CT-FAMILY CARE SERVICES, LLC

"In Collaboration with clients we enhance their wellness through internal and external solutions."

April 11, 2012
Kimberly R. Martone
Director of Operations
Department of Public Health
Office of Care Health Care Access
410 Capital Ave, MS# 13HCA,
BOX 340308 Hartford, CT. 06134

Dear Kimberly R. Martone
I am pleased to inform you that CT-Family Care Services, LLC has been licensed by the Department of Public Health in Massachusetts to provide Outpatient Mental Health Services in Springfield. I hope that its application in Connecticut will be approved soon by your Department in order to enable our agency be licensed and provide services in the Manchester area, Connecticut.

Per your directive, I am pleased to inform you that the agency retained attorney Sandra R. Zlokower in order that she may guide it successfully in its application process for CON certification and licensing from DPH. I believe that attorney Sandra spoke with you few weeks ago. In light of your recommendation, a public notes was placed in the Hartford Courant for Mach 21,22,23,2013 (attached) and today marks twenty days after that public notes had been placed in a newspaper for three days in a row.

Hence, I hereby re-submit the application for CON certification. The last questions that your office had raised are adequately addressed on page 207 onward. Those questions were important as they were seeking to determine quantitatively the number of people who need mental health treatment but their needs have not yet been met. After consultation with Manchester town leaders, school officials and leaders of some local mental health agency ,it is obvious that Manchester area still has a substantial number of people who are struggling with mental health crisis as well as other related social needs. In that section, the number of people whose needs are not yet met are clearly presented with supportive evidences.
Due to the fact that the 6 copies of this application for CON that I am re-submitting has been submitted to your office, I decided to send you only one copy. Thus, I am requesting that you start reading from page 207. I look forward to hearing from you.

Justinian Rweyemamu, MA, M.Div, MS-MFT, PhD student
Manager/President
CT-Family Care Services, LLC

16 Enfield Ave
Enfield, CT 06082

243 Main Street
Manchester, CT 06042

155 Maple St, Unit 204
Springfield, MA 01105

rweye@cox.net (860) 508-8651

HARTFORD COURANT PROOF

Customer: CT-FAMILY CARE SERVICES, LLC
Contact: JUSTINIAN RWEYEMAMU Phone: 8605088651

Ad Number: **2540245**
Insert Dates: 03/21/2013 03/22/2013 03/23/2013

Price: 291.46
Section: CL Class: 2174; CONNECTICUT Size: 1 x 1.50
Printed By: JSMIETAN Date: 03/27/2013

Signature of Approval:_____ Date:_____

NOTICE

CT-Family Care Services, LLC is applying for a Certificate of Need pursuant to Section 19a-638 of the General Statutes to open a Behavioral Health Treatment Center with a focus on Marriage and Family Counseling/Therapy, Student Behavioral Counseling, School Dropout and Low Academic Performance Prevention, Cross-multicultural Counseling Services and Job Preparedness for Returning Veterans suffering Post Traumatic Stress Disorder and their families as well as Therapeutic Treatment and Social Services for the Underserved population. The facility will be located at 243 Main St., Suite 4, Manchester, CT 06042

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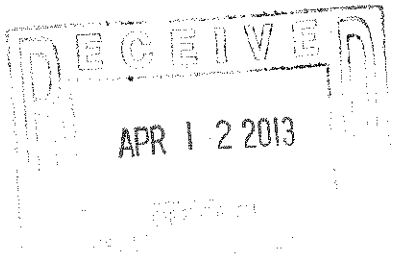
16 Enfield Ave
Enfield, CT 06082
rweye@cox.net
860-508-8651

CT-FAMILY CARE SERVICES, LLC

December 11, 2012

Via First Mail and Electronic Mail



Kimberly R. Martone
Director of Operations
Department of Public Health
Office of Care Health Care Access
410 Capital Ave, MS# 13HCA,
BOX 340308 Hartford, CT. 06134

Dear Kimberly R. Martone

Thank you for your letter dated December 7, 2012. In that letter you showed uncertainity on our part as to whether we are still determined to get a certificate of needs (CON) and the licensure from DPH.

Due to the ambiguity of some requirements from your office, we needed to have some clarifications as we proceeded fulfilling what your office demanded us to do. That is why towards the end of October, 2012, our clinical supervisor contacted your office and spoke with one of your staff members, requesting for a meeting for clarifications on some questions, but the answer was discouraging because no one would meet and talk with us, except by mails or emails. Such a response as well as lack of clarification slowed the process.

Some requirement questions demanded production of photocopied pages of references which were quoted from our research as we proceeded with our proposal write-up of over 170 pages. Some of the references were big books and articles. If all the references had to be photocopied as your office suggested, it would have costed the young agency thousands of dollars, in addition to the $ 16,000 the agency had reported to you earlier plus an addition of $ 8,000 the agency spent for office furniture in October and November, 2012. Normally, when a reference is quoted from some books or articles, they suffice to direct the reader to check and concretize the existence of what has been referenced or quoted. But what aspired from some of your questions is to photocopy the documents which will require photocopying the entire book or article referenced.

Due to constraint requirements on the agency along with the ambiguity of some questions, towards the end of October, 2012, our clinical supervisor contacted your office and spoke with one of your staff members, requesting for a meeting for clarifications on some questions, but the answer was discouraging because no one would meet and talk with us, except by mails or emails. Such a response as well as lack of clarification slowed the process. Thus, I am hereby confirming that the agency has not withdrawn its application. It is still interested and committed to working with your office in order to meet the requirements for the certificate of needs (CON) and the licensure from DPH.

In addition, I am requesting for your assistance to remove the unnecessary constrains such as those mentioned above in order that a small business such as ours can be given a fair chance to provide services as well as create jobs in Connecticut. I am pleased to share with you that the agency has received good collaboration with the Department of Children and Families for the out patient psychiatric clinic for children and families. But, the agency still need the certificate of need (CON) and the license from DPH in order to provide services to the adults such as veterans and seniors as stipulated in our proposal. Our clinicians have been waiting for a long time to start working. The agency is requesting to be certified for the certificate of need (CON and be licensed this month in order to enable it to start providing services as soon as possible.

Furthermore, I am going to submit a check of $1, 000.00 to your office on Thursday this week, for our outpatient adults' mental health facility fee and I am requesting Sandra C. Bauer the licensing examination assistant or her delegate from your office to visit our facility in Manchester, Connecticut.

Thank you for your anticipated assistance.

Justinian Rweyemamu, MA, M.Div, MS-MFT, PhD Student
President

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

December 7, 2012

Via First Class Mail and Electronic Mail

Justinian Rweyemamu, MA, M. Div, MS-MFT
CT-Family Care Services, LLC
16 Enfield Ave.
Enfield, CT 06082

RE: Certificate of Need Application; Docket Number: 12-31773-CON
Establishment of a Behavioral Health Treatment Center in Manchester
Notice of Withdrawal

Dear Mr. Rweyemamu:

On October 5, 2012, the Office of Health Care Access ("OHCA") sent a letter to you requesting additional information for the above referenced Certificate of Need application. The requested information was not submitted to OHCA within the sixty-day period as required under Section 19-639a(c) of the Connecticut General Statutes. Therefore, OHCA considers the above application to have been withdrawn on December 5, 2012.

If you have any questions regarding the above, please feel free to contact me at (860) 418-7001.

Sincerely,

Kimberly R. Martone
Director of Operations

KRM:lkg

"In Collaboration with clients we enhance their wellness through internal and external solutions."

CT-FAMILY CARE SERVICES, LLC

CT-FAMILY CARE SERVICES, LLC PRESENTS
TO THE DEPARTMENT OF PUBLIC HEALTH (DPH)

AN APPLICATION FOR THE CERTIFICATE OF NEEDS ("CON")
FOR AN OUTPATIENT INTEGRATED TREATMENT PROGRAM

FOR THE UNDERSERVED POPULATION IN ENFIELD & MANCHESTER AREA IN CONNECTICUT

The treatment will reduce:

- **School dropout**
- **Delinquency**
- **Problematic behaviors**
- **Mental illnesses, Substance uses & Poverty**
- **Dysfunctional family interactions that affect children and family members**

The treatment will

- **Enhance coping skills**
- **Increase academic performances**
- **Help students to graduate in High Schools and proceed to colleges or embrace careers**
- **Increase recovery and healing from mental illnesses and substance uses**
- **Improve relations between challenged individuals, families and foster wellness and economic success among underserved population**
- **Save taxpayers the burdens and costs of preventable incarceration among children, adults and increase skilled workforce and productive citizens.**
- **Greatly reduce health, educational and economical as well as healthcare disparities among underserved minorities and low income population**

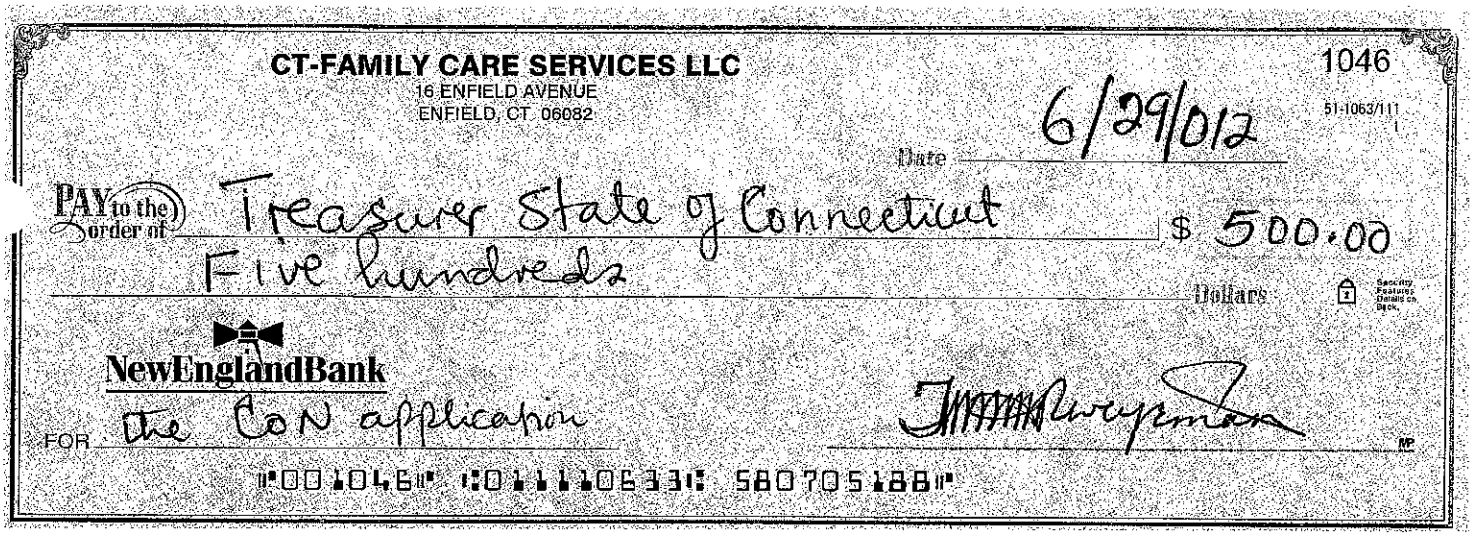
16 Enfield Ave.
Enfield, CT 06082

243 Main Street
Manchester, CT 06042

155 Maple St, Unit 204
Springfield, MA 01105

rweye@cox.net (860) 508-8651

CT-FAMILY CARE SERVICES, LLC



CT-FAMILY CARE SERVICES LLC
16 ENFIELD AVENUE
ENFIELD, CT 06082

1046

51-1063/111

Date 6/29/012

PAY to the order of Treasurer State of Connecticut $ 500.00

Five hundreds Dollars

NewEnglandBank

FOR the CON application

⑈001046⑈ ⑆011110633⑆ 5807051888⑈

HARTFORD COURANT PROOF

Customer: CT-FAMILY CARE SERVICES, LLC
Contact: JUSTINIAN RWEYEMAMU Phone: 8605088651

Ad Number: **2502675**
Insert Dates: 05/31/2012 06/01/2012 06/02/2012

Price: 338.38
Section: CL Class: 2174; CONNECTICUT Size: 1 x 1.75
Printed By: KURCHELL Date: 05/30/2012

Signature of Approval:_____ Date:_____

NOTICE

CT-Family Care Services, LLC is applying for a Certificate of Need pursuant to Section 19a-638 of the General Statutes to open a Behavioral Health Treatment Center with a focus on Marriage and Family Counseling/Therapy, Student Behavioral Counseling, School Dropout and Low Academic Performance Prevention, Cross-multicultural Counseling Services and Job Preparedness for Refugees, and Integrated Therapy for Veterans suffering Post Traumatic Stress Disorder and their families as well as Therapeutic Treatment and Social Services for the Underserved population. The facility will be located at 243 Main St, Suite 4, Manchester, CT 06042.

HARTFORD COURANT PAYMENT RECEIPT

Customer: CT-FAMILY CARE SERVICES, LLC
Account Number: **20257078** Phone: 8605088651

Ad Number: **2502675**
Classi cation: 2174; CONNECTICUT
Start: 05/31/2012 End: 06/02/2012
Insertions: 3 Size: 1 x 1.75

Price: $338.38
Amount Paid: $0.00 Amount Owed: $0.00
Payment Method: CC Check No: 0
Credit Card: VI 10/31/2014

Printed By: KURCHELL Date: 05/30/2012

NOTICE

CT-Family Care Services, LLC is applying for a Certificate of Need pursuant to Section 19a-638 of the General Statutes to open a Behavioral Health Treatment Center with a focus on Marriage and Family Counseling/Therapy, Student Behavioral Counseling, School Dropout and Low Academic Performance Prevention, Cross-multicultural Counseling Services and Job Preparedness for Refugees, and Integrated Therapy for Veterans who suffering Post Traumatic Stress Disorder and their families as well as Therapeutic Treatment and Social Services for the Underserved population. The facility will be located at 243 Main St, Suite 4, Manchester, CT 06042.

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.**

x☐ **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.: 12-31773-CON **Check No.:** 1046
OHCA Verified by: SO **Date:** 7/2/12

x☐ **Attached is evidence demonstrating that public notice has been published in a suitable newspaper that relates to the location of the proposal, 3 days in a row, at least 20 days prior to the submission of the CON application to OHCA. (*OHCA requests that the Applicant fax a courtesy copy to OHCA (860) 428-7053, at the time of the publication)***

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

x☐ **Attached are completed Financial Attachments I and II.**

x☐ **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.

x☐ **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.**

AFFIDAVIT

Applicant: **CT-FAMILY CARE SERVICES, LLC**

Project Title: Outpatient Integrated Treatments for Underserved Population in ENFIELD & MANCHESTER, **Connecticut**.

I, Justinian Rweyemamu, MA, M. Div, MS-MFT, PhD student,
AAMFT Approved Supervisor Candidate.
Founder & President.

(Individual's Name) (Position Title – CEO or CFO)

of **CT-FAMILY CARE SERVICES, LLC** being duly sworn, depose and state that
(Hospital or Facility Name)

CT-FAMILY CARE SERVICES, LLC's information submitted in this Certificate of
(Hospital or Facility Name)

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

Signature 6-30-2012
Date

Subscribed and sworn to before me on 6/30/2012

Notary Public/Commissioner of Superior Court

T CHAUDHRY
NOTARY PUBLIC
MY COMMISSION EXPIRES MAR. 31, 2015

My commission expires:

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: CT-FAMILY CARE SERVICES, LLC

Contact Person: Justinian Rweyemamu, MA, M. Div, MS-MFT, PhD student & AAMFT Approved Supervisor Candidate, **Founder & President.**

Contact Person's Title: Same as above

Contact Person's Address: 16 Enfield Ave, Enfield, CT.06082

Contact Person's Phone Number: 860-508-8651

Contact Person's Fax Number:

Contact Person's Email Address: **rweye@cox.net**

Project Town: ENFIELD and MANCHESTER

Project Name: CT-FAMILY CARE SERVICES, LLC

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

Estimated Total Capital Expenditure: $1, 843,100.00

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

*a. **Please provide a narrative detailing the proposal.***

INTRODUCTION: CT-Family Care Services, LLC is a minority owned and certified consulting company based in Connecticut. It was established and registered in Connecticut in July 2007. CT-Family Care Services is composed of seasoned professional social workers, therapists, teachers, psychiatrists, registered nurses, human rights advocates and administrators who are knowledgeable with different cultures. Some professionals are multi-lingual who speak several languages including the African languages, Swahili, English, Spanish, Italian, and French (The Logic Model Guide for CT-Family Care Services, LLC, 2008)

Through collaboration and partnership with clients, communities and agencies, the company is dedicated to serving the minorities, and low income population who are underprivileged medically, economically and social-culturally in order to reduce and overcome health and economic disparities in Connecticut as presented by researches and Connecticut Department of public Health (DPH website 2012, Healthcare for Connecticut's underserved population 2011, Connecticut's multicultural health 1999).

The company provides integrated treatments which are embedded with strong Academic-Social-Cultural-Emotional-Spiritual-Economic-Relational(ASCESER) components and therapeutic treatments which systemically decrease:

- ***high school dropouts,***
- ***poor academic performances***
- ***delinquencies and imprisonment***
- ***substance uses among students at schools and in their families***
- ***irresponsible parenthood and family dysfunctional relationships that affect children's behaviors, and their safe environments***

The above integrated treatments increase

(1) Positive coping skills in many ways of life (in day to day life)

(2) Behavior improvements at school, home and in community

(3) High academic achievement at schools

(4) Number of students who graduate from high schools with diplomas

(5) The number of students who have been prepared for colleges and careers or both

(6) Skilled productive citizenships in communities

(7) Productive alternatives to incarceration and family/community transformation

(8) Inmates with positive community-re-entry qualifications before and after their discharge from prisons.

(9) Ability to overcome or avoid factors that lead to school dropouts, illegal behaviors and incarcerations among children, students, minorities and from low income families.

10. Understanding marital, couples, or partners relationships in order to enhance couples and families' wellness as well as success.

The goal of CT-Family Care is to provide integrated systemic treatments needed in combating high school dropout, substance uses, delinquencies, poverty, and mental health issues and improve academic performances at schools as well as academic excellence so as to enable potential high school dropouts change course and go to four years colleges or community colleges or embrace meaningful careers or both. CT-Family Care will also prepare underprivileged youth, and families with job training and in a special way, provide integrated treatment to students, adults and families in order to enhance their coping skills, prevent or reduce mental, economic and academic crises and trauma patterns that seem to dominate among minorities and low income populations (Connecticut Department of Public Health on Health Care Disparities for underserved population-website-2011, Hynes 2011). In addition, the company will foster their workforce skills

and cultivate the spirit of self reliance so as to enable them to become productive members in their respective communities and sustain their successes.

CT-Family Care will achieve those goals through its intensive integrated treatment programs and services (Attached-Appendix #1: Organizational Chart with programs and Services). Those integrated services will be implemented in close partnerships and effective collaborations with stakeholders such as: Clients, parents, families, schools as well as Federal and State agencies such as the Department of Public Health(DPH), Department of Children and Families (DCF), Department of Social Services (DSS), Department of Mental Health and Addiction Services(DMHAS), the Department of Education (DE), Department of Correction and Connecticut Juvenile Court System, Department of Veteran Affairs(VA) and Private investors and towns or communities where the company provides services(attached-Appendix # 2 are copies of certification at Federal and State level).

(b) Selected Towns for services: The company has offices in Enfield and Manchester in Connecticut because in those towns, the communities have a good number of minorities and low income population and consequently, health problems are more common among them (Multicultural Health: The Health Statues of Minority groups in Connecticut, 2000). By using an intensive multi-social-cultural approach, CT-Family Care provides integrated academic and behavioral treatments, cross-cultural education, coping skills enhancement leading to high academic achievements, behavioral improvement of students and sustainable healing as well as job embracement for individuals, groups and families in communities (Jezewski, Sotnik 2001)

(c) **Category of Services provided**: The Company provides integrated professional services in the following categories:

1. **Mental health**: Integrated and personalized in-home and in-clinic counseling and **therapy** provided by experienced clinicians, both graduates and licensed Marriage and Family Therapists (MFT's). Potential clients are couples, children, students, individuals and families.

2. **Social Services and Care**: Home Healthcare and Social Services are provided in home by licensed and experienced Social Workers, Certified Nursing Assistants (CNA) and Licensed Practical Nurses (LPNs) to support residents. The goal of these services is to help individuals live comfortably, safely and independently in their homes with professional care and supervision from CT-Family Care Services, LLC. The company has well trained MFTs, Social workers, and Nurses that support seniors and families at this unique stage of their life with emotional well being, healing and growth with a caring, respectful and holistic approach.
3. **Youth with Academic and behavioral enhancement needs:** CT-Family Care Services is focusing on working with school age youths and their families that have specific risk factors such as delinquency, problematic behaviors, school dropouts and dysfunctional family dynamics that are affecting their education and community life.
4. **Services for Veterans and their families.** While veterans continue to offer great sacrifices within the United States and overseas, especially now in Iraq and Afghanistan, veterans as well as their family members, especially their children are being affected with academic, behavioral and mental health issues. The children suffer from the absence of either one or both of their biological parents, who are far from them for a length of time. In addition, often veterans and their families are affected by Post Traumatic Stress Disorder (PTSD), consequently CT-Family Care Services provides customized, integrated therapeutic treatment and social services to veterans and their families in the area.
5. **Refugee and Immigrant Resettlement.** Refugees and Immigrants receive cross-cultural counseling services and job training. Studies and experience with Refugees' resettlements in New England indicate that, minority refugees encounter more hardships in adjusting to American culture even when they have talents. By supporting them through this transition and into the workforce, they contribute greatly to Connecticut economy and cultural diversities.

6. **Job Training and Readiness**. CT Family Care Services provides wrap-around job readiness services to its clients as needed.
7. **Community Re-entry and marital/family crisis:** Connecticut spends between $30,000 to 40,000 per year to keep one inmate in prison and there is no guarantee that once released, they will not commit another crime, and that is a heavy burden to taxpayers. CT-Family Care Services provides intensive, integrated treatment needed in order to rehabilitate them and enable them to have positive outcomes while becoming productive members of our communities.
8. **Integrated Research Team**: The research focuses on treatments in order to find out how best to enhance clients' systemic recovery in a social-cultural context. It is purported that currently there is insufficient clinical researches on cultural competencies in healing mental health problems related to treatment of students, families, seniors, retired professionals and minorities. This research benefits all of those clients as well as mental health and government institutions on how to enhance positive treatment outcomes for those populations.
9. **Substance abuses prevention and treatment**: The misuse of alcohol and drug abuses among students, youth and adults seems to be another major Federal and State mental health challenges in the United States. In Connecticut, the survey among High schools students between 2007 and 2008 indicated that 46% of Connecticut high schools students reported using alcohol, 23% using marijuana, 21% using tobacco, 4% of cocaine, 10% of Heroin, and those misusing the prescription drugs (CT School Health Survey, 2008). The bio-medical approach remains a traditional approach in treating alcohol addiction symptoms and not treating the real problems which are yet hidden. Integrated therapy that CT-Family Care presents will treat both, the symptoms and their hidden causes in family-social-cultural contexts.
10. **Violence prevention:** Through integrated therapy, academic and coping skills enhancement and treatments, individuals will be enabled to identify triggers for their anger and violence, manage

them in order to enhance positive solutions for their needs and resolve conflicts without any harm to self or others in society.

2. Clear Public Need

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

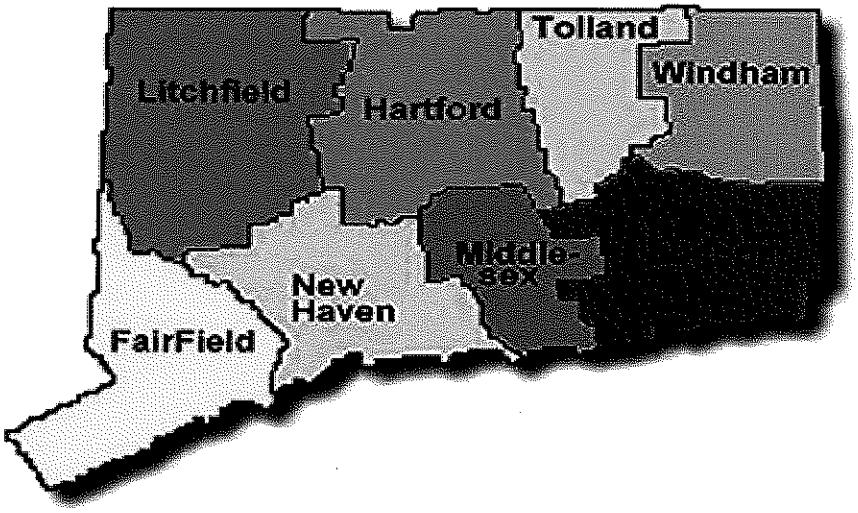
i. **The rationale for choosing the proposed service location**;

In Connecticut, CT-Family Care Services, LLC has offices in Enfield and Manchester because in those towns there are great needs for integrated treatments and expertise for the underserved population in order to prevent the following: **School dropouts, delinquencies, problematic behaviors, poverty, marital or relational crises, trauma, substance abuses, mental illnesses in families and dysfunctional family interactions that affect children and family members. In addition, as a minority owned company that is appreciative of the cross-cultural values, the company provides a bridge for evidence-based researches in multi-cultural treatments in mental health sector for the underprivileged population in order to enhance and sustain their good recovery, and success in Connecticut.**

In Connecticut, minorities have complex medical, economic and mental health issues including inabilities to access medical care. Clients that have medical issues such as Asthma, lead poisoning, tuberculosis and AIDS which seem to be more common among minorities (DPH website 2012) will be provided with integrated therapy and referred to nearby medical hospitals for medical treatments. CT-Family Care will continue to serve as a bridge in reducing those gaps especially through its cross-cultural therapeutic expertise and family therapy as well as **mental health treatments** as **diagnosed in the** Diagnostic and Statistical Manual of Mental Disorders-2012 (or DSM-V-2012) or in a later revised version.

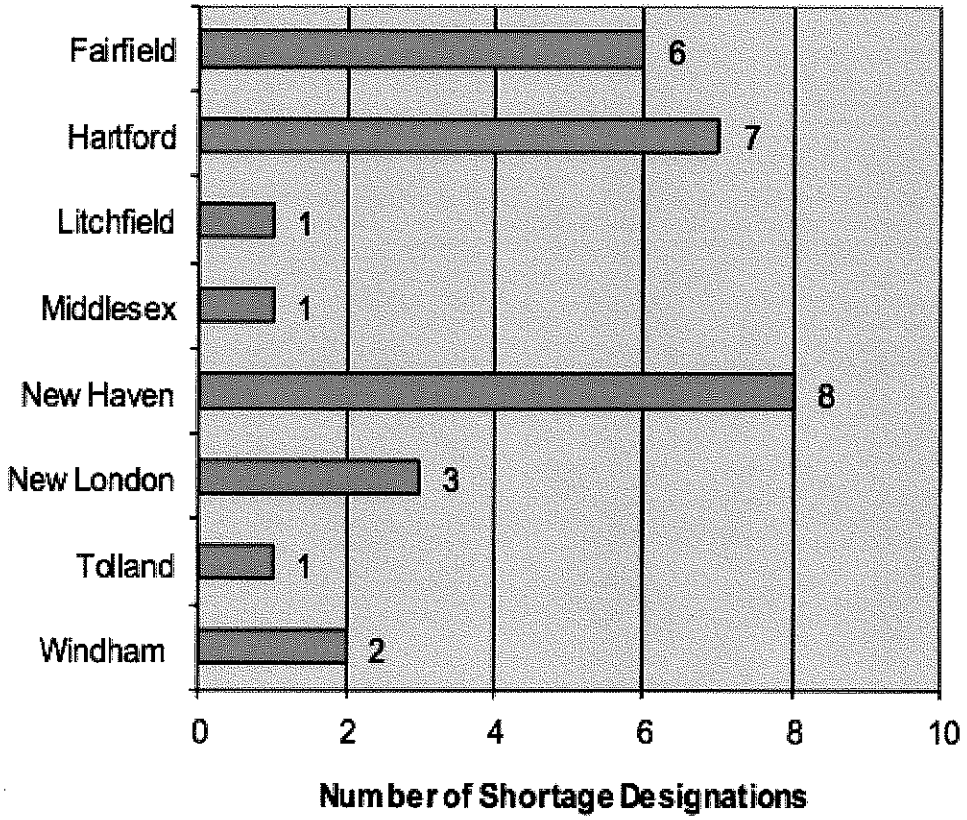
Integrated treatment approach: All those integrated treatments will be embedded with strong Academic-Social-Cultural-Emotional-Spiritual-Economic-Relational (ASCESER) components and behavioral treatments systemically in order to reduce and prevent the epidemics of

high school dropout, lower academic performances, delinquencies, substance uses and behavioral problems among students and families, especially minority students and white students from low income families in Connecticut, starting with Enfield and Manchester where the company has offices. The towns of Enfield and Manchester belong to **Hartford County** which has a significant number of the underprivileged population. Below are counties in Connecticut.



The map above shows Connecticut's counties (Health Care for Connecticut's underserved population-DPH-2011) and the following diagram show the shortages of professions for the underserved population (DHP website- underserved population 2011)

Figure 1. Number of Medically Underserved (MUA/P) Shortage Designations by CT County, October, 2011



(Health Care for Connecticut's underserved population-DPH-2011)

Selected Towns: in Connecticut (1) **TOWN OF ENFIELD,CONNECTICUT:**

CT-Family Care Services, LLC company was founded in 2007 in Enfield which in 2010 had a population of 46,880 of which 88.32% were white, 5.27% black,1.32% Native Americans, 3.74% were Hispanic and 1.19% for others (ww.enfield.ct.gov. filestorage 91/127). The big group of population in Enfield that was not included in the above data is the group of prisoners. The town of Enfield has six State prisons which are overcrowded with the greatest population of minorities and low income residents from different parts of Connecticut. When students drop out of school due to various reasons, research indicates that a good number of them end up in jails (Sum 2009).

Population Counts by Facility
As Of January 1, 2012

Facility	Sentenced	Accused	Total
Bergin CI	0	0	0

Facility	Sentenced	Accused	Total
Bridgeport CC	189	572	761
Brooklyn CI	466	14	480
Cheshire CI	1,452	36	1,488
Corrigan-Radgowski CC	1,206	453	1,659
Enfield CI*	734	12	746
Garner CI*	429	214	643
Niantic Annex	548	12	560
Hartford CC	313	864	1,177
MacDougall-Walker CI*	1,704	421	2,125
Manson YI	313	229	542
New Haven CC	152	634	786
Northern CI*	284	74	358
Osborn CI*	1,835	174	2,009
Robinson CI*	1,439	37	1,476
Webster CI*	0	0	0
Willard-Cybulski CI*	1,146	20	1,166
York CI	745	301	1,046
Total	12,955	4,067	17,022

CI=Correctional Institution.
CC=Correctional Center.
YI=Youth Institution.
VA=Virginia.
(Department of Correction website 2012)

Institutions with a * mark (above) indicates that they are within Enfield town or in the next towns of Somers, Windsor and Suffield which are not far from other prisons in Enfield. Thus, the company plans to provide services to eight state prisons within or around Enfield. According to the report by Connecticut Department of Correction (DOC), Connecticut had about 17,022 inmates in prisons as of January 2012, Connecticut taxpayers pay about $ 33,707. 45 (Department of Correction website- Annual budget 2009) per year to keep one inmate in jail and more often there is no assurance that after an inmate has been discharged from prison, he/she will have been entirely rehabilitated and that he /she would not violate the laws and go to prison again. Often, repetitive law violation leads to a cycle of incarcerations, poor quality of life, low education achievements and low economic income. There is a need for a change. CT-Family care services plans to provide integrated treatments for effective community re-entry to about 1,200 inmates annually from Enfield Prisons. Due to all those facts, CT-Family Care Services plans to continue playing a vital role in rehabilitating and treating inmates who are underserved in order to become positive,

productive and successful citizens. This will be another step towards overcoming health and economic disparities among the underprivileged population in Connecticut (DPH website-2012).

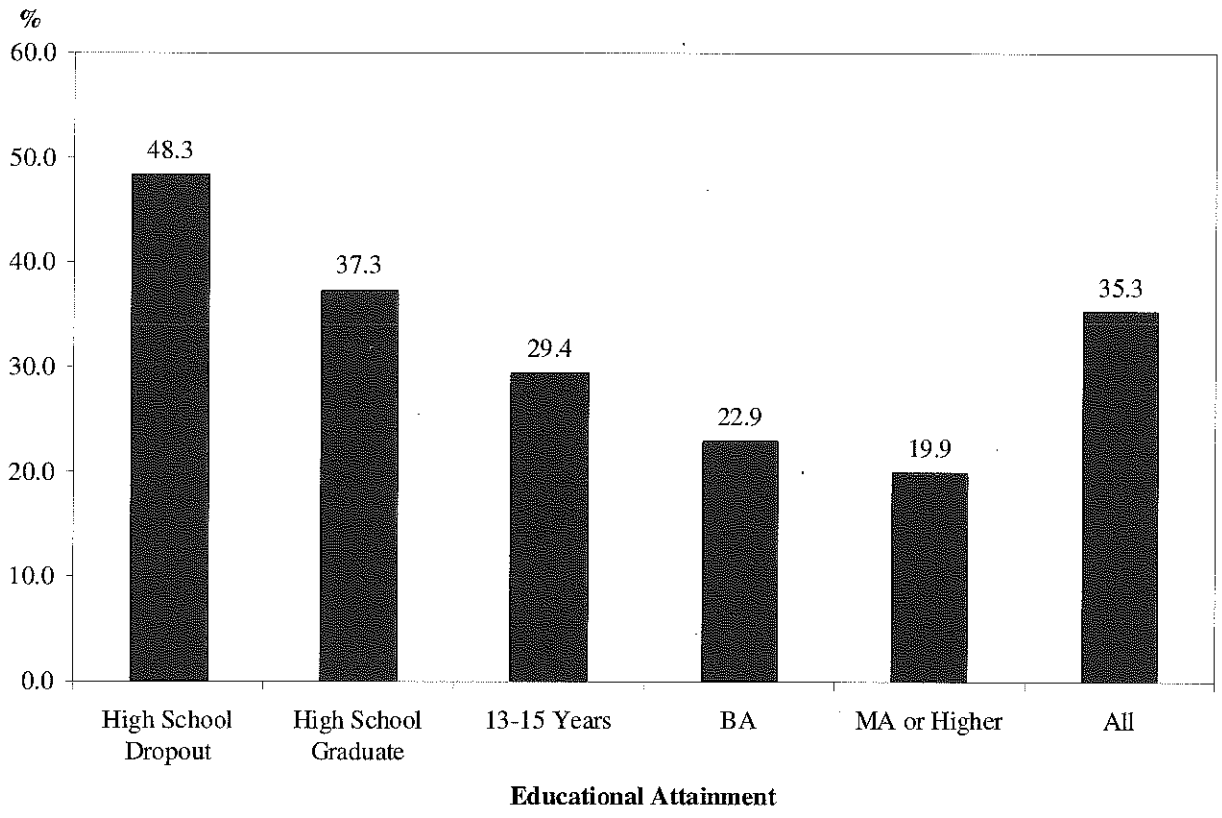
Race/Ethnicity and Gender. For many years, Connecticut Prison systems have been over crowded with minority youths and low income population. This disparity can be traced all the way back to delinquency cases and admission referrals, where minority overrepresentation is also apparent (Meadows, Pearson, Land and Lamb (2008). Thus, Complex issues need multi-faceted solution like the one that CT-Family Care is presenting. The company provides the integrated treatment to partners, families or key supportive friends of those inmates in order to enable the ex-prisoners to have strong supporting systems in their families and communities once they leave prison systems and end the cycle of violence, poverty and re-imprisonment. It is most certainly that many children from minority and low income populations are missing one or both parents because of imprisonments. The company provides a rehabilitation program for both, ex-inmates and their families in order to heal their trauma and foster healthy family as well as its relational family structures that help parents embrace good parenting and success in life.

Some epidemic problems among underserved population:

Town of Manchester, Connecticut: *School* dropouts:

Introduction: According to the study titled "the condition of education in Connecticut, of August 2008", 16.6% (575,540) of the state population (3,405,565) were students enrolled in public schools, the State had 6.6% of high school dropouts (37,986)(Connecticut State Department of Education report (2008, p.2). A report to Connecticut's governor, summer summit in 2009 on the economic, social, civic and fiscal consequences of school dropout, pointed out that, school dropouts in Connecticut left many young people with insufficient competitive labor force skills needed, and a good number of school dropout ended up in prisons and on welfares, thus making a substantial number of Connecticut young generation with lack of sufficient skills and positive productivity as citizens(Sum 2009) who also create a social-fiscal burdens to the tax payers.

A need for an effective response: It is obvious that, Connecticut has a huge number of high school dropouts each year and that creates a social-economic –academic and lawful burden to families, schools, towns and the state taxpayers. High school dropout puts a huge unjust burden to families and to communities in Connecticut including the town of Manchester as demonstrated by Sum (2009) who highlights that government subsidies are correlated with individual's education and labor force skills. For Sum (2009) there was a correlation between high school dropout and receiving public assistance in the State of Connecticut where people are dependent on some form of cash which is a public assistance in the following chart below (Sum 2009).



CT-Family Care Services offers an effective response:

CT-Family Care Services treatment plan and services offers customized social-cultural treatments in therapeutic and academic treatments as well as through social services that enhance

clients' coping skills, healthy family dynamics and recovery with less cost (The Logic Model Guide for CT-Family Care Services, LLC, 2008, CT-Family Care Services, LLC Business Plan 2010)

Consequently, CT-Family Care through its services will benefit students, families and their schools as follows.

FOR STUDENTS:

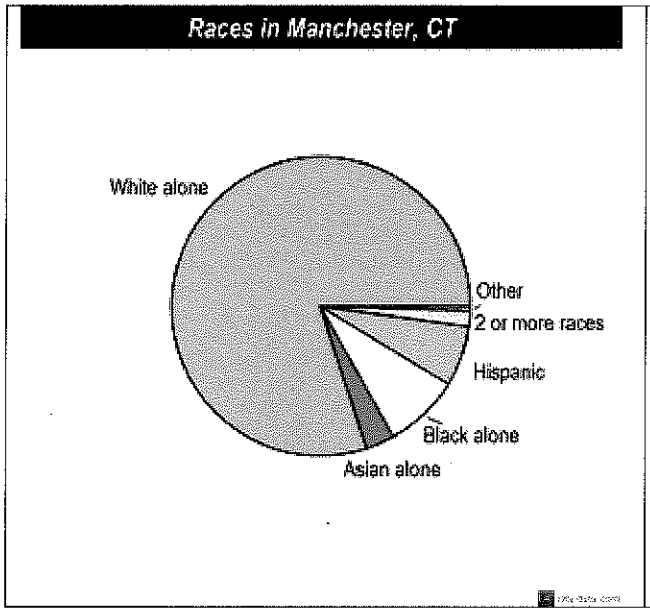
1. 76-87% of students, who will complete the treatment program, will most probably have high academic performances and good behavioral change; hence will likely opt to proceed with college education. College education will be pursued at community colleges or at four year colleges. Students, who will attend Colleges in Connecticut, will continue being monitored by CT-Family Care Services, and support them during their first school semester so that they will be able to maintain their morale and thus stay in colleges.
2. 20-12 % will likely have high academic performances and improved behaviors. This group will presumably choose to pursue careers immediately instead of opting for college education. The agency will also provide integrated counseling to those new first time employees for the first four months at their job sites so that they will be morally encouraged and supported during their transitional experiences.
3. 1-2% this group will likely participate actively in the program and will graduate, but they will most probably refuse to proceed to college education or to any career-related options after completing treatments.

FOR FAMILIES

- 76-87% of students' parents or families, who will participate actively in family therapy and complete the program, will achieve a sustainable recovery and improvements in their family interactions and hence overcome their undesired behaviors that affect their children.
- 24-13% families, who will participate actively and complete the program will attain enhanced coping skills in order to overcome their constrains. In conclusion, CT-Family Care

Services seeks partnerships with stakeholders including families, schools, private investors, and Federal and State agencies in reducing the rate of health and economic disparities among the underserved population(CT-Family Care Services, LLC Business Plan 2010-14)

FOR THE TOWN OF MANCHESTER, CT: School dropouts seem to be common among minorities and low income population. The town of Manchester has the population of about 56,388 and that was 3% increase from the 2000 census when the town had the following population shown below (city data.com/Manchester).



- White alone - 43,820 (80.1%)
- Black alone - 4,430 (8.1%)
- Hispanic - 3,579 (6.5%)
- Asian alone - 1,713 (3.1%)
- Two or more races - 951 (1.7%)
- Other race alone - 144 (0.3%)
- American Indian alone - 85 (0.2%)
- Native Hawaiian and Other Pacific Islander alone - 18 (0.03%)

(http://www.citydata.com/city/Manchester-Connecticut.html)

The town of Manchester has 6,800 public school students from ten elementary schools, one sixth grade academy, one middle school, one regional academy, one alternative education program, as well as one high school(town website-retrieved May 2012).

In relation to school dropout, Manchester high school reports that, it has about 1.4% rate of school dropout (Manchester High School website retrieved May, 2012). There has been an ongoing debate in Connecticut which shows that, the rate of school dropout is much higher in Connecticut schools. In that light, Connecticut Commissioner of Education, Mark K. McQuillan was able to state that, when interpreting the data, that each school district collects its own data which is unaudited, it is important to keep in mind that when we talk about school dropout race, ethnicity,

disability, attitude of some professionals, cultural competency and dominant culture's politics matters holistically (Connecticut Department of Education, 2008).

Manchester High School: Recent studies indicate that the dropout epidemic disproportionately affects young people of low-income, children of single parents, or certain minorities (Balfanz, Fox, Bridgeland & McNaught (2009). While Manchester High School has a total of 1,978 students, 47.6% or 942 are minorities and 52.4% or 1036 are whites (Manchester High school website 2012). Studies indicate that in Connecticut, students of color, males, and students with disabilities are more suspended and removed from school, resulting to lower academic achievements and the risks of school dropout (McQuillan 2008). In that regard, CT-Family Care is committed to taking active roles by working with students and their families, schools and State in utilizing better alternative to prevent school dropouts and enhance academic achievements.

Poverty affects learning: The following figure below indicates that, Manchester High school has a higher rate of students from low income population, as a result, students' lunch meals are subsidized or provided at a much reduced prices. CT-Family Care Services is more focused on high school students, especially those who seem to be more exposed to school dropout symptoms, problematic behaviors as well as some academic challenges.

INDICATORS OF EDUCATIONAL NEED AT MANCHESTER HIGH SCHOOL 2009

Need Indicator	Numbers in school	Percentage in school	High schools	
			% in DRG	% in State
Students eligible for free/reduced priced meal	843	42.6	29.7	27.9
Students –not affluent in English	70	3.5	2.2	3.6
Students who are identified as gifted	127	6.4	5.0	5.1
Students with disabilities	226	11.4	11.5	10.6
Students working 16 or more hrs weekly	152	16.4	14.8	13.6

(Adopted from Manchester High school website-retrieved May 2012)

CT-Family Care Services offers:

(A)Integrated systemic assessment of the problem:

According to the study by the National Women's Law Center & Mexican American Legal Defense and Education Fund(National Women's Law Center & Mexican American Legal Defense Fund or NWL & MALDF, 2009), there is an astounding link between disciplinary, academic problems and dropouts and that "Latino students are more likely to be suspended or expelled than White students and to be retained a grade"((NWL & MALDF 2009, p.15). Those facts indicate that in order to prevent high school dropout, its root-causes and causes have to be diagnosed systemically in a social-cultural-educational and economic context that affect students and their families. In relation to high school dropout, environments, race, economic and ethnicity seem to play a great role.

(b) Some educational challenges are systemic:

While educational institutions have done many accomplishments in educating children from high economic status as well as the underprivileged children, some studies suggest that, educational institutions have always not identified and addressed students' symptoms which lead to school dropouts accordingly (Dynarski, Clarke, Cobb, Rumberger, Smink, Hallgren and Gill (2008). High school dropout is a real problem which affects real people at individual, family, local, State and national levels. When the high school dropouts were interviewed why they left school, about 70% indicated that they left because they were not motivated to work hard and 2/3 of the interviewees said that they would have worked hard if they would have been asked and assisted, 1/3 of the interviewees suggested that they left because of personal reasons such as to get a job, a desire to become parents and support a family member, and another 1/3 indicated that they dropped out of school because they failed academically in school(NWL & MALDF 2009)

In a national wide study, 80% of those dropouts stated that they would have stayed if classes had enhanced their active participation, addressed students' needs and prepared students for real life. Dropout relates to attendance, credits, credit accumulation, age and withdrawal. Often schools

use credit scores to group students into three determinant paths or different tracks (NWL & MALDF 2009, p.25).

(a) **Lower scoring track**. This group includes minority students and students from low income families. Such tracking prepares the feeding ground-for high school dropout and lower-unskilled labor that ends up with minimal wages or unemployment. Once students are placed in this category, teachers do not do much systemically in order to assist them to improve their grade scores, and as a result, students develop low self-esteem, they look at themselves as unable to go to college. Most of the time, students from this group have insufficient support from schools and their dysfunctional families and they end up with dropping out of schools, getting low-skilled jobs, lower wages as well as experiencing unemployment and imprisonment. According to the census in 2006, the annual income for a high school dropout was estimated to be around $ 17,299 compared to that of a high school graduate within the same year as $ 26,933 in 2005 (Sum 2009).

(b) **The second category of students is based on their higher scores**. Students and their families are motivated, engaged and assisted in ways that prepare them to go to college. Dynarski, Clarke, Cobb, Finn Rumberger, Smink, Hallgren and Gill (2008) state that, engagement involves active participation in learning and school work as well as in the social life of school by students, families and school team. This group of students has better labor force skills and able to own homes.

(c) **The third group is for those who have the highest academic scores and are prepared to go to the Ivy League schools like Yale University and the like**. The current educational system has strong elements of being a catalyst that nurtures the high school dropouts' crisis especially among the underserved population. That also can be one of the reasons why integrated educational reforms with strong therapeutic components through social-cultural-educational treatments in context are needed urgently as a best alternative to combating the high school dropout among students who have lower academic scores, especially those from low-income

families as well as those who have problematic behaviors including delinquencies. Other reasons why students drop out of a high school include: life events such as pregnancy, behavioral problems, incarceration, foster home replacement, poverty and family crises (to be referenced).

Some policies and practices promote the increase of school dropout too. According to Balfanz, Horning Fox, Bridgeland, and McNuaught some of these policies focus on attendance, retention, promotion, and grading. All of those encourage students to dropout or to choose the GED options as an alternative to completing high school (Balfanz, Horning Fox, Bridgeland, and McNuaught 2009). Research suggests that GED is not the same as a high school diploma. Students who graduate with a GED are often paid less than students who have graduated with a high school diploma. It is estimated that over one million students who enter the ninth grade every year, do not graduate from a high school on time with a regular diploma.

Even though male students are dropping out of high school, the rate of female students who drop out of school is at a more disturbing rate and female students of color are at a particular risk (Balfanz et al 2009). The national educational association recommends for a whole school reforms nationally, and appeals for organizational structured reforms that make school more personalized, encourages better curriculum assessment reforms, leadership reforms, and professional development region (Balfanz et al 2009).

More recommendations to preventing the high school dropout include: Enhancing the diagnostic process for identifying schools and students who have dropout problems, adopt an accurate data system showing who drops out and their specific situations, introduce targeted interventions for middle and high school students who are struggling at school due to behavioral and academic challenges, foster reforms in schools to increase engagements for all students and prevent dropout, personalize school environment and increase a sense of belonging and at the same time, provide students with a meaningful learning that can motivate them to go to college and seek better job careers as well as use adults professionals to help students with their school work and

establish attainable goals (Dynarski, Clarke, Cobb, Finn Rumberger, Smink, Hallgren and Gill,(2008) In addition, it appears that high school dropout crisis is caused by various systemic factors and hence, there is a need for a systemic response for sustainable solutions. The assessment recommendations provided above are certainly on the target and need to be implemented.

Yet, those recommendations and the current ongoing responses to solving the problem lack an integrated treatment which has a strong social-cultural-academic-spiritual-emotional and economic components needed to enhance the coping skills of targeted individual students and their families in a social-cultural context that enable students who have symptoms of dropping out to stay in school, improve their behaviors and elevate their academic performances to excellence.

CT-Family Care Response: Involve and motivate families' participation.

Often students who have dropout and mental health symptoms come from dysfunctional families whose interactions among family members tend to affect students' abilities in schools and in the society. Thus, there is a need to include family members especially parents, guardians, teachers, spiritual leaders and significant others in supporting personalized integrated treatments for students, in their social-cultural-academic and economic arena that heal and produce the positive results for sustainable success.

Lack of healthy integrated and appropriate coping skills manifests or some of the hidden causes that fuel the symptoms of high school dropouts such as trauma, bullying, poverty and other mental health issues in a social-cultural context. CT-Family Care will continue to address the underlying issues identified above that have been suppressed (McGoldrick, Giordano,& Garcia-Preto, 2005), but have really affected minorities and white students from low income families. In that way, the company treatment response bring HOPE and SUCCESS to thousands of students in Enfield, Manchester and to the neighboring towns such as Windsor, East Windsor, East Hartford, Vernon and Ellington where they have a good number of underprivileged populations who will most likely come to CT-Family Care Services' centers for treatment.

B: CT-Family Care services projects that some of those students will have both parents while others will have single parent. The company fosters collaboration with parents, schools and teachers for effective team work in order to prevent school dropout and increase academic performances. This program is an **outpatient** program whereby students, parents or guardians undergo therapeutic treatment in the afternoon after regular school hours or in the evening and weekends in order to strengthen students' school performances. From treatment perspective, the company clients includes students and their families who are referred by a state agencies, families, schools or juvenile court systems who have symptoms of high school dropout, poor academic performances, delinquencies, substance uses, ADHD, ODD and problematic behaviors, relational and marital crisises as well as trauma among youths and families (Diagnostic and Statistical Manual for Mental Disorders-DSM-IV-TR)

(2) **Problematic behaviors**: Another challenge affecting Manchester schools as well as other schools in Connecticut is problematic behaviors. During the period of 2008-2009, Manchester High School had a significant number of problematic behaviors at school as shown in the following diagram from the Manchester High School website 2012.

Number of Incidents by Disciplinary Offense Category, 2008-09		
Offense Category	**Location of Incident**	
	School	**Other Location**
Violent Crimes Against Persons	1	0
Sexually Related Behavior	1	0
Personally Threatening Behavior	31	0
Theft	13	0
Physical/Verbal Confrontation	78	6
Fighting/Battery	20	1
Property Damage	6	0
Weapons	7	7
Drugs/Alcohol/Tobacco	11	8
School Policy Violations	1,169	132
Total	1,337	154

A school with a total of 1978 Students, having experienced a total of 1337 delinquent incidences at school in one year, suggests that some other underlying factors including bullying and trauma are unfortunately not addressed above. Research suggests that Students who say that their families provide them with love and support are approximately 30% less likely to drink alcohol, binge drink, have sex, become bullies or depressed. Students with supportive families are 50% less likely to smoke cigarettes, experience dating violence, bullying or smoke marijuana, and are five times less likely to report having attempted suicide (McQuillan 2008). McQuillan also noted that "students' health is inextricably linked to academic success and it is vital that schools, families, institutions and communities should support students in making healthy and responsible choices (McQuillan, 2010)

(3) **Bullying**: As bullying continues to be one of the major challenges affecting students in schools and in communities, studies show that bullying has effects on students at schools and on their families (Butter & Anna Lynn Patt, 2008). While, bullying is destructive to families, its treatment solution demands effective collaboration between schools and families (Ahmed & Braith Waite, 2004). Some studies suggest that weekly, over 1.7 million students report being bullied (Butter & Patt, 2008). On July 13, 2011, Governor Dannel Malloy signed into law Public Act 11-232, An Act Concerning the Strengthening of School Bullying laws in order to foster safe learning environments and prevent bullying in Connecticut.

On June 12, 2008, Governor Rell signed into law a measure that strengthens state and local efforts to prevent bullying at school (Connecticut Commission on Children, http://www.cga.ct.gov/coc/bullying.htm)., still bullying remains a threat to safe school environments even in Manchester. One in four students in Connecticut said they had been bullied or harassed during the past 12 months, with 9th graders being more likely (35%) than 12th graders (18%) to have been bullied(to be referenced). Students who say they have been bullied are more likely to get less sleep, have property stolen at school, miss school because they feel unsafe, carry a

weapon to school, experience dating violence, be depressed and attempt suicide. While bullying is more common among male students aging between 10-14 years old, studies suggest that families contribute in cultivating the seeds for bullying as follows:

1. Lack of healthy power balance between parents: Bullies perceive their fathers as having more power than their mothers(Bowers, Smith & Brinney 1992)
2. Students who bully others, tend to have parents who are stricter in giving punishments or parents who have hostile environments to each other, including domestic violence(Olweus, 1980)
3. Bullies are raised in homes of authoritarian parents(Smith & Myron-Wilson 1998)
4. Parents of bullies tend to be punitive and harsh towards their children and they demand "blind obedience" from their children
5. Bulling is derived from family environments in which parents lack good parenting skills and their families have the following characteristics
    - Unhealthy parental discipline
    - Lack of adult supervision
    - Lack of positive adult role models
    - Teasing about appearances

    (Melissa, Powel & Dadd, 2010)

Effects on Bullying:

In relation to effects of bullying, it is believed that

- Bullying is more common among elementary and middle school age students, but such behavior tends to decrease as teens grow up through high schools to young adults(Dublin, Fitzpatrick, & Piko, 2007)
- Physical bullying is more done by males(direct bullying) and spreading rumors(indirect bullying) is more likely done by females(Peskin et al,2006)

- Both direct and indirect bullying lead to negative consequences which affect students, families, communities or a nation. For examples: school shooting at Virginia tech in 2007), Red lake High in CA 2001, Santana High, CA 2005, Columbine High Littleton, CO in 1999 (Butler & Platt, 2008).

Intervention derived from research outcome and evidence based for Schools in Manchester and its neighborhoods: Recent studies indicate , individual and family therapies have proved to be very effective in addressing and preventing bullying by rehabilitating and healing its roots within and outside schools among adolescents (Butler &Platt 2008, Powell & Ladd (2010), In addition, the same studies point out that the combination of some therapies such as solution focused, narrative, and structural/ strategic approaches are effective in helping both the bullies and the victims. CT-Family Care Services will continue working with families, schools, students and the communities in Manchester and in the neighborhoods in order to strengthen families and enhance healthy family dynamics and structures among family members, foster family caring structures collaboratively, as well as helping the bullies and the victims to enhance their self-esteem, coping skills as well as improving their academic performances.

Racism and Poverty reduction:

Studies indicate that institutional racism, school dropouts, mental health crises and poverty, impact significantly on the lives and wellness of African American, Hispanic families and White low income families. For example, in 2000, African Americans averaged just 66 % of the income of whites ($30, 439 vs. 45,904). Twenty-three percent of all African American families lived below the poverty line in 2001 compared with 8% of non- Hispanic Whites, and the unemployment rate for African Americans aged 16 and over was almost twice that for their White counterparts(11% vs5%)(Mickimon,2003). Disparities based on race continue to exist on a host of key quality of life indicators, including education, home and business ownerships, physical health, number employed in professional and managerial specialty occupations and others (McGoldrick, Giordano, Garcia-

Preto 2005, p.88) Those facts here are confirmed below in Connecticut's poverty rate by race/ethnicity.

Connecticut	Percent
White	8%
Black	25%
Hispanic	35%

(Connecticut's poverty rate by race/ethnicity (www.statehealthfacts.org).

According to recent report as of January 3, 2012, the rate of poverty increased in Connecticut. For example, poverty rate increased to 14% among white, 36% for Blacks as well 36% for Hispanic, with 23% others compared to the above poverty rate in the chart (Connecticut, Department of Public Health, Health facts: Minority health, 2012).Poverty in Connecticut is assumed to have significant effects among the underserved population in Manchester area even though there are no sufficient data at the State or Town webstate in that regard. Meanwhile, in Connecticut, the number of medical school graduates for Blacks were 8, 12 for Hispanics, 37 Asian and for white it was 91 (State Health facts: Minority health, 2012, p.1).

Due to the above poverty rate in Connecticut, a number of people on food stamps continue to increase. For example, Manchester has the following percentages of families below poverty line.

PERCENTAGE OF FAMILIES AND PEOPLE WHOSE INCOME IN THE PAST 12 MONTHS IS BELOW THE POVERTY LEVEL				
All families	(X)	(X)	5.5%	+/-1.2
With related children under 18 years	(X)	(X)	9.5%	+/-2.2
With related children under 5 years only	(X)	(X)	9.8%	+/-5.2
Married couple families	(X)	(X)	1.2%	+/-0.6
With related children under 18 years	(X)	(X)	1.4%	+/-1.0
With related children under 5 years only	(X)	(X)	1.1%	+/-1.5
Families with female householder, no husband present	(X)	(X)	19.1%	+/-5.1
With related children under 18 years	(X)	(X)	27.5%	+/-7.2
With related children under 5 years only	(X)	(X)	36.6%	+/-19.5
All people	(X)	(X)	8.1%	+/-1.1
Under 18 years	(X)	(X)	12.4%	+/-2.8
Related children under 18 years	(X)	(X)	11.7%	+/-2.7
Related children under 5 years	(X)	(X)	12.8%	+/-4.4
Related children 5 to 17 years	(X)	(X)	11.2%	+/-2.8
18 years and over	(X)	(X)	6.9%	+/-0.9
18 to 64 years	(X)	(X)	7.3%	+/-1.1

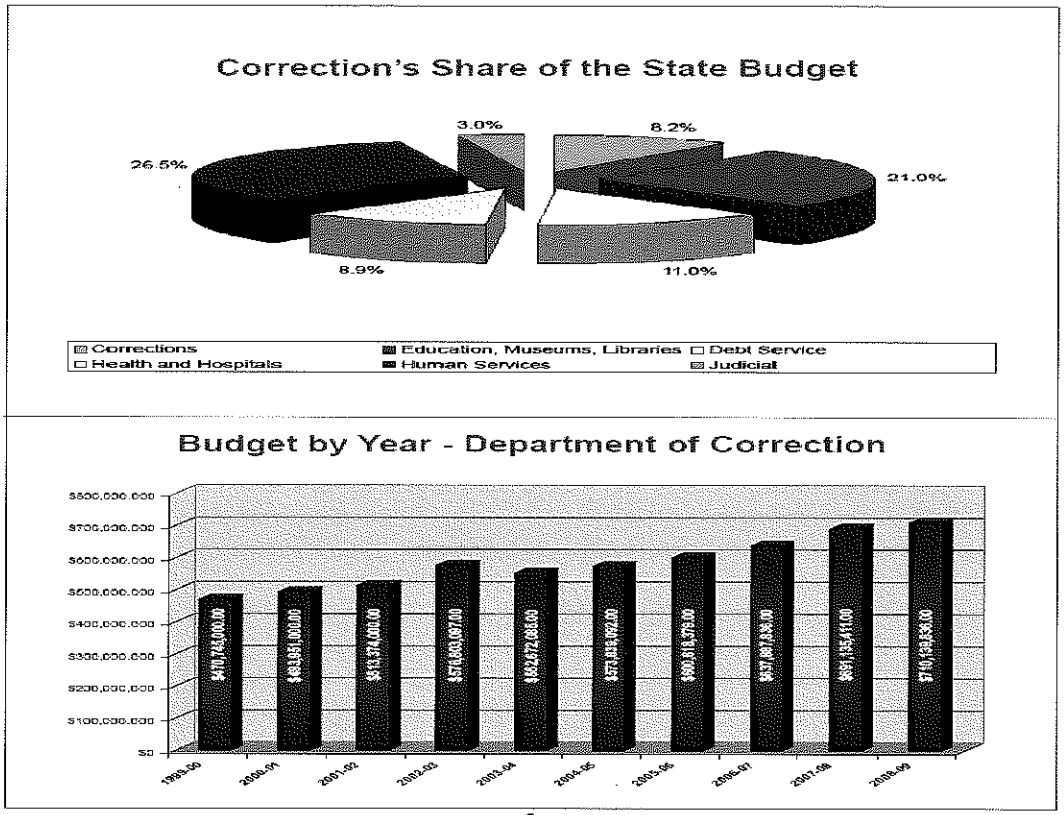
(Department of Economic planning, Manchester & US census 2012)

Therefore, CT-Family Care Services as a minority owned company is dedicated to reaching out to students, and their families in franchised communities with lower income, poverty, lower academic performances, incarceration cycles and other social-cultural-barriers.

Refugees' resettlements in Connecticut:

Another relevant experience is awareness of the needs of the refugees. CT-Family Care Services will also provide integrated services to refugees from Africa or other countries that have been granted settlements in Connecticut. Some of the CT-Family Care team members are natives of foreign countries who have become permanent and naturalized Americans; they share many life experiences with the refugees. Such encounters soothe their worries and provide hope. All of these will serve the body, mind, emotions, and spirit of the individuals in a social-cultural-spiritual context needed for healing and sustainable success. Therefore, CT-Family Care team has vital experiences, zeal and treatment model to treating some epidemic problems in Connecticut among refugees who also face many adjustment problems in their daily lives. When refugees and school dropout minority Americans are not assisted accordingly, some end up in jails and that affect taxpayers in Connecticut.

As of January 2010 Connecticut had a total of 18,053 inmates in prisons(DOC website, retrieved 6/20/010) and Connecticut tax payers pay $ 33,707.45 to keep an inmate in Jail (DOC website-retrieved 6/18/010).



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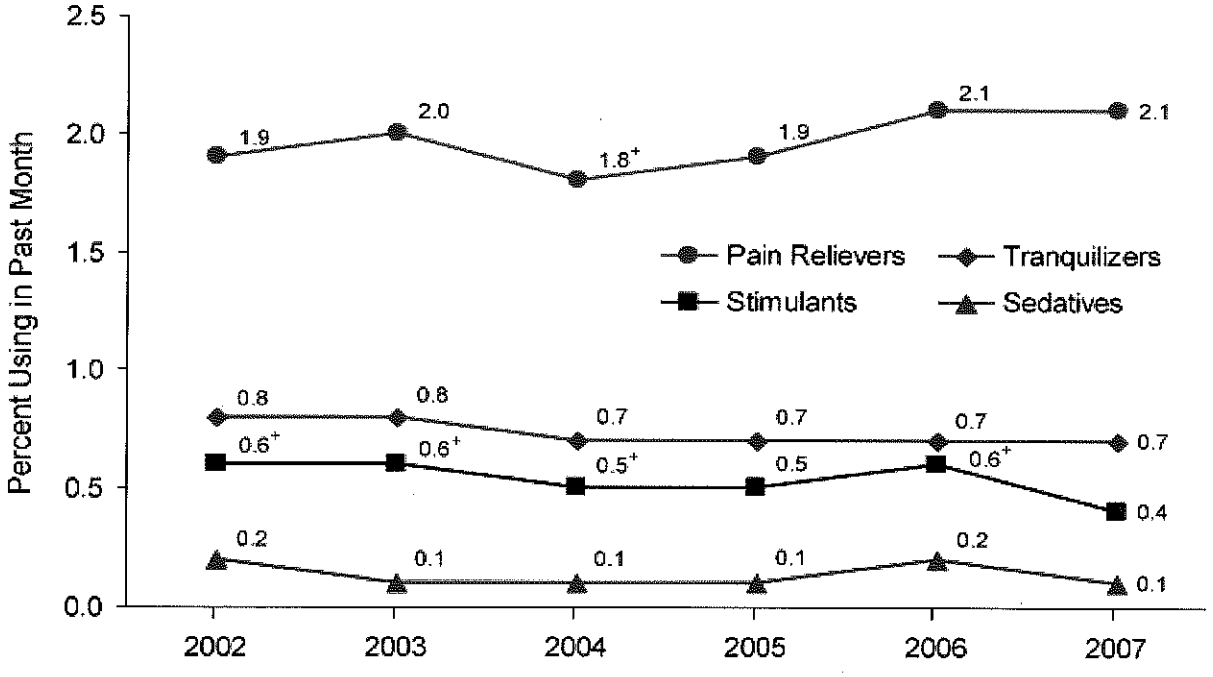
Hence, there is a need and a great relevance for CT-Family Care Services to offer an effective alternative treatment to students, families, refugees and inmates, for sustainable recovery in order to reduce some taxpayers' financial burdens shown above. CT-Family Care Services is committed to working with Federal, State agencies, private investors, schools, students and their families to ensure that its mutual goals are met and that the clients are served in a way that will enable them to sustain their self-determination, safety and positive relationships in social contexts for their well-being.

Substance Abuses:

The misuse of alcohol and drug abuses among students, youth and adults seems to be another major Federal and State mental health challenges in the United States. According to the US Department of Health and Human Services, alcohol is the most substance frequently abused by adolescents, followed by marijuana, cigarettes (tobacco) and other substances (DPH, Office of Adolescent health-2012). For example, between 2006 and 2011, the National Institute on Drug

Abuse (NIDA) funded a survey among 46,733 students from 400 public and private schools who were in the 8th, 10th, and the 12th grade, around the country. The survey points out that over 48% of all participants expressed that they had used alcohol and drugs, but regarding alcohol, there was a **declined** from 8.7% to 6.4% among 8th graders, 19.9% to 14.7% among 10th graders and 25.4% to 21.6% among high school seniors during the period of 2006 to 2011 and **an increase** on drug use especially marijuana for the 10th and 12th graders to 28.8% of 10th graders, and 36.4% of 12th graders respectively (NIDA website 2012).

The above national increase in using drug is also reflected in Connecticut where the survey among High schools students between 2007 and 2008 indicated that 46% of Connecticut high schools students reported using alcohol, 23% using marijuana, 21% using tobacco, 4% of cocaine, 10% of Heroin, and those misusing the prescription drugs (for example: Vicodin 10%, and OxyContin were 10% and 5% respectively within the last one month (CT School Health Survey, 2008). In addition, the research shows that in Connecticut there has been an addiction increase among high school students who are using pain killer drugs excessively as shown below (Drug use in Connecticut).



(DMHAS-website region. #5)

Any misuse of alcohol or other substances do have negative impact on the well-being of individuals and their families. For example substance misuse contributes to physical, mental, and health related conditions including earlier deaths (DMHAS website-Connecticut Alcohol and drug policy 2008). Connecticut is one of the sixteen States in the nation in which many people die from substance overdose than those who die from car accidents(Connecticut Department of Mental Health and Addiction Services-DMHAS, website-2012).Smoking cigarette is another addictive behavior among youths in Connecticut. The US Department of Health on Adolescent substance abuses in 2012, points out the following about Connecticut students and substance abusers.

% of high school students **age 12-17** who drank alcohol for the first time before age 13 years	For Connecticut 18%	For US 21%
Male	19%	24%
Female	16%	18%
% of high school students who had a drink a day before the survey	43%	42%
Male	43%	41%
Female	44%	43%
% of high school students who smoked cigarette 30days before survey	18	19
Male	19%	20%
Female	16%	19%
% high school students used marijuana	38%	37%
% H. school students used cocaine –last 30 days	3%	3%
Male	3%	3%
Female	2%	2%
% H .school students used pain killer	5%	7%
% of H. school students who wanted treatments but did not receive them	6%	6%

(Department of Health and Human Services substance abuse-Connecticut 2012).

Other studies indicate that the lack of access and poor utilization of available resources increase the amount of alcohol or substance abusers and that the five main areas of substance abusers area that seem to be more common are: Alcohol, Misuse of Marijuana, and Tobacco and Pain killer deduction. The misuse of alcohol and drugs has several mental and medical related effects. For example in 2010, 45.9 million adults in the United States aging from 18 years or older were identified having mental illnesses and 9.2% of 45.9 million people met the criteria of misusing the substances excessively or dependence compared to the 6.1% of the 45.9 million adults who did not have mental illnesses, but had addiction to alcohol or other drugs (www.samhsa.gov).

CT-Family Care Services, offers Integrated Therapy: This is a kind of treatment which is necessary to complement the traditional approach (bio-medical) to treating people with mental illness and alcohol as well as other substances uses. The bio-medical approach remains a traditional approach in treating alcohol addiction symptoms and not treating the real problems which are yet hidden. Integrated therapy that CT-Family Care presents will treat both, the symptoms and their hidden causes in family-social-cultural contexts.

Enhancement of unsatisfactory/wounded coping skills. Underneath symptoms for behavioral problems, including addiction to substance misuses, there are unsatisfactory coping skills. To foster a sustainable recovery, there is a need of assisting individuals to strengthen and enhance their coping skills by teaching them new ways of viewing and handling situations (Satir and Baldwin 1983). Sprenkle (2012), highlights some family therapy treatment models that have shown to be effective in treating alcohol and other substances. The Connecticut Family Care Services believes that by introducing intensive and integrated services in the treatment center, will promote various benefits such as enhancing coping skills, addressing the emotional needs of clients

and their caretakers, reducing preventable crises systemically at schools, in families, work places, and in communities and foster sustainable recovery form substance abusers.

Integrated Spirituality: There is a difference between spirituality and religion. All human beings yearn for spirituality such as love, dignity, respect, compassion, righteousness and a relationship with the divine. In order to strengthen individual's coping skills for sustainable success, the company incorporates spiritual values into its holistic treatments.

ii. **The service area: Towns and the basis for their selection**;

CT- Family Care Services, LLC has chosen to start offering services in Enfield and Manchester towns because of the following reasons: Both Enfield and Manchester have a good number of underserved population as well as other people that will benefit from CT-Family Care Services. According to research, the majority of underserved populations live in large cities such as Hartford, Bridgeport, New London and Waterbury (Health Care for Connecticut's Underserved population-PDH website -2011). As a result, more attention and assistance have been available to minorities and low income population in those cities than the underprivileged population who are scattered in small town like Manchester and Enfield. For example, Manchester which has a total population of 58,241 only 34,114 are in civilian labor force as shown below.

Civilian labor force	34,114	+/-629	34,114	(X)
Percent Unemployed	(X)	(X)	6.6%	+/-1.0
Females 16 years and over	24,373	+/-507	24,373	(X)
In labor force	16,371	+/-568	67.2%	+/-1.8
Civilian labor force	16,371	+/-568	67.2%	+/-1.8
Employed	15,472	+/-551	63.5%	+/-1.9
Own children under 6 years	4,423	+/-417	4,423	(X)
All parents in family in labor force	3,074	+/-363	69.5%	+/-5.5
Own children 6 to 17 years	7,503	+/-528	7,503	(X)
All parents in family in labor force	6,286	+/-517	83.8%	+/-4.1

(Fact Finder, American Community census-Survey 2010)

Traditional agencies, programs or services for the underserved populations often lack sufficient cultural competency and sensitivity, as a result; there has been a silent gap of miscommunication and mistrust between the underserved population and those agencies

(McGoldrick et al 2005). CT-Family Care services presents a treatment model that is integrative and renovetional which is embedded with social-cultural-spiritual-emotional-educational-relational and economic components in a cross-cultural context that enables clients' wounded coping skills to be healed in an energizing way with a positive sense of belonging and fostering recovery and success in a multicultural community like Manchester as shown below.

GEO: Manchester town, Hartford County, Connecticut

Subject	Number	Percent
RACE		
Total population	58,241	100.0
One race	56,239	96.6
White	41,585	71.4
Black or African American	7,152	12.3
American Indian and Alaska Native	183	0.3
American Indian, specified [1]	82	0.1
Alaska Native, specified [1]	0	0.0
Both American Indian and Alaska Native, specified [1]	0	0.0
American Indian or Alaska Native, not specified	101	0.2
Asian	4,627	7.9
Native Hawaiian and Other Pacific Islander	21	0.0
Some Other Race	2,671	4.6
Two or More Races	2,002	3.4
Two races with Some Other Race	533	0.9
Two races without Some Other Race	1,320	2.3
Three or more races with Some Other Race	39	0.1
Three or more races without Some Other Race	110	0.2
HISPANIC OR LATINO		
Total Population	58,241	100.0
Hispanic or Latino (of any race)	6,988	12.0
Mexican	344	0.6
Puerto Rican	4,782	8.2
Cuban	145	0.2
Other Hispanic or Latino [2]	1,717	2.9
Not Hispanic or Latino	51,253	88.0
RACE AND HISPANIC OR LATINO		
Total population	58,241	100.0
One race	56,239	96.6
Hispanic or Latino	6,329	10.9
Not Hispanic or Latino	49,910	85.7
Two or More Races	2,002	3.4
Hispanic or Latino	659	1.1
Not Hispanic or Latino	1,343	2.3

(American Fact Finder. Race and Hispanic or Latino-on Manchester-2010)

Manchester and Enfield have a good segment of minority and low income population that has not been provided with the opportunities to prevent the health and economic disparities. CT-Family Care Services is dedicated in reaching out to that underserved population in Enfield, Manchester and to other towns' nearby in order to enrich their wellness systemically and multi-culturally. In the Hartford County, other towns that are close to Enfield and Manchester where minority and low income populations will come from in order to seek treatments are the towns of Windsor, East Windsor, East Hartford, Ellington and Vernon. Those towns still have White majority and who seem to have a good number of middle class incomes, yet, the fact remains that minorities and low income in those towns are underserved in many diversified ways.

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

The following chart below show the estimated number of people who are dealing with the challenges of mental health issues in Manchester.

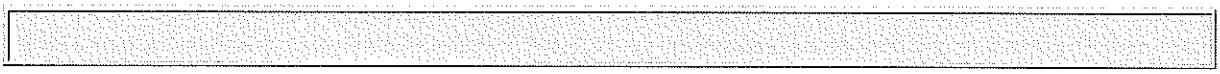
	Central Manchester CDP, Connecticut	
	Estimate	**Margin of Error**
Total:	19,877	+/-1,170
With a mental disability:	1,191	+/-358
Male:	549	+/-207
16 to 34 years:	294	+/-125
Employed	176	+/-101
Not employed	118	+/-80
35 to 64 years:	255	+/-146
Employed	92	+/-72
Not employed	163	+/-126
Female:	642	+/-281
16 to 34 years:	261	+/-184
Employed	148	+/-127
Not employed	113	+/-123
35 to 64 years:	381	+/-196
Employed	154	+/-104
Not employed	227	+/-152

(Fact Finder. American Community census-Mental health issues-Manchester, CT.Survey 2010)

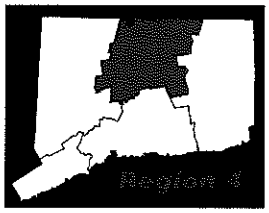
i. **How and where the proposed patient population is currently being served;**

According to the State Department of Mental Health and Addiction Services, the following area are the Mental Health offices serving several towns as indicated below

(http://www.ct.gov/dmhas/cwp/view. retrieved 5/23/2012).All these centers are far from the needy population which commutes long distances in pursuit of treatment. For poor families, the treatment can be unattainable. That means, individuals and their families either have to drive a long distance to where community centers are as indicated below:



LOCAL MENTAL HEALTH AUTHORITIES:



Community Health Resources
(private non-profit)
995 Day Hill Road
Windsor, CT 06095
PH: 877-884-3571 Fax: 860-731-5536

Programs under Community Health Resources:

Genesis Center, Inc.
587 East Middle Turnpike
Manchester, CT 06040
PH: 860-646-3888 FAX: 860-645-4132

(Catchment Area 15)
Serving the towns of Amston, Andover, Bolton, Buckland, Ellington, Hebron, Manchester, Rockville, South Windsor, Talcottville, Tolland, Vernon, and Wapping.

North Central Counseling Services
47 Palomba Drive
Enfield, CT 06082
PH: 860-253-5020 860-253-5020 FAX: 860-253-5030

(Catchment Area 17)
Serving the towns of Bloomfield, Broad Brook, East Granby, **East Hartland, East Windsor, Enfield**, Granby, Hazardville, Melrose, North Granby, Poquonock, Scitico, Somers, Somersville, Stafford, Stafford Springs, Staffordville, Suffield, Thompsonville, Warehouse Point, West Granby, West Suffield, Wilson, Windsor, Windsor Locks, and Windsorville.

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

A study about mental health agencies in Manchester, indicates that, the town of Manchester has some agencies including massage therapy, physical therapy and some psychotherapy agencies.

Some of the agencies have branch offices in Manchester and their main offices in Hartford, or New Britain, etc. Below is a list of the main mental health agencies in Manchester.

Manchester Mental health services

Community Health Resources
(877) 884-3571

Zeh Mary Anne APRN
935 Main St, Suite C2, Manchester, CT 06040.
(860) 649-4477

Institute Of Living
80 Seymour St, Hartford, CT 06102
(860) 545-7000

CREC Polaris Center
474 School St, East Hartford, CT 06108
(860) 289-8131

Inter-Community Mental Health
281 Main St, East Hartford, CT 06118
(860) 569-5900

The Village for Families & Children, Inc
1680 Albany Ave, Hartford, CT 06105 » Map (860) 236-4511

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

Referrals: CT-Family Care Services, approach referrals as a way to utilize the strengths of each agency and that leads to enhancing treatment quality for clients and better cost effectiveness. While, the area has already several mental health related agencies, the company is committed to fostering effective collaboration with other local agencies in order to enhance treatment quality for our clients and avoid unnecessary expenses. In relation to referrals, CT-Family Care Services does referrals as follows:

1. Outward referrals: In relation to mental health issues that CT-Family Care Services has no expertise, the company refers her clients to other mental health and medical agencies in the area that have expertise.

2. **Inward referrals**: Likewise, CT-Family Care Services collaborates with other agencies in the areas for referrals. CT-Family Care Services will receive referrals from other agencies on the area that it has expertise. For example,

Areas of Services: As Connecticut Family Care Services is expanding in Connecticut, it has offices in Enfield and Manchester which are all across the Connecticut River in Hartford County towards Massachusetts Those areas seem to have a good number of underprivileged and privileged population who need integrated treatment services that CT-Family Care Services provides in order to compliment the traditional treatment which appears to take a very longtime of treatment especially when dealing with cross-multicultural mental health and social-economic-spiritual-issues that affect the under privileged and privileged population(McGoldrick et al 2005).

On March 24, 2010, Mark McMullan, Connecticut Education Commissioner was reported saying that "the state's high school graduation rates for black and Hispanic students are alarmingly low" and he added that urgent action was needed. New figures for the class of 2009 show a 58 percent graduation rate for Hispanics, 66 percent for blacks and 87 percent for whites. Connecticut's overall rate was 79 percent" (http://diverseeducation.com/article/1268/1.php,retrieved 6/30/010). Yet, currently, the study suggests that up to now, there are no other agencies in the areas selected by CT-Family Care Services that foster rehabilitation in a holistic care, with strong social-cultural-spiritual-economic-educational-emotional and relational components, in such a way that enhances coping skills of clients and

1. Is dedicated primarily to addressing and reducing the school dropout, poor academic performances and problematic behaviors among minorities
2. Provides intensive integrated academic and behavioral treatment that enables students to graduate from high school and proceed to college, career embracement or both and inspires minority students to persevere effectively and successfully in those programs.

3. Enhances cultural competency in their treatment strategies in such a way that the treatments transform the clients and their environments for sustainable recovery in a social cultural settings.

In addition, it is a fact that the towns selected by CT-Family care Services do have agencies that provide some counseling and social services, which are still offered in line with the traditional/bio-medical treatments which focus on symptoms and fails to go beyond the symptoms, unable to identify the essence of the clients' constraints in order to capacitate clients to solve their constraints (Elrber, et al 2007). In light with that study, CT-Family Care Services does have competitors who do not have integrated treatment tools embedded with social, cultural, spiritual, economic, emotion, education and relational components to reduced or prevented substantially in Connecticut health and economic disparities among the underserved population, especially in big cities and towns where those agencies have been rooted providing services for a long time. If such treatment tools were being used by other agencies, substance uses, school dropout, low academic performances and problematic behaviors would have been reduced significantly.

There is a better alternative to solving those behavioral and academic issues among students as well as mental and relational issues among couples, family members and individual adults or groups. CT-Family Care will run an intensive academic and therapy integrated treatment in order to help students with low academic performances, delinquencies and those from low income families become high academic achievers as well as behaviorally good individuals.

For that reason, it is purported that regardless of student's past history, ethnicity, mistakes, low academic achievements, school dropout, delinquencies, and problematic behaviors, CT-Family Care through its treatment model, intensive integrated academic and therapeutic treatments which have strong social-cultural-spiritual-and economic components that address the needs of clients, believes that, students can be rehabilitated and succeed in life. Hence, even the most competitive programs supported by the state or towns and other funders such as at Stamford Academy and

Westwood academy in Bristol Connecticut, are not effective or strong enough to threaten CT-Family Services or replace the treatments and the services that CT-Family care provides.

The above areas where CT-Family care has chosen to operate; there is no integrated program and services that will greatly threaten CT-Family Care Services. There are some magnet or charter schools in addition to regular public schools that were adopted as one of the way to helping students especially the cross-multicultural students from minorities and low income white families. Those programs and schools provide services during the day with an emphasis on academic achievements. For such schools, CT-Family Care Services provides daily intensive or weekly (after school hours), academic and therapeutic-behavioral treatments in cross-multicultural contexts. Hence, CT-Family Care has a unique window of expertise, potential markets for clients who have not yet undergone its powerful treatments.

Strengths, weakness and market share for the next three to five years?

Studies by CT-Family Care indicate that its competitors in the business of mental health treatments have both, strength and weakness that can have some impact on CT-Family Care services. Their possible strength can include but not limited to long experience in the business before the CT-Family Care Services started. Also, most competitors have more business connections in the health care industry and might have good connections in communities within and probably outside the counties that CT-Family Care Services will be serving. In addition, competitors might have good resources, experienced managements, good manpower, public relations, financial capabilities and good financial management, possibly with a good number of motivated clients, good connections with State Agencies for referrals, good connections with the media, good advertisement and supports from local communities like chambers of commerce, schools and other private enterprises.

Studies by CT-Family Care Services indicate that, the same competitors have some weaknesses too. For example, some agencies prolong treatments for years in a way that discourages

some clients from continuing with treatments. Even though, patients' recovery is not achieved, agencies continue to retain clients in order to be paid, while client's mental health problems remain unresolved.

Another weakness is that, a good number of those competitors lack effective cultural competency experiences as well as applications, and as a result, clinicians or professionals in those agencies sometimes seem to be unable to connect with minorities and white families of low income in a meaningful way that recognizes and utilizes their inner and outside strength to resolving clients' constraints.

Also some of the competitors showed less community investments and interests in helping minorities or the underprivileged individuals who are already stereotyped and as a result, clients go to some of those competitors with less trust, due to prolonged treatments and there is no strong bridge for mutual trust and collaboration between clients and their clinicians. Dialogue and trust are very essential for sustainable healing in a social-cultural treatment context.

Lack of effective cultural competency is another major weakness, a vital step to overcoming racial and cultural distrust in mental health treatment among professionals, clients, caregivers and the minority families. The study also found that some agencies had acquired so many clients that they are relaxed, contented with less enthusiasm for application of effective clinical/treatment renovations. The study also found that competitors do not do clinical researches, but instead, agencies prefer particular forms of therapy modalities and endlessly apply treatment modalities regardless of their inapplicability of the modalities for the minority clients with epidemic mental health problems. Such treatments lead to the question as to why the majority of mental health clients are minorities or whites from low income families and they have not been successful to recover? Some of those clients have been going to the same agencies for the same treatments for many years, but have failed to recover.

CT-Family Care's response to the above competitors' strengths and weakness:

CT-Family Care Services is established among competitors in selected areas and as a minority owned company means that CT-Family care will be more scrutinized, watched at, and most probably opposed by some competitors by claiming that their treatment modalities are better than those of the CT-Family Care Services. Some competitors will probably attempt to influence local communities or Federal and State agencies not to refer clients to CT-Family Care Services due to love of business competition, politics, or simply through genuine error on the part of CT-Family Care Services. Therefore, some of CT-Family Care's strategies will be to adopt and utilize all competitors' strengths in order to promote good public relations with them.

Also, CT-Family Care plans to utilize competitor's weaknesses for its own advantage, for example, CT-Family Care will utilize effective cultural competency treatment plan that incorporates strong social-cultural-spiritual-emotional-academic and relational components which are not available in other competitive agencies. CT-Family Care treatment is evidence –based and will conduct professional clinical researches periodically in order to assess the quality and the effectiveness of its integrated modalities, and in that way, upgrade its treatments accordingly. Reports on the research findings and treatment progresses will be utilized by CT-Family Care Services in order to foster clients-wellness, poverty reduction, better mental health and economic strengths at families. Research outcome will be available upon request from Federal and State agencies as well as stakeholders in accordance with State and Federal laws on confidentiality as well as HIPAA. Furthermore, CT-Family Care will continue marketing itself by a word of mouth and through media.

In addition, CT Family care will remain focused on its goal of enhancing academic performances and behavioral improvements among clients. The company is committed to providing treatments to students and their families in a social-cultural context. Treating both, a student and his/her family is vital to enhancing effective treatment and enabling clients attain their desired goals. Furthermore, CT-Family Care Services intends to donate a portion of its annual income for

re-investment into community economic development in order to enable clients to attain sustainable recovery and economic-self reliance. Integrated Community reinvestment, academic enhancement and behavioral improvement as well as multicultural therapy treatments will most probably strengthen families and greatly reduce their mental health issues.

In conclusion: The following diagram affirms that, people with mental health problems need to go to a specific place where they will be really treated and cured. Mental health symptoms when not properly addressed can cause chaos, disharmony and hostility in families as well as in communities. The diagram below were adopted from A comprehensive mental health report plan for Connecticut, 2006,p. 27).

Figure 1: Where Caucasians (whites) with mental health symptoms turned for help

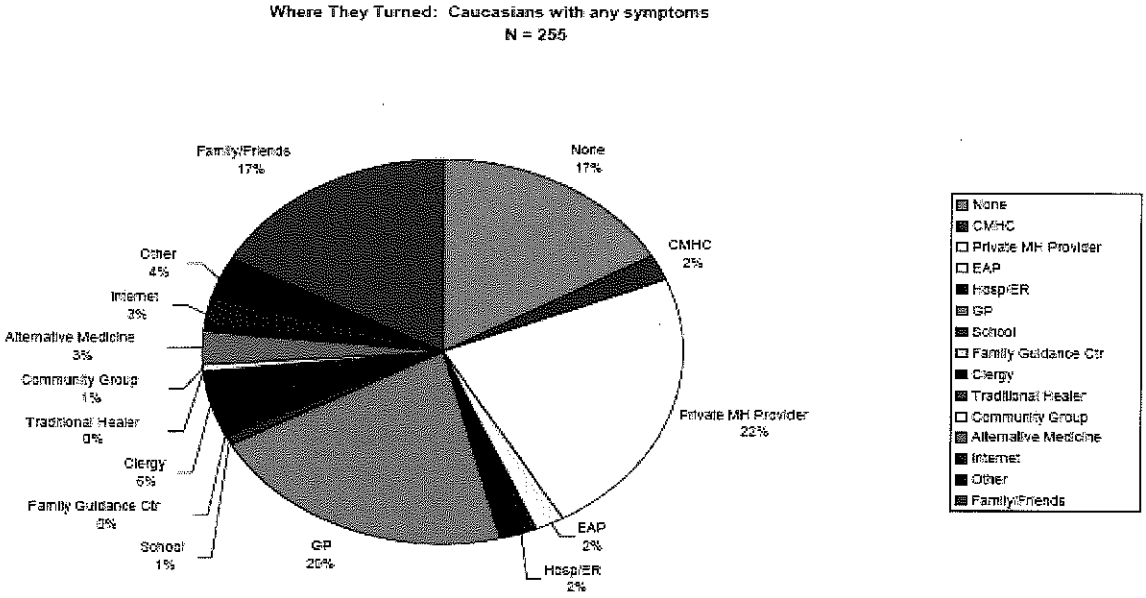


Figure 2: Where all other ethnic groups with mental health symptoms turned for help

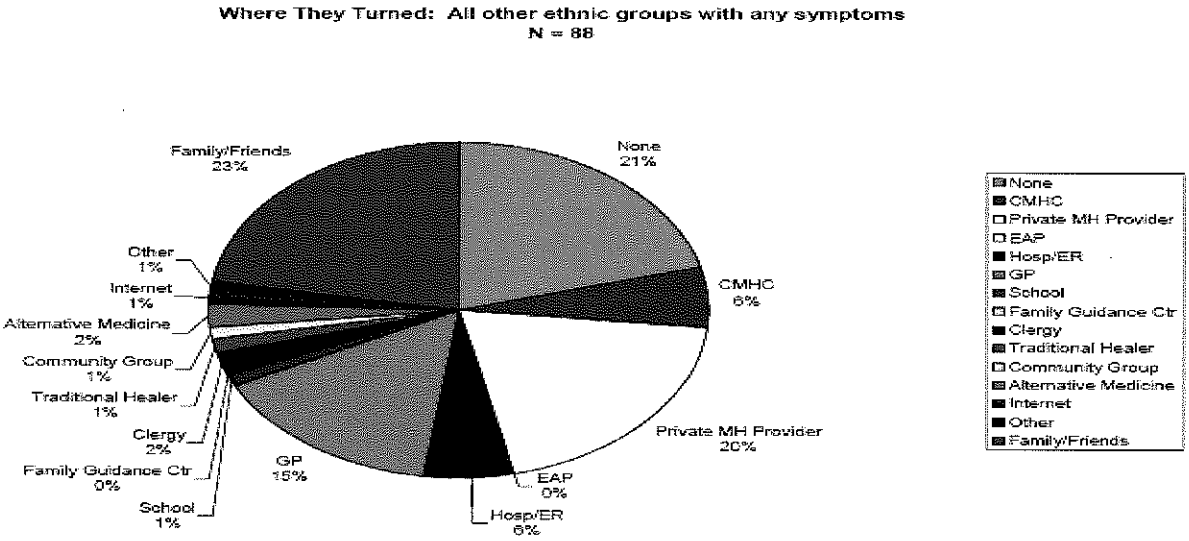


Figure 2 shows that 23 percent of all other ethnic groups said they turned to family a friends; 21 percent turned to no one; 20 percent turned to private mental health provi and 15 percent turned to general practitioners.

(From A comprehensive mental health report plan for Connecticut, Spt.2006, p.27)

In the diagram above 21% of individuals with mental health issues do not seek treatments, while 23% consult their families and friends who are not professionally and adequately trained in treating mental health illness in a systemic context. That is why CT-FCS was established in order to provide integrated professional treatment for the purpose of complementing the traditional (bio-medical) approach in treating mental health issues. CT-Family Care with community support will enhance an invidualized treatment for students and their families in a way that will reduce delinquencies and mental health issues, and change their misbehaviors. CT-Family Care is designed primarily, to complement what is lacking in the current traditional mental healthcare system and that is, to foster integrative systemic solutions for students, families, individuals and groups in order to overcome their internal and external constraints.

Therefore, in the light of the above confirmed facts which show that 21% eligible mental health clients (among ethnic groups/minorities) in Connecticut, do not seek treatment and that 23%

contact their families instead of contacting appropriate mental health professionals, CT-Family Care will provide treatments as needed beyond the above identified category of clients as long as the Federal, State, and insurances will be ready to pay for the treatment costs as contracted.

Who will be CT-Family Care customers (local, regional)?

School students, especially Middle and high school students (grade 6-12) who have dropout symptoms, poor academic performances, problematic behaviors, substance abuses, delinquencies, ADHD, ODD, adjustment disorder and other mental health issues including their families. Other customers will be adults and families who have mental health crises. In addition, the company will work with the juvenile and adult court systems in order to rehabilitate and prevent problematic and delinquent behaviors as well as trauma and its symptoms.

E: Marketing Plan: What marketing researches have you done or plan to do? Through social-interactions, interviews, meetings and seminars, CT-Family Care Services has found out that there is untapped market in Connecticut, especially among minorities and low income population of students, some adults and families who have mental health issues and need Services (Comprehensive mental health plans for Connecticut, 2006). CT-Family Care Services plans to effectively reach those ethnic groups with mental health problems, educational and economic as well as therapeutic challenges in selected areas.

2. Projected Volume

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

Table 1: Projected Volume

OUTPATIENT INTEGRATED TREATMENT	**Projected Volume (INCOME) (First 3 Full Operational FYs)**-July1-June30			
	2012	2013	2014	2015
Customized Behavioral Treatments	$475,200	$576,000	$768,000	
Customized Academic Treatments	$378,200	$576,000	$672,000	
Customized Individual Treatments	$342,200	$384,00	$768,000	
Customized Family Treatments	$297,500	$476,000	$743,750	
GRANTS				
Innovative Research	$150,000	$150,000	$150,000	

Children, Youth & Family Strengthening	$200,000	$200,000	$200,000	
TOTAL	**$1,843,100**	**$2,362,000**	**$3,301,750**	

(adopted from CT-Family Care Services, LLC Business plan)

b. Provide a detailed description of all assumptions used in the derivation/calculation of the projected volumes(**see the appendix**)

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.**(see the appendix**)

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(**see the appendix on References**)

3. 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(**see appendix on Resumes and certificates)**

b. **Explain how the proposal contributes to the quality of health care delivery in the region.**

This proposal contributes to the quality of health care delivery in the region in several ways including but not limited to the fact that the company and its proposal are focused on working and serving minority and low income population who are underserved in the selected focal point- towns of Enfield and Manchester. Services will be extended also to their neighboring towns when needed be.

Even though several State Departments and some non-profit agencies are already working towards reducing the health and economic disparities in Connecticut as articulated by the Department of Public Health on health and economic disparities among the underserved population (DPH website 2012), often the traditional treatment modalities used, have not effectively utilized the social-cultural-spiritual components needed in fostering sustainable recovery among the underserved population through utilizing their ethnical values for healing (Mc Goldrick, Giordano, & Garcia –Preto 2005). In addition, traditional approach alone is so much bio-medically driven, that cultural competency, sensitivity and spirituality for holistic healing have not been embraced. As a result, traditional approach has been less effective in treating some mental health problems including trauma (Erbel et al 2007) and that makes a

good percentage of the underserved population, distrust mental health treatments and some institutions, as well as become reluctant in utilizing professional mental health resources effectively when dealing with mental health problems, but use their family members who are not well trained as demonstrated below.

Figure 2: Where all other ethnic groups with mental health symptoms turned for hel

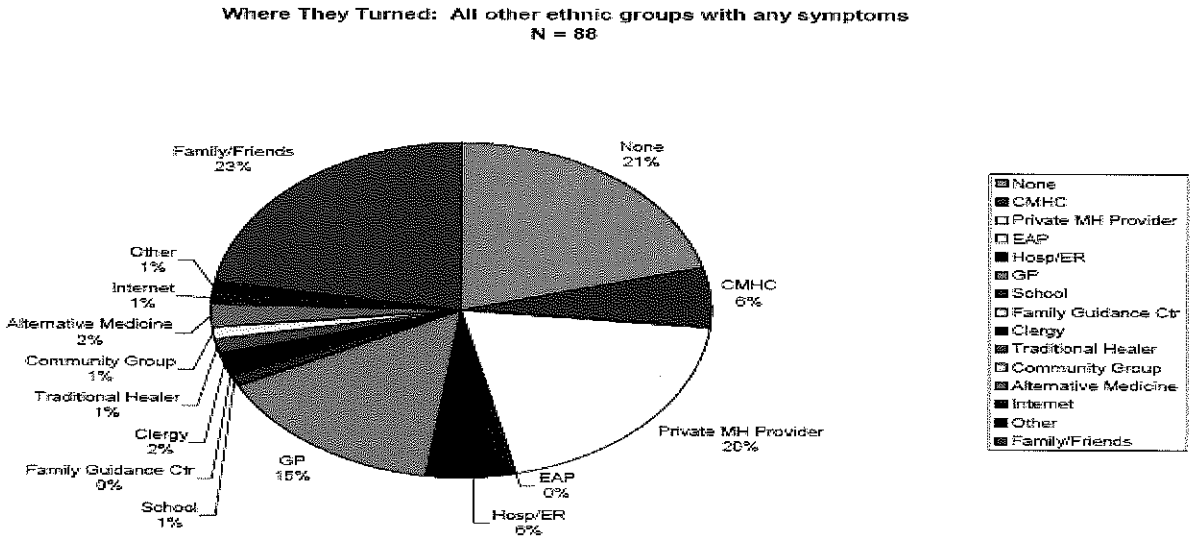


Figure 2 shows that 23 percent of all other ethnic groups said they turned to family a friends; 21 percent turned to no one; 20 percent turned to private mental health provi and 15 percent turned to general practitioners.

(A comprehensive mental health report plan for Connecticut, 2006,p.27)

CT-Family Care Services' treatments seeks to supplement what is lacking in the traditional-biomedical approach. The company provides the academic and behavioral treatments for students, and the treatment formula is embedded with strong social-cultural-spiritual-emotional-relational-educational and economic (SCSEREE) components which heal the hidden underlying factors that lead to mental health cycle of problems and often remain unhealed for a long time when the bio-medical treatment approach which focuses on treating symptoms is applied (Erbes et al, 2007, Ford et al 2007). Thus, CT-Family Care Services, LLC presents valuable treatment resources towards reducing disparities among the underserved population in Connecticut.

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.**

The mission for the CT-Family Care Service, LLC is to provide integrated academic, behavioral and mental health treatments which have strong social-cultural-spiritual-academic-economic and relational components in order to enhance coping skills that enable students, parents and their families and other clients in the treatment setting to overcome their constraints and hence, adopt positive family systems, academic excellence, behavioral rehabilitation, attainment of higher education or employment and better workforce skills in order to foster productivity in the community for sustainable recovery and self-reliance. The needs of clients will be outlined in their Individual Integrated Treatment Plans (IITP).

The CT-Family Care's treatments with strong Academic-Social-Cultural-Emotional-Spiritual-Economic and Relational (ASCESER) components will systemically incorporated into CT-Family Care programs and services which include, but not limited to:

Integrated Therapy: This is a kind of treatment which is necessary to complement the traditional approach (bio-medical) to treating people with mental illness, high school dropout, low academic performances, delinquencies and other problematic behaviors. The bio-medical approach remains a traditional approach in treating symptoms and not in treating the real problems which are hidden by the symptoms. Integrated therapy that CT-Family care presents will treat both, the symptoms and their hidden causes in family-social-cultural contexts.

Integrated Academic Treatment: Often minority students, as well as white students from low income families and people with mental health issues tend to experience discrimination, poor living conditions, stigmatization, low self esteem, and usually they encounter other obstacles that affect their academic performances which lead them to dropout of school and development of some behavioral problems. Through CT-Family care program, students will be assisted in improving their academic performances by utilizing the cross-multicultural resources within and around them so

that they can graduate from high school and proceed to college education, obtain meaningful careers or acquire both.

Integrated Social Services: These services will be provided in the systemic way so that students, families and other clients who receive such help are inspired and motivated so that they can explore repertoires within and around themselves in order to foster their customized self-reliance in line with individual treatment plan. Social services component is very important in preparing individuals and families to (a) enhance their coping skills and (b) increase sustainable academic performances (c) foster good behaviors (d) proceed to college (e)embrace career and higher education (f) strengthen individuals and their families with effective coping skills to solving their problems and succeeding in life. Studies indicate that minority students and white students from low income families often are not given sufficient social-academic-and economic support needed due to stereotype.

Integrated Spirituality: There is a difference between spirituality and religion. All human beings yearn for spirituality such as love, dignity, respect, compassion, righteousness and a relationship with the divine. In order to strengthen individual's coping skills for sustainable success, spirituality (not religiosity/or religion) has to be integrated into holistic treatments. That is why CT-Family Care Services is going to incorporate spirituality into its treatment practices.

Integrated Job Preparedness: The desire to work, to earn a living, to be a productive member in a society, is essential basic needs. CT-Family Care services will help clients and their families with job search and training.

Family Systems: Family systems are the systems on which personal efficacy is based. CT-Family Care Services will make use of family systems to ensure that the consumer has the support needed and that dysfunctional families are not in the way of achieving the self-determined goals set by the individual. By using the CT-Family Care integrated approach in treatment, clients will be

empowered to change their dysfunctional relationships/or constraints that undermine their desires and hence affects their health, growth, and better lives.

Psychiatric medical assistance: Family Care Service will have a medical doctor (psychiatrist) who will meet clients and respond to their medical needs especially those clients who will not have private primary care physician.

Integrated research team: In order to promote sustainable healing and success, research on integrated treatment is very essential. The CT-Family Care services will seek appropriate permissions from individuals and from Connecticut State Commission on human substance in order to conduct a research in accordance with the laws. The research will look into developments and constraints pertaining to the treatments and how best to enhance clients' systemic recovery in a social-cultural context. It is purported that, due to insufficient clinical researches and cultural competencies on mental health issues and treatments among minorities, some traditional treatments and approaches on mental health issues are not helping individuals and their families to attain a sustainable recovery. This is one of the reasons why minorities and lower income white families do not experience healing in the mental health bureaucracy with ineffective treatments which finally drive them into a failure in exploring possible resources in order to solve their constraints responsibly in a family-social context.

Reduction of poverty and disparities. Institutional racism impact significantly on the lives and wellness of African American, Hispanic and other lower income families. CT-Family Care programs are designed in a way that will enable clients to enhance their coping skills, high academic achievements, self-esteem, as well as increase their competitive workforce skills so as to enable individuals and their families overcome the culture of poverty, violence and less productivity in communities. Poverty is a hindrance to human development and success.

Effective Inmate Community Re-entry: The number of inmates to be enrolled in the program will increase greatly starting in 2012. The integrated treatment will include academic and

coping skills enhancements, behavioral improvements, identification of triggers which lead them to unlawful actions and job skills training in order to attain meaningful careers. Less offender-parents who are incarcerated are missed by their children and families, thus causing some bad effects on students academic and good behavioral development. From this point of view, there is a need to strengthen families of minorities and white low income families by preparing inmates for a healthy community re-entry in a way that will support children, inmates themselves and their families for health communities safety, recovery and success.

JOB READINESS PREPARATIONS. CT Family Care Services will provide wrap-around job readiness services to its clients. These will include: Job search so that clients can be matched with the existing openings. Assessment procedures to help clients to define their goals, interests, and strengths. Job search skills, referrals to networking opportunities, resume and cover letter workshops, interviewing workshops and practice. Supported work programs, where appropriate for a given client. Ongoing mentoring of clients at their workplaces. Job development will be the work of a specialist who will be able to identify possible employers. That specialist will be oriented to the needs of the employers and will have the responsibility to review the job market regularly and to see what skills are in demand and how clients can be prepared to meet that demand. Where job openings already exist, the job developer will work directly with the employment advocates to determine which client will qualify for the position.

Where possible, on-the-job training will make up any deficits that the clients may have as they start employment. When clients start working independently, this does not mean that CT Family Care Services will stop efforts to make sure they succeed at their chosen fields. Their primary clinicians will be responsible for monitoring the clients, meeting periodically with their employers, and making any corrections before they are found to be an issue. CT Family Care Services is intended to provide wrap-around services to its clients but without removing autonomy

from them and without compromising their responsibility to find and succeed at their chosen line of work.

Instead, CT-Family Care will put all the supports in place to give the client every chance to successes, whatever their background. It is very urgent that the epidemic of high school dropouts, problematic behaviors, poor academic performances and lack of sustainable meaningful jobs high school dropouts, adults and individuals with mental changes must be prevented, so as to enable individuals graduate in high schools, proceed to college, be productive citizens in community and balance the current unbalance excessive burdens on taxpayers.

Procedures of Admission to the Treatment at CT-Family Care Services Clinic Center: CT-Family Care Services will take referrals from DCF, DSS, and Department of education/schools, court system and the DMHAS. All potential students and their families will have to participate in the admission process which will include:

(a) **Academic assessment**: A designated staff member at the CT-Family care services will conduct an academic assessment so as to determine the academic level and capability of a student. This is an important step so that the treatment team can provide a customized academic treatment plan in order to assist a student to excel academically accordingly. Through the daily intensive academic and therapeutic treatment in a residential treatment program, students will do internal and external exams (SAT, CAT) as scheduled. Those who do not pass those exams will be given another opportunity after six months. The whole treatment program is designed to last either for from three months to two years, depending on when students will have attained good behavioral improvements, completed or passed the internal and Connecticut State exams in order to graduate with high school diplomas.

(b) **Mental diagnostic assessments:** Will be conducted by a designated therapist or a clinician in reference to the diagnostic and statistical manual of mental disorders-DSM-V-2012.

Therapists will conduct a systemic assessment using therapeutic tools such as the genogram and the metaframeworks.

(c) **Medical assessment**: A designated medical doctor, especially a psychiatrist staff member at CT-family care services will conduct a medical-psychiatric assessment so as to know the general health condition of a potential client. When needed, a psychiatrist will refer a potential client to the nearby hospital for some necessary examination in consultation with his/her family.

(c) **A feedback meeting:** Will be attended by a student and his/her parents or a guardian, a representative from a referral agency as well as the treatment team of the CT-Family care services. The final decision of the whole team will be taken into consideration during the treatments.

(d) **A treatment plan**: An integrated customized treatment plan will be developed so as to help clients achieve their goals. The individualized treatment plan will be embedded with strong social-cultural-spiritual-academic and relational components for sustainable recovery.

(e) **Combined Academic and Behavioral Intensive and Integrated treatments**: Students will receive an intensive systemic integrated therapeutic treatment which will include systemic therapy, counseling, coping skills enhancements, social studies, training in mathematics, physics, chemistry, biology geography, english, computer science, conflict resolutions, business, spiritual/ethical values, individual therapy and group therapy, SAT & CMT preparations (see weekly schedule-appendix). Normally, in Connecticut the high school education takes between 3-4 years (grade 9-12). The treatments at CT-Family Care Services are systemically designed to synthesize all of the academic requirements in order to promote academic excellence and prevent the problematic behaviors within the span of six months to two years of treatments. The high academic achievement as well as the changes of behavioral of the targeted students will depend greatly on his/her previous academic and beware, background. The following phases below are designed and expected to reduce greatly the above mentioned epidemics in Connecticut:

Phase one (First 6 months) will consist of the first six months after students and their families have been admitted into the integrated treatment. After an intensive treatment for six months students will be given the opportunity to sit for the appropriate academic exams required, including Connecticut State exams for them to graduate from high school, get their diploma and proceed to college or embrace career.

Phase two(6 +6 =12): Students who do not pass their internal and State Exams in the first phase will continue with phase two and continue with intensive integrated treatment, then after six months, students will do internal and State exams and those who will pass, will graduate with a diplomas and proceed to college, career or both.

Phase three (12 + 6=18): Students who did not do well academically and behaviorally during phase one and two will enter into phase three intensive treatment program. Some students will enter into phase three because of various factors such as low academic skills and immaturity such as students who were still in grades 9-10. In any case, through the integrated treatment at CT-Family Care, it is anticipated that those students in phase three will successfully graduate with diplomas and proceed to colleges, embrace careers or do both.

Phase four (18 + 6 =24 months) students who did not successfully pass the internal and state exams for regular diplomas will be prepared for GED and assisted appropriately to gain some professional skills, so that they graduate with positive behavioral improvements, enhanced coping skills, improved academic performances and some vocational trainings. Therefore, there will be no student who came to the treatment and participated fully will be left out. However, students whose behaviors will threaten the safety of others will be removed from the treatment program and sent back to the juvenile courts or to their families accordingly.

(f) **A commitment to participate actively in the treatment program.** Clients and their families will be encouraged and expected to participate actively in the treatment program. At the

end of each month, a progressive evaluation reports will be available to a student, his/her parents, and to the court system if applicable.

In Conclusion: CT-Family Care, however, is looking for a grant of $ 150,000 towards its program and services. CT-Family Care anticipates that a good number of clients and their families will be referred to its clinics for treatment.

CT-Family Care Services treatment approach presents a win-win window of sustainable HOPE and SUCCESS to all stakeholders and participants. Consequently, CT-Family Care Services is dedicating to ensure that her integrated and intensive treatments will benefit students, youth, veterans, families, adults, families, juvenile and inmates(soon to be released) in court system and their communities. Integrated treatments that CT-Family Care Services provides, build positive self-reliance that empower students, youths, adults, ex-inmates, their families and schools to overcome mental illnesses, school dropout and increase:

- positive behaviors,
- self-discipline from using substance, alcohol or delinquencies
- high academic performances
- college entrants and embrace careers
- Sustainable healing from mental illnesses, poverty and enhance positive citizenship.

CT-Family Care Services, LLC, predicts to succeed in treating clients to such a degree that the following percentages of students will have desires of moving forward to colleges or embracing life careers:

1. 76-87% of students who complete the program will mostly probably have high academic performances and behavioral change; hence will opt to proceed with college education. College education will be pursued at either community colleges or at four year colleges. Students, who will attend Colleges in Connecticut, will continue being monitored and supported for the first school semester so that they will maintain their morale and stay in

colleges. CT-Family Care Services has experienced and qualified staff team will be in charge at assist those students properly.

2. 20-12 % will likely have high academic performances and improved behaviors. This group will choose to seek careers immediately instead of pursuing college education. CT-Family Services staff will prepare and assist students in pursuing their dreams. The agency will also provide integrated counseling to those new employees for the first four months at their job sites so that they will be morally encouraged and supported during their transitional experiences. After four months, CT-Family Care Services will end its treatments unless there will be a special need approved by the relevant parties or administrations.

3. 1-2% this group will participate actively in the program and graduate, but will most probably refuse to choose college education or any career-related options after completing treatments.

4. Organizational and Financial Information

a. Identify the Applicant's ownership type(s) (e.g. Corporation, PC, LLC, etc.).

CT-FAMILY CARE SERVICES, LLC. See appendix # 4 with a Certification of being in good standing from Secretary of State in Connecticut

b. **Does the Applicant have non-profit status?**

☐ Yes (Provide documentation) X☐ 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.

CT-Family Care Services, LLC is in the process of applying for its first license from the Department of Public Health (DPH)

d. Financial Statements

Financial aspects: Attached herewith is CT-Family Care's projected budget for one year (2012-2013) and for the three years (2012-2014) period. Since most CT-Family Care's clients

are minority students, their families and white students from low income families and the inmates who will be seeking effective community re-entry are poor, adults, and underserved families, CT-Family Care seeks to contract with private, Federal and State insurances in order to reimburse the treatment center for its integrated treatments.

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. ANSWER**: NONE APPLICABLE FOR CT-FAMILY CARE SERVICES, LLC

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: **the formatting is N/A, see the attached detailed financial report (2012-2014) on the appendix**

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 See appendix #

5. 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. **N/A.**

Table 3: Patient Population Mix

	Current FY *****	**Year 1 FY *****	**Year 2 FY *****	**Year 3 FY *****
Medicare*				
Medicaid*				
CHAMPUS & TriCare				
Total Government				
Commercial Insurers*				
Uninsured				
Workers Compensation				
Total Non-Government				
Total Payer Mix				

* 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.

6. 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. **See the appendix.**

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. See appendix.

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.). See **appendix**

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). **See appendix.**

e. Provide the minimum number of units required to show an incremental gain from operations for each fiscal year.

f. Explain any projected incremental losses from operations contained in the financial projections that result from the implementation and operation of the CON proposal. **See appendix**

g. Describe how this proposal is cost effective.

G: **Pricing and other benefits:**

How will you price your product or services? Studies suggest that most of the payments or insurance re-imbursements range between $ 250-100 per hour. CT-Family Care Services plans to charge between $ 100 to 150 per hour for most of the services, except when differently indicated in the budget and it will provide competitive salaries in order to attract and retain the best experienced professionals. In line with what is available on the market, CT-Family Care has decided to pay its workers the most competitive salaries. CT-Family Care Services' proposal is cost effective because it presents an effective alternative approach from the traditional way. The cost effectiveness is reflected both in quality and services it provides when serving the underserved population.

Non-residential treatment program: The Company will apply to the Department of Children and Family Services (DCF) for two types of programs (a) **the outpatient psychiatric children and family clinic** (b) ***Day care treatment clinics for students, youths who are extremely troubled behaviorally, academically and those with mental illnesses as an alternative to incarceration.***

Outpatient psychiatric children and family clinic: CT-Family Care Services integrated programs for students will be conducted in the afternoon from Mondays to Saturdays, with some intensive academic-therapeutic treatments in order to alleviate students from school dropout, bad behaviors, and mental health crisis and prepare them for college education or careers. In order to achieve these goals, both programs will involve families in the treatment plans. This systemic family approach will enable students and their family members to enhance their coping skills and improve their behavioral interactions, as well as utilize the family inner repertoires of strengths in

order to solve family problems that affect each family member including a student's bad behaviors leading to poor academic performances at school.

