CFG HEALTH SYSTEMS, LLC

April 19, 2012

James C. Welch RN, HN-BC
Chief Bureau of Correctional Healthcare Services
Department of Corrections
245 McKee Road
Dover, DE 19904

Dear Mr. James Welch:

Enclosed please find CFG Health System's response to the request for proposal for providing ***Professional Services to provide Correctional Mental Health Services/Substance Abuse Treatment/DUI Programming and Sex Offender Treatment Contract # DOC-1202Mental.*** CFG has extensive experience in the development and provision of behavioral healthcare services in correctional settings.

CFG Health Systems, LLC corporate office is located at 765 East Route 70 Building A-100, Marlton, New Jersey 08053.

The contact person for this proposal is:
Al Campana
Chief Operating Officer
Phone 856.797.4804
acampana@cfgpc.com

CFG Health Systems, LLC acknowledges the contents of the successful proposal may become contractual obligations if a contract ensues. CFG does not take any exceptions to the requirements of the RFP including contractual terms and conditions.

CFG Health Systems, LLC attests to the fact that no activity related to this proposal contract will take place outside of the United States.

Please call if additional information is required Thank you in advance for your consideration of the enclosed proposal.

Sincerely,

Les Paschall
Chief Executive Officer
CFG Health Systems, LLC

765 East Rte. 70, Suite A-101
Marlton, NJ 08053

Phone: 856.983.3900
Fax: 856.810.0169
Web: cfghealthsystems.com

EXECUTIVE SUMMARY

CFG is proud to present this proposal in response to the request for correctional Mental Health, Substance Abuse, Sex Offender and DUI Court-Ordered Programming issued by the State of Delaware Department of Correction (Contract No. DOC-1202Mental). As a recognized and respected leader within the industry, CFG is eager to highlight the many innovations and areas of particular expertise that set CFG above other correctional behavioral healthcare providers.

Headquartered less than one hour's drive from DSAMH's headquarters in New Castle and fewer than two hours from the capital and government in Dover (with plans for opening a regional office in Dover specifically for the use of CFG and sub-contractor Statewide and Regional Directors and support staff associated with this contract upon award), CFG has established itself as a local, comprehensive provider of behavioral health services that is focused on increasing access to high-quality care throughout the communities and regions that it serves.

CFG understands that its services (whether within a correctional facility or any other setting) are part of a larger system of care and a continuum of services. Further, CFG understands that communication and collaboration between the stakeholders within that system is of paramount importance. This philosophy particularly holds true when considering correctional services and the importance of successful re-entry planning and programming. To that end, **CFG is not only familiar with, but an active part of the continuum of behavioral health services within Delaware through its sister company, InSight**, who has partnered with numerous substance abuse clinics, youth service programs and acute care hospitals to offer increased mental health services. Active involvement within the Delaware system of care via collaborative discussion groups hosted by DSAMH, the provision of telepsych services, and consultation with the Delaware Department of Health and Social Services (DHSS) translates to a higher quality of care and far supersedes the impersonal, detached approaches of large contractors far removed. Few providers can boast of similar commitment to the entire system of care.

Several of CFG's active Delaware-based programs specifically focus on the co-occurring substance abuse and mental health needs of Delaware's residents and have brought increased psychiatric evaluation and care into underserved communities. This increased psychiatric capacity is targeted to improve treatment compliance and the overall effectiveness of substance abuse treatments by addressing a more comprehensive picture of the individual consumer, including the increasingly prevalent sub-context to addictions - unmanaged behavioral health issues.

CFG's active partners within the system of care in Delaware include:

- Horizon House of Delaware, Inc.
- Thresholds, Inc.
- Beebe Medical Center

- Kent Sussex Counseling Center
- Brandywine Counseling and Community Services
- Crossroads of Delaware

Additionally, CFG maintains on-going, positive relationships with the following provider agencies within the Delaware system of care:

- Fellowship Human Resources
- Northwestern Human Services (NHS)
- Resources for Human Development (RHD)
- Dover Behavioral Health
- Bayhealth Medical Center (which includes Kent General and Milford Memorial Hospitals)

It is through these affiliations, in particular CFG's work with DSAMH to analyze outcomes data of the psychiatric crisis services of Delaware within all three Counties, that CFG came to know and appreciate the work of Horizon House, Inc. – joining forces prior to this venture to propose oversight of a CAPAC (Crisis and Psychiatric Assessment Center) unit in Ellendale. As a large and well-respected not-for-profit community provider of Substance Abuse services in Delaware, Horizon House has extensive knowledge of community resources available throughout the State. With fundamental understanding of the cardinal role of incisive discharge planning and access to a considerable network of area resources, Horizon House remains CFG's ideal choice as the provider of Substance Abuse services.

CFG feels similarly confident in its choice of providers for both Sex Offender and DUI Programming. CFG has engaged James O'Quinn, D. Min., the most experienced sex offender treatment specialist in the DDOC - with acute and nuanced knowledge of the needs of each respective facility and of the requirements, foresight and overarching goals of the DDOC - as a consultant in the development of this proposal. If awarded the contract, it is CFG's intent to retain Dr. O'Quinn as a full-time CFG employee in the role of Director of Sex Offender Treatment Services.

CFG has also enlisted the services of another Delaware-based specialty provider for the provision of DUI services – Thresholds, Inc. With substantial appreciation of the needs of the DUI population and the resources available for meeting those needs, Thresholds is well-versed and accomplished in creating effective discharge planning within the State of Delaware.

Adding to this formidable line-up is CFG itself. Having a corporate profile that includes an extensive history in behavioral healthcare affords CFG a corporate orientation with a clinical perspective, which allows us to look at care holistically. In addition, key corporate personnel have clinical underpinnings – all have been involved in the provision and management of healthcare for their entire professional careers. Our leadership team includes an envious roster of heavy-hitters, whose deep understandings, insight and abundance of experience provide an overwhelming wealth of clinical and administrative ability upon which the DDOC can readily rely. Our Clinical Director, Dr. Joel Friedman, and Mental

Health Director for Middlesex County, Dr. Dennis Sandrock, have both served as former Mental Health Directors for the State. In addition, Dr. Sandrock has been directly involved in the orientation and annual training of corrections officers in prisons and jails and is a certified police trainer. CFG also employs a number of doctors currently licensed and working in Delaware through CFG's telepsychiatry division – InSight.

CFG's range of experience in correctional mental healthcare includes servicing the entire New Jersey Department of Corrections from 1999 – 2005 for the provision of psychological services at all facilities statewide and for psychiatric services in the Southern facilities. The statewide inmate population at the time of contract was approximately 25,000. (In 2005, a no-bid contract was granted to UMDNJ [University of Medicine and Dentistry of New Jersey]). **CFG currently provides pre-parole evaluations for the entire New Jersey state prison system, with approximately 12,000 evaluations completed per year, and impacts the lives of an additional 9,900 offenders via mental health services provided in correctional facilities throughout New Jersey and Pennsylvania**.

Leadership and Collaboration

CFG, as an entity, acts in dual roles with respect to this contract. Working together with our partners, we serve as a key unit of a team tasked with ensuring the fullest integration of the behavioral care delivery system. Working as Prime Contractor, CFG serves as a single point of accountability for meeting DDOC requirements and contract specifications. In attempting to clearly define the aspects of this duality, CFG has settled upon a structure that invests all contractual and financial responsibility in CFG, while allowing clinical and ethical obligations to be shared among the entire proposal team. While CFG shall assume liability as Prime Contractor, a culture centered around collaboration and common purposes shall exist between CFG and the sub-contractors. Managers and staff at all levels and from all involved organizations shall meet regularly to both oversee and improve service delivery systems; create unified, comprehensive treatment plans; engage in Quality Assurance and Continuous Quality Improvement methodologies that critically assess the integration of the service delivery system; work toward unifying in-service training programs; identify complementary aftercare resources; and share in conscientious and continued case management post-release – building a resource presently lacking in the State of Delaware.

While the strengths of the individual entities coming together in response to the DDOC's solicitation are substantial, the clinical integrity of our management plan ensures the clinical competence of our alliance is even greater than the sum of its individual constituents.

Tracking System

To support our mission to provide a unified, comprehensive treatment planning and delivery system, CFG has budgeted significant dollars for creating a new treatment tracking system or for augmenting either present or prospective data base systems. While this tracking system is meant to neither replace nor serve specifically as an Electronic Health Record (EHR), it would significantly enhance the EHR. The

ultimate purpose of the tracking system is the recording of all aspects of the multidisciplinary treatment plan throughout the entire course of treatment – from initiation through subsequent modifications and on beyond offender release. Extending beyond Aftercare plans, the system would be able to track the details and efficacy of all services and modalities - both in-house and post-incarceration. Successful implementation of such a system, together with cutting-edge CQI programming and conscientious, integrated Case Management represents a confluence of actions for significantly reducing the spectre and likelihood of recidivism, while meeting the Governor of Delaware's 2009 I-ADAPT initiative. The system would also make possible assessment of all forces that drive Delaware prison populations for identification of those offenders at particular risk for re-offense and to collaborate with State agencies for appropriate discharge planning for these parties, as informed by the 2011 Delaware Justice Reinvestment Task Force.

When the right data and data analysis tools are in place, it allows for the careful assessment of all aspects of treatment throughout the continuum of care, the ability to make both major and minor adjustments to specific areas, and affords an accurate means of judging the effectiveness of care provided and systems in place. It also offers a look at areas of treatment where additional interventions and activities can be introduced, keeping offenders continually-engaged in the process of developing more productive coping skills.

Advanced CQI

As mentioned above, CFG utilizes a vanguard CQI process. Traditional CQI focuses upon retrospective review of clinical processes and outcomes. Though recognized as a necessary component of any quality program as a means of monitoring and improving the service delivery system, one of its shortcomings is that it is a static examination of what has happened in the past. With the advent of Electronic Health Records, the potential for implementing a concurrent process for ensuring that effective, appropriate and necessary care is rendered expediently exists, as opposed to merely assessing whether care was or was not administered at some time in the past. The care delivery system is adjusted to oversee care **at the actual points of delivery, in real time** -- instead of relying upon reviewing a synapsis of deficiencies or assessing an archive of failings. A simple example is a CQI process that examines the timing of initial mental health assessments and is able to compare all performance over a period of time to an established and optimal standard. The EHR is a powerful tool for conducting such a study, because it allows for easy measurement of the performance ***as an entire data set*** and not just a review of single, seemingly disparate episodes. CFG's CQI program, in relation to the abilities inherent to the use of an EHR, takes this further by allowing users to review and monitor performance and relevant data **in real time**, through dashboards and automatically-generated Exception Reports, which line staff and managers can use to make real time adjustments.

Under the auspices of CFG's continuous quality improvement programs, we have revised the intake screening process to determine more accurate levels of acuity for Mental Health referral and the

prioritization of care. Weighted questionnaire responses and tiered scores have issued positive responses from staff and have made nursing decision-making more consistent and based upon established factors. Using this identifying tool, staff is better able to respond to the specific behavioral health needs of each inmate effectively, efficiently and expeditiously.

Another innovative component of CFG's CQI program is the extension of the CQI process beyond release in order to assess offender compliance with Aftercare plans ***and*** to review the efficacy of the various community behavioral service agencies themselves.

Telepsychiatry

CFG is also a pioneer the use of telepsychiatry, currently providing over 8,000 telepsychiatric evaluations annually – more than any other provider within the U.S. Through the use of telepsychiatric evaluations, CFG has been able to by-pass the use of crisis centers for immediate admissions. The use of telepsychiatric services has also greatly reduced both the costs and risks associated with inmate transport, along with clinician response time – all while maintaining quality and continuity of care.

In Delaware, CFG has consulted with the Department of Health and Social Services and DSAMH on best practices and the appropriate use of telemedicine from a clinical, operational and technical standpoint.

In this effort, CFG has offered input, shared best practices and given examples related to the appropriate role of telemedicine within the psychiatric commitment process. Specifically, CFG has drawn on its experiences in NJ, PA, MI, NC, SC, FL, DE and VA utilizing telepsychiatry within the commitment process to be a resource to DSAMH in considering revisions to Delaware's commitment regulations. Additionally, CFG has proffered models and regulations from other states that have successfully integrated telepsychiatry for commitments. The result of this interaction has been the on-going drafting of revised regulations for involuntary commitment that would clarify and streamline the appropriate use of telepsychiatry for civil commitments in Delaware. In working to affect policy, CFG is working to affect care that mutually benefits not just patients alone, but also the communities they remain integral parts of and the providers and networks charged with facilitating best care and treatment.

Additionally, CFG has worked with the heads of the DE Division of Medicaid and Medical Assistance and DHSS to draft new reimbursement policies and guidelines for telemedicine services. In doing so, CFG has provided resource material from other states and has participated in the review of the first draft of these policies. At present, this telemedicine reimbursement policy is under further review and is expected to be released shortly.

Budgeting Abstractions

In thorough review of all considerations outlined by the DDOC within the Request for Proposals, CFG realizes that the budget we propose is higher than figures associated with the current contract; however, it should be duly noted that the number of FTE (full-time equivalent) units the DDOC has

requested is substantially higher than those delineated in 2010. Bearing this in mind, CFG is willing to discuss other staffing models and approaches. As one possible alternative, CFG would like to suggest using a cost pass-through model for PCO (Psychiatric Close Observation). CFG's extensive experience in the use of observation staff has taught us that Psychiatric Close Observation is a highly-variable event, subject to many factors not easily predicted or consistently accounted for; consequently, arriving at an accurate set number of full-time equivalent (FTE) units necessary may not necessarily be in the best financial interests of the DDOC. CFG endeavors in all contracts to provide service of the highest caliber at the most reasonable cost.

Conclusion

By virtue of a profusion of commitments, contracts and connections, CFG has grown strong roots in Delaware that continue to thrive and branch out. We offer unparalleled customer service and responsiveness, verifiable with any of our references or contract holders. Through our years of experience in behavioral healthcare settings; a multidisciplinary approach; a team comprised of caring, intuitive and highly-qualified professionals; expanded and novel programs; innovative technological projects; collaborative efforts; and a commitment to community involvement, CFG is uniquely poised to meet the rigorous demands and challenges inherent to correctional behavioral healthcare, especially as they pertain to the DDOC. As a diligent, hard-working provider that has gained intimate understandings of regional nuances and detail, while maintaining the know-how and capability for meeting the needs of a large, unified system, CFG is ideally situated to service this contract with the DDOC.

MANAGEMENT STRUCTURE

ESTABLISHMENT OF PRIME CONTRACTOR

In consideration of all material submitted herein, CFG assumes the role and responsibility of the designated Prime Contractor. All contact and correspondence pertaining to this proposal should be directed solely to CFG. CFG assumes all project management, legal and financial responsibilities, implementation of all systems, performance and contract fulfillment in the agreements established between CFG and its sub-contractors – *Horizon House, Inc.*, and *Thresholds, Inc.* Further, CFG shall remain liable for all damages to the DDOC caused by negligent performance or non-performance of work by any and all sub-contractors. CFG understands that any payments due sub-contractors remain the sole responsibility of CFG as the Primary Vendor.

CONSTRUCTION OF AGREEMENTS

While CFG singularly assumes all contractual, legal and fiscal responsibility as the Prime Contractor, we recognize the inherent need of a college of like-minded individuals for the seamless and optimal integration of all disciplines in creation of truly responsive and cohesive offender behavioral healthcare. The teaming agreements submitted herein represent the first step in working toward firmly establishing CFG as the sole and absolute responsible party, while also recognizing its simultaneous role as one element of a multifaceted system of care delivery. With award of contract, the parties (*Horizon House, Inc.,* and *Thresholds, Inc.*) with whom CFG has struck these teaming agreements for the purpose of proposal submission shall therein become sub-contractors of the Prime Contractor and sole responsible party, CFG. **Formal contracts will follow with award of bid, the outlines of which are included as part of the Teaming Agreements.** Further explanation of the philosophies surrounding CFG's choice of and relationships with sub-contractors are outlined below.

A PARTNERSHIP OF PEERS

In all industries, consideration of corporate strengths needs to be balanced by a candid and objective assessment of limitations. While confident of our many strengths in the provision of Mental Health services within correctional settings, CFG -- in its commitment to offer the best possible services to the Delaware Department of Corrections -- has chosen to partner with three Delaware-based providers of care for Substance Abuse, Sex Offender and DUI Court-Ordered Programming.

In our search for experienced providers of substance abuse services that ascribe to the same high standards CFG sets for itself, we approached and interviewed many prospective affiliates before ultimately selecting Horizon House of Delaware. Recent collaboration on a jointly-submitted proposal

for the Ellendale Crisis and Psychiatric Assessment Center made us intimately familiar with the high-quality of Horizon House's work and eager to expand this working relationship. CFG's confidence in Horizon House is furthered by their integral involvement in the overall system of care within the State of Delaware. Fully-aligned with CFG's philosophy regarding the critical importance of establishing connections and linkages that extend beyond incarceration, Horizon House has demonstrated exemplary initiative evident in its work conducted throughout Delaware and Pennsylvania.

Similar processes guided and fostered working relationships established between James O'Quinn, a Delaware-based Sex Offender Program Coordinator, and Thresholds, Inc., another local organization already embedded deeply within the existing system of care for DUI Court-Ordered Programming.

Relying on its substantial experience in both correctional healthcare and mental healthcare within both County and State correctional systems, CFG has been willing to assume the role of Prime Contractor for all services, bearing ultimate responsibility and accountability for all services provided to the DDOC; however, CFG views this venture and the interwoven relationships created as a "partnership of peers." Based upon respect and integrity, each entity is offered the autonomy and independence to design the best programs possible without adhering to a rigid bureaucracy, structure or pre-formatted design to dictate a standard offering.

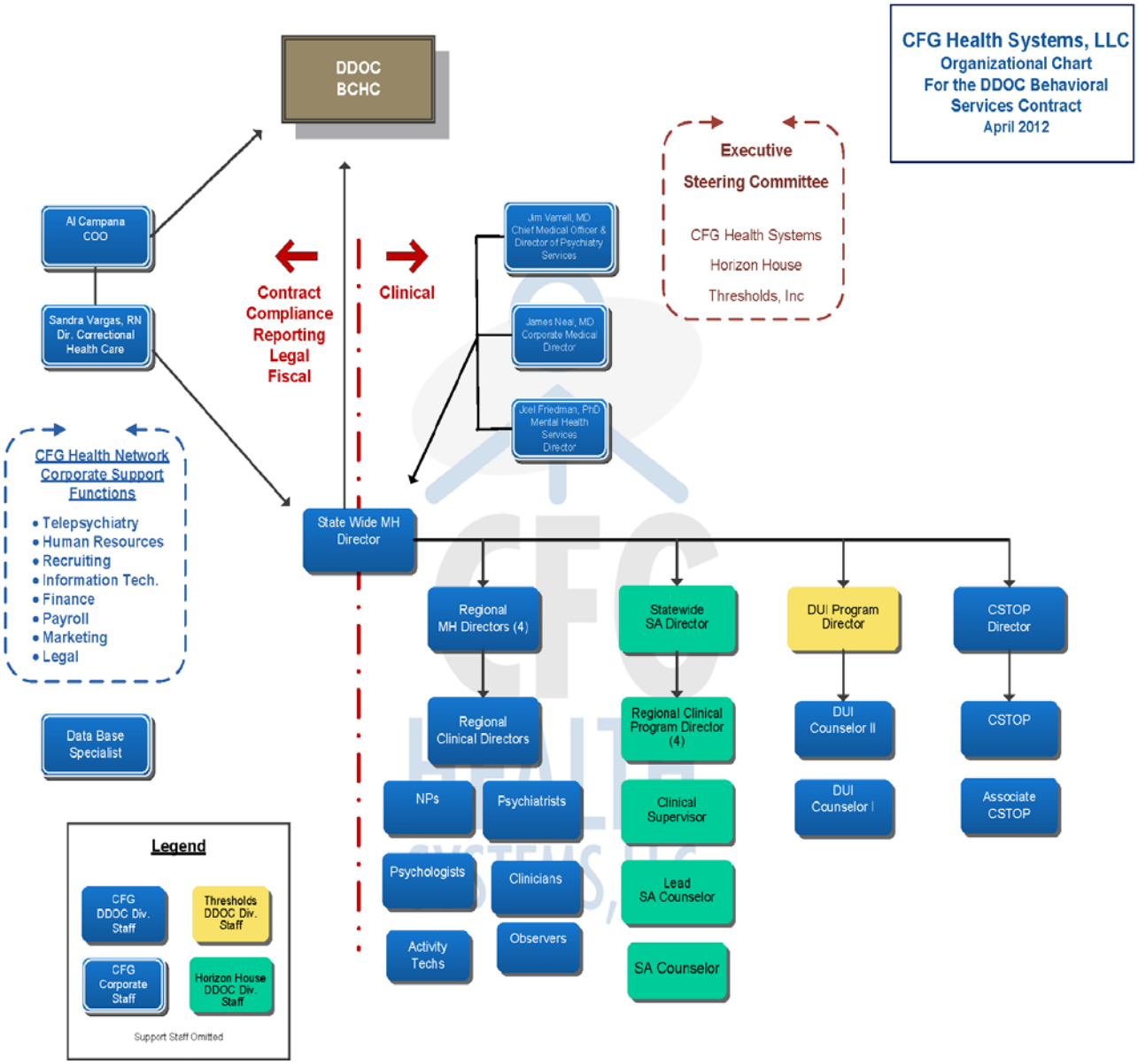
Though viewing autonomy as a necessity in designing best practice clinical protocols and programming, this partnership of peers places great emphasis upon the absolute and uncontested need for open communication and collaboration between the respective disciplines. Mindful of the interrelated roles each member of this team plays and of the direct impact and correlation the integration of services has in affecting clinical outcomes and treatment successes, true coordination of care is considered paramount to success at both a macro and micro level.

Consequently, planning for this proposal was not reduced to divvying up sections of work among discrete and respective groups, but rather focused on introspective discussion of how to build a partnership of consolidated management of all care, centered upon a unified treatment plan that reaches across disciplines.

In planning, the team has identified the need for regular collaborative planning sessions, at both staff and management levels, to fully integrate Quality Assurance and Quality Improvement protocols and to fully understand related measurements. Consistent and regular communication among all parties involved – from staff to program directors to top executives – is vital to achieving integrated services that intersect at multiple points of treatment.

Research demonstrates that the crossover and co-morbidity of issues stemming from mental health, substance abuse and sex offense disorders is such that efforts to assess and treat one without properly managing the other are simply deficient. Secure in the abilities of CFG to lead and of the team of which

it is also a part to effectively treat co-occurring disorders as a unified front, we propose this consolidated response for the consideration of the DDOC.



Initial Teaming Agreement to Develop Treatment Model. If CFG is awarded a contract, Horizon House will enter into a Sub-Contracting Agreement with CFG.

Teaming Agreement

This Teaming Agreement, entered into as of April 23, 2012, by and between CFG Health Systems, LLC, a New Jersey entity, with its principal place of business at: 765 E Route 70 Marlton, NJ 08053 (the "Team Leader"), and Horizon House Delaware, Inc., a Delaware company, with its principal place of business at: 1902A Maryland Avenue, Wilmington, DE 19805 (the "Team Member")

Recitals

WHEREAS, the State of Delaware's Department of Correction ("DDOC") has issued a professional services request for proposal to provide correctional mental health services/substance abuse treatment/DUI programming and sex offender treatment (the "Solicitation"); and

WHEREAS, the DDOC intends to contract with only one "Primary Vendor" which will be solely responsible for the fulfillment of the any obligations resulting from` contract between the DDOC and the Primary Vendor; and

WHEREAS, Team Leader intends to respond to the Solicitation as a Primary Vendor; and

WHEREAS, the Team Leader and the Team Member, (the "Parties"), because of their diverse capabilities, have determined that they would benefit from a Teaming Agreement in responding the Solicitation, and

WHEREAS, the Team Member intends to participate in the response to the Solicitation with the Team Leader with the ultimate goal of serving in a sub-contracting capacity in the event that the DDOC awards a Primary Vendor contract to the Team Leader; and

WHEREAS, the Parties wish to establish a cooperative and supportive team in which each will devote adequate skilled manpower, capital equipment, facilities, and other resources to timely support the objectives of this Teaming Agreement; and

WHEREAS, "Proprietary Information" means technical data, knowledge, patents, marketing data or techniques, cost or pricing information, and ideas that a Party treats as and considers to be unique, valuable, and proprietary, including, without limitation, any information protected under the Trade Secrets Act, 18 U.S.C. § 1905, and information exempt from disclosure under the Freedom of Information Act, 5 U.S.C. §§ 552(b)(3) and (4); and

WHEREAS, the ability of the Parties to competitively respond to the Solicitation and to obtain and perform the proposed contract necessitate the disclosure by each Party to the other of its Proprietary Information; and

WHEREAS, each Party is willing to make its Proprietary Information, as described above, available to the other Party for the limited purpose of competitively responding to the Solicitation; and

WHEREAS, each Party is willing to accept the Proprietary Information received from the other Party in confidence and to hold it in trust for the disclosing Party for use solely and exclusively in connection with competitively responding to the Solicitation, all according to the terms and conditions of this Teaming Agreement; and

WHEREAS, the Team Leader, if it receives a contract as Primary Vendor from the Solicitation, would subcontract the portions of the contract work designated on Exhibit A to the Team Member (the "Subcontract Work"); and

WHEREAS, the Parties wish to enter into this Teaming Agreement to set forth more fully the terms and conditions pursuant to which the Parties will award and perform any contract(s) resulting

therefrom.

NOW, THEREFORE, in consideration of these premises, and in express reliance upon the mutual promises and covenants contained herein, the Parties here agree as follows:

I. Applicability and Relationship of the Parties

A. Applicability:

This Teaming Agreement relates solely and exclusively to the Parties' establishment of and performance as a team with respect to the responses to the Solicitation and to the correlative rights and duties of the Parties within that team.

B. Relationship of the Parties:

1. The Parties agree to work together to fulfill the obligations the Team Leader has committed to in the event that it is awarded one or more contracts in response to the Solicitation. Nothing in this Teaming Agreement shall be construed to grant either the Team Leader or the Team Member the right to make commitments of any kind for or on behalf of the other Party, without the prior written consent of the other Party.

2. The Team Leader shall not perform or subcontract to any other firm other then the Team Member any of the Team Member's Subcontract Work. This Teaming Agreement shall not preclude either Party from competing for, or contracting, independently from the other for any other government or industry program that may develop or arise in the general area of business related to the Solicitation.

3. Team Leader and Team Member shall act as independent contractors in the performance of this Teaming Agreement, and neither Party shall act as agent for or partner of the other Party for any purpose under this Teaming Agreement. The officers and employees of one Party shall not be deemed the employees of the other Party. Nothing in this Teaming Agreement shall be deemed to constitute, create, give effect to, or otherwise recognize a joint venture, partnership, or formal entity of any kind, and the rights and obligations of the Parties shall be limited to those expressly set forth herein. Nothing contained in this Teaming Agreement shall be construed as providing for the sharing of profits or losses arising out of the performance of the contract proposed by the Solicitation. Except as expressly provided herein, neither Party will be liable to the other for any costs, expenses, risks, or liabilities arising out of the other Party's participation in the preparation, submission, or sustaining of competitive proposals under the Solicitation.

IV. Responsibilities of the Parties

A. The Team Leader shall:

1. In a timely manner, furnish to Team Member the Solicitation and any amendments thereto.

2. In a timely manner, keep Team Member fully informed of significant events, deadlines, and milestones regarding the Solicitation.

3. Prepare and submit to DDOC, all proposals and other submissions required or requested, provided however, that any proposal submitted by Team Leader shall identify Team Member as a principal subcontractor to Team Leader and, provided further, however, that Team Leader, as proposal manager, shall make the final determination regarding the form and content of the proposal, including, without limitation:

a. the cost or pricing proposal or information related to prices submitted to the DDOC, subject only to the limitation that Team Leader shall not reduce the price proposed by Team Member for Team Member's proposed contract work without the prior approval of Team Member; and

b. the content of the technical, business management, or other proposals submitted.

4. Maintain responsibility for all contacts and communications with the DDOC and for all decisions

relating to the competitive response to the Solicitation, provided however, that Team Leader shall not unreasonably exclude Team Member from participating in communications with the DDOC regarding the Solicitation.

5. Upon award to Team Leader of any contract resulting from the Solicitation, but subject to Team Member's satisfactory discharge of its antecedent obligations under this Teaming Agreement and except as otherwise agreed upon by the Parties, award to Team Member a subcontract for the Subcontract Work, provided however:

a. that such proposed subcontract shall be subject to the approval of the DDOC;

b. that such proposed subcontract shall be negotiated in good faith by the Parties and shall incorporate the terms of this Teaming Agreement by reference;

c. that such proposed subcontract shall include all clauses required by law, regulation, and such clauses incorporated in Team Leader's prime contract that, by its terms, must be incorporated in subcontracts awarded by Team Leader;

d. that such proposed subcontract shall not include any provision authorizing the termination in whole or in part of the contract work to be performed by Team Member thereunder for the convenience of Team Leader, unless Team Leader's prime contract shall first have been correspondingly terminated, in whole or in part, for convenience, and only if the portion terminated by the DDOC corresponds with the Team Member's share of the contract work;

e. that such proposed subcontract shall not be effective until Team Member executes and submits (where required) to Team Leader all certifications required by law, regulation, the terms of the Team Leader's prime contract, and the Solicitation.

B. The Team Member shall:

1. In a timely manner, respond to all requests by Team Leader for all data and information, including, without limitation, Proprietary Information and any other specifications, designs, process information, cost or pricing information, or information related to prices needed by Team Leader to successfully compete for the contract proposed by the Solicitation.

2. Participate, to the extent deemed necessary or desirable by Team Leader in negotiations, discussions, and other communications with DDOC,

3. Execute and submit to Team Leader all certifications required by law, implementing regulations, the terms of the Team Leaders' prime contract, or the Solicitation.

4. Upon award to Team Leader of a contract by DDOC resulting from the Solicitation, under terms to be mutually agreed accept and perform subcontract(s) for such of the contract work as is required by this Teaming Agreement, provided, however:

a. that such subcontract(s) shall be subject to the conditions set forth in paragraph A. of this Section IV and any other provisions of this Teaming Agreement; and

b. in the event that the Solicitation or the Team Leader's prime contract requires Team Leader to comply with requirements for submission of cost or pricing data, or information related to prices, Team Member shall provide Team Leader the data or information as appropriate. Nothing in this subparagraph or in any other provision of this Teaming Agreement shall be construed as giving one Party the right to audit the books and records of the other Party.

c. Team Member agrees to take responsibility for its cost and pricing data or information related to

prices and hold Team Leader harmless to the full extent of any price or cost reduction effected by the DDOC that may result from: (i) the cost or pricing data or information related to prices submitted or certified by Team Member; or (ii) the failure by Team Member to disclose and consistently follow applicable cost accounting practices and standards or otherwise comply with the Federal laws and regulations.

5. Extend to Team Leader at all times such cooperation as requested by Team Leader to facilitate successful competition for the Solicitation.

V. Proprietary Information

A. Technology Transfer:

1. The Parties shall identify in writing, by appropriate stamp, legend, or otherwise, all such Proprietary Information transferred pursuant to this Teaming Agreement. All such Proprietary Information disclosed under this Teaming Agreement shall remain the property of, and be deemed proprietary to, the disclosing Party. The receiving Party agrees to accept such Proprietary Information in confidence, to accord it the protection required by this Teaming Agreement and such additional protection as the receiving Party customarily accords to its own proprietary information, to hold such Proprietary Information in trust for the disclosing Party, and to use such Proprietary Information solely and exclusively in accordance with the terms of this Teaming Agreement, provided however, that neither Party in its capacity as receiving Party shall be liable for disclosure or use of Proprietary Information if the same:

a. was properly in the public domain at the time it was disclosed,

b. was properly known to and available for use by the receiving Party and recorded as such in its files at the time of receipt from the disclosing Party; or,

c. is proven by the receiving Party to have been independently developed by the receiving Party; or,

d. becomes properly known to and available for use by the receiving Party from a source other than the disclosing Party; or,

e. is disclosed to DDOC in the performance of the obligations of either Party under this Teaming Agreement or under any contract or subcontract resulting from the Solicitation, provided that any such disclosure by the receiving Party is accompanied by such restrictive legends as shall have been affixed thereto or otherwise required by the disclosing Party; or,

f. After expiration of a three (3) year period, which period shall commence upon the date of the last signing of this Teaming Agreement.

2. Subparagraphs A.1.a. through A.1.f. of this Section shall not relieve the receiving Party of restrictions on the use of, or other obligations relating to, Proprietary Information otherwise imposed by this Teaming Agreement unless the receiving Party shall have notified the disclosing Party in writing thirty (30) days before a proposed use or disclosure of Proprietary Information that the receiving Party regards as authorized by one or more of such subparagraphs. The burden of proof with respect to the applicability of any such subparagraph to any proposed use or disclosure of Proprietary Information by the receiving Party shall be upon the receiving Party.

3. Should the receiving Party be faced with legal action or a requirement under government regulations to disclose any of the disclosing Party's Proprietary Information, the receiving Party shall immediately notify the disclosing Party. Upon the disclosing Party's request, the receiving Party shall cooperate fully with the disclosing Party, at disclosing Party's expense, if the disclosing Party elects to

contest such disclosure. Except in connection with a failure in the discharge of responsibilities set forth in the preceding sentence, the receiving Party shall not be liable in damages for any disclosure of Proprietary Information pursuant to judicial decree or government regulation.

B. Use of Proprietary Information:

1. With respect to Proprietary Information disclosed by one Party to another:

a. the Parties agree that each shall retain ownership of their respective Proprietary Information and that the other Party shall not acquire any rights therein, except the right to use such Proprietary Information to the extent provided in this Teaming Agreement.

b. the receiving Party is hereby granted a limited, irrevocable, non-exclusive, royalty-free, non-transferable, worldwide right and license to use the disclosing Party's Proprietary Information according to the terms of this Teaming Agreement.

c. except as otherwise provided in this Teaming Agreement, no Proprietary Information disclosed pursuant to this Teaming Agreement shall be made available by the receiving Party to any third party for any purpose, provided, however, that such Proprietary Information may be disclosed by the Receiving Party to an actual or prospective subcontractor concerning the Solicitation where such disclosure is necessary for the performance of the receiving Party's share of the contract work and provided, further, however, that such disclosure shall not be made without: (i) the prior written approval of the disclosing Party, (ii) an express written agreement of the actual or prospective subcontractor to comply, for the benefit of the disclosing Party, with all restrictions on the use of such Proprietary Information as are imposed upon the receiving Party pursuant to this Teaming Agreement, and (iii) the express written agreement of the receiving Party to indemnify the disclosing Party for any violation or breach of such restrictions by the actual or prospective subcontractor.

d. no Proprietary Information disclosed pursuant to this Teaming Agreement shall be used, duplicated, or disclosed for any purposes not authorized by this Teaming Agreement without the prior written approval of the disclosing Party. Proprietary Information may be disseminated to and used only by officers and employees of the receiving Party where and to the extent required in connection with the Solicitation, and then upon conditions that are consistent with this Section V.B. If the Proprietary Information is reproduced in whole or in part, the reproduction shall carry a proprietary notice or legend similar to that which appears on the original.

2. In the event this Teaming Agreement is terminated, the receiving Party shall cease to make use of the Proprietary Information received from the disclosing Party and, upon the disclosing Party's written request, shall promptly destroy or return such Proprietary Information. In the event that the disclosing Party requests destruction, the receiving Party shall provide written certification of the destruction within thirty (30) days of such request, provided however, that such Proprietary Information may continue to be used by the receiving Party for such time as may be required to compete for, and solely for the purpose of competing for, the contract proposed by the Solicitation.

3. The rights, duties and obligations of the Parties with respect to all Proprietary Information disclosed before the date of this Agreement in contemplation of the execution of this Agreement shall be as set forth in this Section.

C. Rights in Inventions:

1. Any inventions conceived by employees or contractors of either Party while performing work

pursuant to this Teaming Agreement and any patents arising from such inventions shall remain the sole property of the Party employing such employee or contractor.

VI. Termination

Except as otherwise expressly provided herein, this Teaming Agreement shall expire upon one of the following events, whichever shall occur first:

A. Written notice from DDOC that they will not award a contract pursuant to the Solicitation.

B. Written notice from DDOC of award of a contract to a firm other than the Team Leader.

C. Execution of a subcontract by and between the Team Leader and the Team Member for performance of the Subcontract Work.

D. Dissolution hereof by mutual written agreement of the Team Leader and Team Member.

E. If either Party files a petition under any chapter of the Bankruptcy Act, 11 U.S.C. §§ 101 et seq., an involuntary petition under that Act is filed against either Party, a Party commences an action in any country under laws providing for the relief of winding up of insolvent or liquidating persons or entities, or files for the appointment of a receiver or becomes insolvent, and such matters are not discharged or relieved within sixty (60) days.

F. Cancellation of the Solicitation or substantial changes thereto making it undesirable for the Team Leader to submit a proposal supported by a teaming agreement.

G. Debarment or suspension of either Party by competent authority, if such debarment or suspension precludes the participation by such Party in pursuing this Teaming Agreement, or indictment of either Party in any criminal proceeding related to doing business with a public entity as a prime contractor or subcontractor.

H. The expiration of twelve (12) months from the date of this Teaming Agreement; provided, however, this Teaming Agreement shall be extended for one (1) additional year if DDOC has not provided written notice as to contract award within the twelve-month period.

VII. Laws and Regulations

The Team Leader and the Team Member agree to comply with all applicable federal, state, and local laws and regulations, and all applicable orders and regulations of the executive and other departments, agencies, and instrumentalities of the United States Government. The Team Leader and the Team Member agree to indemnify one another against any loss, cost, damage, or liability by reason of the other Party's violation of this Section.

VIII. Publicity

Regardless whether or not restrictions are imposed by the DDOC, each Party agrees not to release any publicity or information concerning the Solicitation or this Teaming Agreement without the prior written approval of the other, which approval shall not be unreasonably withheld.

IX. Disputes

A. The Parties shall exercise their best efforts to settle any claim, controversy, or dispute (hereinafter collectively called "Disputes") concerning questions of fact or law arising out of or relating to this Teaming Agreement or to performance of either Party hereunder, or to the threatened, alleged or actual breach thereof by either Party, including without limitation any claim, controversy or Dispute concerning the determination (in accordance with the provisions of this Teaming Agreement) of the

share of the proposed contract work, or the price, or terms and conditions of any subcontract to be awarded to Team Member by Team Leader.

B. If the Parties are unable to resolve the Dispute within thirty (30) calendar days from the date that either Party is informed in a writing from the other Party that a Dispute exists, the Dispute shall be settled by binding arbitration administered by the American Arbitration Association under its Commercial Arbitration Rules, and judgment on the award rendered by the arbitrators may be entered in any court having jurisdiction thereof.

1. Either Party may initiate an arbitration proceeding by the filing of a demand for arbitration with the American Arbitration Association. A panel of three (3) arbitrators shall be selected to hear and resolve the controversy, with one (1) arbitrator selected by each Party and the third arbitrator selected by the Parties following the procedures set forth in the then current Commercial Arbitration Rules of the American Arbitration Association; provided, however, that if either Party fails to select an arbitrator within thirty (30) days after the arbitration is initiated, the American Arbitration Association shall select an arbitrator on behalf of such Party. Any arbitrator appointed by a Party to this Teaming Agreement shall not be an officer or employee of, consultant for, or otherwise associated with the Party appointing him.

2. Unless an oral hearing is waived in writing by both Parties, the arbitrators shall hold a hearing on the Dispute to be arbitrated. Such hearings shall be held at such time and place as the arbitrators shall determine. The arbitrators shall have the authority to require the presence as a witness at the arbitration proceedings of any current officer or employee of either Party. Except as provided in paragraph B.3, the arbitrators shall provide opportunity to each Party to be present, to be fully heard, by counsel or otherwise, and to cross-examine.

3. The Parties expressly agree that any arbitration hereunder may proceed in the absence of any Party who, after due notice, fails to be represented at such arbitration or to obtain an adjournment thereof, and that, in such event, an award may be made based solely upon the evidence submitted by the Party who is present.

4. The authority of the arbitrators shall be to make a decision with respect to the Dispute in accordance with the provisions of this Teaming Agreement under the applicable law identified in Section XII., "Applicable Law," of this Teaming Agreement. The arbitrators shall not have the power to add to or modify any of the provisions of this Teaming Agreement; provided, however that this provision shall not prevent, in any appropriate case, the interpretation and construction by the arbitrators of the applicable provisions of this Teaming Agreement to the extent necessary to apply such provisions to the Dispute. The arbitrators may issue a decree of specific performance, an injunction, or award compensatory monetary damages. The arbitrators shall not be empowered to issue an award for punitive damages. Each Party shall be responsible for paying all costs and expenses of the arbitrator selected by it and its own attorneys' fees and expert witnesses' fees. All other costs and expenses of the arbitration proceedings, including the fees and expenses of the arbitrator and the cost of transcripts, shall be shared equally by the Parties hereto.

5. All decisions of the arbitrators shall be in writing, shall set forth detailed findings of fact and conclusions of law, and shall be issued to the Parties within thirty (30) calendar days (or such longer period as in the opinion of a majority of the arbitrators may be necessary) after any hearings have been completed and any time allowed for the filing of briefs has elapsed. A signed copy of such decision shall be delivered to each Party.

6. The written decision rendered by a majority of the arbitrators shall be final, binding, and conclusive

upon the Parties unless determined by a court of competent jurisdiction to have been fraudulent, capricious, arbitrary, so grossly erroneous as a matter of law as necessarily to imply bad faith or not be supported by substantial evidence. Judgment upon an award rendered by the arbitrators may be entered in any court of competent jurisdiction.

7. Either Party shall be permitted to resolve all aspects of the Dispute in a single proceeding, and shall not be required to institute additional proceedings to resolve matters that remain in Dispute during continued performance of this Teaming Agreement.

C. Except as otherwise specifically provided in this paragraph C., neither Party shall institute any action or proceeding against the other Party in any court with respect to any Dispute that is or could be the subject of a claim or proceeding pursuant to this Section.

1. The Parties acknowledge that the remedies available to them under this Teaming Agreement, or that would otherwise be available at law, will be inadequate in case of any default or threatened default in the performance of the Parties' respective obligations under this Section and that such obligations shall be specifically enforceable by a decree for the specific performance or by an injunction against any actual or threatened violation thereof.

2. The Parties further acknowledge that the remedies available to them under this Teaming Agreement, or which would otherwise be available at law, will be inadequate in case of any default or threatened default in the performance of the Parties' respective obligations under Section V., "Proprietary Information." Accordingly, the Parties agree that notwithstanding any other provisions of this Teaming Agreement, the rights of the Parties under that Section shall be specifically enforceable by a decree of specific performance, or by an injunction against any violation of its terms, or otherwise.

D. The Parties shall proceed diligently with the performance of this Teaming Agreement pending the resolution of any Dispute that is subject to this Section.

X. Severability

If any term, provision, covenant, or condition of this Teaming Agreement is held invalid or unenforceable for any reason, the remainder of the provisions shall continue in full force and effect as if this Teaming Agreement had been executed with the invalid portion thereof eliminated.

XI. Applicable Law

This Teaming Agreement and all of its amendments entered into after the date of this Teaming Agreement, no matter their place of negotiation, execution, or performance, will be governed by the laws then in effect in the State of with venue of any legal or equitable actions relating to this Teaming Agreement in the State of New Jersey.

XII. Change in Financial Condition

If either Party experiences a material change in its financial condition at any time after the effective date of this Teaming Agreement, the other Party shall be notified in writing of the change at the time the change occurs or is identified. Failure to notify the other Party of a material change in financial condition will be deemed a breach of this Teaming Agreement.

XIII. Assignment

Neither Party shall assign, sell, transfer, or in any way encumber its interest under this Teaming Agreement without obtaining prior written consent of the other Party hereto.

XIV. Amendment

This Teaming Agreement shall be subject to amendment at any time upon the mutual assent of the Parties. Any such amendment shall be in writing, shall identify the provisions of this Teaming Agreement that are to be amended, and shall be signed by authorized signatories of the Parties.

XV. Notices

For purposes of establishing and maintaining effective direct communication between the Parties and providing any notice contemplated hereby, the points of contact for any notices required hereunder are:

Team Leader:	Team Member:
CFG Health Systems, LLC	Horizon House Delaware, Inc
765 East Route 70 - Bldg A, Marlton	_____
NJ 08053 USA	_____

Notices given by mail shall be effective seven (7) calendar days after mailing first class, postage prepaid. Any notice, demand, request, statement, or other writing required or permitted by this Teaming Agreement shall be deemed to have been sufficiently given either when personally delivered, transmitted by facsimile or email and acknowledged as received, or mailed by any carrier providing a receipt. Changes in either of the above appointments must be made in writing.

XVI. Indemnity and Limitation of Liability

A. The officers and employees of the Team Leader and the Team Member shall obey all pertinent rules and regulations of the other while on the premises of the other, including those relating to the safeguarding of classified and/or proprietary information. The Team Leader and the Team Member each shall indemnify and hold the other harmless from any and all claims, actions, damages and liabilities (including reasonable attorney's fees) arising directly and proximately out of the indemnifying Party's negligence, or willful, wanton, or reckless conduct resulting in death or bodily injury to any person or damage to any real or tangible personal property. Without limiting these undertakings in any way, each Party shall maintain public liability and property damage insurance in reasonable limits covering the obligations set forth above and shall maintain proper workmen's compensation insurance covering all employees performing under this Teaming Agreement.

B. In no event, whether through arbitration or court proceeding, shall either Party be liable for special or consequential damages of any kind or nature whether alleged to be attributed to any breach by either Party of this Teaming Agreement, to tort for negligence or otherwise caused, except to the extent of the indemnification set forth in paragraph A. above, for tort claims resulting in death, bodily injury, or property damage.

XVII. Corporate Authority

Team Leader and Team Member each hereby represent and warrant to the other:

A. That it has full corporate power and authority to enter into this Teaming Agreement and to perform its obligations hereunder;

B. That the execution, delivery, and performance of this Teaming Agreement by Team Leader or Team Member, as the case may be, and the implementation by Team Leader or Team Member, as the

case may be, of the transactions contemplated hereby have been duly approved and authorized by all requisite corporate action of Team Leader or Team Member; and

C. This Teaming Agreement has been duly executed and delivered by Team Leader or Team Member, as the case may be, and constitutes a valid and legally binding obligation of Team Leader or Team Member, as the case may be, enforceable against such corporation in accordance with its terms.

XVIII. Entire Agreement; Headings

A. This Teaming Agreement is the entire agreement between the Parties with respect to the subject matter hereof and supersedes with respect to the Solicitation any prior oral or written agreements, commitments, drafts of agreements, understandings, memoranda, or other communications with respect to the subject matter of this Teaming Agreement. The Parties stipulate and agree that no prior drafts, memoranda, notes, or discussions relating to this Teaming Agreement shall be used at any time by either Party in any trial or hearing, or be used or discoverable in any discovery process pertaining thereto, to prove or evidence in any way the intention or understanding of either Party with respect to any provision or part of this Teaming Agreement.

B. The headings of the sections, paragraphs and subparagraphs hereof are included for convenience of reference only and shall not affect the meaning or construction thereof.

IN WITNESS WHEREOF, the Parties have caused their duly authorized representatives to execute this Teaming Agreement on and as of the date first above written.

Team Leader: CFG Health Systems, LLC

By: _____

Title: CEO

Date: 4.25.12

Team Member: Horizon House Delaware, Inc.

By: _____
ROSANNE FAUST

Title: Director H.H.S.I.

Date: 4/23/12

HHDI Substance Abuse Services for CFG
Department of Correction
Professional Services RFP

Position Title	# of FTE	Projected Annual Salary Per FTE	Coverage Costs	Year 1 Projected Annual Salary/Costs	1.5% inc. over 1st Yr 2nd Year Projected Annual	2% inc. over 2nd Yr 3rd Year Projected Annual	2% inc. over 3rd Yr 4th Year Projected Annual	Year 1 Salary and Benefits
STATE SUBSTANCE ABUSE DIRECTOR	1.0	84,000		84,000	85,260	86,965	88,705	105,000
ADMINISTRATIVE ASSISTANT STATE	1.0	38,000		38,000	38,570	39,341	40,128	47,500
CLINICAL QI ASSESSOR	0.2	80,000		16,000	16,240	16,565	16,896	20,000
CLINICAL PROGRAM DIRECTORS	4.0	62,000		248,000	251,720	256,754	261,889	310,000
CLINICAL SUPERVISORS	8.0	47,000		376,000	381,640	389,273	397,058	470,000
ADMINISTRATIVE ASSISTANT REGIONAL	4.0	28,000		112,000	113,680	115,954	118,273	140,000
LEAD SUBSTANCE ABUSE COUNSELORS	17.0	35,000	44,880	639,880	649,478	662,468	675,717	799,850
SUBSTANCE ABUSE COUNSELORS	49.0	32,000	129,360	1,697,360	1,722,820	1,757,277	1,792,422	2,121,700
	84.2			3,211,240	3,259,409	3,324,597	3,391,089	4,014,050
Fringe Benefits(25% of Total Salaries)				802,810	814,852	831,149	847,772	
Liability Insurance(2.5% of Salaries)				80,281	81,485	83,115	84,777	80,281
Training and Development (for on-site training cert/recertification)				18,000	19,890	20,288	20,694	18,000
Staff Travel Costs(18,000 miles @ $.55/per mile)				9,900	9,900	9,900	9,900	9,900
Administrative Over Overhead				151,702				
Performance Bond				11,649	11,828	12,064	12,304	11,649
Total Direct Operating Costs				4,285,582	4,197,364	4,281,113	4,366,536	4,133,880
Management Fee(9%)				385,702	545,657	556,545	567,650	537,404
Total Program Costs				**4,671,284**	**4,743,021**	**4,837,657**	**4,934,185**	**4,671,284**

Note:
Coverage for V, S and H(to cover LC and SAC positions-66FTE* 3 wks/per FTE; est. 7,920hrs@$22/hr)

Exhibit A - Continued

HHDI INTENT OF SERVICE

It is the intent of HHDI to provide best-practice substance abuse treatment to as many individuals as possible by utilizing the available treatment beds and available funds as a priority to providing efficient service to meet the needs of the prison environments. HHDI will utilize the Phase System of the Key, CREST, Boot Camp, 6 for 1, YCOP, and Aftercare programs within the most appropriate settings as set forth by the DOC and USDOJ for all locations as specified within the RFP.

Horizon House Delaware, Inc., proposes to provide Substance Abuse Treatment Services under the Sub-Contracted Partnership, to abide by all standards agreed upon between the Department of Corrections' Contract No. DOC-1202Mental, the CFG Health Systems, LLC and all other standards there within, but not limited to, the Memorandum of Agreement between the State of Delaware and the United States Department of Justice, DDOC policies and NCCHC standards, and the Substance Abuse Treatment Protocol, BCHS Policy G-08.

TREATMENT PLANNING

Prison Programs

HHDI will provide treatment for offenders who have 12-30 months left of their sentence and have committed crimes related to substance abuse and/or carry a history of substance abuse. These individuals will treatment at the 12-Month Key Program followed by the community-based correctional CREST programs after release; both of these will be primarily provided in a group structure, supplemented with one-on-one substance abuse counseling dependent on client need and their level of cognitive functioning. Treatment Planning will be conducted through an Interdisciplinary Treatment Team (ITT) dynamic including the offender.

Community Correction Programs

HHDI will assist the Mental Health services provider, CFG, in transitioning offenders who complete the Key Program to the community-based CREST program; ensuring that Mental Health and Substance Abuse related disorders are communicated simultaneously. These services will be coordinated when an offender is eligible for release in less than 180 days and HHDI will work to facilitate a re-entry into the community. Treatment Planning will occur with the ITT.

Aftercare including Boot Camp

Continuity of Care is an essential component to ensure all offenders re-entering the community have the necessary supports to reduce their potential to re-offend and to reduce recidivism. HHDI will provide 6 months of Aftercare, continuing to provide clinical support to the individual upon discharge from the CREST. HHDI will work closely with probation and parole officers and TASC to create the best possible scenario for every individual re-entering the community.

Special Population Programs

6 for 1 Programs are an additional area of support that HHDI is able to provide management oversight to where all individuals, either voluntary or referred by the DOC, can benefit from a condensed version of substance abuse information.

The Young Criminal Offender Program will be a specially tailored program that discusses substance abuse in a treatment forum appropriate to the 16 to 18 year old age range, targeting areas of concern that individuals face within their particular cohort.

The Boot Camp program will carry all of the benefits of a strong structure coupled with substance abuse treatment and completed in a group dynamic where they can support one another, carrying along with the militaristic style of boot camp programming.

PROGRAMMING OBJECTIVES

HHDI utilizes Evidence-Based Practices and Best Practice Interventions in the treatment of Substance Use Disorders, calling upon the Approaches of Recovery, Motivational Interviewing, Psycho-Education, Co-Occurring Disorder Competent Approaches that treats a Mental Health diagnosis and Substance Use Disorder both simultaneously as primary disorders, and utilizing the Best-Practice Approach presented by Dr. Kenneth Minkoff of Comprehensive Continuous Integrated System of Care Model, Service Planning Guidelines for Co-Occurring Psychiatric and Substance Disorders, as well as many others (ADD HERE – from ECHO).

GENERAL SERVICE REQUIREMENTS

TREATMENT METHODOLOGY

HHDI will employ the approved Treatment Methodology, approved by the State of Delaware Department of Corrections, BCHS, and that works within the current Program Requirements structure as provided within the RFP. Offenders in the Key Programs will have an average participation length of 12 months, dependent on individual's treatment needs or time left before release to the community. The Key will include 3 separate phases covering various substance abuse treatment topics specific to the phase. The CREST and Aftercare Programs will have an average length of 6 months. The 6 for 1 Programs will be a voluntary program with programming running up to 45 days. The Young Criminal Offender Program will have programming offered during the duration of their stay once approved by the DDOC. All of these programs will have built-in objectives for moving forward within the program and from one Phase to the next if applicable to the program, along with earned responsibilities that increase and feature earned privileges. The program will also offer peer support roles, based upon performance within the program.

HHDI Substance Abuse Treatment, under the Primary Contract holder CFG, will operate within the Phase system guidelines. Phase 1 Education will provide a specific curriculum to all Substance Abuse Counselors with lesson plans for treatment topics which include: Group Etiquette and Rules; the Basics of Addiction and Counseling; Disease Concept; Substance Abuse/Dependency Education; Psycho-Pharmacology which discusses type of drugs and

chemicals abused along with the associated Physical and Psychological Addiction and Post Acute Withdrawal Symptoms; Denial and Criminal Thinking Errors; and Introduction to the 12-Step Recovery Programs.

All Phases will cover treatment topics and associated activities that include the following: Cognitive Skills Building, Motivation to Change, Problem Solving, Skill Building, Errors in Judgment; Sober Living Skills; Stress and Anger Management; Interpersonal relationships with family, peers, community; Parenting Skills; Goal Setting; Values Clarification; Criminal Thinking and Behaviors; AIDS/STDs infectious diseases; Fetal Alcohol Syndrome and effects; Mental Health and Co-Occurring Disorders; Relapse Prevention; Recovery, Family Dynamics, Cultural Issues, Gender Issues.

TREATMENT CONTENT

HHDI will employ best-practice methodologies in all programs, including the Special Population Programs, which include proper clinical assessment; individualized treatment planning; individual counseling at a minimum of one (1) session per month; weekly therapeutic groups; Psycho-Educational instruction; weekly Encounter Groups; random urinalysis testing, collected by the DDOC, addiction education; life-management skills; Trauma-Informed Care approaches and screens; co-occurring disorder consultation and treatment which will include voluntary mental health groups; Motivational (Interviewing) Enhancement components with built-in positive reinforcement and graduated sanctions; Relapse Prevention; and comprehensively coordinated Discharge and Transition Planning.

ASSESSMENTS

Based on the information obtained during admission interviews, the clinical substance abuse assessment within 72 hours of admission, and sentence orders, the Key programs will serve all identified offenders. HHDI Substance Abuse will screen all offenders referred by mental health, medical, DDOC or based on an individual's self referral. The CREST Programs will receive most of those who have successfully completed the Key Program. HHDI Substance Abuse does understand that it is the responsibility of HHDI to ensure that eligible candidates are placed in the clinically appropriate treatment program. HHDI will abide by the recruitment expectations and coordinate these movements with classification and security staff in order to properly complete the transferring of offenders.

TREATMENT PLANNING

Offenders' treatment planning will be completed with the ITT within 7 days of their admission and every 90 days thereafter and will be developed based on individual treatment needs, the time left before their intended date of release or clinical status, and the type of program in which they are enrolled. Treatment will provide evidence-based, best practice intervention and treatment components all listed in the RFP. Phase 1 of treatment will be introductory to a Therapeutic Community and basics of treatment which include but are not limited to expectations, vocabulary, and the benefits of treatment. Individuals further along in their treatment will be able to assist as a Peer as long as they are clinically appropriate and the Interdisciplinary Treatment Team finds it appropriate to do so. Movement within the phase system will require review of attendance, completeness of

Treatment Plan assignments, Sanctions and Learning Experiences within 2 weeks of review, adherence of security and institutional requirements, as well as successfully pass a Phase Exam.

Treatment Planning will include "next steps" where review of the offenders' criminal history, directly linked to drug and alcohol relevancy, will be reviewed and referrals to additional community substance abuse programs will be provided to all offenders in an attempt to lessen the potential for recidivism.

EVALUATION PLAN

HHDI will review, with CFG, the effectiveness of the current structure of Drug and Alcohol Treatment Services based on all Reporting Requirements within the RFP, Monthly and Weekly QI and Data collection, and Treatment Team discussion. HHDI Drug and Alcohol State Director will oversee a Clinical QI Assessor and the 4 Clinical Program Directors for each of the 4 regional areas. This team will evaluate the implementation of the Drug and Alcohol Treatment Services, develop action plans for service, employ EBP's, latest theories, and co-occurring competent strategies all with continual analysis.

COORIDINATION OF SERVICES WITH MENTAL HEALTH PROVIDER

As a Co-Occurring Disorder competent provider, Horizon House Delaware, Inc. (HHDI) is prepared to cooperate in all aspects of care including but not limited to Recruiting Offenders, Treatment Planning, ITT Meetings, Referral Processes and Screening, Transition Planning, and in collaboration with all Vendors, the DDOC, Security, and Community Providers within the timeframes outlined by the DDOC.

STAFFING

Clinical Staff certified by the Delaware Certification Board will be provided by HHDI to manage all sites both on-site and regionally. HHDI will instill a management structure that provides 1 (one) State Administrator along with Clerical/QI Support to 4 (four) Regional Clinical Program Directors and 8 (eight) Clinical Site Supervisors. The Clinical Regional Program Directors and Clinical Site Supervisors will carry CADC/CCDP Certification at minimum. Substance Abuse Counselors, all carrying at minimum CAAC certification within 1 year's timeframe, will staff the facilities to provide services to all mentioned facilities within the most fiscally conservative provisions that simultaneously meet program outcome projections with consideration provided to the capacity of each program. Substance Abuse Counselors will be available in both Full-Time and Part-Time capacities, on-sight M-F 7:00 AM to 8:00 PM and 8:00 AM to 8:00 PM Saturdays and Sundays. Clinical Supervision will be available during all working hours (see proposed staffing pattern outline).

A Clinical Regional Program Director will be provided for the Wilmington, DE region which includes Howard R. Young Correctional Institution's (HRYCI) Key North, 6 for 1 for Men, and YCOP Programs as well as Webb Community Correctional Center's (WCCC) Crest North and Aftercare Programs.

Under the direction of the Wilmington Regional Clinical Program Director will be 2 (two) Clinical Supervisors. One Clinical Supervisor will provide management to the Howard R. Young Correctional Institution's (HRYCI) Key North, 6 for 1 for Men, and YCOP Programs. The Second Clinical Supervisor will provide management to the Webb Community Correctional Center's (WCCC) Crest North and Aftercare Programs.

A Clinical Regional Program Director will be provided for the New Castle, DE region which includes the Baylor Women Correctional Institution's (BWCI) Key Village, 6 for 1 for Women as well as the Hazel D. Plant Women's Treatment Facility's (HDPWTF) Crest North and Aftercare Programs.

Under the direction of the New Castle Regional Clinical Program Director will be 2 (two) Clinical Supervisors. One Clinical Supervisor will provide management to the Baylor Women Correctional Institution's (BWCI) Key Village and 6 for 1 for Women Programs. The Second Clinical Supervisor will provide management to the Hazel D. Plant Women's Treatment Facility's (HDPWTF) Crest North and Aftercare Programs.

A Clinical Regional Program Director will be provided for the (Central) Dover, DE and Smyrna, DE region which includes the Central Violation of Probation Center's (CVOP) Crest Primary Program and the Morris Community Correctional Center's (MCCC) Crest Central and Aftercare Programs.

Under the direction of the Central Region Clinical Program Director will be 2 (two) Clinical Supervisors. One Clinical Supervisor will provide management to the Central Violation of Probation Center's (CVOP) Crest Primary Program. A Second Clinical Supervisor will provide management to the Morris Community Correctional Center's (MCCC) Crest Central and Aftercare Programs.

A Clinical Regional Program Director will be provided for the (Southern) Georgetown, DE region which includes the Sussex Correctional Institution's (SCI) Key South, Boot Camp, and Aftercare Programs as well as the Sussex Community Correctional Center's (SCCC) Crest South and Aftercare Programs.

Under the direction of the Southern Regional Clinical Program Director will be 2 (two) Clinical Supervisors. One Clinical Supervisor will provide management to the Sussex Correctional Institution's (SCI) Key South, Boot Camp, and Boot Camp Aftercare Programs. The Second Clinical Supervisor will provide management to the Sussex Community Correctional Center's (SCCC) Crest South and Aftercare Programs.

Initial Teaming Agreement to Develop Treatment Model. If CFG is awarded a contract, Thresholds, Inc will enter into a Sub-Contracting Agreement with CFG.

Teaming Agreement

This Teaming Agreement, entered into as of April 23, 2012, by and between CFG Health Systems, LLC, a New Jersey entity, with its principal place of business at: 765 E Route 70 Marlton, NJ 08053 (the "Team Leader"), and Thresholds, Inc., a Delaware company, with its principal place of business at: 20505 Dupont Boulevard, Unit 1 Georgetown, DE 19947 (the "Team Member")

Recitals

WHEREAS, the State of Delaware's Department of Correction ("DDOC") has issued a professional services request for proposal to provide correctional mental health services/substance abuse treatment/DUI programming and sex offender treatment (the "Solicitation"); and

WHEREAS, the DDOC intends to contract with only one "Primary Vendor" which will be solely responsible for the fulfillment of the any obligations resulting from contract between the DDOC and the Primary Vendor; and

WHEREAS, Team Leader intends to respond to the Solicitation as a Primary Vendor; and

WHEREAS, the Team Leader and the Team Member, (the "Parties"), because of their diverse capabilities, have determined that they would benefit from a Teaming Agreement in responding the Solicitation, and

WHEREAS, the Team Member wishes to participate in the response to the Solicitation with the Team Leader with the ultimate goal of serving in a sub-contracting capacity in the event that the DDOC awards a Primary Vendor contract to the Team Leader; and

WHEREAS, the Parties wish to establish a cooperative and supportive team in which each will devote adequate skilled manpower, capital equipment, facilities, and other resources to timely support the objectives of this Teaming Agreement; and

WHEREAS, "Proprietary Information" means technical data, knowledge, patents, marketing data or techniques, cost or pricing information, and ideas that a Party treats as and considers to be unique, valuable, and proprietary, including, without limitation, any information protected under the Trade Secrets Act, 18 U.S.C. § 1905, and information exempt from disclosure under the Freedom of Information Act, 5 U.S.C. §§ 552(b)(3) and (4); and

WHEREAS, the ability of the Parties to competitively respond to the Solicitation and to obtain and perform the proposed contract necessitate the disclosure by each Party to the other of its Proprietary Information; and

WHEREAS, each Party is willing to make its Proprietary Information, as described above, available to the other Party for the limited purpose of competitively responding to the Solicitation; and

WHEREAS, each Party is willing to accept the Proprietary Information received from the other Party in confidence and to hold it in trust for the disclosing Party for use solely and exclusively in connection with competitively responding to the Solicitation, all according to the terms and conditions of this Teaming Agreement; and

WHEREAS, the Team Leader, if it receives a contract as Primary Vendor from the Solicitation, would subcontract the portions of the contract work designated on Exhibit A to the Team Member (the "Subcontract Work"); and

WHEREAS, the Parties wish to enter into this Teaming Agreement to set forth more fully the terms and conditions pursuant to which the Parties will award and perform any contract(s) resulting therefrom.

NOW, THEREFORE, in consideration of these premises, and in express reliance upon the mutual promises and covenants contained herein, the Parties here agree as follows:

I. Applicability and Relationship of the Parties

A. Applicability:

This Teaming Agreement relates solely and exclusively to the Parties' establishment of and performance as a team with respect to the responses to the Solicitation and to the correlative rights and duties of the Parties within that team.

B. Relationship of the Parties:

1. The Parties agree to work together to fulfill the obligations the Team Leader has committed to in the event that it is awarded one or more contracts in response to the Solicitation. Nothing in this Teaming Agreement shall be construed to grant either the Team Leader or the Team Member the right to make commitments of any kind for or on behalf of the other Party, without the prior written consent of the other Party.

2. The Team Leader shall not perform or subcontract to any other firm other then the Team Member any of the Team Member's Subcontract Work. This Teaming Agreement shall not preclude either Party from competing for, or contracting, independently from the other for any other government or industry program that may develop or arise in the general area of business related to the Solicitation.

3. Team Leader and Team Member shall act as independent contractors in the performance of this Teaming Agreement, and neither Party shall act as agent for or partner of the other Party for any purpose under this Teaming Agreement. The officers and employees of one Party shall not be deemed the employees of the other Party. Nothing in this Teaming Agreement shall be deemed to constitute, create, give effect to, or otherwise recognize a joint venture, partnership, or formal entity of any kind, and the rights and obligations of the Parties shall be limited to those expressly set forth herein. Nothing contained in this Teaming Agreement shall be construed as providing for the sharing of profits or losses arising out of the performance of the contract proposed by the Solicitation. Except as expressly provided herein, neither Party will be liable to the other for any costs, expenses, risks, or liabilities arising out of the other Party's participation in the preparation, submission, or sustaining of competitive proposals under the Solicitation.

IV. Responsibilities of the Parties

A. The Team Leader shall:

1. In a timely manner, furnish to Team Member the Solicitation and any amendments thereto.

2. In a timely manner, keep Team Member fully informed of significant events, deadlines, and milestones regarding the Solicitation.

3. Prepare and submit to DDOC, all proposals and other submissions required or requested, provided however, that any proposal submitted by Team Leader shall identify Team Member as a principal subcontractor to Team Leader and, provided further, however, that Team Leader, as proposal manager, shall make the final determination regarding the form and content of the proposal, including, without limitation:

a. the cost or pricing proposal or information related to prices submitted to the DDOC, subject only to the limitation that Team Leader shall not reduce the price proposed by Team Member for Team Member's proposed contract work without the prior approval of Team Member; and

b. the content of the technical, business management, or other proposals submitted.

4. Maintain responsibility for all contacts and communications with the DDOC and for all decisions relating to the competitive response to the Solicitation, provided however, that Team Leader shall not unreasonably exclude Team Member from participating in communications with the DDOC regarding the Solicitation.

5. Upon award to Team Leader of any contract resulting from the Solicitation, but subject to Team Member's satisfactory discharge of its antecedent obligations under this Teaming Agreement and except as otherwise agreed upon by the Parties, award to Team Member a subcontract for the Subcontract Work, provided however:

   a. that such proposed subcontract shall be subject to the approval of the DDOC;

   b. that such proposed subcontract shall be negotiated in good faith by the Parties and shall incorporate the terms of this Teaming Agreement by reference;

   c. that such proposed subcontract shall include all clauses required by law, regulation, and such clauses incorporated in Team Leader's prime contract that, by its terms, must be incorporated in subcontracts awarded by Team Leader;

   d. that such proposed subcontract shall not include any provision authorizing the termination in whole or in part of the contract work to be performed by Team Member thereunder for the convenience of Team Leader, unless Team Leader's prime contract shall first have been correspondingly terminated, in whole or in part, for convenience, and only if the portion terminated by the DDOC corresponds with the Team Member's share of the contract work;

   e. that such proposed subcontract shall not be effective until Team Member executes and submits (where required) to Team Leader all certifications required by law, regulation, the terms of the Team Leader's prime contract, and the Solicitation.

B. The Team Member shall:

1. In a timely manner, respond to all requests by Team Leader for all data and information, including, without limitation, Proprietary Information and any other specifications, designs, process information, cost or pricing information, or information related to prices needed by Team Leader to successfully compete for the contract proposed by the Solicitation.

2. Participate, to the extent deemed necessary or desirable by Team Leader in negotiations, discussions, and other communications with DDOC,

3. Execute and submit to Team Leader all certifications required by law, implementing regulations, the terms of the Team Leaders' prime contract, or the Solicitation.

4. Upon award to Team Leader of a contract by DDOC resulting from the Solicitation, under terms to be mutually agreed accept and perform subcontract(s) for such of the contract work as is required by this Teaming Agreement, provided, however:

   a. that such subcontract(s) shall be subject to the conditions set forth in paragraph A. of this Section IV and any other provisions of this Teaming Agreement; and

   b. in the event that the Solicitation or the Team Leader's prime contract requires Team Leader to comply with requirements for submission of cost or pricing data, or information related to prices, Team Member shall provide Team Leader the data or information as appropriate. Nothing in this subparagraph or in any other provision of this Teaming Agreement shall be construed as giving one Party the right to audit the books and records of the other Party.

   c. Team Member agrees to take responsibility for its cost and pricing data or information related to prices and hold Team Leader harmless to the full extent of any price or cost reduction effected by the DDOC that may result from: (i) the cost or pricing data or information related to prices submitted or certified by Team Member; or (ii) the failure by Team Member to disclose and consistently follow applicable cost accounting practices and standards or otherwise comply with the Federal laws and regulations.

5. Extend to Team Leader at all times such cooperation as requested by Team Leader to facilitate successful competition for the Solicitation.

V. Proprietary Information

A. Technology Transfer:

1. The Parties shall identify in writing, by appropriate stamp, legend, or otherwise, all such Proprietary Information transferred pursuant to this Teaming Agreement. All such Proprietary Information disclosed under this Teaming Agreement shall remain the property of, and be deemed proprietary to, the disclosing Party. The receiving Party agrees to accept such Proprietary Information in confidence, to accord it the protection required by this Teaming Agreement and such additional protection as the receiving Party customarily accords to its own proprietary information, to hold such Proprietary Information in trust for the disclosing Party, and to use such Proprietary Information solely and exclusively in accordance with the terms of this Teaming Agreement, provided however, that neither Party in its capacity as receiving Party shall be liable for disclosure or use of Proprietary Information if the same:

   a. was properly in the public domain at the time it was disclosed,

   b. was properly known to and available for use by the receiving Party and recorded as such in its files at the time of receipt from the disclosing Party; or,

   c. is proven by the receiving Party to have been independently developed by the receiving Party; or,

   d. becomes properly known to and available for use by the receiving Party from a source other than the disclosing Party; or,

e. is disclosed to DDOC in the performance of the obligations of either Party under this Teaming Agreement or under any contract or subcontract resulting from the Solicitation, provided that any such disclosure by the receiving Party is accompanied by such restrictive legends as shall have been affixed thereto or otherwise required by the disclosing Party; or,

f. After expiration of a three (3) year period, which period shall commence upon the date of the last signing of this Teaming Agreement.

2. Subparagraphs A.1.a. through A.1.f. of this Section shall not relieve the receiving Party of restrictions on the use of, or other obligations relating to, Proprietary Information otherwise imposed by this Teaming Agreement unless the receiving Party shall have notified the disclosing Party in writing thirty (30) days before a proposed use or disclosure of Proprietary Information that the receiving Party regards as authorized by one or more of such subparagraphs. The burden of proof with respect to the applicability of any such subparagraph to any proposed use or disclosure of Proprietary Information by the receiving Party shall be upon the receiving Party.

