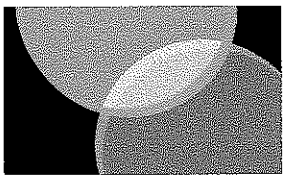


kmb consulting, llc
OPTIMIZE YOUR HEALTH CARE PLANNING RESOURCES

November 28, 2011

Ms. Kimberly R. Martone
Director of Operations
Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS#13HCA
P.O. Box 340308
Hartford, CT 06134-0308

Re: Mountainside Treatment Center Certificate of Need Application

Dear Ms. Martone:

On behalf of Mountainside Treatment Center, I am pleased to submit a Certificate of Need Application for the addition of 16 beds in order to provide residential detoxification and evaluation services.

As requested, I have included an original and four hard copies in 3-ring binders along with electronic files in Adobe, MS Word and MS Excel. Also attached to this letter is a check with the filing fee of $500.00.

Please do not hesitate to contact me at (203) 459-1601 or Terence Dougherty at (860) 824-1397, if you have any questions.

Sincerely,

Karen M. Banoff
Principal

Attachments

Copy to: Terence Dougherty, Mountainside Treatment Center

91 Old Hollow Road • Trumbull, CT 06611 • Phone/Fax: 203-459-1601 • kbanoff@kmbconsult.com

MC1 Healthcare LLC d/b/a Mountainside Treatment Center

Increase in Licensed Bed Capacity of 16 Beds

Certificate of Need Application

November 28, 2011

Mountainside Treatment Center

Increase in Licensed Bed Capacity of 16 Beds

Table of Contents

Attachments

Attachment	Title	Page(s)
G	DMHAS: "Collection and Evaluation of Data Related to Substance Use, Abuse and Prevention Programs, June 2011"	96-134
H	SAMHSA Reports • States in Brief: Substance Abuse and Mental Health Issues At a Glance: Connecticut • Connecticut State Profile and Underage Drinking Facts	135-148
I	Additional Publications in Support of Proposal: • New England High Intensity Drug Trafficking Area: Drug Market Analysis 2010 • Article: "Prescription Drug Abuse in Danbury Area is Stealing Lives"	149-172
J	Admissions by Town of Client Origin, 2010	173-176
K	Curriculum Vitae	177-181
L	Department of Public Health License	182-183
M	Audited Financial Statements	184-194
N	Letter from Bank	195-196
O	Proposed Floor Plan	197-198
P	Financial Attachment I with Assumptions	199-201
Q	Financial Attachment II	202-205

EXHIBIT I

CON Checklist

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.: _____ Check No.: _____
OHCA Verified by:_____ Date: _____

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

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

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

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

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

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

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

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

EXHIBIT II

CON Filing Fee

6764

MOUNTAINSIDE
P.O. BOX 717
CANAAN, CT 06018

Wells Fargo N.A.

51-110-211

11/18/2011

PAY TO THE ORDER OF Treasurer, State of Connecticut $ 500.00

Five Hundred and 00/100********** DOLLARS

Security features. Details on back.

State of Connecticut
Department of Health
PO Box 1080
Hartford, CT 06143-1080

TWO SIGNATURES REQUIRED OVER $500.00

AUTHORIZED SIGNATURE

MEMO CON Application Fee

⑈00006764⑈ ⑆021101108⑆ 2000038276244⑈

MOUNTAINSIDE

6764

Treasurer, State of Connecticut

11/18/2011

CON Application Fee 500.00

Wachovia Operating 6 CON Application Fee 500.00

008

EXHIBIT III

Evidence of Public Notices

Absolutely free

WARNING! ADS FOR FREE PETS

Your beloved pet deserves a loving caring home. The ad for your free pet may draw responses from individuals who will sell your animal for research, breeding or other purposes. Please screen respondents carefully when giving an animal away. Your pet will thank you!

Lost & found

FOUND Adult Shih-Tzu in Historic Overlook District Waterbury. Please call 270-498-2763

FOUND CAT Baldwin St. vicinity. Lg. orange tiger male 203-597-1236

FOUND CAT Grey Tiger, Green yes, white patch under chin & lly, Town Plot Highland Dr. call 6-756-4939

FOUND domestic rabbit @ bottom Maple Hill Rd. in Naugatuck, CT dnesday. Please call 203-720-0750

FOUND female cat in parking lot of ser Tag in Waterbury. Grey and hite. Call to describe, 203-525-00

FOUND male cat white with gray ot, if you need more info. call 3-525-1549

FOUNDED WATERBURY Ihasa white and black. Maltese mix e and tan. Pom mix female n, Amstaff male, blk & Boston Terrier blk & white To redeem or adopt, 203-09

LT Missing Landzeri Area & n Ave. F. Orange/blk Cali- m sz., No front claws, 203- If found

LT Wolcott Clinton Hill te Tiger Female Missing Info 203-879-3813 needs nily heartbroken

y cat, adult. Vicinity of ew Dr & Longmeadow cott. Call 203-910-2079

Legals/ Public Notices

INVITATION TO BID

Fusco Management Company, LLC invites contractors to submit sealed quotations for Refuse Removal and Recycling Services at the New Britain Superior Courthouse, 20 Franklin Square, New Britain, Connecticut. Bidders holding current certification by the Dept. of Administrative Services, Business Set-Aside Unit as a Small Business, Minority-Owned Business or Woman-Owned Business will be given special consideration for this contract.

Sealed bids marked "Bid Enclosed" must be received ON OR BEFORE 10:00 AM, FRIDAY, NOVEMBER 18, 2011, at the offices of Fusco Management Company, LLC, 555 Long Wharf Drive, 14th Floor, New Haven, Connecticut 06511. A PUBLIC OPENING WILL TAKE PLACE AT 10:00 AM ON FRIDAY, NOVEMBER 18, 2011 at the Fusco Management Company, LLC office in New Haven.

A mandatory walk through will take place at 9:30 AM ON THURSDAY, NOVEMBER 10, 2011 at New Britain Superior Courthouse, 20 Franklin Square, New Britain, Connecticut. Bid packages are available at the walk through.

Fusco Management Company LLC reserves the right to accept or reject any or all bids. All bids are subject to approval by the State of Connecticut, Judicial Branch.

Fusco Management Company, LLC is an affirmative action/equal opportunity employer.
R-A October 19-21, 24-27, 2011

Legals/ Public Notices

CITY OF TORRINGTON
PLANNING AND ZONING COMMISSION
LEGAL NOTICE

At its October 12, 2011 meeting,

Legals/ Public Notices

INVITATION TO BID

Fusco Management Company, LLC invites contractors to submit sealed quotations for replacement of a 40-ton compressor for a rooftop air-handling unit at the New Britain Superior Courthouse, 20 Franklin Square, New Britain, Connecticut. Bidders holding current certification by the Dept. of Administrative Services, Business Set-Aside Unit as a Small Business, Minority-Owned Business or Woman-Owned Business will be given special consideration for this contract.

Sealed bids marked "Bid Enclosed" must be received ON OR BEFORE 10:00 AM, THURSDAY, NOVEMBER 3, 2011, at the offices of Fusco Management Company, LLC, 555 Long Wharf Drive, 14th Floor, New Haven, Connecticut 06511. A public opening will take place at 10:00 AM on Thursday, November 3, 2011 at the Fusco Management Company, LLC office in New Haven.

A mandatory WALK THROUGH WILL TAKE PLACE AT 9:30 AM ON FRIDAY, OCTOBER 28, 2011 at New Britain Superior Courthouse, 20 Franklin Square, New Britain, Connecticut. Bid packages are available at the walk through.

Fusco Management Company LLC reserves the right to accept or reject any or all bids. All bids are subject to approval by the State of Connecticut, Judicial Branch.

Fusco Management Company, LLC is an affirmative action/equal opportunity employer.
R-A October 19-21, 24 & 25, 2011

Invitation to Bid
UCONN HEALTH CENTER
Office of Facility Contracts and Leases

State of Connecticut Non Discrimination and Affirmative Action provisions apply pursuant to C.G.S. Chapter 58 , Sections 4a-60 and 4a-60a.

SEALED PROPOSALS AS REQUESTED FOR THE BIDS/RFP'S LISTED BE-

Legals/ Public Notices

LEGAL NOTICE

CITY OF TORRINGTON
INLAND WETLANDS COMMISSION

Pursuant to Section 22a-42a of the Connecticut General Statutes, the Torrington Inland Wetlands Commission hereby serves notice that on October 18, 2011 it acted on the following applications to conduct regulated activities within wetlands/ watercourses, upland review areas and/or regulated activities outside of the upland review areas, subject to the terms and limitations of the permits/orders issued on October 19, 2011:

Violator: Jay Nadeau & Richard W. Crovo
Location: 6 Arbor Ridge Road
Activity: Construction of shed w/in upland regulated area
Action: IW Order WC11-210 was ISSUED w/ conditions

Violator: Joseph & Donna Maneca
Location: 10 Arbor Ridge Road
Activity: Construction of shed w/in upland regulated area
Action: IW Order WC11-220 was ISSUED w/ conditions

Violator: Angelo & Linda Gonzales
Location: 373 New Litchfield Street
Activity: Placing fill w/in upland regulated area
Action: IW Order WC11-230 was ISSUED w/ conditions

Copies of the above mentioned applications, plans and decisions are on file in the Land Use Department, City Hall, 140 Main Street, Torrington, CT

Jay Bate Jr.
Inland Wetlands Commission Chairman

Dated in Torrington, CT this 21st day of October
R-A October 21, 2011

Legal Notice

The Naugatuck Housing Authority is accepting applications for Federal Housing located on Osborn

Legals/ Public Notices

NOTICE TO CREDITORS
ESTATE OF CHARLES CANTONI,
of Prospect
(11-00316)

The Hon. Peter E. Mariano, Judge of the Court of Probate, Naugatuck Probate District, by decree dated October 13, 2011, ordered that all claims must be presented to the fiduciary at the address below. Failure to promptly present any such claim may result in the loss of rights to recover on such claim.
Patricia Alegi, Chief Clerk
The fiduciary is:
GAIL CANTONI
c/o ATTY. ALEXANDER J. MARESCA
Miele and Maresca, LLC
396 South Main ST.
PO Box 724
Cheshire, CT 06410
R-A October 21, 2011

PUBLIC NOTICE

Pursuant to Section 19a-638 of Connecticut General Statutes, MC1 Healthcare d/b/a Mountainside Treatment Center, located at 187 South Canaan Road, Route 7, Canaan, CT 06081, will submit a Certificate of Need application to the Office of Health Care Access for the addition of sixteen (16) residential Detoxification and Evaluation beds to its licensed bed capacity at an estimated total capital expenditure of $10 million.
R-A October 21, 22, & 23, 2011

The University of Connecticut is currently seeking proposals for the following:

1. Stamford MBA Travel-Study Course in Brazil
Bid No: KA101811
Opening Date: November 10, 2011 @ 2:00 PM (EDT)

Interested parties should visit our website at: http://www.purchasing.uconn.edu/currentbid/currentbid.html, or call 860-486-2619. Inquiries must be made by Bid Number.
R-A October 21, 2011

Legals/ Public Notices

The Waterbury Development Corporation
Request for Proposals (RFP)
Brownfield Engineering & Site Cleanup Services

The Waterbury Development Corporation (WDC) is soliciting Proposals from qualified firms interested in providing management, on behalf of the WDC, for the clean-up of two properties, 16 Cherry Avenue and 167 Maple Street, through the administration of two separate grants from the US Environmental Protection Agency (EPA).

The full RFP is available at www.wdconline.org. Proposals must be received at or before Thursday, 3rd of November, 2011 at 4:00pm at the WDC, 24 Leavenworth Street, Waterbury CT, 06702 to the attention of Kevin T. Taylor. If further information is needed, please do not hesitate to contact Kevin T. Taylor @ 203.346.2607 ext.103. The WDC is an Affirmative Action/Equal Opportunity Employer. Minority/Women's Business Enterprises are encouraged to apply.
R-A October 21, 2011

Legals/ Public Notices

TOWN OF THOMASTON
WATER POLLUTION CONTROL AUTHORITY

PUBLIC NOTICE FINAL DECISION

Notice is hereby given, in accordance with Section 7-255 of the Connecticut General Statutes, as amended, that the Thomaston Water Pollution Control Authority (WPCA) held a Public Hearing on Tuesday, October 18, 2011 at 7:00PM at the Thomaston Water Pollution Control Facility located at 258 Old Waterbury Road, Thomaston, CT 06787. The public hearing was held to increase the sewer user fee. Any appeals from such charges must be made within Twenty-one days of the filing date October 21, 2011. New charges will be available in the Town Clerk's Office in the Thomaston Town Hall, 158 Main Street, Thomaston, CT 06787. AL INCREASES WILL TAKE EFFEC JANUARY 1, 2012.

The new rates are as follows:

1. The proposed rate propose rate was $6.61 per thousand ga lons.
The new rate is $6.30 per thou sand gallons

2. The proposed residential rat was $330.00 per unit per year.
The new rate is $315.00 per un per year.

3. Commercial and Industri users will pay for actual gallon used at the new rate.
Proposed minimum rate wa $330.00
New Minimum rate is $315.0 Same minimum rate as reside tial.

4. Municipal users will pay for ac tual gallons used at the new rate

Thomas J. Mueller, Chairperson
Thomaston Water Pollution Control Authority
R-A October 21, 2010

010

Absolutely free

RESCUED KITTENS FREE to good homes. Need spaying/neutering, will deliver call between 6pm-9pm 203-574-4064 btwn 6-9

TURTLE free red-eared slider 203-982-4255 ask for Luke

WARNING! ADS FOR FREE PETS

Your beloved pet deserves a loving caring home. The ad for your free pet may draw responses from individuals who will sell your animal for research, breeding or other purposes. Please screen respondents carefully when giving an animal away. Your pet will thank you!

Lost & found

FOUND Adult Shih-Tzu in Historic Overlook District Waterbury. Please call 270-498-2763

FOUND CAT Baldwin St. vicinity. Lg. orange tiger male 203-597-1236

The Republican-American cannot be responsible for any advertisement and then only to the extent of a "make good" insertion. Errors which do not lessen the value of the advertisement will not be corrected by "make good" insertions.

ANNOUNCEMENT

For the benefit of reader understanding, this newspaper does not accept abbreviations for any words except English standard and industry standard abbreviations. We will not automatically abbreviate and when requested to do so, will follow only standard abbreviations.

