SOUTH BAY
MENTAL HEALTH

Administration
Brockton

Mental Health and Addictions Treatment
Attleboro
Brockton
Cape Cod
Fall River
Lawrence
Lowell
Plymouth
Salem
Weymouth
Worcester

Mental Health Outreach
Leominster
Lynn
New Bedford
Swansea

Adult Day Services
Brockton
Cape Cod
Fall River
Plymouth
Worcester

Children's Day Services
Fall River
Lowell

Early Childhood Services
Brockton
Fall River
Lowell
Worcester

October 25, 2012

State of Connecticut
Department of Public Health
Office of Health Care Assessments
410 Capitol Avenue
Hartford, CT. 06134

To Whom It May Concern:

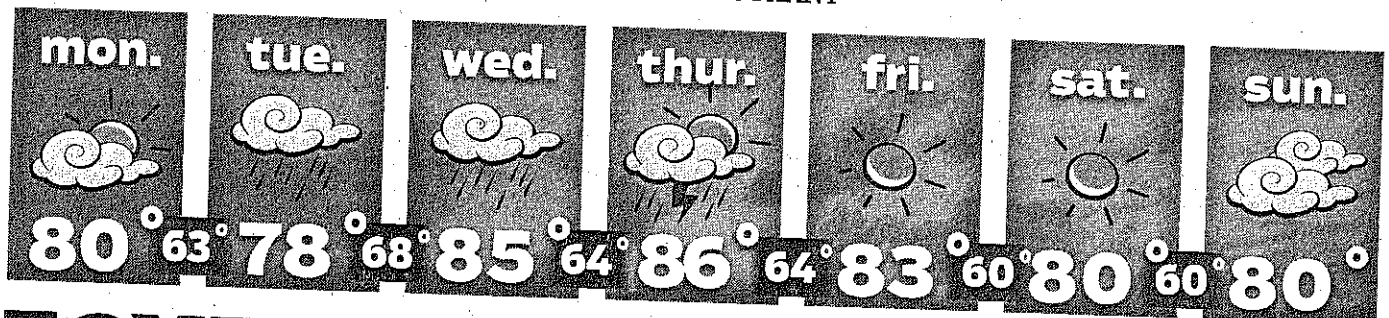
Please find enclosed, South Bay Mental Health application for a Certificate of Need determination to provide Behavioral Health Services in the Hartford, CT area.

Per the instructions enclosed with the original application in a 3 inch binder is the check for the require fee, the disc, and the newspaper ad for evidence of posting South Bay is excited at the opportunity to work in the community of Hartford with our 26 successful years in the State of MA, South Bay is confident that we can ad value to the many services that Hartford currently has to offer.

If you have any other, questions or concerns please do not hesitate to contact me directly.

Sincerely,

Sheena N Green
Operations Manager
1115 W.Chestnut Street
Brockton, MA 02301
508-521-2806
508-584-2227 (fax)
sgreen@southbaymentalhealth.com



FOX CT WEATHER

Joe Furey
Chief meteorologist
WTIC Magic 1080

Rachel Frank
FOX CT meteorologist

Dan Amarante
FOX CT meteorologist

Geoff Fox
FOX CT meteorologist

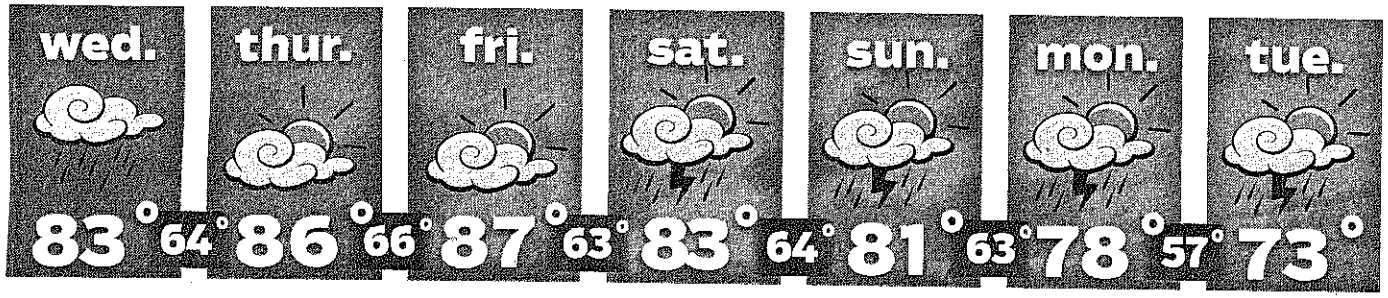
Certificate of Need

South Bay Mental Health is applying for a Certificate of Need pursuant to section 10a-638 of the general statutes for the opening of an outpatient mental health clinic in Hartford, CT.

South Bay's outpatient clinic will provide a continuum of community-based services to children, adults and families in the greater Hartford area including Outpatient Mental Health and Substance Abuse Counseling and Early Intervention services at its Center or in the client's natural environment.

The clinic will be located at 237 Hamilton Street, Suite 205, Hartford CT 06106.

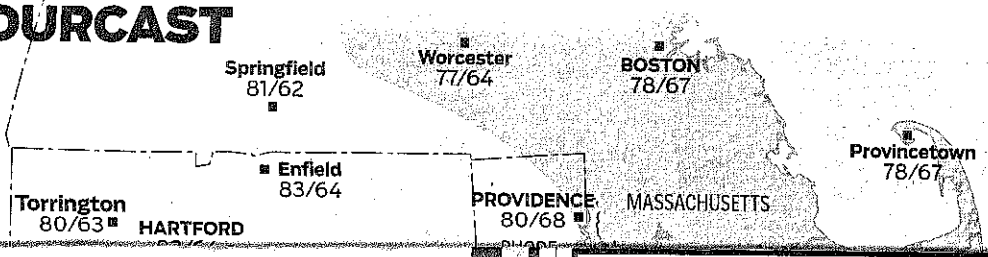
SOUTH BAY MENTAL HEALTH



FOX CT WEATHER

Joe Furey Chief meteorologist WTIC News Talk 1080
Rachel Frank FOX CT meteorologist
Dan Amarante FOX CT meteorologist
Geoff Fox FOX CT meteorologist

YOURCAST



OUTLOOK

So this is what a tropical rain forest feels like! The leftover moisture from Hurricane Isaac has infused our air with loads of moisture and energy. Any showers that develop Wednesday into early Wednesday night are capable of torrential downpours and flash flooding in areas of poor drainage. Although clouds will win out, the sun might make an appearance, allowing temperatures to climb into the low 80s. Thursday will be partly cloudy.

—Rachel Frank

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SOUTH BAY MENTAL HEALTH

Vacation & Travel

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To Advertise call 860.647.5363

MAINE

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Suites $139-$159

Application Checklist

Instructions:

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

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

For OHCA Use Only:

Docket No.: 12-31798 **Check No.:** ~~12-31798~~ 60514
OHCA Verified by: **Date:** 10/31/12

☒ **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. 6**

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

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

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

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

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

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

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

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

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

Docket Number:

Applicant: South Bay Mental Health Center, Inc.

Contact Person: Laura Nolda

Contact Person's Title: Program Director

Contact Person's Address: 237 Hamilton St. Ste 205, Hartford, CT 06106

Contact Person's Phone Number: 860-578-1300

Contact Person's Fax Number: 860-951-7729

Contact Person's Email Address: lnolda@southbaymentalhealth.com

Project Town: Hartford

Project Name: Outpatient Mental Health Clinic

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

Estimated Total Capital Expenditure: N/A

AFFIDAVIT

Applicant: South Bay Mental Health Center, Inc

Project Title: Outpatient Mental Health Clinic

I, Kevin Sheehan, CEO
(Individual's Name) (Position Title – CEO or CFO)

of South Bay Mental Health Center, Inc being duly sworn, depose and state that
(Hospital or Facility Name)

South Bay Mental Health Center, Inc. information submitted in this Certificate of
(Hospital or Facility Name)

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

Signature 10.23.12
Date

Subscribed and sworn to before me on 10/23/12

Notary Public/Commissioner of Superior Court

My commission expires: 5/25/2018

SHEENA GREEN
Notary Public
COMMONWEALTH OF MASSACHUSETTS
My Commission Expires
May 25, 2018

1. Project Description: New Service (Behavioral Health/Substance Abuse)

a. Please provide a narrative detailing the proposal.

South Bay Mental Health Center has more then twenty-six years of experience providing individual, group, and family mental health and substance abuse counseling, as well as psychopharmacology and psychological testing and evaluation, at our main downtown office, located at 37 Belmont Street in Brockton, Massachusetts. The services of South Bay are well integrated with a variety of other community providers as well as our own internal programs and resources. We are committed to fostering the self-sufficiency of our consumers by providing innovative, community-based services that meet their needs, while coordinating the efforts of all stakeholders. Accordingly, South Bay emphasizes the need for assessment of both mental health and substance abuse concerns and collaborates with all of a consumer's caregivers and providers to reduce interagency barriers and efficiently address the unique needs of each consumer.

The South Bay Substance Abuse Counseling Program delivers care through linkage agreements with area providers to ensure expeditious intake, transfer and referral; collaboration with collateral providers including primary care clinicians, inpatient units at area hospitals, local shelters, and detox units, is of our utmost priority. Programs connect with all ages and genders of the populations as well as the BSAS identified high priority populations. Our clinics promote a "culture of recovery" model by managing the continuum of prevention, intervention, treatment and recovery services. South Bay's mental health and substance abuse programs work to identify needs within many different segments of the population including children, adolescents, pregnant women, parents, and the elderly.

Internal collaboration with South Bay's Early Intervention multidisciplinary team allows ease of access to intervention and counseling services for families with young children exposed to domestic violence, substance abuse and mental health concerns.

2. Clear Public Need

a. Provide the following regarding the proposal's location:

i. The rationale for choosing the proposed service location;

237 Hamilton Street is centrally located in downtown Hartford, CT. South Bay believes this is the ideal location to provide Mental Health services because it allows consumers who may have no means of transportation to easily access services. Public transit is less than a quarter mile down the road. This location is within walking distance to other providers such as but not limited to DCF, DDS, CDC, and My Sisters Place Admin office. This will allow consumers to coordinate appointments with multiple providers in one trip as well as allow South Bay staff the ability to have contact with other providers to assure quality service to our consumers. South Bay's delivery of services is unique in that as a community-based center we render services to the consumer who is unable to come to the clinic – these are often our most vulnerable populations.

ii. The service area towns and the basis for their selection;

South Bay would like to serve the people of Hartford, West Hartford, East Hartford and Manchester particularly to assist disadvantaged people in developing self-sufficiency. Within the selected proposed service area, there are many individuals, couples, and families who do not have support in their lives to allow them to live to their full potential. The data provided in 3d supports the need and increasing risk in the proposed areas. Evidence from various sources including the local, state and federal government sources indicates the proposed area is struggling with a variety of issues where South Bay can provide assistance. Some of the identified issues (which will be spoken to at greater detail in the next section [2. Iii] below) are as follows:

- Recent population-hike in Connecticut from 2009 to 2010 of 17%
- Connecticut's unemployment rate has consistently been on the upswing in 2012. As of June 2012 the rate grew to 8.1% -- the highest rate of the year.
- 30.25% of Hartford's families living in poverty
- Hartford's child poverty rate of 47%
- High number of substantiated cases of abused and/or neglect in Hartford County

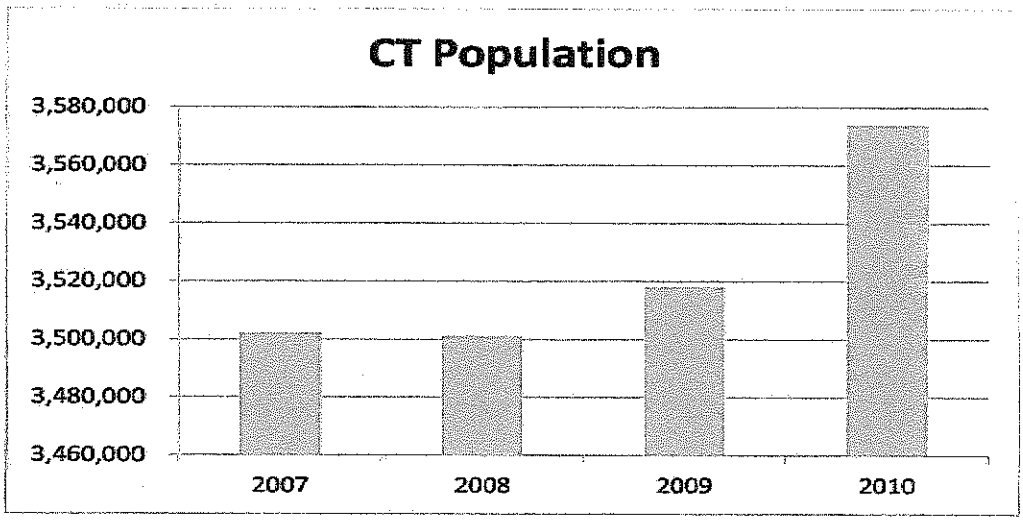
- High number of children entering and exiting foster care and kinship care
- High rate of Substance Abuse According to the National Survey on Drug Use and Health 2007-2008, Connecticut was in the top 10 states for dependence on illicit drugs for adults from 18 to 25 years old.
- High crime rate
- High incidence of teen death due to violence
- High incidence of teen pregnancy
- Higher concentrations of people that are at increased risk for unhealthy living merely because of their race, age, income, educational status, or family status
- Need for the additional services that South Bay is ready to offer the Greater Hartford community

South Bay will join the community to help people address the issues they may have encountered and/or continue to face allowing them to live more self sufficient and productive lives. South Bay is a culturally sensitive agency and can accommodate consumers of various backgrounds, languages and areas of need.

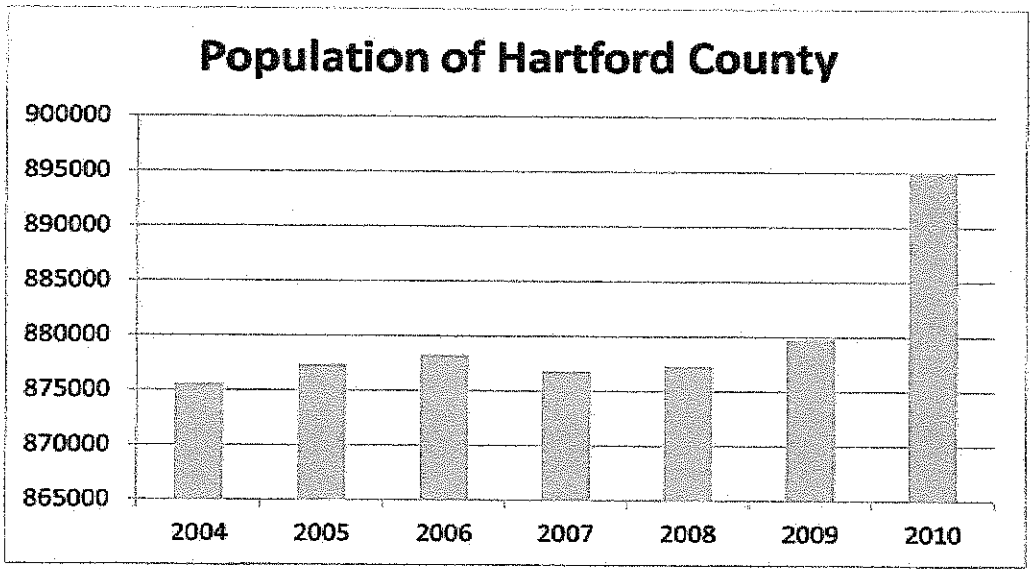
iii. The population to be served, including specific evidence such as incidence, prevalence, or other demographic data that demonstrates need;

South Bay Mental Health believes there is a growing need for additional behavioral healthcare in the Hartford area. There are a number of factors that lead to this increasing need. The population is growing faster than current service providers are able to increase services. The difficult national economy has increased the ranks of the poor, which has especially impacted families and children.

After several years of stable population, Connecticut started to grow dramatically in 2009. In the table below we see data from U.S. Census Bureau, showing the growth of population in the 2010 census – our most recent census. In one year, from 2009 to 2010 we see an increase of 17%.



This was also apparent in Hartford County. The graph below shows data on the growth of population in Hartford County. Again, focusing on the growth from 2009 to 2010, we see a growth of 17%.



Not only is the population of Connecticut growing, especially the Hartford service area, but according to the Kaiser Family Foundation, the number of Medicaid recipients is growing faster than the population. This data source also reported that Medicaid enrollment increased from 2009 to 2010, the most current year for which statistics are available, by 18.3%, compared to a growth of just 7.2% across the nation. There were 571,020 residents in Connecticut enrolled in Medicaid in 2011. The report also indicated a waiting list of 1,917 for Medicaid 1915(c) Home and Community-Based waivers with no change in 2010.

Unemployment has risen in Connecticut as well. The US Bureau of Labor Statistics reported that in June the rate rose to 8.1% -- the highest rate thus far in this year. According to the *Effects of Unemployment on Mental Health and Physical Health,* a study done by Marfaret Linn, PHD, Richard Sandifer, BS, and Shayna Stein, PhD in 1985 states; "Results from this study strongly suggest that unemployment had an adverse impact on psychological function, with the unemployed becoming more anxious, depressed, and concerned with bodily symptoms than those who continued to work," (Linn, Sandifer, Stein 1985). This study supports that in a community where unemployment rates are increasing, mental health issues are an increasing parallel. Another report, *Psychological Effects of Unemployment and Underemployment 2012,* American Psychological Association, goes further to state that particular groups including women, Latinos and African Americans are at greater risk. The case that these populations are highly represented in the Hartford area indicates an increased need for services.

The Hartford Community Needs Assessment of March 2012 stated that the lack of employment has long been linked to increased rates of mortality. For Connecticut, unemployment has been strongly correlated with decreased health care access, which can serve as a partial explanation for the correlations with a decreased life expectancy, and increased incidences of respiratory illness, and infectious and cardiovascular disease, as well as illness among children. This is reinforced by responses to the Key Informant survey where finances and access to health care were identified as significant barriers.

Unemployment and declining mental health lead to the risk of increased poverty rates. Connecticut is an affluent state that unfortunately, has pockets of great poverty – the greatest concerning its children. With 30.25% of Hartford's families living in poverty, the poverty statistics for the city are three times higher for families than in the United States overall and over 4 times greater than in Connecticut. According to the Connecticut Commission on Children, in 2009 Hartford's child poverty rate was 47%. It has been well documented that poverty rate is connected to rates of child neglect and abuse. The Connecticut Association for Human Services substantiated a high rate of child abuse and neglect in Connecticut. The number of substantiated cases of abused and/or neglect in Hartford County in 2008 was listed as 2,260 – with 633 cases stemming from the city of

Hartford, 165 cases in East Hartford, 192 in Manchester and 61 in West Hartford. The cases in these four towns make up almost 40% of abuse and neglect cases in the county. The report further states that child neglect makes up over 60 percent of the abuse and neglect cases in Connecticut and that neglect is often the result of poverty, stemming from reduced access to basic needs, lack of resources, and stressful living conditions. "With proper supports and resources in place around the state, future incidents of child maltreatment can be prevented." South Bay applauds the state's commitment to Connecticut's children and the development of the Differential Response System (DRS). We strongly believe that South Bay can play a vital role as a partner in the effort to present accessible community-based support offering In Home Behavioral Therapy. We can help families positively cope with hardship to prevent unfortunate outcomes such as child abuse and neglect.

It has also been well recognized that children in foster care and kinship care are at higher risk for emotional and psychiatric disorders – approximately 78% of this population are in need of supportive services and/or therapy. *Child Welfare, Children's Defense Fund* reported that in 2009 Connecticut had 2,466 children enter foster care and 2,972 exit foster care through adoption, guardianship or reunification (46.7) with family. The report also showed great instability in placement. This number indicates 5438 children are touched by the foster care system annually further indicating that each year 4241 children in Connecticut have need for mental health services and/or support.

Children living in kinship care also present a greater need for service. The 2010 US Census reported that 61,408 children under age 18 live in homes where the householders are grandparents or other relatives (7.5% of all children in the state.) 1,916 grandparents in Hartford are the householders and have sole responsibility for their grandchildren living with them. These families are often challenged with a myriad of stressors. Additional financial burden, unexpected responsibility for children – particularly at a time in their lives where they may be experiencing health issues etc., can develop great need for mental health services and familial support systems for the care-givers as well as the children. South Bay has expertise in not only child and family In Home Behavioral Health but also specializes in KinCoaching. After recognizing the high number of children being raised by grandparents

or other relatives, South Bay developed a program that provides support and education to these families.

A high incident of behavioral risk factors such as use of alcohol, marijuana, tobacco, cocaine, heroin, and misused prescription drugs were also identified in the proposed service. Substance abuse has been linked to injury, illness, lost productivity, disability, death and crime – including domestic violence, and can also lead to serious chronic mental health problems. According to Connecticut's Department of Public Health, alcohol and drug abuse account for about 650 deaths and 5,000 hospitalizations among Connecticut residents each year. The National Highway Traffic Safety Administration reported that in 2008, 40% of motor-vehicle-related fatalities were alcohol-related and 33% involved alcohol-impaired drivers and these percentages were about the same since 1998. In addition, inpatient hospitalizations for alcohol and drug abuse accounted for $77 million in hospital charges in 2007, and underage drinking cost the state an estimated $621 million in 2005 according to the Connecticut Department of Public Health, 2007 Hospitalization Report. It was further reported that accidental poisoning is the leading cause of unintentional injury death in Connecticut. In 2005-2007, 754 Connecticut resident deaths, including 681 accidental poisoning deaths, had narcotics listed as a secondary cause of death. Cocaine, heroin, and methadone accounted for 75% of these deaths. In addition, the National Survey on Drug Use and Health 2007-2008 reported that Connecticut was in the top 10 states in the nation for dependence on illicit drugs for adults from 18 to 25 years old. Connecticut Department of Public Health has rightfully targeted these behavioral risk factors for prevention efforts. South Bay can assist the state in providing services in prevention and recovery to improve the overall health of the Hartford area and reduce the financial burden to the health care system that results in these risky behaviors.

Hartford has been identified with an extremely high violent crime rate. In 2009 the city was higher than the national violent crime rate average by 200.91% and the city property crime rate in Hartford was higher than the national property crime rate average by 66.56%. In 2009 the city violent crime rate in Hartford was higher than the violent crime rate in Connecticut by 332.66% and the city property crime rate in Hartford was higher than the property crime rate in Connecticut by 116.49%. Hartford's youth are at high risk. According

to CT.gov 52 teens died as a result of homicide in the past decade. Death by homicide accounted for 54 intentional deaths of children ages 12 or younger. For most of these children, their death is the tragic consequence of abuse and neglect. *The Connecticut Youth Behavior Risk Surveillance of 2011* reported that during 2009-2011, the percentage of high school students who carried a weapon on school property increased significantly (3.9%-6.6%). The prevalence of carrying a weapon on school property is significantly higher (almost twice as high) in grade 12 among CT (10%) than among US (5.6%) students. During 2005-2011, a significant linear decrease (12.5%-5.7%) occurred in the percentage of black students who were threatened or injured with a weapon on school property. However from 2009-2011, the percentage of white students who were threatened or injured with a weapon on school property increased significantly (3.4%-5.7%). Moreover, the Community Health Assessment Needs stated that almost 20% of the state's drug abuse violations occur in the city of Hartford.

Nationally and in Connecticut, medical authorities have declared preventable teen deaths a serious public health issue as the rate of teens taking their own lives or suffering from fatal injuries increases. According to the 2009 Connecticut School Health Survey, 25% of high school students felt so hopeless for an extended period of time that they stopped doing regular activities, 14% considered suicide, and slightly more then 7% actually attempted suicide at least once. The number of total preventable teen deaths (ages 15-19) in Hartford County rose from 96 to 168 from 2001 to 2006. However, these numbers do not reflect rates in towns in which fewer than five teens died. The city of Hartford experienced a rise from 33 to 44. While the overall number of suicides have had an up and down pattern, in a 6-week period between late October and December 2011, Connecticut tragically lost five youth to suicide; this surpasses all suicide deaths in 2010.

The Suicide Prevention Resource and the National Suicide Prevention Strategy present protective factors to include strong connections to families and others, access to clinical supports and services, restricting lethal means, a positive belief about the future, and skills in problem solving. South Bay appreciates Connecticut's attention and dedication to present

accessible services to assist its teens. We feel strongly that we will be able to support Connecticut's efforts in decreasing these negative incidents.

Another group identified in need of services is teen mothers. The Connecticut State Department of Education (SCDE) and the Connecticut Department of Public Health (DPH) conducted an analysis of data to identify the geographic areas that would be best served by a school-based teen parent support program. The report showed Hartford to have the highest percentage rate of births to young mothers (18.2%). South Bay can assist the Department of Education and Department of Social Services in reaching the Goals outlined in this program:

Improve the education, health and social outcomes for pregnant and parenting teens.
Promote healthy child development for the children of parenting teens.
Promote positive parenting and reduce incidences of child maltreatment.
The report indicates that although the Nurturing Families Network (NFN) has made great strides in serving this population there continues to be a great gap in services. While "NFN home is at full capacity serving almost 2,000 families in Connecticut, the estimate of need is that 4,000 mothers may be at risk of poor parenting and child maltreatment."

In the Hartford Community Health Needs Assessment (CHNA) of March 2012 it was determined that many socioeconomic and cultural characteristics of the population living in Hartford drive the main health concerns. The findings point to higher concentrations of people that are at increased risk for unhealthy living merely because of their race, age, income, educational status, or family status. All of these indicators have been mentioned prior in this response and noted by various sources. The report listed the five most identified significant health issues in Hartford as obesity, diabetes, mental illness, heart disease, and asthma. Also, the report stated concern about the shifts in cases of HIV and STD in the Hartford area. Hartford is proportionally younger than the state and the U.S., which impacts numerous aspects of health including rates of some types of cancer, violence, and levels of unintended injury.

South Bay not only has extensive experience in successfully treating the populations mentioned above, but has also developed many specialty services integrating Behavioral Health and Physical Medicine – Asthma, Diabetes, COPD, Cardiovascular and others. South Bay is committed to a holistic approach believing that best outcomes in both Behavioral and Physical Health are presented when there is a coordinated effort to address the complex needs of consumers.

Four barriers to access to care were identified in the CHNA survey including lack of knowledge about existing services and access to services. The Key Informant study showed a need for improving access to care across the board for a variety of underserved-populations. These are barriers that South Bay can address.

The most powerful tools in keeping a population healthy are prevention and easy access to quality care. These efforts will result in a dramatic cost savings and reduction in social problems to the community. South Bay's mission has always been to serve the underserved and assist them in gaining a productive and self-sufficient life. We hope to assist Hartford and the surrounding area in providing more opportunities for its citizens to improve their lives and their community.

3. Quality Measures

i. How and where the proposed patient population is currently being served;

Currently, the proposed population is being served at larger agencies, healthcare facilities and emergency rooms. As mentioned previously, many of these other agencies may have a waitlist due to large residential need and lack of appropriate staffing equipped to assist this population. Emergency rooms are available for those who need immediate assistance; however, many times the overall concern could have been prevented or helped if there was prompt and adequate care being offered to the individual. For example, an individual could overdose and end up going to the emergency room for help with detox and care, when in reality; this consumer may have avoided overdosing if they were receiving mental health services initially. By adding a community-based agency such as South Bay to the Hartford

region, this allows consumers in need to access care quickly and utilize places such as health care facilities and emergency rooms less frequently.

ii. All existing providers (name, address, services provided) of the proposed service in the towns listed above and in nearby towns; and

Hartford System of Schls Hlth Svcs	OP Clinic/MH Center	176 Babcock St. Hartford, CT 06106-1343 (860)695-4952
Charter Oak Health Center	OP Clinic/MH Center	282 Washington St – Med Hartford, CT 06106-3322 (860) 550-7500
Charter Oak Health Center	OP Clinic/MH Center	401 New Britain Ave. OTP Hartford, CT 06106-3833 (860) 550-7500
Hartford System of Schls Hlth Svcs	OP Clinic/MH Center	470 Maple Ave. Hartford, CT 06114-1215 (860) 695-3663
Charter Oak Health Center	OP Clinic/MH Center	21 Grand St. – QTP Hartford, CT 06106-1541 (860) 550-7500
Community Renewal Team, Inc.	OP Clinic/MH Center	1921 Park St. Hartford, CT 06106-2118 (860) 951-8770
Catholic Charities, Inc.	OP Clinic/MH Center	45 Wadsworth St. Hartford, CT 06106-1732 (860) 527-1124
Hartford Comm. Mtl Health Center	OP Clinic/MH Center	1 Main Street Hartford, CT 06106-1806 (860) 548-0101
Community Health Services Inc.	OP Clinic/MH Center	80 Seymour St. Hartford, CT 06102-8000 (860) 249-9625
Hartford System of Schls Hlth Svcs	OP Clinic/MH Center	55 Forest St. Hartford, CT 06105-3227 (860) 695-1358
Hartford System of Schls Hlth Svcs	OP Clinic/MH Center	300 Wethersfield Ave. Hartford, CT 06114-1409 (860) 695-1110
Alcohol & Drug Recov. Ctr., Inc.	OP Clinic/MH Center	255 Main St. –OP Hartford, CT 06106-1821 (860) 524-0046
Hartford Dispensary	OP Clinic/MH Center	345 Main St. –Meth Hartford, CT 06106-1824 (860) 525-2181

Hartford Dispensary	OP Clinic/MH Center	335 Broad Street – AMBO Manchester, CT 06040-4036 (860) 643-3210
Hartford Dispensary	OP Clinic/MH Center	335 Broad Street – Meth Manchester, CT 06040-4036 (860) 643-3210
Hartford Dispensary	OP Clinic/MH Center	335 Broad Street – OTP Manchester, CT 06040-4036 (860) 643-3210
East Hartford Comm. Health Care	OP Clinic/MH Center	150 N. Main Street Manchester, CT 06042-2086 (860) 528-1359
Community Child Guidance Clinic	OP Clinic/MH Center	317 N. Main Street Manchester, CT 06042-2007 (860) 643-2101
Community Health Resources	OP Clinic/MH Center	587 Middle Tpke E Manchester, CT 06040-3731 (877) 884-3571
Integrated Health Services Inc.	OP Clinic/MH Center	15 Mercer Ave. E. Hartford, CT 06118-1517 (860) 622-5340
East Hartford Comm. Health Care	OP Clinic/MH Center	94 Connecticut Blvd. E. Hartford, CT 06108-3013 (860) 528-1359
Integrated Health Services Inc.	OP Clinic/MH Center	777 Burnside Ave. E. Hartford, CT 06108-2705 (860) 622-5340
Capitol Region Education Council	OP Clinic/MH Center	474 School St. – Med E. Hartford, CT 06108-1149 (860) 289-8131
Capitol Region Education Council	OP Clinic/MH Center	474 School St. – OTP E. Hartford, CT 06108-1149 (860) 289-8131
Integrated Health Services Inc.	OP Clinic/MH Center	52 Farm Dr E. Hartford, CT 06108-1211 (860) 622-5340
Capital Region Education Council	OP Clinic/MH Center	337 East River Dr E. Hartford, CT 06108-4202 (860) 290-5320
Hartford System of Schls Health Svcs	OP Clinic/MH Center	176 Babcock Street Hartford, CT 01606-1343 (860) 695-4952
Charter Oak Health Center	OP Clinic/MH Center	282 Washington St. – Med Hartford, CT 06106-3322 (860) 550-7500

Charter Oak Health Center	OP Clinic/MH Center	135 Broad Street-OTP Hartford, CT -06105-3718 (860) 550-7500
Catholic Charities, Inc.	OP Clinic/MH Center	896 Asylum Ave. –LCSW Hartford, CT 06105-1918 (860) 728-2560
HARC Behavioral, Health Clinic	OP Clinic/MH Center	900 Asylum Ave. Hartford, CT 06105-1901 (860) 233-6076
Wheeler Clinic, Inc.	OP Clinic/MH Center	645 Farmington Ave. Hartford, CT 06105-2907 (800) 793-3588
Klingberg Family Ctr, Inc.	OP Clinic/MH Center	157 Charter Oak Ave. Hartford, CT 06106-1913 (860) 243-4416
Hartford System of Schls Hlth Svcs	OP Clinic/MH Center	960 Main Street – Unit 8 Hartford, CT 06103-1225 (860) 695-8852
Wheeler Clinic, Inc.	OP Clinic/MH Center	103 Woodland Street Hartford, CT 06105-1233 (800) 793-3588
Hartford System of Schls Hlth Svcs	OP Clinic/MH Center	85 Edwards Street Hartford, CT 06120-2812 (860) 695-2313
Community Renewal, Team Inc.	OP Clinic/MH Center	330 Market Street, 1st Floor Hartford, CT 06120-2901 (860) 761-7900
Community Health Services Inc.	OP Clinic/MH Center	500 Albany Ave. – OTP Hartford, CT 06120-2508 (860) 249-9625
Capital Region Education Council	OP Clinic/MH Center	337 East River Dr. East Hartford, CT 06108-4202 (860) 290-5320
East Hartford Comm. Health Care	OP Clinic/MH Center	94 Connecticut Blvd. East Hartford, CT 06108-3013 (860) 528-1359
Hartford Dispensary	OP Clinic/MH Center	12 Weston St. – Ambo #18 Hartford, CT 06120-1504 (860) 527-5100
Hartford Dispensary	OP Clinic/MH Center	16 Weston St. – OTP #18 Hartford, CT 06120-1504 (860) 527-5100
Hartford Dispensary	OP Clinic/MH Center	12 Weston St. – Meth #18 Hartford, CT 06120-1504 (860) 527-5100

Charter Oak Health Center	OP Clinic/MH Center	401 New Britain Ave – OTP Hartford, CT 06106-3833 (860) 550-7500
Hartford System of Schls Health Svcs	OP Clinic/MH Center	470 Maple Ave. Hartford, CT 06114-1215 (860) 695-3663
Charter Oak Health Center	OP Clinic/MH Center	21 Grand Street-OTP Hartford, CT 06106-1541 (860) 550-7500
Community Renewal Team Inc.	OP Clinic/MH Center	1921 Park Street Hartford, CT 06106-2118 (860) 951-8770
Catholic Charities, Inc.	OP Clinic/MH Center	45 Wadsworth St. Hartford, CT 06106-1732 (860) 527-1124
Hartford Comm Mtl Health Center	OP Clinic/MH Center	1 Main Street Hartford, CT 06106-1806 (860) 548-0101
Community Health Services Inc.	OP Clinic/MH Center	80 Seymour St. Hartford, CT 06102-8000 (860) 249-9625
Hartford System of Schls Hlth Svcs	OP Clinic/MH Center	55 Forest Street Hartford, CT 06105-3227 (860) 695-1358
Alcohol & Drug Recov Ctr Inc.	OP Clinic/MH Center	255 Main St. – OP Hartford, CT 06106-1821 (860) 524-0046
Hartford Dispensary	OP Clinic/MH Center	345 Main St. – Meth Hartford, CT 06106-1824 (860) 525-2181
Charter Oak Health Center	OP Clinic/MH Center	135 Broad St. – OTP Hartford, CT 06105-3718 (860) 550-7500

iii. The effect of the proposal on existing providers, explaining how current referral patterns will be affected by the proposal.

Adding additional mental health services to the Hartford region means creating more opportunity for consumers to access and receive help for their individual issues. South Bays' services will bring expertise to the area where they can collaborate with other providers to best serve the consumers. South Bay Mental Health believes in a foundation and core

value of collaboration. Our belief is that collaboration means working with a team to help individuals reach the goal of self-sufficiency. In addition, South Bay services will allow consumers access to services where other providers are unable, due to a consistent waitlist. From provided data, there is a strong need for services due to many providers having a lengthy waitlist. Adding a new outpatient mental health facility to the community will highly reduce and relieve this waitlist. Given our outreach approach, South Bay has the experience of meeting extremely high risk consumers in their homes, allowing us to provide treatment to those who may otherwise not be engaged. We believe the addition of this type of service will provide relief to consumers, other area providers and the community at large. It is our goal to begin service seven days after the referral has been received.

4. Projected Volume – *Please see attached*

a. Complete the following table for the first three fiscal years ("FY") of the proposed service.

Table 1: Projected Volume

	Projected Volume (First 3 Full Operational FYs)**			
	FY****	FY****	FY****	FY****
Service type***				
Total				

** 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.
*** Identify each service/procedure type and add lines as necessary.
**** Fill in years. In a footnote, identify the period covered by the Applicant's FY (e.g. July 1-June 30, calendar year, etc.).

b. Provide a detailed description of all assumptions used in the derivation/calculation of the projected volumes.

c. Provide historical volumes for three full years and the current year to date for any of the Applicant's existing services that support the need to implement the proposed service.

d. Provide a copy of any articles, studies, or reports that support the statements made in this application justifying need for the proposal, along with a brief explanation regarding the relevance of the selected articles.

4A, B + C

South Bay Mental Health Center, Inc
Service Delivery
Projected Volume

SERVICE CODE DESCRIPTION	Current Hours	Year 1st Hours	Year 2nd Hours	Year 3rd Hours
INDIVIDUAL		5,828	6,994	7,693
FAMILY CONSULTATION		360	432	475
MED VISITS		421	506	556
FAMILY THERAPY		286	343	378
CASE CONSULTATION		268	322	355
DIAGNOSTIC EVAL		220	264	290
GROUP THERAPY		61	74	81
Report Totals.....		7,444.38	8,934.74	9,828.32

Assumptions for projected volume:
Service type volume was developed based on historical trends of new operations opened by South Bay over the last few years. Historically the company's major focus is on Individual and Family treatment.

Historical Volumes:
Historical volumes for the Mental Health Division only for the last three years:

	Sessions	Units	Hours
2009	246,106.00	543,923.00	242,054.50
2010	279,137.00	667,170.00	280,356.00
2011	309,864.00	821,279.00	323,326.50
2012 (Jan 1- July 31)	195,001.00	554,468.00	207,041.25

Index of Articles and Reports supporting the Need for Mental Health Services in the Hartford area:

Connecticut QuickFacts from the US Census Bureau, State and County QuickFacts
(http://quickfacts.census.gov/qfd/states/09000.html)
Demographics of Connecticut, Hartford, East Hartford, Manchester and West Hartford

A Community Health Needs Assessment, Department of Health and Human Services, March 2012 – Healthy Hartford
(http://hhs.hartford.gov/Shared%20Documents/Community%20health%20needs%20assessment%202012.pdf)
Indicates current health needs in the city of Hartford.

Medicaid
Kaiser State Health Facts, Connecticut: Home and Community-Based Services
(http://www.statehealthfacts.org/profileind.jsp?cat=4&sub=62&rgn=8)
The number of Medicaid recipients is growing faster than the population. This data source also reported that Medicaid enrollment increased from 2009 to 2010, the most current year for which statistics are available, by 18.3%, compared to a growth of just 7.2% across the nation. There were 571,020 residents in Connecticut enrolled in Medicaid in 2011.
Indicates a waiting list of 1,917 for Medicaid 1915(c) Home and Community-Based waivers with no change in 2010

Unemployment
Department Numbers, Connecticut Unemployment
(www.deptofnumbers.com/unemployment/connecticut)
According to the US Bureau of Labor Statistics (BLS) current population survey (CPS), the unemployment rate for Connecticut rose 0.3 percentage points in June 2012 to 8.1% -- the highest rate of unemployment this year. Hartford's rate rose to 8.5%. Connecticut holds the 18th highest unemployment rate in the nation.
(http://www.bls.gov/eag/eag.ct.htm)

Date	National Unemployment Rate	Connecticut Unemployment Rate	Connecticut Unemployed
June 2012	8.2%	8.1%	154,614
May 2012	8.2%	7.8%	150,354
April 2012	8.1%	7.7%	147,158
March 2012	8.2%	7.7%	148,072
February 2012	8.3%	7.8%	148,572
January 2012	8.3%	8.0%	152,466

Connecticut's Commission on Children, *Long-Term Unemployment in Connecticut,* by George Wentworth, September 13, 2011
(http://www.cga.ct.gov/coc/PDFs/poverty/2010-09-13/wentworth_ppt.pdf)
Reports the following: While Unemployment Insurance (UI) assists 49% of Connecticut's unemployed, the percentage of a worker's former wages that is made up by the worker's UI is only at a rate of 28% which ranks 45th in the country. The report further states that 45% of unemployed workers exhaust state benefits without finding new work.

Psychological Effects of Unemployment and Underemployment 2012, American Psychological Association
http://www.apa.org/about/gr/issues/socioeconomic/unemployment.aspx)
Report highlights findings from various sources recognizing the detrimental effects unemployment has on individuals, children, families and communities stating, "unemployed workers are twice as likely as their employed counterparts to experience psychological problems." Also, it reports on the effects of different

populations, stating that Latinos, African Americans and women are most negatively affected by the stress of unemployment. (The US Census Bureau reports 51.7% of Hartford's population is female, 43.4% is Latino or Hispanic and 38.7% is Black.) (http://quickfacts.census.gov/qfd/states/09/0937000.html)

Effects of Unemployment on Mental Health and Physical Health, a study done by Marfaret Linn, PHD, Richard Sandifer, BS, and Shayna Stein , PhD
(http://www.scribd.com/doc/87443738/Effects-of-Unemployment)

"Results from this study strongly suggest that unemployment had an adverse impact on psychological function, with the unemployed becoming more anxious, depressed, and concerned with bodily symptoms than those who continued to work," (Linn, Sandifer, Stein 1985). This study supports that in a community where unemployment rates are increasing, mental health issues and need for service will likely increase as well. In addition, this leads to the risk of increased poverty rates.

Poverty

Poverty, Income, and Health Insurance in Connecticut Cities and Towns: summary of 2008-2010 Data from the American Community Survey, Connecticut Voices for Children, November 2011
(www.ctkidslink.org)

Presents three-year estimates of household income, poverty and uninsurance status for Connecticut towns and cities with populations greater than 20,000. Overall, indicators show there had been a drop in median household income and a rise in the number of people living in poverty across the state. Hartford has the highest poverty rate with 32.0% of all people in poverty and 43.1% of all children in poverty. 16.3% of people in Hartford are uninsured, including 5.2% of children. East Harford with a median household Income of $48,887 (as opposed to Harford's $28,069) still has a 13.9% poverty level and 21.0% of its children living in poverty. 10.7% remain uninsured in East Hartford, 4.0% being children.

Child Poverty in Connecticut: January 2009, State of Connecticut, General Assembly, Commission on Children, (www.cga.ct.gov/coc)

States that one in ten of Connecticut's children live in poverty. It further states that in 2007 one in four lived in a household with income below 200% of the Federal Poverty Level. The state's largest cities had extremely high child poverty rates – Hartford (47%), Waterbury (31.4%), New Haven (28.7%) and Bridgeport (28.4%).

This report also addresses both the human and the economic cost of children living in poverty. The loss of future productivity from poverty produces a half-trillion-dollar loss for the nation in foregone earnings, high crime rates and poor health associated with adults who grew up in poor households.

Connecticut Association for Human Services (CAHS) *Kids Count Project*
(www.cahs.org/kidscount/asp)

Despite Connecticut's wealth, the country's poor economy has deeply affected its most vulnerable families. This report states the following:

- In Connecticut, there are 454,613 families, with 803,762 children. Among these children, 26 percent live in families that are low-income, defined as income below twice the federal poverty level (nationally, 44 percent of children live in low-income families). Young children are particularly likely to live in low-income families.
- Low wages and a lack of higher education contribute to families having insufficient incomes. Nationally, 47 percent of low-income children have at least one parent who works full-time, year-round; in Connecticut, the figure is 41 percent.

Children in Poverty 2009 – Data Across States –Kids Count Data Center
(http://datacenter.kidscount.org/data/acrossstates/Trend.aspx?loct=2&map_colors=Solid&dtm=322&ind=43&tf=38)

Lists Hartford, Connecticut as the sixth highest child poverty rate among the nation.

Poor Children in America: A Portrait, Children's Defense Fund
(http://www.childrensdefense.org/child-research-data-publications/data/state-of-americas-2011.pdf)
Extreme Poverty Among Children in 2007
Connecticut – 42,695 children under the age of 18 were reported to live in extreme poverty.

Effects of Poverty
Bridging Tough Times for Connecticut's Families, 2010 Connecticut Kids Count Data Book by Judith Carroll with commentary by CT Policy Analysts
(http://www.cahs.org/publications/Bridging%20Tough%20Times.pdf)
The Connecticut Association for Human Services substantiated a high rate of child abuse and neglect in Connecticut. The number of substantiated cases of abused and/or neglect in Hartford County in 2008 was listed as 2,260 – with 633 cases stemming from the city of Hartford, 165 cases in East Hartford, 192 in Manchester and 61 in West Hartford. The cases in these four towns make up almost 40% of abuse and neglect cases in the County. The report further states that child neglect makes up over 60 percent of the abuse and neglect cases in Connecticut and that neglect is often the result of poverty, stemming from reduced access to basic needs, lack of resources, and stressful living conditions. "With proper supports and resources in place around the state, future incidents of child maltreatment can be prevented." We applaud the state's recognition of this issue and its commitment to Connecticut's children and the development of the Differential Response System (DRS). We strongly believe that South Bay can play a vital role as a partner in the effort to present accessible community based support offering In Home Behavioral Therapy for children and families.

Connecticut Department of Children and Families Differential Response System, Executive Report submitted by Casey Family Services
(http://www.ct.gov/dcf/lib/dcf/drs/pdf/cfs_executivereport_drsfinalreprint.pdf)
In the Regional Planning Teams' Recommendations, mental health, employment training assistance, parent education and skill development, alcohol and drug abuse treatment were four of the eight needed "core services" identified by the teams. These are all services that South Bay delivers with expertise. Furthermore, the first "core service" listed is Basic needs: financial assistance, food stamps, food banks, clothing closets, diaper banks, utilities assistance, transitional and subsidized housing, furniture, healthcare, public benefits enrollment and coordination. South Bay clinicians understand the importance of treating the whole person. Our clinicians work with the consumer to help bring all the pieces together. Again, this is one reason for our choice in location – the proximity to other service agencies will allow our clinicians to work closely with other providers in an effort to deliver cohesive services as well as allow the consumer to attend any meetings with their providers in a minimal number of trips.

Crime Rate and Violence
Hartford Crime Rate Report, Connecticut
(http://www.cityrating.com/crime-statistics/connecticut/hartford.html)

Youth Risk Behavior Surveillance, Connecticut 2011 by Connecticut Department of Public Health and Connecticut Department of Education
(www.ct.gov/dph/CSHS)
This report provides statistics for Connecticut youth risk behaviors that contribute to unintentional injuries, violence, unintended pregnancy and sexually 25 transmitted diseases, including HIV infection, cigarette, alcohol, and other drug use. It also highlights other risk behaviors that lead to poor physical health including obesity.

The report includes trends from 1997 to 2011 as well as protective factors.

High rate of births to young mothers
School-Based Teen Parent Support Programs in Connecticut – Shelby Pons, Connecticut State Department of Education, 9/13/11
(http://www.cga.ct.gov/coc/PDFs/poverty/2010-09-13/pons_ppt.pdf)

Reports on high incident rate of teen births in Hartford.
Child Welfare, Children's Defense Fund
(www.childrensdefense.org/child-research...children.../welfare.pdf)
Children in Foster Care, FYs 2004-2009
The number of children declined over a six-year period from 6,459 in 2004 to 4,761 in 2009. Some of the decline is due to adoption. Another reason is the lack of foster homes and that more children are being raised by grandparents and other family members not counted. In addition to the high number of children living in foster care, the number of children entering and exiting foster care each year must be remembered. In 2009 Connecticut had 2,466 children enter foster care and 2,972 exit foster care through adoption, guardianship or reunification (46.7) with family. Unfortunately, placement stability is difficult. This report states the following:
Children with two or fewer placements:
Less than 12 months – 86.7%
At least 12 but less than 24 months – 66.1%
24 months or longer – 30.8
Children with three or more placements:
Less than 12 months – 13.3%
At least 12 but less than 24 months – 33.9%
24 months or longer – 66.1%

Children in Connecticut, Children's Defense Fund, January 2012
(http://www.childrensdefense.org/child-research-data-publications/data/state-data-repository/cits/2012/2012-connecticut-children-in-the-states.pdf)
This fact sheet contains the most recent data as of January 26, 2012:

- Children living in Connecticut – 821,384
- Children in foster care – 4,462
- Number of grandparents raising grandchildren – 20,620

The data from the two previously mentioned reports demonstrates a great need for support services for children and families in Connecticut, specifically the Hartford area.

Mental Health
Healthy Connecticut 2010, Final Report, by Carol E. Bower, Connecticut Department of Public Health, Planning and Workforce Development Section
(http://www.ct.gov/dph/lib/dph/state_health_planning/healthy_people/hct2010_final_rep_jun2010.pdf)
Impact of Mental Disorders on Health and the Health Care System
In 2007, one in three Americans 18 years of age or older had a diagnosable mental disorder. These mental disorders account for more disability than any other diseases, including heart disease and cancer. Major depression is the leading cause of disability and is responsible for more than two-thirds of suicides. It also states that in Connecticut in 2007, mental disorders, excluding alcohol and drug psychoses, accounted for 17,344 hospitalizations with $332 million in total hospital charges.

- Increase the proportion of adults with recognized depression who receive treatment.
- Decrease the proportion of adults 18 years of age and older who have serious psychological distress.
- Decrease the proportion of children 12-17 years of age and adults 18 years of age and older who have a major depressive episode.
- Decrease the rate of suicide overall and among males in high-risk age groups.
- Decrease the proportion of students in grades 9-12 who attempted suicide in the past 12 months.
- Reduce homicides.
- Reduce hospitalizations for hip fractures.
- Reduce suicides and attempted suicides.

Suicide is a leading cause of death for adolescents. Each year, 250 to 300 Connecticut residents take their own

lives.
This report also provides stats for use of alcohol and illicit drugs and the human cost as well as the financial strain on the health care system in Connecticut.

Anxiety and Depression in Connecticut Adults, results from the 2006 Connecticut BRFSS, Connecticut Department of Public Health
(http://www.ct.gov/dph/lib/dph/hisr/pdf/brfss_anx_dep_fact_sheet2006.pdf)
Results showed 20.7% of Connecticut adults indicated they experienced symptoms of depression. Almost 14.7% indicated symptoms of mild depression, 4.0% indicated moderate depression, 1.5% moderately severe depression and .5% indicated severe depression. Occurrence was greatest in low-income populations – 17.5%. Hispanic adults showed an incidence of 8.4%.

Healthy Connecticut 2000, Final Report, Connecticut Department of Public Health June 2005
(http://www.ct.gov/dph/lib/dph/state_health_planning/dphplans/hct2000_final_report_2005.pdf)
Repeating 2010 report that MH and SA are among the 10 top leading health indicators for CT

Connecticut's Commitment to Meet the Need
Kaiser State Health Facts, Connecticut: Home and Community-Based Services
(http://www.statehealthfacts.org/profileind.jsp?cat=4&sub=62&rgn=8)
Indicates a waiting list of 1,917 for Medicaid 1915(c) Home and Community-Based waivers with no change in 2010

Community Mental Health Services Block Grant for FY 2012-2013
including The Community Mental Health Plan for Children & Adults, submitted by, The Department of Children and Families, The Department of Mental Health & Addiction Services
(www.ct.gov/dcf/...health.../mhbg_plan_2012-2013_-_final_(2).doc)
Clearly documents that the need for child and adolescent mental health services exceeds the available behavioral health resources. The report identifies the unmet service needs and critical gaps within Connecticut's current system, which includes:

- Limited evidence-based treatments and programs available across the continuum of care
- Insufficient evidence-based practices for traumatized children, youth and families
- Insufficient early intervention services available across the state

It is widely recognized that the rates of psychiatric disorder are greater for children living in poverty. Hartford has one of the highest rates in the country. Children involved in the child welfare or juvenile systems also have a higher rate of psychiatric disorders. The report indicated a study that found serious emotional disturbance (SED) present in 78% of children in foster care. In Connecticut, that translates into an estimate of 3,354 children/youth with SED.

Community Mental Health Services Block Grant for FY 2011
including The Community Mental Health Plan for Children & Adults, September 2010, submitted by, The Department of Children and Families, The Department of Mental Health & Addiction Services October 1, 2010 to September 30, 2011
Identifies the challenges that Connecticut faces in delivering services:

- Capacity remains below estimated need
- Uneven distribution of services across communities
- Need for specialized outpatient programs for youth with significant behavioral dyscontrol and aggression, autism spectrum disorders, and substance abuse
- Psychological testing services do not meet the needs
- Insufficient specialty services such as traumatized treatments for children/youth
- Insufficient treatments for consumers with co-occurring disorders
- Continued need for services for those "aging out" of the child welfare system

- Need to expand school-based mental health
- Shortage of child and adolescent psychiatrists who will serve publically funded consumers
- Few behavioral health services designed for child welfare population
- Services designed for adolescents/young adults are insufficient in quantity and quality
- Need to promote mental health of young children
- Need to enhance use of Peer Specialists

Statement of Commission on Children Chair Emerita Laura Lee Simon at the September 13, 2011 Commission forum, "Connecticut Child Trends: The Ups and Downs"
(http://www.cga.ct.gov/coc/PDFs/poverty/2010-09-13/simon_statement_09-13-11.pdf)
Calls for rapid acceleration of efforts provide a holistic approach to delivering services, given the "harsh and worsening conditions for children and their families".

Substance Abuse
Connecticut Department of Mental Health and Addiction Services. 2009 Connecticut Strategic Prevention Framework State Epidemiological Profiles.
(http://www.ct.gov/dmhas/lib/dmhas/prevention/ctspf/SEWprofiles09.pdf)

An Examination of Connecticut Child Fatalities, A Ten Year Review - January 1, 2001 to January 1, 2011
(http://www.ct.gov/oca/lib/oca/Ten_Report_III_in_Publisher_Format_III.pdf)
Accidental drug overdoses accounted for the deaths of 19 children over the age of 13 in the past decade. It is also important to note that these numbers do not include drug over doses categorized by the medical examiner as an undetermined manner. In those cases clear evidence did not exist that the overdose was either accidental or intentional.

Violence
An Examination of Connecticut Child Fatalities A Ten Year Review□January 1, 2001 to January 1, 2011
(http://www.ct.gov/oca/lib/oca/Ten_Report_III_in_Publisher_Format_III.pdf)
Reports that fifty-two (52) children between 13 and 17 years of age died as a result of homicide in Connecticut over the past decade. Death by homicide accounted for 54 intentional deaths of children ages 12 or younger. For most of these children, their death is the tragic consequence of abuse and neglect.

Preventable Teen Deaths
Again, South Bay appreciates Connecticut's attention and dedication to present accessible services to assist its teens. We feel strongly that we will be able to support Connecticut's efforts in decreasing these negative incidents.

Recommendations to Prevent Teen Deaths Through Violence
(www.cdc.gov)
Provides recommendation for prevention including Support efforts and services for positive ways for youth to deal with anger.

Suicide Prevention Resource and the *National Suicide Prevention Strategy*
(www.2.sprc.org and www.samhsa.gov/prevention/suicide)
Lists risk factors or stressful events that may increase the potential for greater suicidal behavior include hopelessness, impulsivity or aggressive tendencies, trauma, abuse, and relational or social loss. Also discusses protective factors, or things that help keep youth safe including strong connections to families and others, access to clinical supports and services, restricting lethal means, a positive belief about the future, and skills in problem solving.

OBJECTIVES TRACKED FOR LEADING HEALTH INDICATORS

The suggested objectives for measuring progress for the Leading Health Indicators in Healthy People 2010 are shown below. Modifications, substitutions or additions for Connecticut, based on data availability or relevance, are noted as "actual".

1. Physical Activity

22-7. Suggested: Increase the proportion of adolescents who engage in vigorous physical activity that promotes cardio-respiratory fitness 3 or more days per week for 20 or more minutes per occasion.

Actual: Increase the proportion of students in grades 9-12 who participated in at least 20 minutes of exercise or physical activity that made them sweat and breathe hard on 3 or more of the past 7 days, or who were physically active doing any kind of physical activity that increased their heart rate and made them breathe hard some of the time for a total of at least 60 minutes per day on 5 or more of the past 7 days.

22-2. Suggested: Increase the proportion of adults who engage regularly, preferably daily, in moderate physical activity for at least 30 minutes per day.

Actual: Increase the proportion of adults with 30+ minutes of any physical activity 5 or more days per week, or adults with 30 or more minutes of moderate physical activity 5 or more days per week, or vigorous physical activity for 20 or more minutes 3 or more days per week.

2. Overweight and Obesity

19-3c. Suggested: Reduce the proportion of children and adolescents who are overweight or obese.

Actual: Reduce the proportions of students in grades 9-12 who are overweight or obese.

Actual: Reduce the proportions of children 10-17 years of age who are overweight or obese.

19-2. Suggested: Reduce the proportion of adults who are obese.

Actual: Reduce the proportions of adults who are overweight or obese.

3. Tobacco Use

27-2b. Suggested: Reduce cigarette smoking by adolescents.

Actual: Decrease the proportion of students in grades 9-12 who currently smoke cigarettes.

27-1a. Suggested: Reduce cigarette smoking by adults.

Actual: Decrease the proportion of adults 18 years of age and older who currently smoke cigarettes.

Healthy Connecticut 2010 Final Report

4. Alcohol and Substance Abuse

26-10a. Suggested: Increase the proportion of adolescents not using alcohol or any illicit drugs during the past 30 days.

Actual: Decrease the proportion of students in grades 9-12 who currently drink alcohol.

Actual: Decrease the proportion of students in grades 9-12 who binge drink (drink 5 or more drinks in a row in the past 30 days.

Actual: Decrease the proportion of persons 12 years of age and older who used illicit drugs during the past month.

26-10c. Suggested and Actual: Reduce the proportion of adults using any illicit drug during the past 30 days.

26-11c. Suggested and Actual: Reduce the proportion of adults engaging in binge drinking of alcoholic beverages during the past month.

5. Responsible Sexual Behavior

13-6. Suggested: Increase the proportion of sexually active persons who use condoms.

Actual: Decrease the proportion of students in grades 9-12 who ever had sexual intercourse.

Actual: Of students in grades 9-12 who had sexual intercourse in the last 3 months, increase

the proportion who used a condom during their last sexual intercourse.

6. Mental Health

18-9b. Suggested: Increase the proportion of adults with recognized depression who receive treatment.

Actual: Decrease the proportion of adults 18 years of age and older who have serious psychological distress.

Actual: Decrease the proportion of children 12-17 years of age and adults 18 years of age and older who have a major depressive episode.

Actual: Decrease the rate of suicide overall and among males in high-risk age groups.

Actual: Decrease the proportion of students in grades 9-12 who attempted suicide in the past 12 months.

7. Injury and Violence

15-5a. Suggested and Actual: Reduce deaths caused by motor vehicle crashes.

15-32. Suggested and Actual: Reduce homicides.

Connecticut-Added Objectives:

Reduce deaths caused by accidental poisoning.

Reduce deaths caused by falls.

Reduce hospitalizations for hip fractures.

Reduce suicides and attempted suicides.

8. Environmental Quality

8-1a. Suggested: Reduce the proportion of persons exposed to air that does not meet the U.S. Environmental Protection Agency's health-based standards for ozone.

Actual: Reduce the number of days that air quality does not meet the U.S. Environmental Protection Agency's health-based standards for ozone.

27-10. Suggested and Actual: Reduce the proportion of nonsmokers exposed to environmental tobacco smoke.

Connecticut-Added Objective:

Reduce asthma hospitalizations.

9. Immunization

14-24a. Suggested: Increase the proportion of young children who receive all vaccines that have been recommended for universal administration for at least 5 years.

Actual: Increase the proportion of children 19-35 months of age who receive all vaccines that have been recommended for universal administration.

14-29 a & b. Suggested: Increase the proportion of non-institutionalized adults who are vaccinated annually against influenza and ever vaccinated against pneumococcal disease.

Actual: Increase the proportion of adults 65 years of age and older who are vaccinated annually against influenza.

Actual: Increase the proportion of adults 65 years of age and older who have ever been vaccinated against pneumococcal disease.

10. Access to Health Care

1-1. Suggested and Actual: Increase the proportion of persons with health insurance.

1-4a. Suggested and Actual: Increase the proportion of persons who have a specific source of ongoing care.

16-6a. Suggested and Actual: Increase the proportion of pregnant women who begin prenatal care in the first trimester of pregnancy.

State & County QuickFacts

Connecticut

People QuickFacts	Connecticut	USA
Population, 2011 estimate	3,580,709	311,591,917
Population, 2010 (April 1) estimates base	3,574,097	308,745,538
Population, percent change, April 1, 2010 to July 1, 2011	0.2%	0.9%
Population, 2010	3,574,097	308,745,538
Persons under 5 years, percent, 2011	5.5%	6.5%
Persons under 18 years, percent, 2011	22.4%	23.7%
Persons 65 years and over, percent, 2011	14.4%	13.3%
Female persons, percent, 2011	51.3%	50.8%
White persons, percent, 2011 (a)	82.3%	78.1%
Black persons, percent, 2011 (a)	11.1%	13.1%
American Indian and Alaska Native persons, percent, 2011 (a)	0.5%	1.2%
Asian persons, percent, 2011 (a)	4.0%	5.0%
Native Hawaiian and Other Pacific Islander persons, percent, 2011 (a)	0.1%	0.2%
Persons reporting two or more races, percent, 2011	2.0%	2.3%
Persons of Hispanic or Latino Origin, percent, 2011 (b)	13.8%	16.7%
White persons not Hispanic, percent, 2011	70.9%	63.4%
ing in same house 1 year & over, 2006-2010	87.4%	84.2%
oreign born persons, percent, 2006-2010	13.2%	12.7%
Language other than English spoken at home, pct age 5+, 2006-2010	20.6%	20.1%
High school graduates, percent of persons age 25+, 2006-2010	88.4%	85.0%
Bachelor's degree or higher, pct of persons age 25+, 2006-2010	35.2%	27.9%
Veterans, 2006-2010	243,147	22,652,496
Mean travel time to work (minutes), workers age 16+, 2006-2010	24.6	25.2
Housing units, 2010	1,487,891	131,704,730
Homeownership rate, 2006-2010	69.2%	66.6%
Housing units in multi-unit structures, percent, 2006-2010	34.6%	25.9%
Median value of owner-occupied housing units, 2006-2010	$296,500	$188,400
Households, 2006-2010	1,359,218	114,235,996
Persons per household, 2006-2010	2.52	2.59
Per capita money income in past 12 months (2010 dollars) 2006-2010	$36,775	$27,334
Median household income 2006-2010	$67,740	$51,914
Persons below poverty level, percent, 2006-2010	9.2%	13.8%

Business QuickFacts	Connecticut	USA
Private nonfarm establishments, 2009	90,048[1]	7,433,465
Private nonfarm employment, 2009	1,468,291[1]	114,509,626
Private nonfarm employment, percent change 2000-2009	-5.0%[1]	0.4%
Nonemployer establishments, 2009	246,784	21,090,761
tal number of firms, 2007	332,150	27,092,908
Black-owned firms, percent, 2007	4.4%	7.1%
American Indian- and Alaska Native-owned firms, percent, 2007	0.5%	0.9%
Asian-owned firms, percent, 2007	3.3%	5.7%

Native Hawaiian and Other Pacific Islander-owned firms, ·rcent, 2007	0.0%	0.1%
·spanic-owned firms, percent, 2007	4.2%	8.3%
Women-owned firms, percent, 2007	28.1%	28.8%
Manufacturers shipments, 2007 ($1000)	58,404,898	5,338,306,501
Merchant wholesaler sales, 2007 ($1000)	107,917,037	4,174,286,516
Retail sales, 2007 ($1000)	52,165,480	3,917,663,456
Retail sales per capita, 2007	$14,953	$12,990
Accommodation and food services sales, 2007 ($1000)	9,138,437	613,795,732
Building permits, 2011	3,173	624,061
Federal spending, 2010	55,978,316[1]	3,251,308,509[2]

Geography QuickFacts	**Connecticut**	**USA**
Land area in square miles, 2010	4,842.36	3,531,905.43
Persons per square mile, 2010	738.1	87.4
FIPS Code	09	

1: Includes data not distributed by county.
2: Includes data not distributed by state.

(a) Includes persons reporting only one race.
(b) Hispanics may be of any race, so also are included in applicable race categories.

D: Suppressed to avoid disclosure of confidential information
F: Fewer than 100 firms
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Source U.S. Census Bureau: State and County QuickFacts. Data derived from Population Estimates, American Community Survey, C··sus of Population and Housing, State and County Housing Unit Estimates, County Business Patterns, Nonemployer Statistics, ·omic Census, Survey of Business Owners, Building Permits, Consolidated Federal Funds Report
Revised: Thursday, 07-Jun-2012 13:28:54 EDT

State & County QuickFacts

Hartford (city), Connecticut

People QuickFacts	Hartford	Connecticut
Population, 2011 estimate	NA	3,580,709
Population, 2010	124,775	3,574,097
Population, percent change, 2000 to 2010	2.6%	4.9%
Population, 2000	121,578	3,405,565
Persons under 5 years, percent, 2010	7.6%	5.7%
Persons under 18 years, percent, 2010	25.8%	22.9%
Persons 65 years and over, percent, 2010	8.9%	14.2%
Female persons, percent, 2010	51.7%	51.3%
White persons, percent, 2010 (a)	29.8%	77.6%
Black persons, percent, 2010 (a)	38.7%	10.1%
American Indian and Alaska Native persons, percent, 2010 (a)	0.6%	0.3%
Asian persons, percent, 2010 (a)	2.8%	3.8%
Native Hawaiian and Other Pacific Islander, percent, 2010 (a)	Z	0.0%
Persons reporting two or more races, percent, 2010	4.2%	2.6%
Persons of Hispanic or Latino origin, percent, 2010 (b)	43.4%	13.4%
White persons not Hispanic, percent, 2010	15.8%	71.2%
ving in same house 1 year & over, 2006-2010	76.6%	87.4%
reign born persons, percent, 2006-2010	21.5%	13.2%
Language other than English spoken at home, pct age 5+, 2006-2010	47.7%	20.6%
High school graduates, percent of persons age 25+, 2006-2010	67.9%	88.4%
Bachelor's degree or higher, pct of persons age 25+, 2006-2010	13.3%	35.2%
Mean travel time to work (minutes), workers age 16+, 2006-2010	20.9	24.6
Housing units, 2010	51,822	1,487,891
Homeownership rate, 2006-2010	25.8%	69.2%
Housing units in multi-unit structures, percent, 2006-2010	81.8%	34.6%
Median value of owner-occupied housing units, 2006-2010	$188,000	$296,500
Households, 2006-2010	46,073	1,359,218
Persons per household, 2006-2010	2.51	2.52
Per capita money income in past 12 months (2010 dollars) 2006-2010	$16,798	$36,775
Median household income 2006-2010	$28,970	$67,740
Persons below poverty level, percent, 2006-2010	32.1%	9.2%

Business QuickFacts	Hartford	Connecticut
Total number of firms, 2007	6,638	332,150
Black-owned firms, percent, 2007	19.4%	4.4%
American Indian- and Alaska Native-owned firms, percent, 2007	S	0.5%
Asian-owned firms, percent, 2007	5.2%	3.3%
Native Hawaiian and Other Pacific Islander-owned firms, percent, 2007	F	0.0%
panic-owned firms, percent, 2007	14.0%	4.2%
omen-owned firms, percent, 2007	24.3%	28.1%
Manufacturers shipments, 2007 ($1000)	242,927	58,404,898
Merchant wholesaler sales, 2007 ($1000)	1,413,431	107,917,037
Retail sales, 2007 ($1000)	1,299,106	52,165,480

Retail sales per capita, 2007	$10,467	$14,953
commodation and food services sales, 2007 ($1000)	294,922	9,138,437

Geography QuickFacts	Hartford	Connecticut
Land area in square miles, 2010	17.38	4,842.36
Persons per square mile, 2010	7,178.8	738.1
FIPS Code	37000	09
Counties		

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State & County QuickFacts

East Hartford CDP, Connecticut

People QuickFacts	East Hartford CDP	Connecticut
Population, 2011 estimate	NA	3,580,709
Population, 2010	51,252	3,574,097
Population, percent change, 2000 to 2010	3.4%	4.9%
Population, 2000	49,575	3,405,565
Persons under 5 years, percent, 2010	6.5%	5.7%
Persons under 18 years, percent, 2010	23.4%	22.9%
Persons 65 years and over, percent, 2010	13.7%	14.2%
Female persons, percent, 2010	52.1%	51.3%
White persons, percent, 2010 (a)	51.3%	77.6%
Black persons, percent, 2010 (a)	26.0%	10.1%
American Indian and Alaska Native persons, percent, 2010 (a)	0.4%	0.3%
Asian persons, percent, 2010 (a)	5.7%	3.8%
Native Hawaiian and Other Pacific Islander, percent, 2010 (a)	0.1%	0.0%
Persons reporting two or more races, percent, 2010	3.7%	2.6%
Persons of Hispanic or Latino origin, percent, 2010 (b)	25.8%	13.4%
White persons not Hispanic, percent, 2010	41.9%	71.2%
Living in same house 1 year & over, 2006-2010	83.2%	87.4%
Foreign born persons, percent, 2006-2010	19.2%	13.2%
Language other than English spoken at home, pct age 5+, 2006-2010	33.6%	20.6%
High school graduates, percent of persons age 25+, 2006-2010	82.6%	88.4%
Bachelor's degree or higher, pct of persons age 25+, 2006-2010	18.0%	35.2%
Mean travel time to work (minutes), workers age 16+, 2006-2010	21.5	24.6
Housing units, 2010	21,328	1,487,891
Homeownership rate, 2006-2010	57.7%	69.2%
Housing units in multi-unit structures, percent, 2006-2010	42.2%	34.6%
Median value of owner-occupied housing units, 2006-2010	$193,000	$296,500
Households, 2006-2010	20,201	1,359,218
Persons per household, 2006-2010	2.50	2.52
Per capita money income in past 12 months (2010 dollars) 2006-2010	$24,373	$36,775
Median household income 2006-2010	$48,613	$67,740
Persons below poverty level, percent, 2006-2010	14.8%	9.2%

Business QuickFacts	East Hartford CDP	Connecticut
Total number of firms, 2007	F	332,150
Black-owned firms, percent, 2007	F	4.4%
American Indian- and Alaska Native-owned firms, percent, 2007	F	0.5%
Asian-owned firms, percent, 2007	F	3.3%
Native Hawaiian and Other Pacific Islander-owned firms, percent, 2007	F	0.0%
Hispanic-owned firms, percent, 2007	F	4.2%
Women-owned firms, percent, 2007	F	28.1%

Manufacturers shipments, 2007 ($1000)	NA	58,404,898
Merchant wholesaler sales, 2007 ($1000)	NA	107,917,037
Retail sales, 2007 ($1000)	NA	52,165,480
Retail sales per capita, 2007	NA	$14,953
Accommodation and food services sales, 2007 ($1000)	NA	9,138,437

Geography QuickFacts	East Hartford CDP	Connecticut
Land area in square miles, 2010	18.00	4,842.36
Persons per square mile, 2010	2,848.0	738.1
FIPS Code	22700	09
Counties		

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Manchester CDP, Connecticut

People QuickFacts	Manchester CDP	Connecticut
Population, 2011 estimate	NA	3,580,709
Population, 2010	30,577	3,574,097
Population, percent change, 2000 to 2010	NA	4.9%
Population, 2000	NA	3,405,565
Persons under 5 years, percent, 2010	6.0%	5.7%
Persons under 18 years, percent, 2010	21.9%	22.9%
Persons 65 years and over, percent, 2010	12.5%	14.2%
Female persons, percent, 2010	52.1%	51.3%
White persons, percent, 2010 (a)	72.3%	77.6%
Black persons, percent, 2010 (a)	13.6%	10.1%
American Indian and Alaska Native persons, percent, 2010 (a)	0.4%	0.3%
Asian persons, percent, 2010 (a)	4.2%	3.8%
Native Hawaiian and Other Pacific Islander, percent, 2010 (a)	Z	0.0%
Persons reporting two or more races, percent, 2010	3.9%	2.6%
Persons of Hispanic or Latino origin, percent, 2010 (b)	14.7%	13.4%
White persons not Hispanic, percent, 2010	65.9%	71.2%
Living in same house 1 year & over, 2006-2010	83.9%	87.4%
Foreign born persons, percent, 2006-2010	11.3%	13.2%
Language other than English spoken at home, pct age 5+, 2006-2010	16.5%	20.6%
High school graduates, percent of persons age 25+, 2006-2010	88.4%	88.4%
Bachelor's degree or higher, pct of persons age 25+, 2006-2010	28.0%	35.2%
Mean travel time to work (minutes), workers age 16+, 2006-2010	21.2	24.6
Housing units, 2010	13,691	1,487,891
Homeownership rate, 2006-2010	59.9%	69.2%
Housing units in multi-unit structures, percent, 2006-2010	46.2%	34.6%
Median value of owner-occupied housing units, 2006-2010	$191,300	$296,500
Households, 2006-2010	12,925	1,359,218
Persons per household, 2006-2010	2.30	2.52
Per capita money income in past 12 months (2010 dollars) 2006-2010	$28,811	$36,775
Median household income 2006-2010	$52,811	$67,740
Persons below poverty level, percent, 2006-2010	9.0%	9.2%

Business QuickFacts	Manchester CDP	Connecticut
Total number of firms, 2007	F	332,150
Black-owned firms, percent, 2007	F	4.4%
American Indian- and Alaska Native-owned firms, percent, 2007	F	0.5%
Asian-owned firms, percent, 2007	F	3.3%
Native Hawaiian and Other Pacific Islander-owned firms, percent, 2007	F	0.0%
Hispanic-owned firms, percent, 2007	F	4.2%
Women-owned firms, percent, 2007	F	28.1%
Manufacturers shipments, 2007 ($1000)	NA	58,404,898

Merchant wholesaler sales, 2007 ($1000)	NA	107,917,037
Retail sales, 2007 ($1000)	NA	52,165,480
Retail sales per capita, 2007	NA	$14,953
Accommodation and food services sales, 2007 ($1000)	NA	9,138,437

Geography QuickFacts	Manchester CDP	Connecticut
Land area in square miles, 2010	6.46	4,842.36
Persons per square mile, 2010	4,731.8	738.1
FIPS Code	44690	09
Counties		

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West Hartford CDP, Connecticut

People QuickFacts	West Hartford CDP	Connecticut
Population, 2011 estimate	NA	3,580,709
Population, 2010	63,268	3,574,097
Population, percent change, 2000 to 2010	-0.5%	4.9%
Population, 2000	63,589	3,405,565
Persons under 5 years, percent, 2010	5.5%	5.7%
Persons under 18 years, percent, 2010	23.3%	22.9%
Persons 65 years and over, percent, 2010	17.1%	14.2%
Female persons, percent, 2010	53.6%	51.3%
White persons, percent, 2010 (a)	79.6%	77.6%
Black persons, percent, 2010 (a)	6.3%	10.1%
American Indian and Alaska Native persons, percent, 2010 (a)	0.2%	0.3%
Asian persons, percent, 2010 (a)	7.4%	3.8%
Native Hawaiian and Other Pacific Islander, percent, 2010 (a)	Z	0.0%
Persons reporting two or more races, percent, 2010	2.7%	2.6%
Persons of Hispanic or Latino origin, percent, 2010 (b)	9.8%	13.4%
White persons not Hispanic, percent, 2010	74.8%	71.2%
Living in same house 1 year & over, 2006-2010	88.3%	87.4%
Foreign born persons, percent, 2006-2010	18.1%	13.2%
Language other than English spoken at home, pct age 5+, 2006-2010	25.1%	20.6%
High school graduates, percent of persons age 25+, 2006-2010	93.4%	88.4%
Bachelor's degree or higher, pct of persons age 25+, 2006-2010	58.1%	35.2%
Mean travel time to work (minutes), workers age 16+, 2006-2010	20.2	24.6
Housing units, 2010	26,396	1,487,891
Homeownership rate, 2006-2010	73.3%	69.2%
Housing units in multi-unit structures, percent, 2006-2010	30.9%	34.6%
Median value of owner-occupied housing units, 2006-2010	$317,400	$296,500
Households, 2006-2010	24,651	1,359,218
Persons per household, 2006-2010	2.45	2.52
Per capita money income in past 12 months (2010 dollars) 2006-2010	$43,534	$36,775
Median household income 2006-2010	$78,530	$67,740
Persons below poverty level, percent, 2006-2010	6.1%	9.2%

Business QuickFacts	West Hartford CDP	Connecticut
Total number of firms, 2007	F	332,150
Black-owned firms, percent, 2007	F	4.4%
American Indian- and Alaska Native-owned firms, percent, 2007	F	0.5%
Asian-owned firms, percent, 2007	F	3.3%
Native Hawaiian and Other Pacific Islander-owned firms, percent, 2007	F	0.0%
Hispanic-owned firms, percent, 2007	F	4.2%
Women-owned firms, percent, 2007	F	28.1%

Manufacturers shipments, 2007 ($1000)	NA	58,404,898
Merchant wholesaler sales, 2007 ($1000)	NA	107,917,037
Retail sales, 2007 ($1000)	NA	52,165,480
Retail sales per capita, 2007	NA	$14,953
Accommodation and food services sales, 2007 ($1000)	NA	9,138,437

Geography QuickFacts	West Hartford CDP	Connecticut
Land area in square miles, 2010	21.84	4,842.36
Persons per square mile, 2010	2,897.3	738.1
FIPS Code	82660	09
Counties		

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A Community Health Needs Assessment

Department of Health and Human Services

March 2012

Healthy Hartford

Acknowledgements

Community Health Needs Assessment Consortium
City of Hartford Department of Health and Human Services
Connecticut Children Medical Center
Hartford Hospital
Saint Francis Hospital and Medical Center
University of Connecticut Health Center

Under the direction of the Community Health Needs Assessment Consortium, the Community Health Needs Assessment Workgroup began planning this assessment in early 2010. Much thought was put into creating a process and document that would be both useful and enlightening to healthcare organizations, community-based health and social services organizations, and the community at large. The City of Hartford Department of Health and Human Services wishes to thank our community health needs assessment partners for their generous support to this project and to their designated representatives on the Community Health Needs Assessment Workgroup for their professional contributions and collaborative efforts throughout the study process. Special thanks go to the Urban Alliance for providing data, analysis, and review of the Hartford Survey Project: Understanding Needs and Service Opportunities.

We would also like to thank Holleran Consulting LLC for their expertise in community health assessments and for preparing the community profile. This document has been produced for the benefit of the community. The City of Hartford Department of Health and Human Services and its community health needs assessment partners encourage use of this report for planning purposes and are interested in learning of its utilization. We would appreciate your comments and questions, which may be directed to the City of Hartford Department of Health and Human Services by phone at (860) 757-4700.

The report, as well as the raw data used to generate our findings is available for download at: http://hhs.hartford.gov.

City of Hartford
Department of Health & Human Services
131 Coventry Street
Hartford, CT 06112

II. Summary of Key Findings

Social Determinants – Many socioeconomic and cultural characteristics of the population living in Hartford drive the main health concerns. The findings in the secondary data profile point to higher concentrations of people that are at increased risk for unhealthy living merely because of their race, age, income, educational status, or family status. The Key Informant interviews, the Hartford Survey Project, and data from the Health Equity Index validate the concern for marginalized and underserved populations.

- The top 5 quality of life issues mentioned by Key Informants as currently having the most negative impact in Hartford were **poverty**, **job opportunities**, **quality of housing**, **neighborhood safety**, and **education**.

- Hartford has a greater number of renters than owners, more households with mothers being the sole head of household, and lower residential property values than the state, overall. These are associated with poor health outcomes. There is also a higher rate of service occupations when compared to the state and nearly 1/5 of the city's labor force unemployed. With subpar housing and employment levels, overall economic security rates low.

- Nearly a third of Hartford's adults do not have a high school diploma, and the average graduation rate is 77%; high educational attainment is one of the key determinants of community health since it leads to increased economic security and occupational prestige.

- More than 10% of all of the crimes committed in Connecticut in 2009 were committed in Hartford, even though Hartford accounts for less than 4% of Connecticut's population, and there are certain types of crimes that occur with greater frequency in Hartford than in the state overall.

- Compared to other Connecticut cities, the overall environmental quality in Hartford is poor; HEI scoring for waste stream and water discharge pollutants were low. The underlying perception of the city as "unclean" could also impact individual health decisions.

- Less than half of Hartford's residents are registered to vote; a trend that is often associated with fewer community resources and support networks.

Health Indicators

Cancer incidence for all types (specifically lung and prostate) is well below the national and state levels; however, it is important to keep in mind that Hartford has a relatively young population when compared to state and national figures. Key Informants also perceived cancer as less of a priority with only 11.9% respondents ranking it within their top five health issues.

- In general, chronic lower respiratory disease death is lower in Hartford than across the nation or in the state; however, asthma hospitalization rates in Hartford are much higher when compared to the state, with children and adult rates that are at least three times higher than the state rate. Asthma, not one of the options provided in the Key Informant survey, was the most frequently written-in health issue by participants.

- Although one of the top health issues identified by Key Informants was violence, most respondents perceive that violent acts, while isolated in Hartford, are a product of a depressed economic situation. Hartford accounts for more than a third of all murders in the state, and experiences a higher percentage of assaults. This disproportionate and avoidable indicator negatively impacts the overall quality of life in the city.

- There is a much younger population in Hartford compared to the state and nation that is reflected in the mortality rate. This is also reflected in a lower occurrence of the top ten national causes of death, which are often age-related. However, the much higher age-adjusted rate suggests that the elderly population, albeit small, is dying at a very high rate. Infant and neonatal death rates are much higher in Hartford than the state and nation. Hartford also has considerably higher rates of infectious/communicable diseases than the state.

- There is an indication that obesity is a concern for Hartford. Health indicators for heart disease are worse for Blacks and Hispanics, and those who live below the poverty threshold; diabetes rates in Hartford have been increasing in recent years.

Access to Care – Access to care was commonly cited in both the Key Informant study and the Hartford Survey Project. While the Hartford Survey Project concluded that the top four barriers to care were lack of knowledge about existing services, lack of available services, inability to pay, and lack of transportation, the Key Informant study showed a need for improving access to care across the board for a variety of underserved populations.

VI. Social Determinants of Health

Quality of life issues are indicators that include not only wealth and employment, but also the built environment, physical and mental health, education, recreation and leisure time, and social belonging [2]. During this assessment, Key Informants were asked a variety of questions about quality of life in Hartford. For nearly all quality of life questions, 50% or more of informants ranked them as "Poor" or "Very Poor."

Table 2. **Poorly Rated Quality of Life Measures by Key Informants**

QUALITY OF LIFE	RATED "POOR" OR "VERY POOR"
Poverty	93.1%
Job opportunities	87.3%
Quality of housing (affordable, in good condition)	72.4%
Neighborhood safety	71.9%
Schools/education	65.5%
Clean, litter-free neighborhoods	63.1%
Road/traffic conditions	53.6%
Availability of recreational activities	52.6%
Availability of care for children	31.6%
Water or air pollution	26.4%

This information provides insight for those who are regularly involved in the health and human services sector. The following section will addresses social determinants of health, and how Hartford rates relative to state and national figures.

Housing

Adequate housing provides shelter and comfort to its inhabitants, both of which impact overall well-being. One of the measures used to evaluate the association of housing and health is the number of subsidized housing units per 1000 local residents as defined by the Connecticut Housing Finance Authority. Using 2005 data, the HEI correlated housing strongly with infectious disease in Connecticut, and Hartford received the overall lowest housing score in the HEI when compared to the rest of the state.

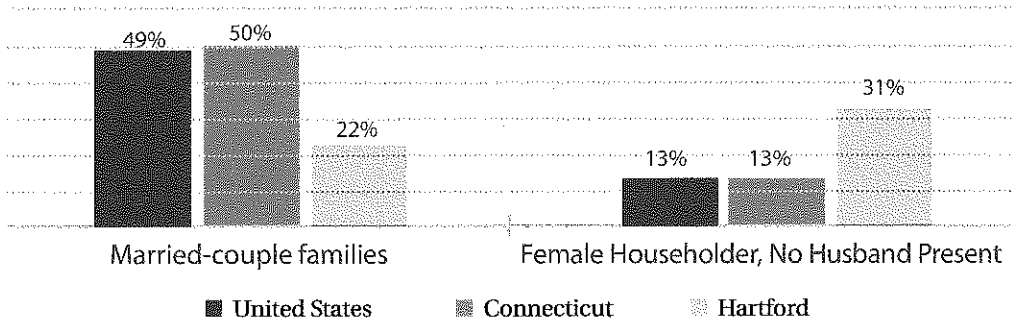
Subsidized housing is abundant in Hartford. As is typical throughout the United States, these subsidized housing units have become a feature of low-income and resource-poor areas. In Hartford, residing in subsidized housing is correlated with numerous health outcomes, such as increased rates of chlamydia and/or gonorrhea, asthma hospitalizations, infectious and parasitic diseases, homicides, drug-induced deaths, mental health hospitalizations, and births not receiving prenatal care in the first trimester.

A cursory analysis of **housing occupancy** in Hartford reveals that the city has over 44,000 occupied housing units of which 26% are owner-occupied; the state average is 69%. A higher rate of rental units is associated with poorer quality of housing and impacts health. Over 70% of Key Informants surveyed ranked housing quality at either "Poor" or "Very Poor." Further highlighting the housing issue, homelessness was the issue recognized as most in need of additional services by those surveyed by the Urban Alliance (45%).

Lower residential property values, accompanied by lower sales prices and a greater number of foreclosures are strongly associated with lower quality neighborhoods. Neighborhoods with these negative housing characteristics typically have higher crime rates, lower quality school systems and a poor physical environment (sidewalks, parks and properties). For 2010, the average assessed residential property value in Hartford was $43,689, which is significantly lower than the state's average value of $209,025; and the average sales price of an existing home was $164,462, which is lower than the state's average home sales price of $288,948.

Hartford **household statistics** for family (59%) and non-family households (42%) are similar to state and national rates, but deviate substantially for the percentage of female householders with no husband present (much higher than state and national) and the percentage of married-couple families (much lower than state and national). Additionally children in Hartford are almost three times as likely (19%) than those in the rest of Connecticut (7%) to live in households with no husband present.

Figure 3. Household Types for Hartford, Connecticut, and the U.S. (2009)



In the HEI, Hartford has a housing indexed score of 3, which is a less favorable condition in this category. Some of the calculating factors used to determine this score are rental vacancy rates as a percentage of rental units, owner occupied housing as a percentage of total housing units, and median gross rent as a percent of household income. These measures were calculated using data from the 2000 US Census.

Table 3. **Health Indicators Related to *Housing***

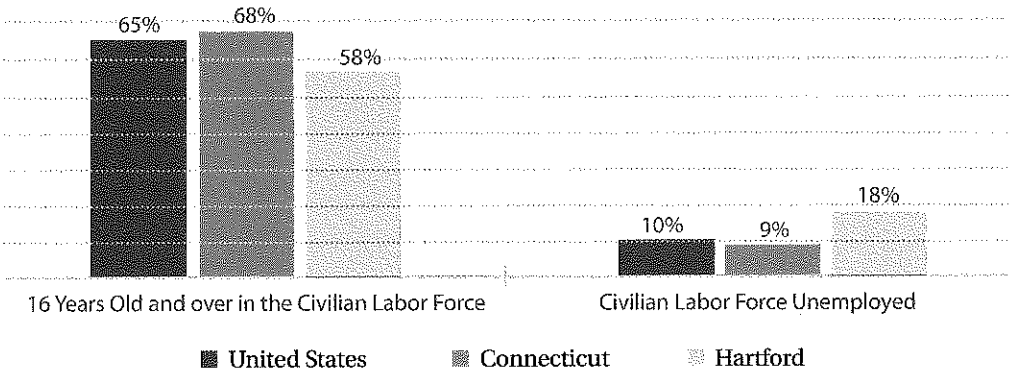
	HEI INDEX	CORRELATION COEFFICIENT
Infectious Disease	2	0.55
Health Care Access	2	0.47
Childhood Illness	1	0.42
Accidents/Violence	3	0.40
Mental Health	2	0.37
Renal Disease	2	0.33
Life Expectancy	3	0.31
Cardiovascular	3	0.29
Respiratory Illness	4	0.29
Diabetes	3	0.24
Perinatal Care	3	0.22
Liver Disease	2	0.20
Cancer	5	0.18

Note: All shown correlations are statistically significant and ranked in order from strong to weak.

Employment

As of September 2011, Hartford's unemployment rate was 15.6% according to the Connecticut Department of Labor's Labor Force Data, which is nearly twice the rate as the United States (8.8%). Against this backdrop, it is fitting that surveyed residents of Hartford rank job training/employment assistance as one of the top three service needs in the community. Key Informants had a similar view with 87% ranking job opportunities in Hartford as "Poor" or "Very Poor."

Figure 4. **Employment in Hartford, Connecticut, and the U.S. (2009)**



The percentage of workers in Hartford in management, professional, and related occupations (21.1%) is smaller than the state and nation (40.3% and 35.7%, respectively). Conversely, the percentage of those in the labor force with service occupations is much higher in Hartford

(34.4%) than across Connecticut and the nation (17.3% and 17.8%, respectively). With this disproportionate representation of Hartford residents across these occupational groups and the strong correlation between employment and health care access, one can see how Hartford struggles to maintain a healthy community profile.

Table 4. **Health Indicators Related to *Employment***

	HEI INDEX	CORRELATION COEFFICIENT
Health Care Access	2	0.54
Childhood Illness	1	0.48
Accidents/Violence	3	0.37
Life Expectancy	3	0.35
Respiratory Illness	4	0.28
Infectious Disease	2	0.28
Cardiovascular	3	0.28
Perinatal Care	3	0.26
Mental Health	2	0.23
Cancer	5	-0.19

Note: All shown correlations are statistically significant and ranked in order from strong to weak.

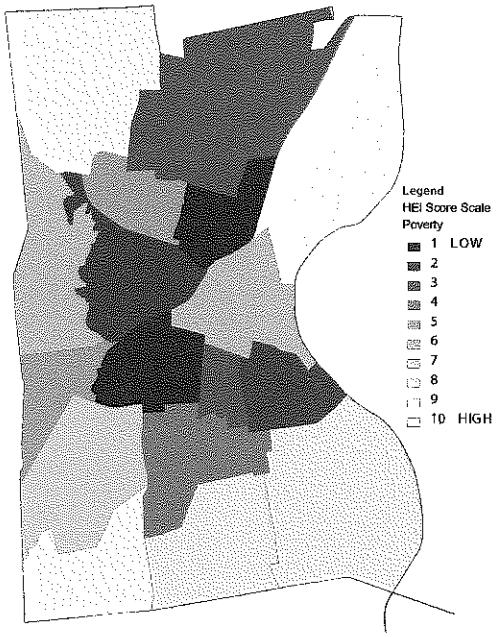
The lack of employment has long been linked to increased rates of mortality. For Connecticut, unemployment has been strongly correlated with decreased health care access, which can serve as a partial explanation for the correlations with a decreased life expectancy, and increased incidences of respiratory illness, and infectious and cardiovascular disease, as well as illness among children. This is reinforced by responses to the Key Informant survey where finances and access to health care were identified as significant barriers.

Economic Security

Hartford received the lowest possible score on the HEI for the majority of factors that determine economic security. Additionally, 93% of Key Informants rated Hartford's poverty level as either "Poor" or "Very Poor" on the Quality of Life section of the survey. Results from the Urban Alliance survey were similar, with employment opportunities and financial assistance topping the list of services needed. According to a report from the Robert Wood Johnson Foundation, income and educational attainment are the two most commonly used markers of socioeconomic status or position in the United States [3]. Both are strongly related measures of health and health-related behaviors. These factors can influence health through the direct effects of extreme poverty (such as malnutrition or exposure to extreme heat or cold) as well as health effects due to chronic stress; these can include the triggering and exacerbation of depression and cardiovascular disease [4].

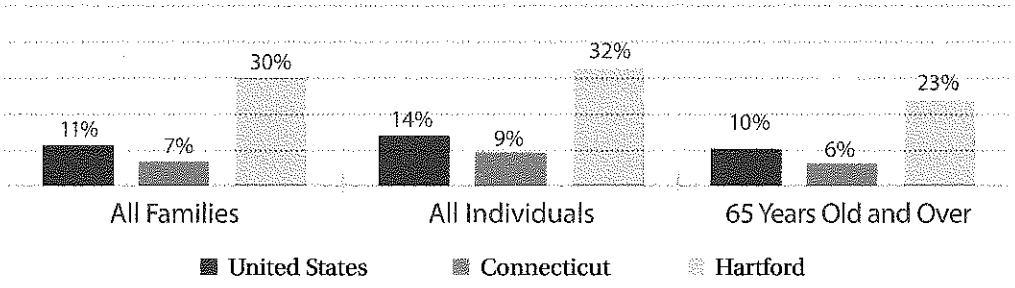
Below is a representation of how Hartford neighborhoods compare to each other with regard to poverty using HEI indexing from the 2000 U.S. Census. Using the color gradient in the legend, the darker colors indicate a lower ranking and higher level of poverty.

Map 2. **HEI Poverty Score by Neighborhood**



With 30.25% of Hartford's families living in poverty, the poverty statistics for the city are three times higher for families than in the United States overall and over 4 times greater than in Connecticut. Similar patterns have been documented for residents and for those over the age of 65.

Figure 5. **Poverty in Hartford, Connecticut, and the U.S. (2009)**



The **income statistics** for Hartford illustrate that the median income per household and family, are significantly less than the state and national figures.

Table 5. **Income Statistics for Hartford versus State and Nation**

	HARTFORD	CT	US
Median Household	$28,300	$67,034	$55,221
Median Family	$33,805	$83,069	$61,082

In Connecticut, living in poverty is correlated with higher rates of chlamydia and gonorrhea, trauma-related hospitalizations and ED visits, mental health ED treatments, homicide, hepatitis C, diabetes, drug and alcohol induced deaths, low and very low birth weight babies, and infectious and parasitic diseases.

Education

Just as low levels of employment impact community health, so does low educational attainment. 13.9% of Hartford residents perceive education to be one of the top three needs for the community. Key Informant survey respondents noted that the best way to promote wellness and prevention of illnesses in Hartford residents is through education. One respondent noted that starting with school-age children is the best way to achieve these goals. Another declared that it is necessary to tailor the education to "racial, cultural and other different types of understandings to get to the people of the city," and that the frequency of wellness education should be "not just doing it once a year" in order to convey necessary concepts.

Results from the Connecticut Mastery Test and Connecticut Department of Education were used to establish a connection to community health, as indicated in the following table:

Table 6. **Health Indicators Related to *Education***

	INDEX SCORE	CORRELATION COEFFICIENT
Childhood Illness	1	0.73
Life Expectancy	3	0.64
Infectious Disease	2	0.59
Health Care Access	2	0.57
Accidents/Violence	3	0.55
Cardiovascular	3	0.51
Mental Health	2	0.42
Respiratory Illness	4	0.41
Renal Disease	2	0.39
Diabetes	3	0.38
Perinatal Care	3	0.34
Liver Disease	2	0.21

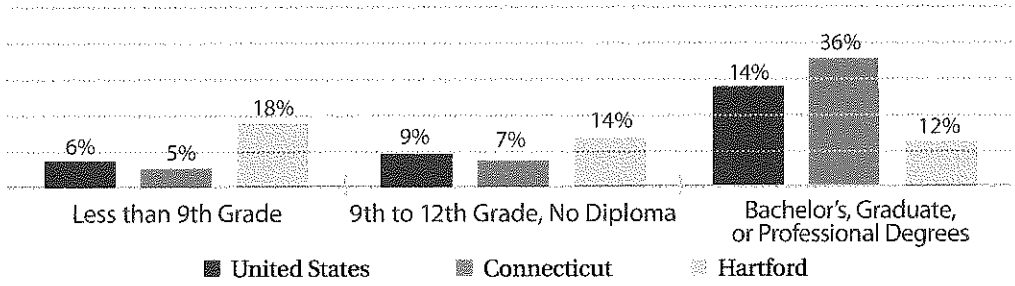
Note: All shown correlations are statistically significant and ranked in order from strong to weak.

As the demographic data indicates, Hartford residents are less likely to graduate from high school and are less likely to obtain post-secondary education when compared to the state or nation as a whole. The strong correlations suggest that a higher educational attainment leads to better health throughout an individual's lifespan, and better health and education enable people to realize their capabilities to be productive members of society [5], with greater potential for positively impacting the community.

In Hartford, low rates of educational attainment are coupled with lower standardized test scores and less frequent renovations of the city's public school facilities; according to the Connecticut State Department of Education's Connecticut Education Data and Research (CEDaR) website, the average number of years since a major renovation for Hartford's elementary, middle, and high schools is 25.8, 33.8, and 17.5 years, respectively. As indicated in the table above, education is correlated with a host of preventable poor health outcomes including increased rates of childhood illness, respiratory illness, renal and liver disease, diabetes, and infectious diseases; poorer cardiovascular health; and frequency of accidents and violent incidents. Other correlations to education include lower life expectancy, lower rates of perinatal care and health care access, and worse mental health outcomes.

Over 30% of Hartford's adults of 25 years and older do not have a high school diploma, which is significantly higher than the 12% for the state. Conversely, the percentage of Hartford's population with a bachelor's degree or higher is also lower than both state and national figures at 12% when compared to 36% for the state. When these data are examined more closely it becomes clear that the problem of low **educational attainment** begins early for many, with 18% of Hartford residents over age 25 having less than a 9th grade education and another 14% having attained from 9th and 12th grade but without a diploma.

Figure 6. **Educational Attainment of Adults 25 Years and Older for Hartford, Connecticut, and the U.S. (2009)**

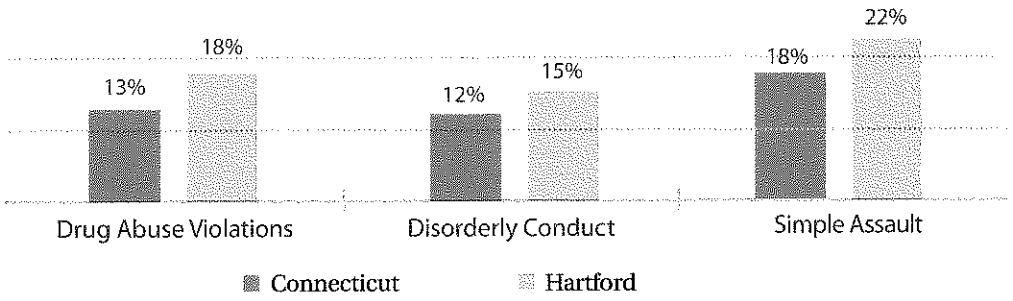


Community Safety

The HEI measures community safety by the rate of crimes against persons or property published by the 2004/2005 Connecticut Uniform Crime Reports, and within this framework Hartford receives the lowest score of 1 indicating high rates of crime. However, the crime statistics found in the Secondary Data Profile are potentially inconclusive because a high

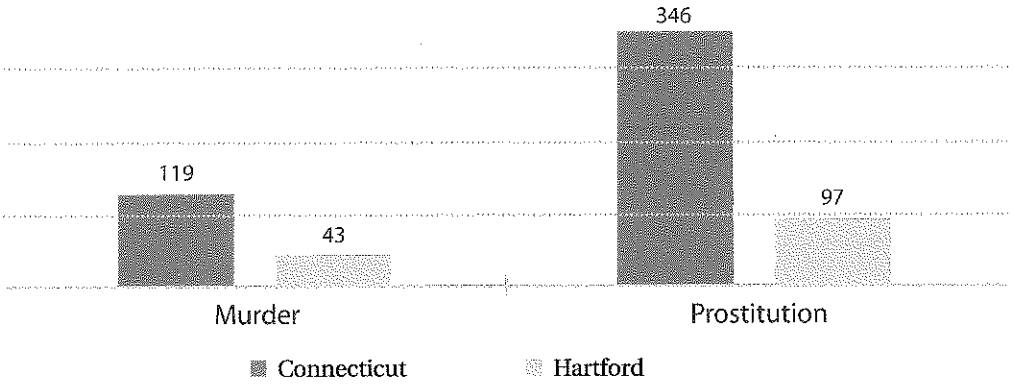
rate of arrests in the city could either indicate that crimes are more prevalent or that more effective law enforcement approaches have been implemented. Nevertheless, according to the 2009 Uniform Crime Report from the Connecticut Department of Public Safety, over one third of all murder arrests in Connecticut occurred in Hartford. Moreover, almost 20% of the state's drug abuse violations occur in the city. Other violent crimes that occur more frequently in the Hartford than in the state are simple assault and disorderly conduct.

Figure 7. **Percent of All Crimes in Hartford and Connecticut (2009)**



Over 70% of Key Informants rated neighborhood safety in Hartford as "Poor" or "Very Poor." Given the opportunity to define a healthy community, one Key Informant stated that it should be "a community where individuals and families would choose to live [and one that can] provide a quality of life that is safe and engaged. People are being physically healthy, not being subject to lead poisoning and toxic things. Violence and noise pollution are not issues." Unfortunately, this community scenario is not widely available for the majority of Hartford residents, but community safety has multiple measures and Hartford experienced proportionally less crime than the state on infractions involving larceny/theft, gambling, liquor laws, and driving under the influence.

Figure 8. **Crime in Hartford and Connecticut (2009)**



VII. Health Indicators

As part of the assessment process, Key Informants were asked to rank the **five most significant health issues** in the City of Hartford. The respondents could choose from a list of 25 health issues as well as suggest their own that were not on the list. The five most identified – obesity, diabetes, mental illness, heart disease, and asthma – consisted of four health issues from the list and one write–in response.Mortality statistics are also noted in this section and infectious disease was included due in part to the unique age distribution of Hartford.

This section will also highlight how Hartford rates low in community health when compared to other Connecticut municipalities. As a result of its relatively low standing, this assessment focuses on a Hartford neighborhood comparative using city–specific indexing from the HEI in order to gain a richer understanding of city health concerns. The health outcomes included here are Life Expectancy, Mortality, Infant Mortality, Infectious Diseases, Respiratory Illness, Obesity/Heart Disease, Diabetes, and Mental Health.

Life Expectancy

Percent of deaths for the City of Hartford due to any of the top 10 causes of death in the U.S. are overall smaller when compared to the state and nation. The strongest positive determinant correlations with life expectancy are education, economic security, and civic involvement; with Hartford rating very low in each (HEI index of 2, 2, and 1, respectively).

Table 8. **Social Determinants of Health Related to *Life Expectancy***

	INDEX SCORE	CORRELATION COEFFICIENT
Education	2	0.64
Economic Security	2	0.61
Civic Involvement	1	0.50
Community Safety	1	0.41
Employment	3	0.35
Environmental Quality	4	0.34
Housing	3	0.31

Note: All shown correlations are statistically significant and ranked in order from strong to weak.

Table 9. **Top 10 Leading Causes of Death for Hartford, Connecticut and the U.S. (ranked from most to least common for Hartford; 2005-2007)**

	CITY OF HARTFORD	CONNECTICUT	U. S.
Heart Disease	24.2%	25.6%	25.4%
Malignant Neoplasms (Cancer)	18.2%	23.8%	23.1%
Accidents (Unintentional Injuries)	5.5%	4.2%	4.8%
Stroke (Cerebrovascular Disease)	4.8%	5.2%	5.5%
Chronic Lower Respiratory Diseases	3.7%	4.9%	5.3%
Diabetes	3.4%	2.6%	3.1%
Septicemia	2.6%	2.1%	1.4%
Influenza/Pneumonia	2.4%	2.9%	2.2%
Nephritis, Nephrotic Syndrome, and Nephrosis (Kidney Disease)	2.3%	1.9%	1.9%
Alzheimer's Disease	1.2%	2.6%	2.9%

However, the age-adjusted mortality rate (AAMR; defined as a death rate that controls for the effects of differences in population age distributions.) for all causes of death for the city is notably larger than that of the state and nation (876 compared to 692 and 778, respectively). With a younger population, this dramatic difference in the age-adjusted rate suggests that the mortality rate for older populations in Hartford is very high even though the elderly population itself may not be very large. Therefore, deaths due to heart disease and cancer low compared to the state and the U. S.

The Years of Potential Life Lost (YPLL; defined as an estimate of the average years a person would have lived if he or she had not died prematurely.) for Hartford was 10,647 per 100,000 for 2005-2007 for all causes of death. HEI scores Hartford 2 for YPLL. This measure correlated inversely with obtaining a bachelor's degree, and having a higher median household income and median value for owner occupied housing. It had a reverse effect for adults with less than a 9th grade education, so the lower level of education, the greater the years of potential life lost.

Infant/neonatal mortality is a major concern for Hartford; the mortality rates in Hartford for infants and neonates are markedly greater than those across Connecticut and the United States. Upon further examination, there is a pronounced disparity among infant deaths for infants of different races and ethnicities in Hartford; from 2001 through 2008, the mortality rate for Black infants was consistently higher than either the white or Hispanic infant mortality rate.

Figure 9. **Infant and Neonatal Mortality Rates* for Hartford, Connecticut, and the U.S. (2006)**

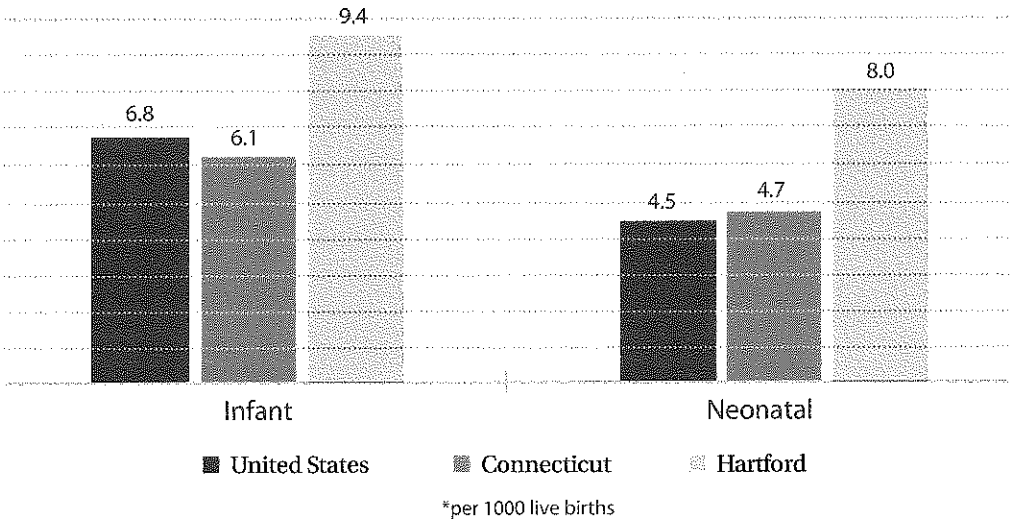
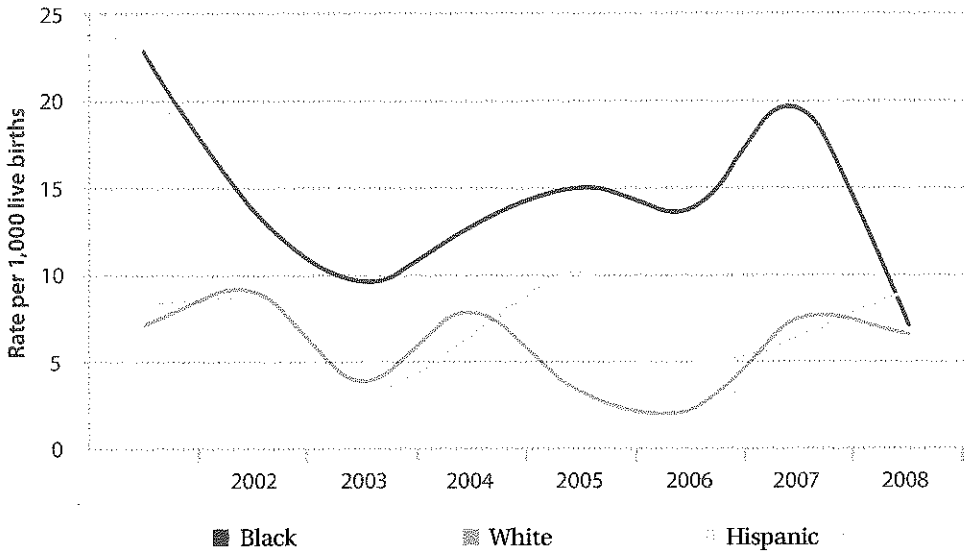
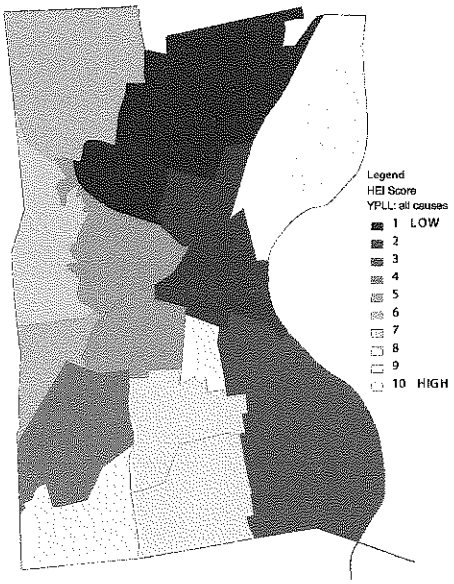


Figure 10. **Infant Mortality Rates by Race/Ethnicity, Hartford, CT (2001-2008)**



These adverse infant health outcomes greatly contribute to a lower than average life expectancy in Hartford. The following map highlights how its neighborhoods compare to each other with regard to the YPLL measure; the darker colors indicate a lower rating (greater number of years) for potential life lost. Six out of 15 neighborhoods (excluding the North and South Meadows neighborhoods) rated low on the YPLL. Per the HEI, the Northeast and Upper Albany neighborhoods were the lowest rated of all Hartford neighborhoods.

Map 3. **HEI Years of Potential Life Loss (YPLL) Score: All Causes by Neighborhood**



Infectious Diseases

In the state of Connecticut, there is a strong correlation of infectious disease with multiple social determinants, as demonstrated in Table 10.

Table 10. **Social Determinants of Health Related to *Infectious Disease***

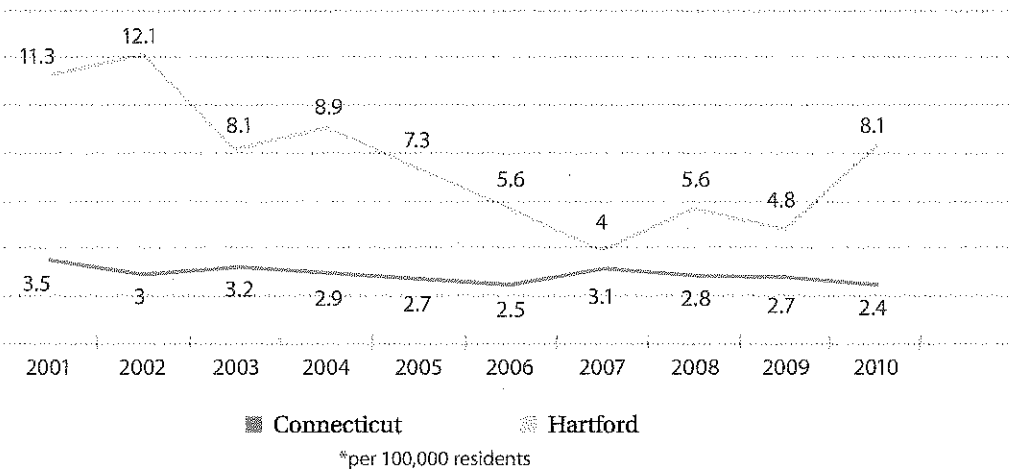
	INDEX SCORE	CORRELATION COEFFICIENT
Community Safety	1	0.67
Education	2	0.59
Environmental Quality	4	0.59
Civic Involvement	1	0.59
Economic Security	2	0.58
Housing	3	0.55
Employment	3	0.28

Note: All shown correlations are statistically significant and ranked in order from strong to weak.

There is particular concern when examining **HIV** trends in the city. From 2002 through 2009 per the Connecticut Department of Public Health HIV Surveillance Program, the number of HIV infection cases declined for the city; however, there has been a 221% increase of new HIV infections among self-reporting men who have sex with men over the same time period, as well as a 123% increase in new infections amongst Hartford's Black residents.

There is an established correlation between HIV rates and rates of tuberculosis infection [9]; however, that does not seem to be the case in Hartford. Data from the Connecticut Department of Public Health's Tuberculosis Control Program shows that while tuberculosis rates in Connecticut are in decline, tuberculosis rates in Hartford are increasing.

Figure 11. **Tuberculosis Prevalence* in Hartford and Connecticut (2004-2010)**



The Connecticut Department of Public Health's STD Control Program provides information on infections more commonly associated with reproductive health. From 2007-2010, a total of 7768 cases of **chlamydia** were reported in Hartford (rate of 157 per 10,000 residents), which is almost 1.5 times higher than the next highest rate of chlamydia infection in the state. Among Blacks and Latinos, the rates were 12.1 and 5.3 times higher than those for whites, respectively. Of all the diagnoses reported during this period, approximately 70% of the cases were among 15 to 24-year olds; Black and Latino female adolescents and young adults accounted for about 36% and 20%, respectively, of all reported chlamydia cases during this same period.

Gonorrhea is the second most commonly reported STI in Hartford after chlamydia. Between 2007 and 2010, approximately 20% of the total reported cases of gonorrhea in the state occurred in Hartford (a rate of 40.5 per 10,000 residents). The rate of infection of women when compared to men was 1.5 times higher (119 versus 78 per 10,000 residents, respectively). Blacks and Latinos also had a disproportionate rate of infection when compared to whites (15.3 and 4.1 times greater, respectively); infection rates were also the highest for 15- to 24-year olds.

Since 2008 the prevalence of **syphilis** in Hartford has increased from 4.1 to 10.5 cases per 100,000 residents; and approximately 94% of all reported cases were male. A racial and ethnic disproportion is also reflected, as African American and Latino male rates were 9.2 and 4.3 times higher than white males, respectively.

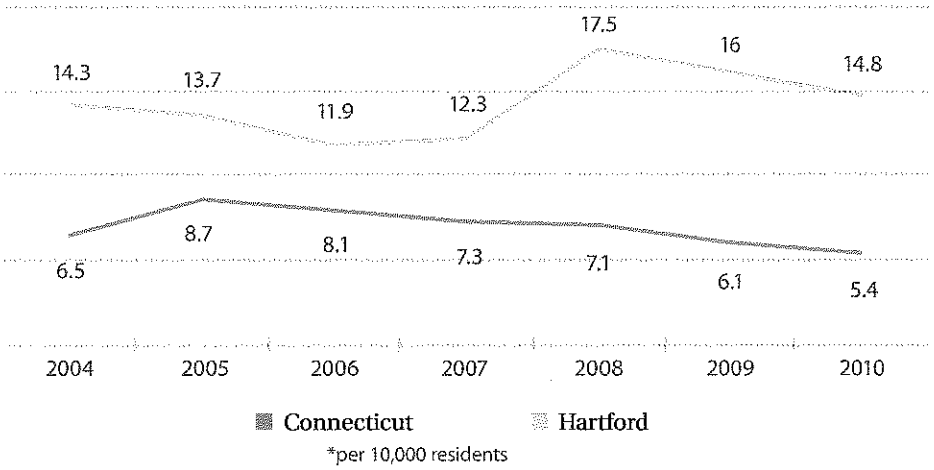
Table 11. **Syphilis in Hartford among Males by Age Category (2007-2010)**

	PERCENT INFECTED
15-24 years old	34%
25-34 years old	10%
35-44 years old	41%

During this same time period, syphilis prevalence among males 25-34 year old increased 81% to 32 cases per 100,000; and among males 35-44 years old it increased 51% to 79 cases per 100,000.

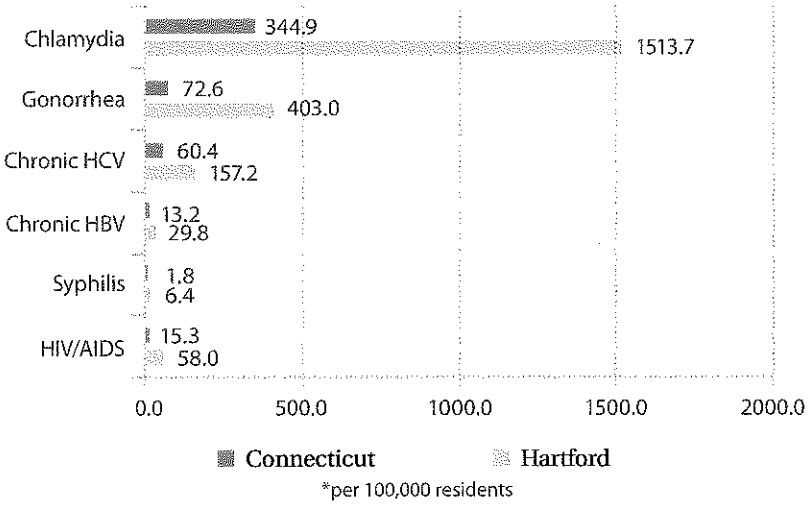
The information concerning **Hepatitis C** (HCV) for the state and the city is limited. From the data available, chronic HCV rates in Hartford have been declining for the past 3 years, yet they still remain 2.7 times greater than the state prevalence.

Figure 12. **Chronic HCV Prevalence* in Hartford and Connecticut (2004-2010)**



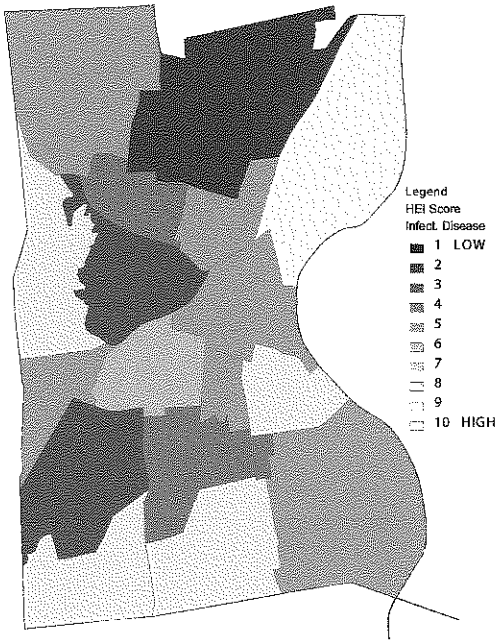
With these disproportionate rates of infection, it is not surprising that when compared to the state the city's HEI rating is 2 for all infectious diseases. The following displays a summary of how the city rates when looking at some of the infectious disease trends:

Figure 13. **Infectious/Communicable Diseases Prevalence* in Hartford and Connecticut (2009)**



Using data from Connecticut's Department of Public Health, a comparison of how Hartford's neighborhoods compare to each other with regard to infectious diseases is demonstrated in the following map using the same HEI rating system; the Northeast rated lowest out of 17 total neighborhoods.

Map 4. **HEI Infectious Disease Score by Neighborhood**



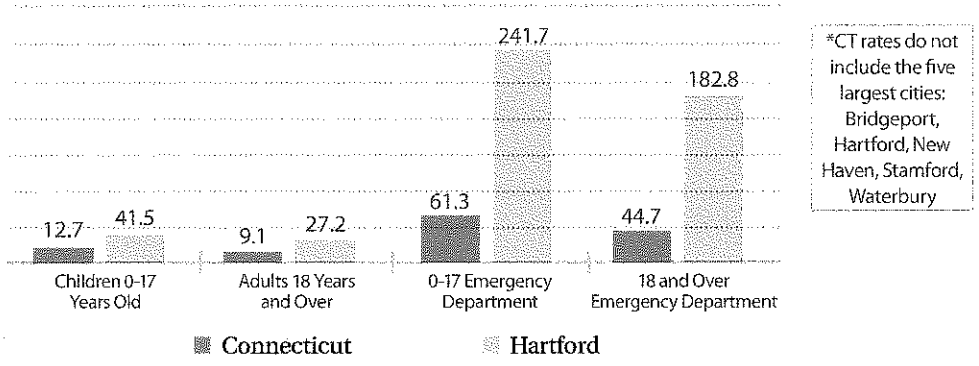
Based on secondary data analysis, Hartford has considerably higher rates of preventable infectious/communicable diseases than the state with the exception of Lyme disease.

The Department of Health and Human Services and the Consortium can identify the prevalence of infectious diseases and provide resources to those who are in most need. The Department's division of Disease Prevention and Health Promotion has both an STD and TB clinic, as well as an HIV program, all geared to curtail infection rates and keep Hartford residents informed and educated. The federal government has passed legislation that provides for individuals who live with HIV/AIDS affordable, high-quality HIV care and related services. For those who are already established Ryan White consumers, there is a network of agencies and area providers that are connected to the city and in position to provide needed services and resources.

Respiratory Illness

Based on data gathered in the Secondary Data Profile, asthma is an area of concern for the community. According to the Connecticut Department of Health, the hospitalization rates for asthma are notably higher for Hartford when compared to the state as seen in the following figure.

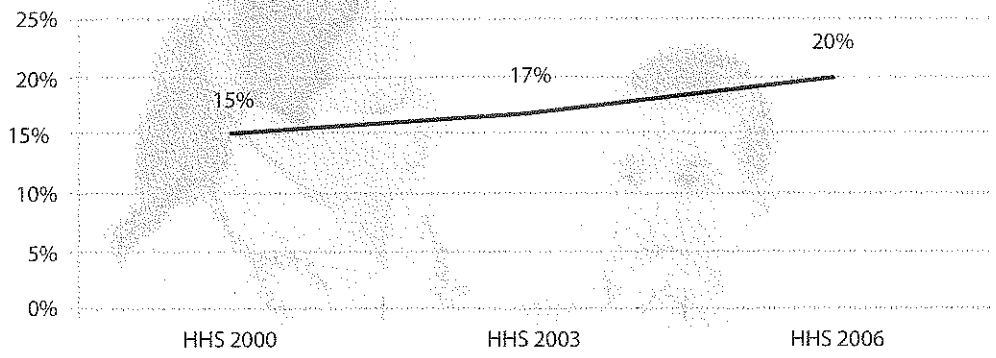
Figure 14. **Asthma Hospitalization Rates* in Hartford and Connecticut (2009)**



*per 10,000 residents

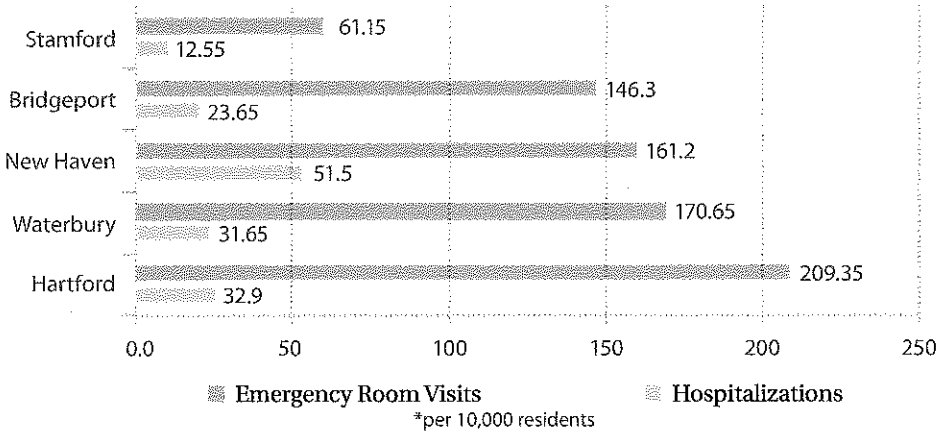
In 2006, the self-reported responses of current asthma among adults were 20%. This is the highest percentage of self-reported asthma in the past three Hartford Health Surveys, an HHS survey conducted through community partners every three years to gauge resident health and access to health care.

Figure 15. **Percent of Self-Reported Asthma from Hartford Health Survey (2006)**



Regardless of how residents self-report, Hartford has the highest rate of emergency room usage (209 ER visits for every 10,000) and the second highest rate of hospitalization for asthma as the primary cause of diagnosis (33 admissions per 10,000) when compared to other major Connecticut cities.