Need for involving family members in treatments: CT-Family Care will receive referrals from appropriate State agencies, schools, court systems, communities or families whose students may need integrated therapeutic treatment, social care and educational support to resolve their current constraints. Such constraints may range from lack of attention at school/home, poor academic performances, mental health illnesses and problematic behaviors at home or at school. CT-Family Care Services holds that, often children are symptoms bearer of their family problems or tensions. CT-Family Care Services will focus on treating a student and her/his family in a family-social-cultural context because when a structure of the family group is transformed, the positions of members in the group are altered, and each individual's experiences change for the better (Minuchin 1974, p.2).

Another cost effectiveness that CT-Family Care Services Presents is embedded in the utilization of its treatment components in reducing school dropout, problematic behaviors and a cycle of mental crises among students and their families of its citizens who cost a lot of dollars a year. For example, when a student drops out of school due to various reasons, and end up in jail/prison, Connecticut taxpayers pay about $ 33,707. 45 (Department of Correction website-Annual budget 2009 retrieved 6/18/010) per year to keep one inmate in jail or on welfares. CT-Family Care Services, bring many benefits to clients and communities in the fact that it will reduce low self-esteem, mental health crisis, and prepare many families and youth to become more productive citizens. To foster a sustainable recovery, there is a need of assisting individuals in strengthening and enhancing their coping skills by teaching them new ways of viewing and handling situations (Satir and Baldwin 1983). The CT- Family Care Services believes that by introducing integrated intensive services in the treatment center, will bring various benefits such as

enhancing coping skills, addressing the emotional needs of clients and their caretakers, reduce preventable crises systemically at schools, in families, work places, and in communities.

Both the **Outpatient Psychiatric Children and Family Clinic and the Day Care Extended Program (operated separately)** will have the intensive integrated treatment components that will last between three months to two years depending on the level of each student's academic performance, mental health statues, change of behaviors during the treatments. Each student will daily be given enough academic and therapeutic attention as needed. The company offers brief targeted solution centered treatments; hence no treatment should exceed two years for each individual simultaneously. If after years clients are unable to recover from the same problem that the company has been treating, then clients will be referred to other agencies.

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Executive summary about CT-Family Care Services, LLC and its benefits (PowerPoint)

CT-FAMILY CARE SERVICES, LLC PRESENTS...

INTRODUCTION:

- CT-Family Care is a Federal and State certified consulting minority owned company, based in Connecticut and now expanding its services into Springfield, Massachusetts.
- Established and registered in Connecticut in July 2007.
- CT-Family Care team is composed of seasoned professionals.

CT-FAMILY CARE SERVICES,LLC PRESENTS...

Problems for common concern in Springfield:

- High rate of school dropout in Springfield area leading in the State.
- Underlining factors for academic & behavioral problems which affect students & families.
- Financial burdens to community due to school dropout, MH issues, unskilled citizens.

CT-FAMILY CARE SERVICES,LLC PRESENTS...

Company's goals: Anticipated outcome

- 76-80 % of Hs graduates, proceed to colleges
- 12-18 % of graduates, embrace career/or both
- 1-2 % graduates Hs, but undecided
- 60-64% Parents & Families participation and success

CT-FAMILY CARE SERVICES,LLC PRESENTS...

Company response:(b) areas of expertise

- Academic treatments
- Behavioral treatments
- Family treatments
- Research on Integrated Treatments
- Job training for families
- Community Economic Development Enhancement.

CT-FAMILY CARE SERVICES,LLC PRESENTS...

Treatment for students:

The treatment will reduce:

- High school dropout
- Delinquency
- Problematic behaviors
- Substance uses
- Unskilled workforce

CT-FAMILY CARE SERVICES, LLC PRESENTS...

Treatment for students...

The treatment will:

- Enhance coping skills
- Increase academic performances
- Improve behaviors
- Help students to graduate from High schools
- Enable students go to colleges or embrace careers

CT-FAMILY CARE SERVICES, LLC PRESENTS...

Treatment for families:

The treatment will reduce:

- Dysfunctional family interactions that affect family members
- Marital / Relational mental health crises
- Substance use, traumatic symptoms and other negative actions
- Unemployment, poverty and social--economic constraints

CT-FAMILYCARE SERVICES,LLC PRESENTS...

Treatment for families...

The treatment will:

- Enhance coping skills for positive solutions
- Foster healthy relationships, and responsible parenthood
- Strengthen families for sustainable success
- Increase skilled workforce and meaningful jobs for better living

CT-FAMILY CARE SERVICES, LLC PRESENTS...

Treatment for veterans. Treatment will reduce:

- Social-academic and economic constraints affecting children and families of veterans when parents are on combats or away from home
- Unsatisfactory coping skills among combat veterans, and minorities
- PTSD symptoms and its constraints on veterans, and their families . Stressors that hamper healthy readjustment into non-combat environments

CT-FAMILY CARE SERVICES,LLC PRESENTS...

Treatment for veterans...

The treatment will:

- Enhance the needed coping skills
- Treat PTSD and its symptoms
- Enable veterans and their children succeed in life
- Families will maintain healthy relationships & jobs for success

CT-FAMILY CARE SERVICES,LLC PRESENTS...

Treatment for effective community re-entry of inmates

The treatment will reduce:

- The cycles of imprisonment among children, veterans, minorities, and white low income families.
- Unsatisfactory coping strategies and other causes that lead to law violations and mental health crises

CT-FAMILY CARE SERVICES ,LLC PRESENTS...

Treatment for inmates for community re-entry...

The treatment will:

- Enhance coping skills, provide academic and behavioral improvements
- Promote effective rehabilitation,
- Strengthen families, and reduce the costs of preventable incarcerations
- Reduce repeated imprisonments which are costly in various aspects

CT-FAMILY CARE SERVICES,LLC PRESENTS...

RESEARCH & INTEGRATED TREATMENT which will

- Promote the relevance of clinical researches on the use of a cultural competencies in MH issues in order to enhance students' success
- Complement the biomedical treatment approach which is less effective for healing and rehabilitating most of the minorities, low income white families and veterans dealing with mental health issues and social-cultural-economic constraints and PTSD symptoms

CT-FAMILY CARE SERVICES, LLC PRESENTS...

Research and Integrated treatment which will:

- Complement biomedical approach by(a) treating problematic behaviors among children (b) improving academic performances (c) reducing family crises
- Provide effective treatment in order to reduce the cost of ineffective prolonged treatment

CT-FAMILY CARE SERVICES,LLC PRESENTS...

Effective solutions that require mutual beneficial partnership- "A WIN –WIN" approach: Thus, company Seeks

I. Support and endorsement from State Rep.
II. Introduction to Schools and Parents, Agencies, Community and Business Leaders in the area
III. Office and Financial assistance
IV. **Insurances: 1. That the Company may be enrolled in all insurances in the area, so that all clients can be served. 2. Secure State grants for services not covered by insurances like academic enhancement after schools.**

CT-FAMILY CARE SERVICES,LLC PRESENTS...

Implementation stages:

1. Plan of action with State Rep and his office:

A.Form a committee for strategies

B.Secure office and some initial funding from insurances, Federal and State grants

C.Involve targeted schools, parents & STUDENTS

D.Foster mutual professional understanding, and cooperation for the common good with State Rep ., families and community of Springfield.

CT-FAMILY CARE SERVICES,LLC PRESENTS,LLC...

Commitment for the common good:

- The company has zeal, dedication and enthusiasm to work with schools, parents students, families and businesses to reduce or prevent constraints that affect students and their families for sustainable success.
- Sustainable success involves collaborations, hard work with courage for renovation. The company is dedicated to working with you and the family-community in Springfield and beyond. Thank you.

CT-FAMILY CARE SERVICES,LLC PRESENTS...

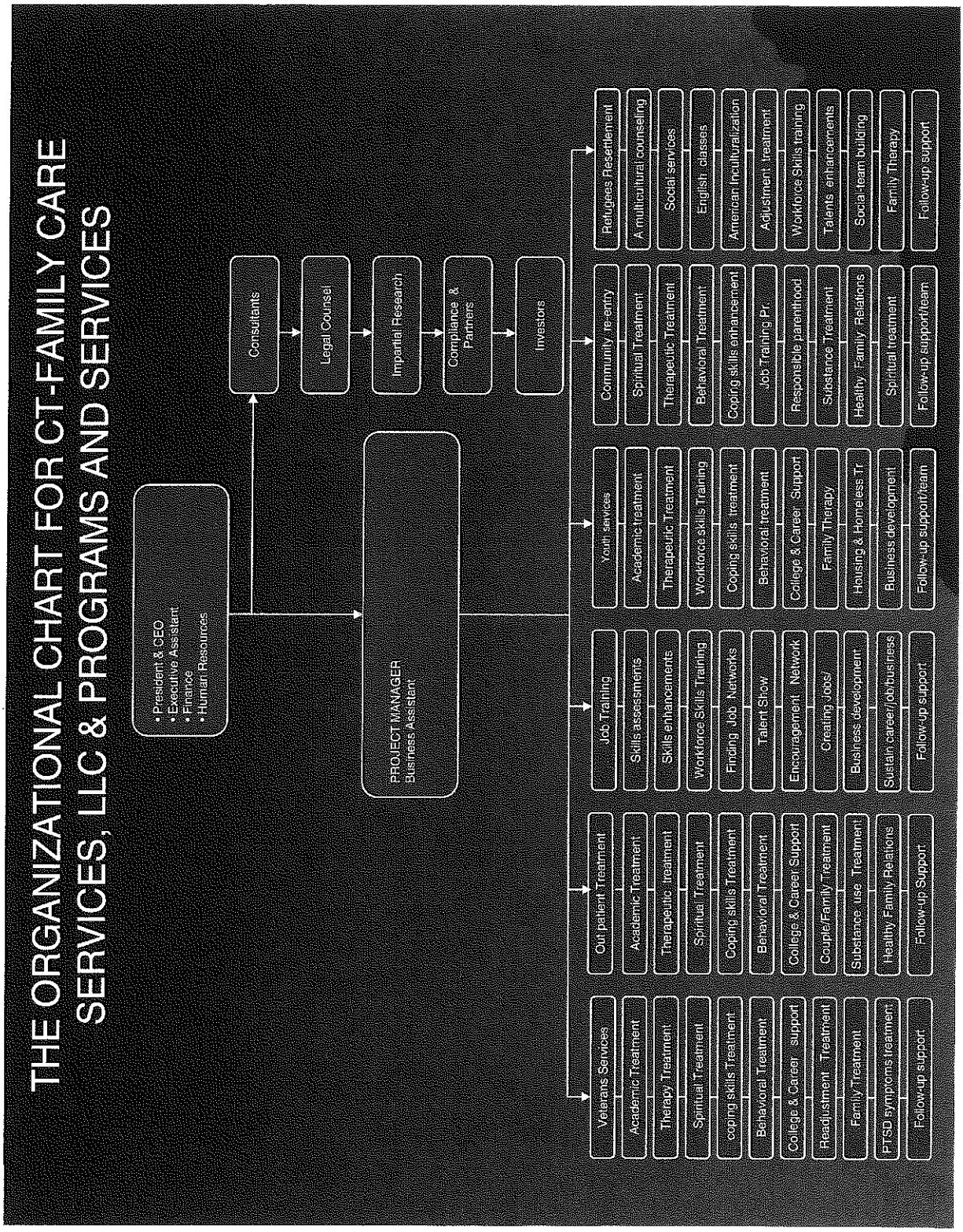
- **References**

CT-Family Care Services, LLC. Business Plan: An integrated response to School dropout Prevention (2010)

SPECIAL COMMISSION ON SCHOOL DISTRICT COLLABORATION & REGIONALIZATION (August 2011). Report to the Legislature.

Massachusetts High School graduation rate up, Long meadow, Springfield among those down.

Making the Connection. A report of the Massachusetts Graduation and Dropout Prevention and Recovery Commission, October 2009.


THE ORGANIZATIONAL CHART FOR CT-FAMILY CARE SERVICES, LLC & PROGRAMS AND SERVICES
• President & CEO
• Executive Assistant
• Finance
• Human Resources
Consultants
Legal Counsel
Impartial Research
Compliance & Partners
Investors
PROJECT MANAGER
Business Assistant
Veterans Services
Academic Treatment
Therapy Treatment
Spiritual Treatment
coping skills Treatment
Behavioral Treatment
College & Career support
Readjustment Treatment
Family Treatment
PTSD symptoms treatment
Follow-up support
Our patient Treatment
Academic Treatment
Therapeutic treatment
Spiritual Treatment
Coping skills Treatment
Behavioral Treatment
College & Career Support
Couple/Family Treatment
Substance use Treatment
Healthy Family Relations
Follow-up Support
Job Training
Skills assessments
Skills enhancements
Workforce Skills Training
Finding Job Networks
Talent Show
Encouragement Network
Creating Jobs/
Business development
Sustain career/Job/business
Follow-up support
Youth services
Academic treatment
Therapeutic Treatment
Workforce skills Training
Coping skills Treatment
Behavioral treatment
College & Career Support
Family Therapy
Housing & Homeless Tr.
Business development
Follow-up support/team
Community re-entry
Spiritual Treatment
Therapeutic Treatment
Behavioral Treatment
Coping skills enhancement
Job Training Pr.
Responsible parenthood
Substance Treatment
Healthy Family Relations
Spiritual treatment
Follow-up support/team
Refugees Resettlement
A multicultural counseling
Social services
English classes
American Inculturalization
Adjustment treatment
Workforce Skills training
Talents enhancements
Social-team building
Family Therapy
Follow-up support

State of Connecticut

Department of Administrative Services
Supplier Diversity Program

This certifies **CT-FAMILY CARE SERVICES**

16 Enfield Ave, Enfield, CT 06082

as a *African-American Owned*
Small/Minority Business Enterprise

October 27, 2010 through October 27, 2012

Owner(s): Justinian Rweyemamu,MA,M.Div.MS-MFT,PhD candidate

Contact: Justinian Rweyemamu,MA,M.Div,MS-MFT **Telephone:** (860) 508-8651 Ext: **FAX:**

EMail: rweye@cox.net **Web Address:**

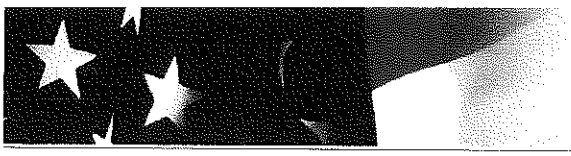
** **Affiliate Companies:**

Product Description: CT-FAMILY CARE SERVICES LLC (summary)
Introduction:
To strategically prevent the epidemic of the high school dropout, poor academic performance, problematic behaviors, and delinquencies as well as substance abuses among high school students and their families in general. CT-Family Care Services will provide intensive residential and non-residential integrated treatments which will be composed of strong Academic-Social-Cultural-Emotional-Spiritual-Economic-Relational (ASCESER)

Meg Yetishefsky
Supplier Diversity Director

Supplier Diversity Specialist

**A contractor awarded a contract or a portion of a contract under the set-aside program shall not subcontract with any person(s) with whom the contractor is affiliated.



Certification for: CT-FAMILY CARE SERVICES, LLC
DUNS: 963691121
Certification Validity:
From: 09/30/2010 10:25:49 AM (EST)
To: 09/30/2011 10:25:49 AM (EST)

By submitting this certification, I, **JUSTINIAN RWEYEMAMU**, am attesting to the accuracy of the representations and certifications contained herein. I understand that I may be subject to penalties if I misrepresent **CT-FAMILY CARE SERVICES, LLC** in any of the above representations or certifications to the Government.

READ ONLY
☐ **Vendor will provide information with specific offers to the Government.**
☒ **I certify that I have read and understand the provision.**

52.203-11 Certification and Disclosure Regarding Payments to Influence Certain Federal Transactions (Sept 2007)

(a) Definitions. As used in this provision—"Lobbying contact" has the meaning provided at 2 U.S.C. 1602(8). The terms "agency," "influencing or attempting to influence," "officer or employee of an agency," "person," "reasonable compensation," and "regularly employed" are defined in the FAR clause of this solicitation entitled "Limitation on Payments to Influence Certain Federal Transactions"(52.203-12).

(b) Prohibition. The prohibition and exceptions contained in the FAR clause of this solicitation entitled "Limitation on Payments to Influence Certain Federal Transactions" (52.203-12) are hereby incorporated by reference in this provision.

(c) Certification. The offeror, by signing its offer, hereby certifies to the best of its knowledge and belief that no Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress on its behalf in connection with the awarding of this contract.

(d) Disclosure. If any registrants under the Lobbying Disclosure Act of 1995 have made a lobbying contact on behalf of the offeror with respect to this contract, the offeror shall complete and submit, with its offer, OMB Standard Form LLL, Disclosure of Lobbying Activities, to provide the name of the registrants. The offeror need not report regularly employed officers or employees of the offeror to whom payments of reasonable compensation were made.

(e) Penalty. Submission of this certification and disclosure is a prerequisite for making or entering into this contract imposed by 31 U.S.C. 1352. Any person who makes an expenditure prohibited under this provision or who fails to file or amend the disclosure required to be filed or amended by this provision, shall be subject to a civil penalty of not less than $10,000, and not more than $100,000, for each such failure.

(End of Provision)

READ ONLY
☐ **Vendor will provide information with specific offers to the Government.**
☒ **I certify that I have read and understand the provision.**

.222-38 Compliance with Veterans' Employment Reporting Requirements (Dec 2001)

By submission of its offer, the offeror represents that, if it is subject to the reporting requirements of 38 U.S.C. 4212(d) (i.e., if it has any contract containing Federal Acquisition Regulation clause 52.222-37, Employment Reports on Special Disabled Veterans, Veterans of the Vietnam Era, and Other Eligible Veterans), it has submitted the most recent VETS-100 Report required by that clause.

business procurement mechanism is authorized and its address has not changed since its certification as a small disadvantaged business concern or submission of its application for certification. The list of authorized small disadvantaged business procurement mechanisms and regions is posted at http://www.arnet.gov/References/ sdbadjustments.htm. The offeror shall use the list in effect on the date of this solicitation. "Address," as used in this provision, means the address of the offeror as listed on the Small Business Administration's register of small disadvantaged business concerns or the address on the completed application that the concern has submitted to the Small Business Administration or a Private Certifier in accordance with 13 CFR part 124, subpart B. For joint ventures, "address" refers to the address of the small disadvantaged business concern that is participating in the joint venture.

(End of Provision)

52.214-14 Place of Performance-Sealed Bidding (Apr 1985)

(a) The bidder, in the performance of any contract resulting from this solicitation, ☐intends, ☒does not intend [check applicable box] to use one or more plants or facilities located at a different address from the address of the bidder as indicated in this bid.

(b) If the bidder checks "intends" in paragraph (a) of this provision, it shall insert in the spaces provided below the required information:

Name and Address of Owner and Operator of the Plant or Facility if Other than Bidder

Address of Place of Performance (Street, Address, City, County, State, Zip Code):	Owner/Operator:	Owner Address (Street, Address, City, County, State, Zip Code):

(End of Provision)

52.215-6 Place of Performance (Oct 1997)

(a) The offeror or respondent, in the performance of any contract resulting from this solicitation, ☐intends ☒does not intend [check applicable block] to use one or more plants or facilities located at a different address from the address of the offeror or respondent as indicated in this proposal or response to request for information.

(b) If the offeror or respondent checks "intends" in paragraph (a) of this provision, it shall insert in the following spaces the required information:

Name and Address of Owner and Operator of the Plant or Facility if Other than Bidder

Address of Place of Performance (Street, Address, City, County, State, Zip Code):	Owner/Operator:	Owner Address (Street, Address, City, County, State, Zip Code):

(End of Provision)

52.219-1 Small Business Program Representations (May 2004)

(a) (1) The North American Industry Classification System (NAICS) code for this acquisition is See Note.*

(2) The small business size standard is See Note.

(3) The small business size standard for a concern which submits an offer in its own name, other than on a construction or service contract, but which proposes to furnish a product which it did not itself manufacture, is 500 employees.

(b) Representations.

(1) The offeror represents as part of its offer that it ☐is, ☐is not a small business concern (see below).

**

NAICS:	Description:	Small Business Concern (Yes/No):
541720	RESEARCH AND DEVELOPMENT IN THE SOCIAL SCIENCES AND HUMANITIES	Yes
621112	OFFICES OF PHYSICIANS, MENTAL HEALTH SPECIALISTS	Yes
621420	OUTPATIENT MENTAL HEALTH AND SUBSTANCE	Yes

	ABUSE CENTERS	

(2) [Complete only if the offeror represented itself as a small business concern in paragraph (b)(1) of this provision.] The offeror represents, for general statistical purposes, that it ☐is, ☒is not, a small disadvantaged business concern as defined in 13 CFR 124.1002.

(3) [Complete only if the offeror represented itself as a small business concern in paragraph (b)(1) of this ** provision.] The offeror represents as part of its offer that it ☐is, ☐is not a women-owned small business concern.

(See Below)

NAICS:	Description:	Women-Owned Small Business Concern (Yes/No):
541720	RESEARCH AND DEVELOPMENT IN THE SOCIAL SCIENCES AND HUMANITIES	No
621112	OFFICES OF PHYSICIANS, MENTAL HEALTH SPECIALISTS	No
621420	OUTPATIENT MENTAL HEALTH AND SUBSTANCE ABUSE CENTERS	No

(4) [Complete only if the offeror represented itself as a small business concern in paragraph (b)(1) of this ** provision.] The offeror represents as part of its offer that it ☐is, ☐is not a veteran-owned small business concern.

NAICS:	Description:	Veteran-Owned Small Business Concern (Yes/No):
541720	RESEARCH AND DEVELOPMENT IN THE SOCIAL SCIENCES AND HUMANITIES	No
621112	OFFICES OF PHYSICIANS, MENTAL HEALTH SPECIALISTS	No
621420	OUTPATIENT MENTAL HEALTH AND SUBSTANCE ABUSE CENTERS	No

(5) [Complete only if the offeror represented itself as a veteran-owned small business concern in paragraph ** (b)(4) of this provision.] The offeror represents as part of its offer that it ☐is, ☐is not a service-disabled veteran-owned small business concern.

(See Below)

NAICS:	Description:	Service-Disabled Veteran-Owned Small Business Concern (Yes/No):
541720	RESEARCH AND DEVELOPMENT IN THE SOCIAL SCIENCES AND HUMANITIES	No
621112	OFFICES OF PHYSICIANS, MENTAL HEALTH SPECIALISTS	No
621420	OUTPATIENT MENTAL HEALTH AND SUBSTANCE ABUSE CENTERS	No

**If you are responding to a Government solicitation for supplies or services under a NAICS code not listed in paragraph (b) of this certification, you must provide this certification directly to the Contracting Officer.*

***Small business concern, Veteran-owned small business concern, Service-disabled veteran-owned small business concern, and Women-owned small business concern status was calculated based on the NAICS codes, Number of Employees, and Average Annual Gross Revenues listed in the CCR Registration for "Company Name " along with the Small Business Administration size standard for each NAICS code.*

(6) [Complete only if the offeror represented itself as a small business concern in paragraph (b)(1) of this provision.] The offeror represents, as part of its offer, that-

(i) It ☐is, ☒is not a HUBZone small business concern listed, on the date of this representation, on the 16

the Pacific Islands (Republic of Palau), Republic of the Marshall Islands, Federated States of Micronesia, the Commonwealth of the Northern Mariana Islands, Guam, Samoa, Macao, Hong Kong, Fiji, Tonga, Kiribati, Tuvalu, or Nauru).

☐Subcontinent Asian (Asian-Indian) American (persons with origins from India, Pakistan, Bangladesh, Sri Lanka, Bhutan, the Maldives Islands, or Nepal).

☐Individual/concern, other than one of the preceding.

(End of Provision)

52.219-2 Equal Low Bids (Oct 1995)

(a) This provision applies to small business concerns only

(b) The bidder's status as a labor surplus area (LSA) concern may affect entitlement to award in case of tie bids. If the bidder wishes to be considered for this priority, the bidder must identify, in the following space, the LSA in which the costs to be incurred on account of manufacturing or production (by the bidder or the first-tier subcontractors) amount to more than 50 percent of the contract price.

State	Eligible Labor Surplus:	Civil Jurisdictions Included:

(c) Failure to identify the labor surplus areas as specified in paragraph (b) of this provision will preclude the bidder from receiving priority consideration. If the bidder is awarded a contract as a result of receiving priority consideration under this provision and would not have otherwise received award, the bidder shall perform the contract or cause the contract to be performed in accordance with the obligations of an LSA concern.

(End of Provision)

52.219-19 Small Business Concern Representation for the Small Business Competitiveness Demonstration Program (Oct 2000)

(a) Definition. "Emerging small business" as used in this solicitation, means a small business concern whose size is no greater than 50 percent of the numerical size standard applicable to the North American Industry Classification System (NAICS) code assigned to a contracting opportunity.

(b) [Complete only if the **Offeror has represented itself under the provision at 52.219-1 as a small business** concern under the **size standards of this solicitation.] The Offeror** ☐**is** ☐**is not an emerging small business.** (See below)

NAICS:	Description:	Emerging Small Business Concern (Yes/No):
541720	RESEARCH AND DEVELOPMENT IN THE SOCIAL SCIENCES AND HUMANITIES	No
621112	OFFICES OF PHYSICIANS, MENTAL HEALTH SPECIALISTS	No
621420	OUTPATIENT MENTAL HEALTH AND SUBSTANCE ABUSE CENTERS	No

(c) [Complete only if the Offeror is a small business or an emerging small business, indicating its size range.] Offeror's number of employees for the past 12 months [check this column if size standard stated in solicitation is expressed in terms of number of employees] or Offeror's average annual gross revenue for the last 3 fiscal years [check this column if size standard stated in solicitation is expressed in terms of annual receipts]. [Check one of the following.]

Number of Employees	Average Annual Gross Revenues
☐__ 50 or fewer	☐__ $1 million or less
☐__ 51-100	☐__ $1,000,001-$2 million
☐__ 101-250	☐__ $2,000,001-$3.5 million
☐__ 251-500	☐__ $3,500,001-$5 million
☐__ 501-750	☐__ $5,000,001-$10 million
☐__ 751-1,000	☐__ $10,000,001-$17 million

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Appendixes:

PERSONNEL INFORMATION FORM Facility Name: CT-FAMILY CARE SERVICES, LLC

Complete information for administrative/supervisory and clinical staff including fee for service, contracted and intern staff. Do not include business and billing staff.

Name of Staff Member	Professional Discipline	License or Registration # (if applicable)	Identify Days & Hours Worked	Total Weekly Hours
Justinian Rweyemamu, MA, M.Div, MS-MFT, PhD student AAMFT Supervisor Candidate Founder & President CT-Family Care Services,LLC	*Marriage and Family Therapist, Clergy (MFT)*	*PhD student & AAMFT Supervisor in Training AAMFT, CTAMFT*	*Monday-Saturday*	*40*
Melissa C	*MFT*	*LMFT, AAMFT*	*Monday-Saturday*	*40*
Saleha Q	*MFT*	*LMFT, AAMFT, CTAMFT*	*Monday-Friday*	*40*
Elizabeth G	*MFT*	*MA-MFT*	*Monday-Friday*	*30*
Joshua C	*MEd MFT*	*M Ed, MA-MFT*	*Tuesday-Saturday*	*30*
Jan L	*MFT-Intern*	*Intern*	*Monday-Friday*	*20*
Margaret J	*RN, CSW*	*RN, CSW*	*Tuesday-Saturday*	*40*
Robert L	*MFT*	*LMFT, AAMFT*	*Tuesday-Saturday*	*40*
Megan A	*MFT*	*MS-MFT*	*Monday-Friday*	*30*
Theresa P	*MFT*	*MFT*	*Monday-Thursday*	*30*
Alexi R	*MFT-Intern*	*Intern*	*Monday-Friday*	*20*
Julie I	*MFT*	*MFT*	*Tuesday-Saturday*	*30*
Laura B	*MFT*	*MA-MFT*	*Tuesday-Saturday*	*30*
Alena Jo	*MFT*	*MA-MFT*	*Monday-Friday*	*30*
Ronak M	*MFT*	*MFT,BHN*	*Monday-Friday*	*40*
Marie C	*MSW*	*MSW*	*Monday-Saturday*	*40*
Marryem	*MSW*	*MSW*	*Monday-Friday*	*30*
Amy S	*LMFT*	*LMFT*	*Tuesday-Saturday*	*40*
Sarah S	*MSW*	*MSW*	*Tuesday-Saturday*	*30*
Kara M	*MSW*	*MSW*	*Monday-Friday*	*30*

Karmisha H	*MSW*	*MSW*	*Monday-Friday*	*30*
Bharati C	*MFT, MSW*	*MFT,MSW*	*Monday-Saturday*	*30*
Susan H	*MSW*	*MSW*	*Tuesday-Saturday*	*40*
Anthony R	*MSW*	*MSW*	*Monday-Friday*	*30*
La'Mora H	*MFT*	*MFT*	*Monday-Friday*	*30*
Seiyefa S	*MFT*	*MFT*	*Monday-Friday*	*30*
Rose B	*MFT*	*BA*	*Tuesday-Saturday*	*20*
Carmen A	*MFT*	*LCSW, MSW, LPN*	*Tuesday -Saturday*	*40*
Erica C	*MFT*	*MS-MFT*	*Monday-Friday*	*30*
Elizabeth B	*MSW*	*MSW*	*Monday-Friday*	*30*
Kristin C	*MFT*	*MA-MFT, AAMFT,CTAM FT*	*Monday-Friday*	*30*
Barbara P	*MSW*	*MSW*	*Monday-Friday*	*20*
Natalie C	*MSW*	*MSW*	*Tuesday-Saturday*	*30*
Laura A	*MSW*	*LCSW*	*Tuesday-Saturday*	*40*
Lorrie W	*MSW*	*MSW*	*Monday-Friday*	*25*
Megan W	*MSW*	*MSW*	*Monday-Friday*	*30*
Ari B	*MSW*	*MSW*	*Monday-Friday*	*30*
Mark M	*MSW*	*MSW*	*Tuesday-Saturday*	*30*
Kelly J	*MSW*	*MSW*	*Tuesday-Saturday*	*30*
Grisella S	*LCSW*	*LCSW*	*Monday- Saturday*	*40*

PERSONNEL INFORMATION FORM

Facility Name: CT-FAMILY CARE SERVICES, LLC

Complete information for administrative/supervisory and clinical staff including fee for service, contracted and intern staff. Do not include business and billing staff.

Address (if satellite):155 MAPLE ST, UNIT 204 SPRINGFIELD, MA 01105

Name of Staff Member	Professional Discipline	License or Registration # (if applicable)	Identify Days & Hours Worked	Total Weekly Hours	Service(s): Medical, Mental Health, Alcoholism, etc.
Justinian Rweyemamu, MA, M.Div, MS-MFT, PhD student AAMFT Supervisor in Training Founder & President CT-Family Care Services,LLC	Marriage and Family Therapist, Clergy (MFT)	PhD student & AAMFT Supervisor in Training AAMFT, CTAMFT	Monday-Saturday	40	Mental Health, Youth, Family, Veteran, Substance abuse, school, PTSD, Supervisor
Melissa Costanzo	MFT	LMFT, AAMFT	Monday-Saturday	40	Mental Health, School Marriage and family Therapist
Saleha Qureshi	MFT	LMFT, AAMFT, CTAMFT	Monday-Friday	40	Substance Abuses,
Elizabeth Golden	MFT	MA-MFT	Monday-Friday	35	Substance abuse, Youth, Family
Joshua Cohen	MEd MFT	M Ed, MA-MFT	Tuesday-Saturday	35	Youth, Family, Veteran, Substance abuse, PTSD
Jan Loomis	MFT-Intern	Intern	Monday-Friday	25	Youth, Family, Substance abuse, PTSD
Margaret Jones	RN, CSW	RN, CSW	Tuesday-Saturday	40	
Robert Ledder	MFT	LMFT, AAMFT	Tuesday-Saturday	40	Youth, Family, School, Clinical Supervisor
Megan Aldridge	MFT	MS-MFT	Monday-Friday	35	Youth, Family, Substance Abuse
Theresa Piotrowski	MFT	MFT	Monday-Thursday	30	Family
Alexi Relyea-Niemann	MFT-Intern	Intern	Monday-Friday	25	Youth, school
Julie Ingenhol	MFT	MFT	Tuesday-Saturday	30	Youth, Family, PTSD
Laura Badecker	MFT	MA-MFT	Tuesday-Saturday	35	Youth, Family, substance abuse
Alena Josephson	MFT	MA-MFT	Monday-Friday	35	Emergency Dispatcher, youth, family

Ronak Mehta	*MFT*	*MFT,BHN*	*Monday-Friday*	*40*	*Youth, family, substance*
Marie Cortez	*MSW*	*MSW*	*Monday-Saturday*	*40*	*Youth, family, school, Social worker supervisor, DCF*
Marryem Vahidy	*MSW*	*MSW*	*Monday-Friday*	*30*	*Youth, Family*
Amy Sartori	*LMFT*	*LMFT*	*Tuesday-Saturday*	*40*	*Youth, family, school, substance abuse, PTSD*
Sarah Shae	*MSW*	*MSW*	*Tuesday-Saturday*	*35*	*Youth, family, school, substance abuse, PTSD*
Kara Margolis	*MSW*	*MSW*	*Monday-Friday*	*35*	*Youth, family, school, substance abuse*
Karmisha Hubbard	*MSW*	*MSW*	*Monday-Friday*	*30*	*Youth, family, school*
Bharati Chakraborty	*MFT, MSW*	*MFT,MSW*	*Monday-Saturday*	*35*	*Youth, family, school, substance abuse, PTSD*
Susan Hogan	*MSW*	*MSW*	*Tuesday-Saturday*	*40*	*Youth, Family*
Anthony Riello	*MSW*	*MSW*	*Monday-Friday*	*30*	*Family, Veterans, Substance Abuse*
La'Mora Hardy	*MFT*	*MFT*	*Monday-Friday*	*30*	*Youth, Family, Substance Abuse*
Seiyefa Skipi	*MFT*	*MFT*	*Monday-Friday*	*35*	*Youth, family, Substance abuse*
Rose Barnes	*MFT*	*BA*	*Tuesday-Saturday*	*20*	*Youth, School*
Carmen Acevedo	*MFT*	*LCSW, MSW, LPN*	*Tuesday -Saturday*	*40*	*Youth ,family, school*
Erica Cuni	*MFT*	*MS-MFT*	*Monday-Friday*	*35*	*Youth, Family, School, Veteran, Substance abuse, PTSD*
Elizabeth Bessette	*MSW*	*MSW*	*Monday-Friday*	*30*	*Youth, School*
Kristin Chabot-Gauld	*MFT*	*MA-MFT, AAMFT,CTAM FT*	*Monday-Friday*	*30*	*Family*
Barbara Parker	*MSW*	*MSW*	*Monday-Friday*	*20*	
Natalie Cooke	*MSW*	*MSW*	*Tuesday-Saturday*	*35*	*Youth, Family, Veteran, Substance Abuse, PTSD*
Laura Abbatemarco	*MSW*	*LCSW*	*Tuesday-Saturday*	*40*	*Youth, Family, School*
Lorrie West	*MSW*	*MSW*	*Monday-Friday*	*25*	*Youth, Family*
Megan Whitehead	*MSW*	*MSW*	*Monday-Friday*	*30*	*Youth, Family*

Ari Brooks	*MSW*	*MSW*	*Monday-Friday*	*30*	*Youth, Family ,Veterans, Substance abuse*
Mark McLaughlin	*MSW*	*MSW*	*Tuesday-Saturday*	*35*	*Youth, Family, School, Veteran*
Kelly Johnson	*MSW*	*MSW*	*Tuesday-Saturday*	*35*	*Youth, school, veteran*

DPHCQ036 Rev. 08/23/05

PERSONNEL POLICY & EMPLOYEE HANDBOOK

OF THE

CT –Family Care Service, LLC

Adopted

May 2012

PERSONNEL POLICIES AND EMPLOYEE HANDBOOK
OF
CT-FAMILY CARE SERVICES, LLC
(Referred to herein as the Agency)

I. GENERAL POLICY

The policies and procedures for personnel management at the CT-Family Care Services, LLC are contained in this document. The purpose of this document is to state, as clearly as possible, the duties and responsibilities of each staff member in this Agency.

Nothing contained in this Manual or in any other CT-Family Care Services, LLC document is intended to create a contract or agreement of employment. CT-Family Care Services, LLC adheres to the principle of "employment at will," which means that CT-Family Care Services, LLC or the employee may terminate the employment relationship at any time and for any reason, with or without cause. No manager, supervisor, employee or other agent of CT-Family Care Services, LLC has the authority to alter our at-will policy. CT-Family Care Services, LLC does not promise or guarantee employment for any fixed period or a set salary for any particular period.

Since this is a printed document, it cannot reflect all the changes in the Agency's policies, procedures and benefits and, therefore, statements in this Handbook are subject to change at any time by the President, as necessary. Please feel free to ask the Office Manager about the current status of our policies, procedures and benefits. All previous editions of this Handbook are superseded and replaced by this version.

In general:

A. Each staff member has the responsibility to adhere to these policies and procedures.

B. It is the responsibility of the President to see that these policies and procedures are carried out. No employee of the Agency except the President is authorized to create, modify or make representations regarding the Agency's policies and procedures.

Ethics and Conflicts of Interest

The CT-Family Care Services, LLC prides itself on high standards of excellence. We expect our staff to live up these ideals as they interact with one another, the public, clients and other agencies. While not every situation can be anticipated, the following code of conduct is intended

to provide guidelines for the professional, ethical, legal and socially responsible behavior expected of all employees.

- Employees are expected to strive to conduct all Agency activities and relationships with integrity, honesty, and respect for others. All transactions should be conducted with fairness, impartiality and effectiveness.
- Employees are responsible for accurate and timely recordkeeping for all Agency assets, liabilities and expenses, in keeping with generally accepted accounting principles.
- Employees, especially clinicians are responsible for accurate and timely record keeping of the progress notes, treatment plan, and treatment plan reviews as required by the agency.
- The Agency does not permit or condone any illegal, secret, or improper payments, transfers or receipts. This prohibition applies to both the giving and receiving of payments, gifts or unusual gains.
- All activities conducted as an Agency employee should place the lawful and legitimate interests of the Agency over personal gain, and any activity or interest which is in conflict with the conduct of official duties is to be avoided.
- All privileged information gained through the course of official duties is to be respected and protected as confidential.

Protection of Personal Information

The Agency's policy is to protect and safeguard the confidential nature of personal, non-public information that it may obtain concerning its employees or other individuals including private client information. This information includes, for example, social security numbers, driver's license numbers, account numbers, passport numbers and health insurance identification numbers. The Agency will disclose such personal information on a strict business need-to-know basis and to the extent required or permitted by law.

The Agency uses reasonable safeguards to prevent unauthorized access and disclosure of such personal information, including procedures that destroy, erase shred or make unreadable all records that contain protected personal information. Employees are prohibited from accessing, using, disclosing, or revealing such personal information for unauthorized purposes, and must take reasonable measures to protect the information from disclosure. Disciplinary measures may be imposed for any actions not in compliance with this policy.

Equal Opportunity Employment Policy

The CT-Family Care Services, LLC is committed to provide equal opportunities in employment to all qualified people on the basis of job-related skills, ability, merit and other bona fide occupational requirements. The Agency takes affirmative action to prevent any discrimination with regard to race, color, religion, age, gender, marital status, sexual orientation, national origin, ancestry, present or past history of mental or physical disability, learning disability or other applicable category as protected by law. This policy extends to

all employment actions, including recruitment, selection, rates of pay, promotion and lay off or termination. Our policies and practices are administered in a non-discriminatory manner.

Sexual Harassment Policy

It is the established policy of the CT-Family Care Services, LLC to ensure equal employment opportunity and to prevent discrimination in all practices. Sexual harassment is a type of sex discrimination. It is prohibited by Title VII of the Civil Rights Act, as amended, and by Connecticut General Statute 46a-60(a)(8) as a Discriminatory Employment Practice. Harassment is defined as: "any unwelcome sexual advances or requests for sexual favors or any conduct of a sexual nature when (1) submission to such conduct is made either explicitly or implicitly a term or condition of an individual's employment, (2) submission to or rejection of such conduct by an individual is used as the basis for employment decisions affecting such individual, or (3) such conduct has the purpose or effect of substantially interfering with an individual's work performance or creating an intimidating, hostile or offensive performance or creating an intimidating, hostile or offensive working environment."

Harassment of an employee by a supervisor, co-worker, vendor, customer or visitor on the basis of sex creates a harmful working environment and is illegal. It is the policy of the CT-Family Care Services, LLC to maintain a working environment free from harassment, insults, or intimidation on the basis of an employee's sex. Verbal or physical conduct by a supervisor, co-worker, vendor, customer or visitor relating to an employee's sex which has the effect of creating an intimidating, hostile, or offensive work environment, unreasonably interfering with the employee's work performance, or adversely affecting the employee's employment opportunities is prohibited.

Although not an exhaustive list, the following are examples of the type of conduct prohibited by the policy against sexual harassment:

1. Unwelcome sexual advances from a supervisor or co-worker, such as unwanted hugs, touches, or kisses;
2. Unwelcome attention of a sexual nature, such as degrading, suggestive, or lewd remarks or noises;
3. Dirty jokes, derogatory or pornographic posters, emails, cartoons or drawing; and
4. The threat or suggestion that continued employment advancement, assignment, or earnings depend on whether or not the individual will submit to or tolerate harassment.

Any infraction of this policy by supervisors, co-workers, vendor, customer or visitor should be reported immediately, as outlined below. Confidentiality at the time of reporting the infraction is assured to the maximum extent feasible. Retaliation against any employee for complaining about sexual harassment is prohibited under this policy and illegal under state and federal law. Violations of this policy will not be permitted and may result in discipline up to and including discharge from employment status. Individuals who engage in acts of sexual harassment may also be subject to civil and criminal penalties.

The sexual harassment complaint process is listed below:

1. Any employee who thinks that she or he has been sexually harassed is to report the incident immediately to his or her direct supervisor or the President.

2. If the incident involves the direct supervisor, the incident is to be reported to the next person in the chain of command, such as the Director of the clinical services, Human resources and the President's office.

3. All complaints will be investigated in a timely manner, and will deal directly with the accuser and accused.

Any employee who believes that she or he has not received satisfaction from the above process may file a complaint with the Connecticut Commission on Human Rights and Opportunities, and/or the Equal Employment Opportunity Commission, Connecticut law requires that a formal written complaint be filed with the Commission on Human Rights and Opportunities within 180 days of the date when the alleged harassment occurred.

Remedies for sexual harassment include cease and desist orders, back pay, compensatory damages, hiring, promotion, or reinstatement.

It is not CT-Family Care Services, LLC's intention to regulate social relationships that are freely entered into by employees. However, it is our affirmative duty to develop and maintain a workplace free of sexual harassment and intimidation. We expect the full support and cooperation of every employee to achieve this goal.

Drug and Alcohol Free Workplace

Maintaining a safe and productive working environment for each employee is of vital concern of the CT-Family Care Services, LLC. To further this goal, the CT-Family Care Services, LLC maintains a strong commitment to a drug-free work environment and has developed these drug and alcohol policies to provide guidance for both supervisors and employees in dealing with substance abuse. To further our commitment to provide a safe, drug free environment, the Agency has adopted the following policies:

1. The CT-Family Care Services, LLC advocates early intervention and treatment for employees who are faced with alcohol and drug-related problems. The Agency encourages employees with a substance abuse problem to avail themselves of this help before disciplinary action becomes necessary. Employees who are in recovery are expected to maintain satisfactory job performance and remain committed to a rehabilitation plan. Employees who successfully complete a rehabilitation program, who remain substance free, and who have violated no other agency policy, will not place their

employment at the Agency in jeopardy by reason of substance abuse.

2. The use, sale, possession or distribution of illegal drugs or the abuse of legal drugs while at work, whether on or away from the Agency's office, is strictly prohibited.

3. Alcohol may not be brought or consumed while at work, whether at or away from the Agency's offices.

4. Being under the influence of alcohol or drugs while at work is strictly prohibited. All employees must report to work in a physical and mental condition necessary to perform their jobs without impairment.

5. Failure to fully cooperate with these policies may result in the termination of employment.

6. The use of legally prescribed drugs is permitted on the job, is such use does not impair the employee's ability to perform his or her duties safely.

The CT-Family Care Services, LLC is committed to implementing this policy in a fair and equitable manner which promotes a safe and drug-free workplace, respects the dignity and privacy of the individual, and respects the safety of all employees. The use of illegal drugs and the abuse of legal drugs and alcohol have no place in the work force. The Agency is committed to maintaining a safe, healthy and drug-free workplace.

Office Safety

The Agency recognizes that every employee is entitled to work under the safest possible conditions available. Every effort will be made by the Agency to provide such conditions and to promote proper attitudes towards injury and illness prevention. It is the basic responsibility shared by everyone to make safety realization a part of their daily concern. Employees are obligated to observe the rules and to use all safety equipment immediately to their supervisors to insure the safety of all Agency employees. Staff is expected to be conscious of fire or accident hazards, and to report any concerns to the Business manager, Fire & Emergency Department or call 911 and to the President's office. All Agency employees shall wear seatbelts at all times while either driving or as a passenger in a moving vehicle that is engaged in conducting Agency business.

Zero Tolerance Policy on Workplace Violence

It is the intent of the CT-Family Care Services, LLC to maintain a zero tolerance policy toward workplace violence, or the threat of violence, by any of its employees, customers, the general public and/pr anyone who conducts business with the Agency.

Prohibited Conduct

The Agency does not tolerate any type of workplace violence committed by or against employees. Employees are prohibited from making threats or engaging in violent activities. This list of behaviors, while not inclusive, provides examples of conduct that is prohibited.

- Verbal or physical harassment
- Verbal or physical threats
- Aggressive or hostile behavior that creates a reasonable fear of injury to another person, or subjects another individual to emotional distress
- Assaults or other violence
- Intentionally damaging Agency property or the property of another employee
- Possession of a weapon or firearm while conducting CT-Family Care Services, LLC business
- Committing acts motivated by or related to harassment or domestic violence
- Any other behavior that causes others to feel unsafe, including bullying, discrimination and sexual harassment.

The President needs to be notified of all restraining orders protecting Agency employees.

Reporting Violations

Any employee who becomes aware of another employee or person violating the Agency's Workplace Violence Policy has a duty and an obligation to properly report such violations by one or more of the following methods:

- Call 911 in the event of an IMMEDIATE EMERGENCY. During an emergency involving violence, the first action is to call 911 and report as many details as possible so appropriate emergency response units can be dispatched.
- Notify the President and/or Business Manager.

Reports can be made anonymously and all reported incidents will be investigated. All parties involved in a situation will be interviewed, counseled and the results of the investigation will be discussed with them.

Harassment

Other forms of harassment are also prohibited, such as inappropriate or unwelcome behaviors based on sexual orientation, race, color, religion, marital status, national origin, ancestry, physical disability, age, or other factors, as addressed in the Agency's Equal Employment Policy. (Refer to Page 3 of this Manual)

Smoke-Free Policy

It is the policy of the Agency that no person shall smoke in the CT-Family Care Services, LLC office or while conducting Agency business. This includes hallways, waiting areas, private

offices, public meetings and in vehicles while on Agency business. All complaints will be investigated fully by the President or Business Manager.

Non-Retaliation and Whistleblower Policy

Retaliation of any kind toward any employee or applicant who in good faith perceives violations of the Agency's policies or participates in any related proceedings will not be tolerated. Any employee complaints regarding perceived violation of the Agency's polices governing non-discriminatory employment, workplace safety, ethics, conflict of interest, protection of personal information, harassment, and drug, alcohol and violence-free environment should be referred to the President. If the employee is not comfortable speaking with the President or is not satisfied with the response, documented complaints should be directed to the Executive Board, as outlined in the Agency's Grievance Policy.

Computer Use Policy

Purpose

To provide our employees with the best tools to do their jobs, the CT-Family Care Services, LLC makes available to our workforce aces to one or more forms of electronic media and services, including computers, email, telephones, voice mail, fax machines, external electronic bulletin boards, wire services, online services intranet, Internet and the World Wide Web.

CT-Family Care Services, LLC encourages the use of these media and associated services because they can make communications more efficient and effective. However, all employees and everyone connected with the organization should remember that electronic media and services provided by the agency are agency property and their purpose is to facilitate and support agency business. All computer users have the responsibility to use these resources in a professional, ethical and lawful manner. In order to safe guard clients' confidentiality and that of the agency under the law, all clinical and administrative related forms or documents should be downloaded, printed, completed and filed by employees only at the agency' offices and not at employees' residences or personal computers,etc.

To ensure that all employers are responsible, the following guidelines have been established for using email and the Internet. No policy can lay down rules to cover every possible situation. Instead, it is designed to express CT-Family Care Services, LLC philosophy and set forth general principles when using electronic media and services.

Prohibited Communications

Electronic media cannot be used for knowingly transmitting, retrieving or storing any communications that is:

1. Discriminatory or harassing;
2. Derogatory to any individual or group;
3. Obscene, sexually explicit or pornographic
4. Defamatory or threatening;
5. In violation of any license governing the use of software; or

6. Engaged in for any purpose that is illegal or contrary to CT-Family Care Services, LLC policy or business interests.
7. Exposing details about clients and their treatments to anyone, except for insurance reimbursements, court orders, and parents of children, but an employee must have a signed consent form from clients/parents as well as permission from the Clinical Director and the President.

Access to Employee Communications

CT-Family Care Services, LLC reserves the right, at its discretion, to review any employee's electronic files and messages to the extent necessary to ensure electronic media and services are being used in compliance with the law, this policy and other agency policies.

Employees should not assume electronic communications are completely private.

Software

To prevent computer viruses from being transmitted through the agency's computer system, unauthorized downloading of any unauthorized software is strictly prohibited. Only software registered through CT-Family Care Services, LLC may be downloaded.

Security/Appropriate Use

Employees must respect the confidentiality of other individuals' electronic communications. Except in cases in which explicit authorization has been granted by agency management, employees are prohibited from engaging in, or attempting to engage in:

1. Monitoring or intercepting the files or electronic communications of other employees or third parties:
2. Hacking or obtaining access to systems or accounts they are not authorized to use:
3. Using other people's log-ins or passwords; and
4. Breaching, testing, or monitoring computer or network measures.

No email or other electronic communications can be sent that attempt to hide the identity of the sender or represent the sender as someone else.

Electronic media and services should not be used in a manner that is likely to cause network congestion or significantly hamper the ability of other people to access and use the system.

Anyone obtaining electronic access to other companies' or individuals' materials must respect all copyrights and cannot copy, retrieve, modify or forward copyrighted materials except as permitted by the copyright owner.

Participation in Online Forums

Employees should remember that any messages or information sent on agency-provided facilities to one or more individuals via an electronic network-for example, Internet mailing lists, bulletin boards, and online services – are statements identifiable and attributable to CT-Family Care Services, LLC

CT-Family Care Services, LLC recognizes that participation in some forums might be important to the performance of an employee's job. For instance, an employee might find the answer to a special problem by consulting members of a new group devoted to the special area.

Violations
Any employee who abused the privilege of their access to agency computers, email or the Internet in violation of this policy will be subject to corrective action including possible termination of employment, legal action, and criminal liability.

Employee Records

Employment-related records of current and former employees are confidential and maintained by the President. Current employees are entitled to review their personnel file twice each year.

II. OFFICE HOURS AND LEAVE POLICY

A. HOURS OF WORK

Full-Time Employees

1. **Office Hours** - The office hours of the Agency are flexible depending on need, Monday through Saturday. Staff is expected to be at work on time each day unless a scheduled absence is previously cleared through the President.

    a. When it is necessary for a staff member to arrive late or leave early, advance approval shall be requested of the Supervisor and/or the President. The office manager shall be informed to facilitate handling telephone calls and visitors

    b. In the event of an unanticipated late arrival, the Supervisor and/or the President should be notified directly.

    c. No employee shall be permitted to enter the office at any time other than the designated office hours. If a staff member feels he/she must be in the office other than the normal office hours, he/she must first receive approval from the President. The use or duplication of office keys by a person other than an Agency staff person is prohibited.

Part-Time Employees Work hours and schedule will be determined by the Clinical Supervisor and/or President

Attendance – Excessive absenteeism or tardiness will result in disciplinary that may include termination.

B. LEAVE TIME

Leave Time is available to all full-time employees, upon completion of their Introductory Period, subject to approval procedures.

1. **Vacation Leave** - Vacation leave for full time staff members shall be earned as follows:

    a. Staff members with less than two (2) years of service earn vacation at the rate of 2.69 hours per pay period or ten (10) days per year.

    b. Staff members with over two (2) years of service but less than five (5) years earn vacation at the rate of 4.04 hours per pay period or fifteen (15) days per year.

    c. Staff members with over five (5) years service earn vacation at the rate of 5.38 hours per pay period or twenty (20) days per year.

Staff members shall request and receive approval from the President for vacation at least one week in advance of the leave being taken. Staff members shall tentatively schedule summer vacations in the spring (preferably by May 1), notifying the Business Manger, Clinical Director and the President if plans change or are confirmed. Vacation leave may be accumulated up to a maximum of twenty-five (25) days and will be paid upon termination, provided that, in cases of voluntary resignation, the requisite working notice (as determined by the President) is given by the employee and, in all cases, payment is made for all items chargeable to the individual and billed to the Agency. Please refer to the Resignation and Layoff/Termination provisions of the Handbook.

2. **Sick Leave** - Sick leave for full-time staff members shall be earned at one-half (1/2) day per pay period within a calendar year, equaling 12 days per year. Sick leave is intended for staff members who are unable to work because of personal illness, to care for a sick family member who resides with them, or for medical appointments. Sick leave is not accumulated past the calendar year, and is not paid upon termination. Employees may request to carryover 8 days of sick leave from the previous year. Part-time employees who work between 10 hours/week and 32 hours/week will receive one hour of sick leave for every 40 hours of work per CT State Statutes

    a. Staff members are to notify the office by 9:00 a.m. each day they are absent due to illness.

b. The Office Manager/Business Manger shall report all absences to the Supervisors and the President each morning.

c. An "Application for Leave" shall be filled out for sick leave before noon on the day the staff person returns to work. The form shall be submitted to the President/Business Manager for approval.

d. Anticipated sick leave for medical appointments shall be applied for at least one (1) working day in advance of the leave being taken. An "Application for Leave" shall be filed with the President for verbal approval. .

e. If a staff person becomes ill on the job and finds it necessary to leave the office, he/she shall inform any one staff member at the office before leaving. The staff person then shall inform the President.

f. When sick leave exceeds two (2) days, the staff member must speak directly to the President when calling the office. All sick leave beyond five days shall be directly requested to the President, in writing, along with the doctor's written instructions. Telephone calls to the office will not be accepted beyond five (5) days.

3. **Conference Leave** - Conference leave may be requested by any staff member and will be granted depending upon the judgment of the President as to the relevance to the staff member's work program, duties and responsibilities.

a. Conference information/costs and a brief statement of specific interests in attending each conference shall be submitted with each conference request. A request for advance travel must be completed and submitted to the President for approval at least two (2) weeks prior to the conference.

b. A brief report shall be submitted by each staff person upon their return from each conference in a typewritten form suitable for circulation within the Agency.

4. **Overtime** - Overtime is not provided for professional staff members. Staff who are eligible must be formally asked to work overtime by the President Eligible employees who are requested to work overtime will be paid at the rate of one-and-one half their regular rate of pay for all hours worked over 40 hours in a workweek.

5. **Leave of Absence** - A leave of absence without pay may be granted to a staff person by the President when, in his/her opinion, it will not damage the program

of the Agency. Request for such leave shall be made in writing to the President and should state the time and circumstances involved. No staff person shall be granted a leave of absence to accept other employment.
Subject employee shall not be allowed to accumulate vacation, sick and personal leave from the first day of approved leave of absence without pay.

Full time employees shall receive the following employee benefits during the period of approved leave of absence without pay:

a. Health Insurance
b. Dental Insurance

6. **Personal Leave** - Each full-time staff person may take up to three (3) days of personal leave per year to meet unexpected or emergency situations. Such leave shall be granted at the discretion of the President and earned at 0.807 hours per pay period or three (3) days per year. Personal leave shall not be used for vacation purposes in advance. Personal leave days must be used within the calendar year and may not be carried over.

Newly hired employees may only take one personal day within their six-month Introductory Period.

7. **Military Leave** –

For other than active duty: An employee shall be allowed military leave for required participation in a military unit of the United States. Such leave is in addition to vacation leave, provided such military leave does not exceed ten (10) working days. The Agency will pay the employee the amount, if any, by which his/her Agency salary exceeds his/her military salary for the period involved. Request for this leave shall be made in writing to the President at least thirty (30) days before the first day of leave. A letter is requested from the Commanding Officer stating the time requested and amount of military leave.

For active duty: The federal Uniformed Services Employment and Reemployment Rights Act (USERRA) establishes job rights of employees who voluntarily or involuntarily leave the Agency to undertake military service or certain types of service in the National Disaster Medical System. These rights include reemployment after such military service, providing the following criteria are met:

- The President receives advance written or verbal notice of service;
- The employee has five years or less of cumulative service in the uniformed services while with the Agency;

- The employee returns to work or applies for reemployment in a timely manner after conclusion of service; and
- The employee has not been separated from service with a disqualifying discharge or other than honorable conditions.

Other USERRA provisions include an employee's right to elect to continue existing employer-based health plan coverage for up to 24 months while in the military. If continued coverage is not elected by the employee during military service, the employee has a right to be reinstated in the Agency's health plan upon reemployment, without waiting periods or exclusions, other than for service-connected illnesses or injuries.

8. **Civil Leave** - An employee who is subpoenaed as a witness in a court of law or is called to serve on a jury in a court of law may be granted paid leave for that period of time the staff member is requested to be away from the Agency's employment. Employees must provide the President with a copy of the jury duty notice. An employee who is excused for a day or partial day of jury duty is expected to report
to work.

Bereavement Leave – The CT-Family Care Services, LLC recognizes that a death in the family creates a very difficult time. The Agency seeks to ensure that the employee is able to attend to family matters. To that end, the bereavement guidelines are as follows:

An employee must have completed three months of continuous regular employment to qualify for bereavement leave. This benefit does not apply if the employee is on a leave of absence. Absence due to a death in an employee's immediate family (spouse, mother, father, sibling or child) will be excused and paid up to a maximum of three business days. Additional days may then be granted by the President to use paid or unpaid time, for circumstances such as travel or extenuating circumstances. A one-day absence to attend a funeral of a relative not in the immediate family will be granted and paid as an excused absence. Time off for other funerals will be considered by the President on an individual basis.

9. **Holidays** - All full-time staff members receive the following paid holidays:

New Year's Day
Martin Luther King Day
Columbus Day
Veterans Day
Good Friday
Memorial Day
Independence Day
Labor Day
President's Day
Thanksgiving Day and the day after
Christmas Day and the day before

Holidays will be established, first by Federal law, and then in conformance with the practices of the State of Connecticut.

10. **Weather Leave** - Staff members are expected to report for work regardless of weather conditions, unless a public announcement is made closing the offices for weather reasons. Staff members who do not report for work because of weather conditions must file an "Application for Leave" form immediately when the staff member reports for work. Such a request will be approved by the President for vacation or personal leave.

11. **Compensatory Leave** - Acceptance of a Professional position with the Agency carries with it a professional obligation to attend meetings after hours. Such meetings contribute to the individuals' professional growth and to the success of the Agency, and are a normal part of this line of work. Therefore, compensatory time shall not be granted to staff members attending meetings for the Agency beyond normal working hours.

12. **Maternity Leave** - It is the intent of the CT-Family Care Services, LLC to fully comply with the provisions of Public Act No. 73-647 as this Act relates to maternity leave. Requests for medical disability leave for pregnancy, miscarriage, abortion, childbirth and recovery will be evaluated by the Agency in accordance with The Agency's medical leave policy and applicable state and federal laws. Sick leave, vacation, or personal leave may be utilized during this leave of absence, and if all such leave is expended, the leave will be granted without pay. Except for medical restrictions, the staff member is expected to return to the position within a reasonable time after the disability has been concluded. Pregnancy related disabilities are treated for salary continuation purposes the same as a disability for any other reason.

13. **Employment Protection for Victims of Domestic Violence (PA 10-144)** – Employees who are victims of domestic violence shall not be terminated, penalized or threatened or coerced with respect to his/her employment because the employee: (1) is a victim of family violence; or (2) attends or participates in civil court proceeding related to a case in which he/she is a family violence victim. Employees who are victims of family violence shall be allowed to take paid or unpaid leave to: (a) seek medical cared or counseling for physical or psychological injury or disability; (b) obtain services from a victim services organization; (c) relocate due to the family violence; or (d) participate in any civil or criminal proceeding related to or resulting from such family violence. The Agency can limit the unpaid leave to 12 days in a calendar year if they deem it is necessary.

III. EMPLOYMENT PROCEDURES

A. RECRUITMENT POLICY

It shall be the responsibility of the President to interview and hire the employees of the CT-Family Care Services, LLC. These responsibilities may be implemented with the assistance or designated supervising personnel. In interviewing and hiring employees of the Agency, no discrimination by race, color, gender,, age, religion, sexual orientation, marital status, membership in the in the uniformed services, citizenship, ancestry or national origin shall be practiced. It is intended that all policies will be complete compliance with the Civil Rights Act and the Fair Employment Practice Act of 1988 as amended. In compliance with immigration laws, all employees are required to provide proof of work eligibility and identification and complete the employee portion of the I-9 Employment Verification Form. All employment offers will be conditioned on providing proof of work eligibility and identification. In addition, third-party background investigations and drug testing are required before any offer of employment. All job openings will be advertised in appropriate publications or on-line. The Agency will utilize professional organizations in recruiting professional personnel.

1. **Employment Requirements** - Applicants for employment by the Agency will be selected on the basis of education, training and employment experience. The selection of employees of the Agency will be the responsibility of the President. All candidates for employment shall meet the basic education and/or experience opportunities offered by the Agency. In the final selection of qualified candidates for staff positions, attention will be given to the best interest of the Agency and its programs.

2. **Interview Expenses** - In the event that the President deems it necessary to have a person travel from out-of-state to the Agency office for the purpose of interviewing for possible employment, the travel expenses incurred by the prospective employee may be reimbursed by the Agency.

3. **Introductory Period** - After accepting employment with the Agency and beginning work, the employee shall be under an Introductory Period of employment for up to six (6) months. During the Introductory Period the employee will be observed and evaluated in terms of his/her competence for the job for which he/she has been employed. At the end of six (6) months, the President shall determine his/her qualifications for continued employment including reviews and discussions with staff members and his/her supervisor. The staff member shall have the opportunity to consider his/her satisfaction with the employment setting and working conditions. A written record of this review shall be placed in the staff member's personnel file. Each staff member shall be notified by the President after the conclusion of the Introductory Period and

employment may be terminated by the President. No salary increase or vacation leave may be granted during the Introductory Period

Outside Employment
Employees may work for another organization if Agency performance standards are met; the employee is able to comply with attendance schedules, including required meetings after hours; and the President determine that no conflict of interest exists with the second employer.

Resignation - Any staff member who desires to terminate his/her services with the Agency shall submit a written resignation to the President and work through the notice period noted below unless this requirement is waived by the President. Resignation for the professional staff shall be submitted not less than thirty (30) days before the final day of work. All other staff members shall not give less than two (2) weeks written notice of resignation. Any staff member who does not provide adequate working notice (as determined by the President) or who is absent from work for a period of three (3) days or more without notifying the President of the reasons for his/her absence may be considered having resigned without notice and not in good standing. Any staff member, who leaves the Agency service without resigning in good standing, as defined in this manual, shall have that fact entered in his/.her personnel record. If the situation warrants, he/she may be deprived of his/her right to receive any reimbursement for accumulated vacation.

Disciplinary Action - Any staff member may be subject to disciplinary action due to the staff member's failure to perform duties in a manner acceptable to his/her supervisor or for personal actions which discredit the Agency's service. An employee whose performance is not satisfactory will generally be counseled by a supervisor, and provided with a performance improvement plan. If performance does not satisfactorily improve, or the employee seriously violates an Agency policy, termination of employment may result. Alternative disciplinary courses are as follows: (1) Written Reprimand), (2) Demotion, (2) Suspension, (3) Other appropriate measures.

The President may suspend, with or without pay, or terminate a staff member with cause. All such actions shall be recorded in the staff member's personnel file. However, any lay-off action due to the Agency's financial conditions shall be approved by the President. A two (2) week advance notice shall be given to the terminated staff member prior to the final work day.

B. COMPENSATION POLICIES

It is the policy of the CT-Family Care Services, LLC to compensate staff members according to their contributions to the Agency's programs. Compensation does not

necessarily correlate with academic qualifications, tenure with the Agency, or titular rank. Other things being equal, longevity will be recognized. Each staff member is entitled to an appraisal of work performance by supervisory personnel. The performance report will be discussed with the staff member before the end of the first six (6) months of service and at least once a year thereafter. The report will be used as a basis for successful completion of the Introductory Period at the end of the staff member's first six (6) months as well as for all promotions and transfers.

A staff member may be considered for a salary increase or promotion at any time. The President will authorize merit increases and/or promotions after consulting with the staff member's supervisor and reaching concurrence with his/her recommendations.

1. **Salaries and Wages** - Salaries and wages will be determined once every year for each staff member as part the Agency's budgetary process. Salaries and wages for new hires, promotions and merit increases may be determined during the year by the President. A written record of this evaluation and determination shall be placed in the staff's personnel file.

   Salary checks will be issued at two-week intervals for a total of twenty-six (26) checks per year. In order to be eligible to receive a salary check, a staff member must have completed a time sheet provided by the Office Manager to the President.

2. **Social Security, Worker's Compensation and Unemployment Compensation** - Staff members will participate in Social Security, and will be covered by Workers Compensation and Unemployment Compensation in accordance with State and Federal regulations.

3. **Insurance and Benefits** -The following plans are presently authorized for full-time employees. It is expected that they will be continued throughout each fiscal year, but that all insurance policies will be reviewed at the annual budget review, at which time changes may be made.

   a. Medical, hospitalization, prescription coverage and dental insurance will be provided for Agency employees and their eligible dependents. Employees and Employers share shall be set each year by the President.

   b. 401 K Plan will be made available to all employees with no contribution by the Agency only by the employee.

   c. If employment with the Agency is terminated for any reason, the employee and his/her dependents are eligible for continuation of health insurance benefits under the Consolidated Omnibus Budget Reconciliation Act (COBRA); certain qualifying events may also

apply. The employee is fully responsible for the costs of COBRA coverage and would receive written notice by the President.

4. **Professional Memberships** - The Agency may reimburse dues for an individual's membership in an appropriate professional organization upon the approval of the President. If funds are available

5. **Conference and Seminar Participation** - Staff members may be reimbursed for attendance of seminars, conferences or workshops. Staff members desirous of participation in such an activity will request approval by his/her immediate supervisor who will in turn make a final recommendation to the President. The final decision shall be rendered by the President. If funds are available

6 **Educational reimbursement** – Professional staff is eligible for 50% reimbursement of enrollment fees for courses directly related to advanced degree requirements within their professional field. Pre-approval by the President is required and the employee must receive a passing grade of "B" or better. If funds are available

7. **Travel**- Travel costs incurred by a staff member on Agency business shall be reimbursed. The use of a personal automobile on such business may be reimbursed at the rate approved by IRS per mile, plus parking charges and highway tolls. All travel and conference expenses must be supported by appropriate forms with receipts or detailed reporting of all expenses on "Travel Expense" vouchers. When required to be out of town overnight on Agency business, the traveling staff person may request an advance of expense money to meet expenses. All out-of-region travel shall be approved by the President in advance.

8. **Meals** - Within limitation, the Agency staff will be reimbursed for actual expenses incurred while the staff member is on authorized Agency business. Expenses for meals on Agency business will be reimbursed whenever the staff member is outside the Region. Receipts are required for all reimbursements. Normally, lunches will be considered reimbursable for staff members departing the office before 10:00 a.m. and returning after 2:00 p.m. Dinner may be reimbursed for staff members departing their duty station before 4:00 p.m. for Agency business and returning after 8:00 p.m. Breakfast expenses may be reimbursed either after an overnight stay from home or when the staff member is required to leave home before 6:00 a.m. to meet his/her business appointment.

Staff members may pay for meals of others with whom Agency business is transacted. Prior approval will be arranged from the President by memorandum naming the person or persons to be fed and the business involved. This practice will be held to a minimum since there is little occasion for its use.

9. **Working Meals** - Exceptions to the above guidelines may be granted in the event of a working meal. A working meal is one in which a staff member has no choice of the place or menu selection, such as a convention banquet or an official luncheon. With appropriate documentation, such meals are reimbursable at the actual cost and without geographic location restraint.

10. **Parking Fees** - Costs incurred for parking of personal vehicles while engaged in Agency business will be reimbursed at the exact expense.

11. **Travel Vouchers** - Reimbursement requests for expenses incurred on official Agency travel shall be submitted for each month on a "Travel Expense" voucher when the monthly total exceeds $5.00. Vouchers for payment should be submitted on the first of the month following the period ended. Each staff member shall submit his/her voucher to his/her immediate supervisor who will review and determine if they are appropriate and reasonable. Supervisors may consider trips made without prior authorization to be inappropriate and not reimbursable. After review by supervisory personnel, vouchers will be submitted to the Office Manager who will assure that the vouchers are arithmetically correct and sufficiently documented to meet auditing standards. Final approval of the reimbursement request will be made by the President.

C. EMPLOYMENT POLICY

Full Time Employees

Full-time employees are defined as an employee who works 35 -40 hours each week.

Part Time Employees

1. Part-time employees shall be defined as an employee who works 10-32 hours a week in the CT-Family Care Services, LLC office.

2. The part-time employees shall have Workman's and Unemployment Compensation. Part-time employees shall not receive holiday or vacation leave pay or health benefits.

3. The working schedule of a fixed-salary, part-time employee shall be determined by the Agency's President and is subject to change.

D. GRIEVANCE PROCEDURES

1. **Definitions** - A grievance shall mean a complaint by a full-time or part-time staff member, that, during the carry-out of authorized work for the CT-Family Care Services, LLC, he/she has been subject to arbitrary, capricious or discriminatory policy or practices have been improperly or inequitable applied.

2. **Step A** - A staff member having a complaint or grievance, as defined above, shall first present and discuss the complaint and grievance with the Business Manager. The Business Manager shall initiate an informal conference with the staff member and all involved parties with notice of right to file a grievance if a satisfactory resolution to the problem is not accomplished. This shall be completed within twenty (20) working days from the date of the complaint. If the aggrieved party is not satisfied, the complaint will move to formal grievance procedures.

3. **Step B** - If the complaint is not resolved to the staff member's satisfaction, the staff member may appeal, in writing, to the President citing specifically the person(s), act(s), or condition(s) against whom or which the grievance is directed, and the grounds on which the written appeal is taken. The President shall conduct an investigation to attempt a solution and will present a decision and notify, in writing, all parties concerned within twenty (20) working days of receipt of the written grievance. If the matter is resolved to the staff member' satisfaction, the staff member shall so state, in writing, to the President and no further action shall be taken.

PERSONNEL POLICIES AND EMPLOYEE HANDBOOK
OF THE
CT-FAMILY CARE SERVICES, LLC

I, _____, hereby acknowledge receipt of my copy of the CT-Family Care

Services Personnel Policies and Employee Handbook

Employee Name (please print) _____

Employee Signature _____

Date _____

Witnesses(Supervisor)_____

Date_____

Some Resumes:

PERSONAL INFORMATION:

JUSTINIAN RWEYEMAMU, MA, M.Div, MS-MFT, PhD student

16 Enfield Avenue
Enfield, CT 06082
Phone 860-508-8651
Email: rweye@cox.net

EDUCATION

- 2010-2013/4
  Doctoral studies and research (PhD) in marriage and family therapy at Antioch New England University, NH. Continue with clinical training, studies, conducting diagnostic assessments and develop treatment plans and researches at doctoral level on enhancing coping skills and effective readjustment for people with trauma symptoms, marital and family issues for individuals, couples and families. In training to become an American Association of Marriage and Family Therapy Approved Supervisor (AAMFT-Approved Supervisor)
- 2009-2010
  Thesis Research at the National Military Premier Hospital-Walter Reed Medical Center-Washington, DC on the need for integrated treatment with social-cultural-emotional-spiritual-relational and economic (SCESRE) components as the keys to effectively enhance coping skills and treating trauma including PTSD as well as its symptoms.
- 2007- 2010
  Master Degree in Marriage and Family Therapy (MS-MFT), Central Connecticut State University, New Britain, CT. USA

- 1992-1993 Master of Arts (M.A), Holy Apostles College, Connecticut, USA
- 1991-1992 Master of Divinity (M.Div), Holy Apostles College, Connecticut, USA
- 1987-1991 Completion of the Bachelor of Arts Degree, AJ Major Seminary, Kenya .
- 1986-1987 Diploma in Philosophy, Apostles of Jesus Major Seminary, Kenya
- 1980-1984 Biharamulo Secondary School, Tanzania

WORK EXPERIENCES:

Areas of Expertise:

Administration

- Program administration
- Team building and leadership
- Public speaking and education
- Program development/enhancement
- Business skills and Community Economic Development Projects

Clinical

- Customized spiritual, social and counseling services
- Enhancing coping skills developments for individuals in a systemic context
- Assistance to veterans, refugees and others for sustainable self-reliance
- Readjustment counseling and treatment plans through individuals, families and group therapies for veterans and others in need of spiritual-clinical- social –mental health care in communities.

- Counselor for students and families on school dropout prevention
- Spiritual and pastoral counseling to individuals, families and groups
- Counselor for Families, Hospices, Hospitals, Home visits, Department of Correction. Family counseling to children, youth, adults and families.
- Supervisor in Training to become an AAMFT approved Supervisor

Education: Holds three Masters Degree and PhD student as well as AAMFT Approved Supervisor in Training

CAREER HIGHLIGHTS

- I have an extensive experience in management and counseling after having worked as a Chaplain and counselor at Connecticut Department of Correction for ten years.
- I was also a Founder and President of an international organization (Buguruka Orphans & community Economic Development or BOCED Inc.) for twelve years.
- I have served as a clergy and a parochial vicar at various parishes and communities for seventeen years in Connecticut and beyond.
- For six years I was a Board member in the State Advisory Board for Connecticut Department of Economic and Community Development(DEC) in promoting mutually beneficial trade between Connecticut and Africa(import and export).
- Currently, I am President of Connecticut Family Care Services, LLC (or CT-Family Care Services, LLC). CT- Family Care Services is a minority owned consulting company in Healthcare industry
- I have intensive clinical experiences working with children, youths, parents, adults, families, seniors, veterans, academicians and professionals

PROFESSIONAL CLINICAL EXPERIENCES

July 2007-Present: President, CT-Family Care services, LLC

- CT- Family Care Services is a minority owned consulting company, registered in Connecticut.
- The company provides integrated treatments which in order to enhance coping skills and
- Decrease high school dropouts, poor academic performances, delinquencies, imprisonment, substance uses and mental health issues among students, irresponsible parenthood and family dysfunctional relationships that affect children and families
- Reduce or prevent social-academic and economic constraints affecting children, families of veterans when parents are on combats or away from home
- Reduce unsatisfactory coping skills among combat veterans, and minorities that hamper healthy readjustment into non-combat daily life routines.

Family Counseling, River Valley Counseling Center, Chicopee, MAL April 2011-August 2011

- Did diagnostic assessments accordingly for individual adults, families and groups.
- Provide individual, couple and Family Therapies
- Directed weekly therapeutic sessions for clients, developed appropriate treatment plans.
- Worked with state agencies such as DCF for the betterment of children and families

Marriage and Family Therapy Graduate Program at Connecticut Central State University:

Jan 2007- May, 2010. This Program has prepared me as follows:

- It has enhanced my therapeutic knowledge and systemic skills in assisting individuals, groups, couples, and families to articulate the issues that affect them.
- Conduct intakes, do diagnostic assessments, treatment plans and therapeutic sessions accordingly.
- Enabled me to work with clients in ways that enhance their coping skills in order to explore and utilize the resources within and around them to solving their constraints.
- Prepared me to integrate effectively the social-cultural-spiritual-relational-economic components needed to compliment the traditional treatment for mental health issues.

Thesis Research at the National Military Premier Hospital: April 2009- August 2010

- Conducted a thesis research at Walter Reed Medical Center in Washington DC, and at the Pentagon, on Post traumatic stress disorder (PTSD) and its symptoms among veterans and families.
- Realized how to enhance their coping skills through an integrated treatment with strong social-cultural-spiritual-emotional and economic components and how to improve their readjustment after deployments or when struggling with PTSD and its symptoms.
- Found out that treatments which downplay the social-cultural-spiritual-emotional components remain ineffective to eliminating PTSD symptoms and their real causes for sustainable recovery (Trauma/PTSD symptoms include substance abuses, alcohol, depression, spiritual guilty, suicide tendencies, relational, marital crises and mental health illnesses).

Internship at Community Mental Health Affiliates (CMHA): April 2010-June 2010

- Did diagnostic assessments accordingly for individual adults, families and groups.
- Directed weekly therapeutic sessions for clients, developed appropriate treatment plans.
- Prepared progress notes and helped clients realize the systemic nature of their constraints and how to overcome them.
- Guided clients to taking active roles to recovery and enhancement of their coping skills so as to enable them overcome their constraints. Assisted clients including veterans utilize other community resources for further assistance according to clients needs.
- Assisted clients and their families through therapeutic treatment in solving crisis situations such as assaults, potential suicides, murder and domestic violence and provide a stabilization and effective follow-up.
- Assisted veterans therapeutically with treatments including development of comprehensive treatment plan for adjustment as needed, including finding housing, jobs, overcoming depressions and substance uses and active integration in civic communities.

Internship (May 2009-May, 2010) at Family Therapy Institute

- Did diagnostic assessments accordingly for individual children and developed appropriate systemic treatment plan for individual children and their families.
- Provided systemic integrated counseling/family therapy to children and their families in social context for sustainable healing.
- Through individual and family therapies, assisted both children and their parents to ***enhance*** clients' coping skills holistically in order to increase concentration on tasks at school and at home.
- Through therapy, reduced problematic behaviors at school and at home and increased children's academic performances at schools.
- Provide therapeutic treatment to children and families in a way that clients are able to identify and find solutions to their mental-social- emotional and relational constraints that affect them.

- Worked with the Department of Children and Families (DCF) representatives, court system, school leaders, church leaders, Department of Developmental Services (DDS), Department of Mental Health and Addiction services (DMHAS) and the Department of Social Services to fostering the well-being of clients in communities.

Practicum at an Alternative High School: April 2008-May 2009

- That school had high risk students.
- Provided integrated family therapy to students and their families.
- Counseled students with issues such as: substance abuses, domestic violence, school dropout, disabilities, family crises, relational crises, lower academic performances and discouragements from pursuing education, delinquencies, trauma and depression on how to overcome those constraints successfully.
- Assisted clients to improve in their academic performances and behavioral recovery

Non-Denominational Chaplain, April 1992 – 2005

- Provided counseling in Nursing Homes, Hospitals. Also I did Home Visits and Hospice Ministries.
- Coordinated, supervised and promoted multi-cultural counseling and social care services.
- Recruited volunteers for nursing homes, hospitals, and hospice ministries.
- Promoted community awareness to the needs of those in nursing homes, prisons, hospitals. Provided integrated pastoral care and spiritual-social counseling to individuals, staff members and families.
- Served at eleven state prisons of different levels including the youth prison and the highest maximum security prisons which enhanced my clinical skills of serving civilians and veterans who are imprisoned

Parochial Vicar April 1992 – December 2006:

- Provided spiritual care and integrated counseling to youth, adults and families. Motivated volunteers in creating and implementing outreach programs in parishes, nursing homes, hospitals, hospices, prisons and in community for people in need.
- Organized and participated in community activities and coordinated outreach activities for families in need including veteran families who were my parishioners and those who were non-parishioners, yet in need of interfaith outreach services.
- Developed spiritual care, integrated social care and customer-focused counseling services for all people including those who have substance abuse issues, the elderly, divorced, remarried individuals, and those who have economical challenges, developmental disabilities, mental health issues including readjustments for veterans and their families. Most of my parishes had a good number of both retired and active veterans, especially in New London, Ledyard and Vernon towns in Connecticut.

State Department's Correctional Institutions, Chaplain, August 1995 – October 2005

- Fostered a non-denominational counseling and teamwork approach to inmates, staff and their families as needed and in line with the Department of Correction (DOC).
- Maintained safety, healthy and healing environments during therapeutic sessions. Developed and implemented integrated trainings and counseling treatments for inmates to embrace responsibilities in life in general in ways that foster positive civic duties.
- Developed programs on multi-cultural diversity, accountability, impartial spirituality, and other habits for integrated successful counseling in prisons/jails.

National Research Center (NORC), the University of Chicago / City of Hartford Connecticut, Aug 2006- Dec 2006

- Fostered a non biased , non judgmental approach to individuals and their communities regardless of their social-statues, so as to gain their trust and the interview's integrity

- As a Field Interviewer, contacted the scientifically selected households/candidates and created a ground for successful interviews in order to complete the task.
- Brought enlightenment and encouragement to individuals, families in order to participate in the project, voice their opinions, and yet remain active participants in their neighborhood improvement initiatives.

Buguruka Orphan and Community Economic Development (BOCED), Inc. July 1997-present

- Improved the standard of living of destitute orphans, children, women, people with disabilities and families, elderly and retired veterans in the area.
- Administered school breakfast program, which fed about 3,500 children on a daily basis, built a dispensary and school
- Acquired donated medicine and medical supplies for dispensary- valued at $200,000.
- Enabled Pfizer to adopt Tanzania into the first five selected nations worldwide for trachoma prevention programs and about $2,000,000.00 was donated for medical supplies and cash.
- Effective advocate for veterans and other people with disabilities, mental health issues, elderly people, children and gender issues for the common good.
- Designed, developed, and conducted guided academic-cultural-business tours from America to Tanzania, East Africa to explore business opportunities, promote charitable donations, and opportunities and met with business as well as communities and governmental health leaders and discussed on social-healthy- economic issues in a win-win approach for both nations.

SPEAKING ENGAGEMENTS

- Regularly spoke to community groups, churches and educational and professional institutions on African and American cultures, Social Services, economic opportunities, and the importance of sustainable self-determination for all people and on how to utilize American cross-multicultural values to healing or reducing mental health crises in America.

PROFESSIONAL ASSOCIATIONS

American Association of Marriage and Family Therapy (AAMFT)
Connecticut Association of Marriage and family Therapy (CTAMFT)
Manchester Chamber of Commerce in Connecticut
Associated Industries of Massachusetts (AIM)

Briefly,

- I believe that I will bring excellent quality of services and values including, trust, respect commitment, dynamic and charismatic teamwork approach filled with empathy, compassion and understanding to each client and his or her family and to staff members.

- I have expertise in providing comprehensive intakes and diagnostic DSM-IV assessments. Working with individuals and families in a way that effective customized, family or group treatment plan is developed and implemented accordingly. Handle crisis interventions timely and build up comprehensive treatment plans for clients.

- I have the ability to manage by inspiring staff and clients when they have complex clinical cases to find better win-win adjustments needed by clients.

- I speak fluently several languages: Swahili, Kihaya and English as well as other African dialects and I have an extensive international experience. I bring comprehensive integrated clinical, academic, research, administrative and business experiences.

Justin's Degrees and Certifications

Central Connecticut State University

New Britain, Connecticut

In recognition of fulfillment of the prescribed course of study
authorized by the Board of Trustees for the Connecticut State University System,
and upon the recommendation of the faculty,
the hereby confer upon

Justinian Benedicto Rweyemamu

the Degree of
Master of Science
in Marriage and Family Therapy

with all the honors, rights, and privileges appertaining thereunto.

In Witness thereof, the undersigned have affixed and subscribed their names
on this the twenty-sixth day of August, two thousand ten.

Karl J. Krueger
Chairman, Board of Trustees
Connecticut State University System

David P. Carter
Chancellor
Connecticut State University System

John W. Miller
President
Central Connecticut State University

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Central Connecticut State University
Department of Counseling and Family Therapy
Marriage and Family Therapy Program

2010 FACULTY CAPSTONE EVALUATION

CANDIDATE: **Justinian Rwyemamu** Date: May 4, 2010

A. Evaluation of Written Case Narrative:

You have demonstrated a general understanding of systemic concepts and a satisfactory ability to apply Metaframeworks domains in assessment and treatment planning. You also demonstrated a good ability to observe meaningful data at different levels of system (individual, family, extrafamilial). Your written work also demonstrated an ability to handle case management procedures professionally.

B. Evaluation of Oral Case Presentation with Videotape Excerpts:

Your videos and presentation offered good interventions that demonstrate your creativity, your poised, solid leadership in the therapy room, and your good use of self. Your use of your own cultural traditions was beautifully and effectively applied. Your videos also reflected a good focus on family strengths and a de-pathologizing of the identified patient. Your presentation was well-organized and offered a well-integrated and interesting systemic description of family relationships. You responded to the questions posed openly and thoughtfully.

C. Combined Evaluation of Written and Oral Presentation:

You have demonstrated: (1) a good link between your theoretical formulations (hypotheses and goals) and your clinical interventions; (2) ability to communicate your work effectively to professional peers; (3) openness to constructive criticism of your work.

D. Faculty Comments:

Your Capstone provides a good demonstration of your growth as a marriage and family therapist.

THEREFORE, It is the unanimous decision of the MFT Program Clinical Faculty that you be deemed to have passed the Capstone Project requirement toward Graduation.

Ralph S. Cohen, Ph.D.
Program Director, Professor

Linda L. Terry, Ed.D.
Adjunct Clinical Professor

Sandi S. Schrader, Ph.D.
Adjunct Clinical Professor

SCHOOL OF
GRADUATE STUDIES
CCSU
Central Connecticut State University

September 2, 2010

Mr. Justinian Rweyemamu
16 Enfield Avenue
Enfield, CT 06082

Dear Mr. Rweyemamu:

I accept your thesis on behalf of the School of Graduate Studies at Central Connecticut State University. I have read your thesis with interest and congratulate you on completion of this important component of your M.S. MFT degree program. You and your thesis advisor, Dr. Daniel Wiener, should be pleased with your research on *PTSD and War: Enhancing Coping Strategies of PTSD Veterans in Their Families and Communities.*

Central takes a special interest in each of its alumni as they become representatives of the institution. Your future achievements will bring honor not only to yourself, but also to your alma mater. I wish you the best as you pursue work in your chosen profession and hope that the degree you earn at Central will contribute to a rewarding and successful career.

Sincerely,

Paulette Lemma

Dr. Paulette Lemma
Assoc. V. P. for Academic Affairs/
Dean, School of Graduate Studies

cc: Dr. Daniel Wiener, Thesis Advisor
Degree Auditor
Dean, School of Education and Professional Studies

1615 Stanley Street ~ P.O. Box 4010 – New Britain, Connecticut 06050-4010 ~ T: 860-832-2363 – F: 860-832-2352 ~ www.ccsu.edu

Justinian Rweyemamu

has attended, in its entirety, the following program:

Responding to the needs of Combat Veterans and Their Families

September 11, 2010, Credit Hours: 6

Co-Sponsored by

The Western Mass EMDRIA Regional Meeting

And

Department of Veterans Affairs Medical Center, Northampton

This Activity has been certified by the Massachusetts Association for Marriage & Family therapy, Inc. for professional continuing education. Certification #PC-09256

This program is authorized by MMCEP to give 6 Category 1 credit hours to LMHC therapists, authorization _____.

Mark Nickerson

Mark Nickerson LICSW
Coordinator
Western Mass EMDRIA Regional Meeting

CHBT

Center for Health & Behavioral Training

"CHBT is a Division of the University of Rochester and Partner of the Monroe County Department of Public Health"

Dear **Justinian Rweyemamu:**

This letter of attendance recognizes your completion of the **Prevention Training Center** training program,

"Selecting Effective Behavioral Intervention"

(attended 16.0 out of 16.0 hours)

This 11th -12th day of October, 2007

Training Highlights of this course include:

- Presentation of a systematic approach to selecting evidence-based behavioral interventions
- Identify key areas to understand in the intervention population, intervention options, and agency capacity
- Practice applying principles learned through case

This training is provided under New York State Office of Alcoholism and Substance Abuse Services (OASAS) Education and Training Provider Certification Number 0305. Training under a NYS OASAS Provider Certificate is acceptable for meeting all or part of the CASAC/CPP/CPS education and training requirements.

Congratulations on Your Achievement!

Kimberly Berkhoudt MS, NP

Kimberly Berkhoudt MS, NP
Training Center Manager

NYS Department of Health AIDS Institute
Regional Training Center

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Holy Apostles College and Seminary

Cromwell Connecticut

ERUNT SICUT STELLAE
HOLY APOSTLES COLLEGE AND SEMINARY

The President and Board of Trustees
of Holy Apostles College and Seminary
in the State of Connecticut announce that

Justinian Benedicto Rweyemamu

is granted the Degree of

Master of Arts

with all the rights and honors therein

On this 12th Day of May 1993 we subscribe our signatures
by the authority granted to us by the State of Connecticut

Sister Mary Regan, R.S.M.
Academic Dean

Rev. Douglas L. Mosey, C.S.B.
Registrar

President and Rector

Rev. Bradley W. Pere, M.S.A.
Secretary of the Board of Directors

Holy Apostles College and Seminary

Cromwell Connecticut

HOLY APOSTLES COLLEGE AND SEMINARY * ERUNT SICUT STELLAE *

The President and Board of Trustees
of Holy Apostles College and Seminary
in the State of Connecticut announce that

Justinian Benedicto Rweyemamu

is granted the degree of

Master of Divinity

with all the rights and honors therein.

On this 13th of May 1992 we hereby affix the seal of this College and subscribe our signatures by the authority granted to us by the State of Connecticut

Rev. Bradley M. Peirce, M.S.A.
Secretary, Board of Directors

Some selected resumes (supervisors):

Sebastian Perumbilly, Ph.D., LMFT

8308 NE 176th place, Unit D, Kenmore, WA 98028
Residence: 425-408-1091, Mobile: 206-446-8865
Perumbil@lclark.edu, Sebpmft@yahoo.com

EDUCATION

University of Connecticut, Storrs, CT
Doctor of Philosophy (Ph.D.) in Human Development and Family Studies August 2011
Department of Human Development & Family Studies
Area of concentration: *Marriage, Couple & Family Therapy*
Dissertation title: *Substance Abuse and Addiction Treatment Programs in India: Exploring the Voices of Indian Treatment and Research Professionals.*

The Gottman Institute, Seattle, WA
Completed **Level 1 & 2 Training focusing on Assessment, Intervention and Co-Morbidities in Gottman Method Couples Therapy** under the direction of Drs. John Gottman and Julie Schwartz Gottman, Seattle, Washington March 2011

University of Connecticut, Storrs, CT
Master of Arts (M.A.) in Human Development and Family Studies May 2005
Department of Human Development & Family Studies
Area of concentration: *Marriage, Couple & Family Therapy*

Holy Apostles College & Seminary, Cromwell, CT
Master of Arts (M.A.) in Theology May 2001
Area of concentration: *Bioethics*
Thesis title: *Ethics of Reproductive Technology*

St. Pius X College & Seminary, Goregaon East, Bombay, India
Bachelor of Theology (B.Th.) October 1996
Area of concentration: *Systematic Theology*
Thesis title: *Divine-Human Intimacy*

RESEARCH EXPERIENCE

Graduate School of Counseling & Education, Lewis & Clark College, Portland, OR
Currently engaged in an ongoing research project focusing on training addiction treatment professionals associated with Regional Resource Training Centers (RRTCs) affiliated to India Government's National Institute of Social Defense (NISD). Foci of this research project are three fold:

- Studying the effects of integrating yoga in substance addiction treatment;
- Studying the effects of integrating couple and family therapy in substance addiction treatment;
- Needs assessment for substance addiction treatment programs in India

Department of Human Development & Family Studies, University of Connecticut, Storrs, CT
Completed a publishable research study on Substance abuse and Addiction Treatment Programs associated with the National Centre for Drug Abuse Prevention (NCDAP), India. This study involved

addiction treatment centers associated with all the eleven Regional Resource Training Centers (RRTCs) in India. This study has potential policy implications for Indian treatment programs under the ministry of India. April 2010-August 2011

Department of Human Development & Family Studies, University of Connecticut, Storrs, CT
Graduate Research Assistant August 2004 - May 2006
Supervisor: Dr. Teresa McDowell, Professor and Director of Marriage, Couple & Family Therapy Program, University of Connecticut.

- Reviewed research literature and coordinated various research projects for Dr. McDowell.
- Assisted Dr. McDowell in her projects on conceptualizing and developing *Multiculturally-Focused Family Therapy approaches*, and *Global Family Therapy* courses.

RESEARCH INTERESTS

- Substance addiction treatment programs in global treatment contexts
- Developing culturally sensitive assessment instruments for working with couples and families
- Integrating spirituality in marriage, couple and family therapy training programs
- Substance addiction treatment program development in postcolonial countries
- Training competent addiction treatment professionals
- Influence of twelve-step programs in treating substance addiction: lessons from postcolonial countries
- Designing and implementing prevention (primary, secondary and tertiary) programs against substance abuse at national and international settings
- Substance abuse and addiction research: integration of prevention and treatment programs
- Influence of using yoga in substance abuse and addiction treatment programs: lessons from postcolonial India
- Role of families in substance abuse and addiction treatment: lessons from global treatment context
- Treating substance abuse and addiction in couples
- Treating substance abuse and addiction in families
- Developing culturally sensitive clinical assessment tools for treating substance abuse and addiction in couples and families

ACADEMIC TEACHING EXPERIENCE

School of Health and Human Services, Southern Connecticut State University, New Haven, CT
Assistant Professor in Marriage and Family Therapy Starting in August 2012

Graduate School of Counseling & Education, Lewis & Clark College, Portland, OR
Assistant Professor August 2011-August 2012
Core Program Faculty August 2009-July2011
Adjunct Faculty June 2008-August 2009

Courses taught at the Graduate level at Lewis & Clark:

- *Family Therapy: Theory and Practice (504)*
- *Family Development (CPSY-516)*
- *Marital, Couple & Family Assessment (CPSY-561)*
- *Advanced Family Therapy (CPSY-562)*
- *Substance Addiction & Treatment Issues in Marriage Couple and Family Therapy (CPSY-563)*

- *Marriage, Couple and Family Therapist & Spirituality (CPSY-563-01)*
- *Treating Addictions in Marriage, Couple & Family Therapy (CPSY-564)*
- *Legal and Ethical Issues in Marriage, Couple & Family Therapy (CPSY-566)*
- *Introduction to the Professional Field of Marriage, Couple and Family Therapy (CPSY-569)*
- *Marriage, Couple & Family Therapy Practicum Supervision (CPSY-584)*
- *Marriage, Couple & Family Therapy Internship Supervision (CPSY-588)*

Department of Marriage and Family Therapy, Seattle Pacific University, Seattle, WA 98119
Adjunct faculty Summer 2009
Courses taught at the Graduate level at Seattle Pacific University
- *Treatment of Adolescents and their Families* (MFT 6642)

Department of Human Development & Family Studies, University of Connecticut, Storrs, CT
Adjunct faculty May 2006 - May 2008
Courses taught at the undergraduate level at the University of Connecticut
- *Individual and Family Development* (HDFS 190)
- *Introduction to Systemic & Family* Counseling (HDFS 266)
- *Family Interaction Processes* (HDFS 273)

Department of Human Development & Family Studies, University of Connecticut, Storrs, CT
Positive Parenting Educator June 2005 - August 2008
- Taught a court-mandated six-hour psycho-educational program for divorcing parents with children below the age of 18 years.
- Program focused on *child-focused family restructuring, psychosocial development of children, dealing with stress*, and post-divorce *positive co-parenting.*

Department of Human Development & Family Studies, University of Connecticut, Storrs, CT
Teaching Assistant August 2005 - May 2006
Supervisor: Dr. Ronald Sabatelli, Professor, School of Family Studies
- Served as a teaching assistant in conducting courses taught by Dr. Sabatelli.
- Tutored students with learning disability in the program.
- Conducted and monitored exams for the undergrad courses taught by Dr. Sabatelli.
- Supervised & graded exams, homework and writing projects.

RECOGNITION & LICENSURE IN CLINICAL SERVICES

- AAMFT Supervisor Candidate (Expected Supervisory Status: July 2012)
- Clinical Fellow of the American Association for Marriage and Family Therapy (AAMFT) Membership #105157
- Licensed Marriage & Family Therapist (#LF60102597) in the State of Washington
- Licensed Marriage & Family Therapist (#27.001532) in the State of Connecticut

CLINICAL EXPERIENCE

Samaritan Center of Puget Sound, Seattle, WA 98115
Clinical Staff Therapist September 2010-Present
Providing therapy for individuals, couples and families in greater Seattle area

Family Services Program, Department of Mental Health & Addiction Services
Connecticut Valley Hospital, Middletown, CT
Marriage, Couple & Family Therapy Doctoral Intern August 2007 – April 2009

Supervisor: Dr. William Boylin, AAMFT Approved Supervisor; disciple of world-renowned family therapist Dr. Carl Whitaker

- Provided individual, couple and family therapy for the inpatients and families.
- Led multi-family treatment sessions with psycho-educational training.
- Collaborated with the interdisciplinary treatment team in clinical diagnosis and therapeutic interventions in the psychiatric hospital.
- Specialized in addiction treatment and *systemically-focused family interventions.*

Humphrey Center for Marriage & Family Therapy, University of Connecticut, Storrs, CT
Marriage, Couple & Family Therapist June 2005 - May 2008
AAMFT Approved Clinical Supervisors from University of Connecticut: Drs. Stephen Anderson, Teresa McDowell, Sandra Rigazzio-DiGilio, Leslie Strong & Doris LaPlante

- Provided individual, couple and family therapy.
- Treated court-mandated *high-conflict couples* and their families.
- Treated *multicultural, immigrant* and *low-income* families.
- Provided therapy in co-therapy treatment teams.
- Provided clinical diagnosis, treatment planning and case management.

Wheeler Clinic, Outpatient & Community-based Adolescent Substance Abuse Treatment Program, Plainville, CT
Marriage, Couple & Family Therapy Intern May 2003 - May 2004
AAMFT Approved Supervisor: William Kanya, LMFT

- Provided treatment for substance abusing adolescents in the intensive outpatient treatment program.
- Provided family focused treatment along with a multidisciplinary treatment team.
- Provided clinical diagnosis, treatment planning and case management.

Humphrey Center for Marriage & Family Therapy, University of Connecticut, Storrs, CT
Marriage, Couple & Family Therapy Intern April 2002 - May 2005
AAMFT Approved Supervisors: Dr. Leslie Strong, Dr. William Boylin & Dr. Sandra Rigazzio-DiGilio

- Provided individual, couple and family therapy at the outpatient center.
- Served as a therapist intern for the student community at the University.
- Provided clinical diagnosis, treatment planning and case management.

Catholic Charities, Family Services, Norwich, CT
Marriage, Couple & Family Therapy Intern May 2002 - April 2003

- Completed Family Therapy Internship at the Outpatient Adolescent Substance Abuse Treatment Unit.
- Conducted treatment planning, family therapy sessions and case management.
- Treated low-income families.

CLINICAL SUPERVISORY EXPERIENCE

Expected AAMFT Approved Supervisory Status: July 2012
AAMFT Approved Supervisors: Dr. Teresa McDowell & Dr. William K. Collins

Samaritan Center of Puget Sound, Clinical Training Program for Externs, Seattle, WA
Marriage, Couple & Family Therapy Supervisor in Training April 2012-June 2012

Graduate School of Counseling & Education, Lewis & Clark College, Portland, OR
Marriage, Couple & Family Therapy Supervisor in Training May 2009 – April 2012

- Provided clinical supervision for Marriage, Couple & Family Therapy practicum students & interns;
- Trained MCFT interns to identity and assess substance abuse and addiction patterns in clients;
- Trained MCFT interns to be culturally sensitive in clinical interventions;
- Trained MCFT interns to design primary, secondary, and tertiary prevention programs

Humphrey Center for Marriage & Family Therapy, University of Connecticut, Storrs, CT
Marriage, Couple & Family Therapy Supervisor in Training August 2005 - May 2006

- Provided clinical supervision for the graduate level Marriage, Couple & Family Therapy interns.
- Trained clinicians to be culturally sensitive in clinical interventions.

SUMMARY OF CLINICAL EXPERIENCE AND SKILLS

- Seven years of clinical experience working in *outpatient, intensive-outpatient* and *inpatient* psychiatric and mental health service settings with *individual, couples* and *families struggling with substance abuse* and *addiction*;
- Extensive clinical training in working with *adolescents, families,* and *high conflict couples*;
- Proficiency in designing *systemically-focused clinical assessments* and *treatment plans;*
- Designing systemically-focused *primary, secondary* and *tertiary prevention programs*;
- Skills in case management, and writing comprehensive case notes;
- Teaching experience in clinically-focused and research-oriented undergraduate & graduate programs;
- Experience working with a wide range of theoretical frameworks for clinical interventions;
- Experience providing psycho-education for divorcing parents to effectively co-parent in a child-focused way in court-mandated programs in the state of Connecticut
- AAMFT supervisory candidate-in-training, and experienced in leading clinical supervision groups in COAMFTE accredited graduate training programs at the University of Connecticut, Connecticut, and at the Graduate School of Counseling Psychology, Lewis & Clark College, Portland, OR. Expected AAMFT Supervisory status: March 2012
- Designed and taught marriage preparation programs for engaged couples, and remarrying couples

RESEARCH PUBLICATIONS

Perumbilly, S. (2011). *Substance abuse and addiction treatment programs in India: exploring the voices of Indian treatment and research professionals* (Doctoral dissertation). Available from *WorldCat Libraries* (OCLC No. 759398205)

Sanderson, J., Kosutic, I., Garcia, M., Melendez, T., Donoghue, J., **Perumbilly, S.**, Franzen, C., Anderson, S. (2009). The measurement of outcome variables in couple and family therapy research. *The American Journal of Family Therapy, 37 (3),* 239-257.

Khanna, A., McDowell, T., **Perumbilly, S.** & Titus, G. (2009). Working with Asian Indian American families: a delphi study. *Journal of Systemic Therapies, 28 (1),* 52-71.

Fang, S., McDowell, T., Goldfarb, T., MacDonald, A., **Perumbilly, S.**, Gonzales-Kruger, G., (2008). Viewing the Asian American experience through a culturally centered research lens: do scholarship in family science and related disciplines fall short? *Marriage & Family Review*, 44(1), 33-51.

McDowell, T., Fang, S., Griggs, J., Speirs, K., **Perumbilly, S.** & Kublay, A., (2006). International dialogue: Our experiences in a family therapy program. *Journal of Systemic Therapies, 25 (1),*1-15.

Perumbilly, S. (2000). *Gift of life* (Master's thesis). Available from *WorldCat Libraries* (OCLC No. 54940631)

MANUSCRIPTS IN PREPARATION

Perumbilly, S. (in progress). Substance abuse and addiction treatment practices in postcolonial India: a research investigation based on a mixed-method descriptive survey research design.

Perumbilly, S. (in progress). Constitutive elements of effective substance addiction treatment programs: an explorative study with postcolonial India's treatment professionals using a mixed-method descriptive survey research design.

Perumbilly, S. (in progress). Designing effective substance abuse prevention programs at national levels: innovative perspectives from postcolonial Indian treatment professionals.

Perumbilly, S. (in progress). Common reasons why people seek and reject addiction treatment: important lessons from postcolonial India's addiction treatment professionals.

Perumbilly, S., McDowell.T., McDowell, F., Brown, A.L., Combs, R.L. (in progress). Integrating yoga practices in substance addiction treatment programs: lessons from postcolonial India's treatment professionals.

Perumbilly, S., McDowell.T., McDowell, F., Brown, A.L., Combs, R.L. (in progress). Why and how to engage families of clients in addiction treatment programs: innovative strategies and perspectives from postcolonial India's treatment professionals.

NATIONAL & INTERNATIONAL CONFERENCE PRESENTATIONS

Perumbilly, S. & McDowell. T. (2012). Treating addiction in couple relationships. A research-focused workshop presentation for the mental health professionals at the National conference of Indian Association of Family Therapy (IAFT), January 6, 2012, New Delhi, India.

Perumbilly, S., McDowell, T. & Brown, A.L. (2011). Integrating couple and family therapy in the treatment of substance abuse and addiction. A one-day theoretical and clinical workshop for India's addiction treatment professionals associated with Regional Resource Training Center, TTK Hospital, December 27, 2011, Chennai, India.

Perumbilly, S. & Anderson, S. (2011) (Research Poster). Role of family in substance addiction treatment: Indian perspectives. National conference of American Association for Marriage and Family Therapy, Dallas, TX.

Perumbilly, S. & Anderson, S. (2011) (Research Poster). Substance addiction treatment in India: innovative perspectives. National conference of American Association for Marriage and Family Therapy, Dallas, TX.

Perumbilly, S., Titus, G., Khanna, A.& McDowell, T. (2006) (Research Poster). Family therapy from an Asian Indian perspective. Presented at the 2006 Annual AAMFT Conference, Houston, TX.

*McDowell, T., Fang, S., Griggs, J., Kublay, A. & **Perumbilly, S.** (2005). Crossing borders: The transferability of culturally bound family therapy knowledge. International Family Therapy Association-American Family Therapy Academy 2005 Conference, Washington, D.C.

**The last four presenters shared equal responsibility for the research and presentation of the research.*

AWARDS/ ACHIEVEMENTS

- Lewis & Clark College ***President's Strategic Research Funds***, Family and Addictions Systemic Therapy Training: International Collaboration between India and the U.S., $11,400 (**Perumbilly**, McDowell, Brown & Hernandez-Wolfe).
- Recipient of ***Faculty Research Grant*** (year 2011) from the Graduate School of Education and Counseling, Lewis & Clark College, Portland, OR.
- Recipient of ***Faculty Research Grant*** (year 2010) from the Graduate School of Education and Counseling, Lewis & Clark College, Portland, OR.
- Recipient of Human Development & Family Studies' (HDFS) ***Predoctoral Fellowship Award*** (year 2010) in recognition of academic excellence from the University of Connecticut.
- Recipient of Dean's ***Graduate Fellowship Award*** (year 2010) in recognition of academic excellence from the College of Liberal Arts and Sciences (CLAS) at the **University of Connecticut**.

PROFESSIONAL AFFILIATIONS

- Clinical Fellow of the American Association for Marriage, Couple & Family Therapy (AAMFT): #105157
- Member of the American Psychological Association (APA): #25460576

SERVICES TO EDUCATIONAL INSTITUTIONS

- Member of graduate school diversity committee (Lewis & Clark College, Portland, OR)
- Member of curriculum development committee (Lewis & Clark College, Portland, OR)
- Major advisor to two master's degree thesis, and on the advisory committee of other theses at the graduate school (Lewis & Clark College, Portland, OR)

Carlos Juan Carmona-Goyena, Ph.D.
Counseling Psychologist

24 Taylor Street
Springfield MA 01103 carlosjcarmona@hotmail.com / 407-694-5046

Objective
To obtain a Mental Health Therapist position.

Summary
Highly knowledgeable Psychologist with remarkable background in diagnosing and treating mental, emotional, and substance abuse disorders within the context of family and systemic approach; Skillful applying therapeutic approaches to families, groups, and individuals.

Summary of Qualification
* Exceptional ability to assess educational, mental, and social needs.
* Profound knowledge of human behavior, mental processes, psychological research, and assessment methods, and the treatment of learning, behavioral and affective disorders.
* Conducting individual, family, and group therapy sessions in accordance with the established treatment plan and providing of crisis intervention when necessary.
* Follow up on results of counseling treatment and clients' adjustments in order to monitor effectiveness of treatments.
* Knowledge of group behavior and dynamics, societal trends and influences, human migrations, ethnicity, cultures and their history and origins.

Education
Doctor of Philosophy in Psychology, Counseling Psychology; June 2005
Doctoral dissertation research measured the relationship between family emotional patterns
Inter American University, San Germán, PR
Master of Science in Psychology, Clinical Psychology,
Graduate School of Southern Puerto Rico, Ponce, PR
Master of Arts Candidate in Psychology, Counseling Psychology
Bachelor of Arts, Concentration in Psychology; Magna Cum Laude
Inter American University, San Juan, PR

Licenses
Licensed Psychologist in Puerto Rico, License # 1508
Licensed Mental Health Counselor in Massachusetts, License # 4199
Certified Adult Deficit Hyperactivity Disorder (ADHD) diagnosis and treatment in Florida

Areas of Specialization
*Family Therapy *Cognitive Therapy *Relational Therapy *Relaxation Techniques

Computer Skills
Proficient in Microsoft Office, including Word, Outlook, Publisher, PowerPoint; Statistical softwares such as SPSS and Excel; Updated operating systems: Windows, Apple, and Android.

Professional Affiliation
*American Psychological Association *Puerto Rico Psychological Association

Carlos Juan Carmona-Goyena, Ph.D.
Counseling Psychologist

Activities and Interests
*Sport: running and exercising *Dancing: skillful dancer *Writer: Family Relationship

Languages
Spanish and English

Professional Experience
Book Writer: April 2011 – Present; Book draft writing of family and couple psychological distress and child's symptom development; Main topics such as development, manifestation, and overcoming relational impairment; Spanish language version.
Psychologist: Solo Private Practice; Guaynabo, PR; August 2006 - December 2011. Individual, group, and family therapy. Therapy sessions addressed multiple factors that influence the client's coping skills for adjustment and development; Treatment and couching of ADHD clientele; Also, consulting and personnel training to organizations.
Assistant Professor of Psychology: University of Turabo, Gurabo, PR; August 2005 - May 2006. Teaching at the Graduate School of Psychology; Course works such as Techniques of Psychotherapy, Family System Theories and Family Psychotherapy, Group Process and Intervention, Psychopathology and DSM-IV-Tx-R Diagnosis; Provision of clinical supervision to graduate students at the University's Mental Health Clinic.
Director: María López, Ph.D.
Researcher of Doctoral Dissertation: Inter American University at San Germán, PR; January 2004 -May 2005. Doctoral dissertation research tested validity of differentiation of self – family therapy pioneer Murray Bowen's most relevant theoretical construct; Puerto Rican cultural and social context, significant statistical level results; Ph.D. degree.
Director: Gloria Asencio, Ph.D.
Doctoral Internship: Centro de Salud Mental de Niños (Mental Health Center for Children) Bayamón, PR; September 2003 - September 2004; Outpatient clinic for children and adolescents; Provision of individual and family therapy to both mental disorder and substance abuse population; Diagnostic testing.
Clinical supervisor: José M. Rivera-Berg, Psy.D.
Research Assistant in Psychology - Student Job Program (part time): Inter American University, San Germán, PR; January 2003 - May 2003. Part-time assistant to the Department Director of Graduate Study in developing study of needs and data gathering.
Director: Carmen Rodríguez, Ph.D.
Psychologist, M.S.: Ángeles Rompiendo Barreras, Juncos, PR; February 2001 - March 2003; Outpatient clinic for children and adolescent students from the public school system; Development of treatment plan; individual and group therapy.
Director: Shirley Feliciano
Psychotherapist/Master Level Clinician in Massachusetts:
1) River Valley Counseling Center, Holyoke, MA; October 1998 - December 2000;
Clinical supervisor: Leticia Muñoz, Psy.D.
2) Gandara Mental Health Center, Springfield, MA. October, 1996 - September,1998;
Clinical supervisor: Alan Kurtz, Ed.D.
3) School Street Counseling Institute - Brightside for Families and Children, Springfield, MA. October
1995 - September 1996;
Clinical supervisor: W. Sydney Stern, Ed.D.

Carlos Juan Carmona-Goyena, Ph.D.
Counseling Psychologist

Therapy to children, families, and individuals of Spanish speaking population. Group therapy to clientele in partial psychiatric hospitalization; Drugs and alcohol counseling.
Psychologist, M.S.: Psychosocial Center (Inpatient Mental Health Center), Bayamón, PR. July, 1994 - June, 1995. One year of Public Service as a requirement by the Puerto Rico Board of Psychology; Development and implementation of individual and group psychotherapy to adult psychiatric inpatient clientele; Administration and evaluation of psychosocial tests.
Director: Brunilda León, M.A.