Legals/ Public Notices

FORECLOSURE AUCTION
SUPERIOR COURT
JUDICIAL DISTRICT OF LITCHFIELD

DOCKET NO.:
LLI-CV-1106004474-S

CASE NAME:
DEUTSCHE BANK NATIONAL TRUST CO., AS TRUSTEE
VS.
KATHLEEN E. CAMPANELLA

PREMISES:
70 PARK AVENUE
OAKVILLE, CT 06779

PROPERTY TYPE:
RESIDENTIAL

DATE: SATURDAY, OCTOBER 29, 2011 AT 12:00 NOON

PLACE: ON THE PREMISES

DEPOSIT: Bank or Certified Check $18,000.00
The premises will be available for inspection from 10:00 a .m. to 12:00 noon on the Date of Sale.

For Further Information Contact:
Mark D. Malley, Esq.
Committee for Sale

Legals/ Public Notices

LIQUOR PERMIT
NOTICE OF APPLICATION

This is to give notice that I,
ROBERT VOLPACCHIO
88 BROOKFIELD RD
SEYMOUR, CT 06483-2378
have filed an application placarded 10/12/2011 with the Department of Consumer Protection for the sale of alcoholic liquor on the premises at
313 MAIN STREET
ANSONIA, CT 06401-2301
The Business will be owned by:
TAMALE EXPRESS CORP
Entertainment will consist of:
NONE
Objections must be filed by:
11/22/2011
ROBERT VOLPACCHIO
R-A October 22 & 29, 2011

LIQUOR PERMIT
NOTICE OF APPLICATION

This is to give notice that I,
ROSANNA F GUERRERA
27 KENNEDY DRIVE
THOMASTON, CT 06787 - 1141
have filed an application placarded 10/22/2011 with the Department of Consumer

The Naugatuck Housing Authority is accepting applications for Federal Housing located on Osborn Road and Weld Drive. Those wishing to apply must be 62 years of age or older. Applications will be available starting 10/24/2011 at the following location:

The Naugatuck Housing Authority
16 Ida Street
Naugatuck Ct, 06770

In addition you may call to have the application mailed. If you have any questions, please call the Naugatuck Housing Authority, (203) 729-8214.

R-A October 21, 22, & 23, 2011

Legals/ Public Notices

TOWN OF WATERTOWN

REQUEST FOR PROPOSAL

REAPPRAISAL AND REVALUATION OF REAL PROPERTY (TAXABLE AND EXEMPT) AND INSTALLATION OF ASSESSMENT/ COLLECTION ADMINISTRATIVE SOFTWARE

The Town of Watertown requests proposals for the reappraisal and revaluation of all real property (taxable and exempt) located within the corporate limits of the Town of Watertown CT effective October 1, 2013, and installation of software for administering assessment and tax collection. Only proposals from State certified revaluation companies will be considered. Request for Proposal documents may be obtained or examined at the office of the Purchasing Agent, Town Hall Annex, 424 Main Street, Watertown, Connecticut 06795, or by accessing the Town of Watertown's website at http://www.watertownct.org. Sealed proposals must be submitted no later than 4:00 P.M., FRIDAY, NOVEMBER 11, 2011. Any Request for Proposals received after said

Republican American

PUBLIC NOTICE

Pursuant to Section 19a-638 of Connecticut General Statutes, MC1 Healthcare d/b/a Mountainside Treatment Center, located at 187 South Canaan Road, Route 7, Canaan, CT 06081, will submit a Certificate of Need application to the Office of Health Care Access for the addition of sixteen (16) residential Detoxification and Evaluation beds to its licensed bed capacity at an estimated total capital expenditure of $10 million.
R-A October 21, 22, & 23, 2011

The Town of Watertown reserves the right to take into account the residency of bidders within the Town of Watertown and/or the location of the bidder's business within the Town of Watertown in awarding this bid.

All bids will be considered valid for a period of sixty (60) days.

Carol Z. Roman
Purchasing Agent
Town of Watertown
R-A October 22, 2011

Legals/ Public Notices

Legal Notice

The Naugatuck Housing Authority is accepting applications for Federal Housing located on Osborn Road and Weid Drive. Those wishing to apply must be 62 years of age or older. Applications will be available starting: 10/24/2011 at the following location:

The Naugatuck Housing Authority
16 Ida Street
Naugatuck Ct, 06770

In addition you may call to have the application mailed. If you have any questions, please call the Naugatuck Housing Authority, (203) 729-8214.

R-A October 21, 22, & 23, 2011

LEGAL NOTICE
BOROUGH OF NAUGATUCK PUBLIC HEARING
OCTOBER 26, 2011

There will be a Public Hearing held on Wednesday, October 26, 2011 at 6:30 p.m. at the Naugatuck High School Auditorium, 543 Rubber Avenue, Naugatuck, CT 06770, for the purpose of a presentation and discussion concerning the Appropriation and Bond Authorization of $61,000,000 for the cost of the Reconstruction and Renovation of the Naugatuck High School.

ATTEST: Nancy K. DiMeo,
Borough Clerk
R-A October 20 & 23, 2011

FORECLOSURE AUCTION SALE

DOCKET NO:UWY-CV-10-6004419-S

CASE NAME:
The Bank of New York as Indenture Trustee for Encore
vs.
ROSSI, DAVID M. et al.

PROPERTY:
100 Idlewood road
Wolcott, CT

PROPERTY TYPE:
RESIDENTIAL

DATE OF SALE:
OCTOBER 29, 2011

The sale will take place at 12:00 noon on the premises
The inspection of the premises will be from 10:00 a.m. to 12:00 noon on the date of sale

DEPOSIT: At time of action all bidders except the Plaintiff must have in their possession, available for confirmation by the Committee, a deposit in the amount of $42,000.00 in a certified or bank check.

FOR FURTHER INFORMATION CONTACT:
Attorney Matthew A. Lucarelli
Committee
250 Wolcott Rd.
Wolcott, CT 06716

See Foreclosure Sales at www.jud.ct.gov for more detailed information.
R-A October 18 & 23, 2011

LEGAL NOTICE
FORECLOSURE AUCTION SALE

DOCKET NO.:
UWY CV11-6009432

CASE NAME:
BOULEVARD SOUTH II CONDOMINIUM ASSN. INC.
VS.
THE BANK OF NEW YORK MELLON

PROPERTY ADDRESS:
35 PEARL LAKE ROAD, UNIT U
WATERBURY, CT

PROPERTY TYPE:
RESIDENTIAL

DATE OF SALE:
OCTOBER 29, 2011

COMMITTEE NAME:
ATTORNEY HILLIARY H. HORROCKS

COMMITTEE PHONE NUMBER:
203-841-2905

See Foreclosure Sales at www.jud.ct.gov for more detailed information.
R-A October 16 & 23, 2011

PUBLIC NOTICE

Pursuant to Section 19a-638 of Connecticut General Statutes, MC1 Healthcare d/b/a Mountainside Treatment Center, located at 187 South Canaan Road, Route 7, Canaan, CT 06081, will submit a Certificate of Need application to the Office of Health Care Access for the addition of sixteen (16) residential Detoxification and Evaluation beds to its licensed bed capacity at an estimated total capital expenditure of $10 million.
R-A October 21, 22, & 23, 2011

012

EXHIBIT IV

Affidavit

AFFIDAVIT

Applicant: **MC1 Healthcare LLC d/b/a Mountainside Treatment Center**

Project Title: **Increase in Licensed Bed Capacity of 16 Beds**

I, **Terence R. Dougherty** (Individual's Name), **President & CEO** (Position Title – CEO or CFO)

of **Mountainside Treatment Center** (Hospital or Facility Name) being duly sworn, depose and state that

Mountainside Treatment Center's (Hospital or Facility Name) information submitted in this Certificate of Need Application is accurate and correct to the best of my knowledge.

Signature

11.17.11
Date

Subscribed and sworn to before me on November 17, 2011

Notary Public/Commissioner of Superior Court

My commission expires:

ALEXANDRA HELFER
NOTARY PUBLIC
State of Connecticut
My Commission Expires
December 31, 2015

EXHIBIT V

CON Application

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:	**TBD**
Applicant:	**MC1 Healthcare LLC d/b/a Mountainside Treatment Center**
Contact Person:	**Terence Dougherty**
Contact Person's Title:	**President & CEO**
Contact Person's Address:	**P.O. Box 717 Canaan, CT 06018**
Contact Person's Phone Number:	**(860) 824-1397**
Contact Person's Fax Number:	**(860) 824-4021**
Contact Person's Email Address:	**terence.dougherty@mountainside.com**
Project Town:	**Canaan**
Project Name:	**Increase in Licensed Bed Capacity of 16 Beds**
Statute Reference:	**Section 19a-638, C.G.S.**
Estimated Total: Capital Expenditure:	**$9,672,513**

1. **Project Description: Increase in Licensed Bed Capacity**

   a. Please provide a narrative detailing the proposal, which chronicles the history of the service earmarked for an increase in licensed beds and provides a rationale for the proposed licensed bed increase.

   This proposal involves a request for an increase in licensed beds at Mountainside Treatment Center ("Mountainside"), a residential drug addiction and alcoholism rehabilitation facility located in Canaan, Connecticut. Mountainside uses a multi-disciplinary approach to help individuals suffering from addiction and provides high quality substance abuse rehabilitation care, including diagnosis, individualized addiction treatment and aftercare that is comprehensive, innovative and cost-effective. Mountainside's staff of licensed and certified social workers and counselors and addiction professionals, all of whom who are highly trained and experienced in treating individuals with drug addiction and alcoholism, have helped thousands of people from Connecticut as well as other New England states and beyond. Care at Mountainside is customized to meet each client's individual needs; this personalized approach is a hallmark of the facility. Mountainside was recognized on a national level in 2005 when its representatives received an invitation by the White House to meet with the Office of National Drug Control Policy and its Director, John Walters. The White House staff was interested in discussing the program's success and, in particular, Mountainside's Outreach Program.

   Mountainside opened in 1998 with 50 beds for rehabilitation, intermediate and long-term care as classified by the State of Connecticut Department of Public Health (DPH). In 2006, it expanded to 66 beds and in 2010, it reduced its bed count to 62. The bed reduction was necessary in order to create physical space for critically important support functions (e.g. rooms for group activities). Mountainside generally admits between 60 and 80 individuals per month and maintains a relatively full census. Mountainside's treatment methods include, but are not limited to, one-on-one counseling, group counseling, gender-specific groups, family counseling, the 12-Step education, a mind body spirit program, adventure based initiatives and continuing care planning. Mountainside also offers day and evening and outpatient treatment as well as Aftercare (e.g. Sober House).

   To meet a need in Connecticut, and to better serve its clients, Mountainside is requesting 16 additional licensed beds. These beds are needed in order to provide critical residential detoxification and

evaluation ("detoxification") services. Access to detoxification beds in Connecticut is problematic, and there are often waiting lists at the few facilities that offer the service. Mountainside currently uses all of its 62 licensed beds for rehabilitation care, and occupancy levels reach 100% regularly throughout the year, resulting in a waiting list. Due to the strong demand for its rehabilitation services, Mountainside can only offer detoxification services with additional beds.

The detoxification beds will be housed in a newly constructed wing of the main Mountainside facility which will be connected by a glass-enclosed walkway. The detoxification does not represent complete substance abuse treatment, but is an important component in the continuum of substance abuse treatment. There are multiple levels and settings where detoxification can be provided. Residential detoxification generally requires five to seven days to complete before the individual is ready to begin substance abuse rehabilitation treatment, which typically continues for 28 days. Mountainside will provide level 3.7 residential detoxification services as defined by the American Society of Addiction Medicine's five levels of detoxification care. This level of care includes providing 24-hour medically supervised evaluation and withdrawal management, a permanent facility with inpatient beds and services that are delivered under a defined set of physician-approved policies and the availability of 24-hour observation, monitoring and treatment. Offering detoxification in the same facility where rehabilitation will be provided will help to ensure completion with the complete treatment process.

Addiction is a chronic medical illness and is often the result of some combination of genetic, environmental factors and personal choice. Individuals who abuse drugs and alcohol are at increased risk for very serious health problems, criminal activity, automobile accidents and lost productivity in the workplace. While treatment is available and effective, the majority who need treatment do not obtain it. It is estimated that for every one person who seeks and/or receives behavioral health care for addiction, there are six individuals with similar conditions who will neither gain access to, nor receive, such care (source: Connecticut Department of Mental Health and Addiction Services Practice Guidelines for Recovery-Oriented Behavioral Health Care – Executive Summary, included as Attachment A). Effective treatment must provide a combination of culturally competent therapies and consider other factors including age, race, culture, language, sexual orientation, gender, family roles, housing, employment, etc. Mountainside's approach to addiction treatment combines a unique set of therapeutic and holistic methods to support its evidence based program to ensure that each individual

becomes engaged and that he or she is motivated to participate in the recovery process.

By adding 16 beds for the provision of residential detoxification and evaluation services, Mountainside will better serve its clients and respond to a statewide need for residential detoxification care.

b. Provide in table format the current and proposed number of (1) licensed, (2) staffed and (3) available beds for each unit/location involved in this proposal.

Please see the following table for current and proposed licensed, staffed and available beds by service at Mountainside.

	Current	Proposed
Licensed Beds	62	78
Staffed Beds	62	78
Available Beds	62	78

c. Provide letters that have been received in support of the proposal.

Mountainside has received numerous letters supporting this proposal from a wide variety of referral sources who stress the need for additional residential detoxification beds in CT and the importance of providing a full continuum of care at the Mountainside facility.

Letters of support have been included in Attachment B.

2. **Clear Public Need**

a. Explain why there is a clear public need for the proposal. Provide evidence that demonstrates this need.

There are several major factors that contribute to the public need for the proposed addition of 16 beds at Mountainside for the provision of detoxification and evaluation services. They include:

- **There are limited residential detoxification beds in Connecticut, and many clients must seek care outside Connecticut;**
- **Mountainside receives numerous requests for residential detoxification services as the provision of detoxification along with residential care will improve the continuum and quality of addiction care; and**
- **Drug and alcohol abuse/addiction continues to be a growing and significant health and societal issue, and treatment often begins with detoxification.**

Each of these factors is described in more detail below.

Limited Residential Detoxification Beds in Connecticut and Outmigration of Clients

Based on information received from the Connecticut Department of Public Health (DPH) and knowledge of Mountainside staff, there are currently 44 licensed residential (non-hospital) substance abuse facilities in Connecticut; however, only six are known to offer level 3.7 residential detoxification services. A listing is provided in Attachment C. In addition, in July 2011, Connecticut Valley Hospital in Middletown announced that it would eliminate 20 detoxification beds as of September 2011 due to state budget cuts, further exacerbating the shortage of detoxification beds in the state. Please see Attachment D for an article regarding the closing of these beds. Residential detoxification is also offered by a number of hospitals in the state, but it is a higher level detoxification (level 4.0) and this higher level of care is not required for many clients.