Figure 16. **Asthma Hospitalizations and Emergency Room Visit Rates* for All Residents by Connecticut City (2001-2007)**



Similar to asthma hospitalization rates, mortality rates are also an area of concern when compared to the rest of the state. The asthma-related mortality rate for men in Hartford is 22.4 per 10,000 men compared to 7.9 for the rest of Connecticut. Similarly, the mortality rate for women in Hartford is 42.5 compared to Connecticut's rate of 16.5.

In general, respiratory illness in Hartford has some moderate correlations, as noted in the following table, but the HEI indexed score is very low for each of the social determinants correlated to respiratory illness.

To help address these issues, the Asthma Call to Action Taskforce, a coalition of representatives from Hartford's Department of Health and Human Services, public schools, area hospitals, community organizations, and other agencies that are concerned about asthma in Hartford, seek to increase awareness about asthma to its residents, improve asthma care, establish a network of individuals and organizations to provide education and resources, and define asthma rate improvement strategies.

Obesity and Cardiovascular Disease

The percentages of obese Connecticut adults 20 years and older are notably higher for the Black and Hispanic populations (39.8% and 29%, respectively) than the state's white population (20.6%) [10]. Obesity is most commonly measured as a percentage of body fat based on height and weight. The following table shows the percent of healthy, overweight, and obese adults in the UnitedStates for all income levels as determined by the National Health and Nutrition Examination Survey. These weight category trends are similar when looking solely at people who are classified as "poor" (those who lived below the poverty threshold, currently set at a yearly income of $11,139 for individuals and $22, 314 for a family of four) by the US government. With a high rate of unemployment and a low HEI ranking for economic security, it can be assumed that obesity trends in Hartford are similar and that there is an increased relative risk for hypertension and adverse cardiovascular outcomes [11]."

Table 13. **United States Weight Categories**

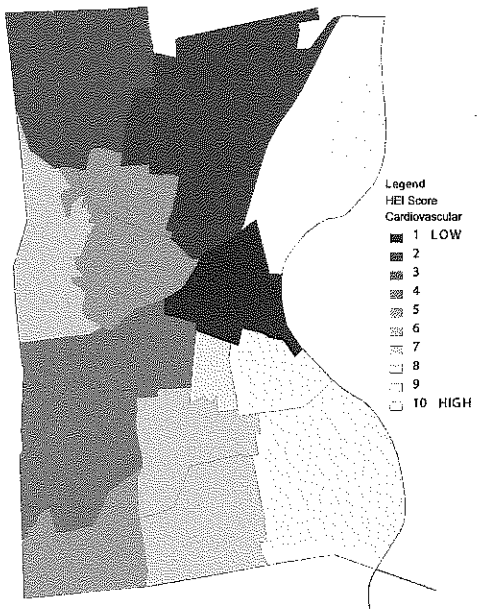
	HEALTHY WEIGHT	OVERWEIGHT	OBESE
1988-1994	41.9%	33.0%	22.7%
2001-2004	32.4%	34.7%	31.2%
2005-2008	30.9%	33.5%	33.9%

Similar rates emerge when looking at people who are classified as "poor" by the US government (those who live below the poverty threshold, currently set at a yearly income of $11,139 for individuals and $22,314 for a family of 4). With high rates of unemployment and a low HEI rating for economic security in Hartford, this trend is most likely mirrored in the city.

Downtown, the neighborhood with the lowest residential density, has the highest economic security and education scores, as well as the largest proportion of white residents. Despite such a low percentage of Hartford residents living Downtown, the fact that this population enjoys greater employment as well as health care coverage contributes to an increase in cardiovascular diagnoses and ultimately prevents undesirable health outcomes. For the remainder of Hartford's residents, cardiovascular health indicators remain elusive.

Obesity has been linked to both cardiovascular health and diabetes [12], and heart disease was the leading cause of death for Hartford from 2005 to 2007. The Northeast and Frog Hollow neighborhoods rate the poorest for these two significant risk factors.

Map 6. **HEI Cardiovascular Disease Score by Neighborhood**



There are several strong and moderate correlations with cardiovascular health, the top being education and economic security; below is a table listing the top five.

Table 14. **Social Determinants of Health Related to *Cardiovascular Health***

	INDEX SCORE	R_s VALUE
Education	2	0.51
Economic Security	2	0.48
Civic Involvement	1	0.42
Environmental Quality	4	0.36
Community Safety	1	0.33
Housing	3	0.29
Employment	3	0.28

Note: All shown correlations are statistically significant and ranked in order from strong to weak.

Diabetes

The fact that diabetes often presents as a co-morbidity with other diseases, it is difficult to segregate the information for just diabetes. The following table shows the age-adjusted percentages for adults 20+ for selected ethnic groups throughout the state; the data are from the Centers for Disease Control Behavioral Risk Factor Surveillance System (BRFSS).

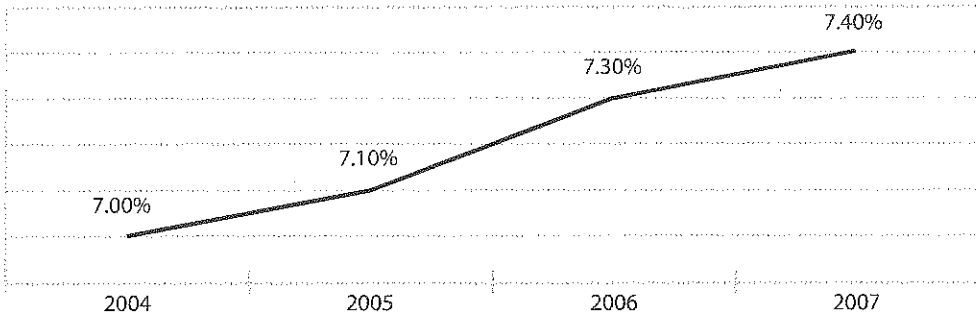
Table 15. **Connecticut Residents with Diabetes by Race**

YEAR	ALL ADULTS	NON-HISPANIC WHITE	NON-HISPANIC BLACK	MEXICAN-AMERICAN
2005	7.2%	6.6%	14.3%	15.1%
2006	6.9%	6.4%	15.0%	10.4%
2007	8.3%	7.1%	20.4%	13.5%
2008	7.2%	6.2%	16.1%	11.6%
2009	6.8%	6.4%	13.0%	9.7%
2010	7.6%	7.0%	13.9%	9.5%

The rates are alarmingly higher for non-Hispanic Blacks, and Hispanics; these trends are the same across all economic levels, and substantially higher for those who live below and near the poverty threshold. Since 2007, there has been a significant improvement in these high rates as both the Black and Hispanic populations in the state have experienced a drop in the rate of diabetes, but there is still a diabetes health disparity drawn along racial lines for the state.

While Hartford's diabetes rate is lower than the state's, the CDC indicates that Hartford's rate is on the rise. If the state trend in diabetes is any indication of how the city is afflicted by this disease, then the assumption would be that the Black population is disproportionately affected when compared to other racial/ethnic groups.

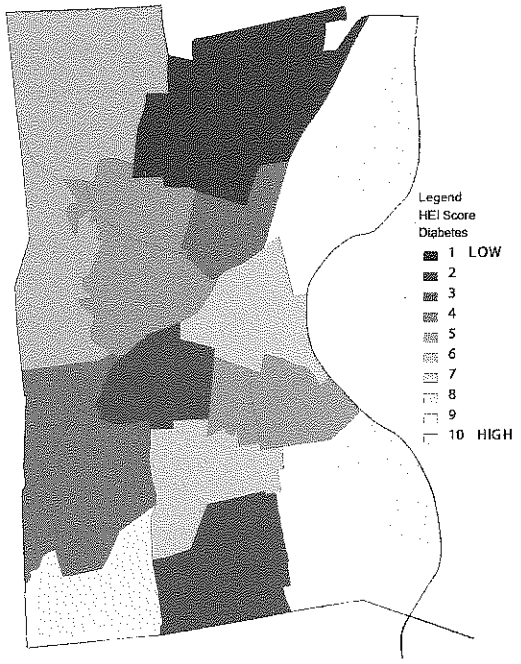
Figure 17. **Diabetes in Hartford for Adults**



Source: US Dept of Health and Human Services, The Office on Women's Health

The neighborhoods are compared to one another in the following map using the HEI indexing giving an indication where in Hartford diabetes is more of a health issue. The Northeast neighborhood ranks the lowest among Hartford neighborhoods.

Map 7. HEI Diabetes Score by Neighborhood

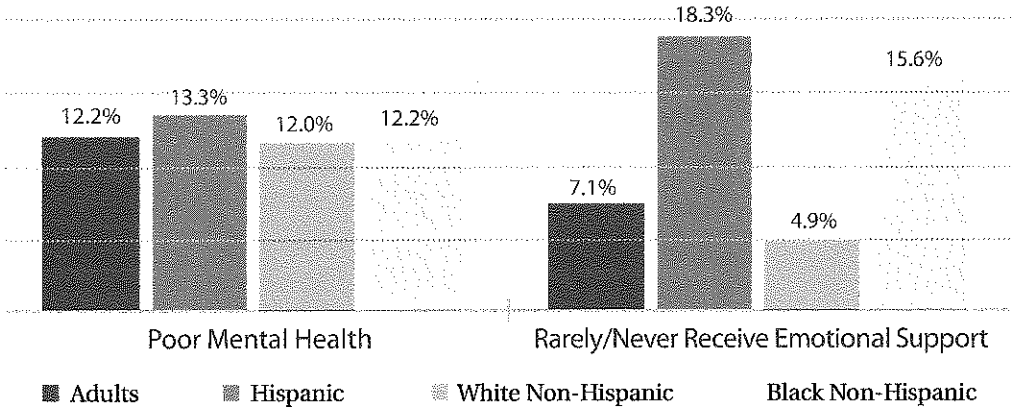


Behavioral Health

The HEI, using discharge data from the Connecticut Hospital Association and death information from the Connecticut Office of Vital Records, calculated an aggregate index score of 2 for mental health as a health indicator for Hartford. There are several significant correlations with mental health, including community safety (Rs=0.55), economic security (Rs=0.47), environmental quality (Rs=0.45), civic involvement (Rs=0.45), education (Rs=0.42), housing (Rs=0.37), and employment (Rs=0.23). With a low-indexed social determinant score, it can be inferred mental health issues are a significant health risk for the city. The BRFSS, a national system of state-based surveys, annually assessed how the residents fare with mental health issues. The results show that there is clearly a greater rate of Hispanics and Blacks self-reporting a lack of emotional support.

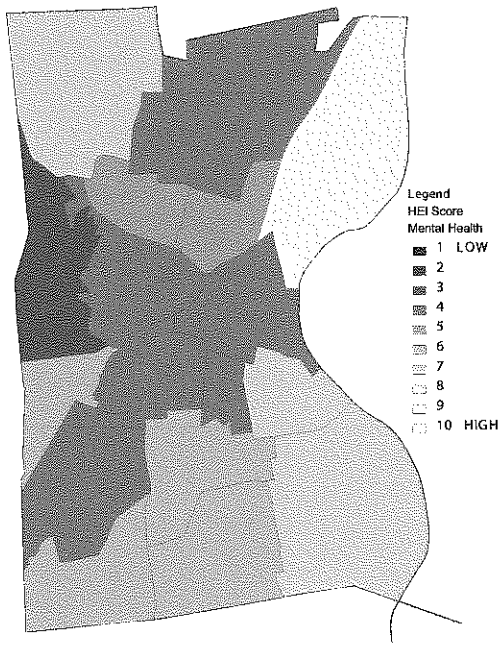
The behavioral health infrastructure is headed by the state through the Department of Mental Health and Addiction Services and its various partners; the complexity of mental health services designed to cater to large geographic regions encompassing the city as well as 37 other municipalities calls for a more thorough investigation and coordinated approach. HHS is currently engaged in a collaborative partnership that includes planning for a Behavioral Health Needs Assessment in order to fully understand the nature of these services.

Figure 18. **Mental Health in Connecticut (Age Adjusted; 2007-2009)**



The neighborhood with the highest utilization of mental health services is the West End, which happens to be relatively affluent when compared to other city neighborhoods. The Consortium could hypothesize that individuals with greater access to specialized health care services would experience higher rates of diagnoses.

Map 8. **HEI Mental Health Score by Neighborhood**



VIII. Barriers to Services

The Urban Alliance survey asked respondents to consider barriers to health services and community resources. The most commonly reported barriers to service areas included not knowing about existing services (27%), lack of available services (22%), not able to pay (20%), and lack of transportation (20%).

Respondents were also asked to identify the most crucial **perceived service needs** for Hartford. Areas perceived as the most in need of additional services included homelessness/ housing (45%), education (41%), job training/employment assistance (39%), and basic needs/food assistance (36%). The top **actual service needs** were determined by respondents indicating that someone in their household would benefit from having additional service in this area. This resident survey found that the actual needs of the respondents were, for the most part, similar to the perceived needs of Hartford; three of the top five needs mentioned were common to both (see table below; ranked by most common responses and common responses bolded). The two areas - perceived and actual service needs - were explored separately to note differences, but with such high correlations in Connecticut between employment, education, and housing, as well as other factors, the overlap between the two areas is not as discordant as they appear to be.

Table 16. Top 5 Needs for Hartford

ACTUAL NEEDS	PERCEIVED NEEDS
Basic needs/food assistance services	Homelessness/housing
Financial support services	Education
Job training/employment assistance	**Job training/employment assistance**
Health and wellness	**Basic needs/food assistance**
Education	Youth development

The Key Informant interviews completed by the Consortium had similar findings. More than half of Key Informants chose either "Disagree" or "Strongly Disagree" with positive statements about access to care regarding dental services, medical specialists, a comprehensive model of primary care, providers who accept Medicaid, transportation, and health care delivery in Hartford.

Table 17. **Key Informant Perceptions of Health Care**

ACCESS/ BARRIERS TO CARE	"DISAGREE" OR "STRONGLY DISAGREE"
The majorities of Hartford residents are able to access and afford a dentist when needed.	88%
The majority of Hartford residents are able to access needed medical specialists.	83%
The majorities of Hartford residents are able to access and afford a primary care provider.	76%
Transportation to medical appointments is available to residents when needed.	73%
The healthcare delivery system in Hartford has a comprehensive approach to patient care.	71%
There is a sufficient number of providers accepting Medicaid or other forms of medical assistance.	70%
There is a sufficient number of bilingual healthcare providers in Hartford.	63%

IX. Conclusions

This Community Health Needs Assessment was assembled to give readers an overview of Hartford public health trends and to provide a platform to increase the communication across non-governmental as well as governmental agencies to improve the lives of city residents. The findings from this process demonstrate that Hartford residents include high concentrations of people at an increased risk for unhealthy living. After examining all the data sources used to create this report – the Key Informant Survey, the Hartford Survey Project, and the various secondary data that were analyzed – it is clear that marginalized and underserved populations are overrepresented in the city, and the need for establishing and expanding effective partnerships among city agencies is critical. Poverty, job opportunities, education, quality of housing, and neighborhood safety are quality of life measures that were most often mentioned by the Key Informants. All of these were highlighted in the data as areas where collaboration and renewed effort are necessary.

According to a recent model created by the University of Wisconsin's Population Health Institute, at least half of community wellness is driven by non-health factors such as education, housing, and pollution [13]. Connecticut, consistently one of the wealthiest states in the union, is also home to some of the nation's most significant gaps in leading societal determinants of health. For instance, when looking at poverty, Latinos are 4.7 times and Blacks are almost 3.6 times more likely to be living in poverty when compared with their white counterparts in Connecticut. These poverty rates among Black and Latino population reflect, in part, the terribly high unemployment rates in cities like Hartford, which have been crippled by unemployment rates at least 50% higher than that of the state. Coupled with things like a high percentage of single parent households with children present, these compromising circumstances make it difficult for Hartford residents and their families to achieve optimal health.

In addition to a high concentration of poverty, this assessment identifies other actionable non-medical factors that drive the state of health in Hartford. **Education**, for example, is a key indicator for economic security; low educational attainment coupled with limited employment opportunities adversely impact economic security of the city on a whole. Hartford's battle is a difficult one as one-third of Hartford adults do not have a high school diploma. And with one-fifth of the city's labor force unemployed and a high rate of service occupations for those who are employed, it is apparent that when people get off on the wrong foot, the path to occupations with increased responsibility and higher wages become all the more difficult.

The **housing** situation in Hartford makes it difficult to find up-to-date accomodations. The housing stock in Hartford is an aging one, where more than half of the housing available for both renters and buyers was built prior to 1950. And of all the housing occupied, less than a quarter of Hartford residents own their domicile; the majority has to choose from these old housing options.

Crime continues to be a problem in Hartford. With such a high number of youth living in the city, there is going to be an increased rate of violent and injury-related deaths. The city, having about 3.5% of the entire state's population, accounts for more than a third of all murders. In addition, there are some very specific health issues that should be highlighted:

- High age-adjusted mortality rates despite a population that is relatively young suggest that the senior population is dying at a high rate
- The diabetes rate, although well below Connecticut's rate, has climbed steadily in recent years
- As a percent of the total population in Hartford, residents who are obese are increasing while the percent of healthy weight adults declines
- The infant mortality rate in Hartford is much higher than Connecticut and the United States

Preventing problems before they arise is a particularly powerful tool in population health. These prevention efforts will result in a dramatic cost savings and reduction in social problems to our community. In 2009, the Mayor's office in collaboration with HHS designed and launched the Healthy Hartford wellness campaign, focused on many aspects of daily life in our urban environment. The goal of this campaign is to increase the availability of health related information and have community discussions designed to influence the choices that the Hartford citizenry at all ages makes regarding health behaviors like physical activity, proper eating, and other aspects of disease prevention. HHS launched a set of creative teams to design high-impact activities and approaches targeting all residents; the Healthy Hartford campaign was recently recognized by the U.S. Surgeon General and received the *Healthy Youth for a Healthy Future Champion Award* for its efforts to curb and prevent childhood overweight and obesity within our community. The Healthy Hartford campaign along with its many partners strives to reach the largest possible number of residents by designing interactive activities that target specific demographic groups throughout Hartford's 17 neighborhoods.

The Healthy Hartford campaign is a collaborative effort with area health providers and organizations to promote healthy choices and solutions to health problems by focusing efforts on a specific segment of the population or aspect of living in Hartford (i.e., youth, women, and men; Hartford workforce; and public policies that affect the health of the people). As an example, the recently formed Hartford Childhood Wellness Alliance draws on the combined leadership and expertise of community and professional groups across a spectrum of public health, medicine, academia, child care, and recreation to address the critical issue of childhood health and weight in Hartford. The Alliance provides a structure through which individuals and organizations can join together in the common interest of creating healthy environments for children and families, which in turn would be a cost saver to the city. Early in 2011, the Society of Actuaries calculated that the total economic cost of overweight and obesity in the United States is $270 billion per year as a result of an increased need for medical care, loss of worker productivity due to higher rates of death, loss of productivity due to disability of active workers, and loss of productivity due to total disability. Providing increased accurate chronic

disease self-management training to Hartford residents would have a positive impact on total cost to the city.

Collaboration holds the promise of allowing progress on issues where multiple parties are involved. Sustaining collaborations in Hartford is possible not only because of established partnerships but also because of efforts like such as this needs assessment, which will further strengthen existing relationships by highlighting where the major needs are. Any local health department is limited by available resources. Therefore, HHS' standard operating procedure is to constantly search for, and partner with, other organizations in order to better the lives of Hartford's citizenry.

The Public Health Advisory Council, a city charter-supported advisory panel, is an example of a sustained collaboration relative to residential health and chronic disease. Members of the panel include high-level representation from area hospitals, the Hispanic Health Council, the State of Connecticut Department of Mental Health and Addiction Services, the Connecticut Association of Directors of Health, and other community health organizations, and has regularly met for approximately the last 15 years. As experts on community health, the Public Health Advisory Council advices the city on many public health policies and initiatives.

In order to have improved collaborations throughout the city, there needs to be better data exchange among health organizations. Both health and societal data are not consistently collected, are difficult to compare longitudinally, and frequently may not tell the whole story. To improve the health of Hartford residents, HHS and its partners must have access to accurate local data. There are opportunities to make significant improvements in gathering and tracking such data on all of these issues, particularly on the issues of chronic diseases and risk factors that contribute to health disparities. It is imperative that those working in public health and providers of direct clinical services collaborate to develop a strategic plan for delivery of health care (including preventive care and mental health services) in a manner best suited to the community being served.

This report has presented a case that trends in health outcomes are determined not just by individual-level factors such as genetic make-up or access to medical services. Rather, these rates are a result of but also social, political, and environmental conditions. At the population level, major influences on health are structural. Throughout the development of this report, it has become clear that the disproportionate rates of morbidity and mortality borne by the city's marginalized communities result from far more than access to medical services, a result of cumulative social and environmental conditions in which Hartford's low-income residents are born, grow up, live and work. Hartford stakeholders can no longer afford to ignore evidence linking social determinants of health with health outcomes. By building on the analysis in this report and partnerships throughout the city, Hartford will take significant steps to build the capacity to understand and address the conditions contributing to the compromised health of our most vulnerable neighborhoods.

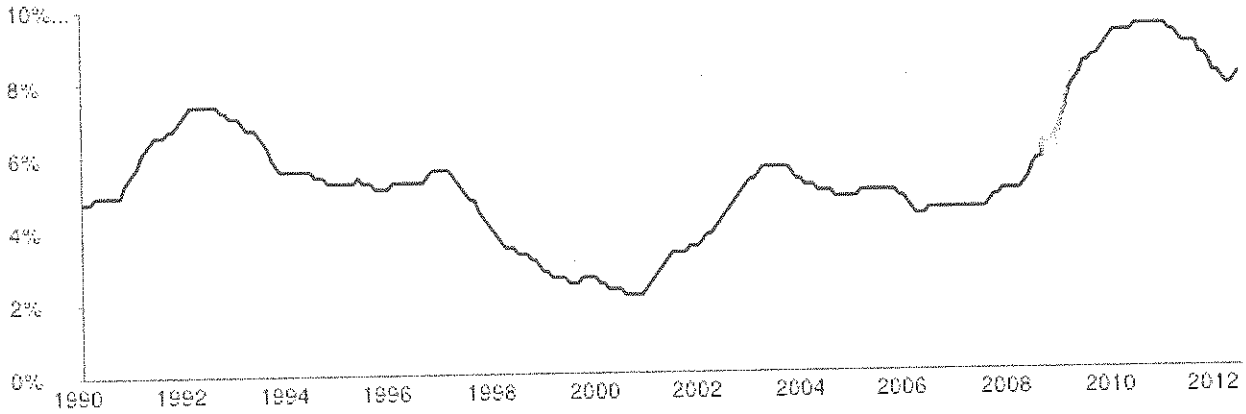
DEPARTMENT NUMBERS

Connecticut Unemployment

According to the BLS current population survey (CPS), **the unemployment rate for Connecticut rose 0.3 percentage points in June 2012 to 8.1%**. The state unemployment rate was 0.1 percentage points lower than the national rate for the month. The unemployment rate in Connecticut peaked in August 2010 at 9.4% and is now 1.3 percentage points lower. From a post peak low of 7.7% in March 2012, the unemployment rate has now grown by 0.4 percentage points. You can also see Connecticut unemployment compared to other states.

Unemployment Rate	June 2012	Month/Month	Year/Year
National	8.2%	0.0	-0.9
Connecticut	8.1%	+0.3	-0.8

Unemployment Rate: Connecticut, National



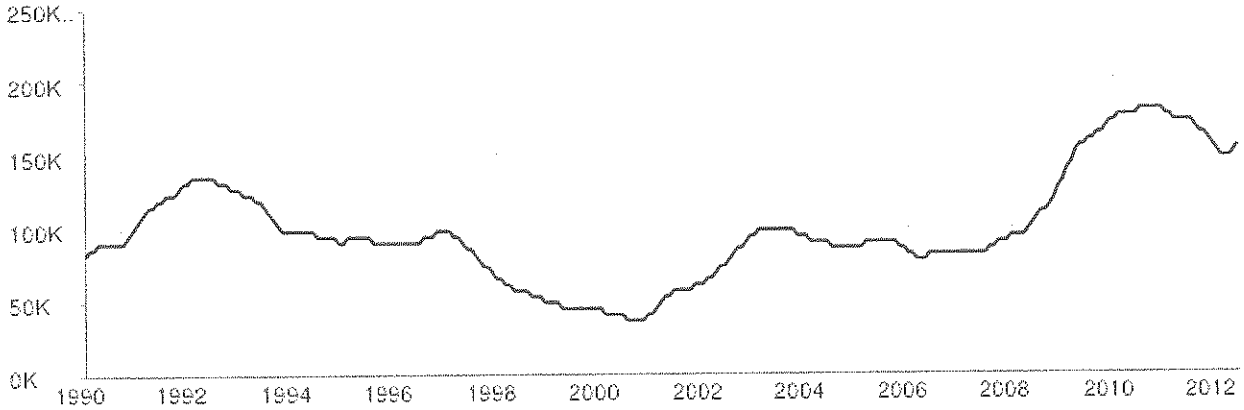
Note: Recessions shown in gray

Connecticut Unemployed

The number of people unemployed in Connecticut peaked in October 2010 at 180,787. There are now 26,173 fewer people unemployed in the state. From a recent trough of 147,158 in April 2012, the number of unemployed has now grown by 7,456. Connecticut job growth data is also available.

Unemployed Persons	June 2012	Month/Month	Year/Year
onnecticut	154,614	+4,260	-16,502

Number of Unemployed Persons



Connecticut Unemployment History

Date	National Unemployment Rate	Connecticut Unemployment Rate	Connecticut Unemployed
ne 2012	8.2%	8.1%	154,614
May 2012	8.2%	7.8%	150,354
April 2012	8.1%	7.7%	147,158
March 2012	8.2%	7.7%	148,072
February 2012	8.3%	7.8%	148,572
January 2012	8.3%	8.0%	152,466
December 2011	8.5%	8.1%	155,815
November 2011	8.7%	8.3%	158,918
October 2011	8.9%	8.5%	162,298
September 2011	9.0%	8.6%	165,670
August 2011	9.1%	8.8%	168,513
July 2011	9.1%	8.9%	170,314
June 2011	9.1%	8.9%	171,116

Department of Numbers

The Department of Numbers contextualizes public data so that individuals can form independent opinions on everyday social and economic matters.

Connecticut Commission on Children

Long-Term Unemployment in Connecticut

George Wentworth
Senior Staff Attorney
National Employment Law Project
September 13, 2011

NELP National Employment Law Project

Goals of UI Program

- Provides partial income replacement for workers who are unemployed through no fault of their own
- Stimulus for local economies: maintains consumer spending & prevents ripple effects on area businesses
- Promotes attachment of unemployed workers to the labor market & sometimes specific employers

Unemployment Insurance: Economic Stabilizer & Poverty Preventer

- UI benefits represent first line of defense against wage loss, homelessness and poverty.
- UI benefits automatically stimulate economic activity. Every dollar in UI benefits generates $2 in economic activity.
- Intercepts family poverty:
  - UI cuts family poverty in half from 50% to 25% after job loss.
  - Average family income drops 40% for long-term unemployed receiving UI vs. 60% for unemployed not receiving UI.
  - In 2009, UI prevented 3.3 million American workers from falling into poverty.

Connecticut UI Program at a Glance

- CT Unemployment Rate: 9.1% - 170,000 unemployed workers
- Average weekly benefit amount : $325 (U.S. average: $295)
- Number of Workers filing for state UI benefits weekly: 51,000
- Number of Workers filing for federal benefits weekly: 62,000
- 45% of unemployed workers exhaust state benefits without finding new work
- State UI benefits paid out in 2010: $1.04 billion
- UI Trust Fund became insolvent and began borrowing from Federal government in October 2009. ($809 million to date).

How Effective is Connecticut's UI Program?

- **Recipiency rate** is the percentage of unemployed workers who are actually receiving UI benefits.
- CT's recipiency rate is 49% which ranks 12th in the country. (US average is 45%)
- **Replacement rate** is the percentage of a worker's former wages that is made up by the worker's UI benefit.
- CT's replacement rate is 28.5% which ranks 45th in the country (US average is 33.4%)

Federally-Funded Extension Benefits

Emergency Unemployment Compensation (EUC)

- Tier I (20 weeks)
- Tier II (14 weeks)
- Tier 3 (13 weeks) - over 6% unemployment rate
- Tier 4 (6 weeks) – over 8.5% unemployment rate

Extended Benefits (EB) - 20 weeks if state's unemployment rate over 8.0% – normally 50/50 state-federal split but funding is 100% federal under ARRA

Reauthorization: Federal authorization of EUC program (and federal funding of EB) scheduled to expire on 12/31/11. Without reauthorization, CT workers exhausting state UI benefits after 1/1/12 will be limited to a maximum of 26 weeks of benefits.

The Problem of Long-Term Unemployment

- Nationally 43% of the nation's unemployed (over 6 million workers) have been jobless 6 months or longer.
- Average duration of unemployment is 40 weeks
- While the number of long-term unemployed is not published for CT, existing data suggests the percentage exceeds the national average.
  - In CT, 62,000 UI claimants are long-term unemployed
  - Since May, 2010, over 53,000 workers exhausted all 99 weeks of state and federal UI benefits without finding a job
  - Preliminary research indicates only about 25% of those who exhausted benefits subsequently found employment

LL

Challenges Facing the Long-Term Unemployed

- Dormant Labor Market/ Employer reluctance to invest in new employees while consumer demand still low
- Most new jobs low & high skill; few in the middle
- Stigmas & Negative Stereotyping
- Discrimination based on unemployment status, age
- Devaluation of existing skills, failure to keep skills current while out of the workplace

Strategies for Helping The Long-Term Unemployed

- Reauthorization of federal UI extensions through 2012
- American Jobs Act :
  - Reemployment Assistance
  - Expand Shared Work
  - Cut wage loss associated with taking lower-paying jobs through wage insurance
  - Subsidized Employment (Revival of TANF Emergency Fund approach)
  - Tax credits for hiring the long-term unemployed

A Connecticut Strategy

- Make reduction of long-term unemployment a state policy priority
- Plan for Jobs Act Innovation funds but find state dollars as well
- Concerted program of reemployment services
- Aggressively market subsidized employment program along with employer hiring tax credits
- Wage insurance
- Prohibit discrimination against the unemployed

- For more information, contact:

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AMERICAN PSYCHOLOGICAL ASSOCIATION

Psychological Effects of Unemployment and Underemployment

The current state of the economy continues to be an enormous stressor for Americans, with 78 percent reporting money as a significant source of stress (APA, 2009). Unemployed workers are twice as likely as their employed counterparts to experience psychological problems such as depression, anxiety, psychosomatic symptoms, low subjective well-being and poor self-esteem (Paul & Moser, 2009). Like unemployment, underemployment (e.g., people working part-time because they cannot find full-time employment) is unequally distributed across the U.S. population, with women, younger workers and African Americans reporting higher rates of involuntary part-time employment and low pay, as well as higher proportions of "discouraged" workers who have given up on searching for a job (McKee-Ryan et al., 2005). Unemployment not only affects those who lose their jobs. Coworkers who are still employed may experience a heavier work load and suffer from anxiety that they too will soon be unemployed, (Kivimaki, Vahtera, Elovainio, Pentti, & Virtanen, 2003). Unemployment and underemployment also affect families and communities.

Effects on Families

According to the Society for the Psychological Study of Social Issues' Policy Statement "The Psychological Consequences of Unemployment," the stress of unemployment can lead to declines in individual and family well-being (Belle & Bullock, 2011). The burden of unemployment can also affect outcomes for children. The stress and depressive symptoms associated with job loss can negatively affect parenting practices such as increasing punitive and arbitrary punishment (McLoyd, 1998). As a result, children report more distress and depressive symptoms. Depression in children and adolescents is linked to multiple negative outcomes, including academic problems, substance abuse, high-risk sexual behavior, physical health problems, impaired social relationships and increased risk of suicide (Birmaher et al., 1996; Chen & Paterson, 2006; Le, Munoz, Ippen, & Stoddard, 2003; Verona & Javdani, 2011; Stolberg, Clark, & Bongar, 2002).

Effects on Communities

Widespread unemployment in neighborhoods reduces resources, which may result in inadequate and low-quality housing, underfunded schools, restricted access to services and public transportation, and limited opportunities for employment, making it more difficult for people to return to work (Brisson, Roll, & East, 2009). Unemployed persons also report less neighborhood belonging than their employed counterparts, a finding with implications for neighborhood safety and community well-being (Steward et al., 2009).

High unemployment and growing income inequalities are key factors in declining social climate (International Labour Office, 2010). The United Nations (2010) claimed that growing social inequality fueled by extended, global unemployment will increase social unrest and tension and a growing sense of unfairness. Increasing inequality in advanced economies is fundamentally linked to growing rates of physical, emotional, social and political disorder (Wilkinson & Pickett, 2010).

Unemployment and Stress in Different Populations

Unemployment does not affect all groups equally. Rates are higher among Latinos/as (13.1%) and African Americans (15.7%) than European Americans (9.5%). Immigrants (Kochhar, 2009) and people with disabilities (Shapiro, 2009) are also especially vulnerable to layoffs as are those without college degrees (Leonhardt, 2009). Unemployed women report poorer mental health and lower life satisfaction than unemployed men (McKee-Ryan et al., 2005). Women are more likely to report that they have consumed unhealthy foods, or skipped a meal as a result of stress. Women are also more likely to report physical symptoms of stress, including irritability, anger, fatigue and lack of interest or motivation and energy (APA, 2009). In combination with other health disparities, the unequal impact of unemployment on some groups may have devastating effects on already vulnerable communities.

Solutions and Recommendations

The negative effects of unemployment can be lessened. Individuals who face unemployment with greater financial resources, as well as those who report lower levels of subjective financial strain, report better mental health and more life satisfaction than those who experience unemployment with fewer economic resources and a greater sense of financial stress (McKee-Ryan et al., 2005). Social support can also mitigate the negative impacts of unemployment and underemployment (Belle & Bullock, 2011). For example, being married is a protective factor during periods of unemployment and underemployment (Dooley & Prause, 2004; McKee-Ryan et al., 2005).

APA supports critical and proven programs to prevent unemployment and provide support for those who are unemployed, and urges Congress to:

Support the National Commission on Employment and Economic Security Act. Sponsored by Representative Alcee Hastings (D-FL), this legislation would establish a national commission to study and address employment and economic insecurity and their effects on mental health. The commission would examine issues of economic and psychological insecurity within our workforce due to employment displacement. Furthermore, the commission would provide recommendations to Congress and the President on how to reduce economic and psychological effects of unemployment.

Fund job training and reemployment programs that take into account the psychological and emotional needs of workers and help prevent long-term unemployment. For example, the Michigan Prevention Research Center (MPRC), a program funded for 20 years by the National Institute for Mental Health, developed and evaluated the JOBS Program to help unemployed workers effectively seek reemployment and cope with the multiple challenges and stressors associated with unemployment and job-searching. Currently supported by the Substance Abuse and Mental Health Services Administration, the JOBS Program is a group-based intervention that has the dual goals of promoting reemployment and enhancing the coping capacities of unemployed workers and their families.

Reauthorize and expand the Temporary Assistance for Needy Families program to provide temporary assistance to the long-term unemployed. APA supports more federal support for increased benefit levels for States, more time for clients to access mental health services, and suspending the work first requirement, to encourage training and education.

Find this article at:
http://www.apa.org/about/gr/issues/socioeconomic/unemployment.aspx

Effects of Unemployment on Mental and Physical Health

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Abstract: From a prospective study of the impact of stress on health in 300 men assessed every six months, men who became unemployed after entering the study were compared with an equal number, matched for age and race, who continued to work. Psychological and health data after unemployment were compared between the two groups by multivariate analysis of variance and covariance. After unemployment, symptoms of somatization, depression, and anxiety were significantly greater in the unemployed than employed. Large standard deviations on self-esteem scores in the unemployed group suggested that some men coped better than others with job-loss stress. Further analysis showed those with higher esteem had more support from family and friends than did those with low self-esteem. Furthermore, unemployed men made significantly more visits to their physicians, took more medications, and spent more days in bed sick than did employed individuals even though the number of diagnoses in the two groups were similar. (*Am J Public Health* 1985; 75:502–506.)

Introduction

For most individuals, basic life requirements are met through employment. However, work does much more than supply the means for meeting physical needs; it also can satisfy creative urges, promote self-esteem, and provide an avenue for achievement and self-realization. Conversely, unemployment might be expected to increase anxiety and depression, lead to lower self-esteem, and produce adverse physical health consequences, particularly when efforts to locate work are met with failure over a long period of time.

Unemployment has occurred in the lives of many people in this country during the past decade. Despite some recent decreases in the numbers of persons unemployed, it has been estimated that more than 9 per cent of the work force will be out of work in 1984.[1] Individual accounts[2] of the devasting impact this can have on day-to-day living cannot be ignored.

In terms of research regarding the effects of unemployment, both macro[3–5] and micro[6–11] studies have contributed to increased understanding over the last two decades. However, research results sometimes have been conflicting and ambiguous partly due to differing research methods, different populations under study, and different interpretations of the data. The strengths and weaknesses of previous research have been done rather extensively by others.[11–15] As Kasl[11] pointed out, ". . . only a painfully prolonged accumulation of diverse evidence holds the best promise of yielding a reasonably clear picture."

One underlying theme which helps to provide some organizational perspective in reviewing previous findings regarding unemployment is that unemployment is considered a stressful event which has the potential for affecting mortality and/or morbidity whether one is examining national trends in health and death rates (macro) or specific changes in selected individuals over time (micro). The extent to which life and physical and psychological health are affected is the subject of study. Catalano and Dooley emphasized the need to broaden the concept of unemployment stress to the stress of economic change. Their study of the Kansas City economy showed that residents reported more stressful events and affirmed more depressive items following economic fluctuations.[16]

In a detailed prospective study which focused directly on the worker facing unemployment, Kasl examined a variety of indicators of health and economic strain over a two-year period.[17] He found elevated depression, anxiety, and somaticism occurring only as brief initial responses for some workers; for others the emotional strain did not abate even when unemployment ended.[18] It is possible, then, that for some of the unemployed, psychiatric symptoms were chronic. The Work and Unemployment Project,[19] a panel study looking at the effects of involuntary loss of jobs by husbands, showed that being without work was strongly associated with higher levels of psychiatric symptoms. Once reemployed, the strain observed during the unemployment period diminished to levels below those of the control group (those persons not experiencing unemployment during the study period). Other investigations dealing with psychological consequences of unemployment have shown that inpatient first admissions to hospitals in a state system are significantly related to economic downturn for low status occupational groups[20] and that there are significant relationships between hospital readmission rates for psychiatric reasons and unemployment.[21]

In an important work by Kasl and Cobb in which cardiovascular functioning was examined in relation to job loss,[8] the authors broadly concluded that their results failed to provide reasonable support for the hypothesis that the job-loss unemployment experience increasd the risk of heart disease. This conclusion disagrees with the inferences drawn from earlier macro studies by Brenner.[3,4] However, Kasl and Cobb went on to indicate why they believed the hypothesis is a tenable one even though their data did not support it. Their discussion, which in a subsequent paper by Kasl[11] was even further enhanced, highlights the importance of interpretation of data and limits of research design.

Social support, as a potential mediator of stress, has been examined for its impact on moderating the consequences of unemployment.[22–28] In general, results have shown that unemployment stress is exacerbated by a low sense of social support. Gore found that the rural unemployed evidenced a significantly higher level of social support than did the urban unemployed.[22] Also, she discovered that while unemployed the unsupported showed significantly higher elevations and more changes in cholesterol measures,

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illness symptoms, and affective responses than did the supported unemployed. Kasl[11] pointed out that the role of social support depends on the person's stage of adaptation to the unemployment experience. For persons whose unemployment status remained uncertain over more prolonged time periods, high levels of social support did have a buffering influence.

The purpose of this paper is to describe the effects of job loss on psychological and physical function and to determine whether the degree of stress perceived as a result of job loss and the level of social support during unemployment are related to psychological and physical function.

Method

Men included in this study are among the participants in a Veterans Administration study of the effect of environmental stress on immune function and the development of disease. The study was initiated in Miami, Florida, at the Veterans Administration Medical Center in 1979 as a prospective and ongoing study of 300 men entered into the project over a three-year period of time. Veterans between the ages of 35 and 60 were screened from outpatient ambulatory clinics and veterans organizations by a project nurse and included in the study if they were free from major illnesses and were willing to sign informed consent. Only 8 per cent of the eligible men declined to participate in the study. The men in the study are followed every six months for five years in regard to stress and psychological, immunological, and physiological status. At the time of entry, demographic information was obtained, and a structured interview was used to obtain the social, marital, work, and health history; these data have been updated every six months. Physical examinations and routine laboratory tests have also been done every six months.

As a part of the assessment of stress, the men complete a modified version of the Holmes and Rahe[29] Social Readjustment Rating Scale which identifies occurrence of any of 41 stressful events over the past six months. Number of months since the event occurred is recorded. For each event endorsed, a 0–9 rating is obtained to indicate the amount of perceived stress associated with the event, the degree to which the event was anticipated, the amount of responsibility the individual felt in bringing the event about, and the degree of support he received from family and friends in coping with the event. Several of the events deal with employment stresses. For the purpose of this study, only the stress of unemployment was considered. Those men who lost their jobs as a result of being fired, laid off, or "dismissed" (let go because of inadequate performance but without the stigma of actually being fired) from work between one of the six-month follow-ups were identifed. Thirty men (10 per cent) qualified for inclusion by virtue of having become unemployed. An equal number of men were matched for age and race with the unemployed men. All of the matched comparison group continued to work during the time of the study. Data describing psychological and physical health status were selected from the rating time preceding job loss to serve as the baseline measurement of functional status. The rating time following job loss was used as the outcome measurement. The paired control was selected from this same time period.

Data describing psychological function and physical function were selected for comparison between the groups before and after job loss. The psychological variables came from reliable and valid scales which measured symptoms[30] such as somatization, obsessive-compulsiveness, depression, interpersonal sensitivity, and anxiety; locus of control;[31] alienation;[32] life satisfaction;[33] and self-esteem.[34] Physical function was described by number of visits to a physician during the prior six months, days in bed sick during the previous six months, self-assessed health (on a 1–5 scale), current number of medications, and current number of diagnoses.

The questions for analyses were whether job loss had an adverse affect on psychological and physical functioning and whether perceived stress and social support were related to functional status. Data were analyzed by comparing psychological and physical function between the two groups of men after job loss by multivariate analysis of variance with and without the baseline measurements covaried.

Results

The 30 men who became unemployed did not differ significantly from the 30 who continued to work in regard to background characteristics. They averaged 49 years of age (S.D. 10 years). Six men in each group (20 per cent) were Black; about three-fourths were married and living with their wives. The average years of education was 12. They averaged 3.8 on Hollingshead's two-factor index,[35] which indicated lower middle class. Most of the unemployed were blue collar workers.

Table 1 shows the reasons for loss of employment and the rating provided by the men regarding this stressful event. Amount of stress associated with loss of work was over 6 on the 0–9 scale. Most of the men had anticipated the event happening to a moderate degree. Very little responsibility was acknowledged for bringing the event about. The degree of social support differed by reason for loss of employment, with those who were fired feeling less support than the other groups.

Although the matched groups were similar in regard to psychological and physical function initially, any minor variations in baseline ratings were removed by holding the prescores constant in analyses as recommended by Bancroft.[36] None of the men who lost their jobs were reemployed at the time of the follow-up rating.

Table 2 shows the adjusted means for the psychological variables at the six-month rating following job loss for those who were unemployed and for their matched controls. Those who lost their jobs had more symptoms of somatization, depression, and anxiety after the experience than those who continued to work. Other psychological scores were also in the expected direction of being less favorable for the unem-

TABLE 1—Ratings of Stress Related to Reasons for Loss of Work

Stress Variables	Reason for Loss of Job			
	Fired (N = 7)	Dismissed (N = 9)	Layed Off (N = 14)	t-Test
Time since occurrence (months)	3.4	3.1	4.0	.58
Degree of stress†	7.1	6.8	6.1	.26
Degree event was anticipated†	4.2	5.0	5.8	1.88
Degree of responsibility for event†	2.0	1.3	1.1	1.04
Degree of support received†	2.3	4.0	4.7	2.05*

*$p < .05$ by Students t-Test.
†Indicates the event was rated 0–9 in regard to degree, with 0 = none to 9 = extreme.

TABLE 2—Adjusted Means for Employed and Unemployed Men on Psychological Function by Multivariate Analysis of Covariance

Variables	Employed Mean	Employed SD	Unemployed Mean	Unemployed SD	F-Ratios
Symptoms					
Somatization	18.0	6.6	22.5	7.9	3.65*
Obsessive-Compulsiveness	12.2	4.7	14.9	5.6	3.44
Depression	16.1	5.7	20.6	7.8	3.78*
Interpersonal Sensitivity	10.8	3.8	12.5	4.8	1.89
Anxiety	9.8	3.0	11.9	4.2	4.92*
Locus of Control	7.9	3.3	8.5	2.9	.45
Alienation	3.5	2.9	4.1	3.0	.58
Life Satisfaction	35.5	6.7	37.1	7.2	1.20
Self-Esteem	40.0	8.1	42.6	13.2	1.98

*$p < .05$. Multivariate $F = 2.87$, $p < .02$.
NOTE: Higher scores indicate less favorable responses.

ployed than employed. Differences were of the same magnitude with and without prescores held constant for the groups.

The standard deviation for the self-esteem ratings was large in the unemployed group. Since this indicated that there was considerable variance in self-esteem ratings, the unemployed group was further divided by median scores on self-esteem into those with high and low esteem. The high and low esteem groups were then compared on perceived stress and family support in dealing with the stress of unemployment. Those with high esteem perceived less stress from job loss than those with low esteem; in addition, those who had high self-esteem receiving more support from family and friends than those with low self-esteem.*

Table 3 shows how physical function of the employed and unemployed men differed after job loss. Days in bed during the six months averaged five for the unemployed and .9 for the employed. Visits to the physician were five times more in the unemployed than employed men; the unemployed men averaged taking twice as many medications as the employed men; self-rated health was less favorable in those who lost their jobs. Although number of diagnosed illnesses did not differ between the groups, the presenting complaints for the increased number of physician visits were most often related to gastrointestinal, respiratory, and skin disorders.

To better understand the relationships between psychological and physical health variables after unemployment, these variables were intercorrelated for the unemployed group. In addition, the outcome variables were also correlated with the degree of stress associated with loss of work and the amount of social support received from family and friends in coping with the stress of unemployment.

Table 4 shows the correlations between psychological and physical health variables after loss of work. Those who made more visits to their physicians had more symptoms of somatization, depression, and anxiety. More time spent in bed was associated with increased somatization and depression. Those who took more medications had more somatization and were less internal in their locus of control. Poorer self-assessed health correlated with several of the psychological states, such as more somatization, obsessive-compulsiveness, depression, and anxiety and less life satisfaction. A

*Data available on request to authors.

TABLE 3—Adjusted Means for Employed and Unemployed Men on Physical Function by Multivariate Analysis of Covariance

Variables	Employed Mean	Employed SD	Unemployed Mean	Unemployed SD	F-Ratios
Physician Visits	1.2	2.6	5.9	4.0	9.23**
Days in Bed	.9	2.2	5.0	6.9	10.67**
Number of Medications	1.9	1.7	3.6	2.0	3.99*
Self-Assessed Health	2.0	.8	2.9	.7	4.36*
Number of Diagnoses	1.8	1.9	1.9	2.0	.02

*$p < .05$; **$p < .01$. Multivariate $F = 3.70$, $p < .001$.
NOTE: Self-assessed health rated 1–5, with higher being less favorable ratings.

higher number of diagnoses was associated with more somatization and less life satisfaction. Higher ratings of somatization or an increase in bodily symptoms was associated significantly with all of the physical health indicators. More adverse psychological states were more often significantly related to poorer self-assessed health.

Table 5 shows how psychological and health status after loss of work correlated with degree of perceived stress from loss of employment and amount of social support from family and friends in coping with the stress of losing a job. Those who perceived more stress from unemployment had increased symptoms of somatization, depression, and anxiety. The higher the perception of the stress, the more visits were made to the physician and the less favorable health was assessed. All of the correlations with social support were in the direction of more support going with more favorable psychological and physical health ratings, but only two of the correlations were significant statistically. Less social support related significantly to poorer self-esteem and more visits to the physician.

Discussion

Results from this study strongly suggest that unemployment had an adverse impact on psychological function, with the unemployed becoming more anxious, depressed, and concerned with bodily symptoms than those who continued to work. Since groups did not differ initially regarding these psychological states, it seems likely that these symptoms were associated with job loss rather than preexisting psychological symptoms. Being unemployed without a primary source of income would be expected to produce anxiety and depression. Further, the increased depression, often manifested by physical symptoms of loss of appetite, sleep, and sexual interests, could account for more worry over physical symptoms as expressed by increased somatization and unfavorable self-health assessments that were observed in the unemployed.

Loss of work would be expected to affect self-esteem. Not having work could limit the person's chances for feelings of achievement, accomplishment, and satisfaction and could increase guilt about failure to provide for one's family. Nevertheless, in this study unemployed men did not differ from employed men in their self-esteem ratings at the six-month rating period. It is interesting to note that the ratings of self-esteem among the unemployed were bimodal. This suggests that some unemployed men may have been able to cope better than others. Further examination of the data showed that perceived amounts of stress from job loss differentiated significantly between those with high and low self-esteem. Also, greater support from family and friends in

TABLE 4—Correlations of Psychological Variables with Physical Health Indicators for the Unemployed

Psychological	Physical Health				
	MD Visits	Days in Bed	Number of Medications	Self-Rated Health	Number of Diagnoses
Symptoms					
Somatization	.50**	.41*	.38*	.66**	.36*
Obsessive-compulsiveness	.24	.01	.14	.35*	.08
Depression	.42*	.38*	.18	.37**	.16
Interpersonal sensitivity	.23	.06	.20	.31	.18
Anxiety	.36*	.07	.16	.42*	.25
Locus of Control	.13	.17	.42*	.19	.29
Alienation	.05	.11	.04	.39	.14
Life Satisfaction	.20	.06	.14	.47**	.35*
Self-Esteem	.04	.17	.23	.16	.08

*$p < .05$; **$p < .01$ Pearson Correlations.
NOTE: Higher scores on psychological variables are less favorable responses. Self-assessed health is rated 1–5 (higher worse).

dealing with unemployment related significantly to better self-esteem. These results lend support to observations by others[7,22] in which the effects of unemployment to some extent are dependent on the strengths within the individuals and the support provided to them by significant persons in their lives.

Examination of correlations between psychological and physical function showed these two areas to be highly correlated. Furthermore, self-assessed health was highly correlated with both psychological and physical functioning, indicating the person's perception of health was related to functional status in general. Tessler, *et al*,[37] found a relationship between psychological distress and use of primary care health services. Persons who were distressed emotionally by being depressed and anxious and who saw their health as poor dealt with these feelings in part by seeking medical advice. In this respect, medical practitioners and institutions often fulfill social and emotional needs of the patients. This is somewhat confirmed in this study in that the number of diagnoses did not differ between the employed and unemployed groups, even though medications, physican visits, and days in bed were significantly greater for the unemployed than employed. These results lend support to those of Kasl and Cobb who found that job loss increased the use of medical care.[8] The types of diagnostic problems identified among those who lost their jobs suggests that illnesses may have been episodic and possibly emotionally derived (skin rashes, colds, respiratory problems, and gastrointestinal complaints). In a study by Fagin, general practitioners were found usually to be unaware of the breadwinner's unemployment.[38] Threfore, it would seem important that physicians assess occurrence of recent major stresses as one factor that may precipitate repeated visits for illnesses over a short span of time.

TABLE 5—Correlations of Psychological and Physical Health Variables with Perceived Stress and Social Support Related to Loss of Work

	Perceived Stress	Social Support
Psychological Function		
Symptoms		
Somatization	.47**	−.08
Obsessive-compulsiveness	.31	−.05
Depression	.51**	−.10
Interpersonal sensitivity	.11	−.08
Anxiety	.49**	−.29
Locus of Control	.54	−.33
Alienation	.33	−.14
Life Satisfaction	.31	−.21
Self-Esteem	.42*	−.49**
Physical Function		
MD Visits	.49**	−.38*
Days in Bed	.30	−.16
Number of Medications	.06	−.05
Self-Rated Health	.55**	−.33
Number of Diagnoses	.28	−.12

*$p < .05$; **$p < .01$.
NOTE: Perceived stress is rated 0–9 (higher more), and social support is rated 0–9 (higher more). Higher scores on psychological variables are less favorable responses. Self-assessed health is rated 1–5 (higher worse).

The increase in utilization of health services in this study may be a result of the men being veterans and able to seek care through the Veterans Administration outpatient clinics. In this sense, the study may indicate what would happen if health services were available generally for the unemployed. There was a 40 per cent increase in patient volume and 60 per cent decrease in personal incomes of Michigan physicians engaged in primary care in areas most affected by unemployment.[39] The long-term effects of forcing people to put off or avoid visits to primary care physicians in order to pay mortage, utility, and food bills has not been studied. Frey[40] has pointed out that the forces of employment and poverty directly affect the functioning of the patient and the physician in the medical marketplace of private practice. He suggests that unemployment breeds a sort of economic "inverse care law" with the accessibility, quality, and available funds to purchase care being inversely proportional to the needs of the populations. He concluded that, in Britain, hard times produced additional work for physicians caring for patients suffering from physical and emotional consequences of poverty, but in the US, hard times produce doctors with nearly empty waiting rooms.

This study is limited by several factors: first, because of the small sample size, it was not possible to appropriately divide the unemployed group by reasons for unemployment to determine the effects of physical and psychological functioning. Liem and Rayman[41] pointed out the importance of determining the economic and social contexts of job loss in micro-level research; second, some of the men may have had jobs that were very stressful.[42] For them, unemployment could have brought some relief. However, both the preceding limitations are partially mitigated by the fact that the men were asked to rate the degree of perceived stress associated

with their unemployment status. A third limitation is that we do not know whether the psychological and physical declines observed in the unemployed group at the six-month rating period began to occur prior to their unemployment (perhaps in anticipation), immediately after losing work, or over a longer time interval, or whether the observed adverse reactions would be subject to adaptation even if unemployment continued beyond six months.

In summary, results suggest that unemployment produces adverse psychological symptoms and that utilization of health services, when they are available, are increased substantially. Some individuals may be able to cope better with the stress of unemployment than others. People with strong support systems and greater self-esteem seemed to experience less unemployment stress. Identifying those who are at high risk for psychological and physical problems and finding ways of preventing them from suffering the adverse effect of unemployment are important areas for further study.

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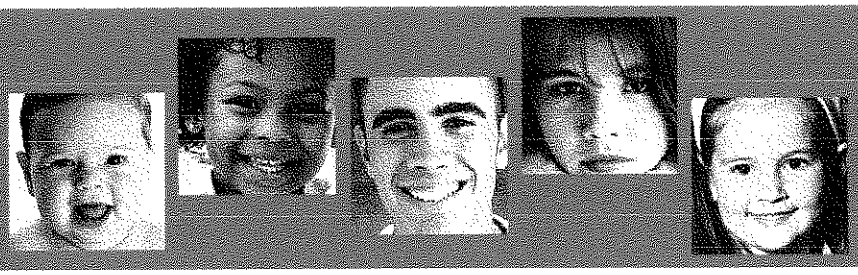
CONNECTICUT VOICES FOR CHILDREN



Poverty, Income, and Health Insurance in Connecticut Cities and Towns: Summary of 2008-2010 Data from the American Community Survey

November 2011

On October 27, 2011, the U.S. Census Bureau released new data on social and economic indicators for Connecticut cities and towns with populations greater than 20,000. Three-year estimates of household income, poverty and uninsurance status are important for understanding the state- and town-level effects of the recent recession.

Margins of error are included for each estimate. Because margins of error for towns can be wide, caution should be exercised in making comparisons between estimates. Additionally, note that these data do not represent a single point in time and may mask trends within the three year period. Arrows next to estimates indicate statistically significant changes in estimates between 2005-2007 and 2008-2010. Because this is the first period for which three-year health insurance coverage estimates are available, it was not possible to make comparisons over time for that indicator.

	Median Household Income*	All People in Poverty	All Children in Poverty**	All People Uninsured#	All Children Uninsured**#
Connecticut	**$67,067 ↓ ($66,547 - $67,587)**	**9.7% ↑ (9.5% - 9.9%)**	**12.8% ↑ (12.3% - 13.3%)**	**8.9% (8.7% - 9.1%)**	**3.8% (3.5% - 4.1%)**
Berlin	$80,702 ↓ ($75,760 - $85,644)	5.3% (3.3% - 7.3%)	10.0% (4.8% - 15.2%)	5.5% (3.6% - 7.4%)	7.1% (1.9% - 12.3%)
Bloomfield	$66,287 ↓ ($63,274 - $69,300)	10.2% ↑ (6.8% - 13.6%)	7.7% ↑ (3.0% - 12.4%)	6.3% (4.3% - 8.3%)	4.8% (1.5% - 8.1%)
Branford	$70,610 ($66,820 - $74,400)	7.3% (4.5% - 10.1%)	10.1% (3.0% - 17.2%)	6.3% (4.7% - 7.9%)	1.7% (0.2% - 3.2%)
Bridgeport	$39,637 ($37,233 - $42,041)	22.7% ↑ (20.8% - 24.6%)	30.2% (26.8% - 33.6%)	19.9% (18.5% - 21.3%)	7.2% (5.6% - 8.8%)
Bristol	$57,294 ($53,829 - $60,759)	8.5% (6.8% - 10.2%)	11.1% (7.2% - 15.0%)	10.1% (8.3% - 11.9%)	2.3% (1.0% - 3.6%)
Cheshire	$107,785 ($101,986 - $113,584)	2.8% (1.4% - 4.2%)	2.4% (0.0% - 5.5%)	3.1% (1.7% - 4.5%)	2.4% (0.0% - 5.1%)
Danbury	$62,541 ($59,033 - $66,049)	10.3% (8.3% - 12.3%)	11.3% ↑ (7.5% - 15.1%)	19.3% (17.3% - 21.3%)	10.7% (8.4% - 13.0%)
Darien	$174,663 ($145,730 - $203,596)	4.6% (1.6% - 7.6%)	5.0% (0.6% - 9.4%)	1.9% (0.9% - 2.9%)	0.2% (0.0% - 0.5%)
East Hartford	$48,887 ($45,435 - $52,339)	13.9% (11.2% - 16.6%)	21.0% (13.9% - 28.1%)	10.7% (8.8% - 12.6%)	4.0% (2.0% - 6.0%)
East Haven	$60,208 ($55,691 - $64,725)	9.1% (6.0% - 12.2%)	15.0% ↑ (8.1% - 21.9%)	7.6% (5.8% - 9.4%)	3.1% (0.7% - 5.5%)

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	Median Household Income*	All People in Poverty	All Children in Poverty**	All People Uninsured#	All Children Uninsured**#
Connecticut	**$67,067 ↓ ($66,547 - $67,587)**	**9.7% ↑ (9.5% - 9.9%)**	**12.8% ↑ (12.3% - 13.3%)**	**8.9% (8.7% - 9.1%)**	**3.8% (3.5% - 4.1%)**
Enfield	$65,472 ↓ ($62,814 - $68,130)	7.0% (4.9% - 9.1%)	8.8% (4.4% - 13.2%)	6.7% (5.0% - 8.4%)	4.9% (1.2% - 8.6%)
Fairfield	$117,178 ↑ ($111,719 - $122,637)	3.6% (2.6% - 4.6%)	3.4% (1.7% - 5.1%)	2.8% (2.1% - 3.5%)	1.6% (0.5% - 2.7%)
Farmington	$88,930 ($80,482 - $97,378)	4.5% (2.2% - 6.8%)	3.4% (0.1% - 6.7%)	3.0% (1.3% - 4.7%)	2.2% (0.0% - 5.6%)
Glastonbury	$103,532 ($96,578 - $110,486)	2.8% (1.7% - 3.9%)	1.6% (0.2% - 3.0%)	4.2% (3.1% - 5.3%)	0.2% (0.0% - 0.6%)
Greenwich	$125,533 ($118,443 - $132,623)	3.2% (2.3% - 4.1%)	2.3% (1.0% - 3.6%)	6.0% (4.7% - 7.3%)	2.5% (1.3% - 3.7%)
Groton	$59,647 ($55,493 - $63,801)	7.8% (5.5% - 10.1%)	11.7% (6.0% - 17.4%)	7.9% (6.1% - 9.7%)	5.4% (2.4% - 8.4%)
Guilford	$91,727 ($82,053 - $101,401)	3.8% (1.5% - 6.1%)	2.4% (0.0% - 5.0%)	3.3% (1.8% - 4.8%)	0.0% (0.0% - 1.2%)
Hamden	$66,300 ($60,401 - $72,199)	8.0% (6.2% - 9.8%)	7.7% (3.8% - 11.6%)	6.6% (5.1% - 8.1%)	2.2% (0.0% - 4.8%)
Hartford	$28,069 ($26,508 - $29,630)	32.0% (29.6% - 34.4%)	43.1% (38.7% - 47.5%)	16.3% (14.9% - 17.7%)	5.2% (3.6% - 6.8%)
Manchester	$61,731 ($58,176 - $65,286)	8.3% (6.2% - 10.4%)	12.9% (7.4% - 18.4%)	8.8% (7.5% - 10.1%)	3.1% (1.2% - 5.0%)
Mansfield	$62,198 ($54,197 - $70,199)	19.6% (13.7% - 25.5%)	18.8% (4.0% - 33.6%)	2.1% (1.2% - 3.0%)	0.6% (0.0% - 1.6%)
Meriden	$52,674 ($49,371 - $55,977)	15.1% (12.1% - 18.1%)	23.5% (17.3% - 29.7%)	10.3% (8.8% - 11.8%)	3.0% (1.1% - 4.9%)
Middletown	$55,570 ($51,816 - $59,324)	12.0% (9.7% - 14.3%)	12.4% (8.1% - 16.7%)	8.8% (7.1% - 10.5%)	5.0% (2.4% - 7.6%)
Milford	$77,170 ($73,822 - $80,518)	4.4% (3.3% - 5.5%)	5.9% (3.6% - 8.2%)	6.1% (4.9% - 7.3%)	3.7% (1.3% - 6.1%)
Naugatuck	$60,186 ($56,660 - $63,712)	9.5% (6.9% - 12.1%)	13.3% (6.3% - 20.3%)	9.3% (7.1% - 11.5%)	3.6% (0.0% - 7.4%)
New Britain	$39,423 ($37,191 - $41,655)	21.2% (18.6% - 23.8%)	31.0% (25.7% - 36.3%)	12.8% (11.3% - 14.3%)	4.4% (1.9% - 6.9%)
New Canaan†	$185,432 ($152,887 - $217,977)	2.3% (1.0% - 3.6%)	0.8% (0.0% - 2.0%)	1.0% (0.5% - 1.5%)	0.4% (0.0% - 1.0%)
New Haven	$38,585 ($36,258 - $40,912)	26.7% (24.8% - 28.6%)	35.6% (32.4% - 38.8%)	13.5% (12.1% - 14.9%)	6.2% (3.7% - 8.7%)
New London	$44,510 ($39,997 - $49,023)	19.7% (15.3% - 24.1%)	28.6% (18.5% - 38.7%)	15.4% (12.5% - 18.3%)	7.6% (1.6% - 13.6%)
New Milford	$81,348 ↓ ($76,402 - $86,294)	4.1% (2.4% - 5.8%)	4.0% (1.4% - 6.6%)	6.7% (5.0% - 8.4%)	1.0% (0.0% - 2.1%)
Newington	$69,385 ($64,640 - $74,130)	5.1% (2.9% - 7.3%)	6.0% (1.8% - 10.2%)	4.7% (3.3% - 6.1%)	0.5% (0.0% - 1.0%)

	Median Household Income*	All People in Poverty	All Children in Poverty**	All People Uninsured#	All Children Uninsured**#
Connecticut	**$67,067 ↓ ($66,547 - $67,587)**	**9.7% ↑ (9.5% - 9.9%)**	**12.8% ↑ (12.3% - 13.3%)**	**8.9% (8.7% - 9.1%)**	**3.8% (3.5% - 4.1%)**
Newtown	$108,581 ($103,086 - $114,076)	3.0% (1.8% - 4.2%)	2.2% (0.2% - 4.2%)	3.8% (1.9% - 5.7%)	4.7% (1.2% - 8.2%)
North Haven	$83,622 ($77,824 - $89,420)	2.7% (1.5% - 3.9%)	2.1% (0.0% - 4.2%)	5.8% (3.9% - 7.7%)	2.6% (0.0% - 5.2%)
Norwalk	$74,229 ($69,536 - $78,922)	10.4% ↑ (8.4% - 12.4%)	15.0% ↑ (10.8% - 19.2%)	12.3% (10.2% - 14.4%)	6.2% (3.7% - 8.7%)
Norwich	$52,075 ($48,953 - $55,197)	15.5% (12.6% - 18.4%)	23.4% (17.1% - 29.7%)	10.6% (8.4% - 12.8%)	5.7% (2.9% - 8.5%)
Ridgefield	$130,134 ($112,778 - $147,490)	1.8% (1.1% - 2.5%)	1.0% (0.1% - 1.9%)	3.7% (2.5% - 4.9%)	1.3% (0.2% - 2.4%)
Shelton	$77,998 ($72,226 - $83,770)	4.8%↑ (3.3% - 6.3%)	5.1% (1.4% - 8.8%)	7.3% (5.0% - 9.6%)	5.0% (0.8% - 9.2%)
Simsbury	$113,068 ($105,175 - $120,961)	2.1% (1.0% - 3.2%)	1.3% (0.0% - 3.4%)	2.3% (1.4% - 3.2%)	1.0% (0.1% - 1.9%)
South Windsor	$88,768 ($80,525 - $97,011)	2.7% (1.2% - 4.2%)	1.9% (0.0% - 4.8%)	4.3% (2.3% - 6.3%)	2.7% (0.0% - 5.6%)
Southington	$79,488 ($75,350 - $83,626)	3.4% (2.2% - 4.6%)	4.3% (1.9% - 6.7%)	5.6% (4.0% - 7.2%)	2.1% (0.0% - 4.4%)
Stamford	$73,965 ($70,894 - $77,036)	12.8% ↑ (11.0% - 14.6%)	14.9% ↑ (11.2% - 18.6%)	20.9% (19.1% - 22.7%)	9.3% (6.5% - 12.1%)
Stratford	$66,824 ($63,514 - $70,134)	5.4% (3.8% - 7.0%)	5.5% (2.9% - 8.1%)	11.3% (9.1% - 13.5%)	7.1% (4.0% - 10.2%)
Torrington	$47,958 ($44,511 - $51,405)	10.8% (8.1% - 13.5%)	14.2% (9.1% - 19.3%)	7.4% (5.6% - 9.2%)	2.0% (0.5% - 3.5%)
Trumbull	$102,413 ($97,127 - $107,699)	2.5% (1.5% - 3.5%)	2.6% (0.7% - 4.5%)	4.6% (3.5% - 5.7%)	1.8% (0.6% - 3.0%)
Vernon	$66,627 ($61,161 - $72,093)	6.4% (4.3% - 8.5%)	9.8% (5.0% - 14.6%)	5.6% (4.2% - 7.0%)	0.0% (0.0% - 1.1%)
Wallingford	$72,736 ($66,902 - $78,570)	6.7% (4.8% - 8.6%)	7.3% (3.6% - 11.0%)	7.6% (5.7% - 9.5%)	1.6% (0.5% - 2.7%)
Waterbury	$38,636 ($35,147 - $42,125)	21.8% (19.6% - 24.0%)	32.6% (27.8% - 37.4%)	11.5% (10.1% - 12.9%)	5.8% (3.8% - 7.8%)
Watertown	$76,605 ($70,565 - $82,645)	3.0% (1.8% - 4.2%)	1.9% (0.0% - 4.1%)	6.9% (4.7% - 9.1%)	6.7% (2.6% - 10.8%)
West Hartford	$77,156 ↓ ($73,487 - $80,825)	7.0% (5.3% - 8.7%)	6.8% (3.5% - 10.1%)	5.6% (4.5% - 6.7%)	2.9% (1.5% - 4.3%)
West Haven	$51,220 ↓ ($49,077 - $53,363)	9.9% (7.5% - 12.3%)	11.4% (6.4% - 16.4%)	10.9% (9.5% - 12.3%)	2.9% (1.3% - 4.5%)
Westport	$142,800 ($121,765 - $163,835)	3.6% (2.1% - 5.1%)	3.9% (1.1% - 6.7%)	3.3% (2.0% - 4.6%)	0.2% (0.0% - 0.5%)
Wethersfield	$72,765 ($67,914 - $77,616)	5.9% ↑ (4.0% - 7.8%)	7.7% ↑ (3.3% - 12.1%)	5.8% (4.2% - 7.4%)	3.3% (0.2% - 6.4%)

	Median Household Income*	All People in Poverty	All Children in Poverty**	All People Uninsured#	All Children Uninsured**#
Connecticut	**$67,067 ↓ ($66,547 - $67,587)**	**9.7% ↑ (9.5% - 9.9%)**	**12.8% ↑ (12.3% - 13.3%)**	**8.9% (8.7% - 9.1%)**	**3.8% (3.5% - 4.1%)**
Windham	$38,432 ($33,822 - $43,042)	24.5% ↑ (19.9% - 29.1%)	36.5% (27.9% - 45.1%)	14.2% (10.7% - 17.7%)	7.3% (0.8% - 13.8%)
Windsor	$76,250 ($72,000 - $80,500)	3.1% (1.7% - 4.5%)	3.3% (0.5% - 6.1%)	5.6% (3.9% - 7.3%)	3.6% (0.8% - 6.4%)

Data from the U.S. Census American Community Survey (ACS) 2008-2010 three-year estimates. Three-year estimates are available only for cities and towns with populations greater than 20,000.

↓ Indicates a statistically significant decrease from 2005-2007 for this town

↑ Indicates a statistically significant increase from 2005-2007 for this town

* Median household income estimates are in 2010 (inflation-adjusted) dollars.

** Children are under 18 years of age.

Because this is the first period for which three-year health insurance coverage estimates are available, it is not possible to make comparisons over time.

† Comparisons over time were not made, as there were no three-year estimates for New Canaan in 2005-2007.

Median household income: Changes from 2005-2007 ACS Estimates

After adjusting for inflation, the statewide median household income in 2010 dollars decreased from $68,880 in 2005-2007 to $67,067 in 2008-2010. Below are the towns that experienced statistically significant changes in inflation-adjusted income estimates over this time period. There were no statistically significant changes in other towns.

Towns with increase in median household income

(margins of error included for each estimate)

	2005-2007 (2010 dollars)	2008-2010 (2010 dollars)
Fairfield	$108,693 ($103,222-$114,163)	$117,178 ($111,719 - $122,637)

Towns with decrease in median household income

(margins of error included for each estimate)

	2005-2007 (2010 dollars)	2008-2010 (2010 dollars)
Berlin	$92,395 ($85,992-$98,797)	$80,702 ($75,760 - $85,644)
Bloomfield	$71,492 ($67,760 - $75,223)	$66,287 ($63,274 - $69,300)
Enfield	$72,944 ($69,010 - $76,878)	$65,472 ($62,814 - $68,130)
New Milford	$92,721 ($86,607 - $98,834)	$81,348 ($76,402 - $86,294)
West Hartford	$83,548 ($79,789 - $87,307)	$77,156 ($73,487 - $80,825)
West Haven	$55,176 ($52,107 - $58,245)	$51,220 ($49,077 - $53,363)

All income estimates are reported in 2010 (inflation-adjusted) dollars. Median income figures from ACS 2005-2007 have been adjusted to 2010 dollars by multiplying by the CPI-U-RS adjustment factor, as advised by the Census Bureau. Note that this is a nationwide measure of inflation and does not account for regional differences in the rate of inflation.

All People in Poverty: Changes from 2005-2007 ACS Estimates

The percent of all Connecticut residents in poverty increased from 8.2% in 2005-2007 to 9.7% in 2008-2010. Below are the towns that experienced statistically significant changes in poverty estimates over this time period. There were no statistically significant changes in other towns.

Towns with Increase in All People in Poverty
(margins of error included for each estimate)

	2005-2007	2008-2010
Bloomfield	2.6% (1.7% - 3.5%)	10.2% (6.8% - 13.6%)
Bridgeport	19.2% (17.3% - 21.1%)	22.7% (20.8% - 24.6%)
Norwalk	6.3% (4.9% - 7.7%)	10.4% (8.4% - 12.4%)
Shelton	2.8% (1.8% - 3.8%)	4.8% (3.3% - 6.3%)
Stamford	8.3% (6.9% - 9.7%)	12.8% (11.0% - 14.6%)
Wethersfield	2.1% (1.3% - 2.9%)	5.9% (4.0% - 7.8%)
Windham	17.5% (14.5% - 20.5%)	24.5% (19.9% - 29.1%)

All Children Under 18 in Poverty: Changes from 2005-2007 ACS Estimates

The percent of children under 18 statewide in poverty increased from 11.2% in ACS 2005-2007 to 12.8% in ACS 2008-2010. Below are the towns that experienced statistically significant changes in estimates of poverty among children over this time period. There were no statistically significant changes in other towns.

Towns with Increase in All Children in Poverty:
(margins of error included for each estimate)

	2005-2007	2008-2010
Bloomfield	0.0% (0.0% - 1.5%)	7.7% (3.0% - 12.4%)
Danbury	6.0% (2.8% - 9.2%)	11.3% (7.5% - 15.1%)
East Haven	6.1% (0.9% - 11.3%)	15.0% (8.1% - 21.9%)
Norwalk	9.2% (5.9% - 12.5%)	15.0% (10.8% - 19.2%)
Stamford	9.4% (6.5% - 12.3%)	14.9% (11.2% - 18.6%)
Wethersfield	1.7% (0.1% - 3.3%)	7.7% (3.3% - 12.1%)

Technical Notes on the Data

Data Source. The United States Census Bureau released 2008-2010 three-year estimates from the American Community Survey (ACS) on October 27, 2011. Three-year estimates are available only for cities and towns with populations greater than 20,000. These data are based on a rolling sample collected between January 2008 and December 2010. Consequently, these data do not represent a specific point in time and may mask trends within the five year period. For more information, refer to the ACS Handbooks for Data Users, available online at http://www.census.gov/acs/www/guidance_for_data_users/handbooks/.

Comparing Data Over Time or Between Geographic Areas. The numbers reported in ACS surveys are estimates because only a sample of the entire population is surveyed. For this reason, estimates reported by the ACS are published with additional data that allow us to estimate the range of values within which the population's actual poverty or uninsured rate is likely to fall. This enables us to determine whether or not the change in an estimate from one time period to the next or between two geographic areas is large enough to conclude that an actual difference in the population exists, or whether the change in the estimate may have been due to random chance. For example, in the field of opinion polling, the "margin of error" of a poll helps to assess whether there has been a significant change in polling results over time. **A change in Census estimates is called "statistically significant" if it is unlikely to have occurred by chance** (this term describes the statistical evidence of change, not whether it is important or meaningful). **Unless a difference in Census estimates is statistically significant, it is not accurate to say, for example, that poverty rates have increased or declined over time.**

Margins of Error. The numbers reported in ACS surveys are estimates because only a sample of the entire population is surveyed. The margin of error estimates the range of values within which the population's actual poverty rate, median income, etc. is likely to fall. For example, there is a 90% probability that the actual percentage of children in poverty in Torrington is between 9.1% and 19.3% (14.2% with a margin of error of +/- 5.1%). Because margins of error around town estimates can be wide, comparisons between estimates for towns should be made with caution.

State of Connecticut
GENERAL ASSEMBLY

Commission on Children

Child Poverty in Connecticut: January 2009

GREAT WEALTH, PERSISTENT POVERTY

Despite Connecticut's great wealth, one in ten children lives in poverty.

Connecticut is one of the wealthiest states in the nation, which compounded with its highly skilled workforce, makes the cost of living very high.[1] The state was one of three states in the nation with the highest median household income in 2007.[2]

Child poverty in Connecticut has not improved in recent years, according to the U.S. Census Bureau:

- In 2007, 10.6% of Connecticut children under 18 (85,530 children) lived in a family with income below the Federal Poverty Level ($21.027 for a two-parent family with two children). This data from the U.S. Census Bureau's American Community Survey (ACS) represents no improvement from the 2004 level (10.1%).[3]

- One in four (25.1%) Connecticut children lived in a household with income below 200% of the Federal Poverty Level in 2007.[4]

Poverty in Connecticut is concentrated in urban areas.

Children living in poverty are unevenly distributed across Connecticut's 169 towns. While 38 towns had child poverty rates of less than 2% in the 2000 Census, seven towns had a rate above 23%, led by Hartford.[5]

In 2007, the state's largest cities had extremely high child poverty rates -- Hartford (47.0%), Waterbury (31.4%), New Haven (28.7%) and Bridgeport (28.4%).[6]

Most low-income families are working families.

Three-quarters (76%) of Connecticut's poor families with a parent able to work have a parent in the workforce (2003 data). Employment is not adequate to lift these working families out of poverty.[7] In 2007, 19.1% of Connecticut workers did not earn enough to generate an income that meets the federal poverty threshold for a family of four, the highest rate since 1998.[8]

THE TWO CONNECTICUTS

The gap between high-wage and low-wage workers is growing.

From 1989 to 2007, the ratio of Connecticut workers' wages at the 90th percentile to the wages of workers at the 10th percentile rose from three and a half times to almost five times. This gap is

the seventh highest in the country, and contributes to much wider gaps in total income and wealth.[9]

Minority children are more likely to live in poverty.
In 2005, Latino/Hispanic and African American children in Connecticut were seven times more likely to live in poverty than white, non-Hispanic youth.[10]

Poor children start from behind because they lack access to good preschools.
Children growing up poor in Connecticut perform on educational tests at a much lower level than do higher-income children. The 2007 Nation's Report Card indicates that Connecticut has some of the largest achievement gaps in the nation between students from low- and high-income families. In reading, less than one in seven (13%) of Connecticut's low-income fourth grade students met the proficiency standard, compared with 53% of children from higher-income families.[11]

An estimated 8,700 children in Connecticut's lowest-income school districts (Priority School Districts) are in need of a quality preschool program.[12]

The lack of quality early education can have a significant impact on children's readiness for school and their potential for lifelong educational and work success. In a survey of kindergarten teachers in low-income school districts in Connecticut:[13]

- 75% of children who did not attend preschool arrived at kindergarten lacking basic language and literacy skills such as being able to use complete sentences, to respond when spoken to, to identify their name in print, or to recognize the first ten letters of the alphabet;

- 70% of children who did not attend preschool were unable to perform basic math tasks such as recognizing numbers, counting to ten or drawing basic shapes; and

- 65% of the teachers identified specific health problems such as asthma, skin rashes, ringworm and lack of physical exams. Nearly one-fifth of the teachers observed children who come to school hungry, tired and unkempt.

ECONOMIC, WORKFORCE COSTS OF POVERTY

Lost future productivity from poverty: a half-trillion-dollar loss for the nation.
The costs to the United States associated with child poverty total about $500 billion per year in foregone earnings and productivity, high crime rates and poor health associated with adults who grew up in poor households, according to a 2007 analysis by researchers from Georgetown University, the University of Chicago and Northwestern University. The nation could raise its overall consumption of goods and services and its quality of life by a half trillion dollars a year if childhood poverty were eliminated.[14]

Each year that a child spends in poverty results in a cost of $11,800 in lost future productivity over his or her working life. The United States labor force will lose an estimated $137 billion in future economic output for every year that more than 12 million poor children grow up to be less productive and effective workers.[15]

Since 85,530 (10.6%) of Connecticut's children live in poverty, the Connecticut labor force is projected to lose over $1 billion in future productive capacity for every year that this number of Connecticut children live in poverty. [16]

Widespread illiteracy hurts business community

The inability of young people to read as they move into adulthood has a negative fiscal impact on businesses. In 2003, more than 240,000 adults in Connecticut – or 9 percent of those 16 and older – lacked even basic reading skills.[17]

Approximately 300,000 Greater Hartford area adults, or roughly 41% of the adult population, are functioning below the literacy level required to earn a living wage.[18] Over $60 billion nationally is lost in productivity each year by American businesses due to employees' lack of basic skills.[19]

January 15, 2009

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[1] Connecticut Child Poverty Council. (2005, Jan.) *Initial plan.* Hartford, CT: Connecticut Office of Policy and Management.

[2] Bishaw, A., & Semega, J. (2008, Aug.). *Income, Earnings, and Poverty Data From the 2007 American Community Survey*, 4. U.S. Census Bureau, American Community Survey Reports, ACS-08. Washington, DC: U.S. Government Printing Office. Online at http://www.census.gov/prod/2007pubs/acs-08.pdf.

[3] U.S. Census Bureau, American Community Survey. Tables C17006 (2007) and B17006 (2007). Table B17006 (2004). Downloaded from www.census.gov (Jan. 9, 2009); DeNavas-Walt, C., Proctor, B.D., & Smith, J. (2008). *Income, Poverty, and Health Insurance Coverage in the United States: 2007*, 45. U.S. Census Bureau., Current Population Reports, P60-235. Washington, DC: U.S. Government Printing Office. Downloaded from http://www.census.gov/prod/2008pubs/p60-235.pdf (Jan. 9, 2009). The U.S. Census Bureau's American Community Survey (ACS) provides a larger sample size than the U.S. Census Bureau's Current Population Survey (CPS) (see U.S. Census Bureau. (2007, Aug. 28). *Differences between the* Income and Poverty *Estimates from the American Community Survey and the Annual Social and Economic Supplement to the Current Population Survey*, Washington, DC: U.S. Government Printing Office, online at: http://www.census.gov/hhes/www/poverty/factsheet.html .

[4] U.S. Census Bureau, 2007 American Community Survey. Reported by Kids Count, Annie E. Casey Foundation. Downloaded from www.kidscount.org/datacenter/compare_results.jsp?i=220&yr=2007&va=&rt=3&s=a (Jan. 9, 2009).

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[6] *Poverty, income & health insurance in Connecticut: summary of 2007 U.S. census data.* (2008, Aug. 26). New Haven: Connecticut Voices for Children. Online at http://www.ctkidslink.org/publications/2008censusreleaseandcs.pdf.

[7] Hall, D.J., & Geballe, S. (2005, Sept.) *The state of working Connecticut, 2005*, VI-1. New Haven: Connecticut Voices for Children.

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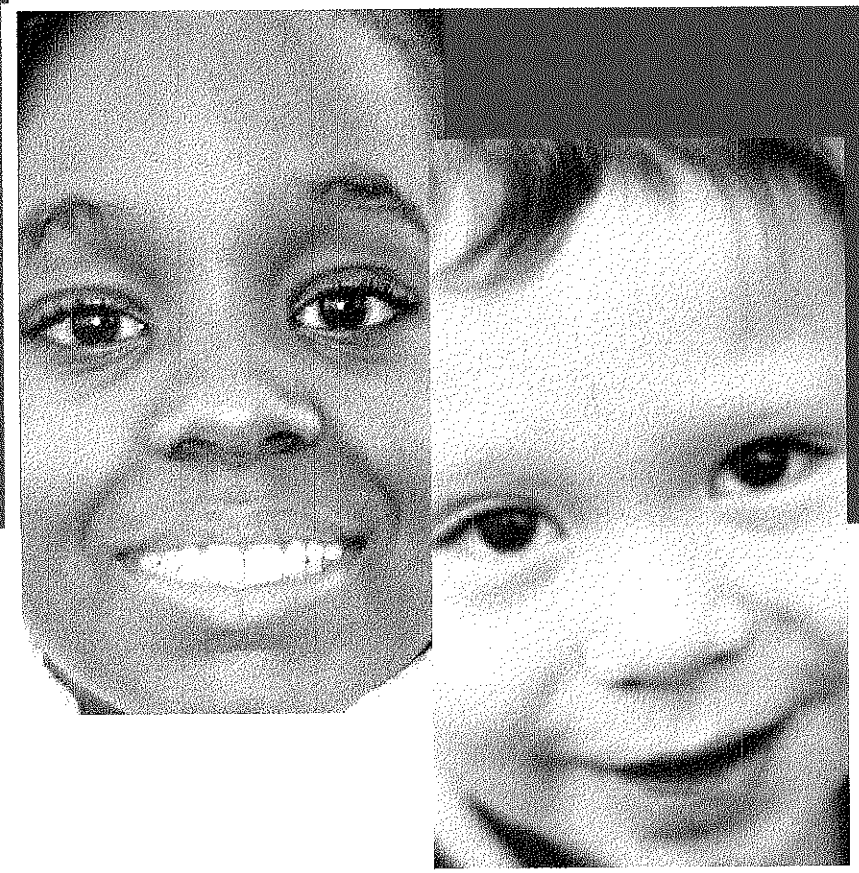
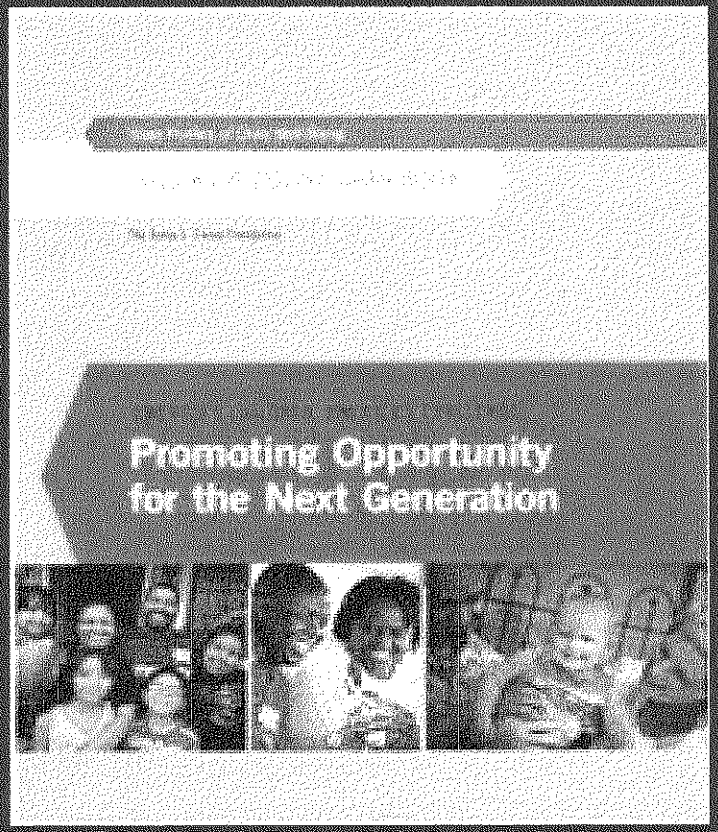


CAHS

Connecticut Association for Human Services

National KIDS COUNT Project

- Project of the Annie E. Casey Foundation
- Provides data on the well-being of children and families
- To educate the public and inform policy discussions
- 2011 Data Book focuses on impact of recession on children



National KIDS COUNT Data Center

- The Casey Foundation developed the KIDS COUNT Data Center in 2009
- National, state, and local data on child well-being
- CAHS updates with state and local data for Connecticut

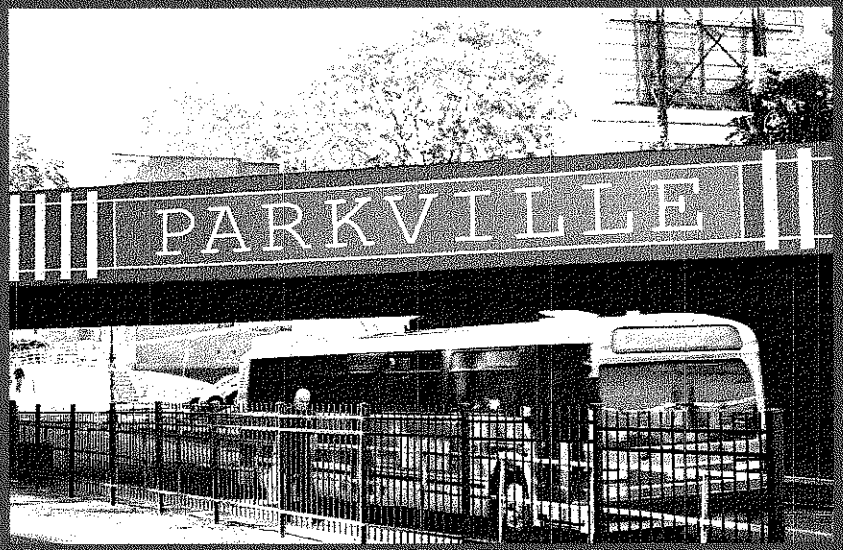
www.datacenter.kidscount.org

Connecticut KIDS COUNT Project

- Project of CAHS, funded by the Casey Foundation
- Biennial data books with state, county, and **town-level** data on child and family well-being
- Data book essays, policy briefs, and special reports
- 2010 Connecticut Data Book focuses on impacts of recession

www.cahs.org/kidscount/asp

Going Beyond State-Level Data



Two Views of Child Poverty

National

- 12% statewide child poverty rate
- CT ranks 2nd best among 50 states
- Rate increased by 9% (from 11% to 12%) between 2000 and 2009

Connecticut

Child poverty rate:

- 27.6% Bridgeport
- 42.8% Hartford
- 31.8% New Haven
- 5% non-Hispanic White
- 25% Black or African American
- 31% Hispanic or Latino

Two Views of Teen Births

National

- CT's teen birth rate was 23 per 1,000 teens in 2008, well below the national rate of 41/1000
- CT ranks 4th best among the 50 states
- Rate decreased by 26% between 2000 and 2008

Connecticut

Teen birth rate:

- 38 per 1,000 Bridgeport
- 47 per 1,000 Hartford
- 44 per 1,000 New Haven
- 10 per 1,000 for Whites
- 44 per 1,000 for non-Hispanic Blacks
- 77 per 1,000 for Hispanics

Effects of Recession on Children and Families

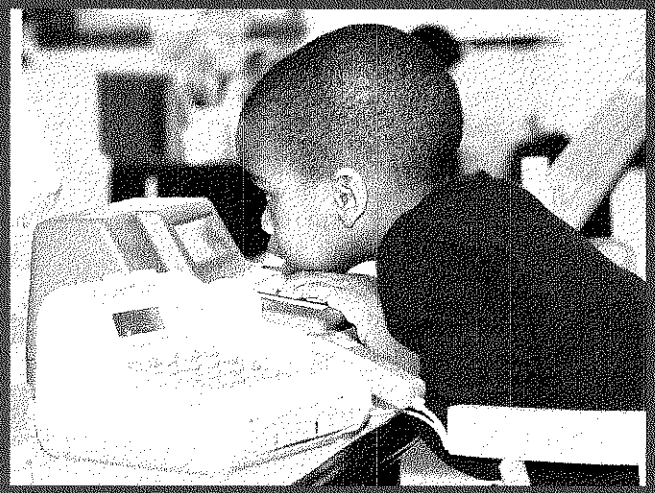
- 79,000 CT children have at least one parent who was unemployed in 2010
- 46,000 CT children have been affected by foreclosure since 2007
- Poor children have worse adult outcomes than those in high-income families

Good News

Since 2000, CT experienced lower rates of:

- Teen births (ranked 4th)
- Child deaths (ranked 3rd)
- Teen deaths (ranked 7th)
- Teen dropouts (ranked 3rd)

Troubling News



Since 2000, CT experienced increased:

- Child poverty (ranked 2nd)
- Percent of children in single-parent families (ranked 12th)
- Percent of low-birth weight babies (ranked 21st)

CT's infant mortality rate remained the same (ranked 22nd)

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What Do We Take Away?

- CT ranks well overall for child well-being
- Some indicators were worsening even before the full impact of the recession
- Indicators are far worse in big cities and for kids of color
- Public policies can improve indicators for children and families

Data Across States

Children in poverty (Percent) - 2009

Data Provided by: National KIDS COUNT Program

Scale: 8% - 59%

Rank			
	United States	20%	
1	San Juan, PR	59%	
2	Detroit, MI	51%	
2	Cleveland, OH	51%	
4	St. Louis, MO	42%	
5	Memphis, TN	40%	
6	Milwaukee, WI	39%	
6	Hartford, CT	39%	
8	Miami, FL	37%	
9	New Orleans, LA	35%	
9	Dallas, TX	35%	
11	Columbus, OH	33%	
11	Philadelphia, PA	33%	
13	Minneapolis, MN	32%	
13	Houston, TX	32%	
13	El Paso, TX	32%	
16	Atlanta, GA	31%	
16	Phoenix, AZ	31%	
16	New Haven, CT	31%	
16	Chicago, IL	31%	
16	Tucson, AZ	31%	
16	Fresno, CA	31%	
22	Baltimore, MD	30%	
22	Denver, CO	30%	
22	Indianapolis, IN	30%	
22	Tulsa, OK	30%	
26	District of Columbia	29%	
26	Los Angeles, CA	29%	
26	Fort Worth, TX	29%	
29	Nashville-Davidson, TN	28%	
29	San Antonio, TX	28%	
31	Providence, RI	27%	
31	Austin, TX	27%	
31	Long Beach, CA	27%	
31	Des Moines, IA	27%	
31	New York, NY	27%	
31	Sacramento, CA	27%	
37	Oakland, CA	26%	
37	Louisville, KY	26%	
37	Oklahoma City, OK	26%	

NATIONAL KIDS COUNT PROGRAM

KIDS COUNT
The Annie E. Casey Foundation
701 St. Paul Street
Baltimore, MD 21202

ph: 410-547-6600
fax: 410-547-6624
http://www.kidscount.org

RELATED RESOURCES

Related Links
KIDS COUNT Indicator Brief: Reducing the Child Poverty Rate
Casey Knowledge Center: Economic Security
Get more poverty information from the Child Trends Data Bank

Related Data
View Poverty indicators in "Data Across States".

KIDS COUNT Census Data Online
View 2000 KIDS COUNT Census data, covering hundreds of indicators for thousands of geographic areas.

40	Kansas City, MO	25%	
41	Jacksonville, FL	23%	
41	Albuquerque, NM	23%	
41	Arlington, TX	23%	
44	Boston, MA	22%	
44	Charlotte, NC	22%	
46	Wichita, KS	21%	
46	Portland, OR	21%	
48	Raleigh, NC	20%	
48	Omaha, NE	20%	
48	Las Vegas, NV	20%	
51	San Diego, CA	19%	
51	Mesa, AZ	19%	
53	Colorado Springs, CO	16%	
54	San Jose, CA	15%	
55	San Francisco, CA	12%	
55	Honolulu, HI	12%	
57	Virginia Beach, VA	10%	
58	Seattle, WA	8%	

Definitions: The share of children under age 18 who live in families with incomes below the federal poverty level.

The federal poverty definition consists of a series of thresholds based on family size and composition. In calendar year 2010, a family of two adults and two children fell in the "poverty" category if their annual income fell below $22,113. Poverty status is not determined for people in military barracks, institutional quarters, or for unrelated individuals under age 15 (such as foster children). The data are based on income received in the 12 months prior to the survey.
More...

Data Source: Population Reference Bureau, analysis of data from the U.S. Census Bureau, Census 2000 Supplementary Survey, 2001 Supplementary Survey, 2002 through 2010 American Community Survey.

The data for this measure come from the 2000 and 2001 Supplementary Survey and the 2002 through 2010 American Community Survey (ACS). The 2000 through 2004 ACS surveyed approximately 700,000 households monthly during each calendar year. In general but particularly for these years, use caution when interpreting estimates for less populous states or indicators representing small sub-populations, where the sample size is relatively small. Beginning in January 2005, the U.S. Census Bureau expanded the ACS sample to 3 million households (full implementation), and in January 2006 the ACS included group quarters. The ACS, fully implemented, is designed to provide annually updated social, economic, and housing data for states and communities. (Such local-area data have traditionally been collected once every ten years in the long form of the decennial census.)
More...

Footnotes: Updated September 2011.
S - Estimates suppressed when the confidence interval around the percentage is greater than or equal to 10 percentage points. N.A. – Data not available.
Data is provided for the 50 most populous cities according to the most recent Census counts. Cities for which data is collected may change over time.
A 90 percent confidence interval for each estimate can be found at Children in poverty.

Note: The District of Columbia, Puerto Rico and the U.S. Virgin Islands are not included in maps and rankings because they are not states and therefore comparisons on many indicators of child well being are not meaningful.

There are more poor White, non-Hispanic children than Black children. However, Hispanic and Black children are about three times as likely to live in poverty than White, non-Hispanic children. Children who live in inner cities, rural areas, in the South or in female-headed families are more likely to be poor. Children under age six are more likely to be poor than school-age children. Poverty and race are the primary factors underpinning the pipeline to prison. In fact, Black juveniles are about four times as likely as their White peers to end up being incarcerated.

Poor Children in America: A Portrait

	Number Poor (thousands) 2007	Percent Poor 2007	Percent Poor 1973
All persons younger than 18	13,324	18.0%	14.4%
White[1]	8,771	15.0	n/a
Black[1]	4,178	33.7	n/a
Asian and Pacific Islander[1]	431	11.9	n/a
Hispanic (may be any race)[2]	4,482	28.6	n/a
Non-Hispanic White[2]	4,255	10.1	n/a
South	5,728	20.8	19.7
All other regions	7,596	16.4	11.6
Central city	5,961	24.9	20.4
Suburb	4,797	12.5	7.8
Rural (nonmetropolitan)	2,566	22.3	16.6
Related to head of household	12,843	17.6	14.2
White[1]	8,388	14.5	9.7
Black[1]	4,121	33.6	40.6
Asian and Pacific Islander[1]	404	11.3	n/a
Hispanic (may be any race)[2]	4,360	28.2	27.8
Non-Hispanic White[2]	4,005	9.7	n/a
In female-headed family	7,567	42.9	52.1
All other family types	5,276	9.5	7.6
Any family member works	9,096	13.3	n/a
Full-time year round	4,405	7.6	n/a
Head of family works	7,269	12.2	8.7
Full-time year round	3,152	7.2	4.1
Under age 6	5,101	20.8	15.7
Ages 6-17	7,701	15.9	13.6
Comparison: Adults 18-64	20,396	10.9	8.3
Seniors 65+	3,556	9.7	16.3

[1]Starting with poverty data for 2002, the Census Bureau permits persons to choose more than one race; racial groups shown here may overlap.

[2]Persons of Hispanic origin may be of any race. White non-Hispanic means White alone (no other race) and not of Hispanic origin

n/a — Not available

Source: U.S. Department of Commerce, Bureau of the Census, Current Population Survey, 2008 Annual Social and Economic Supplement and 1974 March Supplement. Calculations by Children's Defense Fund.

Almost 1 in 13 children in the United States—5.8 million—lives in extreme poverty. A family of four is extremely poor in 2008 if their household income is below $10,600, or half of the official poverty line. Young children are more likely than school-age children to live in extreme poverty.

Extreme Poverty Among Children: 2007

	Number in Extreme Poverty			Percent in Extreme Poverty		
	Under age 18	Under age 6	Ages 6-17	Under age 18	Under age 6	Ages 6-17
Alabama	124,561	49,125	75,436	11.3%	13.6%	10.1%
Alaska	7,851	2,849	5,002	4.4	4.7	4.3
Arizona	152,505	62,627	89,878	9.3	10.8	8.5
Arkansas	68,749	26,249	42,500	10.0	11.4	9.3
California	611,166	226,858	384,308	6.6	7.3	6.3
Colorado	89,519	34,731	54,788	7.6	8.5	7.2
Connecticut	42,695	16,409	26,286	5.3	6.6	4.7
Delaware	13,095	6,307	6,788	6.5	9.1	5.2
District of Columbia	13,570	5,709	7,861	12.0	13.5	11.2
Florida	276,783	116,018	160,765	7.0	8.8	6.1
Georgia	225,591	91,191	134,400	9.1	10.7	8.2
Hawaii	13,181	4,981	8,200	4.7	4.9	4.5
Idaho	24,241	9,095	15,146	6.0	6.6	5.8
Illinois	237,261	89,009	148,252	7.5	8.5	7.0
Indiana	129,755	53,767	75,988	8.4	10.5	7.3
Iowa	40,368	17,378	22,990	5.8	7.6	4.9
Kansas	42,816	17,769	25,047	6.3	7.8	5.5
Kentucky	106,618	44,766	61,852	10.9	13.7	9.4
Louisiana	124,373	49,697	74,676	11.7	14.1	10.6
Maine	17,779	6,660	11,119	6.5	8.1	5.8
Maryland	67,101	26,164	40,937	5.0	5.9	4.6
Massachusetts	86,554	31,645	54,909	6.1	7.1	5.7
Michigan	229,186	86,829	142,357	9.5	11.6	8.6
Minnesota	62,080	25,551	36,529	5.0	6.2	4.4
Mississippi	107,094	42,197	64,897	14.2	16.7	13.0
Missouri	114,660	49,206	65,454	8.2	10.8	6.9
Montana	15,422	6,579	8,843	7.1	9.4	6.0
Nebraska	30,498	12,952	17,546	7.0	8.6	6.1
Nevada	41,019	15,384	25,635	6.3	6.8	6.0
New Hampshire	11,715	4,334	7,381	4.0	4.9	3.6
New Jersey	110,410	42,397	68,013	5.4	6.5	4.9
New Mexico	54,113	22,083	32,030	11.1	13.5	9.9
New York	398,964	148,434	250,530	9.2	10.5	8.5
North Carolina	183,076	74,379	108,697	8.4	10.1	7.5
North Dakota	8,895	3,865	5,030	6.3	8.1	5.4
Ohio	244,966	99,280	145,686	9.1	11.4	7.9
Oklahoma	88,407	38,097	50,310	10.0	12.5	8.7
Oregon	60,920	21,515	39,405	7.2	7.8	6.9
Pennsylvania	209,545	82,521	127,024	7.6	9.6	6.8
Rhode Island	17,697	6,706	10,991	7.6	9.0	7.0
South Carolina	103,398	44,423	58,975	9.9	12.9	8.4
South Dakota	16,166	7,473	8,693	8.4	11.4	6.8
Tennessee	148,229	61,609	86,620	10.3	13.1	8.9
Texas	644,798	267,726	377,072	9.9	11.6	9.0
Utah	28,176	11,076	17,100	3.5	3.8	3.3
Vermont	5,888	2,406	3,482	4.6	6.3	3.9
Virginia	97,487	38,622	58,865	5.4	6.5	4.9
Washington	104,261	40,675	63,586	6.9	8.2	6.3
West Virginia	40,505	16,743	23,762	10.7	13.9	9.2
Wisconsin	75,959	29,904	46,055	5.9	7.1	5.2
Wyoming	6,314	2,811	3,503	5.1	6.8	4.3
United States	5,775,980	2,294,781	3,481,199	7.9	9.5	7.2

Source: U.S. Department of Commerce, Bureau of the Census, 2007 American Community Survey, Table B17024.
Calculations by Children's Defense Fund.

BRIDGING TOUGH TIMES FOR CONNECTICUT'S FAMILIES

2010 Connecticut KIDS COUNT Data Book

CAHS 100 years
Connecticut Association for Human Services

kids count

Substantiated Abuse and Neglect

Connecticut's rate of substantiated child abuse and neglect declined from SFY 2006 to SFY 2008, but the decrease was the smallest in recent years.

Child maltreatment can include child abuse, either physical or emotional, and/or child neglect. Physical and emotional abuse may occur separately, but often overlap. Physical abuse is defined as any non-accidental physical injury to the child, while emotional abuse is defined as injury to the psychological capacity and emotional stability of the child, therefore making it more difficult to identify.

Child neglect makes up over 60 percent of the abuse and neglect cases in Connecticut.[1] Though state law attempts to protect families from a finding of neglect simply for being poor, neglect is often the result of poverty, stemming from reduced access to basic needs, lack of resources, and stressful living conditions.[2] Definitions vary by state, but in Connecticut, child neglect is defined as the failure, whether intentional or not, of the person responsible for the child's care, to provide and maintain adequate food, clothing, medical care, supervision, and/or education.[3]

In an effort to appropriately address and respond to the different factors which contribute to varying levels and types of child maltreatment, a Differential Response System (DRS) is in development for Connecticut. This model provides different pathways or tracks depending on the severity of the allegations. DRS is especially promising in terms of addressing cases defined as neglect in which poverty is the primary factor contributing to compromised safety or threats to a child's well-being.[4]

Various programs across the state help prevent families from falling victim to the stresses which often lead to child maltreatment. Community based services provide prevention, intervention and treatment services to families, including parent education and home visiting programs to expectant parents. With proper supports and resources in place around the state, future incidents of child maltreatment can be prevented.[5]

Sarah Chasse
Regional Coordinator, New England Consortium
Connecticut Association for Human Services

Endnotes

1 KidSafeConnecticut. (n.d.) *Abuse and Neglect*. Retrieved August 10, 2010 from http://www.kidsafect.org/abuse.html

2 Lau, K., Morse, R., Krase, K. (2008). Mandated reporting of child abuse and neglect: A practical guide for social workers. New York: Springer Publishing Company.

5 Connecticut Department of Children and Families. (2007). *Definitions of child abuse and neglect.*

4 Casey Family Services, Connecticut Department of Children and Families Differential Response System Executive Report, June 2010.

5 National Conference of State Legislatures. (n.d.). "States Using Evidence-Based Methods to Prevent Child Abuse". *Public Health News*, May 2004.

Substantiated Cases of Abuse and/or Neglect

Locality	SFY 2006 Sub. Cases	SFY 2006 Rate/1,000	SFY 2008 Sub. Cases	SFY 2008 Rate/1,000
Fairfield Co.	1,590	6.9	1,539	6.7
Bethel	*	*	20	4.0
Bridgeport	642	16.4	582	15.0
Brookfield	*	*	*	*
Danbury	133	7.7	116	6.7
Darien	*	*	*	*
Easton	11	5.2	14	6.7
Fairfield	31	2.3	28	2.1
Greenwich	67	4.2	42	2.7
Monroe	*	*	19	3.4
New Canaan	14	2.2	17	2.7
New Fairfield	*	*	13	3.1
Newtown	13	1.6	25	3.2
Norwalk	248	13.3	192	10.4
Redding	*	*	*	*
Ridgefield	*	*	*	*
Shelton	48	5.1	47	5.0
Sherman	*	*	*	*
Stamford	267	10.1	289	11.0
Stratford	72	6.3	77	6.9
Trumbull	18	2.0	35	3.9
Weston	*	*	*	*
Westport	26	3.5	23	3.1
Wilton	*	*	*	*
Hartford Co.	2,740	12.7	2,260	10.5
Avon	30	6.6	20	4.4
Berlin	14	2.8	29	5.8
Bloomfield	26	5.9	32	7.2
Bristol	362	25.5	240	17.0
Burlington	11	4.3	*	*
Canton	15	5.9	14	5.5
East Granby	*	*	11	8.2
East Hartford	209	17.7	165	14.1
East Windsor	20	8.5	25	10.4
Enfield	153	14.9	157	15.5
Farmington	21	3.4	*	*
Glastonbury	15	1.7	20	2.2
Granby	12	3.9	*	*
Hartford	694	18.9	633	17.3
Hartland	*	*	*	*
Manchester	213	16.8	192	14.9
Marlborough	*	*	*	*
New Britain	543	31.7	399	23.4
Newington	52	8.5	36	5.9
Plainville	55	15.0	29	7.9
Rocky Hill	17	4.6	11	3.0
Simsbury	22	3.2	*	*
South Windsor	18	2.9	43	7.0
Southington	66	5.7	29	2.5

Locality	SFY 2006 Sub. Cases	SFY 2006 Rate/1,000	SFY 2008 Sub. Cases	SFY 2008 Rate/1,000
Hartford Co. cont.				
Suffield	*	*	12	3.6
West Hartford	54	3.9	61	4.4
Wethersfield	46	8.8	24	4.6
Windsor	44	6.2	39	5.5
Windsor Locks	28	9.5	39	13.2
Litchfield Co.	**256**	**5.5**	**198**	**4.3**
Barkhamsted	*	*	*	*
Bethlehem	*	*	*	*
Bridgewater	*	*	*	*
Canaan	*	*	*	*
Colebrook	*	*	*	*
Cornwall	*	*	*	*
Goshen	*	*	*	*
Harwinton	*	*	*	*
Kent	*	*	*	*
Litchfield	*	*	*	*
Morris	*	*	*	*
New Hartford	50	6.4	34	4.4
New Milford	*	*	*	*
Norfolk	*	*	*	*
North Canaan	44	14.0	23	7.4
Plymouth	*	*	*	*
Roxbury	*	*	*	*
Salisbury	*	*	*	*
Sharon	*	*	*	*
Thomaston	109	1.3	104	1.3
Torrington	*	*	*	*
Warren	*	*	*	*
Washington	26	4.7	37	14.8
Watertown	27	10.7	*	*
Winchester	*	*	*	*
Woodbury	**247**	**6.5**	**209**	**5.5**
Middlesex Co.	*	*	*	*
Chester	18	5.3	18	5.3
Clinton	11	3.8	19	6.5
Cromwell	*	*	*	*
Deep River	*	*	*	*
Durham	13	5.8	14	4.2
East Haddam	*	*	*	*
East Hampton	*	*	*	*
Essex	*	*	*	*
Haddam	13	7.5	*	*
Killingworth	*	*	*	*
Middlefield	176	18.0	125	12.6
Middletown	*	*	19	8.3
Old Saybrook	16	6.5	14	5.7
Portland	*	*	*	*
Westbrook	*	*	*	*

Locality	SFY 2006 Sub. Cases	SFY 2006 Rate/1,000	SFY 2008 Sub. Cases	SFY 2008 Rate/1,000
New Haven Co.	**3,069**	**14.8**	**2,583**	**12.5**
Ansonia	102	22.6	54	12.1
Beacon Falls	*	*	*	*
Bethany	*	*	*	*
Branford	41	6.8	39	6.5
Cheshire	*	*	16	2.2
Derby	30	11.1	32	11.9
East Haven	83	13.0	74	11.7
Guilford	15	2.6	22	3.9
Hamden	92	7.6	84	7.0
Madison	*	*	*	*
Meriden	396	25.9	382	25.1
Middlebury	*	*	*	*
Milford	103	8.4	137	11.0
Naugatuck	119	13.9	83	9.7
New Haven	978	31.0	851	27.1
North Branford	*	*	*	*
North Haven	20	3.7	25	4.6
Orange	*	*	*	*
Oxford	*	*	*	*
Prospect	*	*	11	4.7
Seymour	12	0.3	31	0.8
Southbury	*	*	*	*
Wallingford	73	6.8	83	7.7
Waterbury	835	29.3	472	16.6
West Haven	145	11.9	158	13.0
Wolcott	25	5.9	29	6.8
Woodbridge	*	*	*	*
New London Co.	**754**	**11.7**	**607**	**9.4**
Bozrah	*	*	*	*
Colchester	37	8.1	17	3.7
East Lyme	37	9.2	29	7.0
Franklin	*	*	*	*
Griswold	51	17.6	26	8.9
Groton	114	11.6	85	8.8
Lebanon	25	12.2	20	9.7
Ledyard	40	9.4	20	4.7
Lisbon	*	*	*	*
Lyme	*	*	*	*
Montville	42	9.1	19	4.1
New London	119	20.4	128	22.1
North Stonington	*	*	*	*
Norwich	242	27.6	196	22.4
Old Lyme	*	*	*	*
Preston	*	*	*	*
Salem	*	*	*	*
Sprague	*	*	*	*
Stonington	24	6.1	28	7.0
Voluntown	*	*	*	*
Waterford	23	5.4	39	9.2

Locality	SFY 2006 Sub. Cases	SFY 2006 Rate/1,000	SFY 2008 Sub. Cases	SFY 2008 Rate/1,000
Tolland Co.	**199**	**5.8**	**173**	**5.0**
Andover	*	*	*	*
Bolton	*	*	*	*
Columbia	*	*	*	*
Coventry	30	9.0	33	9.9
Ellington	15	4.1	*	*
Hebron	*	*	*	*
Mansfield	14	4.3	*	*
Somers	14	6.2	*	*
Stafford	26	8.6	20	6.7
Tolland	*	*	11	2.6
Union	*	*	*	*
Vernon	100	15.2	95	14.4
Willington	*	*	14	11.0
Windham Co.	**410**	**14.0**	**340**	**11.5**
Ashford	15	13.2	11	9.6
Brooklyn	15	8.1	30	15.9
Canterbury	15	11.4	*	*
Chaplin	*	*	*	*
Eastford	*	*	*	*
Hampton	*	*	*	*
Killingly	113	24.9	72	15.7
Plainfield	66	15.9	67	16.1
Pomfret	*	*	*	*
Putnam	36	16.4	44	20.0
Scotland	*	*	*	*
Sterling	*	*	*	*
Thompson	12	5.1	*	*
Windham	138	25.2	116	21.4
Woodstock	*	*	*	*
CONNECTICUT	**9,279**	**10.7**	**7,909**	**9.1**

Key * Towns with 10 or fewer unduplicated, substantiated cases of abuse, neglect, or uncared for children.

Child Deaths (Ages 1–14)

Locality	1997-2001 Child Deaths	1997-2001 Rate/100,000	2002-2006 Child Deaths	2002-2006 Rate/100,000
Fairfield Co.	**133**	**14.7**	**104**	**11.3**
Bethel	2	*	1	*
Bridgeport	37	23.7	23	14.7
Brookfield	0	0	3	*
Danbury	10	15.8	11	16.6
Darien	4	*	2	*
Easton	3	*	0	0
Fairfield	7	12.7	2	*
Greenwich	11	17.3	5	7.7
Monroe	0	0	1	*
New Canaan	2	*	1	*
New Fairfield	4	*	2	*
Newtown	3	*	4	12.7
Norwalk	13	17.8	11	14.9
Redding	0	0	0	0
Ridgefield	1	*	4	*
Shelton	4	*	10	27.4
Sherman	2	*	1	*
Stamford	12	11.7	11	10.5
Stratford	4	*	6	13.2
Trumbull	5	14.0	3	*
Weston	1	*	2	*
Westport	2	*	1	*
Wilton	5	22.1	0	0
Hartford Co.	**140**	**16.8**	**98**	**11.6**
Avon	1	*	2	*
Berlin	2	*	0	0
Bloomfield	3	*	2	*
Bristol	16	29.2	5	9.0
Burlington	0	0	0	0
Canton	2	*	1	*
East Granby	1	*	0	0
East Hartford	12	25.4	11	23.4
East Windsor	1	*	1	*
Enfield	7	17.3	5	12.3
Farmington	3	*	2	*
Glastonbury	2	*	1	*
Granby	1	*	1	*
Hartford	34	23.7	24	16.6
Hartland	0	0	1	*
Manchester	7	14.3	7	14.1
Marlborough	0	0	1	*
New Britain	16	23.3	10	14.6
Newington	4	*	2	*
Plainville	3	*	1	*
Rocky Hill	3	*	1	*
Simsbury	1	*	3	*
South Windsor	1	*	3	*
Southington	3	*	4	*
Suffield	1	*	0	0
West Hartford	4	*	6	10.9
Wethersfield	2	*	2	*
Windsor	9	33.4	1	*
Windsor Locks	1	*	1	*
Litchfield Co.	**23**	**13.0**	**16**	**8.7**
Barkhamsted	0	0	1	*
Bethlehem	1	*	1	*
Bridgewater	0	0	0	0
Canaan	0	0	2	*
Colebrook	2	*	0	0
Cornwall	0	0	0	0
Goshen	0	0	0	0
Harwinton	1	*	0	0
Kent	0	0	0	0
Litchfield	1	*	2	*
Morris	0	0	1	*
New Hartford	0	*	0	0
New Milford	2	*	2	*
Norfolk	2	*	0	0
North Canaan	0	0	0	0
Plymouth	1	*	0	0
Roxbury	2	*	3	*
Salisbury	0	0	0	0
Sharon	0	0	0	0
Thomaston	1	*	0	0
Torrington	0	0	1	*
Warren	0	0	0	0
Washington	0	0	0	0
Watertown	2	*	1	*
Winchester	2	*	1	*
Woodbury	2	*	0	0.0
Middlesex Co.	**17**	**12.0**	**13**	**8.8**
Chester	2	*	0	0
Clinton	0	0	2	*
Cromwell	1	*	3	*
Deep River	2	*	0	0.0
Durham	0	0	1	*
East Haddam	3	*	0	0
East Hampton	2	*	0	0
Essex	0	0	0	0
Haddam	0	0	0	0
Killingworth	1	*	1	*
Middlefield	2	*	0	0
Middletown	4	*	5	13.2
Old Saybrook	0	0	1	*
Portland	0	0	0	0
Westbrook	0	0	0	0
New Haven Co.	**123**	**15.5**	**103**	**12.6**
Ansonia	3	*	2	*
Beacon Falls	2	*	1	*
Bethany	0	0	1	*
Branford	2	*	3	12.7
Cheshire	4	*	5	17.7
Derby	0	0	1	*
East Haven	2	*	3	11.8
Guilford	3	*	1	*
Hamden	5	22.1	4	*
Madison	4	*	2	*
Meriden	13	21.9	16	26.4
Middlebury	0	0	0	0
Milford	2	*	4	10.2
Naugatuck	5	15.3	4	*
New Haven	21	16.9	23	18.4
North Branford	3	*	0	0
North Haven	4	*	2	*
Orange	1	*	1	*
Oxford	1	*	1	*
Prospect	1	*	1	*
Seymour	2	*	0	0
Southbury	4	*	2	*
Wallingford	3	*	7	16.7
Waterbury	25	22.0	13	27.2
West Haven	6	12.6	4	24.6
Wolcott	6	37.4	2	*
Woodbridge	1	*	0	0
New London Co.	**46**	**18.4**	**51**	**20.0**
Bozrah	0	0	0	0
Colchester	2	*	2	*
East Lyme	2	*	3	*
Franklin	0	0	0	0
Griswold	3	*	1	*
Groton	4	*	13	32.1
Lebanon	1	*	2	*
Ledyard	3	*	1	*
Lisbon	0	0	0	0
Lyme	0	0	0	0
Montville	7	40.9	2	*
New London	2	*	5	0
North Stonington	1	*	1	*
Norwich	12	35.4	10	29.3
Old Lyme	0	0	2	*
Preston	1	*	1	*
Salem	4	*	1	*
Sprague	2	*	0	0
Stonington	0	0	2	*
Voluntown	0	0	1	*
Waterford	2	*	4	*

Locality	1997-2001 Total Deaths	1997-2001 Rate/100,000	2002-2006 Total Deaths	2002-2006 Rate/100,000
Hartford Co. cont.				
West Hartford	4	*	12	49.1
Wethersfield	2	*	0	0
Windsor	3	*	6	65.1
Windsor Locks	1	*	5	135.8
Litchfield Co.	**30**	**55.1**	**24**	**42.5**
Barkhamsted	0	0	1	*
Bethlehem	0	0	1	*
Bridgewater	0	0	0	0
Canaan	0	0	0	0
Colebrook	0	0	0	0
Cornwall	0	0	0	0
Goshen	0	0	0	0
Harwinton	1	*	3	*
Kent	5	196.1	0	0
Litchfield	0	0	0	0
Morris	2	*	0	*
New Hartford	6	76.8	2	*
New Milford	2	*	5	61.0
Norfolk	0	0	1	*
North Canaan	2	*	0	0
Plymouth	0	0	1	*
Roxbury	0	0	1	*
Salisbury	0	0	1	*
Sharon	2	*	1	*
Thomaston	4	*	2	*
Torrington	0	0	0	0
Warren	0	0	2	*
Washington	5	73.7	2	*
Watertown	1	*	0	0
Winchester	0	0	0	0
Woodbury	19	40.6	20	40.9
Middlesex Co.				
Chester	0	0	1	*
Clinton	2	*	1	*
Cromwell	0	0	2	*
Deep River	0	0	0	0
Durham	1	*	0	0
East Haddam	4	*	1	*
East Hampton	0	0	2	*
Essex	1	*	1	*
Haddam	1	*	1	*
Killingworth	0	0	0	0
Middlefield	2	*	1	*
Middletown	6	55.3	5	44.6
Old Saybrook	1	*	2	*
Portland	1	*	2	*
Westbrook	0	0	1	*

Locality	1997-2001 Total Deaths	1997-2001 Rate/100,000	2002-2006 Total Deaths	2002-2006 Rate/100,000
New Haven Co.	**79**	**29.1**	**135**	**48.6**
Ansonia	0	0	3	*
Beacon Falls	0	0	1	*
Bethany	1	*	1	*
Branford	2	*	1	*
Cheshire	1	*	1	*
Derby	1	*	1	*
East Haven	4	*	7	87.6
Guilford	2	*	5	70.1
Hamden	7	31.98	6	26.7
Madison	3	*	5	87.0
Meriden	5	28.0	12	66.1
Middlebury	0	0	0	0
Milford	2	*	6	40.7
Naugatuck	2	*	6	56.0
New Haven	25	45.8	31	56.5
North Branford	1	*	6	137.1
North Haven	2	*	3	*
Orange	1	*	2	*
Oxford	1	*	0	0
Prospect	1	*	0	0
Seymour	0	0	4	*
Southbury	1	*	1	*
Wallingford	2	*	7	55.5
Waterbury	8	23.4	11	32.0
West Haven	6	36.8	10	60.7
Wolcott	0	0	3	*
Woodbridge	1	*	2	*
New London Co.	**38**	**45.3**	**39**	**45.5**
Bozrah	0	0	0	0
Colchester	3	*	1	*
East Lyme	1	*	2	*
Franklin	0	0	0	0
Griswold	1	*	2	*
Groton	7	56.5	1	*
Lebanon	3	*	0	0
Ledyard	2	*	4	*
Lisbon	0	0	1	*
Lyme	0	0	2	*
Montville	5	82.7	3	*
New London	1	*	6	52.2
North Stonington	0	0	0	0
Norwich	5	44.6	11	97.4
Old Lyme	1	*	0	0
Preston	2	*	0	0
Salem	1	*	0	0
Sprague	2	*	0	0
Stonington	2	*	4	*
Voluntown	1	*	1	*
Waterford	1	*	1	*

Locality	1997-2001 Total Deaths	1997-2001 Rate/100,000	2002-2006 Total Deaths	2002-2006 Rate/100,000
Tolland Co.	**11**	**19.4**	**18**	**29.6**
Andover	0	0	2	*
Bolton	0	0	0	0
Columbia	0	0	1	*
Coventry	1	*	4	*
Ellington	1	*	1	*
Hebron	1	*	1	*
Mansfield	0	0	1	*
Somers	1	*	1	*
Stafford	5	127.7	2	*
Tolland	1	*	4	*
Union	0	0	0	0
Vernon	1	*	0	0
Willington	0	0	1	*
Windham Co.	**17**	**41.1**	**15**	**34.6**
Ashford	0	0	0	0
Brooklyn	0	0	3	*
Canterbury	0	0	1	*
Chaplin	0	0	0	0
Eastford	0	0	1	*
Hampton	0	0	0	0
Killingly	4	*	1	*
Plainfield	4	*	6	109.7
Pomfret	2	*	0	0
Putnam	0	0	1	*
Scotland	0	0	0	0
Sterling	3	*	0	0
Thompson	1	*	0	0
Windham	3	*	2	*
Woodstock	0	0	0	0
CONNECTICUT	**397**	**36.6**	**531**	**49.7**

Key * Rates for towns in which fewer than five incidents occurred during the reported time period are not calculated because of the unreliability of small numbers

TEEN BIRTHS

Source: Connecticut Department of Public Health, unpublished data, SFYs 2006 and 2008; Connecticut Department of Public Health, *Estimated Populations in Connecticut as of July 1, 2006*; Connecticut Department of Public Health, *Estimated Populations in Connecticut as of July 1, 2008*; U.S. Census Bureau, *2000 Census, Summary File 1, Table P12 – Sex by Age, Total Population.*

Methodology: The number of births to girls age 15-17 per 1,000 females for that age group in a town or county. The rate is calculated by dividing the number females 15-17 years old who gave birth by the total number of all females in that age group in a town or county and multiplying by 1,000. The total number of girls 15 to 17 years old is estimated by applying the 2000 Census proportions to the population estimates from the Connecticut Department of Public Health for those years. Rates for towns in which fewer than five teens give birth are not calculated because of the unreliability of calculations based on small numbers.

Special Note: This indicator is different than the total number of babies born to women under 18 as a percentage of all live births.

