGISTRATION FOR PRACTITIONER

Registration # CSP.0050075

Schedule 1 No

Schedule 2 Yes

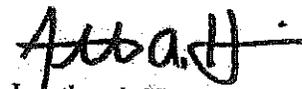
Schedule 3 Yes

Schedule 4 Yes

Schedule 5 Yes

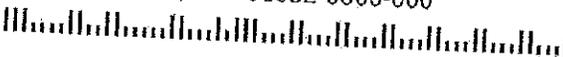
Effective: 03/01/2015

Expiration: 02/28/2017



Jonathan A. Harris, Commissioner

RATHI, AMIT
 CONNECTICUT MENTAL HEALTH SPECIALISTS
 270 FARMINGTON AVENUE
 SUITE 309
 FARMINGTON, CT 06032-0000-000



816000/9871001

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
FR2584008	04-30-2017	\$731
XR2584008		
SCHEDULES	BUSINESS ACTIVITY	ISSUE DATE
2,2N, 3,3N,4,5,	PRACTITIONER-DW/30	05-07-2014
RATHI, AMIT CONNECTICUT MENTAL HEALTH SPECIALISTS 270 FARMINGTON AVENUE SUITE 309 FARMINGTON, CT 06032-0000		

CONTROLLED SUBSTANCE REGISTRATION CERTIFICATE
 UNITED STATES DEPARTMENT OF JUSTICE
 DRUG ENFORCEMENT ADMINISTRATION
 WASHINGTON D.C. 20537

Sections 304 and 1008 (21 USC 824 and 958) of the Controlled Substances Act of 1970, as amended, provide that the Attorney General may revoke or suspend a registration to manufacture, distribute, dispense, import or export a controlled substance.

THIS CERTIFICATE IS NOT TRANSFERABLE ON CHANGE OF OWNERSHIP, CONTROL, LOCATION, OR BUSINESS ACTIVITY, AND IT IS NOT VALID AFTER THE EXPIRATION DATE.

Form DEA-223 (4/07)

CONTROLLED SUBSTANCE REGISTRATION CERTIFICATE
 UNITED STATES DEPARTMENT OF JUSTICE
 DRUG ENFORCEMENT ADMINISTRATION
 WASHINGTON D.C. 20537

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
FR2584008	04-30-2017	\$731
XR2584008		
SCHEDULES	BUSINESS ACTIVITY	ISSUE DATE
2,2N, 3,3N,4,5,	PRACTITIONER-DW/30	05-07-2014
RATHI, AMIT CONNECTICUT MENTAL HEALTH SPECIALISTS 270 FARMINGTON AVENUE SUITE 309 FARMINGTON, CT 06032-0000		

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STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

PURSUANT TO THE PROVISIONS OF THE GENERAL STATUTES OF CONNECTICUT

THE INDIVIDUAL NAMED BELOW IS LICENSED
BY THIS DEPARTMENT AS A
PHYSICIAN/SURGEON

AMIT RATHI, MD

LICENSE NO.

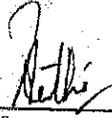
049772

CURRENT THROUGH

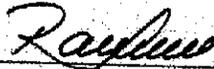
04/30/17

VALIDATION NO.

03-414576



SIGNATURE



COMMISSIONER

Account Number: CT CONN 2700

Date: 1/14/16 Initials: JL

CERTIFICATE OF INSURANCE

DARWIN NATIONAL ASSURANCE COMPANY
C/O: American Professional Agency, Inc.
95 Broadway, Amityville, NY 11701
800-421-6694

This is to certify that the insurance policies specified below have been issued by the company indicated above to the insured named herein and that, subject to their provisions and conditions, such policies afford the coverages indicated insofar as such coverages apply to the occupation or business of the Named insured(s) as stated.

THIS CERTIFICATE OF INSURANCE NEITHER AFFIRMATIVELY NOR NEGATIVELY AMENDS, EXTENDS OR ALTERS THE COVERAGE(S) AFFORDED BY THE POLICY(IES) LISTED ON THIS CERTIFICATE.

Name and Address of Insured:

CONNECTICUT MENTAL HEALTH
SPECIALISTS INC
270 FARMINGTON AVE STE 309
FARMINGTON CT 06032

Additional Named Insureds:

MARTIN COOPER, M.D.
PATRICIA MERRICK, APRN.
IRA ROSOFKY, PH.D.
DAVID SHACK, PH.D.
CLARISSE TULCHINSKY, APRN
CYNTHIA NYE, PH.D.
MOHAMMAD FAROOQ DADA, MD
NICHOLAS TOBIN, APRN
CARLA CORCIONE, PH.D.
THURAYA ABDI, APRN
CONTINUED...

Type of Work Covered: Psychiatry

Location of Operations: N/A
(If different than address listed above)

Claim History:

Retroactive date is 09/22/2005

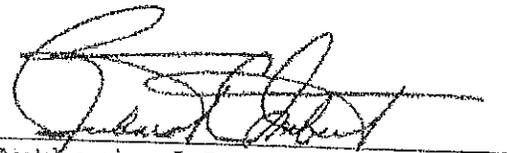
Coverages	Policy Number	Effective Date	Expiration Date	Limits of Liability
PROFESSIONAL/ LIABILITY	0001-3666	9/22/15	9/22/16	1,000,000 3,000,000

NOTICE OF CANCELLATION WILL ONLY BE GIVEN TO THE FIRST NAMED INSURED ON THIS POLICY AND HE OR SHE SHALL ACT ON BEHALF OF ALL INSURED(S) WITH RESPECT TO GIVING OR RECEIVING NOTICE OF CANCELLATION.

Comments:

This Certificate Issued to:

Name: CONNECTICUT MENTAL HEALTH
SPECIALISTS INC
Address: 270 FARMINGTON AVE STE 309
FARMINGTON CT 06032


Authorized Representative

CERTIFICATE OF INSURANCE

DARWIN NATIONAL ASSURANCE COMPANY
C/O: American Professional Agency, Inc.
95 Broadway, Amityville, NY 11701
800-421-6694

This is to certify that the insurance policies specified below have been issued by the company indicated above to the insured named herein and that, subject to their provisions and conditions, such policies afford the coverages indicated insofar as such coverages apply to the occupation or business of the Named insured(s) as stated.

THIS CERTIFICATE OF INSURANCE NEITHER AFFIRMATIVELY NOR NEGATIVELY AMENDS, EXTENDS OR ALTERS THE COVERAGE(S) AFFORDED BY THE POLICY(IES) LISTED ON THIS CERTIFICATE.

Name and Address of Insured:

Additional Named Insureds:

- RICK COMSHAW, APRN
- NILONI H. VORA, MD
- AYESHA AHMED, MD
- JEAN ENDERLE, APRN
- SANDRA RABIS, APRN
- SARAH A. RASKIN, PH.D.
- ARTURO MORALES, M.D.
- LITA LYAKHOVETSKAYA, MD
- ROSE YU-CHIN, MD
- KELLI GAGNE, APRN
- AMIT RATHI, M.D.
- ALEX DESHIELDS, M.D.
- NANCY TREVOR, APRN
- PAMELA PEDRONCELLI, APRN
- LACY BIRDSEYE, APRN
- APRIL DAVIS, APRN
- ERICA JANSON, PSY.D.
- ELIZABETH HALVORSEN, MD
- CONCEPCION CORTES, NP
- MARGARET ZIEGLER, APRN
- NICOLE M. HOLIDAY, APRN

HELENA ROSARIO

322 Elm St, Windsor Locks, CT 06096
Cell: 8608406379 - hrosario1211@gmail.com

PROFESSIONAL SUMMARY

Friendly and energetic with years of experience in childcare and education. Motivated to help children become happy, healthy and well-behaved.

SKILLS

- Knowledge of behavioral disorders
- First Aid and CPR Certified
- Positive and optimistic
- People-oriented
- Social services knowledge
- Infant and child CPR certification
- Highly observant
- Tactful and sensitive
- Outdoor activities
- Conflict resolution
- Food handling preparation
- Summer camp counselor
- Self-sufficient and confident
- Exceptional organizational skills
- Diaper changes and feedings.
- Epi-Pen use
- Creative
- Parent communication
- Lifting up to 60 pounds

WORK HISTORY

08/2014 to Current

Therapeutic Mentor

Eastern Services & Camp Simon - East Windsor, CT

- Promoted good behavior by using the positive reinforcement method.
- Assisted the lead teacher with snack time and arts and crafts.
- Kept group rooms clean by sterilizing and disinfecting children's toys and surfaces.
- Supported group mentors in implementing a developmentally appropriate curriculum for all age group of kids.
- Organized small groups of children while transitioning to and from outdoor play.
- Maintained daily records of children's individual activities, behaviors, meals and naps.
- Identified early warning signs of emotional and developmental problems in children.
- Maintained accurate and detailed records of enrollments, attendance, health and safety, emergency contact information and incident reports.

Baby Sitter/ Nanny

Cynthia - East Windsor, CT

- Drove children in facility van to off-site recreation activities.
- Communicated with children's guardians about daily activities, behaviors and related issues.
- Engaged with children individually to meet their emotional and physical needs.
- Maintained a child-friendly environment by allowing frequent access to outdoor activities.

EDUCATION

2015

certificate: culinary arts
Lincoln Technical - Hartford, CT

ADDITIONAL INFORMATION

Educated in child development, as well as spending her teen years as a "teen helper" influencing her peers to make right choices and being a positive role model.



Kelly Phelan

1 Surrey Lane Enfield, CT 06082 • (860) 995-8032 • kphelan@baypath.edu

Education:

Bay Path University: Longmeadow, MA

Year of Graduation: December 2015

Major: Child Psychology

Work History:

Educational Resources for Children "ERFC": Enfield, CT (September 2014-Present)
Enfield, CT

Site Administrator (August 2015-Present)

- Before and after school program facilitation
- Oversee and manage 3-4 team leaders
- Curriculum development and implementation
- In charge of groups of children upwards of 20+ ages 5-11
- Collaboration with other administration regarding licensure through State of Connecticut

Team Leader/Sports and Activities Coordinator (September 2014-August 2015)

- Before and after school program facilitation (homework help, supervision, various activity coordination)
- Curriculum development
- Kidz Sports "Coach"

Intern (December 2014-May 2015)

- Jobs listed above as well as the creation and implementation of a yoga and mindfulness curriculum.

Old Navy: Enfield, CT (February 2012-October 2014)

Sales Associate/New Employee "Coach"

- Basic skills including register training, upkeep of the store, inventory, and customer service.
- Experience in hiring new staff, employee training, and orientation coordination.

Once Upon A Child: Enfield, CT (March 2011-January 2012)

Sales Associate

- Basic skills including register training, upkeep of the store, inventory, and customer service.
- Inventory acquisition

Awards and Certificates:

Head Teacher Certification through Connecticut's Office of Early Childhood

2014 Psi Chi International Honors Society Inductee

Dean's List

Maroon Key Inductee



Connecticut Office of
Early Childhood

Connecticut Early Childhood Professional Registry

Kelly Phelan

Participant ID: 100-022-126

Career Ladder Level: 6

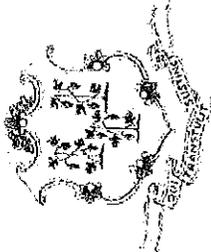
Meets QSM Eligibility: No

www.ccacregistry.org

October 26, 2015



TRIM TO REMOVE CARD



State of Connecticut

Office of Early Childhood

issues this approval to:

Kelly Phelan

to be a

Designated Head Teacher

for

Child Day Care Centers

for

School-Age Children

Having given evidence satisfactory to the Office of Early Childhood
Of having met the qualifications in accordance with Section 19a-79-4a
Of the Regulations of Connecticut State Agencies

Date of Approval: 08/31/2015

Head Teacher Number: 14324



Myra Jones-Taylor, PhD, Commissioner

165 Capitol Avenue • Hartford, CT 06106 • 860-713-6410

Jessica C Hickey
98 Bretton rd., Springfield, Massachusetts 01119
413-427-0515 - bajhickey@comcast.net

Education

Bay Path College
Longmeadow, Massachusetts
Masters of Science in Education with Applied Behavior Analysis
Major: Education
June 2013

Bay Path College
Longmeadow, Massachusetts
Bachelor of Arts
Major: Liberal Arts
GPA: 3.540
September 2007 to May 2010

Experience

Behavioral Health Network
In-home Behavior Management Therapist
Develop and implement FBA's and BAP's
Work closely with families
August 2013-Present

The May Institute
Home based therapist
West Springfield Massachusetts
Nov. 2010 – August 2013

I provide ABA therapy to children age 15 months to 3 years old that have an autism diagnosis.

Supervisor: Sarah Enright (413-734-0300 ext. 246)

Experience Type: Home based therapy

SABIS International Charter school
Teaching assistant One on One
Springfield Massachusetts
Aug 2007 – Nov. 2010

Worked one on one with a child that has autism. Assist her in the classroom and joined her to all her pull out services.

Supervisor: Jill Yvon (413-783-3434)
Experience Type: Public School, Full-time

Girl Scouts of Central and Western Massachusetts
Leader
Sept 2009- June 2011

Brownie and Junior Girl Scout Leader

Supervisor: Tiffany Holmes (800) 462-9100
Experience Type: Volunteer

References Available Upon Request

Catherine Levasseur

8 Elizabeth St. – Enfield, CT 06082 – katie.m.levasseur@gmail.com – (860)810-6568

OBJECTIVE:

To use my skills and education to help those in the Growing Potential Services community.

SUMMARY OF SKILLS:

- **Organizational Skills:**
 - able to create charts, very organized, can read and follow strict schedules
- **Creativity Skills:**
 - very creative mind, good ideas, can compose projects that increase learning
- **Team-building Skills:**
 - works well in a group environment, much experience in sharing ideas
- **Personal Relation Skills:**
 - able to establish and maintain rapport with young and school age children.

EDUCATION:

Eastern Connecticut State University
Bachelor in Psychology **Fall 2015**
Concentration: Childhood
Minor: Art

WORK EXPERIENCE:

Owner, KML Photography, Enfield, CT 2008 – Present
Second Photographer, JMS Art and Photo , Stafford, CT 2014 – Present
Cashier, Stop and Shop , Enfield, CT 03/2015 – 08/2015

VOLUNTEER EXPERIENCE:

After School Program, N. Windham Elementary 2013
Enfield Head Start Present
Facilitating groups, Residential Resource Centers, HAP Housing
06/2015 – 08/2015

COMPUTER:

Microsoft Word, Excel, PowerPoint, Adobe Photoshop, Adobe LightRoom

Jamal Ronaldo Williams

42 Mohawk Drive
East Hartford, CT 06108
Email: jamal1692@yahoo.com
(860) 655-5909

Objective

To work in an environment where there is room for growth

Education

June 2010: High School Diploma East Hartford High School
May 2012: Associate Degree in Liberal Arts University of Hartford
May 2015: Bachelors Degree in Criminal Justice University of Hartford

Work Experience

Summer-2015: The West Indian Foundation
Martin Luther King School
25 Ridgefield Street, Hartford, CT

2010 – 2015: Aramark - Dining Services/Customer service
University of Hartford
200 Bloomfield Avenue, West Hartford, CT

2010 – 2012: Education Main Street- Tutor
University of Hartford/ Global Academy
200 Bloomfield Avenue, West Hartford, CT

Internship

2014 - (CPA)-Community Partners in Action
716 Windsor Street Hartford, CT

Volunteer Work

Peace Jam Northeast 2010
Watkinson School
West Hartford, CT

References

Paula McDonald
23 Latimar St
East Hartford, CT, 06108
(860)-3061362

Felecia Grant
45 Candle wood Circle
Enfield, CT, 06082
(860)-992-4504

KRISTEN A. POMEROY

16 ELM CORNERS

WINDSOR LOCKS, CT 06096

H:(860) 614-1184 • E-MAIL: kristenpomeroy@yahoo.com

EXECUTIVE PROFILE

I am currently seeking a career working with children and families to reflect my degree in Family Studies with a focus in Child Studies. My experience includes my education, hands-on studies and internships making me a well-rounded, creative individual that works well in many environments and well under pressure. I take a lot of pride in my work and utilize sound evidence-based research to support the developmental growth of children and families to build resiliency in families who are at risk. I also have a strong passion to work with families of various cultural backgrounds.

EDUCATION

University of Saint Joseph

Bachelor of Science, 2013;

Psychology Minor

Human Development and Family Studies: Child Study

PROFESSIONAL EXPERIENCE

Head Start

Enfield, CT

Family Advocate

July 2014- Present

As a family advocate, I work with low income families and children in the Head Start program. I go on home visits and work within the school system. I form relationships with the children in the program and their families and act as a liaison to the Head Start program. I provide emotional support as well as provide assistance with information on support services in the area.

The School for Young Children

West Hartford, CT

Full-time Substitute Teacher

January 2014- June 2014

As a substitute teacher, I assisted both head teachers and assistant teachers in their classrooms with children. I also worked in the before and after school program.

The School for Young Children

West Hartford, CT

Student Worker

September 2011- December 2013

Summer 2012

As a student worker, I encouraged growth and development of skills in children age's three to five. I interacted one-on-one with children as well as provided a positive environment for both children and staff.

- Assisted teachers in their classrooms with students and curriculums.
- Nurtured children's creativity and learning experiences.
- Encouraged children's expansion of skills.

**CREC: Birth to Three
Student Intern**

**Hartford, CT
Fall 2013**

As a student intern, I shadowed a special educator through in home visits. I also attended CREC conferences which provided new evidence based research on behavior and sensory issues.

- Gained significant knowledge on working with developmentally delayed children and their caregivers.
- Built relationships with children and families through personal and meaningful interactions.

**Enfield Child Development Center
Pre-school Summer Aid**

**Enfield, CT
Summer 2013**

As a summer aid, I worked in a preschool classroom with children age's three to five. I worked with the head teacher on unit and lesson plans. I facilitated and encouraged new learning experiences.

**Charter Oak Family Resource Center
Student Intern**

**West Hartford, CT
Spring 2013**

As a student intern I was involved in multiple programs for children and families. These programs consisted of after school programs, and parent child-playgroups, as well as special events for families.

- Provided students with homework help.
- Encouraged children's social emotional growth.
- Supported families and children through meaningful interactions.

TECHNICAL SKILLS

- Proficient with Microsoft Word and Windows Operating System.

ADDITIONAL ACTIVITIES AND EXPERIENCE

CPR Certified

Golden Key International Honor Society

Fall 2011- Fall 2013

Inducted into a non-profit, invitation only international honors organization, which strives to recognize and encourage students who have excelled in academics, leadership, and service. Golden Key recognizes undergraduates for being in the top 15% of their class.

**Early Childhood Observations
Student**

**The School For Young Children
Fall 2010- Spring 2011**

I observed at the School for Young Children for various developmental courses. Focusing on the developmental domains of the students, I completed many tasks. Tasks included running records, portfolios, as well as creating and conducting play intervention with student.

*References available upon request

COREY ALEXANDER OVERSTREET

597 Burnside Ave, East Hartford, CT 06108 | 860-869-8278 | Mrcaoverstreet@hotmail.com

SUMMARY OF QUALIFICATIONS

Advocate for children's rights, establishment, and concerns. Hardworking, energetic, flexible, and adapts easily into a working environment and schedule. Maintains critical thinking skills essential to providing competent and dignified care. Personable with a positive attitude, interfaces well with a team, families, co-workers, and improvises well.

EDUCATION

Manchester Community College

Associates Degree in Science and General Studies

- *Expected BA 2017*

Aug. 2005 – May. 2011

PROFESSIONAL EXPERIENCE

Grouped Together for Success – Wethersfield, CT **Co-Founder/Marketing Director / Facilitator**

Jan. 2009 – Present

Not-for-profit organization founded to improve teacher/parent relations worldwide

- Facilitate team-building workshops for parents and teachers through interactive exercises, games, and education
- Provide high level of customer service to client sponsors, program participants, Principals and Board of Directors
- Train colleagues and clients on troubleshooting and resolving issues in real time through developed curriculums

East Hartford Board of Education – East Hartford, CT **Behavior Manager/ Priority Tutor**

Sept. 2004 – Nov. 2015

- Create and execute plans for students challenged mentally and academically. Participate in PPT's, IEP's, EIP's
- Took initiative to design and implement safety procedures with Director of Security/School Administration
- Serve as a liaison for Probation Officers, Therapists, DCF and affiliated outside organization

Gilead Community Services – Middletown, CT **Recovery Assistant/ Case Manager**

Aug. 2011 – May. 2014

- Supervised shift activities, assist completion of appropriate based client activities
- Provided clinical knowledge and education regarding adolescent/ adult disorders to new staff
- Lead in clinical services involving intake, engagement, assessment, treatment planning, client transition in, discharging, incident reporting, mandatory DCF reporting
- Maintain DCF/DHMAS medical certification & CPR/ First Aid

Wheeler Clinic – Plainville, CT

Residential Counselor

Aug. 2007 - Jun. 2009

- Perform a variety of highly skilled casework services: implement behavioral modification programs, counsel families, child and youths both individually and in groups. Served as a community developer
- Maintain medical, physical, social and psychological histories, consult with psychologist, psychiatrist and other staff to develop and administer treatment plans
- Assisted families to resolve a crisis by empowering them in order to strengthen and preserve the family unit

Marine Corps - Twenty-Nine Palms, CA.

Infantry 0311

Jun. 1998 – Sept. 2002

- Served as Combat Medic, Cobra Gold and G8 Summit compound security.
- Trained in nuclear, biological, chemical warfare and CS gases.
- Trained Korean Marines, Thai Marines, and L.A.P.D SWAT in tactical L.I.C exercises.

KILLS

Community Relationship Building | Behavior Analyst | Staff Training | Procedure Development | Team Leadership | Strategic Marketing | Creative Problem Solving | Community Outreach | Recovery Assistant Case Manager

Kaitlin A. Grout, M.S. Ed BCBA

342 Hackmatack St.
Manchester, Ct 06040

Phone: (860)214-3626
E-mail: kaitgrout@gmail.com

OBJECTIVE

Seeking a position within a school system to implement skills learned in Masters of Education with concentration in ABA and currently using within homes.

EDUCATION

Baypath College, Longmeadow, MA 2011-2013
Master of Science in Education with a concentration in ABA GPA 3.96
Coursework includes BCBA completion

Southern Connecticut State University, New Haven, Ct 2007-2009
Bachelor of Science, Therapeutic Recreation Dean's List/GPA 3.94

Manchester Community College, Manchester, Ct 2004-2007
Associate of Science, Therapeutic Recreation Dean's List/GPA 3.7

EMPLOYMENT

Growing Potential Services Therapeutic and Behavioral Solutions, PC Enfield, CT Chicopee, MA
Co-Director of Behavioral Services October 2013-Present

- Oversee running of In-home Behavioral Program including, but not limited to: running meetings and overseeing case loads
- Evaluation of Functional Behavior Assessments and Behavior Intervention Plans created by other clinicians
- Arrange coordinate and facilitate staff development and training groups
- All other duties performed by Behavioral Clinicians

Behavioral Clinician June 2013-October 2013

- Perform functional assessments including, but not limited to: questionnaires, rating scales, checklists, functional analysis, and observations
- Create and maintain contact with other members of CBHI team
- Compose Functional Behavioral Assessments (FBA)
- Compose Behavior Intervention Plans (BIP)
- Carry out BIPs
- Present FBAs and BIPs at team meetings including IEP meetings
- Peer advisor for incoming clinicians
- Support other members of In-Home Behavioral Team with cases

Valley Psychiatric Services, Inc., Springfield, MA

Program Coordinator for In-Home Behavioral Therapy Team

November 2013-Present

- Supervise In-home Behavioral Clinicians
- Evaluate Functional Behavioral Assessments and Behavior Intervention Plans created by IHBT clinicians
- Arrange and coordinate IHBT meetings and trainings
- All other duties performed by Behavioral Clinicians

Behavioral Clinician

June 2012-November 2013

- Perform functional assessments including, but not limited to: questionnaires, rating scales, checklists, functional analysis, and observations
- Create and maintain contact with other members of CBHI team
- Compose Functional Behavioral Assessments (FBA)
- Compose Behavior Intervention Plans (BIP)
- Carry out BIPs
- Present FBAs and BIPs at team meetings including IEP meetings
- Peer advisor for incoming clinicians
- Support other members of In-Home Behavioral Team with cases

Intensive Education Academy, West Hartford, CT

Teacher Aide/Paraprofessional

February 2012-August 2012

Reliance House, Norwich, CT

Teamworks Mental Health Therapeutic Recreation Counselor

November 2009-February 2012

- Perform assessments.
- Create social skills goals.
- Complete progress notes.
- Plan and implement community activities.
- Plan and implement clubhouse and organization activities.
- Establish meaningful relationships with members.
- Facilitate recreation groups.
- Work as a part of a team to create an effective healing environment.
- Document daily activities.

Dairy Queen, Manchester, CT

Assistant Manager

December 2006-November 2009

Supervisor

November 2005

Customer Service

November 2002

Hospital For Special Care, New Britain CT

Certified Therapeutic Recreation Specialist Intern

June-September 2009

- Perform Initial Assessments.
- Complete Progress Notes.
- Set goals for patients.
- Use knowledge of leisure and recreation activities to reach goals.

- Plan and implement activities.
- Set schedules.
- Ensure that all patients have some leisure activity available.

New Haven Parks Eco-Adventure Camp, New Haven, CT
Camp Counselor

June-August 2008

Riverside Health and Rehabilitation Center, East Hartford, CT
Intern to Therapeutic Recreation Director

September-December 2007

Institute of Living, Hartford, CT
Intern to Therapeutic Recreation Director.

September-December 2006

CERTIFICATIONS/TRAININGS

- Board Certified Behavior Analyst Certificate #: 1-13-14709 Recertification in September 2016
- Certified Therapeutic Recreation Specialist ID: 58658 Renewal in October 2015
- First Aid: Renewal in November 2014
- Emotional Intelligence
- Defensive Driving
- Cultural Diversity

References

Name: JoAnne Richards
 Organization: Sound Community Services
 Position: Assistant Supervisor
 Years known: 5
 Contact #: 860-639-0069
 E-mail: onerichj@gmail.com

Name: Cari Chapterlane-Cox
 Organization: Valley Psychiatric Services Inc.
 Position:
 Years Known: 1
 Contact #: (413) 386-4612
 E-mail: cchapterlane@hotmail.com

Name: Nicolle Matthews
 Organization: Valley Psychiatric Services, Inc.
 Position: Consultant
 Years Known: 2
 Contact #: 405-291-0305
 E-mail: nicollematthews@hotmail.com

Marquis I Taliceo
Enfield, CT 06082
(413) 335-8015

Objective

To work in an environment where there is room for growth

Education

June 2014: High School Diploma Enfield High School

Work Experience

January 2014- present Support Staff
Growing Potential Services: Therapeutic and Behavioral Solutions, PC Enfield, CT

Assist staff with activity development

Assist staff with parent contacts

Assist staff with organizing and distributing materials to clinicians and parents.
PMT trained

Volunteer Work

HomeFront 2012-present

Shanna Irene Hebert, LCSW

37 Massachusetts Ave

Longmeadow, MA 01106

(860) 818-2169 (Cell)

shanna.hebert1@gmail.com

SUMMARY OF QUALIFICATION

- Licensed Certified Social Worker with 3-½ years of therapeutic experience working with children, adolescents, and their families.
- 3 years experience working collaboratively with schools, provider networks, and community resources in Massachusetts.
- 2 years experience providing direct individual and family therapy focused on providing support of behavioral and mental health needs.

EDUCATION

Westfield State University, Westfield, MA

May 2013

Master of Social Work

GPA 4.0/4.0

Westfield State University, Westfield, MA

May 2011

Bachelors of Social Work

Minor in Psychology

Major GPA 4.0/4.0 Graduated Magna Cum Laude

EMPLOYMENT

Massachusetts Society for the Prevention of Cruelty to Children June 2013- Present

In-Home Therapy Clinician

Holyoke, MA

Currently providing services to youth and families including direct individual and family therapy, care coordination with school providers and multiple other professional agencies, referrals and linkage to community support, as well as crisis interventions and coordination with hospitals and child protective services. Also providing parent education and support on mental health needs of their children, conducting multi-level assessments and CANS assessments as well as treatment plans, and offering support on children's school needs including IEP and 504 plans.

Mt. Tom Center for Mental Health and Counseling

Sept. 2012-May 2013

Intern Outpatient Clinician

Holyoke & S. Hadley, MA

Provided outpatient therapy to both children and adults in a one-on-one setting as well as family therapy. Completed CANS assessments, created treatment plans and comprehensive assessments. Participated in co-leading an anger management group. Practiced in a co-location model and coordinated with doctors, nurses, psychiatrists and other providers.

Massachusetts Society for the Prevention of Cruelty to Children Aug. 2011- May 2013

Therapeutic Training and Support Worker

Holyoke, MA

Provided services to youth and families including case management, care coordination, assisting youth and caregivers in developing and maintaining informal and formal supports, facilitating and participating in meetings with other professionals, agencies and collaterals for the delivery of coordinated client care according to program specifications, working with the youth to help them in social and emotional areas as well as working with the caregivers on parenting skills.

The Key Program Inc. June 2011-Aug. 2011
Outreach and Tracking Caseworker Springfield, MA
Provided intense family intervention, counseling, advocacy in all life domains, and community networking for troubled teens and their families. Assisted these teens with social skills and adult life skills and worked simultaneously with other agencies and areas involved with the families.

Department of Children and Families, Van Wart Area Office Sept. 2010- May 2011
Intern CHINS Unit Springfield, MA
Carried four cases autonomously while assisting my supervisor with other duties which included: court appearances, home/school visits, foster care reviews, composing dictations, reviewing and writing service plans, conducting and writing case assessments, and making collateral calls.

Westfield State University Sept. 2010-May 2011
Social Work Tutor Westfield, MA
Tutored students with learning disabilities throughout the semester. Duties included assisting students by proof reading papers, researching literature, APA formatting, and test preparation.

VOLUNTEER WORK

Horizons for Homeless Children, Holyoke, MA Jan- Aug. 2010
Completed training on assisting and mentoring homeless children. Interacted with homeless children throughout various shelters in Massachusetts and taught the children through learning and play.

AFFILIATIONS

Massachusetts LCSW Certification Aug. 2013
Massachusetts CANS Certified Assessor Feb. 2012
Social Work Association Group *Westfield State University* Jan. 2010- May 2011
Phi Alpha Honor Society, Member *Westfield State University* April 2010

Engaging Families into Child Mental Health Treatment: Updates and Special Considerations

Geetha Gopalan LCSW, PhD¹; Leah Goldstein LMSW¹; Kathryn Klingenstein²;
Carolyn Sicher Psy.D¹; Clair Blake BA¹; Mary M. McKay LCSW, PhD¹

Abstract

Objective: The current paper reviews recent findings regarding how to conceptualize engagement and factors influencing engagement, treatment attendance rates, and interventions that work. **Method:** Research related to the definition of engagement, predictors of engagement and treatment termination, attendance rates, and engaging interventions are summarized as an update to the McKay and Bannon (2004) review. **Results:** Despite ongoing advances in evidence-based treatments and dissemination strategies, engaging families into mental health treatment remains a serious challenge. Within the last several years, a number of technological advances and interventions have emerged to address this problem. Families with children who present disruptive behavior challenges and symptoms of trauma are considered in terms of the unique barriers they experience regarding engagement in treatment. **Conclusions:** Potential solutions to increase treatment utilization and further research in this area are discussed.

Key words: engagement, child mental health treatment, service utilization

Résumé

Objectif: Réviser les récentes conclusions sur la manière de représenter l'engagement des familles; analyser les facteurs qui influent sur cet engagement, sur le respect du traitement; présenter des interventions efficaces. **Méthodologie:** Les travaux de recherche portant sur la définition de l'engagement, les prédicteurs de l'engagement, la décision de mettre fin au traitement, le taux de participation et les interventions sont présentés, résumés, sous forme d'actualisation de l'étude de McKay and Bannon (2004). **Résultats:** Bien que les traitements factuels et la diffusion de l'information progressent constamment, faire participer les familles au traitement des enfants atteints de maladie mentale reste un défi de taille. Au cours des dernières années, les progrès techniques et les interventions ont permis de résoudre de problème. L'étude porte notamment sur les obstacles cliniques particuliers auxquels se heurtent les familles qui participent au traitement d'enfants qui présentent des troubles du comportement et des traumatismes. **Conclusion:** L'article présente les solutions susceptibles d'améliorer la mise en place du traitement et propose des pistes pour la recherche future.

Mots clés: engagement, traitement troubles mentaux, enfants, utilisation des services

Introduction

Engaging families in child mental health treatment remains challenging despite continuing advances in evidence-based treatment approaches and efforts to disseminate these practices into the field (Hoagwood, Burns, Kiser, Ringeisen, & Schoenwald, 2001). Over the last three decades, rates of child psychopathology in the United States have ranged from 17–26% (Brandenburg, Friedman & Silver, 1990; Costello et al. 1996; Costello, Egger, & Angold, 2005; McCabe et al., 1999; Tuma, 1989; U.S. Public Health Service, 2000), with approximately 1 in

8 children manifesting a psychiatric disorder serious enough to cause significant functional impairment (Costello et al., 2005). This problem is particularly exacerbated in low-income, urban communities, where children are exposed to poverty, community violence and trauma, high rates of psychosocial stress, as well as insufficient housing, health, and mental health resources (Attar, Guerra, & Tolan, 1994; Gustafsson, Larsson, Nelson, & Gustafsson, 2009; Ingoldsby & Shaw, 2002; Jenkins, Wang & Turner, 2009; Leventhal & Brooks-Gunn, 2000; Self-Brown et al., 2006; Siefert, Finlayson, Williams, Delva, & Ismail, 2007).

¹ Department of Psychiatry, Mount Sinai School of Medicine, New York, New York, USA

² Graduate School of Social Service, Fordham University, New York, New York, USA

Corresponding Email: geetha.gopalan@exchange.mssm.edu

Submitted: May 3, 2010; Accepted: May 21, 2010

These environmental factors render children more vulnerable to developing mental health problems. Not surprisingly, rates of child psychopathology in low-income inner-city settings have been found to be as high as 40% (Tolan & Henry, 1996; Xue, Leventhal, Brooks-Gunn & Earls, 2005). At the same time, the National Institute of Mental Health (2001) reports that approximately 75% of children with mental health needs do not have contact with the child mental health service system. As challenges in meeting children's mental health needs persist, national efforts to encourage improved children's access to treatment continue (New Freedom Commission on Mental Health, 2003).

In response, McKay and Bannon's 2004 review focused on empirically supported factors related to engaging families in child mental health treatment. The current paper serves as an update to the 2004 review, as new knowledge has emerged over the last 6 years regarding the definition of engagement, rates of treatment attendance, predictors of engagement, barriers, and engagement interventions. Additionally, as little information has focused specifically on the unique needs of clinical sub-populations, this paper also summarizes issues related to engaging families whose children manifest disruptive behavior disorders and symptoms of trauma. Finally, recent findings are used in a discussion of implications for research and clinical practice.

Definition of Engagement

As indicated by McKay and Bannon (2004), engagement generally encompasses a multi-phase process beginning with (1) recognition of children's mental health problems by parents, teachers, or other important adults; (2) connecting children and their families with a mental health resource; and (3) children being brought to mental health centers or being seen by school-based mental health providers (Laitinen-Krispijn, Van der Ende, Wierdsma & Verhulst, 1999; Zwaanswijk, van der Ende, Verhaak, Bensing, & Verhulst., 2003; Zwaanswijk, Verhaak, Bensing, van der Ende, & Verhulst., 2003). Engagement can also be measured by (Step 1) rates of attendance at the initial intake appointment with a mental health provider, as well as (Step 2) retention in treatment over time. Each of these steps in the engagement process is related to the other. However, rates of engagement, as well as associated child, family, and service system characteristics differ between steps 1 and 2 (McKay & Bannon, 2004). Moreover, Alan Kazdin's work at the Yale Child Study Center argues for a more nuanced definition of service engagement into distinct phases, whereby children exit treatment at diverse points (i.e., while waiting for treatment, after 1–2 sessions, or later in treatment; Kazdin, Holland, & Crowley, 1997; Kazdin & Mazurick, 1994; Kazdin, Mazurick, & Siegal, 1994). Kazdin and Mazurick (1994) further noted that characteristics of children and families vary as a function of the point in time at which they exit services.

More recently, however, Johnson, Mellor and Brann (2008) argued that categorizing drop-outs by the number of sessions

attended can be misleading, as each treatment program requires a different number of treatment sessions to reach completion. Moreover, appropriate termination may occur after only a few sessions, particularly as many clinics limit the number of sessions offered. Instead, Johnson et al. (2008) assert that a more appropriate method for defining dropout rates utilizes the treating therapists' judgment regarding the appropriateness of treatment termination. As a result, inappropriate termination, or dropout, occurs when the therapist believes further treatment is needed while the client explicitly states they wish to discontinue treatment or fails to attend follow-up appointments. Treatment completion occurs when there is no further need for treatment, when the treatment program has been completed, and/or when both the therapist and family agree to terminating treatment.

While attendance is necessary for treatment to be delivered and for outcomes to be attained, many studies maintain that session attendance alone does not effectively describe treatment engagement. More recently, a review by Staudt (2007) emphasizes the importance of differentiating between the behavioral and attitudinal components of engagement. The behavioral component includes attendance, as well as other tasks performed by clients considered necessary to implement treatment recommendations and attain desired outcomes. Such behaviors can include participation in sessions (e.g., talking about relevant topics, practicing new skills), completion of homework assignments, demonstration of progress towards goals, discussing feelings, and engaging in efforts outside of sessions (Cunningham & Henggeler, 1999; Hansen & Warner, 1994; Prinz & Miller, 1991; Staudt, 2007). In relation to attitudes, engagement also refers to the emotional investment and commitment to treatment resulting from clients' belief that treatment is worthwhile and beneficial (Staudt, 2007; Yatchmenoff, 2005). The distinction between behavioral and attitudinal components of engagement is significant, given that many clients attend mental health treatment and other services in a perfunctory manner without ever fully investing in the therapeutic enterprise (Staudt, 2007; Staudt, Scheuler-Whitaker & Hinterlong, 2001).

Attendance at Initial Intake Appointments and Ongoing Treatment Retention

Currently, engagement in mental health care continues to be measured primarily by attendance at treatment sessions. McKay & Bannon (2004) indicated that no-show rates for initial intake appointments ranged from 48% (Harrison, McKay & Bannon, 2004) to 62% (McKay, McCadam, & Gonzales, 1996). More recently, McKay, Lynn and Bannon (2005) reported on attendance rates for 95 caregivers and children seeking treatment in an urban child mental health clinic. Among those who made an initial appointment via a telephone intake system, 28% of children accepted for services never attended an initial face-to-face intake appointment. Consequently, even conservative estimates

indicate that close to 1/3 of children and their families fail to engage at the initial face-to-face intake appointment.

It is not uncommon for length of treatment to average 3–4 sessions in urban, low-income communities (McKay, Harrison, Gonzales, Kim & Quintana, 2002). Studies from across the country estimate that 40% to 60% of children receiving outpatient mental health services attend few sessions and drop out quickly (Andrade, Lambert & Bickman, 2000; Burns et al., 1995; DeBar, Clarke, O'Connor & Nichols, 2001; Goldston et al., 2003; Kazdin & Mazurick, 1994; Lavigne et al., 1998). McKay et al. (2005) found that at the end of 12 weeks, only 9% of children remained in treatment in urban inner-city clinics. Similarly, a national study of private insurance recipients found that children and adolescents averaged 3.9 mental health visits within a six month period, with an average length of stay of less than three months (Harpaz-Rotem, Leslie & Rosenheck, 2004). However, mean number of visits and length of stay varied as a function of age, diagnosis, service setting, provider type, and insurance plan. A recent study of treatment attendance at publicly funded, community-based outpatient child mental health centers in San Diego County indicated that children attended an average of 13.8 treatment sessions (Brookman-Frazee, Haïne, Gabayan & Garland, 2008). While this number is substantially higher than the average 3–4 sessions reported in mental health clinics in urban, inner-city communities (McKay et al., 2002), this discrepancy likely reflects the differing characteristics associated with service engagement between a predominantly urban, low-income setting (e.g., McKay et al., 2002) and a more heterogeneous mix of families from different socioeconomic and geographic circumstances (e.g., Brookman-Frazee et al., 2008).

Predictors of Engagement

In considering the factors affecting engagement rates, McKay & Bannon (2004) reported on associated child and family level characteristics. At the child level, males are more likely to be referred and use more services compared to females (Griffin, Cicchetti, & Leaf, 1993; Padgett, Patrick, Burns, Schlesinger & Cohen, 1993). However, this disparity in service use rates by gender decreases as children get older (Griffin et al., 1993; Wise, Cuffe, & Fischer, 2001). Children with mental health diagnoses and impaired functioning are more likely to engage in services than children without diagnoses or functional impairments (Bird et al., 1996; Burns et al., 1995; Leaf et al., 1996; Offord et al., 1987; Viale-Val, Rosenthal, Curtiss, & Marohn, 1984; Zahner, Pawelkiewicz, De-Francesco & Adnopolz, 1992). Family level factors impacting service engagement include family poverty, parent and family stress, single parent status, effectiveness of parental discipline, whether parents actually receive the type of child mental health services they prefer, and family cohesion and organization (Angold, Erkanli & Farmer, 2002; Angold et al., 1998; Armbruster & Kazdin, 1994; Bannon & McKay, 2005; Brannan, Heflinger, & Foster, 2003; Gavidia-Payne &

Stoneman, 1997; Harrison et al., 2004; Hoberman, 1992; Kazdin et al., 1997; McKay, Pennington, Lynn, & McCadam, 2001; Perrino, Coatsworth, Briones, Pantin & Szapocznik, 2001; Takeuchi, Bui, & Kim, 1993; Verhulst & van der Ende, 1997).

Research also continues to highlight that minority children and their families are less likely to be engaged in mental health services compared to non-Hispanic Caucasian families (Garland et al., 2005; Freedenthal, 2007; Lopez, 2002; Miller, Southam-Gerow & Allin, 2008; Zimmerman, 2005). Even among those receiving mental health treatment, minority children make fewer mental health treatment visits (Harpaz-Rotem et al., 2004) and receive less adequate mental health treatment (Alexandre, Martins & Richard, 2009) than Caucasian children.

Rates of treatment drop-out have also been found to vary by children's clinical diagnoses. Although children with more serious Axis I disorders (internalizing and disruptive behavior disorders) continue to be more likely to receive treatment than those with Axis I adjustment disorders only (Miller et al., 2008), a number of studies indicate that children who drop out of treatment are more likely to display behavioral difficulties, such as Conduct Disorder and delinquency (Baruch, Vrouva & Fearon, 2009; Burns, Cortell & Wagner, 2008; Johnson et al., 2008; Robbins et al., 2006). In comparison, children with higher levels of mood and anxiety disorders are less likely to drop-out of treatment prematurely (Baruch et al., 2009; Burns et al., 2008; Johnson et al., 2008).

The relationship between service engagement and child age remains unclear. It was noted in McKay & Bannon (2004) that some studies found an inverse relationship between child age and rates of engagement (Griffin et al., 1993; Wise et al., 2001) while others reported a positive relationship (Roghamann, Haroutun, Babigian, Goldberg, Zastowny, 1982; Wu et al., 1999). To date, while some findings indicate that pre- and early adolescents are more likely to drop out of treatment than older adolescents (Baruch et al., 2009), others suggest that adolescents in general may be less likely than younger children to engage in formal mental health services due to fears of being stigmatized by peers (Cavaleri, Hoagwood & McKay, 2009; Logan & King, 2001).

Research also indicates that homeless adolescents are vulnerable to service disengagement. Baruch et al., (2009) found that homeless adolescents are more likely to drop out of treatment than those with more stable housing. Instead, street dwelling homeless youth are more tied to 'street' culture and informal peer networks, which meet their primary needs for survival (i.e., eating at soup kitchens, asking for change, etc.) and emotional support (Garrett et al., 2008). Homeless youth who have fewer peers in street culture or who feel rejected by such peers may be more likely to access mental health services than those who have stronger bonds in their street dwelling community (Garrett et al., 2008).

Regarding the attitudinal component of engagement, commonly described as "buy-in," research further indicates that adolescents are more likely to attend treatment when they perceive their mental health as poor (Brookman-Frazee et al., 2008). It has been suggested that treatment engagement for adolescents may require a certain level of self-awareness of mental health symptoms. Moreover treatment attendance increases when parents and adolescents can agree on at least one treatment goal, which may render youth less resistant to investing in the treatment process (Brookman-Frazee et al., 2008).

Research on treatment engagement has also examined the relationship between family process and treatment attendance. Parent interactions with children, for example, have been shown to be strong predictors of treatment drop out. For example, mothers who make more negative statements and praise less are more likely to drop out of Parent-Child Interaction Therapy (Fernandez & Eyberg, 2009). Recent research also indicates that families are more likely to seek treatment in times of stress or crisis (Burns et al., 2008), but are most at risk of dropout due to family difficulties. Similarly, Johnson et al. (2008) found that the highest proportion of dropouts occurred for those families with psychosocial difficulties and problems related to family dynamics. In a qualitative study of factors influencing premature termination of mental health treatment by parents, Attride-Stirling, Davis, Farrell, Groark and Day (2004) found that treatment non-completers were more likely to arrive with multiple family-level problems, while completers were focused on the specific problems of the identified child. These results suggest that non-completion of treatment may result, at least in part, from elevated family distress. Such findings underscore the importance for considering how high levels of family stressors impede treatment engagement. Although highly stressed families may be more in need of supports, such stressors can hinder families' ability to seek and retain child mental health treatment (Thompson et al., 2007).

Barriers to Engagement

McKay & Bannon (2004) reported on specific logistical barriers to service use, which included concrete (e.g., insufficient time, lack of transportation), contextual (e.g., community violence), and agency obstacles (e.g., time on waiting lists) (Armstrong, Ishiki, Heiman, Mundt, & Womack, 1984; Bui & Takeuchi, 1992; Cohen & Heselbart, 1993; Kazdin & Mazurick, 1994; Miller & Prinz, 1990; Russell, Lang, & Brett, 1987; Wahler & Dumas, 1989). Additionally, perceptual barriers including poor therapeutic alliance, perceived need for treatment, perception of barriers, expectations for therapy, and beliefs about the therapeutic process also impacted engagement beyond logistical barriers (Garcia & Weisz, 2002; Kazdin et al., 1997; MacNaughton & Rodrigue, 2001; Nock & Kazdin, 2001). Ethnocultural beliefs and attitudes further influenced service engagement, as some cultural groups subscribe to a belief that parents should overcome

child mental health problems on their own (McCabe, 2002; Snowden, 2001).

Specific barriers which impede successful mental health service use engagement for adolescents include fears of labels or anticipating stigma from others (Boldero & Fallon, 1995; Yeh, McCabe, Hough, Dupuis, & Hazen, 2003). The adolescent developmental period is characterized by a strong need to establish a sense of competence, social acceptance, and autonomy. As a result, adolescents may have great difficulty coming to terms with the undesirable implications of having a mental health difficulty for their sense of normalcy, identity, and independence (Wisdom & Green, 2004). Not surprisingly, adolescents often refuse services due to stigma about mental health difficulties and fears that peers may have knowledge of their psychiatric issues (Cavaleri et al., 2009). Other barriers to engagement in mental health services for adolescents include lack of knowledge about the need for mental health treatment, what services might be helpful, as well as details about the overall treatment process itself (Goldstein, Olfson, Martens, & Wolk, 2006; Logan & King, 2001). Finally, the developmental goals of adolescence, which involve establishing independence from adults, may lead to an increasing tendency to avoid self-disclosure to adults in general (Seiffge-Krenk, 1989), consequently hindering the ability for adolescents to readily seek assistance from traditional mental health providers.

Poor therapeutic alliance is another substantial barrier in engaging and retaining families in child mental health treatment (Kerkorian, McKay & Bannon, 2006; Robbins et al., 2006). Kerkorian et al. found that parents who felt disrespected by their children's prior mental health providers were six times more likely to doubt the utility of future treatment, and were subsequently likely to identify more structural and contextual barriers to treatment. Robbins et al. found that both adolescent and maternal alliances with therapists in Multidimensional Family Therapy for adolescent substance abuse declined significantly between the first two sessions among dropout cases, but not among treatment completers. Moreover, differences between maternal and adolescent therapeutic alliance, as well as differences between maternal and paternal alliance with therapists, predicted treatment dropout (Robbins et al., 2008). Furthermore, the relationship between different levels of therapeutic alliance among family members and treatment dropout has been found to be stronger among Hispanic than Caucasian families. Flicker, Turner, Waldron, Brody, & Ozechowski (2008) noted that among Hispanic families, those who did not complete functional family therapy for adolescent substance abuse experienced more intra-family differences in therapeutic alliances than treatment completers. However, the same effect was not observed among Caucasian families in the study. Flicker et al. (2008) suggested that therapists' inexperience in addition to the insufficient attention to cultural factors (e.g., familism and hierarchy within Hispanic families) may contribute to engagement difficulties. Such

findings indicate that problematic alliance may be observable as early as the first few sessions, particularly the differential treatment alliance between family members and for specific cultural groups. Sufficient therapist training in addressing early alliance problems, as well as respecting culturally specific family processes could lead to increased retention rates.

Parents' beliefs about the causes of their children's problems may also hinder mental health service use. Yeh et al. (2005) determined that parents who believed that their children's problems were due to physical causes or trauma were 1.56 times more likely to use mental health services compared with those who had other etiological beliefs (e.g., personality, relationships with friends and family, family issues). However, parents who believed that their children's relationships with friends caused mental health difficulties were 25% less likely to use services compared to parents who believed that child mental health difficulties were caused by American culture, prejudice, economics, spiritual issues, and nature disharmony. Providing mental health education to parents on the bio-psycho-social model of children's mental health difficulties may assist in addressing this particular barrier to service use.

Interventions That Promote Engagement

McKay & Bannon (2004) identified a number of interventions and strategies designed to overcome logistical, perceptual, and cultural barriers to engaging in child mental health treatment. These involved using reminder letters and phone calls (Kourany, Garber, & Tornusciolo, 1990; MacLean, Greenough, Jorgenson, & Couldwell, 1989; Shivack & Sullivan, 1989), initial telephone contact strategies (i.e., when parents first contact clinics via telephone to set up an intake appointment; Coatsworth, Santisteban, McBride, & Szapocznik, 2001; McKay et al., 1996; Santisteban et al., 1996; Szapocznik et al., 1988) and face-to-face intake procedures (McKay, Nudelman, McCadam, & Gonzales 1996). Additional strategies include those which address parent concerns and barriers during the course of treatment (Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 1998; Kazdin & Whitley, 2003; Prinz & Miller, 1994; Szykula, 1984). Moreover, dedicated paraprofessional and professional clinical staff are also helpful in promoting family engagement (Burns, Farmer, Angold, Costello, & Behar, 1996; Elliott, Koroloff, Koren, & Friesen, 1998; Koroloff, Elliott, Koren, & Friesen, 1994; 1996).

Technology-based interventions

Recent mental health and primary care engagement research indicates that telephone reminders continue to be an effective strategy to increase attendance at mental health treatment appointments, particularly when therapists, rather than clinic staff, make direct contact with clients or families (Shoffner, Staudt, Marcus, & Kapp, 2007). Additionally, new technology to improve appointment attendance includes the use of the internet and cellular telephones. A web-based appointment system that

allows clinicians and staff to make, change, and confirm therapy appointments led to an increased likelihood of attendance at first therapy sessions (74%), as compared to traditional therapist-based scheduling by telephone (54%) (Tambling, Johnson, Templeton, & Melton, 2007). Appointment reminders sent via text-messaging is also an effective way to improve attendance rates at primary care outpatient services (Downer, Meara, Da Costa, & Sethuraman, 2006; Leong et al., 2006), and could be easily implemented at mental health clinics.

Paraprofessional staff

Additionally, research continues to focus on the use of paraprofessional staff to promote engagement. Trained parent, or family, advocates are paraprofessionals who have special needs children themselves. Family advocates are trained to coach and support families in need of mental health services utilizing the skills and knowledge they have already developed by successfully navigating the mental health service system for their own children. Family advocacy and support programs increased in number nationwide (Hoagwood et al. in press; Olin et al., in press), and approximately 10,000 families access training, services, and support through family advocacy programs annually in New York State alone (Olin et al., in press). The Parent Empowerment Program (PEP) in New York State trains family advocates to address the needs of parents dealing with child mental health difficulties by focusing on empowering their clients as active agents of change (Olin et al., in press). PEP integrates practical principals of parent support, the Unified Theory of Behavior Change (UTB; Jaccard, Dodge, & Dittus, 2002; Jaccard, Litardo, & Wan, 1999), and evidence-based engagement strategies (McKay, McCadam, & Gonzales, 1996; McKay, Nudelman, McCadam, & Gonzales, 1996; McKay, Stoewe, McCadam, & Gonzales, 1998). Delivered by current or former parents of children with identified mental health needs, family advocates trained in the PEP model provide instrumental and emotional support, information about mental health services, care coordination, referral and linkage to other services, respite, recreation, and direct advocacy (Jensen & Hoagwood, 2008). Moreover, the personal experience of advocates increases credibility and the ability to engender trust with parents, thereby helping families become more actively engaged in their children's care (Gyamfi et al., 2010; Hoagwood et al., 2008; Koroloff, et al., 1994; 1996; Olin et al., in press; Robbins et al., 2008). Although research on family advocates is in the preliminary stages, it has been suggested that when family advocates are integrated in child mental health service delivery, families are more likely to engage in treatment (McKay et al., in press).

A related area focuses on outreach, engagement, and psychoeducation services provided by peer youth specialists as a promising way to address difficulties in engaging adolescents into mental health treatment. Peer youth specialists, who are adolescents and young adults themselves, are often seen as more

credible and may possess a greater understanding of youths' concerns compared to adult professionals. As a result, peer youth specialists possess an enhanced ability to engage adolescents to address a range of issues, including substance abuse, HIV/STD prevention, suicide prevention, and academic failure (Tindall & Black, 2009). Moreover, adolescents may be more responsive to younger service providers seen as peers rather than older adults (French, Reardon, & Smith, 2003).

Within the mental health field, peer youth specialists have been integrated into a treatment program for sexually abused children and adolescents. In the Peer Support Program (Alaggia, Michalski, & Vine, 1999), peer youth specialists, who have been affected by sexual abuse themselves, liaise with community agencies and schools to identify and engage sexually abused children and adolescents who might not otherwise seek treatment services through formal networks. Consumer feedback indicated that youth found the outreach efforts and availability of the peer youth specialist as one of the most important features of the program (Alaggia et al., 1999). Recent national attention has promoted the use of peers for transition-age (16–25) youth and young adults (e.g., Galasso et al., 2009) to provide support and assist in self-advocacy skills. Additionally, peer youth advocacy groups have emerged across the country (e.g., Youth MOVE: <http://www.youthmove.us/>) to ensure that youth voice is integrated into mental health program planning and service delivery.

Finally, the New York State Office of Mental Health has formalized the peer youth specialist role (called "Youth Advocates") within support services for families whose children manifest significant mental and behavioral health difficulties. Youth advocates are adolescents and young adults (aged 17–22) who have current or prior mental health challenges, for which they have received services through the child-serving system (e.g., mental health, child welfare, juvenile justice; Roussos, Berger, & Harrison, 2008). Currently, eighteen youth advocates in the New York City metropolitan area (1) engage children and adolescents and their families in identifying service needs and goals; (2) provide support, education on mental health issues, and guidance based on youth advocates' personal experiences; (3) organize social, recreational and educational activities for children and adolescents; and (4) represent the interests of youth mental health challenges in public forums (Personal communication with B. Lombrowski, 4/22/10). Although youth advocates have yet to be formally evaluated regarding their ability to promote engagement among youth in outpatient mental health treatment, they represent an emerging national interest in expanding peer outreach services for adolescents involved in the mental health system (Federation of Families for Children's Mental Health, 2001; Children's Mental Health Plan Youth Advisory Workgroup, 2008).

Beyond clinic walls

Improving engagement and access to child mental health services has also been improved by programs operating outside the traditional clinic environment. For example, combining school-based and family-directed mental health services for children through the Positive Attitudes toward Learning in Schools (PALS) program (Atkins et al., 2006) has contributed to success in service engagement and retention. PALS focuses on improving the classroom and home behavior of children with disruptive behavior disorders, consisting of both classroom-based (e.g., posting rules, behavior contingencies, individualized reward systems) and family-directed (e.g., parent groups co-facilitated by clinicians and parent advocates) services. Atkins et al. found that 80% of families agreed to enroll in PALS versus 55% of families engaging in traditional clinic services. At three months, 100% of PALS families remained enrolled in the program, while 0% of control families continued to receive clinic-based services. At 12 months, 80% of PALS families still remained in services, and among these, 83% agreed to re-enroll in PALS for the following year, while 36% of control families agreed to re-enroll in clinic-based services. Atkins et al. attributed the engagement and effectiveness success of the PALS program to the concurrent use of school- and home-based services, as well as the active involvement of parent advocates who were instrumental in helping low-income minority families overcome multiple barriers to mental health service use (Frazier, Abdul-Adil, & Atkins, 2007).

Home-based therapy is also an effective way to deliver mental health services to adolescents and their families. Slesnick and Prestopnick (2004) reported that providing in-home, as opposed to office-based, family therapy significantly increased attendance and participation in therapeutic sessions among adolescents and their family members. Thompson, Bender, Windsor, and Flynn (2009) recently confirmed this finding among adolescents with behavior problems receiving solution-focused family therapy. Participants who received home-based therapy enhanced by experiential activities designed to strengthen communication, relationship-building, and coping, remained in treatment significantly longer than a comparison group who received office-based family therapy (Thompson et al., 2009). Providing services in the home undoubtedly helps to eliminate structural barriers to treatment, such as transportation problems and childcare.

Strength-based approaches

An increasing number of programs that have adopted a strengths-based approach to delivering services to families, sometimes referred to as a family support perspective (Kagan & Shelley, 1987). This philosophy of practice builds on family members' competencies, supports families to make decisions for themselves, and focuses on enhancing the strengths of families, including cultural strengths, rather than fixing deficits (Green, McAllister, & Tarte, 2004). Strength-based practices are likely to

influence the extent to which parents actively engage in program services (Green, Johnson, & Rodgers, 1999). To the degree that parents feel respected, valued, and treated as if they are knowledgeable and capable, they may also be more likely to actively partner with program staff to work toward their goals (DeChillo, Koren, & Schultz, 1994).

Patient empowerment and activation has emerged as a strength-based strategy to increase engagement for minority adult mental health clients, and has potential for parents bringing their children to treatment for mental health problems. The Right Question Project-Mental Health (RQP-MH) program (Alegria et al., 2008) consists of three patient trainings, during which participants are encouraged to identify questions they have for their mental health providers, formulate comfortable ways of phrasing their questions, and engage in role-play to practice asking their questions and following-up on answers. Among a sample of low-income, primarily Spanish speaking adults, Alegria et al. (2008) found that intervention participants were over twice as likely as a comparison group to be retained in treatment, 29% more likely to attend their scheduled visits, and over three times more likely to have at least one follow-up visit.

As another strength-based approach, Motivational Interviewing (MI), is a directive, client-centered counseling style in which providers encourage patients to argue for behavior change for themselves and overcome ambivalence towards such change (Miller & Rollnick, 2002). MI is more focused and goal-directed than traditional counseling methods, with examination and resolution of ambivalence being its central purpose (Miller & Rollnick, 2002). According to Miller and Rollnick (2002), the value of motivational interviewing lies in the patient discovering the advantages and disadvantages of treatment for himself or herself. Essential components of the MI counseling style include reflective listening, use of open-ended questions to explore patients' motivations for change, affirm patient's own change-related statements and efforts, helping patients recognize the gap between current behavior and their desired life goals, asking permission before providing advice or information, using non-confrontational responses to resistance, encouraging patient's self-efficacy, and collaborating with patients on action plans (Miller & Rollnick, 2002).

MI has been found to improve retention rates among adults (e.g., Carroll et al., 2006; Murphy, Thompson, Murray, Rainey & Uddo, 2009; Sherman et al., 2009), and has been used as a treatment model with various adolescent populations, including youth in emergency room settings who are presenting for and currently being treated for injuries (Monti & Colby, 1999), and most commonly, adolescents with substance abuse and addiction issues (Colby, Monti & Barnett, 1998; Monti & Colby, 1999; Sciacca, 1997).

Most recently, MI techniques, such as the expression of empathy, development of discrepancy, rolling with resistance, and support

for self-efficacy, have been integrated into a 1–2 session intervention designed to increase the likelihood that adolescents with serious psychiatric illness successfully participate in mental health treatment (Making Connections Intervention [MCI]; Lindsey, Bowery, Smith, & Stiegler, 2009). The MCI program addresses factors that influence treatment acceptability (i.e., engagement, perceived relevance, and service satisfaction) prior to treatment participation. The MCI program has the potential to enhance help-seeking behaviors by empowering adolescents to identify perceptual and actual barriers that influence their treatment acceptability and equip them with the skills to overcome these barriers. Plans to evaluate the impact of MCI in combination with an evidence-based treatment for adolescent depression (i.e., Interpersonal Psychotherapy for Adolescents [IPT-A]; Mufson, 2010) are currently underway.

Additionally, MI techniques have been integrated into engagement-specific interventions for depressed mothers whose children receive psychiatric treatment (Swartz et al., 2007; Zuckoff, Swartz, & Grote, 2008; Zuckoff, Swartz, Grote, Bledsoe, & Speilvogel, 2004). MI in combination with ethnographic interviewing (EI) has been formulated into a single engagement session designed to enhance clinicians' ability to identify, comprehend, and resolve patients' ambivalence regarding help-seeking and entering treatment. Developed in response to the difficulty in engaging depressed mothers of psychiatrically involved children into their own treatment, the MI/EI intervention was designed to address patient ambivalence as well as clinician biases which could serve as barriers to engaging patients into treatment. A recent study utilized the MI/EI engagement session in combination with brief Interpersonal Psychotherapy (IPT-B as described in Grote et al., 2004). Grote, Zuckoff, Swartz, Bledsoe, & Geibel (2007) found that 96% of women in the MI/EI plus IPT-B condition attended their initial treatment session vs. only 36% of women in the IPT-B alone condition ($p < .001$). Although the MI/EI intervention has been designed to engage adult patients into their own treatment, it may have potential utility with those parents whose children require psychiatric treatment but who may be especially resistant to formal child mental treatment models.

Special Populations

Families of children with disruptive behavior disorders

Childhood disruptive behavior difficulties, including persistent oppositional and/or aggressive behavior, are among the most common reasons for referrals to child mental health clinics (Frick, 1998; Kazdin, 1995). These disorders are particularly concerning because of the high degree of impairment and poor developmental trajectory (Lahey & Loeber, 1997). However, as stated earlier, families whose children manifest such difficulties have an increased likelihood of dropping out of treatment

prematurely (Baruch et al., 2009; Burns et al., 2008; Johnson et al., 2008; Robbins et al., 2006), losing any progress families may have made before terminating services. Such families experience additional stressors and commitments that limit the resources available to facilitate attendance at appointments (Miller & Prinz, 1990), such as insufficient time, lack of transportation, and concerns that services might not help (McKay et al., 2005). Moreover, parents often need support and education on providing reinforcement, using alternatives to physical punishment, focusing on treatment gains rather than on negative behaviors, effective communication skills, and problem solving (Miller & Prinz, 1990). Additionally, these children, by the nature of their difficulties, may not fully participate in sessions despite being physically present. It is not uncommon for such children to disagree with the treatment plan, or resist treatment altogether (McKay et al., 2005).

The Multiple Family Group (MFG) service delivery model to reduce disruptive behavior disorders, developed by Dr. Mary McKay and colleagues at the Mount Sinai School of Medicine (MSSM), is specifically tailored to improve engagement, retention, and effectiveness of services for urban children and families of color (Franco, Dean-Assael, & McKay, 2008; Gopalan & Franco, 2009). This model involves school-age, inner-city children (ages 7 to 11) who meet diagnostic criteria for Oppositional Defiant Disorder (ODD) or Conduct Disorder (CD) and their families (including adult caregivers and siblings between the ages of 6 to 18 years) in a 16-week series of group meetings with 6 to 8 families. The MFG service delivery model addresses those family factors (i.e., poor parental discipline and monitoring, inadequate behavioral limits, lack of parent-child bonding, family conflict, stressors, family disorganization, family communication, within family support, and low level family interactions) which are consistently implicated in the onset and maintenance of childhood behavioral difficulties, and predict the development of child ODD and CD (Alexander, Robbins, & Sexton, 2000; Dishion, French & Patterson, 1995; Egeland, Kalkoske, Gottesman, & Erickson 1990; Keiley, 2002; Kilgore, Snyder, & Lentz, 2000; Kumpfer & Alvarado, 2003; Loeber & Farrington, 1998; Loeber & Stouthamer-Loeber, 1987; Patterson, Reid, & Dishion, 1992; Reid, Eddy, Fetrow, & Stoolmiller, 1999; Sampson & Laub, 1994; Shaw, Vondra, Hommering, & Keenan, 1994; Tremblay, Loeber, Gagnon, & Charlebois, 1991). In addition, MFG content addresses specific family factors related to urban living, socioeconomic disadvantage, social isolation, high stress, and lack of social support. These factors hinder effective parenting and contribute to childhood conduct difficulties, as well as relate to early drop out (Kazdin & Whitley, 2003; Wahler & Dumas, 1989). In addition, intervention sessions have been designed to target factors (e.g., parental stress, use of emotional and parenting support resources, family involvement with the child in multiple contexts, and stigma associated with mental health care) which potentially impact inner-city child mental

health service use and outcomes. Key components are delivered via content and activities based on core elements of parent training and systemic family therapy.

The use of MFGs has been shown to increase family engagement in treatment (McKay et al., 2005). A preliminary study of the MFG model examined the impact of MFGs on 138 children with conduct problems and their families, who were assigned to MFG or service as usual (family therapy or individual therapy). Families in the MFG groups attended on average 7 ± 3.3 sessions during a 16-week period. In comparison, families in the "treatment as usual" family therapy group attended an average of 4 ± 3.2 sessions, while families in the "treatment as usual" individual therapy group attended an average of 3.1 ± 2.7 sessions. Currently, the MFG service delivery strategy to reduce child disruptive behavior disorders is being tested in a large-scale effectiveness study funded by the National Institute of Mental Health (NIMH). Preliminary data indicates that engagement rates for families in the MFG treatment condition far surpass what would normally be seen in urban child mental health clinics (McKay et al., in press; McKay et al., 2005).

Families and children affected by trauma

In a recent study conducted by the Office of Juvenile Justice and Delinquency Prevention (Finkelhor, Turner, Ormrod, Hamby, & Kracke, 2009), more than 60% of children in the United States reported being exposed to violence within the past year. Children exposed to trauma can experience a number of short-term and long-term disturbances in self-regulation (e.g., avoidance, withdrawal, sleep disturbance, changes in appetite, difficulties regulating mood, and difficulties concentrating, exaggerated startle response, hyper-vigilance, a need to repeat the event through words and/or play, flashbacks or re-experiencing), somatic complaints (e.g., headaches, stomachaches and back pain), as well as increased disturbances in mood, developmental achievements, behavior, and risk-taking activities (e.g., using drugs and alcohol, promiscuous sexual activity, skipping school, running away from home) La Greca, Silverman, Vernberg, & Roberts, 2002; Cohen, Mannarino, & Deblinger, 2006). If symptoms do not subside over time on their own or with treatment, individuals may develop depression, anxiety, PTSD, personality changes, substance abuse, and impaired school functioning (La Greca et al., 2002; Cohen et al., 2006). Additionally, traumatized children are more likely to be involved in violent relationships, either as victims or perpetrators (Harpaz-Rotem, Murphy, Berkowitz, & Rosenheck, 2007).

Recommended treatment includes early engagement to identify and monitor initial reactions to trauma which may lead to future disorders (Berkowitz, 2003), ensuring that concrete needs (e.g., safety, shelter, employment, medical care) are met (Saltzman, Layne, Steinberg, Arslanagic, & Pynoos, 2003), providing psychoeducation about normal and abnormal reactions to trauma, and enhancing coping skills (Saltzman et al., 2003).

However, several factors impede engagement for those who have been exposed to violence and trauma. Individuals who suffer post-traumatic reactions often do not recognize the effects of the event until a significant and persistent loss of functioning has occurred (Elhai & Ford, 2009). When someone experiences a traumatic event, they become physically, emotionally, and cognitively dysregulated (Osofsky & Osofsky, 2004). One reaction is a desire to avoid the traumatic incident and any reminders. Moreover, individuals frequently withdraw from the very support systems and routines which are likely to assist with recovery (Cohen et al., 2006). Other engagement barriers specific to trauma include perceived intrusiveness of clinicians, trauma fatigue (a weariness of discussing the tragic event), aversion to being probed about the event and the associated feelings, and parents underestimating the exposure and effects of the traumatic event on themselves and their children (Levitt, Hoagwood, Greene, Rodriguez, & Radigan, 2009). Families often withdraw from their normal daily routines and social supports in order to avoid further exposure to potentially traumatic events or traumatic reminders. Unfortunately, such a withdrawal limits access by mental health providers to victims (particularly children), especially when caregivers fear that children could be re-traumatized if asked to discuss the trauma (Elhai & Ford, 2009).

Early identification is a significant challenge to treating children and families who have been exposed to violence and trauma. Most of the time, families do not seek treatment until and unless their child is exhibiting significant behavioral problems. Many children may minimize their reactions to the traumatic event to avoid upsetting their parents or caregivers (Levitt et al., 2009). Moreover, as typical trauma reactions include internalizing behaviors (e.g., avoidance, denial, depression, withdrawal, sleep disturbances, changes in appetite and concentration), parents who are unaware of such symptoms or who lack education on what to look for may be unlikely to seek appropriate and timely treatment. The result is that a large percentage of children in need of services are never identified or seen by mental health professionals (Finkelhor, Ormond & Turner, 2007).

Even when parents are aware, many feel guilty that they were unable to protect their child from the initial trauma. Fears of being judged and attempts to protect their child from re-traumatization may lead parents to avoid treatment (Elhai & Ford, 2009). Strategies to overcome trauma-specific barriers include providing psychoeducation for children and parents about normal reactions to abnormal events, orienting parents to the treatment process, and assuring them that successful treatment will help children get better faster. As many parents may experience their own difficulties following a traumatic event (deVries et al., 1999), parents should also be educated on the importance of treatment for themselves and provided referrals. Moreover, framing parent well-being within a family systems context helps parents to understand how their own mental health status affects their child.

Finally, additional treatment barriers include socio-economic status, lack of health insurance, negative experiences with clinic staff, lack of knowledge regarding how to access services, bureaucratic red tape, familial discord, lack of transportation, child-and-family care, finances, employment schedules, and environmental chaos (Davis, Ressler, Schwartz, Stephens, & Bradley, 2008). While these obstacles are not unique to those who have experienced trauma, violence tends to occur in the most vulnerable communities (Self-Brown et al., 2006). Community-based interventions that intervene beyond the clinic walls provide an opportunity to collaborate with community stakeholders and provide access to those who need it most. Moreover, collaborative community-based interventions in the acute phase following trauma exposure may assist in early identification and engagement. One example, the Child Development Community Policing Program (CDCP), involves collaboration between the New Haven Department of Police Services and clinicians from the Yale Child Study Center. The model involves a partnered response to children and families following incidents where children are involved as victims and/or witnesses of violence and trauma. This partnered response allows police to secure the scene while clinicians intervene by providing psychoeducation, acute coping strategies, and treatment options. As a result, the family's sense of physical and emotional safety is enhanced. Police/clinician teams follow up with the family within a week to assess current functioning and symptoms, answer questions related to the incident, and continue ongoing treatment planning with the family (Marans, 2004). Recent findings indicate the CDCP program has been particularly successful in reaching Hispanic children, and in responding to incidents involving gang involvement, accidents, felony assaults, property crimes, family violence, and psychiatric crises. Moreover, children and families involved in the most severe incidents and those with a primary mental health component are more likely to utilize intensive CDCP services (Murphy, Rosenheck, Berkowitz, & Marans, 2005).

Implications and Conclusions

Beginning with McKay and Bannon's (2004) review, recent studies suggest broadening the definition of treatment engagement beyond simple treatment attendance. From a clinical perspective, providers are well-advised to pay attention to indicators of treatment disengagement prior to sessions being missed (e.g., difficulty scheduling appointments, lack of follow-through on intervention plans, insubstantial treatment goals, uneven treatment progress, lying about important issues; Cunningham & Henggeler, 1999). Furthermore, future research can measure different behavioral indicators of engagement beyond simple treatment attendance (e.g., participation and cooperation in sessions, homework completion, demonstrating progress towards goals). When distinguishing between appropriate treatment completion and drop-out, clinician/client agreements to treatment

termination should be considered (Johnson et al., 2008). Measurement of engagement should also include an attitudinal component to distinguish those clients who are invested in treatment from those who are simply complying (Staudt, 2007). This may be accomplished by incorporating treatment process measures such as the Metropolitan Area Child Study (MACS) Process Measure (Tolan, Hanish, McKay, & Dickey, 2002).

Although recent data show discrepancies between the average number of treatment sessions attended in child mental health clinic settings (i.e., Brookman-Frazee et al., 2008; McKay et al., 2005), such differences may result from the differing socioeconomic and geographic characteristics between low-income urban settings (i.e. McKay et al., 2005) compared to an entire county consisting of urban, suburban, and rural communities (i.e. Brookman-Frazee et al., 2008). Given an inverse correlation between service use and poverty, parent and family stress, and minority and single parent status (Angold et al., 1988; Armbruster & Kazdin, 1994; Brannan et al., 2003; Freedenthal, 2007; Garland et al., 2005; Gould et al., 1985; Hoberman, 1992; Kazdin et al., 1997; Lopez, 2002; Miller, Southam-Gerow & Allin, 2008; Zimmerman, 2005), it is not surprising that urban clinics may experience greater challenges in retaining low-income, single-parent families of color who typically utilize community mental health services. Moreover, an overall lack of sufficient child mental health service providers in urban, inner-city settings (Asen, 2002) creates even greater obstacles to accessing treatment. Recent findings additionally identify that families whose children have disruptive behavior disorders, homeless adolescents, families where parents and children disagree on treatment goals, families with more hostile parent-child interactions, and families with multiple psychosocial issues are particularly difficult to engage and retain in treatment. Moreover, the quality of the therapeutic alliance with parents and children, as well as parents' etiological beliefs regarding their children's mental health difficulties, also influence child mental health treatment engagement. Clinical solutions may entail the use of more culturally appropriate services and provider engagement of minority families, multi-level services to address complex family needs, psychoeducation about the bio-psycho-social model of child mental health difficulties and continued attention to promoting productive working relationships between parents, children, and therapists. This is particularly important as problems with alliance may be prevalent even within the first few sessions. Finally, specialized treatment programs focused on engaging families whose children manifest disruptive behavior disorders (e.g., Franco, Dean-Assael, & McKay, 2008; Gopalan & Franco, 2009), particularly for urban, low-income, minority families, may be beneficial for those families least likely to engage in child mental health treatment.

Although previous research presents equivocal findings regarding the relationship between child age and engagement, it may be worth exploring how reluctance to seek treatment and treatment

disengagement varies across the different developmental stages of childhood and adolescence. Moreover, clinicians who elicit adolescents' perspectives on their own mental health symptoms to increase self-awareness may be more likely to increase adolescents' motivation for treatment. Finally, resolving potential conflicts between parents and youth by finding common treatment goals may have utility in increasing treatment retention.