When an addict agrees to enter residential detoxification services, he/she needs access to a bed that day. If access is not available, that individual is at risk for continued drug/alcohol use/abuse, overdose and even death. Availability of beds is an urgent situation.

A recent telephone survey was conducted to determine same-day bed availability for the six known level 3.7 residential detoxification facilities in Connecticut. The results are summarized below:

- Three facilities had only between 1 and 3 available beds;
- Three facilities had no available beds for several days.

In addition, four out of state facilities were also called and only one of the four had available beds. Advance knowledge of bed availability is generally dictated by planned discharges, although it is not uncommon for an available bed to be needed by more than one potential client in search of services. Finding an available bed on the day it is needed is very difficult.

As previously mentioned, Mountainside is currently unable to offer detoxification services due to lack of bed availability and therefore must refer clients to other facilities. Frequently, referrals must be made to out- of-state providers due to limited in-state bed availability. Over the past 21 months, Mountainside has referred approximately 170 individuals to facilities outside of Connecticut (New York, New Jersey and Massachusetts) primarily due to limited or lack of bed availability. This outmigration for residential detoxification care is unfortunate and Connecticut's substance

abuse providers should be able to provide the necessary access to needed services for Connecticut residents.

Mountainside Receives Numerous Requests for Detoxification and Adding Detoxification Beds Will Improve Improve Continuity and Quality of Addiction Care

Mountainside routinely receives requests for residential detoxification care from existing referral sources. Because of the high quality of Mountainside's rehabilitation care, referral sources have long requested that Mountainside add detoxification services. The addition of detoxification beds under its current licensure is a logical extension of its services and would help to ensure the completion of treatment for many. Referral sources include physicians, acute care hospitals, family members, interventionists, therapists and other mental health facilities. As mentioned previously, whenever detoxification is provided by the same provider that will provide ongoing residential rehabilitation, the outcome for successful completion of treatment is significantly improved. When individuals have to utilize more than one facility for their addiction care, such as completing detoxification at one facility and then transferring to a second facility for rehabilitation, they are less likely to complete their treatment. In fact, some clients decline to continue to the separate rehabilitation facility and are much more likely to relapse since they have not successfully completed their treatment.

It is not uncommon for a detoxification client to feel better following detoxification treatment and then decline being transferred and adjusting to another facility for 28-day rehabilitation. This is a critical time in a client's treatment and an easy transition to residential rehabilitation is critical. The provision of residential detoxification care will help Mountainside to provide a full continuum of care and better serve the needs of its clients and the requests of its referral sources.

By increasing access to detoxification care through the addition of detoxification beds at Mountainside, continuity of care will be greatly enhanced and will help ensure the successful completion of rehabilitation care. It also will result in less fragmented care for clients and will reduce stress on individuals who are undergoing an extremely challenging and emotionally difficult time in their lives. Rapid access to addiction treatment is consistent with the Connecticut Department of Mental Health and Addiction Services Practice Guidelines for Recovery-Oriented Behavioral Health Care, found in previously referenced Attachment B, which states that "Recovery-oriented practitioners promote access to care by facilitating swift and uncomplicated entry and by removing barriers

to receiving care". Because family and friends play a critical role in motivating individuals to seek and continue with treatment, the improved continuity of care will also reduce associated stress on family members.

Drug and Alcohol Abuse/Addiction is a Significant Health & Societal Issue

Alcohol/drug abuse and addiction is a significant health and societal issue nationally and in Connecticut. In 2009, the Substance Abuse and Mental Health Services Administration (SAMHSA), the federal agency focused on the prevention and treatment for substance abuse and addiction, issued a report entitled, "Results from the 2009 National Survey on Drug Use and Health" (Table of Content and Highlights included as Attachment E), finding that an estimated 8.7% of the population aged 12 or older were illicit drug users, 23.7% of persons aged 12 and older participated in binge drinking and 6.8% reported being a heavy drinker (binge drinking on at least 5 during the past 30 days). Of the 22.5 million people with a substance dependence or abuse, 3.2 million were classified with dependence on or abuse of both alcohol and illicit drugs, 3.9 million were dependent on or abused illicit drugs but not alcohol, and 15.4 million were dependent on or abused alcohol but not illicit drugs. While drug and alcohol abuse are major problems, they are not being adequately treated; of the people who needed treatment at a specialty facility for an illicit drug or alcohol use problem in the past year, only 11.2% of this population received treatment (see http://oas.samhsa.gov/nsduh/2k9nsduh/2k9resultsp.pdf for a copy of the full report).

Substance abuse continues to be a significant health and social problem in the State of Connecticut as well as nationally. There is easy access to illicit drugs since Connecticut is located between New York and Boston and drugs readily travel between these two large cities. Connecticut continues to be faced with some significant substance abuse problems including increasing admissions for heroin addiction in young adults, increasing non-medical use of prescription opiates and significant problems of binge drinking and general alcohol abuse among college students, many of whom often begin drinking in high school. Senator Richard Blumenthal recently held a forum that highlighted the problem of prescription drug abuse among veterans (please see related article in Attachment F). A recent report from the Connecticut Department of Mental Health and Addiction Services (DMHAS), "Collection and Evaluation of Data Related to Substance Use, Abuse and Prevention Programs", June 2011, outlines these problems and describes recent trends in

substance abuse and treatment in the state. The DMHAS report is included as Attachment G.

Prompt access to all levels of addiction services is critical for Connecticut to address its substance abuse problems. This proposal is a significant step towards improving access to addiction services and ultimately addressing the State's substance abuse issues.

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

i. The rationale for choosing the proposed service location;

The proposed service location for the additional beds, at Mountainside Treatment Center in Canaan, Connecticut, was chosen because it is the current location of a well-established and well-respected provider of drug addiction and alcoholism rehabilitation care. The additional beds will be located in a newly constructed wing consisting of a mix of semi-private and private rooms; this new wing will be connected to the main Mountainside building by a glass-enclosed walkway.

Mountainside's location is ideal for the delivery of substance abuse treatment and specifically for residential detoxification. The facility is located at the base of a private mountain amid 39 secluded acres in Litchfield County, in the foothills of the Berkshire Mountains. The tranquil, private setting contributes to the recovery process for individuals seeking treatment there.

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

Mountainside serves individuals from throughout the State of Connecticut as well as surrounding states. The nature of inpatient substance abuse treatment is such that clients are often attracted to seek care outside their local area in order to ensure privacy. As such, Mountainside's service area is considered the entire State of Connecticut.

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

The population to be served includes those in need of residential medically monitored detoxification (level 3.7) who are 18 years of age and older. Recent census data from 2010 indicates there are 2,757,082 Connecticut residents 18 years of age and older, which is approximately 77% of the total population.

According to SAMHSA's States in Brief report for Connecticut, global measures for abuse or dependence on illicit drugs or alcohol are at or above national rates. The report further states that Connecticut has been among the 10 States with the highest rates for past month illicit drug and marijuana use and past year marijuana use for the 18-25 age group as well as past month alcohol use for several age groups including 12+, 18-25 and 26+. This has been a steady trend in Connecticut for survey data collected between 2002-2203 and 2005-2006.

Alcohol abuse and dependence is a significant problem in underage residents. According to SAMHSA's State Profile and Underage Drinking Facts, 137,000 (32.3%) of 12 to 20 year olds consumed alcohol in the past month and 100,000 individuals (23.5%) binged on alcohol. Early alcohol use and binge drinking can lead to regular alcohol abuse and dependence in young adulthood. Mountainside currently treats many young adults with alcohol abuse and dependence and a large percentage of these clients began drinking before they were of legal drinking age.

See Attachment H for copies of the two SAMHSA reports referenced above.

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

There are several possibilities for where the proposed population is currently being served. They are listed below:

- **Some are not being served because it was too difficult to obtain access to a detoxification bed and they decided not to seek treatment;**
- **Some are accessing detoxification services out of state; and**
- **Some were lucky to have been able to access detoxification services in Connecticut.**

As previously stated, an individual who is in need of detoxification for alcohol or drug addiction has an emergent need to access a detoxification bed. Any delay in access to detoxification services can be detrimental to their health.

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

Please see the table previously referenced in Attachment D for a list of the known level 3.7 residential detoxification (non-hospital)

providers in the state of Connecticut.

vi. Describe existing referral patterns in the area to be served by the proposal; and

Individuals with substance abuse/dependence are referred to Mountainside in a variety of ways. Some clients have undergone an intervention with a trained interventionist. The interventionist may then make a referral to Mountainside for care. Individuals are also referred for rehabilitation care by other facilities and/or acute care hospitals when the individual requires hospitalization prior to rehabilitation. In addition, mental health and substance abuse clinicians also refer clients to Mountainside for care. Finally, clients and/or family members may seek out Mountainside directly.

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

Because there are limited detoxification beds and existing providers are generally full or close to full, the proposed addition of 16 detoxification beds at Mountainside is expected to have little or no impact on existing providers.

As evidenced by minimal same day bed availability and the number of clients who have to be referred to out of state facilities, existing providers of residential detoxification care are generally not able to meet the demand for their services.

Finally, Mountainside has an established referral base of interventionists, facilities and clinicians who have been requesting the addition of residential detoxification beds at Mountainside; they are expected to maintain their current referral patterns. In addition, other referral sources have told Mountainside staff that they will refer clients to Mountainside when the facility offers detoxification.

c. Provide the following regarding the proposed increase in licensed beds:

i. Explain the specific rationale for the increase in beds at each unit/location, including:

(1) The calculation or other methods by which the proposed increases were determined, clearly identifying all underlying assumptions used;

Based on available land, capital costs, financial resources and estimates of client admissions, Mountainside has determined

that it can support 16 detoxification beds. Although there is likely demand for more, in order to match demand with Mountainside's resources, 16 beds were determined to be appropriate.

Mountainside developed conservative volume projections for the proposed bed increase. Monthly admissions are estimated to be 65 per month. This is based on Mountainside's recent historical admissions per month which have ranged between 60 and 80. Each admission is expected to utilize the detoxification beds. Some clients will only require 24 hours of observation but most will require up to seven days of detoxification. Therefore projected detoxification admissions for a full year are estimated to be 780.

Projected patient days have been calculated using an average length of stay of 6 days. Therefore for a full year, 4,680 patient days are projected. Based on these projected admissions and patient days, Mountainside's 16 detoxification beds will be operating at 80% occupancy. This occupancy rate would allow Mountainside to respond to many same day requests for bed access. As previously stated, these are considered to be conservative projections and detoxification admissions could exceed these levels. If that were to occur, Mountainside would have to operate at higher occupancy levels.

(2) The patient population that will be served; and

The patient population that will be served consists of clients with drug and/or alcohol abuse and/or dependence in need of residential detoxification care. It is estimated that the age distribution will be similar to the population Mountainside currently serves, which is primarily young adults between 18 and 30 years of age with a smaller percentage being between 30 and 65 years of age.

(3) The benefits of each proposed increase.

The benefits of the increase in total licensed beds at Mountainside include improved and more timely access to residential detoxification care, improved continuity of care due to the provision of detoxification and rehabilitation care at the same location and the ability to retain Connecticut residents who currently leave the state for residential detoxification care.

ii. For the last three complete FYs, the current FY-to-date, and the first three full years of the proposal, provide the following (by service as relevant to the proposal):

(1) Occupancy rate;

	FY 2008	FY 2009	FY 2010	FY 2011
Occupancy Rate	**72%**	**70%**	**74%**	**87%**

(2) Average daily census;

	FY 2008	FY 2009	FY 2010	FY 2011
Average Daily Census	**48**	**46**	**46**	**53**

(3) Variability in census including peak census; and

	FY 2008	FY 2009	FY 2010	FY 2011
Census High	**66**	**66**	**62**	**61**
Census Low	**36**	**36**	**34**	**33**

(4) Patient days.

	FY 2008	FY 2009	FY 2010	FY 2011
Patient Days	**17,342**	**16,762**	**16,820**	**17,429**

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.

In addition to the previous reports referenced, several additional reports and articles have been included in Attachment I that support the statements made in this application and justify the need for the proposal. Highlights from these publications are listed in the table below.

Publication	Relevance
New England High Intensity Drug Trafficking Area: Drug Market Analysis 2010	**Map on page 2 shows that several regions of Connecticut are part of the New England High Intensity Drug Trafficking Area, particularly along major highways such as I-95, I-91 and I-84.**
"Prescription Drug Abuse in Danbury Area is Stealing Lives"	**Prescription drugs and opiates are increasingly accessible and are increasingly being used by young adults, who do not perceive the danger and addictive risk.**

e. Explain why the proposal will not result in an unnecessary duplication of existing or approved health care services.

Because there is a shortage of residential detoxification beds in Connecticut, with many providers operating at full capacity, some individuals are forced to leave the state in order to obtain timely access to a detoxification bed. For these reasons, the proposal is not expected to result in a duplication of services. Instead, it will provide improved access to a much needed service.

3. **Actual & Projected Volume**

a. For each service involved in this proposal, provide volumes for the most recently completed fiscal year ("FY") by town.

Admissions for 2010 by client town of origin (CT) are included in Attachment J.

b. Complete the following table for the past three FYs and current fiscal year ("CFY"), for each service involved in this proposal.

Table 1: Actual Service Volumes

	Actual Volume (Last 3 Completed FYs)			CFY Volume*
	FY *2008	FY 2009	FY 2010	FY 2011
Service**				
Admissions	598	578	580	601
Total				

* For periods greater than 6 months, report annualized volume, identifying the number of actual months covered and the method of annualizing. For periods less than six months, report actual volume and identify the period covered.
** Identify each service type and location and add lines as necessary. Provide number of visits and/or number of admissions for each service listed, as appropriate.
*** Fill in years. In a footnote, identify the period covered by the Applicant's FY (e.g. July 1-June 30, calendar year, etc.).

c. Explain any increases and/or decreases in volume seen in the table above.

In 2008, Mountainside's facility was in need of renovation. Mountainside was started as a non-profit facility but, during the economic challenges of the past few years, Mountainside was unable to obtain the necessary funding to renovate and improve its physical plant. The facility was converted to a for-profit in 2009 in order to obtain the necessary funding to improve the facility. As a result of these facility improvements, admissions and census have increased dramatically. Occupancy this year is approaching 90%.

d. Complete the following table for the first three **full** fiscal years ("FY") of the

proposed service increase (if the first year is a partial year, include that as well).

