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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.: 16-32129-CON **Check No.:** 19458
OHCA Verified by: SLC **Date:** 10-19-16

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

Certificate of Need Application
Main Form
Required for all CON applications

Contents:

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X	Abbreviate Executive Summary
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General Information

Name of Applicant:	Name of Co-Applicant:
MC1 Healthcare, LLC	N/A

Connecticut Statute Reference:

19a – 638 CGS

Main Site

MAIN SITE	MEDICAID PROVIDER ID	TYPE OF FACILITY	MAIN SITE NAME
See Below	N/A	Behavioral Health	MC1 d/b/a Mountainside Treatment Center
STREET & NUMBER			
187 South Canaan Road			
TOWN		ZIP CODE	
Canaan		06018	

Project Site

PROJECT SITE	MEDICAID PROVIDER ID	TYPE OF FACILITY	PROJECT SITE NAME
See Below	N/A	Behavioral Health	MC1 d/b/a Mountainside Treatment Center
STREET & NUMBER			
187 South Canaan Road			
TOWN		ZIP CODE	
Canaan		06018	

Operator

OPERATING CERTIFICATE NUMBER	TYPE OF FACILITY	LEGAL ENTITY THAT WILL OPERATE OF THE FACILITY (or proposed operator)
License Number: 0388	Behavioral Health	
STREET & NUMBER		
187 South Canaan Road		
TOWN		ZIP CODE
Canaan		06018

6Chief Executive

NAME		TITLE	
Stephen Langley		Executive Director	
STREET & NUMBER			
187 South Canaan Road			
TOWN		STATE	ZIP CODE
Canaan		**CT**	**06018**
TELEPHONE	FAX	E-MAIL ADDRESS	
860 362-5007	888 572-5978	stephen.langley@mountainside.com	

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 (attached)	YES ☒ NO ☐	
Does the Applicant have non-profit status? If yes, attach documentation.	YES ☐ NO ☒	
Identify the Applicant's ownership type.	PC ☐ LLC ☒ Corporation ☐	Other: _____
Applicant's Fiscal Year (mm/dd)	Start: January	End: December

Contact:

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

Contact Information			
NAME		TITLE	
Maureen O'Neill Biggs, LPC, LADC		Consultant	
STREET & NUMBER			
26 Halsey Drive			
TOWN		STATE	ZIP CODE
Wallingford		**CT**	**06492**
TELEPHONE		FAX	E-MAIL ADDRESS
203 641-4347		888 572-5978	maureen.biggs01@gmail.com
RELATIONSHIP TO APPLICANT	Consultant		

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

Prepared by			
NAME		TITLE	
Maureen O'Neill Biggs, LPC, LADC		Consultant	
STREET & NUMBER			
26 Halsey Drive			
TOWN		STATE	ZIP CODE
Wallingford		**CT**	**06492**
TELEPHONE		FAX	E-MAIL ADDRESS
203 641-4347		888 572-5978	maureen.biggs01@gmail.com
RELATIONSHIP TO APPLICANT	Consultant		

List of LLC Managers Authorizing the Project
Outpatient Psychiatric Clinic for Adults
Canaan, CT Site

Executive Committee Members	Title
Martin Fedor	Managing Partner
David Matteini	Managing Director Artemis
Roy Sasenaraine	Chief Operating Officer
Stephen Langley	Executive Director
Matt Eakin	Executive Vice President
Alex Helfer	Vice President of Program Development
Sahel Shwayhat	Vice President of Operations
Sarah Verrelli	Vice President of Business Management
Sarah Osborne	Director of Clinical Operations

Affidavit

Applicant: MC1 Healthcare, LLC

Project Title: Mountainside – Canaan, CT Psychiatric Outpatient Clinic for Adults

I, Roy Sasenaraine (Name) Chief Operating Officer (Position – CEO or CFO)

of MC1 Healthcare, LLC being duly sworn, depose and state that the (MC1 Healthcare, LLC) 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.

Roy Sasenaraine 10-03-16

Signature Date

Subscribed and sworn to before me on October 3rd, 2016

Justin Cloutier

Notary Public/Commissioner of Superior Court

JUSTIN R. CLOUTIER
NOTARY PUBLIC
State of Connecticut
My Commission Expires
June 30, 2018

My commission expires:

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.

MC1 Healthcare, LLC d/b/a Mountainside Treatment Center, a for-profit organization registered to conduct business in Connecticut, proposes to add a Psychiatric Outpatient Clinic for Adults which will be located at the Canaan, CT established site.

The proposed service will address the need to provide outpatient/intensive outpatient mental health services to individuals residing in Litchfield County.

Most notably, Community Mental Health Affiliates of Lakeville (proximity 8.6 miles) from the Mountainside Canaan site closed its doors leaving a gap in services in this area.

There are no private psychiatrists in Canaan, CT according to Lifescript.com/doctor/specialty/psychiatry – Connecticut. There is one psychiatrist in private practice in Lakeville (proximity 10.2 miles), two in Litchfield (proximity 16.7 miles), three in Sharon (proximity 15 miles) and five in Torrington (proximity 16.9 miles).

Mountainside proposes to provide outpatient individual sessions, group sessions, psycho-education, intensive outpatient services, medication management, individual psychiatric sessions and other services to individuals with a primary diagnosis of mental illness and/or a co-occurring disorder.

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.**

   MC1 Healthcare, LLC, d/b/a Mountainside Treatment Center ("Mountainside"), a for-profit organization registered to conduct business in Connecticut, proposes to add a Psychiatric Outpatient Clinic for adults which will be located at the Canaan, CT established site. Mountainside currently operates a medically monitored detoxification program, residential, outpatient/intensive outpatient substance abuse/co-occurring services and MAT Services at the above specified site.

   Mountainside is licensed by the Connecticut Department of Public Health (DPH) and accredited by the Council on Accreditation of Rehabilitation Facilities (CARF), at both the main campus in Canaan, CT and the Wilton, CT Outpatient Campus.

   The additional service (Outpatient Psychiatric Clinic for Adults) will typically serve individuals with a primary diagnosis of mental illness in Litchfield County and a marginal group in surrounding towns and/or out-of-state who choose to remain in the Canaan, CT area. The staff scheduled to oversee the outpatient and intensive outpatient service for persons diagnosed with primary mental illness include the Medical Director, the Director of Psychiatry, Director of Clinical Operations, Senior Clinician and two Primary Clinicians all of whom are accomplished in mental illness, co-occurring disorders and substance abuse.

   Mountainside has been operating addiction/co-occurring treatment programs since 1998, providing services to approximately two thousand (2,000) clients annually, including those in the insurance and self-pay sectors exclusively.

   The proposed service will address the need to provide outpatient/intensive outpatient mental health services to individuals residing in Litchfield County which includes Salisbury, North Canaan, Canaan, Norfolk, Colebrook, Winchester, Barkhamsted, Sharon, Cornwall, Goshen, Torrington, New Hartford, Kent, Warren, Litchfield, Harwinton, New Milford, Washington, Morris, Thomaston, Plymouth, Bethlehem, Roxbury, Woodbury, Watertown, and Bridgewater, potential clients who reside in the community and those clients who choose to remain in the Canaan, CT area post discharge from Mountainside's residential services.

   According to the United States Census Bureau, Litchfield County has a population of one-hundred eight-nine thousand, one hundred and thirty (189,130). Male residents total ninety-two thousand nine hundred and ninety-six (92,996) individuals; female residents total ninety-six thousand one hundred and thirty-four (96,134). The total households are seventy-six thousand five hundred and eighty-five (76,585) with two point forty-three (2.43) people per household. The median age is forty-four point seventeen (44.17) years old; sixty-five percent (65%) of the population holds white collar jobs and thirty-five percent (35%) are stated to be blue collar workers. Nineteen point one percent (19.1%) of the population are under eighteen (18) years of age, sixty-one point nine percent (61.9%) of the population are eighteen (18) years to sixty-four (64) years of age and nineteen percent (19%) of the population residing in Litchfield County are sixty-five (65) years of age and older. Total expenditures in Litchfield County are confirmed to be above average according to the United States Census Bureau.1 (Appendix One)

   The Outpatient Psychiatric Clinic for Adults will offer Outpatient Services (both individual and group),

1 United States Census Bureau, Litchfield County, Connecticut; http://census.gov/quickfacts/table/PSTo452115/09005

Intensive Outpatient Services, Psychiatric Evaluation and follow-up, Medication Management, Family Wellness; encompassing family sessions, individual client sessions and family psycho-education, EMDR (Eye Movement Desensitization and Reprocessing) Therapy, Acupuncture, Thai massage, Integrated Positional Therapy, TRE (Tension/Trauma Releasing Exercises), Restorative Yoga and Nutritional Guidance as appropriate.

The hours of operation are Monday – Friday from 8am to 9pm. Most notably, licensed clinical staff is on-call twenty-four (24) hours, seven (7) days per week.

The proposed program is a client-centered, recovery oriented integrated treatment experience that focuses on the physical, emotional and social well-being, growth, education and empowerment of each client, promoting respect and dignity through the efforts of a qualified, well trained, culturally competent clinical staff. The outpatient service will function in partnership with the client admitted to treatment. The program will undergo continued development as part of a commitment to meet the emergent needs of all clients in this least restrictive environment.

Additionally, Community Mental Health Affiliates of Lakeville (proximity 8.6 miles) has closed its' doors leaving a gap in services.

Over the past two (2 1/2) years, Mountainside has realized an increase in admissions of clients diagnosed with a co-occurring disorder.

	2013	2014	2015	2016 (6 months)	Total
Detox					
Total	N/A	381	708	**401**	1,490
% w/Co-Occurring DX	N/A	64.8%	67.7%	**63.8%**	65.9%
Residential					
Total	675	735	685	**329**	2,424
% w/Co-Occurring DX	69.5%	73.6%	74.5%	**73.9%**	72.7%

**Data secured from Electronic Health Record, only includes clients who completed treatment. Detox opened on 6/18/2014

The proposed outpatient/intensive outpatient service will begin operation immediately upon award of a certificate of need (CON) and issuance of a license by the Department of Public Health (DPH). The infrastructure and staffing pattern is in place at the Canaan, CT location.

The capital outlay will be minimal. Mountainside projects operating with a modest margin from startup and will be cost-effective. A gradual increase in both client volume and fees will ensure continued viability. Within the proposed space, Mountainside will be able to expand services to meet actual demand as it is presented.

The proposed outpatient/intensive outpatient mental health service will improve health care services in the area, improve client outcomes and costs to society by enabling clients to increase the likelihood of achieving sustained wellness while being provided with ongoing mental health care. The introduction of this service will have minimal impact on the existing fourteen (14) licensed not-for-profit providers in the Litchfield County area.

Attachment I: **Public Notice: Waterbury American Republican – September 11,12,13, 2016**

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?).

   Throughout the past two and one half (2 1/2) years Mountainside has identified an increase in mental health diagnoses. In 2015 sixty-seven point seven percent (67.7%) of clients admitted to the medically monitored detoxification program and seventy-four point five percent (74.5%) of the clients admitted to the residential program were evaluated as exhibiting a co-occurring mental illness. In the past six (6)

months alone sixty-three point eight percent (63.8%) of clients admitted to the medically monitored detoxification program and seventy-three point nine percent (73.9%) of clients admitted to residential treatment are determined to have a co-occurring disorder.

At the time of preadmission approximately, 223 or 9% of potential candidates were diagnosed with a primary mental health diagnoses were referred to mental health facilities. There is a clear need for service in the Canaan area. Mountainside is positioned and eager to treat this population.

Discussions to hire additional psychiatric staff began in late 2014.
As a result of summit meetings (planning sessions);
Mountainside has:

- Hired a Medical Director/Psychiatrist, Director of Psychiatry, Psychiatric APRN and a Doctor of Nursing.
- Added an assessment series to treatment. Five unique assessments are used to measure the client's baseline and ultimately his/her progress throughout the treatment experience. The Assessment Series measures five (5) domains (depression, anxiety, cravings, sleep and ADHD). The assessment series is administered at three (3) pre-determined points in treatment. The first series is completed soon after the client is admitted to treatment, at day fourteen (14) and just prior to discharge (approximately day thirty (30). Based on the client's scores, the individualized wellness plan addresses any symptomatology within a moderate to severe range. Interventions focusing on these specific areas are included in the wellness plan. Pre and Post testing is completed. The pre and post test scores focus on the expressed interventions noted in the wellness plan in an effort to determine if the established intervention(s) were effective. The wellness plan is reassessed and revised accordingly.
  Measurement:
  - Are we measuring what we aspire to quantify?
  - Are the interventions effective?
  - What do the pre and post-tests demonstrate?
- Each client identified as exhibiting a mental health disorder is referred to the psychiatrist for evaluation of comorbidity and/or his/her psychiatric needs. The treatment team works collaboratively with the psychiatrist to ensure that the client's substance abuse and mental health issues are addressed during treatment and throughout the development of the continuing care plan.
- Additional programming was augmented to enhance the client's treatment experience and to attend to the specific individualized needs of each client.

Thus far, Mountainside has promoted the co-occurring program, engaged complementary psychiatric
staff, appended psychiatric assessment materials, added TRE (Tension/Trauma Releasing Exercises), Mood Boost, Restorative Yoga and Integrated Positional Therapy to the Mind, Body, Spirit Program(MBS) and hired additional acupuncture staff.

Mountainside ensures that each primary clinician meets with his/her client in an individual session as least three (3) times weekly and reassesses the wellness plan at a minimum; every seven (7) days, uses an intervention method to assist clients who may be experiencing difficulties to remain in treatment, has augmented the nutritional component ;remaining cognizant of culture, preferences and medical issues, introduced a sleep sanctuary element to programming, added individual self-empowerment sessions, supported family wellness by enriching an already effective department and added an outcome measurement department.

The Outcomes Measurement Department is focused on categorizing and analyzing client data with the goal of understanding the full impact of the treatment experience on the client as it relates to both short and long term recovery. Mountainside offers a unique set of interventions that are implemented throughout the treatment continuum. The goal of the Outcome Measurement Department is to determine, through the collection and analysis of

data, the best individualized treatment options for each client during his/her stay at Mountainside.

Outcome data is a continuous process involving expectations for successful outcome in a broad range of life domains.2

And has:

- Continued to request that clients voluntarily complete two consumer surveys during the course of his/her treatment and just prior to discharge. Mountainside uses this information to address issues in the here and now, empower clients, enhance current programming, train staff and develop new programs endeavoring to give clients a best in class treatment experience.

Given the increase in co-occurring admissions, staffing enrichment, the increase in Specialized programming and research efforts, Mountainside has been preparing for and trusts that we are currently positioned to assist persons served who are diagnosed with a primary mental illness.

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:

TABLE 1
APPLICANT'S SERVICES AND SERVICE LOCATIONS

Service	Street Address, Town	Population Served	Days/Hours of Operation	New Service or Proposed Termination
Outpatient Psychiatric Clinic	187 South Canaan Rd Canaan, CT 06018	Target population: men and women over 18 years of age diagnosed with mental illness or a co-occurring disorder	Monday thru Friday 8:00am to 9:00pm On-call - licensed staff 24hours, 7 days a week, 24/7	New Service

   b. 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 2
SERVICE AREA TOWNS
List the official name of town*and provide the reason for inclusion.

Towns include: Salisbury, North Canaan, Canaan, Norfolk, Colebrook, Winchester, Barkhamsted, Sharon, Cornwall, Goshen, Torrington, New Hartford, Kent, Warren, Litchfield, Harwinton, New Milford, Washington, Morris, Thomaston, Plymouth, Bethlehem, Watertown, Woodbury, Roxbury and Bridgewater.

2 Practice Guidelines of Recovery-Oriented Health Care, Connecticut Department of Mental Health and Addiction Services (DMHAS)

The main reason rationale for locating an outpatient treatment facility in Canaan, CT is to enable us to better meet Mountainside's existing residential clients continuing care needs; and improve client health outcomes including reduced rates of relapse.

According to reports published in the Journal of the American Medical Association, approximately fifty percent (50%) of individuals with severe mental illness are affected by substance abuse. Thirty-seven percent (37%) of alcohol abusers and fifty-three percent (53%) of drug abusers have at least one serious mental illness. Of all individuals diagnosed as mentally ill, twenty-nine percent (29%) abuse either alcohol or another drug. (Source: National Alliance on Mental Illness).

The above data is consistent with what we have witnessed in our own client base. Over the past two and one half years (2 1/2), seventy-nine percent (79%) of clients admitted to Mountainside's residential treatment program have received extended care in Canaan, CT. Sixty-nine percent (69%) of this population were diagnosed with a co-occurring disorder. (Data source - Electronic Health Record).

It is essential that Mountainside address the ongoing needs of clients diagnosed with mental illness. The best chance of recovery is through integrated treatment for both the substance abuse problem and the mental health problems. This means getting combined treatment, hopefully through the same treatment provider or team (continuity of care). As the person served progresses in his/her journey it is imperative that the mental health issue is addressed ongoing in order to provide sustained supportive care and improve outcomes.

Other factors that were central to our choice:

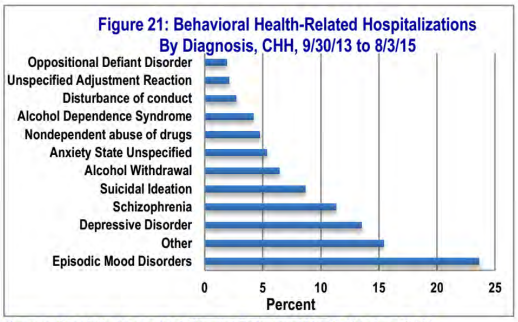
- Infrastructure is in place:
    - Physical environment
    - Spacious well-lit group rooms
    - Confidential Offices
    - Private Waiting Area
    - Psychiatric and Clinical staff engaged
- Minimal financial outlay

According to the Community Needs Assessment for Northwest, Connecticut (2015 update), Connecticut and the Northwest Region have experienced an increase in emergency department visits for mental health and chemical abuse. As we are aware, mental illness and substance abuse disorders affect individuals, families and communities in complex and challenging ways.3

Charlotte Hungerford Hospital Behavioral Health Services data for primary and secondary Mental Health diagnoses (DSM-5) for hospitalized patients from 2013-2015 are shown in Figure 21.4

3 Community Health Needs Assessment for Northwest Connecticut (2015 update) Collaborators: Development of the Community Health Needs Assessment for Northwest, CT 2015 Update is a collaborative and inclusive process that has engaged organizations, agencies and residents from across the Northwest Region.

4 . Community Health Needs Assessment for Northwest Connecticut (2015 update) Collaborators: Development of the Community Health Needs Assessment for Northwest, CT 2015 Update is a collaborative and inclusive process that has engaged organizations, agencies and residents from across the Northwest Region.

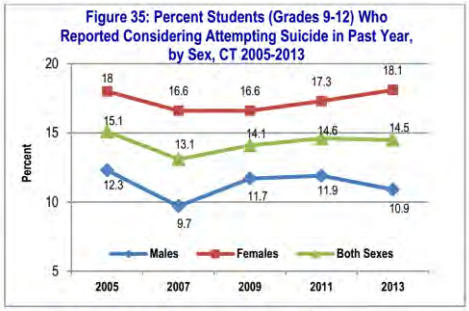


Source: Charlotte Hungerford Hospital-Behavioral Health Services, 2015

Episodic mood disorders, depressive disorder and schizophrenia were the top three behavioral health diagnoses in the Northwest Region.

According to this report Litchfield County is one of the underserved and health professional shortage areas (2013). The designations include: Dental Health, Primary Care and ***Mental Health.***

Based on the findings of 2013 Connecticut Health Survey, Youth Risk Behavior Component and Local Youth Survey conducted in Northwest Connecticut school districts in 2014-2015, mental health issues were relatively common, including depression and suicide ideation.3



Source: Youth Risk Behavior Surveillance - CT, 2005-2013
http://www.ct.gov/dph/lib/dph/hisr/pdf/cshs_ybc2013_report.pdf

By offering an industry-and-client preferred level of continuing care services within reasonable driving distance and within close proximity of the extended care provider, Mountainside will better able to ensure that our client's treatment and continuing care plans can be implemented with greater certainty through a step-down level of mental health services, delivered by the same provider. In a majority of cases, trusting relationships have been formed.

4. List the health care facility license(s) that will be needed to implement the proposal:
   Outpatient Psychiatric Clinic for Adults

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)

Canaan, CT Site	Wilton, CT Site
License # 0388	**License # 0609**
20 Residential Detox and Evaluation Beds	Psychiatric Outpatient Clinic
58 Intermediate and Long-Term and Rehab Beds	**License #0504**
Day or Evening Treatment	Chemical Maintenance Treatment
Outpatient Treatment	Outpatient Treatment

Attachment II: Licenses Canaan and Wilton, CT sites

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:

Key Personnel	
Roy Sasenaraine	Chief Operating Officer
Stephen Langley	Executive Director
Randall Dwenger, MD	Medical Director
Shanthi Mogali, MD	Director of Psychiatry
Sarah Osborne, LPC, LADC	Director of Clinical Operations
Amanda Molner, LMSW	Senior Clinician
Judith O'Callaghan, LMFT, LADC	Clinician
Abdul Shabazz, LPC eligible	Clinician

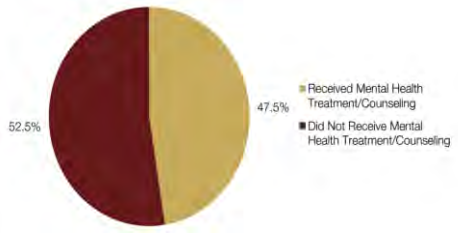
Attachment III: Curriculum Vitae – Key Personnel
Attachment IV: Job Description

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:

Behavioral Health Barometer, Connecticut 2015
NAMI National Alliance for Mental Health
ADAA Anxiety and Depression Association of America
Connecticut Department of Public Health, Healthy Connecticut 2020
State of Connecticut Suicide Prevention Plan 2020
Community Health Assessment for Northwest Connecticut 2015 Update
SAMHSA Mental Health and Substance Use Disorders (Updated 030/2016)
(DPH) Statewide Health Care facilities and Services Plan
Mental Health is Main Cause of Hospitalizations in CT, New Data Show
Article: On and Off Stage with Robin Williams
Article: Telling the Truth about Mental Illness
Article: How Mental Health is Misrepresented in the Media

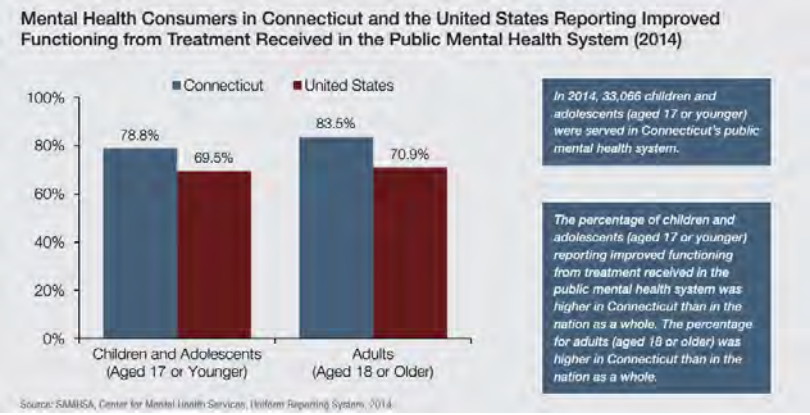
In Connecticut, two hundred fourteen thousand (214,000) adults age eighteen (18) or older with Any Mental Illness (AMI) (47.5%) of all adults with AMI) per year from 2010-2014 received mental health treatment counseling within the year prior to being surveyed. Fifty-two point five percent (52.5% did not receive treatment). 5

5 SAMSHA, Behavioral Health Barometer Connecticut, 2015; www.samhsa.gov



SAMSHA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health, 2010-2014

Eighty-three point five percent (83.5%) of adults in Connecticut eighteen (18) years or older reported improved functioning from treatment vs seventy point nine percent (70.9%) of the United States as a whole.

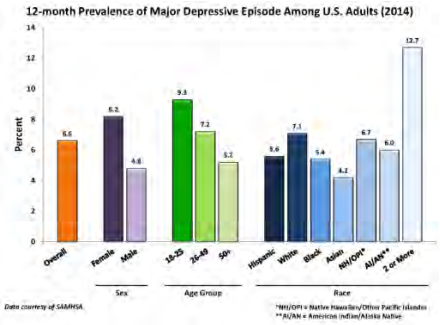


Because recovery in the mental health context refers to the process of changing one's attitudes, values, feelings, goals, and skills in order to live a satisfying life within the limitations caused by illness. Mountainside incorporates the services of alumni support, recovery monitoring, group and individual counseling, psychiatric care and medication monitoring. Here at Mountainside we empower our clients by assuring that supports are in place and with that recovery is achievable. Treatment is key.

One in four (1 in 4) adults approximately 61.5 million Americans experiences mental illness in a given year. One in seventeen (1 in 17) about thirteen point six (13.6) million live with a serious mental illness such as schizophrenia, major depression or bipolar disorder.

Mood disorders such as depression are the third most common cause of hospitalization in the United states for both youth and adults ages eighteen to forty-four (18-44), approximately 2.6% of American adults, 6.1 million people live with bipolar disorder and approximately 6.7% of American adults, about 14.8 million people live with major depression. Most notably, 18.1% of American adults about 42 million people live with anxiety disorders, such as panic disorder, obsessive-compulsive disorder (OCD), post-traumatic stress disorder (PTSD), generalized anxiety disorder and phobias and about 9.2 million adults have co-occurring disorders (mental health and substance abuse). One half of all chronic mental illness begins by the age of 14; three-quarters by age 24. Despite effective treatment there are long delays – sometimes decades – between the first appearance of symptoms and when people get help.6

6 NAMI, National Alliance on Mental Illness, Mental Illness Facts and Numbers, NAMI, www.nami.org



Mountainside currently uses five unique assessments to measure the client's baseline and ultimately his/her progress in wellness planning and throughout the treatment experience. The Assessment Series measures five (5) domains (depression, anxiety, cravings, sleep and ADHD).

As part of this Certificate of Need (CON), it would be judicious to look at mental illness as it pertains to both Attention Deficit Hyperactivity Disorder (ADHD) and Sleep Disorder.

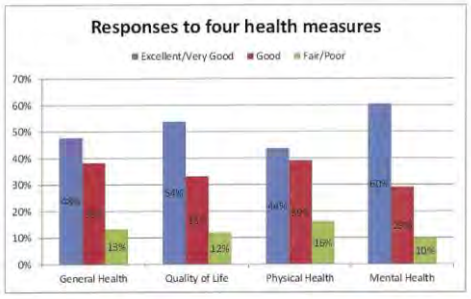
About sixty percent (60%) of children with ADHD in the United States become adults with ADHD; that is about four (4%) of the adult population, or eight (8) million adults. Less than twenty percent (20%) of adults with ADHD have been diagnosed or treated, and only about one-quarter of those adults seek help.

Symptoms of ADHD often include an inability to focus, disorganization, and restlessness/sleeplessness. Adults with ADHD may have a hard time organizing things, listening to instructions, remembering details, or difficulty completing tasks, which can affect their relationships at home, school and work. Overlapping symptoms of comorbid psychiatric conditions often complicate getting an accurate diagnosis. About fifty percent (50%) of adults with ADHD also suffer from an anxiety disorder. Adult ADHD symptoms that coexist with an anxiety disorder or other disorders may significantly impair the ability to function.7

According to Dr. Andrew D. Krystal, "It has long been appreciated that sleep problems are common among those with psychiatric disorders. The longstanding view that treating some psychiatric conditions improves sleep is complemented by recent evidence suggesting that treatment sleep disturbances can have import effects on the outcome of treatment of psychiatric disorders.8 The work in this field has increased over time. Mountainside is working with clients who have difficulty sleeping to identify treatment modalities that may assist over time.

Detailed Findings: ***Sleep and Health***

Americans were asked to rate their general health, quality of life, physical health, mental health, level of stress and level of fatigue. As reported in the figure below, approximately half of respondents rated their general health, quality of life, physical health and mental health very good or excellent.



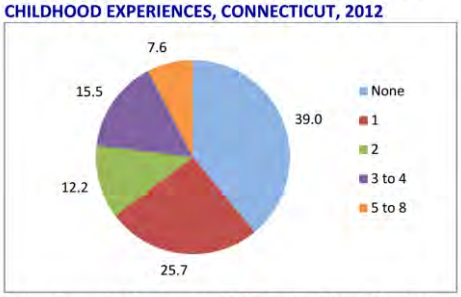
Additionally, according to *Healthy Connecticut, Department of Public Health 2020, State Health Assessment*, it was noted that trauma exposure is an issue that is gaining public health attention and is increasingly prevalent. Special populations affected by trauma include veterans and members of

7 ADAA Anxiety and Depression Association of America, https://www.adaa.org/understanding -anxiety/related-illnesses/other-related-conditions/adult-ADHD
8 Psychiatric Disorders and Sleep, Andrew D. Krystal, M.D., M.S.

communities who have experienced large scale psychological trauma from events such as natural disaster, or other stressors concentrated in their communities. FY 2011, there were twenty-five thousand eighty-five (25,085) clients at DMHAS who were screened for trauma. Of these, thirty percent (30%) screened positive for trauma or symptoms of trauma. Fifty-three percent (53%) were screened by addiction programs to which they were admitted, forty-six percent (46%) were screened by mental health programs and one percent (1%) were screened by forensic mental health programs.
Exposure to trauma may affect mental health, physical health and functioning in the family, at school, or among peers.

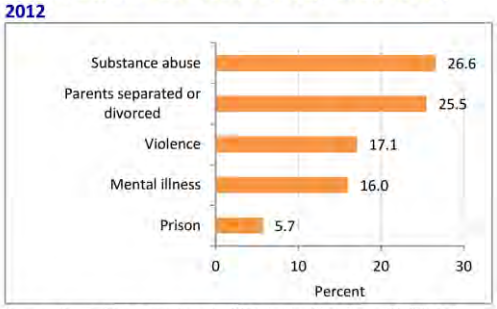
Traumatic events include experiences of sexual abuse, physical abuse, domestic violence, medical trauma, motor vehicle accidents, acts of terrorism, war, natural disasters, suicides and other events. Persons exposed to trauma may experience threat of injury, death, or personal integrity that causes feelings of fear, terror, or helplessness. In 2012, sixty-one percent (61%) of adults reported verbal abuse, seventeen point seven percent (17.7%) reported physical abuse and eight point eight percent (8.8%) reported sexual abuse during childhood. At least one adverse childhood experience affected one point six (1.6) million residents in Connecticut.9

Fig. 255. PERCENT OF ADULTS WHO REPORT ADVERSE CHILDHOOD EXPERIENCES, BY NUMBER OF ADVERSE CHILDHOOD EXPERIENCES, CONNECTICUT, 2012



Source: Connecticut Department of Public Health, *Adverse Childhood Experiences in Connecticut,* 2013.

Fig. 256. PERCENT OF ADULTS WHO EXPERIENCED HOUSEHOLD DYSFUNCTION, BY TYPE, CONNECTICUT, 2012



Source: Connecticut Department of Public Health, *Adverse Childhood Experiences in Connecticut,* 2013.

Mountainside employs staff who are certified in trauma, EMDR is available to clients admitted to Mountainside and trauma assessments are completed as appropriate.

According to the Connecticut Health Investigative Team
Mental Health is the main cause of hospitalizations in Connecticut. Mental disorders surpassed respiratory problems and all other ailments as the leading cause of hospitalization in Connecticut in 2012 children ages 5 to 14, teenagers and younger adults, according to a new state health department report.
The data shows five (5) hospitals had increases of more than twelve (12%) 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 sixty-one percent (61%), and inpatient days jump fifty-one percent (51%) and Waterbury Hospital, with twenty-six percent (26%) more patients and a thirty-seven percent (37%) increase in inpatient days. Carl Schiessl, director of regulatory advocacy for the Connecticut Hospital Association, said the association's own data show that in 2014, more than twenty-five percent (25%) 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 2010-2014, hospitals saw a thirty-one percent (31%) increase in patients with a behavioral health diagnosis. Schiessl noted that will limited resources it is a *situation that is getting worse* in the State of Connecticut. 10

Suicide

According to SAMHSA (Behavioral Health Barometer Connecticut 2015), Connecticut's percentage of adults with suicidal thoughts was similar to the national percentage in 2013-2014. In Connecticut, about 92,000 adults aged 18 or older (3.3%) of all adults per year in 2013-2014 had serious thoughts of suicide

9 Connecticut Department of Public Health, Healthy Connecticut 2020, State Health Assessment
10 According to the Connecticut Health Investigative Team, http://c-hit.org/2015/04/19/mental-health-is-main-cause-of-hospitalizations-in-ct-new-data-show/

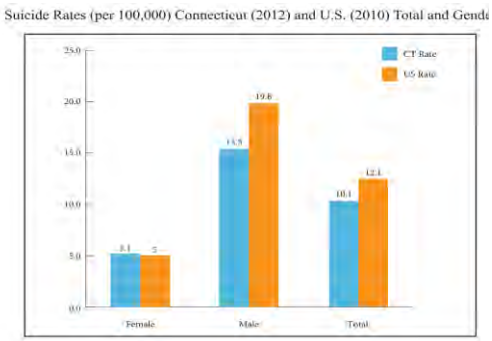
within the year prior to being surveyed. The percentage did not change significantly from 2010-2011 to 2013-2014. 11

Additionally, given the seriousness of the significance of suicide, the State of Connecticut has developed a (*Suicide Prevention Plan 2020, One Word, One Voice, One Life)* which was launched in 2012. The plan explains that suicide deaths are largely preventable. Therefore, a concerted force (committee) organized around the guiding principles outlined in Plan 2020 to address this tragic public and mental health problem. Plan 2020 establishes five (5) goals and twenty-two (22) objectives for Connecticut to initiate State Prevention Activities. The PLAN 2020 is designed to be accessible to everyone and it is the State of Connecticut goal that individuals, communities, institutions and organizations use the plan as their working template to guide their efforts small and large to prevent suicide attempts and deaths and ultimately save lives in Connecticut. The plan includes specific outcomes for 2020.
The World Health Organization reports that each year nearly one million people die by suicide resulting in a mortality rate of sixteen (16) per one hundred thousand (100,000) or a death every forty (40) seconds. This represents an increase over the past forty-five (45) years of sixty (60%), and it is estimated that by the year 2020, suicide will account for two point four percent (2.4%) of the global disease burden. In the United States suicide and suicidal behaviors have been identified as major public health problems that have far reaching personal, social and economic implications. In 2012, there were forty thousand six hundred (40,600) deaths by suicide. In contrast, during the same year, there were fourteen thousand eight hundred and twenty-seven (14,827) homicides (US Department of Justice, 2013) and thirty-three thousand five-hundred and sixty-one (33,561) motor vehicle fatalities (NHTSA, 2013).
Suicide is the tenth (10th) leading cause of death in the United States, accounting for the deaths of approximately 43,000 Americans in 2014.12

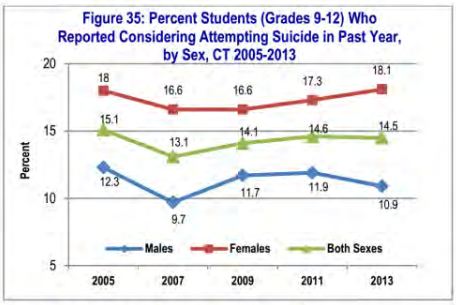
Suicide is the tenth (10th) leading cause of death. Suicide rates have been steadily increasing by more than two (2%) a year (CDC, 2013). Those persons with existing mental health conditions, including substance abuse, are at increased risk for suicidal thoughts, attempts and deaths; it is estimated that ninety percent (90%) of those who die by suicide have at least one diagnosable mental health condition, most commonly a mood disorder. Those with anxiety disorders, borderline personality disorder and schizophrenia are also at elevated risk.

Finally, those with a history of prior suicide attempts remain at the highest risk of dying by suicide. This according to PLAN 2020 has important implications for the need for a broad view of prevention and treatment. 13

Source: State of Connecticut, Department of Public Health. Annual state population with demographics. Retrieved from http://www.ct.gov/dph/cwp/view.asp?a=3132&q=388152; Accessed 2/2/14.
Office of Connecticut Medical Examiner Deaths by Suicide 2006-2012 Retrieved 5/29/13
Healthy People 2020. US rates based on 2010 data. http://www.healthypeople.gov/2020/Data/SEarchREsult.aspx?topicid=28&topic=Mental+Health+and+Mental+Disorders&objective=MHMD-1&anchor=124



11 SAMSHA, Behavioral Health Barometer Connecticut, 2015; www.samhsa.gov
12 Department of Public Health (DPH): Keeping Connecticut Healthy, Where to Find Evidence-based Methods and Interventions; OCHA website
13 State of Connecticut Suicide Prevention Plan 2020, One Word, One Voice, One Life



Source: Youth Risk Behavior Surveillance - CT, 2005-2013
http://www.ct.gov/dph/lib/dph/hisr/pdf/cshs_ybc2013_report.pdf

Attachment V: Scholarly articles, studies or reports

d. Letters of support for the proposal:

Sharon Hospital
Turnbridge
Primary Recovery Services

Attachment VI: Letters of Support

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.

The most relevant and current standards of practice applicable to the proposed project are outlined in the Treatment Improvement Protocol (TIP) 47 and (TIP) 42, published by the Substance Abuse and Mental Health Services Administration (SAMHSA) (2006). This publication, titled Substance Abuse: Clinical Issues in Intensive Outpatient Treatment (TIP 47) and Substance Abuse for Persons with Co-occurring Disorders (TIP 42), clearly identifies several Principles of Intensive Outpatient Treatment (see excerpts in **Attachment VI).** 14

These include (with brief responses describing how Mountainside will address each):

Make treatment readily available:
Mountainside OP/IOP service availability will be guaranteed for the target population, with initial sessions scheduled in advance, for all clients referred directly from Mountainside's residential services. Intake sessions will occur within seventy-two (72) hours of initial call.

Ease of entry
Prior to outpatient treatment admission, client treatment records will be available following the completion of confidentiality regulations-compliant forms by the client. Since outpatient and residential programs are both operated by the same entity, entry will be efficient.

Build on existing motivation
Mountainside residential staff work with each client to encourage continuing care the completion of a continuing care plan prior to discharge from treatment. With no lapse in continuity of care between residential and outpatient treatment, the direct transfer of clients will ensure the maximization of existing client motivation to continue his/her journey.

14 Treatment Improvement Protocol (TIP) 47 and (TIP) 42, published by the Substance Abuse and Mental Health Services Administration (SAMHSA) (2006). This publication, titled Substance Abuse: Clinical Issues in Intensive Outpatient Treatment (TIP 47) and Substance Abuse for Persons with Co-occurring Disorders (TIP 42), clearly identifies several Principles of Intensive Outpatient Treatment

Enhanced Therapeutic Alliance
Mountainside outpatient staff will receive clinical supervision and training with a major focus on engagement skills and other critical factors associated with positive client outcomes. If the potential candidate has participated in the residential program outpatient staff will be afforded the opportunity to meet with the client prior to discharge; providing a veritable continuity of care.

Make retention a priority
Along with engagement, client retention will be a primary performance measure for clinical staff. It will be included as a criterion in annual reviews. Additional efforts to maximize retention will include the use of on-site recovery support meetings and activities to build community among clients.

Assess and address individual treatment needs
An important component of the IOP Program will be case management. Along
with a comprehensive, ongoing clinical assessment, and individual wellness plans, the primary clinician will be responsible for coordinating needed rehabilitative and recovery support services within Mountainside and in the community.

Provide ongoing care
As each client progresses toward his/her treatment goals, monthly reviews will determine the need for, and intensity of, continuing care services. Mountainside will adjust the frequency of outpatient services accordingly, including moving from three (3), three (3) hour Intensive Outpatient sessions per week; to weekly, monthly and eventually quarterly check-in sessions as defined in the individual wellness plan and in team review with the clinician, psychiatrist and other designated treaters.

Monitor mental health issues and as appropriate, abstinence
In addition to weekly observations by staff for physical, behavioral and attitudinal signs of possible chemical use, medication noncompliance or other emerging issues, medical and clinical staff conduct routine and random urines toxicology screens and medication levels on clients. UTox screening is processed through a certified laboratory.

Use mutual help and other community based supports
Mountainside is grounded in the Twelve Steps of Alcoholics Anonymous/Narcotics Anonymous. All outpatient clients are expected to attend AA/NA and/or other appropriate recovery groups and meetings on a regular basis. Such expectations are outlined in writing in each individualized wellness plan.

Use of medications, as indicated
The Mountainside Medical Director and Director of Psychiatry (M.D.) have considerable experience working with individuals experiencing mental illness, co-occurring disorders and substance abuse. While they recognize that professional literature supports the combination of evidenced-based psychosocial therapy and medication-assisted treatment, they take a conservative approach to the use of medication, avoid prescribing those medications with abuse potential, and provide client education.
Educate
Formal education about mental illness, substance abuse, recovery, relapse, family dynamics, wellness and other essential components to recovery is a hallmark of the Mountainside approach, and will be delivered through psycho-educational sessions, process groups, psychiatric evaluation and follow-up, medication management, individual session, individualized collaborative wellness planning, assignments, family programming and added supports as needed.

Engage families, employers and significant others
Family interventions, family therapy and family education will be offered to Mountainside clients/families with the assistance of a Licensed Marital and Family Therapist (LMFT) and Licensed Clinical staff according to individual wellness plans. As appropriate, families will be invited to visit the facility to address the individual goals and continued needs of both the client and family as a whole. For those who are distant from their family members and/or significant others, Mountainside may employ telemedicine and/or telephone/SKYPE voice/video interface to enhance the quality of distance therapy. As appropriate, those area employers who are supportive will be

engaged to provide support through properly client authorized communication with staff.

Incorporate evidence-based approaches
Mountainside utilizes an approach that incorporates research-supported practices, clinical experience, client preferences and feedback as evidence upon which to base the selection of approaches for each individual. This is known as "evidence based practice" as a process. Through this process, individual "evidence-based" interventions may be selected on an individual client basis. Mountainside will typically utilize additional, select practices such as Motivational Interviewing (MI), Cognitive-Behavioral Therapy (CBT), Dialectical Behavioral Therapy (DBT), among others.

Improve program administration
Mountainside benefits from the existing administrative infrastructure of MC1 Healthcare, LLC (d.b.a. Mountainside Treatment Center) which has eighteen (18) years of experience in developing and managing services at the Canaan site to individuals with addictions and co-occurring disorders.
Mountainside continues to grow in scale, diversity of services and sophistication, while drawing upon the talents of individuals with extensive executive, managerial and supervisory experience. The current executive staff will continue to provide expert guidance while drawing on input from line staff, clinical staff and the client population.

Additionally, the core principles of Recovery Oriented Treatment (DMHAS) focuses on "person centered" treatment planning – "nothing about us, without us." The client has reasonable control as to the location and time of planned meetings, as well as to who is involved in the wellness planning process. The focus of planning is on how to create pathways to meaningful and successful community life and not just on how to maintain clinical stability and/or abstinence.
This is primary to the care of the two hundred and six (206) clients who prefer to remain in Canaan, CT.

f. (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.

Memorandum of Understanding/Service Agreements/Contracts
Charlotte Hungerford Hospital: Patient Transfer Agreement
Sharon hospital Memorandum of Understanding
Sharon Hospital Laboratory: Phlebotomy
Physician Choice Laboratory Services (PCI) Services Agreement
Citrix Access for Sharon Hospital Meditech
West River Pharmacy (MedStat Pharmacy)
GeneSight Registration and Agreement
Yale New Haven Hospital Memorandum of Understanding
Affiliation Agreement with Sharon Hospital and Touro College of Osteopathic Medicine

Approximately seventeen percent (17%) of American adults have comorbid mental health and medical conditions which are risk factors for each other and the presence of one can complicate the treatment of the other.

Mountainside works collaboratively with Charlotte Hungerford Hospital in the event a client requires inpatient psychiatric care. Mountainside also works closely with Sharon Hospital in the event a client requires medical treatment. Because behavioral health disorders and medical conditions often co-occur, which raises the risk of suboptimal outcomes.

Attachment VII: Memorandums of Understanding/Agreements/ Contracts

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.

   Mountainside is guided by the policies and standards in the regulations adopted by the Connecticut Department of Public Health which incorporate governance, executive staff, fiscal policies, personnel policies, environment of care, basic requirements, special requirements, Service areas, environment details, emergency and disaster procedures, accident and incident reports, service operations, continuing care activities and other agency agreements and in accordance with the appropriate level of care medication control policies.

   Governance: The governing body develops written policies and protocols for the organization's mission and purpose, ensures that Mountainside is operating in accordance with its mission provides financial oversight to ensure that proper financial controls are in place, ensures adequate financial resources as part of their fiduciary responsibility, which may include such responsibilities as personal contribution, financial planning, has appointed executive director, is responsible for record management, program evaluation, personnel, and maintenance aspects of facility operations. The Governing Body has established an organizational chart, reviews policies semi- annually and serves as a client advocate.

   Executive Director: The designated executive director is accountable to the governing body and is responsible for the day-to day management of Mountainside.

   Fiscal Policies: The VP of Finance in conjunction with the governing body and chief operating officer, develops and implements written policies and procedures which govern the fiscal operation. On a yearly basis, undergoes a financial statement audit performed by an independent accounting firm to ensure its financial statements are present fairly and in accordance with US Generally Accepted Accounting Principles. The auditor's opinion and the report is distributed to the owners of Mountainside and other stakeholders. The report includes the monthly and year to date balance sheet, income statement and statement of cash flows. In addition, the report provides budget vs. actual variances and analysis. In coordination with the month-end reporting, each department manager receives a copy of his or her budget to actual reports. The reports include a monthly comparison to budget, a listing of all the activity allocated to their respective departments and a year to date comparison to the budget. Each manager is expected to review the budget to actual reports to see where variances have occurred, and to make sure that the budget allocated and expense assigned is correct. Records of financial arrangements and transactions are retained in the client's electronic health record for a period of seven (7) years. Clients are advised verbally at the time of prescreening and in writing at admission of all fees and payments charged by Mountainside.

   Personnel Policies: Mountainside follows all guidelines as defined by the Department of Public Health having developed policies and procedures that address recruitment, selection, promotion and termination of staff as well as policies and procedures relating to wage and salary administration, employee benefits, organizational chart, employee work rules, disciplinary action including suspension or dismissal of staff as well as an annual job performance evaluation. Mountainside is an equal opportunity employer, confidential personnel files are maintained identifying all personnel and contain each of the following; an application, resume, licensed staff credential verification, a physical, PPD, job performance evaluations and documented orientation. Each employee participates in a formal orientation, completes assignments as designated in the Relias system and receives an individualized job related 30-60-90-day orientation plan. Clinical staff receives ongoing scheduled clinical supervision by licensed staff and line staff receive ongoing supervision from the designated department manager. All staff are consistently trained in order to maintain current skills and provide for growth in skills which relate to the services offered. In-service training/workshop seminars are documented with date, topic discussed and person conducting the session.

Each job description defines duties to be performed, supervision received, minimum qualifications and revision dates. There are written policies and procedures addressing internship: screening, training, supervision, limitations as to duties, responsibilities and as appropriate termination of services.

Environment of Care: Physical Plan: Mountainside adheres to the standards established by the following sources for the construction, renovation, alteration, maintenance and licensure of all facilities; State of Connecticut Basic Building Code, State of Connecticut Fire Safety Code, State of Connecticut Public Health Code and Local Codes and Ordinances. Mountainside is structurally sound and equipped in a safe and sanitary manner to prevent or minimize all health and fire hazards. Building equipment and services are maintained in a good state of repair. Mountainside has established distinct maintenance schedule to ensure that the interior, exterior and grounds of the building is maintained, clean and free from accumulations of refuse, dilapidated structures or other health hazards.

Basic Requirements: The Canaan site is accessible to the community and to emergency Service vehicles. Established walkways are provided for each exit from the building leading to the driveway and the street. Pubic areas are available. The lobby is well-lit, well-furnished, clean and inviting. A reception area and waiting area is provided, as well as public toilet facilities and telephones upon request. There is storage space for equipment and supplies. Mountainside utilizes an Electronic Health Record (Sigmund).

Special Requirements: The infrastructure is in place for the Outpatient Psychiatric Clinic. Private office space is available to conduct direct client services.

Service Areas: Mountainside provides outpatient/IOP space for group therapy activities, general meetings, educational and other purposes. The area exceeds twenty-five (25) square feet.

Environment Details: All areas used by clients have temperatures not less than 68 degrees F, hot water heating equipment is of sufficient capacity to supply hot water at the temperature of 110-120 degrees F and at amounts required at all times. Central heating systems are used, walls, ceilings and floors are maintained in an excellent state of repair, the minimum width of all doors to rooms accessible to clients are two feet four inches. Effective measures are taken to protect against the entrance into the facility or breeding on the premises of vermin. All windows that open to the outside are effectively screened.

Emergency and Disaster Procedures: Written policies and procedures governing appropriate interventions in the event of an emergency or disaster have been developed and institutionalized. The procedures address: documented orientation of all staff and intern's in the use of fire extinguishers, evacuation plan and the diagram of the facility exit routes, to emergency and disaster procedures. Fire plans and procedures are posted in conspicuous areas throughout the facility and emergency and disaster drills are conducted on a monthly basis for residential clients and on a quarterly basis for all outpatient/IOP clients. Designated staff are assigned specific duties in the event of a disaster or emergency. Additionally, a written plan is available for checking accident and incident reports and first aid supplies on a monthly basis. The plan specifies the supplies to be stocked, the required amounts of each supply and position title of any staff person responsible for the audit. This audit is documented.

Accident or Incident Reports: The Executive Director reports any accident or incident to the Department. The following classifications of such events are employed in accordance with the Department of Public Health regulations (Class A {one which has resulted or had the potential to result in serious injury or death}, Class B, {one which has interrupted or has the potential to interrupt the services provided by the facility} or Class C {One which results in legal action against the facility}). In the event of a Class A or B incident and immediate phone call is placed to the department and confirmed by a written report within seventy-two hours of the event. For

a Class C incident a written report to the department is provided within seventy-two hours of the initiation of legal action. Mountainside ensures that each report contains the following information: Date of report and date of event, facility classification, identification of the individuals affected by the event, including, where available; client identification and age, name of the employee, visitor, or other, nature of the incident, action to be taken by the facility and disposition. If the affected individual is or was at the time of the reported event a client of Mountainside; the Executive Director forwards the following information to DPH: Date of admission, current diagnosis, physical and mental status prior to the event and physical and mental status after the event. Additionally, the location, nature and brief description of the event is forwarded, as is the name of the physician consulted and time of notification of the physician. A report is also summarized by the physician regarding a completed physical examination. This summary includes findings and orders. Witnesses to the event are noted and the report is signed by the Executive Director. The Executive Director as the contact person responds to/submits subsequent reports as required.

Service Operations: Mountainside audits client records on a monthly basis. Each clinician is seen in individualized clinical supervision twice monthly and in group supervision twice monthly. The record, wellness planning, documentation and initial continuing care plans are consistently reviewed (do the goals speak to the issues specific to this client, have the goals been met, are they time-limited, do the goals speak to the client's strengths, has the client assisted in the development of the plan, does the plan need to be reassessed; if so has this been accomplished?) Client records are organized, there is a written record for each client, clients are advised of his/her rights. The biopsychosocial assessment focuses on social or family background, next of kin or designated individual to be notified in the event of an emergency, physical examination, medical history, substance abuse history, mental health issues, mental status, MHF-III, risk assessment as appropriate, educational background, employment history, referral source summary and reason for referral, medication, legal history, releases, individualized wellness plan, description and frequency of services. Specific objectives are formulated which relate to stated goals, name of assigned staff who will develop the plan in collaboration with the client. Each individual client record contains progress notes which document services provided to the client and progress made towards goals and objective in accordance with the individualized care plan. Each record contains a current list of medications and instructions for administration thereof. Each client record contains documentation of the periodic date of the review, person conducting the review and any changes in the individualized wellness plan as a result of the review. The client record also contains a discharge summary and a continuing care plan. This record is completed within seven (7) days of client discharge and includes; the client's progress towards the established individualized care plan goals, original reason for referral, type, frequency and duration of treatment or services, reasons for discharge and expectations for future functioning. Client records are retained for seven (7) years. Prior to the utilizing the EHR, client records were in hard copy. All hard copies will be incinerated or shredded at the seven (7) year mark.

Admissions, Discharge, or Referrals: Mountainside has developed policies that govern admissions, discharges and referrals. The policies include: Identification of the target population and length of stay, preadmission criteria, criteria for admission and readmission; for voluntary and involuntary discharge, discharge summaries and continuing care plans.

Other Agency Agreements: Mountainside has agreements/memorandums of understanding and contracts with several area providers, hospitals, a laboratory, phlebotomy services and a pharmacy. Please see attachments.

Staffing: The proposed Psychiatric Clinic roster includes: Medical Director (board certified psychiatrist), Director of Psychiatry (board certified psychiatrist), Director of Clinical Operations, Senior Clinician and two (2) Clinical staff, all of whom provide direct care.

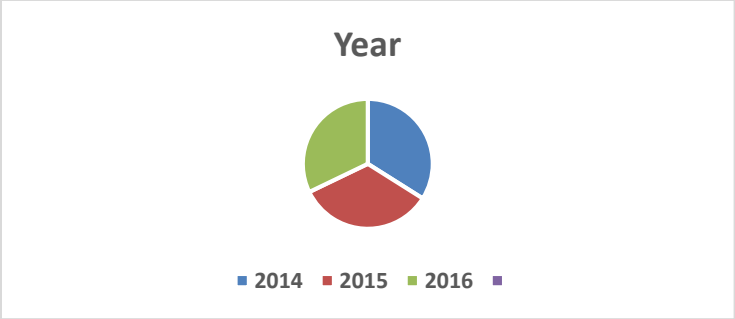
7. Describe how the proposed project aligns with the Connecticut Department of Public Health Statewide Health Care Facilities and Services Plan, available on OHCA's website.

According to the *Department of Public Health: Keeping Connecticut Healthy* the goal is to improve mental health through prevention and by ensuring access to appropriate quality mental health services. "Mental health are health conditions that are characterized by alterations in thinking, mood, and/or behavior that are associated with distress and/or impaired functioning. Mental disorders contribute to a host of problems that may include disability, pain, or death.15
According to DPH, mental disorders are among the most common causes of disability. The resulting disease burden of mental illness is among the highest of all diseases.

Attachment VIII: Department of Public Health: Keeping Connecticut Healthy

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

   a. Identify the target patient population to be served:
   Mountainside's target population is men and women ages 18 years of age and older. The clients include those with relatively high net worth, with many from the high income communities. A number of clients whose continuing care plan incorporates sober housing and OP/IOP care are returning to towns within Litchfield County (Northwest Region) or remaining in Canaan, CT and bordering areas.



Admissions Client Diagnosed with a Co-Occurring Disorder
2016 (Only January – August, 2016)

Admissions to Mountainside:
Of the four thousand-ninety-eight (4,098) admissions to Mountainside in the past two and one half (2 1/2) years, two thousand fourteen (2,014) clients were diagnosed with a co-occurring disorder or (71.11%) of the clients treated.

- (2014 – 72.32% diagnosed with a co-occurring d/o)
- (2015 – 72.24% diagnosed with a co-occurring d/o)
- (2016 seven (7) months diagnosed with a 68.47% co-occurring d/o)

Referrals to Mountainside include a growing percentage of those with a co-occurring disorder. Similar to other programs across the state, Mountainside has seen a dramatic shift in clients being admitted who have a confirmable mental health diagnoses.

   b. Discuss how the target patient population is currently being served:

   The proposed Canaan, CT outpatient target population is currently being served in several parallel and lower levels of care by a variety of community providers; from an assortment of towns and states.

15 Department of Public Health (DPH): Keeping Connecticut Healthy, Where to Find Evidence-based Methods and Interventions; OCHA website

Approximately fifty-two (52) clients completing Mountainside residential treatment, were referred to Outpatient or Intensive Outpatient treatment in Litchfield County and seven (7) clients were referred to a private psychiatrist or therapist in Litchfield County. Two-hundred and six (206) clients were referred for extended care choosing to remain in Canaan, CT. Sixty-nine percent (69%) of the clients referred to Canaan and other facilities located in Litchfield County were diagnosed with a co-occurring disorder.

A small percentage of the clients given to Mountainside's care "only" attend self-help groups. A significant percentage of discharged clients receive other services in conjunction with attending self-help.
Alumni Services are offered to all clients who discharge from Mountainside because recovery is a life-long journey, and Mountainside is committed to being a partner to our alumni along the way. Our care and support extends beyond our campus to wherever our alumni choose to continue their paths of recovery. Mountainside's Alumni Program provides alumni a variety of opportunities to have fun, stay connected to their recovery and to each other, and give back while supporting the positive life changes they have made in treatment. More importantly, our program aims to create and foster a strong alumnus community of like-minded, wellness-oriented individuals that are passionate about helping each other live happy and healthy lives free of addiction.

Our Alumni program includes:
Alumni Share Night: Alumni Share Night: Alumni with at least six months of sobriety share personal stories of recovery with current Mountainside clients who are just starting on their paths to recovery. To learn more or to schedule a time to return and share your story, please email us.
Alumni Support Groups: Alumni-led group for sharing and receiving feedback in a safe, open, honest and healthy environment.
Recovery Meetings: Mountainside hosts several weekly, 12-Step speaker meetings open to all individuals in the community.
Alumni Events: Recreational and social activities that support wellness and long-term recovery, including quarterly gatherings and an annual retreat.
Alumni E-Newsletter: A monthly publication featuring strategies for maintaining sobriety, wellness tips, book recommendations, recipes for recovery as well as an alumni spotlight and Mountainside news.
Alumni Twitter: Daily quotes @MtnsideAlumni to help inspire you and reinforce your commitment to recovery.
Alumni Ambassador Program: An opportunity to give back by volunteering to help those new to recovery and/or those hoping to start recovery. Ambassadors can help provide more information about the Mountainside program to potential clients, act as mentors.

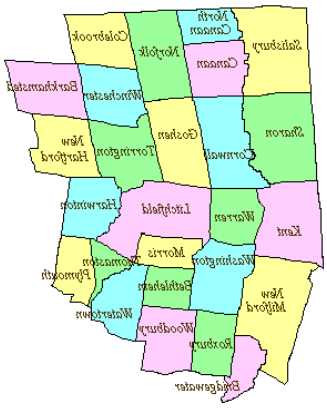
Most significantly, a considerable amount of Mountainside staff is trained as Recovery Guides. Within this model, care incorporates the fact that the lives of people in recovery did not begin with the onset of their disorders, just as their lives are not encompassed totally by substance abuse or psychiatric treatment and rehabilitation. Based on recognition of the fact that people were already on a journey prior to the onset of their disorders, and therefore prior to coming into contact with care, the focus of care shifts to the ways in which this journey was impacted or disrupted by each person's disorder. For example, practitioners strive to identify and understand how the person's substance use or psychiatric disorder has impacted on or changed the person's aspirations, hopes, and dreams. If the person appears to be sticking resolutely to the hopes and dreams he or she had prior to onset of the disorder, and despite of or without apparent awareness of the disorder and its disabling effects, then what steps need to be taken for him or her to get back on track or to take the next step or two along this track? Rather than the reduction of symptoms or the remediation of deficits—goals that we assume the person will share with care providers—it is the person's own goals for his or her life beyond or despite his or her disability that drive the treatment, rehabilitation, and recovery planning and efforts.

The primary vehicle for the delivery of most behavioral health interventions is the relationship between the practitioner and the person in recovery. The care provided must be grounded in an appreciation of the possibility of improvement in the person's condition, offering people hope and/or faith that recovery is "possible for me." Practitioners convey belief in the person even when he or she cannot believe in him or herself and serve as a gentle reminder of his or her potential. In this sense, staff envision a future for the person beyond the role of "mental patient" or "addict" based on the person's own desires and values and share this vision with the person through the communication of positive expectations and hope. A continuity of care affords the client the opportunity to build on trusting relationships that have already been forged in treatment.

c. Document the need for the equipment and/or service in the community:
The anticipated capital expenditure of $10,000 for equipment will be paid by MC1 Healthcare, LLC using cash.

d. Explain why the location of the facility or service was chosen:

Accessibility: Route 44 is an east-west US Highway that runs for 237 miles. The major intersections include US 7 North Canaan, I-84/US6.
US Route 7 continues to the Massachusetts State line in Canaan. It is a north-south US Highway which runs 78 miles in the State of CT. Route 8 is the portion of the multistate New England Route 8 within the State of CT. It is a 67.36-mile state highway running north and south from Bridgeport all the way to Massachusetts. The freeway portion of Route 8 ends at US Route 44,
Proximity: Since a portion of our clients will travel to the facility up to three times per week, drive time is an important factor. 79% of our residential clients were discharged to extended care in Canaan; a large portion of clients are within a 30-minute drive range, should he/she prefer to receive services from Mountainside.



Privacy: Mountainside's private location affords our clients anonymity and privacy. The parking area is private, shielded from Route 7, as is the waiting area, the group rooms and the office space.

The Infrastructure is in place to serve the 79% of clients remaining in Canaan (*69% of whom are diagnosed with a co-occurring disorder). Mountainside has the ability to provide a true continuity of care.
There are no psychiatrists practicing in Canaan, CT and Community Mental Health Affiliates of Lakeville, CT closed, which was approximately 8.6 miles from Mountainside Treatment Center.

Lastly, while convenience is generally highly valued by clients; if it is necessary for some clients to voluntarily drive up to thirty (30) minutes each way for treatment, this will be offset by the benefit that he/she are less likely to be seen by friends and neighbors when accessing services that are located away from his/her hometown. The client may also choose to participate in treatment with individuals that may have also recently completed residential treatment at the Canaan, CT site providing a true continuity of care.

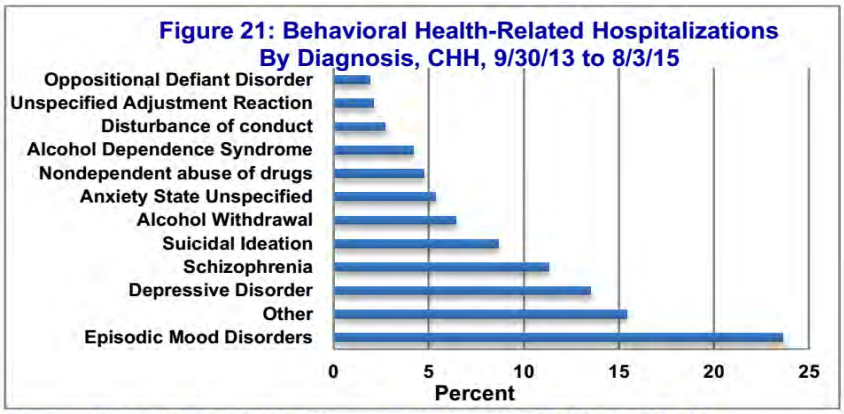
e. Provide incidence, prevalence or other demographic data that demonstrates community need:

The general population segment within which the target population rests, includes adults eighteen (18) years of age and older with diagnosable mental health or co-occurring disorder.
According to NAMI (National Alliance on Mental Illness:

One in four (1 in 4) adults approximately 6,105 million Americans experience mental illness in a given year. One in seventeen (1 in 17) about thirteen point six (13.6) million live with a serious mental illness such as schizophrenia, major depression or bipolar disorder.

Mood disorders such as depression are the third most common cause of hospitalization in the United states for both youth and adults ages eighteen to forty-four (18-44), approximately 2.6% of American adults, 6.1 million people live with bipolar disorder and approximately 6.7% of American adults, about 14.8 million people live with major depression. Most notably, 18.1% of American adults about 42 million people live with anxiety disorders, such as panic disorder, obsessive-
compulsive disorder (OCD), posttraumatic stress disorder (PTSD), generalized anxiety and phobias and about 9.2 million adults have co-occurring disorders (mental health and substance abuse). One half of all chronic mental illness begins by the age of 14; three-quarters by age 24. Despite effective treatment there are long delays – sometimes decades – between the first appearance of symptoms and when people get help.16

Most notably; The 2015 County Health Rankings report indicates that Litchfield County has a ratio of one (1) Mental Health provider to every five hundred and forty-eight (548) residents, considerably below the national benchmark of one (1) provider to every three hundred and eighty-six (386) residents



Source: Charlotte Hungerford Hospital-Behavioral Health Services, 2015

Litchfield County also has a shortage of primary care providers, with one (1) primary care physician to every one thousand five hundred sixty-three (1,563) residents, well below both the national benchmark of one (1) primary care provider for every one thousand persons and the State average of one (1) primary care physician per one thousand one hundred ninety (1,190) residents.17

NAMI: Prevalence of Mental Illness speaks to the need for additional services, continuity of care and solid continuing care planning.

- Approximately 1 in 5 adults in the U.S.—43.8 million, or 18.5%—experiences mental illness in a given year.
- Approximately 1 in 25 adults in the U.S.—10 million, or 4.2%—experiences a serious mental illness in a given year that substantially interferes with or limits one or more major life activities.
- Approximately 1 in 5 youth aged 13–18 (21.4%) experiences a severe mental disorder at some point during their life. For children aged 8–15, the estimate is 13%.

16 NAMI, National Alliance on Mental Illness, Mental Illness Facts and Numbers, NAMI, www.nami.org

17 . Community Health Needs Assessment for Northwest Connecticut (2015 update) Collaborators: Development of the Community Health Needs Assessment for Northwest, CT 2015 Update is a collaborative and inclusive process that has engaged organizations, agencies and residents from across the Northwest Region.

- 1.1% of adults in the U.S. live with schizophrenia.
- 2.6% of adults in the U.S. live with bipolar disorder.
- 6.9% of adults in the U.S.—16 million—had at least one major depressive episode in the past year.
- 18.1% of adults in the U.S. experienced an anxiety disorder such as posttraumatic stress disorder, obsessive-compulsive disorder and specific phobias.
- Among the 20.2 million adults in the U.S. who experienced a substance use disorder, 50.5%—10.2 million adults—had a co-occurring mental illness.

Suicide: State of Connecticut

Table 14.

Primary Methods of Suicide in Connecticut by Age 2012

Year	Hanging/ Strangulation	Gunshot	Substance Overdose	CO Poisoning	Suffocation
10–14	0	1 (100)	0	0	1
15–19	12 (66.7)	2 (11.1)	0	4 (22.2)	18
20–24	8 (47.0)	4 (23.5)	2 (11.8)	3 (17.6)	17
25–34	19 (40.4)	12 (25.5)	5 (10.6)	11 (23.4)	47
35–44	29 (39.7)	17 (23.3)	12 (16.4)	15 (20.5)	73
45–54	30 (32.6)	26 (28.3)	15 (16.3)	21 (22.8)	92
55–64	27 (46.6)	16 (27.6)	9 (15.5)	6 (10.3)	58
65–74	6 (17.6)	16 (47.0)	5 (14.7)	7 (20.6)	34
75 and older	2 (8.7)	12 (52.2)	2 (8.7)	7 (30.4)	23

Source: Office of Connecticut Medical Examiner Deaths by Suicide 2006–2012 Retrieved 5/29/13.

Mental Health/Substance Abuse

Between 90% and 98% of people who die by suicide have a diagnosable mental health condition.[lxxvii] The existence of a psychiatric condition is second only to a prior suicide attempt as a major risk factor for dying by suicide. Comorbidity increases suicide risk. The most common mental health conditions associated with increased risk of suicide are depression and bipolar illness, followed by substance use, borderline personality and eating disorders. Those with schizophrenia have an attempt rate of 20 to 40% and 5% die by suicide.[lxxviii] There is a strong association between suicide fatality and post-traumatic stress disorder. It is important to note, however, that despite these risks, of those with a mental health diagnosis, 90% *do not* die by suicide.[lxxix] It then becomes important to identify which people are at the highest risk of suicidal thoughts and behaviors, while providing high quality and prompt treatment for the mental health condition that places them at elevated risk.

Given the strong association between mental health conditions and suicidal thoughts and behaviors, recommendations for suicide prevention mirror those for good mental health and substance abuse treatment: Suggestions include high quality and highly accessible mental health and substance abuse treatment, strong mental health assessment and ongoing screening for suicidality and the availability and resourcing of high quality mental health and substance abuse services,

Suicide was the second leading cause of injury death in Connecticut accounting for 18.1% of all injury-related deaths between 2000-2004, with 1,396 suicide deaths, for an average of 279 suicides a year.

Consider the death of Robin Williams who suffered from severe depression. He was a proud and loving person. His death did not have to happen. Stigma was quite possibly a factor in his decision to take his own life. After Robin Williams death the television media and social web exploded with questions such as "How could he do this to his children?" "What was he thinking?" These questions themselves are proof of stigma in our society demonstrating a lack of understanding about mental illness.

We all need to do as much as possible on both a clinical and human level to improve the quality of each life, to identify risks, provide support, reduce stigma and empower those who seek assistance. Access to mental health care is primary.

f. Discuss how low income persons, racial and ethnic minorities, disabled persons and other underserved groups will benefit from this proposal:

Mountainside is a for-profit treatment experience. Given this Mountainside has not infringed on the ability for low income persons, and other underserved groups to access treatment in the Litchfield County area.

g. List any changes to the clinical services offered by the Applicant(s) and explain why the change was necessary:

Mountainside has realized an increase in co-occurring disorders over the past two and one half (2 1/2) years. It became increasingly difficult to secure appointments with outside psychiatrists during the client's treatment experience.
As previously discussed, as a result of summit meetings/planning session; Mountainside has:

- Hired psychiatric staff assessment series to treatment.
- Currently assesses risk, trauma and utilizes five unique assessments to measure the client's baseline for five domains (depression, anxiety, cravings, sleep and ADHD).
- Each client identified as exhibiting a mental health disorder is referred to the psychiatrist for evaluation of comorbidity and/or his/her psychiatric needs. The treatment team works collaboratively with the psychiatrist to ensure that the client's substance abuse and mental health issues are addressed during treatment and throughout the development of the continuing care plan.
- Additional programming was augmented to enhance the client's treatment experience and to attend to the specific individualized needs of each client.
- An Outcome Measures Department was developed in order to categorize and analyze data to assist in the identification of patterns and client needs.
- Clinicians currently meet with clients three (3) times weekly on an individual basis, reassess needs ongoing and work closely with the continuing care team
- Clients voluntarily complete two consumer surveys during the course of his/her treatment and just prior to discharge. Mountainside uses this information to address issues in the here and now, empower clients, enhance current programming, train staff and develop new programs endeavoring to give clients a best in class treatment experience.
- EMDR has been added to programming

h. Explain how access to care will be affected:
Access to care will be minimally affected by this proposal. Given admissions over the past two and one half years (21/2) years, we anticipate that approximately fifty-two (52) clients per year of the Litchfield County Pool will likely enroll in the proposed program in Canaan, CT. Two hundred and six (206) clients in this pool had historically opted to remain in the Canaan, CT area.

i. Discuss any alternative proposals that were considered:
Mountainside originally referred clients to an area psychiatrist for evaluation and treatment. As the population diagnosed with co-occurring disorders continued to increase access to psychiatric care decreased. Litchfield County has a shortage of primary care providers, with one (1) primary care physician to every one thousand five hundred sixty-three (1,563) residents, well below both the national benchmark of one (1) primary care provider for every one thousand forty-five (1,045) persons and the State average of one (1) primary care physician per one thousand one hundred-ninety (1,190) residents. Litchfield County is also deficient in the number of psychiatrists practicing in the Northwest Region.
Given this, Mountainside added a Medical Director (psychiatrist), Director of Psychiatric, Psychiatric APRN and Doctor of Nursing to the staffing pattern. The goal is to provide psychiatric evaluation, ongoing care and medication management to this growing population. Programming was also augmented to meet this need; as was the assessment process. Innovated assessments focus on risk, trauma, pain, depression, anxiety, ADHD, sleep, cravings and nutrition complement wellness planning and treatment.

9. Describe how the proposal will:

a. Improve the quality of health care in the region:

In addition to adding a new, high quality psychiatric outpatient facility within the region, Mountainside will serve to improve health care outcomes for individuals with mental illness and co-occurring disorders. By providing essential, continuing treatment (i.e., step-down) following primary inpatient/residential treatment the proposed service enhance transition to productive, independent and self-supporting healthy lifestyles in the community.

It is widely understood in the mental health field that time-in-treatment, the better the odds for wellness. According to the nationals Drug Abuse Treatment Outcome Study (DATOS), “The length of time clients stayed in treatment was directly related to improvements in follow-up outcomes, replicating findings from previous national treatment evaluations.18

b. Improve accessibility of health care in the region

Clients remaining in the town of Canaan, CT will have access to Mountainside services that are located within close proximity to extended care housing in Canaan, access to group and individual treatment, intensive outpatient treatment and ongoing psychiatric care and medication management.

Clients will be invited to participate in Alumni Service activities and events and will be provided with both a continuity of care and continued care.

c. Improve the cost effectiveness of health care delivery in the region.

The Mountainside outpatient psychiatric clinic is designed to provide seamless, continuing treatment for individuals diagnosed with a mental illness disorder. These services provide extended treatment duration in a less-restrictive, and therefore lower cost, setting that maximizes the potential for achievement of long-term wellness. By addressing emerging and underlying emotional and psychological factors, the proposed service will reduce future healthcare costs related to relapse, including associated medical costs.

By providing a dedicated regimen of clinical services that are closely coordinated with sober housing and related recovery supports, pro-social community involvement and wellness activities, the proposed service will contribute to decreasing long-term healthcare costs – especially the

18 Hubbard, R.L., Craddock, S.G., Flynn, P.M., Anderson, J., & Etheridge, R.M. (1997). Overview of 1-year follow-up outcomes in the Drug abuse Treatment Outcome Study (DATOS), Psychology of Addictive Behaviors, 11(4), 261-278.

need for chronic, acute care episodes, and particularly the costs associated with suicide attempts or gestures, major depression episodes, psychosis, noncompliance with medications and lack of self-care.

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)?

    Mountainside prides itself as working closely with area providers with the goal of ensuring that all clients receive the most appropriate level of care and ultimate wellness. Mountainside collaborates with Charlotte Hungerford Hospital, Sharon Hospital, area laboratories and physicians via memorandums of understanding, agreements and contracts for the good of the client, family and community.

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

    Mountainside as a for-profit facility provides treatment to clients with commercial insurance or who have the ability to self-pay. This proposed service should have no impact on current Litchfield County providers or Medicaid recipients and indigent persons located in the county.

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

    Mountainside uses a sliding fee scale based on an individual client or family's ability to pay. The scale is flexible and adjusted to the needs or income of individuals.

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.

    The Mountainside Outpatient Psychiatric Clinic will not infringe on admissions to other outpatient psychiatric providers in Litchfield County who provide services to Medicaid recipients or indigent persons. Mountainside is a for-profit facility.

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.

    The proposed rates for services at Mountainside's Canaan facility will be the same as the current and future rates. Mountainside has had 18 years' experience in setting reasonable private rates that it has been able to successfully collect. The actual experience shows that insurance rates are negotiated lower (beginning at about $375.99/session), and virtually 100% of self-pay clients do pay the full rates in advance.

    Rates are anticipated to be raised a modest 3% per year during the first three years of operation.

    The rate schedule is as follows:

Mountainside Intensive Outpatient Fees*			
Insurance	$560.00	$577.00	$594.00
Uninsured	$255.00	$263.00	$271.00
% change (approximate)		+3%	+3%

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.

The anticipated capital expenditure of $10,000.00 will be paid by MC1 Healthcare, LLC using cash.

16. Provide a final version of all capital expenditure/costs for the proposal using **OHCA Table 3**.

TABLE 3
TOTAL PROPOSAL CAPITAL EXPENDITURE

Purchase/Lease	**Cost**
Equipment (Medical, Non-medical, Imaging)	10,000.00
Land/Building Purchase*	Existing
Construction/Renovation**	
Other (specify)	
Total Capital Expenditure (TCE)	**10,000.00**
Lease (Medical, Non-medical, Imaging) ***	
Total Lease Cost (TLC)	
Total Project Cost (TCE+TLC)	**10,000.00**

* 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.

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.

The anticipated capital expenditure of $10,000.00 will be paid by MC1 Healthcare, LLC using cash.

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:
Attachment IX: Sinnamon and Associates, LLC, Certified Public Accountants

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.**

Attachment X: Financial Worksheet B

19. Complete **OHCA Table 4** utilizing the information reported in the attached Financial Worksheet.

TABLE 4
PROJECTED INCREMENTAL REVENUES AND EXPENSES

	FY 2017*	**FY 2018***	**FY 2019***
Revenue from Operations	$193,091.	$246,615.	$286,790
Total Operating Expenses	187,427.	233,616.	267,676.
Gain/Loss from Operations	$5,664.	$12,999.	$19,114.

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

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

    Mountainside only accepts direct commercial insurance or similar (e.g., managed care) third-party payment assignment or self-pay in full, in advance. Clients are expected to cover the full cost of services, including through a combination of insurance and self-pay. Mountainside does not accept Medicaid or other governmental insurance or entitlements, and receives no state or Federal funding.

    The projected client population mix assumes that 65% of admissions will be supported by commercial insurance (non-governmental). This is a conservative estimate, as the most recent rate of insurance coverage for Intensive Outpatient clients at Mountainside's Canaan location is approaching 80%. The remainder of clients will be "self-pay" and expected to assume the full negotiated cost of care.

    The numbers of projected clients are based upon actual admissions to Mountainside's residential treatment programs in Canaan who are from Litchfield County. These numbers are adjusted using an estimated 25% conversion rate.

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

    There are no projected incremental losses from operations resulting from the implementation of the CON proposal. The infrastructure in in place

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

    Based upon initial, three-year expense and rate projections, the following numbers of units (i.e., 3-hour IOP sessions) will be required to begin to show an incremental gain from operations:
    Fiscal Year One (2017 Apr.-Dec.) 569 units
    Fiscal Year Two (2018) 705 units
    Fiscal Year Three (2019) 796 units

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.

TABLE 5
HISTORICAL UTILIZATION BY SERVICE

Service**	Actual Volume (Last 3 Completed FYs)			CFY Volume*
	FY 20__***	FY 20__***	FY 20__***	FY 20__***
Outpatient Services Intensive Outpatient Services	N/A	N/A	N/A	N/A
Total				

* 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.
** 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.

TABLE 6
PROJECTED UTILIZATION BY SERVICE

Service*	Projected Volume		
	FY 20__**	FY 20__**	FY 20__**
Outpatient Services IOP	N/A	N/A	N/A
Total			

* 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.

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. **Mountainside is applying for a new service license. Prior related program data is not available.**

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.**

TABLE 7
APPLICANT'S CURRENT & PROJECTED PAYER MIX

Payer	Current FY 20__**		Projected					
			FY 20__**		FY 20__**		FY 20__**	
	Discharges	%	Discharges	%	Discharges	%	Discharges	%
Medicare*	0	0%	0		0		0	
Medicaid*	0	0%	0		0		0	
CHAMPUS & TriCare	0	0%	0		0		0	
Total Government	**0**	**0%**	**0**		**0**		**0**	
Commercial Insurers	5	63%	20	67%	25	66%	30	67%
Uninsured	3	37%	10	33%	13	34%	15	33%
Workers Compensation	0	0%	0	0%	0	0	0	0%
Total Non-Government	**15**	**100%**	**30**	**100%**	**38**	**100%**	**45**	**100%**
Total Payer Mix	**15**	**100%**	**30**	**100%**	**38**	**100%**	**45**	**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.

