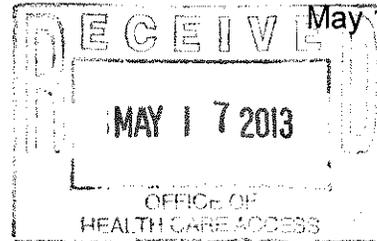


2013 MAY 17 A 9 22

Connecticut Recovery Center, LLC  
P.O. Box 429  
Cheshire, CT 06410  
(203) 806-5355



May 15, 2013

Ms. Lisa A. Davis  
Deputy Commissioner  
State of Connecticut  
Office of Health Care Access (OHCA)  
Department of Public Health  
410 Capitol Avenue MS # 13HCA  
Hartford, CT 06134

Re: Connecticut Recovery Center, LLC - Certificate of Need Application

Dear Ms. Davis,

The Connecticut Recovery Center, LLC, respectfully submits our application for a certificate of need related to our proposed opening of an Intensive Outpatient Program in Cheshire, CT, to provide mental health and substance abuse treatment to adults in the community. Please feel free to contact me if you require any additional information or have any further questions or concerns related to this application. I may be reached by phone (203-806-5355) or by email ([jennifer.ballew@ctrecoverycenter.com](mailto:jennifer.ballew@ctrecoverycenter.com)).

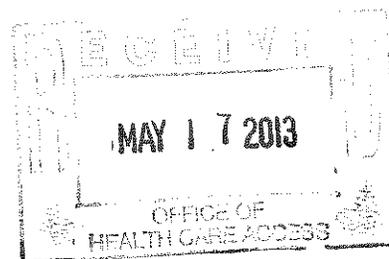
Thank you for your kind consideration.

Best Regards,

A handwritten signature in black ink, appearing to read "J. Ballew".

Dr. Jennifer Ballew  
Medical Director and CEO  
Connecticut Recovery Center, LLC

## Application Checklist



### Instructions:

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

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

### For OHCA Use Only:

Docket No.: 13-31840  
OHCA Verified by: KR

Check No.: 1045355  
Date: 5/17/13

- Attached is evidence demonstrating that public notice has been published in a suitable newspaper that relates to the location of the proposal, 3 days in a row, at least 20 days prior to the submission of the CON application to OHCA. (OHCA requests that the Applicant fax a courtesy copy to OHCA (860) 418-7053, at the time of the publication)
- Attached is a paginated hard copy of the CON application including a completed affidavit, signed and notarized by the appropriate individuals.
- Attached are completed Financial Attachments I and II.
- Submission includes one (1) original and four (4) hard copies with each set placed in 3-ring binders.

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

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

- The following have been submitted on a CD
1. A scanned copy of each submission in its entirety, including all attachments in Adobe (.pdf) format.
  2. An electronic copy of the documents in MS Word and MS Excel as appropriate.

**AFFIDAVIT**

Applicant: Connecticut Recovery Center, LLC

Project Title: Community-based Intensive Outpatient Program for Mental Health and Substance Abuse Treatment

I, Jennifer R. Ballew, Chief Executive Officer  
(Individual's Name) (Position Title – CEO or CFO)

of Connecticut Recovery Center, LLC being duly sworn, depose and state that  
(Hospital or Facility Name)

Connecticut Recovery Center, LLC's information submitted in this Certificate of  
(Hospital or Facility Name)

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

JRBallew  
Signature

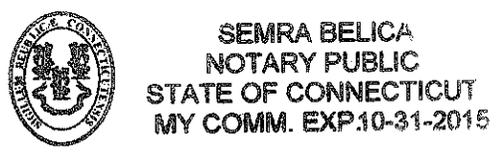
5/11/13  
Date

Subscribed and sworn to before me on May 11, 2013

Semra Belica

Notary Public/Commissioner of Superior Court

My commission expires: 10-31-2015



VERIFY THE AUTHENTICITY OF THIS MULTIFUNCTION SECURITY DOCUMENT. CHECK BACKGROUND AREA CHANGES COLOR GRADUALLY FROM TOP TO BOTTOM.



WebsterBank

OFFICIAL CHECK

0001045355

145 Bank St. 00203 102739  
Waterbury, CT 06702

05/15/2018

447010  
2311

\*\*\*\*\*\$500.00

\*\*500 DOLLARS AND 00 CENTS\*\*

PAY TO THE ORDER OF

TREASURER STATE OF CONNECTICUT

CONNECTICUT RECOVERY CENTER LLC

REMITTER

*Kandi Santos*

AUTHORIZED SIGNATURE

MP

AUTHORIZED SIGNATURE (TWO SIGNATURES REQUIRED OVER \$25,000)

MP

OFFICIAL CHECK

⑈0001045355⑈ ⑆211170101⑆ 0010200104⑈

# AFFIDAVIT OF PUBLICATION

## New Haven Register

STATE OF CONNECTICUT

County of New Haven

I Barbara Colello of New Haven, Connecticut, being duly sworn, do depose and say that I am a Sales Representative of the New Haven Register, and that on

the following date 4/23/13, 4/24/13, 4/25/13 to wit.....

there was published in the regular daily edition of the said newspaper an advertisement,

**PUBLIC NOTICE**

"Pursuant to Section 19a-638 of the Connecticut General Statutes, the Connecticut Recovery Center, LLC, located at 290 Highland Avenue in Cheshire, CT, 06410, will submit a Certificate of Need application to the Department of Public Health, Office of Health Care Access for the establishment of an intensive out-patient program providing mental health and substance abuse treatment to adults. The estimated capital expense is \$15,000."

Barbara Colello 5/6/13

And that the newspaper extracts hereto annexed were clipped from each of the above-named issues of said newspaper.

Subscribed and sworn to this 8th day of May, 2013. Before me.

Mary Feulner  
My Commission Expires 10/31/2012  
2017



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

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

**Docket Number:**

**Applicant:** Connecticut Recovery Center, LLC

**Contact Person:** Dr. Jennifer Ballew

**Contact Person’s  
Title:** CEO and Medical Director

**Contact Person’s  
Address:** P.O. Box 429, Cheshire, CT 06410

**Contact Person’s  
Phone Number:** (203) 806-5355

**Contact Person’s  
Fax Number:** (951) 257-9990

**Contact Person’s  
Email Address:** jennifer.ballew@ctrecoverycenter.com

**Project Town:** Cheshire, CT

**Project Name:** Community Based Intensive Outpatient Program for  
Mental Health and Substance Abuse Treatment

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

**Estimated Total  
Capital Expenditure:** \$15,000.00 over three years

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

- a. Please provide a narrative detailing the proposal.

The Connecticut Recovery Center, LLC, is proposing a new, privately owned and managed clinic that offers both mental health and substance abuse services to a wide range of age strata in the general public. We plan to provide Intensive Outpatient Programming (IOP) in combination with individual medication management for patients experiencing mental health or addiction symptoms severe enough to be interfering with daily functioning. That is to say that the a patient admitted to our program is experiencing symptoms severe enough to require a level of care higher than individual outpatient treatment, and without our proposed level of care, the patient population would generally experience a much more rapid decline in functioning; hence the need for this higher level of care.

Additionally, we plan to offer Suboxone (buprenorphine)-induction and detoxification to aid in the opiate withdrawal process as it has been shown in numerous studies that the use of an opiate agonist therapy in conjunction with high intensity services like an Intensive Outpatient Program, greatly increases a patient's chances at sustained sobriety. Numerous studies have been completed that draw this conclusion, and according to the National Institute of Health's study the Influence of Psychotherapy Attendance on Buprenorphine Treatment Outcomes, "the results suggest that psychotherapy should be an integral part of the buprenorphine treatment plan."

Because these studies are so robust, the proposed services will include medication management, group therapy, and Suboxone induction (to include clinical stabilization and ongoing bi-weekly maintenance scheduling). Within this programming, patients will be clinically guided through the recovery process within a medically-supervised environment that prioritizes the needs of individual patients, as established via a dynamic individualized treatment plan that is continuously updated throughout the patient's admission to our outpatient system.

We plan to build the program gradually over the first year from one track up to three or

more tracks. Each track will have a particular focus (mental health, substance dependence, or co-occurring disorders) and will provide services for up to 10 patients at any given time. We will start with a track specifically tailored to patients suffering from Substance Use Disorders because, in the United States particularly in suburban settings (targeted community), almost twice as many people abuse prescription medications than the number who abuse illicit substances. The vast majority of these people never intended to become addicted to these products and they - and their physicians - find themselves in the scary and unexpected territory of chemical dependency. It is understandably distressing for these patients to identify as "addicts" and therefore they tend to avoid seeking treatment. We will for all of these reasons provide discrete and compassionate care to this patient population with a high emphasis on privacy, compassion, and confidentiality, to help overcome this understandable hesitation in pursuing help for substance use disorders.

The second track, which will be made available within our first months of operation, will be for patients suffering from co-morbid substance abuse and mental health conditions - frequently referred to as a dual diagnosis or co-occurring disorders track. This track will also fill a substantial need within the community, as according to the National Alliance on Mental Illness (NAMI), "as much as fifty percent of the mentally ill patient population also has a substance use disorder." The focused curriculum of this track will overlap significantly with that of the Substance Abuse track, but will also focus heavily on emotional regulation, mental illness symptom identification and management, and understanding the correlations between substance use and mental illness symptomatology. In the months following the establishment of the dual diagnosis track, we will add a third track targeted towards the needs of patients diagnosed exclusively with mental health conditions (ie, no identified substance use disorders). This track will focus in large part on cognitive behavioral approaches to making healthy, positive lifestyle and behavioral changes to promote overall improvement in daily functioning.

All three tracks will provide a goal-setting group, insight-oriented psychotherapy group, and psycho-educational lectures or exercises each day of treatment. Separately from the group process, each patient will also meet at least once per week with the psychiatrist for individual medication management. Across all spheres of treatment, it is our mission to

offer compassionate, non-judgmental, and discrete help within a setting that values patient confidentiality.

**The following bullet points detail our planned treatment offerings:**

- Individual psychiatric assessment for identification of mental health and substance use disorders
- Small group therapy sessions of no greater than ten patients per group geared toward both mental health and substance abuse recovery
- Psychoeducation regarding healthy lifestyles, sleep hygiene, stress management, emotional regulation, interpersonal challenges, and relapse prevention
- Individualized treatment planning to assist patients in developing and utilizing insight as a means towards desired behavioral health changes
- Weekly individualized medication management by a licensed psychiatrist for psychotropic medications and chemical detoxifications
- Individualized Suboxone-assisted agonist therapy for opiate detoxification
- Late afternoon and evening appointments to accommodate patients who are employed during typical business hours

Specifically with respect to treatment intent and duration of treatment, at the Connecticut Recovery Center, LLC, we will provide Intensive Outpatient Programming for both mental health and substance use disorders, generally lasting from four to eight weeks in length. One primary purpose of this application is to obtain intensive outpatient program (IOP) licensure so that Connecticut Recovery Center, LLC, can be recognized by third party payers and a contractual relationship for reimbursement can be established. Insurance companies require Department of Public Health licensure in order to reimburse clients for this level of care.

Our Intensive Outpatient Program will comply with federal, state, and third-party payer regulations. Licensure will help patients who require more than typical outpatient levels of care to use their health insurance to cover the range of services we offer for the treatment of mental illness and substance addictions.

## 2. Clear Public Need

The undeniable need for more accessible, and more comprehensive, mental health and substance abuse treatments in Connecticut has never been more in the public spotlight than in the past few months. In a press release dated April 9, 2013, Governor Dannel P. Malloy stated, “No one should have to overcome mountains of red tape when they are trying to access mental health services.” In the words of Kimberly Beauregard, CEO of InterCommunity, Inc., a nonprofit community organization in Connecticut, writing in the April 11, 2013 edition of the Connecticut Mirror, “...we urge Connecticut government officials to work directly with community-based mental health care providers to better understand the growing need for services and how they can be better delivered through our organizations. We can no longer afford to ignore mental illness - the price we pay for doing so is far too high. Loss of life, overcrowded prisons and countless people living with undiagnosed mental illness cost us much more than dollars.”

The Connecticut Department of Public Health drug overdose death rates are at an all-time high and have been rising steadily since 1970. The Commissioner of the Connecticut Department of Mental Health and Addiction Services, Patricia Rehmer, MSN, provided testimony before the Public Health Committee on March 7, 2012, during which she reported that Connecticut has averaged one opiate death per day among 18-25 year olds in 2009 – the leading rate of death for this age group.

In April 2011, the Connecticut Department of Public Health reported in their National Public Health Week Fact Sheet that overdose death rates in the United States have increased fivefold since 1990. The Center for Disease Control reports this increase in drug overdoses is largely due to the mis-use of prescription opioid painkillers. From 2005-2007, there were 2,578 hospitalizations and 7,140 poisoning-related emergency department visits in Connecticut. In addition, there were 106 suicide deaths due to drug and alcohol poisonings; and over 3, 000 hospitalizations and over 3,000 emergency department visits related to suicide attempts by drug poisoning. Altogether, accidental drug-related poisoning has surpassed motor vehicle crashes as a leading cause of death in Connecticut.

- a. Provide the following regarding the proposal's location:
  - i. The rationale for choosing the proposed service location;

We have carefully researched and analyzed the available resources for this intensive level of mental health and substance abuse treatment in Connecticut, and we have found that the Cheshire/Wallingford/Meriden region has the densest population of people who live more than a twenty minute drive away from an Intensive Outpatient Program (IOP) for mental health services than anywhere else in the state. The closest currently operating IOPs are located in Meriden (the Rushford Center, for substance use disorders only), Hamden (the Yale New Haven Hospital program, for mental health and co-occurring disorders only) and Waterbury (St. Mary's Hospital, for substance abuse and co-occurring disorders only, and Waterbury Hospital, for substance abuse and co-occurring disorders only). Of these four programs, only one (Waterbury Hospital) offers Suboxone assisted opioid detoxification, and is located more than a forty minute drive from the town center of Cheshire. Given the geographical - and socioeconomic - distances of these programs from the proposed location, it is safe to say that a clinic opened in Cheshire, with its proximity to the Connecticut valley and surrounding areas, will see high utilization.

Our specific location was chosen to be not only the most convenient, but also the most appealing, to the largest number of people in need of this service in Connecticut. We have selected a professional office building private suite as our clinic location in order to offer a discrete and professional setting for our future patients. We hope to reduce patient anxiety around seeking treatment by offering services in a discrete, yet non-specific, psychiatric environment. There is a mix of medical and non-medical businesses located within the building and the office park where we will be located. This mix of professional services will help to create an environment of privacy and anonymity for our potential patients, as no one will necessarily know which service they are seeking in our a work area. Additionally, this location is convenient to two major interstates (I-691 and I-84), as well as two Connecticut state routes (68 and 72). Our location is also situated along a major bus line. We offer free and ample parking, handicap accessibility, and a safe, secure environment.

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

We envision our clinic will be most utilized by people living in Cheshire, Meriden, Wallingford, Southington, and Wolcott, quite likely also drawing patients from the Naugatuck Valley (due to our proximity to state routes 68 and 70). The total of all these five towns according to 2011 census data exceeds 190,000 adults. This target region was chosen mainly based on geographical location and the ease of transportation to and from our program. It is also due to the fact, referenced above in 2.a.i., that these towns, though densely populated, do not currently offer mental health IOP services, and further do not offer IOP services in conjunction with Suboxone therapy in the same location. To reiterate, the combination of mental health with a medically-supervised Suboxone regimen greatly increases a patient's chances of sustained recovery.

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

Our current proposal is to treat adult patients over the age of 18 who are diagnosed with a DSM-IV Axis I mental illness or substance use disorder. According to the National Comorbidity Survey Replication, conducted by Harvard Medical School and updated as recently as 2007, the lifetime prevalence of serious mental illness for Americans is 57.4%. The same survey found the percentage of Americans who meet criteria for serious mental illness within any given year is 32.4%. According to the Surgeon General's 1999 report on Substance Abuse and Mental Health Services Administration, less than one-third of American adults with diagnosable serious mental illness receive treatment for these conditions, frequently due to lack of convenient access to the appropriate level of mental health care. Even more concerning, according to the National Survey on Drug Use and Health (NSDUH), a mere 7.1% of Americans received appropriate mental health services between 2005 and 2009. Based on these statistics, and the population data cited in 2.a.i it is fair to say that within any given year, there are roughly 60,000 individuals that could require access to the services we intend to provide.

The 2010 National Survey on Drug Use and Health (NSDUH): Summary of National Findings reported that marijuana is most commonly used illicit drug, followed closely by narcotics. The current rate of use of illicit drugs among young adults 18 to 25 increased from 19.6% in 2008 to 21.2% in 2009 and again increased to 21.5% in 2010.

On June 20, 2012, the Daily News, reported "Heroin use among suburban teens skyrockets; Experts say prescription pills are the new gateway drug." "Twenty years ago half of the heroin addicts in treatment lived in two states-New York and California," according to Dr. Joe Gay director of health Recovery Services in Ohio, "Now we are seeing it spread out of the cities, into the suburbs and rural areas." National data from the Substance Abuse and Mental Health Services Administration (SAMHSA) revealed that in 1999, 198 people between the ages of 15 and 19 died of a heroin overdose, compared to 510 in 2009, the latest year data was taken. Likewise, the number of young adults seeking treatment for heroin dependence increased from 4,414 to more than 21,000 (about 80%) between 1999 and 2009.

Due to the significant proliferation of prescription opioid painkillers over the past 20 years, the general public has developed a sense of familiarity with these substances and have mistakenly come to view these highly potent medications as relatively safe. The result is that, for young people especially, prescription opiates - whether obtained legitimately as prescriptions for pain or obtained illicitly - can act as gateway drugs to heroin. Compounding this problem is the fact that heroin is often far cheaper to obtain than its prescription counterparts.

There has been a particular upsurge in suburban and other relatively affluent areas. In Suffolk County, N.Y., a suburban area of Long Island,, the number of deaths associated with heroin use has more than doubled in just the past few years. In nearby Nassau County, the number of people between the ages of 19 and 25 years old entering into opiate dependence treatment has increased from 59 in 2000 to 458 in 2008. Additionally, people with financial means tend to have more disposable income, as well as transportation options, which give them a greater amount of freedom and mobility to seek substances to maintain their addictions.

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

As referenced above in 2.a.iii., the vast majority of the proposed patient population is not being served at all. With the closing of the inpatient psychiatric unit at Mid-State Hospital in Meriden, patients whose symptoms are severe enough to require inpatient admission will need to travel outside this immediate area and go to Waterbury, New Haven or some other region with an active inpatient psychiatric unit. Even those patients living in this catchment area whose mental health symptoms are severe and chronic enough to reach the threshold criteria for inpatient hospitalization may find themselves briefly admitted to an inpatient unit in Waterbury or New Haven, but will still require follow-up care once discharged from the inpatient psychiatric unit. Due to the increasing problem of overflow in the hospital emergency departments, many of these patients will find that there is either no inpatient bed available for them or that there are so many other patients with even more pressing circumstances that the referral from the emergency department is to seek outpatient level of care.

Given the scarcity of intensive outpatient programming in this identified region, there are few options for patients who find themselves in this "in-between" level of need. Patients in the proposed region who have substance use disorders only, may receive substance abuse Intensive Outpatient Programming at the Rushford Center in Meriden, which generally has an extensive wait list for admission; at time of this writing the wait is eleven days for a mere intake, and this does not guarantee immediate program placement. This serves to emphasize that patients whose symptoms are severe enough to interfere with daily functioning, but not severe enough to warrant inpatient hospitalization, are generally under-treated at an outpatient level by either private-practice psychiatrists or primary care providers. Our clinic will offer a currently unavailable service in this area that bridges this gap between outpatient and inpatient mental health care, with swift admissions, as this is warranted for patients who's symptoms meet our criteria.

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

As referenced above in 2.a.iv., there do not currently exist any programs that offer Intensive

Outpatient Programming for both mental health and substance use disorders in the proposed service area. There are none at all that offer services for people with a diagnosis of serious mental illness. The only program that offers IOP level of care to people specifically with substance use disorders is the Rushford Center at 883 Paddock Avenue, Meriden, CT, 06450.

There are some private practice clinicians within the service area who provide individual therapy based services to address the mental health needs of their patients, but none who readily identify as specifically addressing substance abuse issues. A handful of these clinicians offer some group based treatments but usually either weekly or monthly, and none approach the treatment intensity of an IOP level of care. The closest government-run facility is the Greater Waterbury Mental Health Network located at 95 Thomaston Avenue, Waterbury, CT, 06702.

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

We fully anticipate that the only impact our proposed Intensive Outpatient Program will have on other local mental health care providers will be positive, as we hope to alleviate the overload of existing outpatient services. We will offer an option for local psychiatrists and primary care providers to refer their more challenging cases, and for local hospitals to refer their patients who do not need an inpatient bed yet who are still too symptomatic to return to their daily routines. The only other Intensive Outpatient Program in the proposed area is the substance abuse IOP at Rushford Center in Meriden, which generally has a waitlist of patients needing admission to their program.

We anticipate that the licensure of the Connecticut Recovery Center, LLC, as an Intensive Outpatient Program, will positively impact the local delivery system by both providing a currently absent level of care and by referring stabilized patients back into the currently existing outpatient structure. For patients who may be found to require a higher level of care than an IOP can reasonably provide, we will refer those patients to either local inpatient psychiatric units, residential substance abuse facilities, or the relatively few

existing partial hospital programs in the state, as clinically warranted.

### 3. Projected Volume

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

**Table 1: Projected Volume (First 3 full operational fiscal years)**

<i>Service type***</i>	<i>FY2013</i>	<i>FY2014</i>	<i>FY2015</i>	<i>FY2016</i>
<i>Substance Abuse Intensive Outpatient Program</i>	80	60	60	60
<i>Dual Diagnosis Intensive Outpatient Program</i>	0	60	60	60
<i>Mental Health Intensive Outpatient Program</i>	0	0	60	60
<b>Total</b>	<b>80</b>	<b>120</b>	<b>180</b>	<b>180</b>

(\*\*\* FY September 1 - August 31)

**\*\* If the first year of the proposal is only a partial year, provide the first partial year and then the first three full FYs. Add columns as necessary.**

\*\*\* Identify each service/procedure type and add lines as necessary.

\*\*\*\* Fill in years. In a footnote, identify the period covered by the Applicant’s FY (e.g. July 1-June 30, calendar year, etc.).

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

Our target goal is to have each fully established IOP track serving an average daily census of six patients (ie, 6 patient slots). Each patient will remain in the IOP for an average of five weeks, or 25 days. The number of treatment days in an average fiscal year is 252 (5

work days multiplied by 52 weeks = 260, minus 8 holidays = 252 days). Therefore, if one divides the number of days in a fiscal year (252) by an average admission of 25 days per patient, this results in approximately 10 patients per year per patient slot in each fully established track of the IOP. With 9 patient slots per track, this results in roughly 90 patients per year per IOP track.

The first IOP track we plan to develop, the Substance Abuse track, will likely be the only track running for most, if not all, of the first fiscal year. As we are a brand new service in this community, we expect to fall slightly short of a typical year while we are building up our referral base. Thus, we estimate only 80 patients in our first year of the IOP.

Towards the end of our first year of business, we hope to establish our Dual Diagnosis track, which will run then run for all of the following fiscal year. By this time, we hope to have a strong enough referral base to be up to a full patient census by the end of the second fiscal year.

Lastly, we plan to start our Mental Health track by the end of our second fiscal year.

Similarly to the establishment of the Dual Diagnosis track, we anticipate the Mental Health track will rapidly grow and be up to full patient census by the end of the third fiscal year.

Of note, the patients receiving Suboxone Therapy have not been separately calculated regarding projected volume because it is expected that all patients receiving Suboxone therapy will also be admitted to one of the IOP tracks and therefore should not be counted separately.

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

This is not applicable., as we are proposing a brand new level of care for this area.

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

Please see Appendix A for full bibliography of references.

The National Comorbidity Survey Replication, conducted by the Harvard School of Medicine, was the first large-scale field survey of mental health in the United States. It provides statistical information related to the prevalence and incidence of serious mental health and substance use disorders in the United States.

<http://www.hcp.med.harvard.edu/ncs/><sup>11</sup><http://www.hcp.med.harvard.edu/ncs>

*Mental Health: A Report of the Surgeon General*, published in 1999, is a report on Substance Abuse and Mental Health Service Administration in the United States. It defines mental disorders as diagnosable conditions that impair thinking, feeling and behavior, and interfere with a person's capacity to be productive and enjoy fulfilling relationships. The Substance Abuse and Mental Health Services Administration (SAMHSA) worked with the National Institute of Mental Health (NIMH) to develop the report under the guidance of the Surgeon General. This first-ever Surgeon General's Report on Mental Health reviews the scientific knowledge base to date, and also focuses on the connection between mental health and physical health, barriers to receiving mental health treatment, and the specific mental health issues of children, adults and the elderly.

<http://profiles.nlm.nih.gov/ps/retrieve/ResourceMetadata/NNBBHS>

National Survey on Drug Use and Health (NSDUH), provides national and state-level data on the use of tobacco, alcohol, illicit drugs (including non-medical use of prescription drugs) and mental health in the United States. NSDUH is sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA), an agency of the U.S. Public Health Service in the U.S. Department of Health and Human Services (DHHS).

<http://nsduhweb.rti.org>

#### **4. Quality Measures**

- a. Submit a list of all key professional, administrative, clinical, and direct service personnel related to the proposal. Attach a copy of their Curriculum Vitae.

**Jennifer R. Ballew, D.O., Ph.D.**

*CEO and Medical Director*

Dr. Ballew has over 10 years direct experience working with both the mentally ill and chemically dependent patient populations. Since 2009, she has served as Medical Director of the Yale New Haven Hospital Adult Partial Hospital Program (formerly the Hospital of St. Raphael Partial Hospital Program), where she oversees the delivery of mental health care and substance dependence treatment for patients identified as requiring more than basic outpatient level of care. Dr. Ballew supervised the clinical growth of this program from one evening track to six intensive daytime clinical tracks (Mental Health, Co-Occurring Disorders and Substance Abuse tracks in the Partial Hospital Program, and Mental Health, Co-Occurring Disorders and Substance Abuse tracks in the Intensive Outpatient Program). Previously, Dr. Ballew has served as a Principal Psychiatrist for the State of Connecticut in the Department of Mental Health and Addiction Services and as an attending psychiatrist at the Yale University School of Medicine. Additionally, Dr. Ballew has served as an Assistant Clinical Professor of Psychiatry for the Yale University School of Medicine since 2006.

**Mark A. Lanz**

*Chief Financial Officer and Business Office Manager*

Mr. Lanz is the co-founder of Broadstripes, LLC, a successful small business start-up company in New Haven, CT, that has been in operation since 2006. Previously, he has worked as a project manager at several large technological incorporations including Tangoe, Inc., Sun Microsystems, and Electronic Data Systems.

**Blair MacLachlan, MSW**

*Consultant, Health Care Finance and Management Expert*

Mr. MacLachlan, with over thirty years of experience, specializes in the behavioral health and substance abuse arena. He has provided direct clinical and indirect administrative services in both ambulatory and facility-based settings, directed multi-site programs, developed and directed one of the states first specialty Provider-Hospital-Organizations, and was central to the creation of one of Connecticut's first Provider-Sponsored managed

care companies.

**Douglas Thompson, MS, LPC**

*Mental Health and Substance Abuse Clinician*

Mr. Thompson has many years of experience providing mental health and substance dependence treatment across a broad range of treatment modalities. He has functioned as a direct provider of care through both his private practice and through employment with major health care systems including Paradigm Healthcare Center and Hallbrooke Behavioral Health Services. Additionally, he also has experience working as an Intensive Case Manager for Value Options as part of the Connecticut Behavioral Health Partnership. In this role, Mr. Thompson was assigned to work specifically with patients identified as needing more care and support than is typically available on an outpatient basis.

**Kristin Olsen, MS, LADC**

*Mental Health and Substance Abuse Clinician*

Ms. Olsen has worked as a substance abuse clinician in an Intensive Outpatient Program since 2006. In addition to carrying a full IOP caseload and running daily goals, psychotherapy and psychoeducation groups, Ms. Olsen has also utilized her masters level training in Art Therapy to run bi-weekly Creative Arts Therapy groups. She has served as a lead clinician in both Mental Health and Substance Abuse tracks in the Yale New Haven Hospital Adult Partial Hospital Program and Intensive Outpatient Program.

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

As referenced above in 2.a.iv., the vast majority of the proposed patient population is not being served at all. Patients whose mental health symptoms are severe and chronic enough to reach the threshold criteria for inpatient hospitalization may for example be briefly admitted to an inpatient psychiatric unit in New Haven or Waterbury, but will still require follow-up care once discharged from the inpatient psychiatric unit. Similarly, we fully expect referrals from other treatment facilities for patients needing aftercare that supports responsible, safe, and well controlled patient community reintegration. Patients in the proposed region who have substance use disorders only, may receive substance abuse

Intensive Outpatient Programming at the Rushford Center in Meriden, which generally has a waitlist for admission largely due to their payer mix being inclusive of Medicaid patients, which we do not plan on engaging until several years into operation. In turn, we will offer nearly direct admission to private pay and commercially insured patients that are in desperate need of treatment but would otherwise need to wait for treatment - which greatly increases a patient's incidence of relapse or re-hospitalization. Indeed, a patient whose symptoms are severe enough to interfere with daily functioning, but not severe enough to warrant inpatient hospitalization, are generally under-treated at an outpatient level by either private-practice psychiatrists or primary care providers. Our clinic will offer a currently unavailable service in this area that bridges this gap between outpatient and inpatient mental health care.

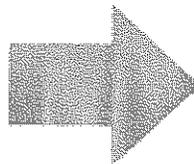
- c. Identify the Standard of Practice Guidelines that will be utilized in relation to the proposal. Attach copies of relevant sections and briefly describe how the Applicant proposes to meet each of the guidelines.

**American Society of Addiction Medicine criteria**

We intend to incorporate the American Society of Addiction Medicine (ASAM) Patient Placement Criteria in our practice. These criteria provide for the development of comprehensive and individualized treatment plans prepared via a multidimensional patient assessment over five broad levels of treatment that are based on the degree of direct medical management provided, the structure, safety and security provided, and the intensity of treatment services provided.

Five Levels of Care Assessed Over Six Dimensions

Level 0.5	Early Intervention
Level I	Outpatient Services
Level II	Intensive outpatient/partial hospitalization services
Level III	Residential/inpatient services
Level IV	Medically managed intensive inpatient services



1. Acute intoxication and/or withdrawal
2. Biomedical conditions and complications
3. Emotional, behavioral, or cognitive conditions and complications
4. Readiness to change
5. Relapse, continued use, or continued problem potential
6. Recovery environment

Through this strength-based multidimensional assessment, the ASAM Patient Placement

Criteria addresses the patient's needs, obstacles and liabilities, as well as the patient's strengths, assets, resources and support structures.

#### **National Alliance for the Mentally Ill standards**

We also intend to incorporate the standards of the National Alliance on Mental Illness (NAMI) regarding integrated dual-diagnosis treatment as an evidence-based model that addresses a patient's substance use in the context of the treatment of their mental illness. Research shows that people with co-occurring disorders need treatment for both problems to recover fully from either one. Research also indicates that people who receive integrated treatment have fewer hospitalizations, relapses or criminal justice problems and have more housing stability.

#### **Clinical Care at the Connecticut Recovery Center, LLC**

Our plan is to adhere to the aforementioned guidelines by first assessing a patient's severity of need through an individual assessment session that clearly documents both the need for service and initial treatment goals. This initial assessment will be conducted by a licensed psychiatrist, who can not only provide the most accurate diagnostic assessment, but will also outline the initial individualized treatment plan that will incorporate medication management, mental health treatment goal development, and relapse prevention planning. The patient's condition will then be presented in a round table fashion to the current treatment team for additional input on therapeutic options and finalization of comprehensive treatment planning. The guidelines set forth also dictate continued treatment, which will be addressed in similar fashion on a daily basis. This will flow largely from the clinical opinion and responsibility of an individual clinician to, on an ongoing basis, establish continued clinical needs and treatment goals that are being met. All of which will be documented and presented at rounding sessions with the acting medical director and other clinical staff on an ongoing basis.

With respect to the quality measures surrounding patient care, our program is intended to reintegrate patients to their psychosocial environments with effective individualized treatment planning, within six weeks of beginning treatment. Within this treatment period,

our measures of success will include items to the effect of negative random urine toxicology testing, lack of relapse reporting, and generalized ability of a patient to adhere to treatment planning and group therapy on a prompt ongoing basis. As a separate entity, our Suboxone induction and maintenance program's quality measures are indicated largely by some of the aforementioned criteria (lack of relapse, successful reintegration of a patient to their social environment). Furthermore, for each patient being maintained on Suboxone, the expectation will be that a patient will report a lack of opiate withdrawal symptoms, a lack of physical symptomology relative to withdrawal or adverse reaction to Suboxone induction, and in addition will report on a consistent basis a reduced interest in returning to abusing opiates. All of this will, of course, be documented accordingly and considered with treatment planning while a patient remains engaged in our IOP and outpatient maintenance services.

## 5. Organizational and Financial Information

a. Identify the Applicant's ownership type(s) (e.g. Corporation, PC, LLC, etc.). Connecticut Recovery Center, LLC is a limited liability corporation registered in the state of Connecticut.

b. Does the Applicant have non-profit status?  
 Yes (Provide documentation)     No

c. Provide a copy of the State of Connecticut, Department of Public Health license(s) currently held by the Applicant and indicate any additional licensure categories being sought in relation to the proposal.

The primary reason for submitting this Certificate of Need application is to obtain licensure from the Department of Public Health for our Intensive Outpatient Program. Although our current program is not yet licensed, our clinical personnel are State of CT licensed:

Jennifer R. Ballew, D.O., Ph.D. - CT license number is 042626

Douglas Thompson, LPC – CT license number is 001819

Kristin Olsen, LADC - CT license number is 1037

d. Financial Statements

- i. If the Applicant is a Connecticut hospital: Pursuant to Section 19a-644, C.G.S., each hospital licensed by the Department of Public Health is required to file with OHCA copies of the hospital's audited financial statements. If the hospital has filed its most recently completed fiscal year audited financial statements, the hospital may reference that filing for this proposal.

Not applicable.

- ii. If the Applicant is not a Connecticut hospital (other health care facilities): Audited financial statements for the most recently completed fiscal year. If audited financial statements do not exist, in lieu of audited financial statements, provide other financial documentation (e.g. unaudited balance sheet, statement of operations, tax return, or other set of books.)

The Applicant is not a Connecticut hospital. Connecticut Recovery Center, LLC, is proposing to open an outpatient psychiatric clinic. We intend to lease meeting space (not purchase land or buildings), and we have no need of expensive medical equipment.

Please refer to Appendix C for financial statements.

- e. Submit a final version of all capital expenditures/costs as follows:

**Table 2: Proposed Capital Expenditures/Costs**

<i>Medical Equipment Purchase</i>	<i>\$0.00</i>
<i>Imaging Equipment Purchase</i>	<i>0.00</i>
<i>Non-Medical Equipment Purchase</i>	<i>\$15,000.00</i>
<i>Land/Building Purchase *</i>	<i>0.00</i>
<i>Construction/Renovation **</i>	<i>0.00</i>
<i>Other Non-Construction (Specify)</i>	<i>0.00</i>
<b><i>Total Capital Expenditure (TCE)</i></b>	<b><i>\$15,000.00</i></b>
<i>Medical Equipment Lease (Fair Market Value) ***</i>	<i>\$0.00</i>
<i>Imaging Equipment Lease (Fair Market Value) ***</i>	<i>0.00</i>
<i>Non-Medical Equipment Lease (Fair Market Value) ***</i>	<i>0.00</i>
<i>Fair Market Value of Space ***</i>	<i>n/a</i>
<b><i>Total Capital Cost (TCC)</i></b>	<b><i>\$0.00</i></b>
<b><i>Total Project Cost (TCE + TCC)</i></b>	<b><i>\$15,000.00</i></b>
<i>Capitalized Financing Costs (Informational Purpose Only)</i>	<i>0.00</i>
<b><i>Total Capital Expenditure with Cap. Fin.</i></b>	<b><i>\$15,000.00</i></b>

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

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

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

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

Not applicable. The Connecticut Recovery Center, LLC, intends to finance the opening of this outpatient psychiatric clinic with the personal savings of it's founders.

**6. Patient Population Mix: Current and Projected**

- a. Provide the current and projected patient population mix (based on the number of patients, not based on revenue) with the CON proposal for the proposed program.

**Table 3: Patient Population Mix**

	<i>Current**</i>	<i>Year 1</i>	<i>Year 2</i>	<i>Year 3</i>
	<i>FY 2013</i>	<i>FY 2014</i>	<i>FY 2015</i>	<i>FY 2016</i>
<i>Medicare*</i>	0	0	0	0
<i>Medicaid*</i>	0	0	0	0
<i>CHAMPUS &amp; TriCare</i>	0	0	0	0
<b>Total Government</b>	0	0	0	0
<i>Commercial Insurers*</i>	100%	100%	100%	100%
<i>Uninsured</i>	0	0	0	0
<i>Workers Compensation</i>	0	0	0	0
<b>Total Non-Government</b>	100%	100%	100%	100%
<b>Total Payer Mix</b>	100%	100%	100%	100%

\* Includes managed care activity.

\*\* New programs may leave the "current" column blank.

\*\*\* Fill in years. Ensure the period covered by this table corresponds to the period covered in the projections provided.

- b. Provide the basis for/assumptions used to project the patient population mix.

The Connecticut Recovery Center, LLC, intends to accept only commercial insurers and patients who opt to self-pay.

## 7. Financial Attachments I & II

- a. Provide a summary of revenue, expense, and volume statistics, without the CON project, incremental to the CON project, and with the CON project. **Complete Financial Attachment I.** (Note that the actual results for the fiscal year reported in the first column must agree with the Applicant's audited financial statements.) The projections must include the first three full fiscal years of the project.

Please refer to Financial Attachment I (attached). Note: as Connecticut Recovery Center, LLC, is being founded specifically with the intent of creating and developing an Intensive Outpatient Program for mental health and substance abuse treatments, it has not previously been operative. Thus, only columns pertaining to projected revenue with the approval of the certificate of need are completed.

- b. Provide a three year projection of incremental revenue, expense, and volume statistics attributable to the proposal by payer. **Complete Financial Attachment II.** The projections must include the first three full fiscal years of the project.

Please refer to Financial Attachment II (attached).

- c. Provide the assumptions utilized in developing **both Financial Attachments I and II** (e.g., full-time equivalents, volume statistics, other expenses, revenue and expense % increases, project commencement of operation date, etc.).

Breakdown of yearly incremental expenses:

### FY2014

(assuming IOP to start in late 2013 or early 2014, fiscal year runs January 1- December 31)

\$52,800	Chief Executive Officer salary (0.25 FTE)
\$43,200	Chief Financial Officer/ Business Office Manager salary (0.5 FTE)

\$158,400	Medical Director/Psychiatrist 1 salary (0.75 FTE)
\$36,000	Psychiatrist 2 salary (0.25 FTE x 9 months)
\$33,600	Clinician 1 salary (0.5 FTE)
\$25,200	Clinician 2 salary (0.5 FTE x 9 months)
\$5,600	Clinician 3 salary (0.5 FTE x 2 months)
\$71,232	Benefits for CEO/Medical Director
\$20,000	Consulting/Contractors
\$8,000	Supplies
\$88,700	Administrative costs (building lease, insurance, etc.)

Total incremental expenses \$542,732

Incremental Salaries \$354,800

FTE: 3.0 (for most of the year)

### **FY2015**

\$57,600	Chief Executive Officer salary (0.25 FTE)
\$48,000	Chief Financial Officer salary (0.5 FTE)
\$172,800	Medical Director/Psychiatrist 1 salary (0.75 FTE)
\$96,000	Psychiatrist 2 (0.5 FTE)
\$35,520	Clinician 1 (0.5 FTE)
\$35,520	Clinician 2 (0.5 FTE)
\$33,600	Clinician 3 (0.5 FTE)
\$33,600	Clinician 4 (0.5 FTE)
\$24,000	Office Manager (0.5 FTE)
\$77,952	Benefits for CEO/Medical Director
\$15,000	Consulting/Contractors
\$12,000	Supplies
\$128,160	Administrative costs

Total incremental expenses \$769,752

Incremental Salaries \$536,640

FTE: 4.5

### **FY2016**

\$62,400	Chief Executive Officer salary (0.25 FTE)
\$79,200	Chief Financial Officer salary (0.5 FTE)
\$187,200	Medical Director/Psychiatrist 1 salary (0.75 FTE)
\$96,000	Psychiatrist 2 (0.5 FTE)
\$37,440	Clinician 1 (0.5 FTE)
\$37,440	Clinician 2 (0.5 FTE)
\$35,520	Clinician 3 (0.5 FTE)

\$35,520	Clinician 4 (0.5 FTE)
\$33,600	Clinician 5 (0.5 FTE)
\$25,920	Office Manager (0.5 FTE)
\$92,064	Benefits for CEO/Medical Director
\$15,000	Consulting/Contractors
\$12,000	Supplies
\$157,560	Administrative costs

Total incremental expenses \$906,864  
 Incremental Salaries \$630,240  
 FTE: 4.5

- d. Provide documentation or the basis to support the proposed rates for each of the FYs as reported in Financial Attachment II. Provide a copy of the rate schedule for the proposed service(s).

Professional Rate Schedules

Based on knowledge of local rates of reimbursement for other providers offering similar levels of care, we can anticipate that the Connecticut Recovery Center, LLC, will be able to charge approximately the following rates for services:

Service	2013 CPT Code	Fee per service
Intensive Outpatient Program Treatment Day	S9480	\$300.00
Psychiatric Diagnostic Interview	90792	\$300.00
Medication Management Visit	99214	\$150.00
Suboxone Induction	99205	\$300.00
Suboxone Follow-up Visits	99215	\$180.00

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

The Connecticut Recovery Center, LLC, plans to bill per patient per Intensive Outpatient

treatment day. Our estimated expenses for the first year of business are \$542,732. Thus, if the number of units is defined as the number of IOP treatment days per year, we will need to add at least 1,810 units per year to break even, or 71 patients. As we increase our program to include multiple tracks, we will incur more expenses, and thus need more patients per year. The addition of each track will cost approximately \$40,000 per year (the cost of a part-time clinician salary plus supplies and administrative costs), or 6 additional patients per year. As each track can absorb greater than 90 patients per year, and there is demonstrated need for these services in this community, we should have little difficulty in meeting these incremental unit gains.

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

We anticipate we will lose money over the first several months of operation, as it will take time to build our program, build a referral base, and collect reimbursements from commercial payors. It is our goal to break even financially by the end of our first year.

- g. Describe how this proposal is cost effective

Once we are licensed with the Connecticut Department of Public Health, we will begin to negotiate with commercial insurance companies for contracts to provide in-network mental health and substance abuse treatment options to their customers. This will almost immediately allow for more patients to quickly and affordably access this level of care. As referenced above in 2.a.vi., this will positively impact care not only for individual patients, but will also positively impact the local treatment community by alleviating the overload on currently existing outpatient and inpatient levels of care.