Melissa L. Costanzo, LMFT
54 Plank Road
Prospect, CT 06712
203-527-9311

Objective:
A hardworking, committed, and enthusiastic, Licensed Marriage and Family Therapist, seeking a position in a creative environment advocating for and providing therapeutic services to families.

Licensure: AAMFT (American Association for Marriage and Family Therapy) 2001

Education:
Master of Arts, Marriage and Family Therapy. December 1999
Saint Joseph College, West Hartford, CT
Associate of Science, Early Childhood Education. May, 1996
Bachelor of Science, General Studies with an emphasis in psychology. May, 1996
Cum Laude
Teikyo Post University, Waterbury, CT

Related Experience:

May 2009- present — **United Health Resources,** Prospect and Meriden, CT
Billing Department, Manager of Care Plan Coordinator Dept.
Schedule and maintain weekly Dental schedules for Nursing Homes throughout CT. Coordinate patient treatment with Dentists and Nursing Home staff and communicate with patient families to ensure continued dental care. Train and supervise dental staff in field and in office (Dental Assistants and Transporters). Maintain patient records/ charts. Assisting Dentist in nursing homes with dental equipment, sterilization and patient care.
Responsible for auditing Audiological and Dental files, requesting physician's orders and prescriptions for hearing aids from physicians, as well as billing and reconciling audiology, dental, optometry and podiatry patients. Bill Medicare, Medicaid, Private Insurance, Nursing Homes, and Patient families for services rendered. Also responsible for accounts receivable; bill Nursing Homes for monthly Administrative Fees. Correspond with Nursing Home Accounts Payable staff regarding monies owed. Train new employee in billing department; responsible for supervising new employee work. Manage in coming phone inquiries from families and Nursing Homes regarding medical program. Work closely with Audiology, Podiatry, Optometry, and Dental professionals to ensure patient files are Medicare and Medicaid compliant and patient care is being met. Working knowledge of Excel, Google spreadsheets and Quick books.

Aug. 2007- Dec. 2008 — **Prospect Youth Service,** Prospect, CT
Assistant to Director
Assisted director in programming recreational activities for Prospect youth, taught jewelry making classes, responsible for data entry and grant writing input, and collaborated with middle and elementary school guidance departments for scheduling therapeutic programs and speakers.

Jan. 2001- Sept. 2002 — **Community Mental Health Affiliates of New Britain,** New Britain, CT
WORTH Program- Marriage and Family Therapist, WORTH Program- LMFT Program Coordinator
Provided individual, family, and group therapy to children diagnosed with mental health disorders and their families in an after school treatment program funded by DCF. Collaborated treatment with staff psychiatrist and schools. Supervised MFT student intern for graduate program.
Hired, supervised and trained employees (therapists and support staff).Coordinated treatment of the children and families. Supervised and evaluated staff, clinicians, and MFT graduate students. Continued to provide individual and family therapy.

Sept. 1999-Jan. 2001 — **Family Services of Greater Waterbury,** Waterbury, CT
Marriage and Family Therapist
Teikyo Post University, Waterbury, CT
School Counselor
Provided individual, family, couples, and group therapy for individuals with mental health diagnoses. Collaborated treatment with staff psychiatrist, schools, pediatricians, and neurologists.Provided individual and group therapy to college students. Coordinated in-service

Melissa L. Costanzo, LMFT
54 Plank Road
Prospect, CT 06712
203-527-9311

lectures and peakers regarding such topics as college life, depression, suicide, alcoholism, substance abuse, date rape, and sexually transmitted diseases.

June 1998-Sept. 1999 **Child Guidance Clinic of Greater Waterbury,** Waterbury, CT
Marriage and Family Therapist Intern
Member of the ADHD treatment team, implementing one way mirror reflecting method. Developed and facilitated ADHD multifamily therapy group. Attended PPT meetings. Worked collaboratively with psychiatrists, teachers, school social workers, school psychologists, and Learning Disability Advocates. Have experience testifying in court.

Sept. 1998-June 1999 **Children's Community School**, Waterbury, CT
School Counselor, Intern
Worked collaboratively with K-3rd grade teachers in providing additional services to children with emotional needs. Developed and facilitated self-esteem, social skills, and loss groups. Attended PPT meetings.

Aug. 1997-May 1998 **St. Joseph College Marriage and Family Therapy Dept. and Academic Resource Center,** West Hartford, CT **Graduate Assistant**
Proof read and edited department materials, organized professors' weekly materials, developed and sent letters to agencies advertising our counseling facility, tutored and facilitated the Writing Portfolio Evaluation process for sophomores and juniors.

May 1995-May 1996 **Teikyo Post University's First Year Experience Class,** Waterbury, CT
Teaching Assistant and Peer Advisor
Assisted professor in developing weekly agendas and lectures, organized class activities, counseled individual students on issues relating to college life.

Dec. 1994-May 1996 **Teikyo Post University's Children's Center,** Waterbury, CT
Teaching Assistant
Assisted head teacher in daily activities and routines, developed and implemented developmentally appropriate lesson plans for ages 3-5.

Aug. 1993-Dec. 1995 **Teikyo Post University,** Waterbury, CT
Assistant Director to Project S.A.G.E. (Students Achieving Greater Excellence) and Proyecto METAS
Planned agendas and organizational needs, prepared weekly materials, researched and coordinated weekly lectures and discussions, counseled and tutored high school and migrant students.

Other Experiences:

April 2007-Present **Prospect Park and Recreation,** Prospect, CT
Assistant Soccer Coach

March 2006-June 2006 **American Cancer Society, Relay For Life of Tribury,** Middlebury, CT
Volunteer

June 1996-Sept. 1998 **Cheshire Country Village Condominiums,** Cheshire, CT
Board of Director, Treasurer, Pool Attendant

Aug. 1994-Mar. 1997 **International Tariff Management,** Waterbury, CT
Telemarketing Supervisor

References for:
Melissa L. Costanzo, LMFT
203-527-9311

Dr. Felicia Zhang, DDS
United Dental Resources
339 225-1717

Dr. Brij Chandwani, DDS
Dental Director
United Health Resources
917 257-7337/ 617 636-3527

James Curtin
Director of Sales and Operations
United Health Resources
203 233-4471

Dr. Jennifer Decker
Podiatrist/ Podiatry Director
United Health Resources/ United Podiatry Resources
312 953-9009

Dr. Jonathan Gorman
Dentist/ Dental Director
United Health Resources/ United Dental Resources
703 582-3493

Danielle Thibodeau
HIS (Hearing Instrument Specialist)
United Health Resources/ United Audiology Resources
860 276-7411

Dee Williams
Prospect Park and Recreation
Soccer Coach
203 758-6593

Janet Jacaruso
Scooter School
Director
203 272-0027/203 272-8403

Trisha Spofford
203-758-3852

Jennifer Smith
203-271-2868

Amy L. S. Sartori

Contact Information
Personal: 139 West Street • Columbia, CT 06237 • (860)-368-9347 • amysartori@gmail.com
Professional: 70 Main Street • Jewett City, CT 06351 • (860)-376-7040 x625 • asartori@ucfs.org

EDUCATION AND LICENSE

Connecticut Licensed Marital and Family Therapist, License No. 1513 March 2012
Connecticut Department of Public Health, Hartford, CT

University of Connecticut, Storrs, CT
Master of Arts in Human Development and Family Studies May 2010
Concentration: Marriage and Family Therapy
Course Work: Included training in various scientifically based therapeutic theories and techniques such as Cognitive Behavioral Therapy, Dialectical Behavioral Therapy including Mindfulness and Relaxation techniques, Motivational Interviewing, and Solution Focused Therapy, among others.

Eastern Connecticut State University, Willimantic, CT
Bachelor of Arts in Psychology May 2005
Concentration: Industrial and Organizational Psychology

PROFESSIONAL EXPERIENCE

United Community and Family Services, Behavioral Outpatient Services, Jewett City, CT
Clinician II, Licensed Marriage and Family Therapist, Full Time, 40 hours/week April 2012 – Present

- Perform duties of Clinician I; in addition: provide supervision for therapy students and interns.
- Trained in Trauma Focused Cognitive Behavioral Therapy (TF-CBT) for children and adolescents up to age 18 who have history of traumatic experiences.
- Implement group therapy for Women age 18 and older titled: "Women's Empowerment Group" using DBT skills for treatment of depression, anxiety, history of substance abuse, and history of traumatic experiences.

United Community and Family Services, Behavioral Outpatient Services, Jewett City, CT
Clinician I, Marriage and Family Therapist, Full Time, 40 hours/week November 2011 – March 2012

- Counsel individuals, couples, and families with diverse backgrounds and a variety of presenting problems. Treat common presenting problems including Relational Conflicts, Depression, Anxiety, and Bipolar Disorders, as well as Substance Abuse, Post-traumatic Stress Disorder, Life Stage Transitions and Adjustment Disorders.
- Perform assessment and diagnosis of clients during intake sessions. Collaborate with clients during treatment and discharge planning. Effectively implement scientifically based therapeutic interventions allowing clients to resolve or manage presenting problems successfully.
- Maintain clients' case management; record session progress notes, collaborate with other health, legal, and government representatives, and advocate for clients welfare.
- Proficient in crisis management and intervention; able to recognize risk and crisis elements and behaviors including suicide and homicide ideation and addressed them appropriately to maintain client safety.
- Initiate, advertise, and implement group therapy for teenage girls age 12-14; engage clients in developing increased self esteem, developing relaxation skills, enhancing social skills, and encourage sharing of experiences and solutions.

Amy L. S. Sartori

PROFESSIONAL EXPERIENCE Continued

United Community and Family Services, Behavioral Outpatient Services, New London, CT
Marriage and Family Therapy Intern, Part Time, 18 Hours/Week, May 2009 – May 2010

- Counseled individuals, couples, and families with diverse backgrounds and a variety of presenting problems. Treated common presenting problems including Relational Conflicts, Depression, Anxiety, and Bipolar Disorders, as well as Substance Abuse, Post-traumatic Stress Disorder, Life Stage Transitions and Adjustment Disorders.
- Performed assessment and diagnosis, treatment and discharge planning, case management, collaborated with mental health professionals and advocated for clients welfare.
- Initiated, advertised, and implemented group therapy, titled "Building Better Bonds." Targeted parents and children ages 6 to 10; educated clients about age appropriate behaviors and developmental milestones, encouraged sharing of experiences and solutions.
- Received above average quarterly evaluations consistently from clinical supervisors on therapeutic knowledge, technique, and implementation.

University of Connecticut, Humphrey Clinic, Storrs, CT
Marriage and Family Therapy Intern, Part Time, 15 Hours/Week, Sept. 2008 - May 2010

- Provided treatment to individuals, couples, and families who had limited access to health care in a rural setting. Performed accurate assessment and diagnosis of clients. Planned effective course of treatment and discharge with clients.
- Skillfully implemented therapeutic techniques resulting in reduced presenting problems. Assessed for risk and intervened appropriately to ensure client safety.
- Collaborated with junior and senior colleagues on client cases; mentored junior clinicians during their initial stages of therapy.
- Participated in group and individual supervision, presented cases to colleagues and supervisors for feedback.
- Successfully created a safe and open therapeutic setting in which clients felt comfortable voicing opinions and problems with family members. Formed a safe environment using humor, caring, empathy, and sincere relationships with clients.
- Excellent knowledge of stress, anger, and conflict management skills. Effectively conveyed information to clients enabling implementation of techniques, reduced negative feelings, and increased coping and communication skills.
- Received above average quarterly evaluations consistently from clinical supervisors on therapeutic knowledge, technique, and implementation.

University of Connecticut Health Center, Department of Psychiatry, Farmington, CT
Neuropsychopharmacologic Treatment and Research Training Center (NTRTC)
Clinical Research Assistant I, Full Time, 40 Hours/Week, 2005 - 2008

- Assisted Doctors' implementation of clinical trials for investigational medications treating persons with Depression, Anxiety, and Bipolar Disorders.
- Conducted phone assessments with subjects in order to determine eligibility for clinical trials. Performed preliminary client assessments including phlebotomy, Electrocardiograms (ECG), health assessments, and medication compliance.
- Administered self-evaluation assessments to clients and maintained case report forms, source documents, and laboratory results.

Amy L. S. Sartori

PROFESSIONAL EXPERIENCE Continued

- Trained and supervised Junior Assistants, Interns, and Volunteers on department procedures and individual projects.
- Assisted Research Coordinators with Internal Review Board (IRB) applications and submissions.
- Performed monthly and annual financial analysis, monthly advertising and enrollment analysis, and data analysis on Investigator-initiated independent research.
- Proficient in research protocols and regulations such as Health Insurance Portability and Accountability Act (HIPAA), Informed Consent, and Collaborative IRB Training Initiative (CITI) trained.

PRESENTATIONS AND LECTURES

Presenter — Feb. 3, 2012
Site Representative for United Community and Family Services
University of Connecticut Internship Fair

Presenter — May 20, 2011
TFCBT Connecticut Conference
"Addressing Challenges in Implementing and Sustaining TF-CBT as an Evidenced-Based Practice"

Guest Lecturer — April 20, 2011 & Nov. 15, 2010
University of Connecticut, Risk and Resilience in Individuals and Families
Topic: Military Families

PROFESSIONAL MEMBERSHIPS

Member — Nov. 2008-Present
American Association for Marriage & Family Therapy (AAMFT)

Student Representative and Member — Nov. 2008-May 2010
Connecticut Association for Marriage & Family Therapy (CTAMFT)
Attended and Presented Special Awards to Distinguished Guests, CTAMFT Annual Conference, April 2010
Assisted in Student Networking Breakfast, Nov. 2009

Student Representative — Jan. 2009-Sept. 2009
Marriage and Family Therapy, University of Connecticut

OTHER WORK HISTORY

Network, Inc., Dept. of Human Resources, Andover, CT, Intern	Sept. 2004- Dec. 2004
Seafood Shanty, Edgartown, MA, Wait Staff	May 2003 - Aug. 2003
People's Bank, Norwich, CT, Teller	April 2002- Sept. 2002
Perini Building Corporation, Uncasville, CT, Administrative Assistant	May 2001- Aug. 2001
Andover Pizza, Andover, CT, Wait Staff	Sept.1997- May 2003

COMPUTER SKILLS

Microsoft Office Suite: Word, Excel, PowerPoint, Outlook, and SPSS and Med Manager.

CARMEN ACEVEDO, LCSW, MSW, LPN
14 Linden Place Meriden, CT 06450 (203) 440-4102
acevedoc54@yahoo.com

SUMMARY Over 15 years of experience providing Masters of Social Work skills to court mandated and non-mandated clients. Ability to integrate nursing experience into the delivery of clinical services. Well organized, independent and self-reliant professional with strong teaching capabilities. Enthusiastic team member who is perceptive and sensitive to the needs of others.

HIGHLIGHTS OF QUALIFICATIONS

- Community Release Evaluations.
- Collaboration with Dept. of Children & Families, Dept. of Corrections & Dept. of Probation.
- Co-facilitation of group therapy for adolescents & children who witnessed domestic violence & homicide.
- Case manager.

Experience

Anthem Blue Cross Blue Shield — May 2008 to Jan. 2012
North Haven, CT
- Developed social work community resource program.
- Provide community referrals/resources for insurance members.

New England Home Care — 1992 to April 2006
Cromwell, CT
- Provided intensive homecare services for medically fragile children while maintaining therapeutic relationships with families.
- Collaboration as team member with referring agencies and community treatment providers.

Maxim Healthcare Services, Inc. — July 2004 to May 2006
Hamden, CT
- Expertise in child development.
- Diagnosed children with life threatening illnesses.

Lake Grove Durham — Aug. 2001 to Oct. 2003
Durham, CT
- Development of sexual offender treatment program for developmentally disabled adolescents.
- Conducted individual, group, cognitive-behavioral and family therapy.
- Liaison with community treatment providers.
- Education and training of clinical staff.

Institute of Professional Practice — May 1999 to Jan. 2000
Woodbridge, CT
- Coordinated individual therapy for children and adolescents in professional foster homes.
- Monitored strict behavior-modification programs.
- Facilitated family therapy.

Cliff House School — March 1997 to June 99
- Created sexual offender treatment program for delinquent male youth in lockdown unit. — Meriden, CT
- Conducted evaluations for community release.
- Testified in court related cases.
- Liaison with parole and probation.

Casey Family Services — March 1996 to Nov. 96
- Provided reunification therapy with children and biological parents. — Hartford, CT
- Co-facilitated group therapy for biological mothers.

Family Services Woodfield — Nov. 1994 to March 1996
- Social work in Bridgeport Primary Care Center. — Bridgeport, CT
- Implemented domestic violence program for women.
- Designed and facilitated group therapy program for children who witnessed domestic violence.
- Provided individual and group therapy for survivors of domestic violence.
- Co-facilitated group therapy for men involved in domestic violence.
- Developed grief and loss therapy groups for teenagers and children who witnessed homicides.
- Provided long-term/short term counseling and crisis intervention for individuals and families.

Volunteer Work

- American Cancer Society
- Red Dress Marathon
- Board Member of Temple B'nai Abraham
- Auxiliary Member of Temple B'nai Abraham

Education

1994 Fordham University — Tarrytown, NY
Masters of Social Work

1988 Eastern CT State University — Willimantic, CT
Bachelor of Art

1986 Manchester Community College — Manchester, CT
Associate of Science

743 Prospect Avenue
West Hartford, CT 06105

Cell Phone (860)-916-4812
E-mail rledder@comcast.net

Robert Ledder

Professional Experience

Presently: New Britain Youth Services, New Britain, CT

Marriage and Family Therapist and Consultant

Supervised interns from area universities to develop therapeutic skills. Counseled children and their families with behavioral and emotional needs. Coordinated services between agencies involved with families. Involved in youth development programs to enhance youth leadership skills with high-risk students. Produced computer projects for advertising services offered and meeting information.

Sept 1985-May 2011: Southern Connecticut State University, New Haven, CT

Adjunct Faculty, Marriage and Family Therapy Program

Supervised practicum and internship students in the Marriage and Family Therapy Program. Delivered live one-way mirror, group supervision sessions, video and audio therapeutic guidance on a weekly basis with advanced graduate students. Reviewed referrals, discussed intervention strategies, assessed therapeutic skills, consulted with staff. Taught introduction and theoretical classes to first year students.

Jan 2009-Jun 2009: E. Green Elementary School, Newington, CT

School Psychologist

Counseled students in kindergarten through 4th grade with adjustment and academic issues. Consulted with parent and teachers concerning student behavior, achievement and social judgment. Attended PPT meeting and implemented IEP's for students with special needs. Interpreted psychological reports for parents and staff.

2004 –2007: Newington Human Services, Newington, CT

Marriage and Family Therapist and Student Assistance Counselor

Counseled families with behavioral and emotional needs referred to the clinic. Coordinated services between two Middle Schools. Implemented individual and group counseling for students at risk. Consulted with teachers, parents and administrators. Completed monthly and weekly reports as necessary.

2005 – 2006: New Britain Systems of Care, New Britain, CT

Care Coordinator

Coordinated family treatment plans for multi-problem families. Assessed needs and coordinated services to individuals and families. Preformed intake and assessment interviews. Administered assessment instruments to determine level of dysfunction and family strengths.

1976 – 2003: Connecticut State Vocational School System, Hartford, Manchester and New Britain, CT

School Counselor and School Psychologist

Counseled, tested and consulted with students, parents and staff members involved in three vocational high schools. Administered the Student Assistance Team for student referrals for special services. Involved in the Peer Mediation program for students as a trainer and coordinator. Chaired the School Psychology steering committee. Involved in the school crisis team. Wrote grants to support females in non-traditional trades. Trained as a mediator of professional faculty and serviced individuals with conflicts in other vocational schools.

East Hartford Youth Services, East Hartford, CT

Youth and Family Counselor

Counseled children and families referred to the youth services bureau through court and the schools. Maintained a caseload of 10 to 15 families for direct service. Coordinated services with other professionals to create effective delivery of services.

Windham Public Schools, Willimantic, CT

Elementary School Counselor

Counseled children and families in three elementary schools. Coordinated services between departments and teaching staff. Made appropriate referral to outside agencies. Participated in a grant that delivered family therapy in the schools.

Education

M.S., Southern Connecticut State University, New Haven, CT

School Psychology

Trained in testing, group counseling, consulting and statistics. Specialized in Marriage and Family Therapy and its application to school issues.

C.A.G.S., Southern Connecticut State University, New Haven, CT

Pupil Personnel

Emphasis in School Counseling, program coordination, guidance services and standardized testing.

M.S., Central Connecticut State University, New Britain, CT

School Counseling

Concentration in Group and individual counseling with practical experiences in the college placement center and the public schools of Rocky Hill, CT.

Certificate, Bristol Hospital Family Therapy Training Program. Bristol, CT

Family Therapy

Group seminars and supervised therapeutic family and couples sessions. Intensive training to develop systemic family therapy skills. Individual and group treatment of two or three families weekly.

Additional mental health in-service programs and an undergraduate degree in computers

Professional Memberships

American Association of Marriage and Family Therapists. Clinical Membership, Approved Supervisor

Connecticut Association of Marriage and Family Therapists

American Federation of University Professors

Connecticut Marriage and Family State License No. 000212

References upon request

D.W.FISH Real Estate

VERNON OFFICE
220 Hartford Turnpike | Vernon, CT 06066
TELEPHONE (860) 871-1400 | **FAX** (860) 870-8337
EMAIL fishrealty@snet.net
www.dwfishrealestate.com

April 12, 2012

Town of Manchester
Zoning Committee
Address

To whom it may Concern:

I am the Landlord of the property (offices) at 243 Main Street in Manchester, Connecticut. The purpose of this communication is to inform you that CT-Family Care Services, LLC represented by its president Justinian Rweyemamu has rented an office at 243 Main Street in Manchester in order to provide Family Therapy/ Counseling/ Social Services to families, children and veterans as well as the academic treatment to students in order to prevent school dropout, poor academic performances, delinquencies and problematic behaviors.

Please assist him accordingly, so that he can get a permit which will enable him to operate his business in Manchester, Connecticut.

Thank you
Don Fish
Landlord

C.C. Justinian Rweyemamu, MA, M.Div, MS-MFT, PhD student
President
CT-Family Care Services, LLC
243 Main St, Manchester, Connecticut
rweye@cox.net

Manchester Office
243 Main Street | Manchester, CT 06042
(860) 643-1591

Hebron Office
Hebron Green | Hebron, CT 06248
(860) 228-9451

Relocation
220 Hartford Turnpike | Vernon, CT 06066
(860) 875-8600

State of Connecticut

Town of Manchester

494 Main Street P.O. Box 191 Manchester, CT 06040 Phone: (860) 647-3052 Fax: 860-647-3144

Application for Building Permit

RECEIPT

Application No: **TB-12-471** Date Recieved: **4/24/2012**

Job Location: **243 MAIN ST**

Contractor's Name: Phone:

Contractor's Address: City:

State: Zip Code: State Lic. No:

(Home)Owner's Name: **FISH, DONALD W** Phone: **(860) 871-1400**

(Home)Owner's Address: **220 HARTFORD TPKE** **VERNON, CT 06066-4701**

Work Description: **243 MAIN STREET, CT FAMILY CARE SERVICES LLC. TENANT BUILD OUT.**

Total Value Of Work To Be Performed: **0.00**

Structure Size:	**0.00**	**0.00**	**0.00**
	Width	Depth	Area

I hereby swear and attest that I will require proof of workers' compensation insurance for every contractor, subcontractor, or other worker before he/she engages in work on the above property in accordance with the Workers' Compensation Act (Chapter 568).

I understand that pursuant to 31-275 C.G.S., officers of a corporation and partners in a partnership may elect to be excluded from coverage by filing a waiver with the appropriate District Office; and that a sole proprietor of a business is not required to have coverage unless he files his intent to accept coverage.

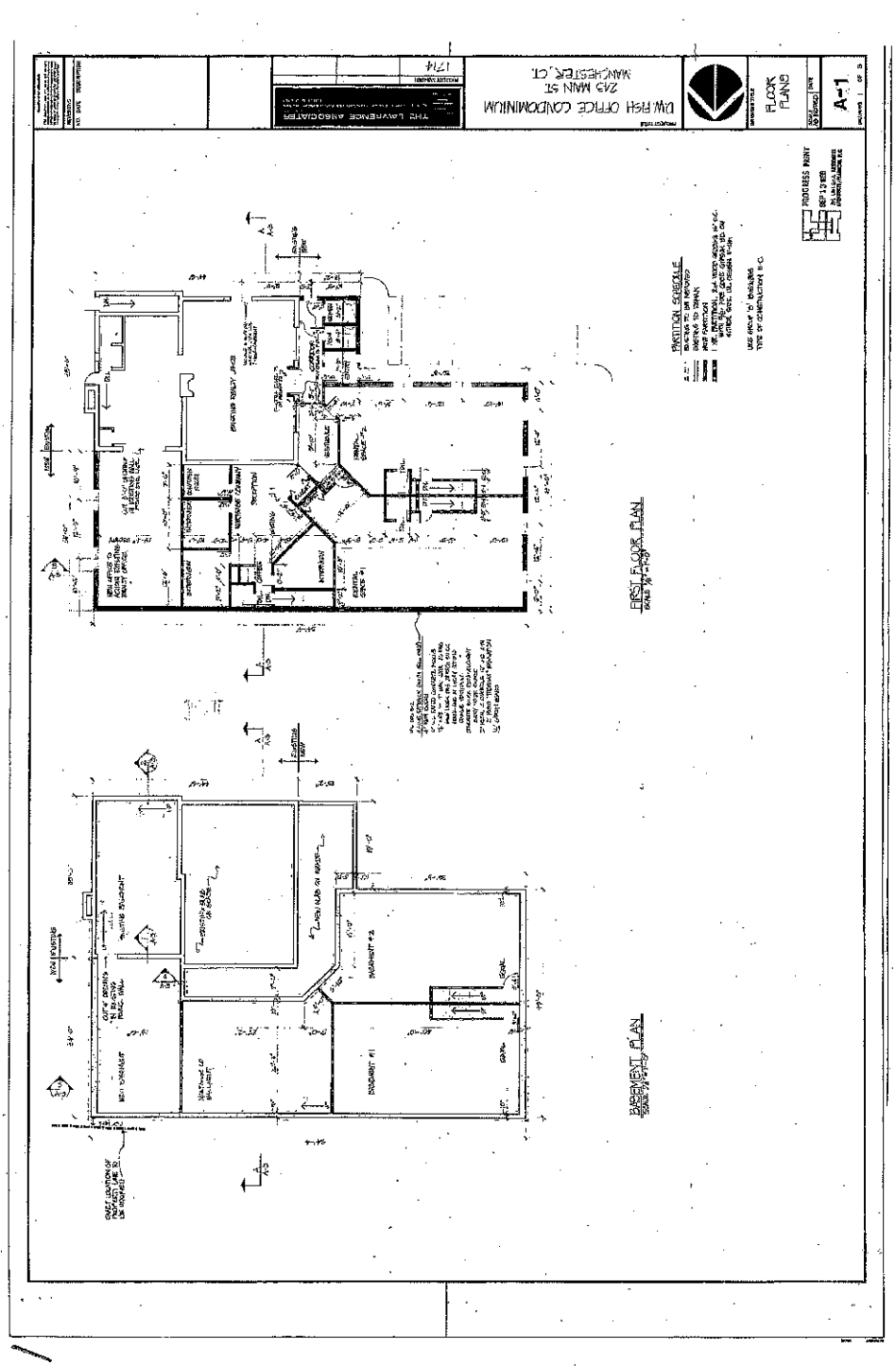
I hereby certify that I am the owner of the property which is the subject of this application or the authorized agent of the property owner and have been authorized to make this application. I understand that when a permit is issued, it is a permit to proceed and grants no right to violate the Connecticut State Building Code or any other code, ordinance or statute, regardless of what might be shown or omitted on the submitted plans and specifications. All information contained within is true and accurate to the best of my knowledge and belief.

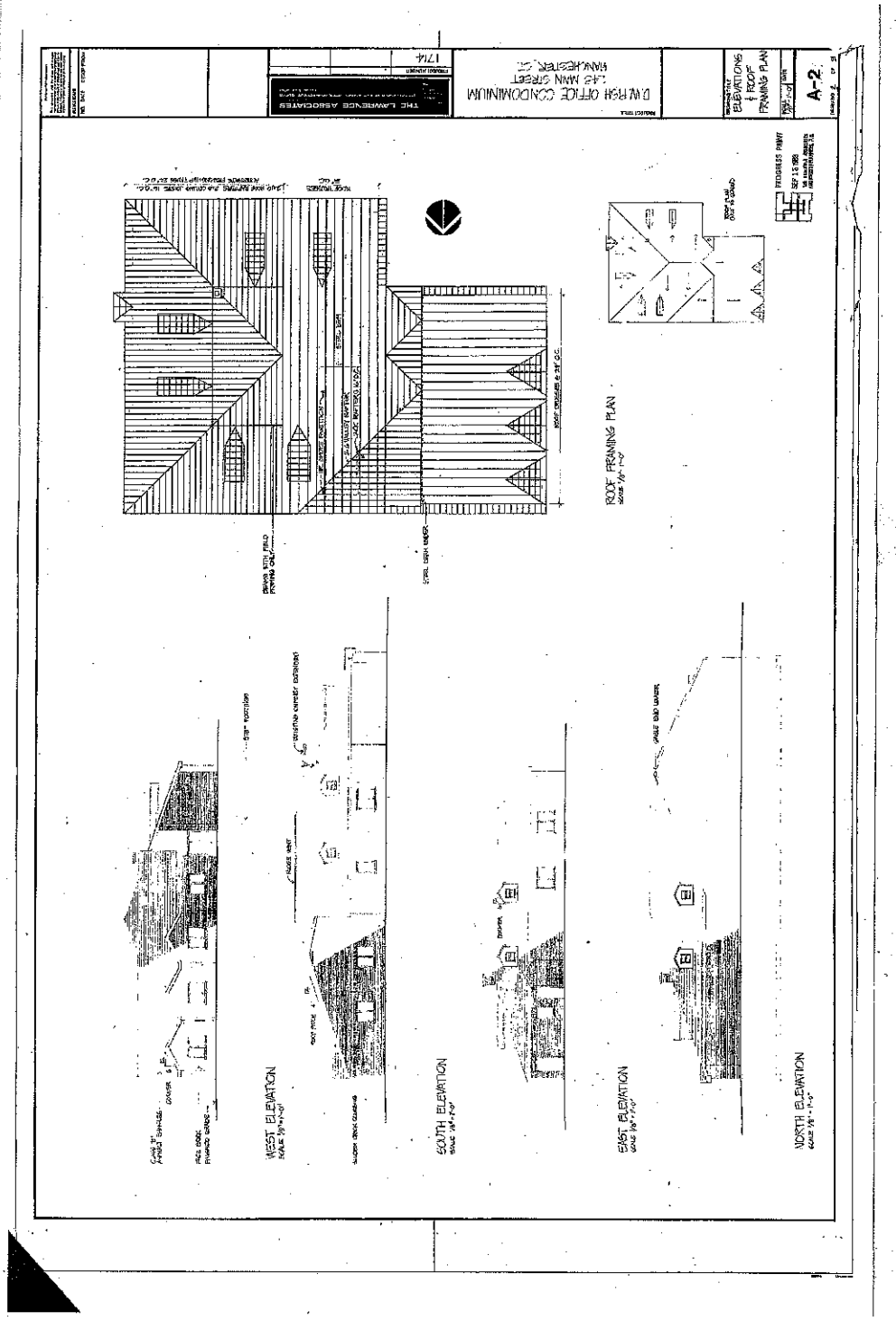
All permits approved are subject to inspections performed by a representative of this office. Requests for inspections must be made at least 24 hours in advance.

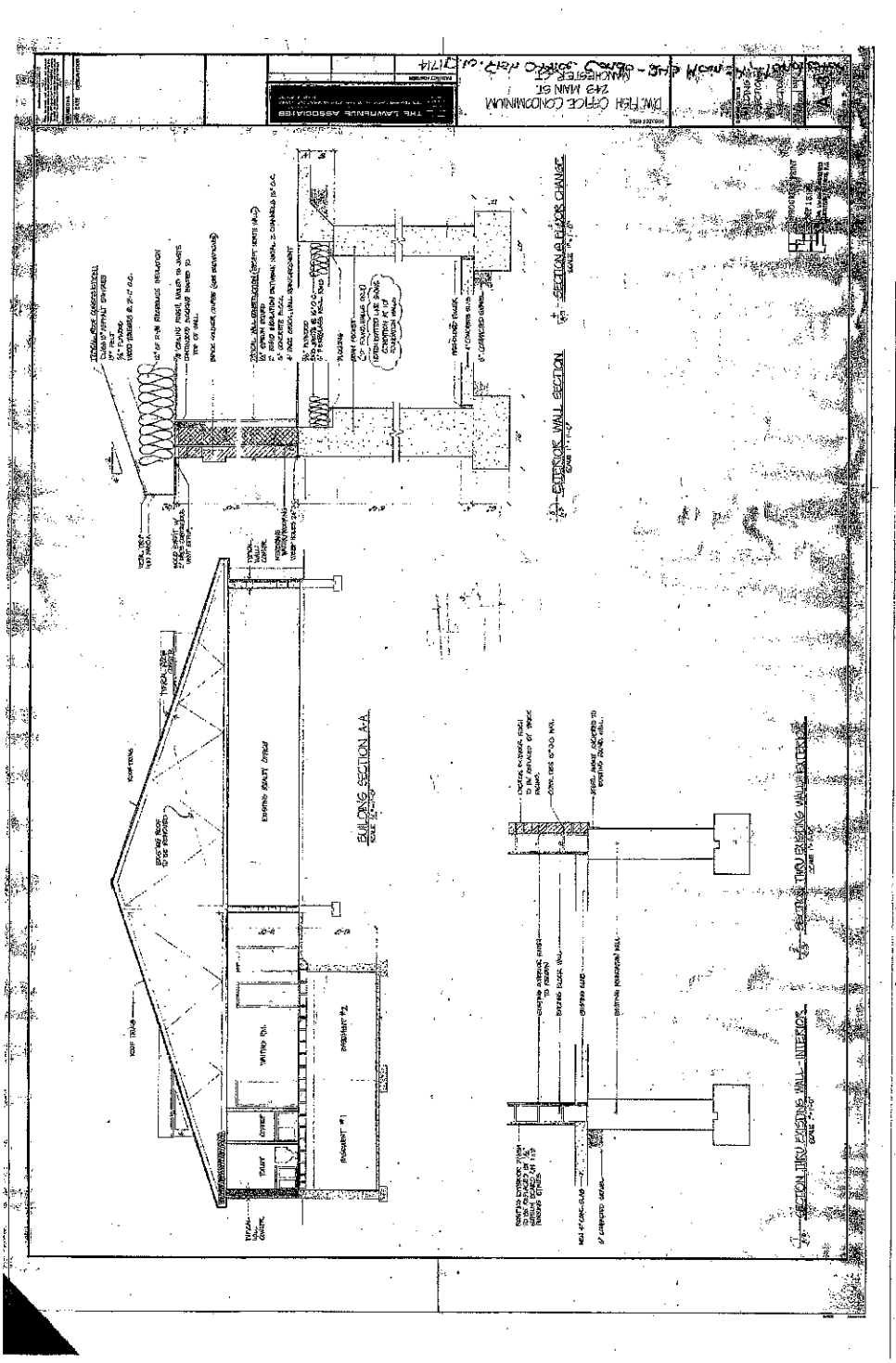
Signed:	**JUSTINIAN RWEYEMAMU**	**4/24/2012**	**(860) 508-8651**
	Applicant	Date	Telephone No.

Estimated Construction Costs / Permit Fees

			Payment Date	Amount Paid	Check No
Total Project Cost :	**$0.00**				
Total Permit Fee:		**$0.00**			
Total Permit Fee Paid:	**$0.00**				


DW RISH OFFICE CONDOMINIUM
245 MAIN ST
MANCHESTER, CT.
THE LAWRENCE ASSOCIATES
1714
FLOOR PLANS
A-1
PROGRESS PRINT
SEP 12 '03
PARTITION SCHEDULE
FIRST FLOOR PLAN
BASEMENT PLAN


DWIRSH OFFICE CONDOMINIUM
142 MAIN STREET
MANCHESTER, CT
THE LAWRENCE ASSOCIATES
ELEVATIONS & ROOF FRAMING PLAN
A-2
ROOF FRAMING PLAN
WEST ELEVATION
SOUTH ELEVATION
EAST ELEVATION
NORTH ELEVATION



"In Collaboration with clients we enhance their wellness through internal and external solutions."

CT-FAMILY CARE SERVICES, LLC

June 28, 2012

Dear Sir/ Madam

Attached herewith is the company's projected budget for July 1, 2012 to June 30, 2014. I am pleased to inform you that besides over $16,000 that the company has already spent this year towards opening its new offices, I have secured the $83,000 (attached) as a personal loan that will be available as of July 17, 2012. I plan to use that personal loan for the business including salaries for employees and the services, while waiting for insurance re-imbursement process to start effectively.

This budget is not yet audited officially because the company is still waiting for some information from some State agencies and insurances on their actual up to date dollar amount for ri-embursements. Once the company has received the Certification Of Need (CON), it will be able to receive that current actual data from the State and insurances on their most recent re – imbursement per hour for the services provided. In this budget the company is charging the lowest rate at $ 100.00 per hour.

Thank you for reviewing the company's application for CON and its budget.

Justinian Rweyemamu, MA, M.Div, MS-MFT,PhD student &
AAMFT Approved Supervisor Candidate
Founder and President

16 Enfield Ave.
Enfield, CT 06082

243 Main Street
Manchester, CT 06042

155 Maple St, Unit 204
Springfield, MA 01105

rweye@cox.net **(860) 508-8651**

emery federal
Established 1939

June 22, 2012

Justinian Rweyemamu

16 Enfield St. Ave
Enfield, CT

Congratulations Justinian!

Based upon review of credit worthiness, income and available assets,Emery Federal has approved the above borrowers through a FHA Loan Program to cash out of their house. The mortgage has been approved through Fannie Mae's Underwriting Service for the purchase of a Single Family Residence. This loan has to be closed after July 15th 2012.

Cash out to be given: **$83,000+**
Property: **Primary**
Loan Type: **FHA 30 Year Fixed Loan @ 3.625%**
Date to be given: **July 17th 2012**

If I can be of further assistance, please do not hesitate to call me
Sincerely yours,

Lucas Roca
Senior Mortgage Banker
Emery Financial Services

Cell: 860.801.0696
Fax: 888.711.4022
E-mail: lroca@emeryfs.com
Federal NMLS ID# 127071

BBB

NATIONAL CREDIT UNION ADMINISTRATION

EQUAL HOUSING OPPORTUNITY

Annual Budget Draft for CT-Family Care Services, LLC:

Item	Description	Income per unit	Units	Unit Measure	Total per year 2012	Total per year 2013	Total per year 2014
Income	OUTPATIENT INTEGRATED TREATMENT						
	Customized behavioral treatment	$100	4752	hours/year	$475,200	$576,000	$768,000
	Customized academic treatment	$100	3782	hours/year	$378,200	$576,000	$672,000
	Customized individual treatment	$100	3422	hours/year	$342,200	$384,000	$768,000
	Customized family treatment	$100	2975	hours/year	$297,500	$476,000	$743,750
	Sub Total				$1,491,100	$2,012,000	$2,951,750
	GRANTS						
	Innovative research	$100	1,500	hours/year	$150,000	$150,000	$150,000
	Youth Build	$100	2,000	hours/year	$200,000	$200,000	$200,000
	Sub Total				$350,000	$350,000	$350,000
	[illegible]				[illegible]	[illegible]	[illegible]
Net Income					$841,100	$1,512,000	$2,301,750

Annual Budget Draft for CT- Family Care Services, LLC:

A SCHEDULE OF ANNUAL SALARIES ESTIMATES FOR
PERIOD ENDING 31TH DECEMBER 2011 TO DEC 2013

SNO.	DESIGNATION	ESTABLISHMENT 2012	ACTUAL STRENGTH	VARIATION + OVER - UNDER	REMARKS	ESTABLISHMENT 2013	ACTUAL STRENGTH	ESTABLISHMENT 2014	ACTUAL STRENGTH
	President	1	1	0			1		1
	Clinical Director/SP	1		-1	Recruitment		1		1
	Office assistant	1		-1	Recruitment		1		1
	CSW	5		-5	Recruitment		5		5
	MFT Therapists	8		-8	Recruitment		8		8
	Job career tr	1		-1	Recruitment		1		1
	Psychiatrist	1		-1	Recruitment		1		1
	TOTAL	**18**	**1**	**-17**	**0**		**18**		**18**

Annual Budget draft for CT- Family Care Services, LLC:

A SCHEDULE OF ANNUAL ESTIMATES SALARIES FOR PERIOD ENDING 31TH DECEMBER 2011

Designatio	Unit cost	Weekly Hours	Weekly Salary	Monthly Salary	Medical insuarance	Total Estimates-2012	Monthly Salary	Total Estimates-2013	Total Estimates-2014
President	$80.00	30	$2,400.00	$9,600.00	4,978	$115,200.00	$9,600.00	$115,200.00	$115,200.00
Clinical Director/Supervisor	$65.00	25	$1,625.00	$6,500.00	4,978	$78,000.00	$6,500.00	$78,000.00	$78,000.00
Office assistant	$22.79	37	$843.23	$3,372.92	4,978	$40,475.04	$3,372.92	$40,475.04	$40,475.04
Teachers	$32.83	38	$1,247.70	$4,990.79	9,956	$59,889.46	$4,990.79	$59,889.46	$59,889.46
Psychiatrist	$36.67	46	$1,703.69	$6,814.75	9,956	$81,777.03	$6,814.75	$81,777.03	$81,777.03
Job/ career trainers	$32.75	35	$1,146.25	$4,585.00	4,978	$55,020.00	$55,020.00	$55,020.00	$55,020.00
MFT Therapists /social w	$32.78	320	$10,489.60	$41,958.40	14,934	$503,500.80	$41,958.40	$503,500.80	$503,500.80
Total Salary expenditure	**$302.82**	**$531.46**	**$19,455.47**	***$77,821.86***	**$54,758.56**	**$933,862.34**	***$128,256.86***	**$933,862.34**	**$933,862.33**

Annual Budget Draft for CT- Family Care Services, LLC:

PROJECT NAME :Connecticut Family Care Services (CT-FCS)

Activity	Required Inputs			Annual Budget Estimates 2012		F/Budget Estimates 2013		F/Budget Estimates 2014	
	Description	Unit of Measure	Unit cost	No of Units	Estimates	No of Units	Estimates	No of Units	Estimates
Objective A: Improving academic perfomances, enhancing coping skills and reduce problematic behaviors									
Target 01:Academic performance improved, school dropout reduced by 97% between 2012 to 2014									
Innovation research assesment on the effectiveness of	School drop out prevention		500	60	30,000	120	60,000	250	125,000
	Talents show enhancements		83	60	4,980	120	9,960	250	20,750
	Research		200	60	12,000	120	24,000	250	50,000
Activity Total					**46,980**	**360**	**93,960**	**750**	**195,750**
To enhance coping skills through research evidence based from 2012 to 2014	Treatment assesment tools		100	60	6,000	120	12,000	250	25,000
	Research : Permit costs for human substance research		17	60	1,020	120	2,040	250	4,250
	Fax,stationaries,		25	60	1,500	120	3,000	**250**	6,250
Activity Total					**8,520**	**360**	**17,040**	**750**	**35,500**

To provide therapeutic treatment to students and their families from 2012 to 2014	Fostering positive solution skills-mental health illinesses treatments		500	60	30,000	120	60,000	250	125,000
Activity Total					**30,000**	**120**	**60,000**	**250**	**125,000**
To enhance systemic coping skills solutions	coping skills treatment &		100	60	6,000	120	12,000	250	25,000
	Genogram assesment tools		20	60	1,200	120	2,400	250	5,000
Activity Total					**7,200**	**240**	**14,400**	**500**	**30,000**
[illegible]					[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Target 02:Sustainable recovery from poor academic perfomances, problematic behaviors and domestic violances in families among students and their families and wholistic success acheved by 90% between 2012- 2014									
Strengthening families, reduce mental illinesses Increase recovery and success. Support students,youth	violence prevention in famillies	man/da	400	60	24,000	120	48,000	250	100,000
	Substance uses prevention in famillies	man/da	400	60	24,000	120	48,000	250	100,000
	Behavirol and academic enhancement	man/da	600	60	36,000	120	72,000	250	150,000
Activity Total					**84,000**	**360**	**168,000**	**750**	**350,000**
To provide training and assist family members to find jobs	Job market connection, support and community business networking	man/da	1,250	60	75,000	120	75,000	250	75,000

Activity Total	**Sub Total**				**75,000**	**120**	**75,000**	**250**	**75,000**
Total Target					75,000	120	75,000	250	75,000
Target 3: To prepare inmates for effctive community re-entry									
To prepare inmates for community re-	Community re-entry services		1000	25	25,000	40	40,000	80	80,000
Activity Total	**Sub Total**				**25,000**	**40**	**40,000**	80	**80,000**
Total Target					25,000	40	40,000	80	80,000
TOTAL OBJECTIVE					**276,700**	**1,600**	**468,400**	**3,330**	**891,250**
0									
Target 1: CT-FCS Staffs recruited and Trained									
Activity	Required Inputs				Annual Budget	Annual Budget		Annual Budget	
	Description	Unit of Measure	Unit cost of Inputs	No of Units	Estimates	No of Units	Estimates	No of Units	Estimates
To recruit CT-Family Care staff and train	Advertising and Publication		100	60	6,000	120	12,000	250	25,000
	Orientation		100	60	6,000	120	12,000	250	25,000
Activity Total					12,000	240	24,000	500	50,000
Total Target					12,000	240	24,000	500	50,000
Target 2: Financial Resource mobilised and management carried out annually									
To prepare Business plan, annual Budget and responsive proposals for soliciting funds done by Dec 2012	cost for grant writing,marketing and public relations	person	100	60	6,000	120	12,000	250	25,000

Activity Total					**6,000**	**120**	**12,000**	**250**	**25,000**
Preparation of CT- Family Care research reports by Dec 2012	Auditing services	units	50	60	3,000	120	6,000	140	7,000
Activity Total					**3,000**	**120**	**6,000**	**140**	**7,000**
[illegible]					[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Target 3: Working and learning Environment for service delivery improv 2012									

Activity	Required Inputs			Budget Estimates		Foward Budget Estimates 2009/2012		Foward Budget Estimates 2012/2014	
	Description	Unit of Measure	Unit cost of Inputs	No of Units	Estimates	No of Units	Estimates	No of Units	Estimates
Insuarance	Liability & Profe insuarences		50	60	3,000	120	6,000	250	12,500
Activity Total					**3,000**	**120**	**6,000**	**250**	**12,500**
To ensure productive treatments & research functioning by Dec 2012	Computer Supplies and Accessories	Lots	50	60	3,000	120	6,000	60	3,000
	Newspapers and Magazines	units	12	60	720	120	720	250	720
	Mailling and postage		25	60	1,500	**120**	3,000	**250**	**6,250**
Activity Total					**5,220**	**360**	**9,720**	**560**	**9,970**
Office and equipment for CT-Family Care staff office use 2012-2014.	Office	units	250	60	15,000	60	15,000	60	15,000
	Projectors, Presentation equipments		25	60	1,500	120	3,000	250	6,250

	Desks, Shelves, Tables and Chairs	units	70	60	4,200	120	8,400	250	6,300
	Servers and wireless	units	50	60	3,000	120	3,000	250	5,000
	Clients & Employees safety and wellness	units	100	60	6,000	120	12,000	250	12,000
Activity Total					**29,700**	**540**	**41,400**	**1,060**	**44,550**
Innovation research	data coding		30	60	1,800	120	3,600	250	7,500
Activity Total					**1,800**	**120**	**3,600**	**250**	**7,500**
Payment of CT-Family Care Services bills 2012-2014	Electricity	units	30	60	1,800	120	3,600	250	7,500
	Heat	units	30	60	1,800	120	3,600	250	7,500
	Phone	units	30	60	1,800	120	3,600	250	7,500
	water	units	30	60	1,800	120	3,600	250	7,500
Activity Total					**7,200**	**480**	**14,400**	**1,000**	**30,000**
To provide adminstrative support	Trauma		50,000	1	50,000	2	75,000	**1**	**75,000**
	Legal		25,000	1	25,000	2	37,500	1	**30,000**
	Accounting		6,000	1	6,000	2	8,000	**1.5**	**9,000**
	Out source-fee for service		15,000	2	30,000	2	45,000	2	45,000
school dropout & mental crises prevention	Indivizualized academic assisance		800	50	40,000		40,000		40,000
	Group academic treatment		800	50	40,000		40,000		40,000
	Individualized behavioral treatment		1,000	50	50,000		50,000		50,000

	Group behavioral treatment		800	50	40,000		40,000		40,000
Workforce skills training	Job career training		900	50	45,000		45,000		45,000
	Leadership devl		600	30	18,000		18,000		18,000
Homeless Prevention	Support for affordable housing		1,200	50	60,000		60,000		60,000
	Juvenile court alternative		2,010	20	40,200		40,200		40,200
Family Treatment	Family therapy		800	50	40,000		40,000		40,000
	educational tours		200	30	6,000		6,000		6,000
For offices	business travel		100	50	5,000		5,000		5,000
	supplies		150	50	7,500		7,500		7,500
	Computers		40	50	2,000		2,000		2,000
	Insurance		200	50	10,000		10,000		10,000
	Legal Fee		600	50	30,000		30,000		30,000
	Contractual		400	50	20,000		20,000		20,000
Activity Total					**564,700**	**8**	**619,200**	**6**	**612,700**
[redacted]									
TOTAL OBJECTIVE B					**909,320**	**3,708**	**1,204,720**	**7,346**	**1,690,470**
TOTAL BUDGET					**1,186,020**	**5,308**	**1,673,120**	**10,676**	**2,581,720**

Annual Budget Draft for CT- Family Care Services, LLC:

A SCHEDULE OF ANNUAL ESTIMATES SALARIES FOR PERIOD ENDING 31TH DECEMBER 201								2012
Designation	**Total Estimates-2012**	**Medical insuarance**	**Other Benefits**	**Total Estimates-2013**	**Medical insuarance**	**Other Benefits**	**Total Estimates-2014**	**Medical insuarance**
President	$100,000.00	4,978		$100,000.00	4,978		$100,000.00	4,978
Clinical Director	$78,000.00	4,978		$78,000.00	4,978		$78,000.00	4,978
Office assistant	$40,475.04	4,978		$40,475.04	4,978		$40,475.04	4,978
Teachers	$59,889.46	9,956		$59,889.46	9,956		$59,889.46	9,956
Job career trainers	$55,020.00	4,978		$55,020.00	4,978		$55,020.00	4,978
Psychiatrist	$81,777.03	9,956		$81,777.03	9,956		$81,777.03	9,956
MFT Therapists/ Clinical social workers	$503,500.80	14,934		$503,500.80	14,934		$503,500.80	14,934
Total Salary expenditur	**$918,662.33**	**$54,758.48**	**$0.00**	**$918,662.33**	**$54,758.48**	**$0.00**	**$918,662.33**	**$54,758.48**

Annual Budget Draft for CT- Family Care Services, LLC:

A SCHEDULE OF ANNUAL ESTIMATES SALARIES FOR PERIOD July 2012 -

S/N	ITEM NO	NUMBER OF EMPLOYEES	ANNUAL SALARY 2012	Other expenditures	HEALTH INSUARANCE	OTHER BENEFIT	NUMBER OF EMPL	ANNUAL SALARY 2013	Other expenditure	HEALTH INSUARANCE	OTHER BE
1	Existing employees on payroll	18	$933,862	$1,186,020	$54,758	-	0	$933,862	$1,673,120	$54,758	$0
	GRAND TOTAL	**18**	**$933,862**	**$1,186,020**	**$54,758**	**$0**	**0**	**$933,862**	**$1,673,120**	**$54,758**	**$0**

June 30, 2014

NUMBER OF EMPLO	ANNUAL SALARY 2014	Other expenditure	HEALTH INSUARANCE	OTHER BENEFITS
0	$933,862	$2,581,720	$54,758	$0
0	**$933,862**	**$2,581,720**	**$54,758**	**$0**

Draft Annual Budget for CT- Family Care Services, LLC:

A SCHEDULE OF ANNUAL ESTIMATES SALARIES FOR PERIOD, July 1, 2012-June30, 2014

S/N	ITEM NO	Total expenditure 2012	Total expenditure 2013	Total expenditure 2014	Grand Total	Total number of employees	
1		$2,174,641	$2,661,741	$3,570,341	$8,406,722	18	
	GRAND TOTAL	**$2,174,641**	**$2,661,741**	**$3,570,341**	**$8,406,722**	**18**	

Draft Annual Budget for CT- Family Care Services, LLC:
PROJECT NAME :CT- Family Care Services (CT-FCS)

Objectives	Targets	Activity	July	Aug	Sep	Nov	Dec	Jan	Feb	Mac	Aprl	May	June	July	Aug	Sep	Oct	Nov
Objective A: Improving academic perfomances, enhencing coping skills and reduce problematic behavors through integrated treatment & innovation research·	**Target 01**:Academic performance improved, school droupout reduced by 97% between 2012 to 2014	To provide integrated accademic treatment to minority and low income white students																
		To enhence evidence based research on integrated treatment																
		To provide therapeutic treatment to students and their families																
		To enhance systemic coping skills solutions between students and parents/families																
	Target 02:	Sustainable recovery from academic and mental illinesses, problematic behavioral																

do	Sustainable recovery from poor academic perfomances, problematic behaviors and domestic violances in families among students and their	To provide training and assist family members to find jobs																	
	Target 3: Inamates with intergrated treatment for effctive community re-entry prepared	To prepare inmates for community re-entry																	

Objective B: Effective Services delivery by CT-FCS as provider	**Target 1:** CT-FCS Staffs recruited and Trained	To recruit CT- Family Care staff and train by July 2012																	
	Target 2: Financial Resource mobilised and management carried out annually	To prepare Business plan, annual Budget and responsive proposals for soliciting funds done by July 1,2012 to June 30,2014																	
		Preparation of CT-FCS reports (quarterly reports, final accounts and audit) by Dec 2012																	
	Target 3: Working and learning Environment for service delivery improved by Dec, 2012	To provide routine maintenance and repair of treatment complex 2012-2014																	
		To ensure efficient functioning of CT-FCS by Dec 2012																	
		To provide academic and behavioral treatments effectively, plus services evaluations quartly																	

	do	To undertake, research phase 1 by Dec 2012																
		To facilitate for phase II research by Dec 2013																

Greer, Leslie

From: Greci, Laurie
Sent: Thursday, August 02, 2012 11:13 AM
To: Greer, Leslie
Subject: FW: CON application for Behavioral Health Outpatient Programs 12-31773-CON
Attachments: Request for Additional Information concerning Docket 12-31773-CON.docx; Financial Attachment II.xlsx; Financial Attachment I.xls

---

From: Greci, Laurie
Sent: Friday, July 27, 2012 2:30 PM
To: 'rweye@cox.net'
Subject: CON application for Behavioral Health Outpatient Programs

Dear Mr. Rweyemamu:

OHCA has reviewed your CON application, identified as Docket Number 12-31773-CON, and requests the additional information. I have attached the letter with the questions and also I have attached the two Financial Attachments (in MS Excel) that you will need to complete and return with your responses.

Please let me know that you have received this email and that the three attachments were also received. You may call with questions concerning the process and clarification of the questions.

Regards,

Laurie K. Greci

Associate Research Analyst
Department of Public Health
Health Care Access
laurie.greci@ct.gov
860 418-7032
860 418-7053

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

July 27, 2012

VIA ELECTRONIC MAIL ONLY

Justinian Rweyemamu, MA, M. Div, MS-MFT
CT-Family Care Services, LLC
16 Enfield Ave.
Enfield, CT 06082

RE: Certificate of Need Application; Docket Number: 12-31773-CON
Establishment of a Behavioral Health Treatment Center in Manchester
CON Completeness Letter

Dear Mr. Rweyemamu:

On July 1, 2012, the Office of Health Care Access ("OHCA") received your initial Certificate of Need ("CON") application filing on behalf of CT-Family Care Services, LLC ("Applicant") proposing to establish a behavioral health treatment center in Manchester ("Center").

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) The newspaper notice provided on page 6 states that the proposed Center will be located in Manchester at 243 Main St. However, on pages 9 and 10, Enfield and Manchester are listed as the project towns.
    a. Please clarify the locations for the proposed Center(s.)
    b. Explain the rationale for choosing the proposed locations.
    c. What are the proposed service hours and days at each location?
    d. What are the service area towns for each location?
    e. Explain the basis for the listed towns.

2) On page 10 of the application it states that there is an estimated total capital expenditure of $1,843,100. However, Table 2 on page 64 is blank. Report the estimated total capital expenditure and complete Table 2. For nonapplicable categories, place a zero in the dollars column. Provide a separate table for each proposed location listed in response to Question 1.

Table 2: Proposed Capital Expenditures/Costs

Non-Medical Equipment Purchase	
Land/Building Purchase *	
Construction/Renovation **	
Other Non-Construction (Specify)	
Total Capital Expenditure	**$**
Fair Market Value of Space ***	
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.

3) Provide copies of documents and articles cited in the submitted application and listed on pages 68 – 71. Provide a brief explanation regarding the relevance of the selected articles and how each supports the need for the proposal.

4) Report the Applicant's fiscal year (FY) by start month and end month. For any information requested in the balance of the letter, please report volumes or dollar amounts using FY 2013, FY 2014, and FY 2015.

5) Please provide a detailed description of the Applicant's existing services that are provided in Springfield, Massachusetts, and in Enfield and Manchester, Connecticut. If the Applicant currently offers mental health or substance abuse services/programs, please address the following:
   a. The units of service (i.e. group/individual counseling sessions, clinic visits) for last three completed Fiscal Years by patient town of origin for each service.
   b. The number of admissions for last three completed FYs by patient town of origin for each service.
   c. The available capacity of each provided service.
   d. For most recent completed fiscal year, provide information regarding backlogs or waiting lists by each provided service.

6) Please provide by month, for the most recent completed fiscal year, the following: average daily census; number of clients on the last day of the month; the number of clients admitted during the month; and the number of clients discharged during the month for each existing service/program in the proposed service areas.

7) Identify the proposed patient population and explain how and where this proposed patient population is currently being served. How does the proposed patient population differ from the Applicant's current patient population, if any? If the proposed patient population is the same as the current patient population, explain the need for the proposed service.

8) Provide a detailed explanation on the effect of the proposal on existing providers, including financial, explaining how current referral patterns will be affected by the proposal. Review the list of existing providers given in the submitted application and list any additional providers in the service area towns for the proposed locations. Discuss how this proposal will not result in an unnecessary duplication of existing services.

9) Discuss the services that the Applicant will provide to each distinct group listed in Question 5. List the services separately by proposed location(s).

10) The Applicant has provided information on numerous socioeconomic groups, such as medically underserved areas and the level of education achieved. However, there is no correlation between the information provided and the unmet need in the proposed service areas. Utilizing the information and statistics provided in the initial CON application and other sources as may be needed to develop the clear public need by determining the number of persons by group, i.e., high school students, families that will benefit from your proposal. Establish the clear public need for each proposed location separately.

11) From the need projected in Question 9 above, determine the Applicant's estimated projected volume for FYs 2013, 2014, and 2015. Determine the projected volume for each proposed location separately and differentiate the volumes by the services that will be provided (mental health services, substance abuse services) and population served (youth, adults, veterans). Provide a separate table for each proposed location. **List all assumptions made to determine the projected volumes.**

Table 1: Projected Volume by Fiscal Year

Service Type*	Projected Volume by Fiscal Year		
	2013	2014	2015
Total			

* Identify each service/procedure type and add lines as necessary.

12) Explain the increases in volume from the relative previous year for FY 2014 and FY 2015.

13) On page 18 there is a discussion around the prisons and the prison population in the greater Enfield area. It must be recognized that the prisons house persons from the entire state. Furthermore, there is no way to predict where prisoners will upon release. Therefore, it is not clear as to where or when the Applicant will provide services to this population. Please discuss the Applicant's intent for this population and provide supporting documentation as appropriate.

14) Much of the information provided in the application refers to mental health services. Provide a discussion on the services that the Applicant proposes to provide its substance abusing or substance dependent clients. Provide documentation or articles that support the discussion. Include statistical information from the Office of Applied Studies of Substance Abuse and Mental Health Administration (SAMSHA) 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). Also, the Department of Mental Health and Addiction Services (DMHAS) collects capacity and actual population statistics on most existing licensed and state operated providers by town and service.

15) On page 45 it states that the Applicant will receive referrals from other agencies. Provide copies of any documents that will support this statement.

16) List each license that the Applicant is seeking from the Department of Public Health (DPH) in relation to the proposed centers by the locations reported in response to Question 1. Information concerning DPH licensure may be obtained by calling Sandra Bauer, DPH Facility Licensing, at (860) 509- 8023.

17) The Applicant on page 64 states that it expects most of its clients to have low incomes. How will the Applicant provide services to the underinsured or uninsured clients?

18) In addition to the funding source reported on page 148, has the Applicant secured any contracts or received any monies to support the establishment of the proposed Center(s)?

19) On page 150 the annual budget given includes income from two grants. Please describe each grant, including what organization is providing the funding, and the number of years the Applicant anticipates receiving the grants.

20) Please provide audited financial statements for the most recently completed fiscal year. If these statements do not exist, provide other financial documentation to show that the Applicant has the financial ability to establish the proposed center and provides services.

21) Complete Table 3. Provide, at a minimum, the projected patient population mix by revenue source for FYs 2013, 2014, and 2015 based on the number of patients as reported in the revision of Table 1 from Question 10. Provide a discussion for the basis and or assumptions that were used to project the reported patient population mix.

Table 3: Patient Population Mix

	Current **	FY 2013	FY 2014	FY 2015
Medicare*				
Medicaid*				
CHAMPUS & TriCare				
Total Government				
Commercial Insurers*				
Uninsured				
Workers Compensation				
Total Non-Government				
Total Payer Mix	**100%**	**100%**	**100%**	**100%**

* Includes managed care activity.
** May be left blank if there are no existing patient populations.

22) Complete the attached Financial Statements I and II. Volume for proposed services must agree with the volume reported on the revised Table 1 from Question 10.

23) Report the minimum number of patient visits required to show an incremental gain from operations for each projected fiscal year and by proposed location.

24) Report the number of staff by position that will be required at each location in order to accommodate the number of patient visits reported in Question 10.

25) In describing how the proposal will be cost effective the Applicant states that it proposes to charge a rate at the lower end of the usual rate, $100 per hour. The Applicant also states that it will provide competitive salaries in order to attract and retain the best experienced professionals. How will the Applicant balance the lower revenues with the higher salaries?

26) Provide a copy of the Applicant's business plan for the proposal.

27) Discuss how this proposal will effect the financial strength of the health care system in the state of Connecticut.

28) Explain how this proposal contributes to the quality of health care delivery in the region.

29) 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 168. Please reference "Docket Number: 12-31773-CON." Submit one (1) original and four (4) hard copies of your response. In addition, please submit a scanned copy of your response including all attachments on CD in an Adobe format (.pdf) and in an MS Word

format. Please submit an electronic version of the financial attachments requested in Question 22 in MS Excel 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 September 25, 2012. If you have any questions concerning this letter, please feel free to contact me at (860) 418-7032.

Sincerely,

LKGreci

Laurie K. Greci
Associate Research Analyst

Attachments

Copy of PDF file: Kim Martone, Director of Operations, DPH OHCA
Kevin Hansted, DPH Staff Attorney
Kaila Riggott, CON Supervisor, DPH OHCA

Financial Attachment 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 _____
Type of Unit Description: _____
# of Months in Operation _____

FY _____ **FY Projected Incremental** Total Incremental Expenses: _____ **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				$0				$0	$0	$0
Medicaid		$0		$0				$0	$0	$0
CHAMPUS/TriCare		$0		$0				$0	$0	$0
Total Governmental			0	$0	$0	$0	$0	$0	$0	$0
Commericial Insurers		$0	5	$0				$0	$0	$0
Uninsured		$0	2	$0				$0	$0	$0
Total NonGovernment		$0	7	$0	$0	$0	$0	$0	$0	$0
Total All Payers		$0	7	$0	$0	$0	$0	$0	$0	$0

Financial Attachment I

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

Total Facility:	FY	FY	FY	FY	FY	FY	FY	FY	FY
Description	**Actual Results**	**Projected W/out Project**	**Projected Incremental**	**Projected With Project**	**Projected W/out Project**	**Projected Incremental**	**Projected With Project**	**Projected W/out Project**	**Projected Incremental**
Revenue from Operations				$0			$0		
Non-Operating Revenue				$0			$0		
Total Revenue:	$0	$0	$0	$0	$0	$0	$0	$0	$0
Total Operating Expenses				$0			$0		
Revenue Over/(Under) Expense	$0	$0	$0	$0	$0	$0	$0	$0	$0

*Volume Statistics:

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

Greer, Leslie

From: Greci, Laurie
Sent: Thursday, August 02, 2012 11:13 AM
To: Greer, Leslie
Subject: FW: CON application for Behavioral Health Outpatient Programs 12-31773-CON

From: Justinian Rweyemamu [mailto:rweye@cox.net]
Sent: Friday, July 27, 2012 3:20 PM
To: Greci, Laurie
Subject: Re: CON application for Behavioral Health Outpatient Programs

Good afternoon Laurie
Thank you for your message with its 3 attachments. I will work on them and get back to you ASAP. Justin

----- Original Message -----
From: Greci, Laurie
To: rweye@cox.net
Sent: Friday, July 27, 2012 2:29 PM
Subject: CON application for Behavioral Health Outpatient Programs

Dear Mr. Rweyemamu:

OHCA has reviewed your CON application, identified as Docket Number 12-31773-CON, and requests the additional information. I have attached the letter with the questions and also I have attached the two Financial Attachments (in MS Excel) that you will need to complete and return with your responses.

Please let me know that you have received this email and that the three attachments were also received. You may call with questions concerning the process and clarification of the questions.

Regards,

Laurie K. Greci

Associate Research Analyst
Department of Public Health
Health Care Access
laurie.greci@ct.gov
860 418-7032
860 418-7053

CT-FAMILY CARE SERVICES, LLC

A response to the "CON Completeness Letter" dated July 27, 2012 From Laurie K. Greci Associate Research Analyst, Department of Public Health (DPH).

RE: "Certificate of Need Application; Docket Number: 12-31773-CON Establishment of a Behavioral Health Treatment Center in Manchester CON Completeness Letter"

Below are the answers to your questions.

1) The newspaper notice provided on page 6 states that the proposed Center will be located in Manchester at 243 Main St. However, on pages 9 and 10, Enfield and Manchester are listed as the project towns.

   a. Please clarify the locations for the proposed Center(s.)

Answer: The newspaper notice provided on page 6, locates 243 Main Street in Manchester. The company hopes to start operating there once the "CON" certificate has been granted. **Manchester** will be our first office to provide behavioral health treatments to children and their families and the company has already applied to DCF for the licensing of an outpatient psychiatric clinic for children and families. In addition, the company plans to provide behavioral treatments to adults, including but not limited to veterans who are dealing with trauma, PTSD and trauma symptoms such as addictions, substance abuses, violence, depression and marital /relational crises. I understand that in order for the company to provide psychiatric or mental health treatments to adults in Manchester, the company needs the certification of need (CON). For that reason, the company applied for CON and the news paper notice focused on Manchester (page 6).

Once the office in Manchester has started providing services, the company plans to open the second office in Enfield for the adults, especially, inmates who need preparations for community re-entry as well as marital and family crises counseling (refer to the initial CON application, pp.16 -20), because the town of Enfield in a special way, has a huge population of minorities and low income population who are incarcerated and need effective and integrated community-re-entry treatments as it has been elaborated in my proposal. Hence, another newspaper notice to the public for the Enfield office will be provided to your office later on. Alternatively, the office in Enfield may start as a satellite office to the main office in Manchester; hence there may be no need of a new newspaper notice to the public.

b. **Explain the rationale for choosing the proposed locations.**

Answer: In the proposal submitted to your office, the company provided the rationale for choosing (a) Manchester and (b) Enfield. Please refer to page 17 to 20 for Enfield and 20 to 24 for Manchester. From page 26 to 39, the initial CON application proposal highlights some of the underlining problems in those towns and the importance of reaching out to minorities with integrated therapeutic treatments that have social-cultural components needed for effective treatments for minorities as well as to the underserved population in the area.

c. What is the proposed service hours and days at each location?

Answer: The service hours will be from 9 am to 7 pm Monday to Friday and Saturday from 10 am to 2pm. The arrangements of services will be extended up to 7pm on Monday to Friday and Saturday from 10 am to 2 pm in order to accommodate clients, parents and families who may be working during the weekdays, hence unable to come to therapy on those days.

d. What are the service area towns for each location?

Answer: From page 13to 16 in the proposal, the categories of services the company provides are presented with some elaborations. The company is dedicated in a special way to serving minorities and low income population or the underprivileged. The company provides individual and family therapy treatments which have an effective cultural sensitivity and competency that are needed when working with diversified population (McGoldrick, Giordano, & Garcia-Preto, 2005). In the town of Manchester, the company will provide services at its outpatient psychiatric clinic for children and families and as the outpatient behavioral treatments for adults and families. For the town of Enfield, the company plans to do the same as in Manchester in the near future.

e. **Explain the basis for the listed towns.**

Answer: The reasons for choosing the towns of Manchester and Enfield are provided in the CON application proposal from page 44 to 52. One of the reasons is that those two towns and their neighboring towns continue to have a significant increase of minority population, but the needs of those minorities are not addressed sufficiently from social-cultural contexts (page 45 to 47). CT-Family Care Services, LLC has expertise needed in those selected areas as presented in the proposal. In addition, studies suggest that minorities with mental health symptoms often do not use the existing recommended mental health services because of social-cultural concerns, and as a result, over 21% of Connecticut ethnic groups with mental health issues tend to turn to their families or friends for help instead of using mental health professionals (Department of Mental Health and Addictions. A comprehensive mental health report, for Connecticut 2006, CON initial proposal, p.54). The company provides treatments that address those social-cultural-mental health issues that affect ethnic groups (CON initial proposal, pp 54-59) in the selected

towns of Manchester and Enfield as well as their surrounding areas where minorities are looking for those services.

2) **On page 10 of the application it states that there is an estimated total capital expenditure of $1,843,100. However, Table 2 on page 64 is blank. Report the estimated total capital expenditure and complete Table 2. For no applicable categories, place a zero in the dollars column. Provide a separate table for each proposed location listed in response to Question 1.**

Answer: The Company's fiscal year starts on July 1 and ends on June 30. Hence, the estimated projection of income from July 1, 2012 to June 30, 2013 is $ 1,843,100.00 and the total expenditure estimated to amount $ **1,784,272.00**. Thus, the $ 1,843,100 as the total expenditure is for the company's fiscal year 2012/2013 was an error and it has accordingly been corrected.

Table 2: Proposed Capital Expenditures/Costs (2012/2013)

Non-Medical Equipment Purchase: **services and office items**	$528,800.00
Land/Building Purchase *	$ 0.00
Construction/Renovation **	$ 0.00
Other Non-Construction (Specify): **Salaries**	$ 1,210,699
Total Capital Expenditure	**$ 1,739,469.00**
Fair Market Value of Space ***	$ 0.00
Capitalized Financing Costs (Informational Purpose Only): **Health Insurances**	**$ 44,802.00**
Total Capital Expenditure with Cap. Fin. Costs	**$ 1,784,271.00**

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

** 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. **N/A**

*** 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 **N/A.**

3) **Provide copies of documents and articles cited in the submitted application and listed on pages 68 – 71. Provide a brief explanation regarding the relevance of the selected articles and how each supports the need for the proposal.**

Answer: From page 68 to 71 in the CON application, the proposal has references of the articles and the texts that have been cited in the proposal. The articles and the texts cited, support the proposals in several ways as they were used to shed some lights on the issues affecting minorities in Connecticut and nationally in literatures and how CT-Family Care Services proposal is both relevant and important in order to break the cycle of mental health crises among minorities in the selected towns and hopefully that could be expanded or adopted to other areas as well. Across the Connecticut River in Hartford County, **the towns of Manchester** and **Enfield** as well as their

neighboring areas such as East Hartford and East Windsor, both have significant number of minorities and low income population who will definitely benefit from CT-Family care services.

4) **Report the Applicant's fiscal year (FY) by start month and end month. For any information requested in the balance of the letter, please report volumes or dollar amounts using FY 2013, FY 2014, and FY 2015.**

Answer: The Company's fiscal year starts in July and ends in June. Since the company has not yet started providing services as it still waits for its licensing from DPH, the actual dollar amount for 2012/2013 will be available next year and it will be supported by the bank statements or tax returns.

5) Please provide a detailed description of the Applicant's existing services that are provided in Springfield, Massachusetts, and in Enfield and Manchester, Connecticut. If the Applicant currently offers mental health or substance abuse services/programs, please address the following:

a. The units of service (i.e. group/individual counseling sessions, clinic visits) for last three completed Fiscal Years by patient town of origin for each service.

Answer: Even though the company has offices in Enfield, Manchester and Springfield, the company has not yet started providing services in those offices as it is still waiting for licensing.

b. The number of admissions for last three completed FYs by patient town of origin for each service.

Answer: N/A, because the company has not yet started providing services.

c. The available capacity of each provided service.

Answer: The Company is capable of serving about 100 clients per day.

d. For most recent completed fiscal year, provide information regarding backlogs or waiting lists by each provided service.

Answer: For now, the backlogs or waiting list is not going to be an issue. The company, however, has a mechanism of not keeping clients on the waiting lists. Clients who will be referred to CT-Family Care Services for treatments or those who will choose to walk in for the services, will be treated within the same day. Assigned clinicians will conduct the initial assessments in order to determine if a client can be treated at the clinic immediately or if a client will have further medical and mental health complications that will demand that further referral to a hospital or to another agency for a specialized advanced care. It is the company's policy not to take clients in order to keep them on the waiting list. In addition the company's treatment is customized and focused and within every three months, the treatment team and clients as well as the key family supportive members, will have treatment evaluations about the recovery progress, or and areas that need improvements. If the indicate satisfactory recovery or complete recovery there will be no need for treatments, clients will be discharged as soon as possible once clients and the treatment team have secured a supportive mechanism for the client after discharge. Again, clients will not be prolonged in treatments unnecessarily.

6) Please provide by month, for the most recent completed fiscal year, the following: average daily census; number of clients on the last day of the month; the number of clients admitted during the month; and the number of clients discharged during the month for each existing service/program in the proposed service areas.

Answer: Since the company has not yet started providing services in order to have the exact number of clients per day, week, or month, the company projects that it will have a capacity of

serving about 100 clients per day. Since the rate of drop out from completing treatment is commonly high among the targeted population, the company anticipates to providing services to between 90 clients per day instead of 100 per day and the company is drafting a plan that will inspire clients to effectively participate and fully complete their treatments in order to overcome the dropout challenges.

7) Identify the proposed patient population and explain how and where this proposed patient population is currently being served. How does the proposed patient population differ from the Applicant's current patient population, if any? If the proposed patient population is the same as the current patient population, explain the need for the proposed service.

Answer: The Company is dedicated to serving all people and with a special focus on minorities and low income population. It is a fact that even in Connecticut, there is still a significant health and economic disparities between the underserved population and the affluent population. Responding to that need, the company has chosen to start providing services in Manchester and in Enfield areas because those areas have minorities and low income populations which are not always sufficiently attended to because traditionally, more emphasis has been geared on major cities which have more minorities and low income populations. In this context, the underserved population includes black, Hispanic, low income Caucasians, veterans, seniors, refugees, prisoners and their children.

8) Provide a detailed explanation on the effect of the proposal on existing providers, including financial, explaining how current referral patterns will be affected by the proposal. Review the list of existing providers given in the submitted application and list any additional providers in the service area towns for the proposed locations. Discuss how this proposal will not result in an unnecessary duplication of existing services.

Answer: While the selected area already has some agencies providing services, the company's proposal will not create any financial burdens on those agencies because, the study conducted by the company indicates that, there are no agenciencies that have strong integrated social –cultural components needed by the minorities. In addition, it is a fact that often ethnic groups with mental health symptoms tend to turn to their families instead of seeking therapeutic treatment, due to social-cultural issues (CON initial proposal, p. 54, Comprehensive mental health plan for Connecticut, 2006, p.27). Thus, the company seeks not to take away clients from other agencies, but rather to reach out to potential clients who are marginalized or who are not sufficiently served. Clients will be free to choose to continue being treated by CT-Family Care Services as it addresses their needs. In relation to mental health issues of which CT-Family Care has no expertise, the company will refer clients to other local agencies where they can get adequate services. The studies by the company indicate that the existing agencies in the area have some strength and weaknesses and the company will respond accordingly (CON proposal, pp. 47-51). CT-Family Care Services brings very valuable and unique social-cultural aspects in mental health treatments in order to effectively serve minorities and low income population.

(b) In addition to the agencies mentioned in the CON proposal on p.44, Below are some additional agencies present in the area (Enfield and Manchester).

9) Discuss the services that the Applicant will provide to each distinct group listed in Question 5. List the services separately by proposed location(s).

Answer: The category of services that CT-Family Care Services provides are more elaborated in the proposal from pages 13 to15. The company will provide services to children, students,

youth and their parents, adults, couples, families, seniors, veterans and prisoners for an effective community –re-entry in Enfield and Manchester.

A: The Company has applied to DCF for the license of an outpatient psychiatric clinic for Children and their families. The clinic will provide integrated treatments as follows:

- **Problematic Behavioral Treatments**: Mental health treatments. For example reduce the incidences of mental illnesses, emotional disturbances, violence, depression, ADHD, delinquencies, addictions and substance uses among children and adolescents,
- **Academic treatments**: in order to reduce or prevent school dropout, poor academic performances, violence and other related behavioral crises which make a good percentage of school dropouts end up in jails or have insufficient work-force skills.
- **Provide therapeutic treatments** to the parents or families of the children who receive treatments at our clinic. This systemic approach seeks to treat the mental health, behavioral and academic problems affecting children from the core-essence of those problems. In addition, the company will provide alternative integrated therapeutic and academic treatments as well as workforce skills enhancements training and treatments as alternative to juvenile imprisonments for children/adolescents (for non-murder cases).

B: Once the company has received the Certificate of Need (CON) from DPH for its **Outpatient Integrated Treatment Program for adults and families**, the company will serve individual adults, couples, partners, senior citizens, veterans, and prisoners for community re-entry by providing social services and therapeutic treatments.

C: Job training and social services to families of those children (clients) in order for the parents/ families to overcome the cycle of poverty and behavioral patterns that are affecting children and society.

D: Research utilization, in order to enhance clients' recovery and wellness in communities

One of the unique contributions that the company brings to Enfield and Manchester communities and their neighbors are integrated therapeutic treatments which are composed of strong *Academic-Social-Cultural-Emotional-Spiritual-Economic-Relational-(ASCESER) components* that are vital for a sustainable healing from mental health issues including but not limited to post-traumatic stress disorder (PTSD) and its symptoms such as depression, anxiety, addictions, violence, alcohol and substance abuses as well as other constraints among children/students, families, couples, individuals and veterans.

CT-Family Care is designed primarily, to complement what is lacking in the current treatment of mental health issues as well as to foster integrative systemic solutions for students, families, couples, veterans, seniors and retired professionals by using the *ASCESER* in order to overcome their internal and external problems that lead to mental health crises.

Clients: Clients are children, students/Youth, individuals, couples and families, veterans, seniors, professionals, refugees and inmates community –re entry.

Integrated Treatments and Services offered:

- **Mental Health**: The Company provides integrated and personalized **therapy** in home or off site through its experienced clinicians, both graduate and licensed Marriage and Family Therapists (MFTs), psychologists, clinical social workers, psychiatrists as well as spiritual counselors. Our seasoned professional are trained to **support veterans, seniors, students, families, couples and individuals** at this unique stage of their life with emotional well being, healing, re-adjustment and growth with a caring, respectful and holistic approach. Integrated individuals, couples/partners, groups and family therapies

with clients' active participations enable clients to overcome their internal and external constraints that slow their progress to recovery and wellness.

- **Social Services and Care**: The Company provides **home therapy, home healthcare** and Social Services by licensed and experienced Social Workers, Therapists, Certified Nursing Assistants, Licensed Practical Nurses, and Registered Nurses to support residents in order to live comfortably and independently. By providing home healthcare, social services and home individual and family therapies to veterans and seniors and their families or care providers (therapy) as needed when those individuals are unable to come to the clinic for therapy treatments enable clients to be served and cared for in their environmental context. A good number of veterans from deployments have psychical injuries and some have lost their body-parts as well as seniors who are aging or care-takers, who are either uncomfortable or unable to drive to the clinic for treatment, but need greatly mental health treatment and social care.
- **Education, Training and Behavioral Enhancement for Students:** The agency will work with schools, families as well as students who have specific risk factors such as delinquency, problematic behaviors, and school dropout or low academic achievements. Integrated academic and therapeutic treatments will be provided accordingly in order to enable students to enhance their coping skills, social skills and learn to overcome or manage the triggers that lead them to school dropout, low academic performances and problematic behaviors. The academic and behavioral treatments provided are intensive and integrated as they include students, their parents, schools and key important support members to that client in a family or a community, so as to foster and sustain recovery and healing successfully. Sometimes, clinicians will visit a student's home in a family

setting in order to understand the environments and the underneath factors that influence the family dynamics in a way that can affect every family members. That is why in different cultures, there is a metaphor which states that "it takes a village to raise a child". Likewise, it takes more than a child/student's participation in the treatment for sustainable success. Thus, supportive and caring members from the immediate or extended families as well as other professionals are welcomed and encouraged for effective collaboration.

- **Veterans and their families.** While veterans continue to offer great sacrifices within the United States and overseas, especially now in Iraq and Afghanistan, veterans as well as their family members, especially their children are being affected with academic, behavior and mental health issues. The children suffer from the absence of either one or both of their biological parents, who are far from them for a length of time. In addition, often veterans and their families are affected by Post Traumatic Stress Disorder (PTSD) consequently; CT-Family Care Services will provide customized, integrated therapeutic treatment and social services, and home healthcare to veterans and their families in the area **as needed.**
- **Job Training and Readiness**. CT Family Care Services will provide wrap-around job readiness and re-adjustment services to its clients as needed**.**
- **Retired Professionals and Senior Citizens:** These members of our community can benefit greatly from accessible, high quality mental health and social services that are result oriented and are delivered in a professional, compassionate and caring manner.
- **Youth and Family Services**: The agency will be focusing on working with school age youth and their families that have specific risk factors such as delinquency, problematic

behaviors, school dropouts and dysfunctional family dynamics that are affecting their education and community life.

- **Community Re-entry:** Connecticut spends over $30,000 to $35,000 per year to keep one inmate in prison and there is no guarantee that once released, they will not commit another crime, and that is a heavy burden to taxpayers. CT-Family Care Services will provide the intensive, integrated treatment needed in order to rehabilitate them and enable them to have positive outcomes while becoming productive members of our communities.
- **Integrated Research Team**: The research will focus on treatments and how best to enhance clients' systemic recovery in a social-cultural context. It is purported that currently there is insufficient clinical research on cultural healing competencies in mental health issues related to treatment of veterans, seniors, retired professionals and minorities. This research will benefit clients and families, seniors and retired professionals as well as mental health and government institution as how to enhance positive outcomes for these populations.
- **Integrated treatments for seniors and veterans: Social services, spiritual care, home healthcare, Therapy and medication.** There are substantial numbers of potential clients especially seniors who need home care and therapy. In addition there is a good number of veterans who need home therapy, social services as well as home health care because they are unable to come to the office for therapy, receive social services or able to care for themselves holistically due to their ageing, health related issues as well as loosing parts of their bodies due to combats and they are struggling with trauma as well as its related symptoms.

- Many veterans returning home from deployments in Afghanistan and Iraq have much health related challenges, including physical injuries (Romberg, in American Association of Marriage and Family Therapy, returning veterans, March 2009, p.43).The towns of Enfield and Manchester and their neighboring towns have both minority and non minority veterans who are dealing with some of those challenges. Due to various safety factors, it seems difficulty finding the accurate number of veterans dealing with the above mentioned challenges in the selected towns. Yet, lack of official statistics should not be taken as a denial that veterans and seniors in the selected towns and their neighboring areas from having services from CT-Family care Services.

In addition, as some men and women veterans struggle with community re-adjustment after combat life styles, some seniors have difficulties of re-adjusting to the reality of aging, retired, or making less money as they used to do in the past and missing a companion. Re-adjustment seems to be a challenge to veterans as well as to seniors due to complex factors including the cultural beliefs and excessive capitalism or consumerism philosophy that one is valued or significant in a community because of the wealth, money or productivity. Such kind of cultural rooted subtle views seem to exercibated anxiety, worries, depressions and other health related crises have left some seniors or veterans unappreciated in a communities accordingly. Hence, veterans and seniors in the selected areas need a company's holistic care approach that integrate therapeutic treatments with social services as well as home health care from experienced social workers, marriage and family therapists, psychiatrists, registered nurses, certified nurse assistants(CNA) and Licensed practical nurses(LPN).CT-Family Care Services is composed of experienced professional on those related areas.

The company is very aware about the complex situations and constraints affecting veterans and seniors, especially those who are home bound as they may be unable to drive to the outpatient center for treatment because they are unable to drive themselves due to physical injuries or lost some parts of their bodies (veterans), disabilities, unable to care for their beloved ones who are very sick and home bound and unable to go out without a professional assistance.

When adults who have mental health symptoms or illnesses are not helped systemically and timely, their issues can lead to situations where some partners feel unable to cope with returning veterans' needs or demands and hence adopt divorce. When divorce or separation takes place between couples or partners it affects other family members including veterans, seniors and children. Providing integrated treatment that includes home family therapy, social services care and home healthcare as needed can greatly reduce mental health crises (Ratlif, Frame, and Moll 209).Thus, it is extremely important that therapeutic, psychiatric(medical), social services care and home health care components be well integrated and available especially for veterans, seniors and their care-providers who need them most.

- **Refugee and Immigrant Resettlement:** Refugees and Immigrants will receive cross-cultural counseling services and job training. Studies and experience with Refugees' resettlement in the region indicate that, minority refugees encounter more hardships in adjusting to American culture even when they have talents. By supporting them through this transition and into the workforce, they will contribute greatly to Connecticut's economy and cultural diversity. Therefore, CT-FAMILY CARE SERVICES aims to utilize her experience, skills and social connections, social services, integrative

counseling, love and care to serve the refugees and the asylum seekers approved by U.S. Committee for Refugees and Immigrants from the moment these refugees arrive in Connecticut, USA. Our services will include: Welcoming refugees in a caring cross-cultural spirit of fellowship into American multi-cultural families and communities, provide personal care, pastoral spiritual care in a non-judgmental settings, and cultural ethnical comforts, counseling, social services, finding jobs, schools and the training process needed all the way to enable our clients achieve a sustainable success in American communities.

10) The Applicant has provided information on numerous socioeconomic groups, such as medically underserved areas and the level of education achieved. However, there is no correlation between the information provided and the unmet need in the proposed service areas. Utilizing the information and statistics provided in the initial CON application and other sources as may be needed to develop the clear public need by determining the number of persons by group, i.e., high school students, families that will benefit from your proposal. Establish the clear public need for each proposed location separately.

Answer: **Manchester**: The town of Manchester has a high rate of students from low income population and as a result, students receive a subsidized meals (proposal, p.24) and about 47.7 %(942) of high school students at Manchester High are minorities and 52.4 %(1036) are white. Studies indicate that the epidemics of school dropout affect more young people of low-income, children of single parents and minorities (Balfanz, Fox, Bridgeland & McNaught, 2009) and that is also true in Manchester. The town of Manchester has about 6,800 students in public school from elementary to High school. Now at a rate of 47.7%, the town of Manchester has about 3,244 minority students. The company plans to reach out to minority students in the high school

as well as in other schools and to their parents. School dropout as well as problematic behaviors among students become exercibated due to what they experience in their families and that is why it is important to provide therapeutic treatments to both, students and their parents in order to improve the environments that affect students' mental health wellness and academic success. By choosing to offer services in Manchester the company plans not only to offer its expertise, but to bring the bridge of HOPE to those children and their families.

11) From the need projected in Question 9 above, determine the Applicant's estimated projected volume for FYs 2013, 2014, and 2015. Determine the projected volume for each proposed location separately and differentiate the volumes by the services that will be provided (mental health services, substance abuse services) and population served (youth, adults, veterans). Provide a separate table for each proposed location. **List all assumptions made to determine the projected volumes.**

Answer: The projected number of clients to be served annually is rooted in the company's projected budget and the needs in the selected areas. In order to accommodate clients' needs and avoid keeping clients on waiting lists clients are encouraged to be flexible so that they receive treatments either from Manchester or Enfield centers. Thus, in the diagram below, is the total projected number of clients who will be annually served and clients will have various mental health related issues such as trauma, substance uses, delinquencies, depressions, alcohol, drugs, school dropout, violence, addictions and preventable unhealthy behaviors.

Table 1: Projected Volume by Fiscal Year

Service Type*	Projected Volume by Fiscal Year

	2013	2014	2015
Children/Youth and Families **(Problematic behavioral treatments)**	4752	5760	7680
Students & their families **(Problematic Behavioral and academic treatments)**	3782	5760	6720
Adults, couples, seniors, families **(Customized individual & couple treatments)**	3422	3840	7680
Veterans & their families **(Customized Individual & family/partner treatments)**	1775	2668	4007
Inmates comm. re-entry **(Customized individual & family/partner treatment)**	1200	2093	3432
TOTAL	**14,931**	**20,121**	**29,519**

* Identify each service/procedure type and add lines as necessary.

12) Explain the increases in volume from the relative previous year for FY 2014 and FY 2015.

Answer: It is estimated that in 2014 about 20,121 clients will be served and the number will increase to 29,519 in 2015. One of the reasons for such increase is due to the fact that in its third

year, the company will have gained peoples' confidence and it will be involved in the communities in fostering individual and family wellness including sponsoring community – social- economic and educational activities. The company is committed to investing in clients and their families for sustainable recovery and success.

13) On page 18 there is a discussion around the prisons and the prison population in the greater Enfield area. It must be recognized that the prisons house persons from the entire state. Furthermore, there is no way to predict where prisoners will upon release. Therefore, it is not clear as to where or when the Applicant will provide services to this population. Please discuss the Applicant's intent for this population and provide supporting documentation as appropriate.

Answer: The town of Enfield alone has six prisons with a total of 6,398 inmates' population (proposal, p.19). For over 10 years, I served as a chaplain for the Department of Correction and I provided services in those prisons as well as in others in the nearby towns of Suffield which has 2,125 inmates (CON Proposal, p. 19). While, it is true that some inmates who are incarcerated in those prisons (in Enfield) come from different towns in Connecticut, it is also a fact that the majority of those inmates are minorities and low income populations who often have children or families that are missing their presence and help in order to enhance their internal healing and social skills including good child-parent relationships. The report by the Department of Correction points out that, as of July 1, 2012 Connecticut inmates had the following ethnic categories: Blacks was 6,886, Whites was 5,298 and Hispanics was 4,299 and other 108(http://www.ct.gov/doc/cwp/view). Such type of ration is also closely related to the inmates' population in Enfield area. In addition, some of the treatment programs available in Enfield prisons reflect most of the programs and services in Connecticut Prison system as presented on

the DOC's website (http://www.ct.gov/doc/lib/doc/pdf/compendium/compendiumrobinson.pdf). While those programs are good, including those in Enfield area, by reviewing those programs, it is clear that often they lack the social –cultural components in therapeutic treatments in order to effectively enhance coping skills and foster effective social skills which are vital to enhance individual and family wellness as well as positive parenthood and productive citizenship among minorities that CT-Family Care Services is dedicated to work with and serve. By opening an outpatient integrated treatment in Enfield, the company will effectively contribute its expertise that is currently lacking in the treatment programs available for the inmates population in the prisons. CT-Family Care Services, LLC requests for CON not merely to be another outpatient agency that treats inmates in Enfield area, but rather as the minority owned company with the outpatient integrated treatment/psychiatric treatments for adults and families. CT-Family Care Services requests for CON certification in order to provide the social –cultural therapeutic treatment components, educational treatments as well as integrated social support services that minorities or the underserved population need in order to foster their internal and external mental health recovery an end the cycle of imprisonments, economic and health disparities.

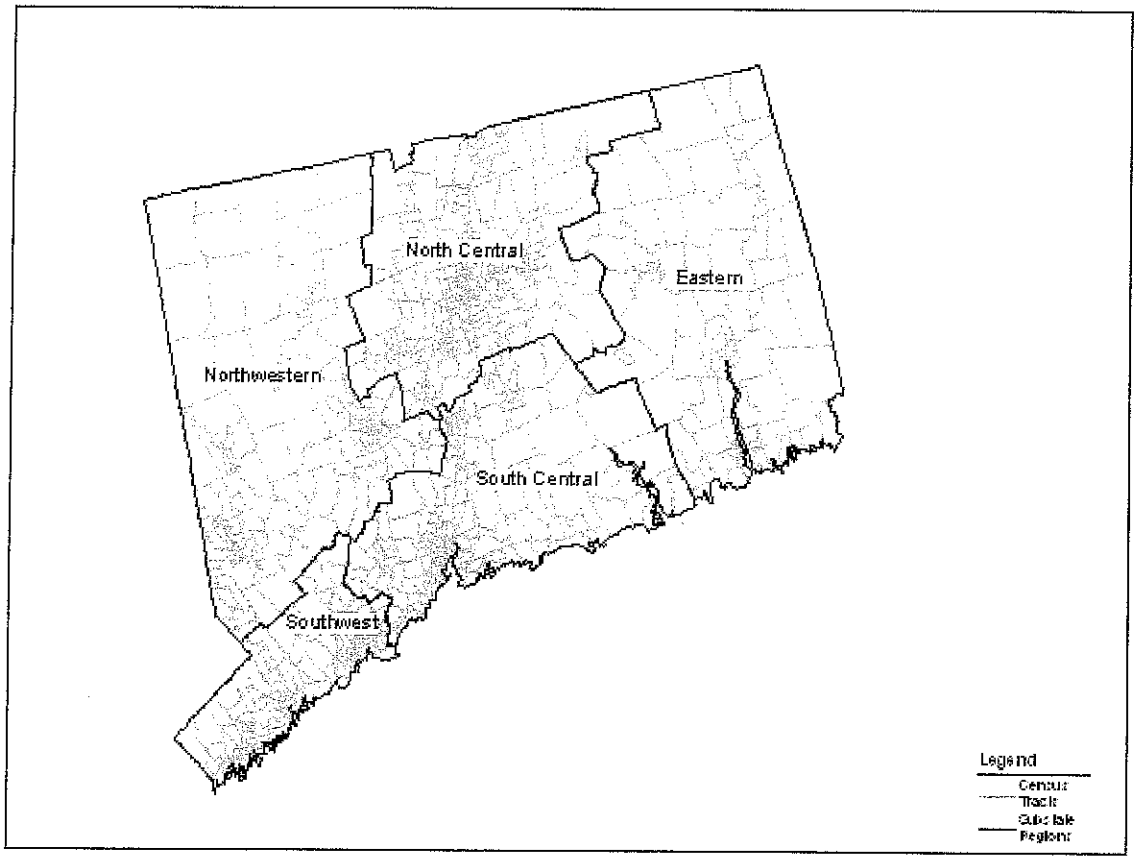
14) Much of the information provided in the application refers to mental health services. Provide a discussion on the services that the Applicant proposes to provide its substance abusing or substance dependent clients. Provide documentation or articles that support the discussion. Include statistical information from the Office of Applied Studies of Substance Abuse and Mental Health Administration (SAMSHA) 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). Also, the Department of Mental Health and Addiction

Services (DMHAS) collects capacity and actual population statistics on most existing licensed and state operated providers by town and service.

Answer: The misuse of alcohol and drug abuses seems to be one of the major challenges affecting USA and Connecticut students, youths, adults and families as well. Alcohol is the most substance frequently abused by adolescents, followed by marijuana, cigarettes (tobacco) and other substances (DPH, Office of Adolescents health-2012). For Connecticut, a study between 2007 and 2008 indicated that 46% of Connecticut High school students reported using alcohol, 23% using marijuana, 21% using tobacco, 4% using cocaine and 10% using Heroin (Connecticut School Health Survey 2008). In addition, according to the office of applied studies (SAMHSA), between 2005 and 2005 Connecticut was one among the 10 States with the highest rate of people who were using alcohol and substance abuses (http://www.samhsa.gov/statesinbrief/2009/CONNECTICUT_508.pdf). Recent studies by the office of applied studies indicate that, about 33,000(10.9%) of Connecticut adolescents reported to have used illicit drugs in the past month and 26,000 (8.9%) used marijuana and 13,000(4.4%) used other drugs (http://www.samhsa.gov/statesinbrief/2009/teens/OASTeenReportCT.pdf). In light of those studies, it is clear that, substance abuse is one of the major mental health issues affecting Connecticut families. Meanwhile, the number of treatment facilities in Connecticut reduced from 274 in 2002 to 209 in 2006 and the majority of those facilities were private non-profit treatment facilities and only 12 treatment facilities were for profit within the entire state(Connecticut, States in Brief, DMHAS, p.2). As a result, the shortage of sufficient treatment facilities, experienced clinicians with cultural competency as well as lack of systemic integration of therapeutic treatment and stable social support have led to a huge percentage of the unmet needs for substance and mental health treatments among students, youths and adults. For

example, in 2005 and 2006 the number of unmet needs among individuals aging from 12 to 25 years old and beyond in Connecticut, was the highest in the nation (DMHAS, p.4). For the adolescents, it is estimated that 15,000 of adolescents (8000 males and 7000 females who needed treatments in Connecticut from substance abuses and alcohol did not receive the treatment (DMHAS, Adolescents in Connecticut, 2009), http://www.samhsa.gov/statesinbrief/2009/teens/OASTeenReportCT.pdf).

The number of the unmet needs for people dealing with substance abuses and mental health crises is also significant in Enfield and Manchester areas commonly known as the North Central or Hartford County region where CT-Family Care will be providing services.



(http://oas.samhsa.gov/subState2k6/gifs/FigD7.pdf)

The North Central has 11.64% rate of the prediction interval. Studies indicate that underneath the symptoms of substance abuses and mental health crisises, there is an effect of trauma and wounded coping skills (Rweyemamu, 2010). Thus, CT-Family Care Services will provide its expertise in enhancing wounded coping skills in order to foster a sustainable recovery from the epidemic of trauma and its symptoms including substance abuses and drugs.

15) On page 45 it states that the Applicant will receive referrals from other agencies. Provide copies of any documents that will support this statement.

Answer: There are no documentations or contracts indicating that the company and other agencies will foster mutual referrals for clients' better and effective services. What aspires to be done is for example, if a client has medical issues, she /he will be referred to a medical doctor or to Manchester hospital for a specific care needed. In a collaborative approach, the company already had some conversations with some agencies in the area that value collaborations including referrals in order to effectively serve clients. Some of those companies are Greater Manchester chamber of Commerce, Connecticut Association of non-profit agencies, Manchester Hospital, Town of Manchester, Family Care Support team, East Catholic High School, 24/7 Home companions and DCF.

16) List each license that the Applicant is seeking from the Department of Public Health (DPH) in relation to the proposed centers by the locations reported in response to Question 1. Information concerning DPH licensure may be obtained by calling Sandra Bauer, DPH Facility Licensing, at (860) 509- 8023.

Answer: From the DPH, the company is requesting for the following:

1. The approval of its application for CON

2. The licensing of its outpatient treatment programs for the adults, veterans, seniors, inmates for community re-entry and their partners and families who are dealing with mental health issues including trauma/PTSD, substance uses, alcohol, addictions, violence, depressions and difficulties in adjusting to new environments.

A: ***Manchester- to start immediately upon receipt of the certification. It will be appreciated if the license will be granted soon. The company has already recruited experienced clinicians who are ready to start working. Please refer to my cover letter on this matter.***

B: Enfield services will start October or November, 2012. The company will provide a newspaper notice to the public. I have been in contact with Sandra Bauer, DPH facility Licensing and I have forms completed and to be returned to her for the Manchester office.

17) The Applicant on page 64 states that it expects most of its clients to have low incomes. How will the Applicant provide services to the underinsured or uninsured clients?

Answer: The Company is dedicated to providing services especially to the minorities and the low income population. Once the company has received the CON approval, as well as the Licensing from DPH, it will complete the process with State and Federal insurances as well as private insurances for reimbursements. For clients who are underinsured for various reasons, the company will have to diagnose them in order to determine why they have no insurances in order to see how best they can be accommodated. If they will not have insurances Company will use some grant funds for that purposes in order to provide services to clients who have no insurances

because of the current social economic meltdown. Each case, whoever, will be treated individually in order to understand the underlining factors for clients' situations. In addition, the company is exploring some options of allocating a percentage of its income toward helping poor and uninsured clients who desperately need mental health treatments.

18) In addition to the funding source reported on page 148, has the Applicant secured any contracts or received any monies to support the establishment of the proposed Center(s)?

Answer: The Company has not secured contract yet because some potential contractors including insurances for reimbursements, will do so once the company has received its CON approval and the licensing from DPH. The DSS for example indicated that they are willing to working with the company and adding the company's name into the lists of providers only after the company has been licensed by the PDH. The company is in the final process of being licensed by DCF for its outpatient psychiatric clinic for children and families. The Director of DCF licensing unit has already visited the Company's office in Manchester and it has been allowed to start providing services. On page 148 in the CON's proposal, I pointed out that I was expecting to receive $ 83,000 as a personal loan and use a large portion of that money into the business, while waiting for the insurance re-imbursement process to start effectively. That plan still stands, it delayed from its implementation because , I had to show 4 pay stabs and as a self –employed I did not have them, but once the company starts providing services this month (September,2012) the company will provide paystubs. Already since April, 2012 the company has spent over $16,000 to $ 20,000 towards the establishment offices and recruitment of experienced staff members. The company is committed to the success of this project.

19) On page 150 the annual budget given includes income from two grants. Please describe each grant, including what organization is providing the funding, and the number of years the Applicant anticipates receiving the grants.

Answer: The company is eligible for State and Federal grants (attached company's State and Federal certifications in the CON application proposal, pg.82-87). In that line, the company plans to apply for grants through State and Federal agencies as well as some private sectors and investors. Some of the agencies that the company will be contacting for grants at the State and Federal levels are DPH, DHHS, SAMH&SA, DSS, DCF, DoD , DOC, DMHAS, VA and private investors. The company had applied for some grants and there was a promising response, but since by then it did not have offices and CON, the grants were not provided. After receiving the CON approval, the company plans to re-apply in order to secure enough funding for the next five years to support services and academic treatments to students who are normally not payed for by insurances. Grants will be needed in order to foster extra academic intensive training for students who have dropout symptoms in order to overcome school dropout tendencies and lower academic performances.

20) Please provide audited financial statements for the most recently completed fiscal year. If these statements do not exist, provide other financial documentation to show that the Applicant has the financial ability to establish the proposed center and provides services.

Answer: The applicant still has the financial ability to establish the proposed center and provide services. The applicant is still eligible for the $ 83,000 personal loan that will be used for the business. The applicant needs to have 4 pay-stubs to present to the lender, the last that will be completed this month. Meanwhile, the company has applied for a grant and loan for small

businesses from the Department of Economic Development (DEC), the company is waiting for the response in September, 2012. That will be additional fundings.Thus, the company has financial ability to conduct its centers and provide its services.

21) Complete Table 3. Provide, at a minimum, the projected patient population mix by revenue source for FYs 2013, 2014, and 2015 based on the number of patients as reported in the revision of Table 1 from Question 10. Provide a discussion for the basis and or assumptions that were used to project the reported patient population mix.

Answer: It appears that question # 21 does not apply (N/A) because the company has not yet started receiving clients as it is still waiting for the CON and the licensing approval from DPH. At the end of the company's fiscal year June 30, 2013 the company will have a concrete answer to Q # 21. In relation to how many clients exactly were treated with mental health issues (categories) such as trauma and trauma symptoms for example: alcohol, substance abuses, depression, violence and relational/marital violence and other crises as well as children with problematic behaviors and school dropout crises. The company has a special focus and dedication to serving all people with special focus to minorities and the underserved population in the selected areas and neighborhoods.

Table 3: Patient Population Mix

	Current **	FY 2013	FY 2014	FY 2015
Medicare*		16	16	15
Medicaid*		25	25	23

CHAMPUS & TriCare		25	25	22
Total Government		**66**	**66**	**60**
Commercial Insurers*		25	25	30
Uninsured		4	4	4
Workers Compensation		5	5	6
Total Non-Government		**34**	**34**	**40**
Total Payer Mix	**100%**	**100%**	**100%**	**100%**

* Includes managed care activity.

** May be left blank if there are no existing patient populations.

NB; please, note that in its first and second year, the company plans to receive its payments (re-imbursements from State/Federal Government insurances at a rate of 66%, but in its third year, the company will have a 6% more re-imbursements increases from the commercial insurances and less 6% re-imbursement from government insurances. One of the strategic rationale is that the company is committed to providing intensive and effective short-term treatments whereby every three months there will be a treatment assessment related to the progress and the setbacks that still need to be addressed and before a client is discharge. There will be a follow-up support in place whose mandate will be to help a discharged client. The length of treatments will be

between 3 months to two years. The company holds that after that period, a clients should have acquired significant recovery and be able to begin the after treatment care program. Effective evidenced based treatment outcome will motivate more commercial as well as the governmental insurances and other private investors to invest in the program. Second, there will be a 6% increase reimbursement from commercial insurances as some of the uninsured clients will find jobs through the job training and the integrated therapeutic treatment programs.

22) Complete the attached Financial Statements I and II. Volume for proposed services must agree with the volume reported on the revised Table 1 from Question 10.

Answer: see the attached Pg 198, 199

23) Report the minimum number of patient visits required to show an incremental gain from operations for each projected fiscal year and by proposed location.

Answer: The minimum number of clients that need to be served daily in order for the company to make some gains is approximately 65 clients. The goal is to serve 100 clients per day. In the future when clients will fail to come to the clinic due to the bad weather- especially during winter, the missed days will be compensated in order to enable the clients to have treatment continuity as scheduled.

24) Report the number of staff by position that will be required at each location in order to accommodate the number of patient visits reported in Question 10.

Answer: The company plans to hire a total of 20 professionals and some will be part time while the majority will be full time with benefits. Some staff members will be stationed at one location while others will rotate to different locations (Manchester, Enfield and Springfield), due to the

Financial Attachment I

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

Total Facility:		2013			2014			2015		
Description	FY Actual Results	FY Projected W/out Project	FY Projected Incremental	FY Projected With Project	FY Projected W/out Project	FY Projected Incremental	FY Projected With Project	FY Projected W/out Project	FY Projected Incremental	FY Projected With Project
Revenue from Operations				$1,493,100			$2,012,000			$2,951,750
Non-Operating Revenue (grants)				$350,000			$350,000			$350,000
Total Revenue:	$0	$0	$0	$1,843,100	$0	$0	$2,362,000	$0	$0	$3,301,750
Total Operating Expenses				$1,784,272			$2,310,812			$3,219,254
Revenue Over/(Under) Expense	$0	$0	$0	$58,828	$0	$0	$51,188	$0	$0	$82,496

*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.

Financial Attachment 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 Treatment
Type of Unit Description: CT-FAMILY CARE SERVICES OUT PATIENT TREATMENT PROGRAM
# of Months in Operation: _____

FY _____ **FY Projected Incremental** Total Incremental Expenses: **$7,314,329** **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			1,201,096						$528,800	$0
Medicaid			1,876,713					$82,496	$1,055,340	$0
CHAMPUS/TriCare			1,876,713					$58,828	$1,963,773	$0
Total Governmental			4,954,522		$0	$0	$0	$141,324	$3,547,913	$0
Commericial Insurers		$1,876,713	5					$51,188	$2,421,338	$0
Grants										
Uninsured		$300,274	2					$0	$1,210,669	$0
Total NonGovernment		$2,176,987	7		$0	$0	$0	$51,188	$3,632,007	$0
Grants		$375,341							$134,406	
Total All Payers		**$7,506,850**			$0	$0	$0	$192,512	**$7,314,326**	$0

nature of their work. For example the business manager, the clinical director and the President will weekly visit and work at all locations in order to ensure that the clinical and business needs of the clients, staff and the company are effectively addressed. Each location will have a minimum of three full time clinical supervisors and other clinicians and the number of clinicians will increase as the number of clients increases. At the same time the company may hire or contract with clinicians and other professionals for a "pay for services" or specific contract agreement for a specific jobs. All employees be full time, part-time, contract or pay for services will have to undergo the background checks in order to ensure that those who are not supposed to be hired such as sex child abusers, as well as adult patient abusers are not hired by the company for safety reasons.

25) In describing how the proposal will be cost effective the Applicant states that it proposes to charge a rate at the lower end of the usual rate, $100 per hour. The Applicant also states that it will provide competitive salaries in order to attract and retain the best experienced professionals. How will the Applicant balance the lower revenues with the higher salaries?

Answer: It appears that CT-Family Care Services, LLC is the first certified minority owned company for profit to operate outpatient clinics in the mental health industries in the region. For example, in the Hartford County, most of the outpatient clinics for mental health are either nonprofit agencies such as Wheeler and Klimberger clinics, NAFI, NEW Direction, Catholic Charities and others as part of the hospitals. Aware of that reality, the company chooses to start charging at a lower rate than some of the current existing agencies. Surely, the company's rate will gradually increase as determined, but the company's core fundamental philosophy is that it wants to operate at effective costly managed enterprise and prevent unnecessary expenses

because unnecessary expenses create a financial burden which results serving less underprivileged population. Since the company will be reimbursed by insurances, as times goes on, the company will request to be reimbursed like any other agencies that provide the same services. The company will use a part of that income by hiring more experienced professionals and investing in community programs that protect and strengthen families for success and in so doing, more mental health issues and economic poverty that affect the underserved population will be reduced, especially in the area that CT-Family Care Services will be serving.

The current lower revenue of charging $100 that the company will start with will be balanced with seeking some State and Federal grants. As a profit making company , it believes that it should pay well its employees at a very competitive rates and make profits as well, yet at the same time, it is the company's moral philosophy not to seek excessive financial profits, instead to foster more profits that enable many clients who are constraints with mental health crises and poverty to overcome those challenges and nurture sustainable recovery, wellness and success as well as becoming more productive citizens in communicates.

26) Provide a copy of the Applicant's business plan for the proposal.

Answer: Attached is business plan

27) Discuss how this proposal will affect the financial strength of the health care system in the state of Connecticut.

Answer: While, the financial strength of the health care system in the State of Connecticut is vital and a necessary engine in preventing or reducing mental health crises as well as economic and health disparities among minorities and low income populations, it is likewise important

that the financial strength of the health care system in Connecticut be strengthened by answering some important key questions on why and where the traditional approach to addressing health, economic and education issues affecting minorities and low income population in Connecticut have not eliminated the roots of the mental health issues affecting minorities or the underserved population.

One of the effects that the company will provide in strengthening the financial strength of healthcare system in Connecticut is to highlight and present the importance of the integrated treatments that have effective social-cultural-economic components in a therapeutic treatment context, in order to address the core needs and issues affecting minorities. As a minority owned company, it has significant experiences, knowledge and skills needed in order to compliment the traditional approach. In addition, the company will effectively contribute to strengthening the financial healthcare system in Connecticut by helping and treating students with mental health issues and school dropout symptoms in order to overcome timely those constraints before those students leave school end up on welfare or jail -which again create financial burdens to tax-payers and the State economy in general. Once the company has been granted the CON and the licensing, it will provide its services to individual adults and to families as well as to veterans who are dealing with mental health issues including Trauma and PTSD and its symptoms which seem to be common among veterans and other people who experienced a life threatening event-encounter. By fostering effective recovery and sustainability through in a short period of treatment will help the State economy to save money. Clients will have alternatives to choose from the treatments that effectively are addressing their core issues and produce quick healing rather than clients going to the same clinician years after years without any improvements. The company will have short and focused treatment for 3 months, 6 months, and 12 months and 24

months. If a client is not treated effectively during or after those stages (evidence based) then, a client will be referred to another agency for the betterment of the client wellness. All those efforts will strengthen the financial healthcare system in Connecticut by reducing or preventing unnecessary expenses or misuses.

28) Explain how this proposal contributes to the quality of health care delivery in the region.