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.

According to the United States Census Bureau, the population of Litchfield County in 2015 was 183,603 (about 5% of the total population of Connecticut). It reports that 81.4% of those are aged 18 and over – placing their estimate of the adult population in Litchfield County at 149,453.

Deducing by applying the SAMHSA prevalence estimate of 18.2%, the census data would suggest there are about 27,200 adults diagnosed with mental illness in Litchfield County. Actual data from Connecticut is not available. For example, DMHAS needs data reflect services only within the public-funded treatment system and do not include data from private, for-profit providers who primarily serve self-pay clients. In addition, high net-worth clients often receive treatment in programs located elsewhere across the country. Therefore, the estimate of 18.2% for the general United States population will be used for projections.

Need for treatment in Litchfield County

Perhaps the most compelling, recent evidence available to demonstrate treatment need in Connecticut comes from the Behavioral Health Barometer – Connecticut 2014, issued by the federal Substance Abuse and Mental Health Services Administration (SAMHSA) in 2015.19 The following excerpt validates the extrapolated estimate of treatment need suggested above and also identifies the percentage of those in need who are not served in any given year:

19 Substance Abuse and Mental Health Services Administration. Behavioral Health Barometer: Connecticut, 2015. HHS Publication No. SMA-15-489CT. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015.

In Connecticut, two hundred fourteen thousand (214,000) adults age eighteen (18) or older with Any Mental Illness (AMI) (47.5%) of all adults with AMI) per year from 2010-2014 received mental health treatment counseling within the year prior to being surveyed. Fifty-two-point five percent (52.5% did not receive treatment). 20

Using this benchmark, it can be estimated that of the 149,453 adults in Litchfield County, 52.5% or 77,716 individuals need treatment but did not receive it. This provides strong evidence of the need for treatment services in Litchfield County, far is excess of what could possibly be provided through the proposed service.

Table 17: 2-1-1 Service Requests for Litchfield County, 1/1/15-12/28/15

2-1-1 Request Category	Totals
Public Assistance Programs	1,354
Individual & Family Support Services	1,163
Utilities	935
Mental Health Evaluation & Treatment	911
Housing/Shelter	888
Counseling Settings	874
Health Supportive Services	663
Legal Services	480
Temporary Financial Assistance	281
Food	274
Substance Abuse Services	262

Source: United Way of CT: http://uwc.211ct.org

For example: In 2015 three thousand eight hundred and seventy-three (3873) calls were made to 2-1-1 alone in Litchfield County requesting mental health evaluation, a counseling setting, health supportive services, substance abuse services and individual and family support services.

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.

20 SAMSHA, Behavioral Health Barometer Connecticut, 2015; www.samhsa.gov

TABLE 8
UTILIZATION BY TOWN

Town	Utilization FY 2015
Salisbury	2
North Canaan	1
Canaan	26
Norfolk	1
Colebrook	0
Winchester	0
Barkhamsted	0
Sharon	3
Cornwall	0
Goshen	1
Torrington	10
New Hartford	4
Kent	1
Warren	0
Litchfield	1
Harwinton	0
New Milford	5
Washington	0
Morris	0
Thomaston	3
Plymouth	0
Bethlehem	1
Watertown	7
Woodbury	2
Roxbury	1
Bridgewater	0

* List inpatient/outpatient/ED volumes separately, if applicable
** Fill in most recently completed fiscal year.

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.

    In order to ensure a thorough accounting of existing intensive outpatient/outpatient psychiatric clinics in the proposed service area, we began with those listed on SAMHSA's website with the following search criteria: Outpatient Psychiatric Clinics; cash (self-pay) or private health insurance; young adults and adults. The resulting list identified ten (10) facilities located in Torrington, one facility located in (1) Kent, one (1) in Bethlehem and two (2) New Milford.
    A second search, which we expected to result in more information, was the State of Connecticut Department of Public Health (DPH) list of licensed outpatient psychiatric clinics providing services within twenty (20) miles of Canaan, CT. This list includes one (1) additional facility located in Windsor, CT.

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
Charlotte Hungerford Hospital	Psychiatric Outpatient Clinic PHP/OP	Not for profit NPI # 1639255870	540 Litchfield Street Torrington, CT	8:30am to 9pm Mon. and Thursday 8:30a – 5p Tues., Weds., and Fri.	Licensed beds 109 ED beds 14 ICU beds 10 ED visits 39,535
Catholic Charities	Psychiatric Outpatient Clinic	Not for profit Employer ID# 06-0667607	132 Grove Street Torrington, CT 06790	Not available on Home page	Not published
Christian Counseling Connection, Inc.	Psychiatric Outpatient Clinic	Not for profit Credential ID 930299	42 Church Street Torrington, CT 06790	10a – 5p Mon. - Friday	Not published
Community Health and Wellness Center	Psychiatric Outpatient Clinic OP	Not for profit Credential ID 995718	469 Migeon Ave. Torrington, CT 06790	8a – 6p M<W<TH<F T 8a-8p Every other Sat.	Not published
Community Mental Health Affiliates, Inc.	Psychiatric Outpatient Clinic	Not for profit Credential ID 929517	100 Commercial Blvd Torrington, CT 06790	Monday: 8a-8p Tues: Th. 9a-6p Friday: 8a-5p	Not published
High Watch Recovery Center	Substance Abuse & Co-occurring D/O	Not for profit NPI # 1275946881	62 Carter Road Kent, CT 06757	8a – 5:30p Mon. – Sun.	Not published
MCCA Torrington	Psychiatric Outpatient Clinic Outpatient	Not for profit NPI # 1992074418	30 Peck Road Torrington, CT 06790	Mon. – Fri. 9:30a – 4p	Not published
McCall Foundation	Psychiatric Outpatient Clinic Outpatient	Not for profit Credential ID: 930804	58 High Street Torrington, CT 06790	Mon.: 9a – 8p Tues-Fri: 9a – 4p	Not published
Hartford Dispensary Torrington Clinic	Psychiatric Outpatient Clinic Outpatient	Not for profit Credential ID 1235540	140 Commercial Blvd Torrington, CT 06790	Mon. - Friday 5a – 1:30p	Not published
Western CT Mental Health	Psychiatric Outpatient Clinic Outpatient State Operated	Not for profit NPI# 1144561051	249 Winsted Road Torrington, CT 06790	Mon., Tues., Thurs. 8:30a – 5p	Not published
Wellspring Foundation	Psychiatric Outpatient Clinic PHP/IOP/OP	Not for profit NPI# 1154475184	21 Arch Bridge Road Bethlehem, CT	Not available on Home page	Not published
New Milford Hospital Behavioral Health Services	Psychiatric Outpatient Clinic Outpatient	Not for profit NPI# 1619938016	23 Popular Street New Milford, CT	Mon. – Fri. 9a – 5p	Licensed beds 85 ED beds 12 ICU beds 6 ED visits 18,780
MCCA New Milford	Psychiatric Outpatient Clinic Outpatient	Not for profit CT License # SA-0215	50 Bridge Street New Milford, CT	Mon. – Fri. 9:30a 4p	Not published
Watkins Network	Psychiatric Outpatient Clinic Outpatient	Not for profit CT License # 1245356	21 Prospect Street Torrington, CT	Mon. 9a-9p, Tues: 11a-7p, W, Thurs: 1p – 9p Fri 9a-5p	Not published

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

In order to ensure a through accounting of existing outpatient psychiatric service providers in the proposed area, we began the search with those providers listed on SAMSHA's website with the following criteria: Outpatient Psychiatric Clinic, cash (self-payment) or private health insurance) young adults and adults.
The second search, was done and included Outpatient Psychiatric Clinics for adults found on the Department of Public Health (DPH) website.
The third search, was done on the internet which added one more facility; Watkins Network is located CT Department of Public Health

29. Describe the effect of the proposal on these existing providers.
Of the fourteen (14) existing treatment providers in Litchfield County, all fourteen (14) served clients with State/Federal funding or Medicaid reimbursement. One of the facilities serve only clients who are currently on Methadone Maintenance/MAT at that location.
We anticipate that the addition of Mountainside's Outpatient Psychiatric Clinic to the area will have a minimal effect on existing area providers. As mentioned previously, discharged Mountainside's residential clients currently receive continuing care services through a variety of community providers including sober living, licensed clinics and licensed professionals.
As noted two-hundred and six (206) or seventy-nine percent (79%) of clients were discharged to Canaan, CT. Sixty-nine (69%) of this population were diagnosed with a co-occurring disorder. Approximately sixty (60) clients were voluntarily referred for continuing care to other facilities located in Litchfield County. The formulation of the above noted continuing care plans were based upon client preference (e.g., proximity, referral to former treater).

Based upon this review, we conclude that the implementation of this proposal will have minimal impact on existing area providers.

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

Of the existing fourteen (14) outpatient providers in Litchfield County, all fourteen (14) serve public-sector clients with State/Federal funding or Medicaid reimbursement and are located in Torrington, Kent, New Milford and Bethlehem. One of the facilities only serves clients on Methadone/MAT at its' location.

Eleven (11) of the facilities located in Litchfield County do not provide Intensive Outpatient Services.

We anticipate that the addition of Mountainside's Canaan Outpatient Psychiatric Clinic to the area will have a minimal effect on existing area providers. Discharged Mountainside residential clients currently receive continuing care services through a variety of community providers including sober living, licensed clinics and independent licensed professionals. Over the past two and one half (2 ½) years 79% of the pool chose to remain in Canaan, CT post discharge.

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

Approximately sixty (60) clients were voluntarily referred for continuing care to other facilities located in Litchfield County. The formulation of the above noted continuing care plans were based upon client preference (e.g., proximity, referral to former treater).

Based on the above data, the referral patterns will not be affected.

Mountainside, however, will have the ability to treat clients diagnosed with mental illness which will contribute positively to the unmet need in the Northwest Region of Connecticut.

According to Hazelden
"Having a mental health disorder could make a person even more sensitive to the effects of substances. The consequences from excessive use or chronic long-term use happen more rapidly. With the best of intentions, a person with a mental health disorder may try to stop

using substances, but after doing so they notice that their psychiatric symptoms return, sometimes more severe. They wonder, "why bother getting clean and sober?"

A mental health disorder complicates and compounds the challenges the clients face.

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

The total hospitalizations and mental Disorder Discharges, FY 2015 for Litchfield County for mental disorders (1079), psychotic conditions (652) and alcohol/other drug psychosis (282).
The fourteen (14) facilities noted which are located in Litchfield County accept clients with Medicare, Medicaid, Uninsured, Commercial Insurance, Veteran's Insurance and State/Federal funding. Mountainside is a for-profit agency that exclusively admits clients with commercial insurance or have the ability to self-pay.

Statewide Totals 2015

Primary Payer	Mental Disorders	Psychotic Conditions	Alcohol/Other Drug Psychosis
Medicare	6297	4727	912
Medicaid	11741	7247	2421
Uninsured	547	265	183
Commercial Insurance	5618	3523	951

Two-hundred and six (206) clients, one hundred and ninety-eighty (198) of whom were diagnosed with a co-occurring disorder were discharged from Mountainside to Canaan, CT over the past two and one half (21/2) years. A good portion of this client base lack transportation, have ties to the Canaan community, participate in alumni services offered at Mountainside and require ongoing mental health treatment. Sixty-nine percent (69%) of the clients who have sought continuing care (extended care) in Canaan were diagnosed with a co-occurring disorder.

Current research demonstrates that integrated treatment, which treats both disorders concurrently, offers the best possible outcomes for clients and client's families.

Mountainside has memorandum of understanding agreements with area hospitals and collaborates with the hospitals as appropriate for the good of the client.

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 primary target population includes clients being discharged from a residential treatment episode at Mountainside in Canaan, Connecticut and remaining in Canaan or within close proximity to Canaan, CT. This could include Canaan, Lakeville, Salisbury, Norfolk, Massachusetts and New York as a prime referral source.

Other Litchfield County towns have been left in the equation in the event the client prefers to be treated further from his/her home in order to maintain confidentiality. The proposed service should have minimal impact on other health care providers in the Litchfield County area.

Based on the historical volume at Mountainside's residential program and the portion of clients who voluntarily remain in the Canaan area, it is reasonable to conclude that there is a solid basis for projecting a subpopulation that will generate actual demand for treatment.

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:

MC1 d/b/a Mountainside Treatment Center

Project Name:

Freestanding Outpatient Psychiatric 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: MC1 Healthcare, LLC

Project Title: Mountainside – Canaan, CT Psychiatric Outpatient Clinic for Adults

I, Roy Sasenaraine (Name) Chief Operating Officer (Position – CEO or CFO)

of MC1 Healthcare, LLC being duly sworn, depose and state that the (MC1 Healthcare, LLC) 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.

Roy Sasenaraine 10-03-16

Signature Date

Subscribed and sworn to before me on October 3rd, 2016

Justin Cloutier

Notary Public/Commissioner of Superior Court

JUSTIN R. CLOUTIER
NOTARY PUBLIC
State of Connecticut
My Commission Expires
June 30, 2018

My commission expires: June 30, 2018

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.
   Mountainside will offer outpatient and intensive outpatient treatment, group and individual sessions, psychiatric evaluation and ongoing care and medication management.

   In conjunction with the above, Mountainside also offers integrated positional therapy, EMDR, acupuncture, Thai massage, Self-Empowerment sessions and a variety of Yoga activities that address trauma, anxiety and depression.

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

   - Medical Director (Psychiatrist), M.D.
   - Director of Psychiatry, M.D.
   - Director of Clinical Operations, LPC, LADC, MAT, EMDR Certification
   - Senior Clinician, LMSW, LADC
   - Two Clinicians one of whom is an LMFT

2. **Projected Volume**

   a. 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

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

The specific target population to be served includes adults returning to towns in Litchfield County, Connecticut following a residential treatment episode at Mountainside Treatment Center in Canaan, Connecticut. This population includes individual with mental illness or a co-occurring disorder in need of continuing care.

CONNECTICUT POPULATION ESTIMATES AS OF JULY 1, 2013
BY COUNTY AND TOWN

Litchfield County: 186,924

Town	Population	In Need	To be Served 2016	% of Need
Salisbury	3693	672	2	0.59%
North Canaan	3241	590	2	0.33%
Canaan	1214	221	226	102%
Norfolk	1678	305	1	0.32%
Colebrook	1457	265	0	0%
Winchester	11013	2207	0	0%
Barkhamsted	3745	681	0	0%
Sharon	2743	499	4	0.80%
Cornwall	1412	257	0	0%
Goshen	2945	536	1	0.18%
Torrington	35611	6481	19	0.29%
New Hartford	6886	1253	10	0.79%
Kent	2939	535	1	0.19%
Warren	1447	263	0	0%
Litchfield	8333	1517	1	0.66%
Harwinton	5593	1018	0	0%
New Milford	27767	5053	8	0.16%
Washington	3526	642	0	0%
Morris	2345	427	0	0%
Thomaston	7761	1412	3	0.21%
Plymouth	12047	2192	0	0%
Bethlehem	3553	647	1	0.58%
Watertown	22228	4045	11	0.27%
Woodbury	9822	1788	5	0.28%
Roxbury	2229	406	1	0.25%
Bridgewater	1696	309	0	0%
TOTAL	**196,993**	**34,221**	**296**	**0.24%**

The data in the chart above are based upon the following assumptions:

- Population numbers are 2014 estimates provided by the Connecticut Department of Public Health on its website
- The estimates of individual “In Need” of Mental Health treatment are calculated by applying the 18.2% estimated average for the United States population provided by SAMSHA
- The estimated number of individuals to be served (client volume) is based upon annual averages of actual past 43-month figures from Mountainside’s residential admission records, by town.
- The percentages reported are the percentage of estimated individuals to be served of the estimated number of person in need of treatment.

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.

The need for mental health services in Connecticut and in Litchfield County far exceeds capacity. According to SAMSHA (Behavior Health Barometer CT 2013), Connecticut's percentage of adults with suicidal thoughts was similar to the national percentage in 2011-2012.

In Connecticut, about 105,000 adults (3.9% of all adults) in 2008-2012 had serious thoughts of suicide within the year prior to being surveyed.

The percentage did not change significantly over this period. Connecticut's rate of serious mental illness among adults was similar to the national rate in 2011-2012. In Connecticut, about 93,000 adults (3.5% of all adults) per year in 2008-2012 had serious mental illness within the year prior to being surveyed. Connecticut's rate of mental health treatment among adults with any mental illness in Connecticut was similar to the national rate in 2008-2012. In Connecticut, about 214,000 adults with any mental illness (46.8% of all adults with AMI) per year 2008-2012 received mental health treatment or counseling within the year prior to being surveyed. 53.2% of this population did not receive treatment.

Of Connecticut's approximately 305 million residents, close to 109,000 adults live with serious mental illness. In 2006, two-hundred and ninety-two (292) Connecticut residents died by suicide. Suicide is almost always the result of untreated or under-treated mental illness. Nationally, we lose one life to suicide every 15.8 minutes. (NAMI, State Advocacy 2010).

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

APPENDIX ONE
United States Census
Litchfield County

Quick Facts **Litchfield County, Connecticut**

Population	
iPopulation estimates, July 1, 2015, (V2015)	183,603
iPopulation estimates base, April 1, 2010, (V2015)	189,927
iPopulation, percent change - April 1, 2010 (estimates base) to July 1, 2015, (V2015)	-3.3%
iPopulation, Census, April 1, 2010	189,927
Age and Sex	
iPersons under 5 years, percent, July 1, 2015, (V2015)	4.2%
iPersons under 5 years, percent, April 1, 2010	4.8%
iPersons under 18 years, percent, July 1, 2015, (V2015)	19.1%
iPersons under 18 years, percent, April 1, 2010	21.6%
iPersons 65 years and over, percent, July 1, 2015, (V2015)	19.0%
iPersons 65 years and over, percent, April 1, 2010	16.0%
iFemale persons, percent, July 1, 2015, (V2015)	50.7%
iFemale persons, percent, April 1, 2010	50.9%
Race and Hispanic Origin	
iWhite alone, percent, July 1, 2015, (V2015) (a)	94.3%
iWhite alone, percent, April 1, 2010 (a)	93.9%
iBlack or African American alone, percent, July 1, 2015, (V2015)(a)	1.9%
iBlack or African American alone, percent, April 1, 2010 (a)	1.3%
iAmerican Indian and Alaska Native alone, percent, July 1, 2015, (V2015) (a)	0.3%
iAmerican Indian and Alaska Native alone, percent, April 1, 2010(a)	0.2%
iAsian alone, percent, July 1, 2015, (V2015) (a)	1.9%
iAsian alone, percent, April 1, 2010 (a)	1.5%
iNative Hawaiian and Other Pacific Islander alone, percent, July 1, 2015, (V2015) (a)	0.1%
iNative Hawaiian and Other Pacific Islander alone, percent, April 1, 2010 (a)	

	Z
iTwo or More Races, percent, July 1, 2015, (V2015)	1.6%
iTwo or More Races, percent, April 1, 2010	1.6%
iHispanic or Latino, percent, July 1, 2015, (V2015) (b)	5.7%
iHispanic or Latino, percent, April 1, 2010 (b)	4.5%
iWhite alone, not Hispanic or Latino, percent, July 1, 2015, (V2015)	89.5%
iWhite alone, not Hispanic or Latino, percent, April 1, 2010	91.3%
Population Characteristics	
iVeterans, 2010-2014	13,885
iForeign born persons, percent, 2010-2014	7.1%
Housing	
iHousing units, July 1, 2015, (V2015)	87,407
iHousing units, April 1, 2010	87,550
iOwner-occupied housing unit rate, 2010-2014	77.3%
iMedian value of owner-occupied housing units, 2010-2014	$259,800
iMedian selected monthly owner costs -with a mortgage, 2010-2014	$1,930
iMedian selected monthly owner costs -without a mortgage, 2010-2014	$772
iMedian gross rent, 2010-2014	$946
iBuilding permits, 2015	112
Families and Living Arrangements	
iHouseholds, 2010-2014	75,229
iPersons per household, 2010-2014	2.45
iLiving in same house 1 year ago, percent of persons age 1 year+, 2010-2014	91.2%
iLanguage other than English spoken at home, percent of persons age 5 years+, 2010-2014	9.7%
Education	
iHigh school graduate or higher, percent of persons age 25 years+, 2010-2014	91.3%
iBachelor's degree or higher, percent of persons age 25 years+, 2010-2014	33.7%
Health	
iWith a disability, under age 65 years, percent, 2010-2014	6.5%
iPersons without health insurance, under age 65 years, percent	⚠ 7.0%
Economy	
iIn civilian labor force, total, percent of population age 16 years+, 2010-2014	

	69.1%
iIn civilian labor force, female, percent of population age 16 years+, 2010-2014	65.1%
iTotal accommodation and food services sales, 2012 ($1,000) (c)	265,230
iTotal health care and social assistance receipts/revenue, 2012 ($1,000) (c)	929,184
iTotal manufacturers shipments, 2012 ($1,000) (c)	2,615,264
iTotal merchant wholesaler sales, 2012 ($1,000) (c)	D
iTotal retail sales, 2012 ($1,000) (c)	2,654,993
iTotal retail sales per capita, 2012 (c)	$14,158
Transportation	
iMean travel time to work (minutes), workers age 16 years+, 2010-2014	26.6
Income and Poverty	
iMedian household income (in 2014 dollars), 2010-2014	$72,068
iPer capita income in past 12 months (in 2014 dollars), 2010-2014	$37,696
iPersons in poverty, percent	⚠ 7.7%
BUSINESSES	
iTotal employer establishments, 2014	4,781
iTotal employment, 2014	52,087
iTotal annual payroll, 2014	2,115,820
iTotal employment, percent change, 2013-2014	1.9%
iTotal nonemployer establishments, 2014	17,010
iAll firms, 2012	20,187
iMen-owned firms, 2012	12,048
iWomen-owned firms, 2012	6,092
iMinority-owned firms, 2012	1,330
iNonminority-owned firms, 2012	18,350
iVeteran-owned firms, 2012	1,755
iNonveteran-owned firms, 2012	17,666
GEOGRAPHY	
iPopulation per square mile, 2010	206.3
iLand area in square miles, 2010	920.56
iFIPS Code	09005

Attachment I
Public Notice
American-Republican

Legals/ Public Notices

LEGAL NOTICE
FORECLOSURE AUCTION SALE

DOCKET NO.:
UWY-CV-15-6029392-S
CASE NAME: Lakeview Loan Servicing, LLC v. Iris E. Mejias aka Iris Bartone, et al
PROPERTY ADDRESS:
119 Beech St, Waterbury, CT
PROPERTY TYPE:
Residential
DATE OF SALE:
September 24, 2016
COMMITTEE NAME:
Patrick Zailckas, Esquire
COMMITTEE PHONE NUMBER:
203-754-0398
See Foreclosure Sales on the Judicial Branch website:
www.jud.ct.gov for more details

R-A September 11 & 18, 2016

HIDDEN TREASURES!

Check Out The Classifieds For Those Hard To Find Items!

LEGAL NOTICE
FORECLOSURE AUCTION SALE

DOCKET NO.
UWY-CV-15-6026844-S
CONNECTICUT HOUSING FINANCE AUTHORITY VS. JOSE ECHEVARRIA, ET AL.
PROPERTY ADDRESS:
108 Highland Drive
Waterbury, CT 06708
PROPERTY TYPE: Residential Single Family
DATE OF SALE: September, 24, 2016 at 12 Noon
COMMITTEE: Robert C. Wilson
COMMITTEE TELEPHONE:
203-879-4644
COMMITTEE EMAIL:
rwilson@bhwlawct.com
See foreclosure sales on the Judicial Department website:
www.jud.ct.gov for more details.
R-A September 11 & 18, 2016

Legals/ Public Notices

LEGAL NOTICE
FORECLOSURE AUCTION SALE

DOCKET #:
UWY CV 16 6030520 S

CASE NAME:
Wells Fargo Bank, N.A.
vs.
Robert J. Swoditch Jr Et Al

PROPERTY ADDRESS:
111 Mallane Lane Unit 9-14-D
Naugatuck, CT

PROPERTY TYPE:
Residential

DATE OF SALE:
Saturday, September 24, 2016

DEPOSIT AMOUNT:
$10,500.00 Deposit
To be paid by bank or certified check only

COMMITTEE NAME:
Mitchell M. Berger

COMMITTEE PHONE NUMBER
203-597-9877

SEE FORECLOSURE SALES AT:
www.jud.ct.gov
for more detailed information
R-A September 11 & 18, 2016

LEGAL NOTICE
FORECLOSURE AUCTION SALE

DOCKET #:
UWY CV 16 6030520 S
PROPERTY ADDRESS:
111 Mallane Lane Unit 9-14-D
Naugatuck, CT
PROPERTY TYPE:
Residential
DATE OF SALE:
September 24, 2016
COMMITTEE NAME:
Mitchell M. Berger
COMMITTEE PHONE NUMBER
203-597-9877
SEE FORECLOSURE SALES AT:
www.jud.ct.gov for more detailed information

R-A September 11 & 18, 2016

LEGAL NOTICE

Notice is hereby given that, Pursuant to Connecticut General Statutes 19a-638, MC1 Healthcare, LLC – a Connecticut Corporation – intends to apply for a certificate of need to locate an outpatient psychiatric clinic counselling service for private adult clients at 187 South Canaan Road, Canaan, CT 06018, with an associated cost to operationalize of $10,000.00. Interested persons may contact the State of Connecticut, Department of Public Health, Office of Health Care Access. Attention: Steven Lazarus, 410 Capitol Ave., NS#13HCA, Hartford, CT 06134 or by phone at (860) 418-7001 for additional information.
R-A September 11, 12&13, 2016

NOTICE

In accordance with the provisions of State law, there being due and unpaid charges for which the undersigned is entitled to satisfy an owner and/or Manager's lien of the goods hereinafter desc ribed and stored at the Uncle Bob's Self Storage location(s) listed below.
And, due notice having been given, to the owner of said property and all parties known to claim an interest therein, and the time specified in such notice for payment of such having expired, the goods will be sold at public auction at the below stated location(s) to the highest bidder or otherwise disposed of on Friday,September 23, 2016 at 12:00 pm
433 Lakewood Rd., Waterbury, CT 06704.
Phone (203) 756-2000

Space number	Customer Name	Inventory
011C	Wesley Hawley	Hsld gds/Furn
054C	Paul Morgan	Personal and Hsld gds
091C	Glenn Richardson	Commercial gds
101C	Bettie Conyers	Personal and hsld gds
107C	Gary Sabia	Personal and hsld gds

Legals/ Public Notices

LIQUOR PERMIT
NOTICE OF APPLICATION

This is to give notice that I,

SO PEN CHENG
26 GRAND ST
THOMASTON, CT 06787-1401

Have filed an application placarded 09/03/2016 with the Department of Consumer Protection for a PACKAGE STORE LIQUOR PERMIT for the sale of alcoholic liquor on the premises at 544 STRAITS TPKE WATERTOWN CT 06795-3340

The business will be owned by:
RAAVA LLC

Objections must be filed by:
10/14/2016

SO PEN CHENG
R-A September 4 & 11, 2016

NOTICE TO CREDITORS
ESTATE OF
Mildred M. Scherer, (16-00639)

The Hon. Thomas P. Brunnock, Judge of the Court of Probate, District of Waterbury Probate Court, by decree dated August 5, 2016, ordered that all claims must be presented to the fiduciary at the address below. Failure to promptly present any such claim may result in the loss of rights to recover on such claim.

Thomas P. Brunnock, Judge

The fiduciary is:
Rosary L. Scherer
134 Dellwood Drive
Waterbury, CT 06708
Cynthia A. Scherer
134 Dellwood Drive
Waterbury, CT 06708
R-A September 11, 2016

Real Estate For Rent

Apartments
Condos
Garages
Houses
Mobile homes
Motels & hotels
Out-of-town
Rental services
Roomates
Rooms
Storage
Suburban
Vacation
Wanted to rent

Apartments for rent

BEACON FALLS 1br studio apt, new appls., no dogs, 1st flr., cr. ck. $675. Call 203-888-9093

NAUGATUCK 2 bedroom $800; Prospect Manor, lndry, storage, prkg, nice sec/ref. 203-753-3239

NAUGATUCK & 2 BR Priv pkng, sec 8 OK. $575 & $750 + sec/cr 203-994-7518 or 203-775-2608

NAUGATUCK 2br 1st flr., off st prkg. 1 car gar appls incl $950+1

Apartments for rent

WATERBURY 1, 2 & 3 rms, nice, heat & appl, secure building, prkg, $450 & up (203) 206-4051

WATERBURY 1 & 2 BR HT/HW, appl & carpet, busline, no pets lead free. 203-479-2218, 8-10a or 4-6p

WATERBURY 1 bedroom heat included, $700/mo+security, credit check. Call 203-300-1992.

WATERBURY 174 Willow St. **studios, 1br** start @ $450 H/HW incl Sect 8 ok. 203-510-6177

WATERBURY **1BR, 2BR, 3BR** available starting @ $550. Section 8 accepted. 203-510-6177

WATERBURY
★
1ST MONTH RENT FREE
Studios & 1BR $450-650 util incl
Se Habla Espanol
Call Cristina 203-509-2025
Call Rosie 203-560-9702

WATERBURY 2 BR, 1st floor near Wtby Hosp, clean, w/refrig & stove Sect. 8 OK. **203-525-7696**

WATERBURY 2 BR's, spacious 3rd Flr, gas heat, appls lots of closets sec. & refs. $750. **203-509-0584**

WATERBURY
2BR & 3BR, No pets. section 8 accepted 929-283-8737

WATERBURY 2BR coin W/D remod kit & bth, tile, off-st prkg, quiet. $850 203-982-7257, 994-8769

WATERBURY 2BR Grandview Ave, 2BR 1874 E. Main St. 2BR 913 Baldwin no pets. 203-644-3998

WATERBURY 3 & 4 BR 1st & 2nd flr., clean, spacious w/w, Sect 8 OK. Habla Espanol 203-982-3885

WATERBURY 3 & 4 BR Chestnut Av WD hkups, remod, clean, no pets. Sec 8 $875 & up. 203-558-5142

WATERBURY 3 rms 3rd flr. Renov, laundry, no utils, prkng, $750+sec & ref. **347-239-2212** Espanol

WATERBURY 3br, 2nd flr., appls., off prkg., $900/mo. Sec. & refs. 203-233-9028. 203-802-2304

WATERBURY 4 BR apt. , by new school. North Main and Tudor St. $925. 917-930-2326

WATERBURY 4rms, 2BR 1st fl Rose/Oak St. area. No pets, Sect. 8 OK $700 Avail now **203-525-5487**

WATERBURY $600 4rm, 2BR
WTBY $750 East End, 5 rms, 3 BRs, 2nd floor. No pets.
Velezis Realty, 203-574-7777

WATERBURY 7RM apt., no pets. heat & utils. not incl. 3rd flr., 203-759-7636 or 203-592-4290

WATERBURY DOWNTOWN
Beautiful renov. apts. in modern 10 story fireproof Elev. Bldg. w/great views; 1 BR $630; Low rentals incl: 1 Parking Space, Carpet/HW Flr., Security / Lndry Rm. No Pets. Habla Espanol. Mgmt: 203-756-1999; 203-837-7428

WATERBURY E.End 2br 4rm 1st fl, beaut remod appl WD off st pkg secure drs no pets 203-565-6628

WATERBURY
EAST END 1 BR apts. Some newly remodeled, on-site laundry, on busline, $675-$700. Credit check. **203-725-6121**

WATERBURY EAST END
SCOTT GARDENS
SPACIOUS TOWNHOUSE APTS.

Apartments for rent

WATERBURY Town Plot, 2 BR, off st. prkg w/laundry & storage in bsmt. No pets. **$850 mo.**, Heat & HW inc. Mandatory $30 background/credit chk application fee..Tony, 203-518-0602, 9-6.

WATERBURY Town Plot 3BR 1st flr, $850. appl no utils WD hkup sec 8 ok. Call 203 592-4323.

WATERBURY Town Plot, beautiful 2 BR apt. W/D hookup, off-st. parking. **203-232 6861**

WATERBURY Town Plot remod., 5 rms. 3rd flr., 2BR, gas heat, appls., W/D hkup, $800 203-233-0729.

Waterbury/Wolcott Line
Mod. elev. bldgs convenient well maintained **HILLTOP MANOR** Studios $570; 1 BR from $670; **LIBERTY COURT** heat, HW, elect. incl.; studios $650+; 1 BR $790+; Both incl. prkg., carpet/HW flrs, sec. & laundry. No pets. **Mgmt:** 203-755-0621; 203-470-9808

Condos for rent

TERRYVILLE Winfield Condos 2BR, 1.5 bath, appl's includ. Finish FR. No Pets $1050/mo 203-232-1433.

WATERBURY 1BR clean, quiet, off st prkg. $650 no pets, garages avail. Wayne 860-868-1256

WATERBURY 2BR TOWNHOUSES NEWLY BUILT Full appl kit, 1.5 ba, HW flr & tile, AC, gas ht, gar EZ Rt 8/184 start@ $1200. **203-756-7068**

WATERBURY 2BR twnhse nice, 1½ bth, HW flrs, prkg, W/D hkup, heat incl. **$875.** 203-206-4051

WATERBURY Twnhse 2br, 1.5, new carpet & flooring, lg gar, appl. No pet/smok $1000 203-228-2160

WATERBURY West side Luxury Tnhse, 2BR, 1½ bath, c/air, fplc., garage, $1200/mo. 203-723-1700

WATERBURY/WOLCOTT Line 4 rm twnhouse w/gar. 2 BR, 1.5 BA. Newly remodeled. Asking $1050. No pets. **203-437-2949**

Houses for rent

NORTHFIELD newer home, 3br, 2 bath, 2 car gar., deck, heat included. $1300/mo. 203-509-2828

WATERBURY 3Br house for rent please call for more information 203-410-6210

WATERBURY Overlook area. updated and renov. 3BR $1350, 2BR $1300. Sec. Call 203-715-1190

WATERBURY single family E.End, Overlook, Bunker Hill, South End Starting @ $1200 203-510-6177

Mobile homes for rent

NAUGATUCK 2 bedrooms, pool & clubhouse. No pets
(203) 729-8277

Rooms

WATERBURY 27 Johnson St, furn room, mens rooming house, sec/clean bldg./ shared bath/ all util & cable inc/$125 wk & up, sec/ref chk req. 203.444.7252

Waterbury East End starting at $125 wk. Shared kit & bath, $400 sec. **Velezis Realty 203-574-7777**

Agents & brokers

Real Estate Agents
needed for 2 local offices. Will Train.
Call Steve 203-509-3194

Mobile home

NAUGATUCK 3BR 1 ba new carp & lino. WAS $32,900; NOW $29,900 Liberty 860-747-6881 860-940-1204

NAUGATUCK 4 units to choose from starting at **$29,900** incl. pool & clubhouse 203-729-8277

NAUGATUCK WAS $65,000; NOW $60,000 2 BR, 2 bath, C/A. Liberty 860-747-6881 860-940-1204

PROSPECT beautiful new 2 BR, 2 bath, large EIK w/appls., **$87,500** LIBERTY 860-747-6881

PROSPECT move in ready! 2br, 1 bath, blk appl pkg. large EIK, $57,500. Liberty 860-747-6881

Open house

OAKVILLE
OPEN HOUSE
Reflections at Echo Lake Unit # 21
SUN. SEPTEMBER 11
1:00-4:00

Ranch style, 1850 sq.ft. 2BR, 2BA, living room, formal dining room, eat-in kitchen and den with fireplace, 330k.

For sale by owner 203-592-8526

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Simply Affordable.
JENSEN communities
A Home and Neighborhood Within Your
Get in on the good life! For Peop
Cedar Springs-Southington
OPEN HOUSES - SUNDAY 9/

8 Meadow
OPEN 12:00

nts

R's, spacious 3rd pls lots of closets . 203-509-0584

RBURY pets. section 8 29-283-8737

2BR coin W/D , tile, off-st prkg, 82-7257, 994-8769

Grandview Ave, ain St. 2BR 913 s. 203-644-3998

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is 3rd flr. Renov, prkng, $750+sec 2 Espanol

2nd flr., appls,, mo. Sec. & refs. 3-802-2304

3R apt. , by new ain and Tudor St. 26

ns, 2BR 1st fl a. No pets, Sect. ow 203-525-5487

00 4rm, 2BR End, 5 rms, 3 o pets. 203-574-7777

1 apt., no pets. incl. 3rd flr., 203-92-4290

DOWNTOWN ov. apts. in tory fireproof eat views; 1 BR ntals incl: 1 , Carpet/HW Lndry Rm. No anol. Mgmt: 203-837-7428

d 2br 4rm 1st fl, pl WD off st pkg ts 203-565-6628

BURY R apts. Some led, on-site ne, $675-$700. 3-725-6121

BURY PLOT 2 BR baths, W/D . $900 bath. Cook St. ardwood floors. pets. $1275. Real Estate -6491

BURY it available 203-509-2025 3-560-9702

ous 1BR & 2BR on-site laundry. 860-810-2941

d of viewing apts, ours are ted. 1 & 2 Br. 0

PLOT 2 BR, 3rd n, safe, off-st. 5. 203-575-9775

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WATERBURY/WOLCOTT Line 4 rm twnhouse w/gar. 2 BR, 1.5 BA. Newly remodeled. Asking $1050. No pets. **203-437-2949**

Garages for rent

WATERBURY East End. 1 bay for storage only. 10X20. **$100/mo. Velezis Realty, 203-574-7777**

Houses for rent

NORTHFIELD newer home, 3br, 2 bath, 2 car gar., deck, heat included. $1300/mo. 203-509-2828

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Real Estate For Sale

Lots for sale

BANTAM LAKE bldg lot, priv community tennis, boat, water,sewer incl. $169,000. 860-868-1256

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PROSPECT move in ready! 2br, 1 bath, blk appl pkg. large EIK, $57,500. Liberty 860-747-6881

If you're trying to BUY, SELL or FIND anything...
CLASSIFIED has the solution!
(203) 574-3616.
RepublicanAmerican

Commercial

Business for sale
Commercial for sale, lease, rent

Commercial for sale, lease, rent

WATERBURY OFFICE 2nd flr. Newly renovated. Perfect for bookkeeping, insurance or tax preparation, small business. Approx 950 sq. ft. plus 800 sq ft storage. $900/mo 203-879-3495

WATERBURY space for rent. Ideal for: drs office, beauty shop or store. 203-756-6838, 860-712-1471

Announcements

Absolutely free
Lost & found
Special notices

Absolutely free

1975 CUDDY CABIN no motor, In/OU, come pick up. 141 Danielle Dr., Waterbury. 203-565-8560

Lost & found

LOST CAT gray female near May Ave, Naug answers to "Pewter" Please check bsmts / cellar. Reward 203-720-2091

Legals/ Public Notices

LEGAL NOTICE
Nonnewaug High School
Records To Be Destroyed

In keeping with state and federal regulation on confidentiality, school officials plan to destroy educational records of students that graduated prior to 1966, who attended Nonnewaug High School in Region 14. The destruction is scheduled to take place on 9/14/2016. Anyone interested in receiving his/her records, or those of their children, should make the request in writing to: Nonnewaug High School Principal, 5 Minortown Road, P.O. Box 469, Woodbury, CT 06798
R-A September 8, 9 & 12

SHARON ZONING BOARD OF APPEALS
LEGAL NOTICE

To Whom It May Concern, notice is hereby given that on September 26, 2016 at 6:30PM, at the Sharon Town Hall, 63 Main Street, Sharon, CT, the Zoning Board of Appeals will hold a public hearing on the following Appeal:

Appeal #176 of James A. Quella, for Q Farms LLC, for a variance to allow a sign up to 9.5 square feet where the Regulations require 4 feet, Article IX Section 7 3b. The property location is – Assessor Map 13 Parcels 23 – 63 Jackson Hill Road, in the Rural Residence District.

At this hearing interested persons may be heard and written communication received. The application is on file at the Selectmen's Office, Sharon, CT.

Dated at Sharon, Connecticut this 11th day of September 2016.
William Trowbridge, Chairman
Sharon Zoning Board of Appeals
RA 9/12 & 20, 2016

TOWN OF WOLCOTT
WARNING OF
SPECIAL TOWN MEETING TUESDAY, SEPTEMBER 20, 2016

The following resolution was approved by the Town Council on Tuesday, August 16, 2016, and will be submitted to the electors and persons qualified to vote at town meetings of the Town of Wolcott for approval or disapproval at a Special Town Meeting to be held in the Council Chambers of the Wolcott Town Hall; 10 Kenea Avenue, Wolcott, Connecticut on Tuesday, September 20, 2016 at 6:00 p.m. (E.D.T.):

RESOLUTION TO AMEND THE $410,000 APPROPRIATION AND BOND AUTHORIZATION FOR THE PURCHASE OF PROPERTY ON EAST STREET
TO CHANGE THE USE OF THE PROPERTY TO OPEN SPACE PRESERVATION, RECREATIONAL ACTIVITIES AND MUNICIPAL PURPOSES

Section 1 of said Resolution is amended by changing the use of the property from the expansion of the Farmingbury Hills Golf Course to open space preservation, recreational activities and municipal purposes, thereby making said Section 1 read as follows:

SECTION 1. That the Town of Wolcott appropriate $410,000 for costs related to the purchase of approximately 38 acres of land on East Street in Wolcott to be used for open space preservation, recreational activities and municipal purposes. The Town shall

Legals/ Public Notices

LEGAL NOTICE

Notice is hereby given that, Pursuant to Connecticut General Statutes 19a-638, MC1 Healthcare, LLC – a Connecticut Corporation – intends to apply for a certificate of need to locate an outpatient psychiatric clinic counseling service for private adult clients at 187 South Canaan Road, Canaan, CT 06018, with an associated cost to operationalize of $10,000.00. Interested persons may contact the State of Connecticut, Department of Public Health, Office of Health Care Access. Attention: Steven Lazarus, 410 Capitol Ave., NS#13HCA, Hartford, CT 06134 or by phone at (860) 418-7001 for additional information.
R-A September 11, 12&13, 2016

INVITATION TO BID

SEALED BIDS ON THE FOLLOWING WILL BE RECEIVED BY THE DIRECTOR OF PURCHASES IN HIS OFFICE IN THE CITY HALL BUILDING, 235 GRAND STREET, WATERBURY CT. UNTIL THE DATE AND TIME SPECIFIED WHEN THEY WILL BE PUBLICLY OPENED AND READ. NO BID SHALL BE ACCEPTED FROM, OR CONTRACT AWARDED TO, ANY PERSON WHO IS IN ARREARS TO THE CITY UPON DEBT OR CONTRACT OR WHO IS A DEFAULTER AS SURETY OR OTHERWISE UPON ANY OBLIGATION TO THE CITY.

Education / IT

Opening Date:
September 27, 2016
at 10:30 A.M.
S2 Security & Database Management System Support

Water Pollution Control

Opening Date:
October 3, 2016 at 10:30 A.M.
High Voltage Electric Svc Maintenance – A mandatory pre-bid will be held at 210 Municipal Rd, Wtby, CT at 10:00 A.M. on September 21, 2016

Public Works

Opening Date:
September 27, 2016
at 11:00 A.M.
Sewer Inspection
Camera Truck
Opening Date:
September 27, 2016
at 11:30 A.M.
Prisoner Transport Van

Education

Opening Date:
October 3, 2016
at 11:30 A.M.
Paints Annual Order
2016 – 2017

Health Dept

Opening Date:
October 3, 2016 at 11:00 A.M.
Lead Hazard Reduction – 17 Mattson Court – A mandatory pre-bid will be held at 17 Mattson Court, Wtby, CT at 10:00 A.M. on September 20, 2016

Waterbury Development Corporation

Opening Date:
September 23, 2016
at 1:30 P.M.
Demolition – 359 Grove St, - A mandatory pre-bid will be held at 359 Grove St, Wtby, CT at 8:30 A.M. on September 16, 2016

This contract is subject to state set – aside & contract

Time to Take Your Career to the Next Level!

Apartments for rent

NAUGATUCK 2 bedroom $800; Prospect Manor, lndry, storage, prkg, nice sec/ref. 203-753-3239

NAUGATUCK & 2 BR Priv pkng, sec 8 OK. $575 & $750 + sec/cr 203-994-7518 or 203-775-2808

NAUGATUCK 2br 1st flr., off st prkg, 1 car gar appls incl $950+1 mo. sec. dep. no pet 203-206-9139

NAUGATUCK 5 rms, 2 bedroom, Appls, W/d hookups, $675/mo Security + Ref. 203-723-5913

NEW HARTFORD 2br, WD hkup sec dept. & check no utils. No smoke. Pets considered. 860-738-3302

WATERBURY 1, 2, 3 & 4 BR apts. available. Property Management Center (203) 755-6649.

WATERBURY 1, 2, 3, 4 BR Apts & Houses available **NEWLY RENOVATED** Agent 203-565-9639

WATERBURY 1, 2 & 3 rm apts clean, appl, util secure bldg lndry $465/up. Sect 8 OK. 203-753-3239

WATERBURY 1, 2 & 3 rms, nice, heat & appl, secure building, prkg, $450 & up (203) 206-4051

WATERBURY 1 & 2 BR HT/HW, appl & carpet, busline, no pets lead free. 203-479-2218, 8-10a or 4-6p

WATERBURY 1 bedroom heat included, $700/mo+security, credit check. Call 203-300-1992.

WATERBURY 174 Willow St. **studios, 1br** start @ $450 H/HW incl Sect 8 ok. 203-510-6177

WATERBURY **1BR, 2BR, 3BR** available starting @ $550. Section 8 accepted. 203-510-6177

WATERBURY
★
1ST MONTH RENT FREE
Studios & 1BR $450-650 util incl
Se Habla Espanol
Call Cristina 203-509-2025
Call Rosie 203-560-9702

Now!
24 Hours-A-Day, 7 Days-A-Week
You can place your private party Classified Ad. Our live representatives are waiting for your call.
(800) 992-3232
RepublicanAmerican
CLASSIFIED
"THE CLASSIFIEDS THAT GET IT DONE"

WATERBURY 2 BR's, spacious 3rd Flr, gas heat, appls lots of closets sec. & refs. $750. **203-509-0584**

WATERBURY 2BR coin W/D remod kit & bth, tile, off-st prkg, quiet. $850 203-982-7257, 994-8769

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WATERBURY Spacious 1BR & 2BR immac. No pets, on-site laundry. Starting at $650. 860-810-2941

WATERBURY tired of viewing dirty, neglected apts, ours are clean and updated. 1 & 2 Br. avail. 203-715-1190

WATERBURY TOWN PLOT 2 BR, 3rd floor, bright, clean, safe, off-st. prkg., no pets. $625. 203-575-9775

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Houses for rent

BEACON FALLS 4 BR ranch, garage, $1850/mo. Motivated. 203-704-0192 for more info.

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Mobil

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Absolutely free
Lost & found
Special notices

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Business for sale
Commercial for sale, lease, rent

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WATERBURY space for rent. Ideal for: drs office, beauty shop or store. 203-756-6838, 860-712-1471

Absolutely free

1975 CUDDY CABIN no motor, in/OU, come pick up. 141 Danielle Dr., Waterbury. 203-565-8560

PIT BULL Older female needs loving home. Waterbury area. 203-598-6647

Lost &

Legals/ Public Notices

Legal Notice
Litchfield Zoning Board of Appeals

At the Litchfield Zoning Board of Appeals meeting held on September 6, 2016 the following variances were granted:
Case 16-9-1 A request from Henry James Stedronsky for Building Coverage variance of 1.4% for a total coverage of 16.7% (from existing 15.3%) from HR-20 #3 for property at 54 Wolcott Street.
Case 16-9-2 A request from Alison Castor for Side yard variance of 2' from RH20 #2 for proposed rear exit stairs for property at 56 Torrington Road.
Case 16-9-3 A request from Susan Nelson Sid Glover for Side yard variance of 4' from HR30 #2 and Enlargement/addition from General Standards and Requirements F(5) for a proposed increase in roof height and new porch addition for property at 59 North Street.

Brian Donohue, Chairman
R-A Septembe 13, 2016

DOCKET NUMBER:
WTH-CV-16-6001125-S
RIVERVIEW ESTATES INC. VS.
KAREN GUDZINSKI
SUPERIOR COURT
JUDICIAL DISTRICT OF WATERBURY
AT WATERBURY HOUSING SESSION
AUGUST 31, 2016
NOTICE OF SALE

Pursuant to an order of the Court dated August 31, 2016 a public sale of a 1979 Caravan Festival mobile manufactured home, Vin# 1192PAFLIA83622, owned by Karen Gudzinski, shall be held at 24 Thunderbird Drive, Naugatuck, Connecticut on September 20, 2016 at 4:00 pm.
Any person, including a lien holder or the owner of the mobile manufactured home park, may bid at the sale.
THE SALE WILL EXTINGUISH ALL PREVIOUS OWNERSHIP AND LIEN RIGHTS.
PLAINTIFF
BY: THOMAS T. LONARDO
ITS ATTORNEY
290 PRATT STREET
MERIDEN, CT 06450
203-639-9860 JURIS #401603

R-A September 13, 15 & 17, 2016

LEGAL NOTICE

The Public Utilities Regulatory Authority (PURA) will conduct a public evidentiary hearing on Tuesday, September 20, 2016, at 9:30 a.m. concerning Docket No. 16-06-01, Application of GenConn Energy for Establishment of 2017 Revenue Requirements, at the PURA's offices, Ten Franklin Square, New Britain, Connecticut. A public comment session will then be held at 6:00 p.m. on the same date and location for the sole purpose of hearing public comments. Pursuant to Conn. Gen. Stat. §16-243u, the purpose of this docket is for the Authority to review the 2017 revenue requirements for GenConn Energy's peaking generating units. Information on any cancellation or postponement of this hearing is available each day commencing from 7:30 am by calling PURA's of

Legals/ Public Notices

INVITATION TO BID
TOWN OF OXFORD
FIRE DEPARTMENT

Notice is hereby given that the Board of Selectmen and Board of Chiefs of the Town of Oxford are requesting bids for:

Pumper Specification with
1500 GPM Pump,
1000 Gallon Tank and Rescue STYLE Body

Bid specifications and instructions are available at the Office of the First Selectman located at the Oxford Town Hall, 486 Oxford Road, Oxford, Connecticut, starting Wednesday, September 14, 2016. Pick-up hours will be 9:30 AM – 4:00 PM. For any questions regarding this bid call Fire Chief Scott Pelletier at 203-881-5230 Monday – Friday 8:00 AM – 2:00 PM.

All bidders shall provide four (4) copies of bid. Bids are due to the Office of the First Selectman, 486 Oxford Road, Oxford, CT 06478 by Monday, October 17, 2016 by 2:00 PM, clearly marked "Pumper Specification with 1500 GPM Pump, 1000 Gallon Tank and Rescue STYLE Body BID".

All proposals shall be submitted in writing with attachment reflecting qualifications, experience, education, licensing, etc. All bids shall be valid for 120 days. Proposals will be considered, awarded and governed pursuant to Section 6-12(D) of the Oxford Town Charter. The Board of Selectmen and Board of Chiefs reserve the right to reject any and all bids, waive irregularities or information in bidding and if necessary, re-advertise for bids. The Board of Selectmen and the Board of Chiefs also reserve the right to make such recommendations and or awards, including accepting a bid, to be in the best interest of the Town of Oxford.

R-A September 13, 2016

Advertise in the classifieds and really clean up! Your unwanted items could be in big demand!

Use the classifieds to turn them into cash fast!

Legals/ Public Notices

LEGAL NOTICE

At the September 8, 2016 meeting of the Morris Inland Wetlands Commission the following were approved: Application 16-010 from Mariah Dice for a new home, septic and well at 441 Lakeside Road; Application 16-011 from Thomas and Cynthia Mazzaferro to repair a seawall at 35 Palmer Road; and Application 16-009 from Scott Richardson for a new well at 4 Yacht Club Passway

Michael Doyle
Morris Inland
Wetlands Commission
R-A September 13, 2016

LEGAL NOTICE

Notice is hereby given that, Pursuant to Connecticut General Statutes 19a-638, MC1 Healthcare, LLC – a Connecticut Corporation – intends to apply for a certificate of need to locate an outpatient psychiatric clinic counseling service for private adult clients at 187 South Canaan Road, Canaan, CT 06018, with an associated cost to operationalize of $10,000.00. Interested persons may contact the State of Connecticut, Department of Public Health, Office of Health Care Access. Attention: Steven Lazarus, 410 Capitol Ave., NS#13HCA, Hartford, CT 06134 or by phone at (860) 418-7001 for additional information.
R-A September 11, 12&13, 2016

LEGAL NOTICE
PROPOSED CHARTER CHANGES
FOR THE
November 8, 2016 Election Ballot
TOWN OF WINCHESTER

The Charter Revision Commission has voted to submit the following Charter changes to be voted on at the November 8, 2016 Presidential Elections.
1).Shall Section 305C of the Charter be amended to change the monetary threshold to require a referendum to nine one-hundredths of one percent (0.09%) of the total expenditures of the latest approved Town budget.

2).Shall Section 305D of the Charter be amended to change the monetary threshold to allow electoral challenges to nine one-hundredths of one percent (0.09%) of the total expenditures of the latest approved Town budget.

3). Shall Section 911 of the Charter be amended to change the minimum monetary threshold for competitive bidding to three one-hundredths of one percent (0.03%) of the total expenditures of the latest approved Town budget.

4). Shall Section 1102B of the Charter be amended to allow confidential ballots as a form of voting.

5). Shall Section 1102C of the Charter be amended to move the Annual Budget meeting to the second meeting in May and change the date of the Budget referendum to a date not less than fourteen (14) days and no more than twenty-one (21) days from the Annual Town Budget Meeting.
6). Shall Section 1108A of the Charter be amended to change any further Annual

Leg Pu

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Wi & Z Notific

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Dated at 1st day of Craig Sanc

R-A Septer

NOTIC ESTATE O of Nau

The Hon. Judge of th District of Court, by d 2016, orde must be pr ciary at th Failure to any such c the loss of such claim

Patricia Ale

Attachment II
State of Connecticut Department of Public Health
State Licenses Currently Held

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

FACILITY LICENSING & INVESTIGATIONS SECTION

TO: Stephen B. Langley, Executive Director
MC1 Healthcare
P.O. Box 717
Canaan, CT 06018

FROM: Sandra C. Bauer, LEA

DATE: September 23, 2015

Enclosed is your license to operate a **Facility for the Care or Treatment of Substance Abusive Persons.**

The license must be posted in a conspicuous place as required by the General Statutes of Connecticut, Section 19a-493.

The license is in effect only for the operation of the facility as it is now organized. The Facility Licensing & Investigations Section **must be notified immediately** if you:

1. Change the Executive Director.
2. Plan any structural changes.
3. Plan to move.
4. Plan to sell the facility.
5. Plan to discontinue operation.
6. Plan to change services.

Any of these changes or proposed changes also requires written notification to this division.

If I can be of any assistance, please do not hesitate to contact me.

Enclosure(s)

Phone: (860) 509-8023 Fax: (860) 509-7538
Telephone Device for the Deaf (860) 509-7191
410 Capitol Avenue - MS # 12FLIS
P.O. Box 340308 Hartford, CT 06134
An Equal Opportunity Employer

STATE OF CONNECTICUT

Department of Public Health

LICENSE

License No. 0388

Facility for the Care or Treatment of Substance Abusive or Dependent Persons

In accordance with the provisions of the General Statutes of Connecticut Section 19a-493:

MC1 Healthcare LLC of Canaan, CT, d/b/a Mountainside Treatment Center is hereby licensed to maintain and operate a private freestanding Facility for the Care or Treatment of Substance Abusive or Dependent Persons.

Mountainside Treatment Center is located at 187 South Canaan Rd, Canaan, CT 06018 with:

Stephen B. Langley as Executive Director.

The service classification(s) and if applicable, the residential capacities are as follows:

20 Residential Detoxification and Evaluation Beds
58 Intermediate and Long Term Treatment and Rehabilitation Beds
Day or Evening Treatment
Outpatient Treatment

This license expires **September 30, 2017** and may be revoked for cause at any time.

Dated at Hartford, Connecticut, October 1, 2015. **RENEWAL**

Jewel Mullen, MD, MPH, MPA
Commissioner

STATE OF CONNECTICUT

Department of Public Health

LICENSE

License No. 0609

Psychiatric Outpatient Clinic for Adults

In accordance with the provisions of the General Statutes of Connecticut Section 19a-493:

MC1 Healthcare LLC of Canaan, CT, d/b/a Mountainside-Wilton CT is hereby licensed to maintain and operate a Psychiatric Outpatient Clinic for Adults.

Mountainside-Wilton CT is located at 372 Danbury Rd, Wilton, CT 06897 with:

Stephen Langley as Executive Director,
Sarah Osborne as Director.

This license expires **March 31, 2020** and may be revoked for cause at any time.

Dated at Hartford, Connecticut, May 2, 2016. **INITIAL**

Raul Pino, MD, MPH
Commissioner

STATE OF CONNECTICUT

Department of Public Health

LICENSE

License No. 0504

Facility for the Care or Treatment of Substance Abusive or Dependent Persons

In accordance with the provisions of the General Statutes of Connecticut Section 19a-493:

MC1 Healthcare LLC of Canaan, CT, d/b/a Mountainside-Wilton CT is hereby licensed to maintain and operate a private freestanding Facility for the Care or Treatment of Substance Abusive or Dependent Persons.

Mountainside-Wilton CT is located at 372 Danbury Rd, Wilton, CT 06897 with:

Stephen Langley as Executive Director.

The service classification(s) and if applicable, the residential capacities are as follows:

Chemical Maintenance Treatment
Outpatient Treatment

This license expires **March 31 2018** and may be revoked for cause at any time.

Dated at Hartford, Connecticut, May 2, 2016. **INITIAL**

Raul Pino, MD, MPH
Commissioner

Attachment III
Professional, Administrative, Clinical and Director Service Personnel
Curriculum Vitae

ROY SASENARAINE

PROFILE:

Healthcare professional, offering 14+ years of comprehensive accomplishments with proven and leadership skills, ability to improve operations, maximize profits, client relations and employee development. Powered with well- defined business acumen, initiative, and outstanding organization, problem resolution, technical, and negotiation skills.

- **Results-oriented executive** with strategic vision, ability to achieve consensus, spearheads growth/changes that conceptualize and implement sustainable initiatives.
- **Versatile, hands-on leader and team player** with strong program implementation skills. A reputation for driving strategic vision and creating long-term value.
- **Negotiator and consultant** expert at establishing strong professional relationships with institutions, clients, medical staff and executives.
- **Physician Recruitment** and contract negotiation creating alignment with organizational objectives and success factors.

Healthcare Operations General/Executive Management Revenue Growth & Business Expansion
Ambulatory Development/Operations Strategic & Business Planning Successful Market Penetration
Medical & Healthcare System Rapid Conflict Resolution Cross-functional Leadership

EXERIENCE:
Mountainside Treatment Center, Canaan, CT 2015-Present
Chief Operating Officer

Yale New Haven Hospital, New Haven, CT 2006–2015

Yale New Haven Health System (YNHHS) is composed of three corporate member delivery networks and a physician foundation with a total of 2,130 licensed beds, 18,000 employees and a medical staff of 5,675. The System generates more than $2.6 billion in revenue and accumulated assets of approximately $3.6 billion. Work history includes the acquisition of the 500+ bed Saint Raphael Healthcare System in 2012.

Summary of Qualifications

Newly formed Cost and Value Positioning (CVP) department charged with enhancing financial results by $600 million over five years. Reporting to the Executive Director of CVP and the President/Chief Operating Officer of Yale New Haven Hospital. Responsible for the management, initiation, development, implementation and monitoring of initiatives for YNHHS.

- Achieved $150M in cost reductions and revenue enhancements within the first 12-months.
- Developed governance, multi-disciplinary team approach, budget and overall infrastructure for Clinical Redesign facet of CVP.

- Led 25+ simultaneous teams in the identification of cost savings, quality improvements and reimbursement opportunities through the standardization of clinical protocols.
- Created a service line approach to clinical integration and accountability across YNHHS.
- Created standardize tools and methodology to assist in identifying and capitalizing on clinical opportunities.
- Responsible for mentoring staff and allocating resources, including internal staff and external consultants.
- Collaborated with Yale University physicians on documentation, presentations and *publication on positive clinical redesign outcome.*

Reporting to the President and Chief Operating Officer, and assigned to assist the executive management team with special projects that required an understanding of the clinical, operational, quality and financial impact. Assignments included:

Feasibility Assessment

- Conducted for the Senior Vice President of Operations an organizational viability assessment and provided options/recommendations of a long standing subsidiary.
- Responsible for an annual cost reduction of $2.5 million dollars with the recommended closure of the subsidiary.
- Architected the operational wind down, communication, human resource and employee retention plan.

Ambulatory

- Appointed to operationalize Yale New Haven Hospital first of its kind medical building within 24-days.
- Oversaw the operational integration and coordination of sixteen service line and 350 employees into a 120 thousand square feet medical building.
- Assumed project management and administrative responsibility for the completion of the building construction.
- Conducted a budgetary assessment and established new operating budgetary parameters.
- Responsible for monitoring and reporting to senior leadership the actual performance against budgetary and business plan projections, as well as a post construction needs assessment.

Reporting to the President and Chief Operating Officer, and assigned to assist the executive management team with special projects that required an understanding of the clinical, operational, quality and financial impact. Assignments included:

- Responsible for monitoring and reporting to senior leadership the actual performance against budgetary and business plan projections, as well as a post construction needs assessment.

Multidisciplinary Center

- Conducted an administrative and clinical operational assessment of the multidisciplinary center and provide leadership and guidance for staff/managers.

- Limited the financial loss and patient dissatisfaction by recommending the delay opening of the Center until an appropriate clinical and operational plan/resources were in place.
- Responsible for operational and clinical redesign of the Center within 60-days.
- Successfully procured funding and coordinated the building of an Allergy Center within 45 days.

Promoted to spearhead the planning, implementation, and growth of the oncology product line. Assumed responsibility for a $10 million budget and 70 employees treating 500 cancer patients, annually.

- Successfully restructured cancer centers, creating an effective management team to ensure the delivery of the highest quality of care.
- Generated over $7 million in revenue by executing new controls and clinical documentation and protocols.
- Increased annual revenue by $500 thousand and enhanced quality patient care by providing strategic insights in overseeing the investigation of different treatment modalities.
- Responsible for reducing claims denial by 50% and the identification/rebilling of $1.7 million of unbilled and missed revenue opportunities over a 15-month period.
- Negotiated the largest discount publicly published for a linear accelerator, as well as $1 million of free upgrades.
- Rapidly increased volume through an aggressive and sustained marketing plan, resulting in a 60% increase in the Cyberknife program volume over a 60-day period.
- Oversaw the operational and clinical logistic of the organization's clinical trial program. Received the national distinguished Certificate of Excellence Award for 2011 from the Radiation Therapy Oncology Group.

Handpicked by the Saint Raphael Healthcare System CEO to manage the largest department. Assumed full accountability in managing an operating budget of $28 million, coordinating 12 sections and 13 ambulatory primary care clinics.

- Established a new structure for the department, creating a new section of Hospitalist Medicine.
- Reduced costs by $1.5 million and increased patient satisfaction, quality outcomes and continuity of care.
- Renegotiated 35 physician employment contracts and financial compensation during the course of 8-months.
- Recruited and negotiated physician contracts for 12 specialties.
- Optimized physician productivity and charge capture with the development of daily physician charge capture and reconciliation process.
- Achieved distinction with the design and execution of new employment contract, incentive structure and language, making physicians accountable for the timely submission of charges.

Streamlined the system's $9 million operation and directing the activities of the agency's 180 plus clinical and administrative staff. Executed key strategic vision, initiating formal planning process, integrating operating departments, creating strategies to foster collaborative physician

relationships, and revising the organizational structure to meet and exceed the growth and demands of continually changing industry.

- Successful reversed annual losses of $3 million and inefficient operational performance within 15-months.
- Reduced monthly expenses and losses by $200 thousand through the implementation of new financial and expense controlling strategies.
- Reduced administrative and clinical expenses consistently by $600 thousand through the formulation a fiscal budget.
- Increased gross revenues by 50% within seven months through the application of new collection procedures, thresholds, and measurable indicators.
- Implemented a culture of transparency, responsiveness and accountability, boosting employee morale and established the credibility of the administration.

Oversaw cash flow management and investment banking relations. Enhanced the cash collections process by restructuring the Billing/Collection Department, eliminating redundancies and implementing performance indicators. Functioned as member of the Board of Directors.

- Uncovered and settled $1.3 million accounting and tax filing irregularities associated with the previous administration within the first 45-days.
- Resolved $350 thousand issues associated with write-offs for the period 2005 to 2007.
- Reduced Medicare monthly low utilization payments by $65 thousand through the development of new review protocols.

EDUCATION:

Quinnipiac University, Hamden, Connecticut

MBA, Healthcare Administration, 2001

BS, Health Administration, 1999

American College of Healthcare Executives (ACHE)
University Health System Consortium (UHC)

Stephen Langley
24 ABBY DRIVE
HEBRON, CT, 06248
(860) 318-5212

Professional Experience

MOUNTAINSIDE TREATMENT CENTER, CANAAN, CT UNITED STATES
Executive Director, Oct 2013 – present

- Steward of the culture of excellence maintained by this CARF accredited, leading provider of chemical dependency detoxification, residential, extended care and outpatient treatment services.
- Day to day responsibilities include leadership of all treatment and services teams: Detox/Residential/Clinical; Client Services; Family Wellness; Outpatient; and Operations. Additional responsibilities include program development, safety and security, and Federal and State regulatory compliance.

Senior Vice President, Client Services, Jan 2013 – Oct 2013
Vice President, Client Services, Jan 2012 – Jan 2013
Director, Client Services, Jan 2011 – Jan 2012
Director, Extended Care, Apr 2008 – Jan 2011

NATIONAL FOOD PROCESSORS ASSOCIATION, WASHINGTON, DC UNITED STATES
Vice-President, Member Services, Mar 1996 – Jan 1999

- Establish and maintain effective working relationships with clients, government officials, and media representatives and use these relationships to develop new business opportunities.
- Write interesting and effective press releases, prepare information for media kits and develop and maintain company internet or intranet web pages.
- Identify main client groups and audiences, determine the best way to communicate publicity information to them, and develop and implement a communication plan.
- Assign, supervise and review the activities of public relations staff.
- Develop and maintain the company's corporate image and identity, which includes the use of logos and signage.
- Respond to requests for information about employers' activities or status.

AMERICAN MEAT INSTITUTE, ARLINGTON, VA UNITED STATES
Director of Member Services, Aug 1989 – Mar 1996

- Formulate, direct and coordinate marketing activities and policies to promote products and services, working with advertising and promotion managers.
- Identify, develop, or evaluate marketing strategy, based on knowledge of establishment objectives, market characteristics, and cost and markup factors.
- Direct the hiring, training, or performance evaluations of marketing or sales staff and oversee their daily activities.

Education

TUNXIS COMMUNITY COLLEGE, BRISTOL, CT UNITED STATES

- Associates Degree, Drug and Alcohol Recovery Counselor, May 2010
- CAC Certification, Connecticut Certification Board, March 2011

Additional Skills

- Strong Communication Skills
- Proven Team Leader
- Able to Multi-Task
- Proven Track Record of Achieving Results
- Proficient in Multiple Computer Programs, Including Microsoft Office

CURRICULUM VITAE

Randall R. Dwenger, MD
PO Box 718
3 Brook Street
Lakeville, CT 06018
860.435.8863

EDUCATION:

Pre-medical: DePauw University, Greencastle, Indiana
1976-1980, BA degree, cum laude in
chemistry and psychology, May 1980

Medical School: Indiana University School of Medicine,
Indianapolis, Indiana, 1980-1984,
MD degree, May 1984

Residency: Institute of Living, Hartford, Connecticut
Psychiatry, July 1984 - June 1988
(includes six-month medicine internship at:
Mount Sinai Hospital, Hartford, Connecticut
January 1985 - June 1985)

PROFESSIONAL EXPERIENCE:

Mountainside Treatment Center, Canaan, CT, 2008 – present

- Medical Director – January 2014 – present
- Clinical Leadership, Supervision and Direct-care Psychiatric Services for Mountainside's 20-bed Detox
- Unit and 58-bed Residential Treatment Program
- Consulting Psychiatrist – Psychiatric Evaluation and Medication Management for referred chemical dependency/dual-diagnosis clients (2008-2014)

Private Practice, Lakeville, CT, July 2007 – present

- Psychiatric Evaluation, Medication Management and Individual Psychotherapy services for adolescent and general adult population
- Consulting Psychiatrist –
  Salisbury School, Salisbury, CT (2007-present)
  Millbrook School, Millbrook, NY (2008-present)
  Kent School, Kent, CT (2013-2014)
  Berkshire School (2008-2012)

Center for Motivation and Change, New Marlboro, MA, February 2014 – August 2014

- Staff Psychiatrist – Psychiatric Evaluation and Medication Management for 13-bed residential rehabilitation facility

Veterans Administration – Winsted CBOC, Winsted, CT, June 2007-October 2013

- Psychiatric evaluation and medication management for general psychiatry and dual-diagnosis veterans in outpatient mental health setting

CMHA (Community Mental Health Affiliates) (at the former "Northwest Center for Family Services" Sites) Lakeville, CT and Torrington CT, May 2007 – December 2009

- Psychiatric Evaluation and Medication Management services for general adult and adolescent population in a community-based outpatient mental health clinic

Veterans Administration – New York Harbor Healthcare System, New York, NY, October 1999 – April 2007

Director, Outpatient Psychiatry Clinic – Manhattan Campus, May 2005 – April 2007

- Clinical and administrative oversight/supervision of outpatient psychiatric services for veteran population within large metropolitan medical center.
- Psychiatric evaluation and medication management for general psychiatry and dual-diagnosis veterans in outpatient mental health setting
- Oversight of several administrative initiatives including: Chairman of Mental Health Stakeholders for JCAHO continued readiness for NY-Harbor VA; Coordinating Performance Improvement for Mental Health for NY-Harbor VA; Monitoring department's performance on National Director Performance Measures, January 2003 - present

Medical Director, Veterans Health Care Center – Chapel Street Clinic, October 1999 – May 2005

- Psychiatric evaluation and medication management for general psychiatry and dual-diagnosis veterans in outpatient Community-Based Mental Health clinic
- Psychiatric/medical oversight and consultation for programs at Chapel Street CBOC, including TORCH (Homeless Veterans Program), Mental Health - Intensive Case Management (MH-ICM), SARP, and Mental Hygiene Clinic programs
- Coordinator/Director of outpatient SARP (Substance Abuse Rehabilitation Program) – July 2004 – April 2005
- Supervision of Psychiatry Residents – SUNY/Downstate

New York Hospital Medical Center of Queens, Fresh Meadows, NY

Medical Director, New Start / New Life Center, January 1998 – September 1999

- Psychiatric evaluation and medication monitoring for dual-diagnosis and general psychiatry clients in outpatient setting

Bayley Seton Hospital, Staten Island, NY, Director, Center for Chemical Dependency, July 1991 - January 1998

- Administrative, fiscal and clinical/programmatic/medical supervision for inpatient chemical dependency detoxification program – including 27-bed Chemical Dependency Unit and 20-bed Alcohol Detox Unit
- Development of Chemical Dependency Outpatient Center
- Supervision of Psychiatry Residents
- Associate Psychiatry Staff, Bayley Seton Hospital and St. Vincent's Medical Center (Staten Island)

Hospital Committees:

- Ethics Committee
- AIDS Task Force
- Medical Records Committee
- Pharmacy and Therapeutics Committee
- Department of Psychiatry, Training Council

- Department of Psychiatry, Quality Assurance – Monitoring and Evaluation Committee, Chairman

Other:

- Continuous Quality Improvement; Facilitator, Team Leader

The Regent Hospital, New York, NY
Director of Chemical Dependency, September 1990 - June 1991

- Program development and administrative, clinical, supervisory responsibilities for inpatient 15-bed chemical dependency program for treatment-resistant Older Adolescent/Young Adult population
- Outpatient therapy and Medication Monitoring for Adolescent and General Adult populations (through Metropolitan Medical Group)

Fair Oaks Hospital, Summit, NJ
Adolescent Center for Chemical Education, Prevention and Treatment (ACCEPT)
Associate Director, July 1988 - July 1989
Director, July 1989 - September 1990

- Administrative, clinical and supervisory responsibilities in a 20-bed inpatient unit for chemically-dependent and dually-diagnosed adolescents
- Outpatient individual and family therapy for Adolescent and General Adult populations

Institute of Living, Hartford, CT
Chief Resident, July 1987 - June 1988
Resident, Adult Psychiatry, July 1984 - June 1988

- Clinical Supervision of PGY-1 Residents, September 1987 - June 1988
- Team Leader, Adolescent Psychiatry Unit, August 1986 - June 1987

MEDICAL LICENSURE:
New York, 1990 - [# 183297]
New Jersey, 1988 - 1990
Connecticut, 1986 – 1996; 2006 – [#027715]
Massachusetts, 2008 – [#238121]
Indiana, 1984 - 1987

BOARD CERTIFICATION:
American Board of Psychiatry and Neurology, November 1992 [#36120]
American Board of Addiction Medicine, December 2014

REGISTRATIONS/CERTIFICATIONS:
DEA: BD 1464611
Buprenorphine Prescriber DEA: XD 1464611
Controlled Substance Registration (CT): CSP.00041336
Controlled Substance Practitioner (MA): MD0940658A

ACADEMIC APPOINTMENTS:

Assistant Professor of Psychiatry, SUNY-Downstate, 2001-2007
Assistant Professor of Psychiatry, New York Medical College, 1993 – 1998

HOSPITAL AFFILIATIONS:

Sharon Hospital – Sharon, CT

AWARDS:

Outstanding Teaching Service, SUNY-Downstate Dept. of Psychiatry, 2000-2001
Outstanding Teaching Service, SUNY-Downstate Dept. of Psychiatry, 2001-2002
Distinguished Teacher Award, SUNY-Downstate Dept. of Psychiatry, 2004-2005

PUBLICATIONS:

"The History of Anorexia," A. Slaby and R. Dwenger, in The Eating Disorders, A. James Gianini (ed.), Springer-Verlay (pub), NY, NY 1991

Shanthi Mogali

Academic Training:

- 08/01-05/05 BA Fisk University Biology
- 07/05-06/09 MD Meharry Medical College Medicine
- 07/09-06/11 Emory University SOM Psychiatry Residency
- 07/11-06/13 Columbia University Addiction Fellowship
- 07/13- present Columbia University/NYSPI Instructor of Clinical Psychiatry
- Georgia State Medical License: 061920 11/07/08- 07/31/12
- New York State Medical License: 251965 02/12/09- 06/30/16
- Connecticut State Medical License: 53341 07/22/14- 07/31/16
- Massachusetts State Medical License 261192 09/2014 - 07/02/16

Board Certification:

- Certified – General Psychiatry and Neurology
- Certified- Addiction Psychiatry

Professional Organizations and Societies:

- 2009-2012 College on Problems of Drug Dependence
- 2007- 2011 American Psychiatric Association
- 2007- 2009 Indo- American Psychiatric Association

Hospital Appointments/Positions Held:

- 2016 Director of Psychiatry, Mountainside Treatment Center, Connecticut
- 2009 On call physician, Psychiatry Admissions, Georgia Regional Hospital, Georgia
- 2009 On call physician, Child and Adolescent Psychiatry, Gwinnett/Rockdale/Newton
- Crisis Stabilization Program, Georgia
- 2009 On call physician, Psychiatry Emergency Department Annex, Atlanta VA Hospital, Georgia
- 7/1/2011- present Faculty, New York Presbyterian Hospital, New York
- 7/1/2011- present Instructor of Clinical Psychiatry, New York State Psychiatric Institute, New York
- 7/1/2011- present Instructor of Clinical Psychiatry, Columbia University, New York
- 10/1/2014- 4/1/16 Medical Director at Center for Motivation and Change: Berkshires, MA

Honors/Awards

- 2002-2005 Merit Based General Endowed Scholarship providing full tuition for Medical College Education.
- 2008 Indo-American Psychiatric Association Outstanding Resident Award Nominee
- 2011 NIDA Director's Travel Award, College on Problems of Drug Dependence

Teaching Experience and Responsibilities:

- 1998-2002 Teacher/ Student Advisor for MCAT courses, Kaplan Testing Center; Nashville, TN

- 2009-2014 Substance Abuse supervisor for resident clinical cases

Publications

2014

1. Mogali S, Khan N, Drill E, Pavlicova M, Sullivan M, Nunes E, Bisaga. Characteristics of Patients Completing Rapid Naltrexone Induction-Detoxification as a Factor in Determining Client Suitability for Opioid-Antagonist Treatment. Am J Addict. 2014 Dec. doi: 10.1111/ j.1521-0391.2014.12180.x. [Epub ahead of print]
2. Mogali, S. Comer, SD. Effects of Minocycline on Oxycodone- Induced Responses. (Submitted)

2013

1. Sandra D Comer, Shanthi Mogali, Phillip A Saccone, Paula Askalsky, Diana Martinez, Ellen A Walker, Jermaine D Jones, Suzanne K Vosburg, Ziva D Cooper, Perrine Roux, Maria A Sullivan, Jeanne M Manubay, Eric Rubin, Abigail Pines, Emily L Berkower, Margaret Haney and Richard W Foltin. Effects of acute oral naltrexone on the subjective and physiological effects of oral damphetamine and smoked cocaine in cocaine abusers. Neuropsychopharmacology doi:10.1038/npp.2013.143; accepted article preview online June 5, 2013
2. Mogali, S. Comer, SD. (2013). Treatment of Pain and Opioid Abuse. In Mei-Chuan Ko, Stephen M. Husbands, Research and Development of Opioid-Related Ligands (pp 39-60). Oxford University Press.

2012

1. Jones JD, Mogali S, Comer SD. Polydrug abuse: A review of opioid and benzodiazepine combination use. Drug Alcohol Depend. 2012 Sep 1;125 (1-2): 8-18.

2001

1. Mogali S, Darville K, Pratt L: . Ab Initio Analysis of Lithium Dimethylaminoborohydride. Journal of Organic Chemistry 2001, Volume: 66 (7), Pages: 2368-2373
2. Gronert S, Pratt L, Mogali S. Substituent Effects in Gas-Phase Substitutions and Eliminations: β- Halo Substituents. Solvation Reverses Sn2 Substituent Effects. Journal of the American Chemical Society 2001, Volume: 123 (13), Pages: 3081-3091.

Abstracts

1. Mogali S, Comer SD. Effects of Minocycline on Oxycodone-Induced Responses. College on Problems of Drug Dependence, San Diego, CA, June 15-20.
2. Mogali S, Comer SD, Saccone PA, Roux P, Jones JD, Cooper SZ, Vosburg SK, Sullivan MA Rubin E, Manubay JM, Martinez DM, Walker EA, Haney M, Foltin RW. Naltrexone reduces the subjective effects of oral d-amphetamine but not smoked cocaine in humans. College on Problems of Drug Dependence, Palm Spring, CA, June, 9-14, 2012.