*Appendix A: Financial Attachments*

**13. B.1. Please provide one year of actual results and three years of projections of Total Facility revenue, expense and volume statistics**

without, incremental to and with the CON proposal in the following reporting format:

Total Facility: Description	FY2012 Actual Results	FY2013		FY2014		FY2015		FY2015 Projected With CON
		Projected W/out CON	Projected Incremental	Projected W/out CON	Projected Incremental	Projected W/out CON	Projected Incremental	
<b>NET PATIENT REVENUE</b>								
Non-Government	0	0	530850	0	854520	0	1107720	\$1,107,720
Medicare			\$0		\$0			\$0
Medicaid and Other Medical Assistance			\$0		\$0			\$0
Other Government			\$0		\$0			\$0
Total Net Patient Revenue	\$0	\$0	\$530,850	\$0	\$854,520	\$0	\$1,107,720	\$1,107,720
Other Operating Revenue								
Revenue from Operations	\$0	\$0	\$530,850	\$0	\$854,520	\$0	\$1,107,720	\$1,107,720
<b>OPERATING EXPENSES</b>								
Salaries and Fringe Benefits			426032		590592		722304	\$722,304
Professional / Contracted Services			20000		15000		15000	\$15,000
Supplies and Drugs			12000		12000		18000	\$18,000
Bad Debts			16584		25635		33231	\$33,231
Other Operating Expense			\$2,000		\$4,000		\$8,000	\$8,000
Subtotal	\$0	\$0	\$476,616	\$0	\$647,227	\$0	\$796,535	\$796,535
Depreciation/Amortization			0		5000		10000	\$0
Interest Expense								\$0
Lease Expense			\$39,600		\$47,850		\$51,150	\$51,150
Total Operating Expenses	\$0	\$0	\$516,216	\$0	\$700,077	\$0	\$857,685	\$857,685
Income (Loss) from Operations	\$0	\$0	\$14,634	\$0	\$154,443	\$0	\$250,035	\$250,035
Non-Operating Income			\$0		\$0			\$0
Income before provision for income taxes	\$0	\$0	\$14,634	\$0	\$154,443	\$0	\$250,035	\$250,035
Provision for income taxes								
Net Income	\$0	\$0	\$14,634	\$0	\$154,443	\$0	\$250,035	\$250,035
Retained earnings, beginning of year			\$0		\$14,634		\$169,077	\$169,077
Retained earnings, end of year	\$0	\$0	\$14,634	\$0	\$169,077	\$0	\$419,112	\$419,112
FTEs			3		4.5			4.5

\*Volume Statistics:

Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

12.C(ii). Please provide three years of projections of incremental revenue, expense and volume statistics attributable to the proposal in the following reporting format:										
Type of Service Description	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
Type of Unit Description:	Units	Rate	Gross Revenue Col. 2 * Col. 3	Allowances/ Deductions	Charity Care	Bad Debt	Net Revenue Col. 4 - Col. 5	Operating Expenses Col. 1 Total *	Gain/(Loss) from Operations Col. 8 - Col. 9	
# of Months in Operation										
FY2014										
Adult Psychiatric Care										
Intensive Outpatient Program										
	0									
<b>FY 2014</b>										
<b>FY Projected Incremental</b>										
Total Incremental Expenses:										
<b>Total Facility by Payer Category:</b>										
Medicare										
Medicaid										
CHAMPUS/Tricare										
<b>Total Governmental</b>	0		\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Commercial Insurers	1,733	\$300	\$519,900				\$12,308	\$507,592	\$515,655	(\$8,063)
Uninsured	91	\$300	\$27,300				\$1,372	\$25,928	\$27,077	(\$1,149)
<b>Total NonGovernment</b>	1,824		\$547,200	\$0	\$0	\$13,680	\$533,520	\$542,732	\$542,732	(\$9,212)
<b>Total All Payers</b>	1,824		\$547,200	\$0	\$0	\$13,680	\$533,520	\$542,732	\$542,732	(\$9,212)



12.C(ii). Please provide three years of projections of incremental revenue, expense and volume statistics attributable to the proposal in the following reporting format:										
Type of Service Description	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
Type of Unit Description:	Rate	Units	Gross Revenue	Allowances/ Deductions	Charity Care	Bad Debt	Net Revenue	Operating Expenses	Gain/(Loss) from Operations	
# of Months in Operation			Col. 2 * Col. 3				Col. 4 - Col. 5	Col. 1 Total *	Col. 8 - Col. 9	
FY2016										
Adult Psychiatric Care										
Intensive Outpatient Program										
	12									
<b>FY 2016</b>										
<b>FY Projected Incremental</b>										
Total Incremental Expenses:	\$906,864									
<b>Total Facility by</b>										
<b>Payer Category:</b>										
Medicare			\$0				\$0	\$0	\$0	\$0
Medicaid			\$0				\$0	\$0	\$0	\$0
CHAMPUS/TriCare			\$0				\$0	\$0	\$0	\$0
<b>Total Governmental</b>		0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Commercial Insurers			\$1,128,600			\$33,858	\$1,094,742	\$861,521	\$233,221	
Uninsured	\$300	3,762	\$59,400			\$1,782	\$57,618	\$45,343	\$12,275	
<b>Total NonGovernment</b>		3,960	\$1,188,000	\$0	\$0	\$35,640	\$1,152,360	\$906,864	\$245,496	
<b>Total All Payers</b>		3,960	\$1,188,000	\$0	\$0	\$35,640	\$1,152,360	\$906,864	\$245,496	

*Appendix B: Letters of Attestation*

<b>Daniel S Mundy MD</b>	276 Fifth Avenue Suite 307A New York, NY 10001 Phone: (646) 801-1246 Fax: (646) 863-4471 E-Mail: daniel.mundy.md@gmail.com
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March 20<sup>th</sup>, 2013

To Whom it May Concern:

This letter serves as means to attest to both the community need for the services intended to be provided by the Connecticut Recovery Center LLC, and also to attest that the services proposed are clinically appropriate to the region in question. Furthermore, I am additionally willing to attest that the individuals organizing as management for this clinic are among the most patient outcome focused and business sensible individuals that I have had the pleasure of working with.

Professionally, I am very involved in the Connecticut mental health treatment community even though I have recently opened my own private practice in Manhattan. I am on the DMHAS approved list of expert witnesses for the Connecticut Probate Court. I serve as a court-appointed psychiatrist in New Haven, and I spend a considerable amount of time in this region working with the psychiatric and substance abusing patient population. Prior to beginning my career in New York, I served as the Medical Director at the Hospital of Saint Raphael's (HSR) inpatient mental health unit for three years. I completed residency training through Yale University. My involvement with the patients and community in question has spanned a decade.

With that being said, I have thoroughly reviewed the business plan, clinical model, and certificate of need that the Connecticut Recovery Center has built, and I am in full support of their current proposal. During my time as a resident and as the medical director at the HSR's adult psychiatric unit, it was a constant struggle finding an appropriate level of care for discharged patients who lived in Naugatuck Valley and the Cheshire/Wallingford regions of Connecticut (notably, the inpatient psychiatry social workers report to the medical director at the Hospital of St. Raphael). The reason for this struggle is evident; an Intensive Outpatient Program (IOP) level of care in this region is either unavailable or not within a reasonable proximity to a patient's primary residence. Moreover, in relation to dually diagnosed patients and primary substance-abuse patients, there are no facilities offering Suboxone induction in conjunction with Intensive Outpatient services. The services being proposed are unique, valuable, and much needed to appropriately treat a patient population that typically requires intense ongoing services to remain stable and asymptomatic within their community setting. Furthermore, the patient population that the Connecticut Recovery Center is envisioning as their target population, middle class and affluent individuals, are typically underserved in this region. Treatment settings are not available, and other more local IOP/Suboxone maintenance providers are overburdened with patients that are insured by either Medicaid or Medicare; as such, these programs are typically tailored toward patients who's needs do not match that of the typical middle or upper class patient population (e.g. flexibility around part-time or full-time employment).

In regards to the medical leadership at the Connecticut Recovery Center, I have always been impressed with the clinical intuition and leadership skills that have been displayed by Dr. Jennifer Ballew, who was the Medical Director of the HSR Adult Partial Hospital Program and Intensive Outpatient Program, and is

## Daniel S Mundy MD

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currently Medical Director of the Yale New Haven Hospital Adult PHP and IOP. In my years spent working directly with Dr. Ballew as a referring doctor, I have seen very positive outcomes with patients in her programs. Her roles include prescribing doctor, supervisor to clinical staff, and provision of strategic business direction. I have no doubt that her leadership in her new venture as President and Chief Medical Director of the Connecticut Recovery Center will lead to the clinic's success.

During my time at HSR, I also had the opportunity to work with Blair MacLachlan in his role as a consultant to our department. While I was Medical Director of adult inpatient psychiatry at HSR, he and I worked very closely in ensuring the financial solidity of our program. During the years I worked with him, I learned that his understanding of the business of psychiatry in Connecticut is unparalleled; he will be a definite asset to ensuring the success of the Connecticut Recovery Center.

In closing, I am quite pleased that the level of psychiatric care proposed by the Connecticut Recovery Center will soon be available. As a community psychiatrist, I would without hesitation refer patients to their care. Had their Intensive Outpatient Program and Suboxone Program been in existence during my time as the medical director of a psychiatric unit that treated patients from the aforementioned geographical areas, I would have, without doubt, referred numerous patients to their care. It is my firm belief that the Connecticut Recovery Center will be an invaluable resource utilized by numerous community psychiatrists, local hospitals, and rehabilitation centers.

Sincerely,



Daniel Mundy, MD



**Psychiatric Services LLC**  
**Nick C. Mellos MD**  
**21 Hazel Terrace Suite B**  
**Woodbridge CT 06525**  
**(203) 389-6000**

TO: Office of Health Care Access

Regarding: Connecticut Recovery Center

April 10, 2013

This letter of support is written on behalf of the Connecticut Recovery Center's petition to open an Intensive Outpatient Mental Health Program and Suboxone induction and maintenance services in the greater Cheshire, Housatonic Valley, and Waterbury area. I can testify personally that a high quality center that provides such services are drastically needed to serve the population in this area. Other settings that offer intensive treatment are overburdened and frequently do not have capacity to accommodate patients. My attempts to refer patients to enhanced levels of care are frequently met with wait lists or responses that they are full. Conversations with other local providers further confirm this.

This leaves many of our vulnerable patients in the area unable to access close and clinically necessary services.

I have worked directly with Dr Jennifer Ballew and I can speak with experience that she has the knowledge, experience, and ingenuity to establish a wonderful center that would meet the needs of patients in this area. I give my full support to this application.

Please do not hesitate to contact me if you have any questions.

Sincerely,

A handwritten signature in black ink, appearing to be 'Nick C. Mellos', written over a horizontal line.

Nick C. Mellos MD

*GBM HealthCare Management Resources, L.L.C.*  
*Integrated Consultation Strategies for Success in Managed-Care*

7 Watrous Point Road  
Old Saybrook, CT 06475  
Phone & Fax: (860) 388-9128  
Cell Phone # 860-208-0998  
E-Mail: bmaclachlan@comcast.net

March 20, 2013

To Whom It May Concern at the Connecticut Office of Health Care Access:

Please accept this letter as my highest recommendation of the opening of an Intensive Outpatient Program at the Connecticut Recovery Center, LLC, in Cheshire. As a behavioral health care consultant with over 30 years experience working with local mental health and substance abuse programs at inpatient, partial hospital, intensive outpatient, and outpatient facilities, I can personally attest to the growing need for this level of care across the entire state.

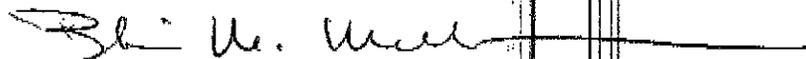
As health care costs continue to escalate, it is becoming more and more difficult for patients with severe mental illness or chronic substance dependence to get admitted to inpatient programs. The severity of their disorders prevent these patients from being able to effectively make use of weekly individual psychotherapy sessions or monthly medication management visits. Thus, this population of patients typically goes under-treated until their symptoms escalate to the point of requiring an expensive inpatient hospitalization. An Intensive Outpatient Program, such as the one proposed by the Connecticut Recovery Center, offers a practical and affordable solution to this common scenario.

I have known and worked with Dr. Ballew in various capacities for the past four years. She has consistently demonstrated a strong work ethic, a deep passion for clinical care, and a high degree of professionalism. In particular, I have been impressed with her leadership in her role as Medical Director of the Yale New Haven Hospital Adult Partial Hospital Program. She has been instrumental in developing the YNH program into an outcome oriented, patient-friendly, and profitable operation.

In summary, I strongly recommend the Connecticut Recovery Center, LLC, and specifically Dr. Ballew, as having a very high likelihood of success in providing much-needed services to the local community.

Please feel free to contact me with any further questions.

Sincerely,



Blair M. MacLachlan, MSW  
Principal – GBM HealthCare Management Resources, LLC

*Appendix C: Curriculum Vitae*

**Jennifer R. Ballew, DO, PhD**  
197 Lanyon Drive, Cheshire, CT, 06410  
(203) 464-9927, drdrjenn@yahoo.com

### **Career Profile**

*As a talented and skilled psychiatrist with practical experience in various mental health settings including hospitals, partial hospitals, intensive outpatient programs, and community clinics, I am intensely passionate about community psychiatry and the efficient and cost-effective delivery of same. I am looking for a challenging position to utilize my clinical and organizational skills, knowledge and experience in a team-based behavioral health organization.*

### **Education and Medical Training**

<b>Residency</b> Yale University School of Medicine, New Haven, CT Department of Psychiatry	07/01/03—07/31/06
<b>Internship</b> Yale University School of Medicine, New Haven, CT Department of Psychiatry	07/01/02—06/30/03
<b>Medical School</b> Michigan State University, East Lansing, MI College of Osteopathic Medicine	09/01/95—05/03/02
<b>Graduate School</b> Michigan State University, East Lansing, MI Department of Pharmacology and Toxicology	06/01/95—08/30/00
<b>Undergraduate Degree</b> University of Michigan, Ann Arbor, MI	09/01/89—05/03/93

## **Professional Work History**

**Medical Director, Partial Hospital Program** 11/01/09—present

*Hospital of St. Raphael, New Haven, CT*

*Manage the daily clinical operations of an adult psychiatric partial hospital program and an intensive outpatient program in an urban community. Supervise an interdisciplinary team of licensed mental health professionals in providing daily structured care for patients with severe mental illness, substance use disorders, and co-occurring disorders. We use a combination approach of group psychotherapy, pharmacotherapy, and education to assist patients who are either stepping down from acute inpatient care or who are trying to avoid an acute inpatient hospitalization.*

**Principal Psychiatrist** 07/01/07—10/15/09

*Greater Waterbury Mental Health Authority, Waterbury, CT*

*Provided direct care, psychiatric treatment, and substance abuse treatment to DMHAS patients assigned to the local Assertive Community Treatment team. Participated in clinical leadership, teaching and supervision of an 8-member clinical team. Directly responsible for supervising, coordinating and signing off on all treatment plans.*

**Attending Psychiatrist** 03/01/07—07/31/07

*Hospital of St. Raphael, New Haven, CT*

*Staffed the inpatient psychiatric ward and tended to hospitalized adult patients with mental illnesses. Coordinated care as needed with Internal Medicine consult teams and community providers. Assisted in the psychiatric emergency department as needed.*

**Attending Psychiatrist** 08/01/06—07/01/07

*Yale University School of Medicine, New Haven, CT*

*Provided psychiatric care, medication management, and brief psychotherapy in outpatient setting. Triage, assessed, treated and appropriately referred walk-in patients in an acute care setting.*

## **Licensure and Certifications**

*Medical License, State of Connecticut, Active since 2004*

*Board Certified, American Board of Psychiatry and Neurology, 2007*

## **Academic Affiliations**

**Assistant Clinical Professor** 08/01/06 - present

*Yale University Schools of Medicine, New Haven, CT*

## ***Professional Memberships***

*American Psychiatric Association, Member since 2002*

## ***Honors***

*Janet M. Glasgow Memorial Scholastic Achievement Citation, American Medical Women's Association, May 2002*

*Who's Who Among American Universities and Colleges, Michigan State University College of Osteopathic Medicine, February 2001*

*Young Investigator Travel Grant, International Society of Hypertension*

*ISH 2000, Chicago, May 2000*

*American Physiological Society Travel Award, Water and Electrolyte Section, Experimental Biology 2000, San Diego, February 2000*

*Procter and Gamble Professional Opportunity Award, First Runner-Up, February 2000*

*American Heart Association Travel Award, AHA Hypertension Summer School, Boulder, CO, May 1999*

*Phyllis K. and Walter P. Dell Endowed Scholarship, Michigan State University College of Osteopathic Medicine, April 1999*

*Sigma Xi Graduate Student Award, Michigan State University Chapter, March 1999*

*American Society for Pharmacology and Experimental Therapeutics Student Award, Robert F. Furchgott Fund, Experimental Biology 1999, Washington D.C., January 1999*

*Bristol-Myers Squibb Foundation, Inc. Travel Grant, American Medical Women's Association (AMWA) 1997 Annual Meeting, Chicago, September 1997*

*Sills Fellowship Award, Medical Scientist Training Program (MSTP) Annual Forum, August 1996*

## ***State of Connecticut Committees***

*Clinical Leadership Committee, Western Connecticut Mental Health Network, October 2007- October 2009*

## ***Michigan State University Committees***

*Committee on Research and Graduate Studies, Graduate Student Representative (elected position), August 1997-2000*

*The University Graduate-Professional Judiciary, Graduate Student Representative (appointed position), April 1996*

### **Extracurricular Officer Positions**

*Yale University Psychiatry Residents Association, Co-President, July 2003-July 2004*

*American Medical Women's Association (AMWA), President, Michigan State University chapter, April 1997- August 1998*

*Peer Mentor (elected position), Michigan State University, June 1996- June 1998*

### **Research and Publications**

*Epperson CN, Ballew J.R. Postpartum Depression: A Common Pregnancy Complication in Treatment of Psychiatric Disorders During Pregnancy and the Postpartum. Psychiatric Disorders in Pregnancy and the Postpartum: Principles and Treatment. Ed. Victoria Hendrick, Humana Press, May 2006.*

*Ballew, J.R. Departure Rulings Must Be Hitched to Sentencing Guidelines: Defendant's Reduced Mental Capacity Alone Cannot Justify Downward Departure of 15 Levels from the Range in the U.S. Sentencing Guidelines Manual. Journal of the American Academy of Psychiatry and the Law. Legal Digest. 2005, 33(1): 128-131.*

*Ballew J.R., Fink, G.D. Role of ETB Receptor Activation in Angiotensin II Induced Hypertension: Effects of Salt Intake. American Journal of Physiology: Heart and Circulatory. 2001 Nov; 281(5): H2218-23.*

*Ballew J.R., Fink, G.D. Characterization of the Antihypertensive Effect of a Thiazide Diuretic in Angiotensin II Induced Hypertension. Journal of Hypertension. 2001, 19 (8): 1-6.*

*Ballew J.R., Fink, G.D. Role of ETA Receptors in Experimental Angiotensin II Induced Hypertension in Rats. American Journal of Physiology: Regulatory, Integrative, and Comparative Physiology. 2001 Jul; 281(1):R150-4.*

*Ballew J.R., Watts, S.W., Fink, G.D. Effects of Salt Intake and Angiotensin II on Vascular Reactivity to Endothelin-1. Journal of Pharmacology and Experimental Therapeutics, 2001, 296(2): 345-350.*

*Wu W, Zhang Y, Ballew J.R., Fink G, Wang DH. Development of hypertension induced by subpressor infusion of angiotensin II: role of sensory nerves. Hypertension, 2000.*

Oct;36(4):549-52.

Cheung, S., **Ballew, J.R.**, Moore, K.E., Lookingland, K.,J. Contribution of Dopamine Neurons in the Medial Zona Incerta to the Innervation of the Central Nucleus of the Amygdala, Horizontal Diagonal Band of Broca and Hypthalamic Paraventricular Nucleus. *Brain Research*, 1998. 808 (2): 174-181.

**Abstracts**

**Ballew, J.R.**, Fink, G.D. Interaction of angiotensin II with the vascular endothelin system in rats. *FASEB Journal*. 2000. 14(8): A1403.

**Ballew, J.R.**, Fink, G.D. Characterization of the antihypertensive effect of thiazide diuretics in the presence of fixed angiotensin II. *Intl. Soc. of HTN*, 2000.

**Ballew, J.R.**, Fink, G.D. Role of ETA receptors in experimental angiotensin II induced hypertension in rats. *FASEB Journal*. 2000. 14 (4): A132.

**Ballew, J.R.**, Fink, G.D. Relationship Between Experimental Angiotensin II Induced Hypertension and Activation of the Endothelin System in Rats. *FASEB Journal*, 1999, 13 (5, part 2): 781.

Wolber, F.M., Craig, R., **Ballew, J.R.**, Abassi, O.,Lobb, R.,Stoolman, L.M. VLA-4 Mediates Leukocyte Attachment to Stimulated Endothelium. *FASEB J.*, 1993.

**Personal and Professional References Furnished Upon Request**

# Mark Lanz

746 Chapel St  
New Haven, CT 06510

203-464-9783

mark.lanz@gmail.com

## SUMMARY

I am an entrepreneur with over twenty years of experience solving problems with technology. The first ten years I was a consultant with both large and small companies, solving client's needs with project management and technical leadership. For the last ten years, I've worked for software product companies, first as an employee and later as a cofounder.

## EMPLOYMENT OVERVIEW

### **CTO and Cofounder, Broadstripes LLC**

New Haven, CT — January 2006 - current  
Cofounder of a company that creating a CRM software as a service tool for nonprofits and labor unions. Developed the system architecture, programming assets, and joined in the day to day running of the company.

### **Senior Technical Leader, Tangoe, Inc.**

Orange, CT — July 2004 - May 2011  
Lead module development in a telecom expense management product. Lead development and mentored junior developers.

### **Senior Software Engineer, Metaserver, Inc.**

New Haven, CT — March 2003 - July 2004  
Designed and developed security modules for a commercial software product.

### **Java Architect, Sun Microsystems Corporation**

Michigan, Indiana, and Rhode Island — November 2000 - March 2003  
Lead the architectural design and technical implementation for Fortune 500 companies.

### **Technical Manager, Cambridge Technology Partners**

Pittsburgh, PA — August 2000 - October 2000  
Led the architectural assessment of an enterprise application for a large bank.

### **Senior Consultant, Digital Fusion, Inc.**

Lansing, MI — April 1998 - October 2000  
Led consulting engagement as a project manager and as a technical manager.

### **Senior Consultant, Anatec, Inc.**

Lansing, MI and Windsor, ON — June 1995 - April 1998  
Technical lead for state organizations as well as a Canadian insurance company.

### **Consultant, Analysts International, Inc.**

Des Moines, IA — March 1995 - June 1995  
Provided technical review for company wide projects at a major financial corporation.

### **Systems Engineer, Electronic Data Systems (EDS)**

Southeastern Michigan — August 1992 - March 1995  
Programmed components for large enterprise computes systems,

## EDUCATION

### **University of Michigan (Ann Arbor, MI)**

Bachelor of Science — 1992

**Blair MacLachlan**  
7 Watrous Point Road  
Old Saybrook, CT 06475  
(860) 388-9128

### **OBJECTIVE**

*As a healthcare leader for a highly market-responsive organization, I will maximize organizational performance, market-share, and profitability.*

### **SUMMARY**

*Accomplished healthcare manager with 30+ years of administrative and clinical experience in the provision of a full spectrum of psychiatric and substance abuse services. Particular areas of expertise include:*

- *Highly strategic in network development and managed-care contracting.*
- *Ability to optimize organizational capacity and processes.*
- *Effective evaluator and interpreter of data.*
- *Strong influencer in context of business development.*
- *A visionary, able to translate creativity into reality.*

### **EXPERIENCE**

**GBM HealthCare Management Resources, LLC**  
**Principal**

**2000-Present**

*Developed / created consulting company providing managed care contracting, clinical operations, accounts receivable/management services.*

- *Within 6 months of operations created a healthcare management consultation company and contracted with 6 Facility based providers, 1 Integrated Health System, 1 Managed care vendor, and 4 Community Based providers.*
- *Developed capacity to deliver comprehensive "Operational Analysis" of organizations clinical, financial and Utilization Management processes.*
- *Established provider accounts receivable systems/process and collected 3.2 million dollars in provider reimbursement.*
- *Re-contracted for services and rates with 6 HMO Behavioral Health Vendors for 10 facilities and 4 community based providers.*
- *Created a State-wide Medicaid network of providers including: Acute-care and Residential Facility providers, community –based Child Guidance Clinics, Family Service Associations, Local Mental Health Clinics, and Federally Qualified Health Clinics.*
- *Current Client portfolio includes: 10 Facility based providers, 1 Integrated Health System, 3 Managed care vendors, 1 Outsource Billing Company, and 5 Community Based providers.*

**New England HealthCare Management Services, LLC  
Director of Consultation Services**

**1999-2000**

*Developed / created consulting company providing managed care contracting, clinical operations, accounts receivable/management services*

- *Within 6 months of operations created a healthcare management consultation company and contracted with 7 healthcare providers, 1 Integrated Health System, a 2 primary-care providers.*
- *Developed capacity to deliver comprehensive "Operational Analysis" of organizations clinical, financial and Utilization Management processes,*
- *Established provider accounts receivable systems/process and collected 1.5 million dollars in provider*
- *Reimbursement,*
- *Re-contracted for services and rates with 6 HMO Behavioral Health Vendors for 5 Facilities and 3 community based providers.*

**Behavioral Health Connecticut, LLC, Hartford, CT  
Network Management & Provider Relations**

**1997 - 1999**

- *State-wide Provider Sponsored Behavioral Health Managed Care/Utilization Management company of the Hartford Health Care Corporation*
- *Created a state-wide ambulatory and facility-based behavioral health provider network, through effectively implementing the selection, credentialing and contracting strategy. Within six months of incorporation, BHC had 580 ambulatory providers and 15 facility based providers under contract.*
- *Established the organizational capacity to provide, analyze, and proactively manage the system of care in a fully at-risk environment. Within 90 days of operation, the system had secured 4 contracts, 2 fully capitated covering 45,000 lives and 2 ASO contracts for network management and support services.*

**Psych Options East, Inc., Mansfield Center, CT  
Executive Director**

**1995 - 1999**

*A leading regional Provider-Hospital-Organization (PHO) providing behavior health services and encompassing 54 direct service healthcare professionals practicing in 21 office locations.*

- *Created an integrated behavioral health provider network, establishing the framework, analyzing the market, and designating target providers, becoming the dominant player in a \$20 million market within one year.*
- *Established the organizational capacity to provide, analyze, and proactively manage the system of care for a service area of 560,000 lives. Within one year of operation, the system had secured five managed-care contracts with a monthly increase of billed services of 30%.*

*Natchaug Hospital, Mansfield Center, CT*  
**Director of Network Development (1993-1999)**

**1989 - 1999**

*A leading regional, private, not-for-profit specialty hospital providing inpatient and partial hospital behavioral health services to adults, adolescents, and children.*

- *Established the organizational capacity to effectively respond to significant changes in the managed-care, public and governmental payers implementing systems to evaluate market share, target payers, and implement marketing strategies. Since 1993, successfully negotiated 39 contracts for services, covering 98% of the lives in the defined service area.*
- *Developed the internal information systems and processes to proactively manage contract performance, monitor payer satisfaction, utilization of services, and reimbursement. Since 1993, have increased third party market share, maintained inpatient census/payer mix, and improved partial hospital census/payer mix during a period of significant state and national reductions in behavioral health expenditures.*

**Director of Adult Services (1991-1995)**

- *Successfully reorganized the clinical program, admissions criteria and processes, and implemented off-site partial hospital program managing total budget of \$6.5 million in gross revenues.*
- *Implemented acute programs to respond to managed-care expectations for decreased length of stay, increasing admissions over 50% and decreasing length of stay by 30%.*

**Director of Adult Partial Hospital Programs (1989-1991)**

- *Successfully redesigned the "Partial Hospital Social Rehabilitation Model" to acute service providers, incorporating chemical dependency services and establishing relapse prevention services. As service of choice by area providers and payers, 80% growth in admissions and gross revenues increased to \$1.5 million.*

*Aetna Life and Casualty, Middletown, CT*  
**Psychiatric Review Specialist**

**1987 - 1989**

*A national leader in insurance and managed care reform providing behavioral health benefits and care management services through pre-certification, concurrent telephonic reviews, and retrospective medical records reviews.*

- *Developed and implemented admission, extended stay, and criteria was utilized to psychiatric and substance abuse treatment, this was adopted company-wide, and was utilized to train review and field office staff.*
- *As Account Manager for an international company, provided review services, decreasing total annual cost for behavioral health from \$72 to \$66 million.*

*Elmcrest Psychiatric Institute, Portland, CT 1980 - 1987*

**Director of Outpatient/EAP Services** (1986-1987)

*State-wide leader in the delivery of behavioral health services providing inpatient, partial hospital and outpatient services.*

- *Proposed and secured first EAP contract for a local municipality including 11 union contracts, successfully negotiating management and labor issues and obtaining first year 7.2% penetration/utilization rate for employees.*
- *Designed, developed, and implemented business office and clinical processes, becoming operational in 90 days, and by year-end was providing services to 80 clients weekly (33% above plan).*

#### **EDUCATION**

**MSW, Group Work/Administration** 1983

*University of Connecticut School of Social Work, West Hartford, CT*

**B.A., Clinical Psychology** 1981

*University of Hartford, West Hartford, CT*

***Douglas F. Thompson, MS, LPC***

*412 Waverly Road, Shelton, CT 06484 - (203) 543-7575 - dagus0423@gmail.com*

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***Mental Health Counselor***

*March 2010 – present*

*Private Practice – Woodbury, CT*

- *Conducting behavioral health counseling for private clients, including individual as well as group treatment.*
- *Conducting psychosocial assessments, maintaining appropriate documentation, and coordinating with providers and collateral contacts.*

***Intensive Care Manager***

*January 2011 – July 2012*

*VALUEOPTIONS/CTBHP – Rocky Hill, CT*

- *Responsible for managing a caseload of members from throughout the state of Connecticut who have been identified as being in need of intensive case management.*
- *Daily collaboration with Emergency Departments throughout the state, in order to assist them in locating available beds at appropriate levels of care for members.*
- *Collaboration with inpatient psychiatric and detox providers, local mental health authorities, and member's caseworkers to create both treatment and discharge plans designed to support the member's continued success upon discharge.*
- *Evaluation of patients' clinical information for pre-certification and concurrent reviews against a variety of clinical criteria for authorization of appropriate level of care.*
- *Conducting telephonic reviews and collaborating with providers of all levels of care, including inpatient, partial hospitalization, intensive outpatient, and outpatient facilities.*
- *Evaluation of clinical cases and authorized care for patients with mental health, chemical dependency and dual diagnoses.*
- *Facilitated doctor consultations for the completion of reviews.*
- *Coordinated transitions to lower levels of care including aftercare planning and placement.*
- *Handled phone calls received on Crisis Line established for members experiencing immediate crises.*

***Director of Social Services***

*February 2009 - December 2011*

**PARADIGM HEALTHCARE CENTER OF TORRINGTON – Torrington, CT**  
**10/09 – 12/11**

**PARADIGM HEALTHCARE CENTER OF NORWALK – Norwalk, CT**  
**02/09 – 10/09**

- *Responsible for the psychosocial needs of the residents of a skilled nursing facility, including residents maintained on secured Memory Support/Dementia and Behavioral units.*
- *Supervision of full-time and part-time social work staff.*
- *Case management of both short and long-term residents, including discharge planning, coordination of services, placement and housing referrals.*
- *Coordination of psychiatric referrals and psychosocial follow-up.*
- *Conducting psychosocial assessments and maintaining psychosocial documentation.*
- *Conducting assessments and maintaining data for MDS 3.0 data set.*
- *Maintaining MIMR and ASCEND/PASRR information.*
- *Facilitating Resident Council and Family Council meetings.*
- *Supporting the emotional needs of the residents' families, and attending to any concerns or requests.*
- *Designing and implementing a behavioral program, including psychotherapeutic groups and activities, to address the specific needs of a secured Behavioral unit.*
- *Conducting a series of educational inservices for the staff of a secured Memory Support unit, covering the specific needs of residents with a diagnosis of dementia.*

**Treatment Coordinator**

**September 2006 – February 2009**

**HALL-BROOKE BEHAVIORAL HEALTH SERVICES – Westport, CT**

- *Case Management for patients of an acute care inpatient hospital, on both adult and child/adolescent units.*
- *Responsible for the rapid stabilization and referral of patients, in cooperation with the treatment team, through the application of one-to-one treatment, as well as family, group and milieu therapy.*
- *Correspondence with patients' previous treatment providers, as well as discharge planning; arrangement of appropriate aftercare providers as a step-down from the inpatient setting upon discharge.*

*Admissions Counselor*

*November 2005 – February 2006*

*LONG ISLAND UNIVERSITY OFFICE OF ADMISSIONS – Brooklyn, NY*

- *Responsible for maintaining segments of Brooklyn Campus' freshman, transfer, international and reapplying student populations; Admissions Office Coordinator to Brooklyn Campus' Athletic Training department.*

*Senior Admissions Counselor*

*August 2002 – October 2005*

*C.W. POST OFFICE OF ADMISSIONS – Brookville, NY*

- *Transfer students' counselor responsible for maintaining admissions in a specific recruitment territory that included Suffolk County Community College (one of the C.W. Post's two main feeder schools within the Transfer demographic); also New York City, Upstate New York, New England and Pennsylvania.*
- *Responsible for tracking and maintaining the Readmitted student population in cooperation with the Academic Standing Committee.*

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*MS, Mental Health Counseling*

*C.W. POST CAMPUS OF LONG ISLAND UNIVERSITY – Brookville, NY*

*BA, English:*

*FAIRFIELD UNIVERSITY – Fairfield, CT*

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*Licensed Professional Counselor # 001819, State of Connecticut, Department of Public Health*

**Kristin M. Olsen**  
kmolsen502@gmail.com  
(203) 570-3909

**OBJECTIVE:** My aspirations are to continue to develop my professional career in the human services field. I look for employment opportunities that are challenging and will enrich me to further enhance my effectiveness to be a well-rounded, versatile therapist.

**Licensure:**

5/13 Licensed Drug and Alcohol Counselor (LADC);  
CT license #1037

**Education:**

9/05-5/12 Albertus Magnus College New Haven, CT:  
Masters of Art in Art Therapy program

9/99-5/03 2003 Graduate Bachelor of Arts Degree at University of Delaware  
Art Major, Psychology Minor

06/02-07/02 Study Abroad Program: Italy (Venice, Florence, Rome, Tour of Tuscany)

**Employment History:**

1/08 – current Hospital of Saint Raphael/Yale New Haven Hospital  
Substance Abuse Clinician; PHP/IOP program  
Variety of clinical duties including facilitating group psychotherapy, group art therapy, group psychoeducation, goal/symptom management group; weekend/leisure planning group; PHP Relapse Prevention Crisis group, biopsychosocial assessments, collecting urine toxicology specimens, insurance authorizations, basic case management, documentation to include treatment plans and discharge summaries

11/05- 1/08 Pitney Bowes Inc. Shelton, CT  
New Hire Fulfillment Team Coordinator  
Variety of Duties within HR arena. Responsibilities include investigation of drug and background checks, data integrity and processing, completion of highly sensitive new hire legal documents.

1/04- 11/05: Pitney Bowes Inc. Stamford CT  
Administrative Assistant to Dir. Customer Relationships  
Variety of Duties within Customer Relations and Business Operations Unit.

7/02-12/03 Pitney Bowes, Inc. Stamford CT via Adecco Temp Agency:  
summers/school holidays-assigned to Pitney Bowes upon repeated requests.  
WorkLife Value Solutions & Workforce Effectiveness Department:

**Intern Experience:**

9/06 – 1/08: St. Raphael's Substance Abuse / Chemical Dependency Unit New Haven, CT  
Intern responsibilities include but not limited to updating charts, authorization management, assisting in interventions to monitor and manage client behaviors, offering insight, co-leading art therapy and psychotherapy groups; co-led family night group session

12/06-6/06: **The University School, Bridgeport, CT Art Therapy Intern**  
*Intern responsibilities include but not limited to co-leading art therapy activities, engaging students in discussions of various interpersonal issues, assisting and encouraging student art making, analyzing art work with students,*

**Volunteer Work:**

6/05-8/05 **Habitat for Humanity; Global Village Outreach program** (Zambia, Africa)

9/04 – 12/04 **Heartsong Organization: Volunteer Art Therapist Assistant**  
*Volunteer responsibilities included working with developmentally disabled children on art projects, offering assistance and reassurance to those having difficulty, giving progress updates to parents about their child's performance in art therapy session.*

11/00-05/03 **Volunteer Outreach Program at Delaware Psychiatric Center**  
*Volunteer responsibilities included working with mentally, physically and emotionally challenged individuals. Assisted in organizing and leading activities for groups as well as one-on-one participation. Monitored patients' abilities to co-mingle. Offering assistance and reassurance to those having difficulty in participating with group activities.*

**References:** Available Upon Request

*Appendix D – References & Bibliography*

1. American Psychiatric Association. DSM-IV-TR or Diagnostic and Statistical Manual, edition IV transitional (2000). The DSM-IV-TR provides a classification of mental disorders, criteria sets to guide the process of differential diagnosis, and numerical codes for each disorder to facilitate medical record keeping. The stated purpose of the DSM is to: 1) provide "a helpful guide to clinical practice"; 2) "to facilitate research and improve communication among clinicians and researchers"; and 3) to serve as "an educational tool for teaching psychopathology."
2. American Society of Addiction Medicine. ASAM Patient Placement Criteria for the Placement of Substance Related Disorders, Second Edition (ASAM PPC-2R) (2001). The ASAM Patient Placement Criteria is the result of a collaboration that began in the 1980s to define one national set of criteria for providing outcome-orientated and results based care in the treatment of outcome-orientated and results based care in the treatment of addiction.
3. Beauregard, Kimberly, LCSW. Connecticut cannot afford to ignore mental health needs. Connecticut Mirror. April 11, 2013. <http://ctmirror.org/node/19702>.
4. CPT 2013 Professional Edition (Current Procedural Terminology, Professional Ed. (Spiral)) (Current Procedural Terminology (CPT) Professional). American Medical Association; 1 edition (October 15, 2012)
5. Connecticut Department of Public Health. National Public Health Week Fact Sheet: Drug and Alcohol-related Poisoning (April 2011). <http://www.ct.gov/dph/cwp/view.asp?q=476708&a=3987>
6. DiClemente, Carlo and James Prochaska. Stages of Change Model. Developed in the late 1970's and early 1980's, the Stages of Change Model is applied to a broad range of behaviors including weight loss, injury prevention, overcoming alcohol, and drug problems. <http://www.addictioninfo.org/articles/11/1/Stages-of-Change-Model/Page1.html>
7. Drake, Robert MD. NAMI National Alliance on Mental Illness. (September 2003). Dual Diagnosis and Integrated Treatment of Mental Illness and Substance Abuse Disorder. [http://www.nami.org/Template.cfm?Section=By\\_Illness&Template=/TaggedPage/TaggedPagedisplay.cfm&TPLID=54&ContentID=23049](http://www.nami.org/Template.cfm?Section=By_Illness&Template=/TaggedPage/TaggedPagedisplay.cfm&TPLID=54&ContentID=23049).
8. Johnston, L. D., O'Malley, P. M., Bachman, J. G., & Schulenberg, J. E. (2012). Monitoring the Future: national survey results on drug use, 1975–2011: Volume I, Secondary school students. Ann Arbor: Institute for Social Research, The University of Michigan.
9. Kessler, Ronald C. NATIONAL COMORBIDITY SURVEY, 1990-1992. Conducted by University of Michigan, Survey Research Center. 2nd ICPSR ed. Ann Arbor, MI: Inter-university Consortium for Political and Social Research, 2002.
10. Malloy, Dannel P. Governor, State of Connecticut. Official Press Release, April 9,

2013.

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15. SAMHSA (Substance Abuse and Mental Health Services Administration), Center for Behavioral Health Statistics and Quality (formerly the Office of Applied Studies) (2007 and 2009). Treatment Episode Data Set. National Admissions to Substance Abuse Treatment Services. <http://www.samhsa.gov/data/DASIS/TEDS2k7AWeb/TEDS2k7AWeb.pdf>

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17. Substance Abuse and Mental Health Services Administration, Results from the 2010 National Survey on Drug Use and Health: Summary of National Findings, NSDUH Series H-41, HHS Publication No. (SMA) 11-4658. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2011.

18. U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General—Executive Summary*. Rockville, MD: U.S. Dept. of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999.

## **Appendix E: Copies of Relevant Sources of Information \***

\*In the interest of conserving time, paper, and financial resources, in some cases (ie, entire textbooks) only partial texts are included to give a representative sampling of the information source. Full references available upon request.

1. American Psychiatric Association. DSM-IV-TR or Diagnostic and Statistical Manual, edition IV transitional (2000). The DSM-IV-TR provides a classification of mental disorders, criteria sets to guide the process of differential diagnosis, and numerical codes for each disorder to facilitate medical record keeping. The stated purpose of the DSM is to: 1) provide "a helpful guide to clinical practice"; 2) "to facilitate research and improve communication among clinicians and researchers"; and 3) to serve as "an educational tool for teaching psychopathology."

From the American Psychiatric Association website at  
<http://www.psychiatry.org/practice/dsm>

The *Diagnostic and Statistical Manual of Mental Disorders (DSM)* is the standard classification of mental disorders used by mental health professionals in the United States. It is intended to be applicable in a wide array of contexts and used by clinicians and researchers of many different orientations (e.g., biological, psychodynamic, cognitive, behavioral, interpersonal, family/systems). The *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)* has been designed for use across clinical settings (inpatient, outpatient, partial hospital, consultation-liaison, clinic, private practice, and primary care), with community populations. It can be used by a wide range of health and mental health professionals, including psychiatrists and other physicians, psychologists, social workers, nurses, occupational and rehabilitation therapists, and counselors. It is also a necessary tool for collecting and communicating accurate public health statistics.

The DSM consists of three major components: the diagnostic classification, the diagnostic criteria sets, and the descriptive text.

### **Diagnostic Classification**

The *diagnostic classification* is the list of the mental disorders that are officially part of the DSM system. "Making a DSM diagnosis" consists of selecting those disorders from the classification that best reflect the signs and symptoms that are exhibited by the individual being evaluated. Associated with each diagnostic label is a diagnostic code, which is typically used by institutions and agencies for data collection and billing purposes. These diagnostic codes are derived from the coding system used by all health care professionals in the United States, known as the *International Classification of Diseases, Ninth Edition, Clinical Modification (ICD-9-CM)*.