3. Should the receiving Party be faced with legal action or a requirement under government regulations to disclose any of the disclosing Party's Proprietary Information, the receiving Party shall immediately notify the disclosing Party. Upon the disclosing Party's request, the receiving Party shall cooperate fully with the disclosing Party, at disclosing Party's expense, if the disclosing Party elects to contest such disclosure. Except in connection with a failure in the discharge of responsibilities set forth in the preceding sentence, the receiving Party shall not be liable in damages for any disclosure of Proprietary Information pursuant to judicial decree or government regulation.

B. Use of Proprietary Information:

1. With respect to Proprietary Information disclosed by one Party to another:

a. the Parties agree that each shall retain ownership of their respective Proprietary Information and that the other Party shall not acquire any rights therein, except the right to use such Proprietary Information to the extent provided in this Teaming Agreement.

b. the receiving Party is hereby granted a limited, irrevocable, non-exclusive, royalty-free, non-transferable, worldwide right and license to use the disclosing Party's Proprietary Information according to the terms of this Teaming Agreement.

c. except as otherwise provided in this Teaming Agreement, no Proprietary Information disclosed pursuant to this Teaming Agreement shall be made available by the receiving Party to any third party for any purpose, provided, however, that such Proprietary Information may be disclosed by the Receiving Party to an actual or prospective subcontractor concerning the Solicitation where such disclosure is necessary for the performance of the receiving Party's share of the contract work and provided, further, however, that such disclosure shall not be made without: (i) the prior written approval of the disclosing Party, (ii) an express written agreement of the actual or prospective

subcontractor to comply, for the benefit of the disclosing Party, with all restrictions on the use of such Proprietary Information as are imposed upon the receiving Party pursuant to this Teaming Agreement, and (iii) the express written agreement of the receiving Party to indemnify the disclosing Party for any violation or breach of such restrictions by the actual or prospective subcontractor.

d. no Proprietary Information disclosed pursuant to this Teaming Agreement shall be used, duplicated, or disclosed for any purposes not authorized by this Teaming Agreement without the prior written approval of the disclosing Party. Proprietary Information may be disseminated to and used only by officers and employees of the receiving Party where and to the extent required in connection with the Solicitation, and then upon conditions that are consistent with this Section V.B. If the Proprietary Information is reproduced in whole or in part, the reproduction shall carry a proprietary notice or legend similar to that which appears on the original.

2. In the event this Teaming Agreement is terminated, the receiving Party shall cease to make use of the Proprietary Information received from the disclosing Party and, upon the disclosing Party's written request, shall promptly destroy or return such Proprietary Information. In the event that the disclosing Party requests destruction, the receiving Party shall provide written certification of the destruction within thirty (30) days of such request, provided however, that such Proprietary Information may continue to be used by the receiving Party for such time as may be required to compete for, and solely for the purpose of competing for, the contract proposed by the Solicitation.

3. The rights, duties and obligations of the Parties with respect to all Proprietary Information disclosed before the date of this Agreement in contemplation of the execution of this Agreement shall be as set forth in this Section.

C. Rights in Inventions:

1. Any inventions conceived by employees or contractors of either Party while performing work pursuant to this Teaming Agreement and any patents arising from such inventions shall remain the sole property of the Party employing such employee or contractor.

VI. Termination

Except as otherwise expressly provided herein, this Teaming Agreement shall expire upon one of the following events, whichever shall occur first:

A. Written notice from DDOC that they will not award a contract pursuant to the Solicitation.

B. Written notice from DDOC of award of a contract to a firm other than the Team Leader.

C. Execution of a subcontract by and between the Team Leader and the Team Member for performance of the Subcontract Work.

D. Dissolution hereof by mutual written agreement of the Team Leader and Team Member.

E. If either Party files a petition under any chapter of the Bankruptcy Act, 11 U.S.C. §§ 101 et seq., an involuntary petition under that Act is filed against either Party, a Party commences an

action in any country under laws providing for the relief of winding up of insolvent or liquidating persons or entities, or files for the appointment of a receiver or becomes insolvent, and such matters are not discharged or relieved within sixty (60) days.

F. Cancellation of the Solicitation or substantial changes thereto making it undesirable for the Team Leader to submit a proposal supported by a teaming agreement.

G. Debarment or suspension of either Party by competent authority, if such debarment or suspension precludes the participation by such Party in pursuing this Teaming Agreement, or indictment of either Party in any criminal proceeding related to doing business with a public entity as a prime contractor or subcontractor.

H. The expiration of twelve (12) months from the date of this Teaming Agreement; provided, however, this Teaming Agreement shall be extended for one (1) additional year if DDOC has not provided written notice as to contract award within the twelve-month period.

VII. Laws and Regulations

The Team Leader and the Team Member agree to comply with all applicable federal, state, and local laws and regulations, and all applicable orders and regulations of the executive and other departments, agencies, and instrumentalities of the United States Government. The Team Leader and the Team Member agree to indemnify one another against any loss, cost, damage, or liability by reason of the other Party's violation of this Section.

VIII. Publicity

Regardless whether or not restrictions are imposed by the DDOC, each Party agrees not to release any publicity or information concerning the Solicitation or this Teaming Agreement without the prior written approval of the other, which approval shall not be unreasonably withheld.

IX. Disputes

A. The Parties shall exercise their best efforts to settle any claim, controversy, or dispute (hereinafter collectively called "Disputes") concerning questions of fact or law arising out of or relating to this Teaming Agreement or to performance of either Party hereunder, or to the threatened, alleged or actual breach thereof by either Party, including without limitation any claim, controversy or Dispute concerning the determination (in accordance with the provisions of this Teaming Agreement) of the share of the proposed contract work, or the price, or terms and conditions of any subcontract to be awarded to Team Member by Team Leader.

B. If the Parties are unable to resolve the Dispute within thirty (30) calendar days from the date that either Party is informed in a writing from the other Party that a Dispute exists, the Dispute shall be settled by binding arbitration administered by the American Arbitration Association under its Commercial Arbitration Rules, and judgment on the award rendered by the arbitrators may be entered in any court having jurisdiction thereof.

1. Either Party may initiate an arbitration proceeding by the filing of a demand for arbitration with the American Arbitration Association. A panel of three (3) arbitrators

shall be selected to hear and resolve the controversy, with one (1) arbitrator selected by each Party and the third arbitrator selected by the Parties following the procedures set forth in the then current Commercial Arbitration Rules of the American Arbitration Association; provided, however, that if either Party fails to select an arbitrator within thirty (30) days after the arbitration is initiated, the American Arbitration Association shall select an arbitrator on behalf of such Party. Any arbitrator appointed by a Party to this Teaming Agreement shall not be an officer or employee of, consultant for, or otherwise associated with the Party appointing him.

2. Unless an oral hearing is waived in writing by both Parties, the arbitrators shall hold a hearing on the Dispute to be arbitrated. Such hearings shall be held at such time and place as the arbitrators shall determine. The arbitrators shall have the authority to require the presence as a witness at the arbitration proceedings of any current officer or employee of either Party. Except as provided in paragraph B.3, the arbitrators shall provide opportunity to each Party to be present, to be fully heard, by counsel or otherwise, and to cross-examine.

3. The Parties expressly agree that any arbitration hereunder may proceed in the absence of any Party who, after due notice, fails to be represented at such arbitration or to obtain an adjournment thereof, and that, in such event, an award may be made based solely upon the evidence submitted by the Party who is present.

4. The authority of the arbitrators shall be to make a decision with respect to the Dispute in accordance with the provisions of this Teaming Agreement under the applicable law identified in Section XII., "Applicable Law," of this Teaming Agreement. The arbitrators shall not have the power to add to or modify any of the provisions of this Teaming Agreement; provided, however that this provision shall not prevent, in any appropriate case, the interpretation and construction by the arbitrators of the applicable provisions of this Teaming Agreement to the extent necessary to apply such provisions to the Dispute. The arbitrators may issue a decree of specific performance, an injunction, or award compensatory monetary damages. The arbitrators shall not be empowered to issue an award for punitive damages. Each Party shall be responsible for paying all costs and expenses of the arbitrator selected by it and its own attorneys' fees and expert witnesses' fees. All other costs and expenses of the arbitration proceedings, including the fees and expenses of the arbitrator and the cost of transcripts, shall be shared equally by the Parties hereto.

5. All decisions of the arbitrators shall be in writing, shall set forth detailed findings of fact and conclusions of law, and shall be issued to the Parties within thirty (30) calendar days (or such longer period as in the opinion of a majority of the arbitrators may be necessary) after any hearings have been completed and any time allowed for the filing of briefs has elapsed. A signed copy of such decision shall be delivered to each Party.

6. The written decision rendered by a majority of the arbitrators shall be final, binding, and conclusive upon the Parties unless determined by a court of competent jurisdiction to have been fraudulent, capricious, arbitrary, so grossly erroneous as a matter of law as necessarily to imply bad faith or not be supported by substantial evidence. Judgment upon an award

rendered by the arbitrators may be entered in any court of competent jurisdiction.

7. Either Party shall be permitted to resolve all aspects of the Dispute in a single proceeding, and shall not be required to institute additional proceedings to resolve matters that remain in Dispute during continued performance of this Teaming Agreement.

C. Except as otherwise specifically provided in this paragraph C., neither Party shall institute any action or proceeding against the other Party in any court with respect to any Dispute that is or could be the subject of a claim or proceeding pursuant to this Section.

1. The Parties acknowledge that the remedies available to them under this Teaming Agreement, or that would otherwise be available at law, will be inadequate in case of any default or threatened default in the performance of the Parties' respective obligations under this Section and that such obligations shall be specifically enforceable by a decree for the specific performance or by an injunction against any actual or threatened violation thereof.

2. The Parties further acknowledge that the remedies available to them under this Teaming Agreement, or which would otherwise be available at law, will be inadequate in case of any default or threatened default in the performance of the Parties' respective obligations under Section V., "Proprietary Information." Accordingly, the Parties agree that notwithstanding any other provisions of this Teaming Agreement, the rights of the Parties under that Section shall be specifically enforceable by a decree of specific performance, or by an injunction against any violation of its terms, or otherwise.

D. The Parties shall proceed diligently with the performance of this Teaming Agreement pending the resolution of any Dispute that is subject to this Section.

X. Severability

If any term, provision, covenant, or condition of this Teaming Agreement is held invalid or unenforceable for any reason, the remainder of the provisions shall continue in full force and effect as if this Teaming Agreement had been executed with the invalid portion thereof eliminated.

XI. Applicable Law

This Teaming Agreement and all of its amendments entered into after the date of this Teaming Agreement, no matter their place of negotiation, execution, or performance, will be governed by the laws then in effect in the State of with venue of any legal or equitable actions relating to this Teaming Agreement in the State of New Jersey.

XII. Change in Financial Condition

If either Party experiences a material change in its financial condition at any time after the effective date of this Teaming Agreement, the other Party shall be notified in writing of the change at the time the change occurs or is identified. Failure to notify the other Party of a material change in financial condition will be deemed a breach of this Teaming Agreement.

XIII. Assignment

Neither Party shall assign, sell, transfer, or in any way encumber its interest under this Teaming Agreement without obtaining prior written consent of the other Party hereto.

XIV. Amendment

This Teaming Agreement shall be subject to amendment at any time upon the mutual assent of the Parties. Any such amendment shall be in writing, shall identify the provisions of this Teaming Agreement that are to be amended, and shall be signed by authorized signatories of the Parties.

XV. Notices

For purposes of establishing and maintaining effective direct communication between the Parties and providing any notice contemplated hereby, the points of contact for any notices required hereunder are:

Team Leader:	Team Member:
CFG Health Systems, LLC	Thresholds, Inc
765 East Route 70 - Bldg A, Marlton	20505 Dupont Boulevard, Unit 1
NJ 08053 USA	Georgetown, DE 19947

Notices given by mail shall be effective seven (7) calendar days after mailing first class, postage prepaid. Any notice, demand, request, statement, or other writing required or permitted by this Teaming Agreement shall be deemed to have been sufficiently given either when personally delivered, transmitted by facsimile or email and acknowledged as received, or mailed by any carrier providing a receipt. Changes in either of the above appointments must be made in writing.

XVI. Indemnity and Limitation of Liability

A. The officers and employees of the Team Leader and the Team Member shall obey all pertinent rules and regulations of the other while on the premises of the other, including those relating to the safeguarding of classified and/or proprietary information. The Team Leader and the Team Member each shall indemnify and hold the other harmless from any and all claims, actions, damages and liabilities (including reasonable attorney's fees) arising directly and proximately out of the indemnifying Party's negligence, or willful, wanton, or reckless conduct resulting in death or bodily injury to any person or damage to any real or tangible personal property. Without limiting these undertakings in any way, each Party shall maintain public liability and property damage insurance in reasonable limits covering the obligations set forth above and shall maintain proper workmen's compensation insurance covering all employees performing under this Teaming Agreement.

B. In no event, whether through arbitration or court proceeding, shall either Party be liable for special or consequential damages of any kind or nature whether alleged to be attributed to any breach by either Party of this Teaming Agreement, to tort for negligence or otherwise caused, except to the extent of the indemnification set forth in paragraph A. above, for tort claims

resulting in death, bodily injury, or property damage.

XVII. Corporate Authority

Team Leader and Team Member each hereby represent and warrant to the other:

A. That it has full corporate power and authority to enter into this Teaming Agreement and to perform its obligations hereunder;

B. That the execution, delivery, and performance of this Teaming Agreement by Team Leader or Team Member, as the case may be, and the implementation by Team Leader or Team Member, as the case may be, of the transactions contemplated hereby have been duly approved and authorized by all requisite corporate action of Team Leader or Team Member; and

C. This Teaming Agreement has been duly executed and delivered by Team Leader or Team Member, as the case may be, and constitutes a valid and legally binding obligation of Team Leader or Team Member, as the case may be, enforceable against such corporation in accordance with its terms.

XVIII. Entire Agreement; Headings

A. This Teaming Agreement is the entire agreement between the Parties with respect to the subject matter hereof and supersedes with respect to the Solicitation any prior oral or written agreements, commitments, drafts of agreements, understandings, memoranda, or other communications with respect to the subject matter of this Teaming Agreement. The Parties stipulate and agree that no prior drafts, memoranda, notes, or discussions relating to this Teaming Agreement shall be used at any time by either Party in any trial or hearing, or be used or discoverable in any discovery process pertaining thereto, to prove or evidence in any way the intention or understanding of either Party with respect to any provision or part of this Teaming Agreement.

B. The headings of the sections, paragraphs and subparagraphs hereof are included for convenience of reference only and shall not affect the meaning or construction thereof.

IN WITNESS WHEREOF, the Parties have caused their duly authorized representatives to execute this Teaming Agreement on and as of the date first above written.

Team Leader: CFG Health Systems, LLC	Team Member: Thresholds, Inc.
By:	By:
Title: CEO	Title: DIRECTOR
Date: 4.25.12	Date: 4/25/12

DUI Clinical Supervision Services for CFG
Department of Correction
Professional Services RFP

Position Title	# of FTE	Projected Annual Salary Per FTE	Coverage Costs	1st Year (6 Months) Projected Annual Salary/Costs	2nd Year Projected Annual	3rd Year Projected Annual	4th Year Projected Annual
Program Director	1.0	65,000		32,500	66,300	67,626	68,979
	1.0			32,500	66,300	67,626	68,979
Fringe Benefits(23% of Total Salaries)				7,475	15,809	16,166	16,532
Liability Insurance(2.5% of Salaries)				813	1,658	1,691	1,724
Staff Travel Costs(16,640 miles @ $.55/per mile)				4,576	9,152	9,152	9,152
Trainers				4,500	-	-	-
Training Materials				750	-	-	-
Performance Bond				165	302	308	313
Total Direct Operating Costs				50,779	93,221	94,943	96,700
Management Fee(30%)				15,234	27,966	28,483	29,010
Total Program Costs				**66,012**	**121,187**	**123,425**	**125,710**

For years 2, 3 and 4, we anticipate annual increases of 2% to the salary line and a regular 9% increase in the cost of health insurance (we project that based on the average of the last four years).

	Annual Increase		Salary increase @ 2%
Year 2	560	6801	66300
Year 3	612	7413	67626
Year 4	667	8080	68978

****MANAGEMENT PIECE ONLY
STAFF PROVIDED BY CFG

CORPORATE OVERVIEW

HISTORY

The CFG Health Network is comprised of several related sister companies with the same management base, ownership and corporate structure. Corporate headquarters are situated at 765 East Route 70, Building A-100 Marlton, NJ 08053, with a satellite Corporate Office for Corrections recently opened in East Brunswick, NJ. Currently, the Network collectively employs over 760 employees, maintaining an average of approximately 725 employees over the last three years. Annualized payroll is approximately $38 million. The Center for Family Guidance was initially established to provide outpatient behavioral health services in the South Jersey area. Growing in response to community needs and guided by the foresight and initiative of Dr. James Varrell, Founder and Chief Medical Officer; Mr. Al Campana, COO; and Mr. Les Paschall, CEO, the company transformed from an eight associate, one site outpatient office to an industry forerunner responsible for the management and development of outpatient, inpatient and residential programs in hospitals and institutions both large and small, public and private. In direct response to the extraordinary behavioral and healthcare challenges facing correctional institutions, the board of directors established CFG Health Systems, LLC (CFG) in 1999.

CFG's foray into correctional healthcare began that same year, as the mental health sub-contractor for the New Jersey Department of Corrections. Soon afterwards, we began providing full spectrum correctional healthcare services for Middlesex County, initiating the contract on a mere week's notice, after the incumbent medical provider walked away from the contract before its term. CFG has since successfully defended this contract in three subsequent RFP cycles and has gone on to obtain numerous additional contracts. At present, CFG currently provides a full spectrum of comprehensive medical services to just under 9,000 offenders throughout the state of New Jersey and behavioral healthcare services to over 21,000 inmates, including pre-parole psychological testing for the New Jersey Department of Corrections.

CFG Health Systems, LLC prides itself on being an innovative, dynamic organization that provides comprehensive, quality healthcare services to correctional facilities and hospitals. Our philosophy of treatment and service is predicated upon the core belief that all individuals deserve to be treated with dignity and respect. Our staff understands the importance of listening to and working closely with our customers and repeatedly demonstrates this understanding through the promotion of team-oriented approaches. Through on-going acquisition, solid internal growth, an intense focus on excellent clinical care and a dedication to providing the highest quality client services, we have grown substantially, becoming a leader in the field of correctional healthcare. CFG's proven ability to quickly integrate new

contracts into a single, coordinated management infrastructure has served to strengthen our corporate resources, further ensuring our accountability to each client.

With the award of this contract, CFG will utilize the demonstrated expertise of our management staff, support specialists and clinicians to build capacity and develop a model correctional behavioral healthcare system.

CORPORATE STRUCTURE

The considerable experience and commendable qualifications of CFG's corporate correctional healthcare management team are described below. These individuals provide oversight and support and are readily available and directly accessible. **Résumés for these individuals can be found in the Résumés section of this proposal.** CFG also employs support professionals who work with our customers in all aspects of correctional healthcare, from the smallest administrative detail to emergency crisis intervention – from day-to-day operations to program development and training.

KEY PERSONNEL AND CORPORATE STAFF

Les Paschall – *Chief Executive Officer*

As the CEO, Mr. Paschall brings over 25 years of creative leadership experience to the development, management and coordination of cost effective healthcare services -- in five major health provider venues. He has championed new models of need-based healthcare services for large hospital systems and state health and education systems and has also served as an advisor to the Governor's Task Force on Mental Health. Mr. Paschall is adept at reviewing systems that cross both the private and public sectors and has been successful in creating solutions to their common goals. In addition, Mr. Paschall brings considerable business acumen to CFG, resulting in CFG's recognition as one of the top 25 fastest growing business organizations in New Jersey.

James Varrell, M.D. – *Chief Medical Officer and Director of Psychiatry*

Dr. Varrell is CFG's founder and President. For the past nine years Dr. Varrell has trained, supervised and, when necessary, provided on-site coverage for the psychiatrists that are part of CFG's correctional healthcare network. Board certified in both adult and child/adolescent psychiatry, and recognized as a "Top Doc" in the area, Dr. Varrell is much sought after for his limited private practice hours. His unique blend of private practice and community psychiatry experience, coupled with his thorough and objective knowledge of psychopharmacology, make him ideally suited for the development and oversight of formularies for psychotropic medications.

Dr. Varrell's duties as Chief Medical Officer and Director of Psychiatry include the hiring of a site Mental Health Director, the review of policies and procedures and the direct oversight of mental health staff until the position of Mental Health Director has been secured. Once a site Mental Health Director has been hired, Dr. Varrell's duties shift to providing peer review, quality assurance and oversight of the use of non-formulary psychotropic medications.

Al Campana, CCHP – *Chief Operating Officer*

Mr. Campana has over 37 years of clinical and administrative management experience in the healthcare field. In the role of COO, Mr. Campana is responsible for all business operations, including the fiscal development of proposals and contracts, as well as the monitoring of performance. In addition, Mr. Campana is adept at developing functional organizational structures and has considerable experience with electronic information systems, including the development and implementation of electronic medical records systems.

Joel Friedman, Ph.D. – *Clinical Director*

Dr. Friedman is a licensed psychologist. Over the past 22 years, Dr. Friedman has provided direct care, managerial services, policy development and consulting services in several different correctional systems, including the California Department of Corrections, the Federal Bureau of Prisons, the New Jersey Department of Corrections and several county jail facilities. Dr. Friedman has also served as the Statewide Director of Mental Health for the New Jersey Department of Corrections. As CFG's Clinical Director, Dr. Friedman's current responsibilities include oversight of all mental health evaluations being completed on inmates who are eligible for parole in the New Jersey State Parole Board system. In the role of Clinical Director, Dr. Friedman also provides support in the areas of policy review and revision, CQI development and in behavioral healthcare programs. In addition, Dr. Friedman provides organizational development assistance, as well as managerial support and consultation.

Dennis Sandrock, Ph.D. – *Director of Mental Health at Middlesex County, Mental Health Training Specialist*

Dr. Dennis Sandrock is a licensed clinical psychologist with 22 years of experience providing and managing mental health care in a variety of settings. His first 10 years of clinical work were spent providing and supervising outpatient mental health care in a large urban hospital setting. For the past 15 years Dr. Sandrock has worked primarily in correctional settings providing clinical supervision and management of mental health programs in NJ state prisons, as well as a number of County jails. He has particular experience in the clinical management of specialized correctional populations such as female offenders, seriously mentally ill offenders, actively suicidal offenders and violent sexual offenders. As a manager of clinical staff treating these populations he has been directly involved in the resolution of problems with these inmates. He has been responsible for the

implementation and direction of both inpatient and outpatient mental health services in correctional settings. He has been responsible for supervising treatment team leaders in managing their CQI projects and has been involved in the development and revision of policies in order to better serve the needs of various correctional facilities. He has been involved in the orientation training and annual training of corrections officers in prisons and jails. He is certified by the Police Training Commission of NJ as a certified police trainer. He brings with him a vast array of practical skills in the management and treatment of inmates and detainees in a variety of correctional settings.

James G. O'Quinn, D.Min., CSTOP – *Director of Sex Offender Program*

With award of contract, Dr. O'Quinn will be procured as part of the CFG team to oversee the Sex Offender Therapy Program. Since January of 2012, Dr. O'Quinn has worked as the lead counselor for the sex offender treatment program covering all Level IV and Level V prisons in the State of Delaware and, thus, has acquired in-depth knowledge concerning the programming needs inherent to the various facilities within the Delaware Department of Corrections. Dr. O'Quinn began work with perpetrators of abuse and their victims through appointment to a specialized ministry, went on to help found Lifeline Counseling Associates, Inc., and has been endorsed by the United Methodist Endorsing Agency for his work as a pastoral counselor. In this specialized work, Dr. O'Quinn has provided individual and group therapy for over 600 batterers and 1200 sexual offenders. Rounding out Dr. O'Quinn's ample qualifications, he maintains certification as a CSOTP (Certified Sex Offender Treatment Provider) and as a Domestic Violence Counselor; is a Diplomate of the National Board of Forensic Counselors; and is also a trained conflict mediator.

Geoffrey Boyce - *Executive Director of Telemedicine*

A former new venture consultant, Mr. Boyce joined CFG in 2008, complementing our team with his expertise in the development and growth of new businesses within the service industry. Before joining CFG, Mr. Boyce helped launch and grow a number of companies in the Atlanta area and led a grassroots lobbying effort to bring commuter rail to Atlanta through a newly-founded, non-profit organization.

James Neal, M.D., FACP, CCHP – *Corporate Medical Director*

With over 31 years in corporate medicine, 20 of which have been focused specifically upon correctional healthcare, Dr. Neal's experience in the management of large correctional healthcare systems is vast. He has served as the former Medical Director for the statewide healthcare provider contracted by the New Jersey Department of Corrections, as a Correctional Healthcare Consultant and as a regional, statewide and Vice President Medical Director in New Jersey, New York and Missouri.

As Corporate Medical Director, Dr. Neal's duties include hiring a Medical Director for the site, the establishment of clinical standards, the review and modification of policies and procedures, clinical management of practitioners, development of quality assurance programs, peer review and review of all practitioner requests for off-site consultation and non-formulary medications. Dr. Neal also develops in-service programs to meet the needs of each contracted site's practitioners and acts as chairman of the quality assurance, pharmacy and therapeutics committees. A major component of Dr. Neal's focus is upon on-going assessment of clinical practice and its compliance with regulatory standards and credentialing bodies' guidelines.

Sandra Vargas, RN, CCHP – *Director of Correctional Health Services*

Ms. Vargas provides direct provider oversight and serves as liaison for all of CFG's correctional contracts. She has worked as a Registered Nurse for nineteen years and has been directly involved in correctional healthcare for the past fifteen. For the last ten years, Ms. Vargas has provided health service supervision and management for the Middlesex County Department of Adult Corrections and Youth Services. As a manager, Ms. Vargas has established systems to monitor health process, indicators and unexpected illness. Ms. Vargas has also worked diligently in the development of multidisciplinary action plans and programs for the provision of quality healthcare to offenders. It has been the philosophy of this healthcare provider and manager to offer prevention and educational programs to those in high-risk populations, in order to help curb outbreaks within correctional facilities and among the public upon inmate release. Ms. Vargas believes the promotion of higher standards of care by nurses in correctional healthcare has potential benefits that extend far beyond the walls of incarceration.

Denise R. Rahaman, RN, CCHP-RN – *Operations Director for Corrections*

Ms. Rahaman is a program administrator with considerable senior management experience in correctional, general and home healthcare facilities. Developed throughout her over 30-year career in health services, Ms. Rahaman has gained valuable experience and excellent practice in turning around poorly-run facilities through rigorous applied management techniques. While adept at identifying system failures, Ms. Rahaman's true specialty lies in instituting the change necessary to make failing or flagging institutions successful by implementing replacement systems that enhance operations in all areas – from program management to budget control to policy development to motivational efforts.

Keith L. Dunoff, D.M.D. – *Corporate Dental Director*

Dr. Dunoff, a University of Pennsylvania School of Dental Medicine graduate, is a member of many professional organizations including: the American Dental Association, the New Jersey Dental Association, the American Society for Geriatric Dentistry's Board of Directors, the Special Care Dentistry Association and the Academy of General Dentistry. He has hospital affiliations at Our Lady

of Lourdes Medical Center and West Jersey Health System's Virtua Hospital. Dr. Dunoff also has a clinical appointment as Associate Professor at the University of Pennsylvania's School of Dental Medicine, where he teaches restorative dentistry on a weekly basis. He has been a consultant to the insurance industry, working with Bravo Elder Health Plans, Prizm Solutions and many long-term care nursing facilities. During the start-up of his private practice, Dr. Dunoff concurrently founded a mobile dental service that provides on-site care to well over 150 facilities in both New Jersey and Pennsylvania, including a vast number of correctional facilities.

Grace Nugent, MD, D.H.L. – *Associate Medical Director of Correctional Healthcare*

Dr. Nugent is a physician with over two decades of experience in General Internal Medicine – Primary Care Medicine and particular expertise in correctional healthcare within New Jersey, working as a Staff Physician, Medical Director and Associate Director of Correctional Healthcare at Midstate State Prison, Riverfront State Prison, the Middlesex County Department of Corrections and the Atlantic County Justice Facility. Dr. Nugent enjoys taking an active role in procedural committees and the organizational development of staff and patient care. She also has taken considerable initiative in coordinating the medical care education of staff, nursing and the community. Falling right in line with CFG's belief in collaboration, Dr. Nugent views medicine as a team effort and takes great pride in the respectful and supportive relationships she has established with colleagues, patients, patient families, staff and other caregivers.

Mike Miller - *Information Technology*

Mr. Miller is a seasoned professional with over 25 years of "hands-on" IT and project management experience. Prior to joining CFG, Mr. Miller held various senior management positions, including Chief Technology Officer (CTO) for a large, publicly-traded corporation. Mr. Miller has earned major certifications from Microsoft, Cisco and Novell and is a member of several professional organizations. Mr. Miller also has an extensive background in consultative services and facilities management. Throughout his career, he has developed a reputation for providing innovative solutions to the IT challenges presented by today's competitive business world.

Jeanine P. Miles, LPC - *Director of Business Development and Training*

Ms. Miles is a New Jersey-licensed Professional Counselor with prior experience working for the New Jersey Department of Corrections (NJDOC). In addition, Ms. Miles has over 17 years administrative and management experience in medical and behavioral healthcare. Ms. Miles' responsibilities with CFG include the development and implementation of new programs and oversight of all start-up projects. Ms. Miles also oversees CFG staff development and training programs, orientation and site management training.

Michael Panisak - *Chief Financial Officer*

Mr. Panisak comes to CFG with over 16 years of experience in management, accounting and finance for both small and large healthcare systems. He has a history of successfully streamlining operations and improving bottom line profit growth. He is also well-versed in mergers and acquisitions of for-profit and non-profit organizations. As CFO, Mr. Panisak plays an integral role in the company's management team. He is responsible for implementing and supervising internal controls and driving strategic financial decisions.

Nancy DeLapo, LPN - *Director of Staff Development & Recruitment*

Ms. DeLapo has over 19 years of experience in the field of recruitment and employee management. Coming to CFG from acute care, LTC and sub-acute nursing facilities, Ms. DeLapo previously managed the recruitment of over 14,000 employees while servicing multiple sites throughout New Jersey. At CFG, Ms. DeLapo specializes in the direct recruitment of RN's, LPN's and medical assistants.

Matt Konstance - *Human Resources Director*

Mr. Konstance has operated in many HR capacities, from a generalist in a one-person department to creating and leading a comprehensive department covering multiple sites. In his role as the Human Resources Director for CFG, Mr. Konstance is responsible for the overall leadership of a department responsible for meeting all of the human resources-related needs of the organization, including: employee relations, policy and procedure development, benefits and compensation, and compliance with all federal, state and local laws.

Stephen D. Holtzman, J.D. - *Risk Management*

Mr. Holtzman is an attorney specializing in healthcare law and contracts. With over 23 years of experience, the last 16 spent focusing mainly upon correctional healthcare, Mr. Holtzman is recognized as the foremost medical malpractice attorney in the State of New Jersey. Client services Mr. Holtzman offers include the development of compliance programs and providing management strategies to corporations, focusing on the reduction of frivolous claims. Mr. Holtzman also runs workshops for clinicians regarding clinical documentation aimed at minimizing inadvertent causes of

litigation. Additionally, Mr. Holtzman provides training and lectures on risk management, audits facility medical units and participates in the development and implementation of related policy.

C & L Bradford and Associates – *Utilization Review*

CFG relies upon the excellent reputation and services of C & L Bradford & Associates for Utilization Review. In business since 2000, C & L's initial primary function was preparing correctional

healthcare facilities for accreditation with NCCHC, with a secondary focus upon redesigning organizations to meet their financial goals and human resource requirements. Over the years, the company expanded its purpose and focus to include utilization review management, provider contract negotiations and case management. In this vein, C & L has been instrumental in reducing healthcare costs for the clients they serve. Their estimable client list includes such notables as the DeKalb County Jail, AstraZeneca Pharmaceuticals, Nassau Healthcare Corporation, the Delaware Department of Corrections, the Fulton County Housing Authority and the Fulton County Jail.

Each member of C & L Bradford's team has over 30 years of experience in the healthcare industry, with the president having more than 20 years of experience in correctional healthcare alone, managing contracts with incarcerated populations ranging from 500 to 28,000 inmates.

C & L realizes the critical importance of risk management in today's fiscal environment and seeks to minimize risk and prevent the occurrence of adverse situations by ensuring patients receive quality care in adherence to established standards.

C & L Bradford and Associates also provides administrative services that reduce processing time, prevent erroneous billing and deny unauthorized services. They can also prepare customized claims analyses suitable to the specific needs of each organization. Using C & L Bradford & Associates' quarterly reports, they are able to help clients recognize trends in service utilization and disease processes, allowing organizations to seriously evaluate their existing needs, make changes accordingly and strategically plan for the future.

CFG EXISTING DELAWARE PSYCHIATRIC TEAM

CFG presently employs a team of Psychiatrists and Nurse Practitioners who actively practice within the State of Delaware. The names of several key team members have been included below. **Résumés for these individuals can be found in the Résumés section of this proposal.**

Maasi Shamilov, MD

Dr. Shamilov has 24 years of psychiatry experience and has been an integral part of the CFG medical staff since 1998. Dr. Shamilov is boarded in Child and Adolescent Psychiatry. He has been practicing via telepsychiatry for over twelve years and also provides in-person psychiatric evaluation and care to correctional facilities, hospitals and outpatient offices throughout the nation.

John Smith, MD

Dr. Smith is board-certified in Child and Adolescent Psychiatry. He joined the CFG team in 2010. Dr. Smith has worked in private practice and served on a number of hospital medical staffs. Dr. Smith is an expert at delivering psychiatric care via telemedicine and holds medical licenses in three states, including Delaware.

Christina Vaglica, MD

Dr. Vaglica has been an enthusiastic member of the CFG medical staff since 2011. She is board-certified in Child and Adolescent Psychiatry and Psychiatric Mental Health. She holds medical licenses in Delaware and eight other states and is capable of servicing clients via telepsychiatry.

Amit P. Kurani, MD

Dr. Kurani has practiced psychiatry with the CFG team for the past eight years. Dr. Kurani is board-certified and holds medical licenses in Delaware and three other states. Dr. Kurani currently provides emergency evaluations via telepsychiatry at multiple facilities and also provides in-person care at a number of hospitals.

CONTRACTS

CFG marked its foray into correctional healthcare services in 1999 as the mental health sub-contractor for the entire New Jersey Department of Corrections, servicing over 25,000 inmates. Since then, CFG has gone on to steadily expand the scope of its care, obtaining numerous contracts in correctional facilities over the past 13 years. As a local, New Jersey-based provider, we've acquired an excellent reputation providing full spectrum correctional healthcare services to nearly 9,000 offenders and behavioral healthcare services to over 21,000.

Working with various accrediting bodies, CFG has also developed surveys, protocol and programs to meet the distinct and specific needs of correctional institutions. Several of these programs and services have garnered praise and accolades from individual sites and NCCHC auditors, among others. Our experience, combined with our philosophy of service, demonstrate CFG's unwavering dedication to the provision of exceptional clinical care and client services.

As evidence of CFG's substantial experience in the delivery and management of comprehensive institutional healthcare services in a correctional facility, we offer the following list of correctional healthcare contracts that CFG either presently holds or has held in the past, in chronological order.

Mental Health Sub-Contractor for the New Jersey Department of Corrections - 1999 to 2005

As sub-contractor to the primary medical services contractor, CFG provided the psychological services at all facilities statewide, employing approximately 65 psychologists. Additionally, CFG provided psychiatric services for the southern region facilities. **The statewide inmate population at the time of contract was approximately 25,000.** Many of the state's facilities were both NCCHC and ACA accredited.

Jamesburg (Concept Program), NJ Juvenile Justice System – 2002 to 2005

CFG provided residential treatment for 24 adolescent offenders, including*:* behavioral healthcare treatment; psychiatric services; academic studies; a behavioral management program; and around the clock supervision.

Middlesex County Department of Corrections & Youth Detention Center – 2002 to Present

CFG currently maintains a full-service medical contract servicing a daily population of approximately 900 adult offenders. Services include the provision of comprehensive medical/primary care physicians, as well as on-site dentistry, around the clock nursing care,

pharmaceuticals and psychological and psychiatric services for both the adult and juvenile population.

The juvenile population is housed in a building separate from the adult facility and is supervised by nursing staff 16 hours a day. In the event a juvenile resident requires additional nursing assessment or assistance after hours, nurses from the adult facility are able to provide additional nursing supervision.

CFG worked with the county municipalities to initiate after-hours telepsychiatry services within this facility, as well. This value-added service has proven to be both cost-effective and successful in curbing unnecessary inmate trips to the emergency room.

CFG is also responsible for oversight and management of the Social Services Department. Social Services manages daily objective inmate classification, courtline, weekend releases, the ordering of NCIC reports for county parole violators, the scheduling and coordination of inmate religious services, volunteer programs, and oversight for the management of student education programs.

This facility is NCCHC accredited.

Mercer County Correction Center, NJ – 2003 to 2006

CFG provided mental health services for an average daily inmate population of 800.

Monmouth County Correctional Facility and Youth Detention Center – 2004 to 2007

CFG provided full-spectrum medical and behavioral health services, as well as processing for off-site medical claims for this 1,300 bed county jail.

New Jersey State Parole Board - 2004 to Present

CFG currently provides pre-parole evaluations for the entire state prison system, with approximately 12,000 evaluations completed per year.

Atlantic County Justice Facility – 2004 to Present

CFG currently provides full-spectrum medical and behavioral health services to an average daily inmate population of 1,000.

This facility is NCCHC accredited.

Camden County Correctional Facility – 2004 to Present

CFG currently provides full-spectrum medical and behavioral health services to **an average daily inmate population of 1,600.** Services include the provision of all comprehensive medical/primary care physicians, on-site dentistry, around the clock nursing care, pharmaceuticals and psychological and psychiatric services for the adult population.

In addition to these services, CFG also manages the hospital utilization review of direct admissions that are considered the security responsibility of the correctional facility while hospitalized. CFG's utilization management approach has assisted in early collaboration for discharge planning to the jail, continuity of services and prompt releases to jail with a full understanding of the level of nursing care needed.

CFG has collaborated with community mental health programs and screening facilities to support discharged inmates.

CFG has also implemented after-hours telepsychiatry services in this correctional facility, providing additional and immediate mental health support for after-hours crises, emergencies and consult.

This facility is NCCHC accredited.

Bucks County Correctional Facility – 2005 to Present

CFG currently provides mental health services for an 800 bed facility.

This facility is NCCHC accredited.

Salem County Correctional Facility – 2005 to Present

CFG currently provides psychiatry and psychology services for an average daily inmate population of 250.

Cumberland County Jail – 2006 to 2009

CFG provided psychiatry, psychology and telemedicine services for an average inmate population of 630.

Warren County Jail – 2006 to Present

CFG currently provides full-spectrum medical and behavioral health services for an average daily inmate population of 250.

This facility is NCCHC accredited.

Cumberland County Jail – 2007 to 2010

CFG provided a Medical Director and telemedicine services for an average inmate population of 630.

Mercer County Jail, PA – 2007 to 2010

CFG provided full-spectrum medical and behavioral health services for an average daily inmate population of 200.

Juniata County Prison – 2007 to Present

CFG currently provides medical services for an average daily inmate population of 50.

Somerset County Jail – 2007 to 2011

CFG provided both social and educational services at this facility.

Essex County Correctional Facility – 2008 to Present

CFG currently provides full-spectrum medical and behavioral health services for **an average daily inmate population of 2,300**. Services include the provision of all medical/primary care physicians, on-site dentistry, around the clock nursing care, pharmaceuticals and psychiatric services for the adult population.

In this facility, CFG manages approximately 80 full-time employees consisting of physicians, nurse practitioners (NP's), physician assistants (PA's), registered nurses (RN's), licensed practical nurses (LPN's) and ancillary staff.

- Essex County Correctional Facility also has a 48 bed in-patient infirmary (38 males/10 females) that is managed by the RN staff and physicians.
- The dental suite operates daily and has three chairs. Additionally, an on-site oral surgeon is available, as needed, for specialty services.
- There is a dialysis suite in the medical department that operates daily, accommodating three treatments concurrently.
- Essex County Correctional Facility also houses County, State, U.S. Marshal and ICE detainees. The ICE and U.S. Marshal detainees have specific federal requirements and policies governing their healthcare and incarceration. Since the arrival of ICE and U.S. Marshal detainees, CFG has maintained 100% compliance with and support of the federally-monitored program.

This facility is NCCHC accredited.

Mercer County Correction Center, NJ– 2009 to Present

CFG currently provides full-spectrum medical and behavioral health services (with the exception of nursing) for this 800 bed county jail.

Hudson County Correctional Center – 2011 to Present

CFG currently has a full-service medical contract with HCCC (with the exception of nursing) to service **an average daily inmate population of 1,900.** Services include the provision of all medical/primary care physicians, on-site dentistry, nursing management, pharmaceuticals, psychiatric services for the adult population, claims management and utilization review.

The 28-bed infirmary at the HCCC admits approximately 50 inmates per month, with nearly 80% reporting for medical reasons and 20% reporting for mental health reasons.

HCCC serves pre-trial inmates (55%); county-sentenced inmates (5.6%); pre-sentenced inmates (2.5%); state-sentenced inmates awaiting transfer to or remanded from a New Jersey State Prison (3%); and Federal and ICE Detainees (33.9%).

Approximately 2,919 prescriptions for about 785 inmates are filled each month. The HCCC averages 32 inmates per month on HIV-AIDS medication and 453 inmates per month on psychotropic medications.

Hudson County Juvenile Detention Center – 2011 to present

The average daily population at the Hudson County Juvenile Detention Center (HCJDC) is 64 residents.

The Hudson County Juvenile Detention Center (HCJDC) processed 1,002 juveniles in 2009. The standards for juvenile care are mandated by the New Jersey Juvenile Justice Commission, Juvenile Manual of Standards.

The Hudson County Juvenile Detention Center is both NCCHC and ACA accredited.

ADMISSIONS DATA

- **Mental Health Admissions are 25 per thousand per year.**
  (Please note: statistics are based upon jail populations, where turnover rates are significantly higher)

- **Average Length of Offender Mental Health stay is 5.76 days.**

PROFESSIONAL REFERENCES

The following individuals can attest to the vision, capacity and resolve CFG demonstrates as an accomplished and adept provider of correctional healthcare services:

Russell Geoffrey, MD

Statewide Mental Health Director, NJ DOC (CMS)
McGuire Air Force Base
CTR USAF AMC 305 MDOS/SGOW
609-315-2048

Dave Parcher

Executive Director
Kent Sussex Counseling Services
302-735-7790
dparcher@kscs.org

Lynn Fehey

Chief Executive Officer
Brandywine Counseling and Community Services
302-454-3020
lfahey@brandywinecounseling.org

Loretta Ostroski, RN

Nurse Manager Department of Emergency Services
Beebe Medical Center
302-645-3294
lostroski@bbmc.org

Paul Minnick

VP, Patient Care Services
Beebe Medical Center
302-645-3270
pminnick@bbmc.org

Herb Kaldany, MD

Director of Psychiatry
New Jersey Department of Corrections
609-984-4102
Herbert.Kaldany@doc.state.nj.us

William Plantier
Director of Corrections
Bucks County, New Jersey
215-340-8484
wfplantier@co.bucks.pa.us

FACILITY REFERENCES

NCCHC Accredited

Middlesex County Correctional Facility and Department of Youth Services
Route 130 & Apple Orchard Lane
North Brunswick, NJ 08902
Edmond Cicchi, Warden
Phone: (732) 297-3636
Fax: (732) 951-3322
edmond.cicchi@co.middlesex.nj.us

NCCHC Accredited

Essex County Correctional Facility
354 Doremus Avenue
Newark, NJ 07105
Alfaro Ortiz, Director
Phone: (973) 274-6253
Fax: (973) 274-6955
aortiz@eccorrections.org

NCCHC Accredited

Camden County Correctional Facility
330 Federal Street
Camden, NJ 08103
Eric Taylor, Warden
Phone: (856) 225-7632
Fax: (856) 964-3207
etaylor@camdencounty.com

NCCHC Accredited

Bucks County Correctional Facility
1730 S. Easton Road
Doylestown, PA, 18901
Terry Moore, Warden
Phone: (215) 345-3798
Fax: (215) 345-3836
tpmoore@co.bucks.pa.us

NCCHC Accredited

Atlantic County Correctional Facility
5060 Atlantic Avenue
Mays Landing, NJ 08330
Joseph Bondiskey, Warden
Phone: (609) 625-4090
Fax: (609) 625-7620
bondiskey_joseph@aclink.org

NCCHC Accredited

Warren County Jail
Adult Correction Center
175 County Road 519 South
Belvidere, NJ 07823
Robert Brothers, Warden
Phone: (908) 475-7915
Fax: (908) 475-7915
rbrothers@co.warren.nj.us

Salem County Correctional Facility
125 Cemetery Road
Woodstown, NJ 08098
Raymond C. Skradzinski, Undersheriff/Warden
Phone: (856) 769-8105
Fax: (856) 769-3578
rskradzinski@salemcountynj.gov

Juniata County Prison
P.O. Box 122
Mifflintown, PA 17059
Teresa O'Neal, Warden
Phone: (717) 436-2213
Fax: (717) 436-7763
toneal@co.juniata.pa.us

Hudson County Correctional Center
30-35 South Hackensack Avenue
Kearny, NJ 07032-4690
Oscar Aviles, Director
Phone: (201) 395-5600
Fax: (201) 395-5614
oaviles@hcnj.us

Mercer County Correction Center
P.O. Box 8068
Trenton, NJ 08650
Charles Ellis, Warden
Phone: (609) 583-3553
Fax: (609) 583-3560
cellis@mercercounty.org

ADDITIONAL VENDOR REFERENCES

Below are references who can attest to CFG's financial capability to carry out the requirements set forth in this bid:

BioReference Laboratories 481 Edward H. Ross Drive Elmwood Park, NJ 07407 800-229-5227 X8767 Contact: Sujaya Swaroop (201) 218-6530	**Contract Pharmacy Services, Inc. (CPS)** 125 Titus Avenue Warrington, PA 18976 Contact: Ann Borell, Senior Vice President (800) 555-8062 x9007	**Bank of America** 4 Sentry Parkway, Suite 200 Blue Bell, Pa. 19422 Contacts: Joseph Campbell, Senior Vice President (888) 852-5000 x1075 MaryAnn McGrath (888) 852-5000 x1076
Mobilex 101 Rock Road Horsham, PA 19044 Contact: Steven Penalver (732) 266-5042	**St. Francis Medical Center** 601 Hamilton Avenue Trenton, NJ 08629 Contact: Jerry Jablonowski, Chief Operating Officer (609) 599-5018	**McKesson Medical-Surgical Supplies** P.O. Box 933027 Atlanta, GA 31193-3027 Contact: Richard Kuball (215) 888-4286
AmeriHealth Administrators 720 Blair Mill Road Horsham, PA 19044 Contact: Gerry Hoffner, Senior Benefits Consultant (215) 830-2709 gerry.hoffner@amerihealth-tpa.com	**Conner Strong & Buckelew** 40 Lake Center Executive Park 401 Route 73 North, Suite 300 P.O. Box 989 Marlton, NJ 08053 Contact: Jack Tarditi, Managing Director (856) 552-4792 jtarditi@connerstrong.com	

ACCREDITATION

CFG shall fully participate in any and all efforts to meet the requirements for accreditation established by the National Commission on Correctional Health Care (NCCHC), the American Corrections Association (ACA) and other accrediting bodies as determined by the DDOC.

CFG is dedicated to improving the quality of correctional health services and helping correctional facilities provide both effective and efficient care. As such, NCCHC and ACA standards are the primary tools we rely upon for assuring proper management, delivering quality healthcare, improving the health of offenders and making connections to the communities to which many offenders return. Many on our correctional healthcare team of professionals are recognized by the NCCHC as CCHP's (Certified Correctional Health Professionals). Certified Correctional Health Professionals are able to demonstrate a unique and specialized understanding of the practice of healthcare within correctional facilities, utilizing standards established by the NCCHC itself. CCHP designees also carry with them professional recognition as leaders in the field.

With over 42 combined years of experience in correctional healthcare, Dr. James Neal, our Corporate Medical Director; Sandra Vargas, RN, the Director of Correctional Healthcare Services; and Denise Rahaman, RN, the Operations Director for Corrections are all seasoned veterans in obtaining and maintaining NCCHC and ACA accreditation, in fully understanding the big and small details that comprise facility operations and in the delivery of exceptional, reliable correctional healthcare.

CFG demonstrates an incomparable level of expertise in meeting and applying accreditation standards and in collaborating with accrediting bodies and agencies. CFG is proud of our having achieved 100% compliance for recent New Jersey contracted facilities including: the Atlantic County Justice Facility, the Camden County Correctional Facility and the Essex County Correctional Facility.

We credit our success to the administration of on-going, rigorous compliance surveys, to the implementation of correctional facility "best practices," to the unique and in-depth knowledge we have of the local communities we serve, to upholding higher standards of care and to working collaboratively with facility monitors and custody representatives.

CFG shall work in collaboration with the DDOC and individual facilities in the development and implementation of all policies and procedures necessary to acquire and maintain current accreditations with the American Correctional Association (ACA) and the National Commission on Correctional health Care (NCCHC).

Accreditation Table (see Table 1.)

Table 1 provides an overview of accreditation status at all facilities CFG is currently contracted with in New Jersey, with the exception of Mercer County Correction Center. **We are proud to report that all sites with NCCHC accreditation have maintained their certification, with three sites scoring 100% on their most recent survey report**. Accreditation has often been achieved in the face of significant challenges. At Hudson County Correctional Facility (HCCC), not only were we able to successfully complete a 30-day start-up in mid-May of 2011, but we were **able to apply for NCCHC initial survey within 6 months**. In addition, we are proud to announce that Mercer County Correction Center has now embarked on a course aimed toward completing the NCCHC accreditation application in 2012.

With the award of this contract, CFG shall bring both our excellent reputation and our considerable expertise to bear in acquiring and maintaining facility accreditation.

Table 1.

Facility	NCCHC Survey Year	NCCHC Survey Results	NJ DOC	ICE	ICE Surveys	ACA	Infirmary
Atlantic County Jail Facility – averages 1,000 inmates; CFG contract established 2004	2011	**100%**	Standards Met; No Health Deficits	N/A	N/A	N/A	10 beds
Bucks County Correctional Facility – averages 800 inmates; CFG contact established 2005	2009	All standards met	Standards Met; No Health Deficits	N/A	N/A	N/A	N/A
Camden County Correctional Facility – averages 1,600 inmates; CFG contract established 2004	2011	**100%**	Standards Met; No Health Deficits	N/A	N/A	N/A	6 beds
Essex County Correctional Facility – averages 2,300 inmates; CFG contract established 2008	2010	**100%**	Standards Met; No Health Deficits	+500 detainees	No Health Deficits	N/A	48 beds
Hudson County Correctional Center – averages 1,900 inmates; CFG contract established May 2011	New Application Filed	Not Applicable	Standards Met; No Health Deficits	+400 detainees	No Health Deficits	N/A	16 beds
Hudson County Juvenile Detention Center – averages 60 inmates; CFG contract established May 2011	2011 Reaccreditation Survey Scheduled for 2012	Not Applicable	Standards Met; No Health Deficits	N/A	N/A	Current	1 bed
Middlesex County Department of Correction – averages 900 inmates; CFG contract established 2002	2010	All standards met	Standards Met; No Health Deficits	N/A	N/A	N/A	14 beds
Warren County Correctional Facility – averages 250 inmates; CFG contract established 2006	2010	All standards met	Standards Met; No Health Deficits	N/A	N/A	N/A	N/A

ADDITIONAL CONSIDERATIONS

Let it be known that:

- No facility contracted with CFG has ever lost accreditation during contract tenure.
- CFG has never experienced a loss of funds due to fines, delay damages, liquidated damages and/or forfeiture of performance or proposal bonds in whole or in part.
- No facilities owned or operated by CFG are on probation.
- CFG has never had a contract terminated or cancelled prior to contract expiration.
- CFG has never had any litigation claims for payments not made for off-site hospital care.
- CFG has never been found liable for any correctional healthcare claim. CFG has never been subjected to any liquidated damages or penalties for contract non-compliance.
- There are not any current or past proceedings, actions, orders or other stipulations against CFG by Federal or State regulatory agencies.
- CFG has never incurred a fine for non-performance of duties, in whole or in part, in its entire history of providing correctional medical and mental health services.
- **A record of litigation relevant to Mental Health services for the past three years has been included on the following page.**
- **Letters attesting to NCCHC certification following the most recent surveys have been included in Appendix A of this document.**

MENTAL HEALTH LITIGATION HISTORY FOR CFG HEALTH SYSTEMS, LLC

DATE FILED	CLAIM NUMBER	NAME	TYPE OF CLAIM	STATUS	DISPOSITION	NATURE OF CLAIM
9/17/2009	2255	Eland, Carol v, CFG	**Suit**	Open	TBD	Failure to treat
5/18/2010	MM261049	Crockett, Laurence v. CFG	**Suit**	Closed	Settled	Failure to treat
12/21/2010	MM258438	Van Leer, David Frank v. CFG	**Claim**	Closed	Dismissed	Failure to treat
2/2/2011	MM258855	Owens, Richard v. CFG	**Suit**	Closed	Dismissed	Failure to treat
3/31/2011	MM259481	Kennedy, Bryan v. CFG	**Suit**	Closed	Dismissed	Failure to treat
8/4/2011	MM260453	Porch, Barry v. CFG	**Suit**	Open	TBD	Failure to treat
3/1/2012	MM262558	Tew, Christopher Scott v. CFG	**Suit**	Open	TBD	Failure to treat

PROPRIETARY

INTRODUCTION

In the Management Structure Section, the relationship between CFG (the Prime Contractor and Mental Health provider) and its sub-contractors was described. This section is devoted to describing how the service providers will work together to ensure a fully unified and efficacious service delivery system.

The underlying tenet of all protocols described here is the concept of a team approach. At every level of the two major service providers -- mental health and substance abuse -- starting with the Statewide Directors and moving down the parallel chains of command, structures have been planned to unite the two disciplines in a common purpose. A few examples of this include the sharing of the planned administrative office space in Dover by the Statewide Directors and their support staff, the weekly Integrated Team Treatment Meetings at each Level V facility, and unified CQI and Staff In-Service Planning committees. The smaller Sexual Offender Treatment and DUI programs will be similarly involved.

This "partnership of peers" concept is meant to close the gap between disciplines and between the Prime Contractor and the sub-contractors. The Executive Staff of CFG, Horizon House and Thresholds will meet at least monthly in the shared administrative offices in Dover to review the operations and assess how well the consolidated organization is meeting its contractual obligations, as well as its clinical standards. This group will help set the team culture which it will pass down to the respective Statewide Directors. While the Statewide Mental Health Director will have final authority over all services as they relate to contract compliance, when it comes to the process of how to best deliver integrated services, all the disciplines will be expected to work together as a team of equals. This value will be conveyed to and expected from every member of the team.

INTEGRATED TREATMENT PLANNING CONTINUUM

INITIAL BEHAVIORAL SERVICES NEEDS ASSESSMENT

Pursuant to DDOC, BOCHC Policy Number E-05, any offender identified by the intake screening nurse as meeting the criteria for a mental health screening will be referred for further assessment by one of CFG's qualified mental health professionals. This assessment will be completed within 14 days of referral. Following that assessment, the CFG mental health professional will document the assessment in the offender's medical record and if behavioral service needs of any modality are indicated, initiate an Integrated Treatment Plan in the Offender Tracking Data Base.

CFG proposed enhancements to this process include the following. CFG proposes to expand the mental health evaluation into a Behavioral Services Needs Assessment which would assess for all of CFG's

contracted service responsibilities, encompassing mental health, substance abuse and sexual offender issues. In addition, CFG is proposing to initiate an Integrated Treatment Plan in an Offender Tracking Data Base which CFG will develop as a stand-alone system or, if feasible, as an enhancement to the DACS and/or future EHR. (See discussion in the Offender Tracking Section below).

If the offender has needs in only one modality, say for example mental health, the appropriate follow-up care indicated in the care plan will be scheduled with the appropriate mental health professional. The data base will also automatically assign the case to a mental health care coordinator who will be responsible for monitoring the case to assure that the care as prescribed by the Integrated Treatment Plan, (ITP) is followed. (There are analogous care coordinator functions for substance abuse and sexual offender cases). When follow-up care or services are rendered, the encounter will document this in the medical record and the ITP shall be revised, if necessary.

The care coordinator concept is meant to assure that no offender's needs are lost in the process and should accomplish one of the target goals identified in the **DOC Health Report of January, 2012 -** i.e., the consistent implementation of treatment plans.

If the offender has co-occurring disorders, the ITP will reflect those needs and referrals will be made to all the appropriate behavioral services professionals. An interim mental health care coordinator will be assigned until all the designated assessments are complete. When the required assessments have been completed the care coordinator will schedule the case for review at the next weekly scheduled Integrated Treatment Team Meeting which will always be attended by representatives from mental health and substance abuse and, if needed, by a representative from the sexual offender treatment program.

The staff of the medical provider will be encouraged to attend these regularly scheduled Integrated Team Treatment Meetings, (ITTPM). In cases in which behavioral issues are negatively impacting medical healthcare, a case specific invitation to the medical treatment staff will be extended.

INTEGRATED TEAM TREATMENT PLANNING MEETINGS

The purpose the ITTPM is to determine the best mix of services to meet the offender's needs. Those service needs will be documented in explicit detail in the offender tracking data base. During the initial ITTPM a determination will be made as to which of the co-occurring disorders is considered primary in order to assign a care coordinator from that discipline.

The assigned care coordinator will function in the same manner as for those offenders receiving services from only one program. When adjustments to the ITP requiring multi-disciplinary participation are necessary, the care coordinator will schedule the case for additional ITTPMs.

THE ON-GOING TREATMENT PLANNING PROCESS

For as long as an offender is incarcerated and continues to be in need of one of the behavioral service modalities, their care coordinator will continue to monitor their care to insure that the ITP is updated and the services dictated by the ITP are delivered as planned. CFG's vision for the Offender Tracking Data Base, in whatever final form it takes, is for it to be a continuously evolving document which serves not only as a guide for the treatment staff, but a guide for the offenders we serve as well. The data base will be designed to produce the most recently updated ITP in a written format. If the data base is not integrated into an HER, the ITP can be printed out and can be placed into a paper record or scanned into an EHR. It can also be given to the offender in certain treatment situations as a guide for their responsibilities in their own treatment and recovery. The value of having offenders sign their ITPs acknowledging their responsibilities to be eligible to participate in any of the structured substance abuse treatment programs is obvious. The document becomes an objective means of measurement used to help keep offenders focused on their goals. In the cases when offenders fail to meet those expectations to the extent that they need to be removed from a program, the ITP can serve as part of the documentation, and in cases where offenders successfully appeal for another opportunity, a more tightly wound ITP may give them a chance for real breakthrough success.

AFTERCARE PLANNING

Aftercare planning is not a discreet function, but an inherent component of the ITP. The Offender Tracking Data Base will be designed to require that, at the very least, a tentative or speculative aftercare plan be described, even for offenders with long sentences. Every time an update is noted in the ITP, the document will require the clinician or care coordinator to verify that the aftercare plan is up-to-date.

As an offender's release date approaches, the care coordinator will begin contacting the identified community programs and support systems to begin solidifying the plan. Whenever feasible, attempts will be made to bring representatives from community support groups into the facility to participate in an aftercare planning meeting with the offender, the care coordinator, and the appropriate Case Manager from either the MH or the SA programs, who will be tracking the offender's progress post-release. The care coordinator will secure the written authorization from the offender using Release of Information Forms generated from the Offender Tracking Data Base, allowing information to be shared with the identified community support agencies **and** for those agencies to share information with the CFG Case Manager post-release.

The Offender Tracking Data Base will also be used to produce a printed copy of the formal aftercare plan to give to the offender before his/her release and to all the community agencies authorized to receive it by the offender's release of information consent.

POST-RELEASE

The post-release phase of the treatment planning continuum is focused on those offenders who have been judged to a have a "high risk of recidivism" (discussed further below). The budget includes Case Management personnel to follow-up on the progress of high-risk offenders after they are released from custody. The Case Manager will have access to the Offender Tracking Date Base, including documenting the offender's/client's progress post release relative to specific key aftercare indicators. The Case Manager's duties will include calling the aftercare agency immediately after the first scheduled appointment to verify whether the client showed up, contacting the client directly and/or the client's family, etc. In situations where the aftercare plan is in danger of collapsing, there is some possibility that some action on the Case Manager's part could resurrect it. These actions could include getting the perspective from both the client and the support agency about why the plan was failing and intercession to improve communication. Actions could also include involving the family to support the client in following through. Actions may entail involving the client's counselor or therapist from when they were still incarcerated, appealing to the support agency's leadership to make good on the commitments it had made to the client as documented in the aftercare plan, or even making a referral to another agency on the client's behalf (with the client's written consent). Obviously there are time and other limitations as to what the Case Manager will be able to do, so these direct intervention activities post-release can only be expended in circumstances in which there is some reasonable likelihood of success.

Ideally the Case Manger will not have to get actively involved so that they can focus on their primary task - i.e. following up on the progress of client's up to six months or more post-release (this time frame is dependent on the particular recidivism risk-factors and the follow-up protocols that are developed in concert with the DDOC, and other State and community stakeholders.) The information collected by the Case Manager in the Offender Tracking Data Base will be invaluable in assessing the effectiveness of the aftercare planning process and to some extent of the community agencies providing the aftercare.

THE INTEGRATED TREATMENT PLANNING CONTINUUM AND I-ADAPT

The treatment planning process outlined here is entirely in synch with the Governor's I-ADAPT initiative (Individual Assessment, Discharge, And Planning Team). Should CFG be awarded the contract, a key task will be to work with the DDOC to extend the use of existing risk of recidivism assessment tools and, if needed, work with other stake holders to refine existing tools and/or develop new ones. Being able to recognize the risk factors during the intake process is a fundamental component of any recidivism reduction program. It also happens to be a great tool from a purely clinical perspective. Individuals, who have maladaptive coping skills demonstrate the same types of destructive behaviors over and over. These types of behaviors can often best be addressed in the highly structured therapeutic programs which the DDOC has developed to a high degree. Quickly identifying these individuals and connecting them with the right treatment modality is simply good clinical care.

THE OFFENDER TRACKING SYSTEM

CFG has been very successful in developing data base systems to help manage both clinical and administrative processes. We have learned that home-grown data base systems can be brought on-line as quickly as or quicker than packaged systems, for a great deal less money. They can also be customized in ways that packaged systems cannot be. In considering the DDOC's requirement for the prospective vendor to develop an offender tracking system, we decided to make it as comprehensive as possible to accommodate our view of the treatment planning process as a continuum. The goal is for it to be a straight line process, i.e. beginning with an initial assessment and ending with the successful aftercare plan. Far too often, it's a closed loop and we believe that the only way to break the circuit is to look at it as an on-going process. Instead of starting over when an offender is reincarcerated and potentially making the same mistakes, we want to be able to adjust the strategy as the situation demands and the best way to do that is to have as much information about what the treatment approach has been before, both in house and in the community. This is the aim of our Offender Tracking concept.

We have designed and budgeted for our system to be a stand-alone system. This of course is not the ideal. It may be feasible to work with the DDOC to enhance the DAC system and/or an EHR which may implemented soon. What CFG brings to the table is a vision of how to use data to manage care. We also have the technical expertise to independently make it a reality. If awarded the contract, CFG proposes to engage in a discussion with the DDOC and the current medical provider to determine the best approach to implement our tracking system. If a stand-alone system is decided upon, CFG will complete the task with the dollars it has budgeted for the project in our cost proposal. If an augmentation to or an interface with another system is decided upon, CFG will commit all the dollars its Offender Tracking System budget for the task. We cannot guarantee that the will task could be completed with our budgeted dollars since we do not know at this point how large an undertaking it may be. We can guarantee that you will find us a capable and determined partner in the endeavor.

EXPANDING THE DIMENSIONS OF THE QUALITY IMPROVEMENT PROCESS

The traditional CQI process is a standard and necessary tool to assess and improve the efficacy of care delivery systems. Its primary limitation, however, is that it takes a retrospective approach -- it measures how well you did with any given performance indicator, which may help you make adjustments which can improve care in the future, but it can't help you avoid performance failures that are happening today. The advent of data base systems and Electronic Health Records opens up a whole new world of

quality improvement initiatives. By using automated exception reports you can measure many parameters automatically and be notified of performance lapses while you still have time to intervene. CFG has begun to aggressively exploit this potential in our contracted jails that currently have EHRs.

Similarly, using a data tool such as our proposed Offender Tracking Data Base, the CQI process can be extended "into the future," - i.e. to assess the care that is provided once the offender leaves a facility. Such a data base tool, combined with a Case Management process that collects data post-release and CQI techniques, can be an invaluable tool in reducing recidivism.

CONTINUOUS QUALITY IMPROVEMENT PROGRAM

CFG maintains a comprehensive clinical Continuous Quality Improvement Program in accordance with professional standards. In support of the ultimate goals of this program (adequate, appropriate, quality and medically-necessary care), CFG shall work closely with the DDOC and individual facility staff.

CFG's Continuous Quality Improvement Program (CQIP) is based upon the PDCA (Plan-Do-Check-Act) cycle (as established and adapted by Dr. W. Edwards Deming) and traditional, didactic principles established by the National Commission on Correctional Health Care (NCCHC). The Plan-Do-Check-Act cycle (PDCA) presents an analytical structure for the continual evaluation of processes and procedures, with a mind toward meeting expected targets and goals. As a cycle, the process is most valuable for:

- Modeling a CQI program
- Starting a new project
- Developing a new procedure, system or service
- Delineating process components
- Preparing data collection tools
- Testing the analytical models and assumptions used to evaluate data
- Prioritizing problems and establishing their causes
- Interpreting outcomes that meet expectations versus those that require change

CFG's CQI program shall include, but shall not be limited to:

- Formal process and outcome studies, as defined by NCCHC
- Continual evaluation of clinical outcomes to assess and ensure:
  - Compliance with clinical pathways
  - That outcomes reviewed are relative to targeted goals

- Patient education and employee training

- Oversight and regulatory testing and reporting including:
  - Medical Audit Committee statistics
  - ICE/U.S. Marshal detainee surveillance and reporting documentation
  - Annual DOC inspections
  - Accreditation surveys
- Staff training and development
  - Orientation and training
  - Competencies and skills assessments
  - Scheduled in-services
  - Maintenance of credentials and licensure, including Basic Life Support (BLS) certification
  - Advanced training and CCHP certification by NCCHC of CFG managerial staff
- Service compliance reports and reviews for:
  - BCHS (Bureau of Correctional Healthcare Services)
  - Custody
  - DOC
  - NCCHC
  - ACA
  - ICE/U.S. Marshals
  - County and State Health Departments
  - Municipal and Federal Courts

Through the implementation of our CQI program, CFG can boast of several notable achievements, including:

- **A 100% pass rate from the NJDOC** for all annual State inspections, including inspections in those facilities where CFG was the newly-appointed vendor and the inspection occurred within 90 days of transfer
- **100% recertification scores from NCCHC** for facility re-accreditations
- Recognition from New York and New Jersey ICE Management for our exceptional medical and mental health management of detainees, as determined by:
  - An expansion contract signed with Essex County
  - Protocol development and systems training by ICE, afforded to CFG management
- Successful collaboration with the Atlantic County Epidemiologist of the New Jersey State Department of Health Bureau of Tuberculosis and the U.S. District Court regarding effective surveillance procedures at the County jail

- Significant Information Technology advances for our clients, including:
  - Electronic medical records (at Essex County)
  - UltiPro Time Management System
  - Pharmacy Management
  - Utilization database
  - Educational in-services
  - Telepsychiatry

Reports shall be distributed to the DDOC Chief of the Bureau of Correctional Healthcare Services on a monthly basis and as needed and shall be certified by the designated supervisory employee.

For all this and more, CFG's team of exceptional, flexible, insightful, responsive and innovative professionals has been recognized by its clients as a premier provider of correctional health services.

PEER REVIEW PROGRAM

CFG mental health staff shall actively participate in the quarterly peer review program as administered by the BCHS and as defined by 24 *DEL. C.* § 1768, and shall discuss all findings with facility managers. CFG shall ensure that all clinical staff implement any corrective action plans developed for the rectification of any deficiencies identified within the peer review process, during a random or scheduled audit or other like processes. CFG acknowledges that providers may have their privileges revoked at any time due to failure to correct identified and outlined deficiencies in performance, or egregious breaches of conduct or clinical performance as judged by BCHS.

MENTAL HEALTH SERVICES

CFG has considerable experience in providing on-site behavioral health services and telepsychiatry services in a number of correctional settings. CFG will comply with all standards established by the American Correctional Association, the National Commission on Correctional Health Care and with policies and procedures established in concert with the Delaware Department of Corrections. CFG, in responding to this proposal, asserts that it maintains the resources to meet this challenge in a competent, efficient and cost-effective manner. Our administrative and clinical leadership teams will be available to confer with the DDOC Bureau Chief at any time, given sufficient notice, in order to address any provisions of our contract with DDOC to provide services, any proposed changes to the contract or any other matter pertaining to the performance of the contract.

The mental health substance abuse treatment, sex offender treatment and DUI offender services we will provide for the DDOC will be informed and guided by the principles and practices that have enabled us to provide high quality services in a number of varied correctional settings. Our clinical team will consist of professionals who have both the experience base and guidance from our management team to meet all of the needs of the programs and services we will provide. It is our philosophy and practice to address the concerns and needs of the correctional systems in which we work in a timely manner. CFG's mental health services are provided within a framework that emphasizes integration of mental health services with the services being provided by substance abuse programs, sex offender treatment programs, DUI programs, vocational programs and classification services. The integration of services starts with the completion of intake assessments that take into consideration the full spectrum of offender needs and the importance of coordination of services between mental health, medical, substance abuse, classification, custody and case management aspects of care for the offender. It is our belief that effective mental health services are best provided when they are founded upon evidence based interventions that have been shown to be both relevant and likely to produce successful outcomes within the offender population. We also believe that mental health services should be guided by the Risk-Need-Responsivity (R-N-R) model that has been offered by leaders in the field of correctional mental health, such as Andrews and Bonta. When the R-N-R approach is taken, the process of reducing potential recidivism, as well as reducing problems that may lead to difficulty in adjusting to the correctional environment, can be initiated from the outset of each offender's time of incarceration.

CLINICAL AND ADMINISTRATIVE SUPERVISOR

CFG will provide a ***Statewide Mental Health Director*** who will maintain administrative and clinical supervision for ***Mental Health Directors*** and ***the behavioral health staff*** at each facility under the purview of the DDOC. The ***Statewide Mental Health Director*** will be held accountable by CFG for meeting the mental health program obligations as outlined in this proposal. The ***Statewide Mental Health Director*** will also work closely with the DDOC Mental Health Administrator to ensure that all

mental health program obligations are met. ***Mental Health Directors*** will be designated at each site and will be responsible for overseeing the behavioral health program and staff at each of the respective facilities.

The ***Statewide Mental Health Director*** position, as well as the ***Mental Health Director*** positions, will be filled by individuals who hold doctorates in psychology and are licensed at that level. The ***Statewide Mental Health Director*** and the ***Mental Health Directors*** will all have experience providing mental health services in correctional environments.

For over a decade CFG has maintained doctoral level Mental Health Directors at the facilities where we provide mental health services. We believe that it is important to have doctoral level psychologists available on-site to provide both clinical supervision and psychological assessments, as needed.

Mental Health Assessments

CFG will provide comprehensive mental health assessments in response to requests for such assessments or as is needed in the course of the provision of mental health services at each facility. Those assessments will contain comprehensive reviews of the offender's psychosocial background, as well as current mental status and treatment needs. In order to ensure that full integration of services occurs, assessments and mental health treatment plans will incorporate input from Substance Abuse, DUI and/or Sex Offender Treatment staff, as is appropriate for each offender. Treatment team leaders from Mental Health Services, Substance Abuse Treatment Programs, DUI Programming and Sex Offender Treatment Programs will work collaboratively in the development of both comprehensive assessments and treatment plans. As noted above, in our general approach to providing services, the Risk-Need-Responsivity model will guide the development of the assessments and treatment plans provided.

Included in the mental health assessments completed by CFG Mental Health Staff will be evaluations to determine whether an offender is competent to make medical decisions. The Mental Health Clinician who completes such an evaluation will work closely with both medical staff and the referral source for the evaluation to ensure that all relevant background information is obtained and taken into consideration as the evaluation is completed.