The birth rate of 18 and 19 year-old girls is not reported because the number of females in this age group is skewed in towns with colleges. Similarly, births to girls under age 15 have been excluded because there are very few for this group (about 60 per year). The inclusion of females under 15 in the denominator would dramatically lower the rate, giving an underestimate of the risk for teen births to teenagers.

HUSKY A AND B – CHILD ENROLLMENT

Source: Connecticut Department of Social Services, published data, January 1, 2006, January 1, 2008, and January 1, 2010, reported by Connecticut Voices for Children. Retrieved from http://www.ctkidslink.org/media/other/covhuskya_kids.xls

Methodology: The number of children under age 19 enrolled in HUSKY A (Medicaid managed care) and HUSKY B (Connecticut's State Child Health Insurance Program – SCHIP) by town or county.

SUBSTANTIATED ABUSE AND/OR NEGLECT

Source: Connecticut Department of Children and Families, published data, SFYs 2006 and 2008; Connecticut Department of Public Health, *Estimated Populations in Connecticut as of July 1, 2006*; Connecticut Department of Public Health, *Estimated Populations in Connecticut as of July 1, 2008*; U.S. Census, *2000 Census, Summary File 1, Table P12 – Sex by Age, Total Population.*

Methodology: The unduplicated number of children under age 18 who were the victims of substantiated abuse and neglect or were uncared for during the stated year. The rate is calculated as the total number of substantiated cases divided by the total number of children under age 18, and multiplied by 1,000. The total number of children under age 18 is estimated by applying the 2000 Census proportions to the population estimates from the Connecticut Department of Public Health for those years. Rates for towns in which fewer than 10 substantiated cases of abuse and neglect occurred are not calculated because of the unreliability of calculations based on small numbers.

Note: According to the Connecticut Department of Children and Families, in both years, a significant number of cases did not correspond with any official Connecticut town name. This anomaly is the result of incorrect data entry or other technical factors.

CHILD DEATHS

Source: Connecticut Department of Public Health, published data, SFYs 1997–2001 and 2002–2006; U.S. Census Bureau, *1990 Census, Summary File 1, Table P011 – Age*; U.S. Census, *2000 Census, Summary File 1, Table P12 – Sex by Age, Total Population.*

Methodology: The total number of child death for a five-year period by town or county. Rates per 100,000 children are calculated as the number of deaths from all causes of children between one and 14 years of age for the reporting period divided by the total number of children in that age group, then multiplied by 100,000. The total number of children ages one to 14 is estimated by applying the 1990 or 2000 Census proportions to the population estimates from the Connecticut Department of Public Health for that year. Rates for towns in which fewer than 5 children died are not calculated because of the unreliability of calculations based on small numbers.

PREVENTABLE TEEN DEATHS

Source: Connecticut Department of Public Health, unpublished data, SFYs 1997–2001 and 2002–2006; U.S. Census Bureau, *1990 Census, Summary File 1, Table P011 – Age*; U.S. Census, *2000 Census, Summary File 1, Table P12 – Sex by Age, Total Population.*

Methodology: The total number of preventable deaths to teens age 15 to 19 for a five-year period by town or county. Preventable deaths are defined as deaths from accidents, suicides, and homicides. Rates per 100,000 teens are calculated as the number of preventable deaths of teens age 15 to 19, divided by the total number of teens in this age group, then multiplied by 100,000. The total number of teens age 15 to 19 is estimated by applying the 1990 or 2000 Census proportions to the population estimates from the Connecticut Department of Public Health for those years. Rates for towns in which fewer than five teens died are not calculated because of the unreliability of calculations based on small numbers.

Preventable Teen Deaths

Overall, the preventable teen death rate for Connecticut increased between the five-year time period 1997-2001 and 2002-2006. Large increases occurred across the state, in mid-size cities, suburbs, and rural areas, at all income levels. The highest rates of relative increase occurred in larger cities and both outer- and inner-ring suburbs.

According to national data, the primary causes of teen deaths are unintentional injuries, homicide, suicide, cancer, and heart disease. Preventable teen death rates vary by age, race/ethnicity, and gender. The incidence of death increases as teens age, especially for boys. Similarly, the type of death varies according to racial/cultural group. Black teens have the highest mortality rate among teenagers. They are twice as likely as Hispanic male teens and 15 times as likely as White male teens to die as a result of a homicide. Nationally, car accidents are the leading cause of death among all teens, accounting for a full third of preventable teen deaths.[1]

Nationally and in Connecticut, medical authorities have declared preventable teen deaths a serious public health issue as the rate of teens taking their own lives or suffering from fatal injuries increases.[2] According to the 2009 Connecticut School Health Survey, 25 percent of high school students felt so hopeless for an extended period of time that they stopped doing regular activities, 14 percent considered suicide, and slightly more than 7 percent actually attempted suicide at least once.[3]

In an attempt to help teens, the state of Connecticut and others are taking action. The Connecticut Departments of Children and Families and Mental Health and Addiction Services to develop the *CT Youth Suicide Prevention Initiative* in 2006. The Initiative is made up of several parts, including: programs for urban middle school students, all high school students, and those attending the Connecticut university system; training for those who work with youth; and a public education and awareness campaign.[4]

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Endnotes

1 Minino, A. (2010). *Mortality among Teenagers Aged 12–19 Years: United States, 1999–2006.* NCHS Data Brief, No. 37. Hyattsville, MD: National Center for Health Statistics. Retrieved November 22, 2010 from http://www.cdc.gov/nchs/data/databriefs/db37.pdf

2 Ibid; Connecticut Department of Mental Health and Addiction Services. (n.d.) *Connecticut Youth Suicide Prevention Initiative Final Report.* Hartford, CT: author.

3 Connecticut Department of Children and Families Youth Suicide Prevention Board. (2010). Youth Suicide Prevention Packet. Retrieved November 22, 2010 from http://www.ct.gov/dcf/lib/dcf/prevention/pdf/2010ysabpacket.pdf

4 Connecticut Department of Mental Health and Addiction Services.

Preventable Teen Deaths (Ages 15–19)

Locality	1997-2001 Total Deaths	1997-2001 Rate/100,000	2002-2006 Total Deaths	2002-2006 Rate/100,000
Fairfield Co.	107	41.9	112	43.0
Bethel	1	*	1	*
Bridgeport	40	76.6	27	51.7
Brookfield	1	*	0	0
Danbury	4	*	8	33.6
Darien	4	*	1	*
Easton	2	*	1	*
Fairfield	5	23.2	3	*
Greenwich	3	*	8	56.2
Monroe	4	*	2	*
New Canaan	2	*	1	*
New Fairfield	2	*	2	*
Newtown	2	*	3	*
Norwalk	5	24.8	15	73.3
Redding	1	*	0	0
Ridgefield	3	*	1	*
Shelton	3	*	5	45.5
Sherman	2	*	1	*
Stamford	10	35.3	14	48.2
Stratford	4	*	9	67.9
Trumbull	3	*	5	53.2
Weston	1	*	2	*
Westport	4	*	1	*
Wilton	1	*	2	*
Hartford Co.	96	35.1	168	60.4
Avon	2	*	0	0
Berlin	0	0	3	*
Bloomfield	1	*	7	125.6
Bristol	6	35.4	7	40.6
Burlington	0	0	1	*
Canton	2	*	4	*
East Granby	1	*	4	*
East Hartford	4	*	11	75.6
East Windsor	1	*	1	*
Enfield	4	*	3	*
Farmington	4	*	4	*
Glastonbury	2	*	3	*
Granby	0	0	1	*
Hartford	33	63.8	44	84.8
Hartland	2	*	0	0
Manchester	3	*	9	58.7
Marlborough	1	*	3	*
New Britain	11	41.9	15	57.2
Newington	0	0	2	*
Plainville	3	*	2	*
Rocky Hill	0	0	4	*
Simsbury	2	*	4	*
South Windsor	2	*	1	*
Southington	1	*	11	138.3
Suffield	1	*	1	*

Child Deaths

Locality	1997-2001 Child Deaths	1997-2001 Rate/100,000	2002-2006 Child Deaths	2002-2006 Rate/100,000
Tolland Co.	18	14.5	11	8.3
Andover	0	0	0	0
Bolton	1	*	0	0
Columbia	0	0	0	0
Coventry	3	*	1	*
Ellington	1	*	2	*
Hebron	3	*	1	*
Mansfield	3	*	1	*
Somers	1	*	3	*
Stafford	3	*	0	0
Tolland	0	0	1	*
Union	0	0	0	0
Vernon	2	*	2	*
Willington	2	*	0	
Windham Co.	25	23.5	7	6.3
Ashford	0	0	0	0
Brooklyn	2	*	0	0
Canterbury	1	*	1	*
Chaplin	0	0	0	0
Eastford	0	0	0	0
Hampton	1	*	0	0
Killingly	4	*	1	*
Plainfield	6	39.1	1	*
Pomfret	2	*	0	0
Putnam	0	0	2	*
Scotland	0	0	0	0
Sterling	0	0	1	*
Thompson	0	0	0	0
Windham	9	44.0	1	*
Woodstock	0	0	0	0
CONNECTICUT	525	15.8	403	11.8

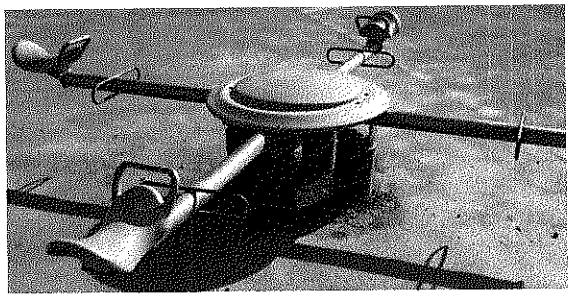
Key * Rates for towns in which fewer than five incidents occurred during the reported time period are not calculated because of the unreliability of small numbers

Overall, the incidence of child deaths in Connecticut decreased between the five-year periods of 1997—2001 and 2002—2006. Declines can be seen not only in our largest cities such as Hartford and Waterbury, but also in smaller cities such as Bristol, Greenwich, and Norwich. Unfortunately, increases are evident in a number of communities as well, including Meriden, New Haven, and Shelton. Many towns—both rural and suburban—were untouched by child deaths.

The causes of child deaths are numerous and include: accidental firearms, abuse and neglect, drowning, fires, homicide, accidents, Sudden Infant Death Syndrome (SIDs), suffocation, and suicide. Communities can find solace through information about the causes of death and prevention activities.[1]

Prevention can occur at several levels of a child's life, referred to as the Spectrum of Prevention. These are: (1) increasing individual knowledge and skills—of children, parents, and others; (2) promoting community education; (3) educating providers; (4) fostering coalitions and networks; (5) changing organizational practices; and (6) influencing policy and legislation.

Accidents to children may be thought of as random, but when examined can be seen as predictable. Many risk factors are modifiable, but some require long-term action. Each cause of child injury and death requires analysis and its own prevention strategy. The focus should extend beyond the most obvious prevention check list of physical and social environments to include maternal and child health, problems related to poverty and low income, access to medical care, the quality of housing available to families, and other larger community issues.[2]



The Connecticut Office of the Child Advocate has developed a compendium of information for towns to develop their own Child Death Review (CDR) Panel and process—to educate families and community members as well as decrease the incidence of child deaths and determine the cause of a particular child's passing. Members of a community's CDR should include a cross section of individuals who work with children as well as those involved with law enforcement, criminal investigation, and the medical examiner's office. Others who also should be included are those who work with families and teens and school administrators.

Judith Carroll
Director, CT KIDS COUNT Project
Connecticut Association for Human Services

Endnotes

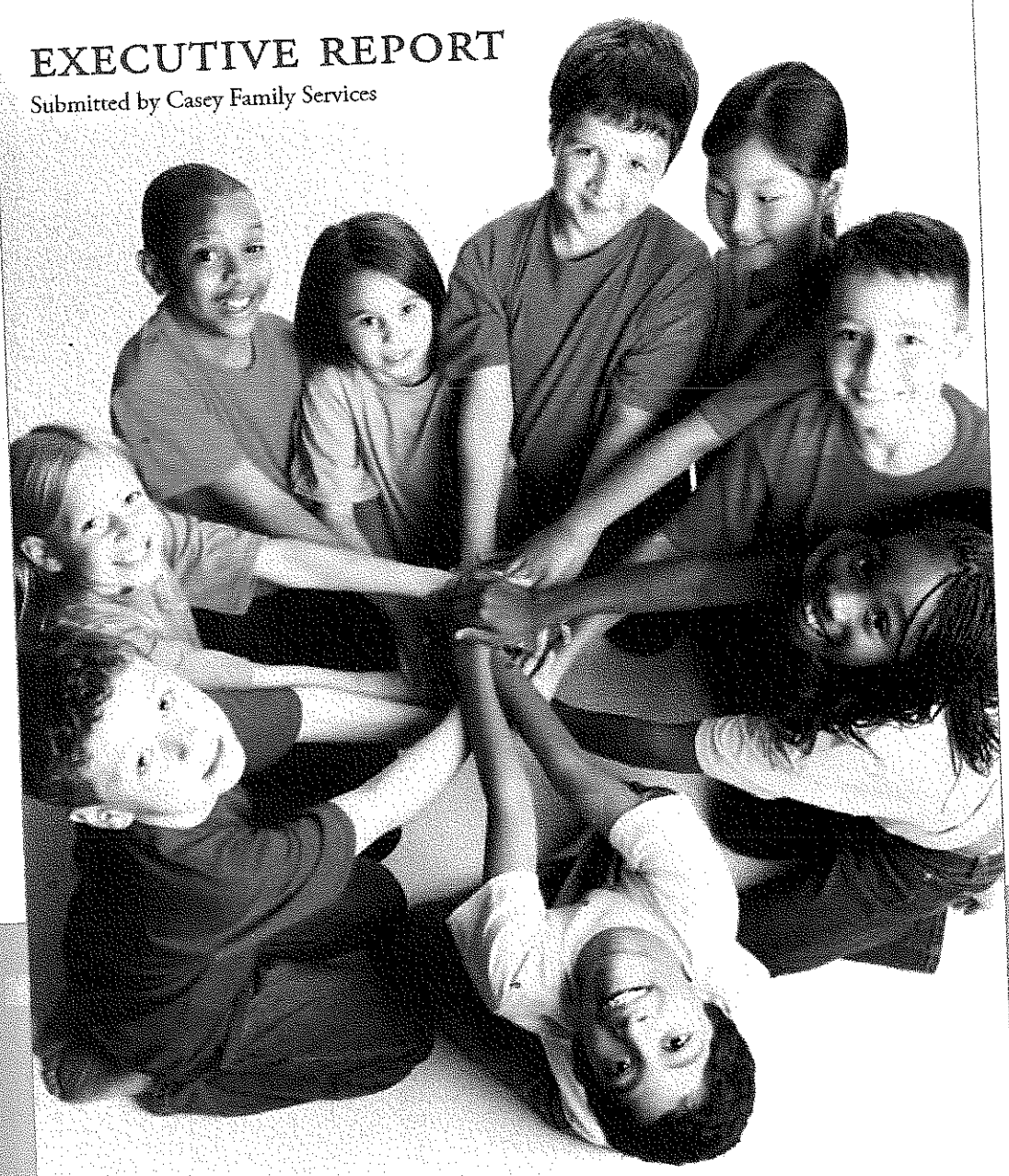
1 Cohen, L. and Swift, S. (1999). The spectrum of prevention: developing a comprehensive approach to injury prevention. *Injury Prevention*. 1999; 5: 203-207.

2 National Center for Child Death Review. (2005). Preventing Child Deaths. Michigan Public Health Institute. Retrieved November 20, 2010 from http://www.childdeathreview.org/preventing.htm#Identify%20Modifiable%20Risk%20Factors

Connecticut Department of Children and Families Differential Response System

EXECUTIVE REPORT

Submitted by Casey Family Services



REGIONAL PLANNING TEAM RECOMMENDATIONS

I. Core Services

Each of the Planning Teams was asked to identify the services they thought would be most important for families in differential response and, therefore, should be available and easily accessible. Not surprisingly, there was a great deal of similarity in the "core services" identified by the five teams.

Evaluations of Minnesota and Missouri's differential response systems described services most often received by families in differential response. These services were strikingly similar to the "core services" identified by the Planning Teams and included services such as:

- Basic needs: financial assistance, food stamps, food banks, clothing closets, diaper banks, utilities assistance, transitional and subsidized housing, furniture, health care, public benefits enrollment, and coordination;
- Mental health (chronic, situational, trauma-informed);
- Alcohol and drug abuse treatment;
- Employment and training assistance;
- Child care (drop-in, after school, special needs, hours to accommodate shift workers)
- Transportation;
- Parenting education and skill development/life coaching and mentoring;
- Parent leadership, peer support, parent advocacy;
- Social supports, enrichment, and recreational activities; and

Cityrating.com

Hartford Crime Rate Report (Connecticut)

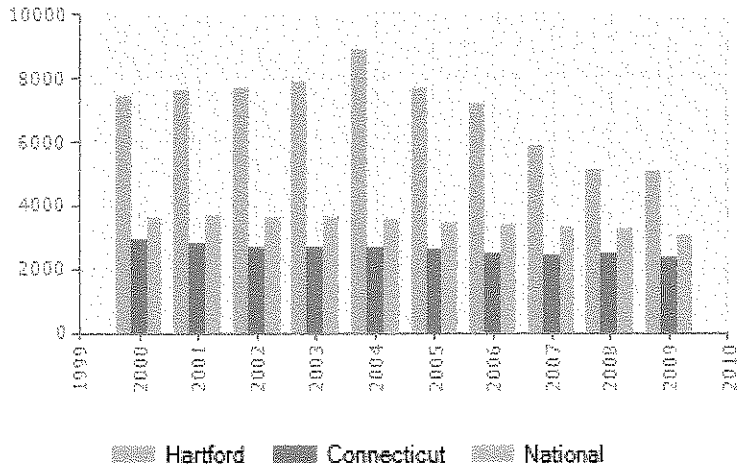
Home > Crime Statistics > Connecticut > Hartford

Hartford crime statistics report an overall downward trend in crime based on data from 11 years with violent crime decreasing and property crime decreasing. Based on this trend, the crime rate in Hartford for 2012 is expected to be lower than in 2009.

The city violent crime rate for Hartford in 2009 was higher than the national violent crime rate average by 200.91% and the city property crime rate in Hartford was higher than the national property crime rate average by 66.56%.

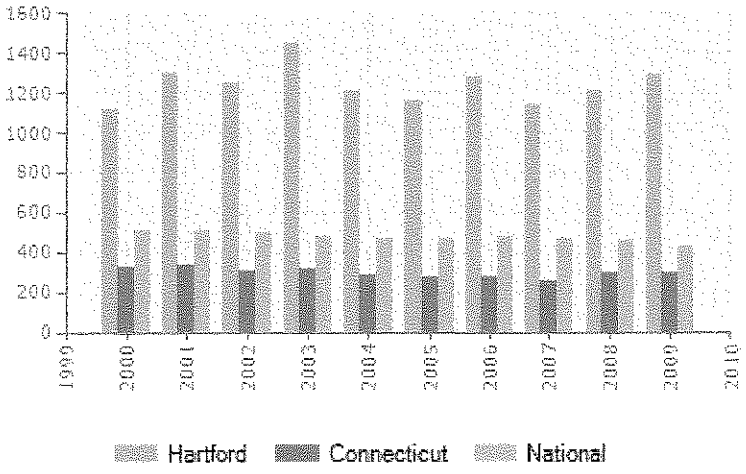
In 2009 the city violent crime rate in Hartford was higher than the violent crime rate in Connecticut by 332.66% and the city property crime rate in Hartford was higher than the property crime rate in Connecticut by 116.49%.

Hartford Property Crime Index



Crime Index corresponds to incidents per 100,000 inhabitants

Hartford Violent Crime Index



Crime Index corresponds to incidents per 100,000 inhabitants

Hartford Crime Statistics
Summary Report

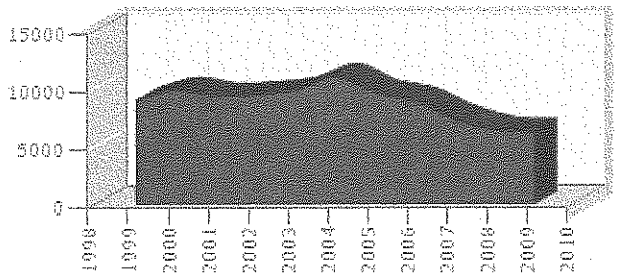
2009 Crime (Actual Data)*	Incidents
Aggravated Assault	921

Arson	84
Burglary	1,135
Forcible Rape	49
Larceny and Theft	4,061
Motor Vehicle Theft	993
Murder and Manslaughter	33
Robbery	600
Crime Rate (Total Incidents)	7,758
Property Crime	6,273
Violent Crime	1,603

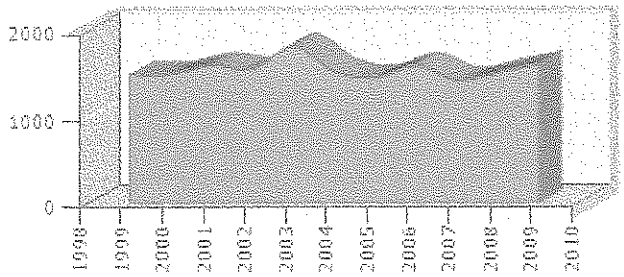
2012 Crime (Projected Data)*	Incidents
Aggravated Assault	923
Arson	20
Burglary	855
Forcible Rape	50
Larceny and Theft	3,839
Motor Vehicle Theft	990
Murder and Manslaughter	35
Robbery	496
Crime Rate (Total Incidents)	7,188
Property Crime	5,703
Violent Crime	1,504

Property and Violent Crime Totals

Hartford Property Crime

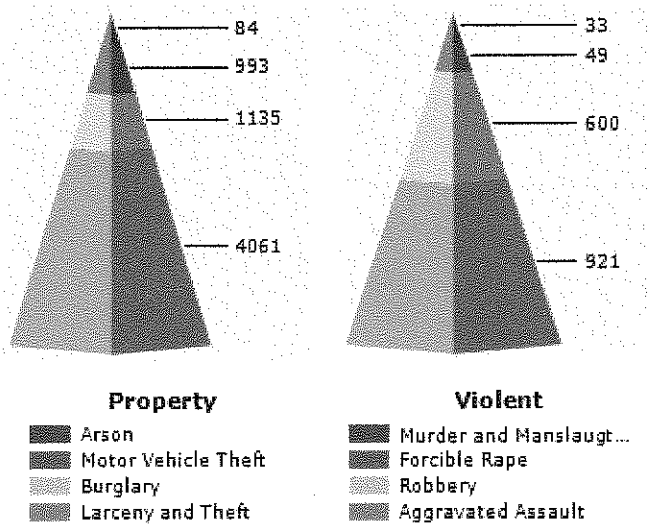


Hartford Violent Crime

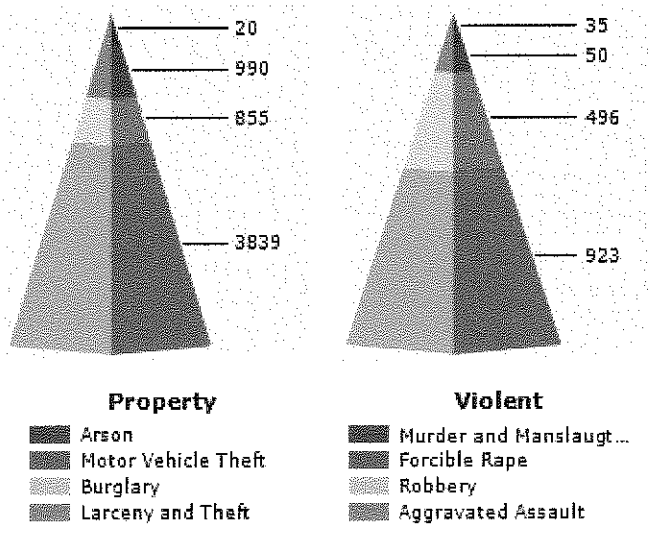


Actual versus Projected Crime Totals

Hartford 2009 Crime

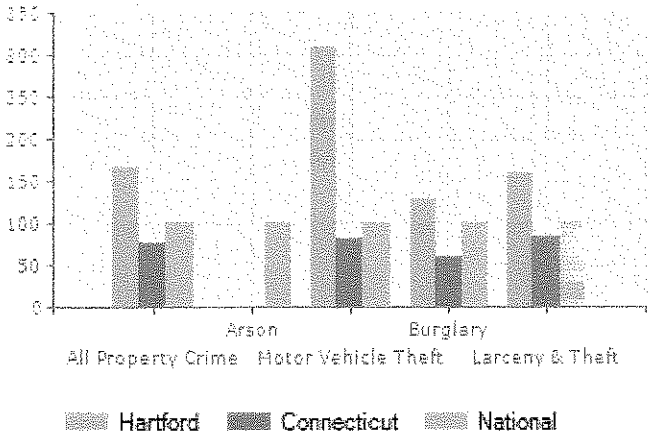


Hartford 2012 Crime (Projected)



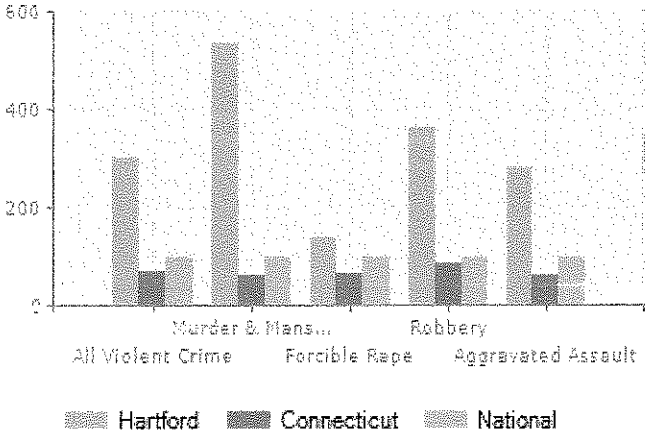
City versus State versus National Crime Comparison

2009 Hartford
Property Crime Comparison



Compared to U.S. average. (U.S. average equals 100)

2009 Hartford
Violent Crime Comparison



Compared to U.S. average. (U.S. average equals 100)

* The source of **actual** data on this Hartford, Connecticut crime rate report is the **FBI Report of Offenses Known to Law Enforcement** for the corresponding year or years. Arson numbers are reported inconsistently. Zero values may indicate the data was not available. The **projected** crime rate data displayed above was generated from the trends and crime data available from previous years of actual reported data. In this case, the Hartford crime report data for 2012 was projected from 11 years of actual data. The last year of actual available crime data, as reported above, was 2009.

The **FBI cautions the data users against comparing yearly statistical data** solely on the basis of their population coverage. The comparisons made herein are thus, only meaningful upon further examination of all variables that affect crime in each reported city, state or other reported jurisdiction.

YOUTH RISK BEHAVIOR SURVEILLANCE
CONNECTICUT, 2011

CONNECTICUT SCHOOL HEALTH SURVEY
YOUTH RISK BEHAVIOR REPORT

CONNECTICUT DEPARTMENT OF PUBLIC HEALTH

IN COLLABORATION WITH

CONNECTICUT STATE DEPARTMENT OF EDUCATION

JUNE 2012

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2011 Connecticut School Health Survey
Youth Behavior Component

Commissioner Jewel Mullen, MD, MPH, MPA

Connecticut Department of Public Health

in collaboration with

Commissioner Stefan Pryor

Connecticut State Department of Education

For additional information about health risk behaviors among Connecticut youth contact:
Connecticut Department of Public Health
Survey Research Unit
410 Capitol Avenue
PO Box 340308, MS #11PSI
Hartford, CT 06134

Phone: 860.509.7658
Or visit: www.ct.gov/dph/CSHS or www.ct.gov/sde/healthyconnections

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Summary of Results

Behaviors that Contribute to Unintentional Injuries

Rarely or Never Wear a Seat Belt

In Connecticut, 9.2% of high school students rarely or never wear a seat belt when riding in a car driven by someone else. Nationwide, the rate is 7.7%. In Connecticut, the prevalence of rarely or never wearing a seat belt is significantly higher among Hispanic (13.8%) than among white (7.3%) students; and significantly higher in grade 9 (12.4%) than in grade 10 (5.2%).

Rode with a Driver Who had been Drinking Alcohol

During the 30 days before the survey, 25.2% of high school students rode one or more times in a car or other vehicle driven by someone who had been drinking alcohol. Nationwide, the rate is 24.1%. Overall in Connecticut, the prevalence of riding with a driver who had been drinking alcohol does not vary significantly by gender, race/ethnicity, or grade.

Drove when Drinking Alcohol

During the 30 days before the survey, 6.9% of high school students drove a car or other vehicle one or more times when they had been drinking alcohol. Nationwide, the rate is 8.2%. In Connecticut, the prevalence of driving when drinking alcohol is significantly higher among male (9.1%) than among female (4.6%) students; and significantly higher in grades 11 (8.5%) and 12 (13.2%) than in grades 9 (2.4%) and 10 (3.9%).

Talked on Cell Phone While Driving

On 1 or more of the 30 days before the survey, 53.2% of high school students who drive a car, talked on a cell phone while they were driving a car or other vehicle. Among students who drive, the prevalence of talking on a cell phone while driving is significantly higher in grades 11 (47.7%) and 12 (66.5%) than in grade 10 (27%); and significantly higher in grade 12 (66.5%) than grade 11 (47.7%).

Texted or E-Mailed While Driving

On 1 or more of the 30 days before the survey, 50.9% of high school students who drive a car, texted or e-mailed while they were driving a car or other vehicle. Among students who drive, the prevalence of texting or e-mailing while driving is significantly higher in grades 11 (46.4%) and 12 (64.2%) than in grade 10 (22.3%); and significantly higher in grade 12 (64.2%) than grade 11 (46.4%).

Behaviors that Contribute to Violence

Carried a Weapon on School Property

In Connecticut, 6.6% of high school students carried a weapon on school property on at least 1 day during the 30 days before the survey. Nationwide, the rate is 5.4%. In Connecticut, the prevalence of carrying a weapon on school property is significantly higher among male (9.8%) than among female (3.4%) students; and significantly higher in grade 12 (10%) than in grade 9 (4.3%).

The prevalence of carrying a weapon on school property is significantly higher in grade 12 among CT (10%) than among US (5.6%) students.

Threatened or Injured with a Weapon on School Property

During the 12 months before the survey, 6.8% of high school students were threatened or injured with a weapon one or more times on school property. Nationwide, the rate is 7.4%. In Connecticut, the prevalence of being threatened or injured with a weapon on school property is significantly higher among male (8.8%) than among female (4.6%) students; and significantly higher among Hispanic (10.6%) than among white (5.8%) students.

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Summary of Results

In a Physical Fight
In Connecticut, 25.1% of high school students were in a physical fight one or more times during the 12 months before the survey. Nationwide, the rate is significantly higher (32.8%). In Connecticut, the prevalence of being in a physical fight is significantly higher among male (32.4%) than among female (17.6%) students.

The prevalence of physical fighting is significantly higher among US male (40.7%) than among CT male (32.4%) students; significantly higher among US female (24.4%) than among CT female (17.6%) students; significantly higher among US white (29.4%) than among CT white (23.1%) students; significantly higher among US black (39.1%) than among CT black (27%) students; and significantly higher in grade 10 among US (35.3%) than among CT (24.5%) students.

In a Physical Fight on School Property
During the 12 months before the survey, 8.7% of high school students were in a physical fight one or more times on school property. Nationwide, the rate is significantly higher (12%). In Connecticut, the prevalence of being in a physical fight on school property is significantly higher among male (12.4%) than among female (4.8%) students.

The prevalence of physical fighting on school property is significantly higher among US male (16%) than among CT male (12.4%) students; and significantly higher among US female (7.8%) than among CT female (4.8%) students.

Bullied on School Property
During the 12 months before the survey, 21.6% of high school students were ever bullied on school property. Nationwide, the rate is 20.1%. In Connecticut, the prevalence of ever being bullied on school property is significantly higher among white (23.2%) than black (13.2%) students; and significantly higher in grade 9 (27.2%) than in grades 11 (16.3%) and 12 (17.1%).

Teased Because of Physical Appearance
During the 12 months before the survey, 25.5% of high school students were ever teased or called names because of their weight, size, or physical appearance. The prevalence of ever being teased because of weight, size, or physical appearance is significantly higher in grade 9 (31.5%) than in grade 12 (19.7%).

Teased Because of Perceived Sexual Orientation
During the 12 months before the survey, 10.2% of high school students were ever teased or called names because someone thought they were gay, lesbian, or bisexual. The prevalence of ever being teased because of perceived sexual orientation is significantly higher in grade 9 (14.8%) than in grade 12 (8%).

Electronically Bullied
During the 12 months before the survey, 16.3% of high school students were ever electronically bullied. Nationwide, the rate is 16.2%. In Connecticut, the prevalence of ever being electronically bullied is significantly higher among female (20.1%) than among male (12.5%) students; and significantly higher among white (17.6%) than among black (8.8%) students.

Did Not Go to School Because of Safety Concerns
In Connecticut, 5.3% of high school students did not go to school on at least 1 day of the 30 days before the survey because they felt they would be unsafe at school or on their way to or from school. Nationwide, the rate is 5.9%. Overall in Connecticut, the prevalence of not going to school because of safety concerns does not vary significantly by gender, race/ethnicity, or grade.

Had Property Stolen or Damaged on School Property
In Connecticut, 25% of high school students had property stolen or deliberately damaged on school property one or more times during the 12 months before the survey. Nationwide, the rate is 26.1%. Overall in Connecticut, the prevalence of having property stolen or damaged on school property does not vary significantly by gender, race/ethnicity, or grade.

Summary of Results

Verbal and Emotional Abuse
During the 12 months before the survey, 16.7% of high school students were ever verbally or emotionally abused by their boyfriend or girlfriend. The prevalence of ever being verbally or emotionally abused by their boyfriend or girlfriend is significantly higher among female (20.7%) than among male (12.7%) students.

Dating Violence
During the 12 months before the survey, 8.2% of high school students were ever hit, slapped, or physically hurt on purpose by their boyfriend or girlfriend (i.e., dating violence). Nationwide, the rate is 9.4%. Overall in Connecticut, the prevalence of dating violence does not vary significantly by gender, race/ethnicity, or grade.

The prevalence of dating violence is significantly higher in grade 10 among US (9.6%) than among CT (5.2%) students.

Forced to have Sexual Intercourse
In Connecticut, 7.3% of high school students were ever physically forced to have sexual intercourse when they did not want to. Nationwide, the rate is 8%. In Connecticut, the prevalence of ever being physically forced to have sexual intercourse is significantly higher among female (10.2%) than among male (4.4%) students; and significantly higher among Hispanic (11.8%) than among white (5.5%) students.

Felt Sad or Hopeless
During the 12 months before the survey, 24.4% of high school students felt so sad or hopeless almost every day for two or more weeks in a row that they stopped doing some usual activities. Nationwide, the rate is 28.5%. In Connecticut, the prevalence of feeling sad or hopeless is significantly higher among female (31%) than among male (18%) students; and significantly higher among Hispanic (33.5%) than among white (22.4%) and black (21.2%) students.

Self-Injury
In Connecticut, 16.1% of high school students purposely hurt themselves without wanting to die (i.e., self-injury) one or more times during the 12 months before the survey. The prevalence of self-injury is significantly higher among female (21.6%) than among male (10.7%) students; and significantly higher among white (16.3%) and Hispanic (20.5%) than among black (9.6%) students.

Seriously Considered Attempting Suicide
In Connecticut, 14.6% of high school students seriously considered attempting suicide during the 12 months before the survey. Nationwide, the rate is 15.8%. Overall in Connecticut, the prevalence of seriously considering attempting suicide does not vary significantly by gender, race/ethnicity, or grade.

Attempted Suicide
In Connecticut, 6.7% of high school students actually attempted suicide one or more times during the 12 months before the survey. Nationwide, the rate is 7.8%. In Connecticut, the prevalence of attempting suicide is significantly higher among Hispanic (11%) than among white (5.5%) students.

The prevalence of attempting suicide is significantly higher in grade 10 among US (8.2%) than among CT (4.8%) students.

Cigarette, Alcohol, and Other Drug Use

Current Cigarette Smoking
In Connecticut, 15.9% of high school students smoked cigarettes on at least 1 day during the 30 days before the survey (i.e., current cigarette smoking). Nationwide, the rate is 18.1%. In Connecticut, the prevalence of current cigarette smoking is significantly higher in grades 11 (19.7%) and 12 (21.2%) than in grade 10 (10%).

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Summary of Results

Frequent Cigarette Smoking
In Connecticut, 5.4% of high school students smoked cigarettes on 20 or more days during the 30 days before the survey (i.e., frequent cigarette smoking). Nationwide, the rate is 6.4%. In Connecticut, the prevalence of frequent cigarette smoking is significantly higher in grades 11 (7.7%) and 12 (9.6%) than in grades 9 (2.2%) and 10 (2.5%).

Drank Alcohol Before Age 13 Years
In Connecticut, 15.6% of high school students drank alcohol (other than a few sips) for the first time before age 13 years. Nationwide, the rate is significantly higher (20.5%). In Connecticut, the prevalence of drinking alcohol before age 13 years is significantly higher among male (18.2%) than among female (12.7%) students; and significantly higher among Hispanic (20.7%) than among white (13.8%) students.

The prevalence of drinking alcohol before age 13 years is significantly higher among US male (23.3%) than among CT male (18.2%) students; significantly higher among US female (17.4%) than among CT female (12.7%) students; and significantly higher in grade 10 among US (21.1%) than among CT (12.3%) students.

Current Alcohol Use
In Connecticut, 41.5% of high school students had at least one drink of alcohol on 1 or more of the 30 days before the survey (i.e., current alcohol use). Nationwide, the rate is 38.7%. In Connecticut, the prevalence of current alcohol use is significantly higher among white (44.8%) than among black (28.1%) students; significantly higher in grades 11 (46.1%) and 12 (54.5%) than in grade 9 (29.9%); and significantly higher in grade 12 (54.5%) than in grade 10 (37.5%).

Binge Drinking
In Connecticut, 22.3% of high school students had five or more drinks of alcohol in a row on at least 1 day during the 30 days before the survey (i.e., binge drinking). Nationwide, the rate is 21.9%. In Connecticut, the prevalence of binge drinking is significantly higher among white (24.8%) than among black (12.3%) students; and significantly higher in grades 11 (28.8%) and 12 (32.1%) than in grade 9 (11.5%).

Drank Alcohol on School Property
In Connecticut, 4.6% of high school students had at least one drink of alcohol on school property during the 30 days before the survey. Nationwide, the rate is 5.1%. Overall in Connecticut, the prevalence of drinking alcohol on school property does not vary significantly by gender, race/ethnicity, or grade.

Someone Gave Alcohol to Them
During the 30 days before the survey, 34.1% of current alcohol users in high school usually got the alcohol they drank from someone who gave it to them. Nationwide, the rate is 40%. In Connecticut, among current alcohol users, the prevalence of someone giving alcohol to them is significantly higher among female (41.4%) than among male (27%) students.

Among current alcohol users in grade 12, the prevalence of someone giving alcohol to them is significantly higher among US (41.3%) than among CT (26.9%) students.

Ever Used Marijuana
In Connecticut, 39.6% of high school students have used marijuana one or more times during their life (i.e., ever used marijuana). Nationwide, the rate is 39.9%. In Connecticut, the prevalence of having ever used marijuana is significantly higher in grades 11 (46.6%) and 12 (52.9%) than in grade 9 (24.5%); and significantly higher in grade 12 (52.9%) than in grade 10 (36.7%).

Tried Marijuana Before Age 13 Years
In Connecticut, 6.3% of high school students tried marijuana for the first time before age 13 years. Nationwide, the rate is 8.1%. Overall in Connecticut, the prevalence of trying marijuana before age 13 years does not vary significantly by gender, race/ethnicity, or grade.

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Summary of Results

The prevalence of trying marijuana before age 13 years is significantly higher in grade 9 among US (9.7%) than among CT (5.9%) students.

Current Marijuana Use
In Connecticut, 24.1% of high school students used marijuana on at least 1 day during the 30 days before the survey (i.e., current marijuana use). Nationwide, the rate is 23.1%. In Connecticut, the prevalence of current marijuana use is significantly higher in grades 11 (29.4%) and 12 (30.6%) than in grade 9 (15%).

Used Marijuana on School Property
In Connecticut, 5.2% of high school students used marijuana on school property one or more times during the 30 days before the survey. Nationwide, the rate is 5.9%. In Connecticut, the prevalence of marijuana use on school property is significantly higher among male (7%) than among female (3.3%) students.

Ever Used Cocaine
In Connecticut, 5% of high school students have used any form of cocaine one or more times during their life (i.e., ever used cocaine). Nationwide, the rate is 6.8%. In Connecticut, the prevalence of having ever used cocaine is significantly higher in grades 11 (7%) and 12 (7%) than in grade 10 (1.6%).

The prevalence of having ever used cocaine is significantly higher in grade 10 among US (6.5%) than among CT (1.6%) students.

Ever Used Inhalants
In Connecticut, 9% of high school students have sniffed glue, breathed the contents of aerosol spray cans, or inhaled any paints or sprays to get high one or more times during their life (i.e., ever used inhalants). Nationwide, the rate is 11.4%. Overall in Connecticut, the prevalence of having ever used inhalants does not vary significantly by gender, race/ethnicity, or grade.

The prevalence of having ever used inhalants is significantly higher in grade 10 among US (11.8%) than among CT (7%) students.

Ever Used Ecstasy
In Connecticut, 6.3% of high school students have used ecstasy one or more times during their life (i.e., ever used ecstasy). Nationwide, the rate is 8.2%. In Connecticut, the prevalence of having ever used ecstasy is significantly higher among Hispanic (9.2%) than among black (1.9%) students.

The prevalence of having ever used ecstasy is significantly higher in grade 10 among US (7.7%) than among CT (3.4%) students.

Ever Used Heroin
In Connecticut, 2.9% of high school students have used heroin one or more times during their life (i.e., ever used heroin). Nationwide, the rate is 2.9%. Overall in Connecticut, the prevalence of having ever used heroin does not vary significantly by gender, race/ethnicity, or grade.

Ever Used Methamphetamines
In Connecticut, 3.2% of high school students have used methamphetamines one or more times during their life (i.e., ever used methamphetamines). Nationwide, the rate is 3.8%. Overall in Connecticut, the prevalence of having ever used methamphetamines does not vary significantly by gender, race/ethnicity, or grade.

Ever Used Over-the-Counter Drugs to Get High
In Connecticut, 9.7% of high school students have used over-the-counter (OTC) drugs one or more times during their life to get high (i.e., ever used OTC drugs to get high). Overall, the prevalence of having ever used OTC drugs to get high does not vary significantly by gender, race/ethnicity, or grade.

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Summary of Results

Ever Taken a Prescription Drug to Get High
In Connecticut, 9.6% of high school students have taken a prescription drug without a doctor's prescription one or more times during their life to get high (i.e., ever taken a prescription drug to get high). Overall, the prevalence of having ever taken a prescription drug to get high does not vary significantly by gender, race/ethnicity, or grade.

Offered, Sold, or Given an Illegal Drug on School Property
During the 12 months before the survey, 27.8% of high school students were offered, sold, or given an illegal drug on school property. Nationwide, the rate is 25.6%. In Connecticut, the prevalence of being offered, sold, or given an illegal drug on school property is significantly higher among male (32.3%) than among female (23.3%) students.

Sexual Behaviors that Contribute to Unintended Pregnancy and Sexually Transmitted Diseases, Including HIV Infection

Ever had Sexual Intercourse
In Connecticut, 42.7% of high school students have ever had sexual intercourse. Nationwide, the rate is 47.4%. In Connecticut, the prevalence of having ever had sexual intercourse is significantly higher among black (55.1%) and Hispanic (51.8%) than among white (38.5%) students; and significantly higher in grades 11 (51.2%) and 12 (64.2%) than in grades 9 (25.4%) and 10 (31.6%).

The prevalence of having ever had sexual intercourse is significantly higher in grade 10 among US (43.8%) than among CT (31.6%) students.

Had First Sexual Intercourse Before Age 13 Years
In Connecticut, 4.9% of high school students had sexual intercourse for the first time before age 13 years. Nationwide, the rate is 6.2%. In Connecticut, the prevalence of having sexual intercourse before age 13 years is significantly higher among black (11.3%) and Hispanic (8.6%) than among white (2.5%) students.

Had Sexual Intercourse with Four or More Persons During Their Life
In Connecticut, 10.6% of high school students have had sexual intercourse with four or more persons during their life. Nationwide, the rate is significantly higher (15.3%). In Connecticut, the prevalence of having had sexual intercourse with four or more persons is significantly higher among black (20.9%) and Hispanic (15.7%) than among white (7.7%) students; and significantly higher in grade 12 (20%) than in grades 9 (5.5%) and 10 (6.3%).

The prevalence of having had sexual intercourse with four or more persons is significantly higher among US male (17.8%) than among CT male (12.6%) students; significantly higher among US female (12.6%) than among CT female (8.6%) students; significantly higher among US white (13.1%) than among CT white (7.7%) students; and significantly higher in grade 10 among US (12.3%) than among CT (6.3%) students.

Currently Sexually Active
In Connecticut, 30.5% of high school students had sexual intercourse with one or more persons during the three months before the survey (i.e., currently sexually active). Nationwide, the rate is 33.7%. In Connecticut, the prevalence of being currently sexually active is significantly higher among black (42.3%) than among white (28.3%) students; and significantly higher in grades 11 (35.4%) and 12 (48.2%) than in grades 9 (16.8%) and 10 (23.3%).

Sexual Identity
In Connecticut, 7.2% of high school students describe themselves as gay, lesbian, or bisexual. The prevalence of describing themselves as gay, lesbian, or bisexual is significantly higher among female (9%) than among male (5.2%) students.

Had Sexual Contact with Males and Females
In Connecticut, 5% of high school students have had sexual contact with males and females during their life. The prevalence of having had sexual contact with males and females is significantly higher among female (6.9%) than among male (2.8%) students; and significantly higher among Hispanic (9.4%) than among white (3.9%) students.

Summary of Results

Condom Use
Among the 30.5% of currently sexually active high school students in Connecticut, 60.5% report that either they or their partner used a condom during last sexual intercourse. Nationwide, the rate is 60.2%. In Connecticut, among currently sexually active students, the prevalence of using a condom during last sexual intercourse is significantly higher among male (68.5%) than among female (53.3%) students.

Used Alcohol or Drugs Before Last Sexual Intercourse
Among the 30.5% of sexually active Connecticut high school students, 18.8% drank alcohol or used drugs before last sexual intercourse. Nationwide, the rate is 22.1%. Overall in Connecticut, among currently sexually active students, the prevalence of using alcohol or drugs before last sexual intercourse does not vary significantly by gender, race/ethnicity, or grade.

Pregnancy
In Connecticut, among the 42.7% of high school students who have ever had sexual intercourse, 6.7% have ever been pregnant or have ever gotten someone pregnant. Among students who have ever had sexual intercourse, the prevalence of ever being pregnant or ever getting someone pregnant is significantly higher among Hispanic (11.6%) than among white (4.2%) students.

Ever Tested for HIV
In Connecticut, 14.2% of high school students have ever been tested for HIV, the virus that causes AIDS. Nationwide, the rate is 12.9%. In Connecticut, the prevalence of having ever been tested for HIV is significantly higher among black (23.8%) than among white (12.1%) students.

The prevalence of having ever been tested for HIV is significantly higher among CT Hispanic (19%) than among US Hispanic (12.5%) students.

Ever had an STD
In Connecticut, 5.2% of high school students have ever been told by a doctor or nurse that they have a sexually transmitted disease (STD). The prevalence of having ever been told they have an STD is significantly higher among black (11.1%) than among white (4%) students.

Dietary Behaviors and Physical Activity

Ate Fruits and Vegetables Five or More Times per Day
In Connecticut, 19.7% of high school students ate fruits and vegetables five or more times per day during the seven days before the survey. Overall, the prevalence of eating fruits and vegetables five or more times per day does not vary significantly by gender, race/ethnicity, or grade.

Did Not Participate in 60 Minutes or More of Physical Activity on Any Day
In Connecticut, 11.5% of high school students did not participate in any kind of physical activity for a total of at least 60 minutes on one or more of the seven days before the survey. Nationwide, the rate is 13.8%. In Connecticut, the prevalence of not participating in at least 60 minutes of physical activity on any day is significantly higher among black (18.7%) than among white (10.%) students.

The prevalence of not participating in at least 60 minutes of physical activity on any day is significantly higher among US female (17.7%) than among CT female (13.2%) students.

Physically Active 60 Minutes or More per Day on Five or More Days
In Connecticut, 49.5% of high school students were physically active for a total of at least 60 minutes per day on five or more of the seven days before the survey. Nationwide, the rate is 49.5%. In Connecticut, the prevalence of being physically active at least 60 minutes per day on five or more days is significantly higher among male (57.9%) than among female (41.1%) students; and significantly higher among white (54.7%) than among black (34.1%) and Hispanic (38.9%) students.

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Summary of Results

Use Computers Three or More Hours per Day
In Connecticut, 30.5% of high school students play video or computer games or use a computer for something that is not school work three or more hours per day on an average school day (i.e., computer use). Nationwide, the rate is 31.1%. In Connecticut, the prevalence of computer use is significantly higher among Hispanic (36.4%) than among white (27.3%) students; and significantly higher in grade 11 (35.2%) than in grade 12 (24%).

Watch Television Three or More Hours per Day
In Connecticut, 27.1% of high school students watch television three or more hours per day on an average school day. Nationwide, the rate is significantly higher (32.4%). In Connecticut, the prevalence of watching television three or more hours per day is significantly higher among black (46%) than among white (22.1%) and Hispanic (32.4%) students; and significantly higher among Hispanic (32.4%) than among white (22.1%) students.

The prevalence of watching television three or more hours per day is significantly higher in grade 9 among US (33.9%) than among CT (25.9%) students.

Obesity, Overweight, and Weight Control

Obese
In Connecticut, 12.5% of high school students are obese (i.e., at or above the 95th percentile for body mass index, by age and sex). Nationwide, the rate is 13%. In Connecticut, the prevalence of obesity is significantly higher among male (16.5%) than among female (8.4%) students; and significantly higher among black (24%) than among white (9.8%) students.

Overweight
In Connecticut, 14.1% of high school students are overweight (i.e., at or above the 85th percentile but below the 95th percentile for body mass index, by age and sex). Nationwide, the rate is 15.2%. In Connecticut, the prevalence of overweight is significantly higher among male (16.5%) than among female (11.7%) students; and significantly higher among black (19.9%) than among white (12.3%) students.

The prevalence of overweight is significantly higher among US female (15.4%) than CT female (11.7%) students.

Describe Themselves as Overweight
In Connecticut, 28.7% of high school students describe themselves as slightly or very overweight. Nationwide, the rate is 29.2%. Overall in Connecticut, the prevalence of describing themselves as overweight does not vary significantly by gender, race/ethnicity, or grade.

The prevalence of describing themselves as overweight is significantly higher among CT black (36.6%) than among US black (26.8%) students.

Trying to Lose Weight
In Connecticut, 47.1% of high school students are trying to lose weight. Nationwide, the rate is 46%. In Connecticut, the prevalence of trying to lose weight is significantly higher among female (59.8%) than among male (34.7%) students.

The prevalence of trying to lose weight is significantly higher among CT black (54.8%) than among US black (40.9%) students.

Dieted to Lose Weight or to Keep from Gaining Weight
During the 30 days before the survey, 57.9% of high school students ate less food, fewer calories, or foods low in fat to lose weight or to keep from gaining weight (i.e., dieted). The prevalence of having dieted to control their weight is significantly higher among female (68%) than among male (48.2%) students.

Summary of Results

Did Not Eat for 24 or More Hours to Lose Weight or to Keep from Gaining Weight
In Connecticut, 8.9% of high school students did not eat for 24 or more hours to lose weight or to keep from gaining weight during the 30 days before the survey. The prevalence of not eating for 24 or more hours to control their weight is significantly higher among female (11.6%) than among male (6.2%) students.

Used Diet Aids or Vomited to Lose Weight or to Keep from Gaining Weight
During the 30 days before the survey, 6% of high school students used laxatives or diet pills, powders, or liquids without a doctor's advice or vomited to lose weight or to keep from gaining weight. Overall, the prevalence of using diet aids or vomiting to control their weight does not vary significantly by gender, race/ethnicity, or grade.

Other Health-Related Topics

Spend Four or More Hours After School Without an Adult Present
In Connecticut, 23.5% of high school students usually spend four or more hours after school without an adult present. Overall, the prevalence of usually spending four or more hours after school without an adult present does not vary significantly by gender, race/ethnicity, or grade.

Whereabouts when Away from Home Rarely or Never Known by Parents
In Connecticut, 8.4% of high school students report that where they will be when they are away from home is rarely or never known by their parents or other adults in their family. The prevalence of parents rarely or never knowing student's whereabouts when away from home is significantly higher among male (10.9%) than among female (5.7%) students.

Gambled for Money or Possessions
In Connecticut, 25.2% of high school students gambled for money or possessions one or more times during the 12 months before the survey. The prevalence of gambling is significantly higher among male (38.2%) than among female (11.8%) students.

Have a Paying Job
In Connecticut, 21.6% of high school students work at a paying job outside of their home five or more hours during an average week when they are in school. The prevalence of having a paying job is significantly higher in grades 11 (25.5%) and 12 (48.3%) than in grades 9 (5.8%) and 10 (9.8%); and significantly higher in grade 12 (48.3%) than in grade 11 (25.5%).

Protective Factors

Get Eight or More Hours of Sleep
In Connecticut, 26.2% of high school students get eight or more hours of sleep. Nationwide, the rate is significantly higher (31.4%). In Connecticut, the prevalence of getting eight or more hours of sleep is significantly higher among white (28.5%) than among black (18.8%) students.

The prevalence of getting eight or more hours of sleep is significantly higher among US male (33.6%) than among CT male (26.9%) students; significantly higher among US black (27.9%) than among CT black (18.8%) students; significantly higher among US Hispanic (30.8%) than CT Hispanic (22.1%) students; and significantly higher in grade 9 among US (40%) than among CT (31.4%) students.

Ate Meals with Their Family
In Connecticut, 65.5% of high school students ate at least one meal with their family on three or more of the seven days before the survey. The prevalence of eating at least one meal with their family on three or more days is significantly higher among white (71.4%) than among black (47.4%) and Hispanic (55.6%) students.

Summary of Results

Live with Two Parents Most of the Time
In Connecticut, 56.2% of high school students live with two parents (not including stepparents or foster parents) most of the time. The prevalence of living with two parents most of the time is significantly higher among white (63.6%) than among black (34.8%) and Hispanic (43.1%) students.

Receive Family Love and Support
In Connecticut, 86% of high school students agree or strongly agree that their family loves them and gives them help and support when they need it. Overall, the prevalence of agreeing that their family loves and supports them does not vary significantly by gender, race/ethnicity, or grade.

Seeking Help from Adults
In Connecticut, 78% of high school students would feel comfortable seeking help from one or more adults besides their parents if they had an important question affecting their life. Overall, the prevalence of feeling comfortable seeking help from other adults does not vary significantly by gender, race/ethnicity, or grade.

Get Help Needed when Upset
In Connecticut, 28.1% of high school students say they most of the time or always get the kind of help they need when they feel sad, empty, hopeless, angry, or anxious. The prevalence of getting the kind of help they need when they are upset is significantly higher in grades 10 (31.1%) and 12 (32.7%) than in grade 9 (21.9%).

Parents Talked to Them About Sex
In Connecticut, 65.1% of high school students report that their parents or other adults in their family talked to them about what they expect them to do or not to do when it comes to sex. The prevalence of parents talking to them about sex is significantly higher among female (69.8%) than among male (60.3%) students.

Disapprove of Drinking Alcohol Nearly Every Day
In Connecticut, 71.1% of high school students strongly disapprove or somewhat disapprove of someone their age having one or two drinks of alcohol nearly every day. The prevalence of disapproving of drinking alcohol nearly every day is significantly higher among female (77%) than among male (65.6%) students.

Believe Heavy Weekend Drinking is Risky
In Connecticut, 36.3% of high school students think people greatly risk harming themselves if they have five or more drinks of alcohol once or twice each weekend (i.e., believe heavy weekend drinking is risky). The prevalence of believing that heavy weekend drinking is risky is significantly higher among female (43.5%) than among male (29.6%) students.

Describe Health as Very Good or Excellent
In Connecticut, 62.9% of high school students describe their health as very good or excellent. The prevalence of describing their health as very good or excellent is significantly higher among male (66.8%) than among female (58.9%) students.

Describe Grades as Mostly As and Bs
In Connecticut, 71.1% of high school students describe their grades in school as mostly As and Bs in the 12 months before the survey. The prevalence of describing their grades as mostly As and Bs is significantly higher among female (78.1%) than among male (64.5%) students; and significantly higher among white (77.1%) than among Hispanic (53.6%) students.

Participated in Organized After School Activities
In Connecticut, 64.3% of high school students took part in after school, evening, or weekend activities on one or more of the seven days before the survey. The prevalence of participating in organized after school activities is significantly higher among white (67.5%) than among Hispanic (55.2%) students; and significantly higher in grade 10 (71.1%) than in grade 12 (59.5%).

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Summary of Results

Volunteered
During the 30 days before the survey, 49.5% of high school students spent one or more hours helping other people without getting paid to make their community a better place for people to live (i.e., volunteered). The prevalence of having volunteered is significantly higher in grade 10 (55.3%) than in grades 9 (44.2%) and 11 (43.9%).

Will Definitely Complete a Post High School Program
In Connecticut, 54.7% of high school students believe that they will definitely complete a post high school program. The prevalence of believing they will definitely complete a post high school program is significantly higher among female (61.6%) than among male (48.4%) students; significantly higher among white (58.7%) than among Hispanic (44.8%) students; and significantly higher in grades 11 (59.1%) and 12 (64%) than in grade 9 (41.9%).

Trends 1997-2011: Significant Findings

Rarely or Never Wear a Seat Belt
During 1997-2011, a significant linear decrease (23.6%-9.2%) occurred in the percentage of high school students who rarely or never wear a seat belt when riding in a car driven by someone else. The prevalence of rarely or never wearing a seat belt decreased significantly during 1997-2011 among male (27%-10.9%), female (20%-7.3%), white (21.2%-7.3%), and Hispanic (37.7%-13.8%) students.

Rode with a Driver Who had been Drinking Alcohol
During 1997-2011, a significant linear decrease (38.3%-25.2%) occurred in the percentage of high school students who rode in a car or other vehicle driven by someone who had been drinking alcohol. The prevalence of riding in a car driven by someone who had been drinking alcohol decreased significantly during 1997-2011 among male (38.2%-25%), female (38.4%-25.4%), white (36.9%-24.7%), and Hispanic (47%-28.4%) students.

Drove when Drinking Alcohol
During 1997-2011, a significant linear decrease (14.6%-6.9%) occurred in the percentage of high school students who drove a car or other vehicle when they had been drinking alcohol. The prevalence of driving a car when they had been drinking alcohol decreased significantly during 1997-2011 among male (18.6%-9.1%), female (10.6%-4.6%), and white (14.7%-7%) students.

Carried a Weapon on School Property
During 2009-2011, the percentage of high school students who carried a weapon on school property increased significantly (3.9%-6.6%). The prevalence of carrying a weapon on school property increased significantly during 2009-2011 among male (5.5%-9.8%) and white (3.4%-5.7%) students.

Threatened or Injured with a Weapon on School Property
During 2005-2011, a significant linear decrease (12.5%-5.7%) occurred in the percentage of black students who were threatened or injured with a weapon on school property. During 2009-2011, the percentage of white students who were threatened or injured with a weapon on school property increased significantly (3.4%-5.7%).

In a Physical Fight
During 1997-2011, a significant linear decrease (33.8%-25.1%) occurred in the percentage of high school students who were in a physical fight. The prevalence of being in a physical fight decreased significantly during 1997-2011 among male (43.5%-32.4%), female (23.9%-17.6%), and white (33.7%-23.1%) students.

In a Physical Fight on School Property
During 1997-2011, a significant linear decrease (13.2%-8.7%) occurred in the percentage of high school students who were in a physical fight on school property. The prevalence of being in a physical fight on school property decreased significantly during 1997-2011 among male (17.6%-12.4%), female (8.5%-4.8%), and white (12.6%-7.8%) students.

Summary of Results

Did Not Go to School Because of Safety Concerns
During 1997-2011, a significant linear increase (2.2%-4.7%) occurred in the percentage of white students who did not go to school because they felt they would be unsafe at school or on their way to or from school. During 2005-2011, a significant linear decrease (10.6%-3.8%) occurred in the percentage of black students who did not go to school because of safety concerns.

Dating Violence
During 2005-2011, a significant linear decrease (16%-8.2%) occurred in the percentage of high school students who were ever hit, slapped, or physically hurt on purpose by their boyfriend or girlfriend (i.e., dating violence). The prevalence of dating violence decreased significantly during 2005-2011 among male (17.8%-9.3%), female (14.1%-7%), white (15.1%-7.8%), black (17.1%-8.6%), and Hispanic (17.6%-8.4%) students.

Forced to have Sexual Intercourse
According to the CDC, during 2007-2011, a significant linear decrease (9.7%-7.3%) occurred in the percentage of high school students who were ever physically forced to have sexual intercourse when they did not want to. During 2007-2011, the prevalence of ever being physically forced to have sexual intercourse decreased significantly among male (7.9%-4.4%) and white (8%-5.5%) students. During 2009-2011, the percentage of male students who had ever been forced to have sexual intercourse decreased significantly (6.3%-4.4%).

Felt Sad or Hopeless
During 2005-2011, a significant linear decrease (30.5%-21.2%) occurred in the percentage of black students who felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities.

Seriously Considered Attempting Suicide
During 1997-2011, a significant linear decrease (21.6%-14.6%) occurred in the percentage of high school students who ever seriously considered attempting suicide. The prevalence of having seriously considered attempting suicide decreased significantly during 1997-2011 among male (15.7%-11.9%), female (27.5%-17.3%), and white (21.4%-13.1%) students.

Attempted Suicide
During 1997-2011, a significant linear decrease (9.1%-6.7%) occurred in the percentage of high school students who actually attempted suicide. The prevalence of having actually attempted suicide decreased significantly during 1997-2011 among female (12.5%-8.2%), white (8.1%-5.5%), and Hispanic (17.6%-11%) students. During 2005-2011, a significant linear decrease (11.5%-6.2%) occurred in the percentage of black students who actually attempted suicide.

Current Cigarette Smoking
During 1997-2011, a significant linear decrease (35.2%-15.9%) occurred in the percentage of high school students who smoked cigarettes on at least 1 day in the past 30 days (i.e., current cigarette smoking).

Frequent Cigarette Smoking
During 1997-2011, a significant linear decrease (17.9%-5.4%) occurred in the percentage of high school students who smoked cigarettes on 20 or more days of the past 30 days (i.e., frequent cigarette smoking).

Drank Alcohol Before Age 13 Years
During 1997-2011, a significant linear decrease (28.7%-15.6%) occurred in the percentage of high school students who drank alcohol for the first time before age 13 years. The prevalence of drinking alcohol before age 13 years decreased significantly during 1997-2011 among male (33.5%-18.2%), female (23.5%-12.7%), white (25.7%-13.8%), and Hispanic (34.2%-20.7%) students. During 2009-2011, the percentage of black students who drank alcohol before age 13 years decreased significantly (25.5%-16.7%).

Summary of Results

Current Alcohol Use
During 1997-2011, a significant linear decrease (52.6%-41.5%) occurred in the percentage of high school students who had at least one drink of alcohol on 1 or more of the past 30 days (i.e., current alcohol use). The prevalence of current alcohol use decreased significantly during 1997-2011 among male (54.1%-41.3%), female (51.3%-42.1%), and white (53.5%-44.8%) students. During 2009-2011, the prevalence of current alcohol use among black students decreased significantly (38.1%-28.1%).

Binge Drinking
During 1997-2011, a significant linear decrease (31.2%-22.3%) occurred in the percentage of high school students who had five or more drinks of alcohol in a row on at least 1 day in the past 30 days (i.e., binge drinking). The prevalence of binge drinking decreased significantly during 1997-2011 among male (34.5%-25.4%), female (27.9%-19.3%), and white (32.2%-24.8%) students.

Drank Alcohol on School Property
During 1997-2011, a significant linear decrease (7.1%-4.6%) occurred in the percentage of high school students who had at least one drink of alcohol on school property. The prevalence of drinking alcohol on school property decreased significantly during 1997-2011 among male (8.4%-5.8%), white (6.2%-4.1%), and Hispanic (14.3%-5.5%) students.

Ever Used Marijuana
According to the CDC, during 1997-2011, a significant linear decrease (44.9%-39.6%) occurred in the percentage of high school students who used marijuana one or more times during their life (i.e., ever used marijuana). According to the CDC, during 1997-2011, the prevalence of having ever used marijuana decreased significantly among male (46.9%-43.7%), female (42.6%-35.7%), and Hispanic (44.6%-40.1%) students.

Tried Marijuana Before Age 13 Years
According to the CDC, during 1997-2011, a significant linear decrease (7.7%-6.3%) occurred in the percentage of high school students who tried marijuana for the first time before age 13 years. During 2005-2011, a significant linear decrease (15.2%-6.9%) occurred in the percentage of black students who tried marijuana before age 13 years.

Used Marijuana on School Property
During 1997-2011, a significant linear decrease (7.9%-5.2%) occurred in the percentage of high school students who used marijuana on school property. The prevalence of having used marijuana on school property decreased significantly (10.2%-7%) among male students during 1997-2011.

Ever Used Inhalants
During 1997-2011, a significant linear decrease (19.1%-9%) occurred in the percentage of high school students who used inhalants one or more times during their life (i.e., ever used inhalants).

Ever Used Methamphetamines
During 2005-2011, a significant linear decrease (5.9%-3.2%) occurred in the percentage of high school students who used methamphetamines one or more times during their life (i.e., ever used methamphetamines).

Ever had Sexual Intercourse
According to the CDC, during 1997-2011, a significant linear decrease (43.5%-42.7%) occurred in the percentage of high school students who have ever had sexual intercourse. During 1997-2011, according to the CDC, a significant linear decrease (42.3%-41.8%) occurred in the percentage of female students who have ever had sexual intercourse.

Had Sexual Intercourse with Four or More Persons During Their Life
According to the CDC, during 1997-2011, a significant linear decrease (11.7%-10.6%) occurred in the percentage of high school students who have had sexual intercourse with four or more persons during their life. During 1997-2011, according to the CDC, a significant linear decrease (10%-8.6%) occurred in the percentage of female students who

have had sexual intercourse with four or more persons during their life. During 2005-2011, a significant linear decrease (26.2%-20.9%) occurred in the percentage of black students who have had sexual intercourse with four or more persons during their life.

Currently Sexually Active
During 2007-2011, a significant linear decrease (41.2%-33.7%) occurred in the percentage of Hispanic students who had sexual intercourse with one or more person in the past three months (i.e., currently sexually active).

Used Alcohol or Drugs Before Last Sexual Intercourse
During 2007-2011, a significant linear decrease (27.9%-18.8%) occurred in the percentage of currently sexually active high school students who used alcohol or drugs before last sexual intercourse. During 2009-2011, the percentage of currently sexually active students who used alcohol or drugs before last sexual intercourse decreased significantly (24.8%-18.8%). The prevalence of alcohol or drug use before last sexual intercourse decreased significantly during 2007-2011 among currently sexually active male (33.9%-19.4%) and white (30.5%-19.8%) students. During 2009-2011, the percentage of currently sexually active male (28.3%-19.4%) and white (28.6%-19.8%) students who used alcohol or drugs before last sexual intercourse decreased significantly.

Did Not Participate in 60 Minutes or More of Physical Activity on Any Day
During 2007-2011, a significant linear decrease (14.5%-11.5%) occurred in the percentage of high school students who did not participate in any kind of physical activity for a total of at least 60 minutes on any day.

Physically Active 60 Minutes or More per Day on Five or More Days
During 2007-2011, a significant linear increase (45.1%-49.5%) occurred in the percentage of high school students who participated in at least 60 minutes of physical activity per day on five or more days.

Watch Television Three or More Hours per Day
During 2005-2011, a significant linear decrease (33.5%-27.1%) occurred in the percentage of high school students who watch three or more hours of television on an average school day.

Trying to Lose Weight
During 1997-2011, a significant linear increase (43%-47.1%) occurred in the percentage of high school students who were trying to lose weight.

Did Not Eat for 24 or More Hours to Lose Weight or Keep from Gaining Weight
During 2005-2011, a significant linear decrease (12.1%-8.9%) occurred in the percentage of high school students who went without eating for 24 or more hours to lose weight or to keep from gaining weight.

Have a Paying Job
During 2005-2011, a significant linear decrease (34.9%-21.6%) occurred in the percentage of high school students who work at a paying job outside their home five or more hours during an average week when they are in school. The prevalence of having a paying job decreased significantly during 2005-2011 among male (35.5%-21.8%), female (33.8%-21.2%), and white (37.8%-22.2%) students.

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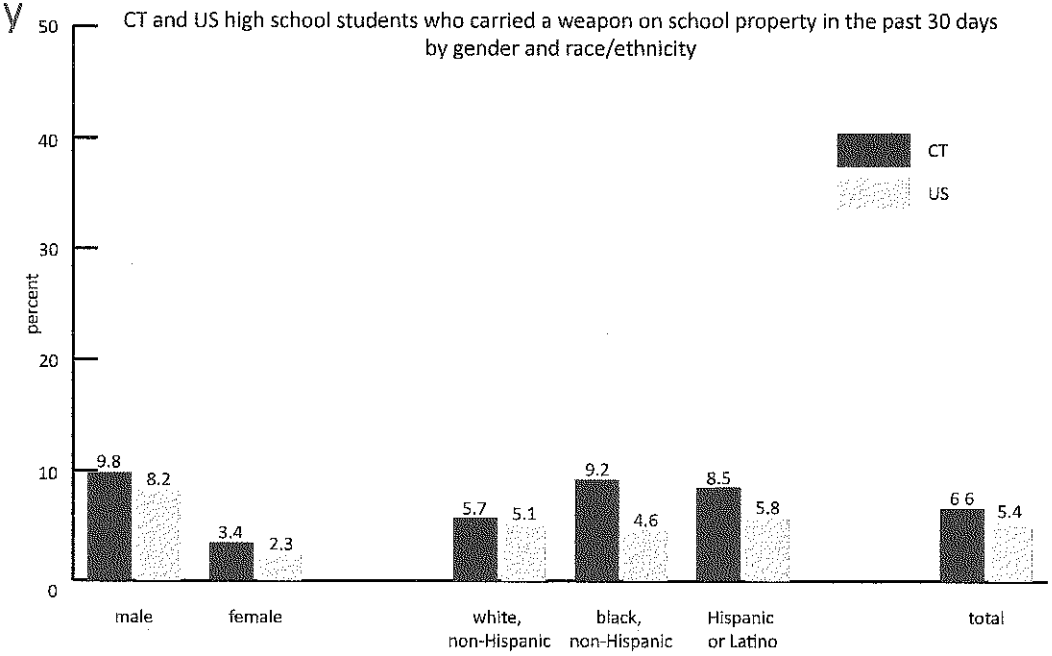
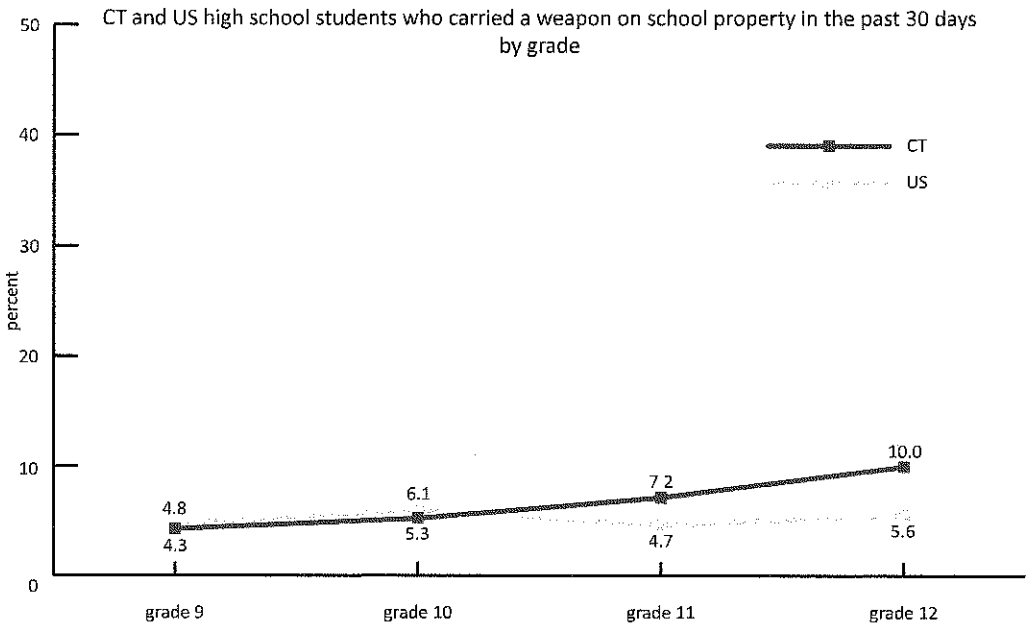
Carried a Weapon on School Property

- In Connecticut, 6.6% of high school students carried a weapon (e.g., gun, knife, or club) on school property on at least 1 day during the 30 days preceding the survey
- Overall in Connecticut, the prevalence of carrying a weapon on school property:
  - Is significantly higher among male (9.8%) than among female (3.4%) students
  - Does not vary significantly by race/ethnicity
  - Is significantly higher in grade 12 (10%) than in grade 9 (4.3%)
- The prevalence of carrying a weapon on school property is significantly higher in grade 12 among CT (10%) than among US (5.6%) students



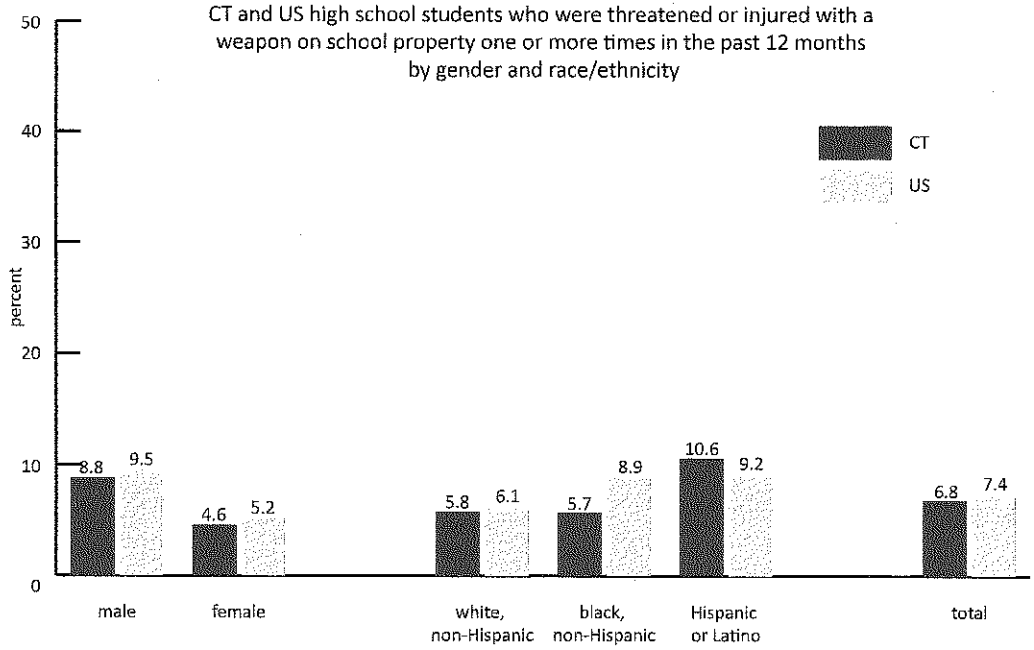


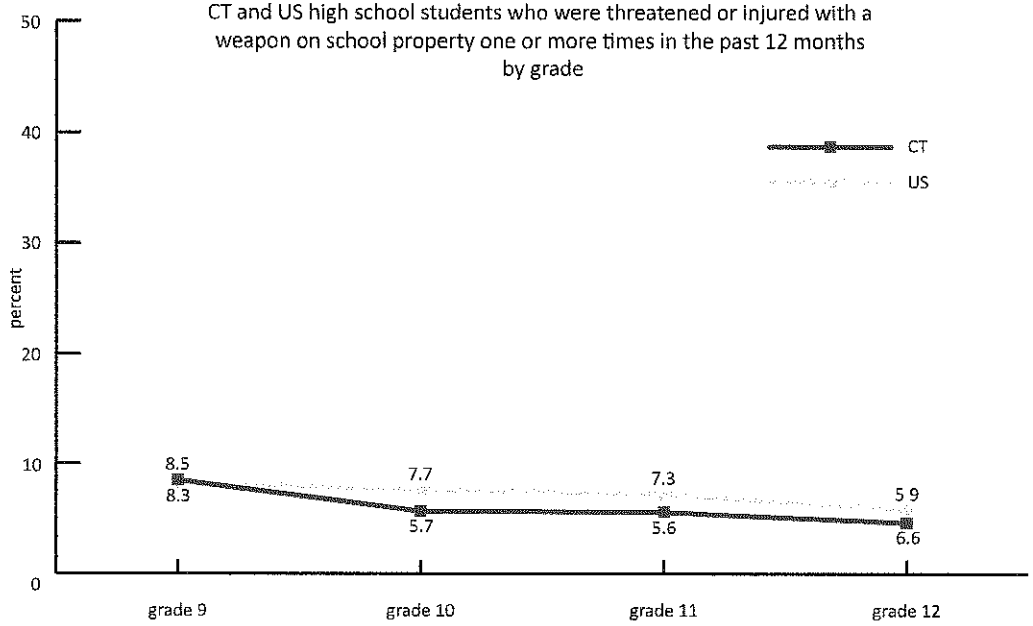
Threatened or Injured with a Weapon on School Property

- During the 12 months preceding the survey, 6.8% of high school students in Connecticut were threatened or injured with a weapon (e.g., gun, knife, or club) one or more times on school property

- Overall in Connecticut, the prevalence of being threatened or injured with a weapon on school property:
  - Is significantly higher among male (8.8%) than among female (4.6%) students
  - Is significantly higher among Hispanic (10.6%) than among white (5.8%) students
  - Does not vary significantly by grade

- None of Connecticut's rates vary significantly from the national rates



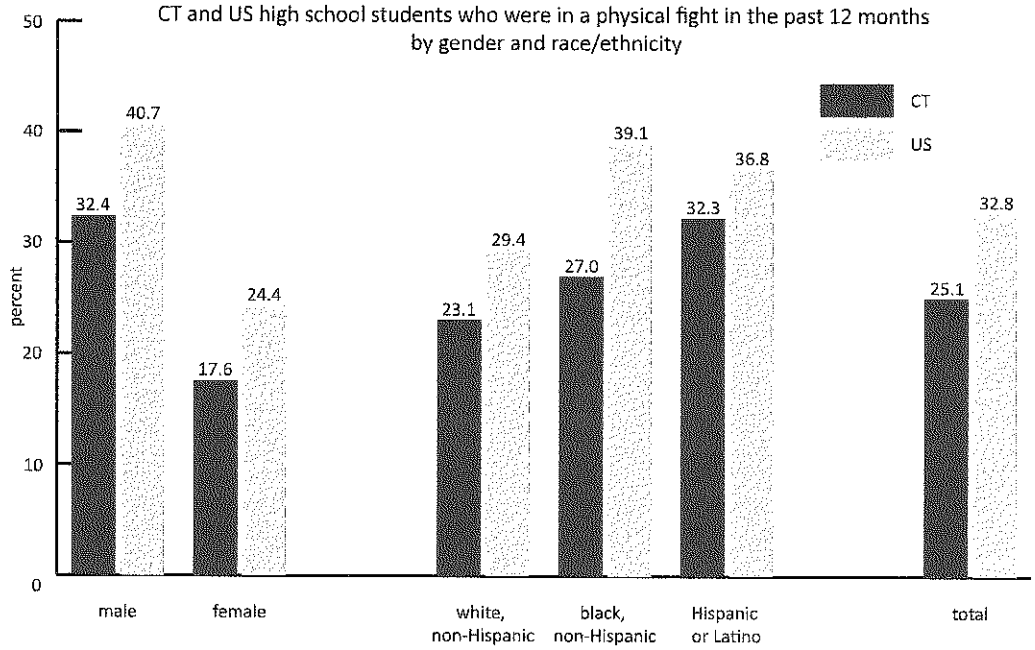


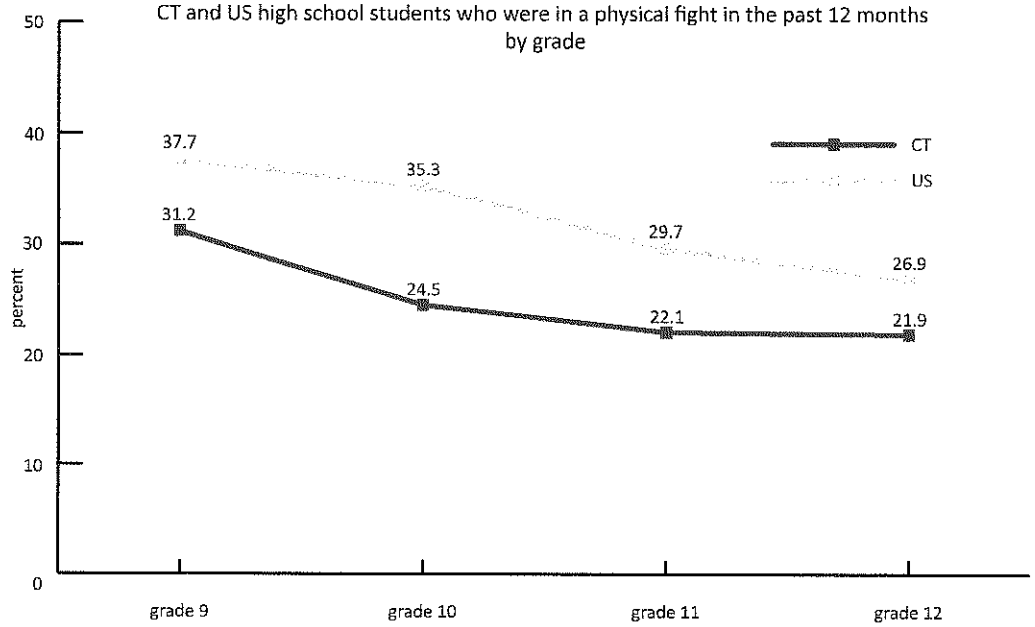
In a Physical Fight

- In Connecticut, 25.1% of high school students were in a physical fight one or more times during the 12 months preceding the survey

- Overall in Connecticut, the prevalence of being in a physical fight:
  - Is significantly higher among male (32.4%) than among female (17.6%) students
  - Does not vary significantly by race/ethnicity or grade

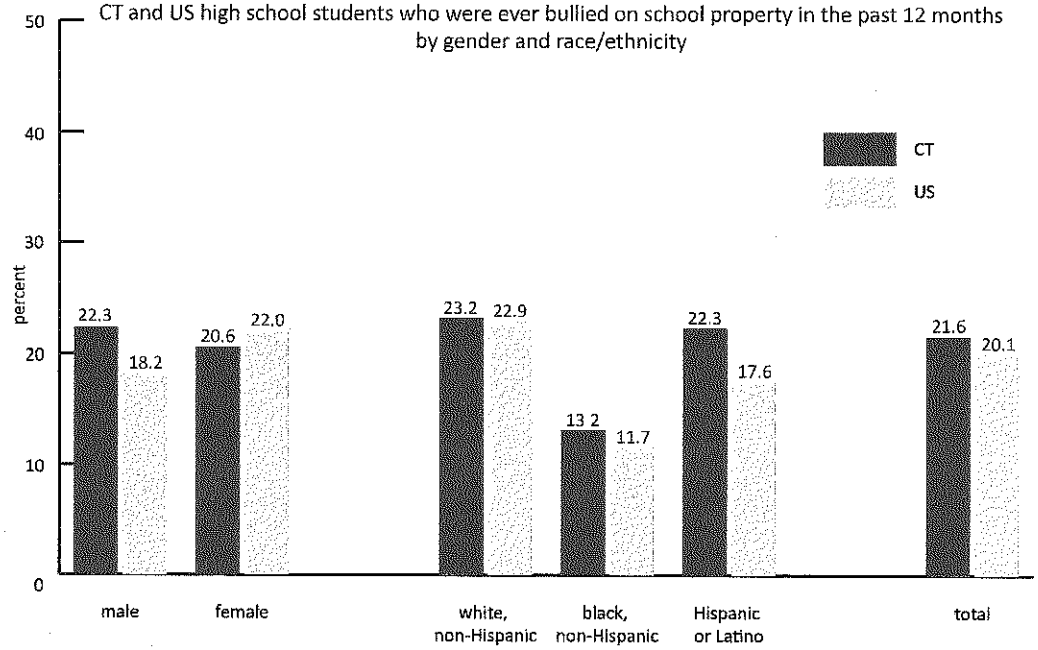
- The prevalence of physical fighting:
  - Is significantly higher nationwide (32.8%) than in CT (25.1%)
  - Is significantly higher among US male (40.7%) than among CT male (32.4%) students and significantly higher among US female (24.4%) than among CT female (17.6%) students
  - Is significantly higher among US white (29.4%) than among CT white (23.1%) students and significantly higher among US black (39.1%) than among CT black (27%) students
  - Is significantly higher in grade 10 among US (35.3%) than among CT (24.5%) students

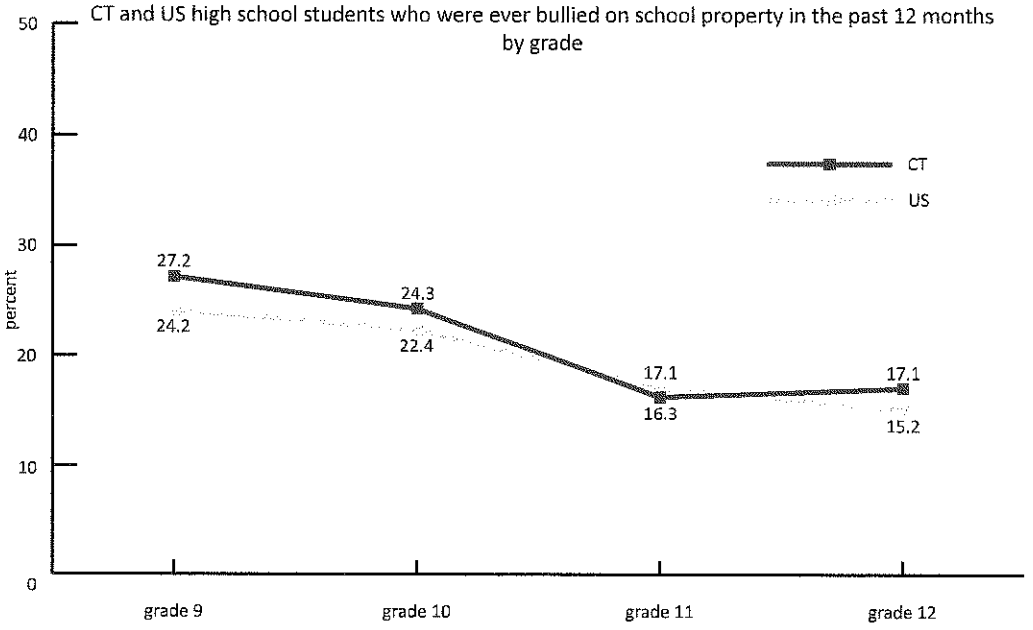




Bullied on School Property

- During the 12 months preceding the survey, 21.6% of high school students in Connecticut were ever bullied on school property
- Overall in Connecticut, the prevalence of ever being bullied on school property:
  - Does not vary significantly by gender
  - Is significantly higher among white (23.2%) than among black (13.2%) students
  - Is significantly higher in grade 9 (27.2%) than in grades 11 (16.3%) and 12 (17.1%)
- None of Connecticut's rates vary significantly from the national rates





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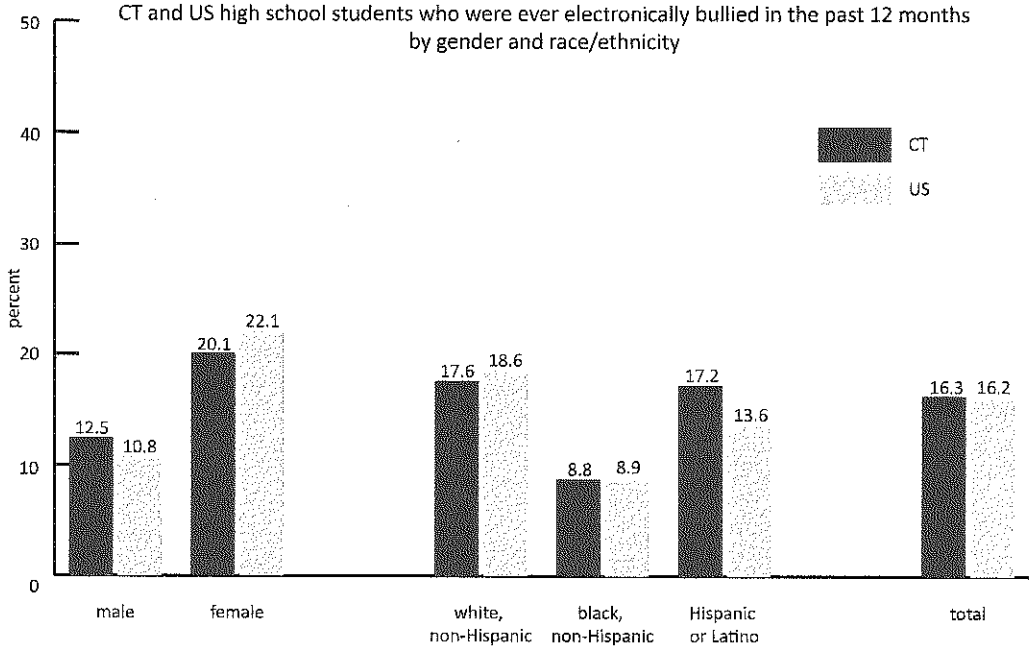
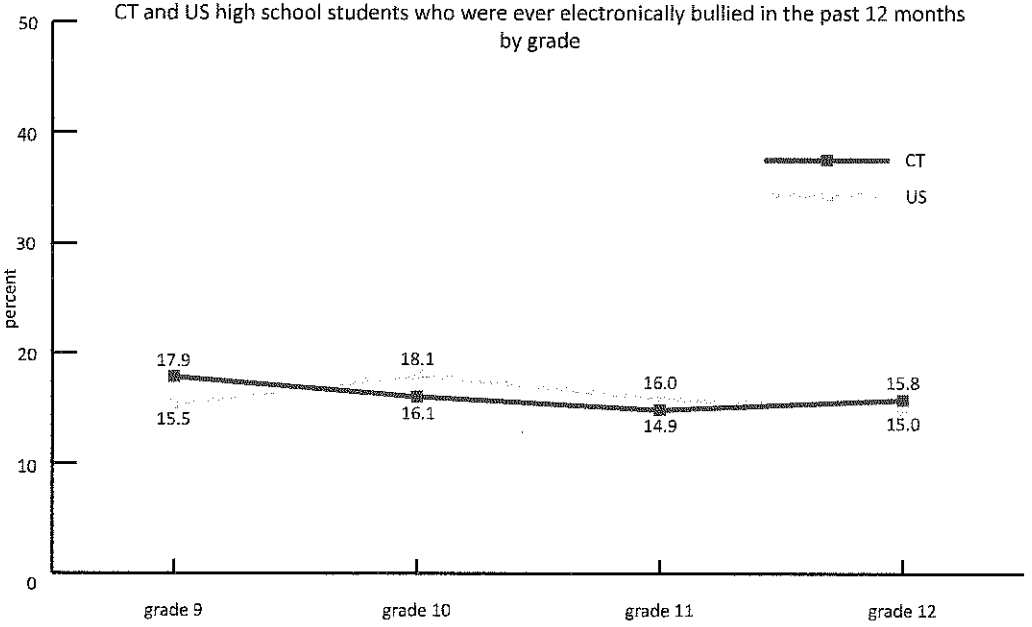
Electronically Bullied

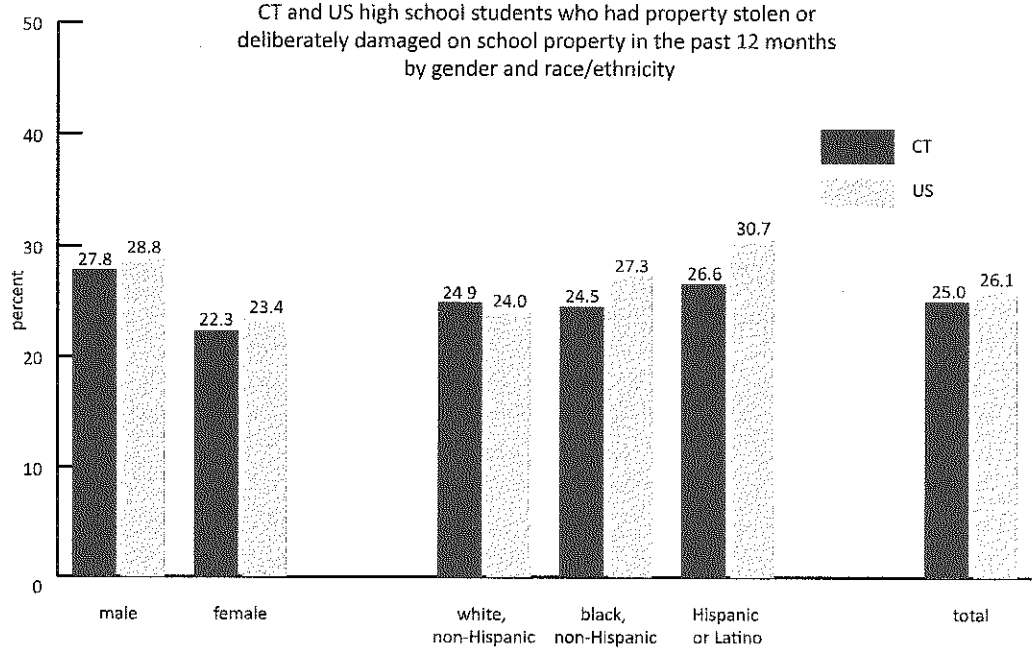
- During the 12 months preceding the survey, 16.3% of Connecticut high school students were ever electronically bullied
- Overall in Connecticut, the prevalence of ever being electronically bullied:
  - Is significantly higher among female (20.1%) than among male (12.5%) students
  - Is significantly higher among white (17.6%) than among black (8.8%) students
  - Does not vary significantly by grade
- None of Connecticut's rates vary significantly from the national rates

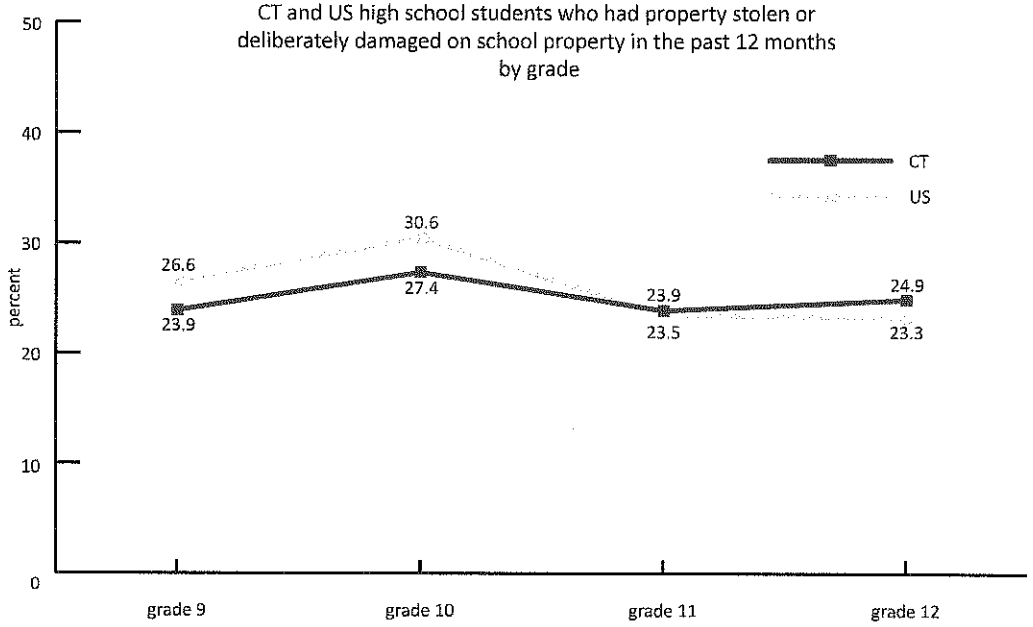




Had Property Stolen or Damaged on School Property

- In Connecticut, 25% of high school students had property (e.g., car, clothing, or books) stolen or deliberately damaged on school property one or more times during the 12 months preceding the survey
- Overall in Connecticut, the prevalence of having property stolen or damaged on school property does not vary significantly by gender, race/ethnicity, or grade
- None of Connecticut's rates vary significantly from the national rates

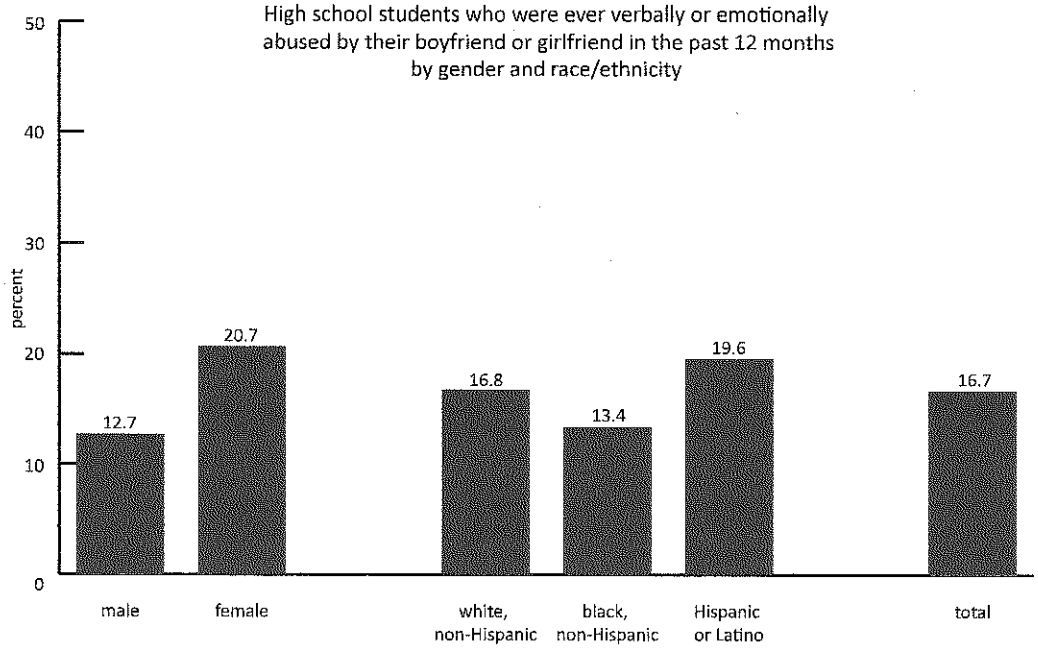


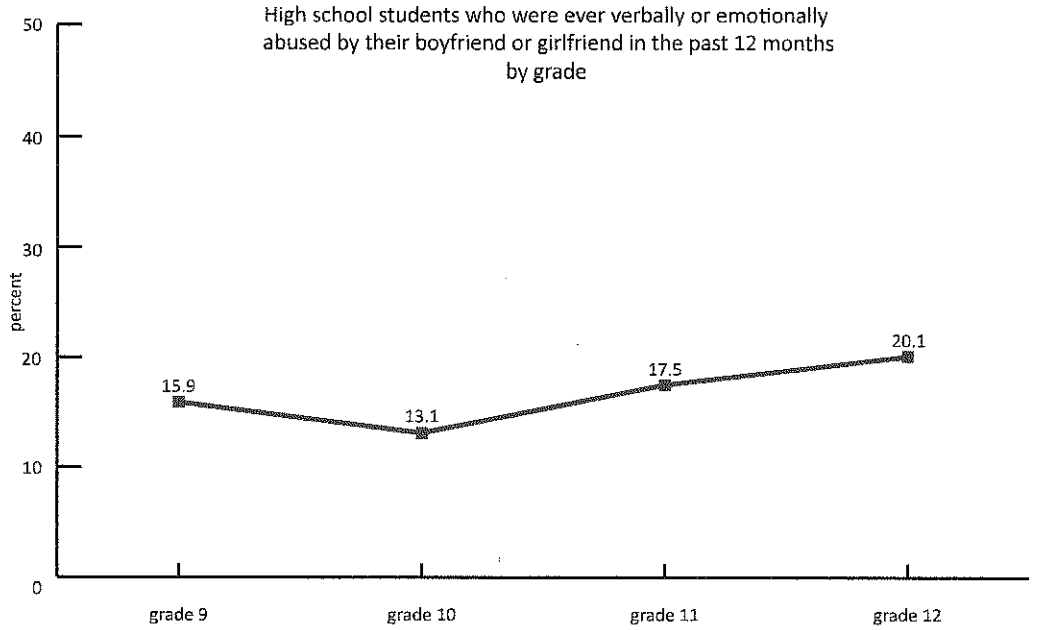


Verbal and Emotional Abuse

- During the 12 months preceding the survey, 16.7% of high school students were ever verbally or emotionally abused (e.g., called names, made fun of in front of others, ridiculed about their body or looks, or told they are no good or worthless) by their boyfriend or girlfriend

- Overall, the prevalence of ever being verbally or emotionally abused by their boyfriend or girlfriend:
  - Is significantly higher among female (20.7%) than among male (12.7%) students
  - Does not vary significantly by race/ethnicity or grade





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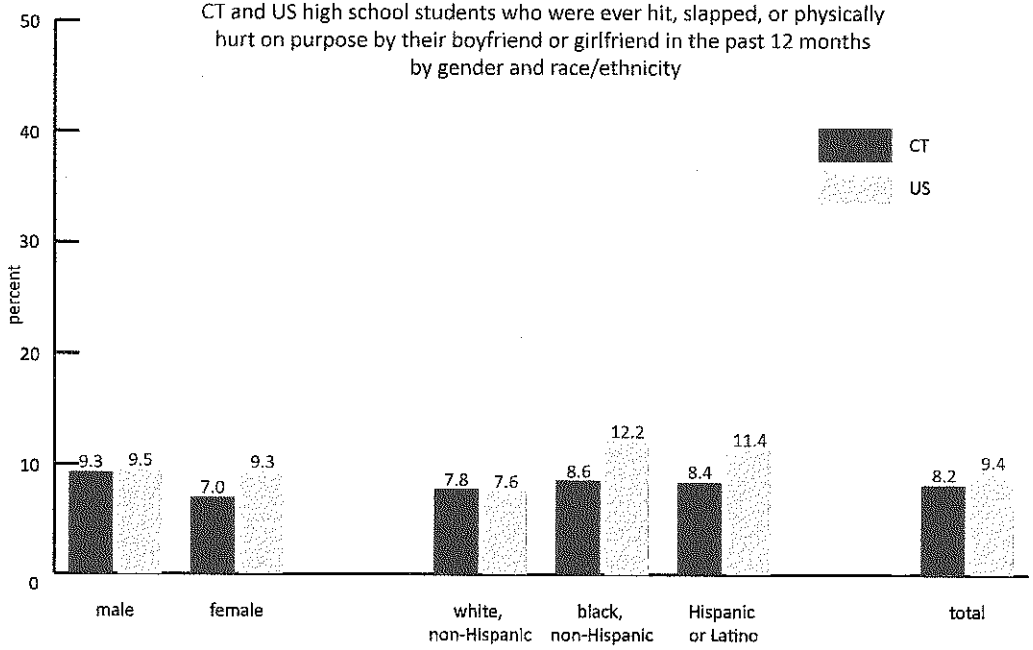
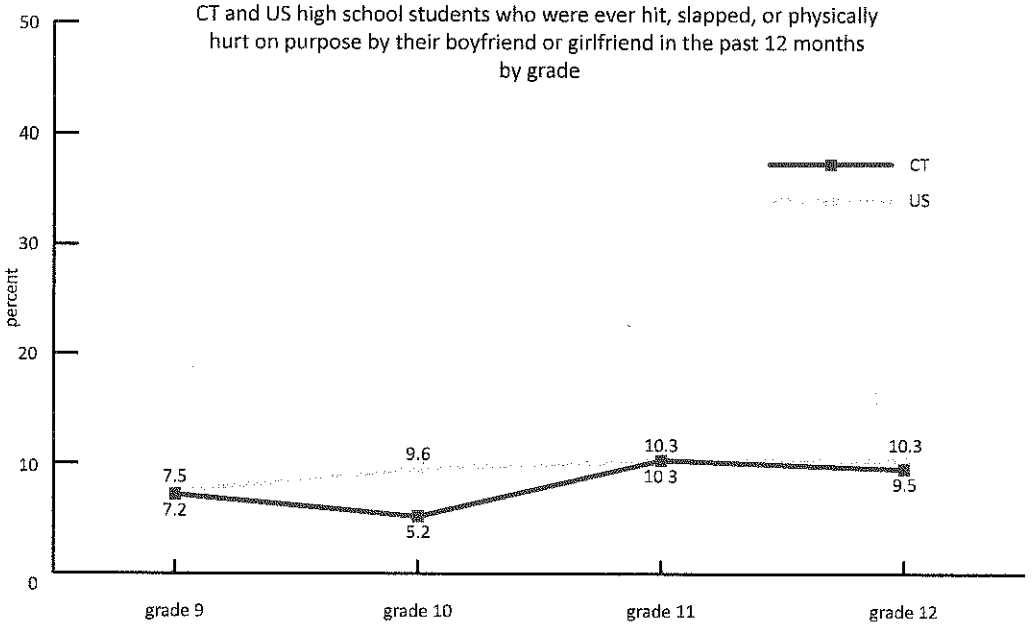
Dating Violence

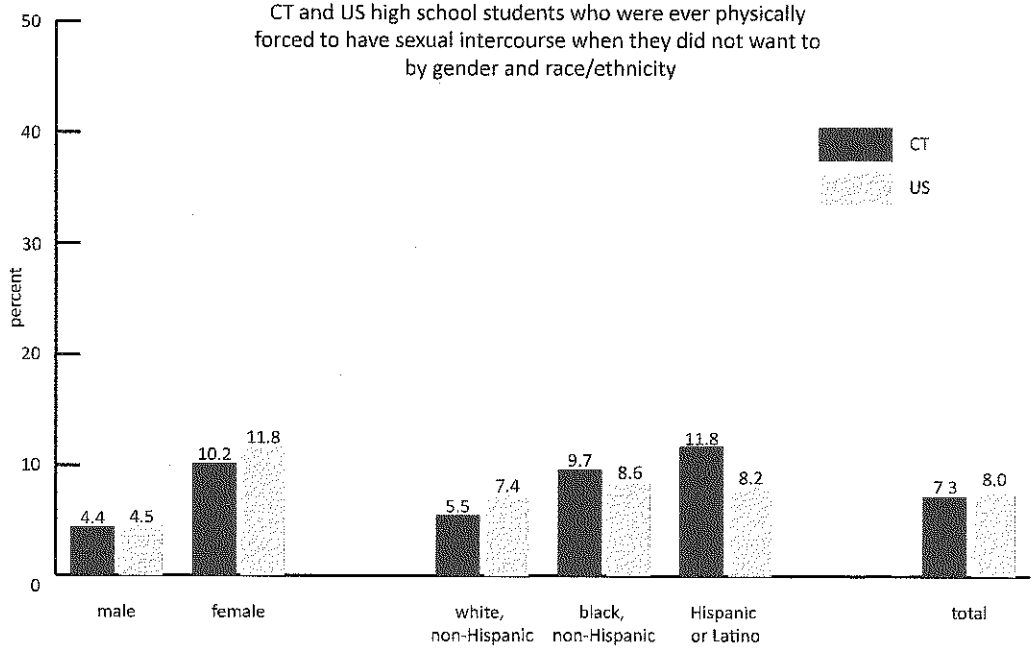
- During the 12 months preceding the survey, 8.2% of Connecticut high school students were ever hit, slapped, or physically hurt on purpose by their boyfriend or girlfriend (i.e., dating violence)
- Overall in Connecticut, the prevalence of dating violence does not vary significantly by gender, race/ethnicity, or grade
- The prevalence of dating violence is significantly higher in grade 10 among US (9.6%) than among CT (5.2%) students

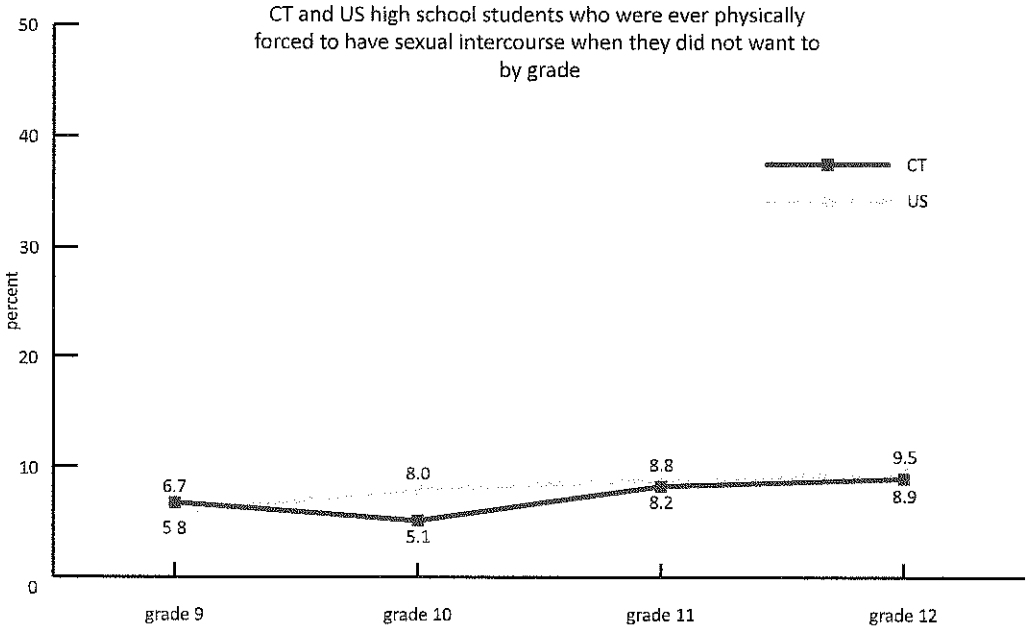




Forced to have Sexual Intercourse

- In Connecticut, 7.3% of high school students were ever physically forced to have sexual intercourse when they did not want to
- Overall in Connecticut, the prevalence of ever being physically forced to have sexual intercourse:
  - Is significantly higher among female (10.2%) than among male (4.4%) students
  - Is significantly higher among Hispanic (11.8%) than among white (5.5%) students
  - Does not vary significantly by grade
- None of Connecticut's rates vary significantly from the national rates



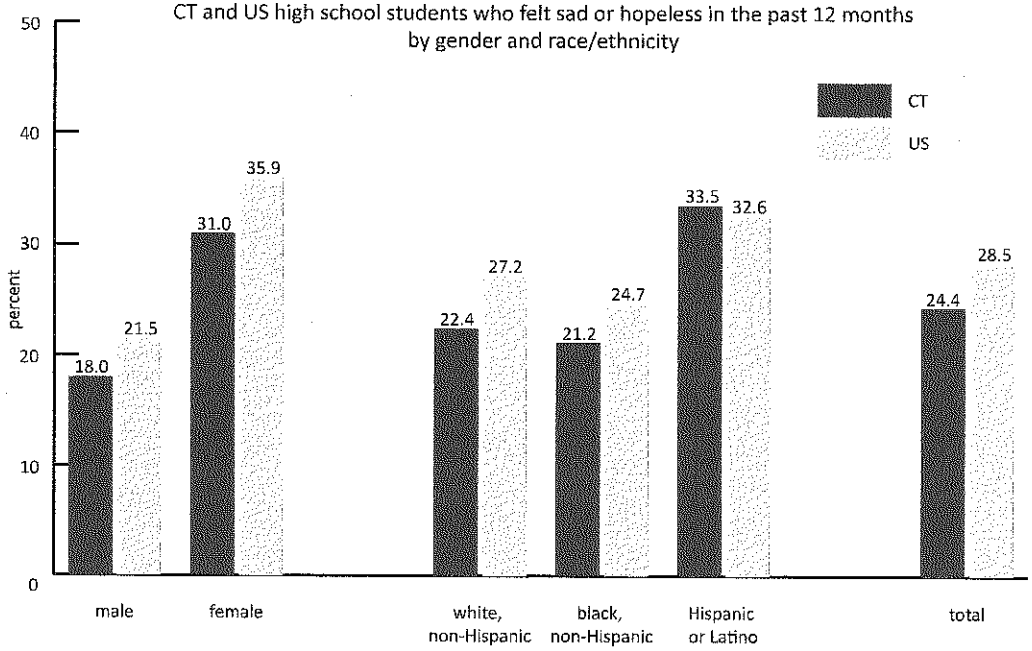


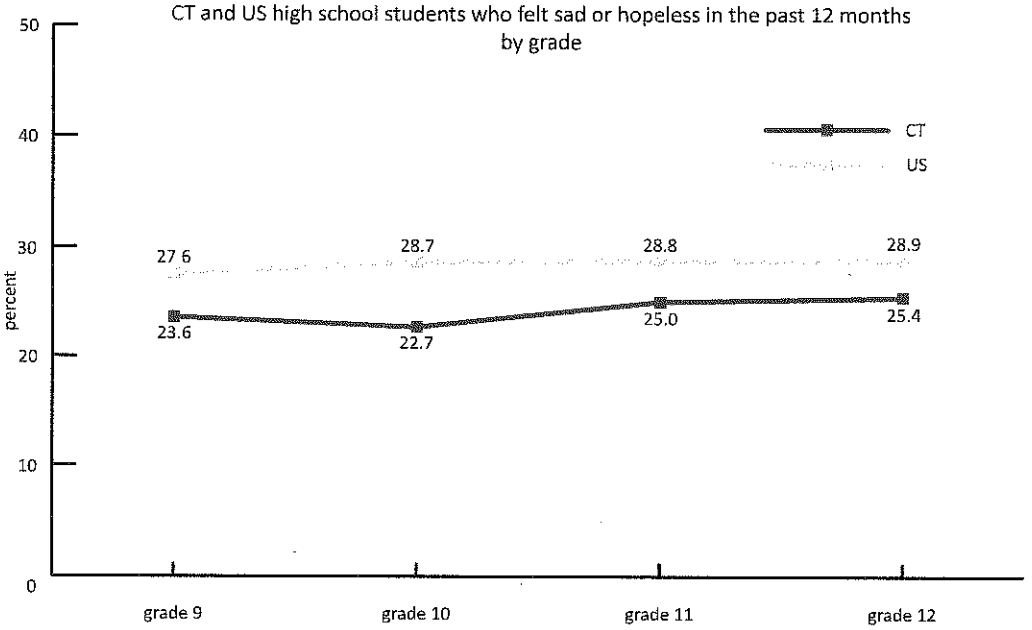
Felt Sad or Hopeless

- During the 12 months preceding the survey, 24.4% of high school students in Connecticut felt so sad or hopeless almost every day for two or more weeks in a row that they stopped doing some usual activities

- Overall in Connecticut, the prevalence of feeling sad or hopeless:
  - Is significantly higher among female (31%) than among male (18%) students
  - Is significantly higher among Hispanic (33.5%) than among white (22.4%) and black (21.2%) students
  - Does not vary significantly by grade

- None of Connecticut's rates vary significantly from the national rates

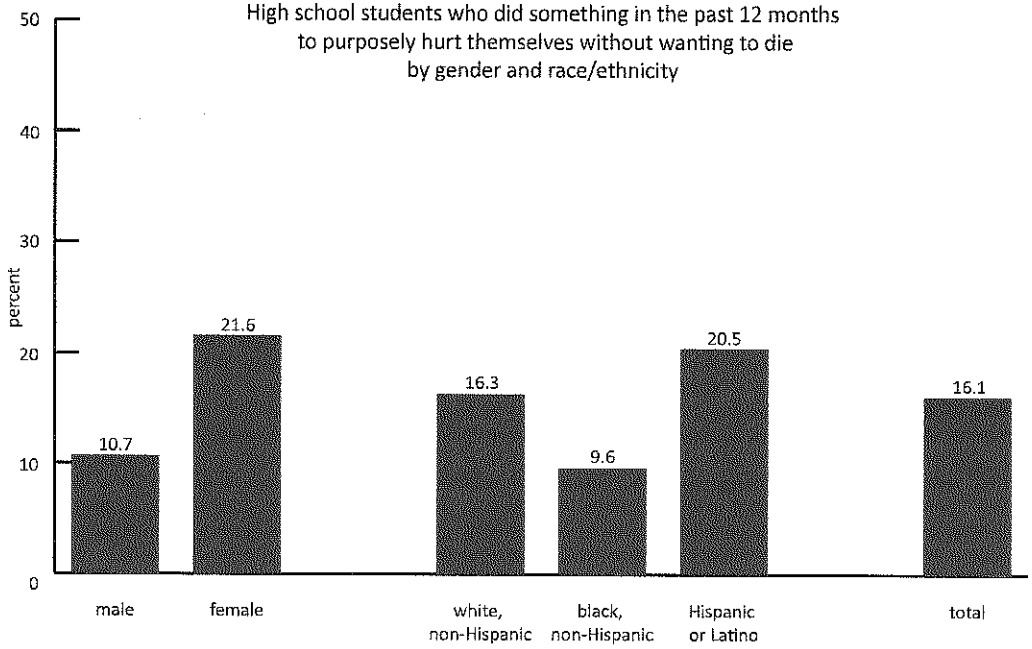


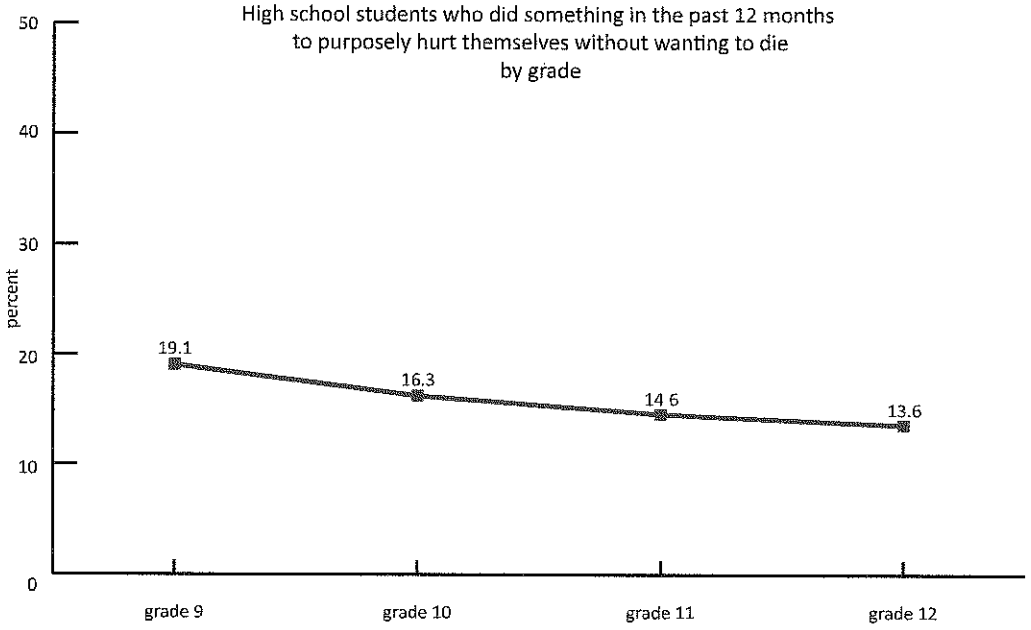


Self-Injury

- In Connecticut, 16.1% of high school students purposely hurt themselves (e.g., cutting or burning) without wanting to die (i.e., self-injury) one or more times during the 12 months preceding the survey

- Overall, the prevalence of self-injury:
  - Is significantly higher among female (21.6%) than among male (10.7%) students
  - Is significantly higher among white (16.3%) and Hispanic (20.5%) than among black (9.6%) students
  - Does not vary significantly by grade





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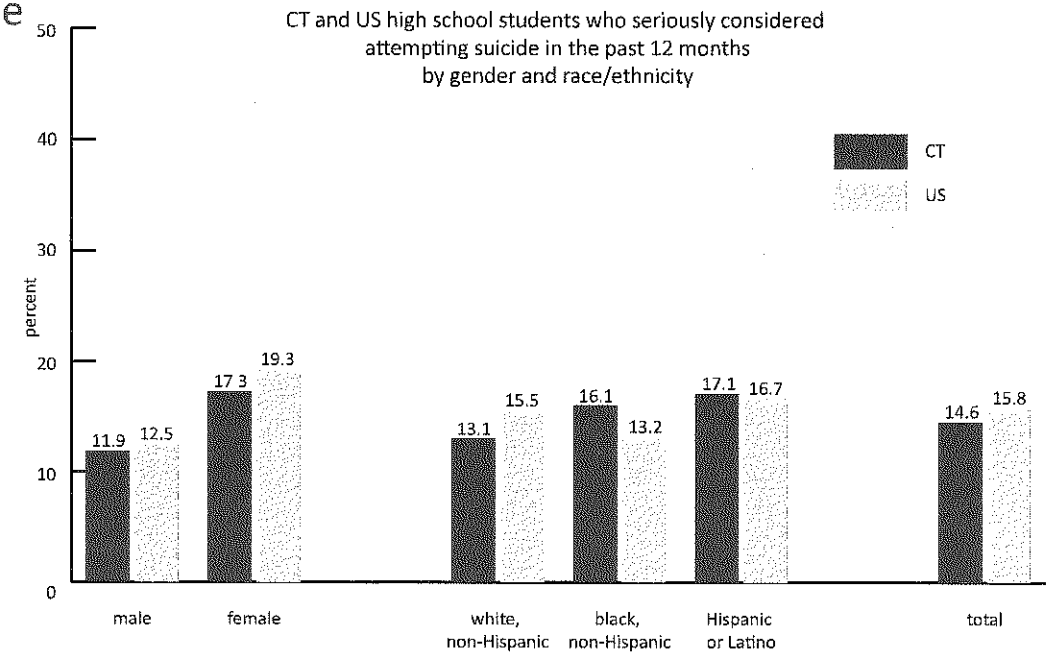
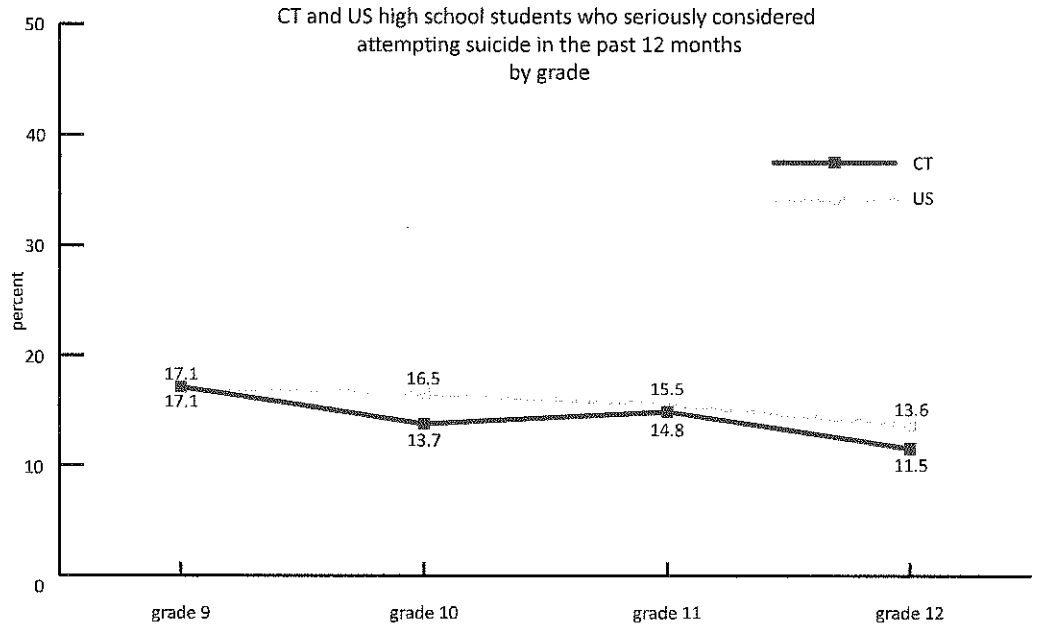
Seriously Considered Attempting Suicide