The advent of new technology means that treatment engagement can be further improved through the use of web-based appointment systems and texting to mobile phones. Additionally, making treatment available outside the traditional clinic walls through school- and home-based service delivery models is promising for the promotion of initial engagement and service retention. Patient empowerment and activation may provide parents with skills to advocate for their children's treatment. As a result, future clinical and research activities may focus on ways to adapt the RQP-MH and MI interventions for the child mental health context. Moreover, the use of paraprofessional family advocates and peer youth specialists are gaining increasing popularity, particularly given a growing demand for consumer-led services in mental health (New Freedom Commission on Mental Health, 2003). Finally, this article focuses attention towards those families whose children manifest disruptive behavior disorders and traumatic symptoms. As these special populations present with unique treatment barriers, both clinical and research activities should explore how the highlighted programs can help to overcome obstacles to treatment engagement faced by families with such needs.

Acknowledgements/Conflicts of Interest

The authors have no financial relationships or conflicts to disclose.

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#5 d

April 1, 2016

To the Department of Public Health regarding Growing Potentials, Marcy Taliceo, President:

I am writing this letter in recommendation for Growing Potentials. I have known Marcy Taliceo for the past going on seven years, of which I have seen her reach many of her goals personally and professionally with her growing business of Growing Potentials and her impeccable clinical work. She has also completed her Master's degree and Licensure of Professional Counseling in the State of CT as well as Massachusetts.

Currently I serve on her advisory board and Growing Potentials has services that are including Assessment, Individual Psychotherapy and case management, group therapy, family therapy, substance abuse consultation, multi-family groups, outreach services, child and adult day treatment programs, child and adult outpatient psychiatric services, developmental screenings and assessment of childhood adolescence, depression, mood and anxiety disorders, psychological testing, occupational therapy, physical therapy, speech and language therapy, and psychiatric testing for diagnostic clarification.

I have no reservations in recommending Growing Potentials as a DPH Provider. It is an excellent agency with a mission doing amazing things. If you have any further questions, do not hesitate to contact me at: 860-471-2057.

Sincerely,

Karen Lapienski, Ed.D.
Chief Executive Officer
Elegant Clinical Corporation
170 North Road
East Windsor, CT 06088
www.elegantclinical.com

#18A

Form 1120S

U.S. Income Tax Return for an S Corporation

OMB No. 1545-0123

2014

Department of the Treasury Internal Revenue Service

Do not file this form unless the corporation has filed or is attaching Form 2553 to elect to be an S corporation. Information about Form 1120S and its separate instructions is at www.irs.gov/form1120s.

For calendar year 2014 or tax year beginning 2014, ending
A S election effective date 06/13/13
B Business activity code number (see instrs) 621399
C Check if Schedule M-3 attached
D Employer identification number 46-3010541
E Date incorporated 06/13/13
F Total assets (see instructions) \$ 40,908.

G Is the corporation electing to be an S corporation beginning with this tax year? Yes No
H Check if: (1) Final return (2) Name change (3) Address change (4) Amended return (5) S election termination or revocation

I Enter the number of shareholders who were shareholders during any part of the tax year 1
Caution. Include only trade or business income and expenses on lines 1a through 21. See the instructions for more information.

Table with columns for Income (1a-6), Deductions (7-21), and Tax and Payments (22-27). Includes sub-rows for gross receipts, cost of goods sold, total income, and various deductions.

Sign Here: Signature of officer (David Livingstone CPA), Date (09/12/15), Title (President).
Paid Preparer Use Only: Print/Type preparer's name, Preparer's signature, Date, Check self-employed, Firm's name, Firm's address, Firm's EIN, Phone no.

IRS e-file Signature Authorization for Form 1120S

▶ Do not send to the IRS. Keep for your records.

▶ Information about Form 8879-S and its instructions is at www.irs.gov/form8879s.

2014

Department of the Treasury
Internal Revenue Service

For calendar year 2014, or tax year beginning _____, 2014, ending _____

Name of corporation

Employer identification number

Growing Potential Services: Therapeutic and Behavioral Solutions, P.C. 46-3010541

Part I Tax Return Information (Whole dollars only)

1	Gross receipts or sales less returns and allowances (Form 1120S, line 1c)	1	244,296.
2	Gross profit (Form 1120S, line 3)	2	244,296.
3	Ordinary business income (loss) (Form 1120S, line 21)	3	-5,982.
4	Net rental real estate income (loss) (Form 1120S, Schedule K, line 2)	4	
5	Income (loss) reconciliation (Form 1120S, Schedule K, line 18)	5	-5,982.

Part II Declaration and Signature Authorization of Officer (Be sure to get a copy of the corporation's return)

Under penalties of perjury, I declare that I am an officer of the above corporation and that I have examined a copy of the corporation's 2014 electronic income tax return and accompanying schedules and statements and to the best of my knowledge and belief, it is true, correct, and complete. I further declare that the amounts in Part I above are the amounts shown on the copy of the corporation's electronic income tax return. I consent to allow my electronic return originator (ERO), transmitter, or intermediate service provider to send the corporation's return to the IRS and to receive from the IRS (a) an acknowledgement of receipt or reason for rejection of the transmission, (b) the reason for any delay in processing the return or refund, and (c) the date of any refund. If applicable, I authorize the U.S. Treasury and its designated Financial Agent to initiate an electronic funds withdrawal (direct debit) entry to the financial institution account indicated in the tax preparation software for payment of the corporation's federal taxes owed on this return, and the financial institution to debit the entry to this account. To revoke a payment, I must contact the U.S. Treasury Financial Agent at 1-888-353-4537 no later than 2 business days prior to the payment (settlement) date. I also authorize the financial institutions involved in the processing of the electronic payment of taxes to receive confidential information necessary to answer inquiries and resolve issues related to the payment. I have selected a personal identification number (PIN) as my signature for the corporation's electronic income tax return and, if applicable, the corporation's consent to electronic funds withdrawal.

Officer's PIN: check one box only

I authorize _____ to enter my PIN _____ as my signature
ERO firm name do not enter all zeros

on the corporation's 2014 electronically filed income tax return.

As an officer of the corporation, I will enter my PIN as my signature on the corporation's 2014 electronically filed income tax return.

Officer's signature ▶ _____ Date ▶ _____ Title ▶ President

Part III Certification and Authentication

ERO's EFIN/PIN. Enter your six-digit EFIN followed by your five-digit self-selected PIN _____ do not enter all zeros

I certify that the above numeric entry is my PIN, which is my signature on the 2014 electronically filed income tax return for the corporation indicated above. I confirm that I am submitting this return in accordance with the requirements of Pub 3112, IRS e-file Application and Participation, and Pub 4163, Modernized e-File (MeF) Information for Authorized IRS e-file Providers for Business Returns.

ERO's signature ▶ _____ Date ▶ 09/12/15

**ERO Must Retain This Form — See Instructions
Do Not Submit This Form to the IRS Unless Requested To Do So**

Schedule B Other Information (see instructions)	Yes	No		
1 Check accounting method: a <input checked="" type="checkbox"/> Cash b <input type="checkbox"/> Accrual c <input type="checkbox"/> Other (specify) ▶ _____				
2 See the instructions and enter the: a Business activity. ▶ <u>Social Services</u> b Product or service. ▶ <u>Service</u>				
3 At any time during the tax year, was any shareholder of the corporation a disregarded entity, a trust, an estate, or a nominee or similar person? If "Yes," attach Schedule B-1, Information on Certain Shareholders of an S Corporation		X		
4 At the end of the tax year, did the corporation: a Own directly 20% or more, or own, directly or indirectly, 50% or more of the total stock issued and outstanding of any foreign or domestic corporation? For rules of constructive ownership, see instructions. If "Yes," complete (i) through (v) below		X		
(i) Name of Corporation	(ii) Employer Identification Number (if any)	(iii) Country of Incorporation	(iv) Percentage of Stock Owned	(v) If Percentage in (iv) is 100%, Enter the Date (if any) a Qualified Subchapter S Subsidiary Election Was Made
b Own directly an interest of 20% or more, or own, directly or indirectly, an interest of 50% or more in the profit, loss, or capital in any foreign or domestic partnership (including an entity treated as a partnership) or in the beneficial interest of a trust? For rules of constructive ownership, see instructions. If "Yes," complete (i) through (v) below				X
(i) Name of Entity	(ii) Employer Identification Number (if any)	(iii) Type of Entity	(iv) Country of Organization	(v) Maximum % Owned in Profit, Loss, or Capital
5a At the end of the tax year, did the corporation have any outstanding shares of restricted stock? If "Yes," complete lines (i) and (ii) below.				X
(i) Total shares of restricted stock ▶ _____				
(ii) Total shares of non-restricted stock ▶ _____				
b At the end of the tax year, did the corporation have any outstanding stock options, warrants, or similar instruments? If "Yes," complete lines (i) and (ii) below.				X
(i) Total shares of stock outstanding at the end of the tax year ▶ _____				
(ii) Total shares of stock outstanding if all instruments were executed ▶ _____				
6 Has this corporation filed, or is it required to file, Form 8918, Material Advisor Disclosure Statement, to provide information on any reportable transaction?				X
7 Check this box if the corporation issued publicly offered debt instruments with original issue discount <input type="checkbox"/> If checked, the corporation may have to file Form 8281, Information Return for Publicly Offered Original Issue Discount Instruments.				
8 If the corporation: (a) was a C corporation before it elected to be an S corporation or the corporation acquired an asset with a basis determined by reference to the basis of the asset (or the basis of any other property) in the hands of a C corporation and (b) has net unrealized built-in gain in excess of the net recognized built-in gain from prior years, enter the net unrealized built-in gain reduced by net recognized built-in gain from prior years (see instructions) ▶ \$ _____				
9 Enter the accumulated earnings and profits of the corporation at the end of the tax year. \$ _____				
10 Does the corporation satisfy both of the following conditions?				
a The corporation's total receipts (see instructions) for the tax year were less than \$250,000	X			
b The corporation's total assets at the end of the tax year were less than \$250,000 If "Yes," the corporation is not required to complete Schedules L and M-1.				
11 During the tax year, did the corporation have any non-shareholder debt that was canceled, was forgiven, or had the terms modified so as to reduce the principal amount of the debt? If "Yes," enter the amount of principal reduction \$ _____				X
12 During the tax year, was a qualified subchapter S subsidiary election terminated or revoked? If "Yes," see instructions				X
13 a Did the corporation make any payments in 2014 that would require it to file Form(s) 1099?				X
b If "Yes," did the corporation file or will it file required Forms 1099?				

Schedule K Shareholders' Pro Rata Share Items		Total amount	
Income (Loss)	1 Ordinary business income (loss) (page 1, line 21)	1	-5,982.
	2 Net rental real estate income (loss) (attach Form 8825)	2	
	3 a Other gross rental income (loss)	3 a	
	b Expenses from other rental activities (attach statement)	3 b	
	c Other net rental income (loss). Subtract line 3b from line 3a	3 c	
	4 Interest income	4	
	5 Dividends: a Ordinary dividends	5 a	
	b Qualified dividends	5 b	
	6 Royalties	6	
	7 Net short-term capital gain (loss) (attach Schedule D (Form 1120S))	7	
Deductions	8 a Net long-term capital gain (loss) (attach Schedule D (Form 1120S))	8 a	
	b Collectibles (28%) gain (loss)	8 b	
	c Unrecaptured section 1250 gain (attach statement)	8 c	
	9 Net section 1231 gain (loss) (attach Form 4797)	9	
	10 Other income (loss) (see instructions) Type ▶	10	
Credits	11 Section 179 deduction (attach Form 4562)	11	
	12 a Charitable contributions	12 a	
	b Investment interest expense	12 b	
	c Section 59(e)(2) expenditures (1) Type ▶ (2) Amount ▶	12 c (2)	
Foreign Transactions	d Other deductions (see instructions) Type ▶	12 d	
	13 a Low-income housing credit (section 42(j)(5))	13 a	
	b Low-income housing credit (other)	13 b	
	c Qualified rehabilitation expenditures (rental real estate) (attach Form 3468, if applicable)	13 c	
	d Other rental real estate credits (see instrs) Type ▶	13 d	
	e Other rental credits (see instrs) Type ▶	13 e	
	f Biofuel producer credit (attach Form 6478)	13 f	
g Other credits (see instructions) Type ▶	13 g		
Alternative Minimum Tax (AMT) Items	14 a Name of country or U.S. possession ▶	14 a	
	b Gross income from all sources	14 b	
	c Gross income sourced at shareholder level	14 c	
	Foreign gross income sourced at corporate level	14 d	
	d Passive category	14 e	
	e General category	14 f	
	f Other (attach statement)	14 g	
	Deductions allocated and apportioned at shareholder level	14 h	
	g Interest expense	14 i	
	h Other	14 j	
	Deductions allocated and apportioned at corporate level to foreign source income	14 k	
	i Passive category	14 l	
	j General category	14 m	
k Other (attach statement)	14 n		
Other information	14 o		
l Total foreign taxes (check one): <input type="checkbox"/> Paid <input type="checkbox"/> Accrued	14 p		
m Reduction in taxes available for credit (attach statement)	14 q		
n Other foreign tax information (attach statement)	14 r		
Items Affecting Shareholder Basis	15 a Post-1986 depreciation adjustment	15 a	0.
	b Adjusted gain or loss	15 b	
	c Depletion (other than oil and gas)	15 c	
	d Oil, gas, and geothermal properties — gross income	15 d	
	e Oil, gas, and geothermal properties — deductions	15 e	
	f Other AMT items (attach statement)	15 f	
Items Affecting Shareholder Basis	16 a Tax-exempt interest income	16 a	
	b Other tax-exempt income	16 b	
	c Nondeductible expenses	16 c	548.
	d Distributions (attach stmt if required) (see instrs)	16 d	
	e Repayment of loans from shareholders	16 e	1,362.

Schedule K		Shareholders' Pro Rata Share Items (continued)		Total amount	
Other information	17 a	Investment income		17 a	
	b	Investment expenses		17 b	
	c	Dividend distributions paid from accumulated earnings and profits		17 c	
	d	Other items and amounts (attach statement)			
Reconciliation	18	Income/loss reconciliation. Combine the amounts on lines 1 through 10 in the far right column. From the result, subtract the sum of the amounts on lines 11 through 12d and 14l		18	-5,982.

Schedule L	Balance Sheets per Books	Beginning of tax year		End of tax year	
		(a)	(b)	(c)	(d)
Assets					
1	Cash		1,492.		
2 a	Trade notes and accounts receivable				
b	Less allowance for bad debts				
3	Inventories				
4	U.S. government obligations				
5	Tax-exempt securities (see instructions)				
6	Other current assets (attach stmt) . . In 6. St . .		201.		36.
7	Loans to shareholders				32,267.
8	Mortgage and real estate loans				
9	Other investments (attach statement)				
10 a	Buildings and other depreciable assets	2,844.		11,449.	
b	Less accumulated depreciation	2,844.	0.	2,844.	8,605.
11 a	Depletable assets				
b	Less accumulated depletion				
12	Land (net of any amortization)				
13 a	Intangible assets (amortizable only)				
b	Less accumulated amortization				
14	Other assets (attach stmt)				
15	Total assets		1,693.		40,908.
Liabilities and Shareholders' Equity					
16	Accounts payable				
17	Mortgages, notes, bonds payable in less than 1 year		1,239.		
18	Other current liabilities (attach stmt) . . In 18. St . .		2,298.		36,826.
19	Loans from shareholders		1,362.		
20	Mortgages, notes, bonds payable in 1 year or more				13,818.
21	Other liabilities (attach statement)				
22	Capital stock		1,000.		1,000.
23	Additional paid-in capital				
24	Retained earnings		-4,206.		-10,736.
25	Adjustments to shareholders' equity (att stmt)				
26	Less cost of treasury stock				
27	Total liabilities and shareholders' equity		1,693.		40,908.

Schedule M-1 Reconciliation of Income (Loss) per Books With Income (Loss) per Return

Note. The corporation may be required to file Schedule M-3 (see instructions)

1	Net income (loss) per books	-6,530.	5	Income recorded on books this year not included on Schedule K, lines 1 through 10 (itemize):	
2	Income included on Schedule K, lines 1, 2, 3c, 4, 5a, 6, 7, 8a, 9, and 10, not recorded on books this year (itemize):		a	Tax-exempt interest \$ _____	
3	Expenses recorded on books this year not included on Schedule K, lines 1 through 12, and 14f (itemize):		6	Deductions included on Schedule K, lines 1 through 12 and 14f, not charged against book income this year (itemize):	
a	Depreciation \$ _____		a	Depreciation . . \$ _____	
b	Travel and entertainment \$ _____	469.	7	Add lines 5 and 6.	
	* STMT _____	79.	548.		
4	Add lines 1 through 3.	-5,982.	8	Income (loss) (Schedule K, ln 18), Ln 4 less ln 7	-5,982.

Schedule M-2 Analysis of Accumulated Adjustments Account, Other Adjustments Account, and Shareholders' Undistributed Taxable Income Previously Taxed (see instructions)

	(a) Accumulated adjustments account	(b) Other adjustments account	(c) Shareholders' undistributed taxable income previously taxed
1	Balance at beginning of tax year	-4,206.	
2	Ordinary income from page 1, line 21		
3	Other additions		
4	Loss from page 1, line 21	5,982.	
5	Other reductions * STMT	548.	
6	Combine lines 1 through 5	-10,736.	
7	Distributions other than dividend distributions		
8	Balance at end of tax year. Subtract line 7 from line 6.	-10,736.	

This list identifies the codes used on Schedule K-1 for all shareholders and provides summarized reporting information for shareholders who file Form 1040. For detailed reporting and filing information, see the separate Shareholder's Instructions for Schedule K-1 and the instructions for your income tax return.

1	Ordinary business income (loss). Determine whether the income (loss) is passive or nonpassive and enter on your return as follows:	
	Passive loss	See the Shareholder's Instructions
	Passive income	Schedule E, line 28, column (g)
	Nonpassive loss	Schedule E, line 28, column (h)
	Nonpassive income	Schedule E, line 28, column (j)
2	Net rental real estate income (loss)	See the Shareholder's Instructions
3	Other net rental income (loss)	
	Net income	Schedule E, line 28, column (g)
	Net loss	See the Shareholder's Instructions
4	Interest income	Form 1040, line 8a
5 a	Ordinary dividends	Form 1040, line 9a
5 b	Qualified dividends	Form 1040, line 9b
6	Royalties	Schedule E, line 4
7	Net short-term capital gain (loss)	Schedule D, line 5
8 a	Net long-term capital gain (loss)	Schedule D, line 12
8 b	Collectibles (28%) gain (loss)	28% Rate Gain Worksheet, line 4 (Schedule D instructions)
8 c	Unrecaptured section 1250 gain	See the Shareholder's Instructions
9	Net section 1231 gain (loss)	See the Shareholder's Instructions
10	Other income (loss)	

	Code	
	A	Other portfolio income (loss) See the Shareholder's Instructions
	B	Involuntary conversions See the Shareholder's Instructions
	C	Sec. 1256 contracts and straddles Form 6781, line 1
	D	Mining exploration costs recapture See Pub 535
	E	Other income (loss) See the Shareholder's Instructions
11	Section 179 deduction	See the Shareholder's Instructions
12	Other deductions	
	A	Cash contributions (50%)
	B	Cash contributions (30%)
	C	Noncash contributions (50%)
	D	Noncash contributions (30%)
	E	Capital gain property to a 50% organization (30%)
	F	Capital gain property (20%)
	G	Contributions (100%)
	H	Investment interest expense Form 4952, line 1
	I	Deductions — royalty income Schedule E, line 19
	J	Section 59(e)(2) expenditures See the Shareholder's Instructions
	K	Deductions — portfolio (2% floor) Schedule A, line 23
	L	Deductions — portfolio (other) Schedule A, line 28
	M	Preproductive period expenses See the Shareholder's Instructions
	N	Commercial revitalization deduction from rental real estate activities See Form 8582 instructions
	O	Reforestation expense deduction See the Shareholder's Instructions
	P	Domestic production activities information See Form 8903 instructions
	Q	Qualified production activities income Form 8903, line 7b
	R	Employer's Form W-2 wages Form 8903, line 17
	S	Other deductions See the Shareholder's Instructions

13	Credits	
	A	Low-income housing credit (section 42(j)(5)) from pre-2008 buildings
	B	Low-income housing credit (other) from pre-2008 buildings
	C	Low-income housing credit (section 42(j)(5)) from post-2007 buildings
	D	Low-income housing credit (other) from post-2007 buildings
	E	Qualified rehabilitation expenditures (rental real estate)
	F	Other rental real estate credits
	G	Other rental credits
	H	Undistributed capital gains credit Form 1040, line 73, box a
	I	Biofuel producer credit
	J	Work opportunity credit
	K	Disabled access credit
	L	Empowerment zone employment credit
	M	Credit for increasing research activities

	Code	Report on
	N	Credit for employer social security and Medicare taxes See the Shareholder's Instructions
	O	Backup withholding
	P	Other credits
14	Foreign transactions	
	A	Name of country or U.S. possession
	B	Gross income from all sources Form 1116, Part I
	C	Gross income sourced at shareholder level
	<i>Foreign gross income sourced at corporate level</i>	
	D	Passive category
	E	General category Form 1116, Part I
	F	Other
	<i>Deductions allocated and apportioned at shareholder level</i>	
	G	Interest expense Form 1116, Part I
	H	Other Form 1116, Part I
	<i>Deductions allocated and apportioned at corporate level to foreign source income</i>	
	I	Passive category
	J	General category Form 1116, Part I
	K	Other
	<i>Other information</i>	
	L	Total foreign taxes paid Form 1116, Part II
	M	Total foreign taxes accrued Form 1116, Part II
	N	Reduction in taxes available for credit Form 1116, line 12
	O	Foreign trading gross receipts Form 8873
	P	Extraterritorial income exclusion Form 8873
	Q	Other foreign transactions See the Shareholder's Instructions
15	Alternative minimum tax (AMT) items	
	A	Post-1986 depreciation adjustment
	B	Adjusted gain or loss
	C	Depletion (other than oil & gas)
	D	Oil, gas, & geothermal — gross income
	E	Oil, gas, & geothermal — deductions
	F	Other AMT items
16	Items affecting shareholder basis	
	A	Tax-exempt interest income Form 1040, line 6b
	B	Other tax-exempt income
	C	Nondeductible expenses
	D	Distributions
	E	Repayment of loans from shareholders
17	Other information	
	A	Investment income Form 4952, line 4a
	B	Investment expenses Form 4952, line 5
	C	Qualified rehabilitation expenditures (other than rental real estate) See the Shareholder's Instructions
	D	Basis of energy property See the Shareholder's Instructions
	E	Recapture of low-income housing credit (section 42(j)(5)) Form 8611, line 8
	F	Recapture of low-income housing credit (other) Form 8611, line 8
	G	Recapture of investment credit See Form 4255
	H	Recapture of other credits See the Shareholder's Instructions
	I	Look-back interest — completed long-term contracts See Form 8697
	J	Look-back interest — income forecast method See Form 8866
	K	Dispositions of property with section 179 deductions
	L	Recapture of section 179 deduction
	M	Section 453(l)(3) information
	N	Section 453A(c) information
	O	Section 1260(b) information
	P	Interest allocable to production expenditures
	Q	CCF nonqualified withdrawals
	R	Depletion information — oil and gas
	S	Reserved
	T	Section 108(f) information
	U	Net investment income
	V	Other information

Form 1120S, Page 1, Line 5
Other Income (Loss)

Miscellaneous Income	868.
Total	<u>868.</u>

Form 1120S, Page 1, Line 19
Other Deductions

Accounting	3,100.
Automobile and truck expense	5,364.
Bank charges	5,294.
Dues and subscriptions	345.
Insurance	3,915.
Meals and entertainment (50%)	469.
Miscellaneous	613.
Office expense	24,489.
Outside services	4,425.
Permits and fees	212.
Postage	132.
Telephone	3,384.
Training/continuing education	62.
Utilities	5,765.
Consultant	1,590.
Payroll Processing Fees	15.
Total	<u>59,174.</u>

Other Current Assets:
1120S, Schedule L, Line 6

Other Current Assets:	Beginning of tax year	End of tax year
Employee Advances	201.	36.
Total	<u>201.</u>	<u>36.</u>

Other Current Liabilities:
1120S, Schedule L, Line 18

Other Current Liabilities:	Beginning of tax year	End of tax year
Cash Overdraft	0.	2,395.
Federal Income Tax Withheld	382.	8,262.
FICA Tax Withheld	415.	6,879.
Medicare Tax Withheld	98.	1,526.
State Income Tax Withheld	87.	3,213.
Accrued Payroll Taxes	1,316.	0.
Accrued FICA	0.	8,405.
Accrued FUTA	0.	505.
Accrued State Unemployment	0.	5,164.
Other Miscellaneous Payables	0.	477.

Other Current Liabilities:
1120S, Schedule L, Line 18

Continued

Other Current Liabilities:	Beginning of tax year	End of tax year
Total	<u>2,298.</u>	<u>36,826.</u>

Form 1120S, Page 5, Schedule M-1, Line 3
Sch M-1, Line 3

Penalties	<u>79.</u>
Total	<u>79.</u>

Form 1120S, Page 5, Schedule M-2, Line 5
Schedule M-2, Other Reductions

Meals and entertainment	<u>469.</u>	
Penalties	<u>79.</u>	
Total	<u>548.</u>	

Shareholder's Basis Statement

2014

► Note to Shareholder: Keep for your records

Shareholder's name <u>Marcy L. Taliceo</u>	Identifying Number
Corporation's name <u>Growing Potential Services: Therapeutic and Behavioral Solutions, P.C.</u>	Employer ID Number <u>46-3010541</u>

Part I – Election

Special ordering election under Reg. Section 1.1367-1(g) has been made

Part II – Stock Basis

1	Beginning of year stock basis	1	1,000.
2	Capital contributions	2	
3	Income items	3	
4	Add lines 1 through 3	4	1,000.
5	Distributions (not to exceed line 4)	5	1,000.
6	Subtract line 5 from line 4	6	0.
7	<input type="checkbox"/> Loss items (not to exceed line 6) or <input checked="" type="checkbox"/> Nondeductible expenses (not to exceed line 6)	7	0.
8	Subtract line 7 from line 6	8	0.
9	<input type="checkbox"/> Nondeductible expenses (not to exceed line 8) or <input checked="" type="checkbox"/> Loss items (not to exceed line 8)	9	0.
10	Subtract line 9 from line 8	10	0.
11	Loan basis restoration	11	0.
12	End of year stock basis (subtract line 11 from line 10)	12	0.

Part III – Loan Balance

13	Beginning of year loan balance	13	1,362.
14	Current year loans to corporation	14	
15	Loan repayments	15	1,362.
16	End of year loan balance	16	0.

Part IV – Loan Basis

17	Beginning of year loan basis	17	1,362.
18	Loan basis restoration	18	0.
19	Current year loans to corporation	19	
20	Add lines 17 through 19	20	1,362.
21	Loan repayments in full <input type="checkbox"/> 1,362. If reduced basis loan, portion allocated to income <input type="checkbox"/>		
	Note: add above portion of loan repayment allocated to income to appropriate category of income, ordinary income, or long or short term capital gain on shareholder's return		
	Portion of loan repayment allocated to loan basis (not to exceed line 20)	21	1,362.
22	Subtract line 21 from line 20	22	0.
23	<input type="checkbox"/> Excess loss items (not to exceed line 22) or <input checked="" type="checkbox"/> Excess nondeductible expense items (not to exceed line 22)	23	0.
24	Subtract line 23 from line 22	24	0.
25	<input type="checkbox"/> Excess nondeductible expense items (not to exceed line 24) or <input checked="" type="checkbox"/> Excess loss items (not to exceed line 24)	25	0.
26	End of year loan basis (subtract line 25 from line 24)	26	0.

Part V – Total Basis

27	Total end of year stock basis and loan basis	27	0.
----	--	----	----

Schedule K Items (continued):

Deductions	2014	2013	Difference 2014 - 2013	
			Amount	%
11 Section 179 expense deduction		2,844.	-2,844.	-100.00
12a Charitable contributions				
b Interest expense on investment debts				
c Section 59(e)(2) expenditures				
d Other deductions				

Credits

13a Low-income housing credit (section 42(j)(5))				
b Low-income housing credit (other)				
c Qualified rehabilitation expenditures (rental real estate)				
d Other rental real estate credits				
e Other rental credits				
f Credit for alcohol used as fuel				
g Other credits				

Foreign Taxes

14b Gross income from all sources				
c Gross income sourced at shareholder level				
<i>Foreign gross income sourced at corporate level:</i>				
d Passive				
e Listed categories				
f General limitation				
<i>Deductions allocated and apportioned at shareholder level:</i>				
g Interest expense				
h Other				
<i>Deductions allocated and apportioned at corporate level to foreign source income:</i>				
i Passive				
j Listed categories				
k General limitation				
l Foreign taxes paid or accrued				
m Reduction in taxes available for credit				

Alternative Minimum Tax (AMT) Items

15a Post-1986 depreciation adjustment	0.	0.	0.	
b Adjusted gain or loss				
c Depletion (other than oil and gas)				
d Oil, gas, and geothermal properties – gross income				
e Oil, gas, and geothermal properties – deductions				
f Other AMT items				

Items Affecting Shareholder Basis

16a Tax-exempt interest income				
b Other tax-exempt income				
c Nondeductible expenses	548.	377.	171.	45.36
d Property distributions	33,361.		33,361.	
e Repayment of loans from shareholders	1,362.		1,362.	

Other Information

17a Investment income				
b Investment expenses				
c Dividend distributions paid from E & P	0.		0.	
d Income (loss)	-5,982.	-3,829.	-2,153.	-56.23

S Corporation Five Year Tax History

▶ Keep for your records

2014

Name as Shown on Return				Employer Identification No.	
Growing Potential Services: Therapeutic and Behavioral Solutions, P.C.				46-3010541	
	2010	2011	2012	2013	2014
1 Gross receipts				38,833.	244,296.
2 Cost of sales					
3 Gross profit				38,833.	244,296.
4 Net 4797 gain (loss)					
5 Other income (loss)					868.
6 Total income (loss)				38,833.	245,164.
7 Salaries				10,507.	138,476.
8 Depreciation					0.
9 Other deductions				29,311.	112,670.
10 Total deductions				-39,818.	-251,146.
11 Business income				-985.	-5,982.
12 Passive investment income					
13 Passive investment expense					
14 Net passive investment income					
15 Excess net passive income tax					
16 Tax from Schedule D					
17 Additional taxes					
18 Tax liability					

► Keep for your records.

Name of Corporation					Employer Identification Number	
Growing Potential Services: Therapeutic and Behavioral Solutions, P.C.					46-3010541	
Ordinary Income (Loss)	2014		2013		Difference 2014- 2013	
	Amount	% of Total Income	Amount	% of Total Income	Amount	%
1a Gross receipts or sales	244,296.		38,833.		205,463.	529.09
b Less returns and allowances						
c Net receipts	244,296.		38,833.		205,463.	529.09
2 Cost of goods sold (Form 1125-A)						
3 Gross profit	244,296.		38,833.		205,463.	529.09
4 Net gain or loss (Form 4797)						
5 Other income	868.				868.	
6 Total income (loss)	245,164.	100.00	38,833.	100.00	206,331.	531.33
Deductions						
7 Compensation of officers	9,750.	3.98	4,465.	11.50	5,285.	118.37
8 Salaries and wages (less employment credits)	138,476.	56.48	10,507.	27.06	127,969.	999.00
9 Repairs and maintenance	119.	0.05	417.	1.07	-298.	-71.46
10 Bad debts		0.00		0.00		
11 Rents	24,015.	9.80	5,060.	13.03	18,955.	374.60
12 Taxes and licenses	18,383.	7.50	1,960.	5.05	16,423.	837.91
13 Interest	1,019.	0.42		0.00	1,019.	
14a Depreciation (Form 4562)	0.	0.00		0.00	0.	
b Depreciation on Schedule A and elsewhere		0.00		0.00		
c Net depreciation	0.	0.00		0.00	0.	
15 Depletion (not oil and gas)		0.00		0.00		
16 Advertising	210.	0.09	3,630.	9.35	-3,420.	-94.21
17 Pension, profit-sharing, etc, plans		0.00		0.00		
18 Employee benefit programs		0.00		0.00		
19 Other deductions	59,174.	24.14	13,779.	35.48	45,395.	329.45
20 Total deductions	251,146.	102.44	39,818.	102.54	211,328.	530.73
21 Ordinary income (loss) from trade/business	-5,982.	-2.44	-985.	-2.54	-4,997.	-507.31
Tax						
22a Excess net passive income tax or LIFO recapture		0.00		0.00		
b Tax from Schedule D		0.00		0.00		
Additional taxes		0.00		0.00		
c Total tax		0.00		0.00		
Tax Payments and Credits						
23d Total payments and credits	0.	0.00		0.00	0.	
24 Estimated tax penalty		0.00		0.00		
25 Tax due	0.	0.00	0.	0.00	0.	
26 Overpayment	0.	0.00		0.00	0.	
Schedule K Items:						
Income (Loss)	2014		2013		Difference 2014 - 2013	
					Amount	%
1 Ordinary business income (loss)	-5,982.		-985.		-4,997.	-507.31
2 Net rental real estate income (loss)						
3 Other net rental income (loss)						
4 Interest income						
5a Dividends — ordinary						
b Dividends — qualified						
6 Royalty income						
7 Net short-term capital gain (loss)						
8 Net long-term capital gain (loss)						
9 Net gain (loss) under section 1231						
10 Other income (loss)						

#5e

Growing Potential Services Standards of Practice will follow the APA Guidelines for Prevention Psychology as well as the SAMHSA National Behavioral Health Quality Framework

The Guidelines for Prevention Psychology read as follows:

The Affordable Care Act (2010) includes preventive services as a key component of overall health care. The legislation strives to make wellness and preventive services affordable and accessible by requiring health plans to cover preventive services without copayments. These services include counseling to improve habits of lifestyle, counseling to reduce depression, and preventive services to foster healthy birth outcomes. The contributions and leadership of psychologists are critical in implementing a prevention focus in the health care system. The guidelines support prevention as an important area of practice, research and training for psychologists. The guidelines identify best practices for psychologists who engage in preventive activities relating to the interface between physical health and emotional well-being.

The Practice of the SAMHSA NBHQF read as follows:

National Behavioral Health Quality Framework OVERVIEW Three Aims Concordant with NQS: -

- 1- Better Care: Improve overall quality by making behavioral health (BH) care more person-, family-, and community-centered; and reliable, accessible, and safe.
- 2- Healthy People/Healthy Communities: Improve U.S. health by supporting (*and disseminating, added by SAMHSA) interventions to address behavioral, social, environmental determinants of positive BH; and delivering higher quality BH care.
- 3- Affordable (Accessible) Care: Increase the value and availability of BH care for individuals, families, employers, and government.

BACB Standards of Practice will be followed with regards to any Applied Behavioral Analysis interventions.

Applicant Name: Growing Potential Services
Financial Worksheet (B)

#18B

FOR-PROFIT

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

LINE	Total Entity:	FY2014		FY2015		FY2015		FY2015		FY2016		FY2016	
		Description	Actual Results	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected
A. OPERATING REVENUE													
1	Total Gross Patient Revenue		\$244,296	\$257,630	\$0	\$302,326	\$298,563	\$395,326					
2	Less: Allowances		\$0	\$0	\$0	\$0	\$0	\$0					
3	Less: Charity Care		\$0	\$0	\$0	\$0	\$0	\$0					
4	Less: Other Deductions		\$251,146	\$259,035	\$0	\$299,355	\$289,359	\$376,645					
	Net Patient Service Revenue		(\$6,850)	(\$1,405)	\$0	\$2,971	\$9,204	\$18,681					
5	Medicare		\$0	\$0	\$0	\$0	\$0	\$0					
6	Medicaid		\$165,420	\$151,945	\$0	\$235,000	\$193,592	\$253,552					
7	CHAMPUS & Tricare		\$5,771	\$1,271	\$0	\$3,526	\$1,365	\$2,658					
8	Other		\$15,715	\$43,907	\$0	\$32,562	\$49,535	\$37,526					
	Total Government		\$186,906	\$197,123	\$0	\$271,088	\$244,492	\$293,736					
9	Commercial Insurers		\$57,390	\$60,507	\$0	\$53,151	\$65,325	\$52,864					
10	Uninsured		\$0	\$0	\$0	\$0	\$0	\$0					
11	Self Pay		\$0	\$0	\$0	\$0	\$0	\$0					
12	Workers Compensation		\$0	\$0	\$0	\$0	\$0	\$0					
13	Other		\$0	\$0	\$0	\$0	\$0	\$0					
	Total Non-Government		\$57,390	\$60,507	\$0	\$53,151	\$65,325	\$52,864					
	Net Patient Service Revenue^a (Government+Non-Government)		(\$6,850)	(\$1,405)	\$0	\$2,971	\$9,204	\$18,681					
14	Less: Provision for Bad Debts		\$0	\$0	\$0	\$0	\$0	\$0					
	Net Patient Service Revenue less provision for bad debts		(\$6,850)	(\$1,405)	\$0	\$2,971	\$9,204	\$18,681					
15	Other Operating Revenue		\$0	\$0	\$0	\$0	\$0	\$0					
17	Net Assets Released from Restrictions		\$0	\$0	\$0	\$0	\$0	\$0					
	TOTAL OPERATING REVENUE		(\$6,850)	(\$1,405)	\$0	\$2,971	\$9,204	\$18,681					
B. OPERATING EXPENSES													
1	Salaries and Wages		\$138,476	\$157,356	\$0	\$165,899	\$169,852	\$198,532					
2	Fringe Benefits		\$0	\$0	\$0	\$0	\$0	\$0					
3	Physicians Fees		\$0	\$0	\$0	\$0	\$0	\$0					
4	Supplies and Drugs		\$0	\$0	\$0	\$0	\$0	\$0					
5	Depreciation and Amortization		\$0	\$0	\$0	\$0	\$0	\$0					
6	Provision for Bad Debts-Other ^b		\$0	\$0	\$0	\$0	\$0	\$0					
7	Interest Expense		\$0	\$0	\$0	\$0	\$0	\$0					
8	Malpractice Insurance Cost		\$1,019	\$0	\$0	\$0	\$0	\$0					
9	Lease Expense		\$0	\$0	\$0	\$0	\$0	\$0					
10	Other Operating Expenses		\$24,015	\$48,000	\$0	\$48,000	\$48,000	\$48,000					
	Other Operating Expenses		\$59,174	\$68,658	\$0	\$79,288	\$66,595	\$136,552					
	TOTAL OPERATING EXPENSES		\$222,684	\$274,014	\$0	\$293,187	\$304,447	\$383,084					
	INCOME/(LOSS) FROM OPERATIONS		(\$6,820)	(\$1,405)	\$0	\$2,971	\$60,757	\$52,864					

#1813

Applicant Name: Growing Potential Services
Financial Worksheet (B)

FOR-PROFIT

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

LINE	Total Entity:	FY2014		FY2015		FY2015		FY2015		FY2016		FY2016		FY2016	
		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)
	Description	Actual Results	Projected W/out CON												
	Income before provision for income taxes														
	Income before provision for income taxes														
	Provision for income taxes ^e														
	NET INCOME														
	Retained Earnings, beginning of year														
	Retained Earnings, end of year														
	Principal Payments														
D. PROFITABILITY SUMMARY															
1	Hospital Operating Margin	99.6%	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%
2	Hospital Non Operating Margin	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
3	Hospital Total Margin	99.6%	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%
E. FTES															
	FTES	0	0	0	0	0	0	0	0	0	0	0	0	0	0
F. VOLUME STATISTICS^d															
1	Inpatient Discharges	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2	Outpatient Visits	175	220	220	251	245	251	245	251	245	251	245	251	245	251
	TOTAL VOLUME	175	220	220	251	245	251	245	251	245	251	245	251	245	251

^aTotal amount should equal the total amount on cell line "Net Patient Revenue" Row 14.
^bProvide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No.2011-07, July 20-
^cProvide the amount of income taxes as defined by the Internal Revenue Services for for-profit entities.
^dProvide 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

Drug-poisoning Deaths Involving Heroin: United States, 2000–2013

NCHS Data Brief No. 190, March 2015

On This Page

- Key findings
- While the age-adjusted rate for drug-poisoning deaths involving opioid analgesics has leveled in recent years, the rate for deaths involving heroin has almost tripled since 2010.
- In 2013, the number of drug-poisoning deaths involving heroin was nearly four times higher for men than women.
- The rate for heroin-related drug-poisoning deaths was highest among adults aged 25–44 from 2000 through 2013.
- In 2000, non-Hispanic black persons aged 45–64 had the highest rate for drug-poisoning deaths involving heroin. In 2013, non-Hispanic white persons aged 18–44 had the highest rate.
- From 2000 through 2013, the age-adjusted rate for drug-poisoning deaths involving heroin increased for all regions of the country, with the greatest increase seen in the Midwest.
- Summary
- Data source and methods
- About the authors
- References
- Suggested citation

[DF Version](#) (953 KB)

Jolly Hedegaard, M.D., M.S.P.H.; Li-Hui Chen, M.S., Ph.D.; and Margaret Warner, Ph.D.

Key findings

Data from the National Vital Statistics System (Mortality)

- From 2000 through 2013, the age-adjusted rate for drug-poisoning deaths involving heroin nearly quadrupled from 0.7 deaths per 100,000 in 2000 to 2.7 deaths per 100,000 in 2013. Most of the increase occurred after 2010.
- The number of drug-poisoning deaths involving heroin was nearly four times higher for men (6,525 deaths) than women (1,732 deaths) in 2013.

- In 2000, non-Hispanic black persons aged 45–64 had the highest rate for drug-poisoning deaths

involving heroin (2.0 per 100,000). In 2013, non-Hispanic white persons aged 18–44 had the highest rate (7.0 per 100,000).

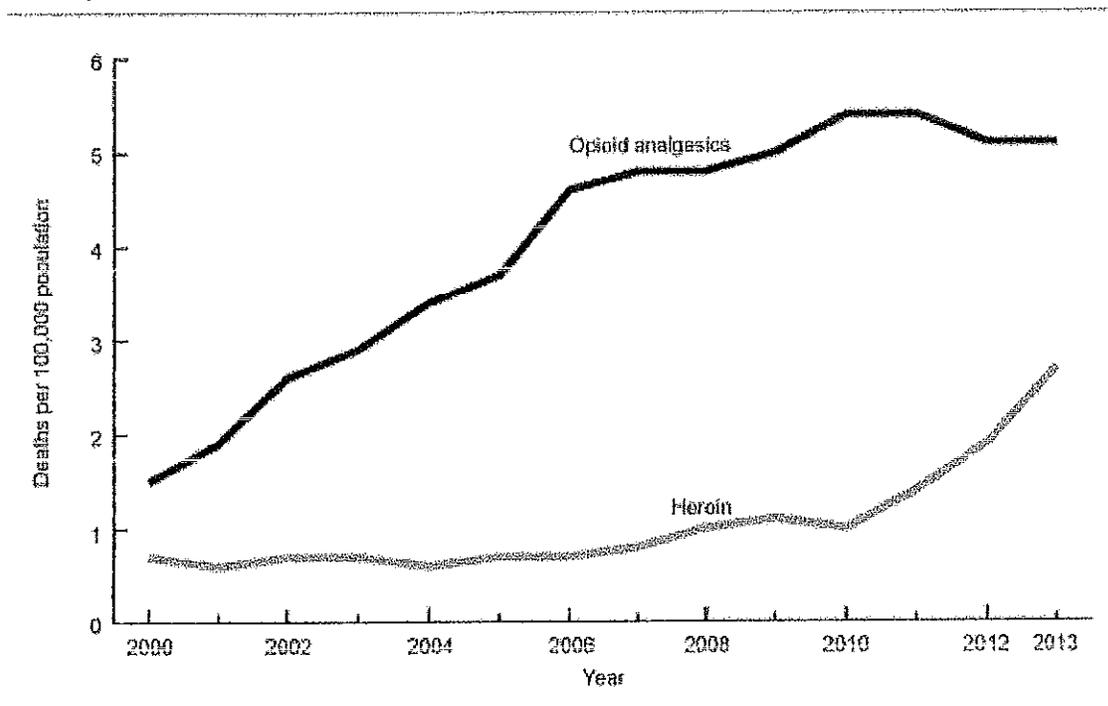
- From 2000 through 2013, the age-adjusted rate for drug-poisoning deaths involving heroin increased for all regions of the country, with the greatest increase seen in the Midwest.

Drug poisoning (overdose) is the number one cause of injury-related death in the United States, with 43,982 deaths occurring in 2013 (1). While much attention has been given to deaths involving opioid analgesics (2), in recent years there has been a steady increase in the number of drug-poisoning deaths involving heroin. A recent study using data from 28 states reported that the death rate for heroin overdose doubled from 2010 through 2012 (3). Using data from the National Vital Statistics System, this data brief provides a description of trends and demographics for heroin-related drug-poisoning deaths in the United States from 2000 through 2013.

Keywords: overdose, mortality, National Vital Statistics System

While the age-adjusted rate for drug-poisoning deaths involving opioid analgesics has leveled in recent years, the rate for deaths involving heroin has almost tripled since 2010.

Figure 1. Age-adjusted rates for drug-poisoning deaths, by type of drug: United States, 2000–2013



NOTES: The number of drug-poisoning deaths in 2013 was 43,982, the number of drug-poisoning deaths involving opioid analgesics was 16,235, and the number of drug-

poisoning deaths involving opioid analgesics was 20,200, and the number of drug poisoning deaths involving heroin was 8,257. A small subset of 1,342 deaths involved both opioid analgesics and heroin. Deaths involving both opioid analgesics and heroin are included in both the rate of deaths involving opioid analgesics and the rate of deaths involving heroin. [Access data table for Figure 1](#) [PDF - 86KB].

SOURCE: CDC/NCHS, National Vital Statistics System, Mortality.

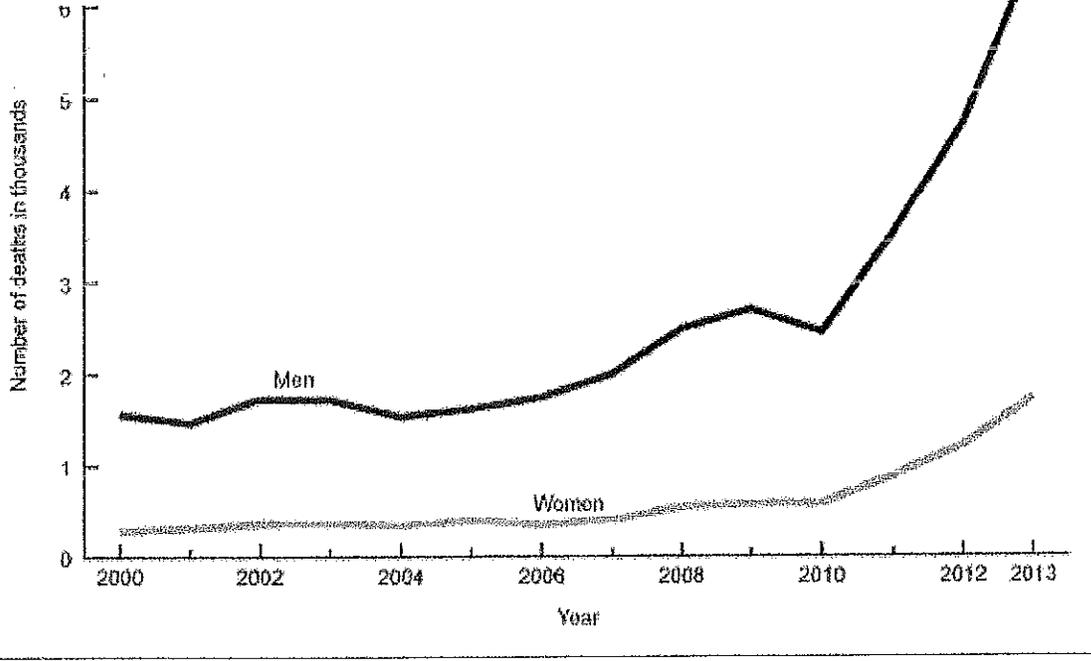
From 2000 through 2013, the age-adjusted rate for drug-poisoning deaths involving opioid analgesics was higher than the rate for drug-poisoning deaths involving heroin ([Figure 1](#)). The age-adjusted rate for opioid-analgesic poisoning deaths increased at a faster pace from 2000 through 2006 (19% per year) than from 2006 through 2013 (2% per year). From 2010 through 2013, the age-adjusted rate for opioid-analgesic poisoning deaths declined slightly from 5.4 to 5.1 per 100,000. In contrast, the age-adjusted rate for drug-poisoning deaths involving heroin showed a different pattern with a slower pace of increase between 2000 and 2010 (6% per year) and a faster pace of increase from 2010 forward (37% per year). From 2010 through 2013, the age-adjusted rate for heroin-related drug-poisoning deaths nearly tripled from 1.0 per 100,000 in 2010 to 2.7 per 100,000 in 2013.

In 2013, the number of drug-poisoning deaths involving heroin was nearly four times higher for men than women.

More men than women died from drug poisoning involving heroin ([Figure 2](#)). In 2013, the number of heroin-related drug-poisoning deaths for men (6,525 deaths) was nearly four times that for women (1,732 deaths). From 2010 through 2013, the age-adjusted rate increased from 1.6 to 4.2 per 100,000 for men and from 0.4 to 1.2 per 100,000 for women.

Figure 2. Number of drug-poisoning deaths involving heroin, by sex: United States, 2000–2013





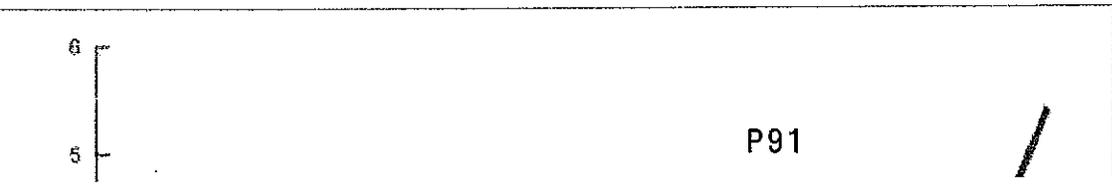
NOTE: [Access data table for Figure 2](#) [PDF - 86KB].

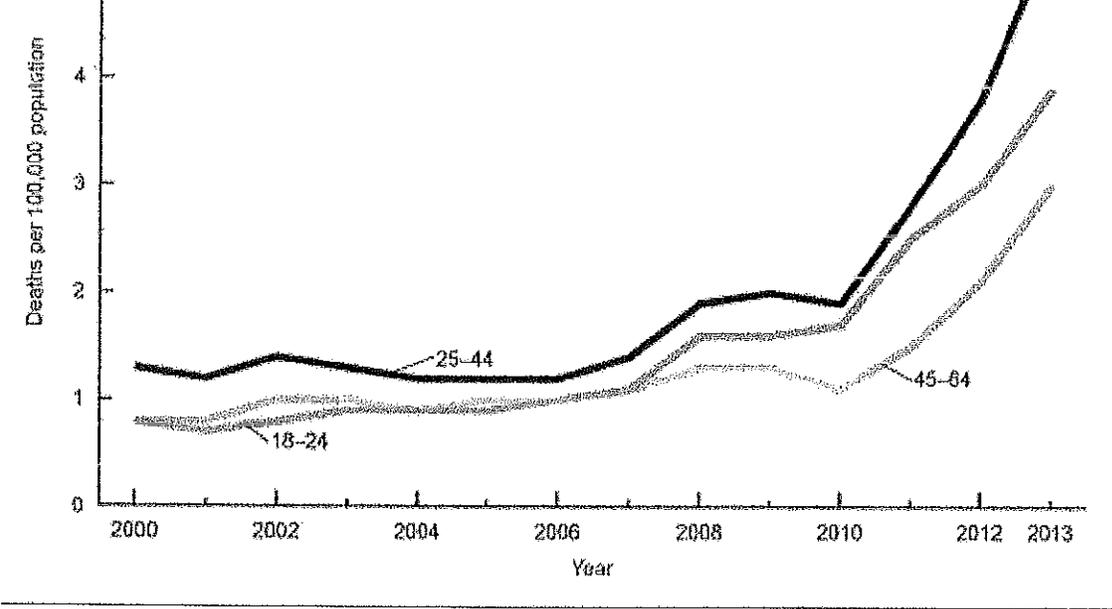
SOURCE: CDC/NCHS, National Vital Statistics System, Mortality.

The rate for heroin-related drug-poisoning deaths was highest among adults aged 25–44 from 2000 through 2013.

Compared with adults aged 18–24 and 45–64, those aged 25–44 had the highest rate for drug-poisoning deaths involving heroin (Figure 3). From 2000 through 2010, the average annual increase in the rates was 10% for adults aged 18–24, 5% for those aged 25–44, and 4% for those aged 45–64. From 2010 through 2013, the death rate for adults aged 18–24 increased 2.3-fold from 1.7 to 3.9 per 100,000, for those aged 25–44 the rate increased 2.8-fold from 1.9 to 5.4, and for those aged 45–64 the rate increased 2.7-fold from 1.1 to 3.0.

Figure 3. Rates for drug-poisoning deaths involving heroin, by selected age groups: United States, 2000–2013





NOTE: [Access data table for Figure 3](#) [PDF - 86KB].
 SOURCE: CDC/NCHS, National Vital Statistics System, Mortality.

In 2000, non-Hispanic black persons aged 45–64 had the highest rate for drug-poisoning deaths involving heroin. In 2013, non-Hispanic white persons aged 18–44 had the highest rate.

In 2000, the highest rate for drug-poisoning deaths involving heroin was among non-Hispanic black persons aged 45–64 (2.0 per 100,000)(Figure 4). In contrast, in 2013, the rate was highest among non-Hispanic white persons aged 18–44 (7.0 per 100,000). From 2000 through 2013, rates increased for both age groups 18–44 and 45–64 and race and ethnicity groups (non-Hispanic white, non-Hispanic black, and Hispanic), with the largest increases seen among non-Hispanic white persons.

Figure 4. Rates for drug-poisoning deaths involving heroin, by selected age and race and ethnicity groups: United States, 2000 and 2013



CDC's Autism and Developmental Disabilities Monitoring (ADDMM) Network

"While typical children are scheduling play dates and extracurricular activities, our children's lives are about therapies, day after day, year after year, usually seven days a week. People on the outside cannot grasp the necessary skills that our children require help with. My ultimate hope is that one day soon my children will live in a world where they will be accepted and appreciated, despite their differences. As long as I am here, I try to surround them with people who love and accept them as they navigate this world, because autism never takes a day off."

—Mary Elizabeth, parent of two children with autism spectrum disorder.



Understanding Autism Spectrum Disorder and Other Developmental Disabilities

The Autism and Developmental Disabilities Monitoring (ADDMM) Network is the only collaborative network to track the number and characteristics of children with autism spectrum disorder (ASD) in multiple communities in the United States. CDC encourages partners to use information from the ADDMM Network in their local communities and across the country to move forward initiatives, policies, and research that help children with ASD.

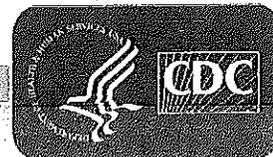


Autism and Developmental Disabilities Monitoring (ADDMM) Network Sites, Surveillance Year 2014



What Do ADDMM Data Tell Us About Autism Spectrum Disorder (ASD)?

- About 1 in 68 children has been identified with ASD, based on tracking in multiple areas of the United States. It is important to remember that this estimate is based on 8-year-old children living in 11 communities. It does not represent the entire population of children in the United States.
- The picture of ASD in communities continues to change. Almost half of children identified with ASD have average or above average intellectual ability; a decade ago, a third of children identified with ASD had average or above average intellectual ability.
- ASD occurs among all racial, ethnic, and socioeconomic groups. However, white children are still more likely to be identified with ASD than black or Hispanic children.
- Boys are about 4.5 times more likely to be identified with ASD than girls. Most children with ASD are diagnosed after age 4, even though ASD can be diagnosed as early as age 2.



Building the Public Health Infrastructure for ASD

To understand the scope of ASD in the United States, the Children's Health Act of 2000 authorized the CDC to create the Autism and Developmental Disabilities Monitoring (ADDM) Network. CDC's ADDM Network has funded 14 sites located in Alabama, Arizona, Arkansas, Colorado, Florida, Maryland, Missouri, New Jersey, North Carolina, Pennsylvania, South Carolina, Utah, West Virginia, and Wisconsin. ADDM Network sites track the number and characteristics of children with ASD and other developmental disabilities using a technique modeled after CDC's Metropolitan Atlanta Developmental Disabilities Surveillance Program (MADDSP). MADDSP represents the ADDM Network site located in Georgia.

There are several major advantages to using the ADDM Network method for tracking the number and characteristics of children with ASD.

CDC's current ADDM Network sites have been funded to track ASD in children at 8 years of age. Arizona, Missouri, New Jersey, South Carolina, Utah, and Wisconsin received additional funding to track ASD in children at 4 years of age.

- The ADDM Network is the largest, ongoing ASD tracking system in the United States.
- The ADDM Network's method is population-based, which means that we study ASD and other developmental disabilities among thousands of children from diverse communities across the country.
- The ADDM Network is able to look at not only how many children have ASD in multiple communities across the United States, but also which groups of children are more likely to be identified with ASD and at what age they are likely to be diagnosed.
- The ADDM Network method is rigorous. We maintain quality and precision by collecting and reviewing information on all children the same way using the same criteria. These steps help ensure that ADDM Network results are accurate and unbiased.

Because of the depth and breadth of ADDM data, we know that the number of children identified with ASD continues to increase and that ASD affects children and communities in very different ways. Some of the children who are most severely affected by ASD are not getting help as early as possible, and most children with ASD are not being diagnosed as

early as they could be. We understand more about ASD than ever before, including which children are more likely to be identified, at what age they are likely to be diagnosed, and what factors may be putting children at risk for ASD, but many important questions remain unanswered.

Moving Forward

CDC will continue tracking the changing number and characteristics of children with ASD, researching what puts children at risk for ASD, and promoting early identification, the most powerful tool we have now for making a difference in the lives of children.

Learn More

The Autism and Developmental Disabilities Monitoring Network. Please visit: www.cdc.gov/addm

The Study to Explore Early Development. Please visit: www.cdc.gov/seed

The Learn the Signs. Act Early. Campaign. Please visit: www.cdc.gov/actearly

"CDC data are a wonderful asset to professionals, advocates, and families – from understanding how a condition affects your community to building the case on how to address it."

Adriane Griffen, Chair Friends of the National Center on Birth Defects and Developmental Disabilities.

National Center on Birth Defects and Developmental Disabilities

For more information please contact the Centers for Disease Control and Prevention

1600 Clifton Road NE, Atlanta, GA 30333

Telephone: 1-800-CDC-INFO (232-4636)/TTY: 1-888-232-63548

Email: cdcinfo@cdc.gov Web: www.cdc.gov

Non-specific Psychological Distress

Surveillance Data Sources

Health-Related Quality of Life—Behavioral Risk Factor Surveillance System (BRFSS)

The BRFSS is an annual state-based telephone survey of the U.S. civilian, non-institutionalized adult population. The Healthy Days measures used to assess health-related quality of life (HRQOL) have been a part of the BRFSS core questionnaire since 1993. For more details, including the Healthy Days questions and links to the data, refer to the following PDF file.

For public health surveillance purposes, the CDC Health-Related Quality of Life (HRQOL) measures have provided a generic HRQOL index operationalized as a person's or group's physical and mental health over time.¹ The data from the mental health questions have been used to calculate frequent mental distress (FMD=14 to 30 mentally unhealthy days in the past 30 days) which has been used as a proxy for poor mental health. The CDC Healthy Days measures were developed with expert input and have been a part of the core BRFSS survey since 1993 and the National Health and Nutrition Examination Survey (NHANES) since 2000.

- [BRFSS—Healthy Days/HRQOL-4 questions PDF](#) [19.87 KB].
- For more information on BRFSS: [Behavioral Risk Factor Surveillance System \(BRFSS\)](#).

Kessler 6 (K6) for Serious Psychological Distress—Behavioral Risk Factor Surveillance System (BRFSS)

The BRFSS is an annual state-based telephone survey of the U.S. civilian, non-institutionalized adult population. The Kessler 6 (K6) is a standardized and validated measure of non-specific psychological distress. During 2007 and 2009, K-6 was added as an optional module on the BRFSS and was administered by 26 states, the District of Columbia and Puerto Rico. A score of 10 or more on the K6 is used to indicate non-specific serious psychological distress (SPD). This information can be used as an estimate of the prevalence of *serious mental illness (SMI)* in community populations^{2,3}. The K6 instrument offers a useful tool for states to assess the potentially unmet mental health needs of a large proportion of adults within their jurisdiction.

- [BRFSS—Mental Illness and Stigma Optional Module](#) [PDF-48KB] (includes Kessler 6).
- For more information on the K6 instrument: [National Comorbidity Survey](http://www.hcp.med.harvard.edu/ncs/k6_scales.php) (http://www.hcp.med.harvard.edu/ncs/k6_scales.php).
- For more information on BRFSS: [Behavioral Risk Factor Surveillance System \(BRFSS\)](#).

Health-Related Quality of Life—National Health and Nutrition Examination Survey

NHANES)

NHANES is a program of studies designed to assess the health and nutritional status of adults and children in the United States. The survey is unique in that it combines interviews and physical examinations. The HRQOL-4 questions are included in the Current Health Status questionnaire and are asked of participants age 12 and older. For more details, including the questions and links to the data, refer to the following PDF file.

- NHANES—[Healthy Days/HRQOL-4 questions](#) [PDF 20.35KB].
- For more information on NHANES: [National Health and Nutrition Examination Survey \(NHANES\)](#).

Non-Specific Distress Battery—National Health Interview Survey (NHIS)

NHIS data are collected through personal household interviews. The Non-Specific Distress Battery is part of the adult questionnaire and has been administered since 1997. For more details, including the questions that make up the module and links to the data, refer to the following PDF file

- NHIS—[Non-Specific Distress Battery](#) [PDF 16.5KB].
- For more information on NHIS: [National Health Interview Survey \(NHIS\)](#).

Statistics

Behavioral Risk Factor Surveillance System Kessler 6 (K6)

For 2007 K6 data, based on a period of "in the past 30 days."

- Approximately 40% of persons in 35 states had serious psychological distress (SPD, defined as a score of 10 or more on the K6)
- Of respondents indicating they had SPD:
 - 37.7% received mental health services in the preceding year
 - 53.4% currently received no treatment
 - A greater percentage were likely to be women
 - Were more likely to be unmarried
 - Were more likely to live in poverty
- Medically, respondents with SPD were more likely to be obese, to smoke, and to report being diagnosed with heart disease.

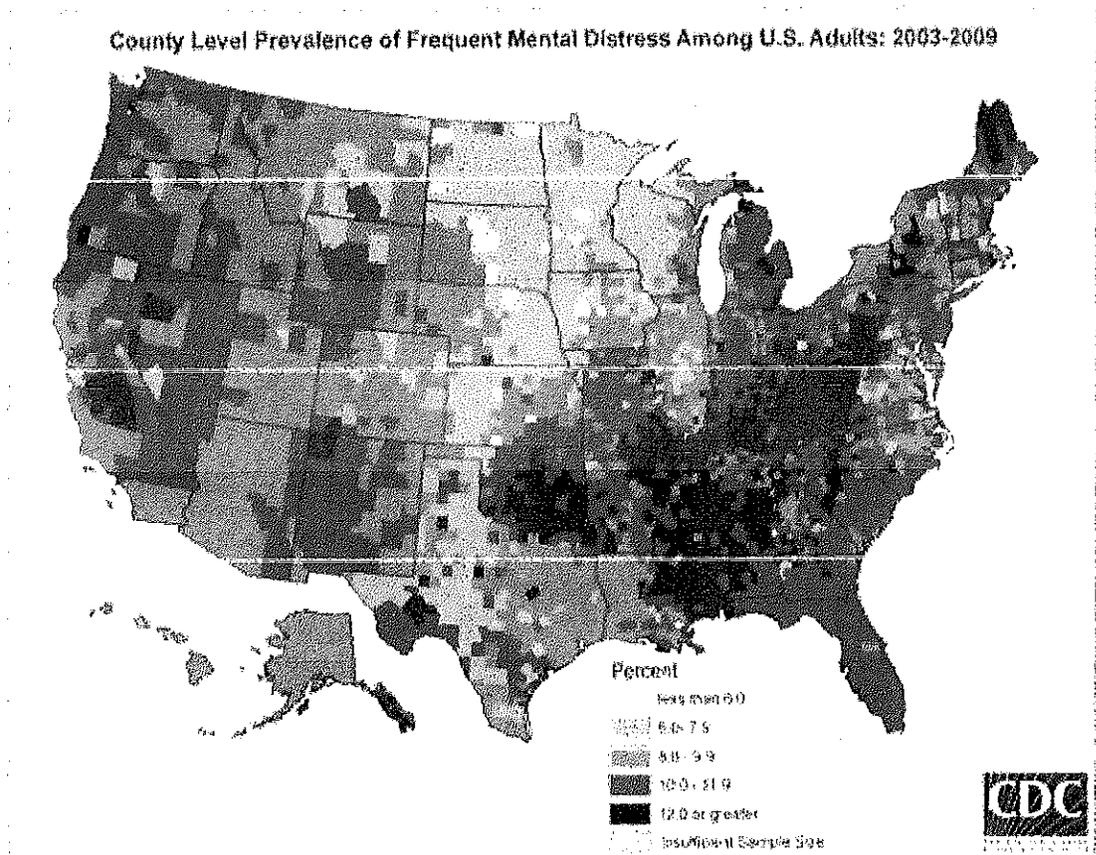
Behavioral Risk Factor Surveillance System (BRFSS) Health Related Quality of Life

For 2004–2008 Health-Related Quality of Life (HRQOL) data, based on a period of "in the past 30 days."

- U.S. adults experienced an average of 3.6 physically unhealthy days.
- U.S. adults experienced an average of 3.4 mentally unhealthy days.
- U.S. adults experienced an average of 6.1 overall unhealthy days.
- U.S. adults experienced an average of 2.2 days of activity limitation.
- An estimated 10.8% of U.S. adults experienced 14 or more physically unhealthy days.

- An estimated 6.7% of U.S. adults experienced 14 or more days of activity limitation.
- An estimated 10.2% of U.S. adults experienced 14 or more mentally unhealthy days (Frequent Mental Distress or FMD).
- The Appalachian and the Mississippi Valley regions have high and increasing FMD prevalence, and the upper Midwest had low and decreasing FMD prevalence.⁴

The figure below presents estimates of the number of respondents on the BRFSS who reported frequent mental distress (14 to 30 mentally unhealthy days in the past 30 days) by county, aggregated over 2003–2009. The prevalence for Alaska is estimated for the state as a whole because Alaska BRFSS did not record county codes. Kalawao County, Hawaii, was excluded as having no respondents. Data are weighted using sampling weights based on the state populations by sex, age group, and race. County-level rates were smoothed using a nonparametric spatial smoothing algorithm⁵. Counties with combined sample sizes 2003–2009) of less than 30 were masked in the accompanying figure.



Data Source: CDC. Behavioral Risk Factor Surveillance System, 2003-2009

learn more about national and state trend data on HRQOL (<http://apps.nccd.cdc.gov/HRQOL>) by sex, age, and race-ethnicity.

References:

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5. Mungiole M, Pickle LW, Simonson KH. 1999. Application of a weighted Headbanging algorithm to mortality data maps. *Statistics in Medicine* 18:3201–9.

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File Formats Help:

How do I view different file formats (PDF, DOC, PPT, MPEG) on this site?

(<http://www.cdc.gov/Other/plugins/>)

(<http://www.cdc.gov/Other/plugins/#pdf>)

Page last reviewed: July 1, 2011

Page last updated: October 4, 2013

Content source: Centers for Disease Control and Prevention (/index.htm), Program Performance and Evaluation Office

<http://www.cdc.gov/program/overview/index.htm>



Supplemental CON Application Form
**Establishment of a New Health Care Facility (Mental
Health and/or Substance Abuse Treatment)***
Conn. Gen. Stat. § 19a-638(1)

Applicant:

**Growing Potential Services: Therapeutic and Behavioral
Solutions, PC**

Project Name:

Freestanding Psychiatric Outpatient and Day Treatment Clinic

*This supplemental form should be included with all applications requesting authorization for the establishment of a **mental health and/or substance abuse treatment facility**. For the establishment of other "health care facilities," as defined by Conn. Gen. Stat § 19a-630(11) - hospitals licensed by DPH under chapter 386v, specialty hospitals, or a central service facility - complete *the Main Form* only.

Affidavit

Applicant: Growing Potential Services: Therapeutic and Behavioral Solutions, PC

Project Title: Freestanding Psychiatric Outpatient and Day Treatment Program

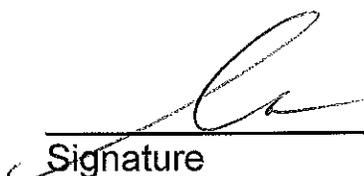
I, Marcy L. Taliceo LPC

CEO

(Name)

(Position – CEO or CFO)

of Growing Potential Services: Therapeutic and Behavioral Solutions, PC being duly sworn, depose and state that the (Facility Name) said facility complies with the appropriate and applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 and/or 4-181 of the Connecticut General Statutes.



Signature

4-14-16

Date

Subscribed and sworn to before me on 4/14/16



Notary Public/Commissioner of Superior Court

LISA A. STROM
NOTARY PUBLIC
MY COMMISSION EXPIRES 9/30/2020

My commission expires: 9/30/2020

1. Project Description: New Facility (Mental Health and/or Substance Abuse)

- a. Describe any unique services (i.e., not readily available in the service area) that may be included in the proposal.**

Children and Adults

(ABA)- Applied Behavior Analysis, Autism screening and evaluation, Dyslexia screening and evaluation, Life skills training, Psychiatric services with minimal waitlist

- b. List the type and number of DPH-licensed health care professionals that will be required to initiate the proposal.**

1- Medical Director/ Psychiatrist, 1- Executive Director/LPC, 1- Director/BCBA, 2- Licensed LPC (outpatient and groups), 2- licensed eligible clinicians (outpatient and groups), 2 Bachelor level case managers, 5 Direct Care Staff

2. Projected Volume

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

- (i) An estimate of the number of persons within the population group by town that need the proposed service; and**

- 1. Outpatient Therapy – 100 Enfield, Windsor Locks E Windsor, Bloomfield, Hartford**
- 2. Medication Management- 150 Enfield, Windsor Locks , E Windsor, Bloomfield, Hartford**
- 3. Case Management- 35 Enfield, Windsor Locks, E Windsor, Bloomfield, Hartford**
- 4. Day Treatment- 55 Enfield, Windsor Locks, E Windsor, Bloomfield, Hartford**

- (ii) The number of persons in need of the service that will be served by the proposal (estimated patient volume). 500 over the next 24 months**

- b. Provide statistical information from the Substance Abuse and Mental Health Administration (“SAMSHA”), or a similar organization demonstrating that the target population has a need for the proposed services. SEE ATTACHED**

Please note: provide only publicly available and verifiable information and document the source.

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Tables

TABLE 1
APPLICANT'S SERVICES AND SERVICE LOCATIONS

Service	Street Address, Town	Population Served	Days/Hours of Operation	New Service or Proposed Termination
Day Treatment	140 Hazard Ave, Enfield	M/F, 18-99, DSM Dx	Mon-Fri 9-12p	New Service
Adult OP Clinic	139/140 Hazard Ave, Enfield	M/F, 18-99, DSM Dx	M-F 8-7p, Sat 9-12p	New Service

[\[back to question\]](#)

TABLE 2
SERVICE AREA TOWNS

List the official name of town* and provide the reason for inclusion.

Town*	Reason for Inclusion
Enfield	Underserved
Somers	Underserved
East Windsor	Underserved
Windsor Locks	Underserved
Hartford	Underserved
Windsor	Underserved

* Village or place names are not acceptable.

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**TABLE 3
TOTAL PROPOSAL CAPITAL EXPENDITURE**

Purchase/Lease	Cost
Equipment (Medical, Non-medical, Imaging)	
Land/Building Purchase*	
Construction/Renovation**	
Other (specify)	
Total Capital Expenditure (TCE)	
Lease (Medical, Non-medical, Imaging)***	
Total Lease Cost (TLC) 3 current locations	5600/month
Total Project Cost (TCE+TLC)	

* If the proposal involves a land/building purchase, attach a real estate property appraisal including the amount; the useful life of the building; and a schedule of depreciation.

** If the proposal involves construction/renovations, attach a description of the proposed building work, including the gross square feet; existing and proposed floor plans; commencement date for the construction/ renovation; completion date of the construction/renovation; and commencement of operations date.

*** If the proposal involves a capital or operating equipment lease and/or purchase, attach a vendor quote or invoice; schedule of depreciation; useful life of the equipment; and anticipated residual value at the end of the lease or loan term.

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TABLE 4
PROJECTED INCREMENTAL REVENUES AND EXPENSES

	FY 20 ¹⁴ *	FY 20 ¹⁵ *	FY 20 ¹⁶ *
Revenue from Operations	\$244,296	\$257,630	\$395,326
Total Operating Expenses	251,146	259,035	376,645
Gain/Loss from Operations	\$(6850)	\$(1405)	\$18,681

* Fill in years using those reported in the Financial Worksheet attached.

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TABLE 5
HISTORICAL UTILIZATION BY SERVICE

Service**	Actual Volume (Last 3 Completed FYs)			CFY Volume*
	FY 6/13/13- 12/31/13_***	FY 2014_***	FY 20_15_***	FY 2016_***
Outpatient Mental Health 2013 6mo	17	43	87	128
Group Therapy 2013 6mo	20	20	32	103
In Home Behavioral Services 2015			19	20
Medication (MD and APRN) 2016				50
Independent Bx Consultations 2015			2	10
Extended Day Treatment 2016				21
Case Management 2016 projected				28
Adult PHP/Day Treatment 2016 projected				73
Psychological Testing 2016 projected				46
Therapeutic Mentoring 2014		3		8
Occupational Therapy				7
Physical Therapy				7
Speech Therapy				7
Total	37	66	140	423

- * 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 6 months, report actual volume and identify the period covered. (m) 444
- ** Identify each service type and level adding lines as necessary. Provide the number of visits or discharges as appropriate for each service type and level listed.
- *** Fill in years. If the time period reported is not *identical* to the fiscal year reported in Table 4 of the application, provide the date range using the mm/dd format as a footnote to the table.

#'s reflect client count not visits per year

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TABLE 6
PROJECTED UTILIZATION BY SERVICE

Service* Enfield	Projected Volume			FY18
	FY 2015_** May 1-Dec 31	FY 20_16_**	FY 20_17_**	
Outpatient Mental Health	87	128	245	299
Group Therapy	32	103	128	158
In Home Behavioral Services (ABA)	19	20	45	45
Medication (MD and APRN)		50	71	98
Independent Bx Consultations	2	10	19	19
Extended Day Treatment		21	39	51
Case Management		28	35	48
Adult PHP/Day Treatment		74 73	121	181
Psychological Testing		46	58	98
Therapeutic Mentoring		8	19	28
Occupational Therapy		7	31	56
Physical Therapy		7	31	56
Speech Therapy		7	31	56
Total	140	444	873	1193

* Identify each service type by location and add lines as necessary. Provide the number of visits/discharges as appropriate for each service listed.

#'s reflect client count not visits per year

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**TABLE 7
APPLICANT'S CURRENT & PROJECTED PAYER MIX**

Payer	Current		Projected					
	FY 2015__**		FY 2016__**		FY 2017__**		FY 2018__**	
	Discharges	%	Discharges	%	Discharges	%	Discharges	%
Medicare*	0		0		0		0	
Medicaid*		15		20		22		30
CHAMPUS & TriCare		.5		1		6		4
Total Government		15.5		21		28		34
Commercial Insurers		6		9		10		8
Uninsured								
Workers Compensation								
Total Non- Government		6		9		10		8
Total Payer Mix		21.5		30		38		42

* Includes managed care activity.

** Fill in years. Ensure the period covered by this table corresponds to the period covered in the projections provided. New programs may leave the "current" column blank.