Delaware Automated Correctional System (DACS)

CFG has significant experience working with various state offender management systems and will ensure all staff utilizes DACS for all its intended purposes as it relates to mental health services. CFG will participate in the DDOC training and will assign CFG trainers who will be tasked with ensuring that all CFG staff is well-trained in the use of DACS.

Case Management of Offenders with Psychiatric Histories or Symptoms

CFG will provide case managers to all offenders with psychiatric histories or symptoms, including: serious mental illness, adjustment difficulties, decomposition, aggressive behavior, suicidal/homicidal ideation, dementia and other significant cognitive/emotional impairment.

Any offender identified as special needs will be assigned a mental health professional. A treatment plan will be formulated and documented, and reviewed regularly. The treatment plan includes, but is not limited to: quantified target symptoms, measurable long and short term goals, projected length of treatment, and appropriate interventions, as well as treatment goal modifications as determined by the treatment team.

MENTAL HEALTH PROGRAMMING

The mental health program is designed to maximize the provision of all mental health services on-site at DDOC institutions through a systematic and continuous program coordinated with compliance plans for NCCHC accreditation.

CFG will work closely with the medical staff to maintain a procedure for brief mental health screening and referral to a designated mental health professional for an offender at admission who is indicated by the screen to require immediate mental health attention. In addition to referrals from the medical department during admission, those offenders referred at other points during their incarceration or those who request services will receive an assessment and orientation to the mental health services available within the DDOC.

If it is determined that mental health services will be needed, the offender will be assigned to a mental health staff member who will serve as a primary therapist for the offender. The primary therapist will ensure that individualized one-on-one treatment services and discharge planning are provided. The process of discharge planning will be taken into account throughout the provision of services and not only as the offender is near his or her projected release date.

CFG is well-versed in evidence-based mental health interventions for offenders with mental health problems and mental health treatment needs. Approaches such as the Illness Management and Recovery model offered by Mueser and correctional programming outlined by Gendreau are examples of the current models of treatment that have been shown to be effective in correctional settings. The current models of correctional treatment will be used to guide CFG staff as they provide both individual and group interventions in the DDOC.

CFG will provide group treatment activities in general population or on Special Needs Units as called for in the program statements developed by the DDOC and determined clinically appropriate by CFG's clinicians.

Groups and other mental health programming will be provided to offenders in segregation based on the clinical needs of the inmates in those units.

CFG has a long history of the development and implementation of group treatment in correctional settings. We will work with the DDOC to provide group interventions that best meet the needs of each facility and the offenders housed in those facilities. Examples of some of the groups that may be offered are:

- **Groups targeting management of Axis I Disorder signs and symptoms**, such as depressed or agitated moods, anxiety, obsessions/compulsions, impulse control problems, thought disorders, etc.
- **Groups for offenders who are diagnosed with personality disorders**. These groups will focus upon improved emotional regulation, increased impulse control and enhanced decision making skills. Included as part of these groups are interventions designed specifically for "cutters" or self-mutilators, often found among those who suffer from Borderline Personality Disorder.
- **Groups for offenders who do not present with a psychiatric diagnosis, but show poor adjustment to prison life due to socialization problems, lack of communication skills or developmental delays.** These groups can often develop a focus or objective over time, but begin as an experience in building social skills.
- **Groups for offenders who are nearing release from incarceration**. These groups will focus on release planning. Topics will include discussion of realistic, functional release plans. Although the topics will be diverse, the group will be consistently focused on the offender meeting the challenges of community life, reintegrating and avoiding the pitfalls that are often associated with recidivism or re-incarceration.

Receiving Screening

Following the mental health screening provided by the Medical Services Vendor staff during the comprehensive intake screening, CFG will complete additional evaluations and testing upon notification via DACS. Offenders who have demonstrated clinical evidence of the following conditions will be evaluated and/or tested by a mental health clinician:

- Impaired cognitive functioning
- Offenders identified as having "special needs" related to mental disorders
- Offenders exhibiting significant psychological distress or positive signs for potential mental health disease/diagnoses

In the event of a positive response to a question on the mental health portion of the receiving screening, qualified mental health professionals, including psychiatrists, psychiatric nurse practitioners, psychologists, psychiatric nurses, mental health clinicians, or psychiatric social workers will perform further mental health evaluation within 24 hours. The mental health evaluation will be filed in the Offender Medical Record. On-call staff will be available 24/7 for those identified during initial screening to require immediate mental health evaluation and assessment. CFG will make available on-call qualified mental health staff, accessible 24/7 to address concerns arising from the following conditions:

- Decompensation
- Aggressive behavior and/or victimization
- Suicidal/homicidal ideation
- Withdrawal
- Dementia
- Other significant cognitive/emotional impairment

Completed full evaluations of offenders will include, at a minimum:

- Psychosocial history; psychiatric history including any hospitalizations, psychotropic medications taken in the past or present; past or present suicidal intent or ideation; history of drug or alcohol abuse; history of any sex offenses or violent behaviors
- Clinical signs of depression or suicidal feelings or thoughts
- Homicidal feelings or thoughts; estimated level of intellectual functioning; history of special education placement; history of developmental disabilities; history of cerebral trauma/seizures
- Current adjustment to incarceration
- Treatment issues
- Recommendations for further assessment for neurological, medical or other follow-up
- Special Housing recommendations, when appropriate
- Need for mental health intervention

Mental Health Training

CFG will maintain responsibility for providing all mental health training for DDOC staff as well as medical, mental health, substance abuse treatment and sex offender treatment providers. **We strongly believe training that is relevant and effectively engages staff members is an essential aspect of the provision of mental health services in correctional settings.** Among our clinical team are many highly-qualified individuals who have provided training and presented on correctional topics for County, State and national organizations. CFG has also been a key contributor to the development of the Crisis Intervention Team program in New Jersey, helping to train hundreds of law enforcement, mental health and medical professionals on several different mental health topics. We have a training academy that

has been credentialed by a national credentialing body to provide training for our staff in New Jersey. CFG has also maintained American Psychological Association approval to provide continuing education for psychologists.

We will provide training on topics such as mental health awareness, co-occurring disorders, suicide prevention, and special needs population to DDOC and medical staff. We will provide ongoing training on topics such as treatment planning, behavior plans, suicide risk assessment, trauma-informed care, evaluation and treatment to our mental health, substance abuse and sex offender treatment staff.

In addition to the topics noted above, CFG recognizes the benefit of enhancing the knowledge and awareness of mental health issues for DDOC staff and administration in a manner tailored to meet the needs of various departments within the DDOC. A program will be implemented on a departmental basis with information suited to the needs of staff in each department. Thus, a program for classification would include topics related to mental health terminology and diagnostic categories, risk factors for the mentally ill in reduced custody settings, medication in reduced custody settings and a history of mental illness as a predictor of adjustment to a custody level.

Treatment Plans

Each offender receiving mental health treatment who remains in the DDOC for more than 72 hours will be offered an opportunity to collaborate with the Interdisciplinary Treatment Team (ITT), including representatives from the Medical Services Vendor, the Mental Health Services Vendor, DDOC Security for the facility, DDOC treatment staff and other ancillary staff in the development of an individualized treatment plan, and to agree to this plan in writing. Basic plans will be developed by the ITT even when offenders decline to participate. The role of each treatment discipline will be discussed during this collaborative effort. It is our belief that treatment should be integrative in nature and not consist of parallel tracks of treatment. The treatment plan will be reviewed and signed by all members of the treatment team. When possible, and with the offender's cooperation, the treatment plan will be signed by the offender.

The process of discharge planning often begins as the offender enters a correctional system. The treatment plan process will integrate not only the various aspects of the offender's care while he or she is incarcerated, but will also be cognizant of the discharge planning needs the offender may have upon release from incarceration.

Mental health staff will actively participate in discharge planning for Special Needs offenders. That participation will begin with the development of a well-integrated treatment plan and continue through outreach efforts to assess the effectiveness of discharge plans as the inmate transitions back to the community. CFG has often utilized outreach connections to community providers to help in the discharge planning for offenders. We have also utilized in-reach programs to bring community providers

into correctional facilities in the development of discharge plans for offenders. We would implement in the DDOC Severely and Persistently Mentally Ill (SPMI) committees at each facility to help develop discharge plans, as well as integrate services offenders with co-occurring disorders receive while they are incarcerated.

Psychiatric Nursing Services

The Medical Services Vendor's nursing staff will provide support in delivering mental health medications to the offenders that require it. CFG will provide training and orientation to nursing staff in the area of the care of special needs offenders. That training and orientation will help the nursing staff provide appropriate care and monitoring to offenders who receive psychiatric services.

ITT Meeting Participation

CFG staff will participate in the ITT meetings, as noted above. We recognize the need for frequent collaboration with medical security treatment and other DDOC staff members. CFG staff will provide mental health input to the classification committee and offender disciplinary hearings as requested and deemed appropriate. Our highly-trained and experienced staff will integrate their knowledge of the offender's mental health status with concerns of administrative and custody staff.

Withdrawal Monitoring

CFG is aware of the importance of close monitoring of offenders who are undergoing withdrawal from habit-forming substances. We will collaborate with the Medical Services Vendor to ensure that coordination of care for those offenders occurs at all points during those offenders' incarcerations. Our staff will be aware of and work within the scope of DDOC policies, NCCHC standards and BCHS Policy G-08 as they relate to the role of mental health staff in the care of offenders receiving withdrawal protocol services.

Psychiatric Watch (PCO)

CFG will be responsible for conducting all PCO watches and conducting daily assessments of those offenders that a psychiatrist has placed under a PCO status. CFG will follow DDOC policies as they relate to psychiatric observation and watch, including Policy G-05. CFG is well aware of the importance of frequent review of the appropriateness of continuation of PCO. We will make every effort to maintain on PCO status only those offenders whose current level of risk warrants placement on PCO. We will ensure that all PCO observers receive specific training on policies and procedures involved in conducting PCO watches. PCO observers will also be trained on the proper protocols for conducting the observations, documenting their observations appropriately and collaborating with medical and custody staff. All PCO observers will receive refresher training on an annual basis or as needed, based on changes in protocols or other needs for training that arise. At a minimum, the training provided to PCO

observers will include content specific to PCO watches, suicide prevention, CPR, sexual harassment and DDOC policies and protocols.

SEGREGATION

CFG will follow DDOC policy E-09, Segregated Offenders and NCCHC standards in the course of evaluating and monitoring the mental status and current condition and treatment needs of offenders placed in segregation. All offenders who have mental illness concerns will be evaluated by a qualified mental health provider. All offenders who are current mental health clients will be rounded on three times per week by a licensed mental health professional. Offenders who are not current mental health clients will be rounded on once per week by a licensed mental health professional.

CONFIDENTIALITY/EXCHANGE OF INFORMATION

CFG will ensure all medical and mental health records are kept confidential, in accordance with all state and NCCHC, ACA standards, HIPAA regulations and Delaware Open Public Records Act (OPRA) guidelines. CFG will comply with all confidentiality provisions applicable to offender medical and mental health records. Our collaborative approach with the Medical Vendor will involve sharing of medical and mental health records as is needed to ensure proper integration and coordination of care.

Upon written consent of an offender, summaries of Mental Health Records will be forwarded to community mental healthcare providers caring for the offender after release from the prison. CFG will also seek to obtain records from community mental health providers for the purposes of coordination and continuity of care.

SUICIDE PREVENTION TRAINING

Management of suicide risk is an integral part of the mental health services CFG provides. Assessment of risk begins during intake, but continues throughout an inmate's period of incarceration. Via our comprehensive Suicide Prevention Program - inclusive of repeat assessments and consultation with correctional officers - staff remains alert to fluctuations in inmates' levels of risk. A vital element of our Suicide Prevention Program is our Suicide Prevention Training Program, which engenders deeper understanding of and heightened sensitivity to risk factors for suicide. That, in turn, aids in early identification of inmates at risk and the use of pre-emptive measures. CFG will provide suicide prevention training, as well as training on managing special mental health populations for DDOC staff, as appropriate. That training will occur on a biennial basis. CFG will submit mental health training curricula to the Bureau Chief for review and approval at least 30 days in advance of the scheduled training. **For more detailed information regarding CFG's Suicide Prevention Training, please see redacted examples of programs currently in use, included in Appendix A.**

Our suicide prevention training is an important aspect of our Suicide Prevention Program. Our Suicide Prevention Program is guided by policies and procedures that guide our staff in the assessments and interventions they employ to minimize the risk of suicidal actions by offenders. Offenders who are referred to the Mental Health Department due to concerns about risk for self-harm or suicide will be thoroughly assessed. Our clinicians will complete structured assessment tools that encompass risk and protective factors in order to obtain the most accurate assessment of risk posed at the time of the assessment. Close monitoring of the offender's mental status and behavior during suicide watch, as well as the provision of psychiatric and mental health interventions, will be utilized to reduce risk and help return the offender to a less restrictive environment as soon as it is safe to do so.

Resolution of Disputes

It is the philosophy and practice of CFG to resolve disputes in a cooperative manner with our customers. The Statewide Mental Health Director will take the lead role for CFG in the daily efforts to resolve problems that arise. The Statewide Mental Health Director will work closely with the DDOC Mental Health Treatment Administrator in order to address any problems concerning mental health services being provided. Other CFG or DDOC staff will be included in dispute resolution efforts, as needed. CFG has a long, successful track record in working closely with correctional administrators to resolve problems and address concerns that may arise. One of our strengths is the ease of access that our customers have to all of our senior management team members. We are a locally-based company and pride ourselves on being responsive to the concerns of our customers.

Medical Peer Review and Continuous Quality Improvement

Please see information regarding CQI in the General Information Section of this proposal.

Performance Measurement

Please see information regarding Performance Measurement in the General Information Section of this proposal.

Case Management of Delaware Psychiatric Center (DPC) Offenders

CFG will ensure there are frequent interactions with providers of mental health service outside of the DDOC. Coordination of care with DPC will be part of our standard operating procedure when offenders are receiving services there. Daily updates on the status of each offender at DPC will be coordinated by the Mental Health Director for the facility from which the offender was referred to DPC. Updates in the status of offenders at DPC will be shared with primary care providers and facility managers as those updates are received. CFG's clinical staff will provide daily reports to the BCHS Medical Director. Summary information regarding offenders in DPC will be sent to the Bureau Chief and DDOC Medical Director on a daily basis. CFG's clinical staff will also maintain close contact with DPC's utilization managers and discharge planners in order to arrange for discharges that occur as soon as possible and

are completed with well-coordinated discharge plans. Discharge summaries will be obtained and information from those summaries will be incorporated into the on-site treatment care offenders receive once they return to DDOC facilities. CFG will work closely with the Utilization Review Services Vendor in cases that have been referred to DPC.

Summary of Service Provision Time Requirements

CFG will meet the time requirements for services as noted in NCCHC/ACA Standards, as well as DDOC policies. We are confident we will be able to meet the time requirements as listed below:

- Mental Health Assessment with the initial intake screening process will be referred immediately if identification of immediate need occurs during intake. These assessments will be completed within 24 hours of intake.
- Emergent referrals will be evaluated within 24 hours of referral and non-emergent referrals will be evaluated within 7 days of referral.
- Routine mental health visits will be provided every 30 days.
- Treatment plans will be completed within 30 days of identification as a mental health client and revised every six months or every three months if identified as a structured care inmate.
- All mental health contacts will be entered into the DACS mental health module.
- Pre-parole and other requested Mental Health Evaluations will be performed by CFG staff and completed by the date specified in the request.
- Sick-Call will be addressed by CFG to ensure proper disposition of mental health concerns 5 days per week for all facilities for non-urgent and/or non-emergent care and Sick-Call Triage 7 days per week for all facilities with urgent or emergent care, available 7 days per week.
- 24 hour emergency mental health care will be provided every day at all facilities (on-site or off-site).
- Initial assessments of offenders placed in segregation will be completed within 24 hours of placement.
- Segregation rounds will be completed three times per week.

Special Accommodation Populations

CFG will provide training in the areas of special needs/accommodations to its treatment staff to ensure that all treatment staff members provide services that are relevant and effective for offenders who may have special treatment needs. In order to meet the specific needs of the special accommodation populations within the DDOC, CFG will provide services that meet the individualized needs of offenders whose mental health treatment needs are affected by their unique issues. A critical component of services to meet the unique treatment needs of offenders will be proper and judicious case management. Case management services ensure there is continuity, coordination and appropriateness of mental healthcare being provided. Treatment plans will be individualized to reflect the needs of each

offender, taking into consideration the needs that may arise from inclusion in any of the populations listed below.

Disabled Offenders

Offenders who have sensory, communication or ambulatory limitations and who need mental health services will receive services appropriate to their condition. The mental health needs that may arise from functional limitations will be addressed in the individualized treatment plans completed for offenders with those limitations. CFG will ensure that all specifications for accommodations included in the Americans with Disabilities Act, 42 U.S.C. Section 12101, et seq. as they relate to mental health services are followed for inmates with disabilities who require mental health services.

Elderly Offenders

Elderly offenders often have a wide variety of mental health and medical treatment needs. Issues such as mobility, vision, hearing and cognitive decline or impairments may often complicate treatment for the elderly population. Mental health treatment provided will take into consideration those needs, as well as the special housing or discharge planning needs that may be necessary for elderly inmates.

Mental Health and Veterans Court

CFG will work with specialized court dockets such as the Mental Health and Veterans Court to provide continuity of care for those offenders. Included in the work with those courts will be timely responses to requests or needs for mental health diagnoses, medication, programming needs and discharge planning. CFG will designate contact staff at each facility to assure good linkage with the court and timely responses.

Mentally Ill Offenders

As outlined throughout this proposal CFG will offer mental health services to all offenders who have an active mental illness. The services offered to offenders will be concordant with the severity of the signs and symptoms of illness. Offenders who are newly diagnosed, unstable (despite psychiatric intervention), prove to be resistant to treatment efforts or who require higher levels of care due to the acuity of their symptoms will be closely monitored and/or referred to a higher level of psychiatric care. That close monitoring may take the form of suicide precautions or referral to DPC. CFG will identify offenders with serious mental illness via DACS.

Offenders in a Diagnostic or Therapeutic "Pipeline"

Successful treatment of exacerbations in mental health problems often requires a seamless referral process and efficient coordination of care when offenders with mental illness require appointments either inside a facility or at an off-site location. CFG will employ case managers who will be tasked with ensuring that appointments are tracked and diagnostic and treatment information is shared among the various providers of care. CFG shall provide monthly Case Management reports to the Bureau Chief.

Special Needs Population

The medical and mental health problems faced by offenders are often complex. Many offenders may suffer from co-occurring medical, mental health and substance abuse conditions. Some of the problems encountered by offenders are based on dangerous or self-injurious behaviors. Other problems may be due to a lifestyle filled with unhealthy behaviors, such as substance abuse and poor health habits.

In order to effectively treat the complex problems presented by offenders with co-occurring conditions, a multidisciplinary treatment team approach is required. It is the philosophy and practice of CFG's mental health staff to actively coordinate and integrate mental health services with medical and substance abuse treatment services. Multidisciplinary treatment team meetings will employ collaborative efforts to identify criteria for enrollment on the special needs roster, as well as treatment goals and objective measurements of progress toward meeting set goals. Multidisciplinary treatment plans will include criteria to identify when an offender no longer requires treatment.

Suicide Prevention

CFG will follow the suicide prevention procedures that have been developed by the DDOC. CFG's suicide prevention policies, procedures and practices will be consistent with DDOC Policy G-05, Suicide Prevention, Policies and Procedures. CFG staff will provide assessment, daily visits, daily progress notes, observation, evaluation, monitoring, treatment plans, and all mental health related training, including suicide prevention training, in accordance with DDOC policy. CFG will be responsible for Psychiatric Close Observation at all DDOC facilities.

Discharge Planning

One of the most important tasks for any correctional mental health provider is the development of an effective discharge planning program. CFG recognizes this is a crucial priority of the DDOC and emphatically contends that we share the same focus on discharge planning.

Mental health staff will actively participate in discharge planning for Special Needs offenders. That participation will begin with the development of a well-integrated treatment plan and continue through outreach efforts to assess the effectiveness of discharge plans as the inmate transitions back to the community. CFG has often utilized outreach connections to community providers to help in discharge planning for offenders. We have also utilized in-reach programs to bring community providers into correctional facilities in the development of discharge plans for offenders. CFG would implement in the DDOC Severely and Persistently Mentally Ill (SPMI) committees at each facility to help develop discharge plans, as well as integrate services offenders with co-occurring disorders receive while they are incarcerated.

CFG will ensure a psychiatrist will review all psychiatric medications prior to discharge. Within 30 days of release, (when release date is known), CFG will provide a thorough discharge plan that will include

referral information and linkages to community providers for all offenders identified as special needs and mentally ill. A discharge plan with the date, place, time and location of scheduled appointments will be provided to each offender with special needs prior to discharge. A copy of that plan will be placed in the offender's medical file. CFG will ensure that linkage to community mental health and public health providers is established for the offender who is being released. The discharge plans developed for each special needs offender will include, as applicable:

- Discussion with the offender about discharge
- Medicaid/Medicare eligibility determination and application submission/coverage
- Obtaining of a social security number, as required for access to the coverage noted above
- Linkage referrals to community services
- Prescription medication supplies

CFG will provide and discuss with offenders with medical needs a written discharge plan that will address each medical need. CFG staff will make referrals to community-based providers to address the offenders' medical needs. When possible, appointments for medical care will be made for offenders. CFG staff will also assist offenders in the completion of Medicaid and Medicare applications. When possible and applicable, offenders who are incarcerated for 14 days or more will be provided with a supply of medication that will be sufficient to ensure there is no gap in medications until the offenders are able to access sources of medication within the community. This medication will be provided prior to the offenders' discharge from the DDOC.

Special considerations will be made for offenders with chronic illnesses, serious mental illnesses and/or HIV/AIDS, as well as women who are pregnant or who have delivered children while incarcerated, in terms of discharge planning. CFG will arrange for linkages to appropriate and necessary community providers for these individuals and will arrange for the provision of a 30 day supply of medication for those offenders with current prescriptions upon release from the DDOC. CFG will assist in the arrangement of transportation, as appropriate, for offenders who will be discharged to another residential setting.

Due to the critical nature of effective discharge planning, CFG will implement a system of supervisory review of discharge plans to ensure plans are comprehensive, complete and meet the needs of the offenders with significant mental health problems who are being released. In order to ensure that the discharge plans being developed are comprehensive, CFG will work together with the Medical Services Vendor via joint case conferences to address the discharge planning needs of inmates with mental health problems. CFG's clinical team will actively participate in post-discharge planning activities to ensure smooth transition to the State Medicaid Waiver or other appropriate program.

NCCHC AND ACA

All mental healthcare programming and care rendered is based upon the statutes, regulations and standards established by the NCCHC and ACA. **A table of reference citing CFG policy and applicable NCCHC and ACA standards governing the various components of care has been included on the following page.**

NCCHC AND ACA TABLE OF CITATION

Policy	RFP Requirement	CFG Policy Number	Applicable NCCHC Standard	Applicable ACA Standard
GOVERNANCE & ADMINISTRATION				
Access to Care	All offenders are able to receive care	A-01	J-A-01	4-4344, 4-4345
Responsible Health Care Authority	A clinical and administrative supervisor will be provided	A-02	J-A-02	4-4380
Medical Autonomy	A clinical and administrative supervisor will be provided	A-03	J-A-03	4-4381
Administrative Meetings and Reports	Participate on review committees and be accessible to DDOC staff	A-04	J-A-04	4-4408, 4-4409
Policies and Procedures	Maintain NCCHC accreditation at all facilities	A-05	J-A-05	4-4012, 4-44013, 4-4014, 4:4424
Continuous Quality Improvement Program	Provide services according to generally accepted practices and gather and maintain measurable data that evaluates all services	A-06	J-A-06	4-4410, 4:4017, 4-4411, 4-4424
Communication on Patients with Special Needs	Train medical vendor staff in psychotropics and supporting medical compliance	A-08	J-A-08	4-4399
Procedure in the Event of a Resident Death	Be available for staff review, train other vendors and DDOC on mental health	A-10	J-A-10	4-4410
PERSONNEL & TRAINING				
Clinical Performance Enhancement	Participate in peer reviews and maintain CQI under a clinical and administrative supervisor	C-02	J-C-02	4-4411
Health Training for Correctional Officers	Train Correctional Officers, other DDOC staff and outside vendors on mental health issues including suicide prevention procedures	C-04	J-C-04	4-4084, 4-4084-1, 4-4089

Policy	RFP Requirement	CFG Policy Number	Applicable NCCHC Standard	Applicable ACA Standard
Medication Administration Training	Train medical vendor nursing staff in psychotropic and supporting medical compliance	C-05	J-C-05	4-4378
Staffing	Orient new staff to mental health services	C-07	J-C-07	4-4412, 4-4382
HEALTH CARE SERVICES & SUPPORT				
Medication Services	Train medical vendor nursing staff in psychotropic and supporting medical compliance	D-02	J-D-02	4-4378
Diagnostic Services	Train staff in psychotropic and supporting medical compliance	D-04	J-D-04	4-4380, 4-427
INMATE CARE & TREATMENT				
Information on Health Services	Orient consumer to mental health services	E-01	J-E-01	4-4422
Receiving Screening	Aid telemedicine and evaluate needs for bridge orders for all new intakes within a single shift. Conduct initial intake and refer mental health consumers as needed. Provide a full psychiatric evaluation within 24 hours in screening is positive. Provide population-specific suicide prevention training to DDOC staff, access segregated offenders with mental illness, place offenders on mental health watch and provide a daily assessment, provide a primary therapist, provide individualized 1:1 treatment and discharge plan, provide care in groups and/or segregation as needed	E-02	J-E-02	4-4285
Initial Health Assessment	Coordinate with DDOC in training and adhering to suicide prevention procedures	E-04	J-E-04	4-4366

Policy	RFP Requirement	CFG Policy Number	Applicable NCCHC Standard	Applicable ACA Standard
Mental Health Screening & Evaluation	Conduct initial intake and refer mental health consumers as needed. Provide a full psychiatric evaluation within 24 hours in screening is positive. Provide population-specific suicide prevention training to DDOC staff, access segregated offenders with mental illness, place offenders on mental health watch and provide a daily assessment	E-05	J-E-05	4-4368
Segregated Inmates	Provide treatment in segregation from other inmates	E-09	J-E-09	4-4271, 4-4400
Continuity of Care During Incarceration	Provide services according to generally accepted practices and gather and maintain measurable data in order to evaluate all services	E-012	J-E-012	4-4367
Discharge Planning	Provide individualized treatment and discharge plans	E-013	J-E-013	4-4347
SPECIAL NEEDS & SERVICES				
Chronic Disease Services	Provide services according to generally accepted practices and gather and maintain measurable data in order to evaluate all services, Create individualized, interdisciplinary treatment plans. Provide new intakes with initial assessment, mental health orientation, a primary therapist, individualized treat plans, segregated or group treatment as needed, and an evaluation of bridge order within one shift	G-01	J-G-01	4-4350
Patients with Special Health Needs	Create individualized, interdisciplinary treatment plans	G-02	J-G-02	4-4399, 4-4429-1

Policy	RFP Requirement	CFG Policy Number	Applicable NCCHC Standard	Applicable ACA Standard
Basic Mental Health Service	Provide new intakes with initial assessment, mental health orientation, a primary therapist, individualized treat plans, segregated or group treatment as needed, and an evaluation of bridge order within one shift	G-04	J-G-04	4-437-, 4-4371, 4-4372
Suicide Prevention Program	Coordinate with DDOC in training and adhering to suicide prevention procedures	G-05	J-G-05	4-4370
Intoxication & Withdrawal	Support the monitoring of inmates undergoing drug withdrawals	G-06	J-G-06	4-4363-1, 4-4376
Inmates with Alcohol & Other Drug Problems	Create individualized, interdisciplinary treatment plans	G-08	J-G-08	4-4438
HEALTH RECORDS				
Confidentiality of Health Records & Information	Keep health records confidential	H-02	J-H-02	4-4095, 4-4396
Management of Health Records	Have records accessible during service delivery	H-04	J-H-04	4-4366

SUBSTANCE ABUSE PROGRAMMING

INTRODUCTION AND BACKGROUND

Horizon House Delaware, Inc. (HHDI) is proud to play an integral part in the wider behavioral health service system in the State of Delaware. Throughout our years of operation, HHDI has developed collaborative partnerships with various non-profit and governmental agencies providing mental health services, alcohol and drug abuse treatment and related social services throughout Delaware. HHDI has also been an active member of the Delaware Association of Rehabilitation Facilities (DELARF) for the last two decades. Currently, Rosanne Faust, Director of HHDI, is the President of the DELARF Board. HHDI participates on DELARF's Behavioral Health, Government Relations and DD Commissions. Ms. Faust also serves on the community advisory board for Rockford Hospital. Housing and employment are two other key areas in which HHDI works collaboratively with other partners in the Delaware social service system.

HHDI is an affiliate of Horizon House, Inc. (Horizon House), an agency headquartered in Philadelphia, PA, and recognized is one the region's oldest and most respected behavioral health service providers.

Horizon House History and Current Services and Structure

Horizon House was founded in 1952 by members of the Society of Friends as a support group for former patients of mental hospitals. Since those early days, the agency has expanded its scope of services considerably to address the needs of adults with drug and alcohol addictions, developmental disabilities and those who are homeless. Today, Horizon House delivers innovative, community-based, recovery-oriented services to over4,500 individuals throughout Pennsylvania and the State of Delaware. The agency is a private, non-profit 501(c)(3) operating on an annual budget in excess of $60 million and employing over 1,300full- and part-time staff members. Service operations are managed in three divisions: Behavioral Health, Developmental Disabilities and Homeless Services. Horizon House is governed by a 14-memberBoard of Directors that is responsible for the fiscal, legal and programmatic oversight of the organization.

Mission

Horizon House, in partnership with individuals with disabilities and their families, provides patient advocacy and comprehensive, community-based services. We create opportunities for those we serve to manage their lives through the creation of environments that nurture and emphasize individual strengths and the power of choice.

Description of Horizon House's Programmatic Experience

The agency's Behavioral Health Services (BHS) division currently serves nearly 4,000consumers throughout Pennsylvania and Delaware. Horizon House manages many licensed behavioral health services, including community rehabilitation residences, personal care homes, targeted case

management/intensive case management services, mental health outpatient services, drug and alcohol outpatient services, psychiatric rehabilitation programs, and assertive community treatment (ACT) teams. Horizon House has demonstrated expertise in operating outpatient service programs and in delivering services to consumers with co-occurring mental health and substance abuse disabilities. The agency manages multidisciplinary teams capable of responding to the needs of clients in acute psychiatric crisis.

HHDI is a component of the Horizon House's Behavioral Health Services division, administrated by the Senior Vice President, Behavioral Health Services (VP, BHS) who, in turn, reports to the Horizon House Chief Executive Officer. The VP, BHS is also responsible for administration of the mental health and substance abuse treatment/rehabilitation services operated by Horizon House in Pennsylvania. The Delaware corporation is overseen by a Director, who reports to the Vice President, Behavioral Health Service. In addition, the HHDI Director is responsible for the Delaware operations' administrative support services in the following areas: human resources, fiscal responsibility, facility management, coordination and management of representative payee accounts, purchasing and payroll.

HORIZON HOUSE LEADERSHIP

Jerry Skillings, Psy.D. -*Horizon House Senior Vice President and Director of Behavioral Health Services*

Dr. Skillings has a solid background in managing behavioral health programs, having served for four years as Senior Executive Director of Behavioral Health and Corporate Services at Elwyn, Inc., and as a part of the management team of Elwyn for more than 10 years. While serving as Deputy Executive Director of Behavioral Health at Warren E. Smith Community Mental Health/Mental Retardation and Substance Abuse Centers, Dr. Skillings was responsible for the development and oversight of a community-based mobile crisis team in the city of Philadelphia. Dr. Skillings also has extensive experience with acute inpatient care, has served as Director of Behavioral Health at Neumann Medical Center, as a staff psychologist for the Fairmount Institute and as the Executive Director of a managed care organization for four years.

Rosanne Faust -*Director of HHDI*

Ms. Faust has been employed by Horizon House since January of 2005 and has a wealth of experience and knowledge regarding the successful start-up and on-going management of high-quality, consumer-centered behavioral health services in the State of Delaware. Prior to joining

Horizon House's Senior Management Team, Ms. Faust worked for Fellowship Health Resources, Inc. (FHRI) for fourteen years. Ms. Faust bears primary responsibility for all Delaware programs and operations. She has successfully led various programs/teams through Medicaid Certification and D&A licensure for over 20 years.

Joshua Warweg, MA, CPRP – *Admissions Director*

Mr. Warweg serves as HHDI's liaison to the Delaware Division of Substance Abuse and Mental Health, providing management and leadership for all HHDI programs regarding compliance with new standards as delineated by the United States Department of Justice Settlement Agreement with the State of Delaware. Mr. Warweg has experience as the Program Director and Mental Health Professional of Psychiatric Residential Programs directly serving individuals re-entering the community from correctional settings in the State of Pennsylvania for Elwyn, Inc., and has developed additional capacity while working within Forensic Treatment in the State of Florida. Upon award of contract, Mr. Warweg will be designated as the State Director of the Substance Abuse Treatment within the DDOC system, providing direct management for the Clinical Substance Abuse Program Directors. Mr. Warweg will also serve as a Team Member of the Primary Contractor, CFG.

INTENT OF SERVICE

It is the intent of HHDI to deliver substance abuse treatment based on established best practices to meet the needs of as many offenders as possible (in consideration of beds and units available) housed within the Delaware Department of Corrections. HHDI shall utilize the Phase System of the Key, CREST, Boot Camp, 6 for 1, YCOP, and Aftercare programs within the most appropriate settings as set forth by the DOC and USDOJ regarding all locations as specified within the RFP.

Horizon House Delaware, Inc., proposes to provide Substance Abuse Treatment Services abiding by all standards established within, but not limited to: the Teaming Agreement entered into with CFG; Delaware Department of Corrections' Contract No. DOC-1202Mental; the Memorandum of Agreement between the State of Delaware and the United States Department of Justice; DDOC policies; NCCHC standards; and Substance Abuse Treatment Protocol, BCHS Policy G-08.

PROGRAMMING

Prison Programs

HHDI will provide substance abuse treatment for offenders who have 12-30 months left of their sentence and have committed crimes related to substance abuse and/or have a demonstrated personal history of substance abuse. Treatment shall be provided for these individuals within the 12-Month Key Program, followed by additional treatment via community-based CREST programming beyond release.

Services rendered through these two programs shall be provided primarily in a group structure and shall be supplemented with one-on-one substance abuse counseling based on client need and demonstrated levels of cognitive functioning. Treatment Planning shall be conducted through the dynamic of an Interdisciplinary Treatment Team (ITT) that includes the input of the offender/patient and is considerate of other aspects of mental health treatment.

Community Correction Programs

HHDI will assist the Mental Health services provider, CFG, in transitioning offenders who have completed the Key Program to the community-based CREST program, ensuring that co-occurring Mental Health and Substance Abuse related-disorders are communicated and treated simultaneously. These services will be coordinated whenever an offender is eligible for release in less than 180 days and HHDI will work to facilitate re-entry into the community. Treatment Planning will occur in coordination with the ITT.

Aftercare (including Boot Camp)

Continuity of Care is an essential component for ensuring all offenders re-entering the community have the necessary support in place in order to minimize the risk of re-offense and recidivism. Upon an offender's completion of the CREST Program, HHDI shall provide six months of Substance Abuse Aftercare through continued clinical support. HHDI will work closely with probation and parole officers and TASC to facilitate the best possible scenario for every individual re-entering the community.

Special Population Programs

- **6 for 1 Programs** are an additional means of support through which HHDI shall be able to provide management and oversight for all individuals that may benefit from a condensed version of substance abuse treatment information, regardless of whether participation is voluntary or based upon a referral by the DOC.
- **The Young Criminal Offender Program** will be a specially-tailored program to discuss substance abuse in a treatment forum appropriate for offenders within the 16 to 18-year-old age range, targeting specific areas of concern that individuals face within that particular cohort.
- **The Boot Camp Program** will include all the benefits of a disciplined, military-style structure, coupled with substance abuse treatment and shall be undertaken using a group dynamic wherein participants are taught how and expected to support one another.

Programming Objectives

In its treatment of clients with substance abuse disorders and co-occurring or dual-diagnoses, HHDI utilizes evidence-based practices and best practice interventions. Anticipated treatment programs utilized by HHDI in the treatment of offenders under the jurisdiction of the DDOC shall include, but not

be limited to: Motivational Interviewing, Psychoeducation, Approaches of Recovery and Psychiatric Rehabilitation, Co-Occurring Illness Management Recovery, Trauma-Informed Treatment Approaches, and the Model of Co-Occurring Psychiatric and Substance Disorders treatment guidelines as developed by Dr. Kenneth Minkoff. HHDI also relies upon treatment centered around the evidence-based approaches outlined by the United States Department of Health and Human Services Substance Abuse and Mental Health Services Administration (SAMHSA), with regard to their Treatment Improvement Protocols (TIP). The above guidelines have proven most effective in the treatment of substance use disorders and provide a backdrop for the philosophy and approach HHDI subscribes to regarding co-occurring competent care. HHDI fully understands the essential role of evidence-based practices in coordinating care with both DUI Court-Ordered Programming and with Sex Offender Treatment and is cognizant of the processes necessary to meet the needs of these programs and the individuals served therein.

GENERAL SERVICE REQUIREMENTS

Treatment Methodology

HHDI shall employ treatment methodologies approved by the State of Delaware Department of Corrections, BCHS that work within the current structure of programming as stipulated within the RFP (any significant alterations during the course of contract shall be submitted in writing for pre-approval by the DDOC). Offenders in the Key Programs will have an average participation length of 12 months, dependent on each individual's treatment needs or time remaining leading up to release. Key Programs will include three separate phases covering various topics related to substance abuse treatment and specific to each Phase. Average length of CREST and Aftercare Programs will be six months. The 6 for 1 Programs are considered voluntary and shall run up to 45 days in length. Participants within the Young Criminal Offender Program will be offered programming throughout the duration of their stay, pending approval by the DDOC. All programs will have built-in objectives for moving forward and making progress and for movement within and among Phases (as applicable), along with earned, graduated responsibilities and privileges. Programs will also offer peer support, based upon individual ability.

HHDI Substance Abuse Treatment, under the Prime Contractor CFG, will operate within the Phase System guidelines. Phase 1 - Education will provide a specific curriculum for all Substance Abuse Counselors with lesson plans for treatment topics including: Group Etiquette and Rules; the Basics of Addiction and Counseling; Disease Concept; Substance Abuse/Dependency Education; Psycho-Pharmacology (this group discusses the types of drugs and chemicals abused, along with associated physical and psychological addiction and post-acute withdrawal symptoms); Denial and Criminal Thinking Errors; and Introduction to 12-Step Recovery Programs.

All Phases will cover treatment topics and associated activities inclusive of the following:

- Cognitive Skills Building

- Motivation to Change
- Problem Solving
- Skills Building
- Errors in Judgment
- Sober Living Skills
- Stress and Anger Management
- Interpersonal Relationships (with family, peers and the community-at-large)
- Parenting Skills
- Goal Setting
- Values Clarification
- Criminal Thinking and Behaviors
- AIDS/STDs/Infectious Diseases
- Fetal Alcohol Syndrome and its Effects
- Mental Health and Co-Occurring Disorders
- Relapse Prevention
- Recovery
- Family Dynamics
- Cultural Issues
- Gender Issues

Treatment Content

HHDI shall employ best-practice methodologies in all programs (including the Special Population Programs) in the provision of:

- Proper Clinical Assessment
- Individualized Treatment Planning
- Individual Counseling (at a minimum of one (1) session per month)
- Weekly Therapeutic Groups
- Psychoeducational Instruction
- Weekly Encounter Groups
- Random Urinalysis Testing (collected by the DDOC)
- Addiction Education
- Life-Management Skills
- Trauma-Informed Care Approaches And Screens

- Co-Occurring Disorder Consultation And Treatment (inclusive of participation within voluntary mental health groups)
- Motivational (Interviewing) Enhancement Components (with built-in positive reinforcement and graduated sanctions)
- Relapse Prevention
- Comprehensively-Coordinated Discharge
- Transition Planning

Referrals/Assessments/Recruitment

Candidates for the Key Programs will be identified based on information obtained during admission interviews, the clinical substance abuse assessment (conducted within 72 hours of admission) and sentencing orders. HHDI Substance Abuse shall screen all offenders referred by mental health, medical staff, the DDOC and offenders who present via self-referral. CREST Programs will receive most individuals who have successfully completed Key Programming. HHDI understands that it is the responsibility of HHDI to ensure all eligible candidates are placed in a clinically-appropriate treatment program and Therapeutic Communities, as vacancies become available. HHDI will commit to expectations established via recruitment and tracking to effectively coordinate offender movement with classification and security staff in order to properly transfer offenders.

Treatment Planning

Offender treatment planning will be completed in collaboration with the ITT within seven (7) days of offender admission and every 90 days thereafter. Treatment development is based upon individual needs, time remaining prior to anticipated date of release, clinical status and the nature/type of program in which a person is to be enrolled. Treatment will consist of evidence-based, best practice interventions and of treatment components as outlined within the RFP.

- Phase 1 of treatment will entail introducing participants to a Therapeutic Community and the basics of treatment which include, but are not limited to, gaining familiarity with expectations, vocabulary and the benefits of treatment. Individuals further along in the treatment process will be able to assist as peer support, as long as they are deemed clinically-appropriate to do so and in accordance with Interdisciplinary Treatment Team findings. Movement within the Phase System will require reviews of:
- Attendance
- Regular Completion of Treatment Plan Assignments
- Sanctions Levied
- Learning Experiences (within two weeks of review)
- Adherence To Security and Institutional Rules and Requirements
- Clean Urinalysis Testing (as conducted by the DDOC)

- Passing Phase Exams

In the event an offender is identified as non-compliant with treatment or has failed to participate successfully in treatment program initiatives, he/she shall not be permitted to continue movement along the program's expected trajectory. An appeal process can be accessed by the individual for further review. A copy of the discharge summary, regardless of outcome, shall be provided to all participants.

In an attempt to lessen the potential for recidivism and increase the likelihood of continued sobriety beyond the prison walls, Treatment Planning will include "next steps" based upon an offender's criminal history relevant to drug and alcohol addiction. Community-based substance abuse program referrals will be made for all offenders and shall include links to outside peer support, as well. Additional resources will be provided (as indicated), along with other recommendations from the entire ITT and in conjunction with all other treating entities including: Mental Health, Sex Offender Programming and DUI Programming. All recommendations and referrals for outside care will be recorded as part of the Discharge Summary.

Evaluation Plan/Offender Tracking System

HHDI will review, with CFG, the effectiveness and structure of all Drug and Alcohol Treatment Services based on reporting requirements established within the RFP including: Monthly and Weekly Quality Improvement, required/requested data collection and Treatment Team discussions. The HHDI State Substance Abuse Director shall provide oversight for the position of Clinical Quality Improvement Assessor and each of the four Clinical Program Directors for each of the four designated regional areas. This group will evaluate, as a team and through continual analysis, the implementation of all Substance Abuse Treatment Services; develop necessary action plans; research and direct the inclusion and administration of evidence-based practices, emerging theories and co-occurring competent strategies.

CFG may utilize Substance Abuse Aftercare staff to provide follow-up Case Management for monitoring care subsequent to offender release to a community outreach program. Community case management providers, as well as TASC and Probation and Parole, shall be invited to participate as part of the Interdisciplinary Treatment Team while Discharge Planning is developed. This initiative shall bolster continuity of care and shall set clear and consistent expectations for each program participant. It also provides additional reinforcement for extended monitoring of offender compliance with Discharge Planning directives, aids in evaluating the effectiveness of treatment and opens up another avenue for relaying post-release data to the ITT and Managers of the Contract. HHDI shall make use of the Offender Tracking System established by CFG to meet these ends.

Treatment Compliance /Reporting

HHDI will comply with all State of Delaware laws as they apply to substance abuse treatment and will work to recruit offenders into appropriate programs based on demonstrated individual needs. All program participants shall have an individualized treatment plan. In the event an offender is denied admission to a court-ordered substance abuse program while meeting written eligibility criteria and/or requesting admission, a written statement will be provided by HHDI to the DDOC or probation officer explaining the reasons for denial. HHDI will also track and monitor all movement within the programming structure and will be available at all times as part of the specifications of this RFP. HHDI shall also follow all reporting guidelines within the established weekly and monthly timeframes.

COORIDINATION OF SERVICES WITH MENTAL HEALTH PROVIDER

As a Co-Occurring Disorder competent provider, Horizon House Delaware, Inc., (HHDI) is prepared to cooperate in all aspects of client care including, but not limited to: the recruitment of program participants, treatment planning, ITT meetings, the referral process, screening and transition planning; and shall work in collaboration with CFG, sub-contractors, the DDOC, security, and community providers within the timeframes outlined by the DDOC. HHDI will provide documentation of all components of care on universal forms, comprehensive of all treatment needs including those pertaining to Mental Health, Sex Offender Treatment and DUI Programming. As part of concise and thorough communication methodology, Treatment and Discharge Plans and Discharge Summaries shall be offered to all offenders to whom service is rendered.

Following discharge from the DDOC, offenders will be linked with interdisciplinary community-based services that address all areas of need including: Community Mental Health, ECHO Centers and Counseling Providers, to name a few.

STAFFING

Clinical Staff, certified by the Delaware Certification Board, will be provided by HHDI for the provision of substance abuse treatment and counseling at all sites. HHDI will instill a management structure that provides:

- One State Administrator
- Four Regional Clinical Program Directors (and all necessary Clinical/CQI support)
- Eight Clinical Site Supervisors

The Regional Clinical Program Directors and Clinical Site Supervisors will be, at minimum, Bachelor Level CADC clinicians with knowledge of criminal behaviors or Master Level clinicians with CADC Certification, (additional CCDP Certification or LCDP preferred). Substance Abuse Counselors will be, at minimum, Bachelor Level clinicians and shall have CAAC certification within one year's timeframe from start of employment, plus knowledge of criminal behaviors or Master Level CADC Clinicians (additional CCDP

preferred). Substance Abuse Counselors will be available in both Full-Time and Part-Time capacities, on-site Monday – Friday from 7:00 AM to 8:00 PM and Saturday – Sunday from 8:00 AM to 8:00 PM. Clinical Supervisors will be available to substance abuse staff during all working hours. **For an outline of proposed staffing, please see below under Supervision of Programs.**

Continuing Education needs will be accessed by HHDI for all clinicians for the maintenance of necessary certification and will be provided as part of clinical supervision. Continuing Education will not be separately billed to the State.

HHDI staff will abide by all State and Federal statutes governing offender's confidentiality, but will be prepared to provide testimony regarding an offender, within the limitations stated by law.

Supervision Of Programs

The State Substance Abuse Director will manage four (4) Clinical Program Directors who will each supervise two (2) Clinical Supervisors. The Clinical Supervisors will be available at their identified program sites at all times, with the Clinical Program Directors providing back-up as needed. The State Substance Abuse Director will operate as a Board Member as part of a team consisting of CFG and its additional sub-contractors.

HHDI Clerical Assistance will be provided for the four (4) Clinical Program Directors and Administrative Assistance will be provided for the State Substance Abuse Director. Primary duties of these clerical and administrative assistant positions will be the gathering and collating of data requested by the DDOC, HHDI and CFG Management.

A Clinical Regional Program Director will be provided for the Wilmington, DE region that includes Howard R. Young Correctional Institution's (HRYCI) Key North, 6 for 1 for Men and YCOP Programs, as well as Webb Community Correctional Center's (WCCC) Crest North and Aftercare Programs.

Under the direction of the Wilmington Regional Clinical Program Director will be 2 (two) Clinical Supervisors. One Clinical Supervisor will provide management for the Howard R. Young Correctional Institution's (HRYCI) Key North, 6 for 1 for Men and YCOP Programs. The Second Clinical Supervisor will provide management for the Webb Community Correctional Center's (WCCC) Crest North and Aftercare Programs.

A Clinical Regional Program Director will be provided for the New Castle, DE region that includes the Baylor Women Correctional Institution's (BWCI) Key Village and 6 for 1 for Women Programs, as well as the Hazel D. Plant Women's Treatment Facility's (HDPWTF) Crest North and Aftercare Programs.

Under the direction of the New Castle Regional Clinical Program Director will be 2 (two) Clinical Supervisors. One Clinical Supervisor will provide management for the Baylor Women Correctional Institution's (BWCI) Key Village and 6 for 1 for Women Programs; the Second Clinical Supervisor will provide management for the Hazel D. Plant Women's Treatment Facility's (HDPWTF) Crest North and Aftercare Programs.

A Clinical Regional Program Director will be provided for the (Central) Dover, DE and Smyrna, DE region that includes the Central Violation of Probation Center's (CVOP) Crest Primary Program and the Morris Community Correctional Center's (MCCC) Crest Central and Aftercare Programs.

Under the direction of the Central Region Clinical Program Director will be 2 (two) Clinical Supervisors. One Clinical Supervisor will provide management for the Central Violation of Probation Center's (CVOP) Crest Primary Program; and a Second Clinical Supervisor will provide management for the Morris Community Correctional Center's (MCCC) Crest Central and Aftercare Programs.

A Clinical Regional Program Director will be provided for the (Southern) Georgetown, DE region that includes the Sussex Correctional Institution's (SCI) Key South, Boot Camp, and Aftercare Programs, as well as the Sussex Community Correctional Center's (SCCC) Crest South and Aftercare Programs.

Under the direction of the Southern Regional Clinical Program Director will be 2 (two) Clinical Supervisors. One Clinical Supervisor will provide management for the Sussex Correctional Institution's (SCI) Key South, Boot Camp and Boot Camp Aftercare Programs; while the Second Clinical Supervisor will provide management for the Sussex Community Correctional Center's (SCCC) Crest South and Aftercare Programs.

SUBSTANCE ABUSE STAFFING SCHEDULE

FTE	Program	Physical Location	Staff Position Title	Total
1	**STATE-WIDE**	DELAWARE	STATE SA DIRECTOR	**2.2**
1	STATE-WIDE	DELAWARE	ADMINISTRATIVE ASSISTANT	
0.2	STATE-WIDE	DELAWARE	CLINICAL QI ASSESSOR	

FTE	Program	Physical Location	Staff Position Title	Total: 28
1	WILMINGTON REGION	HRYCI & WCCC	CLINICAL PROGRAM DIRECTOR	1
1	WILMINGTON REGION	HRYCI & WCCC	CLERICAL ASSISTANT	1
0.5	KEY NORTH	HRYCI	CLINICAL SUPERVISOR	10.5
2	KEY NORTH	HRYCI	LEAD SA COUNSELOR - AM/PM	
8	KEY NORTH	HRYCI	SA COUNSELOR	
0.3	6 FOR 1 MEN	HRYCI	CLINICAL SUPERVISOR	4.3
1	6 FOR 1 MEN	HRYCI	LEAD SA COUNSELOR	
3	6 FOR 1 MEN	HRYCI	SA COUNSELOR	
0.2	YCOP	HRYCI	CLINICAL SUPERVISOR	3.2
1	YCOP	HRYCI	LEAD SA COUNSELOR	
2	YCOP	HRYCI	SA COUNSELOR	
1	CREST NORTH	WCCC	CLINICAL SUPERVISOR	8
1	CREST NORTH	WCCC	LEAD SA COUNSELOR	
4	CREST NORTH	WCCC	SA COUNSELOR	
1	CREST NORTH AFTERCARE	WCCC	LEAD SA COUNSELOR	
1	CREST NORTH AFTERCARE	WCCC	SA COUNSELOR	

FTE	Program	Physical Location	Staff Position Title	Total: 16
1	NEW CASTLE REGION	BWCI & HDPWTF	CLINICAL PROGRAM DIRECTOR	1
1	NEW CASTLE REGION	BWCI & HDPWTF	CLERICAL ASSISTANT	1
0.6	KEY VILLAGE	BWCI	CLINICAL SUPERVISOR	4.6
1	KEY VILLAGE	BWCI	LEAD COUNSELOR	
3	KEY VILLAGE	BWCI	SA COUNSELOR	
0.4	6 FOR 1 WOMEN	BWCI	CLINICAL SUPERVISOR	2.4
1	6 FOR 1 WOMEN	BWCI	LEAD SA COUNSELOR	
1	6 FOR 1 WOMEN	BWCI	SA COUNSELOR	
1	CREST NORTH & AFTERCARE	HDPWTF	CLINICAL SUPERVISOR	7
1	CREST NORTH & AFTERCARE	HDPWTF	LEAD SA COUNSELOR	
5	CREST NORTH & AFTERCARE	HDPWTF	SA COUNSELOR	

FTE	Program	Physical Location	Staff Position Title	Total: 21
1	CENTRAL (DOVER/SMYRNA) REGION	CVOP & MCCC	CLINICAL PROGRAM DIRECTOR	1
1	CENTRAL (DOVER/SMYRNA) REGION	CVOP & MCCC	CLERICAL ASSISTANT	1
1	CREST PRIMARY	CVOP	CLINICAL SUPERVISOR	11
2	CREST PRIMARY	CVOP	LEAD SA COUNSELOR AM/PM	
8	CREST PRIMARY	CVOP	SA COUNSELOR	
1	CREST CENTRAL	MCCC	CLINICAL SUPERVISOR	8
1	CREST CENTRAL	MCCC	LEAD SA COUNSELOR	
3	CREST CENTRAL	MCCC	SA COUNSELOR	
1	CREST CENTRAL AFTERCARE	MCCC	LEAD SA COUNSELOR	
2	CREST CENTRAL AFTERCARE	MCCC	SA COUNSELOR	

FTE	Program	Physical Location	Staff Position Title	Total: 17
1	SOUTHERN (GEORGETOWN)REGION	SCI & SCCC	CLINICAL PROGRAM DIRECTOR	1
1	SOUTHERN (GEORGETOWN)REGION	SCI & SCCC	CLERICAL ASSISTANT	1
0.5	KEY SOUTH	SCI	CLINICAL SUPERVISOR	6.5
1	KEY SOUTH	SCI	LEAD SA COUNSELOR	
5	KEY SOUTH	SCI	SA COUNSELOR	
0.5	BOOT CAMP & AFTERCARE	SCI	CLINICAL SUPERVISOR	1.5
1	BOOT CAMP	SCI	LEAD SA COUNSELOR	
1	CREST SOUTH	SCCC	CLINICAL SUPERVISOR	7
1	CREST SOUTH	SCCC	LEAD SA COUNSELOR	
1	CREST SOUTH AFTERCARE	SCCC	LEAD SA COUNSELOR	
4	CREST SOUTH	SCCC	SA COUNSELOR	

Staffing Totals	
1	STATE SUBSTANCE ABUSE DIRECTOR
1	ADMINISTRATIVE ASSISTANT
0.2	STATE QI ASSESSOR
4	CLINICAL PROGRAM DIRECTORS
8	CLINICAL SUPERVISORS
4	CLERICAL ASSISTANTS
17	LEAD SUBSTANCE ABUSE COUNSELORS
49	SUBSTANCE ABUSE COUNSELORS

SEX OFFENDER PROGRAMMING

INTRODUCTION

With award of contract, Dr. O'Quinn will be procured as part of the CFG team to oversee the Sex Offender Therapy Program. Since January of 2012, Dr. O'Quinn has worked as the lead counselor for the sex offender treatment program covering all Level IV and Level V prisons in the State of Delaware and, thus, has acquired in-depth knowledge concerning the programming needs inherent to the various facilities within the Delaware Department of Corrections. Dr. O'Quinn began work with perpetrators of abuse and their victims through appointment to a specialized ministry, went on to help found Lifeline Counseling Associates, Inc., and has been endorsed by the United Methodist Endorsing Agency for his work as a pastoral counselor. In this specialized work, Dr. O'Quinn has provided individual and group therapy for over 600 batterers and 1200 sexual offenders. Rounding out Dr. O'Quinn's ample qualifications, he maintains certification as a CSOTP (Certified Sex Offender Treatment Provider) and as a Domestic Violence Counselor; is a Diplomate of the National Board of Forensic Counselors; and is also a trained conflict mediator.

SEX OFFENDER THERAPY PROGRAM

Model

The Self-Regulation Model (SRM) will be the primary methodology used for therapy. *SRM is an evidence based model.* Studies have supported the utility of the Self-Regulation Model by differentiating pathways by offender type, offense characteristics and history, victim type, psychopathy, static and dynamic risk, motivation, treatment change, and GLM.[1] The Self-Regulation Model postulates that offenders utilize different pathways in committing their sexual offenses. Sexual offending is viewed as a maladaptive attempt to address specific emotional and environmental stressors. In response to this assumption, SRM goes beyond the "don't do it again" objective of Relapse Prevention as developed for substance abuse programs and applied to sex offenders; instead, the SRM promotes accountability in all parts of an offender's life to reduce the risk of re-offense.

Program Goal

No More Victims. This program goal is reached by working for justice, healing and transformation using therapeutic methods applied to the specific treatment needs of the individual offender because the community is safer if offenders are treated and not just incarcerated.

Recidivism

[1] Kingston, 2010; Kingston et al., 2009; Lambine & Leguizamo, 2010a, 2010b; Simons et al., 2008, 2009; StotlerTurner et al., 2008; Yates et al., 2009; Yates & Kingston, 2006

This model assumes that in helping offenders reach a level of accountability, they will demonstrate positive changes in attitude, behavior, character, relationships and even core personality. Recidivism is defined as a graduate of the program committing a new sexual offense. Recidivism rates over a twelve-year span in the Lifeline program in the Commonwealth of Virginia reported that only six graduates (out of 364) were arrested for a new sexual crime in a ten year follow-up.

Referral

Inmates with any sexual conviction (new or old), serving time for a violation of probation, failure to register or even an intuitional sanction are eligible for referral.

Intake

Once referral is made, the inmate is informed of the limits of confidentiality and informed of the rules and principles of the program. Basic personal information is secured and all necessary forms are signed during the intake session.

STAGES OF THERAPY:

Each offender is made to participate in a psychosexual group. Denial is not an issue for placement. This group will use the **Sex Offender Awareness Program (SOAP)** outline. SOAP is offered at all Level IV and Level V institutions and consists of the following elements:

- **Stage A:** Assessment: All participants of SOAP are formally assessed. An individualized treatment plan is developed utilizing the structure of the sex offender program to address specific treatment needs. Inmates who have a combined MnSOST-R and Static-99R score of twelve (12) points are referred for additional testing using the MSI-II and Able Screening. A written report is included in the offender's file and a copy of the individualized treatment plan will be given to the offender.

- **Stage B:** Those who have protracted sentences (two or more years before release) and could benefit from therapy and will admit to their crime(s) are placed in a more comprehensive group. STP (Specialized Treatment Program) will be offered at the Level V institutions.

Aftercare groups are available to inmates upon completion of Stages A and B.

SPECIAL TREATMENT PROGRAM PROTOCOL:

- Services are provided based upon client need and length of incarceration.

- New referrals will be expected to complete the psychosexual group prior to admission to the broader therapy group called Special Treatment Program (STP). This orientation to group process is expected to shorten the time an offender spends in therapy.

- Offenders are expected to admit their sexual offense to be eligible for STP. Incomplete admission or disagreement with some details will not bar acceptance; however, in such instances, it will be made clear that participants must work toward admitting culpability for their offense(s).

- Offenders demonstrate cooperation with the therapy process to remain in STP.

- Self-regulation will be referred to as accountability for treatment purposes in STP. Living with accountability is the highest therapeutic goal for each client. All other treatment goals are structured with the aim of building capacity to accept accountability.
- Offenders address their own core issues using the framework of structured therapeutic exercises. (Autobiographies, Cycle work, Goal Setting, Re-integration to the Community and Victimology). Didactic methods and therapeutic interventions are geared toward meeting specific individual need. Referral for parallel needs will be made promptly and followed up upon to promote the highest level of interdisciplinary coordination of treatment.

- Offenders who have their own victimization issues “earn the right to do victim work” after they deal with their offending issues.

- Given the setting of the group, STP will strive to be paperless. Therapeutic exercises will be structured to promote confidentiality and shall be presented orally whenever practical.

- Pragmatism is the principle as governed by the rule that everything must connect to the specific sexual offense as it is the referring issue for treatment.

- Therapists employ a variety of psychological methods to meet client needs (i.e., - Relapse Prevention, Cognitive Behavioral Therapy, Reality Therapy, Re-parenting, Social Skill Training, Confrontation, Motivational Interviewing, etc.).

- The model was designed for the motivated client (who is without co-occuring therapeutic need and is not a treatment malingerer) to complete therapy in less than two years. This goal for treatment does not include participation in SOAP or AFTERCARE. This timeframe also does not include interruptions due to violation or a suspension from treatment.

SEX OFFENDER PROGRAM OUTLINE:

I. Referral to Sex Offender Awareness Program (SOAP)

II. Evaluation (Scope of assessment determined by MnSOST-R and Static-99R scoring)

III. Development of Individual Treatment Plan and Group Assignment

IV. Client Placement in Therapy Group

Phase 1 prepares the offender to answer the first questions about the crime:

- Autobiography
- Details of Offense
- Pre-cycle work (two sets of presentation)
- Setting of "My Goals for Change"

Phase 2 helps the offender understand victim impact and develop empathy

- My Primary Victims (required disclosure of all sexual victims)
- My Secondary Victims (The Ripple Effect)
- Future Impact
- Empathy Exercises (without toxic shame)

Phase 3 allows the offender to demonstrate responsibility in a relational context

- Restitution and Amends
- Safety Plans
- Reconciliation Plans (different from reunification)
- Plans for Family Reunification (when appropriate)

Phase 4 confronts sexual interests and deviant behaviors

- Sexual Autobiography
- Deviant Sexual History

- Offense Cycle Work
- Pre-planned exit strategies

Phase 5 prepares the offender for self-management in the recovery process

- Special projects assigned according to client need (impulse control)
- Accountability Letters (4 *symbolic* letters, including the victim)
- Accountability Plan and Personal Safety Contract
- Accountability Partners (4 partners)
- Aftercare Planning

V. Phase Out

VI. Graduation Presentation

VII. Aftercare (Accountability Group-SOAR)

SEX OFFENDER AWARENESS PROGRAM (SOAP)

EIGHT SESSION OUTLINE

Session One: **Relationships ***

- Four types of relationships
- Objectification in our words and actions
- Tactics of power and control
- Intimacy

Session Two: **Feelings/Emotions**

- The process of change (words – behaviors - attitudes)
- Thoughts vs. feelings
- Positive and negative feelings
- Six Primary emotions

Session Three: **Handling Difficult Situations**

- Chain of choices
- The Anger Curve
- 4 step pre-cycle
- Grief and trauma events

Session Four: **Safety Contracts**

- The sex offender registry
- Safety contracts (computer, church, family)
- What to do if you see your victim

Session Five: **Sex Offenses: Rape ***

- Definition of rape
- Four types of rape
- Myths and facts
- 3 ways to gain access (consent, pressure and force)

Session Six: **Sex Offenses: Child Molestation and Incest**

- Pedophilia and Incest
- Typologies (fixated and regressed)
- Myths and facts
- Without consent

Session Seven: **Sex Offenses: Hands-Off Offenses**

- Exposing, peeping, stalking, groping, computer
- Computer sex crimes
- Paraphilias: deviance vs. inappropriate or appropriate behavior
- Misuse of relationships

Session Eight: **Victimology**

- Definition of a victim/ why I'm not the victim
- Secondary Victims (the ripple effect)
- Power and Control from a victim's point of view
- Misuse of relationships
- Reasons adults sexualize children, minors, adults
- Long-term effects

*** New class members accepted in weeks 1 and 5**

Sex Offender Accountability Response (SOAR)

Eligibility

Graduates of STP are eligible for admission to an aftercare program called Sex Offender Accountability Response (SOAR). The SOAR group will meet monthly in space provided at three Level III facilities. For graduates still incarcerated, this group can meet at the Level IV or V institutions. STP graduates with continued community supervision responsibilities may be required to participate in SOAR.

Format

The group will be facilitated by a sex offender counselor. The group will process real life situations and promote a continuation of the self-regulation or accountability model. Topics discussed shall include: Family Issues, Reunification Issues, Interpersonal Conflicts, the Sex Offender Registry, Safety Plans, and New Relationship Issues. Individual group members may provide short presentations for broader discussion with counselor assistance.

Group Rules

Confidentiality will be maintained within appropriate legal constraints. All new romantic relationships and sexual encounters are to be disclosed. Disclosure of any contact with primary or secondary victims is compulsory. Beyond these basics, each group will determine its own rules and standards for participation.

Groups and Scheduling

Please see the following pages for information regarding Group Scheduling at the various DDOC facilities and anticipated staffing needs.

Scheduling					
Time	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**
9:00		BWI STP Group A & C	SCI STP Group B & D	JTVCC STP Group A & B	
10:30		BWI (24 wks.) SOAP A & C	8/8 SCI SOAP B & D	JTVCC STP Group A & D	
1:00	**EVALUATIONS & TRAININGS**	HRYCI SOAP B & C	SCI Group B & D	JTVCC SOAP B & D	**CASE STAFFINGS**
2:30		HRYCC STP Group B & C	8/8 SCI Orientation B & D	JTVCC SOAP B & C	
3:30		HRYCI STP Group B & C			
6:00		SOAP or STP Group Level IV C & D	SOAP or STP Group Level IV C & D	SOAP or STP Group Level IV C & D	

Staff (160 Clock Hours)				
A	**CSOTP-Evaluator-Director**	3 STP Groups	1 SOAP Group	Provide substitute coverage as needed
B	**CSTOP-Evaluator**	5 STP Groups	4 SOAP Groups	
C	**Associate CSOTP**	3 STP Groups	5 SOAP Groups	3 Evenings
D	**Associate CSOTP**	3 STP Groups	5 SOAP Groups	3 Evenings

Level V (Days)	
BWI	1 STP Group + 1 SOAP Groups (24 weeks in length, designed for women offenders)
HRYCC	2 STP Groups + 2 SOUP Groups (8 weeks on; 8 weeks off)
SCI	2 STP Groups + 2 SOAP Groups (8 weeks on; 8 weeks off)
JTVCC	2 STP Groups + 2 SOAP Groups (8 weeks on; 8 weeks off)

Level IV (Evenings)			
PCCC	1 SOAP Groups (8 weeks on; 12 weeks off)	**WCCC**	1 SOAP Group (8 weeks on; 16 off)
MCCC	1 SOAP Group (8 weeks on; 12 weeks off)	**SCCC**	1 SOAP Group (8 weeks on; 16 off)

CFG proposes the following groups for the facilities listed as of October 1, 2012	
BWCHI	one comprehensive therapy group; one didactic or SOAP group, as needed
HRYCI	two comprehensive groups; one didactic or SOAP group, as needed
JTVCC	two comprehensive groups; one didactic or SOAP group, as needed
SCI	two comprehensive groups; two didactic or SOAP groups, as needed
PCCC	one didactic group or one SOAP group, as needed
WCCC	one didactic group or one SOAP group, as needed
MCCC	one didactic group or one SOAP group, as needed
SCCC	one didactic group or one SOAP group, as needed
HDPWCC	one didactic group or one SOAP group, as needed

CFG anticipates need for the following positions as of September 1, 2012.

- Sex Offender Counselor/Evaluator/Director (James G. O'Quinn, D.Min., CSOTP)
- Sex Offender Counselor/Evaluator (position to be filled)
- Sex Offender Counselor (present filled – looking to maintain current staff member)
- Sex Offender Counselor (position to be filled)

DUI COURT-OREDERD PROGRAMMING

INTRODUCTION AND BACKGROUND

Thresholds, Inc., was established in 1985 by two individuals with prior responsibility for running the State of Delaware's DUI treatment program. Due to a hiring freeze, the State was compelled to outsource the program to the private sector. With specific knowledge, experienced oversight and familiarity with program targets and goals, Thresholds was able to single-handedly operate the treatment program statewide for approximately 12 years, until the State adopted policy requiring each County have more than one provider. Overall, Thresholds has been providing DUI-programming for over twenty-five years. During the last fifteen, Thresholds has added evidence-based outpatient treatment services and a Drug Court Diversion program under contract with the Division of Substance Abuse and Mental Health. Thresholds is accredited by the Joint Commission for Accreditation of Healthcare Organizations and licensed by DSAMH as an outpatient treatment program. Our use of group-based programming is vital to our commitment to recovery-oriented systems of care. We chose to adopt these particular models because of the preponderance of research supporting them (please see Treatment Improvement Protocol 47: Clinical Issues in Intensive Outpatient Treatment, DHHS Publication No. (SMA) 07-4233.) We also rely upon Motivational Groups for Community Substance Abuse Programs, Mid-Atlantic Addiction Technology Transfer Center Network, for further guidance in treatment and program development.

PROGRAM CONSTRUCTION

Thresholds has constructed the following suggested programming only after careful consideration of a range of programs currently in use and after hosting many conversations with providers that work with the appointed population subsequent to release. Structured to a large degree upon evidence-based practices recommended by the Center for Substance Abuse Treatment's (CSAT) Treatment Improvement Protocols, programming is focused upon motivational enhancement, group-based services and intensive outpatient treatment. Thresholds believes the population served would most benefit from programming if housed in a self-contained unit and afforded access to programming during daytime hours.

DUI COURT-ORDERED PROGRAMMING

While being arrested for DUI is a statistically significant indicator that an individual has a substance abuse disorder, a third charge tends to remove any lingering ambivalence regarding this question. Experience informs us that most persons adjudicated to prison-based DUI programming have already completed at least an educational program and probably a treatment program consisting of individual and group counseling for one or more prior offenses. While we realize the specific standards for DUI programming have yet to be finalized, in consideration of the aforementioned information, Thresholds strongly recommends the model employed include the framework outlined below.

In Delaware, the DUI education and treatment system relies on a model that proves fairly successful for first offenders, but less so for people with more substantial problems, as the number of hours required for program completion is the same whether a person has one charge of driving under the influence or seven. While associated penalties are progressive and incremental, the same cannot be said for treatment protocol and initiatives, as the expectations for treatment have not changed in over thirty years, with the single exception of the recent inclusion of an in-prison treatment component for felony-level DUI offenders.

There are particular advantages to having a ninety day program housed within correctional institutions, especially if program structure reflects certain realities: First, all DUI offenders will be released to the community within a time frame usually measured in months, rather than years. Second, almost all DUI offenders will be eligible to apply for reinstatement of their driving privileges and will be inclined to do so. To achieve this end, offenders will need to complete another program outside the prison walls. Third, upon release, all offenders will be faced with situations and challenges associated with a return to circumstances that supported the original problem. Connecting these offenders to programs that will support changes facilitated and individual's emerging needs is essential. Though discharged DUI offenders across states and counties may face similar demands and risks, the issue of disparate levels of resources post-release is greatly minimized in Delaware through purposeful transition planning and community outreach.

Thresholds is proposing a model of services that combines a foundation of motivational enhancement with an array of cognitive behavioral treatment services utilized in most traditional co-occurring treatment programs. The range of services and components offered reflects the structure of an intensive outpatient treatment program with a robust schedule. Though the program will be group-based, treatment is considered individualized on the basis of strong clinical focus on both individual strengths and needs.

GROUP FOCUS

Treatment Engagement Groups

While these clients have patterns of behavior indicative of, in most cases, substantial histories of alcohol and drug abuse, offenders are likely to present with a great deal of ambivalence about both the nature and magnitude of the problem. These groups make no unsupported assumptions about whether clients are ready to enter into a process of change. Focus of these groups is upon discovering what individuals are motivated to do and to determining the degree of serious commitment to change.

Psychoeducational Groups

Psychoeducational groups tend to be more information-based and include an emphasis on substance use disorders in terms of how they develop and progress, and how recovery starts and is supported.

The curriculum shall be founded upon evidence-based models. It should be noted that psychoeducational groups do not represent a forum for explicitly challenging patterns of behavior or for engaging in confrontation.

Skills Development Groups

These groups offer clients an opportunity to learn and practice strategies that will assist them as they move into the recovery phase. Content areas include stress management, assertiveness training, drug and alcohol refusal training and relapse prevention.

Support Groups

These groups are part of the program for those clients who have moved into the action and maintenance stages of change. Sessions are process-oriented and focus on any tense issues present. Activities for these groups address learning and interacting with others in ways that promote and support recovery – i.e., - How do we change negative ways of thinking? How do we go about learning how to act deliberately rather than react impulsively? How do we gauge the effect of our behavior on others in our support system? How do we find better ways to resolve conflicts?