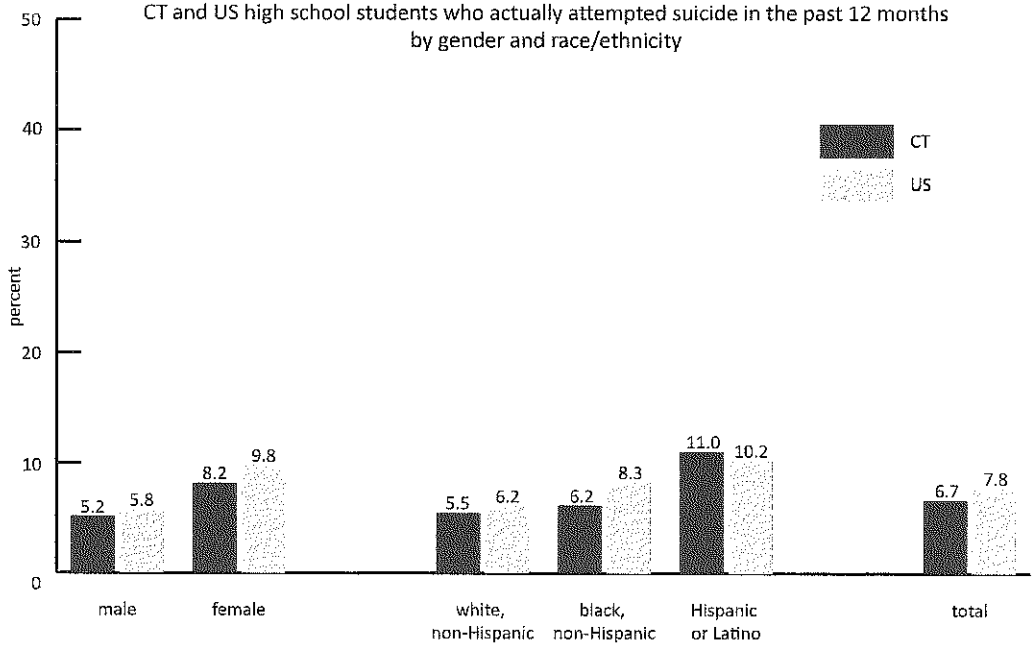
- In Connecticut, 14.6% of high school students seriously considered attempting suicide during the 12 months preceding the survey
- Overall in Connecticut, the prevalence of seriously considering attempting suicide does not vary significantly by gender, race/ethnicity, or grade
- None of Connecticut's rates vary significantly from the national rates

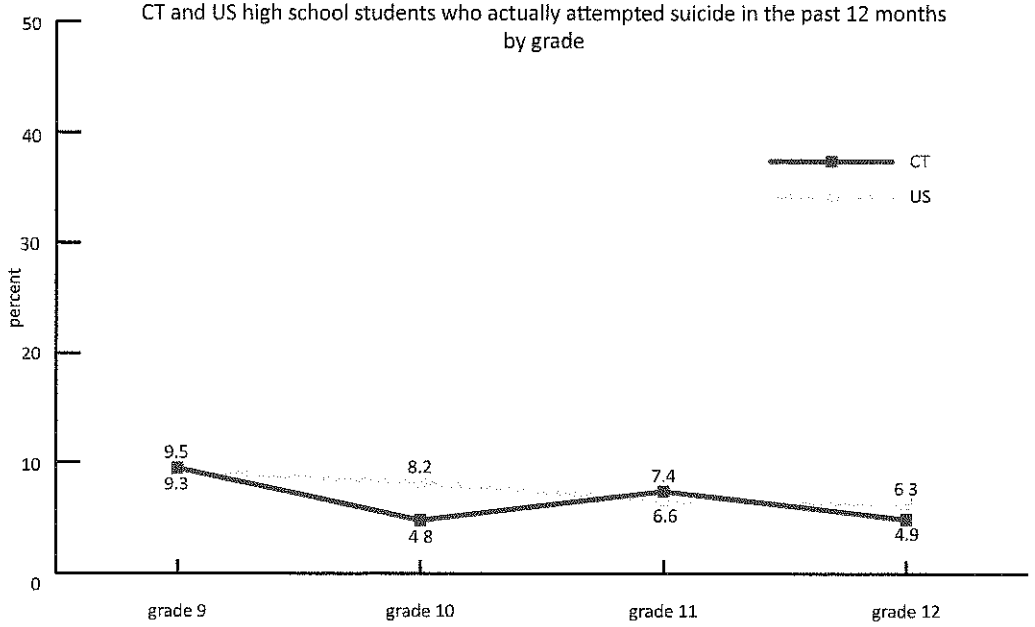




Attempted Suicide

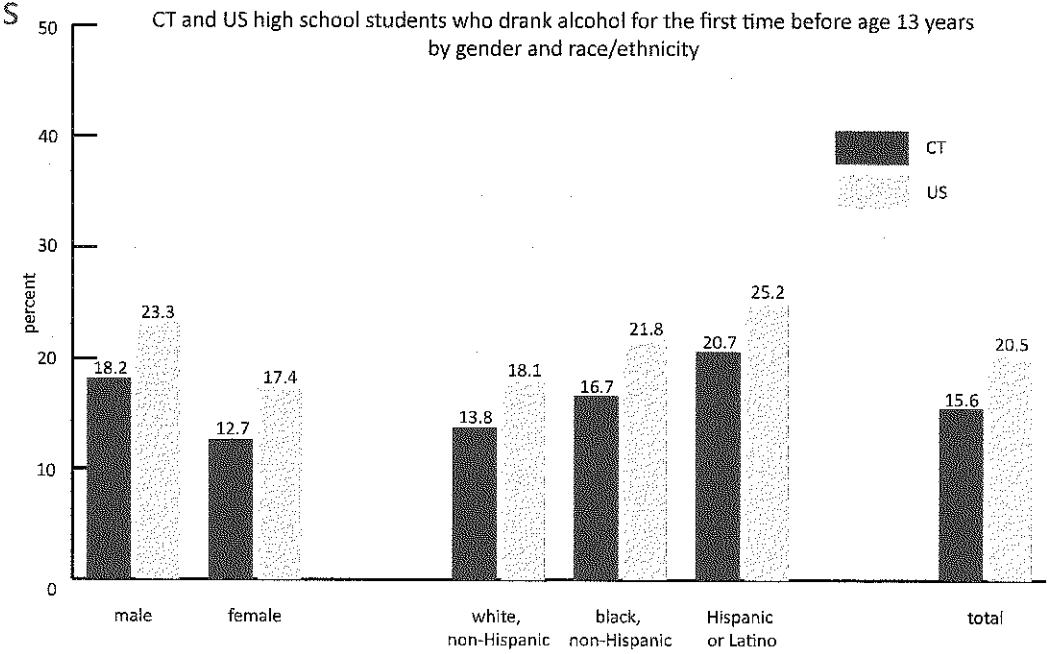
- In Connecticut, 6.7% of high school students actually attempted suicide one or more times during the 12 months preceding the survey
- Overall in Connecticut, the prevalence of actually attempting suicide:
  - Does not vary significantly by gender or grade
  - Is significantly higher among Hispanic (11%) than among white (5.5%) students
- The prevalence of actually attempting suicide is significantly higher in grade 10 among US (8.2%) than among CT (4.8%) students

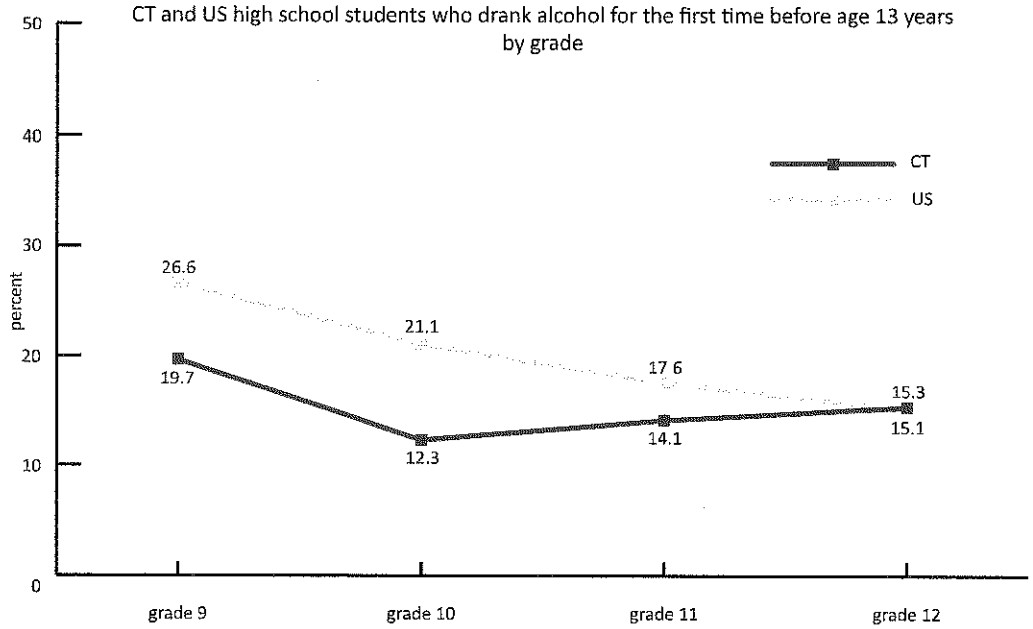




Drank Alcohol Before Age 13 Years

- In Connecticut, 15.6% of high school students drank alcohol (other than a few sips) for the first time before age 13 years
- Overall in Connecticut, the prevalence of drinking alcohol before age 13 years:
  - Is significantly higher among male (18.2%) than among female (12.7%) students
  - Is significantly higher among Hispanic (20.7%) than among white (13.8%) students
  - Does not vary significantly by grade
- The prevalence of drinking alcohol before age 13 years:
  - Is significantly higher nationwide (20.5%) than in CT (15.6%)
  - Is significantly higher among US male (23.3%) than among CT male (18.2%) students and significantly higher among US female (17.4%) than among CT female (12.7%) students
  - Is significantly higher in grade 10 among US (21.1%) than among CT (12.3%) students



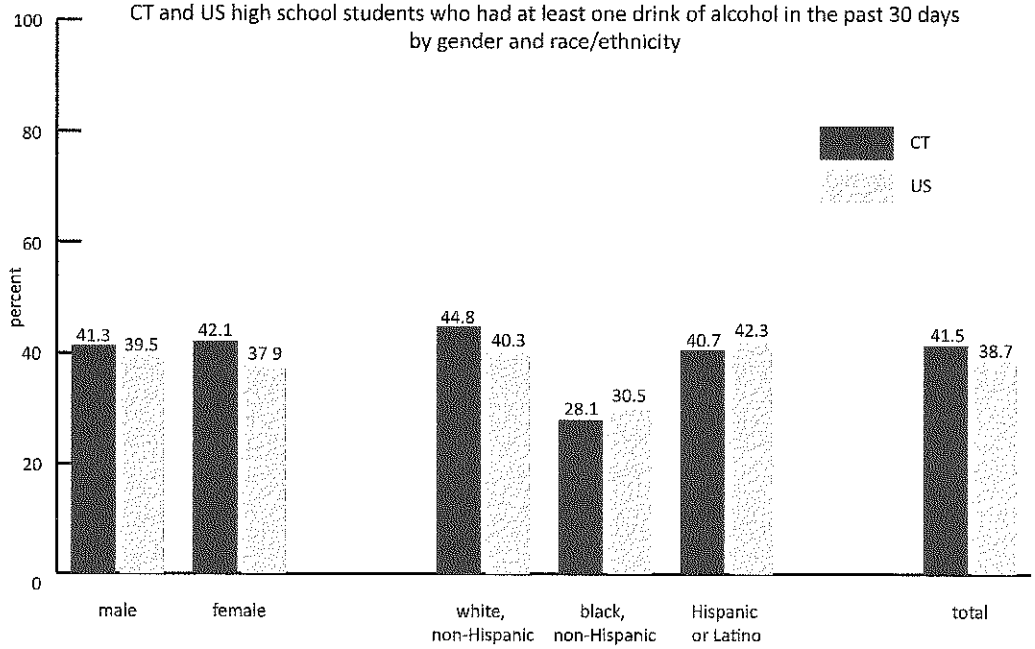


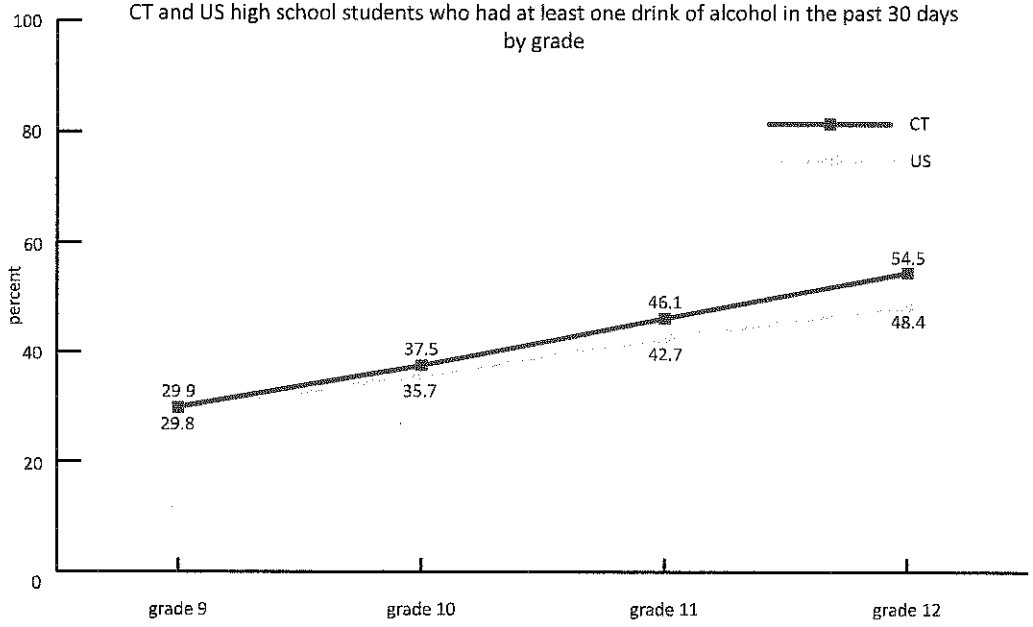
Current Alcohol Use

- In Connecticut, 41.5% of high school students had at least one drink of alcohol on 1 or more of the 30 days preceding the survey (i.e., current alcohol use)

  Overall in Connecticut, the prevalence of current alcohol use:
  - Does not vary significantly by gender
  - Is significantly higher among white (44.8%) than among black (28.1%) students
  - Is significantly higher in grades 11 (46.1%) and 12 (54.5%) than in grade 9 (29.9%); and significantly higher in grade 12 (54.5%) than in grade 10 (37.5%)

- None of Connecticut's rates vary significantly from the national rates



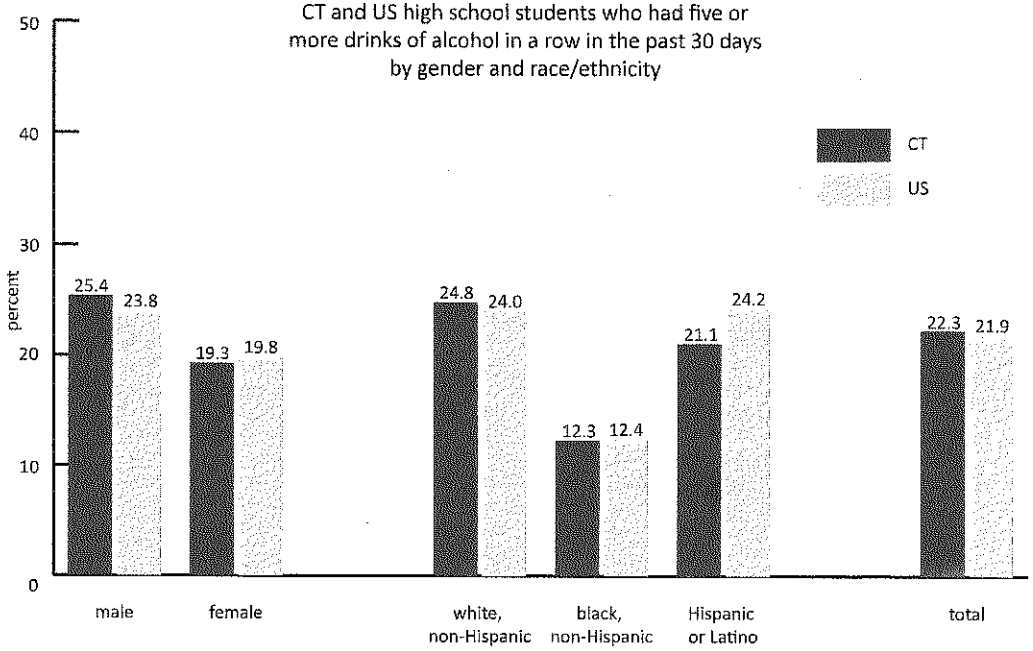


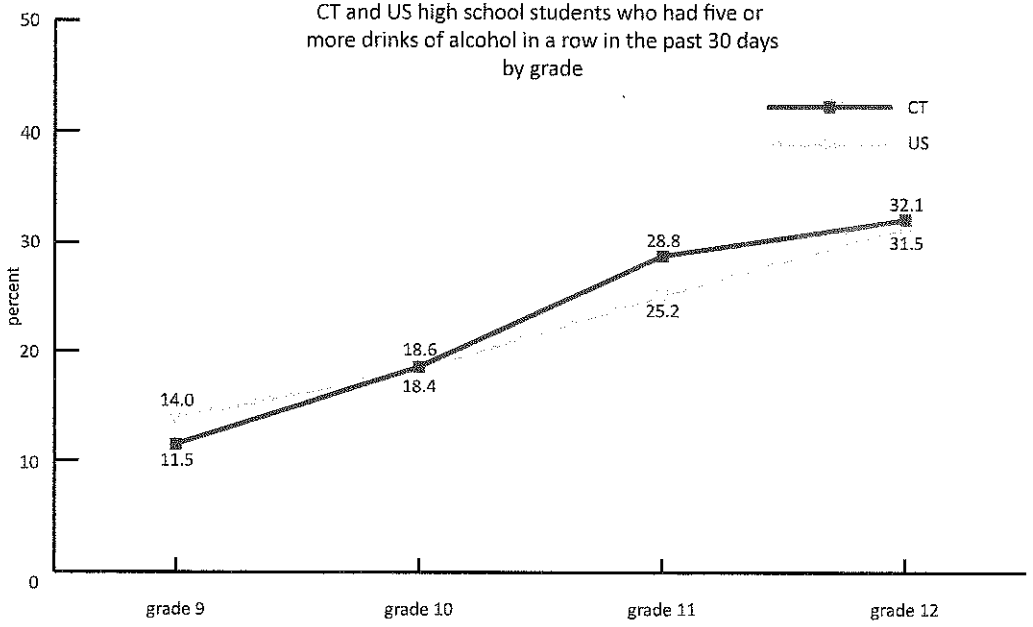
Binge Drinking

- In Connecticut, 22.3% of high school students had five or more drinks of alcohol in a row (i.e., within a couple of hours) on at least 1 day during the 30 days preceding the survey (i.e., binge drinking)

- Overall in Connecticut, the prevalence of binge drinking:
  - Does not vary significantly by gender
  - Is significantly higher among white (24.8%) than among black (12.3%) students
  - Is significantly higher in grades 11 (28.8%) and 12 (32.1%) than in grade 9 (11.5%)

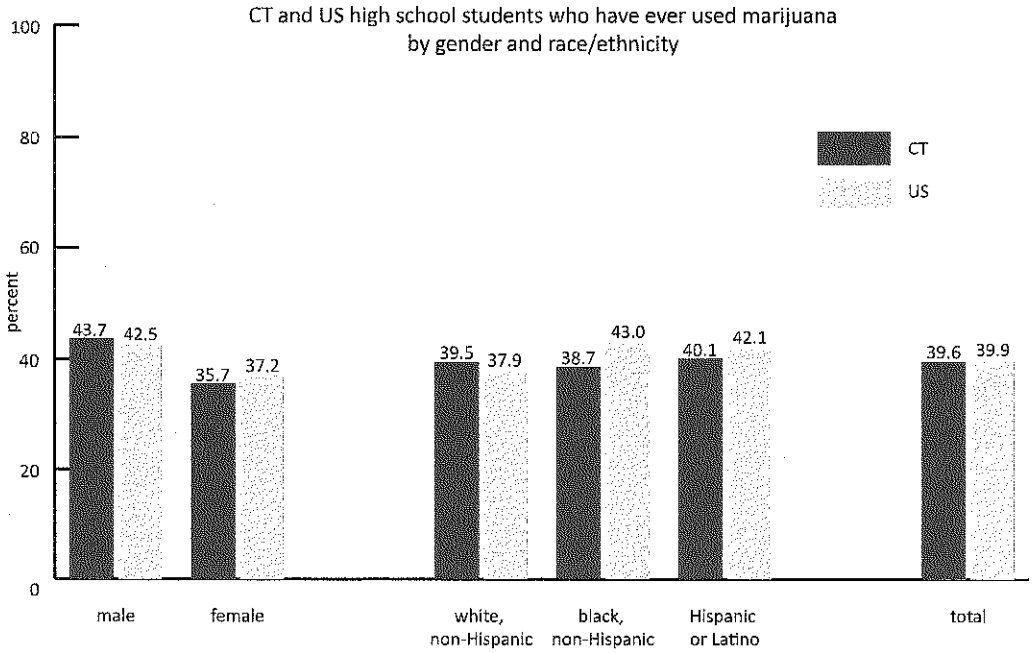
- None of Connecticut's rates vary significantly from the national rates

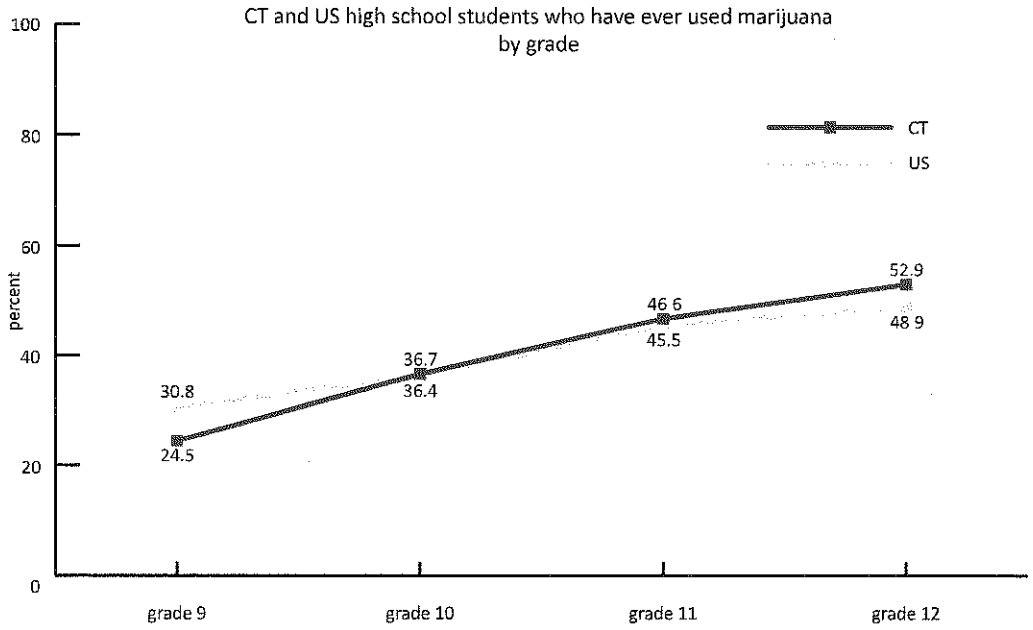




Ever Used Marijuana

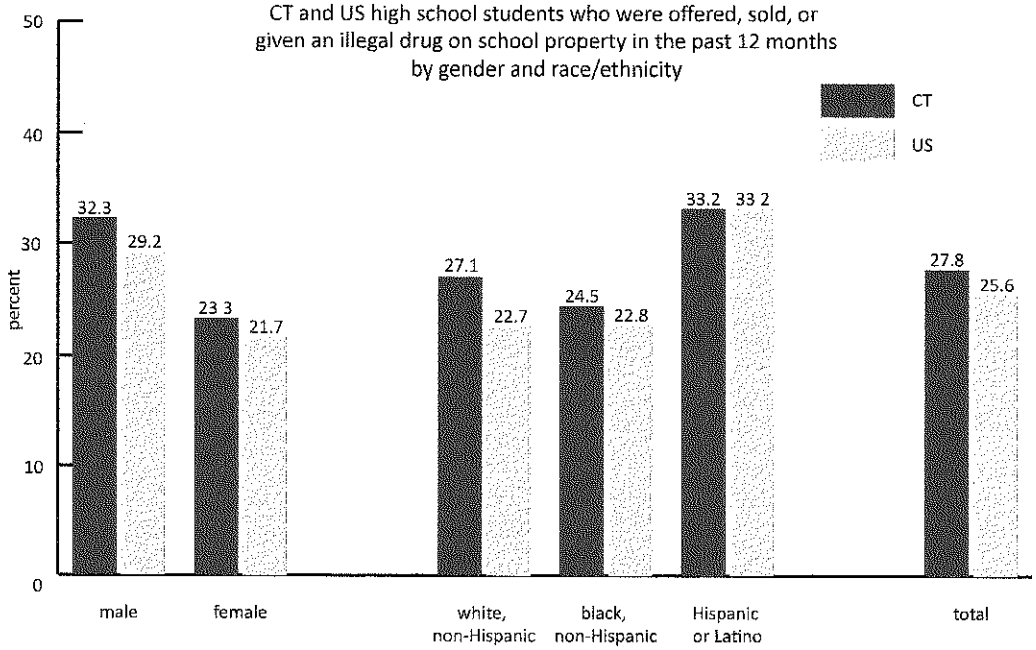
- In Connecticut, 39.6% of high school students have used marijuana one or more times during their life (i.e., ever used marijuana)
- Overall in Connecticut, the prevalence of having ever used marijuana:
  - Does not vary significantly by gender or race/ethnicity
  - Is significantly higher in grades 11 (46.6%) and 12 (52.9%) than in grade 9 (24.5%); and significantly higher in grade 12 (52.9%) than in grade 10 (36.7%)
- None of Connecticut's rates vary significantly from the national rates

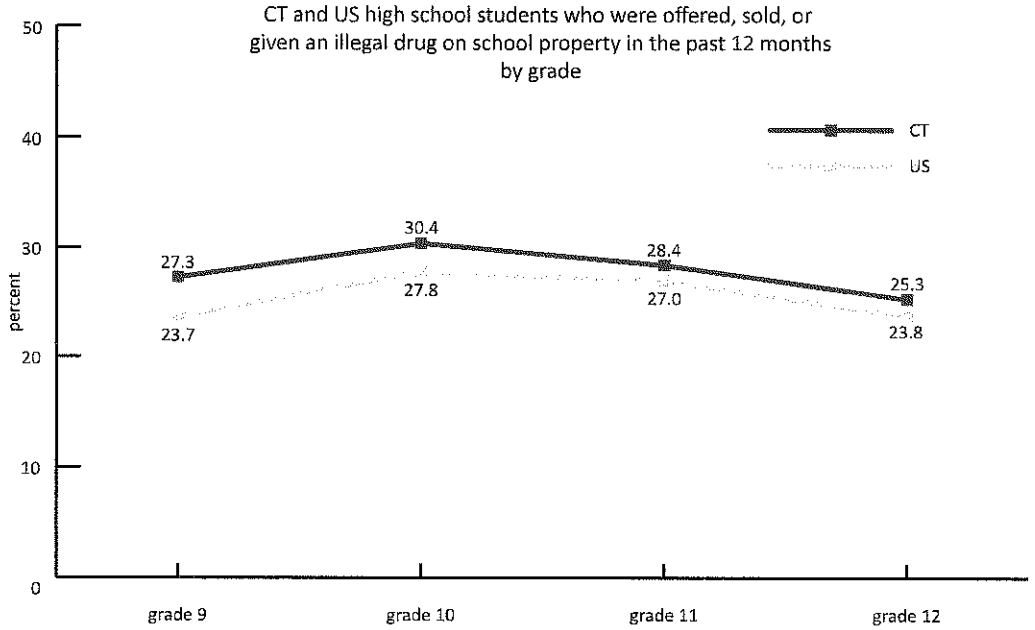




Offered, Sold, or Given an Illegal Drug on School Property

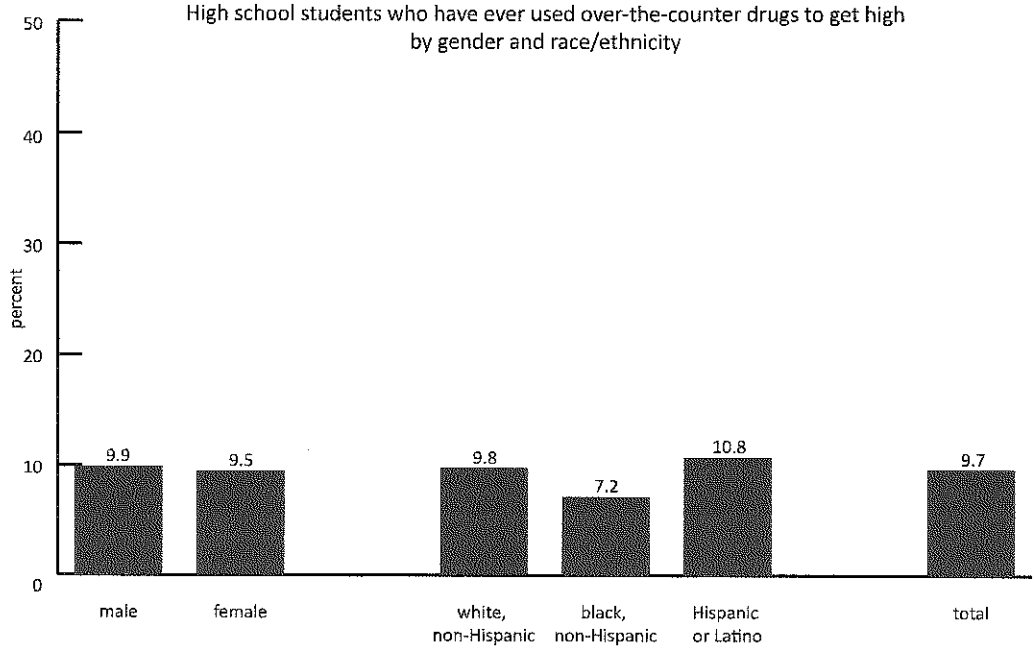
- During the 12 months preceding the survey, 27.8% of high school students in Connecticut were offered, sold, or given an illegal drug on school property
- Overall in Connecticut, the prevalence of being offered, sold, or given an illegal drug on school property:
  - Is significantly higher among male (32.3%) than among female (23.3%) students
  - Does not vary significantly by race/ethnicity or grade
- None of Connecticut's rates vary significantly from the national rates

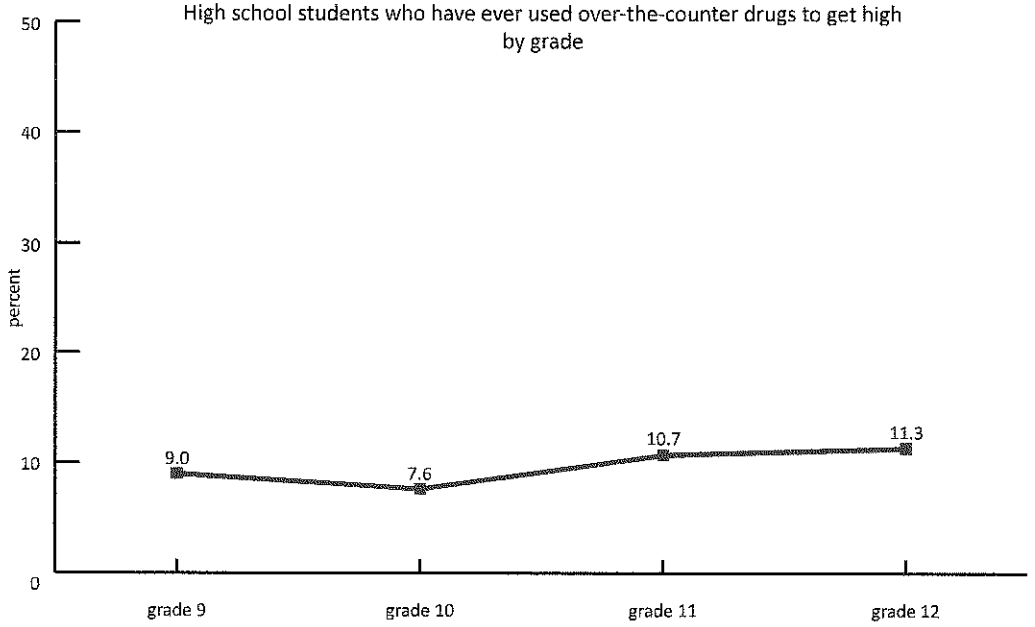




Ever Used Over-the-Counter Drugs to Get High

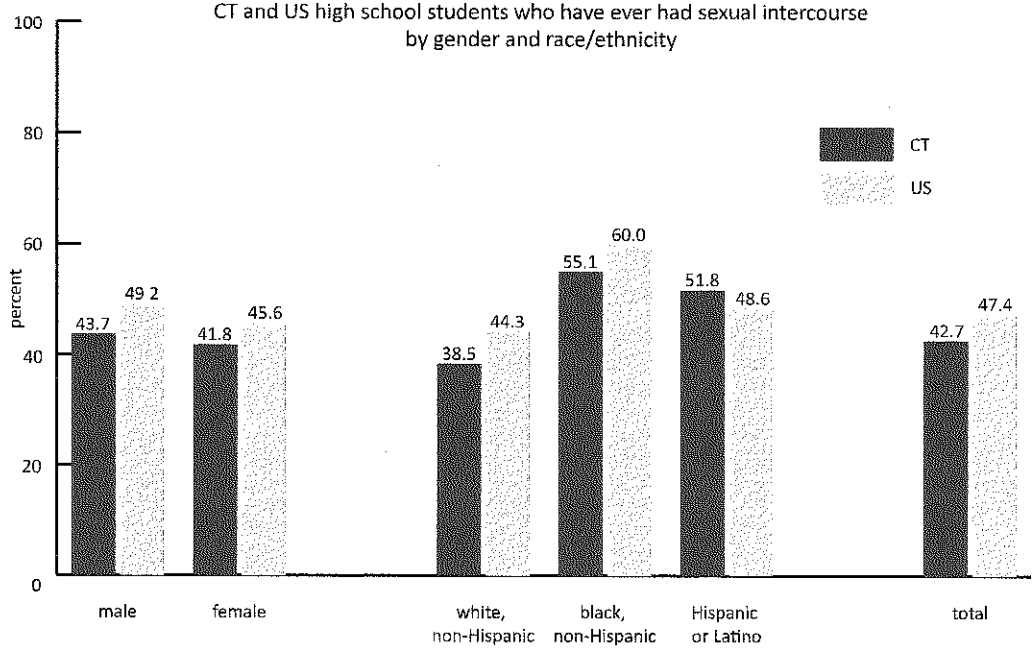
- In Connecticut, 9.7% of high school students have used over-the-counter (OTC) drugs one or more times during their life to get high (i.e., ever used OTC drugs to get high)
- Overall, the prevalence of having ever used OTC drugs to get high does not vary significantly by gender, race/ethnicity, or grade

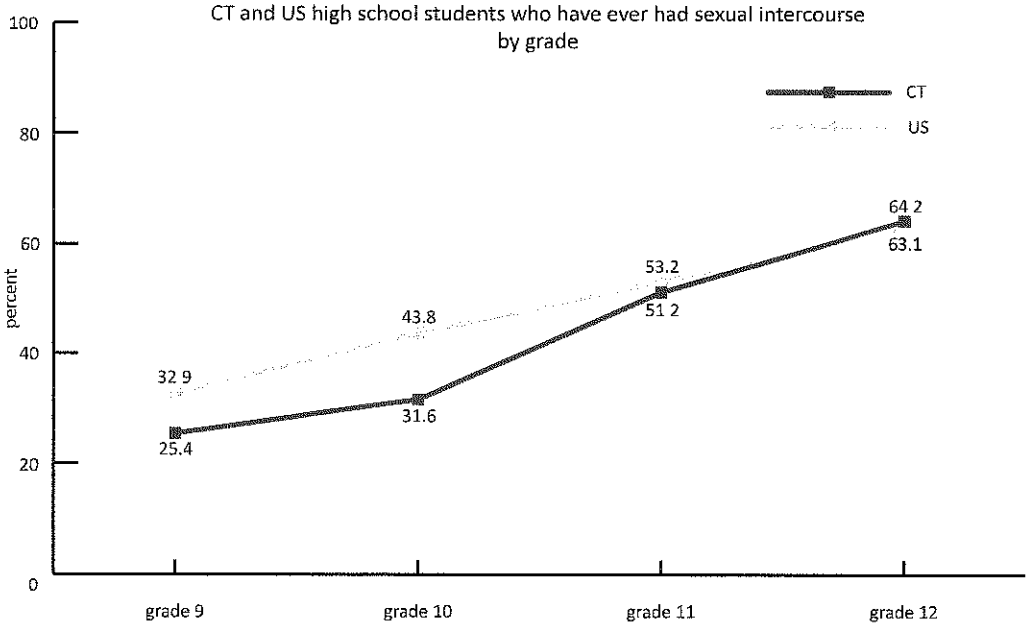




Ever had Sexual Intercourse

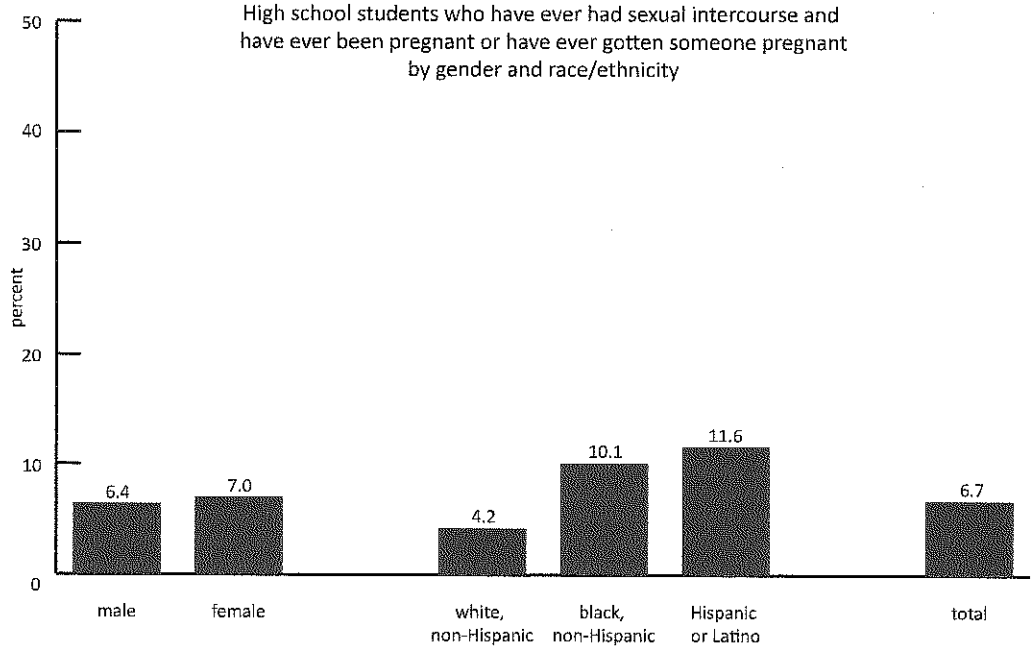
- In Connecticut, 42.7% of high school students have ever had sexual intercourse
- Overall in Connecticut, the prevalence of having ever had sexual intercourse:
  - Does not vary significantly by gender
  - Is significantly higher among black (55.1%) and Hispanic (51.8%) than among white (38.5%) students
  - Is significantly higher in grades 11 (51.2%) and 12 (64.2%) than in grades 9 (25.4%) and 10 (31.6%)
- The prevalence of having ever had sexual intercourse is significantly higher in grade 10 among US (43.8%) than among CT (31.6%) students

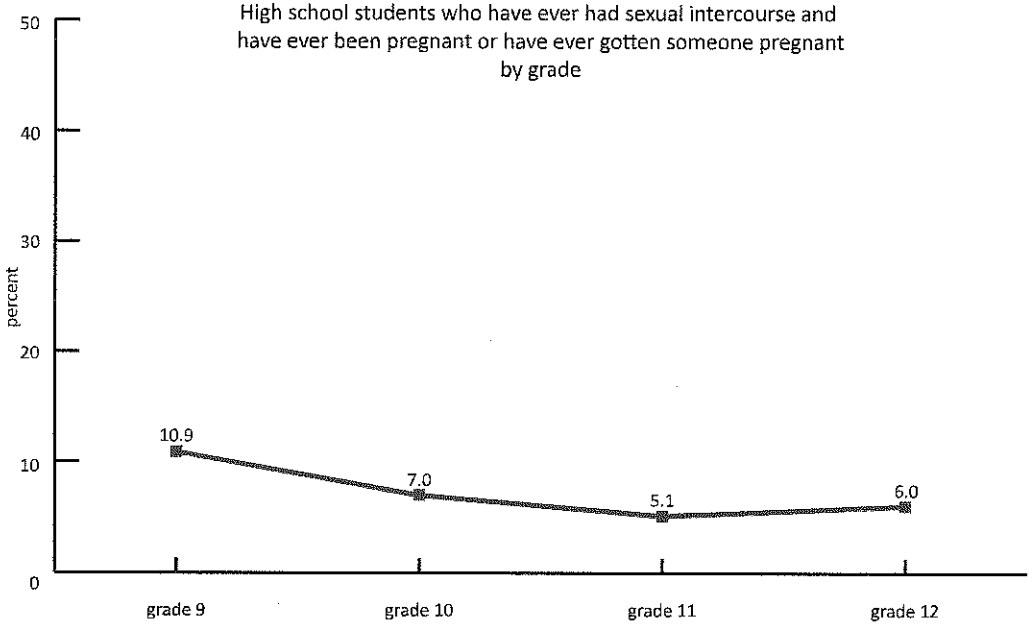




Pregnancy

- In Connecticut, among the 42.7% of high school students who have ever had sexual intercourse, 6.7% have ever been pregnant or have ever gotten someone pregnant
- Overall, among students who have ever had sexual intercourse, the prevalence of ever being pregnant or ever getting someone pregnant:
  - Does not vary significantly by gender or grade
  - Is significantly higher among Hispanic (11.6%) than among white (4.2%) students





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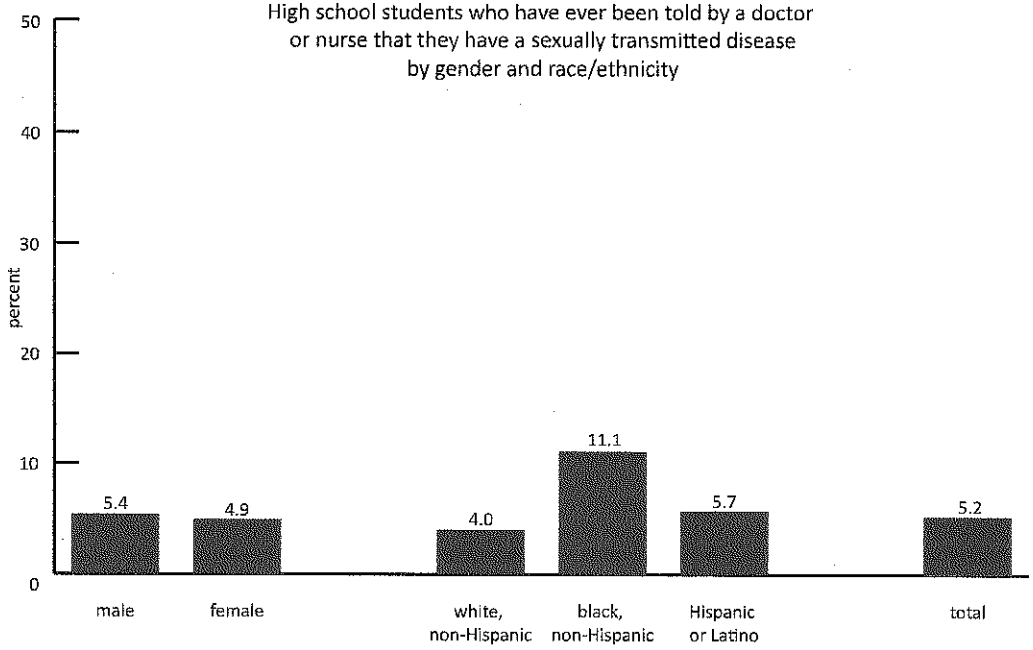
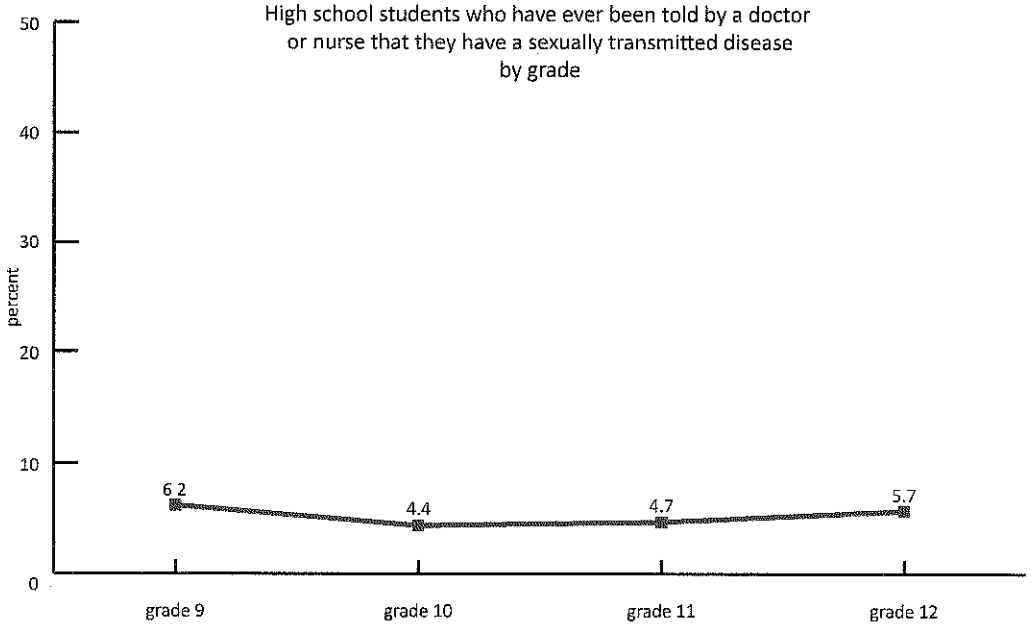
Ever had an STD

- In Connecticut, 5.2% of high school students have ever been told by a doctor or nurse that they have a sexually transmitted disease (STD)
- Overall, the prevalence of having ever been told they have an STD:
  - Does not vary significantly by gender or grade
  - Is significantly higher among black (11.1%) than among white (4%) students





Feeling Sad or Hopeless Among Smokers and Non-Smokers

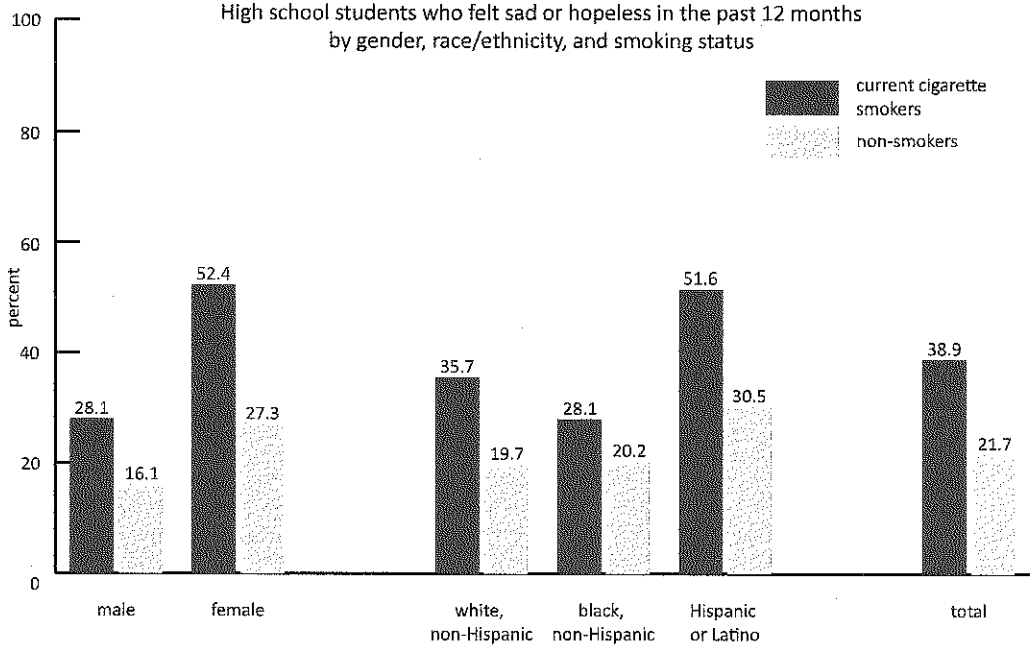
- In high school, during the 12 months preceding the survey, 38.9% of current cigarette smokers* and 21.7% of non-smokers felt so sad or hopeless almost every day for two or more weeks in a row that they stopped doing some usual activities

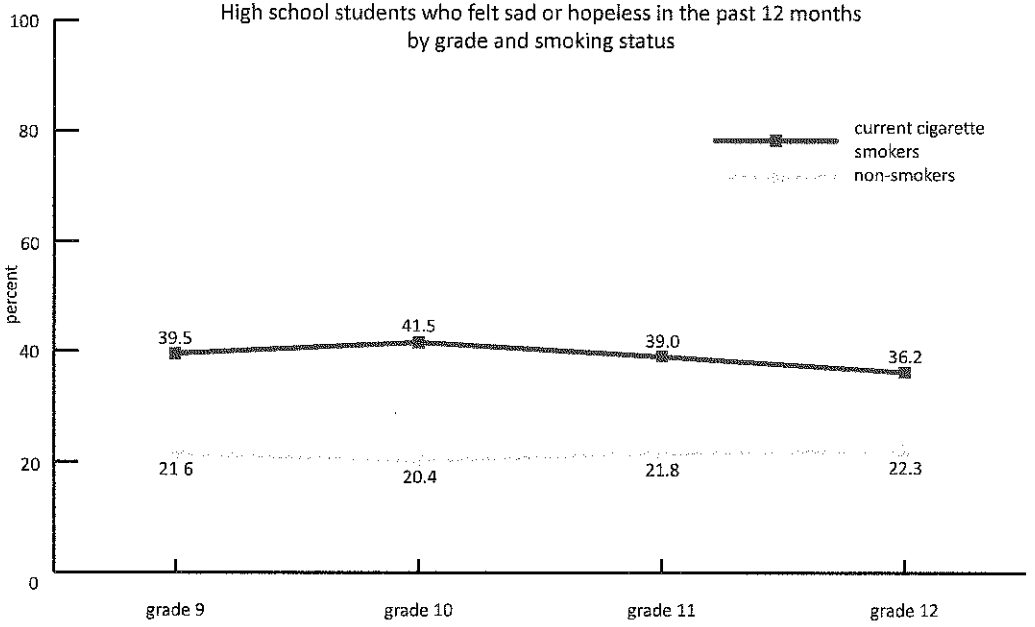
- Overall for current cigarette smokers, the prevalence of feeling sad or hopeless:
  - Is significantly higher among female (52.4%) than among male (28.1%) students
  - Does not vary significantly by race/ethnicity or grade

- Overall for non-smokers, the prevalence of feeling sad or hopeless:
  - Is significantly higher among female (27.3%) than among male (16.1%) students
  - Is significantly higher among Hispanic (30.5%) than among white (19.7%) students
  - Does not vary significantly by grade

- The prevalence of feeling sad or hopeless:
  - Is significantly higher among cigarette smokers (38.9%) than among non-smokers (21.7%)
  - Is significantly higher among male cigarette smokers (28.1%) than among male non-smokers (16.1%)
  - Is significantly higher among female cigarette smokers (52.4%) than among female non-smokers (27.3%)
  - Is significantly higher among white cigarette smokers (35.7%) than among white non-smokers (19.7%)
  - Is significantly higher among Hispanic cigarette smokers (51.6%) than among Hispanic non-smokers (30.5%)
  - Is significantly higher in grade 10 among cigarette smokers (41.5%) than among non-smokers (20.4%)
  - Is significantly higher in grade 11 among cigarette smokers (39%) than among non-smokers (21.8%)

*smoked cigarettes on at least 1 day during the 30 days before the survey





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Self-Injury Among Smokers and Non-Smokers

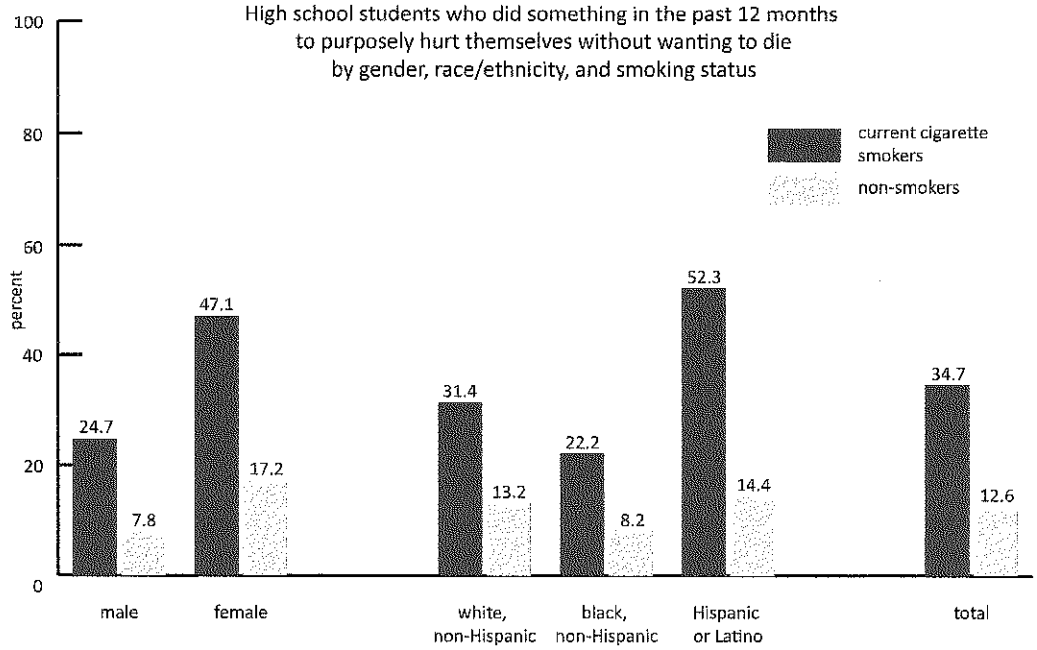
- In high school, 34.7% of current cigarette smokers* and 12.6% of non-smokers purposely hurt themselves (e.g., cutting or burning) without wanting to die (i.e., self-injury) one or more times during the 12 months preceding

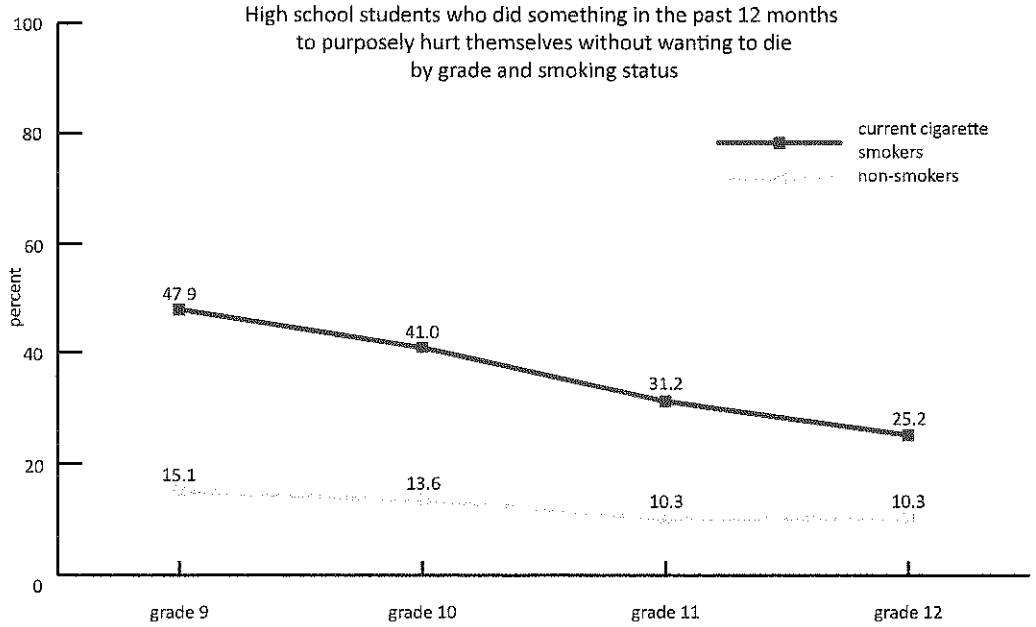
- Overall for current cigarette smokers, the prevalence of self-injury:
  - Is significantly higher among female (47.1%) than among male (24.7%) students
  - Is significantly higher among Hispanic (52.3%) than among white (31.4%) students
  - Does not vary significantly by grade

- Overall for non-smokers, the prevalence of self-injury:
  - Is significantly higher among female (17.2%) than among male (7.8%) students
  - Does not vary significantly by race/ethnicity or grade

- The prevalence of self-injury:
  - Is significantly higher among cigarette smokers (34.7%) than among non-smokers (12.6%)
  - Is significantly higher among male cigarette smokers (24.7%) than among male non-smokers (7.8%)
  - Is significantly higher among female cigarette smokers (47.1%) than among female non-smokers (17.2%)
  - Is significantly higher among white cigarette smokers (31.4%) than among white non-smokers (13.2%)
  - Is significantly higher among Hispanic cigarette smokers (52.3%) than among Hispanic non-smokers (14.4%)
  - Is significantly higher in grade 9 among cigarette smokers (47.9%) than among non-smokers (15.1%)
  - Is significantly higher in grade 10 among cigarette smokers (41%) than among non-smokers (13.6%)
  - Is significantly higher in grade 11 among cigarette smokers (31.2%) than among non-smokers (10.3%)
  - Is significantly higher in grade 12 among cigarette smokers (25.2%) than among non-smokers (10.3%)

*smoked cigarettes on at least 1 day during the 30 days before the survey



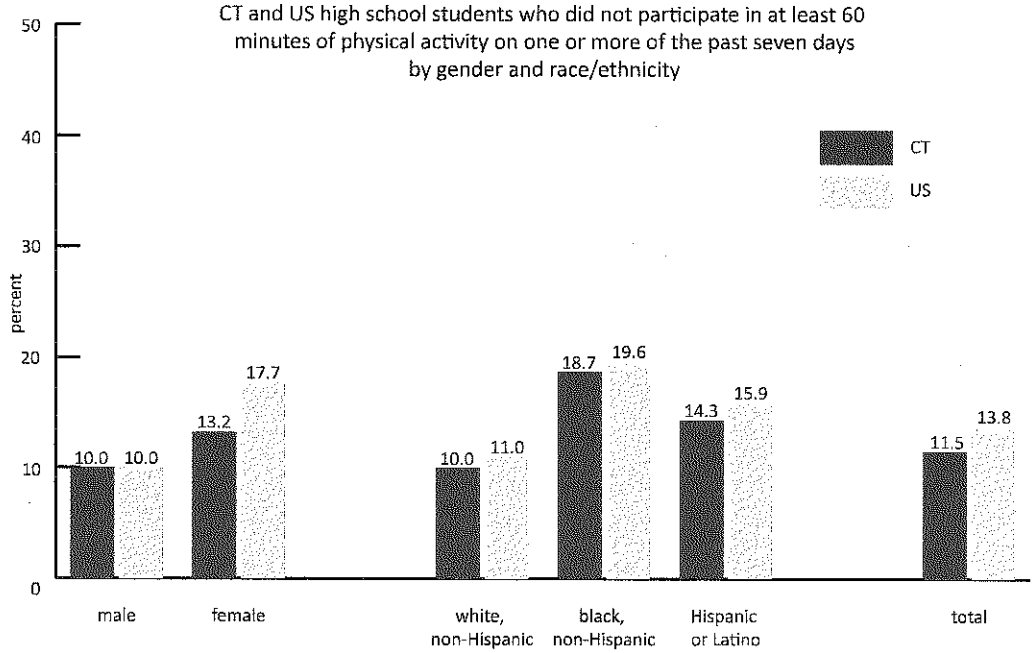


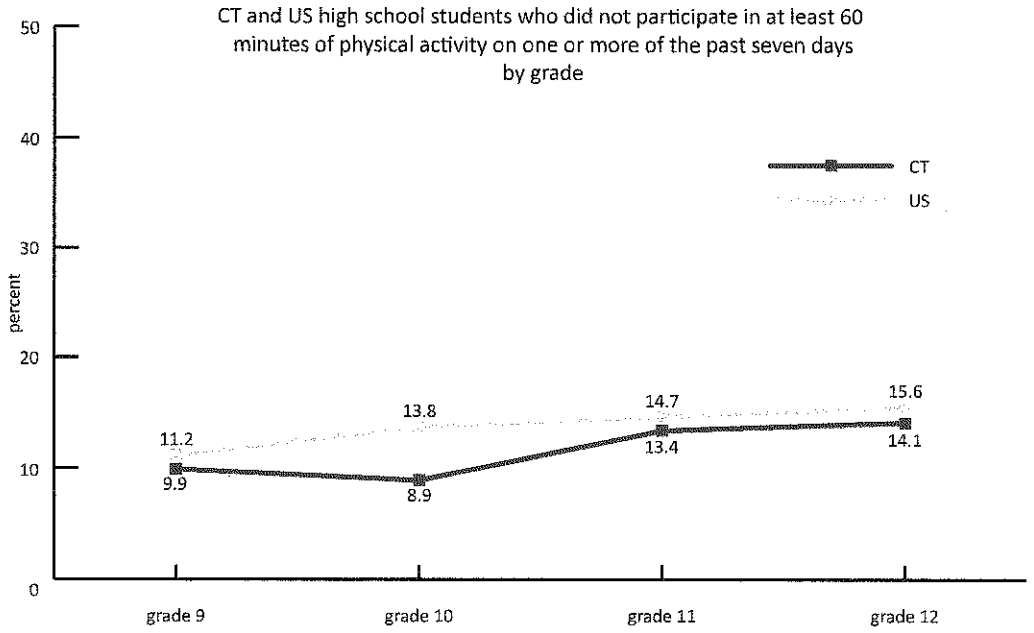
Did Not Participate in ≥60 Minutes of Physical Activity on Any Day

- In Connecticut, 11.5% of high school students did not participate in any kind of physical activity that increased their heart rate and made them breathe hard some of the time for a total of at least 60 minutes on one or more of the seven days preceding the survey (i.e., not participating in at least 60 minutes of physical activity on any day)

- Overall in Connecticut, the prevalence of not participating in at least 60 minutes of physical activity on any day:
  - Does not vary significantly by gender or grade
  - Is significantly higher among black (18.7%) than among white (10%) students

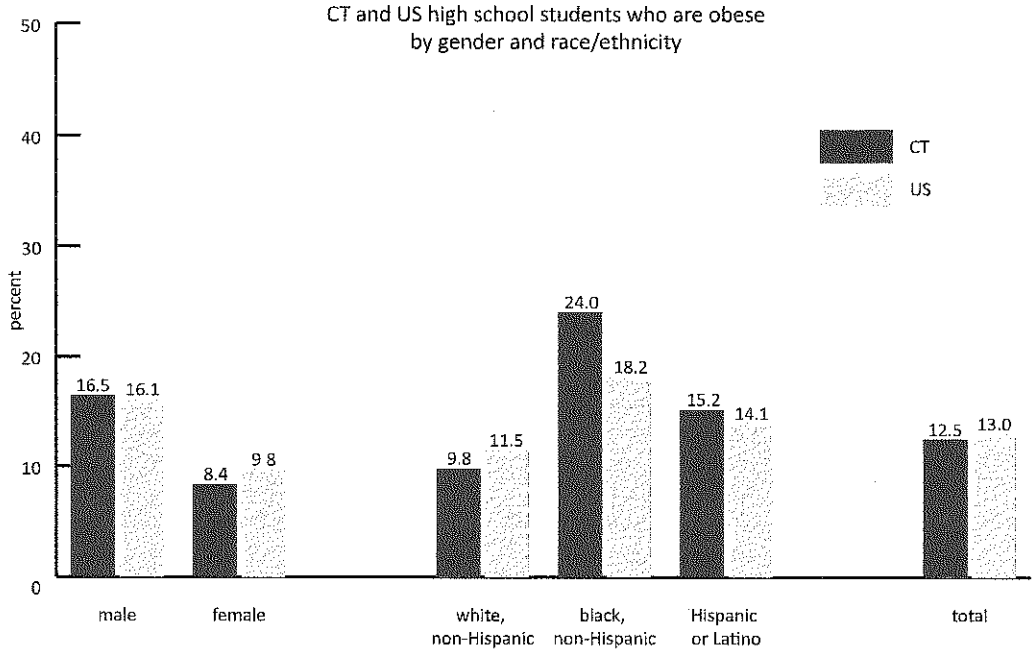
- The prevalence of not participating in at least 60 minutes of physical activity on any day is significantly higher among US female (17.7%) than among CT female (13.2%) students

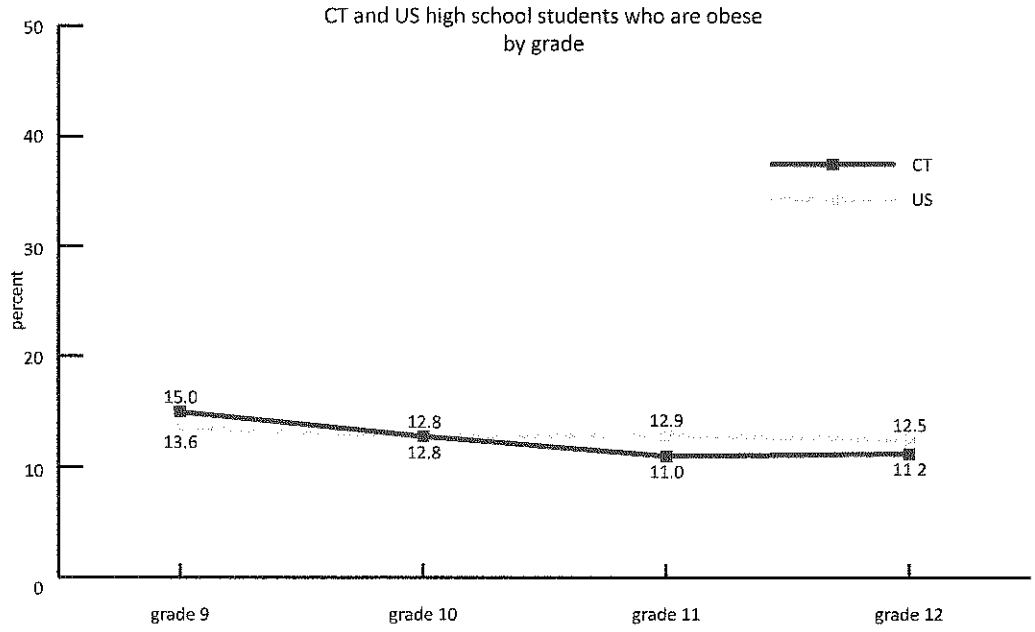




Obese

- In Connecticut, 12.5% of high school students are obese (i.e., at or above the 95th percentile for body mass index, by age and sex)*
- Overall in Connecticut, the prevalence of obesity:
  - Is significantly higher among male (16.5%) than among female (8.4%) students
  - Is significantly higher among black (24%) than among white (9.8%) students
  - Does not vary significantly by grade
- None of Connecticut's rates vary significantly from the national rates





*based on reference data from the 2000 CDC Growth Charts

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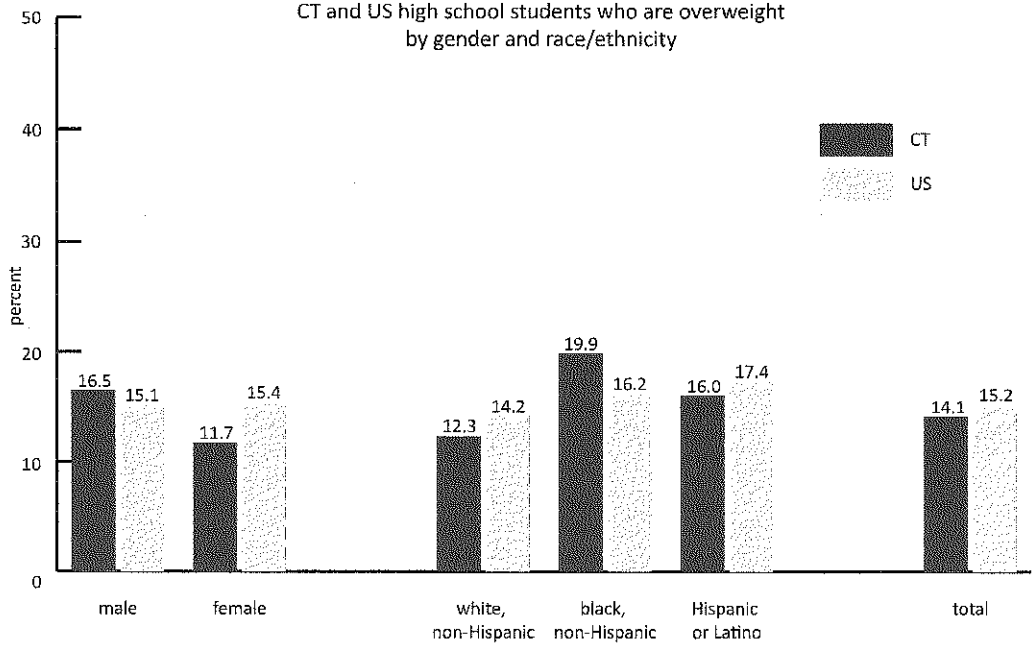
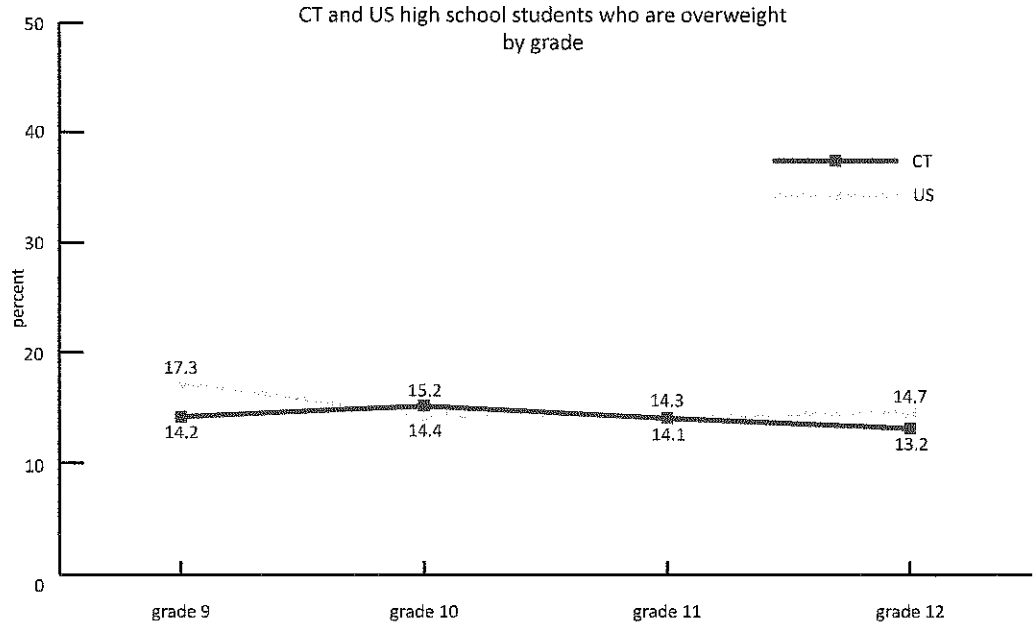
Overweight

- In Connecticut, 14.1% of high school students are overweight (i.e., at or above the 85th percentile but below the 95th percentile for body mass index, by age and sex)*
- Overall in Connecticut, the prevalence of overweight:
  - Is significantly higher among male (16.5%) than among female (11.7%) students
  - Is significantly higher among black (19.9%) than among white (12.3%) students
  - Does not vary significantly by grade
- The prevalence of overweight is significantly higher among US female (15.4%) than among CT female (11.7%) students

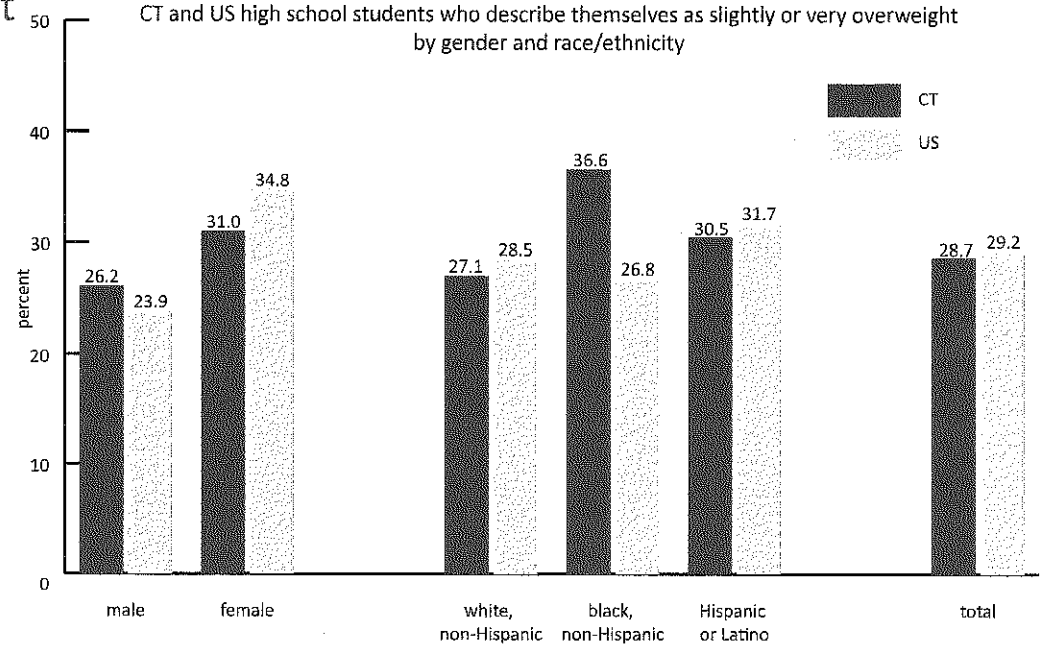


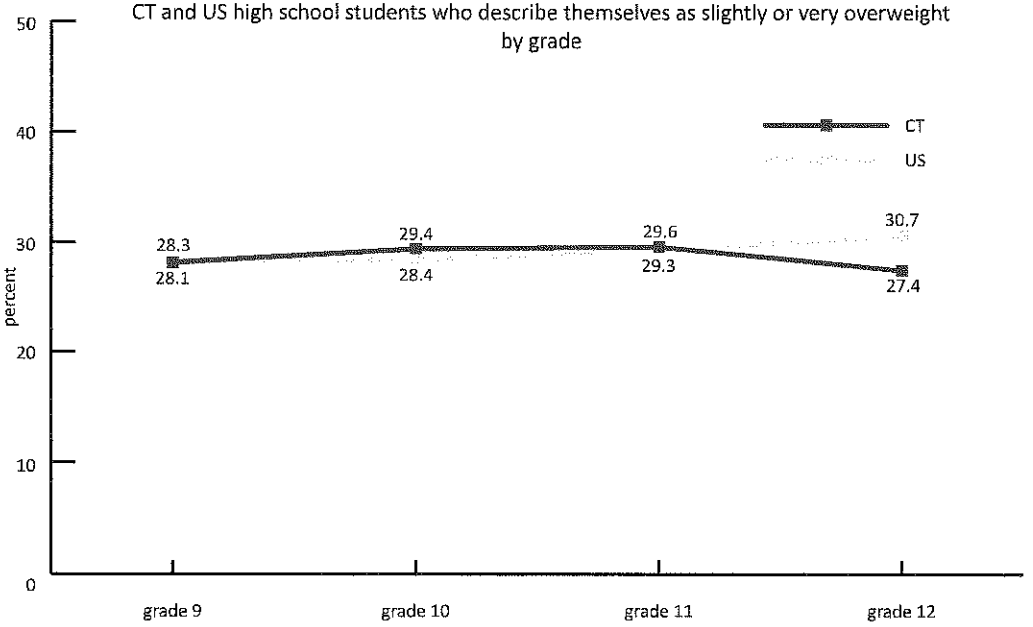


*based on reference data from the 2000 CDC Growth Charts

Describe Themselves as Overweight

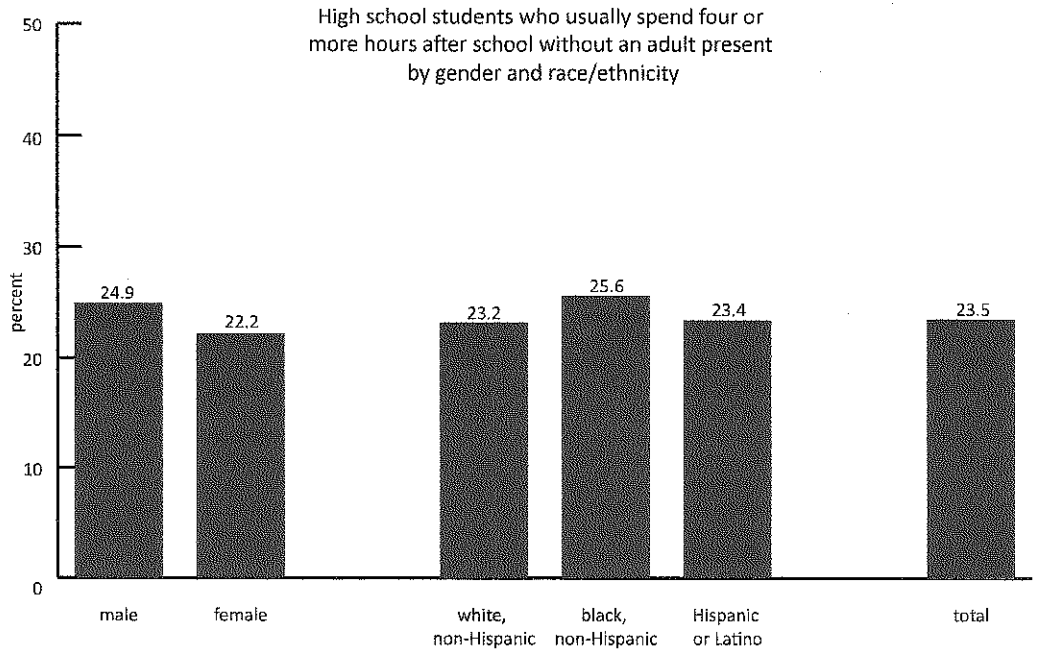
- In Connecticut, 28.7% of high school students describe themselves as slightly or very overweight
- Overall in Connecticut, the prevalence of describing themselves as overweight does not vary significantly by gender, race/ethnicity, or grade
- The prevalence of describing themselves as overweight is significantly higher among CT black (36.6%) than among US black (26.8%) students

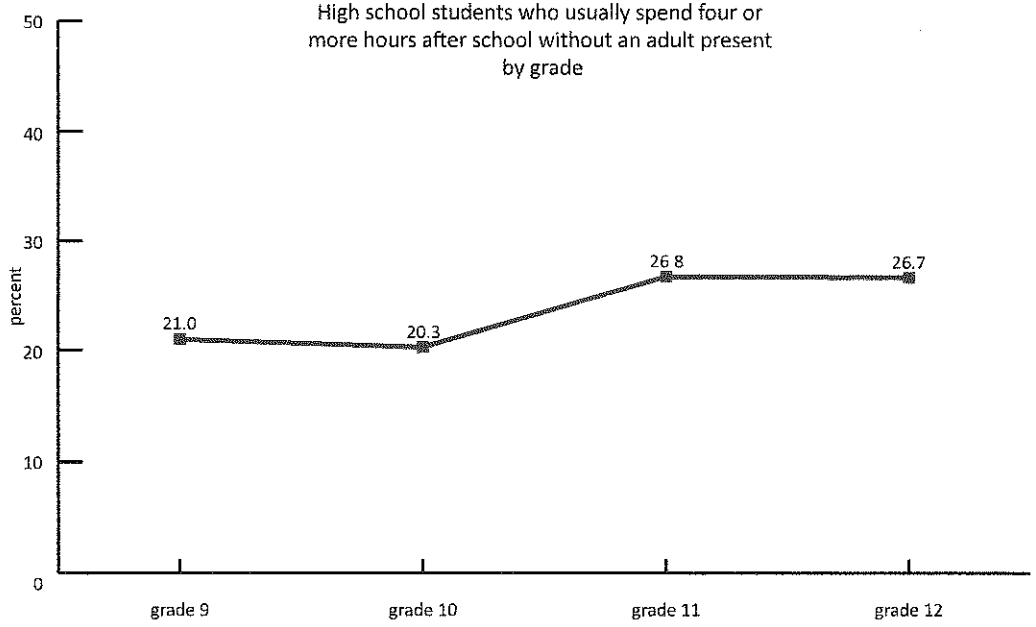




Spend Four or More Hours After School Without an Adult Present

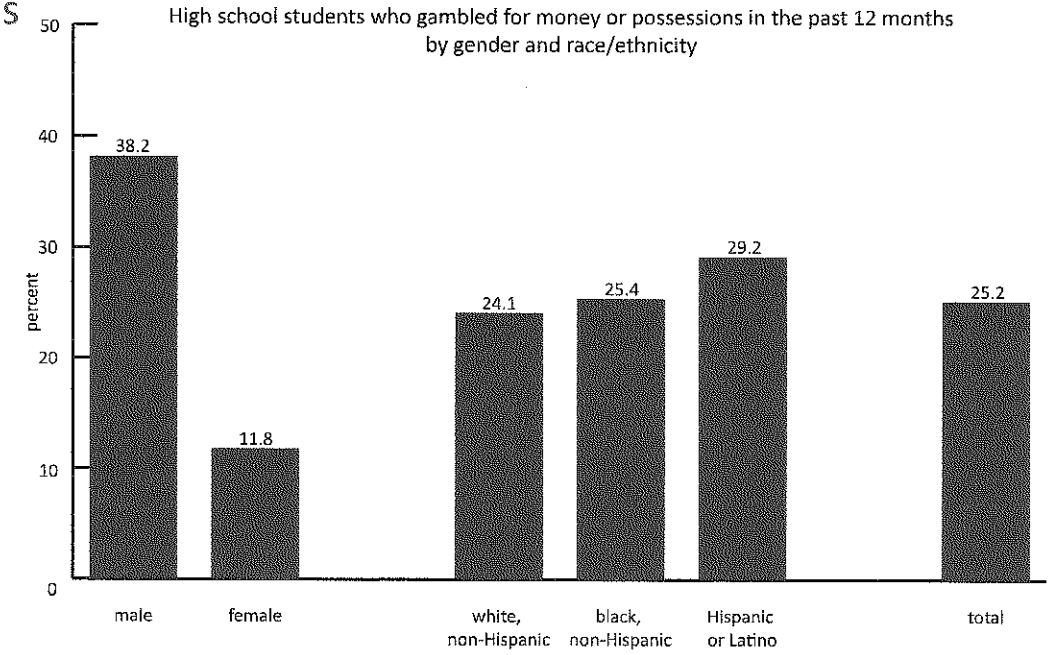
- In Connecticut, 23.5% of high school students usually spend four or more hours after school without an adult present
- Overall, the prevalence of usually spending four or more hours after school without an adult present does not vary significantly by gender, race/ethnicity, or grade

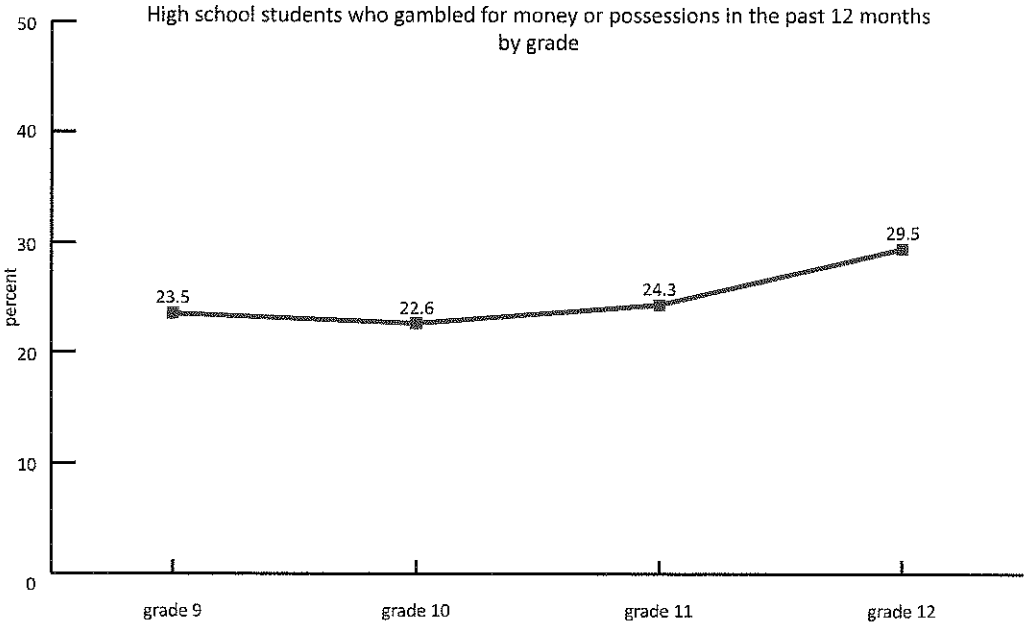




Gambled for Money or Possessions

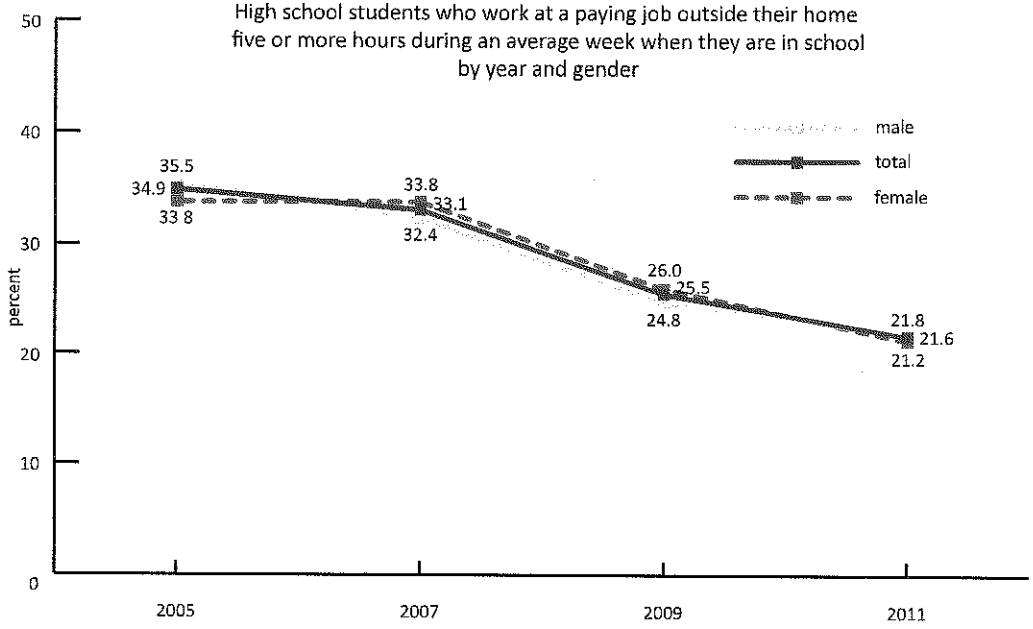
- In Connecticut, 25.2% of high school students gambled for money or possessions one or more times during the 12 months preceding the survey
- Overall, the prevalence of gambling:
  - Is significantly higher among male (38.2%) than among female (11.8%) students
  - Does not vary significantly by race/ethnicity or grade

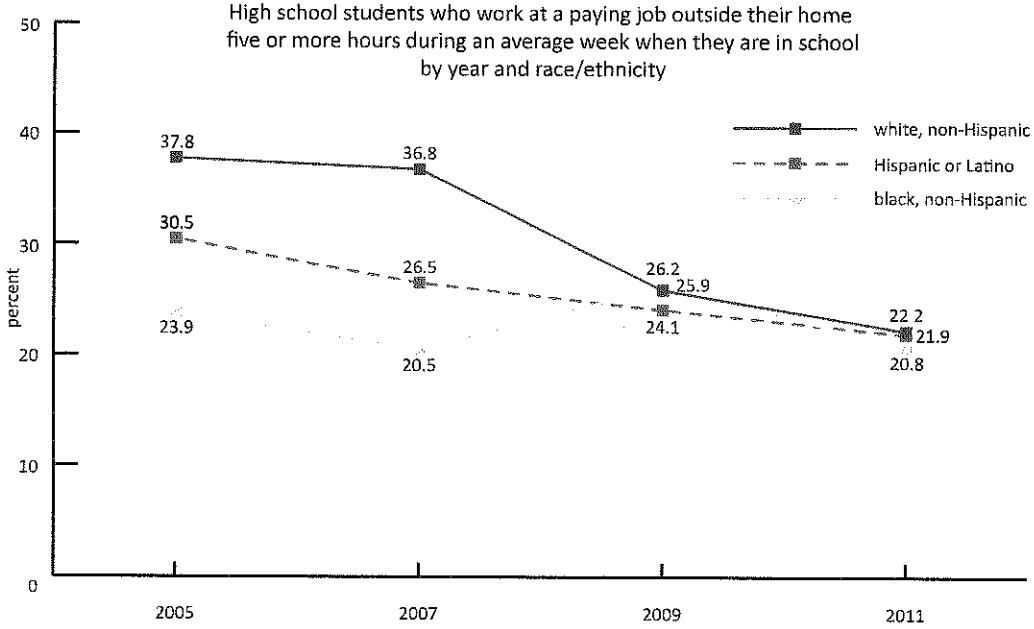




Trends 1997-2011
Have a Paying Job*

- During 2005-2011, a significant linear decrease (34.9%-21.6%) occurred in the percentage of high school students who work at a paying job outside their home five or more hours during an average week when they are in school
- During 2005-2011, a significant linear decrease occurred in the percentage of male (35.5%-21.8%), female (33.8%-21.2%), and white (37.8%-22.2%) students who have a paying job
- During 2005-2011, the percentage of Hispanic and black students who have a paying job did not change significantly





*no data available for 1997

School-Based Teen Parent Support Programs in Connecticut

Shelby Pons

Connecticut State Department of Education

9/13/11

Young Parents Program

Connecticut General Statutes (C.G.S.) Section 10-74c

Annual Funding: $229,330

Purpose: The Young Parents Program provides resources to assist local and regional school districts in designing, developing and implementing an educational program for students who are parents, which in most cases, includes a childcare component in a school setting. The grant ensures that teen mothers and fathers can continue access to an education program.

Young Parents Program
Teen Parents Enrolled By School District
2009-10

School District	Number of Teen Parents	Age Range of Parents	Parents who Dropped Out of School	Parents who Continued in School	Parents who Graduated
1. Bridgeport	85	14-18 yrs.	5	27	24
2. Danbury	25	15-19 yrs.	3	19	10
3. New Haven	43	13-20 yrs.	0	23	18
4. Norwalk	13	16-19 yrs.	0	7	5
5. Windham	24	15-19 yrs.	6	9	9
6. Griswold	2	17-18 yrs.	0	0	2
Totals	191		14	85	68

Young Parents Program
Infants and Toddlers Served
2009-10

School District	Age Range of Infants and Toddlers	Number of Infants and Toddlers
1. Bridgeport	6 weeks to 24 months	68
2. Danbury	4 weeks to 18 months	9
3. New Haven	2 weeks to 7 months	43
4. Norwalk	6 weeks to 2 years	8
5. Windham	6 weeks to 2 ½ years	10
6. Griswold	6 weeks to 4 years	1
Total		139

Supports for Pregnant and Parenting Teens Grant (SPPT)

The CSDE has secured 6 million dollars federal funding from the U.S. Department of Health and Human Services, Office of Adolescent Health. These funds will support grants to the five school districts with the highest teen birth and high school dropout rates over a three year period of time.

In July 2010, the Connecticut State Department of Education (CSDE) and the Connecticut Department of Public Health (DPH) conducted an analysis of data to identify the geographic areas that would best be served by this project.

Table 1: Comparison of Towns by Highest Teen Births and Cumulative Dropout Rates

Towns	Births in Towns to Mothers less than 20 years of age* 2006		District Cumulative Dropout Rate 2007-2008**
	Percentage	Number	Percentage
Bridgeport	14.3	356	23.5
Hartford	18.2	280	12.0
New Britain	17.7	193	23.5
New Haven	13.2	407	15.7
Waterbury	15.0	249	9.3
State Mean	7.0	1,485	6.8

*2006 CT Registration Reports, Births to Teenagers by Town
** 2008 CSDE Public School Information Systems

SPPT Goals

Goals
1. Improve the education, health and social outcomes for pregnant and parenting teens.
1. Promote healthy child development for the children of parenting teens.
1. Educate teen parents about the services that are available to support their education, health, and parenting needs.

This coordinated model will offer:

- flexible, quality schooling to help young parents complete high school
- quality child care for children with links to basic prevention health care
- case management and family support
- parenting and life skills education and support services
- linkages and referrals to prenatal care and reproductive health services
- father involvement services and supports

School-Based Team of Support

Multi-disciplinary team of professionals includes: 1.0 FT Social Worker, 0.5 FT Nurse and 1.0 FT Nurturing Families Network Home Visitation Case Worker.

These school-based professionals will serve as the advocates for pregnant or parenting teen students by providing and/or linking to the identified core services.

Department of Social of Services (DSS) - Nurturing Families Network (NFN)

The NFN is a statewide system of continuous care designed to promote positive parenting and reduce incidences of child maltreatment. The program focuses on high-risk, first-time mothers and starts working with them at or before birth. The evidence-based home-visiting model creates positive change in families identified as high risk for poor parenting.

NFN Service Gap

The gap in services lies in NFN's connection to education. Currently, all NFN home visitors are at full capacity serving almost 2,000 families in Connecticut. The estimate of need is that 4,000 mothers may be at risk of poor parenting and child maltreatment. Through this funding opportunity, the CSDE would provide a full-time NFN home visitor to each of the five identified districts.

SPPT Professional Development & Technical Assistance Partners

- **Department of Social Services, Fatherhood Initiative** (100 hours of training for teen fathers in each district)
- **Hispanic Health Council** (Development of teen parent web site and cross cultural training for SPPT staff)
- **Capital Region Education Council** (On site team building technical assistance, quality support and Family Literacy Training)

Increasing Public Awareness and Education

State and Local Governance

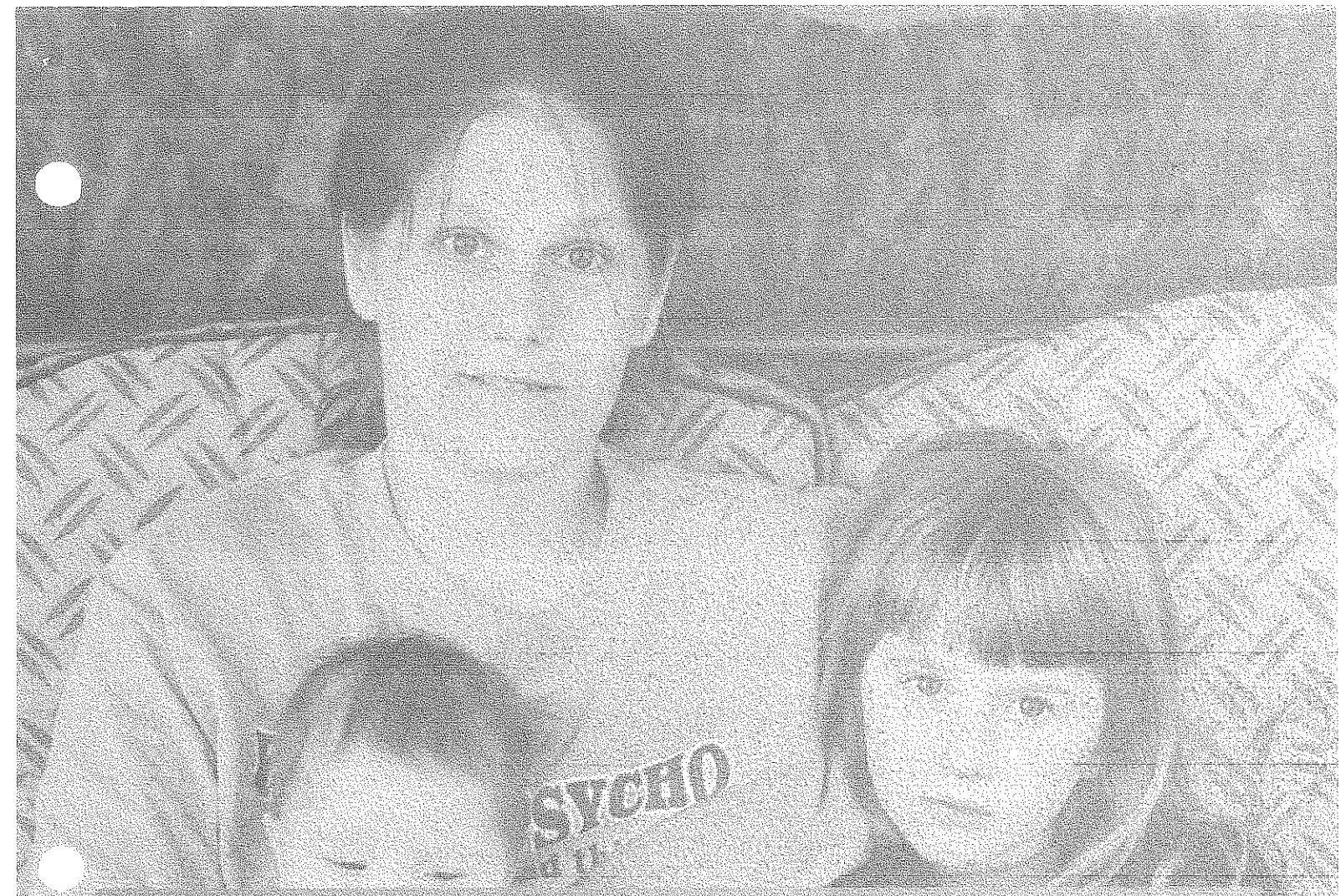
The CSDE co-leads with the HHC, the Statewide SPPT Advisory Council. This strong, diverse network of partners helps meets quarterly to advise and support all of the strategies and objectives of this project.

Social Marketing Research

Social marketing research will identify the most effective "messages" and "messengers" to communicate with teen parents.

Messages support staying in school and goal setting.

End produce: Public awareness campaign which includes audio and visual public service announcements.



Child Welfare

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Child Welfare

Child abuse and neglect and the mental health, substance abuse and other problems often associated with it, can push children into the cradle to prison pipeline. Prevention services and treatment to help children exposed to trauma heal are often lacking. Parents don't get the mental health and substance abuse treatment they need. Children in foster care frequently move from home to home, disrupting any sense of stability and their education. Some move from foster care to the juvenile justice system.

- A child is abused or neglected every 42 seconds; almost 80 percent of them are victims of neglect. Infants are the most likely to suffer from maltreatment. Forty percent of child victims receive no post-investigation services and many more receive far fewer services than they need. Nearly 40 percent are served at home and 20.8 percent are placed in foster care.
- 1,161 children enter foster care each day and remain there on average more than two years. Every two minutes a child enters foster care.
- About two-thirds of the children who exit from foster care in a year exit to a family member. An estimated 115,000 children in foster care are waiting to be adopted.
- While the number of children and Black children in foster care is declining, Black children are still overrepresented. Thirty percent of the children in foster care are Black, double the percent of the child population who are Black.
- Foster care often promotes instability. In every state but one, more than half the children in care for two or more years experience at least three placements.
- More than 29,000 youth aged out of foster care at 18 or older in 2009; in most states more than 60 percent of these youth entered foster care when they older were than 12.

Who Are the Children Who Are Abused and Neglected?

- Infants and toddlers are the most likely to be victims of abuse and neglect. One-third of all victims are three or younger.
- Of all maltreated victims 78.6 percent are victims of neglect; 2.4 percent of medical neglect; 17.8 percent of physical abuse; 9.6 percent of sexual abuse; 7.1 percent of psychological abuse, and 9.8 percent are victims of other or unknown types of maltreatment.
- Nearly half of all abused and neglected children are White; more than one-fifth are African American; and one-fifth are Hispanic.
- Boys and girls are almost equally likely to be victims of abuse or neglect, with girls just slightly more likely.
- More than half of the child victims are reported to child protection agencies by teachers, police officers and other social services or medical professionals.
- Forty percent of child victims receive no services after the investigation.
- Three-quarters of child victims have no history of prior victimization.
- Approximately one in five child victims in 2009 was maltreated by someone other than his/her parents.

Sources: U.S. Department of Health and Human Services, Administration on Children, Youth, and Families, Child Maltreatment: 2009 (December 2010). Calculations by Children's Defense Fund.

A child is abused or neglected every 42 seconds; almost eight out of ten are victims of neglect. Children three or younger are the most likely victims of maltreatment.

Child Maltreatment, 2009*

	Victims of maltreatment		Type of maltreatment** (percent distribution)					
	Number	Rate***	Neglect	Medical neglect	Physical abuse	Sexual abuse	Psychological maltreatment	Other, unknown, or missing
Alabama	8,123	7.2	37.3%	—	48.7%	23.1%	0.4%	—
Alaska	3,544	19.3	89.3	1.9%	12.7	2.9	20.3	—
Arizona	3,803	2.2	72.0	—	25.8	9.1	0.6	—
Arkansas	9,926	14.0	65.7	7.8	19.2	23.4	1.2	0.0%
California	73,962	7.8	82.9	—	11.5	7.4	17.5	0.1
Colorado	11,341	9.2	78.4	1.6	15.1	9.9	4.6	0.7
Connecticut	9,090	11.3	97.0	3.9	6.9	4.5	4.6	—
Delaware	2,015	9.7	42.5	1.1	18.0	7.7	32.9	9.0
District of Columbia	3,279	28.8	67.5	4.1	15.7	3.2	1.2	30.0
Florida	45,841	11.3	52.7	2.3	10.5	4.7	1.4	56.2
Georgia	23,249	9.0	69.1	4.7	13.2	5.0	20.8	—
Hawaii	2,007	6.9	15.4	1.7	9.6	3.8	0.5	94.9
Idaho	1,571	3.7	74.9	1.1	20.8	5.9	0.1	8.6
Illinois	27,446	8.6	74.0	2.3	22.5	16.3	0.1	—
Indiana	22,330	14.0	87.5	2.2	12.1	17.7	0.8	—
Iowa	11,636	16.3	92.2	1.1	13.2	5.0	0.7	5.6
Kansas	1,329	1.9	17.5	3.2	22.0	35.4	10.5	23.0
Kentucky	16,187	16.0	95.3	—	10.0	4.5	0.4	—
Louisiana	9,063	8.1	82.8	—	28.0	7.8	0.9	0.4
Maine	3,809	14.0	75.3	—	17.5	7.1	46.1	—
Maryland	15,310	11.3	72.7	—	25.7	12.4	0.4	—
Massachusetts	34,639	24.2	103.6	—	13.8	2.8	0.2	0.0
Michigan	29,976	12.8	90.1	2.9	23.6	4.2	28.1	32.2
Minnesota	4,668	3.7	75.2	1.4	20.5	16.9	0.8	—
Mississippi	7,369	9.6	65.2	4.2	19.0	14.7	11.0	0.4
Missouri	5,226	3.7	53.5	2.8	33.1	28.5	5.4	—
Montana	1,521	6.9	84.1	1.6	13.7	6.2	22.8	0.3
Nebraska	4,871	10.8	97.4	0.0	11.8	8.1	0.5	—
Nevada	4,443	6.5	75.8	1.8	29.6	8.3	3.1	—
New Hampshire	924	3.2	80.4	3.2	12.0	16.1	1.8	—
New Jersey	8,725	4.3	79.1	2.4	18.7	10.3	0.2	—
New Mexico	4,915	9.6	83.4	2.6	14.9	4.9	18.2	—
New York	77,620	17.5	107.0	6.2	11.4	3.6	1.0	30.0
North Carolina	22,371	9.8	87.4	1.9	10.7	8.2	0.3	0.8
North Dakota	n/r	n/r	n/r	n/r	n/r	n/r	n/r	n/r
Ohio	31,270	11.5	47.7	1.5	37.5	19.4	6.5	
Oklahoma	7,157	7.8	89.0	2.5	19.0	7.8	20.0	0.0
Oregon	n/r	n/r	n/r	n/r	n/r	n/r	n/r	n/r
Pennsylvania	3,913	1.4	3.9	2.9	34.0	64.2	1.1	—
Rhode Island	2,804	12.4	93.1	1.4	14.5	4.3	0.1	1.7
South Carolina	12,381	11.5	72.4	3.8	34.3	6.5	1.0	0.3
South Dakota	1,443	7.2	93.6	—	12.5	4.9	3.1	—
Tennessee	8,822	5.9	59.0	2.9	15.3	31.2	2.4	—
Texas	66,359	9.6	81.8	3.3	21.4	9.5	1.0	0.0
Utah	12,704	14.6	21.0	0.3	13.1	17.8	51.5	22.0
Vermont	696	5.5	4.0	2.0	52.3	52.9	1.4	—
Virginia	5,951	3.2	63.1	2.7	27.9	15.8	1.2	—
Washington	6,070	3.9	82.7	—	24.7	7.4	—	—
West Virginia	4,978	12.9	56.2	1.2	30.4	4.9	32.4	12.1
Wisconsin	4,654	3.6	55.4	1.5	22.2	29.9	1.2	—
Wyoming	707	5.4	70.7	1.3	8.1	12.6	13.0	3.8
United States	682,038	9.6	78.6	2.4	17.8	9.6	7.1	9.8

* The methodology for this analysis was modified by using unique counts of children, rather than duplicate counts. Unique counts identify and count a child once, regardless of the number of reports that received a CPS response, and the duplicate counts identify a child each time that he or she was a subject of a report that received a CPS response.
** May add to more than 100 percent in a state because some children experience more than one type of maltreatment.
*** Number of victims per 1,000 children.
Note: Because of differences in definitions of child abuse and neglect, comparisons of data between states should not be made.
— category not reported by state.
n/r — no data reported by state.

Source: U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth, and Families, Children's Bureau, *Child Maltreatment 2009* (December 2010), Table 3–13 "Reported Maltreatment Types of Victims, 2009" (unique counts). Available at http://www.acf.hhs.gov/programs/cb/pubs/cm09/cm09.pdf#page=31, page 46. Calculations by Children's Defense Fund.

Consistent with recent years, about 40 percent of children abused or neglected in 2009 received no services following the investigation of their maltreatment.

National Estimates of Children Served Following an Investigation of Child Abuse or Neglect

Year	All child victims	Served		Served in home		Removed to foster care		Not served	
		Number	Percent	Number	Percent	Number	Percent	Number	Percent
2002	910,000	535,000	58.8%	363,000	39.9%	172,000	18.9%	375,000	41.2%
2003	905,000	525,000	58.0	358,000	39.6	167,000	18.5	380,000	42.0
2004	892,000	528,000	59.2	359,000	40.2	170,000	19.0	364,000	40.8
2005	900,000	542,000	60.2	346,000	38.4	196,000	21.8	358,000	39.8
2006	905,000	533,000	58.9	338,000	37.4	195,000	21.5	372,000	41.1
2007	794,000	497,000	62.6	333,000	41.9	164,000	20.7	297,000	37.4
2008	772,000	489,000	63.3	331,000	42.9	161,000	20.9	283,000	36.7
2009	763,000	457,000	59.9	298,000	39.1	159,000	20.8	306,000	40.1

Source: U.S. Congress, Library of Congress, Congressional Research Service, "The Child Abuse Prevention and Treatment Act (CAPTA): Background, Programs, and Funding" (November 4, 2009), Table D-1;and U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth, and Families, Children's Bureau, *Child Maltreatment 2009* (April 2010), pp. x. Calculations by Children's Defense Fund.

The number of children in foster care has decreased 20 percent since 2005 and exits from care have exceeded entries from care for the past three years.

Trends in Foster Care and Adoption, FYs 2002–2009

Year	In care on September 30	Entries	Exits	Waiting to be adopted	Adopted
2002	523,000	295,000	278,000	134,000	51,000
2003	510,000	289,000	278,000	131,000	50,000
2004	508,000	298,000	281,000	130,000	51,000
2005	511,000	307,000	287,000	131,000	52,000
2006	505,000	305,000	295,000	135,000	51,000
2007	489,000	293,000	295,000	134,000	53,000
2008	460,000	274,000	288,000	127,000	55,000
2009	424,000	255,000	276,000	115,000	57,000

Source: U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau, AFCARS Data, "Trends in Foster Care and Adoption – FY2002-FY2009," at http://www.acf.hhs.gov/programs/cb/stats_research/afcars/trends02-09.pdf.

Domestic Minor Sex Trafficking

Domestic minor sex trafficking is the commercial sexual exploitation of children under age 18 within U.S. borders. It includes child sex slavery, prostitution of children, commercial sexual exploitation of children, and rape of children. An estimated 100,000 youth are victimized through prostitution in America each year. Too often the child victims, rather than the perpetrators, are the ones reported, arrested and prosecuted.

- In 2008, 643 female and 206 male children were reported to the FBI as having been arrested for prostitution and commercialized vice.[1]
- Since 2003, the Innocence Lost Initiative[2] has recovered over 1,600 child victims of sex trafficking. [3]
- Children as young as seven have been forced into sex trafficking due to fears about sexually transmitted disease among customers.[4]
- A 2001 report by the University of Pennsylvania estimated that about 293,000 American youth are at risk of commercial sexual exploitation.[5] Most of these children have run away from home or been abandoned by their parents, and turn to the sex trade as a means of survival.
- Fifty-five percent of girls who have been away or been forced to live on the street are engaged in formal prostitution, 75 percent of which was controlled by a pimp.[6]
- About 20 percent of children involved in the sex trade are trafficked nationally by organized crime syndicates. These children are often required to pay the costs of their transportation, shelter, and false identity papers.[7]
- The majority of trafficked children both use and sell illegal drugs.[8]
- The risk of a child 10-17 being sexually exploited for commercial purposes is higher than the risk that she or he will die in an accident or be raped or sexually assaulted.[9]

[1] "Trafficking in Persons Report, 10th Edition." (2010). Washington, DC: U.S. State Department. http://www.state.gov/documents/organization/142979.pdf

[2] The Innocence Lost Initiative is a coalition of federal and state law enforcement authorities and victim assistance providers focused on eliminating child prostitution.

[3] "Innocence Lost." (2011). Washington, DC: Federal Bureau of Investigation. http://www.fbi.gov/about-us/investigate/vc_majorthefts/cac/innocencelost

[4] Miko, Francis T. (2006). "Trafficking in Persons: The U.S. and International Response." Washington, DC: Congressional Research Service. http://www.usembassy.it/pdf/other/RL30545.pdf

[5] Richard J. Estes and Neil Alan Weiner. (2002). "Commercial Sexual Exploitation of Children in the U.S, Canada and Mexico: Executive Summary of the U.S. National Study." Philadelphia, PA: University of Pennsylvania. http://www.sp2.upenn.edu/restes/CSEC_Files/Exec_Sum_020220.pdf

[6] Ibid.

[7] Ibid.

[8] Ibid.

[9] Ibid.

Black children are only 15 percent of the child population but 30 percent of children in foster care. About two-thirds of the children who leave foster care exit to a family member; 20 percent are adopted.

Who is in Foster Care?

Number of Children in Foster Care: 423,773

	Percent in foster care 2009	Percent in U.S. child population 2009
Race and ethnicity		
White, non-Hispanic	40%	55%
Black	30	15
Hispanic	20	23
American Indian, Alaska Native	2	1
Asian	1	4
Two or more races	5	3
Age		
Under age 1	6	
1-5 years	30	
6-10 years	20	
11-15 years	24	
16-18 years	20	
19 + years	2	
Type of placement		
Non-relative foster home	48	
Relative foster home	24	
Institution	10	
Group home	6	
Pre-adoptive home	4	
Trial home visit	5	
Runaway	2	
Supervised independent living	1	
Exit from foster care during year		
Reunification	51	
Adoption	20	
Emancipation	11	
Living with relative	8	
Guardianship	7	
Transfer to another agency	2	
Runaway	1	

Note: Race/ethnicity, age, and placement are estimates of children in foster care on September 30, 2009; exit data reflect outcomes for children exiting foster care during FY 2009.

Source: U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau, "The AFCARS Report: Preliminary FY 2009 Estimates as of July 2010," at <http://www.acf.hhs.gov/programs/cb/stats_research/afcars/tar/report17.htm>. Calculations by Children's Defense Fund.

The number of children in foster care has declined each year since 2005. More than half of the children in foster care live in just nine states.*

Children in Foster Care, FYs 2004–2009

Number in foster care on September 30 of each year

	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009
Alabama	5,934	6,913	7,157	7,262	6,876	6,894
Alaska	1,825	1,660	1,919	2,107	2,168	2,166
Arizona	9,194	9,685	9,767	9,569	10,425	10,175
Arkansas	3,124	3,238	3,434	3,616	3,522	3,657
California*	82,641	80,247	76,405	73,998	67,703	60,198
Colorado	8,196	8,213	8,139	7,777	7,921	7,927
Connecticut	6,459	6,249	6,359	5,764	5,373	4,761
Delaware	849	962	1,074	1,157	938	814
District of Columbia	2,641	2,519	2,378	2,197	2,217	2,111
Florida*	28,864	29,312	29,229	26,788	22,187	19,156
Georgia	14,216	13,965	13,175	12,197	9,984	8,020
Hawaii	2,939	2,743	2,357	1,940	1,622	1,455
Idaho	1,565	1,818	1,850	1,870	1,723	1,446
Illinois*	19,931	19,419	18,815	17,864	17,843	17,080
Indiana*	9,778	11,243	11,401	11,372	12,386	12,437
Iowa	5,384	6,794	8,922	8,005	6,743	6,564
Kansas	6,060	5,833	6,237	6,631	6,306	5,691
Kentucky	6,998	7,220	7,695	7,207	7,182	6,872
Louisiana	4,397	4,833	5,213	5,333	5,065	4,786
Maine	2,589	2,339	2,076	1,971	1,864	1,646
Maryland	11,111	10,867	9,051	8,415	7,613	7,052
Massachusetts	12,562	12,197	11,499	10,497	10,427	9,650
Michigan*	21,173	20,498	20,142	20,830	20,171	17,723
Minnesota	6,540	6,989	6,813	6,711	6,028	5,410
Mississippi	2,989	3,269	3,126	3,328	3,292	3,320
Missouri	11,778	11,433	10,207	10,233	10,128	9,912
Montana	2,030	2,222	1,909	1,737	1,600	1,639
Nebraska	6,292	6,231	6,187	5,875	5,591	5,343
Nevada	4,037	4,656	5,068	5,070	5,023	4,779
New Hampshire	1,236	1,178	1,148	1,102	1,029	930
New Jersey	12,282	11,205	10,740	9,056	8,510	7,809
New Mexico	2,157	2,316	2,357	2,423	2,221	2,009
New York*	33,445	30,458	29,973	30,072	29,493	27,992
North Carolina	10,077	10,698	11,115	10,827	9,841	9,547
North Dakota	1,314	1,370	1,331	1,263	1,222	1,224
Ohio*	18,004	17,446	15,741	14,532	13,703	12,197
Oklahoma	11,821	11,334	11,736	11,785	10,595	8,712
Oregon	10,048	11,020	10,661	9,562	8,988	8,650
Pennsylvania*	21,944	21,691	21,135	20,999	19,218	16,878
Rhode Island	2,414	2,509	2,998	2,768	2,407	2,112
South Carolina	4,635	4,757	4,920	5,147	4,999	4,938
South Dakota	1,582	1,704	1,648	1,566	1,482	1,484
Tennessee	9,590	9,017	8,618	7,751	7,219	6,723
Texas*	24,529	28,883	30,848	30,137	28,154	26,686
Utah	2,108	2,285	2,427	2,765	2,714	2,759
Vermont	1,432	1,436	1,379	1,309	1,200	1,062
Virginia	6,869	7,022	7,672	7,718	7,099	5,927
Washington	9,368	10,068	10,457	11,107	11,247	9,922
West Virginia	3,990	4,629	4,018	4,432	4,412	4,237
Wisconsin	7,812	8,076	7,459	7,541	7,403	6,785
Wyoming	1,184	1,244	1,304	1,231	1,154	1,155
United States	499,937	503,913	497,289	482,414	454,231	418,422

Source: U.S. Department of Health and Human Services, Administration for Children and Families, "Foster Care FY2002 - FY2009 Entries, Exits, and Numbers of Children In Care on the Last Day of Each Federal Fiscal Year," at http://www.acf.hhs.gov/programs/cb/stats_research/afcars/statistics/entryexit2009.pdf. Calculations by Children's Defense Fund.

* States where more than half of children in foster care live.

In 2009 more children nationally and in 34 states exited from foster care than entered care.

Number of Children Entering, Exiting and In Foster Care, FY 2009

	Number of children:		
	Entering foster care during the year	Exiting foster care during the year	In foster care on September 30, 2009
Alabama	3,124	2,885	6,894
Alaska	927	915	2,166
Arizona	7,588	7,232	10,175
Arkansas	4,161	3,917	3,657
California	34,826	39,226	60,198
Colorado	6,353	6,204	7,927
Connecticut	2,466	2,972	4,761
Delaware	445	555	814
District of Columbia	624	703	2,111
Florida	14,313	16,400	19,156
Georgia	5,857	7,770	8,020
Hawaii	1,332	1,447	1,455
Idaho	1,215	1,452	1,446
Illinois	5,176	5,876	17,080
Indiana	9,464	8,448	12,437
Iowa	4,728	4,687	6,564
Kansas	3,163	3,615	5,691
Kentucky	5,387	5,434	6,872
Louisiana	3,631	3,683	4,786
Maine	753	959	1,646
Maryland	2,772	3,265	7,052
Massachusetts	6,171	6,673	9,650
Michigan	7,863	10,182	17,723
Minnesota	5,999	6,283	5,410
Mississippi	2,107	2,064	3,320
Missouri	5,636	4,834	9,912
Montana	976	939	1,639
Nebraska	3,563	3,619	5,343
Nevada	2,905	3,092	4,779
New Hampshire	505	558	930
New Jersey	4,800	5,418	7,809
New Mexico	1,991	2,164	2,009
New York	12,876	13,658	27,992
North Carolina	4,971	4,968	9,547
North Dakota	940	877	1,224
Ohio	8,741	10,074	12,197
Oklahoma	4,734	6,580	8,712
Oregon	4,601	4,743	8,650
Pennsylvania	11,226	12,507	16,878
Rhode Island	1,447	1,604	2,112
South Carolina	3,719	3,698	4,938
South Dakota	1,448	1,381	1,484
Tennessee	5,952	6,214	6,723
Texas	12,769	14,160	26,686
Utah	2,060	1,966	2,759
Vermont	550	647	1,062
Virginia	2,582	3,360	5,927
Washington	6,092	5,849	9,922
West Virginia	3,000	3,039	4,237
Wisconsin	4,560	4,923	6,785
Wyoming	1,139	1,079	1,155
United States	254,228	274,798	418,422

Source: U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau, "Foster Care FY 2002 - FY 2009 Entries, Exits, and Numbers of Children In Care on the Last Day of Each Federal Fiscal Year," at http://www.acf.hhs.gov/programs/cb/stats_research/afcars/statistics/entryexit2009.htm.

One-third of the children in foster care are five or younger; one-third are 14 or older. Children who enter care at younger ages stay longer.

Children in Foster Care,* by Age, FY 2009

	Number of children in foster care	Percent distribution by age						
		Under 1	1–2	3–5	6–9	10–13	14–17	18–20+
Alabama	6,894	4.9%	12.5%	14.5%	14.9%	15.9%	25.7%	11.3%
Alaska	2,166	5.6	15.5	18.6	21.7	17.0	16.4	4.3
Arizona	10,175	7.1	16.7	17.2	17.3	14.2	21.7	6.0
Arkansas	3,657	7.7	17.1	16.6	17.6	15.6	25.6	0.0
California	60,198	5.1	12.1	13.8	15.0	16.6	32.1	5.4
Colorado	7,927	4.8	10.2	11.0	11.7	13.1	34.8	14.1
Connecticut	4,761	5.4	11.7	11.5	12.0	15.4	41.9	1.8
Delaware	814	6.1	11.1	10.8	15.5	16.6	37.0	2.7
District of Columbia	2,111	2.2	8.9	11.1	12.3	13.7	26.8	24.8
Florida	19,156	8.0	18.5	18.9	16.9	14.7	22.9	0.0
Georgia	8,020	6.9	16.0	15.8	16.7	16.0	28.5	0.2
Hawaii	1,455	7.0	14.9	18.3	17.8	16.2	25.7	0.1
Idaho	1,446	6.1	17.2	18.3	19.5	15.4	23.6	0.0
Illinois	17,080	4.3	14.2	17.1	16.3	13.2	18.9	13.5
Indiana	12,437	6.3	16.9	18.4	18.0	15.2	22.0	3.2
Iowa	6,564	5.1	13.7	13.8	13.5	13.9	37.4	2.6
Kansas	5,691	4.8	12.8	15.5	17.6	16.4	32.0	0.6
Kentucky	6,872	5.6	12.9	13.9	14.5	15.1	37.0	0.8
Louisiana	4,786	6.8	17.8	19.1	18.6	15.0	22.8	0.1
Maine	1,646	6.6	18.0	18.3	16.3	14.7	25.0	0.9
Maryland	7,052	4.3	11.5	13.0	14.6	18.2	35.4	3.0
Massachusetts	9,650	5.0	12.1	12.5	14.5	16.6	39.1	0.1
Michigan	17,723	5.6	13.3	16.1	15.9	13.9	28.9	6.3
Minnesota	5,410	5.3	10.9	11.4	12.7	16.4	41.6	1.5
Mississippi	3,320	6.0	15.2	16.4	16.7	15.3	25.1	5.3
Missouri	9,912	5.3	12.7	14.4	15.4	14.9	27.2	10.1
Montana	1,639	4.9	16.9	19.0	19.4	15.6	22.4	1.7
Nebraska	5,343	3.7	11.2	13.5	14.1	13.2	36.5	7.7
Nevada	4,779	6.5	18.9	20.7	20.0	15.2	18.2	0.4
New Hampshire	930	3.8	12.5	14.5	15.6	17.2	29.5	6.4
New Jersey	7,809	8.7	18.6	16.8	15.2	14.5	23.2	3.1
New Mexico	2,009	5.4	16.9	20.6	23.2	16.8	17.0	0.0
New York	27,992	3.8	10.9	13.7	15.0	14.1	28.9	13.2
North Carolina	9,547	5.8	14.9	16.8	17.1	16.2	25.5	3.8
North Dakota	1,224	4.9	10.4	13.4	13.5	16.7	38.6	2.4
Ohio	12,197	6.5	14.8	13.8	14.2	14.3	30.3	5.9
Oklahoma	8,712	6.9	19.1	21.3	21.0	15.6	16.1	0.0
Oregon	8,650	5.4	14.9	17.9	17.9	17.0	21.2	5.8
Pennsylvania	16,878	5.0	13.2	13.6	13.7	13.5	32.7	8.3
Rhode Island	2,112	5.8	10.2	10.1	11.4	13.8	40.1	8.7
South Carolina	4,938	6.5	14.5	16.0	16.7	17.8	28.0	0.4
South Dakota	1,484	6.0	16.1	19.7	18.9	16.9	21.2	1.1
Tennessee	6,723	4.5	11.3	12.3	12.3	13.2	43.5	2.6
Texas	26,686	6.8	17.4	18.5	19.3	16.8	21.1	0.0
Utah	2,759	5.1	10.8	10.7	12.7	15.8	37.0	8.0
Vermont	1,062	3.8	8.6	10.1	11.2	14.8	46.6	5.0
Virginia	5,927	3.4	10.3	11.9	14.9	16.4	40.2	2.8
Washington	9,922	6.7	17.8	18.0	18.7	16.1	19.4	3.3
West Virginia	4,237	4.9	13.7	15.0	15.5	15.2	34.3	1.2
Wisconsin	6,785	5.4	13.5	16.6	15.9	14.9	31.1	2.4
Wyoming	1,155	2.8	10.7	14.5	13.7	15.2	37.7	5.3

* In foster care on September 30, 2009.