Table 2: Projected Service Volumes

	Projected Volume (First 3 Years		
	FY 2012	FY 2013	FY 2014
Detoxification admissions	384 (1)	780	780

1. FY 2012 represents 6 months of volume

** 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 type and location and add lines as necessary. Provide number of visits and/or number of admissions for each service listed, as appropriate.

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

a. Provide a detailed explanation of all assumptions used in the derivation/ calculation of the projected volume.

Please refer to the response to question 2c (1)

2. 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.

Please see Attachment K for the Curriculum Vitae of key staff associated with the proposal. Numbers of medical professionals have already been brought in discussions for consideration of employment.

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

The proposal will have a direct and positive impact on the quality of health care delivery. The availability of residential detoxification services in the same facility as residential rehabilitation care will help ensure that more drug-addicted and alcoholic individuals complete their treatment. It also improves the continuity of care and, by improving access to detoxification care, helps to ensure that more individuals are entering the first phase of critical services at the same facility in which they will continue their rehabilitation to help them conquer their addiction.

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.

Mountainside will follow State of Connecticut licensure regulations and incorporate the guidelines issued by SAMHSA in its Treatment

Improvement Protocol (TIP) #45 – Detoxification and Substance Abuse Treatment relative to levels of care and patient placement (TIP 45 can be accessed at http://store.samhsa.gov/product/TIP-45-Detoxification-and-Substance-Abuse-Treatment/SMA08-4131). Mountainside is also pursuing CARF accreditation and will incorporate any standards related to detoxification as required.

3. **Organizational and Financial Information**

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

The Applicant is a for profit corporation.

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

c. Provide a copy of the State of Connecticut, Department of Public Health license(s) currently held by the Applicant.

Mountainside's Department of Public Health license is included as Attachment M.

d. Financial Statements

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

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

Please see Attachment N for Mountainside's audited financial statements for Fiscal Year 2010.

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

Table 2: Proposed Capital Expenditures/Costs

Medical Equipment Purchase	$
Imaging Equipment Purchase	
Non-Medical Equipment Purchase	995,000
Land/Building Purchase *	760,000
Construction/Renovation **	7,295,000

Other Non-Construction (Specify)	
Total Capital Expenditure (TCE)	**$9,672,513**
Medical Equipment Lease (Fair Market Value) ***	$
Imaging Equipment Lease (Fair Market Value) ***	
Non-Medical Equipment Lease (Fair Market Value) ***	
Fair Market Value of Space ***	
Total Capital Cost (TCC)	**$9,672,513**
Total Project Cost (TCE + TCC)	**$9,672,513**
Capitalized Financing Costs (Informational Purpose Only)	
Total Capital Expenditure with Cap. Fin. Costs	**$9,672,513**

* 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.

Attachment O includes a proposed floor plan.

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.

The proposal will be funded by an equity contribution and a bank loan. Please refer to Attachment P for the letter of interest from the Bank of America Merrill Lynch regarding the loan.

g. Demonstrate how this proposal will affect the financial strength of the state's health care system.

The availability of detoxification beds at Mountainside will result in an increase in individuals seeking this care in Connecticut and, consequently, in the number of individuals who successfully complete addiction treatment due to the improved continuum of care. As a result, fewer individuals will need to enter repeat addiction treatment and will incur fewer complex medical issues related to their drug addiction or alcoholism that may be treated in an expensive Emergency Department or inpatient setting. An increase in individuals receiving successful rehabilitation care will help reduce any aberrant behavior while under the influence of drugs or alcohol, such as crimes or unsafe driving. This will in turn have a positive impact on the state's health care system.

4. 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 service increase.

Table 3: Patient Population Mix

	Current** FY ***	Year 1 FY ***	Year 2 FY ***	Year 3 FY ***
Medicare*				
Medicaid*				
CHAMPUS & TriCare				
Total Government	**0%**	**0%**	**0%**	**0%**
Commercial Insurers*	80%	80%	80%	80%
Uninsured				
Workers Compensation				
Self Pay	20%	20%	20%	20%
Total Non-Government	**100%**	**100%**	**100%**	**100%**
Total Payer Mix	**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 projected population mix by payer is the same as the current payer mix, which is not expected to change as a result of this proposal.

5. 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.

Attachment P includes Financial Attachment I showing a summary of revenue, expense and volume statistics without the CON, incremental to the CON and with the CON project.

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

Completed Financial Attachment II is included in Attachment Q.

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.).

Assumptions utilized in developing Financial Attachments I and II are provided in Attachment R.

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) earmarked for licensed bed increase.

Detoxification and evaluation services will be charged on a daily basis at $750/day. This rate is based on market rates of which Mountainside staff is well aware as they currently refer patients to other facilities for this service.

e. Explain any projected incremental losses from operations contained in the financial projections that result from the implementation of the proposed licensed bed increase.

There are minimal incremental losses from operations contained in the first two years, and these can be attributed to depreciation expense which is a non-cash expense.

f. Describe how this proposal is cost effective.

The proposal is cost effective for a number of reasons:

- **Access to detoxification residential services is limited and difficult, resulting in some clients not seeking treatment. Continued use and abuse of substances is a significant risk for those unable to access treatment. As previously stated, drug and alcohol abuse contribute to health (e.g. emergency room visits, illnesses, etc.) and societal costs (e.g. crime, violence, etc.) significantly. This proposal will improve access to addiction treatment and thus reduce some of the significant health and societal costs associated with substance abuse.**
- **The additional beds at Mountainside will permit improved access to in-state detoxification residential services thus reducing the costs incurred by clients and families who have to travel out-of-state.**

Attachment A

Connecticut Department of Mental Health and Addiction Services (DMHAS): Practice Guidelines for Recovery-Oriented Behavioral Health Care

Practice Guidelines for Recovery-Oriented Behavioral Health Care

Connecticut Department of Mental Health and Addiction Services

"No right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his[/her] own person, free from all restraint or interference of others, unless by clear and unquestioned authority of law."

— United States Supreme Court

(Union Pacific Railway Co. v. Botsford)

Prepared for the Connecticut Department of Mental Health and Addiction Services by the Yale University Program for Recovery and Community Health (Tondora & Davidson, 2006).

Forward by Commissioner Thomas A. Kirk, Jr., Ph.D.

The document that you are about to read is an extraordinary one in its origins, its content, and its value as another step toward achieving and maintaining a recovery-oriented health care service system in Connecticut.

In my view, if not *the* most important, the following document is one of the most significant products to result within the last five years from the public/private partnership composed of persons in recovery, families, staff and leadership of DMHAS, prevention specialists, private nonprofit service providers, the academic community, and other advocates and stakeholders. This collective group has focused on assessing and improving the quality of services available for persons with mental illness and/or substance use disorders in the State of Connecticut.

Consider a few of its origins. Listening to the suggestions and continuing guidance of those who need or use our services is one of the most basic and essential characteristics of a recovery-oriented service system. Thus, beginning in 1999 we asked Advocacy Unlimited, Inc. and the Connecticut Community for Addiction Recovery, Inc. to work together to develop a set of **Recovery Core Values** that could serve as guideposts for DMHAS as it began the journey of restructuring its service system. The result was 27 principles divided into four categories: **Direction, Participation, Programming and Funding/Operations.** Go to www.dmhas.state.ct.us, click on major Initiatives, then "Recovery Initiative" for further information about the Recovery Core Values.

Well before 1999, there had been "champions" of recovery in any number of state and private service sectors who understood the meaning of "recovery" and the importance of it in the lives and care of the people receiving services. They now had the opportunity to speak in a louder voice and educate the rest of us. We all stand on the shoulders of those who came before us.

DMHAS later hosted a few statewide Recovery Conferences, established a Recovery Institute and Centers of Excellence, and conducted a series of consensus-building retreats for executive directors, medical and clinical leadership, and several other stakeholder groups within the mental health and addiction service communities and elicited their views about the concept of recovery, what it would mean for their activities, and what gaps needed to be addressed and barriers removed for us to achieve a recovery-oriented system.

All of the above, and other work, led to the signing in September 2002 of **Commissioner's Policy Statement No. 83 on "Promoting a Recovery-Oriented Service System."** This landmark policy designated the concept of recovery as the overarching goal, guiding principle, and operational framework for the system of care supported by the DMHAS. It incorporated the Recovery Core Values. It stated that:

> ***"We shall firmly embed the language, spirit, and culture of recovery throughout the system of services, in our interactions with one another and with those persons and families who trust us with their care."***

In addition, this policy envisioned and mandated services characterized by:

"...a high degree of accessibility, effectiveness in engaging and retaining persons in care

...effects shall be sustained rather than solely crisis-oriented or short-lived

...age and gender appropriate, culturally competent, and attend to trauma and other factors know to impact on one's recovery

...whenever possible, shall be provided within the person's home community, using the person's natural supports."

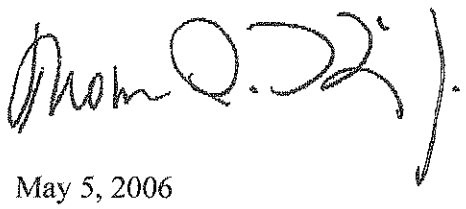
But how do you actually do a recovery-oriented service system? This key question remained after all of the above work and many current activities—too numerous to mention. Absent answers to this question, one may think "all this recovery stuff is conceptual ... it has no real meaning or practical reality. The focus will not really change our system."

The following document answers this question by identifying eight domains of a recovery-oriented service system ranging from degree of participation of persons in recovery in the recovery planning and system development process to "Identifying and Addressing Barriers to Recovery." It then lists a dozen or so concrete, practical and well-researched action steps or guidelines in each domain. It answers questions like: "**You will know when you are placing primacy on the participation of people in recovery when...**"

The document gives examples, identifies potential barriers, and uses the words of people in recovery to explain what each domain means and what they can expect in that domain. It includes a glossary and distinguishes a **Deficit-based Perspective** from a **Recovery-oriented, Asset-based Perspective.** As service providers review their Agency Recovery Assessment Plans and as DMHAS fiscal, service, and quality staff go about their business, they now will have a roadmap to inform policy, develop outcomes and funding strategies, and a framework to monitor our fidelity with the guidelines of a recovery-oriented health care system. Persons in recovery and other recipients of services will know what to expect, what they need to be educated about, and what they have a right to demand in their interactions with the system.

It is said that successful initiatives have a thousand fathers and mothers and failed initiatives are orphans. I believe our journey to a recovery-oriented and transformed service system has many parents. I hope this document will help those who either cannot understand or who have not yet embraced a recovery-oriented service system to become another parent of this journey.

I would welcome any comments about the above or your opinion of this document at Thomas.Kirk@po.state.ct.us.



May 5, 2006

Table of Contents

Executive Summary

The notion of recovery has become the focus of a considerable amount of dialogue and debate between and among various constituencies within the mental health and addiction communities. Following a brief introduction to the topic, in which we clarify various sources of confusion about the term, these practice guidelines begin to operationalize the various components of DMHAS' vision of a recovery-oriented system of behavioral health care. This vision was first put forth in Commissioner's Policy #83, "Promoting a Recovery-Oriented Service System," and has since been embodied in various DMHAS education, training, and program development initiatives. These guidelines represent the first systematic effort to bring recovery into the concrete everyday practice of DMHAS-funded providers.

Defining our Terms

One major source of the confusion surrounding use of the term in recovery in behavioral health derives from a lack of clarity about the respective roles of behavioral health practitioners and those of people with behavioral health disorders themselves. For the purposes of this document, we offer the following two definitions which we have found to distinguish usefully between the process of recovery (in which the person him or herself is engaged) and the provision of recovery-oriented care (in which the practitioner is engaged).

> *Recovery refers to the ways in which a person with a mental illness and/or addiction experiences and manages his or her disorder in the process of reclaiming his or her life in the community.*

> *Recovery-oriented care is what psychiatric and addiction treatment and rehabilitation practitioners offer in support of the person's recovery.*

Practice Guidelines

A. Primacy of Participation

An essential characteristic of recovery-oriented behavioral health care is the primacy it places on the participation of people in recovery and their loved ones in all aspects and phases of the care delivery process. Participation ranges from the initial framing of questions or problems to be addressed and design of the capacity and needs assessments to be conducted, to the delivery, evaluation, and monitoring of care, to the design and development of new services, interventions, and supports.

Practice guidelines to be included in this domain:

A.1. People in recovery are routinely invited to share their stories with current service recipients and/or to provide training to staff.

A.2. People in recovery comprise a significant proportion of representatives to an agency's board of directors, advisory board, or other steering committees and work groups.

A.3. Agencies reimburse people for the time they spend providing input into services, providing peer support and mentoring, and/or providing educational and training sessions for clients or staff.

A.4. Each person served is provided with an initial orientation to agency practices.

A.5. Initial orientation is supplemented by the routine availability of information and agency updates to people in recovery and their loved ones.

A.6. Policies are established and maintained that allow people in recovery maximum opportunity for choice and control in their own care.

A.7. Measures of satisfaction are collected routinely and in a timely fashion from people in recovery and their loved ones.

A.8. Formal grievance procedures are established and made readily available to people in recovery and their loved ones to address their dissatisfaction with services.

A.9. Administration enforces ethical practice (e.g., "first, do no harm") through proactive human resource oversight.

A.10. Assertive efforts are made to recruit people in recovery for a variety of staff positions for which they are qualified.

A.11. Active recruitment of people in recovery for existing staff positions is coupled with ongoing support for the development of a range of peer-operated services that function independent of, but in collaboration with, professional agencies.

A.12. Self-disclosure by employed persons in recovery is respected as a personal decision and is not prohibited by agency policy or practice.

A.13. Staff encourage individuals to claim their rights and to make meaningful contributions to their own care and to the system as a whole.

A.14. The agency offers to host local, regional, state, and/or national events and advocacy activities for people in recovery and their loved ones.

B. Promoting Access and Engagement

For every one person who seeks and/or receives behavioral health care for a diagnosable psychiatric disorder or addiction there are from two (in mental health) to six (in addiction) individuals, with similar conditions, who will neither gain access to nor receive such care. Recovery-oriented practitioners promote access to care by facilitating swift and uncomplicated entry and by removing barriers to receiving care. Engagement involves making contact with the person rather than with the diagnosis or disability, building trust over time, attending to the person's stated goals and needs and, directly or indirectly, providing a range of services in addition to clinical care.

Practice guidelines to be included in this domain:

B.1. The service system has the capacity to go where the potential client is, rather than always insisting that the client come to the service.