### **Diagnostic Criteria Sets**

For each disorder included in DSM, a set of *diagnostic criteria* indicate what symptoms must be present (and for how long) as well as symptoms, disorders, and conditions that must not be present in order to qualify for a particular diagnosis. Many users of DSM find these diagnostic criteria particularly useful because they provide a concise description of each disorder. Furthermore, use of diagnostic criteria has been shown to increase diagnostic reliability (i.e., likelihood that different users will assign the same diagnosis to an individual). However, it is important to remember that these criteria are meant to be used as guidelines informed by clinical judgment and are not meant to be used in a cookbook fashion.

### **Descriptive Text**

Finally, the third component of DSM is the *descriptive text* that accompanies each disorder. The text of *DSM-IV* systematically describes each disorder under the following headings: "Diagnostic Features"; "Subtypes and/or Specifiers"; "Recording Procedures"; "Associated Features and Disorders"; "Specific Culture, Age, and Gender Features"; "Prevalence"; "Course"; "Familial Pattern"; and "Differential Diagnosis."

**2. American Society of Addiction Medicine. ASAM Patient Placement Criteria for the Placement of Substance Related Disorders, Second Edition (ASAM PPC-2R) (2001). The ASAM Patient Placement Criteria is the result of a collaboration that began in the 1980s to define one national set of criteria for providing outcome-orientated and results based care in the treatment of outcome-orientated and results based care in the treatment of addiction.**

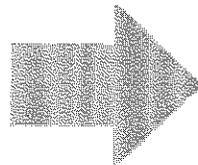
Information obtained at <http://www.asam.org/publications/the-asam-criteria>

## How the ASAM Criteria Work

The ASAM criteria provide separate placement criteria for adolescents and adults to create comprehensive and individualized treatment plans. Adolescent and adult treatment plans are developed through a multidimensional patient assessment over five broad levels of treatment that are based on the degree of direct medical management provided, the structure, safety and security provided and the intensity of treatment services provided.

Five Levels of Care Assessed Over Six Dimensions

Level 0.5	Early Intervention
Level I	Outpatient Services
Level II	Intensive outpatient/partial hospitalization services
Level III	Residential/inpatient services
Level IV	Medically managed intensive inpatient services



1. Acute intoxication and/or withdrawal
2. Biomedical conditions and complications
3. Emotional, behavioral, or cognitive conditions and complications
4. Readiness to change
5. Relapse, continued use, or continued problem potential
6. Recovery environment

Through this strength-based multidimensional assessment the ASAM Criteria addresses the patient's needs, obstacles and liabilities, as well as the patient's strengths, assets, resources and support structures.

## Oversight and Revision of the ASAM Criteria

Oversight and revision of the criteria is a collaborative process between ASAM leadership and the Steering Committee of the Coalition for National Clinical Criteria. The coalition represents major stakeholders in addiction treatment and has been meeting regularly since the development of the first ASAM Patient Placement Criteria in 1991. The coalition addresses feedback and ensures that the Criteria adequately serves and supports medical professionals, employers, purchasers and providers of care in both the public and private sectors. (Full roster of members and their affiliations and minutes of meetings are available upon request).

3. Beaugard, Kimberly, LCSW. Connecticut cannot afford to ignore mental health needs. Connecticut Mirror. April 11, 2013. <http://ctmirror.org/node/19702>.

April 11, 2013

### **Connecticut cannot afford to ignore mental health needs**

By Kimberly Beaugard, LCSW

*Kimberly Beaugard, LCSW, is president and CEO of InterCommunity, Inc., a nonprofit community organization that provides comprehensive recovery-oriented mental health and addiction disorder services to adults, children and families in Connecticut.*

It is news to no one that a mental health crisis exists in this country. Nowhere is that more evident than here in Connecticut.

As we join the state in mourning the loss of life that occurred in Newtown at the hands of a troubled young man, we simultaneously address a seemingly never ending quest to maintain state funding to keep the doors of our community-based mental health services organization open -- how horribly ironic.

As president and CEO of InterCommunity, Inc., I have spent the last 10 years leading a group of dedicated physicians, clinicians and staff in treating thousands of Connecticut's most vulnerable adults and children who live with mental health and addiction disorders. The undisputed statistics regarding mental illness are as real as the people who live with these illnesses:

- One in four adults experiences a mental health disorder in a given year.
- Less than one-third of adults and one-half of children with a diagnosable mental health disorder receive mental health services of any kind in a given year.
- In Connecticut, more than 100,000 adults and 40,000 children live with serious mental health conditions.
- Suicides in Connecticut have reached a 20-year high, with 371 suicides in 2011. Suicide is almost always a result of untreated or undertreated mental illness.

Over the years, Connecticut has systematically moved mental health care away from state-run asylums and institutions, opting for community-based mental health services, like the ones provided by InterCommunity, Inc. Delivery of services through community-based organizations has proven to better integrate mentally ill people in their environment, increasing their chances for rehabilitation and recovery.

In 2006, 59 percent of Connecticut state mental health agency spending was on

community mental health services, which falls seriously short of the national average of 70 percent. Unfortunately, savings derived from the closings of state mental hospitals in the mid-1990s were not reinvested in the already struggling community-based mental health system, thus limiting access to services for many Connecticut residents. Without proper diagnosis and treatment, people suffering with mental illnesses often become dysfunctional, unemployed, uninsured, or homeless.

We must also consider the costly consequences of untreated mentally ill adults and children who become incarcerated. Lack of timely mental health services for people in crisis has increased the burden on Connecticut's judicial system. In 2008, 3,400 adults with mental illnesses were incarcerated in Connecticut. It costs Connecticut nearly double to both incarcerate and treat an offender with mental illness (\$48,000 per year) versus providing mental health treatment alone (\$25,000 per year).

Connecticut is failing its most vulnerable citizens who suffer with undiagnosed mental illness. If we are to succeed as the mental health safety net that the Governor envisions, we must be funded at a level that allows this to happen. Before adopting a biennial state budget, we urge Connecticut government officials to work directly with community-based mental health care providers to better understand the growing need for services and how they can be better delivered through our organizations.

We can no longer afford to ignore mental illness - the price we pay for doing so is far too high. Loss of life, overcrowded prisons and countless people living with undiagnosed mental illness cost us much more than dollars.

If Connecticut is not willing or able to support community-based mental health providers in a way that allows us to meet the critical need for services, it is painfully clear that we run the risk of further tragedy and loss.

4. CPT 2013 Professional Edition (Current Procedural Terminology, Professional Ed. (Spiral)) (Current Procedural Terminology (CPT) Professional). American Medical Association; 1 edition (October 15, 2012).

From the American Medical Association online store at

[https://commerce.ama-assn.org/store/catalog/productDetail.jsp?product\\_id=prod1180004&navAction=push](https://commerce.ama-assn.org/store/catalog/productDetail.jsp?product_id=prod1180004&navAction=push)

*CPT® 2013 Professional Edition* is the definitive AMA authored resource to help health care professionals correctly report and bill medical procedures and services. The AMA publishes the only CPT codebook with the official CPT guidelines. The 2013 edition contains 568 total CPT code changes and 150 CPT guideline changes.

The *CPT® Professional* codebook is used to help health care professionals correctly report and bill medical procedures and services. Written by the CPT Editorial Panel, the *CPT Professional Codebook* presents up-to-date current procedural terminology codes, descriptions and guidelines to provide professionals with an accurate code set.

The *CPT Standard* codebook covers hundreds of code, guideline and text changes. It features the following enhancements:

- **Improved index:** Expands the pathology and laboratory entries to include analytes and eliminates redundancy to improve code searches
- **Background information on the evolution of molecular pathology:** Delivers a concise explanation behind the rapid expansion occurring in the molecular pathology section of the code set so professionals can better apply the codes within this growing subsection
- **Anatomical and procedural illustrations for cardiac coding:** Helps improve coding accuracy and understanding of specified anatomy and procedures
- **Appendix of multianalyte assays with algorithmic analyses:** Provides an administrative code set of single-sourced tests (laboratory or manufacturer)
- **Revision of 18 CPT modifiers:** Reflects the standardization of provider terminology
- **More than 4,600 new citations:** Completes a 12-month initiative to ensure that citations for past editions of *CPT® Changes*, *CPT® Assistant* and *Clinical Examples in Radiology* are comprehensive
- **200 new cross references:** Reflects the standardization of provider terminology
- **Coding tips throughout each section:** Improves understanding of code set nuances
- **Section-specific table of contents:** Helps professionals navigate more effectively through each section's codes
- **Summary of additions, deletions and revisions:** Provides a quick reference to 2013 changes

5. Connecticut Department of Public Health. National Public Health Week Fact Sheet: Drug and Alcohol-related Poisoning (April 2011).

Information obtained at <http://www.ct.gov/dph/cwp/view.asp?q=476708&a=3987>

#### **April 2011**

#### **National Public Health Week Fact Sheet: Drug and Alcohol-related Poisoning**

According to the latest statistics, drug overdose deaths are among the leading causes of death due to unintentional injury.

Drug overdose death rates in the United States have never been higher, rising steadily since 1970. In fact, rates have increased five fold since 1990.

According to state health officials, accidental drug-related poisoning has surpassed motor vehicle crashes as a leading cause of death in Connecticut. From 2005-2007, there were 952 drug and alcohol deaths in Connecticut.

During this time period, there were 2,578 hospitalizations and 7,140 poisoning-related emergency department visits in the state. In addition, there were 106 suicide deaths due to poisoning (drugs and alcohol), and over 3,000 hospitalizations and over 3,000 emergency department visits related to suicide attempt drug poisoning.

A poisoning occurs when a person's exposure to a natural or manmade substance has an undesirable effect. A drug poisoning occurs when that substance is an illegal, prescription, or over-the-counter drug. Most fatal poisonings in the United States result from drug poisoning.

According to the federal Centers for Disease Control and Prevention, the increase in drug overdose deaths is largely due to the use of prescription opioid painkillers, such as oxycodone (OxyContin®), hydrocodone (Vicodin®), and methadone.

The Connecticut Department of Public Health offers the following tips to help prevent accidental drug-related poisoning:

- Talk to your doctor and/or pharmacist about medication purpose, dosage, side effects and potential interactions with other drugs and/or food.
- Keep medications in original containers and locked away if children are in the home or visiting.
- Seek help and /or use a 7-day a week pill box if you take many medications every day.
- Get care for mental and behavioral health issues.
- Supervise medication use by children and teens.
- Keep narcotic and sedative medications prescribed for adults in private adult spaces.
- Program emergency numbers, such as the Poison Control Hotline **(1-800-222-1222)**, into your phone to call in the event of a poisoning or overdose emergency or dial 9-1-1.

During National Public Health Week, April 4-10, 2011, the Connecticut Department of Public Health (DPH) is focusing attention on preventing injuries, a leading cause of death, disability and illness in Connecticut. The DPH Injury Prevention Program analyzes injury data, provides information and works with a variety of public and private partners on reducing and preventing injuries.

Content Last Modified on 4/6/2011 10:51:43 AM

6. DiClemente, Carlo and James Prochaska. Stages of Change Model. Developed in the late 1970's and early 1980's, the Stages of Change Model is applied to a broad range of behaviors including weight loss, injury prevention, overcoming alcohol, and drug problems. Information obtained at <http://www.addictioninfo.org/articles/11/1/Stages-of-Change-Model/Page1.html>.

### Stages of Change Model

The Stages of Change Model was originally developed in the late 1970's and early 1980's by James Prochaska and Carlo DiClemente at the University of Rhode Island when they were studying how smokers were able to give up their habits or **addiction**.

**Addiction:** The negative end state of a syndrome (of neurobiological and psychosocial causes) resulting in continued or increasing repetitive involvement despite consequences and conscious efforts to discontinue the behavior. Addiction to any particular substance or behavior is seen mainly as a matter of personal vulnerability, exposure and access, and the capacity to produce a desirable shift in mental state. This definition was originally formulated by Howard J. Shaffer, Ph.D., C.A.S. Harvard Medical School, Division on Addictions.

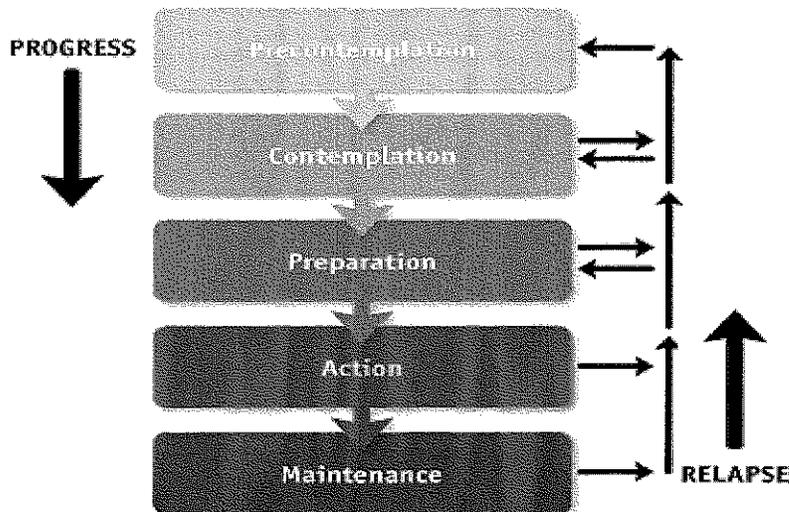
The SCM model has been applied to a broad range of behaviors including weight loss, injury prevention, overcoming alcohol, and drug problems among others.

The idea behind the SCM is that behavior change does not happen in one step. Rather, people tend to progress through different stages on their way to successful change. Also, each of us progresses through the stages at our own rate.

So expecting behavior change by simply telling someone, for example, who is still in the "pre-contemplation" stage that he or she must go to a certain number of AA meetings in a certain time period is rather naive (and perhaps counterproductive) because they are not ready to change.

Each person must decide for himself or herself when a stage is completed and when it is time to move on to the next stage. Moreover, this decision must come from the inside you (see developing an internal locus of control) -- stable, long term change cannot be externally imposed.

In each of the stages, a person has to grapple with a different set of issues and tasks that relate to changing behavior. Thus, for each for each stage of change, tools are available to you through this website in The Toolbox of Change [The [SelfManagement Tool Box](#) section]



The stages of change are:

- Precontemplation (Not yet acknowledging that there is a problem behavior that needs to be changed)
- Contemplation (Acknowledging that there is a problem but not yet ready or sure of wanting to make a change)
- Preparation/Determination (Getting ready to change)
- Action/Willpower (Changing behavior)
- Maintenance (Maintaining the behavior change) and
- Relapse (Returning to older behaviors and abandoning the new changes)

### **Stage One: Precontemplation**

In the precontemplation stage, people are not thinking seriously about changing and are not interested in any kind of help. People in this stage tend to defend their current bad habit(s) and do not feel it is a problem. They may be defensive in the face of other people's efforts to pressure them to quit.

Are you in the precontemplation stage? No, because the fact that you are reading this shows that you are already ready to consider that you may have a problem with one or more bad habits.

(Of course, you may be reading this because you have a loved one who is still in the pre-contemplation stage. If this is the case, keep reading for suggestions about how you can help others progress through their stages of change)

### **Stage Two: Contemplation**

In the contemplation stage people are more aware of the personal consequences of their bad habit and they spend time thinking about their problem. Although they are able to consider the possibility of changing, they tend to be ambivalent about it.

In this stage, people are on a teeter-totter, weighing the pros and cons of quitting or modifying their behavior. Although they think about the negative aspects of their bad habit and the positives associated with giving it up (or reducing), they may doubt that the long-term benefits associated with quitting will outweigh the short-term costs.

It might take as little as a couple weeks or as long as a lifetime to get through the contemplation stage. (In fact, some people think and think and think about giving up their bad habit and may die never having gotten beyond this stage)

On the plus side, people are more open to receiving information about their bad habit, and more likely to actually use educational interventions and reflect on their own feelings and thoughts concerning their bad habit.

### **Stage Three: Preparation/Determination**

In the preparation/determination stage, people have made a commitment to make a change. Their motivation for changing is reflected by statements such as: "I've got to do something about this - this is serious. Something has to change. What can I do?"

This is sort of a research phase: people are now taking small steps toward cessation. They are trying to gather information (sometimes by reading things like this) about what they will need to do to change their behavior.

Or they will call a lot of clinics, trying to find out what strategies and resources are available to help them in their attempt. Too often, people skip this stage: they try to move directly from contemplation into action and fall flat on their faces because they haven't adequately researched or accepted what it is going to take to make this major lifestyle change.

### **Stage Four: Action/Willpower**

This is the stage where people believe they have the ability to change their behavior and are actively involved in taking steps to change their bad behavior by using a variety of different techniques.

This is the shortest of all the stages. The amount of time people spend in action varies. It generally lasts about 6 months, but it can literally be as short as one hour! This is a stage when people most depend on their own willpower. They are making overt efforts to quit or change the behavior and are at greatest risk for relapse.

Mentally, they review their commitment to themselves and develop plans to deal with both personal and external pressures that may lead to slips. They may use short-term rewards to sustain their motivation, and analyze their behavior change efforts in a way that enhances their self-confidence. People in this stage also

tend to be open to receiving help and are also likely to seek support from others (a very important element).

Hopefully, people will then move to:

#### **Stage Five: Maintenance**

Maintenance involves being able to successfully avoid any temptations to return to the bad habit. The goal of the maintenance stage is to maintain the new status quo. People in this stage tend to remind themselves of how much progress they have made.

People in maintenance constantly reformulate the rules of their lives and are acquiring new skills to deal with life and avoid relapse. They are able to anticipate the situations in which a relapse could occur and prepare coping strategies in advance.

They remain aware that what they are striving for is personally worthwhile and meaningful. They are patient with themselves and recognize that it often takes a while to let go of old behavior patterns and practice new ones until they are second nature to them. Even though they may have thoughts of returning to their old bad habits, they resist the temptation and stay on track.

As you progress through your own stages of change, it can be helpful to re-evaluate your progress in moving up and down through these stages.

(Even in the course of one day, you may go through several different stages of change).

And remember: it is normal and natural to regress, to attain one stage only to fall back to a previous stage.

This is just a normal part of making changes in your behavior.

#### **Relapse**

Along the way to permanent cessation or stable reduction of a bad habit, most people experience relapse. In fact, it is much more common to have at least one relapse than not. Relapse is often accompanied by feelings of discouragement and seeing oneself as a failure.

While relapse can be discouraging, the majority of people who successfully quit do not follow a straight path to a life time free of self-destructive bad habits. Rather, they cycle through the five stages several times before achieving a stable life style change. Consequently, the Stages of Change Model considers relapse to be normal.

There is a real risk that people who relapse will experience an immediate sense of failure that can seriously undermine their self-confidence. The important thing is that if they do slip and say, have a cigarette or a drink, they shouldn't see themselves as having failed.

Rather, they should analyze how the slip happened and use it as an opportunity to learn how to cope differently. In fact, relapses can be important opportunities for learning and becoming stronger.

Relapsing is like falling off a horse - the best thing you can do is get right back on again. However, if you do "fall off the horse" and relapse, it is important that you do not fall back to the precontemplation or contemplation stages. Rather, restart the process again at preparation, action or even the maintenance stages.

People who have relapsed may need to learn to anticipate high-risk situations (such as being with their family) more effectively, control environmental cues that tempt them to engage in their bad habits (such as being around drinking buddies), and learn how to handle unexpected episodes of stress without returning to the bad habit. This gives them a stronger sense of self control and the ability to get back on track.

In addition, there is one more stage, Dr. Kern has added which is not part of the Prochaska-DiClemente Stages of Change model:

#### **Transcendence**

Eventually, if you "maintain maintenance" long enough, you will reach a point where you will be able to work with your emotions and understand your own behavior and view it in a new light. This is the stage of "transcendence," a transcendence to a new life. In this stage, not only is your bad habit no longer an integral part of your life but to return to it would seem atypical, abnormal, even weird to you.

When you reach this point in your process of change, you will know that you have transcended the old bad habits and that you are truly becoming a new "you", who no longer needs the old behaviors to sustain yourself.

7. Drake, Robert MD. NAMI National Alliance on Mental Illness. (September 2003). Dual Diagnosis and Integrated Treatment of Mental Illness and Substance Abuse Disorder. Information obtained at [http://www.nami.org/Template.cfm?Section=By\\_Illness&Template=/TaggedPage/TaggedPageDisplay.cfm&TPLID=54&ContentID=23049](http://www.nami.org/Template.cfm?Section=By_Illness&Template=/TaggedPage/TaggedPageDisplay.cfm&TPLID=54&ContentID=23049).

## **Dual Diagnosis and Integrated Treatment of Mental Illness and Substance Abuse Disorder**

### **What are dual diagnosis services?**

Dual diagnosis services are treatments for people who suffer from co-occurring disorders -- mental illness and substance abuse. Research has strongly indicated that to recover fully, a consumer with co-occurring disorder needs treatment for both problems -- focusing on one does not ensure the other will go away. Dual diagnosis services integrate assistance for each condition, helping people recover from both in one setting, at the same time.

Dual diagnosis services include different types of assistance that go beyond standard therapy or medication: assertive outreach, job and housing assistance, family counseling, even money and relationship management. The personalized treatment is viewed as long-term and can be begun at whatever stage of recovery the consumer is in. Positivity, hope and optimism are at the foundation of integrated treatment.

### **How often do people with severe mental illnesses also experience a co-occurring substance abuse problem?**

There is a lack of information on the numbers of people with co-occurring disorders, but research has shown the disorders are very common. According to reports published in the *Journal of the American Medical Association (JAMA)*:

- Roughly 50 percent of individuals with severe mental disorders are affected by substance abuse.
- Thirty-seven percent of alcohol abusers and 53 percent of drug abusers also have at least one serious mental illness.
- Of all people diagnosed as mentally ill, 29 percent abuse either alcohol or drugs.

The best data available on the prevalence of co-occurring disorders are derived from two major surveys: the Epidemiologic Catchment Area (ECA) Survey (administered 1980-1984), and the National Comorbidity Survey (NCS), administered between 1990 and 1992.

Results of the NCS and the ECA Survey indicate high prevalence rates for co-occurring substance abuse disorders and mental disorders, as well as the increased risk for people with either a substance abuse disorder or mental disorder for developing a co-occurring disorder.

For example, the NCS found that:

- 42.7 percent of individuals with a 12-month addictive disorder had at least one 12-month mental disorder.
- 14.7 percent of individuals with a 12-month mental disorder had at least one 12-month addictive disorder.

The ECA Survey found that individuals with severe mental disorders were at significant risk

for developing a substance use disorder during their lifetime. Specifically:

- 47 percent of individuals with schizophrenia also had a substance abuse disorder (more than four times as likely as the general population).
- 61 percent of individuals with bipolar disorder also had a substance abuse disorder (more than five times as likely as the general population).

Continuing studies support these findings, that these disorders do appear to occur much more frequently than previously realized, and that appropriate integrated treatments must be developed.

#### **What are the consequences of co-occurring severe mental illness and substance abuse?**

For the consumer, the consequences are numerous and harsh. Persons with a co-occurring disorder have a statistically greater propensity for violence, medication noncompliance, and failure to respond to treatment than consumers with just substance abuse or a mental illness. These problems also extend out to these consumers' families, friends and co-workers. Purely healthwise, having a simultaneous mental illness and a substance abuse disorder frequently leads to overall poorer functioning and a greater chance of relapse. These consumers are in and out of hospitals and treatment programs without lasting success. People with dual diagnoses also tend to have tardive dyskinesia (TD) and physical illnesses more often than those with a single disorder, and they experience more episodes of psychosis. In addition, physicians often don't recognize the presence of substance abuse disorders and mental disorders, especially in older adults.

Socially, people with mental illnesses often are susceptible to co-occurring disorders due to "downward drift." In other words, as a consequence of their mental illness they may find themselves living in marginal neighborhoods where drug use prevails. Having great difficulty developing social relationships, some people find themselves more easily accepted by groups whose social activity is based on drug use. Some may believe that an identity based on drug addiction is more acceptable than one based on mental illness. Consumers with co-occurring disorders are also much more likely to be homeless or jailed. An estimated 50 percent of homeless adults with serious mental illnesses have a co-occurring substance abuse disorder. Meanwhile, 16% of jail and prison inmates are estimated to have severe mental and substance abuse disorders. Among detainees with mental disorders, 72 percent also have a co-occurring substance abuse disorder.

Consequences for society directly stem from the above. Just the back-and-forth treatment alone currently given to non-violent persons with dual diagnosis is costly. Moreover, violent or criminal consumers, no matter how unfairly afflicted, are dangerous and also costly. Those with co-occurring disorders are at high risk to contract AIDS, a disease that can affect society at large. Costs rise even higher when these persons, as those with co-occurring disorders have been shown to do, recycle through healthcare and criminal justice systems again and again. Without the establishment of more integrated treatment programs, the cycle will continue.

#### **Why is an integrated approach to treating severe mental illnesses and substance abuse problems so important?**

Despite much research that supports its success, integrated treatment is still not made widely available to consumers. Those who struggle both with serious mental illness and substance

abuse face problems of enormous proportions. Mental health services tend not to be well prepared to deal with patients having both afflictions. Often only one of the two problems is identified. If both are recognized, the individual may bounce back and forth between services for mental illness and those for substance abuse, or they may be refused treatment by each of them. Fragmented and uncoordinated services create a service gap for persons with co-occurring disorders.

Providing appropriate, integrated services for these consumers will not only allow for their recovery and improved overall health, but can ameliorate the effects their disorders have on their family, friends and society at large. By helping these consumers stay in treatment, find housing and jobs, and develop better social skills and judgment, we can potentially begin to substantially diminish some of the most sinister and costly societal problems: crime, HIV/AIDS, domestic violence and more.

There is much evidence that integrated treatment can be effective. For example:

- Individuals with a substance abuse disorder are more likely to receive treatment if they have a co-occurring mental disorder.
- Research shows that when consumers with dual diagnosis successfully overcome alcohol abuse, their response to treatment improves remarkably.

With continued education on co-occurring disorders, hopefully, more treatments and better understanding are on the way.

#### **What does effective integrated treatment entail?**

Effective integrated treatment consists of the same health professionals, working in one setting, providing appropriate treatment for both mental health and substance abuse in a coordinated fashion. The caregivers see to it that interventions are bundled together; the consumers, therefore, receive consistent treatment, with no division between mental health or substance abuse assistance. The approach, philosophy and recommendations are seamless, and the need to consult with separate teams and programs is eliminated.

Integrated treatment also requires the recognition that substance abuse counseling and traditional mental health counseling are different approaches that must be reconciled to treat co-occurring disorders. It is not enough merely to teach relationship skills to a person with bipolar disorder. They must also learn to explore how to avoid the relationships that are intertwined with their substance abuse.

Providers should recognize that denial is an inherent part of the problem. Patients often do not have insight as to the seriousness and scope of the problem. Abstinence may be a goal of the program but should not be a precondition for entering treatment. If dually diagnosed clients do not fit into local Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) groups, special peer groups based on AA principles might be developed.

Clients with a dual diagnosis have to proceed at their own pace in treatment. An illness model of the problem should be used rather than a moralistic one. Providers need to convey understanding of how hard it is to end an addiction problem and give credit for any accomplishments. Attention should be given to social networks that can serve as important reinforcers. Clients should be given opportunities to socialize, have access to recreational activities, and develop peer relationships. Their families should be offered support and education, while learning not to react with guilt or blame but to learn to cope with two

interacting illnesses.

**What are the key factors in effective integrated treatment?**

There are a number of key factors in an integrated treatment program.

Treatment must be approached in **stages**. First, a *trust* is established between the consumer and the caregiver. This helps *motivate* the consumer to learn the skills for *actively controlling* their illnesses and focus on goals. This helps keep the consumer on track, *preventing relapse*. Treatment can begin at any one of these stages; the program is tailored to the individual.

**Assertive outreach** has been shown to engage and retain clients at a high rate, while those that fail to include outreach lose clients. Therefore, effective programs, through intensive case management, meeting at the consumer's residence, and other methods of developing a dependable relationship with the client, ensure that more consumers are consistently monitored and counseled.

Effective treatment includes **motivational interventions**, which, through education, support and counseling, help empower deeply demoralized clients to recognize the importance of their goals and illness self-management.

Of course, counseling is a fundamental component of dual diagnosis services. **Counseling** helps develop positive coping patterns, as well as promotes cognitive and behavioral skills. Counseling can be in the form of individual, group, or family therapy or a combination of these.

A consumer's **social support** is critical. Their immediate environment has a direct impact on their choices and moods; therefore consumers need help strengthening positive relationships and jettisoning those that encourage negative behavior.

Effective integrated treatment programs **view recovery as a long-term, community-based process**, one that can take months or, more likely, years to undergo. Improvement is slow even with a consistent treatment program. However, such an approach prevents relapses and enhances a consumer's gains.

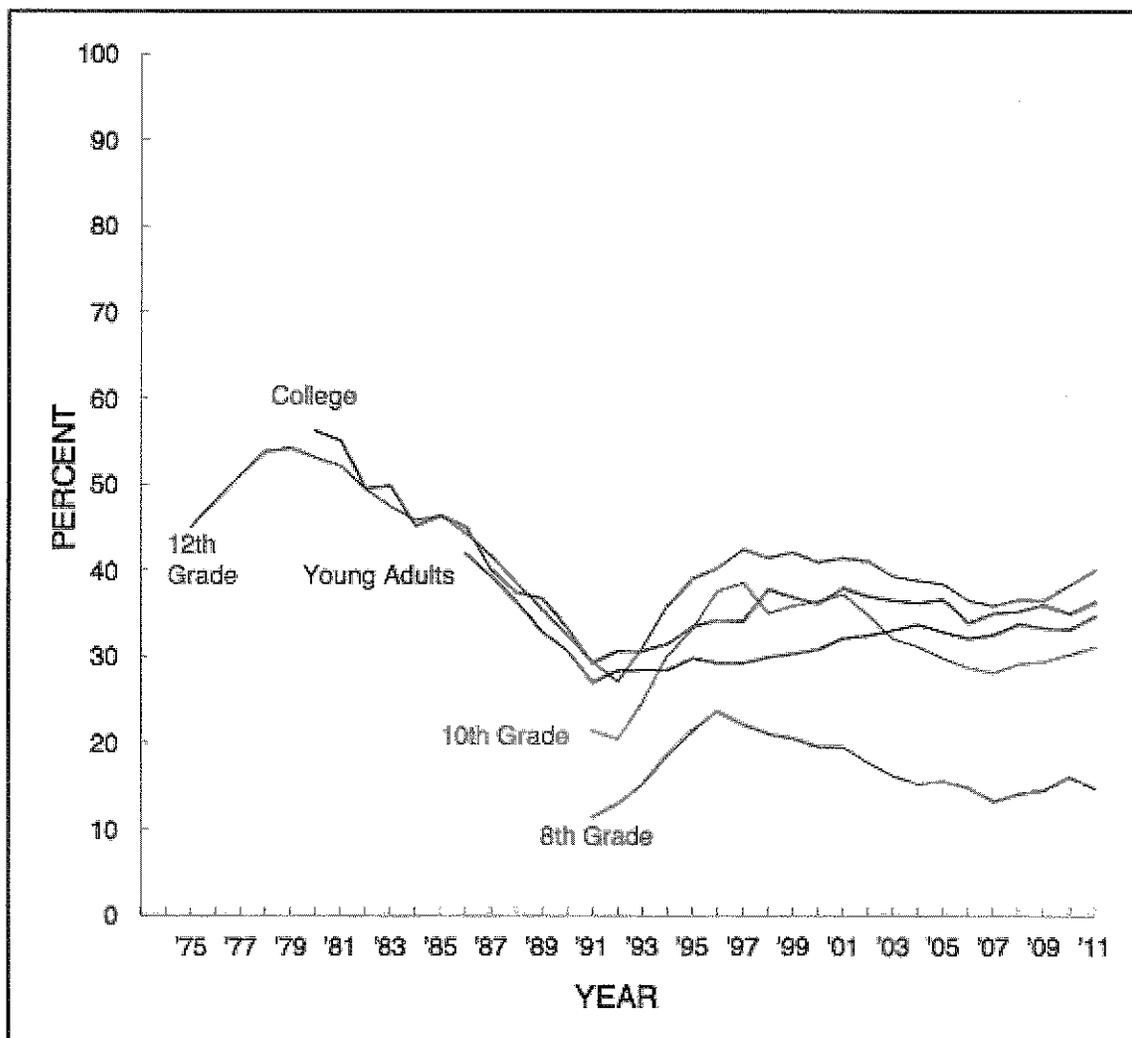
To be effective, a dual diagnosis program must be **comprehensive**, taking into account a number of life's aspects: stress management, social networks, jobs, housing and activities. These programs view substance abuse as intertwined with mental illness, not a separate issue, and therefore provide solutions to both illnesses together at the same time.

Finally, effective integrated treatment programs must contain elements of **cultural sensitivity and competence** to even lure consumers, much less retain them. Various groups such as African-Americans, homeless, women with children, Hispanics and others can benefit from services tailored to their particular racial and cultural needs.

8. Johnston, L. D., O'Malley, P. M., Bachman, J. G., & Schulenberg, J. E. (2012). Monitoring the Future: national survey results on drug use, 1975–2011: Volume I, Secondary school students. Ann Arbor: Institute for Social Research, The University of Michigan. Information obtained at: [http://www.monitoringthefuture.org/pubs/monographs/mtf-vol1\\_2011.pdf](http://www.monitoringthefuture.org/pubs/monographs/mtf-vol1_2011.pdf)

\*The 2012 Monitoring the Future Study is 760 pages long. The following figure is from Chapter 2, page 63:

**FIGURE 2-1**  
**Trends in Annual Prevalence of an Illicit Drug Use Index**  
**across 5 Populations**



The following is directly excerpted from Chapter 10, page 477:

“Prevalence and characteristics of substance abuse treatment utilization by US adolescents: National data from 1987 to 2008

Although many adolescents use and abuse illicit drugs, few of those who could benefit from addictions treatment ever receive these services. This study examined the prevalence of utilization of addictions treatment in national samples of adolescents over the past 22 years, and it identifies characteristics associated with receipt of these services. Lifetime utilization of addictions was asked of 12th-grade students who reported any life time illicit drug use from 1987 to 2008 (N = 25,537). After describing the prevalence of treatment utilization over this time period, logistic regression was used to examine potential predictors of treatment utilization. The overall prevalence of treatment utilization remained relatively unchanged over the time period examined. In multivariable models, 12th graders who reported a greater frequency of lifetime use of marijuana or cocaine were more likely to receive addictions treatment. Additionally, addictions treatment utilization was more likely for those who received other mental health services. Despite increased evidence for the effectiveness of addictions treatment, utilization of these services by adolescents remained low and relatively stable between 1987 and 2008.

Attempts to increase utilization of addictions treatment services would likely benefit from building on existing connections with mental health treatment. “

9. Kessler, Ronald C. NATIONAL COMORBIDITY SURVEY, 1990-1992. Conducted by University of Michigan, Survey Research Center. 2nd ICPSR ed. Ann Arbor, MI: Inter-university Consortium for Political and Social Research, 2002. Information obtained at <http://www.icpsr.umich.edu/icpsrweb/SAMHDA/studies/6693>

#### Scope of Study

**Summary:** The National Comorbidity Survey: Baseline (NCS-1) was a collaborative epidemiologic investigation designed to study the prevalence and correlates of DSM III-R disorders and patterns and correlates of service utilization for these disorders. The NCS-1 was the first survey to administer a structured psychiatric interview to a nationally representative sample. The survey was carried out in the early 1990s with a household sample of over 8,000 respondents. Subsamples of the original respondents completed the NCS-1 Part II survey and Tobacco Use Supplement. Diagnoses were based on a modified version of the Composite International Diagnostic Interview (the UM-CIDI), which was developed at the University of Michigan for the NCS-1. Drugs covered by this survey include alcohol, tobacco, sedatives, stimulants, tranquilizers, analgesics, inhalants, marijuana/hashish, cocaine, hallucinogens, heroin, nonmedical use of prescription drugs, and polysubstance use. Other items include demographic characteristics, personal and family history of substance use and abuse, substance abuse treatment, data on drug use including recency, frequency, and age at first use, problems resulting from the use of drugs, personal and family history of psychiatric problems, mental health treatment, symptoms of psychiatric disorders, mental health status, HIV risk behaviors, and physical health status.

**Geographic Coverage:** United States **Time Period:** 1990-1992

**Date of Collection:** 1990-09-14-1992-02-06 **Unit of Observation:** individual

**Universe:** Persons aged 15 to 54 years in the noninstitutionalized civilian population in the 48 continuous United States.

**Data Types:** survey data

**Data Collection Notes:** Users are reminded that NCS-1 Part I, Part II, and Tobacco Use Supplement variables are all contained in Part 1, the NCS-1 Main Data file. The DSM-III-R diagnosis and demographic variables are contained in Part 2, the NCS-1 Diagnosis/Demographic Data file.

A restricted data file has been produced that contains state and county geography codes. This file is available from ICPSR. To obtain the restricted data file users must first submit a completed restricted data request form. Please read ICPSR's instructions about requesting restricted data. For more information, visit the NCS Web site.

**Methodology Sample:** Stratified, multistage area probability sample. The inclusion of respondents as young as 15 years, compared with the 18-year-old lower age limit found in most general population surveys, was based on an interest in minimizing recall bias of early-onset disorders. The exclusion of respondents aged older than 54 years was based on evidence from the Epidemiologic Catchment Area Study that active comorbidity between substance use disorders and nonsubstance psychiatric disorders is much lower among persons older than 54 years than among those aged 54 years and younger. The Part II NCS-1 survey was administered to a subsample of 5,877 respondents. The Tobacco Use Supplement was completed by a subsample of 4,414 respondents. The NCS-1 also includes a supplemental sample of students living in campus group housing and a nonrespondent survey.

**Weight:** Depending on the section(s) of the NCS-1 survey from which the variable(s) originated, one of four sampling weights must be selected and applied. The Part I and Part II weights (p1fwt and p2wtv3, respectively) are a combination of the various weights described in NCS-1 papers to adjust for differential household size and differential nonresponse and post-stratification. The Tobacco Use Supplement weight (tobacwt) is a rescaling of the Part I weight for analysis of tobacco supplement variables only. The Part II Tobacco Use Supplement weight (p2tobwt) is a rescaling of the Part II weight for analysis of combinations of Part II and Tobacco Supplement variables. Please refer to the Processor Notes in the codebook for details on determining the appropriate weight to use when analyzing a specific variable or combination of variables.

**Mode of Data Collection:** face-to-face interview, telephone interview

**Response Rates:** The response rate was 82.6 percent.

10. Malloy, Dannel P. Governor, State of Connecticut. Official Press Release, April 9, 2013.

**GOV. MALLOY: COLLABORATION WILL HELP FAMILIES ACCESS MENTAL HEALTH TREATMENT**

(HARTFORD, CT) – Governor Dannel P. Malloy today announced that a new collaboration between the Connecticut Insurance Department and the UConn Health Center will help families struggling to get mental health treatment paid through their insurance.

“No one should have to overcome mountains of red tape when they are trying to access mental health services,” said Governor Malloy. “This collaboration allows us to leverage the respective expertise of the Insurance Department and the UConn Health Center to put in place a common-sense approach to what can be a profoundly frustrating process. I commend the Insurance Department and the Health Center for their commitment to improving mental health care access for residents.”

The Insurance Department and UConn Health Center are developing a user-friendly ‘claims tool kit’ for policyholders and providers, especially out-of-network providers who operate on cash basis. The goal is to reduce the number of insurance denials by creating a plain-language claims template specific to behavioral health treatment that policyholders and practitioners can submit to insurance companies for reimbursement. It is intended to help them quickly and accurately prepare claims submissions to reflect medical necessity and increase the number of claims approved on initial submissions.

“It’s been the department’s observations that incomplete or incorrect information, coding errors, and other documentation issues are often the cause of claims denials requiring multiple appeals. We don’t want families having to fight to get the care they need,” said Deputy Insurance Commissioner Anne Melissa Dowling, who oversees the Department’s health insurance initiatives.

Scheduled for completion this summer, the claims tool kit is the first in a series of behavioral health projects the Insurance Department and Health Center are undertaking to assist consumers and providers. Work also includes enhancements to education and outreach materials for mental health insurance coverage.

“We are delighted to work with the Insurance Department on this important initiative and to share our world-class psychiatric and clinical expertise,” said Dr. Frank M. Torti, UConn Health Center Executive Vice President for Health Affairs and Dean of the Medical School. “This project has the potential to improve the quality of life for so many of our families and especially the children.”

About 1.8 million Connecticut residents — roughly half of Connecticut’s population — have private or employer insurance plans.

For Immediate Release: April 9, 2013

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Facebook: [Office of Governor Dannel P. Malloy](https://www.facebook.com/OfficeofGovernorDannelP.Malloy)

11. Montoya, Iván D. Jennifer R. Schroeder, Kenzie L. Preston, Lino Covi, Annie Umbricht, Carlo Contoreggi, Paul J. Fudala, Rolley E. Johnson, David A. Gorelick. **Influence of psychotherapy attendance on buprenorphine treatment outcome.** *Journal of Substance Abuse Treatment* - April 2005 (Vol. 28, Issue 3, Pages 247-254).

Partial excerpts:

**Abstract**

We evaluated the influence of psychotherapy attendance on treatment outcome in 90 dually (cocaine and heroin) dependent outpatients who completed 70 days of a controlled clinical trial of sublingual buprenorphine (16 mg, 8 mg, or 2 mg daily, or 16 mg every other day) plus weekly individual standardized interpersonal cognitive psychotherapy. Treatment outcome was evaluated by quantitative urine benzoylcegonine (BZE) and morphine levels (log-transformed), performed three times per week. Repeated-measures linear regression was used to assess the effects of psychotherapy attendance (percent of visits kept), medication group, and study week on urine drug metabolite levels. Mean psychotherapy attendance was 71% of scheduled visits. Higher psychotherapy attendance was associated with lower urine BZE levels, and this association grew more pronounced as the study progressed ( $p = 0.04$ ). The inverse relationship between psychotherapy attendance and urine morphine levels varied by medication group, being most pronounced for subjects receiving 16 mg every other day ( $p = 0.02$ ). These results suggest that psychotherapy can improve the outcome of buprenorphine maintenance treatment for patients with dual (cocaine and opioid) dependence.