Poster

1. Mogali S, Paula Askalsky, Jessica Fogel, Gabriela Madera, Jermaine Jones, Maria Sullivan, Jeanne Manubay, Sandra Comer. The Effects of Minocycline on Oxycodone-Induced Responses. Experimental Biology, Boston, MA, April 20- 24, 2013.
2. Mogali S, Khan N, Drill E, Pavlicova M, Sullivan M, Nunes E, Bisaga A. Characteristics of Patients Completing Rapid Naltrexone Induction-Detoxification as a Factor in Determining Client Suitability for Opioid-Antagonist Treatment. College on Problems of Drug Dependence, Hollywood, FL, June 18-23 2011.
3. Scott Gronert, Lawrence M. Pratt, Shanthi Mogali. Effects of Lithium Diakylamide Bases on the Stereochemistry of Ester Enolization. American Chemical Society 221s National Meeting, San Diego, CA, April 1-5, 2001.
4. Mogali S, M. E. Bashir and M. Gunasekaran. XVI International Botanical Congess. Effect of Nutritional Factors on Nitrate Reductase Activity in Fusarium Lateritium. Fisk University, Department of Biology, Nashville, Tennessee 1999.

Sarah Osborne, LPC, LADC, NCC, MATS

29 Armbruster Road, Terryville, CT 06786

Phone: 203-947-3764 • E-Mail: sarahdosborne@gmail.com

Working in an innovative and client centered mental health position that allows utilization of creativity, experience, and organization skills with the opportunity for professional development.

Qualification Highlights

- EMDR Trained
- Clinical Care Transformation
- Program Planning/Implementation
- Personnel Supervision/Training
- Clinical Education & Management
- Process Innovation/Improvement
- Team Development/Coaching
- Performance Review/Assessment
- Case Planning & Management
- Quality Assurance Standards
- Extensive Training in Trauma & Co-Occurring Care

Professional Experience

Mountainside • Canaan, CT **September 2013 – Present**

Director of Clinical Operations – April, 2015 - Present
Program Director; Outpatient Services - May 2014 - 2015

- Creating program structure, policies and procedures to open the department.
- Develop program curriculums for Intensive Outpatient and Outpatient.
- Created templates in electronic medical record to ensure quality documentation tailored to the department.
- Introduced EMDR therapy to Outpatient Services Program.
- Provide clinical supervision to student interns, professionals seeking licensure, and department staff
- Carry caseload of 10-15 clients seen 1x week for EMDR, psychotherapy, and/or treatment planning

Clinician; Residential Program - September 2013 – May 2014

- Provide clinical supervision to student interns and professionals seeking licensure
- Manage assigned caseload of 6-8 clients; including case notes, treatment plans, & clinical interventions.
- Coordinating with family members and referents regarding client's progress in treatment & continuing care plans.
- Run daily psychotherapy and psychoeducational groups
- Conduct eight monthly chart audits

Recovery Network of Programs • Bridgeport, CT **February 2011 – October 2013**

Clinical Coordinator; Horizons Residential - October 2012 – October 2013

- Oversee a staff of ten fulltime staff, eight of which are clinicians.
- Counsel, instruct, and discipline staff members while promoting both individual and team strengths.
- Assigning incoming clients and addressing client complaints.
- Creating a family program that centers on co-occurring disorders.

- Supervise the Trauma Initiative within the program. Including supervising staff running Healing Trauma, DBT, M-TREM, and coordinating the creation of a trauma centered clinical environment.
- Creating programmatic flow changes to increase quality and compliance in clinical care
- Teach clinical staff how to implement a client centered co-occurring model. Enhancing clinical documentation in quality and compliance.
- Building rapport to decrease need for crisis intervention and administrative disciplinary actions with clients.

Counselor; New Prospects Residential - February 2011- September 2012

- Manage assigned caseload; including case notes, treatment plans, clinical interventions, & aftercare.
- Run therapy groups daily; both psychoeducational and psychotherapy.
- Facilitate therapy with individuals, groups, and families.
- Established & developed DBT, Healing Trauma, and Women for Sobriety groups within the program.
- Maintain structure and organization on the women's floor to provide a safe environment for clients.
- Oversee per-diem staff in their duties and effectively engaging clients.

Boarding Faculty; Devereux Glenholme School • Washington, CT June 2010 – March 2011

- Implementing individual's behavioral treatment plans to help them understand and overcome personal, social or behavioral problems affecting their educational or vocational situations.
- Observe and evaluate student's performance, behavior and social development.
- Provide crisis intervention and address behavior issues.

Education

Master of Science; Clinical Mental Health Counseling *2009 – 2012*
Western Connecticut University, Danbury, CT

Bachelor of Arts; Art, Concentration Graphic Design *2001 - 2005*
Western Connecticut University, Danbury, CT

Credentials

- LPC – Licensed Professional Counselor CT DPH #002454; Exp 11/30/2015
- LADC – Licensed Alcohol and Drug Counselor CT DPH #001045; Exp 11/30/2015
- NCC – Nationally Certified Counselor NBCC #301314; Exp 11/30/2017
- MATS – Medication Assisted Treatment Specialist CCB #5554; Exp 5/1/2015

Professional Memberships

- American Counseling Association Professional Member
- EMDRIA Member
- IAOCC
- National Board for Certified Counselors

Amanda Molnar
50 Berlin Avenue, Southington, CT 06489
Amanda.molnar05@gmail.com

Objective:
To gain experience in the career field of social work, focusing on collaborating with team members and clients to devise effective prevention and intervention plans for individuals that foster cognitive skills building and strong social support relations.

Education:
University of Connecticut School of Social Work, Storrs, Connecticut
Master in Social Work
Concentration: Group Work

- Cumulative GPA: 3.9
- LMSW License #2441

Bachelor of Arts
Concentration: Psychology

- Cumulative GPA: 3.2

Experience:
Mountainside Treatment Center, Canaan, Connecticut, 2014
Outpatient/Intensive Outpatient
Senior Clinician, 2016 - Present
Clinician, 2014 - 2016

University of Connecticut Health Center, Farmington, Connecticut, 2014 –2015
Social Work Intern – Partial Hospital Program and Intensive Outpatient Program

- Assess individual and group needs to enhance mutual aid and cohesion
- Co-facilitate six groups a week focusing on skill building, education and psychotherapy utilizing evidence-based research to develop group material.
- Co-facilitate TARGET, a trauma based group that meets on a weekly basis
- Attend daily staff team meetings to collaborate and review patient progress
- Rotation on inpatient psychiatry and emergency department: risk assessment, symptomology, plan of treatment

Saint Francis Hospital and Medical Center, Hartford, Connecticut, September 2013 – April, 2014
Behavioral Health Intern

- Assess patient's needs, goals and progress towards treatment plans individually and within the group setting
- Medical social work on rehabilitation unit
- Facilitate inpatient socialization groups on the psychiatry unit and dual diagnosis unit
- Utilize the strengths perspective and biopsychosocial approach in working with patients
- Attend team meetings once a week to enhance knowledge of patient issues and meaningful techniques to practice

Community Health Resources, Hartford, Connecticut, March, 2012 – January, 2013
Community Support Specialist

- Care coordination for adults with mental illness, targeting skill teaching and linking clients to appropriate programs to foster independence within the community
- Perform duties in Community Support program, Recovery Pathways and Community Support Program WISE
- Collectively develop 90-day treatment plans and Daily Living activities assessments to identify areas of need, goals and objectives
- Assist client with identifying personal strengths and possible barriers towards achieving goals
- Assess client's progress towards independence on a weekly basis

Wood n' Tap, Vernon and Southington, Connecticut, August, 2009 – 2014
Supervisor, Server, Host

- Interpreting customer needs to allow for a mutual understanding
- Attending to customer needs to create an enjoyable dining experience
- Ensuring fluid communication between wait staff, cooks and hosts to provide an efficient teamwork orient shift

Perception Programs, Inc., Danville, Connecticut, August, 2010 – December, 2010
Internship: Alternative in The Community: Substance Abuse and Offender Services

- Co-facilitate Reasoning and Rehabilitation Group, a cognitive skills development program focusing on the individual and family relations, and Treating Addictive Disorders Group, effective techniques designed for substance abusers
- Performing intakes, including basic needs and goals of attending the program
- Maintaining up to date progress reports on clients' attendance to group meetings, dates of group completion, basic needs, urinalysis reports, and general living accommodations.

JUDITH O'CALLAGHAN, LMFT, LADC
54 Plumtrees Road, Bethel, Ct 06801 jlunchoc@att.net 206 343-7900

PROFILE:
I have extensive clinical, administrative and supervisory experience and work with a diverse array of client populations and issues. I hold two licenses and am certified as a Co-Occurring Disorders Professional and as a Clinical Trauma Professional.

EXPERIENCE:
Mountainside, Canaan, CT – Clinician
2014 – Present
Assessment and interventions, including individual, family and group therapy.

Psychotherapy Associates of Western Connecticut, Brookfield, CT
2001 – Present
Private Practice
Individual, marital and family therapy – substance abuse assessment and counseling

Town of New Fairfield, CT – EAP Provider and Prevention Counselor
2007 – 2014
EAP assessment, referral and short-term counseling for Town employees and their families; individuation and family counseling for student and their families; substance abuse/prevention education for the school and community.

Recovery Network of Programs, Bridgeport, CT – Clinical Coordinator and Program Director
2009 – 2013
Program administration and supervision of staff at New Prospects Co0occurring Residential Treatment Program
clinical staff; Substance abuse evaluation and treatment; Individual, marital and family counseling

Newton Youth and Family Services, Newtown, CT – Clinician and Clinical Director
2007 – 2009
Community program management, supervision of clinical staff, substance abuse evaluation and treatment, individual, marital and family counseling.

MCCA, Danbury, CT – Clinician and Program Director
2003 – 2007
Individual, family and group therapy, supervision of Women's IOP Program, program management and supervision of staff at New Dawn Therapeutic Group Home for Girls.

Education:
University of Connecticut, Storrs, CT
M.A. Family Studies, 2000
Western Connecticut State University, Danbury, CT
B.A. Psychology, 1995

Credentials:
Licensed Marriage and Family Therapist (CT#000999)
Licensed Alcohol and Drug Counselor (CT#000749) (CAC-4383) (ICADC-4383)
Certified Co-occurring Disorders Professional (CCDP-D4383) (ICCDP-4383)
Certified Medication assisted Treatment Specialist (MATS-4383)
Certified Clinical Trauma Professional (International Association of Trauma Professionals)

Abdul Shabazz, Clinical Social Worker

Profile

Experienced social worker with demonstrated success in counseling individuals, families, and groups on a wide spectrum of issues in outpatient and residential settings. Strong interpersonal, analytical, and communication skills, particularly adept in working with clients having mental health and addiction issues and their families. Additional background includes Intake, Assessments and Utilization Review, Program Development and Discharge/Placement.

Individual and Group Counseling

- Conducted detailed intake and psychosocial assessments to diagnose and assess needs, and complete Utilization Review.
- Set individualized goals based on strengths and coping mechanisms of clients. Client population is diverse and encompasses children, adults, and families.
- Developed and implemented treatment plans to meet identified goals, provide one-on-one counseling, with focus on behavioral methods, to deal with issues related to substance abuse, anger management, separation and divorce, bereavement, juvenile delinquency, self-harm and education.
- Co-dependency focuses upon duel diagnoses, how addictive behaviors affect family members and how members can begin to feel better and get results.
- Provide multi systemic intervention for families, providing Outpatient therapy in the home setting of individuals, and offer additional resources in the community to assist with managing daily living needs, and any mental health issues.
- Plan "Next Step Discharge" for placement based on 30, 60, 90-day progress and make appropriate arrangements based on "Where they are" status

Program Development

- Initiated and developed mentorship program for teenage parents to help parents save their children. Providing platform for clients to learn parenting and social skills, program was a success and helped participants keep their children at home and out of the foster care system.
- Provide multi systemic intervention for families, providing Outpatient therapy in the home setting of individuals, and offer additional resources in the community to assist with managing any and all mental health issues that lead to crisis.
- Develops working relationships with all departments within the agency, including quality improvement/assurance, Human Resources, Utilization Review and Risk management, Communications, Finance and Fundraising.
- At all times, follows the "acting in best interest of the "Agency policies".
  Attends all scheduled trainings and attains knowledge in evidence based practices including, DBT, Recovery Model, Motivational interviewing, Co-occurring disorders, Substance Use, Mental Health issues, Trauma informed care.

Individual and Group Counseling

- Conducted detailed intake and psychosocial assessments to diagnose and assess needs, and complete Utilization Review.
- Set individualized goals based on strengths and coping mechanisms of clients. Client population is diverse and encompasses children, adults, and families.
- Developed and implemented treatment plans to meet identified goals, provide one-on-one counseling, with focus on behavioral methods, to deal with issues related to substance abuse,

anger management, separation and divorce, bereavement, juvenile delinquency, self-harm and education.

- Co-dependency focuses upon duel diagnoses, how addictive behaviors affect family members and how members can begin to feel better and get results.
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- At all times, follows the "acting in best interest of the "Agency policies".
  Attends all scheduled trainings and attains knowledge in evidence based practices including, DBT, Recovery Model, Motivational interviewing, Co-occurring disorders, Substance Use, Mental Health issues, Trauma informed care.

Experience

Family Intervention Center Inc. Waterbury, CT 2014-Present
Clinical Therapist – Hired from Internship through Post University
Duties: assessments, program development & implementation, discharge planning

Independent Living Solutions LLC **Meriden, CT** 2014-2015
Director of Employment Services
Duties: Traumatic Brain Injury Clients reentry programs

Gil Foundation Inc. Prospect CT **2010-2014**
Direct support Staff
Duties: Developmental Disabilities Clients- Independence training and family relationship building
Residential Management Services Inc. Kensington, CT 2003-2013
Program Manager (ICF, CLA, SLA)
Duties: support for daily living services

Additional and Per Diem Experience

Prime Care Inc., Waterbury, CT 2011-2012
Direct Support Staff, Per Diem

All Point Care LLC, Cheshire, CT 2006-2010
Mentor/staff trainer

Cooperative Educational Services, Trumbull, CT 2005-2006
Educational Instructor for Autism Spectrum (Seasonal)

COI Officer United States Army, Hartford CT 1999-2004
Community Development Team

Education
M.S Post University Waterbury, CT
B.A University of Bridgeport, Bridgeport, CT
A.S Naugatuck Valley/Asnuntuck Community College

Professional Development
National Organization of Human Service
American Counseling Association
Mental Health First Aid
Trauma Training

Attachment IV
Job Descriptions

Please note: Attached to Job Description one (1) Chief Operating Officer is a job description acknowledgement page; this page has been eliminated from all other job descriptions in an effort to save space

Job description

Job Holder: **Roy Sasenaraine**

Job Title: Chief Operating Officer

Department: Executive Office

Reports to: Managing Director

FLSA: Exempt

Job Summary: Provides the leadership, management, and vision necessary to ensure that the company has the proper operational controls, administrative and reporting procedure and people systems in place to effectively grow the organization and to ensure financial strength and operating efficiency.

Essential Duties and Responsibilities include the following, other duties may be assigned:

- Provide day-to-day leadership and management to a service organization that mirrors the adopted mission statement.
- Responsible for driving the company to achieve and surpass sales, profitability, cash flow and business goals and objectives
- Develop operational strategies to improve overall performance and positively impact profitability.
- Act as project lead to coordinate and implement corporate project initiatives.
- Support operational leaders in building and maintaining a high performing team that embraces collaboration.
- Appraise and evaluate the results of overall operations regularly and systematically
- Responsible for the measurement and effectiveness of all processes. Provides timely, accurate and complete reports on the operating condition of the company.
- Spearhead the development, communication and implementation of effective growth strategies and processes.
- Collaborate with the management team to develop and implement plans for the operational infrastructure of systems, processes, and personnel designed to accommodate the growth objectives of our organization.
- Create an environment that supports employee satisfaction, improved service and quality. Initiate a strategic process that addresses continuous measurable improvement.
- Contribute to the development of strategic goals and objectives as well as the overall management of the organization.
- Ensure that all activities and operations are performed in compliance with local, state, and federal regulations and laws governing business operations

General

- Adopt the Mountainside culture of providing a Best in Class Service to all of our clients.
- Comply with Mountainside procedures, policies and regulations relevant to your role. Undertake relevant training on Mountainside's policies and procedures as delivered by your manager, Human Resources or other departments.
- Comply with any specific responsibilities necessary for your role as outlined by your line manager or Human Resources to ensure you keep up to date with developments in these areas
- Carry out additional responsibilities as individually notified, either through your objectives or as directed by your manager.

Qualifications:

Perform this job successfully; an individual must be able to perform each essential duty satisfactorily. The requirements listed below are representative of the knowledge, skill, and/or ability required. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

Education and Qualifications

- A Bachelor's degree in Business Administration or other related areas, financial experience a plus
- A minimum of six years of senior management experience

Skills and Abilities

- Strong leadership skills required. Must be able to manage, mentor/coach junior staff members
- Innovative and strategic thinker with ability to work under tight time frames.
- Ability to interpret standards and translate them into organizational policy
- Ability to manage time, set priorities, and focus energies in an efficient manner while analyzing problems and following through on solutions, and facilitating the orderly flow of work
- Demonstrated experience in financial planning and analysis
- Skilled in organizational development, personnel management, budget and resource development, and strategic planning.
- Excellent people skills, with an ability to partner with a dynamic leadership team.
- Possess personal qualities of integrity, credibility, and commitment to corporate mission.
- Flexible and able to multitask; can work within an ambiguous, fast-moving environment, while also driving toward clarity and solutions; demonstrated resourcefulness in setting priorities and guiding investment in people and systems.

Knowledge and Experience

- Experience using process improvement and a proven ability to drive a consensus process to effect significant organizational change is required.
- Experience in using quantitative measurements to ensure quality standards.
- Proficient in Microsoft office – very well versed in Excel

Aptitude, Disposition & Competencies

- Leadership skills
- Strategic Thinking
- Results Driven
- Business Acumen
- Decision Making
- Financial Management
- Planning and Organizing
- Self-motivated, flexible
- Attention to detail
- Problem solver
- Ability to meet deadlines; prioritizes

Job Description Acknowledgement

I have read this job description and fully understand the requirements set forth therein. I understand that this is to be used as a guide and that I will be responsible for performing other duties as assigned. I further understand that this job description does not constitute an employment contract with Mountainside Treatment Center.

_____ _____

Employee Signature Date

_____

Printed Name

Job description

Job Holder: **Stephen Langley**

Job Title: Executive Director

Department: Office of the CEO

Reports to: Chief Operations Officer

FLSA: Exempt

Job Summary: Directs and coordinates operations of Mountainside to provide treatment and other special services by performing the following duties personally or through subordinate supervisors. Provides a welcoming, supportive and structured community living experience which meets or exceeds client expectations for service during treatment.

Essential Duties and Responsibilities include the following, other duties may be assigned:

- Oversees Client Services, the Clinical Director and Clinical Team, Continuing Care and Extended Care activities, working with direct reports to implement policies and procedures
- Maintains stewardship of Mountainside's core tenets and culture of excellence
- Strives to constantly innovate and perfect therapeutic programming and client experience
- Cultivates an organization-wide unsurpassed commitment to client satisfaction and established "Best in Class" service standards
- Promotes communication which is clear, consistent, and always of the highest degree of professionalism
- Participates in community activities to develop opportunities to ascertain needs, serve residents, and promote Mountainside goals
- Promotes 100% client satisfaction throughout the organization
- Works with direct reports and various departments to ensure consistent and smooth handoff of all client-related issues.
- Responsible for all state and regulatory compliance or unusual occurrence reporting
- Establishes and maintains close working relationships with cooperating agencies to avoid duplication of services
- Recommends new policies and procedures and is effective in creating successful momentum
- Assists with implementation and management of CARF accreditation requirements
- Advises staff of potential problems and recommends alternative methods of providing service
- Confers with staff and disseminates written materials to inform staff of current developments
- Ultimate responsibility for all resident and family grievances
- Ensures adherence to legal requirements and government reporting regulations affecting all workplace regulations. Responsible for delivering overall operating plans, and related policies/programs
- Leads the development and implementation of the short and long range plans to achieve the organization's goals and objectives including specific strategy and plans for growth, efficiency, cost management, quality care, and development of human capital

General

- Adopt the Mountainside culture of providing a Best in Class Service to all of our clients
- Comply with Mountainside procedures, policies and regulations relevant to your role. Undertake relevant training on Mountainside's policies and procedures as delivered by Human Resources or Upper Management and ensure you keep up to date with developments in these areas
- Carry out additional responsibilities as individually notified, either through your objectives or as directed by your manager

Qualifications:

Perform this job successfully; an individual must be able to perform each essential duty satisfactorily. The requirements listed below are representative of the knowledge, skill, and/or ability required. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

Education and Qualifications

- Bachelor's Degree
- Experience in Substance Abuse Treatment Facilities; Residential Treatment

Skills and Abilities

- Must possess strong leadership and strong communication skills both verbal and written
- Ability to read, analyze, and interpret general business periodicals, professional journals, technical procedures, or governmental regulations
- Ability to write reports, business correspondence, and procedure manuals
- Ability to effectively present information and respond to questions from groups of managers, clients, customers, and the general public
- Excellent leadership skills
- Computer Skills

Knowledge and Experience

- A minimum of 10 years of comparable executive level experience required
- Must be results focused with the ability to achieve results through other people

Aptitude, Disposition & Competencies

- High standards of Ethics
- Honesty
- Integrity
- Financial Management
- Planning
- Program Delivery
- Marketing
- Staff Relations
- Leadership
- Client / Guest Services
- Operations

Job description

Job Holder: **Randall Dwenger, MD**

Job Title: Medical Director

Department: Detoxification

Reports to: Chief Executive Officer

FLSA: Exempt

Job Summary: The Medical Director will provide guidance and leadership to Mountainside's Detoxification and Residential Services Programs, and will help to ensure that safe and competent protocols and services are provided to clients in all aspects of client medical care. The Medical Director supervises services provided by the physician assistant and/or APRN as it relates to client care. The Medical Director helps to develop and implement policies, procedures and protocols to ensure the appropriateness and quality of medical care provided. The Medical Director provides medical consultation too other medical and clinical staff, and provides direct client care when indicated.

Essential Duties and Responsibilities include the following, other duties may be assigned:

- The medical director or a designee directly supervised by the medical director, provides on-site medical supervision to Mountainside.
- The medical director will ensure that all programing is in compliance with all applicable local, state, and federal regulations regarding the medical treatment of opioid dependence and/or other addictions.
- The medical director and/or designee will be available for consultation in the event of an emergent situation.
- The medical director supervises Physician Assistants or APRNs ensuring that each client served receives within 24 hours of admission a medical history and physical examination.
- The medical director will review all records of the clients served and verify that all medical examinations and laboratory studies have been performed and recorded, and that each client is assessed for appropriateness of treatment.
- Any physical examination that is performed by a physician or APRN shall be dated and countersigned by the medical director within 72 hours signifying his or her review of and concurrence with the findings and treatment plan.
- The medical director or designee will order and prescribe medications and will design / implement safe detoxification protocols to be used in the detoxification program.
- If the person served is readmitted within six months of discharge the decision determining the physical examination, laboratory and diagnostic tests to be performed shall be made by the Medical Director.
- The medical director will review and approve (by signature) treatment plans and treatment plan reviews on a weekly basis.
- The Medical Director practices as a member of the multi-disciplinary team and consults with members of other health professions as appropriate in order to ensure client health care needs are met.
- The medical director implements strategies to promote health with clients.
- The medical director initiates and manages client care within his/her scope of practice.
- The medical director is available on an On-call basis.

General

- Adopt the Mountainside culture of providing a Best in Class Service to all of our clients.

- Comply with Mountainside procedures, policies and regulations relevant to your role. Undertake relevant training on Mountainside's policies and procedures as delivered by your manager, Human Resources or other departments.
- Comply with any specific responsibilities necessary for your role as outlined by your direct manager, or Human Resources to ensure you keep up to date with developments in these areas.
- Carry out additional responsibilities as individually notified, either through your objectives or as directed by your manager.

Qualifications:

To perform this job successfully the individual must be able to perform each essential duty satisfactorily. The requirements listed below are representative of the knowledge, skills, and/or abilities required. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

Education and Qualifications

- Graduation from an accredited medical school
- Passage of a State Board Examination
- Possession of practical experience
- Licensed to practice in the State of CT
- Licensed Physician in good standing (MD)
- Valid and appropriate liability coverage
- Possess active / valid DEA license registration
- Must have certification to prescribe or dispense Suboxone / Buprenorphine
- Must be familiar with the medical complications in treating substance abuse, co-occurring disorders and clients with mental illness

Skills and Abilities

- Mutually agreed performance standards associated with above-referenced responsibilities.

Knowledge and Experience

- Minimum two years' experience/knowledge in substance abuse treatment

Aptitude, Disposition & Competencies

- Articulate
- Enthusiastic
- Appropriate boundaries
- Client-centered
- Attention to detail
- Good judgment / decision making

Job Holder: **Shanthi Mogali, MD**

Job Title: Director of Psychiatry

Department: Clinical

Reports to: Medical Director

FLSA: Exempt

Job Summary: This position will provide psychiatric care for adults age 18 years and older. The Addiction Psychiatrist will collaborate with the multidisciplinary team, attend clinical meetings and see clients as determined by their clinical need. The Addiction Psychiatrist will evaluate, diagnose and medicate clients as indicated and will review medical orders for assigned clients.

Essential Duties and Responsibilities include the following, other duties may be assigned:

- Performs routine mental health exams to clients referred by nursing and the clinical staff, under established guidelines.
- Prescribes psychotropic medication, manages the medications and develops treatment plans
- Ensuring compliance by treatment team of adherence to best practices and State and Federal Regulations.
- Completes MSE
- Order appropriate laboratory or diagnostic procedures
- The psychiatrist practices as a member of the multi-disciplinary team
- Implements strategies to promote mental health and wellbeing with clients
- Initiates and manages client care within his/her scope of practice
- Participates in Infection Control, Quality Improvement and Peer Review activities and committee meetings as they relate to mental health and addiction issues.
- Upholds all rules and regulations governing the client's confidentiality
- Follows designated chain of command for resolution of problems and questions
- Uses Universal Precautions at all times
- Prepares required reports and completes required paperwork as it relates to the programs and services in the expected time frame
- Attends seminars, workshops and conferences as required by Mountainside
- Maintains a current copy of his/her license, as well as current CPR and DEA certification on file with Mountainside
- Performs other related duties as assigned
- On-call.

General

- Adopt the Mountainside culture of providing a Best in Class Service to all of our clients.
- Comply with Mountainside procedures, policies and regulations relevant to your role. Undertake relevant training on Mountainside's policies and procedures as delivered by your manager, Human Resources or other departments.
- Comply with any specific responsibilities necessary for your role as outlined by your line manager or Human Resources to ensure you keep up to date with developments in these areas

- Carry out additional responsibilities as individually notified, either through your objectives or as directed by your manager.

Qualifications:

- Completed US accredited residency program in psychiatry
- Maintains a current CT physician's license and a DEA number
- Board certified and board eligible in psychiatry
- Prefer a minimum of two (2) years of experience practicing as a psychiatrist in a clinical setting
- Experienced in addiction and co-occurring disorders
- Maintains a current CPR certification
- Licensed to practice in the State of CT

Education and Qualifications

- MD Degree
- Board Certified in Psychiatry

Skills and Abilities

- Mutually agreed performance standards associated with above-referenced responsibilities.

Knowledge and Experience

- Minimum two years' experience/knowledge in substance abuse treatment

Aptitude, Disposition & Competencies

- Articulate
- Enthusiastic
- Good Boundaries
- Client-centered

Job description

Job Holder: **Sarah Osborne**

Job Title: Director of Clinical Operations

Department: Clinical

Reports to: Executive Director

FLSA: Exempt

Job Summary: Direct a multi-disciplinary clinical team, on all shifts, to create and deliver an unsurpassed individualized treatment experience

Essential Duties and Responsibilities include the following, other duties may be assigned:

- Assure that the quality of clinical services provided by counselors meets established standards, guidelines and regulations, where applicable
- Oversight of ABC, MBS, Family Wellness, & Nursing to ensure competency and appropriateness of all services rendered per mission statement and licensure
- Establish framework of "Best in Class", evidence-based interventions, tools and modalities
- Utilizing Sigmund, audit clinical staff case management skills and documentation for quantitative fulfillment and quality assurance per regulatory/company standard compliance
- Utilize appropriate performance metric data as a supervision and evaluation tool
- Provide and coordinate clinical supervision of treatment team
- Assist counselors as needed with treatment concerns
- Oversee Nursing and referring relationships with medical and psychiatric providers including business associates as well as community resources
- Communicate deficiencies, concerns and achievements of supervisees to management
- Provide individual and group therapy and facilitate treatment groups
- Develop and maintain Policies and Procedures as needed for CARF
- Serve on committees as required (Safety; Intranet; Unusual Occurrence, etc.)
- Participate in development of training programs, workshops, program development or other activities as appropriate
- Prioritize and schedule professional trainings, continuing education, and in-services and develop a budget for any outside facilitators
- Assist Client Services and other departments as required with professional development and adherence to standards of practice and program goals of second and third shift personnel
- Develop and supervise a clinical internship program
- Additional duties:
    - Model good clinical skills, professionalism and demeanor
    - Maintain integrity of services that is consistent with mission statement
    - Communicate and advise General manager on agency activities when appropriate
    - Promote agency within the community to referring agencies, community partners, alumni and families as appropriate

- Communicate with Human Resources and General Manager on personnel issues involving clinical staff, support staff and /or internship students
- Work closely with HR and SPAC in identifying current and future needs and potential assets

- Supervise and utilize Clinical Coordinator in monitoring functionality of all aspects of program and systems noted above

General

- Adopt the Mountainside culture of providing a Best in Class Service to all of our clients.
- Comply with Mountainside procedures, policies and regulations relevant to your role. Undertake relevant training on Mountainside's policies and procedures as delivered by your manager, Human Resources or other departments.
- Comply with any specific responsibilities necessary for your role as outline by your line manager or Human Resources to ensure you keep up to date with developments in these areas.
- Carry out additional responsibilities as individually notified, either through your objectives or as directed by your manager.

Qualifications:

To perform this job successfully, an individual must be able to perform each essential duty satisfactorily. The requirements listed below are representative of the knowledge, skill, and/or ability required. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

Education and Qualifications

- Graduate Degree
- Current Licensure (LADC, LPC, LCSW)

Skills and Abilities

- Computer Proficient: EMR (Electronic Medical Records), word processing, spreadsheet, and other software applications to prepare reports, invoices, financial statements and letters

Knowledge and Experience

- Minimum five years' experience/knowledge in substance abuse treatment including direct care, program management and supervisory capacities

Aptitude, Disposition & Competencies

- Willingness to work weekends, nights or Holidays when required
- Knowledge of State Regulations and expectations
- Leadership
- Critical Thinking
- Analytical Skills
- Highly Resourceful
- Self-Starter
- Creative
- Highly-Motivated
- Willingness to go "above and beyond"
- Attention to detail
- Initiative

- Human Resources to ensure you keep up to date with developments in these areas.
- Carry out additional responsibilities as individually notified, either through your objectives or as directed by your manager.

Qualifications:

Perform this job successfully; an individual must be able to perform each essential duty satisfactorily. The requirements listed below are representative of the knowledge, skill, and/or ability required. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

Education and Qualifications

- Graduate Degree
- Current Licensure (LADC, LPC, LCSW)

Skills and Abilities

- Computer Skills: EMR (Electronic Medical Records), word processing, spreadsheet, and other software applications to prepare reports, invoices, financial statements and letters

Knowledge and Experience

- Minimum five years' experience/knowledge in substance abuse treatment
- Minimum two years' experience in a senior/supervisory role

Aptitude, Disposition & Competencies

- Articulate
- Enthusiastic
- Good Boundaries
- Client-centered

Job description

Job Holder: **Amanda Molner**

Job Title: Senior Clinician

Department: Clinical

Reports to: Director of Clinical Operations

FLSA: Exempt

Job Summary: Meet the expectations of Clinical Counselor to include: Collaborate with a multi-disciplinary treatment team to create an individualized recovery experience that incorporates the body, mind and spirit of each client. Provide individual and group therapy sessions and facilitate treatment groups. Coordinate care with external providers and community such as: Family Members, Primary Care Physicians, Psychiatrists, Intensive Outpatient programs, Legal Aids, Family Interventionists, University and High School Administrative Staff, and Employee Assistance Program Representatives. In addition, model viable brief treatment and case management strategies to Clinical Team and provide support to Clinical Team in appropriate fashion.

Essential Duties and Responsibilities include the following, other duties may be assigned:

- Review client's discharge records from previous treatment providers, contacting client's emergency contacts and family members, former providers and referral sources
- Complete comprehensive clinical utilization reviews on a regular basis and communicate all Insurance needs to Utilization Review Department
- Ability to utilize identified screening/assessment tools, stage-wise interventions and treatment models.
- Understands group dynamics/processes, facilitate groups with a focus on integrated care and documents efforts via individualized progress notes.
- Create an individualized treatment plan, including referrals to Family Wellness Program, APRN, Psychiatrist, Mind Body Spirit Program, Nicotine Cessation Program, Adventure Based Counseling Program and Continuing Care. Continue to update on weekly basis
- Role model, explain and encourage pro-social behaviors such as: 12-step meeting etiquette, time management, appropriate language, dress and the importance of building same gender fellowships
- Communicate with med room to monitor client medication compliance and med issues
- Continue to collaborate with Mountainside team as a whole
- Participate in weekly individual clinical social work supervision and group clinical supervision.
- Maintain weekly communication with clients' family to report client progress and wellbeing at Mountainside
- Collaborate with client and Continuing Care Staff to create a plan which takes into account the housing and therapeutic needs of the client in order to sustain or continue to develop a program of recovery
- Participate in "on-boarding' of new hires to Clinical Team
- Facilitate Team Meeting in the absence of Clinical Director and/or Clinical Coordinator
- Facilitate Clinical Care Planning in the absence of Clinical Director and/or Clinical Coordinator
- Assist in development and supervision of learning opportunities for interns and new hires to Clinical Team

Managerial Duties

- Responsible for developing, mentoring and coaching direct reports all areas of clinical
- Manages and directs the activities of assigned staff; Ensures a trained, motivated and professional staff capable of providing efficient and effective operations and exceptional service
- Established performance expectations and monitors results
- Coaches and counsels staff as necessary
- Manage all areas of ADP for clinical team; time cards, schedules and PTO
- Facilitate interviews and training for possible new hires

General

- Adopt the Mountainside culture of providing a Best in Class Service to all of our clients.
- Comply with Mountainside procedures, policies and regulations relevant to your role. Undertake relevant training on Mountainside's policies and procedures as delivered by your manager, Human Resources or other departments.
- Comply with any specific responsibilities necessary for your role as outline by your line manager or Human Resources to ensure you keep up to date with developments in these areas.
- Carry out additional responsibilities as individually notified, either through your objectives or as directed by your manager.

Qualifications:

Perform this job successfully; an individual must be able to perform each essential duty satisfactorily. The requirements listed below are representative of the knowledge, skill, and/or ability required. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

Education and Qualifications

- Graduate Degree
- Current Licensure (LADC, LPC, LCSW)

Skills and Abilities

- Computer Skills: EMR (Electronic Medical Records), word processing, spreadsheet, and other software applications to prepare reports, invoices, financial statements and letters

Knowledge and Experience

- Minimum five years' experience/knowledge in substance abuse treatment
- Minimum two years' experience in a senior/supervisory role

Aptitude, Disposition & Competencies

- Articulate
- Enthusiastic
- Good Boundaries
- Client-centered

Job description

Job Holder: **Judith O'Callaghan and Abdul Shabazz**

Job Title: Outpatient Clinician

Department: Outpatient Services

Reports to: Outpatient Senior Clinician

FLSA: Exempt

Job Summary: Collaborate with a multi-disciplinary treatment team to create an individualized recovery experience that incorporates the body, mind and spirit of each client. Provide individual and group therapy sessions and facilitate treatment groups. Coordinate care with external providers and community resources.

Essential Duties and Responsibilities include the following, other duties may be assigned:

- Review discharge records from previous treatment providers
- Collaborate with family members, former providers and referral sources
- Complete comprehensive clinical utilization reviews on a regular basis and communicate all Insurance needs to Utilization Review Department.
- Create a comprehensive and collaborative treatment plan, including referrals to Family Wellness Program, APRN, Psychiatrist, Mind Body Spirit Program, Adventure Based Counseling Program and Continuing Care. Utilize identified screening/assessment tools, stage-wise interventions and treatment models.
- Conduct therapeutic treatment utilizing best practices of counseling, case management and crisis intervention.
- Facilitate groups with a focus on integrated care. Maintain clinical chart in accordance with agency and accreditation standards.
- Role model, explain and encourage pro-social behaviors such as: 12-step meeting etiquette, time management, appropriate language, dress and the importance of building same gender fellowships.
- Continue to collaborate with Mountainside team as a whole
- Participate in individual and group clinical supervision. Attend trainings to improve clinical skills or as assigned by your supervisor.

General

- Adopt the Mountainside culture of providing a Best in Class Service to all of our clients.

- Comply with Mountainside procedures, policies and regulations relevant to your role. Undertake relevant training on Mountainside's policies and procedures as delivered by your manager, Human Resources or other departments.

- Comply with any specific responsibilities necessary for your role as outlined by your line manager or Human Resources to ensure you keep up to date with developments in these areas.

- Carry out additional responsibilities as individually notified, either through your objectives or as directed by your manager.

Qualifications:

Perform this job successfully; an individual must be able to perform each essential duty satisfactorily. The requirements listed below are representative of the knowledge, skill, and/or ability required. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

Education and Qualifications

- Graduate Degree in related field
- Current active State of CT license (LADC, LPC, LCSW)

Skills and Abilities

- Computer Skills: EMR (Electronic Medical Records), word processing, spreadsheet, and other software applications to prepare reports, invoices, financial statements and letters
- Able to work independently and as part of a multi-disciplinary team.

Knowledge and Experience

- Knowledge of principles and techniques of group and individual counseling
- Ability to gather, analyze and evaluate information pertinent to the clinical care of clients
- Knowledge and experience in the provision of evidence based integrated care
- Considerable knowledge of federal and state laws and regulations regarding client confidentiality
- Ability to establish and maintain cooperative professional relationships
- Minimum two years' experience/knowledge in substance abuse and/or co-occurring disorders integrated treatment.

Aptitude, Disposition & Competencies

- Enthusiastic
- Good boundaries
- Client-centered
- Team Player

Attachment V
Scholarly Articles
Studies or Reports

Numbers of Americans Affected by Mental Illness

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

Getting Mental Health Treatment in America

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

The Impact of Mental Illness in America

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

Behavioral Health Barometer

Connecticut, 2015

Substance Abuse and Mental Health Services Administration
SAMHSA
www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

Acknowledgments

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Originating Office

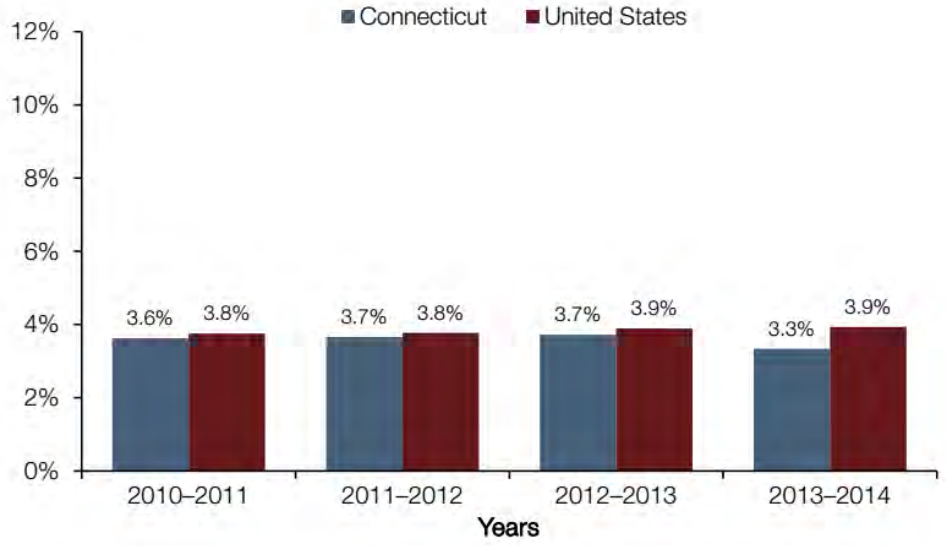
Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, 1 Choke Cherry Road, Rockville, MD 20857.

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 (2010–2011 to 2013–2014)[1,6]

Connecticut's percentage of adults aged 18 or older with suicidal thoughts was similar to the national percentage in 2013–2014.



3.3%

In Connecticut, about 92,000 adults aged 18 or older (3.3% of all adults) per year in 2013–2014 had serious thoughts of suicide within the year prior to being surveyed. The percentage did not change significantly from 2010–2011 to 2013–2014.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health, 2010–2011 to 2013–2014.

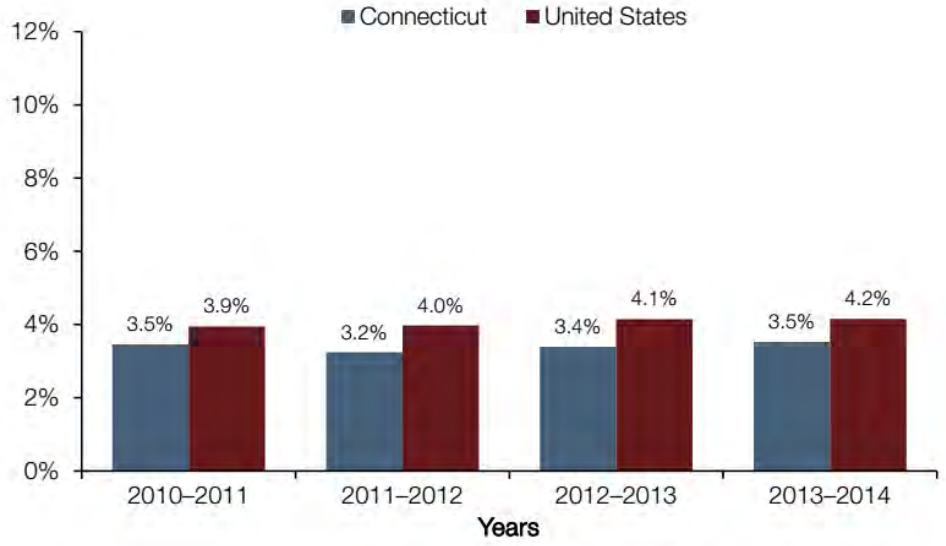
Statistical tests (t-tests) have been conducted for all statements appearing in the text on this page of the report that compare estimates between years or between the state and the nation as a whole. Unless explicitly stated that a difference is not statistically significant, all statements that describe differences are significant at the .05 level.

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 (2010–2011 to 2013–2014)[1,7]

Connecticut's percentage of serious mental illness (SMI) among adults aged 18 or older was similar to the national percentage in 2013–2014.



3.5%

In Connecticut, about 97,000 adults aged 18 or older (3.5% of all adults) per year in 2013–2014 had SMI within the year prior to being surveyed. The percentage did not change significantly from 2010–2011 to 2013–2014.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health, 2010–2011 to 2013–2014.

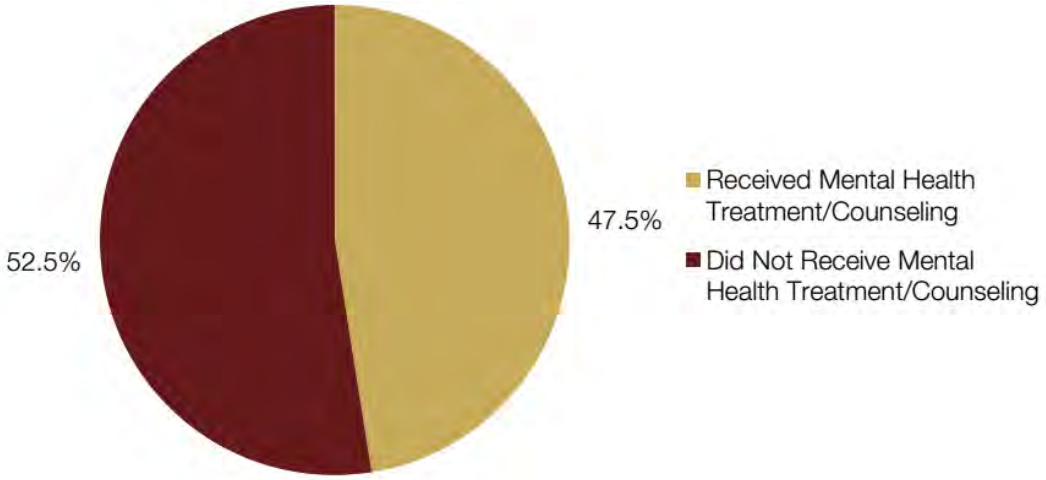
Statistical tests (t-tests) have been conducted for all statements appearing in the text on this page of the report that compare estimates between years or between the state and the nation as a whole. Unless explicitly stated that a difference is not statistically significant, all statements that describe differences are significant at the .05 level.

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 (Annual Average, 2010–2014)[2,8]

Connecticut's annual average of mental health treatment/counseling among adults aged 18 or older with any mental illness (AMI) was similar to the annual average for the nation (42.7%) from 2010 to 2014.



47.5%

In Connecticut, about 214,000 adults aged 18 or older with AMI (47.5% of all adults with AMI) per year from 2010 to 2014 received mental health treatment/counseling within the year prior to being surveyed.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health, 2010–2014.

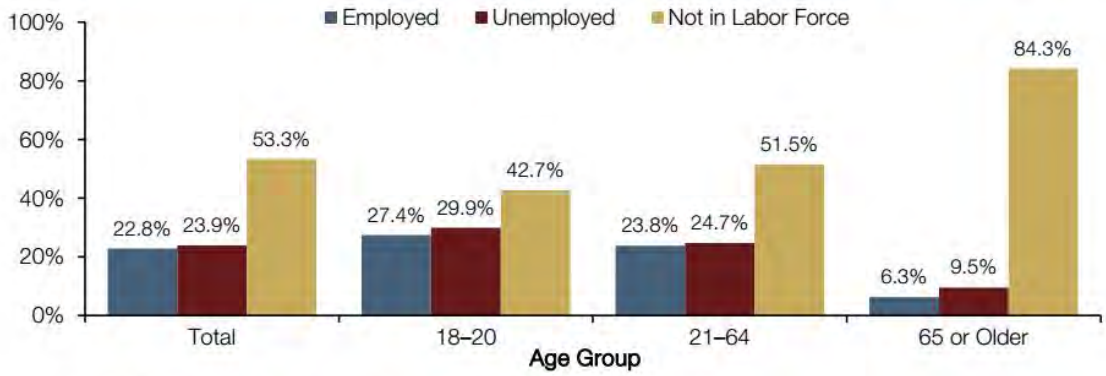
Statistical tests (t-tests) have been conducted for all statements appearing in the text on this page of the report that compare estimates between years or between the state and the nation as a whole. Unless explicitly stated that a difference is not statistically significant, all statements that describe differences are significant at the .05 level.

MENTAL HEALTH AND TREATMENT

MENTAL HEALTH CONSUMERS

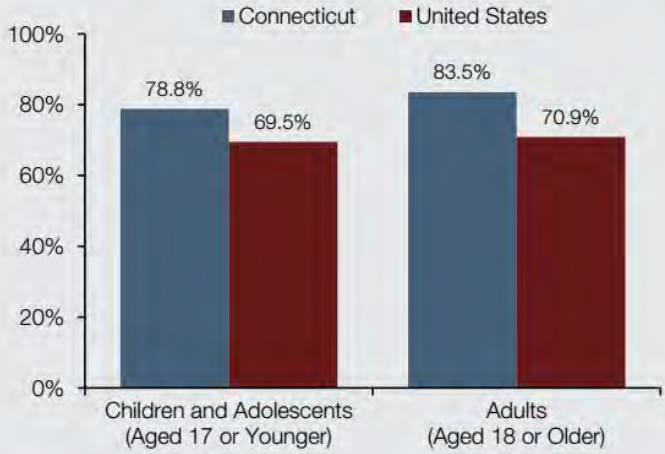
Adult Mental Health Consumers Served in the Public Mental Health System in Connecticut, by Age Group and Employment Status (2014)

Among adults served in Connecticut's public mental health system in 2014, 42.7% of those aged 18–20, 51.5% of those aged 21–64, and 84.3% of those aged 65 or older were not in the labor force.



Source: SAMHSA, Center for Mental Health Services, Uniform Reporting System, 2014.

Mental Health Consumers in Connecticut and the United States Reporting Improved Functioning from Treatment Received in the Public Mental Health System (2014)



In 2014, 33,066 children and adolescents (aged 17 or younger) were served in Connecticut's public mental health system.

The percentage of children and adolescents (aged 17 or younger) reporting improved functioning from treatment received in the public mental health system was higher in Connecticut than in the nation as a whole. The percentage for adults (aged 18 or older) was higher in Connecticut than in the nation as a whole.

Source: SAMHSA, Center for Mental Health Services, Uniform Reporting System, 2014.

Major Depression Among Adults

Major depression is one of the most common mental disorders in the United States.

According to the World Health Organization (WHO; 2010), major depression also carries the heaviest burden of disability among mental and behavioral disorders. Specifically, major depression accounts for:

3.7% of all U.S. disability-adjusted life years (www.nimh.nih.gov//health/statistics/disability/us-dalys-contributed-by-mental-and-behavioral-disorders.shtml) (DALYs); and,

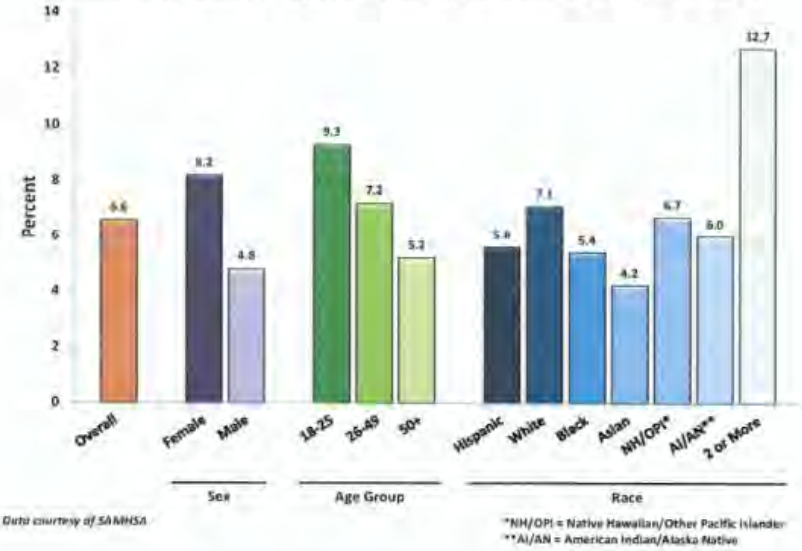
8.3% of all U.S. years lived with disability (www.nimh.nih.gov//health/statistics/disability/us-ylds-contributed-by-mental-and-behavioral-disorders.shtml) (YLDs).

The 12-month prevalence data for major depressive episode presented here are from the National Survey on Drug Use and Health (NSDUH). Based mainly on the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV), in the NSDUH study a major depressive episode is defined as:

> A period of two weeks or longer during which there is either depressed mood or loss of interest or pleasure, and at least four other symptoms that reflect a change in functioning, such as problems with sleep, eating, energy, concentration, and self-image.
>
> Unlike the definition in the DSM-IV, no exclusions were made for a major depressive episode caused by medical illness, bereavement, or substance use disorders.

In 2014, an estimated 15.7 million adults aged 18 or older in the United States. had at least one major depressive episode in the past year. This number represented 6.7% of all U.S. adults.

12-month Prevalence of Major Depressive Episode Among U.S. Adults (2014)



View/Download PDF (www.nimh.nih.gov//health/statistics/prevalence/NSDUH-MDE-2013-Graph-logo_148151.pdf)

Additional information about major depression can be found on NIMH's depression page.

NEXT (www.nimh.nih.gov//health/statistics/prevalence/major-depression-with-severe-impairment-among-adults.shtml)

I-TEAM IN-DEPTH 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.

(http://chit.wpengine.netdna-cdn.com/files/2015/04/YNHH.jpg)

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 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.

(http://chit.wpengine.netdna-cdn.com/files/2015/04/Waterbury.jpg)

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.

(http://chil.wpengine.netdna-cdn.com/files/2015/04/Schwartz-Hank_HS.jpg)

Dr. Harold Schwartz

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.

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

Community Health Needs Assessment For Northwest Connecticut

2015 Update

Charlotte Hungerford Hospital

Commissioned by:
Charlotte Hungerford Hospital (CHH)

Project Advisors:
CHH Community Relations Committee

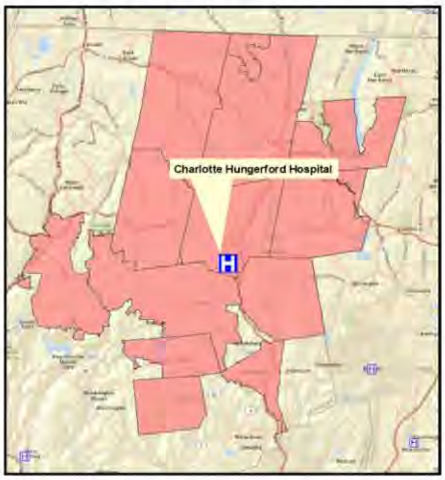
Prepared by:
The Center for Healthy Schools & Communities @ EDUCATION CONNECTION

EDUCATION CONNECTION

EXECUTIVE SUMMARY

The *Community Health Needs Assessment For Northwest CT 2015 Update* provides an overview of the social, economic, physical, and behavioral health of our region's population. Assessment of the current health status of community residents, and the diverse factors that influence health, provides an important foundation for community stakeholders to identify: priorities for health improvement planning, existing community strengths and assets upon which to build, and areas for further collaboration and collective action. This Assessment is an update to the first-ever Community Health Needs Assessment conducted in Northwest CT (NW CT), the 2012 Litchfield County Community Health Needs Assessment (CHNA). The 2012 county-wide assessment was funded by a CDC Community Transformation Grant through the CT State Department of Public Health (DPH), Torrington Area Health District (TAHD), Charlotte Hungerford Hospital (CHH), United Way of Northwest CT, and the Northwest CT YMCA.

This *Community Health Needs Assessment For Northwest CT 2015 Update* concentrates, to the extent possible, on the primary service area of Charlotte Hungerford Hospital, which includes the following 13 communities and zip codes shaded on the map below: Barkhamsted (06063), Bethlehem (06751), Colebrook (06021), Cornwall (06753), Goshen (06756), Harwinton (06791), New Hartford (06057), Norfolk (06058), Litchfield (06759), Morris (06763), Thomaston (06778), Torrington (06790), and Winchester (06098). When service area data was not available, or unreliable due to the small number of health-related events, we have used county-wide data as in the 2012 CHNA.



This CHNA is also informed by and aligned with the focus areas and key health indicators included in the most recent statewide health assessment, *Healthy Connecticut 2020,* and in the *State Health Improvement Plan*. The State Health Assessment and State Health Improvement Plan provide opportunities for organizations and agencies across Connecticut to focus and align dialogue around a common framework for improving health. These documents can be accessed and downloaded from the CT Department of Public Health (DPH) website at: *http://www.ct.gov/dph/cwp/view.asp?a=3130&Q=542346&PM=1*.

Summary of Findings

Northwest CT as a region meets most national targets for health and has better health outcomes compared to many other states, for many indicators, such as obesity prevalence, teen birth rates, and health insurance coverage. Although health statistics indicate an overall healthy profile for the region and the state, disparities are apparent by age, sex, race, ethnicity, geography, and socioeconomics, highlighting areas and populations in need. A summary of findings for Key Health Indicators by Focus Area follows:

Maternal, Infant, and Child Health

- During the past decade, the state and region have both experienced improvements in maternal, infant, and child health, including significant declines in births to teen mothers. However, recent data for several NW CT towns reveal rates of smoking during pregnancy and preterm births above the state average, and a higher infant mortality rate in the county than the state overall (influenced by a higher proportion of multiple-birth pregnancies).
- There were disparities among population groups for births to teen mothers, preterm births, low birthweight births, and non-adequate prenatal care. In CT, preterm birth, low birthweight, and infant mortality remain highest among infants born to Black non-Hispanic women relative to White non-Hispanic and Hispanic women.

Figure 18: Hospital Utilization by Type of Encounter, 2014

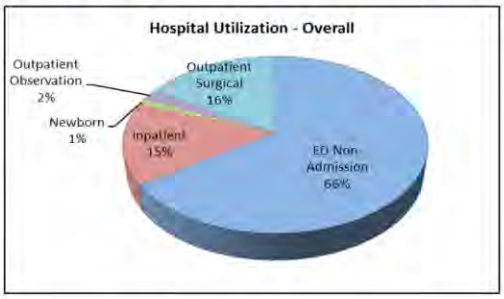


Figure 19: Most Common Medical Diagnoses in Hospitalized Patients, 2014

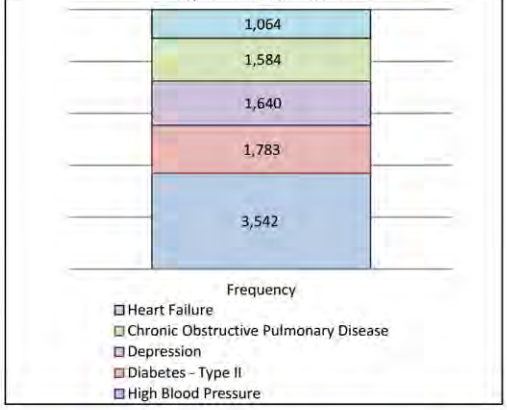


Figure 20: Most Common Medical Diagnoses in ED Non-Admissions, 2014

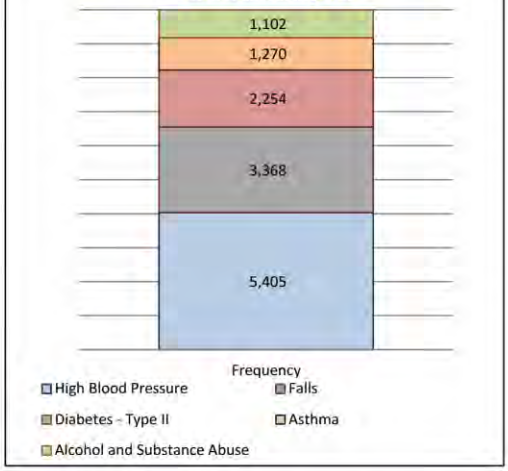


Figure 18-20 Source: The Connecticut Hospital Association FY 2014 CHIMEData

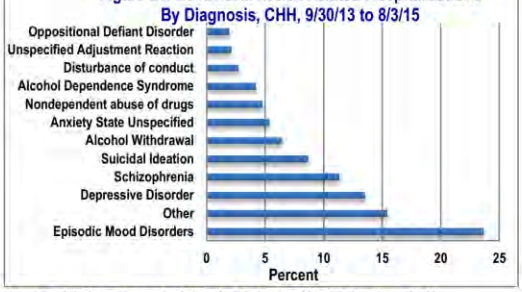
The Connecticut Hospital Association provides data collection and reporting services for its acute care hospital members through the ChimeData program. ChimeData is the most comprehensive hospital database in the state. ChimeData collects discharge data from inpatient admissions, hospital-based outpatient surgery, and emergency department (ED) non-admissions. Fiscal year (FY) 2014 data were analyzed and evaluated by CHA for the Charlotte Hungerford Hospital designated service area. Patient encounter data were extracted for those zip codes identified as being part of the hospital service area, including: Barkhamsted (06063), Bethlehem (06751), Colebrook (06021), Cornwall (06753), Goshen (06756), Harwinton (06791), New Hartford (06057), Norfolk (06058), Litchfield (06759), Morris (06763), Thomaston (06778), Torrington (06790), and Winchester (06098).

Hospital utilization data for Fiscal Year 2014 is presented in Figures 18-20. This data represents patient encounters across all CHA member hospitals with discharges from the 13 zip codes in CHH's service area. The highest frequency of hospital-based service utilization was for Emergency Department (ED) visits that did not result in an inpatient hospital stay; two-thirds of encounters in the service area were ED-based. The next highest areas of utilization were for outpatient surgical and inpatient services respectively.

As shown in Figure 19, the most prevalent medical diagnoses for persons hospitalized in the service area were Hypertension (High Blood Pressure), followed by Type II Diabetes, Depression, Chronic Obstructive Pulmonary Disease, and Heart Failure. Hypertension was also the most common medical diagnosis in persons seen in the emergency department (ED) who did not require hospitalization, followed by falls, Type II Diabetes, Asthma, and Alcohol and Substance Abuse. It is important to note that the data presented in Figures 19-20 does not reflect the primary *reason* for the ED visit or hospitalization.

CHH Behavioral Health Services data for primary and secondary mental health diagnoses (DSM-5) for hospitalized patients from 2013-2015 are shown in Figure 21 below. Episodic Mood Disorders, Depressive Disorder, and Schizophrenia were the top 3 behavioral health diagnoses.

Figure 21: Behavioral Health-Related Hospitalizations By Diagnosis, CHH, 9/30/13 to 8/3/15



Source: Charlotte Hungerford Hospital-Behavioral Health Services, 2015

Figure 18: Hospital Utilization by Type of Encounter, 2014

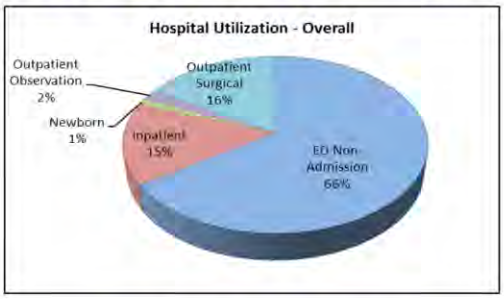


Figure 19: Most Common Medical Diagnoses in Hospitalized Patients, 2014

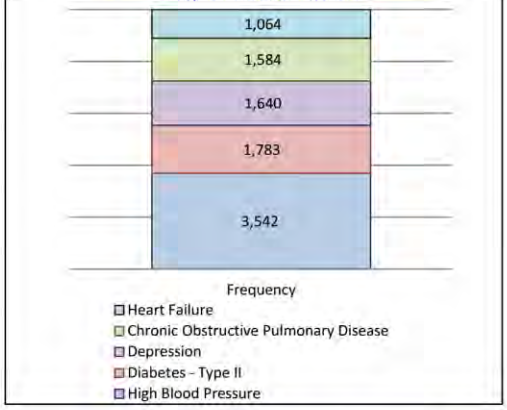
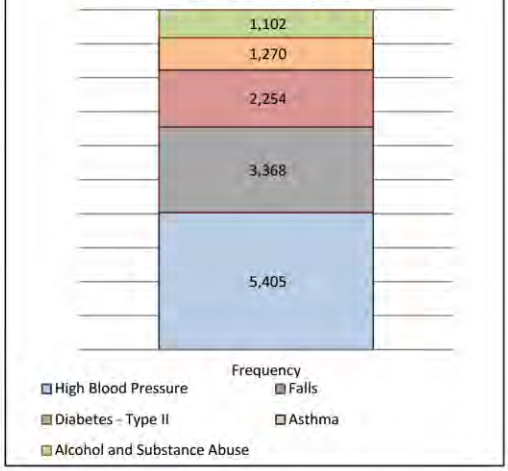


Figure 20: Most Common Medical Diagnoses in ED Non-Admissions, 2014



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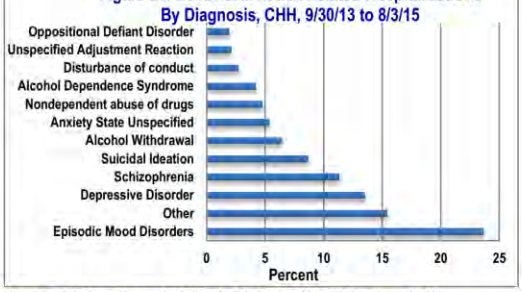
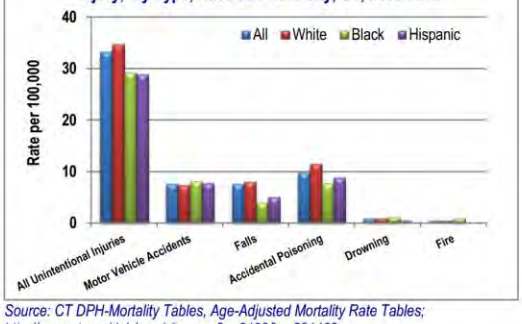


Source: Charlotte Hungerford Hospital-Behavioral Health Services, 2015

INJURY AND VIOLENCE PREVENTION

Figure 56: Age-Adjusted Mortality Rate for Unintentional Injury, as Percent of Total Unintential Injury, by Type, Race and Ethnicity, CT, 2008-2012



Source: CT DPH-Mortality Tables, Age-Adjusted Mortality Rate Tables; http://www.ct.gov/dph/cwp/view.asp?a=3132&q=521462

Figure 57: Number of Deaths Due To Suicide, by Age Group, Connecticut, 2012

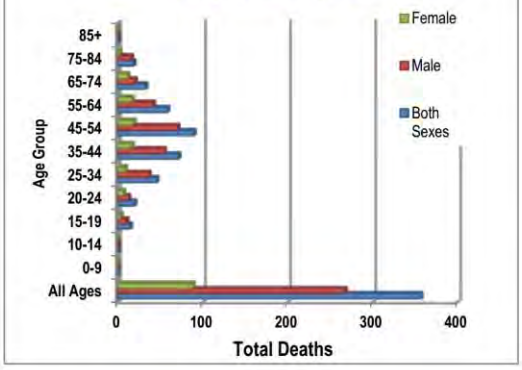


Figure 58: Total Deaths Due to Homicide, by Age Group, Connecticut, 2012

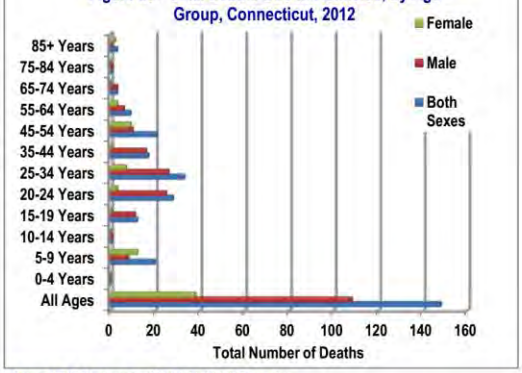


Figure 57 & 58 source: CT DPH: Vital Records; http://www.ct.gov/dph/cwp/view.asp?a=3132&q=394598&dphNav_GID=1601&dphPNavCtr=|#46987

Why Injury and Violence Prevention Are Important

Injuries, whether intentional or unintentional, are a leading cause of premature death and disability, as well as health care costs and lost productivity in the workforce. Importantly, most unintentional injuries are preventable. For example, according to the National Institutes of Health, alcohol is a factor in 30 percent of suicides, 40 percent of crashes and burns, 50 percent of drownings and homicides, and 60 percent of falls. CDC reports that the use of seat belts reduces serious and fatal injuries by more than half. Intentional injuries include suicides, homicides, domestic violence and child abuse. Early intervention and treatment for mental health conditions and alcohol and drug abuse are preventive measures to reduce the rates of intentional injury.

Findings in the State and NW CT

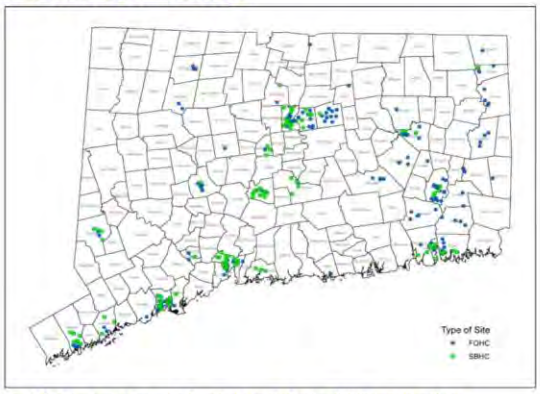
In CT and the region, the major types of unintentional injury as shown in Figure 56, are accidental poisoning, falls, and motor vehicle accidents. Males were nearly twice as likely as females to die from unintentional injuries and motor vehicle accidents were the primary cause of injury death. The primary cause of unintentional injury-related death in females was falls. The rise in deaths by accidental poisoning is in large part attributable to deaths from prescription drug overdose in persons 15-24 years of age, which is addressed further in the Mental Health and Substance Use section of this report. Accidental drug intoxication deaths in CT (pure ethanol intoxications were excluded) are projected to increase by over 90% (from 355 to 679) from 2012-2015; heroin-related deaths are projected to more than double. *Source:http://www.ct.gov/ocme/lib/ocme/AccidentalDrugIntoxication2015.pdf.* Injury-related death rates in SATs were in the highest quartile for Winchester, and second highest quartile for Thomaston and Torrington.

As shown in Figures 57 and 58, CT males are more than twice as likely as females to die from suicide or homicide. Suicide deaths are most prevalent in males and females ages 35-54; homicides are most common in young adults, ages 15-34, with Black or African American males disproportionately affected. In CT, about two-thirds of all homicides and one-third of all suicides involve firearms (Healthy CT 2020).

Figure 59: Unintentional Injury Age-Adjusted Death Rates, By Town, CT, 2006-2010

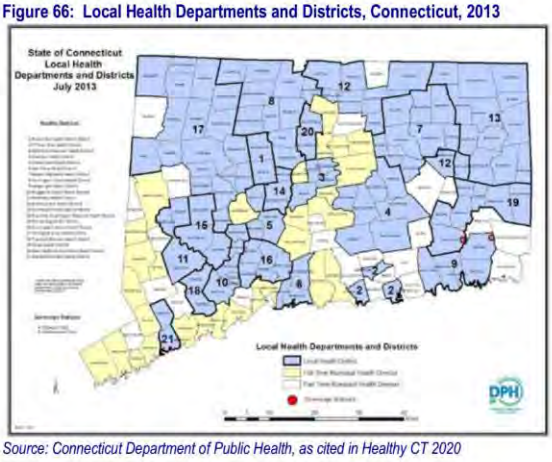
Source: Connecticut Department of Public Health, Health Statistics & Surveillance. Statistics & Analysis Reporting, 2006-2010.

Figure 65: Federally Qualified Health Center and School-Based Health Center Locations, Connecticut, 2014



Note: FQHC indicates Federally Qualified Health Center, SBHC indicates School-Based Health Center. Source: Connecticut Department of Public Health, as cited in Healthy CT 2020

Figure 66: Local Health Departments and Districts, Connecticut, 2013



Source: Connecticut Department of Public Health, as cited in Healthy CT 2020

Table 17: 2-1-1 Service Requests for Litchfield County, 1/1/15-12/28/15

2-1-1 Request Category	Totals
Public Assistance Programs	1,354
Individual & Family Support Services	1,163
Utilities	935
Mental Health Evaluation & Treatment	911
Housing/Shelter	888
Counseling Settings	874
Health Supportive Services	663
Legal Services	480
Temporary Financial Assistance	281
Food	274
Substance Abuse Services	262

Source: United Way of CT: http://uwc.211ct.org

Muncipalities within the CHH service area are served by 2 full-time health districts. Torrington Area Health District serves the following SATs: Bethlehem, Cornwall, Goshen, Harwinton, Thomaston, Torrington, and Winchester. The Farmington Valley Health District serves Barkhamsted, Colebrook, and New Hartford. Phone, email, and website contact information is available at: *http://www.ct.gov/dph/cwp/view.asp?a=3123&q=397740*

There are a wide variety of additional health-related resources within the county. United Way of CT Infoline 2-1-1 maintains an up-to-date online searchable community resource database of health and human service providers, agencies, and organizations, available at *http://www.211ct.org*. United Way also publishes an annual report, The 2-1-1-Barometer - Identifying Unmet Needs in CT, highlighting gaps between service requests and available resources in the community. This report can be accessed at: *http://www.ctunitedway.org/barometer.asp*. There were over 9,500 service requests in NW CT to 2-1-1 in 2015. The most frequent service requests are presented in Table 17.

The *2012 Litchfield County Community Health Assessment* included GIS Asset Maps of Health-Related Programs & Services located within the county compiled by the CT Infoline Research & Evaluation Unit. Each map includes Resource Listings of the types of services provided. More detailed information on the programs and services included is available at *www.infoline.org* or by calling Infoline at 2-1-1. Key findings related to service availability and accessibility included:

- Tobacco cessation programs in the county are limited.
- Opportunities for physical activity appear to be available in most communities; however limited accessibility due to transportation may be a factor for many residents.
- There are no healthy eating/nutrition education programs presently available in the county.
- Clinical and preventive health services are concentrated in the three communities with acute care hospitals (New Milford, Torrington & Sharon); access to these services may be a factor for many residents.
- The geographic availability of health screening services in the county is limited as is the type.
- Health and mental health-related support groups are again concentrated in the three communities with acute care hospitals.
- The availability of mass transportation services in general, as well as medical transportation services and services for disabled persons, is limited in many communities.
- Housing for vulnerable population groups, including the elderly, disabled, and residents in need of emergency or supportive housing is limited and non-existent in many communities.

- Data from the 2012 BRFSS specific to the TAHD service area in NW CT indicate that 21% of residents ages 50+ reported never having colorectal screening (sigmoidoscopy/colonoscopy); 18% of women ages 40+ reported never having a mammogram; 25% of women reported not having a PAP test in the past 3 years, and 63% of men ages 40+ indicated that they had not had PSA testing in the past two years. Participation rates in colorectal and mammography screening were significantly *lower* for persons reporting incomes below $35,000 per year than for those with incomes of $70,000 per year or higher.

Maternal, Infant, and Child Health:

- In 2007-2011, Torrington and Winchester were in the second highest quartile in the state for low birthweight births and highest quartile for preterm births in the state. Notably, based on birth certificate data, mothers in these two communities reported the highest levels of smoking during pregnancy during this period as well.
- In 2010-2012, Infant Mortality Rates in Litchfield County were nearly twice the state rate. According to analyses performed by the CT Department of Public Health, these differences were found to be statistically significant ($p < .05$). This difference is attributed in part to the higher proportion of multiple-birth pregnancies in Litchfield County mothers compared with the state, a known risk factor for poorer birth outcomes.
- According to 2012 BRFSS results, one in five CT children in the TAHD services area was obese according to Body Mass Index (BMI) for age standards. For children living in households with incomes below $35,000, this increased to one in every three children (based on adult parent responses to BRFSS questions).

Mental Health & Substance Use:

- E-cigarette use by youth is significantly higher in CT than in the U.S. overall.
- Reported heroin use in high school students in the state and region exceeded national averages.
- Rates of underage drinking by adolescents and binge/excessive drinking by persons of all ages remain key concerns in the state and region, as rates exceed national averages and benchmarks. Alcohol is a major contributor to both intentional and unintentional injuries.
- Mental health issues such as depression are relatively common in adolescents as well as adults.
- Mental health and substance use disorders are inextricably linked to physical health and are leading causes of disability in the state and region.

Infectious Diseases:

- HIV, Hepatitis B, and Hepatitis C are preventable. Vaccination for Hepatitis B and avoiding risky behaviors such as unprotected sex and injecting illicit drugs are critical.
- Tick-borne diseases, such as Lyme Disease and Babesiosis, are more prevalent in rural areas of the state, such as NW CT. For SATs, Litchfield and Morris had annual Lyme Disease incidence rates above the state average.

Injury:

- The rise in deaths by accidental poisoning is in large part attributable to deaths from prescription drug overdose in persons 15-24 years of age. Accidental drug intoxication deaths in CT are projected to nearly double from 2012-2015; heroin-related deaths are projected to more than double.
- Injury-related death rates in SATs were in the highest quartile in the state for Winchester, and second highest quartile for Thomaston and Torrington.

Health Care Access:

- Within the county, Torrington is a federally designated primary care health professional shortage area. The county has 1 primary care physician to every 1,563 residents, well below both the national benchmark of 1 primary care physician for every 1,045 residents and the state average of 1 primary care physician per 1,190 residents. The county has a ratio of 1 mental health provider to every 548 residents, considerably below the state average of 1 provider to every 323 residents, and national benchmark of 1 provider to every 386 residents. The county also has a lack of dentists, with 1 dentist for every 1,699 residents compared with the national benchmark of 1 provider to every 1,377 residents. Lack of available primary care, specialty, and sub-specialty health services in the region due to provider shortages was a common theme from the Key Informant Interviews and Focus Groups conducted as an integral component of the assessment process.

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ANXIETY AND DEPRESSION ASSOCIATION OF AMERICA

(/)

Adult ADHD (Attention Deficit Hyperactive Disorder)

Attention deficit hyperactive disorder, or ADHD, is a condition characterized by inattention, hyperactivity, impulsiveness, or a combination.

About 60 percent of children with ADHD in the United States become adults with ADHD; that's about 4 percent of the adult population, or 8 million adults.

Less than 20 percent of adults with ADHD have been diagnosed or treated, and only about one-quarter of those adults seek help.

Thought to be biological and most often genetic, ADHD takes place very early in brain development. Adults with ADHD may exhibit the same symptoms they had as children, and although hyperactivity often diminishes by adulthood, inattentiveness and impulsivity may persist.

Symptoms

ADHD symptoms often include an inability to focus, disorganization, and restlessness. Adults with ADHD may have a hard time organizing things, listening to instructions, remembering details, or difficulty completing tasks, which can affect their relationships at home, school, and work.

People who have ADHD may exhibit different symptoms, and they may experience them at different levels of severity, ranging from mild to significant impairment.

PSYCHIATRIC DISORDERS AND SLEEP

Andrew D. Krystal, M.D., M.S.

SYNOPSIS

I. INTRODUCTION

It has long been appreciated that sleep problems are common among those with psychiatric disorders. The prevailing view has been that sleep problems are generally symptoms of the associated psychiatric conditions. Consistent with this point of view is that sleep problems are defining features of a number of psychiatric disorders and included among the diagnostic criteria for these conditions.- However, there are a number of additional ways that psychiatric disorders and sleep are inter-related. The emerging view is that the relationships of psychiatric disorders with sleep are complex and marked by bi-directional causality.

For example, the longstanding view that treating some psychiatric conditions improves sleep is complemented by recent evidence suggesting that treating sleep disturbances can have important effects on the outcome of treatment of psychiatric conditions. Further, contrary to the prevailing view, some sleep disorders increase the risks of developing episodes of psychiatric disorders. It is also the case that some treatments are used to treat both psychiatric disorders and sleep disorders.