B.2. People can access a wide range of services from many different points.

B.3. There is not a strict separation between clinical and case management functions.

B.4. Assessment of motivation is based on a stages of change model, and interventions incorporate motivational enhancement strategies which assist providers in meeting each person where he or she is.

B.5. Staff look for signs of organizational barriers or other obstacles to care before concluding that a client is non-compliant or unmotivated.

B.6. Agencies have "zero reject" policies that do not exclude people from care based on symptomatology, substance use, or unwillingness to participate in prerequisite clinical or program activities.

B.7. Agencies have an "open case" policy which dictates that a person's refusal of services, despite intensive and long-term engagement efforts, does not require that he or she be dropped from the "outreach" list.

B.8. The system builds on a commitment to and practice of motivational enhancement, with reimbursement for pre-treatment and recovery management supports.

B.9. Outpatient addiction treatment clinicians are paired with outreach workers to capitalize on the moment of crisis that can lead people to accept treatment, and to gain access to their appropriate level of care.

B.10. Mental health and addiction practitioners, including people in recovery, are placed in critical locales to assist in the early stages of engagement.

B.11. The agency employs staff with first hand experience of recovery who have a special ability to make contact with and engage people into care.

B.12. Housing and support options are available for people who are not yet interested in, or ready for, detoxification, but who may begin to engage in their own recovery if housing and support are available to them.

B.13. The availability of sober housing is expanded to make it possible for people to go immediately from residential or intensive outpatient treatment programs into housing that supports their recovery.

C. Ensuring Continuity of Care

Recovery is seldom achieved from a single episode of care, so practitioners, as well as people in recovery, families, and policy makers, need to recognize that there are no quick fixes in behavioral health. Similar to other chronic illnesses, previous treatment of a person's condition also should not be taken to be indicative of a poor prognosis, non-compliance, or the person's not trying hard enough to recover. Relapses in substance use and exacerbations of psychiatric symptoms are to be viewed as further evidence of the severity of the person's condition rather than as causes for discharge. All of these principles suggest that treatment, rehabilitation, and support are not to be offered through serial episodes of disconnected care offered by different providers, but through a carefully crafted system that ensures continuity of the person's most significant healing relationships and supports over time and across episodes and agencies.

Practice guidelines to be included in this domain:

C.1. The central concern of engagement shifts from: "How do we get the client into treatment?" to: "How do we nest the process of recovery within the person's natural environment?"

C.2. Services are designed to be welcoming to all individuals and there is a low threshold (i.e., minimal requirements) for entry into care.

C.3. Eligibility and reimbursement strategies for outreach and engagement strategies are established and refined by administrative leadership.

C.4. People have a flexible array of options from which to choose and options are not limited to what "programs" are available.

C.5. Individuals are not expected or required to progress through a pre-determined continuum of care in a linear or sequential manner.

C.6. In a Recovery Management Model, an individual's stage of change is considered at all points in time, with the focus of care on enhancing existing strengths and recovery capital.

C.7. Goals and objectives in the recovery plan are not defined by staff based on clinically-valued outcomes (e.g., reducing symptoms, increasing adherence), but rather are defined by the person with a focus on building recovery capital and pursuing a life in the community.

C.8. The focus of care shifts from preventing relapse to promoting recovery.

C.9. Valued outcomes are influenced by a commitment to ensuring continuity of care and generating long-term effects in the lives of people in recovery.

C.10. The range of valued expertise is expanded beyond specialized clinical and rehabilitative professionals and technical experts to include the contributions of multiple individuals and services. These individuals may include peers in paid or volunteer positions, mutual aid groups, indigenous healers, faith community leaders, primary care providers, and other natural supports.

C.11. Individuals are seen as capable of illness self-management and interventions support this as a valued goal of recovery-oriented services.

C.12. New technologies (e.g., tele-medicine and web-based applications and self-help resources) are incorporated as service options to enhance illness self-management treatment relationships.

C.13. Access is enhanced to housing, employment, and other supports that make recovery sustainable.

C.14. Policy formulation and legislative advocacy at the administrative level is coupled with on-going efforts to work collaboratively with a variety of state systems to ensure continuity of care.

C.15. To facilitate sustained recovery and community inclusion, advocacy efforts are extended beyond institutional policies and procedures to the larger community, including stigma-busting, community education, and community resource development activities.

D. Employing Strengths-Based Assessment

Focusing solely on deficits in the absence of a thoughtful analysis of strengths disregards the most critical resources an individual has on which to build in his or her efforts to adapt to stressful situations, confront environmental challenges, improve his or her quality of life, and advance in his or her recovery. Strengths-based approaches allow providers to balance critical needs that must be met with the resources and strengths that people possess to assist them in this process.

Practice guidelines to be included in this domain:

D.1. A discussion of strengths is a central focus of every assessment, care plan, and case summary.

D.2. Initial assessments recognize the power of simple, yet powerful, questions such as "What happened? And what do you think would be helpful? And what are your goals in life?"

D.3. Staff interpret perceived deficits within a strengths and resilience framework, as this will allow the individual to identify less with the limitations of their disorder.

D.4. While strengths of the individual are a focus of the assessment, thoughtful consideration also is given to potential strengths and resources within the individual's family, natural support network, service system, and community at large.

D.5. The diversity of strengths that can serve as resources for the person and his or her recovery planning team is respected.

D.6. In addition to the assessment of individual capacities, it is beneficial to explore other areas not traditionally considered "strengths," e.g., the individual's most significant or most valued accomplishments, ways of relaxing and having fun, ways of calming down when upset, personal heroes, educational achievements, etc.

D.7. Assessments explore the whole of people's lives while ensuring emphasis is given to the individual's expressed and pressing priorities.

D.8. Assessments ask people what has worked for them in the past and incorporate these ideas in the recovery plan.

D.9. Guidance for completing the assessment may be derived from interviewing strategies used within solution-focused approaches to care.

D.10. Illness self-management strategies and daily wellness approaches such as WRAP are respected as highly effective, person-directed, recovery tools, and are fully explored in the assessment process.

D.11. Cause-and-effect explanations are offered with caution, as such thinking can lead to simplistic resolutions that fail to address the person's situation. In addition, simplistic solutions may inappropriately assign blame for the problem to the individual, with blame being described as "the first cousin" of deficit-based models of practice.

D.12. Assessments are developed through in-depth discussion with the person as well as attempts to solicit collateral information regarding strengths from the person's family and natural supports.

D.13. Efforts are made to record the individual's responses verbatim rather than translating the information into professional language.

D.14. Staff are mindful of the power of language and carefully avoid the subtle messages that professional language has historically conveyed to people with psychiatric disorders, addictions, and their loved ones.

D.15. Practitioners avoid using diagnostic labels as a means of describing an individual, as such labels often yield minimal information regarding the person's experience or manifestation of the illness or addiction.

D.16. Language used is neither stigmatizing nor objectifying. "Person first" language is used to acknowledge that the disability is not as important as the person's individuality and humanity.

D.17. Exceptions to person-first and empowering language that are preferred by some persons in recovery are respected.

E. Offering Individualized Recovery Planning

All treatment and rehabilitative services and supports to be provided shall be based on an individualized, multi-disciplinary recovery plan developed in partnership with the person receiving these services and any others that he or she identifies as supportive of this process. While based on a model of collaboration, significant effort is taken to ensure that individuals' rights to self-determination are respected and that all individuals are afforded maximum opportunity to exercise choice in the full range of treatment and life decisions. The individualized recovery plan will satisfy the criteria of treatment, service, or care plans required by other bodies (e.g., CMS) and will include a comprehensive and culturally sensitive assessment of the person's hopes, assets, strengths, interests, and goals and will reflect a holistic understanding of his or her behavioral health conditions, general medical concerns, and desires to build or maintain a meaningful life in the community

Practice guidelines to be included in this domain:

E.1. Core principles of "person-centered" planning are followed in the process of building individualized recovery plans. For example:

E.1.1. Consistent with the "nothing about us, without us" dictum, staff actively partner with the individual in all planning meetings and/or case conferences regarding his or her recovery services and supports.

E.1.2. The individual has reasonable control as to the location and time of planning meetings, as well as to who is involved.

E.1.3. The language of the plan is understandable to all participants, including the focus person and his or her non-professional, natural supports. Where technical or professional terminology is necessary, this is explained to all participants in the planning process.

E.1.4. When individuals are engaged in rehabilitation services (e.g., housing social, or educational/employment areas), rehabilitation practitioners are involved in all planning meetings (at the discretion of the individual) and are given copies of the resulting plan.

E.1.5. Within the planning process, a diverse, flexible range of options must be available so that people can access and choose those supports that will best assist them in their recovery.

E.1.6. Goals are based on the individual's unique interests, preferences, and strengths, and objectives and interventions are clearly related to the attainment of these stated goals.

E.1.7. Planning focuses on the identification of concrete next steps, along with specific timelines, that will allow the person to draw upon existing strengths to move toward recovery and his or her vision for the future.

E.1.8. Assessments begin with the assumption that individuals are the experts on their own recovery, and that they have learned much in the process of living with and working through their struggles.

E.1.9. Information on rights and responsibilities of receiving services is provided at all recovery planning meetings.

E.1.10. The individual has the ability to select or change his or her service providers within relevant guidelines and is made aware of the procedures for doing so.

E.1.11. In the spirit of true partnership and transparency, all parties must have access to the same information if people are to embrace and effectively carry out responsibilities associated with the recovery plan.

E.1.12. The team reconvenes as necessary to address life goals, accomplishments, and barriers.

E.2. **A wide range of interventions and contributors to the planning and care process are recognized and respected. For example:**

E.2.1. Practitioners acknowledge the value of the person's existing relationships and connections.

E.2.2. The plan identifies a wide range of both professional supports and alternative strategies to support the person's recovery, particularly those which have been helpful to others with similar struggles.

E.2.3. Individuals are not required to attain, or maintain, clinical stability or abstinence before they are supported by the planning team in pursuing such goals as employment.

E.2.4. Goals and objectives are driven by a person's current values and needs and not solely by commonly desired clinical/professional outcomes.

E.3. **Community inclusion is valued as a commonly identified and desired outcome. For example:**

E.3.1. The focus of planning and care is on how to create pathways to meaningful and successful community life and not just on how to maintain clinical stability or abstinence.

E.3.2. Recovery plans respect the fact that services and practitioners should not remain central to a person's life over time, and exit criteria from formal services are clearly defined.

E.3.3. Recovery plans consider not only how the individual can access and receive needed supports from the behavioral health system and the community, but how the individual can, in turn, give back to others.

E.3.4. Practitioners are mindful of the limited resources available for specialized services and focus on community solutions and resources first by asking "Am I about to recommend or replicate a service or support that is already available in the broader community?"

E.4. **The planning process honors the "dignity of risk" and "right to fail" as evidenced by the following:**

E.4.1. Prior to appealing to coercive measures, practitioners relentlessly try different ways of engaging and persuading individuals in ways which respect their ability to make choices on their own behalf.

E.4.2. Unless determined to require conservatorship by a judge, individuals are presumed competent and entitled to make their own decisions.

E.4.3. Practitioners are encouraged to offer their expertise and suggestions respectfully within the context of a collaborative relationship, outlining for the person the range of options and their possible consequences.

E.4.5. In keeping with this stance, practitioners encourage individuals to write their own crisis and contingency plans.

E.5. **Administrative leadership demonstrate a commitment to both outcomes and process evaluation. For example:**

E.5.1. Outcomes evaluation is a continuous process involving expectations for successful outcomes in a broad range of life domains.

E.5.2. There is a flexible application of process tools, such as fidelity scales, to promote quality service delivery.

F. Functioning as a Recovery Guide

The sentiment that "we're not cases, and you're not our managers" has been accepted increasingly as a fundamental challenge to the ways in which behavioral health care is conceptualized within a recovery-oriented system. Rather than replacing any of the skills or clinical and rehabilitative expertise that practitioners have obtained through their training and experience, the recovery guide model offers a useful framework in which these interventions and strategies can be framed as tools that the person can use in his or her own recovery.

Practice guidelines to be included in this domain:

F.1. The primary vehicle for the delivery of most behavioral health interventions is the relationship between the practitioner and the person in recovery. The care provided must be grounded in an appreciation of the possibility of improvement in the person's condition, offering people hope and/or faith that recovery is "possible for me."

F.2. Providers assess where each person is in relation to the various stages of change with respect to the various dimensions of his or her recovery.

F.3. Care is based on the assumption that as a person recovers from his or her condition, the addiction or psychiatric disorder then becomes less of a defining characteristic and more simply one part of a multi-dimensional sense of identity that also contains strengths and competencies.

F.4. Interventions are aimed at assisting people in gaining autonomy, power, and connections with others.

F.5. Opportunities and supports are provided for the person to enhance his or her own sense of personal and social agency.

F.6. Individuals are allowed the right to make mistakes, and this is valued as an opportunity for them to learn.

F.7. People are allowed to express their feelings, including anger and dissatisfaction, without having these reactions attributed to the illness.

F.8. Care is not only attentive to cultural differences across race, ethnicity, and other distinctions of difference (e.g., sexual orientation), but incorporates this sensitivity at the level of the individual.

F.9. Rather than dwelling on the person's distant past or worrying about the person's long-term future, practitioners focus on preparing people for the next one or two steps of the recovery process by anticipating what lies immediately ahead, by focusing on the challenges of the present situation, and by identifying and helping the person avoid or move around potential obstacles in the road ahead.

F.10. Interventions are oriented toward increasing the person's recovery capital as well as decreasing his or her distress and dysfunction.

F.11. Practitioners are willing to offer practical assistance in the community contexts in which their clients live, work, learn, and play.

F.12. Care is not only provided in the community but is also oriented toward increasing the quality of a person's involvement in community life.

F.13. Efforts are made to identify sources of incongruence between the person and his or her environment and to increase person-environment fit.

F.14. In order to counteract the often hidden effects of stigma, practitioners explicitly draw upon their own personal experiences when considering the critical nature of various social roles in the lives of all individuals, continuing to view people in recovery squarely within the context of their daily lives.

F.15. Rather than devaluing professional knowledge, the "recovery guide" approach moves behavioral health much closer to other medical specialties in which it is the health care specialist's role to assess the person, diagnose his or her condition, educate the person about the costs and benefits of the most effective interventions available to treat his or her condition, and then provide the appropriate interventions.