Answer: The proposal will greatly contribute to the quality of health care delivery in the region by proposing effective treatment which uses its unique therapeutic components for fast recovery. Describe the effect of the proposal on the interests of consumers of health care services and the payers of such services. Answer: In relation to consumers' interest in healthcare, the proposal will motivate more to become active participants and not merely passive consumers. BY becoming active consumers, clients will be able to explore, identify and utilize the repertoires within and around them towards solving their problems and in so doing mental health treatment will be brief , customized treatment and more outcome enhancement centered rather than keeping a client with the same clinicians for many years treating the same issues which tend to undermine clients' self esteem and confidence that they can recover, be more productive and pursue their dreams of wellness and success. In addition, the payers of healthcare services, will benefits by knowing that their investments are producing effective results clinically and that unnecessary costs are avoidable and more profits can be made in order to keep funding and paying for the services. Both consumers and the payers of healthcare services will benefit through this proposal because the proposal will enable many clients achieve recovery, wellness and become more productive in their respective communities when their mental health illnesses like excessive alcohol drinking, substance abuses and trauma are treated.

29) Describe the effect of the proposal on the interests of consumers of health care services and the payers of such services. **Answer**: In relation to consumers' interests in healthcare, the proposal will motivate clients more to become active participants and not merely passive consumers. By becoming active consumers, clients will be able to explore, identify and utilize the repertoires within and around them towards solving their problems and in so doing mental health treatment will be brief , customized treatment and more outcome enhancement centered rather than keeping a client with the same clinicians for many years treating the same issues which tend to undermine clients' self esteem and confidence. Short-lived treatments will arouse interests of many more clients to be treated at CT-Family Care Services. That will be true because clients are people who want to enjoy life in wellness and success so that their dreams are achieved. In relation to the payers, short-term payments for their clients, will save some money for others or for other State development projects. Both consumers and the payers of healthcare services will benefit through this proposal because the proposal will enable many clients achieve recovery, wellness and become more productive in their respective communities when their mental health illnesses like excessive alcohol drinking, substance abuses and trauma are treated.

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, profile 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 168. Please reference "Docket Number: 12-31773-CON." Submit one (1) original and four (4) hard copies of your

response. In addition, please submit a scanned copy of your response including all attachments on CD in an Adobe format (.pdf) and in an MS Word format. Please submit an electronic version of the financial attachments requested in Question 22 in MS Excel 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 September 25, 2012. If you have any questions concerning this letter, please feel free to contact me at (860) 418-7032.

References

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Balfanz, Horning Fox, Bridgeland, and McNuaught (2009). Grad Nation. Americans promise Alliance. Guidebook to help communities tackle the Dropout crisis ConnecticutSchool Health survey 2008.

Connecticut Mental Health Needs Assessment and Resource Inventory (2007). SummaryReport.http://www.ct.gov/dmhas/lib/dmhas/transformationgrant/n

Connecticut Department of Social Services, Bureau of rehabilitation services website. http://www.ct.gov/brs/site/default.asp

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Mc Goldrick,Giordanao, & Garcia –Preto (2005).Ethinicity & Family Therapy.3rd edition. The Guilford Press. NY.

Ratlif,D., Frame, R., & Moll, D., 209. Military Families and MFTs-Understanding the Culture. Understanding the Unique culture of the military can strenghtern the MFTs ability to

effectively connect with families dealing with stress of reintegration issues. In the American Association for Marriafe and Families Therapy Magazine, about returning veterans, March/April,2009, vol.8, # 2.

Rweyemamu, J(July. An application for the certificate of need (CON) for an outpatient integrated treatment Program for the underserved population in Enfield and Manchester areas in Connecticut (or in short " initial CON application or proposal), July 1,2012.

"In Collaboration with clients we enhance their wellness through internal and external solutions."

16 Enfield Ave
Enfield, CT 06082
rweye@cox.net
860-508-8651

CT-FAMILY CARE SERVICES, LLC

December 11, 2012

Via First Mail and Electronic Mail

Kimberly R. Martone
Director of Operations
Department of Public Health
Office of Care Health Care Access
410 Capital Ave, MS# 13HCA,
BOX 340308 Hartford, CT. 06134

Dear Kimberly R. Martone

Thank you for your letter dated December 7, 2012. In that letter you showed uncertainity on our part as to whether we are still determined to get a certificate of needs (CON) and the licensure from DPH.

Due to the ambiguity of some requirements from your office, we needed to have some clarifications as we proceeded fulfilling what your office demanded us to do. That is why towards the end of October, 2012, our clinical supervisor contacted your office and spoke with one of your staff members, requesting for a meeting for clarifications on some questions, but the answer was discouraging because no one would meet and talk with us, except by mails or emails. Such a response as well as lack of clarification slowed the process.

Some requirement questions demanded production of photocopied pages of references which were quoted from our research as we proceeded with our proposal write-up of over 170 pages. Some of the references were big books and articles. If all the references had to be photocopied as your office suggested, it would have costed the young agency thousands of dollars, in addition to the $ 16,000 the agency had reported to you earlier plus an addition of $ 8,000 the agency spent for office furniture in October and November, 2012. Normally, when a reference is quoted from some books or articles, they suffice to direct the reader to check and concretize the existence of what has been referenced or quoted. But what aspired from some of your questions is to photocopy the documents which will require photocopying the entire book or article referenced.

Due to constraint requirements on the agency along with the ambiguity of some questions, towards the end of October, 2012, our clinical supervisor contacted your office and spoke with one of your staff members, requesting for a meeting for clarifications on some questions, but the answer was discouraging because no one would meet and talk with us, except by mails or emails. Such a response as well as lack of clarification slowed the process. Thus, I am hereby confirming that the agency has not withdrawn its application. It is still interested and committed to working with your office in order to meet the requirements for the certificate of needs (CON) and the licensure from DPH.

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In addition, I am requesting for your assistance to remove the unnecessary constrains such as those mentioned above in order that a small business such as ours can be given a fair chance to provide services as well as create jobs in Connecticut. I am pleased to share with you that the agency has received good collaboration with the Department of Children and Families for the out patient psychiatric clinic for children and families. But, the agency still need the certificate of need (CON) and the license from DPH in order to provide services to the adults such as veterans and seniors as stipulated in our proposal. Our clinicians have been waiting for a long time to start working. The agency is requesting to be certified for the certificate of need (CON and be licensed this month in order to enable it to start providing services as soon as possible.

Furthermore, I am going to submit a check of $1, 000.00 to your office on Thursday this week, for our outpatient adults' mental health facility fee and I am requesting Sandra C. Bauer the licensing examination assistant or her delegate from your office to visit our facility in Manchester, Connecticut.

Thank you for your anticipated assistance.

Justinian Rweyemamu, MA, M.Div, MS-MFT, PhD Student
President

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STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

December 7, 2012

Via First Class Mail and Electronic Mail

Justinian Rweyemamu, MA, M. Div, MS-MFT
CT-Family Care Services, LLC
16 Enfield Ave.
Enfield, CT 06082

RE: Certificate of Need Application; Docket Number: 12-31773-CON
Establishment of a Behavioral Health Treatment Center in Manchester
Notice of Withdrawal

Dear Mr. Rweyemamu:

On October 5, 2012, the Office of Health Care Access ("OHCA") sent a letter to you requesting additional information for the above referenced Certificate of Need application. The requested information was not submitted to OHCA within the sixty-day period as required under Section 19-639a(c) of the Connecticut General Statutes. Therefore, OHCA considers the above application to have been withdrawn on December 5, 2012.

If you have any questions regarding the above, please feel free to contact me at (860) 418-7001.

Sincerely,

Kimberly R. Martone
Director of Operations

KRM:lkg

CT-FAMILY CARE SERVICES, LLC

"In Collaboration with clients we enhance their wellness through internal and external solutions."

December 20, 2012

Laurie K. Greci
Associate Research Analyst
Department of Public Health
Health Care Access
laurie.greci@ct.gov

Dear Laurie Greci

RE: Certificate of Need Application; Docket Number: 12-31773-CON

Establishment of a Behavioral Health Treatment Center in Manchester

Second CON Completeness Letter

I am in receipt of your electronic mail dated October 5, 2012, below are my responses. I hope this information suffices.

Question # 1. Please complete the following table concerning the service area for the Manchester location adding additional rows as needed:

Answer: Table 1: Service Area Town- According to the Center for Disease Control, 1 out of 2 Americans has a diagnosable mental disorder and fewer than half of Adults receive treatment while one third of children receive treatment

Patients Town of Residence- Population	Basis for inclusion in Service Area- 50%/ CDC
Manchester 58,287	• 29,144
East Hartford 51,293	• 25,647
Vernon 29,139	• 14,570
South Windsor 25,729	• 12,865

5 Enfield Ave.
Enfield, CT 06082

243 Main Street
Manchester, CT 06042

155 Maple St, Unit 204
Springfield, MA 01105

rweye@cox.net (860) 508-8651

(resource: Center for Disease Control www.cdc.gov/omhd/AMH/factsheets/metal.htm; Department of Public Health, Health Care Quality, Statistics, Analysis & Reporting 2011, Town of Manchester, Department of Mental Health and Addiction Services(DMHAS), Town Report 2011, Department of Education-CEDAR 2012, CT-Family Care Services, LLC Application for CON-2012) (See Appendix #1)

Question # 2: Provide available documentation that supports the basis for the inclusion of each town listed in the table above.

Answer: (See Appendix #2). Some of the documentations that were used in answering question#1 above are from the Department of Public Health, Health Care Quality, Statistics, and Analysis & Reporting 2011 as indicated in question # 1. In addition to these documents, the clinical supervisor and I visited almost all schools in Manchester for meetings with teachers, social workers and school administrators in relation to addressing students' needs in the areas of Mental Health, Social and Academics. It was pointed out that there is a great number of children, students and families that have un addressed mental health issues. Currently, several available agencies have a long waiting list.

Due to the fact that, attempts to address the needs of the underprivileged especially in the areas of health , education and economics have traditionally focused in cities or areas that have a very high rate of minorities and low income population, such as Hartford, New Heaven and

Bridgeport, minorities in communities where they are not the majority such as Manchester have either very few or insufficient agencies and integrated treatments such as those provided by the CT-Family Care Services which are customized integratedly and informed by research on the social-cultural-spiritual needs of minorities. For example, in Manchester, there are two schools where majority are overwhelmingly minority students and have both academic and behavioral problems are not yet adequately staffed with enough clinical family therapists who are able to treat both students and their families' simultaneously. Such a pattern seems to be common in some neighboring towns such as East Hartford, Windsor and Vernon. As a result, since the company opened its office in Manchester, already we have some families who are requesting to come to our treatments because parents have options to find a treatment program that have social-cultural components that really addresses their needs.

As mentioned in Question #1, the CDC states that 1 in 2 Americans has a diagnosable mental disorder and fewer than half of adults receive treatment while one third of children receive treatment. The CDC reports that barriers to treatment include: income, Managed Care/ Medicaid, stigma, consumers' unappreciation of treatment, and health care providers being unaware of such treatments. CT Family Care Services, LLC supports the CDC's vision for the future to increase public awareness of effective treatments, to ensure the availability of mental health services and providers are available, and to tailor treatments according to age, gender, race and culture. According to representatives of the Manchester Department of Health, Barbara

Quigley and Edward Pikette, the middle class people are in most need of services. These are the families whose health insurances are being cut back or cancelled and they do not qualify for state insurance and are unable to pay out of pocket for private health insurance. Also, they reported that, there is an ever growing population of South Asian families who are in need of many services but are met with language barrier. Finally, Mr. Pikette discussed a barrier to treatment as the long waiting lists for the current treatment providers in the Manchester area. This is supported by a letter written by the Director of The Community Child Guidance Clinic, Clifford Johnson, who states that "we continue to struggle with limited space to accommodate our increased need to provide services; at this point our building is more than filled with therapists, sometimes having to scramble to find a vacant office to interview families."

www.cgcinc.org/director_message.htm

Question# 3: The response to Question 2) on page 171 listed categories and associated dollars that are operating expenses, not capital expenditures. It appears that there is no capital expenditure associated with this proposal. If true, please state that the proposed capital expenditure associated with the proposal is $0.

Answer: In addition to the information below, up to date, I have spent I have a total of $24,000 of capital expenses including, but not limited to: rent, furniture, office supplies, computers, recruiting, background checks... Upon licensing, I have secured a line of credit as additional capital funds which will suffice payments of other expenses as we await insurance

reimbursement. This is one of the questions that have been addressed several times, but apparently it is always raised over and over with an assumption that the company should put $ 0.00 as its proposed capital expenditure! In the responses dated September 11, 2012 it is clearly presented that the company's total projected capital expenditure which would include the salaries of $ 1,210,699, services and office items for $ 528,800 as well as health insurances of $ 44,802.00 would have been $ 1,784,271.00for its fiscal year for 2012/2013 for the services rendered, if the company had timely been given the CON certificate.

As the company still waits for CON certification, we have remained with about seven or eight months before the company's fiscal year 2012/2013 to come to an end, thus, the company's projected expenditures of $ 1784,271 will not be reached as desired, but the company can reach at least between 40- 50% ($ 713, 708.4 to $ 892, 135.5) of that goal if the company obtains the "CON" certification as well as the licensure from your office in order to enable its clinicians to start providing the long awaited and needed services. As of today, the company has already spent over $ 24,000.00. As a result, I am requesting that the process be speeded up in order to enable the company attain the CON certification needed.

Question # 4: Question 4) of the first completeness letter requested copies of the references as well as the brief explanation regarding the relevance of the selected articles and how each supports the need for the proposal. There were no printouts of the references in the documentation submitted with the responses. Provide a printed copy of the each of the following articles or documents. The page number within the CON application is note that that the relevant pages may be submitted:

Answer:

Copies of the referenced pages are attached- See Appendix 3

Reference	Page No(s).
Balfanz, Horning, Fox, Bridgeland, and McNaught (2009). Grad Nation. Americans promise alliance. Guidebook to help communities tackle the dropout crisis. **See appendix #3 a**	24
Butler, J.L., VI, and Platt, R.A.L. (2008) Bullying: A family and school system treatment model. *The American Journal of Family Therapy, 36*, pp. 18-29. **See appendix #3 b**	30, 32
Erbes, C., Westermeyer, J., Engdahl, B., & Johnsen, E. (2007, April) Post-traumatic stress disorder and service utilization in a sample of service members from Iraq and Afghanistan. *Military Medicine,172(4)*, pp. 359-363. **See appendix 3 c**	46
McGoldrick, Giordano, and Garcia-Preto (2005) Ethnicity and family therapy. **See appendix #3 D(a, b,c)**	28, 32, 40
Meadows, Pearson, Land and Lamb (2008) **See appendix #3 e**	20
National Women's Law Center & Mexican American Legal Defense and Educational Fund. Listening to Latinas: Barriers to high school graduation. August 209. **See appendix # 3 f**	25
Powell, M.D., Ladd, L.D. (2010). Bullying: A review of the literature and implications for family therapists. *The American Journal of Family Therapy, 38*, pp. 189-206. **See appendix # 3 g**	31, 32
Satir, V., & Baldwin, M. (2003). A Guide to creating	67

change in families. Science and Behavior Book, Inc. **See appendix 3 h**	
Sum, A. (2009): The Economic, Social, Civic and Fiscal Consequence of Dropping out of High School. **See appendix 3 i**	18, 20, 21, 26

Question# 5: Question 8) (b) of the first completeness letter requested that any additional agencies within the proposed service area be listed. There were no additional agencies listed in response to the question. Please provide the list of additional agencies, if any. If none, please state "none".

Answer: Mental health Agencies in Manchester, CT as of 12/15/2012. Please, note that some are not clinics.

Eastern CT Health Network	71 Haynes St, Manchester
Community Health Resources	587 Middle Turnpike East, Manchester
Michael Powers, LCSW	139 East Center St, Manchester
David Moyer, PhD	200 Main St, Manchester
Center for Family and Individual	7 Bridle Path Lane and 112 Spencer St, Manchester
Mary Ann Zeh, APRN	935 Main St, Manchester
Michael Westfall, LCSW	243 East Center St, Manchester
Steven Bonanno, PsyD	241 New State St, Manchester
Human Growth Services Hugs	32 Church St, Manchester
Kristine Webb, Lpc	357 East Center St, Manchester
The Bridge Family Center	315 Henry St, Manchester
Scott Moore, LMFT	222 McKee St, Manchester
Psychotherapy & Counseling Assoc.	483 Middle Turnpike West, Manchester
Gloria Brooks, LCSW	483 Middle Turnpikes West, Manchester

ABC Services of Central Ct, Inc.	642 Hilliard St, Manchester
Applied Insight Assoc.	456 Gardner St, Manchester
Nancy Carter, LMFT	1343 Sullivan Ave, Manchester
Psychotherapy services of CT	45 Hartford Turnpike, Vernon-Rockville
Leslie Gorcynski, LMFT	351 Merline Rd, Vernon-Rockville
Hope Center	225 Oakland Rd, South Windsor
Nicholson Counseling Center	435 Buckland Rd, South Windsor
Maros Yudit, LMFT	475 Buckland Rd, South Windsor
Daniel Foley, LMFT	435 Chapel Rd, South Windsor
Sage Counsleing Assoc.	1050 Sullivan Ave, South Windsor
Interface Counseling Center	527 Burnside Ave, East Hartford
Manchester Community Health Services	150 N Main Street # 230, Manchester
Wandembergh Mental Health Services LLC	206 Wells Street, Manchester
Inter-Community Mental Health	281 Main St, East Hartford
New Hope Manor Inc. Residential	48 Hartford Road, Manchester
March of Dimes	867 Main Street # 2, Manchester
Health and Allied Services, NEC	Connecticut North Treatment, Manchester

Question # 6. Question 10) of the first completeness letter requested that the Applicant apply the information on numerous socioeconomic groups present in the initial CON application to develop the need for the proposal. To determine the unmet need for the proposed services in the greater Manchester area the number of potential persons that may benefit from the proposal must be quantified. Please complete the following table utilizing information provided within the CON application as well as other sources as needed to develop a clear public need for the proposal. If additional sources are used, provide hard Please complete the following table utilizing information provided within the CON application as well as other sources as needed to

develop a clear public need for the proposal. The first row of the table demonstrates how to quantify the potential number of persons from a single group, students that have dropped out of high school, for a single town. (Note: the numbers presented are fabricated based on the information in the CON application.) Delete the first row and develop a similar calculation for each group of persons from each 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.

Answer:

Table 2: Number of Persons in Service Area with Unmet Needs (See Appendix #4)

Description	Town	Population of Students	% of population	Number of persons	Rate of need for services- % of Unmet needs	Number of Persons to benefit from proposal
Sc. l dropout/ academic challenges	Manchester	6884	107	117	2/3	78
	East Hartford	7242	4.4	319	2/3	213
	Vernon	3681	3.9	144	2/3	96
	South Windsor	4654	16	74	2/3	62
Problematic Behaviors	Manchester	6884	16	1102	2/3	735
	East Hartford	7242	23.7	1716	2/3	1144
	Vernon	3681	10.1	372	2/3	248
	South Windsor	4654	16.9	786	2/3	524
Disabilities	Manchester	6884	13	895	2/3	597
	East Hartford	7242	13.7	992	2/3	661
	Vernon	3681	10.8	398	2/3	265

	South Windsor	4654	11.6	540	2/3	360
Mental Health of adults	Manchester	58,287	50	29,144	1/2	14,572
	East Hartford	51,293	50	25,647	1/2	12,824
	Vernon	29,139	50	14,570	1/2	7,285
	South Windsor	25,729	50	12,865	1/2	6,433

Connecticut State Department of Education;

http://sdeportal.ct.gov/Cedar/WEB/ct_report/DisciplineReportViewer.aspx

Question # 7: On pages 185 and 186 of the completeness response the Applicant reports projected volumes by fiscal year. However, it not clear what the reported units are and what is the basis for the projections. Utilizing the number of persons quantified in Table 2, report the projected number of persons and number of therapy sessions for FYs 2013, 2014, and 2015. Report the projected numbers by service type and the population to be served (for example, youth, adults, veterans). List all assumptions made to determine the projected volumes. Please identify group vs. private sessions. Add additional rows as needed.

Answer: (See Appendix #5) Utilizing the populations of Manchester, East Hartford, Vernon, and South Windsor and calculating based on the CDC and the National Census Bureau data, the following are the potential number of sessions that CT Family Care Services, LLC will provide in a 6 month time frame.

Table: 2 Number of Persons in Service Area with Unmet needs- to be serviced for 6 months (24 Sessions)

opulation	**Service Type**	**FY 2013**		**FY 2014- 25% increase**		**FY 2015- 32% increase**	
		Persons	*Sessions*	*Persons*	*Sessions*	*Persons*	*Sessions*
tudents/ ouths	Academic Disabilities Enhance academic performances	2825	67,800	3767	90,408	5,540	132,960

	Prevention/reduction of school dropout symptoms	654	15,696	872	20,928	1,282	30,768
	Behavioral Integrated Treatments (Therapy)	3,976	95,424	5301	127,224	7,796	187,104
	Bullying- students being bullied 8.6% of students	1932	46,360	2576	61,824	3,788	90,912
	Psychiatric Medication	1500					
	Total	**10,887**	**225,280**	**12,516**	**300,384**	**18,406**	**441,744**
ıdults	Individual, couple, partners, family Integrated Treatment (therapy & Social services)	70,994	1,703,856	94,657	2,271,176	139,201	3,340,83
	Job Training /Preparedness- 9% unemployment rate	6,389	15,347	8519	204,456	12,528	300,671
	Psychiatric medication	1250		1666	39,984	2450	58,800
	Total	**78,633**	**1,719,203**	**104,842**	**2,516,208**	**154,179**	**3,700,30**
'eterans- % of opulation	Individual, couple, partners, family Integrated Treatment (therapy & Social services) PTSD etc.	9,939	238,536	13,252	318,048	19,488	467,717
eniors ›ver 65 ears old	Individual, couple, partners, family Integrated Treatment (therapy, Social services, & Home care)	7695	184,680	10,260	246,240	15,088	362,117

	Total	**17,634**	**423,216**	**23,512**	**564,288**	**34,576**	**829,834**
nn ; ommunity e-entry Recidivism ; 50% and bove)	Integrated Individual treatments- effective parenting and readjustment to jobs	500	12,000	667	16,008	981	23,544
	Integrated Treatment for individual & Family	300	7200	400	9600	588	14,118
	Total	**800**	**19,200**	**1067**	**25,608**	**1569**	**37,662**
	TOTAL POTENTIAL CLIENTS	**107,954**	**2,590,896**	**141,937**	**3,406,488**	**208,730**	**5,009,54(**
	TOTAL CLIENTS TO BE SERVED BY CT (APPROX. 1 OF 7 ESTABLISHED CLINICS IN AREA) 1/7	**15,422**	**370,128**	**20,277**	**486,648**	**29,819**	**715,649**

Question # 8:

8) Explain the increases in the number of persons and the number of sessions from the relative previous year for FY 2014 and FY 2015

Answer: There will be an increase of 9398 between 2014 and 2015 because the agency will continue to invest both in marketing and in providing good quality services that addresses clients' real needs for recovery and success. Thus, the quality services provided will inspire other clients to pass the word of mouth to another especially among the targeted population which is in great need of integrated treatments that CT-Family Care Services provides, which are customized treatment plans that embrace and utilize individuals' social-cultural-spiritual and ethnic values as well as other clients' strengths for recovery and wellness.

In addition, since this is a new agency, it has the vitality and commitments of building a good reputation in the areas of its services through its outcome based approach as well as collaboration with individuals, families and communities. In addition, the agency is committed to setting aside some of its net profits towards community development in the communities that it will be providing services in order to strengthens clients and their families. Due to the fact that, the agency is outcome or results driven, both in its treatments and in economic projects, the community will be able to realize that the agency is committed to the well-being of the community as a whole because individuals and families that the agency treats live in that very community. Its individuals, families and communities realize that they are appreciated, cared for and are invited to be active as well as supportive members in reducing or preventing mental illness, more people will seek mental health treatments and stop looking at it as a stigma.

The agency is dedicated to providing treatments that effectively supports minorities and the underserved population in need in order to foster their internal and external mental health recovery and end the cycle of mental health crises, imprisonments, economic and health disparities

Question # 9: The response to Question 14) on pages 189 to 191 concerning substance abuse states that there is unmet need for substance and mental health treatment among students, youths and adults. Utilizing the definition of unmet need as those persons seeking treatment and not being able to obtain treatment, discuss the need for your proposal in Manchester. In addition, specify the substance abuse treatment services that you propose to provide to those seeking treatment.

Answer: (See Appendix #6). According to the center of disease control and prevention(CDC) and the Office of Minority Health and Health Disparities(OMHD) mental

illnesses are common among Americans to the point that it is estimated that one in every two Americans has diagnosable mental disorder each year which includes substance abuses(www.cdc.gov/omhd/AMH/facts sheets /mental. Htm, p.1). In 2010, about 45.9 million adults in the United States aging from 18 years or older were identified as having mental illnesses and 9.2% of that population met the criteria of using substances excessively or dependence (www.samhsa.gov). In that light, it is estimated that Manchester has the following population below who are struggling with substance abuses as well related addictions

	Current population In Manchester area in CT .	Dealing with Substance Abuses 8.67%	Receive some form of treatments or group supports	Untreated yet	
	141,987	**12,310**	**6,155 (50%)**	**6,155 (50%)**	

The agency proposes integrated treatments for individuals and their families who are seeking treatments form the effects of substance uses, but they have not been able to receive treatments due to various reasons. Such treatments will include but not limited to a comprehensive diagnostic and psychiatrist assessments including the genogram, the metaframeworks, and clients' social-cultural backgrounds in order to identify the underneath factors that either traumatized clients or wounded clients' inner core of the self and coping skills, hence clients started using substances as well as addictions as an alternatives to health coping mechanism. In addition, the comprehensive assessment will include the medical conditions as well as the social-cultural-relational needs of that individual and family. Once the comprehensive diagnostic assessments have been completed, an integrated treatment team will develop the individualized treatment plan that is customized and imbedded with sufficient social-cultural-spiritual-relational components along with medication needed for intensive and holistic treatments. Ongoing

supports from partner, couple, or family as well as close friends at work-place or church will be utilized daily, along with the collaboration and permission from clients for recovery and healing. One of the treatment strategies will be to enhance client's coping skills such as self-esteem, spirituality and confidence. Informed by the research, the treatment will continue to be enriched by utilizing the most current, effective and systemic family treatments (family therapy) in order to treat both the clients and the family whose dynamics can increase the burning desire to use substances illegitimately. Clients who need very intensive inpatients substance treatments will be referred to the appropriate agencies in the region for that purposes.

Question # 10: Place a checkmark next to each license that the Applicant is seeking from the Department of Public Health (DPH) in relation to the proposed Center in Manchester. Information concerning DPH licensure may be obtained by calling Sandra Bauer, DPH Facility Licensing, at (860) 509- 8023.

Answer:

License	Needed for proposal
X Psychiatric Outpatient Clinic for Adults	**Yes, CT-Family Care Services, LLC is applying for this license.**
Facility for the Care or the Treatment of substance abusive or Dependent Persons(outpatient)	

Question # 11: Although the completeness response provided a business plan for the proposal, there is limited information concerning how the Applicant will meet the financial obligations of the Center. Please provide additional information and documentation to demonstrate that the Applicant has the financial ability to pay expenses incurred during operations until a revenue stream has been established.

Answer: (See Appendix #7)

In addition to the fact that the company has already spent $24,000 as an investment into this project, the company has already secured a line of credit which will be increased upon obtaining a license. Furthermore, we are in the process of applying to various private insurances as well as Connecticut's Medicaid program to become enrolled for reimbursement. Finally, the company is already certified to apply for state and federal grants.

APPENDICES/ REFERENCES:

APPENDIX #1:

A) "Eliminate Disparities in Mental Health" The Center for Disease Control www.cdc.gov/omhd/AMH/factsheets/mental.htm

APPENDIX #2:

A) Letter from Melissa L. Costanzo, LMFT, Clinical Supervisor, CT Family Care Services, LLC regarding meeting and interview of Barbara Quigley and Edward Pikette of the Manchester Department of Health on 12/12/12.

B) Director's Message, Community Child Guidance Clinic, Inc, Johnson, Clifford, http://ccgcinc.org/director_message.htm

APPENDIX #3:

A) Balfanz, Horning, Fox, Bridgeland, and McNaught (2009). Grad Nation. Americans promise alliance. Guidebook to help communities tackle the dropout crisis.

B) Butler, J.L., VI, and Platt, R.A.L. (2008) Bullying: A family and school system treatment model. *The American Journal of Family Therapy, 36*, pp. 18-29.

C) Erbes, C., Westermeyer, J., Engdahl, B., & Johnsen, E. (2007, April) Post-traumatic stress disorder and service utilization in a sample of service members from Iraq and Afghanistan. *Military Medicine,172(4)*, pp. 359-363.

D) McGoldrick, Giordano, and Garcia-Preto (2005) Ethnicity and family therapy

E) Meadows, Pearson, Land and Lamb (2008)

F) National Women's Law Center & Mexican American Legal Defense and Educational Fund. Listening to Latinas: Barriers to high school graduation. August 209.

G) Powell, M.D., Ladd, L.D. (2010). Bullying: A review of the literature and implications for family therapists. *The American Journal of Family Therapy*, *38*, pp. 189-206

H) Satir, V., & Baldwin, M. (2003). A Guide to creating change in families. Science and Behavior Book, Inc.

I) Sum, A. (2009):·The Economic, Social, Civic and Fiscal Consequence of Dropping out of High School

APPENDIX #4:

A) "High School Dropout Rates in Connecticut" Connecticut State Department of Education, November 2009

B)Manchester, East Hartford, Vernon, South Windsor School District Data, http://sdeportal.gov/Cedar.aspx

APPENDIX #5:

A) "Recidivism" Department of Correction, www.ct.gov/doc

B) "Domestic Violence Counts- Connecticut Summary", National Network to End Domestic Violence, www.nnedv.org

C) National Facts, Connecticut Coalition Against Domestic Violence, www.ctcadv.org

D) Regional and State Employment and Unemployment Summary, www.bls.gov/news.release

E) "Bullying: A Family and School System Treatment Model", Butler, John VI and Platt, Rhi Anna Lynn, The American Journal of Family Therapy, 36: pp18-29, 2008.

F) U.S. Veterans: By the Numbers- ABC, Martinez, Luis and Bingham, Amy, Nov. 11,2011 http://abcnews.go.com

G) South Windsor CT Census Records- Community Information for South Windsor, www.americantowns.com

H) "Profile of General Population and Housing Characteristics: 2010; 2010 Demographic Profile Data" for Manchester, East Hartford, Vernon, American Fact Finder- Results, http://factfinder2.census.gov

I) "Post Traumatic Stress Disorder and Service Utilization in a Sample of Service Members from Iraq and Afghanistan", Erbes, Christopher, PhD., Westmeyer, Joseph, PhD, Engdahl, Brian, PhD., Johnson, Erica, PhD. Military Medicine Vol. 172, 4, pp359, 2007.

J) "Past Month Illicit Drug Use among People Age 12 or Older by State", State Level Data on substance Abuse and Mental Illness- SAMHSA News, www.samhas.gov

References

School dropout in CT in 2009.http://sdeportal.ct.gov/Cedar/Files/Pdf/Reports/db_dropout_2008.pdf

OMHD/ AMH/facts sheets/Mental health. http://wwww.cdc.gov/omhd/AMH/facesheets/mental.htm

About Minority Health
Cooperative Agreements
Executive Orders
Reports / Publications
Minority Health Resources
All Populations
Racial & Ethnic Minority Populations
Training Opportunities

SEARCH OMHD Web site

Página principal de la OMHD

Eliminate Disparities in Mental Health

Mental Disorders are common in the United States

1 in 2 Americans has a diagnosable mental disorder each year, including

44 million adults

13.7 million children

Mental Disorders are disabling

Mental disorders are as disabling as cancer or heart disease in terms of premature death and lost productivity

Research has improved our ability to recognize, diagnose, and treat conditions effectively

80 to 90 percent of mental disorders are treatable using medication and other therapies

Of those with a diagnosable mental disorder...

Fewer than half of adults get help

Only one-third of children get help

Suicide as a Public Health Problem

Suicide is the 8th leading cause of death in the U.S.

81 Americans die by suicide each day

Since 1980, suicide has doubled among young black males in America

80 to 90 percent of people who die by suicide are suffering from a diagnosable mental illness

African Americans

More likely to experience a mental disorder than their white counterparts

Less likely to seek treatment

When they do seek treatment, they are more likely to use the emergency room for mental health care, and they are more likely than whites to receive inpatient care

For More Information

SAMHSA Surgeon General's Report: Mental Health Fact Sheet
African Americans
http://www.mentalhealth.samhsa.gov/cre/fact1.asp

Hispanics

Rate of mental illness tends to be similar to that among non-Hispanic whites

About Minority Health Section Menu

- Disease Burden & Risk Factors
- Eliminating Racial & Ethnic Disparities
- Environmental Justice

Fact Sheets

- Cancer
- Cardiovascular Disease (CVD)
- Diabetes
- HIV/AIDS
- Immunization
- Infant Mortality
- Mental Health
  - News
- Tuberculosis (TB)
- Lupus

But, Hispanic women tend to suffer from depression more often than Hispanic men

For More Information

SAMHSA Surgeon General's Report: Mental Health Fact Sheet
Latinos / Hispanic Americans
http://www.mentalhealth.samhsa.gov/cre/fact3.asp

Asian American/Pacific Islanders

Only 25 percent as likely as whites and 50 percent likely as African Americans and Hispanics to seek outpatient care and are less likely than whites to receive inpatient care

When they do seek care, they are more likely to be misdiagnosed as "problem-free"

For More Information

SAMHSA Surgeon General's Report: Mental Health Fact Sheets
Asian Americans/Pacific Islanders
http://www.mentalhealth.samhsa.gov/cre/fact2.asp

American Indians/Alaska Natives

Appear to suffer disproportionately from depression and substance abuse

Overly represented in in-patient care as compared to whites, with the exception of private psychiatric hospitals

For More Information

SAMHSA Surgeon General's Report: Mental Health Fact Sheet
Native American Indians
http://www.mentalhealth.samhsa.gov/cre/fact4.asp

Barriers to Care

- Income
- Managed Care, Medicare/Medicaid
- Stigma
- Consumers unappreciative of treatment
- Health care providers unaware of treatments

Vision for the Future

Increase public awareness of effective treatments:
Overall quality of life improves tremendously when a mental disorder is diagnosed early and treated appropriately

Ensure the supply of mental health services and providers:
Parity in the way we provide services
Community-based approaches
Culturally competent physicians
Facilitate entry into treatment
Reduce financial barriers to treatment

Tailor treatments to age, gender, race and culture

229

"The breach between what we know and what we do is lethal."

Kay Redfield Jamison
Night Falls Fast

Last Reviewed: June 5, 2007
Content Source:
Office of Minority Health & Health Disparities (OMHD)

Other Resources:

Mental Health CDC's National Center for Health Statistics (NCHS), Health, United States, 2006

Mental Health: Culture, Race and Ethnicity, 2001
Supplement to
Mental Health: A Report of the Surgeon General, 1999

National Institutes of Mental Health (NIMH)

National Mental Health Association (NMHA)

Substance Abuse and Mental Health Services Administration (SAMHSA)

- National Mental Health Information Center
- Racial and Ethnic Groups

Mental-Health-Matters.com

Source:

David Satcher, M.D., Ph.D., Mental Health: A Report of the Surgeon General, 1999, presented at the 92nd Annual NAACP Convention, New Orleans, Louisiana.

Appendix # 3 A

12/17/2012

Respectfully submitted by Melissa L. Costanzo, LMFT, Clinical Supervisor, CT Family Care Services, LLC

On 12/12/12, I met with Barbara Quigley and Edward Pikette of the Manchester Department of Health. I was interested in obtaining information regarding the prevalence and need of Mental Health Services among the many diverse populations in Manchester, CT. At CT Family Care Services, LLC we are dedicated to servicing those families who are falling through the cracks, as it were and assist in elevating this community to a higher level of functioning in order to reduce dropout rates, imprisonment and poverty.

According to Barbara Quigley, the middle class is in most need of services. These are the families whose health insurances are being cut back or cancelled. They do not qualify for state assistance, but also are unable to choose to pay for health insurance privately or even through Connecticut's Charter Oak Insurance program. This insurance can be costly in premiums and co-pays and the middle class families need to make decisions for their families; do they put adequate healthy food on their table or pay for health insurance?

Ed Pikette shared that there is an ever growing population of South Asian families (Bangledesh, Pakistan, and Indian). These families are in need of many services from professionals who not only understand their culture, but also are able to communicate in their native language. Parents often feel disconnected from their children's schooling because of the language barrier. Referrals for additional support services may not be followed through with due to a lack of understanding as well as the language barrier.

Both professionals at the Manchester Department of Health agree that there are no statistics available and believe that there is no way to track data regarding the services that are needed in the Mental Health field that are not available or utilized. Mr. Pikette listed the current available Mental Health facilities in Manchester , CT: Hockanum Valley, Manchester Memorial Hospital, CHR, Child Guidance Clinic, New Hope and several private practice practitioners. Both, Mrs. Quigley and Mr. Pikette shared that there are long waiting lists for each of these public service providers and many families again fall through the cracks due to the long waits to meet a Mental Health Professional.

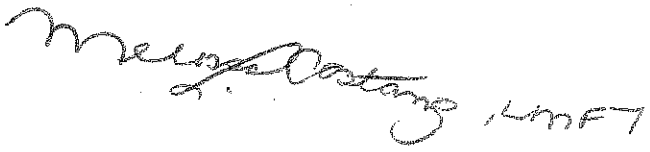
Finally, Mr. Pikette recommended visiting the Center for Disease Control's (CDC) website to investigate the prevalence of the various mental health disorders to which CT Family Cares Services, LLC is planning on targeting and treating and apply those percentages to the Manchester population. In doing so, I have learned that 1 in 2 Americans has a diagnosable mental disorder each year (44 million adults and 13.7 million children). Of these people with a diagnosable mental disorder, fewer than half of the adults get help and only one third of the children get help. The CDC discusses that the barriers to care include: income, Managed Care, Medicare/ Medicaid, stigma, consumers appreciation of treatment and health care providers being unaware of treatment. The CDCs vision for the future is to increase the public awareness of the availability of effective treatments, to ensure the supply of these mental health services and providers and to tailor the treatments to the clients' age, gender, race and culture.

http://www.cdc.gov/omhd/AMH/factsheets/mental.htm

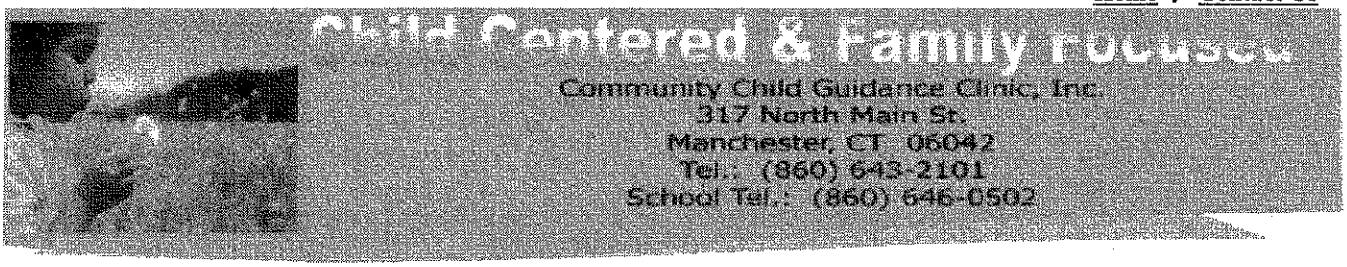
In further research, it came to my attention that approximately 40% of people in 35 states of the USA had serious psychological distress (SPD). Of the 40% a shocking 53.4% did not receive treatment with a higher percentage likely to have been women, the unmarried and those in poverty. On average, US adults report experiencing 3.6 physically unhealthy days per month, 3.4 mentally unhealthy days per month, with an average of 6.1 overall unhealthy days per month. An estimated 10.8% of US adults experience 14 or more physically unhealthy days per month while and estimated 10.2% experience 14 or more mentally unhealthy days per month. http://www.cdc.gov/mental health/data_stas/nspd.htm

Finally, mental illness is a significant public health problem. The World Health Organization states that mental illnesses account for more disability in developed countries that any other group of illnesses. Mental illness is associated with increases in physical diseases of cardiovascular, diabetes, obesity, asthma, epilepsy, and cancer. It is also associated with lower use of medical care and higher risks of adverse health outcomes. There is an increased rate of the use of tobacco and abuse of alcohol among these individuals. Rates of intentional and unintentional injuries are 2 to 6 times higher than the general population overall. http://www.cdc.gov/mentalhealthsurveillance/fact_sheet.html

It is because of these statistics and the information provided by the professionals at the Manchester Department of Health, that CT Family Care Services, LLC is working with the Manchester school system, the Manchester Community Services Council and the Manchester Area of Churches to open our doors to those who are not receiving the necessary treatment to better their quality of life. This agency is dedicated to research and continued training of the therapists and clinicians to provide the best mental health treatments available.



Appendix # 3 B



CLINIC HOURS

MONDAY
8:30 AM—6 PM

TUESDAY
8:30 AM—8 PM

WEDNESDAY
8:30 AM—6 PM

THURSDAY
8:30 AM—8 PM

FRIDAY
8:30 AM—5 PM

DIRECTOR'S REPORT

This has been another excellent year for the Clinic. Our production numbers have been up in every department. Our outpatient programs continue to see an increased number of patients. Our home and community-based programs continue to operate smoothly and our day programs, such as Northstar, IOP (Intensive Outpatient Program), and our school continue to serve high numbers of very difficult children. All of these programs contribute to our mission of maintaining children within their families and within the communities.

We continue to struggle with limited space to accommodate our increased need to provide services. At this point our building is more than filled with therapists, sometimes having to scramble to find a vacant office to interview families. We find ourselves in a position where we could develop new and expanded programs, if we had the space.

Our outpatient programs could grow as well as could our afterschool intensive outpatient program. Our school continues to receive increased referrals, and this year we had as many children as we have ever had before, in the history of the school. The fact that this year we have added a licensed alcohol and drug counselor increases our ability to broaden services. Our priority continues to be to expand our autism services. We want to develop treatment services, now that we have established our Building Blocks Program as an assessment service. All of the above areas are unmet community needs; and to reach our potential to provide the intended services, we need additional space. This will be a priority in the upcoming year for the clinic.

Clifford Johnson, ACSW, LCSW
Executive Director

COMMUNITY CHILD GUIDANCE CLINIC
CHILD CENTERED & FAMILY FOCUSED

Appendix # 3 C

~~Appendix 5~~ # C

Logotherapy as an Adjunctive Treatment for Chronic Combat-related PTSD:
A Meaning-based Intervention

Combat-related Post-traumatic Stress Disorder (PTSD) is often highly debilitating and affects nearly all areas of psychosocial functioning. Veterans with PTSD re-experience their traumas in the form of haunting intrusive memories, nightmares and flashbacks, and have chronic difficulty modulating arousal. As a way to cope with these symptoms, many survivors live isolated and avoidant lives, self-medicate with alcohol and substances of abuse, and numb themselves to emotional experiences and relationships with family and friends. Additionally, many combat veterans report survivor guilt, depression, affect dysregulation, and an altered world view in which fate is seen as uncontrollable and life is viewed as devoid of meaning. In this report we describe the use of logotherapy (healing through meaning) for the treatmeLogotherapy as an Adjunctive Treatment for Chronic Combat-related PTSD:
A Meaning-based Intervention

Combat-related Post-traumatic Stress Disorder (PTSD) is often highly debilitating and affects nearly all areas of psychosocial functioning. Veterans with PTSD re-experience their traumas in the form of haunting intrusive memories, nightmares and flashbacks, and have chronic difficulty modulating arousal. As a way to cope with these symptoms, many survivors live isolated and avoidant lives, self-medicate with alcohol and substances of abuse, and numb themselves to emotional experiences and relationships with family and friends. Additionally, many combat veterans report survivor guilt, depression, affect dysregulation, and an altered world view in which fate is seen as uncontrollable and life is viewed as devoid of meaning. In this report we describe the use of logotherapy (healing through meaning) for the treatment of combat-related PTSD

Chronic combat-related Post-traumatic Stress Disorder (PTSD) is notoriously difficult to treat. While numerous therapeutic approaches have been tried in this population, success rates generally have been modest to moderate. Published therapeutic trials have included treatment with exposure therapies, cognitive processing therapies, psychodynamic psychotherapy, eye movement desensitization and reprocessing (EMDR), hypnotherapy, and pharmacotherapy (Foa et al., 2000, Silver SM and Rogers S, 2002, Wilson, Friedman and Lindy 2001). These therapies have primarily focused on the alleviation of specific symptoms of PTSD and of symptoms accompanying co-morbid psychiatric disorders. However, even when DSM symptoms respond to treatment, many veterans with PTSD, who have experienced the darkest side of human nature, are left with profound existential questions related to the loss of meaning in life. While less symptomatic, they may remain tormented and in some cases feel hopeless

In this report we describe the use of logotherapy for the treatment of combat-related PTSD. Logotherapy is a meaning-centered psychotherapy that draws from the tradition of existential philosophy and is grounded in the professional work and extraordinary life experiences of its originator Viktor Frankl. The literal meaning of logotherapy is "healing through meaning." Logotherapy is sometimes referred to as the "third

Appendix 3 # D (a)

world has changed profoundly. We have witnessed amazing attempts at transforming ethnic group relationships in South Africa, Northern Ireland, the Middle East, and the former Soviet Union, as well as tragic ethnic devastation in the Sudan, Rwanda, Kosovo, Russia, the Middle East, and Latin America. Meanwhile, the United States is being transformed by rapidly changing demographics and has played a most ethnocentric role in going to war in Iraq. This is a role it has unfortunately played in many other regions at other times, most especially in Central and South America, in some of the Caribbean island nations, the Phillipines, and Vietnam (see Chapters 11–19, 23, and 27).

THE MEANING OF ETHNICITY

> Why have we as a people been able to continue to exist? Because we know where we come from. By having roots, you can see the direction in which you want to go.
>
> —JOENIA BATISTE DE CARVAHLO, first Indian woman lawyer in Brazil, who is fighting for the rights of her people.
> (*New York Times*, November 13, 2004, p. 7)

Having a sense of belonging, of historical continuity, and of identity with one's own people is a basic psychological need. Ethnicity, the concept of a group's "peoplehood," refers to a group's commonality of ancestry and history, through which people have evolved shared values and customs over the centuries. Based on a combination of race, religion, and cultural history, ethnicity is retained, whether or not members realize their commonalities with one another. Its values are transmitted over generations by the family and reinforced by the surrounding community. It is a powerful influence in determining identity. It patterns our thinking, feeling, and behavior in both obvious and subtle ways, although generally we are not aware of it. It plays a major role in determining how we eat, work, celebrate, make love, and die.

The subject of ethnicity tends to evoke deep feelings, and discussion frequently becomes polarized or judgmental. As Greeley (1969) has described it, using presumed common origin to define "we" and "they" seems to touch on something basic and primordial in the human psyche. Irving Levine (personal communication, February 15, 1981) observed: "Ethnicity can be equated along with sex and death as a subject that touches off deep unconscious feelings in most people." When there has been discussion of ethnicity, it has tended to focus on nondominant groups' "otherness," emphasizing their deficits, rather than their adaptive strengths or their place in the larger society, and how so-called "minorities" differ from the "dominant" societal definitions of "normality."

Our approach is to emphasize instead that ethnicity pertains to everyone, and influences everyone's values, not only those who are at the margins of this society. From this perspective cultural understanding requires examining everyone's ethnic assumptions. No one stands outside the category of ethnicity, because everyone has a cultural background that influences his or her values and behavior.

Those born White, who conform to the dominant societal norms, probably grew up believing that "ethnicity" referred to others who were different from them. Whites were the definition of "regular." As Tataki (1993, 2002) has pointed out, we have always tended to view Americans as European in ancestry. We will not be culturally competent until we let go of that myth. Many in our country are left with a sense of cultural homelessness because their heritage is not acknowledged within our society.

Our very definitions of human development are ethnoculturally based. Eastern cultures tend to define the person as a social being and categorize development by growth in the human capacity for empathy and connection. Many Western cultures, in contrast, begin by positing the individual as a psychological being and define development as growth in the capacity for autonomous functioning. Even the definitions "Eastern" and "Western," as well as our world maps (Kaiser, 2001), reflect an ethnocentric view of the universe with Britain and the United States as the center.

African Americans (see Chapter 6; Boyd-Franklin, 2003; Carter, 1995; Franklin, 2004) have a very different foundation for their sense of identity, expressed as a communal sense of "We are, therefore I am," contrasting starkly with the individualistic European ideal: "I think, therefore I am." In the United States, the dominant cultural assumptions have generally been derived from a few European cultures, primarily German (Chapter 40), Dutch (Chapter 38), and, above all, British (Chapter 37), which are taken to be the universal standard. The values of these few European groups have tended to be viewed as "normal," and values derived from other cultures have tended to be viewed as "ethnic." These other values have tended to be marginalized, even though they reflect the traditional values of the majority of the population.

Although human behavior results from intrapsychic, interpersonal, familial, socioeconomic, and cultural forces, the mental health field has paid greatest attention to the first of these—the personality factors that shape life experiences and behavior. DSM-IV, although for the first time considering culture in assessing and treating patients, allows one to conduct the entire course of diagnosis and therapy with no thought of the patient's culture at all. Much of the authors' work on culture was omitted from the published manual, and the "culture-bound" syndromes they did mention tended to "exoticize the role of culture" (Lopez & Guarnaccia, 2000). Indeed, the authors decided to exclude disorders seen as primarily North American disorders (anorexia nervosa and chronic fatigue syndrome) from the glossary of culture-bound syndromes because they wanted to restrict the term to problems of "ethnic minorities" (Lopez & Guarnaccia, 2000)!

As things stand now, most mental health record-keeping systems do not even record patients' ethnic backgrounds, settling for minimal reference to race as the only background marker. No other reference is generally made to immigration or heritage. In the broader mental health field, there was a great increase in attention paid to ethnicity in the 1980s. However, since then there has been a distinct retreat from attention to culture as managed care, pharmaceutical, and insurance companies took control of most mental health services and intentionally minimized attention to family, context, and even service for those who cannot afford to pay. Since the early 1990s, the mental health professions in general pay only lip service to the importance of cultural competence. The study of cultural influences on human emotional functioning has been left primarily to the cultural anthropologists. Yet they have preferred to explore remote cultural enclaves, rather than examining culture within our own diverse society.

Even mental health professionals who have considered culture have often been more interested in examining international, cross-cultural comparisons than in studying the ethnic groups within our own society. Our therapeutic models are generally presented as having universal applicability. Only recently have we begun to consider the underlying cultural assumptions of our therapeutic models and of ourselves as therapists. And even now, reference to "cultural competence" varies from complete acceptance to outright derision (Betancourt, 2004).

We must incorporate cultural acknowledgment into our theories and into our therapies, so that clients not of the dominant culture will not have to feel lost, displaced, or mystified. Working toward multicultural frameworks in our theories, research, and clinical practice requires that we challenge our society's dominant universalist assumptions, as we must challenge our other societal institutions as well in order for democracy to survive (Dilworth-Anderson, Burton, & Johnson, 1993; Hitchcock, 2003; Pinderhughes, 1989).

It is unfortunate that society's rules have made it difficult for us to focus our vision on ourselves in this way, but it is essential if we are to become culturally effective clinicians. As Bernard Lewis (2002) has put it:

> When things go wrong in our society, our response is usually to place the blame on external or domestic scapegoats—foreigners abroad or minorities at home. We might ask a different question: What did we do wrong? (pp. 22–23)

This question, which leads us to look in every situation to see what we contribute to misunderstandings, is essential to expanding our cultural awareness. We must understand where we have been and the cultural assumptions and blinders our own history has given us before we can begin to understand those who are culturally different from us.

This book presents a kind of "road map" for understanding families in relation to their ethnic heritage. The paradigms here are not presented as "truth," but rather as maps to some aspects of the terrain, intended as a guide for the explorer seeking a path. They draw on historical traits, residues of which linger in the psyche of families many generations after immigration, long after its members have become outwardly "Americanized" and cease to identify with their ethnic backgrounds. Although families are changing very rapidly in today's world, our focus here is on the continuities, the ways in which families retain the cultural characteristics of their heritage, often without even noticing these patterns. Of course, the clinical suggestions offered by the authors of this book will not be relevant in every case, but they will, it is hoped, expand the readers' ways of thinking about their own clinical assumptions and the thinking of the families with whom they work. Space limitations have made it necessary for us to emphasize characteristics that may be problematic. Thus, we do not always present families in their best light. We are well aware that this can lead to misunderstandings and feed negative stereotypes. We trust the reader to take the information in the spirit in which it is meant—not to limit our thinking, but to expand it.

There has been a growing realization since this book's first edition that a positive sense of ethnic and racial identity is essential for developing a healthy personal and group identity, and for effective clinical practice. So far, more in the field of health care than in mental health, the concept of "cultural competence" has begun to become an accepted value. In recognition of the overwhelming evidence of racial and ethnic disparities in health care, there is a beginning acknowledgment that with every illness and on virtually every measure of functioning, the cultural disparities in health care are staggering and it is time to rethink our cultural attitudes and to address these realities. A new field of "cultural competence" in health care has been emerging, a field that defines the "culturally competent health care system" as one that acknowledges the importance of culture throughout the system and is vigilant in dealing with the dynamics that result from cultural differences, the expansion of cultural knowledge, and the adaptation of services to meet culturally unique needs (Betancourt, Green, Carrillo, & Ananeh-Firempong, 2003).

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This field of culturally competent health care seeks to identify sociocultural barriers to health care and to address them at every level of the system, including the cultural congruity of the interventions provided and the degree to which the leadership and workforce reflect the diversity of the general population (Betancourt et al., 2003).

Within the mental health field, recognition of the importance of culture has been much slower. Family therapy, which was rocked to its foundations by the feminist critique (Luepnitz, 1992; McGoldrick, Anderson, & Walsh, 1989; Wheeler, Avis, Miller, & Chaney, 1985), has been moving toward an awareness of the essential dimension of culture as well as gender. Unfortunately, most of the institutions in the field, such as the major training programs, the publications, and the professional organizations, still view ethnicity as an "add-on" to family therapy, a "special topic," rather than as basic to all discussion. Reactions to the upsurge in "diversity" presentations at the annual Family Therapy Academy meetings have included a frequently articulated request by members to "get back to basics." In our view there is no such thing as moving "back" to basics. Rather, we must re-envision the "basics" from more inclusive perspectives, so that the cultural underpinnings of all therapeutic endeavors will inform our work, allowing us to deal theoretically and clinically with all our clients (see the Appendix on cultural clinical assessment).

For many, the earlier editions of *Ethnicity and Family Therapy* provided an "ah ha!"—a recognition of their own cultural background or that of spouses, friends, or clients. Still, when it was first written, we were all fairly naive about the meaning of culture in our complex world. Some feared that our book reinforced cultural stereotypes, but we believed then, and believe now, that exploring cultural patterns and hypotheses is essential to all our clinical work.

We also recognize that ethnicity is not the only dimension of culture. In this book we illustrate how gender, socioeconomic status, geography, race, religion, and politics have influenced cultural groups in adapting to American life. Knowing that no single book could possibly provide clinicians with all they need to know to work with those who are culturally different, we gave the authors of the chapters the following instructions:

> We have become increasingly convinced that we learn about culture primarily not by learning the "facts" of another's culture, but rather by changing our attitude. Our underlying openness to those who are culturally different is the key to expanding our cultural understanding. Thus, cultural paradigms are useful to the extent that they help us recognize patterns we may have only vaguely sensed before. They can challenge our long-held beliefs about "the way things are." Thus, we ask you to write your chapter with the following aims in mind:
>
> 1. Describe the particular characteristics and values of the group with some context of history, geography, politics, and economics as they are pertinent to understanding the patterns of the group.
> 2. Emphasize especially values and patterns that are relevant for therapy—those an uninformed therapist might be most likely to misunderstand (e.g, related to problems, help seeking, and what is seen as the "cure" when people are in trouble).
> 3. Describe patterns that relate to clinical situations, especially couple relationships; parent–child issues, sibling relationships, three-generational relationships; how families deal with loss, conflict, affection, homosexuality, and intermarriage.
> 4. Include relevant information on the impact of race, class and class change, religion, gender roles, sexual orientation, and migration experiences.
> 5. Offer guidelines for intervention to facilitate client well-being, demonstrating respect for both the historical circumstances and the current adaptive needs of families in the United States at the beginning of the 21st century.

iah!" following every utterance in the church service, which contrasted sharply with his experience of worship in Sierra Leone. She was relieved that what troubled her husband was "no reflection on me or on my relationship with Kwaku." Once Kwaku had explained his discomfort, the couple were able to discuss their different relationships to their respective forms of church worship, spirituality, and the scriptures. Natasha was able to explain to Kwaku her own spiritual background, and he could own his relationship to the scriptures.

Exploring such cultural similarities and differences contributes greatly to achieving harmony in a relationship (Black, 1996). Helping Kwaku and Natasha see what they did, and did not, share, and exploring Christian practices in Africa, helped Natasha to respect the ways in which Kwaku's experience of Christian worship in Africa differed from her own. Kwaku was soon able to honor Natasha's American ways of worship.

African Americans' forms of worship in the United States reflect their people's experience of coming to Christianity while enslaved and are thus necessarily different from the Christianity that emerged in Africa. Indeed, the Exodus theme of redemption from slavery permeated slaves' Christianity, gave them hope for freedom, and even provided a code to communicate their escape plans. Those "Halleluiahs" were not only spiritual communion, but also a call to freedom.

AFRICANS IN THE UNITED STATES: A DIFFERENT SOCIAL CONTEXT

Having to renegotiate their ethnic culture in the United States can leave Africans highly vulnerable to emotional distress. Worrying about how they will fare in a foreign land, they often manifest social anxiety and mistrust of others. Such suspiciousness may have begun in their countries of origin, where their sense of safety was first violated. Having to continually explain themselves in the United States also feeds mistrust. A woman from Nigeria reported frequently hearing inquisitive comments about her unfamiliar dress, accent, and speech. She told how people responded with dismay and disbelief when she talked about each detail on her dress, and then asked her more questions, which suggested there was something more they should learn.

Downward job mobility is a major frustration for many African immigrants. Even those with excellent credentials often cannot find employment commensurate with their training or education and so must work in low-status jobs to support their families here and back at home. Undocumented immigrants must also worry about being discovered by the Immigration and Naturalization Service (especially since September 11, 2001). Such circumstances can create intense feelings of resentment.

Because American society links health insurance to employment, many immigrants have only limited access to medical and mental health services. It can take enormous energy just to keep up one's self-esteem at work. Many Africans work several jobs, for example, as nannies, janitors, or security guards, to make ends meet while also pursuing educational opportunities to earn new credentials. Class, gender role, and life cycle expectations further compound these issues (Kliman & Madsen, 1999). One Ugandan immigrant woman spends several hours a day working as a nanny and many evening

Appendix B # D (6)

CHAPTER 6

African American Families

Paulette Moore Hines
Nancy Boyd-Franklin

Families of African heritage come to the United States from many different countries and are therefore very diverse in terms of geographic origin, acculturation, religious background, skin color, socioeconomic status, and in the implementation of strategies employed to cope with racism and discrimination. The largest group, and our focus here, are descendants of African slaves.

Many early studies of African American families reflected a pejorative view that characterized them as "disorganized, deprived, disadvantaged" (Deutsch & Brown, 1964; Frazier, 1966; Moynihan, 1965). In recent years, African American researchers and scholars have reexamined this deficit view and have presented a more balanced perspective that includes the strengths inherent in these families (Billingsley, 1968, 1992; Boyd-Franklin, 2003; Hill, 1972, 1999; Hines, 1999; Hines & Boyd-Franklin, 1996; Hines, Garcia-Preto, McGoldrick, Almeida, & Weltman, 1992; Jones, 2004; McAdoo, 1996, 2002; Staples, 1994; White, 2004). A number of researchers have also explored the stages of racial identity development among African Americans (Carter, 1995; Cross, 1991; Cross, Parham, & Helms, 1998; Helms & Cook, 1999; Jones, 1998; Parham, 1992).

Afrocentric scholars (Akbar, 1984, 1985; Ani, 1994; Asante, 1988, 1990; Kambon, 1998; Karenga, 1997; Mbiti, 1970; Nobles, 1985, 2004) have concluded that the recognition of ancient African culture and history is paramount to fully comprehending African Americans. This emerging scholarly movement believes that the family and the spiritual dimension of life are essential for the individual's existence (Nobles, 2004).

FAMILY AND CULTURAL CONTEXT OF AFRICAN AMERICANS IN THE 21ST CENTURY

African Americans make up about 13.3% of Americans (U.S. Bureau of the Census, 2004). Between 1940 and 1970, more than 1.5 million African Americans migrated from the South, most frequently to the North and sometimes to the West, in pursuit of greater

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economic opportunities. Currently, more than half (55%) live in the South and a majority live in the central city of a metropolitan area (McKinnon, 2003).

The result of this migration was the emergence of a substantial number of African Americans moving into the middle class. According to the 2000 census, 33% of all Black families were considered middle-income families (earning $50,000–$99,999 annually), as compared with 11.4% in 1970. Blacks also made major advances in education, employment, home ownership, and voter participation (Billingsley, 1992; Staples, 1994). In addition, between 1990 and 2000, the percentage of African Americans living below the poverty level decreased from 27.0 to 22.7% (McKinnon, 2003; U.S. Bureau of the Census, 2000, 2001).

Still, institutional racism exerts a significant impact on the lives and well-being of African Americans. For example, in 2000, African Americans averaged just 66% of the income of Whites ($30,439 vs. $ 45,904). Twenty-three percent of all African American families lived below the poverty level in 2001, as compared with 8% of non-Hispanic Whites, and the unemployment rate for African Americans, aged 16 and over, was almost twice that for their White counterparts (11% vs. 5%) (McKinnon, 2003). Disparities based on race continue to exist on a host of key quality of life indicators, including home and business ownership, physical health, children living at or below the poverty level, number employed in professional and managerial specialty occupations, and others (McKinnon, 2003).

The average life expectancy of African Americans remains substantially lower than that of Whites, and the rate of death among African Americans due to AIDS and homicide exceeds that of any other group (Arias, 2002; Rockeymoore, 2002).The disillusionment and frustration generated by persistent poverty and oppression have resulted in a high rate of drug and alcohol abuse among African Americans, a dependence that makes for what we view as "psychological slavery." Yet, as Billingsley (1968) noted, African Americans generally are noteworthy for their "amazing ability to survive in the face of impossible conditions." Hill (1999), a researcher who focuses on the adaptive strengths in African American families, attributed the group's survival to strong kinship bonds, flexibility of family roles, and the high value placed on religion, education, and work.

KINSHIP BONDS

Strong African American kinship bonds are traceable to Africa, where various tribes shared "commonalities" (e.g., worldview) that were broader than bloodlines (Akbar, 1985; Nobles, 2004). In contrast to the European premise "I think, therefore I am," the prevailing African philosophy is "We are, therefore I am." In effect, individuals owed their existence to the tribe (Nobles, 2004).

Torn from their homelands and tribal connections by slavery, men, women, and children had to abandon their native languages, names, occupations, mates, religions, foods, and customs. Mortality rates were high and life expectancies were low. Families were frequently dissolved by the sale of members to slaveholders on different plantations. Afrocentric scholars (Ani, 1994; Kambon, 1998) have referred to slavery as the *Maafa*, a Kiswahili word meaning "great disaster." The *Maafa* was the African holocaust, with a catastrophic loss of life estimated at 25 to 100 million (Ani, 1994; Boyd-Franklin, 2003; Kambon, 1998).

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With male and female slaves prohibited from marrying, frequent changes of partner became the rule. Black men were used as breeders to increase the labor supply, and their owners sexually exploited Black women. Despite these extreme hardships, slaves sought to form new family units to compensate for losses due to death and slavery. Even after emancipation, many former slaves remained on plantations, hoping that lost family members might return.

Access to and use of their kinship network, which is much broader than traditional "bloodlines," has always been a critical resource for African Americans, given the persistent need to cope with the pressures of an oppressive society (Billingsley, 1992; Boyd-Franklin, 2003; Staples, 1994). White (2004) has noted the number of "uncles, aunts, big mamas, boyfriends, older brothers and sisters, deacons, preachers, and others who operate in and out of the African American home."

Therapists working with African Americans must be willing to take into account, and sometimes work with, an extended kinship system. Because of characteristic extended family orientation and the role flexibility, emotional ties are not predictable solely on the basis of biological relationship. Relatives often live in close proximity and rely on one another in times of need (McAdoo, 2002). The therapist should ask who is in the family, who lives in the home, and what family members and significant others live elsewhere. Often the question, "Whom can you depend on for help when needed?" will uncover key individuals in the family's support system.

A genogram can aid the therapist in gathering information about relationships and the roles of different family members (Boyd-Franklin, 2003; McGoldrick & Gerson, 1999). However, information generally should be gathered only after the therapist senses that a bond of trust has been established with the family (Boyd-Franklin, 2003; Hines, 1999). The therapist should look for natural openings to obtain information, rather than force data gathering, for many African Americans are suspicious about the motivation underlying what they perceive as "prying." Illegitimate births, parents' marital status, the incarceration of family members, or deaths due to AIDS, violence, or substance abuse, may be "secrets" unknown to all family members or information that members are hesitant to discuss with an outsider.

Within the African American family system, it is fairly common for a child to be informally adopted by a grandparent or other extended family member, who may be better able than the child's parents to provide nurture and/or a wholesome environment (Billingsley, 1992; Boyd-Franklin, 2003). Young adults frequently rely on the extended-kin network's support to achieve a college education. This support may also facilitate the transition into adulthood and the work world.

Such role flexibility is often mobilized in times of crisis, such as separation, illness, hospitalization, or the death of a family member. However, for far too many African Americans, there is a growing gap between the cultural ideology that encourages extending help and their ability to be responsive to family members' needs. African American families, particularly those who are poor or of the working class, are disproportionately affected by high unemployment and health crises (e.g., mothers unable to care for their children because of drug addiction and/or AIDS) that financially and emotionally overtax their networks. Sometimes, even when family members can provide assistance, bureaucratic or legal obstacles in school or health and human services policies can impede the involvement of family members (Hill, 1999).

Family therapists must explore and select carefully the core and extended family

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members to include in family therapy. Often, key family members may be unwilling or unable to keep appointments on a regular basis. The therapist might therefore schedule a family session in the home, provided key family members consent.

Too frequently, outsiders assume that certain family structures are inherently dysfunctional (e.g., multigenerational, single-parent). Therapists need to recognize that what matters most is not the structure but the functioning of a family. Sometimes, however, family boundaries and authority lines become quite blurred. Role confusion occurs most frequently in families that include a parental child and three generations, as described in the following sections.

GENDER ROLES AND COUPLE RELATIONSHIPS

Despite stereotypes that characterize African American men negatively, there is considerable variability among African American men, as there is in all ethnic groups. Some live in the home and are very active in child rearing; some live in the home but are peripheral to their children's lives; some are involved but live outside the home.

It is safe to say that the high rate of unemployment among African American men has greatly influenced the willingness of African American women and men to marry (Testa & Krogh, 1995; Tucker & Mitchell-Kernan, 1995) and to assume a central role in the lives of their children. This reality can easily give rise to perceptions of Black men as non-family-oriented or uncaring. Franklin (1993, 2004) coined the term "invisibility syndrome" in his discussion of the marginalization of African American men. White Americans have often been taught to fear Black males in particular and to treat them as if they were "invisible," thus marginalizing them in the larger societal context.

African American women, who are often more actively religious than their mates, are frequently regarded as the "strength of the family." More easily employed than their male counterparts, Black women historically have worked outside the home, sometimes as the sole wage earners, particularly in times of high unemployment (Boyd-Franklin, 2003; Hines, 1999). Still, these relationships are affected by the male–female power differential that characterizes our patriarchal society. Shelton and John (1993) found that, in contrast to European American and Hispanic males, the more time married African American males spent in paid labor, the more time they spent in household labor as well.

Because African American men have a much lower life expectancy than African American women or Whites of either sex (Arias, 2002), the gender ratio among African American adults is quite skewed. The availability of African American men to participate in relationships is affected by incarceration, mental and physical disabilities, drug and alcohol abuse, and deaths on jobs involving a high degree of danger or health hazards (e.g., military service, blue-collar work in hazardous waste, chemical production, or mining), as well as violence of many kinds.

Professional African American women are often left with the choice of marrying less educated, lower-status men or remaining single. Even if a woman is willing to marry, the gender ratio is so skewed that she may not be successful in finding a partner, maintaining a relationship, or remarrying. In addition, African American couples often experience relationship stress because of the added burden of racism and their own internalization of negative projections about each other (Boyd-Franklin, 2003; Hines, 1999; Pinderhughes, 1982).

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Children and, hence, the role of mothers are highly valued within African American culture (Hines, 1990). Across income groups, a growing number of women are choosing to become single parents rather than remain childless. In 2002, 48% of Black children were living with a single mother, as compared with 16% of non-Hispanic White children (Fields, 2003).

The identity of African American fathers, regardless of income, is linked to their ability to fulfill traditional gender functions and to provide for their families. Success in being a provider, however, continues to be influenced by systematic discrimination. They are constantly challenged with negative stereotypes, including the notion that they are absent or, at best, peripheral in their children's lives.

Therapists are particularly likely to overlook noncustodial fathers, as well as other males in the extended family system, particularly a noncustodial father's kinship network. Therapists should involve male partners, fathers, and other significant adult males in family assessment and treatment. However, many African American men are reluctant to enter therapy, because they associate it with distrusted mainstream organizations.

Therapists should explore signs of ambivalence and respond with creativity, sensitivity, and flexibility. A father who is regarded as "unavailable" may more easily be persuaded to attend if a therapy session is scheduled to accommodate his work schedule, perhaps in the evening, or if the request is that he attend a single, problem-focused session (Hines, Richman, Maxim, & Hays, 1989). Recognizing a father's role can decrease sabotaging of the therapeutic process; even limited involvement may facilitate positive individual or family structural changes.

Usually, when relationship issues between adult heterosexual partners are the central concern, African American women initiate the therapy process. It may both surprise and frustrate therapists when women express considerable dissatisfaction, yet exhibit ambivalence toward, if not an outright rejection of, ending unsatisfactory and even dysfunctional relationships. Two contributing factors may be an absence of hope that they can find more rewarding relationships, and anxiety about surviving financially on their own. In some cases, women may be concerned about joining society in "beating their men further down" (Boyd-Franklin, 2003; McGoldrick, Garcia-Preto, Hines, & Lee, 1989). Their discontent is often coupled with an awareness of the pervasive effects that generations of racism have had for both African American men and women.

One task for therapists, in such an instance, is to help the woman to differentiate between empathy for her partner's frustration and sense of powerlessness, and encouraging or enabling the continuation of self- and relationship-defeating behaviors.

PARENT–CHILD SYSTEMS

Sometimes a child is "parentified," particularly when parents work or when there are many children in the home. Parents may consciously decide to have a child assume or assist with parental responsibilities, or the child may take on this responsibility without the adults' direct encouragement. The parental child structure can enhance the parental child's sense of responsibility, competence, and autonomy. However, if there is no explicit delegation of authority, the child may lack power to carry out the responsibilities he or she attempts to assume. Alternatively, if parents abdicate their responsibilities, the child may be forced to become the main source of guidance, control, and decision making,

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Appendix 3 PD(C)

Their parents, who often enter the middle class without sufficient financial assets, and struggle to retain even a tenuous hold on their status, are likely to demand high achievement from their children. Parents' concerns for their children's futures and an awareness of their limited capacity to protect their children may heighten parents' sense of powerlessness and rage about racism. Some may respond in ways that are detrimental (e.g., overprotection, constant lecturing) to their relationships with their children, resulting in self-defeating behaviors (Boyd-Franklin, Franklin, & Toussaint, 2001).

Therapists can assist parents in managing their own stress and anger, in distinguishing between their own and their children's issues and goals, and in engaging their children in joint dialogue about the positive strategies that helped the parents and their ancestors to transcend difficult circumstances.

Believing that "to whom much is given, much is expected," African Americans often feel that they have a responsibility to "give back," especially to less economically advantaged family members. Their sense of responsibility is linked to the belief that individual well-being is tied to the collective welfare. For African Americans, personal accomplishments often are attributed to the sacrifices of others, as well as to individual effort. Some individuals may experience difficulty because their efforts to help extended family members leave them feeling depleted emotionally, physically, and/or financially. In such instances, culturally congruent therapists will support their clients' capacity to develop or maintain a balance between extending help and taking care of themselves, rather than encouraging emotional cutoffs and attention only to individual needs.

A MULTISYSTEM APPROACH TO THE TREATMENT OF AFRICAN AMERICAN FAMILIES

In working with African American families, therapists must be particularly willing to expand the context of therapy to include the impact of social, political, socioeconomic, and other environmental conditions. Aponte (1994) described this broader treatment approach as "ecostructural." Boyd-Franklin (2003) used the term "multisystems," given that poor inner-city African American families are likely to be involved with numerous external systems. Both ask therapists always to consider a family's environment and community in diagnosis and treatment.

Inner-city African American families are often faced with overwhelming socioeconomic problems, such as eviction or termination of public assistance. When these survival issues take precedence over family conflicts, clinicians should not assume responsibility, but rather should act as guides to help families learn how to negotiate complex bureaucratic systems. This sometimes requires the therapists to engage in outreach and often involves substantial amounts of time and energy.

Middle-class African Americans, like their lower-income peers, contend with circumstances that are shaped by racism, even if of a more subtle kind. They are likely to have few or no role models as they enter "unchartered territories' in their workplaces and/or neighborhoods. For some, the stress of having to discern and respond to subtle and overt prejudice may result in social and psychological isolation. Others derive from their experience exceptional strength, flexibility, and tolerance for diversity.

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of Black families as a "tangle of pathology." Willie and Reddick (2003) note that one of the greatest gifts of Blacks to the culture of the nation has been the egalitarian family model in which neither the husband nor the wife is always in charge.

Jones and Shorter-Gooden (2003) offer insights into Black women in America as they negotiate gender and race. The term "shifting" refers to the practice of dissimulation historically utilized by Africans in situations of oppression as a key survival strategy. However, over time this strategy can serve to separate the shifted from his or her essential self; he or she becomes self-alienated to accommodate others' needs.

McAdams-Mahmoud (Chapter 10, this volume) notes that social separation among African American Muslim families serves as a tool for providing support and reinforcing intimacy, and offers insights into practices that are frequently written off as sexist and oppressive. An African American man she interviewed described a ritual he attended with a group of African American Muslim men, who had had no previous connection, in which there was an amazingly high level of self-disclosure as they shared perspectives on marriage and men's roles.

Despite fairly egalitarian values related to gender and work, families of African origin continue to struggle with issues of patriarchal control. Male violence against women is a frequent presenting problem in family therapy. Families of African origin may be inhibited from seeking services related to emotional or physical abuse because of concerns about exposing men to a racist criminal justice system or confronting negative attitudes about their domineering behavior toward Black women. Assisting families in exploring gender role expectations and understanding the impact of institutionalized racism may be a crucial role for clinicians who are working with families of African origin. Head (2004) described the challenges faced by Black men and the contribution of racism to their experiences with clinical depression.

In *Standing the Test of Time* (2001), Julie Rainbow offers loving and honest portrayals of long-term African American couples. Her work serves as a guide for eliciting stories of commitment, resilience, and love from couples and families seeking new ways to relate to each other.

A genogram, which can be a useful tool in exploring intergenerational family stories related to gender roles, marital ties, and power, should include non-nuclear family members, because they contribute to a family's strength and emotional life (Watts-Jones, 1997).

Class

America is a class-saturated, class-silent, and consumption-focused society. Census data consistently point to the asset accumulation gap between Blacks and Whites in America. Immigration to this country often brings with it changes in class status. Individuals holding professional positions in their countries of birth, but whose credentials have not been accepted here, may be required to accept low-wage jobs. The quest for economic security and advancement may be the impetus for migration to, and within, the United States, resulting in family separations and isolation. What does it mean for a family to have to start over and rebuild an economic and social base? Brice-Baker (Chapter 8, this volume) offers insights into the unique class issues of families that immigrated to the United States.

Prior to residential desegregation, African American communities were economically diverse. Integration opened up a wider range of residential choices, resulting in a significant level of "green flight" (i.e., when businesses, and therefore money, leave a community) and the abandonment of traditionally Black neighborhoods by members with means to move to previously all-White settings. Clinicians might explore with a family the rationale for migration out of predominately Black neighborhoods, and its impact on the family. In addition, in most extended family networks, there are some who have done well and others who may continue to struggle economically.

Education and socioeconomic advancement continue to be highly valued among people of African origin, although some individuals entrenched in multigenerational poverty may have more negative attitudes regarding education and upward mobility.

Sexual Orientation/Heterosexism

Within communities of African origin, lesbian, gay, bisexual, and transgendered (LGBT) individuals continue to fight for visibility as marginalized members within their families, communities, and the wider society. Black gays and lesbians have made substantial contributions to their communities but rarely are acknowledged for them. Cohen (1999) states that gay and lesbian acceptance of this conditional status in Black communities is critical because of the racism that they face on the outside.

Homosexuality is considered taboo in many communities of African origin, resulting in its often being kept hidden. Clinicians must balance respect for the cultural and spiritual values of people of African origin with the needs of LGBT members for support in dealing with heterosexism. Clinical issues related to sexual orientation include coming out, gay and lesbian parenting, depression and anxiety, and posttraumatic stress disorder related to physical and emotional abuse based on sexual orientation.

One of the few studies of Black LGBT experiences (Battle, Cohen, Warren, Fergerson, & Audam, 2002) reported that 40 percent of women and 18 percent of men interviewed reported having at least one child. Although she does not specifically address the issue of race and ethnicity, Bernstein (2000) advocates a "cultural literacy" model for heterosexual clinicians working with LGBT clients. To engage in progressive and potentially healing interactions with clients, clinicians should challenge their heterosexist assumptions and develop an understanding of the economic, social, political, and emotional impact of homophobia.

Response to Treatment

Jackson (2002) provides a historic overview of mental health services for Africans in America that was characterized by brutality, segregation, overreliance on institutionalization, and racist application of psychiatric diagnoses. In 1851, Samuel Cartwright, a fierce proponent of slavery, coined the term *Drapetomania*, the "mental disease" causing slaves to run away (Cartwright, 2001). People of African origin have a long history of being labeled pathological because of their efforts to resist racial and economic oppression or their attempts to adapt to such conditions. In addition, people of African origin are vulnerable to the same emotional and family problems that affect non-African-descendent populations.

Family conflicts are primary presenting problems for many families of African origin. It is especially critical for clients who have been mandated to family counseling to share their unique stories about their families, including their encounters with the social welfare and mental health systems. In the engagement process, they should be encouraged to state what they value about their families, and what needs to change to increase a sense of connection and healing (Black, 2003).

Social/Political/Economic Impact

Families of African origin frequently have experiences with social, economic, and political oppression that affect their emotional health. Their giving voice to feelings of fear and outrage at the injustices they experience may result in their being told that they are acting as "victims" or "playing the race card." Some individuals, who have internalized these messages, may need assistance in linking current emotional difficulties to broader social, economic, and political realities. Akinyela (2002) emphasizes the need to place the experiences of people of African origin seeking clinical consultation within a historical and political context. Specifically, he calls for a creation of therapeutic space free from the interpretations and judgments of the dominant Eurocentric culture.

Grief/Rage/Loss

Therapists should acknowledge the resilience of people of African origin, which is reflected in loving familial bonds, economic survival, professional success, and deeply held spiritual values. However, there are deep, unacknowledged pools of grief, rage, and loss that color the experiences of many people of African descent. Enslavement, colonization, migration, and the emotional and physical separation from their homeland, whether by force or by choice, create a need for reflecting on losses even while accomplishments should be celebrated.

Some people of African origin experience internalized rage that can be the result of a lifetime accumulation of micro-aggressions, real and perceived slights and insults, subtle acts of dismissal, and implied suggestions to "stay in your place." Therapists need to provide a safety zone for speaking about these experiences, which often lie beneath conflicts, confusion and disillusionment, depression, and substance abuse. A. J. Franklin outlines strategies and interventions for helping men of African descent to cope and support each other with these complex issues (Franklin, 2004).

Pemina Yellow Bird of the Three Affiliated Tribes (Mandan, Hidatsa, and Arikara) offers three questions that emerged from the healing tradition of the indigenous peoples of America. Makungu Akinyela, an African American activist/therapist suggests an additional question that emerged from testimonial rituals within the Black church:

- What happened to you (your people)?
- How does what happen to you (your people) affect you now?
- In spite of what happened, how were you (your people) able to triumph?
- What do you need to heal?

These questions create a framework for the creation of individual, family, and community narratives. Most people of African origin have had limited opportunity to have

their experiences of trauma, struggle, or triumph witnessed to and validated. The therapeutic encounter should serve as an opportunity for families of African origin to share their stories, construct meaning, and identify internal and external change strategies. The clinician should evaluate his or her role in facilitating or inhibiting these therapeutic processes.

CONCLUSION

Therapists must delve into the complex historical, cultural, and linguistic realities of clients of African descent, including the invisibility syndrome that often haunts them, in order to provide culturally competent interventions. The depth of their presenting problems may not be recognized by a therapist who is unaware that a slight to a White person can be an emotional wound to a Black person because of the weight of history and a lifetime of subtle and sharp injuries (Franklin, 2004). Culturally competent therapists can serve a crucial role in helping families of African descent to reconnect with their unique histories and values.

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many Asian countries, religious organizations are highly respected. The priest, minister, or Buddhist monk is a key figure in the process of solving family problems. The clinician should determine whether the family belongs to a particular church or temple and the availability of emotional support or counseling from the particular organization. In many Asian American households, values that are shared by the grandparents or parents may be challenged by the younger generation, which is typically exposed to Western religions. The clinician should encourage the family members to share their spiritual beliefs in relation to the presenting problem and problem-solving strategies. Acknowledgement of differences in beliefs and other matters can allow clearer family decision making.

Family's Physical Health and Medication History

The clinician should explore the physical health of Asian clients, because they tend to express their emotional problems in somatic terms and usually come to treatment with many physical complaints. Many Asians, especially refugees, are in need of medical attention because of physical injuries, malnutrition, and lack of adequate medical treatment during times of conflict. They are often unfamiliar with Western medicine and may become confused by drug names, dosages, and side effects. Furthermore, for many Asian Americans, concurrent use of Western and traditional medicine is quite common. The family often appreciates the clinician's concern about these health and medication matters. In addition, networking with other skilled providers may facilitate critical aspects of the clinician being trusted as an effective healer and being a provider of tangible help. This has also been described as the clinician's "credibility" and "giving" (Sue & Zane, 1987).

Culturally Specific Responses to Mental Health Problems

Many traditional Asians do not accept Western biopsychological explanations of mental illness. A mental health problem may be conceptualized as a manifestation of organic disorders, hereditary weakness, an imbalance between yin and yang, a disturbance of chi energy, supernatural intervention, or emotional exhaustion caused by external environmental factors. In the assessment process, the clinician should encourage the client or family members to openly discuss their cultural and religious perspectives regarding the presenting problem, their past coping styles, their health-seeking behavior, and their treatment expectations. Questions to ask may include the following (Lee, 1990):

- What are the symptoms and problems as perceived by family members?
- What would be the diagnostic label given in the client's home country?
- What are the family's cultural explanations of the causes of the problem?
- What kind of treatment might the family get if they were back in their home country?
- Where did the family go for help before they came to see the clinician?
- What is the family's experience with herbal medicine, indigenous healers, and Asian healing exercises (such as tai chi, chi gong)?
- What were the family's previous experiences with health care and mental health care systems?
- What exposure has the family had to mental health professionals?

- What are the family's treatment expectations?
- What cultural metaphors or proverbs might be used to describe their symptoms or problems (i.e., are there phrases or stories in their root language that capture aspects of the presenting issues)?

Cultural Strengths

Along with assessment of family stresses and pathologies, an assessment is necessary with respect to individual and family strengths in adaptation, coping, and problem solving. Asian families may arrive in the United States with many challenges. But they are also strengthened by very highly developed cultures, religions and philosophies, as well as by powerful narratives of survival. Reintroducing family rituals can give voice to family connectedness across generations (Mock, 1998a). Asian cultures place great importance on hard work, education, family, friends, and others in the ethnic community. During a crisis, Asian families can usually rely on this network of support. The therapist should explore this with the client and encourage him or her to utilize community networks and organizations. Examining the current crisis may open new opportunities for the family.

Culturally Competent and Relevant Treatment Strategies

Traditional Western psychotherapeutic approaches based on the assumptions of individuation, independence, self-disclosure, verbal expression of feelings, and long-term insight-oriented therapy may go counter to Asian American values of interdependence, self-control, repression of most emotions, and short-term result-oriented solutions. A number of family therapists have offered valuable insights on how to respond to Asian Americans' cultural and expressive styles. Kim (1985) recommended an integrated family therapy orientation drawn from Haley's strategic and Minuchin's structural therapies. Ho (1987) suggested that Bowen's intergenerational perspective and Satir's cognitive approach might help teach the family's rules to its members. Paniagua (1994) suggested several effective treatment strategies, such as the therapist exhibiting expertise and authority, maintaining formality and conversational distance, providing concrete and tangible advice, and giving assurance that stress will be reduced as quickly as possible. Sue and Zane (1987) maintain two therapeutic processes to be critical: credibility and gift giving (i.e., seeing that the client receives a benefit early in the treatment process). Not only do clients need to have a strong belief that the therapist has the ability to be helpful throughout, but the adults also need to leave sessions with tangible evidence of hope, improved ability to problem solve, helpful suggestions to try at home, or potential for symptom relief in the foreseeable future. These are considered "gifts," manifested with the help of the therapist. Effective clinical strategies need to incorporate unique Asian cultural values and family characteristics. The following suggestions are divided into three distinct phases: beginning, problem solving, and termination (Ho, 1987).

Beginning Phase: Engaging the Family

Because Asian American clients are usually unfamiliar with family therapy, the clinician needs to pay special attention to the first contacts and beginning phase of therapy in order to avoid premature termination. The following suggestions may help establish rap-

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they found a cruel punishment. They are perhaps the world's greatest poets, using words to buffer experience—poetry and humor somehow make reality more tolerable. They have tended to use words not particularly to tell the truth, but often, rather, to cover it up or embellish it. The Irish have raised poetry, mystification, double meanings, humorous indirection, and ambiguity to an art form, in part, perhaps, because their history of oppression led them to realize that telling the truth could be dangerous (Chapter 43).

- Norwegians may withhold verbal expression out of respect and politeness, which for them involves not openly stating negative feelings they have about other family members. Such a custom may have nothing to do with guilt about "unacceptable" feelings or awkwardness in a therapy context, as it might for the Irish (Chapter 46).
- In Sioux Indian culture, talking is actually proscribed in certain family relationships. A wife does not talk directly to her father-in-law, for example, yet she may experience deep intimacy with him, a relationship that is almost inconceivable in our pragmatic world. The reduced emphasis on verbal expression seems to free Native American families for other kinds of experiences of each other, of nature, and of the spiritual realm (Chapters 2 and 3).

CULTURAL DIFFERENCES IN WHAT IS VIEWED AS A PROBLEM

Concomitantly, groups vary in what they view as problematic behavior. Anglos may be uncomfortable with dependency or emotionality; the Irish are distressed by a family member "making a scene"; Italians, about disloyalty to the family; Greeks, about any insult to their pride or *filotimo*; Jews, about their children not being "successful"; Puerto Ricans, about their children not showing respect; Arabs, about their daughters' virginity. For Chinese families harmony is a key dimension, and for African Americans bearing witness and testifying about their suffering is a central concept.

Of course, cultural groups also vary in how they respond to problems. Anglos see work, reason, and stoicism as the best responses, whereas Jews often consult doctors and therapists to gain understanding and insight. Until recently, the Irish responded to problems by going to the priest for confession, "offering up" their suffering in prayers, or, especially for men, seeking solace through drink. Italians may prefer to rely on family support, eating, and expressing themselves. West Indians may see hard work, thrift, or consulting with their elders as the solution, and Norwegians may prefer fresh air or exercise. Asian Indians may focus on sacrifice or purity, and the Chinese, on food or prayer to their ancestors.

Groups differ as well in attitudes toward seeking help. In general, Italians rely primarily on the family and turn to an outsider only as a last resort. African Americans have long mistrusted the help they can receive from traditional institutions, except the church, the only institution that was "theirs." Puerto Ricans and Chinese may somatize when under stress and seek medical rather than mental health services. Norwegians, too, often convert emotional tensions into physical symptoms, which they consider more acceptable; thus their preference for doctors over psychotherapists. Likewise, Iranians may view medication and vitamins as a necessary part of treating symptoms. And some groups tend to see their problems as the result of their own sin, action, or inadequacy (Irish, African Americans, Norwegians) or someone else's (Greeks, Iranians, Puerto Ricans).

Appendix 3 # F

Listening to Latinas:

Barriers to High School Graduation

August 2009

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Although the staff we interviewed believe that their students do feel safe at school, the students themselves appear to feel differently. At a focus group we conducted at a high school with a strong presence of security officers patrolling the hallways, girls responded with a chorus of "No!" when asked if they felt safe in their school. One participant responded: "No one feels safe at this school." Girls mentioned fights, gang presence, and drugs as some of the things that affected their safety.

B. Disciplinary issues, poor academic performance, and frequent absences increase Latina and Latino dropout rates.

Students who are disciplined for misbehaving at school, students who have poor grades, students who are retained a grade ("held back"), and students who believe their peers see them as troublemakers all have higher odds of dropping out.[55] Latino students are more likely to be suspended or expelled than White students,[56] and to be retained a grade.[57] Although Latinas are not suspended as often as Latinos, they are suspended at a higher rate than White or Asian girls.[58]

A recent study of North Carolina students highlighted the impact of disciplinary issues on dropout risk. The study found that although more boys than girls overall dropped out in that state for disciplinary reasons, more twelfth grade Hispanic females left for disciplinary reasons than any other group of students.[59] And while disciplinary rates for both White and Black girls decreased over time, they increased for Hispanic females. Even though Hispanic females had the lowest rates of leaving school due to discipline among all groups of ninth, tenth, and eleventh grade dropouts, the number of Hispanic females leaving because of disciplinary issues in twelfth grade rose to over 14%, higher than the 11% of Hispanic males who left for the same reason that year.[60]

Responses to our survey also indicated a link between disciplinary and academic problems and dropout. Of the students responding to our written survey who reported they had ever failed a class, been suspended from school, or held back a grade, around one-third had thought of dropping out of school. By contrast, only about one-tenth of the students who reported that they had never experienced such problems in school had considered dropping out.

Our survey also bolstered the finding that high rates of absenteeism are correlated with dropout rates.[61] Of the 51 students who said that they typically had nine or more absences per semester, 30 had considered dropping out (58.8%). In comparison, of the 139 students who reported that they had only one or two absences per semester, nine of those—a much smaller proportion (6.5%)—had considered dropping out of school.

Appendix 3 # G

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Bullying: A Review of the Literature and Implications for Family Therapists

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This article reviews the current literature regarding childhood bullying and the implications for family therapists in the treatment of bullying and victimizing behaviors. The purpose of the following paper is threefold: (a) to review the current literature regarding bullying behavior and its systemic origins through the view of social learning and attachment theories; (b) to investigate the appropriateness and success of family therapy as a treatment model for this issue, focusing specifically on solution-focused and strategic/structural family therapies; and (c) to discuss implications and dire need for more research on the topic of bullying in family therapy.

Bullying among children has become a serious issue in schools today. Bullying is a universal phenomenon that is affecting an extraordinary number of school-aged children in countries from the United States to Japan (Eslea et al., 2003). Even more disturbing is that the number of children being bullied may be greater than what is published, because many kids fail to report bullying for fear of embarrassment, rejection, or retaliation (Unnever & Cornell, 2004). Bullying can have drastic effects on both the bullies and their victims, and these effects appear to have lifelong consequences. Although many researchers have tackled this issue in the past, the majority have labeled bullying as a school-related issue only. Bullying has only recently begun to gain attention from systemic researchers in the 1980s (Olweus, 1993). Bullying is also a family issue, as the family environment has a major impact on the way children view the world, and this includes the development of both violent and victimizing behaviors (Bandura, 1973). Because bullying is a behavior often impacted by family environment, it seems only logical that intervention and prevention of this issue could be successfully

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addressed by family therapy. The purpose of the following paper is threefold: (a) to review the current literature regarding bullying behavior and its systemic origins through the view of social learning and attachment theories; (b) to investigate the appropriateness and success of family therapy as a treatment model for this issue, focusing specifically on solution-focused and strategic/structural family therapies; and (c) to discuss implications and dire need for more research on the topic of bullying in family therapy.

DEFINITION OF BULLYING

Dan Olweus is one of the first researchers to study bullying, and his work provides an important foundation for what is known about bullying to date. Olweus (1993) defined bullying as a behavior that leaves a child "exposed, repeatedly and over time, to negative actions on the part of one or more other students" (p. 9). He further explained a "negative action" as a behavior that "intentionally inflicts, or attempts to afflict, injury or discomfort upon another" (p. 9). A negative action can be carried out verbally, as in threatening, teasing, name calling, or in physical forms such as hitting, kicking, pushing, shoving, and making faces or gestures. These behaviors have been distinguished into two separate types of bullying: *direct bullying* consists of relatively open and physical attacks on a victim, while *indirect bullying* behaviors include social isolation and intentional exclusion from groups. Indirect bullying has also been labeled *relational aggression*, more commonly associated with bullying behaviors in females. Bullying can be carried out by a single individual or a group, and targets of bullying can also include either individuals or groups. Olweus stressed the term bullying should only be used to describe relationships in which there is an imbalance of power, not merely for two students who happen to be fighting. Thus, the three characteristics that must be present to be labeled bullying, according to Olweus (1993), are harmful intent, imbalance of power or strength, and repetition of negative actions.

The definition of bullying is ever-changing, especially with new forms of bullying being identified over the years. Scaglione and Scaglione (2006) suggest that for this generation, bullying does not necessarily involve the three factors described by Olweus (1993). The observations of these researchers suggest that children often bully other children with similar strength and power. They also note that kids who bully may not have the intention of harming another individual, but bully because they think it is fun or funny (Scaglione & Scaglione, 2006). Thus, there are many reasons why children choose to bully other students and it is difficult to pinpoint one specific definition. However, for purposes of the current paper, the definition provided by Olweus (1993) will be used when referring to bullying behaviors due to the extent of his research on this topic.

Hazing is also considered a form of bullying and can lead to participation in dangerous activities. Hazing involves students coercing their classmates into performing dangerous and often humiliating acts in order to fulfill a rite of passage into a group or organization (Thomas, 2006). The most abusive hazing is often inflicted by members of athletic teams, both male and female, and usually consists of making their victims perform mock sexual acts. In a study of over 1100 sixth through twelfth grade athletic students, researchers found that over 17% of the students had been victims of hazing, with no difference found in frequency between girls and boys (Gershel, Katz-Sidlow, Small, & Zandieh, 2003). Although many athletes felt their hazing experience was embarrassing, only 3% considered the hazing dangerous while actually 22% had engaged in potentially dangerous activities. Even more unsettling is that 86% of the students involved in the hazing process believed the hazing had been worth it in order to join the team (Gershel et al., 2003). This finding highlights the potential danger in hazing behaviors and is unsettling because of the large percentage of children who allow themselves to go through hazing in order to join sports teams or other groups, while possibly putting themselves in danger.

In this age of advancing technology, it was only a matter of time before bullying behaviors began to trickle into the world of cyberspace as well. A new form of electronic bullying, called *cyberbullying*, includes bullying through e-mail, instant messaging, chat rooms, web sites, or through messages or images sent to cell phones (Kowalski & Limber, 2007). One important and interesting component to cyberbullying is that many times the victims do not even know the bully's identity (Kowalski & Limber, 2007). Web sites such as myspace.com, facebook.com, and schoolscandals.com make it easier for bullies to place mean or humiliating information about other people on the internet and have it seen by thousands of other students. The consequences of cyberbullying can be even more devastating than other forms because lies and rumors can spread so quickly over the internet and through digital devices (Scaglione & Scaglione, 2006). Online bullying can have consequences for bullying victims at school as well as home, as researchers have found that youth harassed online were more likely to report two or more detentions or suspensions, skipping school, and are eight times more likely than other youth to report carrying a weapon to school in the last 30 days (Ybarra, Diener-West, & Leaf, 2007). The anonymous identities of bullies also leads to complications and possible setbacks in identifying and preventing bullying behaviors among children in present and future technologically savvy generations.

CHARACTERISTICS OF BULLIES

Many studies have found that bullying behaviors are more common among elementary and middle school-aged students, and slowly decrease as teens

progress through high school (Fitzpatrick, Dulin, & Piko, 2007; Peskin et al., 2006). Gender differences are sometimes found in that physical bullying and some types of verbal bullying are more likely to be carried out by males, while indirect forms such as exclusion and spreading rumors are more likely to be carried out by females (Peskin et al., 2006). Besag (2006) suggested the relational aggression shown primarily in females may be the result of their earlier intellectual development compared with males, or as a result of their socialization, in which they have different views of friendships and interests than males. Although relational aggression does not hurt children physically, the emotional toll of indirect bullying can have the same negative effects on females, maybe even more so than physical bullying, because relational aggression is often not as easily or quickly identified by either adults or victims (Besag, 2006).

Several risk factors for bullying have been found, which include hyperactivity (Gianluca, 2008), involvement in gangs, bringing weapons to school, fighting at school, and cutting class or getting suspended (Fitzpatrick, Dulin, & Piko, 2007). Bullying is also positively associated with middle school-aged children, male gender, tobacco smoking, lower self-esteem, and family teasing about appearance (Jankauskiene et al., 2008).

Over his many years of research, Olweus has developed a psychological profile of bullies. Olweus (1978) has found that bullies typically have an average to high self-esteem, are often characterized by impulsivity and the need to dominate others, have a more positive attitude toward violence, have more physical strength than their victims (in males), and are often more popular than the classmates they choose to bully. The primary characteristic of bullies is the use of an aggressive reaction pattern to cope with everyday situations (Olweus, 1978). Awareness of these characteristics can help professionals and parents identify bullying behaviors in children so that they may intervene with interventions like family therapy.

This tendency to react in an aggressive manner has also been found by other researchers, who say that bullies tend to use more destructive than constructive strategies to deal with problems than their non-aggressive peers (Stevens et al., 2002). Destructive strategies consist of reacting aggressively and getting angry, while constructive strategies include acting assertively and seeking help (Stevens et al., 2002). Although Olweus suggests that bullies have an average self-esteem, Connolly and O'Moore (2003) found that bullies exhibit greater emotional inhibition and attribute more negative statements to themselves than their non-bullying classmates. Bullies were also found to score higher on extraversion, psychoticism, and neuroticism scales of personality tests (Connolly & O'Moore, 2003). This finding highlights an important link between bullying behaviors and personality development.

Some students participate in bullying behaviors but do not necessarily take the initiative. Olweus (1993) calls these students *passive bullies*, *followers*, or *henchmen*. Although the leader of the bullying group is likely to have

a healthy self-esteem, a group of bullies could include anxious and insecure individuals (Olweus, 1993). These children serve as enablers and only help to feed the bully's need for respect, power, and popularity (Scaglione & Scaglione, 2006).

CHARACTERISTICS OF VICTIMS

As a disclaimer to this section of the literature, it is important to note that many therapists and psychologists prefer to use the term "survivor" instead of "victim" as a way to empower the individual dealing with victimizing situations. Although the term "survivor" is much more positive and encouraging, the term "victim" will be used throughout this review because it is the term used across the bullying literature.

Family scientists have also found several characteristics that are common among bullying victims. Olweus suggests that *passive victims* are usually more anxious, insecure, cautious, and quiet than other students. Victims are more likely to react by crying or withdrawal when they are attacked by another student. Victims sometimes suffer from low self-esteem and think of themselves as failures, which makes them feel stupid, ashamed, and unattractive (Olweus, 1993). In a study of 1162 students, children who appeared unhappy and children with low self-esteem prior to being bullied were victims three times more than other children (Janauskiene et al., 2008). Boys who are bullied are usually physically weaker and more vulnerable than the bully, and are often rejected by the class (Veenstra et al., 2007). Males may have "body anxiety," in which they are afraid of getting hurt, and are often poor at sports and have poor physical coordination (Olweus, 1993). Weight issues may also have to do with victimization, as obese students are twice as likely to be bullied as their average-sized peers (Jankauskiene et al., 2008). Victims also appear to be lonely at school and although they may have acquaintances, they have been described as follows: they usually do not have any close friends, relate better to adults than peers, and have a hard time asserting themselves in groups (Olweus, 1993). Overall, the passive victim is characterized by anxious or submissive reaction patterns and somehow seems to signal to other students they are insecure individuals who will not fight back if attacked.

Scaglione and Scaglione (2006) suggested several red flag behaviors that can indicate a child is being bullied at school. These include: a loss of interest in school, drop in grades, development of excuses to avoid school, or a child who becomes quieter at home and withdraws from family interactions, seems more emotional than usual, loses appetite or has difficulty sleeping, comes home from school with bruises or torn clothing, has little interaction with friends at school, does not eat lunch at school, and seems to be developing social and behavioral problems.

CHARACTERISTICS OF BULLY/VICTIMS

Family scientists have also found a less common type of victim referred to as *provocative victim*. Olweus (1978) found that provocative victims were characterized by both anxious and aggressive reaction patterns. Provocative victims are also sometimes characterized by symptoms frequently associated with ADHD like hyperactivity and conduct problems (Gianluca, 2008). These students have problems controlling their excessive energy and cause irritation and tension with their annoying behaviors in class (Olweus, 1993). These students are often the targets of many of their classmates, sometimes the entire class, because of their disruptive behaviors in the classroom. Many researchers have called these students *bully/victims* because they often act out both bully and victim behaviors. In fact, aggressive victims and pure bullies do not differ in how frequently they bully other kids (Unnever, 2005). The socialization of bully/victims most closely resembles pure bullies than pure victims, and surprisingly, they are more likely than pure bullies to use physical aggression (Unnever, 2005) and have low self-esteem (Scaglione & Scaglione, 2006). This may be because aggressive bullies are more likely to be physically bullied than are pure victims (Unnever, 2005). The difference between bully/victims and pure bullies is that bully/victims are motivated by their experiences of being victimized and are not acting out to gain respect or power, but are acting out of anger or the desire for revenge (Scaglione & Scaglione, 2006). This finding highlights the importance of environment in the development of bully/victims, as bully/victims might not engage in aggressive and anxious behavior patterns if they were not first bullied themselves. Adolescent bully/victims have also demonstrated a greater internalizing of problems, peer relational problems, and report a higher level of normative beliefs legitimizing antisocial behavior than pure bullies (Marini et al., 2001). They were found to score higher on emotional loneliness than other types of bullies (Ireland & Power, 2004). Emotional loneliness, or the lack of intimacy in personal relationships, is considered by some the most severe from of loneliness and can result in an increase of aggression (Ireland & Power, 2004). Research also shows that bully/victims report more negative affect and more use of destructive coping strategies, such as acting aggressively or angrily, than do pure victims or uninvolved children (Stevens et al., 2002). Bully/victims are often at the extreme ends of the spectrum, either having more aggressive tendencies than pure bullies or in some cases having more negative affect than pure victims.

EFFECTS OF BULLYING

The effects of bullying can be both short and long term for victims. As a result of being repeatedly bullied at school, victims can often feel ashamed,

depressed, embarrassed, insecure, and can develop low self-esteem and school phobia (Scaglione & Scaglione, 2006). Victims of bullying constantly worry about going to school, and the thought of being attacked again can produce psychosomatic symptoms like headaches or stomachaches as a result of prolonged stress and anxiety. Long-term effects of bullying can include future violence, as children may get so fed up with being bullied that they one day explode and hurt someone, as well as severe depression and anxiety disorders that may continue into adulthood (Scaglione & Scaglione, 2006). More serious psychological effects can include social phobia as an adult (McCabe, Antony, Summerfeldt, Liss, & Swinson, 2003), depression, anxiety, fear of negative evaluation (Roth, Coles, & Heimberg, 2002; Storch et al., 2004), and loneliness (Storch et al., 2004). Bullying and sexual harassment have also been found to have serious effects, specifically for middle and high school-aged girls. One study found that girls often experience indirect bullying such as ridicule and intimidation, and sexual harassment, which included touching inappropriately, writing sexual remarks where others can view it, or pressure to go on dates. Although middle school-aged girls seem to be affected more than their high school counterparts, both ages of girls experienced a decrease in self-esteem, mental and physical health, and life satisfaction, and an increase in substance abuse (Gruber & Fineran, 2007).

Bullying also has an effect on the bullies themselves, such as short-term effects that include poor school performance, use of drugs or alcohol, and perhaps involvement with gangs. As mentioned earlier (Olweus, 1993), despite previous stereotypes of bullies, research has found bullies are often popular and well liked at school. Although this may be true, bullies tend to lack close, long-term relationships with friends (Scaglione & Scaglione, 2006). This can lead to feelings of loneliness, anger, or rejection over time. One serious long-term effect of habitual bullying is that it can lead to criminal behaviors. Bullying is considered a stepping stone for criminal behaviors, as behaviors may continuously get worse or more severe if children learn that bullying is a way to get what they want or need (Scaglione & Scaglione, 2006). However, bullies are not doomed to bully all of their life as long as their behavior is intervened at an early age (Scaglione & Scaglione, 2006). Interventions usually include identifying bullying behaviors and teaching bullies new ways to interact with others or cope with negative feelings (Scaglione & Scaglione, 2006).

FAMILY ENVIRONMENT

Family environment can undoubtedly affect a child's behavior and outlook on life. Research indicates several family environment factors are positively associated with bullying behaviors, which include parental physical discipline, a lack of adult supervision, neighborhood safety concerns, and a lack

of positive adult role models (Espelage, Bosworth, & Simon, 2000). Marini et al. (2006) also found lack of adult supervision to be positively associated with bullies, yet only for males. Janauskiene and fellow researchers (2008) found that teasing about appearance was positively related to bullying behaviors. Interestingly, the one factor of teasing about appearance had two outcomes, as this behavior led to children becoming victims in some cases and bullies in others. Children who were teased about their appearance by their family were more likely to be victims, while those teased by teachers were more likely to be in the bully category. Research also suggests that parental discord can affect children's self-concept because children internalize both positive and negative aspects of parental behavior and this internalization affects future behavior (Christie-Mizell, 2003). Marital discord or negative parental behavior can have direct effects on children's future behaviors.

Olweus (1993) found several factors in the family environment of male bullies that can increase the chances of developing an aggressive reaction pattern, the behavior pattern that characterizes bullies. First, children with parents who lack warmth and are uninvolved are at an increased risk of becoming aggressive and hostile later in life. Low parental involvement was also found to be a risk factor in bullying adolescents, both male and female; father involvement can protect against bullying behaviors when there is low mother involvement, further demonstrating the importance of father-child relationships (Flouri & Buchanan, 2003). Parents who are permissive and allow the child to act out aggressively increase the chances of the child becoming a bully (Olweus, 1993). A child without limits can learn that aggressive behaviors are tolerated and will continue to use this as a method to relate to others, both other students and adults. A parent does not necessarily have to be mean, abusive, or cold (as some have previously thought) to produce a child who bullies. However, parents who use physical discipline may teach children that violence is a way to get others to obey your demands and increases the risk of bullying behaviors (Espelage, Bosworth, & Simon, 2000). This use of "power-assertive" child-rearing methods such as physical punishment and violent outbursts may raise a child's level of aggression and reinforce the familiar saying, "violence begets violence" (Olweus, 1993, p. 40).

Research that deals specifically with the family environment indicates that bullies demonstrate a more ambivalent relationship toward their siblings and parents (Connolly & O'Moore, 2003) and perceive less cohesion, expressiveness, organization, control, and social orientation, and more conflict within the family as compared to other children (Stevens et al., 2002). High school students in Rigby's study (1994) who reported low levels of emotional support were more likely to be bullies, while those who reported their family lacked positive effective communication tended to be bully/victims.

On the other hand, some research exists on the family environment of victims (Bowers et al., 1994; Olweus, 1993). Research indicates victims

usually come from a family in which the parents shelter the child and are overprotective. A study on family environments of bullying victims indicated that victims often perceive their families as enmeshed (Bowers et al., 1994). These parents may avoid conflict with their child and the child is never given the chance to learn positive conflict resolution skills. Olweus (1993) suggests that being overprotective of a child can be both the cause and the consequence of bullying.

Although most people are quick to believe that bullies come from broken homes and unhappy families, some bullies come from loving, accepting, and nurturing family environments (Ball et al., 2008). In the same token, not all victims come from overprotective families. Where do bullying and victimizing behaviors come from in this situation? Why are children acting in such a way that goes against how they are raised and from the environment in which they live? If it is not the environment, could it be genetics? Temperament is thought to be an in-born personality characteristic that affects one's ability to react to certain situations. Temperament could be an individual risk factor for developing an aggressive reaction pattern commonly found in bullies (Olweus, 1993). This suggests that a child who is naturally hot-headed and short-tempered may be more likely to use violence as a way of solving problems if they are not taught otherwise by their parents and teachers. Ball and his colleagues (2008) have also found a genetic component to both bullying and victimizing behaviors. The study included data from almost 1200 sets of twins, and indicated that genetic factors accounted for 73 percent of the variation in victims and 61 percent of the variation in bullies, with the remainder explained by environmental factors (Ball et al., 2008). This ground-breaking research provides an enlightening view on the development of bullying behaviors and its relationship to family environment.

ETIOLOGY FROM A SYSTEMS PERSPECTIVE

Determining the motives behind bullying involves relying on theoretical models to explain the etiology and purpose of aggressive behaviors. Theory should also be used as a foundation for the development of prevention and intervention programs. Orpinas and Horne (2006) suggest that bullying prevention programs have not been successful to date and there has been little advancement in the field thus far because of three reasons: explicit theories have not been used to develop or select prevention programs, key constructs of theories are not being used to develop program evaluations, and the programs being selected do not match the theoretical explanation of the problem. According to these authors, including a theoretical base to prevention programs is essential to the advancement of the bullying research field.

Several theories have been used to explain this phenomenon, including attribution theories, social information-processing theories, ecological theory, and social interactional models (Orpinas & Horne, 2006). However, for the purpose of the current paper, only two theories will be highlighted: social learning theory and attachment theory. The majority of the literature relies on Bandura's social learning theory to explain bullying behaviors. Social learning theory is important for family therapists to be aware of because it presents a systemic view of bullying. This theory suggests that the environment, such as family, school, and peer groups, has a strong impact on the development and maintenance of behavior. However, attachment theory has also been used to describe bullying behavior (Ireland & Power, 2004), as well as other forms of child aggression such as sibling violence (Ayoub, Fischer, & O'Connor, 2003) and courtship aggression (Mayseless, 1991). Attachment theory is also systemic in its view that the establishment of healthy relationships as an infant affects the way one interacts and reacts to others (Bowlby, 1988). Although it is not as popular as social learning theory, attachment theory can be used to explain bullying behaviors in some instances. More research is needed to determine the theory's ability to accurately describe bullying behavior specifically and in its entirety, rather than the topic of child violence in general.

Social Learning Theory

The most popular systemic theory related to the etiology of bullying behaviors is social learning theory. Bandura (1977) described social learning theory as "a continuous reciprocal interaction between cognitive, behavioral, and environmental determinants" (p. 7). Social learning theory posits that children learn behaviors from their environment and the behaviors can then be reinforced in different ways (Bandura, 1977). Once a child learns negative behaviors and finds that he/she can reap rewards from the behavior, the child will continue to choose to act in these negative ways as long as there are foreseen benefits. Social learning theory is important in regards to bullying behaviors because it highlights the family interactions that sustain aggression in children. Witnessing violence between parents, the use of physical punishment, and inconsistent models of punitive discipline provide models of violence for children (Gwartney-Gibbs, Stockard, & Bohmer, 1987). Children, who observe and later imitate violence, not only learn that violence is accepted, but also learn specific rationales and motivations for using violence. Aggression is learned from observing and imitating role models, especially people with whom the learner has close and frequent contact with and who accepts and reinforces aggression (Bandura, 1973). Children can also learn violence from outside sources such as peers, television, and other media, and they are able to learn aggression both directly and indirectly (Mihalic &

Appendix 3 # H

Virginia sees the goal of her work as one of helping people and families to gain a sense of their wholeness, wholeness being the fundamental characteristic of the universe. According to Gen. Jan Smuts (once prime minister of South Africa), who reintroduced holism into Western thinking, "This is a whole-making universe; it is the fundamental character of the universe to be active in the production of wholes, of ever more complete and advanced wholes," human personality being the consummation of this forward movement. All human beings strive toward holism or completion of themselves, although blockages can occur. The therapist's task is to help clients remove the blocks and barriers to this achievement.