Also, some treatments for psychiatric disorders may trigger disturbances of sleep and some treatments for sleep disorders may increase the risks for psychiatric disorders. A further complexity in the sleep-psychiatric disorders relationship is that sleep deprivation may have therapeutic effects for some psychiatric disorders but may aggravate others.[8] In this article we provide the evidence that supports this point of view, reviewing the data on the sleep disturbances seen in patients with psychiatric disorders but also reviewing the data on the impact of sleep disturbances on psychiatric conditions.

It is organized into 6 sections: 1) The sleep of patients with psychiatric disorders; 2) The risks of psychiatric disorders in those with sleep disturbances; 3) The impact of sleep disturbances on the course and treatment of psychiatric conditions; 4) The sleep effects of psychiatric treatments; and 5) The impact of sleep deprivation on psychiatric disorders. This article is focused on the subset of psychiatric disorders which have the most important relationships with sleep including: Major Depressive Disorder Bipolar Disorder Generalized Anxiety Disorder Post-Traumatic Stress Disorder (PTSD)

II THE SLEEP OF PATIENTS WITH PSYCHIATRIC DISORDERS

A. Major Depressive Disorder (MDD)

Problems with sleep, which could include insomnia or hypersomnia, is one of the diagnostic criteria for MD- As such, it is not surprising that some type of sleep difficulty occurs in as many of 90% of MDD patients.[9] The type of sleep difficulty experienced by those with MDD can include difficulty falling asleep, difficulty staying asleep, insufficient sleep quality, nightmares and daytime sleepiness. Troubles falling asleep and staying asleep have been documented polysomnographically, however, there are no studies finding objective evidence of daytime sleepiness with the multiple sleep latency test, the standard for clinical and research assessment of sleepiness-Patients with MDD also appear to have alterations in their sleep stages that are evident with polysomnography. These include: shortened latency to the onset of REM sleep (REM latency) increased number of eye movements per minute of REM sleep (REM density)[10,15,23–24]; increased percentage of the night that meets scoring criteria for REM sleep; a longer duration of the first REM period; and decreased amount of slow-wave sleep.

The prolonged sleep onset and difficulties with sleep maintenance found in patients with MDD are established indicators of disturbance of sleep. However, the significance of the alterations in sleep stages

seen in those with MDD is unknown. There is some evidence suggested that shortened REM latency and diminished slow-wave sleep may be trait markers of MDD, whereas the increased REM density and sleep disturbance appear to be state markers as they are most evident during episodes of depression.[34] However, these sleep-stage changes appear to be of limited clinical utility as they are not specific to those with MDD but are seen in those with other types of psychiatric disorders.

B. Bipolar Disorder

For the manic phase of bipolar disorder, the diagnostic criteria include decreased need for sleep.[1] So, as with MDD, it is not surprising that changes in sleep are nearly universal among those with bipolar mania However, the nature of the sleep problem in this condition, decreased need for sleep, is an alteration in sleep that is only seen in mania. Decreased sleep need is not synonymous with insomnia. It is a condition where an individual can, and do, decrease their sleep time, at least to some degree, without experiencing any impairment in function or quality of life. In contrast, insomnia is a condition where individuals experience impairments in function and/or quality of life due to failing to be able to sleep despite having the adequate opportunity to do so.[1] Diagnostic confusion might arise because those with mania may experience difficulties falling and staying asleep much like insomnia patients. However, in the case of manic patients this problem arises because they are attempting to sleep more than the amount they need to be restored. Whereas insomnia patients are unable to sleep enough to feel restored despite their efforts to do so.

During the depressed phase of bipolar disorder, the most common sleep complaint is hypersomnia, which reportedly occurs more frequently in those with bipolar depression than unipolar depression. The little research carried out to determine if there is objective evidence of daytime sleepiness in patients with bipolar depression using the multiple sleep latency test (MSLT) has not found evidence of clinically significant sleepiness.

Interestingly, the alterations in sleep seen with polysomnography in patients with bipolar mania are comparable to what has been observed in those with MDD. This may indicate that there is a common pathophysiology in MDD and bipolar mania. However, it is important to keep in mind that these polysomnographic findings are also seen in those with other psychiatric conditions and, therefore, may not be reflective of specific pathophysiologic mechanisms.

C. Generalized Anxiety Disorder

As with MDD and bipolar disorder, a change in sleep is among the core features of GAD. In this case this alteration is disturbance of sleep (difficulty falling or staying asleep) which affects over half of those with GAD.

Few data exist on the polysomnographic features that characterize the sleep of patients with GAD. However, those that exist suggest that GAD patients have: longer sleep onset latency, a greater number of arousals, and greater wake time during the night.[42–43] In contrast to bipolar disorder and MDD, GAD does not appear to be marked by any alterations in REM latency or percentage of the night comprised of REM sleep, however, one study reported that GAD patients had a decreased percentage of the night spent in slow-wave sleep and a relative increase in the percentage of the night meeting criteria for stage 1 sleep compared with controls.

D. Post-Traumatic Stress Disorder

Sleep problems are also among the diagnostic criteria for PTSD, though in this case the sleep difficulties include distressing dreams along with difficulties falling or staying asleep.[1] Accordingly, complaints of sleep difficulties are ubiquitous among those who have PTSD.

A number of studies including polysomnography have examined the sleep of patients with PTSD in an effort to explore the associated neurophysiologic changes. The most consistent findings suggest disruption of sleep. This includes diminished total sleep time, which has been reported in 5 studies, while an elevation in the time spent awake after initially falling asleep (WASO) has been noted in 3 reports.[45–49] In one

additional study, there was an association between an increase in WASO and nightmares. However, it should be noted that there are several studies that have not found evidence for sleep difficulties in the PSG in PTSD patients.[51] This inconsistency may not be specific to PTSD, however. There is evidence that among patients with insomnia complaints occurring in other settings there is often a weak relationship between PSG and self-report measures of sleep.

Another frequent PSG finding in PTSD patients is an alteration in REM sleep such as is seen in those with MDD and bipolar disorder. The most frequently reported REM sleep aberration has been an increase in REM density (eye movements per minute of REM sleep). As discussed above, this measure of the "intensity" of REM sleep does not reflect a physiologic alteration specific to PTSD because it has also been reported to be elevated in those with MDD that has a high-rate of co-morbidity with PTSD

III. THE RISKS OF PSYCHIATRIC DISORDERS IN THOSE WITH SLEEP DISTURBANCES;

The risks of psychiatric disorders in those with sleep disturbances are less well appreciated than the sleep disturbances associated with psychiatric disorders. Yet, the evidence that sleep disturbances are associated with an increased risk of developing psychiatric disorders has existed since the 1980s.

A. MDD

In terms of MDD, this evidence includes that those with insomnia and those with hypersomnia are roughly ten times as likely to have MDD as healthy controls without sleep disorders.[80–82] Also, a series of longitudinal studies indicate that having insomnia at one point in time significantly increases the risk for the subsequent development of new onset MDD.[82–84]

B. GAD

There is also longitudinal data indicating that insomnia increases the risk for the subsequent development of anxiety disorders. Those with insomnia appear to have approximately double the risk of healthy controls.[80]

C: PTSD

To date there is no evidence suggesting that pre-existing insomnia is a predisposing factor for the development of the PTSD syndrome following an extreme event, though we are aware of no studies which have specifically investigated this question. There is, however, one study suggesting that sleep complaints occurring at 1 month or longer after trauma were significant predictors of the presence of a diagnosis of PTSD at 1-year post-trauma. While this report is intriguing it is of uncertain significance.

Alcoholism

There is a body of evidence suggesting that sleep difficulties may increase the risks for alcoholism and may contribute to continued alcohol consumption among drinkers. Several longitudinal studies suggest that those with insomnia are at increased risk for the development of subsequent alcohol use problems compared to those without disturbed sleep. Several studies suggest that those with alcoholism often use alcohol as a means to treat sleep difficulties. This includes that such individuals are more likely than those without alcoholism to choose alcohol as a way to improve sleep and to report difficulty falling asleep if they don't drink alcohol prior to going to bed.

IV. THE IMPACT OF SLEEP DISTURBANCES ON THE COURSE AND TREATMENT OF PSYCHIATRIC CONDITIONS;

There is a growing body of literature indicating that sleep disturbances impact the course and treatment of psychiatric conditions. This literature includes reports of studies on the relationship of sleep disturbance to

psychiatric symptoms as well as their relationship with treatment outcome, and risk of relapse in psychiatric conditions. Studies also document the impact of treating sleep disorders on the outcome of psychiatric conditions.

A. MDD

Though long thought of as a symptom of depression, insomnia appears to have an impact on the course and treatment response of MDD. According to the symptom model, sleep disturbance would be expected to resolve with appropriate antidepressant therapy along with the other MDD symptoms. Although this certainly occurs to a degree, the available evidence suggests that in 20–44% of those with MDD, sleep difficulties fail to resolve despite the administration of standard antidepressant treatments. This residual insomnia also appears to be associated with an increased risk of MDD relapse as well as a number of impairments including decreased concentration, sleepiness, and diminished performance capacity

Among those with MDD, there are several other ways that poor sleep appears to have an adverse impact on the course of MDD. Perhaps the most important and most concerning of these is that sleep disturbance appears to increase the risks of suicidal ideation, suicide attempts, and completed suicide. To date, at least 32 studies have identified that sleep disturbance is linked to suicidal ideation or completed suicide. This includes: 10 studies in children and adolescents; 22 studies in younger and older adults; and studies spanning multiple countries (U.S., England, France, Canada, Turkey, Finland, Sweden, Brazil, China, and Japan). Notably, these studies include five prospective studies and in many the associations between sleep disturbance and suicidality remained after adjusting for depression severity. However, despite all of the evidence linking insomnia and suicidality, insomnia is generally overlooked as a suicide risk factor and as a means of preventing suicide in those with MDD.

Sleep disturbance also has other adverse effects on the course of MDD. Those MDD patients with poor sleep have slower treatment response and lower remission rates than those without sleep disturbance. Greater sleep disturbance is also independently correlated (independent of depression severity) with poorer quality of life in those with MDD.

There is additional evidence to support the independent importance of disturbed sleep in MDD and these data speak to the need to target treatment specifically to the sleep problems in those with MDD. Several studies indicate that targeting treatment to insomnia in addition to providing standard antidepressant therapy may improve not sleep but also enhance the improvement in depression. In one such study, the hypnotics lormetazepam and flurazepam were compared with placebo as adjunctive insomnia therapies to antidepressant treatment with nortriptyline or maprotiline.[118] Those subjects randomized to lormetazepam had greater depression improvement than subjects receiving placebo. In another study, co-administration of eszopiclone 3 mg and fluoxetine led to greater improvement in sleep and a more rapid and greater improvement in depression (greater improvement in the Hamilton Depression Rating Scale with sleep items removed and greater percentage of responders and remitters) than fluoxetine plus placebo.[119–120] However, it should be noted that a study of identical design employing zolpidem extended release preparation 12.5 mg instead of eszopiclone found that insomnia therapy improved sleep and sleep related daytime function but not depression outcome compared with placebo.[121] Lastly, a study was carried out where cognitive behavioral insomnia was compared to a behavioral control intervention in depressed patients treated with escitalopram.[122] In this study, those receiving the active insomnia therapy experienced a 62% remission rate compared with 33% for the control intervention.

Thus, three of four studies indicate that targeting treatment to insomnia improves not only sleep outcome but also depression treatment response. In the one study where this was not the case, sleep and function were improved, however, it remains unclear why depression outcome did not improve.[121] Further studies will be needed to better understand the impact of insomnia therapy on MDD treatment outcome. Nonetheless, multiple lines of research suggest that sleep disturbance has a substantial impact on MDD and the antidepressant response, and, generally speak to the need to treat insomnia in those with MDD.

B. Bipolar Disorder

Relatively less research has been carried out on the impact of sleep on the course of bipolar disorder. However, several studies indicate that preventing patients with bipolar disorder from sleeping predisposes them to the development of mania. On this basis it has been hypothesized that sleep loss plays an etiologic role in the development of mania such that loss of sleep predisposes towards mania which, in turn, leads to further loss of sleep in a positive feedback cycle.

Whether this is the case remains unclear as are the mechanisms by which sleep loss might predispose patients with bipolar to develop mania. However, the clinical implications of this hypothesis is that management of bipolar patients should include interventions to prevent sleep loss and lengthen sleep time as a means of preventing and/or treating mania. Although this approach has yet to be systematically studied, it is probably no accident that all anti-manic therapies have significant sleep-enhancing effects.

C. GAD

Relatively few data exist on the impact of sleep on the course of GAD. However, two placebo-controlled trials of adding insomnia co-therapy to the treatment of GAD with escitalopram have been carried out. These studies include a trial of eszopiclone 3 mg plus escitalopram vs placebo plus escitalopram and a trial of zolpidem Extended Release 12.5 mg plus escitalopram vs placebo plus escitalopram. Much like the results seen in nearly identical studies carried out with MDD patients, eszopiclone significantly improved sleep and GAD response/remission compared with placebo, whereas zolpidem Extended-Release only improved sleep and sleep-associated daytime function compared with placebo. As with MDD, these studies support the utility and importance of targeted insomnia therapy in GAD patients, however, it remains unclear whether the treatment of insomnia might impact GAD outcome or whether there are specific characteristics of eszopiclone or zolpidem Extended-Release that affected their impact on GAD outcome.

D. PTSD

There are several placebo-controlled studies demonstrating that treatments aimed at improving sleep in patients with PTSD can improve daytime PTSD symptoms. This includes one study of eszopiclone 3 mg administered at bedtime, four studies of prazosin administered at bedtime, and one study of a behavioral sleep intervention targeting insomnia and nightmares. However, whether these sleep-targeted therapies have direct effects on daytime PTSD symptoms or whether daytime PTSD symptoms are improved due to improvements in sleep has not been definitively established. At least for prazosin, there is evidence that this agent improves daytime PTSD symptoms when administered during the day, so it is at least plausible that nighttime administration could directly improve daytime PTSD symptoms and while the half-life of this drug seems to preclude this possibility (half-life is 2–4 hours) it must be borne in mind that this medication has several active metabolites which could contribute to its therapeutic effect.-There are no data that indicate whether eszopiclone or behavioral sleep therapy might have direct effects on daytime PTSD symptoms.

Alcoholism

A number of studies suggest that sleep problems and polysomnographic alterations in sleep occurring post-abstinence may play an important role in hastening relapse. The link between disturbed sleep during abstinence and relapse to drinking has been identified in several studies. Polysomnographic sleep variables that have been found to be predictors of relapse include: longer sleep onset latency, decreased sleep efficiency, decreased percentage of the night spent in slow-wave sleep, shorter REM onset latency, greater percentage of the night spent in REM sleep, and greater REM density. The variable which best predicts relapse seems to vary with the duration of time since the abstinence period began, though this may not in fact be the case but may reflect that the findings are varying across studies which happened to focus on different time periods. Increased REM density immediately after stopping drinking has been reported to be the best predictor of relapse 3–4 months later, however, at 1 month after the onset of abstinence, sleep onset latency was found to be the best predictor of relapse, whereas at 5 months after the beginning of the

abstinence period sleep onset latency and sleep efficiency best predicted relapse at 1 year.

Although these studies speak to the need to evaluate whether the treatment of sleep disturbances during abstinence might decrease the likelihood of relapse, only two placebo-controlled studies have been carried out addressing this question and both were small trials. One was a study of trazodone 200 mg which included only 16 subjects and found that this medication improved sleep compared with placebo but had no impact on relapse rate, though it could be reasonably argued that the study was under-powered to assess this outcome. The other study evaluated gabapentin 1500 mg in only 21 subjects and, although there was a decrease in relapse rate, there was no difference between drug and placebo groups on sleep parameters. Based on the limited amount of work carried out, it remains unclear whether treating sleep problems during abstinence decreases the rate of subsequent relapse to drinking and studies addressing this issue are clearly needed.

V. THE SLEEP EFFECTS OF PSYCHIATRIC TREATMENTS;

A. MDD

Many antidepressant medications have been documented to have effects on polysomnograhic sleep variables, some are used to treat sleep disturbance, some have a tendency to disturb sleep, and some have a tendency to cause or exacerbate periodic leg movements of sleep (PLMs) and/or restless legs syndrome. In terms of the effects of antidepressant on polysomnographic sleep indices, a number of studies have documented that antidepressant treatments including monoamine oxidase inhibitors, tricyclic antidepressants electroconvulsive therapy, selective serotonin reuptake inhibitors, and serotonin-norepinephrine reuptake inhibitors, suppress REM sleep.[20,146–152] These findings have served as the basis for the hypothesis that suppression of REM sleep is an important part of the mechanism of action of antidepressant therapies. However, evidence to the contrary is provided by a number of effective antidepressant agents, bupropion, nefazodone, mirtazapine, and trazodone which do not suppress REM sleep,[153] though these medications appear to have other polysomnographic effects including increasing the amount of slow-wave sleep and increasing the amplitude of EEG slow-waves in non-REM sleep.[154–159]

A number of antidepressants are also used to treat problems falling and/or staying asleep and are used for the treatment of insomnia, though few have been demonstrated to have therapeutic effects in placebo-controlled studies. The antidepressants most commonly used for this purpose are trazodone, mirtazapine, amitriptyline, and doxepin, which, other than mirtazapine are prescribed in lower dosages than typically used to treat depression when administered to treat insomnia.[2] Data from placebo-controlled trials supporting a sleep onset and/or maintenance exist only for doxepin and trimipramine, though studies carried out in depressed patients or healthy controls suggest that amitriptyline and mirtazapine might have therapeutic effects in this setting.

Another sleep-related effect of antidepressant medications is that some can disturb sleep. This includes the norepinephrine and dopamine reuptake inhibitor bupropion, selective serotonin reuptake inhibitors, and serotonin norepinephrine reuptake inhibitors all of which have an adverse effect rate of insomnia/sleep disturbance that is in the range of 1.5–3 times that of placebo.

Many antidepressants also have the potential to cause or exacerbate PLMs and restless legs syndrome. Agents most often associated with this are: selective serotonin reuptake inhibitors, serotonin norepinephrine reuptake inhibitors, and mirtazapine.

B. Bipolar Disorder

Few studies document the sleep effects of agents used to treat bipolar disorder. Most of the available relevant data relate to antipsychotic medications that are often used to treat mania. The sleep effects of these agents are discussed in the section which follows. Otherwise, data exist only for lithium, long a mainstay of the treatment of patients with bipolar disorder. This agent has been found to increase slow-wave sleep, suppress REM sleep and increase REM latency. Like many of the antidepressant medications, lithium has also been reported to cause or exacerbate restless legs syndrome.

C. Schizophrenia

A number of publications document the sleep effects of antipsychotic medications which are the most common pharmacologic therapies administered to patients with schizophrenia. The sleep-related effect of these medications that is of most clinical importance is their tendency to enhance sleep. This effect may be responsible for daytime sedation which may further impair the already limited daytime functional capacity of many patients with schizophrenia, though for patients with disturbed sleep, this type of effect may be beneficial. Systematic studies of the effects of antipsychotic medications have been carried out in patients with mood disorders, those with schizophrenia, and healthy controls. Both quetiapine (25 and 100 mg) and ziprasidone 40 mg were evaluated in trials in healthy controls where sleep on a night with noise disturbance was compared with a night where no disturbance took place. Quetiapine was found to shorten sleep onset latency, improve total sleep time, sleep efficiency, and sleep quality and also suppressed REM sleep. Ziprasidone increased total sleep time, sleep efficiency, and sleep quality, and decreased number of awakenings but also decreased the percentage of REM and increased REM density and the percentage of slow-wave sleep. Several relatively small studies document the sleep effects of olanzapine. These were carried out in those with schizophrenia and those with mood disorders and indicate that this medication decreases sleep onset latency and wake time after sleep onset and increases sleep efficiency, sleep quality ratings and the amount and percentage of slow-wave sleep. Small studies also document that cloazapine decreases awakenings, and wake time after sleep onset and increases total sleep time and amount of slow-wave sleep and that risperidone 0.5–1 mg decreases wake time after sleep onset as well as the amount of REM sleep

Because so few data exist on the sleep effects of these agents that derive from placebo-controlled trials, it is helpful to consider the rates of reported daytime sedation adverse effects in placebo-controlled trials with these medications, though in some cases daytime sedation may not be accompanied by nighttime sleep enhancement due to slow absorption and in the case of agents with short half-lives, daytime somnolence rates will substantially underestimate their nighttime sleep enhancement. Based on these data the agents with the highest rates of sedation are clozapine, chlorpromazine, and thioridazine (33–60%), followed by risperidone and olanzapine (approximately 30%) and haloperidol (23%), whereas the agents with the least associated sedation are quetiapine and ziprasidone (16%) and aripiprazole (12%).

Antipsychotic medications, due to their dopamine antagonism may also cause or exacerebate PLMs and restless legs syndrome and, due to the potential for weight gain, these agents may increase the risks of developing sleep disordered breathing.

D. Alcoholism

Only one study has been carried out of the sleep effects of a treatment for alcoholism. This study evaluated acamprosate in 24 subjects prior to and 2 weeks after discontinuation of alcohol consumption and found that it decreased wake time after sleep onset and shortened REM latency.[189]

VI. THE IMPACT OF SLEEP DEPRIVATION ON PSYCHIATRIC DISORDERS

A notable and, perhaps surprising, aspect of the relationship of sleep and psychiatric disorders is that sleep deprivation can have a profound effect on individuals with mood disorders.

A. MDD

A night of sleep deprivation has been reported to have robust antidepressant effects. Studies evaluating this phenomenon suggest that at least 50% of those with MDD meet response criteria following a single night of sleep deprivation. However, the clinical utility of sleep deprivation as an antidepressant treatment is limited by the fact that the benefits generally disappear when the treated patient sleeps, even if the period of sleep is short. Attempts to prolong the benefits of sleep deprivation with medications and other interventions have met with limited success such that sleep deprivation is not implemented as a treatment for depression in clinical practice to any significant extent, however, it continues to attract attention as a window into the pathophysiology of MDD and the mechanisms of action of antidepressant treatments. There

is also a small literature related to attempts to treat MDD with chronic (3 week), in-laboratory, REM sleep deprivation which is based on the evidence that many effective antidepressant therapies suppress REM sleep. Unlike a night of total sleep deprivation, one study found that chronic REM deprivation leads to gradual and persistent improvement in depression,[196] though attempts to replicate this finding have not succeeded in doing so.

B. Bipolar Disorder

In contrast to MDD, sleep deprivation tends to exacerbate symptoms in those with bipolar disorder, predisposing individuals with this condition to develop of mania. A series of studies where patients with bipolar disorder underwent experimental sleep deprivation provide the basis for this conclusion. The mechanism by which sleep deprivation predisposes bipolar disorder patients remain unknown. Further, sleep deprivation has never been demonstrated to trigger or exacerbate mania in naturalistic studies in patients with bipolar disorder. However, it is generally assumed that this occurs, and, as a result, prudent clinical care should include taking steps to prevent sleep loss in those with bipolar disorder when depressed and/or euthymic and to increase sleep in bipolar patients when manic.

Go to:

VII. SUMMARY AND CONCLUSIONS

Psychiatric disorders and sleep are related in important ways. In contrast to the longstanding view of this relationship which viewed sleep problems as symptoms of psychiatric disorders,[91] there is growing experimental evidence that the relationship between psychiatric disorders and sleep is complex and includes bi-directional causation. Although much has been learned about the psychiatric disorders-sleep relationship, much remains unknown. For example, further studies are needed to determine if improvement of sleep improves MDD outcome and why some treatments for sleep problems appear to differentially affect the antidepressant response. In some cases, correlations have been identified between alterations in sleep and the course and/or outcome of psychiatric conditions and further work will be needed to determine if these are causal links.

From a clinical point of view, the available research on the psychiatric disorder-sleep relationship speaks to the need to direct treatment to sleep disorders and not simply treat what is assumed to be an underlying psychiatric condition. There is some reason to believe that this has the potential to improve the course and treatment response of some psychiatric conditions. This work also speaks to the need to be aware of the sleep effects of psychiatric interventions which may, in turn, affect the course and treatment response of the psychiatric condition being treated.

There are also research implications of the body of literature elucidating the psychiatric disorder-sleep relationship. This literature suggests that the boundaries between sleep disorders and some psychiatric disorders may be indistinct and in many cases the causal relationships between them are unclear. Nonetheless, the work in this field has increased over time and our understanding of these causal relationships have significantly evolved from the long-held symptom model of sleep disturbance.[91] Although much additional research is needed to address the limitations of the current body of literature and to help us better understand the relationships among psychiatric disorders and sleep, the advances made to date suggest that this work promises to improve our understanding of both sleep and psychiatric conditions and to provide better clinical care to patients with psychiatric disorders and with sleep disorders.

Key Points:

1. Psychiatric disorders can have a major impact on sleep
2. Sleep and sleep disorders can influence psychiatric conditions
3. Treatment of sleep disorders can improve psychiatric disorders
4. Sleep deprivation has a complex relationship with psychiatric disorders

Connecticut Department of Public Health

Healthy Connecticut 2020

1 State Health Assessment

CONNECTICUT DEPARTMENT OF PUBLIC HEALTH

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PHOTO CREDITS

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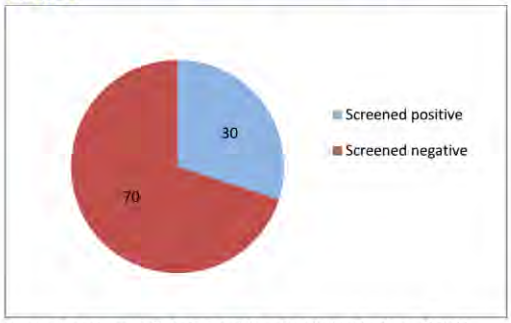
6
MENTAL HEALTH, ALCOHOL, AND SUBSTANCE ABUSE

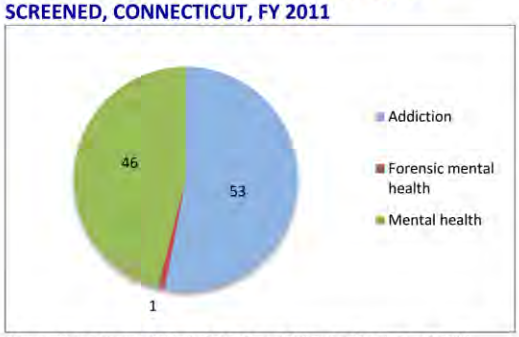
MENTAL HEALTH CARE

Fig. 239. PERCENT OF DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES (DMHAS) CLIENTS WHO SCREENED POSITIVE FOR TRAUMA OR SYMPTOMS OF TRAUMA, CONNECTICUT, FY 2011



Source: Department of Mental Health and Addiction Services. *DMHAS Clients Who Screen Positive for Trauma in SFY11.*

Fig. 240. PROGRAMS IN WHICH DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES (DMHAS) CLIENTS WHO SCREENED POSITIVE FOR TRAUMA OR SYMPTOMS OF TRAUMA WERE SCREENED, CONNECTICUT, FY 2011



Source: Department of Mental Health and Addiction Services. *DMHAS Clients Who Screen Positive for Trauma in SFY11.*

Why Mental Health Care is Important

Trauma exposure is an issue that is gaining public health attention and is increasingly prevalent.[353] Special populations affected by trauma include veterans and members of communities who have experienced large-scale psychological trauma from events such as natural disasters, or other stressors concentrated in their communities.[354] Understanding the influence of trauma on individuals and communities is critical for the provision of appropriate mental health and other social services.

Information about trauma exposures among veterans is located in the Health of High Risk Populations section of the report.

Findings in Connecticut

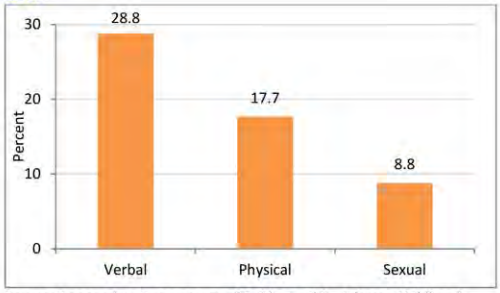
Trends

In FY 2011, there were 25,085 clients at the Department of Mental Health and Addiction Services who were screened for trauma or symptoms of trauma. Of these clients, 30% screened positive for trauma or symptoms of trauma.

In FY 2011, of the DMHAS clients who screened positive for trauma or symptoms of trauma, 53% were screened by addiction programs to which they were admitted, 46% were screened by mental health programs, and 1% were screened by forensic mental health programs.

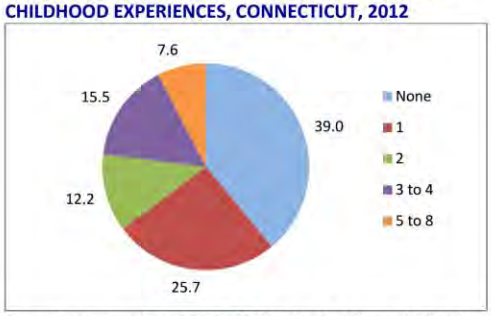
EXPOSURE TO TRAUMA

Fig. 254. PERCENT OF ADULTS WHO EXPERIENCED ABUSE DURING CHILDHOOD, BY TYPE, CONNECTICUT, 2012



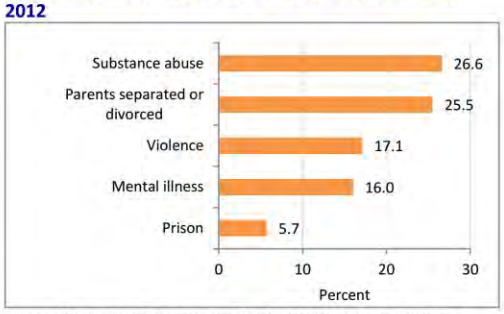
Source: Connecticut Department of Public Health, *Adverse Childhood Experiences in Connecticut,* 2013.

Fig. 255. PERCENT OF ADULTS WHO REPORT ADVERSE CHILDHOOD EXPERIENCES, BY NUMBER OF ADVERSE CHILDHOOD EXPERIENCES, CONNECTICUT, 2012



Source: Connecticut Department of Public Health, *Adverse Childhood Experiences in Connecticut,* 2013.

Fig. 256. PERCENT OF ADULTS WHO EXPERIENCED HOUSEHOLD DYSFUNCTION, BY TYPE, CONNECTICUT, 2012



Source: Connecticut Department of Public Health, *Adverse Childhood Experiences in Connecticut,* 2013.

Why Exposure to Trauma is Important

Exposure to trauma may affect mental health, physical health, and functioning in the family, at school, or among peers.[380,381,382] Traumatic events include experiences of sexual abuse, physical abuse, domestic violence, community and school violence, medical trauma, motor vehicle accidents, acts of terrorism, war, natural disasters, suicides, and other events.[383] Persons exposed to trauma may experience threat of injury, death, or personal integrity that causes feelings of fear, terror, or helplessness. Exposure to trauma varies by race and ethnicity, poverty status, and sex.[384] While those who may need treatment for trauma exposure may not receive adequate services due to limitations in accessing mental health services, family, cultural, and community strengths, as well as governmental supports, may help to promote recovery and resilience among those affected.[385]

Findings in Connecticut

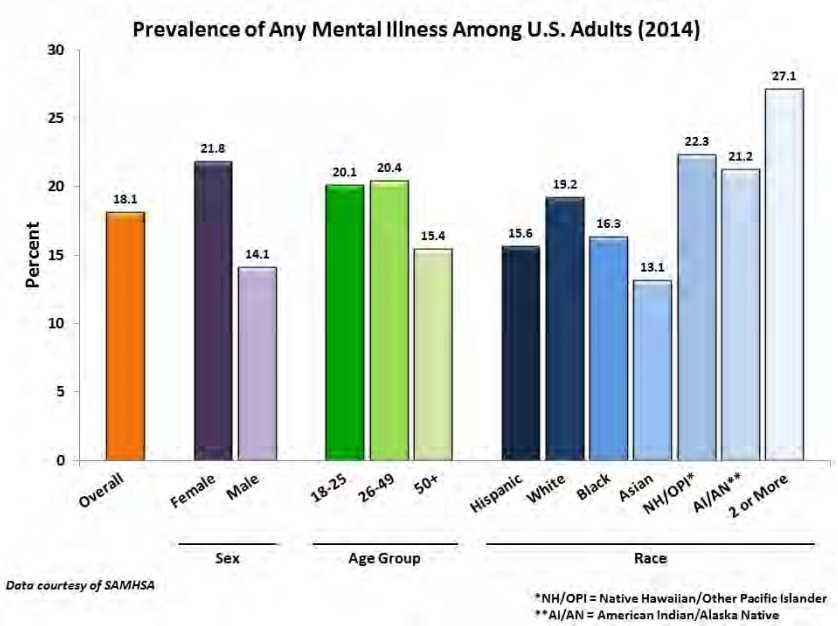
In 2012, 28.8% of Connecticut adults reported experiencing verbal abuse, 17.7% reported physical abuse, and 8.8% reported sexual abuse during childhood.

In 2012, 61.0% of adults reported experiencing at least one adverse childhood experience, affecting 1.6 million residents. Fully 7.6% of adults in Connecticut reported experiencing at least 5 adverse childhood experiences, affecting 200,000 residents in Connecticut.

More than one-quarter of adults in Connecticut grew up in a household where there was substance abuse (26.6%) or where their parents were separated or divorced (25.5%).

Any Mental Illness (AMI) Among U.S. Adults

- Mental illnesses are common in the United States.
- The data presented here are from the National Survey on Drug Use and Health (NSDUH), which defines any mental illness (AMI) as:
  - A mental, behavioral, or emotional disorder (excluding developmental and substance use disorders);
  - Diagnosable currently or within the past year; and,
  - Of sufficient duration to meet diagnostic criteria specified within the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV).
- AMI can range in impact from no or mild impairment to significantly disabling impairment, such as in individuals with serious mental illness (SMI), defined as individuals with a mental disorder with serious functional impairment which substantially interferes with or limits one or more major life activities.
- As noted, these estimates of AMI do not include substance use disorders, such as drug- or alcohol-related disorders. For statistics and other information about drug- and alcohol-related disorders, please visit the statistics pages of the National Institute on Drug Abuse (NIDA), the National Institute on Alcohol Abuse and Alcoholism (NIAAA), and the Substance Abuse and Mental Health Services Administration (SAMHSA).
- In 2014, there were an estimated 43.6 million adults aged 18 or older in the United States with AMI in the past year. This number represented 18.1% of all U.S. adults.



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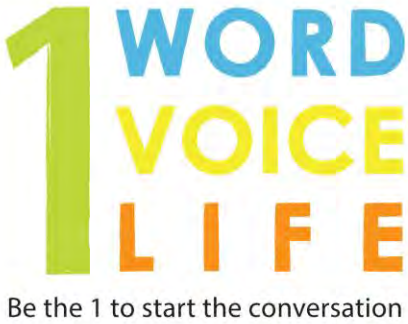
STATE OF CONNECTICUT SUICIDE PREVENTION PLAN 2020



STATE OF CONNECTICUT
SUICIDE PREVENTION PLAN
2020

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Lastly, the PLAN 2020 makes use of the best available data on suicide deaths and suicidal behaviors in the state of Connecticut, to determine a baseline from which we developed measurable and achievable goals for the reduction of suicidal behaviors and the reversal of disturbing trends in Connecticut. These will serve as benchmarks moving forward and will help to direct suicide prevention activities. Annual updates to the plan will allow us to monitor and disseminate our progress toward meeting these benchmarks.

The overarching goal of any suicide prevention plan is the elimination and reduction of suicide and suicide related behaviors. The PLAN 2020 includes specific **targeted outcomes for 2020**.

The Scope of the Problem

Throughout the world, the suicide rate has been climbing. The World Health Organization reports that each year nearly one million people die by suicide, resulting in a mortality rate of 16 per 100,000, or a staggering death every 40 seconds.[iv] This represents an increase over the past 45 years of 60%, and it is estimated that by the year 2020, suicide will account for 2.4% of the global disease burden. At the same time, it should be noted that, given the impact of stigma, obtaining accurate suicide data is a challenge, resulting in false negatives by underreporting and differences in the mechanisms for investigating and reporting these deaths.[v]

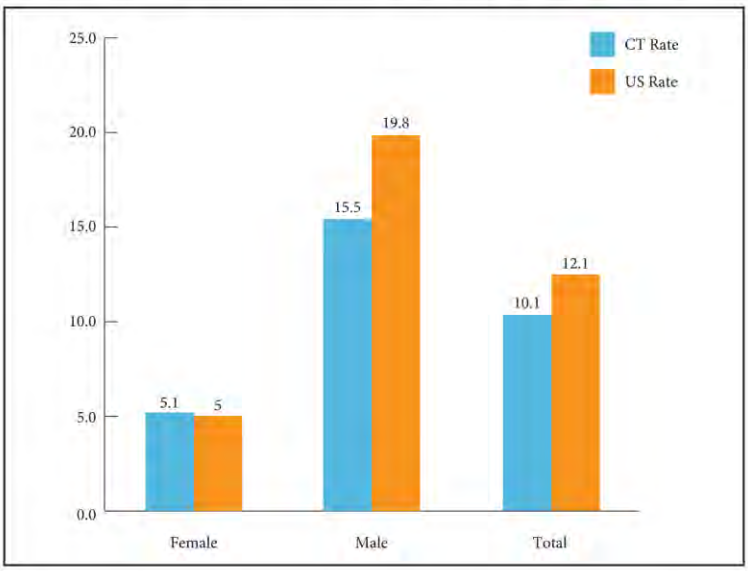
In the United States, suicide and suicidal behaviors have been identified as major public health problems that have far-reaching personal, social and economic implications. In 2012, the latest year for which national data are available, there were 40,600 deaths by suicide. In contrast, during the same year, there were 14,827 homicides (U.S. Department of Justice, 2013)[vi] and 33,561 motor vehicle fatalities (NHTSA, 2013).[vii] Suicide is the tenth leading cause of death and epidemiologists have shown that unlike other causes of death, suicide death rates have been steadily increasing by more than 2% a year (CDC, 2013)[viii].

In 2011, nearly half a million people presented to hospital emergency departments for self-inflicted injuries. Of these, 224,000 sustained injuries significant enough to require hospitalization.[ix] It is estimated that for every person who dies by suicide, 30 others make an attempt. Furthermore, a prior attempt is one of the strongest risk factors for suicide. The human toll is significant; conservative estimates are that for every death by suicide, there are at least six survivors.[x] Nearly five million Americans became survivors of suicide in the past 10 years, placing some at elevated risk for suicide themselves. In 2010 alone, the number of suicide survivors grew by 230,184 people. In addition to the human toll, it is estimated that 41.2 billion dollars were lost in combined medical and work costs in 2011, due to suicide and related suicidal behaviors.[xi]

There exist significant state and regional differences in suicide death rates, ranging from a rate of 23.2 per 100,000 in Wyoming to 6.8 in the District of Columbia. The Mountain states have the highest rate (18.3) and the Middle Atlantic the lowest at 9.4.[xii] United States and Connecticut comparison total and gender data are presented below (Figure 1.). While Connecticut's total and male rates are substantially lower than the U.S. figures, the suicide rate for females is equivalent.

Figure 1.

Suicide Rates (per 100,000) Connecticut (2012) and U.S. (2010) Total and Gender



Source: State of Connecticut, Department of Public Health. Annual State Population with Demographics. Retrieved from http://www.ct.gov/dph/cwp/view.asp?a=3132&q=388152; Accessed 2/2/14.
Office of Connecticut Medical Examiner Deaths by Suicide 2006–2012 Retrieved 5/29/13.

Healthy People 2020. US rates based on 2010 data. http://www.healthypeople.gov/2020/Data/SearchResult.aspx?topicid=28&topic=Mental+Health+and+Mental+Disorders&objective=MHMD-1&anchor=124

There are significant age, gender, racial and ethnic group differences in suicide deaths and behaviors. Furthermore, relative risk among age and cohort groups can shift, making timely reporting and analysis critical to understanding current and emerging needs. For example, whereas in the United States in 2010, suicide was the second leading cause of death[xiii] among 25–34 year olds and the third leading cause of death among those aged 15–24, the recent increase in suicides among 45–54 year olds actually represents the highest actual rate of suicide of any age cohort. According to the Centers for Disease Control and Prevention, the annual age-adjusted suicide rate in the 35–64 year old group increased 28.4%, from 13.7 per 100,000 population in 1999 to 17.6 in 2010. The suicide rate for adults over the age of 65 was 14.9 per 100,000 in 2010.[xiv] Gender differences are fairly consistent, with males representing 80% of all suicide deaths, while females have suicidal thoughts and non-fatal attempts at rates consistently higher.[xv] Among racial and ethnic groups, suicide rates are highest for non-Hispanic Whites (14.1%) followed by those for Am erican Indians and Alaskan Natives (11.0%). Rates are much lower for Asian and Pacific Islanders (6.2%), Hispanics (5.9%), and Blacks (5.1%).[xvi]

Those with existing mental health conditions, including substance abuse, are at increased risk for suicidal thoughts, attempts and deaths; it is estimated that 90% of those who die by suicide have at least one diagnosable mental health condition, most commonly a mood disorder.[xvii] Those with anxiety disorders,

borderline personality disorder and schizophrenia are also at elevated risk. Finally, those with a history of prior suicide attempts remain at the highest risk of dying by suicide.[xviii] This has important implications for the need for a broad view of prevention and treatment. The PLAN 2020 addresses the issues of suicidal thoughts and non-fatal attempts as well as suicide fatalities.

Suicide and Suicidal Behaviors in Connecticut

In Connecticut where the rate of suicide is comparatively low at 45th in the nation in 2010[xix], there are significant trends and concerns that inform our efforts at the state level. The Office of the Connecticut Chief Medical Examiner (OCME) reported 364 suicide deaths in 2012; 367 in 2011; 342 in 2010; 308 in 2009; 296 in 2008; 250 in 2007; and 257 in 2006. Suicide statistics are typically reported as a suicide rate per 100,000. The suicide rate has pushed upward in the state since 2007, and as with the national rate, as of 2012[xx], men have a significantly higher rate (15.49) than women (5.05).[xxi] To put Connecticut deaths by suicide in context, when in 2012, 373 people died in Connecticut by suicide, 151 died by homicide.[xxii]

In addition, people who make non-fatal suicide attempts often require hospitalization. Data show the overall rate of hospitalization from self-injury in 2012 was 78 per 100,000.[xxiii] The highest rates of hospitalization for self-injury were observed among youth aged 20–24 and 15–19, with rates declining by age. Among major racial and ethnic groups, Whites were at highest risk of hospitalization (81/100,000). Consistent with self-report data on suicide attempts, women were at higher risk than men. Among counties, the highest rates of hospitalization were observed among New Haven, Middlesex and New London counties. Most common means of self-injury were poisoning by solid or liquid substances, including narcotics (74%), and cutting or piercing (17%). Outcomes of medically serious self-injury: roughly a third of patients were discharged to a psychiatric facility following hospital discharge, 1% died from their injuries in the hospital, and the average length of stay was nearly five days. This length of stay, similar to stays for other significant medical conditions, underscores the need for intensive treatment.

Data sources in addition to the OCME include the Connecticut School Health Survey/Youth Risk Behavior Survey (YRBS) and the 2012 CT Hospital Inpatient Discharge Database (HIDD). The 2009 and 2011 YRSB, a national school-based survey, provided information about percentages of high school students who felt sad or hopeless, considered attempting suicide, actually attempted suicide and who made an attempt that resulted in need for medical intervention. Results for Connecticut indicate differential risk by gender, as expected, and by race and ethnicity. This data has important implications for suicide prevention in a number of settings. The HIDD hospital data[1] provides information about numbers of hospitalizations for self-injury by gender, age, race/ethnicity and county. These data sources taken together provide baseline data that identifies high-risk groups and trends, providing the basis for determining targets for reduction in suicide and suicide related behaviors in Connecticut.

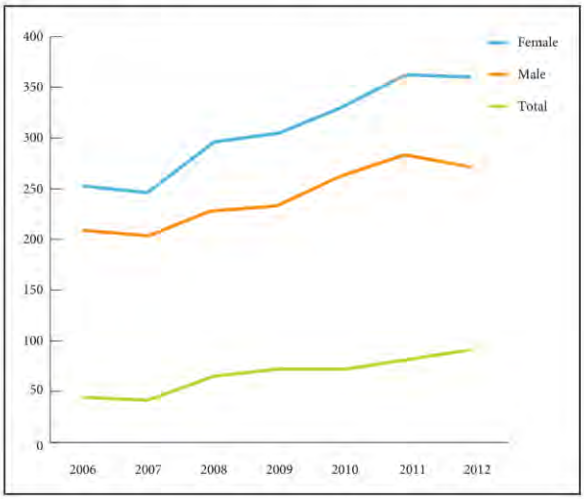
Connecticut Suicide Facts at a Glance

A brief snapshot indicates that certain demographic groups have higher rates of suicide than others; for example, Whites and men, especially ages 35 to 54. There are also regional differences by county. Suicide deaths vary by method of suicide. In 2012, 36.5% of people died by hanging/strangulation, followed by 29.4% by gunshot and 13.7% by substance overdose. The remaining 20.5% involved eight other methods. Method of death also varies by gender and age[xxiv] (Figures 2 and 3).

[1] See Appendix I

Figure 2.

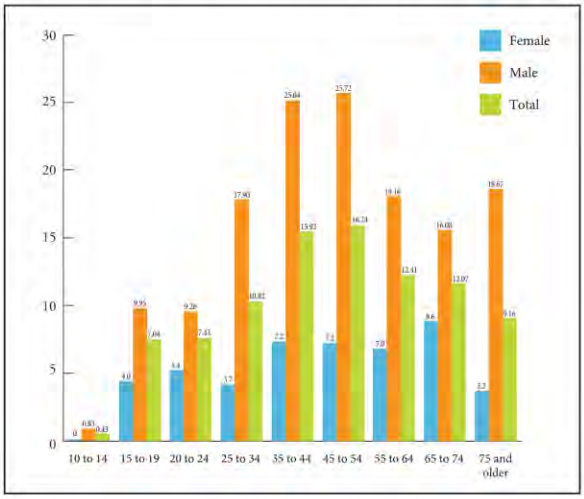
Number of Suicides in Connecticut Total and by Gender 2006–2012



Office of the Medical Examiner Deaths by Suicide 2006–2012
Retrieved 5/29/13. http://www.ct.gov/ocme/lib/ocme/documents/other/07-2011_bereavement_brochure.pdf

Figure 3.

Suicide Rate in Connecticut by Age and Gender 2012



Source: State of Connecticut, Department of Public Health. Annual State Population with Demographics. Retrieved from http://www.ct.gov/dph/cwp/view.asp?a=3132&q=388152; Accessed 7/6/13 and 2/2/14. Office of Connecticut Medical Examiner Deaths by Suicide 2006–2012 Retrieved 5/29/13.[2]

[2] Table with numerical values for age and gender deaths from 2006–2012 appears in the Appendix

Differences by County

There are regional differences in suicide rates in Connecticut by county, ranging from a low of 7.4 in Fairfield County to 15.7 in Middlesex County. This differential is not yet well understood and requires further investigation. (See Table 1.)

Table 1.

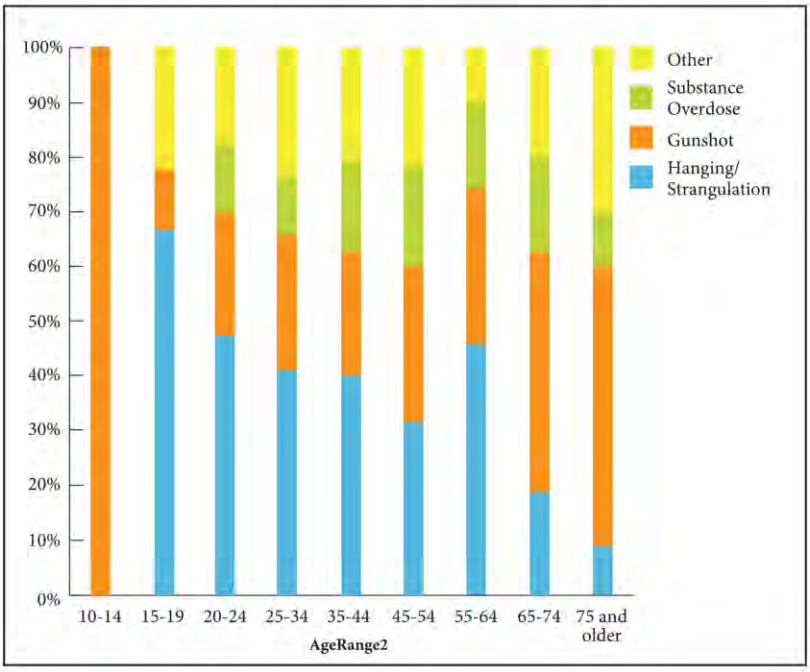
Number and Rate of Suicide by Connecticut County of Residence 2012

County	n	Population	Rate/100,000
Middlesex	26	165,602	15.7
Litchfield	27	187,530	14.4
Windham	14	117,599	11.9
Tolland	17	151,539	11.2
Hartford	99	897,259	11.0
New London	30	274,170	10.9
New Haven	69	862,813	8.0
Fairfield	69	933,835	7.4
Total	351	3,590,347	9.8

Source: State of Connecticut, Department of Public Health. Annual State Population with Demographics. Retrieved from http://www.ct.gov/dph/cwp/view.asp?a=3132&q=388152; Accessed 7/6/13 and 2/2/14.
Office of Connecticut Medical Examiner Deaths by Suicide 2006–2012 Retrieved 5/29/13.

Figure 6.

Primary Methods of Suicide in Connecticut by Age in 2012



Source: Office of Connecticut Medical Examiner Deaths by Suicide 2006–2012 Retrieved 5/29/13.

State of Connecticut Suicide Prevention Goals and Objectives

The State of Connecticut suicide prevention goals, themselves, are derived, in part, from the National Suicide Prevention Strategy 2012 (NSPS), a report of the U.S. Surgeon General, and the National Action Alliance for Suicide Prevention, a public-private partnership. This group developed 13 NSPS goals and 63 objectives, derived from and spanning four strategic directions: 1) Healthy Individuals, Families and Communities; 2) Clinical and Community Prevention; 3) Treatment and Support Services; and 4) Surveillance Research and Evaluation Goals.[xxv] The CTSAB endorses each of these NSPS goals, objectives and directions and through a comprehensive, multi-staged process identified five priority goals and related objectives that reflect the priorities for Connecticut suicide prevention efforts. This process included: 1) an online member survey of priorities and current activities and needs; 2) review of all available state level suicide and suicide related data; 3) consensus building discussions at monthly board meetings; 4) triangulation of diverse opinions through small group discussion; 5) consideration of existing initiatives and gaps, and identification of resource capability. In addition, goals were considered in the context of shifting trends and data provided by our consultants. These processes led us to a general consensus about five priority goals.

These goals were presented at the CTSAB 2014 Annual Meeting at which members were asked to generate examples of possible strategies for each of the objectives of the five goals. These collectively derived goals, objectives and examples of possible strategies form the core of the PLAN 2020. Some of the strategies have been enacted, while others emerged from discussions of gaps in suicide prevention activities and knowledge of national best practices. Consumers of the plan are encouraged to use the goals, objectives and strategies as guides to carrying out their respective suicide prevention activities in their own agencies and communities. In addition, we have identified some of these goals, objectives and strategies for monitoring that will serve as the basis for annual review of data and reorganization of priority planning and programming. We have also, in recognition that "one size does not fit all" in suicide prevention, identified, on the basis of Connecticut and national data and the opinions of suicide prevention experts throughout the state, thirteen priority populations at elevated risk for suicide and related behaviors. For each of these populations we highlight current concerns and areas for future attention.

Finally, this report includes targets for improvement in rates of suicidal behaviors, based upon our current data. This will allow for a central component of the plan, the systematic annual review and an updated report of PLAN 2020.

- Assessing and Managing Suicidal Risk (AMSR)
- Assessing Suicidal and Self-Injurious Youth (ASSIY)
- TIP 50: Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment
- Connect Prevention and Training of Trainers
- Connect Postvention and Training of Trainers
- Mental Health First Aid; Recognizing and Responding to Suicide Risk—
- Primary Care Fresh Check
- SafeTalk
- Survivor Voices Training and Training of Trainers
- Signs of Suicide (SOS)
- Depression Outreach Alliance
- CampusConnect
- Student Support Network; and Active Minds.[6]

General Recommendations: The evaluation of existing and emerging suicide prevention programming is essential to ensuring the provision of *effective* suicide prevention activities. Therefore, we recommend continuing cross-agency collaboration and coordination with planned evaluation activities.

Examples of Possible Strategies:

a. Continue to meet within agencies and the CTSAB to identify gaps in programming and to identify resources and strengthen coordination.

b. Evaluate media campaigns including CTSAB website, social media and mass media placement.

c. Utilize the CT Healthy Campus Initiative to disseminate information and train college staff to implement evidence-based practices on campuses throughout the state.

d. CTSAB to make available through their website links to best practices resources through national organizations such as Suicide Prevention Resource Center (SPRC).

e. Develop and enact legislation requiring suicide prevention training and continuing education for the health, mental health and educational professionals.

Objective 2.2: Encourage community-based settings to implement effective programs and provide education that promote wellness and prevent suicide and related behaviors.

Current Status: The link between mental health and substance use conditions, and suicide and suicide related behaviors is well established. While a small minority of people with mental illness will die by suicide, a large proportion (90%) of those who do die by suicide have struggled with mental health conditions. Community agencies who serve those with mental illness are well positioned to work with those at risk. In addition, other settings whose primary mission and focus are not specifically mental health/illness, such as schools, universities and youth clubs, are well positioned to deliver programs that promote wellness.

General Recommendations: Broaden the scope of suicide prevention to include the promotion of wellness and identify those community organizations and agencies that might be well positioned to

[6] See Appendix J for Trainings by Source and Number Served

develop programs with a focus on wellness, the promotion of protective factors and the reduction of risk factors.

Examples of Possible Strategies:

a. Utilize current infrastructures to enhance/implement suicide prevention/intervention programs.

b. Promote "Connect Prevention" to communities so they can develop unified language to address suicide prevention.

c. Promote "Connect Prevention" to communities so they can develop unified language to address suicide prevention.

d. Use existing campus-community coalitions to provide resources and education to promote wellness and prevent suicide.

e. Provide training and materials to local community agencies.

f. Provide training of trainers for evidence-based programs.

g. Produce suicide prevention curricula for schools.

h. Identify youth leaders and train them as QPR Gatekeepers to bring safe messaging training back to their own communities and priority populations.

i. Educate each of DCF's 25 community collaborations and make recommendations about promoting the implementation of effective suicide prevention and promotion of wellness and recovery.

j. Develop and implement best practices yoga and wellness programs for youth at risk for anxiety and depression.

k. Present healthy lifestyles to promote wellness through media campaigns, workshops for groups at elevated risk for suicidal thoughts and behaviors and mental health conditions.

l. Conduct systematic outreach to key stakeholders to offer training opportunities.

m. Offer professional development on suicide prevention and risk through the CT Department of Education and track the numbers trained per district.

Objective 2.3: Intervene to reduce suicidal thoughts and behaviors in populations at risk.

Current Status: Public and private agencies throughout Connecticut continue to work with people at heightened risk for suicide and suicide related behaviors. Certain demographic groups, however, are at increased risk and may not be sufficiently identified.

General Recommendations: Use emerging data to identify those populations, cohorts and settings that have high and/or increasing vulnerability for suicide and suicide related behaviors. Utilize best practices, specific to a particular cohort, to reduce suicidality in populations.

Examples of Possible Strategies:

a. Use recent Connecticut data about suicide related behaviors to identify trends and groups at elevated risk.

b. Develop programs aimed to ameliorate risk factors in high risk groups.

c. Continue to assess high risk populations in different settings and demographic groups, particularly those populations that may be marginalized or overlooked. For example, the homeless,

p. Use state level data and national research findings to guide targeted areas and resources and gaps in resources.

q. Add suicide prevention questions to the CT Health Survey.

r. Use state level data and the National Action Alliance for Suicide Prevention's *A Prioritized Research Agenda for Suicide Prevention: An Action Plan to Save Lives* to identify the most immediate needs for suicide prevention research in the state of Connecticut.

Introduction to the Groups at Elevated Risk

The 2012 National Strategy for Suicide Prevention identified on the basis of multiple sources of data, groups with particularly increased risk for suicide and suicide related behaviors. These include: American Indians/ Alaska Natives; individuals bereaved by suicide; individuals in justice and child welfare settings; those who engage in nonsuicidal self-injury; those who have attempted suicide; individuals with chronic medical conditions; those with mental health and substance use conditions; lesbian, gay, bisexual and transgender populations (GLBT); military members and veterans; men in midlife and older men.[xxvii] These priorities are based upon national data and trends and do not necessarily reflect regional differences in populations at risk.

Here in Connecticut, several sources inform our selection of populations for inclusion in this version of PLAN- 2020. First, data collected through the Office of the Medical Examiner, the CT Hospital Database, National Vital Statistics Reports, the CDC Morbidity and Mortality Weekly Report, the CDC Youth Online High School Youth Risk Behavior Surveillance Survey among others have been reviewed and inform our recommendations. Here, we report on groups in three domains: by lifespan; by race and ethnicity; and by special population, which is defined as a group holding a certain status/identification, area of challenge or setting. In addition to using data to determine which groups to highlight at this point in time, we relied on a broad group of Connecticut experts in suicide prevention who have expertise in working with members of at-risk groups. Some of these experts are professional providers; others may be suicide survivors; several identify as both. This process has insured both data-driven and expert-driven approaches, from those who have knowledge of the lived experience of suicide and its impact on individuals, families and communities. As with previous sections of the PLAN 2020, users are encouraged to consider this content as a starting point for developing and implementing their own suicide prevention activities, with particular attention to where those efforts can become embedded in their agency's broader visions.

Lifespan:

Suicide occurs with different rates and methods across age groups and these trends change over time. Age groups also share common risk factors and have ones that are specific to each. Finally, while many of our prevention strategies are common to all age groups, some we present here are specific, based upon factors such as prevalence, choice of method and risk factors.

Youth Suicide

Youth suicide is a particularly devastating problem from several different vantage points. The CDC (2012)[xxviii] reports that among those 10 to 24 years of age, suicide is the third leading cause of death, resulting in approximately 4,600 deaths each year. Nationally, the young are most likely to die by firearm (45%), by suffocation (40%) and by poisoning (8%). (Please note: different reporting agencies consider youth to age 19, breaking out 20–24 and 25–29 as young adult; nonetheless, the statistics are troubling.)

Actual deaths by suicide in this age group are not the only concern. Results from the 2011 National Youth Risk Behavior Survey (YRBS) suggest that of US high school students, 16% in a given year reported seriously

Young Adult/College Aged

Accurate data for suicide deaths in young adults is difficult to obtain because of the different age groupings used by reporting agencies. For example, the 2010 U.S. Official Final Report aggregates data for the 15 to 24 year old group, obscuring any differences between adolescents and young adults in morbidity and related factors. In Connecticut the OCME does report data for the 15 to 19 year olds and for the 20 to 24 year olds.

Table 4.

Connecticut Suicide Frequency and Rate by Age and Gender, Late Adolescent and Young Adult 2012

Age Range	Female Number	Female Rate	Male Number	Male Rate	Total Number	Total Rate
15 to 19	5	4.0	13	9.95	18	7.04
20 to 24	6	5.4	11	9.26	17	7.43

Source: State of Connecticut, Department of Public Health. Annual State Population with Demographics. Retrieved from http://www.ct.gov/dph/cwp/view.asp?a=3132&q=388152; Accessed 7/6/13 and 2/2/14.
Office of Connecticut Medical Examiner Deaths by Suicide 2006–2012 Retrieved 5/29/13.

College student data is derived from the American College Health Association/National College Health Assessment (ACHNA/NCHA) Undergraduate Survey (2012). Students reported the following occurrences within the prior 12 months: 44.6% had feelings of hopelessness; 85.2% felt overwhelmed; 56.6% felt very lonely; 59.5% felt very sad; 29.5% felt so depressed it was difficult to function; 49.9% felt overwhelming anxiety; 6.9% seriously considered suicide; 5.5% intentionally cut, burned, bruised or injured themselves; and 1.2% attempted suicide.[xxxi] Additionally, students reported significant difficulty handling academics, finances, intimate relationships and family problems. Furthermore, young adults have the highest rate of treatment for intentional self-injury of all groups. College students with particular needs include those with mental health problems, prior suicide attempts and bereavement by suicide, veterans and active duty students, Hispanic/Latino students and LGBT students.

Programs such as CT Healthy Campuses Initiative, JED Foundation, QPR (Question, Persuade, Refer), Jordan Matthew Porco Healthy Check and the Garrett Lee Smith Grants make it possible to develop programs and provide services for those young adults who are in the educational systems across the state. Young adults who are veterans or active duty military may be identified through DMHAS Military Support Program and Veterans Administration programs. It may be more challenging to reach those young adults who are neither college nor military connected and may have increased rates of unemployment and other challenging life conditions. Pilot data (2002) from the National Violent Death Reporting System found that most 18 to 24 year olds who died by suicide were not students and were as likely to be high school drop-outs or in trouble with the law as to be college students.[xxxii]

Suicide prevention efforts for this population can include, in addition to more universal efforts, the following:

- Involve family members and natural supports in the work with at-risk young adults in ways that are developmentally appropriate.
- Make greater use of social media technology for suicide awareness and referral.
- Encourage young adult participation on the CTSAB.

- Identify particular needs of those youth who are "aging out" of DCF state custody.
- Utilization of the seven strategies referenced in the Jed Foundation Suicide Model for Comprehensive Mental Health Promotion and Suicide Prevention for Colleges and Universities.
- Provide QPR Training (Question, Persuade, Refer) for those working with this age group.
- Encourage the development of peer-run groups on campus, such as Active Minds.
- Develop e-blasts of resources available in CT that address the continuum of services and programs available for young adults to campus leaders.

Middle-Aged Persons

National suicide rates for middle-aged men have increased disproportionately since the 1990s and this is currently the highest risk age/gender group. According to the 2012 National Strategy, men in this cohort share universal risk factors, but may have additive risk related to the under-reporting of mental health problems, avoidance of help-seeking, involvement in interpersonal violence, economic hardship related to the recent recession and attendant longer term unemployment, and disruption of intimate relationships.[xxxiii] At the same time, rates for middle-aged women have not shown the same consistent pattern.

Table 5.

Connecticut Suicide Frequency and Rate by Age and Gender for Middle Aged Adults 2012

Age Range	Female Number	Female Rate	Male Number	Male Rate	Total Number	Total Rate
35 to 44	17	7.2	56	25.04	73	15.92
45 to 54	21	7.2	71	25.72	92	16.24
55 to 64	17	7.0	41	18.16	58	12.41

Source: State of Connecticut, Department of Public Health. Annual State Population with Demographics. Retrieved from http://www.ct.gov/dph/cwp/view.asp?a=3132&q=388152; Accessed 7/6/13 and 2/2/14.
Office of Connecticut Medical Examiner Deaths by Suicide 2006–2012 Retrieved 5/29/13.

Table 6.

Connecticut Suicide Frequency of Middle-Aged Persons
by Gender, 2006–2012

	Ages 30-39		Ages 40-49		Ages 50-59	
	F	M	F	M	F	M
2006	6	45	15	43	17	48
2007	5	28	14	54	12	40
2008	10	36	17	58	21	50
2009	9	47	0	49	24	58
2010	10	34	23	71	16	63
2011	13	37	21	71	19	68
2012	12	44	19	75	22	54

Source: http://www.ct.gov/ocme/cwp/view.asp?a=2165&q=295126
Retrieved 5/22/2014.

Suicide prevention efforts can focus on the following areas:

- Consider public health campaigns targeted to reduce stigma associated with male help-seeking for mental health and substance abuse issues.
- Increase referral and service availability in employer settings.
- Increase training of primary care physicians.
- Develop creative strategies for engaging middle-aged men in treatment.
- Train and counsel professionals, family members and communities for lethal means restriction.
- Greater consideration of the role of job and financial strain as risk factors for suicide, consistent with emerging research.

Older Adults

While all age groups share some risk factors for suicide, older adults have several additional or exacerbating factors including: comorbid general medical conditions that significantly limit functioning or life expectancy, and pain and declining role function; for example, loss of independence or sense of purpose; social isolation, inflexible personality or marked difficulty adapting to change; medication abuse or misuse; and impulsivity in the context of cognitive impairment.[xxxiv] Furthermore, their social isolation may make them less likely to be rescued and their most frequent choice of method, firearm (67%), is more apt to result in a fatality. For every completed suicide among older adults, an estimated two to four attempts occur, while in younger adults the ratio of completed suicide to attempts may be as high as 200 to 1.[xxxv] Research has shown that 58% of older adults who die by suicide have seen a primary care provider within the last month of their life.[xxxvi] Specialized training for geriatricians and primary care physicians is essential.

- Strengthen alliances with local schools regarding stigma and suicide prevention.

Military/Veterans

Suicide rates for members of the military and veterans, historically lower than that of the general population, have been increasing significantly, nearly doubling from 2001 to 2009. As of 2010, the Army National Guard had the largest increase in total suicides, more than doubling the 2009 rate. The CDC now reports that veterans account for 20% of the suicides in the U.S. and are overrepresented in those recently returning from Iraq and Afghanistan and for those who receive Veterans Administration (VA) services.[lxv] In a study of veteran deaths between 2003 and 2008, 69% were caused by firearm, nearly always a fatal method.[lxvi] Half of all people who die by suicide in the Veterans Health Administration have a known mental health condition.

The Department of Defense (DOD) follows active duty/National Guard/Reserves while the VA follows those who have separated from the military. In 2007, the VA initiated an integrated approach to suicide prevention. The DOD developed the Defense Suicide Prevention Office in 2011 to oversee all development and implementation of suicide prevention strategies throughout the military.

The following are risk factors in military personnel, some of which overlap with those for the general population: presence of mental illness, particularly comorbidity; psychological factors such as emotional reactivity; neurocognitive factors such as executive functioning problems such as problem-solving; family history of mental disorders; and childhood adversities.[lxvii] The literature has increasingly focused on the role of deployment and combat exposure on suicide risk, about which there have been some conflicting findings. Future research needs to focus on the circumstances under which deployment raises suicide risk in military personnel and the complex relationships between mental health issues, suicidality and deployment.

Risk factors that may be exacerbated in military personnel include the following:

- The traumatic nature of combat exposure, specifically related to threats of improvised e xplosive devices.
- Prolonged and repeated deployments and uncertainties about tour extensions.
- New life-saving interventions that promote survival but leave individuals with high distress related to serious health issues and disfigurements.
- Effects of traumatic brain injury.

Specific protective factors may include:

- Social support and cohesion within one's unit.
- Positive contact with family and frequency of contact with spouse.
- Buffering effects of positivity.
- Post-traumatic growth in the aftermath of traumatic events.
- Available, quality, non-stigmatizing mental health treatment.

In addition to general suicide prevention strategies, the following may be useful:

- Collaboration between National Guard/Active Duty and VA services to ensure smooth transitions in care.
- Work to engage with families of active duty/veterans in order to educate about risk factors,

Correctional Managed Health Care policy details procedures for prevention and intervention.

In addition to the general suicide prevention strategies, the following can be recommended:

- Continued specific training for all corrections personnel.
- Strong mental health assessment and ongoing screening for suicidality.
- The availability and resourcing of high quality mental health and substance abuse services.
- "Suicide watch" protocols for those assessed at increased risk for suicide.
- A focus on the continuum from pre-adjudication to incarceration to probation and parole.

Mental Health/Substance Abuse

Between 90% and 98% of people who die by suicide have a diagnosable mental health condition.[lxxvii] The existence of a psychiatric condition is second only to a prior suicide attempt as a major risk factor for dying by suicide. Comorbidity increases suicide risk. The most common mental health conditions associated with increased risk of suicide are depression and bipolar illness, followed by substance use, borderline personality and eating disorders. Those with schizophrenia have an attempt rate of 20 to 40% and 5% die by suicide.[lxxviii] There is a strong association between suicide fatality and post-traumatic stress disorder. It is important to note, however, that despite these risks, of those with a mental health diagnosis, 90% *do not* die by suicide.[lxxix] It then becomes important to identify which people are at the highest risk of suicidal thoughts and behaviors, while providing high quality and prompt treatment for the mental health condition that places them at elevated risk.

Given the strong association between mental health conditions and suicidal thoughts and behaviors, recommendations for suicide prevention mirror those for good mental health and substance abuse treatment:

- High quality and highly accessible mental health and substance abuse treatment.
- Focus on a recovery model that values the individual and optimizes symptom reduction and promotes optimal functioning.
- Ongoing training for mental health professionals and paraprofessionals in all settings.
- Increase in availability of Mental Health First Aid and Youth Mental Health First Aid Training.
- Development of culturally competent services.
- Increase linkages with faith-based organizations.
- Provide wrap-around services that address substance abuse problems.
- Consider alcohol and drugs to be lethal means for some addicted persons and others.
- Follow regional trends in "drugs of choice," such as heroin, that may be implicated in intentional overdoses, and develop targeted strategies for prevention.

People with Chronic Health Conditions and Disabilities

Living with chronic or terminal physical conditions can place significant stress on individuals and families. As with all challenges, individual responses will vary. Cancer, degenerative diseases of the nervous system,

traumatic injuries of the central nervous system, epilepsy, HIV/AIDS, chronic kidney disease, arthritis and asthma are known to elevate the risk of mental illness, particularly depression and anxiety disorders.[lxxx] In these situations, integrated medical and behavioral approaches are critical for regularly assessing for suicidality.

Disability-specific risk factors include: a new disability or change in existing disability; difficulties navigating social and financial services; stress of chronic stigma and discrimination; loss or threat of loss of independent living; and institutionalization or hospitalization.[lxxxi]

Until recently, the CTSAB was considering assisted suicide of the terminally ill as a separate issue from suicide prevention. The active disability community in Connecticut, however, has been vocal on the need for suicide prevention services for people with disabilities. There may be unintended consequences of assisted suicide legislation on people with disabilities. Peace (2012) writes that "Many assume that disability is a fate worse than death. So we admire people with a disability who want to die, and we shake our collective heads in confusion when they want to live."[lxxxii] People with disabilities have a right to responsive suicide prevention services. The CTSAB intends to continue to explore the needs of the disability community for such services.

Targeted Recommendations:

- Develop greater scrutiny of someone's intentions to die.
- Identify and train practitioners to develop expertise in the work with disabled people who are suicidal.
- Do not "assume" suicide is a "rational" response to disability.
- Treat mental health conditions as aggressively as with a person without disability.
- CTSAB should encourage and increase participation from the disability community and encourage educational presentations.

Charting the Future: Measuring Our Progress

The overarching goal of any suicide prevention plan is the elimination and reduction of suicide and suicide related behaviors. The PLAN 2020 includes targeted outcomes for 2020. All targets are derived from the analysis of current data. We are tracking one measure of suicide (deaths) and one measure of medically serious attempts (as measured by hospitalization for self-injury). Both measures can be tracked consistently and reliably annually and by demographic group. We have adopted a target of a 10% reduction by 2020, which is in alignment with the mental health goals of Healthy People 2020. Thus, the 2020 targets for the reduction of deaths by suicide is a reduction from the 2012 rate of 10.14 to a 2020 rate of 9.13. We have determined a target of a 10% reduction of hospitalizations for self-injury from 2014 to 2020.[10]

Summary and Conclusions

The impact of suicide and suicidal behaviors have far-reaching implications for individuals, their families, friends and communities. In 2012, more than an average of one person per day died by suicide in Connecticut and thousands more were left to mourn and carry on in the face of devastating loss. As staggering as these losses are, there is hope. Globally, the World Health Organization and in the U.S., the National Action Alliance for Suicide Prevention have pioneered comprehensive suicide prevention strategies

[10] See Appendix I for tables of current hospitalization data

APPENDIX E

Additional Gender and Age Data

Table 8.

Number of Suicides in Connecticut Total and by Gender 2006–2012

Year	Female	Male	Total
2006	45	212	257
2007	43	207	250
2008	66	230	296
2009	73	235	308
2010	74	268	342
2011	84	283	367
2012	93	271	364

Source: Office of Connecticut Medical Examiner Deaths by Suicide 2006–2012 Retrieved 5/29/13.

Table 9.

Number and Rate of Suicides in Connecticut Total and by Gender 2006 to 2012

Year	Female Number	Female Rate	Male Number	Male Rate	Total Number	Total Rate
2006	45	2.50	212	12.40	257	7.32
2007	43	2.40	207	12.13	250	7.14
2008	66	3.68	230	13.47	296	8.45
2009	73	4.05	235	13.68	308	8.75
2010	74	4.03	268	15.40	342	9.57
2011	84	4.58	283	16.22	367	10.25
2012	93	5.05	271	15.49	364	10.14

Source: State of Connecticut, Department of Public Health. Annual State Population with Demographics.
Retrieved from http://www.ct.gov/dph/cwp/view.asp?a=3132&q=388152; Accessed 7/6/13 2/2/14.
Office of Connecticut Medical Examiner Deaths by Suicide 2006–2012 Retrieved 5/29/13.

Table 13.

Primary Methods of Suicide in Connecticut 2006–2012

Year	Hanging/ Strangulation	Gunshot	Substance Overdose	CO Poisoning	Suffocation
2006	85	78	39	12	19
2007	96	71	46	7	8
2008	109	106	36	16	8
2009	111	95	44	20	12
2010	127	105	48	10	9
2011	130	112	54	25	7
2012	133	107	50	15	22
Total	791	674	317	105	85

Source: Office of Connecticut Medical Examiner Deaths by Suicide 2006–2012 Retrieved 5/29/13.

Why Mental Illness Stigma is Lethal

By Danei Edelen | Sep. 07, 2016

The first time suicide impacted me directly was when a friend of mine took his life. As a kid, he always cracked jokes and pulled pranks, and I got to watch him grow into a wonderful, dedicated man. I can still remember standing at work, wearing my green suit, when I heard the news. I was shaken for days. I wasn't able to go to the funeral, but I wish I had. No one can ever fill the special place he had in my life.

Many years later, I learned more details related to his death. He had recently gone through a divorce, and his sister had told his parents to get him help. His parents didn't heed her words. Likely, stigma prevented them from acknowledging the issue. I think about him often. And about his parents who are now burdened with the unfathomable weight of regret.

Mental illness—the topic no one wants to talk about. However, the silence is actually lethal. Here are the facts:

1. The suicide rate jumped 24% from 1999 to 2014, according to an April 2016 report from the Centers for Disease Control and Prevention
2. Suicide is increasing against the backdrop of generally declining mortality, and is currently one of the leading causes of death overall and within each age group. "It is a leading cause of death and we just don't have a handle on it," says Matthew K. Nock, a psychology professor at Harvard and one of the country's leading suicide researchers.
3. The nation's suicide rate is the highest it's been in 30 years.
4. Twenty-two veterans and one service member take their lives each day.
5. "According to the CDC, each year more than 41,000 individuals take their own life. Suicide is the 10th leading cause of death among adults in the U.S. and the 3rd leading cause of death among people aged 10-24."

I have consulted with far too many teens who believe they have a mental health condition, but are afraid to get help. When they confide in me, they often tell me: "My parents don't believe in mental illness." Let me say that again: "**My parents don't believe in mental illness**."

Allow me to clear up any confusion: It is real. And it carries very real consequences if we do not recognize it. Suicide is the second leading cause of death among people 25-34 years of age. It is the third leading cause of death for people 15-24 years old. That is far too significant a number for us to ignore.

Due to medical advancements and an increase in societal awareness, these younger generations are just now starting conversations to reduce the stigma surrounding mental health. But before we judge our elders too harshly, we need to understand that not talking about mental illness was the cultural norm. In previous generations, doctors did not have good solutions for those who lived with a mental health condition. I had a great grandmother who had a psychotic break, but they kept her at home, and she never sought treatment.

Decades ago, cancer was a topic that was avoided too—lack of knowledge and understanding, along with an unwillingness to confront the issue prevented people from opening up. Thanks to foundations like LiveStrong, global efforts are underway to spread information to end the stigma. As a result, we now speak more openly about cancer. It's time for society to follow suit with respect to mental health. Together, we can challenge the stigma—we can fight back.

It's time to end the silence: our societal ignorance and fear is killing future generations. Nothing can bring back my dear friend. But I am determined not to lose another. I know what it feels like to believe you have no other option, but I am living proof that there is always another option. Suicide is a permanent solution to a temporary problem. The best thing you can do for yourself and your family is to get educated.

*** A variation of this blog was first published on the Challenge the Storm website.*

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- See more at: http://www.nami.org/Blogs/NAMI-Blog/September-2016/Why-Mental-Illness-Stigma-is-Lethal#sthash.Nu4SeRkW.dpuf

The New York Times

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On and Off Stage With Robin Williams

By John Leland Aug. 4, 2016 1

When you photograph politicians and celebrities, there is a ritual that sometimes happens at the end. "You get along with someone and they give you their phone number, say 'Let's stay in touch,'" said Arthur Grace, who has photographed presidents and entertainers for Time, Newsweek and other publications. Usually, nothing ever comes of the overture. But with Robin Williams, whom Mr. Grace photographed in 1986 for the cover of Newsweek, that exchange of numbers turned out to be the start of a three-decade friendship and a uniquely intimate working relationship.

"There was probably something in the chemistry between us," Mr. Grace, 69, said from his home in Los Angeles. "And also, I spent a lot of time with him initially. We were together from the first thing in the morning to the club at night, on and off, for a month."

It helped that Mr. Grace knew something about what it was like to get on stage and try to make people laugh. In the late 1960s, he had tried his hand at stand-up at a friend's coffeehouse in Cape Cod. For a week, he took his lumps in front of a live audience. It was a learning experience, he said. "I realized that to be funny on a nightly basis, you have to be a professional." He relinquished any hope of becoming a comedian, but not his interest in the men and women who worked the trade, some of whom – including Mr. Williams – appeared in his 1991 photo book, "Comedians."

From the first assignment in 1986, their friendship flourished, Mr. Grace said. Mr. Williams was interested in the photographer's trade and his life, and peppered him with questions about what it was like to photograph Ronald Reagan or about the Cold War. He asked about photographing in East Germany under the eye of the government's surveillance apparatus.

They went on family vacations together. Mr. Williams insisted on taking Mr. Grace snowboarding (a failure) and throwing Mr. Grace a party to celebrate the photographer's wedding (a happy success). When Mr. Grace took pictures, it was often at Mr. Williams's request, not to fulfill an assignment. It was the kind of access that photographers dream about.

Still, Mr. Grace said he never saw the emotional distress that led to Mr. Williams's suicide in 2014, or the effects of the diffuse Lewy body dementia underlying that distress. In a 2015 interview with People magazine, Mr. Williams's widow, Susan Schneider Williams, was quoted as saying, "It was not depression that killed Robin." She added that "depression was one of, let's call it 50 symptoms, and it was a small one."

After hearing of his friend's death, Mr. Grace holed up for six or seven months, avoiding requests from magazines that were seeking his photographs of Mr. Williams. Finally, he said, "I felt an obligation to his fans that loved him, who respected him. Because I was in a unique position – I'd had unlimited access for three decades. What are you going to do?"

Mr. Grace assembled a makeshift office and began sorting through thousands of photographs, including shots he had taken for Mr. Williams's Christmas cards or during private family outings. The result is his new book, "Robin Williams: A Singular Portrait 1986-2002," and most of the images are appearing in print for the first time.