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TABLE 8
UTILIZATION BY TOWN

Town	Utilization FY 2015_**
Enfield	98
Windsor Locks	07
East Windsor	15
Hartford	06
Somers	07
Suffield	01
Bloomfield	02
Windsor	02
Ellington	01
Vernon	01

* List inpatient/outpatient/ED volumes separately, if applicable

** Fill in most recently completed fiscal year.

#'s reflect patient count not visits per year

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TABLE 9
SERVICES AND SERVICE LOCATIONS OF EXISTING PROVIDERS

Service or Program Name	Population Served	Facility ID*	Facility's Provider Name, Street Address and Town	Hours/Days of Operation	Current Utilization
CHR		1215979810 NPI	Enfield and Windsor	M-F	
The Village		1942573431 NPI	Hartford	M-F	

* Provide the Medicare, Connecticut Department of Social Services (DSS), or National Provider Identifier (NPI) facility identifier and label column with the identifier used.

[\[back to question\]](#)

Illicit Drug Dependence or Abuse ¹	2.91	4.42	7.83	1.90	2.76
Alcohol Dependence	3.22	1.15	5.64	3.06	3.44
Alcohol Dependence or Abuse	7.50	3.35	14.13	6.88	7.93
Alcohol or Illicit Drug Dependence or Abuse ¹	9.47	6.44	18.41	8.32	9.78
Needing But Not Receiving Treatment for Illicit Drug Use ^{1,8}	2.58	4.11	7.30	1.60	2.42
Needing But Not Receiving Treatment for Alcohol Use ⁸	6.94	3.10	13.24	6.33	7.33
PAST YEAR MENTAL HEALTH ISSUES					
Major Depressive Episode ^{3,9}	--	11.68	8.38	5.93	6.29
Serious Mental Illness ^{3,10}	--	--	4.35	3.62	3.73
Any Mental Illness ^{3,10}	--	--	21.24	17.31	17.87
Had Serious Thoughts of Suicide ¹¹	--	--	7.52	3.37	3.97

-- Not available.

NOTE: Estimates are based on a survey-weighted hierarchical Bayes estimation approach.

¹ Illicit Drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically. Illicit Drugs Other Than Marijuana include cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically. These estimates include data from original methamphetamine questions but do not include new methamphetamine items added in 2005 and 2006.

² Average annual initiation of marijuana (%) = $100 \times \{[X_1 \div (0.5 \times X_1 + X_2)] \div 2\}$, where X_1 is the number of marijuana initiates in the past 24 months and X_2 is the number of individuals who never used marijuana (with the at-risk population defined as $0.5 \times X_1 + X_2$). Both of the computation components, X_1 and X_2 , are based on a survey-weighted hierarchical Bayes estimation approach. The age group shown is based on a respondent's age at the time of the interview, not his or her age at first use.

³ For details, see Section B of the "2011-2012 NSDUH: Guide to State Tables and Summary of Small Area Estimation Methodology" at <http://www.samhsa.gov/data/>.

⁴ Binge Alcohol Use is defined as drinking five or more drinks on the same occasion (i.e., at the same time or within a couple of hours of each other) on at least 1 day in the past 30 days.

⁵ Underage drinking is defined for individuals aged 12 to 20; therefore, the "12+" estimate reflects that age group and not individuals aged 12 or older.

⁶ Tobacco Products include cigarettes, smokeless tobacco (i.e., chewing tobacco or snuff), cigars, or pipe tobacco.

⁷ Dependence or abuse is based on definitions found in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)*.

⁸ Needing But Not Receiving Treatment refers to respondents classified as needing treatment for illicit drugs (or alcohol), but not receiving treatment for an illicit drug (or alcohol) problem at a specialty facility (i.e., drug and alcohol rehabilitation facilities [inpatient or outpatient], hospitals [inpatient only], or mental health centers).

⁹ Major depressive episode (MDE) is defined as in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)*, which specifies a period of at least 2 weeks when an individual experienced a depressed mood or loss of interest or pleasure in daily activities and had a majority of specified depression symptoms. There are minor wording differences in the questions in the adult and adolescent MDE modules. Therefore, data from youths aged 12 to 17 were not combined with data from adults aged 18 or older to produce an estimate for those aged 12 or older.

¹⁰ Mental Illness is defined as having a diagnosable mental, behavioral, or emotional disorder, other than a developmental or substance use disorder, assessed by the Mental Health Surveillance Study (MHSS) *Structured Clinical Interview for the Diagnostic and Statistical Manual of Mental Disorders—Fourth Edition—Research Version—Axis I Disorders (MHSS-SCID)*, which is based on the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)*. Three categories of mental illness severity are defined based on the level of functional impairment: mild mental illness, moderate mental illness, and serious mental illness (SMI). Any mental illness (AMI) includes individuals in any of the three categories.

¹¹ Respondents were asked, "At any time in the past 12 months, did you seriously think about trying to kill yourself?" If they answered "Yes," they were categorized as having serious thoughts of suicide in the past year.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2013 and 2014.

150925

New Health Care Facility # 2B
 Supplement

CONNECTICUT

Table 23 – Selected Drug Use, Perceptions of Great Risk, Average Annual Marijuana Initiates, Past Year Substance Dependence or Abuse, Needing But Not Receiving Treatment, and Past Year Mental Health Measures in Connecticut, by Age Group: Estimated Numbers (in Thousands), Annual Averages Based on 2013-2014 NSDUHs

Measure	12+	12-17	18-25	26+	18+
ILLICIT DRUGS					
Past Month Illicit Drug Use ¹	302	27	93	182	275
Past Year Marijuana Use	427	45	148	234	382
Past Month Marijuana Use	259	23	86	151	237
Past Month Use of Illicit Drugs Other Than Marijuana ¹	95	8	24	63	87
Past Year Cocaine Use	66	2	25	39	64
Past Year Nonmedical Pain Reliever Use	114	12	33	70	103
Perception of Great Risk from Smoking Marijuana Once a Month	776	62	45	668	713
Average Annual Number of Marijuana Initiates ^{2,3}	39	19	17	3	20
ALCOHOL					
Past Month Alcohol Use	1,828	37	250	1,541	1,791
Past Month Binge Alcohol Use ⁴	718	18	161	539	700
Perception of Great Risk from Drinking Five or More Drinks Once or Twice a Week	1,235	113	117	1,005	1,122
Past Month Alcohol Use (Individuals Aged 12 to 20)	113 ⁵	--	--	--	--
Past Month Binge Alcohol Use (Individuals Aged 12 to 20) ⁴	70 ⁵	--	--	--	--
TOBACCO PRODUCTS					
Past Month Tobacco Product Use ⁶	645	20	136	490	626
Past Month Cigarette Use	516	13	113	391	503
Perception of Great Risk from Smoking One or More Packs of Cigarettes per Day	2,288	194	266	1,827	2,093
PAST YEAR DEPENDENCE, ABUSE, AND TREATMENT⁷					
Illicit Drug Dependence ¹	68	5	28	34	63
Illicit Drug Dependence or Abuse ¹	88	9	35	44	78
Alcohol Dependence	89	3	23	64	86
Alcohol Dependence or Abuse	206	8	54	144	198
Alcohol or Illicit Drug Dependence or Abuse ¹	257	13	73	171	244
Needing But Not Receiving Treatment for Illicit Drug Use ^{1,8}	75	9	29	37	66
Needing But Not Receiving Treatment for Alcohol Use ⁸	199	8	52	139	191
PAST YEAR MENTAL HEALTH ISSUES					
Major Depressive Episode ^{3,9}	--	28	32	135	167
Serious Mental Illness ^{3,10}	--	--	17	80	97
Any Mental Illness ^{3,10}	--	--	69	386	454
Had Serious Thoughts of Suicide ¹¹	--	--	26	66	92

-- Not available.

NOTE: Estimates are based on a survey-weighted hierarchical Bayes estimation approach.

¹ Illicit Drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically. Illicit Drugs Other Than Marijuana include cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically. These estimates include data from original methamphetamine questions but do not include new methamphetamine items added in 2005 and 2006.

² Average annual number of marijuana initiates = $X_1 \div 2$, where X_1 is the number of marijuana initiates in the past 24 months.

³ For details, see Section B of the "2011-2012 NSDUH: Guide to State Tables and Summary of Small Area Estimation Methodology" at <http://www.samhsa.gov/data/>.

⁴ Binge Alcohol Use is defined as drinking five or more drinks on the same occasion (i.e., at the same time or within a couple of hours of each other) on at least 1 day in the past 30 days.

⁵ Underage drinking is defined for individuals aged 12 to 20; therefore, the **P12-17** estimate reflects that age group and not individuals aged 12 or

older.

⁶ Tobacco Products include cigarettes, smokeless tobacco (i.e., chewing tobacco or snuff), cigars, or pipe tobacco.

⁷ Dependence or abuse is based on definitions found in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV).

⁸ Needing But Not Receiving Treatment refers to respondents classified as needing treatment for illicit drugs (or alcohol), but not receiving treatment for an illicit drug (or alcohol) problem at a specialty facility (i.e., drug and alcohol rehabilitation facilities [inpatient or outpatient], hospitals [inpatient only], or mental health centers).

⁹ Major depressive episode (MDE) is defined as in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV), which specifies a period of at least 2 weeks when an individual experienced a depressed mood or loss of interest or pleasure in daily activities and had a majority of specified depression symptoms. There are minor wording differences in the questions in the adult and adolescent MDE modules. Therefore, data from youths aged 12 to 17 were not combined with data from adults aged 18 or older to produce an estimate for those aged 12 or older.

¹⁰ Mental Illness is defined as having a diagnosable mental, behavioral, or emotional disorder, other than a developmental or substance use disorder, assessed by the Mental Health Surveillance Study (MHSS) *Structured Clinical Interview for the Diagnostic and Statistical Manual of Mental Disorders—Fourth Edition—Research Version—Axis I Disorders* (MHSS-SCID), which is based on the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV). Three categories of mental illness severity are defined based on the level of functional impairment: mild mental illness, moderate mental illness, and serious mental illness (SMI). Any mental illness (AMI) includes individuals in any of the three categories.

¹¹ Respondents were asked, "At any time in the past 12 months, did you seriously think about trying to kill yourself?" If they answered "Yes," they were categorized as having serious thoughts of suicide in the past year.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2013 and 2014.

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CONNECTICUT

Table 24 – Selected Drug Use, Perceptions of Great Risk, Average Annual Incidence Estimates of First Use of Marijuana, Past Year Substance Dependence or Abuse, Needing But Not Receiving Treatment, and Past Year Mental Health Measures in *Connecticut*, by Age Group: Percentages, Annual Averages Based on 2013-2014 NSDUHs

Measure	12+	12-17	18-25	26+	18+
ILLICIT DRUGS					
Past Month Illicit Drug Use ¹	9.91	9.53	24.25	7.65	9.95
Past Year Marijuana Use	14.00	15.65	38.82	9.83	13.83
Past Month Marijuana Use	8.50	7.91	22.41	6.34	8.56
Past Month Use of Illicit Drugs Other Than Marijuana ¹	3.13	2.89	6.36	2.64	3.15
Past Year Cocaine Use	2.17	0.61	6.66	1.64	2.33
Past Year Nonmedical Pain Reliever Use	3.75	4.08	8.55	2.94	3.72
Perception of Great Risk from Smoking Marijuana Once a Month	25.40	21.80	11.72	28.06	25.77
Average Annual Incidence Estimates of First Use of Marijuana ^{2,3}	2.29	7.10	9.01	0.25	1.42
ALCOHOL					
Past Month Alcohol Use	59.92	12.77	65.58	64.68	64.80
Past Month Binge Alcohol Use ⁴	23.54	6.29	42.22	22.63	25.33
Perception of Great Risk from Drinking Five or More Drinks Once or Twice a Week	40.47	39.44	30.68	42.17	40.58
Past Month Alcohol Use (Individuals Aged 12 to 20)	26.29 ⁵	--	--	--	--
Past Month Binge Alcohol Use (Individuals Aged 12 to 20) ⁴	16.24 ⁵	--	--	--	--
TOBACCO PRODUCTS					
Past Month Tobacco Product Use ⁶	21.16	6.83	35.61	20.56	22.64
Past Month Cigarette Use	16.91	4.44	29.50	16.40	18.21
Perception of Great Risk from Smoking One or More Packs of Cigarettes per Day	75.00	67.84	69.80	76.69	75.74

PAST YEAR DEPENDENCE, ABUSE, AND TREATMENT⁷					
Illicit Drug Dependence ¹	2.22	1.78	7.36	1.45	2.26
Illicit Drug Dependence or Abuse ¹	2.88	3.29	9.13	1.83	2.84
Alcohol Dependence	2.92	0.94	5.94	2.67	3.12
Alcohol Dependence or Abuse	6.76	2.71	14.15	6.06	7.18
Alcohol or Illicit Drug Dependence or Abuse ¹	8.43	4.67	19.17	7.16	8.82
Needing But Not Receiving Treatment for Illicit Drug Use ^{1,8}	2.47	3.13	7.63	1.56	2.40
Needing But Not Receiving Treatment for Alcohol Use ⁸	6.53	2.68	13.70	5.84	6.93
PAST YEAR MENTAL HEALTH ISSUES					
Major Depressive Episode ^{3,9}	--	9.70	8.40	5.65	6.03
Serious Mental Illness ^{3,10}	--	--	4.48	3.37	3.53
Any Mental Illness ^{3,10}	--	--	18.01	16.19	16.44
Had Serious Thoughts of Suicide ¹¹	--	--	6.85	2.78	3.34

-- Not available.

NOTE: Estimates are based on a survey-weighted hierarchical Bayes estimation approach.

¹ Illicit Drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically. Illicit Drugs Other Than Marijuana include cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically. These estimates include data from original methamphetamine questions but do not include new methamphetamine items added in 2005 and 2006.

² Average annual initiation of marijuana (%) = $100 \times \{[X_1 \div (0.5 \times X_1 + X_2)] \div 2\}$, where X_1 is the number of marijuana initiates in the past 24 months and X_2 is the number of individuals who never used marijuana (with the at-risk population defined as $0.5 \times X_1 + X_2$). Both of the computation components, X_1 and X_2 , are based on a survey-weighted hierarchical Bayes estimation approach. The age group shown is based on a respondent's age at the time of the interview, not his or her age at first use.

³ For details, see Section B of the "2011-2012 NSDUH: Guide to State Tables and Summary of Small Area Estimation Methodology" at <http://www.samhsa.gov/data/>.

⁴ Binge Alcohol Use is defined as drinking five or more drinks on the same occasion (i.e., at the same time or within a couple of hours of each other) on at least 1 day in the past 30 days.

⁵ Underage drinking is defined for individuals aged 12 to 20; therefore, the "12+" estimate reflects that age group and not individuals aged 12 or older.

⁶ Tobacco Products include cigarettes, smokeless tobacco (i.e., chewing tobacco or snuff), cigars, or pipe tobacco.

⁷ Dependence or abuse is based on definitions found in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)*.

⁸ Needing But Not Receiving Treatment refers to respondents classified as needing treatment for illicit drugs (or alcohol), but not receiving treatment for an illicit drug (or alcohol) problem at a specialty facility (i.e., drug and alcohol rehabilitation facilities [inpatient or outpatient], hospitals [inpatient only], or mental health centers).

⁹ Major depressive episode (MDE) is defined as in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)*, which specifies a period of at least 2 weeks when an individual experienced a depressed mood or loss of interest or pleasure in daily activities and had a majority of specified depression symptoms. There are minor wording differences in the questions in the adult and adolescent MDE modules. Therefore, data from youths aged 12 to 17 were not combined with data from adults aged 18 or older to produce an estimate for those aged 12 or older.

¹⁰ Mental Illness is defined as having a diagnosable mental, behavioral, or emotional disorder, other than a developmental or substance use disorder, assessed by the Mental Health Surveillance Study (MHSS) *Structured Clinical Interview for the Diagnostic and Statistical Manual of Mental Disorders—Fourth Edition—Research Version—Axis I Disorders (MHSS-SCID)*, which is based on the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)*. Three categories of mental illness severity are defined based on the level of functional impairment: mild mental illness, moderate mental illness, and serious mental illness (SMI). Any mental illness (AMI) includes individuals in any of the three categories.

¹¹ Respondents were asked, "At any time in the past 12 months, did you seriously think about trying to kill yourself?" If they answered "Yes," they were categorized as having serious thoughts of suicide in the past year.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2013 and 2014.

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DELAWARE

Table 25 – Selected Drug Use, Perceptions of Great Risk, Average Annual Marijuana Initiates, Past Year
P113

JOURNAL INQUIRER
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(860) 646-0500

*Public*
Notice
Pages

ORDER CONFIRMATION (CONTINUED)

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PUBLIC NOTICE

This notice is being circulated to the community pursuant to section 19a-638 of the CT general statute. Growing Potential Services: Therapeutic and Behavioral Solutions, PC, for Profit Corporation, is applying for a Certificate of Need for the following services to be provided at 139 and 141 Hazard Ave Enfield, CT 06082

Services Include:

- Medication Clinic
- Substance Abuse Consultation
- Outreach Services
- Child and Adult Day Treatment Programs
- Child and Adult Outpatient Psychiatric Services
- Developmental Screenings and Assessment of Childhood and Adolescence
- Psychological Testing
- Occupational Therapy
- Physical Therapy
- Speech and Language Therapy
- Psychiatric Testing for Diagnostic Clarification

The annual capital expenditure to fund this program will be \$461,580.00 per year.

Journal Inquirer
March 29, 2016
March 30, 2016
March 31, 2016

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MANCHESTER CT 06045-0510
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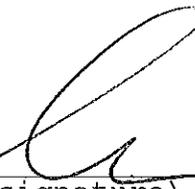
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Payment number:	113041		
Payment date:	03/28/16		
Amount:	377.76		
Payment description:	CLASSIFIED CREDIT CARD PA		

Ad Number:	88564	Class Code:	4000
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Sent: Thursday, May 19, 2016 3:45 PM
To: Growingpotentialservices@gmail.com
Cc: User, OHCA; Armah, Olga; Riggott, Kaila
Subject: Completeness Questions on CON Application # 16-32083
Attachments: 16-32083 Completeness.docx

Dear Ms. Taliceo,

Please see attached request for additional information regarding CON application 16-32083 – Establishment of a psychiatric outpatient extended day treatment and substance abuse or dependence treatment clinic for adults in Enfield. There are additional items that need to be addressed.

Please contact me if you have any questions. Responses are due by **Monday July 18, 2016**.

Regards.

Olga

Olga Armah, M. Phil

Associate Research Analyst
Office of Health Care Access
CT Department of Public Health
410 Capitol Avenue, MS #13HCA
P.O. Box 340308
Hartford, CT 06134

Phone: 860 418 7070

Fax: 860 418 7053

mailto: olga.armah@ct.gov

Web: www.ct.gov/ohca



STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH



Raul Pino, M.D., M.P.H.
Acting Commissioner

Dannel P. Malloy
Governor
Nancy Wyman
Lt. Governor

Office of Health Care Access

May 19, 2016

Via Email Only

Growingpotentialservices@gmail.com

Marcy Taliceo, CEO
Growing Potential Services: Therapeutic and
Behavioral Health Solutions, PC
141 Hazard Ave.
Enfield, CT 06082

RE: Certificate of Need Application; Docket Number: 16-32083-CON
Establishment of a Psychiatric Outpatient Day Treatment and Substance Abuse or
Dependence Treatment Clinic for Adults in Enfield
Connecticut Certificate of Need Completeness Letter

Dear Ms. Taliceo:

On April 21, the Department of Public Health ("DPH"), Office of Health Care Access ("OHCA") received the Certificate of Need ("CON") application from Growing Potential Services ("Applicant") proposing to establish a psychiatric outpatient day treatment clinic and a freestanding facility for the care or treatment of substance abuse or dependence for adults.

OHCA requests additional information pursuant to Connecticut General Statutes §19a-639a(c). *Please electronically confirm receipt of this email as soon as you receive it.* Provide responses to the questions below in both a Word document and PDF format at the earliest convenience as an attachment to a responding email. *Please email your responses to all of the following email addresses:* OHCA@ct.gov; olga.armah@ct.gov; and kaila.riggott@ct.gov.

Pursuant to Section 19a-639a(c) of the Connecticut General Statutes, 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 **July 18, 2016**, otherwise your application will be automatically considered withdrawn.



Phone: (860) 509-8000 • Fax: (860) 509-7184 • VP: (860) 899-1611
410 Capitol Avenue, P.O. Box 340308
Hartford, Connecticut 06134-0308
www.ct.gov/dph

Affirmative Action/Equal Opportunity Employer

Repeat each question before providing your response and paginate and date your response, i.e., each page, in its entirety. Information filed after the initial CON application submission (e.g., completeness response letter, prefile testimony, late file submissions and the like) must be numbered sequentially from the Applicant’s document preceding it. Please begin your submission using **Page 118** and reference “**Docket Number: 16-32083-CON.**”

1. The last paragraph on page 7 of the application indicates “...GPS currently serves adults in its outpatient group.”
 - a. What are the adult services licensed by the Department of Public Health that GPS currently provides?
 - b. Please provide a current valid copy of the DPH license if it exists. Note that DPH provider or facility licenses are different from the Health Inspections Certification attached on pages 17-18.

2. Page 8 of the application indicates “the community at large is in need of more day treatment options for adults.” Provide an expanded discussion of:
 - a. How the Applicant identified the adults in need of services in the proposed service area, including the specific clinical diagnosis(es) or condition(s);
 - b. What DPH licensed day treatment and substance disorder services GPS will be providing;
 - c. Supporting scholarly articles for the proposed treatments (attach relevant additional articles if necessary); and,
 - d. How adults, including low income persons, racial and ethnic minorities, disabled persons and other underserved groups in the service area will access the proposed services (e.g., through referrals from other providers or self referrals).

3. Utilizing supporting scholarly articles, indicate the prevalence rate(s) for the diagnoses/conditions identified in question 2a. Utilize the prevalence rate to estimate incidence rate for the service area population the Applicant proposes to serve. Populate the table below with the estimates and update the footnotes with the data source(s).

**TABLE 1
 ESTIMATE OF BEHAVIORAL HEALTH DISORDER(S) INCIDENCE IN CONNECTICUT**

BEHAVIORAL HEALTH DISORDER (Specify the disorder)	POPULATION (e.g. 18 years and above) ¹	PREVALENCE RATE ²	INCIDENCE (Population multiplied by prevalence rate)
Connecticut			
Proposed Service Area			
Service Area as Percent of Connecticut			

Sources:

¹ Indicate the relevant age group and provide the source of the population data (e.g., Census data).

² E.g., Substance and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality.

4. Which of the clinicians currently employed by GPS will provide the proposed services to adults? If GPS does not currently employ a clinician(s) with the requisite expertise, how many additional clinicians will GPS recruit and how?
5. Describe in detail any relationship(s) the Applicant has with other Connecticut or service area providers that will be the referral base for the proposed adult behavioral services. Identify the provider(s) by name and location, if possible.
6. Identify provider(s) by name and location in the service area that currently provide(s) the proposed services indicated in question 2b.
7. Provide a more detailed description of how the proposed services will reduce the costs of inpatient stays, as stated on page 12.
8. Provide at least one additional letter of support for the proposal.
9. Page 103, Table 3 shows the lease cost for the three GPS locations. Provide the annual lease cost for 141 Hazard Avenue, Enfield, only. Who is the owner of 141 Hazard Avenue, Enfield?
10. Provide a copy of GPS' 2015 federal tax returns.
11. The Financial Attachment I provided on pages 87-88 of the application is filled out incorrectly. For example, column (4) should reflect the sum of columns (2) and (3). Also, provide the actuals for FY 2015 and estimates for FY 2016-18, reflecting expected revenues and expenses with and without approval of this proposal. Submit a revised table and explicitly identify the fiscal years being reported by including them in the column headings. List the assumptions used to prepare the reported information.
12. Reconcile the data in Table 4 page 104 and Financial Attachment I pages 87-88 to ensure they are consistent. Update either or both tables as needed.
13. Page 106, Table 6 reports projected volumes. What are the assumptions used for projecting these volumes?
14. Reconcile the projected volumes in Table 6 with the current and projected payer mix on page 107, Table 7 and the volume statistics on page 88. Include data on only services licensed by DPH in both tables. Update Tables 6 & 7 to ensure their totals are consistent. Make sure the percent columns in Table 7 for each reported year add up to 100%, individually.
15. For DPH licensed services only, report the minimum number of clients required to show an incremental gain from operations for projected FYs 2016, 2017 and 2018.

16. Provide a discussion on GPS's private pay agreement with clients that are uninsured or underinsured. Will the Applicant provide these clients with a sliding fee schedule?

If you have any questions concerning this letter, please feel free to contact me at (860) 418-7001 or (860) 418-7070.

Sincerely,

Olga Armah
Associate Research Analyst

Greer, Leslie

From: growingpotentialservices <growingpotentialservices@gmail.com>
Sent: Thursday, May 19, 2016 7:36 PM
To: Armah, Olga
Cc: User, OHCA; Riggott, Kaila
Subject: RE: Completeness Questions on CON Application # 16-32083

Received. Thank you

Marcy

Sent from my Verizon, Samsung Galaxy smartphone

----- Original message -----

From: "Armah, Olga" <Olga.Armah@ct.gov>
Date: 5/19/16 3:45 PM (GMT-05:00)
To: Growingpotentialservices@gmail.com
Cc: "User, OHCA" <OHCA@ct.gov>, "Armah, Olga" <Olga.Armah@ct.gov>, "Riggott, Kaila" <Kaila.Riggott@ct.gov>
Subject: Completeness Questions on CON Application # 16-32083

Dear Ms. Taliceo,

Please see attached request for additional information regarding CON application 16-32083 – Establishment of a psychiatric outpatient extended day treatment and substance abuse or dependence treatment clinic for adults in Enfield. There are additional items that need to be addressed.

Please contact me if you have any questions. Responses are due by **Monday July 18, 2016**.

Regards.

Olga

Olga Armah, M. Phil

Greer, Leslie

From: User, OHCA
Subject: FW: Completeness Questions on CON Application # 16-32083
Attachments: Response to CON App page 118.doc

From: marcy taliceo [<mailto:growingpotentialservices@gmail.com>]
Sent: Friday, May 20, 2016 1:06 PM
To: Armah, Olga
Cc: User, OHCA; Riggott, Kaila
Subject: Re: Completeness Questions on CON Application # 16-32083

please see attached response

thank you

Marcy L. Taliceo, LPC, LMHC
Owner/ Clinical Director

Growing Potential Services: Therapeutic and Behavioral Solutions, PC
139 and 141 Hazard Ave
Enfield, CT 06082
860-698-6077 phone
860-698-6631 fax

www.growingpotentialservices.com

"And in the end it is not the years in your life that count, it's the life in your years." -Abraham Lincoln

This communication, including attachments, is for the exclusive use of the addressee and may contain proprietary, confidential and/or privileged information. If you are not the intended recipient, any use, copying, disclosure, dissemination or distribution is strictly prohibited. If you are not the intended recipient, please notify the sender immediately by return e-mail, and destroy this material in its entirety, whether electronic or hard copy.

1. **The last paragraph on page 7 of the application indicates “GPS currently serves adults in its outpatient group.”**
 - a. **What are the adult services licensed by the Department of Public Health that GPS currently provides?**
 - b. **Please provide a current valid copy of the DPH license if it exists. Note that DPH provider or facility licenses are different from the Health Inspections Certification attached on pages 17-18.**

Currently GPS is only licensed by DCF to provide services for children under 18yrs old in its Extended Day Program.

GPS has licensed clinicians (LPC, LCSW, LMFT, MD, BCBA) that currently see adults for outpatient services such as individual therapy, couple’s therapy, family and group therapy, Psychiatry. These services do not require licensing by a state agency except that everyone performing services is independently licensed as a qualified provider of their own expertise accordingly by Department of Public Health. These services are billed through mental health group services as defined by the insurance company.

2. **Page 8 of the application indicates “the community at large is in need of more day treatment options for adults.” Provide an expanded discussion of:**
 - a. **How the Applicant identified the adults in need of service area, including the specific clinical diagnosis(es) or condition (s);**

A questionnaire of our current clientele was indicative of more intensive programming that they have not been successful with or have not been able to locate in the town of Enfield. The demographics of the survey were as follows:

Age:	Women 18-69	Men 18-73
Count:	Women: 16	Men: 23
Dx:	Mood Disorder: 22	Substance Abuse/Dependency: 8
	Autism: 9	

Programs requested: Intensive Group Therapies (DBT, Substance recovery and support, Anger Management), Psychological Testing, Occupational Therapy, Physical Therapy, Case Management

- b. **What DPH licensed day treatment and substance disorder services GPS will be providing:**

Intensive Individual and Group Therapies (DBT, Substance recovery and support, Anger Management, Gender Specific Groups, Family Systems), Psychological Testing, Occupational Therapy, Physical Therapy, Case Management and Community Support, Medication Evaluations and Management, Skills Training

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c. Supporting scholarly articles for the proposed treatments (attach relevant additional articles if necessary):

Engaging Families into Child Mental Health Treatment Article:

P 187- Strength Based Approach: This article outlines the increased treatment approaches to the family system as a whole. While a child may be the “Identified Patient”, the whole family including parents and other adults are encouraged to build on family strengths and competencies. Encouraging adult family members to participate in family treatment as well as individually building on their skill set, may reduce the rate of childhood mental illness. **(See appendix A for more information)**

New Attachments: an article that represent the increasingly urgent matter of drug use and sales in the Town of Enfield. **(See Appendix B for more information)**

New Attachment from SAMHSA: statistics on Mental Health and Drug Use/Treatment in CT **(See Appendix C for more information)**

d. How adults, including low income persons, racial and ethnic minorities, disabled persons and other underserved groups in the service area will access the proposed services (e.g. through referrals from other providers or self-referrals).

The referral methods for Individuals to access care at GPS include but are not limited to: Walk-in, Self-referral, PCP, Community Providers, Family, Friends, other clinicians, DCF, DMHAS, DDS, court/probation, etc.

3. Utilizing supporting scholarly articles, indicate the prevalence rate(s) for the diagnoses/conditions identified in questions 2a. Utilize the prevalence rate to estimate incidence rate for the service area populations the Applicant proposes to serve. Populate the table below with the estimates and update the footnotes with the data source.

TABLE 1
ESTIMATE OF BEHAVIORAL HEALTH DISORDER(S) INCIDENCE IN CONNECTICUT

BEHAVIORAL HEALTH DISORDER	POPULATION: 18 AND OVER	PREVALENCE RATE	INCIDENCE
Substance Abuse 1. Connecticut 2. Hartford County	3,590,886 646,351	1. 9.1 % 2. 12%	1. 326,000 2. 79,950
Serious Mental Illness 1. Connecticut 2. Hartford County	3,590,886 646,351	1. 44.9% 2. 19.3%	1. 161,230 2. 124,745
Autism 1. Connecticut 2. Hartford County	3,590,886 646,351	<ul style="list-style-type: none"> • Not enough data available for individuals over 18 	<ul style="list-style-type: none"> • Not enough data available for individuals over 18
Service Area as percent of Connecticut 1. Substance Abuse 2. SMI 3. Autism	1. 18% 2. 18% 3. 18%	N/A	1. 42% 2. 77% 3. Not available

<http://www.census.gov/quickfacts/table/PST045215/09>

<http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=CF>

<http://www.census.gov/quickfacts/table/PST045215/09003>

http://www.samhsa.gov/data/sites/default/files/State_BHBarometers_2014_1/BHBarometer-CT.pdf

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4. Which of the clinicians currently employed by GPS will provide proposed services to adults? If GPS does not currently employ a clinician(s) with the requisite expertise how many additional clinicians will GPS recruit and how?

Adult Day Treatment Programs

- Day treatment groups
- Partial Hospitalization
- Medication Management
- Substance abuse consultations

These services will be provided by: Marcy Taliceo and Yvonne Kintgios. We will also be hiring an additional clinician to provide these services.

- Adult Outpatient Psychiatric Services including Psychiatric testing for diagnostic clarification-- Dr. Amit Rathi will provide these services.
- Psychological Testing--GPS will hire a Psychologist and/or Certified School Psychologist to perform these duties

Outreach Services

- Case Management
- Community Mentor Support

These services will be provided by: Mark Nassau, Kristen Pomeroy, Kelly Phelan, Corey Overstreet, Jamal Williams, Marquis Taliceo, Cynthia Ortiz and Helena Rosario.

Additional Services

- ADL skill assessment and training
- Social Skills

These services will be provided by Kaitlin Grout and Jessica Hickey.

- Occupational Therapy--GPS will hire an OTR-L to provide these services through job application websites
- Physical Therapy--GPS will hire a PT to provide these services through job application websites
- Speech Therapy--GPS will hire a SLP to provide these services through job application websites

5. Describe in detail any relationship(s) the Applicant has with other Connecticut or service area providers that will be the referral base for the proposed adult behavioral services. Identify the provider(s) by name and location, if possible.

Enfield Head Start
1270 Enfield St.
Enfield CT 06082

 Marcy Taliceo sits on the Policy Committee of Head Start in Enfield CT

Options Unlimited Inc.
693 Bloomfield Ave. #2
Bloomfield CT 06002

 Staff at Growing Potential Services provide behavioral consultations for the residential homes.

Elegant Clinical Day Program
488 Spring St.
Windsor Locks, CT 06096

 The owner of Elegant Clinical sits on the GPS Board of Directors.

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Allied Community Resources
3 Pearson Rd.
Enfield, CT 06082

Staff at Growing Potential Services provide behavioral consultations for the day programs.

Dr. Hemant K. Panchel
170 Hazard Ave.
Enfield CT, 06082

Community pediatrician who makes many referrals to programs including referrals for parents who need support.

Dr. Anne Marie Villa
150 Hazard Ave. Bldg. B
Enfield CT 06082

Community pediatrician who makes many referrals to programs including referrals for parents who need support.

North Central Community Collaborative (NCCC)

Marcy attends NCCC meetings and GPS has presented at meetings.

Key Initiatives to Early Education
Enfield KITE
1010 Enfield Street
Enfield, CT 06082

Local group community service providers who come together to help parents and infants/toddlers of Enfield. Marcy is a part of the group.

6. Identify provider(s) by name and location in the service area that currently provide(s) the proposed services indicated in question 2b.

Adult Day Treatments:

Manchester Memorial Hospital
71 Haynes St, Manchester, CT 06040

Intercommunity
281 Main St. East Hartford, CT 06118

Paces Counseling Associates, INC
477 Connecticut Blvd. East Hartford, CT

Adult Outpatient Psychiatric Services

Catholic Charities
896 Asylum Avenue, Hartford, CT 06105-1901

Charter Oak Health Center
21 Grand Street Hartford, CT 06106

Community Health Center, Inc.
635 Main Street Middletown, CT 06457

Community Health Services, Inc.

Growing Potential Services, Docket # 16-32083-CON

500 Albany Avenue Hartford, CT 06120

Community Health Resources

153 Hazard Avenue, Enfield, CT 06082

Community Renewal Team

555 Windsor St. Hartford, CT 06106

East Hartford Community HealthCare, Inc.

94 Connecticut Boulevard East Hartford, CT 06108

Hartford Behavioral Health

1 & 2550 Main St. Hartford, CT 06106

Intercommunity

281 Main St. East Hartford, CT 06118

Manchester Memorial Hospital

71 Haynes St, Manchester, CT 06040

New Directions, Inc. of North Central Conn.

113 Elm Street, Suite 204 Enfield, CT 06082

Paces Counseling Associates, INC

477 Connecticut Blvd. East Hartford, CT

South Bay Mental Health Center

237 Hamilton St. STE 205, Hartford, CT 06106

Wheeler Clinic

999 Asylum Ave. Hartford, CT 06106

Medication Management

Charter Oak Health Center

21 Grand Street Hartford, CT 06106

Community Health Services, Inc.

500 Albany Avenue Hartford, CT 06120

Community Health Resources

153 Hazard Avenue, Enfield, CT 06082

Community Substance Abuse Centers

55 Fishfry Street Hartford, CT 06120

Hartford Behavioral Health

1 & 2550 Main St. Hartford, CT 06106

Intercommunity

281 Main St. East Hartford, CT 06118

Growing Potential Services, Docket # 16-32083-CON

South Bay Mental Health Center
237 Hamilton St. STE 205, Hartford, CT 06106

Case Management

Charter Oak Health Center
21 Grand Street Hartford, CT 06106

Community Health Resources
153 Hazard Avenue, Enfield, CT 06082

Community Health Services, Inc.
500 Albany Avenue Hartford, CT 06120

Wheeler Clinic
999 Asylum Ave. Hartford, CT 06106

Substance Abuse

Catholic Charities
896 Asylum Avenue, Hartford, CT 06105-1901

Charter Oak Health Center
21 Grand Street Hartford, CT 06106

Community Health Resources
153 Hazard Avenue, Enfield, CT 06082

Community Health Services, Inc.
500 Albany Avenue Hartford, CT 06120

Community Renewal Team
555 Windsor St. Hartford, CT 06106

Community Substance Abuse Centers
55 Fishfry Street Hartford, CT 06120

Hartford Behavioral Health
1 & 2550 Main St. Hartford, CT 06106

Intercommunity
281 Main St. East Hartford, CT 06118

New Directions, Inc. of North Central Conn.
113 Elm Street, Suite 204 Enfield, CT 06082

Paces Counseling Associates, INC
477 Connecticut Blvd. East Hartford, CT

South Bay Mental Health Center
237 Hamilton St. STE 205, Hartford, CT 06106

Wheeler Clinic

Growing Potential Services, Docket # 16-32083-CON

999 Asylum Ave. Hartford, CT 06106

Partial Hospitalization

Community Health Resources

153 Hazard Avenue, Enfield, CT 06082

Intercommunity

281 Main St. East Hartford, CT 06118

New Directions, Inc. of North Central Conn.

113 Elm Street, Suite 204, Enfield, CT 06082

Paces Counseling Associates, INC

477 Connecticut Blvd. East Hartford, CT

South Bay Mental Health Center

237 Hamilton St. STE 205, Hartford, CT 06106

Autism Services

Wheeler Clinic (Only up to age 24)

999 Asylum Ave. Hartford, CT 06106

ADL Skill Assessment

None

Speech and Language

None

Social Skills Training

None

Community Mentor Support

Community Health Resources

153 Hazard Avenue, Enfield, CT 06082

Psychological Testing

Community Health Resources

153 Hazard Avenue, Enfield, CT 06082

Occupational Therapy

None

Life Skills Training

None

7. Provide a more detailed description of how the proposed services will reduce the costs of inpatient stays, as stated on page 12. (See Appendix D for more information)

According to the article *Bringing Behavioral Health into the Care Continuum: Opportunities to Improve Quality, Costs and Outcomes*, in 2012 68% of American adults with mental health conditions also had medical conditions. Of those who have comorbid mental health and medical conditions, 37% adults

Growing Potential Services, Docket # 16-32083-CON

admitted to hospitals were readmitted within 1 year compared to the 27% without mental health conditions. Further research from the article concludes that mental health conditions can increase the severity of mental health conditions. Therefore, if outpatient mental health services are provided to Connecticut adults, the costs of inpatient stays for mental health conditions can be reduced. With a mean cost per inpatient stay of \$6300 for adults with mental health conditions (Statistical Brief #191), decreasing the number of inpatient stays is critical in decreasing the costs of mental health services.

Little research has been performed to address the cost of adult outpatient mental health services in Connecticut. This is most likely because up until recently Connecticut has put its main focus on inpatient and crisis services--the system has been more reactive than proactive. As mentioned previously, when provided outpatient services after inpatient services, adults were less likely to return inpatient. It can only be assumed that if outpatient services are provided early on, there would be even fewer inpatient stays.

Between 2004-2009, in Connecticut only 4% of adults received outpatient non-specialty mental health treatment and only 1% of adults served by the State Mental Health Agency responsible for the administration of the SAMHSA Community Mental Health Block Grant received Assertive Community Services even though the population of adults with mental health problems is much higher. (Mental Health Association of Rhode Island, 2013) From 2005-2010, the number of psychiatric beds in Connecticut decreased 14% to 741: this number is 43% lower than the recommended targeted beds per capita. The budgets for mental health services is only decreasing and with an average cost of \$6300 per stay, again, outpatient services can help to offset the costs.

In addition, Sullo (2015) explained that in 2015, of the 16,645 inmates in state prisons, 21% had mental illness. Many of these prisoners are low-level offenders who judges are hesitant to release back into the community due to lack of family or community support. Those that are released back into the community are likely to end back in front of a judge, tying up the judicial system. It costs the state \$45,000 each year to house an inmate without mental health conditions and it is estimated that an inmate with mental health conditions can cost 2-3 times that amount. One of the goals of outpatient services is to reduce the number of first time offenders, another goal is to provide offenders with services that can support them in the community rather than jail.

7. Provide at least one more additional letter of support for the proposal.

Please see attached letter of support from a local educator. **(See appendix E for more information)**

9. Page 103, Table 3 shows the lease cost for the three GPS locations. Provide the annual lease cost for 141 Hazard Ave, Enfield only. Who is the owner of the 141 Avenue, Enfield?

GPS has decided not to expand to the third location. GPS will remain with two: 139 and 141 Hazard Ave, Enfield

Annual lease cost for 141 Hazard Ave, Enfield is \$30,000

The owner is:
Dr. Hemant Panchal
170 Hazard Ave
Enfield, CT

Growing Potential Services, Docket # 16-32083-CON

10. Provide a copy of GPS' 2015 federal tax returns. (See Appendix F for more information)

Please see attached.

11. The Financial Attachment I provided on pages 87-88 of the application is filled out incorrectly. (See Appendix G) For example, column (4) should reflect the sum of the columns (2) and (3). Also, provide the actuals for FY2015 and estimates for FY 2016-18, reflecting expected revenues and expenses with and without approval of this proposal. Submit a revised table and explicitly identify the fiscal years being reported by including them in the column headings. List the assumptions used to prepare the reported information. (Please see Appendix C for more information)

Please see attached chart with revisions. Data from SAMHSA indicates a steady rate and some increase in the diagnosis of serious mental illness in CT. 93,000 CT adults had serious thoughts of suicide each year between 2009-2013 indicating a clear and steady need for service availability for individuals in the CT community. With new services provided by GPS, the hope is that some of these 93,000 individuals will have mental health relief by reaching out for services.¹

12. Reconcile the data in Table 4 page 104 and Financial Attachment I pages 87-88 to ensure they are consistent. Update either or both tables as needed.

**TABLE 4
PROJECTED INCREMENTAL REVENUES AND EXPENSES**

	FY 2016_*	FY 2017__*	FY 2018__*
Revenue from Operations	\$30,307.00	\$146,813	\$ 334,222
Total Operating Expenses	\$5,758.00	\$ 96,394	\$112,088
Gain/Loss from Operations	\$8,642.00	\$50,519	\$222,134

* Fill in years using those reported in the Financial Worksheet attached.

13. Page 106, Table 6 reports projected volumes. What are the assumptions used for projecting these volumes?

The assumptions used are based on company capacity and availability for future care of clients. Based on the data included in this package, the need to increase services in Hartford County is great. GPS hopes to increase volume to better service the community at large.

Data was gather from the SAMHSA, National Survey on Drug Use and Health.
(Same article labeled Appendix C)

Data was also derived from NAMI.org CT State Statistics.
(See Appendix H for more information)

1

14. Reconcile the projected volumes in Table 6 with the current and projected payer mix on page 107, Table 7 and the volume of statistics on page 88. Include date on only services licensed by DPH in both tables. Update Tables 6 and 7 to ensure their totals are consistent. Make sure the percent columns in Table 7 for each reported year add up to 100% individually.

(See Appendix I for Table 6 revision)

**TABLE 7
APPLICANT'S CURRENT & PROJECTED PAYER MIX**

Payer	Current		Projected					
	FY 2016_**		FY 2017_**		FY 2018_**		FY 2019**	
	Discharges	%	Discharges	%	Discharges	%	Discharges	%
Medicare*								
Medicaid*	10	67%	286	79%	365	73%		
CHAMPUS & Tricare								
Total Government	10		286		365			
Commercial Insurers	5	33%	46	13%	73	14%		
Uninsured			32	8%	68	13%		
Workers Compensation								
Total Non- Government	5		78		141			
Total Payer Mix	15	100%	364	100%	506	100%		

* Includes managed care activity.

** Fill in years. Ensure the period covered by this table corresponds to the period covered in the projections provided. New programs may leave the "current" column blank.

5. For DPH licensed services only, report the minimum number of clients required to show an incremental gain from operations for projected FY 2016, 2017 and 2018.

The estimated number of clients required to show annual gain are as follows:

FY 2016- (partial year): Increment of 76

FY 2017- Increment of 309

FY 2018- Increment of 390

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16. Provide a discussion on GPS's private pay agreement with clients that are uninsured or underinsured. Will the Applicant provide these clients with a sliding fee schedule?

All clients will be advised of and sign the following consent for payment at which time they can discuss a sliding fee schedule:

“PAYMENT GUARANTEE

In consideration of the services rendered and to be rendered to the above named patient by GPS, I expressly understand that I (not my insurance company) am responsible for full payment of GPS fees, co-payments, deductibles, non-covered services or services which my insurance carrier may determine to be “not medically necessary” or beyond what they determine to be their maximum allowable charges and as such guarantee payment of the account and agree to pay any charges left unpaid in whole or in part. I have received a copy of the fee structure for GPS services. A sliding fee schedule is available upon request and review of financial information. _____ **Initial “**

Below are the sliding fee program guidelines.

Growing Potential Services Sliding Fee Discount Program

What is the Sliding-fee Discount Program?

The GPS sliding-fee discount program is available to anyone that qualifies based on income and family size who is receiving any service over \$80.00 per hour.

Typically, the discount program benefits individuals who are uninsured, have high deductibles, or have low income. This program provides a discount off of the clinics normal charges and applies to most, but not all, of the services. If you think you may qualify, please review the following pages carefully as it provides all the information you need to get started.

How does the Sliding-fee Discount Program work?

We review your current income and family size to see if you qualify for the program.

What do I need to bring with me?

In order to apply, you will need to provide the following materials and information:

1. Proof of Medicaid coverage denial during the prior 90 days (example: letter of denial).
2. Photo identification and a recently postmarked (within previous 30 days) piece of mail indicating a current address (example: utility bill, bank statement, etc.).
3. Proof of household income and family size. (example: Federal tax return, recent paystubs, etc.). For pay stubs, four current and consecutive stubs are needed if you are paid weekly. If paid bi-weekly, two current and consecutive stubs are needed.
4. If you are married or have a family, you will need to provide identification and proof of income for everyone in the family.

What happens next?

1. The eligibility representative will determine if you qualify and if so, your level of discount.
3. We will notify you, in writing, if you qualify for our discount program.
4. Once approved, you must report any change in your income, family size or insurance status.

(The schedule below is based on federal poverty guidelines)

The discounted rate is due before every appointment. Your income will be verified every 6 months.

Growing Potential Services, Docket # 16-32083-CON

Family Size	Annual Income	Discount Rate
1 Person	\$ 16,242	30%
2 Person	\$21,983	35%
3 Person	\$ 27,724	40%
4 Person	\$ 33,465	45%
5 Person	\$39,205	50%
6 Person	\$ 44,946	55%
7 Person	\$ 50,687	60%
8 Person	\$ 56,428	65%

If you have any question regarding the sliding fee discount, please call Marcy Taliceo, LPC 860-698-6077.

Appendix A

Engaging Families into Child Mental Health Treatment: Updates and Special Considerations, May 2010.

http://www.ctacny.com/uploads/7/6/4/8/7648957/article-engaging_families-mckay-bannon.pdf

Appendix B

Article 1-

<http://www.courant.com/breaking-news/hc-enfield-drug-bust-1218-20151217-story.html>

Enfield Police Rounding Up Suspects in Narcotics Sweep

Mikaela Porter Contact Reporter

In 14 months, Enfield PD have charged 50 with felony drug charges after cracking down on issue in town

ENFIELD — Officers last week swept through town searching for 12 suspects they acquired warrants for related to an ongoing narcotics investigation, police said. In a little over a year, this year's investigation and a similar one last year resulted in the arrests of nearly 50 people on felony drug charges, Police Chief Carl Sferrazza said last week. Many of those arrested, he said, are now serving lengthy prison sentences.

The two investigations centered on heroin, oxycodone and cocaine sales, Sferrazza said, and included detectives making undercover drug purchases, Sferrazza said. Last year's investigation resulted in 23 arrests. Seven were arrested Thursday and three were arrested Friday, police said.

Growing Potential Services, Docket # 16-32083-CON

Thursday's arrests included:

Anthony Vincenze, 21, of West Suffield, charged with sale of certain illegal drugs and conspiracy to commit sale of certain illegal drugs. Shauna Lateano, 19, of West Suffield, charged with sale of certain illegal drugs and conspiracy to commit sale of certain illegal drugs.

Sally Taylor, 46, no known address, charged with conspiracy to obtain a controlled drug prescription through forgery and second-degree forgery. Kenneth Griggs, 22, of Windsor, charged with sale of certain illegal drugs, second-degree forgery and obtaining a controlled drug prescription through forgery. Dylan Branch, 23, of Enfield, charged with sale of certain illegal drugs and sale of controlled substance.

Terrence Jones, 25, no known address, charged with sale of hallucinogen narcotic. Chelsea St. Hilaire, 24, no known address, charged with sale of certain illegal drugs.

Friday's arrests included:

Carlos Morales, 31, of no certain address, charged with sales of narcotics and conspiracy to commit sale of narcotics. Danielle Cyr, 22, of Broad Brook, charged with sales of narcotics and conspiracy to commit sale of narcotics. Joseph Scirica, 44, of Enfield, charged with sale of hallucinogen narcotic. The investigation, which started earlier this year, has already led to the arrests of 15 individuals on narcotics charges.

"In a 14-month period, close to 50 drug dealers in town have been arrested," Sferrazza said. "We're extremely pleased at the work we've done. Our department is laser-focused on narcotics activity, as heroin is a public health issue." Sferrazza said the department has seen its fair share of overdoses, near-deaths and crimes associated with heroin use, but it is prepared to dedicate the resources necessary to combat the problem in town.

Growing Potential Services, Docket # 16-32083-CON

"We don't labor under any false pretenses that we eliminated the drug problem in our community," Sferrazza said. "We're prepared to put forth the resource to show these dealers that this type of behavior won't be tolerated."

Courant staff writers Nicholas Rondinone and David Moran contributed to this story.

Article 2-

<http://patch.com/connecticut/enfield/three-arrested-enfield-drug-bust-0>

ENFIELD, CT - Three people were arrested on drug charges Thursday afternoon after a narcotics task force executed search and seizure warrants at a Route 5 motel.

Kiley Russell, 25, of 5 Cantlewood Dr., Somers, was charged with three counts of sale of certain illegal drugs and possession of narcotics. She was held on \$160,000 bond.

Frank Wien, 27, of no certain address, was charged with sale of certain illegal drugs, possession of narcotics and violation of probation. His bond was set at \$85,000.

Marlene Corey, 42, of no certain address, was charged with possession of narcotics, use of drug paraphernalia, first-degree criminal trespass, second-degree failure to appear, violation of probation and failure to respond to an infraction. She was held on bonds totaling \$80,886.

Deputy Police Chief Gary Collins said members of the North Central Regional Narcotics Task Force executed the warrants around 1:45 p.m. at the Enfield Inn on King Street. In addition to the charges outlined in the warrants, each suspect was found to be in possession of heroin.

The trio was scheduled to be arraigned Friday in Enfield Superior Court.

Photos courtesy of Enfield Police Department

Growing Potential Services, Docket # 16-32083-CON

Appendix C

http://www.samhsa.gov/data/sites/default/files/State_BHBarometers_2014_1/BHBarometer-CT.pdf

pdf also attached

Appendix D

(2012, January). Bringing Behavioral Health into the Care Continuum: Opportunities to Improve Quality, Costs and Outcomes. *American Hospital Association*. 1-12.

<http://www.aha.org/research/reports/tw/12jan-tw-behavhealth.pdf>

(2013, December). Mental Health Measures: Rhode Island, New England, United States. *Mental Health Association of Rhode Island*. 1-41.

http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/MHARI_Mental_Health_Measures_final.pdf

(2015, June). Statistical Brief #191. *Healthcare Costs and Utilization Project*. 1-14. <https://www.hcup-us.ahrq.gov/reports/statbriefs/sb191-Hospitalization-Mental-Substance-Use-Disorders-2012.pdf>

Office of Research and Public Affairs. (2016). Retrieved from: <http://www.tacreports.org/tables>

Sullo, Michelle Tuccitto.(April 24, 2015). Connecticut's mentally ill need services, not prison, lawyers say

New Haven Register. <http://www.nhregister.com/article/NH/20150425/NEWS/150429643>

Appendix E

Please see attached PDF letter of recommendation

Appendix F

Please see attached copy of 2015 tax returns

Appendix G

Please see attached pdf updated spreadsheet

Appendix H

See attached article.

NAMI State Advocacy 2010.

Appendix I

See attached pdf chart

#2, C

Appendix B

LATEST» Sound Bars, Wallet Phone Case, Crocs, Texas: Friday's Best Deals (<http://patch.com/connecticut/enfield/s/fr2no/sound-bars-wallet-phone-case-crocs-tevas-fridays-best-deals>)

Three Arrested in Enfield Drug Bust

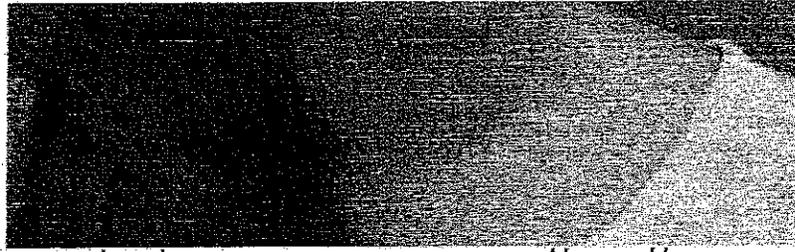
Search and seizure warrants at an Enfield motel led to narcotics charges against three individuals.

Enfield, CT

Like Share 241

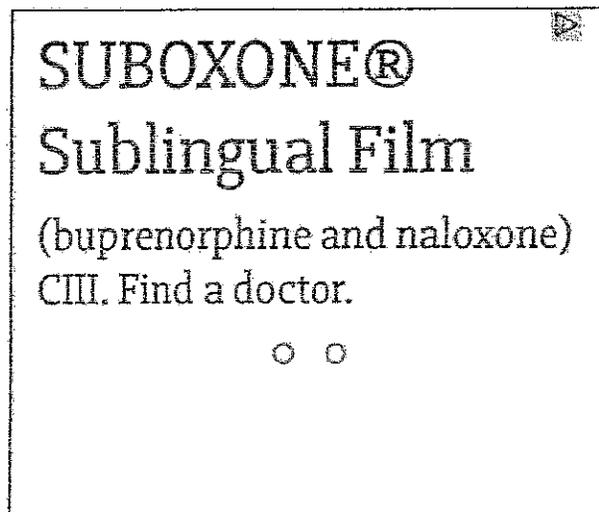
By TIM JENSEN (Patch Staff) - (<http://patch.com/users/tim-jensen>) ☺ May 6, 2016 10:36 am ET





after a narcotics task force executed search and seizure warrants at a Route 5 motel.

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Deputy Police Chief Gary Collins said members of the North Central Regional Narcotics Task Force executed the warrants around 1:45 p.m. at the Enfield Inn on King Street. In addition to the charges outlined in the warrants, each suspect was found to be in possession of heroin. * * *

The trio was scheduled to be arraigned Friday in Enfield Superior Court.

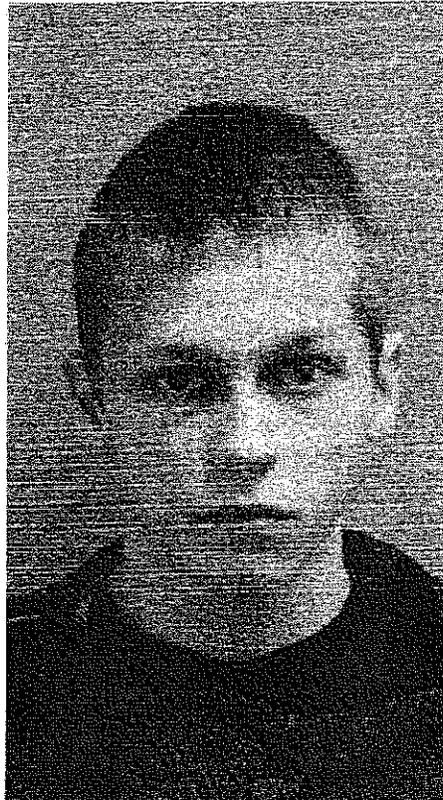
Photos courtesy of Enfield Police Department

More from Across Patch

- Sound Bars, Wallet Phone Case, Crocs, Texas: Friday's Best Deals
(<http://patch.com/connecticut/sound-bars-wallet-phone-case-crocs-texas-fridays-best-deals>)
- 157 Pregnant Women In U.S. Show 'Laboratory Evidence' Of Possible Zika, CDC Says
(<http://patch.com/connecticut/157-pregnant-women-in-u-s-show-laboratory-evidence-of-possible-zika-cdc-says>)
- Giant 'Man-Eating' Crocodiles May Be Florida's Newest Residents, Researchers Say
(<http://patch.com/connecticut/giant-man-eating-crocodiles-may-be-floridas-newest-residents-researchers-say>)
- FDA Makes Clear: Eating Whole Bag of Chips Not a

Breaking News

Enfield Police Rounding Up Suspects In Narcotics Sweep



#2.C

Appendix B



By **Mikaela Porter** · Contact Reporter

DECEMBER 21, 2015, 11:31 AM

ENFIELD — Officers last week swept through town searching for 12 suspects they acquired warrants for related to an ongoing narcotics investigation, police said.

In a little over a year, this year's investigation and a similar one last year resulted in the arrests of nearly 50 people on felony drug charges, Police Chief Carl Sferrazza said last week. Many of those arrested, he said, are now serving lengthy prison sentences.

ADVERTISING



The two investigations centered on heroin, oxycodone and cocaine sales, Sferrazza said, and included detectives making undercover drug purchases, Sferrazza said. Last year's investigation resulted in 23 arrests.

Seven were arrested Thursday and three were arrested Friday, police said.

Thursday's arrests included:

Anthony Vincenzo, 21, of West Suffield, charged with sale of certain illegal drugs and conspiracy to commit sale of certain illegal drugs.

Shauna Lateano, 19, of West Suffield, charged with sale of certain illegal drugs and conspiracy to commit sale of certain illegal drugs.

Sally Taylor, 46, no known address, charged with conspiracy to obtain a controlled drug prescription through forgery and second-degree forgery.

Kenneth Griggs, 22, of Windsor, charged with sale of certain illegal drugs, second-degree forgery and obtaining a controlled drug prescription through forgery.

Dylan Branch, 23, of Enfield, charged with sale of certain illegal drugs and sale of controlled substance.

Terrence Jones, 25, no known address, charged with sale of hallucinogen narcotic.

Chelsea St. Hilaire, 24, no known address, charged with sale of certain illegal drugs.

Friday's arrests included:

Carlos Morales, 31, of no certain address, charged with sales of narcotics and conspiracy to commit sale

of narcotics.

Danielle Cyr, 22, of Broad Brook, charged with sales of narcotics and conspiracy to commit sale of narcotics.

Joseph Scirica, 44, of Enfield, charged with sale of hallucinogen narcotic.

The investigation, which started earlier this year, has already led to the arrests of 15 individuals on narcotics charges.

* * *
"In a 14-month period, close to 50 drug dealers in town have been arrested," Sferrazza said. "We're extremely pleased at the work we've done. Our department is laser-focused on narcotics activity, as heroin is a public health issue."

Sferrazza said the department has seen its fair share of overdoses, near-deaths and crimes associated with heroin use, but it is prepared to dedicate the resources necessary to combat the problem in town.

* * * * *
"We don't labor under any false pretenses that we eliminated the drug problem in our community," Sferrazza said. "We're prepared to put forth the resource to show these dealers that this type of behavior won't be tolerated."

Courant staff writers Nicholas Rondinone and David Moran contributed to this story.

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This article is related to: Drug Trafficking, Drugs and Medicines, Crime

MENTAL HEALTH AND TREATMENT

THOUGHTS OF SUICIDE



Past-Year Serious Thoughts of Suicide Among Adults Aged 18 or Older in Connecticut and the United States (2009–2013)^{1,4}

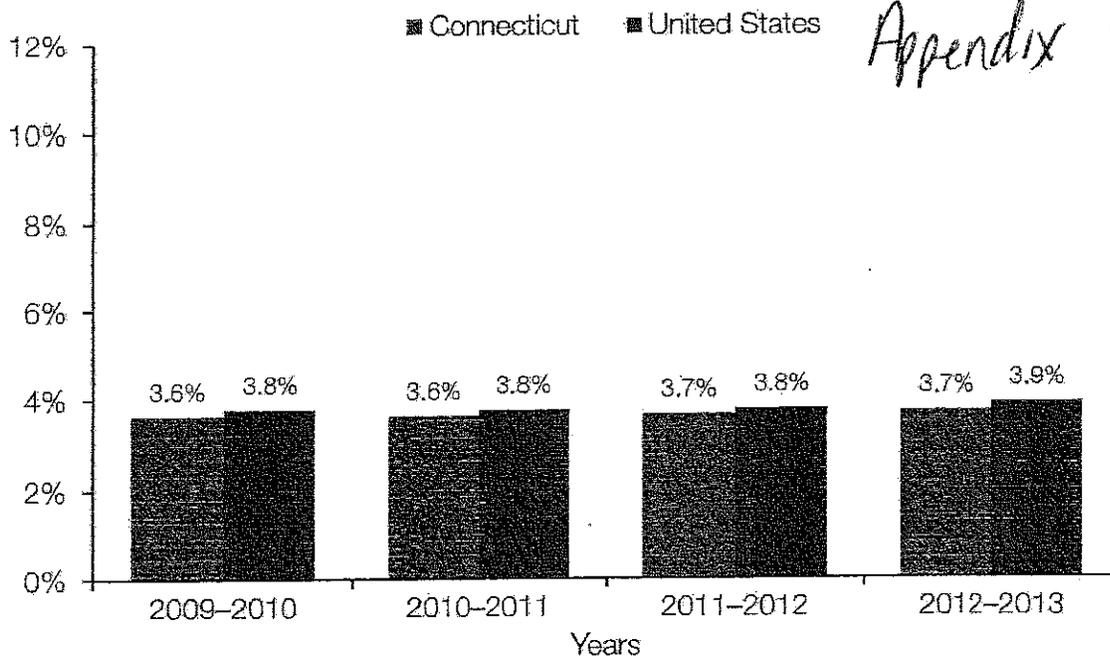
Connecticut's percentage of adults with suicidal thoughts was similar to the national percentage in 2012–2013.

#2, C

Docket #

16-32083-CON

Appendix C



In Connecticut, about 93,000 adults (3.5% of all adults) in 2009–2013* had serious thoughts of suicide within the year prior to being surveyed. The percentage did not change significantly over this period.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2009 to 2013.

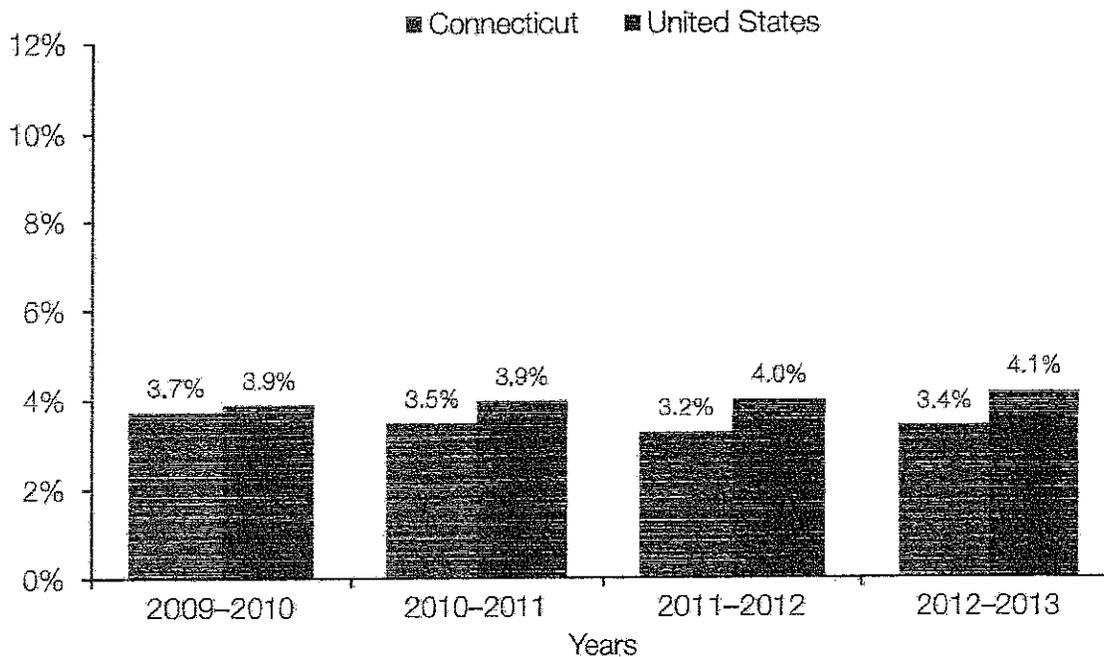
*These estimates are based on combined data from multiple years of the National Survey of Drug Use and Health (NSDUH), whereas estimates in the accompanying figure are from an estimation procedure that uses 2 consecutive years of NSDUH data plus other information from the state. The estimates from these two methods may differ. For more information, please see Figure Notes 1 and 2 on p. 19.

MENTAL HEALTH AND TREATMENT

SERIOUS MENTAL ILLNESS

Past-Year Serious Mental Illness (SMI) Among Adults Aged 18 or Older in Connecticut and the United States (2009–2013)^{1,5}

Connecticut's percentage of SMI among adults was similar to the national percentage in 2012–2013.



In Connecticut, about 82,000 adults (3.0% of all adults) per year in 2009–2013* had SMI within the year prior to being surveyed.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2009 to 2013.

*These estimates are based on combined data from multiple years of the National Survey of Drug Use and Health (NSDUH), whereas estimates in the accompanying figure are from an estimation procedure that uses 2 consecutive years of NSDUH data plus other information from the state. The estimates from these two methods may differ. For more information, please see Figure Notes 1 and 2 on p. 19.

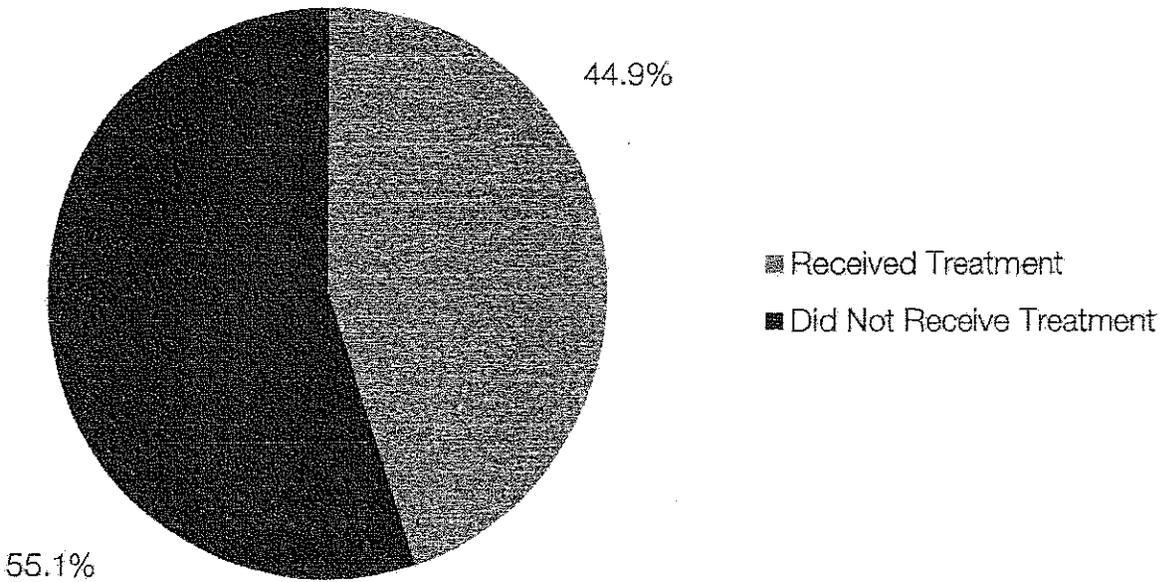
MENTAL HEALTH AND TREATMENT

TREATMENT FOR ANY MENTAL ILLNESS



Past-Year Mental Health Treatment/Counseling Among Adults Aged 18 or Older with Any Mental Illness (AMI) in Connecticut (2009–2013)²

Connecticut's percentage of mental health treatment among adults with AMI was similar to the national percentage in 2009–2013.



In Connecticut, about 200,000 adults with AMI (44.9% of all adults with AMI) per year in 2009–2013 received mental health treatment or counseling within the year prior to being surveyed.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2009 to 2013.

MENTAL HEALTH AND TREATMENT

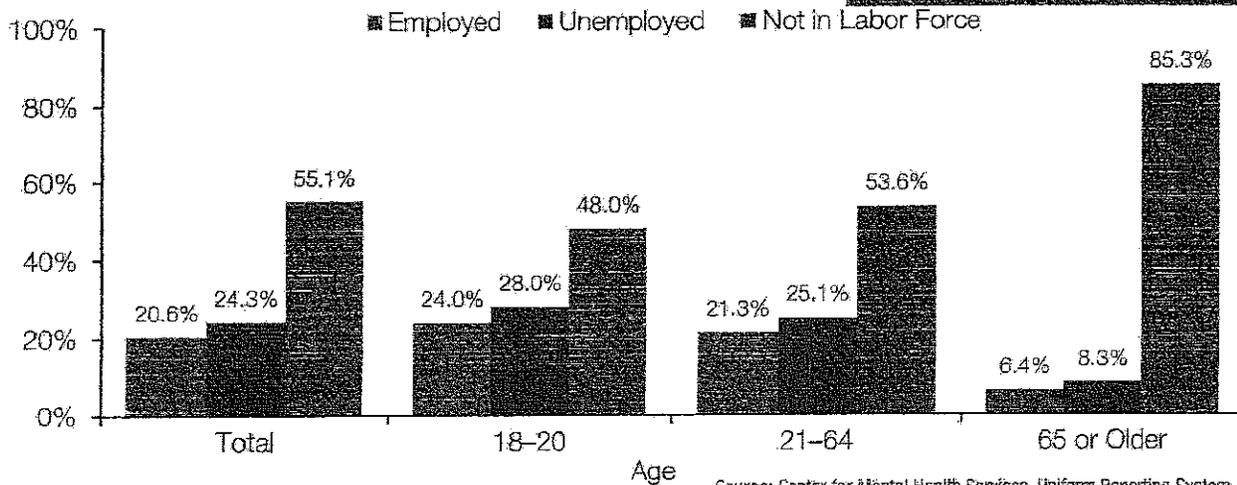
MENTAL HEALTH CONSUMERS



Adult Mental Health Consumers Served in the Public Mental Health System in Connecticut, by Employment Status and Age (2013)⁶

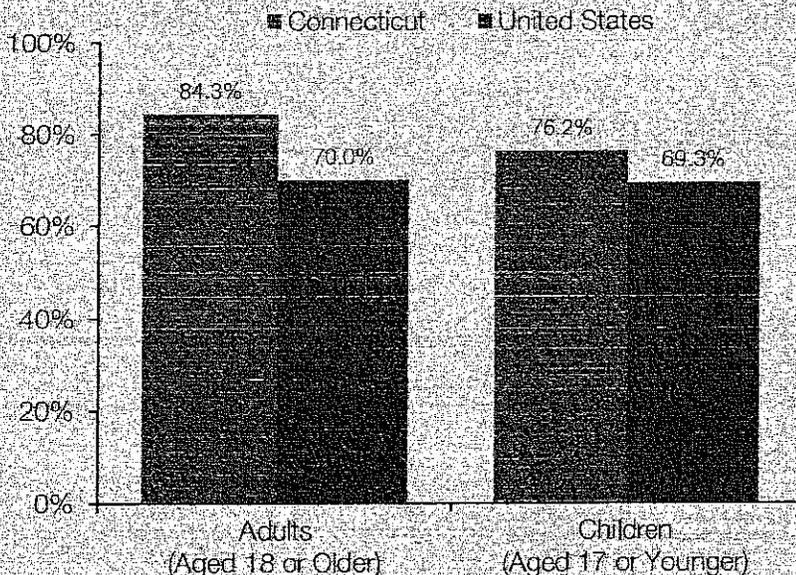
Among adults served in Connecticut's public mental health system in 2013, 48.0% of those aged 18-20, 53.6% of those aged 21-64, and 85.3% of those aged 65 or older were not in the labor force.

In 2013, 31,398 children and adolescents were served in Connecticut's public mental health system.



Source: Center for Mental Health Services, Uniform Reporting System, 2013.

Mental Health Consumers in Connecticut and the United States Reporting Improved Functioning from Treatment Received in the Public Mental Health System (2013)⁶

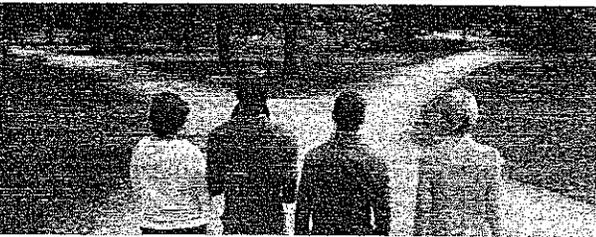


The percentage of adolescents reporting improved functioning from treatment received through the public mental health system was higher in Connecticut than in the nation as a whole.

Source: Center for Mental Health Services, Uniform Reporting System, 2013.

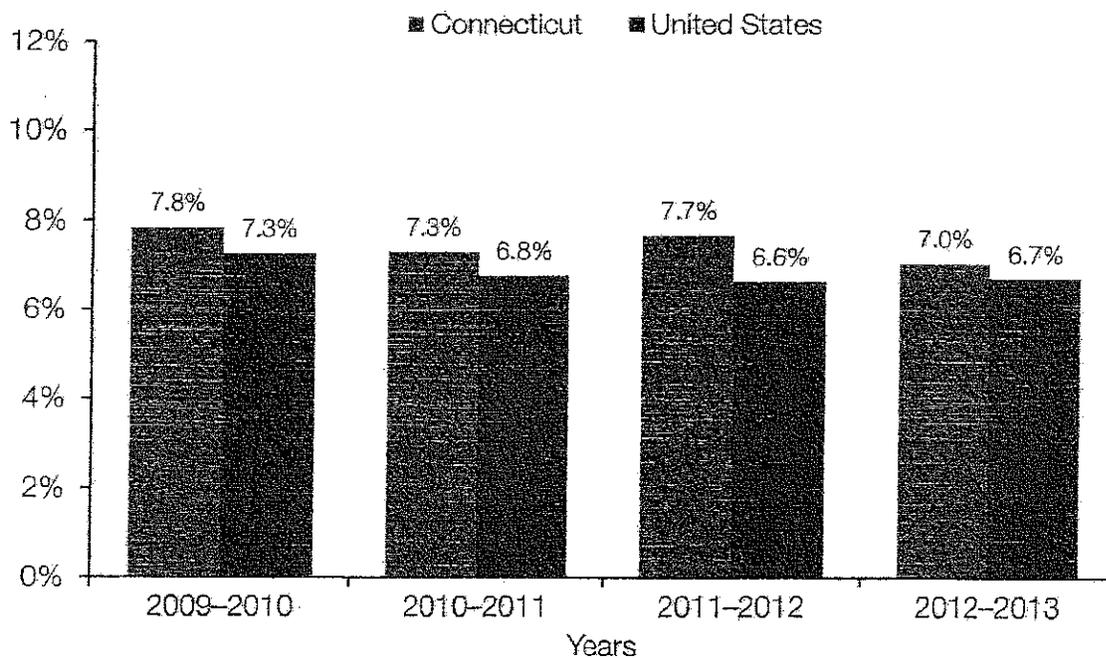
SUBSTANCE USE

ALCOHOL DEPENDENCE OR ABUSE



Past-Year Alcohol Dependence or Abuse Among Individuals Aged 12 or Older in Connecticut and the United States (2009–2013)¹

Connecticut's percentage of alcohol dependence or abuse among individuals aged 12 or older was similar to the national percentage in 2012–2013.