F.16. Recovery is viewed as a fundamentally social process, involving supportive relationships with family, friends, peers, community members, and practitioners

G. Community Mapping and Development

Given its focus on life context, one tool required for effective recovery planning and the provision of recovery-oriented care is adequate knowledge of the person's local community, including its opportunities, resources, and potential barriers. Community mapping and development are participatory processes that involves persons in mapping the resources and capacities of a community's individuals, its informal associations, and its structured institutions, as a means of identifying existing, but untapped or overlooked, resources and other potentially hospitable places in which the contributions of people with disabilities and/or addiction will be welcomed and valued.

Practice guidelines to be included in this domain:

G.1. People in recovery are viewed primarily as citizens and not as clients and are recognized for the gifts, strengths, skills, interests, and resources they have to contribute to community life.

G.2. Community leaders representing a range of community associations and institutions work together with people in recovery to carry out the process of community development.

G.3. Opportunities for employment, education, recreation, social and civic involvement, and religious participation are regularly identified and are compiled in asset maps, capacity inventories, and community guides.

G.4. Asset maps and capacity inventories created collaboratively by actively involved community stakeholders reflect a wide range of *natural* gifts, strengths, skills, knowledge, values, interests, and resources available to a community through its individuals, associations, and institutions.

G.5. Value is placed on the less formal aspects of associational life that take place in neighborhood gatherings, block watch meetings, salons, coffee clatches, barbershops, book groups, etc.

G.6. Institutions do not duplicate services that are widely available in the community through individuals and associations.

G.7. Community development is driven by a creative, capacity-focused vision identified and shared by community stakeholders.

G.8. The relational process of gathering information about community assets and capacities through personal interviews and sharing of stories is recognized as being as important as the information that is collected.

H. Identifying and Addressing Barriers to Recovery

There currently are elements and characteristics of the service delivery system and the broader community that unwittingly contribute to the creation and perpetuation of chronicity and dependency in individuals with behavioral health disorders. There also are several aspects of behavioral health disorders and their place within contemporary society that complicate the person's efforts toward recovery. The competent behavioral health care practitioner will have tools and strategies for identifying and addressing these barriers to recovery.

Practice guidelines to be included in this domain:

H.1. There is a commitment at the local level to embrace the values and principles of recovery-oriented care and to move away from the dominant illness-based paradigm. Systemic changes that reflect this paradigm shift include the following:

H.1.1. Stakeholders understand the need for recovery-oriented system change as a civil rights issue which aims to restore certain elementary freedoms to American citizens with psychiatric disorders and/or addictions.

H.1.2. Stakeholders work together to move away from the criteria of "medical necessity" toward "human need," from managing illness to promoting recovery, from deficit-oriented to strengths-based, and from symptom relief to personally-defined quality of life.

H.1.3. The possibility of recovery, and responsibility for delivering recovery-oriented care, are embraced by stakeholders at all levels of the system.

H.2. **Systemic structures and practices which impede the adoption of recovery-oriented practices are identified and addressed. Representative change strategies in this area include the following:**

H.2.1. Sequential movement through a pre-existing continuum of care is no longer required, as it is inconsistent with a civil rights perspective and contradicts current knowledge suggesting that recovery is neither a linear process nor a static end product or result.

H.2.2. Agencies need to have coordinating structures to attend to both the prioritization and integration of the range of new initiatives, policies, and procedures they are attempting to implement at any given time.

H.2.3. Performance and outcome indicators need to reflect the fact that the desired goal of recovery-oriented care is to promote growth, independence, and wellness; goals which sometimes involve the taking of reasonable risks that may result in interim setbacks.

H.2.4. Continual quality assurance and independent audits are conducted by people in recovery and families trained in recovery-oriented care.

H.2.5. Initial placement and service design are driven as much by the person's perception of what services and supports would be most helpful as by the staff's assessments of what the individual seeking services needs.

H.2.6. Recovery plans respect the fact that services and practitioners should not remain central to a person's life over time.

H.2.7. To integrate employment within the larger system, the task of assisting people in entering employment and education is made inherent to the responsibilities of the entire practitioner network, including those not specifically charged with supported employment or education tasks.

H.3. **Implementation of recovery-oriented care needs to be facilitated, rather than impeded, by funding, reimbursement, and accrediting structures. Change strategies to address this issue include:**

H.3.1. Even though Medicaid is funded by federal dollars, it remains primarily a state-administered program, and considerable flexibility exists in using these dollars to support innovative, community-based, supports.

H.3.2. Within existing funding structures, training and technical assistance can be provided to practitioners attempting to implement recovery-oriented practices to assist them in learning how to translate the wishes of people in recovery into reimbursable service goals and to describe their interventions in a manner that will generate payment.

H.3.3. Rather than being an add-on to existing services, transformation to recovery-oriented care begins with discovering ways to be creative and flexible within the constraints of existing resources.

H.3.4. Self-directed funding opportunities should be considered both on a collective basis and through individualized budget programs.

H.4. **Training and staff development is prioritized as an essential function to increase individual practitioners' competencies in providing recovery-oriented care. Necessary change strategies to address this issue include the following:**

H.4.1. As consensus emerges regarding the knowledge and skills needed to implement recovery-oriented care, this information must lead to the development of competency models, and these models must be disseminated broadly as guidance for training programs and licensing bodies which prepare and accredit providers of behavioral health care.

H.4.2. Once established, competency models should be incorporated in all human resource activities as a means of promoting accountability and quality improvement.

H.4.3. An analysis of staff's current competencies and self-perceived training needs should guide the development of on-going skill-building activities at the agency level.

H.4.4. Competency-based training must be coupled with on-going mentorship, enhanced supervision, recovery-oriented case conferences, and opportunities for peer consultation.

H.4.5. Clinical directors and agency leaders should be involved in ongoing training initiatives so that there is consistency between proposed recovery-oriented practices and the system's administrative structures.

H.4.6. Recovery-oriented care does ***not*** imply that there is no longer any role for the practitioner to play. Rather, the provider's role has changed from that of all-knowing, all-doing caretaker to that of coach, architect, cheerleader, facilitator, mentor, or shepherd—roles that are not always consistent with one's clinical training or experiences.

H.4.7. Training initiatives need to support people in recovery and families to develop their own capacity to self-direct their care and life decisions.

H.5. Forces at the societal level which undermine recovery and community inclusion are identified and addressed. Necessary change strategies to address this issue include the following:

H.5.1. Behavioral health practitioners have significant expertise to address the lack of basic resources and opportunities in the broader community, and are prepared to offer supportive guidance and feedback at both the individual and community level.

H.5.2. Community collaborations and education must be coupled with efforts on the part of behavioral health practitioners to recognize instances of discrimination, to understand relevant disability legislation, and to effectively utilize state and local resources.

H.5.3. Agencies are cautioned to avoid the establishment of 'one stop shopping' service programs which may inadvertently contribute to the perpetuation of discriminatory and unethical practices on the part of community members. We must continue to work with community partners to uphold their obligation to respect people with behavioral health disorders as citizens who have the right to be treated according to the principles of law that apply to all other individuals

H.5.4. Professionals and service recipients should be mindful of the limited resources available for specialized services and should focus on community solutions and resources first by asking "Am I about to recommend or replicate a service or support that is already available in the broader community?"

H.6. Certain internal barriers unique to behavioral health disorders are identified and addressed. Necessary change strategies to address these barriers include the following:

H.6.1. Staff appreciate the fact that, based on a complex interaction of the person's conditions and his or her past experiences in the behavioral health care system, people with behavioral health disorders may be reluctant to assume some of the rights and responsibilities promoted in recovery-oriented systems. They may initially express reluctance, fears, mistrust, and even disinterest when afforded the right to take control of their treatment and life decisions. Exploring and addressing the many factors influencing such responses is an important component of care.

H.6.2. Research indicates that many individuals with behavioral health disorders also have histories of trauma. Failure to attend to such histories may seriously undermine the treatment and rehabilitation enterprises, and further complicate the person's own efforts toward recovery.

H.6.3. Certain symptoms of illnesses may also pose direct impediments to the recovery process. In certain conditions, the elimination or reduction of symptoms may also come with great ambivalence, e.g., while episodes of mania can be destructive, they may include a heightened sense of creativity, self importance, and productivity that are difficult to give up. Being able to identify and address these and other sequelae requires knowledge and skill on the part of the clinical practitioner.

In each of the following sections, practitioners are given examples of what they are likely to hear from people in recovery when these guidelines have been implemented successfully. In addition, there is a list of recommended resources for further reading on transformation to recovery-oriented care, as well as a glossary of recovery-oriented language and examples of strengths-based conceptualizations that are proposed as alternatives to current deficit-based ones.

Attachment B

Letters of Support

LOWER HUDSON VALLEY E.A.P.
3505 HILL BOULEVARD - SUITE A
YORKTOWN HEIGHTS, NY 10598-1283
LOWERHUDSONVALLEYEAP.COM

TEL. (914) 245-6300
FAX (914) 245-3673
1-800-EAP-2799
LHVEAP@OPTONLINE.NET

L.U. 601 057

NO WHERE TO TURN
EMPLOYEE ASSISTANCE PROGRAM
KNOW WHERE TO TURN

A-NOT-FOR PROFIT CORPORATION

November 2, 2011

Ms. Kimberly Martone, Director of Operations
Department of Public Health - Office of Health Care Access
410 Capitol Avenue, MS #13HCA
P. O. Box 340308
Hartford, CT 06134-0308

Re: CON Application / MC1 HEALTHCARE d/b/a Mountainside Treatment Center

Dear Ms. Martone:

We at Lower Hudson Valley Employee Assistance Program would like to express our support for Mountainside Treatment Center's "CON Application".

LHVEAP has been in the business of assisting our 31 Unions, 80,000 members and their families for over 24 years with health and societal problems. We support the additional residential detoxification bed expansion that Mountainside is in the process of building. These beds can only improve the quality of Connecticut's substance abuse / addiction services.

Remember detoxification is often the first step for many individuals with a substance addiction. The approval of this application would assist in increasing the number of referrals LHVEAP could send to Mountainside. We would like to urge the Office of Health Care to approve Mountainsides application which will enhance their treatment program and allow their professional and clinical treatment team to provide a full continuum of services.

Thank you for the opportunity to express our professional approval of this decision.

Cordially,

Michael W. Popp Ph.D.

Michael W. Popp, Ph.D.
Program Director

McLean Hospital

115 Mill Street, Belmont, Massachusetts 02478-9106
Telephone 617 855-2000, FAX 617 855-3536

11/7/11

Ms. Kimberly Martone
Director of Operations
Department of Public Health
Office of Health Care Access
410 Capitol Avenue MS#13 HCA
P.O. Box 34038
Harford, CT 06134-0308

Dear Ms. Martone,

I am pleased to be writing on behalf of The Mountainside Treatment Center's CON application.

McLean Hospital and Mountainside have enjoyed an enduring and successful partnership for many years. McLean Hospital has been very pleased with the current services offered at Mountainside and would offer support for the request to provide a new detoxification unit at their Connecticut facility. We support this intent as the services currently provided by the Mountainside are of quality and we believe this will be true of the new endeavor.

Granting permission for this detoxification unit would enable patients to have a full continuum of services at one site which has the potential to improve treatment continuation. Additional detoxification services in the state of Connecticut would be beneficial to the community at large. McLean Hospital supports this addition to the clinical services at Mountainside as it presents new opportunities to patients and families in need of alcohol and drug services.

Sincerely,

Nancy Merrill PMHC. BC

Nancy Merrill
Director, Alcohol and Drug Abuse Services, Mclean Hospital

DANZIG

Counseling Services

November 4, 2011

Ms. Kimberly Martone
Director of Operations
Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS#13HCA
P.O. Box 340308
Hartford, CT 06134-0308

Re: CON Application: MC1 HEALTHCARE d/b/a Mountainside Treatment Center

Dear Ms. Martone:

I am writing in support of Mountainside Treatment Center's campaign to expand their services to include a detoxification program. As an interventionist and therapist working throughout New England I have experienced the need for additional services within Connecticut.

I have worked with Mountainside for several years and their attention to detail and client focused services are impeccable. Having sent many people to their program I have always had excellent communication while my client was in treatment and participated in aftercare planning.

936 Roosevelt Trail - Suite 14, Windham, Maine 04062
(207) 893-0000 www.danzigcounseling.com

DANZIG

Counseling Services

One issue that is paramount to the continuum of care is a seamless entry from detoxification to treatment. This gap between services is where many get lost and ultimately go back into active addiction. With that service added to Mountainside they would be a full service program and better able to meet the increasing need for treatment in New England and beyond. Unfortunately, without that service interventionists and therapists alike are having to coordinate additional treatment, transportation, financial resources, etc. to insure that our clients get the best possible help available to them. The addition of a detox at Mountainside would eliminate that issue and increase the referrals that I send to their program.

The issues of addiction in Maine are skyrocketing and at the same time the local programs have recently had their bed space reduced by 50%. I count on Mountainside to accept my referrals within days if not that same day. Addiction recovery is an issue that cannot wait until there is space. Mountainside has taken on the task of preparing for the imminent future demands of this problem by expanding their services.

I would happy to discuss this further.

Sincerely,

Steve Danzig

LMSW-CC, LADC, CCS

936 Roosevelt Trail - Suite 14, Windham, Maine 04062
(207) 893-0000 www.danzigcounseling.com

Recovery Network of Programs

061

November 1, 2011

Ms. Kimberly Martone
Director of Operations
Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS#13HCA
P.O. Box 340308
Hartford, CT 06134-0308

Re: CON Application: MC1 HEALTHCARE d/b/a Mountainside Treatment Center

Dear Ms. Martone:

I am writing in support of Mountainside's CON Application for medically monitored 3.7D Detoxification Services. There is a significant and growing need for detoxification services in Connecticut due to the epidemic rise of prescription drug abuse. Detoxification becomes an essential first step in the recovery process for most individuals. Detoxification services would also enhance the continuum of care which already exists at Mountainside. Having an in-house detoxification unit would ensure a more seamless connect to care rate where less clients would "fall through the cracks" in their movement through the addiction treatment system.

Mountainside will have no problem keeping 16 beds filled as Recovery Network of Programs, Inc. continues to operate our medically monitored detoxification at capacity and we are constantly in need of making detoxification referrals.

I have had a very positive experience with the individuals I have referred over the years to Mountainside. Mountainside meets the highest standards of treatment in the field and I would not hesitate to refer a family or friend to them. In fact, when I consulted for the Ministry of Health for the Cayman Islands to help them develop their addiction treatment system, I had them visit programs across the United States and of the 14 programs they reviewed, they were most impressed by Mountainside's model.