Single Interest Groups

While referrals to this program are made on the basis of a prior DUI incident, the number and type of life problems that later-stage DUI offenders bring to treatment are substantial. There are also increasing levels of co-occurring mental health issues and often histories of trauma discerned that have often gone unnoted and/or unaddressed. While the number and type of problems that may need special attention cannot be predicted, we believe there will be a definite need for a set of small, interpersonal process groups that focus on these considerable barriers to recovery. The structure and function of these groups will rely, to a great extent, on the nature of support within the treatment environment.

Outpatient Treatment

In the outpatient DUI treatment system, we have noted increasing numbers of individuals who are experiencing depression, anxiety and bi-polar disorder (these elements tend to be more prominent or obvious in those individuals with longer DUI histories). Addressing these needs in more intensive treatment programs is crucial. Ensuring there is a solid linkage with broad-based recovery services as offenders are released is a critical element of discharge planning.

STAFFING AND GROUP SIZE

The forecasted, total number of clients to be served at the two sites referenced within the RFP is seventy. The program director position is viewed as primarily clinical in nature. Program directors will be responsible for clinical supervision and training, as well as other clinical management tasks. Most residential programs have a 10-to-1 client-to-counselor ratio with some flexibility for vacation and sick time relief. Group sizes above fifteen have shown to be of little therapeutic effectiveness; therefore, the

model proposed assumes a maximum group size below that level (exceptions include groups conducted in a lecture format and large-format mutual support groups). CFG/Thresholds intends to discuss staffing levels and further aspects regarding program structure with the DDOC as we move forward, but proposes the following Staffing Matrix (outlined below).

Staffing Plan for DUI Program	
Program Director	1
Administrative Asst.	0.5
Counselor II	1
Counselor II	1
Counselor I	1
Counselor I	1
Counselor II	0.5
Total	**6**

The Staffing Plan for the DUI program was comprised with the following assumptions in mind: Using the staffing model included in the request for proposals, the project identifies five and a half full-time equivalents. We have added a half-time floater who can step in to cover vacations and perform other relief work. Though this is very tight staffing for a program of this nature, it is workable. The program director shall also be responsible for clinical supervision and counselor training.

TELEPSYCHIATRY PROPOSAL

Though committed to delivering consistently high quality on-site psychiatric services, CFG fully intends to implement a realistic and successful telepsychiatry program within the Delaware DOC.

The goals of CFG's telepsychiatry program are twofold: increase collaboration and access to services between DDOC facilities and increase the pool of qualified professionals that can serve the DDOC by enabling remote access for these clinicians.

While the first goal may be obvious, the second goal merits further discussion. Having been active in the delivery of services within Delaware for the past two years, CFG is intimately familiar with Delaware's shortage of high-quality psychiatry, particularly in the southern Counties. CFG understands that community providers, hospitals and the DDOC continue to face real world challenges in the recruitment and retention of high-quality psychiatric providers. While CFG will deliver on-site psychiatry, it is being realistic in recognizing that Delaware's shortage of clinicians will require that some of this on-site coverage be augmented through telepsychiatry. Further, CFG's extensive experience with telepsychiatry has proven that the carefully planned integration of telepsychiatry into its overall model of mental health services is a major strength of this proposal and that its inclusion brings tremendous benefits in: access to appropriate professionals, improved coverage, strong clinical outcomes, operational and financial efficiency, and increased collaboration within a multidisciplinary team.

To better serve the Delaware DOC, CFG will install dedicated videoconferencing units at each of the four Level V Prisons, as well as at each of the Level IV work release or VOP offices. These secure video conferencing units will enable increased access to psychiatric evaluation and care and will further improved collaboration between the facilities. This telepsychiatry equipment shall serve four major purposes:

- Direct Care to Offenders via:
  - Psychiatric emergency services
    - 24/7/365 access to emergency telepsychiatrists
    - Evaluation of offender's psychiatric state and determination of the most appropriate level of care
    - Avoidance of unnecessary off-site transports to emergency rooms
  - Routine psychiatric services that include:
    - Medication management, intake assessments, crisis visits, sick-call requests
    - Contingency plan, as backup to on-site services for unforeseen sick days, time off or extended vacancies
- Mental Health Treatment Planning Meetings
  - Use of secure video to enable consistent treatment planning meetings that include clinical leadership and staff from multiple facilities

PROPRIETARY

- Enable the active and regular participation of psychiatry in treatment meetings

Multidisciplinary Team Meetings

- Collaboration for improved care to co-occurring offenders
- Treatment meetings with Substance Abuse, Sex Offender and DUI Program teams
- Enabling easier collaboration and communication by limiting travel
- Focused on re-entry planning

Internal Collaboration With and Supervision of Psychiatric Nurse Practitioners

- CFG strongly believes in the clinical and fiscal effectiveness of psychiatric nurse practitioners and uses them extensively within its practice
- Regular and meaningful contact between the nurse practitioners and their collaborating psychiatrist (a key success factor)
- Televideo is an effective tool to enable this collaboration through:
  - Dynamic consultation and case review between the clinicians
  - Direct offender assessment by a psychiatrist for second opinions

Last year, CFG created Delaware's first-ever community-based telepsychiatry program in partnership with a local substance abuse agency and has since kicked off Delaware's first hospital emergency telepsychiatry program at Beebe Medical Center. As an active provider of telepsychiatry services for the last thirteen years, CFG is confident in the power of telepsychiatry to enhance the capacity and effectiveness of o-site mental health services.

TELEPSYCHIATRY STANDARDS

All of CFG's telepsychiatry practices and programs follow evidenced-based clinical practices and adhere to the American Telemedicine Association's Practice Guidelines for Videoconferencing-Based Telemental Health, while also respecting the American Psychiatric Association's position statement on telepsychiatry. Further, CFG's telepsychiatry programs are in alignment with the National Commission on Correctional Health Care's position statement on telemedicine. For more information on the research and evidence behind CFG's telepsychiatry services, please refer to the resource page of CFG InSight Telepsychiatry at http://www.in-sight.net/content/resources/resources.asp for an exhaustive library of content on the appropriate use of telemedicine.

(All technology use by CFG in the delivery of telepsychiatry meets or exceeds the confidentiality, security and encryption requirements of HIPAA and the HITECH Act.)

TRAINING AND PROGRAM DEVELOPMENT

Prior to utilizing its telepsychiatry system, CFG will consult with DDOC, BCHS and any other applicable agencies or departments to review the use and overall goals of the telepsychiatry programs and to jointly develop any applicable policies and procedures for telepsychiatry. These policies would cover

such issues as the physician/patient relationship, technology requirements, collaboration with on-site staff members, medical licensure, informed consent, contingency and emergency planning, documentation and medical record exchange and storage. Further, CFG will bear responsibility for training any on-site staff in the provision of telepsychiatry inclusive of workflows and the technical operation of the equipment.

Telepsychiatry Reporting

CFG will work collaboratively with the DDOC and BCHS to establish a written telepsychiatry plan that includes regular monthly reports about the program. The format for this monthly report will be developed in tandem during the planning and transitional phases. It will include such things as: statistics on the number and type of encounters, issues or concerns with the technology, training updates, significant clinical events, policy and procedure revisions or considerations, and general comments about the efficacy and acceptability of the telepsychiatry program.

Televideo Equipment

CFG will purchase, install and provide support for all televideo equipment necessary to appropriately conduct telepsychiatry. Each unit will be mounted on a sturdy rolling cart that can be safely stored when not in use. CFG recognizes that any unit installed by CFG for these purposes will be subject to the policies of Delaware's Department of Technology and Information Requirements and will function on standards-based transmission protocols. Given present uncertainty about the internet connectivity and networking requirements of each site, the delivery of CFG's telepsychiatry services is contingent upon permission to install IP transmission lines of adequate bandwidth to support the televideo transmissions by the DDOC and the IT department of the Bureau of Management Services. Where necessary, CFG will work in cooperation with the DDOC both administratively and technically to select and install the appropriate transmission lines for each facility included in the telepsychiatry program, though CFG acknowledges that the DDOC has the ultimate authority and responsibility over all IT installations. CFG has budgeted for a business class, dedicated cable or fiber optic connection at each site specifically for televideo.

More detail on the televideo endpoints CFG intends to use in this program is included as part of Appendix A. While economical, the equipment package proposed represents a gold standard in televideo equipment and can be expected to hold a useful life of approximately seven years. Please note that these endpoints will not be set up to conduct point-to-point calling strictly within the DDOC. They will each be registered and configured within CFG's owned and redundant telepsychiatry core infrastructure of a VCS Controller, Gateway and Border Controller.

CFG understands that there are inactive videoconferencing systems at SCI and the Women's Work release program that have not been utilized in two years. Upon being awarded the contract, CFG will investigate the specifications of these video units and their functionality. CFG will make every effort to integrate these units into its telepsychiatry system if they can be used without sacrificing the quality of

PROPRIETARY

the interaction. If successful in using these units, CFG will reposition the telepsychiatry equipment to incorporate two more facilities into the program.

Though the DDOC will have video access to CFG telepsychiatrists outside of DDOC facilities, zero costs for the equipment of these clinicians has been built into or passed on through this proposal. Additionally, the DOC will face no incremental cost for the back-end encryption and security infrastructure that is already an integral part of CFG's telepsychiatry program.

EQUIPMENT SUPPORT

Depending on physician set-up and available space, participating correctional facilities may house their telepsychiatry equipment within a designated "telemedicine space" or, more likely, have the equipment stored on a rolling cart within a secure location when not in use. CFG's technical staff assists in setting up either of these environments to meet standards conducive to conducting interviews via the use of telemedicine equipment.

CFG will provide multiple layers of IT support for any equipment installed at a DDOC facility for telepsychiatry. CFG technical staff provides both initial and on-going training regarding the equipment both internally to the company's own users, as well as to designated staff that will be using the equipment at the remote location. CFG provides 24 hour, 365 days per year technical assistance and back-up in the event of equipment failures. As stated above, any equipment purchased under this agreement will be backed with a 3-year replacement warranty from the distributor.

VIDEO EQUIPMENT FOR TELEMEDICINE OR TELE-COURT

It is worth noting that the televideo equipment posed by CFG is consistent with industry standards and norms, such that it can be paired with other peripherals to be integrated into other healthcare disciplines that may utilize telemedicine in the future. Additionally, the technology posed by CFG is compatible with most video court systems and may prove useful for other non-clinical applications that can help reduce the need for off-site transports for court hearings or judicial meetings. CFG is aware of numerous jails within the region that have implemented a tele-court program with excellent results and has been able to configure its telepsychiatry equipment to serve this dual purpose when necessary.

TELEPSYCHIATRY FOR PSYCHIATRIC EMERGENCIES - GENERAL

Recognizing the urgency and difficulty of appropriately handling psychiatric emergencies within a correctional facility, particularly during off-hours, CFG proposes to leverage its considerable behavioral health infrastructure and experience with the clinical, administrative and technical aspects of telepsychiatry to make psychiatric clinicians available for live, face-to-face psychiatric evaluations around the clock within one hour of a request for service at all Level IV and Level V facilities. This telepsychiatry service will be available for any psychiatric emergency, as well as any potential involuntary psychiatric commitments.

In the event of a psychiatric emergency, telepsychiatry enables an offender to be evaluated in real time by either a Psychiatric Advanced Practice Nurse or a Psychiatrist without having to leave the security of the correctional facility. This emergent telepsychiatry application reduces the expense of off-site transportation, officer wages and overtime. It also reduces flight risk and addresses safety and satisfaction concerns of local emergency departments and psychiatric crisis centers. Utilizing telepsychiatry in this emergent application greatly reduces wait times and enables the psychiatric clinician to evaluate the offender closer to the incident and within the same environment, leading to truer clinical outcomes and better clinical care. This service is far more telling and timely than a typical telephone call schedule using staff resources that relies on audio descriptions and delayed after-hours trips into the facility. Its efficacy has been validated through myriad studies and publications, and CFG has personally been conducting these emergent telepsychiatric evaluations for thirteen years overall and for eight years within correctional facilities.

Whereas some facilities choose to utilize an after-hours call system of telephone support for psychiatric emergencies, CFG finds that these systems often result in unnecessary off-site transports to local emergency rooms or pose problems with having the on-call clinician arrive at the facility for an in-person evaluation in a timely manner. Telepsychiatry enables the offender to safely receive timely psychiatric evaluation through a face-to-face interaction that very closely replicates the in-person experience and results in the most appropriate level of care.

For all psychiatric emergencies that occur after-hours or on the weekends, the on-call mental health professional will be contacted. The on-call mental health professional will determine whether one of CFG's psychiatric clinicians needs to be contacted either by telephone or via telepsychiatry for an emergent evaluation. Should the psychiatrist determine through the face-to-face telepsychiatric evaluation that there is a need for a higher level of care, the psychiatrist or another member of the mental health team will then assist in the process of transferring the offender.

CFG is prepared to address and confront any crisis that involves an offender's mental status, adjustment to the correctional setting or behaviors which place the offender at increased risk. The telepsychiatric clinician will work with the medical staff, custody and administration in identifying offenders in crisis, reducing and controlling risk to the offender and others within the population, ultimately bringing the matter to the attention of the appropriate services staff.

CFG will provide 24/7/365 access to its team of telepsychiatric clinicians for the purpose of using telepsychiatry to respond to psychiatric emergencies. A clinician will be available to conduct an emergency evaluation using televideo equipment installed and maintained within either the infirmary or the mental health unit of the correctional facility within one hour from the request for the evaluation.

PROPRIETARY

EMERGENCY TELEPSYCHIATRY VALUE

While all applications of telepsychiatry offer value, CFG's 24/7/365 emergency telepsychiatry services carry the most significant and time-tested quantifiable results. Within every correctional or acute care facility that these services have been offered, they have been proven to reduce the number of off-site transports in times of crisis and have enabled psychiatric crises to be managed within a safe and secure space. For correctional facilities, these outcomes translate not only into risk reduction, but into real dollar savings - particularly in the areas of correctional officer time and overtime. Additionally, emergency telepsychiatry offers the psychiatrist new, empowering tools for positive clinical outcomes by granting the ability to observe the offender closer to the time and environment of the crisis.

Through CFG's extensive emergency telepsychiatry system, DDOC facilities will access CFG telepsychiatrists that are not part of the regular on-site psychiatric treatment teams. This increased access is a huge benefit to CFG's telepsychiatry program, because it integrates the services of Delaware licensed psychiatrists that are practicing remotely.

CFG'S EMERGENCY TELEPSYCHIATRY EXPERIENCE

While many organizations may profess to offer on-demand telepsychiatry, CFG and its sister organizations have spent the last thirteen years building a business that focuses on just that. Through InSight Telepsychiatry, CFG has immediate internal access to the technical, operational and clinical infrastructure needed to reliably and consistently deliver real-time access to its team of psychiatric clinicians for prompt psychiatric evaluation in times of crisis. These real-time emergency psychiatric services are already being offered regionally to the emergency rooms of hospitals within Delaware, Pennsylvania and New Jersey. Further, they are being considered for the new Crisis and Psychiatric Assessment Center in Ellendale and within other Delaware hospitals.

CFG's emergency telepsychiatry services are managed by its internal 24/7 access center that serves as the link between on-site staff and the covering psychiatric clinicians. This access center provides an immediate response in times of crisis and builds a connection to the appropriate psychiatric clinician for either telephone consultation of to conduct a full psychiatric evaluation through video means. CFG's depth and capacity of providers enables these evaluations to be initiated within less than one hour from the initial call to the access center. In submitting this proposal for emergency telepsychiatry services within these ten DDOC facilities, CFG demonstrates capacity with a team of active, Delaware-licensed psychiatrists to provide true 24/7/365 coverage with accountable and quantifiable results.

TELEPSYCHIATRY DEFINED

Telepsychiatry is the use of video/audio transmission to perform face-to-face psychiatric interviews where the patient and the psychiatrist are in different locations yet connected via a videoconferencing device. This technology allows for a patient-to-provider interaction that very closely replicates physically being present and allows for expert treatment to be provided to patients who are distant from the primary caregiver. The literature is replete with research demonstrating its efficacy and reliability in various settings and in determining a wide range of diagnoses. Where access to appropriate resources has been limited by funds, distance and time, this technology has provided solutions.

This model is designed to address problems such as limited local psychiatric resources, costly offender transfers and delayed or discontinuous treatment. Project objectives are to provide access to psychiatry services, reduce unnecessary travel and initiate earlier and more coordinated care. Expected outcomes include a reduction in transporting offenders to medical facilities, reduced costs for specialty care and earlier intervention and coordination of care.

The benefits of Telepsychiatry are numerous. The most common include:

- Faster access to care than traditional on-site services
- Improved "Call Coverage" enabled by video
  - Option to escalate psychiatric consult to a psychiatric evaluation
- Increased pool of psychiatric providers
  - Increased access to corrections-specific psychiatrists
    - Accurate diagnoses and care
    - Improved formulary adherence
- Reduced transfers and off-site transports
  - Frees up support and custody staff to perform other roles
  - Fewer emergency room visits
  - Reduces transfers for urgent care
  - Eliminates the need to take offenders outside the secure perimeter
    - Lower security risk since offender remains in jail
    - Reduces potential liability of jail
- Reduces the amount of hours needed for on-site clinics
- Saves money for the Department of Corrections

Telepsychiatry's most valuable asset may be its ability to minimize security risks associated with taking offenders outside of a correctional facility for healthcare. There have been reported incidents of corrections officers killed in the line of duty during an outside medical transport. History has also shown that outside transportation is frequently a setting for escapes or attempted escapes during

PROPRIETARY

incarceration. Telemedicine also minimizes the potential for offenders to fake an illness in order to be sent out of an institution for either an attempted escape or for the mere exhilaration of leaving a secure area. With each transport that is diverted by the use of telemedicine, the potential for injury to officers or members of the public is completely eliminated.

CFG's Telepsychiatry Experience and Background

CFG and its sister companies were pioneers in bringing telepsychiatry to the Delaware Valley thirteen years ago. Since then the CFG family has started Delaware's first community-based telepsychiatry program for co-occurring substance abuse and mental health issues and has begun the State's first hospital emergency telepsychiatry program for emergency room dispositions as well as psychiatric consultation liaison services.

CFG and its sister companies presently provide telepsychiatry services within ten states in correctional facilities, hospitals and psychiatric crisis centers. Further, the CFG family of companies provides scheduled and urgent telepsychiatry programs to substance abuse clinics, community mental health centers, primary care practices, residential programs, human service organizations, and military bases within seven other states.

CFG's Telepsychiatry System

Since bringing telepsychiatry services to the Delaware Valley thirteen years ago, CFG has built an infrastructure and level of experience with telepsychiatry's technology, operational structure, and clinical practices that are second to none. Our experienced clinicians are structured into a network to provide telepsychiatry services via live video conferencing at any time day or night, 365 days per year. Our professionals interview patients and consult with on-site staff in order to determine the appropriate level of care for each patient. CFG's telepsychiatry system is specifically structured in order to provide not only around the clock access to experienced clinicians, but also 24/7/365 access to live access center representatives for scheduling, documentation and troubleshooting, as well as a full spectrum of IT support, and management availability.

Telepsychiatry Program Management

As one of its core businesses, CFG has invested heavily in the management infrastructure required to deliver consistently high quality telepsychiatry services. This team is headed by a fulltime Executive Director of telemedicine and includes other fulltime positions for telemedicine administrative support including a telepsychiatry operations manager, access center director, associate access center director, multiple regional account executives, and additional daily support from CFG's departments of medical affairs, scheduling, and information technology.

CFG's clinical leadership for telepsychiatry is equally as strong and is driven directly by its Psychiatric Medical Director, Jim Varrell, MD, and its associate Medical Director, Maasi Shamilov, both dually-boarded psychiatrists that have each been practicing correctional telepsychiatry for about ten years. These clinical leaders will be instrumental in developing appropriate clinical protocols for the adoption of a viable telepsychiatry program within the Delaware DOC and will continue to provide both supervision and active clinical care along with CFG's extensive telepsychiatry team.

Access Center

To provide additional accountability, quality monitoring, and overall service to its telepsychiatry recipients, CFG developed a 24-hour internally staffed Access Center for telepsychiatry. These Access Center representatives are the quarterbacks of every emergency telepsychiatry encounter that make sure the service recipient obtains an immediate response, gets connected to the appropriate clinician, transmits and receives complete clinical documentation, and has access to technical assistance as needed. With the Access Center, telepsychiatry sites do not have trouble with outdated schedules or waiting for clinicians to return pages/calls since everything is routed to one phone number where there is always a live person to answer the call. All emergency telepsychiatry requests are initiated by contacting the Access Center representative who logs the request and routes it to the appropriate clinician. The Access Center is also responsible for managing all medical records, and if there is a request for technical assistance, the representative will assist with trouble-shooting common equipment failures and will route any remaining technical concerns to CFG's multi-level technical support.

Telepsychiatric Clinician Schedule and Support

As CFG has expanded its telepsychiatry business, it has developed a 24/7/365 schedule for its physicians and advanced practice nurses that ensures that multiple clinicians are ready, willing and able to conduct evaluations at any hour. This is not a traditional call schedule that relies on pages to track down a specific doctor who may be otherwise engaged. At any given time, CFG has multiple telepsychiatric clinicians dedicated to telepsychiatry, and it is the responsibility of the Access Center to determine which clinicians are working, credentialed and available to conduct the evaluation for each request for service. In a crisis, client sites do not have to keep up with the traditional, ever-changing call schedule to page a clinician and request an evaluation. With CFG's Access Center and 24/7/365 clinician schedule, the client site must only call one consistent, central number in order to connect with a clinician in a crisis.

Additionally, CFG has built a back-up structure of additional clinicians on call to accommodate for unforeseen spikes in volume. This back-up system also includes multiple physicians, including CFG's Medical Director and Assistant Medical Director. Consequently, multiple layers of clinicians and top medical leadership are available for telepsychiatry at all times.

PROPRIETARY

PERFORMANCE IMPROVEMENT AND QUALITY

CFG has implemented a performance improvement system for its telepsychiatry division that is structured, responsive, sets clear expectations through defined metrics, is well communicated throughout the organization, seeks participation from all levels of staff, and holds to account all those involved in delivering CFG's telepsychiatry services. The guiding principle and goal of this approach to performance improvement is that systems exist that provide a continuous quality approach to all areas of operation. All levels of staff are trained not only during orientation but throughout their employment to take initiative, be problem identifiers and solvers and active communicants in the performance improvement process. The performance improvement committee is a representative group chaired by the telemedicine director that meets regularly. Members of the committee include the Performance Improvement Coordinator, the Director of the Call center, the Medical Director, the Director of Medical Affairs, the Telepsychiatry Operations Manager, and the Chief Information Officer, who is responsible for the technical support services of the telepsychiatry equipment.

INFORMATION TECHNOLOGY

To support its telepsychiatry services, CFG has installed a comprehensive Information Technology infrastructure and support network that includes multiple layers of 24/7 IT support from its internal call center reps, IT support staff, outside vendors and upper management. While all clinicians and assisting staff at client sites are trained on equipment set-up and operation, CFG provides multiple layers of IT support beginning with its call center reps and progressing up to the direct involvement of CFG's Chief Information Officer.

CFG has taken great care to develop an IT infrastructure that includes redundancy in its televideo equipment, network hardware and communication lines to ensure effective technology operation. CFG has the ability to operate its equipment over both ISDN transmission lines, as well as IP (Internet Protocol) transmission. All transmissions are encrypted, secure and HIPAA-compliant and CFG has invested in extra network infrastructure that authenticates each equipment transmission to ensure absolute security. In the unlikely event of unforeseen technical problems, CFG has a disaster recovery plan in place.

SEVERABLE TELEPSYCHIATRY PROGRAM

CFG proposes a more comprehensive telepsychiatry program that would bring secure videoconferencing platforms into the remaining six Probation and Parole offices. The inclusion of these centers within a secure videoconferencing network will further enable efficient use of mental health professionals and increased communication and collaboration between the treatment teams of different programs and facilities. The inclusion of these facilities in the telepsychiatry program will extend the timely reach of CFG's mental health teams to more offenders to reduce wait times for assessment and intervention. While the delivery of necessary onsite psychiatric services will continue to be the priority of CFG at each and every facility as needed, the inclusion of telepsychiatry will offer true 24/7/365 access to face-to-face psychiatric services for any crisis scenarios or for urgent psychiatric intervention, without those resources being limited by distance or time.

Additionally, this severable telepsychiatry program would include the installation of an additional videoconferencing unit at each of the four Level V prisons in a location outside of the mental health unit that would be accessible to law enforcement for psychiatric crisis evaluation of arrested individuals prior to their acceptance into the correctional facility. The aim of this pre-admission service for on-demand psychiatric evaluations focuses on reducing unnecessary delays for local law enforcement. It targets scenarios where an arrested individual has threatened suicide, such that law enforcement is obligated to have the individual's psychiatric state evaluated prior to admission into the correctional facility. The present system and alternative to this program is for these law enforcement officers to transport the individual to a local hospital emergency department where they must obtain not only psychiatric clearance, but also medical evaluation and clearance. These transports by law enforcement officers to hospitals are proven to be time consuming, risky and frustrating to all parties involved.

The aim of this pre-admission psychiatric evaluation service is to quickly evaluate the psychiatric state of the individual in question in order to determine whether he or she meets the admission criteria for the correctional facility, without a need to spend unnecessary time within a hospital. The result is markedly increased access to psychiatric assessment that ultimately diverts inappropriate hospital transports of arrestees to better utilize Delaware's already system of emergency medicine and psychiatric crisis.

CFG implemented the first of these programs in the country about three years ago within NJ's Middlesex County Jail. After the first five months of this program, the local President of the Police Chief's Association cited significant reductions in the time police spent within hospital emergency rooms and a savings of more than $75,000 in officer overtime. This Middlesex program has since been renewed three times, and CFG has launched several more pre-admission psychiatric crisis programs within correctional facilities to similar results.

In keeping with the philosophy that the mental health services of the DDOC and its vendors are only a part of the larger Delaware system of care, this pre-admission psychiatric crisis program brings good will

PROPRIETARY

and benefits to stakeholders outside of the DDOC including: local law enforcement, DSAMH's psychiatric crisis teams, the State's inpatient psychiatric hospitals, and the emergency rooms of Delaware's acute care hospitals. This program is also in keeping with one of the tenets of DSAMH's recent agreement with the US Department of Justice to overhaul its system for psychiatric crisis response.

(A Cost Proposal for the Severable Telepsychiatry Program is Included in the Pricing Section)

SUPPLEMENTAL SEVERABLE PROPOSAL

InWorld Avatar Programming:
An Additional Telemental Health Solution

INWORLD OVERVIEW

InWorld is a virtual environment for skills training, treatment and education.

Taking the concept of telepsychiatry to an innovative new level, CFG has pioneered a next-generation telemedicine technology called InWorld and is offering selected installations and programming within this severable proposal. While telepsychiatry uses real-time secure video as the medium for interaction between clinicians and patients, InWorld relies on real-time secure connections through avatars within virtual worlds. This secure web-based medium of interaction provides increased levels of engagement for participants and is particularly effective for conducting safe and controlled role play scenarios and group sessions.

InWorld can be used with offenders while incarcerated and can be extended to increase mental health services into work release facilities, VOP programs, as well as the probation and parole offices. As with telepsychiatry, the ability to connect colleagues throughout the state is a powerful benefit to the InWorld platform and programming. Through secure online connections, clinicians and supervisors can interact with one another in real time. Additionally, InWorld provides opportunities for offenders to connect with one another and participate in the clinical programming occurring at separate sites. Since InWorld meetings occur within the virtual world through standard PC computers, users are able to interact without a need for transport.

The Substance Abuse and DUI programming within this proposal draws heavily on the power of effective group sessions for psycho-education, skills development, support and single interest focuses. InWorld's virtual capabilities could be an effective and cost-efficient medium for some of these group sessions.

InWorld's potential applications include:

- Uniform training of staff between facilities
- Collaborative treatment team meetings
- Staff supervision
- Mental Health programming
- Substance Abuse programming
- DUI programming
- Sex Offender programming
- Multi-disciplinary treatment sessions
- Re-entry training

PROPRIETARY

CFG recently demonstrated InWorld's capabilities to the Delaware Department of Education and the Division of Prevention and Behavioral Health Services, and both are currently reviewing its potential use.

Research Basis

Though still novel and innovative, the use of virtual environments within the clinical settings has a well-established base within industry research. First explored in the early 1990s, the applications for virtual reality within behavioral health have only expanded from there. **Appendix A includes a literature review article on the use of virtual reality within psychotherapy.** Additional resources on specific applications are also available on request.

PROPOSED SCOPE

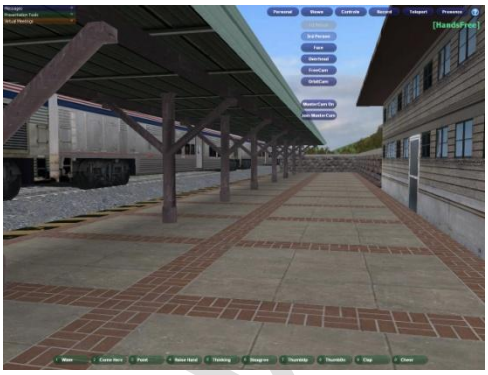
CFG proposes a carefully managed, limited pilot program that would integrate InWorld into the DDOC for both staff training, as well as direct sessions with offenders. Within this proposal CFG has offered several ideas and concepts for the use of InWorld within the DDOC that it has deployed within other settings. Given the innovative nature of this program, CFG and the DDOC will need to collaboratively develop a more detailed scope for the appropriate use of InWorld and a phased implementation that would progressively offer the program into new facilities and new applications as mutually agreed upon and as appropriate. For the purposes of this severable proposal, CFG has posited the implementation of InWorld within four sites that would be selected by the DDOC and CFG during the transitional period. Each of these sites will receive four computer terminals with adequate graphics cards and equipment to run the InWorld program.

Approximately four clinical staff members or supervisors at each site would become active users of the InWorld system. The computer terminals would share the dedicated cable internet connection of the telepsychiatry equipment at the site, but would be connected within CFG's secure InWorld servers for every interaction. Additionally, this supplemental program will have a part-time resource dedicated to supporting the equipment, connectivity and participants in the program. This staff member will be instrumental in the development of the detailed scope of the project with DDOC by drawing on industry best practices for the appropriate use of virtual worlds within a clinical setting. This staff member will also develop customized curricula for the use of InWorld within the DDOC, including regular reporting on the program.

Service Features

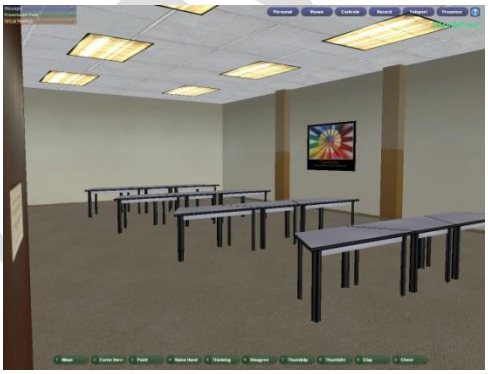
CFG will provide DDOC with the following InWorld products and services:

- Reintegration specialist trained in the InWorld program
- Customized Curriculum
- Hardware
- InWorld Software License
- Hardware and Software IT support



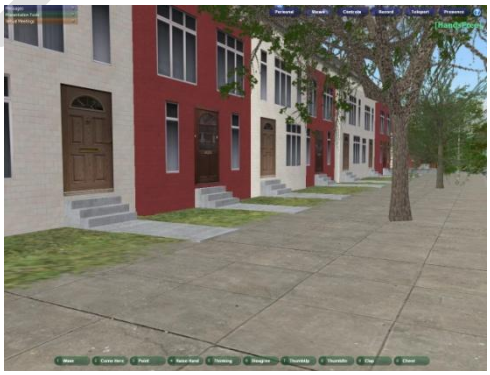
Software Features

- Voice Over Internet Protocol (VOIP)
- Avatars speak to one another rather than type
- Flat screen display and standard central processing units
- No specialty equipment
- Optional recording of virtual sessions
- Role playing
- Training and supervision
- Optional video storage
- Private in-ear coaching



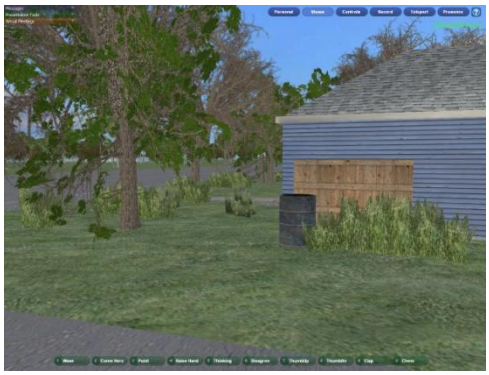
Virtual Environments

- Downtown streetscape
- Suburban streetscape
- Residences
- Mass Transit Centers
- Stores
- Professional Offices
- School and Classrooms
- Hospital
- Hotel and Conference Center
- Nature



Avatar Options

- Male or Female
- Adult, Teen, Child
- Ethnicity options: African American, Caucasian, Asian, Hispanic, Native American
- Wardrobes and Looks: Professional, Casual, Medical, and Law Enforcement



PROPRIETARY

Correctional Applications for InWorld

- Prisoner reintegration preparation
- Education and training
- Individual therapy
- Substance abuse
- Anger and stress management
- Conflict resolution
- Social skills
- Group facilitation

Benefits of InWorld

- Simple and safe role play
- Rapid engagement and active participation
- Encourages social interaction
- Supports anonymity, which lessens stigma and stereotyping
- Provides simulated real-world experience as a means to learn, practice, train and improve

THE INWORLD PROGRAM

InWorld focuses on supplementing a solid plan for discharge into the community by addressing the problems that resulted in the original deleterious behaviors and illustrates alternative actions via simulated, real-world encounters.

InWorld allows clinicians to quickly engage an inmate in order to facilitate a treatment and discharge plan. In addition, it allows the inmate to be submerged into real life situations, enabling them to learn and practice coping skills. In the safety of the virtual environment, inmates are allowed to experiment with new behaviors and skills, eventually leading to new patterns of better impulse control and self-mastery.

Individual Plan and Sessions

The core of the InWorld program for reintegration is the one-to-one interaction between the individual inmate and the InWorld specialist who collaborates with the re-entry case managers and existing on-site clinical team. As the case managers conduct a needs assessment and map out appropriate community resources for the individual inmate, the InWorld specialist will subsequently develop a plan for those inmates needing additional reintegration training. This plan will first focus on taking full advantage of the community resources for medical care, mental health treatment and housing as appropriate, and will ensure that the individual inmate is comfortable with the logistics and social aspects of utilizing those resources. From there, the plan's scope can expand to address the specific needs of individual inmates, whether those needs are for professional development, family reintegration, communication skills, conflict resolution, anger management, or substance abuse refusal.

InWorld's Group Applications

To supplement the individual work, the InWorld specialist will carefully layer in group sessions. By using technology, an InWorld clinician can organize and run a virtual group session where the participants are linked only by computers, thus providing a sense of anonymity. These virtual groups allow a clinician to reach larger audiences with lower security risks. These group sessions become particularly helpful in jointly preparing for social interactions that inmates may experience upon release because users are able to safely role play with one another and learn from the experiences of the group.

STAFF TRAINING USING INWORLD

Virtual Reality Training is the wave of the future. Universities and hospitals are utilizing this advanced technology on a daily basis for training and education. CFG has been utilizing InWorld for several years and has recently implemented a training program among its correctional facilities. The program highlights include staff cross training, competency training on protocols, suicide prevention and discharge planning. In addition, this program can be used for inmate training within the correctional facilities to practice substance abuse refusal skills, role play interviewing skills in preparation for discharge and employment , AA and NA meetings and various group therapies and discussion groups that may include the Houses of Healing model. InWorld's technology allows offenders to practice life skills in a realistic virtual environment and assess the predictability of how successful the inmate might be in the community.

InWorld Clinical Benefits to a Correctional Environment

- Facilitates quicker rapport between inmates and clinicians, resulting in more efficient treatment that leads to serving more inmates with the same resources.
- InWorld gives the inmates the option to be engaged in a corrective environment resembling the outside world, thus facilitating community re-integration.
- Easily and safely practice scenarios like job interviews, social interactions, family reintegration, anger management, conflict resolution, and alcohol or substance abuse refusal skills.
- Effective communication for inmates with reduced cognitive capacity can be established and maintained throughout the clinical encounter delivering increased comprehension and retention of the material.
- InWorld sessions may be recorded for therapeutic intervention, supervision, safety assessment and quality control.
- The non-confrontational interface of InWorld enhances the possibility of increased disclosure, sharing and effective feedback - providing the essential building blocks of a successful therapeutic environment.
- InWorld facilitates the establishment of professional boundaries that are not easily manipulated by anti-social populations.

PROPRIETARY

- Group therapy in InWorld is enhanced by the opportunity for anonymous clinical interaction. This feature gives the inmates the opportunity to engage in sensitive topics rarely addressed due to personal risk within the inmate cohort.
- InWorld offers the clinician the possibility to work as an anonymous avatar while delivering therapeutic services to inmates who have a history of staff assault or indecent exposure and/or stalking behaviors.
- InWorld gives the clinician enhanced capabilities to deliver and practice psycho-educational content prior and during group process when sensitive issues trigger aggressive behaviors.

(A Cost Proposal for the Supplemental Severable Proposal is Included in the Pricing Section)

SAMPLE INWORLD ACTIVITIES

PRACTICE OF RESISTANCE SKILLS

InWorld makes it possible for realistic and culturally appropriate development of violence, drug and alcohol resistance skills, primarily through role-play and session review. Key to InWorld's significance in these settings is the reduction of cognitive load during practice sessions (one doesn't need to remember roles, back-story, setting, etc.) and facilitates post-practice discussion by providing a tangible replay of the events. InWorld can be used in the following ways to facilitate the practice of resistance skills:

- Exploring stressors in a variety of environments
- Trying out positive roles in typically stressful situations
- Desensitization to environmental and social stressors by slowly introducing the stressors in a variety of settings
- Viewing replays of practice sessions to refine and select the best resistance scripts

REINTEGRATION TRAINING

The curriculum is implemented by special InWorld staff in coordination with the re-entry services case managers to create a safe medium for practicing re-entry scenarios and simulating common social and professional interactions within the community.

- These scenarios include situations within both the professional realm and social realm including often difficult family situations where dynamics and responsibilities have changed throughout the period of incarceration.

- Offender can practice identifying local providers for continued medical, mental health and housing, and then practice with related real-world scenarios.

Practice of Professional Skills and Daily Living

The numerous environments within InWorld make it possible to simulate multiple real-world professional scenarios, beginning with a job interview and progressing through appropriate professional interactions with co-workers and managers that can enable inmates to prepare for the transition back into the workforce. InWorld can be used to simulate:

- Job application and interview process
- Reporting structures and professional interactions
- Personal finance (opening a bank account, shopping)
- Casual social interactions

PROPRIETARY

Relationship Conflicts & Social Skills Development

InWorld can help to deal with normal relationships and social skills. It can also be used to prevent future conflicts and resolve existing ones. For example, InWorld can assist with the following:

- Learning when to appropriately start and end a conversation; picking up on non-verbal communication and social cues within the community.
- Conflict resolution: Have two peers or family members each tell their side of a conflict story separately in InWorld and then have them view the replays together; the passive medium of replays can be a mechanism for helping clients be more receptive to alternative viewpoints.
- For those with social skills difficulties that often result in conflict, using InWorld in a practice-review-refine-practice loop can improve the development of useful conflict-resistance scripts.

Controlled Collaborations in Group Sessions

For individuals that have difficulty or discomfort in social situations, participating in group activities in controlled environments can be quite helpful. Unfortunately, in face-to-face settings, clients can become overwhelmed and the collaboration can easily be sidetracked by aggression, bickering, bullying, lack of organization or reticence. InWorld can make a significant contribution in this area by not only providing a well-controlled environment, but also making discreet coaching possible. Here are some examples of how InWorld can improve collaborative group sessions:

- Work in a team to achieve a goal while receiving discrete in-ear coaching from a leader
- Role-play in uncomfortable social environments with a focus on switching roles
- Use alternative role play (i.e., - the client plays the person they wish to become) session replays on relevant themes to begin conversations about changes in the inmate's view of self and others

CONCLUSION

While DDOC clearly has recognized the growing importance of addressing recidivism through building a continuity of care bridge to medical, mental health and housing resources through collaborative discharge planning, CFG believes that even more can be done to enhance the skill sets of certain offenders facing discharge. This alternative proposal is an innovative and cost-effective strategy to improve re-entry services through a technologically augmented curriculum that will distinguish the DDOC from its peers and ultimately lead to decreased recidivism.

This innovative curriculum focuses on the practice of appropriate transitional skills for activities like job interviews, social interactions, family reintegration, anger management, conflict resolution, alcohol abuse and drug refusal skills. The curriculum uses private virtual environments to create a safe medium for practicing re-entry scenarios and simulating common social and professional interactions within the community. By simulating real-world scenarios that the offender can expect to encounter within the community in both the social and professional realm, DDOC can better prepare its inmate population to become productive members of the community upon discharge.

PROPRIETARY

GENERAL INFORMATION

NCCHC/ACA ACCREDITATION

CFG demonstrates an incomparable level of expertise in meeting and applying accreditation standards and in collaborating with accrediting bodies and agencies. CFG is proud of our having achieved 100% compliance for recent New Jersey contracted facilities including: the Atlantic County Justice Facility, the Camden County Correctional Facility and the Essex County Correctional Facility.

We credit our success to the administration of on-going, rigorous compliance surveys, to the implementation of New Jersey correctional facility "best practices," to the unique and in-depth knowledge we have of the local communities we serve, to upholding higher standards of care and to working collaboratively with facility monitors and custody representatives.

CFG shall work in collaboration with all facilities within the DDOC (current and future) in the development and implementation of all policies and procedures necessary to acquire accreditation with the American Correctional Association (ACA) and to maintain accreditation with the National Commission on Correctional Health Care (NCCHC).

Accreditation Table (see next page)

The Accreditation Table on the following page provides an overview of accreditation status at all facilities CFG is contracted with. **We are proud to report that all sites with NCCHC accreditation have maintained their certification, with three sites scoring 100% on the survey report**. Accreditation has often been achieved in the face of significant challenges. At Hudson County Correctional Facility (HCCC), not only were we able to successfully complete a 30-day start-up in mid-May of 2011, but we were able to apply for NCCHC initial survey within **6 months**. In addition, we are proud to announce that Mercer County Correction Center has now embarked on a course aimed toward completing the NCCHC accreditation application in 2012.

For copies of the most recent award letters testifying to NCCHC accreditation, please see the Required Documents section of this proposal.

Facility	NCCHC Survey Year	NCCHC Survey Results	NJ DOC	ICE	ICE Surveys	ACA	Infirmary
Atlantic County Jail Facility – averages 1,000 inmates; CFG contract established 2004	2011	**100%**	Standards Met; No Health Deficits	N/A	N/A	N/A	10 beds
Bucks County Correctional Facility – averages 800 inmates; CFG contact established 2005	2009	All standards met	Standards Met; No Health Deficits	N/A	N/A	N/A	N/A
Camden County Correctional Facility – averages 1,600 inmates; CFG contract established 2004	2011	**100%**	Standards Met; No Health Deficits	N/A	N/A	N/A	6 beds
Essex County Correctional Facility – averages 2,300 inmates; CFG contract established 2008	2010	**100%**	Standards Met; No Health Deficits	+500 detainees	No Health Deficits	N/A	48 beds
Hudson County Correctional Center – averages 1,900 inmates; CFG contract established May 2011	New Application Filed	Not Applicable	Standards Met; No Health Deficits	+400 detainees	No Health Deficits	N/A	16 beds
Hudson County Juvenile Detention Center – averages 60 inmates; CFG contract established May 2011	2011 Reaccreditation Survey Scheduled for 2012	Not Applicable	Standards Met; No Health Deficits	N/A	N/A	Current	1 bed
Middlesex County Department of Correction – averages 900 inmates; CFG contract established 2002	2010	All standards met	Standards Met; No Health Deficits	N/A	N/A	N/A	14 beds
Warren County Correctional Facility – averages 250 inmates; CFG contract established 2006	2010	All standards met	Standards Met; No Health Deficits	N/A	N/A	N/A	N/A

PERSONNEL

All facilities shall have dedicated staff on-site, fulfilling clinical, managerial and supportive roles and duties with ample provisions made for the resources necessary to deliver responsive and efficient care.

CONTRACTING OUT

CFG understands that the use of independent contractors in no way absolves CFG of the legal responsibility to provide timely, appropriate care to all offenders under jurisdiction of the DDOC.

HEALTHCARE RECORDS

CFG recognizes that maintaining a sufficient records keeping process is essential in providing the highest level of patient care and in ensuring that accountability is maintained. CFG shall assume responsibility for maintaining the DDOC unified medical and mental health record in accordance with DDOC policy, HIPAA regulations, NCCHC, ACA and generally-accepted medical practice standards. Routine procedures for the management of medical records shall be instituted and maintained to ensure proper protocol and documentation is followed for both on-site and off-site care. Each encounter with an inmate by any healthcare practitioner shall be documented in the medical record.

Sufficient levels of medical record staff shall be retained to manage the mental health and substance abuse portions of individual offender charts. CFG shall also coordinate with the potential EHR vendor in assuring a smooth conversion from paper to electronic records.

OUTSIDE CARE

The goal, when providing behavioral healthcare services for an incarcerated population, is to ensure that inmates receive timely assessments, necessary follow-up and medication management. With timely and thorough screenings, detailed treatment planning, holistic and appropriate treatment and a wide range of on-site specialty services available, the need for off-site services can be greatly minimized; however, occasions do arise when urgent care or emergency care is clearly indicated. In those instances when outside care is warranted, CFG shall coordinate with the Medical Provider regarding Utilization Review for Mental Health referrals.

To further minimize the risks and costs associated with incidences of off-site care, CFG is also prepared to offer telemedicine/telepsychiatric services (**please see the Telepsychiatry section of this proposal)**. Through telepsychiatry, CFG clinicians are able to interview arrivals, perform psychiatric evaluations, assess disposition and start psychotropic medications, if indicated – all without incurring overtime costs for security officers, the considerable expense associated with Emergency Room visits or the security risks associated with the off-site transport of inmates.

Similar in depth and focus to in-person consultations, telepsychiatry encounters are conducted in real time and face-to-face. CFG supplies on-site training for all staff, continuous IT support and programs that are customized to meet each facility's specific needs.

Facilities and Resources

CFG ensures that all space and supplies afforded CFG shall be appropriately and adequately maintained in order to properly meet the healthcare needs of each institution's population.

Performance Measurements

Mental Health programs shall reflect generally accepted professional standards. CFG's Mental Health Administrator and staff working within each facility shall be responsible for keeping and reporting data necessary for evaluating all programs/services provided. Measurable outcome criteria shall be established that serves as key indicators that mental health generally-accepted professional standards are established and maintained. CFG's Mental Health Administrator shall work cooperatively with the Bureau Chief and any other DDOC Vendors to identify and implement mental health generally-accepted professional standards appropriate to addressing offender mental health issues consistent with applicable DDOC policies and NCCHC/ACA standards. CFG shall compile and submit statistics indicative of whether programs/services meet measurable outcome criteria on a monthly basis in a form and format that meets DDOC requirements.

Research

No research projects involving offenders (other than projects requiring limited information from records compiled in the ordinary delivery of services) shall be conducted without the express prior written consent of the Commissioner of Correction. The conditions under which any approved research would be conducted shall be governed by written guidelines approved by the DDOC. In each case, written, informed consent shall be obtained from each offender identified as a research subject prior to participation. All Federal and State regulations applicable to such research shall be strictly and fully followed, inclusive of HIPAA regulations. CFG understands that any and all research is subject to the approval of a Human Subjects Review Board approved by the Bureau Chief.

Drug-Free Workplace

In compliance with Federal, State and DDOC policies, CFG shall maintain a drug-free workplace. CFG shall develop and execute an employee urine analysis program compatible with the program currently employed by the DDOC itself. CFG shall comply with the DDOC's right to both urine analysis procedures and results. CFG shall also comply with any future drug detection initiatives enacted by the DDOC regarding employees, visitors and consultants.

EMPLOYEE TRAINING AND ORIENTATION

CFG shall be responsible for ensuring all new personnel are properly-cleared for entry into the respective facilities and shall provide appropriate orientation and training regarding medical practices, security and suicide prevention. All newly-hired, full-time healthcare personnel shall receive 40 hours of pre-service training and orientation within the first 30 days of employment, with written and employee-signed documentation of completion of training and orientation submitted within 30 days. CFG shall maintain active records and a comprehensive list of all CFG and DDOC personnel that have been trained, the subject of each training, respective training dates and status updates regarding necessary refresher courses and shall submit said documentation electronically to both the BCHS and all site Wardens on a monthly basis. **Copies of Suicide Prevention Training have been included in Appendix A.**

For a detailed overview of CFG's Orientation Process, please see below.

ORIENTATION

CFG pledges that it will remain compliant with DDOC's requirement regarding the privileging, orienting and training employees assigned to the facility or facilities.

Upon the acceptance of a job offer and obtaining security clearance to their respective facility, all new employees will be scheduled for the DDOC facility orientation as well as CFG's agency orientation, which is intended to introduce and familiarize the employee with the following:

- CFG's History & Leadership
  - Administration and Resources
- New Hire Paperwork
  - W-4
  - I-9
  - Direct Deposit
- CFG Policies and Procedures Manual, with much detail being focused on:
  - Harassment
  - Time & Attendance
  - Confidentiality
  - Customer Service
  - HIPAA
  - Workers Compensation
  - Use of Agency & Facility Property
  - Grievance Procedure
- Training on CFG's Payroll System
  - How to access it
  - How to view an employee's pay

- How to request Paid Time Off
- CFG's Benefits Package

After new employees have received an agency orientation, they will begin the CFG site orientation at the facility/facilities where they will be assigned. This site orientation will last 30 days and will provide the employee with on the job training and will include, but is not limited to the following:

- Department Tour
- Facility Tour
- Job expectations
- Introductions to Leadership
- Site Specific Trainings
  - Performance measures
  - Admission criteria
  - How to perform a History and a Physical
  - Reporting and completion of forms
  - Infection Control
  - Blood borne Pathogen Exposure Control
  - Suicide Prevention
  - Policies/Procedures unique to Facility
  - Computer systems
- Schedule of regular departmental, facility and CFG meetings
- "Shadowing" of an existing employee at the same job level
- Weekly meetings with the employee's supervisor to gauge progress and comfort with the job

At the end of the Site Orientation, both the employee and the supervisor complete a checklist to ensure that all aspects of the Site Training were completed and both individuals provide their signature in acknowledgement.

MEDICAL AUDIT COMMITTEE (MAC)

CFG shall collaborate with the Medical Vendor to disseminate information pertaining to the scheduling and agendas of Medical Audit Committee meetings. Upper level management staff of each site shall be in attendance.

INSPECTIONS

CFG's managers shall conduct formal inspections of all respective work areas at least monthly. If deficiencies are identified, follow-up inspections shall be conducted to ensure corrective actions are taken. Written reports detailing the processes and results of these inspections shall be sent to the

Warden's Office of each respective site. A record of all findings shall be included as an agenda item at the monthly MAC meetings.

Disaster Plan

Within 30 days of award of contract, site-specific disaster plans meeting the specifications provided within the RFP shall be submitted to the BCHS and each respective site's Warden and/or designee.

DACS Data Entry

CFG understands that use of the DACS medical module and all components thereof is a material requirement of the healthcare services contract and shall comply with all specifications of this mandate. Following initial training on the system provided by the DDOC, CFG shall administer all follow-up training.

Transition Plan

Please see Appendix A for a copy of the Transition/Implementation Plan.

Security

CFG has read, acknowledges and will comply with all specifications concerning DDOC security, privileged information, clearance procedures and operating policies.

Confidentiality/Exchange of Information

CFG attests that all offender health information shall be handled with the utmost care and consideration and in accordance with all applicable policies and regulations established by Federal and State laws and statutes.

Resolution of Disputes

CFG considers all of its contracts to be partnerships and approaches conflict resolution as a cooperative effort, believing that efficient, receptive and responsive conflict and dispute resolution is vital to maintaining a trusted and respectful working relationship. CFG understands that the State reserves the right to litigate in the appropriate court of law and/or equity.

Coordination and Communication with the DDOC

CFG relies on an open dialogue to help inform and educate all parties involved in the provision of quality correctional behavioral healthcare services and believes coordination and communication are integral in the successful maintenance of a quality healthcare delivery system. To further the assurance of open and accessible communication between CFG and all relative parties, CFG shall appoint a single contact person within each facility who shall be available on a daily basis. This designated individual shall act in the capacity of liaison and will be responsible for facilitating daily communication among mental health

staff, the medical vendor, the DDOC, the BCHS, facility administrative staff , the Bureau Chief and security. CFG will establish protocols governing daily communication with the DDOC, BCHS and facility administrative staff that meet the approval of the Bureau Chief.

RECRUITMENT AND RETENTION

Drawing upon our considerable experience in contracting with area correctional facilities, our competitive benefits package and corporate ideals that further the support of both administrative and clinical staff, CFG can proudly attest to above 90% fill rates at both Hudson County Correctional Center and Essex County Correctional Facility. Prior to CFG's award of the Essex County contract, temporary staffing levels, at times, exceeded 50%. Throughout our four year tenure with this contract, CFG can boast of maintaining 90% fill rates without the use of a single hour of agency staffing**.** In addition, CFG relies on aggressive recruitment tactics to attract and enlist the most qualified and diverse candidates for any open positions. Through the use of **three separate recruiters (a Physician Recruiter, a dedicated Nursing Recruiter and one Non-Nursing Recruiter** [specifically for filling administrative and behavioral positions]), CFG reaches out to prospective employees via online postings, partnerships with local educational and vocational institutions, well-established relationships with professional organizations, job fairs and internships. CFG also relies upon word-of-mouth referrals from satisfied clientele and existing employees.

Recruiting

CFG employs a specialized and experienced recruiting department that utilizes a proactive and comprehensive approach to meeting all staffing needs. The recruiting department's philosophy is not just to recruit for current needs, but to ascertain a prospectus of future needs, as well.

In order to facilitate seamless transitions, CFG recruiters collaborate regularly with CFG managers to evaluate staffing levels and strategically plan for anticipated personnel requirements. When a definite need has been established, CFG's recruiters have a wealth of possible applicants already on file from whom to draw, but also continue to actively recruit until the ideal candidate has been found.

CFG's recruiters are well-versed in all recruitment methods including:

- Online Recruiting
    - External Job Postings
    - Internal Job Postings
    - Resume "Mining"
    - Social Media Networks
- Partnerships with Professional Organizations (i.e., - the American Psychiatric Association, the Delaware Psychiatric Association, the New Jersey Psychiatric Association and the Pennsylvania Psychiatric Association)
- Regular communication, via e-mail

- Direct Mail Campaigns
- Telephone Recruitment Campaigns
- Advertising in Professional Journals and Periodicals
- Print Advertising
- Collaboration with Academic Institutions
- CFG-Hosted Job Fairs
- Recruiter Attendance of External Career Fairs
- Regular CFG-Hosted Recruiting Breakfasts, Brunches, Luncheons and Dinners
- Referral Bonuses
- Internal Recruiting and Advancement

When a vacancy occurs, CFG's Medical Affairs Department attempts to fill the position with a CFG employee. In the rare event this is not possible, CFG's recruiters have established relationships with several agencies to ensure all positions are adequately and competently staffed at all times.

In CFG's vast experience with being awarded new contracts, it has demonstrated a 90-95% retention rate of a contract's existing staff. In the event that CFG is awarded the DDOC contract, a representative of CFG will meet with the DDOC administrator or his/her designee to evaluate current staffing needs. CFG's recruiters will then establish an "on-site" presence to interview and contract current staff. To ensure that no interruption of patient care occurs, every effort will be made to retain current qualified staff desired by the DDOC administration. Should this not be possible, CFG will recruit from its substantial pool of candidates.

Recruiting Process

Once a recruiting need has been established, a recruiter specializing in the required credentials and qualifications of that position is assigned to draw on all available resources to find suitable candidates.

Upon receipt of an interested party's resume, the recruiter will pre-screen the candidate to determine if the candidate possesses the knowledge, skills and abilities to perform the essential functions of the vacant position. This is done via verification of employment, education and licensure, as well as a background check. If the candidate is deemed qualified, the recruiter schedules an interview between the candidate, the hiring manager and any other key CFG applicable staff.

Once a candidate has been deemed viable, he/she is scheduled for a facility tour where he/she will be introduced to key facility staff with whom he/she will collaborate. Once CFG has determined that it has found the "right" candidate, an employment offer is extended, which is contingent upon his/her obtaining security clearance at the facility.

Retention

CFG constantly strives to minimize the need for recruitment through the maximization of retention. In efforts to reduce turnover and enhance employee satisfaction, CFG continuously examines and evaluates the employment experience. This is done through mechanisms such as salary surveys, market comparisons for benefits, employee suggestions, regular meetings and trainings and CFG's open door policy.

CREDENTIALING AND PRIVILEGING OF PROFESSIONAL STAFF

CFG maintains a comprehensive system for tracking, credentialing and privileging staff that is overseen by a designated credentialing department. All licenses and certifications are kept on file and are part of an automated notification system for renewal. For details regarding CFG's credentialing process, please see below:

Application Process

All applicants must complete CFG's initial application for employment, which is forwarded to the medical affairs department. The following documentation **MUST** be submitted with the application:

- Curriculum vitae (CV) -- must be in month/year format; if there are any gaps in education, work history or malpractice greater than 30 days, a written letter of explanation is required
- Three references -- including one reference from a clinical supervisor and one reference from an administrative supervisor. Individuals supplying references must be in the same specialty as the applicant; have worked with the applicant and directly observed his/her performance; and must be able to provide information regarding clinical ability, health status, ethical character and capacity for working cohesively with others. If the applicant has recently completed residency or a fellowship, a reference from the program director is requested.
- Passport and current driver's license
- Copy of social security card
- Signed and dated consent of release form
- Copies of all state licenses and CDS/DEA licenses (both current and inactive)
- Copies of all diplomas from undergraduate school, medical school, internships, residencies, fellowship programs and ECFMG certification (if applicable)
- Copies of all Board Certifications

An assigned credentialing specialist reviews applications for completeness. If additional information is required, the credentialing specialist contacts the practitioner directly. All Information provided on the application must be verified by a primary source. Primary source verification may include verbal substantiation, but requires a dated and signed note in the credentialing file identifying the primary source and the date and time of verification.

Collection of Primary Source Data includes all of the following:

1. **Online/Telephone Verification:**
   - All active and inactive medical licenses are verified with the appropriate issuing licensing board either online or by telephone (verification is completed bi-annually for reappointments, at time of request of additional privileges and as needed)
   - DEA and CDS licenses (if applicable) are verified with the appropriate licensing board either online or by telephone. DEA/CDS schedules include Schedule 2-5. A practitioner with an out-of-state CDS/DEA license may be credentialed pending change of address or additional request for licensure
   - NPDB (National Practitioner Data Bank) -- completed bi-annually for reappointments and at the time of request for additional privileges or as needed
   - OIG (Office of Inspector General)
   - Board Certification is verified by querying the ABMS (American Board of Medical Specialties); AOA (American Osteopathic Association); AMA (American Medical Association); or ANCC (American Nurse Credentialing Center) either through online databases or through receipt of a letter provided directly by the certification board
   - NPI (National Practitioner Identifier) -- verified via the NPPES (National Plan and Provider Enumeration System) website

2. **Hospital Affiliations and Work History are verified through:**
   - A letter of good standing from current and prior hospital affiliations
   - All current and prior employers

3. **Verification of Graduation from Medical /Professional School and Completion of Residencies and Fellowships:**
   - Verification of medical/professional school graduation and completion of residency and fellowship training may be obtained from the institution(s) where the training was held and/or by an agency that has been deemed a Primary Source, such as the American Medical Association (AMA), American Osteopathic Association (AOA), Federation State Medical Boards (FSMB), Federation Credentialing Services (FCVS) and the Student Clearing House (the Student Clearing House verifies medical degrees and passed attendance only)
   - Foreign Medical Graduates must present evidence of certification from the Education Commission for Foreign Medical Graduates (ECFMG). The ECFMG will be queried via the CVS (Credential Verification Services) website.

4. **Professional Liability Claims History:**
   A ten (10) year claims history is verified with all current and prior malpractice insurance carriers at the time of initial appointment; a five (5) year claims history is verified with current and prior malpractice insurers at the time of reappointment. An NPDB query may be used for evidence of settlement and judgment history.

5. **Background Checks:**
   Verification is performed by the human resources department and forwarded to the medical affairs office. Any adverse information is evaluated by the medical director.

6. **Continuing Medical Education (CME):**
   Evidence of all CME must be included with the application for initial appointment and upon all reappointments. A signed statement indicating the practitioner has met or exceeded all CME requirements for state licensure must be provided.

Work Hours Required On-Site

All CFG full-time staff shall work a 40-hour week, on-site, without reimbursement for meal breaks. A licensed mental health professional shall be on-site from 8:00 AM until 8:00 PM Monday – Friday and from 8:00 AM until 4:30 PM Saturday and Sunday. In regards to all other provisions concerning the work scheduling and related issues, CFG has read, understands and will comply with all specifications established within the RFP.

Offender Grievances and Inquiries/Complaints Regarding Offender Care

CFG shall act on all complaints and inquiries received from the DDOC and BCHS as directed pertaining to healthcare-related problems, shall submit comprehensive written responses to complaints and shall ensure that all matters will be investigated, addressed and resolved. To afford alignment policy and procedural congruence between CFG and the DDOC, all CFG policies shall mirror those established by the DDOC. DACS shall be used for initiation of the grievance process and for all follow-up communication. As part of CQI, Quality Assurance and Quality Improvement efforts and initiatives, comprehensive data shall be maintained regarding all complaints and redress.

Policies, Procedures and Guidelines/Protocols

A uniform Policies and Procedures Manual dictated by the mandates set forth by the NCCHC and consistent with established DDOC protocol shall be submitted for approval within 90 days of contract award.

Morbidity and Mortality and Post-Critical Incident Reviews

CFG staff shall readily participate in any and all post-critical incident reviews and DDOC morbidity and mortality review committee meetings consistent with both NCCHC standards and DDOC Policy A-10.1.

Risk Management

CFG will work with the DDOC and the BCHS to develop and supply reports that will be an essential administrative adjunct component to the CQI program. The reports will be used to identify problem areas of healthcare programming and offer resolution through collaborative efforts.

Informed Consent/Right to Refuse Treatment

To ensure an offender receives the material facts about the nature, consequences and risks of any proposed treatment, examination and/or procedure and any feasible alternatives to the same, a written informed consent shall be obtained in accordance with DDOC policy and using DDOC forms.

In each case in which an offender refuses treatment (after having been debriefed and informed of underlying conditions and proposed/prescribed treatment), the refusal must be in writing, in accordance with DDOC Policy and using DDOC forms.

Response Team

CFG will become a participating member of the DDOC's response team and provide professional assistance in post-trauma incident debriefings and counseling services for critical incidents, including disaster and pandemic episodes.

Cooperative Interaction with Other Offender Health Services Vendors

CFG shall work collaboratively with the DDOC and other vendors to provide comprehensive services to offenders under DDOC jurisdiction. As dedicated healthcare providers, CFG's main focus and commitment is to provide offenders unimpeded access to quality services, in support of the continuity of care.

Continuing Education Requirements

CFG shall provide an on-going program of continuing education for both corrections and mental health services unit staff that enables nursing and behavioral health staff to earn continuing education credits both as specified by the terms of the contract and as legally-required for certification.

CFG prides itself on the constructive and profuse training programs and in-services we routinely offer clinicians and correctional staff in our on-going quest for improvement and furthering knowledge. We have initiated programs for existing police officers regarding mentally ill offenders, for custody staff regarding recognition of inmate signs of substance abuse and withdrawal and chronic disease, and for all staff regarding standard precautionary measures. Working proactively, educational programs have been established for guiding the health-related training of all correctional officers who work with inmates.

Our Suicide Prevention Training Program engenders deeper understanding of and heightened sensitivity to risk factors for suicide that, in turn, aids in early identification of inmates at risk and the use of pre-emptive measures. Some of the nursing training programs we've implemented are CAGE/CIWA-Ar "how-to" sessions and programs focusing on clinical evaluation and diagnostics, among many others. Our involvement as trainers and leaders extends far beyond the correctional facility, too, through our engagement with the Delaware Department of Substance Abuse and Mental Health (DSAMH), New Jersey's Crisis Intervention Team Center for Excellence and numerous community outreach programs.

General Indemnification

CFG shall hold harmless, indemnify and defend the Department, the State of Delaware and their agents, employees, or officers of the State of Delaware from any and all suits, actions, losses, liability, damages (including punitive damages), expenses, reasonable attorney fees (including salaries of attorneys regularly employed by the State of Delaware), judgments, or settlements incurred by the Department, the State of Delaware or their agents, employees, or officers arising out of the provision of services by vendor, its employees, or subcontractors under the contract, including direct or indirect negligence or intentional acts of omission or commission, and professional malpractice regardless of any negligence or any intentional act or omission by employees or officials of the Department. The legal duties and responsibilities set forth in this paragraph include the duty to cooperate with the Department, its employees, and attorneys in the defense of any legal action against the State, its agents, employees, or officers arising out of the provision of services by CFG, which involve claims related to an offender's medical care, or which require information or testimony from CFG's employees or contractors.

Proprietary Rights Indemnification

CFG warrants that all elements of its proposal, including all equipment, software, documentation, services and deliverables do not and will not infringe upon or violate any patent, copyright, trade secret or other proprietary rights of any third party. In the event of any claim, suit or action by any third party against the State of Delaware or the DDOC, CFG agrees to all stipulations as outlined and set forth in the Request for Proposals.

Performance Bond

Upon notification of contract award, CFG shall produce a Performance Bond or other form of security deemed acceptable in the amount of 25% of the negotiated contract for every year of said contract. **In anticipation and support of this requirement, a Letter of Bondability from Argonaut Insurance Company, an A.M. Best "A" rated surety company authorized to do business in the State of Delaware, has been included in Appendix A.**

Insurance

Evidence of all requested insurance coverage including: Comprehensive General Liability, Professional Liability, Automotive Liability has been included in the Required Documents section of this proposal.

Warranty

CFG shall provide a warranty that the deliverables provided pursuant to the contract will function as designed for a period of no less than one year from the date of system acceptance.

TERMINATION FOR CAUSE OR CONVENIENCE

CFG has read, understands and agrees with the terms constituting Termination for Cause and Termination for Convenience as specified within the Request for Proposals.

NON-DISCRIMINATION DISCLOSURE

In performing the services subject to this RFP, CFG agrees not to discriminate against any employee or applicant for employment because of race, creed, color, sex or national origin. CFG shall comply with all Federal and State laws, regulations and policies pertaining to the prevention of discriminatory employment practice. CFG realizes that failure to perform under this provision shall constitute a material breach of contract.

COVENANT AGAINST CONTINGENT FEES

CFG warrants that no person or selling agency has been employed or retained to solicit or secure this contract upon an agreement of understanding for a commission or percentage, brokerage or contingent fee excepting bona-fide employees, bona-fide established commercial or selling agencies maintained by CFG for the purpose of securing business. CFG realizes that with breach or violation of this warranty the DDOC shall have the right to annul the contract without liability or at its discretion to deduct from the contract price or otherwise recover the full amount of such commission, percentage, brokerage or contingent fee.

VENDOR ACTIVITY

No activity is to be executed in an off-shore facility, either by a subcontracted firm or a foreign office or division of CFG. CFG attests to the fact that no activity will take place outside of the United States.

WORK PRODUCT

All materials and products developed under the executed contract by CFG shall remain the sole and exclusive property of the State. CFG shall seek written permission to use any product created under the contract.

CONTRACT DOCUMENTS

The RFP, CFG's response to the RFP, the purchase order, the executed contract and any supplemental documents between the DDOC and CFG shall constitute the contract between the DDOC and CFG. In the event there is any discrepancy between any of these contract documents, the following order of documents governs so that the former prevails over the latter: contract, DDOC's RFP, CFG's response to the RFP, any supplemental documents and purchase order. No other documents shall be considered. These documents will constitute the entire agreement between the DDOC and CFG.

APPLICABLE LAW

CFG consents to jurisdiction and venue in the State of Delaware and certifies that CFG complies with all Federal, State and local laws applicable to its activities and obligations including:

- The laws of the State of Delaware
- The applicable portion of the Federal Civil Rights Act of 1964
- The Equal Employment Opportunity Act and the regulations issued there under by the Federal Government
- A condition that the proposal submitted was independently arrived at, without collusion, under penalty of perjury
- That programs, services, and activities provided to the general public under resulting contract conform to the Americans with Disabilities Act of 1990, and the regulations issued there under by the Federal government

CFG shall keep itself fully informed of and shall observe and comply with all applicable existing Federal and State laws, county and local ordinances, regulations and codes, and those laws, ordinances, regulations, and codes adopted during CFG's performance of the contracted work.

SCOPE OF AGREEMENT

CFG agrees that if the scope of any provision of the contract is determined to be too broad in any respect whatsoever to permit enforcement to its full extent, then such provision shall be enforced to the maximum extent permitted by law, and the parties hereto consent and agree that such scope may be judicially modified accordingly and that the whole of such provisions of the contract shall not thereby fail, but the scope of such provisions shall be curtailed only to the extent necessary to conform to the law.

OTHER GENERAL CONDITIONS

CFG agrees to all specifications of the RFP as outlined below:

1. **Current Version –** "Packaged" application and system software shall be the most current version generally available as of the date of the physical installation of the software.
2. **Current Manufacture –** Equipment specified and/or furnished under this specification shall be standard products of manufacturers regularly engaged in the production of such equipment and shall be the manufacturer's latest design. All material and equipment offered shall be new and unused.
3. **Volumes and Quantities –** Activity volume estimates and other quantities have been reviewed for accuracy; however, they may be subject to change prior or subsequent to award of the contract.

4. **Prior Use –** The DDOC reserves the right to use equipment and material furnished under this proposal prior to final acceptance. Such use shall not constitute acceptance of the work or any part thereof by the DDOC.
5. **Status Reporting –** The selected vendor will be required to lead and/or participate in status meetings and submit status reports covering such items as progress of work being performed, milestones attained, resources expended, problems encountered and corrective action taken, until final system acceptance.
6. **Regulations –** All equipment, software and services must meet all applicable local, State and Federal regulations in effect on the date of the contract.
7. **Changes –** No alterations in any terms, conditions, delivery, price, quality, or specifications of items ordered will be effective without the written consent of the DDOC.
8. **Additional Terms and Conditions –** The DDOC reserves the right to add terms and conditions during the contract negotiations.

PRESS RELEASES AND PUBLIC DISCLOSURE

CFG shall not release any information about this RFP and understands the DDOC reserves the right to pre-approve any news or advertising releases concerning this RFP, the resulting contract, the work performed, or any reference to the State of Delaware or the DDOC with regard to any project or contract performance. CFG acknowledges that any such news or advertising releases pertaining to this RFP or resulting contract shall require the prior express written permission of the DDOC.

CFG'S FINANCIAL POSITION

A careful review of CFG's balance sheet, as well as other audited financial data leads to a very important conclusion – **CFG has significant financial resources to competently service this contract**. In addition to having the resources and capital, CFG has a solid history of performance – **CFG has NEVER lost a contract, NEVER been assessed a performance penalty and NEVER been denied a performance bond**. As further attestation to that final statement, we have submitted a Letter of Surety for a Performance Bond (despite not being required to do so). Inclusion of this Letter of Surety serves as further evidence that our financial and operational capabilities for performing this contract are backed by "A" rated bonding.

BALANCE SHEET

CFG's Balance Sheet shows a strong current ratio (current assets/current liabilities) and a very low debt to equity ratio (total liabilities to total equity). It also demonstrates that CFG has almost no debt and that none of our assets are leveraged. The same cannot be said of some of the larger, "national" provider companies that show large reserves set-up for "loss leaders" or payment hold-backs for non-performance.

"BONDABILITY" EQUALS FINANCIAL STRENGTH

As noted above, **CFG has never been denied a bond.** In fact, we have been able to meet all bonding requirements in situations where other companies have had to augment their bonds with conditional language, resulting in proposal rejection. **CFG has been able to obtain Performance Bonds for contracts where the bond value requirements were four times higher than that stipulated by this RFP** and our national competitor was unable to obtain a bond at all.