**Keywords:** Buprenorphine, Cocaine, Heroin, Dual dependence, Psychotherapy

1. Introduction

Buprenorphine is a partial mu-opioid receptor agonist and kappa-opioid antagonist recently approved by the Food and Drug Administration for the treatment of opioid dependence (FDA Talk Paper & T02-38, 2002). This approval, along with provisions of the Drug Addiction Treatment Act of 2000 (Public Law 106-310, 106th Congress, 2000), allow for the use of buprenorphine in office-based treatment settings. This contrasts with other FDA-approved opioid agonist medications, such as methadone, which can only be prescribed at specialized, DEA-approved substance abuse treatment programs. Cocaine is frequently used by patients receiving opioid-agonist treatment for opioid dependence; such use is associated with poor treatment outcome (Leri, Bruneau, & Stewart, 2003). Buprenorphine has previously been investigated for the treatment of concomitant opioid and cocaine dependence. Some clinical trials conducted in dually-dependent (opioid and cocaine) patients show that buprenorphine reduces cocaine use (Gastfriend, 1993; Kosten, Kleber, & Morgan, 1989a, 1989b; Oliveto, Feingold, Schottenfeld, Jatlow, & Kosten, 2001; Schottenfeld, Pakes, Ziedonis, & Kosten, 1993). Other studies, especially those using lower buprenorphine doses, find no such effect (Oliveto, Kosten, Schottenfeld, & Ziedonis, 1993; Schottenfeld, Pakes, Oliveto, Ziedonis, & Kosten, 1997; Strain, Stitzer, Liebson, & Bigelow, 1994). A recent study by our group showed significant efficacy of buprenorphine sublingual solution in the treatment of dual (cocaine and opiate) dependence with doses of at least 8 mg daily (Montoya et al., 2004). Subjects in that study also received individual, standardized interpersonal cognitive psychotherapy. We address here the question: Does psychotherapy attendance influence buprenorphine treatment outcome?

The combination of non-pharmacological interventions with pharmacotherapy is a common clinical practice in drug abuse treatment in order to obtain a synergistic effect from the two treatment modalities (Covi, Hess, Schroeder, & Preston, 2002; Montoya et al., 2000). In particular, non-pharmacological interventions can improve cocaine-dependence treatment outcome during opioid agonist treatment (McLellan, Arndt, Metzger, Woody, & O'Brien, 1993). Among the behavioral therapies, contingency management has been the most thoroughly investigated for the treatment of cocaine dependence in methadone-maintained individuals. Contingency management, based on the principles of operant conditioning, uses voucher-based incentives (Higgins, Budney, & Bickel, 1994). This approach has been

particularly effective in improving retention and increasing cocaine abstinence (Higgins, Alessi, & Dantona, 2002; Robles et al., 2000; Silverman et al., 1996). Contingency management also appears to improve the treatment outcome of opioid agonist therapy (Bickel, Amass, Higgins, Badger, & Esch, 1997; Preston, Umbricht, & Epstein, 2000). It also showed promising results in reducing cocaine use in a sample of dually (cocaine and heroin) dependent patients treated with buprenorphine (Downey, Helmus, & Schuster, 2000). However, contingency management can be expensive, and does not seem to be widely used by drug abuse treatment programs (Petry & Simcic, 2002).

Less research has been reported on other psychotherapies for treatment of opioid and cocaine dependence. The most commonly used are cognitive-behavioral and interpersonal psychotherapies.

Cognitive-behavioral therapy is based on social learning principles and has shown efficacy when used in manualized protocols (Carroll et al., 1994). Interpersonal psychotherapy is a brief, individual psychological treatment whose goals are reduction or cessation of cocaine use and development of more productive strategies for dealing with social and interpersonal problems associated with the onset and perpetuation of cocaine use (Rounsaville, Gawin, & Kleber, 1985; Rounsaville & Kleber, 1985). Although the effect of contingency management has been reported to be significantly greater during acute treatment, cognitive-behavioral therapy seems to produce comparable long-term outcomes (Epstein, Hawkins, Covi, Umbricht, & Preston, 2003; Rawson et al., 2002).

Studies looking at the effect of psychotherapy attendance on treatment outcome have shown varying results. A study comparing three doses of cognitive behavioral psychotherapy for cocaine dependence showed no differences among groups; however, even the less intensive schedule was effective (Covi et al., 2002). On the other hand, more frequent attendance at group therapy or at self-help (12-step) group meetings has been associated with greater abstinence in patients with alcohol and other drug use (Fiorentine & Hillhouse, 2003). A recent study of dually dependent (cocaine and heroin) outpatients treated with buprenorphine plus desipramine and contingency management showed that participants did better with more intensive psychosocial interventions during treatment (Kosten, Poling, & Oliveto, 2003). In the present study, we examined the relationship between attendance at standardized, manual-based psychotherapy sessions during buprenorphine maintenance treatment and drug use by dually (cocaine, heroin) dependent outpatients (Montoya et al., 2004). We hypothesized that greater attendance at psychotherapy sessions would be associated with lower heroin and cocaine use.

#### 4. Discussion

Psychotherapy has traditionally been an integral part of the treatment of psychiatric disorders, particularly substance use disorders (Colom, Vieta, Martinez, Jorquera, & Gasto, 1998; Montoya et al., 2000). Even when pharmacotherapy is the primary component of treatment, as with opioid agonist treatment for opioid dependence, some form of psychotherapy is usually included (Etheridge, Craddock, Dunteman, & Hubbard, 1995). Consequently, clinicians and clinical investigators make efforts to motivate patients to attend psychotherapy while receiving pharmacotherapy (Barber, Foltz, Crits-Christoph, & Chittams, 2004; Montoya, Hess, Preston, & Gorelick, 1995; Siqueland et al., 2002). Studies of other psychiatric disorders, such as affective disorders, anxiety disorders, and schizophrenia, have shown the positive influence of psychotherapy on pharmacotherapy outcome (Barrowclough et al., 1999; Colom, Vieta, Reinares, et al., 2003; Colom, Vieta, Martinez-Aran, et al., 2003; Colom, Vieta, Martinez, Jorquera, & Gasto, 1998; Paykel et al., 1999; Tarrier et al., 1999). For substance use disorders, several studies have shown that therapist and patient adherence and providing more psychotherapy improve treatment outcome (Barber et al., 2001; Crits-Christoph et al., 2001; Fiorentine, 2001; Fiorentine & Hillhouse, 2003), but these studies did not

involve pharmacological treatment. Furthermore, these studies did not differentiate the influence of attendance on specific substance use disorders. To our knowledge, this is the first study to demonstrate the positive relationship between attendance at prescribed psychotherapy sessions and the outcome of buprenorphine treatment.

Non-adherence by patients to the prescribed treatment is a difficult issue in health care, especially in the treatment of substance use disorders (Barber et al., 2004; Barber, Crits-Christoph, & Luborsky, 1996). Psychotherapy attendance may depend on the psychological characteristics of the patient (e.g., capacity for insight), empathy between the therapist and the patient, the patient's perceived need for treatment, efficacy of the intervention, and external factors (e.g., court mandated therapy, employment supervision, or losing of some rights; Colom, 2002; Lingam & Scott, 2002). In this study, psychotherapy attendance seemed to have been influenced mainly by internal factors; external factors played only a small role. All patients were volunteers, the medication was administered double blind, no contingent vouchers were offered, and only those subjects who completed the treatment were included in the analysis. In addition, there was little or no interaction between psychotherapy attendance and buprenorphine dose on treatment outcome, suggesting that the effect of medication dose on psychotherapy attendance was minimum. However, we cannot rule out that the contingency of being discharged from the study for missing more than six psychotherapy sessions or the perceived benefit of the opioid agonist therapy may have been external factors that motivated subjects to comply with the psychotherapy. Of the subject characteristics that we evaluated, only ethnicity was significantly associated with psychotherapy attendance. Clearly, more research is needed on the characteristics of non-adherent psychiatric patients (Lingam & Scott, 2002).

A strength of this study is its robustness. By limiting the analysis to study completers, the effect of the psychotherapy was not confounded by the likelihood that the subjects most committed to treatment were the ones who show more treatment improvement. In addition, the effect of psychotherapy attendance was apparent against a background of high levels of psychotherapy attendance and treatment participation and administration of an effective treatment medication (buprenorphine).

Limitations of this study include the lack of data on the quality or duration of each psychotherapy visit, the characteristics of the therapist, and therapist adherence to the treatment manual. The generalizability of the findings may also be limited by including in the analysis only subjects who completed the treatment. However, given the lack of systematic evaluation of the influence of psychotherapy attendance on pharmacotherapy trials in substance abuse, and the design strengths of this study (standardized, manual-based psychotherapy in the context of a controlled clinical trial of a medication with significant therapeutic effect), we believe that the results are useful and valid.

The results of this study suggest that psychotherapy should be an integral part of the buprenorphine treatment plan for patients with dual cocaine and opioid dependence. Now that buprenorphine is available for use in office-based environments, it may be advisable for clinicians to include a psychotherapy component of treatment, either directly themselves or through referral elsewhere. There is a need for systematic research on the effect of psychotherapy on other pharmacological treatments for substance use disorders, the factors that may affect psychotherapy attendance, compliance and/or adherence, and the efficacy of behavioral and/or psychotherapeutic interventions to improve treatment adherence.

12. Murray, Rheana. New York Daily News (June 20, 2012). Heroin use among suburban teens skyrockets; Experts say prescription pills are the new gateway drug.

<http://www.nydailynews.com/life-style/health/heroin-soars-suburban-teens-talk-heroin-problem-talking-prescription-drug-problem-article-1.1099140>.

“Heroin use among teenagers is increasing at an alarming rate as experts say the drug, long considered to be prevalent only in urban areas, is infiltrating the suburbs.

All across suburban America, young people are getting hooked on a drug parents never suspected they needed to fear.

“Kids in the city know not to touch it, but the message never got out to the suburbs,” former Chicago Police Capt. John Roberts told NBC News.

Roberts’ 19-year-old son died of a heroin overdose after the family moved to Chicago’s suburbs. Roberts, newly retired from the police department, thought his children would be safer. “We didn’t think it would ever be a problem out here,” he said.

**RELATED: PAINKILLER ADDICTS SWITCHING TO EASIER-TO-GET HEROIN**

National data from the Substance Abuse and Mental Health Services Administration shows that the number of teens dying from heroin abuse has skyrocketed. In 1999, 198 people between the ages of 15 and 24 died of a heroin overdose, compared to 510 deaths in 2009, the latest year data was taken.

More teens are seeking treatment for heroin abuse, too — the figure jumped from 4,414 to more than 21,000 (about 80 percent) between 1999 and 2009. Ninety percent of teen heroin addicts are white, according to the data.

According to NBC News, prescription painkillers are the link between suburban teens and heroin. Teens addicted to pills like Oxycodone can find the same high in heroin, which is cheaper, more intense and easier to buy.

Roberts says his son, Billy, first became addicted to prescription painkillers, but when he and his friends could no longer afford their habit, they turned to heroin, which they could buy for 1/10 of the price.

**RELATED: PENNSYLVANIA MOTHER HOOKED 14-YEAR-OLD DAUGHTER ON HEROIN, INJECTED HER OVER 200 TIMES**

“It’s hard to talk about the heroin problem without talking about the prescription drug problem,” Rafael Lemaitre, of the White House Office of National Drug Control Policy told NBC News.

Death from prescription drugs tripled between 2000 and 2008, according to national data from the Centers for Disease Control and Prevention.

NBC News reports that out of dozens of interviews with former heroin addicts, nearly all reported getting hooked the same way. They started with prescription drugs they purchased from friends, and when they became too addicted to afford the number of pills they needed to get high, they switched to cheaper heroin.

A March 2010 report by ABC News highlights efforts by drug traffickers in Mexico and Columbia to market heroin to suburban teens, by splashing popular logos, like Prada or Chevrolet, on the small drug packets.

Some dealers even give it away for free in the suburbs, then sell to the kids once they become hooked.

**RELATED: TEEN MARIJUANA USE ON THE RISE**

Mexico has seen a huge increase in heroin production to meet the demand — from 7 metric tons in 2002 to 50 metric tons in 2012, according to the National Drug Intelligence Center.

The supply ensures the drug makes it across the United States.

“Twenty years ago, half of the heroin addicts in treatment lived in two states — New York and California,” Dr. Joe Gay, director of Health Recovery Services in Ohio, told MSNBC. “[Now, in Ohio] we’re seeing it spread out of the cities, into the suburbs and into the rural areas.”

*rmurray@nydailynews.com*

Read more:

<http://www.nydailynews.com/life-style/health/heroin-soars-suburban-teens-talk-heroin-problem-talking-prescription-drug-problem-article-1.1099140#ixzz2T7A16O5h>

13. NIDA National Institute on Drug Abuse. Principles of Drug Addiction Treatment: A Research-Based Guide (Third Edition) (October 1999). [www.drugabuse.gov](http://www.drugabuse.gov)

Excerpts:

#### **Evidence-Based Approaches to Drug Addiction Treatment**

Each approach to drug treatment is designed to address certain aspects of drug addiction and its consequences for the individual, family, and society.

This section presents examples of treatment approaches and components that have an evidence base supporting their use. Each approach is designed to address certain aspects of drug addiction and its consequences for the individual, family, and society. Some of the approaches are intended to supplement or enhance existing treatment programs, and others are fairly comprehensive in and of themselves. The following section is broken down into Pharmacotherapies, Behavioral Therapies, and Behavioral Therapies Primarily for Adolescents. They are further subdivided according to particular substance use disorders. This list is not exhaustive, and new treatments are continually under development.

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Buprenorphine is a synthetic opioid medication that acts as a partial agonist at opioid receptors—it does not produce the euphoria and sedation caused by heroin or other opioids but is able to reduce or eliminate withdrawal symptoms associated with opioid dependence and carries a low risk of overdose.

Buprenorphine is currently available in two formulations that are taken sublingually: (1) a pure form of the drug and (2) a more commonly prescribed formulation called Suboxone, which combines buprenorphine with the drug naloxone, an antagonist (or blocker) at opioid receptors. Naloxone has no effect when Suboxone is taken as prescribed, but if an addicted individual attempts to inject Suboxone, the naloxone will produce severe withdrawal symptoms. Thus, this formulation lessens the likelihood that the drug will be abused or diverted to others.

Buprenorphine treatment for detoxification and/or maintenance can be provided in office-based settings by qualified physicians who have received a waiver from the Drug Enforcement Administration (DEA), allowing them to prescribe it. The availability of office-based treatment for opioid addiction is a cost-effective approach that increases the reach of treatment and the options available to patients.

14. Rehmer MSN, Patricia. CT Commissioner Department of Mental Health and Addiction Services presenting before the Public Health Committee on 3/7/2012. Speaking in favor of HB 5063 that would allow Naloxone (a component of Suboxone) to be prescribed more broadly to counteract drug overdoses. Information obtained at <http://www.cga.ct.gov/2012/JFR/H/2012HB-05063-R00PH-JFR.htm>

**Patricia Rehmer, MSN, Commissioner, Department of Mental Health and Addiction Services (DMHAS):** In a study done in Connecticut in 2009, drug overdose was the leading cause of death among 18 to 25 year olds. Drug-induced overdose has been the most common cause of accidental death in Connecticut every year for the past 10 years. During a 3 year period from 2006 to 2008 there were 1256 overdose related deaths (832 males and 424 females) in Connecticut. On average, there is at least one person a day who dies from an opioid overdose in Connecticut. Most deaths occur at home often with other individuals in the house. Most overdoses can be easily reversed if treated promptly.

The current statute allows the drug to be prescribed to individuals suffering from addiction. However, an individual who has overdosed could become unable to self-administer. This proposal would allow family members, significant others, roommates and the like to have Narcan on hand should the situation warrant it.

Narcan works for an opioid overdose like an Epi-pen does when used for an individual with life threatening allergies. It can be administered very simply as a nasal spray.

Narcan can be carried in a purse or pocket or put on a nightstand. Narcan has no street value or addictive potential. It cannot give a "high". If given to someone who is not suffering from an overdose, it may make the individual a little uncomfortable but have no other effect. If it is administered to someone who is using painkillers, methadone or heroin, it can precipitate discomfort due to withdrawal.

Connecticut has a growing addiction problem among all age and socioeconomic groups partially due to easy access to prescription drugs and heroin. We support those that face the challenging and lengthy process of achieving sustained recovery. As part of this effort, we ask you to consider this proposal to allow family, friends, and others to administer Narcan because it will save lives.

15. SAMHSA (Substance Abuse and Mental Health Services Administration), Center for Behavioral Health Statistics and Quality (formerly the Office of Applied Studies) (2007 and 2009). Treatment Episode Data Set. National Admissions to Substance Abuse Treatment Services. Information obtained at <http://www.samhsa.gov/data/DASIS/TEDS2k7AWeb/TEDS2k7AWeb.pdf>

Excerpted Table:

**Table 4.8b**  
**Admissions per 100,000 population aged 12 and over, adjusted for age, gender, and race/ethnicity, by State or jurisdiction, according to primary substance of abuse: TEDS 2007**

[Based on administrative data reported to TEDS by all reporting States and jurisdictions (excl. Puerto Rico). Comparisons among States should be made with caution; see Ch. 4.]

State or jurisdiction	No. of admissions aged 12 and over	Admissions per 100,000 aged 12 and over		Admissions per 100,000 population aged 12 and over, adjusted for age, gender, and race/ethnicity <sup>1</sup>														
		Total		Primary substance at admission														
		Unad-justed	Ad-justed <sup>2</sup>	Alcohol		Opiates		Cocaine		Mari-juana/hashish	Stimulants		Tran-qui-lizers	Seda-tives	Hallu-cinogens	PCP	Inhal-ants	Other/none speci-fied
				Alcohol only	With secondary drug	Heroin	Other opiates	Smoked cocaine	Other route		Metham-phetamine/amphet-amine	Other stimu-lants						
<b>Total</b>	1,809,682	764	803	192	155	91	43	75	27	123	63	†	4	2	†	1	†	25
Alabama	‡	‡	‡	‡	‡	‡	‡	‡	‡	‡	‡	‡	‡	‡	‡	‡	‡	‡
Alaska	‡	‡	‡	‡	‡	‡	‡	‡	‡	‡	‡	‡	‡	‡	‡	‡	‡	‡
Arizona	43,381	833	917	97	53	31	11	33	11	62	82	1	2	†	2	--	†	533
Arkansas	14,471	611	602	132	103	2	48	52	20	114	110	†	8	6	†	†	†	6
California	195,254	642	741	81	85	97	29	76	12	108	246	†	†	1	†	†	†	2
Colorado	76,471	1,933	2,134	1,379	232	38	27	91	42	174	134	3	6	3	1	†	†	5
Connecticut	44,757	1,503	1,390	236	261	432	69	139	66	131	4	1	7	4	3	11	†	26
Delaware	8,424	1,155	1,167	138	181	263	130	123	47	226	5	--	3	1	†	2	†	45
Dist. of Columbia	1,938	378	106	1	†	2	--	2	--	†	†	--	--	--	--	†	--	99
Florida	44,444	285	338	56	44	8	32	48	24	94	7	†	5	†	†	†	†	18
Georgia	‡	‡	‡	‡	‡	‡	‡	‡	‡	‡	‡	‡	‡	‡	‡	‡	‡	‡
Hawaii	6,970	636	788	179	154	21	34	31	14	179	161	†	†	†	†	--	†	12
Idaho	5,464	446	467	63	72	8	13	4	4	108	193	--	†	†	†	--	†	1
Illinois	60,594	471	506	91	78	118	11	78	18	99	10	†	1	†	†	†	†	†
Indiana	29,021	548	558	142	128	10	31	59	14	131	27	†	6	2	†	†	†	6
Iowa	25,437	1,007	1,317	319	293	14	21	134	33	348	144	†	2	†	1	†	2	5
Kansas	15,563	672	754	129	166	5	15	123	25	195	87	†	2	1	†	3	†	2
Kentucky	24,076	672	649	124	135	13	84	90	34	111	25	†	13	†	†	†	†	18
Louisiana	24,372	660	615	75	101	9	79	107	44	116	32	†	10	7	†	†	†	32
Maine	15,702	1,374	1,672	493	307	127	397	80	56	180	9	†	15	3	†	--	†	4

16. SAMHSA, Center for Behavioral Health Statistics and Quality (formerly the Office of Applied Studies), National Survey on Drug Use and Health. (2008 and 2009).  
<http://www.samhsa.gov/data/2k9State/WebOnlyTables/CT.pdf> (CT data)

Excerpted Tables:

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**Table 23. Selected Drug Use, Perceptions of Great Risk, Average Annual Marijuana Initiates, Past Year Substance Dependence or Abuse, Needing But Not Receiving Treatment, and Past Year Mental Health Measures in Connecticut, by Age Group: Estimated Numbers (in Thousands), Annual Averages Based on 2008-2009 NSDUHs**

Measure	12+	12-17	18-25	26+	18+
<b>ILLICIT DRUGS</b>					
Past Month Illicit Drug Use <sup>1</sup>	261	30	91	141	231
Past Year Marijuana Use	368	46	134	188	322
Past Month Marijuana Use	212	24	82	106	188
Past Month Use of Illicit Drugs Other Than Marijuana <sup>1</sup>	100	13	31	56	88
Past Year Cocaine Use	61	4	23	35	57
Past Year Nonmedical Pain Reliever Use	111	14	38	59	97
Perception of Great Risk of Smoking Marijuana Once a Month	969	82	65	822	887
Average Annual Number of Marijuana Initiates <sup>2</sup>	34	17	15	2	17
<b>ALCOHOL</b>					
Past Month Alcohol Use	1,736	54	246	1,436	1,683
Past Month Binge Alcohol Use <sup>3</sup>	792	38	170	583	754
Perception of Great Risk of Drinking Five or More Drinks Once or Twice a Week	1,195	117	117	961	1,078
Past Month Alcohol Use (Persons Aged 12 to 20)	129 <sup>4</sup>	--	--	--	--
Past Month Binge Alcohol Use (Persons Aged 12 to 20) <sup>3</sup>	99 <sup>4</sup>	--	--	--	--
<b>TOBACCO PRODUCTS</b>					
Past Month Tobacco Product Use <sup>5</sup>	744	31	151	561	712
Past Month Cigarette Use	629	25	133	472	605
Perception of Great Risk of Smoking One or More Packs of Cigarettes Per Day	2,175	203	251	1,721	1,972
<b>PAST YEAR DEPENDENCE, ABUSE, AND TREATMENT<sup>6</sup></b>					
Illicit Drug Dependence <sup>1</sup>	55	7	21	27	48
Illicit Drug Dependence or Abuse <sup>1</sup>	86	13	33	40	73
Alcohol Dependence	102	6	26	70	96
Alcohol Dependence or Abuse	253	17	73	163	236
Alcohol or Illicit Drug Dependence or Abuse <sup>1</sup>	287	23	86	179	265
Needing But Not Receiving Treatment for Illicit Drug Use <sup>1,7</sup>	75	12	29	35	63
Needing But Not Receiving Treatment for Alcohol Use <sup>7</sup>	244	17	71	156	227
<b>PAST YEAR MENTAL HEALTH</b>					
Had at Least One Major Depressive Episode <sup>8,9</sup>	--	23	29	127	156
Serious Mental Illness <sup>9,10</sup>	--	--	30	86	116
Any Mental Illness <sup>9,10</sup>	--	--	121	399	521
Had Serious Thoughts of Suicide	--	--	24	80	104

CONNECTICUT

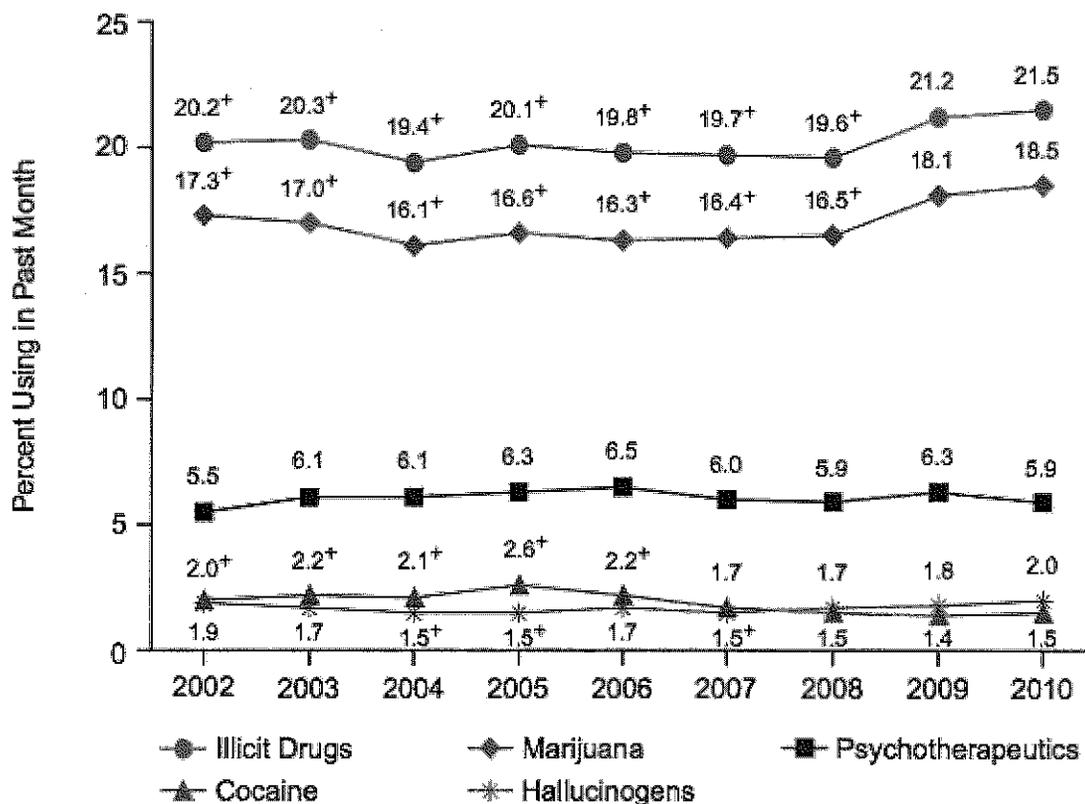
Table 24. Selected Drug Use, Perceptions of Great Risk, Average Annual Rates of First Use of Marijuana, Past Year Substance Dependence or Abuse, Needing But Not Receiving Treatment, and Past Year Mental Health Measures in Connecticut, by Age Group: Percentages, Annual Averages Based on 2008-2009 NSDUHs

Measure	12+	12-17	18-25	26+	18+
<b>ILLCIT DRUGS</b>					
Past Month Illicit Drug Use <sup>1</sup>	8.90	10.27	24.91	6.19	8.75
Past Year Marijuana Use	12.53	15.89	36.95	8.24	12.17
Past Month Marijuana Use	7.24	8.37	22.52	4.68	7.12
Past Month Use of Illicit Drugs Other Than Marijuana <sup>1</sup>	3.42	4.43	8.60	2.48	3.31
Past Year Cocaine Use	2.07	1.25	6.19	1.52	2.16
Past Year Nonmedical Pain Reliever Use	3.79	4.96	10.50	2.59	3.67
Perception of Great Risk of Smoking Marijuana Once a Month	33.12	28.63	17.81	36.10	33.60
Average Annual Rate of First Use of Marijuana <sup>2</sup>	2.15	7.10	9.06	0.13	1.24
<b>ALCOHOL</b>					
Past Month Alcohol Use	59.32	18.63	67.78	63.07	63.72
Past Month Binge Alcohol Use <sup>3</sup>	27.03	13.31	46.83	25.62	28.52
Perception of Great Risk of Drinking Five or More Drinks Once or Twice a Week	40.83	40.68	32.27	42.21	40.85
Past Month Alcohol Use (Persons Aged 12 to 20)	31.03 <sup>4</sup>	--	--	--	--
Past Month Binge Alcohol Use (Persons Aged 12 to 20) <sup>3</sup>	23.70 <sup>4</sup>	--	--	--	--
<b>TOBACCO PRODUCTS</b>					
Past Month Tobacco Product Use <sup>5</sup>	25.40	10.92	41.56	24.65	26.96
Past Month Cigarette Use	21.49	8.64	36.50	20.72	22.88
Perception of Great Risk of Smoking One or More Packs of Cigarettes Per Day	74.28	70.44	69.10	75.58	74.70
<b>PAST YEAR DEPENDENCE, ABUSE, AND TREATMENT<sup>6</sup></b>					
Illicit Drug Dependence <sup>1</sup>	1.89	2.52	5.90	1.17	1.82
Illicit Drug Dependence or Abuse <sup>1</sup>	2.92	4.38	9.11	1.76	2.76
Alcohol Dependence	3.48	2.08	7.24	3.06	3.63
Alcohol Dependence or Abuse	8.63	5.95	20.03	7.16	8.92
Alcohol or Illicit Drug Dependence or Abuse <sup>1</sup>	9.80	7.82	23.67	7.85	10.01
Needing But Not Receiving Treatment for Illicit Drug Use <sup>1,7</sup>	2.55	4.06	7.86	1.53	2.39
Needing But Not Receiving Treatment for Alcohol Use <sup>7</sup>	8.31	5.75	19.49	6.86	8.59
<b>PAST YEAR MENTAL HEALTH</b>					
Had at Least One Major Depressive Episode <sup>8,9</sup>	--	7.96	8.00	5.57	5.90
Serious Mental Illness <sup>9,10</sup>	--	--	8.13	3.79	4.39
Any Mental Illness <sup>9,11</sup>	--	--	33.41	17.53	19.70
Had Serious Thoughts of Suicide	--	--	6.61	3.52	3.94

17. Substance Abuse and Mental Health Services Administration, Results from the 2010 National Survey on Drug Use and Health: Summary of National Findings, NSDUH Series H-41, HHS Publication No. (SMA) 11-4658. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2011. Information obtained at <http://www.samhsa.gov/data/NSDUH/2k10NSDUH/2k10Results.pdf>

Excerpts:

**Figure 2.7 Past Month Use of Selected Illicit Drugs among Young Adults Aged 18 to 25: 2002-2010**



\* Difference between this estimate and the 2010 estimate is statistically significant at the .05 level.

**Adults Aged 26 or Older**

In 2010, the rate of current illicit drug use among adults aged 26 or older was 6.6 percent, with 4.8 percent current users of marijuana and 2.2 percent current nonmedical users of psychotherapeutic drugs. Less than 1 percent each used cocaine (0.5 percent), hallucinogens (0.2 percent), heroin (0.1 percent), and inhalants (0.1 percent). These rates were similar to those reported in 2009. However, the rate of current marijuana use in 2010 was significantly higher than the rates in 2002 through 2008.

Among adults aged 50 to 59, the rate of current illicit drug use increased from 2.7 to 5.8 percent between 2002 and 2010 (Figure 2.8). For those aged 50 to 54, the rate increased from 3.4 percent in 2002 to 7.2 percent in 2010. Among those aged 55 to 59, current illicit drug use increased from 1.9 percent in 2002 to 4.1 percent in 2010. These patterns and trends partially reflect the aging into these age groups of members of the baby boom cohort, whose rates of illicit drug use have been higher than those of older cohorts. The baby boom cohort refers to persons born in the United States after World War II between 1946 and 1964 (Han, Gfroerer & Colliver, 2009).

### 7.3. Need for and Receipt of Specialty Treatment

This section discusses the need for and receipt of treatment for a substance use problem at a "specialty" treatment facility. Specialty treatment is defined as treatment received at any of the following types of facilities: hospitals (inpatient only), drug or alcohol rehabilitation facilities (inpatient or outpatient), or mental health centers. It does not include treatment at an emergency room, private doctor's office, self-help group, prison or jail, or hospital as an outpatient. An individual is defined as needing treatment for an alcohol or drug use problem if he or she met the DSM-IV (APA, 1994) diagnostic criteria for alcohol or illicit drug dependence or abuse in the past 12 months or if he or she received specialty treatment for alcohol use or illicit drug use in the past 12 months.

In this section, an individual needing treatment for an illicit drug use problem is defined as receiving treatment for his or her drug use problem only if he or she reported receiving specialty treatment for drug use in the past year. Thus, an individual who needed treatment for illicit drug use but only received specialty treatment for alcohol use in the past year or who received treatment for illicit drug use only at a facility not classified as a specialty facility was not counted as receiving treatment for drug use. Similarly, an individual who needed treatment for an alcohol use problem was only counted as receiving alcohol use treatment if the treatment was received for alcohol use at a specialty treatment facility. Individuals who reported receiving specialty substance use treatment but were missing information on whether the treatment was specifically for alcohol use or drug use were not counted in estimates of specialty drug use treatment or in estimates of specialty alcohol use treatment; however, they were counted in estimates for "drug or alcohol use" treatment.

In addition to questions about symptoms of substance use problems that are used to classify respondents' need for treatment based on DSM-IV criteria, NSDUH includes questions asking respondents about their perceived need for treatment (i.e., whether they felt they needed treatment or counseling for illicit drug use or alcohol use). In this report, estimates for perceived need for treatment are only discussed for persons who were classified as needing treatment (based on DSM-IV criteria) but did not receive treatment at a specialty facility. Similarly, estimates for whether a person made an effort to get treatment are only discussed for persons who felt the need for treatment.

#### Illicit Drug or Alcohol Use Treatment and Treatment Need

In 2010, 23.1 million persons aged 12 or older needed treatment for an illicit drug or alcohol use problem (9.1 percent of persons aged 12 or older). Of these, 2.6 million (1.0 percent of persons aged 12 or older and 11.2 percent of those who needed treatment) received treatment at a specialty facility. Thus, 20.5 million persons (8.1 percent of the population aged 12 or older) needed treatment for an illicit drug or alcohol use problem but did not receive treatment at a specialty facility in the past year. These population estimates are similar to the estimates for 2009 and for 2002. These percentage estimates for 2010 are similar to the

estimates for 2009. However, the percentage of persons aged 12 or older who needed treatment for an illicit drug or alcohol use problem declined from 9.7 percent in 2002 to 9.1 percent in 2010. The percentage of persons aged 12 or older who needed treatment for an illicit drug or alcohol use problem but did not receive treatment at a specialty facility also declined from 8.7 percent in 2002 to 8.1 percent in 2010.

Of the 2.6 million people aged 12 or older who received specialty substance use treatment in 2010, 958,000 received treatment for alcohol use only, 881,000 received treatment for illicit drug use only, and 625,000 received treatment for both alcohol and illicit drug use. These estimates are similar to the estimates for 2009 and for 2002.

In 2010, among persons who received their most recent substance use treatment at a specialty facility in the past year, 41.5 percent reported using their "own savings or earnings" as a source of payment for their most recent specialty treatment, 36.9 percent reported using private health insurance, 35.6 percent reported using public assistance other than Medicaid, 29.2 percent reported using Medicaid, 27.4 percent reported using Medicare, and 22.6 percent reported using funds from family members. None of these estimates changed significantly between 2009 and 2010 and between 2002 and 2010. (Note that persons could report more than one source of payment.)

Of the 20.5 million persons aged 12 or older in 2010 who were classified as needing substance use treatment but not receiving treatment at a specialty facility in the past year, 1.0 million persons (5.0 percent) reported that they perceived a need for treatment for their illicit drug or alcohol use problem (Figure 7.10). Of these 1.0 million persons who felt they needed treatment but did not receive treatment in 2010, 341,000 (33.3 percent) reported that they made an effort to get treatment, and 683,000 (66.7 percent) reported making no effort to get treatment. These estimates remained stable between 2009 and 2010.

The number and the percentage of youths aged 12 to 17 who needed treatment for an illicit drug or alcohol use problem in 2010 (1.8 million, 7.5 percent) were similar to those in 2009 (1.8 million, 7.2 percent), but they were lower than those in 2002 (2.3 million, 9.1 percent). Of the 1.8 million youths who needed treatment in 2010, 138,000 received treatment at a specialty facility (about 7.6 percent of the youths who needed treatment), leaving 1.7 million who needed treatment for a substance use problem but did not receive it at a specialty facility.

Based on 2007-2010 combined data, the six most often reported reasons for not receiving illicit drug or alcohol use treatment among persons aged 12 or older who needed but did not receive treatment at a specialty facility and perceived a need for treatment were (a) not ready to stop using (40.2 percent), (b) no health coverage and could not afford cost (32.9 percent), (c) possible negative effect on job (11.5 percent), (d) concern that receiving treatment might cause neighbors/community to have negative opinion (11.3 percent), (e) could handle the problem without treatment (9.9 percent), and (f) not knowing where to go for treatment (9.3 percent).

#### 20.5 Million Needing But Not Receiving Treatment for Illicit Drug or Alcohol Use

Based on 2007-2010 combined data, among persons aged 12 or older who needed but did not receive illicit drug or alcohol use treatment, felt a need for treatment, and made an effort to receive treatment, the most often reported reasons for not receiving treatment were (a) no health coverage and could not afford cost (38.1 percent), (b) not ready to stop using (30.3 percent), (c) able to handle the problem without treatment (9.0 percent), (d) no transportation/inconvenient (8.4 percent), (e) might have negative effect on job (7.9 percent), (f) had health coverage but did not cover treatment or did not cover cost (7.4 percent), (g) might cause neighbors/community to have negative opinion (7.1 percent), and (h) did not feel need for treatment at the time (6.5 percent) (Figure 7.11).

#### Illicit Drug Use Treatment and Treatment Need

In 2010, the number of persons aged 12 or older needing treatment for an illicit drug use problem was 7.9 million (3.1 percent of the total population). Of these, 1.5 million (0.6 percent of the total population and 19.1 percent of the persons who needed treatment) received treatment at a specialty facility for an illicit drug use problem in the past year. Thus, there were 6.4 million persons (2.5 percent of the total population) who needed but did not receive treatment at a specialty facility for an illicit drug use problem in 2010. None of these estimates changed significantly between 2009 and 2010 and between 2002 and 2010. Of the 6.4 million people aged 12 or older who needed but did not receive specialty treatment for illicit drug use in 2010, 392,000 (6.1 percent) reported that they perceived a need for treatment for their illicit drug use problem. Of the 392,000 persons who felt a need for treatment in 2010, 193,000 reported that they made an effort, which was similar to what was reported in 2009, and 200,000 reported making no effort to get treatment, which was not significantly different from the 2009 estimate.

The number and the percentage of whites aged 18 or older who needed treatment for an illicit drug problem but did not receive treatment declined between 2009 (3.6 million, 2.3 percent) and 2010 (3.1 million, 2.0 percent). However, the number and the percentage of blacks aged 18 or older who needed treatment for an illicit drug problem but did not receive treatment increased between 2009 (735,000 persons, 2.8 percent) and 2010 (1.0 million, 3.8 percent). Among youths aged 12 to 17, there were 1.2 million (4.8 percent) who needed treatment for an illicit drug use problem in 2010. Of this group, only 98,000 received treatment at a specialty facility (8.4 percent of youths aged 12 to 17 who needed treatment), leaving 1.1 million youths who needed treatment but did not receive it at a specialty facility.

Among people aged 12 or older who needed but did not receive illicit drug use treatment and felt they needed treatment (based on 2007-2010 combined data), the most often reported reasons for not receiving treatment were (a) no health coverage and could not afford cost (41.8 percent), (b) not ready to stop using (30.7 percent), (c) concern that receiving treatment might cause neighbors/community to have negative opinion (14.6 percent), (d) possible negative effect on job (12.4 percent), (e) not knowing where to go for treatment (12.1 percent), and (f) being able to handle the problem without treatment (9.6 percent).

18. U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General—Executive Summary*. Rockville, MD: U.S. Dept. of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999. Information obtained at <http://profiles.nlm.nih.gov/ps/retrieve/ResourceMetadata/NNBBHS>

Excerpted from Chapter 8: A Vision for the Future, pages 455-456:

### **Ensure the Supply of Mental Health Services and Providers**

The service system as a whole, as opposed to treatment services considered in isolation, dictates the outcome of treatment (Goldman, 1998). The fundamental components of effective service delivery include integrated community-based services, continuity of providers and treatments, family support services (including psychoeducation), and culturally sensitive services. Effective service delivery for individuals with the most severe conditions also requires supported housing and supported employment. For adults and children with less severe conditions, primary health care, the schools, and other human services must be prepared to assess and, at times, to treat individuals who come seeking help. All services for those with a mental disorder should be consumer oriented and focused on promoting recovery. That is, the goal of services must not be limited to symptom reduction but should strive for restoration of a meaningful and productive life.

Across the Nation, certain mental health services are in consistently short supply. These include the following:

- Wraparound services for children with serious emotional problems and multisystemic treatment. Both treatment strategies should actively involve the participation of the multiple health, social service, educational, and other community resources that play a role in ensuring the health and well-being of children and their families;
- Assertive community treatment, an intensive approach to treating people with serious mental illnesses;
- Combined services for people with co-occurring severe mental disorders and substance abuse disorders; . A range of prevention and early case identification programs; and
- Disease management programs for conditions such as late-life depression in primary care settings.

All too frequently, these effective programs are simply unavailable in communities. It is essential to expand the supply of effective, evidence-based services throughout the Nation.

The supply of well-trained mental health professionals also is inadequate in many areas of the country, especially in rural areas (Peterson et al., 1998). Particularly keen shortages are found in the numbers of mental health professionals serving children and

adolescents with serious mental disorders and older people (Peterson et al., 1998). More mental health professionals also need to be trained in cognitive-behavioral therapy and interpersonal therapy, two forms of psychotherapy shown by rigorous research to be effective for many types of mental disorders.

### **Ensure Delivery of State-of-the-Art Treatments**

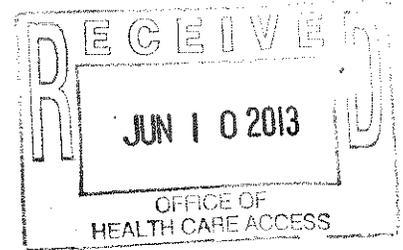
State-of-the-art treatments, carefully refined through years of research, are not being translated into community settings. As noted throughout this report, a wide variety of community-based services are of proven value for even the most severe mental illnesses. Exciting new research-based advances are emerging that will enhance the delivery of treatments and services in areas crucial to consumers and families—employment, housing, and diversion of people with mental disorders out of the criminal justice systems. Yet a gap persists in the broad introduction and application of these advances in services delivery to local communities, and many people with mental illness are being denied the most up-to-date and advanced forms of treatment.

Multiple and complex explanations exist for the gap between what is known through research and what is actually practiced in customary care. Foremost among these are practitioners' lack of knowledge of research results; the lag time between the reporting of research results and the translation of new knowledge into practice; and the cost of introducing innovations in health systems. In addition, significant differences that exist between academic research settings and actual practice settings help account for the gap between what is known and what is practiced. The patients in actual practice are more heterogeneous in terms of their overall health and cultural backgrounds, and both patients and providers are subject to cost pressures. New strategies must be devised to bridge the gap between research and practice (National Advisory Mental Health Council, 1998).



June 6, 2013

Ms. Lisa A. Davis  
Deputy Commissioner  
State of Connecticut  
Office of Health Care Access (OCHA)  
Department of Public Health  
410 Capitol Avenue MS # 13HCA  
Hartford, CT 06134



Dear Commissioner Davis:

I am writing in regard to the CON Application of Connecticut Recovery Center, LLC for an Intensive Outpatient Program to be located in Cheshire, CT (Docket No. 13-31840).