"There are certain people who have a face that the camera loves," Mr. Grace said. "Ronald Reagan looked great all the time. You couldn't take a bad picture of Reagan. Robin always looked great. The camera liked him. But not like a fashion model. And he was always cooperative unless he didn't like you."

His aim with the book, from which the images here are taken, was to convey "the whole picture of what he was like," Mr. Grace said. "Was he depressed? I don't know. I know when something was bothering him, something hurt him. He felt it and got angry just like anybody else."

He added: "No one knew about the Lewy body dementia. The last time I saw him in 2013 or 2014, he was the same old Robin. He came to my house for dinner. He just wanted to be peaceful because the demands on him were hard, and he was over 60 now. He needed more time to be quiet and reflect. But he would switch from that, and the next second he'd be riffing about my dog, and it was so funny you couldn't eat your food."

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Tue, 02/23/2016 - 15:13
Ruth Roth
Special to The Jewish Week
image: http://www.thejewishweek.com/sites/default/files/images/2016/02/18-0_0.feature_por_300px.jpg

The author with her son Jonathan. Courtesy of Ruth Roth

Our son's illness, when we finally became aware of it, was a magnitude-8 earthquake in our lives that came without any warning. It was a calm and beautiful day in July when I found Jonathan the first time he tried to end his life. The mechanics of saving him, calling 911, unlocking and opening the door for the rescue team, calling my husband, and following the ambulance to the hospital all happened on autopilot, step 1, step 2, step 3, and so on. The moments in between and following his arrival at the hospital crawled as I waited to hear whether my son would live and with what possible damage, and wondered in complete ignorance and fear what the next steps would be. How could this possibly be happening, how was it possible that I, who had spent countless hours talking with Jonathan, didn't realize the trouble he was in?

He made it through that episode alive and with minimal impairment to his body. Once out of the hospital he appeared to be the same Jonathan he always was: kind, loving, caring, bright, engaging, witty. He begged us not to tell anyone what happened — not that he needed to. Of course we would keep this a secret, for so many reasons. We didn't want to have our son labeled "crazy"; we didn't want him to endure any comments or knowing glances from well-meaning people. We were private people who never revealed our innermost issues to anyone outside our family. And we certainly didn't want our son to feel exposed.

Without realizing it, by keeping this secret, we validated Jonathan's feeling of shame.

Not only would he have to battle his illness, he would bear the burden of shame about it as well. From this point on, our family would have to present an outside face to the world that did not represent our inner reality. We didn't comprehend the gargantuan weight we would assume with this decision.

Would we have acted the same way had Jonathan been diagnosed with cancer, gastrointestinal illness, severe cardiac illness, or diabetes? Absolutely not — we would never have hidden any of those illnesses. Ask me now and I will tell you that I wish I had shouted it from the rooftop, done anything, taken out an ad in The New York Times: "My son has a devastating mental illness. Can someone, anyone, offer me some advice to save his life?"

Yes, I would have gone that far.

Five months later I found Jonathan again — this time too late. I knew the moment I saw him, my eyes frozen on him, that his body was lifeless. Nonetheless I went through with the rescue attempt, hoping in vain that we could deny reality. Again, time raced and crawled, but this time, that space was filled with planning our son's funeral. In the midst of our turmoil and grief, my husband and I conferred. Should we tell the truth about Jonathan's death? Having lived with the pain of isolation for the previous five months, we decided to be open about Jonathan's having taken his own life. This way, our friends could comfort us appropriately. More important, we would no longer have to bear the burden of living with a lie. It was the right decision for us.

Since then, I have been contacted by people from all over. Either their children are struggling with mental illness, or they are new in their grief for a child who has taken his or her own life. Sometimes they are seeking advice and guidance. More often, they want to share their thoughts with someone whom they know can understand. Many had been secretive about the cause of their own loved one's death. They told only those closest to them, but not others. They related to me that living with the truth hidden away had exacted a terrible toll on them, and they wished that they could turn the clock back. They have since slowly shared the truth with people as time has passed, but they regret not having unburdened themselves from the start.

I have been contacted by parents whose children had taken their own lives; sometimes the call has come mere hours after the horrible event. I was sought out by complete strangers who had heard of me and received my contact information from someone who knew me. They reached out to me because they felt that having "been there," I might be able to help them navigate their terrifying new reality. While I can't give advice — we humans are all so different in our coping mechanisms and our needs — I have shared our experience: we were open about our son taking his own life. That openness has helped us to heal and face life more honestly, and as whole people without a corrosive secret. I explain that being open allowed our friends to console us with the knowledge and proper tools to respond, and that we were, as a direct result, spared the ordeal of wearing a mask for the world.

It now occurs to me that there can be another equally vital benefit to sharing the truth

about this kind of loss, a development I pray will come to pass. Perhaps this openness after our loved ones have lost their lives would eventually be able to work its way back to the source, to conquer the entire stigma of mental illness in the first place.

My son suffered the equivalent of advanced cancer — just as some cancers are incurable, so too was his illness. My son suffered from a chronic disease that would never leave him — just like diabetes, heart disease, arthritis, or multiple sclerosis. Had he lived, it would have had to be monitored and managed forever. There were no MRIs, CT scans, echocardiograms, X-rays, blood tests or PET scans to diagnose, to localize the tumor or lesion. There were no objective treatment regimens or research protocols to test on him. He fought valiantly and he suffered tremendously. Medicine failed him because mental illness doesn't get the same respect as other physical illnesses, even as mental illness is just as legitimate a disease. Finally, because his illness was not obvious and kept a secret, our family received no extra kindness — even though we all could have benefited from it.

My husband and I are not unsophisticated people, but at the time when it was critical for us to be our son's advocates we were shell-shocked and ignorant. While I try not to play the "should have" game, I think it is instructive to play out the scenario that might have taken place had we been open about Jonathan's illness and suicide attempt. When friends asked what had happened, we could have said something like: "We were completely unaware, but Jonathan is suffering from a terrible mental illness and he tried to take his own life, and we are unsure of what to do to help him."

I'm sure that this news would have spread. Perhaps a knowledgeable person, someone with experience in this area, would have contacted us to give us advice and guidance. Just maybe, as a result, we would have obtained a more accurate diagnosis or more effective treatment. There is no guarantee that the outcome would have been any different; still, I believe that with additional knowledge the chance for a better outcome increases.

Jonathan may have been upset with this approach, but he might also have felt unburdened and able to speak openly with his friends about his illness. Perhaps a peer with a similar illness might have contacted him to let him know that he was not alone in his struggle. This would have helped Jonathan avoid the pain of isolation. He would have felt supported and I am certain that this alone would have helped him.

It is unfortunate that even now, as I continue to be contacted by parents whose children are struggling with mental illness, they ask me to keep their secret. Of course, I understand their concerns and honor their requests. I wish things were different because it is surely time for us all to be open about mental illness, a disease like any other, in the same way we are open about all other illnesses with which we struggle.

Notwithstanding the opportunity to reach for a better outcome, there was no need for Jonathan, or for us, his parents, to live in shame, and certainly no benefit in living with the weight of such a lie. Those months we spent pretending things were fine were exhausting and excruciating because of the huge expenditure of energy required to

keep up our façade and the isolation that became our existence. We learned that lesson only after Jonathan died, and that has made an enormous difference in our ability to continue living meaningful lives. It is my hope that by sharing these innermost thoughts about this very painful event in my life I will help others to be open about mental illness. It requires courage, but it is ultimately healing.

It is time for our communities and schools to acknowledge and address the prevalence of mental illness among our young people. This will only come through educational programs that alert clergy, teachers, and students to the early signs of these disorders. Unlike other diseases with their specific screening tests, the detection of mental illness begins with the recognition of its early signs by those around its sufferers. It is only when mental illness achieves its place alongside other "physical" illnesses that we can begin to address its devastating impact.

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Read more at http://www.thejewishweek.com/editorial-opinion/opinion/telling-truth-about-mental-illness#moVW2jFXXuPaZMHO.99

How Mental Illness is Misrepresented in the Media

Insidious portrayals on TV shape perceptions about real-life people with psychological disorders.

By Kirstin Fawcett | Contributor April 16, 2015, at 10:51 a.m.

Unless you majored in psychology or attended medical school, chances are the bulk of your knowledge about mental illness comes from the newspapers you read, the television shows you watch and the movies you see. Studies indicate that mass media is one of the public's primary sources of information about disorders such as bipolar, schizophrenia and depression.

The catch? Research also suggests most media portrayals of mental illness are stereotypical, negative or flat-out wrong – meaning many people gain an unfavorable or inaccurate view of those with psychological disorders simply by skimming a few sentences or picking up a remote control.

"The worst stereotypes come out in such depictions: mentally ill individuals as incompetent, dangerous, slovenly, undeserving," says Stephen Hinshaw, a professor of psychology at the University of California–Berkeley. "The portrayals serve to distance 'them' from the rest of 'us.'"

Over time, the media has slowly become conscious of these harmful portrayals, experts say. In 2013, the Associated Press added an entry on mental illness to its Style Book to help journalists write about mental illness fairly and accurately. And in recent years, Hinshaw notes, screenwriters have made an effort to portray more humanized characterizations of individuals with mental illness – for example, Carrie Mathison on Showtime's "Homeland," who has bipolar disorder; Bradley Cooper's character in "Silver Linings Playbook;" and John Nash, the Nobel Prize-winning economist with schizophrenia in "A Beautiful Mind."

Still needed, Hinshaw says, are more realistic portrayals of the everyday struggles associated with mental illness. And despite new scientific advances in the understanding and treatment of mental illness, recent studies indicate that media depictions of mental illness are as outdated and harmful as ever, says Dr. Otto Wahl, director of the graduate institute of professional psychology at Connecticut's University of Hartford and author of "Media Madness: Public Images of Mental Illness."

If media representations of mental illness aren't improving, individuals can at least become aware of the insidious portrayals that shape their perceptions of real-life people with psychological disorders. That way, they can distinguish between fact and fiction, stereotype and reality and the characters onscreen vs. their real life peers.

Here are a few common, inaccurate and misleading media stereotypes of people with mental illness:

People with mental illnesses are criminal or violent. Studies show that not only are individuals with mental illness less likely to commit violent crimes, they're actually more likely to be victimized. Still, Wahl points out, many news outlets conflate mental illness with violence. A common news

account of mental illness, for instance, involves a sensationalized and violent crime in which an innocent person is killed by a mental health patient. The article is laced with graphic descriptions, emotional diction and a glaring headline. It also depicts the mentally ill person as devoid of social identity and dangerous, capricious, aggressive and irrational.

This goes for fictional media, too. For instance, TV characters who've been identified as having a mental illness are typically shown as violent, says Don Diefenbach, professor and chair of mass communications at University of North Carolina–Asheville, who researches media portrayals of mental health issues.

Diefenbach analyzed the portrayals of psychological disorders on prime time television. He found that characters who were identified through behavior or label as having a mental illness were 10 times more likely than other TV characters to commit a violent crime – and between 10 to 20 times more likely to commit a violent crime than someone with a mental illness would be in real life.

People with mental illness look different than others. Maybe it's the disheveled hair. Maybe it's the rumpled clothes. Maybe it's the wild eyes. Whatever it is, Wahl notes, there's usually something "different" about the appearances of people with mental illnesses – be it on TV shows or in video games, movies or comics. These traits serve as visual signifiers to cast these characters – who are often threatening or evil – as the "other."

Many homeless people – who often lack the resources or wherewithal to take care of their appearances – are mentally ill. "But there are also a huge number of people with mental illnesses who are getting up – showering every day, going to work, etc.," Wahl says.

In short? People with mental illness look like, well, everyone else – not like their media stereotypes.

People with mental illnesses are childish and silly. Many movies and TV shows – for example, "Me, Myself and Irene," starring Jim Carrey as a patient with dissociative identity disorder, or "Monk," the show about a detective with obsessive-compulsive disorder – make light of mental illnesses. They portray otherwise serious psychological conditions as mere quirks, or those who have them as silly, funny and childlike.

These portrayals don't "convey the way most people with serious mental illnesses are in pain," Wahl says. In reality, he says, "they hurt. They're struggling."

Mental illnesses are all severe – or all alike. According to Diefenbach's research, depression only accounted for 7 percent of the psychiatric disorders shown on TV. However, 12 percent of the characters suffered from some form of psychosis – experiencing delusions or voices, or losing touch with reality.

In reality, depression is much more common than mental disorders such as schizophrenia and bipolar disorder. "The real-world relationship is going to be that depression outnumbers the family of psychotic disorders by about 6 or 7 percent to one," Diefenbach says. Yet on TV, the most extreme cases – and the most rare disorders – tend to be disproportionately represented.

Individuals with mental illness also note that various conditions tend to get lumped together. "Mental illness" is used as a catch-all phrase to describe someone's condition, as opposed to specific medical terminologies such as "schizophrenia" or "anxiety disorder." And even then, little

variation is shown from patient to patient; one movie portrayal of bipolar disorder tends to resemble another.

“There’s no discussion that each disease is different in each person, because each person is unique,” notes Nikki Marks, 46, who has bipolar disorder. “In real life, mental illness shows up differently in everybody. The media does not represent the complexity of mental illness in general. There’s this sense that it’s just a one-name-fits-everybody, or one-title-fits-everybody.”

Psychiatric hospitals cause more harm than good. Hospitals for the mentally ill have come a long way since 17th century Europe, when cold, dark facilities housed hoards of physically and mentally disabled patients, along with prostitutes, alcoholics and other social outcasts. Those mental institutions resembled a prison more than a place of healing – an image that’s still perpetuated by cinema, according to a recent study conducted by researchers at the University of Salamanca in Spain.

Despite sweeping reforms that occurred over the past half-century, many films and television shows continue to portraypsychiatric hospitals as bereft of comfort or care – empty corridors, bare walls and intimidating wings filled with manipulative doctors whose treatments cause more harm than good. And patients are often shown as committed against their will, or psychotic and out-of-control.

While all medical facilities differ in quality and care, today’s psychiatric wards and treatments are different – even if the public’s perception of them isn’t, experts say. And despite the common television or movie theme of a patient being sent to a psychiatric hospital against his or her will, that’s often not the case.

“In reality, a great number of people elect to go to [psychiatric wards],” says Wahl, dispelling the notion that most patients are involuntarily committed. Laws differ from state to state, but on average it’s very difficult to send patients to a psychiatric ward against their will.

People with mental illnesses can’t recover. “Recovery is seldom shown” in the media, Wahl notes. “When people [are shown seeking] therapy, when they go to psychiatric hospitals – rarely do they get better.” And if they do get better, he adds, “it’s enough that they’re stabilized, but not enough so that … they’re integrated with the world, and have friends and jobs.” The resulting message, he says, is that individuals with mental illnesses have no hope for a “normal” life.

The reality is that this isn't true: Experts say not only do patients often recover from psychiatric illnesses, but they can live health lives with the help of medications, therapy and support networks.

Pamela, a 57-year-old who lives in the District of Columbia who did not wish to use her last name, cites her story as proof. Pamela has bipolar disorder, and spent years dropping in and out of college and shuffling between doctors. But 10 years ago, she finally found a medication that stabilized her moods. She moved out of a group home, purchased a condo, held down a job and recently retired from her job as an office assistant.

“My recovery,” Pamela says, “was like a phoenix rising out of an abyss.”

Attachment VI

Standard of Practice Guidelines: TIP 42 and 47

Practice Guidelines for Recovery-Oriented Behavioral Health Care

Department of Public Health: Keeping Connecticut Healthy

Substance Abuse Treatment For Persons With Co-Occurring Disorders

A Treatment Improvement Protocol

TIP 42

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Finally, the critical issues in workforce development are discussed, for without a well-prepared staff, the needs of these often-challenging clients cannot be met—regardless of what other systemic changes are made. The chapter describes the attitudes and values needed to successfully treat these clients, required competencies, paths to professional development for those who wish to increase their skills in treating clients with COD, and ways of avoiding staff burnout and reducing turnover—an especially pressing concern for providers who work closely with this demanding population.

Guiding Principles

The consensus panel developed a list of guiding principles to serve as fundamental building blocks for programs that offer services to clients with COD (see Figure 3-1). These principles derive from a variety of sources: conceptual writings, well-articulated program models, a growing understanding of the essential features of COD, elements common to separate treatment models, clinical experience, and available empirical evidence. These principles may be applied at both a program level (e.g., providing literature for people with cognitive impairments) or at the individual level (e.g., addressing the client's basic needs).

In identifying these principles, the TIP consensus panel recognizes that there are a number of carefully elaborated protocols to guide treatment for individuals with COD, including principles identified by Drake and colleagues (1993) and by the Center for Mental Health Services Managed Care Initiative Panel (1998), as well as the assumptions that underlie the model Comprehensive Continuous Integrated Systems of Care described in chapter 2. The principles suggested in this chapter are consistent with these protocols, but reflect the specific focus of the consensus panel on how best to provide COD treatment in substance abuse treatment agencies. (However, the principles apply equally well to the treatment of COD in mental health agencies.)

The following section discusses each of the six principles in turn, highlighting the related field experience that underlies each one.

Employ a Recovery Perspective

There are two main features of the recovery perspective: It acknowledges that recovery is a long-term process of internal change, and it recognizes that these internal changes proceed through various stages. (See De Leon 1996 and Prochaska et al. 1992 for a detailed description. Also see chapter 5 of this TIP for a discussion of the recovery perspective as a guideline for practice.)

The recovery perspective is applicable to clients who have COD. It generates at least two main principles for practice:

Figure 3-1

Six Guiding Principles in Treating Clients With COD

1. Employ a recovery perspective.
2. Adopt a multi-problem viewpoint.
3. Develop a phased approach to treatment.
4. Address specific real-life problems early in treatment.
5. Plan for the client's cognitive and functional impairments.
6. Use support systems to maintain and extend treatment effectiveness.

Develop a treatment plan that provides for continuity of care over time. In preparing this plan, the clinician should recognize that treatment may occur in different settings over time (i.e., residential, outpatient) and that much of the recovery process typically occurs outside of or following treatment (e.g., through participation in mutual self-help groups and through family and community support, including the faith community). It is important to reinforce long-term participation in these continuous care settings.

Devise treatment interventions that are specific to the tasks and challenges faced at each stage of the co-occurring disorder recovery process. Whether within the substance abuse treatment or mental health services system, the clinician is advised to use sensible stepwise approaches in developing and using treatment protocols. In addition, markers that are unique to individuals—such as those related to their cultural, social, or spiritual context—should be considered. It is important to engage the client in defining markers of progress meaningful to the individual and to each stage of recovery.

Adopt a Multi-Problem Viewpoint

People with COD generally have an array of mental health, medical, substance abuse, family, and social problems. Most are in need of substantial rehabilitation and habilitation (i.e., initial learning and acquisition of skills). Treatment should address immediate and long-term needs for housing, work, health care, and a supportive network. Therefore, services should be comprehensive to meet the multidimensional problems typically presented by clients with COD.

Develop a Phased Approach to Treatment

Many clinicians view clients as progressing though phases (Drake and Mueser 1996*a*; McHugo et al. 1995; Osher and Kofoed 1989; Sacks et al. 1998*b*). Generally, three to five phases are identified, including engagement, stabilization, treatment, and aftercare or continuing care. These phases are consistent with, and parallel to, stages identified in the recovery perspective. As noted above, use of these phases enables the clinician (whether within the substance abuse treatment or mental health services system) to develop and use effective, stage-appropriate treatment protocols. (See chapter 5 for a discussion of how to use motivational enhancement therapy appropriate to the client's stage of recovery. Also see TIP 35, *Enhancing Motivation for Change in Substance Abuse Treatment* [Center for Substance Abuse Treatment (CSAT) 1999*b*]).

Address Specific Real-Life Problems Early in Treatment

The growing recognition that co-occurring disorders arise in a context of personal and social problems, with a corresponding disruption of personal and social life, has given rise to approaches that address specific life problems early in treatment. These approaches may incorporate case management and intensive case management to help clients find housing or handle legal and family matters. It may also be helpful to use specialized interventions that target important areas of client need, such as money management (e.g., Conrad et al. 1999) and housing-related support services (e.g., Clark and Rich 1999). Psychosocial rehabilitation, which helps the client develop the specific skills and approaches she needs to perform her chosen roles (e.g., student, employee, community member) also is a useful strategy for addressing these specific problems (Anthony 1996; Cnaan et al. 1990).

Solving such problems often is an important first step toward achieving client engagement in continuing treatment. Engagement is a critical part of substance abuse treatment generally and of treatment for COD specifically, since remaining in treatment for an adequate length of time is essential to achieving behavioral change.

Plan for the Client's Cognitive and Functional Impairments

Services for clients with COD, especially those with more serious mental disorders, must be tailored to individual needs and functioning. Clients with COD often display cognitive and other functional impairments that affect their ability to comprehend information or complete tasks (CSAT 1998*e*; Sacks et al. 1997*b*). The manner in which interventions are presented must be compatible with client needs and functioning. Such impairments frequently call for relatively short, highly structured treatment sessions that are focused on practical life problems. Gradual pacing, visual aids, and repetition often are helpful. Even impairments that are comparatively subtle (e.g., certain learning disabilities) may still have significant impact on treatment success. Careful assessment of such impairments and a treatment plan consistent with the assessment are therefore essential.

Use Support Systems To Maintain and Extend Treatment Effectiveness

The mutual self-help movement, the family, the faith community, and other resources that exist within the client's community can play an invaluable role in recovery. This can be particularly true for the client with COD, as many clients with COD have not enjoyed a consistently supportive environment for decades. In some cultures, the stigma surrounding substance use or mental disorders is so great that the client and even the entire family may be ostracized by the immediate community. Furthermore, the behaviors associated with active substance use may have alienated the client's family and community. The clinician plays a role in ensuring that the client is aware of available support systems and motivated to use them effectively.

Mutual self-help

Based on the Alcoholics Anonymous model, the mutual self-help movement has grown to encompass a wide variety of addictions. Narcotics Anonymous and Cocaine Anonymous are two of the largest mutual self-help organizations for substance use disorders; Recoveries Anonymous and Schizophrenics Anonymous are among the best known for mental illness. Personal responsibility, self-management, and helping one another are the basic tenets of mutual self-help approaches. Such programs apply a broad spectrum of personal responsibility and peer support principles, usually including 12-Step methods that prescribe a planned regimen of change (see Peyrot 1985 for the history, structure, and approach of Narcotics Anonymous, representative of 12-Step approaches in general). However, in the past clients with COD felt that either their mental health or their substance use issues could not be addressed in a single-themed mutual self-help group; that has changed.

Mutual self-help principles, highly valued in the substance abuse treatment field, are now widely recognized as important components in the treatment of COD. Mutual self-help groups may be used as an adjunct to primary treatment, as a continuing feature of treatment in the community, or both. These groups not only provide a vital means of support during outpatient treatment, but also are used commonly in residential programs such as therapeutic communities. As clients gain employment, travel, or relocate, mutual self-help meetings may become the most easily accessible means of providing continuity of care. For a more extensive discussion of dual recovery mutual self-help programs applicable to persons with COD, see chapter 7.

Building community

The need to build an enduring community arises from three interrelated factors—the persistent nature of COD, the recognized effectiveness of mutual self-help principles, and the importance of client empowerment. The therapeutic community (TC), modified mutual self-help programs for COD (e.g., Double Trouble in Recovery), and the client consumer movement all reflect an understanding of the critical role clients play in their own recovery, as well

as the recognition that support from other clients with similar problems promotes and sustains change.

Reintegration with family and community

The client with COD who successfully completes treatment must face the fragility of recovery, the toxicity of the past environment, and the negative impact of previous associates who may encourage drug or alcohol use and illicit or maladaptive behaviors. There is a need for groups and activities that support change. In this context it is important that these clients receive support from family and significant others where that support is available or can be developed. There is also the need to help the client reintegrate into the community through such resources as religious, recreation, and social organizations. (See chapter 6 for a discussion of continuing care issues in treatment.)

Delivery of Services

While the guiding principles described above serve as the fundamental building blocks for effective treatment, ensuring effective treatment requires attention to other variables. This section discusses six core components that form the ideal delivery of services for clients with COD. These include:

1. Providing access
2. Completing a full assessment
3. Providing an appropriate level of care
4. Achieving integrated treatment
5. Providing comprehensive services
6. Ensuring continuity of care

Providing Access

"Access" refers to the process by which a person with COD makes initial contact with the service system, receives an initial evaluation, and is welcomed into services that are appropriate for his or her needs.

Access occurs in four main ways:

1. Routine access for individuals seeking services who are not in crisis
2. Crisis access for individuals requiring immediate services due to an emergency
3. Outreach, in which agencies target individuals in great need (e.g., people who are homeless) who are not seeking services or cannot access ordinary routine or crisis services
4. Access that is involuntary, coerced, or mandated by the criminal justice system, employers, or the child welfare system

Treatment access may be complicated by clients' criminal justice involvement, homelessness, or health status. CSAT's "no wrong door" policy should be applied to the full range of clients with COD, and programs should address obstacles that bar entry to treatment for either the mental or substance use disorders. (See chapter 7 for recommendations on removing systemic barriers to care and the text box on p. 42 for more on CSAT's "no wrong door" policy.)

> It is important that clients receive support from family and significant others where that support is available or can be developed.

Completing a Full Assessment

While chapter 4 provides a complete description of the assessment process, this section highlights several important features of assessment that must be considered in the context of effective service delivery. Assessment of individuals with COD involves a combination of the following:

- Screening to detect the possible presence of COD in the setting where the client is first seen for treatment
- Evaluation of background factors (family, trauma history, marital status, health, education and work history), mental disorders, substance abuse, and related medical and psychosocial problems (e.g., living circumstances, employment, family) that are critical to address in treatment planning
- Diagnosis of the type and severity of substance use and mental disorders
- Initial matching of individual client to services (often, this must be done before a full assessment is completed and diagnoses clarified; also, the client's motivation to change with regard to one or more of the co-occurring disorders may not be well established)
- Appraisal of existing social and community support systems
- Continuous evaluation (that is, re-evaluation over time as needs and symptoms change and as more information becomes available)

The challenge of assessment for individuals with COD in any system involves maximizing the likelihood of the identification of COD, immediately facilitating accurate treatment planning, and revising treatment over time as the client's needs change.

Providing an Appropriate Level of Care

Clients enter the treatment system at various levels of need and encounter agencies with varying capacity to meet those needs. Ideally, clients should be placed in the level of care appropriate to the severity of both their substance use disorder and their mental illness.

The American Society of Addiction Medicine's (ASAM) classification is one standard way of identifying programs that offer the needed services. As described in chapter 2, ASAM describes programs' ability to address COD as "addiction only services," "dual diagnosis capable," and "dual diagnosis enhanced."

Making "No Wrong Door" a Reality

CSAT's "no wrong door" policy states that effective systems must ensure that an individual needing treatment will be identified and assessed and will receive treatment, either directly or through appropriate referral, no matter where he or she enters the realm of services (CSAT 2000*a*). The consensus panel strongly endorses this policy.

The focus of the "no wrong door" imperative is on constructing the healthcare delivery system so that treatment access is available at any point of entry. A client with COD needing treatment might enter the service system by means of primary healthcare facilities, homeless shelters, social service agencies, emergency rooms, or criminal justice settings. Some clients require the creation of a "right door" for treatment entry—for example, mobile outreach teams who can access clients with COD who are unlikely to knock on the door of any treatment facility.

The "no wrong door" approach has five major implications for service planning:

1. Assessment, referral, and treatment planning for all settings must be consistent with a "no wrong door" policy.
2. Creative outreach strategies may be needed to encourage some people to engage in treatment.
3. Programs and staff may need to change expectations and program requirements to engage reluctant and "unmotivated" clients.
4. Treatment plans should be based on clients' needs and should respond to changes as they progress through stages of treatment.
5. The overall system of care needs to be seamless, providing continuity of care across service systems. This can only be achieved through an established pattern of interagency cooperation or a clear willingness to attain that cooperation.

While recognizing ASAM's contribution, the consensus panel suggests an alternative classification system: basic, intermediate, advanced, or fully integrated. As conceived by the consensus panel

- A *basic* program has the capacity to provide treatment for one disorder, but also screens for the other disorder and can access necessary consultations.
- A program with an *intermediate* level of capacity tends to focus primarily on one disorder without substantial modification to its usual treatment, but also explicitly addresses some specific needs of the other disorder. For example, a substance abuse treatment program may recognize the importance of continued use of psychiatric medications in recovery, or a psychiatrist could provide motivational interviewing regarding substance use while prescribing medication for mental disorders.
- A program with an *advanced* level of capacity provides integrated substance abuse treatment and mental health services for clients with COD. Several program models of this sort are described in chapter 6. Essentially, these programs address COD using an integrated perspective and provide services for both disorders. This usually means strengthening substance abuse treatment in the mental health setting by adding interventions such as mutual self-help and relapse prevention groups. It also means adding mental health services, such as psychoeducational classes on mental disorder symptoms and groups for medication monitoring, in substance abuse treatment settings. Collaboration with other agencies may add to the comprehensiveness of services.
- A program that is *fully integrated* actively combines substance abuse and mental health interventions to treat disorders, related problems, and the whole person more effectively.

The suggested classification has several advantages. For one, it avoids the use of the term "dual diagnosis" (instead of COD) and allows a more general, flexible approach to describing capacity without specific criteria. In addition, the recommended classification system conceptualizes a bidirectionality of movement where either substance abuse or mental health agencies can advance toward more integrated care for clients with COD, as shown in Figure 3-2 (p. 44).

Figure 3-2 depicts a model of basic, intermediate (COD capable), and advanced (COD enhanced) programming within mental health services and substance abuse treatment systems. The idea of integrated COD treatment is shown in the center. For the purpose of this TIP, both mental health and substance abuse treatment providers may be conceived of as beginning, intermediate, or advanced in terms of their progress toward the highest level of capacity to treat persons with COD.

It should also be recognized that not all services want or need to be fully integrated, since many clients do not need a full array of services. (See Figure 2-1 in chapter 2.) In Figure 3-2, the middle box—fully integrated—refers to a system that has achieved an integrated setting in which staff, administration, regulations, and funding streams are fully integrated.

Achieving Integrated Treatment

The concept of integrated treatment for persons with severe mental disorders and substance use disorders, as articulated by Minkoff (1989), emphasized the need for correlation between the treatment models for mental health services and substance abuse treatment in a residential setting. Minkoff's model stressed the importance of well-coordinated, stage-specific treatment (i.e., engagement, primary treatment, continuing care) of substance use and mental disorders, with emphasis on dual recovery goals as well and the use effective treatment strategies from both the mental health services and the substance abuse treatment fields.

During the last decade integrated treatment continued to evolve. Several successful treatment models have been described for addiction settings (Charney et al. 2001; McLellan et al.

Figure 3-2
Levels of Program Capacity in Co-Occurring Disorders

1993; Saxon and Calsyn 1995; Weisner et al. 2001), including the addition of psychiatric and mental health services to methadone treatment (Kraft et al. 1997; Woody et al. 1983), and a modified therapeutic community for providing integrated care to persons with COD (De Leon 1993*b*; Guydish et al. 1994; Sacks 2000; Sacks et al. 1997*a*, *b*, 1998*a*, 2002). Likewise, the literature also describes numerous models for mental health settings (CSAT 1994*a*; Drake and Mueser 1996*b*; Lehman and Dixon 1995; Minkoff and Drake 1991; Zimberg 1993). Figure 3-3 illustrates one vision of a comprehensive, fully integrated approach to treatment for persons with severe mental disorders and substance use disorders from the mental health literature. However, as noted in the following section, programs may be integrated in a variety of ways.

The literature from both the substance abuse and mental health fields has evolved to describe integrated treatment as a unified treatment approach to meet the substance abuse, mental health, and related needs of a client. It is the preferred model of treatment.

Integrated treatment can occur on different levels and through different mechanisms. For example:

- One clinician delivers a variety of needed services.
- Two or more clinicians work together to provide needed services.
- A clinician may consult with other specialties and then integrate that consultation into the care provided.
- A clinician may coordinate a variety of efforts in an individualized treatment plan that integrates the needed services. For example, if someone with housing needs was not accepted at certain facilities, the clinician might work with a State-level community-housing program to find the transitional or supported housing the client needs.
- One program or program model (e.g., modified TC or Assertive Community Treatment) can provide integrated care.
- Multiple agencies can join together to create a program that will serve a specific population. For example, a substance abuse treatment program, a mental health center, a local

housing authority, a foundation, a county government funding agency, and a neighborhood association could join together to establish a treatment center to serve women with COD and their children.

Integrated treatment also is based on positive working relationships between service providers. The National Association of State Mental Health Program Directors (NASMHPD) and the National Association of State Alcohol and Drug Abuse Directors' (NASADAD) four-quadrant category framework described in chapter 2 provides a useful structure for fostering consultation, collaboration, and integration among systems and providers to deliver appropriate care to every client with COD (see chapter 2, Figure 2-1). According to the NASMHPD–NASADAD (1999) framework

- *Consultation* refers to the traditional types of informal relationships among providers—from referrals to requests for exchanging information and keeping each other informed. The framework calls for particular attention to the consultation relationship during identification, engagement, prevention, and early intervention activities.
- *Collaboration* is essential when a person who is receiving care in one treatment setting also requires services from another provider. Collaboration is distinguished from consultation on the basis of the formal quality of collaborative agreements, such as memoranda of understanding or service contracts, which document the roles and responsibilities each party will assume in a continuing relationship. For example, parties must ensure that they can share information without violating Federal Law 42 C.F.R. Part 2 on confidentiality (see appendix K for more information). This will require the client to give written authorization for release of information to all providers.
- *Integration* denotes "those relationships among mental health and substance abuse providers in which the contributions of professionals in both fields are moved into a single treatment setting and treatment regimen" (p. 15).

Figure 3-3
A Vision of Fully Integrated Treatment for COD

- The client participates in one program that provides treatment for both disorders.
- The client's mental and substance use disorders are treated by the same clinicians.
- The clinicians are trained in psychopathology, assessment, and treatment strategies for both mental and substance use disorders.
- The clinicians offer substance abuse treatments tailored for clients who have severe mental disorders.
- The focus is on preventing anxiety rather than breaking through denial.
- Emphasis is placed on trust, understanding, and learning.
- Treatment is characterized by a slow pace and a long-term perspective.
- Providers offer stagewise and motivational counseling.
- Supportive clinicians are readily available.
- 12-Step groups are available to those who choose to participate and can benefit from participation.
- Neuroleptics and other pharmacotherapies are indicated according to clients' psychiatric and other medical needs.

Source: Adapted from Drake et al. 1998*b*, p. 591.

For the purposes of this TIP, integration is seen as a continuum. Depending on the needs of the client and the constraints and resources of particular systems, appropriate degrees and means of integration will differ.

Providing Comprehensive Services

People with COD have a range of medical and social problems—multidimensional problems that require comprehensive services. In addition to treatment for their substance use and mental disorders, these clients often require a variety of other services to address other social problems and stabilize their living conditions. Treatment providers should be prepared to help clients access a broad array of services, including life skills development, English as a second language, parenting, nutrition, and employment assistance.

McLellan and colleagues have shown the need for wraparound services to address difficult-to-treat public-sector clients, not all of whom were diagnosed with COD (Gould et al. 2000; McLellan et al. 1997). Two areas of particular value, highlighted below, are housing and work.

Housing

The high proportion of homelessness among clients with COD has focused attention on the importance of providing housing for people with COD and of integrating housing into treatment. Approaches vary from those that provide housing at the point of entry into the service system combined with case management and supportive services (Tsemberis and Asmussen 1999), to those that provide housing as a reward contingent on successful completion of treatment (Milby et al. 1996; Schumacher et al. 1995), or as part of a continuing care strategy that combines housing and continuing care services (Sacks et al. 1998*a*, 2003*a*).

Addressing housing needs requires an ongoing relationship with housing authorities, landlords, and other housing providers. Groups and seminars that discuss housing issues also may be necessary to help clients with COD transition from residential treatment to housing. Another effective strategy for easing the transition has been organizing and coordinating housing tours with supportive housing programs. Finally, relapse prevention efforts are essential, since substance abuse generally disqualifies clients from public housing in the community.

Work

Vocational rehabilitation has long been one of the services offered to clients recovering from mental disorders and, to some degree, to those recovering from substance use disorders. However, in the past clients often were expected first to maintain a period of abstinence. As a result of this policy, people with serious mental disorders often were underserved, if served at all (CSAT 2000*c*). For people with COD, Blankertz and colleagues contend that, "work can serve as a rehabilitative tool and be an integral part of the process of stabilizing the mental illness and attaining sobriety" (Blankertz et al. 1998, p. 114).

The fact is that many individuals with COD are unemployed. However, it is unreasonable to expect employers to tolerate employees who are actively using alcohol on the job or who violate their drug-free workplace policies. Therefore, if work is to become an achievable goal for individuals with COD, vocational rehabilitation and substance abuse treatment must be closely integrated into mental health rehabilitation (Blankertz et al. 1998). For more information about incorporating vocational rehabilitation into treatment, see TIP 38, *Integrating Substance Abuse Treatment and Vocational Services* (CSAT 2000*c*).

Ensuring Continuity of Care

Continuity of care implies coordination of care as clients move across different service systems (e.g., Morrissey et al. 1997). Since both substance use and mental disorders frequently are long-term conditions, treatment for persons with COD should take into consideration rehabilitation and recovery over a significant period of time. Therefore, to be effective, treatment must address the three features that characterize continuity of care:

- *Consistency* between primary treatment and ancillary services
- *Seamlessness* as clients move across levels of care (e.g., from residential to outpatient treatment)
- *Coordination* of present and past treatment episodes

It is important to set up systems that prevent gaps between service system levels and between clinic-based services and those outside the clinic. The ideal is to include outreach, employment, housing, health care and medication, financial supports, recreational activities, and social networks in a comprehensive and integrated service delivery system.

Empirical evidence related to continuity of care

Evidence for the benefits of ensuring continuity of care comes from multiple sources. In one study of criminal justice populations not specifically identified as having COD, Wexler and colleagues (1999) found that at 3 years post-treatment only 27 percent of those prison program completers who also completed an aftercare program were returned to custody. In contrast, about three-fourths of the subjects in all other study groups were returned. Similar findings have been reported by Knight and colleagues (1999). Although selection bias exists in these studies for entry into aftercare, the long-term outcomes suggest the critical role of aftercare in maintaining positive treatment effects in the criminal justice population.

A study of homeless clients with COD provided further evidence (again with selection bias into aftercare) that aftercare is crucial to positive treatment outcomes. In this study, clients who lived in supported housing after residing in a modified therapeutic community demonstrated reductions in antisocial behavior occurring during the residential modified therapeutic community program and stabilizing during supported housing, while increases in prosocial behavior were largely incremental and continuous throughout both the residential and supported housing programs (Sacks et al. 2003*a*).

> Continuity of care implies coordination of care as clients move across different service systems.

Organizing continuity of care

In organizing continuity of care—a high-priority aspect of any treatment plan for a client with COD—the substance abuse treatment agency must carefully consider and strive to overcome systemic barriers. It is important to recognize that the public mental health and substance abuse treatment systems have evolved in different ways, and these differing histories must be recognized as collaborative ventures are formed.

Community mental health centers were created to be relatively comprehensive in nature, but have not been funded to deliver comprehensive services. Furthermore, there are wide variations in the types of mental disorders that publicly funded mental health centers are permitted to treat; many restrict their services to those in acute crisis or who have serious and persistent mental illnesses, such as schizophrenia, bipolar affective disorder, or major depression. Many States explicitly prevent public mental health programs from

treating those with primary substance use disorders.

Substance abuse treatment programs exist within a variety of organizational structures. Many of them are stand-alone substance abuse treatment programs, several are part of comprehensive drug treatment agencies, some are affiliated with hospitals, some are located within hospitals, many have evolved as part of the criminal justice system, some exist in community mental health settings, and still others are faith-based programs. Many substance abuse treatment programs are the last refuge of the most underserved populations (e.g., the homeless).

The different organizational structures and settings in which services occur influence the ease or difficulty of providing a service delivery network that is integrated, comprehensive, and continuous. Many of the larger drug treatment agencies are to be commended for developing state-of-the-art programming for COD, and some smaller programs also have extended themselves to serve this population. Nevertheless, the strains imposed by organizational and system constraints should be recognized. As substance abuse treatment agencies continue to develop their capabilities for treating clients with COD, the consensus panel recommends that groups of providers organize themselves into coherent systems of care that enable them to provide comprehensive services.

An example of a collaborative that promotes the development of a local infrastructure in support of co-occurring treatment is the Co-Occurring Collaborative of Southern Maine. The Collaborative's ways of working, accomplishments, and the critical elements for success identified at the close of Figure 3-4 may well inspire others to weave similar structures, crossing agency boundaries to better serve shared clients.

Improving Substance Abuse Treatment Systems and Programs

Critical challenges face substance abuse treatment systems and programs that are intent on improving care for clients with COD. One of the most critical of these is how to organize a system that will provide continuity of care for these clients, who, as noted previously, often have multifaceted needs and require long-term treatment plans. Another, of course, is how to access funding for program improvement. When treatment providers from different systems cooperate, equitable allocation of funds also becomes an issue. Finally, at every level there is the problem of how best to integrate research and practice to give clients the benefit of the proven treatment strategies. This section addresses each of these major concerns in turn.

Assessing the Agency's Potential To Serve Clients With COD

Every agency that already is treating or planning to treat clients with COD should assess the current profile of its clients, as well as the estimated number and type of potential new clients in the community. It also must consider its current capabilities, its resources and limitations, and the services it wants to provide in the future.

Programs should consider performing a needs assessment to determine the prevalence of COD in their client population, the demographics of those clients, and the nature of the disorders and accompanying problems they present. These data help create a picture of client needs that can be useful not only to the agency itself, but also to other systems of care at various levels. All levels of government demand some form of needs assessment from provider agencies. Block grant requirements from the Federal government require a statewide needs assessment. In turn, States look to regional and county groups to perform a needs assessment

Figure 3-4

The Co-Occurring Collaborative of Southern Maine

The Co-Occurring Collaborative of Southern Maine, a 501(c)(3) nonprofit corporation, is an alliance of member agencies, consumers, and family members in Cumberland County in southern Maine. Formed in 1992 through a State initiative on COD, the Collaborative provided the umbrella structure for a demonstration grant from The Bingham Program and The Robert Wood Johnson Foundation. It received additional support from Maine's Office of Substance Abuse and Maine's Medicaid Program for a project comparing the efficacy of integrated and coordinated care. The Collaborative has continued its work beyond the 3-year demonstration grant with funding from the Maine Office of Substance Abuse, becoming an integral part of the community's efforts to address COD. In 1998, the Collaborative formalized its structure by becoming a Maine nonprofit corporation.

The number of member agencies has expanded from an initial dozen to more than 30, including consumer groups, family groups, and mental health, substance abuse, criminal justice, HIV, and public health service providers. Each member agency has an identified liaison who serves as the bridge between the Collaborative and the agency. Each member agency formally commits through a memorandum of understanding to do the following:

1. Support the Collaborative's mission.
2. Examine and make changes to the services and organizational structures to support improved service provision for persons with COD.
3. Exchange information, share resources, and alter activities to enhance the capacities of all agencies to improve services for persons with COD.
4. Participate actively in, and share responsibility for, the Collaborative.

The Collaborative structure provides a mechanism for cross-agency and cross-disciplinary communication, coordination, training and education, creative interagency problemsolving, resource development for co-occurring recovery capacity, and advocacy. The Collaborative's accomplishments to date include

- Promoting dual competence expectations in the workforce
- Obtaining grants and collaborating on grant submission
- Expanding consumer, family, and provider partnerships
- Developing the mutual self-help option of dual recovery
- Supporting diversion planning from the criminal justice system
- Supporting the creation of an Assertive Community Treatment team for individuals with COD
- Creating a community service consultation team
- Supporting transfer of knowledge to develop new clinical models for treatment of persons with personality and substance use disorders

To achieve success in forging a collaborative structure, the following were found to be critical elements:

- Inviting all relevant agencies to participate and air their concerns
- Nurturing one-to-one relationships among service providers across service sectors
- Creating and maintaining a shared knowledge base and a common vision
- Collaboration, support, and empowerment
- Early and frequent successes
- Encouraging participation in planning and decisionmaking
- Clarifying roles and process
- Ensuring ongoing consumer and family participation
- Conducting periodic self-review
- Having visionary, consistent, and effective leadership

focused on the local level. Local needs assessment information feeds back to the State level and is used to develop a statewide picture that, in turn, is provided to higher-level funding authorities. The data generated through needs assessments also can be used to demonstrate need in support of grant proposals for increasing service capacity prepared by the treatment agency.

It is important to determine what changes need to be made with respect to staff, training, accreditation, and other factors to provide effective services for clients with COD. The agency also should know what resources and services are already available within their local and State systems of care before deciding what services to provide. This assessment of community capacity and the resulting decisionmaking process should involve all stakeholders in the program. Whatever changes the provider decides to make will require an active commitment from all levels of staff as well as from members of the community, advocacy groups, and other interested parties.

The various classification systems described previously can be used to identify missing levels of care and gaps in specific services. Such tools permit clinicians to relate program services to clients' needs for specific activities. They also enable planners to identify gaps in the current system of care and then to design programs that address these gaps. Figure 3-5 provides a list of domains and questions to guide agencies in assessing their potential to serve clients with COD. In doing so, it is assumed that each agency will use the best approach to each task that is possible, given its level of resources. It may, for example, need to use estimates rather than precise data in some instances.

Accessing Funding

System components and financing principles

Both mental health services and substance abuse treatment systems must face the challenge of obtaining funding that supports programming for clients with COD. For substance abuse treatment agencies, which are seeing more clients with COD and clients with more serious COD, it often is difficult to obtain funds to provide needed screening, assessment, specialized mental health service enhancement, and case management.

Developing a comprehensive system of care for people with COD requires committed leadership, joint planning, and the willingness and ability to find creative solutions to difficult problems. Financing a comprehensive system of care requires no less a commitment of time, creativity, and expertise. The process of continuing dialog between NASMHPD and NASADAD has identified key system development components and financing principles shown in Figure 3-6 (p. 52). Like the conceptual framework, these components and principles represent a set of flexible guidelines that can be adapted for use in any State or community.

Each of the six financing principles is a critical element of success and is described below:

1. *Plan To Purchase Together.* It has been found that "in most successful demonstration programs for people with co-occurring disorders, the State mental health agency and the State alcohol and drug abuse agency jointly planned and purchased services" (NASMHPD and NASADAD 2000, pp. 19–20).
2. *Define the Population.* Individuals with COD may fall into any of the four quadrants. Program services must target populations based on the severity of their mental or substance use disorders, among other considerations. However, it is important to keep in mind that due to the illegality of drug use denying services to those whose current condition is not severe may increase the severity of problems associated with that drug use, increasing severity by producing arrests, job loss, and conflicts with the child welfare system.
3. *Secure Financing.* The following section of this chapter will provide some suggestions on this challenging and often complex task.

Figure 3-5

Assessing the Agency's Potential To Serve Clients With COD

1. Describe the profile of current clients with COD and any potential changes anticipated.
   - Estimate the prevalence of persons with COD among the agency's clients. (One of the screening tools recommended in chapter 4 may be appropriate for this purpose.)
   - What are the demographics of persons with COD?
   - What functional problems do they have?
   - Are there clients with COD who seek care at the agency who are referred elsewhere? What is the profile of these clients?
2. Identify services needed by clients.
   - What services are needed by existing and potential clients?
3. Identify and assess resources available to meet client needs.
   - What services are immediately available to the program?
   - What services could be added within the program?
   - What services are available from the community that would enhance care?
   - How well are outside agencies meeting clients' needs?
4. Assess resource gaps.
   - What resources are needed to enhance treatment for persons with COD?
   - What can your agency, specifically, do to enhance its capacity to serve these clients?
5. Assess capacity.
   - Realistically assess the capacity of your agency to address these resource gaps.
6. Develop a plan to enhance capacity to treat clients with COD.
   - How can the skills of existing staff be increased?
   - Can additional expertise be accessed through consulting agreements or similar arrangements?
   - What additional programs or services can be offered?
   - What sources of funding might support efforts to enhance capacity?

4. *Purchase Effective Services.* It is important to purchase services that research has shown to be effective. Unfortunately, COD research tends to focus on those with serious mental disorders. As a result, guidance on which strategies are most cost-effective in treating persons with less serious mental disorders and co-occurring substance use disorders is not readily available.
5. *Purchase Performance.* NASMHPD and NASADAD strongly recommend performance-based contracts that focus on outcomes. "A program's effectiveness should be judged not only by how many people it serves or units of service it delivers, but rather by the level of real change it helps bring about in the lives of consumers who have co-occurring mental health and substance use disorders" (NASMHPD and NASADAD 2000).
6. *Evaluate and Improve.* It is essential to evaluate performance. Findings help providers revise protocols to get better

Practice Guidelines for Recovery-Oriented Behavioral Health Care

Connecticut Department of Mental Health and Addiction Services

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Executive Summary

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

Defining our Terms

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

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

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

Practice Guidelines

A. Primacy of Participation

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

Practice guidelines to be included in this domain:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

B. Promoting Access and Engagement

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

Practice guidelines to be included in this domain:

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

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

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

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

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

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

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

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

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

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

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

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

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

C. Ensuring Continuity of Care

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

Practice guidelines to be included in this domain:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

D. Employing Strengths-Based Assessment

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

Practice guidelines to be included in this domain:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

E. Offering Individualized Recovery Planning

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

Practice guidelines to be included in this domain:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

F. Functioning as a Recovery Guide

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

Practice guidelines to be included in this domain:

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

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

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

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

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

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

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

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

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

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

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

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

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

F.14. In order to counteract the often hidden effects of stigma, practitioners explicitly draw upon their own personal experiences when considering the critical nature of various social roles in the lives of all individuals, continuing to view people in recovery squarely within the context of their daily lives.

F.15. Rather than devaluing professional knowledge, the "recovery guide" approach moves behavioral health much closer to other medical specialties in which it is the health care specialist's role to assess the person, diagnose his or her condition, educate the person about the costs and benefits of the most effective interventions available to treat his or her condition, and then provide the appropriate interventions.

F.16. Recovery is viewed as a fundamentally social process, involving supportive relationships with family, friends, peers, community members, and practitioners

G. Community Mapping and Development

Given its focus on life context, one tool required for effective recovery planning and the provision of recovery-oriented care is adequate knowledge of the person's local community, including its opportunities, resources, and potential barriers. Community mapping and development are participatory processes that involves persons in mapping the resources and capacities of a community's individuals, its informal associations, and its structured institutions, as a means of identifying existing, but untapped or overlooked, resources and other potentially hospitable places in which the contributions of people with disabilities and/or addiction will be welcomed and valued.

Practice guidelines to be included in this domain:

G.1. People in recovery are viewed primarily as citizens and not as clients and are recognized for the gifts, strengths, skills, interests, and resources they have to contribute to community life.

G.2. Community leaders representing a range of community associations and institutions work together with people in recovery to carry out the process of community development.

G.3. Opportunities for employment, education, recreation, social and civic involvement, and religious participation are regularly identified and are compiled in asset maps, capacity inventories, and community guides.

G.4. Asset maps and capacity inventories created collaboratively by actively involved community stakeholders reflect a wide range of *natural* gifts, strengths, skills, knowledge, values, interests, and resources available to a community through its individuals, associations, and institutions.

G.5. Value is placed on the less formal aspects of associational life that take place in neighborhood gatherings, block watch meetings, salons, coffee clatches, barbershops, book groups, etc.

G.6. Institutions do not duplicate services that are widely available in the community through individuals and associations.

G.7. Community development is driven by a creative, capacity-focused vision identified and shared by community stakeholders.

G.8. The relational process of gathering information about community assets and capacities through personal interviews and sharing of stories is recognized as being as important as the information that is collected.

H. Identifying and Addressing Barriers to Recovery

There currently are elements and characteristics of the service delivery system and the broader community that unwittingly contribute to the creation and perpetuation of chronicity and dependency in individuals with behavioral health disorders. There also are several aspects of behavioral health disorders and their place within contemporary society that complicate the person's efforts toward recovery. The competent behavioral health care practitioner will have tools and strategies for identifying and addressing these barriers to recovery.

Practice guidelines to be included in this domain:

H.1. There is a commitment at the local level to embrace the values and principles of recovery-oriented care and to move away from the dominant illness-based paradigm. Systemic changes that reflect this paradigm shift include the following:

H.1.1. Stakeholders understand the need for recovery-oriented system change as a civil rights issue which aims to restore certain elementary freedoms to American citizens with psychiatric disorders and/or addictions.

H.1.2. Stakeholders work together to move away from the criteria of "medical necessity" toward "human need," from managing illness to promoting recovery, from deficit-oriented to strengths-based, and from symptom relief to personally-defined quality of life.

H.1.3. The possibility of recovery, and responsibility for delivering recovery-oriented care, are embraced by stakeholders at all levels of the system.

H.2. Systemic structures and practices which impede the adoption of recovery-oriented practices are identified and addressed. Representative change strategies in this area include the following:

H.2.1. Sequential movement through a pre-existing continuum of care is no longer required, as it is inconsistent with a civil rights perspective and contradicts current knowledge suggesting that recovery is neither a linear process nor a static end product or result.

H.2.2. Agencies need to have coordinating structures to attend to both the prioritization and integration of the range of new initiatives, policies, and procedures they are attempting to implement at any given time.

H.2.3. Performance and outcome indicators need to reflect the fact that the desired goal of recovery-oriented care is to promote growth, independence, and wellness; goals which sometimes involve the taking of reasonable risks that may result in interim setbacks.

H.2.4. Continual quality assurance and independent audits are conducted by people in recovery and families trained in recovery-oriented care.

H.2.5. Initial placement and service design are driven as much by the person's perception of what services and supports would be most helpful as by the staff's assessments of what the individual seeking services needs.

H.2.6. Recovery plans respect the fact that services and practitioners should not remain central to a person's life over time.

H.2.7. To integrate employment within the larger system, the task of assisting people in entering employment and education is made inherent to the responsibilities of the entire practitioner network, including those not specifically charged with supported employment or education tasks.

H.3. Implementation of recovery-oriented care needs to be facilitated, rather than impeded, by funding, reimbursement, and accrediting structures. Change strategies to address this issue include:

H.3.1. Even though Medicaid is funded by federal dollars, it remains primarily a state-administered program, and considerable flexibility exists in using these dollars to support innovative, community-based, supports.

H.3.2. Within existing funding structures, training and technical assistance can be provided to practitioners attempting to implement recovery-oriented practices to assist them in learning how to translate the wishes of people in recovery into reimbursable service goals and to describe their interventions in a manner that will generate payment.

H.3.3. Rather than being an add-on to existing services, transformation to recovery-oriented care begins with discovering ways to be creative and flexible within the constraints of existing resources.

H.3.4. Self-directed funding opportunities should be considered both on a collective basis and through individualized budget programs.

H.4. Training and staff development is prioritized as an essential function to increase individual practitioners' competencies in providing recovery-oriented care. Necessary change strategies to address this issue include the following:

H.4.1. As consensus emerges regarding the knowledge and skills needed to implement recovery-oriented care, this information must lead to the development of competency models, and these models must be disseminated broadly as guidance for training programs and licensing bodies which prepare and accredit providers of behavioral health care.

H.4.2. Once established, competency models should be incorporated in all human resource activities as a means of promoting accountability and quality improvement.

H.4.3. An analysis of staff's current competencies and self-perceived training needs should guide the development of on-going skill-building activities at the agency level.

H.4.4. Competency-based training must be coupled with on-going mentorship, enhanced supervision, recovery-oriented case conferences, and opportunities for peer consultation.

H.4.5. Clinical directors and agency leaders should be involved in ongoing training initiatives so that there is consistency between proposed recovery-oriented practices and the system's administrative structures.

H.4.6. Recovery-oriented care does ***not*** imply that there is no longer any role for the practitioner to play. Rather, the provider's role has changed from that of all-knowing, all-doing caretaker to that of coach, architect, cheerleader, facilitator, mentor, or shepherd—roles that are not always consistent with one's clinical training or experiences.

H.4.7. Training initiatives need to support people in recovery and families to develop their own capacity to self-direct their care and life decisions.

H.5. Forces at the societal level which undermine recovery and community inclusion are identified and addressed. Necessary change strategies to address this issue include the following:

H.5.1. Behavioral health practitioners have significant expertise to address the lack of basic resources and opportunities in the broader community, and are prepared to offer supportive guidance and feedback at both the individual and community level.

H.5.2. Community collaborations and education must be coupled with efforts on the part of behavioral health practitioners to recognize instances of discrimination, to understand relevant disability legislation, and to effectively utilize state and local resources.

H.5.3. Agencies are cautioned to avoid the establishment of 'one stop shopping' service programs which may inadvertently contribute to the perpetuation of discriminatory and unethical practices on the part of community members. We must continue to work with community partners to uphold their obligation to respect people with behavioral health disorders as citizens who have the right to be treated according to the principles of law that apply to all other individuals

H.5.4. Professionals and service recipients should be mindful of the limited resources available for specialized services and should focus on community solutions and resources first by asking "Am I about to recommend or replicate a service or support that is already available in the broader community?"

H.6. Certain internal barriers unique to behavioral health disorders are identified and addressed. Necessary change strategies to address these barriers include the following:

H.6.1. Staff appreciate the fact that, based on a complex interaction of the person's conditions and his or her past experiences in the behavioral health care system, people with behavioral health disorders may be reluctant to assume some of the rights and responsibilities promoted in recovery-oriented systems. They may initially express reluctance, fears, mistrust, and even disinterest when afforded the right to take control of their treatment and life decisions. Exploring and addressing the many factors influencing such responses is an important component of care.

H.6.2. Research indicates that many individuals with behavioral health disorders also have histories of trauma. Failure to attend to such histories may seriously undermine the treatment and rehabilitation enterprises, and further complicate the person's own efforts toward recovery.

H.6.3. Certain symptoms of illnesses may also pose direct impediments to the recovery process. In certain conditions, the elimination or reduction of symptoms may also come with great ambivalence, e.g., while episodes of mania can be destructive, they may include a heightened sense of creativity, self importance, and productivity that are difficult to give up. Being able to identify and address these and other sequelae requires knowledge and skill on the part of the clinical practitioner.

In each of the following sections, practitioners are given examples of what they are likely to hear from people in recovery when these guidelines have been implemented successfully. In addition, there is a list of recommended resources for further reading on transformation to recovery-oriented care, as well as a glossary of recovery-oriented language and examples of strengths-based conceptualizations that are proposed as alternatives to current deficit-based ones.

DEPARTMENT OF PUBLIC HEALTH: Keeping Connecticut Healthy

Where to Find Evidence-based Methods and Interventions

Evidence-based health or public health methods and interventions are practices, procedures, programs, or policies that have been proven effective. The effects are clearly linked to the activities, themselves, not to outside, unrelated events.

Evidence of effectiveness is demonstrated by: 1) inclusion in federal registries of evidence-based interventions; 2) reports in peer-reviewed journals; 3) documentation in other reputable sources of information; or 4) the consensus of opinion among informed experts.

Evidence-based methods and interventions for any given health or public health problem can be found using the resources listed below. This list includes resources covering broad topics. PubMed (see below under **Other Resources**) is recommended for finding the newest methods and interventions related to specific problems or diseases.

Mental Health and Mental Disorders

Goal

Improve mental health through prevention and by ensuring access to appropriate, quality mental health services.

Overview

Mental health is a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with challenges. Mental health is essential to personal well-being, family and interpersonal relationships, and the ability to contribute to community or society.

Mental disorders are health conditions that are characterized by alterations in thinking, mood, and/or behavior that are associated with distress and/or impaired functioning. Mental disorders contribute to a host of problems that may include disability, pain, or death.

Mental illness is the term that refers collectively to all diagnosable mental disorders.

Why Is Mental Health Important?

Mental disorders are among the most common causes of disability. The resulting disease burden of mental illness is among the highest of all diseases. In any given year, an estimated 18.1% (43.6 million) of U.S. adults ages 18 years or older suffered from any mental illness and 4.2% (9.8 million) suffered from

a seriously debilitating mental illness.[1] Neuropsychiatric disorders are the leading cause of disability in the United States, accounting for 18.7% of all years of life lost to disability and premature mortality.[2] Moreover, suicide is the 10th leading cause of death in the United States, accounting for the deaths of approximately 43,000 Americans in 2014.

Mental health and physical health are closely connected. Mental health plays a major role in people's ability to maintain good physical health. Mental illnesses, such as depression and anxiety, affect people's ability to participate in health-promoting behaviors. In turn, problems with physical health, such as chronic diseases, can have a serious impact on mental health and decrease a person's ability to participate in treatment and recovery.[5]

Understanding Mental Health and Mental Disorders

The existing model for understanding mental health and mental disorders emphasizes the interaction of social, environmental, and genetic factors throughout the lifespan. In behavioral health, researchers identify:

- Risk factors, which predispose individuals to mental illness
- Protective factors, which protect them from developing mental disorders

Researchers now know that the prevention of mental, emotional, and behavioral (MEB) disorders is inherently interdisciplinary and draws on a variety of different strategies.[6]

Over the past 20 years, research on the prevention of mental disorders has progressed. The understanding of how the brain functions under normal conditions and in response to stressors, combined with knowledge of how the brain develops over time, has been essential to that progress. The major areas of progress include evidence that:

- MEB disorders are common and begin early in life
- The greatest opportunity for prevention is among young people
- There are multiyear effects of multiple preventive interventions on reducing substance abuse, conduct disorder, antisocial behavior, aggression, and child maltreatment
- The incidence of depression among pregnant women and adolescents can be reduced
- School-based violence prevention can reduce the base rate of aggressive problems in an average school by 25 to 33 percent
- There are potential indicated preventive interventions for schizophrenia
- Improving family functioning and positive parenting can have positive outcomes on mental health and can reduce poverty-related risk
- School-based preventive interventions aimed at improving social and emotional outcomes can also improve academic outcomes

- Interventions targeting families dealing with adversities, such as parental depression or divorce, can be effective in reducing risk for depression among children and increasing effective parenting
- Some preventive interventions have benefits that exceed costs, with the available evidence strongest for early childhood interventions
- Implementation is complex, and it is important that interventions be relevant to the target audiences

The progress identified above has led to a stronger understanding of the importance of protective factors. A 2009 Institute of Medicine (IOM) report advocates for multidisciplinary prevention strategies at the community level that support the development of children in healthy social environments.[7] In addition to advancements in the prevention of mental disorders, there continues to be steady progress in treating mental disorders as new drugs and stronger evidence-based outcomes become available.

Emerging Issues in Mental Health and Mental Disorders

New mental health issues have emerged among some special populations, such as:

- Veterans who have experienced physical and mental trauma
- People in communities with large-scale psychological trauma caused by natural disasters
- Older adults, as the understanding and treatment of dementia and mood disorders continues to improve

As the Federal Government begins to implement the health reform legislation, it will give attention to providing services for individuals with mental illness and substance use disorders, including new opportunities for access to and coverage for treatment and prevention services.

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Substance Abuse: Clinical Issues in Intensive Outpatient Treatment

A Treatment Improvement Protocol

TIP 47

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment
www.samhsa.gov

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2 Principles of Intensive Outpatient Treatment

In This Chapter...

Principle 1: Make Treatment Readily Available

Principle 2: Ease Entry

Principle 3: Build on Existing Motivation

Principle 4: Enhance Therapeutic Alliance

Principle 5: Make Retention a Priority

Principle 6: Assess and Address Individual Treatment Needs

Principle 7: Provide Ongoing Care

Principle 8: Monitor Abstinence

Principle 9: Use Mutual-Help and Other Community-Based Supports

Principle 10: Use Medications if Indicated

Principle 11: Educate About Substance Use Disorders, Recovery, and Relapse

Principle 12: Engage Families, Employers, and Significant Others

Principle 13: Incorporate Evidence-Based Approaches

Principle 14: Improve Program Administration

This chapter presents 14 principles that integrate the findings of addictions research with the opinion of the consensus panel. By synthesizing research and practice, the consensus panel will assist clinicians in applying these principles to the clinical decisions they face daily. The 14 principles are expressed throughout this TIP in the form of specific recommendations. They are summarized here to provide a concise overview of effective intensive outpatient treatment (IOT) principles.

The *Principles of Drug Addiction Treatment: A Research-Based Guide* (National Institute on Drug Abuse 1999) offers a valuable starting point for the principles that are described in this chapter. The National Institute on Drug Abuse (NIDA) principles pertain to the full spectrum of addiction treatment modalities, not only to IOT. The consensus panel chose to accentuate the principles that are critical to effective IOT.

The 14 principles described in this chapter are

1. Make treatment readily available.
2. Ease entry.
3. Build on existing motivation.
4. Enhance therapeutic alliance.
5. Make retention a priority.
6. Assess and address individual treatment needs.
7. Provide ongoing care.
8. Monitor abstinence.
9. Use mutual-help and other community-based supports.
10. Use medications if indicated.
11. Educate about substance abuse, recovery, and relapse.
12. Engage families, employers, and significant others.
13. Incorporate evidence-based approaches.
14. Improve program administration.

Principle 1: Make Treatment Readily Available

Accommodate a Wide Spectrum of Clients Who Are Substance Dependent

Clinical research and practice have established that IOT is an effective and viable way for individuals with a range of substance use disorders to begin their recovery. In the 1980s, it commonly was believed that only clients who were relatively high functioning, employed, and free of significant co-occurring psychiatric disorders could benefit from IOT and that IOT was not effective with clients who were compromised by significant psychosocial stressors such as homelessness or co-occurring disorders. Today substantial research and clinical experience indicate that IOT can be effective for clients with a range of biopsychosocial problems, particularly when appropriate psychiatric, medical, case management, housing, and other support services are provided.

IOT programs have adjusted successfully to the challenges of working with many special population groups that include

- Clients who are economically disadvantaged (Gruber et al. 2000; Milby et al. 1996)
- Clients who are psychiatrically compromised (Drake et al. 1998*a*, 1998*b*; Rosenheck et al. 1998)
- Pregnant women (Eisen et al. 2000; Howell et al. 1999)
- Individuals involved with the criminal justice system and other clients coerced into treatment

IOT programs have modified their treatment models to be responsive to the needs of adolescents (Jainchill 2000) and women with children (Nardi 1998; Volpicelli et al. 2000). In addition, panel members have described the benefits of IOT programs with culturally specific components for Native American and Spanish-speaking clients and IOT services for clients at various stages of treatment readiness. The unique needs of specific client populations often can be met in IOT by adding services and creating linkages with other service providers.

Comparing Inpatient Treatment With Intensive Outpatient Treatment

Several studies comparing intensive outpatient treatment with residential treatment have found no significant differences in outcomes (Guydish et al. 1998, 1999; Schneider et al. 1996). Finney and colleagues (1996), however, in a review of 14 studies, found that the available evidence tended to favor inpatient slightly over outpatient treatment. The consensus panel has concluded that clients benefit from *both* levels of care and that comparing inpatient with outpatient treatment is potentially counterproductive because the important question is not which level of care is better but, rather, which level of care is more appropriate at a given time for each client. Matching clients with enhanced services also improves client outcomes. McLellan and colleagues (1998) found that compared with control subjects, clients with access to case managers who coordinated medical, housing, parenting, and employment services had less substance use, fewer physical and mental health problems, and better social function after 6 months. It is in the best interest of clients to have a broad continuum of treatment options available. Some clients entering IOT may be able to engage in treatment immediately, whereas others may need referral to a long-term residential program or a therapeutic community. Some clients can be detoxified successfully in an ambulatory setting, whereas others need residential services to complete detoxification successfully.

Principle 2: Ease Entry

Make Access to Treatment Straightforward and Welcoming

IOT programs need to examine policies and procedures to remove unnecessary hurdles in the admission process. From the moment a client or family member first contacts the program, efforts should be made to communicate that IOT exists to serve the client. Delays in the admission process contribute significantly to premature dropout from treatment (Festinger et al. 2002). IOT programs should strive to make the initial appointment available on demand.

Programs should address the following:

- Can the admission process be streamlined without hurting revenues?
- Are the program's hours convenient for clients?
- How can the program facilitate transportation for clients?
- How can the program accommodate clients with childcare responsibilities?
- Is the program individualizing treatment for each client?

The initial encounter with the IOT program should help the client feel like a welcomed participant who is responsible for his or her recovery. IOT programs need to develop a strong customer-focused orientation, making entry into treatment a positive and therapeutic experience.

Principle 3: Build on Existing Motivation

Employ Strategies That Enhance the Client's Motivation

One of the oldest, yet still surviving, misconceptions in the substance abuse treatment field is the notion that people have to "hit bottom" before they can be helped. Studies indicate that individuals who enter treatment for "the wrong reasons" (e.g., complying with external pressures) have outcomes that are comparable with outcomes of those who come into treatment for the "right reasons" (e.g., personal commitment to recovery) (Lawental et al. 1996).

Internal or external pressures drive people to enter treatment. Reasons include negative consequences related to substance use such as an arrest for driving under the influence, pressure from family or friends, fear that substance use is out of control, despair, job insecurity, or a trauma. An IOT program should accept that a client's presence in its office indicates some desire for treatment services.

Regardless of how well or poorly motivated clients appear at treatment entry, their motivation is likely to waver repeatedly over time. Both IOT programs and clients benefit when counselors keep clients mindful of what led them to treatment. Counselors should try to understand what clients care about and connect client concerns with addressing substance use. For example, if a client talks frequently about her daughter, the counselor might ask the client to consider how substance use affects her relationship with the child.

Because of the central importance of motivation in substance abuse treatment, strategies to enhance and maintain client motivation have been a priority in substance abuse research. Two well-researched approaches offer insights into and strategies for maximizing client motivation:

- Contingency management and related behavioral interventions use incentives to increase client retention in treatment and abstinence. Contingency management in addiction treatment has been studied for more than 30 years, but recent studies have focused on how its principles can be applied in community-based settings (Budney and Higgins 1998; Higgins and Silverman 1999; Katz et al. 2001; Kirby et

al. 1999*a;* Petry 2000). These behavioral intervention studies show that motivation is negotiable and can be increased when incentives are applied strategically and systematically. IOT programs are encouraged to find creative ways to use incentives to increase treatment adherence and enhance outcomes.

- Motivational enhancement and interviewing are techniques whereby the counselor responds to client denial and resistance by proposing thoughtful and detailed strategies that are designed to increase client readiness to change (CSAT 1999*c;* Miller and Rollnick 2002; Prochaska and DiClemente 1984). The approach is based on the theory that clients being treated for substance use disorders go through five stages of change: precontemplation, contemplation, action, relapse, and maintenance. Client resistance to treatment indicates that the counselor may be attempting to move the client to the next stage too quickly.

Principle 4: Enhance Therapeutic Alliance

Implement Strategies That Build Trust Between Counselor and Client

In treating mental and substance use disorders, research repeatedly has found one factor to be particularly important in influencing positive outcomes: therapeutic alliance (Martin et al. 2000). In fact, therapeutic alliance is one of the few aspects of treatment that consistently has been linked with increased retention in treatment and improvement in a variety of treatment outcomes. The achievement and maintenance of therapeutic alliance are high priorities in treatment.

Therapeutic alliance has four components (Gaston 1991):

- The client's capacity to work on his or her problem
- The client's emotional bond with the therapist
- The therapist's empathic understanding of the client
- The agreement between client and therapist on the goals and tasks of treatment

Therapeutic alliance tends to be enhanced when clinicians are active listeners, empathic, and nonjudgmental and approach treatment as an active collaboration (Mercer and Woody 1999).

Clinical supervisors should consider the counselors' ability to establish and maintain a therapeutic alliance when hiring and evaluating staff. Staff training and supervision should emphasize consistently that therapeutic alliance is an important element of any clinical interaction. Performance monitoring and quality improvement activities can capture and measure data on therapeutic alliance, so staff members can improve their skills at fostering this important treatment element (see CSAT 2006*f*).

Principle 5: Make Retention a Priority

Place a Premium on Retaining Clients

Early termination of treatment harms the client and staff morale. When clients drop out of treatment prematurely, they are at increased risk of relapse. Completing a prescribed treatment episode is associated with better outcomes, regardless of the length of the treatment (Gottheil et al. 1998).

Given the large number of clients who drop out in the first few weeks of treatment, programs should use strategies and approaches that ensure that clients will complete treatment, such as conducting preadmission interviews (Martino et al. 2000), delivering phone reminders and mailed reminders,

using phone orientations, and decreasing the initial call-to-appointment delay (Stasiewicz and Stalker 1999).

A major strength of IOT is that clients have the opportunity to cope with their illness and make changes in their behavior while living at home. Individual differences in how quickly clients adopt new behaviors call for clinical sophistication and flexibility on the part of counselors and the program as a whole. It can be frustrating when clients do not accept immediately the clinical approach that the IOT program is using. Clients can be frustrated when they are forced into making major lifestyle changes that do not yet make sense to them. Under such circumstances, clients may drop out. Programs need counseling approaches that help clients move toward higher levels of healthy functioning.

Principle 6: Assess and Address Individual Treatment Needs

Match Treatment Services to Clients' Needs

At intake, treatment providers gather preliminary information from clients; then, shortly after admission, programs typically complete a comprehensive biopsychosocial assessment. Many programs administer standardized assessments, such as the Addiction Severity Index (McLellan et al. 1992*a*, 1992*b*) as well as other specific and multidomain assessments. After collecting detailed information about clients' histories and future goals, programs need to use this information to tailor treatment services to clients.

When clients have unmet psychiatric, medical, legal, housing, social, family, or other personal needs, their ability to focus on recovery can be compromised. When programs match the individual treatment needs of clients to treatment services that address those needs, outcomes improve (Hser et al. 1999; McCaul et al. 2001; McLellan et al. 1998, 1999). NIDA's *Principles of Drug Addiction Treatment* notes that "matching treatment settings, interventions, and services to each individual's particular problems and needs is critical to his or her ultimate success in returning to productive functioning in the family, workplace, and society" (National Institute on Drug Abuse 1999, p. 3). IOT programs need to find increasingly efficient strategies for assessing treatment needs and implementing individualized care plans.

> The achievement and maintenance of therapeutic alliance are high priorities in treatment.

Principle 7: Provide Ongoing Care

Employ a Chronic Care Model, Adjusting Intensity According to Clients' Needs

A substance use disorder is a complex biopsychosocial illness that is not amenable to a quick fix. In addition to their substance use disorders, clients often have significant psychiatric disorders, criminal involvement, histories of physical and sexual trauma, serious medical illnesses, or profound economic challenges or are homeless. IOT programs contribute to society when they successfully assist clients in improving their ability to function in the community, in the workplace, and in their families. The successful initiation and maintenance of this transformation require sustained and conscientious efforts by the client, his or her support system, and a clinical team.

Substance abuse is a chronic illness similar in many respects to other chronic diseases

such as asthma, diabetes, and hypertension (McLellan et al. 2000). During the early phase of treatment, intensive interventions may be required, including hospitalization. As the client's condition changes, the intensity of treatment gradually can be increased or decreased depending on the client's condition. Eventually client care may be reduced to periodic checkups that evaluate the client's status and adjust treatment accordingly. A substance use disorder often is treated as if it were an acute illness that responds to a brief, acute course of treatment. Frequently, a 6-week IOT experience is not followed by a stepped-down phase of counseling sessions. For many clients, this abrupt shift from intensive treatment to discharge is destabilizing. Because substance abuse is a chronic condition and relapse is always a possibility, IOT programs are encouraged to examine how they can provide smoother stepdown processes and continuing care services that are responsive to the chronic nature of substance use disorders.

Following their successful completion of an intensive phase of treatment, clients should be evaluated for their readiness to be transferred to less intensive levels of care. Gradually, clients should be transitioned from several therapeutic contacts per week to weekly contact to semimonthly contact and so on. The concept of graduation should be reframed to convey clearly—as it is in colleges and universities—not an ending but a commencement or a new beginning.

Principle 8: Monitor Abstinence

Recognize the Progress That Clients Make in Achieving and Maintaining Abstinence

Programs might consider requiring 30 days of abstinence before transitioning clients to a less intense level of care because extended abstinence is associated with positive long-term outcomes (McKay et al. 1999). Although it is true that not all clients readily can achieve abstinence without relapsing a few times, it also is true that outcomes are best for those clients who have stopped using drugs and have submitted a drug-free urine sample before entering treatment (Ehrman et al. 2001). To monitor abstinence, IOT programs should use urine drug screens, Breathalyzer™ tests, or other laboratory tests to confirm self-reported abstinence. Urine drug screens can be an effective adjunct in treatment and can contribute to improved treatment outcomes (National Institute on Drug Abuse 1999). Although cost considerations may limit the frequency of urine drug screens and Breathalyzer tests, the consensus panel strongly encourages the use of these objective measures of abstinence.

Principle 9: Use Mutual-Help and Other Community-Based Supports

Assist Clients in Successfully Integrating Into Mutual-Help and Other Community-Based Support Groups

Participation in mutual-help programs, such as 12-Step programs and treatment programs that facilitate 12-Step membership, is associated with better outcomes than participation in types of treatment that do not facilitate 12-Step membership (Humphreys et al. 1997; Moos et al. 1999; Project MATCH Research Group 1997; Vaillant 1983; see McCrady and Miller 1993, for a review of the Alcoholics Anonymous [AA] research literature). Clients who become involved in 12-Step programs after they step down from IOT tend to do significantly better than those who do not participate in such programs (Moos et al. 1999). IOT programs should facilitate clients' becoming integrated

successfully into healthy, community-based mutual-help groups, such as AA (www.alcoholics-anonymous.org) and Narcotics Anonymous (NA) (www.na.org), during treatment. IOT programs should assist clients directly in locating a home group and a sponsor and in becoming oriented to the culture of 12-Step programs.

It is not sufficient simply to refer clients to AA or other 12-Step groups. Just as a physician works with patients to find the right medication and dosage, counselors need to help clients identify the right type of meeting and frequency of attendance (Forman 2002). Just as patients often have unwanted side effects from medications, particularly when they first start taking them, clients who begin attending 12-Step and other mutual-help groups often experience some minor side effects. IOT programs can help clients minimize the negative side effects by providing orientation and support as clients adjust to this important treatment element. (There are many 12-Step meetings for the family, such as Al–Anon/Alateen [www.al-anon.alateen.org] and Nar-Anon [naranon.com], as well as groups for compulsive behaviors such as sex, gambling, spending, and eating.)

Many individuals who are substance dependent find abstinence through participation in faith-based organizations, and many religious groups offer support for individuals who are seeking recovery. Other individuals have benefited from support groups such as Rational Recovery (www.rational.org), Smart Recovery (www.smartrecovery.org), or Women for Sobriety (www.womenforsobriety.org) that offer an alternative to 12-Step meetings. Giving clients a choice of support groups is empowering because it enables them to make informed decisions.

Principle 10: Use Medications if Indicated

Use Appropriate Medications To Manage Co-Occurring Substance Use and Psychiatric Disorders

A substantial percentage of clients with substance use disorders also have co-occurring psychiatric conditions (Kessler et al. 1996; Marlowe et al. 1995). Psychiatric medications are critically important in the treatment of these co-occurring conditions (Carroll 1996*a*; Drake et al. 1998*b*; Minkoff 1997). Ideally, IOTs should provide psychiatric evaluation and medication management on site. If funding limitations make it impossible to offer this care on site, then efficient and functioning links with mental health providers need to be maintained.