BANKING HISTORY

CFG has an existing line of credit and cash reserves large enough to totally carry this contract for six months. Although CFG could qualify for a larger line of credit based on balance sheet figures, CFG feels this isn't warranted as we are very comfortable in managing our existing contracts profitably. **CFG has never defaulted on a loan nor have we ever missed meeting a loan covenant.** At the DDOC's request, we would be happy to provide letters of reference to the same from our banks.

GROSS REVENUES CAN BE MISLEADING

Although Gross Revenues, at first glance, can look impressive, they can also be deceptive. A company's true financial strength and ability to operate is contingent upon having excess revenues over expenses. It's easy for a company to display high gross revenues, while having little or no income. This outcome could be the result of poor management of operations and/or being severely leveraged in debt. **CFG has experienced steady increases in gross revenue AND income growth over the years, in addition to**

having very little debt. We pride ourselves on maintaining low overhead costs while managing projects profitably and pass these savings on to our clients.

Ownership Structure

CFG is not subject to quarterly earnings pressures, as we are not publicly-traded. Neither are we beholden to venture capitalist groups who have infused capital into an organization in anticipation of reaping large returns on investments. What does this mean to Delaware? It means **CFG will never be forced by powers outside of our own management to sacrifice service in order to meet profit demands.** It also means **our clients do not need to share in the compliance costs associated with public companies**. CFG's existing customers recognize our services as being superior to that of our competitors *and* fairly-priced.

Conclusion

Without a doubt, CFG has the financial resources and ability to more than fully service this contract based on the following:

- Our bonding ability
- Our solid earnings history
- Our excellent balance sheet ratios
- *and the real test* – ***Satisfied existing customers who continue to renew their contracts with CFG***

CFG HEALTH SYSTEMS
COST PROPSAL

This Cost Proposal is completed according to all RFP Specifications.

It contains the following Cost Proposal Sheets:

- Combined Cost Proposal For Substance Abuse and Mental Health
- Mental Health Program
- Substance Abuse Program
- Sex Offender
- DUI Programming

Note: Included in this Admoinistrative Overhead is a budget for a satand alone Offender Tracking System.
Data Base Development-50K
Server and PC Equipment- 30k

DDOC, BCHS RFP		
Vendor Name:		**CFG Health Systems**
Mental Health, Substance Abuse, Sex Offender & DUI Programs		

Based on 7,000 Average Daily Population (ADP)

Fixed Costs (should not include mark-up percent)		
Dr./PA/CRNP (Mid-Level Practicioners and Above)*	$	2,136,263
Line Staff*	$	8,727,417
Performance Bond	$	31,597
Professional Liability/Malpractice Insurance	$	184,038
Subtotal	$	11,079,314
Management Costs (should not include mark-up percent)		
Senior Management		
Administrative Overhead	$	592,177
Office Space	$	50,000
Indirect Costs	$	-
Subtotal	$	642,177
Variable Costs (should not include mark-up percent)		
Outside Consults, Medications (if applicable), Laboratory Tests, Medical Supplies and Equipment, Gross Profit, G & A, Legal Representation, Performance Bond, Professional Liability/Malpractice Insurance.	$	111,650
Subtotal	$	111,650
Mark-up		
Service Fee		9%
Management Fee	$	1,075,623
Profit over Costs (Markup is included in Management Fee)		
Subtotal	$	1,075,623
Annual Base Total	**$**	**12,908,764**
Year 1 Performance Incentive Potential		
Potential Year 1 Not to Exceed Total	**$**	**12,908,764**

Cost Price Inflation Not To Exceed Total		
Year 2**	$	13,208,040
Year 3**	$	13,556,627
Year 4**	$	13,958,319

Cost per Offender /day $ 5.05

*Indicates FT FTE's/Salaried Employees vs Independent Contractors
All FTE's are Employees
Cost per Offender/day is based on Year 1 Total only

DDOC, BCHS RFP		
Vendor Name:		**CFG Health Systems**
Mental Health		

Based on 7,000 Average Daily Population (ADP)

Fixed Costs (should not include mark-up percent)		
Dr./PA/CRNP (Mid-Level Practicioners and Above)*	$	2,136,263
Line Staff*	$	4,218,099
Performance Bond	$	18,287
Professional Liability/Malpractice Insurance	$	98,730
Subtotal	$	6,471,378
Management Costs (should not include mark-up percent)		
Senior Management		
Administrative Overhead	$	285,899
Office Space	$	50,000
Indirect Costs	$	-
Subtotal	$	335,899
Variable Costs (should not include mark-up percent)		
Outside Consults, Medications (if applicable), Laboratory Tests, Medical Supplies and Equipment, Gross Profit, G & A, Legal Representation, Performance Bond, Professional Liability/Malpractice Insurance.	$	111,650
Subtotal	$	111,650
Mark-up		
Service Fee		9%
Management Fee	$	622,703
Profit over Costs (Markup is included in Management Fee)		
Subtotal	$	622,703
Annual Base Total	**$**	**7,541,631**
Year 1 Performance Incentive Potential		
Potential Year 1 Not to Exceed Total	**$**	**7,541,631**

Cost Price Inflation Not To Exceed Total		
Year 2**	$	7,586,774
Year 3**	$	7,814,378
Year 4**	$	8,087,881

Cost per Offender /day **$ 2.95**

*Indicates FT FTE's/Salaried Employees vs Independent Contractors
All FTE's are Employees
Cost per Offender/day is based on Year 1 Total only

DDOC, BCHS RFP	
Vendor Name:	**CFG Health Systems**
Substance Abuse	

Based on 7,000 Average Daily Population (ADP)

Fixed Costs (should not include mark-up percent)		
Dr./PA/CRNP (Mid-Level Practicioners and Above)*	$	-
Line Staff*	$	4,014,050
Performance Bond	$	11,649
Professional Liability/Malpractice Insurance	$	80,281
Subtotal	$	4,105,980
Management Costs (should not include mark-up percent)		
Senior Management		
Administrative Overhead	$	179,602
Office Space	$	-
Indirect Costs	$	-
Subtotal	$	179,602
Variable Costs (should not include mark-up percent)		
Outside Consults, Medications (if applicable), Laboratory Tests, Medical Supplies and Equipment, Gross Profit, G & A, Legal Representation, Performance Bond, Professional Liability/Malpractice Insurance.	$	-
Subtotal	$	-
Mark-up		
Service Fee		9%
Management Fee	$	385,702
Profit over Costs (Markup is included in Management Fee)		
Subtotal	$	385,702
Annual Base Total	**$**	**4,671,284**
Year 1 Performance Incentive Potential		
Potential Year 1 Not to Exceed Total	**$**	**4,671,284**

Cost Price Inflation Not To Exceed Total		
Year 2**	$	4,743,021
Year 3**	$	4,837,657
Year 4**	$	4,934,185

Cost per Offender /day **$** **1.83**

*Indicates FT FTE's/Salaried Employees vs Independent Contractors
All FTE's are Employees
Cost per Offender/day is based on Year 1 Total only

DDOC, BCHS RFP		
Vendor Name:		**CFG Health Systems**
Sex Offender		

Based on 7,000 Average Daily Population (ADP)

Fixed Costs (should not include mark-up percent)		
Dr./PA/CRNP (Mid-Level Practicioners and Above)*	$	-
Line Staff*	$	344,338
Performance Bond	$	1,233
Professional Liability/Malpractice Insurance	$	4,214
Subtotal	$	349,785
Management Costs (should not include mark-up percent)		
Senior Management		
Administrative Overhead	$	116,850
Office Space	$	-
Indirect Costs	$	-
Subtotal	$	116,850
Variable Costs (should not include mark-up percent)		
Outside Consults, Medications (if applicable), Laboratory Tests, Medical Supplies and Equipment, Gross Profit, G & A, Legal Representation, Performance Bond, Professional Liability/Malpractice Insurance.	$	-
Subtotal	$	-
Mark-up		
Service Fee		9%
Management Fee	$	41,997
Profit over Costs (Markup is included in Management Fee)		
Subtotal	$	41,997
Annual Base Total	**$**	**508,632**
Year 1 Performance Incentive Potential		
Potential Year 1 Not to Exceed Total	**$**	**508,632**

Cost Price Inflation Not To Exceed Total		
Year 2**	$	521,348
Year 3**	$	536,988
Year 4**	$	555,783

Cost per Offender /day $ 0.20

*Indicates FT FTE's/Salaried Employees vs Independent Contractors
All FTE's are Employees
Cost per Offender/day is based on Year 1 Total only

DDOC, BCHS RFP	
Vendor Name:	**CFG Health Systems**
DUI	

Based on 7,000 Average Daily Population (ADP)

Fixed Costs (should not include mark-up percent)		
Dr./PA/CRNP (Mid-Level Practicioners and Above)*	$	-
Line Staff*	$	150,930
Performance Bond	$	428
Professional Liability/Malpractice Insurance	$	813
Subtotal	$	152,171
Management Costs (should not include mark-up percent)		
Senior Management		
Administrative Overhead	$	9,826
Office Space	$	-
Indirect Costs	$	-
Subtotal	$	9,826
Variable Costs (should not include mark-up percent)		
Outside Consults, Medications (if applicable), Laboratory Tests, Medical Supplies and Equipment, Gross Profit, G & A, Legal Representation, Performance Bond, Professional Liability/Malpractice Insurance.	$	-
Subtotal	$	-
Mark-up		
Service Fee		16%
Management Fee	$	25,220
Profit over Costs (Markup is included in Management Fee)		
Subtotal	$	25,220
Annual Base Total	**$**	**187,217**
Year 1 Performance Incentive Potential		
Potential Year 1 Not to Exceed Total	**$**	**187,217**

Cost Price Inflation Not To Exceed Total		
Year 2**	$	356,897
Year 3**	$	367,604
Year 4**	$	380,470

Cost per Offender /day	**$**	**0.15**

*Indicates FT FTE's/Salaried Employees vs Independent Contractors
All FTE's are Employees
Estimated start date of program January 1. Above numbers reflect six months woth of cost.
Cost per Offender/day is based on Year 1 Total only

STATE OF DELAWARE DEPARTMENT OF CORRECTIONS

CFG Health Systems, LLC

Staffing Costs by Position, Count & Facility

Position *	CVOP Mental Health JTVCC & Morris		SCI/SCC Mental Health Morris		HRYCI Mental Health Howard Young		Web Mental Health BWCI, WTC, Plummer		Substance Abuse Delaware		Substance Abuse HRYCI		Substance Abuse WCCC		Substance Abuse BWCI		Substance Abuse HDPWTF		Substance Abuse CVOP		Substance Abuse MCCC		Substance Abuse SCI		Substance Abuse SCCC		6 Months Year 1 DUI		Sex Offender		Administration Mental Health				
	FTE	Costs	FTE	Costs	FTE	Costs	FTE	Costs	FTE	Costs	FTE	Costs	FTE	Costs	FTE	Costs	FTE	Costs	FTE	Costs	FTE	Costs	FTE	Costs	FTE	Costs	FTE	Costs	FTE	Costs	FTE	Costs	FTE	Statewide Average Hourly Rate	Costs
Activity Technician	3.00	117,694																															3.00	18.86	117,694
Admin Assistant	1.00	37,502	1.00	37,502	1.00	37,502	1.00	37,502	1.00	47,500	0.50	17,500	0.50	17,500	0.50	17,500	0.50	17,500	0.50	17,500	0.50	17,500	0.50	17,500	0.50	17,500	0.25	8,469			1.00	37,502	10.25	17.99	383,482
Case Manager																															1.00	49,715	1.00	23.90	49,715
Clerk	2.00	83,038	1.00	41,519	1.00	41,519	1.00	41,519																									5.00	19.96	207,595
Clinicians**	9.50	632,747	6.40	419,547	6.40	419,547	5.40	350,196																									27.70	31.62	1,822,038
Clinical Program Manager											0.50	38,750	0.50	38,750	0.50	38,750	0.50	38,750	0.50	38,750	0.50	38,750	0.50	38,750	0.50	38,750								4.00	37.26	310,000
Clinical Supervisors	2.00	117,250	0.50	29,882	1.00	58,625	1.00	58,625			1.00	58,750	1.00	58,750	1.00	58,750	1.00	58,750	1.00	58,750	1.00	58,750	1.00	58,750	1.00	58,750								12.50	28.25	734,382
Clinical QI Assessor									0.20	20,000																							0.20	48.08	20,000
CSOTP-Director																													1.00	118,205			1.00	56.83	118,205
CSOTP																													1.00	93,706			1.00	45.05	93,706
Counselor I																											1.00	41,343					1.00	19.88	41,343
Counselor II																											1.25	61,143					1.25	23.52	61,143
Associate CSOTP																													2.00	132,427			2.00	31.83	132,427
Lead SA Counselors											4.00	188,200	2.00	94,100	2.00	94,100	1.00	47,050	2.00	94,100	2.00	94,100	2.00	94,100	2.00	94,100								17.00	22.62	799,850
MH Director	1.00	71,712	1.00	71,712	1.00	71,712	1.00	71,712																									4.00	34.48	286,848
NP/PA	1.50	233,305	1.00	159,014	1.00	159,014	0.40	59,506																									3.90	75.30	610,840
Observer	9.00	330,649	9.15	334,920	9.60	299,831	10.20	316,914																									37.95	16.24	1,282,314
Program Director																											0.50	39,975					0.50	38.44	39,975
Psychiatrist	1.50	362,256	1.00	243,170	1.50	362,266	1.00	243,170																									5.00	116.43	1,210,863
Psychologist	1.00	101,205	0.20	18,289	0.70	63,093	0.30	27,250																							1.00	104,724	3.20	47.26	314,560
SA Counselor											13.00	562,900	5.00	216,500	4.00	173,200	5.00	216,500	8.00	346,400	5.00	216,500	5.00	216,500	4.00	173,200								49.00	20.82	2,121,700
State Abuse Director									1.00	105,000																							1.00	50.48	105,000
Totals	**31.50**	**2,087,359**	**21.25**	**1,355,556**	**23.20**	**1,513,110**	**21.30**	**1,206,396**	**2.20**	**172,500**	**19.00**	**#######**	**9.00**	**425,600**	**8.00**	**382,300**	**8.00**	**378,550**	**12.00**	**#######**	**9.00**	**425,600**	**9.00**	**#######**	**8.00**	**382,300**	**3.00**	**150,930**	**4.00**	**344,338**	**3.00**	**191,941**	**191.45**		**10,863,679**

** Note: Clinical staff costs include backfill for time off

STATE OF DELAWARE DEPARTMENT OF CORRECTIONS

CFG Health Systems, LLC

Staffing Costs by Position, Count & Pricing Group

Position	Statewide			DUI		Sex Offender		Substance Abuse		Mental Health	
	FTE (Count)	Average Hourly Rate	Total Costs	FTE (Count)	Costs	FTE (Count)	Costs	FTE (Count)	Costs	FTE (Count)	Costs
Activity Technician	3.00	18.86	117,694	-	-	-	-	-	-	3.00	117,694
Admin Assistant	10.25	17.99	383,482	0.25	8,469	-	-	5.00	187,500	5.00	187,512
Case Manager	1.00	23.90	49,715	-	-	-	-	-	-	1.00	49,715
Clerk	5.00	19.96	207,595	-	-	-	-	-	-	5.00	207,595
Clinicians**	27.70	31.62	1,822,038	-	-	-	-	-	-	27.70	1,822,038
Clinical Program Manager	4.00	37.26	310,000	-	-	-	-	4.00	310,000	-	-
Clinical Supervisors	12.50	28.25	734,382	-	-	-	-	8.00	470,000	4.50	264,382
Clinical QI Assessor	0.20	48.08	20,000	-	-	-	-	0.20	20,000	-	-
CSOTP-Director	1.00	56.83	118,205	-	-	1.00	118,205	-	-	-	-
CSOTP	1.00	45.05	93,706	-	-	1.00	93,706	-	-	-	-
Counselor I	1.00	19.88	41,343	1.00	41,343	-	-	-	-	-	-
Counselor II	1.25	23.52	61,143	1.25	61,143	-	-	-	-	-	-
Associate CSOTP	2.00	31.83	132,427	-	-	2.00	132,427	-	-	-	-
Lead SA Counselors	17.00	22.62	799,850	-	-	-	-	17.00	799,850	-	-
MH Director	4.00	34.48	286,848	-	-	-	-	-	-	4.00	286,848
NP/PA	3.90	75.30	610,840	-	-	-	-	-	-	3.90	610,840
Observer	37.95	16.24	1,282,314	-	-	-	-	-	-	37.95	1,282,314
Program Director	0.50	38.44	39,975	0.50	39,975	-	-	-	-	-	-
Psychiatrist	5.00	116.43	1,210,863	-	-	-	-	-	-	5.00	1,210,863
Psychologist	3.20	47.26	314,560	-	-	-	-	-	-	3.20	314,560
SA Counselor	49.00	20.82	2,121,700	-	-	-	-	49.00	2,121,700	-	-
State Abuse Director	1.00	50.48	105,000	-	-	-	-	1.00	105,000	-	-
Totals	191.45		10,863,679	3.00	150,930	4.00	344,338	84.20	4,014,050	100.25	6,354,361

** Note: Clinical staff costs include backfill for time off

CFG HEALTH SYSTEMS
ALTERNATE COST PROPSAL

Due to the fluctuation in the needs for Observer Staff, we propose to submit an alternative bid to utilize their services on an as needed basis. We believe this model can provide significant cost savings to the DDOC.

We are proposing to invoice the DDOC on a monthly basis for the number of hours utilized by the Observer Staff with appropriate documentation.

Attached is an Alternate Proposal reflecting zero wages for Observer Staff.
All other expenses (excluding management fee) as quoted in original proposal remain unchanged.

DDOC, BCHS RFP		
Vendor Name:		**CFG Health Systems**
Mental Health, Substance Abuse, Sex Offender & DUI Programs		
Alternate Proposal (Utilizing Observers as Pass-Thru)		

Based on 7,000 Average Daily Population (ADP)

Fixed Costs (should not include mark-up percent)		
Dr./PA/CRNP (Mid-Level Practicioners and Above)*	$	2,136,263
Line Staff*	$	7,445,102
Performance Bond	$	31,597
Professional Liability/Malpractice Insurance	$	184,038
Subtotal	$	9,797,000
Management Costs (should not include mark-up percent)		
Senior Management		
Administrative Overhead	$	592,177
Office Space	$	50,000
Indirect Costs	$	-
Subtotal	$	642,177
Variable Costs (should not include mark-up percent)		
Outside Consults, Medications (if applicable), Laboratory Tests, Medical Supplies and Equipment, Gross Profit, G & A, Legal Representation, Performance Bond, Professional Liability/Malpractice Insurance.	$	111,650
Subtotal	$	111,650
Mark-up		
Service Fee		9%
Management Fee	$	1,105,212
Profit over Costs (Markup is included in Management Fee)		
Subtotal	$	1,105,212
Annual Base Total	**$**	**11,656,039**
Year 1 Performance Incentive Potential		
***Potential Year 1 Not to Exceed Total**	**$**	**11,656,039**

Cost Price Inflation Not To Exceed Total		
Year 2**	$	11,947,440
Year 3**	$	12,305,863
Year 4**	$	12,736,568

Cost per Offender /day	**$**	**4.56**

*Indicates FT FTE's/Salaried Employees vs Independent Contractors
All FTE's are Employees

***Potential Year 1 Not to Exceed Total **DOES NOT** include Observer's Pass-Thru Cost

Cost per Offender/day is based on Year 1 Total only

STATE OF DELAWARE DEPARTMENT OF CORRECTIONS

CFG Health Systems, LLC

Staffing Costs by Position, Count & Pricing Group Exluding Observers

Position	Statewide FTE (Count)	Statewide Average Hourly Rate	Statewide Total Costs	DUI FTE (Count)	DUI Costs	Sex Offender FTE (Count)	Sex Offender Costs	Substance Abuse FTE (Count)	Substance Abuse Costs	Mental Health FTE (Count)	Mental Health Costs
Activity Technician	3.00	18.86	117,694	-	-	-	-	-	-	3.00	117,694
Admin Assistant	10.25	17.99	383,482	0.25	8,469	-	-	5.00	187,500	5.00	187,512
Case Manager	1.00	23.90	49,715	-	-	-	-	-	-	1.00	49,715
Clerk	5.00	19.96	207,595	-	-	-	-	-	-	5.00	207,595
Clinicians**	27.70	31.62	1,822,038	-	-	-	-	-	-	27.70	1,822,038
Clinical Program Manager	4.00	37.26	310,000	-	-	-	-	4.00	310,000	-	-
Clinical Supervisors	12.50	28.25	734,382	-	-	-	-	8.00	470,000	4.50	264,382
Clinical QI Assessor	0.20	48.08	20,000	-	-	-	-	0.20	20,000	-	-
CSOTP-Director	1.00	56.83	118,205	-	-	1.00	118,205	-	-	-	-
CSOTP	1.00	45.05	93,706	-	-	1.00	93,706	-	-	-	-
Counselor I	1.00	19.88	41,343	1.00	41,343	-	-	-	-	-	-
Counselor II	1.25	23.52	61,143	1.25	61,143	-	-	-	-	-	-
Associate CSOTP	2.00	31.83	132,427	-	-	2.00	132,427	-	-	-	-
Lead SA Counselors	17.00	22.62	799,850	-	-	-	-	17.00	799,850	-	-
MH Director	4.00	34.48	286,848	-	-	-	-	-	-	4.00	286,848
NP/PA	3.90	75.30	610,840	-	-	-	-	-	-	3.90	610,840
Observer	-	16.24	-	-	-	-	-	-	-	-	-
Program Director	0.50	38.44	39,975	0.50	39,975	-	-	-	-	-	-
Psychiatrist	5.00	116.43	1,210,863	-	-	-	-	-	-	5.00	1,210,863
Psychologist	3.20	47.26	314,560	-	-	-	-	-	-	3.20	314,560
SA Counselor	49.00	20.82	2,121,700	-	-	-	-	49.00	2,121,700	-	-
State Abuse Director	1.00	50.48	105,000	-	-	-	-	1.00	105,000	-	-
Totals	153.50		9,581,365	3.00	150,930	4.00	344,338	84.20	4,014,050	62.30	5,072,047

Observer's Salaries Not Included

** Note: Clinical staff costs include backfill for time off

STATE OF DELAWARE DEPARTMENT OF CORRECTIONS

CFG Health Systems, LLC

Staffing Costs by Position, Count & Facility Exluding Observers

	CVOP Mental Health JTVCC & Morris		SCI/SCC Mental Health Morris		HRYCI Mental Health Howard Young		Web Mental Health BWCI, WTC, Plummer		Substance Abuse Delaware		Substance Abuse HRYCI		Substance Abuse WCCC		Substance Abuse BWCI		Substance Abuse HDPWTF		Substance Abuse CVOP		Substance Abuse MCCC		Substance Abuse SCI		Substance Abuse SCCC		6 Months Year 1 DUI		Sex Offender		Administration Mental Health				
Position *	FTE	Costs	FTE	Costs	FTE	Costs	FTE	Costs	FTE	Costs	FTE	Costs	FTE	Costs	FTE	Costs	FTE	Costs	FTE	Costs	FTE	Costs	FTE	Costs	FTE	Costs	FTE	Costs	FTE	Costs	FTE	Costs	FTE	Statewide Average Hourly Rate	Costs
Activity Technician	3.00	117,694																															3.00	18.86	117,694
Admin Assistant	1.00	37,502	1.00	37,502	1.00	37,502	1.00	37,502	1.00	47,500	0.50	17,500	0.50	17,500	0.50	17,500	0.50	17,500	0.50	17,500	0.50	17,500	0.50	17,500	0.50	17,500	0.25	8,469			1.00	37,502	10.25	17.99	383,482
Case Manager																															1.00	49,715	1.00	23.90	49,715
Clerk	2.00	83,038	1.00	41,519	1.00	41,519	1.00	41,519																									5.00	19.96	207,595
Clinicians**	9.50	632,747	6.40	419,547	6.40	419,547	5.40	350,196																									27.70	31.62	1,822,038
Clinical Program Manager											0.50	38,750	0.50	38,750	0.50	38,750	0.50	38,750	0.50	38,750	0.50	38,750	0.50	38,750	0.50	38,750								4.00	37.26	310,000
Clinical Supervisors	2.00	117,250	0.50	29,882	1.00	58,625	1.00	58,625			1.00	58,750	1.00	58,750	1.00	58,750	1.00	58,750	1.00	58,750	1.00	58,750	1.00	58,750	1.00	58,750								12.50	28.25	734,382
Clinical QI Assessor									0.20	20,000																							0.20	48.08	20,000
CSOTP-Director																													1.00	118,205			1.00	56.83	118,205
CSOTP																													1.00	93,706			1.00	45.05	93,706
Counselor I																											1.00	41,343					1.00	19.88	41,343
Counselor II																											1.25	61,143					1.25	23.52	61,143
Associate CSOTP																													2.00	132,427			2.00	31.83	132,427
Lead SA Counselors											4.00	188,200	2.00	94,100	2.00	94,100	1.00	47,050	2.00	94,100	2.00	94,100	2.00	94,100	2.00	94,100								17.00	22.62	799,850
MH Director	1.00	71,712	1.00	71,712	1.00	71,712	1.00	71,712																									4.00	34.48	286,848
NP/PA	1.50	233,305	1.00	159,014	1.00	159,014	0.40	59,506																									3.90	75.30	610,840
Observer	-	-	-	-	-	-	-	-																									-	#DIV/0!	-
Program Director																											0.50	39,975					0.50	38.44	39,975
Psychiatrist	1.50	362,256	1.00	243,170	1.50	362,266	1.00	243,170																									5.00	116.43	1,210,863
Psychologist	1.00	101,205	0.20	18,289	0.70	63,093	0.30	27,250																							1.00	104,724	3.20	47.26	314,560
SA Counselor											13.00	562,900	5.00	216,500	4.00	173,200	5.00	216,500	8.00	346,400	5.00	216,500	5.00	216,500	4.00	173,200								49.00	20.82	2,121,700
State Abuse Director									1.00	105,000																							1.00	50.48	105,000
Totals	**22.50**	**1,756,710**	**12.10**	**1,020,636**	**13.60**	**1,213,279**	**11.10**	**889,481**	**2.20**	**172,500**	**19.00**	**#######**	**9.00**	**425,600**	**8.00**	**382,300**	**8.00**	**378,550**	**12.00**	**#######**	**9.00**	**425,600**	**9.00**	**#######**	**8.00**	**382,300**	**3.00**	**150,930**	**4.00**	**344,338**	**3.00**	**191,941**	**153.50**		**9,581,365**

Observer's Salaries Not Included

** Note: Clinical staff costs include backfill for time off

CFG HEALTH SYSTEMS
SEVERABLE
COST PROPSAL

Attached is a Severable Cost Proposal that contains an alternative cost proposal for our Telepsychiatry Program.

Please see Tab 9, Telepsychiatry for more information.

These costs are NOT included in original proposal and are severable.

DDOC, BCHS RFP	
Vendor Name:	**CFG Health Systems**
Severable Telepsychiatry Program	

Based on 7,000 Average Daily Population (ADP)

Fixed Costs (should not include mark-up percent)		
Dr./PA/CRNP (Mid-Level Practicioners and Above)*		
Line Staff*		
Performance Bond		
Professional Liability/Malpractice Insurance		
Subtotal	$	-
Management Costs (should not include mark-up percent)		
Senior Management		
Administrative Overhead	$	84,400
Office Space		
Indirect Costs	$	-
Subtotal	$	84,400
Variable Costs (should not include mark-up percent)		
Outside Consults, Medications (if applicable), Laboratory Tests, Medical Supplies and Equipment, Gross Profit, G & A, Legal Representation, Performance Bond, Professional Liability/Malpractice Insurance.	$	79,550
Subtotal	$	79,550
Mark-up		
Service Fee		9%
Management Fee	$	-
Profit over Costs (Markup is included in Management Fee)		
Subtotal	$	14,756
Annual Base Total	**$**	**178,706**
Year 1 Performance Incentive Potential		
Potential Year 1 Not to Exceed Total	**$**	**178,706**

Cost Price Inflation Not To Exceed Total		
Year 2**	$	86,932
Year 3**	$	89,540
Year 4**	$	92,226

Cost per Offender /day	**$**	**0.07**

*Indicates FT FTE's/Salaried Employees vs Independent Contractors
All FTE's are Employees
Cost per Offender/day is based on Year 1 Total only

STATE OF DELAWARE DEPARTMENT OF CORRECTIONS

Severable Telepsychiatry Proposal

EQUIPMENT

Telepsych Equipment & Start-up	*Unit price*	*# Units*	*Total*
EX60 or similar	$ 6,500	10	$ 65,000
Tax	$ 0.07	$ 65,000	$ 4,550
Cable installation	$ 500	10	$ 5,000
Equipment Installation	$ 500	10	$ 5,000
		SUBTOTAL	**$ 79,550**

OPERATIONS

Telepsych Year 1 Operating Expense	*Unit price*	*# Units*	*Total*
EX 60 Warranty	$ 800	10	$ 8,000
Cable Service	$ 95	120	$ 11,400
		SUBTOTAL	**$ 19,400**

CLINCAL SERVICES

24/7/365 Emergency Telepsychiatry			
Crisis Psych Evals for Arrrested Individuals	$ 65,000	1	$ 65,000
* Available at Level 5 facilities		**SUBTOTAL**	**$ 65,000**
Management Fee	9%		**$ 14,756**
		Year 1 Total	**$ 178,706**

COLA	**3%**	**Year 2 TOTAL**	**$ 86,932**
		Year 3 TOTAL	**$ 89,540**
		Year 4 TOTAL	**$ 92,226**

CFG HEALTH SYSTEMS SUPPLEMENTAL SEVERABLE COST PROPSAL

Attached is a Supplemental Severable Cost Proposal that contains an alternative cost proposal for our InWorld Avatar Program.

Please see Tab 9, Telepsychiatry for more information.

These costs are NOT included in original proposal and are severable.

DDOC, BCHS RFP	
Vendor Name:	**CFG Health Systems**
Supplemental Severable Proposal	
InWorld Avatar Programming	

Based on 7,000 Average Daily Population (ADP)

Fixed Costs (should not include mark-up percent)		
Dr./PA/CRNP (Mid-Level Practicioners and Above)*		
Line Staff*		
Performance Bond		
Professional Liability/Malpractice Insurance		
Subtotal	$	-
Management Costs (should not include mark-up percent)		
Senior Management		
Administrative Overhead	$	-
Office Space		
Indirect Costs	$	-
Subtotal	$	-
Variable Costs (should not include mark-up percent)		
Outside Consults, Medications (if applicable), Laboratory Tests, Medical Supplies and Equipment, Gross Profit, G & A, Legal Representation, Performance Bond, Professional Liability/Malpractice Insurance.	$	140,750
Subtotal	$	140,750
Mark-up		
Service Fee		9%
Management Fee	$	-
Profit over Costs (Markup is included in Management Fee)		
Subtotal	$	12,668
Annual Base Total	**$**	**153,418**
Year 1 Performance Incentive Potential		
Potential Year 1 Not to Exceed Total	**$**	**153,418**

Cost Price Inflation Not To Exceed Total		
Year 2**	$	112,013
Year 3**	$	115,373
Year 4**	$	118,834

Cost per Offender /day	**$**	**0.06**

*Indicates FT FTE's/Salaried Employees vs Independent Contractors
All FTE's are Employees
Cost per Offender/day is based on Year 1 Total only

STATE OF DELAWARE DEPARTMENT OF CORRECTIONS

Supplemental Severable Proposal

InWorld Avatar Programming

Item	*Item Cost*	*Quantity*	*Total*
InWorld Specialist (MSW)	$ 65,000	0.75	$ 48,750
Curriculum Customization	$ 3,500	1	$ 3,500
Computers (1 time exp)	$ 950	16	$ 15,200
Headsets (1 time exp)	$ 50	16	$ 800
Router (1 time exp)	$ 125	4	$ 500
Installation	$ 1,500	4	$ 6,000
Training	$ 1,500	4	$ 6,000
IW Software License (Annual)	$ 3,000	20	$ 60,000
Management Fee	9%		$ 12,668
		Year 1 Total	**$ 153,418**

COLA	3%	**Year 2 TOTAL**	**$ 112,013**
		Year 3 TOTAL	**$ 115,373**
		Year 4 TOTAL	**$ 118,834**

LICENSE NO. 2010100806 DORBL

POST CONSPICUOUSLY

STATE OF DELAWARE
DIVISION OF REVENUE

VALID
01/01/12 - 12/31/12
NOT TRANSFERABLE

DLN: 12 93316 46

BUSINESS CODE / GROUP CODE: 007

LICENSED ACTIVITY: PROFESSIONAL AND/OR PERSONAL SERVICES

DATE ISSUED: 02/03/12

2012

VALIDATED

LICENSE FEE: $ 75.00

BUSINESS LICENSE

MAILING ADDRESS

#BWNKHPS
#13P5 SEV0 1LM2 5E96#
CFG HEALTH SYSTEMS LLC
765 W ROUTE 70 BLDG A
MARLTON NJ 08053-1643

BUSINESS LOCATION

CFG HEALTH SYSTEMS LLC
765 W ROUTE 70 BLDG A
MARLTON NJ 08053-1643

IS HEREBY LICENSED TO PRACTICE, CONDUCT OR ENGAGE IN THE OCCUPATION OR BUSINESS ACTIVITY INDICATED ABOVE IN ACCORDANCE WITH THE LICENSE APPLICATION DULY FILED PURSUANT TO TITLE 30, DEL CODE.

PATRICK T. CARTER
DIRECTOR OF REVENUE

IMPORTANT - TEAR AT ABOVE PERFORATION AND DISPLAY IN A PUBLIC LOCATION

Federal E.I. No. or Social Security Number: 1 22365 9031 001

Business Code / Group Code: 007

Licensed Activity: PROFESSIONAL AND/OR PERSONAL SERVICES

The State of Delaware Business License printed above must be posted in a public area at the location address listed. If you have any questions regarding this license, please call (302) 577-8778.

REPLACEMENT LICENSES

Keep this portion of your license separate, in case you need a replacement for any lost, stolen or destroyed license. A $15 fee will be charged for the replacement of a license. Send the $15 along with a copy of this form or provide your Federal Employer Identification Number, or Social Security Number, suffix, Business Code, Business Name and address to Delaware Division of Revenue, Attn.: Business Master File, PO Box 8750, Wilmington, DE 19899-8750. You will receive your replacement license within three to four weeks.

OTHER IMPORTANT INFORMATION

Most licensees are also required to pay either gross receipts or excise taxes in addition to the license fee. You can file these taxes online or obtain a paper form from our website at www.revenue.delaware.gov. You must **submit all business tax returns** filed with the Division of Revenue **under the same identification number.** If you are a sole-proprietor, and have a federal employer identification number, use the employer identification number, not your social security number. Only sole proprietors with no employees are allowed to file under their social security number. Inquiries regarding your coupon booklets to pay withholding, corporate tentative, and Sub Chapter "S" estimated taxes, or to make changes to your name, address, or identification number, should be directed to the Business Master File Unit at **(302) 577-8778.**

INTERNET SITE

The Division of Revenue web address is: www.revenue.delaware.gov. Visit our web site for tax tips, links to telephone numbers, forms that you can download, links to other State agencies, the Delaware Code, the publication "Delaware Guide for Small Business" and lots more. Internet filing of personal income tax returns via the Division of Revenue's website is available. Internet filing for Withholding, Gross Receipts and Corporate Tentative payments is also available.

Client#: 295602 CENTEFORFA

ACORD™ CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 04/25/2012

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER
Conner Strong & Buckelew
Two Liberty Place
50 S. 16th Street, Suite 3600
Philadelphia, PA 19102

CONTACT NAME: Tammy Orehek
PHONE (A/C, No, Ext): 877 861-3220 FAX (A/C, No): 856 830-1411
E-MAIL ADDRESS: torehek@connerstrong.com

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : Philadelphia Indemnity Insuranc	18058
INSURER B : Twin City Fire Insurance Co	29459
INSURER C : Nautilus Insurance Company	17370
INSURER D :	
INSURER E :	
INSURER F :	

INSURED
CFG Health Systems, LLC
765 Route 70 East, Building A
Marlton, NJ 08053

COVERAGES CERTIFICATE NUMBER: REVISION NUMBER:

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	GENERAL LIABILITY			PHPK808253	12/31/2011	12/31/2012	EACH OCCURRENCE	$1,000,000
	X COMMERCIAL GENERAL LIABILITY						DAMAGE TO RENTED PREMISES (Ea occurrence)	$1,000,000
	CLAIMS-MADE X OCCUR						MED EXP (Any one person)	$20,000
							PERSONAL & ADV INJURY	$1,000,000
							GENERAL AGGREGATE	$3,000,000
	GEN'L AGGREGATE LIMIT APPLIES PER:						PRODUCTS - COMP/OP AGG	$3,000,000
	X POLICY PRO-JECT LOC							$
A	AUTOMOBILE LIABILITY			PHPK808253	12/31/2011	12/31/2012	COMBINED SINGLE LIMIT (Ea accident)	$1,000,000
	X ANY AUTO						BODILY INJURY (Per person)	$
	ALL OWNED AUTOS / SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	HIRED AUTOS / NON-OWNED AUTOS						PROPERTY DAMAGE (Per accident)	$
								$
A	X UMBRELLA LIAB X OCCUR			PHUB368283	12/31/2011	12/31/2012	EACH OCCURRENCE	$10,000,000
	EXCESS LIAB CLAIMS-MADE			(See Below)			AGGREGATE	$10,000,000
	DED X RETENTION $10,000							$
B	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY			13WEBL1480	04/23/2012	04/23/2013	X WC STATU-TORY LIMITS / OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? Y / N: N (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	N / A		State of DE			E.L. EACH ACCIDENT	$1,000,000
							E.L. DISEASE - EA EMPLOYEE	$1,000,000
							E.L. DISEASE - POLICY LIMIT	$1,000,000
C	Healthcare Prof.			PFP1000186P1	10/01/2011	07/01/2012	See Below	
C	Healthcare Prof.			PFX1000019P1	10/01/2011	07/01/2012	See Below	

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, if more space is required)

*** Umbrella Liability Limits do not apply to the Healthcare Professional Liability Policy ***

******** HEALTHCARE PROFESSIONAL LIABILTY POLICIES **********

Claims-Made Coverage only applies to the correctional operations of the Named Insured.

(See Attached Descriptions)

CERTIFICATE HOLDER

State of Delaware
Attn: James C. Welch, RN,HN-BC
Department of Correction
245 McKee Road
Dover, DE 19904

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

W. Michael Raymond

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DESCRIPTIONS (Continued from Page 1)

***** Primary Healthcare Professional Liability Policy #PFP1000186P1 *****
Limits of Insurance: $1,000,000 Each Medical Incident/$3,000,000 Aggregate
Deductible: $25,000 Each Medical Incident
Retroactive Date: Contract Inception

***** Excess Healthcare Professional Liability & Healthcare Umbrella Liability Policy #PFX1000019P1 *****
Retroactive Date: Contract Inception
Limits of Insurance:
$4,000,000 Each Professional Liability Claim
$4,000,000 Each Umbrella Liability Claim
$4,000,000 Policy Aggregate

Re: RFP #DOC-1202Mental for professional services for correctional mental health services/substance abuse treatment/DUI programming and sex offender treatment

Evidence of Insurance Upon Acceptance of Bid

Certification 32347

CERTIFICATE OF EMPLOYEE INFORMATION REPORT

RENEWAL

This is to certify that the contractor listed below has submitted an Employee Information Report pursuant to N.J.A.C. 17:27-1.1 et. seq. and the State Treasurer has approved said report. This approval will remain in effect for the period of 15-MAY-2011 to 15-MAY-2014

CFG HEALTH SYSTEMS,LLC.
765 ROUTE 70 EAST, BLDG.
MARLTON NJ 08053

Andrew P. Sidamon-Eristoff
State Treasurer

a representative of your company or firm. Immediately upon receipt, this certificate should be forwarded to the person in your company or firm responsible for ensuring equal employment opportunity and/or overseeing the company or firm's contracts with public agencies. Typically, this person may be your company or firm's Human Resources Manager, Equal Employment Opportunity Officer or Contract Administrator. If you do not know to whom the certificate should be forward, kindly forward it to the head of your company or firm. Copies of the certificate should also be distributed to all facilities of your company or firm who engage in bidding on public contracts in New Jersey and who use the same federal identification number and company name. The certificate should be retained in your records until the date it expires. This is very important since a request for a duplicate/replacement certificate will result in a $75.00 fee.

On future successful bids on public contracts, your company or firm must present a photocopy of the certificate to the public agency awarding the contract after notification of the award but prior to execution of a goods and services or professional services contract. Failure to present the certificate within the time limits prescribed may result in the awarded contract being rescinded in accordance with N.J.A.C. 17:27-4.3b.

Please be advised that this certificate has been approved only for the time periods stated on the certificate. As early as ninety (90) days prior to its expiration, the Division will forward a renewal notification. Upon the Division's receipt of a properly completed renewal application and $150.00 application fee, it will issue a renewal certificate. In addition, representatives from the Division may conduct periodic visits and/or request additional information to monitor and evaluate the continued equal employment opportunity compliance of your company or firm. Moreover, the Division may provide your company or firm with technical assistance, as required. Please be sure to notify the Division immediately if your company's federal identification number, name or address changes.

If you have any questions, please call (609) 292-5473 and a representative will be available to assist you.

Enclosure(s)
(AA-01 Rev. 4/10)

State of Delaware

Office of Secretary of State

I, MICHAEL HARKINS, SECRETARY OF STATE OF THE STATE OF DELAWARE DO HEREBY CERTIFY THE ATTACHED IS A TRUE AND CORRECT COPY OF THE CERTIFICATE OF INCORPORATION OF HORIZON HOUSE/DELAWARE, INC. FILED IN THIS OFFICE ON THE EIGHTH DAY OF APRIL, A.D. 1987, AT 9 O'CLOCK A.M.

! ! ! ! ! ! ! ! ! !

DEPARTMENT OF STATE
OFFICE OF THE SECRETARY OF STATE
1835 1793 1970
DELAWARE

Michael Harkins, Secretary of State

AUTHENTICATION: 1198311

DATE: 04/08/1987

870980024

Internal Revenue Service
District Director

Department of the Treasury

Date: SEP 30 1987

Employer Identification Number:
23-2460218
Accounting Period Ending:
June 30
Foundation Status Classification:
509(a)(1)(A)(vi)
Advance Ruling Period Ends:
June 30, 1991
Person to Contact:
William Kane
Contact Telephone Number:
(215) 597-4168

Horizon House/Delaware, Inc.
120 South 30th Street
Philadelphia, PA 19104

Dear Applicant:

Based on information supplied, and assuming your operations will be as stated in your application for recognition of exemption, we have determined you are exempt from Federal income tax under section 501(c)(3) of the Internal Revenue Code.

Because you are a newly created organization, we are not now making a final determination of your foundation status under section 509(a) of the Code. However, we have determined that you can reasonably be expected to be a publicly supported organization described in section 509(a)(1) & 170(b)(1)(A)(vi).

Accordingly, you will be treated as a publicly supported organization, and not as a private foundation, during an advance ruling period. This advance ruling period begins on the date of your inception and ends on the date shown above.

Within 90 days after the end of your advance ruling period, you must submit to us information needed to determine whether you have met the requirements of the applicable support test during the advance ruling period. If you establish that you have been a publicly supported organization, you will be classified as a section 509(a)(1) or 509(a)(2) organization as long as you continue to meet the requirements of the applicable support test. If you do not meet the public support requirements during the advance ruling period, you will be classified as a private foundation for future periods. Also, if you are classified as a private foundation, you will be treated as a private foundation from the date of your inception for purposes of sections 507(d) and 4940.

Grantors and donors may rely on the determination that you are not a private foundation until 90 days after the end of your advance ruling period. If you submit the required information within the 90 days, grantors and donors may continue to rely on the advance determination until the Service makes a final determination of your foundation status. However, if notice that you will no longer be treated as a section 509(a)(1) & 170(b)(1)(A)(vi) organization is published in the Internal Revenue Bulletin, grantors and donors may not rely on this determination after the date of such publication. Also, a grantor or donor may not rely on this determination if he or she was in part responsible for, or was aware of, the act or failure to act that resulted in your loss of section 509(a)(1) & 170(b)(1)(A)(vi) status, or acquired knowledge that the Internal Revenue Service had given notice that you would be removed from section 509(a)(1) & 170(b)(1)(A)(vi) organization.

RECEIVED OCT 0 5 19

HORIZON HOUSE DELAWARE INC

Guidelines under which private foundations may rely on this determination, for gifts, grants, and contributions made after March 12, 1989, were liberalized and published in Rev. Proc. 89-23, Cumulative Bulletin 1989-1, page 844.

LICENSE NO. 1990025304 DORBL

POST CONSPICUOUSLY

STATE OF DELAWARE
DIVISION OF REVENUE

VALID
01/01/12 - 12/31/12
NOT TRANSFERABLE

DLN: 11 85534 21

BUSINESS CODE 099
GROUP CODE 007

LICENSED ACTIVITY PROFESSIONAL AND/OR PRSL SRVCS-UNCLASSIFIED
PROFESSIONAL AND/OR PERSONAL SERVICES

DATE ISSUED: 12/30/11

2012

VALIDATED

LICENSE FEE: $ 75.00

BUSINESS LICENSE

MAILING ADDRESS

#BWNKHPS
#18FT 5YS0 1LM0 8IB4#
THRESHOLDS INC
20505 DUPONT BLVD # 1
GEORGETOWN DE 19947-3173

BUSINESS LOCATION

THRESHOLDS INC
20505 DUPONT BLVD # 1
GEORGETOWN DE 19947-3173

IS HEREBY LICENSED TO PRACTICE, CONDUCT OR ENGAGE IN THE OCCUPATION OR BUSINESS ACTIVITY INDICATED ABOVE IN ACCORDANCE WITH THE LICENSE APPLICATION DULY FILED PURSUANT TO TITLE 30, DEL CODE.

PATRICK T. CARTER
DIRECTOR OF REVENUE

IMPORTANT - TEAR AT ABOVE PERFORATION AND DISPLAY IN A PUBLIC LOCATION

Federal E.I. No. or Social Security Number 1 51028 4404 001

Business Code 099
Group Code 007

Licensed Activity PROFESSIONAL AND/OR PRSL SRVCS-UNCLASSIFIED
PROFESSIONAL AND/OR PERSONAL SERVICES

The State of Delaware Business License printed above must be posted in a public area at the location address listed. If you have any questions regarding this license, please call (302) 577-8778.

REPLACEMENT LICENSES

Keep this portion of your license separate, in case you need a replacement for any lost, stolen or destroyed license. A $15 fee will be charged for the replacement of a license. Send the $15 along with a copy of this form or provide your Federal Employer Identification Number, or Social Security Number, suffix, Business Code, Business Name and address to Delaware Division of Revenue, Attn.: Business Master File, PO Box 8750, Wilmington, DE 19899-8750. You will receive your replacement license within three to four weeks.

OTHER IMPORTANT INFORMATION

Most licensees are also required to pay either gross receipts or excise taxes in addition to the license fee. You can file these taxes online or obtain a paper form from our website at www.revenue.delaware.gov. You must **submit all business tax returns** filed with the Division of Revenue **under the same identification number.** If you are a sole-proprietor, and have a federal employer identification number, use the employer identification number, not your social security number. Only sole proprietors with no employees are allowed to file under their social security number. Inquiries regarding your coupon booklets to pay withholding, corporate tentative, and Sub Chapter "S" estimated taxes, or to make changes to your name, address, or identification number, should be directed to the Business Master File Unit at **(302) 577-8778.**

INTERNET SITE

The Division of Revenue web address is: www.revenue.delaware.gov. Visit our web site for tax tips, links to telephone numbers, forms that you can download, links to other State agencies, the Delaware Code, the publication "Delaware Guide for Small Business" and lots more. Internet filing of personal income tax returns via the Division of Revenue's website is available. Internet filing for Withholding, Gross Receipts and Corporate Tentative payments is also available.

REFERENCES

References for all parties recognized as sub-contractors (*Horizon House, Inc.* and *Thresholds, Inc.*) can be found in this section of the proposal. **Professional references for CFG are located in Section 3 -- Corporate Overview and History.**

REFERENCES

Philadelphia Services
Arthur C. Evans, Ph.D.
Director
Offices of Behavioral Health/
Mental Retardation Services
1101 Market Street, Suite 700
Philadelphia, PA 19107
215-685-4736

Michael J. Covone
Deputy Commissioner
Offices of Behavioral Health/
Mental Retardation Services
1101 Market Street, Suite 700
Philadelphia, PA 19107
215-685-5459

Delaware County Services
Jonna DiStephano
Director, Office of Behavioral Health
20 S. 69th Street
Upper Darby, PA 19082
610-713-2375

State of Delaware Services
John McKenna
Chief Executive Officer
Rockford Center
100 Rockford Drive
Newark, DE 19713
302-996-5480

Magellan Medicaid Services
Evon L. Bergey, MSW
General Manager
Magellan Health Services
Newtown Care Management Center
105 Terry Drive, Suite 103
Newtown, PA 18940
215-504-3905

Open Door, Incorporated
An Affiliate of Holcomb Behavioral Health Systems

3301 Green St., 2nd fl., Claymont, DE 19703
(302) 798-9555 Fax (302) 798-9550

254 E. Main St., Newark, DE 19711
(302) 731-1504 Fax (302) 731-2720

June 29, 2009

Bruce Lorenz
Director
Thresholds, Inc
20505 Dupont Highway
Georgetown, DE 19947

Dear Mr. Lorenz:

Please accept this letter of support for your proposal to the Office of Highway Safety to continue to provide DUI Education and Treatment Programs in Sussex County. Thresholds, Inc. has a long history of being a dedicated and effective provider of DUI education and treatment services.

Open Door, Inc. is excited that Thresholds, Inc. is proposing to continue their DUI Education and Treatment Programs. It has been a pleasure working with you and your staff over the years with clients in the DUI System. Threshold's clinicians have been very helpful in our treatment of clients that were previously involved with your agency. Their professionalism and poignant clinical insights have been appreciated.

Best of luck with your proposal! I look forward to continuing our work with you on behalf of our clients in the DUI System.

Sincerely,

Howard Isenberg
Executive Director

Accredited by
Joint Commission
on Accreditation of Healthcare Organizations

A United Way Agenc

PACE

"A generation of helping others help themselves"

Bruce Lorenz
Executive Director
Thresholds, Inc
526D North Dupont Highway
Georgetown, DE 19947

June 5, 2009

To Whom It May Concern:

This letter serves as a formal document of support for the Thresholds Substance Abuse Treatment Program in their attempt to gain approval for the 2009 DUI state contract number 10-0140-02.

Thresholds has long been a leading agency in Delaware in the battle against substance abuse; and, during that time there has been one constant within the agency -- Bruce Lorenz. I have had the pleasure of knowing Bruce for over 20 years and can proudly say that he is a colleague of the highest moral and ethical standard. Few people in the state of Delaware know more about the issues of substance abuse and substance abuse treatment than Bruce. Whether serving on local government panels, or National boards such as the National Association of Addictions Counselor, Bruce has been a leader in the field of substance abuse and I strongly support his commitment to the DUI Outpatient program.

It is with the strongest of confidence that I recommend Thresholds as a candidate for the DUI substance abuse state contracted program.

If I can be of any further service please let me know. Thank you.

Sincerely,

Bruce C. Johnson, MS CADC
Executive Director

5171 West Woodmill Drive
Woodmill Corporate Center, Suite 9
Wilmington, Delaware 19808
(302) 999-9812 • Fax (302) 999-9820

sodat Delaware, Inc. — 625 N. Orange Street
Wilmington, Delaware 19801 (302) 656-4044
FAX 656-3439

. . . a non-profit organization dedicated to prevention, education, intervention, treatment, research, and evaluation in drug and alcohol abuse . . .

Board of Directors

Chair
Michael Newbold, Jr.

Secretary
Adam Balick

Eileen Curtin

Joseph F. Fitzgerald, Jr.

Andrew Jefferson

John Newlin

David K. Solacoff, M.D.

June 4, 2009

Mr. Bruce Lorenz
Thresholds, Inc.
526 North Dupont Highway
Georgetown, Delaware 19947

Dear Mr. Lorenz,

It is truly a pleasure to offer our ongoing support to Thresholds in your effort to secure continued contractual services with the Delaware Evaluation and Referral Program.

SODAT has always found you and your staff to be both professional and courteous. Furthermore your expertise in dealing with clients has certainly reduced recidivism and kept our highways safer. Thresholds should take great pride in its efforts to improve our community.

Best wishes with your proposal and we look forward to continuing our successful relationship!

Sincerely,

D. Eric Saul, MBA
Executive Director

Accredited by the Joint Commission on Accreditation of Health Care Organization

The Gold Seal of Appro

Approved 501(c)(3) non-profit entity. Charitable donations tax deductible in accordance with IRS regulations.

RESUME TABLE OF CONTENTS

CFG Staff:

- *Les Paschall*
- *Al Campana, CCHP*
- *James Javon Neal, M.D., CCHP*
- *Sandra Vargas RN,MSN,CCHP*
- *Denise R. Rahaman, MBA, BSN, CCHP-RN*
- *James R. Varrell, MD*
- *Keith L. Dunoff, D.M.D*
- *Joel Friedman, PhD*
- *Dennis H. Sandrock, Ph.D.*
- *Michael B. Miller, MCSE, CNE, CCNA, CCAI*
- *Jeanine P. Miles MS, LPC*
- *Michael Panisak*
- *Geoffrey C. Boyce*
- *Nancy I. Delapo*
- *Matthew C. Konstance*
- *Stephen D. Holtzman*
- *Jan David Segal, PH.D.*
- *Maasi Shamilov, MD*
- *Peter Brancato Jr., MD*
- *Rajalla Prewitt, MD*
- *Stan Malkin, Ph.D.*
- *Stephen Neff, APN*
- *James G. O'Quinn, D.Min., CSOTP*
- *Elton John Smith M.D.*
- *Rosilyn T. Smith M.D.*
- *Christina Vaglica M.D.*
- *Amit Pramodrai Kurani M.D.*

RESUME TABLE OF CONTENTS

Subcontractors:

- *Bruce R. Lorenz, CADC, NCAC II*
- *Susan M. Harris*
- *Williard E. Heuser*
- *Joshua T. Warweg, MA, CPRP*
- *Christina O'Connor*

Les Paschall

Chief Executive Officer

PROFESSIONAL EXPERIENCE

Chief Executive Officer, CFG Health Systems, LLC
Responsible for the leadership and direction of a management team overseeing 500 employees in the delivery of healthcare and healthcare management services for large public and private institutions

Within six years developed a team and organizational structure that grew CFG from 8 associates and $400, 000 annual revenue unit to its present 500+ associates and 42 million dollar revenue unit

Expanded the service product line from a basic one site outpatient program to corporation providing programs, management, program development to large hospital and healthcare delivery systems in both the public and private sectors

Though leadership and the selection of a talented team brought the first and only substantial telemedicine program to New Jersey and Pennsylvania

Was recognized in the Philadelphia Business Journal as the leader of the top 100 fastest growing companies in New Jersey

General Operations Director, Rainbow Healthcare Associates, PC
Responsible for the oversight and management of all “operations” related departments including accounting, staff development, and human resources

Negotiated all the corporate contracts with various institutions including hospitals, County and State entities

Researched and implemented management information systems for improved fiscal management and accounts receivable performance

Developed, implemented and managed Mental Health Delivery programs for hospital systems in New Jersey and Pennsylvania in both the private and public sector

Positioned the company for the successful negotiation and acquisition by large a national company

Program and Operations Manager, Overbrook Friedlander Programs
Managed all operational and program delivery aspects of a not for profit residential provider agency serving developmentally delayed

Developed programs and program compliance systems consistent with State Regulatory entities

Prepared all budgets and systems for cost management

Unit Program Director, State of Pennsylvania

Directly responsible for the oversight and management of line and program staff for a Unit housing 24 dually diagnosed adolescent males

Arlington Developmental Center
Served as a speech pathologist clinician

EDUCATION

MA, University of Memphis, Major Speech Pathology
BA, Memphis State University, Major Philosophy

AL CAMPANA, CCHP

Chief Operating Officer

PROFESSIONAL EXPERIENCE

Chief Operating Officer, CFG Health Systems, LLC , Center for Family Guidance, PC
Responsible for oversight of daily operations for a 750+ employee company operating out of multiple sites providing a wide range of services.
Play a central role in the development and implementation of new programs and lines of business, which has contributed to the tripling of revenues in the six years since joining CFG.
Responsible for the ongoing development of the operational infrastructure necessary to support the dynamic growth of the company.
Executive oversight of CFG's Correctional Healthcare business line.

Assistant Vice President, Albert Einstein Healthcare Network
Directed the Belmont campus' efforts during the design & installation of the health system's 26 million dollar Electronic Medical Record.
Saved in excess of 1 million dollars over 5 years by reducing costs 40% through re-negotiation of Laboratory charges.
Reduced costs by 18% by negotiating a transportation contract with a new vendor.
Reduced customer complaints by 75% by re-engineering food delivery process.
Chaired a committee that reduced the frequency of delinquent medical records by 55%.
Led the re-design and refurbishment of the Children's Psychiatric Unit, resulting in greater utilization of the space and new revenue opportunities.

Corporate Vice President, CoreCare Systems, Inc.
Negotiated a contract with a new food service vendor that reduced costs by 15%.
Orchestrated the opening of a new inpatient unit that created new revenue opportunities.
Outsourced security function and reduced costs by 18%.

Director, Behavioral Health Services, Allegheny University Hospitals
Led design efforts of a new Older Adult Psychiatric unit that led to the generation of in excess of $900,000 of new revenue per year.

Senior Director, Department of Psychiatry Mt. Sinai Hospital,
ASSOCIATE VICE PRESIDENT, DEPARTMENT OF PSYCHIATRY
DIRECTOR OF ADMISSIONS
REFERRAL COORDINATOR
Played a key role in the closure of the hospital and the transfer of targeted inpatient and outpatient programs to a sister facility.
Created the first 23-hour assessment center in the region, resulting in a 7% increase in inpatient business and a 12% increase in outpatient business.
Led an effort to streamline the telephone intake screening process, which resulted in a 17% increase in referral calls.
Oversaw the reorganization of the intake department that contributed to a 50% increase in the inpatient census over a nine-month period.

Administrative Coordinator, United Psychiatric Services, Inc.
Developed computerized database to track key business activities.

Referral Services Manager, The Horsham Clinic
Clinical Coordinator / Chief Social Worker
Clinical Social Worker
Developed three new major referral sources.
Streamlined intake process for the Adult Program

Psychiatric Assistant, Albert Einstein Medical Center

Social Worker, Warminster General Hospital
Mental Health Technician

EDUCATION

MBA, Temple University, Major: Business Administration
BS, Pennsylvania State University, Major: Psychology

CERTIFICATION

Certified Correctional Health Professional, (CCHP), National Commission on Correctional Health Care

James Javon Neal, M.D., CCHP

Corporate Medical Director

PROFESSIONAL EXPERIENCE

Corporate Medical Director, Center for Family Guidance, LLC
Correctional Health Division - The senior medical manager for the correctional health program implemented by the CFG network, charged to provide functional and operational direction in the acquisition of jail contracts, the development of comprehensive service delivery programs consistent with oversight and regulatory agencies, and for the direct supervision of professional clinical staff.

CUNY/CCNY Clinical Instructor, Sophie Davis School of Biomedical Education
Serve as an Instructor of Clinical medicine, providing training for physician assistant students in affiliation with Harlem Hospital, Health & Hospital Corporation of New York.

Correctional Healthcare Expert
Medical Clinician with administrative and practical implementation experience in correctional health delivery systems, called on for external reviews by oversight and governmental regulatory agencies. Past litigation involving US Department of Justice with AIDS care in New Jersey in State Prison system. Serve on the National Commission on Correctional Health Care (NCCHC) – Manuscript Review Committee for Correct Care Journal.

Correctional Healthcare Consultant
Provide technical assistance with clinical systems development, program evaluations, interpretation and implementation of services, as stipulated by regulatory and oversight agencies for jails and prison facilities. Implement and provide daily in-patient utilization and review services for several correctional facilities. Conduct clinical outcomes evaluations in support of quality improvement initiatives.

Vice President, Medical Director - Correctional Health, Nassau Health Care Corporation
Principle program director for Nassau University Medical Center responsible for the medical, mental health, dental and related allied health services provided at the Nassau County Correctional Center. Coordinated the development and implementation of a comprehensive, integrated medical and mental health program for the jail designed to meet standards promulgated by the National Commission on Correctional Health Care (NCCHC) and to fulfill existing mandates by the U.S. Department of Justice.

Regional Medical Director, America Service Group Inc. (PHS)
Chief clinical manager of the New York City jails network for Correctional Health Services of Health and Hospitals Corporation, New York City.

Statewide Medical Director, Correctional Medical Services, St. Louis, MO
The senior medical manager for the prison health program implemented by Correctional Medical Services (CMS) for the New Jersey State prison network, charged to provide functional and operational direction for the physicians, nurses, para-professional staff. Provided vision and direction in program development, staff recruitment and training, quality improvement management through outcomes assessments. Planned and implemented the activities leading to certification of the program's facilities by the National Commission on Correctional Health Care (NCCHC).

Associate Executive Director Clinical Affairs, Health and Hospitals Corporation
Senior clinical manager for all correctional health and forensic hospital based services. Chair for Correctional Health Services Continuous Quality Improvement Committee reporting to the President of HHC. Designated coordinator for all facility-based accreditation activities.

Assistant Commissioner for Clinical Affairs, New York City Department of Health
Medical strategist, tasked with establishing clinical objectives and service goals for the program providers. Chairman, Clinical Management Committee NYC-Department of Health and line supervisor for the Directors of Medicine, Mental Health, Nursing, Pharmacy, Continuous Quality Improvement, In-Service Education and Infection Control.

Acting Assistant Commissioner for Clinical Services, New York City Department of Health

Senior Clinical Manager for an expanded Correctional Health Services organization. Divisional Quality Assurance Coordinator. Director, plenary committee who developed and implemented a strategic plan, which prepared the facilities for national accreditation, audits.

Deputy Assistant Commissioner for Clinical Services , New York City Department of Health
Senior Clinical Director for the nursing, medical, quality assurance, pharmacy and mental health services reporting to the Assistant Commissioner. Established and implemented clinical care goals consistent with Community Standards and State and Municipal oversight agencies. Expert witness to the Federal Courts, testifying on behalf of the Department of Health.

Director, Clinical Research - Pacific, Pearl River, NY, American Cyanamid Company
Developed global clinical investigation strategies. Negotiated new clinical research projects, regional staffing needs and annual budgets with corporate and subsidiary management. Established local priorities and assisted in resource allocation decisions. Ensured that all regional medical staff operated within the guidelines of Good Clinical Practice and the Helsinki Accord.

Regional Director - Pacific, Sydney, Australia , American Cyanamid Company
On-sight operations manager for the Asian-Pacific region. Directed the clinical activities of the local country medical directors (and staff) and ensured that implementation was consistent with corporate global objectives while meeting local regulatory and marketing requirements. Directed product license application submissions (new drug - Cefixime, label extension - Mitoxantrone).

Assistant Director - Clinical Investigations, Pearl River, NY, American Cyanamid Company
Divisional project leader with responsibilities for the direction of in-house data management resources.

Associate Director, Pearl River, NY, American Cyanamid Company
Research team leader Phase 2 and 3 clinical trials
Presenter, International Lipids Meeting, Florence, Italy, "A-CAT Inhibitor, Cl 277,082"

Chief Physician, Riker's Island Health Service, Montefiore Hospital
Medical operations manager for a 3,000 patient ambulatory clinic. Drafted the Clinical Procedures Manual

EDUCATION

Wayne State University Monteith College - BPh-Biology, 1971
Wayne State University School of Medicine - M.D., 1978
Detroit Medical Center Harper-Grace Hospital - Internship and Residency - Internal Medicine, 1978 - 1981

LICENSES

New York, New Jersey, Michigan

CREDENTIALS

Society of Correctional Physicians – 2011
Certified Correctional Healthcare Professional (CCHP) – 2009
Fellow – American College of Physicians - 2009
Certified - American Board of Internal Medicine – through year 2019
Certified by SAMHSA to administer Subutex and Suboxone

MEMBERSHIPS

American College of Physicians – Society of Internal Medicine
Board Member – Ellington White Project

AFFILIATIONS

National Medical Association
American Medical Association

Sandra Vargas RN,MSN,CCHP

EXPERIENCE

Director of Correctional Services , CFG Health Systems, LLC
Management and oversight of contract sites to accomplish the provision of quality medical care and the accomplishment of fiscal objectives. Provide direct supervision and leadership to Health Service Administrators who are in turn responsible for the delivery of contract services at remote site locations. Accountable for coordinating the delivery of contract services and ensuring those direct reports and their sites are in compliance with all aspects of the client contract.

Health Service Administrator , CFG Health Systems, LLC
Direct and supervise the day-to-day activities of the Health Services Unit and assigned staff for population of 1300 incarcerated inmate population.
Coordinate the healthcare delivery system with other institutional functions.
Develop healthcare policies and procedures.
Provide administrative support for the Medical Director.
Manage the financial performance of the site by evaluating and approving all expenditures and ensure the cost-effective controls without sacrificing the quality of healthcare.

Director of Nursing, CFG Health Systems, LLC
Organized the delivery of nursing care within the corrections environment to achieve quality and efficient utilization of resources.
Worked closely with the Health Service Administrator and recommended nursing programs, budget and assignment of nursing and support staff to meet the needs of the institution.

Staff Registered Nurse/ Medical Intensive Care Unit, Robert Wood Johnson University Hospital
Performed a comprehensive range of clinical functions for a 16-bed medical
Intensive Care Unit.
Responsibilities include charge nurse and acute care of critically ill patients.

Per Diem Registered/ Medical Intensive Care Unit, Robert Wood Johnson University Hospital

Department: Respiratory Intensive Care Unit, Newark Beth Israel Medical Center
Staff Nurse responsible for direct care of critically ill patients

EDUCATION

University of Medicine and Dentistry - Middlesex County College
Associate Degree in Science - Nursing Major - New Jersey State Registered Nurse
Thomas Edison State College
Bachelors of Science in Nursing
South University
Masters in the Science of Nursing

MEMBERSHIPS/CERTIFICATIONS

New Jersey State Nurses Association (NJSNA)
National Commission of Correctional Healthcare (NCCHC/CCHP)

American Jail Association (ACA)
Mid-Atlantic State Correctional Association (MASCA)
ACLS/BLS

Denise R. Rahaman, MBA, BSN, CCHP-RN

PROFESSIONAL EXPERIENCE

Operations Director for Corrections, CFG Health Systems, LLC
Responsible and accountable for the overall management of nursing practice, nursing education, nurse leader professional development, nursing research, nursing administration and nursing services for regional contracts
Ensures that all direct-care service positions at each facility are sufficiently staffed to meet all contract requirements
Ensures that the administrative duties associated with delivering clinical care are performed in an appropriate, correct and timely manner
Provides effective direction, guidance and leadership over staff to foster effective teamwork and motivation while integrating efforts with system-wide initiatives
Develops and implements plans of orientation to ensure proper and adequate training and education for all nurses and related personnel
Coordinates the delivery of care with medical, dental and mental health services in conjunction with the Department of Corrections
Participates in CQI initiatives using methods of quality improvement that support adherence to ACA, NCCHC and other governing body guidelines
Assists in the development, implementation and enforcement of policies, programs and services consistent with CFG's mission
Anticipates potential clinical problems/situations and intervenes to off-set adverse impact
Monitors quality of care of the provision of services through both routine direct observation of staff and through audits
Evaluates quality of managed care and performance of staff
Actively participates in utilization/care management conferences
Develops and conducts educational sessions
Develops and implements a plan of continued professional growth and development for the Director of Nursing staff (DON)
Participates in all regulatory audits, as requested
Monitors the efficient delivery of appropriate, safe and quality nursing care through on-going direct observation and internal audits of documentation (including medication administration and narcotics management)

Regional Nurse Manager, University Correctional Healthcare/UMDNJ

Was hired to manage the intake facility and to be the Assistant to the Nursing Administrator; subsequently assumed the full-time position as Assistant to the Nursing Administrator
Reviewed and revised the Medication Administration Course for Medication Aide Certification
Annually and as needed reviewed and revised the nursing protocols used for nurse sick-call
Reviewed all nursing policies and procedures annually
Served as a member of the Medical Administrative Committee - responsibilities included providing information regarding statutes, regulations etc., that govern nursing practice for the purpose of making decisions about changes in workflow, policies, etc.
Served as a member of both the Pharmacy and Therapeutics and Quality Improvement committees
Covered as Manager for Facilities when managers were out on extended leaves or a position was vacant
Instrumental in preparation of 12 facilities for successful NCCHC accreditation

Coordinated all nursing education functions for over 12 months while the Nurse Educator position was vacant
Was the resource person for Infection Control and Pharmacy when those positions were vacant
Had primary weekly responsibility for reconciliation of Operational Performance Indicator reports with the DOC Health Services Unit

Assistant Program Manager, Mental Health Management
Operations manager for the mental health program of the Philadelphia Prison System, serving almost 9,000 inmates
Had daily responsibility for the provision of crisis intervention and routine follow-up mental healthcare
Developed a tracking tool for all mental health referrals (urgent, emergency and routine) to ensure that inmate-patients were being seen within specified time frames; this led to a compliance rate of over 95 %
Prepared all five facilities for successful NCCHC surveys

Health Services Administrator, Correctional Medical Services

Developed and managed the facility budget and operational plan; duties included management of a budget over $5 million
Monitored contract compliance to ensure that client expectations were met regarding access to care, fiscal responsibility and performance improvement
Ensured compliance with ACA and NCCHC standards and CMS/DOC policies and procedures
Directed the activities of assigned staff in regards to staffing, development and implementation of the quality improvement program, credentialing and education
Met regularly with the DOC Administrator or his designee to affect the liaison of services within the institution
Reported monthly to the Regional Administrator on budgetary items, operations, changes affecting the contract and activities of the Department

Nurse Manager, Philadelphia VA Medical Center
Daily management of two, 30-bed Acute Medical Units; duties included staffing and supervising staff to ensure compliance with JCAHO standards and facility policies and procedures
In role of Co-Chair of Nursing Practice and Standards Committee, spearheaded the process of revising the unit standards of practice in keeping with ANA standards
Assumed the role and carried out the responsibilities of the Associate Director for Patient Care Services during this person's absence
In conjunction with Nursing ADPAC and Inpatient Pharmacy supervisor, developed policies, procedures and training plan for the implementation of a bar code medication administration program
Instrumental in the reorganization and restructuring of Patient Care Services when the organization shifted towards multidisciplinary product lines
Completed revision of LPN Functional Statements in collaboration with the union to expand the roles and responsibilities of LPN staff
Developed and implemented a training program in rhythm recognition for RN staff on the medical unit in anticipation of the implementation of a telemetry program

Per Diem Staff Nurse - Critical Care, NY Hospital/Cornell University Medical Center

Nurse Corp Officer, US Air Force
Incorporated several unit training requirements into the base training day, resulting in a decrease in training time and an increase in aircrew member's availability by 75 man-days per year

Identified deficiencies in the ER and corrected the problems in three months, resulting in the unit receiving the required satisfactory rating from JCAHO (previously lacking)
Expanded the SCU during Operation Desert Storm
Ensured that adequate supplies and equipment were in place
Provided expert care to 14 litter patients; casualties received immediate treatment and expeditious aeromedical evacuation as a result
Adjusted the standard order of aircraft upgrades to enable the maximum number of students to be qualified, given a large influx of students and limited flight availability; resulted in gaining tri-qualified, mission-ready nurses in minimal time
Coordinated the schedules of aircrew and aeromedical crews to enable 100% attendance for and completion of Aircrew Coordination Training XXX
Anticipated the need for additional flight instructors 6 months prior to this becoming a requirement; had individuals selected, trained and ready to instruct in optimal time

Staff Nurse, ICU, Val Verde Memorial Hospital

Staff Nurse, CCU, S/TICU, Erie County Medical Center

EDUCATION

VA Management/Leadership Development Program
Villanova University Post Masters Certificate in Nursing Administration
Boston University MBA
State University of Buffalo BSN

CERTIFICATIONS

CCHP and CCHP-RN certified
NCCHC Surveyor
Stanford University Chronic Disease Self-Management (CDSMP) and Diabetes Self-Management (DSMP) Master Trainer
ACLS and ACLS Instructor (expired qualification)
CCRN Certified (expired)
PALS, ATLS Trained
BATTLEFIELD NURSING COURSE GRADUATE
FLIGHT NURSE INSTRUCTOR/EVALUATOR

PROFESSIONAL AFFILIATIONS

ANA
NYSNA
AACN
NCCHC

James R. Varrell, MD

Chief Medical Officer

PROFESSIONAL EXPERIENCE

Alcoholism Counselor, UMDNJ-Community Mental Health Center, Piscataway, NJ

Alcoholism Counselor, Ancora State Psychiatric Hospital, Ancora, NJ

Research Assistant, St. Peter's Hospital, New Brunswick, NJ

Consultant in General Psychiatry for Graduate Health System, Philadelphia, PA

Psychiatric Emergency Room Physician, Fitzgerald Mercy Hospital, Upper Darby, PA

Medical Director, Child and Adolescent Psychiatry
The Philadelphia Child Guidance Center, Voorhees, NJ

Consultant in Child Psychiatry, Archway Program, Atco, NJ

Consultant in Child Psychiatry, Camden County Youth Detention Center, Lakeland, NJ

Medical Director, New Jersey Division and the DayTreatment Center, The Philadelphia Child Guidance Center, Cherry Hill, NJ

Medical Director, Center for Family Guidance, Marlton, NJ

Consultant, Bancroft NeuroHealth, Haddonfield, NJ

Psychiatric Consultant, Underwood Hospital, Woodbury, NJ

Psychiatrist, Correctional Medical Services, New Jersey Correctional Facilities

Consultant, Lourdes Hospital, Willingboro, NJ (formerly Rancocas)

Consultant, St. Peter's Hospital, New Brunswick, NJ

EDUCATION

BS Dickinson College (Biology), 1985
MD UMDNJ-Robert Wood Johnson Medical School, 1989

CERTIFICATION

American Board of Psychiatry and Neurology, Board Certified in Psychiatry (#42715), 1996
American Academy of Child and Adolescent Psychiatry (#4283), 1996

POSTGRADUATE TRAINING AND FELLOWSHIP APPOINTMENTS

Internship in Internal Medicine, Hospital of the University of Pennsylvania, 1989-1990
Psychiatry Resident, Hospital of the University of Pennsylvania, 1990-1992

Fellowship, Child and Adolescent Psychiatry, The Philadelphia Child Guidance Center, 1992-1994
Chief Resident, Child and Adolescent Psychiatry, The Philadelphia Child Guidance Center, 1993-1994

MEDICAL LEADERSHIP

Founder and Medical Director - Center for Family Guidance (1997-Present)
Development and implementation of psychiatric treatment systems, including inpatient psychiatric units, hospitals, crisis centers, acute settings within correctional facilities, (adult and juvenile), outpatient, school systems, and residential facilities. Additional responsibilities include recruitment and supervision of professional staff and direct supervision of the medical directors within our system as well as participation in the development of quality assurance and utilization review programs.