8.1%

In Connecticut, about 243,000 individuals aged 12 or older (8.1% of all individuals in this age group) per year in 2009–2013* were dependent on or abused alcohol within the year prior to being surveyed. The percentage did not change significantly over this period.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2009 to 2013.

*These estimates are based on combined data from multiple years of the National Survey of Drug Use and Health (NSDUH), whereas estimates in the accompanying figure are from an estimation procedure that uses 2 consecutive years of NSDUH data plus other information from the state. The estimates from these two methods may differ. For more information, please see Figure Notes 1 and 2 on p. 19.

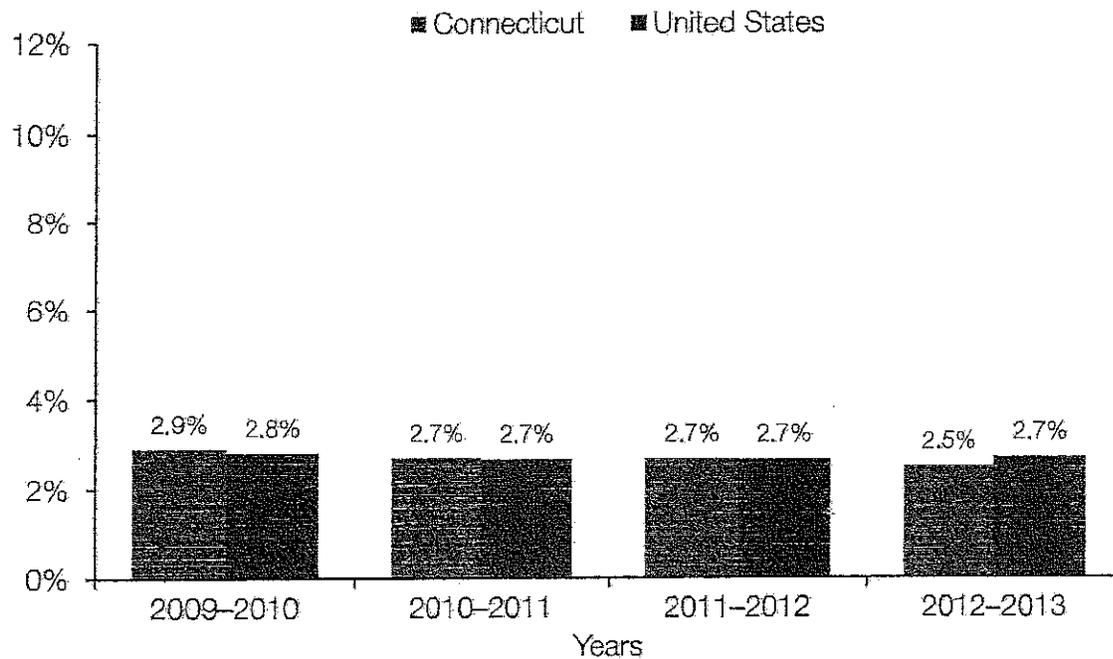
SUBSTANCE USE

ILLICIT DRUG DEPENDENCE OR ABUSE



Past-Year Illicit Drug Dependence or Abuse Among Individuals Aged 12 or Older in Connecticut and the United States (2009–2013)¹

Connecticut's percentage of illicit drug dependence or abuse among individuals aged 12 or older was similar to the national percentage in 2012–2013.



2.8%

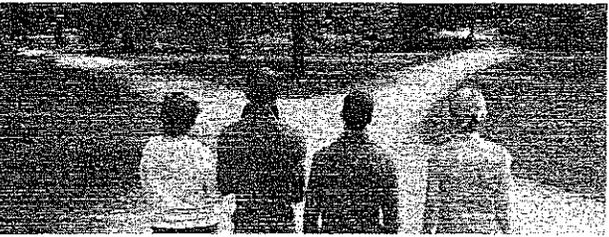
In Connecticut, about 83,000 individuals aged 12 or older (2.8% of all individuals in this age group) per year in 2009–2013* were dependent on or abused illicit drugs within the year prior to being surveyed. The percentage did not change significantly over this period.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2009 to 2013.

*These estimates are based on combined data from multiple years of the National Survey of Drug Use and Health (NSDUH), whereas estimates in the accompanying figure are from an estimation procedure that uses 2 consecutive years of NSDUH data plus other information from the state. The estimates from these two methods may differ. For more information, please see Figure Notes 1 and 2 on p. 19.

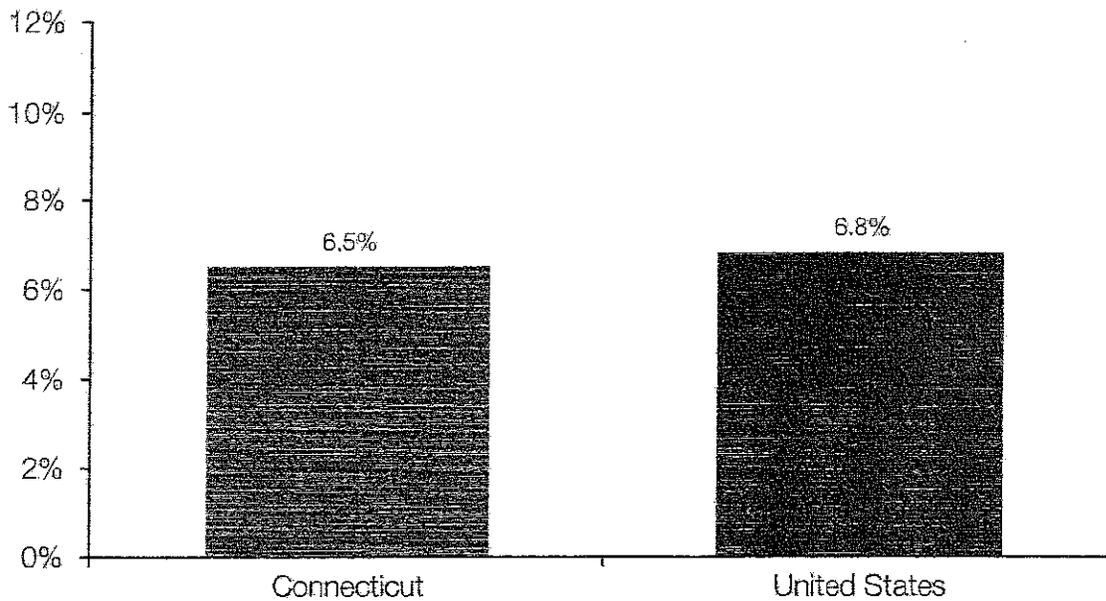
SUBSTANCE USE

HEAVY ALCOHOL USE



Past-Month Heavy Alcohol Use Among Adults Aged 21 or Older in Connecticut and the United States (2009–2013)²

Connecticut's percentage of heavy alcohol use among adults aged 21 or older was similar to the national percentage in 2009–2013.



In Connecticut, about 167,000 adults aged 21 or older (6.5% of all adults in this age group) per year in 2009–2013 reported heavy alcohol use within the month prior to being surveyed.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2009 to 2013.

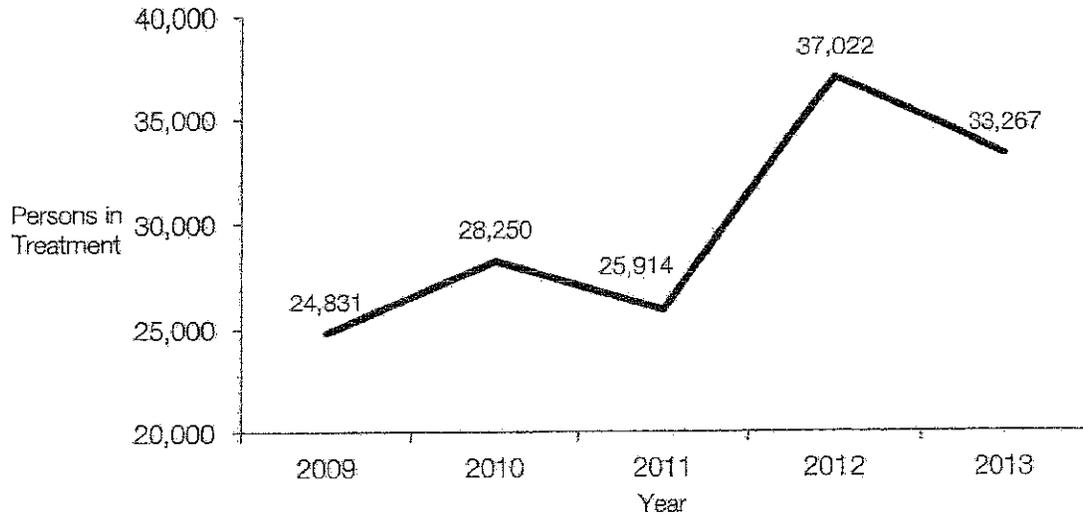
SUBSTANCE USE TREATMENT

ENROLLMENT AND TREATMENT FOCUS



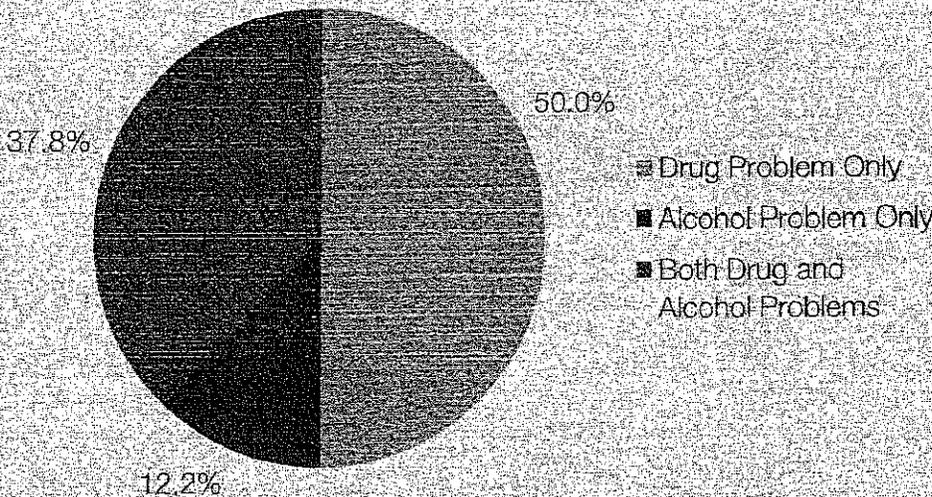
Enrollment in Substance Use Treatment in Connecticut: Single-Day Counts (2009–2013)⁷

In a single-day count in 2013, 33,267 individuals in Connecticut were enrolled in substance use treatment – an increase from 24,831 individuals in 2009.



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey of Substance Abuse Treatment Services, 2009 to 2013.

Substance Use Problems Among Individuals Enrolled in Substance Use Treatment in Connecticut: Single-Day Count (2013)⁷

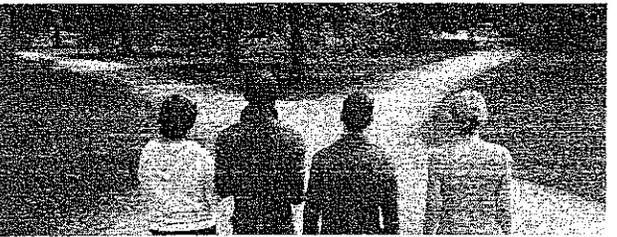


Among individuals in Connecticut enrolled in substance use treatment in a single-day count in 2013, 50.0% were in treatment for drug use only, 12.2% were in treatment for alcohol use only, and 37.8% were in treatment for both drug and alcohol use.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey of Substance Abuse Treatment Services, 2013.

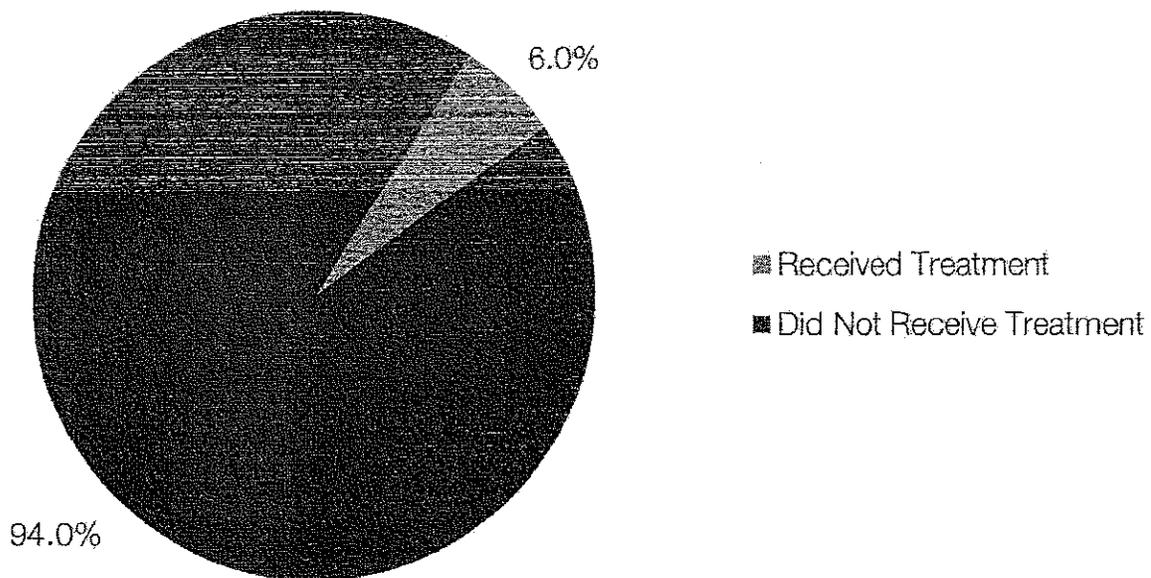
SUBSTANCE USE TREATMENT

ALCOHOL



Past-Year Alcohol Use Treatment Among Individuals Aged 12 or Older with Alcohol Dependence or Abuse in Connecticut (2009–2013)²

Connecticut's percentage of treatment for alcohol use among individuals aged 12 or older with alcohol dependence or abuse was similar to the national percentage in 2009–2013.

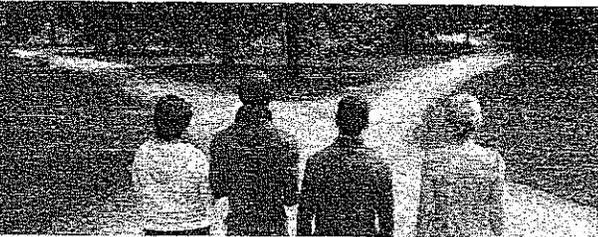


In Connecticut, among individuals aged 12 or older with alcohol dependence or abuse, about 15,000 individuals (6.0%) per year in 2009–2013 received treatment for their alcohol use within the year prior to being surveyed.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2009 to 2013.

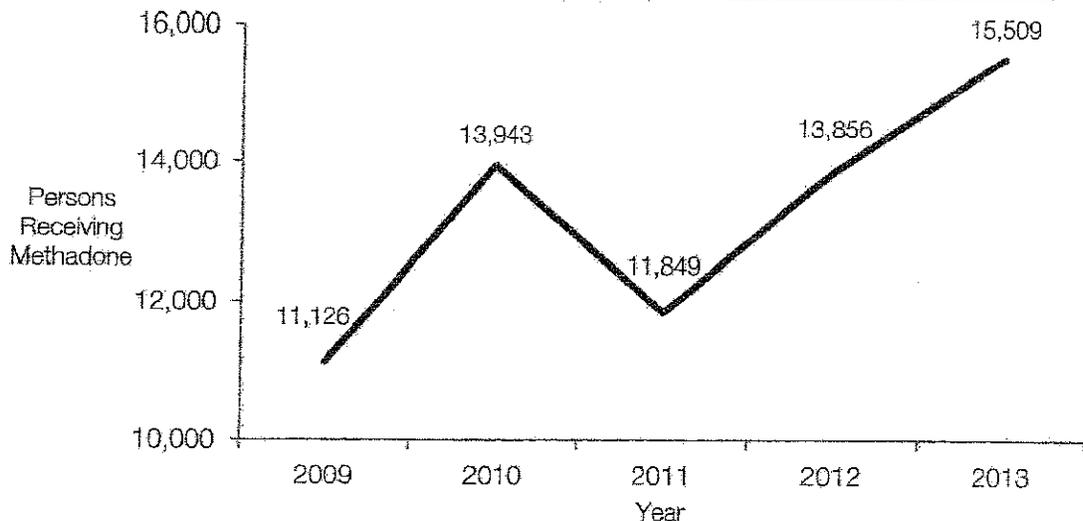
SUBSTANCE USE TREATMENT

OPIOIDS (MEDICATION-ASSISTED THERAPY)



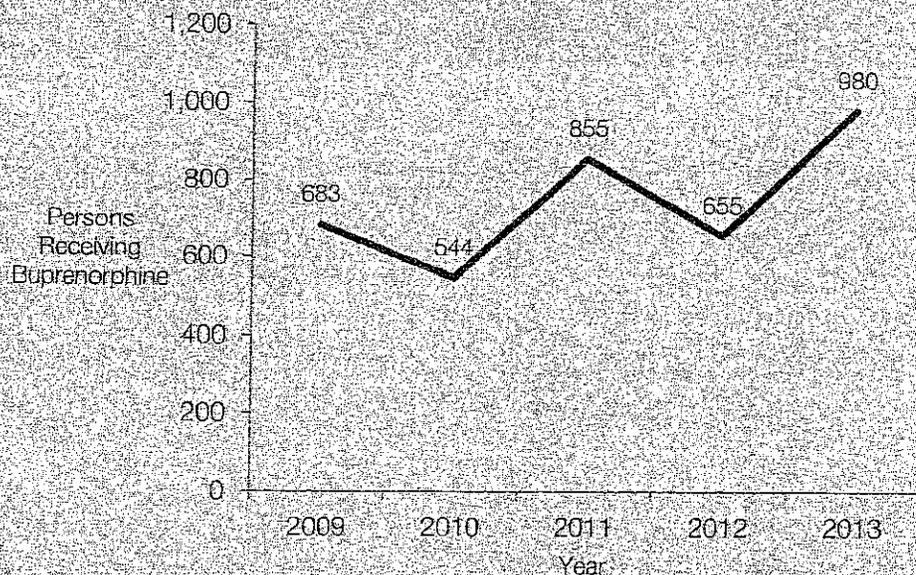
Individuals Enrolled in Opioid Treatment Programs (OTPs) in Connecticut Receiving Methadone: Single-Day Counts (2009–2013)⁷

The number of individuals in Connecticut who received methadone in OTPs as part of their substance use treatment increased from 2009 to 2013.



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey of Substance Abuse Treatment Services, 2009 to 2013.

Individuals Enrolled in Substance Use Treatment in Connecticut Receiving Buprenorphine: Single-Day Counts (2009–2013)^{7,8}



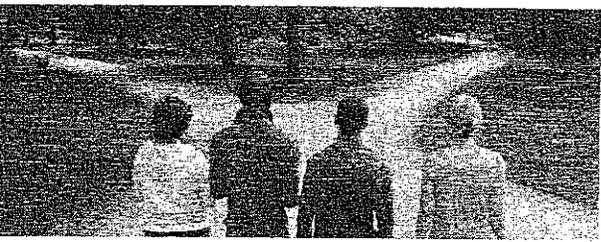
The number of individuals in Connecticut who received buprenorphine as part of their substance use treatment increased from 2009 to 2013.

In a single-day count in 2013, 15,509 individuals in Connecticut were receiving methadone as part of their substance use treatment, and 980 were receiving buprenorphine.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey of Substance Abuse Treatment Services, 2009 to 2013.

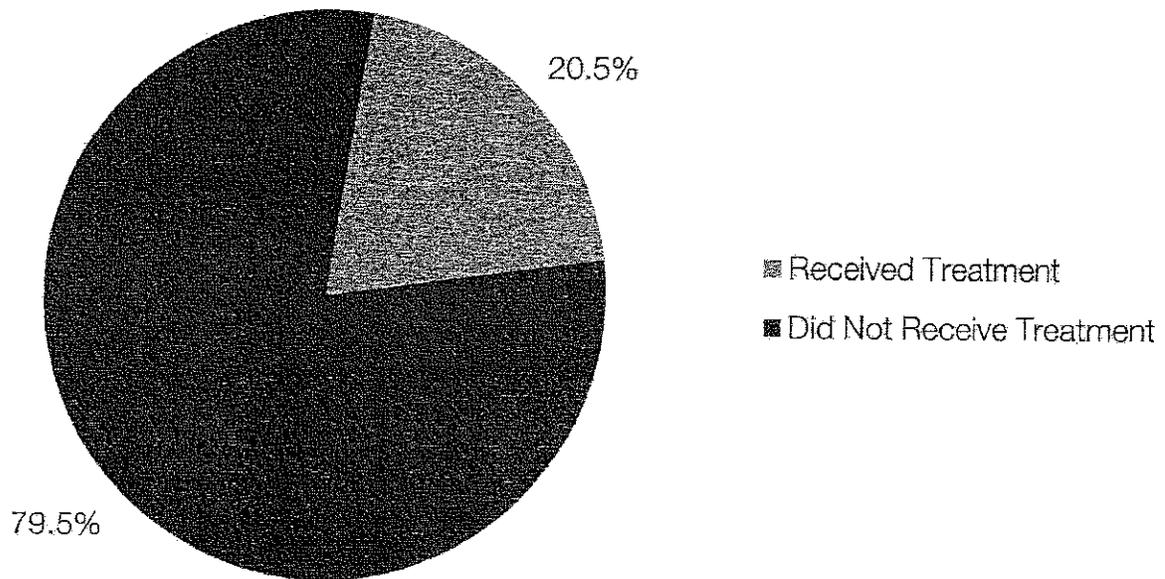
SUBSTANCE USE TREATMENT

ILLICIT DRUGS



Past-Year Illicit Drug Use Treatment Among Individuals Aged 12 or Older with Illicit Drug Dependence or Abuse in Connecticut (2005–2013)²

Connecticut's percentage of treatment for illicit drug use among individuals aged 12 or older with drug dependence or abuse was similar to the national percentage in 2005–2013.



In Connecticut, among individuals aged 12 or older with illicit drug dependence or abuse, about 18,000 individuals (20.5%) per year in 2005–2013 received treatment for their illicit drug use within the year prior to being surveyed.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2005 to 2013.

Statistical tests (z-tests) have been conducted for all statements appearing in the text on this page of the report that compare estimates between years or between the state and the nation as a whole. Unless explicitly stated that a difference is not statistically significant, all statements that describe differences are significant at the .05 level.

Growing Potential Services

Docket # 16-32083-CON

Appendix E

July 6, 2016

To Whom it May Concern:

I am writing to recommend Growing Potential Services (GPS) as a provider for a variety of different health services for adults. GPS already offers many therapy services including, but not limited to, mental health support, social skills groups and autism services for children throughout Hartford County. These services are integral to the development of children with special needs, but in many situations, the parents of these children also need supports in these areas.

The services GPS provides reach throughout Hartford County, but there is a serious lack of therapeutic supports for adults in the northern section of the county, and allowing GPS to work with adults as well as children would help meet the needs of many more individuals. It would also better provide the parents of children with special needs with the supports they need to help raise their children in more beneficial and effective ways.

Thank you for your consideration.

Sincerely,



Elena Thibodeau

10 Woodfield Crossing
Glastonbury, CT 06033

elenagrout@sbcglobal.net

Docket # 16-32083-COD Appendix F

Form **1120S**
 Department of the Treasury
 Internal Revenue Service

U.S. Income Tax Return for an S Corporation
 Do not file this form unless the corporation has filed or is attaching Form 2553 to elect to be an S corporation.

OMB No. 1545-0123
2015

Information about Form 1120S and its separate instructions is at www.irs.gov/form1120s.

For calendar year 2015 or tax year beginning _____, 2015, ending _____, 20

A S election effective date 06-13-2013 B Business activity code number (see instructions) [REDACTED] C Check if Sch. M-3 attached <input type="checkbox"/>	TYPE OR PRINT	Name Growing Potential Services	D Employer identification number [REDACTED]
		Number, street, and room or suite no. If a P.O. box, see instructions. 139 Hazard Ave STE 2-6	E Date incorporated 06-13-2013
		City or town, state or province, country, and ZIP or foreign postal code Enfield CT 06082	F Total assets (see instructions) \$ 40,908

G Is the corporation electing to be an S corporation beginning with this tax year? Yes No If "Yes," attach Form 2553 if not already filed
H Check if: (1) Final return (2) Name change (3) Address change (4) Amended return (5) S election termination or revocation
I Enter the number of shareholders who were shareholders during any part of the tax year _____ 1

Caution. Include only trade or business income and expenses on lines 1a through 21. See the instructions for more information.

Income	1a	Gross receipts or sales	1a	281,459			
		b	Returns and allowances	1b			
		c	Balance. Subtract line 1b from line 1a			1c	281,459
		2	Cost of goods sold (attach Form 1125-A)			2	
		3	Gross profit. Subtract line 2 from line 1c			3	281,459
		4	Net gain (loss) from Form 4797, line 17 (attach Form 4797)			4	
Deductions (see instructions for limitations)	5	Other income (loss) (see instructions - attach statement)	Statement #1		5	27	
	6	Total income (loss). Add lines 3 through 5			6	281,486	
	7	Compensation of officers (see instructions - attach Form 1125-E)			7		
	8	Salaries and wages (less employment credits)			8	162,013	
	9	Repairs and maintenance			9	849	
	10	Bad debts			10		
	11	Rents			11	33,718	
	12	Taxes and licenses	AFT STB		12	14,915	
	13	Interest			13	1,378	
	14	Depreciation not claimed on Form 1125-A or elsewhere on return (attach Form 4562)			14		
	15	Depletion (Do not deduct oil and gas depletion.)			15		
	16	Advertising			16	222	
	17	Pension, profit-sharing, etc., plans			17		
	18	Employee benefit programs			18		
	19	Other deductions (attach statement)	Statement #2		19	53,400	
20	Total deductions. Add lines 7 through 19			20	266,495		
21	Ordinary business income (loss). Subtract line 20 from line 6			21	14,991		
Tax and Payments	22a	Excess net passive income or LIFO recapture tax (see instructions)	22a				
		b	Tax from Schedule D (Form 1120S)	22b			
		c	Add lines 22a and 22b (see instructions for additional taxes)			22c	
	23a	2015 estimated tax payments and 2014 overpayment credited to 2015	23a				
		b	Tax deposited with Form 7004	23b			
		c	Credit for federal tax paid on fuels (attach Form 4136)	23c			
		d	Add lines 23a through 23c			23d	
24	Estimated tax penalty (see instructions). Check if Form 2220 is attached <input type="checkbox"/>			24			
25	Amount owed. If line 23d is smaller than the total of lines 22c and 24, enter amount owed			25			
26	Overpayment. If line 23d is larger than the total of lines 22c and 24, enter amount overpaid			26			
27	Enter amount from line 26 Credited to 2016 estimated tax <input type="checkbox"/> Refunded <input type="checkbox"/>			27			

Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete. Declaration of preparer (other than taxpayer) is based on all information of which preparer has any knowledge.

May the IRS discuss this return with the preparer shown below (see instructions)? Yes No

Sign Here
 Signature of officer: [Signature] Date: 7/14/16 Title: President

Paid Preparer Use Only

Print/Type preparer's name Craig Lubitski	Preparer's signature [Signature]	Date 07-14-2016	Check <input type="checkbox"/> if PTIN self-employed <input checked="" type="checkbox"/>
Firm's name CJLC LLC	Firm's EIN [REDACTED]	Firm's address 225 Pitkin Street East Hartford CT 06108	Phone no. [REDACTED]

Schedule K

Shareholders' Pro Rata Share Items

Total amount

		Total amount	
Income (Loss)	1 Ordinary business income (loss) (page 1, line 21)	1	14,991
	2 Net rental real estate income (loss) (attach Form 8825)	2	
	3a Other gross rental income (loss)	3a	
	b Expenses from other rental activities (attach statement)	3b	
	c Other net rental income (loss). Subtract line 3b from line 3a	3c	
	4 Interest income	4	
	5 Dividends: a Ordinary dividends	5a	
	b Qualified dividends	5b	
	6 Royalties	6	
	7 Net short-term capital gain (loss) (attach Schedule D (Form 1120S))	7	
Deductions	8a Net long-term capital gain (loss) (attach Schedule D (Form 1120S))	8a	
	b Collectibles (28%) gain (loss)	8b	
	c Unrecaptured section 1250 gain (attach statement)	8c	
	9 Net section 1231 gain (loss) (attach Form 4797)	9	
	10 Other income (loss) (see instructions) Type ▶	10	
	11 Section 179 deduction (attach Form 4562)	11	
	12a Charitable contributions	12a	
	b Investment interest expense	12b	
	c Section 59(e)(2) expenditures (1) Type ▶ (2) Amount ▶	12c(2)	
	d Other deductions (see instructions) Type ▶	12d	
Credits	13a Low-income housing credit (section 42(j)(5))	13a	
	b Low-income housing credit (other)	13b	
	c Qualified rehabilitation expenditures (rental real estate) (attach Form 3468, if applicable)	13c	
	d Other rental real estate credits (see instructions) Type ▶	13d	
	e Other rental credits (see instructions) Type ▶	13e	
	f Biofuel producer credit (attach Form 6478)	13f	
	g Other credits (see instructions) Type ▶	13g	
Foreign Transactions	14a Name of country or U.S. possession ▶		
	b Gross income from all sources	14b	
	c Gross income sourced at shareholder level Foreign gross income sourced at corporate level	14c	
	d Passive category	14d	
	e General category	14e	
	f Other (attach statement) Deductions allocated and apportioned at shareholder level	14f	
	g Interest expense	14g	
	h Other Deductions allocated and apportioned at corporate level to foreign source income	14h	
	i Passive category	14i	
	j General category	14j	
	k Other (attach statement) Other information	14k	
	l Total foreign taxes (check one): <input type="checkbox"/> Paid <input type="checkbox"/> Accrued	14l	
	m Reduction in taxes available for credit (attach statement)	14m	
	n Other foreign tax information (attach statement)		
Alternative Minimum Tax (AMT) Items	15a Post-1986 depreciation adjustment	15a	
	b Adjusted gain or loss	15b	
	c Depletion (other than oil and gas)	15c	
	d Oil, gas, and geothermal properties - gross income	15d	
	e Oil, gas, and geothermal properties - deductions	15e	
	f Other AMT items (attach statement)	15f	
Items Affecting Shareholder Basis	16a Tax-exempt interest income	16a	
	b Other tax-exempt income	16b	
	c Nondeductible expenses	16c	
	d Distributions (attach statement if required) (see instructions)	16d	
	e Repayment of loans from shareholders	16e	

Schedule K		Shareholders' Pro Rata Share Items (continued)	Total amount	
Other Information	17 a	Investment income	17a	
	b	Investment expenses	17b	
	c	Dividend distributions paid from accumulated earnings and profits	17c	
	d	Other items and amounts (attach statement)		
Reconciliation	18	Income/loss reconciliation. Combine the amounts on lines 1 through 10 in the far right column. From the result, subtract the sum of the amounts on lines 11 through 12d and 14l	18	14,991

Schedule L		Balance Sheets per Books		Beginning of tax year		End of tax year	
		(a)	(b)	(c)	(d)		
Assets							
1	Cash						
2a	Trade notes and accounts receivable						
b	Less allowance for bad debts	()		()			
3	Inventories						
4	U.S. government obligations						
5	Tax-exempt securities (see instructions)						
6	Other current assets (attach statement)	Statement #19	36	Statement #19	36		
7	Loans to shareholders		32,267		32,267		
8	Mortgage and real estate loans						
9	Other investments (attach statement)						
10a	Buildings and other depreciable assets	11,449		11,449			
b	Less accumulated depreciation	(2,844)	8,605	(2,844)	8,605		
11a	Depletable assets						
b	Less accumulated depletion	()		()			
12	Land (net of any amortization)						
13a	Intangible assets (amortizable only)						
b	Less accumulated amortization	()		()			
14	Other assets (attach statement)						
15	Total assets		40,908		40,908		
Liabilities and Shareholders' Equity							
16	Accounts payable						
17	Mortgages, notes, bonds payable in less than 1 year						
18	Other current liabilities (attach statement)	Statement #22	36,826	Statement #22	27,260		
19	Loans from shareholders		13,818		8,393		
20	Mortgages, notes, bonds payable in 1 year or more						
21	Other liabilities (attach statement)						
22	Capital stock		1,000		1,000		
23	Additional paid-in capital						
24	Retained earnings		(10,736)		4,255		
25	Adjustments to shareholders' equity (attach statement)						
26	Less cost of treasury stock	()		()			
27	Total liabilities and shareholders' equity		40,908		40,908		

EEA

Schedule M-1 Reconciliation of Income (Loss) per Books With Income (Loss) per Return

Note. The corporation may be required to file Schedule M-3 (see instructions)

1 Net income (loss) per books	14,991	5 Income recorded on books this year not included on Schedule K, lines 1 through 10 (itemize):	
2 Income included on Schedule K, lines 1, 2, 3c, 4, 5a, 6, 7, 8a, 9, and 10, not recorded on books this year (itemize): _____		a Tax-exempt interest \$ _____	
3 Expenses recorded on books this year not included on Schedule K, lines 1 through 12 and 14l (itemize):		6 Deductions included on Schedule K, lines 1 through 12 and 14l, not charged against book income this year (itemize):	
a Depreciation \$ _____		a Depreciation \$ _____	
b Travel and entertainment \$ _____		7 Add lines 5 and 6	
4 Add lines 1 through 3	14,991	8 Income (loss) (Schedule K, line 18). Line 4 less line 7	14,991

Schedule M-2 Analysis of Accumulated Adjustments Account, Other Adjustments Account, and Shareholders' Undistributed Taxable Income Previously Taxed (see instructions)

	(a) Accumulated adjustments account	(b) Other adjustments account	(c) Shareholders' undistributed taxable income previously taxed
1 Balance at beginning of tax year			
2 Ordinary income from page 1, line 21	14,991		
3 Other additions			
4 Loss from page 1, line 21	()		
5 Other reductions	()	()	
6 Combine lines 1 through 5	14,991		
7 Distributions other than dividend distributions -			
8 Balance at end of tax year. Subtract line 7 from line 6	14,991		

EEA

Schedule K-1 (Form 1120S)

2015

Final K-1 Amended K-1 OMB No. 1545-0123

Department of the Treasury Internal Revenue Service

For calendar year 2015, or tax year beginning 2015 ending 20

Shareholder's Share of Income, Deductions, Credits, etc. See page 2 of form and separate instructions.

Part I Information About the Corporation

A Corporation's employer identification number
B Corporation's name, address, city, state, and ZIP code. Growing Potential Services, 139 Hazard Ave STE 2-6, Enfield CT 06082
C IRS Center where corporation filed return E-FILE

Part II Information About the Shareholder

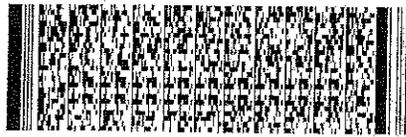
D Shareholder's identifying number
E Shareholder's name, address, city, state, and ZIP code. Marcy L. Taliceo, 7 Quaker Lane, Enfield CT 06082
F Shareholder's percentage of stock ownership for tax year 100.00000 %

Part III Shareholder's Share of Current Year Income, Deductions, Credits, and Other Items

Table with 4 columns: Line number, Description, Column number, and Category. Includes rows for Ordinary business income (loss), Net rental real estate income (loss), Other net rental income (loss), Interest income, Ordinary dividends, Qualified dividends, Royalties, Net short-term capital gain (loss), Net long-term capital gain (loss), Collectibles (28%) gain (loss), Unrecaptured section 1250 gain, Net section 1231 gain (loss), Other income (loss), Section 179 deduction, Other deductions, Credits, Foreign transactions, Alternative minimum tax (AMT) items, Items affecting shareholder basis, and Other information.

* See attached statement for additional information.

For IRS Use Only



Federal Supporting Statements

2015 PG01

Name(s) as shown on return

FEIN

Growing Potential Services

Form 1120S - Line 5 - Other Income

Statement #1

<u>Description</u>	<u>Amount</u>
Interest Income on Receivables	27
Total	27

Form 1120S - Line 19 - Other Deductions

PG01
Statement #2

<u>Description</u>	<u>Amount</u>
Accounting	1,199
Automobile and Truck Expense	1,325
Bank Charges	7,397
Cell Phone	3,124
Education and Training	510
Insurance	4,993
Miscellaneous	6,392
Office Expense	11,237
Payroll Processing Expense	758
Postage/Shipping	56
Supplies	710
Utilities	6,600
Background Checks	650
Holiday Party	2,500
Consumer Meals	113
Recreation	3,632
Snacks	2,204
Total	53,400

Schedule L - Line 6 - Other Current Assets

PG01
Statement #19

<u>Description</u>	<u>Beg Of Year</u>	<u>End Of Year</u>
Advances	36	36
Total	36	36

Federal Supporting Statements

2015 PG01

Name(s) as shown on return

Growing Potential Services

FEIN



Schedule L - Line 18 - Other Current Liabilities

Statement #22

<u>Description</u>	<u>Beg Of Year</u>	<u>End Of Year</u>
Overdraft	2,395	1,736
Payroll Taxes	19,880	10,973
Accrued Payroll Taxe	14,074	14,074
Misc Payable	477	477
Total	36,826	27,260

Taxes and Licenses Attachment

Note: This information does not transmit to the IRS with e-filed returns.
Including with a paper filed return is optional.

2015

S CORPORATION NAME

Growing Potential Services

EIN

██████████

Taxes and Licenses

Form 1120S

Page 1, Line 12

1	State income taxes	1	
2	State franchise taxes	2	
3	City income taxes	3	
4	City franchise taxes	4	
5	Local property taxes	5	
6	Intangible property taxes	6	
7	Payroll taxes	7	14,725
8	Less: credit from Form 8846	8	
9	Foreign taxes paid	9	
10	Occupancy taxes	10	
11	Other miscellaneous taxes	11	
12	Built in gains tax allocated to ordinary income	12	
13	Licenses	13	190
14	Total to Form 1120S, Page 1, Line 12	14	14,915

(Keep for your records)

S CORPORATION NAME

EIN

Growing Potential Services

██████████

Description	Schedule K	K-1 Totals	Difference
1 Ordinary business income (loss)	14,991	14,991	

Form 1120S

Schedule M-2/Retained Earnings Worksheet
(Keep for your records)

2015

Corporation Name

Growing Potential Services

EIN

██████████

Analysis of Current-Year Retained Earnings

1	Beginning retained earnings per balance sheet (Schedule L, column b, lines 24 and 25)	1	(10,736)
2	Book income (loss) (Schedule M-1, line 1, or Schedule M-3, page 1, line 11)	2	14,991
3	Distributions (Schedule K, line 16d)	3	
4	Subtotal (combines lines 1 through 3)	4	4,255
5	Ending retained earnings per balance sheet (Schedule L, column d, lines 24 and 25)	5	4,255
6	Difference (line 4 minus line 5) (should be zero)	6	

Current-Year Change to Retained Earnings Compared to Current-Year Change to AAA & OAA

1	Ending retained earnings (Schedule L, column d, line 24)	1	4,255
2	Beginning retained earnings (Schedule L, column b, line 24)	2	(10,736)
3	Retained earnings change (line 1 minus line 2)	3	14,991
4	Ending AAA plus OAA	4	14,991
5	Beginning AAA plus OAA	5	
6	Difference (line 4 minus line 5)	6	14,991

Current-Year Timing Adjustments per Schedule M-1

Subtractions from net income per books (Schedule M-1, lines 5 and 6 - not included on Schedule M-2)

7	Other income recorded on books not included on Schedule K	7	_____
8	Depreciation on Schedule K not included on books	8	_____
9	Other Schedule K items not included on books	9	_____
10	Total subtractions (lines 7 through 9)	10	_____

Additions to net income per books (Schedule M-1, lines 2 and 3 - not included on Schedule M-2, line 3)

11	Income included on Schedule K not recorded on books	11	_____
12	Depreciation on books not included on Schedule K	12	_____
13	Other items on books not included on Schedule K	13	_____
14	Total additions (lines 11 through 13)	14	_____
15	Sch M-1 timing adjustments not included on Schedule M-2, lines 2 thru 5 (subtract line 14 from line 10)	15	_____

Current-Year Timing Adjustments Per Schedule M-3

Permanent or temporary book-to-tax difference amounts entered on the M32, M33, 8916A, and SCH3 screens appear on line 16 and line 17 as opposite of the actual entries. For example, an entry of -100 would appear as 100.

16	Permanent differences	16	_____
17	Temporary differences	17	_____

18	Timing adjustments not included on Schedule M-2 (combine lines 16 and 17)	18	_____
----	---	----	-------

19	Distributions reported on Schedule K, line 16d, not allowed on Schedule M-2, line 7	19	_____
20	Adjustments to retained earnings (Schedule L, line 25 column d minus Schedule L, line 25, column b)	20	_____
21	M-2 amount after M-1 timing adjustments (add lines 6, 15, 19, and 20)	21	14,991
22	M-2 amount after M-3 timing adjustments (add lines 6, 18, 19, and 20)	22	_____

23	Net reconciliation difference (line 3 minus line 21 or 22)	23	_____
----	--	----	-------

GROWING POTENTIAL SERVICES
Docket # 16-32083-CON

Appendix G

RESPONSE TO CON APP PAGE 128

Applicant Name: Growing Potential Services
Financial Worksheet (B)

FOR-PROFIT
Please provide one year of actual results and three years of projections of Total Entity revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

LINE	Total Entity: Description	(1)	(2)		(3)		(4)			(5)	(6)	(7)	(8)	(9)	(10)
		FY2015 Actual Results	FY2016 Projected W/out CON	FY2016 Projected Incremental	FY2016 Projected With CON	FY2017 Projected W/out CON	FY2017 Projected Incremental	FY2017 Projected With CON	FY2018 Projected W/out CON	FY2018 Projected Incremental	FY2018 Projected With CON				
A. OPERATING REVENUE															
1	Total Gross Patient Revenue	\$281,486	\$295,325	\$30,307	\$325,632	\$306,452	\$146,813	\$453,265	\$325,632	\$334,222	\$659,854				
2	Less: Allowances	\$0	\$0	\$0	\$0			\$0			\$0				
3	Less: Charly Care	\$0	\$0	\$0	\$0			\$0			\$0				
4	Less: Other Deductions	\$0	\$0	\$0	\$0			\$0			\$0				
	Net Patient Service Revenue	\$281,486	\$295,325	\$30,307	\$325,632	\$306,452	\$146,813	\$453,265	\$325,632	\$334,222	\$659,854				
5	Medicare	\$0	\$0	\$0	\$0	\$306,452	\$146,813	\$453,265	\$325,632	\$334,222	\$659,854				
6	Medicaid	\$151,945	\$185,321	\$33,332	\$198,653	\$186,585	\$216,670	\$403,255	\$198,653	\$353,860	\$552,513				
7	CHAMPUS & Tricare	\$1,271	\$1,723	\$1,803	\$3,526	\$2,352	\$3,273	\$5,625	\$3,526	\$2,099	\$5,625				
8	Other	\$27	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0				
	Total Government	\$153,244	\$187,044	\$35,136	\$202,179	\$188,947	\$219,943	\$408,890	\$202,179	\$355,959	\$560,138				
9	Commercial Insurers	\$46,127	\$60,507	\$11,525	\$72,032	\$65,325	\$0	\$93,255	\$72,032	\$0	\$72,032				
10	Uninsured	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0				
11	Self Pay	\$0	\$0	\$0	\$5,325	\$6,852	\$5,689	\$12,521	\$0	\$12,183	\$19,684				
12	Workers Compensation	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0				
13	Other	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0				
	Total Non-Government	\$46,127	\$60,507	\$11,525	\$77,358	\$72,177	\$6,401	\$65,778	\$72,032	\$12,183	\$91,716				
	Net Patient Service Revenue* (Government/Non-Government)	\$281,459	\$295,325	\$30,307	\$325,632	\$306,452	\$146,813	\$453,265	\$325,632	\$334,222	\$659,854				
14	Less: Provision for Bad Debts	\$0	\$0	\$0	\$0			\$0			\$0				
	Net Patient Service Revenue less provision for bad debts	\$281,459	\$295,325	\$30,307	\$325,632	\$306,452	\$146,813	\$453,265	\$325,632	\$334,222	\$659,854				
15	Other Operating Revenue	\$0	\$0	\$0	\$0			\$0			\$0				
17	Net Assets Released from Restrictions	\$0	\$0	\$0	\$0			\$0			\$0				
	TOTAL OPERATING REVENUE	\$281,459	\$295,325	\$30,307	\$325,632	\$306,452	\$146,813	\$453,265	\$325,632	\$334,222	\$659,854				
B. OPERATING EXPENSES															
1	Salaries and Wages	\$162,013	\$170,656	\$15,907	\$186,563	\$176,359	\$58,293	\$234,652	\$166,563	\$59,089	\$225,652				
2	Fringe Benefits	\$0	\$0	\$0	\$0			\$0			\$0				
3	Physicians Fees	\$0	\$0	\$0	\$0			\$0			\$0				
4	Supplies and Drugs	\$0	\$0	\$0	\$0			\$0			\$0				
5	Depreciation and Amortization	\$0	\$0	\$0	\$0			\$0			\$0				
6	Provision for Bad Debts-Other ²	\$0	\$0	\$0	\$0			\$0			\$0				
7	Interest Expense	\$0	\$0	\$0	\$0			\$0			\$0				
8	Malpractice Insurance Cost	\$0	\$0	\$0	\$0			\$0			\$0				
9	Lease Expense	\$0	\$0	\$0	\$0			\$0			\$0				
10	Other Operating Expenses	\$104,482	\$106,598	\$5,758	\$112,356	\$109,651	\$40,001	\$149,652	\$112,356	\$52,999	\$165,355				
	TOTAL OPERATING EXPENSES	\$266,495	\$277,254	\$21,665	\$298,919	\$288,010	\$98,294	\$386,304	\$266,495	\$112,088	\$411,007				
	INCOME/(LOSS) FROM OPERATIONS	\$14,964	\$18,071	\$8,642	\$26,713	\$20,442	\$50,519	\$70,961	\$26,713	\$222,134	\$248,847				
NON-OPERATING INCOME															
	Income before provision for income taxes	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0				
	Provision for income taxes ³	\$0	\$0	\$0	\$0			\$0			\$0				
	NET INCOME	\$14,964	\$18,071	\$8,642	\$26,713	\$20,442	\$50,519	\$70,961	\$26,713	\$222,134	\$248,847				
C. RETAINED EARNINGS															
	Retained Earnings, beginning of year	\$0	\$0	\$0	\$0			\$0	0.0%		37.7%				
	Retained Earnings, end of year	\$0	\$0	\$0	\$0			\$0	0.0%		0.0%				
	Principal Payments	\$0	\$0	\$0	\$0			\$0	0.0%		0.0%				
D. PROFITABILITY SUMMARY															
1	Hospital Operating Margin	5.3%	6.1%	28.5%	8.2%			34.4%	15.7%		66.5%				
2	Hospital Non Operating Margin	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%				
3	Hospital Total Margin	5.3%	6.1%	28.5%	8.2%	6.7%	34.4%	15.7%	0.0%	66.5%	0.0%				
E. FTEs															
	FTEs	0	0	0	0	0	0	0	0	0	0				
F. VOLUME STATISTICS⁴															
1	Inpatient Discharges	0	0	0	0	0	0	0	0	0	0				
2	Outpatient Visits	156	232	85	317	302	367	669	405	390	795				
	TOTAL VOLUME	156	232	85	317	302	367	669	405	390	795				

*Total amount should equal the total amount on call line "Net Patient Revenue" Row 14.

²Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No.2011-07, July 2011.

³Provide the amount of income taxes as defined by the Internal Revenue Services for for-profit entities.

⁴Provide 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.


NAMI State Advocacy 2010
National Alliance for Mental Illness

State Statistics: Connecticut

Appendix H

Mental Illness Is Common

- Of Connecticut's approximately 3.5 million residents, close to 109,000 adults live with serious mental illnessⁱ and about 39,000 children live with serious mental health conditions.ⁱⁱ

Untreated Mental Illness has Deadly and Costly Consequences

- In 2006, 292 Connecticut residents died by suicide.ⁱⁱⁱ Suicide is almost always the result of untreated or under-treated mental illness.
- Nationally, we lose one life to suicide every 15.8 minutes. Suicide is the eleventh-leading cause of death overall and is the third-leading cause of death among youth and young adults aged 15-24.^{iv}
- During the 2006-07 school year, approximately 32 percent of Connecticut students aged 14 and older living with serious mental health conditions who receive special education services dropped out of high school.^v

Public Mental Health Services are Inadequate to Meet Needs

- Connecticut's public mental health system provides services to only 24.5 percent of adults who live with serious mental illnesses in the state.^{vi}
- Connecticut spent just \$170 per capita on mental health agency services in 2006, or \$591.6 million.^{vii} This was just 2.6 percent of total state spending that year.^{viii}
- In 2006, 59 percent of Connecticut state mental health agency spending was on community mental health services; 30 percent was spent on state hospital care.^{ix} Nationally, an average of 70 percent is spent on community mental health services and 28 percent on state hospital care.^x

Criminal Justice Systems Bear a Heavy Burden

- In 2006, 498 children were incarcerated in Connecticut's juvenile justice system.^{xi} Nationally, approximately 70 percent of youth in juvenile justice systems experience mental health disorders, with 20 percent experiencing a severe mental health condition.^{xii}
- In 2008, approximately 3,400 adults with mental illnesses were incarcerated in prisons and jails in Connecticut.^{xiii}

Many Residents Rely on Public Services for Needed Care

- Approximately 11.5 percent of Connecticut residents are enrolled in Medicaid.^{xiv}
- Approximately 334,000 Connecticut residents are uninsured.^{xv}

Housing is Unaffordable for People who Rely on SSI or SSDI

- The average rent for a studio apartment in Connecticut is 96 percent of the average Supplemental Security Income (SSI) payment, making housing unaffordable for adults living with serious mental illness who rely on SSI.^{xvi}

- ¹ Holzer, III, C.E. and Nguyen, H.T., psy.utmb.edu.
- ² U.S. Public Health Service, *Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda*, (Washington, DC: Department of Health and Human Services, 2000).
- ³ McIntosh, J.L. (for the American Association of Suicidology), *U.S.A. Suicide 2006: Official Final Data*, (Washington, DC: American Association of Suicidology, April 19, 2009), <http://www.suicidology.org>.
- ⁴ National Institute of Mental Health, "Suicide in the U.S.: Statistics and Prevention," 2009, <http://www.nimh.nih.gov/health/publications/suicide-in-the-us-statistics-and-prevention/index.shtml>, (January 25, 2010).
- ⁵ U.S. Department of Education, Office of Special Education Programs, Data Accountability Center, *Individuals with Disabilities Education Act (IDEA) Data, "State Rank-Ordered Tables," Table 1.3b, Data Analysis System (DANS)*, (July 15, 2008), <https://www.ideadata.org/StateRankOrderedTables.asp>.
- ⁶ Aron, L., Honberg, R., Duckworth, K., et al., *Grading the States 2009: A Report on America's Health Care System for Adults with Serious Mental Illness*, (Arlington, VA: National Alliance on Mental Illness, 2009).
- ⁷ NASMHPD Research Institute, Inc. (NRI Inc.), "State Mental Health Agency Profiles Systems (Profiles) and Revenues Expenditures Study: Revenues and Expenditures Reports from 2006," National Association of State Mental Health Program Directors Research Institute, Inc., (2006), http://www.nri-inc.org/projects/Profiles/Prior_RE.cfm.
- ⁸ Ibid..
- ⁹ Ibid.
- ¹⁰ Ibid.
- ¹¹ *OJJDP Statistical Briefing Book*, U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention, (September 12, 2008), <http://ojjdp.ncjrs.gov/ojstatbb/corrections/qa08601.asp?qaDate=2006>.
- ¹² Shufelt, M.S. and Cacoza, J., *Blueprint for Change: A Comprehensive Model for the Identification and Treatment of Youth with Mental Health Needs in Contact with the Juvenile Justice System*, National Center for Mental Health and Juvenile Justice, (2007).
- ¹³ Sabol, W. J., West, H. C. and Cooper, M., *Prisoners in 2008*, U.S. Department of Justice, Bureau of Justice Statistics, (2009), and James, D. and Glaze, L., *Mental Health Problems of Prison and Jail Inmates*, U.S. Department of Justice, Bureau of Justice Statistics, (2006).
- ¹⁴ The Kaiser Family Foundation, statehealthfacts.org, Data Source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2008 and 2009 Current Population Survey (CPS: Annual Social and Economic Supplements), <http://www.statehealthfacts.org/comparetable.jsp?typ=1&ind=125&cat=3&sub=39>.
- ¹⁵ Ibid
- ¹⁶ O'Hara, A., Cooper, E., Zovistoski, A., and Buttrick, J., *Priced Out in 2006: The Housing Crisis for People with Disabilities*, Technical Assistance Collaborative, Inc., Consortium for Citizens with Disabilities, Housing Task Force, (Technical Assistance Collaborative, Inc.: 2007).

TABLE 6
 PROJECTED UTILIZATION BY SERVICE

Service*	Projected Volume		
	FY 2016_**	FY 20_17_**	FY 2018_**
Outpatient Therapy	* 32/7	121/31	129/68
Day Treatment (PHP)	0/0	101/71	101/98
Day Treatment (IOP)	15/4	163/88	173/112
Medication	15/0	63/21	63/29
Case Management	3/0	41/20	78/31
Psychological/Autism Testing and Assessment	10/2	45/45	78/78
Occupational Therapy	0/0	12/9	15/9
Group Therapy	10/2	123/79	158/81
Total	85/15	685/304	795/506

* Identify each service type by location and add lines as necessary. Provide the number of visits/discharges as appropriate for each service listed.
 ** If the first year of the proposal is only a partial year, provide the first partial year and then the first three full FYs. Add columns as necessary. If the time period reported is not identical to the fiscal year reported in Table 4 of the application, provide the date range using the mm/dd format as a footnote to the table.

*
 Active/Discharge

Numbers reflect Client Count

Greer, Leslie

From: User, OHCA
Subject: FW: Completeness Questions on CON Application # 16-32083
Attachments: 16-32083 2nd Completeness.docx

From: Armah, Olga
Sent: Wednesday, August 17, 2016 1:46 PM
To: marcy taliceo
Cc: User, OHCA; Riggott, Kaila; Walker, Shauna
Subject: RE: Completeness Questions on CON Application # 16-32083

Dear Marcy,

We have additional questions regarding the application. The response is due by **Monday October 17, 2016**.

Please contact me if you have any questions.

Sincerely,

Olga

Olga Armah

Office of Health Care Access (OHCA)

CT Department of Public Health

Phone: 860 418 7070

Fax: 860 418 7053

Mailto: olga.armah@ct.gov

Web: www.ct.gov/ohca



STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH



Raul Pino, M.D., M.P.H.
Acting Commissioner

Dannel P. Malloy
Governor
Nancy Wyman
Lt. Governor

Office of Health Care Access

August 17, 2016

Via Email Only

Growingpotentialservices@gmail.com

Marcy Taliceo, CEO
Growing Potential Services: Therapeutic and
Behavioral Health Solutions, PC
141 Hazard Ave.
Enfield, CT 06082

RE: Certificate of Need Application; Docket Number: 16-32083-CON
Establishment of a Psychiatric Outpatient Day Treatment and Substance Abuse or
Dependence Treatment Clinic for Adults in Enfield
Connecticut Certificate of Need Second Completeness Letter

Dear Ms. Taliceo:

On July 18, the Department of Public Health ("DPH"), Office of Health Care Access ("OHCA") received completeness responses from Growing Potential Services (the "Applicant"), proposing to establish a psychiatric outpatient day treatment clinic and a freestanding facility for the care or treatment of substance abuse or dependence for adults.

OHCA requests additional information pursuant to Connecticut General Statutes §19a-639a(c). *Please electronically confirm receipt of this email as soon as you receive it.* Provide responses to the questions below in both a Word document and PDF format at the earliest convenience as an attachment to a responding email. *Please email your responses to all of the following email addresses: OHCA@ct.gov; olga.armah@ct.gov; shauna.walker@ct.gov; and kaila.riggott@ct.gov.*

Pursuant to Section 19a-639a(c) of the Connecticut General Statutes, you must submit your response to this request for additional information no later than sixty days after the date that this



Phone: (860) 509-8000 • Fax: (860) 509-7184 • VP: (860) 899-1611
410 Capitol Avenue, P.O. Box 340308
Hartford, Connecticut 06134-0308
www.ct.gov/dph

Affirmative Action/Equal Opportunity Employer

request was transmitted. Therefore, please provide your written responses to OHCA no later than **October 17, 2016**, otherwise your application will be automatically considered withdrawn.

Repeat each question before providing your response and paginate and date your response, i.e., each page, in its entirety. Information filed after the initial CON application submission (e.g., completeness response letter, prefile testimony, late file submissions and the like) must be numbered sequentially from the Applicant’s document preceding it. Please begin your submission using **Page 167** and reference “**Docket Number: 16-32083-CON.**”

1. Page 118 of the application indicates “These services are billed through mental health group services as defined by the insurance company.” Will GPS be billing for the proposed services? If not, who will be billing for them?

2. Page 102 of the application states the proposed service area is Enfield and surrounding towns (Somers, East Windsor, Windsor Locks, Hartford and Windsor), however Table 1 on page 120 provides information for Hartford County. Report data specific to the proposed service area.
Additionally, the proposed population to be served is adults (ages 18 years and over), however the table provides data on the total population.
Based on the following Applicant-provided link http://www.samhsa.gov/data/sites/default/files/State_BHBarometers_2014_1/BHBarometer-CT.pdf the 2012-13 prevalence rate for substance abuse was 7.0% for CT and not 9.1% and 3.4% for serious mental illness and not 44.9%. Utilize the state level prevalence rates for the proposed service area if area specific rates are unavailable.

Update the table to reflect the correct proposed service area, adult population, prevalence rates and corresponding incidence.

**TABLE 1
ESTIMATE OF BEHAVIORAL HEALTH DISORDER(S) INCIDENCE IN CONNECTICUT**

BEHAVIORAL HEALTH DISORDER	POPULATION: 18 AND OVER	PREVALENCE RATE	INCIDENCE/ 100,00
Substance Abuse			
1. Connecticut	3,590,886	9.1%	326,000
2. Hartford County	646,351	12.0%	79,950
Serious Mental Illness			
1. Connecticut	3,590,886	44.9%	161,230
2. Hartford County	646,351	19.3%	124,745
Autism			
1. Connecticut	3,590,886	Not enough data available for individuals over 18	Not enough data available for individuals over 18
2. Hartford County	646,351		
Service Area as percent of Connecticut			
1. Substance Abuse	18%	N/A	42%
2. SMI	18%		77%
3. Autism	18%		Not available

Sources:

¹ Indicate the relevant age group and provide the source of the population data (e.g., Census data).

² E.g., Substance and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality.

3. Update Table 2 on page 102 of the application, indicated below, with data for 2016.

**TABLE 2
FY 2015 CLIENT ORIGIN FOR GPS**

SERVICE AREA*	NO. OF CLIENTS	PERCENT OF CT TOTAL
Enfield	98	70%
East Windsor	15	11%
Somers	7	5%
Windsor Locks	7	5%
Hartford	6	4%
Bloomfield	2	1%
Windsor	2	1%
Ellington	1	1%
Suffield	1	1%
Vernon	1	1%
Total	140	100%

Ex. A, p. 108.

4. Table 6 on page 106 of the application reports projected volumes. What are the assumptions used for projecting these volumes?

The Applicant provided the follow Response:

The assumptions used are based on company capacity and availability for future care of clients. Based on the data included in this package, the need to increase services in Hartford County is great. GPS hopes to increase volume to better service the community at large.

Provide a more specific answer.

5. Update the following tables in the application to include FY 2019 to provide three full years of projections:
- a. Table 4 on page 127;
 - b. Table 6 on page 166; and
 - c. Financial Worksheet on page 163 (Appendix G).

6. Table 3 below is populated with information from the Financial Worksheet (Appendix G) and Table 7 (Total Payer Mix) on page 128 of the application. Provide projected patient volume by payer for FY 2019, the corresponding visit volumes by payer for FY 2016-2019 and correct any inconsistencies.

**TABLE 3
CURRENT AND PROJECTED PAYER MIX FOR
GPS CLIENTS AND VISITS FOR PROPOSED SERVICE**

Payer	Current			Projected								
	FY 2016			FY 2017			FY 2018			FY 2019		
	Patient Vol.	%	Visits Vol.	Patient Vol.	%	Visits Vol.	Patient Vol.	%	Visits Vol.	Patient Vol.	%	Visits Vol.
Medicare*												
Medicaid*	10	67%		286	79%		365	73%				
CHAMPUS & TriCare												
Total Government	10	67%		286	79%		365	73%				
Commercial Insurers	5	33%		46	13%		73	14%				
Self-pay												
Uninsured				32	8%		68	13%				
Workers Compensation												
Total Non-Government	5	33%		78	21%		141	27%				
Total Payer Mix	15	100%	85	364	100%	367	506	100%	390			

If you have any questions concerning this letter, please feel free to contact me or Shauna Walker at (860) 418-7001.

Sincerely,

Olga Armah
Associate Research Analyst

Greer, Leslie

Subject: FW: Completeness Questions on CON Application # 16-32083
Attachments: 2nd response to CON 1632083.pdf

From: marcy taliceo [<mailto:growingpotentialservices@gmail.com>]
Sent: Saturday, September 17, 2016 12:21 PM
To: Armah, Olga
Cc: User, OHCA; Riggott, Kaila
Subject: Re: Completeness Questions on CON Application # 16-32083

Please find attached my response to the letter dated 8/17/16. Thank you

Marcy L. Taliceo, LPC, LMHC
Owner/ Clinical Director

Growing Potential Services: Therapeutic and Behavioral Solutions, PC
139 and 141 Hazard Ave
Enfield, CT 06082
860-698-6077 phone
860-698-6631 fax

www.growingpotentialservices.com

"And in the end it is not the years in your life that count, it's the life in your years." -Abraham Lincoln

This communication, including attachments, is for the exclusive use of the addressee and may contain proprietary, confidential and/or privileged information. If you are not the intended recipient, any use, copying, disclosure, dissemination or distribution is strictly prohibited. If you are not the intended recipient, please notify the sender immediately by return e-mail, and destroy this material in its entirety, whether electronic or hard copy.

On Mon, Sep 12, 2016 at 1:31 PM, Armah, Olga <Olga.Armah@ct.gov> wrote:

Hi Marcy,

Please populate the table with information for the proposed services only.

Thanks.

Growing Potential Services

Docket Number 16-32083-CON

Response to request dated August 17, 2016

- 1. Page 118 of the application indicates “These services are billed through mental health group services as defined by the insurance company”. Will GPS be billing for the proposed services? If not, who will be billing for them?**
 - a. Will GPS be billing for the proposed services?** Yes, GPS will continue to bill the insurance companies for any service approved through them. GPS will submit the billing directly. For those services that are not approved by the insurance company for payment for any reason will be discussed with the individual served and they will be provided a sliding fee schedule should they qualify.
 - b. If not, who will be billing for them?** GPS will bill any services that are approved by the insurance company. For those services that are not approved by the insurance company for payment for any reason will be discussed with the individual served and they will be provided a sliding fee schedule should they qualify.

- 2. Page 102 of the application states the proposed service area is Enfield and surrounding towns (Somers, East Windsor, Windsor Locks, Hartford and Windsor), however Table 1 on page 120 provides information for Hartford County. Report data specific to the proposed service area. Additionally, the proposed population to be serviced is adults (ages 18 years and over), however the table provides data on the total population. Based on the following Applicant-provided link http://www.samhsa.gov/data/sites/default/files/State_BHBarometers_2014_1/BHBarometer-CT.pdf the 2013-13 prevalence rates for substance abuse was 7.0% for CT and not 9.1% and 3.4% for the serious mental illness and not 44.9%. Utilize the state level prevalence rates for the proposed service area if area specific rates are unavailable. Update the table to reflect the correct proposed service area, adult population, prevalence rates and corresponding incidence.**

Response:

TABLE 1
ESTIMATE OF BEHAVIORAL HEALTH DISORDER(S) INCIDENCE IN CONNECTICUT

BEHAVIORAL HEALTH DISORDER (Specify the disorder)	POPULATION (e.g. 18 years and above)	PREVALENCE RATE	INCIDENCE (Population multiplied by prevalence rate)
Substance Abuse 1. Connecticut 2. Hartford County	1. 3,590,886 2. 646,351	1. 7%	1. 251,362
Serious Mental Illness 1. Connecticut 2. Hartford County	1. 3,590,886 2. 646,351	1. 3.4	1. 122,090
Autism 1. Connecticut 2. Hartford County	1. 3,590,886 2. 646,351	Not enough available data for individuals over 18	Not enough available data for individuals over 18
Service Area as a percent of Connecticut 1. Substance abuse 2. SMI 3. Autism	1. 18% 2. 18% 3. 18%	N/A	

The prevalence rates for Hartford County were unavailable for Substance Abuse, Serious Mental Illness and Autism

3. Update Table 2 on page 102 of the application, indicated below, with data for 2016

Response:

Table 2

FY 2016 CLIENT ORIGIN FOR GPS

SERVICE AREA	NO. OF CLIENTS	PERCENT OF CT TOTAL
Enfield	112	68%
East Windsor	20	12%
Somers	10	6%
Windsor Locks	10	6%
Hartford	5	3%
Bloomfield	3	1%
Windsor	2	1%
Ellington	1	1%
Suffield	1	1%
Vernon	1	1%
Total	165	100%

4. Table 6 on page 106 of the application reports projected volumes. What are the assumptions used for projecting these volumes?

The Applicant provided the follow Response:

The assumptions used are based on company capacity and availability for future care of clients. Based on the data included in this package, the need to increase services in Hartford County is great. GPS hopes to increase volume to better service the community at large.

Provide a more specific answer.

Response:

According to (2012, January). Bringing Behavioral Health into the Care Continuum: Opportunities to Improve Quality, Costs and Outcomes. *American Hospital Association*. 1-12. <http://www.aha.org/research/reports/tw/12jan-tw-behavhealth.pdf> . The number of psychiatric hospitals as well as psychiatric units have been on the decline since 2002. With decreasing supports via hospitals, people are relying more on community based supports to help with psychological services. There is also an increased focus on community based supports because noted in studies included in appendix that the cost of community based supports are much lower than inpatient supports. GPS hopes to increase volume to better serve the community at large.

5. **Update the following tables in the application to include FY 2019 to provide three full years of the projections:**

- a. **Table 4 of page 127;**

Response:

Table 4
PROJECTED INCREMENTAL REVENUES AND EXPENSES

	FY 2016_*	FY 2017_*	FY 2018_*	FY 2019_*
Revenue from Operations	\$30,307.00	\$146,813	\$ 334,222	\$835,555
Total Operating Expenses	\$5,758.00	\$ 96,394	\$112,088	\$280,220
Gain/Loss from Operations	\$8,642.00	\$50,519	\$222,134	\$555,335

- b. **Table 6 on page 166; and**

Response:

See Appendix A

- c. **Financial Worksheet on page 163 (Appendix G)**

Response:

See Appendix B attached.

TABLE 6
PROJECTED UTILIZATION BY SERVICE

Service*	Projected Volume			
	FY 2016 **	FY 2017 **	FY 2018 **	FY 2019
Outpatient Therapy	42/9	244/110	287/149	312/191
Day Treatment (PHP)	0/0	101/71	101/98	138/101
Day Treatment (IOP)	15/4	163/88	173/112	192/151
Medication Management	15/0	63/21	63/29	98/58
Case Management	3/0	41/20	78/31	89/42
Psychological/ Social Emotional/ Educational/Developmental Testing and Assessment	10/2	45/45	78/78	91/91
Occupational Therapy	0/0	12/9	15/9	45/21
Total	85/15	685/364	795/506	965/655

* Identify each service type by location and add lines as necessary. Provide the number of visits/discharges as appropriate for each service listed.

** If the first year of the proposal is only a partial year, provide the first partial year and then the first three full FYs. Add columns as necessary. If the time period reported is not identical to the fiscal year reported in Table 4 of the application, provide the date range using the mm/dd format as a footnote to the table.

Active / Discharge (#'s shown)

#'s Reflect Client Counts

CON 16-32083-CON
 Growing Potential Services

Page 17a

Appendix A B

Applicant Name: Growing Potential Ser Please provide one year of actual results and three years of projections of Total Entity revenue, expense and volume statistics
 Financial Worksheet (B) Without incremental to and with the CON proposal in the following reporting format:

FOR PROPT

LINE	Total Entity	FY2015 (1)	FY2016 (2)	FY2017 (3)	FY2018 (4)	FY2019 (5)	FY2020 (6)	FY2021 (7)	FY2022 (8)	FY2023 (9)	FY2024 (10)	FY2025 (11)	FY2026 (12)	FY2027 (13)
	Description	Actual Results	Projected Without CON	Projected With CON										
A. OPERATING REVENUE														
1	Total Gross Patient Revenue	\$281,486	\$295,325	\$300,307	\$328,932	\$306,452	\$146,813	\$453,285	\$25,532	\$334,222	\$959,854	43555	40000	835,555
2	Less: Allowances	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	0	0	0
3	Less: Charity Care	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	0	0	0
4	Less: Other Deductions	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	0	0	0
5	Net Patient Service Revenue	\$281,486	\$295,325	\$300,307	\$328,932	\$306,452	\$146,813	\$453,285	\$25,532	\$334,222	\$959,854	43555	40000	835,555
6	Medicare	\$151,945	\$166,321	\$172,322	\$198,653	\$198,596	\$216,870	\$400,295	\$198,653	\$333,880	\$562,513	367096	35547	720643
7	CHAMPUS & Tricare	\$1,271	\$1,723	\$1,803	\$2,352	\$2,352	\$2,773	\$5,625	\$5,625	\$2,089	\$5,625	5632	1023	7255
8	Other	\$27	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	0	0	0
9	Commercial Insurers	\$147,244	\$167,044	\$166,185	\$202,179	\$185,547	\$219,843	\$408,890	\$202,179	\$335,969	\$568,138	372728	355170	727896
10	Uninsured	\$49,127	\$50,507	\$51,525	\$72,032	\$95,325	\$0	\$52,255	\$72,032	\$0	\$72,032	53265	18787	72032
11	Self Pay	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	0	0	0
12	Workers Compensation	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	0	0	0
13	Other	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	0	0	0
	Total Non-Government	\$46,137	\$60,607	\$61,525	\$17,368	\$72,177	\$6,404	\$65,776	\$79,553	\$12,163	\$91,716	62827	44830	107857
	Net Patient Service Revenue (Government+Non-Government)	\$235,349	\$234,718	\$238,782	\$311,564	\$234,275	\$140,409	\$387,509	\$146,379	\$322,059	\$868,138	367096	437879	835555
14	Less: Provision for Bad Debts	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	0	0	0
15	Other Operating Revenue	\$281,486	\$295,325	\$300,307	\$328,932	\$306,452	\$146,813	\$453,285	\$25,532	\$334,222	\$959,854	437096	437879	835555
17	Net Assets Released from Restrictions	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	0	0	0
	TOTAL OPERATING REVENUE	\$281,486	\$295,325	\$300,307	\$328,932	\$306,452	\$146,813	\$453,285	\$25,532	\$334,222	\$959,854	437096	437879	835555
B. OPERATING EXPENSES														
1	Salaries and Wages	\$102,013	\$170,656	\$155,907	\$186,503	\$176,539	\$66,283	\$232,852	\$186,533	\$550,089	\$245,652	195589	59937	295526
2	Employee Benefits	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	0	0	0
3	Physician Fees	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	0	0	0
4	Supplies and Drugs	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	0	0	0
5	Depreciation and Amortization	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	0	0	0
6	Provision for Bad Debts-Charge	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	0	0	0
7	Interest Expense	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	0	0	0
8	Malpractice Insurance Cost	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	0	0	0
9	Lease Expense	\$104,482	\$106,589	\$5,728	\$112,355	\$100,651	\$40,001	\$144,832	\$112,356	\$52,989	\$165,355	125552	81180	205532
10	Other Operating Expenses	\$286,495	\$277,284	\$21,959	\$293,919	\$286,010	\$96,294	\$282,304	\$296,915	\$112,088	\$431,007	321941	141117	469398
	TOTAL OPERATING EXPENSES	\$148,495	\$190,241	\$161,634	\$228,713	\$204,442	\$50,913	\$170,967	\$206,713	\$222,134	\$248,347	45155	327342	372497
NON-OPERATING INCOME														
	Income before provision for income taxes	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	0	0	0
	Provision for income taxes	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	0	0	0
	NET INCOME	\$14,991	\$18,071	\$6,642	\$26,713	\$20,442	\$50,519	\$70,967	\$20,713	\$222,134	\$248,347	45155	272821	372497
C. Retained Earnings, beginning and of year														
	Retained Earnings, beginning	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	0	0	0
	Retained Earnings, end of year	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	0	0	0
D. PROFITABILITY SUMMARY														
1	Hospital Operating Margin	5.2%	6.1%	28.5%	8.2%	0.0%	34.4%	15.7%	0.0%	66.5%	0	0	0.147563	0
2	Hospital Non-Operating Margin	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0	0	0	0
3	Hospital Total Margin	5.2%	6.1%	28.5%	8.2%	0.0%	34.4%	15.7%	0.0%	66.5%	0	0	0.147563	0
E. FTES														
	FTES	0	0	0	0	0	0	0	0	0	0	0	0	0
F. VOLUME STATISTICS														
1	Inpatient Discharges	0	0	0	0	0	0	0	0	0	0	0	0	0
2	Outpatient Visits	156	232	85	317	302	357	683	405	380	795	519	486	965
	TOTAL VOLUME	156	232	85	317	302	357	683	405	380	795	519	486	965

Total amount spent equal the total amount on call line "Net Patient Revenue" Row 14.
 Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No. 2011-07, July 2011.
 Provide the amount of income taxes as defined by the Internal Revenue Service for corporate entities.
 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.

Greer, Leslie

From: User, OHCA
Subject: FW: Completeness Questions on CON Application # 16-32083

From: Armah, Olga
Sent: Tuesday, September 20, 2016 9:14 AM
To: marcy taliceo
Cc: User, OHCA; Riggott, Kaila
Subject: RE: Completeness Questions on CON Application # 16-32083

Good morning Marcy,

This is to acknowledge receipt of the 2nd Completeness Responses due by Monday October 17, 2016. We will review and get back to you if we have additional questions.

Thanks.