Resistance to the use of psychiatric medications by substance abuse treatment clinicians is gradually being replaced by an appreciation for the valuable role these medications can play when used appropriately. Likewise, both NA and AA historically had been averse to medications of any kind, but both have published statements supporting the appropriate use of medications (Alcoholics Anonymous World Services 1991; Narcotics Anonymous 1998).

> Substance abuse is a chronic illness similar...to other chronic diseases such as asthma, diabetes, and hypertension.

A number of pharmacotherapies have been shown to be effective adjuncts to the treatment of substance abuse. Naltrexone has

been effective with some people who are alcohol dependent (Guardia et al. 2002). However, a multisite study by Krystal and colleagues (2001) found that naltrexone was not effective in treating men with chronic, severe alcohol dependence. Under certain conditions, naltrexone has been effective in treating individuals addicted to opioids (Cornish et al. 1997). Similarly, disulfiram (Antabuse®) has been an effective adjunct in the treatment of alcoholism (O'Farrell et al. 1998). Some IOT programs have implemented treatment tracks for clients maintained on methadone. Buprenorphine (Ling et al. 1998; O'Connor et al. 1998) and buprenorphine combined with naloxone (Fudala et al. 1998; Mendelson et al. 1999) are now available for the treatment of opioid dependence and can be prescribed at IOT programs that have medical personnel on staff.

> Ideally, IOTs should provide psychiatric evaluation and medication management on site.

Principle 11: Educate About Substance Use Disorders, Recovery, and Relapse

Provide Clients and Family Members With Information About Substance Use Disorders, Recovery Skills, and Relapse Prevention

An important task in IOT is educating clients about substance use disorders and the skills they need to live comfortably in recovery. A wealth of accurate, free information about substance abuse and recovery skills is available to clinicians through Web sites and other sources mentioned throughout this volume, but a good starting place is chapter 4 of TIP 33, *Treatment for Stimulant Use Disorders* (CSAT 1999*e*). IOT programs are encouraged to develop recovery curricula for clients (or use one already developed) and to facilitate opportunities for clients to practice recovery skills while in treatment. Substance refusal training, stress management, assertiveness training, relapse prevention, and relaxation training are important behavioral techniques that can be incorporated into IOT programs (Carroll 1998; CSAT 1999*e*; Daley 2001, 2003; Marlatt and Gordon 1985; Mercer and Woody 1999). Clients should be provided with up-to-date information about the biology of substance use disorders, mutual-help programs, and appropriate use of medications.

Given the significant body of information that clients might need to support their recovery, programs are encouraged to explore the use of videotapes, written materials, and Web-based resources to help clients understand addiction and recovery. Consideration should be given to multiple approaches to educating clients, including lectures, discussions, workbook assignments, behavioral rehearsals or role plays, and daily logs or journals. Evaluation processes, such as feedback sessions, that monitor the clients' comprehension of key recovery skills are needed.

Principle 12: Engage Families, Employers, and Significant Others

Include Others Throughout the Treatment Process

The therapeutic involvement of families throughout the recovery process is associated with improved treatment outcomes (Epstein and McCrady 1998; McCrady et al. 1999; O'Farrell and Fals-Stewart 2003; Szapocznik and Williams 2000; White et al.

1998; Winters et al. 2002). Families can be a vital resource and a source of support and encouragement. Conversely, families also can influence the client adversely and undermine recovery. All clients are part of a group that functions as a "family" and as such are subject to the values, traditions, and culture of that family. IOT programs can marshal families' powerful positive influences or counter their negative influences by educating, counseling, and providing therapeutic family services. Referrals to therapists and organizations that provide family therapy should be considered when family therapy is unavailable in the IOT program.

When an individual has been referred for treatment by an employee assistance or student assistance program, representatives of the employer and school can play a potent role in supporting adherence to the treatment plan and ongoing recovery.

Principle 13: Incorporate Evidence-Based Approaches

Seek Out Evidence-Based Training Opportunities and Materials

Over the past 30 years a number of treatment approaches have been developed, tested, and demonstrated to be effective in a variety of settings (see chapter 8 for more information). These approaches include

- Cognitive–behavioral therapy (Carroll 1998)
- Motivational enhancement therapy (CSAT 1999*c*; Miller and Rollnick 2002; Prochaska and DiClemente 1984)
- Individual drug counseling (Mercer and Woody 1999)
- Relapse prevention training (Carroll et al. 1998; Daley 2001, 2003; Daley and Marlatt 1997; Daley et al. 2003)
- Contingency management and incentives (Budney and Higgins 1998; Petry 2000)
- 12-Step facilitation (Nowinski et al. 1992)
- Case management (McLellan et al. 1998, 1999)

IOT programs can adopt methods from these various treatment interventions. NIDA, the National Institute on Alcohol Abuse and Alcoholism (NIAAA), and the Center for Substance Abuse Treatment (CSAT) have published manuals about these approaches, and most of these manuals are available free of charge. A number of other evidence-based manuals are listed throughout this TIP, including documents from NIAAA Project MATCH and CSAT's Addiction Technology Transfer Centers and other CSAT publications.

Some counselors who enter the substance abuse treatment profession do not have extensive training. For them, the needed skills are learned on the job. Evidence-based manuals summarize the experience of knowledgeable clinicians and researchers, passing on effective techniques and approaches that have been refined over the years. Not all IOT programs are the same—some achieve better outcomes than others. IOT programs can improve their outcomes by successfully incorporating evidence-based approaches. The consensus panel encourages the use of evidence-based approaches as a means of improving treatment outcomes.

Principle 14: Improve Program Administration

Focus on Financial, Information, and Human Resource Management

Clinicians frequently are promoted into the role of IOT program director without any formal training in how to function as an administrator. The tasks of management differ significantly from those of a clinician, and the transition from one role to the other is not always a smooth or natural one. IOT

managers focus on the program's finances, regulatory compliance, human resource management, information management, administrative report preparation, and a host of other tasks that were not in their list of responsibilities as clinicians. TIP 46, *Substance Abuse: Administrative Issues in Outpatient Treatment* (CSAT 2006*f*), addresses the administrative issues that IOT managers need to master to manage programs effectively.

Attachment VII
Letters of Support

Turnbridge

September 8, 2016

To Whom It May Concern:

It is my pleasure to write this reference letter in support of Mountainside Treatment Center's Certificate of Need (CON) application for a freestanding outpatient psychiatric clinic.

As Vice President of Turnbridge, I routinely assist individuals and families seeking out addiction treatment and mental healthcare for their loved ones. Mountainside Treatment Center is a provider I often look to for a comprehensive continuum of care. Turnbridge is very selective when it comes to referral relationships with other providers, and Mountainside is at the top of our list for high-quality resources in the northeast.

It is my sincere hope that Mountainside's CON application is approved. Please do not hesitate to reach out to me with any questions or concerns. Thank you for your time.

Sincerely,

Jamie Hazelton
Vice President
Turnbridge
O 203.937.2309 x114
F 203.604.0542
www.TPaddictiontreatment.com

Sharon HOSPITAL
A RegionalCare Hospital Partners Facility

September 8, 2016

Stephen Langley
Executive Director
Mountainside Treatment Center
187 South Canaan Road
Canaan, CT 06018

PO Box 789
50 Hospital Hill Road
Sharon, Connecticut
06069
|
860.364.4000

Our hospital family cares for
our community family every day
|
sharonhospital.com

Dear Mr. Langley,

I am writing this letter of support to assist Mountainside Treatment Center in securing a certificate of need for a freestanding outpatient psychiatric clinic.

We have derived benefit from our relationship with Mountainside and consider Mountainside to be a great resource and collaborator.

Our company supports the work that Mountainside is doing to help individuals address their difficulties with substance abuse and mental health issues.

Sincerely yours,

Peter R. Cordeau

Peter R. Cordeau, RN, MBA
Chief Executive Officer

PRC/al

P R I M A R Y R E C O V E R Y S E R V I C E S

Stephen Langley
Executive Director
Mountainside Treatment Center
187 South Canaan Rd.
Canaan, CT 06018

Dear Mr. Langley, September 13, 2016

As you know I consider Mountainside to be the best treatment center in the country. Unfortunately, I have had to send a few clients to Sierra Tucson recently. The ONLY reason being your lack of psychiatric services. As an Interventionist, it is especially important to have all the necessary services available at one place. It is a logistical problem, as well as a treatment one. We strongly urge you move forward with providing outpatient psychiatric services at Mountainside. I know for certain that it would increase the numbers of individuals that I could refer to Mountainside. I prefer to treat people locally.

We are in full support of a free standing outpatient psychiatric program at Mountainside. Please let me know what I can do to help. We look forward to continuing to work Mountainside.

Best,

Paul J. Gallant MC, LPC, BRI-II
Primary Recovery Services
203-521-1949
paul@primaryrecoveryservices.com

Attachment VIII
Memorandums of Understanding/Agreements/Contracts

PATIENT TRANSFER AGREEMENT

THIS AGREEMENT is entered into and made effective as of July 21, 2014 by and between **THE CHARLOTTE HUNGERFORD HOSPITAL**, a Connecticut non-stock corporation having its principal place of business at 540 Litchfield Street, Torrington, Connecticut 06790 (hereinafter the "Hospital"), and the MC1 Healthcare, LLC, d/b/a Mountainside Treatment Center, a Connecticut limited liability company with an address at 187 South Canaan Road, Canaan, Connecticut 06018, (hereinafter "Facility").

WITNESSETH:

WHEREAS, the Hospital is an acute care hospital providing health care facilities and services to the general public in its service area, including emergency services; and

WHEREAS, Facility is an outpatient behavioral health center which occasionally must transfer a patient to an acute care hospital for emergency services; and

WHEREAS, the Hospital and Facility are desirous of entering into an agreement to affect the transfer of these patients.

NOW THEREFORE, in consideration of the mutual covenants contained herein, and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereto agree as follows:

Section 1. Purpose. The principal purpose of this Agreement is to enable the Hospital and Facility to promote the delivery of planned, well-managed, high quality, cost-effective and comprehensive health care services in the community by entering into a transfer agreement whereby the Hospital is the primary place of transfer for those patients of Facility in need of emergency services.

Section 2. Facility Responsibilities.

2.1 Facility shall obtain consent from the appropriate party at the Hospital for the patient transfer.

2.2 Facility shall make initial contact with the attending ER attending physician at the Hospital who will be responsible for assuming care of the patient at the Hospital.

2.3 Facility shall obtain patient consent and inform the patient or responsible party of the risks involved with transferring the patient to the Hospital and Facility shall document its compliance with this section 2.3. Such consent shall be obtained from the patient at the time such patient enters into treatment at Facility, on a form ("Consent to Transfer Form") to be agreed upon by the parties. The Facility shall provide the Hospital with prior written notice of any changes to the

language, terms or conditions of the Consent to Transfer Form.

2.4 Facility shall arrange and be responsible for patient's transportation to the Hospital.

2.5 Facility shall maintain accurate and complete patient medical records in compliance with all applicable state and federal laws, rules and regulations and exchange with the Hospital such medical and other information needed: (i) for providing optimal care and treatment of the patient; and (ii) when Facility deems appropriate, for determining whether the patient can be adequately cared for in a less expensive setting than either the Hospital or Facility.

2.6 Facility shall complete all necessary patient transfer forms.

2.7 Facility shall cooperate with the Hospital and ensure an orderly transfer in accordance with the Hospital's policies and procedures.

2.8 Facility shall assume responsibility for the delivery of transferred patients' personal effects, money and any other items brought with them into the Facility, provided the same is agreed to by the patient on the Consent to Transfer Form.

2.9 Facility shall assume responsibility for notifying and explaining to patients, patients' families or other guardians or responsible parties the need for the transfer prior to its occurrence. (In extreme emergencies, however, notification may be given as soon as possible following the transfer.)

2.10 Facility shall provide pertinent demographic data to the Hospital including name, date of birth, social security number, insurance information, and next of kin.

2.11 Facility shall fully cooperate in discharge plan and accept patient back into its care (provided patient agrees to return to the Facility, and Facility has an available space at the Facility) once the "acute" episode of care is completed. Facility is under no obligation to maintain an "empty space" at the Facility while the patient receives acute care at the Hospital.

Section 3. Hospital Responsibilities.

3.1 The Hospital shall assess and assure a timely disposition of the patient as medically appropriate, as determined by the attending physician.

3.2 The Hospital shall exchange with Facility such medical and other information needed: (i) for providing optimal care and treatment of the patient; and (ii) when Facility deems appropriate, for determining whether the patient can be adequately cared for in a less expensive setting than either the Hospital or Facility.

Section 4. Compliance. It is the parities' intent that this Agreement shall comply at all times with the provisions of the Emergency Medical Treatment and Active Labor Act (EMTALA), the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA) and all other applicable laws, regulations and orders, including but not limited to, the Internal Revenue Code of 1986, as amended, the Medicare and Medicaid Anti-Kickback statute and Stark law and any regulations promulgated thereunder. The Parties acknowledge that legislation, regulations, an administrative ruling or other legally binding opinion may be adopted, amended, promulgated or issued which effectively renders this Agreement unlawful, could affect the tax exempt status of the Hospital or any affiliates thereof, could impose liability or exclusion from participation in the Medicare or Medicaid program or otherwise have a negative impact on either party. In such event, either party may by written notice propose the termination, restructuring or renegotiation of this Agreement in order to effect compliance. If such notice is given and the parties are unable within thirty (30) days thereafter to reach an agreement with respect to restructuring of the Agreement, then this Agreement shall automatically terminate.

Section 5. Designation of Representatives. The parties shall each designate a representative or representatives to oversee the implementation of this Agreement. Meetings of said representatives shall be scheduled as appropriate and necessary as determined by the Hospital or Facility with appropriate and reasonable notice to the other party.

Section 6. Autonomy of Parties. Each party shall continue its independent existence and control. Neither party shall, by virtue of this Agreement, be constituted as an agent, joint venturer or representative of the other party and each party agrees that it shall conduct itself so as not to act or purport to act on behalf of the other. Nothing in this Agreement shall be construed to affect any activities of a party not expressly covered by its terms, or to impose any financial obligation not expressly provided herein on either party. Nothing in this Agreement is intended to alter, impair, or preclude any other relationships that may exist between a party and other institutions.

Section 7. Use of Name. Neither party shall use the name of the other party or a statement or description of this transfer agreement for any purpose (including, without limitation, marketing or advertising) without obtaining the prior consent of the other party.

Section 8. Charges for Services. Charges for services performed by either party shall be made and collected by the performing party in accordance with its regular policies and procedures. Unless special arrangements have been made to the contrary, the transfer of a patient from Facility to the Hospital shall not be construed as imposing financial liability by one party on the other. The parties shall cooperate with each other in the exchange of information about financial responsibility

for the services rendered by them to the patients who are transferred to the Hospital. Facility shall supply the Hospital with all available insurance and payment information for any transferred patient in order to assist it in billing for services. The Hospital shall not be responsible for the cost of the patient's transfer from Facility to the Hospital.

Section 9. Term/Termination.

9.1 Except as otherwise provided herein, this Agreement shall be effective as of the date set forth above and shall continue in effect for one (1) year. This Agreement may be terminated by either party upon ninety (90) days prior written notice.

9.2 This Agreement may be terminated immediately upon written notice of the termination of the other party's quality accreditation (i.e. Joint Commission, AAAC), or its operating certificate or license, or upon the bankruptcy or insolvency of the other party.

9.3 Each party shall have the right to terminate this Agreement upon thirty (30) days' prior written notice in the event of a material violation of law or regulation by the other party (or the entering into of a consent decree by another party relating to allegations of a material violation of law or regulation), which in the reasonable judgment of the terminating party may materially impair the reputation of the terminating party. If this Agreement is terminated pursuant to this paragraph, any outstanding obligations created under this Agreement prior to execution shall continue to be fulfilled in accordance with this Agreement.

Section 10. Insurance. At its sole expense, Facility shall maintain general and professional liability insurance in the amounts of $1,000,000 per claim and $3,000,000 in the aggregate to insure itself and each physician against any claim or claims for damages occasioned directly or indirectly in connection with the care or transfer of the patients or of any other activities under this Agreement. Facility shall maintain all other necessary insurances as are customary for an institution such as Facility.

Section 11. Indemnification. Facility agrees to indemnify and hold the Hospital and its directors, officers, agents and employees harmless from and against any and all claims, liabilities, losses, damages, expenses, and actions including, without limitation, reasonable attorneys' fees, which result from, are caused by or are related to: (a) Facility or Facility's agents', subcontractors', employees' or licensees' violation of state, federal, or local law, rule or regulation which results in bodily injury or physical or actual damage or the imposition of a fine, penalty or other charge; (b) the acts or omissions of Facility or Facility's agents, subcontractors, employees or licensees; (c) the breach of this Agreement by Facility; and/or (d) the negligence or willful misconduct of Facility or Facility's agents, subcontractors, employees or licensees.

Section 12. Miscellaneous.

12.1 ***Non-Discrimination.*** Neither party shall discriminate against any patient on the basis of race, sex, age, creed, national origin or the ability to pay.

12.2 ***Change of Conditions.*** Facility shall immediately inform the Hospital of any change of corporate condition, policy or procedures that may affect patient care activities at Facility.

12.3 ***Notices.*** Any notice, claim, demand, request or other communication required or permitted under this Agreement shall be valid and effective only if given by written instrument that is (i) personally delivered, (ii) sent by facsimile that is followed by a copy sent by mail or (iii) registered or certified mail (return receipt requested), postage prepaid, addressed as follows:

If to Hospital, to:

The Charlotte Hungerford Hospital
540 Litchfield Street
Torrington, Connecticut 06790
Attn:

If to Facility, to:

The Facility
187 South Canaan Road
Canaan, Connecticut 06018
Attn: Stephen Langley_____

Any notice, claim, demand, request or other communication given as provided in this section if given personally, shall be effective upon delivery; if given by facsimile, shall be effective on day after transmission and electronic confirmation, and if given by mail, shall be effective upon receipt.

Each party may change the address at which it is to be given notice by giving written notice to time other parties.

12.4 ***Assignment; Modification.*** This Agreement may not be assigned without the consent of the other party. Notwithstanding the foregoing, the Hospital may assign this Agreement to a successor corporation. This Agreement contains the entire agreement among the parties with respect to the subject matter hereof and may not be amended except as agreed to in writing by all the parties.

12.5 ***Governing Law.*** This Agreement shall be governed by and construed in accordance with the laws of the State of Connecticut.

IN WITNESS WHEREOF, the parties have caused this Agreement to be executed by their duly authorized representatives as of the day and year written above.

THE CHARLOTTE HUNGERFORD HOSPITAL

BY: _____

MC1 Healthcare, LLC, d/b/a Mountainside Treatment Center

BY: Stephen Langley

Sharon Hospital

MOUNTAINSIDE

Memorandum of Understanding
Sharon Hospital
Mountainside Treatment Center

Mountainside Treatment Center agrees to accept transfers of chemically dependent clients from Sharon Hospital Emergency Department who are in need of alcohol or other drug detoxification and whose BAC is below .36 who meet admission and financial criteria.

Mountainside Treatment Center will detoxify clients that are not acutely medically compromised and can be managed in a Medically Monitored Detoxification (III.7D) Level of Care.

Mountainside Treatment Center will be responsible for the client's continuing care plan unless the medical problems are beyond Mountainside's scope of abilities.

Mountainside Treatment Center will be responsible for the client's continuing care plan, up to and including movement to our Intensive Residential Treatment (III.7D) Level of Care.

Mountainside Treatment Center will provide all necessary, relevant medical information in our possession to the Triage Nurse at Sharon Hospital prior to or at the time of transport of the client diagnosed with a medical emergency.

Mountainside Treatment Center and Sharon Hospital mutually agree to provide each other with any requested client information without delay and consistent with HIPAA and other Federal and State Regulations.

Clients that are currently involved in ongoing Medical Care at Sharon Hospital will be reconnected to care upon completion of detoxification and stabilization of their addiction.

Sharon Hospital will accept for medical care clients whose BAC is above .36.

Sharon Hospital will accept for medical care clients who present with acute medical conditions or whose medical condition emerges during the course of detoxification, and cannot be managed at the level (III.7D) of care.

Mountainside Treatment Center will accept back clients medically cleared for an (III.7D) level of care by Sharon Hospital Emergency Department and who meet financial criteria.

Sharon Hospital will forward copies of all medical assessment materials, laboratory reports, X-ray results and other pertinent data related to the specific medical issue for which the client was transferred to Sharon Hospital.

Page 1 of 2

MOUNTAINSIDE

As part of our mutual agreement both agencies agree to:

1. Communicate freely in order to enhance services to both our patients and the communities we serve.
2. Review this agreement on an annual basis and make any necessary changes deemed necessary.
3. Protect all client information in accordance with all relevant federal and state regulations regarding confidentiality of information.

Signatures:

Kimberly A Smith — 5/12/14

Sharon Hospital — Date

Stephen Langley — 5/09/2014

Mountainside Treatment Center — Date

Sharon Hospital Laboratory

MOUNTAINSIDE

The Laboratory Services Department at Sharon Hospital agrees to perform phlebotomy for ordered blood work on Monday, Wednesday, and Friday mornings (excluding holidays). Sharon Hospital Lab will also send lab results to Mountainside. Sharon Hospital Lab also agrees to process any ordered lab work that they are able to process, they will bill clients' insurances, and submit any other related costs to Mountainside.

Consistent with the Memorandum of Understanding between Sharon Hospital and Mountainside, any information pertaining to clients and ordered lab work may be shared between the two organizations.

Signed:

Kristinley Ofiwa 8/20/15

Sharon Hospital Representative Date

Stephen Langley 8/26/2015

Mountainside Treatment Center Representative Date

SERVICES AGREEMENT

THIS AGREEMENT, which includes all Attachments and or Exhibits, each of which is incorporated herein, (the "Agreement"), is made as of this 17th day of Feb, 2016 (the "Effective Date"), by and between **MC1 HEALTHCARE, LLC**, a limited liability corporation, doing business as **MOUNTAINSIDE TREATMENT CENTER** ("Mountainside") with a business office and address at 187 South Canaan Road, Canaan, Connecticut 06018 and **PHYSICIANS CHOICE LABORATORY SERVICES, ~~Inc.~~** LLC, ~~corporation~~, with a principal office located at 854 Paragon Way, Rock Hill, SC 29730 ("PCLS"). limited liability company

WITNESSETH:

WHEREAS, MOUNTAINSIDE desires to retain the services of a laboratory to perform toxicology urinalysis testing for the clients of MOUNTAINSIDE (the "Laboratory Services", which are more particularly described on **Exhibit A** attached to this Agreement);

WHEREAS, PCLS is knowledgeable about the Laboratory Services, and is able to perform a wide range of tests related to the assessment of MOUNTAINSIDE'S client's conditions and is experienced in providing or arranging for the provision of various support services to assist the operations of such Laboratory Services; and

WHEREAS, MOUNTAINSIDE desires to engage PCLS to provide Laboratory Services and other items as more fully described herein for the Term of this Agreement, as more fully described below, and PCLS is willing to provide such items and Laboratory Services subject to the terms and conditions of this Agreement.

NOW, THEREFORE, in consideration of the mutual covenants and agreements contained herein, and intending legally to be bound, the parties hereto agree as follows:

1. **Engagement.** MOUNTAINSIDE hereby engages and retains PCLS, and PCLS accepts and agrees to perform, Laboratory Services as further set forth herein in **Exhibit A**, and to supply such other services and items as are necessary and appropriate to assist MOUNTAINSIDE in performing toxicology urinalysis otherwise described herein.

2. **Term.** The initial term ("Initial Term") of this Agreement shall be for a one (1) year period. The term of the Agreement may be extended for additional periods of one (1) year at the option of MOUNTAINSIDE ("Renewal Term(s)"), unless MOUNTAINSIDE gives PCLS written notice of its intent to not renew this Agreement at least thirty (30) days prior to the end of the Initial Term or any Renewal Term (a "Non-Renewal Notice"). As used in this Agreement, "year" means the period commencing on the Effective Date and ending twelve (12) months thereafter during the Initial Term and any Renewal Term. PCLS may prohibit renewal by a written notice to MOUNTAINSIDE no less than thirty (30) days prior to the end of the Initial Term or any Renewal Term. In the event MOUNTAINSIDE fails to provide a Non-Renewal Notice to PCLS prior to thirty days before termination, then this Agreement shall automatically be renewed for a period of One (1) Year.

3. **PCLS's Responsibilities.** During the Initial Term and any Renewal Term(s), PCLS agrees to provide the Laboratory Services to MOUNTAINSIDE in connection with the needs of

MOUNTAINSIDE on behalf of its clients, which services shall be provided in a businesslike manner in compliance with all applicable laws and regulations, all of which Laboratory Services are subject to MOUNTAINSIDE's final decision making, as set forth in Section 4.6 below, and PCLS shall be compensated for such services pursuant to Section 5 of this Agreement. Upon termination of this Agreement, MOUNTAINSIDE shall have the continuing right to use any procedures or protocols made available to MOUNTAINSIDE pursuant hereto, and any such procedures or protocols developed specifically for MOUNTAINSIDE shall be and remain the property of MOUNTAINSIDE.

3.1. In consideration of the compensation to be paid by MOUNTAINSIDE to PCLS pursuant to Section 5 hereof, PCLS shall provide the following services, equipment and other items to MOUNTAINSIDE.

3.1.1. Develop and provide (at PCLS's cost) to MOUNTAINSIDE an interface between PCLS's computers and MOUNTAINSIDE's electronic Medical record system ("EMR", which EMR is referred to by MOUNTAINSIDE as "Sigmund"), which interface shall allow the transmission of lab results performed by PCLS into the Sigmund files for MOUNTAINSIDE's clients via a "drop box" capability. In addition, PCLS shall provide a client access option through the same drop box facility; and

3.1.2. Assist MOUNTAINSIDE in implementing QA/QC oversight of the testing processes in connection with the Laboratory Services; and.

3.1.3. Create protocols for the collection, storage and transmittal of urine and other samples ("Samples") taken from MOUNTAINSIDE clients and sent to the PCLS laboratory; and.

3.1.4. Advise and assist MOUNTAINSIDE on the addition of new testing procedures to be performed at the PCLS laboratory; and

3.1.5. Work with MOUNTAINSIDE to create and implement appropriate confidentiality protocols for the handling and transmittal of Samples pursuant to the terms of this Agreement, as well as the transmittal of testing results from PCLS back to MOUNTAINSIDE; and

3.1.6. Pay for the cost of all materials and shipping in connection with the transmittal of Samples from MOUNTAINSIDE to PCLS; and

3.1.7. Pay for all costs and certifications necessary to operate the laboratory owned by PCLS in compliance with federal regulations.

3.1.8. PCLS shall bill and collect all Laboratory Services to clients or third party payors, for all services performed by it. Such billings to clients shall be processed by PCLS not more than once per month.

3.2. PCLS shall periodically consult with MOUNTAINSIDE on the operations of the Laboratory Services as may be necessary to ensure regulatory compliance in the

performance of this Agreement by both parties. PCLS shall help MOUNTAINSIDE train all personnel who are involved in the collection and transmittal of Samples, to assure effective provision of the Laboratory Services.

4. **MOUNTAINSIDE'S Responsibilities.** MOUNTAINSIDE, at its expense, agrees to provide, or arrange for the provision of, the services and items listed below.

4.1. Provide for the collection, storage, transmittal and (when appropriate) disposal of Samples, including, but not limited to, bio-medical waste.

4.2. MOUNTAINSIDE shall engage such staff as it reasonably determines is necessary for the performance of its duties set forth in the Agreement. MOUNTAINSIDE shall be responsible for compensating its own staff.

4.3. MOUNTAINSIDE shall maintain and control all client data in MOUNTAINSIDE's possession, including all lab reports sent to MOUNTAINSIDE by PCLS. MOUNTAINSIDE shall be responsible for making all final decisions with respect to its operations. MOUNTAINSIDE shall bill and collect from appropriate parties, including, but not limited to, patients and third party payors, for the collection and transmittal of all Samples performed at the MOUNTAINSIDE facilities.

4.4. MOUNTAINSIDE shall maintain and retain all patient and testing records. Such record maintenance and retention shall comply with all applicable regulatory records maintenance and retention requirements.

4.5. Subject to PCLS's obligation to provide assistance and consulting services with respect thereto, MOUNTAINSIDE shall comply with all federal and state legislative and regulatory requirements that apply to the ownership and day-to-day operation of the MOUNTAINSIDE facilities.

4.6. MOUNTAINSIDE shall be responsible for the storage Laboratory Services information sent to it by PCLS. Such storage shall comply with applicable federal and state regulatory requirements as identified by PCLS.

5. **Compensation.** In full consideration of the services to be rendered and items to be provided by PCLS hereunder, MOUNTAINSIDE agrees to pay PCLS the following compensation commencing as of the Effective Date.

5.1. For PCLS's services hereunder, and to provide the aforesaid services, software, reagents, consumables and other supplies, MOUNTAINSIDE shall pay PCLS as follows:

5.1.1. For PCLS's provision of services described herein, specifically for the benefit of MOUNTAINSIDE and its clients, all as set out in this Agreement MOUNTAINSIDE shall pay to PCLS a fixed fee of Fifty Dollars dollars per month during the Initial Term. Prior to the commencement of any Renewal Term PCLS and MOUNTAINSIDE shall meet at least sixty (60)

days before the effective date of the Renewal Term to mutually agree in writing a monthly fixed fee compensation rate for each Renewal Term.

5.2. PCLS shall invoice MOUNTAINSIDE monthly for the compensation to be paid by MOUNTAINSIDE to PCLS under Section 5.1. Each such invoice shall include supporting documentation reasonably acceptable to MOUNTAINSIDE. MOUNTAINSIDE shall pay all invoices within thirty (30) days of receipt. Invoices remaining unpaid after the expiration of any such thirty (30) day period shall accrue interest at 1.5% per month.

5.3. MOUNTAINSIDE and PCLS agree that the compensation provided herein was determined in an objective manner in arm's length bargaining, was fixed before or on the Effective Date, and is consistent with fair market value in arm's-length transactions. Furthermore, compensation is not and has not been determined in a manner that takes into account the volume or value of any referrals or business otherwise generated for or with respect to PCLS or between the PCLS and MOUNTAINSIDE for which payment may be made in whole or in part under any federal, state, or other third party payor health care program. Nor are the financial arrangements set forth herein intended to effect any splitting of any revenues that the Laboratory Services may generate, but are strictly intended to compensate PCLS for the services that it is providing to MOUNTAINSIDE hereunder, which both parties believe are consistent with the fair market value of the services to be provided.

6. **Compliance with Laws.** Each of the parties agrees that it will comply with all applicable laws, rules or regulations, including, but not limited to, the federal Medicare/Medicaid Anti-kickback Law, 42 U.S.C. § 1320a-7b(b) and regulations promulgated thereunder, similar state Anti-kickback laws and regulations promulgated thereunder, the Health Insurance Portability and Accountability Act ("HIPAA"), and the regulations promulgated thereunder, any applicable Connecticut anti-fee splitting or self-referral laws, any patient confidentiality laws, and any anti-discrimination laws, including, but not limited to, the Americans with Disabilities Act and regulations and guidelines promulgated or issued thereunder. In addition, the parties expressly acknowledge and agree that MOUNTAINSIDE is not under any obligation to, and that there is no agreement or understanding that MOUNTAINSIDE will, refer any patients or any tests to PCLS or any laboratory affiliated with PCLS. PCLS further represents that this Agreement and the services contemplated hereunder complies with all laws, rules and regulations regarding purchased services, including, but not limited to, Section 1842(n)(1) of the Social Security Act and its implementing regulation at 42 C.F.R. § 414.50, also known as the "Anti-Markup Rule," and such other applicable federal and state laws. If, at any time, the PCLS representations in this Section 6 are determined to be untrue, PCLS shall promptly notify MOUNTAINSIDE and MOUNTAINSIDE shall have the option to terminate this Agreement immediately and if PCLS is not in compliance with any of the above representations it shall indemnify, defend and hold Mountainside harmless from any and

all damage claims or penalties and return any and all monthly fees paid to PCLS from the date of the non-compliance.

7. **Change in Responsibilities.** If, as the result of a change in applicable law or regulation or as a result of MOUNTAINSIDE's needs or financial wherewithal (e.g., nature or volume of MOUNTAINSIDE's practice), there is a change in the scope of the Laboratory Services operations which materially affects the parties' rights and responsibilities hereunder or the basic economics of the relationship as contemplated by the parties upon execution of this Agreement, the parties agree to negotiate in good faith to amend this Agreement as necessary to effectuate the parties' original intentions as set forth in this Agreement. In the event that the parties are unable to reach agreement as to the terms of an amendment within forty-five (45) days of the request by either party to negotiate such amendment, either party may terminate this Agreement upon sixty (60) days written notice to the other party.

8. **Insurance.**

   8.1. Each party shall maintain malpractice insurance coverage in such amounts and with such terms and conditions as it reasonably deems necessary and appropriate to cover the risks associated with their respective responsibilities hereunder. MOUNTAINSIDE'S insurance shall cover the acts and omissions of its employees and PCLS's insurance shall cover the acts and omissions of its employees including those employees described in Section 3.4 hereof.

   8.2. Worker's Compensation Insurance will be the responsibility of the party directly employing the affected individual as an employee. Such insurance shall be paid by each party in the amounts provided by law.

   8.3. In no event shall either party be liable for indirect, special, or consequential damages to the other party, except to the extent of a party's failure to act in good faith under the terms and conditions of this Agreement.

9. **Right to Information.** Subject to any confidentiality restrictions to which the disclosing party is bound and subject also to Section 10, MOUNTAINSIDE and PCLS and their respective officers, employees and agents who have a need to know shall have the right to inspect all documentation in the possession or under the control of the other party for a legitimate business reason relating to this Agreement at such times and places as are reasonably agreeable to the parties, including, without limitation, test procedures, orders, billings and collections of the Laboratory (collectively referred to as "Business Information").

10. **Confidentiality, Employment Restrictions.** The parties agree that the services to be performed hereunder are special, unique and extraordinary and that, by reason thereof, each party and will acquire confidential information and trade secrets (including, without limitation, patent applications, technical and business processes, secret customer lists, special methods of operation, management processes and protocols, and future business plans) concerning the business of the other party ("Confidential Information"). Accordingly, each party agrees, that:

10.1. Except in the course of performance of the duties required to be performed by the parties under this Agreement, neither party will, at any time, disclose or use any Confidential Information pertaining, directly or indirectly, to any aspect of the other party's business or affairs;

10.2 Confidential Information shall not include any information which (a) becomes generally available to the public other than as a result of an impermissible disclosure by a party, (b) was available to a party on a non-confidential basis prior to its disclosure by the other party under this Agreement, (c) becomes available to a party on a non-confidential basis from a source other than the other party, provided that such source is not bound by an obligation of confidentiality with either PCLS or MOUNTAINSIDE or any of their employees or agents or is otherwise prohibited from transmitting the Confidential Information by a contractual, legal or fiduciary obligation or (d) becomes known to similar medical groups and becomes public knowledge irrespective of any prior agreements as along as such was not disclosed by MOUNTAINSIDE.

10.3 During the Term of this Agreement and for a period of one (1) year after this Agreement terminates, neither party shall, directly or indirectly, either alone or in concert with any other person, organization or entity, solicit, induce or influence the termination of the employment or engagement of, or attempt to solicit, induce or influence the termination of the employment or engagement of, any person who is employed or engaged as an employee of the other party;

10.4 A party's remedies at law for any breach or threatened breach of any of the agreements contained in this Section 11 will be inadequate and, in addition to any other remedies that may be available to such party at law or in equity, the non-breaching party shall, in the event of the breach or threatened breach of these provisions by the other party, be entitled to terminate this Agreement immediately and seek injunctive relief. The restrictions set forth in this Section 11 are in addition to, and are not intended to limit or diminish in any way, any other restrictions to which a breaching party may be subject by operation of law;

10.5 This Section 11 shall survive any termination of this Agreement; and

10.6 Upon the expiration or earlier termination of this Agreement for any reason, each party shall return to the other party any and all documents or materials that relate to the business of the other party and that are in such party's possession. Each party also certifies to the other party that it shall not make or keep any copies of such documents or materials. As used herein, the word "materials" refers to any and all trade secret information, including, but not limited to, customer lists, methods of operations, patient specimens, patient reports, statistical reports or summaries, computer programs or any items that afford access to any information in a party's computers. Notwithstanding the foregoing, the provisions of this Section 11.6 shall not require MOUNTAINSIDE to return any policies, protocols, procedures or processes or similar operational or clinical materials that it has developed, adopted or utilized during this Agreement with or without the assistance of PCLS, or that were furnished to it by PCLS in consideration for the fees paid hereunder. In addition, each party may retain documents or materials (or copies) thereof to the extent

and for such period as is required by applicable law. Upon termination by MOUNTAINSIDE through no fault of MOUNTAINSIDE it shall have the right to purchase any leased Equipment which has not already been transferred to it for the balance of the lease payments and the buyout price.

11. **Debarment.**

11.1. PCLS represents and warrants that neither it nor any of its employees or independent contractors working at the Laboratory has been nor will be debarred, suspended, declared ineligible, or excluded from Medicare, Medicaid, or any other federal or state health care program nor have any such claims been filed against them. PCLS understands and agrees, that if after PCLS and MOUNTAINSIDE execute this Agreement, MOUNTAINSIDE learns that either PCLS or any PCLS employee or independent contractor has been so debarred, suspended, declared ineligible, or excluded from Medicare, Medicaid or other federal or state health care program or had such claims made against them (see Section 12.2), this Agreement shall immediately terminate and MOUNTAINSIDE shall be under no further obligation to compensate PCLS.

11.2. MOUNTAINSIDE represents and warrants that neither it nor any of its employees working at the Laboratory has been nor will be debarred, suspended, declared ineligible, or excluded from Medicare, Medicaid, or any other federal or state health care program nor have any such claims been filed against them. MOUNTAINSIDE understands and agrees that if, after PCLS and MOUNTAINSIDE execute this Agreement, PCLS learns that MOUNTAINSIDE has been so debarred, suspended, declared ineligible, or excluded from Medicare, Medicaid or other federal or state health care program or had such claims made against them (see Section 12.2), this Agreement shall immediately terminate and PCLS shall be entitled to be compensated for any services provided by PCLS, as provided herein, up to and including the date of termination of this Agreement.

11.3. In the event an employee of either party who works at the Laboratory has been or becomes debarred, suspended or declared ineligible, or excluded from Medicare or Medicaid or any other federal or state health care program or had any similar claims lodged against him or her, that party shall notify the other party of the matter and the party employing the employee shall immediately remove that employee from working at the laboratory. A violation of this Section 11.3 shall be an Event of Default notwithstanding the removal of the employee.

12. **Termination for Cause.**

12.1. Termination for Cause. Either party may terminate this Agreement for cause if the other party engages in an Event of Default. The following shall each constitute an Event of Default hereunder:

12.1.1. MOUNTAINSIDE's failure to pay to PCLS by the due date the amounts then required to be paid pursuant to Section 5 of this Agreement.

12.1.2. The occurrence of an event that causes the dissolution and liquidation of either party.

12.1.3. A breach by either party of a material provision of this Agreement.

12.1.4. Either party's failure to comply with all applicable laws, rules, regulations and standards that are directly applicable to this Agreement.

12.1.5. Failure of either party to maintain in full force and effect any of the insurance required by Section 9 of this Agreement.

12.1.6. In the event that a party applies for or consents to the appointment of a receiver, trustee or liquidator of all or a substantial part of its assets, files a voluntary petition in bankruptcy, makes a general assignment for the benefit of creditors, files a petition or answer seeking a reorganization or arrangement with creditors, or if any order, judgment or decree shall be entered by any court of competent jurisdiction on the application of a creditor or otherwise adjudicating the party bankrupt or approving a petition seeking reorganization of such party or appointment of a receiver, trustee or liquidator of such party, or of all or a substantial part of its assets, and such order, judgment or decree shall continue unstayed and in effect for a period of thirty (30) days after its entry.

12.2. Notice of Default. Except as otherwise provided in this Agreement including as provided in Section 12.3 hereof, upon discovery of any Event of Default, the party asserting the Event of Default shall give notice of such default to the defaulting party. Such notice shall state the exact nature of the default required to be cured by the defaulting party. In the event that the defaulting party shall fail to cure such Event of Default within thirty (30) days after receipt of the written notice of the default, or, in the case of an Event of Default not curable within said thirty (30) day period, fails to promptly initiate within said thirty (30) day period reasonable steps to cure the Event of Default and diligently pursue such steps to completion to the reasonable satisfaction of the other party, the non-defaulting party may terminate this Agreement by giving written notice of termination to the defaulting party. The termination shall be effective on the thirtieth (30th) day following the defaulting party's receipt of the above-described termination notice. In the event that any Event of Default occurs more than twice in any year or more than four times since the commencement of the Term of the Agreement, the non-defaulting party may terminate immediately upon written notice to the defaulting party, without first affording the defaulting party the opportunity to cure as set forth herein.

12.3. Notwithstanding the foregoing, in the Event of Default described in Section 12, the nonbreaching party will immediately notify the breaching party of the default, and the nonbreaching party shall upon notice to the breaching party have the right to immediately terminate this agreement in the event of such a default.

12.4. PCLS shall be entitled to receive compensation as described in Section 5 of this Agreement for services rendered through the expiration or effective date of any termination of this Agreement. A final invoice (with supporting documentation) shall be submitted by PCLS to MOUNTAINSIDE within sixty (60) days after the expiration or effective date of any termination of this Agreement and shall be due and payable within thirty (30) days of MOUNTAINSIDE'S receipt of such invoice.

12.5. MOUNTAINSIDE shall be entitled to refund of compensation as described in Section 5 of this Agreement for services rendered from the date of the event causing the Event of Default by PCLS through the effective date of any termination of this Agreement within sixty (60) days after the expiration or effective date of any termination of this Agreement.

13. **Certain Rights on Termination or Expiration.**

13.1. PCLS and MOUNTAINSIDE agree to cooperate with each other upon termination or expiration of this Agreement to effect a reasonable and orderly transition of Services so as to minimize disruption to the Laboratory Services. The parties shall meet within ten (10) business days of the receipt of a notice of termination and develop a specific and detailed plan for the transition. If requested by MOUNTAINSIDE and agreed to by PCLS in writing, PCLS shall continue to provide services to MOUNTAINSIDE for an agreed upon period not to exceed six (6) months ("Termination Services"), unless reasonably prevented from doing so. If PCLS provides Termination Services to MOUNTAINSIDE beyond the Termination Date, MOUNTAINSIDE shall reimburse PCLS a fee equal to the fee that would otherwise have been payable under this Agreement (assuming it were still in effect). If PCLS is required to engage additional personnel in order to provide the Termination Services described herein, the charges for such additional personnel shall be invoiced to MOUNTAINSIDE on a time and materials basis at the rates in effect as of the Termination Date. Any compensation payable to PCLS for Termination Services shall be in the same manner and frequency as provided for under the Agreement.

13.2. In addition to the exception contained in Section 3.4, notwithstanding Section 10.3 herein, at the termination or expiration of this Agreement and subject to the prior written consent of PCLS, the MOUNTAINSIDE will have the option, but not the obligation, to make offers of employment to PCLS employees working at the Laboratory. Notwithstanding the above, the parties agree that any offer of employment made hereunder in no way waives any rights or remedies that PCLS may have in connection with employees who are bound by restrictive covenants.

14. **Dispute Resolution.**

14.1. Any dispute, controversy or claim arising out of or relating to this agreement, including its breach, termination and/or validity, ("Dispute") shall be resolved as

set forth in this Section, which shall be the sole and exclusive procedure for the resolution of any such Dispute.

14.2. PCLS and MOUNTAINSIDE shall attempt in good faith to resolve it promptly by escalating the Dispute to persons who have authority to settle the controversy and who are at a higher level of management than the persons with direct responsibility for administration of this Agreement. These persons shall meet within ten (10) business days after delivery of notice, in writing, of the existence and subject matter of the Dispute ("Notice of Dispute").

14.3 If the dispute has not been resolved by negotiation within thirty (30) business days after delivery of the Notice of Dispute, the parties agree to submit the Dispute to mediation through the International Institute for Conflict Prevention & Resolution ("CPR") under the CPR mediation Procedure then in effect or in effect on the Effective Date of this Agreement. Either party may commence mediation by delivering to CPR and the other party a written request for mediation, setting forth with specificity the subject matter of the dispute and the relief requested. Unless otherwise agreed, the parties will select a mediator from CPR's Panel of Neutrals and, if unable to select a mediator by mutual agreement, agree to have CPR select a mediator under the CPR Mediation Procedure. Each party shall bear its own cost and expenses, but those related to the compensation of the mediator and/or administration of the mediation, if any, shall be borne by the parties equally. The mediation shall be completed within forty-five (45) business days of its commencement. All Mediation shall take place in New Haven, Connecticut, or some other mutually agreeable venue.

14.4 All communications during negotiation and mediation are confidential, shall be treated as settlement discussions and shall be inadmissible for any purpose, including impeachment, in any arbitration or other proceeding, provided that evidence that is otherwise admissible or discoverable shall not be rendered inadmissible or non-discoverable as a result of its use during negotiation or mediation.

14.5 Good faith participation in the negotiation and mediation process is a condition precedent to commencement of arbitration. If any party fails to participate or participates in either process in bad faith, however, the other party may commence arbitration forthwith.

15. **Miscellaneous.**

15.1. Amendments. This Agreement contains the entire understanding between the parties hereto and supersedes any and all prior agreements, understandings and arrangements between the parties relating to the subject matter hereof. No amendment, change, modification or alteration of the terms, provisions and conditions hereof shall be binding unless evidenced by a writing signed by the parties hereto.

15.2. Waiver. The failure of MOUNTAINSIDE or PCLS to exercise or enforce any right conferred upon it hereunder shall not be deemed to be a waiver of any such right,

or operate to bar the exercise or performance thereof at any time or times thereafter. A waiver of any right hereunder at any given time, including rights to any payments, shall not be deemed a waiver thereof for any other time.

15.3. Severability. If any provision of this Agreement is held to be illegal, invalid, or unenforceable by a court of competent jurisdiction, the parties shall, in a commercially reasonable manner, negotiate a legal, valid and enforceable substitute provision which is as similar in effect to the deleted provision as possible. The remaining portion of the Agreement not declared illegal, invalid or unenforceable shall, in any event, remain valid and effective for the remainder of the Term; provided, however, if the provision found illegal, invalid, or unenforceable goes to the essence of this Agreement or the parties are unable to negotiate a substitute provision, either party may terminate this Agreement by giving the other party written notice of termination at least thirty (30) days prior to the effective date of such termination.

15.4. Assignment. Neither party may assign any of its rights hereunder without the prior written consent of the other party hereto, which consent shall not be unreasonably withheld, conditioned or delayed. Subject to the foregoing, the rights and obligations of this Agreement shall inure to the benefit of, and shall be binding upon, the successors and assigns of the parties hereto.

15.5. Notice. All notices hereunder shall be in writing addressed to the other party at its respective address set forth on the first page of this Agreement. All notices may be personally delivered or delivered by certified mail, return receipt requested, or by a nationally recognized overnight delivery service. Any notice shall be effective on the date it is actually received by the addressee.

15.6. Independent Contractor. It is understood that PCLS and MOUNTAINSIDE are independent contractors engaged in the operation of their respective businesses. Nothing in this Agreement is intended to create a partnership, joint venture or any other type of relationship other than that of independent entities contracting with each other solely for the purposes expressly set forth in this Agreement. Neither of the parties hereto, nor any of their respective officers or employees, shall be deemed to be the agent or representative of the other, except to the extent expressly provided in this Agreement. Each party agrees not to incur or contract for any debt or obligation on behalf of the other, to commit any act, to advertise, to make any reference, or otherwise make any representation about the other party which may adversely affect any right of the other party or be detrimental to its name. Each party shall be solely responsible for any taxes, including, but not limited to, payroll and income taxes, it is obligated to pay and for providing any benefits to its employees.

15.7. No Exclusion or Ineligibility for Federal Programs. Each party represents and warrants to the other that it is not excluded from participation in any federal or state health care program. For purposes of this Section, the term "excluded" or "exclusion" means a person or entity that either (i) has been convicted of a crime

related to health care, or (ii) is currently listed by a federal or state agency as debarred, excluded or otherwise ineligible for participation in any federally or state funded program (including, without limitation, Medicare and Medicaid). Either party shall notify the other party within five (5) days after the affected party receives notice that it has been or may be excluded. Either party shall have the right to terminate this Agreement in the event that the other party gives such notice of exclusion. This provision shall include (i) with respect to MOUNTAINSIDE, MOUNTAINSIDE and any partners, associates, employees, contractors, agents or representatives of MOUNTAINSIDE, and (ii) with respect to PCLS, its officers, employees, contractors, agents or representatives.

15.8. In accordance with the provisions of Section 1861(v)(1)(I) of the Social Security Act, PCLS agrees, for a period of four (4) years following the rendering of services under this Agreement, to make available, upon request, to the Secretary of the Department of Health and Human Services, the Comptroller General of the United States, or any of their duly authorized representatives, the contract, books, documents, and records necessary to certify the nature and extent of the costs of the services provided under this Agreement. PCLS further agrees that, should it execute a subcontract with a related organization for the performance of services under this Agreement, he shall require such subcontract to obtain a similar provision requiring the organization to make available the contract, books, documents, and records relating to those services as necessary to verify the costs of such arrangement.

15.9. Authorization. MOUNTAINSIDE and PCLS each warrant and represent to the other that the execution and performance of this Agreement by it has been authorized by all applicable laws and regulations and all necessary corporate or partnership action, and that this Agreement constitutes its valid and binding obligation in accordance with the terms, conditions and provisions of this Agreement.

15.10. Captions. The captions and section headings used in this Agreement are for convenience only and shall not affect the interpretation, construction or meaning of any term, condition or provision of this Agreement.

15.11. Governing Law, Venue and Jurisdiction. This Agreement shall be interpreted in accordance with the laws of the state of Connecticut. Each party agrees each submits to the venue and jurisdiction of the Connecticut in the event litigation is required.

[Signatures on the following page]

IN WITNESS WHEREOF, the parties have set their hands the date and year first above written.

Physicians Choice Laboratory Services, ~~Inc.~~ LLC

BY: _____

TITLE: EVP/COO

DATE: 2/17/16

MC1 Healthcare, LLC, d/b/a
Mountainside Treatment Center

BY: _____

TITLE: COO

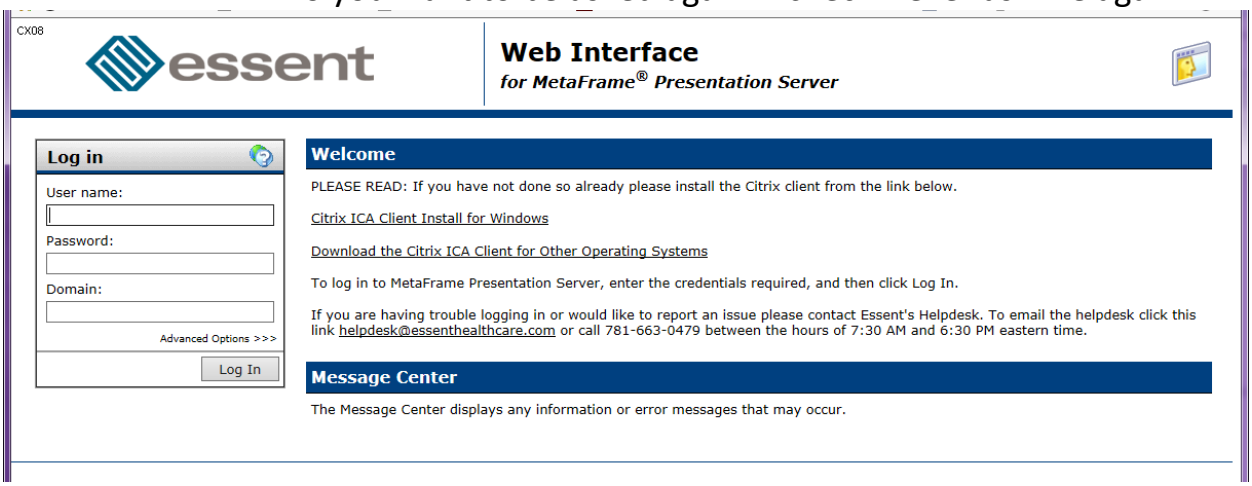
DATE: 03/21/16

Citrix access for Sharon Hospital Meditech

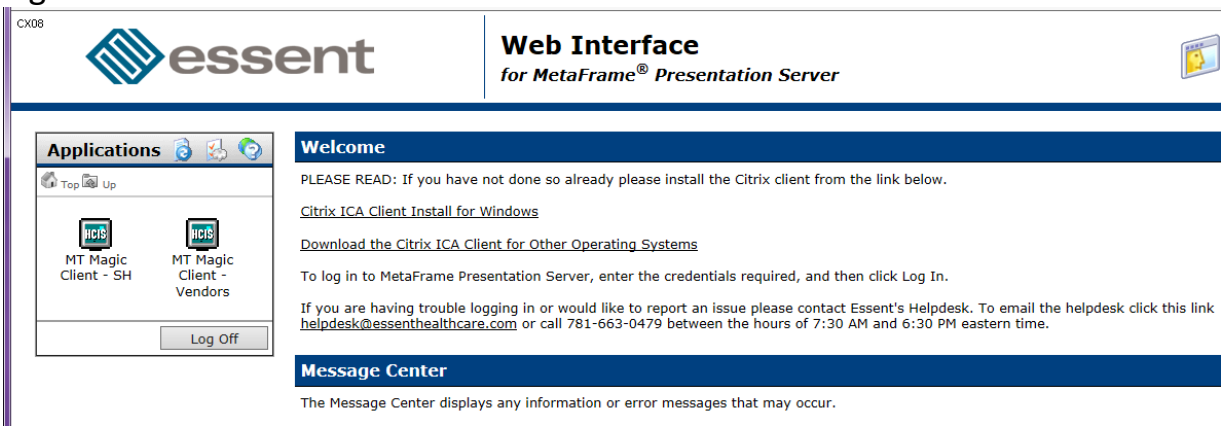
Citrix access to Sharon Hospital: https://citrix.sharonhospital.com
If you get a certificate warning, it's ok to continue to site.

You need to do a one time installation of the client:
"Citrix ICA Client Install for Windows" to right of log in box.

Follow prompts to RUN. If you see a box with "What access to grant" check Full
"Do you want to be asked again" check Never ask me again



Citrix sign on:
User: mtside
Password: live15 - you will be prompted to change
Domain: sh
Then choose Meditech Client –SH icon on left.
Sign into Meditech as usual.



If you need assistance please call Help Desk 860.364.4218 or Liz Hobby 860.364.4412

```
ESSENT HEALTHCARE INFORMATION SYSTEMS 1

 1. Essent Healthcare Information Systems
 2. MERRIMACK VALLEY HOSPITAL (5.4)
 3. NASHOBA VALLEY MEDICAL CENTER (5.4)
 4. SHARON HOSPITAL (5.4)
```

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MIS Directories
Select: 1

1. LIVE 5.66 Directory5.64
2. TEST 5.64 Directory5.64
3. TEST 5.66 Directory5.64
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Sign On

                    Medical Information Technology, Inc.

   MIS System  RegionalCare Hospital Partners
   User ID
   Password
   Application

   Friday  02/27/15     12:38 PM          SH13MISC05.5 (A 10N0T10.1.6.70.5)

REMINDER: Your password should always be kept confidential and never be shared
          When your MEDITECH password expires, you will be prompted:
     "Expired password! You may sign on 3 times before it must be changed!"