In reviewing the application I would like to point out the applicant greatly understated the potential duplication, overlap and impact this project would have on existing providers of this service. For instance, the applicant does not note Wellmore Behavioral Health (Wellmore, Inc.) as a provider of the services it is applying to establish. The applicant also does not note Connecticut Counseling Center, Inc. (CCC) or Mid-western Connecticut Council of Alcoholism, Inc. (MCCA). All three of the aforementioned organizations are longstanding, licensed providers of intensive outpatient services with substantial operations in Waterbury, CT. In the case of Wellmore, we utilize an 'open access' system whereby those in need are rapidly admitted and there is no waitlist. Between these three providers, thousands of adults each year receive the intensive services which the applicant proposes to provide. While I can not speak for CCC or MCCA regarding capacity, both organizations recently won contracts with the Court Support Services Division of the State of Connecticut to provide intensive services in (greater) Waterbury. None of this is noted in the application despite this being readily available public information.

As it relates to 'suboxone' treatment, the applicant again did not thoroughly evaluate the existing capacity in Waterbury or the other towns noted. For instance, the applicant does not mention the very substantial program at Middlesex Hospital, Community Health Center (which has many locations in the region) or any of the other private, for-profit practitioners in this region that provide this therapy.

I urge you to reject the current application, at least until the applicant completes a meaningful needs assessment and provides you will all the factual information on the impact of their proposal on existing providers.

Thank you for the opportunity to comment.

Sincerely,



Gary M. Steck, LMFT  
Chief Executive Officer



**STATE OF CONNECTICUT**  
DEPARTMENT OF PUBLIC HEALTH  
*Office of Health Care Access*

June 14, 2013

VIA FAX ONLY

Dr. Jennifer Ballew  
Medical Director and CEO  
Connecticut Recovery Center, LLC  
P.O. Box 429  
Cheshire, CT 06410

RE: Certificate of Need Application, Docket Number 13-31840-CON  
Connecticut Recovery Center, LLC  
Establishment of an Intensive Outpatient Program in Cheshire for Adults

Dear Dr. Ballew:

On May 17, 2013, the Office of Health Care Access ("OHCA") received your Certificate of Need ("CON") application filing on behalf of Connecticut Recovery Center, LLC ("Applicant") proposing to establish an Intensive Outpatient Program ("IOP") for substance abuse and mental health for adults in Cheshire, with an associated cost of \$15,000.

OHCA has reviewed the CON application and requests the following additional information pursuant to General Statutes §19a-639a(c). The page numbers given in each question refer to the submitted initial Certificate of Need ("CON") application.

1. Please provide a discussion and any available supporting information about how the Applicant determined the clear public need for the proposed service. Provide a copy of the business plan for the proposed new facility.
2. Provide specific articles/studies and relate them to why the Applicant has chosen suboxone as its treatment of choice.
3. Identify the Applicant's referral base and provide evidence.
4. What specific licenses will the Applicant be seeking from the State of Connecticut?
5. Please explain why the Applicant chose the three tracks of treatment. Provide supporting evidence such as Best Practices or Evidence Based Medicine.
6. Please explain the purpose of "phasing in" the three tracks of treatment.

7. Provide a copy of the following for each track:
  - a. Treatment Plan; and
  - b. Daily Patient Schedule.
8. Where are the projected number of patients, between 80-180 annually for FYs 2013-2016, currently receiving the proposed services, since the Applicant states that there are no existing providers of the proposed service in the Applicant's service area?
9. Please explain why Rushford Center (Meriden) and Greater Waterbury Health Network (Waterbury) are not viewed as existing providers, given the Applicant has eluded to waiting lists at these facilities (CON Application, page 18).
10. On page 15 of the CON Application, it is stated that the primary service area ("PSA") for this proposal includes the towns of Cheshire, Meriden, Wallingford, Southington and Wolcott and "quite likely will be drawing patients from the Naugatuck Valley." Please explain:
  - a. How the Applicant determined the towns in the PSA.
  - b. What towns in the Naugatuck Valley will be included in the service area?
  - c. Any existing providers providing similar service in Naugatuck Valley besides Waterbury Hospital.
11. Provide a map of Connecticut identifying your service area towns and the existing providers of similar services throughout Connecticut.
12. In response to Question 3a on page 19 concerning projected volume, Table 1:
  - a. Provide the basis for the annual volume (source of the patients);
  - b. Please clarify if the "Dual Diagnosis IOP" is or is not double counting patients from Substance Abuse IOP and/or Mental Health IOP.
13. On page 29 of the CON Application, the Applicant states that it intends to accept only commercial insurers and self-pay patients. Please complete and submit Table 3, the Patient Population Mix table on page 28 to reflect the break-out of the percentage between Commercial Payers and self-pay patients. Please revise Financial Attachments I&II as appropriate.
14. Does the Applicant have any relationships with any other providers in Connecticut and out-of-state? If so, submit letters from those providers that demonstrate that they will refer patients to your proposed facility. What is the projected split between in-state and out-of-state referrals?
15. Provide documentation that demonstrates that the Applicant has contacted the State of Connecticut Department of Mental Health and Addiction Services to provide information

related to the admission and discharge status of clients at existing facilities in the proposed service area and in Connecticut.

16. On page 19 of the CON Application, the Applicant projects 80,120,180, and 180 patients for FYs 2013-2016, respectively. Provide details as to the source of the projected numbers and the rationale used. Discuss how the Applicant expects to achieve this projected volume.
17. Please revise and update Financial Attachment I, on page 34 of the CON Application, to include FY 2016.
18. On pages 44-59 of the CON Application, the Applicant provided the Curriculum Vitae for all staff related to the proposal. Please confirm that each of the positions listed meets the appropriate level of licensing/credentialing required for the various levels of services proposed and provide evidence thereof.
19. On pages 60-95 of the CON Application, the Applicant provided referencing articles and bibliographies. Please highlight the relevant pages and portions of the referenced material and directly tie into the need for this proposal and specifically, how the provided reference material supports the need for this proposal.

In responding to the questions contained in this letter, please repeat each question before providing your response. **Paginate and date** your response, i.e., each page in its entirety. Information filed after the initial CON application submission (e.g., completeness response letter, prefile testimony, late file submissions and the like) must be numbered sequentially from the Applicant's document preceding it. Please begin your submission using Page 96 and reference "Docket Number: 13-31840-CON." Submit one (1) original and six (6) hard copies of your response. In addition, please submit a scanned copy of your response, in an Adobe format (.pdf) including all attachments on CD. If available, a copy of the response in MS Word should also be copied to the CD.

If you have any questions concerning this letter, please feel free to contact me at (860) 418-7012.

Sincerely,

*S. Lazarus*

Steven W. Lazarus *AV*  
Associate Health Care Analyst

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\*\*\* TX REPORT \*\*\*  
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STATE OF CONNECTICUT  
DEPARTMENT OF PUBLIC HEALTH  
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: Dr. Jennifer Ballew  
FAX: (951) 257-9990  
AGENCY: \_\_\_\_\_  
FROM: Steven Lazarus  
DATE: 6/14/13 TIME: \_\_\_\_\_  
NUMBER OF PAGES: \_\_\_\_\_  
*(including transmittal sheet)*

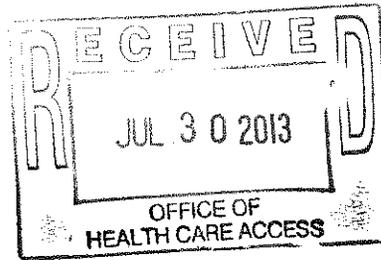


Comments:  
Completeness Letter DIN: 13-31840 - copy Enclosed

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

July 29, 2013

Mr. Steven W. Lazarus  
Associate Health Care Analyst  
State of Connecticut  
Office of Health Care Access (OHCA)  
Department of Public Health  
410 Capitol Avenue MS # 13HCA  
Hartford, CT 06134-0308



RE: Certificate of Need Application, Docket Number 13-31840-CON  
Connecticut Recovery Center, LLC  
Establishment of an Intensive Outpatient Program in Cheshire for Adults

Dear Mr. Lazarus,

Attached please find the response of Connecticut Recovery Center, LLC, to your inquiries related to our Certificate of Need application submitted in May 2013. We hope that you will find our responses to be thorough and comprehensive, but please do not hesitate to contact us if there is any way we can further clarify our proposal.

Thank you and we look forward to hearing back from you soon,

Dr. Jennifer Ballew  
Medical Director and CEO  
Connecticut Recovery Center, LLC  
P.O. Box 429  
Cheshire, CT 06410  
(203) 806-5355

**I. Please provide a discussion and any available supporting information about how the Applicant determined the clear public need for the proposed service.**

**Provide a copy of the business plan for the proposed new facility.**

There is an undisputed and urgent need for both mental health and substance abuse treatment options in our state. As specifically quoted on the first page of section 2 of our original application, the Governor of Connecticut, the Commissioner of the Connecticut Department of Mental Health and Addiction Services, and prominent Connecticut mental health professionals have all spoken publicly in recent months about the pressing need for increased mental health and substance use disorder care in our state. Additionally, Commissioner Rehmer of DMHAS is referenced as pointing out that as of March 2013, the opiate-overdose rate in this state is at an all-time high.

In section 2.a.iii of our original application, we cite two national studies (including the 2010 National Survey on Drug Use and Health, the Substance Abuse and Mental Health Services Administration data from 1999 and 2009), that each reveal a continued and significant rise in opiate dependence over the past two decades and an 80% increase in the number of young adults seeking treatment for opiate dependence. Note, the 80% increase is *not* the increase in patients actually in treatment, but those who are *wanting* to get treatment for their substance use disorder. Specifically, in Connecticut, over 63,000 people meet criteria for addiction to illicit substances and are not receiving treatment. Even more alarming, over 227,000 people in Connecticut meet criteria for alcohol dependence and are not receiving treatment. Please refer to Table 23 of reference #15 from our original application for further detail (page 88 of original application).

On the first page of section 2 of our original application, we referenced the Connecticut Department of Public Health's own fact sheet that underscores the fivefold increase in overdose deaths since 1990.

In section 2.a.iii of our original application, we also cite several news articles pointing out the particular upsurge of opiate dependence in suburban areas.

In section 1.a of our original application, we cited the National Alliance on Mental Illness as reporting "as much as fifty percent of the mentally ill patient population also has a substance use disorder."

Taking all of the above referenced information together, there exists both a growing problem of increasing numbers of patients meeting criteria for mental illness and drug dependence, and a shortage of local mental health and substance abuse treatment facilities to treat all these patients. Additionally, there is an identified rising need for treatment options in non-urban locations. We seek to provide comprehensive mental health and substance use disorder

treatment in a discrete suburban setting that we anticipate will draw in residents from the local area who may not want to venture into more urban settings to seek care.

As initially outlined on the first page of our original application, and subsequently detailed in the following pages, we intend to clinically guide our patients through their recovery process, not simply to help them achieve abstinence, but to progress towards a mental and emotional balance that allows these patients the best possible chance for sustained sobriety and overall well-being. This will be achieved through intensive and frequent therapeutic groups covering a wide range of treatment approaches including process-oriented psychotherapy, coping skills development, stress management, emotional regulation, psychoeducational classes, and relapse-prevention for both mental health and substance use disorders.

Although the majority of our patients will not likely need Buprenorphine-assisted detoxification, we do intend to offer this treatment option for those patients who qualify. This treatment option is further discussed below in our response to question #2 in the Completion letter.

The Connecticut Recovery Center, LLC, Business Plan is included on the following pages:

Connecticut Recovery Center LLC

Business Plan

*Rev: 7/29/13*

Executive Summary

The Connecticut Recovery Center is proposing a new, privately owned and managed clinic that offers both mental health and substance abuse treatment services to a wide age strata in the general public, across Middlesex and New Haven Counties. Our comprehensive behavioral health program will include Intensive Outpatient Programming (IOP), individual medication management, opioid-agonist assisted outpatient detoxing, and family support services. Our focus is to provide cost-effective, quality treatment to individuals who require more frequent and intensive treatment than is typically available on an outpatient basis. Our mission is to create, promote, and maintain a positive customer relationship with our clients, our referral sources, payors, associates and staff, and our community.

The market for behavioral health services is healthy. The undeniable need for more accessible, and more comprehensive, mental health and substance abuse treatments in Connecticut has never been more in the public spotlight than in the past few months. In a press release dated April 9, 2013, Governor Dannel P. Malloy stated, "No one should have to overcome mountains of red tape when they are trying to access mental health services." There is a national push for mental health parity legislation that will require insurance companies to develop benefits for biologically based behavioral health disorders similar to those provided for other medical disorders. This should help sustain the anticipated projected growth.

This business plan provides a map for sustaining growth, expanding revenue collections, and consistently improving our bottom line to produce maximum profit.

## Business Summary and Vision

At the Connecticut Recovery Center, LLC, we plan to provide Intensive Outpatient Programming (IOP) in combination with individual medication management for patients experiencing mental health or addiction symptoms severe enough to be interfering with daily functioning. That is, symptoms severe enough to require a level of care higher than individual outpatient treatment, and without which the patient population would generally experience a much more rapid decline in functioning; hence the need for this higher level of care. Additionally, we plan to offer Suboxone-induction and detoxification to aid in the opiate withdrawal process as it has been shown in numerous studies that the use of an opiate agonist therapy in conjunction with high intensity services like an Intensive Outpatient Program, greatly increases a patient's chances at sustained sobriety.

Services similar to this are available in diverse settings, but not under the direct clinical supervision of any single provider group or treatment center within this catchment area, and are highly needed for this reason. Statistically speaking, within the proposed service area of the Naugatuck Valley, comprised of Cheshire, Meriden, Wallingford, Southington, and Wolcott, there exceeds one hundred ninety thousand adults and adolescents. Nationally, according to the National Comorbidity Survey Replication, conducted by Harvard Medical School and updated as recently as 2007, the lifetime prevalence of serious mental illness for Americans is 57.4%. The same survey found the percentage of Americans who meet criteria for serious mental illness within any given year is 32.4%. According to the Surgeon General's 1999 report on Substance Abuse and Mental Health Services Administration, less than one-third of American adults with diagnosable serious mental illness receive treatment for these conditions, frequently due to lack of convenient access to the appropriate level of mental health care. Even more concerning, according to the National Survey on Drug Use and Health (NSDUH), a mere 7.1% of Americans received appropriate mental health services between 2005 and 2009. It is our intent to markedly improve these statistics within this specific geographical location by making creating an easy to access clinic that offers a

broad base of services. Indeed, based on these statistics, and the population data cited above it is fair to say that within any given year, there are roughly sixty thousand individuals in this immediate vicinity that that may require access to the services we intend to provide in one form or another.

Knowing all of this, our mission and vision is quite simple; to therapeutically guide an under served and under treated population of patients on an outpatient basis; to assist in guiding them back to a standard of living where they can once again be considered a responsible, productive, member of the society from which they came- free of severely impeding mental health and substance abuse symptoms.

### Market Definition

To paraphrase the Diagnostic and Statistic Manual of Mental Disorders, as published by the American Psychiatric Association, mental health and substance abuse disorders vary in intensity but contain some consistent criteria as it relates to the market seeking to be served by The Connecticut Recovery Center, LLC. Whether the condition is of strict mental health criteria, exists with a co-morbid substance abuse problem, or involves substance abuse as a stand alone diagnosis, leaving patients suffering from these conditions undiagnosed and untreated leads to inevitable worsening of symptoms. In fact, because the mental health population in the United States is typically quite underserved, these types of psychiatric conditions often exacerbate to a degree which necessitates urgent intervention, and it is this specific market that will be the main source of revenue for our proposed services.

Furthermore, to speak to the financial viability of our services, our clinic will stand apart from other mental health facilities within Connecticut in that we will not be treating patients who are insured through Medicaid or Medicare. Patients insured through either of these sources are significant in number and due to the chronicity of their mental health and substance abuse issues have over clogged an already overburdened mental health system, normally usurping between thirty to fifty percent of services offered at

clinics within urban settings and outside urban settings. To further compound issues surrounding Medicare and Medicaid patients, the reimbursement of these insurances amounts to less than a quarter of that paid by commercial or self pay patients- normally requiring clinical service providers to operate at a financial loss for every Medicare or Medicaid patient treated. As an example, the present reimbursement rate for Medicaid is 49.5% of billed charges, and physician fees can not be billed independently. In opposition to this a typical IOP day for a patient with commercial insurance, or paying out of pocket, is charged at \$250 per patient, with medication evaluations billed independently at an average cost of \$150. The difference in reimbursement is stark, and it is the financial reason that our market will be limited only to commercially insured or patients paying for their care out of pocket. The attached proforma is based on this model.

Among these two markets- those insured by Medicare and Medicaid versus those whom are commercially insured or self pay, it is important to also note the implication that there are clear class differences between these two subsets of patients. Our market, being one that targets the latter patient subset as opposed to the former, will focus its clinical programming on particularly working class individuals as well as individuals who have the financial means to support paying out of pocket for their treatment. By limiting our patient and payer mix to these patients, we will be setting forth a treatment setting that is both financially viable, but also tailor our treatment to the specific issues facing this patient population that is typically not fully addressed in a 'community based' (Medicare/Medicaid patient setting) because of the social limitations that the 'community based' clinics tend to tailor their treatment too. In summation, our geographical location as well as our payer mix will differ greatly from most other systems, and be more financially stable.

### Description of Services

The three primary sources of revenue for the Connecticut Recovery Center will be 1) daily Intensive Outpatient Program group therapies, 2) ongoing medical and psychiatric services, and 3) Buprenorphine agonist-assisted opioid detoxification and maintenance

services. The Connecticut Recovery Center will receive the bulk of its financial revenue from co-pays and reimbursements from commercial insurance companies.

### **Intensive Outpatient Program**

The Intensive Outpatient Program (IOP) offered by the Connecticut Recovery Center will be a comprehensive and formally-structured multidisciplinary treatment approach for mental illness and substance use disorders. We view both primary mental illness and chemical dependency as medical abnormalities which, if left untreated, can be progressive and often fatal. Our program is designed to provide supportive and solution-oriented interventions tailored to the needs of individual patients. The intensity, focus and length of individual treatments will be proportionate with the client's needs at any given point of care. Our program will support and foster healthy and responsible changes in behavior that can lead to healthier lives for the patient, their families and those in the community.

The program consists of 3-5 treatment days per week and occurs over a 6-12 week period. Each treatment day is composed of three hours of intensive evidenced-based group therapies, each lasting one hour. On any given treatment day, these may include cognitive-behavioral therapy (CBT), dialectical behavioral therapy (DBT), process-oriented recovery groups, skill development groups, relapse prevention strategization groups, or interpersonal insight-oriented group psychotherapy. Although each of the three groups conducted each day will have a specific focus and curriculum, the overall goals of each group are the same. Specifically, we aim to provide a therapeutic venue for group leaders to transmit new information, teach new skills, and guide patients via their individualized treatment plans as they practice new behaviors and introduce appropriate structure and discipline into their daily lives. We will establish a safe and comfortable therapeutic milieu in which patients help, support, and when indicated, confront one another, thereby allowing group interactions to advance individual recovery. This will be accomplished, in part, by providing opportunities for patients to develop communication skills and participate in socialization experiences; this is particularly

useful for individuals whose socializing has previously revolved around using drugs or alcohol.

We will utilize an open-ended heterogeneous group therapy model that provides clinicians the flexibility of assigning new clients to ongoing groups. Individual patients progress towards recovery at different rates and therefore it is difficult to move an entire group along in their treatments at a pre-set pace. With the patient census often in flux from week to week, given the inherent variability in patient response to treatment, the flexibility of this open-ended heterogeneous group model permits immediate responsiveness to individual patient needs. Group members will have varying degrees of recognition and acceptance of their problems, and those on the road to recovery offer hope to those just beginning the process.

We plan to build the program gradually over the few years from one track up to three or more tracks. Each track will have a particular focus (mental health, substance dependence, or co-occurring disorders) and will provide services for up to 10 patients at any given time. We will start with a track specifically tailored to patients suffering from Substance Use Disorders because, in the United States, and in this specific targeted community, almost twice as many people abuse prescription medications than the number who abuse illicit substances.

The second track, which will be made available within 9-15 months of operation, will be for patients suffering from co-morbid substance abuse and mental health conditions - frequently referred to as a dual diagnosis or co-occurring disorders track. This track will also fill a substantial need within the community, as according to the National Alliance on Mental Illness (NAMI), as much as fifty percent of the mentally ill patient population also has a substance use disorder. The focused curriculum of this track will overlap significantly with that of the Substance Abuse track, but will also focus heavily on emotional regulation, mental illness symptom identification and management, and understanding the correlations between substance use and mental illness symptomatology.

In the months following the establishment of the dual diagnosis track, we will add a third track targeted towards the needs of patients diagnosed exclusively with mental health conditions (ie, no identified substance use disorders). This track will focus, in large part, on cognitive behavioral approaches to making healthy, positive lifestyle and behavioral changes to promote overall improvement in daily functioning.

Our first track, the Substance Use Disorders track, will be co-facilitated by the medical director of Connecticut Recovery Center, Dr. Jennifer Ballew, and our senior clinicians, Douglas Thompson, LCSW, and Kristin Olsen, LADC. Dr. Ballew, Mr. Thompson, and Ms. Olsen all have extensive experience in treating patients with severe mental illness and/or substance use disorders, in both individual and group therapeutic settings. As we add in the additional clinical tracks, we will hire other licensed behavioral health professionals with experience in group-based treatment approaches to provide clinical coverage across all active tracks.

### **Psychiatric and Medical Services**

Pharmacotherapy and other medical management are critical adjuncts to effective mental health and substance abuse treatment. As Medical Director of the Connecticut Recovery Center, Dr. Ballew will render psychiatric and other medical services to adults and adolescents within the greater targeted community. These comprehensive psychiatric services include thorough initial psychiatric assessments, mental status examinations, ordering and interpretation of relevant lab work, psychotropic medication management, referrals to physicians specializing outside the discipline of psychiatry and substance dependence, and other basic psychiatric services. When clinically warranted, Dr. Ballew will offer couples and/or family therapy sessions to assist a patient through a particularly difficult emotional or behavioral crisis.

For patients with known or suspected substance use disorders, Dr. Ballew will evaluate and determine whether chemical detoxification is medically necessary prior to starting Intensive Outpatient Programming. She will also order and direct the use of screening measures such as urine toxicology testing and Breathalyzers for individuals suspected

to be under the immediate influence of addictive substances. In some cases of alcohol and/or opioid dependence, medication-assisted may be utilized in helping to alleviate cravings and avoid relapse.

Each patient at the Connecticut Recovery Center will be seen by Dr. Ballew for a comprehensive psychiatric assessment prior to initiating treatment in our Intensive Outpatient Program. After starting in the IOP, each patient will be seen by Dr. Ballew at least once per week for ongoing psychiatric care and, when clinically indicated, medication management. Patients who are undergoing aggressive medication changes or who are experiencing significant adverse effects will be seen by Dr. Ballew more than once per week until clinically stabilized.

As the clinic further develops, Dr. Ballew will seek to hire additional board-certified psychiatrists and other licensed medical personnel that will expand the practice organically through increased patient flow.

### **Agonist-Assisted Opioid Detoxification and Maintenance**

Patients who are chronically and physiologically dependent on opioids may be eligible for therapy with a buprenorphine, a semi-synthetic opioid. Buprenorphine acts as a partial agonist at endogenous *mu* opioid receptors in the human body. This means that buprenorphine can bind to naturally-occurring *mu* receptors in the same manner that an opioid, such as heroin or morphine, but will not produce the same degree of opioid-typical responses. Thus, at low doses, buprenorphine produces sufficient agonist effect to enable opioid-addicted individuals to discontinue the misuse of opioids without experiencing severe withdrawal symptoms. The agonist effects of buprenorphine increase linearly with increasing doses of the drug until, at moderate doses, they reach a plateau. This "ceiling effect" protects against the potentially fatal respiratory depression that can occur with overdose of full opioid agonists. Thus, buprenorphine produces enough opioid receptor stimulation to avoid withdrawal symptoms, but not enough to create an opioid "high" or to cause death by respiratory distress. Additionally,

there is no evidence of significant disruption of cognitive or psychomotor performance with buprenorphine, making this an ideal agent for detoxification from opioids of abuse.

Treatment with buprenorphine consists of four distinct phases: induction, stabilization, maintenance and detoxification. The induction phase requires intensive medical monitoring for the first 24-72 hours after starting the treatment. Stabilization can usually be effectively accomplished with one or two outpatient medical appointments per week, and maintenance occurs once the patient's buprenorphine dose is steady and the patient is no longer abusing opioids. Detoxification from buprenorphine is the opposite of induction and involves an intensive medically monitored taper off the medication, usually occurring over several weeks with frequent medical visits.

Due to the requirements for frequent medical supervision of the administration of this medication, the Drug Enforcement Administration has classified buprenorphine as a Schedule III Narcotic. The Drug Addiction Treatment Act of 2000 requires that eligible licensed physicians must first undergo additional specialized training before they can apply for a waiver allowing them to practice medication-assisted opioid addiction therapy with buprenorphine. Dr. Ballew has undergone this specialized training and has been granted approval to practice buprenorphine-assisted treatment of opioid dependence. We do not intend to store, sell or administer the buprenorphine on site, but if Dr. Ballew finds it is clinically warranted for a particular patient to be started on buprenorphine, she will write a prescription for the patient to have filled at a local pharmacy. The patient will then bring the medication back to our office for medical monitoring during the induction phase.

### Organization and Management Structure

The Connecticut Recovery Center LLC has been envisioned as a split corporate ownership enterprise between Jennifer R. Ballew (75%) and Mark A. Lanz (25%). Our stress will be on the safe, confidential, and discreet treatment of patients in the most efficient manners possible, with great focus on tailoring treatment to meet the needs of

the individual being treated. Jennifer Ballew, DO, PHD, will be the Chief Executive Officer and Director of Medical Operations. Dr. Ballew has over 10 years direct experience working with both the mentally ill and chemically dependent patient populations. Since 2009, she has served as Medical Director of the Yale New Haven Hospital Adult Partial Hospital Program (formerly the Hospital of St. Raphael Partial Hospital Program), where she oversees the delivery of mental health care and substance dependence treatment for patients identified as requiring more than basic outpatient level of care. Dr. Ballew supervised the clinical growth of this program from one evening track to six intensive daytime clinical tracks (Mental Health, Co-Occurring Disorders and Substance Abuse tracks in the Partial Hospital Program, and Mental Health, Co-Occurring Disorders and Substance Abuse tracks in the Intensive Outpatient Program). Previously, Dr. Ballew has served as a Principal Psychiatrist for the State of Connecticut in the Department of Mental Health and Addiction Services and as an attending psychiatrist at the Yale University School of Medicine. Additionally, Dr. Ballew has served as an Assistant Clinical Professor of Psychiatry for the Yale University School of Medicine since 2006.

With respect to administrative and financial duties, Mark A. Lanz will be seated as the Chief Financial Officer. Drawing on his years of experience as the co-founder of a successful start-up company, Broadstripes, LLC, Mr. Lanz will manage our daily operations, billing, collections, and financial negotiations.

Our operations agreement, simply sketched, is proposed as the following:

**Jennifer R. Ballew**

- To develop intensive outpatient clinical programming appropriate to treating substance abuse, dual diagnosis, and mental health disorders
- To provide supervision and oversight of all individualized treatment planning for each patient admitted to the intensive outpatient program
- To provide individual medication management for patients treated at the intensive outpatient level of care

- To provide Suboxone assessment, induction, and ongoing maintenance for agonist therapy patients
- To provide and secure all personal licensure to provide medical and clinical services at the Connecticut Recovery Center LLC
- To provide medical and clinical oversight to all medical and/or clinical staffing
- To manage contract engagement with managed care companies on an annual basis
- To maintain all facility based licensure, to include records related to compliancy issues

### **Mark A. Lanz**

- To manage and ensure that all facility based operational issues are addressed in a timely manner and are seen through to resolution
- To maintain all financial invoice to payment reconciliation
- To ensure timely payment of all creditors as well as lease and utility payments
- To maintain monthly income and expenditure reporting
- To market all programming to both individual and facility in an effective manner
- To monitor growth of programming, and provide data analysis on patient populations
- To assist in planning and program development as it relates to financial feasibility
- To build and maintain claim payment systems

### Marketing and Referral Strategy

The mental health landscape that we are creating will contain a patient population driven largely by family referrals, EAP referrals, and community based referrals. We fully expect that the patients referred to our services will be sent to us by families concerned for their loved ones, employees who have been sent for treatment by their

employers, and patients referred by locally based psychiatrists, psychotherapists, and substance abuse counselors. Additionally, we are anticipating that local hospital emergency departments will refer patients to our services who have been assessed psychiatrically as not meeting criteria for inpatient services, but meeting criteria for a level of care higher than simply outpatient therapy and medication management.

With this in mind, the Connecticut Recovery Center, LLC intends on using a number of marketing strategies that will allow the Medical Practice to easily target men, women, and families within the target market. Our direct marketing campaign will begin with printed educational materials that will be sent to every psychiatric clinician and primary health care providers local to our services whom are also contracted with the managed care networks that we contract with, describing our clinical services and target patient population in detail. This will facilitate understanding and awareness of what we offer clinically, and why the Connecticut Recovery Center is better suited to treat their patients than any other local behavioral health or substance abuse programs. This same direct marketing campaign will be carried out with local EAP programs, here with an emphasis on our focus of clinical discretion and judgment-free delivery of care.

In addition, the Connecticut Recovery Center will implement an internet-based marketing strategy. This is very important as many people who are seeking local health care services, including both the general public and potential referring clinicians, now use the Internet to conduct their preliminary searches. We will register the Connecticut Recovery Center with online portals so that potential customers can easily access our online website.

### Financial Management / Revenue Statement

Financial management in a clinical environment is multi layered, and the attached proforma and treatment projections reflect this. The average reimbursement for IOP services among surveyed insurance payors (Cigna, Anthem Blue Cross, Aetna, and United Behavioral Health) is two hundred and fifty dollars per treatment day, per patient

(reflected in row 8). As made mention of earlier, we will not be accepting Medicaid- or Medicare-insured patients. Notably, this reflects only the payment associated with one patient on each treatment day in IOP. We have been conservative in this measure on our pro forma assuming an average daily census of six patients, while we will have the capacity to treat twelve patients per track at this level of care.

The second treatment projection is for weekly medication management visits with a psychiatrist. Patients in an Intensive Outpatient Program are able to medically managed much more aggressively than in a typical outpatient level of care, and thus need to be personally examined by a physician more frequently. Again our pro forma reflects the going rate reimbursed by several commercial payors, which is one hundred and fifty dollars per visit, per patient, per week. We were again conservative in our estimates, assuming that not every patient will make every scheduled weekly visit.

The third treatment projection is related to Buprenorphine agonist-assisted opioid detoxification and maintenance therapy. As this is a highly specialized area of care, and requires the prescribing psychiatrist to have specific approval granted by the Center for Substance Abuse Treatment (CSAT, a division of the Substance Abuse and Mental Health Services Administration), as well as a second prescriber identification number issued by the Drug Enforcement Administration (DEA) allowing the prescription of Schedule III Controlled Substances, the rates are higher than for more typical types of outpatient medication management. We again surveyed the four prominent commercial payors referenced above, and obtained typical rates for both Buprenorphine induction (between three and four hundred dollars per induction per patient) and for follow-up buprenorphine medication visits (generally around one hundred eighty dollars per patient, per visit).

On the expense side of the equation, by far our largest cost will be labor. We plan to start small, with the barest minimum number of clinicians needed to provide excellent care to our patients. A standard Intensive Outpatient Program generally has twelve patients per group treatment. We estimate that it will take us approximately one year to

consistently have twelve patients attending every single day of each week. The Medicare standard of care is a ratio of one clinician per twelve patients. Thus, we will only need to hire one clinician to cover each track, and will not hire additional staff until we are definitely growing steadily enough to open a second track. Clinicians will be hired on a part-time contract basis and paid only for services provided (ie, no benefits). The only employees working directly for the company (ie, not contracted on a fee-for-service basis) will be the CEO and CFO, thus keeping costs for benefits and other fringe at a minimal amount.

After labor, our only other significant costs will be rent and office supplies.

**2. Provide specific articles and studies and relate them to why the Applicant has chosen suboxone as its treatment of choice.**

To clarify, the Connecticut Recovery Center intends to offer Suboxone-assisted treatment as one of several treatment approaches, not specifically as a "treatment of choice" since each patient will need to be assessed carefully and individually to determine what treatment options are warranted for the individual patient. In fact, we anticipate that the vast majority of our patients will *not* be appropriate candidates for Suboxone-assisted treatment. Our initial estimates, based on conversations with other local Suboxone providers (private practitioners, not Intensive Outpatient Programs), is that we will have 2-3 patients on Suboxone per month.

For the patients in our facility who do meet criteria for Suboxone-assisted treatment, as outlined by the United States Substance Abuse and Mental Health Administration (SAMHSA), we intend to evaluate the patients in the office and write prescriptions as clinically warranted. Patients will then have these prescriptions filled at the local pharmacy of their choice. We will not store, administer or sell Suboxone (or any other pharmacologic agent) at our facility.

During the initial Suboxone induction, patients will be instructed to have the prescription for Suboxone filled at a local pharmacy and then return to our facility for clinical evaluation after they have ingested the medication. This is the typical treatment scenario for Suboxone-certified prescribers and is recommended by SAMHSA.

We are attaching a journal review of buprenorphine-assisted treatments, published in the Cleveland Clinic Journal of Medicine in June 2013, which outlines very explicitly why Suboxone (a combination of buprenorphine and naloxone) should always be considered as a potential treatment option for opiate-dependent individuals. The authors, Dr. Jason Jerry and Dr. Gregory Collins, thoroughly reviewed all of the major national and international published studies on approaches to opiate addiction, including abstinence-only, methadone maintenance, and buprenorphine-naloxone assisted treatments. The key findings of this review, summarized on the first page of the paper, include:

- opiate addicts are less likely to relapse when treated with either Methadone or Suboxone as part of their therapeutic treatment plan

- patients taking methadone or buprenorphine are higher functioning and less preoccupied with opiates as the central focus in their lives compared to opiate-addicts not in substance abuse treatment

- Buprenorphine, unlike Methadone, can be prescribed by a private physician and can be obtained at most local pharmacies for up to a 30-day supply. This allows significantly more privacy and confidentiality to those seeking treatment. The reason Suboxone can be prescribed in this manner, and methadone cannot, is due to the favorable safety profile of Suboxone. Due

to its ceiling effect and poor bioavailability, Suboxone is far less likely to cause respiratory depression than is methadone, and is therefore rarely associated with fatalities from overdoses.

- all recovering addicts, whether prescribed Suboxone or not, need to participate in a full spectrum of recovery-oriented treatments including 12-step recovery groups, skill-building for relapse prevention, and, in some cases, psychotherapy

This review article, published one month after the Connecticut Recovery Center submitted its original Certificate of Need application, completely reinforces the treatment philosophy we intend to manifest. That is, a comprehensive approach to both mental health and substance use disorders that considers the individual patient's needs in the context of all available medical evidence.

## REVIEW



**EDUCATIONAL OBJECTIVE:** Readers will consider a medication-assisted treatment program for patients addicted to opiates

**JASON M. JERRY, MD\***  
Alcohol and Drug Recovery Center, Cleveland Clinic; Clinical Assistant Professor of Medicine, Cleveland Clinic Lerner College of Medicine of Case Western Reserve University, Cleveland, OH

**GREGORY B. COLLINS, MD**  
Section Head, Alcohol and Drug Recovery Center, Cleveland Clinic

# Medication-assisted treatment of opiate dependence is gaining favor

## ABSTRACT

People addicted to opiates are more likely to avoid returning to these drugs if they participate in a program that includes taking maintenance doses of methadone or buprenorphine than with an abstinence program. Although medical opinion has long been divided on the issue of abstinence vs medication-assisted treatment, the latter seems to be gaining respect as an evidence-based approach.

## KEY POINTS

Recidivism rates are high after detoxification without medication-assisted treatment.

Whether staying in a maintenance program truly constitutes recovery continues to be debated, but patients on methadone or buprenorphine maintenance do not report getting "high"—they merely feel normal.

Methadone is dispensed only in special clinics, whereas buprenorphine can be prescribed by a physician. Prescribing physicians must complete an 8-hour course online at [www.buppractice.com](http://www.buppractice.com) or [www.aaap.org/buprenorphine](http://www.aaap.org/buprenorphine) and obtain a waiver from the US Drug Enforcement Administration.

With or without medication-assisted treatment, recovering addicts must learn the skill of sober coping by actively participating in a solid 12-step-based program and, in some cases, in psychotherapy.

\*Dr. Jerry has disclosed consulting, teaching, and speaking for Reckitt Benckiser Pharmaceuticals.

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EXPERTS HAVE ARGUED for decades about how best to manage opiate dependence, with practitioners generally subscribing to one of two strategies: either total abstinence or medication-assisted treatment (MAT).

Although MAT has proven efficacy, it has been slow to gain acceptance, and the gold standard of care since the 1930s has been abstinence-based treatment. Among elite institutional holdouts against MAT was the Hazelden Treatment Center, a leading treatment institution and publishing house that had been wedded to the abstinence model since it was founded in 1949.<sup>1</sup> Now, Hazelden has gone on record as embracing MAT, raising the possibility that the two predominant treatment philosophies for opiate-dependent patients may no longer be at odds.

## FROM ABSTINENCE TO METHADONE MAINTENANCE

The modern day abstinence-based movement in this country started in the decade before the founding of Hazelden. In 1935, the US government opened the first of two federal drug treatment centers, known as the United States Narcotic Farm, in Lexington, KY.<sup>2</sup> The move by the government to get into the addiction treatment business largely stemmed from frustration over the growing problem of addiction at that time, coupled with a dearth of treatment options for addicts in the wake of the 1914 Harrison Narcotics Act.

The Narcotic Farm was an impressive facility—for all intents and purposes, a specialized prison—that initially housed 1,200 people. In addition to prisoners, it also accepted voluntary, nonprisoner patients. In many ways, it

was ahead of its time. It offered a wide variety of services, including detoxification, group therapy, individual therapy, psychiatric and medical services, and vocational rehabilitation.<sup>2</sup> Housed on the premises was the Addiction Research Center at Lexington, the first intramural research branch of the National Institute of Mental Health. After the "Blue Grass" mandatory commitment laws were passed in the 1940s, even the voluntary patients were ultimately committed for a 1-year sentence at Lexington. This facility, and its sister facility in Ft. Worth, TX, would have been the envy of any modern-day abstinence-based treatment center in terms of the services offered and the long lengths of stay.

The quality of the program, as evidenced by the impressive array of services and long stays, would lead one to expect that its treatment outcomes over nearly 40 years of operation were equally stellar. However, in terms of outcomes the Farm was an abysmal failure, as shown by numerous studies demonstrating relapse rates of more than 90% in the patients discharged from it.<sup>2,3</sup>

Similar frustrations at other abstinence-based treatment centers from the 1940s through the 1960s led Dr. Vincent Dole, the "father of methadone maintenance," to conclude in 1971 that after detoxification from opiates, "human addicts almost always return to use of narcotics after they leave the hospital where they have been detoxified."<sup>4</sup> That realization inspired Dr. Dole and his wife and colleague Dr. Marie Nyswander to revisit the idea of medication-assisted treatment, an approach previously used by the morphine maintenance clinics of the early 1900s. This work led to the development of government-sanctioned methadone clinics across America and to the realization that long-term recovery was possible with medication, even without a lengthy hospital stay. For this revolutionary work on opiate addiction, Dr. Dole won the prestigious Lasker Award in 1988.

The major reason for the success of methadone was that, because of its pharmacokinetic profile, it could stabilize the patient through once-daily dosing without sedation or narcosis. As noted by Dr. Dole, once patients are on a stable dosing regimen, the obsessive preoccupation with drug use fades away.<sup>5</sup>

Despite its success, methadone maintenance had its share of detractors. It was fraught with controversy because it was viewed as a crutch, and those who were on it were often not considered by their abstinent peers as being in true recovery. The reasons for the negative attitudes toward MAT are unclear but may reflect antiquated beliefs that addiction may be indicative of a failure of morals or will, and that patients ought to be able to simply stop using.

Whatever the reason for the animosity surrounding MAT, it should be noted that an expert consensus panel convened by the Betty Ford Center in 2007 agreed that patients on MAT met their consensus definition of sobriety.<sup>6</sup> The issue of what constitutes recovery remains a very complex and hotly debated topic that is beyond the scope of this paper and that has been discussed elsewhere.<sup>6,7</sup>

For more than 3 decades, methadone was the only medication available for MAT. Federal regulations limit the dispensing of methadone to licensed clinics, most of which are located in major metropolitan areas. Patients must go to the clinic every day to receive their dose of methadone—a major inconvenience, especially to those with transportation issues. Adding to the lack of appeal of methadone maintenance is that the clinics are typically located in the higher-crime areas of cities. Savvy drug dealers know the location of these clinics and often loiter on nearby street corners in an attempt to lure addicts away from recovery by flaunting their illicit drugs.

A final, very significant drawback of methadone is its safety profile. It is a full-agonist narcotic that can be fatal in overdose or in the induction phase, especially if taken with other drugs, such as benzodiazepines.

### ■ 2003: BUPRENORPHINE-NALOXONE IS APPROVED

Such concerns led researchers to search for other medications to be used for MAT that could perhaps be prescribed in a typical outpatient physician practice. For many reasons, buprenorphine became the most promising candidate. In 2003, the US Food and Drug Administration approved the combination medication buprenorphine-naloxone (Sub-

The Narcotic Farm was an impressive facility—for all intents and purposes, a specialized prison

oxone) as only the second drug indicated for maintenance treatment of opioid dependence in the United States.

Buprenorphine differs from methadone in that it is a partial agonist at mu opiate receptors, and therefore has a “ceiling” or “plateau” effect in terms of dose-response and a much improved safety profile. Unlike methadone, buprenorphine can be prescribed in a doctor’s office and does not have to be dispensed at a government-approved clinic.

Unfortunately, buprenorphine-maintained patients seem to carry the same stigma in the recovery community as those maintained on methadone—that they are simply substituting one drug for another. Detractors usually fail to consider that, as with methadone, patients do not report getting “high” from taking buprenorphine. Patients will often state that when they first start taking it, they “feel something,” but after a few days of adjustment, they simply feel normal. They don’t feel high, they are no longer in withdrawal, their cravings are virtually eliminated, and their opiate receptors are effectively occupied and blocked, so there is no “high” in the event of a relapse.

What’s more, buprenorphine is not a medication that will help them deal with life’s stressors by “chemical coping.” Sober coping is a skill they must learn by actively participating in a solid 12-step-based recovery program and, in some cases, in psychotherapy. By removing the drug obsession, buprenorphine promotes and facilitates the important recovery goal of learning how to deal with life on life’s terms.

■ ADDICTION AS CHRONIC ILLNESS

Outcomes studies of addiction treatment have focused largely on rates of relapse after discharge from acute treatments such as residential rehabilitation, partial hospitalization, and intensive outpatient programs. With MAT, however, outcomes research has primarily looked at the duration of retention in treatment.