I urge approval of this detoxification application for Mountainside and with the addition of these services I will be able to increase the number of referrals to their continuum of care.

If you have any questions, please do not hesitate to contact me at (203) 929-1954.

Sincerely,

John Hamilton
Chief Executive Officer
Recovery Network of Programs, Inc.

November 2, 2011

Ms. Kimberly Martone
Director of Operations
Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS#13HCA
P.O. Box 340308
Hartford, CT 06134-0308

Re: CON Application: MC1 HEALTHCARE d/b/a Mountainside Treatment Center

Dear Ms. Martone:

I am writing in support of a Certificate of Need application which is in process of submission to your office by Mountainside Treatment Center in Canaan, CT. Although I work in Southwestern Massachusetts, (Stockbridge), it has been quite evident to me for some time that there is a strong need for medically supervised and administered detoxification services in the Northwestern quadrant of Connecticut.

On any number of occasions over the past 7 years, I have had to search far and wide for detox beds, and have ended up placing patients as far away as Worcester, MA, and Albany, NY. I have no doubt that I would refer patients in such need to a detox at Mountainside with some frequency, nor that Mountainside's detox beds would ever go unfilled.

I have worked closely with Mountainside clinical and referral staff over the past 7 years, and have been strongly impressed by the high level of professional expertise that is consistently evident at Mountainside. Mountainside Treatment Center has established itself as a nationally known, widely respected and innovative provider of substance abuse rehabilitation treatment at moderate cost.

I hope that Mountainside Treatment Center's CON in this regard will be given the most serious consideration by the CT DPH.

Sincerely,

Michael A. Sugarman, CADC

10/31/11

Ms. Kimberly Martone
Director of Operations
Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS#13HCA
P.O. Box 340308
Hartford, CT 06134-0308

Re: CON Application: MC1 HEALTHCARE d/b/a Mountainside Treatment Center

Dear Ms. Martone:

My name is Michael Ferguson, and I'm the Founder and Executive Director at Ferguson Behavioral Health Consulting. I work with families in crisis all over the country, and do quite a bit of work in Connecticut and the surrounding states. I'm writing to you in regards to Mountainside Treatment Center's CON application.

In my experience, there's a distinct need for detoxification and stabilization services in the state of Connecticut. Often, when I bring a client to Mountainside, they need to go to a facility in either New Jersey or New York, and that includes clients coming directly from Connecticut. Allowing Mountainside to expand their services to allow for detoxification services would greatly improve the resources available. Specifically, Mountainside has consistently done great work with the clients I have and continue to send to them, and adding this service would greatly improve their continuum of care.

From the standpoint of a professional who sends a large number of people to residential treatment every year, allowing Mountainside to have detoxification services would make for an even smoother transition for families and clients. A full continuum of services makes it a single stop for a client in crisis, which makes the entire treatment experience more manageable for families.

I look forward to continuing my work with Mountainside, and I strongly encourage you to approve their requests for the above reasons. Their current clinical excellence will only improve with the addition of comprehensive detoxification services. By removing a barrier to treatment that currently exists (clients have to go to detoxifications services

elsewhere), I can easily see sending even more clients to Mountainside in the future. If you have any questions of concerns, I urge you to contact me at your convenience.

Sincerely,

Michael A. Ferguson
Founder/Executive Director
Ferguson Behavioral Health Consulting
mike@fergusonbhc.com
800-624-2650
www.fergusonbhc.com

Spring Lake Ranch
Therapeutic Community
Working Toward Wellness

1169 Spring Lake Road
Cuttingsville, VT 05738
802.492.3322
www.springlakeranch.org

Rutland Program
26 Washington Street
Rutland, VT 05701
802.775.0808

November 1, 2011

Ms. Kimberly Martone
Director of Operations
Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS#13HCA
P.O. Box 340308
Hartford, CT 06134-0308

Re: CON Application: MC1 HEALTHCARE d/b/a Mountainside Treatment Center

Dear Ms. Martone:

My organization and I are personally are writing to you in support of Mountainside's Certificate of Need Application. We regularly refer to Mountainside and the only obstacle we run into is the fact that they must outsource detox services. In several recent instances we have made referrals and Mountainside has had to spend several days trying to find detox services that have availability. In a few cases, we have both lost clients as all beds were all full.

Not only am I the Director of Admissions for Spring Lake Ranch Therapeutic Community, I am also a graduate of Mountainside. I believe in their program with my whole heart and soul. To be able to offer a complete continuum of care will not only enhance their effectiveness but increase my ability to refer even more clients.

Connecticut is a highly respected state in many ways but it struggles along with other states with substance abuse and the associated problems for society. With all due respect, I implore you to approve the CON so that they may help people like me get well and give back to their community instead of draining it's hope.

Sincerely,

Rachel M. Stark
Director of Admissions

11-1-11

Dear Ms. Martone:

My name is Joshua Benton and I am the Executive Director at Hopewell Recovery Services. I would like to first express my gratitude for the work in the addiction field that Mountainside has done in the years past. Mountainside is a true leader in addiction treatment. The commitment they provide to helping people addicted is second to none. Our company is in full support of their new mission to add detox services for their clients. The level of professionalism they currently have in the industry will make the addition of detox services seamless.

The need for detox services in the state of CT. is overwhelming. Mountainside not only has the ability to fill 16 detox beds but will have the unique ability to further help those individuals with additional residential treatment in their primary program. The ability to offer these services will make them more effective in helping their clients attain long term sobriety.

Hopewell Recovery Services works with many treatment centers across the country and therefore has the unique ability to see the inner working of some of the most well-known facilities. Mountainside is the best of the best in regards to their treatment program and level of professionalism. The clinical staff works with the client through each step of the program, from admission to discharge—advocating for the client's needs every step of the way. Clients in residential treatment have many needs after their initial treatment is complete. Mountainside sets the bar in aftercare.

I would urge you to approve Mountainsides request for the increase in number of beds. Not only will this increase help to save more lives it will help to employ more people in the CT area—the benefits of this increase are endless!

Sincerely,

Joshua Benton

FAMILY HEALING STRATEGIES

November 1, 2011

Ms. Kimberly Martone
Director of Operations
Dept. of Public Health
Office of Health Care Access
410 Capitol Ave, MS#13HCA
PO Box 340308
Hartford, CT 06134-0308

Re: CON Application: MC1 HEALTHCARE d/b/a Mountainside Treatment Center

Dear Ms. Martone

I am writing this letter in support of Mountainside Treatment Center's CON application. As an Addictions Consultant and Interventionist, I can attest to the need for Detoxification services in the state of Connecticut. At least two to three times per month I am forced to refer to other locations for detoxification and arrange transport to Mountainside thereafter.

This is not the best clinical plan. Instead it is more clinically appropriate for detoxification services to be conducted at the same locale as the ultimate treatment for several reasons:

1. Addicts are often resistant to treatment and balk at the idea of continuing with services after detoxification despite the need;
2. Often, addicts agree to accept treatment but renege on their commitments when a detoxification bed can't be found (we have a drastic shortage in the State of Connecticut);

As a referent, I am thrilled by the prospect of Mountainside offering this valuable service. I have been referring there for the last 7 years and I am completely satisfied with the quality of clinical services provided by the professional staff. Despite my respect for

their services I am often forced to refer elsewhere when detoxification and clinical services need to be provided in the same place. I would estimate that I can increase my referrals to Mountainside by at least a couple per month.

Substance abuse and addiction continues to be a significant health and societal problem in Connecticut. Recent statistics reveal that an individual between the ages of 18-34 dies of an opiate overdose every other day! Detoxification is the first step for many. Additional detoxification beds will substantially improve the quality of Connecticut's plan to address this major health risk.

In sum, I strongly urge approval for Mountainside to increase the number of beds to provide this critical addition to their clinical treatment services.

Sincerely,

Diana R Clark

Diana Clark, JD, MA
Addictions Consultant
www.familyhealingstrategies.com

November 3, 2011

Ms. Kimberly Martone
Director of Operations
Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS#13HCA
PO Box 340308
Hartford, CT 06134-0308

Re: CON Application: MC1 HEALTHCARE d/b/a/ Mountainside Treatment Center

Dear Ms. Martone:

I am writing in support of Mountainside Treatment Center's application to incorporate a Detoxification Unit onsite. Presently Mountainside offers an excellent program and the continuum of services will enhance what is already a well-respected Treatment Center in the Northeast. Personal experience in working with Mountainside, their professional program and the clinical treatment team has led me to consistently recommend Mountainside to patients and their families. My only reservation has been that they do not provide onsite detoxification and I urge you to consider the importance of this critical addition to their services. It would unarguably increase the number of referrals I would make. More importantly, it would save lives. I have been working in the field of addiction for the last 30 years and have seen firsthand that we lose patients when it is a two-step process.

Substance abuse and addiction continues to be a significant health and societal problem in Connecticut. Detoxification is often the first step for many patients and residential detoxification beds are crucial to improving the quality and success of Connecticut's substance abuse/addiction services.

I look forward to hearing good news about the success of this application and appreciate your consideration of such an important issue.

Sincerely,

Stephen J. Fitzsimmons

Stephen J. Fitzsimmons
Fitzsimmons Associates
213 Robinson Street
Wakefield, RI 02879
401.632.1333

EDEN HILL Recovery Retreat for Women

November 5, 2011

Ms. Kimberly Martone
Director of Operations
Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS#13HCA
P.O. Box 340308
Hartford, CT 06134-0308

Re: CON Application: MC1 HEALTHCARE d/b/a/Mountainside Treatment Center

Dear Ms. Martone:

I am writing in support of Mountainside's CON application. There is a clear need for more detoxification services in the state of Connecticut. The wait time for a bed can be the difference between life and death. It is my opinion that Mountainside will have no difficulty filling sixteen beds, and be able to keep them full.

It would be beneficial to alcoholics and addicts seeking treatment to be able to detox and then go right in to primary care at the same facility as this provides seamless transition in the continuum of care. Mountainside and its staff have always sought to provide the best possible services to substances abusers and the addition of a detox will enable them to engage and help more people at the onset of their recovery process. It is vital that Connecticut have adequate detox facilities available and I strongly urge you to approve the increase in these beds at Mountainside.

We often get calls from people or their families seeking detox and treatment. They have tried to find help only to be told about long wait lists. It would be reassuring to have another detox to refer these struggling families to. There is a definite need.

Mountainside is an outstanding facility, and it is heartening to know that Mountainside and its clinical team are doing all they can to further serve and offer help to the residents of Connecticut.

Sincerely,

Dori C. Gay

Dori C. Gay LMFT
Director
Eden Hill Recovery Retreat for Women

PO Box 26, Canaan, CT 06018
860-824-7462 (p) 860 824 5009 (f)
www.edenhillrecoveryretreat.com
dgay@edenhillrecoveryretreat.com

October 31, 2011

Ms. Kimberly Martone
Director of Operations
Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS#13HCA
P.O. Box 340308
Hartford, CT 06134-0308

Re: CON Application: MC1 HEALTHCARE d/b/a Mountainside Treatment Center

Dear Ms. Martone:

I am writing in support of Mountainside Treatment Center's Certificate Of Need application to have detoxification services on premises. It is my strong belief that there is a significant need for detox services in the state of Connecticut, at a facility that I trust. Given the fact that they already provide outstanding clinical services, the need for Mountainside to provide this service is obvious, and would easily fill the 16 beds for which they are applying. Detox services at Mountainside would augment their treatment program by providing a full, seamless continuum of services. Even as a "competitor", I have referred to Mountainside on numerous occasions, and they have shown time and again, their professionalism and astute clinical acumen. I therefore, urge approval for Mountainside to increase number of beds to provide this critical addition to their treatment services.

As a professional in the field for over 16 years, and being a resident of this state, there are few places to which I would refer locally. More often than not, for in-state referrals, Mountainside is my first choice. Certainly, the advent of detox services there would go a long way in terms of my sending more people who suffer from the disease of addiction to Mountainside.

Sincerely,

Peter E. Lazar, LCSW
Regional Outreach Director
Elements Behavioral Health
PO Box 1650
Fairfield, CT 06825
646-369-2509
plazar@theelements.com

GALLANT & ASSOCIATES LLC
614 ELM STREET MONROE, CT 06468
WWW.PAULGALLANT.COM

10/31/2011

Ms. Kimberly Martone
Director of Operations
Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS#13HCA
P.O. Box 340308
Hartford, CT 06134-0308

Re: CON Application: MC1 HEALTHCARE d/b/a Mountainside Treatment Center

Dear Ms. Martone:

I am Paul J. Gallant MC, LPC, BRI-II. I have been a drug and alcohol counselor for over twenty five years and presently work throughout the state of Connecticut - helping families affected by addiction. This letter is intended as my support for Mountainside's CON application. We are in dire need of detox services in CT. Presently, I use Sunrise detox in Sterling NJ for the patients I am sending to Mountainside. It is a hardship for some families because of the distance. At times I use MCCA in Danbury - but more often than not I am told that there are "no beds" and to "call back tomorrow".

I have had great outcomes with Mountainside. They are clinically sophisticated and treat each patient with kindness, dignity and respect. The greatest challenge I have faced is their lack of detox. Treatment outcomes would improve if we had "one stop shopping" - and were able to keep patients in the Mountainside program from admission to detox to discharge. There would be no problem filling an additional 16 beds - addiction is a real problem in Connecticut - as you know. I urge you to accept their CON application and am available for further discussion at 203-521-1949

Sincerely,

Paul J. Gallant MC, LPC, BRI-II

11.2.2011

Ms. Kimberly Martone
Director of Operations
Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS#13HCA
P.O. Box 340308
Hartford, CT 06134-0308

Dear Ms. Martone,

Detoxification is an integral part of the treatment continuum. Before a patient can be approached with a treatment plan or be expected to take the necessary action to get well, it is imperative that they be detoxified. This is a necessary first step in the rehabilitation of a substance abuser.

The obvious goal of treatment is to put a person in the best position to succeed. The most difficult part of the process is getting someone who is abusing substances to accept help. Once a person accepts help it is of the greatest urgency to get that person to a Detox. I have seen this process fail many times due to a lack of bed availability at the Detox level. There is a clear need across the country and specifically in the Northeast for more facilities that provide this service.

The next step is primary treatment. In my experience, the substance abuser's chances of success can be dramatically increased if the transition from Detox to primary treatment is a seamless one. A seamless transition can be best achieved when the center administering detoxification also offers a primary treatment program. The patient is then able to step into the primary treatment phase uninterrupted and with continuity.