Source: U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau, Child Welfare Outcomes Report Data, "Age of Children in Foster Care: In Foster Care on 9/30," at http://cwoutcomes.acf.hhs.gov/data/. Calculations by Children's Defense Fund.

Children in foster care are disproportionately Black. Black children account for 45 percent or more of the children in foster care in about a quarter of the states and the District of Columbia.

Children in Foster Care, by Race/Ethnicity, FY 2009

		Percent distribution by race/ ethnicity							
	Number of children in foster care	White	Black	Hispanic	American Indian/ Alaska Native	Asian	Native Hawaiian, Other Pacific Islander	Two or more races	Unknown
Alabama	6,894	46.6%	43.1%	3.9%	0.1%	0.1%	0.0%	3.9%	2.2%
Alaska	2,166	24.8	3.7	4.6	55.5	0.4	1.4	7.8	0.5
Arizona	10,175	37.0	10.0	42.2	3.7	0.1	0.3	3.7	2.9
Arkansas	3,657	57.6	25.9	6.7	0.1	0.3	0.1	9.3	0.2
California	60,198	21.5	23.4	47.5	0.7	1.8	0.3	4.5	0.3
Colorado	7,927	44.1	13.6	36.9	0.7	0.6	0.2	3.8	0.2
Connecticut	4,761	32.0	28.0	32.1	0.1	0.4	0.1	6.3	1.1
Delaware	814	32.3	54.5	7.9	0.2	0.5	0.0	4.5	0.0
District of Columbia	2,111	0.6	86.7	6.9	0.0	0.1	0.0	2.8	0.0
Florida	19,156	46.5	36.2	12.7	0.3	0.2	0.1	3.6	0.3
Georgia	8,020	40.7	47.4	7.1	0.1	0.2	0.0	4.3	0.3
Hawaii	1,455	10.7	1.3	4.5	0.1	10.2	20.6	50.2	2.0
Idaho	1,446	70.1	2.1	13.0	7.7	0.9	0.1	6.1	0.0
Illinois	17,080	35.0	56.7	5.6	0.1	0.3	0.0	0.1	2.2
Indiana	12,437	58.1	27.9	7.7	0.1	0.1	0.1	5.8	0.3
Iowa	6,564	63.5	15.1	8.3	2.0	0.7	0.4	2.2	7.4
Kansas	5,691	65.2	20.6	8.9	1.0	0.4	0.1	3.3	0.3
Kentucky	6,872	73.7	15.3	4.3	0.1	0.1	0.1	4.2	2.2
Louisiana	4,786	46.9	48.0	1.6	0.3	0.1	0.1	1.6	1.6
Maine	1,646	82.8	2.4	4.6	1.1	0.1	0.0	5.3	3.6
Maryland	7,052	21.0	69.7	3.4	0.1	0.2	0.1	3.2	1.8
Massachusetts	9,650	46.3	16.4	26.9	0.2	2.0	0.1	4.6	3.6
Michigan	17,723	40.8	44.9	5.6	0.8	0.1	0.1	7.4	0.3
Minnesota	5,410	42.5	18.3	9.6	15.4	1.9	0.1	8.9	3.2
Mississippi	3,320	41.9	52.8	2.1	0.1	0.1	0.1	1.7	1.2
Missouri	9,912	65.8	29.0	2.8	0.3	0.2	0.1	0.9	0.9
Montana	1,639	48.8	1.2	5.5	35.5	0.1	0.1	6.8	2.1
Nebraska	5,343	54.7	18.9	12.5	7.6	0.7	0.1	2.2	3.4
Nevada	4,779	39.9	25.2	24.7	1.0	1.0	0.8	7.3	0.1
New Hampshire	930	79.9	2.7	8.7	0.3	0.4	0.0	2.9	5.0
New Jersey	7,809	24.3	49.1	15.6	0.1	0.3	0.1	2.2	8.3
New Mexico	2,009	23.8	3.4	58.6	9.7	0.1	0.1	3.8	0.3
New York	27,992	18.4	48.3	21.8	0.2	0.5	0.0	2.7	8.1
North Carolina	9,547	45.5	39.7	8.1	1.2	0.2	0.2	4.5	0.6
North Dakota	1,224	55.2	3.7	5.5	25.1	1.1	0.2	8.9	0.1
Ohio	12,197	50.1	37.8	3.1	0.1	0.1	0.1	4.9	1.6
Oklahoma	8,712	36.1	17.6	15.1	8.7	0.1	0.1	22.4	0.0
Oregon	8,650	55.5	0.9	12.0	1.3	0.3	0.3	22.1	7.7
Pennsylvania	16,878	38.8	45.0	10.1	0.2	0.4	0.0	0.7	4.8
Rhode Island	2,112	48.1	15.5	23.8	0.9	2.4	0.0	7.0	2.2
South Carolina	4,938	44.5	44.7	3.9	0.1	0.1	0.1	6.3	0.4
South Dakota	1,484	29.5	2.8	6.6	52.8	0.2	0.1	8.1	0.0
Tennessee	6,723	60.5	28.5	5.6	0.2	0.1	0.1	2.6	2.4
Texas	26,686	28.7	24.8	40.9	0.2	0.2	0.1	4.0	1.2
Utah	2,759	63.1	4.9	23.7	3.8	0.5	0.6	2.6	0.8
Vermont	1,062	96.5	1.8	0.8	0.0	0.1	0.0	0.0	0.6
Virginia	5,927	46.0	37.7	9.3	0.0	0.4	0.0	5.8	0.8
Washington	9,922	49.6	9.4	15.5	10.9	0.8	0.4	11.3	1.4
West Virginia	4,237	85.1	5.2	1.8	0.0	0.1	0.1	7.1	0.4
Wisconsin	6,785	43.6	36.2	8.9	4.0	0.8	0.1	4.5	0.9
Wyoming	1,155	74.2	4.8	12.3	1.8	0.1	0.0	1.2	5.6

* In Foster Care on September 30, 2009

Source: U.S. Department of Health and Human Services, Administration of Children and Families, Children's Bureau, Child Welfare Outcomes Report Data, 2009 Race and Ethnicity of Children in Foster Care, available at http://cwoutcomes.acf.hhs.gov/data/. Calculations by Children's Defense Fund.

In 21 states, the percent of Black children in foster care is more than twice their proportion in the general child population.

Overrepresentation of Black Children in Foster Care, FY 2009

	Number of children		Black children as a percent of		Ratio of Black children in foster care to Black children in population
	Total	Black	All children	Children in foster care	
Alabama	1,128,864	342,322	30.3%	43.1%	1.4
Alaska	183,546	9,985	5.4	3.7	0.7
Arizona	1,732,019	96,390	5.6	10.0	1.8
Arkansas	709,968	137,298	19.3	25.9	1.3
California	9,435,682	647,685	6.9	23.4	3.4
Colorado	1,227,763	66,997	5.5	13.6	2.5
Connecticut	807,985	103,817	12.8	28.0	2.2
Delaware	206,993	51,501	24.9	54.5	2.2
District of Columbia	114,036	74,129	65.0	86.7	1.3
Florida	4,057,773	877,281	21.6	36.2	1.7
Georgia	2,583,792	845,665	32.7	47.4	1.4
Hawaii	290,361	13,724	4.7	1.3	0.3
Idaho	419,190	7,615	1.8	2.1	1.2
Illinois	3,177,377	556,475	17.5	56.7	3.2
Indiana	1,589,365	181,052	11.4	27.9	2.4
Iowa	713,155	31,058	4.4	15.1	3.5
Kansas	704,951	54,418	7.7	20.6	2.7
Kentucky	1,014,323	98,717	9.7	15.3	1.6
Louisiana	1,123,386	425,858	37.9	48.0	1.3
Maine	271,176	6,650	2.5	2.4	1.0
Maryland	1,351,935	444,146	32.9	69.7	2.1
Massachusetts	1,433,002	138,706	9.7	16.4	1.7
Michigan	2,349,892	401,986	17.1	44.9	2.6
Minnesota	1,260,797	89,815	7.1	18.3	2.6
Mississippi	767,742	333,446	43.4	52.8	1.2
Missouri	1,431,338	203,097	14.2	29.0	2.0
Montana	219,828	3,449	1.6	1.2	0.8
Nebraska	451,641	28,475	6.3	18.9	3.0
Nevada	681,033	63,692	9.4	25.2	2.7
New Hampshire	289,071	7,161	2.5	2.7	1.1
New Jersey	2,045,848	345,066	16.9	49.1	2.9
New Mexico	510,238	21,657	4.2	3.4	0.8
New York	4,424,083	898,042	20.3	48.3	2.4
North Carolina	2,277,967	548,973	24.1	39.7	1.6
North Dakota	143,971	2,871	2.0	3.7	1.9
Ohio	2,714,341	405,986	15.0	37.8	2.5
Oklahoma	918,849	90,643	9.9	17.6	1.8
Oregon	872,811	25,589	2.9	0.9	0.3
Pennsylvania	2,775,132	397,320	14.3	45.0	3.1
Rhode Island	226,825	20,111	8.9	15.5	1.7
South Carolina	1,080,732	352,136	32.6	44.7	1.4
South Dakota	199,616	4,153	2.1	2.8	1.3
Tennessee	1,493,252	309,559	20.7	28.5	1.4
Texas	6,895,969	863,664	12.5	24.8	2.0
Utah	868,824	16,904	1.9	4.9	2.5
Vermont	126,275	2,233	1.8	1.8	1.0
Virginia	1,847,182	414,029	22.4	37.7	1.7
Washington	1,569,592	78,341	5.0	9.4	1.9
West Virginia	386,449	19,283	5.0	5.2	1.0
Wisconsin	1,310,250	117,931	9.0	36.2	4.0
Wyoming	132,025	3,265	2.5	4.8	1.9

Source: U.S. Department of Commerce, Bureau of the Census, State by Age, Sex, Race, and Hispanic Origin, at http://www.census.gov/popest/datasets.html; and U.S. Department of Health and Human Services, Administration of Children and Families, Children's Bureau, Child Welfare Outcomes Report Data, "2009 Race and Ethnicity of Children in Foster Care," available at http://cwoutcomes.acf.hhs.gov/data/. Calculations by Children's Defense Fund.

In the majority of states and the District of Columbia, at least one-third of children in foster care between one and two years experience three or more placements.

Placement Stability, 2009

Number of Placements by Time in Care

	Children with two or fewer placements:			Children with three or more placements:		
	In care less than 12 months	In care at least 12 but less than 24 months	In care 24 months or longer	In care less than 12 months	In care at least 12 but less than 24 months	In care 24 months or longer
Alabama	69.8%	49.8%	27.6%	19.4%	45.8%	69.7%
Alaska	82.6	54.8	23.9	17.4	45.2	76.1
Arizona	87.0	65.5	29.2	11.8	34.5	70.8
Arkansas	74.8	44.0	16.8	24.4	55.8	83.1
California	82.8	61.7	33.8	16.9	38.2	66.1
Colorado	83.3	64.3	33.8	11.1	34.9	65.9
Connecticut	86.7	66.1	30.8	13.3	33.9	66.1
Delaware	82.1	59.8	28.1	17.7	40.2	71.9
District of Columbia	78.0	55.2	21.5	20.7	44.8	78.0
Florida	84.9	60.8	30.5	14.7	39.0	69.3
Georgia	74.3	52.7	27.2	23.7	47.1	72.7
Hawaii	87.1	67.1	40.5	10.2	32.4	59.5
Idaho	88.2	61.9	35.3	11.8	38.1	64.7
Illinois	83.0	68.7	35.6	17.0	31.3	64.4
Indiana	89.1	66.0	36.7	10.9	34.0	63.3
Iowa	88.0	61.3	26.6	12.0	38.7	73.4
Kansas	78.5	52.3	28.8	21.0	45.5	69.8
Kentucky	86.6	60.1	29.6	13.4	39.9	70.4
Louisiana	78.9	54.3	28.3	20.3	45.7	71.7
Maine	86.0	69.3	26.1	13.3	30.8	73.9
Maryland	84.6	76.8	32.1	9.3	19.5	66.9
Massachusetts	74.0	48.7	23.3	25.9	51.3	76.7
Michigan	85.8	72.6	46.5	14.2	27.4	53.5
Minnesota	86.8	58.3	28.2	13.2	41.7	71.8
Mississippi	78.2	56.6	26.4	17.7	42.9	73.6
Missouri	91.0	92.7	91.0	9.0	7.3	9.0
Montana	87.1	63.9	34.9	12.9	36.1	65.1
Nebraska	84.2	55.4	26.0	15.8	44.6	74.0
Nevada	82.9	57.2	26.3	16.3	42.4	73.6
New Hampshire	86.0	63.1	42.9	13.1	36.9	57.1
New Jersey	87.4	72.4	45.7	12.6	27.6	54.3
New Mexico	88.5	55.1	25.3	11.5	44.9	74.7
New York	89.1	72.4	43.9	10.2	27.5	56.1
North Carolina	92.8	75.7	44.6	7.2	24.3	55.4
North Dakota	85.2	54.6	38.6	14.8	45.4	61.4
Ohio	74.0	70.3	37.3	10.0	29.4	62.6
Oklahoma	73.7	47.2	25.3	25.4	52.8	74.6
Oregon	87.4	63.6	33.4	12.6	36.4	66.6
Pennsylvania	87.0	64.7	43.4	13.0	35.3	56.6
Rhode Island	88.4	62.0	34.7	11.6	38.0	65.3
South Carolina	77.6	40.8	17.8	22.4	59.2	82.2
South Dakota	87.1	55.7	19.0	12.9	44.3	81.0
Tennessee	79.8	54.8	35.8	19.7	45.2	64.2
Texas	82.5	55.1	22.2	17.5	44.9	77.8
Utah	77.2	41.2	17.0	21.4	58.8	83.0
Vermont	72.2	43.9	18.5	27.8	56.1	81.5
Virginia	86.1	66.0	36.4	13.5	33.8	63.5
Washington	86.7	66.2	45.2	12.7	33.8	54.7
West Virginia	86.7	66.2	36.2	13.3	33.8	63.8
Wisconsin	86.7	64.7	40.7	13.3	35.3	59.3
Wyoming	82.9	59.1	38.5	13.7	39.6	61.5

* In care on September 30, 2009.

Source: U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau," Child Welfare Outcomes Report Data, Table 6.1 "Number of Placements by Time in Care," at http://cwoutcomes.acf.hhs.gov/data/. Calculations by Children's Defense Fund.

The median length of time a child spends in foster care before exiting is over a year; more than half of the children exit through reunification with family.

Exits of Children from Foster Care, 2009

	Number of children who exited foster care	Median length of stay (months)	Percent distribution by type of exit			
			Adoption	Guardianship	Reunification	Other, missing data
Alabama	2,822	13.3	8.0%	0.0%	69.6%	22.4%
Alaska	851	23.0	37.1	3.8	49.0	10.1
Arizona	7,233	11.0	22.9	9.1	52.6	15.4
Arkansas	3,891	3.3	15.1	3.3	73.6	8.0
California	36,643	14.8	19.4	6.6	56.1	17.9
Colorado	5,971	8.4	15.9	4.8	64.1	15.2
Connecticut	2,932	17.3	22.3	8.9	46.7	22.1
Delaware	555	16.9	22.5	14.4	43.4	19.6
District of Columbia	703	26.6	15.2	12.2	46.5	26.0
Florida	16,064	12.4	21.7	24.0	45.0	9.3
Georgia	7,483	13.6	17.4	7.6	63.2	11.8
Hawaii	1,403	8.7	19.1	8.0	59.2	13.7
Idaho	1,446	11.3	23.3	6.1	61.2	9.4
Illinois	5,108	33.0	27.6	10.0	40.0	22.4
Indiana	8,382	9.7	17.7	8.5	65.2	8.7
Iowa	4,457	14.4	20.1	6.8	62.5	10.7
Kansas	3,615	16.9	22.8	7.1	54.0	16.0
Kentucky	5,183	9.4	15.6	0.2	66.8	17.4
Louisiana	3,660	11.7	15.8	0.9	73.9	9.4
Maine	928	20.5	33.2	8.3	40.2	18.3
Maryland	2,692	27.4	24.1	6.4	35.0	34.5
Massachusetts	6,553	11.6	11.9	7.2	63.8	17.1
Michigan	9,010	20.9	22.6	4.1	52.3	21.1
Minnesota	6,237	5.3	10.5	8.6	66.7	14.1
Mississippi	1,952	12.7	14.8	4.7	74.6	5.9
Missouri	4,983	14.2	20.2	11.1	62.3	6.5
Montana	912	12.3	20.2	5.0	63.6	11.1
Nebraska	3,588	14.7	15.0	8.0	65.0	12.0
Nevada	3,089	12.3	17.2	3.9	67.8	11.1
New Hampshire	561	14.9	25.8	2.1	51.3	20.7
New Jersey	5,320	13.8	26.1	5.5	58.9	9.6
New Mexico	2,149	6.4	23.1	1.5	68.2	7.3
New York	12,808	15.2	18.1	0.0	66.0	15.9
North Carolina	4,970	17.2	29.2	12.4	46.7	11.7
North Dakota	821	9.5	11.1	0.0	66.5	22.4
Ohio	8,218	11.1	16.0	9.4	59.6	15.0
Oklahoma	6,465	18.7	23.1	7.6	59.3	10.0
Oregon	4,745	16.6	23.2	6.1	59.0	11.7
Pennsylvania	12,271	12.7	18.2	8.4	58.4	15.0
Rhode Island	1,493	12.8	18.7	5.5	60.3	15.5
South Carolina	3,669	7.2	14.3	0.9	74.0	10.8
South Dakota	1,374	5.5	12.1	5.4	60.7	21.8
Tennessee	6,218	10.4	16.1	2.3	70.2	11.4
Texas	13,942	17.6	35.2	2.3	50.2	12.2
Utah	1,962	11.0	24.2	8.8	51.9	15.2
Vermont	644	18.5	23.8	2.8	57.0	16.4
Virginia	3,304	18.9	20.0	0.0	44.9	35.1
Washington	5,504	13.9	30.9	25.0	37.2	6.8
West Virginia	2,928	11.8	17.9	5.2	71.6	5.4
Wisconsin	4,772	11.2	14.5	5.0	67.8	12.6
Wyoming	1,030	8.1	6.6	4.8	82.4	6.2
United States	276,266	13.7	20	7	51	22

Source: U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau, Child Welfare Outcomes Report Data, "Overview Foster Care Information: Exited Care" and Table 3.1 "Exits of Children From Foster Care," at http://cwoutcomes.acf.hhs.gov/data/; and U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau, "The AFCARS Report: Preliminary FY 2009 Estimates as of July 2010," at <http://www.acf.hhs.gov/programs/cb/stats_research/afcars/tar/report17.pdf>. Calculations by Children's Defense Fund.

Over 29,000 youth emancipated from foster care in 2009. These youth are at increased risk of not graduating from high school, not enrolling in college and being unemployed, incarcerated or homeless.

Youth Who Exit Foster Care to Emancipation, 2009

	Number	Percent of youth who exited foster care through emancipation	Of the youth who emancipated out of foster, the percent who: Entered care at age 12 or younger	Entered care older than 12
Alabama	280	9.9%	37.9%	62.1%
Alaska	46	5.4	34.8	63.0
Arizona	700	9.7	17.0	83.0
Arkansas	292	7.5	18.2	81.8
California	5,137	14.0	38.8	61.2
Colorado	590	9.9	20.7	79.3
Connecticut	452	15.4	36.3	63.7
Delaware	103	18.6	15.5	84.5
District of Columbia	167	23.8	46.7	53.3
Florida	1,472	9.2	25.4	74.5
Georgia	708	9.5	26.7	73.3
Hawaii	138	9.8	29.7	70.3
Idaho	108	7.5	16.7	83.3
Illinois	1,094	21.4	54.7	45.3
Indiana	137	1.6	13.1	86.9
Iowa	474	10.6	24.1	75.9
Kansas	476	13.2	17.0	83.0
Kentucky	865	16.7	14.8	85.2
Louisiana	293	8.0	39.6	60.4
Maine	157	16.9	44.6	55.4
Maryland	778	28.9	44.9	55.1
Massachusetts	1,070	16.3	25.1	74.9
Michigan	1,143	12.7	30.5	69.3
Minnesota	680	10.9	28.1	71.9
Mississippi	76	3.9	27.6	72.4
Missouri	52	1.0	21.2	78.8
Montana	51	5.6	43.1	56.9
Nebraska	330	9.2	11.8	88.2
Nevada	263	8.5	19.4	80.6
New Hampshire	69	12.3	29.0	71.0
New Jersey	370	7.0	22.7	73.0
New Mexico	106	4.9	22.6	77.4
New York	1,397	10.9	38.8	61.1
North Carolina	492	9.9	23.4	76.4
North Dakota	92	11.2	15.2	84.8
Ohio	1,033	12.6	20.6	79.4
Oklahoma	485	7.5	39.8	60.2
Oregon	255	5.4	43.1	56.9
Pennsylvania	942	7.7	23.2	76.8
Rhode Island	151	10.1	35.1	64.9
South Carolina	359	9.8	31.8	68.2
South Dakota	72	5.2	40.3	59.7
Tennessee	587	9.4	10.2	89.8
Texas	1,522	10.9	41.4	58.6
Utah	193	9.8	13.0	87.0
Vermont	88	13.7	17.0	83.0
Virginia	943	28.5	22.0	78.0
Washington	263	4.8	51.7	48.3
West Virginia	72	2.5	20.8	79.2
Wisconsin	472	9.9	28.6	71.4
Wyoming	37	3.6	8.1	91.9

Source: U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau, Child Welfare Outcomes Report Data, "Overview Foster Care Information: Exited Care" and Table 3.4, at http://cwoutcomes.acf.hhs.gov/data/. Calculations by Children's Defense Fund.

The number of children adopted from foster care almost doubled between 1995 and 2000, but increased by less than seven thousand children (13%) between 2000 and 2009.

Adoptions from Foster Care, Selected Years, FYs 1995–2009

	FY 1995	FY 2000	FY 2005	FY 2009
Alabama	128	202	324	629
Alaska	103	202	204	329
Arizona	215	853	1,012	1,653
Arkansas	84	325	316	601
California	3,094	8,818	7,490	7,438
Colorado	338	711	954	1,070
Connecticut	198	499	740	768
Delaware	38	103	78	125
District of Columbia	86	319	310	103
Florida	904	1,629	3,019	3,711
Georgia	383	1,091	1,127	1,389
Hawaii	42	280	452	279
Idaho	46	140	149	353
Illinois	1,759	5,664	1,837	1,429
Indiana	520	1,160	1,010	1,488
Iowa	227	729	947	967
Kansas	333	468	649	836
Kentucky	197	398	876	842
Louisiana	292	476	469	578
Maine	85	379	316	323
Maryland	324	552	620	734
Massachusetts	1,073	861	832	790
Michigan	1,717	2,804	2,883	3,200
Minnesota	232	614	732	660
Mississippi	109	288	242	306
Missouri	538	1,265	1,309	1,096
Montana	104	238	244	192
Nebraska	208	293	352	588
Nevada	155	231	412	525
New Hampshire	51	97	124	135
New Jersey	616	832	1,377	1,347
New Mexico	141	347	289	437
New York	4,579	4,234	3,407	2,398
North Carolina	289	1,337	1,203	1,725
North Dakota	42	108	152	137
Ohio	1,202	2,044	2,044	1,453
Oklahoma	226	1,096	1,013	1,564
Oregon	427	831	1,030	1,101
Pennsylvania	1,018	1,712	2,065	2,243
Rhode Island	216	260	217	272
South Carolina	231	378	382	513
South Dakota	42	94	113	167
Tennessee	458	431	1,114	1,001
Texas	804	2,045	3,181	4,976
Utah	283	303	346	502
Vermont	62	117	166	156
Virginia	320	448	510	663
Washington	645	1,141	1,305	2,091
West Virginia	139	352	368	541
Wisconsin	360	736	906	769
Wyoming	10	61	61	71
United States	25,693	50,596	51,278	57,264

Source: U.S. Department of Health and Human Services, Children's Bureau, "Adoptions of Children with Public Welfare Agency Involvement by State FY 2002 – FY 2009," at http://www.acf.hhs.gov/programs/cb/stats_research/afcars/adoptchild09.pdf. Calculations by Children's Defense Fund.

While the number of children waiting in foster care to be adopted has declined nationally and in all but a handful of states, the number is still way too high.

Children in Public Foster Care Waiting to be Adopted, FYs 2004–2009

	FY2004	FY2005	FY2006	FY2007	FY2008	FY 2009
Alabama	1,599	2,128	1,658	1,824	1,692	1,582
Alaska	649	520	698	766	807	751
Arizona	2,124	2,478	2,644	2,492	2,153	2,691
Arkansas	949	1,191	945	780	872	850
California	16,299	16,700	21,202	20,830	17,847	15,634
Colorado	1,684	1,785	2,099	1,762	1,878	1,647
Connecticut	986	953	963	1,162	1,430	1,354
Delaware	218	274	302	311	304	239
District of Columbia	837	620	667	560	493	486
Florida	7,690	7,379	7,480	7,927	7,942	6,349
Georgia	2,507	2,370	2,305	2,162	2,244	1,791
Hawaii	1,019	980	808	733	555	401
Idaho	310	373	555	593	576	498
Illinois	3,432	3,408	5,746	5,598	4,608	2,728
Indiana	2,550	3,194	3,345	3,211	2,931	3,136
Iowa	1,139	1,265	1,419	1,299	1,158	1,003
Kansas	1,926	1,811	2,005	1,812	1,960	1,852
Kentucky	1,969	2,125	2,091	2,153	2,101	2,048
Louisiana	1,179	1,162	1,079	1,137	1,069	1,093
Maine	851	787	679	614	619	571
Maryland	2,202	1,954	1,626	1,660	1,506	1,220
Massachusetts	3,006	2,925	2,705	2,868	2,846	2,837
Michigan	6,486	7,061	6,164	6,115	5,674	4,902
Minnesota	1,795	1,579	1,638	1,674	1,393	1,227
Mississippi	914	858	903	898	996	975
Missouri	3,227	3,532	2,722	2,836	2,606	2,335
Montana	713	646	606	597	521	537
Nebraska	920	916	972	805	881	831
Nevada	1,573	1,701	1,786	1,936	2,200	2,095
New Hampshire	239	272	252	325	297	272
New Jersey	5,110	4,845	4,725	3,262	3,009	2,688
New Mexico	634	711	860	963	907	878
New York	10,650	9,238	8,040	7,659	7,014	6,890
North Carolina	3,074	3,137	3,116	3,095	2,903	2,722
North Dakota	277	344	321	337	288	315
Ohio	4,814	4,350	4,087	3,762	3,477	3,382
Oklahoma	4,471	3,504	3,657	4,022	3,766	3,429
Oregon	3,302	3,441	2,776	2,527	2,206	1,840
Pennsylvania	3,996	3,679	3,559	3,408	3,037	3,016
Rhode Island	331	407	405	400	415	333
South Carolina	1,769	1,819	1,771	1,779	1,803	1,807
South Dakota	480	472	507	452	423	380
Tennessee	1,776	1,717	1,788	1,622	1,477	1,326
Texas	9,957	10,947	12,542	13,552	13,414	12,844
Utah	437	436	475	574	553	565
Vermont	267	265	251	257	225	231
Virginia	1,611	1,823	1,783	1,834	1,769	1,612
Washington	2,317	2,167	2,361	2,837	3,025	2,865
West Virginia	976	1,312	1,204	1,278	1,300	1,220
Wisconsin	1,341	1,364	1,237	1,284	1,329	1,255
Wyoming	171	200	209	151	98	73
United States	128,753	129,125	133,738	132,495	124,597	113,606

Source: U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau, "Children in Public Foster Care on September 30th of Each Year Who are Waiting to be Adopted FY2002–FY2009," at http://www.acf.hhs.gov/programs/cb/stats_research/afcars/waiting2009.pdf.

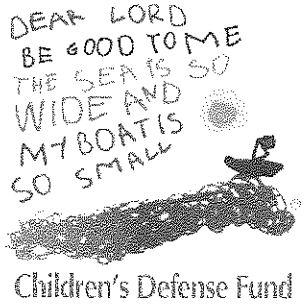
Some children are being raised by grandparents or other relatives when their parents are unable to do so. More than 2.8 million grandchildren live with grandparents who are responsible for them. One-third of them have no parent living with them.

Children Living with Grandparents or Other Relatives, 2009

	Living in households headed by:		Grandchildren living with grandparents responsible for them:		
				No parent of grandchild present	
	Grandparent	Other Relative	Total	Number	Percent
Alabama	110,977	26,954	71,625	26,980	37.7%
Alaska	12,532	3,482	6,925	2,241	32.4
Arizona	144,835	50,610	77,722	22,396	28.8
Arkansas	58,192	11,772	39,302	15,335	39.0
California	735,450	367,117	313,542	75,160	24.0
Colorado	61,202	26,556	33,170	13,047	39.3
Connecticut	48,152	11,862	23,508	8,444	35.9
Delaware	14,852	4,487	9,075	2,469	27.2
District of Columbia	13,397	6,169	5,802	1,691	29.1
Florida	315,514	97,802	171,592	58,614	34.2
Georgia	213,418	73,132	130,841	48,057	36.7
Hawaii	40,584	11,314	10,509	2,788	26.5
Idaho	18,862	6,117	11,156	3,652	32.7
Illinois	213,258	74,899	113,181	33,817	29.9
Indiana	105,558	21,877	66,730	21,124	31.7
Iowa	26,755	7,098	14,120	4,650	32.9
Kansas	31,443	11,160	18,083	7,081	39.2
Kentucky	88,582	19,953	63,493	28,348	44.6
Louisiana	121,196	29,973	75,238	29,128	38.7
Maine	11,521	3,143	5,572	2,564	46.0
Maryland	106,405	34,245	51,916	15,109	29.1
Massachusetts	73,562	22,430	30,637	8,630	28.2
Michigan	134,355	35,082	68,951	20,963	30.4
Minnesota	42,631	14,487	21,194	6,623	31.2
Mississippi	105,511	22,131	69,008	22,358	32.4
Missouri	92,581	24,177	50,460	19,245	38.1
Montana	13,540	3,678	8,829	4,195	47.5
Nebraska	19,563	4,932	11,119	4,531	40.8
Nevada	50,791	21,094	28,337	7,135	25.2
New Hampshire	13,669	2,603	6,247	1,909	30.6
New Jersey	114,430	42,586	50,741	16,147	31.8
New Mexico	51,013	11,144	29,365	9,593	32.7
New York	304,458	106,983	140,185	39,526	28.2
North Carolina	155,146	48,977	99,144	40,564	40.9
North Dakota	5,309	1,117	3,048	1,030	33.8
Ohio	158,704	40,364	90,061	33,999	37.8
Oklahoma	67,976	16,136	43,479	17,062	39.2
Oregon	49,809	14,646	27,189	8,319	30.6
Pennsylvania	172,803	41,379	85,003	32,900	38.7
Rhode Island	13,236	4,799	4,835	1,554	32.1
South Carolina	96,450	25,705	56,740	22,721	40.0
South Dakota	12,506	3,710	8,207	2,818	34.3
Tennessee	138,120	32,339	80,695	29,230	36.2
Texas	610,289	194,691	356,410	103,547	29.1
Utah	46,812	16,885	18,381	4,489	24.4
Vermont	4,365	1,138	1,928	1,115	57.8
Virginia	119,711	39,017	62,220	21,890	35.2
Washington	82,908	28,925	43,781	16,690	38.1
West Virginia	38,366	6,741	23,603	9,916	42.0
Wisconsin	57,033	19,260	29,199	9,563	32.8
Wyoming	7,303	1,603	5,027	2,399	47.7
United States	5,345,635	1,748,481	2,867,125	943,356	32.9

Source: U.S. Department of Commerce, Bureau of the Census, 2009 American Community Survey, Tables B09006 and B10002. Calculations by Children's Defense Fund.

Children's Defense Fund



Children in Connecticut

January 2012

821,384 children live in Connecticut:
- 508,383 are White, non-Hispanic
- 95,260 are Black
- 155,967 are Hispanic
- 33,888 are Asian/Pacific Islander
- 1,858 are American Indian/Alaska Native
- 44,262 are two or more races

In Connecticut:
A child is abused or neglected every 52 minutes.
A child dies before his or her first birthday every 2 days.

Connecticut Ranks:*
20th among states in percent of babies born at low birthweight.
Best state is South Dakota; worst state is Mississippi
20th among states in its infant mortality rate.
Best state is New Hampshire; worst is the District of Columbia
4th among states in per pupil expenditures.
The District of Columbia is best; Utah is the worst state
[*1st represents the best state for children and 51st represents the worst state for children in the country]

Child Poverty in Connecticut	
Number of poor children (and percent poor)	103,498 (12.8%)
Number of children living in extreme poverty (and percent in extreme poverty)	50,340 (6.2%)
Number of adults and children receiving cash assistance from Temporary Assistance for Needy Families (TANF)	32,415
Maximum monthly TANF cash assistance for a family of three	$560

Child Health in Connecticut	
Number of children without health insurance (and percent uninsured)	48,792 (6.0%)
Number of children enrolled in the Children's Health Insurance Program (CHIP)	21,033
CHIP eligibility: 300 percent of federal poverty ($69,150 for a family of four)	
Number of children enrolled in Medicaid	282,100
Children as a percent of total Medicaid enrollment	47.9%
Medicaid and CHIP participation rate	14.7%
Medicaid expenditures on children as a percent of total Medicaid expenditures	90.7%
Percent of two-year-olds not fully immunized	29.9%

Child Hunger in Connecticut	
Number of children who receive SNAP (food stamps)	122,000
Percent of eligible persons who receive SNAP (food stamps)	66%
Number of children in the School Lunch Program	301,259
Number of children in the Summer Food Service Program	10,834
Number of women and children receiving WIC (Supplemental Nutrition Program for Women, Infants, and Children)	56,083

Early Childhood Development in Connecticut	
Percent of children under age 6 with all parents in the labor force	67.6%
Number of children served by Head Start	8,570
Number of children served by the Child Care Development Fund/CCDBG	9,900
Average annual cost of child care for a four-year-old in a center	$10,350
Percent of 3-year-olds enrolled in state pre-k, Head Start, or special education programs	18.4%
Percent of 4-year-olds enrolled in state pre-k, Head Start, or special education programs	26.2%
Education in Connecticut	
Annual expenditure per public school pupil	$15,353
Percent of public school fourth graders:	
unable to read at grade level	58.0%
unable to do math at grade level	54.6%
Percent of public school eighth graders:	
unable to read at grade level	55.3%
unable to do math at grade level	61.9%
Number of 16- to 19-year-olds who have dropped out of high school	7,569
Child Welfare in Connecticut	
Number of children who are victims of abuse and neglect	10,021
Number of children in foster care	4,462
Number of children adopted from foster care	665
Number of grandparents raising grandchildren	20,620
Youth at Risk in Connecticut	
Percent of 16- to 19-year-olds not enrolled in school and not high school graduates	3.8%
Averaged freshman high school graduation rate	75.4%
Percent of 16- to 19-year-olds unemployed	21.9%
Number of juvenile arrests	15,060
Number of children and teens in juvenile residential facilities	303
Ratio of cost per prisoner to cost per public school pupil	3.29
Number of children and teens killed by firearms in homicides	n/a
Number of children and teens killed by firearms in suicides	n/a

This fact sheet contains the most recent data as of January 26, 2012.
For data sources and methodological notes, please visit: www.childrensdefense.org/cits.

For more information on the state of America's children contact:
Children's Defense Fund
25 E Street, NW
Washington, DC 20001
(202) 628-8787 or (800) 233-1200
www.childrensdefense.org

Connecticut Department of Public Health

Planning and Workforce Development Section

2010

Healthy Connecticut 2010

FINAL REPORT

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June, 2010

DPH Keeping Connecticut Healthy

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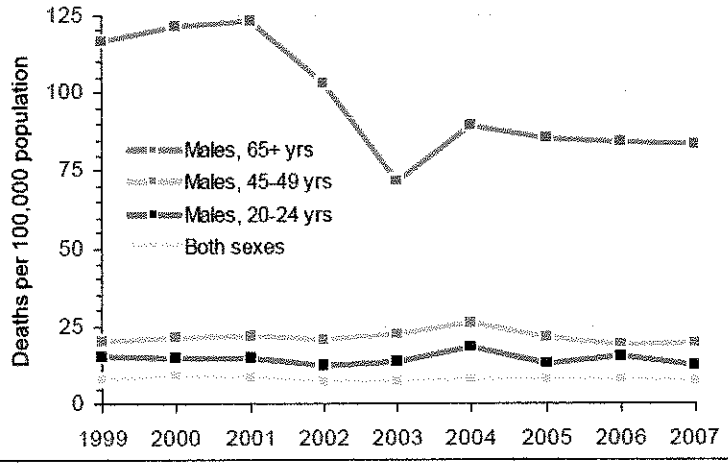
Suicide rates for males 65 years of age and older were 10 to 15 times greater than those for the overall population, and those for males 45-49 years of age were 2.5 to 3 times greater (Fig. 6-4).

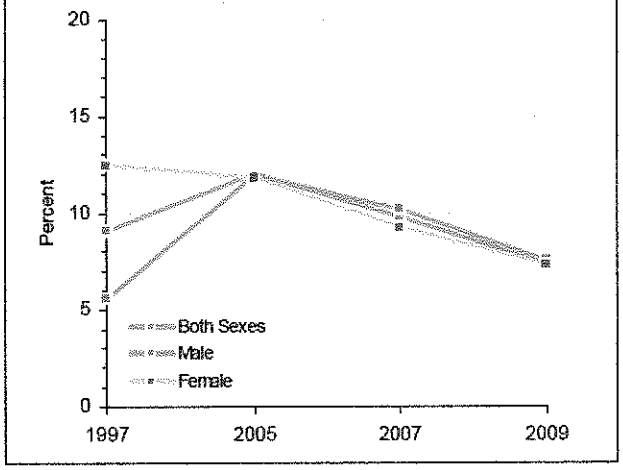
FIGURE 6-4
SUICIDES (Age-Specific Rates)
MALES IN HIGH-RISK AGE GROUPS VS. BOTH SEXES
CONNECTICUT 1999-2007



Source: Connecticut Death Registry (Registration Reports)

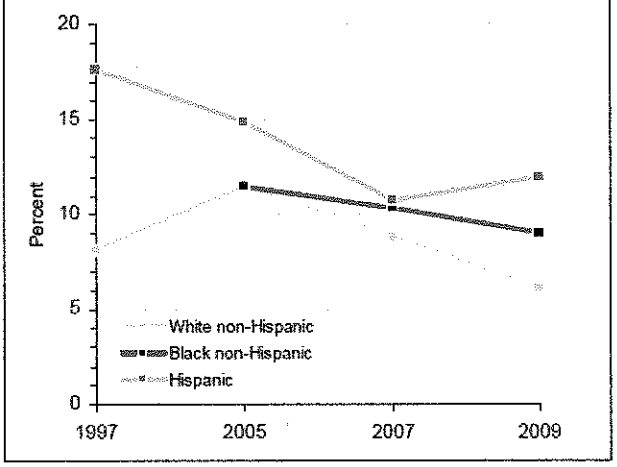
Attempted Suicide. As noted above, suicide is a leading cause of death for adolescents. From 1997 to 2009, the percentage of high school students who said they attempted suicide in the past 12 months decreased overall and for all groups except males (Figs. 6-5a and 6-5b); however, only the decrease among female students was statistically significant. By 2009 the initial gap between rates for males and females had disappeared and was not significant (Fig. 6-5a).

FIGURE 6-5a
ATTEMPTED SUICIDE
STUDENTS IN GRADES 9-12 BY SEX
CONNECTICUT 1997-2009



Source: Youth Risk Behavior Survey

FIGURE 6-5b
ATTEMPTED SUICIDE
STUDENTS IN GRADES 9-12 BY RACE & ETHNICITY
CONNECTICUT 1997-2009



Source: Youth Risk Behavior Survey
Note: Data for black non-Hispanics not available in 1997.

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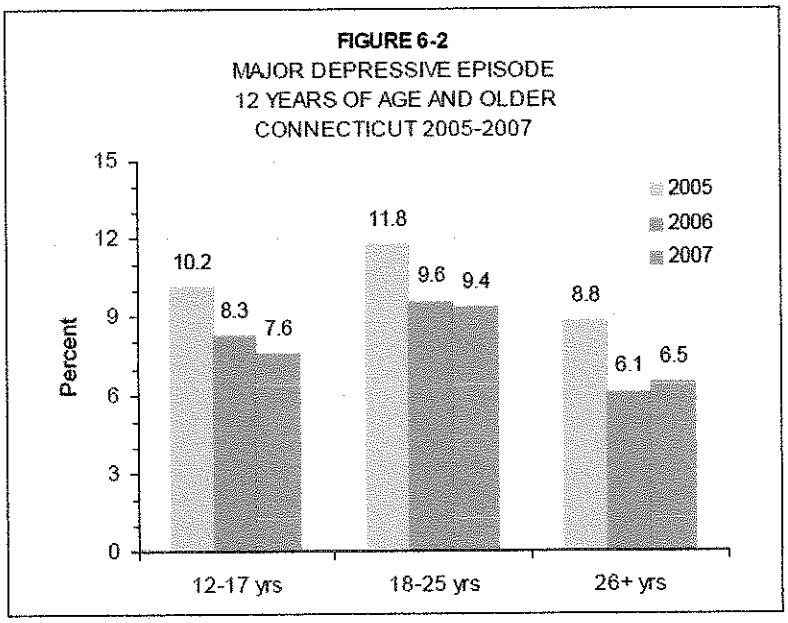
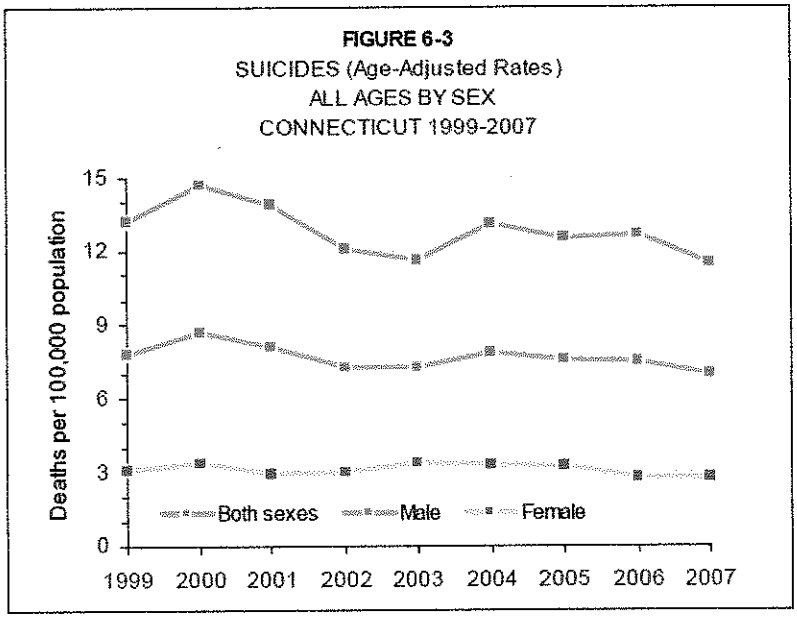
Major Depressive Episodes. From 2005 to 2007, major depressive episodes declined among all age groups. Young adults 18-25 years of age and children 0-17 years of age consistently were more likely than adults 26 years of age and older to have a major depressive episode (Fig. 6-2).



Source: SAMHSA National Survey on Drug Use and Health

Suicide. Each year, 250 to 300 Connecticut residents take their own lives. In 2007, suicide was the second leading cause of death for males 15-19 and 25-34 years of age, the third for males 20-24 years of age, and ranked fourth for males 35-44 and 45-55 years of age.[6] Suicide also is often among the top five leading causes of death for children 10-14 years of age. From 1999 to 2007, the Connecticut suicide rate decreased overall and for both sexes (Fig. 6-3). Suicide rates for males consistently were about 4 times greater than those for females.



Source: Connecticut Death Registry (Registration Reports)

[6] Connecticut Department of Public Health, Health Information Systems and Reporting Section. 2007 Registration Report, Table 10. http://www.ct.gov/dph/cwp/view.asp?a=3132&q=394598.

6 MENTAL HEALTH

Background

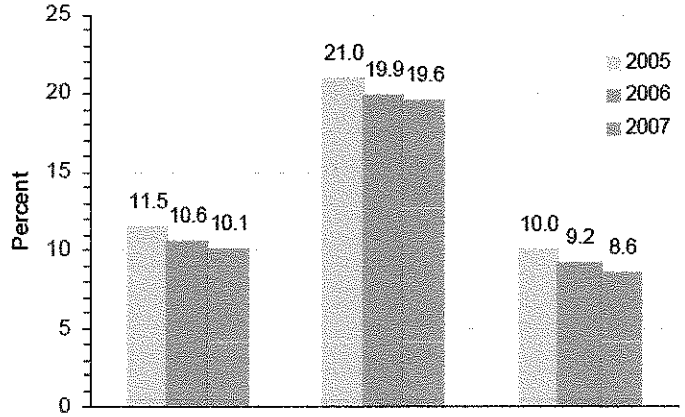
In 2007, one in three Americans 18 years of age and older had a diagnosable mental disorder.[1] The estimated lifetime prevalence was 57% for all mental disorders, 35% for substance use/abuse disorders, 31% for anxiety disorders, 25% for impulse-control disorders (e.g., attention deficit/hyperactivity disorder), and 21% for mood disorders (e.g., major depressive disorder, bipolar disorder).[2] These mental disorders account for more disability than any other diseases, including heart disease and cancer.[3] Major depression is the leading cause of disability and is responsible for more than two-thirds of suicides.[4]

In Connecticut in 2007, mental disorders, excluding alcohol and drug psychoses, accounted for 17,344 hospitalizations (488 per 100,000 population), with $332 million in total hospital charges. Adults 25-44 years of age accounted for 39% of these hospitalizations.[5]

Findings.

Serious Psychological Distress. Serious psychological distress (see *Tracking Data* for definition) is assessed only for persons over 17 years of age. From 2005 to 2007 (data from earlier years not comparable), serious psychological distress declined slightly among all age groups but was more than twice as common among young adults 18-25 years of age than among persons 26 years of age and older (Fig 6-1).

FIGURE 6-1
SERIOUS PSYCHOLOGICAL DISTRESS
ADULTS 18+ YEARS OF AGE
CONNECTICUT 2005-2007



Source: SAMHSA National Survey on Drug Use and Health

[1] Harvard School of Medicine. *National Comorbidity Survey Replication.* Table 2. 12-month prevalence of DSM-IV/WMH-CIDI disorders by sex and cohort. http://www.hcp.med.harvard.edu/ncs/ftpdir/table_ncsr_12monthprevgenderxage.pdf. Accessed 2 February 2010. Diagnosable mental health disorders, as used here, include anxiety, mood, and impulse control disorders, and substance abuse, including tobacco disorders.

[2] Harvard School of Medicine. *National Comorbidity Survey Replication.* Table 1. Lifetime prevalence of DSM-IV/WMH-CIDI disorders by sex and cohort. http://www.hcp.med.harvard.edu/ncs/ftpdir/table_ncsr_LTprevgenderxage.pdf. Accessed 2 February 2010.

[3] World Health Organization. 2005. *Promoting Mental Health: Concepts, Emerging Evidence, Practice.* Geneva: World Health Organization. http://www.who.int/mental_health/evidence/MH_Promotion_Book.pdf. Accessed 5 February 2010.

[4] U.S. Department of Health and Human Service, *Healthy People 2010.* Vol. 1, p. 36. http://www.healthypeople.gov/Document/pdf/uih/uih.pdf.

[5] Connecticut Department of Public Health. Connecticut Resident Hospitalizations, 2007. Table H-1AA. http://www.ct.gov/dph/cwp/view.asp?a=3132&q=397512. Accessed 8 February 2010.

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Anxiety and Depression in Connecticut Adults

Results from the 2006 Connecticut BRFSS

BRFSS

CONNECTICUT DEPARTMENT OF PUBLIC HEALTH

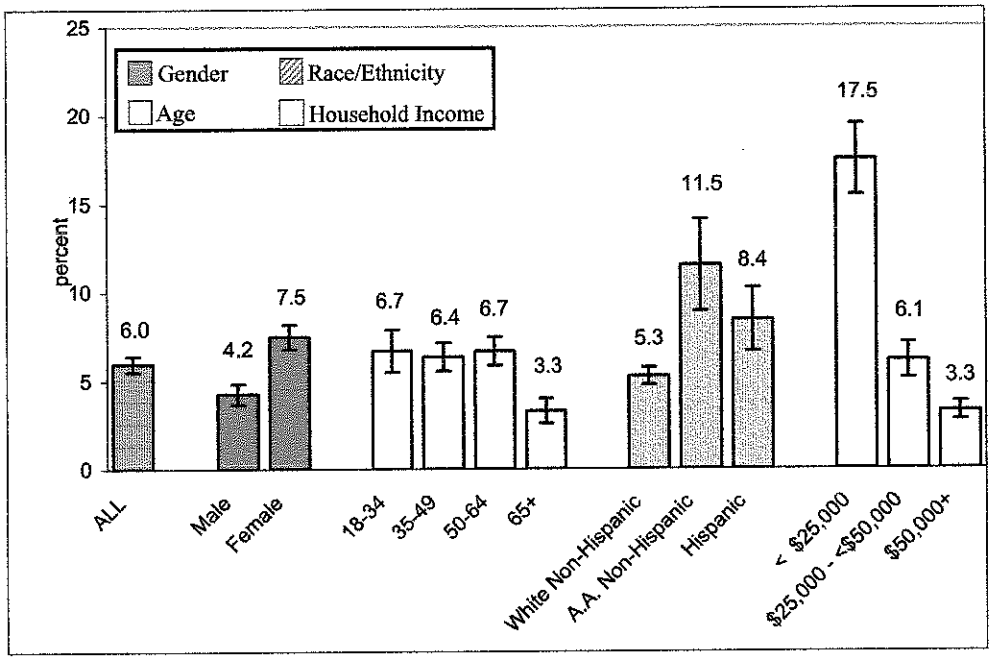
The Behavioral Risk Factor Surveillance System (BRFSS) is a CDC sponsored telephone survey of Connecticut adults age 18 and over. During 2006, the Anxiety and Depression Module was included as part of the Connecticut Department of Public Health BRFSS questionnaire. In collaboration with the Connecticut Department of Mental Health and Addiction Services, the module was asked of 4,498 adult respondents age 18 and older from January to December 2006. The ten questions in the module are used to estimate the prevalence of depression using a point scale depending on the response. Eight items in the interview asked respondents about their emotional state during the past 14 days, and two items asked if a doctor had ever told the respondent that they had a depressive or anxiety disorder. A copy of the 2006 BRFSS is available at the CDC web site www.cdc.gov/brfss or the DPH web site www.ct.gov/dph keyword BRFSS.

Approximately 150,000 Connecticut adults, or 6.0 percent, are estimated to be experiencing symptoms of current depression.

For this analysis, current depression is defined as the combination of moderate, moderate severe, and severe depression. Approximately 150,000 Connecticut adults, or 6.0 percent, are estimated to be experiencing symptoms of current depression. Thirty-seven other states also asked these questions and among the total of these states, 8.0 percent of the adults indicate symptoms of current depression.

The responses to the questions in the Anxiety and Depression Module were then converted to categories indicating mild depression, moderate depression, moderately severe depression and severe depression. These results reveal that almost 370,000 or 14.7 percent of Connecticut adults indicate symptoms of mild depression, approximately 100,000 or 4.0 percent indicate moderate depression, approximately 37,000 adults or 1.5 percent indicate moderately severe depression, and approximately 13,000 or 0.5 percent indicate severe depression.

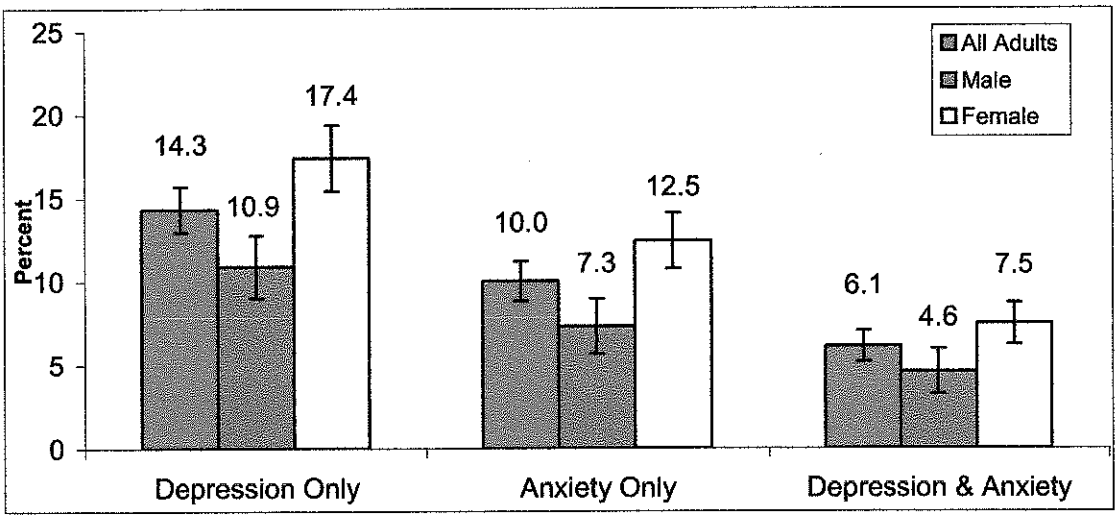
Connecticut Adults with Current Depression, BRFSS 2006



Summary results from the Anxiety and Depression Module

Two questions asked if a health care provider had ever diagnosed the respondent with a depressive disorder or an anxiety disorder. A depressive disorder diagnosis had been received by 14.3 percent of respondents, and an anxiety disorder diagnosis had been received by 10.0 percent of respondents.

Diagnosis of Depression and Anxiety Disorders by Gender in CT, BRFSS 2006



BRFSS Background

The BRFSS is the largest continuously conducted telephone survey in the world. The CDC developed a standard core questionnaire for states to use to provide data that could be compared across states. BRFSS relies on a sample of the population. The sampling method used assures comparability of data across states and over time. Civilian non-institutionalized population ages 18 years and older are randomly selected. They remain completely anonymous. Nationally, 355,710 interviews were completed in 2006. The data from this survey enables the CDC, state health departments, and other health and education agencies to monitor risk behaviors related to chronic diseases, injuries and death.

Nationwide, survey items remain relatively constant from year to year. In contrast, state-specific questions can be changed quickly to track immediate health concerns. CT has used the BRFSS to track the progress of Healthy People 2000 and Healthy Connecticut 2000 Objectives, help identify 25 priorities for improving the quality and length of life for Connecticut residents and describe the prevalence of cancer risk factors among the Connecticut population, including identifying population groups and age groups at increased risk based on their behaviors.

CT Department of Public Health
Keeping Connecticut Healthy

J. Robert Galvin, M.D., M.P.H., M.B.A.
Commissioner

Contact Us:
Health Information Systems and Reporting Section
860-509-7662
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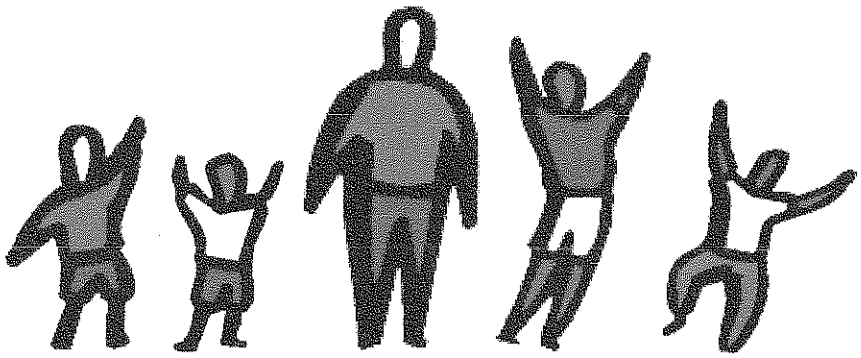
Healthy Connecticut 2000

Final Report



Connecticut Department of Public Health

June 2005

It is important to look behind the data when interpreting outcomes. When there was no apparent change in value for a specific objective, for example, it is helpful to ask certain questions. Was the lack of change an artifact of there being data for a single year only? Was the objective a *process* objective (to develop, review, maintain, etc.), for which the result had already been accomplished at the start? Were both the baseline and final values the lowest or highest attainable values (e.g., 0 cases or 100%)?

The number of objectives in each category is also an important consideration for interpreting the data in this report. Some categories included 50 or more objectives (i.e., Risk Factors, Mortality, Morbidity), whereas others contained fewer than 10 (i.e., Older Adults, Hispanics, and nine Priority Areas). Because of such variability, high percentages of improvement sometimes were based on few objectives (e.g., Priority Area 22--Surveillance & Data Systems, 2 objectives, 100%), whereas lower percentages of improvement could be based on many objectives (e.g., Morbidity, 39 objectives, 64%).

Looking Toward 2010

Despite improvement in many priority areas, numerous risk factors for death and disease were still prevalent among Connecticut residents in 2000. Moreover, certain racial and ethnic groups, women, children, and older adults often had a disproportionate burden of injury, disease, and death.

Health disparities can shorten life expectancies and decrease quality of life and economic opportunities, leading to decreased productivity and increased healthcare costs. The reasons behind health disparities are complex and may be related to behavioral factors such as smoking, diet, and obesity, and to socioeconomic factors like income, education, health insurance status, and level of access to primary and preventive care.

Connecticut's population is older, on average, than the U.S. population, and older adults--the fastest growing age group--represented 14% of the state population in 2000. Racial and ethnic minorities are projected to constitute half of the U.S. population by 2050, and they already account for up to 72% of the population of Connecticut's largest cities. Although population diversity is one of our greatest assets, it also presents myriad health challenges requiring creative interventions for reaching high-risk and underserved groups.

In January 2000, the U.S. Department of Health and Human Services launched *Healthy People 2010,*[12] a comprehensive national agenda for health promotion and disease prevention. Its two overarching goals--to increase quality and years of healthy life, and to eliminate health disparities--guided the development of 467 evidence-based objectives in 28 focus areas. In addition, a set of 10 *Leading Health Indicators* were chosen to track progress toward meeting the initiative's goals. These indicators(Table 9), each of which is

[12] U.S. Department of Health and Human Services. 2000. *Healthy People 2010*, 2nd ed. Washington, DC: U.S. Government Printing Office.

associated with one or more objectives from *Healthy People 2010*, were selected because they represent the nation's major health concerns; data are available for tracking progress, and they have the ability to motivate individuals and communities to take action to improve health.

Table 9
HEALTHY PEOPLE 2010
LEADING HEALTH INDICATORS

	Indicators
1	Physical Activity
2	Overweight and Obesity
3	Tobacco Use
4	Substance Abuse
5	Responsible Sexual Behavior
6	Mental Health
7	Injury and Violence
8	Environmental Quality
9	Immunization
10	Access to Health Care

In developing *Healthy Connecticut 2010,* the state health agenda for the first decade of the new century, the Connecticut Department of Public Health is tailoring the national objectives of *Healthy People 2010* to Connecticut's specific health status and health services needs. Based on the findings of the *Healthy Connecticut 2000* initiative, future public health efforts in Connecticut will be particularly important in the areas discussed below.

Tobacco Use

Smoking is the single most preventable cause of death in Connecticut and the U.S., and it is the most important public health issue facing our society. It is a major risk factor for lung cancer and other respiratory cancers, cardiovascular disease, chronic obstructive pulmonary disease (COPD), and low birthweight.

Rates of death and premature death from lung cancer in Connecticut are significantly greater in men than in women, and black males have the highest death rate among racial and ethnic subgroups.[13] While incidence and death rates for lung cancer among Connecticut males decreased during the 1990's, those for females increased.[13, 14] COPD, comprising chronic airways obstruction, chronic bronchitis, emphysema, and other lung conditions, is the fourth leading cause of death among Connecticut residents.[6] About 80-90% of COPD is attributable to cigarette smoking.[12] COPD death rates are higher among whites than among African-Americans/Blacks and Hispanics.[13]

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[13] Connecticut Department of Public Health. 2004. *Mortality and Its Risk Factors in Connecticut, 1989 to 1998.* Hartford, CT: Connecticut Department of Public Health. http://www.dph.state.ct.us/OPPE/Mortality/mortalityriskfactors.htm.

[14] Connecticut Tumor Registry. 2004. *Connecticut Cancer Surveillance, 1990-2000.* Hartford, CT: Connecticut Department of Public Health. http://www.dph.state.ct.us/OPPE/pdfs/CONNECTICUT%20CANCER%20SURVEILLANCE%20.pdf.

Maternal smoking during pregnancy is harmful to both mother and child, increasing the risk of low birthweight and other adverse maternal events and poor pregnancy outcomes (stillbirth, preterm delivery, neonatal mortality, sudden infant death syndrome).[15] In the 1980's, up to one-fourth of low birthweight among American infants was due, at least in part, to maternal smoking during pregnancy. Low birthweight infants are more susceptible to respiratory infections and other illnesses, and are more likely than normal birthweight infants to be admitted to neonatal intensive care units.[16]

Although smoking prevalence declined overall and for all population groups in Connecticut, at the end of the last decade one in five adults, one in four women of childbearing age, and nearly one in three high school students reported they smoked regularly.

Diet, Physical Activity, and Overweight

Overweight and obesity--which result from a combination of biological factors (e.g., genetics and metabolism) and behavioral factors (e.g., physical inactivity and poor diet)--are associated with four of the top ten leading causes of death: heart disease, certain cancers, stroke, and type 2 diabetes. They also raise the risk of illness from high cholesterol, high blood pressure, arthritis, gallbladder disease, sleep disturbances, and breathing problems.[12] In persons with diabetes, obesity increases the risk for cardiovascular and microvascular disease; the prevalence of obesity among adults with diabetes in the U.S. is nearly double that of the general population.[17]

Overweight among Connecticut adults increased by 55% during the 1990's (Appendix 2). At the end of the last decade, nearly 30% of Connecticut adults were overweight, 70% ate less than five fruits or vegetables daily, and 25% had no leisure time physical activity. Numerous disparities exist in diet, obesity, and physical activity among different population groups in Connecticut. African Americans/Blacks, males, and younger adults have the lowest rates of fruit and vegetable consumption; Hispanic and African American/Black adults are more likely than white non-Hispanics to be obese, and older adults, lower-income persons, African Americans/Blacks, and Hispanics have the highest prevalence of physical inactivity.[18]

Many opportunities exist for promoting healthful diet and exercise, beginning in childhood and continuing through adulthood, by increasing nutrition education and counseling, linking diet and exercise in health promotion programs, and emphasizing prevention of chronic diseases associated with poor diet and overweight.

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[15] Pollack, H., P.M. Lantz, and J.G. Frohna. 2000. Maternal smoking and adverse birth outcomes among singletons and twins. *American Journal of Public Health* 90(3):395-400.

[16] Lightwood, J.M., C.S. Phibbs, and S.A. Glantz. 1999. Short-term health and benefits of smoking cessation: Low birth weight. *Pediatrics* 104(6):1312-1320.

[17] Eberhardt, M.S., C. Ogden, M. Engelgau, et al. 2004. Prevalence of overweight and obesity among adults with diagnosed diabetes - United States, 1988-1994 and 1999-2002. *Morbidity and Mortality Weekly Report* 53:1063-1066.

[18] Adams, M.A. 2000. *Connecticut Behavioral Health Risks: Factors Related to Cancer.* Hartford, CT: Connecticut Department of Public Health.

Choose a different State:
Connecticut

Choose a category
Change Category

Connecticut: Home and Community-Based Services

Compare Connecticut to: United States

Medicaid & CHIP

Medicaid Spending
- Total Medicaid Spending, FY2010
- Spending by Service, FY2010
- Spending on Acute Care, FY2010
- Spending on Long Term Care, FY2010
- Growth in Medicaid Spending, FY90-FY10
- Payments by Enrollment Group, FY2009
- Medicaid Payments per Enrollee, FY2009
- Federal Matching Rate and Multiplier
- Federal/State Share of Spending, FY2010
- Federal DSH Allotments

Medicaid and Health Reform
- Increase in Enrollment and Spending
- State Adoption of Medicaid Options
- State Eligibility Expansion
- Chronic Disease Prevention Program Awards

Temporary Federal Medicaid Relief
- ARRA Federal Matching Rate, FY09 - FY10
- ARRA Federal Matching Rate, FY11
- Federal DSH Allotments under ARRA
- Part D Savings under ARRA

Medicaid Budget Actions
- Medicaid Cost Containment, FY2011
- Medicaid Cost Containment, FY2012
- Positive Medicaid Policy Actions, FY2011
- Positive Medicaid Policy Actions, FY2012

Medicare Drug Benefit: Clawback Payments
- Baseline Dual Eligible Enrollment
- Baseline FFS Drug Payments for Duals
- Estimated Annual Clawback Payments
- Per-Capita Monthly Clawback Amounts

Medicaid Physician Fees
- Medicaid Fee Index
- Medicaid-to-Medicare Fee Index
- Change in Medicaid Fees

Medicaid Beneficiaries
- Total Medicaid Enrollment, FY2009
- Medicaid Enrollment as a % of Pop, FY09
- Distribution by Enrollment Group, FY2009
- Medicaid Enrollment by Gender, FY2008
- Monthly Medicaid Enrollment
- Medicaid Enrollment % Change - June
- Monthly Enrollment % Change - Dec
- Monthly Medicaid Enrollment - Children
- Monthly Enrollment % Change - Children
- Monthly Medicaid Enrollment - Adults
- Monthly Enrollment % Change - Adults
- June Medicaid Enrollment: 01-10
- Dec Medicaid Enrollment: 01-10
- Medicaid Enrollment in the Recession

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- Income Eligibility ($) -- Medicaid
- Income Eligibility -- Separate CHIP Prog
- Upper Income Limit

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- Income Eligibility- Low Income Adults
- Income Eligibility (% FPL) -- Pregnant Women
- Income Eligibility ($) -- Pregnant Women
- Income Eligibility- Aged/Blind/Disabled
- Income Eligibility Nursing Home Services

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- SSI Beneficiaries as % of Population
- Distribution of Total SSI by Age
- Aged SSI

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- Aged SSI as % of Population Ages 65+
- SSI with Disabilities
- SSI with Disabilities as % of Population

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- Enrollment by Eligibility Category
- Medically Needy Total Spending
- Spending by Eligibility Category
- Total per Enrollee Spending
- Per Enrollee Spending by Category

Medicaid Managed Care

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- Medicaid Managed Care as a % of Medicaid
- Enrollment in Comprehensive MC
- Comprehensive MC as % of Medicaid
- Enrollment by Medicaid MC Plan Type
- Medicaid Managed Care Models
- Managed Care Benefit Carve-Outs
- Primary Care Providers in MCOs
- Primary Care Providers in PCCM Programs
- MC Improvement Initiatives
- Managed Care Activity for Dual Eligibles
- MLR Requirements for MCOs

Births Financed by Medicaid

- Total Medicaid Births
- As Percent of State Births

Medicaid/CHIP Eligibility Systems

- Medicaid & CHIP Eligibility Systems

Enrollment Practices for Pregnant Women

- Asset Test
- Presumptive Eligibility

Application Requirements for Children

- Joint Application: Medicaid & CHIP
- Face-to-Face Interview:Medicaid & CHIP
- Asset Test: Medicaid & CHIP
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- Waiting Period: CHIP
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- Express Lane Eligibility: Mcaid and CHIP
- SSA Data Match: Medicaid & CHIP
- Out-Stationed Eligibility Workers

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- Face-to-Face Interview: Medicaid/CHIP
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- Premium Amounts
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- Monthly CHIP Enrollment
- Monthly CHIP Enrollment % Change, Dec
- Trends in Monthly CHIP Enrollment, Dec
- CHIP Enrollment by FPL
- CHIP Program Name and Type
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- Federal CHIP Allotments, FY2009

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- Participants by HCBS Waiver Type
- Expenditures by HCBS Waiver Type
- Aged & Aged/Disabled Participants
- Aged & Aged/Disabled HCBS Expenditures
- Waiting Lists for HCBS Waivers, 2009
- Waiting Lists for HCBS Waivers, 2010
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- Home Health Expenditures
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- Personal Care Expenditures
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- Money Follows the Person Grants

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States With a False Claims Act
State Health Care Fraud Laws
Medicaid Coverage of Preventive Services
HIV Testing

Home and Community-Based Services

Total Number of Medicaid 1915(c) Home and Community-Based Service Waivers, 2008		View 50-State Comparison
	CT #	US #
	5	283

(show/hide notes)

Medicaid 1915(c) Home and Community-Based Service Waiver Participants, by Type of Waiver, 2008		View 50-State Comparison
	CT #	US #
ID/DD	3,238	507,279
Aged	NA	140,110
Aged and Disabled	11,611	457,450
Physically Disabled	775	76,968
Children	NA	29,623
HIV/AIDS	NA	12,530
Mental Health	NA	2,443
TBI/SCI	364	15,009
Total	15,988	1,241,411

(show/hide notes)

Medicaid 1915(c) Home and Community-Based Service Waiver Expenditures (in thousands), by Type of Waiver, 2008		View 50-State Comparison
	CT $	US $
ID/DD	$63,101	$21,760,163
Aged	NA	$1,332,480
Aged and Disabled	$113,975	$4,502,806
Physically Disabled	$17,634	$1,388,771
Children	NA	$326,838
HIV/AIDS	NA	$49,721
Mental Health	NA	$21,480
TBI/SCI	$32,803	$462,164
Total	$227,512	$29,844,423

(show/hide notes)

Total Number of Aged and Aged/Disabled Medicaid 1915(c) HCBS Waiver Participants, 2008		View 50-State Comparison
	CT #	US #
	11,611	597,560

(show/hide notes)

Total Aged and Aged/Disabled Medicaid 1915(c) HCBS Waiver Expenditures, 2008		View 50-State Comparison
	CT $	US $
	$113,975	$5,835,286

(show/hide notes)

Waiting Lists for Medicaid 1915(c) Home and Community-Based (HCBS) Waivers, 2009		View 50-State Comparison
	CT #	US #
ID/DD	1,846	221,898
Aged	NA	6,262
Aged and Disabled	0	101,301
Physically Disabled	71	7,960
Children	NA	25,234
HIV/AIDS	NA	18
Mental Health	NA	0
TBI/SCI	0	2,880
Total	1,917	365,553

(show/hide notes)

Sources: The Kaiser Commission on Medicaid and the Uninsured (KCMU) and The University of California at San Francisco's (UCSF) analysis based on The Centers for Medicare & Medicaid Services (CMS) Medicaid 1915(c) Waiver Policy Survey, February 2011, Table 11. "Medicaid 1915(c) Home and Community-Based Service Programs: Data Update" available at http://www.kff.org/medicaid/7575.cfm.

Definitions: NA: No waiver offered.
Unknown: There was a wait list but the number of persons on list is unknown.
ID/DD: Intellectual Disability and Developmental Disabilities. This waiver type is referred to as MR/DD by CMS and was formerly titled as such in this table.
TBI/SCI: Traumatic Brain and Spinal Cord Injury

Waiting Lists for Medicaid 1915(c) Home and Community-Based (HCBS) Waivers, 2010 View 50-State Comparison

	CT #	US #
ID/DD	1,846	268,220
Aged	NA	24,453
Aged and Disabled	0	96,696
Physically Disabled	71	8,973
Children	NA	27,546
HIV/AIDS	NA	7
Mental Health	NA	10
TBI/SCI	0	2,666
Total	1,917	428,571

(show/hide notes)

Medicaid Home Health Participants, 1999-2008 View 50-State Comparison

	CT #	US #
1999	25,753	679,671
2000	26,372	703,908
2001	26,619	704,631
2002	22,143	766,321
2003	20,933	851,260
2004	21,446	876,591
2005	21,753	864,157
2006	22,217	879,210
2007	14,394	923,103
2008	15,157	922,396

(show/hide notes)

Medicaid Home Health Expenditures, 1999-2008 View 50-State Comparison

	CT $	US $
1999	$120,335,835	$2,094,094,893
2000	$130,897,232	$2,280,401,216
2001	$147,822,566	$2,472,456,345
2002	$159,091,638	$2,681,855,019
2003	$179,555,091	$2,789,269,860
2004	$173,256,410	$4,098,590,974
2005	$178,419,015	$4,352,745,868
2006	$194,779,575	$4,605,145,153
2007	$144,861,753	$4,962,490,956
2008	$148,520,301	$5,068,707,031

(show/hide notes)

Medicaid Personal Care Services Participants, 1999-2008 View 50-State Comparison

	CT #	US #
1999	NA	528,412
2000	NA	578,207
2001	NA	582,298
2002	NA	683,067
2003	NA	720,385
2004	NA	761,308
2005	NA	918,293
2006	NA	814,589
2007	NA	822,509
2008	NA	902,943

(show/hide notes)

227

Medicaid Personal Care Services Expenditures, 1999-2008 View 50-State Comparison

	CT $	US $
1999	NA	$4,080,593,555
2000	NA	$4,556,604,883
2001	NA	$5,261,409,993
2002	NA	$5,491,468,257
2003	NA	$6,534,087,158
2004	NA	$7,158,526,284
2005	NA	$7,711,032,546
2006	NA	$8,654,524,566
2007	NA	$9,482,533,681
2008	NA	$10,060,209,490

(show/hide notes)

State Activity Relating to "Individual Budget" Models of Long Term Care for the Elderly,as of January 2006 View 50-State Comparison

	CT	US
Includes the Elderly?	No	NA
Program Name	Individual and Family Supports Waiver	NA
CMS Waiver Authority	1915 (c)	NA
Status	Connecticut has a 1915 (c) Independence Plus waiver for the MR/DD population, program enrollment began in February 2005. Participants can choose to self-direct their waiver services, hire workers of their choice, use a fiscal intermediary to handle the transfer of funds, payroll, tax filing, and reporting duties. Participants may also use a broker or hire their own individual support person to help workers and develop the individual budget. The state is also implementing a state funded pilot program with self-direction that includes the elderly, but the status of this program and whether it offers an Individual Budget has not been determined.	NA

(show/hide notes)

Money Follows the Person Grant Awardees, 2011 View 50-State Comparison

	CT $	US $
Current MFP Program	Yes	29+DC Yes
2011 Grantee	No	13 States
Grant Award Amount	$24,207,383	$2,051,356,342

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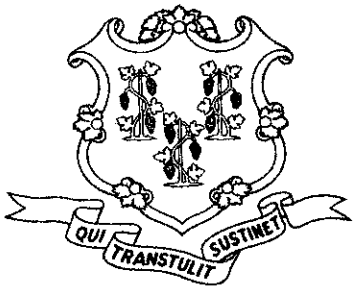
STATE OF CONNECTICUT



Community Mental Health Services Block Grant
FY 2012-2013

In compliance with the requirement of P.L. 102-321

Including

The Community Mental Health Plan
For Children & Adults

September 1, 2011

Submitted By

The Department of Children & Families
The Department of Mental Health & Addiction Services

OCTOBER 1, 2011 to JUNE 30, 2013

Behavioral Health Assessment And Plan

A. Framework for Planning - Mental Health
Identified Populations That Are The Focus Of The Mental Health Block Grant

Comprehensive community-based behavioral health services will be provided to the following specified populations:

- Children/adolescents with serious emotional disturbance (SED) and their families;
- Children/adolescents with mental, emotional and behavioral disturbances, including those at risk of having behavioral health disorders and their families; and
- Adolescents with behavioral health and substance use disorders.

For the specified populations identified above, targeted services will be provided to the following:

- Children/adolescents involved in the child welfare and/or juvenile justice system (Includes children/youth who have experienced chronic trauma and exhibit depression, PTSD or related symptoms);
- Children/adolescents who are homeless;
- Children/adolescents who are "aging out" of the child welfare system and require ongoing behavioral health and/or developmental services;
- Children/adolescents who are underserved due to racial/ethnic/LGBTQ status;
- Schools and local communities to promote emergency/crisis response services and suicide prevention; and
- Families of children/adolescents with behavioral health service needs, targeting family outreach and engagement through use of evidence-based protocols and a Strengthening Families model of care.

The Department will continue to work closely with the Department of Social Services (CT's Medicaid agency) and the CT Behavioral Health Partnership (CT BHP) to determine who will not be covered by Medicaid in 2014. Currently, HUSKY B (Healthcare for Uninsured Kids and Youth) provides health coverage, including behavioral health services, to children in households that have income up to 300% of the Federal Poverty Level. Coverage level is primarily determined by family income, as follows.

HUSKY Part A provides health services for low income children under age 19, pregnant women and some parents or relative caregivers of covered children with family income at or below 185%.

HUSKY Part B Tier 1 provides health services for families with incomes between 185% and 235% of the Federal Poverty Level.

HUSKY Part B Tier 2 provides health services for children in households with income between 236% and 300% of FPL.

HUSKY Part B Tier 3 provides health services for children in households with income above 300% of FPL.

HUSKY Plus provides additional coverage for children with HUSKY B (Tiers 1 and 2 only) who have intensive physical health care needs.

There is NO asset restriction for any level. Higher income families pay co-pays and sometimes premiums.

Management Team about multicultural issues that affect employment and service delivery and develops and implements diversity initiatives to address those issues. The membership includes Co-Chairs of DCF's Diversity Action Teams (DATs), who (along with their team members) identify priority issues and implement the Department's practice initiatives.

Cultural competency training is a standard requirement for the Department's contracted service providers. At the Department interview panels for prospective staff are composed of culturally and linguistically diverse staff, and the Department allows longer periods of time than usual to recruit linguistically and culturally competent staff. Other strategies include basic training in culturally competent services for new staff through the DCF's Training Academy and special training for other staff on selective cultural issues such as gender and transgender issues, the Puerto Rican experience, and trauma-informed care for child welfare staff.

B. Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system

A summary of the most critical unmet service needs and critical gaps within Connecticut's system of care is based on the following sources of information, in addition to the sources cited under #1 below for estimate of prevalence of mental illness.

a. Mental Health Needs Assessment and Resource Inventory - Summary Report Connecticut Workforce Collaborative on Mental Health June 7, 2007
b. Behavioral Health Services for Children & Families A Framework for Planning, Management & Evaluation - Connecticut Department of Children and Families March 2009
c. Strengthening the Foundation: An Analysis of Connecticut's Outpatient Mental Health System for Children - Connecticut Center for Effective Practice of the Child Health and Development Institute of Connecticut May 2010
d. A Framework for Child Health Services Supporting the Healthy Development and School Readiness of Connecticut's Children Paul Dworkin, M.D. and Lisa Honigfeld, Ph.D. and Judith Meyers, Ph.D. Child Health and Development Institute of the Connecticut Center for Effective Practice March 2009
e. Strengthening Family Advocacy in Connecticut Recommendation Report Connecticut Workforce Collaborative on Behavioral Health September 2010
f. DCF's Programs and Services Data Collection and Reporting System (PSDCRS) SFY 2010-2011
g. Utilization Analysis, Qtr 4 2010 Connecticut Behavioral Health Partnership

1. Mental Health Needs Surpass Service Capacity

(Criterion 2A): The need for child and adolescent mental health services exceeds the available behavioral health resources, which is a similar trend across the nation. Between 7% and 9% of children and youth in the United States meet the criteria for serious emotional disturbance (SED) indicating the presence of a psychiatric disorder that seriously interferes with functioning at home, in school, and/or community. Most recent estimates are that up to 20% of children and youth have some form of psychiatric disturbance and almost 70% do not receive treatment for their disorder. Of Connecticut's 807,985 children/youth, this translates to an estimated 60,000 to 76,000 children and youth with SED and up to 100,000 additional children with some form of psychiatric disturbance requiring mental health care (Sources: U.S. Census Bureau; US DHHS

Agency for Health Care Research and Quality; Collaborative Psychiatric Epidemiologic Surveys). DCF's Programs and Services Data Collection and Reporting System (PSDCRS) shows that between 18% and 23% of children/youth with SED were served within the publically funded mental health system during SFY 2010. Further, of the total children/youth served in the public mental health system, 46.8% were diagnosed with SED. (Source: PSDCRS FY 2010)

It is well documented that rates of psychiatric disorder are even higher for those children living in poverty. It is estimated that 12% of Connecticut's children live below federal poverty levels (Sources: US Census Bureau, Current Population Survey, 2008 Annual Social and Economic Supplement; Children's Defense Fund). Although Connecticut has one of the highest state per capita incomes in the country, three of Connecticut's larger cities (Hartford, Waterbury and New Haven) have some of the highest child poverty rates in the nation. Psychiatric disorders are also higher amongst those involved with the child welfare and juvenile justice systems. Some studies (i.e. Farmer et al. (2001) found that SED was present in 78% of the children in foster care. In Connecticut there are 4300 children/youth in state custody on any given day (Source: DCF LINK), which translates into an estimate of 3,354 children/youth with SED. Of those youth served in the DCF juvenile justice system, it is estimated that over half of the adolescents have some type of behavior disorder including mental illness and alcohol/drug dependence.

Access to behavioral health care for eligible children/youth is further challenged due to an uneven distribution of services across large, mid-sized and rural communities. Typically, larger communities deliver substantially more service units per youth and subsequently expend greater sums. Some communities may have a limited menu of service options or there may be wait lists for certain services. Sometimes the "right" type of service may not be available at the time of need. (Sources: DCF Programs/Services Contracts and Assigned Catchment Areas; DCF's PSDCRS SFY 2010).

Transportation continues to be a barrier to accessing services, most particularly in rural areas of the state. There is limited public transportation. Also, there are fixed routes and hours of operation that make it difficult for families to attend support groups or evening appointments.

2. There are limited evidence-based treatments and programs available across the continuum of care.

Connecticut's first foray into evidence-based practice focused on intensive community-based treatments that could divert youth from residential care. Although this focus was strategic and appropriate, it has resulted in less availability of these practices in less intensive outpatient settings and more intensive residential and hospital level of care. There is a need to have evidence-based practices readily available at all levels of care in the continuum of services. Only a small percentage of children are receiving these services, especially in outpatient care. For example, for FY 2010 37% of children/youth residing in the foster care system (excludes inpatient, residential and congregate care settings) resided in therapeutic homes. Only 160 children/youth received Functional Family Therapy.
(Source: PSDCRS FY 2010). Also, there are too few evidence-based early intervention and prevention services available across the state.

Evidence-based practices tend to be more available where there is the largest concentration of the target population. This tends to be in the larger urban areas. While IICAPS and MST are available across the state, many other services are only located in selected areas. The challenge is to develop a full array of these services in rural and suburban areas as well as urban centers.

Many evidence-based practices are not eligible for reimbursement under private insurance plans and various critical components such as supervision, training, program fidelity, and quality assurance activities are not reimbursable under Medicaid. There is a need to develop policy, promote statute reform and establish partnerships with key stakeholders to promote the alignment of the public and private reimbursement systems with evidence-based and best practices.

3. Evidence-based treatments for traumatized children, youth and families are insufficient to meet the level of need.

The prevalence of trauma is high in the general population, and higher in the foster care population. One of four children experience at least 1 potentially traumatic event before the age of 16, almost 2/3 experience more than one type of violence, and 4 in 10 children report witnessing domestic violence (David Finkelhor et al UNH). High risk populations are those that experience chronic traumatic situations including children who experience abuse/neglect, are in out-of-home placement, have been exposed to domestic violence, or are exposed to violence in their schools and communities. Rates for post-traumatic stress disorder are 21% for foster children versus 4.5% for the general population. Connecticut providers report that 70 to 80% of all children receiving mental health services have a history of traumatic events (CT PSDCRS - SFY 2010). Yet, there are few trauma-specific evidence-based treatments available to address the need. During SFY 2010 only 300 children/youth were offered Trauma-Focused Cognitive Behavior Therapy, which represents 6.9% of those children/youth committed to state custody. (Source: TF-CBT Monthly Metrics Child Health and Development Institute of the Connecticut Center for Effective Practice)This is a critical concern because it is well documented that those who are adversely impacted by traumatic experiences in childhood suffer lifelong consequences. These include poor physical and mental health, school failure, teen pregnancy, unemployment, and unsuccessful relationships.

A first step in assuring that traumatized children and youth receive specialized treatment and care is the development of a trauma-informed system of care, including a well-trained workforce that understands the nature of trauma and its impact, recognizes the signs and symptoms, and has the skilled professionals to deliver the right type of treatment at the right time. The Department has begun the process of educating frontline DCF social workers and supervisors, primarily through the use of the Child Welfare Trauma Training Toolkit and other in-service trainings by trauma specialists. Additionally, the Department has sponsored three Trauma-Focused Cognitive Behavior Therapy Learning Collaboratives to train treatment teams from sixteen outpatient mental health clinics. However, considerable resources and support are necessary to sustain and even expand the work of these TF-CBT Teams, plus there are nine additional DCF grant-funded clinics that do not have treatment teams. Ongoing education and training at the local child welfare offices and assuring linkages between child protection social workers and community providers continues to be a critical need. Another need is the dissemination of trauma-informed treatments to all levels of care including residential and inpatient settings.

4. **There is a continued need for transitional services for those youth with behavioral Health and/or developmental needs who are aging out of the child welfare system.**
The Department transfers eligible youth, typically at age 21 to the Department of Developmental Services (DDS). (Only voluntary and in-home cases transfer at an earlier age.) Currently there are 131 youth who are DCF-committed, ages 17 and up who have been accepted to DDS and will transition at age 21. The number of these referrals continues to grow. (Source: DCF LINK)

Currently there are 313 youth ages 17 and up, who have been accepted to the Department of Mental Health and Addiction Services (DMHAS) and are waiting to transition, and an additional 161 who are pending with DMHAS (17 and up). (Source: DCF LINK)

5. **There are insufficient in-state specialized residential services for children/youth who are: fire setters; exhibit problem sexual behavior; present with mental retardation (MR) or pervasive developmental disorder (PDD) including autism spectrum disorders; and those who present with conduct disorders (CD) and have involvement with the juvenile justice (JJ) system.**
Currently, there are no in-state beds for those who are fire starters or those who exhibit problem sexual behavior, and only 69 beds for CD and juvenile justice-involved youth. At this time 100% or 14 children/youth who are fire setters or have sexual problem behavior are placed out-of-state, 60% (12 individuals) with MR or PDD are placed out-of-state, and 20% (9 clients) with CD and JJ involvement are placed out-of-state. Also, there are very few community-based providers to treat these particular populations. Those with MR diagnosis continue to be more than double PDD. The PDD category has more than doubled since Quarter 4 2008 and increased by 29.2% from Quarter 4 2009. The MR category has increased by 30.8% since Quarter 4 2008 and by 7.6% since Quarter 4 2009. These are Medicaid eligible consumers only. (Source: CT BHP Quarterly Reports)

6. **There are insufficient early intervention services available across the state.**
There is a significant need for prevention and early intervention services. 35.2% of Connecticut parents with children ages birth to five express one or more concerns about their child's learning, development or behavior, and 9.2% of parents with children three to seventeen report moderate or severe difficulties in the area of emotions, concentration, behavior, or getting along with others. (Source: National Survey of Children's Health, 2003) Yet, a survey of 48 pediatric and family medicine providers in Connecticut reported that 90% of their patients experience difficulty obtaining mental health services. (Source: Child Health and Development Institute, 2007) These findings mirror another large scale national study. The 1998 Early Childhood Longitudinal Study of children in kindergarten found that 56% of a sample of 40,000 children were deemed not ready for kindergarten, 30% lagged in socio-emotional developmental and more than 36% had one or more health concerns.

Despite robust research support for the value of early intervention and the long term cost-effectiveness of these interventions, they remain sparsely implemented across the state and their full promise unrealized. For example, Child FIRST that provides in-home parent-child psychotherapy and wrap-around services and supports is available in only six cities/regions of the state; and Building Blocks for a Brighter Future that offers mental health services to children ages birth to six is available in only selected areas of the state.

B. Planning Steps
Step 3: Prioritize State Planning Activities

Table 2 Plan Year: 2012-13

	State Priorities
1	Childhood Trauma & Violence
2	Evidence-Based Prevention, Early Intervention and Treatment Services
3	Family/Caregiver Involvement in: ▪ Individual care planning and treatment; and ▪ System development, planning, and oversight
4	Workforce Development

B. Planning Steps
Step 4: Develop Objectives, Strategies and Performance Indicators

Table 3 Plan Year: 2012-2013

Priority Area #1: Childhood Trauma & Violence
Goal: Assure that traumatized children, youth and their families receive evidence-based trauma treatments to meet their needs
Strategy #1: Continue trauma screening for all referrals at the 16 outpatient behavioral health clinics that have TF-CBT Teams Strategy #2: Continue to produce the TF-CBT Metrics Report on a monthly basis and include an analysis with specific areas to be addressed by the teams Strategy #3: Maintain the TF-CBT Learning Collaborative website and TF-CBT Team Roster Strategy #4: Continue the strategizing and planning meetings on a quarterly basis with the TF-CBT Senior Leaders Strategy #5: Deliver a TF-CBT Annual Conference for current TF-CBT teams and DCF staff Strategy #6: Provide a 2-day Introduction to TF-CBT training for new TF-CBT Team members Strategy #7: Continue to develop a statewide trauma-informed system of care through training child welfare workers using the NCTSN Child Welfare Trauma Training Toolkit and other targeted trainings, and through further development of the statewide Trauma-Informed Gender-Responsive (TIGR) model.
Performance Indicator #1: Increase the number of children, youth and their families that are offered Trauma-Focused Cognitive Behavior Therapy by ___ %.
Performance Indicator #2: Increase the number of children, youth and their families that complete the TF-CBT treatment by ___%.
Description of Collecting and Measuring Changes in Performance Indicator: The TF-CBT Metrics Report will be used to identify the number of children/youth who are offered TF-CBT during the year as well as the number of clients that complete the treatment. This database is maintained by the Child Health and Development Institute (CHDI) of the Connecticut Center

for Effective Practice. Contract staff from CHDI oversees the data collection, analysis and reporting. SFY 2012 will serve as the baseline year. SFY 2013 will use the same database to measure a specified percentage of change.

Priority Area #2: Evidence-Based Prevention, Early Intervention and Treatment Services

Goal #1: Enhance the knowledge base of youth, families, Department staff, providers and first responders regarding the prevention of youth suicide

Strategy #1: Use evidence-based curricula, ASIST and Safe Talk to train youth, families, Department staff, and first responder agency staff, through contracts with United Way and Wheeler Clinic

Strategy#2: Use evidence-based curricula, Assessing and Managing Suicide Risk (AMSR) to train clinicians who deliver Emergency Mobile Psychiatric Services (EMPS).

Strategy #3: Implement awareness campaigns that include informational e-mails, a Department website, and suicide prevention brochures

Strategy #4: Continue to engage in collaborative partnerships with DMHAS, schools, and first responder agencies to share delivery of the prevention training

Performance Indicator #1: Increase the number of individuals receiving suicide prevention and/or crisis response training by __%

Description of Collecting and Measuring Changes in Performance Indicator: Provider Reports (based on attendance records - United Way and Wheeler Clinic). SFY 2012 will serve as the baseline year. SFY 2013 will use the same sources of data to measure a specified percent of change.

Goal #2: Promote the statewide dissemination of evidence-based practices (EBP)

Strategy #1: Continue to provide state funds to support the delivery of the existing 12 EBPs

Strategy#2: Continue to develop state interdepartmental partnerships to blend funding in order to maintain, and to the extent that funding permits expand EBPs (DCF/CSSD - IICAPS and MST)

Strategy #3: Provide targeted technical assistance for providers and communities planning on adopting an EBP including focus on organizational and fiscal challenges as well as barriers

Performance Indicator #1: Increase the number of individuals receiving any type of EBP by __%

Description of Collecting and Measuring Changes in Performance Indicator: DCF's PSDCRS will be used to identify the number of clients receiving any type of EBP by aggregating types of EBTs received at time of discharge across service providers. SFY 2012 will serve as the baseline year. SFY 2013 will use the same database to measure a specified percent of change.

Performance Indicator #2: Increase the number of families responding positively about functioning by __%

Description of Collecting and Measuring Changes in Performance Indicator: The Youth Services Survey for Families (YSS-F) will be administered to families at the time of discharge, in accordance with the Guidelines for Administering YSS-F. Responses will be entered into DCF's PSDCRS.

Numerator: # of families of child/adolescent consumers reporting positively about functioning

Denominator: Total # of family responses regarding functioning

SFY 2012 will serve as the baseline year. SFY 2013 will use the same database to measure a

specified percent of change.

Priority Area #3: Family/Caregiver Involvement

Goal #1: Behavioral health care is consumer and family-driven.

Strategy #1: Continue to use a community-based system of care approach and promote wraparound services and supports to respond to child and youth consumer and family needs and preferences, as reflected in individualized plans of care

Strategy #2: Provide two "Improving Engagement and Retention of Children and Families in Mental Health Care" Learning Collaboratives to train teams from outpatient clinics in the evidence-based family engagement protocols developed by Dr. Mary McKay/Mt. Sinai School of Medicine

Strategy #3: Include family partners on each of the clinic's Family Engagement/Quality Improvement Teams and offer family stipends for participation in the learning collaborative

Strategy #4: Develop criteria for the Welcoming and Engaging Families domain for Enhanced Care Clinics through the CT Behavioral Health Partnership

Performance Indicator #1: Increase the # of families that meet treatment goals at outpatient behavioral health clinics by __%

Description of Collecting and Measuring Changes in Performance Indicator: DCF's PSDCRS will be used to identify the number of clients that meet treatment goals at grant-funded outpatient psychiatric clinics. SFY 2012 will serve as the baseline year. SFY 2013 will use the same database to measure a specified percent of change.

Performance Indicator #2: Increase the # of families/caregivers who respond positively about participation in treatment planning by __%

Description of Collecting and Measuring Changes in Performance Indicator: The data source is the Youth Services Survey for Families (YSS-F) which will be administered by contract providers. Responses will be entered into the Department's PSDCRS by the providers and the results and reports will be provided by PSDCRS.

Numerator: # of families reporting positively about participation in treatment planning

Denominator: Total # of family responses regarding participation in treatment planning

SFY 2012 will serve as the baseline year. SFY 2013 will use the same database to measure a specified percent of change.

Goal #2: Ensure that the voices, perspectives and input of family members are included in developing, planning, and overseeing the statewide behavioral health system

Strategy #1: Provide education, training and empowerment through the Parent Leadership Training Network

Strategy #2: Continue to expand family membership in the statewide program and policy advisory committees as well as evaluation committees for procurement of services

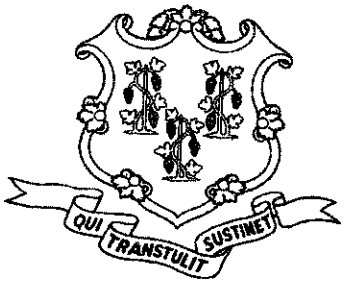
Strategy #3: Continue to deliver case-specific family advocacy services and family/peer support services

Performance Indicator: Increase the number of families that receive family advocacy education, training and direct advocacy services by __%

Description of Collecting and Measuring Changes in Performance Indicator: Provider Reports (Attendance Records) in addition to the family advocacy case-specific numbers served as reported in the PSDCRS. SFY 2012 will serve as the baseline year. SFY 2013 will use the same database to measure a specified percent of change.

Priority Area #4: Workforce Development
Goal: Promote the development of a more informed and skilled workforce who have interest and solid preparation to enter positions within evidence-based in-home treatment programs.
Strategy #1: Provide funding and other support to the Higher Education Partnership on Intensive Home-Based Services Workshop Development-Sustainability Initiative through contract with Wheeler Clinic Strategy #2: Expand the pool of faculty and programs credentialed to teach the Current Trends in Family Intervention: Evidence-Based and Promising Practice Models of In-Home Treatment in Connecticut curriculum and promote accurate implementation of course content that is current and up-to-date through contract with Wheeler Clinic. Strategy #3: Maintain and promote teaching partnerships between higher education and providers delivering evidence-based treatments through ongoing coordination and assignment of provider and client/family guest speakers for the curriculum.
Performance Indicator #1: Increase the number of faculty that will be trained in the curriculum by __%.
Performance Indicator #2: Increase the number of students that will receive certificates of completion for the course by __%.
Description of Collecting and Measuring Changes in Performance Indicator: The contract provider, Wheeler Clinic will maintain records regarding number of faculty members trained and number of students completing the course. 2012 will serve as the baseline year. SFY 2013 will use the same database to measure a specified percent of change.

STATE OF CONNECTICUT



Community Mental Health Services Block Grant for FY 2011

In compliance with the requirement of P.L. 102-321

Including

The Community Mental Health Plan For Children & Adults

September 1, 2010

Submitted By

The Department of Children & Families
The Department of Mental Health & Addiction Services

OCTOBER 1, 2010 to SEPTEMBER 30, 2011

In December 2008 DCF and the CT BHP initiated pilot programs in Norwich and Waterbury areas that were expanded to include Hartford and New Britain in 2009. The focus of the pilot was to support foster children with behavioral health needs and their foster families. Targeting children ages 3 to 18 who are experiencing their first removal from home, receive HUSKY benefits, and have already been identified as having behavioral health issues, the programs' goal has been to reduce the likelihood of disruption within 45 days of placement. If a child was identified as meeting criteria for participation in the pilot project, both the children and their foster families received outreach calls from the CT BHP's peer specialists (employees of the CT BHP who have either experienced behavioral health issues personally or have family members with behavioral heath needs). The peer specialists help the foster parents to understand , predict and plan for the challenges and special behavioral health service needs. The CT BHP's intensive care managers also played a role in assuring that every case was authorized for services and linked with providers in a seamless manner.

While plans had been made to identify variables within the foster families that contributed to either stability or disruption for the children placed in their care, further research efforts were necessarily aborted due to the complexities associated with obtaining permission from each identified foster family and the reduction in resources made available within the Value Options contract due to statewide budget cuts.

Perhaps the most significant set of accomplishments within the CT BHP for CY'09 have involved a targeted and staged set of activities designed to reduce the number of CT youth entering residential care (RTC), reduce the average length of stay for youth in residential care, and improve the quality of care provided within that level of care. Significant effort was directed toward lessoning the length of stay through a concerted effort to promote early discharge planning. The result was a 9% reduction in LOS from 321 days to 291 days.

Simultaneously, working with in-state residential providers, DCF and the Value Options staff identified a set of 24 mutually agreed upon outcome measures designed to track the efficacy of residential care within the system and within individual providers. In 2009 the logic and programming was developed for 7 of these measure using utilization data within the ASO system that tracks admissions and monitors continued stays. The remaining reports were well under development at the close of 2009 and will be available in 2010. The information and trends embedded within these reports will be analyzed and shared with residential providers. Areas for performance improvement will be identified and if possible a Performance Incentive program, similar to those described above for other levels of care will be developed for In-state RTCs to enhance quality of care for youth who require treatment within this restrictive setting.

PART C SECTION 11: IDENTIFICATION AND ANALYSIS OF SYSTEM STRENGTHS, NEEDS, AND PRIORITIES - CHILDREN

A. STRENGTHS AND WEAKNESSES OF THE SERVICE SYSTEM

The behavioral health services system is complex and multi-faceted. A summary of the strengths and weaknesses (challenges) are included under seven core domains as described in the chart below.

DOMAINS	STRENGTHS	WEAKNESSES (CHALLENGES)
1. Access and Service Capacity	Broad range of clinical and non-traditional services available across the state Steady growth in community-based services including Outpatient Care, Extended Day Treatment, Care Coordination, Emergency Mobile Psychiatric Services, Intensive In-Home Services, Therapeutic Group Homes, and Family Advocacy Services 28 Enhanced Care Clinics located across the state that meet timeliness standards for access to care covering emergent (within 2 hours), urgent (within 2 days), and routine care (within 2 weeks) DCF/DSS collaboration through the CT BHP to significantly expand Medicaid enrollment and services to children and families Provision of prevention activities through state agencies, universities, public and private providers, and DCF Prevention Division (Examples: Suicide prevention training for first responders, DCF staff, community providers, school children/college students, parents, foster parents) Partnerships between state agencies and the broader stakeholder community to address the needs of young children, birth to five for the purpose of early identification and intervention	Service capacity remains below estimated need Uneven distribution of services across communities. (Some communities have limited service types or wait lists for selective services) Fewer services available in rural areas "Right" type" of service may not be available at the time of need (Example: Need to develop more in-state capacity to provide specialized residential treatment services, specialized living and outpatient treatment programs for youth with problem sexual behavior, and creation of specialized outpatient programs for youth with significant behavioral dyscontrol and aggression, autism spectrum disorders, substance abuse) psychological testing services do not meet the needs Limited transportation resources in certain areas Insufficient specialty services such as traumatized treatments for children/youth

DOMAINS	STRENGTHS	WEAKNESSES (CHALLENGES)
	Partnerships between state agencies (DCF/DDS/DMHAS) and the broader stakeholder community to address the needs of youth with behavioral health and/or developmental issues who are transitioning to the adult system A network of 25 community collaboratives with specially trained service brokers to assist families in navigating the service system Managed Service Systems within the 15 DCF Area Offices to coordinate care for the DCF target population Strong statewide family advocacy organization, FAVOR to link families with services and organize family support groups Network of Care for Behavior Health website to assist families in locating services and to educate consumers on behavioral health disorders	Insufficient treatments for consumers with co-occurring disorders Insufficient early access options for young children and families for prevention and/or early intervention Need for ongoing monitoring and continued reduction of overstays and unnecessary utilization of hospital emergency departments, inpatient, and residential resources Continued challenges to meet the need for transitional services for those with behavioral health and/or developmental issues who are "aging out" of the child welfare system Need to expand school-based mental health care Continued coordination & integration of child-serving systems needed to address fragmentation Shortage of child and adolescent psychiatrists who will serve publically funded consumers Few behavioral health services designed for child welfare population Shortage of non-therapeutic, natural supports and services in communities (i.e. school and community-based recreational activities;

DOMAINS	STRENGTHS	WEAKNESSES (CHALLENGES)
		housing; legal services; and financial services)
2. Service Effectiveness & Quality	Numerous behavioral health workforce activities to increase knowledge, skills and competencies Practice standards adopted for most service types Broad cross-system collaboration and partnering Extensive array of evidence-based treatments that includes 10 intensive in-home models of care Multiple prevention and early intervention initiatives Trauma screening and treatment (TF-CBT) available across the state at selective outpatient clinics Use of learning collaborative methodology to disseminate and sustain evidence-based practices such as TF-CBT, Child FIRST, and family engagement protocols Educational/collaboration forums held for pediatric and behavioral health providers to promote integrating care, i.e. improving reciprocal communication; co-location; transferring appropriate cases; and co-management of psychotropic medications Collaboration with academic institutions and	Increased client complexity makes it challenging to provide what is needed (Children often present with co-morbid conditions; families experience significant poverty; and some parents have a mental health diagnosis) Need for more case management services to assist with complex client needs Few evidence-based practices available at outpatient psychiatric clinics for children, and implementation barriers exist at the individual, agency and system levels Services designed for adolescents/young adults are insufficient in quantity and quality Need to promote mental health of young children Quality of care varies across providers Weak Continuous Quality Improvement (CQI) process for the system as a whole and for provider agencies

DOMAINS	STRENGTHS	WEAKNESSES (CHALLENGES)
	Decreased utilization of high end institutional care including inpatient and residential care due to improved case management and enhanced tracking and monitoring initiatives	screening and assessment instruments and to incorporate findings into treatment and discharge planning Too few performance indicators and standardized child/family and system outcome measures for evaluation of the effectiveness of the system of care including all programs and services
3. Child & Family Involvement	CT Kid Care and the wrap-around model of care supports a child-focused, family-centered model Extensive training within local systems of care, DCF area offices, and the broader community on family-centered practice Expanded use of peer support through CT BHP Inclusion of family partners as team members in the TF-CBT Learning Collaborative and other initiatives Implementation of an Engaging Families in Services Learning Collaborative for Extended Day Treatment (EDT) providers, with inclusion of family partners on Quality Improvement Teams Parent training and leadership initiatives provided to prepare and support family and caregiver involvement at all levels of the system Funding and other support to sustain the statewide family organization - FAVOR, Inc. Continued support of youth and family advocacy	Too often families are not fully involved in their own service planning and treatment - outreach and treatment engagement need improvement Too few youth and families are involved in system design, planning, evaluation and system oversight Need to enhance use of Peer Specialists for case management activities, family engagement, and community outreach Limited resources dedicated to family outreach and engagement training for DCF staff and providers Few employment opportunities within the system for family members Limited use of family as faculty in training agency personnel

DOMAINS	STRENGTHS	WEAKNESSES (CHALLENGES)
	mental health. Data systems to support state/federal reporting including URS tables for monitoring purposes Development & implementation of a new enhanced behavioral health information system - Programs and Services Data Collection and Reporting System (PSDCRS)	Lack of specially trained staff to aggregate, analyze, and interpret data and to conduct research projects Need to develop a culture where data is viewed as part of the service, not a separate activity
5. Cultural Competence	Promotion of cultural competence through personnel practices DCF Division of Multicultural Affairs develops and sustains initiatives and policies to support diversity needs of clients and staff DCF staff development and training activities support a culturally informed, culturally competent workforce Support of culturally specific projects such as True Colors, Quinceanara, and Black History Improvement of data collection processes to support culturally competent care Use of Mental Health Block Grant funds to support culturally competent initiatives	Need for culturally and linguistically competent services exceeds available resources Growth of non-English speaking families throughout the state strains existing resources Rapid shifts in racial, ethnic, linguistic and other areas present complex challenges for the system Lack of a comprehensive, integrated cultural competency plan to assess, measure and promote cultural competence within the agency and with its contracted providers
6. Public Awareness & Policy	Extensive multi-media public awareness campaign (Opening Doors, Opening Minds) developed and implemented to address mental health myths and facts Delivery of suicide prevention/education training	Need for comprehensive statewide campaign to address stigma and discrimination Need to further educate the public about children's' behavioral health disorders and the availability of effective treatments

PART C SECTION 11: IDENTIFICATION AND ANALYSIS OF SYSTEM STRENGTHS, NEEDS, AND PRIORITIES - CHILDREN

B. UNMET SERVICE NEEDS AND CRITICAL GAPS WITHIN THE CURRENT SYSTEM INCLUDING IDENTIFICATION OF DATA SOURCES

Between 2000 and 2003 a trio of seminal reports were generated that in sum, called for an overhaul and reorganization of the children's behavioral health system, both in Connecticut and across the nation. These reports include:

- Delivering and Financing BH Services in Connecticut (Child Health & Development Institute, 2000)
- Report of the Governor's Blue Ribbon Commission on Mental Health (Governor's Blue Ribbon Commission on Mental Health, 2000)
- Achieving the Promise: Transforming Mental Health Care in America (Report of the President's New Freedom Commission on Mental Health, 2003)

More recently, between 2009 and 2010 the following documents addressed the challenges that remain today and a blueprint for continuing improvement:

- A Framework for Child Health Services Supporting the Healthy Development and School readiness of Connecticut's Children (Child Health and Development Institute of Connecticut) March 2009
- Behavioral Health Services for Children & Families A Framework for Planning, Management & Evaluation (Connecticut Department of Children and Families) March 2009
- Strengthening The Foundation: Analysis of Connecticut's Outpatient Mental Health System for Children (Connecticut Center for Effective Practice of the Child Health and Development Institute of Connecticut) May 2010
- Department of Children and Families Strategic Plan SFY 2010 - 2014

All of the reports referenced above are fairly consistent in their recognition of the unmet service needs and critical gaps within the current behavioral health service system, as summarized below.

Service Capacity

Despite the significant behavioral health resources that are available in CT, it is important that it is understood in the context of the overall magnitude of the problem. Recent estimates indicate that approximately 20% of children and youth have some form of psychiatric disturbance and almost 70% do not receive treatment for their disorder. In Connecticut, this translates to an estimated 60,000 to 76,000 children and youth with SED and up to 100,000 additional youth with some form of psychiatric disturbance requiring specialty care. It is also well documented that rates of psychiatric disorder in children and adolescents are even higher within disadvantaged groups including children in poverty and those involved with the child protective or juvenile justice systems. Despite having one of the highest state per capita incomes in the country, Connecticut cities continue to have some of the highest child poverty rates in the nation. Similar to every other state in the nation, Connecticut has far more children with behavioral health needs than the combined public and private systems have the capacity to serve. Correcting this monumental gap between what is available and what is needed will require a significant infusion of new resources as well as improved effectiveness and efficient management of existing services.

Service capacity across geographic areas is not equitably distributed in proportion to need. Many communities have limited or no access to certain services such as intensive in-home services, extended day treatment, care coordination, emergency mobile psychiatric services, and outpatient clinic services. Also, many areas of the state lack a full array of services from most to least restrictive that assures continuity of care.

Service Needs And Gaps

There are multiple challenges to address in order to meet the service needs of Connecticut's children and families. The most critical needs are listed below.

- Insufficient funding and too few community-based services to meet the needs of the population. Historically, Connecticut's system has been heavily skewed towards inpatient and residential services, with "70% of all behavioral health dollars spent for inpatient psychiatric hospitals and residential care."

- Limited access to assessment and treatment for children with substance abuse, mental retardation and developmental disorders, and autism spectrum disorders, and limited availability of treatment specializations in outpatient clinics.

- Although there has been recent improvement in the past few years, system gridlock continues to occur. In 2007 two reports were released that described service utilization issues for local hospital emergency departments and residential treatment facilities: Use of Emergency Departments For Mental Health Care For Connecticut's Children A Rising Tide: Statewide Utilization 2001 - 2005 by the Child Health and Development Institute of Connecticut, Inc. and Residential Utilization A Report to the CT BHP Oversight Council by the CT Behavioral Health Partnership. A major finding in both studies was the inability to access the appropriate level of service in a timely manner to meet the level of acuity of the children and youth. There were significant discharge delays for those children and adolescents who were residing in inpatient psychiatric hospitals and residential treatment facilities. The lack of availability of community-based treatment options contributed to prolonged and unnecessary lengths of stay as well as unnecessary utilization of these higher level services.

- Lack of comprehensive, standardized screening and assessment tools, and a need for more efficient sharing of assessment data within and across programs and services, within the boundaries of confidentiality laws and regulations. The sharing of assessment data would minimize the redundancies experienced by children and families, while providing consistent assessment of child and family functioning, ongoing treatment need, treatment response, and treatment decision-making.

- Limited availability of evidence-based practices across the continuum of care. Connecticut's first forays into evidence-based practice focused on intensive community-based treatments that could divert youth from residential care. Although this focus was strategic and appropriate, it has resulted in less availability of these practices in less intensive outpatient settings and more intensive residential and hospital level care. There is a need to have evidence-based practices readily available at all levels of care in the continuum of services. Only a small percentage of children are receiving these treatments. There is a need for ongoing funding and infrastructure to fully implement and sustain these practices.

- Lack of sufficient trauma-specific services to insure that all children requiring care can access effective trauma treatments.

- Limited specialty services for children and families that are involved in the child welfare system.

- Limited specialty services for young adults. Young adults often do not respond well to the services and supports designed for the adult population and the existing services to address their needs are insufficient in both quantity and breadth.

- Shortage of child and adolescent psychiatrists to meet the needs of the population. Many psychiatrists are employed in multiple settings due to the high demand.

- Other unmet needs include housing and related support services such as case management, vocational assistance, financial planning and budgeting.

- Transportation resources to access services are not available in all communities, especially the rural areas of the state.

- Lack of capacity to support the diverse needs of clients regardless of their race, religion, color, national origin, gender, disability, sexual orientation, gender identity or expression, age, social or economic status, or language. At present the Department lacks a comprehensive and integrated plan to assess, measure and promote cultural competence within the agency and with its contracted providers.

- Insufficient availability of early intervention services. It has been well-documented that early intervention strategies and services positively impact human and economic outcomes, yet these continue to be limited in scope. .

- Lack of a medical home model to promote both physical and mental health of parents and their children. In order for parents to support their children, both parents and children must be physically and emotionally healthy.

- Incomplete integration of child welfare and behavioral health service systems. There are overlapping mandates without overlapping jurisdictions. There is a need for cross-training of behavioral health and child welfare staff. There are a lack of structures to support joint decision-making and the establishment of priorities for program development.

- Too few youth and families actively involved in their own plans of care. Family involvement is one of the core values of the CT Kid Care system. Research has shown that family involvement makes a difference in many ways including improved outcomes (i.e. reduces emotional and behavioral symptoms; promotes competence; prevents placement in more restrictive settings); maximizes treatment effectiveness, and facilitates generalization of skill acquisition and treatment gains to home, school and community settings. Yet across the spectrum of services few families are involved in the initial assessment process, treatment services, and discharge planning. Too many children and youth are treated in isolation of their family system, and thus it is difficult to sustain treatment gains once services terminate. This was one of the major findings of the Mental Health Needs Assessment and Resource Inventory Summary Report (June 2007) funded by the Mental Health Transformation State Incentive Grant.

- Limited use of evidence-based family engagement models to support the active involvement of families in their children's plan of care. These practices are currently limited largely to the Extended Day Treatment program.

- Too few opportunities for involvement of individuals with lived experience with mental illness or being the family member of an individual with mental illness

1. **Service Capacity**

The Department will continue its efforts to maintain and strengthen the network of statewide community-based services. This includes but is not limited to the following areas:

- Support for the local Systems of Care/Community Collaboratives including Care Coordination Services to provide wrap-around services;
- Support for the Managed Service System to find community-based solutions for DCF-involved youth with complex behavioral health needs;
- Partner with the CT BHP to assure access to, and coordination of, a more effective system of community-based care;
- Continue improved utilization and management of Emergency Mobile Psychiatric Services (EMPS) through: oversight of service delivery; data analysis, reporting, and quality assurance through a contracted vendor; standardized training and practice; enhanced outreach and marketing; and provision of incentives for EMPS/Emergency Department (EDs) collaboration to reduce the number of youth seeking behavioral health services at EDs;
- Continued support for intensive in-home services including MST, MDFT, FFT, IICAPS, FST and hybrid variants of these programs;
- In partnership with stakeholders, explore strategies to support Child FIRST;
- Continued operation and management of Therapeutic Group Homes;
- Continued support for the Child and Adolescent Rapid Emergency Services (CARES) program that provides six short-term crisis stabilization beds to reduce emergency department overstays for Hartford and surrounding communities;
- Continued roll-out of performance measures and ongoing monitoring and related performance improvement plans for Enhanced Care Clinics;
- Sustainability planning for Extended Day Treatment Model of Care initiatives including family engagement protocols, multi-family groups, Ohio Scales implementation/assessment, application of Risking Connection trauma framework within the milieu setting, and continuation of Project Joy including training for new hires and refresher training for seasoned playmakers;
- Support for the statewide and other family advocacy organizations;
- Continued collaboration between DCF/DMHAS and DCF/DDS to address the needs of children/youth with mental health and/or developmental disabilities, including those youth who are transitioning to the adult systems; and
- Continued commitment to deliver early intervention and prevention activities such as suicide prevention training and consultations for child care providers working with young children.

2. **Service Needs and Gaps**

- Explore opportunities to re-allocate resources allotted to residential care to community-based treatment alternatives;
- Continue to align authorization procedures and processes with the goals of increasing outpatient and community-based utilization and reducing residential and inpatient utilization;
- Continue to utilize and strengthen additional CT BHP strategies to reduce inpatient overstays through a combination of provider profiling, incentives/penalties, consultative services, development of alternative services, and other management processes such as data and case review of "stuck children;"
- Continue to explore the feasibility of blending DCF/CT BHP funds to convert the Extended Day Treatment Program from a grant-funded to a fee-for-service program;

State of Connecticut
GENERAL ASSEMBLY

Commission on Children

Statement of Commission on Children Chair Emerita Laura Lee Simon at the September 13, 2011 Commission forum, "Connecticut Child Trends: The Ups and Downs"

"Given the harsh and worsening conditions for children and their families, it is more urgent than ever that we rapidly accelerate our efforts to create a holistic, comprehensive, collaborative public and private approach to delivering services - one that would also aggregate funding streams to provide a single entry system for those whose needs have been identified consistent with dealing with the 'whole child' the social, physical, behavioral, and cognitive facets of their development, starting pre-birth.

"CAHS actively promotes economic self-sufficiency. The Commission consistently promotes preventive, proactive public policies - all serving parents and children.

"We and so many others certainly know what NEEDS to be done. Once again it is truly time to concertedly develop the political WILL to do just that. There is absolutely no justification for Connecticut—one of the country's wealthiest states—to suffer the country's highest achievement gap between our haves and have-nots.

"We simply cannot afford to postpone our future."

18-20 Trinity St. Hartford, CT 06106 Phone: (860) 240-0290 Fax: (860) 240-0248 Website: cga.ct.gov/coc

An Examination of Connecticut Child Fatalities
A Ten Year Review
January 1, 2001 to January 1, 2011

Sudden Infant Death
Accidents
Bullying
Fires
Undetermined
Acute Illness
Trauma
Gun Shot Wounds
Hanging
Infant Safe Sleep
Suicide
Overdose
Drowning
Weapons
Substance Use
Teen Driving
Falls
Asthma
Shaken Baby
Risky Behavior
Abuse
Stabbing
Crashes
Homicide
Youth Violence

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Child Fatality Review Panel (CFRP) Membership—2011

EX-OFFICIO MEMBERS

Office of the Child Advocate: Jeanne Milstein, Chairperson
Office of the Chief State's Attorney: Anne Mahoney, Esq.
Office of the Chief Medical Examiner: H. Wayne Carver, M.D.
Department of Emergency Services and Public Protection: Sgt. Seth Mancini, Esq.
Department of Children and Families: Fernando Muniz, M.P.A.
Department of Public Health: Margie Hudson, R.N., M.P.H.

APPOINTED MEMBERS

Yale New Haven Hospital, Pediatrician: Kirsten Bechtel, M.D. by Governor
Public Welfare Practitioner: Richard Dallavalle, by Senate Minority Leader
Community Service Representative: Jane Norgren, M.Ed., M.B.A. by Speaker of the House
Connecticut Children's Medical Center, Pediatrician: Michael Soltis, M.D. by CFRP
Connecticut Coalition Against Domestic Violence: Tonya T. Johnson, by CFRP
Injury Prevention: Russell A. Kimes, Jr., Esq. by House Minority Leader
Psychologist: Kathleen J. Murphy, Ph.D. by House Majority Leader
Law Enforcement: Chief Margaret Ackley, by Senate Pro Tempore
University of Connecticut Health Center, Neonatology: Ted Rosenkrantz, M.D. by CFRP

The Child Fatality Review Panel's "fatality investigations" are public documents and can be obtained from the Office of the Child Advocate upon request. You may also view the reports online (www.ct.gov/oca). Along with the annual child fatality report, there were additional in-depth fatality investigations that were made available to the public over the course of the past decade. The OCA has also participated in numerous other fatality reviews that are posted on the DCF website (www.ct.gov/dcf).

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Dear Friends of Connecticut's Children,

December 2011

The Child Fatality Review Panel (CFRP) is providing you with data and information related to ten years of reviewing deaths of Connecticut's children. The CFRP was first established in 1995, following public outcry over the tragic death of Baby Emily. We have published annual reports summarizing findings on the fatalities of children in the state for over a decade. The CFRP shares this comprehensive report with the hope that the tragedy of these children's deaths will continue to shine the light on critically important prevention initiatives. The loss of any child has untold and incalculable consequences for their families, friends, and community. However, what we learn from these deaths will help us serve and support other children and hopefully prevent further tragedies.

The CFRP reviews deaths of children from birth through age 17 that are unexpected or unexplained, and primarily focuses its investigations on the fatalities of children involved in state systems. This review presents findings of the past decade. We have observed positive trends, such as an overall decrease in the number of suicide deaths, but other negative trends persist, which are discussed in this report. We continue to partner with community providers and other state agencies to bring forth a coherent message about the importance of safe sleeping conditions for infants. Connecticut is side-by-side with most other states across the county working on a safe sleep message.

As chair, I would like to acknowledge the hard work and dedication of the members of the CFRP. I would also like to thank the members of the CFRP who are no longer panel members but who have given so much over the past ten years. We come together each month to endeavor in the difficult task of discussing the deaths of children, always with our eyes towards how we can make a difference for other children and families. I would like to specifically thank Faith Vos Winkel, Assistant Child Advocate, who has provided strong, tireless leadership to the Panel. Her efforts have made the Connecticut CFRP a model for the country.

In recognition of this dedication and commitment, I present to the people of Connecticut this ten-year review by the Child Fatality Review Panel.

On behalf of the panel,

Jeanne Milstein
Chairperson, Connecticut Child Fatality Review Panel

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"If a disease were killing our children at the rate unintentional injuries are, the public would be outraged and demand that this killer be stopped."

C. Everett Koop, MD, ScD
Former United States Surgeon General
Chairman, The National SAFE KIDS Campaign

Dedication

We dedicate this report to the children of Connecticut who have lost their lives through accidents, homicides, suicides, natural causes, and in ways that remain undetermined.

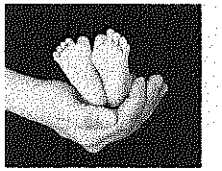
To the families, we are deeply sorry for your loss.

We thank those throughout the state who work tirelessly to protect and serve our young people, and those who positively impact their lives.

To our communities, schools, legislators, media, and the general public, we are grateful for all that you do to prevent childhood injuries and fatalities.

Each of us can make a difference.

Connecticut Child Fatality Review Panel
December 2011



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Introduction

Protecting Children

Concern for the safety and well-being of our children begins even before they are born. Primary prevention begins prior to conception with parents doing all they can do to ensure a healthy outcome for their baby. Certainly after the baby arrives, parents and caregivers endeavor to keep their baby safe. As our children grow, prevention of accidents and injuries remains paramount. Sometimes despite our best efforts, childhood tragedies occur and some children die. In order to understand the best ways to prevent danger and protect children, there must be a thorough understanding of the risk factors contributing to child death and a focused interest in preventing the fatality of any child. Every state in the United States considers the prevention of the death of any child to be of utmost importance. All states across the country, as well as in the countries of Canada and Great Britain have a child death review process. For Connecticut, the Child Fatality Review Panel (CFRP) is responsible for investigating and improving the understanding of the factors involved in the deaths of children in the state. The CFRP uses the expertise of its multidisciplinary panel membership to make recommendations in order to reduce future risk or death to any child.