The change in focus between the two types of treatment coincides with a paradigm shift that views addiction as a chronic condition that requires ongoing care. Continued participation in prescribed care with demonstrated efficacy is considered to be the major indicator of success. Under the chronic illness model

employed by MAT providers, if a patient reverted to briefly using a drug of abuse, this would be an issue to address in his ongoing treatment and would not necessarily indicate treatment failure as with the acute care model. Beyond retention rates, research has demonstrated that MAT with methadone results in reductions in rates of criminal activity, illicit drug use, acquisition of human immunodeficiency virus, and overall mortality.<sup>8-10</sup>

In outcomes studies, MAT has repeatedly shown better efficacy than abstinence-based approaches. During the first 5 years of its implementation, in 4,000 patients, methadone maintenance boasted 1-year retention rates exceeding 98%.<sup>11</sup> Over the subsequent 3 years, with the number of patients approaching 35,000, the 1-year retention rates fell to around 60%—still far exceeding results of abstinence-based treatment and approximating the number cited in most modern studies.<sup>11</sup>

The retention rates in buprenorphine programs are similarly promising. Studies of 12 to 13 weeks duration have shown retention rates of 52% to 79%.<sup>12-15</sup> Six-month studies have demonstrated retention rates of 43% to 100%.<sup>16-19</sup> Another study showed that 38% of opiate-dependent patients remained in treatment with buprenorphine at 5 years.<sup>20</sup> Surprisingly, most of the buprenorphine studies have been conducted in office-based practices, which are less structured than outpatient methadone programs.

■ MEDICATION-ASSISTED TREATMENT IS GAINING ACCEPTANCE

Data from decades of experience with MAT strongly support the conclusion that it is superior to abstinence-based approaches.

The importance of a patient staying in treatment cannot be overemphasized, as the consequence of failing in recovery may well be an early death. On average, heroin addicts lose about 18 years of life expectancy, and the mortality rate for injection users is roughly 2% per year.<sup>21</sup> The mortality rate for heroin users is 6 to 20 times greater than for age-matched peers who are not drug users.<sup>22</sup>

As high as these numbers are, they are even higher for abusers of prescription narcotics. The annual death rate associated with opi-

Although medication-assisted treatment has proven efficacy, it has been slow to gain acceptance

## OPIATE DEPENDENCE

oid pain relievers (4.8 per 100,000) is nearly double that associated with illicit drugs (2.8 per 100,000).<sup>23</sup>

The recent and rather radical change in treatment philosophy by Hazelden came as a shock to some, a disappointment to others, and a welcome change to many who saw this as a move by one of the more respected treatment centers in the country to fall in line with the body of evidence that supports MAT for those suffering from opiate dependence. It remains a mystery why so many, if not most, addiction treatment centers in the United States cling to the abstinence-based philosophy despite the overwhelming data from decades of research and experience that show that abstinence does not work for the majority of opiate addicts.

Complete abstinence from opiate drugs of abuse and potentially addictive medications is a noble but perhaps unreachable goal for many sufferers. Hazelden's announced acceptance of MAT gives credence to the value of recovery goals that are not entirely drug-free.

Dr. Dole was correct in stating that opiate addicts usually return to drugs if not provided with MAT. Treatment programs need to inform opiate-dependent patients that abstinence-based treatment offers only a 1 in 10 chance of success. Perhaps some patients, armed with the daunting statistics regarding abstinence, will be inspired to devote themselves wholeheartedly to their recovery in an effort to make it into that elite 10% group that achieves long-lasting recovery without the aid of medications. But for the other 90%, it is encouraging to hear that Hazelden, the model treatment center for most abstinence-based programs in this country, may now lead other abstinence-based centers to reconsider their treatment philosophies.

Historically, US doctors were not allowed by federal law to prescribe opiates for addiction treatment. With the passage of DATA 2000, buprenorphine (alone or in combination with naloxone) can be prescribed for addiction treatment only by providers who obtain a waiver from the US Drug Enforcement Administration (DEA). Any doctor can become qualified to prescribe buprenorphine or buprenorphine-naloxone after completing an 8-hour online training course (available at [www.buppractice.com](http://www.buppractice.com) and at [www.aaap.org/buprenorphine](http://www.aaap.org/buprenorphine)) and

by obtaining a DATA 2000 waiver and a new prescribing number from the DEA. Doctors are initially limited to treating only 30 patients with buprenorphine-naloxone at any given time, but can apply for an extension to 100 patients after having had their waiver for 1 year.

As MAT continues to gain favor, demand will grow for more providers to obtain their waivers to prescribe buprenorphine and buprenorphine-naloxone. Historically, there have always been too few methadone clinics to meet the demand. One can hope that the growing number of waived providers will greatly improve access to care by opiate addicts, no matter where they reside. Qualified prescribers of buprenorphine and buprenorphine-naloxone are limited by the federal restrictions on the numbers of patients they can treat. If the chronic disease of addiction is to be integrated into the continuing-care approach of modern medicine and managed alongside other chronic diseases, primary care providers who are not specialized in treating addiction will need to become comfortable with maintaining patients on buprenorphine-naloxone.<sup>7</sup> Presumably, such patients will have already been stabilized through participation in addiction treatment programs in their respective geographic areas. Primary care providers will need to develop relationships with local addictionologists and treatment programs so that they will be able to refer those in active addiction for induction and stabilization on MAT and will be able to refer those already stabilized on MAT back to such specialists when relapses occur.

We may finally be approaching a time when structured residential treatment and MAT are not mutually exclusive options for our patients. These treatment options must work together for optimal outcomes. Based on our experience with hundreds of patients at Cleveland Clinic's Alcohol and Drug Recovery Center, we believe this change of treatment philosophy is long overdue. In clinical settings, patients do not fit cleanly into one treatment arm or another and often require a blended approach to effect long-lasting change. Hazelden's shift of treatment philosophy is an indication that this research-supported viewpoint is gaining acceptance in the traditionally drug-free halls of addiction treatment programs. ■

**Heroin addicts lose about 18 years of life expectancy, and the death rate for injection users is roughly 2% per year**

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### **3. Identify the Applicants referral base and provide evidence.**

The mental health landscape that we are creating will contain a patient population driven largely by family referrals, EAP referrals, and community based referrals. We fully expect that the patients referred to our services will be sent to us by families concerned for their loved ones, employees who have been sent for treatment by their employers, and patients referred by locally based psychiatrists, psychotherapists, and substance abuse counselors. Additionally, we are anticipating that local hospital emergency departments will refer patients to our services who have been assessed psychiatrically as not meeting criteria for inpatient services, but meeting criteria for a level of care higher than simply outpatient therapy and medication management.

In our original Certificate of Need application, we included letters of attestation written by two psychiatrists, Dr. Nicholas Mellos and Dr. Daniel Mundy, who are very familiar with the needs for both mental health and substance use disorder treatment options in this area. As both physicians attested, there is a definite need for these services in the specified area and local providers are always looking for appropriate referral options for their patients requiring an intensive, yet outpatient, level of care.

With this in mind, the Connecticut Recovery Center, LCC intends on using a number of marketing strategies that will allow us to easily target men, women, and families within the target market. Our direct marketing campaign will begin with printed educational materials that will be sent to every psychiatric clinician and primary health care providers local to our services whom are also contracted with the managed care networks that we contract with, describing our clinical services and target patient population in detail. This will facilitate understanding and awareness of what we offer clinically, and why the Connecticut Recovery Center is better suited to treat their patients than any other local behavioral health or substance abuse programs. This same direct marketing campaign will be carried out with local EAP programs, here with an emphasis on our focus of clinical discretion and judgment-free delivery of care.

In addition, the Connecticut Recovery Center will implement an internet-based marketing strategy. This is very important as many people who are seeking local health care services, including both the general public and potential referring clinicians, now use the Internet to

conduct their preliminary searches. We will register the Connecticut Recovery Center with online portals so that potential customers can easily access our online website.

**4. What specific licenses will the Applicant be seeking from the State of Connecticut?**

If our requested Certificate of Need is approved, the Connecticut Recovery Center will be applying for facility licenses from the Connecticut Department of Public Health for both Mental Health Day Treatment and Substance Abuse & Dependence Facility.

As we do not intend to store or administer Suboxone (or any other pharmaceuticals), we will not be pursuing any licensure related to the storage or administration of medication.

Of course, all of our individual clinical staff will be responsible for keeping their respective licenses and certifications up-to-date as authorized by the State of Connecticut. This is further discussed in our response to question 18 from the Completion letter.

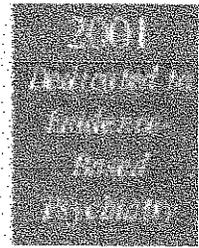
**5. Please explain why the Applicant chose the three tracks of treatment. Provide supporting evidence such as Best Practices or Evidence Based Medicine.**

We intend to offer three types of Intensive Outpatient Programs: one for substance abuse treatment (ie, people who are currently primarily struggling with addiction), one for mental health treatment (ie, people with a diagnosed mental illness who do not also have a substance use disorder) and one for people who have been diagnosed with both mental illness and substance use disorders.

It has long been known within the mental health community that co-occurrence of psychiatric illness and substance dependence is quite common. In fact, according to the 2010 National Survey on Drug Use and Health, over 50% of people diagnosed with a mental illness also suffer from at least one substance use disorder, and approximately 65% of people with a substance use disorder also have at least one diagnosed mental health disorder. Traditionally, patients have had to seek separate treatments for their mental health and substance use disorders. This has led to significant fragmentation of treatments and frequent gaps in one or both aspects of the needed treatment. Thus, an integrated system for simultaneously treating both types of disorders was developed and has been extensively studied over the past 25 years (please see attached review by Drake *et al.*, 2001).

The efficacy of these "co-occurring disorders" programs has been so effectively established that multiple states, including Connecticut, have adapted and implemented policies and procedures in ensure that these types of treatments are offered to all eligible patients (please see attached DMHAS Commissioner's policy and competencies). Similarly, the National Alliance on Mental Illness (NAMI) has issued a statement (attached) endorsing the need for specialized co-occurring disorders treatment.

# Implementing Dual Diagnosis Services for Clients With Severe Mental Illness



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Robin E. Clark, Ph.D.

Lawrence Rickards, Ph.D.

After 20 years of development and research, dual diagnosis services for clients with severe mental illness are emerging as an evidence-based practice. Effective dual diagnosis programs combine mental health and substance abuse interventions that are tailored for the complex needs of clients with comorbid disorders. The authors describe the critical components of effective programs, which include a comprehensive, long-term, staged approach to recovery; assertive outreach; motivational interventions; provision of help to clients in acquiring skills and supports to manage both illnesses and to pursue functional goals; and cultural sensitivity and competence. Many state mental health systems are implementing dual diagnosis services, but high-quality services are rare. The authors provide an overview of the numerous barriers to implementation and describe implementation strategies to overcome the barriers. Current approaches to implementing dual diagnosis programs involve organizational and financing changes at the policy level, clarity of program mission with structural changes to support dual diagnosis services, training and supervision for clinicians, and dissemination of accurate information to consumers and families to support understanding, demand, and advocacy. (*Psychiatric Services* 52:469-476, 2001)

Substance abuse is the most common and clinically significant comorbid disorder among adults with severe mental illness. In this paper the term "substance abuse" refers to substance use disorders, which include abuse and dependence. "Severe mental illness" refers to long-term psychiatric disorders, such as schizophrenia, that are associated with disability and that fall within the traditional purview of public mental health systems. Finally, the term "dual diagnosis" denotes the co-occurrence of substance abuse and severe mental illness.

There are many populations with dual diagnoses, and there are other common terms for this particular group. Furthermore, dual diagnosis is a misleading term because the individuals in this group are heterogeneous and tend to have multiple impairments rather than just two illnesses. Nevertheless, the term appears consistently in the literature and has acquired some coherence as a referent to particular clients, treatments, programs, and service system issues.

Since the problem of dual diagnosis became clinically apparent in the early 1980s (1,2), researchers have established three basic and consistent findings. First, co-occurrence is common;

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about 50 percent of individuals with severe mental disorders are affected by substance abuse (3). Second, dual diagnosis is associated with a variety of negative outcomes, including higher rates of relapse (4), hospitalization (5), violence (6), incarceration (7), homelessness (8), and serious infections such as HIV and hepatitis (9). Third, the parallel but separate mental health and substance abuse treatment systems so common in the United States deliver fragmented and ineffective care (10). Most clients are unable to navigate the separate systems or make sense of disparate messages about treatment and recovery. Often they are excluded or extruded from services in one system because of the comorbid disorder and told to return when the other problem is under control. For those reasons, clinicians, administrators, researchers, family organizations, and clients themselves have been calling for the integration of mental health and substance abuse services for at least 15 years (10,11).

Over that time, integrated dual diagnosis services—that is, treatments and programs—have been steadily developed, refined, and evaluated (11). This paper, part of a series on specific evidence-based practices for persons with severe mental illness, provides an overview of the evolution of dual diagnosis services, the evidence on outcomes and critical components, and the limitations of current research. We also address barriers to the implementation of dual diagnosis services and current strategies for implementation in routine mental health settings.

### Dual diagnosis services

Treatments, or interventions, are offered within programs that are part of service systems. Dual diagnosis treatments combine or integrate mental health and substance abuse interventions at the level of the clinical interaction. Hence integrated treatment means that the same clinicians or teams of clinicians, working in one setting, provide appropriate mental health and substance abuse interventions in a coordinated fashion. In other words, the caregivers take responsibility for combining the interventions

*Editor's note:* This article is part of a series of papers on evidence-based practices being published in *Psychiatric Services* this year. The papers focus on mental health practices for which there is substantial evidence of effectiveness and that should therefore be routinely offered in clinical settings. Articles in previous issues have addressed implementing evidence-based practices for persons with severe mental illness and in routine mental health settings and implementing supported employment as an evidence-based practice. Among other topics, future articles will examine evidence-based practices for case management and assertive community treatment, illness self-management, children's services, and services for the elderly population. Robert E. Drake, M.D., Ph.D., and Howard H. Goldman, M.D., Ph.D., are the series editors.

into one coherent package. For the individual with a dual diagnosis, the services appear seamless, with a consistent approach, philosophy, and set of recommendations. The need to negotiate with separate clinical teams, programs, or systems disappears.

Integration involves not only combining appropriate treatments for both disorders but also modifying traditional interventions (12–15). For example, social skills training emphasizes the importance of developing relationships but also the need to avoid social situations that could lead to substance use. Substance abuse counseling goes slowly, in accordance with the cognitive deficits, negative symptoms, vulnerability to confrontation, and greater need for support that are characteristic of many individuals with severe mental illness. Family interventions address understanding and learning to cope with two interacting illnesses.

The goal of dual diagnosis interventions is recovery from two serious ill-

nesses (16). In this context, “recovery” means that the individual with a dual diagnosis learns to manage both illnesses so that he or she can pursue meaningful life goals (17,18).

### Research on dual diagnosis practices

In most states, the publicly financed mental health system bears responsibility for providing treatments and support services for clients with severe mental illness. Dual diagnosis treatments for these clients have therefore generally been added to community support programs within the mental health system.

Early studies of dual diagnosis interventions during the 1980s examined the application of traditional substance abuse treatments, such as 12-step groups, to clients with mental disorders within mental health programs. These studies had disappointing results for at least two reasons (19). The clinical programs did not take into account the complex needs of the population, and researchers had not yet solved basic methodologic problems. For example, early programs often failed to incorporate outreach and motivational interventions, and evaluations were limited by lack of reliable and valid assessment of substance abuse. Reviews based on these early studies were understandably pessimistic (20).

At the same time, however, a series of demonstration projects using more comprehensive programs that incorporated assertive outreach and long-term rehabilitation began to show better outcomes. Moreover, the projects developed motivational interventions to help clients who did not perceive or acknowledge their substance abuse or mental illness problems (21).

Building on these insights, projects in the early 1990s incorporated motivational approaches as well as outreach, comprehensiveness, and a long-term perspective, often within the structure of multidisciplinary treatment teams. These later studies, which were uncontrolled but incorporated more valid measures of substance abuse, generally showed positive outcomes, including substantial rates of stable remission of substance abuse (22–25). Of course, uncon-

trolled studies of this type often produce findings that are not replicated in controlled studies; they should be considered pilot studies, which are often needed to refine the intervention and the methodologies of evaluation and which should be followed by controlled investigation to determine evidence-based practice (26).

Controlled research studies of comprehensive dual diagnosis programs began to appear in the mid-1990s. Eight recent studies with experimental or quasi-experimental designs support the effectiveness of integrated dual diagnosis treatments for clients with severe mental illness and substance use disorders (27-34). The type and array of dual diagnosis interventions in these programs vary, but they include several common components, which are reviewed below. The eight studies demonstrated a variety of positive outcomes in domains such as substance abuse, psychiatric symptoms, housing, hospitalization, arrests, functional status, and quality of life (19). Although each had methodological limitations, together they indicate that current integrated treatment programs are more effective than nonintegrated programs. By contrast, the evidence continues to show that dual diagnosis clients in mental health programs that fail to integrate substance abuse interventions have poor outcomes (35).

### Critical components

Several components of integrated programs can be considered evidence-based practices because they are almost always present in programs that have demonstrated good outcomes in controlled studies and because their absence is associated with predictable failures (21). For example, dual diagnosis programs that include assertive outreach are able to engage and retain clients at a high rate, while those that fail to include outreach lose many clients.

### Staged interventions

Effective programs incorporate, implicitly or explicitly, the concept of stages of treatment (14,36,37). In the simplest conceptualization, stages of treatment include forming a trusting

relationship (engagement), helping the engaged client develop the motivation to become involved in recovery-oriented interventions (persuasion), helping the motivated client acquire skills and supports for controlling illnesses and pursuing goals (active treatment), and helping the client in stable remission develop and use strategies for maintaining recovery (relapse prevention).

Clients do not move linearly through stages. They sometimes enter services at advanced levels, skip over or pass rapidly through stages, or relapse to earlier stages. They may be in different stages with respect to mental illness and substance abuse. Nevertheless, the concept of stages has proved useful to program planners and clinicians because clients at different stages respond to stage-specific interventions.

### Assertive outreach

Many clients with a dual diagnosis have difficulty linking with services and participating in treatment (38). Effective programs engage clients and members of their support systems by providing assertive outreach, usually through some combination of intensive case management and meetings in the client's residence (21,32). For example, homeless persons with dual diagnoses often benefit from outreach, help with housing, and time to develop a trusting relationship before participating in any formal treatment. These approaches enable clients to gain access to services and maintain needed relationships with a consistent program over months and years. Without such efforts, noncompliance and dropout rates are high (39).

### Motivational interventions

Most dual diagnosis clients have little readiness for abstinence-oriented treatment (40,41). Many also lack motivation to manage psychiatric illness and to pursue employment or other functional goals. Effective programs therefore incorporate motivational interventions that are designed to help clients become ready for more definitive interventions aimed at illness self-management (12,14,21). For example, clients who

are so demoralized, symptomatic, or confused that they mistakenly believe that alcohol and cocaine are helping them to cope better than medications require education, support, and counseling to develop hope and a realistic understanding of illnesses, drugs, treatments, and goals.

Motivational interventions involve helping the individual identify his or her own goals and to recognize, through a systematic examination of the individual's ambivalence, that not managing one's illnesses interferes with attaining those goals (42). Recent research has demonstrated that clients who are not motivated can be reliably identified (43) and effectively helped with motivational interventions (Carey KB, Carey MP, Maisto SA, et al, unpublished data, 2000).

### Counseling

Once clients are motivated to manage their own illnesses, they need to develop skills and supports to control symptoms and to pursue an abstinent lifestyle. Effective programs provide some form of counseling that promotes cognitive and behavioral skills at this stage. The counseling takes different forms and formats, such as group, individual, or family therapy or a combination (15). Few studies have compared specific approaches to counseling, although one study did find preliminary evidence that a cognitive-behavioral approach was superior to a 12-step approach (28). At least three research groups are actively working to refine cognitive-behavioral approaches to substance abuse counseling for dual diagnosis clients (12,13,44). These approaches often incorporate motivational sessions at the beginning of counseling and as needed in subsequent sessions rather than as separate interventions.

### Social support interventions

In addition to helping clients build skills for managing their illness and pursuing goals, effective programs focus on strengthening the immediate social environment to help them modify their behavior. These activities, which recognize the role of social networks in recovery from dual disorders (45), include social network or family interventions.

### *Long-term perspective*

Effective programs recognize that recovery tends to occur over months or years in the community. People with severe mental illness and substance abuse do not usually develop stability and functional improvements quickly, even in intensive treatment programs, unless they enter treatment at an advanced stage (19). Instead, they tend to improve over months and years in conjunction with a consistent dual diagnosis program. Effective programs therefore take a long-term, community-based perspective that includes rehabilitation activities to prevent relapses and to enhance gains.

### *Comprehensiveness*

Learning to lead a symptom-free, abstinent lifestyle that is satisfying and sustainable often requires transforming many aspects of one's life—for example, habits, stress management, friends, activities, and housing. Therefore, in effective programs attention to substance abuse as well as mental illness is integrated into all aspects of the existing mental health program and service system rather than isolated as a discrete substance abuse treatment intervention. Inpatient hospitalization, assessment, crisis intervention, medication management, money management, laboratory screening, housing, and vocational rehabilitation incorporate special features that are tailored specifically for dual diagnosis patients. For example, hospitalization is considered a component of the system that supports movement toward recovery by providing diagnosis, stabilization, and linkage with outpatient dual diagnosis interventions during acute episodes (46). Similarly, housing and vocational programs can be used to support the individual with a dual diagnosis in acquiring skills and supports needed for recovery (47).

### *Cultural sensitivity and competence*

A fundamental finding of the demonstration programs of the late 1980s was that cultural sensitivity and competence were critical to engaging clients in dual diagnosis services (21). These demonstrations showed that

African Americans, Hispanics, and other underserved groups, such as farm workers, homeless persons, women with children, inner-city residents, and persons in rural areas, could be engaged in dual diagnosis services if the services were tailored to their particular racial, cultural, and other group characteristics.

Many dual diagnosis programs omit some of these critical components as evidence-based practices. However, one consistent finding in the research is that programs that show high fidelity to the model described here—those that incorporate more of the core elements—produce better outcomes than low-fidelity programs (32,48,49). A common misconception about technology transfer is that model programs are not generalizable and that local solutions are superior. A more accurate reading of the research is that modifications for cultural and other local circumstances are important, but critical program components must be replicated to achieve good outcomes.

### *Limitations of the research*

The design and quality of research procedures and data across dual diagnosis studies are inconsistent. In addition, researchers have thus far failed to address a number of issues.

Dual diagnosis research has studied the clinical enterprise, that is, treatments and programs, with little attention to the policy or system perspective. Despite widespread endorsement of integrated dual diagnosis services (13,50–53), there continues to be a general failure at the federal and state levels to resolve problems related to organization and financing (see below). Thus, despite the emergence of many excellent programs around the country, few if any large mental health systems have been able to accomplish widespread implementation of dual diagnosis services for persons with severe mental illness. We are aware of no specific studies of strategies to finance, contract for, reorganize, or train in relation to dual diagnosis services.

Lack of data on the cost of integrated dual diagnosis services and the cost savings of providing good care impedes policy development. Dual

diagnosis clients incur high treatment costs in usual services (54,55), and care is costly to their families (56), but effective treatment may be even more costly. Some studies suggest cost savings related to providing good services (57,58), but these are not definitive.

Another limitation of the research is the lack of specificity of dual diagnosis treatments. Interventions differ across studies, manuals and fidelity measures are rare, and no consensus exists on specific approaches to individual counseling, group treatment, family intervention, housing, medications, and other components. Current research will address some of these issues by refining specific components, although efficacy studies may identify complex and expensive interventions that will be impractical in routine mental health settings.

A majority of dual diagnosis clients respond well to integrated outpatient services, but clients who do not respond continue to be at high risk of hospitalization, incarceration, homelessness, HIV infection, and other serious adverse outcomes. Other than one study of long-term residential treatment (33), controlled research has not addressed clients who do not respond to outpatient services. Other potential interventions include outpatient commitment (59), treatments aimed at trauma sequelae (60), money management (61), contingency management (62), and pharmacological approaches using medications such as clozapine (63), disulfiram (64), or naltrexone.

Although a few studies have explored the specific treatment needs of dual diagnosis clients who are women (65,66) or minorities (21,67), particular program modifications for these groups need further validation. For example, many dual diagnosis programs have identified high rates of trauma histories and sequelae among women (46,68,69), and studies have suggested interventions to address trauma; however, no data on outcomes are yet available.

### *Implementation barriers*

Although integrated dual diagnosis services and other evidence-based practices are widely advocated, they

are rarely offered in routine mental health treatment settings (70). The barriers are legion.

#### *Policy barriers*

State, county, and city mental health authorities often encounter policies related to organizational structure, financing, regulations, and licensing that militate against the functional integration of mental health and substance abuse services (71). The U.S. public mental health and substance abuse treatment systems grew independently. In most states these services are provided under the auspices of separate cabinet-level departments with separate funding streams, advocacy groups, lobbyists, enabling legislation, information systems, job classifications, and criteria for credentials. Huge fiscal incentives and strong political allies act to maintain the status quo.

Medicaid programs, which fund a significant and growing proportion of treatment for persons with severe mental illness, vary substantially from state to state in the types of mental health and substance abuse services they fund. In most states, mental health and substance abuse agencies have little control over how Medicaid services are reimbursed or administered, which makes it difficult for public systems to ensure that appropriate services are accessible. Medicare, the federal insurance program for elderly and disabled persons, generally pays for a more limited scope of mental health and substance abuse services. Together Medicaid and Medicare pay for more than 30 percent of all behavioral health services, but their impact on dual diagnosis services has not been studied (72).

#### *Program barriers*

At the local level, administrators of clinics, centers, and programs have often lacked the clear service models, administrative guidelines, contractual incentives, quality assurance procedures, and outcome measures needed to implement dual diagnosis services. When clinical needs compel them to move ahead anyway, they have difficulty hiring a skilled workforce with experience in provid-

ing dual diagnosis interventions and lack the resources to train current supervisors and clinicians.

#### *Clinical barriers*

The beliefs of the mental health and substance abuse treatment traditions are inculcated in clinicians, which diminishes the opportunities for cross-fertilization (73). Although an integrated clinical philosophy and a practical approach to dual diagnosis treatment have been clearly delineated for more than a decade (16), educational institutions rarely teach this approach. Consequently, mental health clinicians typically lack training in dual diagnosis treatment and have to rely on informal, self-initiated opportunities for learning current interventions (74). They often avoid diagnosing substance abuse when they believe that it is irrelevant, that it will interfere with funding, or that they cannot treat it. Clinicians trained in substance abuse treatment, as well as recovering dual diagnosis clients, could add expertise and training, but they are often excluded from jobs in the mental health system.

#### *Consumer and family barriers*

Clients and their families rarely have good information about dual diagnosis and appropriate services. Few programs offer psychoeducational services related to dual diagnosis, although practical help from families plays a critical role in recovery (75). Family members are often unaware of substance abuse, blame all symptoms on drug abuse, or attribute symptoms and substance use to willful misbehavior. Supporting family involvement is an important but neglected role for clinicians.

Consumers often deny or minimize problems related to substance abuse (40) and, like other substance abusers, believe that alcohol or other drugs are helpful in alleviating distress. They may be legitimately confused about causality because they perceive the immediate effects of drugs rather than the intermediate or long-term consequences (76). The net result is that the individual lacks motivation to pursue active substance abuse treatment, which can reinforce clinical inattention.

#### *Implementation strategies*

There are no proven strategies for overcoming the aforementioned barriers to implementing dual diagnosis services, but some suggestions have come from systems and programs that have had moderate success.

#### *Policy strategies*

Health care authorities in a majority of, and possibly all, states have current initiatives for creating dual diagnosis services. Because health care policy is often administered at the county or city level, hundreds of individual experiments are occurring. One initial branch point involves the decision to focus broadly on the entire behavioral health system—that is, on all clients with mental health and substance abuse problems—or more narrowly on services for those with severe mental illness and co-occurring substance abuse. We examine here only strategies for dual diagnosis clients with severe mental illness, for whom the implementation issues are relatively distinct.

Commonly used system-level strategies include building a consensus around the vision for integrated services and then conjointly planning; specifying a model; implementing structural, regulatory, and reimbursement changes; establishing contracting mechanisms; defining standards; and funding demonstration programs and training initiatives (77). To our knowledge, few efforts have been made to study these efforts at the system level.

Anecdotal evidence indicates that blending mental health and substance abuse funds appears to have been a relatively unsuccessful strategy, especially early in the course of system change. Fear of losing money to cover nontraditional populations often leads to prolonged disagreements, inability to develop consensus, and abandonment of other plans. As a less controversial, preliminary step, the mental health authority often assumes responsibility for comprehensive care, including substance abuse treatment, for persons with severe mental illness, while the substance abuse authority assists by pledging to help with training and planning.

This limited approach enables the

mental health system to attract and train dual diagnosis specialists who can subsequently train other clinicians and programs. Without structural, regulatory, and funding changes to reinforce the training, however, the expertise may soon disappear—a common experience after demonstration projects. Thus many experts advise that policy issues should be addressed early in the process of implementation to avoid wasting efforts on training (78–80).

New costs to the mental health system for dual diagnosis training could be offset by greater effectiveness in ameliorating substance-abusing behaviors that are associated with hospitalizations. However, saving costs over time assumes that providers are at risk for all treatment costs, that is, that providers have incentives to invest more in outpatient services in order to spend less on inpatient services. Despite the growth of managed care, providers rarely bear complete financial responsibility for the treatment of clients with severe mental illness.

#### *Program strategies*

At the level of the mental health clinic or program leadership, the fundamental task is to begin recognizing and treating substance abuse rather than ignoring it or using it as a criterion for exclusion (81). After consensus-building activities to prepare for change, staff need training and supervision to learn new skills, and they must receive reinforcement for acquiring and using these skills effectively. One common strategy is to appoint a director of dual diagnosis services whose job is to plan and oversee the training of staff, the integration of substance abuse awareness and treatment into all aspects of the mental health program, and the monitoring and reinforcement of these activities through medical records, quality assurance activities, and outcome data.

Experts identify the importance of having a single leader for program change (82). Fidelity measures for integrated dual diagnosis services can facilitate successful implementation at the program level (50,83). Monitoring and reinforcing mechanisms

also emphasize client-centered outcomes, such as abstinence and employment.

#### *Clinical strategies*

Mental health clinicians need to acquire knowledge and a core set of skills related to substance abuse that includes assessing substance abuse, providing motivational interventions for clients who are not ready to participate in abstinence-oriented treatment, and providing counseling for those who are motivated try to maintain abstinence. Clinicians adopt new skills as a result of motivation, instruc-

Recent  
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care.

tion, practice, and reinforcement (84). Because substance abuse affects the lives of the great majority of clients with severe mental illness—as a co-occurring disorder, family stressor, or environmental hazard—all clinicians should learn these basic skills. Otherwise substance abuse problems will continue to be missed and untreated in this population (85,86).

For example, all case managers should recognize and address substance abuse in their daily interactions, as should housing staff, employ-

ment specialists, and other staff. Until professional educational programs begin teaching current dual diagnosis treatment techniques (87), mental health system leaders will bear the burden of training staff.

Some staff will become dual diagnosis specialists and acquire more than the basic skills. These individuals will be counted on to lead dual diagnosis groups, family interventions, residential programs, and other specialized services.

#### *Consumer and family-level strategies*

Clients and family members need access to accurate information. Otherwise their opportunities to make informed choices, to request effective services, and to advocate for system changes are severely compromised. Consumer demand and family advocacy can move the health care system toward evidence-based practices, but concerted efforts at the national, state, and local levels are required. Researchers can facilitate their efforts by offering clear messages about the forms, processes, and expected outcomes of evidence-based practices. Similarly, local programs should provide information on available dual diagnosis services to clients and their families.

As consumers move into roles as providers within the mental health system and in consumer-run services, they also need training in dual diagnosis treatments. Local educational programs, such as community colleges, as well as staff training programs should address these needs.

#### *Conclusions*

Substance abuse is a common and devastating comorbid disorder among persons with severe mental illness. Recent research offers evidence that integrated dual diagnosis treatments are effective, but basic interventions are rarely incorporated into the mental health programs in which these clients receive care. Successful implementation of dual diagnosis services within mental health systems will depend on changes at several levels: clear policy directives with consistent organizational and financing supports, program changes to incorpo-

rate the mission of addressing co-occurring substance abuse, supports for the acquisition of expertise at the clinical level, and availability of accurate information to consumers and family members. ♦

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**STATE OF CONNECTICUT**  
**Department of Mental Health & Addiction Services**

Department of  
Mental Health and  
Addiction Services

**Commissioner's Policy Statement and Implementing Procedures**

<b>SUBJECT:</b>	Serving Individuals and Families with Co-Occurring Mental Health and Substance Use Disorders
<b>P &amp; P NUMBER:</b>	Chapter 6.4
<b>APPROVED:</b>	Patricia Rehmer, Commissioner <i>PR</i> Date: April 15, 2010
<b>EFFECTIVE DATE:</b>	April 15, 2010
<b>REVISED:</b>	
<b>REFERENCES:</b>	
<b>FORMS AND ATTACHMENTS:</b>	

**STATEMENT OF PURPOSE:** The purpose of the Department of Mental Health and Addiction Services (DMHAS) co-occurring disorders (COD) policy is to define and promote integrated mental health and addiction treatment services for individuals with COD. The single overarching goal of the Department of Mental Health and Addiction Services (DMHAS), as a healthcare service agency, is promoting and achieving a quality-focused, culturally responsive, and recovery-oriented system of care. The full attainment of this goal is not possible if the service system design, delivery, and evaluation are not fully responsive to people with co-occurring mental health and substance use disorders. Given the high prevalence of COD, the high number of critical incidents involving individuals with COD, and the often poor outcomes associated with COD in the absence of integrated care, it is extremely important that we collectively improve our system in this area. There have been advances in research and practice related to COD and it is important that the system close the science to service gap. Through these and other related improvements, the citizens of the state can expect better processes of care and better outcomes for people with COD.

**POLICY:** It is the policy of the Department of Mental Health and Addiction Services to be highly responsive to the multiple and complex needs of persons and families experiencing co-occurring mental health and substance use disorders, in all levels of care, across all agencies, and throughout all phases of the recovery process (e.g., engagement, screening, assessment, treatment, rehabilitation, discharge planning, and continuing care).

Co-occurring disorders are defined as the coexistence of two or more disorders, at least one of which relates to the use of alcohol and/or other drugs and at least one of which is a mental health disorder. Integrated treatment is a means of providing both substance use and mental health interventions concurrently and in relation to each other; it is preferable if this can be done by one clinician, but it can be accomplished by two or more clinicians working together within one

program or a network of services. Integrated services must appear seamless to the individual and family participating in services.

The following guiding principles further define integrated services and DMHAS' COD policy:

- People with COD are the expectation in our healthcare system, and not the exception.
- There is "no wrong door" for people with COD entering into the healthcare system.
- Although a "primary" diagnosis often needs to be identified for billing and some medical record procedures, services should be planned and delivered in a way that considers all identified mental health and substance use disorders, and other goals for treatment, as equally important and of high priority.
- The system of care is committed to integrated treatment with one plan for one person.
- Integrated approaches need to be matched to an individual's needs, strengths, culture, and readiness for change.
- The system offers evidence-based techniques and protocols, and evaluates how these relate to outcomes.
- The system strives to identify, develop, evaluate, and document emerging or promising practices.
- Improvements are made to program structures and milieu, staffing, and workforce development relative to the needs of individuals with COD.
- Recovery support (including self-help, mutual support, peer-delivered and peer-run services) and family education and support are important components of a system of care that is responsive to people with COD.
- Integrated care must be accomplished by preserving and capitalizing on the values, philosophies, and core technologies of both the mental health and addiction treatment fields.
- Statewide continuous quality improvement processes ensure this policy statement is realized.

There has been significant national attention in recent years to the issues associated with COD. The Surgeon General's *Report on Mental Health* in 1999, the Substance Abuse and Mental Health Services Administration's (SAMHSA) 2002 *Report to Congress* on COD, the President's New Freedom Commission Report on *Achieving the Promise* in 2003, and SAMHSA's Treatment Improvement Protocol (TIP) #42 on COD issued in 2005 all note the high prevalence of COD, the lack of integrated care available in our healthcare system, and the poor outcomes experienced in the absence of integrated care. In addition, the National Association of State Alcohol and Drug Abuse Directors (NASADAD) and the National Association of State Mental Health Program Directors (NASMHPD) have jointly promoted a "four quadrant" model describing different groups of people with COD; the American Society of Addiction Medicine (ASAM) developed the vocabulary of "addiction only," "dual diagnosis capable," and "dual diagnosis enhanced" for program assessments; and SAMHSA began awarding Co-Occurring State Incentive Grants (COSIG) in 2002. As is evident throughout these developments and initiatives, there is a clear consensus in the field that the integration of mental health and addiction treatment services is a prerequisite for meeting the needs of individuals with COD.

Connecticut has taken significant and important steps over the last several years to increase the system's capacity to provide accessible, effective, comprehensive, integrated, and evidence-based services for adults with COD. In this respect, Connecticut is fortunate to have combined separate agencies into a single state authority that has responsibility for both mental health and addiction treatment services. Subsequent to this merger, DMHAS has undertaken both an Integrated Dual

Disorders Treatment (IDDT) initiative and a Dual Diagnosis Capability in Addiction Treatment (DDCAT) initiative. Since 2002, DMHAS facilities and DMHAS-funded agencies have received onsite fidelity reviews and feedback reports, and training and consultation from DMHAS-funded national experts, and DMHAS staff, on integrating mental health and addiction treatment services. DMHAS established strong academic partnerships related to COD with Dartmouth Medical School, the University of Connecticut, and Yale University. Connecticut was one of several states to participate in the National Policy Academy on Co-Occurring Disorders and to receive a SAMHSA award for a Co-Occurring State Incentive Grant (COSIG) in 2005. In 2006, DMHAS' Education and Training Division formalized and expanded co-occurring related trainings, and added free web-based trainings on COD in 2009. DMHAS implemented a statewide requirement in 2007 that all state-operated and DMHAS-funded mental health and addiction treatment programs administer standardized mental health and substance use screens upon all admissions to services. This policy is yet an additional important step forward in achieving a fully integrated and COD enhanced system of care for all of the state's citizens receiving publicly funded behavioral health services.

**PROCEDURE:** All employees are responsible and accountable, within their positions, for being highly responsive to the multiple needs of individuals and families with COD in accordance with the COD policy of the Department of Mental Health and Addiction Services.

The following tools and resources are available and should be used to implement this policy:

- The DMHAS Co-Occurring Disorders Initiative website: <http://www.ct.gov/dmhas/cosig>
- Standardized mental health and substance use screening instruments and supporting materials: <http://www.ct.gov/dmhas/cwp/view.asp?a=2901&q=392802>
- DMHAS Co-Occurring Capable Program Guidelines: <http://www.ct.gov/dmhas/lib/dmhas/cosig/CODcapableprogram.pdf>
- DMHAS Co-Occurring Enhanced Program Guidelines: <http://www.ct.gov/dmhas/lib/dmhas/cosig/CODenhancedguidelines.pdf>
- DMHAS Competencies for Providing Services to Individuals with Co-Occurring Mental Health and Substance Use Disorders: <http://www.ct.gov/dmhas/lib/dmhas/cosig/CODcompetencies.pdf>
- DMHAS Latino Co-Occurring Guide: Lessons Learned at the Hispanic Clinic of the Connecticut Mental Health Center: <http://www.ct.gov/dmhas/lib/dmhas/cosig/latinocodguide.pdf>
- Consultation from DMHAS Office of the Commissioner staff on ways to increase co-occurring capability and be in compliance with this policy
- DMHAS Education & Training workshops and web-based curricula
- Integrated Dual Disorders Treatment (IDDT) Toolkit: <http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/cooccurring/>
- Dual Diagnosis Capability in Addiction Treatment (DDCAT) Toolkit: [http://dms.dartmouth.edu/prc/dual/pdf/ddcat\\_toolkit.pdf](http://dms.dartmouth.edu/prc/dual/pdf/ddcat_toolkit.pdf)
- SAMHSA's Treatment Improvement Protocol (TIP) #42: Substance Abuse Treatment for Persons with Co-Occurring Disorders
- Specialty credentials for serving people with co-occurring conditions
- Standardized mental health and substance use screening measures in English and Spanish

- Audiovisuals, books, curricula, pamphlets, and posters on co-occurring conditions:  
<http://www.ct.gov/dmhas/LIB/dmhas/COSIG/resources.pdf>
- The national Co-Occurring Center for Excellence website: <http://coce.samhsa.gov/>
- Commissioner's Policy Statement #83: Promoting a Recovery-Oriented Service System:  
<http://www.ct.gov/dmhas/cwp/view.asp?a=2907&q=334672>
- Commissioner's Policy Statement #33: Individualized Recovery Planning:  
<http://www.ct.gov/dmhas/cwp/view.asp?a=2907&q=334664>
- Commissioner's Policy Statement #76: Policy on Cultural Competence:  
<http://www.ct.gov/dmhas/cwp/view.asp?a=2907&q=334668>
- Practice Guidelines for Recovery-Oriented Behavioral Health Care:  
<http://www.ct.gov/dmhas/lib/dmhas/recovery/practiceguidelines2.pdf>

Although the Department of Mental Health and Addiction Services expects to continue this policy/procedure indefinitely, it reserves the right to interpret, amend or terminate it at any time.

**National Alliance on Mental Illness (NAMI) Statement on the need for Co-Occurring Disorders specialized treatment, 2003:**

**Dual Diagnosis and Integrated Treatment of Mental Illness and Substance Abuse Disorder**

**What are dual diagnosis services?**

Dual diagnosis services are treatments for people who suffer from co-occurring disorders -- mental illness and substance abuse. Research has strongly indicated that to recover fully, a consumer with co-occurring disorder needs treatment for both problems -- focusing on one does not ensure the other will go away. Dual diagnosis services integrate assistance for each condition, helping people recover from both in one setting, at the same time.

Dual diagnosis services include different types of assistance that go beyond standard therapy or medication: assertive outreach, job and housing assistance, family counseling, even money and relationship management. The personalized treatment is viewed as long-term and can be begun at whatever stage of recovery the consumer is in. Positivity, hope and optimism are at the foundation of integrated treatment.

**How often do people with severe mental illnesses also experience a co-occurring substance abuse problem?**

There is a lack of information on the numbers of people with co-occurring disorders, but research has shown the disorders are very common. According to reports published in the *Journal of the American Medical Association (JAMA)*:

- Roughly 50 percent of individuals with severe mental disorders are affected by substance abuse.
- Thirty-seven percent of alcohol abusers and 53 percent of drug abusers also have at least one serious mental illness.
- Of all people diagnosed as mentally ill, 29 percent abuse either alcohol or drugs.

The best data available on the prevalence of co-occurring disorders are derived from two major surveys: the Epidemiologic Catchment Area (ECA) Survey (administered 1980-1984), and the National Comorbidity Survey (NCS), administered between 1990 and 1992.