Virginia believes in the Freudian adage that love and work are essential characteristics of the mentally healthy person. The ability to give and receive love is as important to the soul as inhaling and exhaling air is to the body. As to work, it represents an important source for one's feeling of self-worth. In addition, a mentally healthy person strives for a balance between physical, mental, emotional, and spiritual development and has a positive self-image. Such a person is willing to take risks leading to new possibilities, even if they are totally unfamiliar; does not seek to preserve the status quo; and is constantly engaged in a process of sorting out and letting go of what no longer fits, while adding new things that may fit. Such a person is willing to live with some ambiguity and tries to be nothing other than himself. Such a person is able to practice what Virginia has articulated as the Five Freedoms:

- "To see and hear what is here, instead of what should be, was, or will be.

- To say what one feels and thinks instead of what one should.
- To feel what one feels, instead of what one ought.
- To ask for what one wants, instead of always waiting for permission.
- To take risks in one's own behalf, instead of choosing to be only 'secure' and not rocking the boat."

How Individuals Grow and Develop

Three different types of factors influence the development of human beings. First are the unchangeable genetic endowments that determine an individual's physical, intellectual, emotional, and temperamental potential. This aspect will not be elaborated here. Second are longitudinal influences, which are the result of all the learning an individual acquires. Third are the constant interactions of body and mind.

Longitudinal Influences

At any moment, an individual's thoughts, feelings, and behaviors are determined by longitudinal influences: the sum of his learning experiences since birth. Although an individual is exposed to many different important types of learnings, the subsequent discussion focuses on those learnings that have to do with the development of self-identity and personhood.

A child enters the world in a situation of great inequality with those around him. At birth, he is completely helpless. His survival depends on the experiences, instructions, and behavior of his caretakers, usually his parents. Any adult, therefore, regardless of how de-

prived he feels his early childhood was, received some care as an infant, or he would not have survived. In addition to providing the food and love needed for his physical and emotional survival, his parents are also responsible for all the early learnings and images he forms about the world. The child learns from what he sees, hears, and understands. He develops an understanding of the world through his senses.

Since the nature of humans is to make sense of the world, the child makes up what he does not understand. Later, the conscious and unconscious memories of childhood become an interesting blend of truth and illusion. To the extent that communication is dysfunctional in a family, the child distorts information in his making-sense process. Later in life, this may affect his coping ability.

The first important consideration is that the foundations for adulthood, as well as the seeds for coping deficiencies, are formed in the family. Virginia views the experience of the primary triad (father, mother, and child) as the essential source of identity of the "self." On the basis of his learning experience in the primary triad, the child determines how he fits into the world and how much trust he can put in his relationships with other people. For instance, a child who in his first months of life experienced many feelings of abandonment is likely to have a difficult time forming close, intimate relationships with others unless new learnings can replace the early experiences. It is also in the primary triad that early in life the child develops coping mechanisms to deal with stress. Most stress patterns that individuals ex- ce in their adult lives have their origin in the cra-

The primary triad also teaches the child about discrepancies in communication—inconsistencies between what he observes and what he is told, or between what he feels and hears—and where he first needs to interpret incongruent messages. The following example illustrates this point. The child, seeing his mother frown, asks, "What is wrong?" The mother, who has a rule that says "I must always be happy," responds, "Nothing, I am feeling just fine." Then she turns her back, probably in an effort to conceal from her child the intolerable conflict between what she feels she should be and what she is. The child may come up with many interpretations of the observed discrepancy, including the possibility that he may have some responsibility for his mother's unhappiness. Most parents are not aware of their incongruent messages. Some think they should shield their children from negative messages for fear that they might hurt them. Actually, negative messages, even if they are straight messages of rejection of the child, are less detrimental to the child's mental health than the mixed messages he is unable to figure out. Most of what children learn, and all they learn in the first months of life, is learned not from words but from voice tone, touch, and looks.

Another characteristic of the triad is that one person may feel excluded in certain situations. Indeed, most meaningful communications in the primary triad take place between two people at a time: mother–father, mother–child, or father–child. If the child feels excluded from interactions in the primary triad, perceives this exclusion as a rejection, and develops lo- self-worth as a result, he is setting himself up for a life rustrations.

triadic interaction, the two other members of the tri have something better going. A child who feels that h is usually excluded from interactions in the prima triad may easily develop feelings of low self-worth. mother or father with low self-esteem could come to th same conclusion, but we are emphasizing the child sinc our focus here is on the development into adulthood.

The primary triad, then, is the first place where chil dren learn about inclusion and exclusion and their plac in the world. Unless modified by subsequent differen learning experiences, these learnings will shape thei personality.

By being part of a triad, the child also develops a sense of his own power. He may learn about manipula tion as he becomes part of a potential coalition with either parent against the other. This process may mani fest itself in early infancy, as in the case of a mother who feels that her husband is not handling the child properly. Although he is not aware of it at first, this gives the infant the power to affect the relationship between his parents, as his mother withdraws from the conjugal dyad to occupy herself in the relationship with her baby. Later on, such a child will learn how to use his power effectively to form a coalition with either parent, based on what seems for him a more advantageous outcome.

Virginia often uses the example of thumb sucking to illustrate the complexity of the interactions concerning one simple behavior and to show how the child may be affected by it.

Many small children enjoy sucking their thumbs. Let us pretend that the owner of this thumb is a child with

mother who has no objection to seeing her chil k his thumb and enjoys his contentment about it, so that

ation of his mother. This obviously will be a reinforcement for him. But the father says to himself, "Oh my God, the child is going to have terrible teeth." Right away, he feels he has got to get the thumb out of the child's mouth. So when the child is around his mother he feels reinforced, and when he is around his father he realizes that he should not suck his thumb. So far, no real conflict exists for the child. Children recognize early that different sets of expectations come from different people. The problem arises when the child sucks his thumb in the presence of both parents. Several scenarios are then possible, which will affect the picture of the world that the child develops.

The first scenario could be as follows. When the child sucks his thumb in front of both parents, the parents have agreed not to disagree because they are afraid they would hurt each other by disagreeing. So the issue of the thumb does not come up at all.

Another scenario is that the father looks at the child, sees the thumb, and tells the mother to do something about it. Now the thumb does something else: it can cause a fight if the mother asks why he doesn't do it himself. It sounds very much like father and mother are talking about the thumb, but they are actually talking about who has the right to tell whom what to do. At that moment, the parents can turn to the child and say, "You get us into trouble." This gives their son the awesome power to create considerable negativity between them.

In the third outcome possible, the triad operates with positive effect. The husband might share with his wife his concern that thumb sucking would lead to a lot of orthodontic work. His wife might answer that she was not aware of this and that she appreci ne comfor

and wife would be looking at other ways in which they could provide comfort or limit the thumb sucking. The point here is that the child would never be accused of interfering with his parents' relationship because of his thumb. In other words, the child does not get blamed. This situation also teaches the child that it is possible for people to build with one another instead of using their differences as weapons.

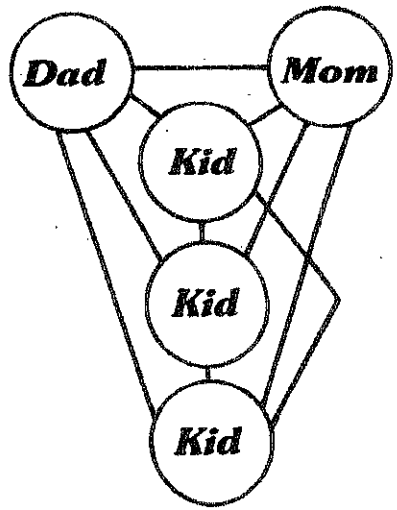
One additional point should be made here about triads. As one reviews the literature, one finds that the triad is frequently presented with negative connotations. This is evident in the title of Caplow's book, *Two Against One,* which implies confrontation, and in the writings of Bowen, who views the family of three as an interlocking and fluid system of dyadic coalitions that isolate the third individual at any given moment.

Indeed, the forces of the triad are powerful and often are in the hands of people struggling with the problems of their own survival and self-esteem. As a result, the outcome often appears negative. On the other hand, a triadic situation can be a source of strong support when three people agree to put their resources together and create a "basket" of possibilities from which they can draw as needed. In healthy families where self-esteem ranks high, the forces of cooperation are stronger than any temporary coalitions.

Most individuals and families who come into therapy do not function effectively in triadic relationships. One of the purposes of therapy is to restore the individual's ability to function effectively in a triadic setting. Parents need to realize the importance of good triadic relationships within their families. This certainly does not mean t agreement between parents (which is impossil unless one parent completely gives up his autonomy

which would bring about an entirely new set of problems), but that parents need to find an effective way to handle their differences. In the thumb-sucking example, it was the incongruency of the parents when they were together that created a problem, not the fact that they had different opinions about thumb sucking. In other words, the specific content of an experience does not generally have a bad effect, but the subliminal messages around the experience may.

We have dealt with the most simple expression of triadic life within the family by discussing a family in which there is only one child. As additional children are born the complexity of triadic formations increases geometrically, and so does the complexity of family interactions. The accompanying illustration shows how a family of more than three is made of sets of interlocking triangles (Bowen, 1972; and Caplow, 1968) that form what Virginia calls a can of worms.



Appendix 3 : 1

The Economic, Social, Civic and Fiscal Consequences of Dropping Out of High School: Findings for Connecticut Adults in the 21st Century

Andrew Sum
Center for Labor Market Studies
Northeastern University

Prepared for:
Governor's Summit on Dropout Prevention
October 19, 2009

"This report was commissioned by Our Piece of the Pie® and Capital Workforce Partners with additional funding support from the Nellie Mae Education Foundation and the Connecticut Office of Workforce Competitiveness."

The Economic, Social, Civic and Fiscal Consequences of Dropping Out of High School in Connecticut

- The economic, civic and social case for addressing high school dropout problems in Connecticut (a need for both prevention and recovery efforts)
- The labor market difficulties of teen and young adult (20-34 year old) dropouts in Connecticut; declining lifetime earnings and income prospects of 18-64 year old dropouts
- The key social consequences of dropping out of high school in Connecticut: declining marriage rates, increasing out-of-wedlock childbearing, high income inadequacy problems of children, lower rates of ownership, less civic engagement and volunteering, poor health, higher rates of incarceration in jails and prisons → to jail + Red jail cost
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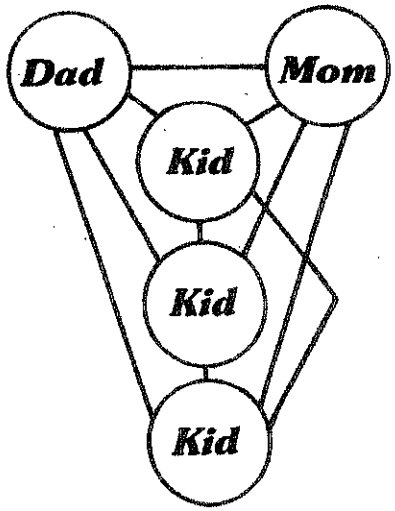

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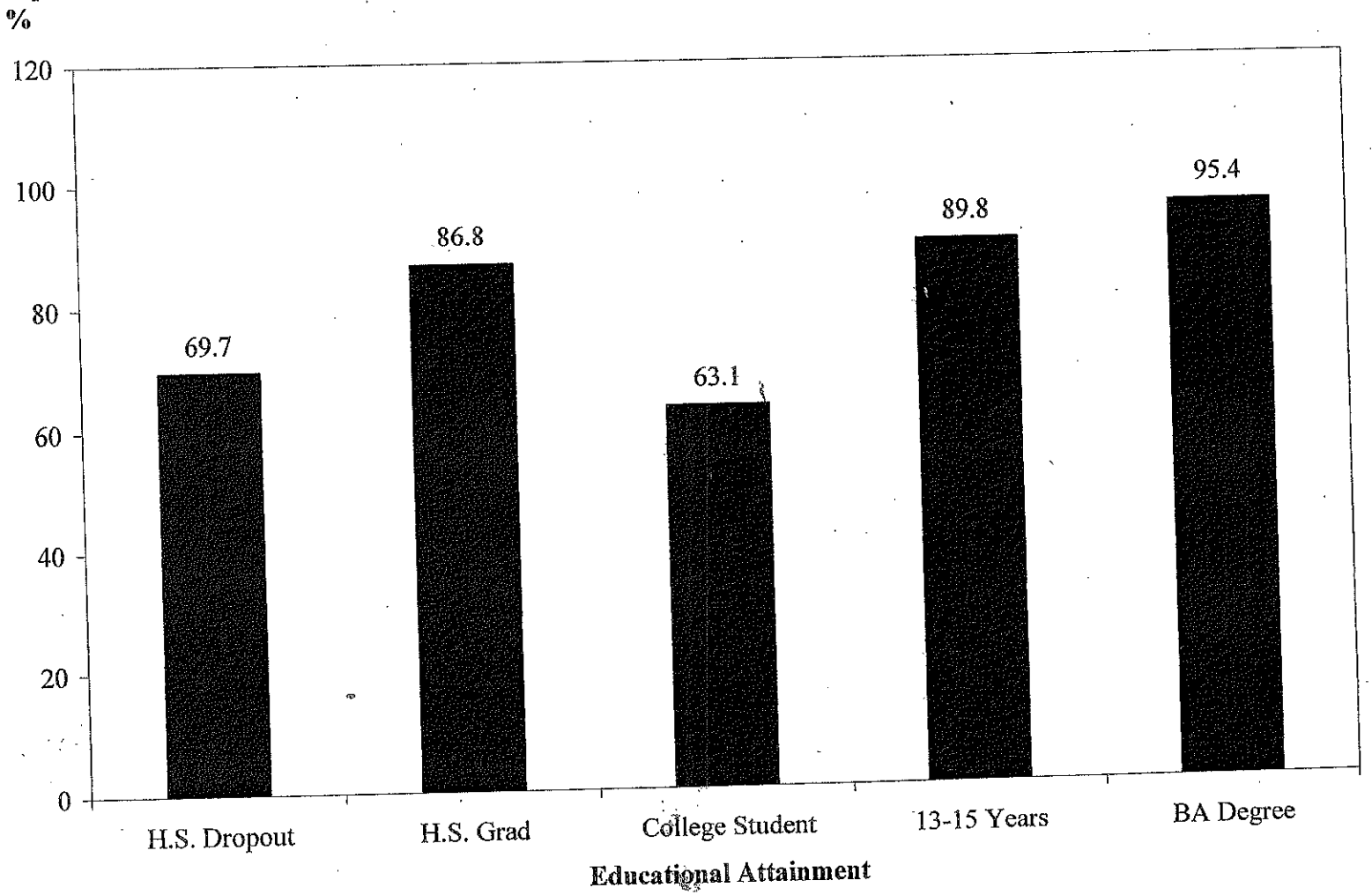
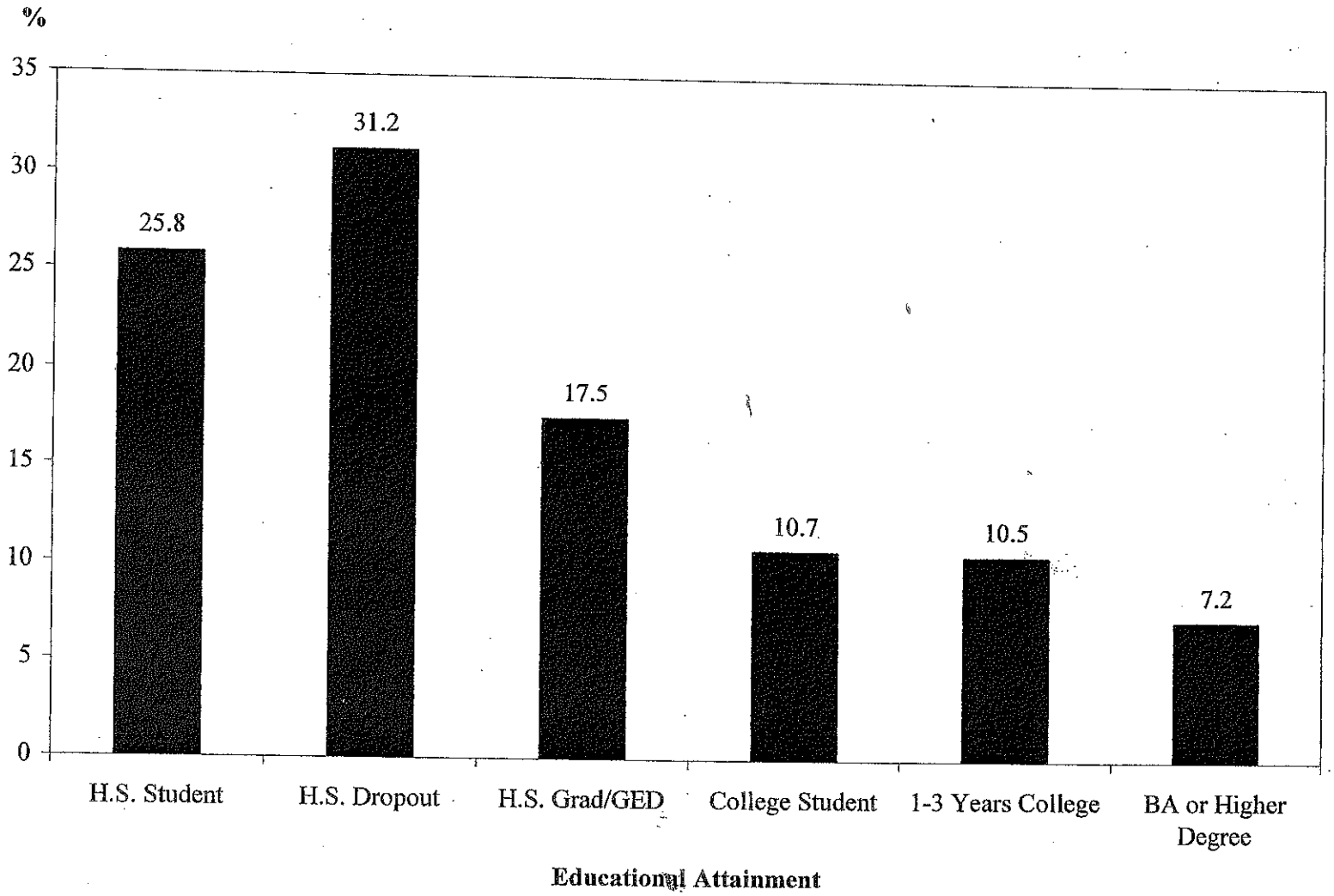
The Labor Market Experiences and Earnings Outcomes of Connecticut Adults (16-64) by Educational Attainment

- The civilian labor force participation behavior and unemployment rates of 16-24 year olds in Connecticut by educational attainment
- The employment rates of 16-24 year olds in Connecticut and the U.S. by educational attainment
- The mean annual hours of work and annual earnings of teens and young adults in Connecticut; large earnings gaps by level of educational attainment
- Trends in lifetime earnings of 18-64 year old men and women in Connecticut by educational attainment
- Differences in the mean expected lifetime earnings of male and female high school dropouts and graduates in Connecticut, 2005-2007
- Mean lifetime years in a poverty/near poverty and low income status among Connecticut men and women by educational attainment, 2005-2007

Civilian Labor Force Participation Rates of 16-24 Year Olds in Connecticut by Educational Attainment, 2005-2007 Averages (in %)



Unemployment Rates of 16-24 Year Olds in Connecticut by Educational Attainment/School Enrollment Status, Both Genders Combined, 2005-2007 Averages (in %)



Appendix #4 A

Connecticut State Department of Education — Division of Assessment, Research and Technology

DATA BULLETIN

Bureau of Data Collection, Research and Evaluation — November 2009

High School Dropout Rates in Connecticut

Dropout Definition

All states are required to use the U.S. Department of Education National Center for Education Statistics (NCES) definition of "dropout" and send these statistics to the federal government in the Common Core of Data (CCD) collection, EDEN and EdFacts Reporting System. The NCES definition of a school dropout is an individual who:

was enrolled in school at some time during the previous school year;
was not enrolled at the beginning of the current school year;
has not graduated from high school or completed a state- or district-approved educational program; and
did not meet any of the following exclusionary conditions - transfer to another public school district, private school, or state- or district-approved educational program, or absence due to suspension, illness or death.

A state- or district-approved educational program may include special education programs, home-based instruction and school-sponsored alternative secondary education programs. If a student completed an approved high school credit-earning program and completed all equivalent high school required courses and/or graduated before the next school year as of October 1, he or she is not a dropout. However, a student who dropped out of school and passed a General Educational Development (GED) test is considered a dropout unless there is a State policy of accepting a GED diploma as a high school diploma. Currently, Connecticut does not have such a policy.

The four categories of dropouts include:

students 16 years of age or older who notified the school, officially dropping out of school with parent signature, or students 18 years of age or older who notified the school officially without parent consent, or students who dropped out without notifying the school;
students who leave school and do not return but for whom no transfer information to another regular private or public secondary school is available;
students who are on a class roster from School A to attend School B but never reported to that school, and for whom no transfer information to another regular secondary program is available; and
students who leave school to enroll in a training program which is a non-high school credit earning program, including GED classes.

Data Collection Methodology

Local public school districts report dropout data to the State Department of Education by submitting individual student data through the Registration Module of the Public School Information System (PSIS).

The Registration Module is open all year. It only closes on a very limited basis when maintenance is necessary.

Students who are unregistered with the following exit codes are considered dropouts:

Code 21 – Discontinued schooling;
Code 23 – Transfer to General Educational Development (GED)/External Diploma Program (EDP);
Code 24 – Transfer to a postsecondary education; and
Code 25 – Moved, not known to be continuing.

The official dropout period begins the summer before the beginning of a new school year and includes the school year, e.g., July 1, 2007, through June 30, 2008. Establishing July 1 as the start date for dropout identification ensures that all students are accounted for in the fall count and those dropouts are reported in the appropriate grade. For example, if a student finishes Grade 10 over the summer and does not return in the fall for the new school year, the student is a Grade 11 dropout. If the same student does not finish Grade 10 and does not return to school in the fall, the student is a Grade 10 dropout.

Calculation of the Annual and Cumulative High School Dropout Rates

Annual Dropout Rate (total dropouts ÷ total October 1 enrollment of Grades 9-12) Percent

The annual dropout rate is calculated based on the formula used by the NCES. The October 1 enrollment data used in the denominator for this formula are drawn from the PSIS and include students in Grades 9-12 enrolled in high school or a self-contained, high-school level program. The annual dropout rate denominator does not include those students entering and transferring out of school after October 1.

Cumulative Dropout Rate (total dropouts of the class ÷ Grade 9 October 1 freshman enrollment of the class) Percent

The cumulative dropout rate is calculated based on the formula researched and recommended, and mandated by the NCES in the past. The cumulative dropout rate is a class rate that reflects the proportion of students within a high school class who dropped out of school *across four consecutive years.* For example, the graduating class of 2008 cumulative dropout rate = percent of (2004-05 Grade 9 dropouts + 2005-06 Grade 10 dropouts + 2006-07 Grade 11 dropouts + 2007-08 Grade 12 dropouts) ÷ Grade 9 enrollment as reported on October 1, 2004.

Highlights of the 2007-08 Connecticut Annual Dropout Rate

The annual dropout rate has ranged from 1.7 to 2.5 percent over seven years, 2001-02 through 2007-08 (see Table 1 and Appendix A).
Among the annual dropout rates for all grades from 2003-04 to 2007-08, Grade 11 had the largest percentage; e.g., 2.0 percent for Grade 9, 2.4 percent for Grade 10, 2.7 percent for Grade 11 and 2.4 percent for Grade 12 in 2007-08. (see Table 2).
The annual dropout rate for females (1.7 percent) was lower than the annual dropout rate for males (3.3 percent) in 2007-08.
The female dropout rate has been consistently lower than the male dropout rate since 2001-02 (see Table 3).
In 2007-08, the annual dropout rates by student race/ethnicity include: 1.4 percent for Asian American students, 2.1 percent for American Indian students, 4.7 percent for black students, 5.3 percent for Hispanic students and 1.4 percent for white students (see Table 4). and
The dropout rates for white and Asian American students were lower than the rates of the other racial/ethnic categories (see Table 4).

Statewide Annual Dropout Rates for Seven Years: 2001-02 through 2007-08. Table 1 displays the statewide annual dropout rates for this period of time.

The state's average annual dropout rate has ranged from a low of 1.7 in 2004-05 to a high of 2.5 percent in 2007-08. The total number of high school dropouts has increased from 3,382 in 2006-07 to 4,404 in 2007-08, while the total number of high school students enrolled has increased slightly from 178,427 in 2006-07 to 178,564 in 2007-08.

Table 1: Statewide Annual Dropout Rates across Grades 9-12: 2001-02 through 2007-08

	2001-02	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08
Dropouts	3,891	3,473	3,196	3,021	3,221	3,382	4,404
Enrollment	158,996	162,463	164,921	174,356	176,766	178,427	178,564
Statewide %	2.4	2.1	1.8	1.7	1.8	1.9	2.5

Statewide Annual Dropout Rates by Grade: 2001-02 through 2007-08. In Table 2, in the most recent year 2007-08, the annual dropout rate has increased in all four grades, as well as statewide. Generally, the Grade 11 dropout rate is the highest rate among the four high school grades.

Table 2: Statewide Annual Dropout Rates by Grade: 2001-02 through 2007-08

	2001-02	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08
Grade 9	2.3	1.8	1.4	1.3	1.7	1.7	2.0
Grade 10	2.5	2.6	1.7	1.7	1.7	1.9	2.4
Grade 11	2.9	2.4	2.1	2.1	2.1	2.2	2.7
Grade 12	2.7	2.1	1.9	1.8	1.7	1.7	2.4
Statewide	2.4	2.1	1.8	1.7	1.8	1.9	2.5

Statewide Annual Dropout Rates by Gender for Seven Years: 2001-02 through 2007-08. Table 3 illustrates that from 2001-02 to 2007-08, the female dropout rates have remained consistently lower than the male dropout rates. The male dropout rate had decreased since 2001-02, but has now increased to 3.3 percent in the 2007-08 school year.

Table 3: Statewide Annual Dropout Rate by Gender: 2001-02 through 2007-08

	2001-02	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08
Female	2.1	1.8	1.6	1.4	1.5	1.6	1.7
Male	2.9	2.5	2.1	2.0	2.1	2.1	3.3
Statewide	2.4	2.1	1.8	1.7	1.8	1.9	2.5

Statewide Annual Dropout Rates by Race: 2001-02 through 2007-08. Table 4 indicates that the dropout rate for American Indian students has been inconsistent from one year to another, which may be due to the very small size of the American Indian student population in Connecticut. The dropout rates for white, Asian, Hispanic and black students have increased from several of the previous years. The average annual dropout rate for Hispanic students has been the highest among all racial/ethnic groups in all seven years.

Table 4: Statewide Annual Dropout Rates by Race: 2001-02 through 2007-08

	2001-02	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08
Asian American	2.4	1.6	1.0	1.1	0.7	1.0	1.4
American Indian	4.9	1.6	1.6	3.0	2.2	2.8	2.1
Black	4.1	3.2	3.0	2.8	2.6	3.2	4.7
Hispanics	5.4	5.2	4.3	4.0	4.4	4.3	5.3
White	1.9	1.5	1.3	1.1	1.2	1.2	1.4
Statewide	2.4	2.1	1.8	1.7	1.8	1.9	2.5

Highlights of the Statewide Cumulative Dropout Rates for the Graduating Classes of 2002 to 2008

Table 6 represents the cumulative dropout rates, i.e., total number of dropouts during a four year period for a freshman cohort.

The cumulative dropout rate in the freshman year (Grade 9) ranges from 3.3 percent for the graduating class of 2002, to a low of 1.3 for the graduating class of 2008. The dropout rate percentage of the sophomore, junior and senior years for all seven classes is similar to the dropout rate percentage of the freshman group.

Table 6: Statewide Cumulative Dropout Rates by Grade for the Graduating Classes of 2002 to 2008

	Class of 2002	Class of 2003	Class of 2004	Class of 2005	Class of 2006	Class of 2007	Class of 2008
Grade 9	3.3	2.8	2.9	2.1	1.8	1.4	1.3
Grade 10	6.2	5.5	5.2	3.9	3.4	3.0	2.9
Grade 11	8.9	7.9	7.2	5.4	5.2	4.8	4.9
Grade 12	10.8	9.5	8.8	7.3	6.6	6.3	6.6

Attached to the data bulletin are Appendix A and Appendix B, which feature detailed Connecticut annual dropout rates from 2001-02 to 2007-08, and Connecticut cumulative dropout rates for the graduating classes of 2002 to 2008, with a district and statewide average breakdown.

Summary

Dropout rates as calculated provide fair and reliable estimates of a school's student dropout pattern on an annual basis or a four-year cohort basis. These statistics are based on uniform definitions applied to all high schools in the state and, therefore, have comparative values. One important purpose of providing a uniform district-by-district report of dropout rates is to give each district the information on the relative performance of its schools in retaining and graduating students. In addition, it gives administrators and policymakers an opportunity to review current conditions. Dropout statistics illustrate what happens to students as they progress through Connecticut's public high schools and can inform decisions regarding the level of support needed to ensure the success of all students.

Increases in dropout counts and percents for the 2007-08 school year are attributed to the implementation of a new unique state assigned student identifier (SASID). The SASID allows the state to track the movement of individual students as they register and unregister in districts across the state. Additionally, the SASID improves the states accountability for highly mobile students and allows for a more accurate tracking of dropouts.

Strategies for Reducing the Dropout Rate

There is a nationwide concern about ensuring that all students complete high school. The America's Promise Alliance lists five things that will help children thrive and succeed: Caring Adults, Safe Places, A Healthy Start, An Effective Education and Opportunities to Help Others. Consequently, under the funding of the America's Promise Alliance Organization, a Dropout Prevention Summit is being held this year in every state in the nation. The Connecticut State Department of Education held its Dropout Prevention Summit on October 19, 2009. The Summit was a collaborative effort among educators, professional staff, parents, local businessmen and other concerned citizens from all related agencies and communities, as well as business and industry.

There are many reasons why students drop out of high school. Some students drop out because of significant academic challenges, such as not being motivated, not being interested or simply failing academically. Some drop out for personal or family reasons, such as the need to earn money to support family, being pregnant or caring for a family member. However, studies have shown that dropping out of school is a gradual process for students. Current practices and guidelines on dropout prevention suggest that state and local school districts can institute policies and employ strategies to reduce the number of students dropping out of school.

The widely effective strategies for dropout prevention include:

1. Establishing for all schools an evolving process of goals and structures related to policies and practices that impact students' learning. These goals and structures may include a system of fostering multiple learning styles/multiple intelligences for all students, a student attendance requirement system, a discipline notification procedure, a tracking system or a graduation requirement system.

2. Building incentives and alternative schooling programs for graduating every student in the high school. These programs may include early intervention at elementary and middle school levels, such as early childhood education programs, reading/writing programs, after school programs, Saturday or summer academies, individualized instruction, mentoring/tutoring programs, alternative programs, adult education, career education/workforce readiness or job-related/employability skills training programs.

3. Providing a supportive and caring environment to better engage all students, in particular, at-risk students. For example, schools can increase student service resources by decreasing the student/staff ratio, adding more counseling staff members, social workers and at-risk case managers, and providing more health education programs, vocational rehabilitation services, literacy programs or violent prevention/conflict resolution services.

4. Establishing the communication and connection among schools, parents and their communities. Schools can offer students access to community-related workshops, programs and services, building a sense of belonging to their communities and presenting them with opportunities to give back to their families and communities.

5. Instituting peer-counseling programs and establishing partnerships with local businesses to provide adult mentors, and creating employment readiness and internship opportunities for students at risk.

Contact Y. H. Alison Zhou, Ed.D., at (860) 713-6893 or via e-mail at alison.zhou@ct.gov, for questions related to this data bulletin.

Appendix A: Connecticut Annual Dropout Rates, Percent for 2001-02 to 2007-08

District	District Name	2001-02	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08
2	Ansonia	5.7	3.9	3.0	2.8	2.0	1.8	1.6
4	Avon	0.0	0.0	0.0	0.0	0.0	0.2	0.4
7	Berlin	1.7	1.2	0.8	0.7	0.6	1.1	2.1
9	Bethel	0.5	0.3	0.0	0.0	0.0	0.3	0.4
11	Bloomfield	3.4	2.3	2.7	2.0	0.7	1.9	1.3
12	Bolton	1.7	0.6	0.0	0.3	0.0	0.7	0.7
14	Branford	1.8	1.9	1.2	0.2	1.0	1.6	1.1
15	Bridgeport	8.7	8.2	4.8	6.4	8.1	7.6	6.9
17	Bristol	1.3	2.3	1.3	0.9	0.8	0.8	1.1
18	Brookfield	0.6	0.6	0.0	0.0	0.5	0.1	0.0
23	Canton	0.0	1.0	0.4	0.6	1.4	0.0	0.6
25	Cheshire	1.0	1.1	1.3	1.0	0.7	0.6	0.6
27	Clinton	4.3	1.3	0.5	1.8	0.0	1.4	3.4
28	Colchester	1.2	0.9	0.6	0.5	0.7	0.8	0.5
32	Coventry	4.3	1.6	0.3	0.7	0.2	0.9	1.1
33	Cromwell	0.2	0.9	0.6	0.8	0.4	0.9	0.5
34	Danbury	3.8	2.7	2.2	2.1	2.6	2.2	2.5
35	Darien	0.2	0.5	0.4	0.2	0.0	0.0	0.3
37	Derby	2.9	2.2	0.7	0.2	1.6	1.4	2.8
40	East Granby	0.8	1.7	0.4	0.4	0.4	1.2	0.8
41	East Haddam	1.7	1.5	1.5	0.3	1.1	2.1	1.0
42	East Hampton	0.8	0.2	0.4	0.0	0.3	0.7	0.5
43	East Hartford	2.8	3.6	2.2	1.5	1.5	3.5	4.4
44	East Haven	0.7	0.9	0.3	0.3	0.0	0.6	0.8
45	East Lyme	1.2	1.0	1.3	0.3	1.6	1.2	1.3
47	East Windsor	4.6	1.9	2.3	2.1	1.6	1.9	0.9
48	Ellington	0.5	1.5	2.2	0.4	0.4	0.5	1.2
49	Enfield	3.1	2.6	2.4	2.5	1.8	2.6	2.5
51	Fairfield	0.6	0.4	0.6	0.8	0.7	0.8	1.3
52	Farmington	0.8	1.2	1.1	0.9	0.4	1.0	0.7
54	Glastonbury	0.5	0.5	0.4	0.2	0.2	0.1	0.5
56	Granby	0.9	0.5	1.0	0.1	0.4	0.1	0.4
57	Greenwich	1.7	0.8	0.6	0.7	0.8	0.8	0.9
58	Griswold	2.8	2.5	3.6	2.7	3.8	2.7	3.8

District	District Name	2001-02	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08
59	Groton	0.7	0.7	0.4	0.3	1.0	0.8	1.5
60	Guilford	0.3	0.3	0.6	0.3	0.5	0.4	0.9
62	Hamden	3.8	1.0	1.0	1.1	0.5	1.6	1.9
64	Hartford	6.2	4.4	3.7	5.6	6.3	2.6	4.8
69	Killingly	5.7	3.4	5.3	5.5	7.2	3.1	5.4
71	Lebanon	1.2	0.5	1.0	0.8	0.2	0.2	1.2
72	Ledyard	2.6	1.0	1.6	1.1	1.3	1.2	0.5
74	Litchfield	0.7	0.7	0.7	2.2	1.4	0.9	1.0
76	Madison	1.2	0.5	0.5	0.2	0.0	0.1	0.2
77	Manchester	1.3	1.4	1.4	1.1	1.7	0.9	1.7
80	Meriden	2.7	3.2	2.1	1.5	1.7	2.1	2.1
83	Middletown	0.8	1.4	0.5	1.6	1.0	0.4	1.0
84	Milford	1.7	2.5	0.7	2.1	2.3	1.7	1.8
85	Monroe	0.1	0.2	0.2	0.1	0.1	0.3	0.1
86	Montville	2.0	2.2	1.4	1.2	1.4	1.5	2.4
88	Naugatuck	3.0	2.4	2.2	1.9	1.7	1.7	1.3
89	New Britain	6.9	7.6	4.6	5.7	5.6	4.1	6.9
90	New Canaan	0.6	0.1	0.1	0.2	0.0	0.5	0.2
91	New Fairfield	0.7	0.9	0.5	0.6	0.4	0.6	0.6
93	New Haven	5.2	4.3	6.1	5.5	4.2	5.6	5.7
94	Newington	0.5	0.4	0.3	0.2	0.2	0.3	0.8
95	New London	13.4	11.7	7.8	7.3	1.3	1.1	2.7
96	New Milford	0.2	0.5	0.4	1.2	1.1	0.6	1.7
97	Newtown	0.8	0.6	1.0	1.2	0.9	0.9	1.9
99	North Branford	1.4	0.3	0.7	1.0	1.8	1.3	1.9
101	North Haven	2.2	1.4	0.6	0.5	0.3	1.3	1.0
102	North Stonington	1.4	0.4	2.5	1.1	1.5	0.9	3.3
103	Norwalk	2.7	1.9	0.8	0.8	0.6	0.9	1.5
104	Norwich*	43.1	46.2	14.8	26.5	0.0	16.3	22.4
106	Old Saybrook	0.0	0.0	0.0	0.0	0.0	0.2	0.4
109	Plainfield	6.0	7.3	5.3	5.7	3.1	3.8	3.4
110	Plainville	0.5	0.4	1.4	0.5	1.3	0.9	2.4
111	Plymouth	2.6	3.2	1.9	2.3	5.0	3.4	2.2
113	Portland	0.3	0.7	0.7	0.0	0.3	1.4	0.3
116	Putnam	3.7	4.4	3.9	1.6	3.1	3.9	6.6
118	Ridgefield	0.5	0.6	0.3	0.5	0.4	0.1	0.5

*Alternative High School

District	District Name	2001-02	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08
119	Rocky Hill	0.0	0.3	0.6	1.1	1.5	0.8	0.8
124	Seymour	2.3	2.8	2.5	2.8	3.1	1.7	2.3
126	Shelton	1.7	1.1	1.7	0.0	5.4	1.8	1.8
128	Simsbury	0.8	0.4	0.5	0.3	0.3	0.5	0.4
129	Somers	4.2	1.2	0.4	1.4	0.2	1.0	0.9
131	Southington	1.7	1.7	1.3	1.8	1.2	1.2	1.5
132	South Windsor	1.3	1.2	0.7	0.8	0.9	0.4	1.6
134	Stafford	2.5	3.6	2.4	0.9	1.6	4.0	3.3
135	Stamford	2.7	1.5	3.2	1.9	1.9	1.8	2.1
137	Stonington	1.9	1.1	2.4	2.0	1.3	1.6	1.8
138	Stratford	2.5	2.7	1.9	1.4	1.5	1.0	0.9
139	Suffield	1.8	0.9	1.0	0.0	0.5	1.6	1.0
140	Thomaston	2.6	2.2	1.6	1.5	3.1	2.4	0.8
141	Thompson	2.7	3.3	2.3	2.5	2.8	1.5	3.5
142	Tolland	1.9	0.9	0.6	0.0	0.6	0.1	0.5
143	Torrington	5.2	3.7	3.4	7.2	6.4	3.0	3.9
144	Trumbull	2.6	2.5	0.2	0.0	0.0	0.1	0.3
146	Vernon	2.8	1.9	2.1	3.8	2.0	1.7	3.9
148	Wallingford	1.1	0.6	1.2	1.6	0.5	0.8	2.2
151	Waterbury	3.0	4.6	3.4	2.6	3.3	1.5	1.0
152	Waterford	0.9	0.8	0.8	1.3	1.8	0.9	1.6
153	Watertown	2.4	1.9	1.1	1.4	1.0	1.0	1.5
154	Westbrook	0.3	0.3	0.7	0.0	0.0	0.3	0.3
155	West Hartford	2.1	1.6	1.1	1.2	1.1	1.3	1.5
156	West Haven	1.6	1.7	0.8	1.5	0.6	0.9	3.0
157	Weston	0.0	0.0	0.0	0.1	0.0	0.0	0.0
158	Westport	1.0	0.2	0.1	0.0	0.0	0.2	0.3
159	Wethersfield	1.4	2.1	1.0	1.0	1.4	2.0	3.2
161	Wilton	0.4	0.4	0.2	0.3	0.0	0.2	0.2
162	Winchester *	16.7	12.5	2.7	8.3	19.2	15.8	8.3
163	Windham	5.0	5.8	2.6	4.5	2.0	4.9	4.5
164	Windsor	3.3	2.0	2.3	1.8	0.7	2.3	1.8
165	Windsor Locks	5.1	4.3	3.5	1.8	2.8	2.2	1.4
166	Wolcott	1.3	1.1	1.6	2.4	2.6	1.1	1.0
201	Regional School District 01	1.4	0.8	2.9	4.2	2.6	1.1	0.4
204	Regional School District 04	4.9	1.0	4.9	0.7	0.7	1.7	1.6

*Alternative High School

District	District Name	2001-02	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08
205	Regional School District 05	1.0	0.2	0.7	0.5	0.7	1.1	0.8
206	Regional School District 06	0.8	1.8	0.8	0.3	0.7	1.3	0.7
207	Regional School District 07	0.4	0.1	1.2	0.7	0.4	0.8	0.5
208	Regional School District 08	1.4	2.0	1.8	3.3	2.4	1.0	0.5
209	Regional School District 09	0.4	0.1	0.5	0.2	0.2	0.8	0.3
210	Regional School District 10	0.3	0.9	1.1	1.0	1.0	0.1	0.5
211	Regional School District 11	5.4	3.6	3.0	2.1	0.5	2.0	0.6
212	Regional School District 12	2.2	1.0	2.5	0.2	0.0	0.0	0.5
213	Regional School District 13	0.7	0.5	0.2	0.3	0.4	0.3	0.0
214	Regional School District 14	0.9	0.1	0.1	0.5	0.3	1.1	1.2
215	Regional School District 15	2.3	1.1	1.1	0.9	1.5	1.3	1.5
216	Regional School District 16	na	1.0	1.7	1.9	1.9	0.9	1.0
217	Regional School District 17	0.2	0.0	0.0	0.0	0.1	0.3	0.1
218	Regional School District 18	1.1	0.9	0.6	1.2	0.0	0.9	0.6
219	Regional School District 19	1.3	3.3	1.3	2.0	1.7	2.2	1.3
241	Capitol Region Education Council	na	4.3	0.0	0.0	0.0	0.0	0.3
244	Area Cooperative Educational Service	na	0.8	0.3	0.6	1.5	2.1	2.3
268	Common Ground High School	na	3.6	0.9	0.0	0.0	0.7	0.0
269	The Bridge Academy	na	1.1	2.3	1.7	3.8	0.6	0.0
272	Explorations	na	4.2	5.7	1.3	1.3	2.4	0.0
282	Stamford Academy	na	na	na	na	na	4.9	2.3
900	Connecticut Technical High School	0.9	1.2	0.6	0.1	0.5	2.1	0.3
901	Norwich Free Academy	4.0	2.4	1.0	0.7	1.4	0.9	2.4
902	The Gilbert School	2.5	2.8	2.5	2.7	2.5	4.5	3.4
903	Woodstock Academy	1.1	0.7	4.2	1.0	1.3	1.1	1.6
	Statewide	**2.4**	**2.1**	**1.8**	**1.7**	**1.8**	**1.9**	**2.5**

Appendix B: Connecticut Cumulative Dropout Rates, Percent for the Graduating Classes of 2002 to 2008

District	District Name	2002	2003	2004	2005	2006	2007	2008
2	Ansonia	16.7	16.9	9.0	11.8	7.3	9.4	7.0
4	Avon	0.0	0.0	0.0	0.0	0.0	0.5	1.2
7	Berlin	7.2	17.1	4.5	2.9	3.8	4.4	7.3
9	Bethel	3.1	2.4	1.9	0.4	0.4	0.0	0.3
11	Bloomfield	10.1	7.9	11.1	6.2	4.6	3.5	7.6
12	Bolton	5.0	5.3	1.2	0.0	1.1	2.3	1.4
14	Branford	6.8	8.3	5.2	2.1	3.4	4.3	6.2
15	Bridgeport	30.5	35.1	25.9	18.9	22.4	23.4	23.3
17	Bristol	10.8	7.3	7.0	5.5	5.2	3.3	3.4
18	Brookfield	4.5	2.6	0.4	1.7	0.9	0.8	0.8
23	Canton	0.8	1.7	0.9	3.7	0.8	5.8	1.5
25	Cheshire	5.1	2.8	3.9	5.1	3.0	3.6	1.9
27	Clinton	14.8	10.7	4.5	6.4	2.5	2.5	5.6
28	Colchester	5.5	7.0	4.7	2.3	2.3	3.4	3.0
32	Coventry	22.7	15.8	5.8	6.7	1.4	3.6	3.3
33	Cromwell	2.8	0.9	0.8	3.5	3.0	2.9	3.5
34	Danbury	14.5	14.4	12.1	9.7	7.9	6.0	8.4
35	Darien	1.5	2.0	1.2	0.5	1.2	0.0	1.1
37	Derby	11.8	14.3	9.6	3.6	2.9	3.1	9.3
40	East Granby	8.8	6.1	5.3	5.3	0.0	2.8	2.7
41	East Haddam	8.2	7.5	9.3	2.7	1.9	3.9	7.4
42	East Hampton	2.1	5.3	0.8	0.8	1.4	0.8	1.4
43	East Hartford	9.8	11.9	8.6	9.2	8.3	6.4	8.3
44	East Haven	6.5	4.9	4.8	0.7	2.1	1.3	2.1
45	East Lyme	5.0	6.7	3.6	3.6	6.8	2.7	4.9
47	East Windsor	16.5	9.0	11.3	9.8	8.0	2.2	4.1
48	Ellington	5.5	6.8	4.5	8.6	2.2	1.9	6.6
49	Enfield	11.3	11.5	12.6	10.5	8.4	7.0	9.5
51	Fairfield	3.5	1.9	2.8	2.9	1.5	2.5	3.6
52	Farmington	4.0	6.1	5.7	5.1	1.9	1.5	3.9
54	Glastonbury	1.7	1.9	2.8	0.7	0.8	0.4	1.1
56	Granby	9.1	1.3	4.1	0.6	2.1	1.3	1.0
57	Greenwich	7.2	3.1	3.7	3.5	2.8	2.9	2.3
58	Griswold	17.5	9.8	10.6	15.4	10.7	11.0	15.8
59	Groton	3.9	4.4	3.5	1.0	2.6	1.3	5.2

District	District Name	2002	2003	2004	2005	2006	2007	2008
60	Guilford	3.5	1.7	2.0	0.7	1.7	2.6	2.3
62	Hamden	11.5	16.9	15.7	7.0	3.9	3.8	3.9
64	Hartford	29.7	21.7	20.8	14.3	13.8	10.8	11.9
69	Killingly	20.1	18.4	23.0	23.8	19.0	16.5	17.0
71	Lebanon	10.3	4.2	3.4	3.8	0.7	1.2	2.9
72	Ledyard	9.7	11.4	7.4	4.3	4.4	4.6	4.1
74	Litchfield	0.0	5.1	3.0	7.2	3.1	1.9	7.8
76	Madison	2.3	1.1	3.9	1.7	0.4	1.0	0.9
77	Manchester	10.9	6.8	4.6	4.6	5.8	3.5	4.7
80	Meriden	17.8	12.1	11.1	7.1	7.3	5.8	7.2
83	Middletown	3.0	4.8	4.8	4.7	4.4	2.0	2.4
84	Milford	10.3	6.5	6.9	6.2	7.5	6.7	7.6
85	Monroe	1.0	0.3	0.6	0.0	0.9	0.5	0.8
86	Montville	8.8	7.4	8.1	3.7	4.4	3.6	6.1
88	Naugatuck	10.0	10.7	11.3	9.1	6.3	8.3	7.9
89	New Britain	28.6	23.7	22.7	20.3	23.9	25.8	25.6
90	New Canaan	2.8	0.4	0.0	1.2	0.0	1.0	1.5
91	New Fairfield	3.2	4.3	2.1	3.8	1.2	2.6	0.8
93	New Haven	18.5	17.7	18.7	16.6	16.2	15.3	15.7
94	Newington	3.4	1.3	2.7	0.9	0.8	0.8	1.5
95	New London	30.8	37.1	60.5	38.2	19.0	8.5	14.2
96	New Milford	2.8	5.3	1.1	3.0	3.5	2.2	3.1
97	Newtown	2.2	3.9	3.3	4.5	4.1	2.1	3.6
99	North Branford	3.7	2.9	2.8	6.3	2.1	5.3	7.7
101	North Haven	6.9	5.8	5.2	2.8	1.8	3.1	3.7
102	North Stonington	8.5	2.9	9.8	7.8	4.0	2.7	8.3
103	Norwalk	8.2	7.8	10.0	6.2	3.1	2.3	2.9
104	Norwich*	64.1	94.4	92.2	85.0	72.5	57.1	92.0
106	Old Saybrook	3.0	0.0	0.0	0.0	0.0	0.0	1.9
109	Plainfield	22.3	19.6	24.3	18.4	18.6	17.1	12.8
110	Plainville	4.1	1.0	4.7	2.7	2.6	3.4	2.7
111	Plymouth	13.9	12.1	5.3	13.4	8.2	9.6	11.4
113	Portland	1.4	5.3	3.0	0.0	0.0	1.1	1.1
116	Putnam	11.4	13.8	17.3	8.9	10.4	11.1	11.5
118	Ridgefield	4.0	2.5	0.9	2.5	1.0	1.1	0.5
119	Rocky Hill	3.4	2.6	2.2	2.2	4.1	0.9	5.8

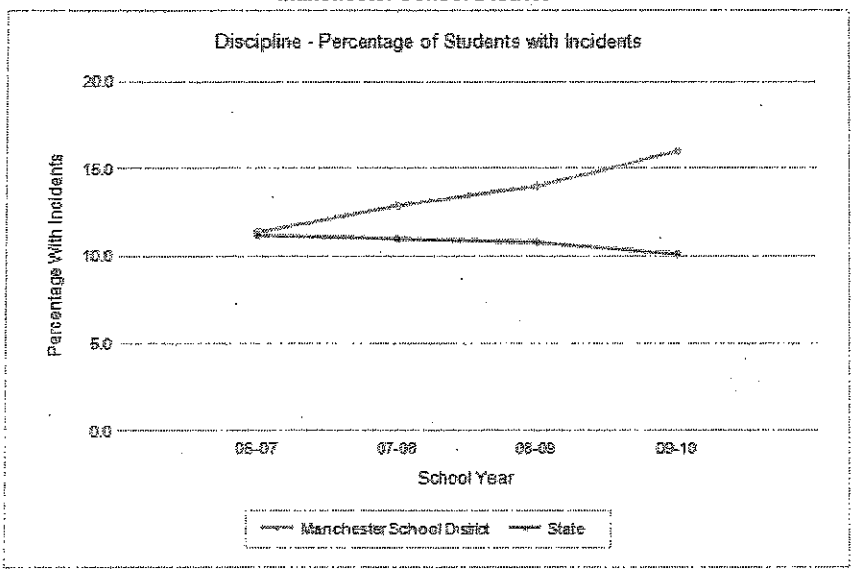
*Alternative High School

District	District Name	2002	2003	2004	2005	2006	2007	2008
124	Seymour	9.5	8.3	8.7	8.2	10.8	6.9	10.5
126	Shelton	9.0	7.7	7.7	5.1	6.0	6.8	6.8
128	Simsbury	1.4	2.2	2.1	2.5	1.5	1.9	1.6
129	Somers	11.9	10.1	7.4	6.9	3.0	1.3	4.5
131	Southington	7.1	6.0	5.3	5.4	8.0	3.4	6.3
132	South Windsor	6.6	3.4	5.3	3.1	3.1	2.0	3.1
134	Stafford	10.4	7.0	7.7	11.5	8.9	6.6	7.5
135	Stamford	16.9	10.0	9.5	8.9	7.3	9.9	7.0
137	Stonington	10.1	5.9	12.3	6.5	6.9	4.3	5.5
138	Stratford	13.1	8.7	7.2	8.9	5.8	5.3	5.5
139	Suffield	8.8	7.2	3.0	4.4	2.1	0.8	4.1
140	Thomaston	8.9	7.6	9.1	7.8	2.9	8.5	7.3
141	Thompson	19.0	16.2	12.3	10.7	7.7	4.8	10.4
142	Tolland	9.3	6.1	4.2	1.9	1.8	0.7	0.5
143	Torrington	24.5	18.7	16.0	19.7	12.4	15.1	13.5
144	Trumbull	1.4	7.0	7.4	1.0	3.3	0.4	0.6
146	Vernon	9.9	8.8	8.5	15.6	8.7	4.0	5.8
148	Wallingford	4.4	2.7	4.5	5.9	4.3	3.2	3.7
151	Waterbury	11.3	9.8	10.3	11.7	13.1	11.1	7.0
152	Waterford	3.2	4.7	2.9	3.8	4.4	5.3	6.4
153	Watertown	11.9	10.2	6.9	7.8	3.2	4.8	3.7
154	Westbrook	2.8	1.1	1.3	0.0	1.3	1.1	1.1
155	West Hartford	8.6	8.4	5.2	4.1	4.3	4.4	5.2
156	West Haven	10.6	4.5	5.8	4.3	5.3	3.3	3.8
157	Weston	0.0	0.0	0.0	0.6	0.0	0.0	0.0
158	Westport	3.6	1.5	1.2	0.3	0.0	0.7	0.3
159	Wethersfield	7.4	4.1	9.9	4.7	3.8	3.7	10.8
161	Wilton	2.4	2.0	0.4	1.2	0.3	0.0	1.0
162	Winchester *	100.0	50.0	16.7	100.0	44.4	14.3	80.0
163	Windham	22.3	19.2	17.9	8.7	8.8	14.6	13.3
164	Windsor	12.4	10.4	7.9	10.6	6.3	5.6	5.9
165	Windsor Locks	20.0	22.4	13.7	13.6	6.4	9.6	9.0
166	Wolcott	4.5	6.9	5.1	7.3	5.5	1.5	8.6
201	Regional School District 01	3.7	5.3	2.9	7.1	11.9	11.3	7.1
204	Regional School District 04	13.0	12.0	14.4	5.5	8.0	7.9	5.7
205	Regional School District 05	3.6	1.9	2.3	1.5	2.4	3.8	1.7

*Alternative High School

District	District Name	2002	2003	2004	2005	2006	2007	2008
206	**Regional School District 06**	3.6	1.9	7.5	2.2	2.6	1.1	1.8
207	**Regional School District 07**	2.0	0.5	2.7	3.7	1.0	1.5	0.5
208	**Regional School District 08**	6.7	10.0	4.2	9.7	6.9	7.0	7.0
209	**Regional School District 09**	1.8	1.0	1.0	0.9	0.8	2.7	0.4
210	**Regional School District 10**	1.9	1.5	1.7	4.0	4.7	1.6	2.6
211	**Regional School District 11**	11.1	13.6	11.3	13.6	2.0	6.8	4.2
212	**Regional School District 12**	9.5	5.1	6.0	6.2	2.7	0.0	0.0
213	**Regional School District 13**	3.0	2.3	2.6	1.3	7.1	1.4	4.9
214	**Regional School District 14**	0.5	1.6	2.0	1.5	0.9	1.0	5.2
215	**Regional School District 15**	5.5	4.8	3.8	6.6	4.0	3.0	4.2
216	**Regional School District 16**	na	0.0	0.0	6.8	6.4	3.0	5.7
217	**Regional School District 17**	1.3	0.7	0.0	0.0	0.6	0.0	0.6
218	**Regional School District 18**	2.9	7.8	4.3	3.1	3.1	1.6	2.3
219	**Regional School District 19**	4.6	9.8	6.7	10.5	5.8	4.2	9.8
241	**Capitol Region Education Council**	na	na	na	7.4	2.6	0.0	0.0
244	**Area Cooperative Educational Service**	na	na	11.1	33.3	4.5	3.1	7.7
268	**Common Ground High School**	na	5.9	3.2	2.0	5.9	2.6	1.9
269	**The Bridge Academy**	na	5.1	9.1	5.9	10.3	6.8	6.5
272	**Explorations**	na	15.0	7.1	12.5	10.5	8.3	0.0
282	**Stamford Academy**	na	na	na	na	na	na	0.0
900	**Connecticut Technical High School**	3.6	3.4	2.0	1.8	1.7	3.0	2.4
901	**Norwich Free Academy**	15.9	12.1	11.2	5.5	5.5	4.4	3.2
902	**The Gilbert School**	12.9	5.6	10.3	7.7	11.8	14.3	11.2
903	**Woodstock Academy**	4.7	4.2	6.7	9.8	8.4	5.7	5.1
	Statewide	**10.8**	**9.5**	**8.8**	**7.3**	**6.6**	**6.3**	**6.6**

Manchester School District



Manchester School District

Discipline - Percentage of Students with Incidents

- Indicates no data

*** Denotes suppressed value***

School Year	Manchester School District			State		
	Students with Incidents	Total Enrollments	Percentage with Incidents	Students with Incidents	Total Enrollments	Percentage with Incidents
2009-10	1,102	6,884	16.0	56,715	563,449	10.1
2008-09	949	6,771	14.0	60,599	563,195	10.8
2007-08	884	6,832	12.9	62,791	570,494	11.0
2006-07	810	7,085	11.4	64,333	574,749	11.2

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Manchester School District
Year(s): 2009-10

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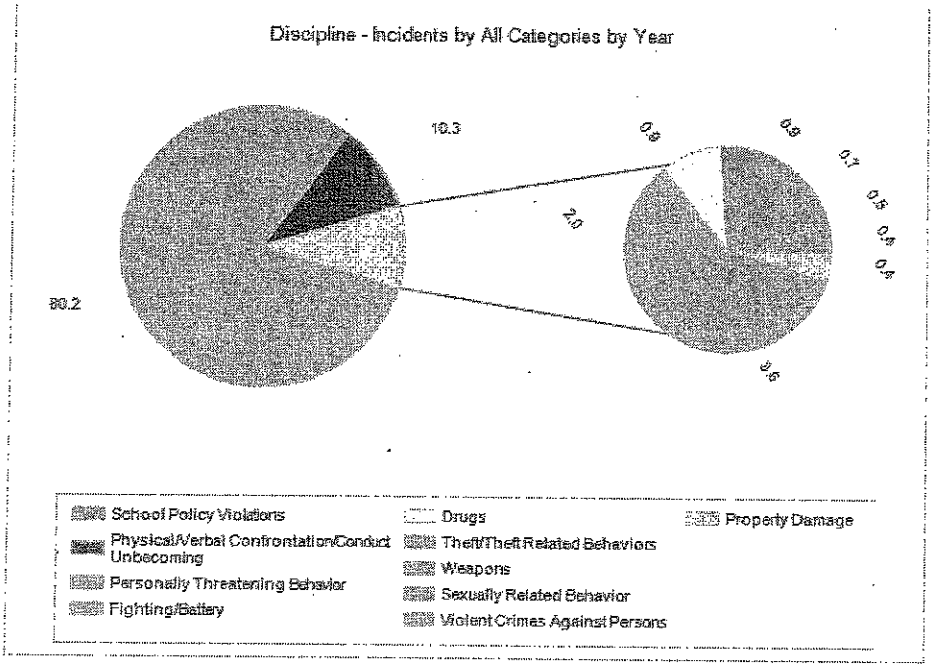
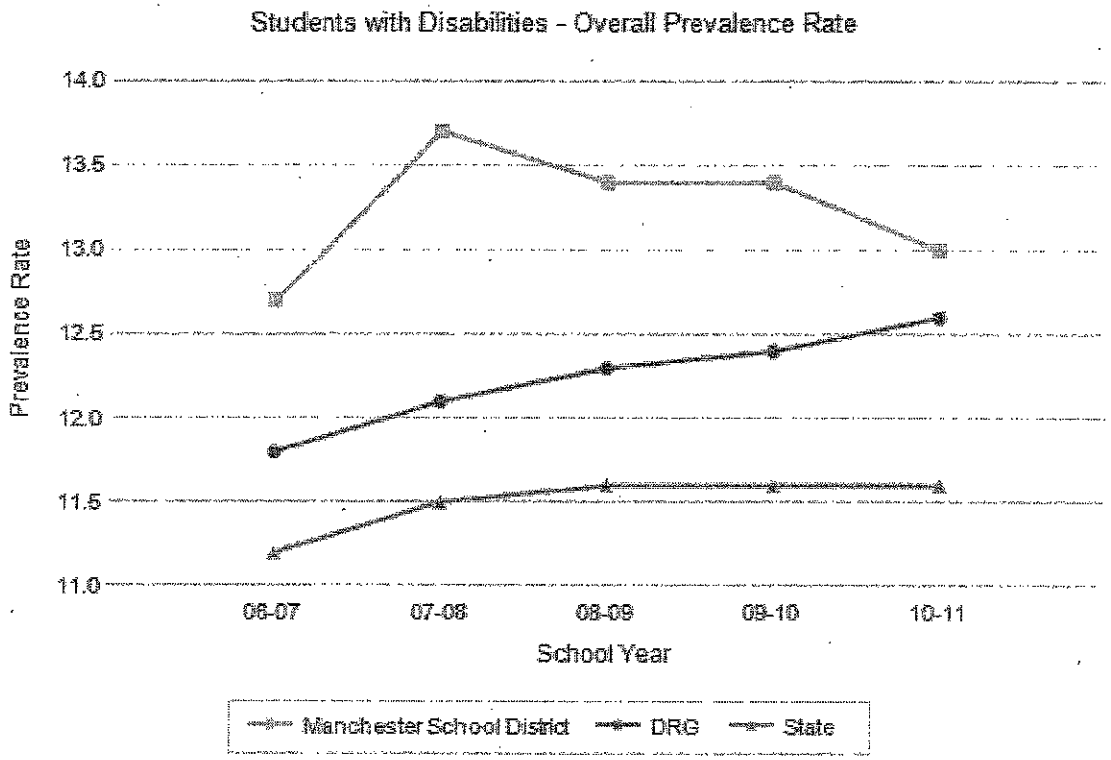


Manchester School District
Discipline - Incidents by All Categories by Year

Year(s): 2009-10

- Indicates no data

Category	Manchester School District
Drugs	18
Fighting/Battery	49
Personally Threatening Behavior	94
Physical/Verbal Confrontation/Conduct Unbecoming	303
Property Damage	14
Sexually Related Behavior	10
Theft/Theft Related Behaviors	28
Violent Crimes Against Persons	11
School Policy Violations	2337
Weapons	11
Total	2,875



Manchester School District

Students with Disabilities - Overall Prevalence Rate

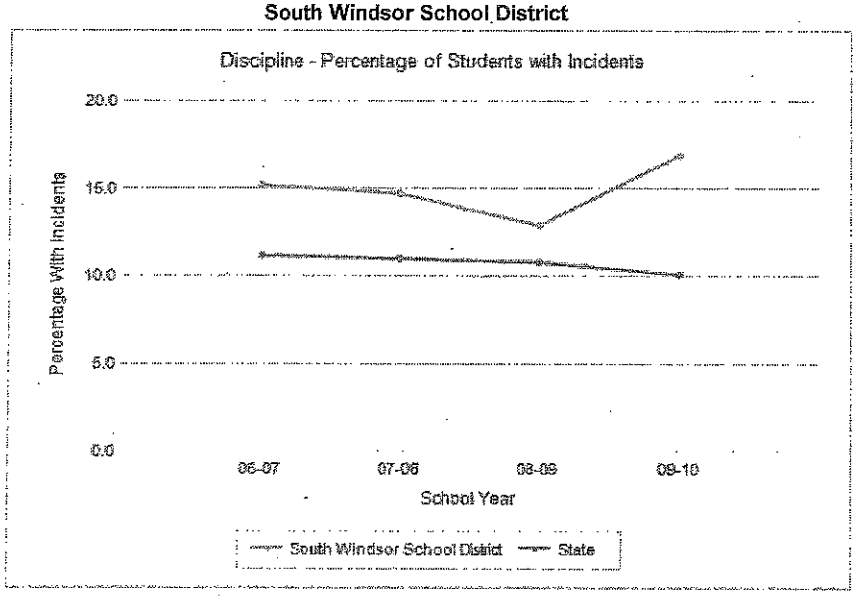
- Indicates no data

***** Denotes suppressed value***

School Year	Manchester School District	District Reference Group (DRG)	State
2010-11	13.0	12.6	11.6
2009-10	13.4	12.4	11.6
2008-09	13.4	12.3	11.6
2007-08	13.7	12.1	11.5
2006-07	12.7	11.8	11.2

State Department of Education - CEDaR

South Windsor School District



South Windsor School District

Discipline - Percentage of Students with Incidents

- Indicates no data

***** Denotes suppressed value***

School Year	South Windsor School District			State		
	Students with Incidents	Total Enrollments	Percentage with Incidents	Students with Incidents	Total Enrollments	Percentage with Incidents
2009-10	786	4,654	16.9	56,715	563,449	10.1
2008-09	618	4,795	12.9	60,599	563,195	10.8
2007-08	726	4,934	14.7	62,791	570,494	11.0
2006-07	764	5,027	15.2	64,333	574,749	11.2

South Windsor School District
Year(s): 2009-10

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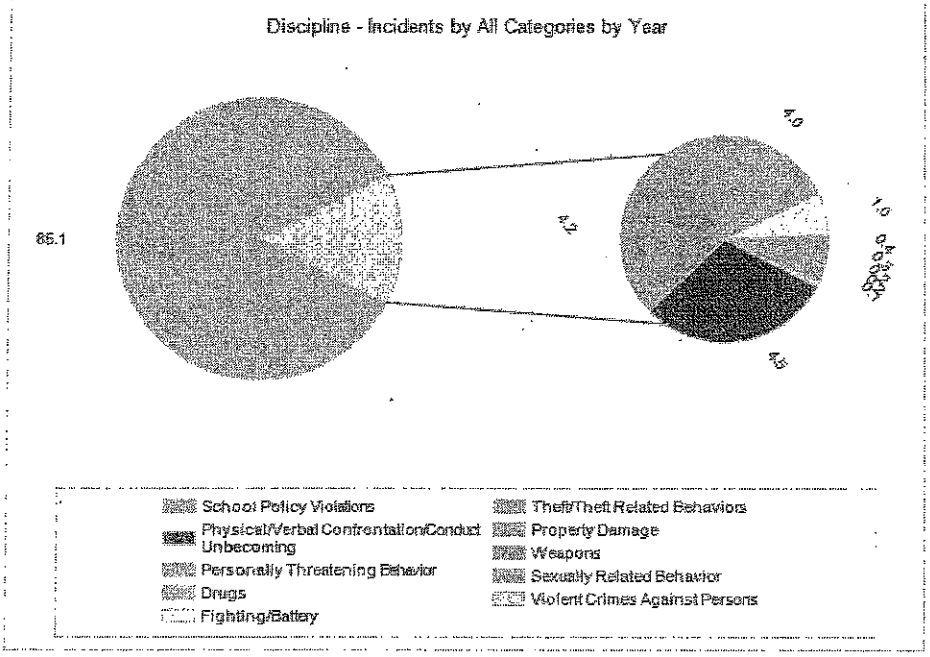
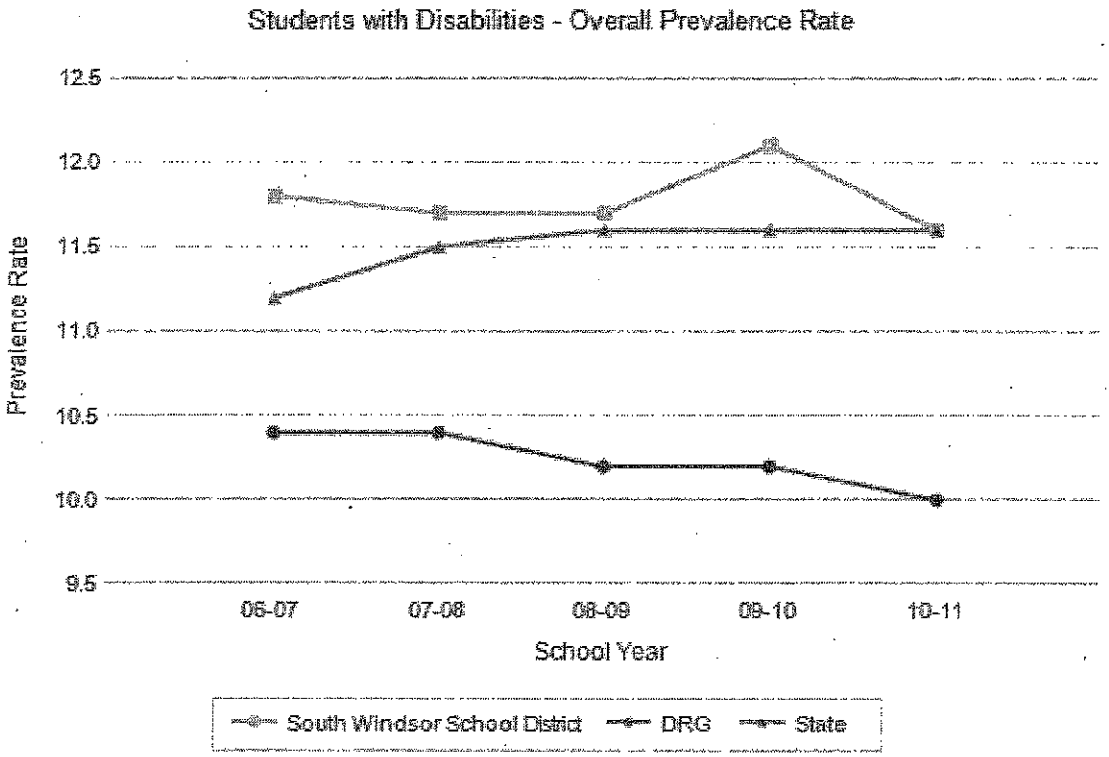


South Windsor School District
Discipline - Incidents by All Categories by Year

Year(s): 2009-10

- Indicates no data

Category	South Windsor School District
Drugs	88
Fighting/Battery	22
Personally Threatening Behavior	93
Physical/Verbal Confrontation/Conduct Unbecoming	99
Property Damage	6
Sexually Related Behavior	5
Theft/Theft Related Behaviors	8
Violent Crimes Against Persons	2
School Policy Violations	1875
Weapons	4
Total	2,202



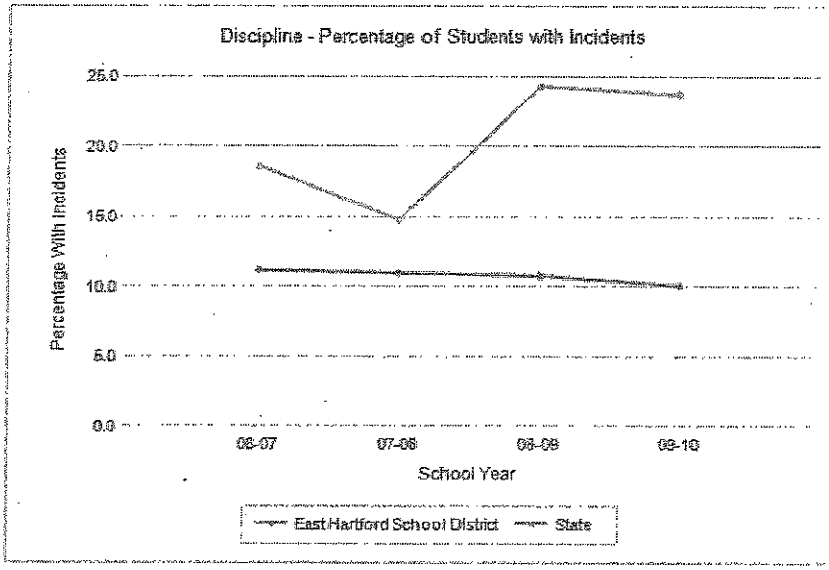
South Windsor School District
Students with Disabilities - Overall
Prevalence Rate

- Indicates no data

*** Denotes suppressed value***

School Year	South Windsor School District	District Reference Group (DRG)	State
2010-11	11.6	10.0	11.6
2009-10	12.1	10.2	11.6
2008-09	11.7	10.2	11.6
2007-08	11.7	10.4	11.5
2006-07	11.8	10.4	11.2

East Hartford School District



East Hartford School District

Discipline - Percentage of Students with Incidents

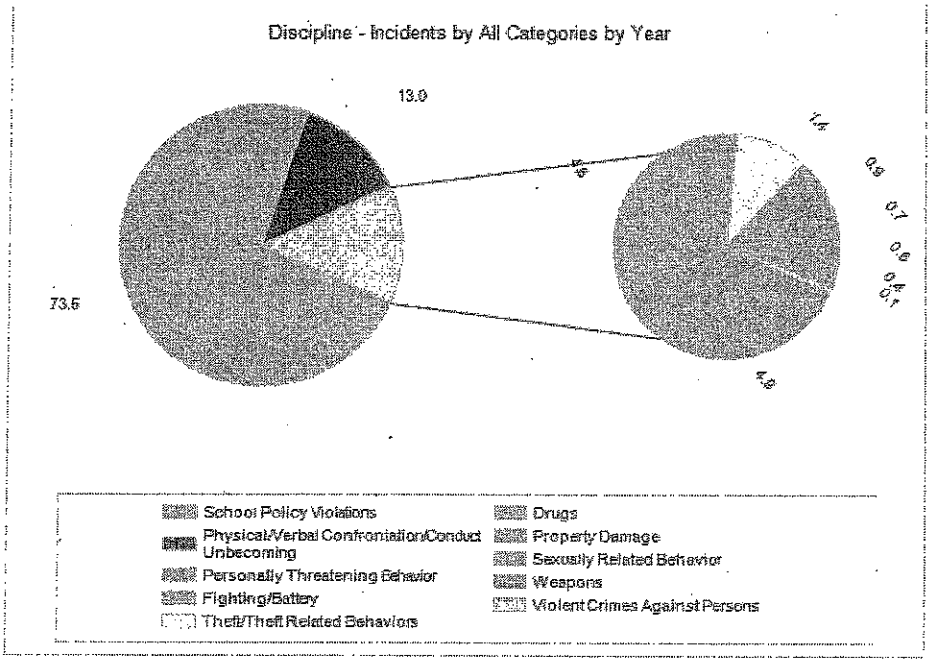
- Indicates no data

***** Denotes suppressed value***

School Year	East Hartford School District			State		
	Students with Incidents	Total Enrollments	Percentage with Incidents	Students with Incidents	Total Enrollments	Percentage with Incidents
2009-10	1,715	7,242	23.7	56,715	563,449	10.1
2008-09	1,717	7,067	24.3	60,599	563,195	10.8
2007-08	1,107	7,465	14.8	62,791	570,494	11.0
2006-07	1,420	7,639	18.6	64,333	574,749	11.2

East Hartford School District
Year(s): 2009-10

Click on a section of the pie to view longitudinal detail.

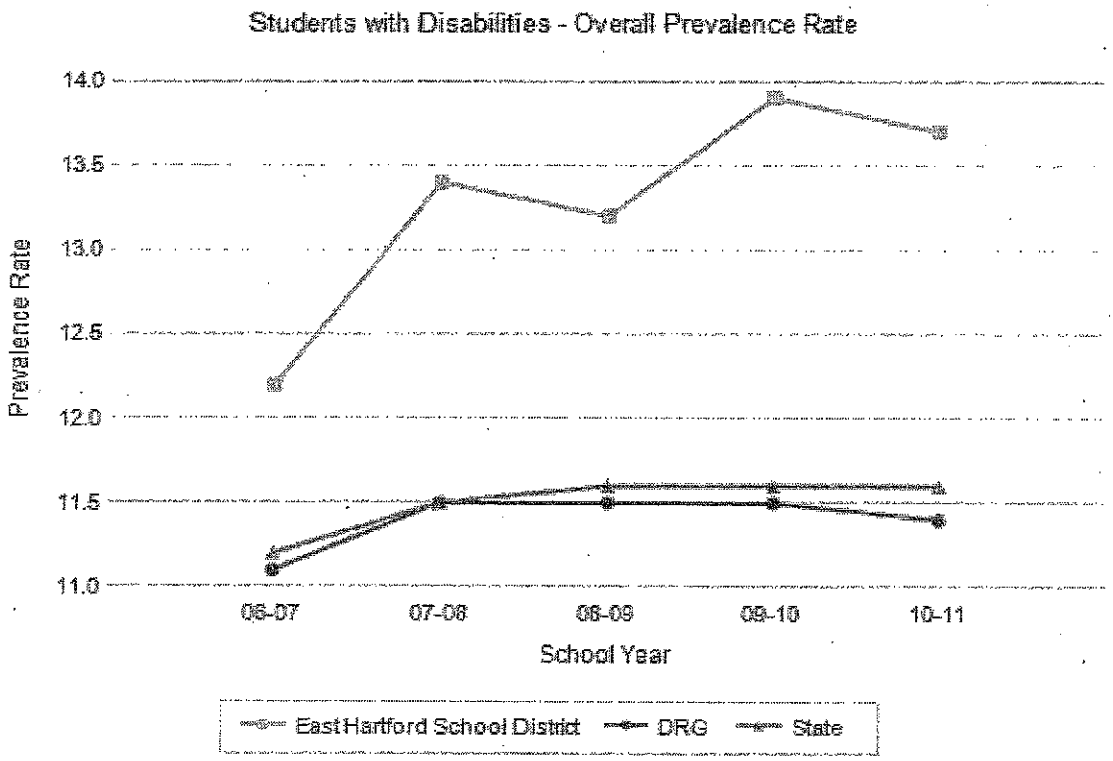


East Hartford School District
Discipline - Incidents by All Categories by Year

Year(s): 2009-10

- Indicates no data

Category	East Hartford School District
Drugs	47
Fighting/Battery	259
Personally Threatening Behavior	257
Physical/Verbal Confrontation/Conduct Unbecoming	717
Property Damage	39
Sexually Related Behavior	35
Theft/Theft Related Behaviors	76
Violent Crimes Against Persons	3
School Policy Violations	4031
Weapons	19
Total	5,483



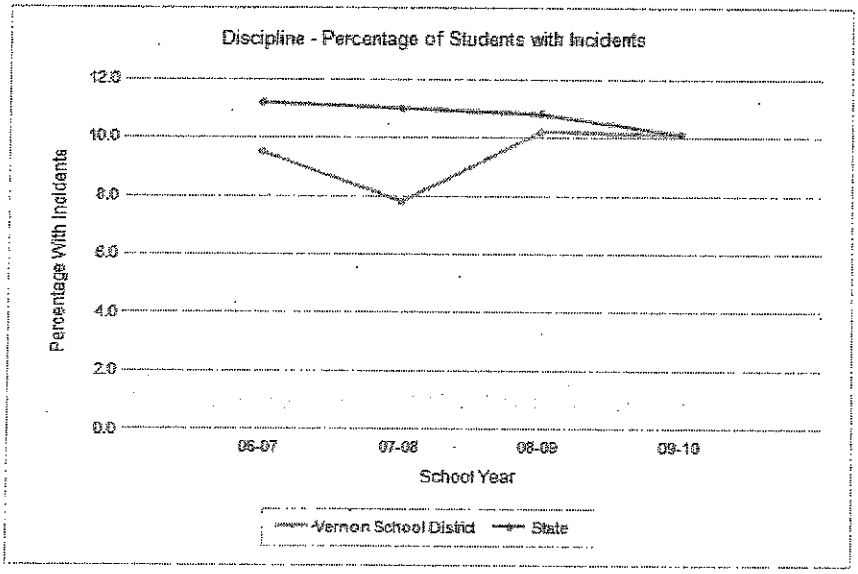
East Hartford School District
Students with Disabilities - Overall Prevalence Rate

- Indicates no data

***** Denotes suppressed value***

School Year	East Hartford School District	District Reference Group (DRG)	State
2010-11	13.7	11.4	11.6
2009-10	13.9	11.5	11.6
2008-09	13.3	11.5	11.6
2007-08	13.4	11.5	11.5
2006-07	12.2	11.1	11.2

Vernon School District



Vernon School District

Discipline - Percentage of Students with Incidents

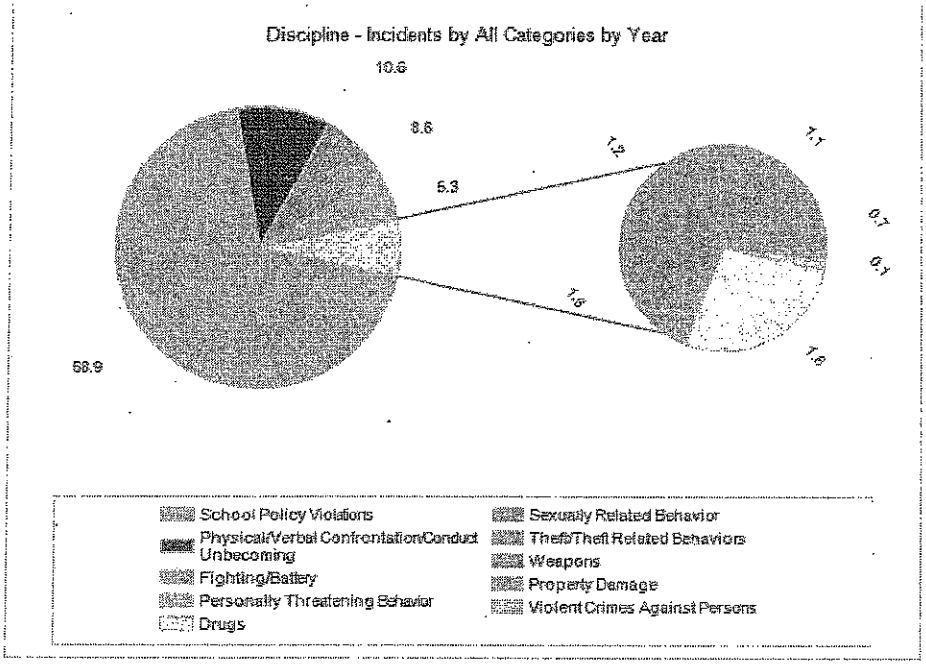
- Indicates no data

***** Denotes suppressed value***

School Year	Vernon School District			State		
	Students with Incidents	Total Enrollments	Percentage with Incidents	Students with Incidents	Total Enrollments	Percentage with Incidents
2009-10	373	3,681	10.1	56,715	563,449	10.1
2008-09	366	3,583	10.2	60,599	563,195	10.8
2007-08	284	3,661	7.8	62,791	570,494	11.0
2006-07	359	3,783	9.5	64,333	574,749	11.2

Vernon School District
Year(s): 2009-10

Click on a section of the pie to view longitudinal detail.

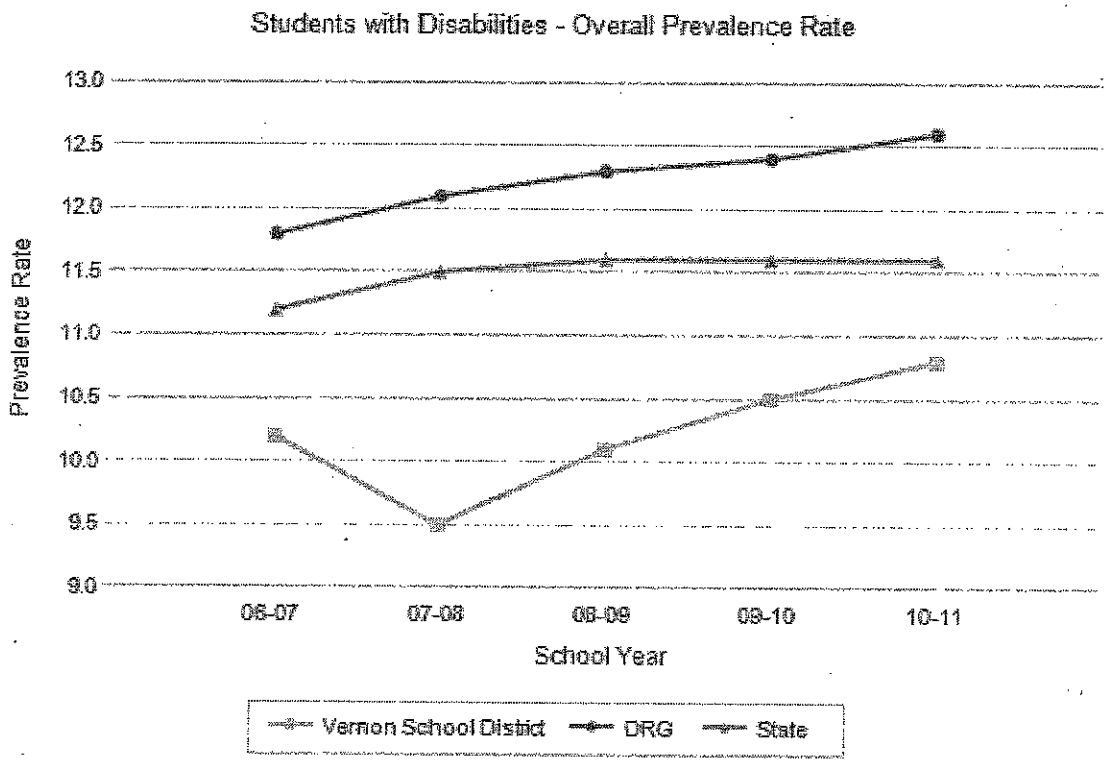


Vernon School District
Discipline - Incidents by All Categories by Year

Year(s): 2009-10

- Indicates no data

Category	Vernon School District
Drugs	18
Fighting/Battery	84
Personally Threatening Behavior	52
Physical/Verbal Confrontation/Conduct Unbecoming	104
Property Damage	7
Sexually Related Behavior	16
Theft/Theft Related Behaviors	12
Violent Crimes Against Persons	1
School Policy Violations	675
Weapons	11
Total	980



Vernon School District
Students with Disabilities - Overall Prevalence Rate

- Indicates no data

*** Denotes suppressed value***

School Year	Vernon School District	District Reference Group (DRG)	State
2010-11	10.8	12.6	11.6
2009-10	10.5	12.4	11.6
2008-09	10.1	12.3	11.6
2007-08	9.5	12.1	11.5
2006-07	10.2	11.8	11.2

Appendix #5A

- Organization
- Facilities
- Inmate Search
- Attorneys/Professional Visits
- Victim Services
- Directives and Policies
- Frequently Asked Questions
- Information for Friends & Families
- Statistics
- Recidivism
- Fugitive Tip Line

RECOVERY INFORMATION

Receive Updates by E-mail Sign-Up for E-alerts

How to Help Sandy Hook Elementary School Shooting Victims

VETERANS

STORM SANDY Region of Recovery

CT Alert WE CAN'T ALERT YOU IF WE CAN'T REACH YOU

Directions

Recidivism

The most recent study of recidivism within the Connecticut Department of Correction was completed in February of 2012 by the State Criminal Justice Policy and Planning Division of the Office of Policy and Management. The study followed 14,398 male sentenced offenders after they were released or discharged from a prison facility in 2005, providing a five year review of recidivism.

The study found that within five years of their release; 79 percent were re-arrested, 69 percent were convicted of a new crime, and 50 percent were returned to prison with a new sentence.

The study also found that; 50 percent of the offender group had served at least one sentence for violating the terms of their probation, 46 percent had served time in prison for a drug charge and 19 percent had served a prior sentence for driving under the influence or alcohol or drugs.

The study focused on the recidivism rate of sex offenders and found overall, their rate of committing new crimes was lower than the overall group of offenders.

The report presents many other parameters of recidivism and is available at Office of Policy and Management site

Sex Offender Recidivism Report (PDF)

Substance Abuse Treatment

A separate study, conducted through the Center for Alcohol and Addiction Studies at Brown University and the Schneider Institute for Health Policy, Heller School at Brandeis University, studied the effects of substance abuse treatment on released offenders. This evaluation sampled inmates who were released between 1996 and 1997 with a sub-sample of 1,463 selected for intensive data collection.

The study found that inmates who had attended the Department of Correction's Tier Substance Abuse Treatment Program were significantly less likely to be rearrested, with 32.5% who attended the Tier Program re-arrested within one year of release compared to 45.9% who did not attend the program. .

The study also found that there was a linear relationship between the intensity of the program and the benefits of treatment. Tier Two participants were re-arrested at a rate of 32%, Tier 3 at a rate of 20% and only 17% of inmates who attended Tier Four, a six-month residential therapeutic community, were re-arrested. The study also found that attending the Tier Program significantly reduced the severity of crimes committed.

Substance Abuse Treatment for Connecticut Prisoners Reduces Rearrest Rates and Is Cost Effective

Charlene Perkins Reentry Center

The Charlene Perkins Reentry Center is a 100 bed stand alone program on the grounds of the York Correctional Institutional Center in Niantic. In keeping with the DOC's Reentry Mission, the program was established by Commissioner Theresa C. Lantz in May of 2005 to facilitate the successful community reintegration of women offenders, moving them from incarceration dependency to community self-sufficiency and law-abiding behavior.

During a average stay of three months prior to release, offenders are provide specialized, evidence based programming to include Addiction Services, Resettlement, Job Center and Intimate Partner Violence.

Between July 1, 2006 and February 28, 2009, 1,212 women were enrolled at the Charlene Perkins Center. While 313 of those did not complete the program, 899 were returned to the community. Of those who returned to their home community, 144 were later returned to York, C.I. for violations of their release conditions or for a new criminal charge. This equates to a return rate of 16 percent.

Northern CI/Administrative Segregation Program

The Administrative Segregation Program at the Northern Correctional Institution provides a highly structured and secure environment for inmates who have engaged in aggressive, violent or disruptive behavior, or pose an imminent risk to the public staff and other inmates. During the years, 2006 and 2007 some 120 offenders were assigned to take part in this program, which requires a minimum 10 month stay. Of that total number of inmates, only nine, were returned to the program over the course of the next two years. This translates into a recidivism rate of just 7.55 percent for this highly successful behavior modification program.

While not scientific, nor of a long duration, a March 2009 review of the graduates from the faith based Chrysalis program at the York Correctional Institution for women, shows promising results for those offenders who discharge after graduating. The program, which embraces all religious beliefs in an atmosphere which encourages faith and commitment to productive lifestyles, found that of the 180 offenders who had completed the program since its inception in May 2003, only 20 of those released have returned to prison with new charges reflecting a rate of about 12 percent.

Gang Management Program

The agency has also had a great deal of success with its innovative gang management program, which has been copied by a number of other states across the country. Initiated in 1994, the intensive Close Custody program requires that designated Security Risk Group/gang members ultimately renounce their membership to successfully complete the program at the state's maximum security Northern Correctional Institution.

To date more than 5,200 offenders have been designated as gang members once admitted to the agency and all have been involved to some extent with the Close Custody program. Recidivism in this regard is defined as gang members who renounce and complete the program, but are then found to have become re-involved with Security Risk Groups either once released or while still incarcerated. To date slightly more than 400 offenders have recidivated and have been re-designated as gang members. This translates into a recidivism rate of approximately 8%.

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Appendix # 5 B

Domestic Violence Counts
Connecticut Summary

heads at night, shelter residents were provided with a variety of comprehensive services, some of which are sted in the chart below.

496 adults and children received non-residential assistance and services, including individual counseling, legal advocacy, and children's support groups.

This chart shows the percentage of programs that provided the following services on the Census Day.

Services Provided by Local Programs:	Sept. 15
Individual Support or Advocacy	100%
Children's Support or Advocacy	94%
Emergency Shelter (including hotels or safe houses)	76%
Court/Legal Accompaniment/Advocacy	76%
Bilingual Advocacy (services by someone who is bilingual)	71%
Advocacy Related to Public Benefits/TANF/ Welfare	71%
Group Support or Advocacy	65%

204 Hotline Calls Answered

Domestic violence hotlines are a lifeline for victims in danger, providing support, information, safety planning, nd resources. In the 24-hour survey period, Connecticut programs answered more than 8 hotline calls every hour.

abuse counseling, and legal representation.

86% of Unmet Requests Were for Housing

With 48 unmet requests, emergency shelter and transitional housing continue to be the most urgent unmet needs. Other frequently requested unmet needs include legal representation, counseling, and legal advocacy.

Programs were unable to provide services for many reasons:

- 35% reported no available beds or funding for hotels.
- 29% reported not enough funding for needed programs and services.
- 29% reported not enough specialized services.
- 24% reported not enough staff.
- 18% reported limited funding for translators, bilingual staff, or accessible equipment.

"This evening we received a crisis call from a 23 year-old woman whose boyfriend had assaulted her when she told him she was leaving. He stood on her feet so she could not leave and punched her. She was able to break away and call the police, who came and helped her get to the emergency room. She had a fractured ankle from the violent attack, but we were able to shelter her and her infant son in a physically accessible room."

National Facts

- In 2009, violent crimes by intimate partners (current or former spouse, boyfriend or girlfriend) accounted for 26 percent of non-fatal crimes against females and 5 percent against males. 1
- Of female murder victims in 2009, 35 percent were killed by an intimate partner.2
- In 2008, 14 percent of state and 17 percent of local firearms application rejections were due to a domestic violence misdemeanor conviction or restraining order. 3
- Domestic violence victims constituted 25 percent of all adult victims compensated by victim compensation programs in 2009. They received compensation for 40 of all assault claims. 4
- One study found that women who had experienced any type of personal violence (even when the episode was 14 to 30 years ago) reported a greater number of chronic physical symptoms than those who had not been abused. The risk of suffering from six or more chronic symptoms increased with the number of forms of violence experienced. 5
- Fifteen percent of teens who have been in a relationship report having been hit, slapped or pushed by their boyfriend or girlfriend. 6
- For two percents of adults on probation, domestic violence was the most serious offense of which they had been convicted. 7
- A study of Native American Women in Oklahoma found that 83 percent had experienced physical or sexual intimate partner violence in their lifetimes, and 68 percent had experienced severe forms of violence. 8
- 89 percent of Native American women who reported partner violence in their lifetime had suffered injuries from the violence, and 73 percent reported moderate or severe injuries, with nearly one in four (22 percent) reporting more than 20 different injury incidents. 9
- During 2001-2005, Native American/Alaska Native females had the highest rate of intimate partner victimization (11.1 per 1,000), compared to black females (5.0), white females (4.0), and Asian American females (1.4). 10
- A 2004 study found that women living in disadvantaged neighborhoods were more than twice as likely to be victims of intimate partner violence compared with women living in more advantaged neighborhoods. 11
- In 2008, lesbians, gays, bisexuals, transgender or queer people (LGBTQ) reported 3,419 incidents of domestic violence to local anti-violence programs. Nine of these incidents resulted in murder. 12
- In 2008, 51 percent of LGBTQ domestic violence victims were women, 42 percent men and 5 percent transgender. 13
- In cases where the age of the victim as reported, 64 percent of LGBTQ domestic violence victims were over the age of 30, while 36 percent were under 30. 14

1. Bureau of Justice Statistics, "Criminal Victimization, 2009," (Washington, DC: U.S. Department of Justice, 2010), 7, http://bjs.ojp.usdoj.gov/content/pub/pdf/cv09.pdf (accessed October 28, 2010).

2. Federal Bureau of Investigation, "Crime in the United States, 2009: Expanded Homicide Data," (Washington, DC: GPO, 2010), calculated from Tables 2 and 10, http://www.fbi.gov/about-us/cjis/ucr/crime-in-the-u.s/2009 (accessed October 18, 2010).

3. Bowling et al., "Background Checks for Firearm Transfers, 2008," (Washington, DC: Bureau of Justice Statistics, 2010), 1, http://bjs.ojp.usdoj.gov/content/pub/html/bcft/2008/bcft08st.pdf (accessible October 18, 2010).

4. National Association of Crime Victim Compensation Boards, "Crime Victim Compensation Helps Victims," (Alexandria, VA: NACVCB, 2010), http://www.nacvcb.org/NACVCB/files/ccLibraryFiles/FILENAME/000000000035/facts%20about%20crime%20victim%20compensation2010.doc (accessed October 18, 2010).

5. Christina Nicolaidis et al., "Violence, Mental Health, and Physical Symptoms in an Academic Internal Medicine Practice," Journal of General Internal Medicine 19 (2004): 823, http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=1492498 (accessed October 18, 2010).

6. Teen Research Unlimited, "Liz Claiborne Inc. Topline Findings: Teen Relationship Abuse Survey (Conducted March 2006)," (Northbrook, IL: Teen Research Unlimited, 2006), 11, http://www.loveisnotabuse.com/pdf/Liz%20Claiborne%20Mar%2006%20Relationship%20Abuse%20Hotsheet.pdf (accessed October 18, 2010).

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8. Lorraine Halinka Malcoe and Bonnie M. Duran, "Intimate Partner Violence and Injury in the Lives of Low-Income Native American Women," in Family Violence and Violence Against Women: Developments in Research, Practice, and Policy, ed. Bonnie Fisher (Washington, DC: NIJ, 2004), I-2-9, http://www.ncjrs.gov/pdffiles1/nij/199703.pdf (accessed October 18, 2010).

9. Ibid., I-2-10.

10. Shannon Catalano, "Intimate Partner Violence in the United States, 2007," (Washington, DC: Bureau of Justice Statistics), http://bjs.ojp.usdoj.gov/content/intimate/victims.cfm (accessed November 15, 2010).

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12. National Coalition of Anti-Violence Programs, "Lesbian, Gay, Bisexual, Transgender, and Queer Domestic Violence in the United States in 2008," (New York: National Coalition of Anti-Violence Programs, 2009), 2, http://www.avp.org/documents/2008NCAVPLGBTQDVReportFINAL.pdf (accessed October 26, 2010).

13. Ibid., 20.

14. Ibid., 23.

Regional and State Employment and Unemployment Summary

Appendix # 5 D

Table A. States with unemployment rates significantly different from that of the U.S., October 2012, seasonally adjusted

State	Rate(p)
United States (1)	7.9
California	10.1
Connecticut	9.0
Delaware	6.8
Georgia	8.7
Hawaii	5.5
Illinois	8.8
Iowa	5.1
Kansas	5.7
Louisiana	6.6
Maryland	6.7
Massachusetts	6.6
Michigan	9.1
Minnesota	5.8
Missouri	6.9
Montana	6.0
Nebraska	3.8
Nevada	11.5
New Hampshire	5.7
New Jersey	9.7
New Mexico	6.3
New York	8.7
North Carolina	9.3
North Dakota	3.1
Ohio	6.9
Oklahoma	5.3
Rhode Island	10.4
South Dakota	4.5
Texas	6.6
Utah	5.2
Vermont	5.5
Virginia	5.7
Wisconsin	6.9
Wyoming	5.2

1 Data are not preliminary.
p = preliminary.

Appendix # 5 E

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Bullying: A Family and School System Treatment Model

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Because bullying is often conceptualized as a school problem, most interventions are school-based and exclude the family. However, joint family and school involvement must occur for long-term problem resolution. This article incorporates structural and narrative interventions within a family and school system treatment model comprised of the following stages: structuring change, changing the story, and solidifying change. The therapist helps to shift family structure, while also changing the dominant bullying story. This article also examines the appropriate implementation of the birth certificate for new identity formation, and death certificate for bullying cessation.

BULLYING: A FAMILY AND SCHOOL SYSTEM TREATMENT MODEL

School shootings, effects of bullying taken to the extreme, have recently been witnessed in the United States at Columbine High (Littleton, CO in 1999), at Santana High (Santee, CA in 2001), at Red Lake High (Ojibwe Reservation, MN in 2005), and at Virginia Tech (Blacksburg, VA in 2007). Possibly due to incidents like these, recent media and public attention has been directed at school bullying. Though interest in the topic appears to have increased dramatically, the field is still lacking in research, especially research related to family-based treatment.

Traditionally, school-based interventions have been the normative means to resolve bullying (Smith & Ananiadou, 2003), but the family must also be involved for the problem to fully abate. Interventions that include the family are desperately needed to confront bullying. The collaboration of family and school systems provides the most effective and lasting means of bullying intervention (Ahmed & Braithwaite, 2004). We propose a bullying

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treatment model that integrates the efforts of these systems at the family and individual level. We will discuss the definition of bullying and its prevalence. We will also discuss the characteristics of bullies and their families, the components and suitability of structural and narrative therapy as treatment modalities, and, finally, the three stages of the family and school system treatment model.

BULLYING DEFINITION AND U.S. PREVALENCE

Bullying behavior is a form of aggression that can be "physical (e.g. hitting, pushing, kicking), verbal (e.g. calling names, provoking, making threats, spreading slander), or can include other behavior such as making faces or social exclusion" (Fekkes, Pijpers, & Verloove-Vanhorick, 2005, p. 81). Bullying is the recurrent exposure of abusive actions on one student by one or more students (Olweus, 1993), and is intended to disturb, harm, or incite fear (Nansel et al., 2001). Additionally, bullying can be characterized by an "imbalance of power" (Fekkes et al., 2005, p. 81), or by pretended or actual power differentials that emerge between students and their aggressors.

In the United States, researchers from the National Institute of Child Health and Human Development (NICHD) surveyed 15,686 public, parochial, and private school students, grades 6 through 10, to assess their experience with bullying (Nansel et al., 2001). Approximately 1.7 million students reported being bullied "about once a week" or "several times a week," while approximately 1.6 million students reported being bullied by aggressors "once a week" or more. This represents 8.4% and 8.8% of the student populace, respectively, which is indicative of an advanced problem.

CHARACTERISTICS OF BULLIES AND THEIR FAMILIES

It has been cross-culturally substantiated that bullying is more prevalent among males, and that the frequency of bullying decreases as the age of school children increases (Nansel et al., 2001). Generally, bullying is more frequent among 10–14 year olds and decreases proportionately with age (Harris & Petrie, 2003; Olweus, 1993). Bullies are also four times more likely to be involved with criminal behavior by age 24 (Olweus, 1992). Additionally, school students who bully others are more likely to be involved in problematic behavior such as under-aged smoking and drinking and have poorer psychosocial adjustment (Nansel et al., 2001). They also tend to have substandard achievement scores, take longer to perceive school conditions as positive (Nansel et al., 2001), and have higher middle- and high-school dropout rates (Harris & Petrie, 2003).

There are also several family characteristics related to bullying. For example, bullies perceive their fathers as having more power than their mothers

(Bowers, Smith, & Binney, 1992). Children who bully tend to have more lenient mothers, and fathers who act hostile and violent when punishing (Olweus, 1980). Bullies are also most likely to be raised in homes of authoritarian parents (Smith & Myron-Wilson, 1998), characterized as high in demandingness and low in responsiveness (Baumrind, 1971). Consequently, parents of bullies tend to be punitive, harsh, and "obedience-or-else"-oriented towards their children.

STRUCTURAL FAMILY THERAPY OVERVIEW

Structural family therapy views families from an organizational perspective. A core tenet attests that families are inherently good and have the capacity to create and maintain change (Minuchin, 1974). Families possess the necessary structures to manage the changes of life. However, when structural shifts do not occur, or when they occur suddenly, maladaptive structures can be introduced into the system that can maintain pathology (Minuchin, 1974). The therapist enters the system to perturb it and shift the family to a more adaptive structure. As such, the therapist assumes the role of leader and the initial agent of change. We will address some components of structural family therapy that we will later apply to bullying, namely: joining, boundary marking, and unbalancing.

COMPONENTS OF STRUCTURAL FAMILY THERAPY

Joining

A vital technique of structural family therapy is for the therapist to understand the family's perspective and empathize with their current situation. The therapist should treat each subsystem with respect by considering every vantage point without imposing his or her own values. The therapist must also accept the organization of the family and blend into their system so as not to be rejected (Minuchin, 1974). Once adequate joining has taken place with the family, the therapist can then use the techniques of boundary marking and unbalancing.

Boundary Marking

Boundary marking (Minuchin, 1974; Minuchin & Fishman, 1981) is a restructuring technique in which the therapist illuminates the boundaries that are adaptive. The therapist strengthens and protects appropriate boundaries while diminishing inappropriate boundaries. For example, the therapist will intervene when a child interrupts a spousal transaction by blocking the child's attempted interference with the executive subsystem (Minuchin, 1974). This

new boundary is further strengthened when the therapist decides to see the couple alone.

Unbalancing

Unbalancing is another restructuring technique in which the therapist temporarily joins with a certain individual or subsystem in order to introduce a shift in power relations. An example of unbalancing could be when the therapist ignores a family member, which can have a quieting effect on that person. After shifting the power structure by siding with an individual or subsystem, the therapist must then rebalance the system by rejoining with the opposed member(s). This reparative attempt is necessary to restore feelings of support and trust with the other family members.

Justification for Structural Family Therapy

Structural family therapy has been integrated into the treatment to shift family structure because of the parental power imbalance which has been found in families of bullies. However, if a structural shift is to be introduced and take effect, joining must occur first so that the therapist gains the family's trust. Boundary marking was adopted because it highlights the adaptive and maladaptive boundaries of the family and bully. It also adds clarity to the necessary structural shift and can assure the family and parents that they do possess noteworthy qualities. Unbalancing was also chosen because it can be used specifically to address parental power imbalances.

NARRATIVE THERAPY OVERVIEW

Proponents of narrative therapy hold that ideas create life stories which constitute meaning in individuals' lives. White and Epston (1990) proposed that "dominant stories" (i.e., individuals' views that are thought to be reality) influence people's lives. According to White and Epston (1990), individuals have difficulties when their dominant stories do not accurately represent their lived experience. However, as individuals break free from these stories, they are capable of identifying "unique outcomes" or times when they were able to solve their problem. They were not previously able to recognize times when the problem did not exist (subjugated stories) because their reality was obscured by the dominant story. As individuals identify their subjugated stories, they are able to intervene in their own lives. Awarding written certificates of achievement solidifies their newly written stories (Freedman & Combs, 1996). We will address some components of narrative therapy that will be incorporated into the bullying treatment model, such as externalizing, landscape of action, and landscape of consciousness questions.

COMPONENTS OF NARRATIVE THERAPY

Externalizing Questions

When individuals view themselves or their relationship as the problem, it hinders their ability to solve the problem. Externalizing questions help clients separate the problem from themselves or their relationship that was recognized as the problem (White & Epston, 1990). The externalizing process enables the clients to bring about new ways to overpower the problem and regain control over their lives. An example of externalizing the problem could be "How has this problem taken control over your life?" The therapist also asks how the problem has influenced others, specifically the client's relationship with others. These questions help clients disconnect from the dominant stories that have been obstructing their lives.

Landscape of Action Questions

After the problem has been externalized, the therapist asks landscape of action questions to help clients identify unique outcomes (White, 1995). Landscape of action questions help clients identify times when they have control over the problem they are experiencing. An example of identifying unique outcomes could be, "At what times in your life was the problem not present?" The therapist can then follow up with more detailed questions. Unique outcomes can also be identified by asking clients about how they are planning to overcome the influence of the problem. Creating those problem-resolving plans empowers clients to personally conquer the problem.

Landscape of Consciousness Questions

Once clients discover and integrate their solutions to the problem, the therapist then asks landscape of consciousness questions. These questions help clients reflect on their strengths that have contributed to their problem solving and to better solve their problems in the future. They also help clients see themselves in a positive new light as competent individuals. An example of a landscape of consciousness question could be, "How did you know this was the right way for you to solve your problem?" (Wetchler, 1999, p. 20). A question such as this empowers individuals, reinforcing their positive self-image.

Justification for Narrative Therapy

Narrative therapy was incorporated into the treatment model because bullying has likely become the dominant story for the child at home and at school. Externalizing the bullying can help change the child from being seen as "the problem-child," and as a result the family can work together to overcome the bullying. It will also help the child become less defensive and resistant

during treatment because instead of being the problem that needs to be fixed, he or she has a problem that the family is trying to overcome together. No longer being the bully will allow the family to view the child in a new light and to rewrite their dominant story. Landscape of action questions will help the child recognize times at school when they did not bully other students. Recognizing these times will help the child recognize how and when he or she had control over the bullying, which ultimately empowers the child.

FAMILY AND SCHOOL TREATMENT MODEL

Family and school cooperation leads to the most effective treatment method for bullying (Ahmed & Braithwaite, 2004). Our model calls for the collaboration of the school counselor and teacher in the process of family therapy. The school becomes more involved with the treatment by having the family and therapist communicate directly with the school on a regular basis throughout the treatment intervention. This will ensure that the child is not relaying messages between the school and his or her parent(s) (Wetchler, 1986). It will also show the child that the family and school are working as a team to overcome the bullying.

Our model is comprised of the following three stages: Stage 1: Structuring Change; Stage 2: Changing the Story; and Stage 3: Solidifying Change. Stage 1 will utilize structural components for several reasons. First, research has shown that families of bullies have power differentials in the executive subsystem (Bowers et al., 1992) which maintain the bullying behavior. This calls for re-structuring at the beginning stage of therapy. Structural family therapy also calls for the parent(s) to collaborate regarding the bullying child. This provides an "initial kick" (Maruyama, 1963) that can elicit an alternate pattern of interaction starting at the parental head, which establishes a standard for lasting change. Finally, it highlights family boundaries which may prepare and buffer against children challenging the boundaries later.

Although the effects of structural interventions will continue throughout therapy, Stage 2 will focus on various narrative therapy components. Families of bullies enter therapy inundated with the dominant bully story. This can become a self-fulfilling prophecy that is difficult to reverse, unless the story is changed starting with the parent(s) and nuclear family. Narrative therapy helps the family change this story and draw out the subjugated stories largely absent in common discourse among school and legal systems. It will continue to build on the new family stories of altered power structure, parental collaboration, and sibling unity. Moreover, during Stage 3, narrative therapy helps the family to continue to look at the child differently and allow the story to gradually spread to the macrosystem. Narrative techniques such as landscape of action questions help the family to be future-focused, which is fitting for families near termination of therapy. They also strengthen the

newly authored story, re-author the parents' sense of self as parents, and increase family unity as they help others see their child or sibling differently. Regarding session structure, it is recommended that the whole family attend for Stages 1 and 3 even if the parents are divorced. If the family desires, a contact from the school may also attend. We recommend that only the parent(s) and the bullying child attend during Stage 2.

Stage 1: Structuring Change

Because of the aforementioned family characteristics associated with bullies, it is crucial that the family be integrated into the treatment model. For example, power imbalances among the parents call for a desperate need of family restructuring. During Stage 1, the therapist will meet with the entire family and use structural techniques of joining, boundary marking, and unbalancing. These techniques will begin to perturb the system and shift the family to a structure that is more adaptive for dealing with bullying. Stage 1 will end when the family has initiated several structural changes (e.g., when the mother of the family is more assertive in her parenting role).

Joining is the first step of the structural intervention. While meeting with the entire family, the therapist initiates by joining with the parent(s) as they might wonder why they are in therapy and may question their continuing presence. The therapist will first get to know the parent(s) and express interest in what they enjoy. Then, the therapist will listen to the parents' perspective about what has been happening and what needs to happen. This will create an initial connection only between the therapist and the parent(s), and will highlight the parent(s) as the executive subsystem. This sets the precedent, in front of the whole family, for the hierarchy that will be called upon later in therapy. Next, the therapist will join with the bully. This emphasizes the therapist's concern for the bully, and sends a message to the family that the therapist is concerned about what has been happening. The therapist will then join with the rest of the family, which emphasizes the importance of family involvement and collaboration. Joining with all family members is a prerequisite to boundary marking and unbalancing; insufficient or ineffective joining would likely result in the family or certain family members discontinuing therapy.

The therapist may also use boundary marking during Stage 1. According to Smith, Schneider, Smith, and Ananiadou (2004), "children can be protected against serious problems associated with bullying by authoritative parents who communicate love and warmth, set appropriate limits, and use nonphysical punishment to correct misbehavior" (p. 548). A structural approach that models authoritative parenting could be the parent(s) setting appropriate limits. For example, the parent(s) could negotiate house rules, consequences, and rewards. These boundaries give the bullying child a sense of security and could help him or her feel less of a need to take frustrations out on others.