Medical Director – Friends Hospital, Philadelphia, PA (October 2003 – October 2005)
Medical Director of 192 bed psychiatric hospital and psychiatric crisis unit with duties including management of all staff psychiatrist, oversight of quality improvement and medical performance of all medical staff. Lead efforts for successful Medicare, JACHO, Department of Health surveys. Also integrated Drexel University Department of Psychiatry into the Friends Hospital culture/system.

FACULTY APPOINTMENT

Assistant Clinical Instructor, University of Pennsylvania School of Medicine, 1989-1994
Clinical Instructor, University of Pennsylvania, School of Medicine, 1994-1997
Associate Professor B, University of Pennsylvania, 2001-present
Clinical Instructor Drexel University Medical School, 2003-present

HOSPITAL AND ADMINISTRATIVE APPOINTMENTS

Psychiatrist, Department of Psychiatry, Mt. Sinai Hospital, Philadelphia, PA.
Psychiatrist, Department of Psychiatry, Graduate Hospital, Philadelphia, PA.
Psychiatrist, Department of Psychiatry, Fitzgerald Mercy Hospital, Upper Darby, PA.
Psychiatrist, Department of Psychiatry, Parkview Hospital, Philadelphia, PA.
Medical Director, Voorhees Division, The Philadelphia Child Guidance Center, Voorhees, NJ
Psychiatrist, Department of Psychiatry, Virtua Hospitals, Voorhees, NJ and Virtua Memorial Hospital of Burlington County Mt. Holly, NJ
Psychiatrist, Underwood Hospital, Woodbury, NJ
Medical Director, Day Treatment Center, The Philadelphia Child Guidance Center, Cherry Hill
Medical Director, Center for Family Guidance, Marlton, NJ
Psychiatrist, Hampton Hospital, Turnersville, NJ
Psychiatrist, South Jersey Hospital System, Bridgeton, NJ
Psychiatrist, Voorhees Pediatric Facility, Voorhees ,Marlton, NJ
Psychiatrist, Virtua Hospital Day Program for Children, Virtua Hospital, Camden Division
Psychiatrist, South Jersey Hospital Systems, Bridgeton, NJ
Psychiatrist, Lourdes Hospital, Willingboro, NJ (formerly Rancocas Valley Hospital)
Psychiatrist, Saint Peter's University Hospital, New Brunswick, NJ
Psychiatrist, Friends Hospital, Philadelphia, PA
Medical Director, Friends Hospital, Philadelphia, PA
Psychiatrist, St. Francis Hospital, Trenton, NJ

MEMBERSHIPS IN PROFESSIONAL SOCIETIES

American Psychiatric Association
American Academy of Child and Adolescent Psychiatry

Keith L. Dunoff, D.M.D

PRIVATE PRACTICE

Berlin Plaza Dental Associates

Pleasantville Dental Group

Diversified Dental Services
a.k.a. Keith L. Dunoff, D.M.D., P.A.
a.k.a. Keith L. Dunoff, D.M.D., P.C.

Linked HealthCare Systems, LLC.
Ancillary Medical Services

Consolidated Services Group
PremierePrizm Solutions
Medical Director Review
Consultant: Dental Claim

Bravo-ElderHealth Pennsylvania
HMO
Dental Director

Dental Health Associates, P.A.
Corporate Dental Director,

Philadelphia Soul Arena Football
Team Dentist

Professional Memberships
American Dental Association
New Jersey Dental Association
Academy of General Dentistry
American Society for Geriatric Dentistry
Special Care Dentistry Association
Alpha Omega Dental Fraternity

Community/Public Activities
Jewish Community Center of Southern NJ
Camden County Democratic Committee
Israel Bonds Committee
Cedar Parke-Gateway Communities

TEACHING EXPERIENCE

Dental School
Assisting Training Program
Hygiene Training Program
Lectures to Dental Students
Lectures to Residents

EDUCATION

B.S. Muhlenberg College
D.M.D., University of Pennsylvania School of Dental Medicine
G.P.R., West Jersey Hospital, General Practice Residency

LICENSURE

New Jersey DI14766
Pennsylvania DS 024382 L

HOSPITAL APPOINTMNETS

Our Lady of Lourdes Medical Center, Camden, NJ
Virtua Health System
West Jersey Hospital, Camden, NJ

SPECIAL AWARDS

Honors Program in Pediatrics

MAJOR COMMITEES

Social Programs Dental School

CONSULTSHIPS

Bravo-ElderHealth Plans
Manor Health Services-Cherry Hill
Lion's Gate Community, Voorhees, NJ
Virtua Nursing Rehabilitation-Berlin
Virtua Nursing Rehabilitation-Mt. Holly

CONTINUING EDUCATION

Prosthetic Curriculum Branemark
Dental Implants
Special Care Dentistry Association
University of Minnesota School of Dentistry
Geriatric Dentistry
Lectures presented to Dental Students
UPSDM 1994,95,96,97,98,07
Lectures presented to Residents

WJHS 1993,1994,1995,1996,1997
UMDNJ AEGD 1993

Joel Friedman, PhD

PROFESSIONAL EXPERIENCE

CFG Health Systems, LLC
Current responsibilities include administrative, consultative and supervisory services for; mental health programs in several county jails, a contract to provide all of the New Jersey State Parole Board mental health evaluations, and EAP services. Previously provided oversight for the daily operations of the mental health programs for the New Jersey Department of Corrections. That involved the supervision of mental health staff, program development, policy development, interfacing with Department of Corrections personnel, overseeing the mental health evaluations of correctional officer candidates and coordination of mental health programs with other services and agencies. Coordinates the American Psychological Association approved Continuing Education Program. Develops and presents continuing education activities for mental health professionals. Previously oversaw the daily operations for an outpatient office for CFG.

InterPsych Associates
Management of managed-care and employee assistance contracts. Supervision of both clinical and administrative staff for a mental health system. Provision of clinical services to a wide variety of outpatient clients.

Federal Correctional Institution
Supervision of institution-wide Drug Abuse Treatment Program. Provision of clinical services. Responsible for 24-hour on-call services. Supervision of psychology intern and practicum students.

Private Practice
Completion of reports for disability evaluations for the Department of Social Services.

Fresno Unified School District
Completion of evaluations of students for Individualized Education Programs.
Provision of student counseling and staff consultation services.

Friendship Home
Provision of behavior modification programs.
Participation in program development.
Participation in crisis intervention.

Associated Psychologists Clinic
Provided individual, family and couples therapy. Conducted parenting classes.

California Mens' Colony
Provision of clinical services to inmates at a state prison. Conducted group therapy.
Administered and interpreted psychological test batteries.

Fresno Unified School District
Completion of evaluations of students for Individualized Education Programs.
Provision of student counseling and staff consultation services.

EDUCATION

PhD Clinical Psychology, CA School of Prof. Psychology, 1992
MA Clinical Psychology, CA School of Prof. Psychology, 1989
MA Psychology, The New School for Social Research, 1987
BA Psychology, University of New York at Albany, 198 4

INTERNSHIP

Clinical Psychology Intern, Bellevue Hospital/NY University Medical Center ,1990-1991

PROFESSINAL AFFILIATIONS

American Psychological Association
New Jersey Psychological Association
Member of the Camden County Mental Health Leadership Task Force

LICENSURE

Licensed in New Jersey and Pennsylvania

Dennis H. Sandrock, Ph.D.

Licensed Psychologist

PROFESSIONAL EXPERIENCE

Director of Psychology, CFG Health Systems, LLC, Middlesex County Jail Contract
Responsible for the provision of mental health services at a large county correctional facility. Direct care services include: crisis intervention, intake assessment, individual treatment, and the management of potentially suicidal inmates. Services to the facility also include initial psychological assessments for new correctional officer recruits and civilian applicants to the county facility. Suicide prevention training is provided regularly to correction officer staff.

Regional Director of Mental Health, CFG Health Systems, NJ DOC Contract
Supervise and administrate mental health services in the five central region prisons of New Jersey (NJSP, EMCFW, CRAF, ACWYCF, GSCF). Responsible for both inpatient and outpatient treatment services offered to mentally ill offenders at these sites. Staff training, supervision, program implementation, and quality assurance are specific professional responsibilities. Also provide supervision and support for specialized forensic evaluations done at these sites and off-site (e.g., risk assessments, pre-parole evaluations, fitness for duty evaluations, and correction officer recruit evaluations).

Lead Psychologist and Regional Mental Health Director, CFG Health Systems, LLC, NJ DOC Contract
Functioned as Lead Psychologist for a specific site (EJSP) as well as the Regional Mental Health Director for Northern Region prisons (ADTC, EMCFW, MYCF, NSP). Supported the transition of outpatient mental health services to a new provider (CBS to CFG/CMS). Trained professional staff to complete specialized evaluations (sex offender risk assessments, disciplinary evaluations, correction officer recruit evaluations, reduced custody evaluations, fitness for duty evaluation). Developed and coordinated program documentation to present quarterly to federal court appointed monitors. Provided lead psychologist services as described below.

Lead Psychologist, East Jersey State Prison, Rahway, NJ. Correctional Behavioral Solutions (CBS)
Administrate the Psychology Department in a large maximum security, correctional facility. Perform parole and reduced custody evaluations and specialized risk assessments. Perform evaluations to restore weapons privileges to correction officers who have been involved in domestic violence disputes. Provide individual and group psychotherapy to special needs inmates. Supervise licensed clinical staff in their evaluation/therapeutic duties. Administrate department policies, interface with other institutional departments and chair the CQI effort for the medical department. Provided periodic correctional officer recruit evaluations for NJ DOC.

Elizabeth General Medical Center, Elizabeth NJ ,Coordinator of the employee assistance program at the hospital. Responsible for providing psychological services to hospital staff and their family members (adult and children). Responsible for coordination the services for employees with four other clinicians who staff the program.

Team Leader in the Adult Outpatient Unit. Treat a small caseload of outpatient and biofeedback cases. Psychological assessments are performed on both an inpatient and outpatient basis. Lead a weekly multidisciplinary treatment and provide weekly supervision for junior staff psychologist, social workers, and students.

Senior psychologist at the Family Resource Center, a hospital sponsored therapy center in Cranford, NJ. Responsibilities include individual and family treatment as well as psychological evaluation for the Criminal Case Management program of the Union County Court.

Coordinator of the Student Support Program for the School of Nursing at EGMC. Manage the provision of psychological services to student nurses and their facilities. Provide utilization reports and analysis to document service.

Private Practice
Practicing as a NJ state licensed clinical psychologist (Lic. #2769) in the treatment of adults and adolescents. Individual and couple therapy provided. Specialization in the treatment of psychological trauma and anxiety/panic, as well as sub-specialty of neuropsychological testing. Provide supervision for permit holding psychologist in preparation for their eventual licensure.

Clinical Psychology Internship, APA Approved, Elizabeth General Medical Center
Psychology Intern in the adult track. Two six-month rotations: Partial Hospital and Adult Unit, as well as an ongoing outpatient caseload. Responsibilities included individual and group therapy, psychological testing, and intake interviews.

Project NSTM, Fairleigh Dickinson University
Worked as a behavioral technician in an applied setting providing direct service and training to the caretakers of mentally retarded/behaviorally oriented treatment plans designed to modify a variety of inappropriate behaviors (e.g., aggressive behaviors, tantrums, self-abuse).

Holley Child Development Center For Health Psychology
Practicum placement for doctoral program (10 hrs. per week). Responsibilities involved play therapy and psychological testing of conduct disordered and emotionally disturbed children in a residential setting. Age range of the children was 7 to 14 years old.

Division of Psychological Services, Fairleigh Dickinson University
Practicum placement for doctoral program. Responsibilities involved individual and martial therapy, psychological testing, and intake assessments.

Bristol-Bensalem Human Services Center
Practicum placement for master's program. Responsibilities included weekly individual and family therapy,and intake interviews.

Behavior Therapy Unit, Temple University
Under supervision provided therapy utilization muscle relaxation, assertiveness training, and systematic desensitization.

RESEARCH

Research Committee (Chair, 5/88 to 10/96),Elizabeth General Medical Center
Participate in the evaluation of research proposals for the Department of Psychiatry. Organize and coordinate activities of volunteer research assistants from local undergraduate institutions. Current research projects on violence, earliest memories, and trauma inoculation.
Co-author departmental research on earliest memories and on patterns of substance abuse in psychiatric patients.

Fluent in the use of the system for statistics (SYSTAT) computer packages. Firm conceptual and practical grasps of multivariate analyses, regression and log linear analysis.

Division of Psychological Services, Fairleigh Dickinson University
Worked 10 hours per week as a research assistant. Duties included organizing, coding, and analyzing data for a study designed to assess the efficacy of a stress management program for first year dental students.

Division of Continuing Mental Health Education, Medical College of Pennsylvania
Worked 10 hours per week as a research assistant. Responsibilities included recording, organizing, and analyzing data to assess the impact of various curricula presented to state hospital staff.

Systems Research Unit, Eastern Pennsylvania Psychiatric Institute
Worked 20 hours per week as a paid research assistant. Duties included the organizing, coding, and analyzing data for a study evaluating the functioning of area partial hospital patients. Used mainframe SPSS-X program for statistical analyses.

Temple University
Worked as a volunteer assistant under supervision of psychology professor. Responsibilities included co-leading group experiences and discussing relevant theoretical issues and strategies pertaining to group therapy practice.

TEACHING

Instructor, Union County Police Academy
Teach cadets fundamental topics in stress management, domestic violence, psychological trauma, and suicide. Also provide in-service seminars for active duty officers.

Intern Instructor, Elizabeth General Medical Center
Teach psychology intern special topics in psychotherapy, psychological trauma and a seminar in neuropsychological assessment. Also teach medical students the fundamentals of neuropsychological testing.

Undergraduate Instructor, Fairleigh Dickinson University
Courses taught: Experimental Psychology, General Psychology, Statistics

Division of Psychological Services, Fairleigh Dickinson University
Served as a group, leader and presented first year dental students with both didactic and experiential training in stress management.

EDUCATION

Ph.D. in Clinical Psychology, Fairleigh Dickinson University, 1988
M.Ed. in Counseling Psychology, Temple University, 1983
BA in Psychology, Temple University, 1981

HONORS AND DISTINCTIONS

National Mental Health Association (1993)
New Jersey state media spokesperson for the National Mental Health Association national educational campaign on clinical depression.

National Academy of Neuropsychologist (1988)

Fairleigh Dickinson University (1985)
Passed doctoral comprehensive examinations with distinction.

Temple University (1980, 1981)
Participated in Psychology Honors Research Program

PROFESSIONAL COMMITTEES

New Jersey Psychological Association
Utilization of Professional Services
Committee, Member (1990-1995)

Research Committee, Chair (1990-1996)
Department of Psychiatry
Elizabeth General Medical Center

Psychology Internship Planning Committee, Member (1990-1996)
Psychological Services
Elizabeth General Medical Center

Michael B. Miller, MCSE, CNE, CCNA, CCAI

Chief Information Officer

PROFESSIONAL EXPERIENCE

Chief Information Officer, CFG Health Systems

Technology Consultant, Around the Clock Networks

Chief Technology Officer, Strategic Distribution Inc

Director of Information Technology, New Jersey School Boards Association

Manager of Information Technology, The Cura Group

Principal and Consultant, Computer Services Group

Service Manager, American Appliance

EDUCATION AND ACHIEVEMENTS

Microsoft Certified Systems Engineer (MSCE)

Cisco Certified Network Associate (CCNA)

Cisco Certified Academy Instructor (CCAI)

Certified Novell Engineer (CNE)

A+ Certified Computer Technician (A+)

Barrington University – Bachelor of Science Degree – Computer Science

Montgomery County College – Cisco Networking Academy

Lincoln Technical Institute – Computer and Electronics Servicing Technology Certificate

National Electronics Service Dealers Association – Certified Service Manager

Jeanine P. Miles MS, LPC

PROFESSIONAL EXPERIENCE

Director of Business Development and Marketing, CFG Health Systems, LLC,
Develop and implement various new healthcare/behavioral health programs throughout New Jersey and Pennsylvania including outpatient, school based programs, partial hospital, community based partial care and correctional and juvenile justice programs
Fiscally responsible for multi-million dollar contracts
Responsible for entire organization's public relations and marketing efforts generating growth of over $12 million in patient services and new contracts for organization.
Management of Development including, Grant Writing, Responding to Request for Proposals, and Research.
Management of 8 programs 12 direct program director employees including Staffing, Retention, Program Development, Policy and Procedures
Created and implemented Employee Orientation Guide, Policies and Procedures for entire organization

State Wide Mental Health Director, Correctional Medical Services (CMS)
Developed and implemented new mental health program for 14 state correctional facilities.
Liaison to the NJ State Department of Corrections
State Wide Public Speaking and Education engagements.
Developed and implemented State Wide Policies and Procedures
Budgetary responsibilities, 10 million dollars minimum, Long range planning & CQI
Responsible for overall operations and staffing of approximately 250 Full time equivalents

Director/Director of Clinical Operations, Rainbow Healthcare Associates
Adult Intensive Outpatient Mental Health Program, South Jersey Behavioral Health Resources
Adult Behavioral Health Program, Allegheny – Rancocas Hospital

Managed the development and implementation of partial hospital program from inception including building construction, staffing, training, policies and procedures.
Marketing/Public Relations, Community Education/Public Speaking
Managed Care Contracts/Medicare & Medicaid billing
Budgetary responsibilities/Long range planning
Quality Assurance/Program Evaluation

Executive Director, Danbury Regional Commission on Child Care, Rights and Abuse, Inc
Management of programs and the development of new services.
Grant Writing, Fundraising, Public Relations, and Long-Range planning.
Development of policies and procedures.
Liaison and direct reporting relationship to the Board of Directors.
Managed the development and administration of the annual budget.
Recruitment, staffing, training, retention, employee policies and procedures.

Director of Adult Services, St. Luke's Community Services Inc.
Gilead House
Women's Housing Program and Adult Transitional Living Program

Managed budget of 1.2 million dollars
Managed staff of 30 employees including recruitment, training, staff development and retention.
Managed Grant writing, and overseeing day to day operations of each of the 3 programs.
Budgeting/implementing and coordinating organizations policies and procedures.

Social Worker, Wilton Meadows Health Care Center
Provided social services to the elderly and their families
Conducted individual and group counseling.
Case Management (including Medicare and Medicaid procedures), Admissions and discharges.

Residential Counselor, Options, Mental Health Association of Connecticut
Provided mental health services to individuals with emotional and psychological, and economic difficulties associated with chronic mental illness in a residential setting.
Case Management, Education/ and Training of life skills, Economic Development

Medical Social Worker, Medical Center of Delaware
Assisted patients with emotional, psychological, and economic difficulties associated with serious illness and consequent hospitalization. Provided case management and supportive counseling to patients and families.

EDUCATION

LPC Licensed Professional Counselor
Master of Science, Counseling
Western Connecticut State University, Danbury, CT.
Bachelor of Science, Human Resources , University of Delaware

Michael Panisak

Chief Financial Officer

PROFESSIONAL EXPERIENCE

Chief Financial Officer, CFG Health Systems, LLC
Proactively advise and educate management on all aspects which financially impact CFG's operations
Manages, plans and organizes the financial operations of CFG including financial planning, budgeting, analysis and revenue cycle functions
Develops, interprets, coordinates and communicates policies on finance, accounting, budgeting, insurance, financial/accounting systems, internal controls and auditing
Facilitates organization-wide strategic financial planning and resources allocation
Communicates financial information to Senior Management as well as to Divisional Leadership
Manages CFG's Finance, Accounting and Billing staff
Organizes and maintains an effective system of accounting that is aligned with CFG's strategic plan
Presents recommendations to CFG's management with respect to costs, charges, rates, etc.
Collaborates with Senior Management and Divisional Leadership on the creation and implementation of policies, operations and objectives

Chief Operating Officer/Chief Financial Officer
Responsible for the fiscal operating results, financial statement preparation and administration of accounting practices to the board of directors and Finance Committee
100% increase In EBITDA from prior year and delivered revenue growth of 7%
Managerial responsibility for Accounting, Payroll, Human Resources, Materials Management, Business Office, Reimbursement, HIM, IT, Dietary and Environment of Care
Advise CEO on business strategies, financial models, strategic revenue stream development and tactical partnership identification
Responsible for formulation of operating budget, establishing fiscal responsibility and performance indicators for all department directors
Proactively identify budget variances and recommend effective solutions to improve performance
Led HMS IT system implementation
Completed year end audit and restored financial credibility
Establish a month end close process within five business days
Development of daily dashboard and weekly forecasts for management team
Daily rounding on all departments to monitor patient volume and insure appropriate staffing levels
Implementation of internal controls to assure integrity of financial information
Interacting with all levels of staff to ensure management of expenditures and cost effectiveness
Responsible for all aspects of mergers and acquisitions and capital planning
Establish policies and procedures that reflect superior customer service standards and allegiance

Assistant Chief Financial Officer, WVHCS (Division of CHS) Community Health Systems (Fortune 500 Company)
(*392 Bed Hospital, 106 Bed Psychiatric Hospital, 50 Bed Skilled Nursing Facility,80 Unit Retirement Home, Residency Program)* $1B in Revenue

Assistant Chief Financial Officer, Phoenixville Hospital (Division of CHS)
(147 Bed Hospital, 25 Bed Outpatient Surgery Center) $800M in Revenue

Led central financial planning and analysis team supporting CEO, CFO and SVP in acquisition of new hospital and entities
Transformed system from a non-profit to a for profit institution
Shortened month end financial process from 14 to 5 days
Achievement of operational efficiencies in clinical, ancillary and physician practices
Direct supervision of Accounting, Payroll, Materials Management, Business Office, IT and HIM
Assisted in strategic long term planning to meet current and future goals
Prepared financial projections
Identified/corrected financial reporting discrepancies to comply with external regulations
Analyzed departmental operating budgets and conducted monthly meetings with managers
Prepared ROI's for departmental requests assess feasibility of capital expenditures
Conducted review of revenues and expenses to ensure operational efficiency

Corporate Assistant Controller, Blue Mountain Healthcare System, Blue Mountain Healthcare System
(105 Bed Hospital, 24 Bed Psychiatric Hospital, 70 Bed Hospital, 50 Bed Assisted Living) $300M in Revenue
Supervised the fiscal operating results, financial reports and statements of the system
Chairperson of cost containment to ensured proper utilization of financial resources to maintain profitability and enhance revenues without compromising quality of services
Directed, coordinated and motivated staff to ensure established objectives and standards
Directed and supported all activity associated with external auditors
Researched and obtained a $200K grant
Led Siemens IT system implementation

Controller, Palmerton Hospital, PA (Division of Blue Mountain Healthcare System)
(70 Bed Hospital, 50 Bed Assisted Living) $53M in Revenue
Approved all Capital Requests & Purchase Orders prior to processing
Performed due diligence and feasibility study in reference to purchasing bonds
Prepared annual Operational and Capital Equipment Budget
Monitored progress of key metrics
Led Meditech IT system implementation

Assistant Controller, Gans Multimedia
Supervised accounts payable and accounting department
Researched contracts to verify terms and conditions
Coordinated the preparation of journal entries necessary to close the general ledger each month
Prepared financial statements and reconciled bank accounts for multiple companies

EDUCATION
Bachelor of Science, Accounting/Business Administration, Bloomsburg University

Geoffrey C. Boyce

PROFESSIONAL EXPERIENCE

Director of Telepsychiatry, CFG Health Systems, LLC
Launch of sister company within CFG Health Network dedicated to national expansion of telepsychiatry
Development of Virtual Reality clinical tool-suite for internal use and external sale
Joint Venture partnerships for large-scale development and distribution

Partial Owner, Business Strategy Consultant, Manager, Innovative Outdoors, LLC
Business strategy, logistics, and management consulting directly to president of company, helping triple revenues.
Design & Implementation of online platforms for estimation, project management, scheduling, billing and logistics.
Efforts guided rapid expansion into new business line of landscape lighting with 40% margins.

Independent Business Strategy Consulting
Advising president of large mental health services provider on the formation of a joint venture partnership.
Structuring the launch of an innovative virtual reality product for mental health therapy.

Project Manager, Land Acquisition Intern, Morsberger Group
Sales and Acquisitions Manager for Gwinnett County operations in improved property and raw land.
Pre-Construction management of 4-story, 32 unit mixed-use condo and townhome development in Lawrenceville
Pre-Development team of Ponce Park Redevelopment Project.
2 million of warehouse conversion into 1,200 condos and 300,000 sf commercial along Atlanta's Beltline.

ADDITIONAL EXPEREINCE

Atlanta Charter School: Smile Inc
Member of business plan team and start-up advisory board to found an elementary charter school within the Atlanta Public School system to serve underperforming students from low socio-economic backgrounds.

109 Cherry St, LLC
Founder and Managing Partner of family-run real estate investment vehicle.

Georgia Brain Train Group, University Student Coordinator
Founder of intercollegiate student group working to promote construction of a commuter rail line between Atlanta and Athens. Efforts include: public relations, advertising, polling, community education, and political lobbying.

International Travel
Visited 29 countries on five continents for study, exchange, and vacation.
Fluent in written and spoken French. Conversational Spanish skills.

EDUCATION

MBA, University of Georgia, Major: Business Administration
BA, Furman University, Major: English

Nancy I. Delapo

Director of Staff Development

PROFESSIONAL EXPERIENCE

Director of Recruitment, CFG Health Systems, LLC
Responsible for all recruitment operations for both CFG Health Systems, and Center for Family Guidance. Recruiting Psychiatrist, Psychologist, Psychiatric APN, Internal Medicine MD's. LCSW, LSW,LPC, RN, LPN for Adult Correctional Institutions, Adolescent Residential Programs, Adult Inpatient Units, Partial Day Programs for Children, Outpatient Facilities, Telepsychiatry.

Southern NJ Regional Recruiter, CareOne/Healthbridge
Responsible for overseeing the recruitment process at multiple centers within the southern New Jersey region; assisted in opening new Sub-acute and LTC and Assisted Living facilities for the company; job fairs; write copy for advertising; training to Department Heads on interviewing skills; consult with facilities in the southern region for recruitment strategies and monitor and audit the hiring process; assist facilities in arranging open houses; and develop and foster community relations; oversee the set up of clinical rotation of Nursing students and C.N.A. students for the facilities; assist in the set up of C.N.A. classes at the facilities.

Recruitment Coordinator, Genesis Elder Care
Responsible for overseeing the recruitment process at multiple centers within the southern new Jersey region; organize and coordinate job fairs; advertise and market Genesis Elder Care; consult with facilities in the southern region for recruitment strategies and monitor and audit the hiring process; oversee the recruitment –retention recognition committee; assist facilities in arranging open houses; and develop and foster community relations.

Director of Recruitment, Inglis House
Responsible for the daily activities of the recruitment process at a 289 bed long-term care facility including participation in job fairs and workshops, interviewing, updating job descriptions, overseeing background checks drug testing, and sending offer letters; ensuring compliance with all state and federal regulation; developing methods for meeting budgeted staffing needs for the entire organization; conduction new employee orientation program; planning and overseeing the employee recognition program

Nursing and Allied Health Recruiter, North Philadelphia Hospital
Responsible for the recruitment and retention of nursing and allied health professionals; managed advertising campaigns; job fairs, and orientation programs; chaired nursing retention committee.

New Era Nursing Kennedy Health System
Responsible for the recruiting and retention of nursing professionals; conducted job fairs and orientation programs.

Charge Nurse, LPN, Bay Pines Veterans' Medical Center
Provided nursing care to the medical surgical unit, ICU unit and to the long-term unit; coordinator of the pacemaker and cardiology clinics.

United States Army Reserves
Chief Ward Master and Recruitment and Retention Officer
Managed the 349th Combat Support Hospital, oversaw three hundred nursing personnel; responsible for the recruitment and retention of the nursing personnel.

EDUCATION

Tomlinson School of Nursing, LPN, 1965
United States Army Academy, 1980
United States Army Management and Leadership Institute, 1981
Certification in Professional Human Resources Management, Villanova University, 1998

CONTINUING EDUCATION

Interviewing people, Certificate earned, 1992
Developing Effective Employee Orientation, Certificate earned, 1994
Human Resources Challenges for Health Care Recruiters, Certificate earned, 1994
Fundamentals of personnel Law, Certificate earned, 1997
Creative Training Techniques , Certificate earned, 1997
Internet Skill for Health Care providers, Certificate earned, 1999

PROFESSIONAL AFFILIATIONS

New Jersey Association of Health Care Recruiters, Member, Membership Chairman, President Elect, President.
Mercer County LPN School Advisory Board.
Philadelphia health Care Recruiters, Member; former president, Vice-President, and Treasurer.
Hospital Managers' Association of Pennsylvania, member; former president, Vice-President, and Secretary.
Philadelphia job Corps-Community Relations Council Advisory Committee.
Temple University Certified Nursing Assistants Health Care Advisory Committee.
National Association of Health Care Recruiters, Member.
Drexel University, Adjunct Professor-"The Drexel Experience

Matthew C. Konstance

Director of Human Resources

PROFESSIONAL EXPERIENCE

Directing and leading the overall activities of meeting the Human Resources related needs to the organization and its staff.
Development, implementation and coordination of Human Resources policies, procedures and practices.
Provision of strategic planning advice and counsel to Senior Management.
Staff recruitment, initial screening and hiring activities.
Ensuring that employer is compliant with all Local, State and Federal Regulations
Organization and conducting of new hire orientations.
Negotiation with insurance brokers to obtain the most cost effective benefits packages and presentation of options to staff.
Labor Relations, Negotiation of Collective Bargaining Agreements, Benefits enrollment and counseling.
Counseling of managers on matters of coaching and progressive discipline.
Reporting work related illnesses/injuries to Worker's Compensation carrier, monitored trends & patterns and took proactive steps to implement preventative polices and procedures
Conducting Employee Relations investigations to provide resolution to staff and management.
Performance of salary/wage comparisons and recommending adjustments for positions compensated below market-level.
Approval of merit increases permitted within budgetary limits and according to pay policies.
Recorded and reported Affirmative Action and Equal Employment data.
Conducting of exit interviews to determine reasons for resignations and based on the information obtained, implements changes or recommends changes to increase retention.
Sat as Chair of a staff development committee responsible for reducing employee turnover, determining the need for internal & external trainings and facilitating methods of employee recognition & appreciation.
performance and achievements.

Director of Human Resources, Center for Family Guidance, P.C. /CFG Health Systems, LLC

Director of Human Resources, Southern Jersey Family Medical Centers, Inc.

Director of Human Resources, The Lester A. Drenk Behavioral Health Centers, Inc.

Broker Commissions Coordinator, Independence Blue Cross

EDUCATION

Master of Science in Human Resource Management, Holy Family College
Bachelor of Arts in Management/ Marketing, Holy Family College

ORGANIZATIONS

Society for Human Resources Management (SHRM)
Board of Directors, Medford Lakes Colony Club

Stephen D. Holtzman

Holtzman & McClain, P.C.

PROFESSIONAL EXPERIENCE

Partner, Holtzman & McClain, P.C.
All phases of complex litigation (defense for carriers), including medical malpractice, Federal Civil Rights, products liability, slip and fall, automobile, commercial and construction; and Matrimonial

Partner,Lally, Holtzman, Gilligan & Quasti, P.C.
All phases of complex litigation (defense for carriers), including medical malpractice, Federal Civil Rights, products liability, slip and fall, automobile, commercial and construction; Matrimonial; General Real Estate and Commercial matters.

Partner/Associate, Montano, Summers, Mullen, Manuel, Owens & Gregorio
Atlantic County Office

Partner/Associate, Todd, Gemmel, Nugent & Fitzgerald

EDUCATION

Cleveland-Marshall College of Law

Board of Governors Moot Court, National Mock Trial Competition
Cleveland-Marshall College of Law Scholarship

Rutgers College, New Brunswick, New Jersey

Omicron Delta Epsilon (Economic Honor Society)

QUALIFICATIONS

Admitted to New Jersey and United States District Court,
District of New Jersey 1979;
Pennsylvania 1984;
Third Circuit Court of Appeals
United States Supreme Court
New Jersey Superior Court Appointed Mediator

ASSOCIATIONS

American Arbitration Association
Atlantic County Civil Automobile Program

Atlantic County Bar Association, New Jersey Defense Association
The Association of Trial Lawyers of America

Jan David Segal, PH.D.

PROFESSIONAL EXPERIENCE

Center for Family Guidance, Marlton, NJ, Licensed Psychologist
Conduct assessments for suicide risk of newly admitted inmates at a county jail setting and provide other mental health services as needed; provide pre-employment psychological evaluations for persons applying to become law enforcement officers and fitness for duty employment evaluations.

Center for Family Guidance, Marlton, NJ, Parole Project Manager
Manage contract for provision of mental health parole evaluations for New Jersey Department of Corrections including hiring, training and reviewing clinician performance; coordination of administrative support services; overseeing quality assurance review process, and serve as liaison between CFG and host agencies. Licensed Psychologist; Conduct assessments for suicide risk of newly admitted inmates at a county jail setting and provide other ongoing or consultative mental health services; provide pre-employment psychological evaluations for persons applying to become law enforcement officers and fitness for duty employment evaluations.

VisionQuest, New Lisbon, NJ, Clinical Director, Program Psychologist
Responsible for overseeing all clinical services to adolescent males and females for a psychiatric residential treatment program in a wilderness setting including from admission through discharge, perform psychological evaluations, supervision of clinical staff, program development, lead a multidisciplinary treatment team, and provide training for all staff.

Private Practice, San Antonio, TX, Licensed Psychologist
Provide individual, marital and family therapy and psychological evaluations to child, adolescent and adult populations in a private practice setting. In addition, offer biofeedback treatment for stress related disorders.

VisionQuest, Uvalde, TX, Consulting Psychologist
Provide psychological services, consultation and staff training at an adolescent residential facility for adjudicated youths.

LaPryor Independent School District, LaPryor, TX, Consulting Psychologist
Provide psychological services to rural district student population as well as consultation to staff on dealing with children with special needs as well as emotional and behavioral difficulties.

Southwest Independent School District, San Antonio, TX, Consulting Psychologist
Provide psychological services to special education student population. Led parent training programs for special needs children.

Crystal City Correctional Center, TX, Consulting Psychologist
Provide clinical and consultative psychological services to inmates in a medium security correctional facility.

Warm Springs Rehabilitation Center, Babcock Outpatient Center, San Antonio, TX, Consulting Psychologist.

Perform psychological evaluations, clinical supervision and consultative services to outpatient rehabilitation population.

Northside Independent School District, San Antonio, TX, Consulting Psychologist
Developed and taught parent training programs for parents of special education and regular education children. Also, trained NISD staff in the implementation of these programs. Developed program for managing aggression in preschoolers in early childhood classrooms.

Hutchings Psychiatric Center, Syracuse, NY, Associate Psychologist
Provided individual and marital therapy and family consultation from a moderately to severely disturbed chronic adult psychiatric population. Also, performed psychological evaluations, psychological autopsies, intake evaluations and consultation as part of an interdisciplinary treatment team.

Dallas Child Guidance Clinic, Dallas, TX, Staff Psychologist, Fellow in Child Clinical Psychology
Provided outpatient individual, marital, family and group therapy and psychological evaluations with outpatient child and adult populations. Area of specialization dealt primarily with physically abused, sexually abused and neglected children and their families. Court testimony and consultation to the Department of Human Services were provided as well as supervision to practicum students.

Association for Behavioral Change, Dallas, TX, Psychology Staff
Provide outpatient therapy and psychological evaluations to child and adolescent outpatient population.

Connecticut Valley Hospital, Clinical Psychology Intern
Provided individual and group psychotherapy and psychological evaluations with a chronic adult inpatient psychiatric population. Participated as a member of treatment teams on admission and brief treatment units which included intake interviewing, diagnosis, case and ward management and consultations to other ward personnel.

Outpatient Mental Health Department, Bristol Hospital, Clinical Psychology Intern
Provided individual psychotherapy and psychological testing to an adult outpatient population.

TEACHING/TRAINING
Clinical Assistant Professor, University of Texas Health Services Center at San Antonio
Taught biofeedback treatment to family practice residents

Adjunct Faculty, Chapman College
Taught graduate level courses in psychological assessment, psychopathology and research methods

Co-led and coordinated monthly seminar on current issues in mental health for psychiatry residents and psychology interns at Connecticut Valley Hospital

Denton County Safety Education Program, Denton, TX, Director of Training
Responsible for training, administrative and instructive functions regarding a course for DWI offenders as well as serving as a liaison to the probation department.

CLINICAL TRAINING

Psychology Clinic, University of North Texas, Denton, TX,Student Clinician
Provided individual, family, marital and group psychotherapy to child and adult outpatient populations as well as performing psychological evaluations.

Counseling and Testing Center, University of North Texas, Denton, TX, Student Clinician
Provided individual and group psychotherapy to a university population.

St. Joseph's Hospital, Philadelphia, PA, Medical Social Work Intern
Provided interviewing, evaluation general hospital inpatient caseload, on-call coverage of the emergency room and some counseling with their alcohol rehabilitation program.

Otsego County Training Center, Oneonta, NY, Recreational Therapy Intern
Coordinated recreational activities for multiply-disabled adults attending a sheltered workshop.

EDUCATION

University of North Texas, Denton, TX; Doctor of Philosophy
State University of New York at Oneonta, NY; Bachelor of Science (Psychology)

LICENSES

Licensed as a Psychologist in the State of New Jersey since 4/2000 (SI-3795)
Licensed as a Psychologist in the State of Texas from 1986-2001

PUBLICATIONS

Segal, J.D. & Campbell, V.L. (1986). Bulimia: The salience of past anorectic-like behaviors. Paper presentation at the annual convention of the Southwestern Psychological Association, Fort Worth, TX.

Sterling, J.W. & Segal, J.D. (1985). Anorexia nervosa in males: A critical review. International Journal of Eating Disorders, 4, 559-572.

Segal, J.D. & Weinberg, R.S. (1984). Sex role orientation and competitive trait anxiety. Journal of Sport Behavior, 17, 153-159.

Sterling, J.W. & Segal, J.D. (1983). Anorexia nervosa in males: A Critical review. Paper presentation at the annual convention of the Southwestern Psychological Association; San Antonio, TX.

Maasi Shamilov, MD

PROFESSIONAL EXPERIENCE

Associate Medical Director, Center for Family Guidance, PC, Marlton, NJ

Child adolescent and Adult Psychiatrist, Rainbow Health Care Associates
Inpatient, outpatient hospital programs as well as consultations.

Psychiatrist, "Choices" Mental Health Clinic, Rego Park, N.Y.

Psychiatrist, The Holliswood Hospital , Queens, N.Y.

Physician Assistant, Pain Treatment Center, Queens, N.Y.

Psychiatrist, Regional Health Center in District Hospital, Nalchik, Russia

EDUCATION

Kabardino Balkarian State University, Medical Faculty, Nalchik, Russia

POSTGRADUATE TRAINING

Schneider Children Hospital, Long Island Jewish Medical Center
New Hyde Park, NY, Fellow in Child and Adolescent Psychiatry

Cooper Hospital/University Medical Center, Camden, N.J., Resident in Psychiatry

Raritan Bay Medical Center, Perth Amboy Division , Resident in Internal Medicine

Psychiatric and Neurological Hospital, Nalchik, Russia

CERTIFICATIONS

Board Certified in General Psychiatry
Board Certified in Child and Adolescent Psychiatry

LICENSURE
New York
New Jersey

MEMBERSHIPS

American Psychiatric Association
American Academy of Child and Adolescent Psychiatry

HOSPITAL AND ADMINISTRATIVE APPOINTMENTS

Lourdes Medical Center of Burlington County
Virtua West Jersey
N.J. State Prison System
South Jersey Health Systems
Underwood Memorial Hospital
Group Home for Boys
Camden County Correctional Facility
Saint Peter's University Hospital
Mercer County Correctional Center
Middlesex County correctional Center
Saint Francis Medical Center
Atlantic County Justice Facility
Monmouth County Jail
Virtua Memorial Hospital of Burlington County
Atlantic City Medical Center

Peter Brancato Jr., MD

PROFESSIONAL EXPERIENCE

Center for Family Guidance

Shoreline Behavioral Health

Advance Provider System Advance Psychological Assessment

Private Practice

Hampton Hospital

Fair Oaks Hospital

Bellevue Hospital

Private Practice

Ellwood City Hospital

EDUCATION

Queens College
University of Pennsylvania, Medical
Montefiore Hospital, Internship
New York Universiry, Residency
New York University, Fellowship

LICENSURE AND CERTIFICATIONS

NJ and PA
American Board of Psychiatry & Neurology – Psychiatry
American Board of Psychiatry & Neurology - Child

Rajalla Prewitt, MD

PROFESSIONAL EXPERIENCE

Center for Family Guidance
Drexel University
PATH
Veteran's Administration Medical Center

EDUCATION

John Carroll University
Ohio State University College of Medicine
University of Cincinnati, Residency
University of Cincinnati – Children's Hospital and Medical Center, Teaching Appointments

LICENSURE AND CERTIFICATIONS

NJ and PA
American Board of Psychiatry & Neurology – Psychiatry
American Board of Psychiatry & Neurology – Child and Adolescent Psychiatry
American Psychiatric Association
South Jersey Medical Association

Stan Malkin, Ph.D.

Licensed Psychologist

PROFESSIONAL EXPERIENCE
Mental Health Director, CFG Health Systems

Regional Clinical Director, CFG Health Systems

Clinical Director, Rossi Psychological Group

Organizational Effectiveness Consultant, AT&T Bell Laboratories

Private Practice, Scotch Plains, NJ

Clinical Director, Outpatient Recovery Centers

Consulting Psychologist and Clinical Supervisor, Outpatient Recovery Centers

Vice President and Clinical Director, Human Concepts

Director of Psychology and Internship Training Director, Essex County Guidance Center

CLINICAL INTERSHIPS
New York University Medical Center
United States International University Academy of Clinical Psychology Internships

EDUCATION
PH.D. United States International University
M.A. Goddard College
B.A. Fairleigh Dickinson University

PROFESSIONAL AFFILIATIONS
American Psychological Association
New Jersey Psychological Association

SPECIAL CERTIFICATIONS
Certified Addictionologist, American Psychological Association
Certified Clinical Supervisor, NJ Psychology Internship Programs

Stephen Neff, APN

PROFESSIONAL EXPERIENCE
Center for Family Guidance, PC
Friends Hospital

EDUCATION
Wake Forest University
University of Pennsylvania

HOSPITAL AFFILIATIONS
Virtua West Jersey
Lourdes Medical Center of Burlington County
Virtua Memorial
South Jersey Hospital
Virtua Berlin Rehab
Lourdes Specialty Hospital of Southern New Jersey
Underwood Memorial Hospital

MEDICAL LICENSURE
New Jersey

SPECIALTIES
Board Certified – American Nurse Credentialing Center

James G. O'Quinn, D.Min., CSOTP

PROFESSIONAL EXPERIENCE

MHM-Services, Inc. Delaware Special Treatment Program (Lead Counselor)
Lifeline Counseling Associates, Inc.
United Methodist Minister in the Virginia Conference
Case Manager, Chesterfield County Community Corrections and Pre-Trial Services
United Methodist Minister in the North Alabama Conference

PROFESSIONAL TRAINING

Certified Sex Offender Treatment Provider (CSOTP # 0812-000102)
Department of Health Professions, Board of Psychology, Commonwealth of Virginia
Abel Assessment for Sexual Interest (AASI-2)
Assessing and Treating Personality Disorders (Certificate)
Personality Assessment with the MMPI-2 (Certificate)
Sex Offender Re-Offense Risk Prediction (ASSECT Certificate)
Assessing Individuals Charged with Sexual Crimes (ILPPP Certificate)
Risk Assessment of Sexually Violent Predators: Dynamic Risk Factors in Sexual Offender and Sexually Violent Predator Risk Assessment (ILPPP Certificate)
Sex Offender Evaluation and Treatment Training. (ASSECT Certificate)
Testing and Clinical Evaluation of Psychopathy using the PCL-R (Certificate)Certified Domestic Violence Counselor (Level IV Certificate)
Diplomate - National Board of Forensic Counselors (Certificate)
Working with Men who Batter. (Certificate)
Domestic Abuse Intervention Project, Duluth, Minnesota
Conflict Meditation and Intervention Procedures. (Certificate)
Pastoral Counselor appointed by the Virginia Conference, The United Methodist Church
Endorsed by United Methodist Endorsing Agency, General Board of Higher Education and Ministry
The Diana Screen (designed for measuring sexual interest in clergy)
Working with Perpetrators of Clergy Sexual Misconduct. (Certificate)

EDUCATION

Doctor of Ministry (D.Min.), United Theological Seminary
Master of Divinity (M.Div.), Candler School of Theology, Emory University
Bachelor of Arts (B.A.), Birmingham-Southern College

Elton John Smith M.D.

Staff Psychiatrist

PROFESSIONAL EXPERIENCE

Center for Family Guidance, PC
765 East Route 70 Bldg. A
Marlton, NJ 08053
07/02/2007 – Present

National Association for the Treatment and Prevention of Substance Abuse
Philadelphia, PA

CATCH Inc.
Philadelphia, PA

Elton J. Smith MD Private Practice
Wilmingon, DE

Friends Hospital
Philadelphia, PA

AFFILIATIONS

Lower Bucks Hospital
Atlantic City Medical Center
Warren Hospital
Friends Hospital
St. Peter's University Hospital
South Jersey Hospital
Underwood Memorial Hospital
Hackettstown Regional Medical Center
Kennedy Health System
Lourdes Medical Center of Burlington County
Somerset Medical Center
St. Mary's Medical Center
St. Clare's Hospital
St. Francis Medical Center

EDUCATION

Xavier University of Louisiana
Morehouse School of Medicine
Temple University Hospital (Residency- Psychiatry)
Thomas Jefferson University (Fellowship: Child Psychiatry)

LICENSES
Delaware, New Jersey, Pennsylvania

BOARD CERTIFIED
American Board of Psychiatry and Neurology: Psychiatry
American Board of Psychiatry and Neurology: Child Psychiatry

Amit Pramodrai Kurani M.D.

Staff Psychiatrist

PROFESSIONAL EXPERIENCE

Center for Family Guidance, PC
765 East Route 70 Bldg. A
Marlton, NJ 08053
07/02/2007 – Present

Pediatrics in India and USMLE exams I and II

State Government Medical Office of India

AFFILIATIONS

South Jersey Hospital
The Chester County Hospital
St. Peter's University Hospital
Underwood Memorial Hospital
Somerset Medical Center
Hackettstown Regional Medical Center
Atlantic Center Medical Center
St. Francis Medical Center
Reading Hospital and Medical Center
Kennedy Heath System
Lourdes Medical Center of Burlington County

EDUCATION

Mithibai Cchauhan Institute of Science
Topiwala National Medical College, Mumbai Central MBBS
BYR Nairr Hospital, Mumbai, India (Internship)
UMDNJ Newark, NJ (Residency)

LICENSES
Delaware, New Jersey, Florida, Pennsylvania

BOARD CERTIFIED
American Board of Psychiatry and Neurology

Rosilyn T. Smith M.D.

Staff Psychiatrist

PROFESSIONAL EXPERIENCE

Center for Family Guidance, PC
765 East Route 70 Bldg. A
Marlton, NJ 08053
07/02/2007 – Present

Gaudenzia, Inc.
Philadelphia, PA

Community Education Center
Philadelphia, PA

WES Health Center
Philadelphia, PA

Community Council MH/MR
Philadelphia, PA

Plateau Mental Health Center
Cookeville, TN

Hanemann University Hospital
Philadelphia, PA

Community Council MH/MR
Philadelphia, PA

AFFILIATIONS

Virtua West Jersey Medical Staff Office
Memorial Hospital of Salem County
Underwood Memorial Hospital
Hackettstown Regional Medical Center
Kennedy Health System
Lourdes Medical Center of Burlington County
South Florida Baptist Hospital
St. Mary's Medical Center
St. Clare's Hospital
St. Francis Medical Center

EDUCATION

Winston-Salem State University
Wake Forest University Medical School
Eastern Virginia Medical School (Internship: Family Medicine)
Hahnemann University Hospital (Residency)

LICENSES
Delaware, New Jersey, Pennsylvania, Virginia, Tennessee, North Carolina, Florida

BOARD CERTIFIED
American Board of Psychiatry and Neurology: Psychiatry

ASSOCIATIONS
American Psychiatric Association

Christina Vaglica M.D.

Staff Psychiatrist

PROFESSIONAL EXPERIENCE

Center for Family Guidance, PC
765 East Route 70 Bldg. A
Marlton, NJ 08053
07/02/2007 – Present

Center Nassaeu Guidance & Counseling Center- PR05 Program
Brentwood, NY

AFFILIATIONS

The Chester County Hospital
St. Mary's Medical Center

EDUCATION

Hofstra University
New York College of Osteopathic Medicine
North Shore-Long Island Jewish Health System-Zucker Hillside Hospital (Residency)
North Shore-Long Island Jewish Health System-Zucker Hillside Hospital (Fellowship)

LICENSES
Delaware, New Jersey, Pennsylvania, Virginia, North Carolina, Missouri, New York, Michigan

BOARD CERTIFIED
American Board of Psychiatry and Neurology: Psychiatric Mental Health
American Board of Psychiatry and Neurology: Child and Adolescent Psychiatry

BRUCE R. LORENZ, CADC, NCAC II
20505 Dupont Highway
Georgetown, Delaware 19947
(302) 856-1835
blorenz@thresholdsinc.com

EMPLOYMENT:

May '85 to Present Director, Thresholds, Inc. (Director of Treatment Services until 1997.)

Responsible for the operation of a comprehensive outpatient treatment program. Administrative and management responsibilities, and clinical oversight for the entire operation.

May '83 -June '85 Clinic Director, Bureau of Alcoholism and Drug Abuse, Georgetown, Delaware

Managed full-service drug and alcohol counseling clinic. Responsible for staff supervision, clinic maintenance, liaison with criminal justice and treatment agencies. Also responsible for clinical supervision.

September '79- May '83 Clinical Supervisor, Bureau of Alcoholism and Drug Abuse, Georgetown, Delaware

Supervised professional staff of 6 counselors in delivering a full range of drug and alcohol counseling services. Responsible for clinical oversight of 150 outpatient, 10 inpatient clients, personnel selection, training and evaluation. Developed staff orientation and training package which was later implemented bureau-wide.

February '79 August '79 Counselor, Bureau of Alcoholism and Drug Abuse, :Dover, Delaware

Screened and evaluated clients for drug/alcohol abuse, and referred for appropriate treatment. Provided individual and group counseling and education. Responsible for case management, maintaining project records, and court/treatment program liaison.

1974-1981: Counselor, People's Place II
Milford, Delaware

Practice included marriage, family, group, and individual counseling with emphasis on personal and educational problems of adolescents.

EDUCATION:

Delaware State University, B.S. in Psychology
University of Delaware, graduate study in counseling.

OTHER EXPERIENCE:

2002-Present NAADAC Bylaws Committee Chair

1999-2007 Delaware Certification Board, Member and Treasurer.

1998-2000 NAADAC Executive Committee , Secretary to the Board of Directors of the National Association of Alcoholism and Drug Abuse Counselors.

1996-Present Associate Member, Governors Advisory Council to the Division of Alcoholism Drug Abuse and Mental Health.

1995-1999 Member, National Standards Workgroup, Participated in the development of a set of national standards for the practice of addiction counseling. Coordinated an overlay of the standards with the competency-based credentialing processes at the national and state levels.

1992-1998 NAADAC Certification Commission, Served as Chair of this national certifying body. Developed and implemented a process to certify professional and advanced level addiction counselors. Included in this work was the establishment of standards of professional practice, maintenance of written testing protocols, liaison with state and national credentialing bodies.

1990-1992: Regional Vice-President, Mid-Atlantic Region, National Association of Alcoholism and Drug Abuse Counselors. Served as liaison between member states and the national association governing body.

Resume of
SUSAN M. HARRIS
P.O. Box 119
Georgetown, DE 19947
Phone: (302) 228-6537

EXPERIENCE:

June, 1992 to Present: Thresholds, Inc., Georgetown, Delaware. Progressive responsibilities within this organization as follows:

1992 to 1997: Counselor/Clinical Supervisor: Responsibilities included assessment, treatment planning, individual and group counseling for substance use disorders, along with clinical supervision of 5 to 7 counselors. Also provided in-service training on a variety of topics, and community presentations at local schools and health fairs. Presented a workshop on case management at the 1992 Delaware Association of Alcoholism and Drug Abuse Counselors, Inc., Annual Conference. Have chaired the Quality Improvement Committee, which includes conducting and analyzing date from audits and analyze effectiveness of changes.

1997 to 2000: Drug Court Coordinator: Assumed the responsibility for the management and supervision of Thresholds' Drug Court Diversion and TASC Treatment Program. Responsibilities included assessment, individual and group counseling, and treatment planning for clients referred through the Superior Court Drug Court. Tasks have also included presenting cases in court.

2000 to present: Treatment Services Director: In this position, I have expanded my responsibilities for management and supervision to include the DUI programming operated by Thresholds, Inc. As such, I have implemented bi-weekly peer supervision groups, more effectively utilizing the information gathered from quarterly record reviews. Also achieved accreditation through the Joint Commission on Accreditation of Healthcare Organizations.

November, 1990 to June, 1992: Chrysalis, Inc., Dover, Delaware Program Supervisor: Responsible for program design, funding and implementation. Provided outpatient addictions treatment for adolescents and adults.

January, 1991 to January, 1992: YMCA Resource Center, Dover, Delaware Prevention Specialist: Provided community presentations, on a part-time basis, covering a variety of alcohol/other drug-related topics.

November, 1989 to November, 1990: Turnabout Counseling, Georgetown, Delaware Case Management Supervisor: Implemented a case management/community support program, which included hiring, training and supervising case managers.

July, 1985 to November, 1989: Delaware Drinking Driver Program, Georgetown, Delaware Sussex County Coordinator: Provided administrative management and clinical supervision for a county office with an average monthly census of 150 clients.

EDUCATION:

B.S. in Rehabilitation Education from the Pennsylvania State University (August, 1981).

Over 800 hours of continuing education related to alcohol/other drug dependency issues.

CERTIFICATIONS:

- Certified Alcoholism and Drug Abuse Counselor (CADC), State of Delaware (since 1986).
- Internationally Certified Alcohol and Drug Counselor (ICADC), International Certification and Reciprocity Consortium
- Certified NIATx Change Leader (Network to Improve Addiction Treatment)

PROFESSIONAL ACTIVITIES:

- Delaware Association of Alcohol and Drug Counselors, Inc.: Current board member

- Delaware Alcoholism and Drug Abuse Certification Board, Inc.: Member of the Board of Directors from 1989 to 1996. Held offices of Chairperson and Treasurer.

- Delaware Association for Children of Alcoholics: Held office of Vice-President, 1988-89. Participated in the task force which resulted in the formation of this organization.

- International Counselor Reciprocity Consortium of Alcohol and Other Drug Abuse Counselors: Have been a trained case presentation evaluator since 1989.

- Have presented workshops/seminars at professional conferences on a variety of topics related to treatment of addiction and the certification process.

RESUME

Willard E. Heuser, L.C.S.W., I.C.A.D.C.
49-51 High Street
Port Deposit, Maryland 21904-1724
(410) 378-3633 (h) (302) 750-1888 (c)
Wheuser@aol.com Willard.Heuser@hhinc.org

Willard E. Heuser, L.C.S.W., I.C.A.D.C., was awarded his Bachelors in Elementary Education and Library Science from James Madison and his Master of Social Work from Delaware State. He maintains a private clinical social work practice and contracts to provide consultation, supervision and training. He is an expert witness for the Office of the Public Defender of the State of Delaware and an adjunct professor with Wilmington University and Delaware State University.

EDUCATION:
Delaware State College/University - Dover, Delaware
Master of Social Work –1993

Delaware Technical and Community College - Wilmington, Delaware
Courses included: Psychology, Introduction to Human Services, Principles of Interviewing, Counseling I and II

Madison College/James Madison University - Harrisonburg, VA
Bachelor of Science - 1973
Majors: Elementary Education and Library Science

Credentials:
Licensed Clinical Social Worker – DE license # Ql0000481
Internationally Certified Alcohol and Drug Counselor – DADCCB - #407

EXPERIENCE:
May 2007 to Present
Director CCCP
Horizon House Delaware, Inc.
500 South Madison Street
Wilmington, DE 19801
Provision of supervision and administrative management of the CCCP composed of 3 Psychiatrist, 6 nurses, 4 Directors, 4 Clinical Supervisors, mental health, employment and drug/alcohol specialists, and 25 case managers, in the provision of CCCP services to 450+/- mental health consumers. Responsible for compliance with Medicaid Certification Standards, including both provision and documentation of services.

May 2006 to May 2007
Team Director
Horizon House Delaware, Inc.
500 South Madison Street
Wilmington, DE 19801
Provision of supervision and administrative management of a CCCP team composed of a Psychiatrist, 2 nurses, Clinical Supervisor, mental health, employment and drug/alcohol specialists, and six case managers, in the provision of CCCP services to 140 mental health consumers. Responsible for team compliance with Medicaid Certification Standards, including both provision and documentation of services.

May 2005 to May 2006
Private Clinical Social Work and Consulting

April 2004 to May 2005
Director
NorthEast Treatment Centers
Kirkwood Detoxification Center
3315 Kirkwood Highway
Wilmington, DE 19808
Responsible for all phases of the operation of the sub-acute medically monitored detoxification facility. Ensure adherence to all state and federal laws and regulations, internal and JCAHO standards. Establish, implement and maintain the philosophic basis for treatment services, design programmatic and operational aspects of the program and supervise clinical staff.

October 2000 to April 2004
Director, Residential Services
NorthEast Treatment Centers
Recovery Center of Delaware
P.O. Box 546
Delaware City, DE 19706
Responsible for all phases of the operation of the treatment facility. Ensure adherence to all state and federal laws and regulations, internal and JCAHO standards. Establish, implement and maintain the philosophic basis for treatment services, design programmatic and operational aspects of the program and supervise clinical staff for the Variable Length of Stay, Alternatives and Reflections programs.

May 1997 - October 2000
Unit Manager for Evaluation and Quality Assurance, Licensing and Medicaid Certification
State of Delaware, Division of Alcoholism, Drug Abuse and Mental Health
1901 North DuPont Highway
New Castle, Delaware, 19720
Supervision of the Senior Quality Assurance Operations Specialists as described below.
April 1995 - May 1997
Senior Quality Assurance Operations Specialist

Develop administrative and programmatic policies and procedures, and licensure standards for quality assurance programs. Review and analyze comprehensive organizational, managerial and client treatment data for drug, alcohol and mental health programs, hospitals and treatment facilities. Review and analyze CSP Continuous Treatment Teams, State Service Center Mental Health Clinics, and Group Homes for the Mentally Ill to ensure compliance with Federal Medicaid standards. Work with other divisions and operating departments in the development and implementation of minimum patient treatment standards. Assist in the administration of the Alcohol and Drug Screening and Evaluation Team, ensuring appropriate referral and facilitation of placement of clients in treatment for both mental health and alcohol and other drug abuse. Ensures consistent and uniform client treatment for public and private agencies involved in the DUI programs and administer the DUI referral appeal process. Review requests for proposals, recommend selection of bidder, and provide technical assistance in the implementation of contracts. Provide training and technical guidance to supervisory and management staff in the application and interpretation of applicable laws, rules and regulations.
Provide direct service staff training in clinical documentation of intake, treatment planning, progress note documentation, discharge planning and clinical supervision as well as standards

compliance. Prepare interpretive reports on quality assurance evaluation findings, problems and their causes and recommendations for corrective action, and follow up to ensure corrective action plans are implemented. Conduct special studies of internal or statewide issues regarding the delivery of alcohol and other drug and mental health services.

June 1993 - March 1995
Unit Director
Alternatives Treatment Center
Recovery Center of Delaware/NorthEast Treatment Centers
Governor Bacon Health Center
Delaware City, Delaware, 19706

Overall responsibility for all phases of the implementation and operation of the treatment facility, under the general direction of the Project Director. Ensure adherence to all state and federal laws and regulations, internal and JCAHO standards. Establish, implement and maintain the philosophic basis for treatment services, design programmatic and operational aspects of the program and supervise clinical staff. Conduct client case reviews with individual staff, monitor client progress, have overall authority for all clinical decisions. Facilitate referrals to ancillary agencies. Evaluate clients referred to treatment for appropriateness and clinical necessity as outlined in program operations manual. Review of all client files for accuracy, completeness and therapeutic issues. Conduct direct client services including lectures and community meetings, conduct group and individual therapy sessions as needed. Evaluate, plan and conduct training sessions for staff, approve outside training events. Prepare reports and studies as required. Represent the agency at community and agency functions.

May 1991- June 1993
Counselor II
SENTAC Program/NorthEast Treatment Centers
Recovery Center of Delaware
Governor Bacon Health Center
Delaware City, Delaware, 19706

Provide counseling and education supportive of recovery, to teach life work and leisure adjustment skills. Conduct individual and group therapy sessions. Responsible for documentation, case management services, attend staff meetings and case consultations as required.

1989 – 1992 (Part time concurrent)
Weekend Educator
Glass House Program/NorthEast Treatment Centers
Recovery Center of Delaware
Governor Bacon Health Center
Delaware City, Delaware, 19706

Supervise clients in residential treatment center. Provide family education regarding addiction treatment, family issues, disease concept, and the newly recovering person. Assist with medications as needed, facilitate client education groups, provide crisis intervention as necessary.

1979 - 1991 (concurrent)
Assistant to the President
Independence Mall, Inc.,
Suite 45-B
1601 Concord Pike,
Wilmington, DE, 19803

Assist in day to day operations of Independence Mall as required, including, scheduling and supervising maintenance crews, liaison between tenants and Mall management, trouble shooting, maintenance of payroll time records and public relations.

1983 – 1988
Owner/Operator
Independence Liquors, Inc.
T/A Eagle Liquors
1601 Concord Pike
Wilmington, DE, 19803
Management of medium size retail liquor store grossing $850,000.00 annually.

1975 – 1983
Master Franchisor, Delaware, Maryland, Washington, D.C.
Fred Astaire Dance Studios
1700 Augustine Cut-off
Wilmington, DE, 19803
Opened and operated five dance studios in Baltimore, MD and Wilmington DE, including all phases from site location, design, staff training, scheduling, maintaining all state and federally required records.

1970 - 1975
Assistant Manager
KOA Kampgrounds
General Booth Blvd.
Virginia Beach, VA

1972 – 1973
Teacher - Media Specialist
John F. Kennedy High School
Suffolk, VA

REFERENCES:
References are available upon request.

Joshua T. Warweg, MA, CPRP

joshua.warweg@hhinc.org

1902-A Maryland Avenue, Wilmington, DE 19805 302-655-7108

Mission

To develop and expand mental health and substance use services that support and demonstrate a recovery orientation based on empowerment, choice, respect, illness self- management, and accountability by providing both managerial supervision and clinical support to those programs.

Education

Master of Arts, Thanatology *May 16th, 2009*
Hood College, Frederick, Maryland

Bachelor of Science, Psychology *April 27th, 2007*
Minor, Communications (Concentration in Public Relations)
Florida State University, Tallahassee, Florida

Continuing Education

Certified Psychiatric Rehabilitation Practitioner / CPRP *November, 2011*
United States Psychiatric Rehabilitation Association

Certified Co-Occurring Disorders Professional – Diplomate / CCDP-D
Drexel University College of Medicine - Behavioral Health Education - Anticipated Aug, 2012

Professional Development & Training

Provided and Trained Peer Support Specialists in Death Notification and Post-Crisis Intervention for Sudden and Traumatic Death
Elwyn, Inc.

Developed Training for Supporting Consumers &Provider Staff on Grief
Adult Residential Behavioral Health Services – Elwyn, Inc.

Co-Facilitated Training for Psychiatric Rehabilitation Basics
Adult Residential Behavioral Health Services – Elwyn, Inc.

Attendant at NASMHPD experts meeting on Principled Leadership for Mental Health Program Directors

Institute for Recovery & Community Integration
Training for Supervisors of Certified Peer Support Specialists

National Association for Addiction Professionals
Co-Occurring Disorders Integrated Treatment Series

National Association of State Mental Health Program Directors
Trauma Informed Care

Middle Atlantic States Correctional Association (MASCA)
Member of the Board

Employment History

Admissions Director / Liaison to the Delaware Psychiatric Center &DSAMH
Horizon House Delaware, Inc., Wilmington, DE
(August 2011 – Present)
Coordinated with the State Substance Abuse and Mental Health Services to implement and maintain compliance to the new standards of care as detailed by the USDOJ in the Delaware Settlement Agreement

- Developed non-traditional methodologies to retain individuals in their desired environmental settings
- Coordinated with Treatment Teams for adequate placement and care
- Provided organizational support for the transformation of HHDI services

Program Director/Mental Health Professional, Elwyn, Harrisburg, PA
(July 2009 – August 2011)
Adult Residential Behavioral Health Services Program Director for 16-Bed Maximum-Care Community Residential Rehabilitation Center, serving individuals with Co-Occurring Disorder, and/or Chronic or Persistent Mental Health Diagnoses

- Successfully attained Annual DPW Licensure 2 years consecutively without Citation
- Provided direct clinical oversight to program staff, attaining multiple Recovery-Based Discharges
- Lead of Site-Based Admission Team, interviewing and assessing potential referrals for CRRS placement
- Supported individuals transitioning from In-Patient & Correctional Settings into the community, attaining volunteer, work, and social opportunities as well as successful community living in apartment settings

Program Supervisor/Mental Health Professional, Elwyn, Harrisburg, PA
(*April 2009 – June 2009)*

- Supervised Direct Care Staff Duties, Life-Skills Group, Recovery Group Orientation
- Supported Residents in the development of WRAP and Community Reintegration Initiatives

Behavioral Specialist/Mobile Therapist, NHS Human Services, Carlisle, PA
(May 2009 – July 2009)

- Treatment Plan development and supervision of Therapeutic Staff Support for clinical implementation of Behavioral Modification plans for children and adolescents on the Autism Spectrum

Program Specialist II, Elwyn, Harrisburg, PA
(December 2008 – April 2009)

- Primary Counselor, Provided Assistance with Medication Administration, ADL skill development, Assisted with preparation for Annual Survey

Therapeutic Staff Support, NHS Human Services, Carlisle, PA
(August 2008- March 2009)

- Data Collection & Implementation of Person and Family-Directed Treatment Plans with Behavioral Modification for children and adolescents on the Autism Spectrum

Student Activities Specialist, Hood College, Frederick, MD
(August 2007 – May 2008) 2-Semester Graduate Assistant Position
Graduate Assistantship for start-up position as Advisor to Commuter Life Board

- Supervised Board of Undergrad Students in regards to Recruitment, Budgeting, Programming, Student Advocacy, Advertising and Campus Representation for the 50% of students who lived off-campus

Mental Health Tech/HR Assistant/Pharmacy Tech., Geo Care Inc., Florida
(June 2001 – May 2007)
Atlantic Shores Healthcare, Inc., Pembroke Pines, FL
&
Treasure Coast Forensic Treatment Center, Indiantown, FL
* Began as a volunteer in 1998 to later become an employee in 2001
* Intake Clinic during Nursing Clinicals during Allied Health Sciences program
* Shadowed ARNP's, Psychiatrists, Administration and Direct-Care Professionals

Public Relations / Lead Caterer, Klassic Katering, Tallahassee, FL
(September 2004 – March 2007)
* Planning, Staff Training, Public Relations Opportunities, Services Representative
* Company Received 'Caterer of the Year' recognition twice, during employment

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Christina O'Connor, L.C.S.W., I.C.A.D.C.
4765 Weatherhill Drive – Wilmington, DE 19808
(302) 250-7071

Ms. O'Connor has over twenty- three years experience in the delivery, planning and coordination of Co-Occurring clinical services. She has experience in program direction, clinical supervision and team leadership. In addition to her clinical expertise, she has experience in providing training and supervision.

EDUCATION:
Temple University, Philadelphia, PA
Master of Social Work - 1991

Gwynedd- Mercy College, Gwynedd, PA
Bachelor of Arts, Psychology - 1986

Delaware Technical Community College, Wilmington, DE
Associate Degree, Human Services - 1982

Credentials:
Licensed Clinical Social Worker – DE license # Ql0000528
Internationally Certified Alcohol and Drug Counselor – DADCCB - #590

EXPERIENCE:
8/2005 to Present
Team Director
Horizon House of Delaware, Inc.
Wilmington, DE

Provision of supervision and administrative management of a CCCP team composed of a Psychiatrist, 2 nurses, Clinical Supervisor, mental health, employment and drug/alcohol specialists, and six case managers, in the provision of CCCP services to 155 mental health consumers. Responsible for team compliance with Medicaid Certification Standards, including both provision and documentation of services.

4/2004 to 7/2005
Clinical Director
NorthEast Treatment Centers
Kirkwood Detoxification Center
3315 Kirkwood Highway
Wilmington, DE 19808

Responsible for all phases of the operation of the sub-acute medically monitored detoxification facility. Ensure adherence to all state and federal laws and regulations, internal and JCAHO standards. Establish, implement and maintain the philosophic basis for treatment services, design programmatic and operational aspects of the program and supervise clinical staff.