The Child Fatality Review Panel

Connecticut General Statutes §46-13k established the state's CFRP to review the circumstances surrounding all unexplained or unexpected child deaths. The statutory authority for the CFRP is embedded in the Office of the Child Advocate (OCA) statute. The CFRP reviews a child's death to determine whether there were contributing risk factors that could be impacted by systemic interventions. Identified risk factors are then incorporated into proposed prevention initiatives designed to decrease the incidence of such deaths. As outlined in statute, the goal of the child fatality review process is to "facilitate development of prevention strategies to address identified trends and patterns of risk and to improve coordination of services for children and families in the state". The CFRP reviews all unexplained and unexpected child deaths, but typically conducts a full fatality investigation of deaths where state agencies or state-supported services either were or should have been involved in the child's life. The goal of these investigations is to determine the effectiveness of state programs, and to identify what actions or changes can be made to improve the policies, practices, procedures, or the structure of the programs themselves. The fatality review into the death of Michael B. is an example of the importance of a timely and comprehensive fatality investigation. In May 2010 the OCA released a public report on the homicide of this infant. The report outlined 15 comprehensive recommendations for systemic reform. Throughout the course of the investigation, critical findings were provided to the Department of Children and Families. One of the major findings was related to the long-standing practice of recording reports and investigations of DCF employees in a paper record only, rather than in the Department's electronic database. This practice was halted and a several month process ensued to enter all of those paper records into the database. Other recommendations included improving the recruitment, training, support, and assessment of foster parents, as well as enhancing and expanding family-centered practice to focus on families needing substance abuse and mental health treatment.

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The Child Fatality Review Panel works closely with the Office of the Chief Medical Examiner (OCME). The OCME determines the manner (Natural, Accidental, Homicide, Suicide, or Undetermined) and cause of death. Connecticut's medical examiner system has all Board Certified Forensic Pathologists, thereby ensuring a robust forensic examination of child fatality cases that fall under their purview. The OCME provides the OCA/CFRP with timely notice of child deaths as outlined in statute. The CFRP publishes an annual report, which is a section in the OCA annual report. These reports offer a brief analysis of child deaths that occurred in a twelve-month period. Information for these reports, as well as this ten-year review, came from the OCA fatality database that was designed in 2001. Unfortunately, that child fatality data collection system has not been upgraded in nearly a decade. Therefore, some trend data require hand counting. Nevertheless, the database remains a good source of information as it contains all records for this ten year reporting period.

A National Initiative

In response to a report by the United States Office of Government Accountability, the United States House of Representatives held a hearing in July 2011 on the issue of child maltreatment deaths. The primary recommendation from that report was "to improve the comprehensiveness, quality, and use of national data on child fatalities from maltreatment" *(www.gao.gov/products/GAO-11-599)*. Recently, the OCA began entering child fatality data on a secure national server sponsored by the National Center for the Review and Prevention of Child Deaths. This data system is funded by the U.S. Health and Human Services Administration and the Centers for Disease Control and Prevention (CDC). At present, nearly 100,000 cases have been entered from 37 states participating in this effort. Compiling comprehensive child fatality data on this system will help to more accurately identify state and national trends in child death. The National Center also serves as the clearinghouse for child death trends and public policy initiatives related to child fatality issues (*www.childdeathreview.org*). Connecticut has been involved in many national events surrounding child fatality policy. The National Center and the CDC utilized data collected from 18 states on sudden infant death to support the development of a sudden infant death registry; Connecticut's data was part of that project and will help to shape ongoing policy and practice related to infant death.

Connecticut Child Deaths

In Connecticut, for the ten year period from January 1, 2001 to January 1, 2011, the CFRP reviewed the deaths of 1,529 children.

Natural Deaths=840
Accidental Deaths=400
Homicide Deaths=106
Undetermined Deaths=106
Suicide Deaths=77

Footnote: The 1,529 death does not include 5 out-of-state deaths and 2 cases that remain pending further study. The CFRP does not typically review the deaths of infants that survive less than 24-hours after birth due to the sheer volume of those infants; nearly all of these deaths are from complications associated with premature birth. In 2010, 242 infant and fetal deaths were reported to the OCA.

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Ten Year Overview

The categories below provide a brief overview of the child deaths over the past decade. Each classification is more thoroughly explained and examined throughout the report.

Natural *deaths of children, as with all age groups, accounted for the largest percentage of fatalities for each year. Over the past decade, the CFRP reviewed 840 natural child deaths. However, this is not representative of all natural child deaths in the state. It excludes many natural deaths from cancer, complex heart conditions, chronic health conditions, asthma, complications associated with prematurity, and other acute illnesses. The CFRP does not conduct a thorough review of most of these natural deaths with the exception of Sudden Unexplained Infant Death (SUID)/ Sudden Infant Death Syndrome (SIDS) cases.*

Accidental *deaths of children are the second leading manner of death in children as well as in people across the life span. Over the past decade, the CFRP reviewed 400 accidental child deaths. Often, accidental deaths are the leading cause of "preventable" death. Examples of accidental deaths include drowning, falls, and motor vehicle crashes. Automobile related fatalities account for over half of the accidental deaths. Overall, the incidence of accidental deaths has decreased in ten years. In 2001, accidents caused 31% of child deaths reviewed by the CFRP. In 2010, accidents accounted for 20% of child deaths reviewed.*

Homicide *deaths represent the leading cause of intentional injuries of children. During the ten year period, homicides accounted for 106 child deaths in Connecticut. In 2001 and 2004 homicide accounted for 7% of child fatalities. While the number of child homicides peaked in 2006, it has not decreased to a level below that of 2001. Overall, child homicide rates are not significantly different today than they were ten years ago.*

Undetermined *deaths of children have increased in the past decade. This is largely due to the examination of infant deaths more closely, with a particular focus on the scene. Over the past decade, the CFRP reviewed 106 Undetermined child deaths. Many of these deaths no longer fit into the SIDS category, and instead fall into an undetermined manner of death. In fact, 73% of the undetermined deaths were among infants.*

Suicide *deaths accounted for the lowest number of child fatalities in Connecticut. Over the past decade the CFRP reviewed 77 child-youth suicides. Suicides represented 9% of child fatalities in 2001 and 2% in 2010. While it is typically teenagers who die by suicide and youth suicide has been considered a 'teen' issue, children as young as 10 years old have died by suicide.*

"The most important reason to review child deaths is to improve the health and safety of children and to prevent other children from dying."

Michigan Public Health institute

Natural Deaths

The CFRP reviewed 840 natural deaths over the past decade. Children with heart disease, cancer, medically complex conditions, and complications associated with prematurity accounted for nearly 50% of those natural deaths reviewed. Another 117 cases were classified as Sudden Infant Death Syndrome (SIDS). A great deal of focus and prevention efforts have been on the SIDS cases. SIDS had historically been associated with a natural manner of death. However, the Centers for Disease Control and Prevention (CDC) has put forth a more comprehensive sudden infant death protocol. According to the CDC, "*each year in the United States, more than 4,500 infants die suddenly of no obvious cause. Half of these Sudden Unexplained Infant Death (SUIDs) are due to Sudden Infant Death Syndrome (SIDS), the leading cause of SUIDs and of deaths among infants aged 1 month to 1 year. Only sudden infant deaths that remain unexplained after a thorough examination of the death scene, a review of the clinical history, and an autopsy should be classified as SIDS. However, since 1999, some deaths due to SIDS are classified as due to an unknown cause or to accidental suffocation. Inaccurate or inconsistent classification of causes of infant deaths impedes prevention efforts because researchers cannot monitor national trends, determine risk factors, or evaluate prevention programs*". Connecticut, along with many other states is working to implement a model similar to what is recommended by the CDC *(www.cdc.gov/SIDS)*.

Overall, the percentage of SIDS deaths per year has shown a downward trend which has not translated into an overall decline in infant deaths. There is speculation that the decrease in the diagnosis of SIDS is a result of the increased awareness of the importance of safe sleeping conditions for young children such as the 'Back to Sleep' campaign promoted by the American Academy of Pediatrics. The CFRP has focused on spreading the message that the safest place for an infant to sleep is on his back and in his own sleep environment. In June 2011, the Keeping Infants Safe and Secure (KISS) committee hosted an invitation-only safe sleep forum. Over 100 attendees heard state and national leaders speak on the issue of infant sleep environment. The primary purpose of the event was to begin to lay the groundwork for a statewide safe sleep message.

149 Infant Deaths

86 Boys
63 Girls
54 White
53 Black
30 Hispanic/White
5 Asian-Indian
2 Black Hispanic
1 Asian-other
4 no race identified

The infants were from 46 towns, with New Haven, Harford, Waterbury, Bridgeport, and Stamford accounting for over 40% of cases.

The OCA staff, along with graduate forensic nursing students and graduate social work students, conducted a small research study focusing on 149 infants who died between 2002-2010 and were identified as having one or more risk factors associated with an unsafe sleep environment at the time of their death. Over 100 of the cases reviewed were infants under 5 months of age. The study revealed that these babies were in unsafe sleep environments including in bed with adults, in bed with other children, and in bed with adult pillows, toys, comforters, stuffed animals and other items.

The study suggested that the safest place for a baby is in his or her own bassinet, crib, or pack and play with *nothing* else. Soft items like blankets, pillows, stuffed animals or bumpers are especially hazardous. This safe sleep message is in keeping with the recent guidelines established by the American Academy of Pediatrics *(www.aap.org)*.

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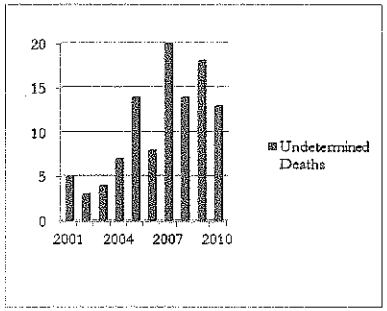
Undetermined Deaths

For children who died in a manner that remains "Undetermined" there was not enough evidence to conclude disease, suicide, accident or homicide. Of the 106 child deaths that were classified as "undetermined" over the past decade, 73% were infants. These deaths coupled with the Sudden Infant Death Syndrome (SIDS) or Sudden Unexplained Infant Death (SUID) deaths occupy a significant focus for the CFRP. The number of undetermined deaths per year has increased over the course of the decade most likely as a direct correlation to the decrease in the diagnosis of SIDS. The focus on these SUID and SIDS deaths has been a concern in Connecticut as well as across the country.



Nationally, there has been a great deal of attention by the CDC, and the U.S. Department of Health and Human Services Maternal Child Health Bureau on Sudden Unexplained Infant Deaths (SUID). Currently, about a dozen states receive funding related to SUID and the collection of comprehensive data so that a more targeted national prevention initiative can be developed to reduce SUID death rates. The SUID database is a critical component to prevention efforts related to infant fatalities and will help us understand more fully how these babies die. In nearly all other types of fatalities, a robust death scene review occurs. However, for infants there is a "scoop and run" philosophy; first responders try to get the baby to the hospital as soon as possible. While this is a laudable effort, specific scene information is sometimes overlooked. There is tremendous inconsistency across the nation and in the state as to whether investigators return to the scene to obtain critical information. In 2004, the CDC trained a team in every state to begin to work closely with first responders examining the position of the found infant, the contents of sleep environment, and which parent or caregiver was the last person to put the baby to sleep, or see the baby alive. Gathering detailed information and supporting statewide efforts on the importance of infant death scene investigation is a critically important issue and various initiatives will continue.

Recommendations

* **Continue collaborative efforts to establish a statewide infant safe sleep message, reinforcing the "back to sleep" campaign.**
* **Support the recently released American Academy of Pediatric Infant Guidelines.**
* **Explore the feasibility of obtaining additional funding related to the SUID database.**
* **Collaborate with state and local officials to ensure the utilization of a standard infant death scene protocol.**

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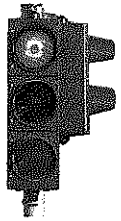
Accidental Deaths



Accidents or unintentional injuries are the leading manner of preventable death, both in Connecticut and across the nation. During this ten year period, injuries from accidents caused 400 child fatalities in this state. While the deaths per year showed an up-and-down trend over the decade, there has been an overall decrease in accidental deaths of children since 2007. Nevertheless, accidental deaths still accounted for a substantial number of child deaths.

400 Accidental Deaths

Motor vehicle accidents=214

Drowning=67

Asphyxia=27

Fires=20

Drug Overdose=19

Other=53 (choking, falls, poisoning, electrocutions, gun shot wounds, ATV crashes, objects falling, etc.)

Motor Vehicles

Motor vehicle crashes are the leading cause of unintentional injury deaths in Connecticut for people ages 1-44 and it is the leading cause of death for children. These motor vehicle fatalities account for over half of all accidental deaths of children. In 2000, 6,466 American children of all ages died in automobile accidents *(The National Resource Center for Child Death Review)*. In Connecticut, motor vehicles caused 54% of accidental child fatalities. The number of motor vehicle deaths was highest in the early part of the decade, with annual incidence between 25 to 27 deaths per year through 2004. After a sharp decline to 17 deaths in 2005, the number increased again through 2007. However, the number of motor vehicle accident deaths has been on a general decline since then. The deaths were categorized based on the role of the child in the accident whether the deceased was a teenage driver, passenger, or pedestrian (including bicyclists and skateboarders). For a small percentage of the children, their role could not be determined based on the circumstances of the accidents.

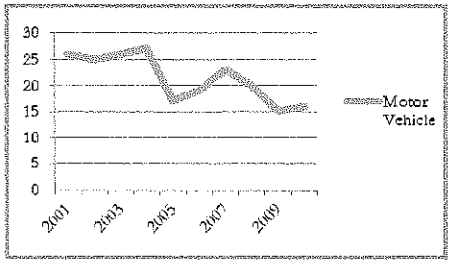
Child Motor Vehicle Deaths

Passengers=45%

Driver=30%

Pedestrians=23%

Other=2%



Race

70% White

12% Black

10% Hispanic

3% Asian

5% not recorded

The loss of these children from motor vehicle crashes is devastating to families, friends and communities. The cost associated with these crashes has both incalculable costs and finite cost. According to the Children's Safety Network, Connecticut's "average cost per case of unintentional motor vehicle traffic death for children ages 0-14 was approximately $2.2 million in 2002-2006 (in 2008 dollars) compared to the national average cost per case of $1.5 million" *(www.childrensSafetyNetwork.org)*. The implications for these numbers cut across public policy and prevention efforts and require further study.

Teen driving fatalities remain a significant concern. The enforcement of existing graduated driving licensing laws remains a challenge. The majority (58%) of the children who died in motor vehicle accidents were 16 or17 years old. Fourteen percent of the children were between 0-4 years of age, 10% were between 5-8 years of age, and 18% were between 9-15 years old. To address the significant concerns about teen driving fatalities the first iteration of a graduated drivers license was passed in 1996 with the latest modification to the law in 2008. The law has subsequently been modified to address gaps in licensing restrictions for new teen drivers. Under the new law *(CGS 14-36g)* teen drivers must first pass a 25 question test to obtain their learner's permit, they must have their permits for a longer period of time before getting their license (120 days if enrolled in a driving school or 180 days if taught at home), they must wait twelve months to drive non-family passengers, and there is a restriction on driving between 11pm and 5am. In October 2011, the Commissioner of the Department of Motor Vehicles formed an advisory committee to continue policy work on teen driving safety.

Connecticut is also the only state that allows police to seize a teen's license and issue an immediate on-the-spot 48-hour license suspension *(www.ct.gov/teendriving)*. The goal of this law was to decrease the number of accidents and deaths caused and associated with young, inexperienced drivers. States with teen licensing laws that are rated as "good" are associated with a 30% decrease in fatal car crashes among 16-17 year old drivers *(Insurance Institute for Highway Safety: Highway Loss Data Institute, Teenagers- Graduated Licensing)*. Connecticut's rating is good, and since the 2008 iteration of the graduated licensing law, there has been a decrease in the number of motor vehicle deaths among children per year. However, with just two years of data since the law most recent change, further surveillance will be needed to discern any meaningful impact. Key injury prevention researchers affiliated with The Injury Prevention Center at Connecticut Children's Medical Center looked at the impact of the Connecticut graduated drivers licensing system on teenage motor vehicle crashes. This study examined data from 1999-2008, and determined that the motor vehicle crash rate decreased by 40% for 16 year old drivers and 30% for 17 year olds drivers *(http://journals.lww.com/jtrauma/abstract/2011/110020)*.

Even with fewer motor vehicle fatalities among new drivers, a higher percentage of yearly deaths related to motor vehicle accidents were with the 16 and 17 year olds in 2009 than in 2001. One issue among young passengers is seat belt use; 9.4% of Connecticut high school students reported that they rarely or never wore a seat belt while riding in a car driven by someone else *(Connecticut Youth Behavior Component Executive Summary, 2009)*. Alcohol use among both young passengers and drivers is also a significant problem, with 26.7% of high school students reporting that they had ridden in a car operated by someone who had consumed alcohol. Nearly 9% of teens reported that they had driven a car when drinking alcohol. While underage drinking is illegal, it is clear that it is still occurring frequently among youth in our state. The combination of inexperienced drivers and alcohol can make for a dangerous situation behind the wheel. The CFRP has seen all of the factors listed above come into play in the review of these motor vehicle deaths.

Recommendations

* **Continue to inform statewide prevention efforts of all accidental deaths including partnerships with primary prevention providers.**

* **Work with stakeholders to continue to monitor trends in teen driving laws.**

Drowning

Drowning accounted for 67 child deaths in Connecticut in the past decade. Drowning deaths are preventable deaths. Since the eight drowning deaths in 2007, the number per year has been on the decline. The type of drowning accident is generally dependent on the age and gender of the child. Infants can drown in just one inch of water, and most often die when left unattended, even for just a moment, in bathtubs. Toddlers are at the highest risk for drowning because they are often curious near bodies of water, such as pools, but most do not yet know how to swim or understand the dangers of water. It is also reported that toddlers often drown silently, rather than shouting for help or splashing for attention and older children are more likely to drown in unsupervised swimming areas *(National MCH Center for Child Death Review: Drowning Fact Sheet)*. In July of 2011, the OCA partnered with the Connecticut Children's Medical Center and other community partners to bring attention to summer safety tips for families. Drowning was part of that initiative. Efforts to disseminate summer safety tips will continue.

Drowning Deaths of Children

Environment

54% died in natural bodies of water (lakes, rivers, streams, reservoirs)

37% died in pools or hot tubs

9% died in bathtubs

Gender

73% of the drowning victims were boys

27% were girls

Age

40% were 0-4 years old

16% were 5-9 years old

23% were 10-14 years old

21% were 15-17 years old

Asphyxia

This report has already discussed infant deaths in the natural and undetermined categories, infant death is also a concern in the accidental death category. Of the 27 children who died as a result of accidental asphyxia, 17 were infants who were determined to be in unsafe sleep environments. Five other children died from a combination of some type of cord getting wrapped around their neck and playing with plastic. The remaining 5 accidental asphyxia deaths were teenagers engaged in risky behavior that unfortunately ended in tragedy.

Fire

Accidental fires accounted for 20 deaths of children. These fatalities occurred in 12 separate fires. In 7 of the fires there were multiple fatalities including 6 adults. There were no accidental deaths from fires in 2003 or in 2008. Causes of these fires vary and include playing with matches, some electrical/wiring issues, faulty or non existent smoke detectors, or batteries that were removed from smoke detectors. Of the children that died, 12 were Black, 4 White, 3 Asian, and 1 Hispanic. Of the 12 fires, Bridgeport had 4 accidental fires all of which involved multiple fatalities; no other town had multiple accidental fires. Nine of the fires occurred between the months of November to March.

Recommendation

* **Continue collaborative efforts related to all child safety initiatives and other public awareness campaigns that keep the focus on safety as the first step in preventing injury and death.**

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Overdose

Accidental drug overdoses accounted for the deaths of 19 children over the age of 13 in the past decade. It is also important to note that these numbers do not include drug over doses categorized by the medical examiner as an undetermined manner. In those cases clear evidence did not exist that the overdose was either accidental or intentional. Over half of deaths from accidental overdose occurred among 17-year-old white males. One-third of the deaths involved use of heroin. In 2004, the Office of Child Advocate (OCA) conducted a comprehensive fatality investigation regarding the drug overdose death of Makayla. Three days before she died, 16 year old Makayla had been drinking alcohol at a party and later took the drug Ecstasy. In the hospital, she suffered seizures that would not stop, before she died she had gained forty pounds from fluid build up as her liver and kidneys ceased to function. Makayla's mother held her and rocked her until her daughters heart stopped beating. The investigative report outlined specific policy recommendations related to schools, health care providers, community based therapies, psychiatric care providers, out-patient services, public safety authorities and public policy makers.

"Parents can prevent their children from using drugs by talking to them about drugs, open communication, role modeling responsible behavior, and recognizing if problems are developing."

American Academy of Child & Adolescent Psychiatry: Teen, Alcohol and Other Drugs.

While efforts to implement many of the recommendations have been ongoing, specifically related to trauma informed treatment, understanding the complexity of adolescent mental health, and adolescent brain development, more needs to be done based upon what the youth are reporting about themselves. According to the 2009 Connecticut School Health Survey Youth Behavior Component, "an estimated 36,000 high school students had used marijuana one or more times during the 30 days before the survey ...an estimated 8,800 had used any form of cocaine one or more times during their life ...an estimated 18,000 high school students had sniffed glue, breathed the contents of aerosol spray cans, or inhaled any paints or sprays to get high ...and an estimated 8,300 had used ecstasy one or more times during their life ...3.2% of high school student had used heroin one or more times during their life ...and 3.3% of high school students had used methamphetamines one or more time during their life" *(www.ct.gov/dph or www.ct.gov/sde/healthconnections).* The information provided in the survey by the youth themselves is a primary indication that teenage drug use and the potential for overdose is significant. Additionally, significant concerns exist regarding the abuse of prescription medication for teenagers. The Partnership for a Drug Free American recently reported that "1 out of every 5 teenagers has abused a prescription pain killer and most believe that since these drugs are prescription drugs, they are safe" *(www.drugfree.org).*

Recommendations

* **Support statewide efforts to reduce and eliminate illicit substance use among children and teens.**
* **Encourage strong partnerships to reduce underage drinking, binge drinking and prescription drug abuse.**
* **Explore the establishment of a working group to analyze the per case cost of motor vehicle fatalities.**

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Homicide Deaths

Homicides accounted for 1,363 child deaths in the United States in 2008 *(The U.S. Census Bureau, Statistical Abstract of the United States)*. In general, children who are victims of homicide most often die from injuries associated with either gunshot or stab wounds, head trauma from abuse, or strangulation. In the past decade, 106 Connecticut children have died as a result of homicide. Child homicide data is analyzed by age cohort: children 12 and younger and teenagers 13 and older. Because these two groups represent different patterns of homicide, and risk and protective factors vary, they are analyzed separately.

All Homicides

Race

White=53%

Black=24%

Hispanic=18%

Other=5%

Gender

62%=boys

38%=girls

Young Children

Death by homicide accounted for 54 intentional deaths of children ages 12 or younger. For most of these children, their death is the tragic consequence of abuse and neglect. Among this group, homicide is most often at the hand of a known perpetrator who is a family member or friend. It is a rare occurrence for a young child to be killed by a stranger. Nearly all of the children in the past decade had an identified known perpetrator. The exception was the 2005 homicides by fire of two young children and their mother in Bridgeport, no perpetrator has been identified and the Cheshire homicides by home invaders in 2007. The geographic distribution for this age group represents over 30 different communities in Connecticut.

Mechanism

Abusive Trauma=66%
(blunt force & head trauma)

Penetrating Trauma=17%
(gun shot wounds & stabbing)

Fire=5%

Drowning=4%

Strangulation=4%

Hyperthermia=2%

Other=2%

Over the past decade data shows an increase in annual deaths among children under 12 that peaked in 2006. Seventy-three percent of the children 12 and under who died as a result of homicide were 2 years old or younger. The average age at death was 4.8 years. The majority of children died as a result of blunt force trauma. Some children who suffered Shaken Baby Syndrome/Abusive Head Trauma died years later as a consequence of the effects of those injuries.

Recommendations

* **Continue statewide efforts to prevent abusive head trauma and other forms of child abuse.**
* **The CFRP will work in collaboration with the Domestic Violence Fatality Review Committee to strengthen the review process for children who are victims, witnesses, or directly impacted by domestic violence fatalities.**

Children Under 2

About three-quarters of children under 2 years-old died as result of blunt force trauma. The vast majority of the homicides were perpetrated by individuals who knew the children. The perpetrators were most often relatives of the victim, or otherwise intimately involved with the child's family. The most common perpetrators were fathers, followed by boyfriends and ex-boyfriends of mothers, which is consistent with the national data on child homicide perpetrators *(www.childwelfare.gov).* Fourteen-percent of the homicides had companion cases, which is to say that there was another victim of homicide as well. These companion cases involved domestic violence and in all of those cases it was the mother of the child(ren) that was killed.

Teenagers

Fifty-two (52) children between 13 and 17 years of age died as a result of homicide in Connecticut over the past decade with the number increasing substantially as the age increases from 15 to 17. Forty-four percent of the deaths in this category were 17-year-olds, 36% 16-year-olds, and 10% were 15-year-olds. Four percent of the children died at age 14, and 6% at age 13. This pattern matches the national trend of children most likely to be victims of homicide before age 1, and then again at ages 16 and17 *(Trends in the Murder of Juveniles: 1980-2000 OJJDP Bulletin, September).* Forty-five boys that died from homicide, 37 of those boys died from gun shot wounds, 7 were stabbed to death, and 1 was intentionally run-over by a vehicle. Nationally, as well as in Connecticut, homicide in this age group is considered a major concern for Black and Hispanic males, their families, and their communities. The State of Connecticut matches the national trend of higher homicides among the 13-17 grouping occurring in urban communities. *(Homicides of Children and Youth, OJJDP Bulletin, October 2001, www.OJJDP.gov).*

These homicides are often precipitated by arguments and fighting between people who know each other. According to the 2009 Connecticut School Health Survey, "28.3% of high school students had been in a physical fight one or more times during the 12 months before the survey ...an estimated 6,500 high school students carried a weapon (gun, knife, or club) on school property on the least 1 of the 30 days before the survey."

Teenagers

Race

Black=61%

Hispanic=25%

White=14%

Gender

Boys=87%

Girls=13%

Urban Geographic Distribution

Over 60% of the teen homicides are from 3 urban communities: New Haven, Hartford, and Bridgeport

Recommendations

* **Support efforts for positive ways for youth to deal with anger. (www.cdc.gov).**
* **Continue statewide efforts to prevent abusive head trauma stemming from abuse in infants and children.**
* **Support efforts related to stemming youth violence and access to weapons.**

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Suicide Deaths

Suicide deaths per year have decreased in the past decade. While the three suicides in 2010 compared to the fifteen suicides in 2001 certainly shows progress in the field, it is important to note that there has been significant fluctuation with these numbers increasing and decreasing over the years. Continued work and attention to this issue will be necessary in order to continue the downward trend visible since 2008. Over the past decade the CFRP/OCA has been involved with a variety of statewide suicide prevention initiatives including the Youth Suicide Advisory Board, the Interagency Suicide Prevention Network, and the Garret Lee Smith Suicide Prevention Grant. Activities included youth specific training, public education, screening and brief intervention activities, as well as coalition building in various communities.

Youth Suicide

In Connecticut...

74% =hanging

14% =weapon

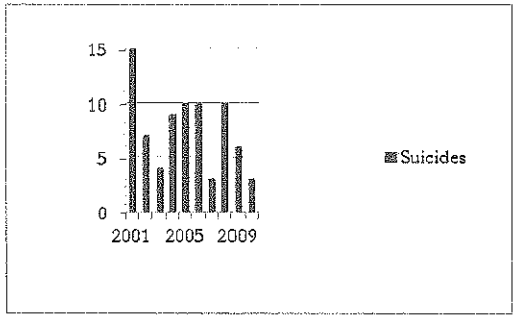
8%=drug overdose

4% =other means

In Connecticut, as well as nationally, girls attempt suicide more often, but males are four times more likely to actually die by suicide (*The National Resource Center for Child Death Review*). Correspondingly, in Connecticut 69% of the child suicides were male compared to 31% female. White children accounted for 77% of the child suicides, with Black children at 16%, Hispanic 5%, and Asian 3%. The CDC reports that on the national level, "Native American/Alaskan Native and Hispanic youth [have] the highest rates of suicide-related fatalities and Hispanic youth [are] more likely to report attempting suicide than their Black and White peers" (*Youth Suicide: www.cdc.gov*). Over the ten years, November was the most common month for suicides to occur, followed by June and October.

For youth, risk factors or stressful events that may increase the potential for greater suicidal behavior include hopelessness, impulsivity or aggressive tendencies, trauma, abuse, and relational or social loss. Protective factors, or things that help keep youth safe include strong connections to families and others, access to clinical supports and services, restricting lethal means, a positive belief about the future, and skills in problem solving (*Suicide Prevention Resource, www.2.sprc.org and the National Suicide Prevention Strategy at www.samhsa.gov/prevention/suicide*).

In January 2003, the investigative report regarding the suicide death of 12 year old Joseph Daniel was released. Even prior to the release of this report, transformative public policy efforts began with the first iteration of anti-bullying legislation. Further policy changes occurred regarding school truancy, and other safety nets that failed this child (*www.ct.gov/oca*).



The issue of bullying among school children has moved to the forefront of public consciousness following the tragic suicides of some American teenagers after serious bullying incidents came to light. Dr. Ken Rigby refers to this type of bullying as "bullycide" *(www.education.unisa.edu.au/bullying)*. Research indicates that some groups may be at greater risk for being bullied such as children with disabilities, children who are overweight, children experiencing discrimination due to their gender identity, children who are gay, lesbian, bi-sexual, transgendered, or questioning, and children whose culture and heritage may be different than their peers. In Connecticut, Public Act 11-232 passed in 2011 strengthening current anti-bullying laws.

CT Public Act 11-232, School Bullying Laws (July 2011)

The expansion of current anti-bullying laws was signed by Governor Dannel Malloy on July 13, 2011. The strengthened state law speeds school response, expands staff training, makes all public school employees mandated reporters of bullying, addresses cyberbullying and launches statewide school climate assessments.

Bullying has been identified as a risk factor for suicide among youth in Connecticut. Over 25% percent of Connecticut high school students reported having been bullied on school property *(Connecticut Youth Behavior Component Executive Summary, 2011)*. While this is already a high statistic, it does not include bullying that might have occurred off-campus, including online. Over 900,000 high school students across the country reported having been cyberbullied within one year *(Commission on Children, Anti-Bullying Bill Becomes Law, July 18, 2011)*.

Protective factors are critical to keep Connecticut youth safe. Strong and positive connections to others, feeling safe at school or in the community can help prevent teen suicide *(National Center for Child Death Review- Suicide Fact Sheet)*. Many Connecticut schools appear to be aligning with these protection factors. An increased focus on school climate, ensuring that students feel safe and accepted at school and with the important new provisions of the anti-bullying law, Connecticut has the ingredients necessary to eradicate the epidemic of bullying behavior *(Connecticut's Bullying Prevention & School Climate Law: Policy Checklist for Educators, Parents and Students)*.

Recommendations

* **Continue statewide partnerships with the Connecticut Youth Suicide Advisory Board, the Interagency Suicide Prevention Network, and the Garret Lee Smith initiative, to promote training initiatives, and other primary prevention efforts.**
* **Work with key community stakeholders to support public education and awareness efforts to reduce the risk of suicide.**
* **Initiate efforts to capture and analyze suicide attempt data.**
* **Secure statewide suicide attempt data as a critical component in monitoring for trends in suicide deaths.**

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Summary

Trends of child deaths may rise and fall from year to year. While the overall number of suicides have been had an up and down pattern, in a 6- week period between late October and December 2011, Connecticut tragically lost five youth to suicide; this surpasses all suicide deaths in 2010. We need to keep working at all levels and maintain a vigilance in all aspects of child death review; ultimately one preventable death is one too many.

The recommendations included in this report outline a beginning strategy to protect children. In the meantime all Connecticut citizens share an obligation to keep children safe and to work together in partnership to do everything possible to put and keep comprehensive prevention initiatives at the forefront of our conversations about risks to children. After all, they are our future.

It is with deep gratitude that we would like to extend a heartfelt thank you to everyone who contributed to this ten year report.

To the content experts near and far, thank you.

To the readers who reviewed this report over and over and offered incredible comments; thank you as well.

To the Office of Governmental Accountability for the printing of this document.

We are grateful to each of you for your time and talent.

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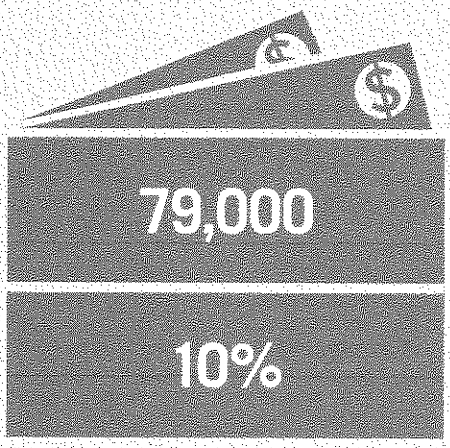
2011 KIDS COUNT® Data Book

The Annie E. Casey Foundation

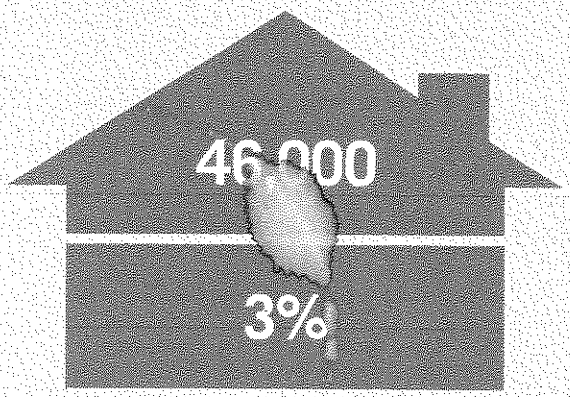
Connecticut

The recession hit vulnerable families hard, and unemployment and foreclosure starts remain high. In 2010, 11 percent of children in the U.S. had at least one unemployed parent and 4 percent have been affected by foreclosure since 2007. It is critical that we address these economic challenges to ensure the well-being of children, families, and the nation.

Find more State and community-level data at The KIDS COUNT Data Center datacenter.kidscount.org/CT



Children With at Least One Unemployed Parent: 2010



Children Affected by Foreclosure Since 2007

Find more information and the definitions and data sources for indicators at datacenter.kidscount.org/databook/2011

2011 KIDS COUNT Data Book

The Annie E. Casey Foundation

Connecticut

6
OVERALL RANK

4	3	1
IMPROVED	WORSENED	UNCHANGED

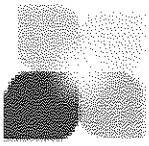
KEY INDICATORS	STATE TREND			NATIONAL TREND			NATIONAL RANK
Percent low-birthweight babies	2000	7.4	8%	2000	7.6	8%	21
	2008	8.0		2008	8.2		
Infant mortality rate (deaths per 1,000 live births)	2000	6.6	0%	2000	6.9	-1%	22
	2007	6.6		2007	6.8		
Child death rate (deaths per 100,000 children ages 1–14)	2000	15	-20%	2000	22	-14%	3
	2007	12		2007	19		
Teen death rate (deaths per 100,000 teens ages 15–19)	2000	47	-6%	2000	67	-7%	7
	2007	44		2007	62		
Teen birth rate (births per 1,000 females ages 15–19)	2000	31	-26%	2000	48	-15%	4
	2008	23		2008	41		
Percent of teens not in school and not high school graduates (ages 16–19)	2000	11	-64%	2000	11	-45%	3
	2009	4		2009	6		
Percent of teens not attending school and not working (ages 16–19)	2000	N.A.	—	2000	N.A.	—	2
	2009	6		2009	9		
Percent of children living in families where no parent has full-time, year-round employment	2000	N.A.	—	2000	N.A.	—	13
	2009	26		2009	31		
Percent of children in poverty (income below $21,756 for a family of two adults and two children in 2009)	2000	11	9%	2000	17	18%	2
	2009	12		2009	20		
Percent of children in single-parent families	2000	27	11%	2000	31	10%	12
	2009	30		2009	34		

PERCENT CHANGE OVER TIME

GETTING BETTER | GETTING WORSE

Find more state and community-level data at the KIDS COUNT Data Center: datacenter.kidscount.org/CT

N.A.: Comparable data not available for 2000 for these indicators. Find more information and the definitions and data sources for indicators at: datacenter.kidscount.org/databook/2011



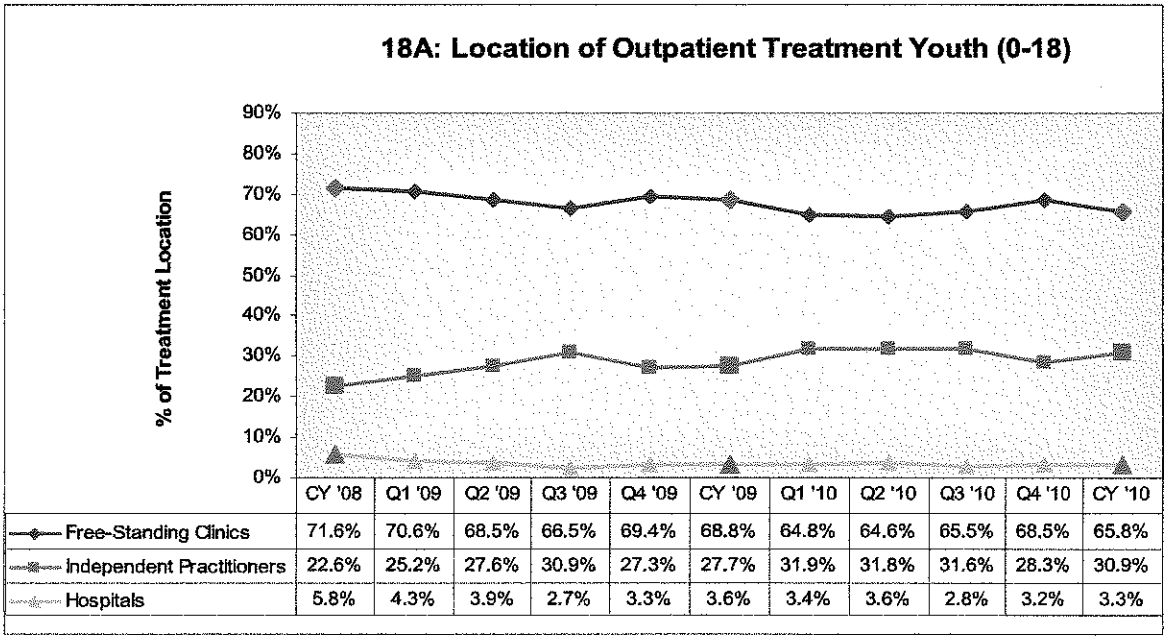
Connecticut BHP
Supporting Health and Recovery

The Connecticut Behavioral Health Partnership

2010 Quality Management Program Evaluation

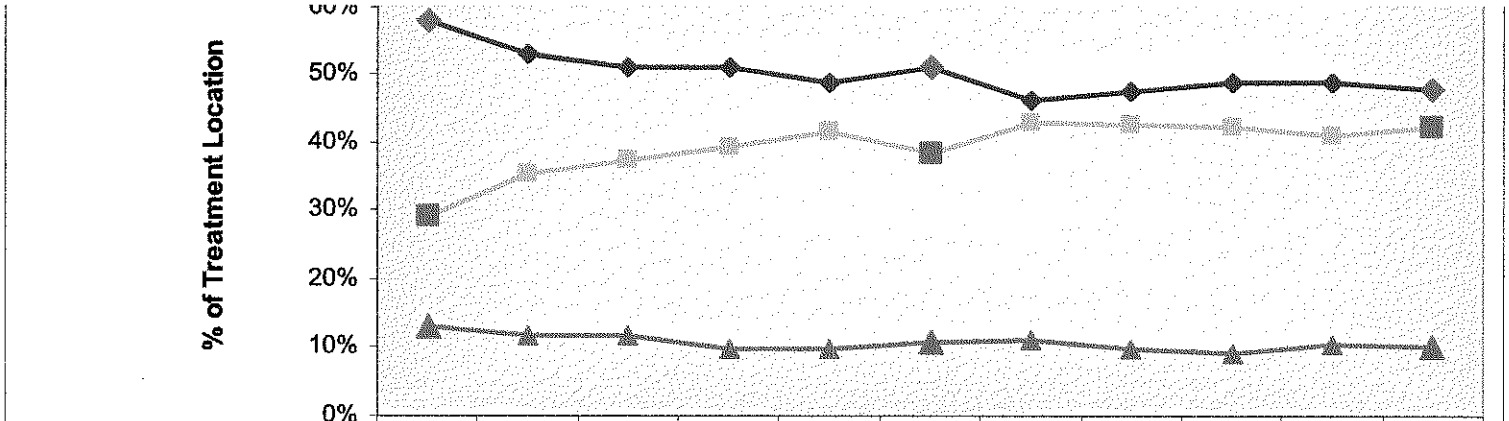
11% increase in the combined youth and adult evaluations in CY 2010 compared to CY 2009 (39,807). There was a 9.9% increase in CY 2010 (24,890) of the youth outpatient registrations compared to CY 2009 (22,654). Adults had an even greater increase than the youth CY 2010 with a 12.4% increase in evaluations from CY 2010. It is believed that the increase in outpatient treatment registrations corresponds to the increase in membership.

There was an increase of outpatient services cases for all youth and adults in CY 2010. CY 2009 reported 77,066 cases and CY 2010 reported 88,610 for a 15% increase. Consistent with the evaluation data there was an increase in both youth cases and adult outpatient cases in CY2010. Youth outpatient cases reported a 13.4% increase CY 2010 (51,084) from CY 2009 (45,042). There was also a large increase in the adult cases in CY 2010 (37,526) with a 17.2% increase from CY 2009 (32,024). Again, this is most likely related to the increase in the membership.



	CY '08	Q1 '09	Q2 '09	Q3 '09	Q4 '09	CY '09	Q1 '10	Q2 '10	Q3 '10	Q4 '10	CY '10
Free-Standing Clinics	71.6%	70.6%	68.5%	66.5%	69.4%	68.8%	64.8%	64.6%	65.5%	68.5%	65.8%
Independent Practitioners	22.6%	25.2%	27.6%	30.9%	27.3%	27.7%	31.9%	31.8%	31.6%	28.3%	30.9%
Hospitals	5.8%	4.3%	3.9%	2.7%	3.3%	3.6%	3.4%	3.6%	2.8%	3.2%	3.3%

In terms of the location of the outpatient treatment of HUSKY youth, the rate of registration in Free-Standing Clinics increased over the four quarters of 2010, whereas Independent Practitioners and Hospitals percentage of outpatient treatment registrations has been flat.



	CY '08	Q1 '09	Q2 '09	Q3 '09	Q4 '09	CY '09	Q1 '10	Q2 '10	Q3 '10	Q4 '10	CY '10
Free-Standing Clinics	57.9%	53.0%	51.1%	50.9%	48.7%	50.9%	46.2%	47.6%	48.8%	48.7%	47.8%
Independent Practitioners	29.0%	35.2%	37.2%	39.3%	41.4%	38.4%	42.8%	42.6%	42.0%	40.9%	42.1%
Hospitals	13.1%	11.7%	11.7%	9.8%	9.9%	10.7%	11.0%	9.8%	9.2%	10.4%	10.1%

Regarding the location of new registrations for outpatient treatment of adults, independent practitioners have seen a fairly steady increase in the number of adult outpatient treatment registrations within the last two years, with Free-standing clinics slowly declining and Hospitals maintaining a flat rate.

Total Number of Evaluations
ECC vs. FSC

Goal 16. Measure network adequacy; support Departments in maintaining adequate Provider Network to ensure member access (Contract Reference N.5.1.4)

A. Number of network providers by degree type
B. % of members with access to each provider type in each county within appropriate radius
C. Density ratios of providers to members

This goal has been suspended since 2007 when it was discovered that counts of network providers were significantly inflated as a result of outdated information in the data uploaded from the state into the ProviderConnect system. Assessment of these indicators will resume when the data are corrected and more accurate assessment becomes available.

Recommendations for continuing sub-Goal in 2011:
With the new contract, this sub-goal may be applicable for 2011 and should be included in the 2011 Workplan.

Goal 17. Maintain the Provider Analysis and Reporting (PARs) Initiatives for Inpatient Child and Adolescent, Enhanced Care Clinics and Psychiatric Residential Treatment Facilities (PRTF) Levels of Care and implement initiatives with CT Emergency Departments, Residential Treatment Centers (RTCs), and Emergency Mobile Psychiatric Services (EMPS), levels of care.

Activities and Findings that include trending and analysis of the measures to assess performance:

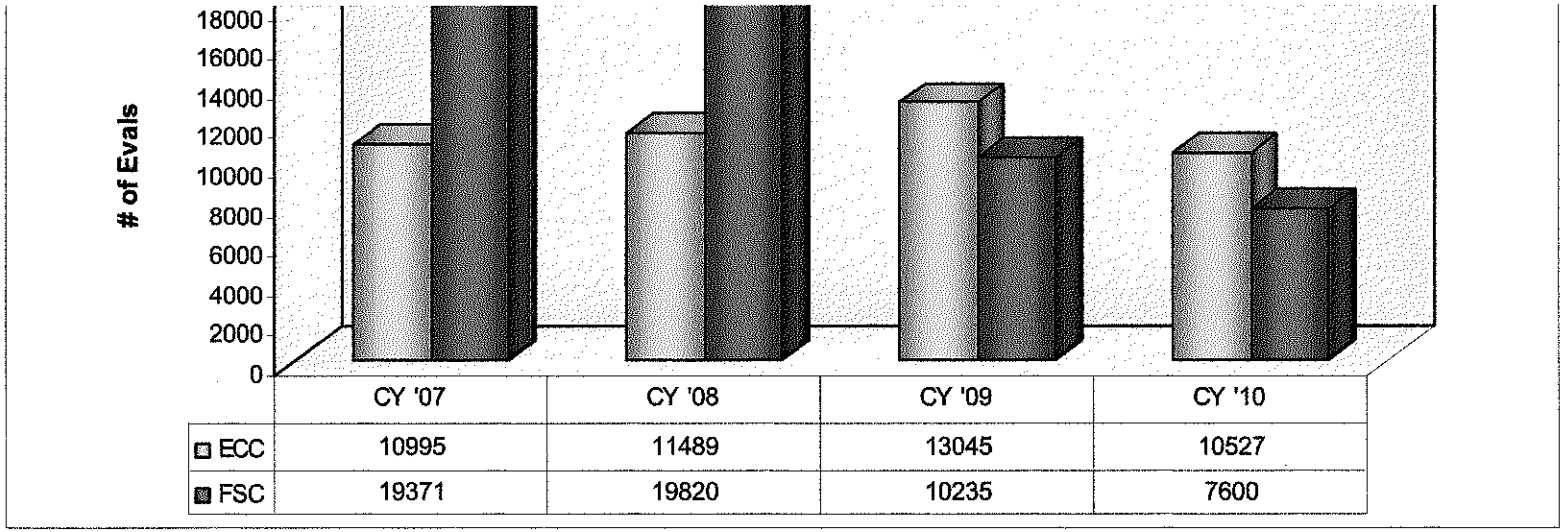
The Provider Analysis and Reporting (PAR) Program continues to be a vital strategy used to improve the quality and value of the CT behavioral health service system.

The PAR program and Performance Initiatives typically entail two phases of development.

Specifically:
1. The initial phase of the PAR program involves the establishment of a workgroup that includes provider representatives from level of care specific programs (i.e., child and adolescent inpatient, PRTF, etc.). The workgroup then collaborates with the CT BHP to agree upon measures that allow for the assessment of key aspects of their performance in relationship to other providers supplying the same or similar services and to develop a "profile".

   The providers then continue to meet with CT BHP on at least a quarterly basis. Some of these meetings are with individual providers and some include multiple providers. During these meetings, providers are given data regarding their own performance, and a collaborative review/analysis of the findings is conducted. Variation between programs and the identification of variables that may be responsible for those differences occurs. This is the time when providers learn from each other with regard to best practices. Most importantly, goals for improving performance are agreed upon by all participants.

2. The second phase of the PARs program entails the attachment of financial incentives to the accomplishment of goals in an effort to motivate progress and expedite change. The first



	CY '07	CY '08	CY '09	CY '10
ECC	10995	11489	13045	10527
FSC	19371	19820	10235	7600

In 2010 there were a total of 10,527 ECC evaluations. There is a 19.3% decrease in total number of ECC evaluations in 2010 compared to CY 2009. There was also a decrease in free-standing clinic evaluations by 25.7% in 2010. Free-standing clinics are used as the basis of comparison to the enhanced care clinics in the above graph because they are the most alike providers.

The first set of reports were reviewed by the departments. In particular, the DCF Medical Directors and PMAC made several recommendations regarding the indicators in the reports and the break-out of the data into sub-populations of the HUSKY membership. The following recommendations were made:

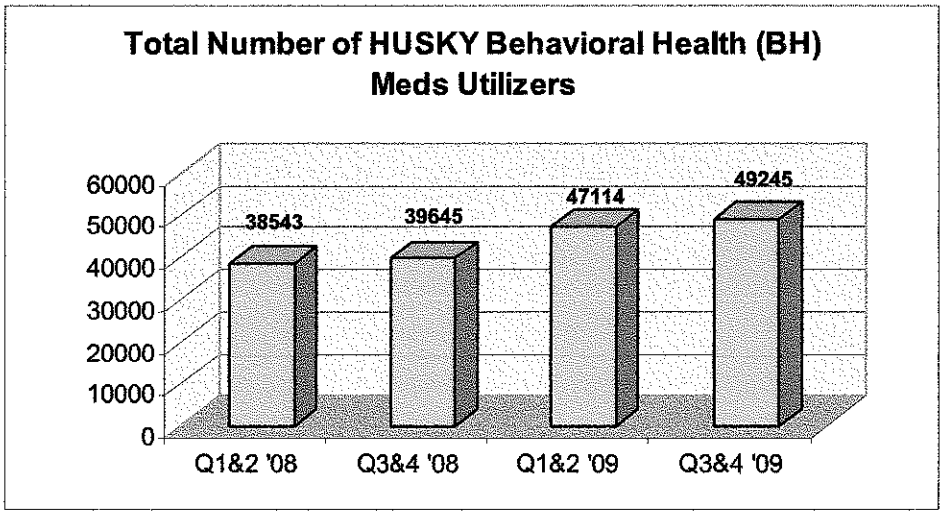
1. Reprogram reports so that they use the count of members being prescribed a medication as the basic metric rather than the number of prescriptions of a medication. The rationale for this change was that there is variation between prescribers regarding the frequency with which the write prescriptions. For example, some prescribers write a script for two week supplies while others write for a months supply. As a result, the number of scripts per medication was an unreliable metric for determining the rate of use of a medication or drug category.
2. It was also recommended that the reports be reprogrammed to break out DCF Involved and Non-DCF involved categories and delete the "DCF approves meds/ DCF does not approve meds" distinction.
3. "Metric Quantity" and "Average Days Supply" measures were deleted from the reports.
4. Consumers/1000 on medications in each age/gender category be added in order to identify high utilization age groups.

In September 2010, the second cycle of behavioral health pharmacy reports were submitted to the departments. The second cycle of pharmacy reports included five (5) separate reports, each of which compared four (4) six month periods of data (2/1/08 to 6/30/08; 7/1/08 to 12/31/08; 1/1/09 to 6/30/09; and 7/1/09 to 12/31/09). The first timeframe (2/1/08 to 6/30/08) was of necessity only five months long as 2/1/08 was the date when a single pharmacy vendor began supplying pharmacy data to DSS. All of the requested changes were incorporated into the second cycle of reports.

The following is a summary of the highlights of the findings for each of the five reports:

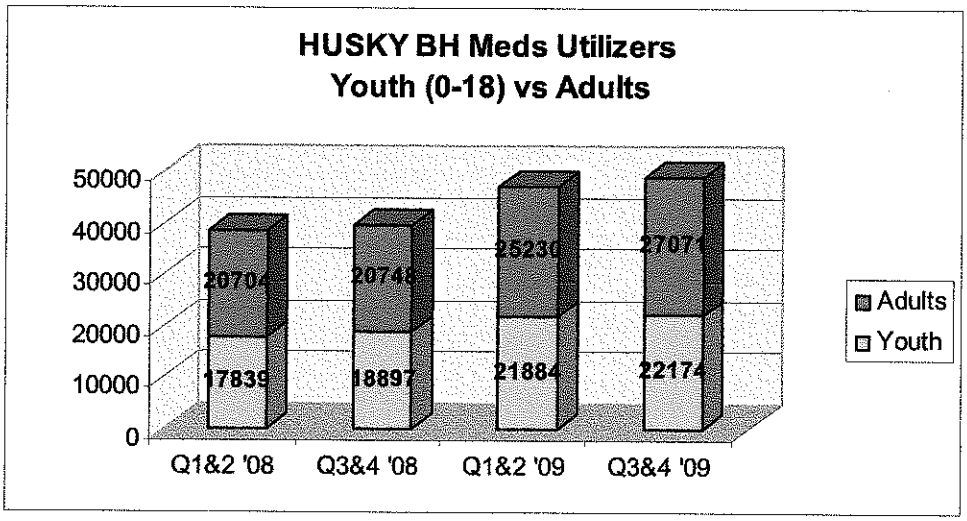
CHARACTERISTICS OF HUSKY BEHAVIORAL HEALTH MEDICATION UTILIZERS

These data are based on reports of all pharmacy claims with a date of service occurring between the date ranges of the report spans. The reports provides aggregate demographic data regarding the prescribing of behavioral health medications broken out by gender and age and, in some instances, DCF/ Non-DCF Involvement status.



Meds ↑

The growth in HUSKY membership accounts for some but not all of the increase in number of behavioral health medication consumers. While there was a 12.8% increase from Q1 '08 to Q4 '09 in total membership for all HUSKY members, there was a 27.8% increase in the total number of HUSKY behavioral health medication consumers from Q1-2 '08 to Q3-4 '09. The % of HUSKY members who are utilizing behavioral health medications climbed from 10.2% in 2008 to 11.5% in Q3-4 '09.

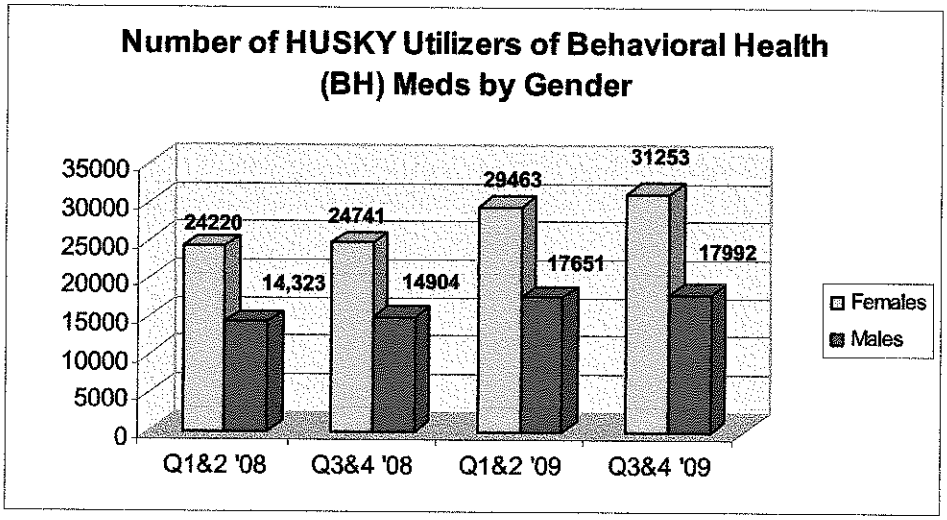


HUSKY Youth behavioral health medication utilizers increased 24.3% from Q1-2 '08 to Q3-4 '09 while HUSKY youth membership increased 9.3% between Q1 '08 and Q4 '09.

- The % of HUSKY Youth utilizing behavioral health meds increased from 6.9% in Q1-2 '08 to 7.7% in Q3-4 '09

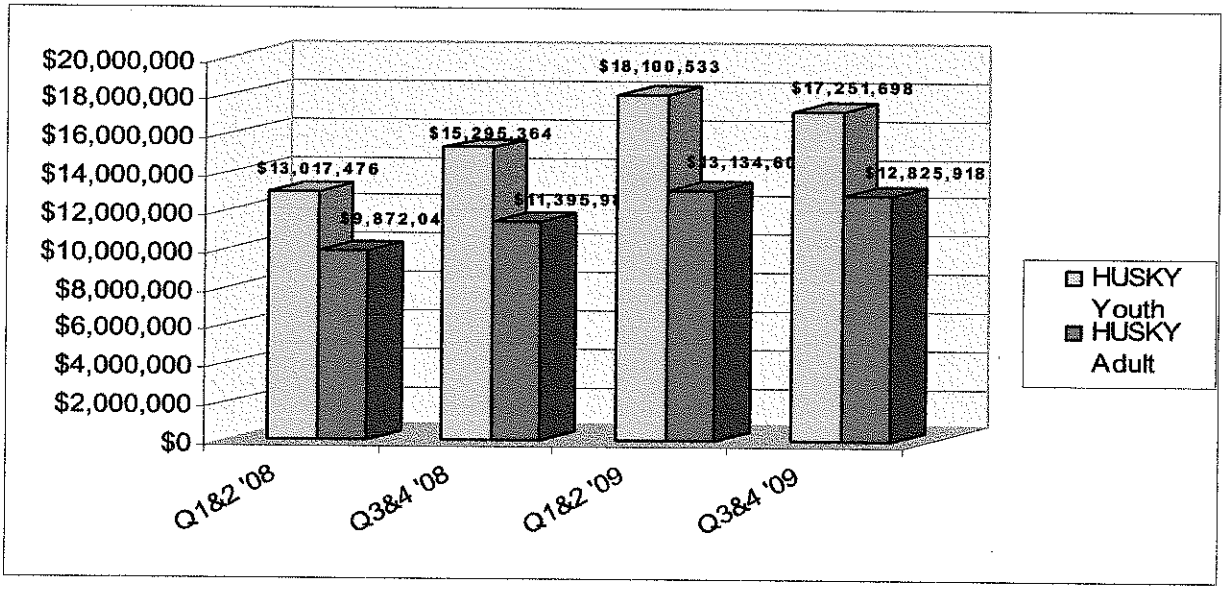
HUSKY adult behavioral health medication utilizers increased 30.8% from Q1-2 '08 to Q3-4 '09.

- Although 34% of the HUSKY population are adults, 55% of the behavioral health medication utilizers are adults.
- The % of HUSKY adults utilizing behavioral health medications increased from 17.9% in Q1-2 '08 to 19.5% in Q3-4 '09.



- The gender differences in behavioral health medication utilization far exceeds any differences that could be accounted for by membership

Husky Behavioral Health Medication Expenditures: Youth Vs. Adults



While HUSKY adults account for a third of the HUSKY population, expenditures for adult behavioral health medications during 2009 were 42.3% of the total expenditure.

Expenditure by Therapeutic Class:

For HUSKY youth, antipsychotics and stimulants accounted for 85.9% of total behavioral health medication expenditure in 2009.
For HUSKY adults, antidepressants and antipsychotics accounted for 66.6% of total behavioral health medication expenditure in 2009.

Conclusions

- Pharmacotherapy as an intervention for both youth and adults in HUSKY population is increasing faster then membership growth
- HUSKY adults use behavioral health medication at a disproportionately greater percent then HUSKY youth (19.5% vs. 11.5% Q3-Q4 '09)
- Profiles of specific medication classes is distinctly different for HUSKY youth then either adults or young adults; though the latter two groups are very similar in their use and should be combined in the next cycle of pharmacy reports
- Among youth, DCF identified youth use medications with a three fold increase over non-DCF youth
- HUSKY youth medication patterns reflect a much greater use of "off label" medications then adults, and also have a higher percent use of antipsychotic medications then either adult or young adult groups

Recommendations for continuing sub-Goal in 2011: This sub-goal will be applicable for 2011 and should be included in the 2011 Project Plan.

5. Quality Measures

a. Submit a list of all key professional, administrative, clinical, and direct service personnel related to the proposal. Attach a copy of their Curriculum Vitae.

b. Explain how the proposal contributes to the quality of health care delivery in the region.

South Bay has a quality improvement program which has proven to show high quality in the area of Access, Accountability, and Efficiency. For each goal identified, a specific measure must be determined as well as the population to whom the goal applies, when the measure will be taken, the data source, the person responsible for obtaining the data, its importance by the relative weight, and the acceptable level of goal achievement. For those measures where expectations are not met, action for the next quarter is reported on a mechanism toward meeting the expectancy and therefore, increasing quality. Thus, the plan utilized the "Plan, Do, Check, Act" cycle.

Goals are established by the program director in collaboration with the Director of Clinical Services. Training occurs with all staff involved in utilization of program evaluation information prior to implementation and at least annually thereafter. We utilize outcomes measures that have shown high outcomes in all life clinical domains overtime.
Attached are examples of the grids utilized to collect data.

c. Identify 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 each of the guidelines.

South Bay maintains a Patient Care Assessment Committee, which will develop and publish a Patient Care Assessment Plan. This Committee will be responsible to the Board of Directors for the evaluation and improvement of the quality of health care rendered by staff; the determination of whether health care services were performed in compliance with acceptable standards of care; the determination of whether the cost of health care services rendered by the Agency is considered reasonable in comparison to the cost of services in the area, and the determination of the Rate Setting Committee; the determination of whether the actions of professional staff call into question such health provider's fitness to provide health care services; and the evaluation of a professional whose effectiveness may be impaired by reason of substance abuse, physical disability, mental instability, communicable

disease, or otherwise. The PCA Committee shall be responsible to oversee the safety and maintenance of facilities and equipment in compliance with standards established by the Agency. The PCA Committee shall also be responsible for establishing and enforcing policies for the control of infectious diseases and for reporting to the relevant Board of Health. The membership of the PCA Committee shall come from the Multi-Disciplinary Team as appointed by the Board of Directors and one member of the Multidisciplinary Teams.

Each service area shall maintain a Multidisciplinary Team, appropriate to the needs of the consumers of this service area. The Multidisciplinary Team will review the work of the clinical staff and establish guidelines for the adequacy of care, proper utilization of services and quality of services provided. Staff on the Multidisciplinary Team will also serve on the Utilization Review Committee.

Each service program will maintain a Utilization Review Committee, which will assure that resources are utilized appropriate to the needs of the person. These committees shall assure that the services that are provided are sufficient and necessary to address the person's needs. The Utilization Review Committee shall also assure that the services that are provided are medically necessary and consistent with the guidelines and regulations established by appropriate state and federal regulatory authorities.

South Bay's Compliance Committee consists of the Compliance Officer, Chief Clinical Officer and the Operating Committee. South Bay Mental Health Center seeks to conduct itself in accordance with the highest level of business and community ethics and in compliance with applicable governing laws. South Bay Mental Health Center, Inc. recognizes the problems that both deliberate and accidental misconduct in the healthcare industry can pose to society. South Bay Mental Health Center is committed to ensuring that it operates under the highest ethical and moral standards and that its activities comply with applicable laws.

South Bay Mental Health Center, Inc.'s Compliance Plan (the "Plan") has been developed in accordance with applicable law, with guidance from state and federal authorities when

Name	Title	Degree	Professional License	Supervisor
Annino, Kelly	Speech and Language Pathologist	SLP	SLP	Nolda, Laura
Barkalow, Mary	Medical Director	M.D.	M.D.	Gearhart, Jennifer
Burr, Janelle	Early Intervention Associate	BS-Human Development and Family Studies	N/A	Nolda, Laura
Miner-Fletcher, Amy	Early Childhood Division Director	MA-Counseling Psychology	LMHC	Scanlon, Peter
Nolda, Laura	Program Director	MSW	LCSW	Scanlon, Peter

Laura Nolda, LCSW

14 Kingfisher Way Waterford, CT 06385
(860)912-0149
laura.nolda@yahoo.com

Education

2007-2009 University of Connecticut West Hartford, Connecticut

School of Social Work, Group Work focus

2001-2005 University of Connecticut Storrs, Connecticut

Bachelors of Arts in Psychology

Work Experience

October 2011-present Director of Mental Health Services Hartford, CT
South Bay Mental Health, Inc.
Leading in the program development for Birth to Three and Mental Health services. Duties include but not limited to; RFP writing, community development, staff interviewing, and educating about community resources, supervising clinical support team, and managing a case load .

March 2010- October 2011 Director of Day Services S. Yarmouth, MA
South Bay Mental Health, Inc.
Clinically responsible for the Partial Hospital and Day Service Program for adults who are recovering from emotional, social, and mental disabilities. Supervised a staff of six clinician and/or direct care staff to promise quality care to our consumers and the community. Developed positive relationships with other community resources to ensure our consumers received the best after care. Provided diagnostic consultation as well as individual, group, and family therapy.

October 2009- March 2010 Group Facilitator Plymouth, MA
South Bay Mental Health
Responsible for a case load of 17 consumers who were discharged from an inpatient unit or at risk of going inpatient. Provided five psychotherapy groups a day as well as ongoing case management services.

May 2009- August 2009 Temporary Clinician New London, CT
Child and Family Agency- Child Guidance Clinic
A non- profit outpatient facility offering diagnostic treatment and consultation services. Responsibilities included; individual, group, and family counseling with children of the ages 3 to 18 who are experiencing emotional, social, behavioral or academic difficulties along with other regular contact and consultation with schools or other agencies involved with the child and family. Worked with children with a variety of different disabilities such as but not limited to; RAD, Autism, ADHD, and Bipolar Disorder.

September 2008- May 2009 MSW Intern New London, CT
Child and Family Agency- Child Guidance Clinic
A non- profit outpatient facility offering diagnostic treatment and consultation services. Responsibilities included; individual, group, and family counseling with children of the ages 3 to 18 who are experiencing emotional, social, behavioral or academic difficulties along with other regular contact and consultation with schools or other agencies involved with the child and family.

Friendship School Waterford, CT
School- based health center offering diagnostic treatment and consultation services. Responsibilities included; individual, group, and family therapy for children ages 3 to 6 who are expericieng emotional, social, or behavior difficulties. Maintain regular contact with teachers and other health care professional involved with the child and family. Develop curriculum for children who have behavioral issues in the classroom.

April 2006-September 2008 Case Manager
Reliance House, Inc. Norwich, CT
A program providing intensive substance abuse and mental health support for adults ages 18 and older who are diagnosed with substance disorder and chronic mental illness. Responsibilities include; creating a group curriculum as well as facilitation on a weekly basis as well as providing support with the clients cognitive, emotional, and social function in efforts to promote positive growth with their sobriety and facilitation health integrating within the community.

September 2002-December 2003 Child Care Provider Waterford, CT
Ballestrini's Daycare
Provided care for the infant and toddler room. Over saw safety, basic needs, and encouragement for growth with each child cared for.

Additional Training

Completed training on the following topics; Solution Based Therapy, Motivational interviewing, Job training, Cognitive- Behavioral Therapy, Dialectical Behavior Training, Substance Abuse Treatment, Reactive Attachment Disorder, Asperger's, provided childcare for a child with autism approximately one time a week.

Amy D. Miner-Fletcher, LMHC, CEID, CIMI

18 Laura Drive. Attleboro, MA 02703
Work email: aminerfletcher@southbaymentalhealth.com
Home email: minerfletch@yahoo.com
Phone: W: 508-559-0473 H· 508-455-2871

PROFESSIONAL EXPERIENCE

South Bay Mental Health, Brockton, MA

Division Director, Early Childhood Services October 2002-Present

- Oversee Early Intervention programs in Brockton, Fall River, Lowell and Worcester, Trauma Institute and CBHI In Home Behavioral Services Program (IHBS) serving over 2200 children annually.
- Supervise regional directors, program directors, coordinators of program development, speech, OT, PT, BCBA and Behavior Management Services and staff
- Program Development
- Monitor fiscal responsibility and viability of the early childhood division
- Monitor compliance with applicable state, local and federal regulations
- Evaluate programs and maintain quality assurance, and quality improvement
- Supervise the staff recruitment, selection, evaluation and termination process
- Establish and maintain policies and procedures for client treatment and care coordination
- Collaborate with Human Resources, Recruiting, Billing, MIS and other divisions as necessary
- Provide leadership and clinical training and consultation around program needs
- Serve on agency executive management team

Program Director, Brockton Early Intervention January 1998-October 2002

- Directed the Brockton Early Intervention program including providing supervision, monitoring and delivery of EI services, serving on management team, and coordinating EI services and program oversight
- Initiate, maintain, and complete clinical files and records for each client, including initial evaluations, assessments, treatment plans, session notes, transfer and termination summaries and other required documentation.
- Recruit, interview, train, evaluate and terminate staff
- Monitor the caseload and groups for EI staff along with Clinical Supervisors
- Supervise EI staff, both in an administrative and clinical capacity, ensure that clinical EI staff meet and maintain service delivery and productivity goals
- Plan, develop, and implement EI programs and services, including in-service education and program evaluation
- Attend weekly management meetings
- Maintain applicable reports for state and federal requirements
- Develop programs and outreach in the community
- Conduct weekly staff meetings
- Consult on program evaluation and development, provide recommendations
- Manage general maintenance of program operations, including physical site

Assistant Director October 1997-January 1998

- Assisted Program Director in all responsibilities noted above.
- Provide direct service and care coordination to children ages 0-3 and families
- Provide clinical and administrative supervision to assigned clinicians, EI service coordinators, and coordinate clinical services of assigned EI staff with clients, referral agencies, collateral agencies, and the program.
- Assist in employee recruitment, selection, evaluation and terminations
- Develop programs and outreach in the community
- Provide and participate in training and team meetings as necessary
- Monitor adequacy and appropriateness of client treatment and groups
- Monitor compliance with applicable state, local and federal regulations
- Meet with other teams/departments as necessary

Clinician June 1996-October 1997

- Coordinated treatment and implemented services for assigned clients, including outreach visits, as a member of a transdisciplinary Early Intervention team. Conduct visits with clients and relevant collaterals in natural environments according to the needs of the child and family. Conducted assessment and development of Individualized Family Service Plans.
- Initiate, maintain, and complete clinical files and records for each client, including initial evaluations, assessments, treatment plans, session notes, transfer and termination summaries and other required documentation.
- Provide outreach counseling to individual, group, family, and couples
- Consult with team members in the development of individualized plans and multidisciplinary services for assigned clients
- Maintain the accuracy of client records
- Complete billing documentation according to the clinic's established schedule
- Adhere to professional standards and guidelines according to their respective disciplines
- Adhere to provisions of M.G.L. Chapter 119, Section 51A (Mandated Reporter); report all occurrences immediately to the clinic
- Adhere to clinical recommendations from clinical administration
- Maintain confidentiality in all clinical matters
- Remain compliant with billing, documentation and minimum service delivery to substantiate each billable hour
- Document client progress in the program , required contact with collaterals and family members, arena assessments, DPH forms and regulations regarding intake and discharge of clients
- Lead or co-lead groups within Early Intervention standards according to program needs and design (both child and parent focused)
- Develop group curricula for assigned groups
- Maintain supplies for groups and program facility
- Establish policies and procedures for client treatment

EDUCATION & PROFESSIONAL DEVELOPMENT

Boston College, Chestnut Hill, MA, Graduate School of Education
M.A. Counseling Psychology September 1993-May 1995
University of Colorado, Boulder, Boulder, CO
B.A. Psychology August 1988-May 1992

Train the Trainers Curriculum Completed

Supporting Children's Play – DPH Core Training
Service Coordination – DPH Core Training
Strengthening Families June 2011
Connected Beginnings IN-TIME Infant Mental Health Spring 2009

Agency/Community Trainings Provided

Evidence Based Early Childhood Intervention in the context of social emotional development and relationships August 7, 2009
Supporting Children's Play
February 2009, January 2008, June 2007, February 2007, October 2006, February 2006, November 2004, October 2004, July 2004
Service Coordination
November 2004, August 2004
Young Parents Raising Young Children
March 2006
Childhood Trauma: Symptoms, Implications and Treatment Interventions
February 6, 2004
Developmental Delay and Autism Spectrum Disorders in Young Children
February 2002
Mentor training – Bi-annual training for mentors, supervisors and directors
Compliance training – Bi-annual training for Early Intervention teams
IFSP training – Annual training for Early Intervention teams

LICENSURE/CERTIFICATIONS/AFFILIATIONS

Licensed Mental Health Counselor	#4692	July 2000-Present
Certified Infant Massage Instructor	#C17817	July 2006-Present
Certified Early Intervention Director	#154D	May 2002 -Present

Community Services of Greater Brockton 2002-Present
President June 2008-Present
Vice-President June 2006-June 2008
Secretary 2002 - 2006

Massachusetts Early Intervention Consortium Board Member since 2000
Board roles included Regional Representative and Conference Chair and Co-chair for multiple years.
Shaken Baby Syndrome Statewide Advisory Group 2008-2010
Certified Early Intervention Specialist portfolio reviewer 2008-2010

JANELLE C. BURR

38 Woodhaven Road, Rocky Hill, CT 06457
(860) 770-3366 Janelle.Burr@gmail.com

Education

University of Wisconsin-Stout, Menomonie, WI — December 2005
Bachelor of Science- Human Development & Family Studies

Experience

Program Director — Nov 2010- Current
Family Junction Birth to Three
Oakville, CT

- Manages Birth to Three Program, early intervention service provider of 200+ families and their children. Monitors and ensures quality home-based therapy services, provided by staff of 30+ employees. Supervises scheduling and productivity to ensure efficiency of staff. Maintains knowledge of current Birth to Three practice, procedure and service coordination.

Early Intervention Associate — Oct 2007- Nov 2010
Family Junction Birth to Three
Oakville, CT

- Provides quality early intervention services to children and families within Connecticut. Maintains knowledge of appropriate developmental practice, as well as creative and routine-based strategies for child outcomes. Knowledgeable in state-wide resources. Held position of Lead Service Coordinator, responsible for orientation of new staff and paperwork monitoring.

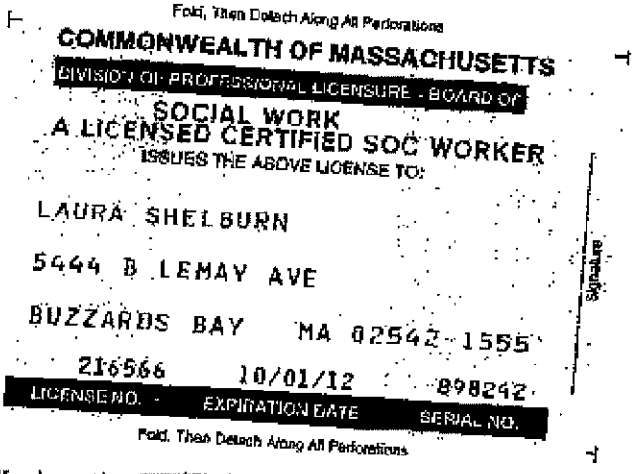
Early Intervention Associate — July 2007-Oct 2007
Building Bridges Birth to Three, LLC
South Windsor, CT

- Provides early intervention services to children with developmental delays/diagnosis. Teams with a variety of therapists to maintain current knowledge of developmentally appropriate strategies and teaching styles. Strives to meet individually based outcomes and curbs learning to family/child's personality style.

Head Teacher — Feb 2006- July 2007
Northern Middlesex YMCA
Middletown, CT

- Teaches early education concepts to toddler-aged children. Meets child's individual learning needs with curriculum, observations and goals. Follows standards for the National Association for the Education of Young Children (NAEYC) and Early Head Start.

Nurda, Laura



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COMMONWEALTH OF MASSACHUSETTS

DIVISION OF PROFESSIONAL LICENSURE - BOARD OF

OARD
W

SOCIAL WORK
A LICENSED CERTIFIED SOC WORKER
ISSUES THE ABOVE LICENSE TO:

YPE

LAURA SHELBURN

5444 B LEMAY AVE

BUZZARDS BAY MA 02542-1555

8242

216966 10/01/12 898242

LICENSE NO. EXPIRATION DATE SERIAL NO.

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Signature

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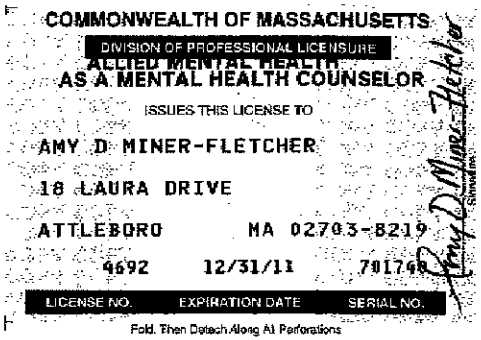

COMMONWEALTH OF MASSACHUSETTS

DIVISION OF PROFESSIONAL LICENSURE

ALLIED MENTAL HEALTH

AS A MENTAL HEALTH COUNSELOR

ISSUES THIS LICENSE TO

AMY D MINER-FLETCHER

18 LAURA DRIVE

ATTLEBORO MA 02703-8219

4692 12/31/11 701748

LICENSE NO. EXPIRATION DATE SERIAL NO.

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Amy D Miner-Fletcher

Signature

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DIRECTOR OF EARLY INTERVENTION SERVICES

Revised: 7/25/07

Classification: 2
Division: Early Intervention
Reports To: Executive Director

JOB SUMMARY: To serve as overall administrator and clinical director of the Early Intervention program

ESSENTIAL FUNCTIONS:

- Oversee general maintenance of program operations, including physical site
- Fiscal responsibility and viability of the program
- Monitor compliance with applicable state, local and federal regulation
- Chair Core team meetings as needed
- Responsible for program evaluation and development
- Assist in staff recruitment, selection, evaluation and termination of staff
- Establish and maintain policies and procedures for client treatment
- Provide supervision for EI staff
- Work closely with Human Resources, Recruiting, Billing, MIS and other departments as necessary
- Provide training and consultation as needed
- Other supervisory duties as required

PHYSICAL REQUIREMENTS:

a) Lifting:	Less than 15lbs.
b) Stooping/bending:	Seldom
c) Crawling/climbing/kneeling:	Seldom
d) Reaching/pulling/pushing:	Seldom

QUALIFICATIONS:

Education: Must qualify in one of the core disciplines set forth in Early Intervention standards.

Experiential: Must have two years of full-time, supervised clinical experience in a team treatment setting serving client population birth to three years of age. Supervisory experience is preferred.

Signature: Amy D. Miner-Fletcher *Date:* 10/20/09

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Program Evaluation - Program Objectives

Access - Plan for 2011 - YTD

Program Objectives	Measures	To Whom Applied	Time of Meas.	Data Source	Rel Wt.	Expectancy			2011 Total MH Actual Outcome	Prior Year 2010	Prior Year 2009	Site
						Min	Goal	Opt				
Maximize no. of intakes seen within 7 days of assignment	Intake	All Clinicians	Qrtly	Intake								
Action Taken/ Result of Action												
Maximize the no. of outpatient clinical appts. for clients discharged from an acute level of care within 7 calendar days.	Intake Report Restrictive Placement Tracking Form Access Track Sheet	All clients being discharged from hospital	Weekly	Intake Rpt; MIS								
Action Taken/ Result of Action												
Maximize no. of outpatient appts. offered within 3 calendar days from date of discharge from acute level of care.	Intake Report Access Track Sheet; Restrict- ive Placement Track Sheet	All clients being discharged from hospital	Weekly	MIS Data Report								
Action Taken/ Result of Action												
Maximize no. of medication appts. offered to anyone discharged from an acute level of care within 14 business days of date of discharge	Back page of Psychiatric Medication Consultation Request Form	Monthly	Monthly	MIS Data Base Rpt								
Action Taken/ Result of Action												

Program Evaluation - Program Objectives

Accountability - Plan for 2011 YTD

Program Objectives	Measures	To Whom Applied	Time of Meas.	Data Source	Rel Wt.	Expectancy			2011 Total MH Actual Outcome	Prior Year 2010	Prior Year 2009	Site
						Min	Goal	Opt				
Maximize no. of positive responses in the Consumer Satisfaction Survey done annually	Consumer Questionnaire	Random sample of clients	Annual	Data Analysis Rpt on consumer questionnaire								
Action Taken/ Result of Action												
Maximize no. of client not re-admited to inpatient within 30 days of discharge	Restrictive Placement Tracking Form	All client discharged from hosp	Weekly	Track Form MIS Date Reports								
Action Taken/ Result of Action												
Maximize the Agency's efficiency in providing services that are only medically necessary	Internal Treatment Guideline UM Report	All Clients	Quarterly	UM Report								
Action Taken/ Result of Action												

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Program Evaluation - Program Objectives

Accountability - Plan for 2011 YTD

Program Objectives	Measures	To Whom Applied	Time of Meas.	Data Source	Rel Wt.	Expectancy			2011 Total MH Actual Outcome	Prior Year 2010	Prior Year 2009	Site
						Min	Goal	Opt				
Maximize no. of clients whom the PCC has identified and contacted to ensure appropriate continuity of care	Documentation of PCC Form & communica-	All Clients	Monthly	Medical Records								
Action Taken/ Result of Action												
Maximize number of collateral contacts made per client, at least 1 contact per quarter per client	MIS report	All Staff	Quarterly	MIS report								
Action Taken/ Result of Action												
Minimize Employee Turnover	Recruiting Retention Report	All Staff	Quarterly	Recruiting								
Action Taken/ Result of Action												
Minimize % of Terminated Staff	Recruiting Retention Report	All Staff	Quarterly	Recruiting								
Action Taken/ Result of Action												

QI Program Evaluation - Program Objectives

Efficiency - Plan for 2011 - YTD

Program Objectives	Measures	To Whom Applied	Time of Meas.	Data Source	Rel Wt.	Expectancy			2011 Total MH Actual Outcome	Prior Year 2010	Prior Year 2009	Site
						Min	Goal	Opt				
Minimize no. of total "Failed Intakes" *Intakes received over the 6 month period prior to the start of the QI quarter*	MIS Report	All Clinicians	Qrtly	MIS Rpt.								
Action Taken/ Result of Action												
Minimize no. of "Failed Intakes" from Hospital Discharges	MIS Report	All Clinicians	Qrtly	MIS Rpt.								
Action Taken/ Result of Action												
Minimize no. of non - Hopsital Discharge "Failed Intakes"	MIS Report	All Clinicians	Qrtly	MIS Rpt.								
Action Taken/ Result of Action												

available, including the Federal Sentencing Guidelines. The Plan focuses on the prevention of fraud, abuse, and waste in federal, state, and private healthcare plans. The scope of the Plan may be expanded in the future to cover other areas of compliance to which South Bay Mental Health Center, Inc. is subject. With this Plan, South Bay Mental Health Center, Inc. will seek to promote full compliance with all legal duties applicable to it, foster and assure ethical conduct, and provide guidance to each employee and agent of South Bay Mental Health Center, Inc. for his/her conduct. The procedures and standards of conduct contained in this Plan are intended to generally define the scope of conduct which the Plan is intended to cover and are not to be considered as all inclusive.

The Plan is intended to prevent accidental and intentional noncompliance with applicable laws, to detect such noncompliance if it occurs, to discipline those involved in noncompliant behavior, to remedy the effects of non-compliance and to prevent future noncompliance. This Compliance Plan is a "living document" and will be updated periodically to keep South Bay Mental Health Center, Inc.'s employees and agents informed of the most current information available pertaining to compliance requirements in the health care industry.

The Board of Directors will receive quarterly compliance reports from the Compliance Officer and an annual report recommending any changes necessary to improve the compliance program. Annually, the Board of Directors will review the Plan and compliance efforts during the year and will act on any suggested revisions necessary to improve the compliance program.

6. Organizational and Financial Information

a. Identify the Applicant's ownership type(s) (e.g. Corporation, PC, LLC, etc.).
For Profit Corporation

b. Does the Applicant have non-profit status?
☐ Yes (Provide documentation) ☒ No

c. Provide a copy of the State of Connecticut, Department of Public Health license(s) currently held by the Applicant and indicate any additional licensure categories being sought in relation to the proposal.
South Bay has applied

d. Financial Statements

i. If the Applicant is a Connecticut hospital: Pursuant to Section 19a-644, C.G.S., each hospital licensed by the Department of Public Health is required to file with OHCA copies of the hospital's audited financial statements. If the hospital has filed its most recently completed fiscal year audited financial statements, the hospital may reference that filing for this proposal.

ii. If the Applicant is not a Connecticut hospital (other health care facilities): Audited financial statements for the most recently completed fiscal year. If audited financial statements do not exist, in lieu of audited financial statements, provide other financial documentation (e.g. unaudited balance sheet, statement of operations, tax return, or other set of books.)

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

Table 2: Proposed Capital Expenditures/Costs

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

* 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.

f. 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.

6D II

SOUTH BAY MENTAL HEALTH CENTER, INC.

Financial Statements

December 31, 2011 and 2010

SOUTH BAY MENTAL HEALTH CENTER, INC.

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Certified Public Accountants
Business Consultants

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K P M Kevin P. Martin & Associates, P.C.

Independent Auditors' Report

To the Board of Directors of
South Bay Mental Health Center, Inc.

We have audited the accompanying balance sheets of South Bay Mental Health Center, Inc. (a Massachusetts S Corporation) (the Company) as of December 31, 2011 and 2010, and the related statements of income, changes in shareholder's equity and cash flows for the years then ended. These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control over financial reporting. Accordingly, we express no such opinion. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of the Company as of December 31, 2011 and 2010, and the results of its operations, changes in shareholder's equity and its cash flows for the years then ended in conformity with accounting principles generally accepted in the United States of America.

In accordance with *Government Auditing Standards*, we have also issued our report dated April 4, 2012, on our consideration of the Company's internal control over financial reporting and our tests of its compliance with certain provisions of laws, regulations, contracts and grant agreements and other matters. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing and not to provide an opinion on the internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* and should be considered in assessing the results of our audits.

Kevin P. Martin & Associates, P.C.

Braintree, Massachusetts
April 4, 2012

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Business Consultants

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K P M Kevin P. Martin & Associates, P.C.

Independent Auditors' Report on Internal Control over Financial Reporting and on Compliance and Other Matters Based on an Audit of Financial Statements Performed in Accordance with *Government Auditing Standards*

To the Board of Directors of
South Bay Mental Health Center, Inc.

We have audited the financial statements of South Bay Mental Health Center, Inc. (a Massachusetts S Corporation) (the Company) as of and for the year ended December 31, 2011, and have issued our report thereon dated April 4, 2012. We conducted our audit in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States.

Internal Control over Financial Reporting

In planning and performing our audit, we considered the Company's internal control over financial reporting as a basis for designing our auditing procedures for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness the Company's internal control over financial reporting. Accordingly, we do not express an opinion on the effectiveness of the Company's internal control over financial reporting.

A deficiency in internal control exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct misstatements on a timely basis. A *material weakness* is a deficiency, or combination of deficiencies, in internal control such that there is a reasonable possibility that a material misstatement of the Company's financial statements will not be prevented, or detected and corrected on a timely basis.

Our consideration of internal control over financial reporting was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control over financial reporting that might be deficiencies, significant deficiencies or material weaknesses. We did not identify any deficiencies in internal control over financial reporting that we consider to be material weaknesses, as defined above.

Compliance and Other Matters

As part of obtaining reasonable assurance about whether the Company's financial statements are free of material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts and grant agreements, noncompliance with which could have a direct and material effect on the determination of financial statement amounts. However, providing an opinion on compliance with those provisions was not an objective of our audit, and accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards*.

This report is intended solely for the information and use of the board of directors and management and is not intended to be and should not be used by anyone other than these specified parties.

Melanson Heath & Company P.C.

Braintree, Massachusetts
April 4, 2012

SOUTH BAY MENTAL HEALTH CENTER, INC.

Balance Sheets

As of December 31, 2011 and 2010

Assets

	2011	2010
Current Assets:		
Cash and cash equivalents	$ 1,796,216	$ 1,282,341
Accounts receivable - net of allowance for doubtful accounts	3,058,440	3,044,348
Prepaid expenses	137,369	71,671
Refundable income taxes	-	135,439
Deferred tax asset - current portion	14,434	-
Due from related parties	158,963	90,091
Total Current Assets	5,165,422	4,623,890
Fixed Assets:		
Total fixed assets	2,366,914	2,224,637
Less: accumulated depreciation	(1,993,358)	(1,845,102)
Net Fixed Assets	373,556	379,535
Other Assets:		
License	44,617	44,617
Deposits	90,249	63,197
Marketable securities	251,167	225,847
Annuity investment	73,277	81,292
Deferred tax asset - net of current portion	11,053	6,462
Total Other Assets	470,363	421,415
Total Assets	$ 6,009,341	$ 5,424,840

Liabilities and Shareholder's Equity

Current Liabilities:		
Accounts payable	$ 104,684	$ 171,733
Accrued expenses	1,674,981	1,399,190
Note payable - current portion	17,494	-
Due to related party	2,259	-
Accrued income taxes	5,071	-
Deferred tax liability	-	65,045
Total Current Liabilities	1,804,489	1,635,968
Long Term Liabilities:		
Note payable - net of current portion	28,264	-
Total Long Term Liabilities	28,264	-
Total Liabilities	1,832,753	1,635,968
Shareholder's Equity:		
Common stock, no par value, 100 shares authorized, 100 shares issued and outstanding	3,000	3,000
Retained earnings	4,201,105	3,793,312
Accumulated other comprehensive loss	(27,517)	(7,440)
Total Shareholder's Equity	4,176,588	3,788,872
Total Liabilities and Shareholder's Equity	$ 6,009,341	$ 5,424,840

The accompanying notes are an integral part of these financial statements.

SOUTH BAY MENTAL HEALTH CENTER, INC.

Statements of Income

For the Years Ended December 31, 2011 and 2010

	2011	2010
Income:		
Service income	$ 38,020,498	$ 34,209,372
Expenses:		
Salaries and fringe benefits	27,401,542	24,072,732
General and administrative expenses	1,762,323	1,739,878
Occupancy expenses	2,151,106	2,102,509
Other program expenses	1,636,868	1,951,695
Depreciation	148,256	134,922
Total Expenses	33,100,095	30,001,736
Income from Operations	4,920,403	4,207,636
Other Income:		
Interest and dividend income	14,969	16,597
Total Other Income	14,969	16,597
Income before provision for state income taxes	4,935,372	4,224,233
Provision for state income taxes	141,440	138,020
Net Income	4,793,932	4,086,213
Other Comprehenisve Income:		
Unrealized (loss) gain on marketable securities and annuity investment, net of deferred tax benefit expense	(20,077)	29,513
Comprehensive Income	$ 4,773,855	$ 4,115,726

The accompanying notes are an integral part of these financial statements.

SOUTH BAY MENTAL HEALTH CENTER, INC.

Statements of Changes in Shareholder's Equity

For the Years Ended December 31, 2011 and 2010

	Common Stock	Retained Earnings	Accumulated Other Comprehensive (Loss) Gain	Total
Balance, December 31, 2009	$ 3,000	$ 3,532,722	$ (36,953)	$ 3,498,769
Net income	-	4,086,213	-	4,086,213
Less:				
Distributions to shareholder	-	(3,825,623)	-	(3,825,623)
Unrealized gain on marketable securities and annuity investment	-	-	29,513	29,513
Balance, December 31, 2010	3,000	3,793,312	(7,440)	3,788,872
Net income	-	4,793,932	-	4,793,932
Less:				
Distributions to shareholder	-	(4,386,139)	-	(4,386,139)
Unrealized loss on marketable securities and annuity investment	-	-	(20,077)	(20,077)
Balance, December 31, 2011	$ 3,000	$ 4,201,105	$ (27,517)	$ 4,176,588

The accompanying notes are an integral part of these financial statements.

SOUTH BAY MENTAL HEALTH CENTER, INC.

Statements of Cash Flows

For the Years Ended December 31, 2011 and 2010

	2011	2010
Cash Flows from Operating Activities:		
Comprehensive Income	$ 4,773,855	$ 4,115,726
Adjustments to reconcile comprehensive income to net cash provided by operating activities:		
Depreciation	148,256	134,922
Unrealized loss (gain) on marketable securities and annuity investmen	20,077	(29,513)
Changes in assets and liabilities:		
(Increase) decrease in:		
Accounts receivable - net allowance for doubtful accounts	(14,092)	(213,666)
Prepaid expenses	(65,698)	(8,168)
Refundable income taxes	135,439	(69,763)
Due from related party	(68,872)	100,136
Deposits	(27,052)	(7,475)
Deferred tax asset	(19,025)	8,538
Increase (decrease) in:		
Accounts payable	(67,049)	37,681
Accrued expenses	280,862	207,652
Due to related party	2,259	-
Deferred tax liability	(65,045)	(10,755)
Net Cash Provided by Operating Activities	5,033,915	4,265,315
Cash Flows from Investing Activities:		
Purchase of fixed assets	(89,321)	(256,093)
Investments in marketable securities	(37,382)	(30,000)
Net Cash Used in Investing Activities	(126,703)	(286,093)
Cash Flows from Financing Activities		
Payments of note payable	(7,198)	-
Distributions to shareholder	(4,386,139)	(3,825,623)
Net Cash Used in Financing Activities	(4,393,337)	(3,825,623)
Net Increase in Cash and Cash Equivalents	513,875	153,599
Cash and Cash Equivalents, Beginning	1,282,341	1,128,742
Cash and Cash Equivalents, Ending	$ 1,796,216	$ 1,282,341
Supplemental Disclosure of Cash Flow Information		
Cash paid for interest	$ 389	$ -
Cash paid for income taxes	$ 85,000	$ 210,000
Supplemental Disclosure of Non Cash Activities		
Automobile financed with note payable	$ 52,956	$ -
Disposal of fixed asset	$ -	$ 8,500

The accompanying notes are an integral part of these financial statements.

SOUTH BAY MENTAL HEALTH CENTER, INC.

Notes to Financial Statements

December 31, 2011 and 2010

(1) Summary of Significant Accounting Policies

The following is a summary of significant accounting policies followed by South Bay Mental Health Center, Inc. (the Company) in the preparation of the financial statements.

(a) Nature of Activities

The Company was incorporated under the laws of the Commonwealth of Massachusetts in September 1986. The Company provides behavioral health care services, utilizing a community-based approach, to encourage the self-sufficiency of disadvantaged people primarily throughout Massachusetts.

The following program divisions are listed in order of relative size based on expenditures:

(1) Outpatient Mental Health and Counseling Services

The Outpatient Mental Health and Counseling Services division provides psychological therapy to individuals and families. Services include, but are not limited to, individual therapy, couples and family therapy, behavior management, substance abuse, intensive family services and school-based services. The Outpatient Mental Health and Counseling Services division accounted for approximately 65% and 64%, respectively, of total program expenditures for the years ended December 31, 2011 and 2010.

(2) Early Intervention Services

The Early Intervention Services division provides children and families the resources they need to plan for the child's growth and development. Services include, but are not limited to, developmental evaluations, parent support and education, physical and occupational therapy and nursing services. The Early Intervention Services division accounted for approximately 23% and 24%, respectively, of total program expenditures for the years ended December 31, 2011 and 2010.

(3) Day Treatment and Partial Hospitalization Services

The Day Treatment and Partial Hospitalization Services division provides children and adults with psychiatric and emotional disabilities a structured, therapeutic environment in order to enhance interpersonal social skills. Services include, but are not limited to, behavior management, partial hospitalization and after-school programs. The Day Treatment and Partial Hospitalization Services division accounted for approximately 12% of total program expenditures for the years ended December 31, 2011 and 2010.

(b) Business Organization

The Company is a Subchapter S Corporation which was formed with the consent of its shareholder.

(c) Method of Accounting

The accompanying financial statements have been prepared on the accrual basis of accounting in accordance with generally accepted accounting principles in the United States of America (GAAP).

(1) Summary of Significant Accounting Policies - continued

(d) Use of Estimates

In preparing the Company's financial statements in conformity with GAAP, management is required to make estimates and assumptions that affect the reported amounts of assets and liabilities and the disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

(e) Revenue Recognition

The Company operates its programs under various unit and cost reimbursement contracts with the Commonwealth of Massachusetts. Under unit rate programs, recognition of income takes place as services are provided. Under cost reimbursement programs, recognition of income takes place as costs related to the services provided are incurred.

The Company has entered into payment agreements with Medicaid, Medicare and various commercial insurance carriers, health maintenance organizations and preferred provider organizations. The revenue is generated by billing units of service delivered to pre-approved and covered individuals. Revenue reported is recorded at the estimated net realizable amounts. The Company has no costs reimbursement agreements during the years ended December 31, 2011 and 2010.

During the year ended December 31, 2011, the Company derived approximately 53% of its revenue from governmental agencies, 46% from medical insurance companies and 1% from private clients. During the year ended December 31, 2010, the Company derived approximately 54% of its revenue from governmental agencies, 45% from medical insurance companies and 1% from private clients.

(f) Accounts Receivable

The Company carries its accounts receivable at an amount equal to uncollected but earned revenue less an allowance for doubtful accounts. Accounts receivable outstanding for 90 days or more are deemed delinquent. On a periodic basis, the Company evaluates its accounts receivable and establishes an allowance for doubtful accounts, based on a history of past write-offs and collections and current credit conditions. The Company does not have a policy to accrue interest or to require collateral to secure accounts receivables. The allowance for doubtful accounts was $356,847 and $306,847 as of December 31, 2011 and 2010, respectively.

Substantially all of the Company's accounts receivable are due from entities in Massachusetts. As of December 31, 2011, the Company's accounts receivable consisted of approximately 56% from governmental agencies, 42% from medical insurance companies and 2% from private clients. As of December 31, 2010, the Company's accounts receivable consisted of approximately 48% from governmental agencies, 51% from medical insurance companies and 1% from private clients.

The Company does not have a policy to accrue interest on accounts receivable. The Company has no policies requiring collateral or other security to secure the accounts receivable.

(1) Summary of Significant Accounting Policies - continued

(g) Cash and Cash Equivalents

The Company considers all highly liquid investments purchased with an original maturity of three months or less to be cash equivalents. The Company maintains its cash balances in a bank located within Massachusetts. Interesting-bearing cash balances maintained with Rockland Trust Bank amounted to $2,714,855 and $1,842,415 as of December 31, 2011 and 2010, respectively. The Company did not maintain interest-bearing cash balances in excess of FDIC insured limits in any other financial institution as of December 31, 2011 and 2010.

In order to earn a higher return, the Company entered into a repurchase agreement with Rockland Trust Bank whereby excess cash is swept each night into a mutual fund account comprised of United States Government Obligations. The repurchase agreements mature overnight and earned interest at rates of approximately .355% and 1.019% during the years ended December 31, 2011 and 2010, respectively.

(h) Investments

Marketable Securities

The Company classifies the marketable securities held for the benefit of its deferred compensation plan as available for sale under GAAP. In accordance with the provisions, the investment balance is stated at fair market value, based on third party market quotes. Unrealized gains and losses are reflected in other comprehensive income; realized gains and losses are reflected in retained earnings.

The investments in this plan consist of investments in mutual funds as of December 31, 2011 and 2010. Unrealized losses included in comprehensive income during the year ended December 31, 2011 amounted to $12,062. Unrealized gains included in comprehensive income during the year ended December 31, 2010 amounted to $18,510.

Annuity Investment

The Company classifies the annuity investment as available for sale under GAAP. In accordance with the provisions, the investment balance is stated at fair market value, based on third party market quotes. Unrealized gains and losses are reflected in other comprehensive income; realized gains and losses are reflected in retained earnings.

As of December 31, 2011 and 2010, the annuity investment consists of investments in a variable annuity fund. Unrealized losses included in comprehensive income during the year ended December 31, 2011 amounted to $8,015. Unrealized gains included in comprehensive income during the year ended December 31, 2010 amounted to $11,003.

(1) Summary of Significant Accounting Policies - continued

(i) Comprehensive Income

GAAP established standards for the reporting and display of comprehensive income, its components and accumulated balances in a full set of general purpose financial statements. The provisions define comprehensive income to include all changes in equity except those resulting from investments by owners and distributions to owners. Among other disclosures, the provisions require that all items that are required to be recognized under current accounting standards as components of comprehensive income be reported in a financial statement that is presented with the same prominence as other financial statements. The Company's only current component of comprehensive income is the unrealized gains and losses on their marketable securities and annuity investment.

(j) Fair Value Measurements

Recurring Measurements

The Company determines the fair market values of its financial assets and liabilities, as well as non-financial assets and liabilities that are recognized or disclosed at fair value on a recurring basis, based on the following fair value hierarchy established in accordance with GAAP.

Level 1: Quoted prices in active markets for identical assets or liabilities the Company has the ability to access. The Company's Level 1 assets include marketable securities and an annuity investment which are measured at fair value on a recurring basis. The Company currently has no Level 1 liabilities that are measured at fair value on a recurring basis.

Level 2: Observable inputs other than Level 1 prices such as quoted prices for similar assets or liabilities; quoted prices in markets that are not active; or other inputs that are observable or can be corroborated by observable market data for substantially the full term of the assets or liabilities. The Company currently has no Level 2 assets or liabilities that are measured at fair value on a recurring basis.

Level 3: Unobservable inputs that are supported by little or no market activity and that are significant to the fair value of the assets or liabilities. Level 3 assets and liabilities include items where the determination of fair value requires significant management judgment or estimation. The Company currently has no Level 3 assets or liabilities that are measured at fair value on a recurring basis.

The following table represents the fair value hierarchy for those financial assets measured at fair value on a recurring basis as of December 31, 2011.

	Fair Value Measurements on a Recurring Basis as of December 31, 2011			
	Level 1	Level 2	Level 3	Total
Marketable securities	$ 251,167	$ -	$ -	$ 251,167
Annuity investment	73,277	-	-	73,277
	$ 324,444	$ -	$ -	$ 324,444

(1) Summary of Significant Accounting Policies - continued

(j) Fair Value Measurements - continued

Recurring Measurements - continued

The following table represents the fair value hierarchy for those financial assets measured at fair value on a recurring basis as of December 31, 2010.

	Fair Value Measurements on a Recurring Basis as of December 31, 2010			
	Level 1	Level 2	Level 3	Total
Marketable securities	$ 225,847	$ -	$ -	$ 225,847
Annuity investment	81,292	-	-	81,292
	$ 307,139	$ -	$ -	$ 307,139

Based on the analysis of the nature and risks of these investments, the Company has determined that presenting them as a single class is appropriate.

The Company's policy is to recognize transfers in and transfers out as of the actual date of the event or change in circumstances that caused the transfer. There were no transfers between levels during the years ended December 31, 2011 and 2010.

Non-Recurring Measurements

The Company determines the fair market values of its financial assets and liabilities, as well as non-financial assets and liabilities that are recognized or disclosed at fair value on a non-recurring basis, based on the fair value hierarchy established in accordance with GAAP. The Company has no non-financial instruments required to be accounted for on a non-recurring basis as of December 31, 2011 and 2010.

Financial Instruments

The Company's financial instruments include cash and cash equivalents, accounts receivables, refundable income taxes, due from/to related party, accounts payable and accrued expenses. The carrying amount of these financial instruments approximates their fair value due to their short maturities. The fair value of the Company's long-term debt, including the current portion, is estimated based on the borrowing rates currently available for loans with similar terms and maturities.

(1) Summary of Significant Accounting Policies - continued

(k) Capitalization and Depreciation

Equipment, furniture and fixtures, leasehold improvements and automobiles are recorded at cost or if donated at fair value on the date of receipt. Depreciation is provided for in amounts sufficient to relate the cost of depreciable assets to operations over their estimated service lives. Improvements, including planned major maintenance activities are capitalized, while expenditures for routine maintenance and repairs are charged to expense as incurred. Upon disposal of depreciable property, the appropriate property accounts are reduced by the related costs and accumulated depreciation. The resulting gains and losses are reflected in the statements of income.

The Company computes depreciation using the straight-line method over the following estimated lives:

Equipment	3-7 Years
Furniture and fixtures	5-7 Years
Leasehold improvements	5 Years
Automobiles	5 Years

The Company reviews its long-lived assets for impairment whenever events or changes in circumstances indicate that the carrying amount may not be recoverable. Recoverability is measured by a comparison of the carrying amount of the assets to the future net undiscounted cash flow expected to be generated by the assets and any estimated proceeds from the eventual disposition of these assets. If the assets are considered to be impaired, the impairment to be recognized is measured at the amount by which the carrying amount of the assets exceeds the fair value. There were no impairment losses recognized in 2011 or 2010.

(l) Income Taxes

The Company, with the consent of its shareholder, had elected under the Internal Revenue Code to be a Subchapter S Corporation. In lieu of corporate income taxes, federal and state taxable income of the Company is reported on the tax return of the stockholder. However, Massachusetts corporate income taxes are also required to be paid on the Company's net taxable income at a rate of 2.95% and 3.45% for the years ended December 31, 2011 and 2010, respectively, when its gross revenues are over $9,000,000.

Deferred tax assets and liabilities are computed annually for temporary differences between financial statement and tax basis of assets and liabilities that will result in taxable or deductible amounts in the future, based on enacted tax laws and rates applicable to the periods in which the differences are expected to affect taxable income. Deferred tax assets and liabilities are computed for state purposes only. Current and non-current balance sheet classification is based on the timing of the reversal of the temporary differences.

(1) Summary of Significant Accounting Policies - continued

(l) Income Taxes - continued

GAAP prescribes a recognition threshold and measurement attribute for financial statement recognition and measurement of a tax position taken or expected to be taken in a tax return. For those benefits to be recognized, a tax position must be more-likely-than-not to be sustained upon examination by taxing authorities. For the years ended December 31, 2011 and 2010, the Company does not believe its financial statements include any uncertain tax positions. The Company recognizes interest and penalties, if any, related to unrecognized tax benefits in interest expense.

All tax years prior to 2008 are closed via the passing of the Statute of Limitations. No notices have been received from either the Internal Revenue Service or Commonwealth of Massachusetts addressing any subsequent year.

(m) Advertising Costs

The Company expenses advertising costs when they are incurred. Advertising expense was immaterial for the years ended December 31, 2011 and 2010.

(n) Reclassification

Certain amounts in the prior year have been reclassified to conform to the current year presentation.

(o) Variable Interest Entities ("VIEs")

GAAP prescribes accounting principles which requires management to assess VIEs for consolidation. Among other things, the provisions require more qualitative than quantitative analyses to determine the primary beneficiary of a VIE, continuous assessments of whether an enterprise is the primary beneficiary of a VIE, disclosures about an enterprise's involvement with a VIE and certain guidance be used for determining whether an entity is a VIE. Under the provisions, a VIE must be consolidated if the enterprise has both (a) the power to direct the activities of the VIE that most significantly impact the entity's economic performance, and (b) the obligation to absorb losses or the right to receive benefits from the VIE that could potentially be significant to the VIE. The Company has determined that they had no variable interest in other entities in which they were also the primary beneficiary of those entities during the years ended December 31, 2011 and 2010.

(p) Intangible Assets

Licenses are recorded at cost. The Company reviews its unamortized costs for impairment whenever events or changes in circumstances indicate that the carrying value may not be recoverable. Recoverability is measured by using a variety of methodologies to determine the fair value of intangible assets including undiscounted cash flow models. No impairment losses on intangible assets were recognized in 2011 or 2010.

(2) Property and Equipment

Property and equipment consists of the following as of December 31, 2011 and 2010:

	2011	2010
Equipment	$ 1,057,173	$ 1,046,027
Furniture and fixtures	296,044	291,265
Leasehold improvements	960,741	887,345
Automobiles	52,956	-
	$ 2,366,914	$ 2,224,637

(3) Related Party Transactions

The clients of the Company receive transportation services from Community Access, Inc., a company related by common ownership. Community Access, Inc. receives revenue under independent transportation contracts. During 2011 and 2010 the Company incurred $31,084 and $46,022, respectively, of expense for rental of Community Access, Inc.'s vans and for rides for the Company's clients.

Community Access, Inc. pays the Company a management fee which amounted to $46,614 and $43,777 for the years ended December 31, 2011 and 2010, respectively. Community Access, Inc. reimburses the Company for various operating expenses paid on their behalf, including payroll and vehicle maintenance and repairs. During the years ended December 31, 2011 and 2010, these expenses amounted to $90,771 and $83,446, respectively. As of December 31, 2011 and 2010, $124,963 and $54,957, respectively, was receivable and included in due from related parties.

The Company leases space for the Day Services Program under a four year lease from 50 Aldrin Road, LLC, which is related by common ownership. As of December 31, 2011 and 2010, $34,000 and $33,000 was receivable and included in due from related parties, respectively. The lease expires August 31, 2014. The monthly rental payments were $14,300 as of December 31, 2011 and 2010. Rent expense under the lease amounted to $171,600 for the years ended December 31, 2011 and 2010.

The Company holds a variable interest in 50 Aldrin Road LLC but is not deemed to be the primary beneficiary. As of December 31, 2011 and 2010, the maximum exposure to loss as a result of this variable interest was $204,787 and $289,036, respectively, which is equal to the mortgage loan guarantee. Subsequent to year end, as a part of the sale of the Company, the Company was released from this guarantee (see Note 10).

The Company leases space from Scanlon Realty Trust, LLC, which is related by common ownership. As of December 31, 2011 and 2010, there were no outstanding payables. The original lease has been extended through February 27, 2016. The Company records rental expense equal to certain costs that Scanlon Realty Trust, LLC incurred for the operations of the building. Rent expense amounted to $52,219 and $64,014, respectively, for the years ended December 31, 2011 and 2010.

The Company leases space from West Chestnut, LLC, which is related by common ownership. As of December 31, 2011, $2,259 was payable and included in due to related party. As of December 31, 2010, $2,134 was receivable and included in due from related parties. The lease expires August 31, 2014. The Company records rental expense equal to certain costs that West Chestnut, LLC incurred for the operations of the building. Rent expense under the lease amounted to $283,527 and $322,245 for the years ended December 31, 2011 and 2010, respectively.

(4) Operating Leases

In addition to the related party operating leases, as described in Note 3, the Company engaged in the following various operating leases:

The Company leases various office locations and storage space as a tenant-at-will at agreed-upon monthly rentals, plus certain operating costs. Monthly payments range from $700 to $10,243. Rent expense under these agreements for the years ended December 31, 2011 and 2010 amounted to $221,842 and $267,345, respectively.

The Company has entered into several long-term leases for its various office locations and certain office equipment expiring through February 28, 2017 with monthly payments ranging from $1,430 to $28,636. Rent expense under these agreements for the years ended December 31, 2011 and 2010 amounted to $642,261 and $499,932, respectively.

Minimum annual rental commitments are as follows:

2012	$ 1,579,131
2013	1,603,879
2014	1,353,675
2015	915,959
2016	570,693

(5) Line of Credit

The Company has a demand line of credit with Rockland Trust Bank of $500,000 to be drawn upon as needed, with interest at the bank's Prime Lending Rate of 3.75% as of December 31, 2011 and 2010. The line is secured by all business assets. As of December 31, 2011 and 2010, there was no outstanding balance. Subsequent to year end, the line of credit was closed (see Note 10).

(6) Debt

During 2011, the Company entered into a note payable with the following lender in the original amount of $52,956:

Ally Bank	
Secured by vehicle	
Payable in monthly installments of $1,514	
including interest at 1.8%, payable through July 31, 2014	$ 45,758
Less current portion	(17,494)
Total long-term note payable, net of current portion	$ 28,264

Interest expense on the note payable totaled $389 for the year ended December 31, 2011. Below is a summary of minimum principal payments due under the Company's long-term obligations:

2012	$ 17,494
2013	17,838
2014	10,426

(7) Income Taxes

Income tax expense includes the state income taxes payable or refundable for the years plus or minus the change during the year in deferred tax assets and liabilities. The current provision for state income taxes as of December 31, 2011 and 2010 is as follows:

	2011	2010
Current:		
Taxes currently payable	$ 166,927	$ 149,241
Benefit on temporary financial and tax differences	(25,487)	(11,221)
Net income tax	$ 141,440	$ 138,020

The Company up to December 31, 2010 filed its state income tax returns on the cash basis whereby trade accounts receivable and various operating payables have no tax basis. During 2011, management came to the conclusion that the Company should have been filing on the accrual basis for state income tax returns. As a result, deferred taxes on certain timing differences related to receivables and payables as of December 31, 2011 are reflected as accrued income tax liability. As of December 31, 2010, deferred taxes are primarily attributable to timing differences in depreciation, net unrealized losses on investments and accrual to cash differences. As of December 31, 2011, deferred taxes are primarily attributable to timing differences in depreciation, net unrealized losses on investments and accrued vacation expense.

The net deferred state tax assets and (liabilities) are summarized as follows:

	2011	2010
Current:		
Deferred state tax liabilities	$ -	$ (65,045)
Deferred state tax assets	14,434	-
Net current deferred state tax assets (liabilities)	$ 14,434	$ (65,045)
Noncurrent:		
Net noncurrent deferred state tax assets	$ 11,053	$ 6,462

Valuation allowances are established when necessary to reduce deferred tax assets to the amounts expected to be realized. As of December 31, 2011 and 2010, there were no valuation allowances.

The net tax effect of temporary differences between the carrying amounts of assets and liabilities for financial reporting purposes and the amounts used for income tax purposes are reflected in deferred income taxes. Significant components of the Company's deferred tax assets and liabilities as of December 31, 2011 and 2010 are as follows:

Temporary differences:

	2011	2010
Income	$ -	$ 2,894,778
Expenses	(66,205)	(1,396,057)
Depreciation	(374,658)	(187,298)
Total temporary differences	$ (440,863)	$ 1,311,423

(8) Employee Benefit Plans

The Company has a plan, which qualifies as a "Cafeteria Plan" under Section 125 of the Internal Revenue Code. The plan allows the Company's employees to pay for medical insurance, daycare and medical expenses on a pre-tax basis. All employees whose customary employment is full-time are eligible to participate in the plan.

The Company has a plan, which qualifies as a Tax-Sheltered Account under Section 401(k) of the Internal Revenue Code for the benefit of employees whose customary employment is at least 20 hours per week and who meet the plan's eligibility requirements. Under the retirement plan, employees can invest pre-tax dollars. The employees are not taxed on contributions or earnings until they receive distributions from the account. The Board of Directors shall determine each year in its sole discretion whether or not to make a contribution to the plan on behalf of the participants for such year. The employer shall have the right to make plan amendments at any time and from time to time in whole or in part. Contributions in the amount of $22,191 and $19,181 were made to the plan for the years ended December 31, 2011 and 2010, respectively.

The Company maintains a deferred compensation plan for death and retirement benefits for certain key employees. The plan requires that benefit obligations be funded commencing in 2012 in accordance with the vesting schedules attributable to each employee. Employee benefits vest commencing in 2012 at a rate of 5% per year and become fully vested when the employee reaches the age of sixty-five years old. As no obligation accrues until the commencement of the vesting period, no liability has been recorded as of December 31, 2011 and 2010. In order to fund these future obligations, the Company has invested certain funds in mutual funds.

(9) Commitments and Contingencies

The Company is involved in legal actions arising in the normal course of business. In the opinion of management, such matters will not have material effect upon the financial position of the Company.

The Company entered into an agreement with the Commonwealth's Department of Public Health with respect to the Early Intervention program whereby the subsequent years' rate will be determined based upon review of prior years' financial operating results. During the years ended December 31, 2011 and 2010, revenue offsets evidenced by rate reductions of $594,506 and $554,545, respectively, of which $451,037 and $251,338, respectively were applied through invoice offsets. In addition, the Company will be allowed to retain surplus revenues in an amount equal to 5% of all Early Intervention revenues. Return of surplus revenues will be in the form of a rate reduction taken through future invoice offsets; as a result, no liability has been reflected in these financial statements.

The Company has entered into a Guaranty Agreement to guarantee the mortgage obligations of 50 Aldrin Road, LLC, a company whose ownership is common to the Company (see Note 3). In the opinion of management, the valuation of the guarantee is immaterial. Subsequent to year end, as a part of the sale of the Company, the Company was released from this guarantee (see Note 10).

(10) Subsequent Events

The Company has performed an evaluation of subsequent events through April 4, 2012, which is the date the Company's financial statements were available to be issued. No material subsequent events, other than the items disclosed below, have occurred since December 31, 2011 that required recognition or disclosure in these financial statements.

Subsequent to year end, the management of the Company entered into an agreement with Community Intervention Services, Inc. whereby the Company will be sold to Community Intervention Services, Inc. effective April 11, 2012. The Company will continue normal operations under the new management. As such, no adjustments have been made to these financial statements concerning the subsequent sale.

Additionally, subsequent to year end and in anticipation of the sale to Community Intervention Services, Inc., the Company was released from its guarantee of the mortgage obligations of 50 Aldrin Road, LLC (see Note 9), and the Company's line of credit with Rockland Trust Bank was closed (see Note 5). No adjustments have been made to these financial statements concerning the subsequent release.

SOUTH BAY MENTAL HEALTH CENTER, INC.

Schedule of Findings and Responses

December 31, 2011 and 2010

(1) Current Year Audit Findings

No significant deficiencies or material weaknesses reported.

(2) Prior Year Audit Findings

No significant deficiencies or material weaknesses reported.

7. Patient Population Mix: Current and Projected

a. Provide the current and projected patient population mix (based on the number of patients, not based on revenue) with the CON proposal for the proposed program.

Table 3: Patient Population Mix

	Current** FY ***	Year 1 FY ***	Year 2 FY ***	Year 3 FY ***
Medicare*		26	31	34
Medicaid*		399	479	527
CHAMPUS & TriCare		0	0	0
Total Government		**425**	**510**	**561**
Commercial Insurers*		40	48	52
Uninsured			0	0
Workers Compensation			0	0
Total Non-Government		**40**	**48**	**52**
Total Payer Mix		**465**	**558**	**613**

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

b. Provide the basis for/assumptions used to project the patient population mix.

8. Financial Attachments I & II

a. Provide a summary of revenue, expense, and volume statistics, without the CON project, incremental to the CON project, and with the CON project. **Complete Financial Attachment I.** (Note that the actual results for the fiscal year reported in the first column must agree with the Applicant's audited financial statements.) The projections must include the first three full fiscal years of the project.

b. Provide a three-year projection of incremental revenue, expense, and volume statistics attributable to the proposal by payer. **Complete Financial Attachment II.** The projections must include the first three full fiscal years of the project.

c. Provide the assumptions utilized in developing **both Financial Attachments I and II** (e.g., full-time equivalents, volume statistics, other expenses, revenue and expense % increases, project commencement of operation date, etc.).

d. Provide documentation or the basis to support the proposed rates for each of the FYs as reported in Financial Attachment II. Provide a copy of the rate schedule for the proposed service(s).

e. Provide the minimum number of units required to show an incremental gain from operations for each fiscal year.

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

Total Facility:			1.1	2%		110%	120%		110%	120%	
Description	FY 2011 Actual Results	FY Projected W/out CON	FY Projected Incremental	FY Projected With CON	FY Projected W/out CON	FY Projected Incremental	FY Projected With CON	FY Projected W/out CON	FY Projected Incremental	FY Projected With CON
NET PATIENT REVENUE										
Non-Government	$3,140,618	$3,454,680	$62,812	$3,517,492	$3,800,148	$75,375	$3,875,523	$4,180,163	$90,450	$4,270,612
Medicare	$2,034,612	$2,238,073	$40,692	$2,278,765	$2,461,881	$48,831	$2,510,711	$2,708,069	$58,597	$2,766,665
Medicaid and Other Medical Assistance	$17,107,275	$18,818,003	$342,146	$19,160,148	$20,699,803	$410,575	$21,110,377	$22,769,783	$492,690	$23,262,473
Other Government	$15,640,055	$17,204,061	$312,801	$17,516,862	$18,924,467	$375,361	$19,299,828	$20,816,913	$450,434	$21,267,347
Total Net Patient Patient Revenue	$37,922,560	$41,714,816	$758,451	$42,473,267	$45,886,298	$910,141	$46,796,439	$50,474,927	$1,092,170	$51,567,097
Other Operating Revenue	$112,907	$124,198	$2,258							
Revenue from Operations	$38,035,467	$41,839,014	$760,709	$42,473,267	$45,886,298	$910,141	$46,796,439	$50,474,927	$1,092,170	$51,567,097
OPERATING EXPENSES										
Salaries and Fringe Benefits	$27,401,542	$30,141,696	$548,031	$30,689,727	$33,155,866	$657,637	$33,813,503	$36,471,452	$789,164	$37,260,617
Professional / Contracted Services		$0	$0	$0	$0	$0	$0	$0	$0	$0
Supplies and Drugs		$0	$0	$0	$0	$0	$0	$0	$0	$0
Bad Debts		$0	$0	$0	$0	$0	$0	$0	$0	$0
Other Operating Expense	$5,550,297	$6,105,327	$111,006	$6,216,333	$6,715,859	$133,207	$6,849,066	$7,387,445	$159,849	$7,547,294
Subtotal	$32,951,839	$36,247,023	$659,037	$36,906,060	$39,871,725	$790,844	$40,662,569	$43,858,898	$949,013	$44,807,911
Depreciation/Amortization	$148,256	$163,082		$163,082	$179,390	$0	$179,390	$197,329	$0	$197,329
Interest Expense				$0			$0			$0
Lease Expense				$0			$0			$0
Total Operating Expenses	$33,100,095	$36,410,105	$659,037	$37,069,141	$40,051,115	$790,844	$40,841,959	$44,056,226	$949,013	$45,005,239
Income (Loss) from Operations	$4,935,372	$5,428,909	$101,673	$5,404,126	$5,835,183	$119,297	$5,954,480	$6,418,701	$143,157	$6,561,858
Non-Operating Income	($20,077)	$12,000		$12,000	$13,200	$0	$13,200	$14,520	$0	$14,520
Income before provision for income taxes	$4,915,295	$5,440,909	$101,673	$5,416,126	$5,848,383	$119,297	$5,967,680	$6,433,221	$143,157	$6,576,378
Provision for income taxes	$141,440	$155,584			$171,142	$0		$188,257	$0	
Net Income	$4,773,855	$5,285,325	$101,673	$5,416,126	$5,677,240	$119,297	$5,967,680	$6,244,964	$143,157	$6,576,378
Retained earnings, beginning of year	($572,750)	$4,201,105	$4,201,105	$4,201,105	$9,486,430	$4,302,778	$9,617,231	$15,163,670	$4,422,075	$15,584,911
Retained earnings, end of year	$4,201,105	$9,486,430	$4,302,778	$9,617,231	$15,163,670	$4,422,075	$15,584,911	$21,408,635	$4,565,232	$22,161,289
FTEs	596	656	12	668	721.74	14.32	736.06	793.91	17.18	811.09

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

85

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: Behavioral Health Services
Type of Unit Description: Hour sessions
# of Months in Operation: 12

FY _13 **FY Projected Incremental** Total Incremental Expenses: **$650,922** **Total Facility by Payer Category:**	(1)	(2) Rate	(3) Units	(4) Gross Revenue Col. 2 * Col. 3	(5) Allowances/ Deductions	(6) Charity Care	(7) Bad Debt	(8) Net Revenue Col.4 - Col.5 -Col.6 - Col.7	(9) Operating Expenses Col. 1 Total * Col. 4 / Col. 4 Total	(10) Gain/(Loss) from Operations Col. 8 - Col. 9
Medicare	$40,692	$82	499	$40,692			$435	$40,257	$34,819	$5,437
Medicaid	$654,947	$82	8,036	$654,947			$7,008	$647,939	$560,423	$87,516
CHAMPUS/TriCare		$82		$0			$0	$0	$0	$0
Total Governmental	$695,639		8,535	$695,639	$0	$0	$7,443	$688,196	$595,242	$92,953
Commericial Insurers	$62,812	$82	771	$62,812			$672	$62,140	$53,747	$8,393
Uninsured	$2,258	$82	28	$2,258				$2,258	$1,932	$326
Total NonGovernment	$65,070	$82	798	$65,070	$0	$0	$672	$64,398	$55,679	$8,719
Total All Payers	$760,709	$82	9,334	$760,709	$0	$0	$8,115	$752,594	$650,922	$101,672

3/0

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: Behavioral Health Services
Type of Unit Description: Hour sessions
# of Months in Operation: 12

FY _14 **FY Projected Incremental** Total Incremental Expenses: **$781,105** **Total Facility by Payer Category:**	(1)	(2) Rate	(3) Units	(4) Gross Revenue Col. 2 * Col. 3	(5) Allowances/ Deductions	(6) Charity Care	(7) Bad Debt	(8) Net Revenue Col.4 - Col.5 -Col.6 - Col.7	(9) Operating Expenses Col. 1 Total * Col. 4 / Col. 4 Total	(10) Gain/(Loss) from Operations Col. 8 - Col. 9
Medicare	$48,831	$82	599	$48,831			$522	$48,309	$41,908	$6,401
Medicaid	$785,935	$82	9,643	$785,935			$8,410	$777,525	$674,509	$103,017
CHAMPUS/TriCare		$82		$0			$0	$0	$0	$0
Total Governmental	$834,766		10,243	$834,766	$0	$0	$8,932	$825,834	$716,417	$109,417
Commericial Insurers	$75,375	$82	925	$75,375			$807	$74,568	$64,689	$9,880
Uninsured		$82	0	$0				$0	$0	$0
Total NonGovernment	$75,375	$82	925	$75,375	$0	$0	$807	$74,568	$64,689	$9,880
Total All Payers	$910,141	$82	11,167	$910,141	$0	$0	$9,739	$900,402	$781,105	$119,297

11/3

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: Behavioral Health Services
Type of Unit Description: Hour sessions
# of Months in Operation: 12

FY _14 **FY Projected Incremental** Total Incremental Expenses: **$937,327**	(1)	(2) Rate	(3) Units	(4) Gross Revenue Col. 2 * Col. 3	(5) Allowances/ Deductions	(6) Charity Care	(7) Bad Debt	(8) Net Revenue Col.4 - Col.5 -Col.6 - Col.7	(9) Operating Expenses Col. 1 Total * Col. 4 / Col. 4 Total	(10) Gain/(Loss) from Operations Col. 8 - Col. 9
Total Facility by Payer Category:										
Medicare	$58,597	$82	719	$58,597			$627	$57,970	$50,289	$7,681
Medicaid	$943,124	$82	11,572	$943,124			$10,091	$933,033	$809,411	$123,621
CHAMPUS/TriCare		$82		$0			$0	$0	$0	$0
Total Governmental	$1,001,721		12,291	$1,001,721	$0	$0	$10,718	$991,003	$859,700	$131,302
Commericial Insurers	$90,450	$82	1,110	$90,450			$968	$89,482	$77,626	$11,856
Uninsured		$82	0	$0				$0	$0	$0
Total NonGovernment	$90,450	$82	1,110	$90,450	$0	$0	$968	$89,482	$77,626	$11,856
Total All Payers	$1,092,171	$82	13,401	$1,092,171	$0	$0	$11,686	$1,080,485	$937,327	$143,158

3/2

- 8C, D, E, F

South Bay Mental Health Center, Inc

Assumptions:

Assumptions for developing the financial attachments are based on historical growth of existing and new operations.
The assumptions are based on the full year of operations after the initial start-up phase of 6-9 months.
The new operation is projected to grow at least 20% per year in the first 3 years and taper down to a consistent growth after year 4.
Our model will allow us to build volume without incurring significant start-up costs. Additional staff and resource will increase as volume grows.
Once the operation is past the start up phase we are projecting minimum units at approximately 8000 per year. Consistent growth in revenue and operations will allow adequate return. No losses are contained in the financial projections.