Also, as part of marking boundaries, if the bullying child acted out during therapy or interrupted one of the parents, the parent(s) will in turn interrupt the bully. As a case example, the two teenage boys of the "C" family had school-based aggression problems and frequently interrupted the parents. The therapist encouraged the parents to not let this happen, but to allow the parents to interrupt the children so as to demarcate the executive subsystem. The therapist could also ask to see the parent(s) alone, thus removing the bullying child and other children out of the executive subsystem and creating or highlighting a clear boundary between the parent(s) and children.

As bullies perceive their fathers as having more power than their mothers (Bowers et al., 1992), the therapist will form a temporary coalition with the mother as an unbalancing technique. The therapist could form this temporary coalition with the mother by specifically asking her questions regarding the bullying child or blocking questions or interactions from others regarding the bully. The therapist could also meet with the mother individually. This will alter existing power differentials and empower the mother in the eyes of the father, the family, and most importantly, the bully. The therapist would eventually have to re-join with the opposed partner to restore feelings of support and trust and re-establish the executive subsystem. If the caregiver is a single parent or if one of the parents could not be involved with therapy, the therapist will still form a temporary coalition with the present parent; however, in this case, it would be against the bully. This will empower the single parent against the behavioral assertions that the bullying child makes. In this case, a total rebalance with the bullying child in the presence of the parent is unnecessary because the therapist does not want to deemphasize the established boundary between parent and child. However, as the therapist does not want to alienate the parent and the bullying child, the therapist must later express some form of support to the child (Minuchin, 1974).

Stage 2: Changing the Story

During Stage 2, the therapist will see the parent(s) and the bullying child separately. He or she will use the narrative techniques of landscape of action and landscape of consciousness questions with the parent(s). Generally, the parent(s) will talk about the bullying child as the "problem child;" thus, questions that externalize bullying will not be used with the parent(s) so that they feel understood and willing to return to therapy. As noted previously, when individuals view themselves as the problem, they become disempowered and have difficulty effectively resolving problems. Thus, externalizing the problem becomes especially important with the child, as the bullying child typically gets labeled by the parent(s) and school system as "the problem." Externalizing questions, as well as questions that deconstruct the dominant bad-kid story and amplify the subjugated good-kid story, will be used during individual meetings with the bullying child. As a case example, the oldest

teenage son Nathaniel from the "C" family wielded a knife at school and was quickly labeled as the school problem. The therapist ensured the language used separated Nathaniel from the aggression, and this precipitated a notable positive effect in the child and family.

During our individual sessions with the parent(s), the therapist will ask landscape of action and landscape of consciousness questions to rewrite their story of self. As the parent(s) of bullies are more likely to be authoritarian and not have a confident sense of self (Baumrind, 1971), landscape of action questions must be asked to identify times when they parent confidently. For example, the therapist could ask the parent(s), "Has there ever been a time when the bullying problem tried to get the upper hand, but you were able to resist it through your confident parenting?" Landscape of action questions like these allow the parent(s) to note the times when they are in control, while also helping them see the positive aspects of having a confident sense of self.

Likely the dominant story told by the school and others is that the parents are not doing a good job with the child. A landscape of action question like, "When were you able to parent in a way that caused your child to act differently?" accentuates the subjugated story of being a good parent. The therapist could also help the parent(s) to identify unique outcomes with their child and think in terms of being in control of their child. Once the parent starts to identify and implement authoritative parenting solutions to the problem, the therapist then asks landscape of consciousness questions such as, "How did you know this was the right way for you to parent?" (Wetchler, 1999). This helps parents to self-reflect on their parenting skills and gives them some necessary authoritative parenting and problem resolution skills.

Children labeled as the bullies often get blamed by students and teachers for starting altercations. Thus, during our individual sessions with the bullying child, the therapist will first externalize the problem from the child. For example, he or she will begin by labeling bullying as "the problem" and have the child name the problem. For instance, suppose the child named the problem "the rebel." A question such as, "How has the rebel sometimes taken control over your life?" is effective at externalizing the problem.

After externalizing the problem, the therapist will then deconstruct dominant bullying stories and amplify subjugated stories through landscape of action and consciousness questions. Landscape of action questions like, "When were you able to take control of the rebel and not allow it to hurt others?" accentuate the subjugated story of being a good child. The therapist could also say something like, "Tell me about times when you talk the rebel into acting differently," which encourages the child to identify unique outcomes and think in terms of being in control.

Once the child starts to identify and implement solutions to the problem, the therapist then asks landscape of consciousness questions. A question such as, "What does this say about you, that you were able to defeat the rebel?" (Wetchler, 1999) forms a stronger self-concept by helping the child to

realize that he or she has the expertise to solve bullying and other problems. These questions also help the child to see himself or herself as a competent individual, to capitalize on inner strengths, and to better prepare for future problem resolution.

Stage 3: Solidifying Change

Continuing with narrative techniques, during Stage 3 the therapist would help the child and the family identify their unique outcomes. For example, the therapist could ask the parent(s) in the presence of the family, "How were you able to help your child overcome bullying?" Note that the therapist avoids usage of the word "bully" in order to avoid labeling the child and re-circulating the previously dominant bully story. The therapist would seal the therapeutic change by asking landscape of action questions like, "How were you able to overcome bullying and come so far?" Other questions like, "How will your ability to pull together as a family shape your future?" serve to strengthen the rewritten family story for future reference. Finally the therapist would provide compliments for their new family story. The therapist would compliment each family member as an important author in this reworked story.

At the final session of therapy the entire family would return to receive a certificate for their collaborated efforts and progress. A family certificate would be handed to the parent(s) for the family's unity and strength at tackling this problem. The child who previously bullied would also specifically be awarded a certificate for defeating bullying. This would continue to reaffirm the new story authored by the child and serve to empower his or her positive behavior. As a case example, Nathaniel who had previously acted as a school bully, started respecting his parents more and started managing his anger even at school. The therapist awarded Nathaniel with a congratulatory certificate of achievement which caused him to be notably emotional and proud of his new identity.

Furthermore, the therapist might award either a "birth certificate" for the child's new-found identity or a "death certificate" for the previous bullying. Once explained, these certificates could be shared with school personnel. The birth certificate celebrates and strengthens the child's identity of having positive interactions in the academic setting. It also provides a new beginning for the family by inviting positive interactions with their child's/sibling's new life. At the discretion of the child, the child and others may participate in identifying the new-formed aspects of his or her positive identity. Additionally, the therapist might consider the awarding of a death certificate, which celebrates the "death" of the previous bullying behavior. This intervention puts the bullying to rest and provides an ending point for social stereotypes of expected bullying behavior. As a cautionary note, the therapist should not conceptualize the certificate as the death of the child, but as the cessation and interment of the bullying behavior.

Both concepts of birth and death certificates incorporate boundary marking and externalizing the problem. For instance, the birth certificate marks a major life event, creating a new child identity which is incompatible with the previous bullying behavior. Additionally, the death certificate separates the child from the problem by "burying" the bullying and encouraging the survivor to live separate from it. These certificates help solidify change by being a constant physical reminder of their newly re-written stories.

CONCLUSION

Ahmed and Braithwaite (2004) posited that, "interventions solely on a family level will not be sufficient to impact on bullying at school" (p. 51). Thus it is essential that the therapist and family collaborate their efforts with the school system throughout all stages of therapy. Our family and school system treatment model focuses on family intervention with school involvement and consists of three stages: structuring change, changing the story, and solidifying change. During the first stage, the therapist will meet with the entire family and use the structural techniques in order to shift the family to a structure that is more adaptive for bullying. During the second stage, the parent(s) and the child identified as the bullying child meet individually. Narrative techniques are employed, to rewrite the dominant story for the parent(s) and externalize the bullying for the child. During the last stage, the therapist continues working with the family from a narrative perspective. The therapist helps the child and the family to continue to identify their unique outcomes, and awards the clients with certificates for their progress. The therapist may also introduce a birth certificate to celebrate the child's new-formed identity and a death certificates to demarcate the separation of the child from the bullying.

Our model advances the Marriage and Family Therapy field by approaching bullying from a systemic perspective. Not only does it include the family, but it also involves the school. As it is implemented, this model can help families and schools from the community collaborate their efforts in overcoming bullying. Consequently, positive results of treatment may materialize quicker and last longer than conventional methods. Further research is still warranted, however, on school bullying and its treatment. Large scale research on family treatment models are needed, especially longitudinal studies done at the state or community level. Most importantly, more research is needed on treatment models that combine the efforts of schools and families.

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U.S. Veterans: By the Numbers - ABC News

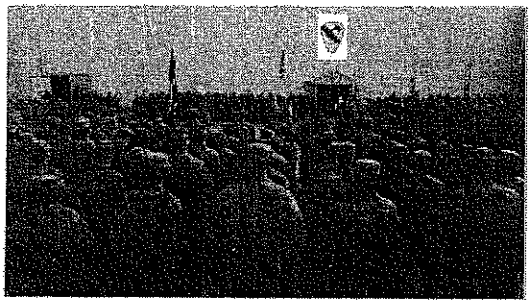
Appendix #5 E

By LUIS MARTINEZ (@LMartinezABC) and AMY BINGHAM (@Amy_Bingham)
Nov. 11, 2011

< 2,317,761 4 of 5 12.1 PERCENT >

POPULATION

.75 percent



John Moore/Getty Images

According to the 2010 Census, the population of the United States is 308,745,538. Including active duty, national guard and reserves, the population of Americans in uniform is 2,317,761, meaning that less than1 percent, .75 percent to be exact, of the country's population is a member of the military.

While only a fraction of a percent of the country's population is currently serving, 7 percent of the population is veterans. There are 22,658,000 veterans in america today, just 8 percent of which are female.

As of September 30, 2011, there are about 1,981,000 living veterans of World War II, a war that more than 4 million Americans were deployed to fight. About 800 of those veterans die every day.

Appendix # 5 B

Female Population
The estimated female population in South Windsor is 12,650 which is 51.8 of the total population (Compared to the national average of 50.90%).

Female Population, Married in South Windsor, Connecticut
There are an estimated 5,900 married women in the community. 59.2 percent of females over the age of 15 are married, compared to the national average of 52.10%.

AGE

Median Age in South Windsor, CT
The median age of people living in South Windsor, CT was 39 at the time of the last full census survey. (The United States average at the time was 35.3)

At that time, the number of people under the age of 5 living in South Windsor was 1,540. There were 17,735 people above the age of 18, which represents 72.6 percent of the entire population (compared to the national average of 74.30%). 11.9 percent of the population (2,900) in the community was 65 years and over, compared to 12.40% nationally.

RACE

One Race Percent in South Windsor, CT
At the time of the last census survey, the number of people of one race in South Windsor, CT was 24,177.

White Population in South Windsor, CT
The estimated White population in the South Windsor community is 22,336, which is 91.5 percent of the total population (The U.S. average is 75.10%).

Black Population in South Windsor, Connecticut
The estimated Black/African American population is 721, which is 3 percent of the total population in town (The U.S. average is 12.30%).

American Indian and Alaska Native Population in South Windsor, CT
In 2000, the number of American Indians or Alaska Natives in South Windsor, CT was 45.

Asian Population in South Windsor, Connecticut
At the last survey, the total Asian population in the community was 905.

Native Hawaiian and other Pacific Islander Population in South

Appendix #5 H

U.S. Census Bureau

AMERICAN FactFinder

DP-1

Profile of General Population and Housing Characteristics: 2010
2010 Demographic Profile Data

NOTE: For more information on confidentiality protection, nonsampling error, and definitions, see http://www.census.gov/prod/cen2010/doc/dpsf.pdf.

Geography: Manchester CDP, Connecticut

1 - 186 of 186

Subject	Number	Percent
SEX AND AGE		
Total population	19,249	100.0
Under 5 years	1,184	6.2
5 to 9 years	1,260	6.5
10 to 14 years	1,289	6.7
15 to 19 years	1,316	6.8
20 to 24 years	1,173	6.1
25 to 29 years	1,352	7.0
30 to 34 years	1,277	6.6
35 to 39 years	1,196	6.2
40 to 44 years	1,403	7.3
45 to 49 years	1,578	8.2
50 to 54 years	1,450	7.5
55 to 59 years	1,178	6.1
60 to 64 years	1,001	5.2
65 to 69 years	762	4.0
70 to 74 years	546	2.8
75 to 79 years	443	2.3
80 to 84 years	422	2.2
85 years and over	419	2.2
Median age (years)	38.4	(X)
16 years and over	15,235	79.1
18 years and over	14,670	76.2
21 years and over	13,956	72.5
62 years and over	3,188	16.6
65 years and over	2,592	13.5
Male population	9,265	48.1
Under 5 years	612	3.2
5 to 9 years	627	3.3
10 to 14 years	698	3.6
15 to 19 years	665	3.5
20 to 24 years	562	2.9
25 to 29 years	628	3.3
30 to 34 years	624	3.2
35 to 39 years	596	3.1
40 to 44 years	681	3.5
45 to 49 years	751	3.9
50 to 54 years	722	3.8

U.S. Census Bureau

AMERICAN FactFinder

DP-1 | **Profile of General Population and Housing Characteristics: 2010**
2010 Demographic Profile Data

NOTE: For more information on confidentiality protection, nonsampling error, and definitions, see http://www.census.gov/prod/cen2010/doc/dpsf.pdf.

Geography: East Hartford CDP, Connecticut

1 - 186 of 186

Subject	Number	Percent
SEX AND AGE		
Total population	51,252	100.0
Under 5 years	3,339	6.5
5 to 9 years	3,212	6.3
10 to 14 years	3,245	6.3
15 to 19 years	3,496	6.8
20 to 24 years	3,286	6.4
25 to 29 years	3,778	7.4
30 to 34 years	3,474	6.8
35 to 39 years	3,342	6.5
40 to 44 years	3,537	6.9
45 to 49 years	3,879	7.6
50 to 54 years	3,758	7.3
55 to 59 years	3,187	6.2
60 to 64 years	2,674	5.2
65 to 69 years	2,041	4.0
70 to 74 years	1,566	3.1
75 to 79 years	1,275	2.5
80 to 84 years	1,086	2.1
85 years and over	1,077	2.1
Median age (years)	37.8	(X)
16 years and over	40,788	79.6
18 years and over	39,275	76.6
21 years and over	37,305	72.8
62 years and over	8,606	16.8
65 years and over	7,045	13.7
Male population	24,558	47.9
Under 5 years	1,712	3.3
5 to 9 years	1,647	3.2
10 to 14 years	1,632	3.2
15 to 19 years	1,867	3.6
20 to 24 years	1,608	3.1
25 to 29 years	1,774	3.5
30 to 34 years	1,684	3.3
35 to 39 years	1,588	3.1
40 to 44 years	1,717	3.4
45 to 49 years	1,819	3.5
50 to 54 years	1,839	3.6

U.S. Census Bureau

AMERICAN FactFinder

DP-1

Profile of General Population and Housing Characteristics: 2010
2010 Demographic Profile Data

NOTE: For more information on confidentiality protection, nonsampling error, and definitions, see http://www.census.gov/prod/cen2010/doc/dpsf.pdf.

Geography: Rockville CDP, Connecticut

Subject	Number	Percent
SEX AND AGE		
Total population	7,474	100.0
Under 5 years	565	7.6
5 to 9 years	475	6.4
10 to 14 years	459	6.1
15 to 19 years	475	6.4
20 to 24 years	635	8.5
25 to 29 years	692	9.3
30 to 34 years	557	7.5
35 to 39 years	416	5.6
40 to 44 years	498	6.7
45 to 49 years	519	6.9
50 to 54 years	548	7.3
55 to 59 years	411	5.5
60 to 64 years	317	4.2
65 to 69 years	239	3.2
70 to 74 years	171	2.3
75 to 79 years	150	2.0
80 to 84 years	159	2.1
85 years and over	188	2.5
Median age (years)	33.7	(X)
16 years and over	5,894	78.9
18 years and over	5,720	76.5
21 years and over	5,387	72.1
62 years and over	1,080	14.5
65 years and over	907	12.1
Male population	3,560	47.6
Under 5 years	268	3.6
5 to 9 years	244	3.3
10 to 14 years	240	3.2
15 to 19 years	233	3.1
20 to 24 years	290	3.9
25 to 29 years	326	4.4
30 to 34 years	267	3.6
35 to 39 years	209	2.8
40 to 44 years	254	3.4
45 to 49 years	251	3.4
50 to 54 years	275	3.7

MILITARY MEDICINE, 172, 4:348, 2007

Appendix # 5 I

Post-Traumatic Stress Disorder and Service Utilization in a Sample of Service Members from Iraq and Afghanistan

Guarantor: Christopher Erbes, PhD

Contributors: Christopher Erbes, PhD*; Joseph Westermeyer, MD*; Brian Engdahl, PhD*; Erica Johnsen, PhD*†

Objective: The purpose of this study was to evaluate levels of post-traumatic stress disorder (PTSD), depression, alcohol abuse, quality of life, and mental health service utilization among returnees from Operation Enduring Freedom and Operation Iraqi Freedom. **Methods:** One hundred twenty returnees, enrolled for health care at a midwestern Veterans Affairs medical center, completed questionnaires approximately 6 months after their return from deployment. **Results:** PTSD levels (12%) were consistent with previous research while problematic drinking levels were also elevated (33%). PTSD and, to a lesser degree, alcohol abuse were associated with lower quality of life in multiple domains, even when controlling for the influence of depression. Of those screening positive for PTSD, 56% reported using mental health services. Only 18% of those screening positive for alcohol abuse reported using such services. **Conclusions:** PTSD and alcohol problems are prevalent in Operation Enduring Freedom/Operation Iraqi Freedom returnees and associated with lower quality of life. Mental health service utilization is limited, even among returnees enrolled for Veterans Affairs health care.

Introduction

Recent research suggests that the wars in Iraq and Afghanistan pose substantial mental health challenges to American service members, mental health systems, and the public at large. Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) are protracted engagements with frequent surprise attacks in settings where it is difficult to distinguish enemies from civilians. Early work by Hoge et al.[1,2] suggests that these conflicts are leading to high psychiatric distress rates among returnees including post-traumatic stress disorder (PTSD) and depressive symptoms. These reports also document that substantial proportions of returnees in psychological distress do not seek or receive mental health services.

Chronic combat-related PTSD leads to a host of long-term family and workplace problems.[3–5] It is also comorbid with other psychiatric and physical disorders.[6,7] PTSD treatments proven effective in other populations are less effective among those with chronic combat-related PTSD.[8] The accompanying social, physical, and economic problems all too often cut veterans off from important social support and social incentives that otherwise would facilitate treatment seeking, compliance, and effectiveness.

Timely detection and intervention with returnees suffering from PTSD is thus a high priority. The U.S. Department of Veterans Affairs (VA) is making efforts to avoid past mistakes by responding quickly and directly to the psychiatric difficulties among OIF/OEF returnees. VA facilities are attempting to give them priority in receiving medical and psychiatric care and to offer programs to increase resilience and provide early and effective treatment. To our knowledge, there are no published reports regarding the success of such programs. However, many returnees appear to be reluctant to seek mental health care, even if they are experiencing distressing psychiatric symptoms.[2]

Low mental health service utilization is unfortunately common with PTSD across multiple trauma types and populations.[8,9,10] Even within VA medical centers, which are typically informed and equipped to deal with post-traumatic stress, PTSD identification and treatment rates within general outpatient medical samples are low.[11] Hoge et al. found that 6.2% of Afghanistan returnees and 12.2 to 12.9% of Iraq returnees screened positive for PTSD using the Post-Traumatic Symptom Checklist (PCL).[1,2] Rates for other psychiatric distress (depression or generalized anxiety) were between 6.9 and 7.4% for Afghanistan returnees and between 6.6 and 7.9% for Iraq returnees. However, among those screening positive for mental health problems, only 23% of Afghanistan returnees and 29 to 40% of Iraq returnees reported receiving any mental health services. A subsequent population-based study found rates of PTSD at 9.8% for Iraq and 4.7% for Afghanistan veterans, as well as 19.1 and 11.3% of Iraq and Afghanistan returnees screening positive for either PTSD, depression, suicidal ideation, interpersonal conflicts, or aggressive ideation.[2] This second study found rates of mental health service utilization of 30.1% for Iraq and 19.1% for Afghanistan returnees. However, only 48 to 56% of individuals specifically referred for mental health care after screening positive for mental health problems actually obtained such care.

An effort is underway to evaluate the mental health problems and service utilization of returnees enrolled at the Minneapolis VA Medical Center (MVAMC). Enrolled returnees are asked to complete questionnaires assessing trauma experiences, post-traumatic stress, other psychiatric symptoms, quality of life, and service utilization. This article is an initial report from this ongoing study. Returnees in this sample have been home at least 6 months longer than those surveyed by Hoge et al.[1,2] Therefore, their rates of psychiatric distress and or mental health service utilization could be higher (in the case of delayed reactions) or lower (if some recovery has occurred). This report focuses on psychiatric distress levels (specifically PTSD, depression, and alcohol use), functional impairment, and service utilization. Based on the research discussed above, we expected to find elevated PTSD rates and low to moderate levels of mental health service utilization.

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Appendix # 5 J

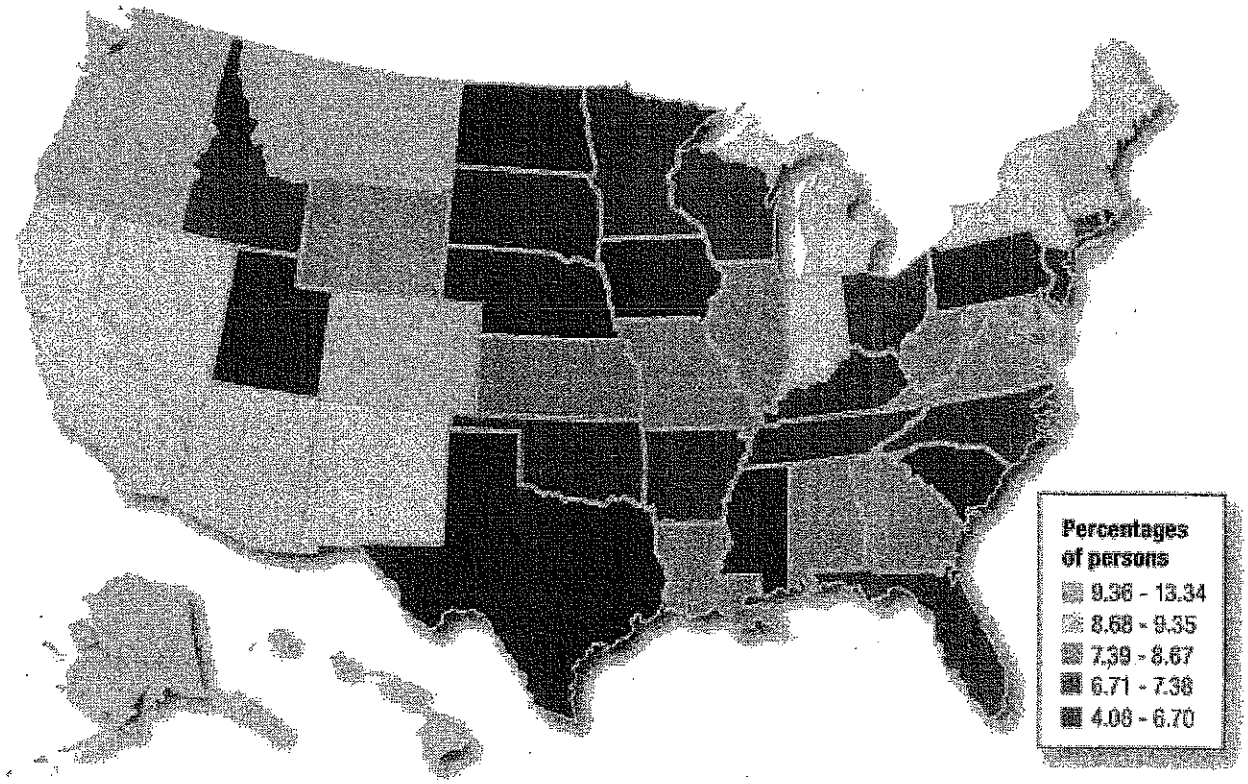
Past-Month Illicit Drug Use among People Age 12 or Older by State

State	Percentages of Persons
Alabama	6.71 to 7.38
Alaska	9.36 to 13.34
Arizona	8.68 to 9.35
Arkansas	7.39 to 8.67
California	8.68 to 9.35
Colorado	9.36 to 13.34
Connecticut	7.39 to 8.67
Delaware	8.68 to 9.35
District of Columbia	9.36 to 13.34
Florida	7.39 to 8.67
Georgia	6.71 to 7.38
Hawaii	9.36 to 13.34
Idaho	7.39 to 8.67
Illinois	6.71 to 7.38
Indiana	8.68 to 9.35
Iowa	4.08 to 6.70
Kansas	6.71 to 7.38
Kentucky	7.39 to 8.67
Louisiana	6.71 to 7.38
Maine	8.68 to 9.35
Maryland	6.71 to 7.38
Massachusetts	8.68 to 9.35
Michigan	8.68 to 9.35
Minnesota	7.39 to 8.67
Mississippi	4.08 to 6.70
Missouri	6.71 to 7.38
Montana	9.36 to 13.34
Nebraska	4.08 to 6.70
Nevada	8.68 to 9.35
New Hampshire	9.36 to 13.34
New Jersey	4.08 to 6.70
New Mexico	8.68 to 9.35
New York	8.68 to 9.35
North Carolina	7.39 to 8.67
North Dakota	4.08 to 6.70
Ohio	7.39 to 8.67
Oklahoma	7.39 to 8.67
Oregon	9.36 to 13.34
Pennsylvania	4.08 to 6.70
Rhode Island	9.36 to 13.34

South Dakota	4.08 to 6.70
Tennessee	7.39 to 8.67
Texas	4.08 to 6.70
Utah	4.08 to 6.70
Vermont	9.36 to 13.34
Virginia	6.71 to 7.38
Washington	9.36 to 13.34
West Virginia	6.71 to 7.38
Wisconsin	7.39 to 8.67
Wyoming	6.71 to 7.38

Source: SAMHSA, Office of Applied Studies. Figure 2.1. Illicit Drug Use in Past Month among Persons Age 12 or Older, by State: Percentages, Annual Averages Based on 2007 and 2008 NSDUHs. *State Estimates of Substance Use from the 2007–2008 National Surveys on Drug Use and Health.* Rockville, MD.

Back to homepage


Percentages of persons
9.36 - 13.34
8.68 - 9.35
7.39 - 8.67
6.71 - 7.38
4.06 - 6.70

Greer, Leslie

From: Greer, Leslie
Sent: Thursday, April 25, 2013 12:15 PM
To: rweye@cox.net
Cc: Riggott, Kaila; Hansted, Kevin; Martone, Kim
Subject: CT-Family Care Services, LLC - CON Application
Attachments: 31773.pdf

Tracking:

Recipient	Delivery	Read
rweye@cox.net		
Riggott, Kaila	Delivered: 4/25/2013 12:15 PM	
Hansted, Kevin	Delivered: 4/25/2013 12:15 PM	
Martone, Kim	Delivered: 4/25/2013 12:15 PM	Read: 4/26/2013 2:27 PM

Mr. Rweyemamu,
Please see the attached letter regarding submission of CT-Family Care Services CON application.

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

April 25, 2013

Justinian Rweyemamu, MA, M. Div, MS-MFT
CT-Family Care Services, LLC
16 Enfield Ave.
Enfield, CT 06082

Via First Class Mail and Electronic Mail

RE: Certificate of Need Application; Docket Number: 12-31773-CON
Establishment of a Behavioral Health Treatment Center in Manchester
Request for Additional Components of the Application

Dear Mr. Rweyemamu:

On April 12, 2013, the Office of Health Care Access ("OHCA") received the resubmitted Certificate of Need ("CON") application for the above proposal. Under Section 19a-639a (b) of the Connecticut General Statutes, OHCA shall not accept the applicant's certificate of need application for filing unless the application is accompanied by the application fee prescribed in subsection (a) of this section and proof of compliance with the publication requirements prescribed in this subsection.

For OHCA to accept the submitted CON application please submit the following items:

1. The CON application fee of $500.00 payable to "Treasurer, State of Connecticut".

2. A payment receipt from the Hartford Courant for the legal notices placed on March 22, 23, and 24, 2013 OR copies of the pages from the newspaper that clear show the public notice appeared and the publication date.

If you have any questions regarding the above, please feel free to contact me at (860) 418-7001.

Sincerely,

Kimberly Martone KRM

Kimberly R. Martone
Director of Operations

Copy: Sandra R. Zlokower, Esquire

KRM:lkg

Greer, Leslie

From: rweye@cox.net
Sent: Monday, April 29, 2013 11:01 AM
To: Greer, Leslie
Cc: Hansted, Kevin; Riggott, Kaila; Martone, Kim; srz@zlokowermiller.com
Subject: Re: CT-Family Care Services, LLC - CON Application
Attachments: con4.30.02.pdf

Hi Leslie
In response to your letter dated April, 25,2013. Attached herewith are the documents that you requested.
The Check($500) has been mailed to you today Thank you. Justin

---- "Greer wrote:
> Mr. Rweyemamu,
> Please see the attached letter regarding submission of CT-Family Care Services CON application.
>
> 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<http://www.ct.gov/ohca>
> P Please consider the environment before printing this message
>
>

PUBLIC NOTICES

West Hartford

Sealed Bid Notices

All bid notices for the Town of West Hartford are available at http://www.westhartford.com/. Bid notices may also be obtained through public access computers at any Town library. Questions may be directed to the Town at 860-561-7470.

Estuary Transit District – Request For Proposals

The Estuary Transit District (ETD) in Centerbrook, CT is seeking proposals from a firm to provide professional transportation management and operation of ETD's public transportation services. Proposals must be received by April 23, 2013 before 3:30 pm. ETD will ensure that respondents will not be discriminated against based on sex, race, creed or national origin in the consideration of an award. Request for Proposal packages are available at www.estuarytransit.org or via email olsenson@estuarytransit.org.

Connecticut

Invitation to Bid

Project Title: Fine Arts Instructional Center, Eastern Connecticut State University, Willimantic, CT

Project Number: [illegible]

1. Sealed bids for all bid packages addressed to Gary P. Collette, Project Manager, Barr & Barr, Inc. 33 Hampden Street, Springfield, MA 01103 will be received until 2:00 PM local time on April 30, 2013. All bids will be opened publicly and read aloud shortly thereafter. Specific questions regarding procedures, schedules and site visits may be directed in writing to Gary P. Collette at gcollette@barrandbarr.com.

DAS Prequalification is required for all bid packages in excess of $500,000.00

Set-Aside Requirements: [illegible]

2. Bidder Prequalification and Security: [illegible]

[illegible]

Connecticut

REQUEST FOR BIDS

The Town of Wethersfield is accepting bids for [illegible]. Town Hall, Town Garage, Library & Police Department. Bid packages may be downloaded at www.wethersfieldct.com [illegible]. Bids [illegible] Proposals are also available at the Wethersfield Town Hall Finance Office, 505 Silas Deane Highway, Wethersfield, CT 06109. All proposals must be received by [illegible] EST, May 24, 2013.

LEGAL NOTICE

TOWN OF SOUTH WINDSOR AND SOUTH WINDSOR BOARD OF EDUCATION INVITATION TO BID FOR HEALTH CARE BENEFIT CONSULTING SERVICES Bid# HCB-2013

Bid documents for Health Care Benefit Consulting Services for the Town of South Windsor & South Windsor Board of Education for the 2013-2014 and 2014-2015 fiscal years, Bid #HCB-2013, may be obtained at the Business Office of the [illegible] South Windsor Public Schools, 1737 Main Street, Room 103, South Windsor, CT or online at www.southwindsorschools.org [illegible].

Sealed bids will be received at the address listed above until [illegible] Eastern Standard Time, on April 10, 2013. The sealed bids will be publicly opened and read aloud.

The Board reserves the right to amend or terminate this invitation to bid, accept all or any part of a bid or reject any or all bids, waive any informalities or non-material deficiencies in a bid, and award the bid to the bidder that, in its judgment, will be in the Board's best interest.

SUPERIOR COURT J.D. OF HARTFORD AT HARTFORD RETURN DATE: APRIL 16, 2013

DEUTSCHE BANK NATIONAL TRUST COMPANY, AS TRUSTEE FOR HSI ASSET SECURITIZATION CORPORATION TRUST 2007-NC1 MORTGAGE PASS-THROUGH CERTIFICATES, SERIES 2007-NC1

VS.

SAMBA, JULIETTE ET AL

STATE OF CONNECTICUT

NOTICE TO THE HEIRS OR BENEFICIARIES OF HENRY WILLIAMS, DECEASED, IF LIVING, OR THEIR WIDOWS, HEIRS, OR THEIR REPRESENTATIVES AND CREDITORS

The Plaintiff has named THE HEIRS AND/OR BENEFICIARIES OF HENRY WILLIAMS, DECEASED, IF LIVING, and their widows, heirs, beneficiaries, representatives and creditors [illegible]

[illegible]

Now, therefore, it is hereby ordered that [illegible] THE HARTFORD COURANT once a week for two consecutive weeks, commencing on or before March 21, 2013, and that return of service be made to the Court.

Adam Bulevych
Assistant Clerk, Superior Court
Judicial District of HARTFORD

A TRUE COPY ATTEST:
[illegible]
CONNECTICUT STATE MARSHAL
HARTFORD COUNTY

NOTICE

CT Family Care Services, LLC is applying for a Certificate of Need pursuant to Section 19a-638 of the General Statutes to open a Behavioral Health Treatment Center with a focus on Marriage and Family Counseling, Therapy, Student Behavioral Counseling, School Dropout and Low Academic Performance Prevention, Crisis, Intercultural Counseling Services and Pre-Programmes for Returning Veterans suffering Post Traumatic Stress Disorder and their families as well as Therapeutic Treatment and Social Services for the Underserved population. The facility will be located at 343 Main St., Suite 4, Manchester, CT 06042.

NOTICE OF DISSOLUTION

NOTICE IS HEREBY GIVEN THAT Sarum of Connecticut, LLC a Connecticut limited liability company having its principal place of business in Greenwich, Connecticut, is dissolved. The resolution of its members as of February 22, 2013. Articles of Dissolution have been filed with the Secretary of State of Connecticut as required by law.

All creditors are warned to present their claims to Nicholas Pandiris of BROWN PAINDIRIS & SCOTT, LLP, 2252 Main Street, Glastonbury, Connecticut 06033. Within 120 days of publication. Any claim will be barred if not brought within the statutory period.

Dated at Glastonbury, Connecticut this 22nd day of February, 2013.

By BROWN PAINDIRIS & SCOTT, LLP
Their Attorneys

SUPERIOR COURT J.D. OF HARTFORD AT HARTFORD

DOCKET NO: HHD-CV-11-6024413-S

WELLS FARGO BANK, NATIONAL ASSOCIATION, AS TRUSTEE FOR SECURITIZED ASSET BACKED RECEIVABLES LLC 2005-FR5 MORTGAGE PASS-THROUGH CERTIFICATES, SERIES 2005-FR5

VS.

RODRIGUEZ, MIGUEL A., ET AL.

STATE OF CONNECTICUT

NOTICE TO MIGUEL A. RODRIGUEZ AND LIDIA RODRIGUEZ [illegible]

The Plaintiff Wells Fargo Bank National Association as Trustee for Securitized Asset Backed Receivables LLC 2005-FR5 Mortgage Pass-Through Certificates, Series 2005-FR5 has named [illegible]

[illegible]

Now, therefore, it is hereby ordered that notice of the institution of the action be given to [illegible] [illegible] The Hartford Courant once a week for 2 consecutive weeks, commencing on or before March 14, 2013 and that return of service be made to the Court.

M. NAWAZ WAHLA
Judge, Superior Court
Judicial District of Hartford

A TRUE COPY ATTEST:
JOHN T. FIORILLO
CONNECTICUT STATE MARSHAL
HARTFORD COUNTY

Hartford

ORDER OF NOTICE STATE OF CONNECTICUT

SUPERIOR COURT
J.D. OF HARTFORD
AT HARTFORD
FEBRUARY 13, 2013

DOCKET NUMBER:
HHD-CV11-6022191-S

AMERICAN TAX FUNDING, LLC
V.
CHARMAINE HAYLES
(16-18 Pershing Street, Hartford)

NOTICE TO: George W. Smith, now of parts unknown.

Upon the complaint of the plaintiff in the above-entitled action, praying for reasons therein set forth, for a foreclosure of tax liens on the properties known as:

16-18 Pershing Street, Hartford, CT

and possession of said premises, returnable to the above court on June 7, 2011, and upon a motion in said action for an order of notice, it appearing to and being found by the subscribing authority, that the identities and residences of the defendant named above are unknown to the Plaintiff, and that notice of the institution of this action most likely to come to their attention is that hereinafter prescribed it is

ORDERED, that notice of the institution of this action be given to the said defendant by some proper officer or other person causing a true and attested copy of this order of notice to be published in the Hartford Courant, a newspaper of general circulation in the Hartford, Connecticut area, once a week for two successive weeks, commencing on or before March 26, 2013, and that return of such notice be made to the above-named court.

Robert E. Vacchelli
Judge - Superior Court
Judicial District of Hartford at Hartford

A TRUE COPY
ATTEST:
JOSEPH F. KLETT, STATE MARSHAL
COUNTY OF HARTFORD

ORDER OF NOTICE STATE OF CONNECTICUT

SUPERIOR COURT
J.D. OF HARTFORD
AT HARTFORD
FEBRUARY 13, 2013

DOCKET NUMBER:
HHD-CV13-6037693-S

AMERICAN TAX FUNDING, LLC
V.
JUANITA BEASLEY, ET AL
(34 Burnham Street, Hartford)

NOTICE TO: Heirs of Juanita Beasley, now of parts unknown.

Upon the complaint of the plaintiff in the above-entitled action, praying for reasons therein set forth, for a foreclosure of tax liens on the properties known as:

34 Burnham Street, Hartford, CT

and possession of said premises, returnable to the above court on April 30, 2013, and upon a motion in said action for an order of notice, it appearing to and being found by the subscribing authority, that the identities and residences of the defendants named above are unknown to the Plaintiff, and that notice of the institution of this action most likely to come to their attention is that hereinafter prescribed it is

ORDERED, that notice of the institution of this action be given to the said defendant by some proper officer or other person causing a true and attested copy of this order of notice to be published in the Hartford Courant, a newspaper of general circulation in the Hartford, Connecticut area, once a week for two successive weeks, commencing on or before March 28, 2013, and that return of such notice be made to the above-named court.

Robert E. Vacchelli
Judge - Superior Court
Judicial District of Hartford at Hartford

A TRUE COPY
ATTEST:
JOSEPH F. KLETT, STATE MARSHAL
COUNTY OF HARTFORD

Connecticut

STATE OF CONNECTICUT SUPERIOR COURT JUVENILE MATTERS

ORDER OF NOTICE

Notice to Giyan Grant, father of child born to Jessica F. on 9/17/2012 of parts unknown

The petition, whereby the court's decision can affect your parental rights, if any, regarding minor child(ren) will be heard on 4-23-13 at 2:00 P.M. at Rockville Court, 920 Broad Street, Hartford, CT 06106.

Hearing on an Order of Temporary Custody will be heard on 4-23-2013 at 10:15 A.M.

Therefore, ORDERED, that notice of the hearing of this petition be given by publishing this Order of Notice once, immediately upon receipt, in the Hartford Courant, a newspaper having a circulation in the town/city of Hartford, CT.

Hon. Michael Dannehy, Judge
Tara Ortiz, Clerk
3-11-13

Right to Counsel: Upon proof of inability to pay for a lawyer, the court will make sure that an attorney is provided to you by the Chief Public Defender. Request for an attorney should be made immediately in person, by mail, or by fax at the court office where your hearing is to be held.

SUPERIOR COURT J.D. OF HARTFORD AT HARTFORD FEBRUARY 22, 2013

RETURN DATE: APRIL 9, 2013

BANK OF AMERICA, N.A.

VS.

WIDOWER, HEIR, BENEFICIARIES REPRESENTATIVES AND CREDITORS OF MARION F. WARREN, DECEASED ET AL

STATE OF CONNECTICUT

NOTICE TO WIDOWER, HEIRS, BENEFICIARIES, REPRESENTATIVES AND CREDITORS OF MARION F. WARREN, DECEASED, AND TO ALL UNKNOWN PERSONS CLAIMING OR WHO MAY CLAIM ANY RIGHTS, TITLE, INTEREST OR ESTATE IN OR LIEN OR ENCUMBRANCE UPON THE REAL PROPERTY DESCRIBED IN THIS COMPLAINT, ADVERSE TO THE PLAINTIFF, WHETHER SUCH CLAIM OR POSSIBLE CLAIM BE VESTED OR CONTINGENT.

The Plaintiff has named Widower, Heir, Beneficiaries, Representatives and Creditors of Marion F. Warren, Deceased, as parties defendant to the complaint which it is bringing to the above-named court seeking a foreclosure of its mortgage upon premises known as 33 O'CONNELL DRIVE, EAST HARTFORD, Connecticut. This complaint is returnable to court on April 9, 2013 and will be pending thereafter until final date.

The plaintiff has represented to said court by means of an affidavit annexed to the said complaint, that despite all reasonable efforts to ascertain such information, it has been unable to determine the residence of the Widower, Heir, Beneficiaries, Representatives and Creditors of Marion F. Warren, Deceased.

Now, therefore, it is hereby ordered under C.G.S. § 52-68 that notice of the institution of this action be given to such defendants by some proper officer causing a true and attested copy of this order to be published in THE HARTFORD COURANT once a week for 2 weeks, commencing on or before March 14, 2013 and that return of service be made to the Court.

Adam Bulevych
Assistant Clerk, Superior Court
Judicial District of HARTFORD

A TRUE COPY ATTEST:
JOHN T. FIORILLO
CONNECTICUT STATE MARSHAL
HARTFORD COUNTY

CT-FAMILY CARE SERVICES LLC
16 ENFIELD AVE.
ENFIELD, CT 06082-3606

1070
51-7218/2211
B0113

4/29/2013
Date

Pay to the Order of Treasurer State of CT. $ 500.00

Five hundreds Only Dollars

People's United Bank
peoples.com

For CON-application fee

⑆221872186⑆ 650005836 7⑈ 1070

Connecticut

NOTICE

CT-Family Care Services, LLC is applying for a Certificate of Need pursuant to Section 19a-638 of the General Statutes to open a Behavioral Health Treatment Center with a focus on Marriage and Family Counseling/Therapy, Student Behavioral Counseling, School Dropout and Low Academic Performance Prevention, Cross-multicultural Counseling Services and Job Preparedness for Returning Veterans suffering Post Traumatic Stress Disorder and their families as well as Therapeutic Treatment and Social Services for the Underserved population. The facility will be located at 243 Main St., Suite 4, Manchester, CT 06042

Connecticut

Invitation to Bid

Project Title: **Fine Arts Instructional Center, Eastern Connecticut State University, Willimantic, Ct.**

Project Number: **BI-RW-295-CMR**

1. Sealed bids for all bid packages addressed to Gary P. Collette, Project Manager, Barr & Barr, Inc. 32 Hampden Street, Springfield, Ma 01103 will be received until 2:00 PM local time on April 30, 2013. All bids will be opened publicly and read aloud shortly thereafter. Specific questions regarding procedures, scopes and site visits may be directed in writing to Gary P. Collette at gcollette@barrandbarr.com.

DAS Prequalification is required for all bid packages in excess of $500,000.00

Set-Aside Requirements: Please take note that certain Bid packages are identified to be deemed for the Small Business Set-Aside Program ONLY. Bidders shall be responsible to award not less than 25% of the cost of construction to subcontractors that are certified and eligible to participate under the State of Connecticut Set Aside program for small, minority and women owned business enterprises including 25% of this amount (or 6.25% of construction) that must be awarded to certified and eligible minority and/or women owned enterprises, in accordance with Connecticut General Statutes section 4a-60g through 4a-60i. This requirement must be met even if the Bidder is certified and eligible to participate in the Small Business Set-Aside program. Subcontractors shall compile and submit for approval an affirmative action plan in accordance with the rules and regulations of the Connecticut Human Rights and Opportunities Commission (CHRO). The affirmative action plan must be approved by the CHRO as a condition precedent to subcontractor approval.

Bidder Prequalification and Security
a. For work to be performed with an estimated value in excess of Five Hundred Thousand Dollars ($500,000.00), the subcontractor shall be prequalified by the State of Connecticut Department of Administrative Services classification noted on the pertinent invitation to bid.
b. The bid shall be accompanied by a bid bond or certified check in an amount which shall be Ten Percent (10%) of any bid for work with an amount value of at least Fifty Thousand Dollars ($50,000.00). If the bidder is a small contractor or minority business enterprise.
c. Pursuant to Connecticut General Statutes Section 4a-60g and further described in Appendix 1 to this agreement "Administrative and Statutory Requirements" (Appendix 1), it may provide in lieu of a bid bond, a letter of credit in an amount equal to Ten Percent (10%) of the bid amount if the estimated value is less than one hundred thousand dollars and in an amount equal to Twenty Five Percent (25%) of the bid amount, if the estimated value is one hundred thousand dollars or greater; and
The bidder shall possess experience with projects of a similar nature and scope.
There will be a Meet and Greet with Barr & Barr, Inc., State of Connecticut DCS, State of Connecticut CHRO, and the Architect on Thursday evening 3/28/13 at 6 PM to be held in the Science Auditorium #104 on the grounds of Eastern Connecticut State University in Willimantic, Ct.
There will be a MANDATORY prebid meeting for this bid on April 9, 2013 at 6PM. The prebid meeting will be held in the Science Auditorium #104 on the grounds of Eastern Connecticut State University in Willimantic, Ct. A jobsite walk will be held immediately after the prebid meeting.
Bid Packages & Bid Documents will be made available on April 2, 2013
Bid Documents will be available for electronic viewing and download on Barr & Barr's website www.barrandbarr.com in our Online Plan Room (tab at bottom of home page). Please find the ECSU Fine Arts Instructional Center in our list of projects and click on any specific line for this project. You will be asked for a Password to gain access which is ECSUFINEARTS (all upper case). To secure hard copies of bid documents, at bidders' expense, contact either NE Blueprint in Springfield, Ma at (413) 737-3556 or by e-mail plots@newenglandblue.com., or Joseph Merritt & Company in Hartford, Ct at (860) 296-2500. Documents will also be available to review at both of Barr & Barr's offices located at either 32 Hampden Street Springfield, Ma 01103 or 280 Cochituate Road Framingham, Ma 01701.

Document clarification requests or Bid Questions (RFI's) must be submitted in writing to the Construction Manager ONLY via fax at (413) 739-7684 Attention: Gary Collette or e-mail at (gcollette@barrandbarr.com). **Telephone inquiries will not be accepted/acknowledged during the bidding process. Bidders are to communicate only with the Construction Manager during the bidding process.** Answers received directly from Owner, Architect or Engineers will not be binding on Construction Manager. **All questions must be submitted no later than April 12, 2013 any questions received after this date will not be responded to.**
This project is being performed under the Construction Manager at Risk (CMR) form of construction. Each Trade Contractor's contract shall be with the Construction Manager. The Owner has contracted with Barr & Barr, Inc to serve as the CMR.
No oral, telephone or telegraphic proposals will be considered. All bids shall remain available for acceptance for a period of ninety (90) days from the date proposals are received.
No bid shall be accepted from any person/company who is in arrears to the Owner and/or Construction Manager upon debt, or contract, or whom is a defaulter as surety or otherwise upon obligations to the Owner and/or Construction Manger.
The Construction Manager reserves the right to reject any or all bids, without stating reasons therefore, including without limitation the right to reject any or all nonconforming, non-responsive, unbalanced or conditional bids and to reject the bid of any bidder if the Construction Manager believes that it would not be in the best interest of the Owner or the project to make an award to that bidder, whether because the bid is not responsive or the bidder is unqualified or of doubtful financial ability or fails to meet any other pertinent standard or criteria established by the Owner or Construction Manager. The Construction Manager reserves the right to waive informalities and to negotiate contract terms with one or more bidders without reopening the bidding process in so far such negotiations are not in violation of applicable competitive bidders' statue of law. In evaluating bids, the Construction Manager will consider the qualifications of the bidder, whether or not the bids comply with the prescribed requirements, and such alternates, unit process, and other data, as may be requested in the form of Bid or prior to Notice of Award. The Construction Manger may consider the qualifications and experience of subcontractors and other persons and organizations proposed for those portions of the work as to which the identity of subcontractors and other persons or organizations must be submitted as provided by the documents. The Construction Manger reserves the right to require, prior to Notice of Award, a statement of facts in detail of the business and technical organization and plant of the bidder of the bidder available for the contemplated work, including financial resources, present commitments, and experience of the bidder in performance of past comparable work. Construction Manager recommended trade contractors are subject to DCS approval.
Barr & Barr, Inc. is an Affirmative Action Equal Opportunity Employer M/F/H/V.

Farmington

TOWN OF FARMINGTON, CT
REQUEST FOR PROPOSALS
FOR
CONSTRUCTION EQUIPMENT RENTALS

The Town of Farmington Department of Public Works is seeking proposals for the purpose of establishing a list of companies that the Department can contact when it needs to rent construction equipment in order to complete routine projects and for emergencies should the need occur. The list of equipment shall include but is not limited to loaders, excavators, dozers, combination loaders/backhoes, tri-axles, off-road trucks, tractors, graders, rollers, pumps, chippers, trench boxes, compactors, and pickups.

In order to be included on the construction equipment rental list, quotes must be returned in a sealed envelope to the Town of Farmington Finance Office, One Monteith Drive, Farmington, CT 06032, by 4:00 p.m. on Wednesday, April 17, 2013. Faxed and e-mailed quotes will not be accepted.

Joseph Swetcky
Director of Finance

East Granby

TOWN OF EAST GRANBY
NOTICE OF A SPECIAL TOWN MEETING

Notice is hereby given that a Special Town Meeting of the Town of East Granby, Connecticut will be held in the East Granby Senior/Community Center on Thursday, March 28, 2013 at 7:30 pm for the following purposes:

1. To elect a Moderator.

2. To consider and act upon the ratification of the contract between the East Granby Board of Education and the East Granby Education Association as recommended by the Board of Education.

Dated in East Granby Connecticut this 22nd day of March, 2013

Sheila M. Bailey, Town Clerk
James M. Hayden, First Selectman
M. Thomas Short, Selectman
John Ziobro, Selectman

Meriden

INVITATION TO BID
ADDITIONS AND ALTERATIONS TO FRANCIS T. MALONEY HIGH SCHOOL
PHASE 1
STATE PROJECT NO. 080-0092 RNV/E
GILBANE JOB NO. J05523.000
CITY OF MERIDEN BID NO. B013-19R

1. The City of Meriden invites sealed bids for the bid package listed below. Sealed bids will be received at the Purchasing Department, Room 210, City of Meriden, 142 East Main Street, Meriden, CT 06450-8022 on April 4, 2013 until 11:00 a.m. Bids will be opened and publicly read aloud immediately following the close of the bid period.

2. Bidders, at the time the bid is submitted, must be prequalified with the State of Connecticut Department of Administrative Services (DAS) in accordance with C.G.S. 64b-91, for the bid package(s) listed below. In accordance with C.G.S. 54a-100, 64b-91, and 64b-101, any trade contractor submitting a bid is required to submit their DAS Update (Bid) Statement with their bid. Failure to submit this item with the bid will result in rejection of the bid. All lower tier subcontractors with contracts in excess of $500,000 must be pre-qualified in the applicable classification at the time of performance of their work.

3. Each Bid shall be accompanied by a bid security in the form of a Bid Bond in an amount not less than Ten Percent (10%) of the total amount of the base bid. Said surety shall be issued by a surety that is licensed to do business in the State of Connecticut and is rated A-(VII) or better by A.M. Best. The bid security shall be drawn in favor of The City of Meriden.

4. The work consists of additions and alterations to the existing Francis T. Maloney High School including abatement/demolition of existing building, site construction, general construction, plumbing, mechanical, electrical, and technology work.

The work has been divided into the following bid packages:

Bid Package Number & Name	DAS Prequalification Category	Bid Due Time
04A Masonry	Masonry	11:00 a.m.

5. Complete copies of the Plans and Specifications may be obtained from BL Graphics, 355 Research Parkway, Meriden, CT 06450, t. 203.630.2671, attention Stephen Smith, ssmith@blcompanies.com. The non-refundable fee is Four Hundred dollars ($400.00), inclusive of CT sales and use tax, excluding any bid addenda which will be priced separately. If sets are to be shipped, a separate non refundable fee for shipping and handling charge will be required, or just a handling charge if a courier shipping number is provided. Electronic copies of the bid documents, inclusive of any Addenda, are available for download free of charge from ftp://files.gilbanetech.com and/or http://files.gilbanetech.com, enter username: maloney_hs and password: gilbane Plans are also available for review at the City of Meriden purchasing department.

6. The Project is being performed under a Construction Manager contractor agreement. Gilbane Building Company is the Construction Manager. Successful bidders will contract with the Construction Manager for the work. The requirement for performance and payment bonds shall be in accordance with Article 6.2 of the sample contract contained within project documents. Sufficient insurance as described in Article 6.3 of the sample Trade Contract Agreement will be required.

7. This is a Project Labor Agreement project. The greater of the Project Labor Agreement rates and the State of Connecticut Department of Labor prevailing minimum wages as published in the Contract Documents apply in accordance with Connecticut General Statutes §31-53, §31-53a, and Public Act 05-50 for this Project. The Project has a minimum goal of Thirty percent (30%) workforce participation by City of Meriden residents.

8. The City of Meriden reserves the right to reject any or all bids, without stating reasons therefore, including without limitation the right to reject any or all nonconforming, non-responsive, unbalanced, or conditional bids and to reject the bid of any bidder if the City of Meriden believes that it would not be in the best interest of the City of Meriden or the project to make an award to that bidder, whether because the bid is not responsive or the bidder is unqualified or of doubtful financial ability or fails to meet any other pertinent standards or criteria established by the City of Meriden and/or Construction Manager. The City of Meriden and/or Construction Manager reserves the right to waive informalities and to negotiate contract terms with one or more bidders without reopening the bidding process insofar as such negotiations are not violative of applicable competitive bidding statutes or law. In evaluating bids, the City of Meriden and/or Construction Manager will consider the qualifications of the bidder, whether or not the bids comply with the prescribed requirements, and such alternates, unit prices, and other data, as may be requested in the Form of Bid or prior to Notice of Award. The City of Meriden and/or Construction Manager may consider the qualification and experience of subcontractors and other persons and organizations proposed for those portions of the work as to which the identity of subcontractors and other persons and organizations must be submitted as provided by the bid documents. The City of Meriden and/or Construction Manager reserves the right to require, prior to Notice of Award, a statement of facts in detail of the business and technical organization and plant of the bidder available for the contemplated work, including financial resources, present commitments, and experience of the bidder in performance of comparable work.

Wilma C. Petro, CPPB, C.P.M.,
Purchasing Officer
City of Meriden
Dated: March 23, 2013

Connecticut

ADVERTISEMENT FOR BIDS

The Capitol Region Education Counc[il] will receive qualification packages an[d] sealed cost proposals for Move Management Services for the four schools listed below:

CREC Public Safety Academy
CREC Medical Professions and Teache[r] Preparation Magnet School
International Magnet School for Global Citizenship
Reggio Magnet School for the Arts

The Request for Qualifications and Proposal packages may be obtained at http://www.crec.org/construction/rfq-rfp.php. Responses are due April 3, 2013 at 2:00 pm.

The CREC Council shall have the right to reject any or all proposals, and in particular, to reject a proposal not accompanied by data required as incomplete or irregular. The CREC Council shall have the right to waive any informality or irregularity in any proposal received, to negotiate changes to offered terms, and to accept the proposal that, in its judgment, will be in the best interest of the CREC Council.

Liquor Notices

LIQUOR PERMIT
NOTICE OF APPLICATION

This is to give notice that
I, **JOHNNY WEBSTER, 39 SPRING ST. APT. 2B, HARTFORD, CT 06105-2104** Have filed an application placarded **02/28/13** with the Department of Consumer Protection for a **GROCERY BEER PERMIT** for the sale of alcoholic liquor on the premises at **717 ALBANY AVE., HARTFORD, CT 06112-2305**. The business will be owned by: HOT CONER MARKET LLC. Objections must be filed by **04/11/2013**.

2/28/13
JOHNNY WEBSTER

Bloomfield

LEGAL ADVERTISEMENT

ADVERTISEMENT FOR BIDS

The Town of Bloomfield (HA) is seeking sealed bids for:

Miscellaneous Residential Upgrades for Various Addresses, Bloomfield, CT.

Bids will be received and publicly opened and read aloud at the Town of Bloomfield, 800 Bloomfield Avenue, Bloomfield, CT 06002-0337. **Bids are due by 2:00 p.m. on Tuesday, April 16, 2013.**

The work of the contract includes, but is not limited to, miscellaneous residential upgrades.

Site review by all bidders will be on Wednesday, April 3, 2013 at 3:30 p.m. at 15 Brooke Street, 4:15 p.m. at 144 E Harold Street, 5:00 p.m. at 15 Crestview Drive and 5:45 p.m. at 32 Terry Plains Road, Bloomfield, CT 06002.

Contract Documents, Plans and Specifications will be available at the **Town of Bloomfield, in the office of Planning and Zoning, Town Hall, Tuesday, March 26, 2013** with $25.00 non-refundable deposit. Additional sets at $25.00 each non-refundable.

Bids must include a 5% Bid Security. Successful bidder must furnish a 100% Performance/Payment Bond.

Bidders will note requirements of non-discrimination/equal opportunity rules (Executive Order 11246) and related provisions in the General Conditions.

Contractors are expected to make a good faith effort in complying with Section 3 requirements for hiring and local contracting. All contractors must be licensed in the State of CT and also must be trained in Healthy Homes requirements.

No bid shall be withdrawn for ninety (90) days.

Complete bidding requirements are noted in the Contract Documents.

Louie Chapman, Jr.
Town Manager

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

April 25, 2013

Justinian Rweyemamu, MA, M. Div, MS-MFT
CT-Family Care Services, LLC
16 Enfield Ave.
Enfield, CT 06082

Via First Class Mail and Electronic Mail

RE: Certificate of Need Application; Docket Number: 12-31773-CON
Establishment of a Behavioral Health Treatment Center in Manchester
Request for Additional Components of the Application

Dear Mr. Rweyemamu:

On April 12, 2013, the Office of Health Care Access ("OHCA") received the resubmitted Certificate of Need ("CON") application for the above proposal. Under Section 19a-639a (b) of the Connecticut General Statutes, OHCA shall not accept the applicant's certificate of need application for filing unless the application is accompanied by the application fee prescribed in subsection (a) of this section and proof of compliance with the publication requirements prescribed in this subsection.

For OHCA to accept the submitted CON application please submit the following items:

1. The CON application fee of $500.00 payable to "Treasurer, State of Connecticut".

2. A payment receipt from the Hartford Courant for the legal notices placed on March 22, 23, and 24, 2013 OR copies of the pages from the newspaper that clear show the public notice appeared and the publication date.

If you have any questions regarding the above, please feel free to contact me at (860) 418-7001.

Sincerely,

Kimberly Martone (KR)

Kimberly R. Martone
Director of Operations

Copy: Sandra R. Zlokower, Esquire

KRM:lkg

The Hartford Courant.

A TRIBUNE PUBLISHING COMPANY

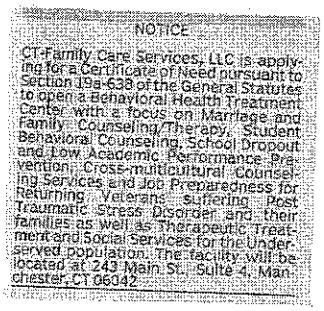
Affidavit of Publication

State of Connecticut

Monday, March 25, 2013

County of Hartford

I, Rena Matus, do solemnly swear that I am Financial Operations Assistant of the Hartford Courant, printed and published daily, in the state of Connecticut and that from my own personal knowledge and reference to the files of said publication the advertisement of Public Notice was inserted in the regular edition.



NOTICE

CT-Family Care Services, LLC is applying for a Certificate of Need pursuant to Section 19a-638 of the General Statutes to open a Behavioral Health Treatment Center with a focus on Marriage and Family Counseling/Therapy, Student Behavioral Counseling, School Dropout and Low Academic Performance Prevention, Cross-multicultural Counseling Services and Job Preparedness for Returning Veterans suffering Post Traumatic Stress Disorder and their families as well as Therapeutic Treatment and Social Services for the Underserved population. The facility will be located at 243 Main St., Suite 4, Manchester, CT 06042

On dates as follows:

3/23/2013	$93.82
3/21/2013	$103.82
3/22/2013	$93.82

In the amount of $291.46
CT-FAMILY CARE SERVICES, LL
20257078
Full Run

Financial Operations Assistant
Rena Matus

Subscribed and sworn to before me on March 25, 2013

Notary Public

WILLIAM B. McDONALD
NOTARY PUBLIC, CONNECTICUT
MY COMMISSION EXPIRES FEB. 28, 2014

2540245

Hartford Courant.

THE HARTFORD COURANT
285 BROAD STREET
HARTFORD, CT 06115-2510

Classified Advertising Invoice — **Page 1 of 1**

Billed Account #	8605088651
Invoice #	3806968
Client Name	
Telephone #	860-508-8651
Billing Period	03/21/13 - 03/23/13
Billing Date	03/23/13
Payment Term	PAYABLE UPON RECEIPT
TOTAL AMOUNT DUE	291.46

3.1.388.1 MB 0.405 50524D11:p01 569012888 1-1 6

C/O CT-FAMILY CARE SERVICES, LLC
16 ENFIELD AVE
ENFIELD CT 06082-3606

CLASSIFIED ADVERTISING: 860-525-2525
OBITUARY QUESTIONS: 860-241-6392
TOLL FREE: 800-842-8824
BILLING QUESTIONS: 860-241-6343

Detail

Date	Advertiser/ Agency PO #	Reference #	Description	Ad Size/ Units	Rate	Gross Amount	Net Amount
03/21/13		E2540245	NOTICECTFAMILY CARE START DATE:03/21 END DATE:03/23 1x1.50 3/21,3X CLASS:2174 DAILY COUNT: 3 SUNDAY COUNT: 0 ORDERED BY:JUSTINIAN	1			291.46

TOTAL: 291.46

To ensure proper credit, please detach and return with remittance.

Hartford Courant.

MAKE CHECKS PAYABLE TO:
THE HARTFORD COURANT

THE HARTFORD COURANT
PO BOX 416414
BOSTON MA 02241-6414

Classified Advertising Invoice — **Page 1 of 1**

Billed Account #	8605088651
Client Account #	3806968
Client Name	
Telephone #	860-508-8651
Billing Period	03/21/13 - 03/23/13
Billing Date	03/23/13
Payment Term	PAYABLE UPON RECEIPT
TOTAL AMOUNT DUE	291.46
TOTAL AMOUNT ENCLOSED	_____

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: 13-31837-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

Greer, Leslie

From: rweye@cox.net
Sent: Wednesday, May 22, 2013 3:16 PM
To: Greci, Laurie
Cc: Greer, Leslie; Riggott, Kaila
Subject: RE: 13-31837-CON CT-Family Services, Inc.

Ok. Great.
---- "Greci wrote:
> Dear Mr. Rweyemamu,
>
> Thank you for letting me know that you received the email. The next step in the process is to schedule a public hearing. I will contact you tomorrow with possible dates.
>
> Sincerely,
>
> Laurie Greci
>
> -----Original Message-----
> From: rweye@cox.net [mailto:rweye@cox.net]
> Sent: Wednesday, May 22, 2013 2:16 PM
> To: Greci, Laurie
> Cc: Greer, Leslie; srz@zlokowermiller.com; Riggott, Kaila
> Subject: Re: 13-31837-CON CT-Family Services, Inc.
>
> Thank you Laurie for the message. What is the next step that you want me do? Justin
>
> ---- "Greci wrote:
> >
> > Dear Mr. Rweyemamu,
> >
> > On May 17, 2013, the Office of Health Care Access deemed complete the application you submitted proposing to establish a behavioral health treatment center in Manchester. Attached please find the deemed complete letter.
> >
> > Sincerely,
> >
> > Laurie K. Greci
> >
> > Associate Research Analyst
> > Department of Public Health
> > Health Care Access
> > * laurie.greci@ct.gov<mailto:laurie.greci@ct.gov>
> > ' 860 418-7032
> > 7 860 418-7053
> >
>

Greer, Leslie

From: Greci, Laurie
Sent: Thursday, May 23, 2013 1:30 PM
To: rweye@cox.net
Cc: Riggott, Kaila; Greer, Leslie
Subject: Possible Hearing Dates for CT-Family Services, Inc. CON Application 13-31837-CON

Dear Mr. Rweyemamu,

This email is a follow-up to the voice mail message I left for you earlier today. The two dates available for the hearing concerning the above CON application are June 26 or June 27, 2013. The hearing will take place at 410 Capitol Ave. at 10:00 a.m.

Please let me know either by telephone or email which of the two dates will work best for you. Thank you.

Sincerely,

Laurie K. Greci

Associate Research Analyst
Department of Public Health
Health Care Access
laurie.greci@ct.gov
860 418-7032
860 418-7053

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 29, 2013

RE: Certificate of Need Application; Docket Number: 13-31837-CON
CT-Family Care Services, Inc.
Establishment of a behavioral health treatment center in Manchester

---

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

Greer, Leslie

From: Greci, Laurie
Sent: Wednesday, May 29, 2013 8:26 AM
To: Greer, Leslie
Subject: FW: Possible Hearing Dates for CT-Family Services, Inc. CON Application 13-31837-CON

-----Original Message-----
From: rweye@cox.net [mailto:rweye@cox.net]
Sent: Tuesday, May 28, 2013 4:09 PM
To: Greci, Laurie
Subject: RE: Possible Hearing Dates for CT-Family Services, Inc. CON Application 13-31837-CON

OK.

---- "Greci wrote:
> Dear Mr. Rweyemamu,
>
> I shall be preparing a letter to send you concerning the requirements for the hearing.
>
> Laurie
>
> -----Original Message-----
> From: rweye@cox.net [mailto:rweye@cox.net]
> Sent: Tuesday, May 28, 2013 2:03 PM
> To: Greci, Laurie
> Cc: Greer, Leslie; Riggott, Kaila
> Subject: RE: Possible Hearing Dates for CT-Family Services, Inc. CON Application 13-31837-CON
>
> Thanks.
> Is there any thing you want us do or bring? Justin
> ---- "Greci wrote:
> > Dear Mr. Rweyemamu,
> >
> > Thank you for your message. I will go ahead and schedule the hearing for June 26, 2013, starting at 9 a.m.
> >
> > Regards,
> > Laurie
> >
> > -----Original Message-----
> > From: rweye@cox.net [mailto:rweye@cox.net]
> > Sent: Friday, May 24, 2013 3:39 PM
> > To: Greci, Laurie
> > Cc: Greer, Leslie; Riggott, Kaila
> > Subject: RE: Possible Hearing Dates for CT-Family Services, Inc. CON Application 13-31837-CON
> >
> > Hi Laurie
> > Wednesday, June 26, 2013 starting at 9 am is fine. I look forward to seeing you. Justin

> >
> > ---- "Greci wrote:
> > > Dear Mr. Rweyemamu,
> > >
> > > Thank you for your quick reply. Unfortunately, the date, June 27, 2013, is not available due to a scheduling conflict. We are holding Wednesday, June 26, 2013. If you need a different date, please suggest one that works with your schedule. Hearings are generally held in the morning starting no earlier than 9:00 a.m. OHCA needs at least a three week lead to do the administrative process.
> > >
> > > Sincerely,
> > > Laurie
> > >
> > >
> > > -----Original Message-----
> > > From: rweye@cox.net [mailto:rweye@cox.net]
> > > Sent: Friday, May 24, 2013 2:18 PM
> > > To: Greci, Laurie
> > > Cc: Greer, Leslie; Riggott, Kaila
> > > Subject: Re: Possible Hearing Dates for CT-Family Services, Inc. CON Application 13-31837-CON
> > >
> > > Hi Laurie
> > > I prefer Friday, June 27, 2013 . Thank you. Justin
> > >
> > >
> > > ---- "Greci wrote:
> > > >
> > > > Dear Mr. Rweyemamu,
> > > >
> > > > This email is a follow-up to the voice mail message I left for you earlier today. The two dates available for the hearing concerning the above CON application are June 26 or June 27, 2013. The hearing will take place at 410 Capitol Ave. at 10:00 a.m.
> > > >
> > > > Please let me know either by telephone or email which of the two dates will work best for you. Thank you.
> > > >
> > > > Sincerely,
> > > >
> > > > Laurie K. Greci
> > > >
> > > >
> > > > Associate Research Analyst
> > > > Department of Public Health
> > > > Health Care Access
> > > > * laurie.greci@ct.gov<mailto:laurie.greci@ct.gov>
> > > > ' 860 418-7032
> > > > 7 860 418-7053
> > > >
> > >
> >
>

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
Office of Health Care Access

June 7, 2013

Justinian Rweyemamu, MA, M.Div. MS-MFT
CT-Family Care Services, Inc.
16 Enfield Avenue
Enfield, CT 06082

RE: Certificate of Need Application, Docket Number 13-31837-CON
CT-Family Care Services, LLC.
Establishment of a Behavioral Health Treatment Center in Manchester

Dear Mr. Rweyemamu,

With the receipt of the completed Certificate of Need ("CON") application information submitted by CT-Family Care Services, LLC. ("Applicant") on May 17, 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:	CT-Family Care Services, LLC
Docket Number:	13-31837-CON
Proposal:	Establishment of a Behavioral Health Treatment Center with an associated capital expenditure of $1,843,100

Notice is hereby given of a public hearing to be held in this matter to commence on:

Date: June 26, 2013

Time: 9:00 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 *Journal Inquirer* 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

June 7, 2013 Requisition # 42386

Journal Inquirer
306 Progress Drive
Manchester, CT 06040

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, June 8, 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

Journal Inquirer **June 7, 2013**
Notice of Public Hearing, Docket Number 13-31837-CON

PLEASE INSERT THE FOLLOWING:

Office of Health Care Access Public Hearing

Statute Reference:	19a-638
Applicant:	CT-Family Services, LLC
Town:	Manchester
Docket Number:	13-31837-CON
Proposal:	Establishment of a Behavioral Health Treatment Center, with a total capital expenditure of $1,843,100
Date:	June 26, 2013
Time:	9:00 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 21, 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.

Greer, Leslie

From: rweye@cox.net
Sent: Friday, June 07, 2013 10:29 PM
To: Greci, Laurie
Cc: Greer, Leslie; Riggott, Kaila
Subject: Re: Hearing Notice for 13-31837

Thank you Laurie. Justin

---- "Greci wrote:
>
> Dear Mr. Rweyemamu,
>
> Attached you will find a letter to you that announces the hearing date and another letter requesting publication in the local newspaper.
>
> If you have any questions, please call me.
>
> Regards,
>
> Laurie K. Greci
>
> Associate Research Analyst
> Department of Public Health
> Health Care Access
> * laurie.greci@ct.gov<mailto:laurie.greci@ct.gov>
> ' 860 418-7032
> 7 860 418-7053
>

Greer, Leslie

From: ADS <ADS@graystoneadv.com>
Sent: Friday, June 07, 2013 11:20 AM
To: Greer, Leslie
Subject: Re: Hearing Notice DN: 13-31837-CON

Importance: High

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, June 7, 2013 10:50 AM
To: ads <ads@graystoneadv.com>
Subject: Hearing Notice DN: 13-31837-CON

Please run the attached hearing notice in the Journal Inquirer by 6/8/13. For billing purposes, refer to requisition 42386. In addition, please forward 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
Please consider the environment before printing this message

Greer, Leslie

From: Robert Taylor <RTaylor@graystoneadv.com>
Sent: Tuesday, June 11, 2013 11:12 AM
To: Greer, Leslie
Cc: Laurie
Subject: FW: Hearing Notice DN: 13-31837-CON
Attachments: 13-31837np Journal Inquirer.doc

Hi Leslie,

The notice was published in the Manchester Journal Inquirer on Saturday, 6/8. The cost is $181.80.

Thanks,

Robert Taylor
Graystone Group Advertising
www.graystoneadv.com
2710 North Avenue, Suite 200
Bridgeport, CT 06604
Phone: 203-549-0060
Fax: 203-549-0061

From: ADS <ADS@graystoneadv.com>
Date: Fri, 7 Jun 2013 12:17:00 -0400
To: RTaylor <rtaylor@graystoneadv.com>
Subject: FW: Hearing Notice DN: 13-31837-CON

From: <Greer>, Leslie <Leslie.Greer@ct.gov>
Date: Friday, June 7, 2013 12:06 PM
To: Laurie Miller <Laurie@graystoneadv.com>
Cc: "Olejarz, Barbara" <Barbara.Olejarz@ct.gov>
Subject: Hearing Notice DN: 13-31837-CON

Hi Laurie,
I submitted this request earlier today. I am leaving for the day. In the event there are issues or concerns, please contact Barbara Olejarz in my absence.
Thank you,
Leslie Greer

From: Greer, Leslie
Sent: Friday, June 07, 2013 10:50 AM
To: ads@graystoneadv.com
Subject: Hearing Notice DN: 13-31837-CON
Importance: High

Please run the attached hearing notice in the Journal Inquirer by 6/8/13. For billing purposes, refer to requisition 42386. In addition, please forward me a "proof of publication" when available.

Thank you,

Greer, Leslie

From: Greer, Leslie
Sent: Tuesday, June 11, 2013 4:49 PM
To: rweye@cox.net
Cc: 'Greci, Laurie'; 'Riggott, Kaila'; 'Hansted, Kevin'; Martone, Kim; 'srz@zlokowermiller.com'
Subject: Request for Prefiled Testimony
Attachments: 31837.pdf

Mr. Rweyemamu,
Attached is a request for prefiled testimony and issues which must be submitted to OHCA no later than 12:00 p.m. on June 21, 2013.

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

June 11, 2013

VIA ELECTRONIC MAIL ONLY

Justinian Rweyemamu, MA, M.Div. MS-MFT
CT-Family Care Services, LLC
16 Enfield Ave.
Enfield, CT 06082

RE: Certificate of Need Application; Docket Number: 13-31837-CON
CT-Family Care Services, LLC
Establishment of a Behavioral Health Treatment Center in Manchester
Request for Prefiled Testimony and Issues

Dear Mr. Rweyemamu:

The Office of Health Care Access ("OHCA") will hold a public hearing on the above docket number on June 26, 2013. The hearing is at 9:00 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. CT-Family Care Services, Inc. ("Applicant") must submit prefiled testimony to OHCA no later than 12:00 p.m. on June 21, 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: 13-31837-CON

CT-Family Care Services, LLC
Establishment of a Behavioral Health Treatment Center
in Manchester

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 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. The levels of treatment to be provided under the proposal and the licenses needed to provide those levels of treatment.

4. Ability of CT-Family Services, LLC to cover operating costs until reimbursements under contracts with third-party payers, including Medicare, Medicaid and commercial insurance companies, begin to be received.

Greer, Leslie

From: rweye@cox.net
Sent: Tuesday, June 11, 2013 5:17 PM
To: Greer, Leslie
Cc: Greci, Laurie; srz@zlokowermiller.com; Hansted, Kevin; Riggott, Kaila; Martone, Kim
Subject: Re: Request for Prefiled Testimony

Thank you Leslie. I have received the attachment and will respond as requested. Justin

Justinian Rweyemamu, MA, M.Div, MS-MFT, PhD Students President CT-Family Care Services, LLC
243 Main St, Unit # 4 Manchester,CT. 06042
Tel: 860-432-8862,
Cell: 860-508-8651
rweye@cox.net
155 Maple St, Unit # 204
Springfield, MA. 01105
Tel: 413-285-8722
Cell: 860-508-8651
rweye@cox.net

---- "Greer wrote:
> Mr. Rweyemamu,
> Attached is a request for prefiled testimony and issues which must be submitted to OHCA no later than 12:00 p.m. on June 21, 2013.
>
> 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<http://www.ct.gov/ohca>
> P Please consider the environment before printing this message
>
>

--

Olejarz, Barbara

From: Martone, Kim
Sent: Tuesday, June 25, 2013 10:41 AM
To: Olejarz, Barbara
Subject: FW: Hearing Notice for 13-31837-answers attached-powerpoint.--CT-Family Care Care-LLC-6-26-013
Attachments: 6-24-2013-CT-FAMILY CARE SERVICES,LLC PRESENTS-DPH-Hartford.ppt

Kimberly R. Martone
Director of Operations
Office of Health Care Access
860-418-7029

-----Original Message-----
From: rweye@cox.net [mailto:rweye@cox.net]
Sent: Monday, June 24, 2013 9:13 PM
To: Greci, Laurie
Cc: Riggott, Kaila; srz@zlokowermiller.com; Greer, Leslie; Hansted, Kevin; Martone, Kim; srz@zlokowermiller.com; justinr@ctfcs.necoxmail.com
Subject: Re: Hearing Notice for 13-31837-answers attached-powerpoint.--CT-Family Care Care-LLC-6-26-013

Hi Laurie
Attached herewith is the document answering all 4 questions about the public needs in Manchester area as requested. I will use this power-point for the presentation on wednesday, June 26,2013 at 9 am as scheduled in Hartford. I look forward to seeing you all. I will email you the letter from the bank confirming that the agency has a line of credit. Thus, it has the ability to cover the operating costs before insurance reimbursements start . Thanks. Justin

Justinian Rweyemamu, MA, M.Div, MS-MFT, PhD Students President CT-Family Care Services, LLC
243 Main St, Unit # 4 Manchester,CT. 06042
Tel: 860-432-8862,
Cell: 860-508-8651
rweye@cox.net
155 Maple St, Unit # 204
Springfield, MA. 01105
Tel: 413-285-8722
Cell: 860-508-8651
rweye@cox.net

---- "Greci wrote:
>
> Dear Mr. Rweyemamu,
>

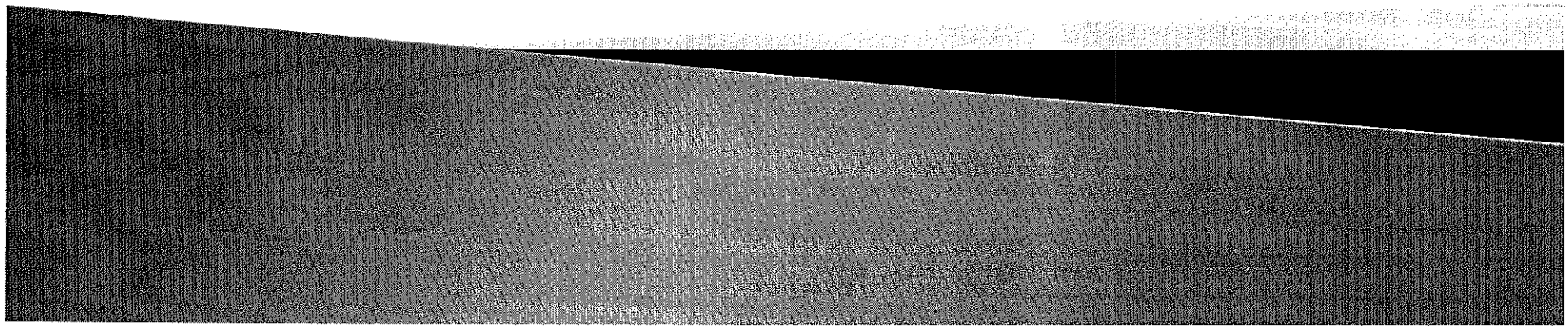
> Attached you will find a letter to you that announces the hearing date and another letter requesting publication in the local newspaper.
>
> If you have any questions, please call me.
>
> Regards,
>
> Laurie K. Greci
>
> Associate Research Analyst
> Department of Public Health
> Health Care Access
> * laurie.greci@ct.gov<mailto:laurie.greci@ct.gov>
> ' 860 418-7032
> 7 860 418-7053
>

--

CT-FAMILY CARE SERVICES,LLC PRESENTS: The Public needs.

Executive summary: Public needs in Manchester area

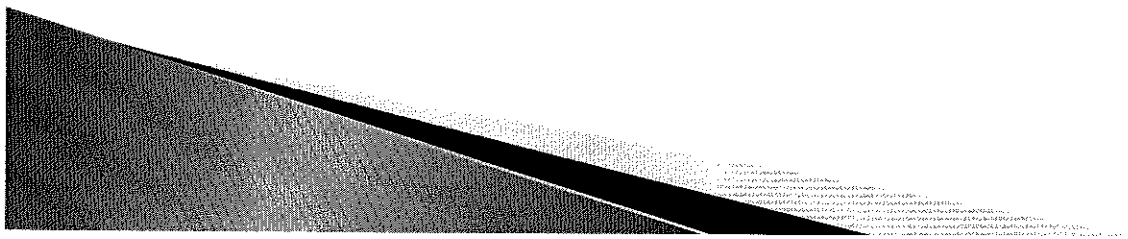
Justinian Rweyemamu,MA, M.Div, MS-MFT, PhD student, President
Sherilyn Barao, B.A., Dipl(paralegal),Office Manager



CT-FAMILY CARE SERVICES,LLC PRESENTS...

INTRODUCTION:

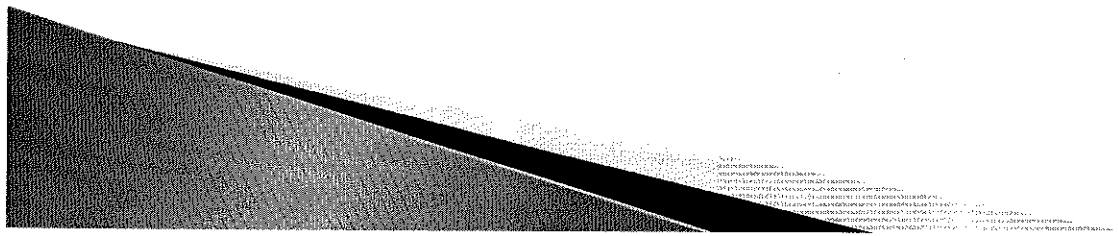
- CT-Family Care Services,LLC is a State and Federal certified minority owned company, mental health agency based in Connecticut.
- Established and registered in Connecticut in July 2007.
- CT-Family Care team is composed of seasoned professionals.



CT-FAMILY CARE SERVICES,LLC PRESENTS...

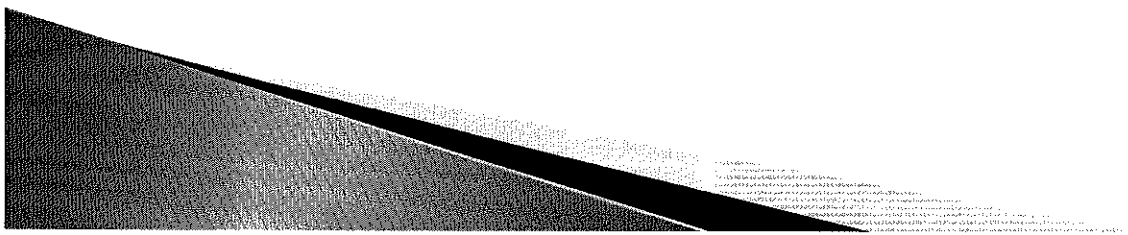
MISSION STATEMENT:

- The mission of CT-Family Care Services, LLC is to foster collaboration and partnership with individuals, couples, families, care-takers and the underserved populations who seek to enhance wellness and strengthen their families.
- We are dedicated to serving our clients by using strengths base approach to overcome their current struggles. Our organization seeks to build on the strengths and resources of clients while incorporating social, cultural, emotional, relations, educational, economic and spiritual values.



CT-FAMILY CARE SERVICES,LLC PRESENTS...

- We seek to foster client's' active participation in all aspects of the treatment process, including therapy, social services, medical resources, research and academic enhancement.
- Through their active engagement in treatment, our goal for services is to enhance the skills of clients that extend beyond the therapy relationship.



CT-FAMILY CARE SERVICES,LLC PRESENTS...

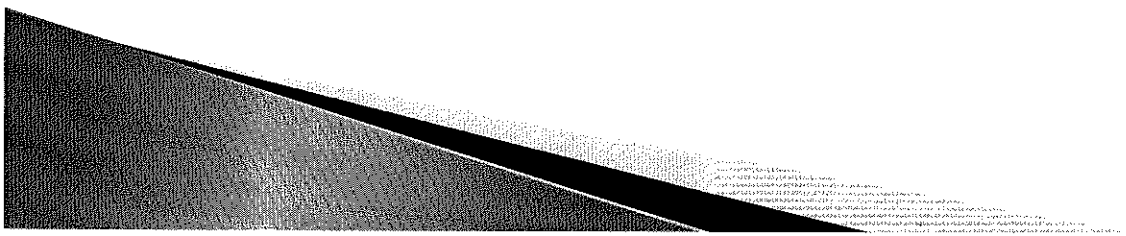
GOAL:

- Collaboration among clients, their family members, and the treatment team yields the following goals for CT - Family Care Services, LLC:
- Conduct integrated assessments in order to identify contributions to clients constraints, needs to overcome those constraints, and attainable outcome goals.
- Provide integrated and empirically supported treatments in order to effectively address clients' concerns for recovery and wellness.

CT-FAMILY CARE SERVICES,LLC PRESENTS...

Q1. Service area demogragraphics:

- Manchester area which includes neighbors such as East Hartford, Vernon, South Windsor, Ellington, East Windsor & Suffield
- **Patient population**: Special focus will be directed to the **underserved population** who need the services that the agency provides.



CT-FAMILY CARE SERVICES,LLC PRESENTS...

Q.1 b. Answer: Table 1: Public needs

- The Center for Disease Control, points out that 1 out of 2 Americans has a diagnosable mental disorder and fewer than half of Adults receive treatment while one third of children receive treatment
- **Town & Population and estimated needs -50%/ CDC**

Manchester	58,287	29,144
East Hartford	51,293	25,647
Vernon	29,139	14,570
South Windsor	25,729	12,865
Ellington	15,582	7,791
East Windsor	11,170	5,585
Suffield	15,747	7,8734

(CDCwww.cdc.gov/omhd/AMH/factsheets/metal.htm; http://www.ct.gov/ecd/lib/ecd/dphpopulation/dph_pop_2011.pdf)

CT-FAMILY CARE SERVICES,LLC PRESENTS...

In Support of the above data:

- CT-Family Care Services team visited almost all schools and met with teachers, social workers and mental Health staff in Manchester
- It was pointed out that there is a great number of children, students and families that have unaddressed mental health issues. Currently, several available agencies have a long waiting list of patients

CT-FAMILY CARE SERVICES,LLC PRESENTS...

- Attempts to address the needs of the underprivileged especially in the areas of health, education and economics have traditionally focused in cities.
- Minorities in communities where they are not the majority such as in Manchester area have either very few or insufficient agencies and integrated treatments such as those provided by the CT-Family Care Services, LLC.
- CT-Family Care Services' treatments are customized, integrated and informed by research on the social-cultural-spiritual-emotional-economic-academic needs of minorities.

CT-FAMILY CARE SERVICES,LLC PRESENTS…

Q2: **Need for the proposal based on incidences/or prevalence in the area**:

- For example, in Manchester, there are two schools where the majority are overwhelmingly minority /underserved students and have both academic and behavioral problems.
- Schools are not yet adequately staffed with enough clinical family therapists who are able to treat both students and their families' simultaneously and timely.
- Such a pattern seems to be common in Manchester and its selected neighboring towns

CT-FAMILY CARE SERVICES,LLC PRESENTS...

School dropout: Table 2:

- **Number of Persons in Service Area with Unmet Needs (See Appendix #4).**

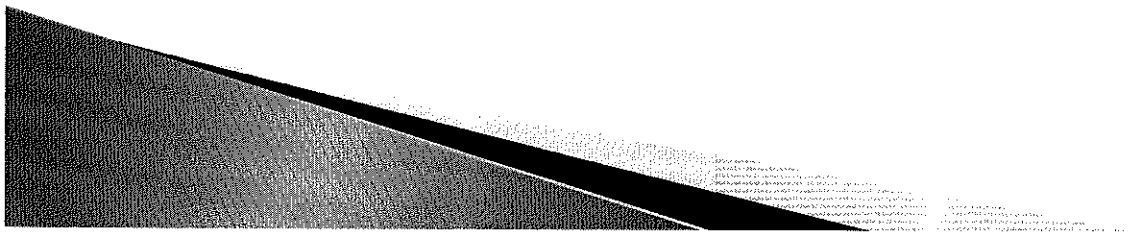
Students	#,	# of persons,	# to benefit(min)
Manchester	6884	117	2/3 78
East Hartford	7242	319	2/3 213
Vernon	3681	144	2/3 96
S. Windsor	4654	74	2/3 62
Ellington	2726	130	2/3 87
East Windsor	1329	110	2/3 73

CT-FAMILY CARE SERVICES,LLC PRESENTS...

Problematic Behaviors (students)

- Students #, # of persons, # to benefit(m

Manchester	6884	1102	2/3	735
East Hartford	7242	1716	2/3	1144
Vernon	3681	372	2/3	248
S. Windsor	4654	786	2/3	524
Ellington	2726	313	2/3	208
East Windsor	1329	347	2/3	231



CT-FAMILY CARE SERVICES,LLC PRESENTS...

Disabilities

- Students #, # of persons, # to benefit(min

Manchester	6884	895	2/3	597
East Hartford	7242	992	2/3	661
Vernon	3681	398	2/3	265
S. Windsor	4654	540	2/3	360
Ellington	2726	286	2/3	190
East Windsor	1329	188	2/3	125

(Connecticut State Department of Education http://sdeportal.ct.gov/Cedar/WEB/ct_report/DisciplineReportViewer.aspx)

CT-FAMILY CARE SERVICES,LLC PRESENTS...

Mental Health of adults

- Population, people with MH, % , # to benefit

Manchester:	58,287	29,144	1/2	14,572
E. Hartford:	51,293	25,647	1/2	12,824
Vernon:	29,139	14,570	1/2	7,285
S. Windsor:	25,729	12,865	1/2	6,433

(Center for Disease Control www.cdc.gov/omhd/AMH/factsheets/metal.htm)

CT-FAMILY CARE SERVICES,LLC PRESENTS…

Some barriers to treatments in Manchester area:

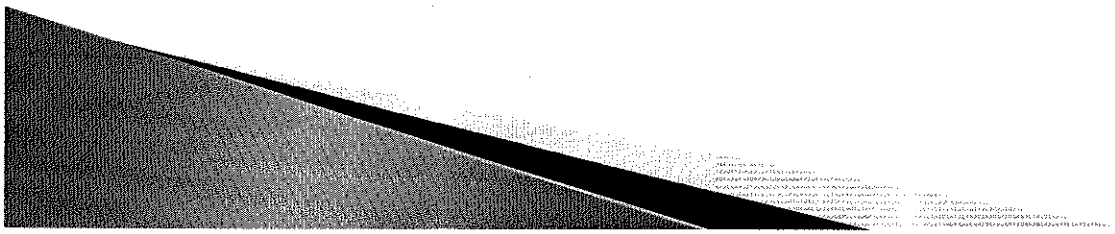
- Long waiting lists for the treatments from the current existing providers in the Manchester area. For example:
- "We continue to struggle with limited space to accommodate our increased need to provide services; at this point our building is more than filled with therapists, sometimes having to scramble to find a vacant office to interview families"

  (Director, The Community Child Guidance Clinic www. cgcinc.org/director_message.htm)

CT-FAMILY CARE SERVICES,LLC PRESENTS...

- There is an ever growing population of South Asian families in Manchester area who are in need of many services but are met with language barriers.
- They are families whose health insurances are being cut back or cancelled and they do not qualify for state insurance and are unable to pay out of pocket for private health insurance

(Manchester Department of Health, Barbara Quigley and Edward Pikette).



CT-FAMILY CARE SERVICES,LLC PRESENTS...

Number of students/youth in Service Area with Unmet needs-

	FY 2013,	FY 2014(25% +),	FY 2015 (32% +)
➢ Academic difficulties: Enhance academic performances	2,825	3,767	5,540
➢ Prevention/reduction of school dropout symptoms	654	872	1,282
➢ Behavioral Integrated Treatments	3,976	5,301	7,796
➢ Students being bullied 8.6% of students	1,932	2,576	3,788
➢ Psychiatric Med	1,500	1,875	1,980
Total	**10,887**	**12,891**	**18,886**

CT-FAMILY CARE SERVICES,LLC PRESENTS...

Adults: Number of Individuals, couples, partners, families, groups in Service Area with Unmet needs- to be serviced:

FY 2013, FY 2014(25% +) FY 2015 (32% +)

- Integrated Treatment (therapy & social services)
  70,994(1,365*52 weeks) 94,657 139,201

- Job Training /Preparedness- 9%+ unemployment rate(minority/underserved)
  6,389 8,519 12,528

- Psychiatric services(outpatients)
  1250 1,666 2,450

Total: 78,633 104,84 2 154,179

CT-FAMILY CARE SERVICES,LLC PRESENTS...

Veterans: Number of Individuals, couples, partners, families, groups in Service Area with Unmet needs-to be serviced:

	FY 2013, (32% +)	FY 2014(25% +)	FY 2015
➢ Integrated Treatment (therapy & Social services & Home Health care)	9,939	13,252	19,488
➢ **Seniors**:	7695	10,260	15,088
➢ **Total:**	**17,634**	**23,512**	**34, 576**

CT-FAMILY CARE SERVICES,LLC PRESENTS...

Inmates /Juvenile community re-entry: Number of Individuals, couples, partners, families, groups in Service Area with Unmet needs- to be serviced:

FY 2013, FY 2014(25% +) FY 2015 (32% +)

- Integrated Individual treatments- effective responsibilitities: parenting and readjustment to jobs and reduce recidivism

  500 667 981

- Integrated Treatment for individual & Family

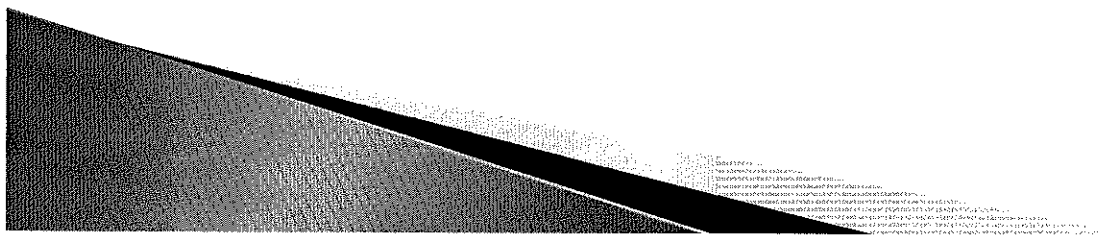
  300 400 588

- **Total 800 1067 1569**

CT-FAMILY CARE SERVICES,LLC PRESENTS...

In 2010, about 45.9 million adults in the United States aging from 18 years or older were identified as having mental illnesses and 9.2% of that population met the criteria of using substances excessively or dependence (www.samhsa.gov).

- **Below is an estimated population who are struggling with substance abuses as well related addictions in Manchester area**
- Population In Manchester area in Connecticut **141,987**
- Dealing with Substance Abuses (8.67%) **12,310**
- Receive some form of treatments or group supports **6,155** (50%)
- **Untreated yet 6,155 (50%)**



CT-FAMILY CARE SERVICES,LLC PRESENTS...

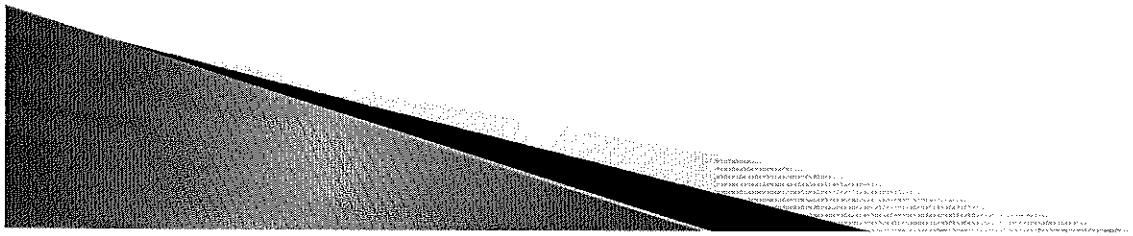
Immigrants and Refugees settlements

- While Connecticut has a population of 3,580,701, it is estimated 478,323 to be refugees.
- Manchester area is estimated to have 679 immigrants/refugees
- Often refugees /immigrants come with trauma related issues and need some mental health, social services & cross-cultural orientations and other related services.

CT-FAMILY CARE SERVICES,LLC PRESENTS...

Q: 3. Answer: Types of Treatments Provided:

- **1.Outpatient psychiatric mental health services** for children, youths, & families.
- **2. Outpatient psychiatric mental health services** for adults(individuals, seniors, veterans, groups & families
- **3. Social services, home therapy, and home Care**
- **4.Psychiatric services (medical services, refills for children & adults) and**
- **5. Addiction and substance abuses services**
- **6. Research in line with AAMFT & State Guidelines**



CT-FAMILY CARE SERVICES,LLC PRESENTS...

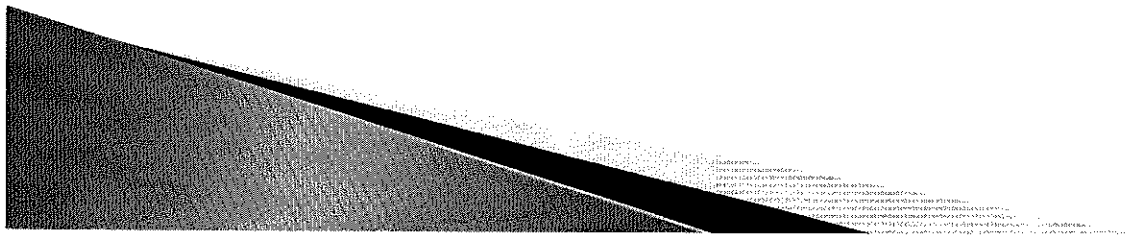
Q: 3. Types of Licenses requested:

- Outpatient Psychiatric mental health, home therapy, home care, social services, research and substance abuse services for youth, adults, groups & families
- Outpatient psychiatric integrated mental Health Clinic, Social services, Home Therapy & Home Care, Substance abuse services, & Research(for children, families, adults and groups)

CT-FAMILY CARE SERVICES,LLC PRESENTS...

Q4. Financial capability to provide services

- Agency has a line of credit(see attached letter) to be used before insurance reimbursements starts



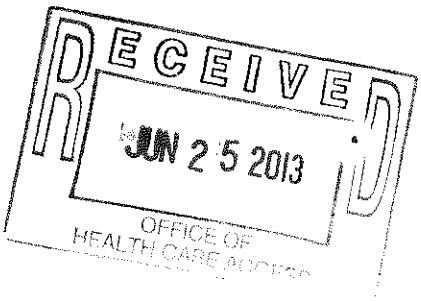
CT-FAMILY CARE SERVICES,LLC PRESENTS...

References:

- CT-Family Care Services, LLC, Application for the certificate of needs "CON"2012/2013
- Center for Disease Control www.cdc.gov/omhd/AMH/factsheets/metal.htm
- Connecticut State Department of Education) http://sdeportal.ct.gov/Cedar/WEB/ct_report/DisciplineReportViewer.aspx
- Town of Manchester Public schools,
- Manchester Public health Department
- North Central Regional Mental health Board www.ncrmhb.org

Olejarz, Barbara

From: Martone, Kim
Sent: Tuesday, June 25, 2013 10:56 AM
To: Olejarz, Barbara
Subject: FW:
Attachments: People's Bank -line of credit.pdf



Kimberly R. Martone
Director of Operations
Office of Health Care Access
860-418-7029

-----Original Message-----
From: rweye@cox.net [mailto:rweye@cox.net]
Sent: Tuesday, June 25, 2013 10:05 AM
To: Greci, Laurie
Cc: Riggott, Kaila; srz@zlokowermiller.com; Greer, Leslie; Hansted, Kevin; Martone, Kim; srz@zlokowermiller.com; justinr@ctfcs.necoxmail.com
Subject:

Good morning Laurie
Attached herewith is the letter from the Bank as promised. Thank you. Justin

Justinian Rweyemamu, MA, M.Div, MS-MFT, PhD Students President CT-Family Care Services, LLC
243 Main St, Unit # 4 Manchester,CT. 06042
Tel: 860-432-8862,
Cell: 860-508-8651
rweye@cox.net
155 Maple St, Unit # 204
Springfield, MA. 01105
Tel: 413-285-8722
Cell: 860-508-8651
rweye@cox.net

People's United Bank

Enfield Office

T: 860.745.0354 F: 860.280.2713
800.894.0300

June 12, 2013

To Whom It May Concern:

This letter is to confirm that CT-Family Care Services LLC currently has active accounts at our institution. CT-Family Care Services LLC has a Business Line of Credit at our institution.

Thank you,

Jody Benton
Sr. Financial Service Associate
Enfield Traditional Office

Greer, Leslie

From: Greci, Laurie
Sent: Tuesday, June 25, 2013 3:34 PM
To: Greer, Leslie
Subject: FW: Documents Concerning Tomorrow's Hearing

-----Original Message-----
From: rweye@cox.net [mailto:rweye@cox.net]
Sent: Tuesday, June 25, 2013 3:33 PM
To: Greci, Laurie
Subject: Re: Documents Concerning Tomorrow's Hearing

Thank you. Justin
---- "Greci wrote:
>
> Dear Mr. Rweyemamu,
>
> I have attached to this email the agenda for tomorrow's hearing, the table of the record that lists all documents contained in the docket identified as 13-31837-CON and instructions for parking.
>
> The powerpoint presentation that you submitted may be presented at the hearing verbally. We will not have a personal computer and projector for you to do the presentation. Paper copies of the presentation, two slides per page, will be available at the hearing.
>
> Regards,
>
> Laurie Greci
>
> Laurie K. Greci
> Associate Research Analyst
> Department of Public Health
> Health Care Access
> * laurie.greci@ct.gov<mailto:laurie.greci@ct.gov>
> ' 860 418-7032
> 7 860 418-7053
>

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

TENTATIVE AGENDA

PUBLIC HEARING

Docket Number: 13-31837-CON

CT-Family Care Services, LLC.

Establishment of a Behavioral Health Treatment Center in Manchester

June 26, 2013 at 9:00 a.m.

I. Convening of the Public Hearing

II. Applicant's Direct Testimony (10 minutes)

III. OHCA's Questions

IV. Closing Remarks

V. Public Hearing Adjourned

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

TABLE OF THE RECORD

APPLICANT: **CT-Family Care Services, LLC**

DOCKET NUMBER: **13-31837-CON**

PUBLIC HEARING: **June 26, 2013 at 9:00 a.m.**

PLACE: **410 Capitol Avenue, Third Floor Hearing Room**
Hartford, Connecticut

EXHIBIT	DESCRIPTION
A	Letter from CT-Family Care Services, LLC ("Applicant") dated April 11, 2012 enclosing the Certificate of Need for the Establishment of a Behavioral Health Treatment Center in Manchester, received by the Office of Health Care Access ("OHCA") on April 12, 2013 (check was received on May 1, 2013). (328 pages)
B	OHCA's letter to the Applicant dated April 25, 2013 requesting application fee and payment receipt for legal notices to complete the CON application under Docket Number 13-31837.(2 pages)
C	Applicant's responses to OHCA's letter of April 25, 2013, dated April 29, 2013, in the matter of the CON application under Docket Number 13-31837, received by OHCA on April 29, 2013.(7 pages)
D	OHCA's letter to the Applicant dated May 22, 2013 deeming the application complete as of May 17, 2013 in the matter of the CON application under Docket Number 13-31837. (3 pages)
E	OHCA's emails to the Applicant dated May 24 thru May 28, 2013 regarding possible hearing dates in the matter of the CON application under Docket Number 13-31837. (2 pages)
F	Designation letter dated May 29, 2013 of Hearing Officer in the matter of the CON application under Docket Number 13-31837. (1 page)
G	OHCA's request for legal notification in the *Journal Inquirer* and OHCA's Notice to the Applicant of the public hearing scheduled for June 26, 2013 in the matter of the CON application under Docket Number 13-31837, dated June 7, 2013. (4 pages)

H	OHCA's letter to the Applicant dated June 11, 2013 requesting prefile testimony and issues outlining topics to be discussed at the hearing in the matter of the CON application under Docket Number 13-31837.(2 pages)
I	Email from the Applicant enclosing prefile testimony dated June 24, 2013 in the matter of the CON application under Docket Number 13-31837, received by OHCA on June 25, 2013. (27 pages)
J	Email from the Applicant dated June 25, 2013 enclosing letter from People's United Bank in the matter of the CON application under Docket Number 13-31837, received by OHCA on June 25, 2013. (2 pages)

Directions to the Office of Health Care Access

From I-91 North or South and from East of the River:

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:

From I-91 (north or south) and from east of the river

In Hartford, take I-84 west. Take Exit 46, Sisson Avenue. At the end of the exit ramp, turn left at the signal light onto Sisson Avenue. Take your first left onto **Capitol Ave. Take your first left onto Forest Street. The parking lot is on your left and is labeled State of Connecticut. A shuttle bus to take you to our offices will either be waiting, or will appear in a few minutes.**

From the West

Take I-84 East to Exit 46, Sisson Avenue. At the end of the exit ramp, turn left at the light onto Sisson Avenue. Take you first left onto **Capitol Avenue. Take your first left onto Forest Street. The parking lot is on your left and is labeled State of Connecticut. A shuttle bus to take you to our offices will either be waiting, or will appear in a few minutes**

	South Windsor	4654	11.6	540	2/3	360
Mental Health of adults	Manchester	58,287	50	29,144	1/2	14,572
	East Hartford	51,293	50	25,647	1/2	12,824
	Vernon	29,139	50	14,570	1/2	7,285
	South Windsor	25,729	50	12,865	1/2	6,433

Connecticut State Department of Education;

http://sdeportal.ct.gov/Cedar/WEB/ct_report/DisciplineReportViewer.aspx

Question # 7: On pages 185 and 186 of the completeness response the Applicant reports projected volumes by fiscal year. However, it not clear what the reported units are and what is the basis for the projections. Utilizing the number of persons quantified in Table 2, report the projected number of persons and number of therapy sessions for FYs 2013, 2014, and 2015. Report the projected numbers by service type and the population to be served (for example, youth, adults, veterans). List all assumptions made to determine the projected volumes. Please identify group vs. private sessions. Add additional rows as needed.

Answer: (See Appendix #5) Utilizing the populations of Manchester, East Hartford, Vernon, and South Windsor and calculating based on the CDC and the National Census Bureau data, the following are the potential number of sessions that CT Family Care Services, LLC will provide in a 6 month time frame.

Table: 2 Number of Persons in Service Area with Unmet needs- to be serviced for 6 months (24 Sessions)

›pulation	**Service Type**	**FY 2013**		**FY 2014- 25% increase**		**FY 2015- 32% increase**	
		Persons	*Sessions*	*Persons*	*Sessions*	*Persons*	*Sessions*
udents/ ›uths	Academic Disabilities Enhance academic performances	2825	67,800	3767	90,408	5,540	132,960

	Prevention/reduction of school dropout symptoms	654	15,696	872	20,928	1,282	30,768
	Behavioral Integrated Treatments (Therapy)	3,976	95,424	5301	127,224	7,796	187,104
	Bullying- students being bullied 8.6% of students	1932	46,360	2576	61,824	3,788	90,912
	Psychiatric Medication	1500		375 12891		480 18,886	
	Total	**10,887**	**225,280**	~~**12,516**~~	**300,384**	~~**18,406**~~	**441,744**
dults	Individual, couple, partners, family Integrated Treatment (therapy & Social services)	70,994	1,703,856	94,657	2,271,176	139,201	3,340,835
	Job Training /Preparedness- 9% unemployment rate	6,389	15,347	8519	204,456	12,528	300,671
	Psychiatric medication	1250		1666	39,984	2450	58,800
	Total	**78,633**	**1,719,203**	**104,842**	**2,516,208**	**154,179**	**3,700,306**
eterans- % of opulation	Individual, couple, partners, family Integrated Treatment (therapy & Social services) PTSD etc.	9,939	238,536	13,252	318,048	19,488	467,717
eniors ver 65 ears old	Individual, couple, partners, family Integrated Treatment (therapy, Social services, & Home care)	7695	184,680	10,260	246,240	15,088	362,117

	Total	**17,634**	**423,216**	**23,512**	**564,288**	**34,576**	**829,834**
ommunity e-entry Recidivism 50% and bove)	Integrated Individual treatments- effective parenting and readjustment to jobs	500	12,000	667	16,008	981	23,544
	Integrated Treatment for individual & Family	300	7200	400	9600	588	14,118
	Total	**800**	**19,200**	**1067**	**25,608**	**1569**	**37,662**
	TOTAL POTENTIAL CLIENTS	**107,954**	**2,590,896**	**141,937**	**3,406,488**	**208,730**	**5,009,546**
	TOTAL CLIENTS TO BE SERVED BY CT (APPROX. 1 OF 7 ESTABLISHED CLINICS IN AREA) 1/7	**15,422**	**370,128**	**20,277**	**486,648**	**29,819**	**715,649**

Question # 8:

8) Explain the increases in the number of persons and the number of sessions from the relative previous year for FY 2014 and FY 2015

Answer: There will be an increase of 9398 between 2014 and 2015 because the agency will continue to invest both in marketing and in providing good quality services that addresses clients' real needs for recovery and success. Thus, the quality services provided will inspire other clients to pass the word of mouth to another especially among the targeted population which is in great need of integrated treatments that CT-Family Care Services provides, which are customized treatment plans that embrace and utilize individuals' social-cultural-spiritual and ethnic values as well as other clients' strengths for recovery and wellness.

OHCA HEARINGS - EXHIBIT AND LATE FILE FORM

Applicants: CT-Family Care Services, LLC

DN: 13-31837-CON

Hearing Date: June 26, 2013

Time: 9:00 a.m.

Proposal: Establishment of a Behavioral Health Treatment Center in Manchester

OHCA Exhibit #	Description
K	pages from Applicant 217-219 that are not numbered the same as in Ex A.
2	
3	
4	
5	

Applicant Late File #	Description	Due Date	Rec'd
1	Letters from Referrals with request from Applicant can be extended.	+30 days	
2	pg 219 220 • 221 row total clients Breakdown by service & age group		
3			
4			
5			
6			

Applicant Exhibit #	Description
1	3 pages 217, 218, 219
2	
3	
4	
5	

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

AGENDA

PUBLIC HEARING

Docket Number: 13-31837-CON

CT-Family Care Services, LLC.

Establishment of a Behavioral Health Treatment Center in Manchester

June 26, 2013 at 9:00 a.m.

I. **Convening of the Public Hearing**

II. **Applicant's Direct Testimony (10 minutes)**

III. **OHCA's Questions**

IV. **Closing Remarks**

V. **Public 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

Office of Health Care Access

TABLE OF THE RECORD

APPLICANT: **CT-Family Care Services, LLC**

DOCKET NUMBER: **13-31837-CON**

PUBLIC HEARING: **June 26, 2013 at 9:00 a.m.**

PLACE: **410 Capitol Avenue, Third Floor Hearing Room**
Hartford, Connecticut

EXHIBIT	DESCRIPTION
A	Letter from CT-Family Care Services, LLC ("Applicant") dated April 11, 2012 enclosing the Certificate of Need for the Establishment of a Behavioral Health Treatment Center in Manchester, received by the Office of Health Care Access ("OHCA") on April 12, 2013 (check was received on May 1, 2013). (328 pages)
B	OHCA's letter to the Applicant dated April 25, 2013 requesting application fee and payment receipt for legal notices to complete the CON application under Docket Number 13-31837.(2 pages)
C	Applicant's responses to OHCA's letter of April 25, 2013, dated April 29, 2013, in the matter of the CON application under Docket Number 13-31837, received by OHCA on April 29, 2013.(7 pages)
D	OHCA's letter to the Applicant dated May 22, 2013 deeming the application complete as of May 17, 2013 in the matter of the CON application under Docket Number 13-31837. (3 pages)
E	OHCA's emails to the Applicant dated May 24 thru May 28, 2013 regarding possible hearing dates in the matter of the CON application under Docket Number 13-31837. (2 pages)
F	Designation letter dated May 29, 2013 of Hearing Officer in the matter of the CON application under Docket Number 13-31837. (1 page)
G	OHCA's request for legal notification in the *Journal Inquirer* and OHCA's Notice to the Applicant of the public hearing scheduled for June 26, 2013 in the matter of the CON application under Docket Number 13-31837, dated June 7, 2013. (4 pages)

H	OHCA's letter to the Applicant dated June 11, 2013 requesting prefile testimony and issues outlining topics to be discussed at the hearing in the matter of the CON application under Docket Number 13-31837.(2 pages)
I	Email from the Applicant enclosing prefile testimony dated June 24, 2013 in the matter of the CON application under Docket Number 13-31837, received by OHCA on June 25, 2013. (27 pages)
J	Email from the Applicant dated June 25, 2013 enclosing letter from People's United Bank in the matter of the CON application under Docket Number 13-31837, received by OHCA on June 25, 2013. (2 pages)

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

TENTATIVE AGENDA

PUBLIC HEARING

Docket Number: 13-31837-CON

CT-Family Care Services, LLC.