5/2000 to 4/2004
Director, Reflections
NorthEast Treatment Centers
Recovery Center of Delaware
P.O. Box 546
Delaware City, DE 19706

Responsible for all phases of the operation of the treatment facility specifically designed for treatment of women of child bearing age, pregnant women and their children with substance abuse needs. Ensure adherence to all state and federal laws and regulations, internal and JCAHO standards. Establish, implement and maintain the philosophic basis for treatment services, design programmatic and operational aspects of the program and supervise clinical staff for the Reflections program.

1/1998 to 5/2000
Clinical Director
NorthEast Treatment Centers
Kirkwood Detoxification Center
3315 Kirkwood Highway
Wilmington, DE 19808

Responsible for all clinical aspects of the sub-acute medically monitored detoxification facility. Ensure adherence to all state and federal laws and regulations, internal and JCAHO standards. Establish, implement and maintain the philosophic basis for treatment services, design programmatic and operational aspects of the program and supervise clinical staff.

8/1995 to12/1998
Clinical Supervisor
Catholic Charities
2400 Greenhill Avenue
Wilmington, DE 19805

Trained and supervised staff on all clinical procedures, and ensured practices were in compliance with facility and licensure requirements
Provided therapeutic services for dually diagnosed adults, children and their families

6/1991 to11/1994
Group Psychotherapist/Clinical Coordinator
Caron Foundation
P.O. Box 150
Wernersville, PA 19565

Provided psychotherapy for dually diagnosed clients
Managed caseload of clients which included back-to-work conferences, family sessions, and didactic lectures
Documentation of clients progress, completed in DAP format

2/1988 to 7/1992
Staff Psychotherapist
Addiction Counseling Services
100 High Street
Pottstown, PA

Private practice responsibilities included facilitating individual sessions and psychotherapy groups for dually diagnosed clients and their families

6/1986 to 6/1989
Staff Psychotherapist
Eagleville Hospital
1000 Eagleville Road
Eagleville, PA

Responsible for the delivery, planning and coordination of therapeutic services for drug and alcohol addicted clients.
Facilitated seminars and workshops e.g., treatment planning, ACOA, PTSD, and childhood trauma

APPENDIX A TABLE OF CONTENTS

1. CFG Audited Financials
2. Transition Plan
3. Atlantic County NCCHC Letter
4. Bucks County NCCHC Letter
5. Camden County NCCHC Letter
6. Essex County NCCHC Letter
7. Middlesex County NCCHC Letter
8. Warren County NCCHC Letter
9. Suicide Prevention- Officer
10. Suicide Prevention Training- Medical & Custody Staff
11. Televideo Equipment- Tanberg EX 60 Product Sheet
12. Televideo Equipment - TANDBERG Quick Set C20 Product Sheet
13. Empirical Evidence on the Use of Telepsych
14. Virtual Reality In Psychotherapy Review
15. Letter of Bondability

Element	Task	Issues/Concerns/ Obstacles/Solutions	Assigned To:	DDOC Role	Timeline
Cooperation From Outgoing Vendor					
Cooperation From Outgoing Vendor	Obtain Commitment From Current Vendor to: • Keep Existing Management Team Onsite Until New Contract Starts • Refrain From Terminating Staff Who Make Commitments to CFG • Allow Staff to Speak with CFG Representatives During Their Breaks Without Fear of Reprisals • Retain all relevant records on-site including MAC mtg., CQI, M&M, NCCHC reports, training attendance logs, etc.	It is critical that outgoing vendor commits to and honors the expectation that the existing management team will stay in place up to last day of the existing contract to avoid confusion and potential negative patient outcomes. It is also important that the incumbent's staff should not feel intimidated about speaking with CFG about employment or accepting employment offers. Similarly the outgoing vendors should refrain from disseminating misinformation about CFG, or the contract award in a effort to interfere with CFG's recruitment of existing staff.	CFG/Incumbent	To establish and enforce expectations for the level of cooperation from the outgoing vendor.	Award Date
Cooperation with Current Medical Provider	Provide integrated comprehensive professional services	It is critical that the current medical provider work collaboratively with the behavioral health provider in effort to maintain continuity of care and coordinated integrated services.	CFG/Current Medical provider	To establish and enforce expectations for the level of cooperation from the current medical provider	Award Date
Initial Preparations					
Implementation Team	Identify Implementation Team	Identify Implementation Team, convene Team meetings, Review Implementation Plan and revise as needed, prioritize assignments based on needs, schedule future meetings and determine need for additional resources.	Implementation Team		Award Date to Effective Date of Contract
Program Sites					
Site Review	Prepare Site specific Review	Site visits to all facilities to review current policies and procedures	Implementation Team		Award Date to Effective Date of Contract

Element	Task	Issues/Concerns/ Obstacles/Solutions	Assigned To:	DDOC Role	Timeline
Recruitment					
Staffing	Pre-Award Recruiting	Introduction - CFG has created an Introduction Packet to distribute to current and prospective staff. DDOC Portal on CFG website - A portal specific to existing DDOC Medical Staff has been created for the CFG website and will be launched as soon as CFG is awarded the contract. Ads - CFG has already begun placing non-contract specific ads on-line and in local newspapers & periodicals. Staffing Agencies - CFG has developed relationships with local staffing agencies for interim staffing purposes if needed.	HR/Recruiting/IT	N/A	Award Date to As Needed
	Transition Recruiting	CFG/Subcontractors will establish off-site meeting areas in each region of the State to hold on-site meetings with existing staff, discuss employment & benefits and distribute New Hire Packets. If permitted CFG will hold on-site meetings with staff in designated locations	HR/Recruiting	Grant security clearance for CFG transition team, provide transition team with workspace that is convenient for current staff to visit and allow access to current staff.	Award Date to Effective Date of Contract
	Ongoing Recruiting	Once the remaining staff have been absorbed, CFG/Subcontractors will fill vacancies through continued recruiting efforts (on-line and print advertising, drawing from existing pool of applicants, communication with local educational institutions & vocational schools and job fairs)	HR/Recruiting	N/A	Award Date to As Needed
	Temporary Staffing	CFG/Subcontractor will be able to provide temporary employees from staffing agencies with which it has developed relationships, while focusing its efforts to finding permanent staffing remedies.	HR/Recruiting	Providing temporary staff with security clearance	Award Date to As Needed
	New Hire Processing	Once CFG's/Subcontractor's HR department has received the completed new hire packets from staff, a background check (educational, criminal, employment history) is conducted, Once cleared, a formal offer letter is sent to the employee's home and the employee is processed into CFG's payroll.	HR/Payroll	N/A	Award Date to First Payroll after

Element	Task	Issues/Concerns/ Obstacles/Solutions	Assigned To:	DDOC Role	Timeline
Recruitment (cont)					
Staffing	Transition Management Team	Dedicated CFG healthcare professionals to be identified to the DDOC that will lead the transition of health services	Transition Coordinator		Award to 30 post start
	Transition Staffing	CFG to obtain the staffing schedule with updates to ensure coverage during the transition process to ensure necessary coverage.	Transition Team		Within 14 days of award of notice
Orientation	Clinical Orientation	DDOC healthcare staff and newly hired CFG employees/Subcontractors will need to be oriented to the site specific policies and procedures developed for the facility for effective delivery of healthcare services.	Transition Team	Custody Training Department	Within 60 days of award and on-going
	Staff Orientation to the Facility	CFG Staff/Subcontractors will need to be orientated to the facility procedures	Transition Team	Custody Training Department	Within 45 days of award and on-going
Security Clearance	Establish Process	It is important to establish the most efficient process to obtain security clearance for new staff.	Transition Team	Provide clear guidelines for the process including turn-around times for clearance decisions. Oversight to insure that the process as defined is adhered to by the facilities.	Ongoing through transition
Reports	Outline of Reports of Transition Progress	Progress Reports including: Recruitment, sub-contractors, management plan, supplies, policy and procedures, etc.	CFG		Ongoing through transition
Risk Management					
Program/ Policy Review	Policy Review	Review program site & staff for all insurance, health & safety, workers comp.etc.	Transition Team		Within 45 days of award and on-going
Training	Implement Training	Train Staff in first aid, CPR, Crisis management, fire safety disaster plan etc.	Transition Team		Within 45 days of award and on-going

Element	Task	Issues/Concerns/ Obstacles/Solutions	Assigned To:	DDOC Role	Timeline
Telepsychiatry					
Telepsychiatry	Jointly establish a written telepsychiatry plan	Identify appropriate uses of telepsychiatry. Discuss sites and physical or space limitations or restrictions. Discuss clinical and operational protocols for telepsychiatry. Establish final timeline for telepsychiatry implementation. Establish a format for regular telepsychiatry reports	Telepsychiatry Transition Team and IT	DDOC designate a primary point of contact for telepsychiatry initiative. Engage in discussions and offer feedback on written telepsychiatry plan.	Within 45 days of award and on-going
	Physical Site Surveys	Access to each facility to survey physical setup for equipment and offender encounters	Telepsychiatry Transition Team and IT	Access to facilities and information about internal networking or cabling requirements or restrictions	Within 60 days of award
	Internet Service Surveys	Installations contingent upon successful site surveys that would show availability of adequate bandwidth in the area and plausibility of installing or provisioning existing lines.	Telepsychiatry Transition Team, IT, and local Internet Service Provider	IT Dept and Bureau of Management Services involvement on appropriate internet	Within 15 days of Site Surveys
	Line Installation	Install cable or fiber internet connection for dedicated hardwire installation of video equipment	Local Internet Service Provider, Telepsychiatry Transition team, IT	Approve line installation plan	Within 30 days of internet service surveys
	Equipment Installation	Install dedicated videoconferencing units at each DDOC telepsychiatry site	CFG IT and equipment vendor	IT Dept and Bureau of Management Services involvement on appropriate internet	Within 15 days of line installation
	Telepsychiatry work-flow	Establish a customized workflow diagram for the clinical encounter process at each site	Telepsychiatry Transition Team and clinical leadership at each site	Engage in discussion around workflows that are consistent with overall telepsychiatry project plan	Within 45 days of physical site surveys
	Training (Equipment and Operations)	Provide onsite training to clinical and technical staff that will be involved in delivery of telepsychiatry. Coordination across disciplines	Telepsychiatry Transition Team and clinical leadership at each site	None	Within 30 days of Equipment Installation
	Launch Telepsychiatry Services	Provide 24/7 availability of tele-psychiatrists for psychiatric crises. Conduct routine telepsychiatry services as needed	CFG	None	Within 60 days of contract start date

Element	Task	Issues/Concerns/ Obstacles/Solutions	Assigned To:	DDOC Role	Timeline
Telepsychiatry (cont.)					
Telepsychiatry	Telepsychiatry Regular Reporting	Monthly report including include such things as statistics on the number and type of encounters, issues or concerns with the technology, training updates, significant clinical events, policy and procedure revisions or considerations, and general comments about the efficacy and acceptability of the telepsychiatry program	CFG	Review of monthly reports	Ongoing monthly from Telepsychiatry Launch
Subcontractors					
Substance Abuse	Provide substance abuse programming and maintain continuity of care	Horizon House will participate in recruiting, selecting and training of staff in coordination with CFG procedures as stated above	Horizon House and CFG		Within 45 days of award and on-going
DUI	Establish a new DUI Program	Develop standards as they are critical to the success of the program prior to implementation. The DUI program is a new program for the DDOC system. Threshold will participate in recruiting, selecting and training of staff in coordination with CFG procedures as stated above	Threshold and CFG		Within 45 days of award and on-going
Sex offender Treatment	Provide sex offender programming and maintaining continuity of care	Will provide evaluations for level V and VI institutions and implement new sex offender groups . Will follow CFGs recruitment and training procedures as stated above	Consultant with CFG James G. O'Quinn		Within 45 days of award and on-going
Identification of Special Needs Patients					
Professional Services	Identifying Special Need Patients	CFG will ask to view the most current behavioral health/substance abuse patient list completed within the past six months and obtain a current roster, monthly; to review current treatment plans to ensure continuity of care.	Mental Health Director	DDOC to allow CFG access to medical records and sit through meetings that affect patient care	Within 30 days of award and on-going
		Review current special needs roster (determine acuity levels)/ scheduled services/treatment plans	Mental Health Director Director		Within 30 days of award and on-going
		Review current policies and procedures i.e.: Suicide Watch etc.	Mental Health Director/ Director of Operations		Within 30 days of award and on-going

Element	Task	Issues/Concerns/ Obstacles/Solutions	Assigned To:	DDOC Role	Timeline
Orientation of New Staff					
New Staff Hires		CFG will work with the DDOC to develop a process for potential clients to interview at the correctional facilities	HR/Recruiting/Operations Director	DDOC Role	Within 60 days of award and on-going
	Civilian Transition Orientation	CFG and the DDOC will discuss if there is a current listing of candidates that are not eligible for rehire. Once the security clearances are complete for the DDOC, all new CFG hires will be orientated off-site to CFG Policies, NCCHC Standards and DDOC institutional policies and practices	HR/Recruiting/Operations Director		Within 60 days of award and on-going
		Training will commence for mandatory in-service requirements such as: Suicide Prevention Program/ Sexual Harassment/ CPR training/OSHA/Universal Precautions/ Patient Safety Issues Procedures/Code of Conduct/ Drug Free Workplace/Code of Ethics	HR/Recruiting/Operations Director		Within 60 days of award and on-going
	Custody Orientation	Orientating new CFG staff to the custody environment and institutional programs is en essential component to staff retention. CFG will work with the DDOC to have the required security orientation prior to the start of the contract.	HR/Recruiting/Operations Director	DDOC Role	Within 60 days of award and on-going
Staff Orientation for Existing Personnel		CFG will need to work with the existing staff upon hire to orienting them to CFG polices and procedures.	HR/Recruiting/Operations Director		Within 30 days after start of contract.
Information Technology: Requirements (Non-Telepsychiatry)					
General	Asses IT Need	• Assess site for IT configuration • Identify any connectivity issues relating to facility • Ensure secured portal or internet connection with site • Install software on computers • Identify DOC reporting • Develop formats for reporting • Ensure HIPAA compliance	IT Team		Ongoing throughout transition
Offender Tracking System	Determine Whether CFG's Offender Tracking System Will be Integrated into DACS and/or an EHR or Stand Alone	Enter into discussions with DDOC and with the Medical Provider to determine the best approach to implement CFG's proposed Offender Tracking System. Based on the decisions made, an implementation plan will be developed with task timelines and responsibilities.	IT Team	Assign Appropriate DDOC and Medical Provider Staff to Participate in the Decision Process	Initial Meeting within 30 days of award.

Element	Task	Issues/Concerns/ Obstacles/Solutions	Assigned To:	DDOC Role	Timeline
Quality Improvement					
CQI	Implement CQI Plan	• Implement CQI Plan according to proposal, evidence-based practices & projected outcomes • Implement Building, Vehicle & Fire Safety Inspections • Implement Incident Reporting & Tracking • Implement Compliant & Grievance Tracking • Identify CQI Indicators • Identify Outcome Measures • Include Compliance Plan into operations • Plan audits, compliance reviews & inspections • Develop chart audit protocol • Plan Satisfaction Surveys • Ensure HIPAA program compliance • CQI Plan Completed • Gather and analyze data and outcome measures in order to track quality improvement	CQI Team		Within 45 days of aware and ongoing

1145 W. Diversey
Parkway
Chicago, IL 60614
(773) 880-1460 phone
(773) 880-2424 fax
ncchc@ncchc.org
www.ncchc.org

November 16, 2010

Joseph Bondiskey
Atlantic County Justice Facility
5060 Atlantic Avenue
Mays Landing, NJ 08330

Dear Warden Bondiskey,

Congratulations! The Accreditation Committee of the National Commission on Correctional Health Care (NCCHC), during its meeting on November 12, 2010, voted to continue to accredit Atlantic County Justice Facility for its compliance with NCCHC's *Standards for Health Services in Jails*. Enclosed are the accreditation report and the Certificate of Accreditation.

NCCHC congratulates you on your achievement and wishes you continued success in the future. It is anticipated that the next scheduled on-site survey of the facility will occur sometime prior to October 1, 2013. If we can be of any assistance to you, please feel free to contact us.

Sincerely,

Jennifer Snow

Jennifer E. Snow, MPH, CCHP
Director of Accreditation

Enclosures

CC: Edward A. Harrison, NCCHC President
Cheryl L Dubose, RN

National Commission on Correctional Health Care

Certificate of Accreditation

Bucks County Correctional Facility
Doylestown, Pennsylvania

The above named facility is hereby recognized by the National Commission on Correctional Health Care upon recommendation of its Accreditation Committee to have met all the requirements of accreditation under NCCHC's *Standards for Health Services*.

October 2009

Chair, NCCHC Accreditation Committee

Chair, NCCHC Board of Directors

President, NCCHC

National Commission on
Correctional Health Care

1145 W Diversey Pkwy
Chicago, Illinois
60614-1318

773-880-1460 phone
773-880-2424 fax
www.ncchc.org

November 29, 2011

Warden Eric Taylor
Camden County Correctional Facility
330 Federal Street
Camden NJ 08101

Dear Warden Taylor:

Congratulations! The Accreditation Committee of the National Commission on Correctional Health Care (NCCHC), during its meeting on November 18, 2011, voted to continue to accredit Camden County Correctional Facility for its compliance with NCCHC's *Standards for Health Services in Jails*. Enclosed are the accreditation report and the Certificate of Accreditation.

NCCHC congratulates you on your achievement and wishes you continued success in the future. It is anticipated that the next scheduled on-site survey of the facility will occur sometime prior to October 2014. If we can be of any assistance to you, please feel free to contact us.

Sincerely,

Jennifer Snow

Jennifer E. Snow, MPH, CCHP
Director of Accreditation

Enclosures

cc: Edward Harrison, President
Melanie Julie, Health Services Administrator

1145 W. Diversey
Parkway
Chicago, IL 60614
(773) 880-1460 phone
(773) 880-2424 fax
ncchc@ncchc.org
www.ncchc.org

March 14, 2011

Alfaro Ortiz
Director
Essex County Correctional Facility
354 Doremos Avenue
Newark, NJ 07105

Dear Mr. Ortiz,

Congratulations! The Accreditation Committee of the National Commission on Correctional Health Care (NCCHC), during its meeting on March 11, 2011, voted to continue to accredit Essex County Correctional Facility for its compliance with NCCHC's *Standards for Health Services in Jails*. Enclosed are the accreditation report and the Certificate of Accreditation.

NCCHC congratulates you on your achievement and wishes you continued success in the future. It is anticipated that the next scheduled on-site survey of the facility will occur sometime prior to February 1, 2014. If we can be of any assistance to you, please feel free to contact us.

Sincerely,

Jennifer Snow

Jennifer E. Snow, MPH, CCHP
Director of Accreditation

Enclosures

CC: Edward A. Harrison, NCCHC President
Madaline Bell
Heidi Reifenberg, Coordinator of Monitoring and Evaluation

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National Commission on
Correctional Health Care

1145 W Diversey Pkwy
Chicago, Illinois
60614-1318

773-880-1460 phone
773-880-2424 fax
www.ncchc.org

March 22, 2011

Francesco Russo, MBA
Health Services Administrator
Middlesex County Adult Correction Center
Route 130 South and Apple Orchard Lane
North Brunswick, NJ 08903

Dear Mr. Russo:

Congratulations! The Accreditation Committee of the National Commission on Correctional Health Care (NCCHC), upon receipt of further documentation, voted to continue to accredit Middlesex County Adult Correction Center for its compliance with NCCHC's *Standards for Health Services in Jails*. We will be sending the accreditation report and Certificate of Accreditation next week.

NCCHC congratulates you on your achievement and wishes you continued success in the future. It is anticipated that the next scheduled on-site survey of the facility will occur sometime before October 1, 2013. If we can be of assistance to you, please feel free to call us at any time.

Sincerely,

Scott Chavez

R. Scott Chavez, PhD, MPA, CCHP-A
Vice President

Suicide Prevention and Mental Health Issues

Dennis Sandrock, Ph.D.
CFG Health Systems

Agenda

- Refresh everyone's awareness of suicide and suicide prevention at
- Discuss mental illness at it relates to the management of inmates at
- Let's try to keep it interesting. Your participation will help.

Suicide Rates

- In U.S. General Population*
  - Ideation: 5.6% of U.S. pop per year
  - Attempts: 0.7% of U.S. pop per year
  - Completed: 0.0107% (10.7 per 100,000)

    -- At least 30,000 people/year

(Example of Suicide Prevention Training Program Intended for Custody Staff - Slide # 3)

Suicide Rates

- In Jails: 47 per 100,000 (129 in 1983)
- In Prisons: 14 per 100,000 (34 in 1983)
- In state prisons, suicide was never the leading cause of death, but that rate was also reduced by half over the period 1980 to 1995 and has since stabilized (USDOJ BJS 2005).

(Example of Suicide Prevention Training Program Intended for Custody Staff - Slide # 4)

The First Week in Jail is a Critical Time

- 50% of all jail suicides occur within the first 7 days of confinement.
- 25% of all jail suicides occur within the first 2 days of confinement.

(Example of Suicide Prevention Training Program Intended for Custody Staff - Slide # 5)

Based on your experience as officers

- Who do you think are the high risk cases to hang up?
- If you had your own jail, what kind of suicide prevention plan would you have?
- What are the flaws/loopholes/weaknesses in our facility?

(Example of Suicide Prevention Training Program Intended for Custody Staff - Slide # 6)

Suicide in Prisoners (Risk Factors)

Red items are most associated with risk

- Suicidal Ideation
- Single Cell Occupancy
- Hx of Attempted Suicide
- Current Psychiatric Diagnosis
- Detainee/Remand Status!!
- Psychotropic Medication
- Life Sentence
- Murder/Manslaughter Offense
- Violent Offense
- Alcohol Use Problems

J Clin Psychiatry, November 2008 (34 studies, 4780 suicides)

(Example of Suicide Prevention Training Program Intended for Custody Staff - Slide # 7)

Suicide Screening at _____

- R & D Officers ask screening questions
- Medical Services Screen for Suicidality
- Social Services Staff asks screening questions
- Bail Unit/Crim. Case asks about it.
- All sources can notify/refer to Mental Health
- If you're not sure, refer to mental health

(Example of Suicide Prevention Training Program Intended for Custody Staff - Slide # 8)

Suicide and Mental Illness

Listed Highest to Lowest
for risk of completing suicide

- Previous Attempters
- Polysubstance Abusers
- Major Depression
- Bipolar Disorder
- Schizophrenia
- Alcohol Abusers

(Example of Suicide Prevention Training Program Intended for Custody Staff - Slide # 9)

Part 2: Mental Illness and Jail

- How to manage the increasing population of mentally ill offenders in our correctional facilities.

(Example of Suicide Prevention Training Program Intended for Custody Staff - Slide # 10)

The Path to Correctional Facilities as the New State Hospitals Started Closing in the 1970s

- Rockefeller Drug Laws: Harsher sentences for CDS charges
- Deinstituionalization
- Failure of Community Mental Health Programs and Community Living Arrangements.
- Ease of access into criminal justice system
- Public comfort with confining the mentally ill

(Example of Suicide Prevention Training Program Intended for Custody Staff - Slide # 11)

Incarcerated and Mentally Ill

- **65,000** patients nationwide in state hospitals
- **200,000 to 400,000** inmates nationwide with mental illness
- **5%** of US community population is mentally ill, **8-19%** of IMs have diagnosable mental illness
- **Jails and prisons are the country's frontline mental health providers. (You may not have signed up for this part when you became an officer.)**

(Asst'd Sources)

(Example of Suicide Prevention Training Program Intended for Custody Staff - Slide # 12)

Antisocial Personality Disorder

(This is why we have more behavior problem IMs)

- In The Community:
  - 1% of Females
  - 3% of Males
- In Correctional Settings:
  - 50-70% of incarcerated individuals meet diagnostic criteria for ASP
  - New MH workers are unprepared for managing/treating offenders

(Example of Suicide Prevention Training Program Intended for Custody Staff - Slide # 13)

When should an IM be sent to _____?

- IM makes a serious, life threatening suicide attempt (usually go to hospital first.)
- IM is **excessively** agitated, disorganized, or psychotic.
- IM's physical well being is in jeopardy as a result of mental health symptoms (truly refusing food or essential medical medication.)
- IM continues to try to **seriously** harm self, even after a stint in the restraint chair.
- Any others?

(Example of Suicide Prevention Training Program Intended for Custody Staff - Slide # 14)

Identifying Mental Illness: Based on your experience as officers

- How can you tell if someone is really crazy?
- Who are some of the IMs you think are really, truly mentally ill? How can you tell?
- Who are some of the IMs you think are really not mentally ill? How can you tell?

(Example of Suicide Prevention Training Program Intended for Custody Staff - Slide # 15)

When should an IM not be sent to _____?

- Mild to moderate suicide attempt.
- Throwing or smearing his/her own feces.
- Yelling and screaming with no physical escalation.
- IM says they want to die, but does nothing else.
- Any others?

(Example of Suicide Prevention Training Program Intended for Custody Staff - Slide # 16)

Alternatives to ____ at _____

- Suicide Watch
- Psych Watch
- The Chair
- Medication under protest (Dr. ---has done this once.)
- Referral for Competency Evaluation by Courts (if truly mentally ill will get sent to TPH or AKFC.)

(Example of Suicide Prevention Training Program Intended for Custody Staff - Slide # 17)

'The Chair'

(Example of Suicide Prevention Training Program Intended for Custody Staff - Slide # 18)

When to use 'The Chair'

Can be ordered by custody or MD

- IM becomes physically agitated and disruptive to the point that they are a danger to themselves or others.
- Any others?

(Example of Suicide Prevention Training Program Intended for Custody Staff - Slide # 19)

Usefulness of Restraints

- Who thinks the chair works?
- Who thinks it doesn't work?
- Why?
- Can you remember/identify IMs for which the chair worked? Didn't work?

(Example of Suicide Prevention Training Program Intended for Custody Staff - Slide # 20)

Characteristics of Malingerers

- **Telegraph their intention** (e.g., go to hospital, move to another area, get a phone call, get specific meds)
- If you look you will find a motive; demands and goals are apparent
- Appear non-symptomatic when not aware of being observed
- Look for a **wrong** to make them **right**
- Reported symptoms do not make clinical sense
- Vary widely in their motivation and ability to escalate their behavior

(Example of Suicide Prevention Training Program Intended for Custody Staff - Slide # 21)

Characteristics of Many Seriously Mentally Ill IMs

- Don't want medication
- Want to go to GP, not special housing
- Hide their symptoms/symptoms are obvious
- Care little for their hygiene and appearance
- Alienate other IMs
- Positive response to treatment, medication in particular

(Example of Suicide Prevention Training Program Intended for Custody Staff - Slide # 22)

Mentally Ill with Behavior Problems

- Behavioral disruptiveness is a function of their illness
- Tends to be responsive to medication and therapeutic intervention
- If sent out because of disruptiveness, tends to be a more legitimate referral
- Prolonged confinement and isolation may worsen symptoms
- Too much stimulation increases symptoms in schizophrenia

Managing Mentally Ill Inmates

- Stay neutral
- Use the IM's name
- Give short, simple commands (break it down)
- Don't ask inane questions
- Try not to make fun of the IM
- Maintain the integrity of specialized housing units

Obstacles to Success

- Lack of agreement/communication how to manage IM among Administrative, Custody, Medical and MH staff
- Staff inconsistency or avoidance (different shift commanders or area sergeants)
- Provocation of IM by staff
- Lack of neutrality in managing IM
- Intense, unusual presentation by IM
- Phone call by family or attorney

(Example of Suicide Prevention Training Program Intended for Custody Staff - Slide # 25)

Obstacles to Success (cont'd)

- Lack of physical resources or watch areas
- Fatigue and exasperation with IM and his/her behavior
- Community mental health professionals reinforce the idea of mental illness (they cannot detect feigned symptoms)
- Fear of legal fallout

(Example of Suicide Prevention Training Program Intended for Custody Staff - Slide # 26)

(Example of Suicide Prevention Training Program Intended for Custody Staff - Slide # 27)

Suicide Prevention Training

Joel Friedman, Ph.D.
CFG Health Systems

Agenda

- Why have a Suicide Prevention Program?
- Not all Suicides are the same
- Basic Elements of a Suicide Prevention Program
- Some Facts about Mental Illness and Jails
- Some Statistics Concerning Suicide Rates in Jails
- Overview of Major Mental Illness
- Self Injury and Self Mutilation

Agenda

- Fact or Myth
- The Process of Assessing Suicide Risk
- How Much Risk?
- Referrals for Mental Health Intervention
- Housing Considerations
- Suicide Prevention and Cell Design
- Reviews of Completed Suicides and Serious Suicide Attempts

(Example of Suicide Prevention Training Program for Medical & Custody Staff - Slide # 3)

Why have a Suicide Prevention Program?

- We are charged with the care and custody of inmates – ensuring the greatest chance they will live through their incarceration is a basic part of that responsibility.
- The way in which we handle inmates who have problems, mental health or other problems, greatly affects how we are seen by the rest of the inmate population.

(Example of Suicide Prevention Training Program for Medical & Custody Staff - Slide # 4)

Why have a Suicide Prevention Program?

- Completed suicides in jails can greatly increase the level of agitation in the rest of the inmate population.
- Completed suicides can also have a significant impact on the stress level of correctional staff.

Why have a Suicide Prevention Program?

- Completed suicides can lead to investigations by the press and other outside agencies/organizations.
- There is also the possibility of litigation following a completed suicide – errors in fact vs. errors in judgment are crucial in this regard.
- It is cause for great concern if there is a finding of deliberate indifference.

Not All Suicides are the Same

- NASH – what is it?
- There are many different methods and reasons for suicide
- Many different psychological profiles and risk factors
- Hopelessness and/or Helplessness

Basic Elements of a Suicide Prevention Program

- Training – you're doing that now.
- Assessment – intake screening and mental health evaluation.
- Intervention – housing considerations, levels of observation, mental health services, restriction of items/activities.
- Follow-up in cases where there has been a serious attempt or a completed suicide.

Some Facts about Mental Illness and Jails

Fewer than 55,000 Americans currently receive treatment in psychiatric hospitals. Meanwhile, almost 10 times that number -- nearly 500,000 -- mentally ill men and women are serving time in U.S. jails and prisons. As sheriffs and prison wardens become the unexpected and often ill-equipped caretakers of this burgeoning population, they raise a troubling new concern: Have America's jails and prisons become its new asylums? – From a Frontline Documentary May 10, 2005 titled "The New Asylums"

Some Facts about Mental Illness and Jails

Of the nearly 2 million inmates being held in prisons and jails across the country, experts believe nearly 500,000 are mentally ill. According to the National Alliance for the Mentally Ill (NAMI), 16 percent of the prison population can be classified as *severely* mentally ill, meaning that they fit the psychiatric classification for illnesses such as schizophrenia, major depression, and bipolar disorder. According to staff at city and community jails, 25 percent of the jail population is severely mentally ill. However, when other mental illnesses, such as anti-social personality disorder, borderline personality disorder and depression, are included, the numbers are much higher, and NAMI puts the number of inmates suffering from both mental illness and substance abuse the percentage at well over 50 percent. – Also from Frontline's "The New Asylums"

Some Facts about Mental Illness and Jails

- According to the U.S. Dept. of Justice, inmates with mental health problems were more likely to have had 3 or more prior incarcerations.
- Female inmates had higher rates of mental health problems in jails as compared to males 75% to 63%.
- About 1 out of 6 jail inmates who had a mental health problem received treatment since their admission.

Some Facts about Mental Illness and Jails

- About 64% of jail inmates had mental health problems, as compared to 56% of state prisoners and 45% of federal prisoners.
- 76% of jail inmates were dependent on or abusing drugs or alcohol.

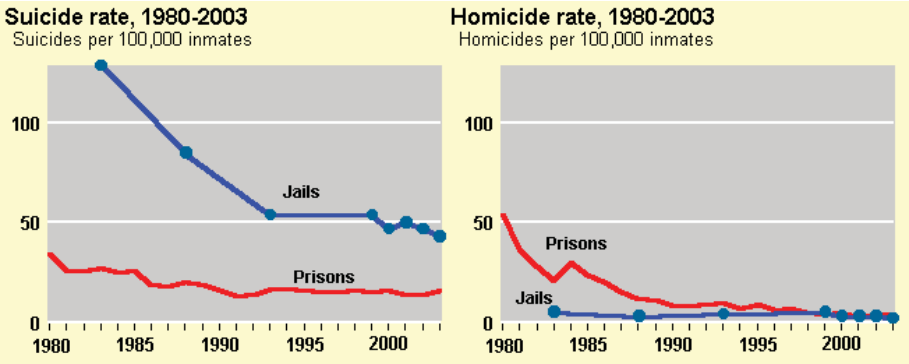
Some Statistics Concerning Suicide Rates in Jails

- The rate of incarceration in jails keeps growing – from 193 per 100,000 to 259 per 100,000 U.S. residents during the period from 1995 to 2007 according to the U.S. Dept of Justice.
- At midyear 2007, 780,581 inmates were held in the nation's local jails.

Some Statistics Concerning Suicide Rates in Jails

- Suicide rates in jail had been nine times higher than the rates for the general population in the United States in 1983.
- In the period from 1983 to 2002 the suicide rate in jails fell from 129 per 100,000 to 47 per 100,000, according to the Department of Justice's Bureau of Justice Statistics.
- The homicide rates in jails was 3 per 100,000.

Some Statistics Concerning Suicide Rates in Jails



(Example of Suicide Prevention Training Program for Medical & Custody Staff - Slide # 15)

Some Statistics Concerning Suicide Rates in Jails

- The same Bureau of Justice study found that in 2002 there were 978 jail inmate deaths, 314 of which were due to suicides.
- During 2002 the nation's smallest jails (fewer than 50 inmates) had a suicide rate five times higher than the largest jails (2,000 or more inmates).

(Example of Suicide Prevention Training Program for Medical & Custody Staff - Slide # 16)

Some Statistics Concerning Suicide Rates in Jails

- Other facts from the Bureau of Justice study:
  - White jail inmates were six times more likely to commit suicide than Black inmates and more than three time more likely than Hispanic inmates.
  - The male suicide rate in local jails (50 per 100,000 inmates) was more than 50 percent higher than that of female inmates (32 per 100,000).

Some Statistics Concerning Suicide Rates in Jails

- Some statistics from the National Center on Institutions and Alternatives:
  - 75% of jail inmates who committed suicide were detained on non-violent charges
  - 60% of jail inmates who committed suicide were intoxicated at the time of their admission into the jail
  - 51% of the suicides were committed within 24 hours of admission, 29% within three hours of admission

Some Statistics Concerning Suicide Rates in Jails

- Most suicides in custody occur when inmate is housed alone or at night when cell mate is asleep
- In U.S. Overall, method is usually Firearms
  - 55% - 60%
- Vast majority of suicides in custody occur by <u>Hanging</u>

(Example of Suicide Prevention Training Program for Medical & Custody Staff - Slide # 19)

Overview of Major Mental Illness

- Signs and Symptoms
- Types of mental illness
  - Psychotic Disorders
  - Affective (Mood) Disorders
  - Anxiety Disorders
  - Personality Disorders
  - Substance Abuse Disorders

(Example of Suicide Prevention Training Program for Medical & Custody Staff - Slide # 20)

Self Injury and Self Mutilation

- Many different reasons for this type of behavior
  - Relief from psychological pain
  - Dislike of their body
  - Rage
  - Psychosis
  - Affect others
  - Suicide rehearsal or test

(Example of Suicide Prevention Training Program for Medical & Custody Staff - Slide # 21)

Fact or Myth

- Each year in the United States there are more homicides than suicides.

(Example of Suicide Prevention Training Program for Medical & Custody Staff - Slide # 22)

Fact or Myth

- If someone attempts suicide and does not kill themselves they are unlikely to actually complete a suicide in the future.

(Example of Suicide Prevention Training Program for Medical & Custody Staff - Slide # 23)

Fact or Myth

- Most people who kill themselves can be easily identified as severely mentally ill.

(Example of Suicide Prevention Training Program for Medical & Custody Staff - Slide # 24)

Fact or Myth

- Most people who kill themselves give no clues about their intention to end their lives.

(Example of Suicide Prevention Training Program for Medical & Custody Staff - Slide # 25)

Fact or Myth

- Ignoring suicidal gestures will lead to them stopping, once the person doesn't get the attention they seek they stop making those gestures.

(Example of Suicide Prevention Training Program for Medical & Custody Staff - Slide # 26)

Fact or Myth

- There is a statistically significant correlation between weather patterns and suicide rates.

Fact or Myth

- Suicide attempts in some cases are not about death or ending one's life.

Fact or Myth

- Men complete suicides more often than women.

(Example of Suicide Prevention Training Program for Medical & Custody Staff - Slide # 29)

Fact or Myth

- Women attempt suicide more often than men.

(Example of Suicide Prevention Training Program for Medical & Custody Staff - Slide # 30)

Fact or Myth

- Asking a person with depression or significant stress about suicide will not increase the chances they will attempt or commit suicide.

Fact or Myth

- People can be both “manipulative” and have an increased risk for suicide.

Suicide Rates in General

- In U.S. General Population*
  - Ideation: 5.6% of U.S. pop per year
  - Attempts: 0.7% of U.S. pop per year
  - Completed: 0.0107% (10.7 per 100,000)
    -- At least 30,000 people/year

(Example of Suicide Prevention Training Program for Medical & Custody Staff - Slide # 33)

Suicide Rates in the General Population: US & NJ

- General Population
  - 0.01% suicide rate/year. Alternatively,
  - 99.99% do **not** commit suicide
  - 11 suicides per 100,000 in US
  - **7** suicides per 100,000 in New Jersey

(Example of Suicide Prevention Training Program for Medical & Custody Staff - Slide # 34)

Suicide Rates in General

- Psychological autopsy studies have consistently shown that more than 90% of persons who die from suicide satisfy the criteria for one or more psychiatric disorders.
- Almost all psychiatric disorders except mental retardation have been shown to increase suicide risk as measured by Standardized Mortality Ratios (SMR's).

Suicide Rates in General

- The lifetime risk of suicide, as compared to the general population:
  - Major Depression 20 times the risk.
  - Bipolar Disorder 22 times the risk.
  - Schizophrenia 8 times the risk.
  - Mixed Drug Problems 20 times the risk.
  - Alcohol Abuse 6 times the risk.
  - Previous suicide attempts 38 times the risk.

Assessing Suicide Risk

- Assessment is based on a Foreseeability standard = the reasonable anticipation that harm or injury is a likely result from certain acts or omissions. Risk must be adequately **assessed** when it is indicated.
- No standard exists for the Prediction of suicide
  - Inmates with certain major psychiatric disorders and other risk factors are at increased risk of suicide, but it is not possible to identify precisely which inmates will commit suicide, or when.

(Example of Suicide Prevention Training Program for Medical & Custody Staff - Slide # 37)

Assessing Suicide Risk

- The assessment of suicide risk is an ongoing process, as the risk for suicide changes over time and across circumstances.
- Like predicting the weather, astronomical events like eclipses can be predicted ~100%, but weather forecasts are made within certain **probabilities**

(Example of Suicide Prevention Training Program for Medical & Custody Staff - Slide # 38)

Assessing Suicide Risk

- Short-term assessments are more accurate than long-term assessments. Therefore it is important to update your assessment of suicide risk as often as is indicated by circumstances, the course of mental illness symptoms and treatment, etc.
- A good assessment changes over time, looking more like a movie than a snapshot.

Assessing Suicide Risk

- The intake screening is the start, but not the end of the suicide risk assessment process.
- Further evaluation of the risk factors by the mental health staff will add to the assessment process.

Assessing Suicide Risk

- When we assess risk for suicidal actions we look at several categories of risk:
  - Clinical risk factors
  - Personal stressors
  - Jail-related stressors
  - Behavioral risk factors

Assessing Suicide Risk

- In order to assess the current status of clinical risk factors we look at both the inmate's history and current signs and symptoms of mental illness.
- Signs are observable to another person.
- Symptoms are reported by the individual being assessed.

Assessing Suicide Risk

- Clinical factors include a history of mental illness and/or a history of suicide attempts, self-injurious or impulsive behavior. A family history of suicide also increases one's risk
- Signs/symptoms of risk for suicidal behavior include:
  - Sadness/depression
  - Tearfulness
  - Flat affect

(Example of Suicide Prevention Training Program for Medical & Custody Staff - Slide # 43)

Assessing Suicide Risk

- Dramatic shift in emotional state, either from depression to elation, or from agitated depression to calmness
- Loss of future orientation
- References to death
- Increase in intensity of psychiatric symptoms
- Recent discharge from a psychiatric hospital
- Non-compliance with medical/MH treatment

(Example of Suicide Prevention Training Program for Medical & Custody Staff - Slide # 44)

Assessing Suicide Risk

- Personal stressors include
  - Recent Loss (job, housing status, death of friend/relative), anniversary event
  - Recent rejection by spouse, lover, family; or humiliation
  - Chronic or terminal illness, esp. with alteration in body image or lifestyle
  - Extreme guilt about crime
  - Lacks close family or friends in the community and in jail

(Example of Suicide Prevention Training Program for Medical & Custody Staff - Slide # 45)

Assessing Suicide Risk

- Jail-related stressors include
  - Recent trauma or harassment
  - Segregated housing assignment
  - Recent or pending disciplinary action, court or parole decision
  - Fearfulness about safety
  - Anticipated or actual life or long sentence
  - Insistence on single or double cell

(Example of Suicide Prevention Training Program for Medical & Custody Staff - Slide # 46)

Assessing Suicide Risk

- Behavioral risk factors include
  - Statements about suicide
  - Refusal to comply with treatment or facility rules
  - Unwillingness to agree with “no harm” contract
  - Recently giving away possessions
  - Recent suicidal or self-injurious behavior

(Example of Suicide Prevention Training Program for Medical & Custody Staff - Slide # 47)

Assessing Suicide Risk

- More behavioral risk factors
  - Hoarding medication
  - Bizarre or dangerous behavior
  - Social withdrawal
  - Changes in personal hygiene
  - Changes in sleep patterns
  - Increase in agitated behavior or a sudden change to calmness, no-worry presentation

(Example of Suicide Prevention Training Program for Medical & Custody Staff - Slide # 48)

Assessing Suicide Risk

- Do not be afraid to ask directly about suicidal thoughts and plans. It is best to ask questions about suicide when the inmate can respond without others hearing him or her.
- Suicide is not predictable, but your assessment and intervention can and will save lives!

(Example of Suicide Prevention Training Program for Medical & Custody Staff - Slide # 49)

How Much Risk?

- Next we are going to look at risk and protective factors as they apply to several hypothetical cases.
- First we will review the risk and protective factors and determine the level of risk, given what we know about the person.
- Then we will discuss what additional information would be most helpful to more accurately assess the level of risk in each case.

(Example of Suicide Prevention Training Program for Medical & Custody Staff - Slide # 50)

How Much Risk?

- 18 y.o. single White male, no children, first incarceration, evidence of recent heroin use, unclear legal situation.

How Much Risk?

- 31 y.o. single Hispanic female, multiple prior incarcerations, history of treatment for depression, no prior suicide attempts.

How Much Risk?

- 19 y.o. single Black male, facing possible long sentence, no documented history of mental health problems.

(Example of Suicide Prevention Training Program for Medical & Custody Staff - Slide # 53)

How Much Risk?

- 57 y.o. divorced White male, multiple incarcerations, no contact with his children, no prior suicide attempts.

(Example of Suicide Prevention Training Program for Medical & Custody Staff - Slide # 54)

How Much Risk?

- 27 y.o. married Black female, has two children and a long history of suicidal gestures, incarcerated for DWI, history of psychiatric hospitalization.

(Example of Suicide Prevention Training Program for Medical & Custody Staff - Slide # 55)

Housing Considerations

- When the risk for suicidal actions is high it is best that the individual be observed on a constant basis in a setting where it is difficult for self-harm to be inflicted.
- At XXX Jail this is accomplished though placement in suicide prevention cells, which may include both direct observation and direct observation and camera surveillance.

(Example of Suicide Prevention Training Program for Medical & Custody Staff - Slide # 56)

Housing Considerations

- Actively suicidal inmates are placed under constant observation.
- They are housed in the Infirmary area for their safety

(Example of Suicide Prevention Training Program for Medical & Custody Staff - Slide # 57)

Referrals for Mental Health Intervention

- This is most commonly done through the intake screening process.
- It is important that the assessment of suicide risk be done whenever there appears to be an increased risk for suicidal behaviors.
- If you are unsure about whether a referral for suicide precautions is necessary contact the Mental Health and/or Medical Department.

(Example of Suicide Prevention Training Program for Medical & Custody Staff - Slide # 58)

Referrals for Mental Health Intervention

- The information the mental health and medical departments receive from the rest of the facility is very helpful in our understanding of what is actually going on with the inmate.
- Even after someone has been released from suicide watch, observation of their behavior is very important, as the risk for suicide can change at any time.

(Example of Suicide Prevention Training Program for Medical & Custody Staff - Slide # 59)

Suicide Prevention and Cell Design

- Over the past few years there has been an increase in the attention paid to designing cells for close or constant observation that are safer for inmates who are at an increased risk for suicide.
- The standards for safe cells are becoming increasingly well known by both the correctional and legal communities.

(Example of Suicide Prevention Training Program for Medical & Custody Staff - Slide # 60)

Reviews of Completed Suicides and Serious Suicide Attempts

- In cases where there has been either a serious suicide attempt or a completed suicide, it is common for a review of the case to take place.
- The objective of such a review is to understand what happened and what, if anything should be changed in the policies and operations at the facility.

(Example of Suicide Prevention Training Program for Medical & Custody Staff - Slide # 61)

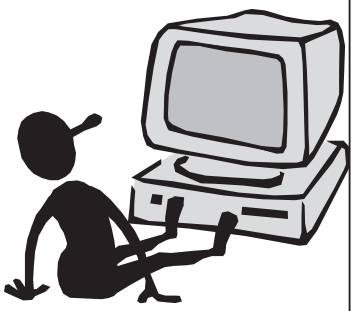
Conclusion

- Over 90-95% of people who went on to commit suicide had a treatable mental illness
  - Many risk factors (anxiety, bad news) are modifiable with support, treatment, time

(Example of Suicide Prevention Training Program for Medical & Custody Staff - Slide # 62)

Where to get More Information

- American Foundation for Suicide Prevention
  - 1-888-333-AFSP
  - Online at *www.afsp.org*



Thank You for Your Time and Participation!

Cisco TelePresence EX Series

The Cisco TelePresence EX Series transforms the workplace by combining work, communications, and collaboration—all on the desktop with just the touch of a finger. Colleagues can instantly collaborate face-to-face whether they are separated by a hallway, a street, or several time zones.

Figure 1. The EX Series transforms the desktop with an all-in-one work, meet and collaborate tool

The Cisco TelePresence EX Series is an all-in-one tool that enables individual contributors and knowledge workers to fluidly move from independent work on the laptop to joining project meetings or larger team telepresence meetings, to problem solving over shared spreadsheets—all directly from their desks. With the Cisco TelePresence EX Series, the productive power of personal telepresence can be shared throughout the organization with absolute quality and natural collaboration. Simple control from the Cisco TelePresence touch screen makes calling and sharing on the Cisco TelePresence EX Series easy and intuitive, while video on a large display brings about face-to-face interaction for more natural discourse.

No matter what your role, the Cisco TelePresence EX Series will become an integral part of the work flow—contributing to faster decision making and better relationships, and encouraging greater efficiencies.

Cisco TelePresence EX Series Features and Benefits

- Work, connect, and collaborate: Significantly improve productivity with an all-in-one tool that allows you to work independently, meet with others, and share content—all on a large high-definition (HD) screen. With multiple uses as a PC monitor and a telepresence system, the Cisco TelePresence EX Series offers high utility at the desk.
- Natural collaboration: The Cisco TelePresence EX Series allows you to transcend time and distance to meet instantly, face-to-face with the highest-quality video and audio. Sharing materials and ideas fluidly becomes as natural as if you were all in the same room. With just a quick flip of the camera, it is almost effortless to move from sharing HD content sources to instantly showing documents or objects on the desk.
- Simplicity with a touch: Superior technology is only superior if it has both high utility and usability. The Cisco TelePresence touch screen interface provides an intuitive and comfortable interaction, allowing you to place and manage calls with the glide of a finger.

Figure 2. The Cisco TelePresence touch screen enables simple control

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Cisco TelePresence EX Series

The Cisco TelePresence EX Series is unprecedented in desktop personal telepresence design, features, and usability. The family consists of the EX90 and EX60, which share a sleek, modern design that integrates many of the same important features:

- Optimal full HD 24- or 21.5-inch screen
- Eight-inch Cisco TelePresence touch screen for simple control
- 1080p30 and 720p60 video resolution for telepresence experience at the desk
- H.323 and Session Initiation Protocol (SIP) with bandwidth up to 6 Mbps point-to-point
- Integrated document camera that allows for easy sharing of physical documents and objects with a quick flip of the main camera
- Included wideband handset; you can add a headset input for privacy
- Standards-based for immediate connectivity to anyone regardless of system; from PC video or immersive telepresence to meeting rooms around the globe

	Cisco TelePresence EX90 Personal TelePresence for Organizational Leaders	**Cisco TelePresence EX60** Personal TelePresence for Knowledge Workers
Value Proposition	For the executive or manager, the Cisco TelePresence EX90 enables immediate presence with customers, partners, colleagues, and employees.	With the Cisco TelePresence EX60, you can share the power of telepresence throughout the organization, designed especially for the knowledge worker or individual contributor.
One-tool desktop for computer screen and personal telepresence	24-inch PC Screen with crisp 1920 x 1200 resolution	21.5-inch PC Screen with clear 1920 x 1080 resolution
PrecisionHD™ Camera supports fantastic 1080p HD	PrecisionHD™ Camera with optical zoom and F1.7, 45-65° field of view	PrecisionHD™ Camera with optimal F1.7, 50° field of view
Share content easily	Multiple digital inputs (DVI and HDMI) for flexible sharing of various content sources.	DVI input makes it easy to connect and share PC content
Superior CD-quality sound	Dual front speakers and a subwoofer for superior audio	Dual front speakers for superior audio
Additional Unique Features	Four locations can meet together at 720p30 HD with embedded MultiSite™. Continuous presence brings everyone into the picture.	Wall-mountable. Select VESA wall mount bracket can be added for scenarios where space is limited or the system is a shared or public resource.
	Dual display capable (HDMI out) enables a second screen that can be dedicated to content.	

Figure 3. The EX Series includes the EX90 for team leaders and the EX60 for knowledge workers

Why Cisco?

The Cisco TelePresence EX Series is part of the broad portfolio of Cisco TelePresence Systems offering immersive, multipurpose, and personal endpoints to meet the needs of organizations of all sizes. Cisco TelePresence solutions power the new way of working where everyone, everywhere can be more productive through face-to-face collaboration.

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C45-627751-00 10/10

TANDBERG

Quick Set C20

Transform any meeting space into a video communications hub. The TANDBERG Quick Set C20 delivers the absolute quality of 1080p video in a simple-to-deploy, easy-to-manage and easy-to-use system. Whether you're just getting started with video communications or conducting a large-scale deployment, the Quick Set C20 delivers the performance you would expect from a larger system — in a compact, feature-rich package.

Quick Set C20 includes the Codec C20, PrecisionHD 1080p 4x or 12x Camera, Performance Mic 20, remote control and cables.

DESIGN FEATURES

- Transforms a flat panel display into a 1080p high-definition meeting space
- Simple, intuitive connections make set up as easy as connecting a DVD player
- Quick Set C20 provides up to 1080p30 resolution with a 4x zoom camera
- Quick Set C20 *Plus* provides up to 1080p30 and 720p60 resolution with a 12x zoom camera
- Standards-compliant 1080p solution — compatible with standards-based video without loss of features
- Sleek, compact design

APPLICATION FEATURES

- Share multimedia and presentations at the touch of a button
- Basic API available over IP (Telnet or SSH)
- Dual-display option available
- HD content sharing with 720p and WXGA

PERFORMANCE FEATURES

- Optimal definition up to 1080p30
- H.323/SIP up to 6 Mbps
- Takes advantage of the TANDBERG Total Solution for Management, including Multiway, recording and streaming and firewall traversal services

GET THE MOST FROM YOUR INVESTMENT. WITH PROFESSIONAL SERVICES, TANDBERG EXPERTS SUPPORT TANDBERG QUICK SET C20 DEPLOYMENT AND TRAINING. VISIT WWW.TANDBERG.COM

SET DELIVERED COMPLETE WITH:
Codec C20, PrecisionHD 1080p 4x or 12x Camera, Performance Mic 20, remote control, cables and power supply

BANDWIDTH
H.323/SIP up to 6 Mbps point-to-point
720p30 from 768kbps
720p60 from 1152kbps
1080p30 from 1472kpbs

FIREWALL TRAVERSAL
TANDBERG Expressway™ Technology
H.460.18, H.460.19 Firewall Traversal

VIDEO STANDARDS
H.261, H.263, H.263+, H.264

VIDEO FEATURES
Native 16:9 Widescreen
Advanced Screen Layouts
Intelligent Video Management
Local Auto Layout

VIDEO INPUTS (2 INPUTS)
1 X HDMI INPUTS, SUPPORTED FORMATS:
1920 x 1080@60, 59.94 Hz (1080p60)
1920 x 1080@50 Hz (1080p50)
1920 x 1080@30, 29.97 Hz (1080p30)
1920 x 1080@25 Hz (1080p25)
1920 x 1080@24, 23.97 Hz (1080p24)
1280 x 720@60, 59.94 Hz (720p60)
1280 x 720@50 Hz (720p50)
720 x 480@60, 59.94 Hz (480p60)
640 x 480@60 Hz (480p60)
1600 x 1200@50, 60 Hz (UXGA)
1280 x 1024@60, 75 Hz (SXGA)
1024 x 768@60, 70, 75, 85 Hz (XGA)
800 x 600@56, 60, 72, 75, 85 Hz (SVGA)
1920 x 1200@50, 60 Hz (WUXGA)
1680 x 1050@60 Hz (WSXGA+)
1440 X 900@60 Hz (WXGA+)
1280 x 768@60 Hz (WXGA)
1 X DVI-I INPUTS, SUPPORTED FORMATS:
Analog (VGA):
1920 x 1080@60 Hz (1080p)
1280 x 720@60 Hz (720p)
1600 x 1200@60 Hz (UXGA)
1280 x 1024@60, 75 Hz (SXGA)
1280 x 960@60 Hz
1024 x 768@60, 70, 75, 85 Hz (XGA)
1920 x 1200@50 Hz (WUXGA)
1680 x 1050@60 Hz (WSXGA+)
1440 x 900@60 Hz (WXGA+)
1280 x 800@60 Hz (WXGA)
1280 x 768@60 Hz (WXGA)
Digital (DVI-D):
1920 x 1080@60, 59.94 Hz (1080p60)
1920 x 1080@50 Hz (1080p50)
1920 x 1080@30, 29.97 Hz (1080p30)
1920 x 1080@25 Hz (1080p25)
1920 x 1080@24, 23.97 Hz (1080p24)
1280 x 720@60, 59.94 Hz (720p60)
1280 x 720@50 Hz (720p50)
720 x 480@60, 59.94 Hz (480p60)
640 x 480@60 Hz (480p60)
1600 x 1200@50, 60 Hz (UXGA)
1280 x 1024@60, 75 Hz (SXGA)
1024 x 768@60, 70, 75, 85 Hz (XGA)
800 x 600@56, 60, 72, 75, 85 Hz (SVGA)
1920 x 1200@50, 60 Hz (WUXGA)
1680 x 1050@60 Hz (WSXGA+)
1440 X 900@60 Hz (WXGA+)
1280 x 768@60 Hz (WXGA)

VIDEO OUTPUTS (2 OUTPUTS)
2 X HDMI OUTPUT, SUPPORTED FORMATS:
1920 x 1080@60 Hz (1080p60)
1280 x 720@60 Hz (720p60)
1600 x 1200@60 Hz (UXGA)
1280 x 1024@60 Hz (SXGA)
1024 x 768@60 Hz (XGA)
800 x 600@60 Hz (SVGA)
640 x 480@60 Hz (VGA)
1920 x 1200@60Hz (WUXGA)
1360 x 768@60 Hz
1366 x 768@60 Hz
1280 x 768@60 Hz (WXGA)
LIVE VIDEO RESOLUTIONS (ENCODE/DECODE)
176 x 144@30 fps (QCIF)
352 x 288@30 fps (CIF)
512 x 288@30 fps (w288p)
576 x 448@30 fps (448p)
768 x 448@30 fps (w448p)
704 x 576@30 fps (4CIF)
1024 x 576@30 fps (w576p)
1280 x 720@30 fps (720p30)
1920 x 1080@30 fps (1080p30)**
512 x 288@60 fps (w288p60)
768 x 448@60 fps (w448p60)
1024 x 576@60 fps (w576p60)
1280 x 720@60 fps (720p60)**
640 x 480@30 fps (VGA)
800 x 600@30 fps (SVGA)
1024 x 768@30 fps (XGA)
1280 x 768@30 fps (WXGA)

AUDIO STANDARDS
G .711, G.722, G.722.1, 64 kbps MPEG4 AAC-LD

AUDIO FEATURES
CD-Quality 20KHz Mono
1 acoustic echo canceller
Automatic Gain Control (AGC)
Automatic Noise Reduction
Active lip synchronization

AUDIO INPUTS (4 INPUTS)
2 x microphone, 4-pin MiniJack
2 x RCA/Phono (mixed to mono)

AUDIO OUTPUTS (3 OUTPUTS)
2 x RCA/Phono (dual mono)1 x HDMI, (digital main audio)

DUAL STREAM
H.239 (H.323) dual stream
BFCP (SIP) dual stream
Support resolutions up to WXGAp15 (Main video maximum 720p30)

PROTOCOLS
H.323
SIP

EMBEDDED ENCRYPTION
H.323/SIP point-to-point
Standards-based: H.235 v2 & v3 and AES
Automatic key generation and exchange
Supported in Dual Stream

IP NETWORK FEATURES
DNS lookup for service configuration
Differentiated Services (QoS)
IP adaptive bandwidth management (including flow control)
Auto gatekeeper discovery
Dynamic playout and lip-sync buffering
H.245 DTMF tones in H.323
Date and Time support via NTP
Packet Loss-based Downspeeding
URI Dialing
TCP/IP
DHCP
802.1x network authentication
ClearPath

SECURITY FEATURES
Management via HTTPS and SSH
IP Administration Password
Menu Administration Password
Disable IP services
Network Settings protection

NETWORK INTERFACES
1 x LAN/Ethernet (RJ-45) 10/100/1000 Mbit

OTHER INTERFACES
USB device for future usage

PRECISIONHD 1080P
1/3" CMOS
12 x zoom / 4 x zoom
+15°/-25° tilt, +/- 90° pan
43.5° vertical field of view
72° horizontal field of view
Focus distance 0.3m–infinity
1920 x 1080 pixels progressive @ 60fps (12 x version)
1920 x 1080 pixels progressive @ 30fps (4 x version)
Other formats supported (configurable through Dip-switch):
*1920x1080@60fps (HDMI only)
*1920x1080@50fps (HDMI only)
1920x1080@30fps
1920x1080@25fps
*1280x720@60fps
*1280x720@50fps
1280x720@30fps
1280x720@25fps
Automatic or manual focus/brightness/white balance
Far-end camera control
*Daisy-chain support (Visca protocol camera)
Dual HDMI and HD-SDI output
Upside-down mounting with automatic flipping of picture

SYSTEM MANAGEMENT
Support for the TANDBERG Management Suite
Total management via embedded SNMP, Telnet, SSH, XML, SOAP
Remote software upload: via web server, SCP, HTTP, HTTPS
Remote control and on-screen menu system
1 x RS-232 for local control and diagnostics (Y-cable required)

DIRECTORY SERVICES
Support for Local directories (My Contacts)
Corporate Directory
Unlimited entries using Server directory supporting LDAP and H.350
Unlimited number for Corporate directory (through TMS)
200 number local directory
Received Calls
Placed Calls
Missed Calls with Date and Time

POWER
Auto-sensing power supply
100–240 VAC, 50/60 Hz
75 watts max. for codec and main camera

OPERATING TEMPERATURE AND HUMIDITY
0° C to 35° C (32° F to 95° F) ambient temperature
10% to 90% Relative Humidity (RH)

STORAGE AND TRANSPORT TEMPERATURE
-20° C to 60° C (-4° F to 140° F) at RH 10–90% (non-condensing)

APPROVALS
Directive 2006/95/EC (Low-Voltage Directive) — Standard EN 60950-1
Directive 2004/108/EC (EMC Directive) — Standard EN 55022, Class B — Standard EN 55024 — Standard EN 61000-3-2/-3-3
Approved according to UL 60950-1 and CAN/CSA-C22.2 No. 60950-1-07
Complies with FCC15B Class A

DIMENSIONS CODEC C20
Length: 13.8"/35.0 cm
Height: 1.2"/3.0 cm
Depth: 5"/12.7 cm
Weight: 4 lbs/1.8 kg

** not supported on 4x zoom camera*

*** requires option*

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Power On Hours (POH) > 69 000 hours

Useful Life Cycle > 6 years

ISO 9001 certificate is available upon request

TANDBERG

Quick Set C20

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March 2010

Behavioral Sciences and the Law
Behav. Sci. Law **26**: 253–269 (2008)
Published online in Wiley InterScience
(www.interscience.wiley.com) DOI: 10.1002/bsl.812

Empirical Evidence on the Use and Effectiveness of Telepsychiatry via Videoconferencing: Implications for Forensic and Correctional Psychiatry

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A growing body of literature now suggests that use of telepsychiatry to provide mental health services has the potential to solve the workforce shortage problem that directly affects access to care, especially in remote and underserved areas. Live interactive two-way audio–video communication—videoconferencing—is the modality most applicable to psychiatry and has become synonymous with telepsychiatry involving patient care, distance education, and administration. This article reviews empirical evidence on the use and effectiveness of videoconferencing in providing diagnostic and treatment services in mental health settings that serve child, adolescent, and adult populations. Descriptive reports, case studies, research articles, and randomized controlled trials related to clinical outcomes were identified and reviewed independently by two authors. Articles related to cost-effectiveness, technological issues, or legal or ethical aspects of telepsychiatry were excluded. The review of the evidence broadly covers mental health service provision in all settings, including forensic settings. Given the sparse literature on telepsychiatry in forensic settings, we discuss implications for mental health care across settings and populations and comment on future directions and potential uses in forensic or correctional psychiatry. Copyright © 2008 John Wiley & Sons, Ltd.

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Many states have extreme disparities in population density and resource distribution, with substantial health and human service resources in urban centers and relative scarcity of services in rural areas. Such disparities are particularly evident in the area of mental health services (*New Freedom Commission on Mental Health, Subcommittee on Rural Issues: Background paper*, 2004). Many states have employed telepsychiatry to improve mental health services' cost, quality, and availability. Indeed, a growing body of literature now suggests that use of telepsychiatry to provide mental health services has the potential to mitigate the workforce shortage that directly affects access to care, especially in remote and underserved areas.

Telepsychiatry has been variously defined. The National Library of Medicine defines telemedicine as it applies to psychiatry [telepsychiatry] as the use of electronic communication and information technologies to provide or support clinical psychiatric care at a distance. This definition includes many communication modalities such as phone, Fax, e-mail, the Internet, still imaging, and live interactive two-way audio–video communication (*American Psychiatric Association resource document on telepsychiatry via videoconferencing*, 1998). Live interactive two-way audio–video communication—videoconferencing—is the modality most applicable to psychiatry and has become synonymous with telepsychiatry involving patient care, distance education, and administration. Regardless of how these applications are defined, telepsychiatry and e-mental health comprise one of the largest uses of telehealth nationwide (Grigsby et al., 2002; Krupinski et al., 2002). Videoconferencing primarily involves interactive audiovisual conferencing systems over high-capacity (high-bandwidth) networks. Historically, interactive telepsychiatry applications have used point-to-point network connections, usually as full or fractional T-1 or integrated services digital network (ISDN) circuits. However, the rapid diffusion of Internet and Ethernet networks has led to the development of videoconferencing systems that can work over these types of network, i.e. Internet Protocol (IP) networks. If a telepsychiatry application uses IP networks, then security must be ensured—this can be accomplished by using encrypted codecs or by setting up a virtual private network (VPN) and/or virtual local area networks (VLANs).

This article reviews empirical evidence on the use and effectiveness of videoconferencing in providing diagnostic and treatment services in the area of mental health. Based on our review of the literature, we draw conclusions regarding telepsychiatry in general mental health populations and comment specifically on implications for forensic or correctional psychiatry.

REVIEW OF THE LITERATURE

We searched the literature for reports about telepsychiatry programs and services. The search focused on the English language literature and identified journal articles and reports. The electronic databases MEDLINE via Ovid, PsycINFO and the Telemedicine Information Exchange were searched from 1950 to June 2007. Approximately 385 citations were identified by using the search terms telemedicine, telepsychiatry, telepsychology, or videoconferencing, along with psychiatry, child and adolescent psychiatry and forensic psychiatry. Abstracts were reviewed for relevance by two authors (D.A. and Y.Y.), who identified all citations pertaining to

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DOI: 10.1002/bsl

telepsychiatry demonstration projects, program descriptions, empirical evaluations, satisfaction and acceptance, clinical outcome and cost-effectiveness. The initial review identified 121 articles. Articles related to cost-effectiveness, technological issues, and legal or ethical aspects of telepsychiatry were excluded. Descriptive reports, case studies, research reports, and randomized controlled trials related to clinical outcomes were identified and reviewed independently. Forty-five articles fulfilled these criteria.

In our literature review, 34 of 45 articles were related to clinical efficacy of telepsychiatry in general adult psychiatry (Table 1). Most of them were case-studies (Deitsch, Frueh, & Santos, 2000), case-series (Bose, McLaren, Riley, & Mohammedali, 2001; Bouchard et al., 2000; Himle et al., 2006; Cluver et al., 2005; Shepherd et al., 2006; Shore & Manson, 2004; Thomas, Miller, Hartshorn, Speck, & Walker, 2005), or studies of patient or clinician satisfaction (Bishop, O'Reilly, Maddox, & Hutchinson, 2002; Dongier, Tempier, Lalinec-Michaud, & Meunier, 1986; Frueh, Henderson, & Myrick, 2005; Greenwood, Chamberlain, & Parker, 2004; Griffiths, Blignault, & Yellowlees, 2006; Morland, Pierce, & Wong, 2004).

Only five articles could be considered randomized clinical trials (De Las Cuevas, Arredondo, Cabrera, Sulzenbacher, & Meise, 2006; Fortney et al., 2007; O'Reilly et al., 2007; Poon, Hui, Dai, Kwok, & Woo, 2005, Ruskin et al., 2004) related to treatment outcome. In addition to being recognized as markedly few in number (Frueh, Monnier, Elhai, Grubaugh, & Knapp, 2004; O'Reilly et al., 2007), these studies used mixed diagnostic groups, mixed medication and psychotherapy interventions, and a variety of outcome assessment measures to conclude that telepsychiatric intervention outcomes were equivalent to face-to-face outcomes (De Las Cuevas et al., 2006; O'Reilly et al., 2007; Ruskin et al., 2004). Lack of control comparisons and use of superiority designs rather than equivalence designs (McAlister & Sackett, 2001) were additional problems.

Articles without random assignment (Bouchard et al., 2004; Griffiths et al., 2006; Jones, Johnston, Reboussin, & McCall, 2001; Kennedy & Yellowlees, 2000, 2003; Marcin et al., 2005; Modai et al., 2006; Shepherd et al., 2006; Shore, Savin, Orton, Beals, & Manson, 2007; Urness, Wass, Gordon, Tian, & Bulger, 2006) included a single study in a forensic setting (Zaylor, Nelson, & Cook, 2001). All had similar methodological problems, with an even higher risk of bias.

A recent randomized, controlled study by Fortney et al. (2007) compared the usual primary care treatment of depression with primary care treatment plus collaborative psychiatric medication monitoring in 395 patients and demonstrated a strong positive effect of telepsychiatry on measures of treatment compliance, symptom improvement, remission, and satisfaction. This superiority trial shows that, whether or not telepsychiatric care is equivalent to in-person care, it is more effective than a common alternative care, and meets the criterion for an evidence-based treatment for depression. Because a single disorder was treated with a specified treatment via telepsychiatry, it is possible for providers to replicate this process, to recognize patients who are likely to benefit from it, and to compare their outcomes to those reported in the literature. This study suggests that collaborative telepsychiatric care is better than usual non-psychiatric care for depression. Although the Fortney study (Fortney et al., 2007) was conducted in a VA primary care setting, the results should apply to collaborative depression care in other settings as well. Extrapolating from this study, one could infer that

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telepsychiatric management of antidepressant medications should produce similar benefits over usual medical care in forensic settings and correctional facilities.

Several articles addressed diagnosis or assessment studies with adult patients, including a meta-analysis (Hyler, Gangure, & Batchelder, 2005). There were four studies in forensic settings (Leonard, 2004; Lexcen, Hawk, Herrick, & Blank, 2006; Nelson, Zaylor, & Cook, 2004; Zaylor, Nelson, & Cook, 2001) (see Table 2). Like studies on treatment outcome, the assessment articles focused on patient or clinician satisfaction (Matsuura et al., 2000) and equivalence of telepsychiatric assessment to in-person assessment (Baer et al., 1995; Cullum, Weiner, Gehrmann, & Hynan, 2006; Hersh et al., 2002; Marcin et al., 2005; Shore et al., 2007; Zarate et al., 1997). The forensic assessment studies compared prisoner self-ratings with telepsychiatric ratings (Nelson et al., 2004; Zaylor et al., 2001) or in-person ratings to telepsychiatric ratings (Leonard, 2004; Lexcen et al., 2006). The presumption is that in-person assessments are the gold standard to be matched by telepsychiatric assessments. This was the assumption underlying the meta-analysis on telepsychiatric assessment (Hyler et al., 2005). Patient selection factors, small study size, variable assessment instruments, varied patient problems, and lack of connection with treatment initiation and outcome are common study problems. However, there is no indication that telepsychiatric assessment, including forensic assessments and assessments in correctional facilities, induces systematic biases.

Application of telepsychiatry to child and adolescent patients has also been tested (see Table 3). In addition to case studies demonstrating feasibility (Alessi, 2003; Savin, Garry, Zuccaro, & Novins, 2006), telepsychiatry programs targeting children and adolescents have been described (Myers, Sulzbacher, & Melzer, 2004; Neufeld, Yellowlees, Hilty, Cobb, & Bourgeois, 2007; Starling, Rosina, Nunn, & Dossetor, 2003). In much the same way as in the adult literature, patient and clinician acceptance is relatively high.

There are only two randomized controlled trials with children, one on treatment efficacy and one on assessment reliability and satisfaction. The efficacy study compared eight weeks of in-person to telepsychiatry CBT treatment for depression (Nelson, Barnard, & Cain, 2003). Both telepsychiatry and in-person treatment produced significant reductions in depression scale scores, although the telepsychiatry condition produced faster reductions.

The assessment study (Elford et al., 2000) compared telepsychiatric assessments with in-person assessments to see whether they produce the same diagnoses and are acceptable to patients, clinicians, and parents. There was a high degree of agreement between telepsychiatric and in-person diagnoses and general satisfaction with telepsychiatric care.

While not the focus of the current review, it should be noted that there are comparisons of successful telephone-based interventions that show better effects than usual care (Rollman et al., 2005; Simon, Ludman, Tutty, Operskalski, & Von Korff, 2004). There is even a non-inferiority trial of telephone-delivered cognitive–behavior therapy for obsessive–compulsive disorder comparing eight 30 minute telephone sessions with nine 60 minute in-person sessions (Lovell et al., 2006) that suggests that the same outcomes can be achieved with half the therapist time using telephone-delivered care. Some telepsychiatry studies hint at comparable advantages in time savings (Nelson et al., 2003; Zaylor, 1999) or treatment adherence (Modai et al., 2006).