Results of the NCS and the ECA Survey indicate high prevalence rates for co-occurring substance abuse disorders and mental disorders, as well as the increased risk for people with either a substance abuse disorder or mental disorder for developing a co-occurring disorder. For example, the NCS found that:

- 42.7 percent of individuals with a 12-month addictive disorder had at least one 12-month mental disorder.
- 14.7 percent of individuals with a 12-month mental disorder had at least one 12-month addictive disorder.

The ECA Survey found that individuals with severe mental disorders were at significant risk for developing a substance use disorder during their lifetime. Specifically:

- 47 percent of individuals with schizophrenia also had a substance abuse disorder (more than four times as likely as the general population).
- 61 percent of individuals with bipolar disorder also had a substance abuse disorder (more than five times as likely as the general population).

Continuing studies support these findings, that these disorders do appear to occur much more frequently than previously realized, and that appropriate integrated treatments must be developed.

**What are the consequences of co-occurring severe mental illness and substance abuse?**

For the consumer, the consequences are numerous and harsh. Persons with a co-occurring disorder have a statistically greater propensity for violence, medication noncompliance, and failure to respond to treatment than consumers with just substance abuse or a mental illness. These problems also extend out to these consumers' families, friends and co-workers. Purely health-wise, having a simultaneous mental illness and a substance abuse disorder frequently leads to overall poorer functioning and a greater chance of relapse. These consumers are in and out of hospitals and treatment programs without lasting success. People with dual diagnoses also tend to have tardive dyskinesia (TD) and physical illnesses more often than those with a single disorder, and they experience more episodes of psychosis. In addition, physicians often don't recognize the presence of substance abuse disorders and mental disorders, especially in older adults.

Socially, people with mental illnesses often are susceptible to co-occurring disorders due to "downward drift." In other words, as a consequence of their mental illness they may find themselves living in marginal neighborhoods where drug use prevails. Having great difficulty developing social relationships, some people find themselves more easily accepted by groups whose social activity is based on drug use. Some may believe that an identity based on drug addiction is more acceptable than one based on mental illness.

Consumers with co-occurring disorders are also much more likely to be homeless or jailed. An estimated 50 percent of homeless adults with serious mental illnesses have a co-occurring substance abuse disorder. Meanwhile, 16% of jail and prison inmates are estimated to have severe mental and substance abuse disorders. Among detainees with mental disorders, 72 percent also have a co-occurring substance abuse disorder.

Consequences for society directly stem from the above. Just the back-and-forth treatment alone currently given to non-violent persons with dual diagnosis is costly. Moreover, violent or criminal consumers, no matter how unfairly afflicted, are dangerous and also costly. Those with co-occurring disorders are at high risk to contract AIDS, a disease that can affect society at large. Costs rise even higher when these persons, as those with co-occurring disorders have been shown to do, recycle through healthcare and criminal justice systems again and again. Without the establishment of more integrated treatment programs, the cycle will continue.

**Why is an integrated approach to treating severe mental illnesses and substance abuse problems so important?**

Despite much research that supports its success, integrated treatment is still not made widely available to consumers. Those who struggle both with serious mental illness and substance abuse face problems of enormous proportions. Mental health services tend not to be well prepared to deal with patients having both afflictions. Often only one of the two problems is identified. If both are recognized, the individual may bounce back and forth between services for

mental illness and those for substance abuse, or they may be refused treatment by each of them. Fragmented and uncoordinated services create a service gap for persons with co-occurring disorders.

Providing appropriate, integrated services for these consumers will not only allow for their recovery and improved overall health, but can ameliorate the effects their disorders have on their family, friends and society at large. By helping these consumers stay in treatment, find housing and jobs, and develop better social skills and judgment, we can potentially begin to substantially diminish some of the most sinister and costly societal problems: crime, HIV/AIDS, domestic violence and more.

There is much evidence that integrated treatment can be effective. For example:

- Individuals with a substance abuse disorder are more likely to receive treatment if they have a co-occurring mental disorder.
- Research shows that when consumers with dual diagnosis successfully overcome alcohol abuse, their response to treatment improves remarkably.

With continued education on co-occurring disorders, hopefully, more treatments and better understanding are on the way.

#### **What does effective integrated treatment entail?**

Effective integrated treatment consists of the same health professionals, working in one setting, providing appropriate treatment for both mental health and substance abuse in a coordinated fashion. The caregivers see to it that interventions are bundled together; the consumers, therefore, receive consistent treatment, with no division between mental health or substance abuse assistance. The approach, philosophy and recommendations are seamless, and the need to consult with separate teams and programs is eliminated.

Integrated treatment also requires the recognition that substance abuse counseling and traditional mental health counseling are different approaches that must be reconciled to treat co-occurring disorders. It is not enough merely to teach relationship skills to a person with bipolar disorder. They must also learn to explore how to avoid the relationships that are intertwined with their substance abuse.

Providers should recognize that denial is an inherent part of the problem. Patients often do not have insight as to the seriousness and scope of the problem. Abstinence may be a goal of the program but should not be a precondition for entering treatment. If dually diagnosed clients do not fit into local Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) groups, special peer groups based on AA principles might be developed.

Clients with a dual diagnosis have to proceed at their own pace in treatment. An illness model of the problem should be used rather than a moralistic one. Providers need to convey understanding of how hard it is to end an addiction problem and give credit for any accomplishments. Attention should be given to social networks that can serve as important reinforcers. Clients should be given opportunities to socialize, have access to recreational activities, and develop peer relationships. Their families should be offered support and education, while learning not to react with guilt or blame but to learn to cope with two interacting illnesses.

#### **What are the key factors in effective integrated treatment?**

There are a number of key factors in an integrated treatment program.

Treatment must be approached in **stages**. First, a *trust* is established between the consumer and the caregiver. This helps *motivate* the consumer to learn the skills for *actively controlling* their illnesses and focus on goals. This helps keep the consumer on track, *preventing relapse*. Treatment can begin at any one of these stages; the program is tailored to the individual.

**Assertive outreach** has been shown to engage and retain clients at a high rate, while those that fail to include outreach lose clients. Therefore, effective programs, through intensive case management, meeting at the consumer's residence, and other methods of developing a dependable relationship with the client, ensure that more consumers are consistently monitored and counseled.

Effective treatment includes **motivational interventions**, which, through education, support and counseling, help empower deeply demoralized clients to recognize the importance of their goals and illness self-management.

Of course, counseling is a fundamental component of dual diagnosis services. **Counseling** helps develop positive coping patterns, as well as promotes cognitive and behavioral skills. Counseling can be in the form of individual, group, or family therapy or a combination of these. A consumer's **social support** is critical. Their immediate environment has a direct impact on their choices and moods; therefore consumers need help strengthening positive relationships and jettisoning those that encourage negative behavior.

Effective integrated treatment programs **view recovery as a long-term, community-based process**, one that can take months or, more likely, years to undergo. Improvement is slow even with a consistent treatment program. However, such an approach prevents relapses and enhances a consumer's gains.

To be effective, a dual diagnosis program must be **comprehensive**, taking into account a number of life's aspects: stress management, social networks, jobs, housing and activities. These programs view substance abuse as intertwined with mental illness, not a separate issue, and therefore provide solutions to both illnesses together at the same time.

Finally, effective integrated treatment programs must contain elements of **cultural sensitivity and competence** to even lure consumers, much less retain them. Various groups such as African-Americans, homeless, women with children, Hispanics and others can benefit from services tailored to their particular racial and cultural needs.

[http://www.nami.org/Template.cfm?Section=By\\_Illness&template=/ContentManagement/ContentDisplay.cfm&ContentID=13693](http://www.nami.org/Template.cfm?Section=By_Illness&template=/ContentManagement/ContentDisplay.cfm&ContentID=13693)

**6. Please explain the purpose of “phasing in” the three tracks of treatment.**

The rationale for phasing in the three types of treatment tracks is entirely practical, rather than clinical, in nature. As a brand new business venture, the Connecticut Recovery Center simply does not have the financial resources to start all 3 clinical tracks at once. As we build our practice, we plan to be able to afford to hire more clinical staff and thereby add in more clinical options for our patient population.

We are opting to start our practice with the Substance Abuse group because there is the clearest public need for this type of treatment in the specified area, as discussed in our response to question 1 of the Completion Letter. This is due to the unprecedented increase in opiate dependence, particularly in suburban areas, over the past two decades.

**7. Provide a copy of the following for each track:**

- a. Treatment Plan; and**
- b. Daily Patient Schedule.**

A.) As the Connecticut Recovery Center is not yet approved to open for business, we do not have all of our forms ready for implementation quite yet. However, our treatment plan will consist of an initial plan outlining broad goals, followed up with weekly updates to this initial document. It is important to always keep in mind why a person is in need of this particular level of care. Due to the high acuity of patient pathology, Intensive Outpatient Programs must emphasize risk management, safety, symptom stabilization, and development of specific skill sets to improve independent functioning.

The initial plan is completed within the first 7 days of treatment and is used to conceptualize the entire treatment process. It will guide the weekly creation of treatment plan updates. This page must be updated whenever there is a significant change in clinical status or treatment goals.

**GOALS:** The goals are identified on the initial plan and are used to establish discharge criteria. They are the final measures used to determine when the patient has successfully completed this level of treatment or is in need of a different level of care. The goals should reflect why the person was referred to our program and why IOP level of care is needed.

*Example:* Jane will develop adequate emotional regulation to be able to effectively implement a pre-determined safety plan before acting on self-harm impulses.

*Example:* Fred will identify behavioral patterns that have lead him to require repeated psychiatric hospitalizations and will develop a plan to recognize circumstances that make him vulnerable to re-hospitalization.

*Example:* Arthur will remain completely abstinent from crack cocaine and will develop a reliable support network to assist him in maintaining his sobriety.

The weekly treatment plan update is completed every 7 days. It identifies specific problems, objectives and interventions that will be addressed during the next 7 days of treatment. From week to week, the consecutive treatment updates should reflect the entire course of treatment by outlining the patient's weekly progress towards achieving the treatment goals identified on the initial treatment plan.

**PROBLEMS:** The problems are used to identify what specific needs, challenges, or difficulties will be addressed in the coming week. They should be limited to those symptoms, behaviors, or other obstacles that can reasonably be addressed within this time frame.

*Example:* Jane made a suicide attempt last week and remains ambivalent about being alive.

*Example:* Fred has resumed antipsychotic medication and is not currently overtly symptomatic but remains uncertain as to why he periodically stops taking his prescribed meds.

*Example:* Arthur has repeatedly relapsed with crack cocaine over the past 6 months despite negative personal and legal consequences.

**OBJECTIVES:** The short term objectives are the actions the patient agrees to work on over the course of the next 7 days to reduce/resolve the identified problems and thus get a step closer to achieving the overall treatment goals. Objectives must be identifiable, measurable from week to week and meaningful to the overall goals of treatment.

*Example:* Jane will identify and label her current emotional state at least 3 times per day this week.

*Example:* Fred will identify two specific reasons why he stopped taking his medication last month.

*Example:* Arthur will attend the PHP program every day this week in addition to obtaining an AA/NA sponsor.

**INTERVENTIONS:** The interventions are the specific actions the PHP/IOP staff will take over the coming week to assist the patient in meeting the specified short-term objectives. These need to be specific and must correspond to an identified objective.

*Example:* Staff will assist Jane in using the group process to help her explore her current emotional state and identify the predominant emotion at the present time.

*Example:* Staff will assist Fred in examining the patterns that lead to his deciding to stop taking medication.

*Example:* Staff will work with Arthur to obtain reliable transportation to/from the program and AA/NA meetings each day.

Of note: Any identified problem can have multiple objectives.  
Every objective must have at least one correlating intervention.

The purpose of the IOP is to help the patient obtain enough mental/emotional stabilization to begin to formulate his/her own reasonable short-term goals and outline obtainable steps towards the long-term goals.

B.) A typical treatment day at the Connecticut Recovery Center IOP will consist of three one-hour groups, each facilitated by a licensed mental health professional. A least once per week, each patient will additionally meet with a psychiatrist for relevant medication management (more frequent meetings with psychiatrist for those patients undergoing Suboxone induction). For patients with identified or suspected substance use disorders, urine specimens will be collected at random to verify the patients use of substances of abuse.

The first hour of each treatment day will consist of skill development groups aimed at the teaching and practicing of specific recovery-oriented behaviors within the safety of the treatment setting. Examples include groups focused on goal-setting, stress management, emotional regulation, appropriate navigation of interpersonal conflicts, and identification of potential high-risk situations for the relapse of either mental health symptoms or substance abuse.

The second hour of each treatment day will consist of insight-oriented group psychotherapy to identify, explore and develop positive changes in feelings, thoughts, and behaviors that make individuals susceptible to either a decline in mental health or substance addiction.

The last hour of each treatment day will consist of psychoeducational groups where patients will learn about mental illness and/or substance use disorders, as well as evidence-based mechanisms of coping. This type of group tends to be less emotionally-intense than the skills development or psychotherapy groups, while still providing key components of the treatment process. This allows for patients to mentally decompress before leaving the treatment setting for the day.

**8. Where are the projected number of patients, between 80-180 annually for FYS 2013-2016, currently receiving the proposed services, since the Applicant states that there are no existing providers of the proposed service in the Applicants service area?**

As stated in sections 2, 2.a.iii, 2.a.iv, 2.a.v, and 2.a.vi of our original application, most of our potential patient population is not being served at all - anywhere. It's not that they are going outside the proposed service area, it's that they are remaining undiagnosed and untreated. This is underscored in the remarks by Governor Malloy, Commissioner Rehmer, and others quoted in our original application, and is evidenced by the data tables provided in reference #16 of our original application.

As detailed in section 2.a.v of our original application, patients in need of an IOP level of care may receive substance abuse IOP treatment at the Rushford Center in Meriden, which is located in an urban environment and does not provide Suboxone-assisted detoxification. Alternatively, these patients will need to either seek a higher level of care (ie, inpatient or residential treatment) or will have to settle for a lower level of care (ie, individual psychotherapy via private practitioners). As we have previously pointed out, most patients whose symptoms warrant IOP level of care are either being under-treated at an outpatient level by private-practice mental health professionals or primary care providers, or are simply not receiving any care at all.

**9. Please explain why Rushford Center (Meriden) and Greater Waterbury Health Network (Waterbury) are not viewed as existing providers, given the Applicant has eluded to waiting lists at these facilities (CON Application, page 18).**

Both Rushford Center and Greater Waterbury Mental Health Network are specifically identified as existing providers in Section 2.a.v of our original application (under the heading "All existing providers of the proposed service in the towns listed above and in nearby towns"). Addresses of each are provided on page 18 and specific services are described.

As discussed at length in sections 2.a.iv and 2.a.v of our original application, neither Rushford Center nor Greater Waterbury Mental Health Network (nor any of the other existing providers we referenced) offer the combination of treatment options that we propose to offer. None of the existing providers offer comprehensive mental health and substance abuse services under one roof. None of them offer daily treatment. Some of the private practitioners in this area provide Suboxone-assisted treatment for opiate dependence, but none offer this option in combination with intensive outpatient group therapies.

10. On page 15 of the CON Application, it is stated that the primary service area ("PSA") for this proposal includes the towns of Cheshire, Meriden, Wallingford, Southington and Wolcott and "quite likely will be drawing patients from the Naugatuck Valley." Please explain:

a. HOW the Applicant determined the towns in the PSA.

b. What towns in the Naugatuck Valley will be included in the service area?

c. Any existing providers providing similar service in Naugatuck Valley besides

**Waterbury Hospital.**

A.) As outlined in Sections 2.a.i and 2.a.ii of our original application, pages 14 and 15, we chose the Cheshire location because there is not currently an Intensive Outpatient Program offered in this town and there are limited number of Suboxone-certified physicians in this town. As detailed in our response to question #11, there is a scarcity of Intensive Outpatient Programming in the geographical area that includes Cheshire, Southington, Meriden, Wallingford, Prospect and Wolcott as compared to similarly populated regions of the state.

B.) We will not be specifically targeting our marketing towards any towns in the Naugatuck Valley area, unless one includes Cheshire and Prospect within the boundaries of Naugatuck Valley. We merely speculate that, given the scarcity of suburban IOPs in the entire state of Connecticut, combined with the easy access to our location from state routes 68 and 70, patients from outlying areas who are currently not receiving treatment because they do not wish to go to urban centers will perhaps seek treatment in a private facility that emphasizes confidentiality and individual treatment options.

C.) According to the United Way of Connecticut's infoline website, [www.211ct.org](http://www.211ct.org), there are 3 sites providing some level of psychiatric day treatment in the Naugatuck Valley. All three are located in the city of Waterbury and include the Connecticut Counseling Center, St. Mary's Hospital, and Waterbury Hospital.

**11. Provide a map of Connecticut identifying your service area towns and the existing providers of similar services throughout Connecticut.**

Using the United Way of Connecticut's infoline website, [www.211ct.org](http://www.211ct.org), we obtained a list of 75 facilities offering Intensive Outpatient Programs in this state. When we filtered out the programs that were specifically identified as treating children, adolescents, or veterans only, and filtered out facilities that do not operate in Connecticut (ie, one facility listed is actually located in New York state), there were 47 facilities identified as providing IOP level of care to adult patients in Connecticut. Of these 47 agencies, only 5 are located within a 15-mile radius of our proposed site as calculated by the United Way of Connecticut infoline website (Rushford, CT Counseling Centers, St. Mary's Hospital, Yale New Haven Hospital St. Raphael Campus in Hamden, and Waterbury Hospital).

The list of the 47 psychiatric day treatment facilities for adults in Connecticut is attached on the following pages, as are two maps of Connecticut, one demonstrating the distribution of IOPs in the state (please note: this map includes all 75 facilities, not just the adult facilities), and one highlighting our projected service area. As is very clearly viewed on the map with the distribution of current IOPs, there is a distinct paucity of this level of psychiatric care in the Southington/Cheshire/Wallingford area.

From United Way of Connecticut 2-1-1 website: [www.211ct.org](http://www.211ct.org)  
MENTAL HEALTH CARE - Psychiatric Services, Outpatient - Psychiatric Day Treatment  
Providers are listed by city

**BHCARE - SHORELINE**

14 Sycamore Way, Branford, CT 06405  
(203) 483-2630 Voice <http://www.bhcare.org>  
Intensive Outpatient Program (IOP)

**SAINT VINCENT'S BEHAVIORAL HEALTH SERVICES - THE CENTER AT BRIDGEPORT**

2400 Main Street, Bridgeport, CT 06606  
(203) 362-3900 Voice  
Intensive Outpatient Program (IOP)

**BRISTOL HOSPITAL - COUNSELING CENTER**

440C North Main Street, Bristol, CT 06010  
(860) 583-5858 Voice <http://www.bristolhospital.org>  
Partial Hospital/Intensive Outpatient Program (IOP)

**CONNECTICUT COUNSELING CENTERS - DANBURY SITE**

60 Beaver Brook Road, Danbury, CT 06810  
(203) 743-7574 Voice <http://www.ctcounseling.org>  
Intensive Outpatient Treatment Program (IOP)

**DANBURY HOSPITAL - COMMUNITY PSYCHIATRIC CENTER**

152 West Street, Danbury, CT 06810  
(203) 207-5480 Voice <http://www.danburyhospital.org>  
Partial Hospital/Intensive Outpatient Program (IOP)

**NATCHAUG HOSPITAL - JOSHUA CENTER - NORTHEAST**

934 North Main Street, Danielson, CT 06239  
(860) 779-2101 Voice <http://www.natchaug.org>  
Partial Hospital/Intensive Outpatient Program (IOP)

**NATCHAUG HOSPITAL - QUINEBAUG DAY TREATMENT PROGRAM**

11 Dog Hill Road, Dayville, CT 06241  
(860) 779-0321 Voice <http://www.natchaug.org>  
Partial Hospital/Intensive Outpatient Program (IOP)

**GRIFFIN HOSPITAL - INTENSIVE OUTPATIENT PROGRAM/PARTIAL HOSPITAL PROGRAM**

241 Seymour Avenue, Derby, CT 06418  
(203) 732-7541 Voice <http://www.griffinhealth.org/>  
Intensive Outpatient Program (IOP)/Partial Hospital Program

COMMUNITY HEALTH RESOURCES - ENFIELD  
153 Hazard Avenue, Enfield, CT 06082  
(877) 884-3571 Voice  
Enfield Partial Hospital/Intensive Outpatient Program (IOP)

NATCHAUG HOSPITAL - JOSHUA CENTER - ENFIELD  
72 Shaker Road, Enfield, CT 06082  
(860) 749-2243 Voice <http://www.natchaug.org>  
Partial Hospital/Intensive Outpatient Program (IOP)

UNIVERSITY OF CONNECTICUT HEALTH CENTER - DEPARTMENT OF PSYCHIATRY  
CLINICAL SERVICES  
263 Farmington Avenue, Farmington, CT 06030  
(860) 679-2553 Voice <http://www.uchc.edu>  
Partial Hospital/Intensive Outpatient Program (IOP)

NATCHAUG HOSPITAL - CARE PLUS  
1353 Gold Star Highway, Groton, CT 06340  
(860) 449-9947 Voice <http://www.natchaug.org>  
Partial Hospital/Intensive Outpatient Program (IOP)

YALE-NEW HAVEN HOSPITAL SAINT RAPHAEL CAMPUS - ADULT OUTPATIENT  
PSYCHIATRIC/ SUBSTANCE ABUSE SERVICES  
1100 Sherman Avenue, Hamden, CT 06514  
(203) 784-8770 Voice  
Partial Hospital/Intensive Outpatient Program (IOP)

COMMUNITY RENEWAL TEAM - BEHAVIORAL HEALTH PARTIAL HOSPITAL PROGRAM  
330 Market Street, Hartford, CT 06120  
(860) 714-9200 Voice <http://www.crtct.org>  
Partial Hospital Program

INSTITUTE OF LIVING - ADULT DAY TREATMENT PROGRAM  
200 Retreat Avenue, Hartford, CT 06106  
(800) 673-2411 Voice <http://www.instituteofliving.org>  
Partial Hospital/Intensive Outpatient Program (IOP)

INSTITUTE OF LIVING - GERIATRIC PROGRAM  
200 Retreat Avenue, Hartford, CT 06106  
(800) 673-2411 Voice <http://www.instituteofliving.org>  
Intensive Outpatient Program (IOP)/Geriatric Outpatient Clinic

INSTITUTE OF LIVING - PROFESSIONALS' PROGRAM

200 Retreat Avenue, Hartford, CT 06106  
(800) 673-2411 Voice <http://www.instituteofliving.org>  
Intensive Outpatient Program (IOP)/Program for Professionals

INSTITUTE OF LIVING - YOUNG ADULT SERVICES  
200 Retreat Avenue, Hartford, CT 06106  
(800) 673-2411 Voice  
Intensive Outpatient Program (IOP)/Partial Hospital Program

MANCHESTER MEMORIAL HOSPITAL - ADULT AMBULATORY BEHAVIORAL HEALTH SERVICES

150 North Main Street, Manchester, CT 06040  
(860) 533-3434 Voice <http://www.echn.org>

NATCHAUG HOSPITAL - JOSHUA CENTER - MANSFIELD

189 Storrs Road, Mansfield Center, CT 06250  
(860) 456-1311 Voice <http://www.natchaug.org>  
Partial Hospital/Intensive Outpatient Program (IOP)

NATCHAUG HOSPITAL - SACHEM HOUSE

189 Storrs Road, Mansfield Center, CT 06250  
(860) 456-1311 Voice <http://www.natchaug.org>  
Partial Hospital/Intensive Outpatient Program (IOP)

RUSHFORD - MERIDEN SERVICES

883 Paddock Avenue, Meriden, CT 06450  
(203) 630-5280 Voice <http://www.rushford.org>  
Partial Hospital/Intensive Outpatient Program (IOP)

MIDDLESEX HOSPITAL - PSYCHIATRIC DEPARTMENT/PARTIAL HOSPITAL PROGRAM/INTENSIVE/OUTPATIENT PROGRAM

33 Pleasant Street, Middletown, CT 06457  
(860) 358-8805 Voice <http://middlesexhospital.org>  
Partial Hospital/Intensive Outpatient Program (IOP)

HOSPITAL OF CENTRAL CONNECTICUT, THE - NEW BRITAIN GENERAL CAMPUS - COUNSELING CENTER

73 Cedar Street, New Britain, CT 06051  
(860) 224-5267 Voice <http://www.thocc.org>

HOSPITAL OF CENTRAL CONNECTICUT, THE - NEW BRITAIN GENERAL CAMPUS - HISPANIC COUNSELING CENTER - WHITING STREET

145 Whiting Street, New Britain, CT 06050  
(860) 224-5300 Voice <http://www.thocc.org>

Intensive Outpatient Program (IOP)

HOSPITAL OF CENTRAL CONNECTICUT, THE - NEW BRITAIN GENERAL CAMPUS -  
OLDER ADULT PROGRAM - HIGHLAND ST

33 Highland Street, New Britain, CT 06052  
(860) 224-9919 Voice <http://www.thocc.org>

Intensive Outpatient Program (IOP)

SILVER HILL HOSPITAL

208 Valley Road, New Canaan, CT 06840  
(866) 542-4455 Voice <http://www.silverhillhospital.org>

Intensive Outpatient Program (IOP)

YALE-NEW HAVEN HOSPITAL - YALE-NEW HAVEN PSYCHIATRIC HOSPITAL - INTENSIVE  
OUTPATIENT PROGRAM

425 George Street, New Haven, CT 06510  
(203) 688-9907 Voice <http://www.ynhh.org/>

Intensive Outpatient Program (IOP)

YALE-NEW HAVEN HOSPITAL SAINT RAPHAEL CAMPUS - ADULT OUTPATIENT  
PSYCHIATRIC SERVICES

1294 Chapel Street, New Haven, CT 06511  
(203) 784-8750 Voice <http://www.srhs.org>

Partial Hospital/Intensive Outpatient Program (IOP)

LAWRENCE & MEMORIAL HOSPITAL - INTENSIVE OUTPATIENT PROGRAM

365 Montauk Avenue, New London, CT 06320  
(860) 444-5141 Voice <http://www.lmhospital.org>

Intensive Outpatient Program (IOP)

SOUND COMMUNITY SERVICES

165 State Street, New London, CT 06320  
(860) 443-0036 Voice <http://www.soundcommunityservices.org>

Intensive Outpatient Program (IOP)

CONNECTICUT COUNSELING CENTERS - NORWALK SITE

20 North Main Street 3rd Floor, Norwalk, CT 06854  
(203) 838-6508 Voice <http://www.ctcounseling.org>

Intensive Outpatient Treatment Program (IOP)

NORWALK HOSPITAL - BEHAVIORAL HEALTH AND ADDICTION SERVICES

24 Stevens Street, Norwalk, CT 06856  
(203) 852-2988 Voice <http://www.norwalkhosp.org>

Intensive Outpatient Program (IOP)

SAINT VINCENT'S BEHAVIORAL HEALTH SERVICES - HALLBROOKE AT LOIS ST  
One Lois Street, Norwalk, CT 06851  
(203) 221-8878 Voice <http://www.stvincentsbehavioralhealth.org/>  
Adolescent Intensive Treatment Program (IOP)

THE WILLIAM W. BACKUS HOSPITAL, THE WILLIAM W. - PSYCHIATRIC OUTPATIENT  
SERVICES - CENTER FOR MENTAL HEALTH  
326 Washington Street, Norwich, CT 06360  
(860) 823-6322 Voice <http://www.backushospital.org>

SOUTHEASTERN MENTAL HEALTH AUTHORITY  
401 West Thames Street Building 301, Norwich, CT 06360  
(860) 885-7255 Voice <http://www.ct.gov/dmhas/cwp/view.asp?a=2917&q=335372>  
cheryl.jacques@ct.gov

NATCHAUG HOSPITAL - JOSHUA CENTER - OLD SAYBROOK  
5 Research Parkway, Old Saybrook, CT 06475  
(860) 510-0163 Voice  
Partial Hospital/Intensive Outpatient Program (IOP)

OPTIMUS HEALTH CARE - STAMFORD AMBULATORY CARE CENTER - DOROTHY  
BENNETT BEHAVIORAL HEALTH CENTER  
1351 Washington Boulevard, Stamford, CT 06902  
(203) 621-3700 Voice <http://www.optimushealthcare.org>  
Intensive Outpatient Program (IOP)

BRIDGEPORT HOSPITAL - RESOURCE FOR ADULT AND CHILD MENTAL HEALTH  
(REACH)  
305 Boston Avenue, Stratford, CT 06615  
(203) 384-3377 Voice <http://www.bridgeporthospital.org>  
Partial Hospital/Intensive Outpatient Program (IOP)

CHARLOTTE HUNGERFORD HOSPITAL - BEHAVIORAL HEALTH SERVICES  
540 Litchfield Street, Torrington, CT 06790  
(860) 496-6380 Voice <http://www.charlottehungerford.org>  
Adult Partial Hospital Program

NATCHAUG HOSPITAL - JOSHUA CENTER - MONTVILLE  
20 Maple Avenue, Uncasville, CT 06382  
(860) 848-3098 Voice <http://www.natchaug.org>  
Partial Hospital/Intensive Outpatient Program (IOP)

NATCHAUG HOSPITAL - RIVEREAST DAY HOSPITAL AND TREATMENT CENTER

428 Hartford Turnpike, Vernon, CT 06066  
(860) 870-0119 Voice <http://www.natchaug.org>  
Partial Hospital/Intensive Outpatient Program (IOP)

CONNECTICUT COUNSELING CENTERS - WATERBURY SITE  
4 Midland Road, Waterbury, CT 06705  
(203) 755-8874 Voice <http://www.ctcounseling.org>  
Intensive Outpatient Treatment Program (IOP)

SAINT MARY'S HOSPITAL - BEHAVIORAL HEALTH CARE SERVICES  
56 Franklin Street, Waterbury, CT 06706  
(203) 709-6201 Voice <http://www.stmh.org>  
Partial Hospital/Intensive Outpatient Program (IOP)

WATERBURY HOSPITAL HEALTH CENTER - CENTER FOR GEROPSYCHIATRY  
88 Grandview Avenue, Waterbury, CT 06708  
(203) 573-7265 Voice <http://www.waterburyhospital.org>  
Intensive Outpatient Program (IOP)

WATERBURY HOSPITAL HEALTH CENTER - GRANDVIEW ADULT BEHAVIORAL HEALTH  
88 Grandview Avenue, Waterbury, CT 06708  
(203) 573-7265 Voice <http://www.waterburyhospital.org>  
Partial Hospital/Intensive Outpatient Program (IOP)

VETERANS AFFAIRS, UNITED STATES DEPARTMENT OF - CONNECTICUT HEALTHCARE  
SYSTEM, ERRERA COMMUNITY CARE CENTER  
114-152 Boston Post Road, West Haven, CT 06516  
(203) 479-8000 Voice <http://www.erreraccc.com>  
Intensive Outpatient Program (IOP)





**12. In response to Question 3a on page 19 concerning projected volume, Table 1:**

- a. Provide the basis for the annual volume (source of the patients);**
- b. Please clarify if the “Dual Diagnosis IOP” is or is not double counting patients from Substance Abuse IOP and/or Mental Health IOP.**

A.) As detailed in our response to question 3 above, we expect to obtain referrals from community sources including primary care providers and direct marketing to local families. There was a slight error in the assumptions outlined for Table 1, detailed in Section 3.b of our original application. With 10 patients per year per patient slot, and 6 patients slots per track (mis-stated as 9 in original application), this results in roughly 60 (10 x 6) patients per year per track, not 90.

B.) The Dual Diagnosis IOP track will be completely separate from either the Mental Health or Substance Abuse tracks. There is no overlap, as the Dual Diagnosis population is very distinctly identified as

Therefore, each track will operate independently of the other two and the numbers provided in Table 1 on page 19 are not double counting.

**13. On page 29 of the CON Application, the Applicant states that it intends to accept only commercial insurers and self-pay patients. Please complete and submit Table 3, the Patient Population Mix table on page 28 to reflect the break-out of the percentage between Commercial Payers and self-pay patients. Please revise Financial Attachments as appropriate.**

It is the intention of Connecticut Recovery Center to work primarily with commercial insurers, but we will not turn away those patients who meet criteria for treatment but prefer to pay out-of-pocket for privacy reasons. We accounted for up to 5% of our patients being self-pay in the Financial Attachments we submitted with our original application.

We had interpreted the “uninsured” row of Table 3 to mean those patients who have no means to pay (ie, indigent) but have updated this row to reflect patients who opt to pay out-of-pocket (regardless of whether they have insurance coverage or not). We are including an updated Table 3 (below), but the previously submitted Financial Attachments are as accurate as any projection of this sort can be until we are operating and have actual data and thus will not be re-submitted.

- a. Provide the current and projected patient population mix (based on the number of patients, not based on revenue) with the CON proposal for the proposed program.

**Table 3: Patient Population Mix**

	<i>Current**</i> <i>FY 2013</i>	<i>Year 1</i> <i>FY 2014</i>	<i>Year 2</i> <i>FY 2015</i>	<i>Year 3</i> <i>FY 2016</i>
<i>Medicare*</i>	0	0	0	0
<i>Medicaid*</i>	0	0	0	0
<i>CHAMPUS &amp; TriCare</i>	0	0	0	0
<b><i>Total Government</i></b>	0	0	0	0
<i>Commercial Insurers*</i>	0%	95%	95%	95%
<i>Uninsured</i>	0	5%	5%	5%
<i>Workers Compensation</i>	0	0	0	0
<b><i>Total Non-Government</i></b>	0%	100%	100%	100%
<b><i>Total Payer Mix</i></b>	0%	100%	100%	100%

*\* Includes managed care activity. \*\* New programs may leave the “current” column blank.*

*\*\*\* Fill in years. Ensure the period covered by this table corresponds to the period covered in the projections provided.*

**14. Does the Applicant have any relationships with any other providers in Connecticut and out-of-state? If so, submit letters from those providers that demonstrate that they will refer patients to your proposed facility. What is the projected split between in-state and out-of-state referrals?**

No, the Connecticut Recovery Center does not have any professional, financial or contractual relationships with any other providers, either in Connecticut or out-of-state. As we are proposing an outpatient facility located in the middle of the state, we anticipate all of our potential patients will be residents of Connecticut.

**15. Provide documentation that demonstrates that the Applicant has contacted the State of Connecticut Department of Mental Health and Addiction Services to provide information related to the admission and discharge status of clients at existing facilities in the proposed service area and in Connecticut.**

We have contacted multiple people at DMHAS to try to get clarification around this request, including Lauren Siembab, Director of the Community Services Division, and Debra Lynch in Fiscal Services. We were ultimately directed to James Siemianowski, Director of the Evaluation, Quality Management and Improvement Division (EQMI) at DMHAS (860-418-6810), who in turn spoke with DMHAS Commissioner Patricia Rehmer about this request. Mr. Siemianowski reported back that the Connecticut legislation related to the role of DMHAS in the Certificate of Need process has changed in recent years and their department no longer tracks or provides this type of data.

We explained our proposal in detail to Mr. Siemanowski and he indicated he did "not see any reason why DMHAS would oppose" our proposal to open an IOP in Cheshire.

**16. On page 19 of the CON Application, the Applicant projects 80,120,180, and 180 patients for FYS 2013-2016, respectively. Provide details as to the source of the projected numbers and the rationale used. Discuss how the Applicant expects to achieve this projected volume.**

Please refer to our responses to questions 1, 3, 6 and 12, above, where we specifically addressed both the projected numbers and the rationale used. In short, we expect roughly 60 patients per track per year once we are fully operational. Since we will only have one track running for much of the first year, and likely only two tracks running in the second year of operations, we anticipate lower numbers for the first two years. Initially, our referrals will come mostly from local primary providers who are already well-aware of the need for this type of service in this area. It is our expectation that our business will grow rapidly over the first two years, and we will be able to open the third track by our third year.

**17. Please revise and update Financial Attachment I, on page 34 of the CON Application to include FY 2016.**

Please see attached updated Financial Attachment I. Since the Connecticut Recovery Center is a brand-new venture, we do not have any actual financial results for FY2013 and therefore can only make projections for future years as detailed on the worksheet.



**18. On pages 44-59 of the CON Application, the Applicant provided the Curriculum Vitae for all staff related to the proposal. Please confirm that each of the positions listed meets the appropriate level of licensing/Credentialing required for the various levels of services proposed and provide evidence thereof.**

Under Section 70.1.C.1 of the Centers for Medicare and Medicaid Services manual (attached), covered services for the Intensive Outpatient Treatment of psychiatric patients include group therapies conducted by "physicians, psychologists, or other mental health professionals authorized by the State."

The State of Connecticut recognizes and grants licensure to those who meet qualifications for the following mental health professions:

- physician (MD or DO)
- psychologist (PhD or PsyD)
- social workers (LCSW)
- alcohol and drug abuse counselors (LADC)
- professional counselors (LPC)

All of our proposed clinical staff currently hold valid licenses in their respective disciplines in the state of Connecticut, and all have current and past work experience at credentialed Intensive Outpatient Programs in this state.

We are also attaching the relevant practice act from the Connecticut General Statutes for both LPCs and LADCs.

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**CMS Manual System**  
**Pub. 100-02 Medicare Benefit Policy**

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**Department of Health &  
Human Services (DHHS)  
Centers for Medicare &  
Medicaid Services (CMS)**

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**Transmittal 10****Date: MAY 7, 2004**

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**CHANGE REQUEST 3298**

**I. SUMMARY OF CHANGES:** Adding information from Transmittal 761, published September 2000, also found in sections 230.5 and 230.7 of the Hospital Manual, to Chapter 6, sections 70.1 and 70.3 of the on-line Medicare Beneficiary Manual, that had been accidentally left out during the transition from paper based manuals to on-line manuals.

**MANUALIZATION – EFFECTIVE/IMPLEMENTATION DATE: N/A**

*Disclaimer for manual changes only: The revision date and transmittal number apply only to the red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will only receive the new/revised information, and not the entire table of contents.*

**II. CHANGES IN MANUAL INSTRUCTIONS:**  
**(R = REVISED, N = NEW, D = DELETED)**

<b>R/N/D</b>	<b>CHAPTER/SECTION/SUBSECTION/TITLE</b>
<b>R</b>	6/70.1/General
<b>R</b>	6/70.3/Partial Hospitalization Services

**\*III. FUNDING:**

**These instructions should be implemented within your current operating budget.**

**IV. ATTACHMENTS:**

	<b>Business Requirements</b>
<b>X</b>	<b>Manual Instruction</b>
	<b>Confidential Requirements</b>
	<b>One-Time Notification</b>
	<b>Recurring Update Notification</b>

**\*Medicare contractors only**

## 70.1 - General

(Rev. 10, 05-07-04)

### A3-3112.7.A, HO-230.5.A

There is a wide range of services and programs that a hospital may provide to its outpatients who need psychiatric care, ranging from a few individual services to comprehensive, full-day programs; from intensive treatment programs to those that provide primarily supportive.

In general, to be covered the services must be:

- Incident to a physician's service (see §20.4); and
- Reasonable and necessary for the diagnosis or treatment of the patient's condition.

This means the services must be for the purpose of diagnostic study or the services must reasonably be expected to improve the patient's condition.

A. Coverage Criteria.--*The services must meet the following criteria:*

1. Individualized Treatment Plan.--*Services must be prescribed by a physician and provided under an individualized written plan of treatment established by a physician after any needed consultation with appropriate staff members. The plan must state the type, amount, frequency, and duration of the services to be furnished and indicate the diagnoses and anticipated goals. (A plan is not required if only a few brief services are furnished.)*

2. Physician Supervision and Evaluation.--*Services must be supervised and periodically evaluated by a physician to determine the extent to which treatment goals are being realized. The evaluation must be based on periodic consultation and conference with therapists and staff, review of medical records, and patient interviews. Physician entries in medical records must support this involvement. The physician must also provide supervision and direction to any therapist involved in the patient's treatment and see the patient periodically to evaluate the course of treatment and to determine the extent to which treatment goals are being realized and whether changes in direction or emphasis are needed.*

3. Reasonable Expectation of Improvement.--*Services must be for the purpose of diagnostic study or reasonably be expected to improve the patient's condition. The treatment must, at a minimum, be designed to reduce or control the patient's psychiatric symptoms so as to prevent relapse or hospitalization, and improve or maintain the patient's level of functioning.*

*It is not necessary that a course of therapy have as its goal restoration of the patient to the level of functioning exhibited prior to the onset of the illness, although this may be*

appropriate for some patients. For many other psychiatric patients, particularly those with long-term, chronic conditions, control of symptoms and maintenance of a functional level to avoid further deterioration or hospitalization is an acceptable expectation of improvement. "Improvement" in this context is measured by comparing the effect of continuing treatment versus discontinuing it. Where there is a reasonable expectation that if treatment services were withdrawn the patient's condition would deteriorate, relapse further, or require hospitalization, this criterion is met.

Some patients may undergo a course of treatment that increases their level of functioning, but then reach a point where further significant increase is not expected. Such claims are not automatically considered noncovered because conditions have stabilized, or because treatment is now primarily for the purpose of maintaining present level of functioning. Rather, coverage depends on whether the criteria discussed above are met. Services are noncovered only where the evidence clearly establishes that the criteria are not met; for example, that stability can be maintained without further treatment or with less intensive treatment.

B Partial Hospitalization.--Partial hospitalization is a distinct and organized intensive treatment program for patients who would otherwise require inpatient psychiatric care. See §70.3 for specific program requirements.

C. Application of Criteria.--The following discussion illustrates the application of the above guidelines to the more common modalities and procedures used in the treatment of psychiatric patients and some factors that are considered in determining whether the coverage criteria are met.

1 Covered Services.--Services generally covered for the treatment of psychiatric patients are:

- \* Individual and group therapy with physicians, psychologists, or other mental health professionals authorized by the State.
- \* Occupational therapy services are covered if they require the skills of a qualified occupational therapist and be performed by or under the supervision of a qualified occupational therapist or by an occupational therapy assistant.
- \* Services of social workers, trained psychiatric nurses, and other staff trained to work with psychiatric patients.
- \* Drugs and biologicals furnished to outpatients for therapeutic purposes, but only if they are of a type which cannot be self-administered.
- \* Activity therapies but only those that are individualized and essential for the treatment of the patient's condition. The treatment plan

must clearly justify the need for each particular therapy utilized and explain how it fits into the patient's treatment.

- Family counseling services. Counseling services with members of the household are covered only where the primary purpose of such counseling is the treatment of the patient's condition.
- Patient education programs, but only where the educational activities are closely related to the care and treatment of the patient.
- Diagnostic services for the purpose of diagnosing those individuals for whom an extended or direct observation is necessary to determine functioning and interactions, to identify problem areas, and to formulate a treatment plan.

2. Noncovered Services.--The following are generally not covered except as indicated:

- Meals and transportation.
- Activity therapies, group activities or other services and programs which are primarily recreational or diversional in nature. Outpatient psychiatric day treatment programs that consist entirely of activity therapies are not covered.

"Geriatric day care" programs are available in both medical and nonmedical settings. They provide social and recreational activities to older individuals who need some supervision during the day while other family members are away from home. Such programs are not covered since they are not considered reasonable and necessary for a diagnosed psychiatric disorder, nor do such programs routinely have physician involvement.