Olga

Olga Armah

Office of Health Care Access (OHCA)
CT Department of Public Health
Phone: 860 418 7070
Fax: 860 418 7053
Mailto: olga.armah@ct.gov
Web: www.ct.gov/ohca



From: marcy taliceo [<mailto:marcytaliceo@gmail.com>]
Sent: Monday, September 19, 2016 5:08 PM
To: Armah, Olga
Cc: User, OHCA; Riggott, Kaila
Subject: Re: Completeness Questions on CON Application # 16-32083

Hi there

I just wanted to confirm receipt of the 2nd response send 9/17? Thanks

Marcy L. Taliceo, LPC, LMHC
Owner/ Clinical Director

Growing Potential Services: Therapeutic and Behavioral Solutions, PC
139 and 141 Hazard Ave
Enfield, CT 06082
860-698-6077 phone

Greer, Leslie

From: Armah, Olga
Sent: Tuesday, October 18, 2016 3:17 PM
To: marcy taliceo
Cc: User, OHCA; Riggott, Kaila; Walker, Shauna
Subject: RE: Completeness Questions on CON Application # 16-32083
Attachments: 16-32083 3rd Completeness.docx

Dear Ms. Taliceo,

See attached request for additional information regarding CON application 16-32083 – Establishment of a psychiatric outpatient day treatment and substance abuse or dependence treatment clinic for adults in Enfield. There are additional items that need to be addressed.

Please contact me if you have any questions. Responses are due by **Monday December 19, 2016**.

Regards.

Olga

Olga Armah

Office of Health Care Access (OHCA)
CT Department of Public Health
Phone: 860 418 7070
Fax: 860 418 7053
Mailto: olga.armah@ct.gov
Web: www.ct.gov/dph/ohca



From: marcy taliceo [mailto:growingpotentialservices@gmail.com]
Sent: Monday, September 12, 2016 1:39 PM
To: Armah, Olga
Cc: User, OHCA; Riggott, Kaila
Subject: Re: Completeness Questions on CON Application # 16-32083

thank you

Marcy L. Taliceo, LPC, LMHC
Owner/ Clinical Director

Growing Potential Services: Therapeutic and Behavioral Solutions, PC
139 and 141 Hazard Ave
Enfield, CT 06082
860-698-6077 phone
860-698-6631 fax

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner



Dannel P. Malloy
Governor
Nancy Wyman
Lt. Governor

Office of Health Care Access

October 18, 2016

Via Email Only

Growingpotentialservices@gmail.com

Marcy Taliceo, CEO
Growing Potential Services: Therapeutic and
Behavioral Health Solutions, PC
141 Hazard Ave.
Enfield, CT 06082

RE: Certificate of Need Application; Docket Number: 16-32083-CON
Establishment of a Psychiatric Outpatient, Day Treatment and Substance Abuse or
Dependence Treatment Clinic for Adults in Enfield
Connecticut Certificate of Need Second Completeness Letter

Dear Ms. Taliceo:

On September 19, the Department of Public Health ("DPH"), Office of Health Care Access ("OHCA") received completeness responses from Growing Potential Services (the "Applicant"), proposing to establish a psychiatric outpatient, day treatment and a substance abuse or dependence treatment clinic for adults.

OHCA requests additional information pursuant to Connecticut General Statutes §19a-639a(c). *Please electronically confirm receipt of this email as soon as you receive it.* Provide responses to the questions below in both a Word document and PDF format at the earliest convenience as an attachment to a responding email. *Please email your responses to all of the following email addresses:* OHCA@ct.gov; olga.armah@ct.gov; shauna.walker@ct.gov; and kaila.riggott@ct.gov.

Pursuant to Section 19a-639a(c) of the Connecticut General Statutes, 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 **December 19, 2016**, otherwise your application will be automatically considered withdrawn.



Phone: (860) 509-8000 • Fax: (860) 509-7184 • VP: (860) 899-1611
410 Capitol Avenue, P.O. Box 340308
Hartford, Connecticut 06134-0308
www.ct.gov/dph

Affirmative Action/Equal Opportunity Employer

Repeat each question before providing your response and paginate and date your response, i.e., each page, in its entirety. Information filed after the initial CON application submission (e.g., completeness response letter, prefile testimony, late file submissions and the like) must be numbered sequentially from the Applicant’s document preceding it. Please begin your submission using **Page 173** and reference “**Docket Number: 16-32083-CON.**”

1. Page 10 of the application indicates “the need for entire families to engage in services whether for themselves or the child. Without family involvement, the rates of attendance and compliance with treatment decreases significantly.” What percentage of GPS’s current clients are ages 18 years old and under? On average, what percentage of this age cohort has significantly low treatment attendance and compliance rates and how does this compare to the state or national rate? Please provide a nationally recognized source for the state and/or national rate(s).
2. What percentage of GPS’ parents and/or relatives of current clients aged 18 years old and under would account for projected patient and visit volumes for the proposed program?
3. Explain the structure of the proposed treatment program as it relates to intensive outpatient treatment and partial hospitalization.
4. Page 102 of the application states the proposed service area is Enfield and surrounding towns (Somers, East Windsor, Windsor Locks, Hartford and Windsor), however Table 1 on page 120 provides information for Hartford County. Report data specific to the **proposed service area comprising Somers, East Windsor, Windsor Locks, Hartford and Windsor which account for 95% of current utilization.** Additionally, the proposed population to be served is **adults (ages 18 years and over)**, however the table provides data on the total population.

Utilize the example completed for substance abuse disorder in the table below to update the table to reflect the **service are** (as indicated by the towns listed in bold above), **adult** population, prevalence rates and corresponding incidence. Utilize the national autism rate for Connecticut and service area if the state rate is unavailable.

**TABLE 1
ESTIMATE OF BEHAVIORAL HEALTH DISORDER(S) INCIDENCE IN CONNECTICUT**

BEHAVIORAL HEALTH DISORDER	POPULATION (18 AND OVER)	PREVALENCE RATE	INCIDENCE/ 100,000
Substance Abuse			
1. Connecticut	2,768,573	7.0%	251,940
2. Service Area	166,275		11,639
Serious Mental Illness			
1. Connecticut		3.4%	
2. Service Area			
Autism			
1. Connecticut			
2. Service Area			

5. Page 102 indicates the hours of operation for the proposed program are:

TABLE 1
GPS PROPOSED SERVICE HOURS OF OPERATION

SERVICE	DAYS/HOURS OF OPERATION
Day Treatment	Monday-Friday - 9:00 AM – 12:00 PM
Adult Outpatient Clinic	Monday – Friday - 8:00 AM-7:00 PM Saturday - 9:00 AM – 12:00 PM

Mental health day treatment is four or more hours per session. How will GPS accommodate the four hour sessions with a 9:00 to 12:00 schedule?

6. On page 169 of the application, the Applicant provided the following response regarding what assumptions were used for projecting these volumes:

According to (2012, January). Bringing Behavioral Health into the Care Continuum: Opportunities to Improve Quality, Costs and Outcomes. *American Hospital Association*. 1-12. <http://www.aha.org/research/reports/tw/12jan-tw-behavhealth.pdf> . The number of psychiatric hospitals as well as psychiatric units have been on the decline since 2002. With decreasing supports via hospitals, people are relying more on community based supports to help with psychological services. There is also an increased focus on community based supports because noted in studies included in appendix that the cost of community based supports are much lower than inpatient supports. GPS hopes to increase volume to better serve the community at large.

Table 6 on page 171 of the application reports projected active client counts indicating an average of 20% year-to-year growth in patient volume and on page 172, a minimum of 27% growth in revenue with mostly Medicaid clients accounting for growth in both patients and revenues. Provide a more specific answer supported by and indicating how the Applicant calculated and arrived at patients/clients and visit volume (or treatment sessions) and the year to year growth provided in Table 2 below.

7. The Total Payer Mix row in Table 2 below is populated with information from Table 2 page 169, Table 6 page 171 and the “Outpatient Visits” row from the updated Financial Worksheet on page 172. Provide the corresponding patient and visit volumes by payer for FY 2016-2019. For example, if there are 10 self-pay clients and each is to receive 2 IOP sessions per week, then the visit volume will be: 10 (clients) x 2 (sessions) x 52 (weeks) = 1,040 (visits). Correct any inconsistencies among the sources e.g. for FY 2017 patient volume exceed visit volume.

**TABLE 2
CURRENT AND PROJECTED PAYER MIX FOR
GPS CLIENTS AND VISITS FOR PROPOSED SERVICE**

Payer	Current			Projected								
	FY 2016			FY 2017			FY 2018			FY 2019		
	Patient Vol.	%	Visit Vol.									
Medicare*												
Medicaid*												
CHAMPUS & TriCare												
Total Government												
Commercial Insurers												
Self-pay												
Uninsured												
Workers Compensation												
Total Non-Government												
Total Payer Mix	165	100%	317	685	100%	669	795	100%	795	965	100%	985

If you have any questions concerning this letter, please feel free to contact me or Shauna Walker at (860) 418-7001.

Sincerely,

Olga Armah
Associate Research Analyst

Greer, Leslie

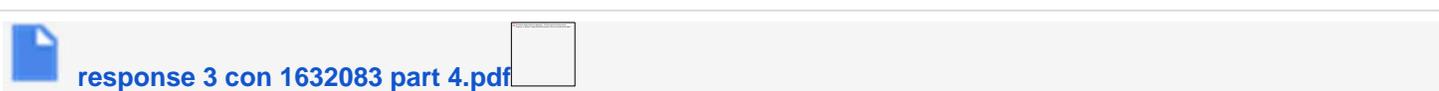
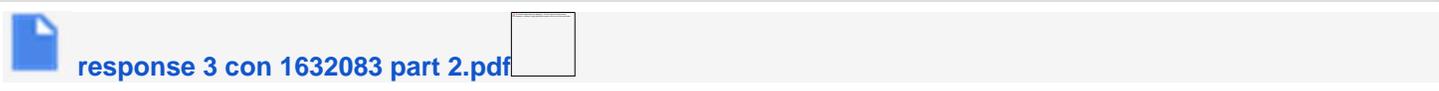
From: User, OHCA
Subject: FW: Completeness Questions on CON Application # 16-32083
Attachments: response 3 con 1632083 part 1.pdf

From: Marcy Taliceo [<mailto:growingpotentialservices@gmail.com>]
Sent: Wednesday, November 30, 2016 10:51 AM
To: Armah, Olga
Cc: User, OHCA; Riggott, Kaila; Walker, Shauna; Kaitlin Grout
Subject: Re: Completeness Questions on CON Application # 16-32083

hi there

please find attached the 3rd response. We worked and worked and worked on this and we hope this is good to go

😊 thank you



*Marcy L. Taliceo, LPC, LMHC
Owner/ Clinical Director*

*Growing Potential Services: Therapeutic and Behavioral Solutions, PC
139 and 141 Hazard Ave
Enfield, CT 06082
860-698-6077 phone
860-698-6631 confidential fax
860-265-3262 general fax*

"The best way to predict the future is to create it" "Dont count the day, make the days count"

www.growingpotentialservices.com

Docket Number: 16-32083-CON

1. Page 10 of the application indicates “the need for entire families to engage in services whether for themselves or the child. Without family involvement, the rates of attendance and compliance with treatment decreases significantly. “What percentage of GPS’s current clients are ages 18 years and under? On average, what percentage of this age cohort has significantly low treatment attendance and compliance rates and how does this compare to the state or national rate? Please provide a nationally recognized source for the state and national rate (s).

a: “What percentage of GPS’s current clients are ages 18 years and under? “

Response: Currently the 18 and under population at GPS is 64%.

b: On average, what percentage of this age cohort has significantly low treatment attendance and compliance rates and how does this compare to the state or national rate? Please provide a nationally recognized source for the state and national rate (s).

Response: 32% of clients 18 and under have low treatment attendance and compliance at GPS. Nationally, the rates are as follows:

Data source 1: (Appendix A: Engaging Families into Child Mental Health Treatment: Updates and Special Considerations. 15pages)

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2938751/>

“Not surprisingly, rates of child psychopathology in low-income inner-city settings have been found to be as high as 40% (Tolan & Henry, 1996; Xue, Leventhal, Brooks-Gunn & Earls, 2005). At the same time, the National Institute of Mental Health (2001) reports that approximately 75% of children with mental health needs do not have contact with the child mental health service system. As challenges in meeting children’s mental health needs persist, national efforts to encourage improved children’s access to treatment continue (New Freedom Commission on Mental Health, 2003).”

“Currently, engagement in mental health care continues to be measured primarily by attendance at treatment sessions. McKay & Bannon (2004) indicated that no-show rates for initial intake appointments ranged from 48% (Harrison, McKay & Bannon, 2004) to 62% (McKay, McCadam, & Gonzales, 1996). More recently, McKay, Lynn and Bannon (2005) reported on attendance rates for 95 caregivers and children seeking treatment in an urban child mental health clinic. Among those who made an initial appointment via a telephone intake system, 28% of children accepted for services never attended an initial face-to-face intake appointment. Consequently, even conservative estimates indicate that close to 1/3 of children and their families fail to engage at the initial face-to-face intake appointment.”

Docket Number: 16-32083-CON

“A recent study of treatment attendance at publicly funded, community-based outpatient child mental health centers in San Diego County indicated that children attended an average of 13.8 treatment sessions (Brookman-Frazee, Haine, Gabayan & Garland, 2008). While this number is substantially higher than the average 3–4 sessions reported in mental health clinics in urban, inner-city communities (McKay et al., 2002), this discrepancy likely reflects the differing characteristics associated with service engagement between a predominantly urban, low-income setting (e.g., McKay et al., 2002) and a more heterogeneous mix of families from different socioeconomic and geographic circumstances (e.g., Brookman-Frazee et al., 2008).”

Data source 2: (Appendix B:

Connecticut Children’s Behavioral Health Plan. 63 pages) [http://www.plan4children.org/wp-content/uploads/2014/10/CBH_PLAN_FINAL-2 .pdf](http://www.plan4children.org/wp-content/uploads/2014/10/CBH_PLAN_FINAL-2.pdf)

“There are approximately 783,000 children under age 18 currently in Connecticut, constituting 23% of the state’s population. Epidemiological studies using large representative samples suggest that as many as 20% of that population, or approximately 156,000 of Connecticut’s children, may have behavioral health symptoms that would benefit from treatment.7,8 Researchers have found that between 37 and 39 percent of youth in the three studies had received one or more behavioral health diagnoses between ages 9 and 16.9 Half of all lifetime diagnosable mental illness begins by age 14.10 Despite the prevalence of behavioral health conditions, an estimated 75-80% of children in Connecticut with behavioral health needs do not receive treatment.11”.

Data source 3: (Appendix C: SAMHSA Uniform Reporting. 28 pages)

<http://www.samhsa.gov/data/sites/default/files/URSTables2014/Connecticut.pdf> p19-21”

Table developed from data source 3

INDICATORS	CHILDREN: STATE	CHILDREN: US AVERAGE	STATE REPORTING
Reporting Positively About Access	96.0%	82.8%	47
Reporting Positively About Quality and Appropriateness			
Reporting Positively About Outcomes	78.1%	67.3%	48
Reporting on Participation in Treatment Planning	94.2%	87.0%	48
Family Members Reporting High Cultural Sensitivity of Staff	97.8%	92.7%	47
Reporting positively about General Satisfaction with Services	93.1%	87.2%	48

1. What percentage of GPS' parents and/or relatives of current clients aged 18 years old and under would account for projected patient and visit volumes for the proposed programs?

Response: Approximately 22% of the parents of current children under the age of 18 admitted to GPS would qualify to participate in the proposed programs.

2. Explain the structure of the proposed treatment program as it relates to intensive outpatient treatment and partial hospitalization.

Response: Based on a 6-12-week model and depending on client's progress and clinical recommendations. PHP is the more intensive model (5 days/wk) while IOP is less intensive (3 days a week). Level or programming is decided by GPS therapeutic team along with referring source. A client may start in PHP and drop down to IOP when symptomology is stabilized.

IOP - Mon, Wed, Fri: 9-1:30p (case management, psychiatric and individual therapy appointments scheduled throughout the week)

PHP - Mon-Fri: 9-1:30p (case management, psychiatric and individual therapy will be built into the 5 day schedule)

9:00-9:30- Check In, Emotional Intelligence Exercise

9:30-10:00 - Social Skills Group

10:00-11:00 Evidence Based Group Therapy (CBT, TF CBT, Motivational Interviewing, Applied Behavior Analysis, Dialectical Behavioral Therapy, Interpersonal Therapy)

11:00: 11:30- Break, beverage and snack

11:30-12:15 -Process Group

12:15-1:15- Case Management, Psychiatric or Individual Therapy Check in

1:15-1:30- Check out, Emotional Intelligence Exercise

3. Page 102 of the application states the proposed service area is Enfield and surrounding towns (Somers, East Windsor, Windsor Locks, Hartford and Windsor), however Table 1 on page 120 provides information for Hartford County. Report data specific to the **proposed service area comprising Somers, East Windsor, Windsor Locks, Hartford and Windsor which account for 95% of current utilization.** Additionally, the proposed population to be served is **adults (ages 18 years and over)**, however the table provides data on the total population.

Docket Number: 16-32083-CON

Utilize the example completed for substance abuse disorder in the table below to update the table to reflect the **service are** (as indicated by the towns listed in bold above), **adult** population, prevalence rates and corresponding incidence. Utilize the national autism rate for Connecticut and service area if the state rate is unavailable.

ESTIMATE OF BEHAVIORAL HEALTH DISORDER(S) INCIDENCE IN CONNECTICUT

BEHAVIORAL HEALTH DISORDER	POPULATION (18 AND OVER) ¹	PREVALENCE RATE	INCIDENCE
Substance Abuse			
1. Connecticut	2,819,794	9.1%	251,94
2. Service Area ²	166,275	7.0%	11,639
Serious Mental Illness			
1. Connecticut	2,819,794	3.5%	98,693
2. Service Area	166,275	3.5% ³	5,820
Autism ⁴			
1. National	2,819,794	11%	300,000
Service area as percent of Connecticut	5.9%		5.9%

Sources: (**Appendix D: United States Census Bureau 3 pgs**)

¹ <http://www.census.gov/quickfacts/table/PST045215/09> 2014 Connecticut population estimate is 3,590,886.

²Service area includes: Somers, East Windsor, Windsor Locks, Hartford and Windsor which makes up 95% of consumers

³ Prevalence rates for individual towns was not available so state prevalence rates were used

⁴Data for adults with autism is currently only provided on a National basis. Even national figures are only estimated. <http://www.afa-us.org/about>

5. Page 102 indicates the hours of operation for the proposed programs are:

Service	Days/hours of operation
Day Treatment	Monday-Friday – 9:00 AM- 1:30PM
Adult Outpatient Clinic	Monday -Friday 8:00AM-7:00PM Saturday 9:00AM-12:00PM

Mental health day treatment is four or more hours per session. How will GPS accommodate the four hour sessions with a 9:00 to 12:00 schedule?

Docket Number: 16-32083-CON

Response:

The Outpatient and Day Treatment Schedule will be as follows:

Service	Days/hours of operation
PHP	Monday-Friday : 9AM-1:30PM
IOP	Monday, Wednesday, Friday: 9AM-1:30PM
Adult Outpatient Clinic	Monday -Friday 8:00AM-7:00PM Saturday 9:00AM-12:00PM

6. On page 169 of the application, the Applicant provided the following response regarding what assumptions were used for projecting these volumes:

According to (2012, January). Bringing Behavioral Health into the Care Continuum: Opportunities to Improve Quality, Costs and Outcomes. *American Hospital Association*. 1-12. <http://www.aha.org/research/reports/tw/12jan-tw-behavhealth.pdf>. The number of psychiatric hospitals as well as psychiatric units have been on the decline since 2002. With decreasing supports via hospitals, people are relying more on community based supports to help with psychological services. There is also an increased focus on community based supports because noted in studies included in appendix that the cost of community based supports are much lower than inpatient supports. GPS hopes to increase volume to better serve the community at large.

Table 6 on page 171 of the application reports projected active client counts indicating an average of 20% year-to-year growth in patient volume and on page 172, a minimum of 27% growth in revenue with mostly Medicaid clients accounting for growth in both patients and revenues. Provide a more specific answer supported by and indicating how the Applicant calculated and arrived at patients/clients and visit volume (or treatment sessions) and the year to year growth provided in Table 2 below.

Response:

According to: *Mental Health Is Main Cause Of Hospitalizations in CT, New Data Show* (2015), in Connecticut, "Between 2010 and 2014, hospitals saw a 31 percent increase in patients with a behavioral health diagnosis." With such a large rise in patients going to hospital, there can only be the assumption that these same patients will require step-down services in the community. In addition, with the number of psychiatric beds on the decline, hospitals are not able to provide the services required for the number of patients looking for services. Having community based mental health centers will help alleviate the stress that hospitals are under due to lack of accommodations and services.

<http://c-hit.org/2015/04/19/mental-health-is-main-cause-of-hospitalizations-in-ct-new-data-show/> (**Appendix E : Mental Health Is Main Cause of Hospitalizations in CT, New Data Show**)

Updated Table 6

<i>Service*</i>	<i>Projected Volume</i>			<i>FY 2019</i>
	<i>FY 20 16_**</i>	<i>FY 20_17_*</i>	<i>FY 20_18_*</i>	
<i>Outpatient Therapy</i>	<i>138/9198</i>	<i>180/3024</i>	<i>212/3705</i>	<i>223/4446</i>
<i>PHP</i>	<i>2/0</i>	<i>25/7555</i>	<i>35/9263</i>	<i>40/11115</i>
<i>IOP</i>	<i>2/0</i>	<i>25/10078</i>	<i>41/12350</i>	<i>52/14820</i>
<i>Medication Mgnt</i>	<i>21/183</i>	<i>50/3024</i>	<i>56/3705</i>	<i>61/4446</i>
<i>Testing/Assessments</i>	<i>10/65</i>	<i>23/1511</i>	<i>29/1852</i>	<i>32/2223</i>
<i>Total*</i>	<i>173 /9446</i>	<i>207/25196</i> <i>(303)</i>	<i>250/30875</i> <i>(373)</i>	<i>300/37050</i> <i>(408)</i>

Current 2016 client count included adults and children. 2017 and beyond only reflects adult projections. Projected increases in client volume is based on the Day Treatment 6-12-week model which is a crossover of services. Client count "207" indicates projected client count with multiple services in place. For example, 2017- of the 207 clients, it is projected that those in a PHP and IOP program (at minimal) will be admitted into Outpatient and Med Management at the same time giving the client count of 303 only because the table is separated by service. Clients will also have services available to them after completion of the Day Treatment programs. Outpatient visits will be a requirement for continued Medication Management.

Docket Number: 16-32083-CON

7. The Total Payer Mix row in Table 2 below is populated with information from Table 2 page 169, Table 6 page 171 and the "Outpatient Visits" row from the updated Financial Worksheet on page 172. Provide the corresponding patient and visit volumes by payer for FY 2016-2019. For example, if there are 10 self-pay clients and each is to receive 2 IOP sessions per week, then the visit volume will be : 10 (clients) x 2 (sessions) x 52 (weeks) = 1,040 (visits). Correct any inconsistencies among the sources e.g. for FY 2017 patient volume exceed visit volume.

Response:

TABLE 2
CURRENT AND PROJECTED PAYER MIX FOR
GPS CLIENTS AND VISITS FOR PROPOSED SERVICE

Payer	Current			Projected								
	FY 2016			FY 2017			FY 2018			FY 2019		
	Pati ent Vol.	%	Visit Vol.	Pati ent Vol.	%	Visit Vol.	Pati ent Vol.	%	Visit Vol.	Pati ent Vol.	%	Visit Vol.
Medicare*												
Medicaid*	147	85%	8029	176	85%	21411	213	85.5	26367	255	85%	31489
CHAMPUS & TriCare	6	3.5%	331	7	3.4%	855	8	3%	926	10	3.3%	1222
Total Government	154	89%	8360	184	88.4 %	22268	221	88.4 %	27293	265	88%	32711
Commercial Insurers	19	11%	1040	23	11.1 %	2794	28	11.2 %	3458	33	11%	4136
Self-pay	1	.5%	47	1	.45%	131	1	.4%	124	2	.66%	203
Uninsured												
Workers Compensation												
Total Non- Government	19	11%	1087	23	11.56 %	2928	29	11.6 %	3582	36	11.7%	4339
Total Payer Mix	173	100%	9446	207	100%	25,196	250	100 %	30,875	300	100%	37,050

FY 2016: Out of the 173 patients:

10% are seen 1 session a week x 26 weeks= 450 visits

10% are seen 2 sessions a week x 52 weeks= 1799 visits

80% are seen 1 session a week x 52 weeks= 7197 visits

Docket Number: 16-32083-CON

FY 2017--Out of the 207 patients (day treatment will be open)

5% are seen 1 session a week x 26 weeks= 269 visits

5% are seen 2 sessions a week x 52 weeks= 1076 visits

45% are seen 1 session a week x 52 weeks= 4471 visits

45% are seen 4 sessions a week x 52 weeks= 19,375 visits

FY 2018--Out of the 250 patients:

5% are seen 1 session a week x 26 weeks= 325

5% are seen 2 sessions a week x 52 weeks= 1300

45% are seen 1 session a week x 52 weeks= 5850

45% are seen 4 sessions a week x 52 weeks= 23,400

FY 2019--Out of the 300 patients

5% are seen 1 session a week x 26 weeks= 390

5% are seen 2 sessions a week x 52 weeks= 1560

45% are seen 1 session a week x 52 weeks= 7020

45% are seen 4 sessions a week x 52 weeks= 28080

APPENDIX

Appendix A:

Engaging Families into Child Mental Health Treatment: Updates and Special Considerations. 15pages

Appendix B:

Connecticut Children's Behavioral Health Plan. 63 pages

Appendix C:

SAMHSA Uniform Reporting. 28 pages

Appendix D:

United States Census Bureau 3 pgs

Appendix E :

Mental Health Is Main Cause of Hospitalizations in CT, New Data Show

Appendix F:

Updated Table 4

	FY 2016_*	FY 20_17_*	FY 20_18_*	FY 2019
Revenue from Operations	\$944,600	\$2,519,600	\$3,087,500	\$3,705,000
Total Operating Expenses	\$343,021	\$369,011	\$438,298	\$506,801
Gain/Loss from Operations	\$601,579	\$2,150,589	\$2,649,202	\$3,198,199

Appendix G:

Updated Financial Worksheet

Con-16-32083

Appendix A

Engaging Families into Child Mental Health Treatment: Updates and Special Considerations

Geetha Gopalan LCSW, PhD¹; Leah Goldstein LMSW¹; Kathryn Klingenstein²;
Carolyn Sicher Psy.D¹; Clair Blake BA¹; Mary M. McKay LCSW, PhD¹

Abstract

Objective: The current paper reviews recent findings regarding how to conceptualize engagement and factors influencing engagement, treatment attendance rates, and interventions that work. **Method:** Research related to the definition of engagement, predictors of engagement and treatment termination, attendance rates, and engaging interventions are summarized as an update to the McKay and Bannon (2004) review. **Results:** Despite ongoing advances in evidence-based treatments and dissemination strategies, engaging families into mental health treatment remains a serious challenge. Within the last several years, a number of technological advances and interventions have emerged to address this problem. Families with children who present disruptive behavior challenges and symptoms of trauma are considered in terms of the unique barriers they experience regarding engagement in treatment. **Conclusions:** Potential solutions to increase treatment utilization and further research in this area are discussed.

Key words: engagement, child mental health treatment, service utilization

Résumé

Objectif: Réviser les récentes conclusions sur la manière de représenter l'engagement des familles; analyser les facteurs qui influent sur cet engagement, sur le respect du traitement; présenter des interventions efficaces. **Méthodologie:** Les travaux de recherche portant sur la définition de l'engagement, les prédicteurs de l'engagement, la décision de mettre fin au traitement, le taux de participation et les interventions sont présentés, résumés, sous forme d'actualisation de l'étude de McKay and Bannon (2004). **Résultats:** Bien que les traitements factuels et la diffusion de l'information progressent constamment, faire participer les familles au traitement des enfants atteints de maladie mentale reste un défi de taille. Au cours des dernières années, les progrès techniques et les interventions ont permis de résoudre de problème. L'étude porte notamment sur les obstacles cliniques particuliers auxquels se heurtent les familles qui participent au traitement d'enfants qui présentent des troubles du comportement et des traumatismes. **Conclusion:** L'article présente les solutions susceptibles d'améliorer la mise en place du traitement et propose des pistes pour la recherche future.

Mots clés: engagement, traitement troubles mentaux, enfants, utilisation des services

Introduction

Engaging families in child mental health treatment remains challenging despite continuing advances in evidence-based treatment approaches and efforts to disseminate these practices into the field (Hoagwood, Burns, Kiser, Ringeisen, & Schoenwald, 2001). Over the last three decades, rates of child psychopathology in the United States have ranged from 17–26% (Brandenburg, Friedman & Silver, 1990; Costello et al. 1996; Costello, Egger, & Angold, 2005; McCabe et al., 1999; Tuma, 1989; U.S. Public Health Service, 2000), with approximately 1 in

8 children manifesting a psychiatric disorder serious enough to cause significant functional impairment (Costello et al., 2005). This problem is particularly exacerbated in low-income, urban communities, where children are exposed to poverty, community violence and trauma, high rates of psychosocial stress, as well as insufficient housing, health, and mental health resources (Attar, Guerra, & Tolan, 1994; Gustafsson, Larsson, Nelson, & Gustafsson, 2009; Ingoldsby & Shaw, 2002; Jenkins, Wang & Turner, 2009; Leventhal & Brooks-Gunn, 2000; Self-Brown et al., 2006; Siefert, Finlayson, Williams, Delva, & Ismail, 2007).

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These environmental factors render children more vulnerable to developing mental health problems. Not surprisingly, rates of child psychopathology in low-income inner-city settings have been found to be as high as 40% (Tolan & Henry, 1996; Xue, Leventhal, Brooks-Gunn & Earls, 2005). At the same time, the National Institute of Mental Health (2001) reports that approximately 75% of children with mental health needs do not have contact with the child mental health service system. As challenges in meeting children's mental health needs persist, national efforts to encourage improved children's access to treatment continue (New Freedom Commission on Mental Health, 2003).

In response, McKay and Bannon's 2004 review focused on empirically supported factors related to engaging families in child mental health treatment. The current paper serves as an update to the 2004 review, as new knowledge has emerged over the last 6 years regarding the definition of engagement, rates of treatment attendance, predictors of engagement, barriers, and engagement interventions. Additionally, as little information has focused specifically on the unique needs of clinical sub-populations, this paper also summarizes issues related to engaging families whose children manifest disruptive behavior disorders and symptoms of trauma. Finally, recent findings are used in a discussion of implications for research and clinical practice.

Definition of Engagement

As indicated by McKay and Bannon (2004), engagement generally encompasses a multi-phase process beginning with (1) recognition of children's mental health problems by parents, teachers, or other important adults; (2) connecting children and their families with a mental health resource; and (3) children being brought to mental health centers or being seen by school-based mental health providers (Laitinen-Krispijn, Van der Ende, Wierdsma & Verhulst, 1999; Zwaanswijk, van der Ende, Verhaak, Bensing, & Verhulst., 2003; Zwaanswijk, Verhaak, Bensing, van der Ende, & Verhulst., 2003). Engagement can also be measured by (Step 1) rates of attendance at the initial intake appointment with a mental health provider, as well as (Step 2) retention in treatment over time. Each of these steps in the engagement process is related to the other. However, rates of engagement, as well as associated child, family, and service system characteristics differ between steps 1 and 2 (McKay & Bannon, 2004). Moreover, Alan Kazdin's work at the Yale Child Study Center argues for a more nuanced definition of service engagement into distinct phases, whereby children exit treatment at diverse points (i.e., while waiting for treatment, after 1–2 sessions, or later in treatment; Kazdin, Holland, & Crowley, 1997; Kazdin & Mazurick, 1994; Kazdin, Mazurick, & Siegal, 1994). Kazdin and Mazurick (1994) further noted that characteristics of children and families vary as a function of the point in time at which they exit services.

More recently, however, Johnson, Mellor and Brann (2008) argued that categorizing drop-outs by the number of sessions

attended can be misleading, as each treatment program requires a different number of treatment sessions to reach completion. Moreover, appropriate termination may occur after only a few sessions, particularly as many clinics limit the number of sessions offered. Instead, Johnson et al. (2008) assert that a more appropriate method for defining dropout rates utilizes the treating therapists' judgment regarding the appropriateness of treatment termination. As a result, inappropriate termination, or dropout, occurs when the therapist believes further treatment is needed while the client explicitly states they wish to discontinue treatment or fails to attend follow-up appointments. Treatment completion occurs when there is no further need for treatment, when the treatment program has been completed, and/or when both the therapist and family agree to terminating treatment.

While attendance is necessary for treatment to be delivered and for outcomes to be attained, many studies maintain that session attendance alone does not effectively describe treatment engagement. More recently, a review by Staudt (2007) emphasizes the importance of differentiating between the behavioral and attitudinal components of engagement. The behavioral component includes attendance, as well as other tasks performed by clients considered necessary to implement treatment recommendations and attain desired outcomes. Such behaviors can include participation in sessions (e.g., talking about relevant topics, practicing new skills), completion of homework assignments, demonstration of progress towards goals, discussing feelings, and engaging in efforts outside of sessions (Cunningham & Henggeler, 1999; Hansen & Warner, 1994; Prinz & Miller, 1991; Staudt, 2007). In relation to attitudes, engagement also refers to the emotional investment and commitment to treatment resulting from clients' belief that treatment is worthwhile and beneficial (Staudt, 2007; Yatchmenoff, 2005). The distinction between behavioral and attitudinal components of engagement is significant, given that many clients attend mental health treatment and other services in a perfunctory manner without ever fully investing in the therapeutic enterprise (Staudt, 2007; Staudt, Scheuler-Whitaker & Hinterlong, 2001).

Attendance at Initial Intake Appointments and Ongoing Treatment Retention

Currently, engagement in mental health care continues to be measured primarily by attendance at treatment sessions. McKay & Bannon (2004) indicated that no-show rates for initial intake appointments ranged from 48% (Harrison, McKay & Bannon, 2004) to 62% (McKay, McCadam, & Gonzales, 1996). More recently, McKay, Lynn and Bannon (2005) reported on attendance rates for 95 caregivers and children seeking treatment in an urban child mental health clinic. Among those who made an initial appointment via a telephone intake system, 28% of children accepted for services never attended an initial face-to-face intake appointment. Consequently, even conservative estimates

indicate that close to 1/3 of children and their families fail to engage at the initial face-to-face intake appointment.

It is not uncommon for length of treatment to average 3–4 sessions in urban, low-income communities (McKay, Harrison, Gonzales, Kim & Quintana, 2002). Studies from across the country estimate that 40% to 60% of children receiving outpatient mental health services attend few sessions and drop out quickly (Andrade, Lambert & Bickman, 2000; Burns et al., 1995; DeBar, Clarke, O'Connor & Nichols, 2001; Goldston et al., 2003; Kazdin & Mazurick, 1994; Lavigne et al., 1998). McKay et al. (2005) found that at the end of 12 weeks, only 9% of children remained in treatment in urban inner-city clinics. Similarly, a national study of private insurance recipients found that children and adolescents averaged 3.9 mental health visits within a six month period, with an average length of stay of less than three months (Harpaz-Rotem, Leslie & Rosenheck, 2004). However, mean number of visits and length of stay varied as a function of age, diagnosis, service setting, provider type, and insurance plan. A recent study of treatment attendance at publicly funded, community-based outpatient child mental health centers in San Diego County indicated that children attended an average of 13.8 treatment sessions (Brookman-Frazee, Haine, Gabayan & Garland, 2008). While this number is substantially higher than the average 3–4 sessions reported in mental health clinics in urban, inner-city communities (McKay et al., 2002), this discrepancy likely reflects the differing characteristics associated with service engagement between a predominantly urban, low-income setting (e.g., McKay et al., 2002) and a more heterogeneous mix of families from different socioeconomic and geographic circumstances (e.g., Brookman-Frazee et al., 2008).

Predictors of Engagement

In considering the factors affecting engagement rates, McKay & Bannon (2004) reported on associated child and family level characteristics. At the child level, males are more likely to be referred and use more services compared to females (Griffin, Cicchetti, & Leaf, 1993; Padgett, Patrick, Burns, Schlesinger & Cohen, 1993). However, this disparity in service use rates by gender decreases as children get older (Griffin et al., 1993; Wise, Cuffe, & Fischer, 2001). Children with mental health diagnoses and impaired functioning are more likely to engage in services than children without diagnoses or functional impairments (Bird et al., 1996; Burns et al., 1995; Leaf et al., 1996; Offord et al., 1987; Viale-Val, Rosenthal, Curtiss, & Marohn, 1984; Zahner, Pawelkiewicz, De-Francesco & Adnopolz, 1992). Family level factors impacting service engagement include family poverty, parent and family stress, single parent status, effectiveness of parental discipline, whether parents actually receive the type of child mental health services they prefer, and family cohesion and organization (Angold, Erkanli & Farmer, 2002; Angold et al., 1998; Armbruster & Kazdin, 1994; Bannon & McKay, 2005; Brannan, Heflinger, & Foster, 2003; Gavidia-Payne &

Stoneman, 1997; Harrison et al., 2004; Hoberman, 1992; Kazdin et al., 1997; McKay, Pennington, Lynn, & McCadam, 2001; Perrino, Coatsworth, Briones, Pantin & Szapocznik, 2001; Takeuchi, Bui, & Kim, 1993; Verhulst & van der Ende, 1997).

Research also continues to highlight that minority children and their families are less likely to be engaged in mental health services compared to non-Hispanic Caucasian families (Garland et al., 2005; Freedenthal, 2007; Lopez, 2002; Miller, Southam-Gerow & Allin, 2008; Zimmerman, 2005). Even among those receiving mental health treatment, minority children make fewer mental health treatment visits (Harpaz-Rotem et al., 2004) and receive less adequate mental health treatment (Alexandre, Martins & Richard, 2009) than Caucasian children.

Rates of treatment drop-out have also been found to vary by children's clinical diagnoses. Although children with more serious Axis I disorders (internalizing and disruptive behavior disorders) continue to be more likely to receive treatment than those with Axis I adjustment disorders only (Miller et al., 2008), a number of studies indicate that children who drop out of treatment are more likely to display behavioral difficulties, such as Conduct Disorder and delinquency (Baruch, Vrouva & Fearon, 2009; Burns, Cortell & Wagner, 2008; Johnson et al., 2008; Robbins et al., 2006). In comparison, children with higher levels of mood and anxiety disorders are less likely to drop-out of treatment prematurely (Baruch et al., 2009; Burns et al., 2008; Johnson et al., 2008).

The relationship between service engagement and child age remains unclear. It was noted in McKay & Bannon (2004) that some studies found an inverse relationship between child age and rates of engagement (Griffin et al., 1993; Wise et al., 2001) while others reported a positive relationship (Rohmann, Haroutun, Babigian, Goldberg, Zastowny, 1982; Wu et al., 1999). To date, while some findings indicate that pre- and early adolescents are more likely to drop out of treatment than older adolescents (Baruch et al., 2009), others suggest that adolescents in general may be less likely than younger children to engage in formal mental health services due to fears of being stigmatized by peers (Cavaleri, Hoagwood & McKay, 2009; Logan & King, 2001).

Research also indicates that homeless adolescents are vulnerable to service disengagement. Baruch et al., (2009) found that homeless adolescents are more likely to drop out of treatment than those with more stable housing. Instead, street dwelling homeless youth are more tied to 'street' culture and informal peer networks, which meet their primary needs for survival (i.e., eating at soup kitchens, asking for change, etc.) and emotional support (Garrett et al., 2008). Homeless youth who have fewer peers in street culture or who feel rejected by such peers may be more likely to access mental health services than those who have stronger bonds in their street dwelling community (Garrett et al., 2008).

Regarding the attitudinal component of engagement, commonly described as "buy-in," research further indicates that adolescents are more likely to attend treatment when they perceive their mental health as poor (Brookman-Frazee et al., 2008). It has been suggested that treatment engagement for adolescents may require a certain level of self-awareness of mental health symptoms. Moreover treatment attendance increases when parents and adolescents can agree on at least one treatment goal, which may render youth less resistant to investing in the treatment process (Brookman-Frazee et al., 2008).

Research on treatment engagement has also examined the relationship between family process and treatment attendance. Parent interactions with children, for example, have been shown to be strong predictors of treatment drop out. For example, mothers who make more negative statements and praise less are more likely to drop out of Parent-Child Interaction Therapy (Fernandez & Eyberg, 2009). Recent research also indicates that families are more likely to seek treatment in times of stress or crisis (Burns et al., 2008), but are most at risk of dropout due to family difficulties. Similarly, Johnson et al. (2008) found that the highest proportion of dropouts occurred for those families with psychosocial difficulties and problems related to family dynamics. In a qualitative study of factors influencing premature termination of mental health treatment by parents, Attride-Stirling, Davis, Farrell, Groark and Day (2004) found that treatment non-completers were more likely to arrive with multiple family-level problems, while completers were focused on the specific problems of the identified child. These results suggest that non-completion of treatment may result, at least in part, from elevated family distress. Such findings underscore the importance for considering how high levels of family stressors impede treatment engagement. Although highly stressed families may be more in need of supports, such stressors can hinder families' ability to seek and retain child mental health treatment (Thompson et al., 2007).

Barriers to Engagement

McKay & Bannon (2004) reported on specific logistical barriers to service use, which included concrete (e.g., insufficient time, lack of transportation), contextual (e.g., community violence), and agency obstacles (e.g., time on waiting lists) (Armstrong, Ishiki, Heiman, Mundt, & Womack, 1984; Bui & Takeuchi, 1992; Cohen & Heselbart, 1993; Kazdin & Mazurick, 1994; Miller & Prinz, 1990; Russell, Lang, & Brett, 1987; Wahler & Dumas, 1989). Additionally, perceptual barriers including poor therapeutic alliance, perceived need for treatment, perception of barriers, expectations for therapy, and beliefs about the therapeutic process also impacted engagement beyond logistical barriers (Garcia & Weisz, 2002; Kazdin et al., 1997; MacNaughton & Rodrigue, 2001; Nock & Kazdin, 2001). Ethnocultural beliefs and attitudes further influenced service engagement, as some cultural groups subscribe to a belief that parents should overcome

child mental health problems on their own (McCabe, 2002; Snowden, 2001).

Specific barriers which impede successful mental health service use engagement for adolescents include fears of labels or anticipating stigma from others (Boldero & Fallon, 1995; Yeh, McCabe, Hough, Dupuis, & Hazen, 2003). The adolescent developmental period is characterized by a strong need to establish a sense of competence, social acceptance, and autonomy. As a result, adolescents may have great difficulty coming to terms with the undesirable implications of having a mental health difficulty for their sense of normalcy, identity, and independence (Wisdom & Green, 2004). Not surprisingly, adolescents often refuse services due to stigma about mental health difficulties and fears that peers may have knowledge of their psychiatric issues (Cavaleri et al., 2009). Other barriers to engagement in mental health services for adolescents include lack of knowledge about the need for mental health treatment, what services might be helpful, as well as details about the overall treatment process itself (Goldstein, Olfson, Martens, & Wolk, 2006; Logan & King, 2001). Finally, the developmental goals of adolescence, which involve establishing independence from adults, may lead to an increasing tendency to avoid self-disclosure to adults in general (Seiffge-Krenk, 1989), consequently hindering the ability for adolescents to readily seek assistance from traditional mental health providers.

Poor therapeutic alliance is another substantial barrier in engaging and retaining families in child mental health treatment (Kerkorian, McKay & Bannon, 2006; Robbins et al., 2006). Kerkorian et al. found that parents who felt disrespected by their children's prior mental health providers were six times more likely to doubt the utility of future treatment, and were subsequently likely to identify more structural and contextual barriers to treatment. Robbins et al. found that both adolescent and maternal alliances with therapists in Multidimensional Family Therapy for adolescent substance abuse declined significantly between the first two sessions among dropout cases, but not among treatment completers. Moreover, differences between maternal and adolescent therapeutic alliance, as well as differences between maternal and paternal alliance with therapists, predicted treatment dropout (Robbins et al., 2008). Furthermore, the relationship between different levels of therapeutic alliance among family members and treatment dropout has been found to be stronger among Hispanic than Caucasian families. Flicker, Turner, Waldron, Brody, & Ozechowski (2008) noted that among Hispanic families, those who did not complete functional family therapy for adolescent substance abuse experienced more intra-family differences in therapeutic alliances than treatment completers. However, the same effect was not observed among Caucasian families in the study. Flicker et al. (2008) suggested that therapists' inexperience in addition to the insufficient attention to cultural factors (e.g., familism and hierarchy within Hispanic families) may contribute to engagement difficulties. Such

findings indicate that problematic alliance may be observable as early as the first few sessions, particularly the differential treatment alliance between family members and for specific cultural groups. Sufficient therapist training in addressing early alliance problems, as well as respecting culturally specific family processes could lead to increased retention rates.

Parents' beliefs about the causes of their children's problems may also hinder mental health service use. Yeh et al. (2005) determined that parents who believed that their children's problems were due to physical causes or trauma were 1.56 times more likely to use mental health services compared with those who had other etiological beliefs (e.g., personality, relationships with friends and family, family issues). However, parents who believed that their children's relationships with friends caused mental health difficulties were 25% less likely to use services compared to parents who believed that child mental health difficulties were caused by American culture, prejudice, economics, spiritual issues, and nature disharmony. Providing mental health education to parents on the bio-psycho-social model of children's mental health difficulties may assist in addressing this particular barrier to service use.

Interventions That Promote Engagement

McKay & Bannon (2004) identified a number of interventions and strategies designed to overcome logistical, perceptual, and cultural barriers to engaging in child mental health treatment. These involved using reminder letters and phone calls (Kourany, Garber, & Tornusciolo, 1990; MacLean, Greenough, Jorgenson, & Couldwell, 1989; Shivack & Sullivan, 1989), initial telephone contact strategies (i.e., when parents first contact clinics via telephone to set up an intake appointment; Coatsworth, Santisteban, McBride, & Szapocznik, 2001; McKay et al., 1996; Santisteban et al., 1996; Szapocznik et al., 1988) and face-to-face intake procedures (McKay, Nudelman, McCadam, & Gonzales 1996). Additional strategies include those which address parent concerns and barriers during the course of treatment (Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 1998; Kazdin & Whitley, 2003; Prinz & Miller, 1994; Szykula, 1984). Moreover, dedicated paraprofessional and professional clinical staff are also helpful in promoting family engagement (Burns, Farmer, Angold, Costello, & Behar, 1996; Elliott, Koroloff, Koren, & Friesen, 1998; Koroloff, Elliott, Koren, & Friesen, 1994; 1996).

Technology-based interventions

Recent mental health and primary care engagement research indicates that telephone reminders continue to be an effective strategy to increase attendance at mental health treatment appointments, particularly when therapists, rather than clinic staff, make direct contact with clients or families (Shoffner, Staudt, Marcus, & Kapp, 2007). Additionally, new technology to improve appointment attendance includes the use of the internet and cellular telephones. A web-based appointment system that

allows clinicians and staff to make, change, and confirm therapy appointments led to an increased likelihood of attendance at first therapy sessions (74%), as compared to traditional therapist-based scheduling by telephone (54%) (Tambling, Johnson, Templeton, & Melton, 2007). Appointment reminders sent via text-messaging is also an effective way to improve attendance rates at primary care outpatient services (Downer, Meara, Da Costa, & Sethuraman, 2006; Leong et al., 2006), and could be easily implemented at mental health clinics.

Paraprofessional staff

Additionally, research continues to focus on the use of paraprofessional staff to promote engagement. Trained parent, or family, advocates are paraprofessionals who have special needs children themselves. Family advocates are trained to coach and support families in need of mental health services utilizing the skills and knowledge they have already developed by successfully navigating the mental health service system for their own children. Family advocacy and support programs increased in number nationwide (Hoagwood et al. in press; Olin et al., in press), and approximately 10,000 families access training, services, and support through family advocacy programs annually in New York State alone (Olin et al., in press). The Parent Empowerment Program (PEP) in New York State trains family advocates to address the needs of parents dealing with child mental health difficulties by focusing on empowering their clients as active agents of change (Olin et al., in press). PEP integrates practical principals of parent support, the Unified Theory of Behavior Change (UTB; Jaccard, Dodge, & Dittus, 2002; Jaccard, Litardo, & Wan, 1999), and evidence-based engagement strategies (McKay, McCadam, & Gonzales, 1996; McKay, Nudelman, McCadam, & Gonzales, 1996; McKay, Stoewe, McCadam, & Gonzales, 1998). Delivered by current or former parents of children with identified mental health needs, family advocates trained in the PEP model provide instrumental and emotional support, information about mental health services, care coordination, referral and linkage to other services, respite, recreation, and direct advocacy (Jensen & Hoagwood, 2008). Moreover, the personal experience of advocates increases credibility and the ability to engender trust with parents, thereby helping families become more actively engaged in their children's care (Gyamfi et al., 2010; Hoagwood et al., 2008; Koroloff, et al., 1994; 1996; Olin et al., in press; Robbins et al., 2008). Although research on family advocates is in the preliminary stages, it has been suggested that when family advocates are integrated in child mental health service delivery, families are more likely to engage in treatment (McKay et al., in press).

A related area focuses on outreach, engagement, and psychoeducation services provided by peer youth specialists as a promising way to address difficulties in engaging adolescents into mental health treatment. Peer youth specialists, who are adolescents and young adults themselves, are often seen as more

credible and may possess a greater understanding of youths' concerns compared to adult professionals. As a result, peer youth specialists possess an enhanced ability to engage adolescents to address a range of issues, including substance abuse, HIV/STD prevention, suicide prevention, and academic failure (Tindall & Black, 2009). Moreover, adolescents may be more responsive to younger service providers seen as peers rather than older adults (French, Reardon, & Smith, 2003).

Within the mental health field, peer youth specialists have been integrated into a treatment program for sexually abused children and adolescents. In the Peer Support Program (Alaggia, Michalski, & Vine, 1999), peer youth specialists, who have been affected by sexual abuse themselves, liaise with community agencies and schools to identify and engage sexually abused children and adolescents who might not otherwise seek treatment services through formal networks. Consumer feedback indicated that youth found the outreach efforts and availability of the peer youth specialist as one of the most important features of the program (Alaggia et al., 1999). Recent national attention has promoted the use of peers for transition-age (16–25) youth and young adults (e.g., Galasso et al., 2009) to provide support and assist in self-advocacy skills. Additionally, peer youth advocacy groups have emerged across the country (e.g., Youth MOVE: <http://www.youthmove.us/>) to ensure that youth voice is integrated into mental health program planning and service delivery.

Finally, the New York State Office of Mental Health has formalized the peer youth specialist role (called "Youth Advocates") within support services for families whose children manifest significant mental and behavioral health difficulties. Youth advocates are adolescents and young adults (aged 17–22) who have current or prior mental health challenges, for which they have received services through the child-serving system (e.g., mental health, child welfare, juvenile justice; Roussos, Berger, & Harrison, 2008). Currently, eighteen youth advocates in the New York City metropolitan area (1) engage children and adolescents and their families in identifying service needs and goals; (2) provide support, education on mental health issues, and guidance based on youth advocates' personal experiences; (3) organize social, recreational and educational activities for children and adolescents; and (4) represent the interests of youth mental health challenges in public forums (Personal communication with B. Lombrowski, 4/22/10). Although youth advocates have yet to be formally evaluated regarding their ability to promote engagement among youth in outpatient mental health treatment, they represent an emerging national interest in expanding peer outreach services for adolescents involved in the mental health system (Federation of Families for Children's Mental Health, 2001; Children's Mental Health Plan Youth Advisory Workgroup, 2008).

Beyond clinic walls

Improving engagement and access to child mental health services has also been improved by programs operating outside the traditional clinic environment. For example, combining school-based and family-directed mental health services for children through the Positive Attitudes toward Learning in Schools (PALS) program (Atkins et al., 2006) has contributed to success in service engagement and retention. PALS focuses on improving the classroom and home behavior of children with disruptive behavior disorders, consisting of both classroom-based (e.g., posting rules, behavior contingencies, individualized reward systems) and family-directed (e.g., parent groups co-facilitated by clinicians and parent advocates) services. Atkins et al. found that 80% of families agreed to enroll in PALS versus 55% of families engaging in traditional clinic services. At three months, 100% of PALS families remained enrolled in the program, while 0% of control families continued to receive clinic-based services. At 12 months, 80% of PALS families still remained in services, and among these, 83% agreed to re-enroll in PALS for the following year, while 36% of control families agreed to re-enroll in clinic-based services. Atkins et al. attributed the engagement and effectiveness success of the PALS program to the concurrent use of school- and home-based services, as well as the active involvement of parent advocates who were instrumental in helping low-income minority families overcome multiple barriers to mental health service use (Frazier, Abdul-Adil, & Atkins, 2007).

Home-based therapy is also an effective way to deliver mental health services to adolescents and their families. Slesnick and Prestopnick (2004) reported that providing in-home, as opposed to office-based, family therapy significantly increased attendance and participation in therapeutic sessions among adolescents and their family members. Thompson, Bender, Windsor, and Flynn (2009) recently confirmed this finding among adolescents with behavior problems receiving solution-focused family therapy. Participants who received home-based therapy enhanced by experiential activities designed to strengthen communication, relationship-building, and coping, remained in treatment significantly longer than a comparison group who received office-based family therapy (Thompson et al., 2009). Providing services in the home undoubtedly helps to eliminate structural barriers to treatment, such as transportation problems and childcare.

Strength-based approaches

An increasing number of programs that have adopted a strengths-based approach to delivering services to families, sometimes referred to as a family support perspective (Kagan & Shelley, 1987). This philosophy of practice builds on family members' competencies, supports families to make decisions for themselves, and focuses on enhancing the strengths of families, including cultural strengths, rather than fixing deficits (Green, McAllister, & Tarte, 2004). Strength-based practices are likely to

influence the extent to which parents actively engage in program services (Green, Johnson, & Rodgers, 1999). To the degree that parents feel respected, valued, and treated as if they are knowledgeable and capable, they may also be more likely to actively partner with program staff to work toward their goals (DeChillo, Koren, & Schultz, 1994).

Patient empowerment and activation has emerged as a strength-based strategy to increase engagement for minority adult mental health clients, and has potential for parents bringing their children to treatment for mental health problems. The Right Question Project-Mental Health (RQP-MH) program (Alegria et al., 2008) consists of three patient trainings, during which participants are encouraged to identify questions they have for their mental health providers, formulate comfortable ways of phrasing their questions, and engage in role-play to practice asking their questions and following-up on answers. Among a sample of low-income, primarily Spanish speaking adults, Alegria et al. (2008) found that intervention participants were over twice as likely as a comparison group to be retained in treatment, 29% more likely to attend their scheduled visits, and over three times more likely to have at least one follow-up visit.

As another strength-based approach, Motivational Interviewing (MI), is a directive, client-centered counseling style in which providers encourage patients to argue for behavior change for themselves and overcome ambivalence towards such change (Miller & Rollnick, 2002). MI is more focused and goal-directed than traditional counseling methods, with examination and resolution of ambivalence being its central purpose (Miller & Rollnick, 2002). According to Miller and Rollnick (2002), the value of motivational interviewing lies in the patient discovering the advantages and disadvantages of treatment for himself or herself. Essential components of the MI counseling style include reflective listening, use of open-ended questions to explore patients' motivations for change, affirm patient's own change-related statements and efforts, helping patients recognize the gap between current behavior and their desired life goals, asking permission before providing advice or information, using non-confrontational responses to resistance, encouraging patient's self-efficacy, and collaborating with patients on action plans (Miller & Rollnick, 2002).

MI has been found to improve retention rates among adults (e.g., Carroll et al., 2006; Murphy, Thompson, Murray, Rainey & Uddo, 2009; Sherman et al., 2009), and has been used as a treatment model with various adolescent populations, including youth in emergency room settings who are presenting for and currently being treated for injuries (Monti & Colby, 1999), and most commonly, adolescents with substance abuse and addiction issues (Colby, Monti & Barnett, 1998; Monti & Colby, 1999; Sciacca, 1997).

Most recently, MI techniques, such as the expression of empathy, development of discrepancy, rolling with resistance, and support

for self-efficacy, have been integrated into a 1–2 session intervention designed to increase the likelihood that adolescents with serious psychiatric illness successfully participate in mental health treatment (Making Connections Intervention [MCI]; Lindsey, Bowery, Smith, & Stiegler, 2009). The MCI program addresses factors that influence treatment acceptability (i.e., engagement, perceived relevance, and service satisfaction) prior to treatment participation. The MCI program has the potential to enhance help-seeking behaviors by empowering adolescents to identify perceptual and actual barriers that influence their treatment acceptability and equip them with the skills to overcome these barriers. Plans to evaluate the impact of MCI in combination with an evidence-based treatment for adolescent depression (i.e., Interpersonal Psychotherapy for Adolescents [IPT-A]; Mufson, 2010) are currently underway.

Additionally, MI techniques have been integrated into engagement-specific interventions for depressed mothers whose children receive psychiatric treatment (Swartz et al., 2007; Zuckoff, Swartz, & Grote, 2008; Zuckoff, Swartz, Grote, Bledsoe, & Speilvogle, 2004). MI in combination with ethnographic interviewing (EI) has been formulated into a single engagement session designed to enhance clinicians' ability to identify, comprehend, and resolve patients' ambivalence regarding help-seeking and entering treatment. Developed in response to the difficulty in engaging depressed mothers of psychiatrically involved children into their own treatment, the MI/EI intervention was designed to address patient ambivalence as well as clinician biases which could serve as barriers to engaging patients into treatment. A recent study utilized the MI/EI engagement session in combination with brief Interpersonal Psychotherapy (IPT-B as described in Grote et al., 2004). Grote, Zuckoff, Swartz, Bledsoe, & Geibel (2007) found that 96% of women in the MI/EI plus IPT-B condition attended their initial treatment session vs. only 36% of women in the IPT-B alone condition ($p < .001$). Although the MI/EI intervention has been designed to engage adult patients into their own treatment, it may have potential utility with those parents whose children require psychiatric treatment but who may be especially resistant to formal child mental treatment models.

Special Populations

Families of children with disruptive behavior disorders

Childhood disruptive behavior difficulties, including persistent oppositional and/or aggressive behavior, are among the most common reasons for referrals to child mental health clinics (Frick, 1998; Kazdin, 1995). These disorders are particularly concerning because of the high degree of impairment and poor developmental trajectory (Lahey & Loeber, 1997). However, as stated earlier, families whose children manifest such difficulties have an increased likelihood of dropping out of treatment

prematurely (Baruch et al., 2009; Burns et al., 2008; Johnson et al., 2008; Robbins et al., 2006), losing any progress families may have made before terminating services. Such families experience additional stressors and commitments that limit the resources available to facilitate attendance at appointments (Miller & Prinz, 1990), such as insufficient time, lack of transportation, and concerns that services might not help (McKay et al., 2005). Moreover, parents often need support and education on providing reinforcement, using alternatives to physical punishment, focusing on treatment gains rather than on negative behaviors, effective communication skills, and problem solving (Miller & Prinz, 1990). Additionally, these children, by the nature of their difficulties, may not fully participate in sessions despite being physically present. It is not uncommon for such children to disagree with the treatment plan, or resist treatment altogether (McKay et al., 2005).

The Multiple Family Group (MFG) service delivery model to reduce disruptive behavior disorders, developed by Dr. Mary McKay and colleagues at the Mount Sinai School of Medicine (MSSM), is specifically tailored to improve engagement, retention, and effectiveness of services for urban children and families of color (Franco, Dean-Assael, & McKay, 2008; Gopalan & Franco, 2009). This model involves school-age, inner-city children (ages 7 to 11) who meet diagnostic criteria for Oppositional Defiant Disorder (ODD) or Conduct Disorder (CD) and their families (including adult caregivers and siblings between the ages of 6 to 18 years) in a 16-week series of group meetings with 6 to 8 families. The MFG service delivery model addresses those family factors (i.e., poor parental discipline and monitoring, inadequate behavioral limits, lack of parent-child bonding, family conflict, stressors, family disorganization, family communication, within family support, and low level family interactions) which are consistently implicated in the onset and maintenance of childhood behavioral difficulties, and predict the development of child ODD and CD (Alexander, Robbins, & Sexton, 2000; Dishion, French & Patterson, 1995; Egeland, Kalkoske, Gottesman, & Erickson 1990; Keiley, 2002; Kilgore, Snyder, & Lentz, 2000; Kumpfer & Alvarado, 2003; Loeber & Farrington, 1998; Loeber & Stouthamer-Loeber, 1987; Patterson, Reid, & Dishion, 1992; Reid, Eddy, Fetrow, & Stoolmiller, 1999; Sampson & Laub, 1994; Shaw, Vondra, Hommering, & Keenan, 1994; Tremblay, Loeber, Gagnon, & Charlebois, 1991). In addition, MFG content addresses specific family factors related to urban living, socioeconomic disadvantage, social isolation, high stress, and lack of social support. These factors hinder effective parenting and contribute to childhood conduct difficulties, as well as relate to early drop out (Kazdin & Whitley, 2003; Wahler & Dumas, 1989). In addition, intervention sessions have been designed to target factors (e.g., parental stress, use of emotional and parenting support resources, family involvement with the child in multiple contexts, and stigma associated with mental health care) which potentially impact inner-city child mental

health service use and outcomes. Key components are delivered via content and activities based on core elements of parent training and systemic family therapy.

The use of MFGs has been shown to increase family engagement in treatment (McKay et al., 2005). A preliminary study of the MFG model examined the impact of MFGs on 138 children with conduct problems and their families, who were assigned to MFG or service as usual (family therapy or individual therapy). Families in the MFG groups attended on average 7 ± 3.3 sessions during a 16-week period. In comparison, families in the "treatment as usual" family therapy group attended an average of 4 ± 3.2 sessions, while families in the "treatment as usual" individual therapy group attended an average of 3.1 ± 2.7 sessions. Currently, the MFG service delivery strategy to reduce child disruptive behavior disorders is being tested in a large-scale effectiveness study funded by the National Institute of Mental Health (NIMH). Preliminary data indicates that engagement rates for families in the MFG treatment condition far surpass what would normally be seen in urban child mental health clinics (McKay et al., in press; McKay et al., 2005).

Families and children affected by trauma

In a recent study conducted by the Office of Juvenile Justice and Delinquency Prevention (Finkelhor, Turner, Ormrod, Hamby, & Kracke, 2009), more than 60% of children in the United States reported being exposed to violence within the past year. Children exposed to trauma can experience a number of short-term and long-term disturbances in self-regulation (e.g., avoidance, withdrawal, sleep disturbance, changes in appetite, difficulties regulating mood, and difficulties concentrating, exaggerated startle response, hyper-vigilance, a need to repeat the event through words and/or play, flashbacks or re-experiencing), somatic complaints (e.g., headaches, stomachaches and back pain), as well as increased disturbances in mood, developmental achievements, behavior, and risk-taking activities (e.g., using drugs and alcohol, promiscuous sexual activity, skipping school, running away from home) La Greca, Silverman, Vernberg, & Roberts, 2002; Cohen, Mannarino, & Deblinger, 2006). If symptoms do not subside over time on their own or with treatment, individuals may develop depression, anxiety, PTSD, personality changes, substance abuse, and impaired school functioning (La Greca et al., 2002; Cohen et al., 2006). Additionally, traumatized children are more likely to be involved in violent relationships, either as victims or perpetrators (Harpaz-Rotem, Murphy, Berkowitz, & Rosenheck, 2007).

Recommended treatment includes early engagement to identify and monitor initial reactions to trauma which may lead to future disorders (Berkowitz, 2003), ensuring that concrete needs (e.g., safety, shelter, employment, medical care) are met (Saltzman, Layne, Steinberg, Arslanagic, & Pynoos, 2003), providing psychoeducation about normal and abnormal reactions to trauma, and enhancing coping skills (Saltzman et al., 2003).

However, several factors impede engagement for those who have been exposed to violence and trauma. Individuals who suffer post-traumatic reactions often do not recognize the effects of the event until a significant and persistent loss of functioning has occurred (Elhai & Ford, 2009). When someone experiences a traumatic event, they become physically, emotionally, and cognitively dysregulated (Osofsky & Osofsky, 2004). One reaction is a desire to avoid the traumatic incident and any reminders. Moreover, individuals frequently withdraw from the very support systems and routines which are likely to assist with recovery (Cohen et al., 2006). Other engagement barriers specific to trauma include perceived intrusiveness of clinicians, trauma fatigue (a weariness of discussing the tragic event), aversion to being probed about the event and the associated feelings, and parents underestimating the exposure and effects of the traumatic event on themselves and their children (Levitt, Hoagwood, Greene, Rodriguez, & Radigan, 2009). Families often withdraw from their normal daily routines and social supports in order to avoid further exposure to potentially traumatic events or traumatic reminders. Unfortunately, such a withdrawal limits access by mental health providers to victims (particularly children), especially when caregivers fear that children could be re-traumatized if asked to discuss the trauma (Elhai & Ford, 2009).

Early identification is a significant challenge to treating children and families who have been exposed to violence and trauma. Most of the time, families do not seek treatment until and unless their child is exhibiting significant behavioral problems. Many children may minimize their reactions to the traumatic event to avoid upsetting their parents or caregivers (Levitt et al., 2009). Moreover, as typical trauma reactions include internalizing behaviors (e.g., avoidance, denial, depression, withdrawal, sleep disturbances, changes in appetite and concentration), parents who are unaware of such symptoms or who lack education on what to look for may be unlikely to seek appropriate and timely treatment. The result is that a large percentage of children in need of services are never identified or seen by mental health professionals (Finkelhor, Ormond & Turner, 2007).

Even when parents are aware, many feel guilty that they were unable to protect their child from the initial trauma. Fears of being judged and attempts to protect their child from re-traumatization may lead parents to avoid treatment (Elhai & Ford, 2009). Strategies to overcome trauma-specific barriers include providing psychoeducation for children and parents about normal reactions to abnormal events, orienting parents to the treatment process, and assuring them that successful treatment will help children get better faster. As many parents may experience their own difficulties following a traumatic event (deVries et al., 1999), parents should also be educated on the importance of treatment for themselves and provided referrals. Moreover, framing parent well-being within a family systems context helps parents to understand how their own mental health status affects their child.

Finally, additional treatment barriers include socio-economic status, lack of health insurance, negative experiences with clinic staff, lack of knowledge regarding how to access services, bureaucratic red tape, familial discord, lack of transportation, child-and-family care, finances, employment schedules, and environmental chaos (Davis, Ressler, Schwartz, Stephens, & Bradley, 2008). While these obstacles are not unique to those who have experienced trauma, violence tends to occur in the most vulnerable communities (Self-Brown et al., 2006). Community-based interventions that intervene beyond the clinic walls provide an opportunity to collaborate with community stakeholders and provide access to those who need it most. Moreover, collaborative community-based interventions in the acute phase following trauma exposure may assist in early identification and engagement. One example, the Child Development Community Policing Program (CDCP), involves collaboration between the New Haven Department of Police Services and clinicians from the Yale Child Study Center. The model involves a partnered response to children and families following incidents where children are involved as victims and/or witnesses of violence and trauma. This partnered response allows police to secure the scene while clinicians intervene by providing psychoeducation, acute coping strategies, and treatment options. As a result, the family's sense of physical and emotional safety is enhanced. Police/clinician teams follow up with the family within a week to assess current functioning and symptoms, answer questions related to the incident, and continue ongoing treatment planning with the family (Marans, 2004). Recent findings indicate the CDCP program has been particularly successful in reaching Hispanic children, and in responding to incidents involving gang involvement, accidents, felony assaults, property crimes, family violence, and psychiatric crises. Moreover, children and families involved in the most severe incidents and those with a primary mental health component are more likely to utilize intensive CDCP services (Murphy, Rosenheck, Berkowitz, & Marans, 2005).

Implications and Conclusions

Beginning with McKay and Bannon's (2004) review, recent studies suggest broadening the definition of treatment engagement beyond simple treatment attendance. From a clinical perspective, providers are well-advised to pay attention to indicators of treatment disengagement prior to sessions being missed (e.g., difficulty scheduling appointments, lack of follow-through on intervention plans, insubstantial treatment goals, uneven treatment progress, lying about important issues; Cunningham & Henggeler, 1999). Furthermore, future research can measure different behavioral indicators of engagement beyond simple treatment attendance (e.g., participation and cooperation in sessions, homework completion, demonstrating progress towards goals). When distinguishing between appropriate treatment completion and drop-out, clinician/client agreements to treatment

termination should be considered (Johnson et al., 2008). Measurement of engagement should also include an attitudinal component to distinguish those clients who are invested in treatment from those who are simply complying (Staudt, 2007). This may be accomplished by incorporating treatment process measures such as the Metropolitan Area Child Study (MACS) Process Measure (Tolan, Hanish, McKay, & Dickey, 2002).

Although recent data show discrepancies between the average number of treatment sessions attended in child mental health clinic settings (i.e., Brookman-Frazee et al., 2008; McKay et al., 2005), such differences may result from the differing socioeconomic and geographic characteristics between low-income urban settings (i.e. McKay et al., 2005) compared to an entire county consisting of urban, suburban, and rural communities (i.e. Brookman-Frazee et al., 2008). Given an inverse correlation between service use and poverty, parent and family stress, and minority and single parent status (Angold et al., 1988; Armbruster & Kazdin, 1994; Brannan et al., 2003; Freedenthal, 2007; Garland et al., 2005; Gould et al., 1985; Hoberman, 1992; Kazdin et al., 1997; Lopez, 2002; Miller, Southam-Gerow & Allin, 2008; Zimmerman, 2005), it is not surprising that urban clinics may experience greater challenges in retaining low-income, single-parent families of color who typically utilize community mental health services. Moreover, an overall lack of sufficient child mental health service providers in urban, inner-city settings (Asen, 2002) creates even greater obstacles to accessing treatment. Recent findings additionally identify that families whose children have disruptive behavior disorders, homeless adolescents, families where parents and children disagree on treatment goals, families with more hostile parent-child interactions, and families with multiple psychosocial issues are particularly difficult to engage and retain in treatment. Moreover, the quality of the therapeutic alliance with parents and children, as well as parents' etiological beliefs regarding their children's mental health difficulties, also influence child mental health treatment engagement. Clinical solutions may entail the use of more culturally appropriate services and provider engagement of minority families, multi-level services to address complex family needs, psychoeducation about the bio-psycho-social model of child mental health difficulties and continued attention to promoting productive working relationships between parents, children, and therapists. This is particularly important as problems with alliance may be prevalent even within the first few sessions. Finally, specialized treatment programs focused on engaging families whose children manifest disruptive behavior disorders (e.g., Franco, Dean-Assael, & McKay, 2008; Gopalan & Franco, 2009), particularly for urban, low-income, minority families, may be beneficial for those families least likely to engage in child mental health treatment.

Although previous research presents equivocal findings regarding the relationship between child age and engagement, it may be worth exploring how reluctance to seek treatment and treatment

disengagement varies across the different developmental stages of childhood and adolescence. Moreover, clinicians who elicit adolescents' perspectives on their own mental health symptoms to increase self-awareness may be more likely to increase adolescents' motivation for treatment. Finally, resolving potential conflicts between parents and youth by finding common treatment goals may have utility in increasing treatment retention.

The advent of new technology means that treatment engagement can be further improved through the use of web-based appointment systems and texting to mobile phones. Additionally, making treatment available outside the traditional clinic walls through school- and home-based service delivery models is promising for the promotion of initial engagement and service retention. Patient empowerment and activation may provide parents with skills to advocate for their children's treatment. As a result, future clinical and research activities may focus on ways to adapt the RQP-MH and MI interventions for the child mental health context. Moreover, the use of paraprofessional family advocates and peer youth specialists are gaining increasing popularity, particularly given a growing demand for consumer-led services in mental health (New Freedom Commission on Mental Health, 2003). Finally, this article focuses attention towards those families whose children manifest disruptive behavior disorders and traumatic symptoms. As these special populations present with unique treatment barriers, both clinical and research activities should explore how the highlighted programs can help to overcome obstacles to treatment engagement faced by families with such needs.

Acknowledgements/Conflicts of Interest

The authors have no financial relationships or conflicts to disclose.

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Appendix B

Connecticut Children's Behavioral Health Plan

Prepared pursuant to Public Act 13-178
And Submitted to Connecticut General Assembly

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I. Introduction

A. Legislative Charge: PA 13-178

The Connecticut Department of Children and Families (DCF) is submitting this Connecticut Children's Behavioral Health Plan in fulfillment of the requirements of Public Act (PA)13-178, one part of the Connecticut General Assembly's response to the tragedy in Newtown in December 2012.¹ The legislation called for development of a "comprehensive implementation plan, across agency and policy areas, for meeting the mental, emotional and behavioral health needs of all children in the state, and preventing or reducing the long-term negative impact of mental, emotional and behavioral health issues on children." Although developed under the guidance of DCF, this Plan is the product of extensive public input and discussion over the past eight months and aspires to be owned by the diverse set of organizations and individuals who had a part in its design and hopefully will be invested in making it a reality.

Every child deserves the opportunity to grow up in a nurturing and supportive home and in a community and school that promotes optimal social and emotional development. To achieve their best possible health and well-being, children require, at a minimum: safety and security, positive relationships with peers and caring adults; a sense of meaning and purpose; connections to community; physical activity and nutrition; and opportunities for play and learning.^{2,3} Existing frameworks for well-being differ but all underscore the basic principle that the absence of illness is not the same as the presence of health. The well-being framework adopted by the Administration on Children, Youth and Families (ACYF) specifies measurable domains of well-being in the areas of cognitive functioning, physical health, behavioral/emotional health, and social functioning.^{4,5} Domains of health and well-being can be threatened throughout the lifespan by trauma, maltreatment, and other adverse childhood experiences that result in toxic stress and can lead to emotional or mental illness.⁶ The scope of PA 13-178 envisions a statewide children's behavioral health system in which the well-being of all children is actively promoted, the damaging consequences of toxic stress are prevented, and children with identified needs and their families have access to timely, appropriate and effective supports and interventions that will restore them to a path toward sustained well-being.

There are approximately 783,000 children under age 18 currently in Connecticut, constituting 23% of the state's population. Epidemiological studies using large representative samples suggest that as many as 20% of that population, or approximately 156,000 of Connecticut's children, may have behavioral health symptoms that would benefit from treatment.^{7,8} Researchers have found that between 37 and 39 percent of youth in the three studies had received one or more behavioral health diagnoses between ages 9 and 16.⁹ Half of all lifetime diagnosable mental illness begins by age 14.¹⁰ Despite the prevalence of behavioral health conditions, an estimated 75-80% of children in Connecticut with behavioral health needs do not receive treatment.¹¹

Exposure to trauma or Adverse Childhood Experiences (ACE) is a growing concern, with a recent study suggesting that two-thirds of children have at least one ACE and 10% have five or more.¹² Eighty percent of the youth admitted to detention in Connecticut report a history of trauma.¹³ The federal Substance Abuse and Mental Health Services Administration (SAMHSA) reports the prevalence rates for substance abuse by age 17 (nationwide) as more than 30% for marijuana and more than 60% for alcohol.¹⁴ Additionally, according to DCF data, more than 60% of boys in the CT Juvenile Training School (CJTS) over the past three years had a substance use diagnosis. Additionally, youth who are involved in the juvenile justice system have high rates of diagnosable behavioral health conditions, as high as 70% for youth in juvenile detention.¹⁵

A recent Institute of Medicine report on prevention concludes that "there is consistent evidence from multiple recent studies that early [behavioral health] disorders should be considered as commonplace as a

fractured limb: not inevitable but not at all unusual. The prevalence of these disorders is the same in young people as it is in adults. An implication for prevention is that universal programs will not be wasted on large numbers of risk-free children.”¹⁶

Despite the prevalence of behavioral health and substance abuse concerns and that an estimated 96% of children are covered by health insurance, practitioners and policy makers still have extensive work to do to ensure compliance with federal and state mandates regarding promotion, prevention, and early identification, access to care, parity between behavioral health care and medical care, and access to treatment in the least restrictive environment.