Establishment of a Behavioral Health Treatment Center in Manchester

June 26, 2013 at 9:00 a.m.

I. **Convening of the Public Hearing**

II. **Applicant's Direct Testimony (10 minutes)**

III. **OHCA's Questions**

IV. **Closing Remarks**

V. **Public Hearing Adjourned**

ORIGINAL

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

OFFICE OF HEALTH CARE ACCESS

CT-FAMILY CARE SERVICES, LLC

ESTABLISHMENT OF A BEHAVIORAL HEALTH TREATMENT CENTER IN MANCHESTER

DOCKET NO. 13-31837-CON

JUNE 26, 2013

9:00 A.M.

410 CAPITOL AVENUE
HARTFORD, CONNECTICUT

POST REPORTING SERVICE
HAMDEN, CT (800) 262-4102

HEARING RE: CT-FAMILY CARE SERVICES, LLC
JUNE 26, 2013

. . .Verbatim proceedings of a hearing before the State of Connecticut, Department of Public Health, Office of Health Care Access, in the matter of CT-Family Care Services, LLC, Establishment of a Behavioral Health Treatment Center in Manchester, held at 410 Capitol Avenue, Hartford, Connecticut, on June 26, 2013 at 9:00 a.m. . . .

HEARING OFFICER KEVIN HANSTED: Good morning, everyone. This public hearing before the Office of Health Care Access, identified by Docket No. 13-31837-CON, is being held on June 26, 2013 to consider Connecticut Family Care Services, LLC's application to establish a behavioral health treatment center in Manchester, 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 as the Hearing Officer for this matter.

The staff members assigned to assist me in this case today are Kaila Riggott and Laurie Greci. The hearing is being recorded by Post Reporting Services.

Following the hearing, a decision will be made 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, Connecticut Family Care Services, LLC, 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 this case. All documents have been identified in the Table of the Record for reference purposes. Ms. Greci?

MS. LAURIE GRECI: Laurie Greci. I'd like to read into the record Exhibits A through J, as identified on the Table of the Record provided.

HEARING OFFICER HANSTED: Does the Applicant have any objections to the exhibits? Can you

verbally say it?

MR. JUSTINIAN RWEYEMAMU: No.

HEARING OFFICER HANSTED: Thank you. At this time, I would like all the individuals, who are going to testify 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, both. And when you first speak today, please state your full name for the record. Thank you. At this time, Connecticut Family Services, you may proceed.

MR. RWEYEMAMU: Good morning.

HEARING OFFICER HANSTED: Good morning.

MR. RWEYEMAMU: My name is Justinian Rweyemamu. I am the founder and the president of CT-Family Care Services.

I would like to take this opportunity in a very special way to thank God and thank each one of you for your presence, but, also, to thank you for inviting us to meet with you.

I understand that I have been given 10 minutes to do the brief presentation.

HEARING OFFICER HANSTED: I won't hold you to that. You can go over the 10 minutes.

MR. RWEYEMAMU: That is really good, because I was going to two minutes, two minutes, two minutes. Okay, very good.

Now, at this moment, before I proceed, do you want her to introduce herself, or introduce herself when she wants to say something?

HEARING OFFICER HANSTED: No. Only when she's going to speak. Thank you.

MR. RWEYEMAMU: Okay, so, I think we have four questions that I will be addressing briefly, but I think the first one is to introduce ourselves, who we are.

I believe that you do have the PowerPoint that I presented, and this is on page one. CT-Family Care Services is a state and federal satisfied minority-owned company, mental health agency, which was established in 2007, registered in Connecticut, and, as far as I understand, as of today, this is the first minority-owned mental health agency in Connecticut, as well as in Massachusetts, where we're already licensed.

CT-Family Care Services provides integrated treatment, with the special focuses to serving the underserved population.

Now on your first question, you also asked

me to identify the area of those services, and, so, at this juncture, I would invite you that we go to page three. The areas of service that we have selected are the Manchester area, which may include Manchester, and then its neighbors, such as East Windsor, South Windsor, Vernon, Ellington and Suffield.

In terms of the public need, that is what you waited as to go there, and, as you got your public need, I would invite you that you go to page four, whereby, according the Center for Disease Control, it is estimated that almost one out of two Americans do have mental disorder symptoms.

And, so, if we take that, I will try to provide you the population for all the towns, all the areas that we would be serving, and, then, also to say that about half of those populations do not yet receive mental health treatments, even though they do need greatly.

So, in that page, I was able to provide you the population of the towns, the population of the people with mental health needs, and, also, after we have done that quantification, we visited various schools in the towns in Manchester area, as well as we met with town officials, some social health workers, to assess the

situation.

We were told many times in different ways that the reality is there is a great need in Manchester area, particularly on the population that we are targeting, namely, the underserved population.

We were told that there were a good number of students and families whose mental health needs are at risk, because of various factors, one being the fact that even though in those areas they do have some agencies, but the wait list is too high.

I made a quotation from one of their, which on page five, on page five, the first side, from the Child Guidance Counselor, the Director, who said that there are overwhelmed because they don't have enough space. But that sometimes another challenge is that while some of the schools may still have some social workers, who are providing counseling, still, it is difficult to provide integrated treatment to students and their families, particularly since some of the parents are working.

So if the social workers at the school want to meet with the families, it is difficult, but for CT-Family Care Services, our schedule is very flexible to be able to reach out, by providing an integrated

treatment that we can be able to provide the needed mental health treatment to the child, but, also, with the family, and that's why we will be providing services even on Saturday, so that we can be able to accommodate families that may not be able to come during the weekdays.

Now when we go to question number two, question number two is asking us to highlight some of the instances on those selected areas. One of the incidents that actually we found to be really predominant is about school dropout, and this is page six.

If you go to page six, you will see school dropout in those areas, in those towns, and, also, they are, on the left side, I presented the number of the students, and I got this information from the Connecticut Department of Education from the school's dropout.

As you know, school dropout is one of the challenges affecting the state, but it is more common among minorities and the underserved population.

So taking that formula of one-third, some are getting some services, but about two-thirds of those students are at risk, so you can see that there's very substantial need, whereby CT-Family Care Services is needed and whereby they are dedicated to providing these

services.

And, also, the second one is about behavior, which is still on the same page, number six. Using the data from the Department of Public Health, we went to all the schools, and we quantified the number of the students there, who are reported to have these incidents.

Of course, some are receiving some treatment, but, again, to address this kind of perennial issues affecting students from much behaviors and integrating the approach is needed to strengthen, so that at least they can be able to improve -- not only to improve periodically -- but by providing them treatment that would enable the students and their parents, most of the time, when you see students acting out at the school, there is in the light of research a correlation between what is happening in their families with how a student behaves outside their families.

So I was think plan, in the light of modern family therapy and also in the light of research is provide an integrated treatment, whereby we treat both the student and their parents, so that we can be able to enhance them to maintain recovery and sustain a change in their behavior.

And another instance, which you also found on page seven, is about disabilities. Now on the side of disabilities, of course we also were told, in the light of the statistics we found, supported by various schools that we visited, there's a substantial good number of students who are participating in the mental health-related issues that sometimes even their caretakers, their parents are both constrained in many ways. So another component with CT-Family Care Services will be providing is not only to provide those, who have disabilities, but those, who provide integrative treatment in the mental health and social services, along with treating their families or their caretakers, so they know how to address the issues that they have been weighing with stress to the point that you become so stressed out that the entire family or the caretaker breaks down, and things exacerbates to another level.

And, also, when you come down to the side of the children -- but when you come to the side of their desk, you see, also, on the same page, page number seven, there's a substantial amount of adapts -- or mental health issues.

Now in the Town of Manchester, for example, there's a population of about 58. About half of

those ones do have mental health symptoms in the light of Center for Disease Control statistics.

Then, when we take the half that we have treated, they are receiving treatment, that means half of this population they still have needs which are not yet met.

And, also, when we went to the Department of Public Health, the office in Manchester, one of the things which I made a petition here I think on the next page, we were told that, in Manchester for example, there are more people, more families with major mental health issues, because some during the financial crisis they lost their jobs. And when they lost their jobs, they lost their insurance.

And, at the same time State Insurance is perhaps is a bit higher. They don't qualify for state insurance, so some of them are caught between. They don't know what to do, and, so, they're hoping more -- they need mental health treatment, but they don't know how to do.

So on the side of the CT-Family Care Service that will be receiving those that have insurances, but, also, CT-Family Care Service, through grants, that we're going to be able to provide treatments

and even have special arrangement for pay.

At the same time, we have people, who don't have insurance, and they can't afford, so CT-Family Care Services we have to take some of the proceeds in providing services to assist those, who are unable to pay for their services, but, certainly, they need mental health and the other social services urgently.

So, then, when we go to the third question -- when we go to the -- somewhat to highlight it -- in terms of, if you go to page number nine, I tried, also, to present some of as a consensus the summary in the light of the statistics and the number we have how many students we are going to be serving in the first year, second year, third year or the fiscal year. So that's why that's 2013, 2014, 2015.

Someone tried to target to highlight those areas that we are targeting and whole number of the people we are expecting to reach, so you can see that there's a substantial amount of people that their needs are not getting met.

Now if we go to number three, which talks about the levels of treatment, that one we ask you that we go to page number I think it should be page number 12.

On page number 12 there, I tried to

briefly highlight type of the services that CT-Family Care Services will be providing, namely, an outpatient psychiatric mental health services for children, youth and families, but also be providing an outpatient psychiatric mental health services for the adults, which means individuals, seniors, Veterans, groups and families.

And I would like here to highlight some fact that we do have a special dedication to serving the Veterans. As a matter of fact, I did my research for my thesis at the (indiscernible) at Walter Reed on trauma and how to enhance the coping skills of traumatized Veterans and individuals, because when one member of the family is traumatized, that trauma affects not only one individual, but it does affect other members.

And, so, an integrated strategy treatment, which is informed by the research, that's why research is very important, is essential to provide and support our Veterans in a very special way, as well as their children and their families, so that we can be able to assist them to adjust to the non-deployment environment, at the same time to be able to assist them to sustain recovery in a very meaningful way.

And, then, the final question -- actually,

also, within the third question, of course there was an issue raised about the types of licenses requested. Now, here, I tried to put together all the services that we are providing, so please advise me, in case I didn't articulate them specifically in terms of the license that you provide, but you can be able to guide us.

In terms of the types of licenses requested, one is outpatient psychiatric mental health, which this is on page number 12, so you can be able to see them, because I enumerated them, which would cover the home therapy, home care, social services, research and substance abuse services for youth, adults, groups and families.

I do hope that you have the time to look at this part, which is where I identified, even in my previous presentation, about the number of substance abuse among youth within those selected areas. It is one of the major issues that needs to be addressed.

And, also, there is a good number of substance abuse among the adults. Also, the license that we are looking outpatient psychiatric integrated mental health clinic, social services, home therapy, home care, substance abuse services and research.

Now the question can be raised, then, why

do we have to say home therapy to let people come to the clinic? Why do we have to do home therapy? Now we have to be in the light of research in the reality.

We do understand that there are some patients, seniors, Veterans, who may not be able to afford to come to the clinic, because of various reasons, lack of transportation. Even the Veterans, perhaps they lost part of their body, so they need us to reach out to them to do home therapy.

At the same time, when they have home therapy, especially Veterans and the seniors, they need someone to assist them, in terms of home care, that they can be able to lead a dignified and a healthy life as they are receiving treatment, and that's why home care and home therapy are very essential in assisting and enabling particularly the Veterans and the seniors, who cannot be able to come to the clinic to receive the services.

Also, I put the research. Now, traditionally, researchers in the mental health often is not done, especially in the mental health, because most of the conditions are (indiscernible), but traditionally I hope they're not.

However, there is a tremendous need of

using research to inform clinicians, so that they can be able to use better ways, in terms of treatment, and be more outcome-based, rather than sometimes having people can come to the treatment, five years, ten years going to therapy, nothing is happening, particularly when it happens to the unprivileged population. Sometimes, unfortunately, they lose hope.

They can with stress five years going to the same therapist -- the same way over and over. Perhaps I cannot recover, but with this approach that we are presenting, we have a three-month review, where we have to review ourselves for three months, where the treatment provided by the team, we work together, psychiatrist, modern family therapists and social workers, professional counselors, so the therapist, on one condition, is not only cutting the (indiscernible) and then every three months we sit together and evaluate where are you?

But, also, we have to be sure to make a good assessment and to be able to identify the needs and the goals, and you want the patient to be a part of the treatment. And once you identify their needs and their goals and you motivate them to participate, then, within a short time, three months, six months, one year, we can

be able to assess where we are.

If it exceeds one year to two years, we need a special reassessment why, and if we cannot within that short time, then we need to be honest and say perhaps we are not helpful here. Can we work with you to find a place where we can refer you, rather than keeping you sometimes, when our services do not necessarily assist you to recover?

So we have to promote these people being evidence-based, but, also, to promote research, so that research is looked at at Yale, UConn, and by the time it comes to be implemented, it is outdated.

And, also, particularly, there is a special need of focusing on underprivileged and minorities, so that we can provide integrated treatment that do have a social, cultural, educational, economical components, because those are the issues that affect them, and they're addressing the treatment. Treatments may not always bring outcome results in sustaining recovery.

So, finally, we got question number four, which is about the financial capability, provided services while we are waiting for the insurance. I think, in regard to that, I did provide the letter from

the bank, which is the next page, from the bank People's United Bank, which confirms that they have the account there, but, also, a line of credit.

So that means, when we get the license from you, I know it takes about, from the Department of Social Services, which takes about three to four weeks. Let me say five weeks before, once we are licensed to start teaching.

During that time, we do have enough funds to be able to pay for the cost, and even if it would take two months, we still have enough funds to pay for the cost.

So I think that this life I know, slow down and thank you, and, please, you may have some questions to ask.

HEARING OFFICER HANSTED: We do have some questions. Thank you for your presentation. Very quickly, how much is the line of credit?

MR. RWEYEMAMU: As of now, it is 10,000, but I can be able to increase it as need arises.

HEARING OFFICER HANSTED: Okay. I just wanted to ask that before I forgot that question.

MS. GRECI: Laurie Greci, OHCA staff. Can you currently, I mean, can you describe those services

that you're currently providing in Massachusetts?

MR. RWEYEMAMU: In Massachusetts, we are not, as I speak right now, we already been licensed, but we are waiting for the finalization of the Mass. Medicare. We are waiting for Medicare number. When I leave here, I'll get the number.

We do have clients, but we haven't started official to provide services, but we have already secured some good arrangement with the Department in a special way with the Department of -- the Sheriff's Department. In Connecticut, we call them DOC. I think for them it's the Sheriff's Department in Springfield, whereby they have a huge amount of clients, who need the services that we are providing.

And, also, a good number of those clients happen to be underprivileged minorities, so the services we are providing are highly needed there.

MS. GRECI: Have you applied to the Connecticut Department of Children and Families for the outpatient psychiatric clinic for children?

MR. RWEYEMAMU: Yes. As a matter of fact, as I speak, probably this week, we should be, either this week or next week, we should be receiving our license, because everything is already in place.

MS. GRECI: At what point in the continuum of care do you believe your clients are going to enter into your care, I mean from like a referral from another provider, or physician?

MR. RWEYEMAMU: I think, for as clients enter into our care, once they have been referred and the call is made, once a referral is made, and then the staff members makes the call as a follow-up to make an arrangement, and that's why the assessment for it must be done quickly, as soon as possible, without keeping people waiting, so that some people have to wait one to three months before they seek admission or whatever.

We cannot be able to afford that, because we don't know their mental status, so we need to be sure, once they are referred to us, within 24 hours a clinician will be assigned, call them, assist them, make an arrangement, come to do the quick assessment, and then we are liable actually from the beginning, once the call is made.

HEARING OFFICER HANSTED: And what would be some examples of your referral sources?

MR. RWEYEMAMU: Now for Manchester area, the referral sources have been having some good connection in schools, some churches, some mental health

agencies, because even some say, well, thank you for coming here, because we are overwhelmed, and those are because of the strategic approach that we are presenting.

HEARING OFFICER HANSTED: Okay, thank you.

MR. RWEYEMAMU: You're welcome.

MS. GRECI: Who is making the diagnoses for the clients that you're going to be treating?

MR. RWEYEMAMU: Well we have two separate diagnoses. Actually, one would be done by licensed marriage and family therapist or licensed social workers, another one is also done by the psychiatrist, the medical side, and then those puts together, and that's why we are working as a team.

Once the first assessment is done, the psychiatrist will do the second assessment to be sure that the medical side, the psychiatric side is taken care of, and, then, working as a team, we craft an appropriate customized treatment plan, which includes the patient being a part of the process in formulating, which is achievable and sustainable.

And even we do have the plan that, when the discharge is about to be done, we don't discharge them, oh, you are fine, you are cured, go in peace. No, no. Research has shown sometimes people need support.

We all do in life. So before discharge is done, we work with the client, and then to identify some important people, particularly in the light of research.

For example, for African Americas or for black people, when they have issues they have a tendency -- actually this was done at UConn -- a tendency to go -- for black people when they have issues in their relationship or their families, they will go to their Pastor. While for the non black people, when they have issues, they tend to go to their counselors, so those are the very important things.

Before they are discharged, because we are working with the minorities, the African-Americans, we need to be sure we talk to them. Who are the most important people in your family that supports you? We identify them. We prepare them. They become a part of preparation in an effective discharge, which will enable the individual to maintain their recovery and then to be able to move on.

MS. GRECI: As far as the licenses go, on page 223, you indicated that you're seeking a psychiatric outpatient clinic for adults licensed.

MR. RWEYEMAMU: Yes.

MS. GRECI: But you didn't check the

license for the facility care and treatment, substance abuse and --

MR. RWEYEMAMU: Okay. Just one minute, please. Kindly, would you repeat?

MS. GRECI: You only checked the one license. You didn't check the two.

MR. RWEYEMAMU: Oh, okay. Okay. That was a mistake on my part.

MS. GRECI: Okay.

HEARING OFFICER HANSTED: So they should both be checked?

MR. RWEYEMAMU: Yes, please.

HEARING OFFICER HANSTED: Okay.

MS. GRECI: Bear with me for a moment, please.

MR. RWEYEMAMU: Sure.

MS. GRECI: You speak about integrated therapy.

MR. RWEYEMAMU: Yes.

MS. GRECI: Are you referring to like the mental health counseling, as well as the social services? I mean is that what you're referring to as therapy? I'm not really understanding that.

MR. RWEYEMAMU: Okay. The integrated

treatment includes the essential constructive path that is guided by professional with skills of identifying the needs of their clients, their goals, and the ways to enable them, achieve them in sustained recovery. So the integrated treatment includes, but not limited to, individual therapy, family therapy, even sometimes group therapy. It depends. Even the couple or children.

No one, no human being lives an island. We have to find a way of including those who are vital, at the same time helping them to identify what is it that keeps them, from time-to-time, repeating this behavior or having the situation, the constraint that they do.

MS. GRECI: Okay. I have another question. On page 219, at the bottom of the table, it states that the table reports number of persons with unmet needs to be serviced for six months. Are these numbers only six-month numbers?

MR. RWEYEMAMU: No.

MS. GRECI: I'm a little confused.

MR. RWEYEMAMU: Thank you for identifying that. That was a mistake there. That was a typo mistake. This number that's presented here is responding to the question that I had in terms of three years. If you go before then, should be -- yes, that's the

continuation from page 217, so if you go to 217, where we have the headings, you will see that fiscal year 2014, 2015.

MS. GRECI: That was actually reporting persons in sessions for a full year?

MR. RWEYEMAMU: Yes.

MS. GRECI: But they might only need -- be in treatment for six months?

MR. RWEYEMAMU: Yes. Yes. Our role is not to keep people, and I'm a strong believer, because with the lack of experience sometimes you'll find people go to the same treatment for so long time, and they need -- there's so many people, especially the minorities or the underserved population, the mental health, that we need to find a way that what is it that our treatment -- they are there for so long time.

We need to find a way is there any alternative that we can provide them what they need, in terms of treatment, and help them sustain it and help them to move forward. That's why three months, six months, three months, then we must assess ourselves.

MS. GRECI: On page 220 in the table, you refer to psychiatric medications. Who is actually going to be prescribing that and following the patients on

that?

MR. RWEYEMAMU: We do have Dr. John Haney. John, J-O-H-N. The last name is H-A-N-E-Y. He's a licensed psychiatrist, and I think he's also the Director of Psychiatry at UConn, with quite extensive experience in mental health for many, many years.

He will also be assisted with licensed APRNs, and he's also a strong believer of approaching this issue of provide treatment, but, also, provide medication, when needed, or refill, but, also, with the group therapy and support.

MS. GRECI: Okay. On the volumes that you're reporting, especially in the sessions, are you including social work with that?

MR. RWEYEMAMU: Yes, because the role that we have has to do in terms of when all things are put together. That's why sometimes the number may be more, because, also, I think on that side I was trying to answer to the equation at the time -- how the equation was formulated. But it would be how they provided individual therapy, and sometimes the same person coming for therapy. We may have individual therapy. We also have family therapy, and we'll also be receiving some social services, otherwise, if we provide them only one

component.

HEARING OFFICER HANSTED: So are there individuals, who may possibly only be receiving the social services, rather than the mental health services?

MR. RWEYEMAMU: No. All who are coming here, all these things are tied together. In other words, you are coming there, okay. I have, let us say depression, what is happening? We assess what is happening with the depression. But, also, perhaps, you don't have food, so we need to find a way how to refer you to the soup kitchen, or how to refer you to the social services that you need, or sometimes people come, they need -- when people come to see a clinician, we naturally come the best way, but you should go to their homes.

You see what goes on there -- whatever situation, so we -- because when you have good environment even within the family, it comes down to situation. It help people to change the dynamics.

HEARING OFFICER HANSTED: Okay and just to clarify, the reason why I ask this question is because OHCA doesn't get involved in the social services side, so I want to clarify for the record that the figures you presented are actually clients that would be receiving

mental health services. That is accurate?

MR. RWEYEMAMU: Yes, that is accurate.

HEARING OFFICER HANSTED: Okay, thank you.

MS. GRECI: When you begin or when you propose to begin services, how many personnel would you require to provide the services that you're outlining for the first year?

MR. RWEYEMAMU: Actually, as of now, in terms of personnel, we have about six, seven people, and we are waiting. We have also included, I think, if you go back here, I put the list of some of the clinicians. Before I didn't know all this, so they are waiting, so we have about 20, 25, 35 that would be working as part-time for services, but we have a good number of people coming in by the time need them, because we don't want to keep people waiting.

In other words, we don't want them to wait for a long time, or they, today, they meet this clinician. Tomorrow, sorry, Justin is not here, they meet -- breaking the trust.

MS. GRECI: You indicate in part of the application that you were applying for a small business loan. Did you follow through with that?

MR. RWEYEMAMU: Yes, I did. I applied for

a small business loan, yes. For the record, I was told to wait.

MS. GRECI: Okay.

MR. RWEYEMAMU: I never heard from them what happened. We were told that was a special, I think that was special offer by the Governor to support small businesses, and, so, many people have many small businesses, so I don't know.

MS. GRECI: Okay, thank you.

MR. RWEYEMAMU: You're welcome.

HEARING OFFICER HANSTED: So that was you applied for that through the state?

MR. RWEYEMAMU: Yes. I think it was the Department of -- Development, small businesses can apply, but a special kind of discount and so on, so many people applied.

HEARING OFFICER HANSTED: Okay and is that the $84,000 loan?

MR. RWEYEMAMU: No, no, no, no.

HEARING OFFICER HANSTED: That's different?

MR. RWEYEMAMU: That's different.

HEARING OFFICER HANSTED: Do you know when you expect to hear back from the community development

loan?

MR. RWEYEMAMU: I don't know, but, as of now, as I stand, I may not need that loan.

HEARING OFFICER HANSTED: Okay.

MR. RWEYEMAMU: Because once we get the license and we have the line of credit, then we have enough money to be able to come in to start with, and then the reimbursement starts and then we can be able to proceed.

Now when it assess that you right, that will be a different case, but, right now may not be necessary.

HEARING OFFICER HANSTED: Okay and you had mentioned earlier that you will be applying for grants, so that you can serve the uninsured. Have you applied for those grants yet?

MR. RWEYEMAMU: Not yet, because in order for me to get grants, I have to be sanctified, so I'm waiting for you. Once you clear us -- then we can be able to, and, also, for the record, since we are the first minority sanctified mental health clinic, we can also apply for the state, but, also, we can apply for the federal grant, and this grant will be specifically targeting providing mental health where insurance may not

be able insurances may not be able to cover.

HEARING OFFICER HANSTED: Okay, thank you.

MR. RWEYEMAMU: You're welcome.

MS. GRECI: You provided a payer mix on page 196. I know that was part of the original application. Could you just review that for us? Are there any changes, or is this pretty much the volumes by payer mix that you are proposing?

I'm only a little concerned that the uninsured is only four percent, when you're emphasizing that "fall through the cracks" population.

MR. RWEYEMAMU: Yes. I have to be realistic, because the number here may seem small, but I didn't want to put higher number which I could not help. Indicate the few that I'm going to be able to support, and the number may increase.

As I said, we are going to serve the uninsured -- twenty percent -- and then we don't have funds. So then if, when we get funds, which may come from the proceeds, the company this is LLC where we will be making profit, as well as the funds we get from the grant, then the number next time you can come to do assessment while we have six, seven person. Perhaps the number increase. So that's why I put very minimum.

HEARING OFFICER HANSTED: All right, so, the number is conservative on your part?

MR. RWEYEMAMU: Yes, exactly. Thank you.

HEARING OFFICER HANSTED: Okay, nothing else? Okay. Kaila, do you have anything?

MS. KAILA RIGGOTT: No.

HEARING OFFICER HANSTED: I want to clarify just one or two things. In reading the application and hearing your presentation today, it seems to me that you want to serve a very broad population, Veterans, children, there's mention of incarcerated individuals, which is wonderful.

My question is do you intend on starting this with a more limited population, or do you want to reach out to everyone at the same time?

MR. RWEYEMAMU: Thank you for the question. When we start, we better start slow, like a seed, and grow by the grace of God to come and be a tree, so we are going to start with a small number, and that's why we see in projections the first year start small, the second year the number increasing, the third year is increasing, so it will be gradual. There will be a gradual progress.

HEARING OFFICER HANSTED: Right. No, I

understand that. I guess my question more is will you start with the children, or the Veterans, or the incarcerated individuals, or will you tap into each one of those populations?

MR. RWEYEMAMU: I will tap those populations as you are referring to. For example, parents have asked to be referred to me, but, at the same time, they may say from their views we are struggling with this son. We can't understand your son, so that can move the tide already, or a student going back to school. So even if we are one to one person to one the child if you involve the parent.

Either way -- it may end up including some family, so we will start in the light of day -- follow many -- and the people walk in -- but at the same time we would try to be sure we don't take so many at once that we cannot be effective, because once you lose confidence, once people lose trust, you lose them. They don't come back.

HEARING OFFICER HANSTED: Okay, thank you.

MR. RWEYEMAMU: You're welcome.

HEARING OFFICER HANSTED: One of the things that OHCA focuses on is the actual need for a program, such as this, well any CON that comes before us

we need to focus on, on need, and in the mental health arena, it's difficult, both on our side and I presume on your side, to gather information to document a true need, and the statistical evidence is certainly out there, and you provided that, and I appreciate that.

One of the things that I ask for for a CON application like this and I've done it in the past is letters from referral sources, evidencing that this need exists, and, for instance, in your situation in the Manchester area, and you had mentioned earlier in your presentation that you were talking to schools and town officials.

Would you be able to provide me letters from some of these sources, stating that there is a need for this specific population for the specific service that you would like to provide?

MR. RWEYEMAMU: Okay, I will try.

HEARING OFFICER HANSTED: Okay.

MR. RWEYEMAMU: Now that also would depend on the -- let me put it this way. I will try to go back again to those schools that we passed and see if they can be able to provide that.

Now I don't know. In some schools, we met with social workers. In some schools, met with some

principals. In some schools, we met with some mental health counselors most of the time, so I don't know whether some will feel comfortable to do, in terms of to be more spontaneous providing the letter, because they may think, okay, these are the facts we shared with you, but I'm not in the position, I don't have the authority to do so, so you have to go the principal.

The principal may say let me go to the Board. I will do my best, and may God help me.

HEARING OFFICER HANSTED: That's certainly understandable, and I thought about that, as well. And, certainly, don't feel like you need limit it to just the schools. Any of the referral sources that you plan on using, reach out to them and ask them if they could provide letters to us.

I'll order that as Late File No. 1. How long do you think you need? I've been generally giving folks 30 days to provide those letters. Certainly, if you need more time, I'm happy to give that to you.

COURT REPORTER: One moment, please.

MR. RWEYEMAMU: I have to be honest. From my point of view, obtaining those letters as soon as I can is very vital, so that you can be able to make a final well-informed decision, in terms of you assessing

whether we get the license or not, whether we become licensed and so on. So when we leave here, within next week, we will be able to reach out to various schools.

Now in terms of how that is going to take from their point of view, I don't know, because the reason I'm saying that I remember last time you asked me the statistics and so on -- town officials, Department of Public Health in Manchester took us time.

That was the reason why, when I submitted the application, we'd wait for about three weeks, we were late, because to gather the information, even though you are the asking people, it was not always easy.

The situation that I have (indiscernible) if this is made as a prerequisite for our licensing, then I don't know when we can get those letters to your satisfaction. or if you would suggest that those letters are required, you can still in the light of all this information you have, you say, perhaps, we cannot give you a license, but at least provide those letters. I will work hard to provide them, if we are not constrained with things beyond our control.

HEARING OFFICER HANSTED: Well what I'm looking for and as part of the application, we view that as evidence to base our decision upon, and, certainly,

letters, such as I'm suggesting you submit, are stronger evidence and will help us make our decision in a more well-informed manner.

And keep in mind, when I'm saying 30 days, I'm not holding you to that number. If it takes folks longer to get back to you, just let us know, and we're okay with that.

If you have those letters to us within a week, that's wonderful. I'll close the hearing after I have those letters after a week. That shouldn't impact how you go about getting the letters.

MR. RWEYEMAMU: Thank you.

HEARING OFFICER HANSTED: Okay, so, for our purposes today, I'll order that as Late File No. 1, those letters.

MR. RWEYEMAMU: Okay.

HEARING OFFICER HANSTED: And just so we have a time frame on it, it will be 30 days. As I said, if you need more time, contact us, and I'd be happy to give you more time to get those letters in.

MR. RWEYEMAMU: Thank you.

HEARING OFFICER HANSTED: You're welcome. And those are all the questions I had. One more thing I need to ask, just for the record, is if there are any

folks in the room that would like to give a public statement on this application, and I do not see any members of the public in the room, so let the record reflect that there are none.

I just want to go off the record for a moment.

(Off the record)

HEARING OFFICER HANSTED: Okay, one more thing I want from you, and I'll order this as Late File No. 2. On page 221, actually, I think it starts on page 219, 220, but on page 221, you have a column or row, which gives the total clients to be served by CT-Family Services.

I'd like you to provide us with a breakdown by service and age group of those, the total numbers you've given.

MR. RWEYEMAMU: On page 221?

HEARING OFFICER HANSTED: Correct.

MR. RWEYEMAMU: This is the -- okay.

HEARING OFFICER HANSTED: So, for instance, in the first column, you have 15,422. What I'm looking for is a breakdown of that number by service and age group.

MR. RWEYEMAMU: Page 221?

HEARING OFFICER HANSTED: Yes. Page 221 of the application.

MR. RWEYEMAMU: I have 221 says current population in Manchester area.

HEARING OFFICER HANSTED: We'll go off the record.

(Off the record)

MR. RWEYEMAMU: For the record, what you're asking me that you'd like me to breakdown this number population, in terms of gender, so in terms of age, children from this time to this time, for the youth from this age to this age, adults from this age to this age?

HEARING OFFICER HANSTED: Correct. And, also, by the service being provided.

MR. RWEYEMAMU: Okay.

HEARING OFFICER HANSTED: And that will be Late File No. 2.

MR. RWEYEMAMU: Now may I ask, sir?

HEARING OFFICER HANSTED: Sure.

MR. RWEYEMAMU: As regard to by the service being provided, on the same chart, which if you go to the previous page, from pages 218, 218 or even 217, it was identifying the number that says. In 217, it says

academic disabilities and academic performances, so the services provided they are already -- I enumerated them, the services provided. What is lacking here is the age. Is that correct?

HEARING OFFICER HANSTED: That's correct. I just want to make sure we have the information we need, as far as the services being provided.

MR. RWEYEMAMU: Okay.

HEARING OFFICER HANSTED: Let's go off the record again. Sorry.

(Off the record)

HEARING OFFICER HANSTED: Thank you. What we're trying to do is get a breakout of -- again, like I said before, we don't deal with the social services aspect of what you're proposing.

What we're looking for is a breakdown of the adult age groups specifically for the mental health services that you'd like to provide.

MR. RWEYEMAMU: Okay.

HEARING OFFICER HANSTED: So and by looking at the application, it appears that you have everything lumped together, social services and mental health, etcetera, and I understand that your program is a totality of services, but, just for the record, I would

like to have it broken down specifically for the mental health services by age group.

MR. RWEYEMAMU: Okay. May I make some clarification?

HEARING OFFICER HANSTED: Sure.

MR. RWEYEMAMU: The clarification that even though we are providing social services, or we are going to have (indiscernible), all patients, who are referred to us, do receive or will receive mental services, so the number that you have here mental services is included. It is the central theme in that chart -- in those statistics -- whatever the chart has put in there. And even the session in line with the mental services.

One question was how many sessions we're going to have, so I think, if I'm understanding the question correctly, what you're asking me some of what you need is already provided, except one thing, which is to go back and breakdown this number, in terms of age.

If I'm going to provide mental health to the adults, what type of age? Youth, whatever, younger, whatever, and then, for the children, what's the age do we start with? Are we providing mental services to the babies? So the idea is to break them down.

HEARING OFFICER HANSTED: Right. If that's accurate, that you're going to provide mental health services to this total number that you presented to us, then, yes, you're accurate, that we're looking for an age breakdown.

MR. RWEYEMAMU: Okay.

HEARING OFFICER HANSTED: Okay? And that will be Late File No. 2. Again, I'll make that due the same 30-day time period. If you get it into us sooner, that's great.

And just a bit of housekeeping. We now have a copy of three pages from your notebook, which are pages 217, 218 and 219, and I'm going to make those Exhibit -- what are on? Okay. This will be OHCA Exhibit K.

MR. RWEYEMAMU: And this is the number that you are looking for the breakdown?

HEARING OFFICER HANSTED: The breakdown that I spoke of, that is Late File No. 2. The pages that we had copied from your notebook, which appear not to correspond with our page numbers, that I'm making Exhibit K, so two separate things.

You don't have to do anything, as far as the Exhibit K. That's just for our clarification

purposes.

MR. RWEYEMAMU: Okay. Thank you.

HEARING OFFICER HANSTED: You're welcome. With that, I think we have all of our housekeeping matters cleaned up here, and, with that, I will adjourn this hearing. Thank you, both, for coming.

MR. RWEYEMAMU: You're welcome.

(Whereupon, the hearing adjourned at 10:03 a.m.)

HEARING RE: CT-FAMILY CARE SERVICES, LLC
JUNE 26, 2013

AGENDA

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 2nd day of July, 2013.

Paul Landman
President

Post Reporting Service
1-800-262-4102

PUBLIC HEARING
APPLICANT
SIGN UP SHEET

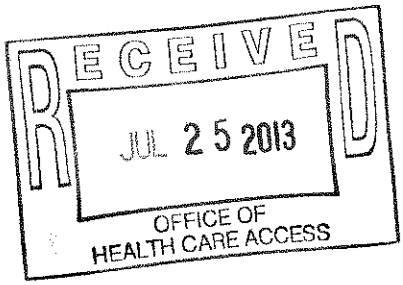
June 26, 2013
9:00 a.m.

Docket Number: 13-31837-CON
CT-Family Care Services, LLC
Establishment of a Behavioral Health Treatment Center in Manchester

PRINT NAME	Phone	Fax	Representing Organization
SHERILYN BARAO	860-668-7761		CT-Family Care Services, LLC
Justinien Nwayemamu	860-432-8562	860-432-8645	CT-Family Care Serv. LLC

Greer, Leslie

From: justinr@ctfcs.necoxmail.com
Sent: Wednesday, July 24, 2013 7:07 PM
To: Riggott, Kaila; srz@zlokowermiller.com; Greer, Leslie; Hansted, Kevin; Martone, Kim; srz@zlokowermiller.com; justinr@ctfcs.necoxmail.com
Subject: Letters of support and Population breakdown



Hi Laurie
Attached herewitth are the documents that you requested.
Thank you. Justin

Justinian Rweyemamu, MA, M.Div, MS-MFT, PhD Students President CT-Family Care Services, LLC
243 Main St, Unit # 4 Manchester,CT. 06042
Tel: 860-432-8862,
Cell: 860-508-8651

155 Maple St, Unit # 204
Springfield, MA. 01105
Tel: 413-285-8722
Cell: 860-508-8651
rweye@cox.net
justinr@ctfcs.necoxmail.com

-------- Begin forwarded message --------
Subject: Fwd: RE: Hearing Notice for 13-31837-answers attached-powerpoint.--CT-Family Care Care-LLC-6-26-013
Date: 6/26/13 1:14:36 PM
From: rweye@cox.net
To: justinr@ctfcs.necoxmail.com

> From: "Sandra Zlokower" <srz@zlokowermiller.com>
> To: <rweye@cox.net>
> Subject: RE: Hearing Notice for 13-31837-answers
> attached-powerpoint.--CT-Family Care Care-LLC-6-26-013
> Date: Tue, 25 Jun 2013 23:36:13 -0400
>
> Justin,
>
> Good luck tomorrow at the hearing. I was hoping to be able to attend
> for a while but unfortunately I have a number of conflicting
> obligations and cannot make it. The power point your prepared is

> impressive as is the effort you have made to date, so I am sure you
> will do well.
> I look forward to being available to assist you in the future.
> Best wishes,
>
> Sandra
>
> Sandra R. Zlokower
> Zlokower & Miller, LLP
> Attorneys at Law
> 901 Farmington Avenue *NEW MAILING ADDRESS AS OF MAY 1, 2013*
> West Hartford, CT 06119
> Voice/Fax: (860) 523-8381
> www.zlokowermiller.com
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> distribution or copying of this communication is strictly prohibited.
> If you have received this message in error, please immediately notify
> us by telephone and destroy the original message.
>
>
>
>
> -----Original Message-----
> From: rweye@cox.net [mailto:rweye@cox.net] Sent: Monday, June 24, 2013
> 9:13 PM
> To: Greci, Laurie
> Cc: Kaila.Riggott@ct.gov; srz@zlokowermiller.com; Leslie.Greer@ct.gov;
> Kevin.Hansted@ct.gov; Kimberly.Martone@ct.gov; srz@zlokowermiller.com;
> justinr@ctfcs.necoxmail.com
> Subject: Re: Hearing Notice for 13-31837-answers
> attached-powerpoint.--CT-Family Care Care-LLC-6-26-013
>
> Hi Laurie Attached herewith is the document answering all 4 questions
> about the public needs in Manchester area as requested. I will use
> this power-point for the presentation on wednesday, June 26,2013 at 9
> am as scheduled in Hartford. I look forward to seeing you all. I will
> email you the letter from the bank confirming that the agency has a
> line of credit. Thus, it has the ability to cover the operating
> costs before insurance reimbursements start . Thanks. Justin
>
> Justinian Rweyemamu, MA, M.Div, MS-MFT, PhD Students President
> CT-Family Care Services, LLC
> 243 Main St, Unit # 4 Manchester,CT. 06042
> Tel: 860-432-8862,
> Cell: 860-508-8651
> rweye@cox.net
> 155 Maple St, Unit # 204
> Springfield, MA. 01105

> Tel: 413-285-8722
> Cell: 860-508-8651
> rweye@cox.net
>
>
>
>
>
> ---- "Greci wrote:
>>
>> Dear Mr. Rweyemamu,
>>
>> Attached you will find a letter to you that announces the hearing
>> date and another letter requesting publication in the local
>> newspaper.
>>
>> If you have any questions, please call me.
>>
>> Regards,
>>
>> Laurie K. Greci
>>
>> Associate Research Analyst
>> Department of Public Health
>> Health Care Access
>> * laurie.greci@ct.gov<mailto:laurie.greci@ct.gov>
>> ' 860 418-7032
>> 7 860 418-7053
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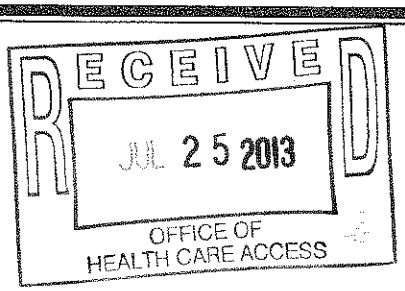
CT-FAMILY CARE SERVICES, LLC

"In Collaboration with clients we enhance their wellness through internal and external solutions."



July 24, 2013

Laurie K. Greci
Associate Research Analyst
Department of Public Health
Health Care Access
laurie.greci@ct.gov

Dear Laurie Greci

13-31837-CON

RE: Certificate of Need Application; Docket Number: ~~12-31773-CON~~.

First, I am pleased to inform you that CT-Family Care Services, LLC has obtained its license (attached) from the Department of Children and Families (DCF). Second, I am pleased to present to you the followings:

1. Letters of support

2. The breakdown according to age/years for our potential clients

For the adult's population, the current number (attached) is lower than that was presented before because I estimated that about 25% of the adult population needed social services only without psychiatric medication or therapeutic treatments. Thus, I deducted the 25% from the previous total number of 70, 994.

I look forward to hearing from you as well as anticipated receipt of obtaining the licenses from your department.

Justinian Rweyemamu, MA, M.Div, MS-MFT, PhD student

President

16 Enfield Ave.
Enfield, CT 06082

243 Main Street
Manchester, CT 06042

155 Maple St, Unit 204
Springfield, MA 01105

rweye@cox.net (860) 508-8651

DEPARTMENT of CHILDREN and FAMILIES
Making a Difference for Children, Families and Communities

Joette Katz
Commissioner

Dannel P. Malloy
Governor

July 11, 2013

Mr. Justinian Rweyemamu, President
CT Family Care Services, LLC
243 Main Street
Manchester, CT 06042

Re: OPCC License,

Dear Mr. Rweyemamu,

The Department hereby issues the enclosed license to your agency to operate an Outpatient Psychiatric Clinic for Children effective July 12, 2013. This license will remain in effect for a period of time not to exceed twenty-four months.

We want to thank you for your cooperation during the licensing process. Should you have any questions regarding this license please do not hesitate to contact Regulatory Consultant, Terri Bohara, at 860-550-6395, or the undersigned at 860-550-6532.

Sincerely,

Jim McPherson, Program Manager
DCF Licensing Unit
Office of Legal Affairs

STATE OF CONNECTICUT
DEPARTMENT OF CHILDREN AND FAMILIES

This is to certify, that, in accordance with the provisions of Section 17a-20 of the Connecticut General Statutes, as amended, CT FAMILY CARE SERVICES, LLC located at 243 MAIN STREET in the Town of MANCHESTER is hereby licensed as an OUTPATIENT PSYCHIATRIC CLINIC FOR CHILDREN to provide OUTPATIENT PSYCHIATRIC CLINIC SERVICES to children at the locations listed below *.

This license is issued effective JULY 12, 2013 for a period of TWENTY FOUR MONTHS and is conditional upon compliance with all regulations of the Department of Children and Families and may be revoked for cause at any time.

License No. OPCC-70
Signed and dated this 11th day of July, 2013 at Hartford, CT.

James MePherson, Program Manager
Office of Legal Affairs

* 243 Main Street, Manchester, CT

Town of Manchester

41 Center Street • P.O. Box 191
Manchester, Connecticut 06045-0191
www.manchesterct.gov

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July 2, 2013

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Sincerely,

Mary Roche Cronin

Mary Roche Cronin, Director
Manchester Human Services Department

Cc: Ed Paquette, Case Management Supervisor
File

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July 12, 2013

To whom it may concern:

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Thank you for your assistance to the CT-Family Care Services, LLC and its leadership to the Greater Hartford, specifically the Manchester area. I can be reached at (860) 243-8734 if you have further questions.

Sincerely,

Carolyn Brooks-Burton, BS

STATE OF CONNECTICUT

DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES
A Healthcare Service Agency

DANNEL P. MALLOY
GOVERNOR

PATRICA A. REHMER, MSN.
COMMISSIONER

July 17, 2013
State of Connecticut
Dept. of Mental Health & Addiction Services
410 Capitol Ave, P.O. Box 341431
Hartford, CT 06134

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Neiima R. Edwards

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www.dmhas.state.ct.us

STATE OF CONNECTICUT – COUNTY OF TOLLAND
INCORPORATED 1786

TOWN OF ELLINGTON

Human Services Department

DORIS R. CRAYTON
Director

31 ARBOR WAY – P.O. BOX 187
ELLINGTON, CONNECTICUT 06029-0187
www.ellington-ct.gov

Tel: 860-870-3128
Fax: 860-870-3198
dcrayton@ellington-ct.gov

July 12, 2013

CT Family Care Services, LLC.
243 Main Street, Unit # 4
Manchester, CT 06042

To Whom It May Concern:

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We will be glad to cooperate with them and make appropriate referrals. We look forward to creating a business relationship with CT Family Care Services, LLC.

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Doris R. Crayton

Doris R. Crayton
Director

Ramon A. Nieto M.D.
153 Main Street
Manchester Ct 06040

7/5/13

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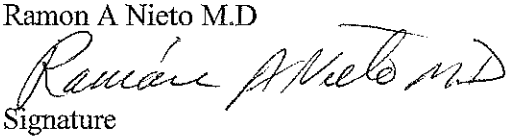

Signature

CT-Family Care Services, LLC: Exhibit # K

Number of students/Youth in service area with unmet needs

Population	Service Type	**FY 2013 Total Persons: 2,825**					**FY 2014, 25% increase Total Person: 3,767**					**FY 2015, 32% Increase Total Person: 5,540**				
		Age/years					Age/Years					Age/Years				
		3-5	**6-11**	**12-13**	**14-18**	**18 +**	**3-5**	**6-11**	**12-13**	**14-18**	**18 +**	**3-6**	**6-11**	**12-13**	**14-18**	**18 +**
Students/Youths	Academic difficulties /Disabilities	163	1168	445	976	73	218	1559	595	1303	92	321	1659	706	2230	624
School dropout prevention treatments		**Total persons: 654**					**Total Persons: 872**					**Total Person:1,282**				
				326	288	40			450	400	22			724	518	40
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		62	627	276	489	46	101	680	333	511	250	134	929	436	707	269
Adults below																

CT-Family Care Services, LLC: Exhibit # K

	FY 2013 **Total persons: 53,245**					**FY 2014** **Total persons: 61,231**					**FY2015, 32% increase** **Total persons: 70, 415**				
	Age/Years					**Age/Years**					**Age/Years**				
Adults	**19**	**20-24**	**25-44**	**45-64**	**65+**	**19**	**20-24**	**24-44**	**45-64**	**65+**	**19**	**20-24**	**25-44**	**45-64**	**65+**
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Individuals, couples, partners, families therapies	1829	1233	3320	1033	2524	2451	1706	4315	1456	3324	3635	2651	6094	2322	4786
Seniors:	**Total Persons:6,541**					**Total Persons: 9,106**					**Total Persons:13,934**				
Age		**65**	**70**	**75**	**80+**		**65**	**70**	**75**	**80+**		**65**	**70**	**75**	**80+**
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References

www.cdc.gov/omhd/AMH/factsheets/metal.h

Connecticut State Department of Education: Connecticut Education Center and Research (CEDAR). Retrieved from http://www. ct.gov/Cedar/WEB/ct_report/District and school snap shots

Department of Public health: Connecticut Community Health Center (CHC) Data. Retrieved from http://www.ct.gov./dph/cwp on patients by age.

USA Center for Diseases Control (CDC). Retrieved from www.cdc.gov/omhd/AMH/factsheets/mental Health

Meetings with Manchester Area Officials

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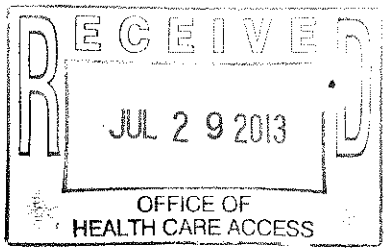

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Department of Public Health
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laurie.greci@ct.gov

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James McPherson, Program Manager
Office of Legal Affairs

* 243 Main Street, Manchester, CT

Town of Manchester

41 Center Street • P.O. Box 191
Manchester, Connecticut 06045-0191
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STATE OF CONNECTICUT – COUNTY OF TOLLAND
INCORPORATED 1786

TOWN OF ELLINGTON

Human Services Department

DORIS R. CRAYTON
Director

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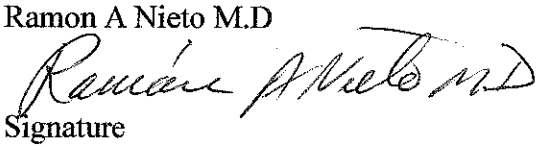

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www.cdc.gov/omhd/AMH/factsheets/metal.h

Connecticut State Department of Education: Connecticut Education Center and Research (CEDAR). Retrieved from http://www. ct.gov/Cedar/WEB/ct_report/District and school snap shots

Department of Public health: Connecticut Community Health Center (CHC) Data. Retrieved from http://www.ct.gov./dph/cwp on patients by age.

USA Center for Diseases Control (CDC). Retrieved from www.cdc.gov/omhd/AMH/factsheets/mental Health

Meetings with Manchester Area Officials

Greer, Leslie

From: rweye@cox.net
Sent: Wednesday, July 31, 2013 10:45 AM
To: Greci, Laurie
Cc: Greer, Leslie; Riggott, Kaila; Hansted, Kevin
Subject: Re: Late File 1 for 13-31837-CON

Thank you Laurie for your message and I will get back to you . Justin
---- "Greci wrote:
> Dear Mr. Rweyemamu,
> On July 29, 2013, the Office of Health Care Access received the referral letters requested as Late File 1 at the hearing held on June 26, 2013 for CT-Family Care Services Certificate of Need application under Docket 13-31837-CON.
>
> Neiima R. Edwards, an intern coordinator with the State of Connecticut Department of Mental Health and Addiction Services ("DMHAS"), wrote a letter using DMHAS letterhead. Her letter cannot be accepted as it is not an official DMHAS official letter. You may replace the letter with one that Ms. Edwards has written on personal or plain paper.
>
> If you have any questions concerning OHCA's request 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<mailto:laurie.greci@ct.gov>
> ' 860 418-7032
> 7 860 418-7053
>

Greer, Leslie

From: Martone, Kim
Sent: Wednesday, August 07, 2013 1:48 PM
To: Roberts, Karen
Cc: Greer, Leslie
Subject: FW: Norwalk Hospital Primary Antigoplasty Myocardial Infarction (PAMI) Program - Year 4 Annual Utilization Report
Attachments: NH PAMI Annual Utilization Letter.pdf; NH PAMI Volume - Year 4.pdf; 2012Q1_990294_151_CathPCIv4_Standard_rev8.pdf; 2012Q2_990294_151_CathPCIv4_Standard_rev9.pdf; 2012Q3_990294_151_CathPCIv4_Standard_rev10.pdf; 2012Q4_990294_151_CathPCIv4_Standard_rev11.pdf

Kimberly R. Martone
Director of Operations
Office of Health Care Access
860-418-7029
-----Original Message-----
From: Jeryl.Topalian@Norwalkhealth.org [mailto:Jeryl.Topalian@Norwalkhealth.org]
Sent: Wednesday, August 07, 2013 1:44 PM
To: Martone, Kim; Fiducia, Paolo
Cc: Edward.Staunton@Norwalkhealth.org; Kristen.Staikos@Norwalkhealth.org; Anne.Bartolone@Norwalkhealth.org
Subject: Norwalk Hospital Primary Antigoplasty Myocardial Infarction (PAMI) Program - Year 4 Annual Utilization Report

Dear Ms. Martone -
Attached please find the Year 4 annual utilization report and ACC-NCDR Institutional Outcome Reports, as stipulated in the Agreed Settlement for
DN: 08-31079-CON Establish and Operate a Primary Angioplasty Myocardial Infarction (PAMI) Program at Norwalk Hospital.

(See attached file: NH PAMI Annual Utilization Letter.pdf)(See attached file: NH PAMI Volume - Year 4.pdf)

(See attached file: 2012Q1_990294_151_CathPCIv4_Standard_rev8.pdf)(See attached file: 2012Q2_990294_151_CathPCIv4_Standard_rev9.pdf)(See attached file: 2012Q3_990294_151_CathPCIv4_Standard_rev10.pdf)(See attached file: 2012Q4_990294_151_CathPCIv4_Standard_rev11.pdf)

Please contact me directly if you have any questions.

Regards,
Jeryl

Jeryl Topalian
Executive Director
Planning & Business Development
Norwalk Hospital

203-852-2354 (office)
203-515-7036 (mobile)
jeryl.topalian@norwalkhealth.org

August 5, 2013

Nelima R. Edwards
54 Daniel St.
East Hartford, CT 06108

To whom it may concern,

I am pleased to recommend and support the CT-Family Care Services, LLC to provide mental health services in the Manchester area.

My experience is that there is a great need to provide mental health services for children, youth, adults and families in our area. The fact that CT-Family Care services has opened its office in Manchester and that it is dedicated to serving the under-represented population is commendable.

The agency focuses on serving underserved populations in the Manchester area in order to help them sustain their integrated recovery and wellness, in a way that may not be available among the already existing agencies in the area. It seems that there are many students, youth, adults, and families, who have needs for mental health services, but they have been on waiting lists for a long time before receiving mental health services needed or their mental health needs are unaddressed. As a result, I plan to refer people to Ct-Family Care Services, LLC for treatment. I strongly recommend their expertise, vision and service.

Thank you for your assistance to CT-Family Care Services, LLC and its leadership.

Nelima Edwards

Greer, Leslie

From: Greci, Laurie
Sent: Wednesday, August 07, 2013 12:56 PM
To: rweye@cox.net
Cc: Hansted, Kevin; Riggott, Kaila; Greer, Leslie
Subject: CON Application 13-31837-CON
Attachments: 31837 Closure of Hearing.pdf

Dear Mr. Rweyemamu,

Attached you will find a letter from OHCA closing the hearing that was held for concerning the above CON application.

If you have any questions please 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

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

August 7, 2013

VIA ELECTRONIC MAIL ONLY

Justinian Rweyemamu, MA, M.Div. MS-MFT
CT-Family Care Services, LLC
16 Enfield Ave.
Enfield, CT 06082

RE: Certificate of Need Application; Docket Number: 13-31837-CON
CT-Family Care Services, LLC
Establishment of a Behavioral Health Treatment Center in Manchester
Closure of Public Hearing

Dear Mr. Rweyemamu:

On July 29, 2013, and August 6, 2013, the Office of Health Care Access ("OHCA") received the information as part of late file submissions requested by OHCA at the public hearing held in this matter on June 26, 2013. With the receipt of the late file submissions, 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

Greer, Leslie

From: rweye@cox.net
Sent: Monday, August 12, 2013 2:59 PM
To: Greci, Laurie
Cc: Greer, Leslie; Riggott, Kaila; Hansted, Kevin
Subject: Re: CON Application 13-31837-CON

Laurie K. Greci
This is to inform you that after obtaining the license from DCF, we applied for Husky insurance. A Medicare number is needed in order to be enrolled into Husky insurance. Since we are serving the underserved population it is important that the agency become enrolled into Husky and Medicare insurances for the reimbursements. I received from the Department of Social Services (DSS) in Hartford for the Medicare. In order to complete the agency's enrollment a copy of the license from DPH is required.
I understand that a final decision in relation to our agency's application for CON will be made by your office soon. With respect, I am requesting if your ruling can be completed at your earliest convenience, in order for our agency to take that recommendation to the DPH-Licensing Unit and request for its licensing so that the agency may obtain its license from DPH and submit a copy to the DDS for the Medicare number and enrollment into Husky Insurance.
Thank you for your understanding.
Justin

---- "Greci wrote:
> Dear Mr. Rweyemamu,
>
> Attached you will find a letter from OHCA closing the hearing that was held for concerning the above CON application.
>
> If you have any questions please contact me.
>
> Regards,
>
> Laurie K. Greci
>
>
> Associate Research Analyst
> Department of Public Health
> Health Care Access
> * laurie.greci@ct.gov<mailto:laurie.greci@ct.gov>
> ' 860 418-7032
> 7 860 418-7053
>

Greer, Leslie

From: justinr@ctfcs.necoxmail.com
Sent: Tuesday, September 24, 2013 11:32 AM
To: Greci, Laurie
Cc: Hansted, Kevin; Riggott, Kaila; Greer, Leslie; Sandra Zlokower
Subject: RE: RE: CON Application 13-31837-CON

Good morning Laurie
The purpose of this communication is to do a follow-up for our CON certification as well as obtaining the license from DPH. The last correspondence from your office dated August 22, 2013 informed me that you were in the processing of reviewing the application and crafting a decision. But, it is over 30 days now since your office determined that our application was completed.
Currently, I am preparing for the RFP # 3325 application to be submitted to the Judicial Branch on Monday, September 2013(deadline) in order to provide therapeutic and psychiatric treatments to adolescents, adults, groups and families who are dealing with delinquencies, problematic behaviors and other mental health issues in the Rockville/Vernon Judicial Branch region which covers the areas that our agency is serving.
The RFP# 3325A is a part of the state arrangement for the 25% of its business to be allocated to the Minority owned and certified businesses.
CT-Family Care Services is the first minority owned and State certified and licensed small business as Mental Health Agency in Connecticut. As a result, it has higher probability of winning the grant.
Our agency need the license from DPH in order that it may provide service to the adults who have no children (not covered under DCF
license) and may be refereed to our agency because they need the integrated treatments that CT-Family Care Services, LLC provides. The grant will be awarded on October 30, 2013 and the Judicial Branch wants the service deliveries to start in November, 2013.
In the light of those essential facts, time is of essence. Thus, I am requesting for your assistance the CON Certification in order for the agency to obtain its license from DPH and be enrolled into Husky insurance for reimbursement of its services to the adults. Thank you for your anticipated assistance. Justin

Justinian Rweyemamu, MA, M.Div, MS-MFT, PhD Students President CT-Family Care Services, LLC
243 Main St, Unit # 4 Manchester,CT. 06042
Tel: 860-432-8862,
Cell: 860-508-8651

155 Maple St, Unit # 204
Springfield, MA. 01105
Tel: 413-285-8722
Cell: 860-508-8651
rweye@cox.net
justinr@ctfcs.necoxmail.com

On Tue, Sep 24, 2013 at 11:16 AM, rweye@cox.net wrote:

>> From: "Riggott, Kaila" <Kaila.Riggott@ct.gov>
>> To: "rweye@cox.net" <rweye@cox.net>
>> cc: "Greci, Laurie" <Laurie.Greci@ct.gov>
>> Date: Thu, 22 Aug 2013 10:26:43 -0400
>> Subject: RE: CON Application 13-31837-CON
>>
>> Dear Mr. Rweyemamu,
>>
>> We are still in the process of reviewing your application and
>> drafting a decision.
>>
>> Kaila Riggott, MPA
>> Planning Specialist
>> State of Connecticut
>> Department of Public Health
>> Office of Health Care Access
>> Hartford, CT 06134
>> phone: 860.418.7037
>> fax: 860.418.7053
>> http://www/ct.gov/ohca
>>
>>
>>
>> -----Original Message-----
>> From: rweye@cox.net [mailto:rweye@cox.net] Sent: Tuesday, August 20,
>> 2013 9:19 AM
>> To: Greci, Laurie; rweye@cox.net
>> Cc: Greer, Leslie; Hansted, Kevin; Riggott, Kaila
>> Subject: Re: CON Application 13-31837-CON
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>>>> Regards,
>>>>
>>>> Laurie K. Greci
>>>>
>>>>
>>>> Associate Research Analyst
>>>> Department of Public Health
>>>> Health Care Access
>>>> * laurie.greci@ct.gov<mailto:laurie.greci@ct.gov>
>>>> ' 860 418-7032
>>>> 7 860 418-7053
>>>>
>>

Greer, Leslie

From: Riggott, Kaila
Sent: Friday, September 27, 2013 9:29 AM
To: justinr@ctfcs.necoxmail.com
Cc: Hansted, Kevin; Greer, Leslie; Sandra Zlokower; Greci, Laurie
Subject: RE: Fwd: RE: CON Application 13-31837-CON

Dear Mr. Rweyemamu,

We are still in the process of reviewing your application and drafting a decision.

Kaila Riggott, MPA
Planning Specialist
State of Connecticut
Department of Public Health
Office of Health Care Access
Hartford, CT 06134
phone: 860.418.7037
fax: 860.418.7053
http://www/ct.gov/ohca

-----Original Message-----
From: justinr@ctfcs.necoxmail.com [mailto:justinr@ctfcs.necoxmail.com]
Sent: Tuesday, September 24, 2013 11:32 AM
To: Greci, Laurie
Cc: Hansted, Kevin; Riggott, Kaila; Greer, Leslie; Sandra Zlokower
Subject: RE: Fwd: RE: CON Application 13-31837-CON

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Justinian Rweyemamu, MA, M.Div, MS-MFT, PhD Students President CT-Family Care Services, LLC
243 Main St, Unit # 4 Manchester,CT. 06042
Tel: 860-432-8862,
Cell: 860-508-8651

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>> Date: Thu, 22 Aug 2013 10:26:43 -0400
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>>>> Laurie K. Greci
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>>>>
>>>> Associate Research Analyst
>>>> Department of Public Health
>>>> Health Care Access
>>>> * laurie.greci@ct.gov<mailto:laurie.greci@ct.gov>

>>>> ' 860 418-7032
>>>> 7 860 418-7053
>>>>
>>

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

December 17, 2013

IN THE MATTER OF:

An Application for a Certificate of Need filed Pursuant to Section 19a-638, C.G.S. by:	Notice of Final Decision Office of Health Care Access Docket Number: 13-31837-CON
CT-Family Care Services, LLC	Establishment of a Behavioral Health Treatment Center in Manchester

To: Justinian Rweyemamu, MA, M.Div. MS-MFT
CT-Family Care Services, LLC
16 Enfield Ave.
Enfield, CT 06082

Dear Mr. Rweyemamu:

Enclosed please find a copy of the Proposed Final Decision rendered by Hearing Officer Kevin T. Hansted, Esq. in the above-referenced case.

Pursuant to Connecticut General Statutes § 4-179, CT-Family Care Services, LLC, the party in this matter, may request in writing the opportunity to file exceptions and a brief and a request to present an oral argument with the Deputy Commissioner of the Office of Health Care Access within twenty-one (21) days from the mailing of the decision, or by January 6, 2014. If no such request is received by this date, the Deputy Commissioner will take those rights to be waived and will render a Final Decision in this matter.

If you wish to expedite the process and avoid the necessity that the Deputy Commissioner await the expiration of the aforementioned twenty-one days, you may submit a written statement to the Deputy Commissioner affirmatively waiving those rights.

Kimberly R. Martone
Director of Operations

Enclosure
KRM:KTH:lkg

Copy: Sandra R. Zlokower, Esq.

Department of Public Health
Office of Health Care Access
Certificate of Need Application

Proposed Final Decision

Applicant: **CT-Family Care Services, LLC**
243 Main Street, Manchester, CT 06042

Docket Number: **13-31837-CON**

Project Title: **Establishment of a Behavioral Health Treatment Center**

Project Description: CT-Family Care Services, LLC ("Applicant") is seeking authorization to establish a behavioral health treatment center at 243 Main Street, Manchester, Connecticut.

Procedural History: The Applicant published notice of its intent to file the Certificate of Need ("CON") application in the *Hartford Courant* on March 21, 22 and 23, 2013. On May 1, 2013, the Office of Health Care Access ("OHCA") received the CON application from the Applicant for the above-referenced project. On May 17, 2013, OHCA deemed the CON application complete.

On June 7, 2013, OHCA notified the Applicant of the date, time and place of the public hearing. On June 8, 2013, a notice to the public announcing the hearing was published in the *Hartford Courant*. Thereafter, pursuant to Connecticut General Statutes ("Conn. Gen. Stat.") § 19a-639a(f), a public hearing regarding the CON application was held on June 26, 2013.

Commissioner Jewel Mullen designated Attorney Kevin T. Hansted as the hearing officer in this matter. The hearing was conducted in accordance with the provisions of the Uniform Administrative Procedure Act (Chapter 54 of the Conn. Gen. Stat.) and Conn. Gen. Stat. § 19a-639a(f).

The public hearing record was closed on August 7, 2013. The Hearing Officer considered all evidence in the record.

Findings of Fact and Conclusions of Law

To the extent the findings of fact actually represent conclusions of law, they should be so considered, and vice versa. *SAS Inst., Inc., v. S & H Computer Systems, Inc.*, 605 F.Supp. 816 (Md. Tenn. 1985).

1. The Applicant was established as a Connecticut limited liability company in 2007 and has three locations: 234 Main St., Manchester, Connecticut; 6 Enfield St., Enfield, Connecticut; and 155 Maple St., Springfield, Massachusetts. Ex. A, pp. 1, 11

2. The Applicant is a consulting company dedicated to serving minorities and low income populations who are underprivileged medically, economically, socially and culturally. Ex. A, p. 11

3. The Applicant is seeking authorization to establish an outpatient behavioral health treatment center at its Manchester location. Ex. A, p. 10

4. Justinian Rweyemamu, M.A., M. Div., MS-MFT, President of CT-Family Care Services, LLC stated that the Applicant provides integrated behavioral health treatment with special focus on serving the underserved, underprivileged and minorities. The Applicant did not define the population groups that are "underprivileged" or "underserved." The Applicant has failed to define the persons that comprise these two groups and therefore the number of persons that may be in need of the Applicant's proposal. The Applicant has proposed supplementing what is lacking in the traditional-biomedical approach and incorporate its Academic-Social-Cultural-Emotional-Spiritual-Economic-Relational ("ASCESER") components to heal the factors that lead to the mental health cycle of problems. While the Applicant submitted several articles concerning integrated treatment for black and Asian racial groups, the information did not offer any discussion as to the benefit of the ASCERER approach to behavioral health treatment over the traditional-biomedical approach.
Ex. A, pp. 11, 240, 252; Transcript of the June 26, 2013, Public Hearing ("Tr."), Testimony of Mr. Rweyemamu, pp. 5, 17, 24

5. The Applicant proposes providing outpatient psychiatric mental health services to children, youth and families, and also outpatient psychiatric mental health services for adults, including individuals, seniors, and veterans. The outpatient psychiatric mental health license will cover home therapy, home care, social services, research and substance abuse services for youth, adults, groups and families. Ex. A, pp. 12, 14, 34, 49, 51, 52, 168, 175, 192; Tr. Testimony of Mr. Rweyemamu, pp. 13, 14

6. The Applicant proposes it will provide services to residents of Manchester, East Hartford, Vernon and South Windsor. Ex. A, pp. 210, 212

7. The Applicant has demonstrated that a need exists for its proposed services within the youth and adolescent segment of the population. In doing so, it describes two schools in Manchester as having overwhelmingly minority students with academic and behavioral problems and insufficient staff to treat students and their families and the same has been assumed for East Hartford, South Windsor and Vernon schools. Using the information

provided for each town's school system by the Connecticut State Department of Education, the Applicant has determined that there are 4,744 youth and adolescents in the service area with unmet need for behavioral health services. The Applicant illustrates the number of youth and adolescents by group and town that may benefit from the proposal:

Table 1: Number of Youth and Adolescents in the Four Town Service Area that May Benefit from the Proposal

Description	Town	Student Popu-lation	% of Popu-lation*	Number of Youth/ Adoles.	% Needing Services**	Number that May Benefit from the Proposal
Academic Challenges	Manchester	6,884	1.7	117	67%	78
	East Hartford	7,242	4.4	319		213
	Vernon	3,681	3.9	144		96
	South Windsor	4,654	1.6	74		62
					Total	**449**
Problematic Behaviors	Manchester	6,884	16	1,102	67%	735
	East Hartford	7,242	23.7	1,716		1,144
	Vernon	3,681	10.1	372		248
	South Windsor	4,654	16.9	786		524
					Total	**2,651**
Disabilities	Manchester	6,884	13	895	67%	597
	East Hartford	7,242	13.7	992		661
	Vernon	3,681	10.8	398		26
	South Windsor	4,654	11.6	540		360
					Total	**1,644**
					Grand Total	**4,744**

* Based on information reported by the Connecticut State Department of Education, Connecticut Education Data and Research, School Year 2009-10.
** Basis for the Applicant's estimate of need for services not provided.
Ex. A, pp. 211, 218, 219, 281-300

8. While the Applicant has demonstrated a need for its proposed services among the youth and adolescent population within its Proposed Service Area, it has not done so for the adult population.

9. Existing mental health providers in the Manchester area include private, non-profit agencies and private practitioners. The Applicant listed 22 providers in Manchester, 2 providers in Vernon, 5 providers in South Windsor and 2 providers in East Hartford. Ex. A, pp. 43, 44, 216, 217

10. The following table lists the facilities that currently hold the "Outpatient Psychiatric Clinic for Adults" license issued by the Connecticut Department of Public Health and are located in the Applicant's proposed service area:

Table 2: Outpatient Psychiatric Clinics for Adults in Proposed Service Area

Facility Name and Address	Town	Zip Code
InterCommunity, Inc. 287 Main St.	East Hartford	06118
Capitol Region Education Council 474 School St.	East Hartford	06108
Community Health Resources, Inc. 587 East Middle Turnpike	Manchester	06040
Hartford Dispensary 335 Broad St.	Manchester	06040
New Hope Manor, Inc. 935 Main St.	Manchester	06040
Hockanum Valley Community Council, Inc. 27 Naek Rd.	Vernon	06066

Source: Statewide Health Care Facilities and Services Plan, October 2012, Connecticut Department of Public Health, Office of Health care Access
Ex. A, pp. 43, 44, 216, 217

11. The following table lists the facilities that currently hold the "Facility for the Care and Treatment of Substance Abusive or Dependent Persons" licensed issued by the Connecticut Department of Public Health" and are located in the Applicant's proposed service area:

Table 3: Facilities for the Care and Treatment of Substance Abusive or Dependent Persons in Proposed Service Area

Facility Name and Address	Town	Zip Code
Intercommunity Inc. 281 Main St.	East Hartford	06118
Intercommunity Inc. 287 Main St.	East Hartford	06118
Paces Counseling Associates, Inc. 991 Main St.	East Hartford	06108
Community Child Guidance Clinic, Inc. 317 North Main St.	Manchester	06042
Hartford Dispensary 335 Broad St.	Manchester	06040
Community Health Resources 587 East Middle Turnpike	Manchester	06040
New Hope Manor, Inc. 935 Main St.	Manchester	06040
Hockanum Valley Community Council, Inc. 27 Naek Rd.	Vernon	06066

Source: Statewide Health Care Facilities and Services Plan, October 2012, Connecticut Department of Public Health, Office of Health Care Access

12. The Applicant has not submitted any financial statements to support its ability to establish and operate the proposed clinic. Ex. A, p. 64, Ex. A, 193-194

13. OHCA is currently in the process of establishing its policies and standards as regulations. Therefore, OHCA has not made any findings as to this proposal's relationship to any regulations adopted by OHCA. (Conn .Gen. Stat. § 19a-639(a)(1))

14. This CON application is consistent with the overall goals of the Statewide Health Care Facilities and Services Plan. (Conn. Gen. Stat. § 19a-639(a)(2))

15. The Applicant has failed to establish a clear public need for its proposal. (Conn. Gen. Stat. § 19a-639(a)(3))

16. The Applicant has not satisfactorily demonstrated that its proposal is financially feasible. (Conn. Gen. Stat. § 19a-639(a)(4))

17. The Applicant has failed to satisfactorily demonstrate that the proposal would improve the accessibility of health care delivery in the region and has not satisfactorily demonstrated a potential improvement in quality and cost effectiveness. (Conn. Gen. Stat. § 19a-639(a)(5))

18. The Applicant has not shown that there will be an increase in access to the provision of health care services to the relevant populations and payer mix. (Conn. Gen. Stat. § 19a-639(a)(6))

19. The Applicant has not satisfactorily identified the population to be served by the proposal. (Conn. Gen. Stat. § 19a-639(a)(7))

20. The Applicant has not provided any historical utilization of behavioral health treatment services in the service area that would support this proposal. (Conn. Gen. Stat. § 19a-639(a)(8))

21. The Applicant has failed to satisfactorily demonstrate that the proposal will not result in an unnecessary duplication of existing services in the area. (Conn. Gen. Stat.. § 19a-639(a)(9))

Discussion

CON applications are decided on a case by case basis and do not lend themselves to general applicability due to the uniqueness of the facts in each case. In rendering its decision, OHCA considers the factors set forth in General Statutes § 19a-639(a). The Applicant bears the burden of proof in this matter by a preponderance of the evidence. *Jones v. Connecticut Medical Examining Board, 309 Conn. 727 (2013).*

CT-Family Services, LLC is described as a consulting company that is dedicated to serving minorities and low income populations who are underprivileged medically, economically, socially and culturally. *FF 2* The Applicant is seeking authorization to establish an outpatient behavioral health treatment center in Manchester. Ex. A, p. 10. The Applicant proposed providing youth and adult clients with integrated treatment, focusing on serving the underserved, underprivileged and minorities. The Applicant stated that integrated treatment having social, cultural, educational and economic components will supplement what is lacking in the traditional-biomedical approach to treating mental health clients. *FF 4,5* The Applicant stated that the proposal would contribute to the quality of health care delivery in the region by providing treatment that is lacking in the traditional biomedical approach, as the ASCERER approach would provide valuable treatment resources to reduce disparities among the minority and low income populations who are underserved. Ex. A, p. 11, 54.

In support of its proposal, the Applicant reported the number of potential adult clients by town in the following table:

Table 4: Number of Adults in the Four Town Service Area that May Benefit from the Proposal

Description	Town	Adult Population	% of Adult Population	Number of Adults	Need for the services	Number of Persons that May Benefit from the Proposal
Mental Health, Adults	Manchester	58,287	50%	29,144	50%	14,572
	East Hartford	51,293		25,647		12,824
	Vernon	29,139		14,570		7,285
	South Windsor	25,729		12,865		6,433
					Total	**41,114**
Substance Abuse, Adults	Manchester	141,987*	8.67%	12,310	50%	6,155
	East Hartford	**		**		**
	Vernon	**		**		**
	South Windsor	**		**		**
					Total	**6,155**
					Grand Total	**50,269**

* The correct total adult population in Manchester is 58,287 persons.
** Not reported by Applicant.
Ex. A, pp. 218, 219, 223

To prepare Table 4, the Applicant relied upon a fact sheet issued by the Office of Minority Health and Health Disparities of the Centers for Disease Control and Prevention ("CDC") and dated June 5, 2007, to report that 1-in-2 Americans has a diagnosable mental disorder each year, including 44 million adults and 13.7 million children. Ex. A, p. 228. However, a more recent report by the CDC in September 2011 indicates that only about 25% of the adults in the United States have a mental illness. http://www.cdc.gov/mentalhealthsurveillance/ Therefore, the Applicant has overstated its estimate of persons having mental health disorders. The Applicant also claims that there are 6,155 substance abusing or dependent persons in the town of Manchester. This number is also overstated as the Applicant has utilized the incorrect adult population for the calculation. The correct adult population in Manchester is 58,287. Ex. A, p. 45. The Applicant failed to report the number of substance abusing or dependent persons for the remaining towns in the proposed service area.

The projected volumes by group and service type were reported by the Applicant in the following table:

Table 5: Projected Volumes by Population, Service Type and Fiscal Year

Population	Service Type	FY 2013 Persons(sessions)	FY 2014 Persons(sessions)	FY 2015 Persons(sessions)
Students/ youth	Academic disabilities	2,825 (67,800)	3,767 (90,408)	5,540 (132,960)
	Dropout symptoms	654 (15,696)	872 (20,928)	1,282(30,768)
	Behavioral Issues	3,976(95,424)	5,301(127,224)	7,796 (187,104)
	Bullying*	1,932(46,360)	2,576(61,824)	3,788 (90,912)
	Psychiatric Medication	1,500	375	480
Total	**Clients Sessions**	**10,887 (225,280)**	**12,891 (300,384)**	**18,406 (441,744)**
Adults	Integrated Treatment (therapy and social services)	70,994 (1,703,856)	94,657 (2,271,176)	139,201 (3,340,835)
	Job training	6,389 (15,347)	8,519 (204,456)	12,528(300,671)
	Psychiatric medication	1,250 (***)	1,666 (***)	2,450(***)
Veterans	Integrated Treatment (therapy and social services)	9,939(238,536)	13,252(318,048)	19,488(467,717)
Seniors Over 65 years old	Integrated Treatment (therapy and social services)	7,695 (184,680)	10,260(246,240)	15,088 (362,117)
Total**	**Clients Sessions**	**78,633 1,719,203**	**104,842 2,516,208**	**154,179 3,700,300**
Community -reentry	Integrated Individual Treatment	500(12,000)	667 (16,008)	981 (23,544)
	Integrated Treatment for individual and family	300(7,200)	400 (9,600)	588(14,118)
Total **	**Clients Sessions**	**800 19,200**	**1,067 25,608**	**1,569 37,662**
Grand Total**	**Clients Sessions**	**107,954 2,590,896**	**141,937 3,405,896**	**209,210 5,009,546**
Projected Number to Be Served by Applicant ***	***Clients Sessions***	***15,422 (340,986)***	***20,330 (443,645)***	***29,887 (715,649)***

* Students being bullied = 8.6% of students

** Totals are calculated from the clients and sessions reported by the Applicant for each unique population.

*** Applicant projects capturing 1/7 of the potential volume based on 7 clinics in the proposed service area. Ex. A, pp. 219-221 and Ex. K

The Applicant reports that blacks, Hispanics and white low income families are impacted by institutional racism, school dropouts, mental health crises and poverty. However, the Applicant failed to provide evidence as to the number of persons in these distinct population groups that reside within the proposed service area. Ex. A, p. 167.

The Applicant requested authorization to establish a behavioral health clinic for the treatment of youth, adolescents and adults. While the Applicant has sufficiently established the number of youth and adolescents that may benefit from its proposal, it has failed to do the same for the adult population. Without the clear establishment of the populations to which the Applicant is proposing to provide services, the adults' need for the proposed services cannot be determined. *FF 4, 5, 7, 8* The Applicant estimated that it will serve 1-in-7 persons since there are approximately seven clinics in the proposed service area. The Applicant assumed that it will serve every seventh client since there are seven other clinics, yet provided no basis for this assumption. *FF 10*

Moreover, while the Applicant provided much discussion in its proposal, about its desire to provide services to the underprivileged and underinsured, the populations of these groups within the proposed service area have not been reported by the Applicant. *FF 7* Furthermore, the Applicant's reported payer mix projections do not reflect this desire. As shown in Table 6, provided by the Applicant, the percentages begin at 4% for the Medicaid-enrolled clients and self-pay clients in FY 2013 with no projected increase in each of the following two years. In fact, the Applicant's projections indicate a decrease in the amount of Medicare, Medicaid and CHAMPUS and TriCare payers.

Table 6: Patient Population Mix by Payer and Fiscal Year

Payer	FY 2013	FY 2014	FY 2015
Medicare	16%	16%	15%
Medicaid	25%	25%	23%
CHAMPUS & TriCare	25%	25%	22%
Total Government	66%	66%	60%
Commercial Insurers	25%	25%	30%
Uninsured	4%	4%	4%
Workers Compensation	5%	5%	6%
Total Non-government	34%	34%	40%
Grand Total	**100%**	**100%**	**100%**

Ex. A, p. 196

Given the lack of documentation to support the assumptions made by the Applicant in developing the need in the proposed service area for the adult population and, in turn, the projected volume of clients, the Applicant has failed to demonstrate that there is a clear public need for the proposal or whether it would result in a duplication of services in the proposed service area. *FF 9-11*

In addressing certain financial questions, the Applicant projected that its hourly rate for services would be $100 to $150. The Applicant projected that its operating expenses in FY 2013 would be $1,784,272. The Applicant reported its projected revenues and expenditures for the first three fiscal years in the following table:

Table 7: Projected Revenues and Expenditures for the Proposal

Description	FY 2013	FY 2014	FY 2015
Revenue from operations	$1,493,100	$2,012,000	$2,951,750
Grants	350,000	350,000	350,000
Total Revenue	$1,843,100	$2,362,000	$3,301,750
Operating Expenses	1,784,272	2,310,812	3,219,254
Net Revenues prior to taxes	**$ 58,828**	**$ 51,188**	**$ 82,496**

Ex. A, p. 66, 198, 201

As shown in Table 5, the Applicant projected that it would provide 340,986 sessions in its first year of service. Using the Applicant's reported hourly rate of $100 to $150, the projected revenue from operations should be much higher than the reported $1,493,100. The revenues from operations reported for the first three years of service appear to have no relationship to the projected volumes.

In support of its financial stability, the Applicant provided documentation that it has secured a loan for $83,000 and a line of credit of $10,000. Ex. A, p. 194 and Tr. Testimony of Mr. Rweyemamu, p. 18. However, there was no evidence provided to illustrate that this is an adequate amount of funds to support the facility until reimbursements from third-party payers or potential grants become available. Moreover, the Applicant failed to provide financial statements even though the Applicant became a limited liability company in 2007. *FF 1* Due to the Applicant's unexplainable financial projections and the lack of evidence demonstrating financial integrity,the Applicant has failed to show that the proposal is financially feasible.

Although the Applicant provided letters of community support for its proposal (*See,* Applicant Late File 1), since both the application and testimony lacked evidence to substantiate clear public need or the financial feasibility of the proposal, the Applicant has failed to demonstrate that the proposal would improve the accessibility, quality or cost effectiveness of health care delivery in the proposed service area.

Order

Based upon the foregoing Findings and Discussion, I respectfully recommend that the Certificate of Need application of CT-Family Services, LLC to establish a behavioral health treatment center in Manchester, Connecticut, be **DENIED**.

Respectfully submitted,

12/17/13
Date

Kevin T. Hansted
Hearing Officer

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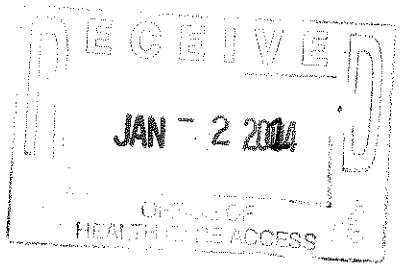


FAX TRANSMITTAL

To: **Lisa Davis, Deputy Commissioner**
From: Sandra R. Zlokower
Date: January 2, 2014
Pages: 2 pages (including cover)
Facs #: **(860) 418-7053**
Subject: Notice of Final Decision, Office of Health Care Access
Docket Number 13-31837-CON

Zlokower & Miller, LLP

Attorneys at Law

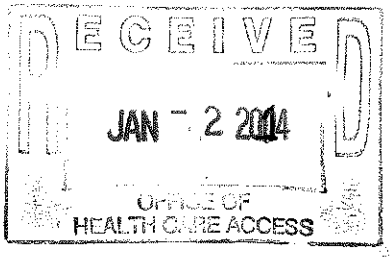
Sandra R. Zlokower

901 Farmington Avenue
West Hartford, Connecticut 06119

Voice and Fax : (860) 523-8381
Email: SRZ@zlokowermiller.com

2014 JAN 02

VIA CERTIFIED MAIL
January 2, 2014



Lisa Davis
Deputy Commissioner
State of Connecticut
Department of Public Health
Office of Health Care Access
410 Capitol Avenue
P.O Box 340308
Hartford, CT 06134-0308

IN THE MATTER OF:

An Application for a Certificate of Need filed Pursuant to Section 19a-678, CGS by:	Notice of Final Decision Office of Health Care Access Docket Number 13-31837-CON
CT-Family Care Services, LLC	Establishment of a Behavioral Health Treatment Center in Manchester

Greetings:

On behalf of CT-Family Care Services, LLC and pursuant to Section 4-179 of the Connecticut General Statutes, we hereby request the opportunity for CT-Family Care Services, LLC to file exceptions and present briefs and oral argument to the members of the agency who are to render the final decision with respect to a Proposed Final Decision rendered by Hearing Officer Kevin T. Hansted, Esq.

Please respond to this request directly to the applicant with a copy to this office at your earliest convenience.

Thank you for your attention to this matter.

Very truly yours,

Sandra R. Zlokower

Cc: Kimberly Martone, Department of Public Health
Kevin T. Hansted, Esq., Department of Public Health
Justinian Rweyemamu, CT-Family Care Services, LLC

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

January 10, 2014

Sandra R. Zlokower, Esq.
Zlokower & Miller, LLP
901 Farmington Ave.
West Hartford, CT 06119

Certified Mail: 7005 03900001 3506 9747

In RE: Certificate of Need Application; Docket Number: 13-31837-CON
CT-Family Care Services, LLC
Establishment of a Behavioral Health Treatment Center in Manchester

NOTICE OF ORAL ARGUMENT

CT-Family Care Services, LLC has requested an oral argument regarding the recommendation of Hearing Officer Kevin Hansted, Esq. Pursuant to Section 4-179 C.G.S., Oral Argument for the above cited case has been scheduled as follows:

January 23, 2014 at 1:00 p.m.
Department of Public Health
3rd Floor, DPH Hearing Room
410 Capitol Avenue, Hartford, Connecticut

On January 23, 2014, you will have fifteen minutes to make your argument. If you wish to file briefs or exceptions, you must do so by January 17, 2014. Please call Barbara Olejarz at (860) 418-7005 if you have any questions.

Lisa Davis, MBA, BSN, RN
Deputy Commissioner

Date 1/10/14

C: Jewel Mullen, M.D., M.P.H., M.P.A., Commissioner
Justinian Rweyermamu, CT-Family Care Services, LLC

Connecticut Department of Public Health

Phone: (860) 509-8000 • Fax: (860) 509-7184 • VP: (860) 899-1611
410 Capitol Avenue, P.O. Box 340308
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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: JUSTINIAN R MEYERMAMU

FAX: 860 432 8845

AGENCY: CT-FAMILY CARE SERVICES, LLC

FROM: OHCA

DATE: 1/10/14 Time:

NUMBER OF PAGES:
(including transmittal sheet)

Comments:

Oral Argument Notice for DN: 13-31837, CT-Family Care Services, LLC

PLEASE PHONE Barbara K. Olejarz IF THERE ARE ANY TRANSMISSION

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

FAX SHEET

TO: SANDRA R. ZLOKOWER ESQ.

FAX: 860 523-8381

AGENCY: ZLOKOWER & MILLER, LLP

FROM: OHCA

DATE: 1/10/14 Time:

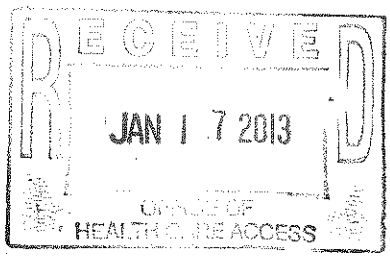
NUMBER OF PAGES:
(including transmittal sheet

Comments:

Oral Argument Notice for DN: 13-31837. CT-Family Care Services, LLC

PLEASE PHONE Barbara K. Olejarz IF THERE ARE ANY TRANSMISSION

"In Collaboration with clients we Enhance their wellness through Internal and external solutions."



CT-FAMILY CARE SERVICES, LLC

January 17, 2014

Response to notice of final decision, Office of Health Care Access docket number: 13-31837-CON
Application for a Certificate of Need filed pursuant to Section 19a-638, C.G.S. by
CT-Family Care Services, LLC for the establishment of a behavioral health treatment center in Manchester

To: Lisa Davis
Deputy Commissioner
Office of Health Care Access
Department of Public Health
410 Capitol Ave. MS#13HCA
Hartford, CT 06134-0308

Dear Deputy Commissioner Davis:

Enclosed please find our response to the final decision of Hearing Officer Kevin T. Hansted, Esq. in the above-referenced case for CT-Family Care Services, LLC. We look forward to presenting our oral argument to you on January 23.

Regards,

Justinian Rweyemamu, MA, M.Div., MS-MFT
President
CT-Family Care Services, LLC
16 Enfield Ave.
Enfield, CT 06082

43 Main Street, Unit 4
Manchester, CT 06042
Tel: 860-432-8862
Fax: 860-432-8845

155 Maple Street, Unit 204
Springfield, MA 01105
Tel: 413-285-8722
Fax: 413-285-8642

In the Matter of:

Appeal of the final decision, Office of Health Care Access, Docket Number: 13-31837-CON

Application for a Certificate of Need filed Pursuant to Section 19a-638, C.G.S. by:

CT-Family Care Services, LLC

The applicant is responding to Hearing Officer Kevin T. Hansted's numbered comments, as follows:

1. The applicant has two outpatient mental health clinics at two locations namely: 243 Main St, Unit #4 in Manchester, Connecticut and 155 Main St, Unit # 204, Springfield, Massachusetts. To clarify, no clients are seen at the principal address of the company -- 16 Enfield Ave, Enfield, Connecticut 06082.

2. The applicant is a state-certified minority-owned outpatient mental health agency, dedicated to serving minorities and the underserved population who are medically, economically, socially, educationally and culturally underprivileged.

3. On July 12, 2013 the applicant was licensed by The Department of Children and Families (DCF) as an outpatient psychiatric clinic in order to provide outpatient psychiatric clinic services to children (exhibit #1). In addition, on April 10, 2013 the applicant became licensed by the Department of Public Health (DPH) as an outpatient mental health service provider for children, adults, and families in Massachusetts (exhibit #2). Furthermore, the applicant has been successfully enrolled into Husky/Medicaid, Medicare, Blue Cross BlueShield, Aetna and other private insurances in Connecticut (exhibit #3) as well as Mass Health, Medicare, Blue Cross BlueShield and Aetna in Massachusetts (exhibit #4).

4. The applicant is the first minority-owned, state-certified and licensed mental health company that is licensed in Connecticut. The nature of the targeted population is the underserved population. The applicant is dedicated to serving all people, but with a special concentration on serving the underserved population in the selected areas. The underserved population is defined as individuals, families and groups whose demographic, geographic, or economic, education, medical and social-cultural characteristics impede or prevent their access to health care services (Weitz, 2000), referring to Hispanic or Latino, Black or African American, Asian, Native Hawaiian, Pacific Islander, American Indian, or Alaska Native and Caucasian low income families or groups. "The lack of accessible health care services is particularly acute for poor and low-income people, who do not have the financial resources to travel to find health care and may not be accepted by physicians due to low reimbursement rates in Medicaid (the health insurance program for low-income people" (http://hrc.nwlc.org/status-indicators/people-medically-underserved-areas#sthash.uAVy4OOF.dpuf). The underserved population is also defined as "medically vulnerable populations as those that are wounded by the social forces placing them at the disadvantage of their health" (King, et al, 2007, p.626). Those social-cultural-economical-medical constraints often exacerbate the mental health crises of the underserved population.

"Mental illnesses know no social economics or geographic boundaries. It affects people who are rich and poor, urban and rural, young and old. However, the frequency with which mental health illnesses occur and the burden it imposes are felt disproportionably by people in the lower social economic group" (Governor's Blue Ribbon Committee Report, 2000, p.1). Minorities are often underserved in mental health treatment. Among the reasons for this is a gap in social/cultural competence among treatment professionals (citation Gov. Blue Ribbon Committee Report), which results in a tendency for about 23% of minority clients to turn to family or friends for help instead of mental health professionals.

Figure 2: Where all other ethnic groups with mental health symptoms turned for hel

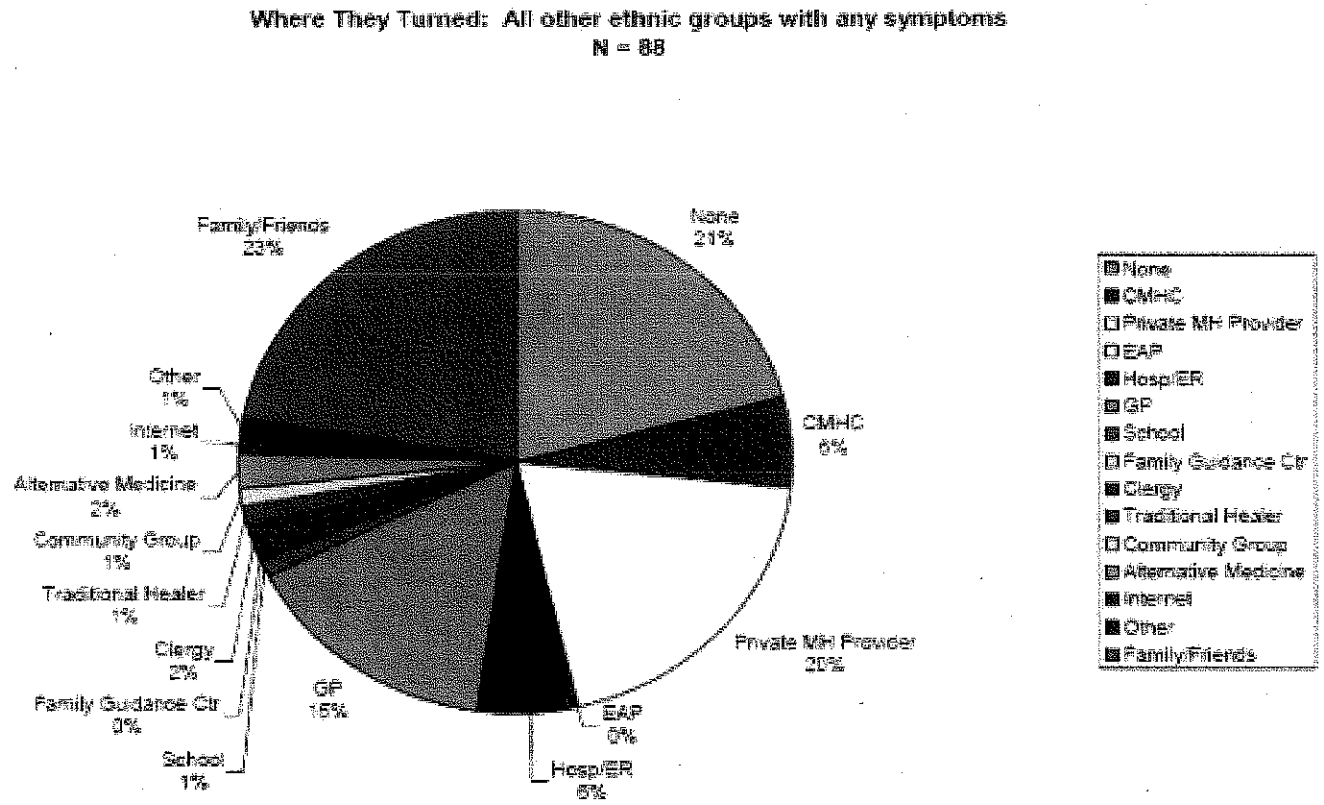


Figure 2 shows that 23 percent of all other ethnic groups said they turned to family a friends; 21 percent turned to no one; 20 percent turned to private mental health provi and 15 percent turned to general practitioners.

Source: Governor's Blue Ribbon Committee Report, 2000

This social/cultural competence gap is a failure to address mental health needs in an integrated social-cultural context (Department of Mental Health and Addictions Comprehensive Report for CT 2006, p. 27). In order to effectively treat the

?3% as well as the 20% indicated above, the applicant uses integrated treatments which are embedded with the Academic-Social-Cultural-Emotional-Spiritual-Economic-Relational (ASCESER) components in a way that respects and

treats adolescents, families, young adults as well as older adults in their systemic cultural context. Carter and McGoldrick, 2005, suggest that for individuals and families to be understood and changed, they need to feel respected in their cultural and historical context of the past, and present. Here, OHCA seems to misunderstand the applicant. The applicant will continue to use both the bio-medical (traditional approach) and the integrated approach (with social-cultural components or ASCERER). The applicant will use the ASCERER in order to supplement the traditional approach which tends to deal primarily with treating the symptoms while the integrated approach goes beyond treating symptoms to treating the causes of the symptoms as well as the factors that feed or fuel those causes. Thus, the integrated approach that the applicant presents is aimed at treating the systemic roots of the mental health problems in a customized way for each adult. This approach supports the DMHAS Region IV Services and Priorities Report and Recommendations of 2012 for a focus on wellness and recovery (Submitted by the North Central Regional Mental Health Board). What the applicant is trying to do is to implement what the mental health industry in Connecticut has been urged to do in the past, to foster a system of care which goes beyond the goal of reducing symptoms only, but provide the support which encompasses assistance in a broad range of life activities such as self-care, socialization, education and employment and therapy. This is in line with the recommendation of the Blue Ribbon Committee, 2000, p.15 and the Department of Mental Health and Addiction Services Service Priorities Report and Recommendations of July 27, 2012. The applicant is a pioneer. One of the many benefits this proposal presents to the targeted population is that it is designed primarily for minorities and low income population in ways that motivate them to come forward for treatment. Our treatment will support them to feel culturally listened to, connected, acknowledge their inner repertoires of strengths and weaknesses holistically and incorporate them into their customized treatment plans. As a result, the treatment will enhance recovery, wellness and success.

Figure 3 below shows a need for the applicant's services. There are 58,147 minorities in the service area and 16,593 people with low income. Minorities and low income people are often underserved.

Figure 3 – the Underserved Population by Town, Minorities and Income

Town	Total Population	Minority Population				Income $10,000-$14,999	Income $15,000-$24,999	Income $25,000-34,999
		African American	Latino	Other*	Total			
East Hartford	49,575	18.83%	15.23%	13.13%	23,300	1194	2193	2358
East Windsor	9,818	4.09%	2.11%	3.03%	884	87	371	377
Manchester	58,241	8.42%	6.54%	6.5%	12,813	810	2071	2553
South Windsor	25,709	5.95%	2.27%	4.58%	3,342	121	566	514
Suffield	13,552	6.95%	4.25%	3.25%	2,033	58	241	339
Windsor	29,044	34.3%	8.4%	7.81%	14,812	266	613	614
Windsor Locks	12,043	2.67%	2.22%	3.44%	963	266	590	391
Total	**197,982**				**58,147**	**2,802**	**6,645**	**7,146**

* Native American, Asian, Pacific Islander and other races.
Sources: U.S. Census Bureau, 2008-2012 American Community Survey, DP03 Selected Economic Characteristics; U.S. Census 2000 and 2010.

5. No response.

6. In Connecticut, the applicant proposes that it will provide services in the Manchester area, which includes Manchester, East Hartford, East Windsor, Windsor, South Windsor, Windsor Locks, Suffield, Ellington and Vernon. Those areas

continue to have an increase of minority and underprivileged populations. For example, Windsor is one of the most culturally diverse communities in Connecticut (U.S. Census Bureau, 2008-2012 American Community Survey, DP03 Selected Economic Characteristics; U.S. Census 2000 and 2010). While the Manchester area has no primary care health professional shortage because Manchester and Rockville hospitals are in the area, the Manchester area does have a mental health professional shortage (USA Department of Health and Human Services-Health Resource and Services Administration, http://datawarehouse.hrsa.gov/GeoAdvisor/shortagedesignationadvisor.aspx.

7. The applicant has proved that 4,744 youth need behavioral care and the applicant is licensed by the Department of Children and Families for that purpose(exhibit # 6).

8. Mental health/behavioral problems among school aged children may be an indicator of additional mental health problems among the young and older adults in the child's home environment (Horigian, Vivian, Suarez-Morales, Lourdes, Robinson & Michael S (2005). In light of that fact, Scheibe (2000) points out that the problematic behaviors we see in mental health including schools indicate that "one train may hide another, that our current problem may hide many other possible concerns" even among young and older adults and their families. Thus both children and adults need to be treated because the problematic symptoms that we see in children or adults today are like a warning light on the dashboard of a car: "if one part breaks down, the whole system is affected" (Satir,1983, p.195). There is a correlation between students' problematic behaviors and the environmental dynamics that students witness among their parents, families and adults, for example, bullying in school. Adults and families contribute in cultivating the seeds for bullying. Students who bully others, tend to have parents or adult caretakers who are stricter in giving punishments or parents who are hostile to each other, including domestic violence (Olweus, 1980). Bullying is derived from family environments in which parents and guardians lack appropriate parenting skills and their families have the following characteristics: Unhealthy parental discipline, lack of adult supervision, lack of positive adult role models, teasing about appearances (Powell & Ladd, 2010). Butler & Platt (2008) as well as Powell & Ladd (2010) documented that family therapy interventions are effective in addressing adolescent school bullying issues and their families. The commitment for the applicant is to connect and gain the trust of children and their older adults' trust in a way that will help the identified adults and the families to enhance their social-cultural-spiritual values in order to enhance their wounded coping skills during and after their therapeutic, psychiatric and social services provided by the applicants through facilitating the transformation of the whole family. CT-Family Services, LLC would be applying an approach that could likely unearth mental health issues among adults in the home of a child being treated. With a certification from DPH to treat the adults in the home, CT-Family Services, LLC would provide a continuity of integrated mental health treatment that is socially-culturally, psychiatric and therapeutically competent, therefore addressing the needs of adult clients and their families.

Figure 3a – the Underserved *Adult* Population by Town, Minorities and Income

Town	Adult Population	Minority Population				Income $10,000-$14,999	Income $15,000-$24,999	Income $25,000-34,999
		African American	Latino	Other*	Total			
East Hartford	37,627	18.83%	15.23%	13.13%	17,685	906	1665	1790
East Windsor	7,638	4.09%	2.11%	3.03%	705	68	289	293
Manchester	45,020	8.42%	6.54%	6.5%	9,661	626	1601	1973
South Windsor	18,665	5.95%	2.27%	4.58%	2,389	88	411	373
Suffield	10,557	6.95%	4.25%	3.25%	1,525	45	188	264
Windsor	22,770	34.3%	8.4%	7.81%	11,501	209	480	481
Windsor Locks	9,201	2.67%	2.22%	3.44%	766	203	451	299
Total	**151,478**				**44,232**	**2,145**	**5,085**	**5,473**

* Native American, Asian, Pacific Islander and other races.
Sources: U.S. Census Bureau, 2008-2012 American Community Survey, DP03 Selected Economic Characteristics; U.S. Census 2000 and 2010.

3b: Number of Adults who May Benefit from the Proposal

Description	Town	Adult Population	% of Adult Population	Number of Adults	Need for the Services	Number of Persons who May Benefit from the Proposal	Number of adults served by outpatient MH clinics
Mental Health, Adults	Manchester	58,287	25%	14,572	25%	3,643	6,810*
	East Hartford	51,293		12,823		3,206	
	Vernon	29,139		7,285		1,821	
	S. Windsor	25,729		6,432		1,608	
	East Windsor	7,638		1,910		477	
	Windsor	22,770		5,693		1,423	
	Suffield	10,557		2,639		660	
	Ellington	9,665		2,416		604	
					Total	**13,442**	
Substance Abuse, Adults	Manchester	58,287	8.67%	5,053	25%	1,263	Total population to be served by applicant 6,632*
	East Hartford	51,293		4,447		1,112	
	Vernon	29,139		2,526		632	
	South Windsor	25,729		2,231		558	
	East Windsor	7,638		662		166	
	Windsor	22,770		1,974		494	
	Suffield	10,557		915		229	
	Ellington	9,665		838		210	
					Total	**4,664**	
					Grand Total	**18,106**	

Sources: U.S. Census, 2000 and 2010; Centers for Disease Control, September 2011, http://www.cdc.gov/mentalhealthsurveillance/.
*See table 3c.

9. No response.

10. In December, 2013, the applicant contacted the facilities that currently hold the outpatient psychiatric clinic for adults license from the Connecticut Department of Public Health and are located in the applicant's service area. By the six agencies, approximately 6,810 adults are served. The total adult population that would benefit from the applicant's proposal is 13,442 in the service area, so if one subtracted those already served, then the potential population (for calculation, see table 4 on p. 13) to be served by the applicant is 6,632. It is important to note:

- One agency – New Hope Manor -- has closed.
- Some of these agencies serve people outside of the applicant's service area.
- One agency – Hartford Dispensary -- does not offer therapy to families.
- One agency – Capitol Region Education Council -- focuses on children's services.
- Community Health Resources' clients average 1.5 years in therapy whereas the applicant proposes a 3-month intensive individual/family approach with a 2-month follow-up.

In interviews conducted at the end of December, 2013, the clinical directors were enthusiastic about working with the applicant. Peg Kirkpatrick, InterCommunity, Inc.'s Director of Outpatient Services, said, "Your program – intensive individual/family/group therapy with incentives such as family dinners -- sounds very interesting. I think it is good that you're doing an outcomes-based program. How can I refer clients to you?" Erica Cyr, Adult Clinical Director, Community Health Resources, said, "Your approach sounds like a real interesting approach that would appeal to families." Russ Buchner, quality improvement, Hartford Dispensary, says that his agency is eager to refer families to the applicant for therapy, since his agency does not provide family therapy. Jenifer Gietek, the Director of Outpatient Services for Hockanum Valley Community Council, said, "It sounds great! Focusing on the Manchester area and providing a holistic approach can only enhance the treatment." She is interested in referring clients to the applicant as well.

\ study by the applicant indicates that that there are many young and older adults and families in the above selected areas who have needs for mental health services, but either they have been on waiting lists for a long time before receiving mental health services or their mental health needs are unaddressed at all. The DMHAS Services Priorities and Recommendations report of 2012 supports this assertion as borne out in the focus group comments about problems with ready access to necessary services. In addition, while the applicant listed several mental health providers in the Manchester areas as cited by OHCA, some of those mental health providers that are identified as agencies such as The Bridge Family Center and Wheeler Clinic have a limited presence in the Manchester area, while their major offices of operations are in New Britain and West Hartford areas or outside the areas of service selected by the applicant. Also, none of those listed mental health providers is a minority owned and certified mental health agency. Currently, the applicant is the first and the only minority owned and certified mental health agency in Connecticut dedicated to serving minority, ethnic groups and underserved populations with mental health issues who tend to turn to their families or friends for help instead of using mental health professionals because the needs of those minorities are not addressed sufficiently from social-cultural contexts. Addressing the role of Black and Hispanic physicians in providing health care for the underserved population, the *New England Journal of Medicine* (1996) pointed out that "Patients who are members of minority groups may be more likely than others to consult physicians of the same race or ethnic group. Black and Hispanic physicians have a unique and important role in caring for poor, black, and Hispanic patients. Dismantling affirmative-action programs, as is currently proposed, may threaten health care for both poor people and members of minority groups" (p. 626).

While there are some outpatient psychiatric clinics for adults (OPCA) in the proposed service area, there is no evidence to support the fact that those already existing OPCA satisfactorily and sufficiently address the needs of the populations as well as the needs of the minorities in those communities to a point that approving and licensing the applicant as a new and the first minority owned mental health agency in the Manchester area would be duplicative of and jeopardize the already existing OPCA. The figure 3c below demonstrates that it is impossible for 2 OPCA in East Hartford, 3 in Manchester (one of which – New Hope Manor – has closed) and 1 in Vernon would lead to duplication of services as implied by the hearing officer.

Figure 3c – Adults served by agencies located in applicant's service area

Agency	Location	Serve
InterCommunity, Inc.	287 Main St., East Hartford	3,500 adults from East Hartford, Glastonbury, Marlborough, Newington, Rocky Hill and Wethersfield
Capitol Region Education Council	474 School St., East Hartford	Children from Hartford and 35 surrounding towns; several school-based programs; families seen at John J. Allison Jr. Polaris Center outpatient clinic. No figure available for adults served. Clients wait for a week for an initial appointment.
Community Health Resources, Inc.	587 East Middle Tnpk, Manchester	2500 adults from Amston, Andover, Bolton, Buckland, Ellington, Hebron, Manchester, Rockville, South Windsor, Talcottville, Tolland, Vernon and Wapping. Clients average 1.5 years in therapy.
Hartford Dispensary	335 Broad St., Manchester	510 adults (6.4% African American and 25.3% Latino) from Hartford, Manchester, Bristol, New Britain, New London, Norwich, Willimantic. Primarily detox and methadone maintenance. No family therapy. Caseload 50-80 per clinician.
New Hope Manor, Inc.	935 Main St., Manchester	Closed. Offered behavioral health & substance abuse clinic for ages 4 through adult for residents of Manchester and surrounding communities.
Hockanum Valley Community Council, Inc.	27 Naek Rd., Vernon	Serve 300 clients per week – mostly adults from Tolland County. 19% African American; 17% Latino; 2% Asian; 1% Native American.

In fact, Figures 3, 3a, 3b & 3c above, shows the need for the applicant's services. There are 58,147 minorities in the service area and 16,593 people with low income. Minorities and low income people are often underserved. As for now, out of 13,442 adults in the service area who could benefit from treatment, only 6,810 are receiving treatment at the already existing OPCAs. That leaves 6,632 available for the applicant to serve. Thus, there is a clear and an urgent public need for treatment for those who are not receiving services.

OHCA claims that the Manchester areas selected by the applicant already have outpatient mental health agencies for adults (OPCA) that cover those areas. But, according to the Department of Mental Health and Addiction Services (DMHAS) the area that the applicant has selected to provide services -- Manchester, East Hartford, East Windsor, Windsor, South Windsor, Windsor Locks, Suffield, Ellington and Vernon -- is in region 4. The local mental health authorities recognized by DMHAS serve different towns or other towns than what OHCA suggests. For example:

- **InterCommunity**, Inc., 287 Main St, East Hartford, serves the towns of East Glastonbury, East Hartford, Glastonbury, Maple Hill, Marlborough, Newington, Rocky Hill, South Glastonbury, and Wethersfield.
- **Capital Region Education Council**, 474 School St., East Hartford, which is in Catchment Areas 18 and 23, serves the towns of Avon, Canton, Canton Center, Collinsville, Elmwood, Farmington, Hartford, Simsbury, Tariffville, Unionville, Weatogue, West Hartford, and West Simsbury.
- **Community Health Resources** (CHR), Inc., 587 East Middle Turnpike, Manchester, which is in Catchment Area 15, serves the towns of Amston, Andover, Bolton, Buckland, Ellington, Hebron, Manchester, Rockville, South Windsor, Talcottville, Tolland, Vernon and Wapping.

- **Hartford Dispensary** has nine clinics – three in Hartford and one in Manchester on 335 Broad St., Bristol, New Britain, New London, Norwich, and Willimantic. It is funded by DMHAS and it works with individual adults who need methadone maintenance and detox, and they do not treat families. In fact when the applicant was looking for an office in the Manchester area in 2012, the Hartford Dispensary had asked if the applicant would assist in providing its expertise on integrated family therapy to some of the Hartford Dispensary clients and their families. (http://www.ct.gov/dmhas/cwp/view.asp?a=2902&q=335258)

- **New Hope Manor, Inc.,** 935 Main St., Manchester, has closed. The agency offered behavioral health and substance abuse services in Manchester and the surrounding area.

- **Hockanum Valley Community Council, Inc.,** 27 Naek Rd., Vernon, serves East Hartford, Enfield, Stafford, Vernon, Rockville, Ellington and Tolland.

Furthermore, the already existing agencies (above mentioned OPCAs) are not primarily tailored to the needs of minorities and older adults. In fact there is a great need in the region of mental health services that are primarily customized for young and older adults (2012 Report Statewide Priority Services). The above OPCAs do have some pictures of minorities on their websites and may treat some adult minorities. For example, Hockanum Valley Community Council, Inc., serves 19% African American, 17% Hispanic, 2% Asian and 1% Native American clients, according to Jenifer Gietek, Director of Outpatient Services, yet 58% are Caucasian. Hartford Dispensary serves 6.4% African American and 25.3% Latino clients, according to Russ Buchner, Director of Quality Control, yet 68.3% are Caucasian. Treating some minorities, however, is not what cultural competency is all about.