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DOI: 10.1002/bsl

Table 1. Telepsychiatry studies on treatment feasibility, satisfaction, efficacy or effectiveness in the general adult population

Author	Study objective	Main study outcomes
Ruskin et al. (2004)	Compared treatment outcomes of depressed patients treated in person with those treated remotely. To determine whether patients' rates of adherence to and satisfaction with treatment were as high with remote as compared with in-person treatment and to compare costs.	$N=119$, 8 sessions of 20 minutes each over a 6 month period. Both groups were equally adherent. No between group differences in satisfaction or dropout rates. Telepsychiatry was more expensive until costs of psychiatrist travel were factored in. Telepsychiatry did not increase health care resource consumption.
Fortney et al. (2007)	This study evaluated a telemedicine based collaborative care model adapted for small clinics without on site psychiatrists.	$N=395$ primary care patients in VA community clinics. Depression scores on the PHQ9 >12. Intervention patients more likely to be adherent at 6 and 12 months. Intervention patients more likely to respond at 6 months and remit at 12 months. They reported larger gains in mental health status, improved health-related quality of life, and higher satisfaction.
O'Reilly et al. (2007)	Compared a variety of clinical outcomes after psychiatric consultation and, where needed, brief follow-up for OP referred to a psychiatry clinic with random assignment to telepsych. or F2F.	495 patients, 254 F2F and 241 telepsych. Consultation and follow-up produced clinical outcomes that were equivalent between the 2 groups. Patient satisfaction levels were similar. Telepsych. was at least 10% less expensive
De Las Cuevas et al. (2006)	Evaluated efficacy of telepsych. in the tx of mental disorders by comparing F2F treatment.	RCT of 140 OP. Tx was 8 consultations lasting 30 minutes over 24 weeks. Medications plus CBT were used. 130 completed, 534 teleconsultations, 522 F2F consultation. Both groups improved but no differences were observed between groups.
Bishop et al. (2002)	Pilot comparing satisfaction levels between patients seen F2F and those seen via VC.	Random assignment, $N=24$ with 17 completing. Assessed 4 months after. Although there was a trend in favor of F2F the difference was not significant.
Morland et al. (2004)	Investigated the feasibility of using VC to provide coping skills group for veteran pts with PTSD who live in remote locations.	$N=20$, 3 withdrew. 9 to VC and 8 FTF. At end of 8 wks, 4 left in F2F and 8 left in VC. F2F attended 4.9 sessions and VC 6.3 sessions (not significant). No differences in levels of satisfaction in patients or clinicians. Retention of info. similar in both groups. VC can be used to provide coping skills.

(*Continues*)

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Table 1. (Continued)

Author	Study objective	Main study outcomes
Poon et al. (2005)	This project examined and compared the feasibility, acceptability, and clinical outcome of a cognitive intervention program for older patients with mild cognitive impairment and mild dementia using TM vs F2F.	$N=22$. 12 sessions conducted via F2F or VC. Cognitive impairment was significant and comparable across groups. Compliance was 95% overall. Satisfaction was measured among pts and staff. Significant improvement in the areas of attention, memory, and language areas were observed following cognitive intervention with no difference in outcomes between the 2 intervention arms.
Bouchard et al. (2004)	Compared effectiveness of CBT for panic disorder when delivered F2F or by VC.	$N=21$. CBT F2F was just as effective as VC. Both groups improved. VC participants reported development of excellent DP relationship as early as the first session.
Jones et al. (2001)	Test the hypothesis that VC ratings based on visual observations of behavior would be less reliable that ratings based on patients' verbal reports of symptoms.	$N=30$ VC assessments. BPRS was used. Reliability of BPRS subjective items was consistently higher than for the observational items (used low band width).
Modai et al. (2006)	Compared institutional ambulatory and hospital costs, treatment adherence, patient and physician satisfaction, and treatment safety between VC and F2F treatment.	1 year of telepsychiatry treatment ($N=39$) compared to previous year (F2F) and matched comparison group ($N=42$). Patients and physicians were satisfied and treatment was safe. Telepsychiatry was more expensive and there was a trend toward increased IP. Adherence rates before and during telepsych. were similar but were twice as high as the comparison group.
Kennedy and Yellowlees (2003)	Data were collected from 124 patients attending hospital and GP facilities. 32 were using telepsychiatry. Follow-up data were collected a year later.	There was a significant difference between initial assessment and follow-up in both groups but no significant difference between the face-to-face and telepsychiatry groups. Both groups were improved and telepsychiatry was as effective as face to face.
Urness et al. (2006)	Evaluated client satisfaction and one month MH outcomes for TP compared with F2F. The SF-12 survey was used.	48 of the 62 (77%) initial responders were available for f/u one month later. TP pts demonstrated significant improvements on pre and post tests while there was no change for the F2F group. This was a single first time consultation.

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Hyler et al. (2005)	A review and meta-analysis of the literature comparing TP with in-person psychiatric assessments.	1956 to 2002. $N = 380$. 14 with $N > 10$ compared TP with IP using objective assessment instruments or satisfaction instruments. 14 studies with 500 patients. TP was similar to IP using objective assessments. Effect sizes were small, suggesting no difference. HB was slightly superior for assessments requiring detailed observation of subjects. Out of a large TP literature published over the last 40+ years, only a handful of studies have attempted to compare TP with IP directly using standardized assessments.
Hersh et al. (2002)	Systematic review of the literature to evaluate the efficacy of telemedicine for making dx and management decisions in 3 classes of application: office/hospital based, store and forward, and home based.	The strongest evidence came from psychiatry and dermatology. There was reasonable evidence for general medical history and physical exams. There is some evidence in cardiology and certain areas of ophthalmology. Despite widespread use, there is strong evidence in only a few specialties that dx and tx decisions provided by TM are comparable to F2F.
Shore et al. (2007)	Examined the reliability of SCID in the administration of psych. assessments by VC vs F2F.	$N = 53$, randomly assigned. Comparisons made with prevalences, the McNemar test and the kappa statistics. Percent agreement b/w modalities was >80% except for lifetime drug abuse (76%), lifetime substance abuse (72%) and lifetime MDD (66%). Externalizing disorders elicited a higher kappa than internalizing disorders. Overall SCID live did not differ from VC statistically.
Cullum et al. (2006)	Administered a brief battery of common neuropsych. tests via VC and F2F to 14 patients with mild cognitive impairment and 19 with AD.	Highly similar test scores were obtained for the two groups. The VC group had a partner to decrease anxiety and assist with equipment.
Kennedy and Yellowlees (2000)	Evaluated a pilot project that supported visiting psychiatrists and local private/public practitioners through telemedicine.	Data collected over 2 years with 124 patient subjects. Nine additional refused to participate. 32/124 used telemed. No significant improvements in wellbeing or quality of life. Most found moderately or greatly helpful. (98% preferred telemed. in combination with local service)
Deitsch et al. (2000)	Case report of a group therapy session with 4 patients. The group had been meeting with variable attendance	There was one 55 minute session. Feedback was by questionnaire and verbal. Patient satisfaction was rated as good to very good. Delay in responses was distracting to the remote therapist.

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Table 1. (Continued)

Author	Study objective	Main study outcomes
Cluver et al. (2005)	Feasibility study of remote psychotherapy with terminally ill cancer patients with dx of adjustment disorder or major depression.	$N=10$. 6 sessions of CBT with remote alternating with face to face. 9 patients completed 53 therapy sessions. 21 remote and 32 face to face. Acceptance and perceptions were positive after almost all therapy sessions, regardless of delivery mode.
Frueh et al. (2005)	Videoconferencing was used in open sessions for subjects with alcohol use disorders. 8 sessions of group therapy over a 4 week period.	$N=18$ with 14 attending at least 4 sessions. Patients reported high levels of satisfaction, found intervention to be credible, and had good session attendance and attrition comparable to conventional tx. 82% indicated they would recommend the treatment.
Marcin et al. (2005)	Determine if OP telemed. specialist consultation to primary care clinicians resulted in changes in pt dx, tx, management and outcomes.	Retrospective chart review. $N=223$. Diagnosis changed in 48%, tx changed in 81.6% and clinical improvement was shown in 60.1%. Consistent with literature regarding changes in process of care with F2F. Changes in dx or tx found to be associated with clinical improvement.
Bouchard et al. (2000)	Preliminary results of an outcome study on the effectiveness of telepsychiatry for panic disorder with agoraphobia.	12 sessions of CBT delivered by VC. $N=8$. Improvements were made on measures of target symptoms and measures of global functioning. A very good therapeutic alliance was built after only the 1st session.
Thomas et al. (2005)	Description of a telemed. program that provides psychiatric screening, evaluation, treatment and referral for ongoing care to clients of a rural women's crisis center.	$N=38$. 35 completed an evaluation and 31 entered treatment. Anxiety and major affective disorders were the most commonly identified disorders followed by substance use disorders. Telepsych. can provide rapid crisis intervention and effective mental health services to victims of domestic violence in rural settings.
Griffiths et al. (2006)	To explore the feasibility and acceptability of delivering CBT via TP to patients with depression and/or anxiety.	$N=15$. CBT delivered to patients (and case managers (CM)). Dx of GAD, MDD, panic disorder. Outcome measures were Mental Health Inventory by pts and Health of the Nation Outcome Scale by CM. Significant improvement in all measures. TP consultations were acceptable to CM and pts.
Baer et al. (1995)	Assess reliability of rating scales administered in person and over video to patients with OCD.	Near perfect interrater agreement on rating scale scores. Reliability was excellent in both.
Shore et al. (2004)	This article describes a weekly TP clinic treating PTSD in American Indian veterans.	$N=50$ clinic interactions in 7 months. Consisted of ongoing group tx, individual tx and med. mgmt. Patient satisfaction and comfort were rated highly.

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Himle et al. (2006)	Three cases of OCD treated with CBT via VC.	12 wk manualized therapy including family members in sessions 1, 6 and 12. ERP was primary intervention, delivered in session and as homework. Measures YBOCs, CGI, Ham D, Working Alliance Inventory and Telepresence and VC Scale.
Shepherd et al. (2006)	Studies anxiety, depression and quality of life in rural cancer patients.	25 patients, average of 3 CBT sessions. Data collected pre, post and 1 month later. Hospital Anxiety and Depression Scale, Functional Assessment of Cancer Therapy—General, patient satisfaction questionnaire. Anxiety decreased and quality of life increased. The service was practical and acceptable.
Matsuura et al. (2000)	Assess the reliability of psych. evals via VC.	Interrater reliability measured with BPRS and Interclass Correlation Coefficient. Compared F2F with VC. Reliability showed perfect agreement. $N = 17$, 9 were volunteers and 8 were patients
Bose et al. (2001)	Evaluated patient satisfaction	$N = 13$. Brief counseling of non-psychotic patients, 4 month duration, 11 men and 2 women for 29 total sessions. 93% would like to use it again, 75% said could see well and 86% said they could hear. Overall patients were happy.
Dongier et al. (1986)	To carry out a quantified and controlled assessment of patients' and staffs' reactions to TP and to examine feasibility of TP.	50 telepsych. consultations and 35 F2F consultations compared from among those normally presenting to the 3 psychiatric consultants on staff. Consultant, patient, and consultee slightly preferred F2F but TP consultation was well accepted.
Greenwood et al. (2004)	Evaluate a TP clinical service in rural New South Wales. A retrospective evaluation was done to determine acceptance of TP and F2F.	$N = 31$ referred to a specialty mood clinic in a rural setting. 20 completed. A F2F semistructured interview was done on admission and immediately afterward a VC interview was performed. Dx were mood do (80%), anxiety do (20%). High satisfaction with F2F. Differences b/w F2F and TP were difficulty discussing problems, not finding consultation informative, not feeling comfortable on camera. 80% indicated they would use TP again.
Zarate et al. (1997)	Assessed reliability of BPRS, SAPS, SANS (1) in person, (2) by VC at low bandwidth, (3) by VC at high bandwidth.	$N = 45$ with dx of schizophrenia. 15 in each group. No significant differences existed among the groups.

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Table 1. (Continued)

Author	Study objective	Main study outcomes
Zaylor et al. (2000)	Retrospective review of charts comparing clinical outcomes of patients seen by TP and F2F.	$N = 49$ with SZA or MDD. GAF was used as measure at initial visit and subsequent visits. Patients seen by TP had a greater attendance rate and follow-up visitstook less than half the time compared to F2F.

VC = video conferencing.
F2F = face to face.
TP = telepsychiatry.
TM = telemedicine.
tx = treatment.
dx = diagnosis.

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Table 2. Telepsychiatry studies on treatment feasibility, satisfaction, efficacy or effectiveness in the forensic population

Authors	Objective	Outcomes
Brodey et al. (2000)	Level of satisfaction with TP evaluations was determined.	$N = 43$. A forensic psychiatrist interviewed 20 in person and 23 by VC. Satisfaction was moderately high in both groups with no difference between the 2 groups. The psychiatrist felt comfortable with his ability to dx remotely.
Leonard (2004)	This article reviews the current prison health care system and then describes a research study focused on development and evaluation of a TP service for prisoners.	$N = 80$. Pt assessed by 1 psychiatrist at the local site doing the interview by VC and simultaneously by a 2nd psychiatrist at the remote site in the same room as the prisoner. Satisfaction was measured with 20 prisoners and 2 staff. Only study design is outlined.
Nelson et al. (2004)	The effectiveness of a jail telepsychiatry service was evaluated by comparing psychiatrist and inmate report of psychopathology.	$N = 62$ inmates, 107 consultations in a rural county jail. Inmates completed the SCL-90-R and the psychiatrist completed a Psychiatrist Evaluation Form including a CGI. Most inmates were rated as mildly to moderately ill. There was significant high correlation between TP psychiatrist rating on CGI and inmate report on SCL-90-R. The findings support effectiveness of TP evaluation for the jail population.
Zaylor et al. (2001)	The effectiveness of a prison telepsychiatry service was evaluated from the user perspective.	$N = 45$. Completed the SCL-90-R three times. The psychiatrist completed the CGI. Mean SCL scores decreased with time. The psychiatrists reported improvement over time on CGI. Telepsychiatry is an effective means of delivering MH services to the prison population.
Lexcen et al. (2006)	The authors investigated the quality of results from VC vs F2F with 72 forensic patients. Three administration and observation conditions were used.	Interrater reliability for 2 VC interview conditions were compared to those for F2F using BPRS—Anchored version and MacArthur Competence Assessment Tool—Criminal Application.

VC = video conferencing.
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Table 3. Telepsychiatry studies on treatment feasibility, satisfaction, efficacy or effectiveness in the child and adolescent population

Authors	Objective	Outcomes
Nelson et al. (2003)	This is an evaluation of an 8 week CBT intervention for childhood depression, either F2F or VC.	28 children were randomized to 2 tx groups. CBT across the 2 conditions was effective. Patients and parents were satisfied with VC and preferred VC over F2F. CBT was effective across both delivery methods. 82% no longer met criteria at the end. VC reported a greater decrease in depressive symptoms over time as compared to F2F. This is a model for RC trials in the future.
Elford et al. (2000)	The authors established a TP system for children and conducted an assessment of its utility.	$N=23$ children with parents. 2 psychiatric assessments completed, one F2F and one VC. Order was randomized. In 22 cases (96%) dx and tx recommendations were same across both groups. Psychiatrists said VC assessment was adequate but F2F was preferred. Satisfaction measured in patients and parents was the same across groups. The majority of children liked TP and preferred it to F2F. Most parents indicated they preferred VC to traveling a long distance.
Alessi (2003)	Case report of 15 year old evaluated and treated by telepsychiatry.	Diagnosis was changed, medications discontinued and the patient improved. All scales showed reduced severity of symptoms.
Savin et al. (2006)	Description of twice monthly child and adolescent telepsych service.	21 evaluations in 12 months. 2 cases illustrate issues encountered. Patients and families were receptive. Cost is similar to F2F. Emphasizes importance of alcohol abuse in this population.
Starling et al. (2003)	This article describes the initial evaluation of the child and adolescent psychological telemedicine outreach service in New South Wales and changes made to the service after the initial evaluation.	136 rural families, 20 rural clinicians and 8 psychiatrists. Satisfaction was high, with clinicians and families the most satisfied. Psychiatrists felt that they were usually able to perform an adequate consultation but few felt the consultations were as satisfactory as F2F. Other initiatives included telenursing, professional skills training, sabbaticals for rural clinicians and a clinical skills workshop.
Myers et al. (2004)	Examined whether TP patients are representative of those in usual OP care.	$N=369$, 2 clinics. Youth evaluated were broadly comparable in both. TP appears to serve youth that are representative of those seeking psych. care. Diagnoses were similar and suggest that TP provides adequate technical resolution and doctor–patient rapport to detect psychopathology.
Neufield et al. (2007)	Describes the University of CA program. Used for clinical services, consultation and education.	289 consults in first year. ADHD was most common dx in kids, mood disorders in adults. A convenience sample of 33 adults (SF-12 health status measure) showed improvements in MH status at 3 and 6 months.

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Comparisons between telepsychiatry via video conferencing and telephone have not been made. Having shown success with specific populations using telephonic interventions, it may be more appropriate to conduct equivalence studies with telepsychiatry via videoconferencing compared with telepsychiatry via telephone rather than comparing videoconferencing to face to face treatment. Likewise, finding that telephone interventions may require less time for an equivalent effect (Lovell et al., 2006) suggests that telepsychiatry interventions should be tested for a similar effect. The growing literature on both telephone-aided and video-conferencing treatments makes the determination of which technology is effective with what types of patient, and the need to match technology with patient values and needs (Ryan, Kobb, & Hilsen, 2003), a possibility. Telephonic interventions may be more feasible in settings where videoconferencing equipment is unavailable or impractical, including forensic and correctional facilities.

This review of the literature covers a time period of over half a century, but efficacy and effectiveness data are still rather sparse. The limited evidence is from 2000 or later and is relatively weak due to the problems discussed above. The literature began with descriptive articles looking at feasibility, acceptance, satisfaction, and cost. There was then movement toward comparing telepsychiatry to services provided face to face. A few studies that provide the same treatment across the two modalities and measure clinical outcomes have emerged. However, the treatment is very limited, usually medication management or a short course of CBT, and if there is therapy it is often paired with some type of face-to-face contact as well. Outcomes appear to be the same. Acceptance is good in general. If there are acceptance problems, it is usually the professional who is reluctant, not the patient or family. Usage is primarily in rural areas or jails, or with underserved subpopulations such as children. The state of the literature is generally weak but there is more in psychiatry than other medical specialty areas, probably because of the greater reliance on the mental status examination and verbal communication and not on a physical examination.

IMPLICATIONS FOR FORENSIC OR CORRECTIONAL PSYCHIATRY

Our review of the literature yielded 12 articles from forensic settings. Five addressed efficacy and are included in our review. The total number of subjects in these five articles was 345. One article (Leonard, 2004) only outlined study design, one looked at symptom improvement (Zaylor et al., 2001), two examined patient satisfaction (Brodey, Claypoole, Motto, Arias, & Goss, 2000; Myers et al., 2004), one examined interrater reliability in telepsychiatric assessments based on interviews (Lexcen et al., 2006) and one focused on the effectiveness of a jail telepsychiatry service (Nelson et al., 2004). The Myers study (Myers et al., 2004) looked at an adolescent population while the others focused on adults. All studies had significant methodological limitations, making confident conclusions difficult.

The overall view that emerges is that, despite methodological problems, telepsychiatry seems to be an appropriate option to provide services to patients in correctional facilities in order to improve access to psychiatric services. The Zaylor study (Zaylor et al., 2001) showed improvement in symptoms per patient and

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psychiatrist report. The Nelson study (Nelson et al., 2004) showed a high correlation between the telepsychiatrist evaluation and inmate report of symptoms. The Brodey study (Brodey et al., 2000) notes that the physician felt comfortable making diagnoses via telepsychiatry and did not find a difference in satisfaction between those who received care via telepsychiatry and those who received care in person.

Telepsychiatric treatment in correctional facilities may differ from telepsychiatric treatment in outpatient clinics in important ways. Because the patients are in correctional facilities, it is most likely they will have at least one staff member present during their telepsychiatry session. This eliminates the privacy usually available in a physician/patient relationship. Indeed, the youths in the Myers article expressed concerns about their lack of privacy. It would be difficult to eliminate this problem completely, as correctional facilities must maintain safety and security at all costs. This lack of privacy may be most noticeable to those patients who have had outpatient experiences with psychiatric providers outside the correctional system.

When initiating a telepsychiatry service within a correctional facility, it will be important to clearly identify the facility's expectations of the psychiatrist and the limits of the physician/patient relationship. It should be understood how the recommendations made will be carried out by correctional facility staff. In addition, a plan would be needed for dealing with patient problems when the psychiatrist is not available. It will also be important to plan ahead and anticipate how potential growth of a telepsychiatry clinic will be handled in order to ensure adequate time for new evaluations and follow-up treatment.

OPPORTUNITIES FOR CORRECTIONAL AND FORENSIC PSYCHIATRY

Despite the methodological cautions, there are no data that demonstrate that telepsychiatric services are harmful, either to general psychiatric patients, children, or to prisoners. It appears that telepsychiatric assessments are acceptable to individuals in forensic and correctional facilities, and that telepsychiatric services can be used effectively with prisoners with certain psychiatric disorders. More comparisons on specific psychiatric subgroups, using specific treatment interventions, are needed to optimally match the technological medium of intervention with particular prisoner or patient problems.

While telepsychiatry seems to be a viable option for providing psychiatric care to those in correctional facilities, there is still a need for more research in this field. Comparing telephone and telepsychiatry treatments with each other and with usual care would be useful, as telephonic consultation may be more feasible than videoconferencing in some correctional settings. It would also be beneficial to look at efficacy differences for different disorders and for differences related to demographic factors such as age, race, and gender.

In terms of the long-term development of telepsychiatry, we offer the following recommendations for correctional systems.

1. Foster pilot projects in telepsychiatry, particularly utilizing evidence-based approaches.
2. Aggressively pursue tele-training, leveraging existing resources to the greatest practical extent. Extensive high-speed networking and videoconferencing

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resources may already be in place. Additional video-conferencing resources may be available through public and private higher education institutions, Area Health Education Center (AHEC) offices, and Public Health systems.

3. In situations where teleconferencing cannot be implemented, telephone services should be considered.
4. The correctional systems should look to professional societies and other states' telepsychiatry programs to develop guidelines and best practices.
5. The forensic systems should identify technology infrastructure needs, and then implement a plan to meet these needs. There are many Federal programs that can assist with infrastructure, including the FCC Universal Services Fund (communications subsidies) and the U.S. Department of Agriculture/Rural Utility Service's Telemedicine and Distance Learning grant and loan program (equipment purchases).

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DOI: 10.1002/bsl

CyberPsychology & Behavior
Volume 8, Number 3, 2005
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Virtual Reality in Psychotherapy: Review

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ABSTRACT

Virtual reality (VR) has recently emerged as a potentially effective way to provide general and specialty health care services, and appears poised to enter mainstream psychotherapy delivery. Because VR could be part of the future of clinical psychology, it is critical to all psychotherapists that it be defined broadly. To ensure appropriate development of VR applications, clinicians must have a clear understanding of the opportunities and challenges it will provide in professional practice. This review outlines the current state of clinical research relevant to the development of virtual environments for use in psychotherapy. In particular, the paper focuses its analysis on both actual applications of VR in clinical psychology and how different clinical perspectives can use this approach to improve the process of therapeutic change.

INTRODUCTION

What is the future of psychotherapy? How will future changes impact on psychotherapy, psychologists, and our patients? Recently, a panel of 62 psychotherapy experts using Delphi methodology tried to answer these questions.[1] According to their answers, only 18 out of the 38 therapeutic interventions analyzed were predicted to increase in the next decade. In particular, the use of VR and computerized therapies were ranked third and fifth, preceded only by homework assignments (first), relapse prevention (second), and problem solving techniques (fourth). On the other side, traditional psychotherapy interventions such as hypnosis (32nd), paradoxical interventions (33rd), or dream interpretation (35th) were predicted to drastically diminish.

Even if these data may be provocative to some psychotherapists, there is no doubt that rapid and far-reaching technological advances are changing the ways in which people relate, communicate, and live. Technologies that were hardly used 10 years ago, such as the internet, e-mail, and video teleconferencing, are becoming familiar methods for diagnosis, therapy, education, and training.

However, the possible impact of VR on psychotherapy could be even higher than the one offered by the new communication technologies.[2] In fact, VR is at the same time a technology, a communication interface, and a compelling experience. Because VR could be part of the future of clinical psychology, it is critical to all psychotherapists that it should be defined broadly. To ensure appropriate development of VR applications, clinicians must have a clear understanding of the opportunities and challenges it will provide to professional practice.

The paper tries to outline the current state of clinical research that is relevant to the development of virtual environments for psychotherapy use. In particular, the paper focuses its analysis on both actual applications of VR in clinical psychology and how different clinical perspectives can use this approach to improve the process of therapeutic change.

VR IN PSYCHOTHERAPY: THE PRESENT

Research in the VR field is moving fast.[2,3] If we check the leading psychology database—PSYCINFO—using "virtual reality" as key words,

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we find 996 journal articles listed (quick search query, accessed April 18, 2005). Most of them (371) were written in the last 3 years and include different controlled trials (Table 1).

Shifting our analysis to psychotherapy application, it is easy to find that the most common application of VR in this area is the treatment of phobias. Since the early 1990s, when Hodges and colleagues[4,5] reported on a project that used virtual environments to provide acrophobic patients with fear-producing experiences of heights in a safe situation, VR exposure therapy (VRE) has been proposed as a new medium for exposure therapy.[6] The rationale behind its use is very simple: in VR the patient is intentionally confronted with the feared stimuli while allowing the anxiety to attenuate. Because avoiding a dreaded situation reinforces all phobias, each exposure to it actually lessens the anxiety through the processes of habituation and extinction. Moreover, VRE offers a number of advantages over *in vivo* or imaginal exposure; it can be administered in traditional therapeutic settings, and is more controlled and cost-effective than *in vivo* exposure.

In different controlled studies, VRE was as effective as *in vivo* therapy in the treatment of acrophobia,[7,8] spider phobia,[9] and fear of flying.[10–13] However, in fear of flying treatment, Maltby and colleagues did not find significant differences between VR exposure or attention-placebo group treatment at 6-month follow-up.[13] Other phobias currently under investigation are agoraphobia,[14] claustrophobia,[15] panic disorder with agoraphobia,[16–18] and public speaking disorder.[19,20]

VRE is also used as an alternative to typical imaginal exposure treatment for Vietnam combat veterans with posttraumatic stress disorder (PTSD).[21] Rothbaum and colleagues[22] exposed a sample of 10 combat veterans with PTSD to two virtual environments: a virtual Huey helicopter flying over a virtual Vietnam and a clearing surrounded by jungle. All the patients interviewed at the 6-month follow-up reported reductions in PTSD symptoms ranging from 15% to 67%.

Riva and colleagues[23–25] are using experiential cognitive therapy (ECT), an integrated approach ranging from cognitive-behavioral therapy to VR sessions, in the treatment of eating disorders and obesity. In this approach, VR is mainly used to modify body image perceptions. What is the rationale behind this approach? Different studies show that body image dissatisfaction can be considered a form of cognitive bias.[26,27] The essence of this cognitive perspective is that the central psychopathological concerns of an individual bias the manner in which information is processed. In most cases, this biased information processing occurs automatically. Also, it is generally presumed that the process occurs more or less outside the person's awareness, unless the person consciously reflects upon his or her thought processes (as in cognitive therapy).

According to Williamson and colleagues,[26] body size overestimation can be considered as a complex judgment bias, strictly linked to attentional and memory biases for body-related information: "If information related to body is selectively processed and recalled more easily, it is apparent how the self-schema becomes so highly associated with body-related information. If the memories related to body are also associated with negative emotion, activation of negative emotion should sensitize the person to body-related stimuli, causing even greater body size overestimation."

It is very difficult to counter a cognitive bias. In fact, biased information processing occurs automatically, and the subjects are not aware of it. So, for them, the biased information is real. They are not able to distinguish between perceptions and biased cognitions. Moreover, any attempt at convincing them otherwise is usually useless and sometimes produces strong emotional defense. In fact, the denial of the disorder and resistance to treatment are two of the most vexing clinical problems in these pathologies.[28,29]

Given these difficulties, there are two different approaches to the treatment of body image disturbances[27]:

- *Cognitive-behavioral strategies*: This approach is based on assessment, education, exposure, and modification of body image. The therapy both identifies and challenges appearance assumptions and modifies self-defeating body image behaviors.[30–32]
- *Feminist approach*: Feminist therapists usually use experiential techniques, such as guided imagery, movement exercises, and art and dance therapy.[33,34] Other experiential techniques include free-associative writing regarding a problematic body part, stage performance, or psychodrama.[34,35]

Unfortunately, both approaches, even if effective in the long term, require a strong involvement of the patient and many months of treatment.

The use of VR offers two key advantages. First, it is possible to integrate all different methods (cognitive, behavioral, and experiential) commonly used in the treatment of body experience disturbances

TABLE 1. APPLICATIONS OF VIRTUAL REALITY IN PSYCHOTHERAPY: CONTROLLED TRIALS WITH 10 OR MORE PATIENTS RESEARCH AS OF MARCH 9, 2004. SOURCES: PSYCINFO AND MEDLINE.

Authors	*Paper*	*Approach*	*Sample*
Emmelkamp, P.M.G., Bruynzeel, M., Drost, L. & van der Mast, C.A.P.G.	(2001). Virtual reality treatment in acrophobia: , a comparison with exposure *in vivo. CyberPsychology & Behavior,* 4:335–339.	Cognitive-behavioral	10 acrophobia patients
Emmelkamp, P.M.G., Krijn, M., Hulsbosch, A.M., de Vries, S., Schuemie, M.J., & van der Mast, C.A.P.G.	(2002). Virtual reality treatment versus exposure in vivo: a comparative evaluation in acrophobia. *Behavior Research and Therapy* 40:509–516.	Cognitive-behavioral	33 acrophobia patients
Garcia-Palacios, A., Hoffman, H., Carlin, A., Furness, T.A., III, & Botella, C.	(2002). Virtual reality the treatment of spider phobia: a controlled study. *Behavior Research and Therapy,* 40:983–993.	Cognitive-behavioral	23 phobics
Maltby, N., Kirsch, I., Mayers, M., & Allen, G.	(2002) Virtual reality exposure therapy for the treatment of fear of flying: a controlled investigation. *Journal of Consulting & Clinical Psychology,* 70: 1112–1118.	Cognitive-behavioral	45 phobics
Optale, G., Munari, A., Nasta, A., Pianon, C., Baldaro Verde, J., & Viggiano, G.	(1997). Multimedia and virtual reality techniques in the treatment of male erectile disorders. *International Journal of Impotence Research* 9:197–203.	Psycho-dynamic	60 patients of male erectile disorders
Riva, G., Bacchetta, M., Baruffi, M., & Molinari, E.	(2001). Virtual reality–based multidimensional therapy for the treatment of body image disturbances in obesity: controlled study. *CyberPsychology & Behavior* 4:511–526.	Experiential-cognitive	28 obese patients
Riva, G., Bacchetta, M., Baruffi, M., & Molinari, E.	Virtual reality–based multidimensional therapy for the treatment of body image disturbances in binge eating disorders: a preliminary controlled study *IEEE Transactions on Information Technology in Biomedicine,* 6:224–234.	Experiential-cognitive	20 binge eating patients

TABLE 1. APPLICATIONS OF VIRTUAL REALITY IN PSYCHOTHERAPY: CONTROLLED TRIALS WITH 10 OR MORE PATIENTS RESEARCH AS OF MARCH 9, 2004. SOURCES: PSYCINFO AND MEDLINE. (*CONTINUED*)

Authors	*Paper*	*Approach*	*Sample*
Riva, G., Bacchetta, M., Cesa, G., Conti, S., & Molinari, E.	(2003). Six-month follow-up of in-patient Experiential-Cognitive Therapy for binge eating disorders. *CyberPsychology & Behavior* 6:251–258.	Experiential-cognitive	36 binge eating patients
Rothbaum, B.O., Hodges, L.F., Kooper, R., Opdyke, D., et al.	(1995). Effectiveness of computer-generated (virtual reality) graded exposure in the treatment of acrophobia. *American Journal of Psychiatry* 152:626–628.	Cognitive-behavioral	17 college students
Rothbaum, B.O., Hodges, L., Smith, S., Lee, J.H., & Price, L.	(2000). A controlled study of virtual reality exposure therapy for the fear of flying. *Journal of Consulting and Clinical Psychology* 68:1020–1026.	Cognitive-behavioral	49 fear of flying patients
Rothbaum, B.O., Hodges, L., Anderson, P.L., Price, L., & Smith, S.	(2002). Twelve-month follow-up of virtual reality and standard exposure therapies for the fear of flying. *Journal of Consulting and Clinical Psychology* 70:428–432.		
Vincelli, F., Anolli, L., Bouchard, S., Wiederhold, B.K., Zurloni, V., & Riva, G.	(2003). Experiential cognitive therapy in the treatment of panic disorders with agoraphobia: a controlled study. *CyberPsychology & Behavior* 6:312–318.	Experiential-cognitive	12 panic disorders with agoraphobia patients
Wiederhold, B.K., Jang, D.P., Kim, S.I., & Wiederhold, M.D.	(2002). Physiological monitoring as an objective tool in virtual reality therapy. *CyberPsychology & Behavior* 5:77–82.	Cognitive-behavioral	36 fear of flying patients, 22 non-phobics
Wiederhold, B.K., Jang, D.P., Kim, S.I., & Wiederhold, M.D.	(2002). A controlled trial comparing physiologicalresponses during virtual reality exposure and imaginal exposure in flight phobics. *IEEE Transactions on Information Technology in Biomedicine* 6:218–223.	Cognitive-behavioral	30 fear of flying patients

within a single virtual experience. Second, VR can be used to induce the patient in a controlled sensory rearrangement that unconsciously modifies his or her bodily awareness (body schema). When we use a VR system, we feel our self-image projected onto the image of the visual cues (i.e., a certain figure or an abstract point, such as a cursors, which moves in accordance with the movement of our own hand) appearing in the video monitor, as a part of or an extension of our own hands.[36] As noted by Iriki and colleagues,[37] "Essential elements of such an image of our own body should be comprised of neural representations about the dimension, posture and movement of the corresponding body parts in relation to the environmental space. Thus, its production requires integration of somatosensory (intrinsic) and visual (extrinsic) information of our own body in space." When this occurs, the information itself becomes accessible at a conscious level[38] and can be modified more easily.

In a case study, a 22-year-old female university student diagnosed with anorexia nervosa was submitted to ECT treatment.[39] At the end of the inpatient treatment, the patient increased her bodily awareness, at the same time reducing her level of body dissatisfaction. Moreover, the patient presented a high degree of motivation to change. Expanding these results, the researchers carried out different clinical trials on female patients[40–43]; 25 patients suffering from binge-eating disorders were included in the first study, 20 in the second, and 18 with obesity in the third. At the end of the inpatient treatments, the patients from each sample significantly modified their bodily awareness. This modification was associated with a reduction in problematic eating and social behaviors.

Optale et al.[44,45] used immersive VR to improve the efficacy of a psychodynamic approach in treating male erectile disorders. In the VE, four different expandable pathways open up through a forest, bringing the patients back into their childhood, adolescence, and teens, when they started to get interested in the opposite sex. Different situations are presented with obstacles that the patient has to overcome to proceed. VR environments are here used as a form of controlled dreams allowing the patient to express in a non-verbal way transference reactions and free associations related to his sexual experience. General principles of psychological dynamisms, such as the difficulty with separations and ambivalent attachments, are used to inform interpretive efforts.

The obtained results—30 out of 36 patients with psychological erectile dysfunction and 28 out of 37 patients with premature ejaculation maintained partial or complete positive response after 6-month follow up—show that VR hastens the healing process and reduces dropouts. Moreover, Optale et al. used positron emission tomography (PET) scans to analyze regional brain metabolism changes from baseline to follow-up in patients treated with VR.[46] The analysis of the scans showed different metabolic changes in specific areas of the brain connected with the erection mechanism.

WHAT IS VR?

As we have just seen, the rationales behind the use of VR in psychotherapy are very different. What is the common link between them, and what is the future of VR in psychotherapy? Our attempt to identify a possible answer starts from a broader question: what is VR?

Since 1986, when Jaron Lamier used the term for the first time, VR has been usually described as a collection of technological devices: a computer capable of interactive three-dimensional (3D) visualization, a head-mounted display, and data gloves equipped with one or more position trackers. The trackers sense the position and orientation of the user, and report that information to the computer that updates (in real time) the images for display.

For instance, Rubino et al.,[47] McCloy and Stone,[48] and Székely and Satava,[49] in their reviews about the use of VR in health care, share this vision: "VR is a collection of technologies that allow people to interact efficiently with 3D computerized databases in real time using their natural senses and skills."[48]

However, when we shift our attention to behavioral sciences, we find a different vision: VR is described as "an advanced form of human–computer interface that allows the user to interact with and become immersed in a computer-generated environment in a naturalistic fashion."[50]

In fact, psychologists use specialized technologies—head-mounted displays, tracking systems, earphones, gloves, and sometimes haptic feedback—to provide a new human–computer interaction paradigm. In VR, users are no longer simply external observers of images on a computer screen, but are active participants within a computer-generated 3D virtual world.[51]

Bricken[52] identifies the core characteristic of VR in the inclusive relationship between the participant and the virtual environment, where direct experience of the immersive environment constitutes communication. According to this position, VR can be considered as the leading edge of a general evolution of present communication interfaces such as

television, computer, and telephone,[53,54] whose ultimate goal is the full immersion of the human sensorimotor channels into a vivid and global communication experience.[55]

This position better clarifies the actual role of VR in psychotherapy and the common link between the different clinical applications presented: VR is an advanced communication interface based on interactive 3D visualization, able to collect and integrate different inputs and data sets in a single real-like experience.

What distinguishes VR from other media or communication systems is the sense of *presence*.[56] What is presence? Even if usually presence is defined as the "sense of being there"[57] or as the "feeling of being in a world that exists outside of the self,"[58] it is now widely acknowledged that presence should be treated as a neuropsychological phenomenon.[54,56,59–65] In particular, Riva and Waterworth described presence as a defining feature of self, related to the evolution of a key feature of any central nervous system[58]: the embedding of sensory-referred properties into an internal functional space. More specifically, without the emergence of the sense of presence, it is impossible for the nervous system to differentiate between an external world and the internal one. If, in simple organisms, this differentiation involves only a correct coupling between perceptions and movements, in humans it also requires the shift from meaning-as-comprehensibility to meaning-as-significance.

Meaning-as-comprehensibility refers to the extent to which the event fits with our view of the world (e.g., as just, controllable, and nonrandom), whereas meaning-as-significance refers to the value or worth of the event for us.[66] Following this point, contributions to the intensity of the sense of presence come from three layers of the self recently defined by Damasio[67]: proto self, core self, and autobiographical self. The more the three layers are integrated (focused on the same events), the stronger the intensity of the presence feeling. This means that, between two equally stimulating virtual environments, humans are more present in the one more relevant to their own goals.

VR IN PSYCHOTHERAPY: THE NEXT STEPS

How is it possible to change a patient? Even if this question has many possible answers according to the specific psychotherapeutic approach, in general change comes through an intense focus on a particular instance or experience[68]: by exploring it as much as possible, the patient can relive all of the significant elements associated with it (i.e., conceptual, emotional, motivational, and behavioral) and make them available for a reorganization of his or her perspective.

Within this general model, we have the insight-based approach of psychoanalysis, the schema-reorganization goals of cognitive therapy, the functional analysis of behavioral activation, the interpersonal relationship focus of interpersonal therapy, or the enhancement of experience awareness in experiential therapies.

What are the differences between them? According to Safran and Greenberg,[69] behind the specific therapeutic approach we can find two different models of change: bottom-up and top-down. Bottom-up processing begins with a specific emotional experience and leads eventually to change at the behavioral and conceptual level, whereas top-down change usually involves exploring and challenging tacit rules and beliefs that guide the processing of emotional experience and behavioral planning. These two models of change are focused on two different cognitive systems, one for information transmission (top-down) and one for conscious experience (bottom-up), both of which may process sensory input.[70] The existence of two different cognitive systems is clearly shown by the dissociation between verbal knowledge and task performance: people learn to control dynamic systems without being able to specify the nature of the relations within the system, and they can sometimes describe the rules by which the system operates without being able to put them into practice.

Even if many therapeutic approaches are based on just one of the two change models, a therapist usually requires both.[68] Some patients seem to operate primarily by means of top-down information processing, which may then prime the way for corrective emotional experiences. For others, the appropriate access point is the intensification of their emotional experience and their awareness of both it and related behaviors. Finally, different patients who initially engage therapeutic work only through top-down processing may be able, later in the therapy, to make use of bottom-up emotional processing.

In this situation, a critical advantage can be provided by the sense of presence provided by VR. As we have seen before, the sense of presence is strictly related to all the three layers of self recently identified by Damasio.[67] Using it accordingly, it is possible to target a specific cognitive system without any significant change in the therapeutic approach. For instance, behavioral therapists may use a virtual environment for activating

the fear structure in a phobic patient through confrontation with the feared stimuli; a cognitive therapist may use VR situations to assess situational memories or disrupt habitual patterns of selective attention; experiential therapists may use VR to isolate the patient from the external world and help him or her in practicing the right actions; psychodynamic therapists may use virtual environments as complex symbolic systems for evoking and releasing affect.

In fact, VR can also be described as an advanced imaginal system: an experiential form of imagery that is as effective as reality in inducing emotional responses.[71-73] As outlined by Baños et al.,[74] the VR experience can help the course of the therapy for "its capability of reducing the distinction between the computer's reality and the conventional reality." In fact, "VR can be used for experiencing different identities and . . . even other forms of self, as well." The possibility of structuring a large amount of real-like or imaginary controlled stimuli and, simultaneously, of monitoring the possible responses generated by the user of the virtual world offers a considerable increase in the likelihood of therapeutic effectiveness, as compared to traditional procedures.[54] As noted by Glantz et al.[75]: "One reason it is so difficult to get people to update their assumptions is that change often requires a prior step—recognizing the distinction between an assumption and a perception. Until revealed to be fallacious, assumptions constitute the world; they seem like perceptions, and as long as they do, they are resistant to change." Using the sense of presence induced by VR, it is easier for the therapist to develop real-like experiences demonstrating to the patient that what looks like a perception (e.g., the body image distortion) is produced by his or her mind. Once this has been understood, individual maladaptive assumptions can then be challenged more easily.

Moreover, patients usually accept very well the use of VR. In a recent study, Garcia-Palacios et al. compared the acceptance of one-session and multi-session *in vivo* exposure versus multi-session VR exposure therapy.[76] More than 80% of the sample preferred VR to *in vivo* exposure.

Finally, VR can play an important role in psychotherapy as a particular form of supportive technique, contributing to the therapist–patient relationship as well as enhancing the therapeutic environment for the patient. Even if supportive techniques are more common in psychodynamic approaches, they are widely used in different treatments.[77] In general, they are considered as supportive as the following techniques[77,78]:

- Demonstration of support, acceptance, and affection toward the patient
- Emphasis on working together with the patient to achieve results
- Communication of a hopeful attitude that the goals will be achieved
- Respect of the patient's defenses
- Focus on the patient's strengths and acknowledgment of the growing ability of the patient to accomplish results without the therapist's help

Using VR, it is possible for the patient to manage successfully a problematic situation related to his or her disturbance. By creating a synthetic environment in which the patient is likely to feel more secure, VR may enable the patient to express thoughts and feelings that are otherwise too difficult to discuss, thereby increasing the degree of closeness between the patient and therapist. Using VR in this way, the patient is more likely not only to gain an awareness of his or her need to do something to create change but also to experience a greater sense of personal efficacy.

VR can be employed as a supportive technique at the onset of treatment to create an atmosphere in which the patient feels stable, which in turn allows treatment to progress. Alternatively, it may be used in the course of treatment should a crisis occur, enabling the patient to overcome the situation responsible for halting further improvement. In general, VR can be used throughout treatment to foster a positive therapeutic alliance and as a trigger for a broader empowerment process. In psychological literature, empowerment is considered a multifaceted construct reflecting the different dimensions of being psychologically enabled, and is conceived of as a positive additive function of the following three dimensions[79]:

- *Perceived control*: This includes beliefs about authority, decision-making skills, availability of resources, and autonomy in the scheduling and performance of work.
- *Perceived competence*: This reflects role-mastery, which, besides requiring the skillful accomplishment of one or more assigned tasks, also requires successful coping with non-routine role-related situations.
- *Goal internalization*: This dimension captures the energizing property of a worthy cause or exciting vision provided by the organizational leadership.

VR is a special, sheltered setting where patients can start to explore and act without feeling threat-

ened. In this sense, the virtual experience is an "empowering environment" that therapy provides for patients. As noted by Botella and colleagues,[80] nothing the patient fears can "really" happen to them in VR. With such assurance, they can freely explore, experiment, feel, live, and experience feelings and/or thoughts. VR thus becomes a very useful intermediate step between the therapist's office and the real world.

CONCLUSION

As we have seen, in the last 5 years there has been a steady growth in the use of VR in clinical psychology due to advances in information technology and a decline in costs.[2] However, several barriers still remain.

The first is the lack of standardization in VR devices and software. The PC-based systems, while inexpensive and easy-to-use, still suffer from a lack of flexibility and capabilities necessary to individualize environments for each patient.[81] To date, very few of the various VR systems available are interoperable. This makes their use difficult in contexts other than those in which they were developed.

The second is the lack of standardized protocols that can be shared by the community of researchers. If we check the two clinical databases, we can find only five published clinical protocols: for the treatment of eating disorders,[24] fear of flying,[82,83] fear of public speaking,[84] and panic disorders.[16]

The third is the costs required for the set-up trials. As we have just seen, the lack of interoperable systems added to the lack of clinical protocols force most researchers to spend a lot of time and money in designing and developing their own VR application: many of them can be considered "one-off" creations tied to a proprietary hardware and software, which have been tuned by a process of trial and error. According to the European funded project VEPSY Updated,[85] the cost required for designing a clinical VR application from scratch and testing it on clinical patients using controlled trials may range between 150,000 and 200,000 US$. Finally, the introduction of patients and clinicians to virtual environments raises particular safety and ethical issues.[86] In fact, despite developments in VR technology, some users still experience health and safety problems associated with VR use. It is however true that, for a large proportion of VR users, these effects are mild and subside quickly.[87]

Significant efforts are still required to move VR into commercial success and therefore routine clinical use. It is clear that building new and additional virtual environments is important so that therapists will continue to investigate applying these tools in their day-to-day clinical practice.[88] In fact, in most circumstances, the clinical skills of the therapist remain the key factor in the successful use of VR systems. Here, VR can have a role both as supportive technique and for targeting a specific cognitive system without any significant change in the therapeutic approach.

Finally, communication networks have the potential to transform virtual environments into shared worlds in which individuals, objects, and processes interact without regard to their location. In the future, such networks will probably merge VR and telemedicine applications, allowing us to use VR for such purposes as distance learning and e-therapy.

ACKNOWLEDGMENTS

The present work was supported by the Commission of the European Communities (CEC), in particular by the IST Programme (Project VEPSY UPDATED, IST-2000–25323, <www.cybertherapy.info>, <www.e-therapy.info>; Project EMMA, IST-2001–39192).

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CyberPsychology & Behavior
Volume 8, Number 3, 2005
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Commentary on Riva, G., Virtual Reality in Psychotherapy: Review

According to Riva, as virtual reality (VR) is set to enter mainstream psychotherapy delivery, it could be part of clinical psychology's future. For the appropriate development of VR applications to be guaranteed, Riva argues that VR should be defined, and that the opportunities and the challenges it may provide to professional practice be understood. When outlining the current state of relevant clinical research to the development of VR in psychotherapy use, Riva observes that, since the early 1990s, virtual environments have been used as a medium for exposure in phobias.[1,2] He notes that VR exposure therapy (VRE) has been shown to be as effective as *"in vivo"* exposure in the treatment of specific phobias (e.g., acrophobia,[3,4] spider phobia,[5] fear of flying[6]). Its clinical application to more complex disorders (e.g., agoraphobia,[7] claustrophobia,[8] panic disorder,[9] public speaking disorder,[10] eating disorders[11]) is currently being examined. He describes how VRE has also been used as an alternative to "imagery" exposure treatment with post-traumatic stress disorder.[12]

Riva identifies several advantages of VRE when compared to *"in vivo"* or "imagery" exposure. VRE can be administered in traditional therapeutic settings (hence can be more controlled and possibly more cost effective); it can provide stimuli for individuals who have difficulty in imaging scenes; it can provide opportunities for those individuals who are too phobic to experience real situations; and it can generate stimuli of greater magnitude than other more standard techniques (it can therefore produce alternative and fantastic worlds). According to Riva, it is these advantages that arguably position VR as an "intermediate step between the therapist's office and the real world."

Nevertheless, before it becomes part of mainstream use, Riva also identifies several technological, practical, procedural, and ethical barriers still remaining for VR. VR devices, software, and protocols lack standardization, and only a few of the VR systems available are interoperable, rendering most systems only useful in the contexts in which they were developed. As noted by Riva, the above issues force most researchers to spend a lot of time and money designing and developing "one-off" VR creations. These barriers, when added to the particular safety and ethical issues associated with using virtual environments, lead Riva to conclude that much effort will be needed to move VR to commercial success and therefore to become part of routine clinical use.

Riva offers a thoughtful and stimulating commentary on VR in psychotherapy. However, in addition to the ideas provided by Riva and in line with the statement of the nature, purpose, and characteristics of clinical psychology offered by the British Psychological Society's (BPS) Division of Clinical Psychology's (DCP),[13] it is the author's contention that clinical psychology is more than psychotherapy for those of working age. "Clinical psychologists can work with individuals, couples, families, groups (therapeutic, staff), and at the organizational level (e.g., hospital wards, day centres, Community Mental Health Teams, National Health Service Trusts). They also work with all age groups from very young children to older people. They work with people with mild, moderate, and severe mental health problems, people with learning disabilities, people with physical and sensory handicaps, people with brain injury, people who have alcohol and other drug problems, and people with a range of physical health problems."[13]

When considering the assertion above, it may be argued that the above-mentioned benefits of using virtual environments may be extended to other clinical psychologists working in a variety of user group settings. Indeed, there are already examples of the use of VR in the field of neuropsychology rehabilitation,[14–18] in older adult psychology services,[17,19] and in pediatric services.[20] Their use within learning difficulties services has also been discussed.[21]

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VIRTUAL REALITY (VR) is a very powerful tool that has shown its potential in many fields. Its wide range of utility was quickly evident for both basic research and applications in different scientific ambits. Clinical psychology was also very interested in the versatility of VR and its use as a therapeutic resource. More than a decade has passed since the first clinical applications—which were focused mainly on the treatment of specific phobias, that is "virtual exposure"—were brought to the attention of academic and therapeutic audiences. The application of VR to clinical psychology is expanding fast to encompass more

complex disorders, such as eating disorders, panic disorder, and post-traumatic stress disorder. It is also beginning to encompass a broader range of psychotherapeutic approaches. After more than 10 years of work on VR clinical applications, a detailed reflection about the work achieved and the work in prospect is useful. This reflection should go beyond the initial enthusiasm, pointing out the weaknesses and strengths of VR. This is the purpose of Riva's paper—to outline the current state of VR for use in psychotherapeutic contexts. If VR is expected to be an effective and efficient therapeutic tool, its utility should be extended from universities and research centers to "clinical reality." Riva's work also addresses this, and shows the opportunities and limitations of VR applications for professional practice.

As Riva points out, at first VR was defined as a collection of machines. However, this kind of definition was too restricted, and the focus changed quickly to include the individual who uses the technology. We prefer to consider VR as a human experience, that is, an advanced communication interface that enables the user to experience "other" worlds, "other realities." This is why VR is so useful and versatile for psychotherapy. The focus of psychological treatments lies in modifying some of the person's experiences, and it is necessary to create experiences that individuals assume as their own. As Osberg[1] claimed, VR could be considered as an alternative reality based on perception, instead of as a perception based on reality; it may not be necessary to copy physical reality exactly. A user could experience a virtual world even when the virtual environment does not provide a complete or totally precise representation of the real world. Furthermore, VR could produce alternative and fantastic worlds, which is one of its more attractive features, especially for clinical psychology because the goal is to achieve important changes in the users.[2]

We have to be aware of VR's limitations. Riva points out that some problems still remain. Some of them are mainly technological, but others are related to clinical issues. It is necessary to standardize VR devices, software, and protocols, and to take into account ethical issues. It is also necessary to continue working on VR's utility for other clinical tasks, such as assessment and research. VR can be helpful to increase the ecological validity of our assessment tools, and it can be considered as an "ecological" laboratory where behaviors, feelings, and human experiences can be studied in a controlled and rigorous way.[3] Furthermore, when VR is combined with the internet, its applications multiply.

However, many clinical psychologists still have misgivings about the use of VR. We need to keep working to offer empirical data about the efficacy of VR applications, to develop more user-friendly applications, to improve software and protocols, to individualize environments, and to decrease costs. We also need to keep working to disseminate the results of all this work. VR is a tool—only a tool—but one of the most powerful tools that the clinical community has had to date. There is general agreement that three "I's" are needed to design a VR application: Interaction, Immersion, and Imagination. Imagination is also needed to transfer VR research to day-to-day clinical practice.

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DRAMATIC TECHNOLOGICAL ADVANCES took place in the 20th century, and we are sure that these advances will be even more dramatic and faster in the 21st century. Some aspects that still seem scientific fiction today will become part of our daily life. One of these advances has been the development of virtual reality (VR). The progress achieved from the time of Sutherland, one of the pioneers of VR, is surprising even to researchers who work in the field.[1,2]

Riva's aim is to present a state of the art review about the progress achieved in the application of VR to clinical psychology. Riva analyzes the present situation, and reviews most of the developments and clinical trials carried out for the treatment of many mental disorders. He describes in more detail the work done by his team about the use of VR for the treatment of body image disturbances in eating disorders. Then he presents his own vision of the rationale of this new technology in this field, analyzing the concept of *presence*. Finally, he presents the future of research in VR.

From Riva's review, we can conclude that VR is no longer a promise of the future, but a present reality. This new technology offers many possibilities for psychology, including assessment, treatment, and research. In the field of clinical psychology, VR is a known, accepted, and widespread tool used in exposure treatments of anxiety disorders, especially phobic disorders. Virtual exposure has many advantages compared with *"in vivo"* exposure and "imagery" exposure. VR provides stimuli for individuals who have difficulty in imagining scenes; it represents an opportunity for those individuals who are too phobic to experience real situations; it can be performed within the privacy of the consulting room; and it can generate stimuli of greater magnitude than standard techniques. Its utility and effectiveness have been demonstrated in the treatment of many disorders (e.g., flying phobia, claustrophobia, acrophobia, driving phobia).[3,4]

Furthermore, its use is being expanded, including in other anxiety disorders such as post-traumatic stress disorder and panic disorder.[5,6] The impact of VR applications is reflected in the growing number of publications, not only in specialized journals on VR (e.g., *CyberPsychology & Behavior, and Presence: Teleoperators and Virtual Environments*), but also in very prestigious classical journals in clinical psychology (e.g., *Behaviour Research and Therapy, Behaviour Therapy, Clinical Psychology and Psychotherapy, and Journal of Behaviour Therapy and Experiential Psychiatry*).

The time of expensive and big equipment is over, and we are demonstrating utility and effectiveness in several fields. Now, besides improving the VR applications, it is time to pay attention to other important tasks. It is urgent to reflect on and do research into the meaning of the increasing use of this new technology—that is, the benefits, the delimitation of parameters and variables that could be important to a good mastery of this tool, and the management of the possible negative side effects. We should not forget that VR can be understood as a *new sense* that becomes a part of our device to explore the world involving issues related to development and evolution, ontogenesis, and filogenesis.

In summary, besides progressing in the development of more powerful VR systems, we should be on the alert and reflect on the effects of VR applications. Bateson[7] stated, every intervention and each human artifact has a price, no matter how good the purpose of the agent of the intervention is. Finally, we are sure that VR will achieve important progress in the field of clinical psychology in the next few years. The efficacy of this tool in the treatment of some mental disorders has been demonstrated, and we have data that suggest that this new tool is well accepted by patients.[8] It has also been shown that VR can be effective with relatively cheap hardware. All these issues suggest that VR will become a usual tool in the work of clinical psychologists in the future.

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THERE IS MUCH TO AGREE WITH in Riva's review, although I prefer a more down to earth approach to the promises of VR and am less optimistic about the implementation of these technologies in daily clinical practice.

IMPLEMENTATION OF VR IN ROUTINE CLINICAL PRACTICE

Currently, there are a number of technological limitations that limit the widespread clinical application of VR at this moment. Apart from these technical impediments, which may be solved by technological developments in the near future, there are other reasons not to expect that VR psychotherapies will be applied in routine clinical practice in the near future. It took decades for behavior therapy to be accepted as one of the main schools of psychotherapy, despite its being evidence-based as demonstrated in hundreds of controlled outcome studies.[1] Apparently, in the mental health field and in psychotherapy, in particular, there are other motives and arguments than an intervention's approved efficacy that determine whether an evidence-based intervention will be accepted by the larger community of professionals or not. Especially when technology is involved, there are a number of reasons that will preclude large-scale implementation within a couple of years. Among psychotherapists, the value of the therapeutic relationship is felt to be very important, and for some therapy schools, even of paramount importance. When discussing our clinical research on VR,[2,3] and our studies into psychotherapy delivered through the Internet,[4,5] we sometimes get hostile reactions by psychotherapists because they—albeit incorrectly—feel that there is no place for a therapeutic relationship. However, as in any therapy, in technology-driven therapies the therapeutic relationship is important. Further, I am afraid that we must deal with a technology phobia among psychotherapists before widespread application of VR will occur. Most current psychotherapists, who are in their forties and fifties, are not familiar with technological innovations and are anxious about using them. Finally, some therapists feel threatened that, at the end of the day, technology-driven therapies will make their work superfluous. Perhaps it is more realistic to expect that in a few years time there will be specialized centers which will provide such therapies with sufficient technical support, than that VR will be integrated into routine clinical care.

IS VR EVIDENCE-BASED?

But what evidence is there for the effectiveness of VR in psychotherapy? Riva reviews a number of studies into eating disorders, anxiety disorders, and sexual dysfunctions and concludes that VR is highly effective. We recently reviewed research on VR in anxiety disorders, and our conclusions are more modest.[6] Few studies have been published in which virtual reality exposure therapy (VRET) is compared to exposure *in vivo*, the golden standard for treatment of phobias to date. Promising results show that VRET is as effective as exposure *in vivo* in treating fear of heights and fear of flying, but as far as other anxiety disorders are concerned, the promise is as yet unfulfilled. With respect to the impressive series of studies into experiential cognitive therapy with a variety of eating disorders by Riva's group, results support the effectiveness of VR. It should be noted, however, that VR was integrated in a multimodal treatment

program. There is a clear need to study the effectiveness of VR treatment for eating disorders as a stand-alone treatment. The same criticism applies to the application of VR in the treatment of impotence and premature ejaculation. When VR is not studied in isolation and compared with gold standard evidence-based treatments, any conclusions on the effects of VR as a therapeutic method are precluded.

PRESENCE

The most evidence for the efficacy of VR as stand-alone treatment is provided by studies with patients with acrophobia.[3,7] However, the high dropout rates during therapy due to low levels of experienced presence temper the optimism somewhat. Some participants are not able to involve themselves in the virtual world to the extent that they experience relevant emotions, thus precluding extinction and emotional processing. Therefore, there is a clear need to study presence in more detail. There is some evidence that the quality of the system has some influence on the level of presence felt.[8] The main techniques used to immerse participants in the virtual environment are a head-mounted display (HMD) or computer automatic virtual environment (CAVE). The CAVE is a multi-user projection-based VR system. The patient is surrounded by stereoscopic computer-generated images on four to six sides (cubicle). In a recent study with patients with acrophobia,[7] we found that CAVE presentation of VR environments resulted in higher levels of presence than HMD presentation of these environments. However, this did not result in more anxiety reduction.

To date, most virtual worlds used in psychotherapy have concentrated on visual realism, but progress is limited by computer-processing power. There are some interesting developments in the area of creating emotionally evocative environments. In order to immerse patients into the virtual world, auditory and tactile stimuli may be added to virtual environments. For example, in our studies we use a railing for hold onto in a height virtual environment, and vibrations in the airplane-chair during take-off or turbulence in our flight virtual environment.

Morie et al.[10] hold that, by combinations of sensory inputs designed to trigger emotional responses, a "feels real" rather than a photo-real world can be achieved. In their VR world, they make use of visceral low-frequency sounds, which may actually be below the threshold of hearing, but still can have impact, like a musical score does in movies. Smell is now hardly used in VR but may also enhance a "feels real" experience. There is quite some research suggesting that smell is associated with memories, and an integration of smells with virtual worlds might also enhance the "feels real" experience. Clinical applications are especially worthwile in the area of cue exposure therapy for substance abuse and eating disorders, but are not restricted to these areas.

Finally, individual differences related to the experience of presence in VR need our attention. There is some evidence that such personal characteristics as degree of absorption and hypnotisability may mediate the effectiveness of VR.[10] Other possible predictor variables for presence are the propensity of participants to get involved passively in some activity (like reading a book and watching movies), the ability to concentrate, and alexithymia. Research into these moderating individual traits will be of value because it may enhance selecting patients who profit most from treatment using VR.

CONCLUDING REMARKS

In sum, given the many advantages of VR over conventional psychotherapies and the results achieved so far, further research efforts in this area are needed. But the proof of the pudding is the effectiveness of VR treatment as stand-alone intervention versus the gold-standard intervention in the respective areas. There is a clear need for further controlled randomized studies evaluating VR therapies, especially for eating disorders, sexual dysfunctions, addictions, and other anxiety disorders than acrophobia and fear of flying

ACKNOWLEDGMENT

This paper was written while Paul Emmelkamp was Fellow-in-Residence at the Netherlands Institute for Advanced Study in the Humanities and Social Sciences, Wassenaar, The Netherlands.

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As Riva observed in his review, it is not without difficulties that virtual reality (VR) has become a recognized therapy tool. Having acquired an incontestable role in telemedicine,[1] VR seems to be a promising support for psychotherapy in numerous clinical contexts. Riva's review provides a clear and effective depiction of the state of the art in psychotherapy written from an experienced author in the field who has been involved in more than one application himself, and concludes with a list of possible explanations for the limits that cybertherapy may find in its development. However, current limitations cannot only be traced back to a poor technical flexibility, scarcity of clinical protocols, and high costs. In our opinion, these aspects, although important, are a part of the problem rather than its deep cause. We would like to extend the reflection on what is slowing down, whilst not stopping, a thriving growth in this area.

VR applications to psychotherapy move on a very dangerous cliff: expectations, high in any psychotherapy, are increased by the power with which VR and new technologies are popularly entrusted. In order to meet these expectations, cybertherapy has to undergo a reinvigorating cure itself, necessarily including the development of a shared vision on interaction in a mediated world. Such a shared vision allows avoidance of practical mix-ups and conceptual confusion that would seriously interfere with the therapeutic goal. VR-supported psychotherapy is always an interdisciplinary endeavour, where "boundary objects" are necessary to allow different communities to understand each other on a common terrain.[2] The concept of presence in mediated environments could serve as an inclusive, fresh boundary object. Unfortunately, there is an abundance of independent presence definitions, almost outnumbering the amount of virtual environments, and a certain reluctance to capitalize on reflections already available in neighborhood fields on mediation, engagement, interaction, and ergonomics. These facts make presence contribution quite nebulous, and theoretical statements and individual studies difficult to translate into design guidelines for VR applications.[3] To account for the way in which people manage to be present in a cybertherapy setting, some issues should be dealt with that are currently among the crucial ones in social science and technology application.

A therapeutic setting is much more complex than those usually considered in presence models,[4] where the focus is almost exclusively on the digital simulation, and external events are considered only as a threat to a good virtual experience. These kinds of environment have a mixed (real-virtual) nature, and

existent models of presence like "Break in Presence" [5] cannot account for them.[6,7] Moreover, a therapeutic setting is relational, symbolic, and immersed in the personal history of the patient and of the therapist, as well as in the simulation, constituting what can be defined as a hybrid environment.[4] These considerations notwithstanding, the *context* in which a virtual environment is used, while at the top of the list in any other approach to human–computer interaction,[8] is completely disregarded in this field. It looks as if the excitement and the rhetoric of virtual environments as an artificial reality on its own were taken as a serious description of what actually happens during the session. Instead, the actual, sequential interaction with the system must be observed in the situated, contingent circumstances in which it takes place.[9,10]

Another necessary entry in the agenda is a deep investigation on *cultural* factors. Virtual environments for psychotherapy are often inspired by real-life environments and interspersed with symbolic implications. While designers cannot be personally aware of the extent to which their work is located in their own culture, the possibility that the intended meaning of a simulation be subverted in another community is very high,[11] along with the risk that the whole therapeutic strategy makes no sense at all in a different culture. The idea to scale e-health products for a worldwide distribution at no additional cost has then to be abandoned. A virtual environment, as many other psychological tools (e.g., questionnaires, tests), needs to be culturally adapted in order to make it compatible with the target users' experience and with the general therapeutic goal.[12] The cultural dimension also provides a framework to discuss ethical and sustainability issues that are folded into the valuable goal of alleviating people's psychic sufferance, as Riva reminds in his review.

The involvement of the body and of the physical setting in any cybertherapy is another point to be defined. The experience with the simulation is a complex one, incorporated and *distributed* on both physical and cultural-cognitive dimensions, as mentioned above. "What people perceive, how they conceive of their activity and what they physically do develop together,"[13] says Clancey. The strict interconnection between cognitive-cultural dimension and body should be considered when planning psychotherapy using VR, because the use of the technology, the conditions during the session, and the involvement in the simulated experience rely on embodied coordinates. The moment of full presence in the simulation does not amount to a disappearance of the real environment, but to its reconfiguration with respect to the virtual action. A good model would admit that different configurations are possible and that selecting one as desirable is a choice.

The ultimate issue of any psychotherapy is the way in which the experience in the clinical setting relates with the real one. A general, flexible model that connects the virtual "experience" to a broader cultural, physical, and cognitive context may help understand the possible consequences of cybertherapy in everyday life.

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GIUSEPPE RIVA IS A LEADER in the field of the application of virtual reality (VR) to the therapeutic arena, and I am honored to be asked to comment on his review paper. I agree with many of Riva's conclusions, in particular that, "VR thus becomes a very useful intermediate step between the therapist's office and the real world."

I would like to emphasize that VR is a *tool* to be used in therapy, not a replacement for any of the essential elements in therapy. To paraphrase poorly, bad therapy with VR is still just bad therapy. We have tried to emphasize this point from the beginning, and it has been stressed in every treatment manual we have written since the early 1990s. I believe the ultimate goal of any therapy is to decrease the patient's functional impairment. For most, and with my cognitive behavioral theoretical orientation, this translates into some needed change in *behavior*.

Therefore, our use of VR-assisted therapy grew out of (1) my theoretical orientation (i.e., cognitive behavioral therapy [CBT] and information processing); (2) the needs of the patients we see (i.e., patients with anxiety disorders who generally require exposure therapy); (3) the obstacles to standard CBT therapy, especially exposure therapy (e.g., actually having to travel to the airport and an airplane, finding an audience); and (4) our desire to improve existing therapies or make them more accessible to therapists and patients or more efficient to implement. We don't create new virtual applications and environments because we can or because it is popular; we have attempted to only create new applications where some advance is needed. As Riva points out, one of the obstacles to VR therapy is the expense, especially of creating the virtual environment, so the incremental advantage must justify the incremental cost. This is also exactly why VR therapies have required more empirical validation than existing therapies. There must be empirical evidence of the efficacy of VR therapies to justify their use. The same standards have not been applied to many existing therapies (e.g., psychoanalysis).

I would like to emphasize here also that the power of the virtual experience also requires extra sensitivity to ethical considerations. Elsewhere, we have discussed ethical issues in VR applications.[1] Here, I'd like to emphasize three important points. One, therapists should use VR to enhance therapy rather than substitute for it. VR should be approached as a tool to be used by clinicians experienced with the types of patient problems and treatment they are treating. It is not meant to be a convenient way of attracting new patients or of administering a new type of therapy that they are not qualified to provide. Two, there is a different therapist–patient dynamic in VR therapy that must be taken into account. As in any social interaction, non-verbal communication is of paramount importance in the therapist/patient dyad. Much of this non-verbal communication comes from facial expression, body posture, hand gestures, and intonations. If patients are wearing head-mounted displays, they cannot see the therapist and therefore lose all of the non-verbal communication absorbed visually. Three, what is considered unethical in standard therapy would still be considered unethical in VR therapy. Variations on sex therapy have been held up as prime examples of this warning, but there are certainly others.

In closing, I think that VR-assisted therapy has great potential. We now have the ability to bring the real world into the therapist's office in more than a verbal or imagined representation. Current projects in the Virtually Better laboratory not mentioned in Riva's review include several studies with the fear of public speaking using virtual audiences,[2] including in a self-help format, a current study of the virtual relaxation chamber with patients with chronic pain, a study examining the ability of VR to distract pediatric cancer patients during painful medical procedures,[3] a larger controlled study of the virtual airplane for the fear of flying with 75 treatment completers,[4] the use of VR exposure therapy combined with medication,[5] and current studies applying VR to addictions with a virtual party for smokers and a virtual crack house for

crack cocaine addicts. These are but a few of the potential applications of VR in therapy, and I encourage the development and testing of more applications.

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R.G. Anderson, Inc.
Surety Bonds

MEMBER ***N A S B P***
National Assoc
Surety Bond Producers

April 26, 2012

To: State of Delaware, Dept. of Correction

Re: CFG Health Systems, LLC - Letter of Bondability

Project: Contract No. DOC-1202Mental

Argonaut Insurance Company, an A.M. Best "A" rated surety company, authorized to do business in the State of Delaware, does hereby agree and consent that if the proposal for the above referenced project be accepted and the contract timely awarded & executed, that we will, become surety for the said contract, as required in the Request for Propsal.

Should additional information be required, please contact our office.

Sincerely,

Gina M. Pepe

Gina M. Pepe, Attorney-in-Fact
Argonaut Insurance Company

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AS-0022270

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POWER OF ATTORNEY

KNOW ALL MEN BY THESE PRESENTS: That the Argonaut Insurance Company, a Corporation duly organized and existing under the laws of the State of Illinois and having its principal office in the County of Cook, Illinois does hereby nominate, constitute and appoint:

Richard G. Anderson, Joseph T. Catania, Anna Everly, Gina M. Pepe

its true and lawful agent and attorney-in-fact, to make, execute, seal and deliver for and on its behalf as surety, and as its act and deed any and all bonds, contracts, agreements of indemnity and other undertakings in suretyship provided, however, that the penal sum of any one such instrument executed hereunder shall not exceed the sum of:

$15,000,000.00

This Power of Attorney is granted and is signed and sealed under and by the authority of the following Resolution adopted by the Board of Directors of Argonaut Insurance Company:

"RESOLVED, That the President, Senior Vice President, Vice President, Assistant Vice President, Secretary, Treasurer and each of them hereby is authorized to execute powers of attorney, and such authority can be executed by use of facsimile signature, which may be attested or acknowledged by any officer or attorney, of the Company, qualifying the attorney or attorneys named in the given power of attorney, to execute in behalf of, and acknowledge as the act and deed of the Argonaut Insurance Company, all bond undertakings and contracts of suretyship, and to affix the corporate seal thereto."

IN WITNESS WHEREOF, Argonaut Insurance Company has caused its official seal to be hereunto affixed and these presents to be signed by its duly authorized officer on the 15th day of September, 2008.

Argonaut Insurance Company

By: _____

Michael E. Arledge President

STATE OF TEXAS
COUNTY OF BEXAR SS:

On this 15th day of September, 2008 A.D., before me, a Notary Public of the State of Texas, in and for the County of Bexar, duly commissioned and qualified, came THE ABOVE OFFICER OF THE COMPANY, to me personally known to be the individual and officer described in, and who executed the preceding instrument, and he acknowledged the execution of same, and being by me duly sworn, deposed and said that he is the officer of the said Company aforesaid, and that the seal affixed to the preceding instrument is the Corporate Seal of said Company, and the said Corporate Seal and his signature as officer were duly affixed and subscribed to the said instrument by the authority and direction of the said corporation, and that Resolution adopted by the Board of Directors of said Company, referred to in the preceding instrument is now in force.

IN TESTIMONY WHEREOF, I have hereunto set my hand, and affixed my Official Seal at the County of Bexar, the day and year first above written.

BECKY JIMENEZ
Notary Public, State of Texas
My Commission Expires
December 30, 2011

_____
(Notary Public)

I, the undersigned Officer of the Argonaut Insurance Company, Illinois Corporation, do hereby certify that the original POWER OF ATTORNEY of which the foregoing is a full, true and correct copy is still in full force and effect and has not been revoked.

IN WITNESS WHEREOF, I have hereunto set my hand, and affixed the Seal of said Company, on the 26 day of April, 2012

_____
Robert F. Thomas Vice President

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