Rates:

Rates are based on the MBHP (Massachusetts Behavioral Health Provider) current rate schedule.

	Rate	Unit
Individual and family	40.75	Half hour
Diagnostic Services	111.38	Hour
Psych Testing	88.32	Hour
Group therapy	14.23	Half hour *# clients
Medication	50.70	15 min
Case Consulting	36.52	Half hour
Family consultation	36.40	Half hour

f. Explain any projected incremental losses from operations contained in the financial projections that result from the implementation and operation of the CON proposal.
Please see attached

g. Describe how this proposal is cost effective.
Behavioral health is a recognized element of health service systems that improves health status and contains health care and other costs to society. However, too often, consumers with mental and substance abuse disorders fail to receive treatment through the health care system and rely on public safety-net programs. This drains resources that are typically meant to be short-term provisions and are usually provided at greater cost. Often it is not until an emergency episode where inpatient is required that these consumers receive treatment. As a result, more intensive long-term services are required rather than if preventative and community based support services were utilized. This population typically relies on hospital emergency departments to meet their behavioral and physical health care needs at a much greater cost.

SAMHSA reported that " last year (2011) alone approximately 20 million people who needed substance abuse treatment did not receive it and an estimated 10.6 million adults reported an unmet need for mental health care. As a result the health and wellness of the individual is jeopardized and the unnecessary costs to society ripple across America's communities, schools, businesses, prisons & jails, and healthcare delivery systems."

South Bay's outreach and community-based approach to care provides our consumers with the support they need to remain in the community and develop the necessary skills to become as self-sufficient as possible. Our goal is to assist our consumers in becoming productive members within their families and communities.

South Bay is result oriented – we seek measurable outcomes not only for our consumers but also for the community and system at large. Through our main focus of providing the best evidence based and holistic treatment to our consumers we find that we are able to impact many areas of their lives that in turn impact the greater community. Some of the areas we measure as a result of our services are a decrease in the following: loss of time at school and work, hospital emergency

department over-utilization, hospital admission, involvement with correction systems to name a few.

Page numbers 316 – 325 were not used

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

November 16, 2012

VIA FAX ONLY

Laura Nolda
Program Director
South Bay Mental Health Center, Inc.
237 Hamilton St., Suite 205
Hartford, CT 06106

RE: Certificate of Need Application; Docket Number: 12-31798-CON
Establishment of an Outpatient Mental Health Clinic in Hartford
CON Completeness Letter

Dear Ms. Nolda:

On October 26, 2012, the Office of Health Care Access ("OHCA") received your initial Certificate of Need ("CON") application filing on behalf of South Bay Mental Health Center, Inc. ("Applicant") proposing to establish an outpatient mental health clinic in Hartford ("Clinic").

OHCA has reviewed the CON application and requests the following additional information pursuant to General Statutes §19a-639a(c). The page numbers given in each question refer to the submitted initial Certificate of Need ("CON") application.

1) Explain why there is a clear public need for the proposal and provide evidence that demonstrates this need. Include statistical information, as appropriate, from the Center for Behavioral Health Statistics and Quality of the federal Substance Abuse and Mental Health Administration relating to the need for the proposal (i.e. the number of patients needing but not receiving treatment, the percentage of population in Connecticut needing treatment) and from the State's Department of Mental Health and Addiction Services.

2) Provide additional rationale for selecting the town of Hartford as the location for the proposed Clinic.

3) On page 6 of the CON application it states that the population growth in Connecticut increased by 17% from 2009 to 2010. The population was 3,577,845 in 2010 and 3,518,288 in 2009, for an increase of 1.7%. On page 7 it states the population of Hartford County increased by 17%, when the increase was also 1.7%. Please revise the discussion concerning population to reflect the correct increases for the State and for Hartford County.

4) Identify the specific patient population to be served by the proposal. Explain how and where the specific patient populations identified are currently being served.

5) Provide a detailed explanation on the effect of the proposal on existing providers listed on pages 14 to 17, including the effect on volume, finances, and current referral patterns.

6) Discuss how this proposal will not result in shift of volume from existing providers to the proposed center resulting in an unnecessary duplication of services.

7) The Applicant has provided information on numerous socioeconomic groups living within the greater Hartford area. However, there is no correlation between the information provided and the unmet need in the proposed service areas.

   a. Utilizing the information and statistics provided in the initial CON application and other sources as may be needed, address the public need for the proposal by determining the number of persons by group, i.e., high school students, families that will benefit from your services.

   b. Complete the following table utilizing the information obtained from Question a. The first row of the table demonstrates how to quantify the potential number of persons from a single group for a single town. (*Note: the numbers are meant to demonstrate the method only).* Delete the first row and develop a similar calculation for each group of persons from each town in your proposed service area. Add additional rows as needed to quantify the total number of persons from the various groups and towns that may benefit from the proposal.

Table 1: Number of Persons in Service Area with Unmet Need

Description of Population	Town	Number of Persons	% Needing Services	Number of Persons Needing Services	% of Persons Proposed to be Served by the Applicant	Number of persons that may benefit from proposal
Children in foster care	Hartford	2,500	2%	50 (2,500 * .02)	30%	15 (2,500 * .02 *.60)
Total number of persons that may benefit from proposal:						

8) From the need projected in Question 6, determine the Applicant's estimated projected volume as number of persons for FYs 2013, 2014, and 2015. Differentiate the volumes by the service to be provided and population served (youth, adults). **List all assumptions made to determine the projected volumes.**

Table 2: Projected Volume by Fiscal Year

Population	Service Type	FY 2013		FY 2014		FY 2015	
		Persons	Sessions	Persons	Sessions	Persons	Sessions
Total							

* Identify each service/procedure type and add lines as necessary.

9) Explain the increases in the number of persons and the number of sessions from the relative previous year for FY 2014 and FY 2015.

10) Place a checkmark (✓) in the "Need for Proposal" column for each license that the Applicant is seeking from the State's Department of Public Health (DPH) or the State's Department of Children and Families (DCF) in relation to the proposal.

Information concerning DPH licensure may be obtained by contacting Sandra Bauer, DPH Facility Licensing, at (860) 509- 8023 or Sandra.Bauer@ct.gov. Licenses to provide behavioral health care to children may be obtained by contacting Jim McPherson, Program Manager for DCF Licensing Unit, at (860) 550-6532 or Jim.Mcpherson@ct.gov.

Table 3: Licenses Need for the Proposal

Agency	License	Needed for Proposal
DPH	Psychiatric Outpatient Clinic for Adults	
	Facility for the Care or the Treatment of Substance Abusive or Dependent Persons (Outpatient)	
	Mental Health Day Treatment Facility	
DCF	Outpatient Psychiatric Clinic for Children	
	Extended Day Treatment	

11) On page 19 of the CON Application, the table used to project hours of service includes service code descriptions. Please explain the services that the Applicant proposes to provide under each service code listed. Specify the services to be provided and the clients that will receive the services.

12) On page 19, the historic volumes for the Mental Health division of the application for the past three years were reported. Please explain the relationship of the sessions, units and hours.

13) On page 13 of the CON application it states that many of the existing agencies in the proposed service area have waitlists due to a large residential need and lack of appropriate staffing equipped to assist the population. Please provide additional discussion including supporting documentation concerning this statement.

14) On page 318 of the CON application, the proposed patient population mix by payer is provided. Please explain the basis and the assumptions used to project the reported numbers.

15) Describe the services that the Applicant will provide to underinsured or uninsured clients.

16) On page 323 of the CON application it states that the projected growth per year in the first 3 years will be 20%. Provide a discussion that supports the 20% yearly increase. Provide documentation that supports the discussion.

17) Report the minimum number of patient visits required to show an incremental gain from operations for each projected fiscal year.

18) Report the number of staff by position that will be required to accommodate the number of patient visits reported in Question 7.

19) Provide a copy of the Applicant's business plan for the proposal.

20) Explain how this proposal contributes to the quality of health care delivery in the region.

21) Describe the effect of the proposal on the interests of consumers of health care services and the payers of such services.

In responding to the questions contained in this letter, please repeat each question before providing your response. Information filed after the initial CON application submission (e.g., completeness response letter, prefile testimony, late file submissions and the like) must be numbered sequentially from the Applicant's document preceding it. **Paginate and date** your response (e.g., each page in its entirety) beginning with Page Number 326. Please reference "Docket Number: 12-31798-CON." Submit one (1) original and four (4) hard copies of your response. Each copy must be fully paginated. In addition, please submit a scanned copy of your response paginated and including all attachments on CD in an Adobe format (.pdf) and in an MS Word format.

Pursuant to Section 19a-639a(c) you must submit your response to this request for additional information not later than sixty days after the date that this request was transmitted. Therefore, please provide your written responses to OHCA no later than January 15, 2013. If you have any questions concerning this letter, please feel free to contact me at (860) 418-7032.

Sincerely,

Laurie K. Greci

Laurie K. Greci
Associate Research Analyst

Copy of PDF file: Kim Martone, Director of Operations, DPH OHCA
Kevin Hansted, DPH Staff Attorney
Kaila Riggott, CON Supervisor, DPH OHCA

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*** TX REPORT ***
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STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: Laura Nolda, Program Director

FAX: (860) 951-7729

AGENCY: South Bay Mental Health Center, Inc

FROM: Laurie Greci

DATE: 11/16/2012 TIME: 3:17 pm

NUMBER OF PAGES: 5
(including transmittal sheet

Comments: Completeness Letter concerning Certificate of Need Application for Establishing Outpatient Mental Hlth Clinic

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

SOUTH BAY
MENTAL HEALTH

Administration
Brockton

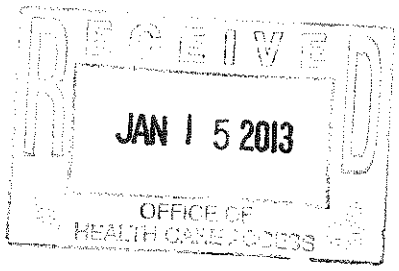
Mental Health and Addictions Treatment
Attleboro
Brockton
Cape Cod
Fall River
Lawrence
Lowell
Plymouth
Salem
Weymouth
Worcester

Mental Health Outreach
Leominster
Lynn
New Bedford
Swansea

Adult Day Services
Brockton
Cape Cod
Fall River
Plymouth
Worcester

Children's Day Services
Fall River
Lowell

Early Childhood Services
Brockton
Fall River
Lowell
Worcester



January 14, 2013

Lori K. Grecci
State of CT Department of Public Health
410 Capitol Avenue
Hartford, CT 06134

Dear Ms. Grecci,

Enclosed please find South Bay Mental Health's response to OHCA's completeness letter.

If there are any questions or concerns please do not hesitate to contact me.

Sincerely,

Kim Arouca
Director of Program Initiatives
karouca@southbaymentalhealth.com
South Bay Mental Health Center, Inc.

1115 West Chestnut Street
Brockton, MA 02301
P: 508-580-4691
southbaymentalhealth.com

Item 1) Explain why there is a clear public need for the proposal and provide evidence that demonstrates this need. Include statistical information, as appropriate, from the Center for Behavioral Health Statistics and Quality of the federal Substance Abuse and Mental Health Administration relating to the need for the proposal (i.e. the number of patients needing but not receiving treatment, the percentage of population in Connecticut needing treatment) and from the State's Department of Mental Health and Addiction Services.

Utilizing data from the Federal Fiscal Year 2012 - 2013 Community Mental Health Services Block Grant Report (CMHS BG) including The Community Mental Health Assessment and Plan For Adults September 1, 2011 submitted by The Department of Mental Health & Addiction Service we have identified a great need for increased mental health services in the proposed service area. Table 1 below (CMHS BG 2012-2013 page 53) indicates that 185,515 adults have been identified with mental illness in the North Central Region of Connecticut – 41,916 of those individuals have Serious Mental Illness (SMI). The table further illustrates that a total 658,943 adults across the state of Connecticut experience some form of mental illness.

Using the CMHS definition and methodology, DMHAS estimates the prevalence of mental illness and SMI in Connecticut based on 2010 U. S. Census for FFY 2012-2013 as follows:
Table 1: Prevalence of SMI and SPMI by Region and in Connecticut

Region/State	Estimate 2010 Census Adult (18+) Population*	2010 Census Any Form of Mental Illness (23.9%)	2010 Census Serious Mental Illness (SMI) (5.4%)
Southwest (1)	511,312	122,204	27,611
South Central (2)	654,624	156,455	35,350
Eastern (3)	341,930	81,721	18,464
North Central (4)	776,214	185,515	41,916
Northwest (5)	473,002	113,047	25,542
CT TOTAL:	**2,757,082**	**658,943**	**148,882**

According to the same report, Table 2 (page 54 CMHS BG) shown below indicates that in 2011 only 36.5% or 54,300 adults in need of mental health services in the state of Connecticut were actually served. The fact that 63.5% or 510,061 individuals in need of services were left untreated clearly indicates the need for additional mental health services in the state. Using the data above, 63.5% of 185,515 would translate into 117,802 adults with unmet needs in the proposed Region 4 and that over 26,600 of those who are untreated are suffering from Serious Mental Illness (SMI).

Table 2: Percentage of Adults Receiving Publicly Funded Services Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Projected
% of people receiving publicly funded mental health services	39.0%	40.78% **39.5%** **Actual**	39.7% **36.5%** **Actual**
Numerator	55,440	56,483 **54,656** **Actual**	58,000 projected **54,300** **Actual**
Denominator	138,500	138,500	145,950* **148,882****

Using the CMHS definition and Methodology along with the above data, we estimate the prevalence of mental illness and the number of adults in the proposed service area currently not receiving treatment as follows:

Table 3: Adults with Unmet Need in Proposed Service Area

City/Town	Over 18 Population	23.9% with mental illness	63.5% of 23.9% of adults with unmet need
Hartford	92,558	22,121	14,047
East Hartford	39,275	9,387	5,960
West Hartford	48,503	11,592	7,361
Manchester	45,988	10,991	6,979
Total Proposed Service Area	**226,324**	**54,091**	**34,347**

The same CMHS BG Report also stated, "the need for child and adolescent mental health services exceeds the available behavioral health resources, which is a similar trend across the nation. Between 7% and 9% of children and youth in the United States meet the criteria for serious emotional disturbance (SED) indicating the presence of a psychiatric disorder that seriously interferes with functioning at home, in school, and/or community. Most recent estimates are that up to 20% of children and youth have some form of psychiatric disturbance and almost 70% do not receive treatment for their disorder. Of Connecticut's 807,985 children/youth, this translates to an estimated 60,000 to 76,000 children and youth with SED and up to 100,000 additional children with some form of psychiatric disturbance requiring mental health care (Sources: U.S. Census Bureau; US DHHS Agency for Health Care Research and Quality; Collaborative Psychiatric Epidemiologic Surveys). "

Using the above statistics along with total population for each city/town in the proposed service area and the percentage of population under age 18 as indicated in the US Census 2010/11 we calculated the total number of children and youth in proposed service area currently in need of mental health services not yet being served as follows:

Table 4: Number of children and Youth in the proposed area with mental illness not yet being served:

Service Area	Total population	Percentage of total population under 18 years of age	Number under 18 years of age	20% of population under 18 with MI	70% of the 20% not being served
Hartford	124,867	26%	32,216	6,443	4,510
East Hartford	51,252	23%	11,993	2,399	1,679
West Harford	63,268	23%	14,741	2,948	2,063
Manchester	30,577	22%	6,696	1,339	937
Total Number of Children and Youth in the Proposed Service Area with Unmet Need					**9,189**

As mentioned in our original application, it is well documented that rates of psychiatric disorder are even higher for those children living in poverty. Although Connecticut has one of the highest state per capita incomes in the country, three of Connecticut's larger cities (Hartford, Waterbury and New Haven) have some of the highest child poverty rates in the nation – Hartford ranked 6th in the country with 47% of its children living in poverty (Connecticut Commission on Children 2009). Given the tipped scale related to poverty, one may assume that the percentage of children in need in the proposed area is higher than the above calculation.

In an effort to gain more recent and specific data we have personally contacted many Hartford providers of like services as well as those who serve potential South Bay consumers in other ways. We discovered that existing providers are having difficulty addressing the current demand and collaterals are seeking new providers to assist with their populations' needs. Several providers who were contacted reported that they are unable to take new referrals including two of the largest behavioral health providers in the area. Charter Oak Health Center and Community Health Services Inc., two of the most established mental health centers in the area are unable to take new consumers at this time and were unable to say when they may be able to accept new referrals. All of the other providers that were contacted indicated a waiting period between 3-6 weeks for services. Wheeler Clinic is unable to offer consumers an appointment for 5 weeks and Catholic Charities, shared they had over a three week waiting list, to name a couple. Several other providers in the area were unable to take the phone call and our call went from an automated message to a voicemail box. The inability to be able to directly connect to services when you are someone in need of therapeutic services can be challenging and discouraging. We know that when individuals reach out for services and are unable to access them, they often give up and choose to go without treatment. This can have devastating effects on the individual, their family and/or the community at large. South Bay wants to make sure that when an individual is ready to access treatment, a treatment source is ready to assist.

Furthermore, when speaking with providers at area schools we consistently heard there is a need for more services for children. For example:

The Social Worker at Achievement First Hartford Academy Elementary School located at 305 Greenfield Street, Hartford, reported no less than 50 children are not receiving the mental health support they need. And while some children are able to receive services at the school setting through Intensive In-Home Child and Adolescent Psychiatric Services (IICAPS) or other in-home treatment models, there are many who do not qualify for these intense services, but are in need of less intense services at this time. Our hope is that we would be able to reach them before their needs intensify. The Social Worker is the only provider in this school and identifies a need for more support. She stated that she personally sought other mental health agencies to assist in the school; however, others stated they were unable to assist due to their own overwhelming demands. She further reported that many

children are unable to receive after school services due to lack of transportation and parents working several jobs.

The clinician at LW Batchelder Elementary School located at 757 New Britain Ave in Hartford, reported a need for more in-school therapy for no less than 30 students. She stated that many parents have no means to take children to appointments after school. Therefore, many children go without services. She also indicated a need for specialty groups as well as a need for a therapist without DCF connections. Some issues she reported with the children were depression, ADHD, and bullying. She stated she was the only support within the school.

Division of Children and Families Director of Clinical Services, Jamie Lehane reported the area is in need of more providers with trauma specialists. Various other government and academic sources have noted this same need. The CMHS BB 2012-2013 State Plan clearly avowed that evidence based treatments for traumatized children, youth, and families are insufficient to meet the level of need.

"The prevalence of trauma is high in the general population, and higher in the foster care population. One of four children experience at least 1 potentially traumatic event before the age of 16, almost 2/3 experience more than one type of violence, and 4 in 10 children report witnessing domestic violence (David Finkelhor et al UNH). High-risk populations are those that experience chronic traumatic situations including children who experience abuse/neglect, are in out-of-home placement, have been exposed to domestic violence, or are exposed to violence in their schools and communities. Rates for post-traumatic stress disorder are 21% for foster children versus 4.5% for the general population. Connecticut providers report that 70 to 80% of all children receiving mental health services have a history of traumatic events (CT PSDCRS - SFY 2010). Yet, there are few trauma-specific evidence- based treatments available to address the need. During SFY 2010 only 300 children/youth were offered Trauma-Focused Cognitive Behavior Therapy, which represents 6.9% of those children/youth committed to state custody. (Source: TF-CBT Monthly Metrics Child Health and Development Institute of the Connecticut Center for Effective Practice) This is a critical concern because it is well documented that those who are adversely impacted by traumatic experiences in childhood suffer lifelong consequences. These include poor physical and mental health, school failure, teen pregnancy, unemployment, and unsuccessful relationships. "

The National Survey of Children's Health, 2003 reported, "There is a significant need for prevention and early intervention services. 35.2% of Connecticut parents with children ages birth to five express one or more concerns about their child's learning, development or behavior, and 9.2% of parents with children age three to seventeen report moderate or severe difficulties in the area of emotions, concentration, behavior, or getting along with others. Yet, a survey of 48 pediatric and family medicine providers in Connecticut reported that 90% of their patients experience difficulty obtaining mental health services."

A continued need for transitional services for those youth with behavioral health and/or developmental needs that are aging out of the child welfare system was also identified in the CMHS BG State Plan 2012-2013. Currently there are 131 youth who are DCF-committed, ages 17 and up who have been accepted to DDS and will transition at age 21. The number of these referrals continues to grow. (Source: DCF LINK) And, there are 313 youth ages 17 and up, who have been accepted to the Department of Mental Health and Addiction Services (DMHAS) and are waiting to transition. An additional 161 referrals are pending with DMHAS (17 and up). (Source: DCF LINK) This indicates a total of 605 youth currently identified (with the number growing) statewide in need of services. With the earlier indication that 70% of youth in need of services are not being served this would translate to approximately 423 individuals across the state in need. Given the total population of the proposed service area is 269,964 or 7.5% of the total state population of 3,580,709, we estimate that 32 or more youth are in need of transitional services in the proposed service area.

Another concern identified in the CMHS BG plan is limited access to services for those involved with the child welfare and juvenile justice systems. "In Connecticut there are 4300 children/youth in state custody on any given day (Source: DCF LINK), which translates into a very conservative estimate of almost 400 children/youth with SED. Of those youth served in the DCF juvenile justice system, it is estimated that over half of the adolescents have some type of behavior disorder including mental illness and alcohol/drug dependency."

Overall limited evidence based treatments and programs availability across the continuum of care was identified as a major concern.

According to the Connecticut Mental health Report commissioned by Governor Rell, "treatment that works ends up being appropriate, accessible and sustained". The report further states that Connecticut must build a comprehensive, accessible, affordable, community based family oriented system of care, otherwise individuals with mental illness will continue to fill expensive and inappropriate settings such as hospital emergency rooms, the criminal justice system, nursing homes or just go untreated. The report further states that of the nearly 600,000 Connecticut adults who evidence symptoms of mental illness, 135,000 have serious mental illness and 66,000 suffer from persistent mental illness. The report concludes that those individuals with unmet mental health needs become unemployed and often homeless with their families becoming dysfunctional.

South Bay is in position to respond to the above-mentioned needs with expertise. We specialize in evidence-based Trauma Recovery, Disrupted Adoption, Kinship Homes, Forensics-Cases involving children and adolescents as well as adults working toward reintegration and reunification and Early Intervention. We also, develop specialized groups with direct input regarding particular need. We will be able to provide immediate service bringing some relief to both the consumers and existing

providers. Our goal is always to serve new consumers within 0-14 days, triaging the needs of consumers at intake.

South Bay also understands there is a need for additional IICAP services and continues to have an ongoing dialogue with DCF and Yale and intend to adopt the ICCAPs model to provide further treatment to children not yet served. An initial meeting was held on 3/19/2012 and with Robert Plant, Kristin Holdt and other members of the ICCAPS team to begin the application process.

Finally, the CMHS BG 2012-2013 plan reported there is a continuing need to offer education and training in multiple areas to assure a well-trained, diverse and culturally competent workforce. South Bay has a long-standing tradition of providing free CEU trainings* in the communities we serve.
*(Please see attachment "Fall & Winter—2012/2013, Training Calendar, For Social Workers, LMFTs and LMHCs" offered by South Bay Mental Health.)

Item 2) Provide additional rationale for selecting the town of Hartford as the location for the proposed clinic.

As shown above, Region 4, in which Hartford is the hub, has over 117,000 adults in need of additional behavioral health services; over 34,000 adults live in the proposed service area. In addition we identified over 9,000 children and youth in the specific proposed service area in need and we believe that number to be much greater given the number of children living in poverty, low-income households and foster care or kinship care in Hartford. We also believe Hartford allows for easy and centralized access for consumers.

South Bay's mission has always been to reach people in need of treatment and assist them in accessing all of the services available to them. As mentioned in this response as well as in our initial CON application, many official reports have indicated a great need for additional mental health and substance abuse recovery services in the Hartford area as well as the state of Connecticut at-large. A high concentration of other needed services involve populations such as children and youth suffering from trauma and violence related issues, transitional youth, individuals suffering from mental illness and/or substance abuse as well as others.

South Bay has a long history of providing specialized treatment to these populations including a commitment to evidence-based practices. We believe this is a geographic area where South Bay can make a difference.

Item 3) Correct 17% population growth to 1.7%.

Corrections needed and made in sec a. i and iii highlighted in yellow

Clear Public Need

a. Provide the following regarding the proposal's location:

(i) The service area towns and the basis for their selection;

South Bay would like to serve the people of Hartford, West Hartford, East Hartford and Manchester particularly to assist disadvantaged people in developing self-sufficiency. Within the selected proposed service area, there are many individuals, couples, and families who do not have the support in their lives to allow them to live to their full potential. The data provided in 3d supports the need and increasing risk in the proposed areas. Evidence from various sources including the local, state, and federal government sources indicated the proposed area is struggling with a variety of issues where South Bay can provide assistance. Some of the identified issues (which will be spoken to at greater detail in the next section below) are as follows:

- The recent population-hike in Connecticut from 2009 to 2010 of 1.7%
- Connecticut's unemployment rate has consistently been on the upswing in 2012. As of June 2012 the rate grew to 8.1% -- the highest rate of the year.
- 30.25% of Hartford's family living in poverty
- Hartford's child poverty rate reached 47%.
- High numbers of substantiated cases of abused and/or neglect in Hartford County
- High number of children entering and exiting foster care and kinship care
- High rate of Substance Abuse According to the National Survey on Drug use and Health 2007-2008, Connecticut was in the top 10 states for dependence on illicit drugs for adults from 18 to 25 years olds.
- High crime rate
- High incidence of teen pregnancy
- High concentration of people that are at increased risk for unhealthy risk for unhealthy living merely because of their race, age, income, educational status or family status
- Need for the additional services that South Bay is ready to offer the Greater Hartford community

South Bay will join the community to help people address the issues they may have encountered and/or continue to face allowing them to live more self sufficient and productive lives. South Bay is culturally sensitive agency and can accommodate consumers of various backgrounds, languages and area of need.

ii. The population to be served, including specific evidence such as incidence, prevalence, or other demographic data that demonstrates need;

South Bay Mental Health believes that there is a growing need for additional behavioral healthcare in the Hartford area. There are a number of factors that lead to this increasing need. The population is growing faster than current service providers are able to increase services. The difficult national economy has increased the ranks of the poor, which has especially impacted families and children.

After several years of stable population, Connecticut started to grow dramatically in 2009. in the table below we see data from the U. S. Census Bureau, showing the growth of population in the 2010 census-our most recent census. In one year, from 2009 to 2010 we see an increase of 1.7%.

Item 4) Identify the specific patient population to be served by the proposal. Explain how and where the specific patient populations identified are currently being served.

The population served will be for the most part low-income individuals and families – recipients of Medicaid, HUSKY and IICAP. A small percentage of the population may be privately insured. South Bay intends to serve adults and children (ages 3-80) with mental illness and/or substance abuse with a focus on the following sub-groups:

- Children and Youth suffering from trauma and violence related issues
- Transitional Youth
- Children and Youth involved with Juvenile Justice System
- Low-income individuals and families
- Individuals in need of Psychotropic services
- Individuals suffering from Mental Illness and/or Substance Abuse

As mentioned earlier in Item 1, the population with unmet needs in the proposed service area is approximately 34,347 adults and 9,189 children. South Bay will reach out to these consumers who are not currently being served whether it is due to waitlists, the severity of their illness, transportation or other barriers yet to be determined. We intend to assist consumers in accessing insurance, transportation, and to refer them to other appropriate services for which they are eligible. As always, we will collaborate with local educators and providers as well as local and state agencies to identify, locate and reach out to individuals and families in need as well as other providers such as schools, shelters, housing complexes, etc., that may be in need of support.

South Bay strongly believes in outreach, collaboration and a comprehensive team approach. Our clinicians provide case consultation as well as bridge visits. When an individual is being discharged from inpatient the clinician will visit them before discharge, talk about a treatment plan and set up the first appointment. We have found this initial appointment helpful in making individuals feel more comfortable with the clinician/agency and can improve the chance of follow-through with treatment. However, should an individual fail to keep an appointment, our clinician's will contact the consumer by phone and if necessary will go to the consumer's home to encourage follow-through with treatment. South Bay has found these interventions successful in increasing compliance. We believe we will be able to reach those in need and engage them in treatment that will assist them in becoming self-sufficient and productive participants in the community.

Item 5) Provide a detailed explanation on the effect of the proposal on existing providers listed on pages 14-17, including the effect on volume, finances and current referral patterns.

The effect on volume and finances of the proposal on existing Outpatient Clinic providers is expected to be minimal if at all. South Bay's goal is to reach the 63.5% of adults and 70% of children and youth in need of services but have not yet been able to access them.

Given the number of persons in the proposed service area with unmet need, we believe the addition of more mental health services in the Hartford region will present a beneficial effect for both the current providers as well as the consumers in need of care. As mentioned in Item 1, when South Bay reached out to the current providers it became evident that there is a critical need for more services.

South Bay will add to the referral pattern in the Hartford Region by opening up availability in a timely manner. We look forward to collaborating with the other agencies by offering our services to the consumers they are unable to serve at the time. Adding South Bay will also offer consumers choice. South Bay commits to serve consumers in need and will hire staff as warranted to accommodate them.

Historically South Bay is a strong collaborator within the communities we work and serve. We work closely with local, state and federal agencies as well as providers who share a mutual concern with our consumers. We will offer a comprehensive array of services including: Individual Therapy, Group Therapy, Cognitive Behavioral Therapy, Dialectical Behavioral Therapy Treatment, Trauma Recovery, Forensics, Family Therapy, Drug and Alcohol Counseling and Psychiatric Services. South Bay's services will complement the community-based services offered in the area for treatment of substance abuses and mental health disorders.

Community based treatment helps to decrease the number of admissions, readmissions and duration of stay in more intense and expensive inpatient facilities. South Bay will help Connecticut address these issues by assisting people in becoming more self-sufficient and healthy, active participants in their community.

Item 6) Discuss how this proposal will not result in shift of volume from existing providers to the proposed center resulting in an unnecessary duplication of services.

Little to no shift of volume from existing providers is expected. As stated earlier, South Bay is seeking to provide treatment to the large population in need of services and not yet served. Our focus will include specific populations where it has been cited that there is a lack of sufficient and appropriate services available, i.e. Trauma focused CBT, Evidence-based prevention, Early Intervention and Treatment and Forensics.

Item 7a) Utilizing the information and statistics provided in the initial CON application and other sources as may be needed, address the public need for the proposal by determining the number of persons by group, i.e. High school students, families that would benefit from your services.

Group	# that may benefit	Source
Adults (18+) with Mental Illness that have no services in proposed region	226,324 adults in service area. 23.9% with MI. 63.5% of the 23.9% with unmet needs = **34,347 of adults in need of services**	Census 2010/11, CMHS BG 2012-2013, 9/1/2011- DMHAS – Please see Item 1 Table 3
Transitional Youth	605 referrals or pending referrals for children aging out of Department of Developmental Services (DDS) or merging into Department of Mental Health and Substance Abuse (DMHAS). 7.5% of the state's population or 45 transitional youth reside in the proposed service area of which 70% or **32 transitional youths need services**	Department of Children and Families
Children in Juvenile Justice System	4,300 children in the state's Juvenile Justice System each day with over 50% or 2150 experiencing emotional disturbance or behavioral issues. Most recent estimate – 7.5% of the state's population or 161 children involved with Juvenile Justice Systems live in the proposed service area. 70% or **113 children need services**	DMHAS
Childhood Trauma and Violence	4.5% of the general population has been diagnosed with Post-Traumatic Stress Disorder (PTSD) - 4.5% Hartford's population of **124,867 is 5,619 estimated individuals with PTSD.**	9/1/2011 DMHAS
IICAPS Consumers	IICAPS is a community based service to youth and children who are either discharged from inpatient facility or are at risk of going inpatient due to psychiatric and/or substance abuse. Based on inpatient alone, according to data in 2008 2,603 individuals received inpatient treatment across CT. In Region 4 that would indicate 25% or 146 persons 18 and younger (eligible for the IICAPS program). Proposed area represents 30% of the Region translating to: **44 children who could benefit from IICAPS.**	National Survey of Mental Health Treatment Facilities (NSMHTF), 2008
Low-income households with Children in Hartford	32,191 children in Hartford and 47% live in poverty estimating **15,130 children in impoverished households.**	US Census Bureau, Current Population Survey, 2008 Annual Social and Economic Supplement; Children's Defense Fund), DMHAS
Individuals in need of Psychotropic in Hartford	Population with geographical shortage is 64,868. This indicates to satisfy the 20,000:1 psychiatrist to patient ratio that at least **3 additional psychiatrists are needed**	Health Resources and Services Administration (HRSA), Application Submission and Processing System, Health Professional Shortage Areas (HPSA)
Children (17-) with Mental Illness that have no service in proposed region	Utilizing data from identified sources the total population of children in the area is 65,646. Given 20% or 13,129 with some form of mental illness and 70% of those without service indicates an approximate **9,190 children in need of service**	US Census 2011, CMHS BG 2012-2013 9/1/2011- DMHAS Please see Table 4 in Item 1
Agencies in need of training	Need for training in Evidence Based Practice (EBP) was indicated. 14+ agencies mentioned in this proposal as well as schools in Region 4 could benefit from South Bay Mental Health trainings.	CMHS BG 2012-2013

335

Item 7b) Complete the following table utilizing the information obtained from Question a. The first row of the table demonstrates how to quantify the approximate number of persons from a single group for a single town.

Table 1: Number of Persons in Service Area with Unmet Need

Description of Population	Towns	Number of Persons	% Needing Services	Number of Persons Needing Services	% of Persons Proposed to be Served by the Applicant	Number of Persons that may benefit from proposal
Transitional Youth	Hartford	21	70%	15	100%	15
Transitional Youth	East Hartford	9	70%	6	100%	6
Transitional Youth	West Hartford	11	70%	8	100%	8
Transitional Youth	Manchester	5	70%	4	100%	4
Low Income Households with Children	Hartford	15,130	25%	3,782	.02%	76
Children in Juvenile Justice System	Hartford	74	70%	52	100%	52
Children in Juvenile Justice System	East Hartford	31	70%	21	100%	21
Children in Juvenile Justice System	West Hartford	39	70%	27	100%	27
Children in Juvenile Justice System	Manchester	18	70%	12	100%	12
Childhood Trauma and Violence	Hartford	5,619	50%	2,810	.025%	70
Children in Need of Intense In-Home Therapy	Hartford	20	70%	14	100%	14
Children in Need of Intense In-Home Therapy	East Hartford	8	70%	6	100%	6
Children in Need of Intense In-Home Therapy	West Hartford	11	70%	8	100%	8
Children in Need of Intense In-Home Therapy	Manchester	5	70%	4	100%	4
Psychotropic Need	Hartford	64,868	70%	45,408	.0035%	159
Total number of persons that may benefit from proposal:						**481**

Item 7b) Table 2:

Using the CMHS definition and methodology, and in support of Question 7b this is an estimation of prevalence of Transitional Youth, Children in the Juvenile Justice System with Estimated Emotional or Behavioral Issues, and Children in need of Intense In-Home Therapy in Connecticut, and the proposed towns as follows to:

Population in Need	Total in need of this population for the State of Connecticut	Proposed Service Area represents 7.5% of total population	70% not yet receiving services
Transitional Youth	605	45	32
Children in the Juvenile Justice System with estimated Emotional or Behavioral Issues	2,150	161	113
Children in Need of Intense In-Home Treatment	583	44	31
Total Proposed Area	**3,338**	**250**	**176**

Item 7b Table 3 below supports question 7b by estimating the prevalence of Childhood Trauma and Violence (CT&V) and Low-Income Households with Children in the City of Hartford:

Population	City of Hartford's Population	% of CT&V population in Hartford	Estimated CT&V population in need of services in Hartford	70% in need but not yet receiving services in Hartford
Childhood Trauma and Violence	124,867	4.5%	5,619	3,933
Children living in Poverty - Hartford	32,192	47%	15,130	10,591

Item 7b Table 4 below is data from United States Census Bureau -2010/2011 to support estimated prevalence of need in this proposal:

Town	Total Population	18 and Under	18+	% of population in proposed area
Hartford	124,867	32,216	92,651	46%
East Hartford	51,252	11,993	39,275	19%
West Hartford	63,268	14,741	48,503	24%
Manchester	30,577	6,696	45,988	11%
Total	269,964	65,646	226,417	100%

Item 8) From the need projected in Question 6, determine the Applicant's estimated projected volume as number of persons for FYs 2013, 2014, and 2015. Differentiate the volumes by the service to be provided and population served (youth, adults). List all assumptions made to determine the projected volumes.

Clients may receive more than one service – each client will have a diagnostic assessment which will assess functioning capacities develop a case formulation, identify treatment goals and determine discharge plan. We assume groups will have approximately 10 participants. Our experience is that children and youth are best served by involving family. Assuming approximately 40% of our consumers will have an evaluation for medication, although not all will be determined to require medications. Clients working with other providers will require consultation with those providers to coordinate care.

Population	Service Type	FY 2013		FY 2013		FY 2013	
		Persons	Sessions	Persons	Sessions	Persons	Sessions
Children, Adolescents and Adults	Individual Therapy	285	2,680	356	3,280	461	4,104
Children, Adolescents and Adults	Psychological Testing	20	20	30	30	35	35
Children and Adolescents	Family Consultation	90	350	100	420	125	504
Children, Adolescents and Adults	Medication Visit	105	1,100	180	1,350	185	1,700
Children, Adolescents and Adults	Family Therapy	94	1800	118	2,160	152	2,592
Children, Adolescents and Adults	Case Consultation	342	1250	428	1500	553	1800
Children, Adolescents and Adults	Diagnostic Consultation	285	300	356	360	461	475
Children, Adolescents and Adults	Group Therapy	50	500	90	900	120	1,200
	Total	285	8,000	356	10,000	461	12,500

Item 9) Explain the increases in the number of persons and the number of sessions from the relative previous year for FY 2014 and FY 2015.

Assuming a 20% increase in the number of people served each year.

Item 10) Place a checkmark ( ) in the "Need for Proposal" column for each license that the Applicant is seeking from the State's Department of Public Health (DPH) or the State's Department of Children and Families (DCF) in relation to the proposal.

Table 3: Licenses Needed for the Proposal

Agency	License	Needed for Proposal
DPH	Psychiatric Outpatient Clinic for Adults	✓
	Facility for the Care and Treatment of Substance Abusive or Dependent Persons (Outpatient)	✓
	Mental Health Day Treatment Facility	
DCF	Outpatient Psychiatric Clinic for Children	✓
	Extended Day Treatment	

Item 11) On page 19 of the CON Application, the table used to project hours of service includes service code descriptions. Please explain the services that the Applicant proposes to provide under each service code listed. Specify the services to be provided and the clients that will receive the services.

- **Individual Therapy**: Therapeutic services provided to an individual.
- **Psychological Testing:** The use of standardized test instruments to evaluate aspects of an individual's functioning, including aptitudes, educational achievements, cognitive processes, emotional conflicts and type and degree of psychopathology.
- **Family Consultation**: A preplanned meeting of at least one-half hour with the parent/guardian or parents/guardians of a child who is being treated at the Clinic.
- **Medication Visit:** A person served visit to the Clinic specifically for prescription, review and monitoring of medication by a prescriber.
- **Family Therapy**: The treatment of more than one member of a family simultaneously in the same session.
- **Case Consultation:** A preplanned meeting of at least one-half hour's duration with an appropriate party from an agency or program when the Clinic has accepted the person served for treatment and continues to assume primary responsibility for the person's therapeutic Treatment and the other party continues to provide ancillary services.

- **Diagnostic Services:** The determination and examination by interview techniques of a patient's physical, psychological, social, economic, educational and vocational assets and disabilities for the purpose of designing a treatment plan.
- **Group Therapy**: The application of psychotherapeutic or counseling techniques to a group of people; most of who are not related by blood, marriage or legal guardianship.

All clients will be offered the above services as appropriate.

Item 12) On page 19, the historic volumes for the Mental Health division of the application for the past three years were reported. Please explain the relationship of the sessions, units and hours.

- Session: may be 30 minutes or 60 minutes
- Unit: 30 minutes
- Hour: 2 units

Item 13) On page 13 of the CON application it states that many of the existing agencies in the proposed service area have waitlists due to a large residential need and lack of appropriate staffing equipped to assist the population. Please provide additional discussion including supporting documentation concerning this statement.

On page 13 of the CON application we found "many of these other agencies ***may*** have a waitlist due to large residential need and lack of appropriate staffing equipped to assist this population." This statement was general observation made after reviewing many state and federal documents highlighting insufficient services available.

Item 14) On page 318 of the CON application, the proposed patient population mix by payer is provided. Please explain the basis and the assumptions used to project the reported numbers.

South Bay proposed a patient population mix by payer which is consistent with its current payer mix. Historically, South Bay has received 80-90% of its payments via government payers including Medicare and Medicaid. South Bay does not forecast a shift in payer mix and therefore believes it is indicative for go-forward business.

Item 15) Describe the services that the Applicant will provide to the underinsured or uninsured clients.

South Bay has made a commitment to serving the entire community, both those who have comprehensive insurance and those who are without adequate coverage. There are many consumers who are eligible for insurance but who are unaware of the benefits to which they are entitled and there are also others whose lives are so chaotic that they are not currently enrolled in programs that are available to them. We are entirely willing to provide services to these uninsured individuals free of charge but also provide them with the case management services needed to assist them in securing health insurance and to access other services and benefits they are entitled to. It is also our practice to

continue to provide services to consumers who have applied for coverage while they are awaiting enrollment. Our goal is to help them secure a sustainable self-sufficiency and we believe that health coverage is an important part of this.

In addition to those who are insurable but not currently enrolled, there are always some consumers who simply do not have insurance and are not eligible for coverage. We have available a sliding scale for these consumers which allows them to receive services at a very nominal charge - often as low as five dollars for an hour of therapy. We feel that these consumers should be responsible for their own care and should make a commitment to pay something. That having been said, we have always been willing to excuse payment in cases of hardship.

We do refer out consumers who are insured by carriers who have not yet included us on their panels and provide follow up to assure that they did connect with a provider that is able to take their insurance.

Item 16) On page 232 of the CON application it states that the projected growth per year in the first 3 years will be 20%. Provide a discussion that supports the 20% yearly increase. Provide documentation that supports the discussion.

South Bay calculated an estimated revenue growth rate by evaluation of historical growth rates of start-up clinics. While each clinic's growth rate may vary according to the needs of the Service Area, South Bay believes a 20% growth is achievable.

Revenue growth is attributable to increase in number of consumers along with related service hours. To illustrate, South Bay has included a summary of revenues for its Lynn, MA Mental Health Clinic.

	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11
Month/Month Incremental Revenue Increase								0%	264%	41%	26%	2%

	Year 2 - Post Start-Up Period											
	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12
Month/Month Incremental Revenue Increase	5%	-6%	11%	1%	3%	0%	1%	2%	0%	2%	1%	
um Monthly Growth 2012 (YTD 2012)	20%											

Item 17) Report the minimum number of patient visits required to show an incremental gain from operations for each projected year.

South Bay estimates that 4,000 patient visits (200x20 visits per patient) will yield operating profitability.

Item 18) Report the number of staff by position that will be required to accommodate the number of patient visits reported in Question 7.

Table represent 3rd year estimate volume
Proposed Number of Clients: 481
1 clinician: 23 clients at a given time

Staff Type	# of Staff Needed
Psychiatrist	1
Billing Support	4
Program Director	1
Clinical Supervisor	2
Masters Level Clinician	10.5
Masters Level Clinician specializing in Forensics	5
Masters Level Clinician specializing in Trauma	2.5
IICAPS Masters Level Clinician	3.5
Bachelors Level Mental Health Counselor	3.5

Item 19.) Provide a copy of the Applicant's buisness plan for the proposal.

Description	Fiscal Year 1 Projected P&L	Fiscal Year 2 Projected P&L	Fiscal Year 3 Projected P&L
NET PATIENT REVENUE *1			
Non-Government	$ 62,812	$ 75,375	$ 90,450
Medicare	40,692	48,831	58,597
Medicaid and Other Medical Assistance	342,146	410,575	492,690
Other Government	312,801	375,351	450,434
Total Net Patient Revenue	758,451	910,132	1,092,171
Other Operating Revenue	2,258	-	-
Revenue from Operations	760,709	910,132	1,092,171
OPERATING EXPENSES			
Salaries and Fringe Benefits *2	548,031	657,637	789,164
Professional / Contracted Services	-	-	-
Supplies and Drugs	-	-	-
Bad Debts	-	-	-
Other Operating Expense *3	111,006	133,207	159,849
Subtotal	659,037	790,844	949,013
Depreciation/Amortization/Misc./Start-Up *4	65,000	75,000	90,000
Total Operating Expenses	724,037	865,844	1,039,013
Income (Loss) from Operations	36,672	44,288	53,158
Operating Margin	4.8%	4.9%	4.9%
Non-Operating Income	-	-	-
Income before provision for income taxes	$ 36,672	$ 44,288	$ 53,158
Provision for income taxes	-	-	-
Net Income	36,672	44,288	53,158
Retained earnings, beginning of year	-	36,672	80,960
Retained earnings, end of year	$ 36,672	$ 80,960	$ 134,118

* 1 - Revenue is based upon South Bay's current patient population mix for its MA clinics. It was assumed the patient population mix would remain unchanged in CT. Government payments represents a majority of the mix and overall projected revenues.

* 2 - South Bay will grow its employee headcount as number of clients and sessions increase.

* 3 - South Bay has entered into a 3 year office lease (with 3 year option to extend) in Hartford CT. with an annual cost of $20,873.

* 4 - South Bay anticipates incremental costs associated with purchase of cap-ex items including computers, software, furniture & fixtures, leasehold improvements and other additional start-up costs in the initial years. Additionally, South Bay will be required to make additional cap-ex purchases for additional hires.

Item 20) Explain how this proposal contributes to the quality of health care delivery in the region.

South Bay has developed systems of care that encourage our consumers to achieve self-sufficiency and maintain healthy life styles. Our services are based on evidence-based practices and our outcome data shows both positive consumer satisfaction and measurable improvements in consumer functioning. We have demonstrated effectiveness in working with consumers suffering from major depression, serious and persistent mental illnesses, dual recovery and personality disorders. We have extensive experience in working from a family systems perspective and in helping families stay together and care for their loved ones at home. We are a recognized leader in treating trauma, including child mal-treatment, domestic violence and the effects of trauma on the academic performance of school age children. We have partnered with inpatient and residential providers to develop systems of care that are effective in helping to avoid or shorten the length of stay in restrictive settings and increase community tenure. We are currently working with primary care providers to accomplish the integration of behavioral health with physical medicine. Our interventions in managing behaviors have benefited juvenile offenders and women returning to the community from correctional programs. Because of our well developed information management and utilization management systems we have been asked to partner with a number of managed care organizations to keep consumers in their communities at lower levels of care. Our work in the Hartford area with children on the autism spectrum and their families has been recognized and has led to our service area being greatly expanded.

We are very proud of these accomplishments but we also recognize the excellence of the service providers currently serving the region. What we believe we can truly and uniquely contribute to the quality of health care delivery in the region stems from our commitment to provide meaningful access to services to many people by providing services in natural settings. When South Bay was founded in 1986 it was with the intention of making it possible for people who have difficulty leaving their homes to receive services - the elderly person who suffers from arthritis and has difficulty with mobility, the disorganized schizophrenic who can't keep an appointment for Thursday morning if he doesn't know it's Friday already, the depressed person who has just left the inpatient unit and intends to attend aftercare but just can't get the motivation to leave the house, the foster mother who works a full-time job and is also caring for three children who need therapy – all on different days, the agoraphobic who is unable to leave the house, and so many who suffer from problems that prevent them from getting into a clinic, who lack access to transportation or who are too disorganized to maintain involvement in the care that they need. Simply put, we will do home visits just as family doctors used to do decades ago.

When we pioneered home visits in 1986 it was with the intention of giving meaningful access to those who would not otherwise have access. We thought that this would be sufficient to justify our existence. We thought that we would simply give people the same treatment they receive if they came to the office. What we found was that the service was not the same treatment that they would get in an office. It was a markedly better service for this needy population. By working with people in their homes we see them in the one place where they are in control and this empowers them - the elderly person who gets flustered in a doctor's office and forgets to tell the doctor the most important symptom, the schizophrenic who is too suspicious to go to the clinic, the immigrant family that mistrusts an establishment that does not include them. We fund that providing services is the one place where people have control empowers them in treatment. Our staff embodies the philosophy of 'meeting the client where they are'.

The second, and somewhat unsuspected, advantage to home visits is that we get to meet and work with all the stakeholders in the consumer's life. We meet and talk with the relatives that are providing a home for the consumer, we talk to them about what problems they see and we get to work on those problems before the consumer becomes homeless because the family is stretched beyond their limits. We incorporate the parents of children and adolescents into treatment. We get to work with the family members who just wouldn't come to a clinic. We are able to coordinate with visiting nurses and other caregivers who are so important in the lives of our consumers.

The third aspect of home visiting that we did not predict, but has been tremendously important, was how it would change us as providers. We are invited guests in the homes of our consumers and we get to spend a short time sharing their lives. We get to have a brief glimpse into the reality of their lives. This is a reality that no talking about can do justice to. Our clients share a bit of their lives and it gives us a tremendous respect and admiration of the struggles their lives have become. With this understanding comes a humility that has made all the difference.

With the understanding that Connecticut's current review of such practices we look forward to being able to offer our expertise in this area.

Item 21) Describe the effect of the proposal on the interests of the consumers of health care services and the payers of such services

South Bay has a proven history of effectiveness as demonstrated by consistently high scores on both functional client outcomes measures and consumer satisfaction. We provide uniquely accessible service because of our willingness to provide services in the consumer's home and, again because we are out in the community rather than in our offices, we are committed to collaboration with other providers. We regularly meet with state workers, primary care providers and other caregivers. Our

commitment to see consumers communicates a sense of concern and dedication to the consumer and the family. There are many consumers who lack a means of transportation or access to public transportation and our willingness to come to their homes can make the difference between them getting services or not.

Payers of behavioral health services have been very encouraging to our services. One of the strongest predictors of re-hospitalization is the failure to follow through with aftercare. We have been able to reduce re-hospitalization rates simply by knocking on the consumer's door. Many consumers have the intention of following through but loose the appointment card, lack transportation or they are unsure and afraid to seek help. Our effectiveness in this area has been recognized by managed care organizations. We have partnered with MCOs to provide more intensive services for those leaving inpatient or detoxification units, reduce emergency department use, and reach out to homeless individuals in shelters. One MCO partnered with us to reduce readmission by allowing us to meet consumers while they were still in inpatient settings. After a meeting or two while they were still in the inpatient unit, the consumer was much more willing to follow-through with aftercare. They knew their provider and had built trust before being discharged from inpatient care.

Both consumers and primary care providers have benefited from our integrated behavioral services as we have put behavioral health professionals in the offices of primary care providers. This has been particularly effective with those who struggle with medical disorders that may require change in life style, such as diabetes, asthma, conditions complicated by substance use, weight control and conditions that benefit from increased exercise. Our work with substance abusers from a perspective of motivational enhancement has taught us how to help people change lifestyle. More effective prevention and healthier lifestyles make for better health and a reduction in the total medical expense.

Item 1) Attachment

Fall & Winter – 2012/2013
Training Calendar
For Social Workers, LMFTs and LMHCs

August 17, 2012
"DBT: An Overview of Dialectical Behavior Therapy"
Shaw's Conference Center, Brockton, MA
• Stacy Weckwerth, LMHC
Utilization Reviewer
South Bay Day Services

September 21, 2012
"Self-Injurious Behavior in the Adolescent and Adult Population"
Holiday Inn & Suites, Peabody, MA
• Peter Scanlon, Ph.D.
Executive Director
South Bay Mental Health

October 26, 2012
"Multi –Cultural Counseling and Therapy: Competencies, Challenges & Caveats"
Hilton Garden Inn, Worcester, MA
• Maxine L. Rawlins, Ph.D.
Clinical Psychologist
Professor, Bridgewater State University
Department of Counselor Education

November 9, 2012
"Behavioral Health Care Interventions for Medical Disorders"
KROC Center, Salvation Army
Dorchester, MA
• Peter Scanlon, Ph.D.
Executive Director
South Bay Mental Health
• Danielle Dunn, LMHC
Regional Director of South Bay Mental Health, Brockton
• Amy Miner-Fletcher, LMHC
Director of South Bay Early Childhood Services
• Nicole Costa, LICSW
Director of South Bay Day Services

January 25, 2013
"Evidence-Based Practices and Treatment for Children with Autism"
University of Lowell, Lowell, MA
• Heather David, LMHC, CEIS
Regional Early Childhood Director
South Bay Early Childhood Services
• Kristen Woodman, BCBA
Early Intervention Specialist
South Bay Early Childhood Services
• Dan Knight, BCBA
Regional Coordinator of Behavior Management Services
South Bay Early Childhood Services

February 22, 2013
"Treatment Planning Training for Consumers with SPMI"
Holiday Inn, Falmouth, MA
• Nicole Costa, LICSW
Director of South Bay Day Services

6.0 CE Credits available to psychologists. Applications have been made for continuing education credits for social workers, LMFTs and LMHCs. There is no charge for trainings although preregistration is required. Individuals seeking NASW or CADAC CEU's are required by their licensing boards to attend the full length of the program.

South Bay Mental Health Center is approved by the American Psychological Association to sponsor continuing education for psychologists. South Bay Mental Health maintains responsibility for this program and its content. Call 508-559-0473 to request further information regarding education objectives or faculty credentials. Participants needing special accommodation should call ahead to identify their needs.

REGISTRATION
South Bay Mental Health Center
1115 W. Chestnut Street, Brockton MA 02301
Contact: Joan Baacke – Phone: 508-559-0473

SOUTH BAY
MENTAL HEALTH

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

February 14, 2013

VIA FAX ONLY

Laura Nolda
Program Director
South Bay Mental Health Center, Inc.
237 Hamilton St., Suite 205
Hartford, CT 06106

RE: Certificate of Need Application; Docket Number: 12-31798-CON
Establishment of an Outpatient Mental Health Clinic in Hartford
CON Completeness Letter

Dear Ms. Nolda:

On January 15, 2013, the Office of Health Care Access ("OHCA") received completeness responses to the Certificate of Need ("CON") Application of South Bay Mental Health Center, Inc. ("South Bay" or "Applicant") proposing to establish an outpatient mental health clinic in Hartford ("Clinic").

OHCA has reviewed the responses and requests the following additional information pursuant to General Statutes §19a-639a(c). The page numbers given in each question refer to the page number of the initial Certificate of Need ("CON") application or the completeness responses.

1) Please provide additional information on the history and operations of South Bay Mental Health's services provided in the state of Massachusetts. Include the locations of the clinics, operating hours and number of full time staff and full time equivalents for each location.

2) On Item 1 (OHCA has assigned Page Number 38 to the attachment) of the completeness response, there are various training programs listed that South Bay Mental Health offers to licensed professionals. Please provide a brief history of the establishment of these programs including when they became available to professionals, the names of boards or other organizations that applications have been forwarded to and how the courses are financially supported.

3) Please provide Curriculum Vitaes for the officers and directors of South Bay Mental Health.

4) Please explain how the Applicant proposes to establish itself as a provider in Connecticut. How will the Applicant attract patients to provide the volume of persons needed to operate without a loss? How is the Applicant planning to establish itself in Hartford and obtain payers, commercial or government, for reimbursement?

5) On page 334 it states that the proposal will not result in a shift in volume and the Applicant is seeking to provide treatment to those in need and not yet served. Discuss the various populations residing within the proposed service area that will be served by the proposal. Provide examples of how the Applicant will attract patients or obtain contracts to provide services to these population groups.

6) The Applicant has provided supporting information to establish the number of persons in the proposed service area that may benefit from the proposal. It is also required to provide an argument with supporting information to establish the number of persons within that group that are seeking treatment but were unable to receive it. Provide a discussion and any available supporting information about the number of persons in the proposed service area that have sought treatment and were unable to receive care. Also, on page 313 it states that there is a start-up phase of 6 to 9 months for the proposal. Please revise the tables on pages 309 - 312 and 338 to include the start-up phase and three full years of operations, adjusting the projected utilizations as needed.

7) The Applicant reports on page 308 that over 85% of its payer mix will be Medicaid, based on patient population. How does the Applicant propose to establish itself as a Medicaid provider in Connecticut?

8) On page 309, the payer mix based on patient revenue reports that Medicaid will be 45% and other government payers, not including Medicare, will be 41%. Please explain what government programs have been included in the "other government payers" category.

9) In response to Question 1 on page 328 the Applicant states that the initial CON application supported the statement that rates of psychiatric disorder are higher for those children living in poverty. Provide additional discussion on this topic and cross-reference with the articles and information within the application.

10) The information provided by the Applicant has a focus on treatment and services to children. Please discuss the ratio of volumes that will be given to children, adults, and patients requiring drug and alcohol counseling. Explain the similarities and differences that the Clinic will experience trying to establish itself as a psychiatric outpatient clinic for children and as a psychiatric clinic for adults.

11) Under the services to be provided, the Applicant lists medication visits. Please explain these visits in relation the prescribing physician and the services provided by the Applicant. Include in the response when patients will see the prescribing physician and how the patients will pay for the medications.

12) Please explain how the Applicant will establish itself as a community-based provider.

13) On page 334 it is stated that the Applicant is a collaborator within the communities and will work with local, state and federal agencies as well as providers. Discuss any relationships related to the proposal that the Applicant has currently or plans to establish.

14) On page 345 it states that South Bay Mental Health has worked with children on the autism spectrum in the Hartford area. Please provide a discussion on the services provided, including location, payers and how long these services have been provided.

In responding to the questions contained in this letter, please repeat each question before providing your response. Information filed after the initial CON application submission (e.g., completeness response letter, prefile testimony, late file submissions and the like) must be numbered sequentially from the Applicant's document preceding it. **Paginate and date** your response (e.g., each page in its entirety) beginning with Page Number 349. Please reference "Docket Number: 12-31798-CON." Submit one (1) original and four (4) hard copies of your response. Each copy must be fully paginated. In addition, please submit a scanned copy of your response paginated and including all attachments on CD in an Adobe format (.pdf) and in an MS Word format.

Pursuant to Section 19a-639a(c) you must submit your response to this request for additional information not later than sixty days after the date that this request was transmitted. Therefore, please provide your written responses to OHCA no later than **April 14, 2013**. If you have any questions concerning this letter, please feel free to contact me at (860) 418-7032.

Sincerely,

Laurie K. Greci

Laurie K. Greci
Associate Research Analyst

Copy of PDF file: Kim Martone, Director of Operations, DPH OHCA
Kevin Hansted, DPH Staff Attorney
Kaila Riggott, CON Supervisor, DPH OHCA

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*** TX REPORT ***
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STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: Laura Nolda

FAX: 860 951 7729

AGENCY: South Bay Mental Health Clinic

FROM: Laurie Graci

DATE: 2/14/2013 TIME: 3:25 PM

NUMBER OF PAGES: 4
(including transmittal sheet

Comments: Re 12-31798-CON

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

SOUTH BAY
MENTAL HEALTH

Administration
Brockton

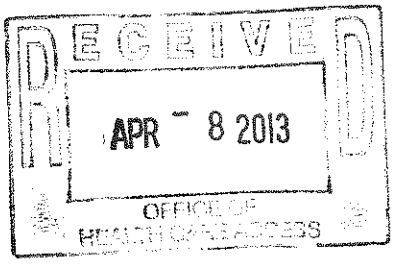
Mental Health and Addictions Treatment
Attleboro
Brockton
Cape Cod
Fall River
Lawrence
Lowell
Plymouth
Salem
Weymouth
Worcester
Hartford, CT

Mental Health Outreach
Leominster
Lynn
New Bedford
Swansea

Adult Day Services
Brockton
Cape Cod
Fall River
Plymouth
Worcester

Children's Day Services
Fall River
Lowell

Early Childhood Services
Brockton
Fall River
Lowell
Worcester



April 8, 2013

Ms. Laurie K. Greci
Associate Research Analyst
410 Capitol Ave
Hartford, CT 06134

RE: Certificate of Need Application; Docket Number: 12-31798-CON

Dear Ms. Greci,

Enclosed you will find our responses to your letter on 2/14/2013 . Please do not hestitate to contact me with any questions.

Sincerely,

Laura Nolda

237 Hamilton Street
Suite 205
Hartford, CT 06106
P: 860-578-1300
southbaymentalhealth.com

1.) Please provide additional information on the history and operations of South Bay Mental Health's services provided in the state of Massachusetts. Include the locations of the clinics, operating hours and number of full time staff and full time equivalants for each location.

South Bay provides a continuum of community-based services to children, adults and families in Massachusetts. South Bay offers Outpatient Mental Health and Substance Abuse counseling, Day Treatment and Partial Hospital Programs and Early Intervention service as well as a full scope of services under Massachusetts' Children's Behavioral Health Initiative (CBHI). This comprehensive range and intensity of services, combined with our community-based approach to treatment, makes South Bay expertly qualified to care for children, adults and families at its Centers, or in the client's natural environment.

South Bay Mental Health Center was founded in 1986 in Brockton, Massachusetts, a city of 100,000 approximately 25 miles south of Boston. Under the leadership of Dr. Peter Scanlon, South Bay's original staff of twelve clinicians focused on delivering outpatient mental health services to children and families. South Bay's innovative, community-based approach to services helped eliminate many barriers that prevent and disrupt families from receiving treatment. This approach was immediately successful and sough after by referral agencies.

The success of clinicial programs offered in the Brockton area led to requests for services from surrounding communities. In 1990, South Bay opened an outpatient clinic in Plymouth. The Plymouth site quickly grew and led to the opening of a site in Weymouth in 1991. In response to growing requests for services in new communities, South Bay opened clinics in Attleboro, Fall River, South Yarmouth, and Lowell in the early 1990s. To complement the existing mental health services, South Bay began providing outpatient substance abuse conseling services in 1992.

In 1993, South Bay diversified its programs by expanding into Adult Day Treatment Services and Early Intervention. A day treatment program was opened to care for adults who had been hospitalized. South Bay opened its first Early Intervention program in 1993 to provide education and developmental services for infants, toddlers and their families. Early Inteverntion programs in Fall River and Lowell soon followed to meet the growing demand for services. Two years later, a children's therapeutic day activity program was established to divert childrent from inpatient settings. In 1995, South Bay's Day Services Division was also approved to open a partial hospital program for adults.

Today, South Bay's continuum of services reaches tens of thousands of individuals and families throughout the sate. We have over 30 programs and our team consists of over 900 dedicated professionals. South Bay's clear mission, innovation and strong commitment to service have made the organization readily recognizable throughout Massachusetts.

Below, please find a list of South's Bay locations, operating hours and number of full time staff and full time equiviants for each location:

Attleboro ***Mental Health Clinic***
607 Pleasant St., Suite 115
Attleboro, MA 02703
Phone: 508-223-4691
Fax: 508-223-3397
Hours of Operation: M-F: 9am-5pm; appointments available upon request
FTE: 61

Boston ***Mental Health – Outreach***
415 Neponset Ave, 3rd floor
Dorchester, MA 02122
Phone: 857-217-3700
Fax: 857-217-3750
Hours of Operation: M-F: 9am-5pm; appointments available upon request
FTE: 18

Brockton ***Mental Health Clinic***
37 Belmont St. 2nd floor
Brockton, MA 02301
Phone: 508-580-4691
Fax: 508-588-5751
Hours of Operation: M-F: 9am-5pm; appointments available upon request
FTE: 129

Adult Day Services
56 Cherry St. 3rd floor
Brockton, MA 02301
Phone: 508-521-1020
Fax: 508-521-1030
Hours of Operation: M-F: 8:30am-5pm; appointments available upon request
FTE: 15

Early Intervention & Administration
1115 West Chestnut St., Suite 101 & 102
Brockton, MA 02301
Phone: 508-559-0473
Fax: 508-427-5361
Hours of Operation: M-F: 9am-5pm; appointments available upon request
FTE: 65

Cape Cod ***Mental Health Clinic***
470 Main Street
Mashpee, MA 02649
Phone: 508-760-1475
Fax: 508-760-3719
Hours of Operation: M-F: 9am-5pm; appointments available upon request
FTE: 20

Adult Day Services

470 Main Street
Mashpee, MA 02649
Phone: 508-398-5277
Fax: 508-398-4959
Hours of Operation: M-F: 8:30am-5pm; appointments available upon request
FTE: 7

Fall River

Mental Health Clinic
1563 North Main St., Suite 202
Fall River, MA 02720
Phone: 508-324-1060
Fax: 508-672-3619
Hours of Operation: M-F: 9am-5pm; appointments available upon request
FTE: 53

Adult Day Services
1563 North Main St., Suite 202
Fall River, MA 02720
Phone: 508-324-4202
Fax: 508-672-0927
Hours of Operation: M-F: 8:30am-5pm; appointments available upon request
FTE: 18

Children's Day After-school Program
1563 North Main St., Suite 202
Phone: 508-324-1060
Fax: 508-672-3619
Hours of Operation: M-F: 9am-5pm; appointments available upon request
FTE: 5

Early Intervention
1563 North Main St., Suite 202
Fall River, MA 02720
Phone: 508-324-1060
Fax: 508-672-3619
Hours of Operation: M-F: 9am-5pm; appointments available upon request
FTE: 38

Hartford CT

Mental Health Clinic - Outreach
237 Hamilton St. Suite 205
Hartford, CT 06106
Phone: 860-578-1300
Fax: 860-951-7729
Hours of Operation: M-F: 9am-5pm; appointments available upon request
FTE: 2

Early Intervention

237 Hamilton St. Suite 205
Hartford, CT 06106
Phone: 860-578-1300
Fax: 860-951-7729
Hours of Operation: M-F: 9am-5pm; appointments available upon request
FTE: 6

Lawrence ***Mental Health Clinic***
15 Union St., 2nd floor
Lawrence, MA 01840
Phone: 978-688-4830
Fax: 978-688-4901
Hours of Operation: M-F: 9am-5pm; appointments available upon request
FTE: 50

Leominster ***Mental Health***
80 Erdman Way, Suite 208
Leominster, MA 01453
Phone: 978-870-1840
Fax: 978-870-1846
Hours of Operation: M-F: 9am-5pm; appointments available upon request
FTE: 16

Lowell ***Mental Health Clinic***
77 East Merrimack St., Suite 1, 9B & 22
Lowell, MA 01852
Phone: 978-453-6800
Fax: 978-458-1428
Hours of Operation: M-F: 9am-5pm; appointments available upon request
FTE: 68

Early Intervention
148 Warren Street
Lowell, MA 01852
Phone: 978-452-1736
Hours of Operation: M-F: 9am-5pm; appointments available upon request
FTE: 49

Day Services
148 Warren Street
Lowell, MA 01852
Phone: 978-452-1736
Fax: 978-452-6625
Hours of Operation: M-F: 8:30am-5pm; appointments available upon request
FTE: 2

Children's Day After-school Program
148 Warren Street
Lowell, MA 01852
Phone: 978-452-1736
Fax: 978-452-6625
Hours of Operation: M-F: 9am-5pm; appointments available upon request
FTE: 4

Lynn ***Mental Health***
181 Union Street, Suite J
Lynn, MA 01901
Phone: 781-244-1950
Fax: 781-244-1941
Hours of Operation: M-F: 9am-5pm; appointments available upon request
FTE: 16

Malden ***Mental Health – Outreach***
22 Pleasant Street
Malden, MA 02148
Phone: 781-851-2648
Fax: 781-851-2699
Hours of Operation: M-F: 9am-5pm; appointments available upon request
FTE: 7

New Bedford ***Mental Health –Outreach***
222 Union Street, Suite 317 & 318
New Bedford, MA 02740
Hours of Operation: M-F: 9am-5pm; appointments available upon request

Plymouth ***Mental Health Clinic***
50 Aldrin Rd. 3.25.07
Plymouth, MA 02360
Phone: 508-830-0000
Fax: 508-746-8429
Hours of Operation: M-F: 9am-5pm; appointments available upon request
FTE: 31

Day Treatment
50 Aldrin Rd.
Plymouth, MA 02360
Phone: 508-830-0004
Fax: 508-830-0295
Hours of Operation: M-F: 8:30am-5pm; appointments available upon request
FTE: 16

Salem ***Mental Health Clinic***
35 Congress St., Suite 214
Salem, MA 01970
Phone: 978-542-1951
Fax: 978-542-1954
Hours of Operation: M-F: 9am-5pm; FTE: 24

Springfield

Mental Health
140 High Street, Suite 230
Springfield, MA 01199
Phone: 413-495-1500
Fax: 413-747-1811
Hours of Operation: M-F: 9am-5pm; appointments available upon request
FTE: 10

Swansea

Mental Health – Administration
463 Swansea Mall Drive
Swansea, MA 02777
Phone: 508-324-1060
Fax: 508-672-3619
Hours of Operation: M-F: 9am-5pm; appointments available upon request
FTE: 26

Early Intervention – Administration
463 Swansea Mall Drive
Swansea, MA 02777
Phone: 508-324-1060
Fax: 508-679-8590
Hours of Operation: M-F: 9am-5pm; appointments available upon request
FTE: 19

Weymouth

Mental Health Clinic
541 Main St.
Stetson Building, Suite 303
Weymouth, MA 02190
Phone: 781-331-7866
Fax: 781-331-7976
Hours of Operation: M-F: 9am-5pm; appointments available upon request
FTE: 53

Worcester

Mental Health Clinic
340 Main St., Suite 818
Worcester, MA 01608
Phone: 508-791-4976
Fax: 508-791-6723
Hours of Operation: M-F: 9am-5pm; appointments available upon request
FTE: 43

Day Services
340 Main St., Suite 819
Worcester, MA 01608
Phone: 508-752-3968
Fax: 508-752-3967
Hours of Operation: M-F: 8:30am-5pm; appointments available upon request
FTE: 17

Early Intervention
548 Park Ave, Suite B
Worcester, MA 01603
Phone: 774-823-1500
Fax: 774-823-1481
Hours of Operation: M-F: 9am-5pm; appointments available upon request
FTE: 24

2.) **On Item 1 (OHCA has assigned Page Number 38 to the attachment) of the completeness response, there are various training programs listed that South Bay Mental Health offers to licensed professionals. Please provide a brief history of the establishment of these programs including when they became available to professionals, the names of the boards of other organizations that applications have been forwarded to and how the courses are financially supported.**

Trainings began in 1989 and were open to South Bay Mental Health Staff only. In 1999 the agency began offering the trainings to collaterals within Massachusetts. There are ten trainings offered throughout the year on a variety of topics. The presenter is usually a South Bay Mental Health Inc. employee who has a specialty in the particular topic. Collaterals are able to view the training programs offered on South Bay's website. They may also be notified directly by a South Bay employee through email and/or a flyer that is generally distributed to other community providers. South Bay supports the training program financially. These trainings are free to both South Bay staff as well as all collateral agencies. South Bay receives the opportunity to offer Continuing Education Units (CEUs) for each training program by applying to the all of the appropriate licensing agencies including NSWA, MaMHCA, LMFT, etc. After an individual has completed a training program they are able to receive 6 CEUs through their personal licensing unit (if applicable). As leaders in the industry, South Bay believes it is our responsibility to assist in keeping our community providers, as well as our own staff, trained in best practices associated with Early Childhood, Mental Health, Substance Abuse and other related topics.

3.) **Please provide Curriculum Vitaes for the officers and directors of South Bay Mental Health.**

Attached please find Curriculum Vitaes for; CEO Kevin Sheehan, President, Chief Clinical Officer Dr. Peter Scanlo, Director of Utilization Management Sarah Farley, CFO Adam Schauer; Director of Outpatient Mental Health Services Jennifer Gearhart, Director of Early Childhood Services Amy Miner-Fletcher, and Director of Day Treatment Services Nicole Costa.

(Please see Attachments 1 – 7)

4.) **Please explain how the Applicant proposed to establish itself as a provider in Connecticut. How will the applicant attract patients to provide the volume of persons needed to operate without loss? How is the Applicant planning to establish itself in Hartford and obtain payers, commercial or government for reimbursement?**

The Applicant proposes to establish itself as a provider in Connecticut by educating the current providers of South Bay's existence. The program director will have both a clinical and developmental role and will reach out to local agencies. The director will contact school social workers, homeless shelters, WIC offices, Head Start Programs, Birth to Three Programs, State of CT Probation Department, Department of Children and Families, Department of Developmental Services, and any other place where the proposed population utilizes services. Education of our services will be delivered through staff meeting presentations, director meetings and training opportunities to inform others of South Bay services. This is a typical role for a South Bay director in MA and continues to be so in CT. When other agencies are aware of our services and the availability for collaboration, we believe that they will refer to South Bay for mental health and/or substance abuse services as well as appreciate reciprocal collaboration.

South Bay will obtain payers by applying to be a Medicaid provider as well as a provider for all commercial Insurance companies in the state of Connecticut.

5.) **On page 334 it states that the proposal will not result in a shift in volume and the Applicant is seeing to provide treatment to those in need and not yet served. Discuss the various populations residing within the proposed service area that will be served by the proposal. Provide examples of how the Applicant will attract patients or obtain contract to provide services to these population groups.**

As stated in our previous response the various populations residing within the proposed service area that will be served are; Transitional Youth, Low-income Households with Children, Children in the Juvenile System, Individuals with a Psychotropic Need, Children in Need of Intense In-Home Services, Individuals with Mental Health Needs, Children with Trauma. South Bay will develop working relationships with collaterals in the community such as but not limited to Department of Children and Families, Department of Developmental Services, Justice Departments, Head Start, Local shelters and other agencies that serve the proposed population. It is the director's responsibility to connect with these programs by providing presentations and attending staff meetings to create a working relationship. The director will keep all collaterals informed of services offered by South Bay as well as provide guidance regarding how to refer consumers to the program.

6.) **The Applicant has provided supporting information to establish the number of persons in the proposed service area that may benefit from the proposal. It is also required to provide an arugment with supporting information to establish the number of persons within that group that are seeking treatment but were unable to receive it. Provide discussion and any available supporting information about the number of persons in the proposed service area that have sought treatment and were unable to receive care.**

There are many reasons why people may not be receiving treatment to date. Many are afraid of the stigma attached to mental health issues. Others feel they cannot commit the time and/or financial resources required to engage in therapy. Some may not be willing to admit that they have a problem in the first place, or may not think that treatment will not work for them (despite clear research evidence to the contrary).

While we recognize that sometimes lack of treatment is a choice, we also know that the majority of those suffering with disabling mental illness do wish to be treated. Access to care was commonly cited in both the Key Informatn study and the Hartford Survey Project. While the Hartford Survey Project concluded that the top four barriers to care were lack of knowledge about existing services, lack of available services, inability to pay, and lack of transportation, the Key Informant study showed a need for improving access to care across the board for a variety of underserved populations.

The Community Mental Health Services Block Grant for FY 2011 identified the challenges that Connecticut faces in delivering services. Among them were the facts that: Capacity remains below estimated need, Need for specialized outpatient programs for youth with significant behavioral dyscontrol and aggrssion, autism spectrum disorders and substance abuse, Psychological testing services do not meet the needs, Insuffiecient specialty services such as traumatized treatments for children/youth, Insufficient treatments for consumers with co-occurring disorders, Continued need for services for those "aging out" of the child welfare system, Need to expand school-based mental health, Shortage of child and adolescent psychiattrists who will serve publically funded consumers, Few behavioral health services designed for child welfare population, Services designed for adolescents/young adults are insufficient in quantity and quality, Need to promote mental health of young children and Need to enchance use of Peer Specialists.

These are all areas in which South Bay has over 26 years of experience and expertise.

Given the data that was provided earlier in our original application and trailed in our last Completeness Letter Response, and the outreach South Bay did to survey need among other providers, we can determine the number of people in need in the proposed service area with significant assuredness.

When an idividual has co-occuring disorders such as substance abuse and mental illness the desire for treatment can be non-exsitent. Often those who have mental illness use substance to alleviate symptoms they may be experiencing from their illness. They will use a drug to "feel better" for a temorary ammount of time until their symtoms reoccur and are often heighten. The individual will

often seek the drug again to make the symptoms go away and may develop dependence for this drug. The indvidual may feel they are "treating" their mental illness and the need for evidence-based services is not necessary. Often it takes an indiviual to seek substance abuse treatment before addressing their mental health issues. South Bay recognizes this barrier and plans on reaching out to those with co-occuring disorders who may not have sought services in the past due to their substance dependence. South Bay plans to work closely with hospital and detox centers to reach those indivuals and help them through their process of recovery when they chose to do so.

For those who choose not to be treated, whatever the reasons may be, being the loved one of someone who is engaging in self- destructive behavior, and refuses to take steps toward change, can be difficult to understand and often can create issues within the nuclear family. In this position, many loved ones begin to experience depression, stress, and often enable the loved one they are concerned about. South Bay clinicians have extended expertise in working with family members to develop positive coping skills to become more independent and decrease co-dependency towards their loved one's illness. South Bay has experience working with families and individuals around their loved one's mental health and recognizes that when a loved one goes without treatment the whole family is ill. South Bay will provide individual, family, and group counseling to help those who seek treatment around coping with mental illness and co-occurring disorders whether they are experiencing these issues directly or indirectly.

6.b) Also on page 313 it states that there is a start-up phase of 6 to 9 months for the proposal. Please revise the tables on pages 309-312 and 338 to include the start-up phase and three full years of operations, adjusting the projected utilizations as needed.

Please see Attachment 8

7.) The Applicant reports on page 308 that over 85% of its payer mix will be Medicaid, based on patient population. How does the Applicant propose to establish itself as a Medicaid provider in Connecticut?

South Bay will submit all the necessary applications to through the Department of Social Services to enroll as a Medicaid provider. Furthermore, as stated in Question 4, South Bay's CT Director of Programs will begin outreach once all pertinent licenses have been received.

8.) On page 309, the payer mix based on patient revenue reports that Medicaid will be 45% and other government payers, not including Medicare, will be 41%. Please explain what government programs have been included in the "other government payers" categories.

Once established as a licensed provider, South Bay plans to apply for relevant state contracts to provide needed services. These other government payers may include state departments such as Birth to Three, DPH, DCF, DMHAS, Rehabilitation Services, etc.

9.) In response to Question 1 on page 328 the Applicant states that the initial CON application supported the statement that rates of psychiatric disorder are higher for those children living in poverty. Provide additional discussion on this topic and cross-reference with the articles and information within the application.

In Bridging the Gaps, the World Health Organization (1995) states, "The world's most ruthless killer and the greatest cause of suffering on earth is extreme poverty." This statement emphasizes the importance of poverty as a variable adversely influencing health. Poverty is a multidimensional phenomenon, encompassing inability to satisfy basic needs, lack of control over resources, lack of education and poor health. Poverty can be intrinsically alienating and distressing, and of particular concern are the direct and indirect effects of poverty on the development and maintenance of emotional, behavioral and psychiatric problems.

Psychiatric disorders of childhood result from the interplay between genetic and environmental factors. There is a growing body of research relating to poverty and health indicating that low income combined with disruptive demographic factors and poor external support generate the stress and life crises that put children at risk, and may precipitate psychiatric disorders in childhood.

Children in the poorest households are three times more likely to have a mental illness than children in the best-off households (Department of Health, 1999b). Poverty and social disadvantage are most strongly associated with deficits in children's cognitive skills and educational achievements (Duncan & Brooks-Gunn, 1997). In the behavioral domain, conduct disorder and attention-deficit hyperactivity disorder show links with family poverty and this is most marked for children in families facing persistent economic stress. The relationship between poverty and childhood disorder appears to be more marked for boys than for girls, and seems to be stronger in childhood than in adolescence. It is well recognized that conduct disorder is three to four times more common in children who live in socio-economically deprived families with low income, or who live in a poor neighborhood.

Erratic, threatening and harsh discipline, lack of supervision and weak parent–child attachments mediates the effects of poverty and other structural factors on delinquency. In the Cambridge Study in Delinquent Development, one of the most important childhood predictors of delinquency was poverty (Farrington, 1995).

Poverty was also found to have an effect on both academic failure and extreme delinquency (Pagani et al, 1999). Eyler & Behnke (1999) studied the outcome during the first 2 years in children prenatally exposed to the most commonly used drugs of misuse, and concluded that the effects of drugs appear to be exacerbated in children living in poverty.

A recent study conducted by researchers at Penn State University, New York University, and Chapel Hill found that stress induced by poverty could affect kids by lowering their ability to perform well in school. Unfortunately, this is just another negative side effect of a widespread problem.

Stress is known to affect the executive functions of the brain, such as independent thinking. The study

showed that children as young as 3 years old could be adversely affected by an increased stress level. It also showed that stress levels were often more elevated in African American children than in Caucasian children.

An elevated stress level is known to deteriorate the health of adults. It can be traced as the cause of several diseases, including heart disease, and can lead to a higher mortality rate. The effects of elevated stress levels on children are less readily apparent because kids don't typically suffer from such a malady. This study shows that even at a very young age, stress can result from something as prevalent as poverty. It demonstrates that stress can lead to other lifestyle problems such an increased chance of an inhospitable living environment, less parental attention, and lower grades in school. This study also seems to show that a child who starts life as poor may be handicapped for a long time, throughout his learning career. By resolving the issue of poverty, a child's stress tends to diminish and the effects of stress aren't as dominant. Providing support services to children living in poverty such as developing positive coping skills vs. negative copings skills or helping them strengthen self-esteem can help to diminish stress and its effects.

Children in low-income families start off with higher levels of antisocial behavior than children from more advantaged households. And if the home remains poor as the children grow up, antisocial behavior becomes much worse over time compared to children living in households that are never poor or later move out of poverty, says new University of Alberta research. "In other words, the lowest levels of antisocial behavior are found in kids whose parents start and stay in the highest income bracket while their kids grow up," says Dr. Lisa Strohschein, author of the study and sociologist at the U of A.

Findings show that the effects of low income at an early age on antisocial behavior--conduct such as bullying, being cruel, breaking things, cheating or telling lies -- persist, as kids get older. The research is published in the current issue of the "Journal of Health and Social Behavior." As clinicians we recognize that these behaviors are learned survival mechanisms and we believe these individuals can learn positive survival methods through interventions from Cognitive Behavioral Therapy (CBT) and implementing positive problem solving techniques.

"These findings might mean that antisocial behavior is an example of biological embedding--it is possible that poverty early in life helps to set into motion a consistent pattern of antisocial behaviors that are difficult to change once learned," says Strohschein. This finding supports at least one developmental theory that posits that early childhood constitutes a sensitive period of development in which insults suffered during this time are likely to have long lasting effects on child development.

In "A Snapshot of Childhood Poverty in Connecticut", prepared by the Connecticut Commission on Children, updated January 2013, it was reported that in 2008, 2009 and 2010, Connecticut ranked 50th in the United States for percent of children living in households earning less than 200% of FPL (Federal Poverty Level).

According to the Connecticut Commission on Children, in 2009 Hartford's child poverty rate was 47% . It has been well document that poverty rate is connected to rates of child neglect and abuse. The Connecticut Association for Human Services substantiated a high rate of child abuse and neglect in Connecticut. The number of sustantiated cases of abuse and/or neglect in Hartfort County in 2008 was listed as 2,260 – with 633 cases stemming from the city of Hartford, 165 cases in East Hartford, 192 in Manchester and 61 in West Hartford. The cases in these four proposed service towns make up almost 40% of the abuse and neglect cases in the county. The report further states the child neglect makes up over 60% of the abuse and neglect cases in Connecticut and that neglect is often the result of poverty, stemming from reduced access to basic needs, lack of resources, and stressful living conditions. "With proper supports and resources in place around the state, future incidents of child maltreatment can be prevented."

The State of Connecticut General Assembly Commission on Children provided the following information in their report titled Child Poverty in Connecticut: January 2009

- *Child poverty in Connecticut has not improved in recent years, according to the U.S. Census Bureau: In 2007, 10.6% of Connecticut children under 18 (85,530 children) lived in a family with income below the Federal Poverty Level ($21.027 for a two-parent family with two children). This data from the U.S. Census Bureau's American Community Survey (ACS) represents no improvement from the 2004 level (10.1%).*
  ** (We also now know, from the most recently updated report from the Connecticut Commission on Children that number has continued to grow since then, presenting Connecticut with the highest rate of children living in poverty in the United States.)*
- *One in four (25.1%) Connecticut children lived in a household with income below 200% of the Federal Poverty Level in 2007 – that number is closer to one in two children living in Hartford.*
- *Poverty in Connecticut is concentrated in urban areas.*
  Children living in poverty are unevenly distributed across Connecticut's 169 towns. While 38 towns had child poverty rates of less than 2% in the 2000 Census, seven towns had a rate above 23%, led by Hartford. In 2007, the state's largest cities had extremely high child poverty rates -- Hartford (47.0%), Waterbury (31.4%), New Haven (28.7%) and Bridgeport (28.4%).
- *Minority children are more likely to live in poverty.*
  In 2005, Latino/Hispanic and African American children in Connecticut were seven times more likely to live in poverty than white, non-Hispanic youth.
- *Poor children start from behind because they lack access to good preschools.*
  Lost future productivity from poverty: a half-trillion-dollar loss for the nation.
- *Widespread illiteracy hurts business community*
  The inability of young people to read as they move into adulthood has a negative fiscal impact on businesses. In 2003, more than 240,000 adults in Connecticut – or 9 percent of those 16 and older – lacked even basic reading skills.

The same report provided the following findings in relating poverty to behavioral health:

- *Research has shown that children from low-income families experience emotional and behavioral problems more often than non-poor children, in fact, "one study of low birth*

weight five-year-olds found that children in persistently poor families had more internalizing and externalizing behavior problems than children who had never been poor."

- *A number of factors have been cited to explain increased emotional and behavioral problems in poor children, including increased exposure to parental depression, domestic violence, substance abuse, and alcoholism.*
- *According to the National Institute of Child Health and Development, poor behavioral and cognitive performance was exhibited more often among three year-old children with depressed mothers than children whose mothers were not depressed.*
- *Poor children with depressed mothers may also suffer from aggression, problems forging relationships with other children, trust issues, and future vulnerability to substance abuse.*

Connecticut Department of Children and Families Differential Response System, Executive Report submitted by Casey Family Services states in the Regional Planning Teams' Recommendations, mental health, employment training assistance, parent education and skill development, alcohol and drug abuse treatment were four of the eight needed "core services" identified by the teams. These are all services that South Bay delivers with expertise. Furthermore, the first "core services" listed are Basic needs: financial assistance, food stamps, food banks, clothing closets, diaper banks, utilities assistance, transitional and subsidized housing, furniture, healthcare, public benefits enrollment and coordination. South Bay clinicians understand the importance of treating the whole person. Our clinicians work with the consumer to help bring all the pieces together. We will assist our consumers in accessing the resources they need.

Again, South Bay applauds the state's commitment to Connecticut's children and the development of the Differential Response System (DRS). We strongly believe that South Bay can play a vital role as a partner in the effort to present accessible community-based support helping families positively cope with hardship to prevent unfortunate outcomes such as child abuse and neglect, anti-social behavior, bullying and other negative situations.

10.) The information provided by the Applicant has a focus on treatment and services to children. Please discuss the ratio of volumes that will be given to children, adults, and patients requiring drug and alcohol counseling. Explain the similarities and differences that the Clinic will experience trying to establish itself as a psychiatric outpatient clinic for children and as a psychiatric clinic for adults.

Studying demographics at other sites South Bay operates and given the population of the proposed service area along with direct contact with others serving this population, we project that our consumer make up will be roughly 60% children and 40% adults. Our many years of experience tells us that those requiring drug and alcohol counseling will make up approximately 10% or 50 of the 478 identified projected consumers with 5% of the 50 being children.

South Bay plans to staff the clinic with Child Psychologists who will also have a background in treating adults. Clinicians will be added to meet the needs of the consumer population that presents itself.

11.) Under the services to be provided, the Applicant lists medication visits. Please explain these visits in relation to the prescribing physician and the services provided by the Applicant. Include in the response when patients will see the prescribing physician and how the patient will pay for the medication.

Patients will have access to a psychiatrist when governed appropriate. To determine need, the patient must go through an intake process with his or her therapist and attend a therapy session. If the therapist indicates there is a clinical need for medication and the patient/patient's caregiver would like to seek consultation with a psychiatrist then an appointment will be set up with South Bay's psychiatrist. Our psychiatrist will consult with the patient to further establish if medication is necessary. Follow-up appointments will be made with the psychiatrist for medication monitoring purposes. The patient or patient's caregiver will have access to the psychiatrist by calling the office and all appointments will occur at 237 Hamilton Street Hartford, CT. The patient will pay for the medication through their current health insurance plan. If a patient is uninsured, South Bay's clinician will assist them in applying for health insurance and should they be deemed ineligible, South Bay will offer services on a sliding scale basis. Please see attached document titled "Sliding Scale or Reduced Rate Request" (Attachment 9)

12.) Please explain how the Applicant will establish itself as a community-based provider.

As stated in South Bay's previous responses, staff members in several local Hartford schools have indicated a need for treatment services. South Bay plans to become a community provider initially by collaborating with local school principals and social workers to provide services within the identified schools such as group and individual counseling. This will allow the children to have easy access to treatment and will provide support to both the family and the school staff. Furthermore, the Community Mental Health Services Block Grant for FY 2011 identified a high need for school-based mental health services in Hartford.

In addition, South Bay plans to apply for the IICAPS Program – a community-based evidence-based model. A meeting has already occurred and Yale is interested in South Bay becoming a provider for this evidence-based practice. Once South Bay is established as an IICAPS provider, we will be able to go into the homes and provide services to children and families in their natural setting. This is an area in which South Bay has been widely recognized as a leader.

(In addition, please see response to Number 4).

13.) On page 334 it is stated that the Applicant is a collaborator with the communities and will work with local, state and federal agencies as well as providers. Discuss any relationships related to the proposal that the applicant has currently or plans to establish.

South Bay Mental Health currently has a working relationship with local Birth to Three providers such as but not limited to: Building Bridges, Jane Bizants & Associates, CREC Birth to Three, Oak Hills Birth

to Three and Wheeler Clinic. South Bay has also connected with many other providers in the community to begin the process of building an affiliation. These providers include: Lutheran Social Services, My Sisters Place, Hospital for Special Care, local pediatricians, community daycare providers, and Hartford Special Education Department to begin the process of building affiliations. South Bay Mental Health has met with Hartford Department of Children Families to learn about the needs within the community as well as to share information about our services. In addition, we have met with Congressman Larson to discuss the Hartford area mental health needs. Congressman Larson and his staff were supportive of our efforts, and assisted us with introductions to other community providers, helping to foster new working relationships.

We also currently have an affiliation with the Department of Developmental Services under our Autism Birth to Three contract.

14.) On page 345 it states that South Bay Mental Health has worked with children on the autism spectrum in the Hartford area. Please provide a discussion on the service provided, including location, payers, and how long these services have been provided.

South Bay is currently contracted through Connecticut's Department of Developmental services to provide diagnostic and Early Intervention services to the following towns; Avon, Bloomfield, East Hartford, East Windsor, Farmington, Glastonbury, Hartford, Manchester, New Britain, Newington, Rocky Hill, South Windsor, West Hartford, Wethersfield, and Windsor. The children are identified with risk factors for Autism Spectrum Disorder and are referred to South Bay either through Connecticut's Child Development Infoline or a General Birth to Three provider. Once a child is referred, South Bay goes to the child's home to conduct an assessment as well as parent interview and clinical observation. If the child is determined to be on the spectrum, the child is eligible to receive services and a service plan is developed with the family and all appropriate therapists and team members. All treatment is conducted in the home or other community setting. The cost of the service is determined by the family income and payments go through the family's current insurance provider. Services are provided by South Bay from time of diagnosis until age three at which time the child will transition to the Special Education System if their parent/guardian so chooses.

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Kevin P. Sheehan
1313 N. Weston Lane
Austin, Texas 78733

Home: (512) 327-0321
Cell: (512) 636-0000
kevin.sheehan@kpsheehan.com

April 1, 2011 to October 31, 2011
Founder, Community Intervention Services, Inc. ("CISI")

Focus: behavioral health, alcohol and related drug services in the home and community to children, adolescents, young adults; adults and geriatrics.
Objective: in partnership with a private equity firm to build a national community-based services company.

April, 1997 to March 31, 2011
Co-founder, Chairman, President & Chief Executive Officer
Youth & Gamily Centered Services, Inc. ("YFCS")
Co-founded YFCS with Cravey, Green & Whalen (now MSOUTH)

Goal: build a national company focused on delivering behavioral, educational and medical services to infants, children and adolescents. Services included acute psychiatric, sub-acute, residential treatment, group homes, therapeutic foster care, accredited schools and a range of community-based services. Operated in (9) nine states, employed 3,400 and provided services **daily** to over 4,400 patients.

From Inception: start-up to approximately $ 200 million in net revenues generating EBITDA over $ 33 million with significant cash flow as evidenced by net accounts receivables days of 33. Developed a reputation for excellent clinical and educational services supported by outcome measures for the past (11) years. ***In 2003, Millcreek subsidiary was the recipient of the CODMAN AWARD from the Joint Commission for its demonstrated reduction in the use of restraints by over 95% in one year.***

1993 to 1996
President and Chief Executive Officer, Health Care International, Inc. (NASDAQ)

Recruited by the Board of Directors to lead this health care services organization post bankruptcy.
Approximately $ 270 million in net revenues with a staff of 4,000+ employees. Historically incurred significant operating losses. Owned medical/surgical and psychiatric hospitals, as well as, The Brown Schools, a national leader in rendering services to abused and neglected children and adolescents.

1989 to 1993
President and Chief Executive Officer, Comprehensive Addiction Programs, Inc.
Recruited by the Board of Directors to rescue this troubled chemical dependency treatment company with operations in (7) seven states.
Net revenues of $ 54 million with losses of $ 8+ million upon joining as CEO.
Accomplishments: Over a period of (2) two years and through a series of lender negotiations, a complete restructuring of operations and management, the Company became profitable and was subsequently sold to C.R.C. (post my resignation to became CEO of Health Care International).

1986 to 1989
President of Health Services Division, Primedica, Inc.
Acquisitions: (2) two subsidiaries from American Medical International.
Both operations went from losing money to profitable within (9) nine months.
1982 to 1986
Chief Financial Officer, Faxon Incorporated, Information Data Base Management Co.
Additional Responsibilities: Book Division Operations
1977 to 1982
Chief Financial Officer, Epsco Incorporated, small publicly-held electronics manufacturer. Led secondary public offering, November, 1980 by LF Rothchild, Unterberg & Tobin.
1971-1977
C.P.A. Staff Accountant promoted to Audit Manager. Deloitte & Touche

Education: Boston College, 1971, cum laude
1984, Harvard Advanced Management Program
Certified Public Accountant
Member of AICPA

Associations: Board of Trustees, National Association of Psychiatric Health Systems
Past Chairman of Board, 2010
Current Member of Executive Committee and Chair of 2012 Election Committee

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Attachment 2
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PETER SCANLON, Ph.D.
9 Eastwood Lane
North Easton, MA 02356
home: (617) 238-0401
work: (617) 583-3508

EDUCATION

1979 Ph.D. Florida State University
1971 M.S. Florida State University
1969 B.S. University of Massachusetts

Cambridge Family Institute: Sept. 73 - March 74
Northeastern University: June 1974 - Sept. 1976

EMPLOYMENT

HALLGARTH INSTITUTE 2/85 - present
Bourne, MA
Clinical Director: Direct clinical services for staff of 45 masters and doctoral level therapists; develope and implement guidelines and procedures for client care and service delivery; lead Utilization Review and Multidisciplinary Team; institute inservice training program; and coordinate research, surveys, audits and license reviews. Along with the Medical Director the Clinical Director shares accountability for the adequacy, appropriateness and quality of client care.

FAMILY SERVICE CENTER 9/81 - 2/85
Brockton, MA
Clinical Director: Supervised staff, provided direct services, established procedural regulations in complicance with state regulations, and serve as liason to referring agencies. Serve on the Mayor's Task Force on Social Services in Brockton. FSC is a non-profit mental health clinic serving adolescents, children and families.

STONEHILL COLLEGE 8/79 - 8/81
Easton, MA
Director of Counseling: Supervised and trained professional staff. Provided individual, group, and family therapy. Developed a procedural manual which is currently in use in several college counseling centers. Led case conferences involving counseling psychologists, nurses and consulting psychiatrist.

PSYCHONOMICS 5/79 - 8/81
Brookline, MA
Psychological Consultant: Conducted diagnostic teast batteries and psychological evaluations of children, adolescents, and adults. Specialized in forensic evaluations and evaluations with the elderly. Consulted with temporary shelter for adolescents.

FLORRIDA STATE UNIVERSITY 9/77 - 8/78
Tallahassee, FL
Coordinator of Counseling Clinic: Within a teaching clinic serving rural community supervised masters and doctoral level students, conducted program development for diverse populations and maintained quality control assessment system. Taught graduate pre-practicum course.

EASTWOOD COUNSELING CLINIC 9/77 - 5/79
Tallahassee, FL
Doctoral Resident: Conducted individual, group and family treatment and psychological evaluations.

DANVERS STATE HOSPITAL 9/74 - 9/76
Danvers, MA
Staff Psychologist: Developed and implemented treatment plans for inpatients of the Adolescent Treatment Program. Conducted Individual, group and family therapy. Consulted to all Hospital units on diagnosis of learning disabilities and neurological impairments. Researched behavioral treatment for control of seizure activity. Student Intern until May 1975.

ATLANTIS COMMUNITY MENTAL HEALTH CENTER 9/72 - 12/74
Stoneham, MA
Counselor: Led group for drug abusers, operated crisis intervention hot-line and co-led staff training group.

PROFESSIONAL ORGANIZATIONS

American Psychological Association
Massachusetts Psychological Association
Association for the Advancement for the Advancement of Behavior Therapy
Massachusetts Association of Licensed Psychiatric Clinics - Board of Trustees

AWARDS

Diplomat - American Board of Professional Psychotherapists
Award of Outstanding Service - Boston Association for Retarded Citizens
Research Fellow - Florida State University
Who's Who Among Students in American Colleges and Universities

CERTIFICATIONS

Licensed Psychologists: Massachusetts and Rhode Island
School Psychologist: Massachusetts
Qualified Psychologist: Massachusetts (c123s, 12a)

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Attachment 3
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Sara J. Farley, MS, LMHC
75 Clarendon Street Apartment 208 Boston, MA 02116
sarafarley2@gmail.com (401) 835-2185

LICENSURE

Licensed Mental Health Counselor 2010
Massachusetts Board of Allied Mental Health and Human Service Professionals
License #7486

RELEVANT WORK EXPERIENCE

Care Manager
Massachusetts Behavioral Health Partnership, Boston, Ma 2011-*Present*

- Responsible for clinical decisions related to assessment, referral, coordination of care, and appropriateness of care for members seeking access to their benefits for Mental Health or Substance Abuse services for all levels of care covered by contracts, using established criteria, guidelines and policies
- Responsible for meeting standards related to: clinical documentation, clinical policies and procedures, accreditation and regulatory standards and contract compliance
- Actively participates in clinical rounds/case review process, and seeks consultation with the Clinical Director and Medical Director as needed
- Assists with the management of treatment across the continuum of care

Clinic Director
South Bay Mental Health Center, Lawrence, MA 2009-2011

- Oversee all operations of mental health clinic
- Responsible for recruiting, interviewing, training, and evaluating Master's-level and licensed staff
- Work with and manage two clinical supervisors and 20+ staff therapists
- Provide clinical and administrative supervision to staff therapists and monitor caseloads of all clinicians
- Coordinate and monitor clinical services and programs (i.e. Children's Behavioral Health Initiative Services, Urgent Outpatient Services)
- Provide in-service education, program evaluation, and clinical trainings on specific treatment modalities, diagnoses, assessment tools, etc.
- Program development and marketing (i.e. Hospital Bridge Programs)
- Participate in research, surveys, audits, and license reviews (i.e. CARF accreditation)
- Provide on call, telephonic support for emergency consultation and intervention to clients and therapists
- Conduct weekly staff meetings review, train and implement clinical and administrative policies
- Provide individual, group, family and couples counseling
- Other supervisory duties as required

Clinic Supervisor
South Bay Mental Health, Lawrence, MA 2009

- Provided clinical and administrative supervision to staff therapists
- Assisted in program development and marketing

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Staff Therapist
South Bay Mental Health Center, Brockton, MA 2008-2009

- Provided outpatient mental health and substance abuse services to individuals, groups, families and couples in their natural environments, such as homes, schools, and others
- Maintained clinical files and records for each client, including initial evaluations, assessments, treatment plans, session documentation, and others
- Consulted with outside agencies and other professionals as necessary in order to provide appropriate clinical care and resources
- Created curriculum and piloted 8 week substance abuse class for an alternative high school in the Brockton Area as well as for the Department of Youth Services

Counseling Intern
St. Elizabeth's Comprehensive Addictions Program (SECAP), Boston, MA 2007-2008

- Lead multiple groups on recovery, self awareness, and other psycho-educational topics for both inpatient and outpatient clients
- Conducted individual sessions with inpatient clients daily
- Completed psychosocial assessments and intakes for intensive outpatient programs
- Prepared for the Joint Commission review (i.e. chart utilization and review)

Practicum Student
Fisher College, Boston, MA 2007

- Co-lead substance abuse group and completed alcohol and drug screenings for mandated clients
- Co-lead international student support group to help international students adjust to attending school in a new culture and being away from family and friends

Research Assistant to Professor of Graduate School Psychology
Northeastern University, Boston, MA 2006-2007

- Conducted literature research on cross-cultural counseling
- Systematically evaluated curriculum and program of the Northeastern University Graduate School Psychology in reference to NASP standards

Clinical Volunteer/Intern
Butler Hospital, Providence, RI 2005

- Assisted with providing therapeutic programming to patients on both the adolescent and children's unit.
- Observed patients and participated in developing individual treatment strategies as well as treatment groups

EDUCATION
Northeastern University, Boston, MA
Masters in Counseling Psychology 2008

James Madison University, Harrisonburg, VA
Bachelor of Science in Psychology, Minor in Family Studies 2006

SKILLS

- Knowledge of Microsoft Office Suite, Windows 2000/XP/Vista/Windows 7, Internet Search Engines and SPSS

REFERENCES AVAILABLE UPON REQUEST

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ADAM B. SCHAUER

EDUCATION & CERTIFICATION

Northeastern University, Boston, MA
Graduate School of Professional Accounting
Masters of Business Administration
Master of Science in Accountancy

University of Vermont, Burlington, VT
Bachelor of Arts – Major in Sociology and Minor in Political Science (1993)

CPA – Certified Public Accountant (not active, presently taking CPE credits to reactivate certification)

TECHNICAL SUMMARY

Softrax, Solomon - Also, in-charge of systems conversion and integration FrX (financial reporting package), Great Plains, Quickbooks, Microsoft Office (Word, Excel, PowerPoint and Access), Transcentive (stock option software), Two Step Software (stock option software), CCH Prosystem Fx (corporate and personal tax software)

PROFESSIONAL EXPERIENCE

South Bay Mental Health (Community Intervention Services) **September 2012 to Present**
(H.I.G. Capital private equity Portfolio Company)
Vice President of Finance and Controller

- Responsible for overseeing all accounting, finance, FP&A, payroll, accounts payable, tax, corporate insurance, cash management.
- Assisted board of directors and chief executive officer in the successful negotiations of the acquisition of two companies.
- Assisted in the securing of additional debt financings with the company's lenders.
- Responsible for preparing bank reporting and managing banking relationship with company lenders.
- Managed the preparation of financial presentations used in board of directors meetings including attendance and presenting to the board of directors and executive management team.
- Managed preparation and implementation of annual budget, forecasting, financial planning, model, variance planning including presentation to the board of directors for approval and rollout to executive management team.
- Supervise a staff responsible for General Ledger/financial reporting, payroll, accounts payable and financial planning and analysis and tax.
- In-charge of overseeing annual audit and assistance and review of corporate tax returns.

ET International and Engage Now **November 2011 to August 2012**
Consulting

- Providing Company contract CFO services including development of 2012 budget, corporate business plan.

Rogue Wave Software, Inc. / TotalView Technologies **February 2006 – September 2011**
(Battery Venture private equity Portfolio Company – acquired TotalView Technologies in February of 2010)
Vice President of Finance *(March 2010 to September 2011)*

- Assisted board of directors and the chief executive officer in the successful negotiations of an amended credit agreement whereby increasing outstanding loan amount.
- Managed on-going relationships with lenders including monthly bank reporting and covenant compliance.
- Responsible for preparation of financial presentations used in board of directors meetings including attendance and presenting to the board of directors and executive management team.
- Managed preparation and implementation of annual budget including presentation to the board of directors for approval and rollout to executive management team.
- Ensured successfully completion of significant tax projects including transfer pricing, annual loss limitations resulting from change-of-control (IRC Section 382), earnings and profits (conducting in-conjunction with dividend to the Company's common stockholders).
- Reviewed and assisted sales in negotiation of material license and distribution deals in order to maximize revenues while maintaining compliance with revenue recognition rules (SoP 97-2 and SoP 81-1).
- Supervised a staff of 9 employees including staff responsible for financial reporting (3), revenue recognition (2), payroll and accounts payable (1), financial and business analysis (1), collections (1), accounts receivable and invoicing (1).
- Managed outsourced foreign accounting (third party accounting firm) including monthly close, foreign cash repatriation, transfer pricing implementation and compliance, statutory audits and tax reporting.

- Responsible for managing annual audit and assistance and review of corporate tax returns.
- Assisted Vice President of Sales in design and implementation of all direct and channel sales plans.
- Lead company's 401(k) plan merger (merging of three plans from prior acquisitions).
- Assisted in due diligence of asset purchase of foreign assets including integration of employees and set-up of new foreign subsidiary and set-up of financial reporting.
- Managed hiring and training of new finance staff including controller, accounts receivable manager, and accounting manager.

TotalView Technologies, Inc., Natick, MA
(Norwegian-Over the Counter, NOTC Listed Under Ticker: TVTI)
Vice President of Finance and Operations & Chief Financial Officer *(February 2006 to February 2010)*

- Co-lead with CEO the successful sale of Company to Rogue Wave Software, Inc. (Battery Venture private equity portfolio company) without assistance from investment bank
- Lead financial presentations and negotiations including structuring of acquisition terms, due diligence, final closing documents and distribution of merger consideration to approx. 300 shareholders
- Lead preparation and presentation of all financial and corporate matters to the Board of Directors
- Lead on investor relations matters including shareholders (approx. 300) presentations (annual shareholder meeting) and written communications.
- Responsible for preparing, presenting and implementing annual budget and forecasts to the management team and Board of Directors.
- Responsible for reviewing all GAAP financial reporting including review of supporting account reconciliations.
- Managed business operations including but not limited to order processing and licensing, maintenance renewal sales and maintenance sales retention.
- Supervised a staff of 4 employees including staff responsible for financial reporting (1), order processing and licensing, financial and business analysis (1) and maintenance renewal sales (2).
- Oversaw all compensation and human resource matters including benefit plan renewals and implementations, legal and tax compliance, design and implementation of employee compensation plans (direct sales commissions plans and Company-wide bonus plans).
- Managed relationships with auditors, attorneys Norwegian Securities Dealers Association (NOTC), and transfer agent (Den Norske Bank).
- In-charge of managing annual audit and assistance and review of corporate tax returns.
- Responsible for overseeing administration of Company's stock option plans.

AMICAS, Inc., Boston, MA January 2005 to January 2006
(NASDAQ Listed Under Ticker: AMCS)
Controller

- Supervised all GAAP financial reporting including review of supporting account reconciliations.
- Responsible for researching technical accounting issues (including revenue recognition, FAS 123(R) – expensing of stock options).
- Responsible for reviewing Company's quarterly earnings releases and assisted in the preparation of earnings call materials for CEO and CFO.
- Responsible for reviewing and filing of SEC filings including Form 10-K, DEF 14A (Proxy Statement), and 10-Q.
- Successfully hired and trained new accounting staff in-conjunction with Company's corporate office relocation from Ridgefield, Connecticut to Boston, Massachusetts.
- Supervised a staff of 12 employees including staff responsible for financial reporting, financial application specialist, billing, collections, G/L maintenance, A/P, payroll administration and employee compensation, employee benefit plans.
- Reviewed new product licensing for proper revenue recognition in accordance to Company's revenue recognition policy (under SoP 97-2, SoP 81-1, and Staff Accounting Bulletin).
- Managed timely completion of quarterly reviews with independent accountants.
- Oversaw review of all corporate tax returns.
- Responsible for overseeing administration of Company stock option plans and employee stock purchase plan including managing relationships with transfer agent.
- Responsible for overseeing selection and implementation of a new Company 401(k) plan.
- Lead in arbitration case related to the Company's $100 million sale of its Medical Business, which resulted in a favorable outcome.
- Successfully integrated accounting systems (Quickbooks to Softrax), policies and procedures of Company's previous acquisition of another software company.

APPLIX, INC., Westborough, MA — October 2001 to October 2004
(NASDAQ Listed Under Ticker: APLX)
Controller

- Responsible for reviewing all GAAP financial reporting, including worldwide consolidation of its five foreign subsidiaries.
- Responsible for researching all technical accounting issues including revenue recognition in accordance with SoP 97-2, SoP 81-1 and Staff Accounting Bulletins).
- Responsible for reviewing Company's quarterly earnings releases and assisted in the preparation of earnings call materials for CEO and CFO.
- Responsible for reviewing and filing of SEC filings including Form 10-K, DEF 14A (Proxy Statement), 10-Q, 8-K, S-8, Forms 3, 4 and 5s.
- Responsible for facilitating timely implementation and compliance of all necessary changes relating to corporate governance/updated disclosure requirements as required under Sarbanes-Oxley Act (Act), NASDAQ rules and SEC rules/regulations. Responsible for implementation and testing of Company's disclosure controls under the Act and preparation for testing of internal controls by independent accountants under the Act.
- Supervised an accounting staff of 5 employees. Staff responsible for financial reporting, company consolidation, G/L maintenance, A/P, payroll administration and employee compensation, employee benefits plans.
- Responsible for reviewing Board presented financial information including Board packages and attended Audit Committee meetings which included making presentations to and answering inquiries by the Audit Committee.
- Key team member in Company's successful sale of its CRM business including team leader of all necessary SEC filings and statutory requirements. Worked closely with outside accountants and lawyers including researching accounting and tax issues and review of all closing documents.
- Managed timely completion of annual audits with independent accountants including coordinating local statutory audits of its foreign subsidiaries.
- Responsible for reviewing all corporate tax returns including new transfer pricing study and implementation of its results.
- Responsible for overseeing administration of the Company's stock option plans and employee stock purchase plans including managing relationship with the Company's transfer agent.

SERVICESOFT, INC (acquired by Broadbase and Kana Software), Natick, MA — January 1999 to May 2001
Controller - Operations

- Key team member in the preparation of the Company's S-1 (Registration Statements). Worked closely with independent accountant, attorney and underwriters in the preparation of the document including member of key drafting sessions with aforementioned parties.
- Responsible for reviewing financial reports to ensure compliance with GAAP and related disclosures including consolidation of its five foreign subsidiaries (in compliance with FAS 52).
- Team leader responsible for the selection of a multi-currency, multi-company, project accounting software package (Solomon IV BackOffice and FRx). Directed and supervised all accounting staff in a successful conversion of historical G/L, A/R and A/P data and integration with legacy systems (QuickBooks and Great Plains).
- Appointed to select and execute an implementation of stock option administration software. Software fully and timely implemented in anticipation of company's IPO.
- In-charge of the administration of the Company's stock option plan including reporting and withholding requirements.
- Directed preparation of annual Company budgets, reviewed budget proposals, and prepared necessary supporting documentation. Worked directly with department vice presidents and assisted in the preparation of company-wide budget.
- Drafted and executed Company's critical policies and procedures relating procurement of goods & services (purchase order), travel and entertainment guidelines and employee expense reporting. Responsible for ensuring proper approval and compliance in order maximize corporate spending.
- Supervised an accounting staff of 5 employees including accountant of Canadian subsidiary. Staff responsible for financial reporting, company consolidation, G/L maintenance, A/P, payroll administration and employee compensation, employee benefits plans.

Controller - Operations - *Acquisition Related Responsibilities*

- Key team leader in the successful integration of operations and financial reporting of the $647 million dollar tax-free acquisition of Servicesoft, Inc. by Broadbase Software, Inc. (a public company) including all necessary SEC filings.
- Key team member in preparation of year annual operating budget crucial to strategic decisions to be made by senior management.

- Managed the tax relationships and related engagements with outside accountants (including transfer pricing, calculation of IRC annual NOL limitations, R&D tax credit, etc.)
- Spearheaded the merger and integration of all employee benefits plans, including 401(k), fringe & welfare plans, and stock option plan.
- Key team leader in the successful integration of operations and financial reporting of Internet Business Advantages, Inc. as corporate controller.
- Assisted in the update of the Company's business plan and revenue model affected by the acquisition.
- Worked diligently with Servicesoft's CFO, attorneys, and independent accountants in the due diligence process including review and comment on closing documents.

Corporate Controller **(Internet Business Advantages, Inc., Acquired by Servicesoft)**

- Drafted and implemented Company's revenue recognition policy in conformance with SoP 81-1 and SoP 97-2.
- Worked closely with Company's growing professional services organization in-order to determine current services revenue (percentage complete method) and calculate future services revenue for forecast.
- Assisted Company's CFO in the establishment of Company's management and board reporting, including annual operating budget, monthly & quarterly forecasts, revenue forecasting by project, job costing/project profitability, employee utilization and other critical metrics.
- Supervised staff accountant in maintaining accounts receivable, accounts payable, payroll, GAAP financial reporting, financial policies and procedures.
- Assisted Company's CEO and CFO in obtaining a mezzanine round of financing with venture capital firms including preparation of capitalization tables, financial statements and financial projections.

CATURANO & COMPANY (acquired by McGladrey Pullen), Boston, MA 1997 to 1998
Senior Accountant

- Supervised accounting staff in performance of financial statement audits, reviews, and other attestation services.
- Performed extensive accounting research for the firm in preparation of company's financial statements, including derivatives, investments, and revenue recognition.
- Prepared corporate and individual tax returns (federal and state).

PRICEWATERHOUSECOOPERS, L.L.P., Boston, MA 1995 to 1997
Senior Accountant

- Supervised financial statement audits specializing in high-technology companies.
- Performing extensive accounting research in related topics, including revenue recognition, stock options.
- Performed annual audit and quarterly reviews of numerous publicly traded companies, including Cambridge Heart, W.R. Grace, and Turner Broadcasting.
- Assisted in the multiple SEC filings including S-1 Registration Statement (American Ski Company), S-4.

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Attachment 5
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VITA

JENNIFER G. GEARHART, MA, LICSW
36 Sachem Circle
Pembroke, MA 02359
(781) 293-9497

EDUCATION

SIMMONS COLLEGE — **Masters of Social Work** (1990)
School of Social Work

BOSTON COLLEGE — **Masters of Arts** (1986)
Counseling Psychology

BOSTON COLLEGE — **Bachelors of Arts**
Summa Cum Laude — Psychology (1984)
Phi Beta Kappa

EXPERIENCE

SOUTH BAY MENTAL HEALTH CENTER, **Brockton, MA**

1992-Present

Director of Mental Health and Substance Abuse Services
Responsible for overseeing administrative and clinical operations of seven outpatient mental health/substance abuse clinics. Supervise and manage all mental health clinic directors and all seven site locations. Chair of the Clinical Directions Committee and the Quality Management and Quality Improvement programs. Conduct weekly mental health management team. Oversee all psychiatric services in the agency. Responsible for coordinating efforts for agency certification by the Commission for the Accreditation of Rehabilitation Facilities (CARF). Coordinated and supervised the mental health 24 hour on-call emergency system. Responsible for supervising the director of South Bay's newly developed Trauma Recovery Institute.

1990-1992 **SOUTH BAY MENTAL HEALTH CENTER,** **Weymouth, MA**

Clinic Director - Weymouth Mental Health Site
Responsible for monitoring and coordinating and overseeing all clinical and administrative aspects of the Weymouth outpatient MH/SA clinic. Provided group and individual supervision to staff therapists. Conducted weekly team meetings. Participated in Utilization Review and Multi-disciplinary Team. Coordinated program development program with collateral agencies such as the Department of Social Services, the Department of Mental Health, and Public School Systems. Trained staff clinically in areas of child maltreatment, sexual and physical abuse, sexual abuse evaluations, domestic violence, family systems, and parenting and adolescent conduct disorders. Developed policies and procedures to meet agency, Department of Public Health, and Department of Medical Assistance licensing requirements. Ensured quality and accuracy of all clinical documentation. Recruited, oriented, and provided ongoing training to new and current staff members. Performed individual and family therapy as needed and conducted sexual abuse and trauma evaluations. Participated in Mental Health Management Team.

1987-1990 **SOUTH BAY MENTAL HEALTH CENTER, Brockton, MA**

Staff Therapist - Responsibilities included: assessment and diagnostic evaluation of referred clients (using DSM-III); individual, family, and couples therapy with adults; family and individual therapy with children and adolescents, establishment of treatment plans tailored to individual client needs; working with clients in creative ways to achieve specified treatment goals; consultation with outside agencies and professionals such as the Department of Social Services, Department of Mental Health, teachers, school adjustment counselors, and parents; preparation of all third party (Medicaid) billing documentation; participation in weekly child and family seminars featuring individual case presentations. Diagnostic range included: schizophrenic disorders, affective disorders, anxiety disorders, severe personality disorders, alcoholism, posttraumatic stress disorder, acting-out and conduct disorders, attention deficit disorder, sexual/physical abuse and neglect, and specific developmental disorders. Referral sources included: Department of Social Services, Department of Mental Health, Department of Youth Services, Brockton and Quincy Public Schools, parents, and teachers.

6/86 to 12/86 **CHARLES HAYDEN GOODWILL SCHOOL, Dorchester, MA**

Assessment Coordinator: Adolescent Assessment Unit
Responsibilities included: Coordination of all aspects of comprehensive assessment process, which included family consultation, psychological testing, educational testing, meetings with social workers, and individual therapy sessions; preparation of all relevant assessment documentation; establishment of short-term treatment plans tailored to individual students; weekly meetings with consulting psychiatrists; facilitation of all referral contacts and placement of students; clinical supervision of staff; participation in weekend "on-call" clinical/administrative team. Students on Unit: 6. Length of stay: 90 day/Residential. Referral source: Department of Social Services.

9/85 to 5/86 **PRACTICUM: TUFTS NEW ENGLAND MEDICAL CENTER DEPARTMENT OF CHILD PSYCHIATRY SCHOOL CONSULTATION TEAM**

Counseling Intern - Responsibilities included: assessment and diagnostic evaluation of referred children; individual counseling; consultation with teachers and parents; psychological testing; participation in Chapter 766 evaluations; and consultation with outside agencies and professionals. Presenting problems for cases referred included depression, acting-out and conduct disorders, attention deficit disorder, and questions of abuse and neglect.

5/84 to 9/84 **GAEBLER CHILDREN CENTER, Waltham, MA**

Mental Health Worker - Responsibilities included: monitoring and supervising children and adolescents in varied settings at a resident care facility; assessing daily resident progress and determining "privilege levels" for assigned residents; problem assessment and adoption of resolution strategies as need arose, constructing individual care plans; planning group activities; interacting with patients on an individual basis as part of multifaceted therapy programs.

LICENSE LICSW, License # 1021126

REFERENCES Available upon request

DOCKET 12-31798CON

Attachment 3
Appendix A

South Bay Mental Health Center

DIRECTOR OF CLINICAL SERVICES

Revised: 1/31/2007

Classification: 2
Division: Mental Health
Reports To: Executive Director

JOB SUMMARY: Responsible for overseeing all outpatient mental health and substance abuse programs, providing supervision to clinic and regional directors, serving on the agency management team, and coordinating all clinical services.

ESSENTIAL FUNCTIONS:

- Provide clinical and administrative supervision as needed to clinic and regional directors
- Assist in employee recruitment, selection, evaluation and termination of staff
- Work closely with Human Resources, Recruiting, Billing, Intake and MIS departments
- Provide training and consultation as needed
- Provide program development and marketing in the communities
- Assist in the research, planning, development, and implementation of clinical and administrative policies
- Participate in surveys, audits, license reviews, and budgeting
- Oversee all psychiatric services
- Provide emergency consultation to clients and therapists in the absence of the Medical Director and on-call clinicians
- Oversee Utilization Review/Multidisciplinary Team
- Oversee Quality Improvement/Quality Management plan and process
- Oversee operations of Clinical Directions Committee

PHYSICAL REQUIREMENTS:

a) Lifting:	Less than 15lbs.
b) Stooping/bending:	Seldom
c) Crawling/climbing/kneeling:	Seldom
d) Reaching/pulling/pushing:	Seldom

QUALIFICATIONS: Master's degree in Psychology, Social Work, or other relevant areas of social or human services, five years full-time clinical supervisory experience and licensure as an Independent Clinical Social Worker by the Massachusetts Registry of Social Work

Signature: Jennifer Dearnley Date: 10/23/09

DOCKET 12-31798 CON

Attachment 6
Pg 1 of 2

AMY D. MINER
8 KINROSS ROAD APT. 9
BROOKLINE, MA 02146
(617) 232-0456

OBJECTIVE: **To combine my education and experience to develop a fulfilling career helping children and their families improve the quality of their lives.**

EDUCATION:

Boston College, Chestnut Hill, MA
Master of Arts Degree, May 1995
Major: Counseling Psychology

University of Colorado, Boulder, CO
Bachelor of Arts Degree, May 1992
Major: Psychology
Cumulative Average: 3.3/4.0

RELATED EXPERIENCE:

PROJECT JOY, Cambridge, MA
Assistant Program Director/Counselor 9/94-Present
Completed a paid internship co-leading therapeutic activity based play groups for homeless and economically disadvantaged preschool and toddler children. Other responsibilities included grant writing, fundraising, and program development. Currently leading three groups: children of battered women, disadvantaged children in a boys'and girls' club, and children in a low income housing project.