There is a great need of having an OPCA that truly is minority owned and implements the core principles of cultural competencies that address the social-cultural needs of minorities and seniors and enhance their wellness in line with the core competencies outlined by the American Association of Marriage and Family Therapy (AAMFT, exhibit # 5). These competencies are outcome driven and research centered in order to effectively treat the underserved adults and their families simultaneously. Studies continue to show that although minorities tend to have more mental health issues and greatly need mental health care, often minorities do not receive adequate mental health care timely and effectively. Also, the above mentioned list of OPCAs referenced by OHCA as adequate for the area is incorrect. For example, New Hope Manor in Manchester has been closed. Meanwhile, Hartford Dispensary is more based in Hartford and its services in Manchester are for treating individual adults who are dealing with substance abuses, but the Hartford Dispensary has no integrated systemic treatment of treating an adult and his/her family simultaneously in a systemic social-cultural context that leads to recovery and wellness. But more importantly, people need a choice when deciding on their mental health needs. The absence *of a* wide variety of outpatient psychiatric clinics that are culturally tuned to serve minorities and seniors as well as their families in the Manchester area is one of the major public issues that the applicant is dedicated to effectively address. Often, literature continues to confirm that most of the time minorities either do not effectively seek or utilize mental health treatment where their sense of belonging and trust is limited due to social cultural concerns (Mental Health, Culture, Race & Ethnicity: A report of the USA Surgeon General, Department of Health,1999).

In fact the applicant is not only the first minority mental health agency in Connecticut and Massachusetts, the applicant is the first mental health agency owned by a licensed Marriage and Family Therapist who seeks to treat the whole person and the family units therefore supplementing the already existing OPCA in their traditional approach of treating individual adults and their symptoms only. The above mentioned OPCA, Hartford Dispensary, treats individuals who are dealing with substance abuse or addiction and not the whole family. The applicant provides integrated mental health treatment that is culturally responsive and sensitive to the needs of diverse groups including seniors, young adults, children and families. This approach has been advocated for in Connecticut even in past administrations (Blue Ribbon Commission on Mental Health (2000) because seniors as well as young adults are "often reluctant to connect with recovery programs and social clubs which they perceive as not geared for them" (DMHAS, 2012 Report on Statewide Priority Services, July 15, 2013, p.6).

n addition, the existing OPCAs that OHCA presents to be sufficient for the Manchester area, *lack* integrated services for young adults and seniors. According to DMHAS, there is an acute shortage of age appropriate services for the elderly which include socialization, substance abuse treatment, geriatric psychiatrist and in home care and therapeutic treatment. There is *a* three month waiting period for an appointment with a psychiatrist. "Behavioral services in general are not specialized for older adults" (DMHAS, 2012 Report on Statewide Priority Services, p.8).

Furthermore, the existing OPCAs do not have integrated research components in order to inform their treatment and enhance the clients' sustainable recovery and wellness. Traditionally research in the mental health industry is done by prestigious schools or universities and minorities are often less represented in those studies (Mental Health, Culture, Race & Ethnicity: A report of the USA Surgeon General, Department of Health,1999), and this applies to the Manchester area. That may explain why we have so many minorities and the underserved population as the highest percentage between 38 to 43% of mental health population who are receiving services (Department of Mental Health, Office of Multicultural Affairs Health Disparities Initiatives, 2008).

11. No response.

12. ACCOUNTANT's Report (attached Exhibit 6)

13. No response.

14. No response.

15. There is a clear public need for CT Family Care Services. The report of the Governor's Blue Ribbon Commission on Mental Health cited a gridlock resulting from the closure of four major hospitals and a shortage of appropriate community services available for patients being discharged from acute psychiatric hospital settings. A corresponding gridlock exists or individuals needing acute hospitalization with no available beds. Criminal justice officials, operators of homeless shelters and nursing homes report increasing numbers of people with psychiatric diagnoses entering their facilities. In the North Region or Region 4 which covers the Manchester area that the applicant will be serving, there is still a clear public need for mental health services for minorities, young and older adults. Current issues include: Young adults are less reluctant to connect with recovery programs because they perceive them as not geared for young people. The number of older adults who have medical and mental issues is increasing. Many older adults do not have families to support their growing frailty and the needs associated with that situation. As a result, many older adults find themselves isolated, under socialized and often depressed. The growing numbers of older adults in need of mental health treatment is an indication that "there is not enough outreach by the behavior health system to this population" (DMHAS, 2012 Report on Statewide Priority Services, p. 8). Older adults with behavior issues have a great possibility of becoming homeless, often experience home insecurity, and poverty as the result of ineffective or disjointed community support systems and a shortage of integrated mental health treatment for seniors. When mental health providers and the families of those dealing with mental health issues were surveyed by DMHAS in 2012 (including Region 4), it was reported that there are still waiting lists of about 6-8 weeks or more in order to see a psychiatrist for medication and therapy treatment in an outpatient clinic . There is a shortage of mental health and social services for ex-inmates who become discharged from prisons or the court system and urgently need services and programs including medication and therapy in order to support them and avoid recidivism. The report goes on to highlight the increase of substance use among young and older adults as well as pregnant mothers, a great need for well skilled mental health professionals who are culturally in tune, and provide integrated medical care and behavioral health (pp 8-11). It appears that OHAC was unaware of those needs.

16. ACCOUNTANT: PROPOSAL IS FINANCIALLY FEASIBLE(refer to Accountant report, # 12)

17. At the time of the Commission's report, only about half of the 600,000 adults in Connecticut with mental health problems were receiving any form of publicly or privately funded mental health services. A stigma remains associated with the seeking out and receipt of mental services. For some cultures, the stigma is greater than for others and is a barrier to

the receipt of care and interferes with recovery. The Commission's vision included services that are culturally responsive and sensitive to the needs of diverse groups and individuals. CT-Family Care Services' programs provide exactly this type of service.

The applicant will improve the quality and the cost of effectiveness of healthcare delivery in the region in several ways including:

Cost: The applicant has successfully been enrolled in all state and some major private insurance as indicated earlier in this proposal (refer to number 3). The applicant will bill the insurances at the competitive rates like other already existing OPCA in the region. The applicant presents a unique quality in the social-cultural spiritual components of its treatments found lacking in several OPCAs in the area. The applicant has a special dedication and an appeal to minorities that will address their needs. This will help the state to reach more minorities who will come forward looking for treatments and be treated effectively and timely. That alone will enable people to overcome the cultural stigmas and get treatments timely instead of waiting for a crisis (Mental Health, Culture, Race & Ethnicity, A Report of the USA Surgeon General, Department of Health, 1999). When mental health issues are treated effectively and in a timely fashion, the state, taxpayers and private insurances save millions of dollars annually from the minimizing of prolonged mental health treatments. Treating mental health issues in a timely fashion with a focus on recovery helps the young and older adults to become more effective and productive in their communities. Reports indicate that the mother of Adam Lanza did not want her son to seek mental health treatment. Most probably that mother was in a denial of her own mental health conditions (Hartford Courant Newspaper, December, date. 2013). Additionally, the state will save money because the applicant has an integrated treatment plan and strategies of providing effective brief (three to six months with follow-up) and customized treatments that address the needs of clients and it is imbedded social-cultural-spiritual components needed to enhance client recovery and wellness. Every month and every 3 months the treatment team, client and family will collaborate and evaluate their progress and areas that need to be treated. Then, the treatment plan will be extended for another 3 months. Those who recover and achieve their treatment goals are discharged and assisted for three months in order to sustain their recoveries and succeed in life. Such brief and focused treatment will enable people to recover and move on with life effectively within a short period of time. Keeping clients in weekly treatment for many years and even to five or more years without clear goals moving toward recovery perpetuates the mental health issue resulting in more chronic, more difficult to treat mental health issues.

The applicant will assist unemployed clients in job search or the development of their own business plan. Thus, the treatments are brief and focused for 3, 6, 9, 12 months. If the treatment team, clients, and family determine that the agency can't effectively address a client's needs, then a client will be referred to another agency that may have that expertise. Often minorities are grouped without cultural consideration in the mental health system therefore resulting in a preponderance of minorities remaining among the underserved in the Connecticut Mental Health Service System. Another advantage that the applicant presents is that a percentage of its profits will be dedicated to servicing those who have no insurance due to various social-economic-legal factors such as undocumented pregnant mothers or other adults who are desperately in need of the services. In so doing, the applicant will help the state to bring health access to all residents including the most vulnerable group of people in the region in order that every person is given equal opportunities to enhance their well-being and become effectively productive in society.

The Blue Ribbon Commission included among its recommendations, that OPM, DSS, DCF, and DMHAS address the gridlock and improve cultural competency of mental health service delivery. According to representatives of the Manchester Department of Health, Barbara Quigley and Edward Pikette, the middle class people in the area are in most need of services. These are the families whose health insurances are being cut back or cancelled and they do not qualify for state insurance and are unable to pay out of pocket for private health insurance. Also, they reported that, there is an ever growing population of South Asian and African families who are in need of many services but are met with language and cross-cultural barriers. Finally, Mr. Pikette discussed a barrier to treatment as the long waiting lists for the current treatment providers in the Manchester area. This is supported by a letter written by the Director of The Community Child

Guidance Clinic, Clifford Johnson, who states that "we continue to struggle with limited space to accommodate our increased need to provide services; at this point our building is more than filled with therapists, sometimes having to scramble to find a vacant office to interview families."(www.cgcinc.org/director_message.htm). The population to be served by the applicant is that percentage of the underserved population in the region that either has not yet been reached by the current OPCA or may not be satisfied on how their needs are addressed and hence are looking for better alternatives where they can feel that they have a voice, strengths and a choice to become active participants in their treatment in a social-cultural context to enhance their recovery, wellness and success (Bell-Tolliver, Burges & Brook, 2009).

18. In light of those facts already presented in this proposal as well as in literature, some of the major reasons why minorities do not utilize the already existing mental health services provided by the traditional mental health agencies are: that more often those OPCAs lack treatments that are embedded with social cultural –spiritual values which address minorities' needs and strengthen their sense of feeling belonging, trusted and accepted (DMHAS, 2012 Report on Statewide Priority Services). That is what exactly the applicant is trying to do and in doing that that will increase access of healthcare services to more minorities in the area. For example, it is estimated that the Manchester area has about or over 900 Indian/Asian families. In its study, the applicant found that there are no integrated mental health treatment programs and services for this ethnic group. As a result, the applicant has customized its treatment services and programs for immigrants in order to address their mental health issues as well as cultural adjustment in the USA and in the Manchester region. One of the treatment team members is a Professor, PhD, LMFT, and AAMFT Approved Supervisor from India and another clinician is a female therapist with three Masters degrees in mental health. Another clinician is a professor, PhD, LMFT, and AAMFT Approved Supervisor from Hong Kong/China. The founder of CT-Family Care services, LLC is also an immigrant who holds three Masters Degrees and he is currently a PhD student. The agency does have other clinicians who speak Spanish, English and other languages of the ethnic groups available in the selected area and that is opening doors for minorities to come forward for treatment. The applicant has seasoned clinicians who are culturally diversified, competent and tuned to address the needs of minorities and seniors.

For seniors, the applicant will be providing home therapy, psychiatric services as well as some home health services to those who can't travel to the clinic because of age, lack of transportation, cultural-stigma and uncomfortable feelings. Sometimes some seniors find themselves lonely in their homes with unresolved family problematic or stressful issues which can easily exacerbate the senior's mental health crises. As a part of its systemic approach, the applicant will provide home therapy as well as other related services weekly in a way that enables seniors and their family members to connect often and help resolve their issues and enhance their relationships. Apparently this is not done either sufficiently or not done completely by the majority of the existing OPCAs.

Town	Seniors age 65+	Seniors in need of mental health services – 25%*
Manchester	8,270	2,068
Vernon	4.056	1,014
East Windsor	1,443	361
East Hartford	8,002	2,000
Ellington	1,253	313
Suffield	1,911	478

Sources: U.S. Census Bureau, 2008-2012 American Community Survey, DP03 Selected Economic Characteristics; U.S. Census 2000 and 2010. *Centers for Disease Control, September 2011, http://www.cdc.gov/mentalhealthsurveillance/

19. There are 18,106 adults who could benefit from the applicant's proposal. The CDC in September 2011 indicated that about 25% of the adults in the U.S. have a mental illness, so the applicant used the 25 percent figure to estimate the number of adults with mental illness in the towns below (Centers for Disease Control, September 2011, http://www.cdc.gov/mentalhealthsurveillance/).

Table 4: Number of Adults who May Benefit from the Proposal

Description	Town	Population	% of Adult Population	Number of Adults	Need for the Services	Number of Persons who May Benefit from the Proposal
Mental Health, Adults	Manchester	58,287	25%	14,572	25%	3,643
	East Hartford	51,293		12,823		3,206
	Vernon	29,139		7,285		1,821
	South Windsor	25,729		6,432		1,608
	East Windsor	7,638		1,910		477
	Windsor	22,770		5,693		1,423
	Suffield	10,557		2,639		660
	Ellington	9,665		2,416		604
					Total	**13,442**
Substance Abuse, Adults	Manchester	58,287	8.67%	5,053	25%	1,263
	East Hartford	51,293		4,447		1,112
	Vernon	29,139		2,526		632
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	East Windsor	7,638		662		166
	Windsor	22,770		1,974		494
	Suffield	10,557		915		229
	Ellington	9,665		838		210
					Total	**4,664**
					Grand Total	**18,106**

Sources: U.S. Census, 2000 and 2010; Centers for Disease Control, September 2011, http://www.cdc.gov/mentalhealthsurveillance/

20. The applicant holds that it has provided sufficient evidence that is literature-based (OHCA letter, 12/17/2013, pp # 4) to indicate that the integrated approach embedded with social-cultural values that holistically address clients' needs is vital in order to enhance sustainable recovery and wellness among minorities. That is the new direction recommended to the health care agencies in Connecticut (Governor's Blue Ribbon Committee report, 2000, DMHAS, 2012 Report on Statewide Priority Services, Bell-Tolliver, Burges & Brook, 2009), but the responses have been slow (DMHAS, 2012 Report on Statewide Priority Services). The applicant believes that in line with the literature, the agency has demonstrated the importance of incorporating the social-cultural-spiritual-economic components in mental health treatment in order to treat both the symptoms that bring people to therapy and the hidden social-cultural-medical components that cause or exacerbate mental health problems (Southwick, Gilmartin, McDonough & Morrissey, 2006; McGoldrick et al, 2005). In addition, the applicant does not seek to abandon the traditional approach, but rather to effectively supplement it with what it lacks -- an integrated response that is customized and culturally balanced and responsive to clients' needs for sustainable recovery and wellness as recommended by the state. The following quoted abstracts refer to some concrete historical studies on the utilization of the behavioral health treatment services that support what the applicant is presenting: Outcome driven treatments that treat a client and a family as a whole in an integrated context.

Abstract: Costs of Treating Depression with Individual versus Family Therapy

"Depression is one of the most common concerns that bring clients to treatment. Although marriage and family therapy has been shown to be an effective treatment, little research exists regarding the cost-effectiveness of related services. In this study, we examined claims data for 164,667 individuals diagnosed with depression to determine (a) differences in the cost of treating depression according to type of therapy and license type, (b) differences in recidivism rates by age, gender, type of therapy, and type of mental health professional, and (c) differences in cost-effectiveness by therapy modality and type of professional. The results showed that services provided by marriage and family therapists resulted in the lowest recidivism rate, and family therapy services were the least expensive" (Crane, D.R., Christenson, J.D., Dobbs, S.M., Schaalje, G.B., Moore, A.M., Pedal, F.F.C. et al. (2013).

Abstract: Costs of treating depression with individual versus family therapy. Journal of Marital and Family Therapy.

In an effort to understand how psychotherapy is practiced in the "real world," outpatient claims data were examined to determine the cost of individual and family therapy provided by marital and family therapists, master's nurses, master's social workers, medical doctors, psychologists, or professional counselors. Claims for 490,000 unique persons over 4 years were obtained from CIGNA. Family therapy proved to be substantially more cost-effective than individual or "mixed" psychotherapy. Physicians provided care in the fewest sessions, marital and family therapists had the highest success (86.6%) and lowest recidivism rates (13.4%), and professional counselors were the least costly. Outcomes were overwhelmingly successful, with 85% of patients requiring only one episode of care" (Russell Crane, D. and Payne, S. H. (2011), Individual Versus Family Psychotherapy in Managed Care: Comparing the Costs of Treatment by the Mental Health Professions. Journal of Marital and Family Therapy, 37: 273–289. doi: 10.1111/j.1752-0606.2009.00170.x

Abstract: Toward mutual support: A task analysis of the relational justice approach to infidelity.

"Gender, culture, and power issues are intrinsic to the etiology of infidelity, but the clinical literature offers little guidance on how to work with these concerns. The Relational Justice Approach (RJA) to infidelity (Williams, Family Process, 2011, 50, 516) uniquely places gender and power issues at the heart of clinical change; however, this approach has not been systematically studied. Therefore a qualitative task analysis was utilized to understand how change occurs in RJA. The findings indicated four necessary tasks: (a) creating an equitable foundation for healing, (b) creating space for alternate gender discourse, (c) pursuing relational responsibility of powerful partner, and (d) new experience of mutual support. Therapists' attention to power dynamics that organize couple relationships, leadership in intervening in power processes, and socio-cultural attunement to gender discourses were foundational to this work. These findings help clarify the processes by which mutual healing from the trauma of infidelity may occur and offer empirically based actions that therapists can take to facilitate mutual support" (Williams, K., Galick, A., Knudson-Martin, C. & Huenergardt, D. (2013). Toward mutual support: A task analysis of the relational justice approach to infidelity. Journal of Marital and Family Therapy, 39, 285–298. doi: 10.1111/j.1752-0606.2012.00324.x

Abstract: The impact of the within my reach relationship training on relationship skills and outcomes for low-income individuals. Journal of Marital and Family Therapy.

"A federal grant was awarded to provide the Within My Reach healthy relationships curriculum to low-income, at-risk individuals involved with various social service agencies. The effectiveness of this curriculum was evaluated for 202 participants through measures of training and relationship outcomes pre-, immediately post- and 6 months post training. Participants experienced high levels of training satisfaction; significant increases in knowledge, communication/conflict resolution skills, and relationship quality; as well as a trend in the reduction of relationship violence. An important implication of this research is that MFTs may broaden their service delivery to at-risk individuals by collaborating with community agencies to adapt established relationship enhancement programs, evidence-based tools, and principles that complement traditional couples therapy" (Antle, B., Sar, B., Christensen, D., Karam, E., Ellers, F., Barbee, A. et al. (2013). The impact of the within my reach relationship training on relationship skills and outcomes for low-income individuals. Journal of Marital and Family Therapy, 39, 346–357. doi: 10.1111/j.1752-0606.2012.00314.

Abstract: Creating culturally responsive family therapy models and research: Introducing the use of responsive evaluation as a method

"Models of marriage and family therapy (MFT) typically reflect Western values and norms, and although cultural adaptations are made, many models/frameworks continue to be inappropriate or inadequate for use with non-Western cultures. Worldwide, therapists are examining ways of using MFT models in a culturally sensitive manner, especially when working with clients who are seen as having minority status or perceived as "other" by the dominant group. This essay suggests the use of responsive evaluation as a theoretically consistent methodology for creating and evaluating culturally responsive therapies. This approach rigorously evaluates each unique client/therapist context, culture, power, needs, and beliefs. We describe responsive evaluation and discuss how each component addresses the research needs of examining culturally responsive family therapies. A case illustration is offered delineating the process of conducting culturally

esponsive therapy with a Cambodian sample using solution-focused and narrative therapy" (Seponski, D.M., Bermudez, J.M. & Lewis, D.C. (2013). Creating culturally responsive family therapy models and research: Introducing the use of responsive evaluation as a method. Journal of Marital and Family Therapy, 39, 28–42. doi: 10.1111/j.1752-0606.2011.00282.x.

Abstract: Review of Outcome Research on Marital and Family Therapy in Treatment for Alcoholism. Journal of Marital and Family Therapy

"This review of controlled studies of marital and family therapy (MFT) in alcoholism treatment updates the earlier review by O'Farrell and Fals-Stewart (2003). We conclude that, when the alcoholic is unwilling to seek help, MFT is effective in helping the family cope better and motivating alcoholics to enter treatment. Specifically, both Al-Anon facilitation and referral and spouse coping skills training (based on new findings) help family members cope better, and CRAFT promotes treatment entry and was successfully transported to a community clinic in a new study. Once the alcoholic enters treatment, MFT, particularly behavioral couples therapy (BCT), is clearly more effective than individual treatment at increasing abstinence and improving relationship functioning. New BCT studies showed efficacy with women alcoholics and with gay and lesbian alcoholics, and BCT was successfully transported to a community clinic, a brief BCT version was tested, and BCT was adapted for family members other than spouses. Future studies should evaluate the following: MFT with couples where both members have a current alcohol problem and with minority patients, mechanisms of change, transportability of evidence-based MFT approaches to clinical practice settings, and replication of MFT outcomes of reduced partner violence and improved child functioning." O'Farrell, T. J. and Clements, K. (2012), Review of Outcome Research on Marital and Family Therapy in Treatment for Alcoholism. Journal of Marital and Family Therapy, 38: 122–144. doi: 10.1111/j.1752-0606.2011.00242.x

Abstract: Developing Culturally Competent Marriage and Family Therapists: Treatment Guidelines for Non-\frican American Therapists Working with African-American Families

"To serve African-American families effectively, marriage and family therapists need to develop a level of cultural competence. This content analysis of the relevant treatment literature was conducted to examine the most common expert recommendations for family therapy with African Americans. Fifteen specific guidelines were generated, including orient the family to therapy, do not assume familiarity, address issue of racism, intervene multi-systemically, do home visits, use problem-solving focus, involve religious leader, incorporate the father, and acknowledge strengths. conceptual and empirical support for each guideline is discussed, and conclusions are made regarding culturally competent therapy with African-American families." Bean, R. A., Perry, B. J. and Bedell, T. M. (2002), Developing Culturally Competent Marriage and Family Therapists: Treatment Guidelines for Non-African American Therapists Working with African-American Families. Journal of Marital and Family Therapy, 28: 153–164. doi: 10.1111/j.1752-0606.2002.tb00353.x

Abstract: Spirituality and Relationship: A Holistic Analysis of How Couples Cope With Diabetes.

"This study explores how couples' spirituality and relationship processes holistically interact to inform diabetes management. Qualitative analysis of interviews with 20 heterosexual couples identified five spiritual coping styles based on the spiritual meaning they ascribed to the situation and the nature of their relationships with God and each other: (a) opportunists approach the illness as an opportunity for growth; (b) mutual problem solvers collaborate with their partners to respond to their disease; (c) individualistic problem solvers take personal responsibility for managing their disease; (d) accepters endure their disease; and (e) victims take a hopeless, discouraged approach. Results suggest that spirituality and couple communication and problem-solving patterns appear intertwined and integral to the practice of family therapy" (Cattich, J. and Knudson-Martin, C. (2009), Spirituality and Relationship: A Holistic Analysis of How Couples Cope With Diabetes. Journal of Marital and Family Therapy, 35: 111–124. doi: 10.1111/j.1752-0606.2008.00105.x

\bstract: An Assessment of Family Resiliency Following Hurricane Katrina. Journal of Marital and Family Therapy

"This study explored the role of family characteristics in the coping process of a family after having experienced Hurricane Katrina to gain an understanding of the relationship between family resiliency, hope, family hardiness, and spirituality for survivors of this natural disaster. It was hypothesized that families who demonstrate higher levels of hope, family hardiness, and spirituality would be more likely to effectively cope after the storm. Further, great resource loss was hypothesized to diminish a family's ability to cope. Four hundred fifty-two participants completed the survey. Results indicate a relationship between hope, family hardiness and spirituality, and the criterion variable, family coping. The importance of these findings in terms of exploring family resiliency following a natural disaster is discussed." Hackbarth, M., Pavkov, T., Wetchler, J. and Flannery, M. (2012), Natural Disasters: An Assessment of Family Resiliency Following Hurricane Katrina. Journal of Marital and Family Therapy, 38: 340–351. doi: 10.1111/j.1752-0606.2011.00227.

Abstract: Intervention Research in Couple and Family Therapy: A Methodological and Substantive Review and an Introduction to the Special Issue

"This article serves as an introduction to this third version of research reviews of couple and family therapy (CFT) that have appeared in this journal beginning in 1995. It also presents a methodological and substantive overview of research in couple and family therapy from about 2001/2002 to 2010/2011 (the period covered in this issue), while also making connections with previous research. The article introduces quantitative research reviews of family-based intervention research that appear in this issue on 10 substantive areas including conduct disorder/delinquency, drug abuse, childhood and adolescent disorders (not including the aforementioned), family psycho-education for major mental illness, alcoholism, couple distress, relationship education, affective disorders, interpersonal violence, and chronic illness. The paper also introduces the first qualitative research paper in this series, as well as a paper that highlights current methodologies in meta-analysis. The first part of this article rates the 10 content areas on 12 dimensions of methodological strength for quantitative research and makes generalizations about the state of quantitative methodology in CFT. The latter part of the papers summarizes and makes comments on the substantive findings in the 12 papers in his issue, as well as on the field as a whole" (Sprenkle, D. H. (2012), Intervention Research in Couple and Family Therapy: A Methodological and Substantive Review and an Introduction to the Special Issue. Journal of Marital and Family Therapy, 38: 3–29. doi: 10.1111/j.1752-0606.2011.00271.x

21. The proposal will not result in an unnecessary duplication of existing services in the area. The Blue Ribbon Commission recommended that OPM, DSS, DCF, DMHAS address the programmatic and financial needs of mental health service delivery, and enhance community services for children and adults. Based upon information provided in the Blue Ribbon Commission's Report and the Service Priorities and Recommendations (2012), effective mental services, especially those serving minority populations, either are not sufficiently accessible to the individuals needing treatment or the individuals needing treatment do not perceive them as an option, perhaps due to socio-cultural conflicts. A minority owned treatment program focusing on culturally sensitive avenues for providing a continuity of client-centered services can prove effective for successful recovery. A service such as this would certainly not be duplicative.

Discussion:

In essence, OHCA recommended that the applicant's application for the Certificate of Need (CON) be denied because of two key points (1) the error in the population statistic for one town, thus inflating the number to benefit from the applicant's services, making it seem as if the applicant did not provide "a clear public need" for the adult population and (2) the financial feasibility of the proposal.

The applicant acknowledges that the population for Manchester is 58,287. The applicant had correctly mentioned this figure on p. 7 (OHCA letter) in the mental health section, but a typo occurred in the substance abuse column, stating that Manchester has a population of 141,987. At that time, the applicant did not provide the total population for East Hartford, Vernon and South Windsor. The applicant acknowledges that he used the 2007 data from the Center for Disease Control (CDC) -- instead of the 2011 data in which it is estimated that about 25% of the people in the USA have some form of mental illness. The 2007 data stated that 50% suffer from mental illness. Table 3b has the corrected figures.

Furthermore, it is important to note that for fiscal year 2013, the applicant did not provide services to the 15,422 adult clients as shown on page 9 in the letter from OHCA. One of the reasons was that the applicant obtained the license from the Department of Children and Families in July 12, 2013 and successfully and completely enrolled into insurances such as Husky, Medicaid and Medicare in October and December 2013 (refer to exhibit # 3). The applicant's projection of 15,422 as people in need of its services in 2013 was not far from the current total of 18,106 adults that may benefit from the applicant's services as projected by the applicant in 2014 and beyond, supported by the facts (refer to figure above). As demonstrated in table #4, the 18,106 adults in the selected area of service who may benefit from the applicant's services minus the 16,593 as the total of minorities and low-income in the selected areas of service (refer to figure #3) equals 1,513 people. The applicant hopes that this has resolved OHCA's claim on page 10 (paragraph 1) that the applicant has not provided numbers of how many minorities and low-income adults will benefit from the applicant's proposal. The already existing OPCAs in the area serve less than 10,000 minorities in the area. That means around 8,000 people are not using the existing OPCAs or seeking their traditional approach. Those underserved people need to be given the opportunity to make a choice on where to go for integrated mental health treatment. CT-Family Care Services welcomes them. Figures #3 and 4 clearly demonstrate that.

The financial feasibility of the proposal:

In regard to the financial feasibility of the proposal, please refer to the attached financial report from the applicant's certified public accountant (CPA) who is a member of its advisory committee. The current budget provides a monthly breakdown of the projected income and expenditures for 2014 and 2015. Now that the applicant has started to receive some funds as insurance reimbursement for its services, the applicant's budget demonstrates that the program is worthwhile. It provides needed services to those who need such services. Second, it strengthens clients and their families. Third, the program creates jobs in the area. The agency provides excellent competitive salaries and it attracts seasoned professionals to serve minorities and the underserved population. A good percentage of its net profit is re-invested in the ompany in order to support and strengthen clients and their families. As you see in the budget the proposal makes good economic sense.

Conclusion:

In light of the above-mentioned facts, it is evident that the already existing OPCAs are not sufficient or totally effective in addressing the needs of the underserved population in the region. While the existing OPCAs are dedicated mental health agencies, the OPCAs that the applicant contacted recently acknowledged that there is a need and CT-Family Care Services can serve an important role. The existing OPCAs have not been holistically effective in reaching, retaining and serving in a social-cultural competency context that addresses client wellness.

As the first minority-owned mental health agency and state-certified small business in Connecticut, the applicant brings dedication and social-cultural components that are relevant and urgently needed by the minorities and low -income population in the selected areas. The integrated approach is innovative and has been recommended as the best alternative in the state (Governor Blue Ribbon report), but the approach has not yet been fully implemented in the region. Denying the applicant an opportunity to serve the adults will have several negative effects:

1. It will mean that the 8,000 minorities whose needs are not yet met or even addressed are not important in the community. And if that is the case, then the effects of mental health issues, and the factors that often exacerbate mental health crises such as poverty, delinquency, substance abuse and unhealthy relational dynamics will continue in the area.

2. The applicant is already licensed by the Department of Children and Families in order to provide services to children. Both literature and experience confirm that there is a correlation between the problematic behaviors that we see in children in schools and homes with the relational dynamics among their parents and other adults. Thus, treating children alone without treating the adults will essentially undermine the treatment components of our

program. The applicant seeks to treat both children and their families holistically in their societal context for sustainable recovery. Denying the applicant the opportunity to serve adults undermines the applicant's core mission.

3. Denying the applicant the opportunity to serve the adults will create a hardship even in treatment because in the communities we are already known as dedicated to serving minorities and the low income population. The applicant may have to turn adults away because we can't treat them as adults if the current OHCA is upheld.

4. Meanwhile already existing OPCAs in the area are licensed to provide services to children and adults. It will be the applicant alone that is licensed to provide services to children and not licensed by DPH to provide the services needed to the adults, even when evidence confirms that there is a great need for a minority owned mental health agency that is capable to effectively reach and serve more minorities in need. That creates an unnecessary burden to the applicant. This could deprive many minorities and low-income population the freedom to choose from a variety of mental health agencies. The applicant wants to address their needs holistically in their journey.

5. Fostering innovation and competition are part of the American heritage and when allowed, competition and innovation have served the American people. That has been true with baseball great Jackie Robinson as well as new advancements in information technology and communication. Where creative and dedicated newcomers were allowed to compete, Americans have benefited. Likewise, in the mental health industry, it is time that we allow what has effectively worked in other sectors (innovation and health competition) in order to enhance the wellness of the targeted population. The applicant is the first minority mental health agency in the state. Thus, the applicant should be given the same opportunity to demonstrate its innovation and compete in the mental health industry.

Therefore, the applicant requests that the OHCA decision to deny the applicant the certificate of need (CON), an essential component to obtain the license from DPH, be rescinded and the applicant be allowed to obtain the license and provide services to the adults in needs of the services.

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Exhibit #2

Exhibit #1

DEPARTMENT of CHILDREN and FAMILIES
Making a Difference for Children, Families and Communities

Joette Katz
Commissioner

Dannel P. Malloy
Governor

July 11, 2013

Mr. Justinian Rweyemamu, President
CT Family Care Services, LLC
243 Main Street
Manchester, CT 06042

Re: OPCC License,

Dear Mr. Rweyemamu,

The Department hereby issues the enclosed license to your agency to operate an Outpatient Psychiatric Clinic for Children effective July 12, 2013. This license will remain in effect for a period of time not to exceed twenty-four months.

We want to thank you for your cooperation during the licensing process. Should you have any questions regarding this license please do not hesitate to contact Regulatory Consultant, Terri Bohara, at 860-550-6395, or the undersigned at 860-550-6532.

Sincerely,

Jim McPherson, Program Manager
DCF Licensing Unit
Office of Legal Affairs

STATE OF CONNECTICUT
DEPARTMENT OF CHILDREN AND FAMILIES

This is to certify, that, in accordance with the provisions of Section 17a-20 of the Connecticut General Statutes, as amended, CT FAMILY CARE SERVICES, LLC located at 243 MAIN STREET in the Town of MANCHESTER is hereby licensed as an OUTPATIENT PSYCHIATRIC CLINIC FOR CHILDREN to provide OUTPATIENT PSYCHIATRIC CLINIC SERVICES to children at the locations listed below *.

This license is issued effective JULY 12, 2013 for a period of TWENTY FOUR MONTHS and is conditional upon compliance with all regulations of the Department of Children and Families and may be revoked for cause at any time.

License No. OPCC-70
Signed and dated this 11th day of July, 2013 at Hartford, CT.

James McPherson, Program Manager
Office of Legal Affairs

* 243 Main Street, Manchester, CT

The Commonwealth of Massachusetts

DEPARTMENT OF PUBLIC HEALTH

CLINIC LICENSE

In accordance with the provisions of the General Laws, Chapter 111, Sections 51-56 inclusive, and the regulations promulgated thereunder, a license is hereby granted to:

CT-Family Care Service, LLC
Name of Applicant

for the maintenance of

CT-Family Care Service, LLC, 155 Maple Street, Unit 204, Springfield, MA 01105
Name and Address of Clinic

and Satelites as listed below.

The license is valid until **April 10, 2015**, subject to revocation or suspension, either wholly or with respect to a specific service or specific services, or a part or parts thereof.

SERVICE(S):

- [ ] Medical
- [ ] Surgical
- [ ] Dental
- [X] Mental Health
- [ ] Physical Rehabilitation
- [ ] Substance Abuse
- [ ] Birth Center
- [ ] Mobile Medical
- [ ] Radiology (MRI)
- [ ] Pharmacy
- [ ] Limited Services

Commissioner of Public Health

LICENSE № 4W93

April 11, 2013
Date Issued

POST CONSPICUOUSLY
(SEE REVERSE SIDE FOR ADDITIONAL

Exhibit #3

10/11/2013

CT–FAMILY CARE SERVICES, LLC
243 MAIN STREET
UNIT 4
MANCHESTER, CT 06042–3539

Dear CT–FAMILY CARE SERVICES, LLC:

We are pleased to advise you that in accordance with the Department of Social Services' policy, your application for enrollment in the Connecticut Medical Assistance Program has been approved:

NPI/Non–medical Provider Identifier:	NPI 1174868442
Program Participation:	Clinic Mental Health
AVRS/Initial Web User ID*:	008046953

Based on the information provided on the enrollment application, you are enrolled with the following provider type, specialty, and primary taxonomy, as well as any additional taxonomies you provided. Please notify us in writing on office letterhead should any of these taxonomies change. Billing providers are required to submit claims for reimbursement using your National Provider Identifier (NPI) and taxonomy. If the billing provider is an atypical provider who does not have an NPI, claims must be submitted with the non–medical provider identifier.

Type Description	Specialty Description
Clinic	Mental Health Clinic

Primary Taxonomy	261QM0801X	Clinic/Center – Mental Health (Including Community Mental Health Center)

If you are a billing provider or a performing provider within an organization, the effective date of your Provider Enrollment Agreement is 10/11/2013, and the Provider Enrollment Agreement shall thereafter be in effect until 10/11/2015, unless terminated by either DSS or the Provider prior to the stated ending date. As stated in the Provider Enrollment Agreement, this approval letter containing your enrollment period is incorporated into and made part of your Provider Enrollment Agreement. Please note that you will be required to successfully re–enroll prior to the end date of this application/agreement. Providers who do not successfully re–enroll before that period of time will be dis–enrolled. A letter will be sent notifying you when you are due for re–enrollment.

If you are enrolling as an ordering/prescribing/referring provider only, you will also be required to successfully re–enroll. A letter will be sent notifying you when you are due for re–enrollment.

PLEASE DETACH CHECK AND CASH PROMPTLY

Anthem.

PO Box 533
North Haven CT 06473-0533

64-1278
611 GA

C004206

NO. 2010067831

OCT. 18, 2013

50CTFAMCSCT01

PAY TO THE ORDER OF

CT FAMILY CARE SERVICES LLC
16 ENFIELD AVE
ENFIELD, CT 06082

$*******399.00

Bank of America
Controlled Disbursement
Bank of America, N.A. (329 911 5396)
Atlanta, Dekalb County, Georgia

AUTHORIZED SIGNATURE

Security features included. Details on back.

CHECKING THE ENDORSEMENT

[redacted]

Provider Enrollment Part B Connecticut, PO Box 7149 Indianapolis, IN 46207-7149

December 18, 2013

CT Family Care Services LLC
Attention: Justinian Rweyemamu
Re: John Haney MD
243 Main St Unit 4
Manchester, CT 06042

Case Number: 227401327304420

Dear CT Family Care Services LLC:

We are pleased to inform you that your CMS855R application is approved. Listed below are your National Provider Identifier (NPI) and Provider Transaction Access Number (PTAN).

To start billing, you must use your NPI on all Medicare claim submissions. Because the PTAN is not considered a Medicare legacy identifier, do not report it as an "other" provider identification number to the National Plan and Provider Enumeration System (NPPES).

Your PTAN has been activated and will be the required authentication element for all inquiries to customer service representatives (CSRs), written inquiry units, and the interactive voice response (IVR) system. The IVR allows you to inquire about claims status, beneficiary eligibility and transaction information.

If you plan to file claims electronically, please contact our EDI department at 877-273-4334.

Our files show that the group member(s) is/are employed by CT Family Care Services LLC and PTAN D100102667.

Medicare Enrollment Information

Group Member Name:	John Haney MD
Group Member Effective Date:	07/28/2013
Group Member NPI:	1699719120
Group Member PIN/PTAN:	D400102703

[] Our records indicate that you have an active Medicare enrollment record in the state of . If you no longer intend to practice in that state, you must submit a CMS-855I Voluntary

Exhibit # 4

ATN: 47739

NHIC, Corp.
PO Box 3434
Hingham, MA 02044-3434

August 23, 2013 In any inquiry refer to: 96-13-163-303-000

Justinian Rweyemamu
16 Enfield Ave
Enfield, CT 06082-3606

Dear CT-Family Care Services:

We are pleased to inform you that your Medicare enrollment application is approved. Listed below is the information reflected in your Medicare enrollment record, including your National Provider Identifier (NPI) and Provider Transaction Access Number (PTAN). Your file has been updated in Provider Enrollment, Chain and Organization System (PECOS).

If you plan on filing claims electronically, please contact our EDI department (877) 386-1056 or go to: http://www.medicarenhic.com/ne_prov/edi_index.shtml where you can request a copy of our ***free billing software.*** To start billing with the Medicare program, you must use your NPI on all Medicare claim submissions. Your PTAN is also activated for use and will be the required authentication element for all inquiries to customer service representatives (CSRs), written inquiry units and the Interactive Voice Response (IVR) system for inquiries concerning claims status, beneficiary eligibility and to check status or other supplier related transactions, therefore keep your PTAN secure. Because the PTAN is not considered a Medicare legacy identifier, do not report this identifier to the National Plan and Provider Enumeration System (NPPES) as an "other" provider identification number.

Medicare Enrollment Information

Provider/Supplier Name:	**CT-Family Care Services**
Practice Location:	**155 Maple Street Unit 204, Springfield, MA 01105-**
National Provider Identifier (NPI):	**1174868442**
Active Provider Transaction Access Number (PTAN):	**0033274**
Specialty:	**Group Practice**
You ~~are a~~:	**Non-Participating**
PTAN Effective Date:	**May 23, 2013**

Your request for Electronic Funds Transfer has been completed.

Ralph Cohen is linked to group with PTAN Y0203903.

A CMS Medicare Administrative Contractor

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

MassHealth
The Commonwealth of Massachusetts
Executive Office of Health and Human Services
www.mass.gov/masshealth

DECEMBER 12, 2013

PRV-9008-P
CT-FAMILY CARE SERVICES LLC
155 MAPLE ST STE 204
SPRINGFIELD, MA 01105-1828

PID: 110097795A

NPI: 1174868442

Dear MassHealth Provider:

Your application for participation in MassHealth has been approved. You will receive a copy of the fully executed MassHealth provider contract in a separate mailing. Your MassHealth provider contract is effective 12/12/2013.

Provider Information

NPI: 1174868442

Provider Name: CT-FAMILY CARE SERVICES LLC

155 MAPLE ST STE 204

SPRINGFIELD, MA 01105-1828

Provider Type: MENTAL HEALTH CENTER

Provider Specialty: MENTAL HEALTH CLINIC

Provider Taxonomy: 261QM0801X

Current Programs

Program: MENTAL HEALTH CLINIC

Status: ACTIVE

Please note that MassHealth cannot pay for services provided before the effective date of your approved contract. For information about covered services, service limitations, payment methodology, and other MassHealth information and requirements, refer to the MassHealth provider manual for your provider type. Go to www.mass.gov/masshealthpubs, click on Provider Library, then on MassHealth Provider Manuals. If you cannot find your provider manual on the list provided, e-mail MassHealth Customer Service at providersupport@mahealth.net or call 1-800-841-2900.

Most MassHealth forms that may be necessary to conduct MassHealth business are available for download and printing at www.mass.gov/masshealth. Click Order Provider Publications in the Online Services box on the right side of the screen. You can also request supplies of MassHealth forms by e-mail at providersupport@mahealth.net or by calling MassHealth Customer Service at the phone number listed at the end of this letter.

As required by MassHealth regulations at 130 CMR 450.223(B), you must notify MassHealth of changes in the information submitted on your application, which is reflected in your provider contract, within 14 business days of the change. This includes, but is not limited to, changes to your address, telephone number, licensure and certification information, Medicare provider status (including the addition or deletion of Medicare provider numbers), and ownership information.

You can initiate an update online at www.mass.gov/masshealth/providerservicecenter. For updates that require additional documentation, follow the online instructions.

Sincerely,
MassHealth Provider Enrollment and Credentialing
E-mail: providersupport@mahealth.net
Phone: 1-800-841-2900

Exhibit #5a

American Association for Marriage and Family Therapy
Advancing the Professional Interests of Marriage and Family Therapists

112 South Alfred Street
Alexandria, VA 22314
Telephone: (703) 838-9808
Fax: (703) 838-9805
Website: www.aamft.org

Marriage and Family Therapy Core Competencies©
December, 2004

The marriage and family therapy (MFT) core competencies were developed through a collaborative effort of the American Association for Marriage and Family Therapy (AAMFT) and interested stakeholders. In addition to defining the domains of knowledge and requisite skills in each domain that comprise the practice of marriage and family therapy, the ultimate goal of the core competencies is to improve the quality of services delivered by marriage and family therapists (MFTs). Consequently, the competencies described herein represent the minimum that MFTs licensed to practice independently must possess.

Creating competencies for MFTs and improving the quality of mental health services was considered in the context of the broader behavioral health system. The AAMFT relied on three important reports to provide the framework within which the competencies would be developed: *Mental Health: A Report of the Surgeon General*; the President's New Freedom Commission on Mental Health's *Achieving the Promise: Transforming Mental Health Care in America*; and the Institute of Medicine's *Crossing the Quality Chasm.* The AAMFT mapped the competencies to critical elements of these reports, including IOM's 6 Core Values that are seen as the foundation for a better health care system: 1) Safe, 2) Person-Centered, 3) Efficient, 4) Effective, 5) Timely, and 6) Equitable. The committee also considered how social, political, historical, and economic forces affect individual and relational problems and decisions about seeking and obtaining treatment.

The core competencies were developed for educators, trainers, regulators, researchers, policymakers, and the public. The current version has 128 competencies; however, these are likely to be modified as the field of family therapy develops and as the needs of clients change. The competencies will be reviewed and modified at regular intervals to ensure the competencies are reflective of the current and best practice of MFT.

The core competencies are organized around 6 primary domains and 5 secondary domains. The primary domains are:

1) **Admission to Treatment** – All interactions between clients and therapist up to the point when a therapeutic contract is established.
2) **Clinical Assessment and Diagnosis** – Activities focused on the identification of the issues to be addressed in therapy.
3) **Treatment Planning and Case Management** – All activities focused on directing the course of therapy and extra-therapeutic activities.
4) **Therapeutic Interventions** – All activities designed to ameliorate the clinical issues identified.
5) **Legal Issues, Ethics, and Standards** – All aspects of therapy that involve statutes, regulations, principles, values, and mores of MFTs.
6) **Research and Program Evaluation** – All aspects of therapy that involve the systematic analysis of therapy and how it is conducted effectively.

The subsidiary domains are focused on the types of skills or knowledge that MFTs must develop. These are: a) Conceptual, b) Perceptual, c) Executive, d) Evaluative, and e) Professional.

Although not expressly written for each competency, the stem "Marriage and family therapists..." should begin each. Additionally, the term "client" is used broadly and refers to the therapeutic system of the client/s served, which includes, but is not limited to individuals, couples, families, and others with a vested interest in helping clients change. Similarly, the term "family" is used generically to refer to all people identified by clients as part of their "family system," this would include fictive kin and relationships of choice. Finally, the core competencies encompass behaviors, skills, attitudes, and policies that promote awareness, acceptance, and respect for differences, enhance services that meet the needs of diverse populations, and promote resiliency and recovery.

Domain 1: Admission to Treatment

Number	Subdomain	Competence
1.1.1	Conceptual	Understand systems concepts, theories, and techniques that are foundational to the practice of marriage and family therapy
1.1.2	Conceptual	Understand theories and techniques of individual, marital, couple, family, and group psychotherapy
1.1.3	Conceptual	Understand the behavioral health care delivery system, its impact on the services provided, and the barriers and disparities in the system.
1.1.4	Conceptual	Understand the risks and benefits of individual, marital, couple, family, and group psychotherapy.
1.2.1	Perceptual	Recognize contextual and systemic dynamics (e.g., gender, age, socioeconomic status, culture/race/ethnicity, sexual orientation, spirituality, religion, larger systems, social context).
1.2.2	Perceptual	Consider health status, mental status, other therapy, and other systems involved in the clients' lives (e.g., courts, social services).
1.2.3	Perceptual	Recognize issues that might suggest referral for specialized evaluation, assessment, or care.
1.3.1	Executive	Gather and review intake information, giving balanced attention to individual, family, community, cultural, and contextual factors.
1.3.2	Executive	Determine who should attend therapy and in what configuration (e.g., individual, couple, family, extrafamilial resources).
1.3.3	Executive	Facilitate therapeutic involvement of all necessary participants in treatment.
1.3.4	Executive	Explain practice setting rules, fees, rights, and responsibilities of each party, including privacy, confidentiality policies, and duty to care to client or legal guardian.
1.3.5	Executive	Obtain consent to treatment from all responsible persons.
1.3.6	Executive	Establish and maintain appropriate and productive therapeutic alliances with the clients.
1.3.7	Executive	Solicit and use client feedback throughout the therapeutic process.
1.3.8	Executive	Develop and maintain collaborative working relationships with referral resources, other practitioners involved in the clients' care, and payers.
1.3.9	Executive	Manage session interactions with individuals, couples, families, and groups.
1.4.1	Evaluative	Evaluate case for appropriateness for treatment within professional scope of practice and competence.
1.5.1	Professional	Understand the legal requirements and limitations for working with vulnerable populations (e.g., minors).
1.5.2	Professional	Complete case documentation in a timely manner and in accordance with relevant laws and policies.
1.5.3	Professional	Develop, establish, and maintain policies for fees, payment, record keeping, and confidentiality.

Domain 2: Clinical Assessment and Diagnosis

Number	Subdomain	Competence
2.1.1	Conceptual	Understand principles of human development; human sexuality; gender development; psychopathology; psychopharmacology; couple processes; and family development and processes (e.g., family, relational, and system dynamics).
2.1.2	Conceptual	Understand the major behavioral health disorders, including the epidemiology, etiology, phenomenology, effective treatments, course, and prognosis.
2.1.3	Conceptual	Understand the clinical needs and implications of persons with comorbid disorders (e.g., substance abuse and mental health; heart disease and depression).
2.1.4	Conceptual	Comprehend individual, marital, couple and family assessment instruments appropriate

Number	Subdomain	Competence
		to presenting problem, practice setting, and cultural context.
2.1.5	Conceptual	Understand the current models for assessment and diagnosis of mental health disorders, substance use disorders, and relational functioning.
2.1.6	Conceptual	Understand the strengths and limitations of the models of assessment and diagnosis, especially as they relate to different cultural, economic, and ethnic groups.
2.1.7	Conceptual	Understand the concepts of reliability and validity, their relationship to assessment instruments, and how they influence therapeutic decision making.
2.2.1	Perceptual	Assess each clients' engagement in the change process.
2.2.2	Perceptual	Systematically integrate client reports, observations of client behaviors, client relationship patterns, reports from other professionals, results from testing procedures, and interactions with client to guide the assessment process.
2.2.3	Perceptual	Develop hypotheses regarding relationship patterns, their bearing on the presenting problem, and the influence of extra-therapeutic factors on client systems.
2.2.4	Perceptual	Consider the influence of treatment on extra-therapeutic relationships.
2.2.5	Perceptual	Consider physical/organic problems that can cause or exacerbate emotional/interpersonal symptoms.
2.3.1	Executive	Diagnose and assess client behavioral and relational health problems systemically and contextually.
2.3.2	Executive	Provide assessments and deliver developmentally appropriate services to clients, such as children, adolescents, elders, and persons with special needs.
2.3.3	Executive	Apply effective and systemic interviewing techniques and strategies.
2.3.4	Executive	Administer and interpret results of assessment instruments.
2.3.5	Executive	Screen and develop adequate safety plans for substance abuse, child and elder maltreatment, domestic violence, physical violence, suicide potential, and dangerousness to self and others.
2.3.6	Executive	Assess family history and dynamics using a genogram or other assessment instruments.
2.3.7	Executive	Elicit a relevant and accurate biopsychosocial history to understand the context of the clients' problems.
2.3.8	Executive	Identify clients' strengths, resilience, and resources.
2.3.9	Executive	Elucidate presenting problem from the perspective of each member of the therapeutic system.
2.4.1	Evaluative	Evaluate assessment methods for relevance to clients' needs.
2.4.2	Evaluative	Assess ability to view issues and therapeutic processes systemically.
2.4.3	Evaluative	Evaluate the accuracy and cultural relevance of behavioral health and relational diagnoses.
2.4.4	Evaluative	Assess the therapist-client agreement of therapeutic goals and diagnosis.
2.5.1	Professional	Utilize consultation and supervision effectively.

Domain 3: Treatment Planning and Case Management

Number	Subdomain	Competence
3.1.1	Conceptual	Know which models, modalities, and/or techniques are most effective for presenting problems.
3.1.2	Conceptual	Understand the liabilities incurred when billing third parties, the codes necessary for reimbursement, and how to use them correctly.
3.1.3	Conceptual	Understand the effects that psychotropic and other medications have on clients and the treatment process.
3.1.4	Conceptual	Understand recovery-oriented behavioral health services (e.g., self-help groups, 12-step

Number	Subdomain	Competence
		programs, peer-to-peer services, supported employment).
3.2.1	Perceptual	Integrate client feedback, assessment, contextual information, and diagnosis with treatment goals and plan.
3.3.1	Executive	Develop, with client input, measurable outcomes, treatment goals, treatment plans, and after-care plans with clients utilizing a systemic perspective.
3.3.2	Executive	Prioritize treatment goals.
3.3.3	Executive	Develop a clear plan of how sessions will be conducted.
3.3.4	Executive	Structure treatment to meet clients' needs and to facilitate systemic change.
3.3.5	Executive	Manage progression of therapy toward treatment goals.
3.3.6	Executive	Manage risks, crises, and emergencies.
3.3.7	Executive	Work collaboratively with other stakeholders, including family members, other significant persons, and professionals not present.
3.3.8	Executive	Assist clients in obtaining needed care while navigating complex systems of care.
3.3.9	Executive	Develop termination and aftercare plans.
3.4.1	Evaluative	Evaluate progress of sessions toward treatment goals.
3.4.2	Evaluative	Recognize when treatment goals and plan require modification.
3.4.3	Evaluative	Evaluate level of risks, management of risks, crises, and emergencies.
3.4.4	Evaluative	Assess session process for compliance with policies and procedures of practice setting.
3.4.5	Professional	Monitor personal reactions to clients and treatment process, especially in terms of therapeutic behavior, relationship with clients, process for explaining procedures, and outcomes.
3.5.1	Professional	Advocate with clients in obtaining quality care, appropriate resources, and services in their community.
3.5.2	Professional	Participate in case-related forensic and legal processes.
3.5.3	Professional	Write plans and complete other case documentation in accordance with practice setting policies, professional standards, and state/provincial laws.
3.5.4	Professional	Utilize time management skills in therapy sessions and other professional meetings.

Domain 4: Therapeutic Interventions

Number	Subdomain	Competence
4.1.1	Conceptual	Comprehend a variety of individual and systemic therapeutic models and their application, including evidence-based therapies and culturally sensitive approaches.
4.1.2	Conceptual	Recognize strengths, limitations, and contraindications of specific therapy models, including the risk of harm associated with models that incorporate assumptions of family dysfunction, pathogenesis, or cultural deficit.
4.2.1	Perceptual	Recognize how different techniques may impact the treatment process.
4.2.2	Perceptual	Distinguish differences between content and process issues, their role in therapy, and their potential impact on therapeutic outcomes.
4.3.1	Executive	Match treatment modalities and techniques to clients' needs, goals, and values.
4.3.2	Executive	Deliver interventions in a way that is sensitive to special needs of clients (e.g., gender, age, socioeconomic status, culture/race/ethnicity, sexual orientation, disability, personal history, larger systems issues of the client).
4.3.3	Executive	Reframe problems and recursive interaction patterns.
4.3.4	Executive	Generate relational questions and reflexive comments in the therapy room.
4.3.5	Executive	Engage each family member in the treatment process as appropriate.
4.3.6	Executive	Facilitate clients developing and integrating solutions to problems.

Number	Subdomain	Competence
4.3.7	Executive	Defuse intense and chaotic situations to enhance the safety of all participants.
4.3.8	Executive	Empower clients and their relational systems to establish effective relationships with each other and larger systems.
4.3.9	Executive	Provide psychoeducation to families whose members have serious mental illness or other disorders.
4.3.10	Executive	Modify interventions that are not working to better fit treatment goals.
4.3.11	Executive	Move to constructive termination when treatment goals have been accomplished.
4.3.12	Executive	Integrate supervisor/team communications into treatment.
4.4.1	Evaluative	Evaluate interventions for consistency, congruency with model of therapy and theory of change, cultural and contextual relevance, and goals of the treatment plan.
4.4.2	Evaluative	Evaluate ability to deliver interventions effectively.
4.4.3	Evaluative	Evaluate treatment outcomes as treatment progresses.
4.4.4	Evaluative	Evaluate clients' reactions or responses to interventions.
4.4.5	Evaluative	Evaluate clients' outcomes for the need to continue, refer, or terminate therapy.
4.4.6	Evaluative	Evaluate reactions to the treatment process (e.g., transference, family of origin, current stress level, current life situation, cultural context) and their impact on effective intervention and clinical outcomes.
4.5.1	Professional	Respect multiple perspectives (e.g., clients, team, supervisor, practitioners from other disciplines who are involved in the case).
4.5.2	Professional	Set appropriate boundaries, manage issues of triangulation, and develop collaborative working relationships.
4.5.3	Professional	Articulate rationales for interventions related to treatment goals and plan, assessment information, and systemic understanding of clients' context and dynamics.

Domain 5: Legal Issues, Ethics, and Standards

Number	Subdomain	Competence
5.1.1	Conceptual	Know state, federal, and provincial laws and regulations that apply to the practice of marriage and family therapy.
5.1.2	Conceptual	Know professional ethics and standards of practice that apply to the practice of marriage and family therapy.
5.1.3	Conceptual	Know policies and procedures of the practice setting.
5.1.4	Conceptual	Understand the process of making an ethical decision.
5.2.1	Perceptual	Recognize situations in which ethics, laws, professional liability, and standards of practice apply.
5.2.2	Perceptual	Recognize ethical dilemmas in practice setting.
5.2.3	Perceptual	Recognize when a legal consultation is necessary.
5.2.4	Perceptual	Recognize when clinical supervision or consultation is necessary.
5.3.1	Executive	Monitor issues related to ethics, laws, regulations, and professional standards.
5.3.2	Executive	Develop and assess policies, procedures, and forms for consistency with standards of practice to protect client confidentiality and to comply with relevant laws and regulations.
5.3.3	Executive	Inform clients and legal guardian of limitations to confidentiality and parameters of mandatory reporting.
5.3.4	Executive	Develop safety plans for clients who present with potential self-harm, suicide, abuse, or violence.
5.3.5	Executive	Take appropriate action when ethical and legal dilemmas emerge.
5.3.6	Executive	Report information to appropriate authorities as required by law.

Number	Subdomain	Competence
5.3.7	Executive	Practice within defined scope of practice and competence.
5.3.8	Executive	Obtain knowledge of advances and theory regarding effective clinical practice.
5.3.9	Executive	Obtain license(s) and specialty credentials.
5.3.10	Executive	Implement a personal program to maintain professional competence.
5.4.1	Evaluative	Evaluate activities related to ethics, legal issues, and practice standards.
5.4.2	Evaluative	Monitor attitudes, personal well-being, personal issues, and personal problems to insure they do not impact the therapy process adversely or create vulnerability for misconduct.
5.5.1	Professional	Maintain client records with timely and accurate notes.
5.5.2	Professional	Consult with peers and/or supervisors if personal issues, attitudes, or beliefs threaten to adversely impact clinical work.
5.5.3	Professional	Pursue professional development through self-supervision, collegial consultation, professional reading, and continuing educational activities.
5.5.4	Professional	Bill clients and third-party payers in accordance with professional ethics, relevant laws and polices, and seek reimbursement only for covered services.

Domain 6: Research and Program Evaluation

Number	Subdomain	Competence
6.1.1	Conceptual	Know the extant MFT literature, research, and evidence-based practice.
6.1.2	Conceptual	Understand research and program evaluation methodologies, both quantitative and qualitative, relevant to MFT and mental health services.
6.1.3	Conceptual	Understand the legal, ethical, and contextual issues involved in the conduct of clinical research and program evaluation.
6.2.1	Perceptual	Recognize opportunities for therapists and clients to participate in clinical research.
6.3.1	Executive	Read current MFT and other professional literature.
6.3.2	Executive	Use current MFT and other research to inform clinical practice.
6.3.3	Executive	Critique professional research and assess the quality of research studies and program evaluation in the literature.
6.3.4	Executive	Determine the effectiveness of clinical practice and techniques.
6.4.1	Evaluative	Evaluate knowledge of current clinical literature and its application.
6.5.1	Professional	Contribute to the development of new knowledge.

Exhibit # 5b

CODE OF ETHICS
Effective July 1, 2012

Preamble

The Board of Directors of the American Association for Marriage and Family Therapy (AAMFT) hereby promulgates, pursuant to Article 2, Section 2.01.3 of the Association's Bylaws, the Revised AAMFT Code of Ethics, effective July 1, 2012.

The AAMFT strives to honor the public trust in marriage and family therapists by setting standards for ethical practice as described in this Code. The ethical standards define professional expectations and are enforced by the AAMFT Ethics Committee. The absence of an explicit reference to a specific behavior or situation in the Code does not mean that the behavior is ethical or unethical. The standards are not exhaustive. Marriage and family therapists who are uncertain about the ethics of a particular course of action are encouraged to seek counsel from consultants, attorneys, supervisors, colleagues, or other appropriate authorities.

Both law and ethics govern the practice of marriage and family therapy. When making decisions regarding professional behavior, marriage and family therapists must consider the AAMFT Code of Ethics and applicable laws and regulations. If the AAMFT Code of Ethics prescribes a standard higher than that required by law, marriage and family therapists must meet the higher standard of the AAMFT Code of Ethics. Marriage and family therapists comply with the mandates of law, but make known their commitment to the AAMFT Code of Ethics and take steps to resolve the conflict in a responsible manner. The AAMFT supports legal mandates for reporting of alleged unethical conduct.

The AAMFT Code of Ethics is binding on members of AAMFT in all membership categories, all AAMFT Approved Supervisors and all applicants for membership or the Approved Supervisor designation. AAMFT members have an obligation to be familiar with the AAMFT Code of Ethics and its application to their professional services. Lack of awareness or misunderstanding of an ethical standard is not a defense to a charge of unethical conduct.

The process for filing, investigating, and resolving complaints of unethical conduct is described in the current AAMFT Procedures for Handling Ethical Matters. Persons accused are considered innocent by the Ethics Committee until proven guilty, except as otherwise provided, and are entitled to due process. If an AAMFT member resigns in anticipation of, or during the course of, an ethics investigation, the Ethics Committee will complete its investigation. Any publication of action taken by the Association will include the fact that the member attempted to resign during the investigation.

Principle I
Responsibility to Clients

1. Responsibility to Clients

Marriage and family therapists advance the welfare of families and individuals. They respect the rights of those persons seeking their assistance, and make reasonable efforts to ensure that their services are used appropriately.

1.1 Non-Discrimination. Marriage and family therapists provide professional assistance to persons without discrimination on the basis of race, age, ethnicity, socioeconomic status, disability, gender, health status, religion, national origin, sexual orientation, gender identity or relationship status.

1.2 Informed Consent. Marriage and family therapists obtain appropriate informed consent to therapy or related procedures and use language that is reasonably understandable to clients. The content of informed consent may vary depending upon the client and treatment plan; however, informed consent generally necessitates that the client: (a) has the capacity to consent; (b) has been adequately informed of significant information concerning treatment processes and procedures; (c) has been adequately informed of potential risks and benefits of treatments for which generally recognized standards do not yet exist; (d) has freely and without undue influence expressed consent; and (e) has provided consent that is appropriately documented. When persons, due to age or mental status, are legally incapable of giving informed consent, marriage and family therapists obtain informed permission from a legally authorized person, if such substitute consent is legally permissible.

1.3 Multiple Relationships. Marriage and family therapists are aware of their influential positions with respect to clients, and they avoid exploiting the trust and dependency of such persons. Therapists, therefore, make every effort to avoid conditions and multiple relationships with clients that could impair professional judgment or increase the risk of exploitation. Such relationships include, but are not limited to, business or close personal relationships with a client or the client's immediate family. When the risk of impairment or exploitation exists due to conditions or multiple roles, therapists document the appropriate precautions taken.

1.4 Sexual Intimacy with Current Clients and Others. Sexual intimacy with current clients, or their spouses or partners is prohibited. Engaging in sexual intimacy with individuals who are known to be close relatives, guardians or significant others of current clients is prohibited.

1.5 Sexual Intimacy with Former Clients and Others. Sexual intimacy with former clients, their spouses or partners, or individuals who are known to be close relatives, guardians or significant others of clients is likely to be harmful and is therefore prohibited for two years following the termination of therapy or last professional contact. After the two years following the last professional contact or termination, in an effort to avoid exploiting the trust and dependency of clients, marriage and family therapists should not engage in sexual intimacy with former clients, or their spouses or partners. If therapists engage in sexual intimacy with former clients, or their spouses or partners, more than two years after termination or last professional

contact, the burden shifts to the therapist to demonstrate that there has been no exploitation or injury to the former client, or their spouse or partner.

1.6 Reports of Unethical Conduct. Marriage and family therapists comply with applicable laws regarding the reporting of alleged unethical conduct.

1.7 No Furthering of Own Interests. Marriage and family therapists do not use their professional relationships with clients to further their own interests.

1.8 Client Autonomy in Decision Making. Marriage and family therapists respect the rights of clients to make decisions and help them to understand the consequences of these decisions. Therapists clearly advise clients that clients have the responsibility to make decisions regarding relationships such as cohabitation, marriage, divorce, separation, reconciliation, custody, and visitation.

1.9 Relationship Beneficial to Client. Marriage and family therapists continue therapeutic relationships only so long as it is reasonably clear that clients are benefiting from the relationship.

1.10 Referrals. Marriage and family therapists assist persons in obtaining other therapeutic services if the therapist is unable or unwilling, for appropriate reasons, to provide professional help.

1.11 Non-Abandonment. Marriage and family therapists do not abandon or neglect clients in treatment without making reasonable arrangements for the continuation of treatment.

1.12 Written Consent to Record. Marriage and family therapists obtain written informed consent from clients before videotaping, audio recording, or permitting third-party observation.

1.13 Relationships with Third Parties. Marriage and family therapists, upon agreeing to provide services to a person or entity at the request of a third party, clarify, to the extent feasible and at the outset of the service, the nature of the relationship with each party and the limits of confidentiality.

1.14 Electronic Therapy. Prior to commencing therapy services through electronic means (including but not limited to phone and Internet), marriage and family therapists ensure that they are compliant with all relevant laws for the delivery of such services. Additionally, marriage and family therapists must: (a) determine that electronic therapy is appropriate for clients, taking into account the clients' intellectual, emotional, and physical needs; (b) inform clients of the potential risks and benefits associated with electronic therapy; (c) ensure the security of their communication medium; and (d) only commence electronic therapy after appropriate education, training, or supervised experience using the relevant technology.

Principle II
Confidentiality

2. Confidentiality
Marriage and family therapists have unique confidentiality concerns because the client in a therapeutic relationship may be more than one person. Therapists respect and guard the confidences of each individual client.

2.1 Disclosing Limits of Confidentiality. Marriage and family therapists disclose to clients and other interested parties, as early as feasible in their professional contacts, the nature of confidentiality and possible limitations of the clients' right to confidentiality. Therapists review with clients the circumstances where confidential information may be requested and where disclosure of confidential information may be legally required. Circumstances may necessitate repeated disclosures.

2.2 Written Authorization to Release Client Information. Marriage and family therapists do not disclose client confidences except by written authorization or waiver, or where mandated or permitted by law. Verbal authorization will not be sufficient except in emergency situations, unless prohibited by law. When providing couple, family or group treatment, the therapist does not disclose information outside the treatment context without a written authorization from each individual competent to execute a waiver. In the context of couple, family or group treatment, the therapist may not reveal any individual's confidences to others in the client unit without the prior written permission of that individual.

2.3 Confidentiality in Non-Clinical Activities. Marriage and family therapists use client and/or clinical materials in teaching, writing, consulting, research, and public presentations only if a written waiver has been obtained in accordance with Subprinciple 2.2, or when appropriate steps have been taken to protect client identity and confidentiality.

2.4 Protection of Records. Marriage and family therapists store, safeguard, and dispose of client records in ways that maintain confidentiality and in accord with applicable laws and professional standards.

2.5 Preparation for Practice Changes. In preparation for moving from the area, closing a practice, or death, marriage and family therapists arrange for the storage, transfer, or disposal of client records in conformance with applicable laws and in ways that maintain confidentiality and safeguard the welfare of clients.

2.6 Confidentiality in Consultations. Marriage and family therapists, when consulting with colleagues or referral sources, do not share confidential information that could reasonably lead to the identification of a client, research participant, supervisee, or other person with whom they have a confidential relationship unless they have obtained the prior written consent of the client, research participant, supervisee, or other person with whom they have a confidential relationship. Information may be shared only to the extent necessary to achieve the purposes of the consultation.

2.7 Protection of Electronic Information. When using electronic methods for communication, billing, recordkeeping, or other elements of client care, marriage and family therapists ensure that their electronic data storage and communications are privacy protected consistent with all applicable law.

Principle III
Professional Competence and Integrity

3. Professional Competence and Integrity
Marriage and family therapists maintain high standards of professional competence and integrity.

3.1 Maintenance of Competency. Marriage and family therapists pursue knowledge of new developments and maintain their competence in marriage and family therapy through education, training, or supervised experience.

3.2 Knowledge of Regulatory Standards. Marriage and family therapists maintain adequate knowledge of and adhere to applicable laws, ethics, and professional standards.

3.3 Seek Assistance. Marriage and family therapists seek appropriate professional assistance for their personal problems or conflicts that may impair work performance or clinical judgment.

3.4 Conflicts of Interest. Marriage and family therapists do not provide services that create a conflict of interest that may impair work performance or clinical judgment.

3.5 Veracity of Scholarship. Marriage and family therapists, as presenters, teachers, supervisors, consultants and researchers, are dedicated to high standards of scholarship, present accurate information, and disclose potential conflicts of interest.

3.6 Maintenance of Records. Marriage and family therapists maintain accurate and adequate clinical and financial records in accordance with applicable law.

3.7 Development of New Skills. While developing new skills in specialty areas, marriage and family therapists take steps to ensure the competence of their work and to protect clients from possible harm. Marriage and family therapists practice in specialty areas new to them only after appropriate education, training, or supervised experience.

3.8 Harassment. Marriage and family therapists do not engage in sexual or other forms of harassment of clients, students, trainees, supervisees, employees, colleagues, or research subjects.

3.9 Exploitation. Marriage and family therapists do not engage in the exploitation of clients, students, trainees, supervisees, employees, colleagues, or research subjects.

3.10 Gifts. Marriage and family therapists do not give to or receive from clients (a) gifts of substantial value or (b) gifts that impair the integrity or efficacy of the therapeutic relationship.

3.11 Scope of Competence. Marriage and family therapists do not diagnose, treat, or advise on problems outside the recognized boundaries of their competencies.

3.12 Accurate Presentation of Findings. Marriage and family therapists make efforts to prevent the distortion or misuse of their clinical and research findings.

3.13 Public Statements. Marriage and family therapists, because of their ability to influence and alter the lives of others, exercise special care when making public their professional recommendations and opinions through testimony or other public statements.

3.14 Separation of Custody Evaluation from Therapy. To avoid a conflict of interest, marriage and family therapists who treat minors or adults involved in custody or visitation actions may not also perform forensic evaluations for custody, residence, or visitation of the minor. Marriage and family therapists who treat minors may provide the court or mental health professional performing the evaluation with information about the minor from the marriage and family therapist's perspective as a treating marriage and family therapist, so long as the marriage and family therapist does not violate confidentiality.

3.15 Professional Misconduct. Marriage and family therapists are in violation of this Code and subject to termination of membership or other appropriate action if they: (a) are convicted of any felony; (b) are convicted of a misdemeanor related to their qualifications or functions; (c) engage in conduct which could lead to conviction of a felony, or a misdemeanor related to their qualifications or functions; (d) are expelled from or disciplined by other professional organizations; (e) have their licenses or certificates suspended or revoked or are otherwise disciplined by regulatory bodies; (f) continue to practice marriage and family therapy while no longer competent to do so because they are impaired by physical or mental causes or the abuse of alcohol or other substances; or (g) fail to cooperate with the Association at any point from the inception of an ethical complaint through the completion of all proceedings regarding that complaint.

Principle IV
Responsibility to Students and Supervisees

4. Responsibility to Students and Supervisees

Marriage and family therapists do not exploit the trust and dependency of students and supervisees.

4.1 Exploitation. Marriage and family therapists who are in a supervisory role are aware of their influential positions with respect to students and supervisees, and they avoid exploiting the trust and dependency of such persons. Therapists, therefore, make every effort to avoid conditions and multiple relationships that could impair professional objectivity or increase the risk of exploitation. When the risk of impairment or exploitation exists due to conditions or multiple roles, therapists take appropriate precautions.

4.2 Therapy with Students or Supervisees. Marriage and family therapists do not provide therapy to current students or supervisees.

4.3 Sexual Intimacy with Students or Supervisees. Marriage and family therapists do not engage in sexual intimacy with students or supervisees during the evaluative or training relationship between the therapist and student or supervisee. If a supervisor engages in sexual activity with a former supervisee, the burden of proof shifts to the supervisor to demonstrate that there has been no exploitation or injury to the supervisee.

4.4 Oversight of Supervisee Competence. Marriage and family therapists do not permit students or supervisees to perform or to hold themselves out as competent to perform professional services beyond their training, level of experience, and competence.

4.5 Oversight of Supervisee Professionalism. Marriage and family therapists take reasonable measures to ensure that services provided by supervisees are professional.

4.6 Existing Relationship with Students or Supervisees. Marriage and family therapists avoid accepting as supervisees or students those individuals with whom a prior or existing relationship could compromise the therapist's objectivity. When such situations cannot be avoided, therapists take appropriate precautions to maintain objectivity. Examples of such relationships include, but are not limited to, those individuals with whom the therapist has a current or prior sexual, close personal, immediate familial, or therapeutic relationship.

4.7 Confidentiality with Supervisees. Marriage and family therapists do not disclose supervisee confidences except by written authorization or waiver, or when mandated or permitted by law. In educational or training settings where there are multiple supervisors, disclosures are permitted only to other professional colleagues, administrators, or employers who share responsibility for training of the supervisee. Verbal authorization will not be sufficient except in emergency situations, unless prohibited by law.

Principle V
Responsibility to Research Participants

5. Responsibility to Research Participants
Investigators respect the dignity and protect the welfare of research participants, and are aware of applicable laws, regulations, and professional standards governing the conduct of research.

5. 1 Protection of Research Participants. Investigators are responsible for making careful examinations of ethical acceptability in planning studies. To the extent that services to research participants may be compromised by participation in research, investigators seek the ethical advice of qualified professionals not directly involved in the investigation and observe safeguards to protect the rights of research participants.

5. 2 Informed Consent. Investigators requesting participant involvement in research inform participants of the aspects of the research that might reasonably be expected to influence willingness to participate. Investigators are especially sensitive to the possibility of diminished

consent when participants are also receiving clinical services, or have impairments which limit understanding and/or communication, or when participants are children.

5.3 Right to Decline or Withdraw Participation. Investigators respect each participant's freedom to decline participation in or to withdraw from a research study at any time. This obligation requires special thought and consideration when investigators or other members of the research team are in positions of authority or influence over participants. Marriage and family therapists, therefore, make every effort to avoid multiple relationships with research participants that could impair professional judgment or increase the risk of exploitation.

5.4 Confidentiality of Research Data. Information obtained about a research participant during the course of an investigation is confidential unless there is a waiver previously obtained in writing. When the possibility exists that others, including family members, may obtain access to such information, this possibility, together with the plan for protecting confidentiality, is explained as part of the procedure for obtaining informed consent.

Principle VI
Responsibility to the Profession

6. Responsibility to the Profession
Marriage and family therapists respect the rights and responsibilities of professional colleagues and participate in activities that advance the goals of the profession.

6.1 Conflicts Between Code and Organizational Policies. Marriage and family therapists remain accountable to the AAMFT Code of Ethics when acting as members or employees of organizations. If the mandates of an organization with which a marriage and family therapist is affiliated, through employment, contract or otherwise, conflict with the AAMFT Code of Ethics, marriage and family therapists make known to the organization their commitment to the AAMFT Code of Ethics and attempt to resolve the conflict in a way that allows the fullest adherence to the Code of Ethics.

6.2 Publication Authorship. Marriage and family therapists assign publication credit to those who have contributed to a publication in proportion to their contributions and in accordance with customary professional publication practices.

6.3 Authorship of Student Work. Marriage and family therapists do not accept or require authorship credit for a publication based on research from a student's program, unless the therapist made a substantial contribution beyond being a faculty advisor or research committee member. Co-authorship on a student thesis, dissertation, or project should be determined in accordance with principles of fairness and justice.

6.4 Plagiarism. Marriage and family therapists who are the authors of books or other materials that are published or distributed do not plagiarize or fail to cite persons to whom credit for original ideas or work is due.

6.5 Accuracy in Publication and Advertising. Marriage and family therapists who are the authors of books or other materials published or distributed by an organization take reasonable precautions to ensure that the organization promotes and advertises the materials accurately and factually.

6.6 Pro Bono. Marriage and family therapists participate in activities that contribute to a better community and society, including devoting a portion of their professional activity to services for which there is little or no financial return.

6.7 Advocacy. Marriage and family therapists are concerned with developing laws and regulations pertaining to marriage and family therapy that serve the public interest, and with altering such laws and regulations that are not in the public interest.

6.8 Public Participation. Marriage and family therapists encourage public participation in the design and delivery of professional services and in the regulation of practitioners.

Principle VII
Financial Arrangements

7. Financial Arrangements
Marriage and family therapists make financial arrangements with clients, third-party payors, and supervisees that are reasonably understandable and conform to accepted professional practices.

7.1 Financial Integrity. Marriage and family therapists do not offer or accept kickbacks, rebates, bonuses, or other remuneration for referrals; fee-for-service arrangements are not prohibited.

7.2 Disclosure of Financial Policies. Prior to entering into the therapeutic or supervisory relationship, marriage and family therapists clearly disclose and explain to clients and supervisees: (a) all financial arrangements and fees related to professional services, including charges for canceled or missed appointments; (b) the use of collection agencies or legal measures for nonpayment; and (c) the procedure for obtaining payment from the client, to the extent allowed by law, if payment is denied by the third-party payor. Once services have begun, therapists provide reasonable notice of any changes in fees or other charges.

7.3 Notice of Payment Recovery Procedures. Marriage and family therapists give reasonable notice to clients with unpaid balances of their intent to seek collection by agency or legal recourse. When such action is taken, therapists will not disclose clinical information.

7.4 Truthful Representation of Services. Marriage and family therapists represent facts truthfully to clients, third-party payors, and supervisees regarding services rendered.

7.5 Bartering. Marriage and family therapists ordinarily refrain from accepting goods and services from clients in return for services rendered. Bartering for professional services may be

conducted only if: (a) the supervisee or client requests it; (b) the relationship is not exploitative; (c) the professional relationship is not distorted; and (d) a clear written contract is established.

7.6 Withholding Records for Non-Payment. Marriage and family therapists may not withhold records under their immediate control that are requested and needed for a client's treatment solely because payment has not been received for past services, except as otherwise provided by law.

Principle VIII
Advertising

8. Advertising
Marriage and family therapists engage in appropriate informational activities, including those that enable the public, referral sources, or others to choose professional services on an informed basis.

8.1 Accurate Professional Representation. Marriage and family therapists accurately represent their competencies, education, training, and experience relevant to their practice of marriage and family therapy.

8.2 Promotional Materials. Marriage and family therapists ensure that advertisements and publications in any media (such as directories, announcements, business cards, newspapers, radio, television, Internet, and facsimiles) convey information that is necessary for the public to make an appropriate selection of professional services and consistent with applicable law.

8.3 Professional Affiliations. Marriage and family therapists do not use names that could mislead the public concerning the identity, responsibility, source, and status of those practicing under that name, and do not hold themselves out as being partners or associates of a firm if they are not.

8.4 Professional Identification. Marriage and family therapists do not use any professional identification (such as a business card, office sign, letterhead, Internet, or telephone or association directory listing) if it includes a statement or claim that is false, fraudulent, misleading, or deceptive.

8.5 Educational Credentials. In representing their educational qualifications, marriage and family therapists list and claim as evidence only those earned degrees: (a) from institutions accredited by regional accreditation sources; (b) from institutions recognized by states or provinces that license or certify marriage and family therapists; or (c) from equivalent foreign institutions.

8.6 Correction of Misinformation. Marriage and family therapists correct, wherever possible, false, misleading, or inaccurate information and representations made by others concerning the therapist's qualifications, services, or products.

8.7 Employee or Supervisee Qualifications. Marriage and family therapists make certain that the qualifications of their employees or supervisees are represented in a manner that is not false, misleading, or deceptive.

8.8 Specialization. Marriage and family therapists do not represent themselves as providing specialized services unless they have the appropriate education, training, or supervised experience.

Exhibit #6

Finance Section

CT-Family Care Services, LLC
Monthly Budget for
Six Months Ended June 30, 2014

Income	**January**	**February**	**March**	**April**	**May**	**June**	**Six Month Total**
Individual/Family/Group Therapy and Assessment	$ 65,772	$ 65,772	$ 65,772	$ 65,772	$ 65,772	$ 65,772	$ 394,632
Income Contingency and Insurance Adjustment	(13,154)	(13,154)	(13,154)	(13,154)	(13,154)	(13,154)	(78,926)
Net Income Projection	52,618	52,618	52,618	52,618	52,618	52,618	315,706
Operating Expenses							
Clinincal Payroll	13,552	13,552	14,297	15,117	16,019	17,010	89,547
Administrative Payroll	3,500	6,400	9,900	9,900	9,900	9,900	49,500
Payroll Taxes/Insurance	3,521	4,120	4,997	5,166	5,352	5,557	28,713
Travel/Training	1,332	1,332	1,332	1,332	1,332	1,332	7,992
Office Supplies	210	210	210	210	210	210	1,260
Professional Fees	2,000	2,000	2,000	2,000	2,000	2,000	12,000
Advisory Board Stipend	2,916	2,916	2,916	2,916	2,916	2,916	17,496
Cellphones	250	250	250	250	250	250	1,500
Software & supplies	65	65	65	65	65	65	390
Office Cleaning and Maintenance	1,200	1,200	1,200	1,200	1,200	1,200	7,200
Facilities Rent	1,954	1,954	1,954	1,954	1,954	1,954	11,724
Utilities and Outside Maintenance	392	392	392	292	292	292	2,052
Liability Insurance	667	667	667	667	667	667	4,002
Equipment Repair	167	167	167	167	167	167	1,002
Membership and Subscriptions	29	29	29	29	29	29	174
HIPAA Training	83	83	83	83	83	83	500
Program Supplies and Assessment Tools	1,510	1,510	1,510	1,510	1,510	1,510	9,060
Licensure Training and Fees	800	800	800	800	800	800	4,800
Grant Expense	500	500	500	500	500	500	3,000
Advertising and Publication	833	833	833	833	833	833	4,998
Postage and Mailing	165	165	165	165	165	165	990
Total Operating Expenses	8,300	39,145	44,267	45,156	46,244	47,441	230,554
Excess (Deficit) Income Over Expenses	$ 44,317	$ 13,472	$ 8,350	$ 7,461	$ 6,373	$ 5,177	85,151
Capital Expenditures							27,550
Loan Repayment							20,000
Excess (Deficit) After Capital Expenditures and Loan Repayment							$ 37,601

Income Projected based on 54 one hour sessions per week(27 hours for individual therapy, 27 hours for couple/group/family theropy (ave 6 participants equals 189 billable hours at $87/hr)
at an average rate of $80 per session. Increasing 10%.
Contingency of 20% loss of income due to insurance adjustment or nonpayment.

CT-Family Care Services, LLC
Monthly Budget for
For The Year Ended June 30, 2015

Income	**July**	**August**	**September**	**October**	**November**	**December**	**January**	**February**	**March**	**April**	**May**	**June**	**Year End Total**
Individual/Family/Group Therapy and Assessment	$ 65,772	$ 65,772	$ 65,772	$ 65,772	$ 65,772	$ 65,772	$ 65,772	$ 65,772	$ 65,772	$ 65,772	$ 65,772	$ 65,772	$ 789,264
Income Contingency and Insurance Adjustment	(13,154)	(13,154)	(13,154)	(13,154)	(13,154)	(13,154)	(13,154)	(13,154)	(13,154)	(13,154)	(13,154)	(13,154)	(157,853)
Net Income Projection	52,618	52,618	52,618	52,618	52,618	52,618	52,618	52,618	52,618	52,618	52,618	52,618	631,411
Operating Expenses													
Clinincal Payroll	17,010	17,010	17,010	17,010	17,010	17,010	17,010	17,010	17,010	17,010	17,010	17,010	204,120
Administrative Payroll	9,900	9,900	9,900	9,900	9,900	9,900	9,900	9,900	9,900	9,900	9,900	9,900	118,800
Payroll Taxes/Insurance	5,557	5,557	5,557	5,557	5,557	5,557	5,557	5,557	5,557	5,557	5,557	5,557	66,684
Travel/Training	1,332	1,332	1,332	1,332	1,332	1,332	1,332	1,332	1,332	1,332	1,332	1,332	15,984
Office Supplies	210	210	210	210	210	210	210	210	210	210	210	210	2,520
Professional Fees	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	24,000
Advisory Board Stipend	2,916	2,916	2,916	2,916	2,916	2,916	2,916	2,916	2,916	2,916	2,916	2,916	34,992
Cellphones	250	250	250	250	250	250	250	250	250	250	250	250	3,000
Software & supplies	65	65	65	65	65	65	65	65	65	65	65	65	780
Office Cleaning and Maintenance	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	14,400
Facilities Rent	1,954	1,954	1,954	1,954	1,954	1,954	1,954	1,954	1,954	1,954	1,954	1,954	23,448
Utilities and Outside Maintenance	202	292	292	292	292	392	392	392	392	292	292	292	3,814
Liability Insurance	667	667	667	667	667	667	667	667	667	667	667	667	8,004
Equipment Repair	167	167	167	167	167	167	167	167	167	167	167	167	2,004
Membership and Subscriptions	29	29	29	29	29	29	29	29	29	29	29	29	348
HIPAA Training	83	83	83	83	83	83	83	83	83	83	83	83	996
Program Supplies and Assessment Tools	1,510	1,510	1,510	1,510	1,510	1,510	1,510	1,510	1,510	1,510	1,510	1,510	18,120
Licensure Training and Fees	800	800	800	800	800	800	800	800	800	800	800	800	9,600
Grant Expense	500	500	500	500	500	500	500	500	500	500	500	500	6,000
Advertising and Publication	833	833	833	833	833	833	833	833	833	833	833	833	9,996
Postage and Mailing	165	165	165	165	165	165	165	165	165	165	165	165	1,980
Total Operating Expenses	8,110							47,540	47,540	47,440	47,440	47,440	245,510
Excess (Deficit) Income Over Expenses	$ 44,508							$ 5,078	$ 5,078	$ 5,178	$ 5,178	$ 5,178	70,196
Loan Repayment													20,000
Excess (Deficit) After Capital Expenditures and Loan Repayment													$ 50,196

	Jan	Feb	Mar	Apr	May	June	Total	
Therapy Personnel								
Licensed Therapists	4,212	4,212	4,633	5,097	5,606	6,167	29,927	Currently 4 therapist on staff at rate of $39/hr 27 hrs per month. Increase in c
Therapist/Soc Wkr	3,240	3,240	3,564	3,920	4,312	4,744	23,021	Currently 2 licensed eligible therapist on staff at rate of $30/hr 27 hrs per mo
Licensed Psychiatrist	5,000	5,000	5,000	5,000	5,000	5,000	30,000	Curently 1 licensed psychiatrist on staff at rate of $250/hr 20 hrs per month. I
Licensed APRN	1,100	1,100	1,100	1,100	1,100	1,100	6,600	Curently 1 licensed APRN on staff at rate of $55/hr 20 hrs per month.
Total Therapy Personnel	13,552	13,552	14,297	15,117	16,019	17,010	89,547	
Administrative Payroll								
Office Manager ($20/hr, 30hrs/week)		2,400	2,400	2,400	2,400	2,400	12,000	Currently only administrative employee is interim business manager. Assum
Business Manager ($84,000 annual salary)	3,500	3,500	7,000	7,000	7,000	7,000	35,000	Manager and Receptionist will be hired in second month ofudget year and fu
Receptionist/Billing ($25/hr, 5 hrs/week)		500	500	500	500	500	2,500	third month of budget year.
Total Administrative Payroll	3,500	6,400	9,900	9,900	9,900	9,900	49,500	
Total Payroll	17,052	19,952	24,197	25,017	25,919	26,910	139,047	
Payroll Taxes/Insurance								
Unemployment	512	599	726	751	778	807	4,171	FUTA/SUTA 3% of total payroll.
FICA	1,304	1,526	1,851	1,914	1,983	2,059	10,637	7.65% of total payroll.
Workmen's Compensaiton	1,705	1,995	2,420	2,502	2,592	2,691	13,905	10% of total payroll.
Total Personnel Expenses	3,521	4,120	4,997	5,166	5,352	5,557	28,713	
Travel/Training	1,332	1,332	1,332	1,332	1,332	1,332	7,992	IRS standard rate $.551/2 per mile, 600 per week for travel to 2nd CT office
Office Supplies	210	210	210	210	210	210	1,260	Printer Toner and copier paper
Professional Fees	2,000	2,000	2,000	2,000	2,000	2,000	12,000	Legal and Accounting Fees ($6,000 annual audit and Lawyers $18000)
Advisory Board Stipend	2,916	2,916	2,916	2,916	2,916	2,916	17,496	Stipend of $7,000 for each of the 5 members
Cellphones	250	250	250	250	250	250	1,500	5 leases at $50 per month
Software & supplies	65	65	65	65	65	65	390	
Office Cleaning and Maintenance	1,200	1,200	1,200	1,200	1,200	1,200	7,200	CT location only 15 hours per week at $20/hour
Facilities Rent	1,954	1,954	1,954	1,954	1,954	1,954	11,724	CT locations only at $1,954 per month
Utilities and Outside Maintenance	392	392	392	292	292	292	2,052	Monthly electric and heat plus snow removal for winter months Jan. Feb. Mai
Liability Insurance	667	667	667	667	667	667	4,002	
Equipment Repair	167	167	167	167	167	167	1,002	
Membership and Subscriptions	29	29	29	29	29	29	174	
HIPAA Training	83	83	83	83	83	83	500	Annually training cost $500.
Program Supplies and Assessment Tools	1,510	1,510	1,510	1,510	1,510	1,510	9,060	Supplies $2,800 annually and Assessment Tools $12,000 annually.
Licensure Training and Fees	800	800	800	800	800	800	4,800	Study Guides and Fees for 8 clinicians currently on staff at $600 each
Grant Expense	500	500	500	500	500	500	3,000	Grant writier $6,000 annually
Advertising and Publication	833	833	833	833	833	833	4,998	Expected annual investment in advertising and promotion $10,000
Postage and Mailing	165	165	165	165	165	165	990	
Total Operating Expenses	15,073	15,073	15,073	14,973	14,973	14,973	90,140	
Total Expenses	35,647	39,145	44,267	45,156	46,244	47,441	257,900	

Computer and Electronic Equipment:	
Laptops: 5 x $400	2,000
Desktops: 3 x $600	1,800
Webcams 5 x $40	200
Projector/teleconference screen $600 x 3	1,800
DVDs $50	50
Speakers $20 x 5 = $100	100
Security Videos/carmera& cabinet storages	12,000
Total Computer and Electronic Equipment	17,950
Office Furniture	9,600
Total Capital Expenditures	27,550

Exhibit #7

STATE OF CONNECTICUT
DEPARTMENT OF CHILDREN AND FAMILIES

This is to certify, that, in accordance with the provisions of Section 17a-20 of the Connecticut General Statutes, as amended, CT FAMILY CARE SERVICES, LLC located at 243 MAIN STREET in the Town of MANCHESTER is hereby licensed as an OUTPATIENT PSYCHIATRIC CLINIC FOR CHILDREN to provide OUTPATIENT PSYCHIATRIC CLINIC SERVICES to children at the locations listed below.*

This license is issued effective JULY 12, 2013 for a period of TWENTY FOUR MONTHS and is conditional upon compliance with all regulations of the Department of Children and Families and may be revoked for cause at any time.

License No. OPCC-70
Signed and dated this 11th day of July, 2013 at Hartford, CT.

James McPherson, Program Manager
Office of Legal Affairs

* 243 Main Street, Manchester, CT

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

February 6, 2014

Certified Mail: 7005 0390 0001 3507 1023

IN THE MATTER OF:

An Application for a Certificate of Need filed Pursuant to Section 19a-638, C.G.S. by:	Notice of Final Decision Office of Health Care Access Docket Number: 13-31837-CON
CT-Family Care Services, LLC	Establishment of a Behavioral Health Treatment Center in Manchester

To: Justinian Rweyemamu, MA, M.Div. MS-MFT
CT-Family Care Services, LLC
16 Enfield Ave.
Enfield, CT 06082

Dear Mr. Rweyemamu:

In accordance with the Connecticut General Statutes Section 4-180, the Proposed Final Decision dated December 17, 2013, by Hearing Officer Kevin T. Hansted, Esq., has been adopted by Deputy Commissioner Davis as the decision in this matter. A copy of the decision is attached hereto and incorporated herein.

Kimberly R. Martone
Director of Operations

Enclosure
KRM:KTH:lkg

Copy: Sandra R. Zlokower, Esq.

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

In Re: **CT-Family Care Services, LLC**
Docket Number: 13-31837-CON

FINAL DECISION

On December 17, 2013, a Proposed Final Decision was issued in the above matter pursuant to Section 4-179 of the Connecticut General Statutes.

In accordance with Connecticut General Statutes Section 4-180, the attached Proposed Final Decision dated December 17, 2013, by Hearing Officer Kevin T. Hansted, Esq., is hereby adopted as the final decision of the Deputy Commissioner of the Department of Public Health in this matter. A copy of the Proposed Final Decision is attached hereto and incorporated herein.

WHEREFORE, it is the decision of the Deputy Commissioner that the application of CT-Family Care Services, LLC to establish a Behavioral Health Treatment Center in Manchester, is hereby denied.

2/4/14
Date

Lisa A. Davis, MBA, BSN, RN
Deputy Commissioner

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

Department of Public Health
Office of Health Care Access
Certificate of Need Application

Proposed Final Decision

Applicant: **CT-Family Care Services, LLC**
243 Main Street, Manchester, CT 06042

Docket Number: **13-31837-CON**

Project Title: **Establishment of a Behavioral Health Treatment Center**

Project Description: CT-Family Care Services, LLC ("Applicant") is seeking authorization to establish a behavioral health treatment center at 243 Main Street, Manchester, Connecticut.

Procedural History: The Applicant published notice of its intent to file the Certificate of Need ("CON") application in the *Hartford Courant* on March 21, 22 and 23, 2013. On May 1, 2013, the Office of Health Care Access ("OHCA") received the CON application from the Applicant for the above-referenced project. On May 17, 2013, OHCA deemed the CON application complete.

On June 7, 2013, OHCA notified the Applicant of the date, time and place of the public hearing. On June 8, 2013, a notice to the public announcing the hearing was published in the *Hartford Courant*. Thereafter, pursuant to Connecticut General Statutes ("Conn. Gen. Stat.") § 19a-639a(f), a public hearing regarding the CON application was held on June 26, 2013.

Commissioner Jewel Mullen designated Attorney Kevin T. Hansted as the hearing officer in this matter. The hearing was conducted in accordance with the provisions of the Uniform Administrative Procedure Act (Chapter 54 of the Conn. Gen. Stat.) and Conn. Gen. Stat. § 19a-639a(f).

The public hearing record was closed on August 7, 2013. The Hearing Officer considered all evidence in the record.

Findings of Fact and Conclusions of Law

To the extent the findings of fact actually represent conclusions of law, they should be so considered, and vice versa. *SAS Inst., Inc., v. S & H Computer Systems, Inc.*, 605 F.Supp. 816 (Md. Tenn. 1985).

1. The Applicant was established as a Connecticut limited liability company in 2007 and has three locations: 234 Main St., Manchester, Connecticut; 6 Enfield St., Enfield, Connecticut; and 155 Maple St., Springfield, Massachusetts. Ex. A, pp. 1, 11

2. The Applicant is a consulting company dedicated to serving minorities and low income populations who are underprivileged medically, economically, socially and culturally. Ex. A, p. 11

3. The Applicant is seeking authorization to establish an outpatient behavioral health treatment center at its Manchester location. Ex. A, p. 10

4. Justinian Rweyemamu, M.A., M. Div., MS-MFT, President of CT-Family Care Services, LLC stated that the Applicant provides integrated behavioral health treatment with special focus on serving the underserved, underprivileged and minorities. The Applicant did not define the population groups that are "underprivileged" or "underserved." The Applicant has failed to define the persons that comprise these two groups and therefore the number of persons that may be in need of the Applicant's proposal. The Applicant has proposed supplementing what is lacking in the traditional-biomedical approach and incorporate its Academic-Social-Cultural-Emotional-Spiritual-Economic-Relational ("ASCESER") components to heal the factors that lead to the mental health cycle of problems. While the Applicant submitted several articles concerning integrated treatment for black and Asian racial groups, the information did not offer any discussion as to the benefit of the ASCERER approach to behavioral health treatment over the traditional-biomedical approach.
Ex. A, pp. 11, 240, 252; Transcript of the June 26, 2013, Public Hearing ("Tr."), Testimony of Mr. Rweyemamu, pp. 5, 17, 24

5. The Applicant proposes providing outpatient psychiatric mental health services to children, youth and families, and also outpatient psychiatric mental health services for adults, including individuals, seniors, and veterans. The outpatient psychiatric mental health license will cover home therapy, home care, social services, research and substance abuse services for youth, adults, groups and families. Ex. A, pp. 12, 14, 34, 49, 51, 52, 168, 175, 192; Tr. Testimony of Mr. Rweyemamu, pp. 13, 14

6. The Applicant proposes it will provide services to residents of Manchester, East Hartford, Vernon and South Windsor. Ex. A, pp. 210, 212

7. The Applicant has demonstrated that a need exists for its proposed services within the youth and adolescent segment of the population. In doing so, it describes two schools in Manchester as having overwhelmingly minority students with academic and behavioral problems and insufficient staff to treat students and their families and the same has been assumed for East Hartford, South Windsor and Vernon schools. Using the information

provided for each town's school system by the Connecticut State Department of Education, the Applicant has determined that there are 4,744 youth and adolescents in the service area with unmet need for behavioral health services. The Applicant illustrates the number of youth and adolescents by group and town that may benefit from the proposal:

Table 1: Number of Youth and Adolescents in the Four Town Service Area that May Benefit from the Proposal

Description	Town	Student Population	% of Population*	Number of Youth/ Adoles.	% Needing Services**	Number that May Benefit from the Proposal
Academic Challenges	Manchester	6,884	1.7	117	67%	78
	East Hartford	7,242	4.4	319		213
	Vernon	3,681	3.9	144		96
	South Windsor	4,654	1.6	74		62
					Total	**449**
Problematic Behaviors	Manchester	6,884	16	1,102	67%	735
	East Hartford	7,242	23.7	1,716		1,144
	Vernon	3,681	10.1	372		248
	South Windsor	4,654	16.9	786		524
					Total	**2,651**
Disabilities	Manchester	6,884	13	895	67%	597
	East Hartford	7,242	13.7	992		661
	Vernon	3,681	10.8	398		26
	South Windsor	4,654	11.6	540		360
					Total	**1,644**
					Grand Total	**4,744**

* Based on information reported by the Connecticut State Department of Education, Connecticut Education Data and Research, School Year 2009-10.

** Basis for the Applicant's estimate of need for services not provided.

Ex. A, pp. 211, 218, 219, 281-300

8. While the Applicant has demonstrated a need for its proposed services among the youth and adolescent population within its Proposed Service Area, it has not done so for the adult population.

9. Existing mental health providers in the Manchester area include private, non-profit agencies and private practitioners. The Applicant listed 22 providers in Manchester, 2 providers in Vernon, 5 providers in South Windsor and 2 providers in East Hartford. Ex. A, pp. 43, 44, 216, 217

10. The following table lists the facilities that currently hold the "Outpatient Psychiatric Clinic for Adults" license issued by the Connecticut Department of Public Health and are located in the Applicant's proposed service area:

Table 2: Outpatient Psychiatric Clinics for Adults in Proposed Service Area

Facility Name and Address	Town	Zip Code
InterCommunity, Inc. 287 Main St.	East Hartford	06118
Capitol Region Education Council 474 School St.	East Hartford	06108
Community Health Resources, Inc. 587 East Middle Turnpike	Manchester	06040
Hartford Dispensary 335 Broad St.	Manchester	06040
New Hope Manor, Inc. 935 Main St.	Manchester	06040
Hockanum Valley Community Council, Inc. 27 Naek Rd.	Vernon	06066

Source: Statewide Health Care Facilities and Services Plan, October 2012, Connecticut Department of Public Health, Office of Health care Access
Ex. A, pp. 43, 44, 216, 217

11. The following table lists the facilities that currently hold the "Facility for the Care and Treatment of Substance Abusive or Dependent Persons" licensed issued by the Connecticut Department of Public Health" and are located in the Applicant's proposed service area:

Table 3: Facilities for the Care and Treatment of Substance Abusive or Dependent Persons in Proposed Service Area

Facility Name and Address	Town	Zip Code
Intercommunity Inc. 281 Main St.	East Hartford	06118
Intercommunity Inc. 287 Main St.	East Hartford	06118
Paces Counseling Associates, Inc. 991 Main St.	East Hartford	06108
Community Child Guidance Clinic, Inc. 317 North Main St.	Manchester	06042
Hartford Dispensary 335 Broad St.	Manchester	06040
Community Health Resources 587 East Middle Turnpike	Manchester	06040
New Hope Manor, Inc. 935 Main St.	Manchester	06040
Hockanum Valley Community Council, Inc. 27 Naek Rd.	Vernon	06066

Source: Statewide Health Care Facilities and Services Plan, October 2012, Connecticut Department of Public Health, Office of Health Care Access

12. The Applicant has not submitted any financial statements to support its ability to establish and operate the proposed clinic. Ex. A, p. 64, Ex. A, 193-194

13. OHCA is currently in the process of establishing its policies and standards as regulations. Therefore, OHCA has not made any findings as to this proposal's relationship to any regulations adopted by OHCA. (Conn .Gen. Stat. § 19a-639(a)(1))

14. This CON application is consistent with the overall goals of the Statewide Health Care Facilities and Services Plan. (Conn. Gen. Stat. § 19a-639(a)(2))

15. The Applicant has failed to establish a clear public need for its proposal. (Conn. Gen. Stat. § 19a-639(a)(3))

16. The Applicant has not satisfactorily demonstrated that its proposal is financially feasible. (Conn. Gen. Stat. § 19a-639(a)(4))

17. The Applicant has failed to satisfactorily demonstrate that the proposal would improve the accessibility of health care delivery in the region and has not satisfactorily demonstrated a potential improvement in quality and cost effectiveness. (Conn. Gen. Stat. § 19a-639(a)(5))

18. The Applicant has not shown that there will be an increase in access to the provision of health care services to the relevant populations and payer mix. (Conn. Gen. Stat. § 19a-639(a)(6))

19. The Applicant has not satisfactorily identified the population to be served by the proposal. (Conn. Gen. Stat. § 19a-639(a)(7))

20. The Applicant has not provided any historical utilization of behavioral health treatment services in the service area that would support this proposal. (Conn. Gen. Stat. § 19a-639(a)(8))

21. The Applicant has failed to satisfactorily demonstrate that the proposal will not result in an unnecessary duplication of existing services in the area. (Conn. Gen. Stat.. § 19a-639(a)(9))

Discussion

CON applications are decided on a case by case basis and do not lend themselves to general applicability due to the uniqueness of the facts in each case. In rendering its decision, OHCA considers the factors set forth in General Statutes § 19a-639(a). The Applicant bears the burden of proof in this matter by a preponderance of the evidence. *Jones v. Connecticut Medical Examining Board, 309 Conn. 727 (2013).*

CT-Family Services, LLC is described as a consulting company that is dedicated to serving minorities and low income populations who are underprivileged medically, economically, socially and culturally. *FF 2* The Applicant is seeking authorization to establish an outpatient behavioral health treatment center in Manchester. Ex. A, p. 10. The Applicant proposed providing youth and adult clients with integrated treatment, focusing on serving the underserved, underprivileged and minorities. The Applicant stated that integrated treatment having social, cultural, educational and economic components will supplement what is lacking in the traditional-biomedical approach to treating mental health clients. *FF 4,5* The Applicant stated that the proposal would contribute to the quality of health care delivery in the region by providing treatment that is lacking in the traditional biomedical approach, as the ASCERER approach would provide valuable treatment resources to reduce disparities among the minority and low income populations who are underserved. Ex. A, p. 11, 54.

In support of its proposal, the Applicant reported the number of potential adult clients by town in the following table:

Table 4: Number of Adults in the Four Town Service Area that May Benefit from the Proposal

Description	Town	Adult Population	% of Adult Population	Number of Adults	Need for the services	Number of Persons that May Benefit from the Proposal
Mental Health, Adults	Manchester	58,287	50%	29,144	50%	14,572
	East Hartford	51,293		25,647		12,824
	Vernon	29,139		14,570		7,285
	South Windsor	25,729		12,865		6,433
					Total	**41,114**
Substance Abuse, Adults	Manchester	141,987*	8.67%	12,310	50%	6,155
	East Hartford	**		**		**
	Vernon	**		**		**
	South Windsor	**		**		**
					Total	**6,155**
					Grand Total	**50,269**

* The correct total adult population in Manchester is 58,287 persons.
** Not reported by Applicant.
Ex. A, pp. 218, 219, 223

To prepare Table 4, the Applicant relied upon a fact sheet issued by the Office of Minority Health and Health Disparities of the Centers for Disease Control and Prevention ("CDC") and dated June 5, 2007, to report that 1-in-2 Americans has a diagnosable mental disorder each year, including 44 million adults and 13.7 million children. Ex. A, p. 228. However, a more recent report by the CDC in September 2011 indicates that only about 25% of the adults in the United States have a mental illness. http://www.cdc.gov/mentalhealthsurveillance/ Therefore, the Applicant has overstated its estimate of persons having mental health disorders. The Applicant also claims that there are 6,155 substance abusing or dependent persons in the town of Manchester. This number is also overstated as the Applicant has utilized the incorrect adult population for the calculation. The correct adult population in Manchester is 58,287. Ex. A, p. 45. The Applicant failed to report the number of substance abusing or dependent persons for the remaining towns in the proposed service area.

The projected volumes by group and service type were reported by the Applicant in the following table:

Table 5: Projected Volumes by Population, Service Type and Fiscal Year

Population	Service Type	FY 2013 Persons(sessions)	FY 2014 Persons(sessions)	FY 2015 Persons(sessions)
Students/ youth	Academic disabilities	2,825 (67,800)	3,767 (90,408)	5,540 (132,960)
	Dropout symptoms	654 (15,696)	872 (20,928)	1,282(30,768)
	Behavioral Issues	3,976(95,424)	5,301(127,224)	7,796 (187,104)
	Bullying*	1,932(46,360)	2,576(61,824)	3,788 (90,912)
	Psychiatric Medication	1,500	375	480
Total	**Clients Sessions**	**10,887 (225,280)**	**12,891 (300,384)**	**18,406 (441,744)**
Adults	Integrated Treatment (therapy and social services)	70,994 (1,703,856)	94,657 (2,271,176)	139,201 (3,340,835)
	Job training	6,389 (15,347)	8,519 (204,456)	12,528(300,671)
	Psychiatric medication	1,250 (***)	1,666 (***)	2,450(***)
Veterans	Integrated Treatment (therapy and social services)	9,939(238,536)	13,252(318,048)	19,488(467,717)
Seniors Over 65 years old	Integrated Treatment (therapy and social services)	7,695 (184,680)	10,260(246,240)	15,088 (362,117)
Total**	**Clients Sessions**	**78,633 1,719,203**	**104,842 2,516,208**	**154,179 3,700,300**
Community -reentry	Integrated Individual Treatment	500(12,000)	667 (16,008)	981 (23,544)
	Integrated Treatment for individual and family	300(7,200)	400 (9,600)	588(14,118)
Total **	**Clients Sessions**	**800 19,200**	**1,067 25,608**	**1,569 37,662**
Grand Total**	**Clients Sessions**	**107,954 2,590,896**	**141,937 3,405,896**	**209,210 5,009,546**
Projected Number to Be Served by Applicant ***	***Clients Sessions***	***15,422 (340,986)***	***20,330 (443,645)***	***29,887 (715,649)***

* Students being bullied = 8.6% of students

** Totals are calculated from the clients and sessions reported by the Applicant for each unique population.

*** Applicant projects capturing 1/7 of the potential volume based on 7 clinics in the proposed service area. Ex. A, pp. 219-221 and Ex. K

The Applicant reports that blacks, Hispanics and white low income families are impacted by institutional racism, school dropouts, mental health crises and poverty. However, the Applicant failed to provide evidence as to the number of persons in these distinct population groups that reside within the proposed service area. Ex. A, p. 167.

The Applicant requested authorization to establish a behavioral health clinic for the treatment of youth, adolescents and adults. While the Applicant has sufficiently established the number of youth and adolescents that may benefit from its proposal, it has failed to do the same for the adult population. Without the clear establishment of the populations to which the Applicant is proposing to provide services, the adults' need for the proposed services cannot be determined. *FF 4, 5, 7, 8* The Applicant estimated that it will serve 1-in-7 persons since there are approximately seven clinics in the proposed service area. The Applicant assumed that it will serve every seventh client since there are seven other clinics, yet provided no basis for this assumption. *FF 10*

Moreover, while the Applicant provided much discussion in its proposal, about its desire to provide services to the underprivileged and underinsured, the populations of these groups within the proposed service area have not been reported by the Applicant. *FF 7* Furthermore, the Applicant's reported payer mix projections do not reflect this desire. As shown in Table 6, provided by the Applicant, the percentages begin at 4% for the Medicaid-enrolled clients and self-pay clients in FY 2013 with no projected increase in each of the following two years. In fact, the Applicant's projections indicate a decrease in the amount of Medicare, Medicaid and CHAMPUS and TriCare payers.

Table 6: Patient Population Mix by Payer and Fiscal Year

Payer	FY 2013	FY 2014	FY 2015
Medicare	16%	16%	15%
Medicaid	25%	25%	23%
CHAMPUS & TriCare	25%	25%	22%
Total Government	66%	66%	60%
Commercial Insurers	25%	25%	30%
Uninsured	4%	4%	4%
Workers Compensation	5%	5%	6%
Total Non-government	34%	34%	40%
Grand Total	**100%**	**100%**	**100%**

Ex. A, p. 196

Given the lack of documentation to support the assumptions made by the Applicant in developing the need in the proposed service area for the adult population and, in turn, the projected volume of clients, the Applicant has failed to demonstrate that there is a clear public need for the proposal or whether it would result in a duplication of services in the proposed service area. *FF 9-11*

In addressing certain financial questions, the Applicant projected that its hourly rate for services would be $100 to $150. The Applicant projected that its operating expenses in FY 2013 would be $1,784,272. The Applicant reported its projected revenues and expenditures for the first three fiscal years in the following table:

Table 7: Projected Revenues and Expenditures for the Proposal

Description	FY 2013	FY 2014	FY 2015
Revenue from operations	$1,493,100	$2,012,000	$2,951,750
Grants	350,000	350,000	350,000
Total Revenue	$1,843,100	$2,362,000	$3,301,750
Operating Expenses	1,784,272	2,310,812	3,219,254
Net Revenues prior to taxes	**$ 58,828**	**$ 51,188**	**$ 82,496**

Ex. A, p. 66, 198, 201

As shown in Table 5, the Applicant projected that it would provide 340,986 sessions in its first year of service. Using the Applicant's reported hourly rate of $100 to $150, the projected revenue from operations should be much higher than the reported $1,493,100. The revenues from operations reported for the first three years of service appear to have no relationship to the projected volumes.

In support of its financial stability, the Applicant provided documentation that it has secured a loan for $83,000 and a line of credit of $10,000. Ex. A, p. 194 and Tr. Testimony of Mr. Rweyemamu, p. 18. However, there was no evidence provided to illustrate that this is an adequate amount of funds to support the facility until reimbursements from third-party payers or potential grants become available. Moreover, the Applicant failed to provide financial statements even though the Applicant became a limited liability company in 2007. *FF 1* Due to the Applicant's unexplainable financial projections and the lack of evidence demonstrating financial integrity,the Applicant has failed to show that the proposal is financially feasible.

Although the Applicant provided letters of community support for its proposal (*See,* Applicant Late File 1), since both the application and testimony lacked evidence to substantiate clear public need or the financial feasibility of the proposal, the Applicant has failed to demonstrate that the proposal would improve the accessibility, quality or cost effectiveness of health care delivery in the proposed service area.

Order

Based upon the foregoing Findings and Discussion, I respectfully recommend that the Certificate of Need application of CT-Family Services, LLC to establish a behavioral health treatment center in Manchester, Connecticut, be **DENIED**.

Respectfully submitted,

12/17/13
Date

Kevin T. Hansted
Hearing Officer

* * * COMMUNICATION RESULT REPORT (FEB. 6. 2014 1:30PM) * * *

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FAX SHEET

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FROM: OHCA

DATE: 2/6/14

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NUMBER OF PAGES: 15
(including transmittal sheet

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