     FOLLOW THESE STEPS to change your MEDITECH password when it expires:
  1) When you get the box stating your password expired, press <ENTER>.
  2) A box will pop up saying : ENTER NEW PASSWORD.  Enter a password of your
     choice following the format AAAANN, for example "ABCD12"  Press <ENTER>.
  3) A box will pop up asking you to RE-ENTER TO VERIFY:
  4) Re-enter your password and press <ENTER>
```

STAT
Moving Pharmacy Forward.

41 Northwest Dr.
Plainville CT 06062

September 24, 2015
MC1 Healthcare LLC (d/b/a Mountainside)
Route 7
Box 717
Canaan, CT 06018

Re: Pharmacy Services Agreement, dated as of December 1, 2014, between MedStat Pharmacy, LLC, and MC1 Healthcare LLC (d/b/a Mountainside) (the "Agreement")

Dear Alex:

MedStat Pharmacy, LLC, a Connecticut limited liability company (the "Company"), intends to sell certain of its assets to West River Pharm of Connecticut, LLC, a Connecticut limited liability company ("Buyer"), pursuant to that certain Pharmacy Asset Purchase Agreement, by and among Buyer, the Company, and certain other parties thereto (the "Sale"). In connection with the Sale, the Company intends to assign all of its right, title and interest in, to and under the Agreement to Buyer, and Buyer intends to assume and agree to pay, perform and discharge, as and when due, all of the Company's obligations arising from and after the date of the Sale under the Agreement (such assignment and assumption, the "Assignment").

We are writing to request that you (a) waive any notice requirement regarding the Sale and Assignment that may be required under the Agreement, and (b) consent to the Sale and Assignment. By countersigning this letter below, you acknowledge your consent to each of the Sale and the Assignment, your waiver of any advance notice, termination or other rights that may arise under the Agreement with respect to the Sale or the Assignment and your confirmation that neither the Sale nor the Assignment will constitute a breach of the Agreement.

Please confirm your waiver and consent by returning a signed copy of this letter to Edward Pelc by email at EPelc@ medstatpharmacy.com or by facsimile at 860-351-5110 as soon as possible. Please feel free to contact me at 860-351-5093 if you have any questions.

Sincerely,

Edward Pelc
MedStat Pharmacy, LLC

By: [signature]

ACKNOWLEDGED AND AGREED:

MC1 Healthcare LLC (d/b/a Mountainside)

By: [signature]
Name: Roy Sasenarain
Title: Chief Operating Officer

toll free: 855.298.4183 · phone: 860.351.5093 · fax: 860.351.5110
medstatpharmacy.com

4827-1853-5720.1

Pharmacy Services Agreement

Between

MC1 Healthcare LLC (d/b/a Mountainside)

And

MedStat Pharmacy, LLC

Dated:

12/01/14

Pharmacy Services Agreement

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Pharmacy Services Agreement

This Pharmacy Services Agreement (the "Agreement"), is dated as of December 1, 2014 between MedStat Pharmacy, LLC (the "Pharmacy") located at 41 Northwest Drive in Plainville, CT 06062, and MC1 Healthcare LLC (d/b/a Mountainside) (the "Facility") Located at Route 7, Box 717, Canaan, CT 06018.

Recitals

A. The Facility is a licensed substance abuse and outpatient psychiatric facility operating a total of 78 beds, for which it requires pharmacy services in accordance with applicable local, state, and federal laws and regulations.

B. The Pharmacy is qualified, licensed, and capable of providing approved drugs, intravenous solutions, biologicals, and pharmaceutical supplies as required by the residents of the Facility upon order of their licensed health care providers and in accordance with accepted professional principles and applicable local, state, and federal laws and regulations.

C. The Facility desires to utilize the Pharmacy's services, and the Pharmacy is willing to furnish such services as provided herein.

Agreement

In consideration of the mutual covenants contained herein and for the reliance of the parties hereto, the Facility and Pharmacy agree as follows:

1. Responsibilities of the Pharmacy

1.1 ***Services***. For the benefit of the Facility, the Pharmacy will:

a) Supply only approved drugs, intravenous solutions, biologicals, and supplies in compliance with applicable local, state, and federal laws and regulations for residents and the Facility;

b) Render all services in accordance with any applicable requirements of local, state, and federal laws and regulations, community standards of practice, and the Pharmacy's Policies and Procedures Manual, a true and correct copy of which is attached hereto as **Exhibit A**;

c) Label all medications in accordance with local, state, and federal laws, rules, and regulations;

d) Provide drugs, intravenous solutions, biologicals, and supplies in a prompt and timely manner and consistent with the terms of this Agreement;

e) Provide the Facility with a medication administration system, medication carts, fax machines, and related equipment and supplies sufficient to meet the needs of the Facility, as reasonably determined by Facility and Pharmacy in compliance with all applicable laws and regulations;

f) As set forth in Section 3.1 of the Agreement, with reasonable assistance of the Facility and the Facility's Medical Director, the Pharmacy will be fully responsible for all third party billing for Medicaid, private pay, insurance, individuals eligible to receive coverage under any other state reimbursement program, and for all other third parties that permit direct Pharmacy billing such as Medicare Part D ("Direct Billing"). The Pharmacy and the Facility will work together to secure all approvals and prior authorizations required for any medication, service, or products provided hereunder. The Pharmacy will be responsible for billing the appropriate Direct Billing party for residents who require non-covered drugs, intravenous solutions, biological, and supplies. Further, with the reasonable assistance of the Facility and the Facility's Medical Director, the Pharmacy will make all reasonable efforts to secure all required approvals for payment or coverage when any non-covered/non-formulary medication is ordered for a resident covered under Direct Billing.

    1. Provided, however, that notwithstanding anything in this Agreement to the contrary, if Pharmacy has not received any required resident consents and/or prior authorizations from any required source, regardless of whether the drugs or services are Direct Billing, the Pharmacy shall notify the Facility in writing of such missing consents and/or prior authorizations. In the event that the Facility fails to provide such consents and/or prior authorizations within ten (10) business days of receipt of notice, the Pharmacy will have no obligation to continue to provide such drugs and/or services, unless an authorized representative of the Facility agrees to assume all payment obligations with respect to such drugs and services at the rates provided herein.

g) Maintain drug profiles on each resident in the Facility and upon each new medication order, cause the Pharmacy Consultant to perform a review of the dosage, compatibility with current medications, allergies, and other appropriate indicators;

h) Provide drug information and consultation to the Facility's licensed professional staff regarding such drugs, intravenous solutions, biologicals and supplies ordered, along with copies of the Pharmacy's facility procedure manuals, and all other Pharmacy policies and procedures related to the provision of pharmacy services by the Pharmacy;

i) Ensure a pharmacist from the Pharmacy is available for attendance at the meetings of the Facility committee(s) responsible for Quality Assurance, and any other committee meetings with reasonable prior notice, up to 4 meetings per year; and

j) Conduct up to 4 in-person programs per year, for Facility staff at the Facility, including but not limited to programs for in-service education for subjects related to the pharmaceutical services rendered; said in-service education to be conducted by the pharmacist or his/her designee.

1.2 ***Delivery Schedule***. The Pharmacy agrees to deliver to the Facility any legal and approved prescriptions and supplies on a mutually agreed upon schedule with an additional delivery if an emergency arises, except for circumstances and conditions beyond its control, which may include, but not be limited to, situations where the Pharmacy's manufacturer/supplier is unable to provide the required item and the Pharmacy is unable to provide an acceptable alternative. In the event that the Pharmacy is unable to provide the requested product in a timely manner, Pharmacy shall notify the Facility of such failure and the reason(s) therefor. Pharmacy shall take reasonable measures to obtain the requested product or a comparable product approved by the prescribing health care professional, from a third-party pharmacy at no additional cost to the Facility.

1.3 ***Emergency Drug Service***. The Pharmacy will provide any drugs, intravenous solutions, biologicals, and supplies needed on an emergency basis in a prompt and timely manner and within no more than 4 hours of request by the Facility. In the event the Pharmacy cannot furnish an ordered within four (4) hours of request by the Facility, the Pharmacy will make arrangements with another pharmacy supplier in a community local to the Facility to provide such service(s) to the Facility. The Pharmacy will notify the Facility if such arrangement is necessary.

1.4 ***Physician Order Sheets and Medication Administration Records***. The Pharmacy shall provide computerized Physician Order Sheets (POSs) and the Medication Administration Records (MARs), upon request. The Facility will pay the Pharmacy $__0___ per patient per month for copies of such records.

1.5 ***Equipment***. The Pharmacy will furnish, at its expense, all equipment necessary for its provision of services under this Agreement. The Pharmacy will, at its expense, be responsible for ongoing maintenance and repairs to the Pharmacy's equipment utilized at the Facility, unless the need for such maintenance and repair is due to the Facility's abuse of the

equipment due to gross negligence or willful misconduct. In such event, the expense for maintenance and repairs will be borne by the Facility. All such equipment shall remain the property of the Pharmacy. Pharmacy shall provide instructions and training to the Facility and its staff with respect to such equipment, as reasonably requested by the Facility.

1.6 ***Operational Matters.***

a) If any Pharmacy personnel repeatedly fails, in the Facility's sole discretion, to perform in a competent manner, the Facility notifies Pharmacy in writing that such Pharmacy personnel is no longer acceptable to Facility, citing the grounds and specific supporting facts, then, after written notification from Facility, Pharmacy shall no longer schedule such Pharmacy personnel to provide or support services for Facility under this Agreement or any other agreement with Facility. Facility, in its sole discretion, may modify this prohibition upon presentation in writing by Pharmacy of adequate reasons and facts for modifying the prohibition.

b) On-site Pharmacy personnel shall follow and adhere to the Facility policies and procedures applicable to the provision of the services hereunder including, by way of example only and without limitation (i) sign-in procedures, (ii) identification badges, (iii) executing confidentiality statements, (iv) participation in any required training and (v) parking regulations.

c) Pharmacy agrees that unless otherwise approved by Facility in writing in advance, no Pharmacy personnel shall provide services pursuant to this Agreement or any other agreement with the Facility if any of the following have occurred: (i) any applicable registration, certification, licensure of Pharmacy personnel, in any state, is or has been threatened with limitation, suspension, revocation or exclusion; (ii) any applicable registering, certifying, or licensing board reprimands, sanctions or otherwise disciplines Pharmacy personnel; or (iii) a negligence of malpractice claim related to the provisions of the services to be provided hereunder or similar services has been asserted against Pharmacy or its personnel.

d) Facility acknowledges Pharmacy's right to make public statements regarding the existence of the contract, its terms and conditions, and an accurate description of the services being provided, provided that Pharmacy has obtained the prior written consent of the Facility prior to making any such public statements or announcements. Furthermore, Pharmacy may not make any public statement (for example a press release or any form of advertisement) describing the Facility's relationship with Pharmacy or Facility's endorsement of Pharmacy without the prior written consent of Facility. Facility may withhold its consent in its absolute

discretion. Pharmacy acknowledges that Facility will require ten (10) business days to consider any request for consent. Likewise, Pharmacy may not use any Facility trademark without prior consent obtained through the procedure described above.

e) Pharmacy shall neither use nor allow Pharmacy personnel to use any part of Facility premises or property for any purpose other than the performance of the services under this Agreement.

f) Without regard to any other section of this Agreement, Pharmacy shall be responsible for the costs to return to "as was" condition from any damage caused to the building, grounds, or other equipment and furnishings caused in whole or part by (i) Pharmacy personnel while performing activities arising under this Agreement or (ii) equipment supplied by the Pharmacy pursuant to Section 1.5 of this Agreement.

2. Responsibilities of the Facility

2.1 ***Operational***. The Facility will be responsible for the implementation of the Pharmacy's Policies and Procedures applicable to the services to be provided hereunder within a reasonable time after the commencement of this Agreement. Pharmacy shall provide to the Facility copies of all policies and procedures for which Facility will have implementation responsibility upon execution of this Agreement and shall promptly notify Facility of any changes thereto.

The Facility will make available to the Pharmacy reasonably adequate working and storage space to allow the Pharmacy to fulfill the services required of Pharmacy under this Agreement, including, but not limited to, adequate space at each nursing station for the storage of medication carts, containers, or cards and equipment to be provided by the Pharmacy. The Pharmacy will instruct the Facility's personnel to utilize the equipment properly and the Facility shall provide reasonable assistance to facilitate such instruction.

2.2 ***Ordering***. The Facility may order from the Pharmacy all drugs, intravenous solutions, biologicals, and supplies for individual residents which are not commonly stocked in the Facility, except in cases where a resident has requested purchases be made from another pharmacy, in which case the request will be honored. The Facility may also purchase "house stock" items from the Pharmacy, as allowed by applicable local, state, and federal laws and regulations. Provided however, in the event the Facility does not purchase from the Pharmacy

at least 75% of the drugs and pharmaceutical services used by Facility residents that have elected to receive drugs and pharmaceutical services from the Pharmacy, the Pharmacy may terminate this agreement upon 30 days' notice.

2.3 ***Billing Date and Reimbursement Status***. The Facility will provide the Pharmacy with the necessary billing date, including, but not limited to, Medicare and Medicaid numbers, resident name, responsible party, billing address, phone number, health care provider or physician name(s), and any other pertinent date as may be reasonably required by the Pharmacy. This information will be provided at time of admission and as changes occur.

The Facility will provide timely notifications to the Pharmacy as to the change of status of each resident regarding source of reimbursement for drugs, intravenous solutions, biologicals, and supplies. The Facility will notify the Pharmacy within one (1) business day of any changes in medication upon receipt of physicians' or other licensed health care providers' orders or of changes as a result from room transfer or discharge. To the extent permitted by law, the Facility will give the Pharmacy reasonable access to all resident records, facilities, and supplies necessary for the performance of the Pharmacy's duties under this Agreement. The Pharmacy will furnish to the Facility, upon request, all information relating to the drugs, intravenous solutions, biologicals, and supplies furnished to the Facility or to Facility residents.

The Facility, with the reasonable assistance of the Pharmacy shall be responsible for obtaining appropriate billing consent signatures with respect to each resident for which the Pharmacy will perform billing. The Pharmacy will respond to reasonable requests for assistance relative to securing such consents.

2.4 ***Patient Choice.*** Pharmacy understands and agrees that residents of the Facility may elect not to use Pharmacy for drugs and pharmacy services. In the event that a resident elects not to use the Pharmacy for such services, the resident may obtain the prescription from the prescriber and then obtain the drug(s) from a pharmacy provider of his or her choice. The Facility will notify the Pharmacy of such elections and the Pharmacy shall have no responsibilities for any such resident.

3. Billing

3.1 ***Charges***. As set for in 1.1 (f), and subject to 1.1 (f)(i), the Pharmacy shall be responsible for all costs related to drugs, intravenous solutions, biological, and related equipment and supplies rendered to residents who are covered by Direct Billing parties, in accordance with applicable laws and regulations.

3.2 ***Invoices***. The Pharmacy will submit a monthly invoice to the Facility for Direct Billing items and services with such detail as the Facility may reasonably require. No charge may be made by the Pharmacy to the Facility for any items or services covered by Direct Billing later than thirty (30) days following the last day of the month in which such was provided to the Facility or its residents, including circumstances involving failure to obtain prior authorization or resident consent.

3.3 ***Payments***. The Pharmacy shall receive payment for undisputed invoices from the Facility in full within thirty (30) days of the date the Facility receives the Pharmacy's invoice ("Invoice Date"). Such invoices may be submitted via e-mail with receipt and read confirmation and must be submitted no later than the 8th day of each month. Payments will be applied first to interest and any remainder will be applied to any late charge penalties and then the principle sum.

The Facility will notify the Pharmacy within thirty (30) days of the Invoice Date of any amounts in dispute. The Facility will be deemed to accept such invoices as correct and accurate, without dispute, if notice is not provided within such 30 day period. The Pharmacy shall respond to such dispute within fifteen (15) days. In the event that the Facility is not satisfied with the Pharmacy's response, representatives from both the Facility and the Pharmacy, who have authority to resolve such disputes will meet, telephonically or in person and resolve such dispute in no more than thirty (30) days. Both the Pharmacy and the Facility agree to diligently and reasonably cooperate to resolve such disputes in the timeframe provided.

In the event the representatives of the Parties are unable to resolve the dispute informally, the Parties hereby agree to submit the dispute to private mediation, with each Party to pay its own costs and attorney's fees associated with the mediation; and in the event, and only in the event, that mediation is unsuccessful; the Parties may proceed with litigation of the dispute.

Notwithstanding the above, the parties understand and agree that the terms of this Agreement are reasonable and necessary to protect the interests of the Pharmacy and Facility. The parties further agree that the Facility would suffer irreparable harm if the Pharmacy breached this Agreement. Thus, in addition to any other rights or remedies, all of which shall be deemed cumulative, the Facility shall be entitled to obtain injunctive relief to enforce the terms of this Agreement.

In the event of any dispute arising from any claim or bill submitted by the Pharmacy, and to the extent permitted by applicable law, the Pharmacy will have access to all reasonable and

necessary documents and records that would, in the discretion of the Pharmacy, tend to sustain its claim.

4. Term and Termination

4.1 ***Initial and Renewal Terms***. The term of this Agreement will commence on December 1st, 2014 and continue through and include November 30th, 2017 ("Initial Term") and shall renew automatically for successive one (1) year terms at the end of each term, unless either party provides written notice of its intent not to renew, no less than ninety (90) days prior to end of term. Notwithstanding the foregoing, the Facility shall have the right to terminate this Agreement at any time during the Initial Term and any additional terms by providing thirty (30) days' prior written notice to the Pharmacy.

4.2 ***Termination for Default***. If either party defaults in the performance of its obligations under this Agreement and such default is not cured within thirty (30) days of the receipt of written notice from the non-defaulting party, then the non-defaulting party will have the right, in addition to any other rights it may have, by further written notice to terminate this Agreement on any future date not less than ten (10) days from the date of such further notice.

4.3 ***Immediate Termination.*** Facility may terminate this Agreement immediately; (i) upon delivering written notice to Pharmacy in the event that Pharmacy makes an assignment for the benefit of creditors, files a petition in bankruptcy, is adjudicated insolvent or bankrupt, or if a receiver or trustee is appointed with respect to all of a substantial part of Pharmacy's property, or a proceeding is commenced against it which will substantially impair its ability to perform hereunder; (ii) upon termination of Pharmacy's insurance coverage described herein; (iii) if Pharmacy or any Pharmacy personnel is found guilty of fraud, or is the subject of an action taken, or proposed to be taken, against Pharmacy or any Pharmacy personnel resulting in Pharmacy or any Pharmacy personnel being disbarred, suspended, proposed for debarment or declared ineligible to participate in any federal or state healthcare program with termination effective on receipt of such notice; or (iv) if Facility reasonably determines that Pharmacy or any Pharmacy personnel has violated any law, regulation, or accreditation standard.

4.4 ***Obligations Upon Expiration or Termination.***

a) Upon expiration or termination of this Agreement, Facility shall pay to Pharmacy all outstanding, undisputed fees owed for services provided during the term hereof.

b) Upon expiration or sooner termination of this Agreement: (i) the Facility will return to the Pharmacy, in good working condition, all of the Pharmacy's

equipment, formulary documents, policies and procedures manuals and forms; (ii) and each party will promptly deliver to the other all memoranda, notes, plans, records, reports and other documents, information and materials, and all copies thereof in any tangible form relating to the Confidential Information (as defined in Section 6.18), business or affairs of the party or the party's clients which are in the possession or under the control of the other party. Neither party will (i) reproduce or permit the reproduction of the other party's documents, policies or procedures manuals, and forms or Confidential Information, nor (ii) circulate such information to any third-party individual or entity without the prior written consent of the other party.

5. Representations and Warranties

Each party warrants and represents the following to the other party, and that each warranty and representation shall continue throughout the term of the Agreement.

5.1 Each is a corporation, limited liability company or other recognized legal business or entity duly organized, validly existing, and in good standing under the laws of the state in which it is incorporated, organized, and/or operating.

5.2 Each party (i) has the requisite power and legal authority to enter into this Agreement and to perform its obligations hereunder, and (ii) has taken all necessary corporate or other action on its part to authorize the execution and delivery of this Agreement and the performance of its obligation hereunder.

5.3 This Agreement has been duly executed and delivered by the party, and constitutes a legal, valid, and binding obligation that is enforceable against such party in accordance with its terms.

5.4 Each party has all of the necessary qualifications, including but not limited to, certificates, permits, registrations, and/or licenses, pursuant to federal, state, and local laws and regulations to perform its obligations under this Agreement, and all required consents, approvals and authorizations of all governmental authorities and other persons that must be obtained by such party in connection with this Agreement have been obtained.

5.5 The execution and delivery of this Agreement and the performance of each party's obligations hereunder do not (i) conflict with or violate any requirement of applicable laws or regulations, or (ii) conflict with, or constitute a default under, any contractual obligation of that party, including contractual obligations with any other pharmacy provider.

5.6 The party and any individual it employs has or has contracted with to perform any part of this Agreement has not been excluded from participation in any federal health care program, as defined under 42 U.S.C. section 1320a 7b(f), nor is currently debarred or suspended or listed on the General Services Administration's ("GSA") List of Parties Excluded from Federal Procurement or Non-procurement Programs in accordance with Executive Orders 12549 and 12689, "Department and Suspension". Pharmacy further represents that no adverse action by the federal government that will or may result in exclusions from a federal health care program has occurred or is pending or threatened against Pharmacy, or to the best of its knowledge, against any Pharmacy personnel. Pharmacy agrees that is shall not perform any act that shall cause Pharmacy to be excluded from a federal health care program or debarred, suspended, or listed in the GSA's List of Parties Excluded from Federal Procurement or Non-procurement Programs during the term of this Agreement.

5.7 Pharmacy represents and warrants that: (a) it employs, and will continue to employ throughout the term of this Agreement, sufficient qualified and credentialed personnel needed to provide services anticipated hereunder in a timely, professional, competent, and ethical manner; (b) it owns, possesses, and employs, and will continue to employ throughout the term of this Agreement, sufficient technology and equipment as needed to provide the services in the manner anticipated hereunder; and (c) it will render the services hereunder in accordance with prevailing pharmaceutical and medical standards and will apply them in the same fashion to all residents of the Facility.

5.8 Pharmacy warrants that the Pharmacy's services and/or the Facility's use of products, processes, techniques, and methodologies provided by Pharmacy shall not infringe upon the copyright, patent, or other proprietary rights of others.

5.9 Each party shall immediately notify the other in writing in the event of any representation or warranty made hereunder is or becomes untrue for any reason.

6. Miscellaneous

6.1 ***Status of Parties.*** Neither the Parties nor the Facility is, for any purpose, an agent, partner, or employee of the other. This Agreement does not constitute a joint venture between the parties. It is agreed that in performing pharmacy services pursuant to this

Agreement, the Pharmacy and its employees will, at all times, be an independent contractor to the Facility and its residents.

6.2 ***Late Charges***. If any undisputed amount is not paid when due under this Agreement, whether such payment is due by Facility to Pharmacy or by Pharmacy to Facility related to disputed amounts, the party owing such amount shall pay the other party a late charge on such amount equal to one percent (1%) per month or the maximum rate allowed by law, if less. Such late charge will accrue from the date any party's invoice is due and will continue to accrue until receipt of payment by the invoicing party. Either party's failure to request or demand payment of any late charges will not constitute a waiver of that party's right to receive such late charge.

6.3 ***Force Majeure***. If either party fails to perform its obligations hereunder (except for the obligation to pay money) because of strikes, accident, acts of God, weather conditions, or action or inaction of any government body or other proper authority or other causes beyond its control, then such failure to perform will not be deemed a default hereunder and will be excused without penalty until such time as said party is capable of performing.

6.4 ***Notices***. Notices or communications to be given under this Agreement will be given to the respective parties in writing either by personal delivery or by registered or certified mail, postage prepaid, or by overnight delivery as follows:

To the Facility:

Mountainside

Route 7, Box 717

Canaan, CT 06018

Attn: Alexandra Helfer

And **To the Pharmacy**:

MedStat Pharmacy, LLC
41 Northwest Drive
Plainville, CT 06062
Attention: Ed Pelc, Executive VP Pharmacy Services

Or at such other addresses and to such other persons as either party may from time to time designate by notice given as herein provided. Such notices or communications will be deemed to have been given three (3) days after deposit in the United States mail or one (1) day after delivery to an overnight delivery service.

6.5 ***Successors and Assignment***. This Agreement will be binding upon and insure to the benefit of both parties and their permitted successors and assigns. Nothing in this Agreement is intended nor will be deemed to confer any benefits on any third party. Notwithstanding the foregoing, in the event of any sale, lease, assignment, delegation, or transfer of all or any portion of the Facility's or Pharmacy's management, operations, facilities, assets, or business to any other person, corporation, or entity, including to any Facility management company (each a "Transfer"), the Facility or the Pharmacy, as applicable, shall provide thirty (30) days prior written notice to the other of its intent to assign the Agreement and this Agreement will be assigned on the same terms and conditions to the successor, operator, or owner unless either party provides notice of a rejection of the Transfer within ten (10) business days from the receipt of such notice. In the event that the Facility or Pharmacy rejects a Transfer, either party may terminate this Agreement within thirty (30) days of such notice of rejection.

6.6 ***Civil Rights***. The Pharmacy will comply with Title VI of the Civil Rights Act of 1964 and § §503-504 of the Rehabilitation Act of 1973 and all requirements imposed by or pursuant to the applicable civil rights regulations of the Department of Health and Human Services or other government agency. Further, the Pharmacy will provide its Pharmacy services equally to the residents residing at the Facility as required by the residents, pursuant to the instructions of the attending physician or health care professional of any resident.

6.7 ***Governing Law***. This Agreement will be construed and governed according to the laws of the state of Connecticut, without giving effect to any choice of law or conflict of laws, provision, or rule that would cause the laws of another jurisdiction to be applied.

6.8 ***Waiver***. Neither waiver by either party of a breach or violation of any provision of this Agreement, nor failure to enforce any term or condition of this Agreement, will operate as, nor be construed to be, a waiver of any prior, concurrent, or subsequent breach or a waiver of any term or condition. None of the provisions of this Agreement will be considered waived by either party except when such waiver is given in writing.

6.9 ***Entire Agreement; Amendment***. This Agreement and any Amendments or Addenda hereto, and ancillary agreements referred to herein (including the Consulting Agreement and Confidentiality Agreement) constitute the entire agreement between the parties regarding the subject matter hereof and supersede all prior or contemporaneous discussions, representatives, correspondence and agreements, whether oral or written, pertaining thereto.

6.10 ***Severability***. If any term or provision of this Agreement is held invalid or unenforceable to an extent, the remainder of this Agreement will be unaffected thereby and each term and provision of this Agreement will be valid and enforceable to the fullest extent

permitted by law, unless doing so will materially alter the relative benefits and burdens the parties bargained for herein.

6.11 ***Consulting Agreement***. The parties hereto have simultaneously entered into the Pharmacy Consultant Agreement in the form of **Exhibit B** in connection with the provision of services hereunder, and agree that any default in the performance by either party under the Pharmacy Consultant Agreement shall be a simultaneous default hereunder.

6.12 ***Compliance with Law***.

6.12.1 Each party shall comply with all applicable federal, state, and local laws, rules, and regulations (collectively, "Laws") now in effect or enacted during the term of this Agreement, including (without limitation) Laws about the dispensing of prescription drug products, pharmaceutical billing or sales practices, and governmental reporting and disclosure requirements.

6.12.2 Confidentiality of Patient Records. The parties acknowledge and agree that Facility currently is not a "Covered Entity" as that term is defined by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and thus is not subject to HIPAA or the regulations promulgated thereunder. Notwithstanding, each party shall keep, transmit, and maintain patient information and records in accordance with applicable Laws (including, but not limited to state data privacy and medical privilege laws) and Facility policies and procedures and shall not use or release such information except as permitted or required by applicable laws or Facility policies and procedures. The parties shall enter into Confidentiality Agreement attached hereto as **Exhibit C** and agree that any default in the performance by either party under the Confidentiality Agreement shall be a simultaneous default hereunder.

6.13 ***Indemnity***. Each party shall indemnify and hold harmless the other party and their respective officers, directors, employees, shareholders, and agents from and against any and all claims, damages, demands, actions, liabilities, penalties, costs, and expenses (including without limitation, attorneys' fees, expenses, and costs) (collectively "Loss") arising out of the actual or alleged acts or omissions of such indemnifying party, its employees or agents, in connection with the Agreement (including any Exhibits hereto) or any breach of any representation, warranty, or covenant under the Agreement by the indemnifying party. Notwithstanding, indemnification obligations of the Pharmacy with respect to the use or disclosure of Facility resident health, personal or financial information shall be governed by the Confidentiality Agreement attached hereto as Exhibit C.

6.14 ***Insurance***. Each party shall maintain at all times during the term of this Agreement, at its sole cost and expense, appropriate workers' compensation insurance coverage for its employed personnel and shall carry general and professional liability insurance covering it and all of its personnel in the minimum amount of One Million Dollars ($1,000,000) for each occurrence and Three Million Dollars ($3,000,000) annual aggregate. Pharmacy's general and professional liability insurance shall be on an occurrence basis or the Pharmacy shall provide tail coverage for a period of no less than three (3) years following termination of this Agreement.

6.15 ***No Special Damages***. Neither party shall have liability for special, incidental, or consequential damages of the other party, even if the other party has been advised of the possibility of such damages.

6.16 ***Changes in Law***. If there is a change in an existing (or adoption of a new) law, rule, regulation, or administrative policy ("Change in Law") during the term of this Agreement that alters a party's rights or responsibilities hereunder in a material way, then upon request of the affected party, the parties will (in good faith) negotiate the terms of this Agreement, as applicable, so that for the remainder of the Term of this Agreement the parties will be in the same position performing the Agreement that they would have been in without the Change in Law. If the parties are unable to agree upon such an amendment despite good faith negotiations over a period of 30 days, either party may thereafter terminate the Agreement by giving the other party 60 days written notice of termination.

6.17 ***Non-Exclusive***. The parties do not intend that this be an exclusive agreement and thus, the Facility may contract with other retail pharmacies to provide the services described herein or similar services.

6.18 ***Confidential Information***.

6.18.1 In carrying out this Agreement, each party (the "Protected Party") may disclose to the other party (the "Restricted Party") certain proprietary, confidential, or other non-public information (collectively, the "Confidential Information") relating to its business.

6.18.2 Without limiting the definition of Confidential Information in the foregoing paragraph, Confidential Information shall include: (i) the Pharmacy's business processes, pricing, customer materials (such as training manuals and policy and procedures manuals); (ii) the terms of this Agreement; (iii) all information regarding the Facility's business operations, treatment programs, marketing, patient care and finances; and (iv) all information regarding the residents of Facility, including medical records.

6.18.3 The Restricted Party agrees that it (i) shall hold the Protected Party's Confidential Information in confidence and protect it with the same degree it of care

that it uses to protect its own and most confidential information, but in no event shall it use less than reasonable care, and (ii) shall not use such information for its own business other than as necessary to carry out this Agreement. The Restricted Party's obligations under this Section will not apply to information that (i) is already in the Restricted Party's possession at the time of disclosure, (ii) is or later becomes part of the public domain through no fault of the Restricted Party, (iii) is received from a third party having no obligation of confidentiality to the Protected Party, (iv) is independently developed by the Restricted Party without any use of Confidential Information of the Protected Party or (v) is required by law or judicial process to be disclosed. If the Restricted Party is requested to disclose Confidential Information pursuant to clause (v) of the immediately preceding sentence, it will promptly notify the Protected Party and provide such information as the Protected Party reasonably requires to allow the Protected Party to seek a protective order or other order prohibiting or limiting the disclosure of such Confidential Information. Each party's obligations under this Section 6.18 supplement and do not supersede the obligations imposed on the party by applicable law, including applicable trade secrets law.

6.18.4 The Protected Party's Confidential Information shall remain the sole property of the Protected Party. The Restricted Party shall return all such Confidential Information upon the termination of this Agreement in accordance with Section 4.4 of this Agreement.

6.18.5 The Restricted Party recognizes and agrees that there is no adequate remedy at law for a breach of this section, that such a breach would irreparably harm the Protected Party and that the Protected Party shall be entitled, without posting bond, to equitable relief (including, without limitation, injunctions) with respect to any such breach or potential breach in addition to any other remedies.

6.19 ***Status of the Parties***. Neither the Pharmacy nor the Facility is, for any purpose, an agent, partner, or employee of the other. This Agreement does not constitute a joint venture between the parties. It is agreed that in performing services pursuant to this Agreement, the Pharmacy and its employees will, at all times, be an independent contractor the Facility and its residents.

genesight

Assurex HEALTH

GeneSight® Registration and Agreement

Clinic/Facility Name: Mountainside Treatment Center		
Phone: (860) 362-5023	Fax:	
Address: 187 Route 7		
City: Canaan	State: CT	Zip Code: 06018

This Agreement is effective on the last date signed (the "Effective Date") by and between Assurex Health, Inc. ("Assurex") and the clinic, practice, or hospital named above (including any employees, contractors, affiliates, agents or representatives of the foregoing, the "Customer").

(1). Placing Orders: Customer will place orders for medically necessary laboratory testing services ("Services") from Assurex using the secure online web portal. Authorized representatives of Customer shall place such orders personally and Customer shall not authorize any other individuals to place such orders on Customer s behalf. Customer shall not knowingly share online web portal log-in information with any other individuals.

(2). Performing Services: After Assurex receives all necessary samples and documentation from Customer, in accordance with the terms of this Agreement and in compliance with all instructions and requirements set forth in the online web portal, Assurex will perform the Services and provide a genotyping report to Customer that will be available through the online web portal. Customer understands that orders for Services may not be cancelled once Assurex performs the Services.

(3). Billing: Assurex shall be responsible for billing for the Services and for collecting payment for the Services from Customer's patients and/or from legally responsible third party insurers. In the event that Customer's patient and/or a third party insurer fails to pay Assurex for Services, Customer shall not be responsible for compensating Assurex for the Services. Customer does not accept Medicare Part A patients and therefore anticipates no services to be ordered for patients under Medicare Part A.

(4). Assurex Warranty: Assurex warrants that the Services shall be performed in accordance with good laboratory practices and established laboratory protocols and all applicable laws, regulations, and rules and that it is not currently excluded from a federal or state health care program.

(5). Customer Warranty: Customer warrants that it (a) has the legal authority to place orders for laboratory tests; (b) shall obtain any and all patient consents to collect, transfer, and have tested any samples necessary for Services, as required by applicable laws, regulations, and rules; (c) is not currently excluded from a federal or state health care program; (d) shall use information derived from a genotyping report provided by Assurex only for treatment of the patient or for other legally permissible purposes.

(6). Confidentiality: Assurex and Customer shall maintain in strict confidence all information received in connection with this Agreement and will not disclose the information to any third party except as permitted or required by applicable law, regulation, or rule.

(7). Non-Exclusive Agreement: Assurex and Customer acknowledge that this Agreement is not exclusive and does not preclude Customer from ordering laboratory testing services from another laboratory provider.

(8). Limitation of Liability: Neither party shall have any liability of any type for any special, incidental, indirect, or consequential damages, including but not limited to the loss of opportunity, loss of use, or loss of revenue or profit in connection with or arising out of this Agreement. In no event shall Assurex's total liability for direct damages under this Agreement exceed the amount of fees paid to Assurex in connection with this Agreement as of the date that the cause of action is alleged to have arisen.

(9). Publicity: Neither party may use the name, trademark, or service mark of the other party in connection with any publicity without the prior written consent of the other party; provided, however, that Assurex may include Customer's name as a customer of Assurex in its promotional and marketing materials and on Assurex's website. Assurex, without prior written consent, may use Customer's name as a referral with Assurex customers or potential customers.

(10). Assignment: This Agreement is not assignable by either party without the prior written consent of the other party, except that either party may assign this Agreement in connection with the merger or sale of all or substantially all of its assets without such prior consent, and Assurex may delegate or otherwise assign any portion of the Services to a third party laboratory or other provider, provided that such third party is subject to and complies with performance standards comparable to those agreed upon by the parties to this Agreement.

(11). Governing Law: This Agreement shall be governed by the laws of the State of Ohio without regard to conflicts of law principles.

(12). Term and Termination: The Term of this Agreement shall begin on the Effective Date and continue until terminated. This Agreement may be terminated at any time by either party upon written notice to the other party.

(13). Prior Agreements: This Agreement and any written amendment hereof executed by the parties constitutes the entire understanding between the parties with respect to the subject matter hereof and replaces and supersedes all prior agreements, written or oral, with respect thereto. All purchases of Services by Customer after the Effective Date will be governed by the terms of this Agreement and any prior agreements with respect to the Services shall be deemed cancelled.

Customer Authorized Signature		Assurex Health, Inc.		Account Representative
Signature:	RR Dwenger MD	Signature:	Donald R. Wright	Matt Montano
Name:	Randall Dwenger MD	Name:	Donald R. Wright	
Date:	August 24, 2016	Date:	8/24/2016	

CONFIDENTIAL HEALTHCARE INFORMATION
Customer Service 866.757.9204 • Fax 888.894.4344
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TRANSFER AGREEMENT

This Transfer Agreement ("Agreement") is made as of the 31 day of August, ~~2014~~ 2015 ("Effective Date"), by and between YNHH Hospital, Inc. ("Hospital"), a Connecticut non-stock corporation located at 20 York Street, and Northwinside Treatment Center ("Facility"), a Substance Abuse Treatment Center with a principal address at 187 S Cassaway Board. AMM

WHEREAS, Hospital is an acute care hospital that is available as a resource to other health care facilities and their patients; and

WHEREAS, in the order to provide optimal care to its community, Facility from time to time desires to transfer patients to Hospital; and

WHEREAS, to the best of its ability, Hospital desires to accept such patients in order to provide them with optimal care:

NOW THEREFORE, in the consideration of the mutual undertakings set forth below, Hospital and Facility, the "parties" to this transfer protocol and Agreement ("Agreement") hereby agree as follows:

A. The Decision

1. Facility's transferring attending physician shall be responsible for evaluating the patient's condition and shall determine the appropriateness or advisability of transfer. In any such case which Facility's physician determines that a transfer to Hospital is medically necessary and/or appropriate in accordance with state and federal statutes and regulations. Facility's attending physician shall follow the protocol set forth below to request transfer of the patient to Hospital:

   i. Emergency Transfers. Facility will call the Hospital Y Access Line at -------- to inform Hospital of the transfer, and to speak with the appropriate physician or physician assistant regarding the patient's status and condition. Facility will promptly fax all relevant patient information to such physician or physician assistant, as necessary or upon Hospital's request.

   ii. Non-Emergency Transfers/Direct Admissions. Facility will coordinate the transfer of Facility patients requiring non-emergency direct admissions to Hospital via the Hospital Y Access Line at ----------. Facility will obtain the name and fax number of the patient's assigned physician or Hospital location from Y Access, and promptly fax all relevant medical records to Hospital.

2. Subject to the availability of beds, staff and resources necessary for the care and treatment of the patient, the Hospital receiving physician shall call to accept or decline to accept transfer of the patient. After Hospital has accepted the patient and the patient is en route, Hospital may not subsequently cancel orders to accept the patient unless Hospital arranges for another acute care hospital or or other appropriate facility to accept the patient.

3. Facility's transferring physician shall provide all necessary medical treatment within the capabilities of the staff and facilities available at Facility in order to minimize the risks of transfer to the patient's health, and in consultation with Hospital's receiving physician, shall determine the selection of appropriate transportation and the level of care required for appropriate management of the patient *en route* to Hospital.

4. Facility's transferring physician shall be responsible for the oversight of *en route* patient management. Upon arrival at Hospital the receiving physician or Emergency Department agrees to assume medical control and direction, all in accordance with applicable protocols and operating procedures.

5. All Transfers shall be subject to each party's admission and discharge policies as well as their usual rules, regulations, and other policies.

6. Each Party will maintain required medical care and transfer documentation in accordance with state and federal statute and regulations.

7. In order for Hospital to maintain tertiary care capacity, Facility agrees upon the request of Hospital, to accept for return transfer and prompt admission to Facility any patient who has been transferred by Hospital hereunder and who has been medically stabilized and becomes once again appropriate.for the level of care available at Facility. Such return transfer shall be for the convenience of the patient and his or her family, and shall occur upon the appropriate communication and acceptance by attending physicians of both parties.

B. Patient Information

1. At the time of transfer, Facility shall provide Hospital with all the medical records associated with the admission as required by federal and state statutes and regulations, including but not limited to the reason for transfer, information about the patient's condition, the treatment given, the patient's status at the time of transfer, and any other available, relevant information, such as test results, x-ray films, and imaging studies. In addition, Facility should provide an initial diagnostic impression as well as whatever available patient information (the patient's name, address, hospital number, and the name, address, and the next of kin or other person responsible for the patient) that Facility may have.

2. In the event full patient information is not provided at the time of transfer and subsequently becomes available; Facility shall promptly transmit it to Hospital.

3. Facility shall provide Hospital with all available information required for patient charges, including but not limited to any insurance information and demographic and financial data, in order to facilitate proper and efficient billing at Hospital of the service it renders. If Hospital obtains such information from another source, upon request from Facility, Hospital shall provide the information to Facility to assist it to properly bill for Facility's services.

4. If the patient is to be transferred back to Facility subsequent to treatment at Hospital, Hospital shall promptly provide Facility with summaries of medical records and other pertinent information.

C. Compliance with Applicable Federal and State Statues and Regulations and Other Standards

1. The parties recognize that the Agreement and any patient transfers made in accordance with the Agreement are subject to applicable state and federal statutes and regulations, as well as any applicable accreditation and verification requirements. The parties agree to conform their respective obligations under this Agreement in accordance with the applicable requirements.

D. Quality Assurance, Education, and Research

1. Upon request, Facility shall cooperate with Hospital in the development and implementation of any patient transfer quality assurance or research program(s).

2. Whenever possible, Hospital shall include Facility in programs such as public education for injury prevention, outreach programs, and continuing education programs for staffs, community nurses, physicians, and allied health personnel.

E. Insurance

At all times, each party shall maintain in full force and effect policies of professional and general liability insurance (or equivalent self-insurance mechanisms) insuring itself and its employees. Each party shall ensure that members of its medical staff who may not be employees are appropriately and adequately insured for professional liability. These insurance or equivalent self-insurance mechanisms shall include tail coverage for the period of this Agreement.

F. Term of Agreement and Termination

This Agreement shall commence as of the Effective Date, and shall continue for a period of two years. This Agreement may be terminated by either party at any time without cause by providing the other party with at least sixty (60) days advance written notice. This Agreement will terminate automatically should either party fail to maintain its license or accreditation, or become excluded from participation in any federal health care program.

G. Other Terms and Conditions

1. If any change in law or regulation would cause any provision of the Agreement to jeopardize either party's tax exempt status under section 501(C)(3) of the Internal Revenue Code, the party at its option may terminate this Agreement. However, prior to such termination, the parties agree to use their best efforts to amend this Agreement so that its intent conforms to such applicable laws and/or regulations and to preserve their respective tax-exempt status without terminating this Agreement.

2. If any provision of this Agreement is determined by final decision of an administrative agency or court (after exhaustion of appeals or appeal rights) to be invalid or in violation of any law or regulations, such provision shall be severed from this Agreement and the remainder of this Agreement shall be given effect by the parties as if such provision never had been part of this Agreement.

3. This Agreement is not intended and shall not be construed to create any agency relationship between the parties. Furthermore, this Agreement is not intended and shall not be construed to create an exclusive transfer relationship between the parties.

4. Each party shall directly bill any patient transferred hereunder (or the patient's payer) for its respective services rendered to the patient, and neither party shall be responsible to the other for payment for services rendered by the other.

5. Nothing contained in this Agreement is intended to nor shall be construed to create any third party rights for a patient or any other person or entity not a party to this Agreement.

6. This Agreement shall be construed and all of the rights, powers and liabilities of the parties shall be determined in accordance with the laws of the State of Connecticut.

7. This Agreement contains the whole understanding of the parties and supercedes all prior oral or written representations and agreements between the parties or between the parties and any of their representatives or staff as to the subject matter of this Agreement, and may not be varied except in a writing executed by the parties.

8. This Agreement may not be assigned by either party without the prior written consent of the other party, except that upon advance written notice to the other party either party may assign this Agreement to a successor corporation that carries on all or substantially all of its business. Subject to the foregoing limitation upon assignment, this Agreement shall be binding upon and insure to the benefit of the successors and assigns of the parties

9. To the extent that any of the services provided in accordance with this Agreement are deemed by the Secretary of the Federal Department of Health and Human services, the U.S. Comptroller General, or the Secretary's or Comptroller's delegate, to be subject to the provisions of section 952 of Public Law 96-499, the parties, until the expiration of four (4) years subsequent to the furnishing of services, shall make available, upon written request of the Secretary, or of the Comptroller, or any of their duly authorized representatives, this Agreement, and the books, documents and records of the parties that are necessary to certify the nature and extent of the charges to patients for service provided under this Agreement.

10. If either party carries out any of the duties of this Agreement through a Subcontract, with a value or cost of $10,000 or more over a twelve month period, with a related organization (as that term is defined with regard to a provider in 42 C.F.R. Section 405.427(b)), such subcontract shall contain a clause to the effect that until the expiration of four (4) years after the furnishing of such services pursuant to such subcontract, the related organization upon written request shall make available, to the Secretary or the Comptroller, or any of their duly authorized representatives, the subcontract, and books, documents, and records of such organization that are necessary to verify the nature and extent of such costs.

11. To the extent that any of the provisions of Section G-9 and G-10 of this Agreement vary from any provision required by final regulations issued under the authority of Section 952 of Public Law 96-499, the provision required by the final regulations shall be deemed by the parties to supercede these sections and be made a part of this Agreement by reference.

12. If either party is requested to disclose any books, documents, or records relevant to this Agreement for the purpose of an audit or investigation relating directly to the provision of services under this Agreement (e.g. a governmental investigation of billing practices or services provided to patients), such party shall notify the other party of the nature and scope of the request and, to the extent permitted, shall make available to the other party, upon its written request, relevant books, documents or records.

13. The headings, titles and captions used in this Agreement are merely for the convenience of the parties and are not intended to add to, subtract from, or in any other manner modify or affect the construction of the substantive terms of this Agreement.

14. This Agreement shall be executed in at least two counterparts; each of which shall be deemed an original, but all such counterparts shall together constitute one and the same instrument. It shall not be necessary in making proof of this Agreement to produce or account for more than one counterpart.

In witness hereof, the authorized representatives of Hospital and Facility do hereby execute this Transfer Protocol and Agreement.

Facility: _____

_____ Date: 8/31/15

Name: Martin Fecker
Title: Managing Partner

Hospital

_____ Date: 9/1/15

Name: Stephen M. Mere
Title: Vice President

Sharon Hospital Affiliation Agreement with Touro College of Osteopathic Medicine

AFFILIATION AGREEMENT

THIS AFFILIATION AGREEMENT is dated 2/22/16 and is entered into by and between Sharon Hospital (hereinafter referred to as Provider), and **Touro College of Osteopathic Medicine**, a division of Touro College, a New York not-for-profit education corporation (hereinafter referred to as TouroCOM).

WITNESSETH:

WHEREAS, Provider is providing health care services; and

WHEREAS, TouroCOM is engaged in educating osteopathic medical students, coordinating the training of osteopathic interns and residents (such medical students, interns and residents being hereinafter collectively referred to as Students), and advancing osteopathic medical education; and

WHEREAS, TouroCOM believes it will be beneficial to its Students to obtain clinical education and experience with Provider; and

WHEREAS, Provider is willing to provide the necessary facilities and supervision of TouroCOM Students as part of said clinical experiences,

NOW, THEREFORE, for the purpose of providing for the education and clinical experience of Students, and in consideration of the mutual obligations set forth herein, the parties hereto hereby agree as follows:

1. Provider Obligations. During the term of this Agreement, Provider agrees to the following with respect to clinical experience of Students from TouroCOM:

A. To provide and maintain an environment conducive to the clinical education and training of Students;

B. To assist Students in obtaining experience in patient care by allowing Students to observe and assist in patient care under the supervision of qualified Provider physicians;

C. To provide and maintain an environment which encourages critical dialogue between the Provider physicians and Students through clinical experiences, rounds and conferences; and

D. To provide access to Provider's medical library, teaching materials, and Provider facilities, to assist said Students in their efforts with Provider's professional staff in providing proper care for patients.

2. TouroCOM Obligations. During the term of this Agreement, TouroCOM agrees to provide the following with respect to clinical clerkships of undergraduate osteopathic students participating in clinical clerkships at the Provider Institution:

A. TouroCOM shall maintain professional liability insurance coverage for student while student is performing duties under the scope of this Agreement in the minimum amount of $2,000,000 per claim and a $4,000,000 in the aggregate; and

B. TouroCOM shall send copies of the following to Provider Institution no less than two weeks prior to the commencement of the clinical clerkship assignment:

1. Names of the relevant Students
2. Relevant TouroCOM procedures and policies
3. Evaluation procedures and forms
4. Each Student's proof of current immunization record
5. Each Student's proof of professional liability insurance

3. Criminal Background Checks. TouroCOM will have conducted a background check on each medical student participating in the program. The background check shall comply with the JCAHO's Standard HR. 1.20.

4. Clinical Assignments, Conferences. All clinical experiences and conferences assigned pursuant to this Agreement shall be mutually agreed upon by the Office of Clinical Rotations for TouroCOM and the Director of Medical Education for Provider (or other appropriate individual designated by Provider) in concert with designated physicians on the professional medical staff of Provider.

5. Assignment of Students. All Students subject to this Agreement shall be assigned to Provider by TouroCOM pursuant to the oversight of the CAO (Dean) of TouroCOM and the CAO (Dean) of Provider, or such other persons as they may designate, who will develop the operative parameters of this clinical education agreement. Each assignment shall be directed toward developing the Student's clinical competence (knowledge, procedures/skills, clinical problem solving, and professional attitudes and behaviors) in the diagnosis and management of fundamental medical problems.

6. Term; Termination. This Agreement shall commence on the date set forth above and shall continue for period of 5 years. It shall automatically renew thereafter for additional successive terms of two years each. Either party may terminate this Agreement, with or without cause, on ninety (90) days' written notice to the other party. In the event of termination, students then enrolled in the Program shall be permitted to complete their clinical rotations.

7. Rules and Regulations. The Students are subject to and must abide by all written rules, regulations, and guidelines established by the American Osteopathic Association and the Joint Commission on Accreditation of Health Care Organizations. In addition, all Students must comply with Provider's written rules and regulations, all of which shall be available to Students during orientation, and all federal, state and local statutes and regulations which pertain to this Agreement and the services hereunder.

8. Withdrawal of Students. Upon the request of Provider, TouroCOM agrees to withdraw any Student from the training program when, in the reasonable opinion of the Provider and TouroCOM, such Student's work, conduct or health may be deemed detrimental to patients or others. Any Student who is removed under the provisions of this paragraph may return to the clinical training when and if the cause of removal is resolved to the satisfaction of Provider.

9. Audit. Provider shall permit visits by such persons as TouroCOM, the American Osteopathic Association, and its affiliated specialty colleges shall designate from time to time for the purpose of observing, auditing and participating in the teaching and training process.

10. Confidentiality. TouroCOM shall not disclose and shall prohibit the disclosure by Students of any information relating to the terms of this Agreement, or of Provider's hospital operations, or any privileged information relating to Provider's patients, to persons or organizations other than authorized members of Provider's medical staff, state licensing boards, third party reimbursement agencies, professional peer review organizations and insurance carriers or legal representatives, without the prior written consent of Provider or pursuant to duly issued court process or orders.

11. Independent Entities. This Agreement shall not be construed to create a general partnership, joint venture or any other organizational combination of the parties, nor shall it authorize either party to act as an agent for, or bind the other party in any manner. Provider and TouroCOM shall be and remain independent entities with respect to the performance of their respective duties and obligations hereunder.

12. Inspection of Records. In accordance with the Social Security Act and regulations thereunder or as otherwise provided by law, TouroCOM, Provider, third party

payors, the Secretary of Health and Human Services, and the Comptroller General, and their authorized representatives, shall have access to all data and records relating to the services provided under this Agreement for a period of four (4) years after the furnishing of such services, or for such other period of time as may be required by law..

13. Governing Law. This Agreement shall be interpreted, governed and construed according to the laws of the State of New York.

14. Successors and Assigns. This Agreement is binding upon the parties hereto, and their respective successors and/or assigns.

15. Severability. This Agreement is intended to be formed in accordance with, and only to the extent permitted by, all applicable laws, ordinances, rules and regulations. If any provision of this Agreement or the application thereof to any person, entity or circumstance shall for any reason and to any extent be held to be invalid or unenforceable, the remainder of this Agreement and the application of such provision to the other person or circumstances shall not be affected thereby, but rather shall be enforced to the greatest extent permitted by law.

16. Entire Agreement. This Agreement constitutes the entire agreement between the parties hereto with respect to the subject matter hereof and it is understood and agreed that all undertakings and agreements heretofore had between the parties with respect to the subject matter of this Agreement are merged herein. The provisions herein shall inure to the benefit of and shall be binding upon the parties hereto and their respective successors and assigns. This Agreement may only be modified by a subsequent written agreement executed by all parties hereto.

17. Notices. Notices or communication required or permitted to be given under this Agreement shall be deemed given to the respective parties on the date personally delivered or posted by certified mail to the following addresses, unless a different address is otherwise designated in writing in accordance herewith:

If to Provider:

If to TouroCOM: Touro College of Osteopathic Medicine
230 West 125th Street
New York, NY. 10027
Attention: Dean

18. Nondiscrimination. Each party agrees that it will not discriminate in any fashion in violation of any federal, state or municipal laws.

19. Patient Care. Provider shall retain ultimate responsible for ensuring that health care services provided or activities performed pursuant to this Agreement comply with all applicable provisions of federal, state and local laws, rules and regulations.

20. Emergency Medical Care. Provider shall make available emergency treatment to Students who may be injured during clinical rotations. Such injuries may include needle stick injury or other substantial exposure to bodily fluids of another or other potentially infectious material while participating in the program. PROVIDER shall not be financially responsible for the costs of treatment to Students. Rather, the Student shall be solely financially responsible for such costs.

21. Education Records. . All records kept by the Hospital relating to Student performance during the affiliation period shall be made available to the Parties and to the Student, and not to other persons, as required by the Family Educational Rights and Privacy Act of 1974, 20 U.S.C. §1212(g) (FERPA). A Student's written permission must be obtained before releasing specific student data to anyone other than School. In addition to the foregoing, in the event Hospital receives a request for access to education records (as such term is defined in FERPA), Hospital shall promptly notify School so that School can take prompt legal action to protect its interests.

22. Evaluations. Upon completion of clinical rotations, PROVIDER shall prepare comprehensive performance evaluation of each Student, using evaluation forms provided by TouroCOM, and shall provide TouroCOM with originals of such evaluations.

23. Costs. Each party shall pay its own costs and expenses associated with the program. PROVIDER shall not charge TouroCOM with a "clinical rotation fee" or any other fee related to TouroCOM's participation in the program.

24. Indemnification. Each party shall indemnify the other party against claims, losses, liabilities and costs and expenses (including reasonable attorneys' fees) arising out of the breach of this Agreement. The parties' indemnification obligations are conditioned on the following: (a) the indemnified party must provide the indemnifying party with: (i) prompt written notice of such claim (but in any event notice in sufficient time for the indemnifying party to respond without prejudice); (ii) the exclusive right to control and direct the investigation, defense and settlement (if applicable) of such claim; except that the indemnified party may participate in such defense at its own cost; and (iii) all reasonable necessary cooperation at the indemnifying party's expense in defending the claim; and (b) the indemnifying party will not settle any indemnifiable claim without the indem-

nified party's prior written consent to the extent such settlement requires the indemnified party to admit any liability or pay any amount not reimbursed by the indemnifying party.

25. Arbitration. Any and all disputes arising out of or relating to this Agreement or its termination shall be settled through expedited binding arbitration before a single arbitrator (who shall be an attorney knowledgeable about matters relating to health care) and shall be conducted at and by the American Arbitration Association ("AAA") or its successor pursuant to its rules and procedures in the offices of TouroCOM. The arbitrator shall be vested with determining all matters surrounding this Agreement, including, but not limited to, the enforceability and scope of this arbitration clause. The costs of such arbitration shall be borne equally by the parties with each party bearing its own attorneys' fees and any costs associated with presenting its proof. Judgment upon the award shall be final and binding on the parties and may be entered in any court of competent jurisdiction.

26. Accreditation, Licensing, Credentialing. Each party shall be responsible for its own accreditation, licensing and credentialing of its employees, as applicable, and each party agrees to furnish to the other party evidence of such accreditation, licensing and credentialing upon the written request of the other party. Without limiting the foregoing, during the term of this Agreement, all precepting faculty members of PROVIDER assigned to instruct TouroCOM students at PROVIDER'S facility(ies) shall be credentialed and maintain board certification or equivalent, appropriate hospital privileges, and an unrestricted license to practice in the state where the clinical training occurs.

IN WITNESS WHEREOF, the parties have executed this Agreement to be effective as of the ___ day of 2/22/16. Lin 1. Pf., CNO

PROVIDER:	**TouroCOM:**
Sharon Hospital	Touro College of Osteopathic Medicine
By: Peter R Cordean	By: [illegible]
By: CEO	By: Dean

Attachment IX
Standards of Practice
Department of Public Health
Keeping Connecticut Healthy

DEPARTMENT OF PUBLIC HEALTH: Keeping Connecticut Healthy

Where to Find Evidence-based Methods and Interventions

Evidence-based health or public health methods and interventions are practices, procedures, programs, or policies that have been proven effective. The effects are clearly linked to the activities, themselves, not to outside, unrelated events.

Evidence of effectiveness is demonstrated by: 1) inclusion in federal registries of evidence-based interventions; 2) reports in peer-reviewed journals; 3) documentation in other reputable sources of information; or 4) the consensus of opinion among informed experts.

Evidence-based methods and interventions for any given health or public health problem can be found using the resources listed below. This list includes resources covering broad topics. PubMed (see below under **Other Resources**) is recommended for finding the newest methods and interventions related to specific problems or diseases.

Mental Health and Mental Disorders

Mental Health and Mental Disorders

Goal

Improve mental health through prevention and by ensuring access to appropriate, quality mental health services.

Overview

Mental health is a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with challenges. Mental health is essential to personal well-being, family and interpersonal relationships, and the ability to contribute to community or society.

Mental disorders are health conditions that are characterized by alterations in thinking, mood, and/or behavior that are associated with distress and/or impaired functioning.

Mental disorders contribute to a host of problems that may include disability, pain, or death.
Mental illness is the term that refers collectively to all diagnosable mental disorders.

Why Is Mental Health Important?

Mental disorders are among the most common causes of disability. The resulting disease burden of mental illness is among the highest of all diseases. In any given year, an estimated 18.1% (43.6 million) of U.S. adults ages 18 years or older suffered from any mental illness and 4.2% (9.8 million) suffered from a seriously debilitating mental illness.[1] Neuropsychiatric disorders are the leading cause of disability in the United States, accounting for 18.7% of all years of life lost to disability and premature mortality.[2] Moreover, suicide is the 10th leading cause of death in the United States, accounting for the deaths of approximately 43,000 Americans in 2014.
Mental health and physical health are closely connected. Mental health plays a major role in people's ability to maintain good physical health. Mental illnesses, such as depression and anxiety, affect people's ability to participate in health-promoting behaviors. In turn, problems with physical health, such as chronic diseases, can have a serious impact on mental health and decrease a person's ability to participate in treatment and recovery.[5]

Understanding Mental Health and Mental Disorders

The existing model for understanding mental health and mental disorders emphasizes the interaction of social, environmental, and genetic factors throughout the lifespan. In behavioral health, researchers identify:

- Risk factors, which predispose individuals to mental illness
- Protective factors, which protect them from developing mental disorders

Researchers now know that the prevention of mental, emotional, and behavioral (MEB) disorders is inherently interdisciplinary and draws on a variety of different strategies.[6]
Over the past 20 years, research on the prevention of mental disorders has progressed. The understanding of how the brain functions under normal conditions and in response to stressors, combined with knowledge of how the brain develops over time, has been essential to that progress. The major areas of progress include evidence that:

- MEB disorders are common and begin early in life
- The greatest opportunity for prevention is among young people

- There are multiyear effects of multiple preventive interventions on reducing substance abuse, conduct disorder, antisocial behavior, aggression, and child maltreatment
- The incidence of depression among pregnant women and adolescents can be reduced
- School-based violence prevention can reduce the base rate of aggressive problems in an average school by 25 to 33 percent
- There are potential indicated preventive interventions for schizophrenia
- Improving family functioning and positive parenting can have positive outcomes on mental health and can reduce poverty-related risk
- School-based preventive interventions aimed at improving social and emotional outcomes can also improve academic outcomes
- Interventions targeting families dealing with adversities, such as parental depression or divorce, can be effective in reducing risk for depression among children and increasing effective parenting
- Some preventive interventions have benefits that exceed costs, with the available evidence strongest for early childhood interventions
- Implementation is complex, and it is important that interventions be relevant to the target audiences

The progress identified above has led to a stronger understanding of the importance of protective factors. A 2009 Institute of Medicine (IOM) report advocates for multidisciplinary prevention strategies at the community level that support the development of children in healthy social environments.[7] In addition to advancements in the prevention of mental disorders, there continues to be steady progress in treating mental disorders as new drugs and stronger evidence-based outcomes become available.

Emerging Issues in Mental Health and Mental Disorders

New mental health issues have emerged among some special populations, such as:

- Veterans who have experienced physical and mental trauma
- People in communities with large-scale psychological trauma caused by natural disasters
- Older adults, as the understanding and treatment of dementia and mood disorders continues to improve

As the Federal Government begins to implement the health reform legislation, it will give attention to providing services for individuals with mental illness and substance use

disorders, including new opportunities for access to and coverage for treatment and prevention services.

References

1Center for Behavioral Health Statistics and Quality. Behavioral health trends in the United States: Results from the 2014 National Survey on Drug Use and Health. 2015. HHS Publication No. SMA 15-4927, NSDUH Series H-50. Available from**http://www.samhsa.gov/data/sites/default/files/NSDUH-FRR1-2014/NSDUH-FRR1-2014.htm**

2US Burden of Disease Collaborators. The state of US health, 1990-2010: burden of diseases, injuries, and risk factors. JAMA, 310(6): 591-608, 2013.

3Centers for Disease Control and Prevention (CDC), National Center for Injury Prevention and Control (NCIP). Web-based injury statistics query and reporting system (WISQARS) [Internet]. Atlanta: CDC; 2014. Available from: **http://www.cdc.gov/ncipc/wisqars**.

4National Institutes of Health, National Institute of Mental Health (NIMH). NIMH strategic plan (revised 2008) [Internet]. Bethesda, MD: NIMH; 2008 [cited 2010 May 6]. Available from: **http://www.nimh.nih.gov/about/strategic-planning-reports/index.shtml**

5Lando J, Marshall Williams S, Sturgis S, et al. A logic model for the integration of mental health into chronic disease prevention and health promotion. Prev Chronic Dis. 2006 April;3(2):A61.

6National Research Council and Institute of Medicine, Committee on the Prevention of Mental Disorders and Substance Abuse Among Children, Youth, and Young Adults. Preventing mental, emotional, and behavioral disorders among young people: Progress and possibilities [Internet]. O'Connell ME, Boat T, Warner KE, editors. Washington: National Academies Press; 2009. 562 p. Available from:**http://www.iom.edu/Reports/2009/Preventing-Mental-Emotional-and-Behavioral-Disorders-Among-Young-People-Progress-and-Possibilities.aspx**. This book, which can be read online for free, provides the most current evidence on preventing mental, emotional, and behavioral disorders among young people.

7National Research Council and Institute of Medicine, Committee on the Prevention of Mental Disorders and Substance Abuse Among Children, Youth, and Young Adults. Preventing mental, emotional, and behavioral disorders among young people: Progress and possibilities [Internet]. O'Connell ME, Boat T, Warner KE, editors. Washington: National Academies Press; 2009. p 18. Available from:**http://www.iom.edu/Reports/2009/Preventing-Mental-Emotional-and-Behavioral-Disorders-Among-Young-People-Progress-and-Possibilities.aspx**

Attachment X
Audited Financial Statements
Sinnamon and Associates, LLC
Certified Public Accountants
Fiscal Year 2015

MC1 Healthcare, LLC

Compiled Financial Statements
December 31, 2015 and December 31, 2014

SINNAMON & ASSOCIATES, LLC
CERTIFIED PUBLIC ACCOUNTANTS

MC1 HEALTHCARE, LLC

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December 31, 2015 and December 31, 2014

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SINNAMON & ASSOCIATES, LLC
Certified Public Accountants

MC1 Healthcare, LLC
Route 7, Box 717
Canaan, CT 06018

Management is responsible for the accompanying financial statements of MC1 Healthcare, LLC, which comprise the balance sheet as of December 31, 2015, and the related statements of income, changes in member's equity and cash flows for the year then ended in accordance with accounting principles generally accepted in the United States of America. We have performed a compilation engagement in accordance with Statements on Standards for Accounting and Review Services promulgated by the Accounting and Review Services Committee of the AICPA. We did not audit or review the financial statements nor were we required to perform any procedures to verify the accuracy or completeness of the information provided by management. Accordingly, we do not express an opinion, a conclusion, nor provide any form of assurance on these financial statements.

Management has elected to omit substantially all of the disclosures required by accounting principles generally accepted in the United States of America. If the omitted disclosures were included in the financial statements, they might influence the user's conclusions about the Company's financial position, results of operations, and cash flows. Accordingly, the financial statements are not designed for those who are not informed about such matters.

We are not independent with respect to MC1 Healthcare LLC as of and for the year m ended December 31, 2015 because we performed certain accounting services that impaired our independence.

Sinnamon & Associates LLC

Sinnamon & Associates, LLC
Certified Public Accountants

March 21, 2016
Canaan, Connecticut

CPA
America Counts on CPAs℠

194 Ashley Falls Road, P.O. Box 665
Canaan, CT 06018
860.824.7734 *phone*
860.584.9927 *fax*

Bristol Office 860.582.0119
george@sinnamoncpa.com
www.sinnamoncpa.com

237 East Center Street
Manchester, CT 06040

MC1 HEALTHCARE, LLC

CONSOLIDATED BALANCE SHEET

DECEMBER 31, 2015 and DECEMBER 31, 2014

ASSETS

	2015	2014
Current Assets:		
Cash and Cash Equivalents	$ 5,903,510	$ 430,844
Other Current Assets	5,674,794	4,547,608
Total Current Assets	11,578,304	4,978,452
Property and Equipment, net of Depreciation	2,694,232	1,770,065
Other Assets:	-	45,185
TOTAL ASSETS	$ 14,272,536	$ 6,793,702

LIABILITIES AND MEMBER'S EQUITY

Current Liabilities	3,606,131	2,307,535
Long-Term Liabilities	232,702	345,623
Member's Equity:	10,433,703	4,140,544
TOTAL LIABILITIES AND MEMBER'S EQUITY	$ 14,272,536	$ 6,793,702

See Accountant's Compilation Report

MC1 HEALTHCARE, LLC

CONSOLIDATED STATEMENT OF INCOME AND CHANGES IN MEMBER'S EQUITY
FOR THE YEARS ENDED DECEMBER 31, 2015 and DECEMBER 31, 2014

	2015	2014
Revenue	$ 33,306,314	$ 24,238,849
Operating Expenses	23,702,230	19,169,470
Total Operating Income	9,604,084	5,069,379
Other (Income) Expense	1,510,925	1,893,163
Net Income	8,093,159	3,176,216
Member's Equity - Beginning of Year	4,140,544	4,287,602
Distributions	(1,800,000)	(3,323,274)
Member's Equity - End of Year	$ 10,433,703	$ 4,140,544

See Accountant's Compilation Report

MC1 HEALTHCARE, LLC

CONSOLIDATED STATEMENT OF CASH FLOWS

FOR THE YEARS ENDED DECEMBER 31, 2015 and DECEMBER 31, 2014

	2015	2014
Cash Flows From Operating Activities:		
Net Income	$ 8,093,159	$ 3,176,216
Adjustments To Reconcile Change In Net Assets To Net Cash Provided By Operating Activities:		
Depreciation and Amortization	362,714	314,758
Loss on Disposal of Assets	22,069	12,719
(Increase) Decrease in Other Current Assets	(1,127,186)	(2,044,193)
Increase (Decrease) in Current Liabilities	1,298,596	1,037,992
Net Cash Provided By Operating Activities	8,649,352	2,497,492
Cash Flows From Investing Activities:		
Purchase of Property, Equipment and Improvements	(1,212,381)	(469,785)
Net Cash Used in Investing Activities	(1,212,381)	(469,785)
Cash Flows From Financing Activities:		
Changes in Notes Payable Debt	(164,305)	(162,455)
Distributions to Member	(1,800,000)	(3,323,274)
Net Cash Used In Financing Activities	(1,964,305)	(3,485,729)
Net Increase (Decrease) in Cash and Cash Equivalents	5,472,666	(1,458,022)
Cash and Cash Equivalents - Beginning	430,844	1,888,866
Cash and Cash Equivalents - Ending	$ 5,903,510	$ 430,844
Supplemental Information:		
Cash Paid for Interest	9,463	12,544
Property Acquired with Loan Obligations	50,111	-

See Accountant's Compilation Report

Attachment XI
Financial Worksheet B

FINANCIAL WORKSHEET I (B)

FOR-PROFIT

Applicant Name: MC1 Healthcare LLC

Financial Worksheet (B)

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:

		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
LINE	Total Entity:	FY2016*	FY 2017	FY 2017	FY 2017	FY 2018	FY 2018	FY 2018	FY 2019	FY 2019	FY 2019			
		Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected
	Description	Results	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON
A.	**OPERATING REVENUE**													
1	Total Gross Patient Revenue	$0	$0	$0	$0			$0			$0			$0
2	Less: Allowances	$0	$0	$0	$0			$0			$0			$0
3	Less: Charity Care	$0	$0	$0	$0			$0			$0			$0
4	Less: Other Deductions	$0	$0	$0	$0			$0			$0			$0
	Net Patient Service Revenue	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
5	Medicare	$0	$0	$0	$0			$0			$0			$0
6	Medicaid	$0	$0	$0	$0			$0			$0			$0
7	CHAMPUS & TriCare	$0	$0	$0	$0			$0			$0			$0
8	Other	$0	$0	$0	$0			$0			$0			$0
	Total Government	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
9	Commercial Insurers	$0	$0	$144,918	$144,918		$185,089	$185,089		$215,240	$215,240			$0
10	Uninsured	$0	$0	$0	$0		$0	$0		$0	$0			$0
11	Self Pay	$0	$0	$50,761	$50,761		$64,832	$64,832		$75,393	$75,393			$0
12	Workers Compensation	$0	$0	$0	$0			$0			$0			$0
13	Other	$0	$0	$0	$0			$0			$0			$0
	Total Non-Government	**$0**	**$0**	**$195,678**	**$195,678**	**$0**	**$249,921**	**$249,921**	**$0**	**$290,633**	**$290,633**	**$0**	**$0**	**$0**
	Net Patient Service Revenue[a] (Government+Non-Government)	**$0**	**$0**	**$195,678**	**$195,678**	**$0**	**$249,921**	**$249,921**	**$0**	**$290,633**	**$290,633**	**$0**	**$0**	**$0**
14	Less: Provision for Bad Debts	$0	$0	$2,588	**$2,588**		$3,305	**$3,305**		$3,844	**$3,844**			**$0**
	Net Patient Service Revenue less provision for bad debts	**$0**	**$0**	**($2,588)**	**($2,588)**	**$0**	**($3,305)**	**($3,305)**	**$0**	**($3,844)**	**($3,844)**	**$0**	**$0**	**$0**
15	Other Operating Revenue	$0	$0	$0	**$0**			**$0**			**$0**			**$0**
17	Net Assets Released from Restrictions	$0	$0	$0	**$0**			**$0**			**$0**			**$0**
	TOTAL OPERATING REVENUE	**$0**	**$0**	**$193,091**	**$193,091**	**$0**	**$246,615**	**$246,615**	**$0**	**$286,790**	**$286,790**	**$0**	**$0**	**$0**
B.	**OPERATING EXPENSES**													
1	Salaries and Wages	$0	$0	$75,000	$75,000		$77,250	$77,250		$99,459	$99,459			$0
2	Fringe Benefits	$0	$0	$22,500	$22,500		$23,175	$23,175		$29,838	$29,838			$0
3	Physicians Fees	$0	$0	$0	$0		$0	$0		$0	$0			$0
4	Supplies and Drugs	$0	$0	$6,427	$6,427		$7,391	$7,391		$8,500	$8,500			$0
5	Depreciation and Amortization	$0	$0	$0	$0			$0			$0			$0
6	Provision for Bad Debts-Other[b]	$0	$0	$0	$0		$0	$0		$0	$0			$0
7	Interest Expense	$0	$0	$0	$0			$0			$0			$0
8	Malpractice Insurance Cost	$0	$0	$6,000	$6,000		$6,500	$6,500		$7,000	$7,000			$0
9	Lease Expense	$0	$0	$60,000	$60,000		$61,800	$61,800		$63,654	$63,654			$0
10	Other Operating Expenses	$0	$0	$17,500	$17,500		$57,500	$57,500		$59,225	$59,225			$0
	TOTAL OPERATING EXPENSES	**$0**	**$0**	**$187,427**	**$0**	**$0**	**$233,616**	**$233,616**	**$0**	**$267,676**	**$267,676**	**$0**	**$0**	**$0**
	INCOME/(LOSS) FROM OPERATIONS	**$0**	**$0**	**$5,664**	**$193,091**	**$0**	**$12,999**	**$12,999**	**$0**	**$19,114**	**$19,114**	**$0**	**$0**	**$0**
	NON-OPERATING INCOME	**$0**	**$0**	**$0**	**$0**			**$0**			**$0**			**$0**
	Income before provision for income taxes	**$0**	**$0**	**$5,664**	**$193,091**	**$0**	**$12,999**	**$12,999**	**$0**	**$19,114**	**$19,114**	**$0**	**$0**	**$0**
	Provision for income taxes[c]	**$0**	$0	**$2,549**	**$2,549**		**$5,850**	**$5,850**		**$8,601**	**$8,601**			**$0**

[redacted]

FINANCIAL WORKSHEET I (B)

FOR-PROFIT

Applicant Name: MC1 Healthcare LLC

Financial Worksheet (B)

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:

		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
LINE	Total Entity:	FY2016*	FY 2017	FY 2017	FY 2017	FY 2018	FY 2018	FY 2018	FY 2019	FY 2019	FY 2019			
		Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected
	Description	Results	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON
	NET INCOME	$0	$0	$3,115	$3,115	$0	$7,150	$7,150	$0	$10,513	$10,513	$0	$0	$0
C.	**Retained Earnings, beginning of year**	$0	$0	$0	$0		$3,115	$3,115		$10,265	$10,265			$0
	Retained Earnings, end of year	$0	$0	$3,115	$3,115		$10,265	$10,265		$20,777	$20,777			$0
	Principal Payments	$0	$0	$0	$0			$0			$0			$0
D.	**PROFITABILITY SUMMARY**													
1	Hospital Operating Margin	0.0%	0.0%	2.9%	100.0%	0.0%	5.3%	5.3%	0.0%	6.7%	6.7%	0.0%	0.0%	0.0%
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%
3	Hospital Total Margin	0.0%	0.0%	1.6%	1.6%	0.0%	2.9%	2.9%	0.0%	3.7%	3.7%	0.0%	0.0%	0.0%
E.	**FTEs****	2	0	2.5	2.5		2.5	2.5		2.5	2.5			0
F.	**VOLUME STATISTICS[d]**													
1	Inpatient Discharges	0	0	0	0			0			0			0
2	Outpatient Visits***	0	0	569	569		705	705		796	796			0
	TOTAL VOLUME	0	0	569	569	0	705	705	0	796	796	0	0	0

[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 change due to the proposal.

* Projected entity start-up April 1, 2017: FY2017 amounts reflect 9 months initial operation projections (Apr 1- Dec 31); applicant fiscal year is Jan 1-Dec 31.

** FTEs represent 1 clerical position and 1 clinical position

** Outpatient visits are counted as single encounters/groups. The Outpatient program provides clients with three 3-hours encounters/groups per week for 12 weeks. The total number of units is calculated as follows:
Group size x 3 sessions/week x 12 week duration x 4.33 group rotations per year.

[redacted]

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

Type of Service Description	Outpatient
Type of Unit Description:	Encounter/visit
# of Months in Operation	2

FY 2016	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
FY Projected Incremental		Rate	Units	Gross	Allowances/	Charity	Bad	Net	Operating	Gain/(Loss)
Total Incremental Expenses:	**$0**			Revenue	Deductions	Care	Debt	Revenue	Expenses	om Operations
				Col. 2 * Col. 3				Col.4 - Col.5 -Col.6 - Col.7	Col. 1 Total *Col. 4 / Col. 4 Total	Col. 8 - Col. 9
Total Facility by Payer Category:										
Medicare				$0				$0	$0	$0
Medicaid		$0		$0				$0	$0	$0
CHAMPUS/TriCare		$0		$0				$0	$0	$0
Total Governmental			0	$0	$0	$0	$0	$0	$0	$0
Commericial Insurers			0	$0	$0	$0	$0	$0	$0	$0
Self-Pay			0	$0	$0	$0		$0	$0	$0
Total NonGovernment		$0	0	$0	$0	$0	$0	$0	$0	$0
Total All Payers		$0	0	$0	$0	$0	$0	$0	$0	$0

Type of Service Description	Outpatient
Type of Unit Description:	Encounter/visit
# of Months in Operation	12

FY 2017 (Apr-Dec)	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
FY Projected Incremental		Rate	Units	Gross	Allowances/	Charity	Bad	Net	Operating	Gain/(Loss)
Total Incremental Expenses:	**$187,427**			Revenue	Deductions	Care	Debt	Revenue	Expenses	om Operations
				Col. 2 * Col. 3				Col.4 - Col.5 -Col.6 - Col.7	Col. 1 Total *Col. 4 / Col. 4 Total	Col. 8 - Col. 9
Total Facility by Payer Category:										
Medicare				$0				$0	$0	$0
Medicaid		$0		$0				$0	$0	$0
CHAMPUS/TriCare		$0		$0				$0	$0	$0
Total Governmental			0	$0	$0	$0	$0	$0	$0	$0
Commericial Insurers		$560	370	$207,025	$62,108	$0	$2,588	$142,330	$150,521	($8,191)
Self-Pay		$255	199	$50,761				$50,761	$36,906	$13,854
Total NonGovernment		$0	569	$257,786	$62,108	$0	$2,588	$193,091	$187,427	$5,664
Total All Payers		$0	569	$257,786	$62,108	$0	$2,588	$193,091	$187,427	$5,664

[redacted]

Type of Service Description	Outpatient									
Type of Unit Description:	Encounter/visit									
# of Months in Operation	12									
FY 2018	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
FY Projected Incremental		Rate	Units	Gross	Allowances/	Charity	Bad	Net	Operating	Gain/(Loss)
Total Incremental Expenses:	**$233,616**			Revenue	Deductions	Care	Debt	Revenue	Expenses	om Operations
				Col. 2 * Col. 3				Col.4 - Col.5	Col. 1 Total	*Col. 8 - Col. 9
Total Facility by								-Col.6 - Col.7	l. 4 / Col. 4 Total	
Payer Category:										
Medicare				$0				$0	$0	$0
Medicaid				$0				$0	$0	$0
CHAMPUS/TriCare				$0				$0	$0	$0
Total Governmental			0	$0	$0	$0	$0	$0	$0	$0
Commericial Insurers		$577	458	$264,412	$79,324	$0	$3,305	$181,783	$187,614	($5,831)
Self-Pay		$263	247	$64,832				$64,832	$46,002	$18,830
Total NonGovernment		$0	705	$329,244	$79,324	$0	$3,305	$246,615	$233,616	$12,999
Total All Payers		$0	705	$329,244	$79,324	$0	$3,305	$246,615	$233,616	$12,999

Type of Service Description	Outpatient									
Type of Unit Description:	Encounter/visit									
# of Months in Operation	12									
FY 2019	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
FY Projected Incremental		Rate	Units	Gross	Allowances/	Charity	Bad	Net	Operating	Gain/(Loss)
Total Incremental Expenses:	**$267,676**			Revenue	Deductions	Care	Debt	Revenue	Expenses	om Operations
				Col. 2 * Col. 3				Col.4 - Col.5	Col. 1 Total	*Col. 8 - Col. 9
Total Facility by								-Col.6 - Col.7	l. 4 / Col. 4 Total	
Payer Category:										
Medicare				$0				$0	$0	$0
Medicaid		$0		$0				$0	$0	$0
CHAMPUS/TriCare		$0		$0				$0	$0	$0
Total Governmental			0	$0	$0	$0	$0	$0	$0	$0
Commericial Insurers		$594	518	$307,486	$92,246	$0	$3,844	$211,397	$214,968	($3,571)
Self-Pay		$271	279	$75,393				$75,393	$52,708	$22,685
Total NonGovernment		$0	796	$382,879	$92,246	$0	$3,844	$286,790	$267,676	$19,114
Total All Payers		$0	796	$382,879	$92,246	$0	$3,844	$286,790	$267,676	$19,114

[redacted]

Greer, Leslie

From: Walker, Shauna
Sent: Friday, November 18, 2016 10:28 AM
To: maureen.biggs01@gmail.com
Cc: Riggott, Kaila; Fernandes, David; User, OHCA; Walker, Shauna
Subject: Completeness Questions on CON Application # 16-32129
Attachments: 16-32129 Completeness.docx

Dear Ms. O'Neill Biggs:

Please see attached request for additional information regarding CON application 16-32129 – Establishment of a Psychiatric Outpatient Clinic for Adults in Litchfield County. There are additional items that need to be addressed.

Please contact me if you have any questions. Reponses are due by **Tuesday January 17, 2017**.

Much Regards,

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

November 18, 2016 VIA EMAIL

Maureen O'Neill Biggs, LPC, LADC
Consultant
26 Halsey Drive
Wallingford, CT 06492
maureen.biggs01@gmail.com

RE: Certificate of Need Application, Docket Number 16-32129-CON
Establishment of a Psychiatric Outpatient Clinic for Adults

Dear Ms. O'Neill Biggs:

On October 19th, 2016, the Department of Public Health ("DPH"), Office of Health Care Access ("OHCA") received the Certificate of Need ("CON") application on behalf of MC1 Healthcare, LLC, d/b/a/ Mountainside Treatment Center ("Mountainside" or "Applicant") proposing to establish a psychiatric outpatient clinic for adults residing in Litchfield County.

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; david.fernandes@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 **January 17, 2017**, 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 296** and reference "**Docket Number: 16-32129-CON**."

1. Provide the referral sources for Mountainside's residential and OP ("Outpatient") /IOP ("Intensive Outpatient") substance abuse treatment programs. In addition, provide the referral sources for Mountainside's proposed psychiatric outpatient clinic.

2. Describe how other residents in Canaan and surrounding towns (not discharged from Mountainside's residential program) would be referred to the proposed psychiatric outpatient clinic (e.g., self-referrals, referrals through behavioral health professionals, Connecticut state agencies, etc.). How and where are these potential clients currently receiving mental health treatment?

3. Please update the chart on page 10 of the application with current year-to-date data indicating the trend of co-occurring disorders.

4. Are the number of referrals made to other mental health facilities known? If so, please complete the table below documenting where the 223 clients were referred to (as stated on page 11 of the application).

Mental Health Facility	Number of Clients

5. Page 11 of the application states that a Medical Director/Psychiatrist, Director of Psychiatry, Psychiatric APRN, and a Doctor of Nursing were hired in response to increased need for mental health services for its substance abuse programs. Will these individuals staff the proposed psychiatric outpatient clinic?

6. Page 13 of the application states that the existing location was chosen for the psychiatric outpatient clinic to improve client health outcomes, including reduced rates of relapse. Provide specific examples of how client health outcomes will be improved. What is the rate of relapse for Mountainside clients? Provide evidence such as scholarly articles, studies or reports which demonstrate how location of services may impact rates of relapse.

7. Explain what is meant by extended care, as mentioned throughout the application.

8. Pages 27 and 31 of the application state 52 previously referred clients from the "Litchfield County Pool" will likely enroll in the proposed program per year, but page 41 states referral

patterns will not be affected. Please clarify the effects of the referral process on area providers with the addition of the proposed psychiatric outpatient clinic.

9. Please provide a copy of the charity care policy and sliding fee scale.

10. The application specifies that Mountainside does not accept Medicaid or other governmental insurance or entitlements. Page 33 of the application indicates the proposal will not impact access to care for Medicaid recipients or indigent persons. Pursuant to Conn. Gen. Stat. Section 19a-639(10) italicized below, please provide in detail, good cause for not providing services to Medicaid recipients.

    Conn. Gen. Stat. § 19a-639(a)(10))§ Whether an applicant, who has failed to provide or reduced access to services by Medicaid recipients or indigent persons, has demonstrated good cause for doing so, which shall not be demonstrated solely on the basis of differences in reimbursement rates between Medicaid and other health care payers.

11. Please indicate the fiscal years for each of the columns of the rate schedule table on page 33 of the application.

12. Define "conversion rate," as mentioned on page 35 of the application. What methods and calculations are used in calculating the 25% conversion?

13. Complete Tables 5 and 6 on page 36 of the application. Historical utilization should include volume by program type for the residential and IOP/OP substance abuse treatment programs. Projected utilization should include volume by program type for both programs currently offered and the proposed psychiatric outpatient clinic. Provide the unit of measure (clients, sessions or visits).

14. Page 37 of the application states that the SAMHSA prevalence rate is 18.2% for adults diagnosed with mental in the United States. According to SAMHSA's National Survey for Drug Use and Health, however, the percentage of adults diagnosed is 18.1%. Please confirm the correct SAMHSA prevalence rate, and provide a revised response for question 26 on page 37.

15. What treatment programs are the basis for the utilization data in Table 8 on page 39? Include utilization by town of client origin for all treatment programs and provide the unit of measure (clients, sessions or visits).

16. Page 41 of the application states that 11 of the existing outpatient psychiatric service providers located in Litchfield County do not provide intensive outpatient services. However, the list of providers in Table 9 on page 40 indicates one provider, Wellspring Foundation, provides IOP treatment. An additional three providers are confirmed as providing IOP treatment via their company websites. These include MCCA New Milford, MCCA Torrington, and McCall Foundation. Update the table on page 40 and provide a revised response to question 30 on page 41 with the correct number of IOP providers.

17. Page 41 of the application states that the existing 14 outpatient providers in Litchfield County are located in Torrington, Kent, New Milford and Bethlehem. Are there means of public transportation from Canaan to these areas?

18. Update and resubmit the Financial Worksheet (B) on pages 292 and 293 of the application to include financial results for the current fiscal year, as well as projections through fiscal year 2019 without the proposal. These projections should be based on current treatment programs offered at Mountainside in Canaan. Ensure the calculations for net patient service revenue less provisions for bad debt are correct. Also, confirm the projected with CON amount in total operating expenses for fiscal year 2017.

19. Update Table 7 on page 37 of the application based on patient and visit volume. Utilize the table format below. Ensure visit totals are consistent with "Outpatient Visits" in the Financial Worksheet (B). Also, please explain the basis and the methods and calculations used to project the reported numbers.