RELIEF RESOURCES, INC., Northampton, MA
Relief Worker 9/93-Present
Provide relief coverage in mental health settings and substitute teaching in schools. Mental health settings include emotionally disturbed shelters, group homes and agencies in need of supportive assistance. (20-40 hours per week)

THE ACADEMY OF PHYSICAL AND SOCIAL DEVELOPMENT, Newton, MA
Co-Counselor 8/94-Present
Completed a ten-month internship leading and co-leading activity based therapy groups for children ages six to eleven. Therapeutic issues included behavioral, learning disabilities, Attention Deficit Hyperactivity Disorder, Asperger's Syndrome, Tourettes and Pervasive Developmental Delay. Participated in and observed intake interviews. Wrote detailed progress reports. Researched and presented case material on a wide range of relevant topics. Currently substituting for counselors on an on-call basis.

CHILDREN'S GROUP THERAPY ASSOCIATION, Boston, MA
Volunteer/Conference Committee 4/95-Present
Participated in organization and operation of 1995 annual conference. Currently a member of the 1996 conference committee.

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FATHER FLANAGAN'S BOYS' HOME - BOYS' TOWN, Grand Island, NE
Volunteer Mentor 12/92-2/93
Assisted in providing emotional and physical care for youth and families in need of a support system prior to, during, and following shelter services.

DIET CENTER, Boulder, CO
Assistant 2/92-5/92
Monitored individuals on the weight loss program. Provided basic counseling, weight measurement, and provided information.

UNIVERSITY OF COLORADO, Boulder, CO
Peer Advisor 1/92-5/92
Attended peer advising course in conjunction with holding office hours weekly. Counseled students regarding vocational, educational, and personal issues. Completed a paper and presentation on eating disorders.

ALPHA CHI OMEGA, Boulder, CO
Vice-President Pledge Education 1/91-1/92
Implemented and organized pledge education concerning academic, social, and personal issues among new members. Issues included alcohol and drug awareness, date rape, time management, personal development. Served on Chapter Relations Board and Executive Board to develop, strengthen, and uphold standards of excellence within the organization.

MASLIN HOUSE BOULDER COUNTY MENTAL HEALTH CENTER, Boulder, CO
Volunteer Case Manager Aide, Recreation Group Leader 1/90-1/92
Leader for schizophrenic and manic depressive clients. Collaborated with therapist to provide case management services for clients. Facilitated weekly recreational activities.

References available upon request.

Docket 12-31798 CON

Attachment 6
Appendix A

South Bay Mental Health Center

DIRECTOR OF EARLY INTERVENTION SERVICES

Revised: 7/25/07

Classification: 2
Division: Early Intervention
Reports To: Executive Director

JOB SUMMARY: To serve as overall administrator and clinical director of the Early Intervention program

ESSENTIAL FUNCTIONS:

- Oversee general maintenance of program operations, including physical site
- Fiscal responsibility and viability of the program
- Monitor compliance with applicable state, local and federal regulation
- Chair Core team meetings as needed
- Responsible for program evaluation and development
- Assist in staff recruitment, selection, evaluation and termination of staff
- Establish and maintain policies and procedures for client treatment
- Provide supervision for EI staff
- Work closely with Human Resources, Recruiting, Billing, MIS and other departments as necessary
- Provide training and consultation as needed
- Other supervisory duties as required

PHYSICAL REQUIREMENTS:

a) Lifting:	Less than 15lbs.
b) Stooping/bending:	Seldom
c) Crawling/climbing/kneeling:	Seldom
d) Reaching/pulling/pushing:	Seldom

QUALIFICATIONS:

Education: Must qualify in one of the core disciplines set forth in Early Intervention standards.

Experiential: Must have two years of full-time, supervised clinical experience in a team treatment setting serving client population birth to three years of age. Supervisory experience is preferred.

Signature: Amy D. Miner-Fletcher *Date:* 10/20/09

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Attachment 7
pg 1 of 2

9 WENTWORTH DR. AUBURN, MA 01501
508.982.6892 • COLELGR24@YAHOO.COM

NICOLE L. LOPES

OBJECTIVE

Clinical social worker (MSW, LCSW) currently employed in civil service, looking to focus on Forensic Services.

EDUCATION

May 2005 Boston College Chestnut Hill, MA
M.S.W. Boston College Graduate School of Social Work
Clinical Concentration
Social Work Tuition Remission Scholarship

May 2002 Gordon College Wenham, MA
Bachelor of Arts in Psychology
Dean's Scholarship for GPA above 3.25

WORK EXPERIENCE

Feb. 2005-present Project Place/Suffolk County H.O.C. Boston, MA
Supervisor/ Life Skills Instructor for Community Re-Entry for Women
Supervise the CREW Outreach case manager and Career coach (this includes weekly individual and group supervision, as well as monitoring job responsibilities)
Educate female offenders on basic life skills and job readiness
Implemented new curriculum
Responsible for discharge planning and continued services to women up to 2 years post-release (developing resumes, housing assistance, and job training)
Collaborate with outside government and civil service agencies providing services to inmates, post-release

Nov. 2005-present Bridging the Gap Worcester, MA
Assistant Director
Teach life skills, anger management, positive thinking skills, etc to juvenile offenders
Conduct family and individual counseling with participants and their families

April 2004-Feb.2005 Project Place/Betty's T.P. Boston, MA
Case Manager
Manage cases of ten women in transitional program
Lead 'Life Skills' group sessions
Connect with community resources available to clients

Aug. 2003-Feb. 2004 Plymouth County Correctional Facility Plymouth, MA
Clinical Social Work Intern
Group and individual counseling in Substance Abuse Unit
Led AA/NA meetings
Facilitated psychoeducational groups
Completed mental health evaluations/assessments

Aug. 2002-May 2003 Caritas Carney Hospital Dorchester, MA
Medical Social Work Intern
Caritas Carney is a Catholic community hospital under the Archdiocese of Boston
Responsibilities include: nursing home placement, discharge planning, case management, intakes and group therapy

Summer 2002 Camp Wonderland Sharon, MA
Christian Education/Junior Staff Supervisor
Supervised twenty staff, ages 14-18
Planned daily activities and evening programs
Mentored all 75 staff members

Summer 2000, 2001 Camp Wonderland Sharon, MA
Younger/Older Girls Unit Leader
Supervised nine counselors from all areas, Internationally
Planned and led daily activities for sixty girls, ages 6-14
Carried out any disciplinary action for both counselors and campers

Spring 2000 The Salvation Army Headquarters Boston, MA
Social Services Administrator
Gave financial assistance to residents of the Boston area
Provided intake for those requesting food vouchers
Handled application process with clients

VOLUNTEER EXPERIENCE

Kids F.E.A.S.T.—1999-present * Riverside Children's Center – Fall 199
READS – Academic Year 1999 * Brookline Extended Day Program assis
1998 – North Shore ARC Women's Group – Spring 2000

Attachment 7
Appendix A

DIVISION DIRECTOR

Revised: 2/26/2007

Classification: 2
Division: Adult Day Services
Reports To: Executive Director

JOB SUMMARY: Responsible for overseeing both psychiatric day services and partial hospital programs, providing supervision to program and regional directors, serving on the agency management team, and coordinating all day services for South Bay.

ESSENTIAL FUNCTIONS:

- Develop systems for clinical documentation in consultation with regulatory bodies and central office staff
- Provide supervision for senior clinical and administrative staff
- Supervise development for both day treatment and partial hospital programs
- Monitor medical oversight within the Division
- Evaluate staff performance to meet program goals and objectives
- Participate on CORE teams as needed (per payer regulations)
- Monitor program outcomes including consumer satisfaction, treatment compliance, quality improvement, and other identified measures
- Work closely with Human Resources, Billing, Intake, Project Management, and IT departments
- Provide training and consultation as needed
- Oversee all Day Services documentation including initial certifications, re-certifications, group and session notes, as well as treatment plans, comprehensive and medical overviews
- Develop new programs, specialized activities, and relevant tracks within the existing programs
- Other supervisor duties as required

PHYSICAL REQUIREMENTS:

a) Lifting:	Less than 15lbs.
b) Stooping/bending:	Seldom
c) Crawling/climbing/kneeling:	Seldom
d) Reaching/pulling/pushing:	Seldom

QUALIFICATIONS:

Education:

a) Master's degree in one of the core disciplines set forth in Psychiatric Day Treatment Center Manual Subsections 421 B (2) and (3), except for Occupational therapy and psychiatric nursing
b) Master's degree in a related health field (i.e. health administration or public health)
c) Bachelor's degree in nursing (RN) or occupational therapy unless the basic Preparation took place at master's degree level

Experience: Must have 5 years of full-time, supervised clinical experience in a multidisciplinary team treatment setting broken down as follows: 2 years experience working with a similar client population, 1 year in a day treatment program (which may be concurrent with foregoing 2 years), and 2 years in an administrative/supervisory capacity. Two years of the above experience must be attained post-graduate.

Signature: _____ *Date:* 12.14.09

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Question 6 - Also, on page 313 states that there is a start-up phase of 6 to 9 months for the proposal. Please revise the tables on pages 309-12 and 338 to include the start-up phase and three full years of operations, adjusting the projected utilizations as needed.

Response - See below.

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

Total Facility:			1.1	2%		110%	120%		110%	120%	
Description	FY 2011 Actual Results	FY 2013 Initial (6 Month) Start-up Phase	FY 2014 Projected W/out CON	FY 2014 Projected Incremental	FY 2014 Projected With CON	FY 2015 Projected W/out CON	FY 2015 Projected Incremental	FY 2015 Projected With CON	FY 2016 Projected W/out CON	FY 2016 Projected Incremental	FY 2016 Projected With CON
NET PATIENT REVENUE											
Non-Government	$ 3,140,618	$ 15,703	$ 3,454,680	$ 62,812	$ 3,517,492	$ 3,800,148	$ 75,375	$ 3,875,523	$ 4,180,163	$ 90,450	$ 4,270,612
Medicare	2,034,612	10,173	2,238,073	40,692	2,278,765	2,461,881	48,831	2,510,711	2,708,069	58,597	2,766,665
Medicaid and Other Medical Assistance	17,107,275	85,536	18,818,003	342,146	19,160,148	20,699,803	410,575	21,110,377	22,769,783	492,690	23,262,473
Other Government	15,640,055	78,200	17,204,061	312,801	17,516,862	18,924,467	375,361	19,299,828	20,816,913	450,434	21,267,347
Total Net Patient Revenue	37,922,560	189,613	41,714,816	758,451	42,473,267	45,886,298	910,141	46,796,439	50,474,927	1,092,170	51,567,097
Other Operating Revenue	112,907		124,198	2,258							
Revenue from Operations	38,035,467	189,613	41,839,014	760,709	42,473,267	45,886,298	910,141	46,796,439	50,474,927	1,092,170	51,567,097
OPERATING EXPENSES											
Salaries and Fringe Benefits	27,401,542	171,600	30,141,696	548,031	30,689,727	33,155,866	657,637	33,813,503	36,471,452	789,164	37,260,617
Professional / Contracted Services		-	-	-	-	-	-	-	-	-	-
Supplies and Drugs		-	-	-	-	-	-	-	-	-	-
Bad Debts		-	-	-	-	-	-	-	-	-	-
Other Operating Expense	5,550,297	36,498	6,105,327	111,006	6,216,333	6,715,859	133,207	6,849,066	7,387,445	159,849	7,547,294
Subtotal	32,951,839	208,098	36,247,023	659,037	36,906,060	39,871,725	790,844	40,662,569	43,858,898	949,013	44,807,911
Depreciation/Amortization	148,256		163,082		163,082	179,390	-	179,390	197,329	-	197,329
Interest Expense					-			-			-
Lease Expense					-			-			-
Total Operating Expenses	33,100,095	208,098	36,410,105	659,037	37,069,141	40,051,115	790,844	40,841,959	44,056,226	949,013	45,005,239
Income (Loss) from Operations	4,935,372	(18,485)	5,428,909	101,672	5,404,126	5,835,183	119,297	5,954,480	6,418,701	143,157	6,561,858
Non-Operating Income	(20,077)	-	12,000	-	12,000	13,200	-	13,200	14,520	-	14,520
Income before provision for income taxes	4,915,295	(18,485)	5,440,909	101,672	5,416,126	5,848,383	119,297	5,967,680	6,433,221	143,157	6,576,378
Provision for income taxes	141,440		155,584			171,142	-		188,257	-	
Net Income	4,773,855	(18,485)	5,285,325	101,672	5,416,126	5,677,240	119,297	5,967,680	6,244,964	143,157	6,576,378
Retained earnings, beginning of year	(572,750)	4,201,105	4,182,620	4,182,620	4,284,292	9,466,430	4,284,292	9,605,728	15,163,670	4,403,590	15,573,407
Retained earnings, end of year	$ 4,201,105	$ 4,182,620	$ 9,466,430	$ 4,284,292	$ 9,700,418	$ 15,163,670	$ 4,403,590	$ 15,573,407	$ 21,408,635	$ 4,546,746	$ 22,149,785
FTEs	596	5	656	12	668	722	14	736	794	18	812

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Question 6 - Also, on page 313 states that there is a start-up phase of 6 to 9 months for the proposal. Please revise the tables on pages 309-12 and 338 to include the start-up phase and three full years of operations, adjusting the projected utilizations as needed.

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	Behavioral Health Services										
Type of Unit Description:	Hour sessions										
# of Months in Operation	12										
FY _13 Start-Up Phase (6 Month)	(1)		(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
FY Projected Incremental			Rate	Units	Gross Revenue Col. 2 * Col. 3	Allowances/ Deductions	Charity Care	Bad Debt	Net Revenue Col.4 - Col.5 -Col.6 - Col.7	Operating Expenses Col. 1 Total * Col. 4 / Col. 4 Total	Gain/(Loss) from Operations Col. 8 - Col. 9
Total Incremental Expenses:	**$206,069**										
Total Facility by Payer Category:											
Medicare	$10,173	$	82.00	124	$10,173			$109	$10,064	$11,056	($992)
Medicaid	$163,737	$	82.00	1,997	$163,737			$1,752	$161,985	$177,947	($15,962)
CHAMPUS/TriCare	$0	$	82.00		$0			$0	$0	$0	$0
Total Governmental	$173,910			2,121	$173,910	$0	$0	$1,861	$172,049	$189,003	($16,954)
Commericial Insurers	$15,703	$	82.00	192	$15,703			$168	$15,535	$17,066	($1,531)
Uninsured	$0	$	82.00	0	$0				$0	$0	$0
Total NonGovernment	$15,703	$	82.00	192	$15,703	$0	$0	$168	$15,535	$17,066	($1,531)
Total All Payers	$189,613	$	82.00	2,312	$189,613	$0	$0	$2,029	$187,584	$206,069	($18,485)

Question 6 - Also, on page 313 states that there is a start-up phase of 6 to 9 months for the proposal. Please revise the tables on pages 309-12 and 338 to include the start-up phase and three full years of operations, adjusting the projected utilizations as needed.

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: Behavioral Health Services
Type of Unit Description: Hour sessions
# of Months in Operation: 12

FY _14 **FY Projected Incremental** Total Incremental Expenses: **$650,921**	(1)		(2) Rate	(3) Units	(4) Gross Revenue Col. 2 * Col. 3	(5) Allowances/ Deductions	(6) Charity Care	(7) Bad Debt	(8) Net Revenue Col.4 - Col.5 -Col.6 - Col.7	(9) Operating Expenses Col. 1 Total * Col. 4 / Col. 4 Total	(10) Gain/(Loss) from Operations Col. 8 - Col. 9
Total Facility by Payer Category:											
Medicare	$40,692	$	82.00	496	$40,692			$435	$40,257	$34,819	$5,437
Medicaid	$654,947	$	82.00	7,987	$654,947			$7,008	$647,939	$560,423	$87,516
CHAMPUS/TriCare		$	82.00		$0			$0	$0	$0	$0
Total Governmental	$695,639			8,483	$695,639	$0	$0	$7,443	$688,196	$595,242	$92,953
Commericial Insurers	$62,812	$	82.00	766	$62,812			$672	$62,140	$53,747	$8,393
Uninsured	$2,258	$	82.00	28	$2,258				$2,258	$1,932	$326
Total NonGovernment	$65,070	$	82.00	794	$65,070	$0	$0	$672	$64,398	$55,679	$8,719
Total All Payers	$760,709	$	82.00	9,277	$760,709	$0	$0	$8,115	$752,594	$650,921	$101,672

Question 6 - Also, on page 313 states that there is a start-up phase of 6 to 9 months for the proposal. Please revise the tables on pages 309-12 and 338 to include the start-up phase and three full years of operations, adjusting the projected utilizations as needed.

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: Behavioral Health Services
Type of Unit Description: Hour sessions
# of Months in Operation: 12

FY _15 **FY Projected Incremental** Total Incremental Expenses: **$781,106**	(1)		(2) Rate	(3) Units	(4) Gross Revenue Col. 2 * Col. 3	(5) Allowances/ Deductions	(6) Charity Care	(7) Bad Debt	(8) Net Revenue Col.4 - Col.5 -Col.6 - Col.7	(9) Operating Expenses Col. 1 Total * Col. 4 / Col. 4 Total	(10) Gain/(Loss) from Operations Col. 8 - Col. 9
Total Facility by Payer Category:											
Medicare	$48,831	$	81.50	599	$48,831			$522	$48,308	$41,908	$6,401
Medicaid	$785,936	$	81.50	9,643	$785,936			$8,410	$777,526	$674,509	$103,017
CHAMPUS/TriCare		$	81.50		$0			$0	$0	$0	$0
Total Governmental	$834,767			10,243	$834,767	$0	$0	$8,932	$825,835	$716,417	$109,418
Commericial Insurers	$75,375	$	81.50	925	$75,375			$807	$74,568	$64,689	$9,880
Uninsured		$	81.50	0	$0				$0	$0	$0
Total NonGovernment	$75,375	$	81.50	925	$75,375	$0	$0	$807	$74,568	$64,689	$9,880
Total All Payers	$910,141	$	81.50	11,167	$910,141	$0	$0	$9,739	$900,403	$781,106	$119,297

Question 6 - Also, on page 313 states that there is a start-up phase of 6 to 9 months for the proposal. Please revise the tables on pages 309-12 and 338 to include the start-up phase and three full years of operations, adjusting the projected utilizations as needed.

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: Behavioral Health Services
Type of Unit Description: Hour sessions
# of Months in Operation: 12

FY _16 **FY Projected Incremental** Total Incremental Expenses: $937,327	(1)		(2) Rate	(3) Units	(4) Gross Revenue Col. 2 * Col. 3	(5) Allowances/ Deductions	(6) Charity Care	(7) Bad Debt	(8) Net Revenue Col.4 - Col.5 -Col.6 - Col.7	(9) Operating Expenses Col. 1 Total * Col. 4 / Col. 4 Total	(10) Gain/(Loss) from Operations Col. 8 - Col. 9
Total Facility by Payer Category:											
Medicare	$58,597	$	82.00	715	$58,597			$627	$57,970	$50,289	$7,681
Medicaid	$943,123	$	82.00	11,502	$943,123			$10,091	$933,032	$809,411	$123,620
CHAMPUS/TriCare		$	82.00		$0			$0	$0	$0	$0
Total Governmental	$1,001,720			12,216	$1,001,720	$0	$0	$10,718	$991,002	$859,701	$131,301
Commericial Insurers	$90,450	$	82.00	1,103	$90,450			$968	$89,482	$77,626	$11,856
Uninsured		$	82.00	0	$0				$0	$0	$0
Total NonGovernment	$90,450	$	82.00	1,103	$90,450	$0	$0	$968	$89,482	$77,626	$11,856
Total All Payers	$1,092,170	$	82.00	13,319	$1,092,170	$0	$0	$11,686	$1,080,484	$937,327	$143,157

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SOUTH BAY MENTAL HEALTH CENTER, INC.

Sliding Scale or **Reduced Rate Request
(Does not apply to Medicare Only)**

Clients who are actively involved in treatment at South Bay, and who unexpectedly lose insurance benefits, can request to continue services under our sliding scale program. In order to assure coordination of care, the request for sliding scale status must be made by the Primary Therapist and approved by the Supervisor. South Bay is committed to provide for the continuity of services and is willing to discount the customary fee by as much as 90%, but expects that clients will demonstrate a commitment to treatment by making some payment toward their fees. The purpose is to provide an appropriate termination or transfer to a DMH funded service rather than to provide continuing care. The sliding scale, which was developed along federal guidelines, is on the reverse side of this form. After determining the client's income and dependents, please take the sliding scale amount from this chart and enter it below.

Client's Name _____ DOB ____/____/____

Services Requested: (Circle any that apply)
Individual
Family
Case Consultation
Testing
Medication Visit
Day Treatment
Group Treatment _____ (name of group)

Client's Income: _____ Number of Dependents _____

Fee Requested: _____ (from chart on reverse side)

<u> Reduced Rate Request Information</u>**

Date entered treatment at South Bay ____/____/____

Type of Insurance: _____

Reason for needing Sliding Scale or Reduced Rate:

Insurance Pays @ _____ per visit

Co-Pay is: _____ per visit

Deductible is: _____ per visit

Purpose of the Continuation of Treatment:

2. _____ Billing Staff Initials -- Forward to Site Director

3. _____ Site Director, if approved, sends to Jennifer G. for her approval

1. _____ Primary Therapist -- gives to Billing for Reduced Rate Request

Approved _____ Not Approved _____

Approval -- Fee: _____ for _____ Not Approved _____
Number & Type of Sessions

Comments:

4. _____ Director of Clinical Services

____/____/____ Date

** this approval is valid for ** 6 months from date signed

SLIDING FEE SCALE
INDIVIDUAL/FAMILY SESSIONS

Yearly Income	Weekly Income	1	2	3	4	5	6	
0 - 4,000	77.00	10.00	10.00	10.00	5.00	5.00	5.00	
4,500	87.00	15.00	10.00	10.00	10.00	5.00	5.00	
5,000	96.00	15.00	15.00	10.00	10.00	10.00	5.00	
5,500	106.00	18.00	15.00	15.00	10.00	10.00	10.00	
6,000	115,00	18.00	18.00	15.00	15.00	10.00	10.00	
6,500	125.00	20.00	18.00	18.00	15.00	15.00	10.00	
7,000	135.00	20.00	20.00	18.00	18.00	15.00	15.00	
8,000	154.00	25.00	20.00	20.00	18.00	18.00	15.00	1
9,000	173.00	25.00	25.00	20.00	20.00	18.00	18.00	1
10,000	192.00	30.00	25.00	25.00	20.00	20.00	18.00	1
11,000	211.00	30.00	30.00	25.00	25.00	20.00	20.00	1
12,000	231.00	35.00	30.00	30.00	25.00	25.00	20.00	2
13,000	250.00	35.00	35.00	30.00	30.00	25.00	25.00	2
14,000	269.00	40.00	35.00	35.00	30.00	30.00	25.00	2
15,000	288.00	40.00	40.00	35.00	35.00	30.00	30.00	2
16,000	308.00	45.00	40.00	40.00	35.00	35.00	30.00	3
17,000	327.00	45.00	45.00	40.00	40.00	35.00	35.00	3
18,000	346.00	50.00	45.00	45.00	40.00	40.00	35.00	3
19,000	365.00	50.00	50.00	45.00	45.00	40.00	40.00	3
20,000	385.00	55.00	50.00	50.00	45.00	45.00	40.00	4
21,000	404.00	55.00	55.00	50.00	50.00	45.00	45.00	4
22,000	423.00	60.00	55.00	55.00	50.00	50.00	45.00	4
23.000	442.00	60.00	60.00	55.00	55.00	50.00	50.00	4
24,000	462.00	65.00	60.00	60.00	55.00	55.00	50.00	5
25,000	481.00	65.00	65.00	60.00	60.00	55.00	55.00	5
26,000	500.00	70.00	65.00	65.00	60.00	60.00	55.00	5
27.000	519.00	70.00	70.00	65.00	65.00	60.00	60.00	5
28,000	538.00	75.00	70.00	70.00	65.00	65.00	60.00	6
29,000	558.00	75.00	75.00	70.00	70.00	65.00	65.00	6
30,000	577.00	80.00	75.00	75.00	70.00	70.00	65.00	6

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

May 8, 2013

VIA FACISIMILE ONLY

Laura Nolda
Program Director
South Bay Mental Health Center, Inc.
237 Hamilton St., Suite 205
Hartford, CT 06106

RE: Certificate of Need Application; Docket Number: 12-31798-CON
South Bay Mental Health Center, Inc.
Establishment of an Outpatient Mental Health Clinic in Hartford
CON Application Deemed Complete

Dear Ms. Nolda:

This letter is to inform you that, pursuant to Section 19a-639a (d) of the Connecticut General Statutes, the Office of Health Care Access has deemed the above-referenced application complete as of May 6, 2013.

If you have any questions regarding this matter, please feel free to contact me at (860) 418-7001.

Sincerely,

Laurie K. Greci
Associate Research Analyst

****
*** TX REPORT ***
****

TRANSMISSION OK

TX/RX NO	3467
RECIPIENT ADDRESS	98609517729
DESTINATION ID	
ST. TIME	05/08 10:30
TIME USE	00'21
PAGES SENT	2
RESULT	OK

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

FAX SHEET

TO: Laura Volda

FAX: (860) 951-7729

AGENCY: South Body Mental Health Center

FROM: Laura K Gucci

DATE: 5/8/2013 **TIME:** 10:25 AM

NUMBER OF PAGES: 2
(including transmittal sheet

Comments: Re: CON Application # 12-31798-CON

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

May 22, 2013

VIA ELECTRONIC MAIL ONLY

Justinian Rweyemamu, MA, M.Div. MS-MFT
CT-Family Care Services, Inc.
16 Enfield Ave.
Enfield, CT 06082

RE: Certificate of Need Application; Docket Number: 12-31798-CON
CT-Family Care Services, Inc.
Establishment of a behavioral health treatment center in Manchester
CON Application Deemed Complete

Dear Mr. Rweyemamu:

This letter is to inform you that, pursuant to Section 19a-639a (d) of the Connecticut General Statutes, the Office of Health Care Access has deemed the above-referenced application complete as of May 17, 2013.

If you have any questions regarding this matter, please feel free to contact me at (860) 418-7001.

Sincerely,

Laurie K. Greci

Laurie K. Greci
Associate Research Analyst

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Jewel Mullen, M.D., M.P.H., M.P.A.
Commissioner

Dannel P. Malloy
Governor
Nancy Wyman
Lt. Governor

TO: Kevin Hansted, Hearing Officer

FROM: Jewel Mullen, M.D., M.P.H., M.P.A., Commissioner

DATE: May 22, 2013

RE: Certificate of Need; Docket Number: 12-31798-CON
South Bay Mental Health Center, Inc.
Establishment of an Outpatient Mental Health Clinic in Hartford

---

I hereby designate you to sit as a hearing officer in the above-captioned matter to rule on all motions and recommend findings of fact and conclusions of law upon completion of the hearing.

Connecticut Department of Public Health

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

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
Office of Health Care Access

May 24, 2013

Laura Nolda
Program Director
South Bay Mental Health Center, Inc.
237 Hamilton Street, Suite 205
Hartford, CT 06106

RE: Certificate of Need Application, Docket Number 12-31798-CON
South Bay Mental Health Center, Inc.
Establish and Operate an Outpatient Mental Health Center, Inc.

Dear Ms. Nolda,

With the receipt of the completed Certificate of Need ("CON") application information submitted by South Bay Mental Health Center, Inc. ("Applicant") on May 6, 2013, the Office of Health Care Access ("OHCA") has initiated its review of the CON application identified above.

Pursuant to General Statutes § 19a-639a (f), OHCA may hold a hearing with respect to any Certificate of Need application.

This hearing notice is being issued pursuant to General Statutes § 19a-639a (f)

Applicant:	South Bay Mental Health Center, Inc.
Docket Number:	12-31798-CON
Proposal:	Establish and Operate an Outpatient Mental Health Clinic, with no capital expenditure

Notice is hereby given of a public hearing to be held in this matter to commence on:

Date: June 13, 2013

Time: 10:00 a.m.

Place: Department of Public Health, Office of Health Care Access
410 Capitol Avenue, Third Floor Hearing Room
Hartford, CT 06134

The Applicant is designated as party in this proceeding. Enclosed for your information is a copy of each hearing notice for the public hearing that will be published in the *Hartford Courant* pursuant to General Statutes § 19a-639a (f).

Sincerely,

Kimberly R. Martone
Director of Operations

Enclosure

cc: Henry Salton, Esq., Office of the Attorney General
Marianne Horn, Department of Public Health
Kevin Hansted, Department of Public Health
Wendy Furniss, Department of Public Health
Marielle Daniels, Connecticut Hospital Association

KRM: LKG:lmg

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH
Office of Health Care Access

May 24, 2013 Requisition # 42139

Hartford Courant
285 Broad Street
Hartford, CT 06115

Gentlemen/Ladies:

Please make an insertion of the attached copy, in a single column space, set solid under legal notices, in the issue of your newspaper by no later than **Saturday, May 25, 2013.** Please provide the following **within 30 days** of publication:

- Proof of publication (copy of legal ad. acceptable) showing published date along with the invoice.

If there are any questions regarding this legal notice, please contact Kaila Riggott at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Director of Operations

Attachment

cc: Danielle Pare, DPH
Marielle Daniels, Connecticut Hospital Association

KRM:LKG:lmg

Hartford Courant **May 24, 2013**
Notice of Public Hearing, Docket Number 12-31798-CON

PLEASE INSERT THE FOLLOWING:

Office of Health Care Access Public Hearing

Statute Reference:	19a-638
Applicant:	South Bay Mental Health Center, Inc.
Town:	Hartford
Docket Number:	12-31798-CON
Proposal:	Establish and Operate an Outpatient Mental Health Clinic, with no capital expenditure
Date:	June 13, 2013
Time:	10:00 a.m.
Place:	Department of Public Health, Office of Health Care Access 410 Capitol Avenue, Third Floor Hearing Room Hartford, CT 06134

Any person who wishes to request status in the above listed public hearing may file a written petition no later than June 7, 2013 (5 calendar days before the date of the hearing) pursuant to the Regulations of Connecticut State Agencies §§ 19a-9-26 and 19a-9-27. If the request for status is granted, such person shall be designated as a Party, an Intervenor or an Informal Participant in the above proceeding. Please check OHCA's website at **www.ct.gov/ohca** for more information or call OHCA directly at (860) 418-7001. If you require aid or accommodation to participate fully and fairly in this hearing, please phone (860) 418-7001.

****
*** TX REPORT ***
****

TRANSMISSION OK

TX/RX NO	3500
RECIPIENT ADDRESS	98609517729
DESTINATION ID	
ST. TIME	05/24 11:22
TIME USE	00'38
PAGES SENT	5
RESULT	OK

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

FAX SHEET

TO: LAURA NOLDA

FAX: (860) 951-7729

AGENCY: SOUTH BAY MENTAL HEALTH CLINIC

FROM: LAURIE GRECI

DATE: 5/24/13 **TIME:** _____

NUMBER OF PAGES: _____
(including transmittal sheet

Comments: DN: 12-31798-CON Public Hearing Notice

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

Phone: (860) 418-7001 ***Fax: (860) 418-7053***

Greer, Leslie

From: ADS <ADS@graystoneadv.com>
Sent: Friday, May 24, 2013 10:41 AM
To: Greer, Leslie
Subject: Re: Hearing Notices 12-31798-CON & 13-31822-CON

Good day!

Thanks so much for your ad submission.
We will be in touch shortly and look forward to serving you.

If you have any questions or concerns, please don't hesitate to contact us at the number below.

We sincerely appreciate your business.

PLEASE NOTE: New Department of Labor guidelines allow web base advertising when hiring foreign nationals. To provide required documentation Graystone will retrieve & archive verification for the 1st and 30th days of posting for $115.00/web site. If required, notify Graystone when ad placement is approved.

Thank you,
Graystone Group Advertising

2710 North Avenue
Bridgeport, CT 06604
Phone: 800-544-0005
Fax: 203-549-0061

E-mail new ad requests to: ads@graystoneadv.com
http://www.graystoneadv.com/

From: <Greer>, Leslie <Leslie.Greer@ct.gov>
Date: Friday, May 24, 2013 10:15 AM
To: ads <ads@graystoneadv.com>
Subject: Hearing Notices 12-31798-CON & 13-31822-CON

Please run the attached public hearing notices in the Hartford Courant by May 25, 2013. For billing, refer to requisition 42319. . In addition, please submit to me a "proof of publication" when available.

Thank you,

Leslie M. Greer
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS#13HCA
Hartford, CT 06134
Phone: (860) 418-7013
Fax: (860) 418-7053
Website: www.ct.gov/ohca

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

May 30, 2013

Via Fax Only

Laura Nolda
Program Director
South Bay Mental Health Center, Inc.
237 Hamilton St., Suite 205
Hartford, CT 06106

RE: Certificate of Need Application; Docket Number: 12-31798-CON
South Bay Mental Health Center, Inc.
Establishment of an Outpatient Mental Health Clinic in Hartford
Request for Prefile Testimony and Issues

Dear Ms. Nolda:

The Office of Health Care Access ("OHCA") will hold a public hearing on the above docket number on June 13, 2013. The hearing is at 10:00 a.m. in the Department of Public Health's third floor hearing room, 410 Capitol Avenue, Hartford. Pursuant to the Regulations of Connecticut State Agencies § 19a-9-29 (e), any party or other participant is required to prefile in written form all substantive, technical, or expert testimony that it proposes to offer at the hearing. South Bay Mental Health Center, Inc. ("Applicant") must submit prefiled testimony to OHCA no later than 12:00 p.m. on June 7, 2013.

All persons providing prefiled testimony must be present at the public hearing to adopt their written testimony under oath and must be available for cross-examination for the entire duration of the hearing. If you are unable to meet the specified time for filing the prefiled testimony you must request a time extension in writing, detailing the reasons for not being able to meet the specified deadline.

Additionally, please find attached OHCA's Issues outlining the topics that will be discussed at the hearing.

Please contact Laurie Greci at (860) 418-7032, if you have any questions concerning this request.

Sincerely,

Kevin T. Hansted
Hearing Officer

Attachment

Issues

Certificate of Need Application, Docket Number: 12-31798-CON

South Bay Mental Health Center, Inc.
Establishment of an Outpatient Mental Health Clinic in Hartford

Applicant should prepare to argue and present supporting evidence on the following issues to support the proposal identified above:

1. Clear public need, including the specific need of patient populations to be served and service area demographics.

2. Need for the proposal based on incidence and/or prevalence in the service area.

3. How will South Bay Mental Health Center, Inc. support its proposed services should the government-provided funds not reach the anticipated level report in the application?

****
*** TX REPORT ***
****

TRANSMISSION OK

TX/RX NO	3504
RECIPIENT ADDRESS	98609517729
DESTINATION ID	
ST. TIME	05/30 15:03
TIME USE	00'30
PAGES SENT	3
RESULT	OK

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

FAX SHEET

TO: Laura Nolda

FAX: 860 951 7729

AGENCY: South Bay Mental Health Center, Inc.

FROM: Laura Greci

DATE: 5/30/2013 TIME: 2:55 pm

NUMBER OF PAGES: 3
(including transmittal sheet

Comments: Re: 13-31798-CON

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

SOUTH BAY
MENTAL HEALTH

237 Hamilton St.
Suite 205
Hartford, CT 06106
☎ 860-578-1300
🖷 860-951-7729
www.southbaymentalhealth.com

FAX

Date: 6/6/13

To: Kevin Hansted
Fax: 860-418-7053

From: Laura Nolda

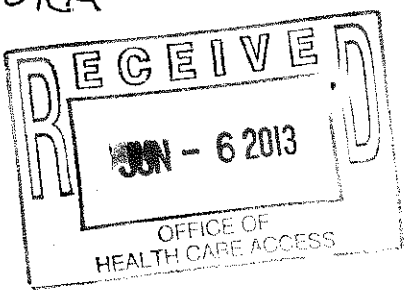
Number of Pages Including Cover Sheet: 15

☐Urgent ☒For Review ☐Please Comment ☐Please Reply ☐Please Recycle

Comments: Docket# 12-31798-CON
Final Statement and testimonies
for June 13th, 2013 Hearing.

Thank you,

Laura Nolda



SOUTH BAY
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Children's Day Services
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Early Childhood Services
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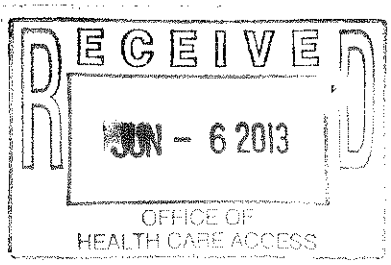
Fall River
Lowell
Worcester

June 5, 2013



Office of Health Care Access
410 Capitol Avenue
Hartford, CT 06134

RE: Certificate of need Application; Docket Number: 12-31798- CON
South Bay Mental Health Center, Inc.
Establishment of an Outpatient Mental Health Clinic in Hartford

To Whom It May Concern:

Enclosed you will find South Bay Mental Health's final statement as well as testimonies for the following individuals who will be present on June 13, 2013; Dr. Peter J. Scanlon, Jennifer Gearhart, Adam Schauer, Kim Arouca, and Laura Nolda.

Sincerely,

Laura Nolda

237 Hamilton Street
Suite 205
Hartford, CT 06106
P: 860-578-1300
southbaymentalhealth.com

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June 5, 2013

Office of Health Care Access
410 Capitol Avenue
Hartford, CT 06134

RE: Certificate of need Application; Docket Number:12-31798- CON
South Bay Mental Health Center, Inc.
Establishment of an Outpatient Mental Health Clinic in Hartford
Testimony for Trial

We appreciate the opportunity to be able to present South Bay Mental Health to you and speak to the need for additional behavioral healthcare services in the greater Hartford Area.

I am proud that we have become the leading community-based provider of outpatient mental health and substance abuse services in Massachusetts. We have long experience working with disadvantaged families, individuals with serious and persistent mental illness, behavioral disorders, substance abuse problems and those who have suffered trauma. As we have worked with developmentally delayed children and their families in the Hartford area we have come to appreciate the need for mental health services and feel confident that we can be of help.

South Bay has extensive experience working with multi-problem families and those who suffer from disabilities. We have worked to improve the quality of services offered to those who suffered trauma and the establishment of our Trauma Institute has allowed us to do training for professionals in the community, established prevention programs and raised awareness of the effects of trauma and the availability of effective treatment. We have enjoyed working with public schools to address behavioral disorders in the academic setting, prevent bullying, improve individual learning and create trauma sensitive schools. Our work in the correctional field has helped youthful offenders address underlying issues and move their lives in a positive direction and we have been able to help adult offenders reintegrate into the community. In our work with individuals with serious and persistent mental illnesses (SPMI) we have been able to promote the Recovery movement and help people to become more self-sufficient. Our use of peer specialists in our SPMI group treatment programs and resulted in South Bay being named Employer of the Year by NAMI. Our work in substance abuse recovery is based on Motivational Interviewing and has been found helpful in a variety of settings form public schools to correctional facilities, medical settings, homelessness programs and senior care programs.

South Bay has been fortunate to have established close working collaborations with other caregivers in the community, state agencies and managed care organizations. Through innovative pilot programs we have been able to reduce inpatient readmissions, increase time in

237 Hamilton Street
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P: 860-578-1300
southbaymentalhealth.com

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the community, reduce recidivism and improved compliance with treatment. In working with the Massachusetts DCF we were able to pilot a training program for kinship homes which reduced the length of foster care placements. We are currently working with primary care providers to integrate behavioral healthcare into physical medicine.

We are anxious to expand the services we currently provide in Hartford and feel confident that we can contribute to the services available. Our commitment to collaboration, innovation and the self sufficiency of disadvantaged individuals can make an impact on lives.

Dr. Scanlon founded South Bay Mental Health in 1986. He is a licensed psychologist trained in clinical psychology and family systems therapy and has specialized in working with disadvantages families for over 30 years. Dr. Scanlon was instrumental in the establishment of a community substance abuse treatment program in 1971, has served as staff psychologist in a state psychiatric hospital and is currently on staff at a local general hospital. He has as an active member of several State and community boards. Dr. Scanlon received the 2012 Friend and Leader award from the Massachusetts Association for Mental Health.

Sincerely,

Dr. Peter J. Scanlon

237 Hamilton Street
Suite 205
Hartford, CT 06106
P: 860-578-1300
southbaymentalhealth.com

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June 5, 2013

Office of Health Care Access
410 Capitol Avenue
Hartford, CT 06134

RE: Certificate of need Application; Docket Number: 12-31798- CON
South Bay Mental Health Center, Inc.
Establishment of an Outpatient Mental Health Clinic in Hartford
Testimony for Trial

To Whom It May Concern:

Mr. Schauer holds the position of Vice President Finance and Controller at South Bay where he currently oversees the finance, accounting and human resources. Mr. Schauer has over 17 years in finance and accounting at both public and private companies and started his career in public accounting at PricewaterhouseCoopers LLP. He received a Bachelor's degree in Sociology from the University of Vermont and an MBA and Master in Accounting from Northeastern University.

Sincerely,

Adam Schauer

237 Hamilton Street
Suite 205
Hartford, CT 06106
P: 860-578-1300
southbaymentalhealth.com

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Worcester

June 5, 2013

Office of Health Care Access
410 Capitol Avenue
Hartford, CT 06134

RE: Certificate of need Application; Docket Number: 12-31798- CON
South Bay Mental Health Center, Inc.
Establishment of an Outpatient Mental Health Clinic in Hartford
Testimony for Trial

To Whom it May Concern:

Thank you for providing the opportunity for South Bay Mental Health Center to speak with you on June 13, 2013.

I have been employed as the Director of Program Initiatives at South Bay Mental Health Center since March 2011. As my responsibilities include strategic planning and assisting in the development of new programming, I facilitated the collection and presentation of data in the response to the CON completeness letters dated November 16, 2012 and February 14, 2013.

I will be in attendance at the hearing and will to the best of my ability offer any additional information you may require.

Thank you again for this opportunity. I look forward to meeting you.

Sincerely,

Kim Arouca

237 Hamilton Street
Suite 205
Hartford, CT 06106
P: 860-578-1300
southbaymentalhealth.com

SOUTH BAY
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Worcester

June 5, 2013

Office of Health Care Access
410 Capitol Avenue
Hartford, CT 06134

RE: Certificate of need Application; Docket Number:12-31798- CON
South Bay Mental Health Center, Inc.
Establishment of an Outpatient Mental Health Clinic in Hartford
Testimony for Trial

To Whom It May Concern,

My name is Jennifer Gearhart, LICSW, and I am the director of the Division of Outpatient/Mental Health and Substance Abuse for South Bay Mental Health Center. I have been with South Bay since its inception 26 years ago. My role is to supervise all clinic directors at South Bay and to run all the operations of the outpatient division. I also oversee all the services under the Children's Behavior Health Initiative (CBHI). In my role, I work with all stakeholders including collaterals and state agencies (e.g., DCF, DMH, DYS, DDS), and all of our payers such as MBHP and Beacon Health Strategies. Important to my role is my presence on multiple stakeholders committees and councils, and to oversee the pilot projects South Bay gets selected to run due to our outstanding performance on performance standards set by the insurance companies. We are considered a Best Practice agency across the state of Massachusetts. Best practices include programs such as our bridge programs with hospitals and detox facilities, our community tenure program where we have shown that we can increase the community tenure of consumers coming out of high-level of care. We have also worked closely with MBHP and Beacon to decrease emergency department utilization.

Lastly, South Bay has been recognized by state agencies and our payers to have quick access to care, and positive treatment outcomes through outcome tool measurement.

Sincerely,

Jennifer Gearhart

237 Hamilton Street
Suite 205
Hartford, CT 06106
P: 860-578-1300
southbaymentalhealth.com

SOUTH BAY
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Worcester

June 5, 2013

Office of Health Care Access
410 Capitol Avenue
Hartford, CT 06134

RE: Certificate of need Application; Docket Number:12-31798- CON
South Bay Mental Health Center, Inc.
Establishment of an Outpatient Mental Health Clinic in Hartford
Testimony for Trial

To Whom it May Concern,

My name is Laura Nolda and I am a Licensed Clinical Social Worker in the State of Connecticut. I have been with South Bay Mental Health Center, Inc. since 2009 and since my employment have had several roles within the agency. I had the opportunity to work in our Day Service Department where I was able develop and implement curriculum for adults with Serious and Persistent Illness and/or Substance Abuse in our Partial Hospital Program in Plymouth, MA. As a director, I was able to build our Cape Cod Partial Hospital Program and Day Services to become a successful resource for the Cape Cod community. In 2012 I worked with our Early Intervention Team to launch our Connecticut Birth to Three Autism Specific Program where I am currently the acting director as well as clinician. In my current role I maintain a working relationship with other collaterals in the Hartford community while supervising an eclectic group of staff and provide diagnostic services to the Hartford region.

I look forward to the opportunity to grow in the State of Connecticut and to begin working with consumers outside the Birth to Three Program as well as develop new working relationships with collaterals in the Hartford community.

Sincerely,

Laura Nolda

237 Hamilton Street
Suite 205
Hartford, CT 06106
P: 860-578-1300
southbaymentalhealth.com

South Bay Mental Health, Inc. Docket # 12-31788-CON

South Bay Mental Health

South Bay Mental Health is pleased to have this opportunity to attend this hearing sponsored by the Office of Healthcare Access in response to our proposal to provide mental health services to the residents of the Hartford area. We are extremely excited by the prospect of being able to serve the residents of the Hartford area and team with the wonderful providers currently serving the area. Our experience providing early intervention services to the children and families of Hartford has convinced us that we can work effectively in this community. Our view of the future demand for behavioral healthcare services has convinced us that our services are needed and can be a crucial addition to the array of services currently available.

We believe that there will be an increased demand for behavioral healthcare services over the next decade and that this demand will arise for various initiatives and emerging trends in health care and social services. Below, please find an outline of what I believe to be some of these trends.

Federal Initiatives Will Increase Access to Behavioral Health Care

Still too many Americans with behavioral health problems have been uninsured and underinsured. Beginning in 2014, the Affordable Care Act will provide access to quality health care that includes coverage for mental health and substance use disorder services. All new small group and individual private market plans will be required to cover mental health and substance use disorder services as part of the health care law. Additionally, the Mental Health Parity and Addiction Equity Act was passed into law in 2008 and promised fairer treatment of mental health and substance use disorders by requiring group insurance plans that offered such treatments to be no more restrictive than treatments offered for other medical or surgical procedures. Both these pieces of legislation mandate parity for behavioral healthcare.

The Affordable Care Act will provide insurance for more people and will guarantee the access to behavioral healthcare through the recognition that mental health issues are on parity with other medical disorders. In an article published April 10, 2013, Secretary of Health and Human Services Kathleen Sebelius stated that, "60 percent of people with mental health conditions and nearly 90 percent of people with substance use disorders don't receive the care they need". The Affordable Care Act and the Mental Health Parity and Addiction Equity Act will expand benefits and parity protections for 62 million Americans. The federal budget provides a number of important initiatives and funding sources toward this end. The federal budget reflects the following initiatives:

- President's Fiscal Year 2014 Budget includes a critical $205 million investment in programs to help identify mental health concerns early, improve access to mental health services and support safer school environments.
- The budget supports initiatives to help teachers and other adults identify early signs of mental health problems and refer young people to services they may need, and to advance new state-based strategies to prevent young people ages 16 to 25 with mental health or substance abuse problems from falling through the cracks when they leave home.
- The budget will help 8,000 schools implement evidence-based behavioral practices to improve

school climate and behavioral outcomes for all students.

- The budget provides for the training more than 5,000 mental health professionals such as master's level social workers and psychologists. Together with doctorate-level psychiatrists, family practitioners, and other health care providers, these providers play a critically important role in serving our youth with mental health problems.

- The budget also invests in public health research on gun violence prevention and an expansion of our public health data on homicides and suicides to help inform prevention strategies.

An essential feature of the Affordable Care Act is that behavioral health services will be covered at parity with medical and surgical benefits. Insurers will no longer be able to deny anyone coverage because of a pre-existing behavioral health condition. The Affordable Care Act also ensures that new health plans cover recommended preventive benefits without cost sharing, including depression screening for adults and adolescents and behavioral assessments for children. As screening becomes more universal more consumers, especially children and young adults, will be referred for services.

Victoria Veltri, general counsel for Connecticut's Office of the Healthcare Advocate, described this as "probably the most consumer-oriented regulations I've ever seen." At its core, the law prohibits insurance plans from placing limits or costs on mental health and substance abuse services that are more restrictive than those imposed on medical and surgical services. That means an end to a common restriction, limits on the number of outpatient therapy sessions a patient can receive. Under the law, a health plan can only impose those limits if it puts the same restrictions on "substantially all" outpatient medical and surgical benefits. Similarly, limits on the number of days a person can receive inpatient behavioral health treatment are likely to be eliminated since most plans do not impose such strict limits on most inpatient medical and surgical care.

Dr. Mark Friedlander, a psychiatrist and the Chief Medical Officer for Aetna Behavioral Health, predicted that, in the long run, the mental health parity portion of the ACA would change the behavior of providers. "Many providers are just not used to operating in an environment where there are no limits on behavioral health, particularly outpatient sessions," he said. "I think many of them have kind of been more sparing than they needed to have been. I think that that mindset will disappear."

People will only benefit from the programs that are available if those who need help aren't afraid to seek it. Secretary Sebelius and Arne Duncan, Secretary of Education, have started a national dialogue to increase awareness about mental health and reduce the fear, shame, and misperceptions that too often prevent people from getting the help they need.

All of us – community leaders, advocates, teachers, faith leaders, health providers, parents, neighbors, and friends – have a role to play in spreading the message that it's okay to talk about mental health. We can encourage people to seek help if they are struggling, and we can reach out and assist a struggling friend or loved one in finding help when needed. We can let them know that prevention works, treatment is effective, and people do recover.

In general, Connecticut has done well in providing health care for its citizens but mental health parity has been a slower process. The Connecticut Health Foundation (CT Health) has been monitoring recent state developments intended to increase mental health parity (MHP). On May 29, 2013 the Connecticut Health Foundation made a statement summarizing Connecticut's progress toward mental health parity.

"To date, it's the privately insured who have faced multiple barriers to mental health care, making it something of a health equity anomaly. As the nation fully implements health reform, populations of color will gain access to public and private mental health and substance use coverage in large numbers. Supporting diverse, newly insured consumers in accessing and navigating culturally and linguistically effective mental health and substance use treatment systems that deliver on the promise (and law) of MHP must be part of the health reform equity agenda."

The failure of some insurance plans to fully implement the provisions of mental health parity has become a heated issue. On April 10, 2013, the law firm of Murtha Cullina LLP filed suit in the U.S. District Court in Connecticut against Anthem Health Plans, Inc. d/b/a Anthem Blue Cross and Blue Shield of Connecticut and its parent company, Wellpoint, Inc. The suit, filed on behalf of the American Psychiatric Association (APA), the Connecticut Psychiatric Society, the Connecticut Council on Child and Adolescent Psychiatry, a physician and a patient, was brought against the companies for violation of the Mental Health Parity and Addiction Equity Act (MHPAEA), Connecticut parity law and provider agreements Anthem holds with physicians. The Complaint also alleges violations of the Connecticut Unfair Insurance and Trade Practices Acts.

The formal Complaint of the suit asserts as follows: "In their lifetime, one in five Americans will suffer a mental illness and five percent of Americans will suffer a severe mental illness. But, less than one third of those who need treatment will have access to the treatment they need to live normal and productive lives. Some will not seek treatment because of the stigma associated with mental illness. Others, who are courageous enough to seek treatment despite unfair stigma, are denied the medically necessary treatment (including psychotherapy services) they seek or are discouraged from obtaining such medically necessary treatment from appropriately trained mental health and substance abuse providers by health insurance companies.... For those fortunate enough to receive adequate treatment, 70 to 90 percent will find relief and a reduction in symptoms, allowing them to be productive members of society."

Connecticut already has a mental health parity law, which prohibits insurance plans from placing a "greater financial burden" on people accessing service for mental health than for medical, surgical or other physical health conditions. But when the federal law comes into effect these provisions will be strengthened. Domenique Thornton, general counsel for the Mental Health Association of Connecticut states, "People may not have been aware of [the changes] and so they may have been reluctant to avail themselves of the benefits they now have." The federal law goes further, requiring that consumers of behavioral health services are treated the same as those accessing medical/surgical services in such areas as coverage of out-of-network services and copayment costs. The federal law will also apply to more types on insurance. Connecticut law covers only about half of insured Connecticut residents because plans that are self-insured, which is common among large companies, are not subject to state regulation.

As recently as April 4, 2013 Governor Malloy signed into law Public Act 13-3 which advanced mental health parity and required that decisions about behavioral health care be made by mental health professionals.

There has been surprisingly little concern regarding the possible increased cost that these provisions may imply for the cost of insurance. Andrea Stillman, who represents Connecticut's 20TH Senatorial District, stated: "For those who suggest this additional coverage would adversely impact insurance providers and premiums, advocates offered a reminder that without parity, health care costs will only

continue to climb. No untreated illness becomes less expensive or easier to treat over time." 11/29/2012 the Connecticut Day.com. Advocates for mental health parity have also pointed out that the federal government, through Medicare and Medicaid already bears the greatest financial burden for these untreated patients without any other coverage.

Increased Awareness of the Mental Health Needs of Children, Adolescents and Young Adults

In addition to increases in the demand for behavioral health services due to the increased number of insured lives and the expansion of mental health parity, we believe that there will be an increase in demand as people become more aware of the availability and efficacy of these services. This is especially true with respect to increased awareness of mental health issues in children and young adults. Just weeks ago the House unanimously passed a proposal aimed at better coordinating mental health services for young people, a measure described as a response to the massacre at Newtown's Sandy Hook Elementary School. This proposal has already been approved by the State Senate and is now headed for the Governor's desk. Gov. Malloy stated that it complements the legislation passed earlier this year in response to the Newtown shootings. That proposal contained several mental health measures, but they focused primarily on adults and young people aged 16 and up.

Rep. Diana Urban, (North Stonington), who co-chairs the Children's Committee, said the proposal puts a "laser-like focus on prevention," and seeks to break down barriers that keep various parts of the service system from working together. Urban cited three statistics: About two-thirds of youths in the juvenile justice system have a diagnosable mental health disorder. About 1 in 10 young people have mental disorders so severe it impairs their functioning. And 44 percent of youths in high school with mental health problems drop out. Sen. Dante Bartolomeo called the bill a first step, in a framework for the mental health system and we can expect more progress.

A commission recently appointed by Gov. Malloy is expected to make recommendations on mental health policy changes, especially focusing on the issues facing young people. The task force on adolescent and young adult mental health would be charged with examining insurance changes, as well as the shortage of psychiatric professionals, improving early intervention and treatment, and alternate service delivery and payment models.

Reduce use of Residential Treatment

It is our observation that the State has made great progress in providing for people with mental health needs while they continue to live in their homes. It has long been found that treating people in their community is both more effective and more affordable (What are the arguments for community based mental health care? World Health Organization, 2003)

Following the lead of DMH and DSS, DCF has worked to reduce the number of children who reside in congregate care and foster homes. As more people are served in community setting, there will inevitably be an increased need for community based mental health care.

DCF has been working to reduce the use of congregate care and foster care. In a 2011 report from the Department of Children and Families Commissioner Justice Joette Katz proposed a new direction for the Department that included reducing the reliance on congregate care. Commissioner Katz stated, "While

progress has been made under the current administration – notably the share of children receiving treatment in congregate settings has declined 26 percent and the number of children sent out of state to receive treatment has declined 77 percent – much improvement remains necessary. Despite the notable progress made by DCF, Connecticut Voices for Children commented that the Department was ..."not sufficiently focused on strengthening families and averting out-of-home placement." In Massachusetts, South Bay developed a pilot project with the Massachusetts DCF to develop and train Kinship Homes. This allowed children to live with relatives and served to make reentry to their homes easier, reduced the length of stay in foster care, and established opportunities for informal respite care as the family left protective services.

We also believe that the juvenile justice system will rely more on community-based interventions and reduce the use of restrictive settings. In Connecticut, Juvenile Services shares the responsibility for serving children in the juvenile justice system with the Judicial Branch, Court Support Services Division and the Strategic Plan for working with these youth.

These services include:

- Strengthening families
- Providing community-based services
- Reintegration efforts from the moment a child enters a residential facility
- Improved system of care using a wraparound approach
- More services closer to home

As more youths receive services in community settings there will need to be an increase of services available in these communities. South Bay has a long history of working with youthful offenders as well as experience working with adult offenders and the Federal Probation Office. We recently developed a program in conjunction with the Massachusetts Department of Corrections to assist incarcerated women as they reintegrate to the community.

Integration of Behavioral Health and Medical/Surgical Care

The integration of behavioral healthcare and physical medicine is a national movement (SAMSA Center for Integrated Health Solutions, 2011). There are specific provisions in the Accountable Care Act which encourage this and we expect the State to choose the Health Home option offered by Medicaid if for no other reason than to take advantage of the time limited 90% federal funding match. There are two major reasons for the importance of this (1) the value of behavioral health in treating illnesses traditionally thought to be of physical medicine and (2) the co-occurrence of certain physical disorders found in individuals suffering from some mental illnesses.

Many people suffering from physical illnesses need to make changes in their life style, such as controlling unhealthy habits, accepting an illness or maintaining treatment compliance. Aetna (2013) has stated that a ... "majority of patients treated in a primary care setting have a physical ailment that is affected by stress, difficulty maintaining a healthy lifestyle or a psychological disorder. Behavioral health disorders are also often under-diagnosed and need the support of a behavioral health clinician to achieve optimum treatment outcomes. Because of this, it can be both clinically and cost-effective, to integrate behavioral health clinicians into primary medical care." Dr. Mark Friedlander, a psychiatrist

and the chief medical officer for Aetna Behavioral Health said, "There is substantial scientific literature showing that if you treat both, the overall total costs are lower than if you treat one but not the other." South Bay has worked with health centers, primary care providers, health insurance companies, managed care organizations and with the Massachusetts Department of Public Health to develop treatment for such disorders as asthma, diabetes, postpartum depression, high blood pressure, weight control and cardio-pulmonary issues. Operating from a Motivational Enhancement model, we have been able to assist individuals in accepting their illness, actively cooperating in treatment and maintaining a healthy life style.

An additional issue is the prevalence of certain physical illnesses found among individuals suffering from certain serious mental illnesses. Rebecca B. Chickey, MPH, Director of the American Hospital Association's Section for Psychiatric and Substance Abuse Services, indicated the following statistics underscore the need for integrating behavioral and physical health care:

- 57% of U.S. adults will meet the criteria for a behavioral health condition at some point.
- 68% of adults with mental health conditions also have medical conditions where people with severe and persistent mental illness die 8 to 25 years earlier than adults without mental illness.
- 29% of adults with medical conditions also have co-occurring behavioral health conditions.

South Bay has worked with the New England regional office of the Substance Abuse and Mental Health Services Administration in their 10 By 10 Campaign: A National Wellness Action Plan to Improve life expectancy by 10 Years in 10 Years for people with mental illness.

Specific Populations and Disorders Need to Be Addressed

There are a number of special populations that have been underserved or for whom new treatment protocols are available and we believe that this will increase the demand for services in the area. Of particular interest to South Bay are services to individuals on the autism spectrum. South Bay has a program serving Hartford and surrounding towns funded through the Connecticut's Birth to Three System. This program is funded through Early Intervention (EI) and only covers children up to their third birthday. We have experienced a dearth of community behavioral health services for these children and their families as they age out of our EI system. The Autism Society estimates that the number of children diagnosed on the autism spectrum is growing by up to 17% a year while other sources, such as the Autism and Developmental Disabilities Network (2012), report prevalence rates growing as high as 23% a year.

In the March 20, 2013 National Health Statistics Report an article was presented by the Centers for Disease Control and Prevention comparing the prevalence rate of autism spectrum disorders over time. This study confirmed the marked growth of the diagnosis siting data from 2007 indicating a prevalence rate of 1.16% and data from 2011-2012 showing a rate of 2.00%, indicating a 72% increase.

Dr. Ann Milanese, a developmental pediatrician who serves as division chief for developmental

pediatrics at Connecticut Children's Medical Center in Hartford, reported that Connecticut offers excellent hospital-based services to children on the autism spectrum but that there are needs at the community based level. "For many parents, there's quite a waiting list for the few people who are available and who are any good at it," said Sara Reed, Executive Director of ASCONN, a parent advocacy group in Gilford, CT devoted to autism. DDS spokeswoman Joan Barnish said the agency frequently fields calls from families interested in afterschool supports, behavioral intervention, in-home services, socialization activities and alternate living arrangements.

In response to this increased need, Commissioner Justice Joette Katz stated, "Notably, the Department also is making strides in expanding the array of in-state resources for youth on the autistic spectrum. The services will include evidence-informed, community based programming as well as closely linked residential services and family supports (Dec 25, 2012).

Conclusion

In conclusion, the evidence is clear that there is a need for expanded behavioral healthcare services in the area.

- More people will have insurance and the insurance will cover behavioral healthcare without restrictions. More people will seek behavioral healthcare, and there will be no limits to sessions as long as medical necessity is justified.
- There is an increased awareness of the mental health needs of children, adolescents and young adults and an identified need to intervene sooner and provide preventive services.
- As the State works to keep people with mental health needs and children under protective services in the community, rather than in residential care, it is clear that these community services need to expand.
- The movement to integrate behavioral healthcare into the treatment of medical/surgical care will place a demand on community mental health centers to expand their services.
- There is a growing need for services for children with specific disabilities, such as autism, as this population grows.

Although South Bay has only been providing services in Connecticut for a year, we have a 27-year history of innovation; commitment and collaboration in providing community based behavioral health care. We have experience in some of the state's most pressing needs such as the treatment of people on the autism spectrum, assisting consumers to remain in the community and the integration of behavioral medicine with primary care. It is our hope that we can continue to grow our services in Connecticut and continue to serve our consumers and their families.

South Bay Mental Health, Inc. Docket # 12-31788-CON

Commitment to our Consumers

South Bay has been opening new programs for 27 years and we have never closed a program. We have a substantial budget and are capable of sustaining operating losses for as long as it takes for new programs to find their footing. With revenues in excess of fifty million dollars we can tolerate operating losses in programs that provide good service.

In July 2012 we were awarded a contract through Connecticut's Birth to Three System to provide services for children who were diagnosed on the autism spectrum. After one month of operation we had two children. However, we felt great confidence in our staff and the quality of services they were providing and were convinced that there was a need for these services. A year later we have 21 families involved in these services. We have lost money every month for the past year but never considered that it was not going to be a valuable and viable program. We hope someday to break even with this program but we have made a commitment to the community and to the families we serve and have every intention of honoring that commitment. South Bay has never failed to satisfy its commitments.

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

TENTATIVE AGENDA

HEARING

Docket Number: 12-31798-CON

South Bay Mental Health Center, Inc.

Establishment of an Outpatient Mental Health Clinic in Hartford

June 13, 2013, 10:00 a.m.

I. **Convening of the Hearing**

II. **Applicant's Direct Testimony (10 minutes)**

III. **OHCA's Questions**

IV. **Closing Remarks**

V. **Hearing Adjourned**

An Equal Opportunity Provider
(If you require aid/accommodation to participate fully and fairly, contact us either by phone, fax or email)
410 Capitol Ave., MS#13HCA, P.O.Box 340308, Hartford, CT 06134-0308
Telephone: (860) 418-7001 Fax: (860) 418-7053 Email: OHCA@ct.gov

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

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TABLE OF THE RECORD

APPLICANT: **South Bay Mental Health Center, Inc.**

DOCKET NUMBER: **12-31798-CON**

PUBLIC HEARING: **June 13, 2013 at 10:00 a.m.**

PLACE: **410 Capitol Avenue, Third Floor Hearing Room**
Hartford, Connecticut

EXHIBIT	DESCRIPTION
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In Hartford take I-84 westbound. Exit at Asylum Street, exit 48.

At the signal at the bottom of the ramp, make a gradual right, staying to the left of the fork in the road.

At the first light, take an immediate left onto Broad Street.

Travel on Broad Street to the light at the first four-way intersection; take a right onto Capitol Avenue. OHCA (tan brick building at 410 Capitol Avenue) is two blocks down on the right.

* Pass 410 and enter in the driveway between 410 and 450 Capitol Avenue. Turn right into the parking lot behind the building and proceed to the Security building in the lot. You will be directed to available parking.

From the West:

Take I-84 East to Capitol Avenue, Exit 48B. Bear right on the exit ramp. At the end of the ramp, turn right onto Capitol Avenue. OHCA is 3 blocks down on the right (tan brick building at 410 Capitol Avenue).

Proceed from * above

Directions to Forest and Sisson (Lot C) for visitor shuttle service:

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

FAX SHEET

TO: Laura Nolta

FAX: 860 951 7729

AGENCY: Silver Hill Mental Health Center

FROM: Laurie Ward

DATE: 6/12/2013 TIME: 12.45 pm

NUMBER OF PAGES: 5
(including transmittal sheet

Please call if you have questions. Laurie

Comments: Documents for tomorrow's hearing
& directions for parking

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

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V. **Hearing Adjourned**

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410 Capitol Ave., MS#13HCA, P.O.Box 340308, Hartford, CT 06134-0308
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STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

TABLE OF THE RECORD

APPLICANT: **South Bay Mental Health Center, Inc.**

DOCKET NUMBER: **12-31798-CON**

PUBLIC HEARING: **June 13, 2013 at 10:00 a.m.**

PLACE: **410 Capitol Avenue, Third Floor Hearing Room**
Hartford, Connecticut

EXHIBIT	DESCRIPTION
A	Letter from the Applicant dated October 25, 2012 enclosing the CON application under Docket Number 12-31798, received by OHCA on October 26, 2012. (315 pages)
B	OHCA's letter to the Applicant dated November 16, 2012 requesting additional information and/or clarification in the matter of the CON application under Docket Number 12-31798. (4 pages)
C	Applicant's responses to OHCA's letter of November 16, 2012, dated January 14, 2013, in the matter of the CON application under Docket Number 12-31798, received by OHCA on January 15, 2013. (23 pages)
D	OHCA's letter to the Applicant dated February 14, 2013 requesting additional information and/or clarification in the matter of the CON application under Docket Number 12-31798. (3 pages)
E	Applicant's responses to OHCA's letter of February 14, 2013, dated April 8, 2013, in the matter of the CON application under Docket Number 12-31798, received by OHCA on April 8, 2013. (62 pages)
F	Designation letter dated May 22, 2013 for Hearing Officer in the matter of the CON application under Docket Number 12-31798. (1 page)
G	OHCA's letter to the Applicant dated May 8, 2013 deeming the application complete as of May 6, 2013 in the matter of the CON application under Docket Number 12-31798. (1 page)

H	OHCA's request for legal notification in the Hartford Courant and OHCA's Notice to the Applicant of the public hearing scheduled for June 13, 2013 in the matter of the CON application under Docket Number 12-31798, dated May 24, 2013. (4 pages)
I	OHCA's letter to the Applicant dated May 30, 2013 requesting prefile testimony along with issues to be discussed at the hearing in the matter of the CON application under Docket Number 12-31798. (2 pages)
J	Letter from the Applicant enclosing prefile testimony dated June 6, 2013 in the matter of the CON application under Docket Number 12-31798, received by OHCA on June 6, 2013. (26 pages)

OHCA HEARINGS - EXHIBIT AND LATE FILE FORM

Applicant: South Bay Mental Health Center, Inc

DN: 12-31798-CON

Hearing Date: June 13, 2013

Time: 10:00 a.m.

Purpose: Establishment of an Outpatient Mental Health Clinic in Hartford

OHCA Exhibit #	Description
1	
2	
3	
4	
5	

Applicant Late File #	Description	Due Date	Rec'd
1	Referral Letters	June 13 +30 days.	
2			
3			
4			
5			
6			

PUBLIC HEARING
APPLICANT
SIGN UP SHEET

June 13, 2013
10:00 a.m.

Applicant: Docket Number: 12-31798-CON
South Bay Mental Health Center, Inc.
Establishment of an Outpatient Mental Health Clinic in Hartford

Name	Phone	Fax	Representing Organization/Self
Peter Scanlon	508-5804691	508 584-2227	South Bay Mental Health
Jennifer Gearhart	508-559-0473	508-584-2227	South Bay Mental Health
Laura Noida	860-578-1300	860 951-7729	South Bay Mental Health
Kim Arouca	7816355647	5085842227	" " "
Adam Schaver	508-521-2296	508-584-2227	South Bay Mental Health

PUBLIC HEARING
INFORMAL PARTICIPANT
SIGN UP SHEET

June 13, 2013
10:00 a.m.

Applicant: Docket Number: 12-31798-CON
South Bay Mental Health Center, Inc.
Establishment of an Outpatient Mental Health Clinic in Hartford

Name	Phone	Fax	Representing Organization/Self
Laura Nolda	860-578-1300	860-951-7729	South Bay
Jennifer Gearhart	508-559-0473	508-584-2727	South Bay

Greer, Leslie

From: Greci, Laurie
Sent: Friday, June 14, 2013 11:58 AM
To: lnolda@southbaymentalhealth.com
Cc: Hansted, Kevin; Riggott, Kaila; Greer, Leslie
Subject: Late File for 12-31798-CON

Dear Ms. Nolda,

At the hearing for 12-31798-CON (South Bay Mental Health Center, LLC's proposal to establish a behavioral health clinic in Hartford), the Office of Health Care Access requested that you provide the following late file within 30 days:

> Referral letters or similar documents that provide evidence of clear public need for the services to be provided in Hartford.

The 30th day is July 13, 2013. As the office is not open on the weekends, please submit your late file by 4:30 p.m. on Monday, July 15, 2013.

If you have any questions, please do not hesitate to contact me.

Regards,

Laurie K. Greci

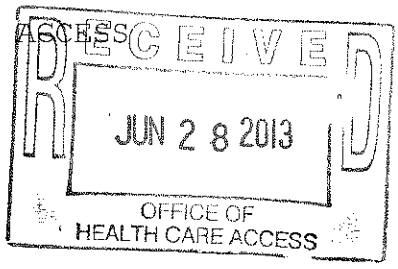
Associate Research Analyst
Department of Public Health
Health Care Access
laurie.greci@ct.gov
860 418-7032
860 418-7053

ORIGINAL

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

OFFICE OF HEALTH CARE ACCESS



SOUTH BAY MENTAL HEALTH CENTER, INC.

ESTABLISHMENT OF AN OUTPATIENT MENTAL HEALTH CLINIC IN HARTFORD

DOCKET NO. 12-31798-CON

JUNE 13, 2013

10:00 A.M.

410 CAPITOL AVENUE
HARTFORD, CONNECTICUT

POST REPORTING SERVICE
HAMDEN, CT (800) 262-4102

. . .Verbatim proceedings of a hearing before the State of Connecticut, Department of Public Health, Office of Health Care Access, in the matter of South Bay Mental Health Center, Inc., Establishment of an Outpatient Mental Health Clinic in Hartford, held at 410 Capitol Avenue, Hartford, Connecticut, on June 13, 2013 at 10:00 a.m. . . .

HEARING OFFICER KEVIN HANSTED: Good morning, everyone.

ALL: Good morning.

HEARING OFFICER HANSTED: Today's public hearing before the Office of Health Care Access, identified by Docket No. 12-31798-CON, is being held on June 13, 2013 to consider South Bay Mental Health Center, Inc.'s application for the establishment of an outpatient mental health clinic in Hartford, Connecticut.

This public hearing is being held pursuant to Connecticut General Statutes, Section 19a-639a, and will be conducted as a contested case, in accordance with the provisions of Chapter 54 of the Connecticut General Statutes.

My name is Kevin Hansted, and I've been designated by Commissioner Jewel Mullen of the Department of Public Health to serve as the Hearing Officer for this matter.

The staff members assigned to assist me in this case today are Kaila Riggott and Laura Greci. Laurie Greci. Sorry. The hearing is being recorded by Post Reporting Services.

Following the hearing, a decision will be issued, in accordance with Connecticut General Statutes, Section 4-179.

In making its decision, OHCA will consider and make written findings concerning the principles and guidelines set forth in Section 19a-639 of the Connecticut General Statutes.

The Applicant, South Bay Mental Health Center, Inc., has been designated as a party in this proceeding.

At this time, I will ask staff to read into the record those documents already appearing in OHCA's Table of the Record in the case.

MS. LAURIE GRECI: Thank you. Laurie Greci, OHCA staff. I'd like to read in the Table of the Record the exhibits listed as A through J on the Table of

the Record sheet made available to us.

HEARING OFFICER HANSTED: And are there any additional exhibits?

MS. GRECI: No, there is not.

HEARING OFFICER HANSTED: Okay. Does the Applicant have any objection to the exhibits?

DR. PETER SCANLON: No, sir.

HEARING OFFICER HANSTED: Thank you. At this time, I would ask all the individuals, who are going to testifying on behalf of the Applicant, to stand, raise your right hand, and be sworn in.

(Whereupon, the parties were sworn.)

HEARING OFFICER HANSTED: Thank you. And I would ask each of you, when you first speak today, please state your full name and adopt any written testimony you have supplied this office. At this time, South Bay, you may proceed.

DR. SCANLON: Thank you, sir.

HEARING OFFICER HANSTED: You're welcome.

DR. SCANLON: My name is Peter Scanlon, and I'm the Executive Director and founder of South Bay Mental Health Center, and we are very pleased to have this opportunity to attend this hearing sponsored by the Office of Health Care Access and respond to our proposal

to provide services in the Hartford area.

We're extremely excited about this. We have been providing services for the past year for children, birth to three, who suffer from autism services, and we're just very excited to be able to expand these services in the Hartford area to serve older children and adults in an outpatient mental health capacity.

Our experience providing early intervention services to children and families in Hartford has convinced us that we can work effectively in this community.

Our view of the future demands for behavioral health care services has convinced us that services are needed and can be a crucial addition to the array of services currently available.

We believe that there is an increased demand for behavioral health care services over the next decade, and that this demand will arise from various initiatives and emerging trends, both from behavioral health care, from social services, and from the public stewardship for the citizens of the state.

I'd like to outline some of what I believe these trends to be. The first trend is the federal

initiative to increase access to behavioral health care.

The Affordable Care Act will provide increased access to services for coverage and will guarantee those services will include outpatient mental health and substance abuse services. All small group insurance plans will now be required to provide services in behavioral health care and substance abuse disorders.

Additionally, the Federal Mental Health Parity and Addictions Equity Act of 2008 is going to require group insurance plans to offer behavioral health treatments and going to prevent them from restricting the treatments, or requiring coinsurances, or additional payments beyond what would be provided for medical or surgical procedures.

The Accountable Care Act will cover more people, and both of these two pieces of legislature, the Parity Act and the Accountable Care Act, will mandate behavioral health care.

The Affordable Care Act will provide insurance for more people and will guarantee access to behavioral health care. There will be a recognition of either necessity of behavioral health care and parity of medical services with behavioral health care.

U.S. Secretary of Health and Human

Services, Kathleen Sebelius, recently stated that 60 percent of people with mental health conditions and nearly 90 percent of people with substance abuse conditions don't receive the services that they need.

The Affordable Care Act and the Mental Health Parity Law will require that those services are provided and will expand those services to 62 million Americans.

The federal budget is going to provide some supports for that. In the 2014 budget, there will be help in identifying mental health concerns early, improved access to mental health services, support for safer schools, certainly something that's close to our heart after the recent tragedy in Newtown.

The budget will also support initiatives to help teachers, who identify early signs for mental health problems, and to offer services to young people.

The budget will also help to develop preventative services for young adults, ages 16 to 25, who have both mental health or substance abuse problems, keep them from falling through the cracks.

The budget will help 8,000 schools implement evidence-based behavioral practices to improve school climate and to improve behavioral outcomes for all

students.

The budget includes funding for (coughing) 5,000 additional mental health professionals, Master's level, and psychologists.

An additional feature of the Accountable Care -- Affordable Care Act is the behavioral health services are covered at parity, with medical and health surgical benefits.

Insurers can no longer be able to deny coverage to people, because of preexisting behavioral health conditions, and the Affordable Care Act will also insure that plans cover recommended preventative benefits, things, such as depression screening for adults and adolescents, behavioral assessment for children.

Screening will become more universal for all consumers, especially for young children and young adults, and then referral for services.

Victoria Valente, who is the general counselor for the Connecticut Office of Health Advocate, has described this as, quote, "probably the most consumer-oriented regulations that I've seen," end quote.

At its core, the law prohibits health insurers from placing limits on the cost of mental health services, or substance abuse services, or from otherwise

restricting people's access to those services any more than they would to medical or surgical procedures.

This means that there will be an end to the common restriction, the limits on the number of outpatient therapy sessions, or days in the hospital. There are no such limits on physical medicine. If you break your arm, you will be fixed, it will be fixed, and, if you break it again that year, they'll fix it again, and there should be no similar service restrictions for mental health or substance abuse services.

Similarly, the limits on the number of days a person can receive inpatient behavioral treatment will be eliminated.

Dr. Mark Friedlander, who is a psychiatrist and Chief Medical Officer of the Aetna Behavioral Health, predicted that, in the long run, mental health parity portion of the ACA will change the behavior of providers.

Quote, he says, "Many providers are just not used to operating in an environment where there are no limits on behavioral health, particularly outpatient sessions," end quote.

I think that many -- he goes on to say that "I think that many of them have been kind of more

sparing than they need to have been, and I think that this mindset will disappear," end quote.

The federal government and the State of Connecticut both have initiatives to increase awareness of the availability and the effectiveness of behavioral health care. There's a national dialogue to increase the awareness about mental health services and to reduce the fear, shame and misperceptions that people have that prevent them from getting this care.

In general, Connecticut has done a very good job in providing health care for its citizens, but mental health parity has been a much slower process.

In May of 2013, the Connecticut Health Foundation made a statement about Connecticut's progress to its mental health parity, and they said, quote, "To date, it is the privately-held insureds, who have faced multiple barriers."

They go on to say that, "As the nation fully implements health care reform, populations of color will gain access to private and public mental health and substance abuse coverage in large numbers, supporting diverse new insured consumers, and accessing culturally and linguistic effective mental health and substance abuse treatment."

The failure of some health insurance plans in the state to fully implement the provisions of mental health parity have been a heated issue.

In April of 2013, a lawsuit was filed in the District Court of Connecticut against Anthem health plans, doing business as Anthem Blue Cross and Blue Shield of Connecticut.

The suit was filed on behalf of the American Psychiatric Association, the Connecticut Psychiatric Society, the Connecticut Council on Children and Adolescent Psychiatry, and patients and psychiatrists has alleged that, in their lifetime, one in five Americans will suffer a mental illness, and five percent of Americans will suffer a severe mental illness, but less than one-third of those, who need treatment, will have access to the treatment that they need.

The suit alleges that consumers are discouraged from obtaining medically-necessary treatment by insurance providers.

For those fortunate enough to receive adequate treatment, 70 to 90 percent will find relief in reduction of symptoms, allowing them to live more productive lives.

I remember that Connecticut already has a

mental health parity law, which prohibits insurance plans from placing a greater financial burden on people, but, because it's a State law, State law only refers to insurance products that are governed by the State. Many insurance carriers or insurance plans are national plans. They're self-insured plans. They're plans that cut across other states, so they're not covered by State law. This federal insurance -- federal law will cover all of those.

Dominique Thornton, who is general counsel to the Mental Health Association of Connecticut, states people may not be aware of the changes, but they have also been reluctant to avail themselves of the benefits they now have.

It's been estimated that close to 50 percent of people covered by insurance in the State of Connecticut are covered by large companies or companies that aren't regulated by State regulations.

April 4th of this year, 2014(sic), Governor Malloy signed into law Public Act 13-3, which advances mental health parity and requires that decisions about behavioral health care are being made by behavioral health professionals.

There's been surprisingly little concern

regarding the possible increase in cost for the provision of these services.

Andrea Stillman, who represents Connecticut's 20th Senatorial District, states, for those who suggested additional coverage would adversely impact insurance providers and premiums, advocates offer a reminder that, without parity, mental health costs will only continue to climb. No untreated illness is less expensive than one treated in time.

A third reason that we expect to see an increase in the demand for services is increased awareness for mental health needs of children, adolescents and young adults.

In addition to the increased demand for behavioral health services, we expect that more lives will be covered in mental health parity that this additional awareness of the need for services for this population will increase the demand for community-based services.

Just two weeks ago, the House unanimously passed the proposal aimed at better coordinating mental health services for young people, a measure that is described as a response to the tragedy in Newtown, Sandy Hook Elementary School.

This proposal has already been approved by the Senate and is now headed for the Governor's desk. Governor Malloy has stated that it compliments legislation passed earlier this year in response to the tragic shootings.

That proposal contains several mental health measures, but they focus primarily on young adults and older adolescents.

Representative Urban from North Stonington, who co-Chairs the Children's Committee, said that the proposal has a laser-like focus on prevention. Urban goes on to state that two-thirds of youth in Juvenile Justice System have a diagnosable mental health disorder, and one in 10 young people have mental health disorders that severely impair their functioning.

She quotes that 44 percent of youth in high school have mental health problems. Forty percent of the dropouts in high schools have mental health problems.

Senator Dante Bartolomeo has called this Bill the first step in the framework for mental health system, and we can expect more progress.

A Commission has recently been appointed by Governor Malloy and is expected to make more

recommendations about health care policy changes, especially focusing on issues facing young people.

The Task Force on Adolescence in Young Adults is charged with examining insurance changes, shortages, psychiatric professionals, improved early intervention, and treatment and alternative methods of delivering services.

Another reason why we think there's an increase in demand is the reduction in the use of residential treatment.

The State has made great progress in providing services for people, who have mental health needs while they continue to live in their homes. It's long been found that treating people in the community is more effective and more affordable than sending them to residential facilities.

Following the lead of DMH, DSS, DCF, have worked to reduce the number of children, who reside in congregate care, are in foster homes, and as more are served in the community, there is inevitably going to be an increased need for community-based services.

DCF has worked to reduce the use of congregate care, and a report in 2011 from DCF proposed a new direction for the Department to reduce even further

its use of congregate care.

Commissioner Katz has stated that while progress has been made under the current administration, notably the share of children receiving treatment in congregate settings has declined 26 percent, and the number of children receiving care in out-of-state settings is down 77 percent, but she states that, despite this notable progress made by DCF, Connecticut Voices for Children has commented the Department has not sufficiently focused on strengthening families and averting out-of-home placement.

South Bay has been very active in providing community-based services for children in danger of out-of-home placement or for those, who are returning for home and reintegrating into the community.

South Bay is currently the largest provider of behavioral health care services to children in Massachusetts, who are in danger of out-of-home placement.

South Bay has developed a pilot project with the Massachusetts DCF to train and improve kinship homes, that is foster homes provided by people, who are related to the families, and this has been extremely effective, both in terms of providing a more enhanced

foster care setting, but, also, in setting up respite availability.

Once these kids are out of foster care, they're back home. When things go bad, they go back to their kinship home for the weekend, and it really prevents longer placements.

We also believe that the juvenile justice system will rely more on community-based interventions and reduce its use of restrictive settings, and, in Connecticut, juvenile justice shares the responsibility for serving children in the juvenile justice system with the Judicial Branch, the Court Support Services Division, and, in their joint strategic plan for working with youth, they say that their objectives include strengthening family, providing community-based services, reintegration efforts for the movement, as children leave residential settings, improved systems for care for wraparound approach, and more services closer to home.

As youths receive services in community-based settings, there will be an increased need for services available to them on an outpatient basis.

South Bay has a long history of working with youthful offenders. We also have experience in working with adult offenders through our contracts with

the Federal Probation Office.

We recently developed a program in conjunction with the Massachusetts Department of Corrections to provide services to incarcerated women. Seventy percent of incarcerated women are mothers, and what we do is work with them to maintain families while they're incarcerated, and then to help the reintegration.

An additional trend, which we are very interested in and believe is extremely crucial, is the integration of behavioral health with medical surgical care.

The integration of behavioral health and physical medicine is really a national movement. There are specific provisions in the Accountable Care Act that encourage this, and we expect Connecticut to expand its use of health homes or medical homes, which is funded through Medicaid, if for no other reason than to take advantage of the 90 percent federal match, which is time limited.

There are two major reasons for the importance of behavioral -- integration of behavioral health with physical medicine. The first is that behavioral health can help treat physical illnesses, which are thought of traditionally as physical illnesses,

which really involve behavioral factors.

And the second is the co-occurrence of certain physical disorders found in individuals, who suffer from serious mental illnesses.

Regarding the first, many people suffer from physical illness, but they really need to make life changes. They need to control unhealthy habits. They need to accept their illness. They need to maintain treatment of clients.

Aetna, in 2013, stated that the majority of patients treated in primary care settings have a physical ailment that is effected by stress, difficulty maintaining a healthy lifestyle, or psychological disorders.

Aetna has also stated that behavioral health disorders are often undiagnosed, and they pointed to the need for behavioral health clinicians to achieve optimal treatment in physical disorders.

Because of this, we can both clinically and cost-effectively integrate behavioral health care into primary care settings.

Dr. Mark Friedlander, who is a psychiatrist and Chief Medical Officer of Aetna Behavioral Health, said there is substantial scientific

literature, showing that, if you treat both, the overall costs are lower, and, then, if you treat one, but not the other.

South Bay has worked with health centers, primary care providers, health insurance companies, managed care organizations, and with the Massachusetts Department of Public Health and, also, the Connecticut Department of Public Health to develop treatment for such disorders as asthma, diabetes, postpartum depression, high blood pressure, weight control, and cardiovascular diseases.

We operate from a motivational enhancement model. We've been able to assist individuals to accept their illness, actively cooperate with the treatment, and maintain healthy lifestyles.

In addition to the people, who have physical illnesses, who need to make changes in their lifestyle, we also work with a number of people, who suffer from serious and persistent mental illness and who have co-occurring physical illnesses.

The following statistics underscore the need for integration of behavioral health. Fifty-seven percent of U.S. adults suffer from criteria for behavioral health illnesses at some point.

Sixty-eight percent of adults with mental health conditions also have medical conditions, where people with severe and persistent mental illness die eight to 25 years earlier than adults without these illnesses. Twenty-nine percent of adults with medical conditions also have a co-occurring health disorder.

South Bay has worked with the New England Regional Office of SAMHSA, Substance Abuse and Mental Health Services Administration, in their 10 by 10 Campaign, which is a program for helping people, who suffer from a serious and persistent mental illness.

The findings are this population dies 10 years earlier than their cohort, and our goal is to reduce this, bring it to -- reduce that within 10 years.

A final factor, which we think has increased the need, is that there are special populations that are starting to be identified and specific treatments, which have been found to be evidence-based practice.

A number of those populations are underserved, and we found that, in our work with autism, we have difficulty finding after-care providers for our kids graduating from our programs.

Our current programs are funded under the

Birth to Three initiative of the State, and, when kids turn three, they age-out of our system, and we just can't find good referral sources for them, and we would hope to be able to provide outpatient services through this license to be able to do that.

Autism is a growing condition. Autism Society estimates the number of children diagnosed with autism is growing by 17 percent a year, and other sources, such as the Autism and Development Disabilities Network, reported, estimated that it might be growing as high as 23 percent a year.

One study confirmed the marked growth of diagnosis. Comparing 2007 data to 2012 data, it showed that the rate has increased by 72 percent.

Dr. Ann Milanese, the Developmental Pediatrician, who serves as Division Chief of Development of Pediatrics at Connecticut Children's Hospital in Hartford, has reported that Connecticut offers excellent hospital-based services on autism, but there's a need at the community-based level.

She says, quote, "For many patients, there's quite a waiting list for people, who are available, and quite a waiting list, and few people available, who are any good at it," end quote.

Sarah Reed, Executive Director of ASCONN, a parent efficacy group in Guilford, Connecticut, which is devoted to autism, has made similar comments, noting the need for community-based services.

A DDS spokeswoman, Joan Barnish, said that the agency frequently fields calls from families interested in after-care supports and isn't able to find adequate sources for them.

In response to this increased need, Commissioner Katz has stated, quote, "Notably, the Department is also making strides and exploring array of in-state resources for youth on the autism spectrum," close quote.

So, in conclusion, I believe that the evidence is clear, that there's a need for expanded behavioral health care services in the area. More people have insurance, and the insurance will cover more behavioral health care, without restrictions.

More people will seek behavioral health care, because there are no limits, and the medical necessity, as long as medical necessity is justified.

There's an increased awareness of mental health needs, especially in children, in adolescents, in young adults, and are identified sooner, in order to

prevent further difficulties.

As the State works to keep people out of mental health services, children, especially, who have mental health needs or protective services, will be treated in the community rather than in residential care, and that is going to require more community-based services.

The movement to integrative care will require more behavioral health care co-located and working cooperatively with health care providers.

And, finally, there's a growing need for services for children with specific disabilities, such as autism.

Although South Bay has only been providing services in Connecticut for a little over a year, we do have a 27-year history of innovation, commitment and collaboration with community-based providers of behavioral health care.

We have experience in some of the state's most pressing needs, such as treatment for children with behavioral disorders, those, who have trauma, who have survived trauma, children, who are on the autism spectrum, assisting consumers to remain in the community, integration of behavioral health care with primary care,

and it is our hope that we'll be able to grow those services in Connecticut and continue to serve our consumers and their families.

South Bay has been opening new programs for 27 years, and we have never closed a program. We have a substantial budget and are capable of sustaining operating losses for as long as it takes for new programs to find their footing.

With revenues in excess of 40 million dollars, we can tolerate operating losses in programs that provide good services.

In July of 2012, we were awarded a contract with the Connecticut's Birth to Three system to provide services for children, who are diagnosed on the autism spectrum.

After one month of operation, we had two consumers, two children in our program, however, we felt great confidence in our staff and the quality of the services that they were providing, and we were convinced that there was a need for those services.

A year later, we have 21 families enrolled in services, and six more families that are in the determination process.

We've lost money every month in this

program, but we've never once considered closing it, because we believe it's a valuable and a viable program.

We hope someday to break even with the program, but we've made a commitment to the community and to the families we serve, and we have every intention of honoring that commitment. South Bay has never failed to satisfy its commitments. Thank you.

HEARING OFFICER HANSTED: Thank you, Doctor. Is there anyone else from South Bay that would like to offer testimony this morning? OHCA has some questions for you.

MS. GRECI: Laurie Greci, OHCA staff. Can you describe the current services being provided in Hartford? I believe you say it's the Birth to Three Program, and under what professional license is it being provided, and who awarded the contract?

DR. SCANLON: Okay. Perhaps Laura Nolda could speak to that. She's our Hartford Director of our Birth to Three Program.

HEARING OFFICER HANSTED: Why don't you come on up in front of the microphone?

MS. LAURA NOLDA: Oh, sure. Absolutely.

HEARING OFFICER HANSTED: Thank you.

MS. NOLDA: Yup. Laura Nolda, Director of

South Bay Connecticut Services. We are currently providing Birth to Three services in 13 surrounding towns in the Hartford area.

Our role is that we serve children, who have been -- we go into the homes, and we conduct evaluations and diagnose them with autism, and, if they are found to be on the autism spectrum, then they're able to come to our program, where we provide intensive in-home service treatment with their family and their teams.

We were contracted this through the Department of Developmental Services, and I am a Licensed and Clinical Social Worker doing the diagnostic treatment.

We have speech and language pathologists, Special Education teachers, occupational therapists, physical therapists, who go in the homes and provide these services, and we're required to cover over 17 services, if found necessary, within the home.

HEARING OFFICER HANSTED: And you currently have 21 families signed up for this program?

MS. NOLDA: Yes.

HEARING OFFICER HANSTED: Of the 21 families, were those all referred to you by the Department of Developmental Services, and, beyond the 21,

were there any that were referred that didn't choose to accept your services?

MS. NOLDA: Sure. So how the process works is, I think, off the top of my head, there was three families that came directly from info line, so what that is is their pediatrician will call info line and state that there is red flags, and this child should be evaluated.

The remainder of our 21 children came from other programs within the area, general Birth to Three programs, who they have an option between our agency and another agency, who provides diagnostic services within the Hartford community, and they chose to bring the services to us.

The feedback, as the Program Director, have conducted feedback, and they appear to be extremely happy with our services.

The families, who have not come to us, it hasn't been because they chose not to, but because they were not eligible, because they weren't found to be on the autism spectrum disorder.

HEARING OFFICER HANSTED: What is the name of the other facility that they can choose?

MS. NOLDA: Creative Interventions.

HEARING OFFICER HANSTED: Okay, thank you.

MS. NOLDA: Yes.

MS. GRECI: On page 352, the second completeness, you listed that there's six full-time equivalents in your office currently. Is that the LCSW and the speech pathologists?

MS. NOLDA: Yes.

MS. GRECI: I just didn't know there were so many.

MS. NOLDA: Yeah.

MS. GRECI: And they're all practicing under their own license?

MS. NOLDA: Exactly.

MS. GRECI: Okay. Are any of the clients you have now Medicaid, or Medicare, or underinsured clients?

MS. NOLDA: Many are Medicaid. We have very seldom private insurance.

MS. GRECI: Okay and you also have some that are self-pay?

MS. NOLDA: None.

MS. GRECI: None, okay. It appears that the application focuses a lot on children, and you stated that 60 percent of your services will be provided to

children. The services that you will provide to adults, can you kind of describe what you're envisioning that you will be offering?

DR. SCANLON: Can I take that?

HEARING OFFICER HANSTED: Sure.

DR. SCANLON: About 60 percent of our services are geared to children. Of the adults that we serve, many of the adults are associated with the children, so we're working with children, and their parents have substance abuse disorders. We may refer those to a specific substance abuse treatment facility, or we may provide it for ourselves, for those who are dual diagnosed.

We tend to work with people, who have serious and persistent mental illness, adult offenders, people, who have had hospital discharges, those folks, who have had more than one hospitalization for either a major mental illness or for recurring depressions and, of course, substance abuse are dual diagnosis people.

MS. GRECI: So of the 40 percent adults, would you say perhaps half are associated with the children and half might come from --

DR. SCANLON: Probably less than half.

MS. GRECI: Less than half?

DR. SCANLON: I'd say maybe 20 percent. I'm sorry I don't have an exact number.

MS. GRECI: No, that's okay.

DR. SCANLON: Yeah, that's an estimate.

MS. GRECI: And in your startup period, what services will you be focusing on? You have a lot of services listed in your application.

DR. SCANLON: Right.

MS. GRECI: I'm just trying to get a real concrete feel for how you're going to develop the program.

DR. SCANLON: Well one of our first steps will, of course, be to hire a child psychiatrist. Because we have so many children that we traditionally serve, we prefer to have always on a site a psychiatrist, who is capable of working with children, and we go through national searches for that, just because they're just so hard to find, but we've had good results in the national searches. They're expensive, but you really have to do it.

So we would first establish psychiatric services and psychological services, social workers, and we would provide services to kids. Traditionally, we work with a lot of kids, who have protective issues, who

have behavioral control issues, ADHD kids, youthful offenders, so that's where we would really put the most of our focus.

And whenever you start to work with populations like that, you always wind up working with folks, who have some substance abuse issues, just because that's how life is. Seventy percent of our consumers are touched by substance abuse.

Even in our Early Childhood Program, a high percentage of those young children are somehow effected by substance use in the family, so we always have a strong bias towards treating the addictions.

MS. GRECI: Okay. Also in the application, of course everything I get is from the application, you state that you want to offer home services. Not in relation to the autistic program, but in relation to the new mental health center, what type of services would you be offering?

DR. SCANLON: We have been down to Yale and found out about the evidence-based practice that they have there. One of our -- and discussed this with DCF. One of our goals, at some point, we were not certainly ready to do that, there's a long process for that to be certified as a home-based provider, and that's a service

that we provide in Massachusetts.

We've had very great success and are very anxious to learn this evidence-based practice, learn more about it, and to be certified in that, so one of our goals would be to do that, and I think that's probably realistically a year away would you say? Jen, you've been down to Yale.

MS. JENNIFER GEARHART: Yale, yeah. At least a year away.

DR. SCANLON: Yeah, but that would be something we would work on right away.

MS. GRECI: Who does the certification, when you say certified?

DR. SCANLON: Yale.

MS. NOLDA: Yale does it. Kristen Holtz, who is head of it, it's an application process, and then they would oversee us.

MS. GRECI: Is that considered like a national program? Do they certify people all over, or just within the state?

MS. NOLDA: No, just within the state.

MS. GRECI: Okay.

DR. SCANLON: But it's recognized by the Department of Children and Family.

MS. NOLDA: Yes.

MS. GRECI: Okay. This is a very general question, but kind of important. What's so special about South Bay? What makes you special in what you do?

DR. SCANLON: I'll jump in. We have a commitment to disadvantaged consumers. Our goal is to increase the self-sufficiency of people, who are disadvantaged. That disadvantage could be that they are suffering from substance abuse, or a major mental illness.

They may be kids, who have been abused or neglected, people, who have developmental disabilities, people, who are suffering from the effects of poverty, so we have a commitment to this population.

The vast majority of the work we do is geared to this, so I think that's one of our -- that's part of our mission.

We believe in innovation. We're willing to get out there and try new things. We were one of the first providers to implement dialectical behavior therapy, motivational interviewing.

Obviously, we are focused on evidence-based practice. As those practices are identified and certified by a national foundation that they practice,

we're ready to put it into practice, so I believe that we're innovative.

MS. GRECI: Okay, thank you. Have you established any relationships with local providers? I know you said that you will have a program director that will reach out to schools, homeless shelters. Have you done any of this yet, and could you describe what you've done?

MS. NOLDA: Yeah, sure. So within the past year and working in the Birth to Three system, I've created relationships with individuals in the DDS, Department of Developmental Services.

Along with that, also, with the Special Education Departments within the Hartford and Manchester community. I've reached out working with many DCF workers, as well as I think that's already noted, the Clinical Director at DCF.

I've reached out to My Sister's Place and neighboring community resources, shelters and whatnot to families that are working with these providers, as well. It's a really important part of my job.

MS. GRECI: Now how are they recognizing you? What's your like -- what do you call yourself when you go out and talk to these people? You call yourselves

South Bay? Are you calling yourself something else?

MS. NOLDA: They know us primarily as South Bay.

MS. GRECI: Okay.

MS. NOLDA: In Birth to Three, we're South Bay Early Childhood, but, also, in the greater scheme of things, they know we're a part of South Bay Mental Health.

COURT REPORTER: One moment, please.

MS. GRECI: Have you begun your application process with any of the other State agents, DCF, DDS, DSS, or Medicaid?

MS. NOLDA: Yes.

MS. GRECI: Where do you stand in those processes?

MS. NOLDA: With DCF, we're in the final phase. We've had the investigator coming out, and my final meeting with her is May 27th.

MS. GRECI: And what is DCF going to license you or what will you be able to do for DCF? What are they going to call you?

MS. NOLDA: It's to see children from zero to 18.

MS. GRECI: Okay.

MS. NOLDA: Within our clinic.

MS. GRECI: Okay, so, you would be an outpatient clinic for children?

MS. NOLDA: Yes.

MS. GRECI: Okay. Other than some of the State agencies, what will be your referral base?

MS. NOLDA: What will be our referral base?

MS. GRECI: Yes.

MS. NOLDA: Other agencies, a lot of times, we like to develop relationships with other providers in the area, self-referrals, doctors, hospitals.

MS. GRECI: Okay.

DR. SCANLON: You also do a lot of work in schools, public schools.

MS. NOLDA: Yes.

DR. SCANLON: And homeless shelters. And we traditionally do a lot of services for other providers, since substance abuse providers, who are focused on the addictions, if the person has a co-occurring mental illness, they would want to refer them to traditionally a mental health center that has a tradition of working with addicts.

MS. GRECI: Okay, let's see. On the balance sheet, I'm just focusing on financial now, on the balance sheet, you state that you have accrued expenses of 1.6 million. By looking at your expenses, I imagine a lot of that is just carryover, such as salaries, rent, that type of thing? Okay.

HEARING OFFICER HANSTED: Did you say yes?

MS. GRECI: Somebody needs to say something.

DR. SCANLON: Sorry. Yes.

MS. GRECI: Thank you. Okay. And, then, you have an accounts receivable balance of three million, and 56 percent is due from government agencies, and what's the time period that, you know, from billing to receiving funding?

DR. SCANLON: Adam, do you want to?

MR. ADAM SCHAUER: Sure. My name is Adam Schauer, the Controller at South Bay. Our turnaround is relatively quick. It's less than 30 days from billing to collections. We're very efficient in the billing, but, then, the collection side. We have a very clean billing, so things come in pretty quickly.

MS. GRECI: So the three million is maybe a three-month --

MR. SCHAUER: Worth of receivables?

MS. GRECI: Yeah.

MR. SCHAUER: Less than that.

MS. GRECI: Less than that, but you're always carrying about that amount?

MR. SCHAUER: It's, actually, it's three million. It's growing. As we are successful, it grows, but the receivables are very clean and come quickly to cash.

MS. GRECI: Okay and just to reiterate, you know, based on testimony today, how long do you think it's going to take you to get to a point, where you're going to be collecting funds and not totally relying on operating without it, any revenues?

DR. SCANLON: I wish I knew. Part of the problem is because making application for Medicaid. Once we're approved for Medicaid and we're good to go, then we're going to be billing Medicaid. Prior to that, it's all private insurances.

MS. GRECI: Do you have any idea how long that process takes, or you're not really aware?

DR. SCANLON: We've been told somewhere around 30 days.

MS. GRECI: Oh, okay.

DR. SCANLON: And we've got our fingers crossed.

HEARING OFFICER HANSTED: Who told you that?

MS. NOLDA: Within the Medicaid application? Is that what you're talking about?

DR. SCANLON: Yes.

MS. NOLDA: I think he's talking about within becoming a Medicaid.

HEARING OFFICER HANSTED: Okay.

MS. GRECI: In Connecticut?

MS. NOLDA: Yes.

MS. GRECI: And who do you apply through through that, DDS, DSS, or Medicaid, or CMS?

MS. NOLDA: DSS, yes. Yes, yes, yes. With DSS.

MS. GRECI: Alphabet soup. Okay, so, you do that through DSS, and they say double it, right?

DR. SCANLON: And, actually, it would also be applying to value options for, you know, the vendorship through their MCO.

MS. GRECI: Now do you have to be a value option provider to provide for the State agencies? Does that kind of go hand-in-hand?

DR. SCANLON: Not necessarily.

MS. GRECI: Not necessarily? Okay.

DR. SCANLON: But many of the consumers, a good majority of the consumers have that as their insurance and it's managed, so we'd certainly want to do it when -- keep us from opening, starting, but that would be a real high priority. We've had discussions with Laurie Ansorge Ball, who is the Executive Director of that program.

MS. GRECI: Okay. I notice that you closed your line of credit. Have you opened another one, or you don't -- haven't needed it? I'm just curious, again.

MR. SCHAUER: Yeah. It was closed. It was originally with Rockland Trust. We have a new-baked relationship with TD Bank.

MS. GRECI: TD Bank?

MR. SCHAUER: Yeah.

MS. GRECI: And have you opened a line of credit with them?

MR. SCHAUER: We do have a line of credit with them.

MS. GRECI: Okay.

HEARING OFFICER HANSTED: How much is that

line of credit?

MR. SCHAUER: In total, it's -- total available, four million.

HEARING OFFICER HANSTED: Okay, thank you.

DR. SCANLON: Wow. I didn't know that.

HEARING OFFICER HANSTED: You see that? You learned something.

DR. SCANLON: That would be good. There's some things I want to buy.

HEARING OFFICER HANSTED: That's right. (Laughter)

MS. GRECI: You've got to pay it back. I know you made quite a few statements in the application about wait lists. Have you done any kind of research or phone surveys for Connecticut area providers, as far as determining what kind of wait list they have?

MS. NOLDA: Our submission in the CON was from myself conducting that research and calling all areas, all local providers, and that's how we came up with what we submitted within the CON.

MS. GRECI: Okay.

MS. NOLDA: Many of them, several were not major, we're not taking, and many were on a three to six-week wait list.

MS. GRECI: Okay, so, they said try again in six weeks?

MS. NOLDA: Yes.

MS. GRECI: See if we have a spot for you?

MS. NOLDA: Yeah.

MS. GRECI: Okay. All right and I'm going to ask this anyway. How will you alleviate these wait lists, without having an effect on any of the existing providers? I mean how are you going to -- you know, you'll be taking clients that might have gone to one provider, but might be going to you. Is that going to have an effect on the existing providers, or do you feel that --

DR. SCANLON: Our belief is that the demand is increasing much faster than the current provider community can adequately serve, as evidenced by a wait list.

That's just never been a problem. We've opened programs for 27 years, and it's never been a problem that other providers. I wish it were true. I wish there was a bottom to the demand, but we really haven't found it to be the case and certainly don't expect it, given all of the new trends and new services and expanded eligibility and demand for integrated

behavioral health and work for youth and adolescents, so I'm just seeing an increased demand.

MS. GRECI: Okay. I have another question. You state in the application that you'll be doing medication prescriptions?

DR. SCANLON: Yes.

MS. GRECI: For psychotropic drugs, etcetera?

DR. SCANLON: Yes.

MS. GRECI: Are most of those going to be prescribed by the child psychiatrist, or will you be getting a psychiatrist that would deal with adults and families?

DR. SCANLON: We will hire a child psychiatrist, but the child psychiatrist will also work with adults.

MS. GRECI: Okay.

DR. SCANLON: Child psychiatrists do their -- first, they do their adult rotation, and then they specialize. They do another practicum internship.

MS. GRECI: So you will hire somebody, who can do everything?

DR. SCANLON: Do both, yes. Absolutely. All of our child psychiatrists also work with adults. I

wish it was the other way around, too, but adult psychiatrists really don't feel comfortable working with children.

MS. GRECI: Well I've gone through my entire list.

HEARING OFFICER HANSTED: Okay. Do you have any questions, Kaila?

MS. KAILA RIGGOTT: No.

HEARING OFFICER HANSTED: I just have a couple of questions. One of the things I need more concrete evidence of is the need for these services in Connecticut and, specifically, the area you want to serve.

I understand you provided quotes from folks, and you did surveys, and while I appreciate that, unfortunately, that's considered hearsay, and I can't consider that in the decision.

Is there any evidence that you could provide me to quantify the need for your services? And, again, I understand, as well, that you provided statistics, but what I'm looking for is concrete evidence that the need is out there, and that could be done via referral letters, letters from your referral sources, saying that we have a need for the proposed project and

programs, and we would refer patients to the programs.

MS. NOLDA: You'd like us to provide that?

HEARING OFFICER HANSTED: If you could, yes. Yes. And if you want to speak to it today, that's fine, as well.

MS. NOLDA: No, I certainly can, and I can also can attest that, when I go into work, as you already know, it's always just the autism-specific program, but I have people calling, actual consumers calling to see if we're open yet, and that's on a daily basis. I get voicemails of people calling to see if we're even open, which, to me, is an indication that there certainly is a need, and they're not getting it in other places.

HEARING OFFICER HANSTED: Are they new services? They're asking for new services?

MS. NOLDA: Yeah. Even though we're an autism-specific program, they're calling to see what else we can do.

DR. SCANLON: And we would be glad to try and get some letters to support that.

HEARING OFFICER HANSTED: Yeah, that would be helpful.

MS. NOLDA: Sure.

HEARING OFFICER HANSTED: And I'll order

that as Late File No. 1, and how long do you think you'd need to provide those? I mean I'm not limiting your time at all.

MS. NOLDA: Ten days? Two weeks?

HEARING OFFICER HANSTED: Is that enough?

DR. SCANLON: Give yourself some time.

HEARING OFFICER HANSTED: Yeah.

DR. SCANLON: It requires people to really write letters. Thirty days, I think.

HEARING OFFICER HANSTED: Thirty days?

DR. SCANLON: Yeah.

HEARING OFFICER HANSTED: Okay, so, those will be due 30 days from today's date. Okay, that was the only question I had, the only concern I had.

Is there anything else you'd like to provide to us today? Any other testimony at this point? No? Okay, thank you.

I don't see any members of the public here today, but I have to ask this question anyway for the record. Is there anyone here today that would like to give any comments or testimony regarding this application?

Hearing none, just for the record, let it show that there were no individuals requesting comment

today, requesting to give comment today.

And, with that, I thank you, all, and I will adjourn this hearing.

ALL: Thank you.

(Whereupon, the hearing adjourned at 10:55 a.m.)

HEARING RE: SOUTH BAY MENTAL HEALTH CENTER, INC.
JUNE 13, 2013

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young [12] 7:17 7:19 8:16 8:16 13:13 13:22 14:7 14:14 15:2 15:3 23:24 32:10
yourself [3] 35:23 36:1 47:6
yourselves [1] 35:24
youth [5] 14:12 14:16 17:14 23:12 44:1
youthful [2] 17:23 32:1
youths [1] 17:19
Yup [1] 26:24
zero [1] 36:22

CERTIFICATE

I, Paul Landman, a Notary Public in and for the State of Connecticut, and President of Post Reporting Service, Inc., do hereby certify that, to the best of my knowledge, the foregoing record is a correct and verbatim transcription of the audio recording made of the proceeding hereinbefore set forth.

I further certify that neither the audio operator nor I are attorney or counsel for, nor directly related to or employed by any of the parties to the action and/or proceeding in which this action is taken; and further, that neither the audio operator nor I are a relative or employee of any attorney or counsel employed by the parties, thereto, or financially interested in any way in the outcome of this action or proceeding.

In witness whereof I have hereunto set my hand and do so attest to the above, this 19th day of June, 2013.

Paul Landman
President

SOUTH BAY
MENTAL HEALTH

237 Hamilton St.
Suite 205
Hartford, CT 06106
☎ 860-578-1300
🖷 860-951-7729
www.southbaymentalhealth.com

FAX

Date: 7/2/13

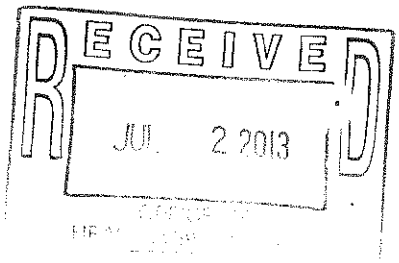
To: Mr. Kevin Hansted
Fax: 860-418-7053

From: Laura Nolde

Number of Pages Including Cover Sheet: 2

☐Urgent ☒For Review ☐Please Comment ☐Please Reply ☐Please Recycle

Comments:



SOUTH BAY
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Brockton

Mental Health and Addictions Treatment
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Mental Health Outreach
Leominster
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Brockton
Cape Cod
Fall River
Plymouth
Worcester

Children's Day Services
Fall River
Lowell

Early Childhood Services
Brockton
Fall River
Lowell
Worcester

July 2, 2013

Kevin T. Hansted
Hearing Officer
Office of Health Care Access
410 Capitol Avenue
Hartford, CT 06134

Dear Mr. Hansted

South Bay Mental Health, Inc. would like to request a two week extension on providing letters of need for Docket Number: 12-31798-CON. We are successful obtaining letters from providers in the area however, it has been a challenge to connect with school officials due to summer break.

Please contact me with any questions concerning this request.

Laura Nolda

Laura Nolda
Program Director
860-578-1301

237 Hamilton Street
Suite 205
Hartford, CT 06106
P: 860-578-1300
southbaymentalhealth.com

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

July 3, 2013

VIA FAX ONLY

Laura Nolda
Program Director
South Bay Mental Health Center, Inc.
237 Hamilton St., Suite 205
Hartford, CT 06106

RE: Certificate of Need Application; Docket Number: 12-31798-CON
South Bay Mental Health Center, Inc.
Establishment of an Outpatient Mental Health Clinic in Hartford
Request for Time Extension for Submission of Late File

Dear Ms. Nolda:

On July 2, 2013, the Office of Health Care Access received the request from South Bay Mental Health Center, Inc. to extend by two weeks the submission date for the late file requested at the hearing held on the above matter on June 13, 2013.

OHCA hereby extends the required submission date of the late file from July 15, 2013, to August 1, 2013.

Please contact Laurie Greci at (860) 418-7032, if you have any questions.

Sincerely,

Kevin Hansted
Hearing Officer

Copy of PDF file: Kim Martone, Director of Operations, DPH OHCA
Kaila Riggott, CON Supervisor, DPH OHCA

****
*** TX REPORT ***
****

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

FAX SHEET

TO: Laura Nolda

FAX: 860 951 7729

AGENCY: Cedar Bay Dental Health Center

FROM: Laura Nolda

DATE: 7/3/13 TIME: 1:12 pm

NUMBER OF PAGES: 2
(including transmittal sheet

Comments: [illegible]

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

SOUTH BAY
MENTAL HEALTH

237 Hamilton St.
Suite 205
Hartford, CT 06106
☎ 860-578-1300
🖷 860-951-7729
www.southbaymentalhealth.com

FAX

Date: 7/17/13

To: Mr. Kevin Hansted | Ms. Laurie Greci

Fax: 860-418-7053

From: Laura Nolda

Number of Pages Including Cover Sheet: 8

☐Urgent ☐For Review ☐Please Comment ☐Please Reply ☐Please Recycle

Comments:

Copies are also being mailed out.

Thankyou

Laura

SOUTH BAY
MENTAL HEALTH

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Brockton

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Lawrence
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Plymouth
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Fall River
Lowell

Early Childhood Services
Brockton
Fall River
Lowell
Worcester

Mr. Kevin Hansted
Hearing Officer
410 Capitol Avenue
Hartford, CT 06134

RE: Certificate of Need Application; Docket Number:12-31798-CON
Submission of letters of need.

Dear Mr. Hansted,

Enclosed is South Bay Mental Health Center, Inc. submission of letters of need as requested on June 13, 2013.

Please contact me with any questions at 860-578-1301.

Sincerely,

Laura Nolda

Laura Nolda
Program Director

237 Hamilton Street
Suite 205
Hartford, CT 06106
P: 860-578-1300
southbaymentalh...

July 10, 2013

To whom it may concern,

My name is Adam Reid and I am a therapist in the Greater Hartford area in private practice. Over the past year I have tried to link my patients with outpatient case management and medication management services only to be told that the wait lists for such services is anywhere between 3-6 months. Needless to say, this is frustrating as a therapist and even more so for my patients who are overwhelmed with daily challenges and who could benefit from these services.

I would welcome any agency that can fill this void, for there is a large need for these services within the Greater Hartford area.

Sincerely,

Adam Reid, M.A.,LPC

CT Lic #1856

support ENFORCEMENT services
SECURING SUPPORT FOR CHILDREN

Judicial Branch
Court Operations Division
287 Main Street – 3rd Floor
East Hartford, CT 06118
www.jud.ct.gov

To Whom It May Concern:

I am a Court Planner II with the State of Connecticut Judicial Branch – Court Operations Division. I work along side community resources to make sure Mental Health Services and other resources are available for the clients that our staff serve in the Hartford area. Finding Mental Health Services in the Hartford area has proven to be especially challenging due to the lack of services available and also the waitlists at the existing services. At this point, it is unrealistic for this population to obtain services in a reasonable amount of time.

In Hartford, we serve clients both our Hartford office as well as in court. We deal with families; often around crisis points, dealing with barriers of mental health, substance abuse, lack of education, and reentry issues. We deal with parents with the ultimate goal of providing emotional, psychological, and financial stability for themselves and their children. Staff, Family Support Magistrates, and Family Judges will make referrals right out of the court room to local community providers when a barrier is presented. This will often happen in lieu of incarceration with the hopes of stabilizing parents so they are able to provide for themselves and their children.

As someone who works to secure relationships with community providers, I can say that there is a lack of Mental Health Services available in the Hartford community. I look forward to collaborating with providers at the South Bay Clinic for the purposes of making Hartford families able to eliminate barriers and secure futures for themselves and their families. I welcome the opportunity for further discussion if needed.

Thank you

Cristina Johnson

Cristina Johnson

Court Planner II
CT Judicial Branch
Court Operation Division
Support Enforcement Services
860-569-6233 x3001
Cristina.Johnson@jud.ct.gov

Building Bridges, LLC
435 Buckland Rd.
South Windsor, CT 06074
(860) 432-8636 Fax (860) 432-8637
buildingbridges@bbl.necoxmail.com

June 20, 2013

Office of Health Care Access
410 Capitol Avenue
Hartford, CT 06106

To Whom it May Concern;

I am Steven Hunt and I am the director of Building Bridges, LLC. Building Bridges has been a Birth to Three provider in CT for more than six years and is currently providing services to approximately 180 families. We currently provide services in 17 towns in CT. The families in Hartford represent more than 25% of our current enrollment.

I am pleased to provide this letter of support for South Bay Mental Health Center Inc. and their proposal of an Outpatient Mental Health Clinic in Hartford, CT. Building Bridges has had positive interactions with South Bay as an Autism Provider as part of the Birth to Three system. The director, Laura Nolda, has been responsive and professional with myself, my team and our families.

One of the priorities of Birth to Three is to transition our clients to other supportive agencies and resources once they turn three. There is an obvious need in the community for mental health services. If there were more agencies available to provide these services it would create a more comprehensive and timely transition process.

Overall, I believe that the Hartford Community will benefit from more mental health options.

Sincerely,

Steven Hunt
Director of Building Bridges, LLC

JANE BISANTZ & ASSOCIATES, LLC
voice 860 267-6768 fax 860 267-0560 91 Main Street East Hampton, CT 06424

June 25, 2013

To Whom It May Concern:

I am the director of an agency that provides early intervention services to hundreds of families with infants and toddlers with disabilities. We have been serving families in the greater Hartford area since 1994, and over the years have developed an extensive knowledge of the needs of local families and the resources available to meet those needs. There has always been a shortage of mental health services for the families we serve and this shortage has become more severe over time.

As providers in the state's Birth to Three system, we regularly come face to face with serious mental health needs in the young families we serve. We are reluctant to establish therapeutic relationships with family members who will be cut off from our services the day before their child turns three, and so try to connect our families with mental health resources that will remain in place after a child's third birthday. This is increasingly hard to do, and the need for more resources could not be greater.

For the past several months I have had the opportunity to work with the South Bay Birth to Three Autism Program. I've been impressed with their skill level, professionalism, responsiveness, and customer service. I would be thrilled if an organization of this caliber were available to provide mental health support to the families we serve.

Sincerely,

Jane Bisantz, Director
Jane Bisantz & Associates, LLC

June 27, 2013

Office of Healthcare Access
410Capitol Avenue
Hartford, CT 06106

Re: South Bay Mental Health, Inc.

To Whom it May Concern:

It is my great pleasure to write a letter of support for South Bay Mental Health Center in encouragement of their proposal to become an Outpatient Mental Health Clinic in the Hartford Region.

I am the senior pastor of the Hartford First Church of the Nazarene situated at 932 capitol Avenue, Hartford, Connecticut, a well established church in the community in existence for almost one hundred years serving the Hartford community. It has been my pleasure to have a working relationship with South Bay Mental Health for the past fifteen years and has all confidence they will be an asset to the residents of Hartford.

South Bay Mental Health embraces the value of partnership with other community providers to provide the best clinical care to all consumers of its services.

South Bay Mental Health Center is a family centered organization. Its practices seek to incorporate treatment around the needs of individual family members, listen to their concerns and provide treatment based on the best outcomes for family members.

South Bay Mental Health Center is always concerned about best practice methods. They rigorously evaluate their standards and constantly seek to keep up with state and federal guidelines, implementing the necessary standards, additions or recommendations as well as keeping abreast with policy changes and innovative electronic media which maintain consumer confidentiality.

As a senior pastor working in the Hartford community I believe there is always a need for more mental health clinics. The demand is high for quality mental health clinics. It is without hesitation that I strongly support South Bay Mental Health as a outpatient clinic. I have no doubt that they will demonstrate commitment to children, adults, and families using best practices. South Bay Mental Health Center is a valuable resource to your system.

Feel free to contact me should you have further questions at 860-830-5565.

Sincerely,
Rev Augustus Sealy PhD, LMHC

MY SISTERS' PLACE, INC.
Working to eliminate homelessness

July 12, 2013

To Whom It May Concern:

On a daily basis My Sisters' Place, Inc. supports those living in the Greater Hartford community who are struggling with mental health issues. Our Case Managers are responsible for helping them to be able to continue to live independently in the community. In order for them to be able to be successful, we need to be able to partner with mental health providers to also provide appropriate and timely services.

The challenge we face is that when trying to make appointments for a client to be seen by a Psychiatrist or other Mental Health Professional ---- there is often a 4 month wait. This is not a viable option especially when the client may be in crisis. My Sisters' Place would support having more mental health options in our area because of this issue.

Sincerely,

Kathleen R. Shaw
Vice President of Programs & Operations

SOUTH BAY
MENTAL HEALTH

Administration
Brockton

Mental Health and Addictions Treatment
Attleboro
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Cape Cod
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Worcester

Mr. Kevin Hansted
Hearing Officer
410 Capitol Avenue
Hartford, CT 06134

RE: Certificate of Need Application; Docket Number:12-31798-CON
Submission of letters of need.

Dear Mr. Hansted,

Enclosed is South Bay Mental Health Center, Inc. submission of letters of need as requested on June 13, 2013.

Please contact me with any questions at 860-578-1301.

Sincerely,

Laura Nolda

Laura Nolda
Program Director

237 Hamilton Street
Suite 205
Hartford, CT 06106
P: 860-578-1300
southbaymentalhealth.com

July 10, 2013

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MA LPC

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CT Lic #1856

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ENFORCEMENT
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FOR CHILDREN

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Thank you

Cristina Johnson

Cristina Johnson

Court Planner II
CT Judicial Branch
Court Operation Division
Support Enforcement Services
860-569-6233 x3001
Cristina.johnson@jud.ct.gov

Building Bridges, LLC
435 Buckland Rd.
South Windsor, CT 06074
(860) 432-8636 Fax (860) 432-8637
buildingbridges@bb1.necoxmail.com

June 20, 2013

Office of Health Care Access
410 Capitol Avenue
Hartford, CT 06106

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Jane Bisantz, Director
Jane Bisantz & Associates, LLC

June 27, 2013

Office of Healthcare Access
410Capitol Avenue
Hartford, CT 06106

Re: South Bay Mental Health, Inc.

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Working to eliminate homelessness

July 12, 2013

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Sincerely,

Kathleen R. Shaw
Vice President of Programs & Operations

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

August 7, 2013

Via Fax Only

Laura Nolda
Program Director
South Bay Mental Health Center, Inc.
237 Hamilton St., Suite 205
Hartford, CT 06106

RE: Certificate of Need Application; Docket Number: 12-31798-CON
South Bay Mental Health Center, Inc.
Establishment of an Outpatient Mental Health Clinic in Hartford
Closure of Public Hearing

Dear Ms. Nolda:

On July 18, 2013, the Office of Health Care Access ("OHCA") received the information requested as a late file submission by OHCA at the public hearing held in this matter on June 13, 2013. With the receipt of the late file submission, the hearing on the above application is hereby closed.

If you have any questions regarding this matter, please feel free to contact Laurie Greci at (860) 418-7001.

Sincerely,

Kevin Hansted, Esq.
Hearing Officer

KH:lkg

****
*** TX REPORT ***
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TRANSMISSION OK

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

FAX SHEET

TO: Laura Nolda

FAX: 860 951 7729

AGENCY: South Bay Mental Health Center

FROM: Laurie Green

DATE: 8/1/2013 **TIME:** 11:10

NUMBER OF PAGES: 2
(including transmittal sheet

Comments: Re: 12-3798-CON

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.