The State of Connecticut has made tremendous strides in building a more responsive, publicly funded behavioral health service system in recent years that includes an array of school, center- and home-based services (See Section III.B.). Twenty-four Child Guidance Clinic (representing upwards of 90 sites) have been designated as Enhanced Care Clinics with increased reimbursement for providers committed to achieving a set of pre-defined service improvements. Forty-seven of these locations offer specialty evidence-based trauma focused clinical treatment for children suffering from adverse child experiences. Twenty-six System of Care (SOC) community collaboratives across the state are supported by a workforce of care coordinators who coordinate cross-sector child and family teams to individualize treatment planning for children with serious emotional disturbance (SED). State-supported School-Based Health Centers (SBHC) have expanded in number to 96, many more schools receive behavioral health supports through other means, including hospital and community-clinic partnerships and the co-location of pediatric and family behavioral health providers. There is increasing attention to the behavioral health needs of very young children through such interventions as Early Head Start/Head Start, Birth to Three, the Early Childhood Consultation Partnership, Child First and the Infant Mental Health Endorsement. Statewide and community-level family advocacy organizations have resulted in a stronger presence of family advocacy and family and youth participation in governance and service delivery. Through the Connecticut Behavioral Health Partnership (CT BHP), resources and services for children enrolled in Medicaid are much more efficiently and effectively managed through an Administrative Services Organization.

Notwithstanding these significant improvements and reforms for children served through the public sector, too many families with children in need of immediate behavioral health services struggle to understand and navigate a difficult and fragmented system that lacks basic capacity across the array of services. Identified roadblocks for accessing care include a diffuse network of payers, differing categorical and financial eligibility criteria, restrictions on covered services, and inconsistent standards for clinical practices. Access issues are compounded by inadequate training for specific behavioral health conditions as well as lack of trained personnel. Policymakers have faced a barrage of constituent complaints about the lack of access to services, lack of complete and clear data on the current system and a conflicting array of prescriptive actions for remedying the situation. The many families who told their stories in the course of gathering information for this Plan attest to the fact that, despite significant improvements, the system remains broken.

Table I.1 Coverage Status of Connecticut Children Under Age 18

Coverage Category	Percent	Number of Children
Covered by private commercial plans subject to State coverage mandates	28.0%	219,240
Covered by private plans of self-insured employers (not subject to State mandates)	28.0%	219,240
Covered by public plans (HUSKY A, HUSKY B, other)	40.0%	313,099
Uninsured	4.0%	31,000
Total	100.0%	783,000

NOTE: These are estimates based on multiple sources to provide a sense of proportions in each system, not exact numbers. Sources: U.S. Census, American Community Survey, 2012 (denominator); CT Department of Social Services, CT Department of Children and Families.

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This Plan provides Connecticut with a timely opportunity to institute substantive changes that will align policy, practice and systems development, building on the strengths in the current system while rectifying the weaknesses that exist. The goal of the Plan is to ensure that all children and their families have access to effective behavioral health prevention, treatment and support. DCF, as the State's children's behavioral health authority, was designated as the lead agency to develop and submit this Plan in consultation with: families and youth; representatives of the children and families served by the Department; providers of mental, emotional or behavioral health services for children and families; advocates; and others invested in the well-being of children.¹⁷

While this Plan builds on many recent analyses, recommendations, and previous plans (see Appendix B, Bibliography), its main distinguishing factor is that it addresses the entire public and private children's behavioral health system, approached from the standpoint of the families and children who rely on these services. It seeks to build an integrated, comprehensive system that delivers needed services to all children in the most efficient and effective manner, regardless of system involvement, payment source, race and ethnicity, age, geography or any other factors.

At a minimum, Public Act 13-178 calls for the Plan to include the following strategies to prevent or reduce the long-term negative impact of mental, emotional and behavioral health issues on children:

- A. Employing prevention-focused techniques, with an emphasis on early identification and intervention;
- B. Ensuring access to developmentally-appropriate services;
- C. Offering comprehensive care through an array of services;
- D. Engaging communities, families and youths in the planning, delivery and evaluation of mental, emotional and behavioral health care services;
- E. Being sensitive to diversity by reflecting awareness of race, culture, religion, language and ability;
- F. Establishing results-based accountability measures to track progress towards the goals and objectives outlined in this section and sections 2 to 7, inclusive, of this act;
- G. Applying data-informed quality assurance strategies to address mental, emotional and behavioral health issues in children;
- H. Improving the integration of school- and community-based behavioral health services; and
- I. Enhancing early interventions, consumer input and public information and accountability by:
 - (i) increasing family and youth engagement in medical homes in collaboration with the Department of Public Health,;
 - (ii) increasing awareness of the 2-1-1 Infoline program in collaboration with the Department of Social Services,; and
 - (iii) increasing the collection of data on the results of each program, including information on issues related to response times for treatment, provider availability and access to treatment options, in collaboration with each program that addresses the mental, emotional or behavioral health of children within the state, insofar as they receive public funds from the state.

Although the State has made important strides in reforming the publicly funded components of the system through the CT BHP,¹⁸ this Plan recognizes that only about 40% of children in the State are covered by that system (Table 1.1). Furthermore, of the estimated 56% of children covered by private plans, only half are in plans that are subject to state-level public mandates related to coverage. Larger companies that are self-insured cover the remaining children. Companies who self-insure their employees

are covered by federal law (ERISA) but are subject to limited state oversight.¹⁹ A shrinking but still significant segment of children, ranging from 2-6% depending on location,²⁰ remain completely uninsured due to immigration status or other factors. Families in all three covered categories as well as the uninsured use many of the same providers and systems, with variation in access and services offered.

This Plan will address these challenges directly, reflecting a growing determination across sectors to create a behavioral health service system that not only provides the best possible treatment but promotes social, emotional, and behavioral well-being and provides all Connecticut's children the opportunity to live happy, healthy and richly rewarding lives.

B. Plan Structure

- Section II provides an overview of the current system as reflected in available data, background and history of selected recent efforts to develop the children's behavioral health system and the main findings from extensive community discussions and stakeholder input;
- Section III presents the conceptual framework used in the Plan including the System of Care principles guiding its design;
- Section IV presents the proposed goals and strategies of the Plan organized by the seven thematic areas identified through the input-gathering process;
- Section V addresses implementation;
- Section VI presents a brief conclusion.

C. Methods

The development of the Plan was funded through a public/private partnership including DCF, the Connecticut Health Foundation, the Children's Fund of Connecticut and the Grossman Family Foundation. DCF contracted with the Child Health and Development Institute of Connecticut (CHDI) to facilitate the information-gathering process and the preparation of the Plan. DCF and CHDI established the Connecticut Children's Behavioral Health Plan Advisory Committee to guide the development of the Plan (see inside cover for membership). A Steering Committee composed of DCF and CHDI staff, a FAVOR family advocate, and experts from Yale University monitored progress, reviewed input, and examined the results of a number of current and recent planning efforts (see inside cover for individuals involved). CHDI developed a Plan website, www.plan4children.org, to share information about PA 13-178, upcoming events and opportunities for input, summaries and notes from the information-gathering and Advisory Committee meetings and to allow the public to monitor Plan development and provide feedback on drafts.

The Steering Team gathered input from nearly 1,000 people including families, youth, advocates, providers, and recognized experts over the course of three months, from March-June, using the following strategies:

- **Website Input.** The Steering Team asked individuals and groups with an interest in the children's behavioral health system for input through a structured feedback questionnaire that could be entered through the website, completed and emailed, or mailed to CHDI. Forty-five individuals and nineteen groups submitted comments on a range of topics.²¹

After the draft Plan was posted to the website, 115 people submitted a total of 73 pages of detailed comments and suggested changes.

- **Open Forums.** Six forums open to the public were held across the state and attended by a total of 232 individuals. The Forums were publicized on the Plan website, in the media, and through email blast communications to numerous listservs operated by a variety of stakeholders. Each Open Forum was facilitated by experts from Yale University and from the African Caribbean American Parents of Children with Disabilities (AFCAMP). Each Open Forum included Spanish

and American Sign Language translation as needed by attendees. One or more Advisory Committee members attended each Open Forum.

- **Network of Care Community Conversations.** FAVOR, Connecticut's non-profit Statewide Family Advocacy Organization, convened a total of 26 family and community meetings regarding the Plan. These Community Conversations, co-facilitated by FAVOR Family System Managers and family members, were held in large and small cities and towns across the state, in English and Spanish, and involved a total of 339 adults and 94 youth. The Community Conversations were initially developed as part of the SAMHSA-funded CONNECT System of Care Expansion Planning Grant that was being implemented simultaneously to this Plan's input-gathering activities, creating opportunities for synergy.
- **Facilitated Discussions.** A series of Facilitated Discussions were held across the state on various topic areas. Facilitated Discussions were facilitated by experts from Yale University and from AFCAMP. A total of 220 individuals participated in these opportunities including invited stakeholders, experts, and family members with specific expertise in the topic. Facilitated Discussion topics included the following:
 - The Juvenile Justice System and Behavioral Health
 - Infant and Early Childhood Behavioral Health
 - Crisis Response and Management
 - The Education System and Behavioral Health
 - Autism Services and Supports
 - Coordination of Care
 - The Role of Commercial Insurance
 - Evidence-Based Practices
 - Substance Use and Recovery
 - Law Enforcement and Behavioral Health
 - Keep the Promise Children's Coalition
 - DCF Senior Team Discussion on Child Welfare and Behavioral Health

Several cross-cutting themes were identified and integrated into each Discussion rather than being addressed independently. These themes were: 1) cultural competence; 2) access to services; 3) workforce development; 4) family engagement; 5) developing the network of care; and 6) data systems and infrastructure.

- **Review of Background Documents and Data.** The Planning Team reviewed documents from a number of intensive planning processes and ongoing initiatives, which are listed in Appendix B and referenced in Section II.B. The team also reviewed national reports and systems building efforts in other states.
- **National Literature Review.** At the national level, a series of plans and reports from the Institute of Medicine, the Substance Abuse and Mental Health Services Administration (SAMHSA), the U.S. Surgeon General, the Robert Wood Johnson Foundation, university-based centers (at Georgetown, UCLA and elsewhere), specialized think tanks (e.g., Zero To Three and ChildTrends), and others have informed Connecticut's work.

In addition to the input-gathering activities above, the Advisory Committee held five meetings to review progress and provide guidance and feedback on the process, the emerging themes, and the Connecticut context that would further inform the Plan (see inside cover for list of Advisory Committee members).

Although it would have been useful, there was not sufficient time or resources in the planning process to conduct a detailed secondary analyses of Medicaid or other quantitative data sources. Such sources of information are of great value and should be called upon in the future to guide system development and implementation efforts.

II. The Current System

A. Quantitative Description of System

U.S. Census data indicate that Connecticut has 783,945 residents under the age of 18. Recent data from the CT BHP indicates enrollment of 313,099 youth under age 18, or approximately 40% of the statewide youth population. State employees are Connecticut's largest group of individuals covered by self-insured/employer-sponsored plans.

Data received from the Connecticut Insurance Department, gathered from four of the largest commercial insurance providers in Connecticut, indicate that a total of 136,007 children age 18 and younger were insured in Calendar Year 2013, 100% of whom had some form of behavioral health coverage. Across all four carriers, 9% of covered youth used behavioral health services during the year, primarily for outpatient care (see Table II.A.1 below).

According to the Office of the State Comptroller, in Calendar Year 2013, there were 38,728 children under age 18 covered by the state's health insurance plan. All of these children had behavioral health coverage, and 6,654 (17.2%) used behavioral health services during the year.

Quantitative indicators of behavioral health service utilization can help inform an understanding of the current children's behavioral health system and the issues in that system. Utilization of crisis services (e.g., emergency departments), for example, is one way to assess the overall functioning of the children's behavioral health system. High rates of Emergency Department (ED) utilization for behavioral health concerns suggest a behavioral health system that is not sufficiently meeting the needs of children and their families. National data suggests an alarming increase in the number of youth presenting to EDs for behavioral health treatment, with one study indicating an increase of 26% from 2001 to 2010.²² A review of Connecticut data indicates a similar trend. One study reported that Connecticut has experienced a 30% increase in behavioral health ED utilization between 2011 and 2012. The study found that DCF-involved youth, even though they make up only 2.6% of the state population, accounted for 22% of all behavioral health ED visits.²³

ED utilization is likely influenced by a number of additional factors, including, but not limited to: increased recognition and awareness among families and schools of behavioral health symptoms; zero tolerance policies, overreliance on 911, demand for services that exceeds the supply of services; historical patterns of service utilization; lack of information about or access to appropriate community-based services; and fragmentation associated with multiple payers and systems that provide behavioral health care.

Looking at data from Emergency Mobile Psychiatric Services (EMPS), we can glean insight into overall patterns of the use of crisis behavioral health services and the systems issues facing Connecticut's children's behavioral health system. For example, EMPS is one of the few behavioral health services in Connecticut that is accessible to all children in the state, regardless of system involvement, insurance status, or geographic location. In Fiscal Year 2011, there were 9,455 EMPS episodes of care and 12,367 episodes of care in Fiscal Year 2014, a 31% increase. Most referrals to EMPS during that timeframe came from families (43.0%) and schools (34.6%).²⁴ In Fiscal Year 2014, 62% of youth served by EMPS were enrolled in Medicaid, 32% were privately insured and more than 80% had no DCF involvement. Hospital EDs and community-based EMPS providers report significant difficulties meeting the elevated

demand for their services, and a lack of appropriate follow-up care options for youth and their families that might divert the youth from future ED utilization and ensure that all youth are able to receive effective treatment while remaining in their homes, schools, and communities.

Table II.A.1 Information on Commercial Insurance Coverage for Behavioral Health Services (Youth under 18 years): Calendar Year 2013

Served	Anthem	United Healthcare/Oxford Health	CIGNA and Affiliates	ConnectiCare Inc. & Affiliates	Aetna
Total Members Covered	46,118	23,297	22,948	43,644	23,816
Children who Received Behavioral Health Care	5,788 (12.6%)	1,970 (8.5%)	1,915 (8.3%)	2,565 (5.9%)	2,699 (11.3%)
Children who Received Behavioral Health Care, by Level of Care*					
<i>Inpatient Hospitalization</i>	130 (2%)	88 (4%)	97 (5%)	103 (4%)	106 (4%)
<i>Outpatient Treatment</i>	5,777 (99%)	1,955 (99%)	1,384 (72%)	2,554 (99%)	2,657 (98%)
<i>Emergency Services</i>	235 (4%)	6 (<1%)	56 (3%)	78 (3%)	181 (7%)
<i>Residential Treatment</i>	20 (<1%)	12 (<1%)	378 (20%)	20 (<1%)	18 (<1%)

* Data were supplied by commercial insurance providers to the Connecticut Insurance Department. These data exclude self-insured private and public employers. Utilization at various levels of care represents unduplicated counts within each service category, although youth could use services at more than one level of care in the calendar year.

The children's behavioral health system also struggles with significant racial/ethnic disparities in access to and outcomes of treatment. A recent review found that the Black, Hispanic and Asian youth in the Medicaid population in Connecticut used behavioral health services at low rates relative to their proportion of the population. White children, by contrast, make up only 39% of the Connecticut youth Medicaid population, yet account for 45-46% of the use of behavioral health services.²⁵ System reforms must address racial and ethnic disparities in behavioral health care to ensure that all children have equal access to the full array of behavioral health services and supports.

This data supports the contention that Connecticut is in need of significant reforms that emphasize promotion of social and emotional skills and well-being, the ongoing development of a comprehensive service array at all levels of care, and a number of other supports that reduce the burden of behavioral health concerns that currently impact children and families across the state. Furthermore, the lack of easily accessible data is a barrier to statewide planning and implementation efforts. Systematic data collection and reporting on a common set of system-level indicators will help statewide stakeholders monitor implementation of the children's behavioral health system and allow for timely responses to issues that negatively affect service delivery for children and families. Ideally, this data should be integrated across insurance types and child-serving systems.

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B. Developing Connecticut's System of Care, 1980 to the Present

This Plan builds on a series of efforts over the last four decades to develop a more responsive and effective children's behavioral health system nationally and in Connecticut. This section recounts, in a timeline, the highlights of these efforts in Connecticut, as reflected in published plans and reports.

Connecticut Milestones in the Development of Children's Behavioral Health Services and Systems

- 1980:** The Department of Children and Youth Services (precursor to DCF) adopts recommendations of a broad-based public-private working committee that children's behavioral health services be described and developed according to a Continuum of Care model.²⁶
- 1989:** Publication of the Department's first ever children's mental health plan,²⁷ including a new mission statement and operating principles.
- 1997:** The Legislature mandates the development of a "system of care" in Connecticut and articulates the guiding principles (P.A. 97-272); these became the genesis of the 26 local System of Care groups in operation covering all 169 towns in the state.
- 1999:** Young Adult Service Program Launched, a partnership among DCF, DMHAS, DDS, and OPM to assist with transitions from adolescence to young adulthood
- 2000:** Creation of FAVOR, a statewide family advocacy organization.
- 2001:** The Department of Social Services (DSS) leads a planning effort in 1999-2000 that results in Connecticut Community KidCare and the formation of the Connecticut Behavioral Health Partnership (BHP).²⁸ The resulting report identifies all public funding sources supporting children's behavioral health and recommends a new structure for improving services through an Administrative Services Organization (ASO).
- 2006:** DSS and DCF launch the BHP, carving out behavioral health services from the HUSKY managed care contracts and blending it with DCF funding through an ASO (ValueOptions, Inc.) selected through an RFP process to manage development of and access to an integrated continuum of services.
- 2008:** Passage of the Mental Health Parity and Addiction Equity Act of 2008
- 2010:** A Joint Task Force of the Connecticut Chapter of the American Academy of Pediatrics and the Connecticut Chapter of the American Academy of Child and Adolescent Psychiatry issues Mental Health Care 'Blueprint' for Children in Connecticut in June.
- 2011:** DMHAS joins the BHP, adding management of services for eligible adults.
- 2011:** Implementation of Rehabilitation Option in Medicaid allowing for reimbursement for in-home services and expansion of IICAPS (Sec 17a-22q-1)
- 2011:** DCF leadership emphasizes greater engagement with families and communities to assure children's health, safety, learning, and success²⁹ with enhanced focus on supporting birth families and relative foster family care when a child must be placed out of home.
- 2013:** OHA publishes January 2013 report, "Findings and Recommendations: Access to Mental Health and Substance Use Services"
- 2013:** PRI Reports on Access to Substance Use Services for Privately Insured Youth
- 2013:** DCF receives a planning grant to develop a "Network of Care," which provides the foundation for this Plan and is described in Section III. DCF leads a collaborative that applied for federal implementation funds for the Connecticut Network of Care Transformation (CONNECT).
- 2013:** The Office of the Health Care Advocate leads a team developing the Connecticut Healthcare Innovation Plan under the State Innovation Model (SIM) Grant from the Center for Medicare and Medicaid Innovation (CMMI; Implementation funding application submitted in July 2014).
- 2013:** Passage of Public Act 13-3 – sections 64-79, provisions on Behavioral Health Taskforce, reforms to behavioral health and substance use utilization review for insurance plans, Access Mental Health and assertive community teams under DMHAS, DMHAS care coordination teams, and mental health first aid training.
- 2014:** Connecticut Department of Public Health issues Healthy Connecticut 2020 State Health Assessment and Health Improvement Plan (Focus Area 6 is Mental Health, Alcohol, and Substance Abuse).

- 2014: Task Force to Study the Provision of Behavioral Health Services for Young Adults, Established Pursuant to Public Act 13-3 (Section 66), issues its report on April 20.
- 2014: Passage of P.A. 14-115 requires OHA to establish, by January 1, 2015, a behavioral health care provider information and referral service to help residents and providers with resources, timely referrals, and access. OHA is required to report annually on “...gaps in services and the resources needed to improve behavioral healthcare options...” PA 14-115 mandates collaboration with stakeholders, a public awareness and educational campaign and a data-reporting mechanism for measuring effectiveness.

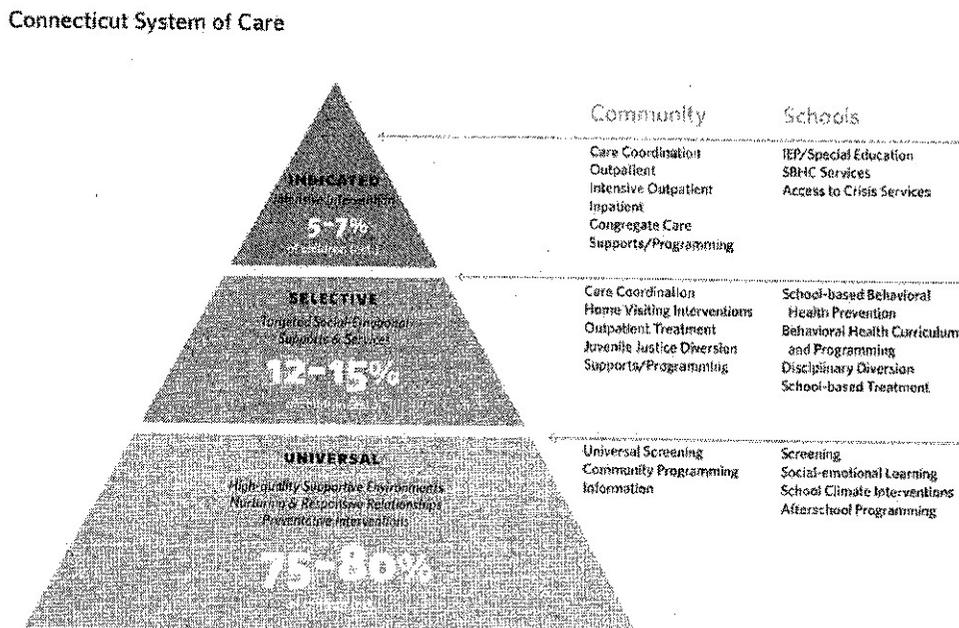
Notwithstanding all these efforts and some measureable improvements, the goal of an efficient, accessible system that meets families’ needs eludes our state. Building on a series of in-depth analyses and the work of a number of committees, this Plan identifies the critical system development tasks that represent a growing consensus and have the potential to move the entire system beyond the bottlenecks and fragmentation that have frustrated improvement efforts to date.

III. Conceptual Framework for the Plan

Plan development was guided by values and principles underlying recent efforts in Connecticut to create a “system of care” for youth and families facing behavioral health challenges and by the Institute of Medicine’s (IOM) framework for addressing the full array of services and supports that comprise a comprehensive system (see Figures III.1 and III.2). A system of care is defined as:

“A spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families, that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them to function better at home, in school, in the community, and throughout life.”³⁰

Figure III.1



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The system of care offers states and communities a conceptual and practical framework on which to base system and service development that benefits the behavioral health and wellness of children and their families. Such a system also ensures access to services regardless of geographic location, race, ethnicity, agency affiliation (or not), or insurance status. Connecticut to date has undertaken efforts to incorporate some, but not all, elements of the system of care concept.

The IOM's framework aligns services and resources along an axis that includes universal services for all children to promote optimal social and emotional development and well-being, selective services (e.g., early identification, early intervention) for children at high risk of developing a behavioral health condition, and indicated services for treating those with serious and complex disorders.³¹ According to this framework, preventive interventions aim to reduce risk factors and promote protective factors (at the child and family level), and prevent or reduce the impact of behavioral health conditions. This array of services and supports is used to organize the planning and implementation of a system that will meet the needs of all youth and their families.

The theory of change driving this Plan is that a children's behavioral health system based on the system of core care values and principles will result in improved behavioral health outcomes. Four core values driving the development of a system of care include the following:

- **Family-driven and youth-guided**, with the strengths and needs of the child and family determining the types and mix of services and supports provided;
- **Community-based**, with the locus of services as well as system management resting within a supportive, adaptive infrastructure of structures, processes, and relationships at the community level;
- **Culturally- and linguistically-competent**, with agencies, programs, and services that reflect the cultural, racial, ethnic, and linguistic differences of the populations they serve to facilitate access to and utilization of appropriate services and supports and to eliminate disparities in care.
- **Trauma informed**, with the recognition that unmitigated exposure to adverse childhood experiences including violence, physical or sexual abuse, and other traumatic events can cause serious and chronic health and behavioral health problems and is associated with increased involvement with the criminal justice and child welfare systems.

*Thirteen guiding principles are listed in Table III.1.

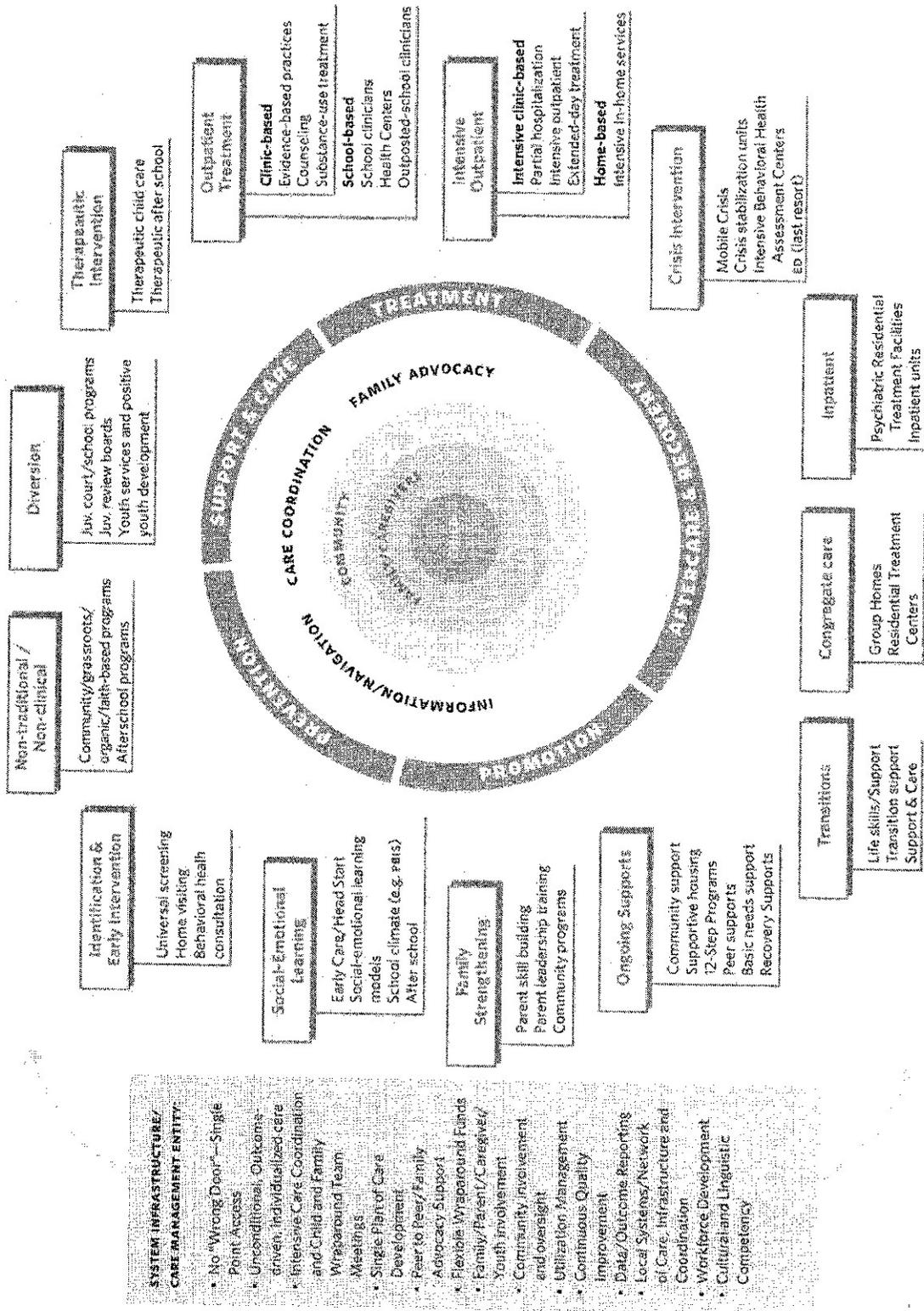
*Figure 3.2 illustrates an improved service array and highlighting primary system infrastructure functions

Table III.1 Guiding Principles of the Connecticut System of Care

- **Ensure availability and access** to a broad, flexible array of effective, community-based care, services and supports for children and their families that address their emotional, social, educational, and physical needs, including traditional and nontraditional services as well as natural and informal supports.
- **Provide individualized care** in accordance with the unique potentials and needs of each child and family, guided by a strengths-based, child and family team approach to a care planning process and an individualized Plan of Care developed in true partnership with the child and family.
- Ensure that care, services and supports **include evidence-informed and promising practices**, as well as interventions supported by practice-based evidence, to ensure the effectiveness of services and improve outcomes for children and their families.
- **Deliver care, services and supports within the least restrictive**, most normative environments that are clinically appropriate.
- **Ensure that families, other caregivers, and youth are full partners** in all aspects of the planning and delivery of their own care/services and in the policies and procedures that govern care for all children and youth in their community.
- **Ensure that care, support and services are integrated at the system level**, with linkages between child-serving agencies and programs across administrative and funding boundaries and mechanisms for system-level management, coordination, and integrated care management.
- **Provide care management** or similar mechanisms at the practice level to ensure that multiple services are delivered in a coordinated and therapeutic manner and that children and their families can move through the system of care in accordance with their changing needs.
- **Provide developmentally appropriate mental health care and supports** that promote optimal social-emotional outcomes for young children and their families in their homes and community settings.
- Provide developmentally appropriate care and supports, **to facilitate the transition of youth to adulthood** and to the adult service system.
- **Incorporate or link with mental health promotion, prevention, and early identification** and intervention in order to improve long-term outcomes, including mechanisms to identify problems at an earlier stage and mental health promotion and prevention activities directed at all children and adolescents.
- **Incorporate continuous accountability and quality improvement mechanisms** to track, monitor, and manage the achievement of system of care goals; fidelity to the system of care philosophy; and quality, effectiveness, and outcomes at the system level, practice level, and child and family level.
- **Protect the rights of children and families** and promote effective advocacy efforts.
- **Provide care, services and supports without regard to race, religion, national origin, gender, gender expression, sexual orientation, physical disability, socio-economic status, geography, language, immigration status, or other characteristics**, and ensure that services are sensitive and responsive to these differences.

Figure III.2. Array of Services and Supports in the Connecticut Behavioral Health System of Care

CT Children's Behavioral Health System of Care



IV. Implementation Plan by Thematic Area

The Plan is organized into six major thematic categories. For each area, the Plan sets from one to three major goals and associated strategies, for a total of 14 goals and 38 strategies. In each area, we provide a brief overview of the findings that form the basis for the goals and strategies; we also provide explanations of the strategies. The six thematic areas, and associated goals, are summarized in Table IV.1

Table IV.1 Plan Thematic Areas and Goals

A. System Organization, Financing and Accountability

Goal A.1 Redesign the publicly financed system of behavioral health care for children to direct the allocation of existing and new resources.

Goal A.2 Create a Care Management Entity to streamline access to and management of services in the publicly financed system of behavioral health care for children.

Goal A.3 Develop a plan to address the major areas of concern regarding how commercial insurers meet children's behavioral health needs.

Goal A.4 Develop an agency- and program-wide integrated behavioral health data collection, management, analysis and reporting infrastructure across an integrated public behavioral health system of care.

B. Health Promotion, Prevention and Early Identification

Goal B.1 Implement evidence-based promotion and universal prevention models across all age groups and settings to meet the statewide need.

Goal B.2 All children will receive age-appropriate periodic standardized screening for developmental and behavioral concerns as part of a comprehensive system for screening, assessment, and referral for services.

Goal B.3. Ensure that all providers and caregivers who work with young children and youth demonstrate competency in promoting social and emotional development in the context of families, recognizing risk factors and early signs of social-emotional problems and in connecting all children to appropriate services and supports.

Goal B.4. Develop, implement, and monitor effective programs that promote wellness and prevent suicide and suicidal ideation

C. Access to a Comprehensive Array of Services and Supports

Goal C.1 Build and adequately resource an array of behavioral health care services that has the capacity to meet child and family needs, is accessible to all, and is equally distributed across all areas of the state.

Goal C.2 Expand crisis-oriented behavioral health services to address high utilization rates in emergency departments.

Goal C.3 Strengthen the role of schools in addressing the behavioral health needs of students.

Goal C.4. Integrate and coordinate suicide prevention activities across the behavioral health service array and multiple sectors and settings.

D. Pediatric Primary Care and Behavioral Health Care Integration

Goal D.1 Strengthen connections between pediatric primary care and behavioral health services.

E. Disparities in Access to Culturally Appropriate Care

Goal E.1 Develop, implement, and sustain standards of culturally and linguistically appropriate care.

Goal E.2 Enhance availability, access, and delivery of services and supports that are culturally and linguistically responsive to the unique needs of diverse populations.

F. Family and Youth Engagement

Goal F.1 Include family members of children with behavioral health needs, youth, and family advocates in the governance and oversight of the behavioral health system.

G. Workforce

Workforce strategies are distributed across the other thematic sections.

A. System Organization, Financing and Accountability

Among the most consistent themes from the input gathering process is the “fragmentation” of the children’s behavioral health system reported in different ways by family members, providers, and advocates and repeatedly identified in past reports on Connecticut’s and the national children’s behavioral health systems.³²

Goals in this section are designed to move toward a system in which access to services will be de-linked from system involvement, insurance status, geographic location, and other factors, resulting in access to the system of care by all children and their families based on their needs.

A primary driver of fragmentation is the presence of multiple payers in the behavioral health arena, each with different eligibility criteria, enrollment processes, service arrays, and reimbursement strategies. Those payers include state agencies, commercial insurance providers, and self-insured/employee-sponsored plans. A partial list of the state agencies involved in funding behavioral health care for children and youth includes: DCF; The Department of Social Services (DSS); the Department of Mental Health and Addiction Services (DMHAS); the Department of Public Health (DPH); the State Department of Education (SDE); the Judicial Branch’s Court Support Services Division (CSSD); the Department of Developmental Services (DDS); the Department of Rehabilitation Services (DRS); and the Office of Early Childhood (OEC).

Families describe the current behavioral health system as one in which the availability of services is linked to one’s system involvement and/or insurance status, with each system/payer purchasing its own array of services. Families also describe the system as difficult to understand and navigate, especially for families who are in the midst of a behavioral health crisis. Others underscore the theme of fragmentation by describing a system that lacks coordination and integration. Some families with commercial insurance report that they were forced to allow their child to go untreated and to therefore decompensate in order to meet medical necessity criteria required to receive services. Others describe being advised to allow their child to be arrested so that they could access needed services that were only available to those involved in the juvenile justice system. Providers cite as major hurdles outdated provider information in commercial plans and extremely low reimbursement levels.

In addition to the problems cited above, families indicate that they are not aware of available services. Even the best designed and implemented service system will not address the behavioral health needs of families if they are unaware of or unable to access those services. For example, families report that, especially in the early stages of behavioral health difficulties, they may not identify the problems their child is experiencing as behavioral health symptoms. This failure to identify may be due to lack of awareness and lack of education about behavioral health issues as well as the persistent stigma associated with mental illness. Even once families were clear that their child was in need of behavioral health services, they weren’t always sure where to find the right services. For example, 2-1-1 and Child Development Infoline systems are widely thought of as helpful resources; however, many parents report that 2-1-1 is not sufficiently tailored to families seeking behavioral health services and supports, and that the Child Development Infoline is only available for young children. The expansion of the Child Development Infoline and coordination with the efforts of OHA to implement PA 14-115, as described later in this Plan, will help address concerns such as these. In addition, DCF and DSS will continue to improve promotional opportunities to build awareness of the 2-1-1 and EMPS system.

In addition to concerns about fragmentation in the state-funded system, parents, providers and advocates raised significant concerns about the commercial insurance system in the majority of the meetings held to gather input. The many comments received on this topic yielded matters that can be grouped into five categories:

1. Coverage for selected services (e.g., intensive, in-home/community evidence-based practices; emergency mobile psychiatric services; other home and school-based services);
2. Adequacy of coverage/services for selected conditions (e.g., autism, substance abuse);
3. Medical necessity criteria and utilization management and review procedures (e.g., authorized access to care; time limits);
4. Adequacy of provider networks;
5. Perceived cost shifting to individuals and to the State.

The Connecticut Insurance Department convened a productive meeting between the CHDI Planning Team and representatives of DCF and major insurance carriers in the state. The representatives of the carriers and DCF acknowledged shared interests in potential collaboration on issues such as utilization of high intensity and crisis services, monitoring and improving service quality, and examining service utilization data. A few carriers acknowledged selected challenges, such as difficulty finding a sufficient number of child psychiatrists to participate in their networks. By and large, however, the carriers questioned what they viewed as inaccuracies about commercial insurance, stating that their networks, covered services, policies on covered conditions, and procedures were of high quality.

The Connecticut Insurance Department, the Office of the Healthcare Advocate, DCF, various state agencies, and others have made concerted efforts to review the behavioral health services that are and are not covered by commercial insurance providers, to investigate complaints, and to intervene in various ways to address identified problems regarding the commercial insurance industry's role in providing behavioral health services. Education of the public can help to ensure an understanding of the responsibilities of the commercial insurance industry (both commercial plans and self-insured employers); however, the public has numerous, valid concerns about commercial insurance coverage that can be addressed through continued formal reviews, legislative actions, and other focused strategies. Valid, reliable, and objective data will help in the ongoing investigation of all concerns and claims, and those data can be used to devise strategies that effectively address those concerns, with the overarching goal of ensuring that youth who are covered by commercial insurance have access to a full array of behavioral health services and supports.

Some participants suggest that Connecticut has failed to adopt and embed important characteristics of the system of care, which has contributed to less-than-desired outcomes over time. Fully adopting those characteristics would require significant restructuring with respect to: public financing, organizational structure, integration of commercial payers, and data reporting infrastructure. Each of these areas is addressed below.

Goal A.1 Redesign the publicly financed system of behavioral health care for children to direct the allocation of existing and new resources.

The redesign of the publicly financed system of behavioral health care has the potential to significantly reduce fragmentation, increase access to a full array of care, save money, and support better access to care and outcomes. A fully integrated system of care would place Connecticut at the forefront nationally in the funding and delivery of children's behavioral health services. Participation of the commercial insurance industry in the funding of that system would represent transformational progress in ensuring that all children have access to a full array of effective behavioral health services.

A financial analysis will help to determine the costs of creating infrastructure that supports an expansion of services and the potential sources of funding for that work, including direct appropriations, grants, and reimbursement through insurance (federal, state, private). The financial analysis should also address the opportunity costs of not providing these services as well as the cost offsets that would result from a comprehensive system of services that would fully meet the needs of all children in the state.

Funding additional administrative infrastructure should be undertaken in addition to, not in place of, ensuring sufficient funding for a significant expansion of children's behavioral health services (see Section C).

Strategy A.1.1 Establish a process to guide the redesign of the publicly financed system.

The Children's Behavioral Health Implementation Team (see Section V) should be charged with driving this system redesign process and with implementing the resulting design based on the principles and recommendations in this Plan. This Team will include representatives from all state agencies that fund children's behavioral health, other relevant state agency representatives (including the Department of Insurance), behavioral health providers, advocates, family members, and youth.

This work will include the following:

- **Identify existing spending on children's behavioral health services and supports across all state agencies.** Connecticut should identify the total spending on children's behavioral health and related interventions to generate a baseline understanding of the funding that is available, the services those funds are purchasing, gaps in services, areas of redundancy, and opportunities for creating efficiencies.
- **Determine if those existing funds can be re-aligned or used more efficiently to fund the full array of services and supports.** If, as expected, existing funding is not sufficient to implement the full service array including the expansions described in this report, stakeholders will need to implement all relevant strategies to identify sufficient funding (e.g., direct appropriations, pooled state agency funds, re-directed cost savings, federal grant funding, social entrepreneurship).
- **Explore mechanisms for pooling funding across all state agencies.** The task force will explore specific strategies for pooling funding and organizing it under a single entity that will finance and deliver children's behavioral health care. It is recommended that the state examine the Connecticut Behavioral Health Partnership as an effective model.
- **Identify a full array of services and supports that will constitute the children's behavioral health system of care (See Strategy C.1.1).** The full array will include a range of services across all age groups that includes promotion, prevention, screening and early identification, early intervention, all levels of treatment, and aftercare, with a focus on services that are evidence-based as well as innovative and promising services that meet the needs of specific populations (those interventions are described more fully in Section C). The pooled funding structure will create a single point of entry into the system of care that will reduce fragmentation for Connecticut's youth and families. The pooled funding system should be sufficiently flexible to allow for the funding of family-based services that treat children, caregivers, and siblings together as a family unit.
- **Conduct a cost analysis to identify cost savings associated with implementation of the system of care approach and a focus on prevention.** Contract with a health economist or another qualified professional to conduct a comprehensive cost analysis. It is presumed that there will be significant, long-term cost savings associated with preventing serious behavioral health problems, avoiding costly and restrictive treatment and placement settings when clinically appropriate (e.g., congregate care, emergency departments, inpatient hospitalization, juvenile detention), and expanding access to effective home-, school-, and community-based services. Those savings can be re-invested into developing and sustaining the full system of care. The findings also can be used to justify ongoing participation among state agencies and to attract the participation of other payers and funders, including federal agencies, philanthropy, commercial insurance providers, employee-sponsored plans and social entrepreneurship entities.
- **Identify and address workforce development needs in the children's behavioral health system of care.** The Plan identifies a number of goals and strategies with direct implications for

workforce development (see Section IV.G for a review). The Plan necessitates workforce development activities that will take place across sectors (e.g., behavioral health, primary care, education, child welfare, law enforcement) involving various system stakeholders (e.g., providers, caregivers, parents, youth, school personnel), across age groups (e.g., early childhood, adolescent, transition-age youth), and for various behavioral health conditions (e.g., mental health, autism, traumatic stress disorders, substance abuse). In addition, there is a significant need to identify and recruit professionals into the workforce to enhance its representativeness relative to the population served, with respect to race, ethnicity, culture, and language. It is recommended that the Children's Behavioral Health Implementation Team establish a committee within its governance structure to identify and address a number of workforce development challenges. This committee should have funding available to systematically address various workforce challenges.

Goal A.2 Create a Care Management Entity to streamline access to and management of services in the publicly financed system of behavioral health care for children.

Stakeholders expressed the following concerns (among others) in the planning process regarding the current quality of care coordination:

- The need for better coordination of services within the behavioral health sector as well as between behavioral health and other sectors that serve children (e.g. schools, health care, juvenile justice).
- Fragmentation and gaps in care as children move from inpatient to outpatient services, from home visiting programs to school reentry and from screening in primary care medical services to outpatient behavioral health services.
- Families having several care coordinators, working in different systems and no "coordination among the coordinators."

Effective access to and management of the full array of preventive and treatment services within a well-designed "system of care" will improve outcomes for children and will lower costs of behavioral health services.³³

A care management entity (CME) is "an organizational entity that serves as a centralized accountable hub to coordinate all care for youth with complex behavioral health challenges and their families."³⁴ There are several models with respect to the organization implementing the CME, as well as their financing, structure, and function. CMEs have been implemented within state agencies, non-profit agencies with no service delivery role, and non-profit service providers that take on additional administrative roles and functions. Some models include a single statewide CME whereas other models use a network of CMEs. Funding for CMEs varies, but generally comes from State agency grant funds, a blending of child serving cross sector funds or at times with Medicaid options or waivers.

Regardless of the model utilized, a CME is intended to put into effect system of care values and principles and work toward the primary goals of reducing fragmentation, improving efficiencies, improving clinical and functional outcomes and resilience, and reducing costs.³⁵ Some CME models espouse goals similar to those of health homes for children with behavioral health needs. A CME can take on key administrative and service delivery functions of the system of care. Service delivery activities may include screening and assessment, care coordination using high-quality wraparound implementation, and ensuring access to a full array of behavioral health services and supports (including youth and caregiver peer supports and family advocacy). Administrative functions can include information management, utilization management, purchasing services, quality improvement, outcomes measurement, training, and care monitoring/review.³⁶ CMEs can be used to implement a value-based purchasing approach that emphasizes reimbursement for service quality and outcomes. CMEs can play a role in

disseminating information on behavioral health services and affirmatively connecting families to services. A CME can connect locally to Connecticut's 26 Community Collaboratives to localize family and youth engagement efforts and ensure the implementation of services that are culturally and linguistically appropriate. The CME approach can help ensure the family's experience of a system as having "no wrong door" by centralizing and coordinating administrative and service functions and by improving a family's access to information and care.

Although the system of care and CME approach would be created initially for families and children in the public systems, information on the outcomes and cost savings associated with this approach would be made freely available and commercial payers would be able to participate in the system of care based on demonstrated effectiveness (a development that has occurred in New Jersey's system of care).

In order for a CME approach to be effective, each of the strategies below must be carried out with focused attention to cultural and linguistic appropriateness to ensure access for all children and families. Parent and youth peer-to-peer networks within the CME must promote full engagement of youth and families in services and supports (see Section IV.F for detail on Family and Youth Engagement).

Strategy A.2.1 Design and implement a Care Management Entity (CME) to create an effective care coordination model based on proven Wraparound and child and family teaming models, with attention to integration across initiatives and training.

Effective care coordination is a foundation of Connecticut's efforts to build a System of Care for children with behavioral health needs (as reflected in a recent federal grant submitted by the State).³⁷ Care coordination will be expanded and coordinated across sectors and providers based on evidence-based models of Wraparound services and child and family teaming. The service is delivered by a number of providers at the regional and local levels. A CME, operating within statewide standards and protocols, can be made responsible for purchasing or delivering care coordination services. The 75 care coordinators currently supporting the 26 system of care community collaboratives would be incorporated into this model, with the specific details of that design to be determined. The CMEs would also need to interface seamlessly with the work proposed for "Advanced Medical Homes" under the State Implementation Model (SIM) and other efforts to move pediatric care to a Medical Home model of integrated care. Pediatric providers could contract with the CME for care coordination for behavioral health services.

The Hartford Care Coordination Collaborative serves as one model on which to build. The Collaborative brings together care coordinators from several agencies and organizations that serve children in the greater Hartford area. Participating partners include: DCF, DSS Person Centered Medical Home (PCMH) program, Community Health Network care management and practice support programs, CT Family Support Network and several private agencies that provide direct services and coordinate care. Care coordinators from the involved organizations, who are all using different models, meet regularly to review family needs and develop better ways of serving families across their individual sectors and with connection to their medical homes. Based on the success of this pilot in Hartford, DPH has included the development of care coordination collaboratives as a requirement in the five regional care coordination center contracts.

Another model for integrating pediatric and behavioral health services through care coordination is New Haven Wraparound, in development by Clifford Beers Child Guidance Clinic under a recent \$9 million federal Center for Medicaid and Medicare Services system innovation grant. These initiatives, and others, should be closely examined for integration and possible statewide replication.

The system of care model can be extended to function across behavioral health, health, education, juvenile justice, and community support services to ensure better cross-sector coordination of care for children in the behavioral health system as well as for children in other systems who need connection to behavioral health services. The care coordination collaborative model can bring together behavioral

health service coordinators in a variety of treatment settings (e.g. DCF, Enhanced Care Clinics, residential treatment services) and connect them with others who are coordinating other services that children with behavioral health challenges use, such as schools and health care.

Strategy A.2.2 Develop a family support clearinghouse to increase access to information about available behavioral health services and improve supports for behavioral health system navigation.

Findings strongly indicate a need for families to have access to information and resources that are specific to mental health and substance use services. Public Act 14-115 charged the Office of the Healthcare Advocate (OHA) with establishing “an information and referral service to help residents and providers receive behavioral health care information, timely referrals and access to behavioral health care providers,” and in doing so, required OHA to work with state agencies, the Behavioral Health Partnership, 2-1-1, community collaboratives, and providers. Given the overlap of this OHA-led initiative with this plan and the proposed functions of the CME, integration of the PA 14-115 initiative within the CME array of information and services should be strongly considered.

A family support clearinghouse can serve as a central hub for information that is specific to behavioral health services and supports, including substance use, and will be accessible to any family member, youth, professional, or community member who is concerned about a child and is seeking information, resources, supports and services, regardless of level of risk, system involvement, or insurance status.

Preliminary plans for the OHA-led effort under PA 14-115 include an on-the-ground referral service that also conducts assessments and warm handoffs. The proposed service would coordinate with 2-1-1 and Child Development Infoline (for children with developmental concerns), OHA, service providers and agencies and would also collect data on access and waiting lists. Collaborative and technological linkage to 2-1-1 is required in order to quickly access EMPS services for those families who call in the midst of an active behavioral health crisis situation.

The clearinghouse will disseminate information using established and emerging technologies, including smart phone apps, as opposed to disseminating information solely through printed resources such as booklets, flyers, and reports. All information should be available in English and Spanish, at minimum. A campaign to reduce the stigma and discrimination associated with behavioral health issues would be a central focus of this work. The target audiences for disseminating information include primarily youth and families directly but also schools, child health providers, police, probation officers, and early childcare and education providers, and, the general public.

Goal A.3 Develop a plan to address the major areas of concern regarding how commercial insurers meet children's behavioral health needs.

The role of the commercial insurance industry is complex and requires additional analysis and planning. Public Act 13-178 calls for an implementation plan that addresses the behavioral health needs of all children in the state. Given the number of children covered by commercial plans and self-employed plans (Table I.1), the full participation of the commercial insurance industry in the ongoing funding, design, and delivery of behavioral health services is critical to achieving that goal. A number of state entities have processes in place to systematically identify and address concerns with the role of commercial insurance providers in the behavioral health system. Connecticut should continue to build on those processes, including those that have led to the development of the Children's Behavioral Health Plan. Those processes can be organized around the systematic investigation of the five areas of concern identified in the findings above.

1. Coverage for selected services (e.g., intensive, in-home/community evidence-based practices; emergency mobile psychiatric services; other home- and school-based services);
2. Adequacy of coverage/services for selected conditions (e.g., autism, substance abuse);
3. Medical necessity criteria and utilization management procedures (e.g., authorized access to care, time limits);
4. Adequacy of provider networks
5. Perceived cost shifting to individuals and the state.

Strategy A.3.1 Conduct a detailed, data-driven analysis of each of the five issues identified in the information gathering process and recommend solutions.

Steps in this process, involving the Connecticut Insurance Department, the Office of the Healthcare Advocate, state agencies (e.g., DCF, DMHAS), advocacy groups, youth and families, and other stakeholders, should include the following: (1) **assemble and summarize all available relevant data and input**, starting with the sources listed in Table A.3.1; (2) **produce a report for the legislature** that will:

1. Clarify the issues that are under the purview of the commercial insurance industry, employee-sponsored plans, and Medicaid;
2. Identify the issues for which carriers may not be fully meeting their responsibilities under law, regulation, or contract; and
3. Formulate specific recommendations for action to address substantive concerns.

The report to the legislature will summarize the general findings and implications of the process, and will be used to guide and inform system of care planning and implementation efforts, as described in this plan.

Table A.3.1 Sources of Information Related to Commercial Insurance
* Connecticut Insurance Department
* Office of the Healthcare Advocate
* The Connecticut Legislature
* Office of the Child Advocate
* Other state agencies, offices, or commissions
* Insurance carriers
* Professional associations
* Trade associations
* Advocacy organizations
* Families and youth

Strategy A.3.2 Apply findings from the process described above to self-funded/employee-sponsored plans.

The Federal Department of Labor, OHA and other entities review and monitor self-funded/employer-sponsored plans. OHA and other entities should come together in a process similar to the one described above, to generate information that could inform efforts to examine or address concerns regarding self-funded/employer-sponsored plans in subsequent phases of the effort to improve children’s behavioral health services.

Goal A.4 Develop an agency- and program-wide integrated behavioral health data collection, management, analysis and reporting infrastructure across an integrated public behavioral health system of care.

Section 1 of PA 13-178 calls for “establishing results-based accountability measures to track progress towards the goals and objectives” as well as “increasing the collection of data on the results of each program, including information on issues related to response times for treatment, provider availability, and access to treatment options.” Furthermore, ongoing reviews of system implementation following plan development include the use of “data-driven recommendations to alter or augment the implementation in

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accordance with section 11-4a of the general statute." Data collection, analysis, and reporting will support the delivery of effective services across the service array. Systematic reporting on indicators of access, service quality, and outcomes will contribute to a culture of data-informed decision-making. This work should be objective and transparent, and promote public accountability using the Results Based Accountability (RBA) framework, as well as quality improvement, program evaluation, and research methodologies.

There are pockets of excellence in data collection, analysis, and reporting in Connecticut including a small number of behavioral health services where support for data collection, analysis, and reporting are completed in collaboration between DCF, the providers and a Performance Improvement Center. In addition, Value Options, on behalf of the CTBHP, has a robust data collection approach for individual service categories that allows a nuanced examination of access, quality, and outcomes. These data, however, are only for youth enrolled in the state Medicaid program.

Our findings indicate a need for data infrastructure at the systems level to support a fully integrated system, as well as the need for data that allows stakeholders to engage in program-specific evaluation and quality improvement. Data infrastructure development at the systems level should parallel the proposed reorganization of the behavioral health system to integrate across disparate child-serving systems. Issues of confidentiality and data security are of paramount importance in these efforts.

The challenges in this work are many:

- Data sources tend to be in siloes within state agencies without a common identifier that would allow more efficient tracking of outcomes across systems;
- Programmatic data that are housed within a single state agency often are not linked in order to track and monitor service utilization and outcomes over time;
- DCF, for example, does not have sufficient numbers of personnel to analyze and report data that are collected from their funded services, as noted by some stakeholders;
- Data are not shared across systems to promote accountability and transparency; and
- It is crucial to guard the security of protected health information, as families and providers strongly cautioned.
- Data and data reports are not routinely made available to all stakeholders including members of the public for the purposes of accountability and transparency.

The system of care should include outcome measurement that captures meaningful changes in child and family functioning, improves the effectiveness of the interventions we are offering, and determines which interventions work best for which populations. This type of data management system can be transformational in ensuring accountability for quality behavioral health services that are provided to all youth.

Strategy A.4.1 Convene a statewide Data-Driven Accountability (DDA) committee grounded in new legislative authority to design a process to oversee all efforts focused on data-driven accountability for access, quality, and outcomes.

This Data Driven Accountability Committee, working under the Children's Behavioral Health Implementation Team, should ensure that mechanisms and resources are in place to implement the data-related activities outlined in the following strategies. The committee should consist of representatives from all agencies participating in providing behavioral health services for families and youth, and data analysts and evaluation experts in the field. The committee should ensure that the data systems are independent (i.e., not collected and managed by the people providing the services being evaluated), objective, and transparent. This is aligned with

Executive Order 39, the establishment of the CT Open Data Portal, supporting the timely and consistent publication of public information and data as an essential component of an open and effective government.

There are significant efforts under way across the health care system, both in Connecticut and nationally, to develop Quality Measure Sets to collect, report, and compare health care outcomes. This committee could also be charged with developing the **Children's Behavioral Health Utilization and Quality Measure Set**. This comprehensive measure set should be required for all insurance plans in Connecticut and would allow systematic collection, reporting via a dashboard, and comparing utilization trends and outcomes across payers. An example of such a measure set covering both utilization and quality measures is included in Appendix C.

Strategy A.4.2 Utilize reliable standards to guide the new data collection, management and reporting system.

The new system should utilize guidelines and protocols from the RBA framework used by the Connecticut General Assembly to connect all programs to desired population and system level results while answering the three RBA questions: how much did we do, how well did we do it, and is anyone better off as a result? Additionally, the new system should incorporate the new Affordable Care Act performance reporting requirement for reporting to HHS and Treasury (e.g., reporting on the verification of eligibility and reporting related to Medicaid).

Strategy A.4.3 Improve current data collection systems to serve in an integrated system across all agencies involved in providing children's behavioral health services.

Current systems such as PSDCRS at DCF and systems set up for particular programs or evidence-based practices provide a good foundation for a comprehensive integrated system but they need to be expanded and integrated across agencies. The ValueOptions data system, Epic Electronic Medical Records systems, and the All Payer Claims Database can serve as additional resources in this effort. The data systems must easily link to one another across all systems, which will allow for analyses that examine access, quality, and outcomes in a way that addresses the interests of each participating entity in the integrated system described in Section IV-A. There should be linkages to adult behavioral health service data for families in the children's behavioral health system. Centralized statewide data with capacity for aggregating data at the levels of the region, the site, and the program will allow for flexible and meaningful data analyses and results. The new system should allow for flexibility so that regions may use the data for secondary analysis to respond to regional/community-level needs.

Strategy A.4.4 Increase State capacity to analyze data and report the results.

Analytic staff supporting the Implementation Team and within the CME should work together to: (1) standardize key data collection process and outcome measures across agencies and programs as appropriate; (2) monitor and manage the data collection process; and (3) analyze and report results. The Implementation Team support staff, the CME, and the funding agencies must have the capacity to conduct data analyses and develop reports that help state, regional, and local directors and program managers to make data-driven program management and supervision decisions. Data-informed management must be part of the service array, not separate from it.

B. Health Promotion, Prevention and Early Identification

Prevention of mental, emotional and behavioral health concerns for children is one of the key goals of the plan called for by PA 13-178. The law requires the inclusion of strategies that employ prevention-

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focused techniques, with an emphasis on early identification and intervention and access to developmentally appropriate services.

In the information gathering process, parents, providers and advocates repeatedly highlighted the importance of both promotion and prevention in the system of care. Many suggested a significant shift of focus from treatment to prevention of mental, emotional, and behavioral disorders by investing in the following: promoting nurturing environments and addressing basic material needs; promoting social and emotional skill development across the age span such as through evidence-based school curriculum; and engaging in screening and early identification among pre-school and school-aged children. Participants presented the following concerns and associated recommendations:

1. Include in all parent strengthening programs for caregivers of young children the importance of early relationships and social-emotional development;
2. Include social and emotional skill development in school health curriculum;
3. Increase prevention efforts and early interventions, especially for children under three years of age but also across all ages.
4. Identify children at risk for difficulties in social-emotional development and behavioral health problems at the earliest possible point through a combination of screening with standardized tools and surveillance by child health providers and school personnel, recognizing that many issues emerge as children enter teenage years.
5. Screen for maternal depression, trauma and other behavioral health risk factors in the family, and ensure that appropriate interventions are available and accessible.
6. Train child health providers on infant mental health and screening for behavioral and neurodevelopmental concerns such as autism among very young children, to ensure referrals for further assessment and intervention including through the Birth-to-Three system when appropriate.
7. Provide more statewide cross-system training in early childhood mental health for staff across all early childhood systems as well as for foster parents.
8. Recruit, train, and hire more bilingual providers to ensure that prevention, early identification and early intervention services are accessible and culturally relevant for children and families.
9. Expand existing evidence-based programs for young children to meet the mental and behavioral health concerns of children birth to five years old.

Participants identified the important role of promoting nurturing environments and relationships among children, acknowledging that Connecticut has an opportunity to strengthen this aspect of the system to ensure well-being among all children and prevent the onset of behavioral health concerns. Furthermore, the process revealed a strong desire among participants to address the significant gap in the service array in the area of universal prevention. This speaks to a public-health approach to prevention as outlined in the 2009 Institute of Medicine Report on the Prevention of Mental, Emotional, and Behavioral Disorders Among Young People.³⁸ The IOM report documents the science and practical knowledge that can guide efforts to prevent, reduce or avert mental illnesses in our children cost-effectively, with a return on investment as high as 80-to-1 for simple universal strategies.³⁹ Such a public-health prevention model has been elaborated in multiple publications subsequently.⁴⁰ Connecticut has the opportunity to be the first state to systematically implement preventive strategies across our communities and schools and reduce the number of youth who develop behavioral health concerns.

Significant expansion of promotion and prevention activities has been proven to reduce the number of youth who will develop behavioral health concerns; nevertheless, some children are at high risk for developing problems and must be identified early. The value of providing services and supports to children with signs of early delay and their families pays off many times over in school success and life

outcomes. Although the number of children in Connecticut screened for behavioral health concerns has increased a great deal over the past five years, screening is nowhere near universal. Connecticut does not have the data needed to precisely measure penetration rates but we estimate about half of all recommended early childhood developmental screening are taking place.⁴¹ Screening also needs to occur for older youth to aid in early identification of behavioral health concerns that may surface at later stages of development. Many participants, however, cautioned that increasing the understanding of behavioral health issues across all child-serving systems and moving to universal behavioral health screening will generate an increase in referrals for services that are already overburdened. Screening needs to go hand-in-hand with an expansion of services for those identified as in need to avoid longer waiting lists, delayed treatment and increased frustration for parents, caregivers, and providers.

The goals and strategies in this Plan address the need to strengthen early identification and screening activities, so that children with emerging behavioral health concerns receive the earliest interventions possible resulting in the best possible outcomes. The approach also seeks to change the environments and experiences of children in their homes, at school and in the community through proven strategies that are effective at promoting well-being and preventing poor outcomes beginning in the earliest years through the transition to adulthood.

Goal B.1 Implement evidence-based promotion and universal prevention models across all age groups and settings to meet the need statewide.

The behavioral health system should increasingly focus on promotion and universal prevention strategies to reduce or eliminate child and family risk factors, and enhance protective factors, to prevent the development of mental, emotional or behavioral disorders.

Strategy B.1.1 Enhance the ability of caregivers, providers and school personnel to promote healthy social and emotional development for children of all ages and develop plans to coordinate existing evidence-based efforts to take them to scale to meet the need statewide.

CT has a wealth of expertise and programmatic efforts to train early care and education and school personnel on the promotion of social and emotional competence and how to address behavioral health concerns in school settings. Examples include: the use of the Pyramid Model in settings for young children birth to five, developed by the Center on the Social and Emotional Foundations for Early Learning, used by a collaboration of early childhood systems in CT;⁴² Yale's Center for Emotional Intelligence RULER program;⁴³ UCONN Neag School of Education and the State Education Resource Center's Positive Behavioral Interventions and Supports;⁴⁴ Mental Health First Aid being taught in schools and communities throughout CT;⁴⁵ and the Campaign for Grade-Level Reading – Social Emotional Peer Learning Pilot through a partnership with the Office of Early Childhood and several foundations.⁴⁶

Although there are myriad initiatives to address promotion and prevention, they reach different audiences with different approaches and are nowhere near taken to scale to reach all children and providers statewide. Therefore, we recommend developing steps to ensure coordination across sectors and accessibility statewide. (See also Strategy C.3.3. regarding professional development for school personnel in behavioral health).

Goal B.2 All children will receive age-appropriate periodic standardized screening for developmental and behavioral concerns as part of a comprehensive system for screening, assessment, and referral for services.

Enhancing the identification of early-onset behavioral health disorders for children and adolescents was one of the seven goals of the Task Force on Behavioral Health Services for Young Adults with a specific recommendation to mandate screening for behavioral health problems by primary care providers in the health care setting and reimbursing providers for the time and effort required. Our approach in this Plan shares a similar goal but deviates slightly in approach. We believe this goal can be achieved without a mandate but through providing sufficient financial incentives and services and supports. There are already many such supports in CT but they will need to be reviewed for effectiveness, and then the most effective approaches expanded and sustained to reach a higher number of children. We also are recommending screening needs to take place in both health care settings and other settings (e.g. early care and education, home visits, and public and private schools), as after the age of three, children are seen less frequently for well-child visits.

Specific actions to increase the rate of screenings and assuring children have access to further assessments and services involves a coordinated approach across systems not only for children birth to three but throughout the school years as well. There are already significant efforts underway in Connecticut, in cooperation with key state agencies that could serve as a locus to oversee the implementation of the recommended strategies, notably the Connecticut Health Innovation Plan (the "SIM" Plan) and the Early Childhood Comprehensive Systems grant-funded initiative. The work must ensure that all of the thousands of high-risk infants and toddlers who come into contact with any state department or their provider network, have access to screening, evaluation and appropriate referral to evidence-based, developmentally appropriate, trauma-informed supports.

The barriers to universal screening most often cited are inadequate reimbursement, cost, lack of time, inadequate behavioral health training for health providers and lack of resources for referral. Children covered by Medicaid in Connecticut already have several avenues through which to access Medicaid-reimbursable developmental or behavioral health screenings including in primary care offices, free-standing clinics, and school-based health centers, and most commercial insurers cover screening as well. Primary care providers can obtain reimbursement separately for behavioral health screenings conducted as part of a well-child visit by both Medicaid and commercial insurers. Reimbursement, however, should be contingent on adding the results to the child's medical record to support continuity of services. This plan addresses the barriers related to training and expansion of resources for referral.

Strategy B.2.1 Expand the use of validated screening tools to assist parents and other caregivers and health, education and home visiting providers to promote social and emotional development, identify behavioral health needs and concerns, document results, and communicate findings with other relevant caregivers and providers in a child's life.

Behavioral health screening using validated tools is an effective and evidence-based approach to providing early detection of children in need of assessment, leading to early intervention services across all age groups. Screening criteria and processes for young children should be aligned with the Office of Early Childhood's Early Learning and Development Standards⁴⁷ and screening for youth of all ages should identify risk conditions in the environment, which lead to significant behavioral health problems, specifically maternal depression, child trauma, domestic violence, substance abuse, or homelessness. The research on the effect of toxic stress (Harvard Center on the Developing Child) and adversity (ACE Study) clearly indicates that these conditions damage the developing brain and lead to serious behavioral health, cognitive, and health problems. We need to identify these high-risk conditions in which children are developing in order to intervene early and prevent later developmental problems.

There are a number of validated screening measures that can assist parents and other caregivers to identify children and youth across all ages who may be exhibiting behavioral health concerns. The Office of Early Childhood seeks to expand the number of parents engaged in assessing their children's

development using a standardized tool in seven communities through a campaign to expand use of Help Me Grow. Help Me Grow at CDI administers the Ages and Stages Monitoring System, one of many tools available. The ASQ:SE is an add-on to the standard ASQ-3 and could be included in the standard set of tools provided to parents. ASQ-3 reaches several thousand parents. Pediatric practices, early care and education providers and schools use a range of other tools to screen youth for developmental concerns. These are models that can be the basis for a statewide strategy.

Strategy B.2.2 Link all children who screen positive for developmental and behavioral concerns to further assessment and intervention using existing statewide systems to identify appropriate resources when needed.

This strategy assures that screening does not happen in isolation of appropriate follow-up and treatment when needed, which requires a broader systemic approach. Many stakeholders noted that periodic screening will only be of value if there is an adequate network to refer children and families who screen positive for further prompt, adequate, and efficient assessments and early intervention. An important resource in CT is the Child Development Infoline Program that provides services to parents and providers to link children to needed services (a model being replicated in 18 other states); currently it only serves children birth to five. We are recommending not only providing the resources to assure this service has the capacity to meet an increased demand as more children are screened but also that it be enhanced, or that a similar service be developed to meet the needs of school age children. This should be coordinated with the work underway at the Office of the Health Care Advocate to support information and referral as authorized in PA 14-115 (see Strategy A.2.2). Any system enhancement needs to ensure that high-risk families use it and are actually connected to services as a result, and that the system is accessible across languages and cultures.

Goal B.3 Ensure that all providers and caregivers who work with young children and youth demonstrate competency in promoting social and emotional development in the context of families, recognizing risk factors and early signs of social-emotional problems and in connecting all children to appropriate services and supports.

A workforce competent in behavioral health across all settings is key to promoting healthy social and emotional development, recognizing the early signs of problems and connecting children to services as early as possible. Those who work with young children need very specific training.

Strategy B.3.1. Conduct statewide trainings on infant mental health competencies and increase the number of providers across all relevant systems who receive Endorsement in Infant Mental Health.

The CT Association for Infant Mental Health (CT-AIMH) has been a leader in this regard, having developed specific early childhood mental health training, a set of competencies that can lead to an Endorsement in Infant Mental Health, and provided reflective supervision opportunities. To date, 23 people in CT have earned an IMH Endorsement and 25 more are progressing toward Endorsement. Several efforts already underway serve as models upon which to build including CT-AIMH's partnership with DCF to cross-train child welfare and Head Start staff and CT-AIMH's partnership with OEC to develop and deliver training on infant mental health for pediatricians and child care providers. These efforts, however, are limited in scale and scope. Training opportunities need to be expanded, with increased opportunities for all those who work with young children including but not limited to DCF personnel, early care and education providers, early interventionists through Birth to Three, home visitors, and health and behavioral health providers.

Goal B.4 Develop, implement, and monitor effective programs that promote wellness and prevent suicide and suicidal ideation.

Suicide prevention programming and training have been a central focus of the Connecticut Suicide Advisory Board with member agencies having greatly expanded. The following suicide prevention programs, among others, have been offered in the state during the last year: Question, Persuade and Refer (QPR) accompanied by Training of Trainers; Applied Suicide Intervention Skills Training (ASIST); Assessing and Managing Suicidal Risk (AMSR); Assessing Suicidal & Self-Injurious Youth (ASSIY); TIP 50: Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment; Connect Prevention and Training of Trainers; Connect Prevention and Training of Trainers; Mental Health First Aid; Recognizing and Responding to Suicide Risk – Primary Care; and SafeTalk.

Strategy B.4.1 Continue cross agency collaboration and coordination with planned evaluation activities of the Connecticut Suicide Advisory Board.

The evaluation of existing and emerging suicide prevention programming is essential to ensuring the provision of effective suicide prevention activities.

C. Access to a Comprehensive Array of Services and Supports

PA 13-178 identifies a number of strategies that can be broadly characterized as promoting access to a comprehensive array of behavioral health services. Central strategies identified in the legislation include:

- Ensuring access to developmentally-appropriate services;
- Offering a comprehensive array of services;
- Improving the integration of school- and community-based behavioral health services;
- Enhancing consumer input and public information and accountability and in partnership between DCF and DSS increasing awareness of the 2-1-1- Infoline program.

Numerous stakeholders identified the need for a comprehensive array of services and supports that includes promotion, prevention, early identification, early intervention, treatment, and transition services (see Figure III.2 above). Full access to that service array must be in place for all children regardless of insurance status, system involvement and geographic location. For example, a number of participants note that many elements of the current array of services and supports are not covered by commercial insurance plans. Furthermore, services may only be available to youth involved in certain public systems, and many services are not equally distributed and accessible in all parts of the state. Although Connecticut is considered a national leader in the provision of many elements of the service array (e.g., in-home evidence-based practices), significant expansion is required to establish Connecticut as a national leader in the full service array and ensuring that all youth and families have access to those services.

Providers and family members repeatedly indicate lack of capacity and not enough services across the service array, and report long wait lists for some service categories. There are significant service gaps in some parts of the state, particularly in the Northeast, Northwest, and Southwest regions of Connecticut. One result of the dearth of services is an increase in emergency department visits. Providers suggest the level of acuity of youth presenting at all levels of care is much higher than it was even a few years ago, noting various contributing factors such as greater awareness of behavioral health needs and zero tolerance policies at schools that result in more referrals to EDs and other services. Utilization data indicates large increases in emergency department utilization for youth presenting with primary behavioral health diagnoses and reductions in inpatient hospital lengths of stay and capacity issues during

period of high volume. Schools and families refer the majority of children that are seen in EDs. Providers strongly indicate that the statewide network of outpatient psychiatric clinics for children and child guidance clinics is consistently underfunded and has difficulty attracting and retaining a stable, highly trained workforce. This situation has contributed to problems ensuring a full service array and continuity of care in all parts of the state. Utilization of EMPS has increased 31% since Fiscal Year 2011 and further increases should be anticipated given the requirements of PA 13-178 for schools to establish MOAs with EMPS to avoid referrals to an ED whenever children can be safely and effectively treated in home and community settings.

Stakeholders also noted a decrease in the number of congregate facilities, stressing the importance of service availability for those with higher acuity needs. According to CTBHP data, since October 2009 six residential treatment centers have closed, in-state bed capacity has reduced by 54%, and the utilization of out-of-state providers has decreased by 85% in the past five years.⁴⁸ Occupancy data from the CTBHP illustrates consistent vacancies across a range of congregate treatment settings, including Therapeutic Group Homes and Residential Treatment Centers. In 2012, Connecticut's overreliance of congregate care settings for children in DCF custody was among the highest in the country and above the national average of approximately 14%.⁴⁹ At the time of this report, although Connecticut has seen a decrease in congregate care utilization and a simultaneous increase in children remaining at home with one or more biological parents, Connecticut remains above the national average in congregate care placement rates. Many states have demonstrated that congregate care reductions have resulted in better outcomes and reduced costs, and these efforts are effective when accompanied with significant increases in funding for community-based service and data-driven monitoring of needs and service utilization. Yet it is clear that residential treatment and other congregate care settings are needed for some youth. Efficient use of this level of care for youth who require this level of treatment should be fully supported as an important part of the full service array.

The primary recommended action with respect to treatment services was to ensure sufficient capacity across the array of behavioral health services, care and support, delivered in various settings (community-based clinics, schools, home-based) that will assist in maintaining children in their homes, schools, and communities, consistent with national research. Many service categories were identified as needing sufficient expansion (Goal C.1).

Goal C.1 Build and adequately resource an array of behavioral health care services that has the capacity to meet child and family needs, is accessible to all, and is equally distributed across all areas of the state.

Our findings indicate a need for significant expansion in many sectors of the service array and ongoing monitoring of the adequacy of the service array. Unless services are enhanced, screening for behavioral problems is likely to lead to an increase in demand for services from an already overburdened system, resulting in children being referred to longer wait lists rather than effective services. Although service expansion across the full array will be complex and costly, and will require further specification and planning to ensure that the most effective services are targeted for expansion, a growing body of literature and community experience documents strategic service expansion as an investment that will ultimately have a positive impact on outcomes for Connecticut's children and prove to be cost effective. In many cases, service expansion is in fact mandated in the Medicaid system by requirements like EPSDT.

Significant service expansion should take place quickly, simultaneous to the system infrastructure enhancements described in Section IV.A. This work will draw on extensive recent efforts to document the service array and gaps in that array, and to recommend solutions (see Section I-III and Appendix B). This work would become a core responsibility of the governance entity established to oversee plan

implementation (see Section V). Service expansion should be informed by the emerging field of implementation science, which examines approaches to disseminating and implementing treatment models.⁵⁰

The service array would emphasize prevention activities and non-traditional/informal supports while also providing sufficient evidence-based and evidence-informed behavioral health services. New, innovative services to meet the needs of specific populations should also be fully promoted in the service array, with adequate supports to ensure effectiveness (e.g., access and knowledge of services, training, data collection, quality assurance/improvement). Services should continue to be delivered across settings (e.g., home-based, early care and education, schools, outpatient clinics) to increase access and prevent and treat social/emotional disorders as early as possible.

The following goals and strategies provide guidance as to where the state can begin to make significant improvements to enhance the service array.

Strategy C.1.1 Establish a process for initial planning of the array of services and supports and ongoing needs assessment, across local, regional, and statewide levels.

Within the context of the system structure and governance articulated in Section IV.A, DCF and its partners will lead the process, with strong family and provider input, to: consistently assess the array of services and supports involved in the System of Care; quantify the gaps identified through an ongoing needs assessment process; and implement a plan for service enhancements. A transparent, web-based process to document each component of the service array, its requirements, its funding, and its place in the overall system will aid in identifying the specific steps to enhance each component and then enable tracking of progress.

Needs assessment is critical for identifying and responding to gaps in the service array, and should be conducted at the local and regional level, employing a broad definition of the array of services. Information on known service gaps can be gleaned from existing reports including regular Value Options reports, the Juan F. Court Monitor process, and recent reports from Office of the Health Care Advocate, the Legislature's Program Review and Investigations Committee, and from the Early Childhood Comprehensive Systems grant. A process and online data collection tools for conducting these local/regional needs assessments and rolling them up to the statewide level should commence immediately and be pursued with some urgency based on public and providers concerns about capacity issues. The strategy for financing this expansion of services is articulated in Goal A.2 above.

Strategy C.1.2 Finance the expansion of the services and supports within the array that have demonstrated gaps.

The planning process has identified a number of components of the service array that require increased investment to meet current and projected needs. As noted throughout this report, the current high utilization of EDs is related to an insufficient supply of community-based alternatives across the service array; consequently, expansion across the service array is strongly recommended. The section below describes a number of service categories that were identified as lacking capacity. Expansion in each area is strongly recommended.