3.

- Psychosocial programs. These are generally community support groups in nonmedical settings for chronically mentally ill persons for the purpose of social interaction. Outpatient programs may include some psychosocial components; and to the extent these components are not primarily for social or recreational purposes, they are covered. However, if an individual's outpatient hospital program consists entirely of psychosocial activities, it is not covered.
- Vocational training. While occupational therapy may include vocational and prevocational assessment and training, when the services are related solely to specific employment opportunities, work skills or work settings, they are not covered.

4. Frequency and Duration of Services.--There are no specific limits on the length of time that services may be covered. There are many factors that affect the outcome of treatment; among them are the nature of the illness, prior history, the goals of treatment, and the patient's response. As long as the evidence shows that the patient continues to show improvement in accordance with his/her individualized treatment plan, and the frequency of services is within accepted norms of medical practice, coverage may be continued.

*If a patient reaches a point in his/her treatment where further improvement does not appear to be indicated, evaluate the case in terms of the criteria to determine whether with continued treatment there is a reasonable expectation of improvement.*

## CHAPTER 376b

### ALCOHOL AND DRUG COUNSELORS

Section 20-74s. Licensure and certification of alcohol and drug counselors. (a) Definitions. For purposes of this section and subdivision (18) of subsection (c) of section 19a-14:

- (1) "Commissioner" means the Commissioner of Public Health;
- (2) "Licensed alcohol and drug counselor" means a person licensed under the provisions of this section;
- (3) "Certified alcohol and drug counselor" means a person certified under the provisions of this section;
- (4) "Practice of alcohol and drug counseling" means the professional application of methods that assist an individual or group to develop an understanding of alcohol and drug dependency problems, define goals, and plan action reflecting the individual's or group's interest, abilities and needs as affected by alcohol and drug dependency problems;
- (5) "Private practice of alcohol and drug counseling" means the independent practice of alcohol and drug counseling by a licensed or certified alcohol and drug counselor who is self-employed on a full-time or parttime basis and who is responsible for that independent practice;
- (6) "Self-help group" means a voluntary group of persons who offer peer support to each other in recovering from an addiction; and
- (7) "Supervision" means the regular on-site observation of the functions and activities of an alcohol and drug counselor in the performance of his or her duties and responsibilities to include a review of the records, reports, treatment plans or recommendations with respect to an individual or group.

(b) Except as provided in subsections (s) to (x), inclusive, of this section, no person shall engage in the practice of alcohol and drug counseling unless licensed as a licensed alcohol and drug counselor pursuant to subsection (d) of this section or certified as a certified alcohol and drug counselor pursuant to subsection (e) of this section.

(c) Except as provided in subsections (s) to (x), inclusive, of this section, no person shall engage in the private practice of alcohol and drug counseling unless (1) licensed as a licensed alcohol and drug counselor pursuant to subsection (d) of this section, or (2) certified as a certified alcohol and drug counselor pursuant to subsection (e) of this section and practicing under the supervision of a licensed alcohol and drug counselor.

(d) To be eligible for licensure as a licensed alcohol and drug counselor, an applicant shall (1) have attained a master's degree from an accredited institution of higher education and have completed a minimum of eighteen graduate semester hours in counseling or counseling-related subjects at an accredited institution of higher education, except that applicants holding certified clinical supervisor status by the Connecticut Certification Board, Inc. as of October 1, 1998, may substitute such certification in lieu of the master's degree requirement and graduate coursework requirement, and (2) have completed the certification eligibility requirements described in subdivisions (1), (2) and (4) of subsection (e) of this section.

(e) To be eligible for certification by the Department of Public Health as a certified alcohol and drug counselor, an applicant shall have (3) completed three hundred sixty hours of commissioner-approved education, at least two hundred forty hours of which relates to the

knowledge and skill base associated with the practice of alcohol and drug counseling; and (4) successfully completed a department prescribed examination.

(f) For individuals applying for certification as an alcohol and drug counselor by the Department of Public Health prior to October 1, 1998, current certification by the Department of Mental Health and Addiction Services may be substituted for the certification requirements of subsection (e) of this section.

(g) The commissioner shall grant a license as an alcohol and drug counselor to any applicant who furnishes satisfactory evidence that he has met the requirements of subsection (d) or (o) of this section. The commissioner shall develop and provide application forms. The application fee shall be one hundred ninety dollars.

(h) A license as an alcohol and drug counselor shall be renewed in accordance with the provisions of section 19a-88 for a fee of one hundred ninety dollars.

(i) The commissioner shall grant certification as a certified alcohol and drug counselor to any applicant who furnishes satisfactory evidence that he has met the requirements of subsection (e) or (o) of this section. The commissioner shall develop and provide application forms. The application fee shall be one hundred ninety dollars.

(j) A certificate as an alcohol and drug counselor may be renewed in accordance with the provisions of section 19a-88 for a fee of one hundred ninety dollars.

(k) The commissioner may contract with a qualified private organization for services that include (1) providing verification that applicants for licensure or certification have met the education, training and work experience requirements under this section; and (2) any other services that the commissioner may deem necessary.

(l) Any person who has attained a master's level degree and is certified by the Connecticut Certification Board as a substance abuse counselor on or before July 1, 2000, shall be deemed a licensed alcohol and drug counselor. Any person so deemed shall renew his license pursuant to section 19a-88 for a fee of one hundred ninety dollars.

(m) Any person who has not attained a master's level degree and is certified by the Connecticut Certification Board as a substance abuse counselor on or before July 1, 2000, shall be deemed a certified alcohol and drug counselor. Any person so deemed shall renew his certification pursuant to section 19a-88 for a fee of one hundred ninety dollars.

(n) Any person who is not certified by the Connecticut Certification Board as a substance abuse counselor on or before July 1, 2000, who (1) documents to the department that he has a minimum of five years full-time or eight years part-time paid work experience, under supervision, as an alcohol and drug counselor, and (2) successfully passes a commissioner-approved examination no later than July 1, 2000, shall be deemed a certified alcohol and drug counselor. Any person so deemed shall renew his certification pursuant to section 19a-88 for a fee of one hundred ninety dollars.

(o) The commissioner may license or certify without examination any applicant who, at the time of application, is licensed or certified by a governmental agency or private organization located in another state, territory or jurisdiction whose standards, in the opinion of the commissioner, are substantially similar to, or higher than those of this state.

(p) No person shall assume, represent himself as, or use the title or designation "alcoholism counselor", "alcohol counselor", "alcohol and drug counselor", "alcoholism and drug counselor", "licensed clinical alcohol and drug counselor", "licensed alcohol and drug counselor", "licensed

associate alcohol and drug counselor", "certified alcohol and drug counselor", "chemical dependency counselor", "chemical dependency supervisor" or any of the abbreviations for such titles, unless licensed or certified under subsections (g) to (n), inclusive, of this section and unless the title or designation corresponds to the license or certification held.

(q) The commissioner shall adopt regulations, in accordance with chapter 54, to implement provisions of this section.

(r) The commissioner may suspend, revoke or refuse to issue a license in circumstances that have endangered or are likely to endanger the health, welfare or safety of the public.

(s) Nothing in this section shall be construed to apply to the activities and services of a rabbi, priest, minister, Christian Science practitioner or clergyman of any religious denomination or sect, when engaging in activities that are within the scope of the performance of the person's regular or specialized ministerial duties and for which no separate charge is made, or when these activities are performed, with or without charge, for or under the auspices or sponsorship, individually or in conjunction with others, of an established and legally cognizable church, denomination or sect, and when the person rendering services remains accountable to the established authority thereof.

(t) Nothing in this section shall be construed to apply to the activities and services of a person licensed in this state to practice medicine and surgery, psychology, marital and family therapy, clinical social work, professional counseling, advanced practice registered nursing or registered nursing, when such person is acting within the scope of the person's license and doing work of a nature consistent with that person's license, provided the person does not hold himself or herself out to the public as possessing a license or certification issued pursuant to this section.

(u) Nothing in this section shall be construed to apply to the activities and services of a student intern or trainee in alcohol and drug counseling who is pursuing a course of study in an accredited institution of higher education or training course, provided these activities are performed under supervision and constitute a part of an accredited course of study, and provided further the person is designated as an intern or trainee or other such title indicating the training status appropriate to his level of training.

(v) Nothing in this section shall apply to individuals who are on October 1, 2010, employed by a state agency as a rehabilitation counselor who is acting in the capacity of an alcohol and drug counselor.

(w) Nothing in this section shall be construed to apply to the activities and services of paid alcohol and drug counselors who are working under supervision or uncompensated alcohol and drug abuse self-help groups, including, but not limited to, Alcoholics Anonymous and Narcotics Anonymous.

(x) The provisions of this section shall apply to employees of the Department of Correction, other than trainees or student interns covered under subsection (u) of this section and persons completing supervised paid work experience in order to satisfy mandated clinical supervision requirements for certification under subsection (e)

of this section, as follows: (1) Any person hired by the Department of Correction on or after October 1, 2002, for a position as a substance abuse counselor or supervisor of substance abuse counselors shall be a licensed or certified alcohol and drug counselor; (2) any person employed by the Department of Correction prior to October 1, 2002, as a substance abuse counselor or supervisor of substance abuse counselors shall become licensed or certified as an

alcohol and drug counselor by October 1, 2007; and (3) any person employed by the Department of Correction on or after October 1, 2007, as a substance abuse counselor or supervisor of substance abuse counselors shall be a licensed or certified alcohol and drug counselor.

Section 20-74t. Continuing Education Requirement.

(a) On and after October 1, 2004, each alcohol and drug counselor licensed or certified pursuant to chapter 376b of the general statutes shall complete a minimum of twenty hours of continuing education each registration period. For purposes of this section, registration period means the twelve-month period for which a license or certificate has been renewed in accordance with section 19a-88 of the general statutes and is current and valid. The continuing education shall be in areas related to the individual's practice. Qualifying continuing education activities are educational offerings sponsored by a hospital or other licensed health care institutions, courses offered by a regionally accredited institution of higher education or courses offered by individuals or organizations on the list maintained by the Connecticut Certification Board, Inc. as approved providers of such continuing education activities.

(b) Each licensee or certificate holder shall obtain a certificate of completion from the provider of continuing education activities for all continuing education hours successfully completed. Each licensee or certificate holder shall maintain such written documentation for a minimum of three years following the license or certificate renewal date for which the activity satisfies continuing education requirements. Certificates of completion shall be submitted by the licensee or certificate holder to the Department of Public Health upon the department's request. A licensee or certificate holder who fails to comply with the continuing education requirements shall be subject to disciplinary action pursuant to subsection (r) of section 20-74s or section 19a-17 of the general statutes.

(c) The continuing education requirements shall be waived for licensees and certificate holders applying for licensure or certification renewal for the first time. The department may, for a licensee or certificate holder who has a medical disability or illness, grant a waiver of the continuing education requirements for a specific period of time or may grant the licensee or certificate holder an extension of time in which to fulfill the requirements.

CONNECTICUT GENERAL STATUTES  
PROFESSIONAL COUNSELORS  
CHAPTER 383c

Sec. 20-195aa.

Definitions: As used in sections 20-195aa to 20-195ee, inclusive, of this act: "Professional counseling" means the application, by persons trained in counseling, of established principles of psycho-social development and behavioral science to the evaluation, assessment, analysis and treatment of emotional, behavioral or interpersonal dysfunction or difficulties that interfere with mental health and human development.

"Professional counseling" includes, but is not limited to, individual, group, marriage and family counseling, functional assessments for persons adjusting to a disability, appraisal, crisis intervention and consultation with individuals or groups.

Sec. 20-195bb. Practice restricted to licensed persons. Exceptions. Title protection.

(a) Except as provided in subsection (c) of this section, no person may practice professional counseling unless licensed pursuant to section 20-195cc.

(b) No person may use the title "licensed professional counselor" or make use of any title, words, letters or abbreviations that may reasonably be confused with licensure as a professional counselor unless licensed pursuant to section 20-195cc.

(c) No license as a professional counselor shall be required of the following: (1) A person who furnishes uncompensated assistance in an emergency; (2) a clergyman, priest, minister, rabbi or practitioner of any religious denomination accredited by the religious body to which the person belongs and settled in the work of the ministry, provided the activities that would otherwise require a license as a professional counselor are within the scope of ministerial duties; (3) a sexual assault counselor, as defined in section 52-146k; (4) a person participating in uncompensated group or individual counseling; (5) a person with a master's degree in a health-related or human services-related field employed by a hospital, as defined in subsection (b) of section 19a-490, performing services in accordance with section 20-195aa under the supervision of a person licensed by the state in one of the professions identified in subparagraphs (A) to (F), inclusive, of subdivision (2) of subsection (a) of section 20-195dd; (6) a person licensed or certified by any agency of this state and performing services within the scope of practice for which licensed or certified; (7) a student, intern or trainee pursuing a course of study in counseling in a regionally accredited institution of higher education, provided the activities that would otherwise require a license as a professional counselor are performed under supervision and constitute a part of supervised course of study; (8) a person employed by an institution of higher education to provide academic counseling in conjunction with the institution's programs and services; or (9) a vocational rehabilitation counselor, job counselor, credit counselor, consumer counselor or any other counselor or psychoanalyst who does not purport to be a counselor whose primary service is the application of established principles of psycho-social development and behavioral science to the evaluation, assessment, analysis and treatment of emotional, behavioral or interpersonal dysfunction or difficulties that interfere with mental health and human development.

Sec. 20-195cc. Licensure application. Renewal. Fees.

(a) The Commissioner of Public Health shall grant a license as a professional counselor to any applicant who furnishes evidence satisfactory to the commissioner that he has met the requirements of section 4 of this act. The commissioner shall develop and provide application forms. The application fee shall be three hundred fifteen dollars.

(b) The license may be renewed annually pursuant to section 19a-88 of the general statutes, as amended by section 8 of this act, for a fee of one hundred ninety dollars.

Sec. 20-195dd. Qualifications. (a) Except as provided in subsections (b) and (c) of this section, an applicant for a license as a professional counselor shall submit evidence satisfactory to the Commissioner of Public Health of having:

(1) Completed sixty graduate semester hours in or related to the discipline of counseling at a regionally accredited institution of higher education, which included coursework in each of the following areas: (A) human growth and development, (B) social and cultural foundations, (C) counseling theories and techniques or helping relationships, (D) group dynamics, (E) processing and counseling, (F) career and lifestyle development, (G) appraisals or tests and measurements for individuals and groups, (H) research and evaluation, and (I) professional orientation to counseling;

(2) earned, from a regionally accredited institution of higher education a master's or doctoral degree in social work, marriage and family therapy, counseling, psychology or a related mental health field

(3) acquired three thousand hours of postgraduate-degree-supervised experience in the practice of professional counseling, performed over a period of not less than one year, that included a minimum of one hundred hours of direct supervision by (A) a physician licensed pursuant to chapter 370 who has obtained certification in psychiatry from the American Board of Psychiatry and Neurology, (B) a psychologist licensed pursuant to chapter 383, (C) an advanced practice registered nurse licensed pursuant to chapter 378 and certified as a clinical specialist in adult psychiatric and mental health nursing with the American Nurses Credentialing Center, (D) a marital and family therapist licensed pursuant to chapter 383a, (E) a clinical social worker licensed pursuant to chapter 383b, (F) a professional counselor licensed, or prior to October 1, 1998, eligible for licensure, pursuant to section 20-195cc, or (G) a physician certified in psychiatry by the American Board of Psychiatry and Neurology, psychologist, advanced practice registered nurse certified as a clinical specialist in adult psychiatric and mental health nursing with the American Nurses Credentialing Center, marital and family therapist, clinical social worker or professional counselor licensed or certified as such or as a person entitled to perform similar services, under a different designation, in another state or jurisdiction whose requirements for practicing in such capacity are substantially similar to or higher than those of this state; and (4) passed an examination prescribed by the commissioner.

(b) Prior to December 30, 2001, an applicant for a license as a professional counselor may, in lieu of the requirements set forth in subsection (a) of this section, submit evidence satisfactory to the commissioner of having: (A) Earned at least a thirty-hour master's degree, sixth-year degree or doctoral degree from a regionally accredited institution of higher education with a major in social work, marriage and family therapy, counseling, psychology or forensic psychology; (B) practiced professional counseling for a minimum of two years within a five-year

period immediately preceding application; and (C) passed an examination prescribed by the commissioner.

(c) An applicant for licensure by endorsement shall present evidence satisfactory to the commissioner that the applicant is licensed or certified as a professional counselor, or as a person entitled to perform similar services under a different designation, in another state or jurisdiction whose requirements for practicing in such capacity are substantially similar to or higher than those of this state and that there are no disciplinary actions or unresolved complaints pending.

#### Sec. 20-195ee. Disciplinary action. Grounds.

The Commissioner of Public Health may take any disciplinary action set forth in section 19a-17 of the general statutes against a professional counselor for any of the following reasons:

- (1) Failure to conform to the accepted standards of the profession;
- (2) conviction of a felony;
- (3) fraud or deceit in obtaining or seeking reinstatement of a license to practice professional counseling;
- (4) fraud or deceit in the practice of professional counseling;
- (5) negligent, incompetent or wrongful conduct in professional activities;
- (6) physical, mental or emotional illness or disorder resulting in an inability to conform to the accepted standards of the profession;
- (7) alcohol or substance abuse;
- (8) wilful falsification of entries in any hospital, patient or other record pertaining to professional counseling; or
- (9) violation of any provision of sections 1 to 4 , inclusive, of this act or any regulation adopted pursuant to section 6 of this act. The commissioner may order a license holder to submit to a reasonable physical or mental examination if his physical or mental capacity to practice safely is the subject of an investigation. The commissioner may petition the superior court for the judicial district of Hartford-New Britain to enforce such order or any action taken pursuant to said section 19a-17. The commissioner shall give notice and an opportunity to be heard on any contemplated action under said section 19a-17.

#### Sec. 20-195ff. Regulations.

The Commissioner of Public Health may adopt regulations, in accordance with the provisions of chapter 54, to further the purposes of subdivision (18) of subsection (c) of section 19a-14, subsection (e) of section 19a-88, subdivision (15) of section 19a-175, subsection (b) of section 20-9, subsection (c) of section 20-195aa to 20-195ff, inclusive, and sections 20-206jj to 20-206oo, inclusive.

**19. On pages 60-95 of the CON Application, the Applicant provided referencing articles and bibliographies. Please highlight the relevant pages and portions of the referenced material and directly tie into the need for this proposal and specifically, how the provided reference material supports the need for this proposal.**

The following are the references included with the original application. The italicized sections refer to the relevancy of the reference to the Connecticut Recovery Center proposal.

1. American Psychiatric Association. DSM-IV-TR or Diagnostic and Statistical Manual, edition IV transitional (2000). The DSM-IV-TR provides a classification of mental disorders, criteria sets to guide the process of differential diagnosis, and numerical codes for each disorder to facilitate medical record keeping. The stated purpose of the DSM is to: 1) provide "a helpful guide to clinical practice"; 2) "to facilitate research and improve communication among clinicians and researchers"; and 3) to serve as "an educational tool for teaching psychopathology." *The DSM provides the standardization for the classification of mental health and substance use disorders. We cite it as one of our means of determining who will or will not meet criteria for treatment at our proposed facility. DSM-IV-TR was updated and released as DSM-V in late May 2013 (after our original application was submitted).*
2. American Society of Addiction Medicine. ASAM Patient Placement Criteria for the Placement of Substance Related Disorders, Second Edition (ASAM PPC-2R) (2001). The ASAM Patient Placement Criteria is the result of a collaboration that began in the 1980s to define one national set of criteria for providing outcome-orientated and results based care in the treatment of outcome-orientated and results based care in the treatment of addiction. *The ASAM Patient Placement Criteria were cited as an example of the Standard Practice Guidelines we intend to utilize, as requested in section 4c of the original application.*
3. Beauregard, Kimberly, LCSW. Connecticut cannot afford to ignore mental health needs. Connecticut Mirror. April 11, 2013. <http://ctmirror.org/node/19702>. *Cited as an example of a prominent member of the Connecticut Mental Health community describing the urgent need for more services in this state, section 2 of the original application.*
4. CPT 2013 Professional Edition (Current Procedural Terminology, Professional Ed. (Spiral)) (Current Procedural Terminology (CPT) Professional). American Medical Association; 1 edition (October 15, 2012). *Cited as documentation of the basis for defining proposed services, as requested in section 7d of the original application.*
5. Connecticut Department of Public Health. National Public Health Week Fact Sheet: Drug and Alcohol-related Poisoning (April 2011). <http://www.ct.gov/dph/cwp/view.asp?q=476708&a=3987>. *Included as evidence of growing problem of opiate overdose deaths and the need for more substance abuse treatment options, section 2 of the original application.*
6. DiClemente, Carlo and James Prochaska. Stages of Change Model. Developed in the late 1970's and early 1980's, the Stages of Change Model is applied to a broad range of behaviors

including weight loss, injury prevention, overcoming alcohol, and drug problems.

<http://www.addictioninfo.org/articles/11/1/Stages-of-Change-Model/Page1.html>

*The Stages of Change are cited as an example of the Standard Practice Guidelines we intend to utilize, as requested in section 4c of the original application.*

7. Drake, Robert MD. NAMI National Alliance on Mental Illness. (September 2003). Dual Diagnosis and Integrated Treatment of Mental Illness and Substance Abuse Disorder.

[http://www.nami.org/Template.cfm?Section=By\\_Illness&Template=/TaggedPage/TaggedPageDisplay.cfm&TPLID=54&ContentID=23049](http://www.nami.org/Template.cfm?Section=By_Illness&Template=/TaggedPage/TaggedPageDisplay.cfm&TPLID=54&ContentID=23049). *The NAMI standards were cited as an example of the Standard Practice Guidelines we intend to utilize, as requested in section 4c of the original application.*

8. Johnston, L. D., O'Malley, P. M., Bachman, J. G., & Schulenberg, J. E. (2012). Monitoring the Future: national survey results on drug use, 1975–2011: Volume I, Secondary school students. Ann Arbor: Institute for Social Research, The University of Michigan. *Cited as a reference for the prevalence of mental illness and addiction treatments, section 2.a.iii of the original application.*

9. Kessler, Ronald C. NATIONAL COMORBIDITY SURVEY, 1990-1992. Conducted by University of Michigan, Survey Research Center. 2nd ICPSR ed. Ann Arbor, MI: Inter-university Consortium for Political and Social Research, 2002. *Cited as a reference for the prevalence of mental illness and addictions, section 2.a.iii of the original application.*

10. Malloy, Dannel P. Governor, State of Connecticut. Official Press Release, April 9, 2013. *Cited as an example of a prominent member of the Connecticut community describing the urgent need for more mental health services in this state, section 2 of the original application.*

11. Montoya, Iván D. Jennifer R. Schroeder, Kenzie L. Preston, Lino Covi, Annie Umbricht, Carlo Contoreggi, Paul J. Fudala, Rolley E. Johnson, David A. Gorelick. **Influence of psychotherapy attendance on buprenorphine treatment outcome** Journal of Substance Abuse Treatment - April 2005 (Vol. 28, Issue 3, Pages 247-254). *Cited as evidenced-based best practices for treatment utilizing buprenorphine, section 1.a of the original application.*

12. Murray, Rheana. New York Daily News (June 2012). Heroin use among suburban teens skyrockets; Experts say prescription pills are the new gateway drug. <http://www.nydailynews.com/life-style/health/heroin-soars-suburban-teens-talk-heroin-problem-talking-prescription-drug-problem-article-1.1099140>. *Cited as a reference for the prevalence of opiate addictions and the pressing need for more treatment options in suburban areas, section 2.a.iii of the original application.*

13. NIDA National Institute on Drug Abuse. Principles of Drug Addiction Treatment: A Research-Based Guide (Third Edition) (October 1999). [www.drugabuse.gov](http://www.drugabuse.gov) *Cited as evidenced-based best practices to drug addiction treatments, specifically utilizing buprenorphine, sections 1.a and 4.c of the original application.*

14. Rehmer MSN, Patricia. CT Commissioner Department of Mental Health and Addiction Services presenting before the Public Health Committee on 3/7/2012. Speaking in favor of HB 5063 that would allow Naloxone (a component of Suboxone) to be prescribed more broadly to counteract drug overdoses. *Cited as an example of a prominent member of the Connecticut community describing the urgent need for more mental health and addiction services in this state, section 2 of the original application.*

15. SAMHSA (Substance Abuse and Mental Health Services Administration), Center for Behavioral Health Statistics and Quality (formerly the Office of Applied Studies) (2007 and 2009). Treatment Episode Data Set. National Admissions to Substance Abuse Treatment Services. <http://www.samhsa.gov/data/DASIS/TEDS2k7AWeb/TEDS2k7AWeb.pdf> *Cited as a reference for the prevalence of mental illness and addictions, section 2.a.iii of the original application. Highlights the particular problem of heroin/opiate addiction in this state, compared to others.*

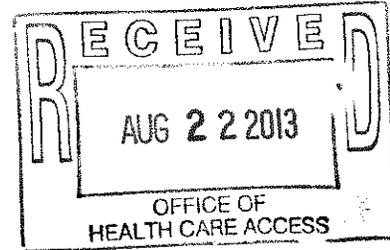
16. SAMHSA, Center for Behavioral Health Statistics and Quality (formerly the Office of Applied Studies), National Survey on Drug Use and Health. (2008 and 2009). <http://www.samhsa.gov/data/2k9State/WebOnlyTables/CT.pdf> (CT data). *Cited as a reference for the prevalence of mental illness and addictions, section 2.a.iii of the original application, specific to the state of Connecticut, demonstrating that over 227,000 people over the age of 18 needed - but did not receive - treatment for substance dependence in this state annually.*

17. Substance Abuse and Mental Health Services Administration, Results from the 2010 National Survey on Drug Use and Health: Summary of National Findings, NSDUH Series H-41, HHS Publication No. (SMA) 11-4658. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2011. *Cited as evidence of both the continued increase in the use of illicit substances in recent years and the lack of accessible treatment options, section 2.a.iii of original application.*

18. U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General—Executive Summary*. Rockville, MD: U.S. Dept. of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999. *Cited as evidence of both the continued increase in the use of illicit substances in recent years and the need for increased treatment options, specifically the need for more co-occurring disorders treatment options, section 2.a.iii of original application.*

CONNECTICUT RECOVERY CENTER, LLC

# Fax



<b>TO:</b>	Mr. Steven Lazarus	<b>TO FAX:</b>	860-418-7053
<b>From:</b>	Dr. Jennifer Ballew	<b>From FAX:</b>	951-257-9990
<b>DATE:</b>	August 22, 2013	<b>PAGES:</b>	2 (inc. this cover page)

<b>re:</b>	Letter from Jim Siemianowski
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**MESSAGE:**

Dear Mr. Lazarus,

Attached is the letter from Jim Siemianowski as discussed in our recent telephone conversation.

Thank you,

Dr. Jennifer Ballew  
 Medical Director and CEO  
 Connecticut Recovery Center, LLC



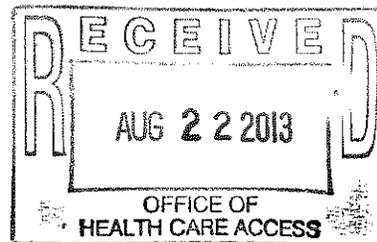
# STATE OF CONNECTICUT

DEPARTMENT OF MENTAL HEALTH  
AND ADDICTION SERVICES  
*A HEALTHCARE SERVICE AGENCY*

DANNEL P. MALLOY  
GOVERNOR

PATRICIA A. REHMER, MSN  
COMMISSIONER

August 6, 2013



Dr. Jennifer Ballew  
Medical Director and CEO  
Connecticut Recovery Center, LLC  
P.O. Box 429  
Cheshire, CT 06410

RE: Certificate of Need Application, Docket Number 13-31840-CON  
Connecticut Recovery Center, LLC  
Establishment of an Intensive Outpatient Program in Cheshire for Adults

Dear Dr. Ballew,

I am writing to you regarding the Certificate of Need Application you submitted to the Office of Health Care Access (OHCA). It is my understanding that you expect to open a 6 to 12 slot Intensive Outpatient Program (IOP) in Cheshire, Connecticut. You expect to serve approximately 60 patients annually with substance use issues. You have indicated that you will target individuals with private insurance and may expand to serve Medicaid patients sometime in the future. The Office of Health Care Access is now routinely asking that our agency provide applicants with utilization and capacity data for other programs in your target area in order to assist you to make determinations regarding the need for such a program.

Currently, the Department of Mental Health and Addiction Services (DMHAS) does not fund any Substance Abuse IOP programs in the Cheshire, Southington, or Wallingford area. The Department currently funds 16 IOP programs across the state which has a capacity of 233 individuals monthly. Last fiscal year we served approximately 3,200 individuals in these programs. Over 3,100 individuals were admitted during the state fiscal year 2013. These data reflect the individuals that seek treatment but they do not provide information regarding the need. As you indicated when we spoke, you had reviewed data pertaining to service penetration rates and your research indicated this area was underserved.

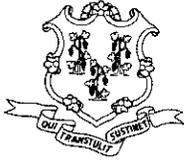
I hope this correspondence serves to address the item that OHCA identified in their response to your application. Please be aware that if your application is approved, Connecticut Public Act No. 99-273 requires all substance abuse agencies in Connecticut to report admission and discharge data for all clients served, regardless of whether your organization is a DMHAS funded provider. For more information regarding this requirement, please contact Mark McAndrew at 860-418-6843.

Sincerely,

Jim Siemjanowski  
Director of Evaluation, Quality Management, and Improvement

Cc Kimberly Martone, Director of Operations, Office of Health Care Access  
Steven Lazarus Office of Health Care Access  
Lauren Siembab Director of Community Services Division, DMHAS

(AC 860) 418-7000  
410 CAPITOL AVENUE, P.O. BOX 341431 • HARTFORD, CT 06134  
www.dmhas.state.ct.us  
*An Equal Opportunity Employer*



**STATE OF CONNECTICUT**  
DEPARTMENT OF PUBLIC HEALTH  
*Office of Health Care Access*

September 26, 2013

FAX ONLY

Dr. Jennifer Ballew  
Medical Director and CEO  
Connecticut Recovery Center, LLC  
P. O. Box 429  
Cheshire, CT 06410

RE: Certificate of Need Application, Docket Number 13-31840-CON  
Connecticut Recovery Center, LLC  
CON Application Deemed Complete

Dear Dr. Ballew:

This letter is to inform you that, pursuant to Section 19a-639a (d) of the Connecticut General Statutes, the Office of Health Care Access has deemed the above-referenced application complete as of September 26, 2013.

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

Sincerely,

A handwritten signature in black ink, appearing to read "Steven W. Lazarus", with a long horizontal flourish extending to the right.

Steven W. Lazarus  
Associate Health Care Analyst

*An Equal Opportunity Provider*

*(If you require aid/accommodation to participate fully and fairly, contact us either by phone, fax or email)*

410 Capitol Ave., MS#13HCA, P.O.Box 340308, Hartford, CT 06134-0308  
Telephone: (860) 418-7001 Fax: (860) 418-7053 Email: OHCA@ct.gov

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\*\*\* TX REPORT \*\*\*  
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STATE OF CONNECTICUT  
DEPARTMENT OF PUBLIC HEALTH  
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: DR. JENNIFER BALLEW

FAX: 1(951) 257-9990

AGENCY: \_\_\_\_\_

FROM: STEVEN W. L. ZARUS

DATE: 9/26/13 Time: \_\_\_\_\_

NUMBER OF PAGES: 2

*(including transmittal sheet)*

Comments: Letter deeming CON Application Complete for DN: 13-31840 (CT Recovery Center, LLC)



STATE OF CONNECTICUT  
DEPARTMENT OF PUBLIC HEALTH  
*Office of Health Care Access*

October 21, 2013

Dr. Jennifer Ballew  
CEO and Medical Director  
Connecticut Recovery Center  
P.O. Box 429  
Cheshire, CT 06410

RE: Certificate of Need Application, Docket Number 13-31840-CON  
Connecticut Recovery Center, LLC  
Establishment of an Intensive Outpatient Program in Cheshire for Adults

Dear Dr. Ballew,

With the receipt of the completed Certificate of Need ("CON") application information submitted by Connecticut Recovery Center, LLC ("Applicant") on September 26, 2013, the Office of Health Care Access ("OHCA") has initiated its review of the CON application identified above.

Pursuant to General Statutes § 19a-639a (f), OHCA may hold a hearing with respect to any Certificate of Need application.

This hearing notice is being issued pursuant to General Statutes § 19a-639a (f)

Applicant: Connecticut Recovery Center, LLC  
Docket Number: 13-31840-CON  
Proposal: Establishment of an Intensive Outpatient Program in Cheshire for Adults

Notice is hereby given of a public hearing to be held in this matter to commence on:

Date: November 13, 2013

Time: 10:00 a.m.

Place: Department of Public Health, Office of Health Care Access  
410 Capitol Avenue, Third Floor Hearing Room  
Hartford, CT 06134

The Applicant is designated as party in this proceeding. Enclosed for your information is a copy of each hearing notice for the public hearing that will be published in the *Waterbury Republic* pursuant to General Statutes § 19a-639a (f).

Sincerely,



Kimberly R. Martone  
Director of Operations

Enclosure

cc: Henry Salton, Esq., Office of the Attorney General  
Marianne Horn, Department of Public Health  
Kevin Hansted, Department of Public Health  
Wendy Furniss, Department of Public Health  
Marielle Daniels, Connecticut Hospital Association

KRM: SWL:lmg



**STATE OF CONNECTICUT**  
DEPARTMENT OF PUBLIC HEALTH  
*Office of Health Care Access*

October 21, 2013

Requisition # 43559

Republican-American  
389 Meadow Street, P.O. Box 2090  
Waterbury, CT 06722-2090

Gentlemen/Ladies:

Please make an insertion of the attached copy, in a single column space, set solid under legal notices, in the issue of your newspaper by no later than **Wednesday, October 23, 2013**. Please provide the following **within 30 days** of publication:

- Proof of publication (copy of legal ad. acceptable) showing published date along with the invoice.

If there are any questions regarding this legal notice, please contact Kaila Riggott at (860) 418-7001.

**KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.**

Sincerely,

A handwritten signature in cursive script, appearing to read "Kim Martone".

---

Kimberly R. Martone  
Director of Operations

Attachment

cc: Danielle Pare, DPH  
Marielle Daniels, Connecticut Hospital Association

KRM:SWL:lmg

**PLEASE INSERT THE FOLLOWING:**

Office of Health Care Access Public Hearing

Statute Reference: 19a-639  
Applicant: Connecticut Recovery Center, LLC  
Town: Cheshire  
Docket Number: 13-31840-CON  
Proposal: Establishment of an Intensive Outpatient Program in Cheshire for Adults  
Date: November 13, 2013  
Time: 10:00 a.m.  
Place: Department of Public Health, Office of Health Care Access  
Third Floor Hearing Room, 410 Capitol Avenue, Hartford, CT 06134

Any person who wishes to request status in the above listed public hearing may file a written petition no later than November 8, 2013 (5 calendar days before the date of the hearing) pursuant to the Regulations of Connecticut State Agencies §§ 19a-9-26 and 19a-9-27. If the request for status is granted, such person shall be designated as a Party, an Intervenor or an Informal Participant in the above proceeding. Please check OHCA's website at [www.ct.gov/ohca](http://www.ct.gov/ohca) for more information or call OHCA directly at (860) 418-7001. If you require aid or accommodation to participate fully and fairly in this hearing, please phone (860) 418-7001.

\*\*\*\*\*  
\*\*\* TX REPORT \*\*\*  
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TRANSMISSION OK

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STATE OF CONNECTICUT  
DEPARTMENT OF PUBLIC HEALTH  
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: DR. JENNIFER BALLEW  
FAX: (951) 257-9990  
AGENCY: CONNECTICUT RECOVERY CENTER, LLC  
FROM: STEVEN LAZARUS  
DATE: 10/22/13 TIME: \_\_\_\_\_  
NUMBER OF PAGES: 5  
*(including transmittal sheet)*

Comments: DN: 13-31840- NON Hearing Notice

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

## Greer, Leslie

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**From:** ADS <ADS@graystoneadv.com>  
**Sent:** Monday, October 21, 2013 4:56 PM  
**To:** Greer, Leslie  
**Subject:** Re: Hearing Notice DN: 13-31840-CON

Good day!

Thanks so much for your ad submission.  
We will be in touch shortly and look forward to serving you.

*Consider adding **color** to your Chronicle of Higher Education print ads or upgrading to a Featured Job Banner online.*

PLEASE NOTE: New Department of Labor guidelines allow web base advertising when hiring foreign nationals. To provide required documentation Graystone will retrieve & archive verification for the 1st and 30th days of posting for \$115.00/web site. If required, notify Graystone when ad placement is approved.

If you have any questions or concerns, please don't hesitate to contact us at the number below.

We sincerely appreciate your business.

Thank you,  
Graystone Group Advertising

2710 North Avenue  
Bridgeport, CT 06604  
Phone: 800-544-0005  
Fax: 203-549-0061

**E-mail new ad requests to:** [ads@graystoneadv.com](mailto:ads@graystoneadv.com)  
<http://www.graystoneadv.com/>

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**From:** <Greer>, Leslie <Leslie.Greer@ct.gov>  
**Date:** Monday, October 21, 2013 4:32 PM  
**To:** ads <ads@graystoneadv.com>  
**Subject:** Hearing Notice DN: 13-31840-CON

Please run the attached hearing notice in the Republican-American by 10/23/13. For billing, refer to requisition 43559. In addition, please forward me a copy of the "proof of publication" for my records when available.

Thank you,

*Leslie M. Greer* ✉  
CT Department of Public Health  
Office of Health Care Access  
410 Capitol Avenue, MS#13HCA  
Hartford, CT 06134  
Phone: (860) 418-7013  
Fax: (860) 418-7053  
Website: [www.ct.gov/ohca](http://www.ct.gov/ohca)

 Please consider the environment before printing this message

## Greer, Leslie

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**From:** Laurie <Laurie@graystoneadv.com>  
**Sent:** Tuesday, October 22, 2013 4:12 PM  
**To:** Greer, Leslie  
**Subject:** FW: Hearing Notice DN: 13-31840-CON  
**Attachments:** 13-31840np Republican.doc

Your legal notice is all set to run as follows:

Waterbury Republican, 10/23 issue - \$170.41

Thanks,  
Laurie Miller

### Graystone Group Advertising

2710 North Ave., Ste 200, Bridgeport, CT 06604  
Ph: 203-549-0060, ext 319, Fax: 203-549-0061, Toll free: 800-544-0005  
email: [laurie@graystoneadv.com](mailto:laurie@graystoneadv.com)  
[www.graystoneadv.com](http://www.graystoneadv.com)

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**From:** <Greer>, Leslie <[Leslie.Greer@ct.gov](mailto:Leslie.Greer@ct.gov)>  
**Date:** Monday, October 21, 2013 4:32 PM  
**To:** ads <[ads@graystoneadv.com](mailto:ads@graystoneadv.com)>  
**Subject:** Hearing Notice DN: 13-31840-CON

Please run the attached hearing notice in the Republican-American by 10/23/13. For billing, refer to requisition 43559. In addition, please forward me a copy of the "proof of publication" for my records when available.

Thank you,

*Leslie M. Greer* 

CT Department of Public Health  
Office of Health Care Access  
410 Capitol Avenue, MS#13HCA  
Hartford, CT 06134  
Phone: (860) 418-7013  
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Website: [www.ct.gov/ohca](http://www.ct.gov/ohca)

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**STATE OF CONNECTICUT**  
DEPARTMENT OF PUBLIC HEALTH  
*Office of Health Care Access*

October 28, 2013

VIA FACSIMILE ONLY

Jennifer Ballew, M.D.  
Medical Director and CEO  
Connecticut Recovery Center, LLC  
P.O. Box 429  
Cheshire, CT 06410

RE: Certificate of Need Application; Docket Number: 13-31840-CON  
Connecticut Recovery Center, LLC  
Establishment of Intensive Outpatient Program for Adults in Cheshire

Dear Dr. Ballew:

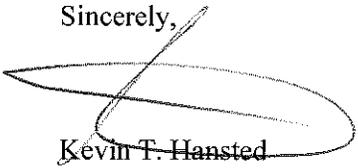
The Office of Health Care Access ("OHCA") will hold a public hearing on the above docket number on November 13, 2013. The hearing is at 10:00 a.m. in the Department of Public Health's third floor hearing room, 410 Capitol Avenue, Hartford. Pursuant to the Regulations of Connecticut State Agencies § 19a-9-29 (e), any party or other participant is required to prefile in written form all substantive, technical, or expert testimony that it proposes to offer at the hearing. Connecticut Recovery Center, LLC ("Applicant") must submit prefiled testimony to OHCA **no later than 12:00 p.m. on November 8, 2013.**

All persons providing prefiled testimony must be present at the public hearing to adopt their written testimony under oath and must be available for cross-examination for the entire duration of the hearing. If you are unable to meet the specified time for filing the prefiled testimony you must request a time extension in writing, detailing the reasons for not being able to meet the specified deadline.

Additionally, please find attached OHCA's Issues outlining the topics that will be discussed at the hearing.

Please contact Steven W. Lazarus at (860) 418-7012, if you have any questions concerning this request.

Sincerely,



Kevin T. Hansted  
Hearing Officer

Attachment

*An Equal Opportunity Provider*

*(If you require aid/accommodation to participate fully and fairly, contact us either by phone, fax or email)*

410 Capitol Ave., MS#13HCA, P.O.Box 340308, Hartford, CT 06134-0308  
Telephone: (860) 418-7001 Fax: (860) 418-7053 Email: OHCA@ct.gov

**Issues**

**Certificate of Need Application; Docket Number: 13-31840-CON**

**Connecticut Recovery Center, LLC**

**Establishment of an Intensive Outpatient Program for Adults in Cheshire.**

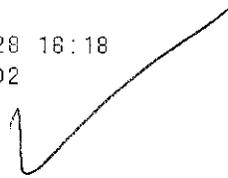
**Applicant should prepare to argue and present supporting evidence on the following issues to support the proposal identified above:**

1. Clear public need, including the patient populations to be served.
2. Impact on existing providers.
3. The financial feasibility of the proposal, including documentation.

\*\*\*\*\*  
\*\*\* TX REPORT \*\*\*  
\*\*\*\*\*

TRANSMISSION OK

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STATE OF CONNECTICUT  
DEPARTMENT OF PUBLIC HEALTH  
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: DR. JENNIFER BALLEW

FAX: (951) 257-9990

AGENCY: CONNECTICUT RECOVERY CENTER, LLC

FROM: STEVEN W. LAZARUS

DATE: 10/28/13 Time: \_\_\_\_\_

NUMBER OF PAGES: 3

*(including transmittal sheet)*

Comments:

Enclosed is the Request for Profile and the Issues Paper. Any questions, please contact Steven W. Lazarus @ 860-418-7012 or at [steven.lazarus@ct.gov](mailto:steven.lazarus@ct.gov).