CURRENT AND PROJECTED PAYER MIX FOR MOUNTAINSIDE, BY NUMBER OF CLIENTS AND VISITS

Payer	**Current**			**Projected**								
	FY 2016			**FY 2017**			**FY 2018**			**FY 2019**		
	Patient Vol.	**%**	**Visit Vol.**	**Patient Vol.**	**%**	**Visit Vol.**	**Patient Vol.**	**%**	**Visit Vol.**	**Patient Vol.**	**%**	**Visit Vol.**
Medicare*												
Medicaid*												
CHAMPUS & TriCare												
Total Government												
Commercial Insurers												
Self-pay												
Uninsured												
Workers Compensation												
Total Non-Government												
Total Payer Mix												

If you have any questions concerning this letter, please feel free to contact me or David Fernandes at (860) 418-7069, (860) 418-7032 or (860) 418-7001.

Sincerely,

Shauna Walker
Research Analyst

Greer, Leslie

From: Walker, Shauna
Sent: Friday, November 18, 2016 11:52 AM
To: User, OHCA; Fernandes, David; Riggott, Kaila
Subject: FW: Completeness Questions on CON Application # 16-32129
Attachments: image001.jpg

From: Maureen Biggs [mailto:maureen.biggs01@gmail.com]
Sent: Friday, November 18, 2016 11:25 AM
To: Walker, Shauna <Shauna.Walker@ct.gov>
Subject: Re: Completeness Questions on CON Application # 16-32129

Thank you. I will address the issues and call if I don't understand a question
Thanks again
Maureen

On Fri, Nov 18, 2016 at 10:28 AM Walker, Shauna <Shauna.Walker@ct.gov> wrote:

> Dear Ms. O'Neill Biggs:
>
> Please see attached request for additional information regarding CON application 16-32129 – Establishment of a Psychiatric Outpatient Clinic for Adults in Litchfield County. There are additional items that need to be addressed.
>
> Please contact me if you have any questions. Reponses are due by **Tuesday January 17, 2017**.
>
> Much Regards,
>
> **Shauna L. Walker**
>
> Office of Health Care Access
>
> Connecticut Department of Public Health
>
> 410 Capitol Avenue
>
> Hartford, CT 06134

Greer, Leslie

From: maureen.biggs01@gmail.com
Sent: Saturday, January 14, 2017 11:16 AM
To: User, OHCA; Fernandes, David; Walker, Shauna; Riggott, Kaila
Cc: Roy Sasenaraine; Sahel Shwayhat
Subject: Supplemental Questions MC1 Healthcare d/b/a Mountainside Docket # 16-32129-CON
Attachments: State of CT CON Questions 01132017 Final.docx; State of CT CON Questions 01132017 Final.pdf

I am forwarding the responses to the Supplemental Questions
Please contact me if there is anything else that you need.
Thank you so much

Maureen

Sent from Mail for Windows 10

1. **Provide the referral sources for Mountainside's residential and OP ("Outpatient") /IOP ("Intensive Outpatient") substance abuse treatment programs. In addition, provide the referral sources for Mountainside's proposed psychiatric outpatient clinic.**

   Please see Appendix One for the Referral Sources. It is our expectation that the proposed psychiatric outpatient clinic will have the same referral sources.

2. **Describe how other residents in Canaan and surrounding towns (not discharged from Mountainside's residential program) would be referred to the proposed psychiatric outpatient clinic (e.g., self-referrals, referrals through behavioral health professionals, Connecticut state agencies, etc.).**

   Clients will be referred to the proposed psychiatric outpatient clinic via self-referrals, therapists, other behavioral health agencies, hospitals (Sharon Hospital and Charlotte Hungerford Hospital, word of mouth, internet, interventionists/consultants, employee assistance programs, family members, significant others, friends, prior Mountainside clients, sober coach, sober housing, detox program, alumni services, attorneys, case managers, self-help meetings, area churches, psychiatrists, etc. Appendix One

   How and where are these potential clients currently receiving mental health treatment?

   Prior to admission to treatment a preadmission evaluation is initiated. This evaluation focuses on the clients' medical issues, medications, emotional, social, and chemical dependency issues. An initial wellness plan is formulated and the client is either referred to a higher level of care or admitted to Mountainside to what has been determined to be the most appropriate individualized level of care for the identified person served.

   On occasion, it is determined via biopsychosocial assessment, psychiatric evaluation, wellness planning and his/her social skill set that the client may have a diagnosis of primary mental illness that cannot be addressed at Mountainside. Although (given the comprehensive preadmission evaluation) this has only occurred with approximately 31/2% of the client population over the past three (3) years. Mountainside has referred to Charlotte Hungerford Hospital, Silver Hills, McClean Hospital or an appropriate level of inpatient care close to the clients' residence. If the client is stabilized and it is determined that he/she can be treated appropriately/positively at Mountainside, the client is returned to residential treatment.

3. **Please update the chart on page 10 of the application with current year-to-date data indicating the trend of co-occurring disorders.**

	2013	2014	2015^	2016^
Detox				
Total	**N/A**	**381**	**798**	**1,010**
% w/Co-Occurring DX	**N/A**	**64.8%**	**67.7%**	**75.04%**
Residential				
Total	**675**	**735**	**751**	**760**
% w/Co-Occurring DX	**69.5%**	**73.6%**	**74.5%**	**77.66%**

Data secured from Electronic Health Record, only includes clients who completed treatment. Detox opened on 6/18/2014
^ Data different from 10/19/2016 CON submission due to an unintentional error in the original data pull.
2016 numbers are 10 months annualized

4. **Are the number of referrals made to other mental health facilities known? If so, please complete the table below documenting where the 223 clients were referred to (as stated on page 11 of the application).**

Mental Health Facility	Number of Clients
McLean Hospital	90
Silver Hill Hospital	90
Other	43

Numbers in table are based on estimates of 40/40/20%. Clients are typically given a recommendation to go to either of the two hospitals listed. We have no way of knowing where they eventually went. Occasionally, if we deem the call as urgent, we recommend they go to their nearest Emergency Department.

5. **Page 11 of the application states that a Medical Director/Psychiatrist, Director of Psychiatry, Psychiatric APRN, and a Doctor of Nursing were hired in response to increased need for mental health services for its substance abuse programs. Will these individuals staff the proposed psychiatric outpatient clinic?**

   Yes they will.

6. **Page 13 of the application states that the existing location was chosen for the psychiatric outpatient clinic to improve client health outcomes, including reduced rates of relapse.**

   Provide specific examples of how client health outcomes will be improved.

   We consistently identify opportunities for improvement, utilize an assessment series to determine both ongoing client needs (Appendix Three) and progress and request that clients complete a minimum of three client surveys during active treatment so that we may continually identify issues throughout treatment focusing on both "here and now" assessment of needs and on individualized wellness planning development and reassessment in an effort to provide the most appropriate care for our clients.

Mountainside monitors engagement rates, attendance rates, retention rates, client satisfaction with treatment services, clinicians, referral sources and premature drop-out rates.

Mountainside also tracks changes over time via Alumni Support.

Our Alumni program includes:

Alumni Share Night: Alumni Share Night: Alumni with at least six months of sobriety share personal stories of recovery with current Mountainside clients who are just starting on their paths to recovery. To learn more or to schedule a time to return and share your story, please email us.

Alumni Support Groups: Alumni-led group for sharing and receiving feedback in a safe, open, honest and healthy environment. Recovery Meetings: Mountainside hosts several weekly, 12-Step speaker meetings open to all individuals in the community.

Alumni Events: Recreational and social activities that support wellness and long-term recovery, including quarterly gatherings and an annual retreat.

Alumni E-Newsletter: A monthly publication featuring strategies for maintaining sobriety, wellness tips, book recommendations, recipes for recovery as well as an alumni spotlight and Mountainside news

Alumni Twitter: Daily quotes @MtnsideAlumni to help inspire you and reinforce your commitment to recovery.

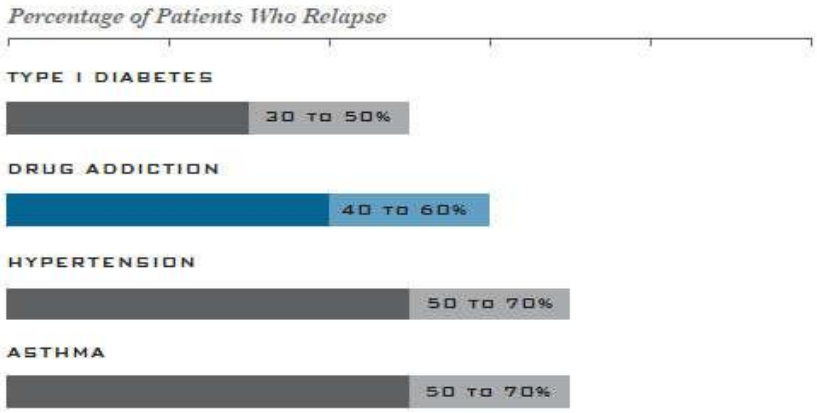
Alumni Ambassador Program: An opportunity to give back by volunteering to help those new to recovery and/or those hoping to start recovery. Ambassadors can help provide more information about the Mountainside program to potential clients, act as mentors.

What is the rate of relapse for Mountainside clients?

According to data secured via the Mountainside Outcome Measures Department, the rate of relapse for clients is approximately 20% according to readmission data and follow up calls.

"According to The National Institute on Drug Abuse, relapse rates for addiction resemble those of other chronic diseases such as diabetes, hypertension and asthma. Like other chronic diseases, addiction can be managed successfully. Unfortunately, when relapse occurs many deem treatment a failure. This is not the case: successful treatment for addiction typically requires continual evaluation and modification as appropriate, similar to the approach taken for other chronic diseases."

The following chart, according to NIDA, demonstrates the percentage of patients who relapse.[1] The national rate of relapse is stated to be 40 – 60%.



Provide evidence such as scholarly articles, studies or reports which demonstrate how location of services may impact rates of relapse.

Each client admitted to Mountainside discuss continuing care options upon admission with and with both his/her primary clinician and the continuing care department case managers.

To prepare clients for what life is like after treatment, the treatment team discusses the daily challenges they may face, how to avoid common pitfalls and where to find helpful resources. Our client's continuing care plan contains specific next steps for obtaining the level of structured recovery support he or she requires after completing treatment. The continuing care case managers work to ensure that the client's transition to the next phase of recovery is smooth and as stress-free as possible.

The treatment team and the continuing care team work collaboratively with each client to develop an individualized continuing care plan, additionally offering said client the choice of at least four (4) continuing care options in order to empower the client in an effort to improve progress and retention with the goal of relapse prevention.

The National Empowerment Center – Articles state: "Although we recognized that empowerment had elements in common with such concept as self-esteem and self-efficacy, we also felt that these concepts did not fully capture what we saw as distinctive about empowerment. After much discussion, we defined empowerment as having a number of qualities, as follows: having decision-making power, access to information and resources, a range of options from which to make choices (not just yes or no), assertiveness, a feeling that the individual can make a difference (being hopeful), effecting change in one's life and one's community, growth and change that is never ending and self-initiated, etc."[2] Appendix Three

"Empowerment has been defined in many ways but typically emphasizes client choice and control. For example, Staples (1990) defined empowerment as having ongoing capacity of individuals or groups to act

[1] National Institute on Drug Abuse, Advancing Addiction Science: Principles of Drug Addiction Treatment: A Research-Based Guide (Third Edition), Frequently Asked Questions: How Effective is drug addiction treatment?
[2] National Empowerment Center – Articles, A working definition of empowerment by Judi Chamberline

on their own behalf to achieve a greater measure of control over their lives and destinies." "Empowerment can refer to both an outcome and a process (Kieffer,1984; McLean, 1995; Rappaport, 1987; Salzer, 1997; Staples). From this viewpoint, a client is empowered not only by the outcomes of the decisions he or she makes, but also by being an active participant in the decision-making process."[3] Appendix Three

"Choice is vital to recovery for those with behavioral health issues. As new forms of health care delivery and payment are implemented, it is important that consumer choice be protected in order to improve and sustain the efficacy of treatment."

"Not only is choice of provider important to the recovery process, but choice of treatment by individuals receiving services improves health care delivery and outcomes. By giving individuals choice of treatment, it empowers them and improves their engagement with services. Studies show that choice of treatment is linked with an increased likelihood of remaining in treatment and recovery."[4]
Length of stay in treatment is also predictive of a positive outcome. Appendix Three

Additionally, Young notes:
"The therapeutic relationship provides a framework for developing collaborative wellness (relapse prevention) plans. Studies have shown that the most constructive discussions around personal growth and relapse prevention occur in the context of well-recognized elements of the therapeutic alliance – (an) empathic, collaborative, mutually trusting…..relationship." (Young et al., 2008)[5]

Data in the article notes that "Anticipation and planning are empowering processes, as they allow people to make choices and exercise personal control."[6]

"NCBI Bookshelf: 6 Traditional Settings and Models notes that adding an onsite psychiatrist in an addiction treatment setting to evaluate and prescribe medication for clients with COD has been shown to improve treatment retention and decrease substance use (Charney et al.2001; Saxon and Calsyn 1995). The onsite psychiatrist brings diagnostic, medication and psychiatric counseling services directly to the location clients are based for the major part of their treatment. This approach often is the most effective way to overcome barriers presented by offsite referral, including distance and travel limitation, the inconvenience of enrolling in another agency and of the separation of clinical services, fears, etc.[7]
We are positioned to meet this need. Appendix Three

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[3] Opportunities and Barriers to Empowering People with Severe Mental Illness through Participation in Treatment Planning; Donald M. Linhorst, Gary Hamilton, Eric Young and Anne Eckert; CCC Code 0037.
[4] Mental Health Legal Advisors Committee; www.mhlac.org, June, 2013
[5] MHOD Relapse Prevention – Working with Consumers and Others for Relapse (../index_html.html)
[6] MHOD Relapse Prevention – Working with Consumers and Others for Relapse (../index_html.html)

[7] NCBI Bookshelf, A service of the National Library of Medicine, National Institutes of Health. Center for Substance Abuse Treatment. Substance Abuse Treatment for persons with Co-Occurring Disorders. Rockville (MD) SAMHS 2005, TIP 42. 6 Traditional Settings and Models

7. Explain what is meant by extended care, as mentioned throughout the application.

Extended Care

- For individuals who seek the benefits of a longer period of treatment and greater support returning to real world settings, we offer a unique Extended Care drug and alcohol treatment program. This program serves a vibrant community of individuals in early recovery, and it focuses more deeply on developing constructive behaviors that enable long-term sobriety and smooth functioning in social, family, and vocational or educational contexts.

- Our Extended Care clients live together in a supervised sober house within walking distance of Mountainside's 24/7 recovery care and support. During the day, they work part-time in various capacities at Mountainside affiliated facilities.

- Ecare clients interact with the local community in a real-world setting while still remaining in a safe and structured sober environment.

- Clients receive outpatient addiction treatment from Mountainside's compassionate, professional team of drug abuse and alcoholism rehabilitation specialists. Through Mountainside's Extended Care rehab program, clients learn a myriad of skills including: Accountability, Communication, Life, Marketable Work Skills, Teamwork, as well as Time and Money Management.

- The length of our Extended Care addiction treatment program starts at the 90-day mark and continues as long as required to meet the needs of each individual. A flexible wellness plan is developed for each client and adjusts to meet changing needs and goals as the client progresses in recovery.

8. Pages 27 and 31 of the application state 52 previously referred clients from the "Litchfield County Pool" will likely enroll in the proposed program per year, but page 41 states referral patterns will not be affected. Please clarify the effects of the referral process on area providers with the addition of the proposed psychiatric outpatient clinic.

Mountainside will have the ability to treat clients diagnosed with mental illness which will contribute positively to the unmet need in the Northwest Region of Connecticut. As noted in Table 8, Litchfield County meets National Benchmarks and compares favorably to the state on a number of health status indicators including: residents reporting poor or fair health, prevalence of adult obesity and physical inactivity, healthy food environments, teen births, sexually transmitted infections, health insurance, and children in poverty. The county does not meet National Benchmarks but compares favorably to the state for: low birthweight, preventable hospital stays, alcohol-impaired driving deaths, diabetic monitoring and has comparable rates for poor physical and mental health days, and excessive drinking.

Other county health status indicators that do not meet National Benchmarks include premature death; adult smoking; excessive drinking (county rate is almost double the National Benchmark); ratio of primary care physicians, dentists, and mental health providers; mammography screening; and injury deaths.

Age-adjusted premature mortality is measured in years of potential life lost. Indicates the burden of premature deaths in a given population. As shown in Figure 14, for CT residents, Cancer, Heart Disease, and Unintentional Injuries were the primary causes of premature mortality, followed by drug-induced deaths. Within the service area, rates were highest in Barkhamsted, Bethlehem, Thomaston, Torrington, and Winchester.

As shown in Table 10, overall age-adjusted mortality rates in 2008-2012 were higher by one point or more than the state rates for county residents for chronic liver disease and cirrhosis, accidents, and alcohol and drug induced cause of death.

Table 10: AAMR Rates by Cause, Race, and Ethnicity, CT and Litchfield County, 2008-2012

Cause of Death	Age-Adjusted Mortality Rates (2008-2012) Per 100,000 Residents							
	Connecticut				Litchfield County			
	Total	White	Black	Hispanic	Total	White	Black	Hispanic
All causes	660.4	656.8	764.7	517.7	656.2	669.4	671.8	446.7
Malignant neoplasms	160.0	161.9	179.0	110.4	150.2	153.5	183.7	68.2*
Diabetes mellitus	14.8	13.4	31.9	20.8	10.4	10.4	-	-
Alzheimer's disease	16.9	17.4	13.5	9.5	17.6	17.8	-	-
Major cardiovascular diseases	200.2	199.9	231.8	149.9	216.9	220.9	231.8	161.0
Pneumonia and Influenza	13.7	13.5	16.1	12.4	13.0	13.3	-	-
Chronic lower respiratory diseases	32.2	33.7	22.7	17.6	38.0	39.4	-	-
Chronic liver disease and cirrhosis	7.4	7.5	4.9	11.1	8.4	8.5	-	-
Accidents (unintentional injuries)	33.3	34.8	29.3	28.8	36.4	37.4	-	26.5*
Alcohol-induced	4.9	5.3	3.6	3.9	6.6	6.8	-	-
Drug-induced	10.9	12.6	8.2	8.9	12.9	13.1	-	-

Backus K, Mueller L (2015) Age-Adjusted Mortality Rates by Race/Ethnicity for Litchfield County and Connecticut, 2008-2012. CT Department of Public Health.
Notes: Rates that are based on < 5 deaths are suppressed and indicated by a dash (-).
Rates noted with a (*) are based on < 15 deaths and should be interpreted with caution.

"Connecticut and the Northwest region have experienced an increase in emergency department visits for alcohol and other substance use disorders. Specifically, deaths due to overdoses of prescription pain killers and heroin have increased in the state and region.

Mental health and substance use disorders affect individuals, families, and communities in complex and challenging ways. In addition to premature mortality, mental health and substance use disorders contribute to substantial social and economic costs to families and communities."[8]

9. Please provide a copy of the charity care policy and sliding fee scale.

Mountainside supports other substance abuse treatment programs through contributions in form of donations, sponsorships, and participating in funds raising events (outings, dinners, etc.). Our sliding scale fee is determined based on the disposable income and is considered on the case by case basis. Clients are admitted in the order they enter the pre-admissions screening queue.

10. The application specifies that Mountainside does not accept Medicaid or other governmental insurance or entitlements. Page 33 of the application indicates the proposal will not impact access to care for Medicaid recipients or indigent persons. Pursuant to Conn. Gen. Stat. Section 19a-639(10) italicized below, please provide in detail, good cause for not providing services to Medicaid recipients.

Conn. Gen. Stat. § 19a-639(a)(10))§ Whether an applicant, who has failed to provide or reduced access to services by Medicaid recipients or indigent persons, has demonstrated good cause for doing so, which shall not be demonstrated solely on the basis of differences in reimbursement rates between Medicaid and other health care payers.

Mountainside is a private institution that does not receive any public funding. While we hope to help as many individuals is possible, it proves difficult to extend services to all. We offer an innovative and comprehensive addiction treatment program that is outside the bounds of Medicaid reimbursement. With greater public awareness of the opioid epidemic, we do hope that Title 19 can be modified to extend coverage to a greater amount of services and care providers.

11. Please indicate the fiscal years for each of the columns of the rate schedule table on page 33 of the application.

The rate schedule is as follows:

Mountainside Intensive Outpatient Fees*			
	2017	**2018**	**2019**
Insurance	$560.00	$577.00	$594.00
Uninsured	$255.00	$263.00	$271.00
% change (approximate)		+3%	+3%

[8]Northwest Connecticut Community Health Needs Assessment – 2015 Update; commissioned by Charlotte Hungerford Hospital, Project Advisors (CHH Community Relations Committee; Prepared by: The Center for Health Schools & Communities

12. Define "conversion rate," as mentioned on page 35 of the application. What methods and calculations are used in calculating the 25% conversion?

Mountainside defines the "conversion rate" as a number of potential clients that are going to utilize the co-occurring program as a percentage of total annual number of admissions. The number of potential clients is predetermined by a diagnosis code of clients who admitted to Mountainside program in the last 3 years.

13. Complete Tables 5 and 6 on page 36 of the application. Historical utilization should include volume by program type for the residential and IOP/OP substance abuse treatment programs. Projected utilization should include volume by program type for both programs currently offered and the proposed psychiatric outpatient clinic. Provide the unit of measure (clients, sessions or visits).

TABLE 5 HISTORICAL UTILIZATION BY SERVICE

	Actual Volume (Last 3 Completed FYs)			CFY Volume*
Service**	FY 2013***	FY 2014***	FY 2015***	FY 2016***^
Detoxification	n/a–opened in 2014	381	798	1,010
Residential	675	735	751	760
Outpatient/IOP	n/a–opened in 2014	95	150	190
Total	675	1,211	1,699	1,960

* 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.
** 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.
^ 2016 is 10 months annualized

14. TABLE 6
15. PROJECTED UTILIZATION BY SERVICE
16.

	Projected Volume		
Service*	FY 2017**	FY 2018**	FY 2019**
Detoxification	1,015	1,025	1,050
Residential	760	765	765
Outpatient/IOP	200	210	220
Total	1,965	1,990	2,025

* 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

14. Page 37 of the application states that the SAMHSA prevalence rate is 18.2% for adults diagnosed with mental in the United States. According to SAMHSA's National Survey for Drug Use and Health, however, the percentage of adults diagnosed is 18.1%. Please confirm the correct SAMHSA prevalence rate, and provide a revised response for question 26 on page 37.

The correct prevalence rate is 18.1%.

According to the United States Census Bureau, the population of Litchfield County in 2015 was 183,603 (about 5% of the total population of Connecticut). It reports that 81.4% of those are aged 18 and over – placing their estimate of the adult population in Litchfield County at 149,453.

Deducing by applying the SAMHSA prevalence estimate of 18.1%, the census data would suggest there are about 27,051 adults diagnosed with mental illness in Litchfield County. Actual data from Connecticut is not available. For example, DMHAS needs data reflect services only within the public-funded treatment system and do not include data from private, for-profit providers who primarily serve self-pay clients. In addition, high net-worth clients often receive treatment in programs located elsewhere across the country. Therefore, the estimate of 18.1% for the general United States population will be used for projections.

15. What treatment programs are the basis for the utilization data in Table 8 on page 39? Include utilization by town of client origin for all treatment programs and provide the unit of measure (clients, sessions or visits).

Table 8 on page 39 of CON provided Litchfield county towns only. Tables below provide counts for all Admissions, by town and by county. (An admission may result in multiple outpatient visits).

Utilization (Admissions) Sorted by CT Town for 2015

CT City/Town	Outpatient Only	Residential Only	Residential & Outpatient
Ansonia	0	1	0
Avon	0	1	1
Berlin	0	1	0
Bethel	0	2	2
Bethlehem	1	1	0
Bloomfield	0	1	0
Bozrah	0	2	0
Branford	0	2	0
Bridgeport	0	4	0
Bristol	0	13	3
Broad Brook	0	2	0
Brookfield	0	3	0
Burlington	0	2	0
Canaan	13	0	1
Canton	0	2	0
Cheshire	0	3	2
Chester	0	1	0
Columbia	0	1	0
Cos Cob	0	1	2
Danbury	0	20	1
Darien	0	4	0
Dayville	0	1	0
Deep River	0	1	0
Derby	0	1	0
Durham	0	2	0
East Canaan	0	0	1
East Granby	1	0	0
East Haddam	0	1	0
East Hartford	0	2	0
East Haven	0	5	0
Easton	0	2	0
Enfield	0	4	0
Fairfield	0	8	3
Falls Village	1	0	0
Farmington	0	1	1
Glastonbury	0	4	0
Granby	0	1	0
Greenwich	8	2	1
Groton	0	2	0
Guilford	0	3	0
Hamden	0	11	0
Hartford	0	4	0
Harwinton	0	0	1
Kensington	0	2	0
Kent	0	1	0
Killingworth	0	2	0
Lakeville	4	3	1

CT City/Town	Outpatient Only	Residential Only	Residential & Outpatient
Lebanon	0	1	0
Ledyard	0	1	0
Litchfield	0	2	0
Madison	0	11	1
Mansfield Center	0	1	0
Meriden	0	5	0
Middlebury	0	0	1
Middlefield	0	2	0
Middletown	0	3	0
Milford	0	3	1
Monroe	0	2	1
Mystic	0	2	0
Naugatuck	0	3	0
New Britain	0	4	0
New Canaan	0	1	0
New Fairfield	0	0	1
New Hartford	0	0	2
New Haven	0	4	2
New Milford	0	2	0
Newington	0	1	0
Newtown	0	0	2
Niantic	0	3	0
Norfolk	0	1	0
North Branford	0	2	0
North Franklin	0	1	0
North Granby	0	1	0
North Haven	0	1	0
Northfield	0	1	0
Norwalk	0	5	0
Norwich	0	1	0
Oakdale	0	1	0
Old Lyme	0	1	0
Old Saybrook	0	1	0
Orange	0	2	0
Oxford	1	4	0
Plainfield	0	1	0
Plainville	0	1	0
Plantsville	0	0	1
Pleasant Valley	0	1	0
Pomfret	0	2	0
Prospect	0	2	0
Putnam	0	1	0
Redding	0	1	0
Ridgefield	0	4	0
Rocky Hill	0	1	0
Roxbury	0	1	0
Sandy Hook	0	1	0

CT City/Town	Outpatient Only	Residential Only	Residential & Outpatient
Sharon	0	1	1
Shelton	1	12	0
Simsbury	0	3	2
Somers	0	1	0
South Glastonbury	0	10	0
South Windsor	0	4	0
Southbury	0	3	1
Southington	0	1	0
Southport	0	1	0
Stafford Springs	0	1	0
Stamford	6	15	1
Stonington	0	1	0
Storrs Mansfield	0	1	0
Stratford	0	3	0
Terryville	0	3	0
Thomaston	0	2	0
Tolland	0	1	1
Torrington	1	5	11
Trumbull	0	5	1
Uncasville	0	1	0
Unionville	0	2	0
Vernon Rockville	0	1	0
Wallingford	0	10	0
Waterbury	0	2	1
Waterford	0	3	0
Watertown	0	1	1
West Hartford	0	5	2
West Haven	0	2	0
Westbrook	0	1	0
Weston	0	1	0
Westport	1	5	2
Wethersfield	0	1	0
Wilton	0	5	1
Windsor	0	4	0
Windsor Locks	0	1	1
Winsted	0	1	0
Wolcott	0	2	0
Woodbridge	0	2	0
Woodbury	0	2	2
Woodstock	1	1	0
Out of State	15	310	36
Total Admissions 2015	**54**	**655**	**96**

Utilization (Admissions) Sorted by CT County for 2015

CT County	Outpatient Only	Residential Only	Residential & Outpatient
Fairfield	16	100	18
Hartford	1	79	11
Litchfield	20	35	21
Middlesex	0	14	0
New Haven	1	80	9
New London	0	24	0
Tolland	0	7	1
Windham	1	6	0
Out of State	15	310	36
Total Admission 2015	**54**	**655**	**96**

16. Page 41 of the application states that 11 of the existing outpatient psychiatric service providers located in Litchfield County do not provide intensive outpatient services. However, the list of providers in Table 9 on page 40 indicates one provider, Wellspring Foundation, provides IOP treatment. An additional three providers are confirmed as providing IOP treatment via their company websites. These include MCCA New Milford, MCCA Torrington, and McCall Foundation. Update the table on page 40 and provide a revised response to question 30 on page 41 with the correct number of IOP providers.

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
Charlotte Hungerford Hospital	Psychiatric Outpatient Clinic PHP/OP	Not for profit NPI # 1639255870	540 Litchfield Street Torrington, CT	8:30am to 9pm Mon. and Thursday 8:30a – 5p Tues., Weds., and Fri.	Licensed beds 109 ED beds 14 ICU beds 10 ED visits 39,535
Catholic Charities	Psychiatric Outpatient Clinic	Not for profit Employer ID# 06-0667607	132 Grove Street Torrington, CT 06790	Not available on Home page	Not published
Christian Counseling Connection, Inc.	Psychiatric Outpatient Clinic	Not for profit Credential ID 930299	42 Church Street Torrington, CT 06790	10a – 5p Mon. - Friday	Not published
Community Health and Wellness Center	Psychiatric Outpatient Clinic OP	Not for profit Credential ID 995718	469 Migeon Ave. Torrington, CT 06790	8a – 6p M<W<TH<F T 8a-8p Every other Sat.	Not published
Community Mental Health Affiliates, Inc.	Psychiatric Outpatient Clinic	Not for profit Credential ID 929517	100 Commercial Blvd Torrington, CT 06790	Monday: 8a-8p Tues: Th. 9a-6p Friday: 8a-5p	Not published
High Watch Recovery Center	Substance Abuse & Co-occurring D/O	Not for profit NPI # 1275946881	62 Carter Road Kent, CT 06757	8a – 5:30p Mon. – Sun.	Not published
MCCA Torrington	Psychiatric Outpatient Clinic Outpatient Intensive Outpatient Services	Not for profit NPI # 1992074418	30 Peck Road Torrington, CT 06790	Mon. – Fri. 9:30a – 4p	Not published
McCall Foundation	Psychiatric Outpatient Clinic Outpatient Intensive Outpatient Services	Not for profit Credential ID: 930804	58 High Street Torrington, CT 06790	Mon.: 9a – 8p Tues-Fri: 9a – 4p	Not published
Hartford Dispensary Torrington Clinic	Psychiatric Outpatient Clinic Outpatient	Not for profit Credential ID 1235540	140 Commercial Blvd Torrington, CT 06790	Mon. - Friday 5a – 1:30p	Not published
Western CT Mental Health	Psychiatric Outpatient Clinic Outpatient State Operated	Not for profit NPI# 1144561051	249 Winsted Road Torrington, CT 06790	Mon., Tues., Thurs. 8:30a – 5p	Not published
Wellspring Foundation	Psychiatric Outpatient Clinic PHP/IOP/OP	Not for profit NPI# 1154475184	21 Arch Bridge Road Bethlehem, CT	Not available on Home page	Not published
New Milford Hospital Behavioral Health Services	Psychiatric Outpatient Clinic Outpatient	Not for profit NPI# 1619938016	23 Popular Street New Milford, CT	Mon. – Fri. 9a – 5p	Licensed beds 85 ED beds 12 ICU beds 6 ED visits 18,780
MCCA New Milford	Psychiatric Outpatient Clinic Outpatient	Not for profit CT License # SA-0215	50 Bridge Street New Milford, CT	Mon. – Fri. 9:30a 4p	Not published

	Intensive Outpatient Services				
Watkins Network	Psychiatric Outpatient Clinic Outpatient	Not for profit CT License # 1245356	21 Prospect Street Torrington, CT	Mon. 9a-9p, Tues: 11a-7p, W, Thurs: 1p – 9p Fri 9a-5p	Not published

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

Of the existing fourteen (14) outpatient providers in Litchfield County, all fourteen (14) serve public-sector clients with State/Federal funding or Medicaid reimbursement and are located in Torrington, Kent, New Milford and Bethlehem. One of the facilities only serves clients on Methadone/MAT at its' location.

Eight (8) of the facilities located in Litchfield County do not provide Intensive Outpatient Services.

We anticipate that the addition of Mountainside's Canaan Outpatient Psychiatric Clinic to the area will have a minimal effect on existing area providers. Discharged Mountainside residential clients currently receive continuing care services through a variety of community providers including sober living, licensed clinics and independent licensed professionals. Over the past two and one half (2 ½) years 79% of the pool chose to remain in Canaan, CT post discharge.

17. Page 41 of the application states that the existing 14 outpatient providers in Litchfield County are located in Torrington, Kent, New Milford and Bethlehem. Are there means of public transportation from Canaan to these areas?

There is no available public transportation from Canaan, CT to Torrington, Kent, New Milford and Bethlehem.

18. Update and resubmit the Financial Worksheet (B) on pages 292 and 293 of the application to include financial results for the current fiscal year, as well as projections through fiscal year 2019 without the proposal. These projections should be based on current treatment programs offered at Mountainside in Canaan. Ensure the calculations for net patient service revenue less provisions for bad debt are correct. Also, confirm the projected with CON amount in total operating expenses for fiscal year 2017.

Please see Appendix Four

19. Update Table 7 on page 37 of the application based on patient and visit volume. Utilize the table format below. Ensure visit totals are consistent with "Outpatient Visits" in the Financial Worksheet (B). Also, please explain the basis and the methods and calculations used to project the reported numbers.

CURRENT AND PROJECTED PAYER MIX FOR MOUNTAINSIDE, BY NUMBER OF CLIENTS AND VISITS

Payer	Current			Projected								
	FY 2016			FY 2017			FY 2018			FY 2019		
	Patient Vol.	%	Visit Vol.	Patient Vol.	%	Visit Vol.	Patient Vol.	%	Visit Vol.	Patient Vol.	%	Visit Vol.
Medicare*												
Medicaid*												
CHAMPUS & TriCare												
Total Government												
Commercial Insurers	0			16	64%	370	20	65%	458	22	63%	518
Self-pay	0			9	36%	166	11	35%	347	13	37%	279
Uninsured												
Workers Compensation												
Total Non-Government	**0**			**25**	**100%**	**569**	**31**	**100%**	**705**	**35**	**100%**	**796**
Total Payer Mix	**0**			**25**	**100%**	**569**	**31**	**100%**	**705**	**35**	**100%**	**796**

If you have any questions concerning this letter, please feel free to contact me or David Fernandes at (860) 418-7069, (860) 418-7032 or (860) 418-7001.

Appendix One
Referrals Sources

Referral Sources										
Referral Sources	2014				2015			2016		
	Outpatient Services	Residential	Residential /OP		Outpatient Services	Residential	Residential /OP	Outpatient Services	Residential	Residential /OP
Detox-Residential-Exteneded Care	0	73	8		2	46	0	7	37	7
Insurance	0	0	0		1	2	0	0	2	0
Internet-Word of Mouth	3	144	14		2	145	19	1	132	20
IOP-OP	0	16	3		0	27	3	0	16	6
Prior client	14	146	20		17	151	49	17	295	87
Other-Uncatogorized	18	112	0		3	86	29	1	12	2
Private Practice-Hospital	2	110	12		3	112	13	1	52	20
Sober Living	0	15	0		1	11	1	2	7	6
Support Group	0	61	1		0	50	7	1	47	12
Totals	37	677	58		29	630	121	30	600	160

Appendix Two
Assessment Series

Assessment Series

Attention Rating Scale **Within the past week, have you noticed that you:**
1. Fail to give close attention to details or make careless mistakes doing work.
2. Fidget with hands or feet or squirm in seat
3. Do not follow through on instructions or fail to finish work
4. Have difficulty organizing tasks or activities
5. Avoid, dislike, or is reluctant to engage in work that requires sustained mental effort
6. Blurt out answers before questions have been completed
7. Interrupt or intrude on others

GAD – 7 Scale **Over the last two weeks, how often have you been bothered by the following problems?**
1. Feeling nervous, anxious, or on edge
2. Not being able to stop or control worrying
3. Worrying too much about different things
4. Trouble relaxing
5. Being so restless that it's hard to sit still
6. Becoming easily annoyed or irritable
7. Feeling afraid as if something awful might happen
8. If you have had any problems above, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Mountainside Craving Scale
1. On a scale of 0-10, during the past week how often have you thought about using your substance of choice?
2. On a scale of 0-10, during the past week how often have you thought about how good using your substance of choice would make you feel?
3. On a scale of 0-10, at its most severe point, how strong was your craving to use your substance of choice during the past week?
4. On a scale of 0-10, during the past week how difficult would it have been to resist using your substance of choice if you had known your drug of choice was available?
5. How often in the past week have you experienced using via drug dreams?

Mountainside Sleep Assessment
1. In the past week, how long (in minutes) has it typically taken you to fall asleep at night?
2. During the past week, how would you rate your overall sleep quality?
3. During the past week, how often have you taken medicine to help you sleep (prescribed or over-the-counter)
4. During the past week, how often have you had trouble staying awake while eating meals, during groups, or engaging in a social activity?
5. During the past week, how much has fatigue or sleepiness caused a lack of enthusiasm to get thing done?

PHQ – 9 **Over the last two weeks, how often have you been bothered by any of the following problems?**
1. Little interest or pleasure in doing things
2. Feeling down, depressed, or hopeless
3. Trouble falling or staying asleep, or sleeping too much
4. Feeling tired or having little energy
5. Poor appetite or overeating
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down
7. Trouble concentrating on things, such as reading the newspaper or watching television
8. Moving or speaking so slowly that other people could have noticed?
9. Thoughts that you would be better off dead or of hurting yourself in some way
10. If you did have any of the above problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Appendix Three
Articles, Research

Opportunities and Barriers to Empowering People with Severe Mental Illness through Participation in Treatment Planning

Donald M. Linhorst, Gary Hamilton, Eric Young, and Anne Eckert

Participation in treatment planning can be one means of empowering clients. However, significant barriers exist to empowering people with severe mental illness through treatment planning. This qualitative study reviewed documents and conducted focus groups with clients and staff of a public psychiatric hospital to identify barriers to empowerment and the conditions that must be present for client empowerment to occur through treatment planning. The conditions for empowerment were based on both psychological and organizational factors. For empowerment to occur, clients need psychiatric stability and decision-making skills. Organizations promote empowerment by ensuring that clinical staff have the time to involve clients in treatment planning, promoting staff attitudes that are respectful of clients' ability to participate in treatment planning, providing clients with a range of treatment options, designing programs that have a strong philosophical commitment to client empowerment, and implementing programs properly.

Key words: *empowerment; mental illness; psychiatric hospitals; treatment planning*

Client empowerment is fundamental to social work practice (Dubois & Miley, 1999; Lee, 1994). Historically people with severe mental illness have lacked empowerment (Carling, 1995; Goffman, 1961). One way to empower this group is through participation in treatment planning. However, is it possible for social workers to empower all people with mental illness through participation in treatment planning? What conditions must be present for empowerment to occur through treatment planning? We argue that the achievement of empowerment through treatment planning is based on both psychological and organizational factors. That is, for empowerment to occur, people with severe mental illness need a minimal level of psychiatric stability and decision-making skills, as well as an organizational culture that promotes shared decision making and provides the resources required for empowerment.

Empowerment has been defined in many ways but typically emphasizes client choice and control. For example, Staples (1990) defined *empowerment* as "the ongoing capacity of individuals or groups to act on their own behalf to achieve a greater measure of control over their lives and destinies" (pp. 30–31). Empowerment can refer to both an outcome and a process (Kieffer, 1984; McLean, 1995; Rappaport, 1987; Salzer, 1997; Staples). From this viewpoint, a client is empowered not only by the outcomes of the decisions he or she makes, but also by being an active participant in the decision-making process. Staples described this empowerment process as "a continuing development involving many changes whereby

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National Empowerment Center - Articles

A Working Definition of Empowerment

By Judi Chamberlin

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"Empowerment" has become a popular term in mental health programs, yet it has lacked a clear definition. In a research project designed to measure empowerment in programs funded by and for mental health services users, we first undertook to come up with a working definition. Key elements of empowerment were identified, including access to information, ability to make choices, assertiveness, and self-esteem. Empowerment has both an individual and a group dimension. Details of the definition are provided, along with a discussion of the implications of empowerment for psychiatric rehabilitation programs.

INTRODUCTION

"Empowerment" is a term that has become very popular in mental health services (at least in the United States). Nearly every kind of mental health program claims to "empower" its clients, yet in practice there have been few operational definitions of the term, and it is far from clear that programs that use the term are in any measurable way different from those that do not. Still lacking a definition, the word has become common political rhetoric, with a flexibility of meaning so broad that it seems to be in danger of losing any inherent meaning at all. Some conservative U.S. politicians have promoted welfare "reform," for example, by claiming that cutting off benefits will "empower" recipients (who would thus, presumably, become self-sufficient)! Such usages make it difficult to claim that "empowerment" is a meaningful concept. The problem of using the term meaningfully becomes even more problematic in other countries and other languages. When I have spoken abroad, I find that the word is usually not translated; the translator merely repeats "empowerment," in English, perhaps hoping that the listeners will be able to draw some meaning from the context. Nonetheless, I believe that the term can have real meaning, and that the first step in making it meaningful is to define it.

A WORKING DEFINITION

At the Center for Psychiatric Rehabilitation, I directed a research project that studied participants in user-run self-help programs for people with psychiatric disabilities.[1] At the beginning of the study, we found that many of these groups included the term "empowerment" in their program definitions. It was clearly a key concept, making it necessary to define empowerment as part of the project. We therefore brought together a group of a dozen leading U.S. consumer/survivor self-help practitioners,[2] who formed the Advisory Board of our project, and we made our first task the formulation of a definition. Although we recognized that empowerment had elements in common with such concepts as self-esteem and self-efficacy, we also felt that these concepts did not fully capture what we saw as

distinctive about empowerment. After much discussion, we defined empowerment as having a number of qualities, as follows:

1. Having decision-making power.
2. Having access to information and resources.
3. Having a range of options from which to make choices (not just yes/no, either/or.)
4. Assertiveness.
5. A feeling that the individual can make a difference (being hopeful).
6. Learning to think critically; learning the conditioning; seeing things differently; e.g.,
   a. Learning to redefine who we are (speaking in our own voice).
   b. Learning to redefine what we can do.
   c. Learning to redefine our relationships to institutionalized power.
7. Learning about and expressing anger.
8. Not feeling alone; feeling part of a group.
9. Understanding that people have rights.
10. Effecting change in one's life and one's community.
11. Learning skills (e.g., communication) that the individual defines as important.
12. Changing others' perceptions of one's competency and capacity to act.
13. Coming out of the closet.
14. Growth and change that is never ending and self-initiated.
15. Increasing one's positive self-image and overcoming stigma.

We decided early in our discussions that empowerment was complex, multidimensional concept, and that it described a process rather than an event. Therefore, we did not believe that an individual had to display every quality on the list in order to be considered "empowered." This definition is not necessarily a global one, but is linked specifically to the research project, and is offered as a working definition for the purpose of opening discussion as to whether "empowerment" is a meaningful term that describes a discrete mechanism used by members of the self-help groups in our study. In fact, I have found that in presenting the definition to various groups, it often does begin such a useful discussion, and I have been told by non-English speakers that the definition has been useful in their attempts to translate the word.

EMPOWERMENT: THE ELEMENTS

Returning to the definition, let us now look at each of the elements:

Having decision-making power.

Clients of mental health programs are often assumed by professionals to lack the ability to make decisions, or to make "correct" decisions. Therefore, many programs assume the paternalistic stance of limiting the number or quality of decisions their clients may make. Clients may be able to decide on the dinner menu, for example, but not on the overall course of their treatment. Yet, without practice in making decisions, clients are maintained in long-term dependency relationships. No one can become independent unless he or she is given the opportunity to make important decisions about his or her life.

Importance of Choice of Provider and Treatment

Choice is vital to recovery for those with behavioral health issues. As new forms of health care delivery and payment are implemented, it is important that consumer choice be protected in order to improve and sustain the efficacy of treatment.

Choice of Provider

The relationship between those rendering services and those receiving services is key to the delivery of quality and effective health care. Quality outcomes stem from the therapeutic alliance, or trust formed between the client and clinician, which allow them to collaborate effectively, overcome obstacles, and work together towards the client's agreed-upon long-term goals.[1]

- Research over the past several decades has demonstrated that the therapeutic alliance to be a strong forecaster of positive outcomes.[2]
- Clients that have weaker therapeutic alliances with their clinician were more likely to drop out of psychotherapy.[3]
- Patient experience of a provider's services is closely linked to both adherence to recommended treatment and to outcomes.[5]

Choice of Treatment

Not only is choice of provider important to the recovery process, but choice of treatment by individuals receiving services improves health care delivery and outcomes. By giving individuals choice of treatment, it empowers them and improves their engagement with services. Studies show that choice of treatment is linked with an increased likelihood of remaining in treatment and of recovery.

- Within the older adult population, individuals who were given a choice of treatment options were less likely to drop out of treatment prematurely.[6]
- Individuals who received their preferred treatment were half as likely to drop out of treatment as those who did not receive their preferred treatment, and also had a higher probability of showing greater improvement on the road to recovery than individuals who did not receive their preferred treatment.[8]
- Individuals experiencing a phobia who were able to choose their treatment from a list of alternatives scored significantly higher on a behavioral scale after treatment than their peers with no choice.[10]

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[1] G. Tryon and A. Kane, *The Helping Alliance and Premature Termination*, 3 Counseling Psychology Quarterly 233-238 (1990).
[2] J. Safran, et al., *Alliance, Negotiation and Rupture Resolution*, in Handbook of Evidence Based Psychodynamic Therapy, at 208 (2009)("the quality of the patient-therapist relationship is more important than the treatment modality").
[3] J. Sharf, et al., *Dropout and Therapeutic Alliance: a Meta-Analysis of Adult Individual Psychotherapy*, 47 Pychotherapy Theory, Research, Practice, Training, 637-645 (2010).
[5] C. Dolyle, et al., *A systematic review of evidence on the links between patient experience and clinical safety and effectiveness*, http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3549241/ (Jan. 2013).
[6] P. Rokke and et al., *The Role of Client Choice and Target Selection in Self-management Therapy for Depression in Older Adults*, 14 Psychology and Aging 155-169 (1999).
[8] J. Swift and J. Callahan, *The impact of client treatment preferences on outcome: a meta-analysis*, 65 J. Clinical Psychology 368-381(2009).
[10] D. Devine and P. Fernald, *Outcome effects of receiving a preferred, randomly assigned, or nonpreferred therapy*, 41 J. Counseling and Clinical Psychology 104-107 (1973).

MHPOD (../index_html.html)

X Exit

Relapse Prevention

Working with Consumers & Others for Relapse Prevention

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Relapse prevention is an important part of a personal wellness plan. The goal of relapse prevention is dual: to reduce the likelihood and impact of relapse, and to optimise wellness and personal control. Relapse prevention is an empowering process where consumers build skills in self-management of their illness by recognising early warning signs and enacting collaboratively-developed prevention plans in a timely way (Rickwood, 2006).

Relapse prevention involves a collaborative effort between a consumer, their family, carers and friends, primary health care services, specialist mental health services and community services. It involves identification of risk and protective factors for an individual, then implementing strategies that simultaneously boost protective factors and reduce or eliminate the impact of risk factors (Rickwood, 2006).

There is now strong evidence that many people who live with mental illness experience a consistent set of warning signs prior to reoccurrence of an acute phase of their illness. This is termed the relapse signature. While some early warning signs are common to many people, some signs can be very specific to an individual and they may not be found in any published list of early warning signs (Agius, Oakham, Biocina, & Murphy, 2006).

Relapse prevention plans may be highly structured and individualised to the consumer's own pattern of symptoms, and address both risk and protective factors. Butler and Butler (2005) outlined three goals of relapse prevention plans:

- To develop an individual relapse 'picture' that helps to identify 'at-risk' mental states;

Risk factors	Protective factors
Poor physical health	Physical wellbeing: general health, nutrition, sleep, exercise
Insecure, inappropriate and unsafe accommodation	Secure, appropriate and safe accommodation
Exposure to physical and emotional violence and threat of violence	Physical and emotional security
Harmful alcohol, tobacco and other drug use	No harmful alcohol, tobacco and other drug use
Lack of meaningful daily activities	Meaningful daily activities (employment, education, volunteer work, hobbies)
Lack of purpose and meaning in life	Sense of purpose and meaning in life
Lack of control over one's life	Sense of control and efficacy
Financial hardship	Financial security
Exposure to environmental stressors (eg, legal proceedings, imprisonment)	Lack of exposure to environmental stressors
Poor coping skills	Good coping skills

- To develop a relapse plan or 'drill' as part of the collaborative therapeutic relationship between the consumer and the service;
- To promote the consumer's self-efficacy and sense of control over recurring symptoms.

It is useful to distinguish between 'growth-oriented' relapse prevention and 'risk-oriented' relapse prevention. Consumers have argued that their recovery may be hampered when the focus is primarily on avoidance of relapse, rather than healthy risk taking and the pursuit of activities that enhance personal growth and recovery (Young et al., 2008). Relapse prevention that focuses primarily on avoidance of symptoms and illness, but at the expense of involvement in activities and responsibilities necessary for personal growth, may be said to be 'risk-oriented'.

'Growth-oriented' relapse prevention focuses on the person's own efforts towards maintaining wellness in the context of a satisfying life and healthy risk taking. This includes identifying early warning signs and recognising what the person does to 'get up again' after a relapse or set back. Previous 'failures' or set backs should not be seen as reason to not try again: the learning that occurs during these events can contribute to self-knowledge, recognition of strengths and coping skills. In 'growth-oriented' relapse prevention, a relapse is not seen as a failure, but part of the process of developing self-management knowledge and skills.

The therapeutic relationship provides a framework for developing collaborative wellness (relapse prevention) plans. Studies have shown that the most constructive discussions around personal growth and relapse prevention occur 'in the context of well-recognised elements of the therapeutic alliance – (an) empathic, collaborative, mutually trusting... relationship' (Young et al., 2008).

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Rickwood (2006) has devised a framework for relapse prevention to guide Australian mental health workers in this approach: The 4As Framework. The 4As describe awareness, anticipation, alternatives and action. These four basic elements provide a framework for promoting mental health recovery and

Ineffective use of medication	Effective use of medication (when required)

The 4As approach (adapted from Rickwood, 2006)

wellness, and preventing, delaying or mitigating the occurrence of relapse and the associated harm of further episodes.

Awareness

Awareness is a critical step in a relapse prevention approach. It can occur at multiple levels. Most people experience a building sense of awareness over time. Awareness involves both an understanding of self and of mental illness' role in one's self-identity. Most people can learn to recognise early warning signs, although stigma may impact the development of awareness. Sometimes, denial of awareness can be an important coping strategy.

Awareness also applies to families and carers who develop awareness of a loved one's illness signs and symptoms in their own way, over time.

Workers can contribute to the development of awareness for consumers, families and carers when they:

- Model a positive attitude toward people who have experienced mental illness.
- Model a recovery orientation.
- Support consumers, carers and families to develop awareness.
- Support other service providers to better understand mental illness.
- Help reduce stigma in the community.

Anticipation

Anticipation and planning are empowering processes, as they allow people to make choices and exercise personal control.

Collaborative plans should cover the domains of self-management, recovery, continuity of care and crisis. A collaborative plan should include strategies for people to stay well (strategies that optimise protective factors and minimise the impact of risk factors) and plan for the possibility of relapse. Planning for relapse or crisis allows consumers to identify supporters and their roles ahead of time, so support of their choosing can be provided in a timely way.

Awareness	Knowledge of one's own state of mental health and factors that impact it, including the potential for future episodes.
Anticipation	A personal plan for managing one's own mental health in recovery and in times of crisis.
Alternatives	Knowledge and availability of a holistic range of options that address risk and protective factors for mental health.
Access	Equitable access to services as needed, when needed.

NCBI Bookshelf. A service of the National Library of Medicine, National Institutes of Health.

Center for Substance Abuse Treatment. Substance Abuse Treatment for Persons With Co-Occurring Disorders. Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 2005. (Treatment Improvement Protocol (TIP) Series, No. 42.)

6 Traditional Settings and Models

What happens to clients with co-occurring disorders (COD) who enter traditional substance abuse settings? How can programs provide the best possible services to these people?

This chapter adopts a program perspective to examine both outpatient and residential settings, highlighting promising treatment models that have emerged both within the substance abuse field and elsewhere. It also discusses the various treatment approaches and models available to those working in substance abuse settings.

The chapter opens with a review of the seven essential programming elements in COD programming for substance abuse treatment agencies that treat clients with COD: (1) screening, assessment, and referral; (2) mental and physical health consultation; (3) the use of a prescribing onsite psychiatrist; (4) medication and medication monitoring; (5) psychoeducational classes; (6) onsite double trouble groups; and (7) offsite dual recovery mutual self-help groups. These elements are applicable in both residential and outpatient programs. This section of the chapter also discusses general considerations in treatment of clients with COD.

Essential background related to outpatient care for this population, including available data on its effectiveness, follows the discussion of essential programming. The chapter then turns to an overview of the critical factors in the successful design, implementation, evaluation, and maintenance of effective outpatient programs for clients with COD. Two examples of successful outpatient programs are highlighted: the Clackamas County Mental Health Center of Oregon City, Oregon, an outpatient substance abuse and mental health treatment center; and the Arapahoe House of Denver, Colorado, which is the State's largest provider of substance abuse treatment services. These are intended to "prime the pump" for readers considering the addition of new program elements to serve clients with COD. The section closes with an exploration of two specialized outpatient models for clients with co-occurring substance use and serious mental disorders, Assertive Community Treatment and Intensive Case Management.

A discussion of residential substance abuse treatment programs for clients with COD completes the chapter. Like the discussion of outpatient care, this section describes the background and effectiveness of residential care for the COD population, the key issues that arise in program design and implementation, and the challenges of evaluating and sustaining residential programs. Modified therapeutic communities (MTCs)—forms of residential care particularly well suited to clients with COD—are described in detail. The chapter closes with a presentation of two other residential models: Gaudenzia, Inc., located in Norristown, Pennsylvania, which uses an MTC to provide care for its clients, the majority of whom have serious mental illness, and the Na'nizhoozi Center, Inc., located in the rural community of Gallup, New Mexico, a program that uses a range of culturally appropriate interventions to meet the needs of its predominantly American-Indian clients.

Overview

Essential Programming for Clients With COD

Screening, Assessment, and Referral

approaches, and models described in the TIP and from consensus panel discussion of current clinical programming. The panel believes these elements constitute the best practices currently available for designing COD programs in substance abuse treatment agencies. A detailed discussion of these elements appears in chapter 1. What follows are program considerations for implementing these essential components.

Screening, Assessment, and Referral

All substance abuse treatment programs should have in place appropriate procedures for screening, assessing, and referring clients with COD. It is the responsibility of each provider to be able to identify clients with both mental and substance use disorders and ensure that they have access to the care needed for each disorder. For a detailed discussion, see chapter 4. If the screening and assessment process establishes a substance abuse or mental disorder beyond the capacity and resources of the agency, referral should be made to a suitable residential or mental health facility, or other community resource. Mechanisms for ongoing consultation and collaboration are needed to ensure that the referral is suitable to the treatment needs of persons with COD.

Physical and Mental Health Consultation

Any substance abuse treatment program that serves a significant number of clients with COD would do well to expand standard staffing to include mental health specialists and to incorporate consultation (for assessment, diagnosis, and medication) into treatment services. Adding a master's level clinical specialist with strong diagnostic skills and expertise in working with clients with COD can strengthen an agency's ability to provide services for these clients. These staff members could function as consultants to the rest of the team on matters related to mental disorders, in addition to being the liaison for a mental health consultant and provision of direct services.

A psychiatrist provides services crucial to sustaining recovery and stable functioning for people with COD: assessment, diagnosis, periodic reassessment, medication, and rapid response to crises. (See the section below on the advantages of having a psychiatrist on staff as part of the treatment team.) If lack of funding prevents the substance abuse treatment agency from hiring a consultant psychiatrist, the agency could establish a collaborative relationship with a mental health agency to provide those services. A memorandum of agreement formalizes this arrangement and ensures the availability of a comprehensive service package for clients with COD. Such arrangements are used widely in the field, and examples of "best practices" are available (Ridgely et al. 1998; *Treatment of Persons* 2000).

Prescribing Onsite Psychiatrist

Adding an onsite psychiatrist in an addiction treatment setting to evaluate and prescribe medication for clients with COD has been shown to improve treatment retention and decrease substance use (Charney et al. 2001; Saxon and Calsyn 1995). The onsite psychiatrist brings diagnostic, medication, and psychiatric counseling services directly to the location clients are based for the major part of their treatment. This approach often is the most effective way to overcome barriers presented by offsite referral, including distance and travel limitations, the inconvenience of enrolling in another agency and of the separation of clinical services (more "red tape"), fears of being seen as "mentally ill" (if referred to a mental health agency), cost, and the difficulty of becoming comfortable with different staff.

The consensus panel is aware that the cost of an onsite psychiatrist is a concern for many programs. Many agencies that use the onsite psychiatrist model find that they can afford to hire a psychiatrist part-time, even 4 to 16 hours per week, and that a significant number of clients can be seen that way. A certain amount of that cost can be billed to Medicaid, Medicare, insurance

agencies, or other funders. For larger agencies, the psychiatrist may be full time or share a full-time position with a nurse practitioner. The psychiatrist also can be employed concurrently by the local mental health program, an arrangement that helps to facilitate access to such other mental health services as intensive outpatient treatment, psychosocial programs, and even inpatient psychiatric care if needed. Studies describing this model more fully and including outcome data include Saxon and Calsyn (1995) and Charney and colleagues (2001). The approach also has been shown to be cost effective in a large health maintenance organization (Weisner et al. 2001).

Some substance abuse programs may be reluctant to hire a psychiatrist or to provide psychiatric services. This issue can be resolved through agencywide discussions of the types of clients with COD seen by the agencies, how their services are coordinated, and the barriers clients experience to receiving all the elements of COD treatment. In many cases, the largest and most obviously missing elements of good, integrated, onsite COD treatment are mental disorder diagnosis and treatment. It also should be noted that an onsite psychiatrist fosters the development of substance abuse treatment staff, enhancing their comfort and skill in assisting clients with COD. The psychiatrist may be able upgrade counselors' skills through seminars on medication management and other pertinent topics. Also, the psychiatrist usually attends the weekly meeting of the clinical team, helping to develop effective treatment plans for active cases of clients with COD. For many psychiatrists, this arrangement also affords a welcome opportunity for further exposure to substance abuse treatment.

Ideally, agencies should hire a psychiatrist with substance abuse treatment expertise to work onsite at the substance abuse treatment agency. Finding psychiatrists with this background may present a challenge. Psychiatrists certified by the American Society of Addiction Medicine (ASAM), the American Academy of Addiction Psychiatry, or the American Osteopathic Association (for osteopathic physicians) are good choices. They can provide leadership, advocacy, development, and consultation for substance abuse staff. Historically, however, substance abuse education in medical schools and residencies has received little attention, though promising efforts on multiple levels are working to ensure that all physicians receive at least a basic knowledge of substance use disorders. Thus, learning usually flows both ways, to the benefit of the client. When recruiting a psychiatrist, the substance abuse treatment program should discuss key issues around this bi-directional flow of clinical information and knowledge. In addition, a discussion of prescribing guidelines (such as those included in appendix F) is in order.

The prescribing onsite psychiatrist model is a useful and recommended step that substance abuse treatment agencies can take to provide integrated COD treatment services. A detailed manual is needed to help agencies install this model and to guide the participating psychiatrists to provide the best services within the model. Further research is needed to document cost offsets for implementing the model and gauge its clinical effectiveness in a variety of substance abuse treatment settings.

Medication and Medication Monitoring

Many clients with COD require medication to control their psychiatric symptoms and to stabilize their psychiatric status. The importance of stabilizing the client with COD on psychiatric medication when indicated is now well established in the substance abuse treatment field. (See appendix F for a comprehensive description of the role of medication and the available medications.) One important role of the psychiatrist working in a substance abuse treatment setting is to provide psychiatric medication based on the assessment and diagnosis of the client, with subsequent regular contact and review of medication. These activities include careful monitoring and review of medication adherence.

Practice Guidelines for Recovery-Oriented Care for Mental Health and Substance Use Conditions

Connecticut Department of Mental Health and Addiction Services

Second Edition—December 2008

A. Recovery-Oriented Care is Consumer and Family-Driven[22]

An essential characteristic of recovery-oriented care is the primacy it places on the participation of people in recovery and their loved ones in all aspects and phases of the care delivery process. Beginning with the Federal Rehabilitation Act of 1973 and reaffirmed in 1990 in Public Law 99-660, federal and state governments have mandated the involvement of people with mental health and substance use conditions in all components of designing and implementing systems of community-based care. This mandate has been confirmed consistently in numerous federal and state statutes and regulations issued since, and forms the foundation of CT DMHAS' Recovery and System Transformation Initiative.

> *Recovery-oriented care requires that people in recovery be involved in all aspects and phases of the care delivery process, from the initial framing of questions or problems to be addressed and design of the needs assessments to be conducted, to the delivery and ongoing monitoring of care, to the design and development of new services and supports.*

For the involvement of people in recovery and their families to be meaningful and substantive, it must go well beyond their signing off on provider-driven treatment plans or endorsing the replication of practitioner-driven models of care. Recovery-oriented care requires that people in recovery be involved in all aspects and phases of the care delivery process, from the initial framing of questions or problems to be addressed and design of the needs assessments to be conducted, to the delivery and ongoing monitoring of care, to the design and development of new services and supports. It is in this way that consumer and family-driven care is distinguished from person-centered care (discussed in Section 3 below). Consumer and family-driven refers to the involvement of people in recovery and family members in the process of designing, monitoring, and changing systems of care; it is a systemic principle that refers to the ways in which care as a whole is reformed. Person-centered care, on the other hand, refers to the care provided to each individual being based on his or her unique needs, values, and preferences. In this sense, person-centered care unfolds at the level of each person's individualized recovery plan. While perhaps an essential element of a consumer and family-driven system, ***person-centered care is not by itself sufficient to making care recovery-oriented or responsive. Changes are also required at the system level to make sure that the right types of services and supports are available to be included in individualized recovery plans.***

[22] By "family" we include all of those persons who an individual identifies as being part of his or her family, i.e., his or her immediate, intimate social network, regardless of biological ties.

National Institute on Drug Abuse
Advancing Addiction Science

Principles of Drug Addiction Treatment: A Research-Based Guide (Third Edition)

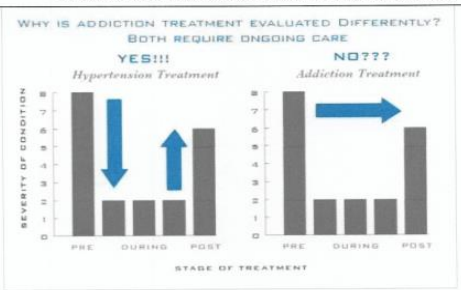
Print

How effective is drug addiction treatment?

In addition to stopping drug abuse, the goal of treatment is to return people to productive functioning in the family, workplace, and community. According to research that tracks individuals in treatment over extended periods, most people who get into and remain in treatment stop using drugs, decrease their criminal activity, and improve their occupational, social, and psychological functioning. For example, methadone treatment has been shown to increase participation in behavioral therapy and decrease both drug use and criminal behavior. However, individual treatment outcomes depend on the extent and nature of the patient's problems, the appropriateness of treatment and related services used to address those problems, and the quality of interaction between the patient and his or her treatment providers.

Relapse rates for addiction resemble those of other chronic diseases such as diabetes, hypertension, and asthma.

Like other chronic diseases, addiction can be managed successfully. Treatment enables people to counteract addiction's powerful disruptive effects on the brain and behavior and to regain control of their lives. The chronic nature of the disease means that relapsing to drug abuse is not only possible but also likely, with symptom recurrence rates similar to those for other well-characterized chronic medical illnesses—such as diabetes, hypertension, and asthma (see figure, "Comparison of Relapse Rates Between Drug Addiction and Other Chronic Illnesses")—that also have both physiological and behavioral components.



Unfortunately, when relapse occurs many deem treatment a failure. This is not the case: Successful treatment for addiction typically requires continual evaluation and modification as appropriate, similar to the approach taken for other chronic diseases. For example, when a patient is receiving active treatment for hypertension and symptoms decrease, treatment is deemed successful, even though symptoms may recur when treatment is discontinued. For the addicted individual, lapses to drug abuse do not indicate failure—rather, they signify that treatment needs to be reinstated or adjusted, or that alternate treatment is needed (see figure, "Why is Addiction Treatment Evaluated Differently?").

Prev Next

This page was last updated December 2012

NCBI Bookshelf. A service of the National Library of Medicine, National Institutes of Health.

Center for Substance Abuse Treatment. Substance Abuse Treatment for Persons With Co-Occurring Disorders. Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 2005. (Treatment Improvement Protocol (TIP) Series, No. 42.)

6 Traditional Settings and Models

What happens to clients with co-occurring disorders (COD) who enter traditional substance abuse settings? How can programs provide the best possible services to these people?

This chapter adopts a program perspective to examine both outpatient and residential settings, highlighting promising treatment models that have emerged both within the substance abuse field and elsewhere. It also discusses the various treatment approaches and models available to those working in substance abuse settings.

The chapter opens with a review of the seven essential programming elements in COD programming for substance abuse treatment agencies that treat clients with COD: (1) screening, assessment, and referral; (2) mental and physical health consultation; (3) the use of a prescribing onsite psychiatrist; (4) medication and medication monitoring; (5) psychoeducational classes; (6) onsite double trouble groups; and (7) offsite dual recovery mutual self-help groups. These elements are applicable in both residential and outpatient programs. This section of the chapter also discusses general considerations in treatment of clients with COD.

Essential background related to outpatient care for this population, including available data on its effectiveness, follows the discussion of essential programming. The chapter then turns to an overview of the critical factors in the successful design, implementation, evaluation, and maintenance of effective outpatient programs for clients with COD. Two examples of successful outpatient programs are highlighted: the Clackamas County Mental Health Center of Oregon City, Oregon, an outpatient substance abuse and mental health treatment center; and the Arapahoe House of Denver, Colorado, which is the State's largest provider of substance abuse treatment services. These are intended to "prime the pump" for readers considering the addition of new program elements to serve clients with COD. The section closes with an exploration of two specialized outpatient models for clients with co-occurring substance use and serious mental disorders, Assertive Community Treatment and Intensive Case Management.

A discussion of residential substance abuse treatment programs for clients with COD completes the chapter. Like the discussion of outpatient care, this section describes the background and effectiveness of residential care for the COD population, the key issues that arise in program design and implementation, and the challenges of evaluating and sustaining residential programs. Modified therapeutic communities (MTCs)—forms of residential care particularly well suited to clients with COD—are described in detail. The chapter closes with a presentation of two other residential models: Gaudenzia, Inc., located in Norristown, Pennsylvania, which uses an MTC to provide care for its clients, the majority of whom have serious mental illness, and the Na'nizhoozi Center, Inc., located in the rural community of Gallup, New Mexico, a program that uses a range of culturally appropriate interventions to meet the needs of its predominantly American-Indian clients.

Overview

Essential Programming for Clients With COD

Screening, Assessment, and Referral

approaches, and models described in the TIP and from consensus panel discussion of current clinical programming. The panel believes these elements constitute the best practices currently available for designing COD programs in substance abuse treatment agencies. A detailed discussion of these elements appears in chapter 1. What follows are program considerations for implementing these essential components.

Screening, Assessment, and Referral

All substance abuse treatment programs should have in place appropriate procedures for screening, assessing, and referring clients with COD. It is the responsibility of each provider to be able to identify clients with both mental and substance use disorders and ensure that they have access to the care needed for each disorder. For a detailed discussion, see chapter 4. If the screening and assessment process establishes a substance abuse or mental disorder beyond the capacity and resources of the agency, referral should be made to a suitable residential or mental health facility, or other community resource. Mechanisms for ongoing consultation and collaboration are needed to ensure that the referral is suitable to the treatment needs of persons with COD.

Physical and Mental Health Consultation

Any substance abuse treatment program that serves a significant number of clients with COD would do well to expand standard staffing to include mental health specialists and to incorporate consultation (for assessment, diagnosis, and medication) into treatment services. Adding a master's level clinical specialist with strong diagnostic skills and expertise in working with clients with COD can strengthen an agency's ability to provide services for these clients. These staff members could function as consultants to the rest of the team on matters related to mental disorders, in addition to being the liaison for a mental health consultant and provision of direct services.

A psychiatrist provides services crucial to sustaining recovery and stable functioning for people with COD: assessment, diagnosis, periodic reassessment, medication, and rapid response to crises. (See the section below on the advantages of having a psychiatrist on staff as part of the treatment team.) If lack of funding prevents the substance abuse treatment agency from hiring a consultant psychiatrist, the agency could establish a collaborative relationship with a mental health agency to provide those services. A memorandum of agreement formalizes this arrangement and ensures the availability of a comprehensive service package for clients with COD. Such arrangements are used widely in the field, and examples of "best practices" are available (Ridgely et al. 1998; *Treatment of Persons* 2000).

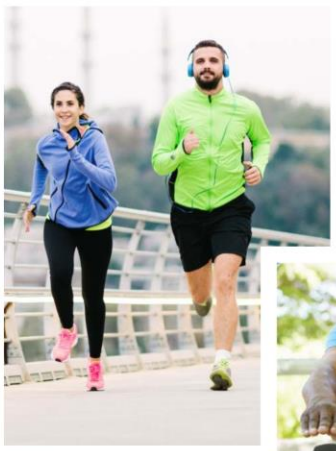
Prescribing Onsite Psychiatrist

Adding an onsite psychiatrist in an addiction treatment setting to evaluate and prescribe medication for clients with COD has been shown to improve treatment retention and decrease substance use (Charney et al. 2001; Saxon and Calsyn 1995). The onsite psychiatrist brings diagnostic, medication, and psychiatric counseling services directly to the location clients are based for the major part of their treatment. This approach often is the most effective way to overcome barriers presented by offsite referral, including distance and travel limitations, the inconvenience of enrolling in another agency and of the separation of clinical services (more "red tape"), fears of being seen as "mentally ill" (if referred to a mental health agency), cost, and the difficulty of becoming comfortable with different staff.

The consensus panel is aware that the cost of an onsite psychiatrist is a concern for many programs. Many agencies that use the onsite psychiatrist model find that they can afford to hire a psychiatrist part-time, even 4 to 16 hours per week, and that a significant number of clients can be seen that way. A certain amount of that cost can be billed to Medicaid, Medicare, insurance

Community Health Needs Assessment For Northwest Connecticut

2015 Update



Charlotte Hungerford Hospital

Commissioned by:
Charlotte Hungerford Hospital (CHH)

Project Advisors:
CHH Community Relations Committee

Prepared by:
The Center for Healthy Schools & Communities @ EDUCATION CONNECTION

EDUCATION CONNECTION

Chronic Diseases and Their Risk Factors

- Similar to the rest of the state and nation, in NW CT, chronic conditions such as heart disease, cancer, stroke, and chronic lower respiratory disease rank among the leading causes of death. Some diseases and risk factors, such as asthma, diabetes, high blood pressure, and high cholesterol, are more prevalent among persons with lower educational attainment or lower incomes. Furthermore, there is greater mortality among Black non-Hispanics relative to other racial and ethnic groups for cancer and major cardiovascular diseases.
- The prevalence of overweight and obesity has increased in NW CT and the state during the past decade, and is most prevalent among adult and adolescent males and persons with lower educational attainment.
- There is much room for improvement in risk factors associated with chronic diseases, such as unhealthy eating, lack of physical activity, and smoking. Health behaviors associated with chronic diseases are shaped by socioeconomic status - persons with lower educational attainment or lower income are more likely to smoke, be less physically active, and less likely to consume a healthy diet.
- There are important disparities in cancer incidence and mortality. In CT, Black non-Hispanics experience higher breast cancer mortality, prostate cancer incidence and mortality, and colorectal cancer incidence and mortality. Hispanics have higher cervical cancer incidence; and White non-Hispanics have higher incidence rates of breast cancer, lung cancer, and melanoma.
- Chronic diseases are among the leading causes of death in the region and state, and they encompass many conditions that can be prevented or minimized. In the past decade, there has been a significant decline in certain risk factors, such as smoking in adolescents and adults, and increases in preventive screenings among adults. At the same time, there were increases in the prevalence of obesity, overweight, high blood pressure, high cholesterol, diabetes, and asthma among adults.

Infectious Diseases

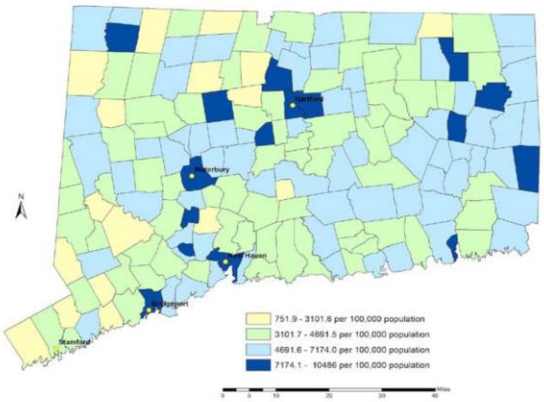
- Consistent with the state and nation, the region has experienced significant improvements in the treatment, survival, and quality of life of persons with HIV, as evidenced by a decline in the number of new HIV cases and deaths among persons with HIV. Disparities remain, however, with males and Black non-Hispanics more likely than others to be diagnosed with HIV.
- Substantial reductions in the incidence of infectious disease have been achieved largely through vaccine development and delivery and advances in medication therapy, which have contributed to decreases in infectious disease deaths and increased life expectancy.

Mental Health, Alcohol, and Substance Use Disorders

- Connecticut and the Northwest region have experienced an increase in emergency department visits for alcohol and other substance use disorders. Specifically, deaths due to overdoses of prescription pain killers and heroin have increased in the state and region.
- Mental health and substance use disorders affect individuals, families, and communities in complex and challenging ways. In addition to premature mortality, mental health and substance use disorders contribute to substantial social and economic costs to families and communities.
- There are disparities by age, sex, race, ethnicity, and educational attainment in the prevalence of diagnosed depression and poor mental health days, emergency department visits due to mental health, alcohol and substance use disorders. Additionally, over the past decade, the region and state have experienced an increase in binge drinking among adults and adolescents. Prescription drug misuse and overdose are an emerging public health challenge and a leading cause of injury death.

Leading Causes of Death and Hospitalization

Figure 15: All-Cause Premature Mortality, By Town, CT, 2006-2010



Source: CT Department of Public Health, Health Statistics & Surveillance, Statistics & Analysis Reporting, 2006-2010; as cited in Healthy CT 2020

Table 10: AAMR Rates by Cause, Race, and Ethnicity, CT and Litchfield County, 2008-2012

Cause of Death	Age-Adjusted Mortality Rates (2008-2012) Per 100,000 Residents							
	Connecticut				Litchfield County			
	Total	White	Black	Hispanic	Total	White	Black	Hispanic
All causes	660.4	656.8	764.7	517.7	656.2	669.4	671.8	446.7
Malignant neoplasms	160.0	161.9	179.0	110.4	150.2	153.5	183.7	68.2*
Diabetes mellitus	14.8	13.4	31.9	20.8	10.4	10.4	-	-
Alzheimer's disease	16.9	17.4	13.5	9.5	17.6	17.8	-	-
Major cardiovascular diseases	200.2	199.9	231.8	149.9	216.9	220.9	231.8	161.0
Pneumonia and Influenza	13.7	13.5	16.1	12.4	13.0	13.3	-	-
Chronic lower respiratory diseases	32.2	33.7	22.7	17.6	38.0	39.4	-	-
Chronic liver disease and cirrhosis	7.4	7.5	4.9	11.1	8.4	8.5	-	-
Accidents (unintentional injuries)	33.3	34.8	29.3	28.8	36.4	37.4	-	26.5*
Alcohol-induced	4.9	5.3	3.6	3.9	6.6	6.8	-	-
Drug-induced	10.9	12.6	8.2	8.9	12.9	13.1	-	-

Backus K, Mueller L (2015) Age-Adjusted Mortality Rates by Race/Ethnicity for Litchfield County and Connecticut, 2008-2012. CT Department of Public Health.
Notes: Rates that are based on < 5 deaths are suppressed and indicated by a dash (-).
Rates noted with a (*) are based on < 15 deaths and should be interpreted with caution.

As shown in Table 10, overall Age-Adjusted Mortality Rates (AAMR) in 2008-2012 were ***higher*** (by one point or more) than the state rates for county residents for major cardiovascular diseases (CVD), chronic lower respiratory diseases (CLRD), chronic liver disease and cirrhosis, accidents, and alcohol and drug induced causes of death.

By race and ethnicity, deaths from all causes were highest in Black or African American residents in both the state and county; however AAMRs for Black residents were considerably lower in Litchfield County than in the state. Overall mortality rates in the state and county were lowest for Hispanic or Latino residents, which is consistent with the findings from the 2012 Community Health Needs Assessment (CHNA). This may be due in part to underreporting of ethnicity on death certificates.

Death rates were ***lower*** (by one point or more) for White residents of Litchfield County compared with the state average for White residents for malignant neoplasms (cancer) and diabetes, and ***higher*** (by one point or more) than the state average for all causes, major CVD, CLRD, chronic liver disease and cirrhosis, accidents, and alcohol induced deaths.

AAMR rates for many causes of death for Black or African American and Hispanic or Latino residents in the county are not indicated in Table 10 due to the small number of events (<5 deaths in the 5 year period). For rates based on 5 or more deaths in the 5-year time interval, AAMRs were ***lower*** for Black or African American county residents than the state average for all-cause mortality, and identical to the state rate for major CVD. AAMR rates were ***higher*** for Black or African American residents than the state average for malignant neoplasms.

For Hispanic or Latino county residents, AAMR rates that could be calculated were ***lower*** than the state rates for all causes, malignant neoplasms, and accidents. AAMR rates were ***higher*** for Hispanic or Latino county residents than state residents for major CVD.

Appendix Four
Financials

FINANCIAL WORKSHEET I (B)

FOR-PROFIT

Applicant Name: MC1 Healthcare LLC
Financial Worksheet (B)

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) FY2016* Projected Results	(2) FY 2017 Projected W/out CON	(3) FY 2017 Projected Incremental	(4) FY 2017 Projected With CON	(5) FY 2018 Projected W/out CON	(6) FY 2018 Projected Incremental	(7) FY 2018 Projected With CON	(8) FY 2019 Projected W/out CON	(9) FY 2019 Projected Incremental	(10) FY 2019 Projected With CON
A.	**OPERATING REVENUE**										
1	Total Gross Patient Revenue	$0	$0	$0	$0			$0			$0
2	Less: Allowances	$0	$0	$0	$0			$0			$0
3	Less: Charity Care	$0	$0	$0	$0			$0			$0
4	Less: Other Deductions	$0	$0	$0	$0			$0			$0
	Net Patient Service Revenue	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
5	Medicare	$0	$0	$0	$0			$0			$0
6	Medicaid	$0	$0	$0	$0			$0			$0
7	CHAMPUS & TriCare	$0	$0	$0	$0			$0			$0
8	Other	$0	$0	$0	$0			$0			$0
	Total Government	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
9	Commercial Insurers	$250,000	$257,500	$144,918	$402,418	$265,225	$185,089	$450,314	$273,182	$215,240	$488,422
10	Uninsured	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
11	Self Pay	$45,000	$46,350	$50,761	$97,111	$47,741	$64,832	$112,572	$49,173	$75,393	$124,566
12	Workers Compensation	$0	$0	$0	$0	$0		$0	$0		$0
13	Other	$0	$0	$0	$0	$0		$0	$0		$0
	Total Non-Government	**$295,000**	**$303,850**	**$195,678**	**$499,528**	**$312,966**	**$249,921**	**$562,886**	**$322,354**	**$290,633**	**$612,988**
	Net Patient Service Revenue[a] (Government+Non-Government)	**$295,000**	**$303,850**	**$195,678**	**$499,528**	**$312,966**	**$249,921**	**$562,886**	**$322,354**	**$290,633**	**$612,988**
14	Less: Provision for Bad Debts	$3,688	$3,798	$2,588	**$6,386**	$3,912	$3,305	**$7,217**	$4,029	$3,844	**$7,873**
	Net Patient Service Revenue less provision for bad debts	**($3,688)**	**($3,798)**	**($2,588)**	**($6,386)**	**($3,912)**	**($3,305)**	**($7,217)**	**($4,029)**	**($3,844)**	**($7,873)**
15	Other Operating Revenue	$0	$0	$0	**$0**	$0		**$0**	$0		**$0**
17	Net Assets Released from Restrictions	$0	$0	$0	**$0**	$0		**$0**	$0		**$0**
	TOTAL OPERATING REVENUE	**$291,313**	**$300,052**	**$193,091**	**$493,143**	**$309,053**	**$246,615**	**$555,669**	**$318,325**	**$286,790**	**$605,115**
B.	**OPERATING EXPENSES**										
1	Salaries and Wages	$125,000	$128,750	$75,000	$203,750	$132,613	$77,250	$209,863	$136,591	$99,459	$236,050
2	Fringe Benefits	$37,500	$38,625	$22,500	$61,125	$39,784	$23,175	$62,959	$40,977	$29,838	$70,815
3	Physicians Fees	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
4	Supplies and Drugs	$12,500	$12,875	$6,427	$19,302	$13,261	$7,391	$20,652	$13,659	$8,500	$22,159
5	Depreciation and Amortization	$0	$0	$0	$0	$0		$0	$0		$0
6	Provision for Bad Debts-Other[b]	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
7	Interest Expense	$0	$0	$0	$0	$0		$0	$0		$0
8	Malpractice Insurance Cost	$7,500	$7,725	$6,000	$13,725	$7,957	$6,500	$14,457	$8,195	$7,000	$15,195
9	Lease Expense	$80,000	$82,400	$60,000	$142,400	$84,872	$61,800	$146,672	$87,418	$63,654	$151,072
10	Other Operating Expenses	$0	$0	$17,500	$17,500	$0	$57,500	$57,500	$0	$59,225	$59,225
	TOTAL OPERATING EXPENSES	**$262,500**	**$270,375**	**$187,427**	**$457,802**	**$278,486**	**$233,616**	**$512,102**	**$286,841**	**$267,676**	**$554,517**
	INCOME/(LOSS) FROM OPERATIONS	**$28,813**	**$29,677**	**$5,664**	**$35,341**	**$30,567**	**$12,999**	**$43,566**	**$31,484**	**$19,114**	**$50,598**
	NON-OPERATING INCOME	**$0**	**$0**	**$0**	**$0**	**$0**		**$0**	**$0**		**$0**
	Income before provision for income taxes	**$28,813**	**$29,677**	**$5,664**	**$35,341**	**$30,567**	**$12,999**	**$43,566**	**$31,484**	**$19,114**	**$50,598**
	Provision for income taxes[c]	**$12,966**	**$13,355**	**$2,549**	**$15,903**	**$13,755**	**$5,850**	**$19,605**	**$14,168**	**$8,601**	**$22,769**
	NET INCOME	**$15,847**	**$16,322**	**$3,115**	**$19,437**	**$16,812**	**$7,150**	**$23,962**	**$17,316**	**$10,513**	**$27,829**
C.	**Retained Earnings, beginning of year**	**$30,000**	**$45,847**	**$45,847**	**$91,694**	**$62,169**	**$48,962**	**$111,131**	**$78,981**	**$56,111**	**$135,093**
	Retained Earnings, end of year	**$45,847**	**$62,169**	**$48,962**	**$111,131**	**$78,981**	**$56,111**	**$135,093**	**$96,297**	**$66,624**	**$162,922**
	Principal Payments	$0	$0	$0	**$0**	$0		**$0**	$0		**$0**
D.	**PROFITABILITY SUMMARY**										
1	Hospital Operating Margin	**9.9%**	**9.9%**	**2.9%**	**7.2%**	**9.9%**	**5.3%**	**7.8%**	**9.9%**	**6.7%**	**8.4%**
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	**5.4%**	**5.4%**	**1.6%**	**3.9%**	**5.4%**	**2.9%**	**4.3%**	**5.4%**	**3.7%**	**4.6%**
E.	**FTEs****	**2**	**0**	**2.5**	**2.5**		**2.5**	**2.5**		**2.5**	**2.5**
F.	**VOLUME STATISTICS[d]**										
1	Inpatient Discharges	0	0	0	**0**			**0**			**0**
2	Outpatient Visits***	0	0	569	**569**		705	**705**		796	**796**
	TOTAL VOLUME	**0**	**0**	**569**	**569**	**0**	**705**	**705**	**0**	**796**	**796**

[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 change due to the proposal.
* Projected entity start-up April 1, 2017: FY2017 amounts reflect 9 months initial operation projections (Apr 1- Dec 31); applicant fiscal year is Jan 1-Dec 31.
** FTEs represent 1 clerical position and 1 clinical position
** Outpatient visits are counted as single encounters/groups. The Outpatient program provides clients with three 3-hours encounters/groups per week for 12 weeks. The total number of units is calculated as follows:
Group size x 3 sessions/week x 12 week duration x 4.33 group rotations per year.

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

Type of Service Description	Outpatient									
Type of Unit Description:	Encounter/visit									
# of Months in Operation	2									
FY 2016	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
FY Projected Incremental		Rate	Units	Gross	Allowances/	Charity	Bad	Net	Operating	Gain/(Loss)
Total Incremental Expenses:	**$262,500**			Revenue	Deductions	Care	Debt	Revenue	Expenses	om Operations
				Col. 2 * Col. 3				Col.4 - Col.5	Col. 1 Total *	Col. 8 - Col. 9
Total Facility by								-Col.6 - Col.7	4 / Col. 4 Total	
Payer Category:										
Medicare				$0				$0	$0	$0
Medicaid		$0		$0				$0	$0	$0
CHAMPUS/TriCare		$0		$0				$0	$0	$0
Total Governmental			0	$0	$0	$0	$0	$0	$0	$0
Commericial Insurers			0	$0	$0	$0	$0	$0	$0	$0
Self-Pay			0	$0	$0	$0		$0	$0	$0
Total NonGovernment		$0	0	$0	$0	$0	$0	$0	$0	$0
Total All Payers		$0	0	$0	$0	$0	$0	$0	$0	$0

Type of Service Description	Outpatient									
Type of Unit Description:	Encounter/visit									
# of Months in Operation	12									
FY 2017 (Apr-Dec)	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
FY Projected Incremental		Rate	Units	Gross	Allowances/	Charity	Bad	Net	Operating	Gain/(Loss)
Total Incremental Expenses:	**$187,427**			Revenue	Deductions	Care	Debt	Revenue	Expenses	om Operations
				Col. 2 * Col. 3				Col.4 - Col.5	Col. 1 Total *	Col. 8 - Col. 9
Total Facility by								-Col.6 - Col.7	4 / Col. 4 Total	
Payer Category:										
Medicare				$0				$0	$0	$0
Medicaid		$0		$0				$0	$0	$0
CHAMPUS/TriCare		$0		$0				$0	$0	$0
Total Governmental			0	$0	$0	$0	$0	$0	$0	$0
Commericial Insurers		$560	370	$207,025	$62,108	$0	$2,588	$142,330	$150,521	($8,191)
Self-Pay		$255	199	$50,761				$50,761	$36,906	$13,854
Total NonGovernment		$0	569	$257,786	$62,108	$0	$2,588	$193,091	$187,427	$5,664
Total All Payers		$0	569	$257,786	$62,108	$0	$2,588	$193,091	$187,427	$5,664

Type of Service Description	Outpatient									
Type of Unit Description:	Encounter/visit									
# of Months in Operation	12									
FY 2018	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
FY Projected Incremental		Rate	Units	Gross	Allowances/	Charity	Bad	Net	Operating	Gain/(Loss)
Total Incremental Expenses:	**$233,616**			Revenue	Deductions	Care	Debt	Revenue	Expenses	om Operations
				Col. 2 * Col. 3				Col.4 - Col.5	Col. 1 Total *	Col. 8 - Col. 9
Total Facility by								-Col.6 - Col.7	4 / Col. 4 Total	
Payer Category:										
Medicare				$0				$0	$0	$0
Medicaid				$0				$0	$0	$0
CHAMPUS/TriCare				$0				$0	$0	$0
Total Governmental			0	$0	$0	$0	$0	$0	$0	$0
Commericial Insurers		$577	458	$264,412	$79,324	$0	$3,305	$181,783	$187,614	($5,831)
Self-Pay		$263	247	$64,832				$64,832	$46,002	$18,830
Total NonGovernment		$0	705	$329,244	$79,324	$0	$3,305	$246,615	$233,616	$12,999
Total All Payers		$0	705	$329,244	$79,324	$0	$3,305	$246,615	$233,616	$12,999

Type of Service Description	Outpatient									
Type of Unit Description:	Encounter/visit									
# of Months in Operation	12									
FY 2019	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
FY Projected Incremental		Rate	Units	Gross	Allowances/	Charity	Bad	Net	Operating	Gain/(Loss)
Total Incremental Expenses:	**$267,676**			Revenue	Deductions	Care	Debt	Revenue	Expenses	om Operations
				Col. 2 * Col. 3				Col.4 - Col.5	Col. 1 Total *	Col. 8 - Col. 9
Total Facility by								-Col.6 - Col.7	4 / Col. 4 Total	
Payer Category:										
Medicare				$0				$0	$0	$0
Medicaid		$0		$0				$0	$0	$0
CHAMPUS/TriCare		$0		$0				$0	$0	$0
Total Governmental			0	$0	$0	$0	$0	$0	$0	$0
Commericial Insurers		$594	518	$307,486	$92,246	$0	$3,844	$211,397	$214,968	($3,571)
Self-Pay		$271	279	$75,393				$75,393	$52,708	$22,685
Total NonGovernment		$0	796	$382,879	$92,246	$0	$3,844	$286,790	$267,676	$19,114
Total All Payers		$0	796	$382,879	$92,246	$0	$3,844	$286,790	$267,676	$19,114

User, OHCA

From: Walker, Shauna
Sent: Wednesday, February 08, 2017 3:00 PM
To: maureen.biggs01@gmail.com
Cc: Riggott, Kaila; User, OHCA
Subject: Completeness Questions on CON Application # 16-32129
Attachments: 16-32129 2nd completeness.docx

Dear Ms. O'Neill Biggs:

See attached request for additional information regarding CON application 16-32129 – Establishment of a Psychiatric Outpatient Clinic for Adults in Litchfield County. There are additional items that need to be addressed.

Reponses are due by **Monday April 10, 2017**.

Regards,

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

February 8, 2017 VIA EMAIL

Maureen O'Neill Biggs, LPC, LADC
Consultant
26 Halsey Drive
Wallingford, CT 06492
maureen.biggs01@gmail.com

RE: Certificate of Need Application, Docket Number 16-32129-CON
Establishment of a Psychiatric Outpatient Clinic for Adults
Connecticut Certificate of Need Second Completeness Letter

Dear Ms. O'Neill Biggs:

On January 14th, 2017, the Department of Public Health ("DPH"), Office of Health Care Access ("OHCA") received completeness responses from MC1 Healthcare, LLC, d/b/a/ Mountainside Treatment Center ("Mountainside" or "Applicant") proposing to establish a psychiatric outpatient clinic for adults residing in Litchfield County.

OHCA requests additional information pursuant to Connecticut General Statutes §19a-639a(c). *Please "reply all" to 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 as an attachment to a responding email. *Please email your responses to all of the following email addresses:* **OHCA@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 **April 10, 2017**, 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, prefiled testimony, late file submissions and the like) must be numbered sequentially from the applicant's document preceding it. Please begin your submission using **Page 334** and reference "**Docket Number: 16-32129-CON**."

1. Page 296 of the application states that during preadmission evaluation, clients that have a mental illness that cannot be addressed at Mountainside have been referred to Charlotte Hungerford Hospital, Silver Hills Hospital or other area providers capable of providing an appropriate level of inpatient care close to the client's residence. Explain the impact of the potential loss of clients on these existing providers if Mountainside begins treating this population.

2. Explain the reasoning for referring more clients to McLean Hospital and Silver Hills Hospital (151 and 68 miles, respectively, from Mountainside) when Charlotte Hungerford Hospital is closer in proximity to Mountainside (21 miles).

3. Page 27 of the application states that approximately 52 clients completing Mountainside residential treatment were referred to outpatient or intensive outpatient treatment in Litchfield County. Will the proposed psychiatric outpatient clinic treat such patients? If so, explain the impact of the potential loss of clients on the existing providers.

4. Provide the unit of measure (clients, sessions or visits) for Tables 5 and 6 on page 304 of the application. Confirm if the projected utilization for the proposed psychiatric outpatient clinic is included in Table 6. If so, identify separately the proposed outpatient clinic volume and ensure it is consistent with the projected totals included in Table 7 on page 309.

5. Explain the discrepancies in the total utilization by town for Litchfield County on pages 39 and 306 of the application, and the total utilization for all towns and villages in Litchfield County on page 306 of the application.

6. Page 308 of the application states that eight of the existing 14 outpatient psychiatric service providers located in Litchfield County do not provide intensive outpatient services. However, the list of providers in Table 9 on pages 308 and 309 indicates that four providers offer IOP treatment. Please identify the additional two providers that offer intensive outpatient services.

7. Explain the basis and the methods/calculations used to project the reported numbers in Table 7 on page 309 of the application.

8. Clarify the percentage of clients that receive a diagnosis of a primary mental health illness and are transferred to other facilities. Page 296 of the application states a percentage of 3.5% whereas page 11 of the application has a percentage of 9%. Explain the discrepancy.

9. Page 298 of the application states that "the rate of relapse for clients is approximately 20%." Does Mountainside offer specific treatment for clients that have relapsed that is not offered elsewhere in the area?

10. Explain what is meant by the comprehensive addiction treatment program is "outside the bounds of Medicaid reimbursement," as stated on page 303 of the application. Are the provided services reimbursable by the CT Medicaid Program?

If you have any questions concerning this letter, please feel free to contact Kaila Riggott at (860) 418-7037.