In addition to meeting existing demand, expansion is recommended to plan for the anticipated growth in demand for services resulting from increased efforts in the area of screening for behavioral health concerns, as described in Section IV.B.

While this Section IV.C covers the comprehensive view of developing the entire system of care, much of which will be enhanced through the existing network of child guidance clinics and outpatient psychiatric clinics for children, two areas targeted for development intersect with many components of this array of services and were pulled out in separate goals below:

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- **Crisis response services (Goal C.2).** Many stakeholders noted significant increases in the number of youth presenting in behavioral health crisis to services such as Emergency Mobile Psychiatric Services (EMPS), EDs, and inpatient hospitals. Further expansion of this level of care is an immediate need and an important part of the overall system of care; accordingly, it is described in further detail in Goal C.2 below.
- **School-based behavioral health (Goal C.3).** Many planning participants cited schools as ideal settings for screening, early identification of behavioral health needs, and delivery of and linkage to treatment services. Further expansion of school-based behavioral health care, in close cooperation with existing community-based clinics, is an important part of the overall system of care and is described in further detail in Goal C.3 below.

The services in this array will continue to be delivered by providers with extensive experience and deep roots in the community. Services and supports in need of expansion are described below, including: early childhood interventions; non-traditional/non-clinical interventions; care coordination; and behavioral health treatment options.

a. Early Childhood Interventions

Section B includes description and strategies for increasing the incorporation of universal prevention approaches as an important element of the service array; this section describes preventive interventions primarily at the selective and indicated levels for youth who are found to be at-risk for social, emotional, and behavioral problems. The early childhood behavioral health system must include an array of evidence-based interventions from low to high intensity, delivered in a variety of settings. Early childhood behavioral health intervention/treatment can dramatically decrease the need for deep end services later delivered by schools and community-based agencies. Intervening early is documented to be effective, both in terms of cost and morbidity, with a convincing body of evidence that home visitation programs improve developmental outcomes,⁵¹ increase caregiver capacity, reduce incidents of abuse and neglect, and address the implications of Adverse Childhood Experiences on health and well-being.⁵² By considering these programs as Community Health Providers within the SIM framework, an opportunity may be created to further develop and bring to scale critical and cost-efficient early interventions.⁵³

Infant mental health advocates point out that intervention and treatment for infants and young children is very different than for older youth. Services for the very young are not simply a downward extension of intervention used for older children. Infancy is the time of the most rapid brain development and trauma and other adversity that occurs at that developmental stage has profound effects on behavioral health, cognition, and physical health. A two-generation, trauma-informed, developmentally appropriate approach that focuses on the relationship between caregiver and child is fundamental to protecting the developing brain from the devastating effects of stress and trauma and is the foundation for interventions for this population.

In every case, the level of intensity of service and the setting must be matched with the unique needs of the young child and family. For example, children meeting typical developmental benchmarks might be served with a consultation in a pediatric office; challenging behaviors in preschool might benefit from a behavioral health consultation model; and some parents might need skill building as a third possibility. Young children who have experienced trauma, who have parents with significant challenges (e.g., depression, domestic violence, substance use), or who have experienced abuse and neglect need more intensive, home-based, trauma-informed, two-generation services.

The state's service capacity to offer preventive interventions is inadequate, with long waitlists for some evidence-based interventions. Consequently, the state should ensure a sufficient capacity of early childhood interventions to meet the needs of all families, including home visiting services featuring trauma-informed models, early care-based interventions, and clinic or community-based interventions to ensure that such services are scaled up.

b. Non-Traditional/Non-Clinical Services

Families point to the need for an expansion of non-traditional, non-clinical services that include community-based, faith-based, after-school, grassroots, and other supports for youth who are exhibiting, or identified as at risk for, behavioral health symptoms. Such interventions should be supported as important element of the service array in the area of promotion, prevention or early intervention (depending on the nature of the program and its target population). Families identify such interventions as being highly responsive to community needs, family-friendly, accessible, and effective. Furthermore, families report that such interventions often are delivered by individuals who know their community, which contributes to the acceptability of those services. Included in this category are community-based services that provide a bridge between families, schools, and pediatric health care providers.

Considerable work is underway to ensure that children with behavioral health and substance use issues are not ensnared in a juvenile justice process that could contribute to negative longer-term outcomes and not address their underlying issues. Programs have been piloted across the state to work with schools, Juvenile Review Boards, or Youth Service Boards, to identify at-risk children, facilitate assessment of their needs, and connect them with services or pro-social community activities. These prevention and early intervention programs often are small and grant-funded. As Connecticut re-imagines its health care delivery and payment system, these services should be considered, potentially with a plan for certification or licensing, support for fidelity and outcomes measurement, and a path for insurance reimbursement.

c. Care Coordination

Care coordination utilizing high-fidelity Wraparound and child and family teaming approaches is highly recommended, and as described in Section IV.A.2, such services are an essential component of the proposed re-organization and the roles and functions of the system of care. Youth and family members who are involved in multiple systems indicate difficulties meeting the varying recommendations, protocols, and requirements for treatment across those systems. Families report that they constantly feel the need to “start over” when circumstances change, and that information about their behavioral health and treatment history “does not follow” them, suggesting that treatment information is not shared efficiently with the next clinician or agency. This often results in frustration and lack of continuity of care. Effective care coordination can address this issue and streamline access to the most appropriate services and address issues of continuity of care.

Care Coordination should also connect families to the array of services that will reduce family stress, which can be “toxic” to the development of the child. Examples include services to address treatment for maternal depression, parental substance use, or behavioral health disorders; domestic violence; homelessness; food insecurity; and more. As per the Guiding Principles of a System of Care, care coordination is not just about coordination of behavioral health services but about coordination and access to the services and resources across systems that a family needs to promote health and well-being.

d. Behavioral Health Treatment Options

The findings strongly support the need to expand and/or enhance several areas of the treatment service array. Treatment options should be available at varying levels of intensity to meet individual needs. Services should be accessible regardless of insurance type, system involvement, and geographic location. Described below are areas of the service array that are in need of expansion.

Outpatient care. Some providers from the state's Child Guidance Clinics report high numbers of referrals to outpatient services but a lack of sufficient funding to meet the need. Routine outpatient care is often a first referral for a young person with behavioral health needs, a follow-up service referral for youth discharged from other services, and a “step-down” referral from more intensive levels of care. This results in high demand at the outpatient level of care and youth presenting with various presenting concerns and levels of acuity. Increasingly families, providers, and funders understand the high rate of

trauma experienced by youth in our behavioral health and juvenile services system and the associated lifelong medical and societal costs of unaddressed trauma exposure.⁵⁴ In recent years, Connecticut has increased its adoption of evidence-based practice models and in partnership with providers has implemented several of these models in an effort to enhance the quality and outcomes of outpatient care.

Connecticut should continue to support the outpatient level of care and scale-up its nationally recognized trauma support and evidence-based services - including TARGET, TF-CBT, MATCH-ADTC, and other models - to prevent system involvement and reduce escalation of need. Implementation of evidence-based practices at the outpatient level of care may require new reimbursement strategies to participating clinics to cover the additional costs associated with implementing evidence-based practices. Associated costs often are related to reduced productivity related to training and support (e.g., learning collaboratives, consultation calls, supervision), smaller caseloads, and increased requirements for data collection and quality improvement activities.

Intensive treatment models. Many note the need for sufficiently intensive treatment options to meet the needs presented by many youth and their families. This level of care is critical to maintain youth with behavioral health needs in their homes, schools, and communities. Access to intensive treatment models, delivered primarily in community-based settings, is needed, including Extended Day Treatment, Intensive Outpatient Programs, and Partial Hospitalization Programs.

Child and adolescent psychiatry. Many stakeholders identify a significant shortage of qualified child and adolescent psychiatrists to conduct psychiatric evaluations and provide medication management to children who require this level of care.

Substance use services. Participants identify substance use issues as a growing concern among youth. Opiate and prescription drug use are identified as increasingly prevalent among the adolescent population. Participants noted that some excellent, evidence-based services exist for treating adolescent substance use; however, they do not have the capacity necessary to meet the need. Furthermore, Connecticut lacks a recovery-oriented system of care for youth, although such a system does exist for adults through DMHAS. Many of the substance use services in the state are available through the justice system, but children should not need to be arrested to access those services. Reimbursement strategies, particularly among private insurers, do not sufficiently fund a long-term recovery model. A more effective approach would be to enhance access to substance use treatment for all youth who need it, thereby preventing juvenile justice and other system involvement. Consultation between DMHAS and the youth-serving system of care is recommended in order to apply relevant lessons learned to the youth population in further developing recovery-oriented services and supports. Better coordination between substance use treatment providers and behavioral health providers, who are often from different agencies, is also needed.

Services and supports for children with autism. Participants feel that the system of care for individuals with autism is overly complicated and insufficient to meet the need. The responsibility for treating youth with autism continues to be shared by too many programs and agencies, and the waitlist to see an expert on autism can be as long as six months. A trained workforce that can provide specialty care for youth with autism is highly recommended. Furthermore, there is a pressing need for all youth, including those with autism, to have access to transition services as they age out of the child-serving system and need supports for independent living, employment, and housing.

Goal C.2 Expand crisis-oriented behavioral health services to address high utilization rates in emergency departments.

It is generally acknowledged that EDs are an inappropriate setting for treating youth with behavioral health needs and their families. High utilization of EDs can be addressed through expansion of crisis-oriented services like EMPS, short-term (e.g., 23 hour) behavioral health assessment centers, and longer-term (e.g., 14 day) crisis stabilization units.

EMPS is a proven service that helps divert youth from the ED by responding to families and schools, and helps reduce ED volume by diverting youth who are in the ED from inpatient admission. EMPS also provides linkages to community-based care for families who are in the ED. The ongoing growth in EMPS utilization suggests that EMPS requires further expansion to meet the demand; in addition, it underscores the important finding that EMPS is necessary but not sufficient to address the high utilization of EDs. A sufficient service array at varying levels of intensity, as described in this section, is required so that EMPS can ensure ongoing treatment at an appropriate level of care. In addition to expanding EMPS, expansion of crisis behavioral health assessment centers and crisis stabilization units are highly recommended as they provide critically important alternatives to EDs.

Strategy C.2.1. Expand EMPS by adding clinicians across the statewide provider network to meet the existing demand for services.

The ongoing growth in utilization of EMPS services over the last several years, as well as growing utilization of EDs among youth with primary behavioral health concerns, justifies an expansion of EMPS to address the crisis needs of youth and families. EMPS helps to divert youth from EDs by responding directly to families and schools. Continued outreach to families and execution of MOAs with schools (as required under PA 13-178) and police is likely to significantly expand EMPS volume. Expansion of capacity within EMPS is required to meet the current and projected increases in demand for this service.

Strategy C.2.2. Enhance partnerships between EMPS clinicians and EDs to facilitate effective diversions and linkages from EDs to community-based services.

Along with the expansion of EMPS clinicians generally, enhancements in partnerships between EMPS clinicians with the EDs can further support the diversion of youth from inpatient hospitalization when children can be safely and effectively treated in their homes, schools, and communities. It will also assist EDs by providing direct access to experts in establishing linkages to community-based care. EMPS also works closely with police to divert youth with behavioral health needs from ED utilization as well as arrest.

Strategy C.2.3. Explore alternative options to ED's, through short-term (e.g., 23 hour) behavioral health assessment centers and expanded crisis stabilization units.

For youth who are experiencing a behavioral health crisis and are in need of acute care, EDs are not an appropriate setting; however, alternative treatment settings do not exist or are in short supply across the state. Families and providers identified the importance within the service array of behavioral health assessment services (e.g., 23 hour beds) and crisis stabilization units that provide assessment and treatment for longer periods of time (e.g., up to 14 days). An enhanced crisis service system should ensure that EMPS can provide direct access to these treatment settings, which will help alleviate the current crisis in EDs and provide families and youth with a safe treatment environment at a less intensive level of care than inpatient hospitalization. In-state and out-of-state models for crisis respite and crisis stabilization units should be considered as models for expansion. With the proposed expansion of crisis services as alternatives to EDs, some stakeholders have concerns about current federal and state regulations as they relate to accessing these services. For example, the federal Emergency Medical Treatment and Labor Act (EMTALA) describes hospitals' obligations when an individual presents for treatment to an emergency department, and contains other stipulations relating to ambulance transport to a hospital. We recommend that the state closely examine the federal EMTALA law and relevant state law and make appropriate changes to state law as needed to ensure that youth have access to crisis treatment options designed to serve as alternatives to the ED.

Goal C.3 Strengthen the role of schools in addressing the behavioral needs of students.

A significant expansion of school-based behavioral health services is recommended, built on an "expanded school mental health" framework that includes significant collaboration between community-based behavioral health providers and schools.⁵⁵

There is growing evidence that students with behavioral health needs have higher rates of academic failure and also are subject to high rates of "exclusionary discipline" (e.g., arrest, expulsion, suspension). While appreciating that the schools' primary role is to educate children, schools are also ideal settings for screening and early identification of behavioral health needs and linkages to services. Research suggests that behavioral health services are effective and more accessible to youth when delivered in schools.⁵⁶ School-based behavioral health services are provided by clinicians employed by school districts, school-based health center staff, and/or community-based providers who are either co-located in the schools or located in the community but linked to the school.

Schools have the potential to be the best places for identifying youth in need of intervention and reducing access barriers to provide effective care. Many schools, however, require assistance in building their capacity for these services in order to realize that potential. Over time, school districts have reduced the number of guidance counselors, school social workers and school psychologists due to budget cuts, reducing the schools' ability to meet the behavioral health needs of students and provide guidance to teachers about how to do the same. School-employed clinicians were reported to have extensive responsibilities related to developing and reviewing Individualized Education Programs/Plans (IEPs) but less available time to provide prevention and intervention services. Additionally, there are difficulties meeting the behavioral health needs of youth with autism in schools, responding to behavioral health crises in schools, and facilitating transitions from inpatient hospitalization back to the school. Parental engagement in care can be more difficult during the school day, and feedback to the primary care provider is inadequate, even with fairly straightforward medical problems. Communication and coordination between schools and community-based behavioral health providers is a significant challenge. School-based health centers, though helpful and effective, are not sufficiently taken to scale across the state and may not have the full capacity needed to ensure coordination of care between the school and the community, particularly when school ends in the summer but children and families require ongoing services. It is clear that if schools are to play a broader role in the delivery of behavioral health services, support will be required to address these various concerns.

It is critical that efforts to enhance the delivery of school-based behavioral health services provide financial support to schools and also to the network of child guidance clinics in Connecticut that will be involved in this effort. Coordination with community-based providers, perhaps through co-location of clinicians in schools, will ensure that youth who are identified or treated in schools have access to the full service array available in the community and experience continuity of care during the after-school hours and over the summer.

School-based services will also need to be coordinated with the overall development of the system of care and the role of the Care Management Entities proposed in Goal A.2, with school-based services part of a broader evaluation and care plan for children served. This will also allow for enhanced data collection and accountability for the delivery of school-based behavioral health services. Data collection practices at the system level should incorporate results of school-based behavioral health screening, referrals and linkages to treatment, and outcomes including school attendance and academic achievement. Annual student health surveys that include questions about physical health, behavioral health, social life, and school engagement and link to health and educational outcomes can help identify needed services (individual, group, school-wide).

Specific strategies in this area are outlined and explained below.

Strategy C.3.1 Develop and implement a plan to expand school-based behavioral health services.

This plan should include the following elements:

- **Increase the number of community-based clinicians who are co-located in schools.** It is critically important to integrate delivery of school-based behavioral health services with the state's network of community-based clinics (e.g., child guidance clinics, outpatient psychiatric clinics for children) and the overall system of care described in this report. This is the best way to ensure that students who are identified or treated in schools have access to the full service array and that they experience continuity of care when schools are not in session. All goals and strategies described in this section should be pursued in close coordination with the network of community-based clinics.
- **Address licensing, funding or other regulatory issues** to enable community providers to deliver services on school grounds and receive reimbursement from insurers and/or Medicaid. This alleviates transportation and "no show" issues because the child is already at school, and also helps to address stigma because the youth is going to the school for services, not to a "clinic."
- **Increase the number of school-based behavioral health clinicians.** Connecticut must ensure that all schools have a sufficient number of social workers and school psychologists to meet or exceed recommended standards and to meet the demand for treatment.
- **Adopt and implement standardized screening instruments.** Standardized screening instruments will help school personnel identify behavioral health and support needs, including trauma exposure. Schools need to identify key points of contact among school staff who can administer the universal screening (e.g. school nurse, SBHC clinicians, guidance counselors, school social workers, community-based clinicians), provide training, and create a centralized data system for sharing of results and to avoid duplication of screenings. Section IV.B provides additional details on behavioral health screening in the system of care.
- **Expand the number of school based health centers (SBHCs).** School-based health centers, staffed by either school employees or contracted staff from local providers, are an effective model for addressing the health and behavioral health needs of students and integrating care. Medical clinicians are now required (for sites funded by DPH) to conduct behavioral health screenings at all visits, which increases the likelihood of early detection and referral. Connecticut should ensure that all school-based health centers achieve the "gold standard" of optimal comprehensive SBHC care that involves having both a health and behavioral health clinician with administrative support. Expansion of SBHCs should follow the establishment of quality standards and the development of effective programmatic oversight at DPH.⁵⁷ DPH will need an increase in funds for administrative staff support to implement and monitor this expansion.
- **Implement evidence-based treatments tailored to schools.** Require that all school-based behavioral health providers are trained in the use of trauma-informed evidence based treatments that are designed for delivery in a school setting and utilize group and individual treatment modalities.
- **Identify model plans across the state that accomplish the goals and strategies outlined in this section, and systematically support replication of those models across the state.** There are a number of potential models for enhancing school-based behavioral health in collaboration with community-based providers. Existing or emerging evidence-based models, such as the Cognitive Behavioral Intervention for Trauma in Schools (CBITS), should be identified and replicated.
- **Integrate measurement of outcomes with statewide data collection and reporting efforts.** Data collection and reporting of outcomes across SBHCs and other school-based services

throughout the state should connect to the statewide model of quality assurance, continuous quality improvement and monitoring of outcomes (see Section IV.A).

Strategy C.3.2 Create a blended funding strategy to support expansion of school-based behavioral health services.

Municipal funds will be insufficient to support an expansion of school-based behavioral health services. A combination of federal, state, local, and private and public philanthropic funds can be pooled together to fund school-based behavioral health services, reduce fragmentation and cost shifting, and improve the coordination of school- and community-based behavioral health services.

Strategy C.3.3 Develop and implement a behavioral health professional development curriculum for school personnel.

In-service professional development will help build the capacity of school personnel to recognize, refer, and/or treat behavioral health concerns. School administrators, teachers, clinical personnel, School Resource Officers, and other school personnel all require different behavioral health competencies and the curriculum should be tailored to their needs and to the developmental level of the students they serve. Initial training for teachers and administrators in behavioral health and developmental issues should be incorporated in teacher and administrator training curriculums in higher education. SDE, school behavioral health trade associations, and school personnel should guide curriculum development for continuing education. All School Resource Officers should be required to undergo training in recognizing and responding to youth with behavioral health needs, increasing rates of diversion from exclusionary discipline including arrests, expulsions, and suspensions, and implementing restorative practices. Training modules should include, at a minimum, the following:

- Introduction to Child/Adolescent Development;
- Recognizing Behavioral Health Concerns and Trauma Exposure;
- Developing Empathy and Reducing Stigma/Discrimination Associated with Behavioral Health Concerns;
- Effective Classroom Behavior Management Strategies;
- Violence Risk Assessment;
- Diversion from Exclusionary Discipline; and
- Cultural Competency.

Strategy C.3.4 Require formal collaborations between schools and the community.

PA 13-178 calls for establishment of MOUs between schools and EMPS providers and between schools and police. Schools and community-based agencies should develop much broader MOUs that articulate roles and responsibilities in meeting the behavioral health needs of students, using EMPS as well as other services and supports. MOUs must address the need for improved communication between schools, police, community-based providers and hospitals in order to promote coordination and continuity of care.

Goal C.4 Integrate and coordinate suicide prevention activities across the behavioral health service array and across multiple sectors and settings.

Behavioral health providers should work within their respective agencies and communities to raise the profile of suicide prevention initiatives and activities that promote health and wellness. There is strong institutional and leadership support for suicide prevention through DMHAS, DPH, DOC, DCF and other state agencies.

Strategy C.4.1 Continue to identify and foster attitudes and behaviors within agencies and programs that support the evaluation and adoption of new initiatives for prevention, intervention and postvention.

Central to this effort is the institutionalization of embedded language, policy and activity in agencies for which suicide prevention may not traditionally be part of the central mission.

D. Pediatric Primary Care and Behavioral Health Care Integration

Section 1.1 of PA 13-178 calls for offering comprehensive, coordinated care within a continuum of services. The legislation also calls for DPH to work with DCF to increase family involvement in the medical home and integrated care models. Among the challenges in an integrated care delivery system identified by experts in the field through facilitated discussions, community conversations, and a review of the literature, two were most salient and are identified as key goals for addressing continuity, coordination, and integration of care: (1) the integration of pediatric primary care and behavioral health services within Patient Centered Medical Homes (PCMHs); and (2) enhancements to the care coordination systems in the State. Integration of pediatric care and behavioral health is addressed in this section, complementing the recommendation in Section A regarding care coordination and the creation of Care Management Entities as the major system enhancement to ensure coordination and continuity of care across all involved sectors.

Challenges regarding the integration of pediatric primary care and behavioral health services include:

- Electronic health record systems do not allow for sharing of information across care settings, such as health and behavioral health;
- State confidentiality laws require parental consent for health and behavioral health providers to share information;
- Pediatric providers are not comfortable treating their patients' behavioral health conditions;
- Behavioral health providers are not trained to work in pediatric primary care settings;
- Reimbursement policies don't easily support behavioral health clinicians delivering care in pediatric primary care settings;
- The lack of 24/7 availability of providers, including behavioral health clinicians, contributes to overuse of Emergency Departments; and
- Parents are left to do the bulk of coordination of care between their children's health and behavioral health providers.

Integration of pediatric care and behavioral health applies in both the public and private sectors for behavioral health care systems and will need to be coordinated with the role of the Care Management Entities to avoid duplication. An approach will be needed for families with children with a high level of need who are presently looking to the DCF Voluntary Services program for assistance.

Goal D.1 Strengthen connections between pediatric primary care and behavioral health services.

Pediatric primary care services provide a unique opportunity to address children's behavioral health needs. They are universally used across age groups, racial and ethnic groups and geographic locations. For example, children cannot attend childcare, school, camp or play organized sports without first having a physical exam by a licensed child health provider. Engaging at the primary care level also facilitates a family-based approach. Providers can engage families in behavioral health services for their children and

for adults in the family. Integration into primary care more easily allows providers to work with children and their families over time, observing changes in concerns and circumstances. Lastly, primary care services are connected to a wide array of community services that children use, including preschools, schools, and specialty services. Several individuals commented that these connections are not strong enough in Connecticut, and this concern is addressed in this recommendation as well as in the system integration recommendations.

Connecticut has several initiatives in place for improving connections and coordination between health and behavioral health providers, including co-locating behavioral health providers on-site in pediatric practices. These can be integrated and brought to scale to improve access to behavioral health services. Some examples of such initiatives include:

- The State Innovation Model (SIM) calls for integrated services with strong care coordination across levels of care and systems of care;
- Medicaid's Person Centered Medical Home (PCMH) program requires that practices hire or contract for the services of a care coordinator;
- The National Committee on Quality Assurance (NCQA) 2014 medical home standards, on which Connecticut's PCMH program is based, requires that practices have agreements with behavioral health providers and inform patients of those agreements;
- The CT BHP Enhanced Care Clinic (ECC) program requires that behavioral health agencies with ECC status have at least two memoranda of agreement with primary care sites to provide services and supports;
- DCF recently launched a consultation program (Access MH CT) through Value Options that provides primary care child health providers with direct contact to a child psychiatrist. Three hubs within the state deliver the consultation in their respective geographic areas;
- DPH recently funded the development of five regional care coordination collaboratives that will bring cross-sector care coordination services from a variety of providers (DCF, BHP, Community Health Network) to primary care sites;
- Connecticut's Federally Qualified Health Centers have worked to integrate behavioral health and pediatric care through both their clinics and their school-based health services;
- The Educating Practices in the Community (EPIC) program provides education to pediatric primary care sites on many behavioral health issues, including integrated care and connecting children to behavioral health services. More than 200 practices have received EPIC training on one or more behavioral health topics;
- CHDI has developed algorithms for co-management of pediatric anxiety and depression, two common child behavioral health conditions. Co-management shifts care from psychiatrists to pediatricians, thereby increasing access and expanding the capacity of the medical home to address behavioral health issues.

Coordination between pediatric care and behavioral health care needs to be implemented within the overall approach to coordinating and financing behavioral health care to ensure that developing models work smoothly together.

Strategy D.1.1 Support co-location of behavioral health providers in child health sites by ensuring public and commercial reimbursement for behavioral health services provided in primary care without requiring a definitive behavioral health diagnosis.

Behavioral health providers who work in primary care sites often are challenged to gather reimbursement for services. This gap results from requirements that children served have a behavioral

health diagnosis. Yet, the goal of co-location is to address behavioral health concerns before they reach the stage of a full diagnosis; for example, brief intervention that often is accomplished with parent support counseling, or identification of children who need full assessments elsewhere in the system. These two services are ideally provided as part of primary care.

Strategy D.1.2 Support the development of educational programs for behavioral health clinicians interested in co-locating in pediatric practices.

The provision of behavioral health services in primary care is different from services provided in behavioral health agencies, where care is generally long term and assessments are comprehensive. In primary care sites, the treatment model is primarily brief intervention with the family with follow-up, and children with higher intensity needs are triaged to community based behavioral health services. Behavioral health clinicians are rarely trained in providing the primary care brief intervention model of care. For co-location to be successful, programs are needed to provide such training at the graduate and continuing education level.

Strategy D.1.3 Require child health providers to obtain Continuing Medical Education (CME) credits each year in a behavioral health topic.

The opportunity to provide education on behavioral health topics—from screening to brief intervention—can be supported through CME requirements for professional licensure. This effort would be similar to requirements for child health providers to obtain CME credits in child abuse. Connecticut statute currently requires that child health providers also receive CME in the following topics annually: Infectious diseases, risk management, sexual assault, domestic violence and cultural competency. Required hours for behavioral health education can be added to this list.

Strategy D.1.4 Ensure public and private insurance reimbursement for care coordination services delivered by pediatric, behavioral health or staff from sites working on behalf of medical homes.

To explore care coordination reimbursement for Medicaid enrolled children with behavioral health needs. Such reimbursement will allow practices to connect children and families to helpful community-based services at the earliest stage of behavioral health concerns.

Strategy D.1.5 Reform state confidentiality laws to allow for sharing of behavioral health information between health and behavioral health providers.

Unlike other states, Connecticut's confidentiality laws do not allow health and behavioral health providers to share patient behavioral health information. This prohibition hampers communication and coordination of care between the two providers. Although families express concern about confidentiality, they also express frustrations with uncoordinated care between their children's many providers. Allowing health and behavioral health providers to share information would be a positive step toward improved coordination, though we recognize this may be somewhat controversial in relation to rights of privacy.

E. Disparities in Access to Culturally Appropriate Care

Section 1 of PA13-178 identifies a primary strategy for plan development in the area of "being sensitive to diversity by reflecting awareness of race, culture, religion, language and ability." The planning process identifies the following needs of families, providers, and other stakeholders regarding disparities in access to culturally and linguistically appropriate services:

- A need for additional staff who are from the same community and speak the same language as the families seeking services;

- A need for a culturally specific social marketing campaign within specific ethnic minority communities to reduce stigma among families seeking behavioral health services;
- Lack of awareness of and access to culturally and linguistically competent services and supports in the behavioral health system of care;
- A need for training among all behavioral health clinicians on delivering services in a manner that respects the culture (e.g., family composition, religion, customs, sexual orientation, gender expression) of each youth and their family;
- A need for training for school personnel, school resource officers (school-based police) and behavioral health providers to reduce implicit biases that lead to disparities in youth of color being overrepresented in CT's juvenile justice system and underrepresented in CT's behavioral health system;
- Limited access to the closest available care for families in rural communities and areas along the state borders, as appropriate care is often across state lines and not reimbursable by insurance; and
- A need to reduce the underrepresentation of youth of color in CT's behavioral health system and their overrepresentation in CT's juvenile justice system.

Although this section presents recommendations specific to building a system of behavioral health care that addresses disparities in access to culturally appropriate services, additional recommendations that address culturally and linguistically appropriate services are integrated into other sections of the report as these were noted areas of concern heard across the input gathering process.

Goal E.1 Develop, implement, and sustain standards of culturally and linguistically appropriate care.

Connecticut Public Act 13-217 calls for continuing education training for physicians in cultural competency. The Connecticut Commission on Health Equity, established by the Legislature, has adopted the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (i.e., "CLAS standards") and is working with state agencies to assess their compliance with the standards and develop plans to meet them.

Connecticut's behavioral health system of care must include formal adoption and monitoring of CLAS standards in order to reduce disparities in access, service quality, and outcomes. Closely connected to disparities in access to culturally appropriate behavioral health services are the well-documented issues of racial and ethnic disparities in academic achievement and disproportionate minority contact in the juvenile justice system. Two documents, *A Blueprint for Advancing and Sustaining CLAS Policy and Practice* (Office of Minority Health, U.S. Department of Health and Human Services; 2013) and *The Cultural and Linguistic Competence Implementation Guide* (Martinez & Van Buren, 2008), are available electronically to guide implementation.

Strategy E.1.1 Conduct an ongoing needs assessment at the statewide, regional, and local level to identify gaps in culturally and linguistically appropriate services.

Needs assessments should include an assessment of workforce and recruitment and retention of diverse staff into the behavioral health field to meet the need for services that are appropriate to the cultural and linguistic characteristics of the service area. Implementation should include: (1) a stakeholder analysis to identify formal and informal youth and family leaders, reflective of the population of focus, to consider for leadership roles within the governance structure; (2) a review and incorporation of findings from the Asian Pacific American Community Needs Assessment and other relevant needs assessments;

(3) ongoing self-assessments to assess and monitor competencies and resources available to promote governance and oversight related to eliminating disparities in access to culturally appropriate services.

Strategy E.1.2 Ensure that all data systems and data analysis approaches are culturally and linguistically appropriate.

Data systems and processes should take into consideration examination of access, service quality, and outcomes that are disaggregated by race, ethnicity, gender, language, culture, sexual orientation and gender expression and other characteristics of diversity with known disparities. When disparities and disproportionality are identified, these disparities must be formally addressed through corrective action plans and monitored for improvements.

Strategy E.1.3 Require that all service delivery contracts reflect principles of culturally and linguistically appropriate services.

Funded behavioral health providers should be required to formally review and plan to strengthen culturally and linguistically appropriate services within their organizations. Contracting agencies should ensure that funding and supports are available so that service providers can achieve and maintain these standards (e.g., higher salaries for bilingual staff, funding/support for staff to become bilingual).

Goal E.2 Enhance availability, access, and delivery of services and supports that are culturally and linguistically responsive to the unique needs of diverse populations.

The Enhanced National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care must be fully incorporated into the service system to improve availability, access, and delivery of services and supports for all children and families regardless of demographic characteristics, place of residence, or insurance status across the service array. A primary overarching strategy for improving direct services is through workforce development that emphasizes recruiting, retaining, and promoting a diverse workforce and leadership structure that reflects the demographics of the service area. Findings indicate that families feel most comfortable seeking services from clinicians and service providers from their own community, and who reflect their racial, ethnic, cultural, and linguistic background. Families should be engaged as full partners in designing and implementing activities related to cultural and linguistic competency. In addition, it is critical to integrate systems enhancements across the array, including access to services and supports, prevention and education, screening and assessment, early identification and early intervention, and transition planning. Services should be designed to address known disparities related to factors such as race, ethnicity, gender, language, culture, sexual orientation and gender expression and other characteristics of diversity.

Strategy E.2.1 Enhance training and supervision in cultural competency.

Training and supervision for staff should also include strategies to track accountability among system partners and leadership to sustain enhancements in culturally appropriate care. This can be executed through the implementation of a learning community focused on culturally and linguistically appropriate service standards and competencies including ongoing education, training, support, and self-assessment. In addition, cultural competence should be integrated into professional credentialing processes for providers.

Strategy E.2.2. Ensure that all communication materials for service access and utilization are culturally and linguistically appropriate.

Communication materials should be developed and/or interpreted into the preferred language and cultural perspectives of families served. Competent and professional language assistance services must be

included at all points of contact to allow all youth and families to fully participate in services, and selected and endorsed treatments must be deemed effective with the target populations to be served.

Strategy E.2.3. Provide financial resources dedicated to recruitment and retention to diversify the workforce.

Financial incentives are required to support the recruitment of diverse professionals into the children's behavioral health field, in order to create a supply of clinicians that can meet the demand that exists, improve quality of care, and reduce disparities. The children's behavioral health system should establish partnerships with university training programs, which play an important role in recruiting and preparing a diverse and culturally competent workforce.

F. Family and Youth Engagement

PA 13-178 identifies that a central strategy for the Plan is "engaging communities, families, and youth in the planning, delivery, and evaluation of mental, emotional, and behavioral health care services" and "in collaboration with the Department of Public Health, increasing family and youth engagement in medical homes."

Youth and family members' concerns and recommendations are integrated throughout all sections of the report along with those of advocates, providers, and other stakeholders in the children's behavioral health system. There also is a need, however, to specifically identify the topic of family and youth engagement as a core area in the development and implementation of the system of care, and to outline goals and strategies that ensure the **ongoing and full partnership of youth and families in the planning, delivery, and evaluation of services**. Families and youth strongly requested this throughout the input gathering process, but it is important to note the strong consensus among providers, advocates, state agency representatives, and other stakeholders. Family and youth engagement in the children's behavioral health system of care will help ensure that their input is fully incorporated in the children's behavioral health service delivery system and that Connecticut continues to move toward the goal of a family-driven and youth-guided system of care.⁵⁸ Many families indicate that Connecticut has made progress in this regard but more needs to be done.

At the systems-level, families and other stakeholders strongly urge that youth, family members, and family/youth advocates have "a seat at the table" in the governance and oversight of the service delivery system. In addition, families, youth, and family advocates identified the need for paid positions within the governance structure of the children's behavioral health system. Families and youth viewed this change in the system as a significant validation of the importance and professionalization of their role within the system. Families, youth, and advocates indicated that their participation in meetings and system governance is frequently desired or expected but infrequently paid for. The implementation of this Plan and the resulting expansion of the children's behavioral health system of care present an opportunity to fully recognize the important contributions of families and youth in the governance of the behavioral health system by offering paid roles in that system. At the service delivery level, family-advocacy, parent-to-parent and peer-to-peer support groups are highlighted as important elements of the service array and workforce. Stigma reduction and anti-discrimination campaigns and comprehensive efforts to disseminate information about behavioral health services are highlighted as strategies for ensuring that families have awareness of and access to the service system. Opportunities for regular family and youth input and feedback into service delivery, at the local and regional level, are also highlighted as extremely important.

This section addresses specific strategies for youth and family involvement in system development, although family involvement in the system of care process itself is assumed as a basic principal (Section III) as well as across all thematic areas.

Goal F.1 Include family members of children with behavioral health needs, youth, and family advocates in the governance and oversight of the behavioral health system.

The realization of a family-driven and youth-guided system of behavioral health care requires the full participation of families, youth, and advocates in the planning, delivery, and evaluation of behavioral health services, at the systems and the local/regional levels. This should be coordinated with broader efforts to engage families at the practice and medical home levels for all health services. Many families requested ongoing opportunities to provide feedback into system development and evaluation using some of the strategies from this Plan's development as well as other feedback opportunities.

Strategy F.1.1 Increase the number of family advocates and family members who serve as paid members on statewide governance structures of the children's behavioral health system.

Family and youth should have paid roles at all levels of the governance structure of the children's behavioral health system of care. Families and youth already make significant contributions to system planning and development efforts, and this Plan calls for an expansion of their roles. Given this expansion, the current Plan provides a unique opportunity to recognize and professionalize their role within the system. Consideration should be given to compensation for family members to be full participants at the table given that professionals are compensated for their time spent in these processes.

Strategy F.1.2 Expand the capacity of organizations providing family advocacy services at the systems and practice levels.

Families point to family advocates as an important part of the service array. Family advocates are increasingly called upon to offer guidance in system planning and development and their role within system governance structure must also be sufficiently funded to support that expanding role. Family advocates can also help to recruit youth and parent participants in system governance structures.

Strategy F.1.3 Increase the number of parents who are trained in parent leadership curricula to ensure that families develop the skills to provide meaningful and full participation in system development.

Parents consistently note their desire for opportunities to gain additional skills in fulfilling their role in the system governance structure. A number of parent leadership training curricula is offered in Connecticut including Agents of Transformation, Parent Leadership Training Institute (PLTI), Parent Seeking Educational Excellence (Parent SEE), and People Empowering People (PEP). Funding should be available to provide expanded opportunities for families to develop those skills. Trainings should be offered in face-to-face and webinar formats to ensure multiple opportunities for participation.

Strategy F.1.4 Provide funding to support at least annual offerings of the Community Conversation and Open Forums, and continue to sustain the infrastructure of the Plan4children website input mechanism to ensure ongoing feedback into system development.

Funding should be identified for co-facilitation, ideally by a family member and a family advocate, of community conversation and open forum sessions. Funding should also support an evaluation consultant to assist families in the preparation of findings and recommendations from these input sessions. Funding also should be included to provide the necessary supports to ensure inclusiveness of a diverse community of parents and youth, including: sessions offered in English and Spanish; availability of Spanish and American Sign Language translation services; convenient meeting times; centralized locations for meetings in community locations (e.g., schools, community centers); child care and supervised child

activities during meetings; and transportation. Findings from these input sessions should be used for planning, delivery, and evaluation of services at the statewide and regional level, and summarized for inclusion in the centralized governance structures of the system of care.

G. Workforce

Another area of focus that emerged during the planning process was workforce development, which is reflected in goals and strategies across most of the thematic categories. A workforce subcommittee of the overall governance structure for the system of care is described in Section IV.A. Public Act 13-178, section (4d) calls for “the Department of Children and Families, in collaboration with agencies that provide training for mental health care providers in urban, suburban and rural areas, shall provide phased-in, ongoing training for mental healthcare providers in evidence-based and trauma-informed interventions and practices.” The topic of the workforce emerged in almost every discussion held as part of the planning process.

It is clear from the input received during the planning process that the concept of “workforce” is used broadly in Connecticut with respect to children’s behavioral health. It includes, but is not limited to: licensed behavioral health professionals; primary care providers; direct care staff across child-serving systems; parent and family caregivers and advocates; school personnel; and emergency responders including police. It also includes youth as they engage in self-care and peer support.

Some participants noted Connecticut’s strengths related to its workforce, which included: compassionate and dedicated staff at the direct care, managerial, and leadership levels; a strong group of parent and family advocates; state operated training academies; and the numerous private non-profit organizations and associations that offer training and consultation. Despite these strengths, many specific concerns about the workforce were raised frequently throughout the planning process. These concerns included, for example: shortages of key professionals or skills in the current workforce; lack of training capacity, including required follow-up coaching, monitoring, and reinforcement in order to maintain gains; insufficient knowledge among many parents as to recognizing behavioral health concerns; secondary traumatic stress or vicarious trauma; and the lack of adequate knowledge among every sector of the workforce about children’s behavioral health conditions and resources to address them. These discussions contributed directly to the development of strategies above (Table IV.G.1) which together seek to improve the recruitment, training, and effective practice of those who provide services and supports to children, adolescents, and families with behavioral health needs.

Table IV.G.1: Strategies Involving Workforce Development

- A.2.1 Design and implement a Care Management Entity with attention to integration across initiatives and training.
- A.4.4 Increase staff capacity to analyze data and report results
- B.1.3 Expand the use of validated screening tools
- B.3.1 Conduct statewide trainings on infant mental health
- C.1.2 Child mental health workers, clinicians, and psychiatrists across all settings
- C.2.1 Increase EMPS clinicians
- C.3.1 Increase school-based services
- C.3.3 Mental Health professional development for school personnel
- D.1.2 Education for clinicians seeking to co-locate with primary care providers
- D.1.3 Require CME credits in mental health
- E.2.1 Enhance training and supervision in CLAS
- E.2.3 Cultural competencies are integrated into professional credentialing
- F.1.1 Participation of family members in governance
- F.1.2 Expand capacity of family advocacy organizations
- F.1.3 Parents trained in parent leadership curricula

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V. Implementation Plan

In order to turn this Plan into reality, legislative action is highly recommended to fully authorize DCF and other key agencies and systems to ensure that the most urgent plan components are implemented in the short term and a detailed workplan, financing strategy and timeline are in place to implement the longer term strategies. We recommend the creation of a Children's Behavioral Health Implementation Team to guarantee integrated, coordinated efforts as well as full transparency and meaningful engagement of all stakeholders, including families and youth. This team should draw on lessons from implementation science that can be applied to complex systems reforms.⁵⁹ Each core initiative could be documented on a searchable web site with clear goals, progress benchmarks, and reporting of all actions and results. These individual component reports could then be "rolled up" into a Children's Behavioral Health Dashboard that will clearly report progress on a range of system and outcome measures.

State level implementation will include connection to DCF regional offices and to the 26 regional System of Care collaboratives for guidance on implementation. In the substance use area, implementation will connect to the 13 Regional Action Councils established by DMHAS under their federal prevention grant that are crafting regional strategies to prevent substance use. In the early childhood area, implementation will connect to the 46 community collaboratives that are crafting or implementing early childhood plans within their communities with support from the Graustein Memorial Fund's Discovery Initiative and the Office of Early Childhood.

An early task will be to design the longer-term governance structure charged with building the System of Care. The governance structure needs to have the authority to advance the ambitious agenda laid out in the plan, to develop the RBA templates to hold the initiative accountable, and a commitment to study the cost-effectiveness of service delivery types within the state.

The proposed timeline for implementation (Table V.1) focuses on the development of the infrastructure and the planning of the array of services that will comprise the System of Care. In keeping with the statutory mandate, DCF would convene the Children's Behavioral Health Implementation Team in the Second Quarter of SFY 2014-15 to begin the implementation process. An early step would be to create the detailed work plan and timeline to carry out the remaining strategies in the Plan related to: services, integration of pediatric and behavioral health care, addressing disparities, and Family and Youth Engagement. As implementation proceeds, the Team also would identify needs for legislative statutory and budgetary actions required for implementation.

Table V.1 Timeline for Implementation of the Connecticut Behavioral Health Plan

□=Initiate a process ♦=ongoing operation / work ❖ = plan/report ⊙= legislation

I. Tasks by Goal (with Strategies in parentheses)	SFY 2014-15			SFY 2015-16				SFY 16-17	SFY 17-18	SFY 18-19
	Q2	Q3	Q4	Q1	Q2	Q3	Q4			
Goal A.1 System Redesign										
Convene Implementation Team (A.1.1) (with regular reports)	□	♦	❖	♦	❖		❖	❖	❖	❖
Develop overall work plan and timeline for all goals/strategies	❖									
Develop web-based tools for presenting plans and data in dashboards	□	❖	♦	♦	♦	♦	♦	♦	♦	♦
Launch system redesign process (A.1.1)		□	♦	♦						
Complete initial report on system redesign				❖						
Implement system redesign				□	♦	♦	♦	♦	♦	♦
Form Workforce Committee of Implementation Team (A.1.1)		□	♦	♦						
Complete initial report on workforce				❖						
Implement workforce recommendations				□	♦	♦	♦	♦	♦	♦
Secure Legislation necessary to Implementation				⊙			⊙		⊙	
Issue "State of Implementation" Report			❖		❖		❖	❖	❖❖	❖
Goal A.2 Care Management Entity										
Complete design of proposed Care Management Entity (CME) (A.2.1)		□	♦	♦	❖					
Implement CME (A.2.1)						□	♦	♦	♦	♦
Integration of family support clearinghouse function (A.2.2)		□	♦	♦	♦	♦	♦	♦	♦	♦
Goal A.3 Address Concerns about Commercial Insurance										
Initiate process to address concerns re commercial insurance A.3.1	□	♦	♦	❖						
Apply findings from A.3.1 to self-insured				□	♦	♦	❖			
Goal A.4 Data System and Capacity Development										
Convene a statewide Data-Driven Accountability (DDA) committee (A.4.1)			□	♦	♦					
Complete initial assessment and plan for data system integration and reporting and capacity development (A.4.1)						❖				
Implement data system recommendations						□	♦	♦	♦	♦
Goal B.1										
Develop plans to expand preventive social-emotional learning and support interventions (B.1.1)		□	♦	❖	♦	♦	❖	❖	❖	❖
Goal B.2 Universal Screening with Validated Tools										
Implement plan for universal screening (B.2.1)		□	♦	❖	♦	♦	❖	❖	❖	❖
Develop and implement mechanisms to link children with positive screens to services (B.2.2)			□	♦	❖	♦	❖	❖	❖	❖
Goal C.1 Build and resource array of services										
Create plan for expansion of services and ongoing needs assessment (C.1.1)		□	♦	♦	❖					
Monitor needs and adjust plan annually (C.1.1)					♦	♦	❖	❖	❖	❖
Create short term plan to address highest priority gaps in SFY 2015-17 biennial budget (C1.2)	□	❖	⊙							
Create longer term financing plan			□	♦	❖	⊙				
Goal C.2 Expand Crisis Services										
Expand EMPS (C.2.1)	□	❖	⊙							
Enhance linkages between EMPS and EDs (C.2.2)		□	♦	❖	♦	♦	❖	❖	❖	❖
Expand crisis stabilization resources (C.2.3)	□	❖	⊙							

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I. Tasks by Goal (with Strategies in parentheses)	SFY 2014-15			SFY 2015-16				SFY 16-17	SFY 17-18	SFY 18-19
	Q2	Q3	Q4	Q1	Q2	Q3	Q4			
Goal C.3 Strengthen the Role of Schools										
Develop and implement plan for school-based services (C.3.1)		□	◆	◆	◆	◆	◆	◆	◆	◆
Create a blended funding strategy to support expansion of school-based behavioral health services (C.3.2)		□	◆	◆	◆	◆	◆	◆	◆	◆
Goal C.4 Integrate and Coordinate Suicide Prevention Activities										
Implement 2014 Statewide Suicide Prevention Plan (C.4.1)		◆	□	◆	◆	◆	◆	◆	◆	◆

VI. Conclusion

Children and families in Connecticut currently experience significant barriers to accessing quality behavioral health care. Throughout every element of the information gathering process, it was clear that Connecticut can, and should, do better to meet those needs. The process for developing the Plan yielded a comprehensive set of goals and strategies that will require a significant commitment of time and resources with the full participation of all key partners in the public and private sector and a deep commitment from state government, communities, families and youth to reach full implementation over the next five years. It is our hope that this Children’s Behavioral Health Plan provides the foundation for fulfilling the vision of PA 13-178, that together we can meet the mental, emotional and behavioral health needs of all children in the state, and prevent or reduce the long-term negative impact of mental, emotional and behavioral health issues on children.

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Appendix A. Summary Table of Goals and Strategies

Cost: Symbols are assigned based on Low Cost (\$), Moderate Cost (\$\$), High Cost (\$\$\$ and \$\$\$\$)

Goals and Strategies	Cost	Measures
A. System Organization, Financing, and Accountability		
Goal A.1 Redesign the publicly financed system of mental health care for children to direct the allocation of existing and new resources.		
Strategy A.1.1 Establish a process to guide the redesign of the publicly financed system.	\$	<ul style="list-style-type: none"> Redesign plan developed Public financing pooled
Goal A.2 Create a Care Management Entity to streamline access to and management of services in the publicly financed system of behavioral health care for children.		
Strategy A.2.1 Design and implement a Care Management Entity (CME) to create an effective care coordination model based on proven Wraparound and child and family teaming models, with attention to integration across initiatives and training.	\$\$\$	<ul style="list-style-type: none"> CME created and operational # of families engaged with CME for care coordination
Strategy A.2.2 Develop a family support clearinghouse to increase access to information about available behavioral health services and improve supports for behavioral health system navigation.	\$	<ul style="list-style-type: none"> Clearinghouse operational on web and in person Materials developed and disseminated Coverage of clearinghouse # of families using clearinghouse to navigate systems
Goal A.3 Develop a plan to address the major areas of concern regarding how commercial insurers meet children's behavioral health needs		
Strategy A.3.1 Conduct a detailed, data-driven analysis of each of the five issues identified in the information gathering process and recommend solutions	\$	<ul style="list-style-type: none"> Commercial insurance plan issues defined and quantified Plan to address issues is completed
Strategy A.3.2 Apply findings from the commercial insurance report to self-funded/employee-sponsored insurance plans.	\$	<ul style="list-style-type: none"> Self-insured employer plan issues defined and quantified Plan to address issues is completed
Goal A.4 Develop an agency- and program-wide integrated behavioral health data collection, management, analysis and reporting infrastructure across an integrated public mental health system of care.		
Strategy A.4.1 Convene a statewide Data-Driven Accountability (DDA) committee grounded in new legislative authority to design a process to oversee all efforts focused on data-driven accountability for access, quality, and outcomes.	\$\$	<ul style="list-style-type: none"> Integrated data capability developed Regular system reports available
Strategy A.4.2 Utilize reliable standards to guide the new data collection, management and reporting system.	\$	<ul style="list-style-type: none"> Standards developed Standards adopted across systems Adherence to standards across systems
Strategy A.4.3 Improve current data collection systems to serve in an integrated system across all agencies involved in providing child mental health services.	\$\$	<ul style="list-style-type: none"> Integrated data available for system planning (see Appendix C re Measures)

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Goals and Strategies	Cost	Measures
Strategy A.4.4 Increase State capacity to analyze data and report results.	\$\$	<ul style="list-style-type: none"> • Increase in funding dedicated to building capacity to analyze data and report results at systems and practice levels • Production of usable reports for the purposes of system and program monitoring and quality improvement
B. Health Promotion, Prevention, and Early Identification		
Goal B.1 Implement evidence-based promotion and universal prevention models across all age groups and settings to meet the need statewide.		
Strategy B.1.1 Enhance the ability of caregivers, providers and school personnel to promote healthy social and emotional development for children of all ages and develop plans to coordinate existing evidence-based efforts to take them to scale to meet the need statewide.	\$\$	<ul style="list-style-type: none"> • Number and percent of children receiving effective social-emotional learning in schools and community by model used
Goal B.2 All children will receive age-appropriate periodic standardized screening for developmental and behavioral concerns as part of a comprehensive system for screening, assessment, and referral for services.		
Strategy B.2.1 Expand the use of validated screening tools to assist parents and other caregivers and health, education and home visiting providers to promote social and emotional development, identify behavioral health needs and concerns, document results, and communicate findings with other relevant caregivers and providers in a child's life.	\$	<ul style="list-style-type: none"> • Number of entities actively promoting and using validated screening tools and reporting data • Number of children with completed validated screening • Number of children identified as requiring follow up and getting services
Strategy B.2.2 Link all children who screen positive for developmental and behavioral concerns to further assessment and intervention using existing statewide systems to identify appropriate resources when needed.	\$	<ul style="list-style-type: none"> • Percent of children referred who are connected to services
Goal B.3 Ensure that all providers and caregivers who work with young children and youth demonstrate competency in promoting social and emotional development in the context of families, recognizing risk factors and early signs of social-emotional problems and in connecting all children to appropriate services and supports.		
Strategy B.3.1 Expand statewide trainings on infant mental health competencies and increase the number of providers across all relevant systems who receive Endorsement in Infant Mental Health.	\$	<ul style="list-style-type: none"> • # of people trained • # of people earning CT-AIMH Endorsement (IMH-E®)
Goal B.4 Develop, implement, and monitor effective programs that promote wellness and prevent suicide and suicidal ideation.		
Strategy B.4.1 Continue cross agency collaboration and coordination with planned evaluation activities of the Connecticut Suicide Advisory Board.	\$	<ul style="list-style-type: none"> • Evaluation of suicide prevention activities completed • Number of suicide prevention efforts active
C. Access to a Comprehensive Array of Services and Supports		

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Goals and Strategies	Cost	Measures
Goal C.1 Build and adequately resource an array of behavioral health care services that has the capacity to meet child and family needs, is accessible to all, and is equally distributed across all areas of the state.		
Strategy C.1.1 Establish a process for initial planning of the array of services and supports and ongoing needs assessment, across local, regional, and statewide levels.	\$	<ul style="list-style-type: none"> • Completion of initial assessment of array of services and supports • Completion of web-based presentation of array of services for information and analysis • Completion of at least annual needs assessment (local and regional).
Strategy C.1.2 Finance the expansion of the services and supports within the array that have demonstrated gaps	\$\$\$	<ul style="list-style-type: none"> • Increase in funding • Increase in capacity across critical component so Continuum of Services, e.g. • More child and adolescent psychiatrists working in Connecticut • Additional in-patient and intensive outpatient treatment slots as needed • Reduction in average time from referral to treatment initiation • Reductions in emergency department utilization and inpatient hospitalization • Demonstration of positive outcomes
Goal C.2 Expand crisis-oriented behavioral health services to address high utilization rates in emergency departments		
Strategy C.2.1 Expand EMPS by adding clinicians across the statewide provider network to meet the existing demand for services	\$\$	<ul style="list-style-type: none"> • # of clinicians in EMPS • # of cases handled
Strategy C.2.2 Enhance partnerships between EMPS clinicians in EDs to facilitate effective diversions and linkages from EDs to community-based services		<ul style="list-style-type: none"> • # of EMPS clinicians co-located in EDs • Develop additional measures re: EMPS
Strategy C.2.3 Explore alternative options to ED's, through short-term (e.g., 23 hour) behavioral health assessment centers and expanded crisis stabilization units.		<ul style="list-style-type: none"> • # of crisis assessment centers • # of crisis stabilization beds • Utilization of crisis assessment centers and stabilization beds
Goal C.3 Strengthen the role of schools in addressing the behavioral needs of students.		
Strategy C.3.1 Develop and implement a plan to expand school-based behavioral health services.	\$\$\$	<ul style="list-style-type: none"> • # of clinics, # students served, # with clinicians % screened, # of positive referred • # of schools with personnel trained in EBPs
Strategy C.3.2 Create a blended funding strategy to support expansion of school-based behavioral health services		<ul style="list-style-type: none"> • Funding for school-based services, by source
Strategy C.3.3 Develop and implement a mental health professional development curriculum for school personnel	\$	<ul style="list-style-type: none"> • Curriculum developed • # /% of staff trained
Strategy C.3.3 Require formal collaborations between schools and the community.	\$	<ul style="list-style-type: none"> • # of MOUs executed between schools and providers

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Goals and Strategies	Cost	Measures
Goal C.4 Integrate and coordinate suicide prevention activities across the behavioral health service array and multiple sectors and settings.		
Strategy C.4.1 Continue to identify and foster attitudes and behaviors within agencies and programs that support the evaluation and adoption of new initiatives for prevention, intervention and postvention.	\$	<ul style="list-style-type: none"> • # of initiatives for suicide prevention • # of suicides
D. Pediatric Primary Care and Mental Health Care Integration		
Goal D.1 Strengthen connections between pediatric primary care and behavioral health services.		
Strategy D.1.1 Support co-location of behavioral health providers in child health sites by ensuring public and commercial reimbursement for behavioral health services provided in primary care without requiring a definitive behavioral health diagnosis.	\$	<ul style="list-style-type: none"> • Number of pediatric primary care practices with mental health practitioners on site or written memoranda of understanding between health/ behav health. health providers
Strategy D.1.2 Support the development of educational programs for behavioral health clinicians interested in co-locating in pediatric practices	\$	<ul style="list-style-type: none"> • Delivery of education programs at graduate and postgraduate levels; Number of mental health clinicians trained to work in pediatric practices
Strategy D.1.3 Require child health providers to obtain Continuing Medical Education (CME) credits each year in a behavioral health topic.	\$	<ul style="list-style-type: none"> • Documentation of CME obtained in mental health topic for all child health providers licensed by DPH
Strategy D.1.4 Ensure public and private insurance reimbursement for care coordination services delivered by pediatric, behavioral health or staff from sites working on behalf of medical homes.	\$\$	<ul style="list-style-type: none"> • Payment approved and used for care coordination in, or on behalf of, primary care efforts to connect children to services
Strategy D.1.5 Reform state confidentiality laws to allow for sharing of behavioral health information between health and mental health providers.	\$	<ul style="list-style-type: none"> • Legislation allowing health and mental health providers to share mental health information
E. Disparities in Access to Culturally Appropriate Care		
Goal E.1 Develop, implement, and sustain standards of culturally and linguistically appropriate care.		<ul style="list-style-type: none"> • Reduction in disparities in access and outcomes • Increase in patient satisfaction across racial/economic groups
Strategy E.1.1 Conduct a needs assessment at statewide, regional, and local level to identify gaps in culturally and linguistically appropriate services.	\$	<ul style="list-style-type: none"> • Completion of needs assessment every other yr (state, regional, and local); completion of annual self-assessments (state, regional, and local);
Strategy E.1.2 Ensure that all data systems and data analysis approaches are culturally and linguistically appropriate	\$\$	<ul style="list-style-type: none"> • Data systems are adjusted to facilitate analysis of equity issues
Strategy E.1.3 Require all service delivery contracts to reflect principles of culturally and linguistically appropriate services	\$	<ul style="list-style-type: none"> • # and % of contracts incorporating CLAS principles
Goal E.2 Enhance availability, access, and delivery of services and supports that are culturally and linguistically responsive to the unique needs of diverse populations.		
Strategy E.2.1 Enhance training and supervision in cultural competency.	\$	<ul style="list-style-type: none"> • Development and execution of new or adapted training programs • All credentialing contains requirements for cultural competencies

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Goals and Strategies	Cost	Measures
Strategy E.2.2 Ensure that all communication materials for service access and utilization are culturally and linguistically appropriate.	\$	<ul style="list-style-type: none"> • All material meet this requirement
Strategy E.2.3 Provide financial resources dedicated to recruitment and retention to diversify the workforce.	\$\$	<ul style="list-style-type: none"> • Additional funds are provided for this strategy
F. Family and Youth Engagement		
Goal F.1 Include family members of children with behavioral health needs, youth, and family advocates in the governance and oversight of the behavioral health system.		
Strategy F.1.1 Increase the number of family advocates and family members who serve as paid members on statewide governance structures of the children's behavioral health system.	\$	<ul style="list-style-type: none"> • # of family members and advocates on governance bodies
Strategy F.1.2 Expand the capacity of organizations providing family advocacy services at the systems and practice levels.	\$\$	<ul style="list-style-type: none"> • # of FTEs working in advocacy organizations
Strategy F.1.3 Increase the number of parents who are trained in parent leadership curricula to ensure that families develop the skills to provide meaningful and full participation in system development.	\$	<ul style="list-style-type: none"> • # of parents trained
Strategy F.1.4 Provide funding to support at least annual offerings of the Community Conversation and Open Forums, and continue to sustain the infrastructure of the Plan website input mechanism to ensure ongoing feedback into system development.	\$	<ul style="list-style-type: none"> • # of community conversations / forums • # of attendees • # of unique website visitors • Evaluation results from forums
G. Workforce		
Workforce strategies are included across other thematic areas as noted in Plan		<ul style="list-style-type: none"> • See measures for strategies listed in Table IV.G.1

Appendix B: Bibliography: Major Documents in Development of Connecticut's System of Care in Chronological Order

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- Task Force to Study the Provision of Behavioral Health Services for Young Adults (April 2014). Report prepared pursuant to Public Act 13-3 (Section 66).
<http://www.cga.ct.gov/ph/BHTF/docs/Final%20Report%20for%20the%20Task%20Force%20to%20Study%20the%20Provision%20of%20Behavioral%20Health%20Services%20for%20Young%20Adults.pdf>

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Recommendations: http://www.ct.gov/oca/lib/oca/Final_OCA_Infant_Toddler_Fatality_Report.pdf

Appendix C Connecticut Behavioral Health Utilization and Quality Measures

Below is an initial draft set of sample utilization and quality measures for Connecticut’s children’s behavioral health system as discussed with ValueOptions and members of the CT Behavioral Health Partnership. The governance body overseeing plan implementation will develop and promulgate, with extensive input, the measures that will guide system development.

Each measure will be available in aggregate from and will be disaggregated by the following factors to aid in assessing equitable outcomes:

- Age cohort 0-6, 7-12, 13-18
- Non-Hispanic Black/African American Caucasian Asian Native American
- Latino or Hispanic
- Other
- By geography (levels to be determined)
- By system (public, private commercial, private self-insured)

Utilization Measures

Number of members, 18 and younger, who were continuously enrolled in the health plan for at least six months during measurement period
Unduplicated Number/Rate of members who received any behavioral health services during measurement period
Unduplicated Number/Rate of Behavioral Health ED Admission during measurement period
Unduplicated Number/Rate of Behavioral Health Hospital Admissions during measurement period
Unduplicated Number/Rate of Development or BH Screenings during measurement period
Unduplicated Number/Rate of members who had at least one primary care visit during measurement period
Unduplicated Number/Rate of members with at least two outpatient BH services during measurement period
Unduplicated Number/Rate of members with at least two home-based therapeutic services during measurement period
Behavioral health general hospital inpatient average length of stay during measurement period
Unduplicated Number/Rate of members with a diagnosis of autism spectrum disorder during measurement period
Unduplicated Number/Rate of members with a diagnosis of autism spectrum disorder who received an assessment specific to ASD service needs during measurement period

For consideration:

A measure related to the juvenile justice system, e.g. Number of children discharged from a behavioral health program, service, placement who are arrested or referred to court within 6 months or number of kids in detention

Quality Measures

Measure	Reference*
Behavioral health hospital re-admission 7 and 30 days during measurement period	NCQA- 1937
Follow up after behavioral health hospitalization during measurement period	NCQA-0576
Initiation and engagement of alcohol and other drug dependence treatment during measurement period	NCQA-0004
Use of Multiple Concurrent Antipsychotics in Children and Adolescents during measurement period	HEDIS-0552

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Measure	Reference*
Children’s and Adolescents’ Access to Primary Care Practitioners during measurement period	HEDIS-0724
Asthma Admission Rate during measurement period	NQF/AHRQ- 0283
Development screening in the first three years of life during measurement period	NCQA-1399
Metabolic Monitoring for Children and Adolescents on Antipsychotics during measurement period	HEDIS-0552
Child and adolescent major depressive disorder- Diagnostic Evaluation during measurement period	NQF-1364
Percentage of discharges for members age 6 and older who were hospitalized for treatment of selected behavioral health disorders and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a behavioral health practitioner during measurement period	NCQA/HEDIS-0576
Discharge Follow-Up: Percentage of beneficiaries with 30 days between hospital discharge to first follow-up visit during measurement period	NCQA-0576
Percentage of patients aged 12 years and older screened for clinical depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen during measurement period	NQF/CMS-0418
Follow-Up after Hospitalization for Mental Illness during measurement period	NCQA-0576

* from Center for Medicaid and Medicare Services (CMS), National Center for Quality Assurance (NCQA), National Quality Forum (NQF), and Healthcare Effectiveness Data and Information Set (HEDIS)

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Endnotes

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Appendix C

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Connecticut 2014 Mental Health National Outcome Measures (NOMS): SAMHSA Uniform Reporting System

	U.S.	State	U.S. Rate	States
Utilization Rates/Number of Consumers Served				
Penetration Rate per 1,000 population	7,296,842	25.82	22.78	59
Community Utilization per 1,000 population	7,148,971	25.53	22.33	58
State Hospital Utilization per 1,000 population	144,695	0.35	0.45	53
Other Psychiatric Inpatient Utilization per 1,000 population	349,528	0.16	1.32	39
Adult Employment Status				
Employed (Percent in Labor Force)*	617,174	48.8%	39.0%	57
Employed (percent with Employment Data)**	617,174	22.8%	17.9%	57
Adult Consumer Survey Measures				
Positive About Outcome		State 81.4%	U.S. Rate 71.3%	States 51
Child/Family Consumer Survey Measures				
Positive About Outcome		State 78.1%	U.S. Rate 67.3%	States 48
Readmission Rates:(Civil "non-Forensic" clients)				
State Hospital Readmissions: 30 Days	8,203	2.2%	8.2%	51
State Hospital Readmissions: 180 Days	18,762	4.6%	18.8%	53
State Hospital Readmissions: 30 Days: Adults	7,648	2.2%	8.4%	50
State Hospital Readmissions: 180 Days: Adults	17,385	4.6%	19.1%	52
State Hospital Readmissions: 30 Days: Children	498	0.0%	6.3%	17
State Hospital Readmissions: 180 Days: Children	1,286	0.0%	16.3%	22
Living Situation				
Private Residence	4,292,455	83.9%	78.8%	58
Homeless/Shelter	176,675	2.6%	3.2%	55
Jail/Correctional Facility	86,078	0.5%	1.6%	54
Adult EBP Services				
Supported Housing	81,422	3.0%	2.9%	36
Supported Employment	61,511	7.1%	2.0%	41
Assertive Community Treatment	61,445	0.7%	2.0%	38
Family Psychoeducation	23,228	-	1.4%	16
Dual Diagnosis Treatment	205,709	6.1%	10.9%	25
Illness Self Management	242,621	-	15.8%	20
Medications Management	369,008	-	24.5%	19
Child/Adolescent EBP Services				
Therapeutic Foster Care	8,859	3.7%	1.1%	24
Multisystemic Therapy	17,988	0.4%	2.6%	16
Functional Family Therapy	20,996	2.0%	3.7%	13
Change in Social Connectedness				
Adult Improved Social Connectedness		State 75.5%	U.S. Rate 72.8%	States 51
Child/Family Improved Social Connectedness		91.7%	83.9%	46

*Denominator is the sum of consumers employed and unemployed.
 **Denominator is the sum of consumers employed, unemployed, and not in labor force.

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SAMHSA Uniform Reporting System - 2014 State Mental Health Measures

STATE: Connecticut

Utilization	State Number	State Rate	U.S.	U.S. Rate	States
Penetration Rate per 1,000 population	92,857	25.82	7,296,842	22.78	59
Community Utilization per 1,000 population	91,791	25.53	7,148,971	22.33	58
State Hospital Utilization per 1,000 population	1,261	0.35	144,695	0.45	53
Medicaid Funding Status	55,278	64%	4,453,600	64%	57
Employment Status (percent employed)	9,829	23%	617,174	18%	57
State Hospital Adult Admissions	1,027	0.93	110,845	0.83	53
Community Adult Admissions	44,624	0.76	11,138,443	2.32	55
Percent Adults with SMI and Children with SED	63,920	69%	5,048,543	69%	58

Utilization	State Rate	U.S. Rate	States
State Hospital LOS Discharged Adult patients (Median)	66 Days	68 Days	51
State Hospital LOS for Adult Resident patients in facility <1 year (Median)	66 Days	67 Days	50
Percent of Client who meet Federal SMI definition	67%	71%	56
Adults with Co-occurring MH/SA Disorders	37%	22%	51
Children with Co-occurring MH/SA Disorders	6%	5%	48

Adult Consumer Survey Measures	State Rate	U.S. Rate	States
Access to Services	90%	82%	50
Quality/Appropriateness of Services	93%	89%	50
Outcome from Services	81%	71%	51
Participation in Treatment Planning	92%	82%	50
General Satisfaction with Care	92%	89%	50

Child/Family Consumer Survey Measures	State Rate	U.S. Rate	States
Access to Services	96%	83%	47
General Satisfaction with Care	93%	88%	48
Outcome from Services	78%	67%	48
Participation in Treatment Planning	94%	87%	48
Cultural Sensitivity of Providers	98%	93%	47

Consumer Living Situations	State Number	State Rate	U.S.	U.S. Rate	States
Private Residence	63,312	83.9%	4,292,455	78.8%	58
Jail/Correctional Facility	392	0.5%	86,078	1.6%	54
Homeless or Shelter	1,958	2.6%	176,675	3.2%	55

Hospital Readmissions	State Number	State Rate	U.S.	U.S. Rate	States
State Hospital Readmissions: 30 Days	8	2.2%	8,203	8.2%	51
State Hospital Readmissions: 180 Days	17	4.6%	18,762	18.8%	53
Readmission to any psychiatric hospital: 30 Days	-	-	27,706	13.4%	24

State Mental Health Finance (FY2013)	State Number	State Rate	U.S.	U.S. Rate	States
SMHA Expenditures for Community MH *	\$542,700,000	69.8%	\$28,397,464,444	74.5%	50
SMHA Revenues from State Sources **	\$702,300,000	94.3%	\$14,435,904,841	38.7%	50
Total SMHA Expenditures	\$777,700,000	-	\$38,098,637,217	-	50

Adult Evidence-Based Practices	State Number	State Rate	U.S.	U.S. Rate	States
Assertive Community Treatment	274	0.7%	61,445	2.0%	38
Supported Housing	1,194	3.0%	81,422	2.9%	36
Supported Employment	2,840	7.1%	61,511	2.0%	41
Family Psychoeducation	-	-	23,228	1.4%	16
Integrated Dual Diagnosis Treatment	2,439	6.1%	205,709	10.9%	25
Illness Self-Management and Recovery	-	-	242,621	15.8%	20
Medications Management	-	-	369,008	24.5%	19

Child Evidence Based Practices	State Number	State Rate	U.S.	U.S. Rate	States
Therapeutic Foster Care	1,059	3.7%	8,859	1.1%	24
Multisystemic Therapy	122	0.4%	17,988	2.6%	16
Functional Family Therapy	565	2.0%	20,996	3.7%	13

Outcome	State Number	State Rate	U.S.	U.S. Rate	States
Adult Criminal Justice Contacts	-	-	22,817	4.4%	36
Juvenile Justice Contacts	521	3.7%	5,834	3.6%	38
School Attendance (Improved)	-	-	12,072	36.5%	25

* Includes Other 24 -Hour expenditures for state hospitals.

** Revenues for state hospitals and community MH

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Mental Health Community Services Block Grant: 2014 State Summary Report

Connecticut

State URS Contact Person	State Revenue Expenditure Data	Amount
Karin Haberlin	FY 2013 Mental Health Block Grant Revenues	\$4,000,000
410 Capitol Avenue Hartford, CT 06134	FY 2013 SMHA Community MH Expenditures	\$542,700,000
(860) 418-6842	FY 2013 Per Capita Community MH Expenditures	\$151.26
karin.haberlin@ct.gov	FY 2013 Community Percent of Total SMHA Spending	69.78%
	FY 2013 Total SMHA Mental Health Expenditure	\$777,700,000
	FY 2013 Per Capita Total SMHA Mental Health Expenditures	\$216.76

Statewide Mental Health Agency Data*

Measure	Number of Clients	Utilization Rate Per 1,000 Population
Total Clients Served by SMHA System	92,857	25.8
Clients Served in Community Settings	91,791	25.5
Clients Served in State Hospitals	1,261	0.4

Gender	Percent
Female	48.5%
Male	51.5%
Not Available	-

Race/Ethnicity	Percent
American Indian or Alaska Native	0.5%
Asian	0.8%
Black or African American	17.5%
Native Hawaiian or Other Pacific Islander	0.2%
White	61.2%
Hispanic or Latino	0.0%
More Than One Race	1.6%
Not Available	18.1%

Employment With Known Status (Adults)	Percent
Employed	22.8%
Unemployed	23.9%
Not In Labor Force	53.3%

Medicaid Funding Status of Consumers	Percent
Medicaid Only	52.7%
Non-Medicaid	36.4%
Both Medicaid and Other Funds	10.9%

Consumer Perception of Care: (Adults)	Percent
Access to Services	90.0%
Quality/Appropriateness of Services	92.6%
Outcome from Services	81.4%
Participation in Treatment Planning	92.2%
Overall Satisfaction with Care	92.2%

Implementation of Evidence-Based Practices	Percent
Assertive Community Treatment	0.7%
Supported Housing	3.0%
Supported Employment	7.1%
Family Psychoeducation	-
Integrated Dual Diagnosis Treatment	6.1%
Illness Self-Management and Recovery	-
Medications Management	-
Therapeutic Foster Care	3.7%
Multisystemic Therapy	0.4%
Functional Family Therapy	2.0%

Age	Percent
0 to 12	18.5%
13 to 17	17.0%
18 to 20	4.4%
21 to 24	4.5%
25 to 44	23.3%
45 to 64	27.9%
65 to 74	3.3%
75 and over	1.1%
Not Available	0.2%

Living Situation (with Known Status)	Percent
Private Residence	83.9%
Foster Home	1.7%
Residential Care	3.5%
Crisis Residence	0.2%
Residential Treatment Center	0.5%
Institutional Setting	1.8%
Jail (Correctional Facility)	0.5%
Homeless (Shelter)	2.6%
Other	5.3%
Not Available	-

Consumer Perception of Care: (Children/Adolescents)	Percent
Access to Services	96.0%
Overall Satisfaction with Care	93.1%
Outcome from Services	78.1%
Participation in Treatment Planning	94.2%
Cultural Sensitivity of Providers	97.8%

Outcome Measures Developmental	Percent
Adults Arrested this Year	-
Youth Arrested this Year	3.7%
Improved School Attendance	-

Hospital Readmissions (Civil Status Patients)	Percent
State Hospital Readmissions: 30 Days	2.2%
State Hospital Readmissions: 180 Days	4.6%
Readmission to any psychiatric hospital: 30 Days	-

* Based on 2014 URS data provided by US States and Territories per annual reporting guidelines.



The Community Mental Health Block Grant is administered by the Center for Mental Health Services within the Substance Abuse and Mental Health Services Administration of the US Department of Health and Human Services

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**Access Domain: Demographic Characteristics of Persons Served by the State Mental Health Authority, FY 2014
Connecticut**

Demographics	Total Served				Penetration Rates			States Reporting
	States		US		(per 1,000 population)			
	n	%	n	%	State	Northeast	US	
Total	92,857	100.0%	7,296,842	100.0%	25.8	34.5	22.8	59
0-12	17,145	18.5%	1,122,137	15.4%	31.6	31.0	21.3	59
13-17	15,751	17.0%	867,639	11.9%	65.0	56.6	41.6	59
18-20	4,057	4.4%	332,349	4.6%	25.0	37.2	25.4	59
21-24	4,208	4.5%	435,212	6.0%	23.2	37.4	23.7	59
25-44	21,632	23.3%	2,241,835	30.7%	24.4	39.4	26.9	59
45-64	25,881	27.9%	1,959,353	26.9%	25.0	36.0	23.6	59
65-74	3,031	3.3%	224,035	3.1%	10.3	17.6	8.9	59
75 and over	997	1.1%	108,373	1.5%	4.0	12.4	5.6	57
Age Not Available	155	0.2%	5,909	0.1%	-	-	-	26
Female	45,028	48.5%	3,772,848	51.7%	24.4	34.6	23.2	59
Male	47,800	51.5%	3,515,504	48.2%	27.2	34.2	22.3	59
Gender Not Available	29	0.0%	8,490	0.1%	-	-	-	36
American Indian/Alaskan Native	498	0.5%	88,919	1.2%	26.9	25.1	22.7	52
Asian	708	0.8%	87,758	1.2%	4.6	6.8	5.3	55
Black/African American	16248	17.5%	1,435,048	19.7%	39.8	52.1	34.5	53
Native Hawaiian/Pacific Islander	213	0.2%	15,541	0.2%	57.1	49.9	21.8	55
White	56833	61.2%	4,520,482	62.0%	19.4	27.1	18.4	57
Hispanic or Latino Race	31	0.0%	66,977	0.9%	0.1	-	3.6	11
Multi-Racial	1489	1.6%	176,328	2.4%	19.3	23.9	23.9	51
Race Not Available	16837	18.1%	905,789	12.4%	-	-	-	53
Hispanic or Latino Ethnicity	23,552	25.4%	961,361	13.6%	44.7	41.0	17.9	53
Not Hispanic or Latino Ethnicity	65,036	70.0%	5,458,877	77.5%	21.2	31.6	21.3	58
Ethnicity Not Available	4,269	4.6%	627,296	8.9%	-	-	-	49

Note:

Are Client Counts Unduplicated? Unduplicated **Number of States with Unduplicated Counts** 43
 Duplicated between children and adults

This table uses data from URS/DIG Table 2a, Table 2b and from the US Census Bureau. All denominators use US Census data from 2013

US totals are calculated uniquely for each data element based on only those states who reported clients served.

Regional groupings are based on SAMHSA's Block Grant Regions.

State Notes:

Table 2a

Age Age is calculated at midpoint of the State's elected reporting period (i.e., December 31, 2013). See General Notes on duplication.
 Gender See General Notes
 Race See General Notes
 Overall See General Notes

Table 2b

Age None
 Gender None
 Race See General Notes
 Overall See General Notes

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Access Domain: Persons Served in Community Mental Health Programs by Age and Gender, FY 2014

Connecticut

Demographic	Served in Community				Penetration Rates (rate per 1,000 population)		States Reporting
	State		US		State	US	
	n	%	n	%			
Age 0-17	32,728	35.7%	1,963,839	27.5%	41.7	26.7	58
Age 18-20	3,967	4.3%	323,935	4.5%	24.4	24.7	58
Age 21-64	50,975	55.5%	4,536,361	63.5%	24.2	24.6	58
Age 65+	3,967	4.3%	319,424	4.5%	7.3	6.5	57
Age Not Available	154	0.2%	5,412	0.1%	-	-	23
Age Total	91,791	100.0%	7,148,971	100.0%	25.5	22.3	58
Female	44,722	48.7%	3,711,358	51.9%	24.3	22.8	58
Male	47,042	51.2%	3,429,670	48.0%	26.8	21.8	58
Gender Not Available	27	0.0%	7,943	0.1%	-	-	35
Total	91,791	100.0%	7,148,971	100.0%	25.5	22.3	58

Note:

US totals are based on states reporting.

This table uses data from URS/DIG Table 3.

US penetration rates are calculated uniquely for each data element based on only those states who reported numerator (clients served) data.

State Notes:

Age None
 Gender See General Notes
 Overall See General Notes

2103

Access Domain: Persons Served in State Psychiatric Hospitals by Age and Gender, FY 2014

Connecticut

Demographic	Served in State Psychiatric Hospitals				Penetration Rates (rate per 1,000 population)		States Reporting
	State		US		State	US	
	n	%	n	%			
Age 0-17	151	12.0%	10,896	7.5%	0.2	0.2	41
Age 18-20	49	3.9%	6,247	4.3%	0.3	0.5	53
Age 21-64	975	77.3%	120,179	83.1%	0.5	0.7	53
Age 65+	86	6.8%	7,370	5.1%	0.2	0.2	53
Age Not Available	-	-	3	0.0%	-	-	2
Age Total	1,261	100.0%	144,695	100.0%	0.4	0.5	53
Female	370	29.3%	49,636	34.3%	0.2	0.3	53
Male	891	70.7%	95,035	65.7%	0.5	0.6	53
Gender Not Available	-	-	24	0.0%	-	-	9
Total	1,261	100.0%	144,695	100.0%	0.4	0.5	53

Notes:

US totals are based on states reporting.

This table uses data from URS/DIG Table 3.

US penetration rates are calculated uniquely for each data element based on only those states who reported numerator (clients served) data.

State Notes:

Age None
 Gender See General Notes
 Overall See General Notes

264

Access Domain: Demographic Characteristics of Adults with SMI and Children with SED Served by the State Mental Health Authority, FY 2014
Connecticut

Demographics	Total Served				Penetration Rates			States Reporting
	State		US		(per 1,000 population)			
	n	%	n	%	State	Northeast	US	
Total	63,920	100.0%	5,048,543	100.0%	17.8	22.2	15.8	58
0-12	13,007	20.3%	817,974	16.2%	23.9	24.5	15.5	58
13-17	11,066	17.3%	647,416	12.8%	45.7	42.9	31.0	58
18-20	2,422	3.8%	206,767	4.1%	14.9	21.2	15.8	58
21-64	34,527	54.0%	3,158,903	62.6%	16.4	22.9	17.1	58
65-74	2,272	3.6%	153,788	3.0%	7.7	11.0	6.1	58
75 and over	598	0.9%	62,429	1.2%	2.4	6.5	3.5	55
Age Not Available	28	0.0%	1,266	0.0%	-	-	-	19
Female	31,650	49.5%	2,602,515	51.5%	17.2	21.8	16.0	58
Male	32,256	50.5%	2,443,006	48.4%	18.4	22.6	15.5	58
Gender Not Available	14	0.0%	3,022	0.1%	-	-	-	33
American Indian/Alaskan Native	325	0.5%	57,235	1.1%	17.6	13.6	14.6	52
Asian	500	0.8%	66,479	1.3%	3.2	4.8	4.0	54
Black/African American	11,168	17.5%	1,050,479	20.8%	27.4	36.2	25.2	52
Native Hawaiian/Pacific Islander	151	0.2%	9,740	0.2%	40.5	36.3	13.5	55
White	39,207	61.3%	3,062,185	60.7%	13.4	17.0	12.5	55
Hispanic or Latino Race	17	0.0%	33,097	0.7%	0.0	-	0.6	10
Multi-Racial	1,017	1.6%	127,822	2.5%	13.2	18.6	16.5	51
Race Not Available	11,535	18.0%	641,506	12.7%	-	-	-	52
Hispanic or Latino Ethnicity	17,002	26.6%	736,273	15.2%	32.3	28.7	13.6	52
Not Hispanic or Latino Ethnicity	44,542	69.7%	3,653,475	75.4%	14.5	20.2	13.9	57
Ethnicity Not Available	2,376	3.7%	454,506	9.4%	-	-	-	48

Note:

This table uses data from URS/DIG Table 14a, Table 14b and from the US Census Bureau. All denominators use US Census data from 2013

US totals are calculated uniquely for each data element based on only those states who reported clients served.

Regional groupings are based on SAMHSA's Block Grant Regions.

State Notes:

Table 14a	
Age	None
Gender	None
Race	None
Overall	See General Notes
Table 14b	
Age	None
Gender	None
Race	None
Overall	See General Notes

2105

Access Domain: Adults with SMI and Children with SED Served in Community Mental Health Programs by Age and Gender, FY 2014

Connecticut

Demographic	Served in Community				Penetration Rates (rate per 1,000 population)		States Reporting
	State		US		State	US	
	n	%	n	%			
Age 0-17	23,985	38.0%	1,344,656	28.7%	30.5	19.0	56
Age 18-20	2,387	3.8%	189,120	4.0%	14.7	15.0	56
Age 21-64	33,918	53.7%	2,955,579	63.1%	16.1	16.6	56
Age 65+	2,825	4.5%	196,492	4.2%	5.2	4.2	56
Age Not Available	28	0.0%	1,192	0.0%	-	-	17
Age Total	63,143	100.0%	4,687,039	100.0%	17.6	15.2	56
Female	31,398	49.7%	2,418,863	51.6%	17.0	15.5	56
Male	31,733	50.3%	2,265,273	48.3%	18.1	14.9	56
Gender Not Available	12	0.0%	2,903	0.1%	-	-	30
Total	63,143	100.0%	4,687,039	100.0%	17.6	15.2	56

Note:

US totals are based on states reporting.

This table uses data from URS/DIG Table 15a.

US penetration rates are calculated uniquely for each data element based on only those states who reported numerator (clients served) data.

State Notes:

Age None
 Gender None
 Overall See General Notes

2666

Access Domain: Adults with SMI and Children with SED Served in State Psychiatric Hospitals by Age and Gender, FY 2014

Connecticut

Demographic	Served in State Psychiatric Hospitals				Penetration Rates (rate per 1,000 population)		States Reporting
	State		US		State	US	
	n	%	n	%			
Age 0-17	149	14.3%	8,241	7.7%	0.2	0.1	32
Age 18-20	35	3.3%	4,133	3.9%	0.2	0.3	47
Age 21-64	795	76.1%	88,794	83.1%	0.4	0.5	47
Age 65+	66	6.3%	5,441	5.1%	0.1	0.1	46
Age Not Available	-	-	211	0.2%	-	-	1
Age Total	1,045	100.0%	106,820	100.0%	0.3	0.4	48
Female	342	32.7%	36,266	34.0%	0.2	0.2	48
Male	703	67.3%	70,534	66.0%	0.4	0.5	48
Gender Not Available	-	-	20	0.0%	-	-	8
Total	1,045	100.0%	106,820	100.0%	0.3	0.4	48

Notes:

US totals are based on states reporting.

This table uses data from URS/DIG Table 15a.

US penetration rates are calculated uniquely for each data element based on only those states who reported numerator (clients served) data.

State Notes:

Age None
 Gender None
 Overall See General Notes

267

Appropriateness Domain: Percent of Adults and Children Served Who Meet the Federal Definition for SMI/SED and Percent of Adults and Children Served Who Have Co-Occurring MH/AOD Disorders, FY 2014

Connecticut

Adults and Children who meet the Federal Definition of SMI/SED	State	US Average	US Median	States Reporting
Percent of Adults served through the SMHA who meet the Federal definition for SMI	66.5%	71.4%	71.5%	56
Percent of Children served through the SMHA who meet the Federal definition for SED	78.8%	72.5%	76.0%	57

Co-occurring MH and Substance Abuse Consumers	State	US Average	US Median	States Reporting
Percent of Adults served through the SMHA who had a co-occurring MH and AOD disorder	36.6%	21.9%	20.0%	51
Percent of Children served through the SMHA who had a co-occurring MH and AOD disorder	6.0%	4.4%	3.5%	50
Percent of Adults served through the SMHA who met the Federal definitions of SMI who also have a substance abuse diagnosis	45.7%	22.3%	21.0%	51
Percent of Children served through the SMHA who met the Federal definitions of SED who also have a substance abuse diagnosis	6.0%	4.3%	3.5%	50

Note

This table uses data from URS/DIG Table 12.

State Notes

None

268

ACCESS DOMAIN: Persons Served by SMHA System through Medicaid and Other Funding Sources by Race, Gender, and Ethnicity, FY 2014

STATE: Connecticut

Demographic	State							US Averages							States Reporting
	Number Served				% Served			Number Served				% Served			
	Medicaid Only	Non-Medicaid Only	Both Medicaid & Other	Total Served with Known Funding Status	Medicaid Only	Non-Medicaid Only	Both Medicaid & Other	Medicaid Only	Non-Medicaid Only	Both Medicaid & Other	Total Served with Known Funding Status	Medicaid Only	Non-Medicaid Only	Both Medicaid & Other	
Female	21,908	16,275	4,720	42,901	51%	38%	11%	1,556,580	1,230,729	603,988	3,591,297	43%	34%	22%	56
Male	23,867	15,350	4,780	43,997	54%	35%	11%	1,324,731	1,235,595	755,032	3,325,358	40%	37%	23%	56
Gender Not Available	4	10	1	15	27%	67%	7%	1,951	2,995	1,316	6,165	32%	47%	21%	35
Total	45,777	31,635	9,501	86,913	53%	36%	11%	2,893,262	2,469,220	1,580,338	6,922,820	42%	36%	23%	56
American Indian or Alaska Native	253	142	47	442	57%	32%	11%	42,289	26,883	12,750	81,922	52%	33%	16%	51
Asian	288	315	65	648	41%	46%	10%	37,576	30,807	14,758	83,141	45%	37%	18%	53
Black or African American	9,005	4,243	1,552	14,800	61%	28%	10%	647,589	414,877	305,631	1,368,097	47%	30%	22%	51
Native Hawaiian or Other Pacific Islander	105	69	15	189	56%	37%	8%	5,620	4,766	1,713	12,099	46%	39%	14%	51
White	24,515	22,085	6,534	53,134	46%	42%	12%	1,687,601	1,507,262	1,019,177	4,204,040	39%	37%	24%	54
Hispanic or Latino	*	*	*	*	*	*	*	28,614	27,353	3,284	59,251	48%	46%	6%	9
More Than One Race	1,169	327	25	1,521	77%	21%	2%	78,943	57,421	34,100	168,464	46%	34%	20%	51
Race Not Available	10,462	4,454	1,263	16,179	65%	28%	8%	367,030	308,651	166,925	845,806	43%	37%	20%	51
Total	45,777	31,635	9,501	86,913	53%	36%	11%	2,893,262	2,469,220	1,580,338	6,922,820	42%	36%	23%	56
Hispanic or Latino	15,980	5,588	1,440	22,968	69%	24%	6%	389,454	309,705	236,160	915,319	40%	34%	26%	51
Not Hispanic or Latino	28,167	24,809	7,755	60,531	47%	41%	13%	2,076,616	1,870,287	1,281,230	5,208,133	40%	36%	24%	55
Ethnicity Not Available	1,050	1,458	305	3,414	46%	43%	9%	288,864	225,545	65,440	580,862	48%	40%	12%	48
Total	45,777	31,635	9,501	86,913	53%	36%	11%	2,715,964	2,405,540	1,562,630	6,684,334	41%	36%	23%	55

* Reported under Hispanic Ethnicity.

Note:

This table uses data from DIG Tables 5a, and 5b (Hispanic Origin).

Type of Medicaid Data Reported

Data based on Medicaid Eligibility, not Medicaid Paid Services.
 People Served by Both includes people with any Medicaid

State Notes

- 5a Age None
- 5a Gender None
- 5a Overall We believe that child counts are duplicated. In subsequent submissions, DMHAS will attempt to obtain eligibility information for children to include in de-duplication efforts. See General Notes.
- 5b Overall We believe that child counts are duplicated. In subsequent submissions, DMHAS will attempt to obtain eligibility information for children to include in de-duplication efforts. See General Notes.

269

APPROPRIATENESS DOMAIN: NUMBER OF ADMISSIONS DURING THE YEAR TO STATE HOSPITAL INPATIENT AND COMMUNITY-BASED PROGRAMS, FY 2014

STATE: Connecticut

Setting	Demographic	State			US			Admission Rate		States Reporting
		Admissions During Year	Total Served At Start of Year	Total Served During Year	Admissions During Year	Total Served At Start of Year	Total Served During Year	State	US	
State Psychiatric Hospitals	Total	1,248	713	1,281	120,912	42,121	144,695	0.99	0.84	53
	Children	221	189	151	10,065	1,585	10,837	1.46	0.93	37
	Adults	1,027	524	1,110	110,845	40,461	133,796	0.93	0.83	53
	Age NA	-	-	-	2	75	2	-	1.00	1
Other Inpatient	Total	530	63	562	457,874	38,754	348,822	0.94	1.31	39
	Children	-	-	19	65,184	2,275	51,464	-	1.27	30
	Adults	528	63	543	392,611	36,403	297,187	0.97	1.32	39
	Age NA	2	-	-	79	76	71	-	1.11	6
Residential Treatment Centers	Total	235	222	1,546	59,805	13,130	41,036	0.15	1.46	39
	Children	235	222	168	41,538	6,252	18,535	1.40	2.23	38
	Adults	-	-	1,377	18,241	6,874	20,938	-	0.87	30
	Age NA	-	-	1	26	4	23	-	1.13	1
Community Programs	Total	74,160	55,789	91,791	19,160,103	4,362,424	6,635,383	0.81	2.89	55
	Children	28,976	12,599	32,728	8,011,615	1,130,744	1,837,226	0.89	4.36	54
	Adults	44,624	53,007	58,909	11,138,443	3,228,884	4,792,729	0.76	2.32	55
	Age NA	560	183	154	10,045	2,816	5,075	3.64	1.98	15

Note:

Admission Rate= number of admissions divided by total served during the year

US Admissions During Year uses data from states reporting data only. States are only included in "US Total Served" if they also reported data on admissions.

US Total Served During Year is calculated using data in URS/DIG Table 3.

This table uses data from URS/DIG Table3 and 6.

Table 3 State Notes:

Age None
 Overall See General Notes
 Gender See General Notes

Table 6 State Notes:

Hospital None
 Other Inpatient None
 Residential None
 Community None
 Overall None

270

APPROPRIATENESS DOMAIN: Length of Stays in State Psychiatric Hospitals, Other Psychiatric Inpatient and Residential Treatment Centers for Children Settings, FY 2014

STATE: Connecticut

Setting	Demographic	State						US						States Reporting
		Length of Stay (Days)						Length of Stay (Days)						
		Discharged Clients		Resident Clients in Facility 1 year or less		Resident Clients in Facility more than 1 year		Discharged Clients		Resident Clients in Facility 1 year or less		Resident Clients in Facility more than 1 year		
		Average	Median	Average	Median	Average	Median	Average	Median	Average	Median	Average	Median	
State Hospitals	All	-	-	-	-	-	-	157	57	98	74	1,463	897	12
	Children	79	61	107	102	468	468	87	70	78	66	492	498	32
	Adults	181	66	101	66	988	622	213	68	91	67	1,688	1,072	52
	Age NA	-	-	-	-	-	-	2	-	147	-	-	-	1
Other Inpatient	All	-	-	-	-	-	-	411	117	50	37	1,902	832	5
	Children	-	-	-	-	-	-	13	9	27	23	611	621	23
	Adults	9	6	10	6	-	-	85	33	46	36	1,050	759	31
	Age NA	11	11	11	11	-	-	14	9	30	29	-	-	5
Residential Treatment Centers	All	-	-	-	-	-	-	181	190	113	111	486	445	3
	Children	-	-	-	-	-	-	149	124	106	96	642	562	31
	Adults	-	-	-	-	-	-	232	165	132	118	1,195	929	21
	Age NA	-	-	-	-	-	-	12	13	139	139	-	-	1

Note:

Resident clients are clients who were receiving services in inpatient settings at the end of the reporting period.

This table uses data from URS/DIG Table 6.

Table 6 State Notes:

Hospital None
 Other Inpatient None
 Residential None
 Community None
 Overall None

271

Appropriateness Domain: Evidence-Based Practices Reported by SMHAs, FY 2014

Connecticut

	State		US		Penetration Rate: % of Consumers Receiving EBP/Estimated SMI		Measuring Fidelity		States Reporting
	EBP N	SMI N	EBP N	SMI N	State	US Average	State	US	
Adult EBP Services									
Supported Housing	1,194	39,937	81,422	3,296,592	3.0%	2.9%	Yes	7	36
Supported Employment	2,840	39,937	61,511	3,296,592	7.1%	2.0%	Yes	18	41
Assertive Community Treatment	274	39,937	61,445	3,296,592	0.7%	2.0%	Yes	19	38
Family Psychoeducation	-	-	23,228	3,296,592	-	1.4%	-	3	16
Dual Diagnosis Treatment	2,439	39,937	205,709	3,296,592	6.1%	10.9%	Yes	11	25
Illness Self Management	-	-	242,621	3,296,592	-	15.8%	-	5	20
Medication Management	-	-	369,008	3,296,592	-	24.5%	-	4	19

	State		US		Penetration Rate: % of Consumers Receiving EBP/Estimated SED		Measuring Fidelity		States Reporting
	EBP N	SED N	EBP N	SED N	State	US Average	State	US	
Child/Adolescent EBP Services									
Therapeutic Foster Care	1,059	28,390	8,859	1,159,589	3.7%	1.1%	Yes	6	24
Multi-Systemic Therapy	122	28,390	17,988	1,159,589	0.4%	2.6%	Yes	8	16
Family Functional Therapy	565	28,390	20,996	1,159,589	2.0%	3.7%	Yes	6	13

Note:

US totals are based on states reporting.

This table uses data from URS/DIG Tables 16 and 17.

US averages are calculated uniquely for each data element based on only those states who reported numerator (clients served) data.

State Notes:

Table 16: DMHAS "Other" and "Unknown" are grouped together in URS "Unknown" race category.

Table 17: DMHAS "Other" and "Unknown" are grouped together in URS "Unknown" race category.

272

**Outcomes Domain: Employment Status of Adult Mental Health Consumers Served in the Community by Age and Gender, FY 2014
Connecticut**

Demographics	State				Employed as Percent of those in Labor Force		Employed as Percent of Known Employment Status		States Reporting
	Employed	Unemployed	In Labor Force*	With Known Employment Status**	State	US	State	US	
Age Not Available	6	5	11	17	55%	73%	35.3%	42.2%	7
Age 21 to 64	9,238	9,580	18,818	38,770	49%	39%	23.8%	18.8%	57
Age 65 and over	178	270	448	2,845	40%	37%	6.3%	8.6%	56
Age 18 to 20	407	444	851	1,486	48%	38%	27.4%	14.2%	57
Age TOTAL	9,829	10,299	20,128	43,118	49%	39%	22.8%	17.9%	57
Female	5,529	5,137	10,666	23,135	52%	40%	23.9%	18.3%	57
Male	4,299	5,159	9,458	19,975	45%	37%	21.5%	17.3%	57
Gender Not Available	1	3	4	8	25%	42%	12.5%	17.8%	28
Gender TOTAL	9,829	10,299	20,128	43,118	49%	39%	22.8%	17.9%	57

What populations are reported? Number of States Reporting All Clients: 41 Number of States Reporting Some Clients: 16

When Is Employment Status Measured?	At Admission	At Discharge	Monthly	Quarterly	Other
	Yes	Yes			6-month assessment
CT					
US	39	28	3	4	35

Note:

*In Labor Force is the sum of consumers employed and unemployed.
 **With Known Employment Status is the sum of consumer employed, unemployed and not in labor force.
 Consumers employed as a % of those in labor force uses adults employed and unemployed as the denominator.
 Consumers employed as % of known employment status uses the sum of persons employed, unemployed and not in labor force as the denominator.
 This table uses data from URS/DIG Table 4.

State Notes:

Age: None
 Gender: None
 Overall: DCF does not collect employment data. DMAS: recent status is reported unless Unknown/Not Available and a search for valid employment status within a 12-month period are initiated. This accounts for a higher number with employment status other than NA. See General Notes.

273

Outcomes Domain: Employment Status of Adult Mental Health Consumers Served in the Community by Diagnosis, FY 2014
Connecticut

Diagnosis	State				Employed as a % of Labor Force		Employed as % of Known Employment Status		% of Consumers with Dx		States Reporting
	Employed	Unemployed	In Labor Force*	With Known Employment Status**	State	US	State	US	State	US	
Schizophrenia and Related Disorders	830	1,135	1,965	7,890	42.2%	25.6%	10.5%	6.4%	18.3%	13.8%	48
Bipolar and Mood Disorders	5,086	5,298	10,384	21,328	49.0%	37.2%	23.9%	14.3%	49.5%	47.7%	48
Other Psychoses	172	217	389	948	44.2%	25.1%	18.1%	7.1%	2.2%	3.4%	45
All other Diagnoses	2,352	1,783	4,135	7,715	56.9%	47.8%	30.5%	18.8%	17.9%	27.2%	48
No Diagnosis and Deferred Diagnosis	1,379	1,866	3,245	5,237	42.5%	41.2%	26.3%	12.8%	12.1%	7.9%	44
TOTAL	9,829	10,299	20,128	43,118	48.8%	39.2%	22.8%	14.1%	100.0%	100.0%	48

Note:

*In Labor Force is the sum of consumers employed and unemployed.

**With Known Employment Status is the sum of consumer employed, unemployed and not in labor force.

Consumers employed as a % of those in labor force uses adults employed and unemployed as the denominator.

Consumers employed as % of known employment status uses the sum of persons employed, unemployed and not in labor force as the denominator.

This table uses data for URS/DIG Table 4a.

State Notes:

DCF does not collect employment data. See General Notes.

274

APPROPRIATENESS DOMAIN: Living Situation of Consumers Served by State Mental Health Agency Systems, FY 2014

STATE: Connecticut

Age Group	Setting	State			US			States Reporting
		Living Situation	Percent in Living Situation	Percent with Known Living Situation	Living Situation	Percent in Living Situation	Percent with Known Living Situation	
All Persons Served	Private Residence	63,312	68.2%	83.9%	4,292,455	65.8%	78.8%	58
	Foster Home	1,259	1.4%	1.7%	88,652	1.4%	1.6%	49
	Residential Care	2,643	2.8%	3.5%	208,478	3.2%	3.8%	53
	Crisis Residence	136	0.1%	0.2%	8,703	0.1%	0.2%	31
	Residential Treatment Center	380	0.4%	0.5%	17,133	0.3%	0.3%	35
	Institutional Setting	1,374	1.5%	1.8%	95,645	1.5%	1.8%	52
	Jail (Correctional Facility)	392	0.4%	0.5%	86,078	1.3%	1.6%	54
	Homeless (Shelter)	1,958	2.1%	2.6%	176,675	2.7%	3.2%	55
	Other	4,009	4.3%	5.3%	475,868	7.3%	8.7%	44
	Not Available	17,394	18.7%	-	1,072,891	16.4%	-	46
	Total	92,857	100.0%	100.0%	6,522,578	100.0%	100.0%	58
Children under age 18	Private Residence	24,479	74.4%	92.5%	1,172,078	67.7%	82.3%	58
	Foster Home	1,080	3.3%	4.1%	53,919	3.1%	3.8%	49
	Residential Care	2	0.0%	0.0%	20,046	1.2%	1.4%	46
	Crisis Residence	26	0.1%	0.1%	1,960	0.1%	0.1%	25
	Residential Treatment Center	-	-	-	9,820	0.6%	0.7%	33
	Institutional Setting	672	2.0%	2.5%	11,096	0.6%	0.8%	45
	Jail (Correctional Facility)	38	0.1%	0.1%	4,407	0.3%	0.3%	49
	Homeless (Shelter)	142	0.4%	0.5%	7,488	0.4%	0.5%	51
	Other	37	0.1%	0.1%	143,310	8.3%	10.1%	43
	Not Available	6,420	19.5%	-	306,290	17.7%	-	42
	Total	32,896	100.0%	100.0%	1,730,414	100.0%	100.0%	58
Adults over age 18	Private Residence	38,820	64.9%	79.3%	3,113,361	65.1%	77.5%	58
	Foster Home	179	0.3%	0.4%	34,331	0.7%	0.9%	47
	Residential Care	2,638	4.4%	5.4%	187,431	3.9%	4.7%	53
	Crisis Residence	110	0.2%	0.2%	6,742	0.1%	0.2%	29
	Residential Treatment Center	380	0.6%	0.8%	7,309	0.2%	0.2%	27
	Institutional Setting	701	1.2%	1.4%	83,788	1.8%	2.1%	52
	Jail (Correctional Facility)	354	0.6%	0.7%	81,581	1.7%	2.0%	53
	Homeless (Shelter)	1,816	3.0%	3.7%	169,116	3.5%	4.2%	54
	Other	3,952	6.6%	8.1%	331,500	6.9%	8.3%	43
	Not Available	10,856	18.2%	-	763,942	16.0%	-	46
	Total	59,806	100.0%	100.0%	4,779,101	100.0%	100.0%	58

This table uses data from URS/DIG Table 15.

State Notes:

See General Notes

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APPROPRIATENESS DOMAIN: Persons Who were Homeless by Age, Gender, Race, and Ethnicity, FY 2014

STATE: Connecticut

Demographic	Homeless or Living in Shelters				Percent of Total with Known Living Situation		States Reporting
	State		US		State	US	
	N	%	N	%	%	%	
Age 0 to 17	142	7.3%	7,488	4.2%	0.5%	0.5%	51
Age 18 to 64	1,779	90.9%	165,093	93.4%	3.9%	4.4%	54
Age 65+	37	1.9%	4,023	2.3%	1.1%	1.6%	51
Age Not Available	-	-	71	0.0%	-	0.7%	10
Age Total	1,958	100.0%	176,675	100.0%	2.6%	3.2%	55
Female	690	35.2%	69,169	39.2%	1.8%	2.5%	54
Male	1,268	64.8%	107,318	60.7%	3.4%	4.1%	54
Gender Not Available	-	-	188	0.1%	-	2.8%	19
Gender Total	1,958	100.0%	176,675	100.0%	2.6%	3.2%	55
American Indian or Alaska Native	10	0.5%	2,454	1.4%	2.4%	3.4%	48
Asian	12	0.6%	1,325	0.7%	2.0%	1.8%	46
Black or African American	591	30.2%	57,144	32.3%	4.6%	5.2%	51
Native Hawaiian or Other Pacific Islander	10	0.5%	364	0.2%	5.8%	3.2%	34
White	977	49.9%	93,620	53.0%	2.1%	2.9%	52
Hispanic or Latino	*	*	940	0.5%	*	1.7%	6
More Than One Race	11	0.6%	4,342	2.5%	1.0%	2.8%	43
Race Not Available	347	17.7%	16,486	9.3%	2.5%	2.3%	45
Race Total	1,958	100.0%	176,675	100.0%	2.6%	3.2%	55
Hispanic or Latino	467	23.9%	29,369	16.6%	2.5%	2.7%	49
Not Hispanic or Latino	1,420	72.5%	132,750	75.1%	2.6%	3.4%	54
Not Available	71	3.6%	14,556	8.2%	2.3%	3.1%	43
Ethnicity Total	1,958	100.0%	176,675	100.0%	2.6%	3.2%	55

* Reported under Hispanic ethnicity.

Note:

US totals are based on states reporting.

This table uses data from URS/DIG Table 15.

US totals are calculated uniquely for each data element based on only those states who reported numerator (clients served) data.

State Notes:

See General Notes

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CONSUMER SURVEY RESULTS, FY 2014

STATE: Connecticut

Indicators	Children: State	Children: U.S. Average	States Reporting	Adults: State	Adults: U.S. Average	States Reporting
Reporting Positively About Access	96.0%	82.8%	47	90.0%	85.1%	50
Reporting Positively About Quality and Appropriateness				92.6%	88.5%	50
Reporting Positively About Outcomes	78.1%	67.3%	48	81.4%	69.7%	51
Reporting on Participation in Treatment Planning	94.2%	87.0%	48	92.2%	80.1%	50
Family Members Reporting High Cultural Sensitivity of Staff	97.8%	92.7%	47			
Reporting positively about General Satisfaction with Services	93.1%	87.2%	48	92.2%	89.0%	50

Note: U.S. Average Children & Adult rates are calculated only for states that used a version of the MHSIP Consumer Survey

This table uses data from URS/DIG Table 11.

Children/Family	State	U.S.
Type of Survey Used	YSS-F	YSS-F=39

Type of Adult Consumer Survey Used	28-Item MHSIP	Other MHSIP	Other Survey
state	-	Yes	-
U.S.	26	24	1

Sample Size & Response Rate	Children: State	Children: U.S.	States Reporting	Adults: State	Adults: U.S. Average	States Reporting
Response Rate	17.9%	40.0%	39	-	42.0%	41
Number of Surveys Attempted (send out)	28,322	171,107	39	-	234,854	40
Number of Surveys Contacts Made	28,322	142,206	37	-	179,944	39
Complete Surveys	5,063	64,648	42	24,233	126,490	45

Populations covered in survey	Children: State	Children: U.S.	Adults: State	Adults: U.S.
All Consumers	Yes	4	-	1
Sample	-	43	Yes	50

Sample Approach	Children: State	Children: U.S.	Adults: State	Adults: U.S.
Random Sample	-	7	-	7
Stratified Sample	-	15	-	17
Convenience Sample	-	18	Yes	22
Other Sample	-	5	-	4

Who is Sampled?	Children: State	Children: U.S.	Adults: State	Adults: U.S.
Current Clients	Yes	45	Yes	50
Former Clients	-	16	-	18

Populations included in sample: (e.g., all adults, only adults with SMI, etc.)	Children: State	Children: U.S.	Adults: State	Adults: U.S.
All Children or Adults Served	Yes	26	Yes	32
SMI Adults or SED Children	-	18	Yes	23
Persons Covered by Medicaid	-	11	Yes	13
Other	-	7	-	7

State Notes:
None

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OUTCOMES DOMAIN: Consumer Survey Results, by Race/Ethnicity FY 2014

STATE: Connecticut

Adult Consumer Survey Indicators: Reporting Positively About...															
Race/Ethnicity	Access		Quality & Appropriateness		Outcomes		Participation In Tx Planning		General Satisfaction		Social Connectedness		Improved Functioning		States
	State	US Average	State	US Average	State	US Average	State	US Average	State	US Average	State	US Average	State	US Average	
Total	90%	86%	93%	89%	81%	70%	92%	82%	92%	89%	75%	70%	83%	71%	42
American Indian or Alaska Native	82%	84%	88%	85%	76%	69%	85%	78%	89%	86%	74%	71%	74%	70%	36
Asian	90%	88%	92%	87%	82%	72%	92%	81%	95%	91%	82%	71%	88%	73%	34
Black or African American	91%	87%	93%	89%	85%	74%	93%	82%	93%	88%	81%	73%	87%	74%	39
Native Hawaiian or Other Pacific Islander	92%	84%	96%	87%	75%	73%	96%	82%	92%	90%	70%	63%	71%	72%	28
White	90%	86%	93%	90%	80%	70%	92%	83%	92%	89%	72%	70%	82%	70%	39
Hispanic or Latino	92%	88%	94%	91%	86%	73%	93%	84%	93%	90%	79%	73%	86%	74%	32
More Than One Race	81%	82%	89%	86%	78%	67%	89%	78%	87%	87%	81%	65%	83%	69%	32
Not Available	90%	84%	92%	88%	84%	72%	91%	81%	92%	88%	78%	70%	84%	71%	37

Family of Children Survey Indicators: Reporting Positively About...															
Race/Ethnicity	Access		General Satisfaction with Services		Outcomes		Participation In Tx Planning		Cultural Sensitivity of Staff		Social Connectedness		Improved Functioning		States
	State	US Average	State	US Average	State	US Average	State	US Average	State	US Average	State	US Average	State	US Average	
Total	96%	86%	93%	87%	78%	89%	94%	88%	98%	94%	92%	87%	79%	71%	39
American Indian or Alaska Native	94%	84%	83%	85%	61%	69%	94%	86%	94%	92%	89%	87%	61%	70%	35
Asian	100%	82%	97%	88%	86%	71%	94%	88%	100%	92%	91%	82%	89%	76%	27
Black or African American	96%	86%	94%	86%	79%	68%	93%	88%	97%	95%	94%	87%	79%	69%	35
Native Hawaiian or Other Pacific Islander	100%	86%	100%	90%	100%	79%	100%	84%	100%	90%	100%	87%	83%	75%	20
White	98%	87%	92%	87%	77%	87%	94%	90%	98%	95%	91%	87%	78%	69%	35
Hispanic or Latino	97%	84%	95%	88%	82%	70%	94%	84%	88%	91%	92%	87%	82%	75%	29
More Than One Race	-	83%	-	85%	-	65%	-	87%	-	94%	-	84%	-	69%	27
Not Available	97%	85%	93%	88%	77%	71%	94%	86%	99%	94%	92%	86%	78%	74%	35

Notes:
 This table uses data from URS/DIG Table 11a.
State Notes:
 None

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Outcomes Domain: Change in Social Connectedness and Functioning, FY 2014

Connecticut

Indicators	Children				Adults			
	State	US Average	US Median	States Reporting	State	US Average	US Median	States Reporting
Percent Reporting Improved Social Connectedness from Services	91.7%	83.9%	85.5%	46	75.5%	72.8%	70.0%	51
Percent Reporting Improved Functioning from Services	78.8%	69.5%	64.3%	48	83.5%	70.9%	70.2%	50

Note:

This table uses data from URS/DIG Table 9.

US State Averages and Medians are calculated only with states which used the recommended Social Connectedness and Functioning questions.

Adult Social Connectedness and Functioning Measures	State	US
Did you use the recommended new Social Connectedness Questions?	No	48
If No, what Measure did you use?	MHSIP 20,21,24,28	
Did you use the recommended new Functioning Domain Questions?	No	48
If No, what Measure did you use?	MHSIP 17-19,22,23,25,26	
Did you collect these as part of your MHSIP Adult Consumer Survey?	Yes	50

Children/Family Social Connectedness and Functioning Measures	State	US
Did you use the recommended new Social Connectedness Questions?	Yes	44
Did you use the recommended new Functioning Domain Questions?	Yes	45
Did you collect these as part of your YSS-F Survey?	Yes	45

State Notes:

None

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OUTCOMES DOMAIN: Civil (Non Forensic) & Forensic Patients Readmission within 30 Days by Age, Gender, and Race, FY 2014

STATE: Connecticut

Demographic	Readmissions within 30 days to state psychiatric hospitals: "Civil" (Non-Forensic) Patients							Readmissions within 30 days to state psychiatric hospitals: Forensic Patients						
	State			US			States Reporting	State			US			
	Readmissions N	Discharges N	%	Readmissions N	Discharges N	%		Readmissions N	Discharges N	%	Readmissions N	Discharges N	%	States Reporting
Age 0 to 12	0	-	-	145	1,914	7.6%	11	0	-	-	1	100	10.0%	1
Age 13 to 17	0	-	-	353	5,987	5.9%	16	0	-	-	20	833	2.4%	8
Age 18 to 20	1	21	4.8%	394	5,158	7.6%	32	0	12	0.0%	101	1,606	6.3%	15
Age 21 to 64	5	308	1.6%	7,068	82,213	8.6%	49	1	234	0.4%	1,440	20,251	7.1%	38
Age 65 to 74	2	29	6.9%	158	2,711	5.8%	27	0	15	0.0%	34	587	5.8%	14
Age 75 and over	0	8	0.0%	28	924	3.0%	16	0	6	0.0%	8	190	4.2%	6
Age Not Available	0	-	-	57	1,085	5.3%	2	0	-	-	-	191	-	0
Age Total	8	366	2.2%	8,203	99,992	8.2%	51	1	267	0.4%	1,604	23,768	6.7%	40
Female	4	124	3.2%	3,178	40,728	7.8%	46	1	43	2.3%	512	4,925	10.4%	28
Male	4	242	1.7%	4,978	58,255	8.5%	48	0	224	0.0%	1,094	18,630	5.8%	38
Gender Not Available	0	-	-	47	1,011	4.6%	3	0	-	-	8	213	3.8%	1
Gender Total	8	366	2.2%	8,203	99,992	8.2%	51	1	267	0.4%	1,604	23,768	6.7%	40
American Indian or Alaska Native	0	-	-	205	1,897	10.8%	16	0	4	0.0%	32	288	11.1%	7
Asian	0	8	0.0%	79	1,084	7.3%	19	0	4	0.0%	34	384	8.9%	8
Black or African American	4	88	4.5%	2,080	23,689	8.6%	38	0	92	0.0%	368	8,539	4.2%	30
Native Hawaiian or Other Pacific Islander	0	-	-	22	171	12.9%	6	0	-	-	13	48	27.1%	3
White	4	234	1.7%	5,365	66,464	8.1%	45	0	135	0.0%	945	11,768	8.0%	37
Hispanic or Latino	0	-	-	45	659	8.8%	7	-	-	-	8	814	1.0%	1
More Than One Race	0	-	-	138	2,017	6.8%	18	0	-	-	48	525	9.1%	9
Race Not Available	0	36	0.0%	269	3,991	6.7%	24	1	32	3.1%	156	1,102	14.2%	11
Race Total	8	366	2.2%	8,203	99,992	8.2%	51	1	267	0.4%	1,604	23,768	6.7%	40
Hispanic or Latino	0	47	0.0%	635	9,923	7.1%	28	1	45	2.2%	146	2,532	5.8%	14
Not Hispanic or Latino	8	314	2.5%	5,927	73,481	8.1%	48	0	219	0.0%	1,265	15,374	8.2%	33
Not Available	0	5	0.0%	1,641	17,608	9.3%	26	0	3	0.0%	174	5,429	3.2%	16
Ethnicity Total	8	366	2.2%	8,203	99,992	8.2%	51	1	267	0.4%	1,686	23,335	6.8%	39

* Reported under Hispanic Ethnicity.

Forensics included in "non forensic" data? No

Note:
US totals are based on states reporting.
This table uses data from URS/DIG Tables 20a and 20b.

State Notes:
Discharges resulting to client transferring to a different unit of the state hospital to another state hospital were excluded from the count of discharges. Consequently, transfer admissions were not counted as readmission. See General Notes

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OUTCOMES DOMAIN: Civil (Non Forensic) & Forensic Patients Readmission within 180 Days by Age, Gender, and Race, FY 2014

STATE: Connecticut

Demographic	Readmissions within 180 days to state psychiatric hospitals: "Civil" (Non-Forensic) Patients							Readmissions within 180 days to state psychiatric hospitals: Forensic Patients						
	State			US			States Reporting	State			US			States Reporting
	Readmissions N	Discharges N	%	Readmissions N	Discharges N	%		Readmissions N	Discharges N	%	Readmissions N	Discharges N	%	
Age 0 to 12	0	-	-	369	1,914	19.3%	16	0	-	-	6	100	6.0%	5
Age 13 to 17	0	-	-	917	5,987	15.3%	20	0	-	-	47	833	5.6%	11
Age 18 to 20	1	21	4.8%	850	5,158	16.5%	43	2	12	16.7%	275	1,606	17.1%	25
Age 21 to 64	13	308	4.2%	16,098	82,213	19.6%	52	3	234	1.3%	3,505	20,261	17.3%	44
Age 65 to 74	3	29	10.3%	360	2,711	13.3%	35	0	15	-	75	587	12.8%	22
Age 75 and over	0	8	0.0%	77	924	5.3%	22	0	6	-	21	190	11.1%	15
Age Not Available	0	-	-	91	1,085	8.4%	4	0	-	-	8	191	4.2%	1
Age Total	17	366	4.6%	18,762	99,992	18.8%	53	5	267	1.9%	3,938	23,768	16.6%	47
Female	8	124	6.5%	7,374	40,726	18.1%	49	2	43	4.7%	1,096	4,925	22.3%	38
Male	9	242	3.7%	11,318	58,265	19.4%	50	3	224	1.3%	2,817	18,630	15.1%	45
Gender Not Available	0	-	-	70	1,011	6.9%	3	0	-	-	25	213	11.7%	2
Gender Total	17	366	4.6%	18,762	99,992	18.8%	53	5	267	1.9%	3,938	23,768	16.6%	47
American Indian or Alaska Native	0	-	-	507	1,897	26.7%	23	0	4	-	65	288	22.6%	15
Asian	1	8	12.5%	174	1,084	16.1%	29	0	4	-	78	384	20.3%	17
Black or African American	5	88	5.7%	4,715	23,689	19.9%	44	3	92	3.3%	1,202	8,839	13.6%	38
Native Hawaiian or Other Pacific Islander	0	-	-	33	171	19.3%	11	0	-	-	23	48	47.9%	4
White	11	234	4.7%	12,403	66,484	18.7%	49	1	135	0.7%	2,109	11,768	17.9%	44
Hispanic or Latino	*	*	*	119	659	18.1%	8	*	*	*	49	814	6.0%	7
More Than One Race	0	-	-	247	2,017	12.2%	24	0	-	-	99	525	18.9%	11
Race Not Available	0	38	0.0%	564	3,991	14.1%	28	1	32	3.1%	313	1,102	28.4%	14
Race Total	17	366	4.6%	18,762	99,992	18.8%	53	5	267	1.9%	3,938	23,768	16.6%	47
Hispanic or Latino	0	47	0.0%	1,438	8,923	16.1%	34	1	45	2.2%	385	2,532	15.2%	21
Not Hispanic or Latino	17	314	5.4%	13,916	73,461	18.9%	49	4	219	1.8%	2,892	15,374	18.8%	41
Not Available	0	5	0.0%	3,408	17,608	19.4%	33	0	3	-	578	5,429	10.6%	22
Ethnicity Total	17	366	4.6%	18,762	99,992	18.8%	53	5	267	1.9%	3,855	23,335	16.5%	46

* Reported under Hispanic Ethnicity.

Forensics included in "non forensic" data? No

Note:

US totals are based on states reporting.

This table uses data from URS/DIG Tables 20a and 20b.

State Notes:

Discharges resulting to client transferring to a different unit of the state hospital/to another state hospital were excluded from the count of discharges. Consequently, transfer admissions were not counted as readmission. See General Notes

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**Structure Domain: Federal Mental Health Block Grant Expenditures for Non-Direct Service Activities, FY 2014
Connecticut**

Service	Non-Direct Block Grant Expenditures	% Total	US % Total
Technical Assistance Activities	\$1,850	1.9%	40.4%
Planning Council	\$2,974	3.1%	4.2%
Administration	-	-	24.0%
Data Collection/Reporting	\$15,999	16.5%	7.3%
Other Activities	\$76,256	78.6%	24.2%
Total	\$97,079	100.0%	100.0%

Note: This table use data from URS/DIG Table 8.

State Notes:

CT DMHAS \$76,256.00 - Year 2 of young adult online engagement contract (<http://www.TurningPointCT.org>) with Southwest Regional Mental Health Board.

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STRUCTURE DOMAIN: State Mental Health Agency Controlled Expenditures for Mental Health, FY 2013

STATE Connecticut

	Expenditures: State	Percent of Total Expenditures: State	Expenditures: U.S.	Percent of Total Expenditures: U.S.
State Hospitals-Inpatient	\$194,100,000	24%	\$8,891,294,399	23%
Other 24-Hour Care	\$234,000,000	30%	\$7,208,595,272	19%
Ambulatory/Community	\$308,700,000	40%	\$21,188,959,172	56%
Total	\$777,700,000		\$38,098,637,217	

Note:

Other 24-Hour Care includes state psychiatric hospital and community based other 24-hour as well as community based inpatient expenditures.

Ambulatory/Community includes expenditures for less than 24-hour care services provided at state psychiatric hospitals. It excludes community based other-24 hour and community based inpatient expenditures.

Total also includes additional SMHA Expenditures for research, training, administration, and other central and regional office expenditures.

Data from NRI's Funding Sources and Expenditures of State Mental Health Agencies, FY 2013 reports - Table 18 "SMHA-Controlled Expenditures for Mental Health Services."

U.S. totals are based on 50 states reporting.

More information on the State Mental Health Agency's Revenues & Expenditures as well as State Footnotes can be found on the NRI website: <http://www.nri-incdata.org/>

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STRUCTURE DOMAIN: State Mental Health Agency Controlled Revenues by Funding Sources, FY 2013

STATE Connecticut

Funding Source	Ambulatory/Community			State Hospital		
	State Revenues	Percent Total (State)	Percent Total (US)	State Revenues	Percent Total (State)	Percent Total (US)
Medicaid	\$1,200,000	0.2%	59.2%	\$4,600,000	2.3%	22.2%
Community MH Block Grant	\$4,000,000	0.7%	1.3%	-	-	-
Other SAMHSA	\$800,000	0.1%	0.3%	-	-	-
other Federal(non-SAMHSA)	\$14,800,000	2.7%	2.5%	\$8,600,000	4.3%	4.2%
State	\$520,200,000	95.4%	28.2%	\$182,100,000	91.2%	68.0%
Other	\$4,300,000	0.8%	5.6%	\$4,400,000	2.2%	4.5%
Total	\$545,300,000	100.0%	100.0%	\$199,700,000	100.0%	100.0%

Note:

Data from NRI's Funding Sources and Expenditures of State Mental Health Agencies, FY 2013 reports - State Mental Health Agency Controlled Expenditures and Revenue, Table 24, 25, and 26.

This table does not show Revenues for state central office including Research, Training, and Administration expenses.

More information on the State Mental Health Agency's Revenues & Expenditures as well as State Footnotes can be found on the NRI website: <http://www.nri-incdata.org/>

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Structure Domain: Mental Health Programs Funded By the Federal Mental Health Block Grant, FY 2014

Connecticut

Adult Programs = 18 Child Programs = 9 Total Programs = 27 Adult Total: \$2,900,380 Child Total: \$1,205,772 Total: \$4,106,152

Agency Name	Address	Area Served	Block Grant for Adults with SMI	Block Grant for Children with SED
FAVOR, Inc.	2138 Silas Deane Hwy, Suite 103, Rocky Hill, CT 06067	Statewide	\$0	\$504,407
Hospital of Saint Raphael	Adult Outpatient Psychiatric Services, 1294 Chapel St., New Haven, CT 06511	South Central	\$107,231	\$0
Immaculate Conception Shelter	560 Park Street, Hartford, CT 06126	North Central	\$51,834	\$0
Sound Community Services	165 State Street, P.O. Box 2170, New London, CT 06320	Eastern	\$178,674	\$0
Inter-Community, Inc.	281 Main Street, East Hartford, CT 06118	North Central	\$136,713	\$0
Kennedy Center, Inc.	2440 Reservoir Avenue, Trumbull, CT 06611	Southwest	\$26,162	\$0
Kuhn Employment Opportunities, Inc.	1630 North Colony Road, Meriden, CT 06450	South Central	\$26,162	\$0
Mercy Housing and Shelter Corp.	211 Wethersfield Avenue, Hartford, CT 06114	North Central	\$21,284	\$0
NAMI of Connecticut, Inc.	241 Main Street, Hartford, CT 06106	North Central	\$67,576	\$0
Regional Mental Health Boards	Statewide, Statewide, CT	Statewide	\$48,920	\$0
Rushford Center, Inc/ Midstate	883 Paddock Avenue, Meriden, CT 06450	South Central	\$427,045	\$0
South Central Behavioral Health Network, Inc.	1435 State Street, New Haven, CT 06511	South Central	\$104,648	\$0
United Services, Inc.	P.O. Box 839 , 1007 North Main Street, Dayville, CT 06241	Eastern	\$490,769	\$0
Waterbury Hospital Health Center	64 Robbins Street, Waterbury, CT 06721	Northwest	\$249,763	\$0
Family and Children's Agency, Inc.	9 Mott Avenue, Norwalk, CT 06850	Sub-State Planning Area	\$0	\$71,000
Family and Children's Aid, Inc.	75 West Street, Danbury, CT 06810	Sub-State Planning Area	\$0	\$43,206
Jewish Family Services, Inc.	1440 Whalley Avenue, New Haven, CT 06515	Sub-State Planning Area	\$0	\$53,459
Klingberg Family Center, Inc.	370 Linwood Street, New Britain, CT 06052	Sub-State Planning Area	\$0	\$115,497
United Way of CT	1344 Silas Deane Hwy, Rocky Hill, CT 06067	Statewide	\$0	\$16,125
YMCA of No. Middlesex County	99 Union Street, Middletown, CT 06457	Sub-State Planning Area	\$0	\$52,393
Child Health and Development Institute of CT	270 Farmington Ave, Farmington, CT 06032	Statewide	\$0	\$331,112
Family and Children's Aid, Inc. (Therapeutic Activity Groups - EDT)	75 West Street, Danbury, CT 06810	Statewide	\$0	\$18,573
Coordinating Council for Children in Crisis, Inc.	131 Dwight Street, New Haven, CT 06511	South Central	\$52,324	\$0
Charlotte Hungerford Hospital	540 Litchfield Street, Torrington , CT 06790	Northwest	\$143,334	\$0
Community Health Resources Inc. Genesis	995 Day Hill Road, Windsor, CT 06095	North Central	\$215,476	\$0
Community Mental Health Affiliates, Inc	270 John Downey Drive, New Britain, CT 06051	North Central	\$258,464	\$0
Danbury Hospital	24 Hospital Avenue, Danbury, CT 06810	Northwest	\$294,001	\$0

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Connecticut

URS Table Number	General Notes
All	DCF: There is some duplication in the tables of the clients receiving community services, resulting from characteristics of the CT Department of Children and Families' Programs and Services Data Collection System (PSDCRS). Client data entered into PSDCRS is unduplicated within each provider. Normally data is de-duplicated across providers by assuming that clients are the same if they have the same first and last name, DOB, and gender. For most of the tables in this report (those not involving SED) we also require that they have the same race, Hispanic/Latino origin status, health insurance coverage and living situation, so if any of these data elements are reported differently between providers this client would be counted more than once. This is done because all of the data elements just listed are used to classify clients in one or more tables in the MHBG report, so if they were not included in the de-duplication process as just described, the totals in the tables would be inconsistent with each other. There is also possible duplication by simple data entry errors, such as different spellings of a client's name by different providers.
2A, 2B, 3, 4, 4A, 14A, 14B, 15A, 15, 20A, 20B	DMHAS: DMHAS: This table has been populated using MH-TEDS data files for adult clients. The data source, methodology, and basic assumptions used in populating the 2014 URS Tables may account for significant differences from earlier state Tables.
2A, 2B, 3, 4, 4A, 14A, 14B, 15A, 15	Demographic values (age, gender, race, ethnicity) - value was based on the last record except when the value is Unknown and search for a valid value from admission records more than 12 months prior the beginning of the reporting period.
2	Duplication in client count between the Children MH System and Adults MH System is limited to 100 individuals based on a procedure conducted to identify clients served by both agencies.
2	Pregnant women - pregnancy status search was limited within the reporting period for clients 15 years and older, which is the earliest age used by CDC to report teen pregnancy.
5A/5B	DMHAS: DMHAS collects an "Other" category for race. These clients have been recoded to the "Unknown" category.
6	DCF continues to reduce the number of dependents in congregate care. The number of clients in RTCs for 2013 was underreported
8	The reduction in non-direct service activity spending from FY13 is due to the federal budget recession, as it was the MHA's policy to prevent cuts to direct service funding.
16	DCF: Family Functional Therapy (FFT): In accordance with FT protocol, our agency monitors fidelity through the clinical lead. Fidelity is also monitored on an ongoing basis by FFT, Inc. through a variety of measures including the national supervisor who monitors our site. Adherence information are recorded on the web-based FFT Client Service System and is measured weekly by the on-site clinical lead and monthly by FFT, Inc., through our national consultant.
16	DCF: Multi-Systemic Therapy (MST): Therapist Adherence Measures (TAM), Supervisory Adherence Measures (SAM) and Program Implementation Reports are used to monitor fidelity by Advanced Behavioral Health, Inc. (vendor) on weekly and monthly basis.
17	There was an error in the reported the number of patients receiving IDDT treatment in FY13. The correct number of patients receiving this services was 1,975 not 3,149.
19A	DCF: At this time DCF's data system, Programs and Services Data Collection and Reporting System (PSDCRS) does not provide the data necessary for T1 time period, because it asks whether the client has been arrested during the six months prior to admission, and T1 requires whether the client has been arrested in the previous twelve months. For T2 the data comes primarily from a PSDCRS question asked at discharge, which asks whether the client was arrested during the episode, and the table addresses whether the client has been arrested in the previous twelve months. Plans are being developed to correct this error to enable full reporting for FY 2015.
19B	DCF: At this time DCF's data system, Programs and Services Data Collection and Reporting System (PSDCRS) does not provide the data necessary for T1 time period, because it asks whether the client has been suspended or expelled from school during the six months prior to admission, and T1 requires whether the client has been suspended or expelled from school in the prior twelve months. For T2 the data comes primarily from a PSDCRS question asked at discharge, which asks whether the client was suspended or expelled during the episode, and the table addresses whether the client has been expended or expelled in the previous twelve months. Efforts are underway to correct the problem.

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Appendix D



//www.census.gov/en.html

Search

U.S. Census Quick Facts

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QuickFacts Connecticut

QuickFacts provides statistics for all states and counties, and for cities and towns with a population of 5,000 or more.

All Topics ▼

CONNECTICUT

People

Population

Population estimates, July 1, 2015, (V2015)	3,590,886
Population estimates base, April 1, 2010, (V2015)	3,574,118
Population, percent change - April 1, 2010 (estimates base) to July 1, 2015, (V2015)	0.5%
Population, Census, April 1, 2010	3,574,097

Age and Sex

Persons under 5 years, percent, July 1, 2015, (V2015)	5.2%
Persons under 5 years, percent, April 1, 2010	5.7%
Persons under 18 years, percent, July 1, 2015, (V2015)	21.3%
Persons under 18 years, percent, April 1, 2010	22.9%
Persons 65 years and over, percent, July 1, 2015, (V2015)	15.8%
Persons 65 years and over, percent, April 1, 2010	14.2%
Female persons, percent, July 1, 2015, (V2015)	51.2%
Female persons, percent, April 1, 2010	51.3%

Race and Hispanic Origin

White alone, percent, July 1, 2015, (V2015) (a)	80.8%
White alone, percent, April 1, 2010 (a)	77.6%
Black or African American alone, percent, July 1, 2015, (V2015) (a)	11.6%
Black or African American alone, percent, April 1, 2010 (a)	10.1%
American Indian and Alaska Native alone, percent, July 1, 2015, (V2015) (a)	0.5%
American Indian and Alaska Native alone, percent, April 1, 2010 (a)	0.3%
Asian alone, percent, July 1, 2015, (V2015) (a)	4.6%
Asian alone, percent, April 1, 2010 (a)	3.8%
Native Hawaiian and Other Pacific Islander alone, percent, July 1, 2015, (V2015) (a)	0.1%
Native Hawaiian and Other Pacific Islander alone, percent, April 1, 2010 (a)	Z
Two or More Races, percent, July 1, 2015, (V2015)	2.2%
Two or More Races, percent, April 1, 2010	2.6%
Hispanic or Latino, percent, July 1, 2015, (V2015) (b)	15.4%
Hispanic or Latino, percent, April 1, 2010 (b)	13.4%
White alone, not Hispanic or Latino, percent, July 1, 2015, (V2015)	68.2%
White alone, not Hispanic or Latino, percent, April 1, 2010	71.2%
Population Characteristics	
Veterans, 2010-2014	209,882

Housing

Foreign-born persons, percent, 2010-2014	13.7%
Housing units, July 1, 2015, (V2015)	1,495,963
Housing units, April 1, 2010	1,487,891
Owner-occupied housing unit rate, 2010-2014	67.3%
Median value of owner-occupied housing units, 2010-2014	\$274,500
Median selected monthly owner costs -with a mortgage, 2010-2014	\$2,110
Median selected monthly owner costs -without a mortgage, 2010-2014	\$832
Median gross rent, 2010-2014	\$1,069
Building permits, 2015	6,077

Families and Living Arrangements

Households, 2010-2014	1,356,206
Persons per household, 2010-2014	2.56
Living in same house 1 year ago, percent of persons age 1 year+, 2010-2014	87.8%
Language other than English spoken at home, percent of persons age 5 years+, 2010-2014	21.6%

Education

High school graduate or higher, percent of persons age 25 years+, 2010-2014	89.5%
Bachelor's degree or higher, percent of persons age 25 years+, 2010-2014	37.0%

Health

With a disability, under age 65 years, percent, 2010-2014	7.0%
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Economy

Persons without health insurance, under age 65 years, percent	6.9%
In civilian labor force, total, percent of population age 16 years+, 2010-2014	67.5%
In civilian labor force, female, percent of population age 16 years+, 2010-2014	62.9%
Total accommodation and food services sales, 2012 (\$1,000) (c)	9,542,068
Total health care and social assistance receipts/revenue, 2012 (\$1,000) (c)	29,573,119
Total manufacturers shipments, 2012 (\$1,000) (c)	55,160,095
Total merchant wholesaler sales, 2012 (\$1,000) (c)	161,962,244
Total retail sales, 2012 (\$1,000) (c)	51,632,467
Total retail sales per capita, 2012 (c)	\$14,381

Transportation

Mean travel time to work (minutes), workers age 16 years+, 2010-2014	25.1
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Income and Poverty

Median household income (in 2014 dollars), 2010-2014	\$69,899
Per capita income in past 12 months (in 2014 dollars), 2010-2014	\$38,480
Persons in poverty, percent	10.5%

Businesses

Total employer establishments, 2014	88,555 ¹
Total employment, 2014	1,485,426 ¹
Total annual payroll, 2014	87,866,508 ¹
Total employment, percent change, 2013-2014	0.8% ¹
Total nonemployer establishments, 2014	269,845
All firms, 2012	326,693
Men-owned firms, 2012	187,845
Women-owned firms, 2012	106,678
Minority-owned firms, 2012	56,113
Nonminority-owned firms, 2012	259,614
Veteran-owned firms, 2012	31,056
Nonveteran-owned firms, 2012	281,182

Geography

Population per square mile, 2010	738.1
Land area in square miles, 2010	4,842.36

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I-TEAM IN-DEPTH

Appendix

E
April 19, 2015

Mental Health Is Main Cause Of Hospitalizations in CT, New Data Show

By Lisa Chedekel



YNHH.org Photo

Yale-New Haven was among the hospitals reporting a large increase in patient hospitalizations for mental health disorders.

Mental disorders surpassed respiratory problems and all other ailments as the leading cause of hospitalization in Connecticut in 2012 for children ages 5 to 14, teenagers and younger adults, according to a new state health department report.

The report (http://www.ct.gov/dph/lib/dph/ohca/publications/2014/final_2014_facilities_plan_-_2_24_15.pdf) shows that the number of days that patients with behavioral health problems were hospitalized surged 5.3 percent between 2011 and 2013, to nearly 260,000 patient days. Other categories of hospitalizations, including cardiac and cancer care, declined during that time.



YNHH.org Photo

Yale-New Haven Hospital reported a large increase in patient hospitalizations for mental health disorders.

The data show five hospitals had increases of more than 12 percent in the number of days that patients with behavioral health problems were hospitalized. The biggest increases were at Yale-New Haven Hospital, which saw the number of patients rise 61 percent, and inpatient days jump 51 percent; and

Waterbury Hospital, with 26 percent more patients and a 37 percent increase in inpatient days. The increase at Yale-New Haven is partly due to its merger with the Hospital of St. Raphael's in 2012.

Some hospitals, such as Hartford Hospital and MidState Medical Center, saw a decline in the number of patients admitted for mental health problems from 2011 to 2013, but increases in the number of inpatient days, indicating longer lengths of individual patient

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stays. A few hospitals, including Greenwich and Norwalk, saw a decline in both patients and hospitalization days.

The report – the “Statewide Health Care Facilities and Services Plan, 2014 Supplement,” compiled with input from a large group of health providers – does not speculate on why hospitalizations for mental health have climbed in recent years. But it does make recommendations for improving behavioral health treatment options, including creating an “inventory of distinct service levels” related to mental health and pursuing better coordination or co-location of mental health services within primary care offices and other settings.



Waterbury Hospital had a 37 percent increase in inpatient days.

Carl Schiessl, directory of regulatory advocacy for the Connecticut Hospital Association, said the association’s own data show that in 2014, more than 25 percent of all inpatient and emergency department visits to hospitals were to treat patients with a primary or secondary behavioral health disorder, including those related to substance abuse. Between 2010 and 2014, hospitals saw a 31 percent increase in patients with a behavioral health diagnosis.

“That’s a big number,” Schiessl said.

“Our hospitals are doing the best we can with the limited resources we have, but it is a situation that is getting worse in the state of Connecticut.”

He said some possible factors fueling the increase include a “heightened awareness” of behavioral health, particularly among children, which could be a consequence of the Sandy Hook Elementary School shooting in December 2012; greater access to insurance under Obamacare; and a shortage of residential or outpatient treatment placements for children and adolescents in need of specialized care.

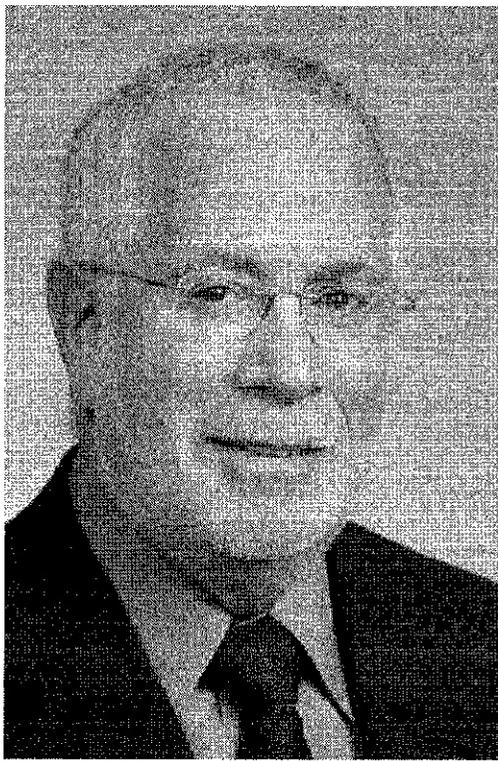
The hospital association is supporting a proposed [bill](https://legiscan.com/CT/text/SB01089/2015) that would make grants available to providers to expand acute and emergency mental health services, and to establish hospital-based “intermediate” care units that would provide 30-45 day evaluation and treatment. The association also is seeking state support to create community care teams in every region, which would have hospitals and local agencies meeting regularly to discuss patients with chronic mental health problems.

Dr. Harold Schwartz, psychiatrist-in-chief at the Institute of Living and vice president of behavioral health for Hartford HealthCare, said the clearest explanation for the increase in mental health visits is the expansion of Medicaid and other insurance options under the Affordable Care Act. Some patients are identified with mental health issues after coming to the hospital with other conditions, he said.

Anecdotally, Schwartz said, “We seem to be dealing with a more highly stressed population,” with “more serious suicide attempts” among people not receiving regular mental health care.

The state report shows that for children younger than 5 years old, asthma and other respiratory problems were the leading cause of hospitalization in 2012. Mental disorders were the leading cause of hospitalization for males and females ages 5 to 14, 15 to 24, and 25 to 44. For men ages 45 to 64, a diagnosis for mental disorders was the leading cause of hospitalization, while for females in that age group, digestive system issues, such as hernias and colitis, were the leading cause.

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Dr. Harold Schwartz

The report also shows that of about eight million visits made to Connecticut emergency departments from 2009 to 2013, one million were for psychiatric or drug- or alcohol-related mental disorders. Most of the psychiatric visits (58.3 percent) were made by white patients; about 40 percent were people ages 18 to 39. The primary reasons for visiting the emergency room were for “nonpsychotic disorders” such as anxiety or depression.

Among children, common diagnoses included mood disorders, depression, attention deficit disorder and disruptive behaviors.

Almost one-third of patients who came to emergency rooms with psychiatric problems needed to be admitted for inpatient treatment, the report says.

Administrators of some hospitals, including Connecticut Children’s

Medical Center and Yale-New Haven, have reported (<http://c-hit.org/2014/07/10/long-er-stays-for-kids-in-crisis-on-the-rise/>) increasing numbers of children with mental health problems showing up in emergency rooms, sometimes staying multiple nights before residential placements or support services can be found.

Both Schwartz and Schiessl said the emergency room crunch and long lengths of inpatient stays were exacerbated by a lack of residential treatment beds for children and adolescents – a problem that Schwartz said the state Department of Children and Families needs to remedy, not worsen.

“With so many fewer state beds available for adolescents, we have kids who might spend weeks or even months in our unit, waiting for placement,” he said.

Several task forces and state agencies have released reports since the Sandy Hook shooting calling for better coordination of mental health services to children and young adults to reduce fragmentation, improve screening, and expand emergency response teams and access to care. Few recommendations have been implemented so far, though many are being considered.

On May 7, C-HIT will host a community forum on teen mental health at The Lyceum, 227 Lawrence St., in Hartford. The event, which features an expert panel, is being held in collaboration with ConnectiCare and Hartford Hospital’s Institute of Living. For information and to purchase a ticket, go here (<http://c-hit.org/sign-up-uncovering-our-kids/>).

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FOR-PROFIT

Applicant Name: Growing Please provide one year of actual results and three years of projections of Total Entity revenue, expense and volume statistics
Financial Worksheet (B) without, incremental to and with the CON proposal in the following reporting format:

LINE	Total Entity Description	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	11	12	13
		FY2015	FY2016	FY2016	FY2016	FY2017	FY2017	FY2017	FY2018	FY2018	FY2018	FY2019	FY2019	FY2019
		Actual Results	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected
	Without CON	Incremental	With CON	Without CON	Incremental	With CON	Without CON	Incremental	With CON	Without CON	Incremental	With CON		
A. OPERATING REVENUE														
1	Total Gross Patient Revenue	\$281,486	\$337,783	\$606,817	\$944,600	\$405,340	\$2,114,260	\$2,519,600	\$486,408	\$2,537,112	\$3,087,500	\$583,689	\$3,044,533	\$3,705,000
2	Less: Allowances	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
3	Less: Charity Care	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
4	Less: Other Deductions	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
	Net Patient Service Revenue	\$281,486	\$337,783	\$606,817	\$944,600	\$405,340	\$2,114,260	\$2,519,600	\$486,408	\$2,537,112	\$3,087,500	\$583,689	\$3,044,533	\$3,705,000
5	Medicare	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
6	Medicaid	\$214,384	\$254,379	\$24,676	\$802,910	\$305,255	\$28,611	\$2,141,660	\$366,306	\$2,273,507	\$2,639,813	\$439,567	\$2,704,971	\$3,038,100
7	CHAMPUS & TriCare	\$2,271	\$2,725	\$473	\$33,061	\$3,270	\$82,396	\$85,866	\$3,924	\$88,701	\$92,626	\$4,709	\$106,441	\$111,150
8	Other	\$68	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
	Total Government	\$214,384	\$257,104	\$25,149	\$835,971	\$308,525	\$112,007	\$2,227,326	\$370,230	\$2,362,207	\$2,732,439	\$444,276	\$2,811,411	\$3,149,250
9	Commercial Insurers	\$67,102	\$80,616	\$5,053	\$103,306	\$96,742	\$6,064	\$279,676	\$116,090	\$226,622	\$342,713	\$139,309	\$268,241	\$407,550
10	Uninsured	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
11	Self Pay	\$0	\$60	\$5,000	\$4,723	\$72	\$12,526	\$12,988	\$86	\$12,264	\$12,350	\$104	\$148,066	\$148,200
12	Workers Compensation	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
13	Other	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
	Total Non-Government	\$67,102	\$80,678	\$10,053	\$108,629	\$96,814	\$18,580	\$292,274	\$116,177	\$236,866	\$355,063	\$139,412	\$416,338	\$656,750
	Net Patient Service Revenues (Government+Non-Government)	\$281,486	\$337,783	\$631,966	\$944,600	\$405,340	\$130,597	\$2,519,600	\$486,407	\$334,222	\$3,087,500	\$583,688	\$3,227,751	\$3,705,000
14	Less: Provision for Bad Debts	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
	Net Patient Service Revenue less provision for bad debts	\$281,486	\$337,783	\$606,817	\$944,600	\$405,340	\$2,114,260	\$2,519,600	\$486,408	\$2,537,112	\$3,087,500	\$583,689	\$3,044,533	\$3,705,000
15	Other Operating Revenue	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
17	Net Assets Released from Re	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
	TOTAL OPERATING REVENUE	\$281,486	\$337,783	\$606,817	\$944,600	\$405,340	\$2,114,260	\$2,519,600	\$486,408	\$2,537,112	\$3,087,500	\$583,689	\$3,044,533	\$3,705,000
B. OPERATING EXPENSES														
1	Salaries and Wages	\$162,013	\$170,656	\$60,000	\$230,656	\$176,359	\$72,000	\$248,359	\$186,563	\$86,400	\$272,963	\$196,588	\$103,680	\$300,289
2	Fringe Benefits	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
3	Physicians Fees	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
4	Supplies and Drugs	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
5	Depreciation and Amortization	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
6	Provision for Bad Debts-Other	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
7	Interest Expense	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
8	Malpractice Insurance Cost	\$10,000	\$10,000	\$0	\$10,000	\$10,000	\$0	\$10,000	\$10,000	\$0	\$10,000	\$10,000	\$0	\$10,000
9	Lease Expense	\$18,000	\$18,000	\$0	\$18,000	\$18,000	\$0	\$18,000	\$18,000	\$0	\$18,000	\$18,000	\$0	\$18,000
10	Other Operating Expenses	\$76,482	\$78,598	\$5,767	\$84,365	\$81,651	\$11,001	\$92,652	\$85,366	\$61,970	\$137,335	\$87,352	\$81,180	\$178,532
	TOTAL OPERATING EXPENSE	\$266,495	\$277,254	\$65,767	\$343,021	\$286,010	\$83,001	\$369,011	\$299,928	\$138,370	\$438,298	\$321,941	\$184,860	\$606,601
	INCOME/(LOSS) FROM OPERATIONS	\$14,991	\$60,529	\$541,050	\$601,579	\$119,330	\$2,031,259	\$2,150,589	\$186,480	\$2,398,742	\$2,649,202	\$261,748	\$2,859,671	\$3,198,199
NON-OPERATING INCOME														
	Income before provision for income taxes	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
	Provision for income taxes	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
	NET INCOME	\$14,991	\$60,529	\$541,050	\$601,579	\$119,330	\$2,031,259	\$2,150,589	\$186,480	\$2,398,742	\$2,649,202	\$261,748	\$2,859,671	\$3,198,199
C. RETAINED EARNINGS														
	Retained Earnings, beginning of year	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
	Retained Earnings, end of year	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
	Principal Payments	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
D. PROFITABILITY SUMMARY														
1	Hospital Operating Margin	5.3%	17.9%	89.2%	63.7%	29.4%	96.1%	85.4%	0	94.5%	1	45%	94%	86%
2	Hospital Non Operating Margin	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0	0.0%	0	0%	0%	0%
3	Hospital Total Margin	5.3%	17.9%	89.2%	63.7%	29.4%	96.1%	85.4%	0	94.5%	0	45%	94%	86%
E. FTEs														
	FTEs	0	0	0	0	0	0	0	0	0	0	0	0	0
F. VOLUME STATISTICS														
1	Inpatient Discharges	0	0	0	0	0	0	0	0	0	0	0	0	0
2	Outpatient Visits	1,560	1,872	7,574	8,446	2,246	22,950	25,196	2695	28,180	30,675	3191	33859	37060
	TOTAL VOLUME	1,560	1,872	7,574	8,446	2,246	22,950	25,196	2695	28,180	30,675	3191	33859	37060

a Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.
b Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No.2011-07, July 2011.
c Provide the amount of income taxes as defined by the Internal Revenue Services for for-profit entities.
d 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

Greer, Leslie

From: Walker, Shauna
Sent: Tuesday, January 03, 2017 8:02 AM
To: Growingpotentialservices@gmail.com
Cc: Riggott, Kaila; Armah, Olga; User, OHCA
Subject: CON Application # 16-32083
Attachments: 16-32083-CON Notification of Application Deemed Complete.docx

Good Morning,

Please see attached. Your application has been deemed complete as of 12/30/2016.

Shauna L. Walker

Office of Health Care Access

Connecticut Department of Public Health

410 Capitol Avenue

Hartford, CT 06134

Phone: (860) 418-7069

Email: Shauna.Walker@ct.gov



STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner



Dannel P. Malloy
Governor
Nancy Wyman
Lt. Governor

Office of Health Care Access

December 30, 2016

Via Email Only

Marcy Taliceo, CEO
Growing Potential Services: Therapeutic and
Behavioral Health Solutions, PC
141 Hazard Ave.
Enfield, CT 06082
Growingpotentialservices@gmail.com

RE: Certificate of Need Application; Docket Number: 16-32083-CON
Establishment of a Psychiatric Outpatient, Day Treatment and Substance Abuse or
Dependence Treatment Clinic for Adults in Enfield

Dear Ms. Taliceo:

This letter is to inform you that, pursuant to Section 19a-639a (d) of the Connecticut General Statutes, the Office of Health Care Access has deemed the above-referenced application complete as of December 30, 2016.

If you have any questions concerning this letter, please feel free to contact me at (860) 418-7070.

Sincerely,

Olga Armah
Associate Research Analyst



Phone: (860) 418-7001 • Fax: (860) 418-7053
410 Capitol Avenue, P.O. Box 340308
Hartford, Connecticut 06134-0308
www.ct.gov/dph

Affirmative Action/Equal Opportunity Employer

Greer, Leslie

From: Marcy Taliceo <growingpotentialservices@gmail.com>
Sent: Tuesday, January 03, 2017 8:43 AM
To: Walker, Shauna
Cc: User, OHCA; Armah, Olga; Riggott, Kaila; Bauer, Sandra
Subject: Re: CON Application # 16-32083

Great. Thank you

On Jan 3, 2017 8:02 AM, "Walker, Shauna" <Shauna.Walker@ct.gov> wrote:

Good Morning,

Please see attached. Your application has been deemed complete as of 12/30/2016.

Shauna L. Walker

Office of Health Care Access

Connecticut Department of Public Health

410 Capitol Avenue

Hartford, CT 06134

Phone: [\(860\) 418-7069](tel:(860)418-7069)

Email: Shauna.Walker@ct.gov