I am the founder and CEO of Foundation House in Portland, Maine. We are an extended care sober living facility for young men in early recovery from drugs and alcohol, specializing in post-primary treatment. Together with Mountainside we have worked to achieve continuity between the primary treatment and extended care phase of the process. I have a shared vision with Mountainside on what recovery should look like for for the alcoholic and the addict. With this shared vision we have successfully placed many residents into our facility who have completed the Mountainside program. We fully understand that momentum and consistency are very important components in a successful treatment plan. In working with Mountainside we have been blessed with

38 Deering Street Portland, ME 04101 Ph: 207-771-0235 Fax: 207-771-0236
recovery@foundationhouse.net www.foundationhouse.net

unbelievable, industry leading results. Much of our success has been attributed to this continuity of care between our programs. Our residents experience a seamless transition into our environment where they are immersed in a similar culture. This same approach would yield similar results when going from Detox to primary treatment.

With my professional experience in the recovery world and my personal experience with Mountainside I am able to fully support the proposed Detox facility. As stated above, there is, without question a general need for Detox facilities on a local and national level. In addition, any new Detox bed would be used most effectively if managed by a treatment facility like Mountainside that will be able to offer the next step in treatment under the same program.

Please feel free to contact me with any questions or concerns.

Best regards,

Patrick Babcock
Founder / CEO

38 Deering Street Portland, ME 04101 Ph: 207-771-0235 Fax: 207-771-0236
recovery@foundationhouse.net www.foundationhouse.net

Fairfield UNIVERSITY

November 1, 2011

Ms. Kimberly Martone
Director of Operations
Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS#13HCA
P.O. Box 340308
Hartford, CT 06134-0308

Re: Certificate of Need Application: MC1 HEALTHCARE, LLC d/b/a Mountainside Treatment Center

Dear Ms. Martone,

I am writing to support the Certificate of Need application for Mountainside Treatment Center to expand their services to include a medical detoxification unit. In my work at Fairfield University, and in my private practice, I routinely send individuals to Mountainside Treatment Center. Mountainside provides quality treatment to individuals who are struggling with chemical dependency. The program at Mountainside is very holistic in approach, and very effective in outcome.

It has been less than ideal when an individual needs a medical detox prior to being admitted to Mountainside. In such a situation, arrangements must be made with another facility that provides medical detox services, and the coordination of care among all the providers can be challenging.

It is unfortunate that so many individuals suffer with substance abuse, especially with teenagers and young adults. A recent government survey shows the number of Americans using illicit drugs is rising. "Nearly 9 percent of the U.S. population, or 22.6 million people, abused prescription drugs last year or regularly used marijuana, cocaine, heroin, hallucinogens, or inhalants", according to the National Survey on Drug Use and Health released on September 2011. There is a significant need for a detox program under the auspices of a substance abuse program such as Mountainside which enjoys a reputation of excellence. Given the *increasing need* for detox treatment and *Mountainside's reputation*, it is a guarantee that their detox facility will be highly utilized and routinely at capacity.

Detox is the first step in healing and recovery from addiction. For Mountainside Treatment Center to provide an inpatient detoxification program would enhance their services and provide their patients with a more coordinated experience of treatment. Mountainside has a proven track record of professionalism, extraordinary treatment, and outstanding outcomes. They can be trusted to continue to provide the very best for individuals struggling with drug addiction and alcoholism. I strongly urge you to approve Mountainside's application for this much needed service.

Sincerely,

Susan N. Birge

Susan N. Birge, Ed.D., M.A., L.P.C
Assistant Vice President/Director of Cousneling & Psychological Services

TURNING POINT

1212 Quinnipiac Ave.
New Haven, CT 06513
203-937-2309

November 1, 2011

Ms. Kimberly Martone
Director of Operations
Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS#13HCA
P.O. Box 340308
Hartford, CT 06134-0308

Re: CON Application: MC1 HEALTHCARE d/b/a Mountainside Treatment Center

Dear Ms. Martone:

I am writing in support of Mountainside Treatment Center's (Mountainside) Certificate of Need application. The obvious need for more quality detoxification services is overwhelming,

Over the past eight years, Turning Point has worked closely with Mountainside Treatment Center. During this period, Mountainside has continued to prove that they are among the elite treatment centers in the country. They have consistently operated at near to full capacity, while exuding a level of excellence in both patient care and community relations that is often sought after but rarely achieved in our industry.

The addition of these proposed detoxifications services will not only fulfill the tremendous need locally in Connecticut, furthermore, it will strengthen Mountainside's existing program. The "continuum of care" philosophy provided by many nationally recognized treatment programs has proven to dramatically increase the success rates of substance abuse patients. By effectively streamlining the treatment process, it allows the patient to work with the same professionals throughout this process, making a historically difficult endeavor, which often involves moving from treatment provider to treatment provider, less cumbersome for families and more beneficial to the patient.

As a fellow industry professional, I have great admiration for Mountainside C.E.O. Terrance Dougherty and his continued commitment to strive for better care for those in need. It is his unprecedented dedication to this process that drives Turning Point to refer so many of our clients to Mountainside each year. Time and time again, the feedback we receive from these clients and their families has been overwhelmingly positive.

If I can convey anything through this letter, it is that there is not only a need for more detoxification services, but there is a dramatic need for better detoxification services in Connecticut, and Mountainside's proven history as a premier provider of substance abuse services makes them a perfect candidate to fulfill this need.

In summation, I am in full support this application, and can only urge you to approve it

Should you have any questions, please do not hesitate to contact me at 203-937-2309 ext. 101.

With regard,

David Vieau
President & C.E.O.
Turning Point
www.tpextendedcare.com

Attachment C

Listing of Residential Detoxification Facilities in Connecticut

State of CT Residential Detoxification Facilities (Level 3.7, non-hospital)
As of November, 2011

NAME	PHONE	FAX	ADDR1	TOWN	STATE	ZIP	COUNTY	BEDS	Resident Detox	Detox Beds
FIRST STEP	(203)416-1950	(203)4161919	425 GRANT ST	BRIDGEPORT	CT	06610	FAIRFIELD	19	Yes	19
MCCA	(203)792-4515	(203)7482604	38 OLD RIDGEBURY ROAD	DANBURY	CT	06810	FAIRFIELD	30	Yes	10
DETOXIFICATION CENTER (Blue Hills & ADRC)	(860)714-3701	(860)7148974	500 BLUE HILLS AVENUE	HARTFORD	CT	06112	HARTFORD	73	Yes	35
RUSHFORD CENTER INC	(860)3460300	(860)3466417	1250 SILVER ST	MIDDLETOWN	CT	06457	MIDDLESEX	58	Yes	16
SOUTH CENTRAL REHABILITATION CENTER (SCRC)	(203)5033300	(203)4013352	232 CEDAR STREET	NEW HAVEN	CT	06519	NEW_HAVEN	29	Yes	29
STONINGTON INSTITUTE	(860)4453008	(860)4453010	75 SWANTOWN HILL RD	NORTH STONINGTON	CT	06359	NEW_LONDON	63	Yes	13
								272		103

Source: DPH Listing of Licensed Substance Abuse Facilities
and Mountainside's staff review of list to identify those with detox beds

Attachment D

Article: "Budget Cuts Eliminating Beds for Substance Abuse Treatment"

Budget cuts eliminating beds for substance abuse treatment

Connecticut Mirror, July 20, 2011

By Arielle Levin Becker

MIDDLETOWN--So far, in his 25-year career as a state employee providing addiction treatment services, Ken Kroll has worked at two facilities that have since closed their substance abuse programs.

Connecticut Valley Hospital, where he works now, has also cut back. And on Sept. 1, it will eliminate 20 detoxification beds and 60 rehabilitation beds for men.

"It just keeps shrinking," Kroll said Wednesday.

Ken Kroll and other CVH workers rally outside Merritt Hall

The planned closure of two rehabilitation units at the Middletown hospital's Merritt Hall, part of $1.6 billion in cuts announced last week, represents the elimination of more than 15 percent of the intensive substance abuse rehabilitation beds at facilities the state either operates or contracts with.

A ratified agreement between state employee unions and the administration of Gov. Dannel P. Malloy could avert the closures. But if the 60 rehabilitation beds are closed, the state will be left with 284 comparable beds, including 30 for women at CVH that will remain open, 21 beds at the state's Blue Hills campus in Hartford, and 233 run by private nonprofits.

Private substance abuse treatment providers are working with the state Department of Mental Health and Addiction Services to try to absorb the demand. The private facilities also offer detox services, but not with the level of medical care that Merritt Hall has, so some patients will likely go to acute care hospitals for detox when the 20 Merritt Hall beds are closed.

"Eighty beds is a huge, huge reduction in capacity on the substance abuse side," said Jeff Walter, President and CEO of Rushford, which provides substance abuse and mental health services. Rushford has 42 beds for intensive rehabilitation--comparable to the beds the state is cutting--and 16 detox beds.

Walter said he doesn't think the existing providers can completely absorb the need created by the planned closures. The implications, he said, will be "pretty dire": Instead of treatment, people will end up in jail, emergency rooms, or hospitals that cost more.

"I hope this can be averted," said Walter, the longtime co-chair of the council that oversees the state's Behavioral Health Partnership, which handles mental health and substance abuse care for people in Medicaid and other state programs.

Rushford has some beds available now--not uncommon in the summer--but Walter said it's not clear how long that will last.

Bill Young, chief operating officer of Alcohol and Drug Recovery Centers, Inc., in Hartford, said his agency has "some small amount" of capacity in a program that's comparable to the rehabilitation units being closed. Overall, ADRC has 28 intensive rehabilitation beds and 35 detox beds.

"From our perspective, we can help out a little," Young said. "I guess the question becomes...when you add together all the small contributions that a bunch of providers within the system can make, is that enough?"

DMHAS is hoping that it will be. "Some providers currently have some unused capacity, which we will utilize," department spokesman James Siemianowski said.

Going forward, substance abuse services at state facilities will be reserved for patients with no insurance who meet the medical necessity criteria for the services. "We are the payor of last resort," Siemianowski said.

DMHAS closed admissions to the intensive residential programs for men on Wednesday, a move intended to give current patients enough time to receive treatment and get follow-up care in the community. Admissions to the detox program will be closed Aug. 15. Both dates were set based on customary lengths of stay, according to the department.

Siemianowski said the general hospitals in the state provide detox services at the level that Merritt Hall does now, and can adapt to demand. In addition, Blue Hills has 21 detox beds at a lower level of medical care, while community providers that contract with the department have 130.

Patty Charvat, a spokeswoman for the Connecticut Hospital Association, said hospitals are particularly concerned about the closure of detox beds, which she said will lead people to seek services in emergency departments that are already at or near capacity.

"We are definitely anticipating that we'll be impacted by this closure, and it will start in the ED," she said.

During a rally outside Merritt Hall Wednesday, addiction services workers, many of whom received layoff notices, said they hoped an agreement on a concessions deal would make the cuts and layoffs unnecessary. Their union, the New England Health Care Employees Union, District 1199, SEIU, voted for the concession package.

But workers warned that the closure of the substance abuse beds would mean some people would be shut out from care altogether, with potentially dangerous consequences.

"Many patients here have been turned away by private sector agencies because of their complex issues or inability to pay," said Sarah Woolard-Raczka, an addiction counselor. She said the programs have at times had waiting lists of six weeks, and that the beds slated to be eliminated serve about 1,600 people a year.

"In the short term, it might look like money saved, but in the process, lives will be lost," she said.

Others said that patients who can't get into Merritt Hall could wind up in emergency departments, on the streets, or in jail.

"Or a community!" one worker shouted.

"A community near you!" someone else added.

"If they live!" a third called out.

Ann Marie Rankins, a mental health worker who has worked at CVH for about 12 years and received a layoff notice, said patients have learned about the planned closure through the media and have asked what they will do now, if they'll just be left on the streets to die.

"At least we can find jobs," she said. "But our patients need somewhere to go."

Attachment E

Substance Abuse and Mental Health Services Administration (SAMHSA): Results from the 2009 National Survey on Drug Use and Health

Results from the 2009 National Survey on Drug Use and Health: Volume I. Summary of National Findings

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Office of Applied Studies

Acknowledgments

This report was prepared by the Office of Applied Studies (OAS), Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (HHS), and by RTI International (a trade name of Research Triangle Institute), Research Triangle Park, North Carolina. Work by RTI was performed under Contract No. 283-2004-00022.

Public Domain Notice

Recommended Citation

Substance Abuse and Mental Health Services Administration. (2010). *Results from the 2009 National Survey on Drug Use and Health: Volume I. Summary of National Findings* (Office of Applied Studies, NSDUH Series H-38A, HHS Publication No. SMA 10-4856Findings). Rockville, MD.

Electronic Access and Copies of Publication

This publication may be downloaded from http://www.oas.samhsa.gov. Hard copies may be obtained from http://www.oas.samhsa.gov/copies.cfm. Or please call SAMHSA's Health Information Network at 1-877-SAMHSA-7 (1-877-726-4727) (English and Español).

Originating Office

Substance Abuse and Mental Health Services Administration
Office of Applied Studies
Division of Population Surveys
1 Choke Cherry Road, Room 7-1044
Rockville, MD 20857

September 2010

Table of Contents

Highlights

This report presents the first information from the 2009 National Survey on Drug Use and Health (NSDUH), an annual survey sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA). The survey is the primary source of information on the use of illicit drugs, alcohol, and tobacco in the civilian, noninstitutionalized population of the United States aged 12 years old or older. The survey interviews approximately 67,500 persons each year. Unless otherwise noted, all comparisons in this report described using terms such as "increased," "decreased," or "more than" are statistically significant at the .05 level.

Illicit Drug Use

- In 2009, an estimated 21.8 million Americans aged 12 or older were current (past month) illicit drug users, meaning they had used an illicit drug during the month prior to the survey interview. This estimate represents 8.7 percent of the population aged 12 or older. Illicit drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically.
- The rate of current illicit drug use among persons aged 12 or older in 2009 (8.7 percent) was higher than the rate in 2008 (8.0 percent).
- Marijuana was the most commonly used illicit drug. In 2009, there were 16.7 million past month users. Among persons aged 12 or older, the rate of past month marijuana use and the number of users in 2009 (6.6 percent or 16.7 million) were higher than in 2008 (6.1 percent or 15.2 million) and in 2007 (5.8 percent or 14.4 million).
- In 2009, there were 1.6 million current cocaine users aged 12 or older, comprising 0.7 percent of the population. These estimates were similar to the number and rate in 2008 (1.9 million or 0.7 percent) but were lower than the estimates in 2006 (2.4 million or 1.0 percent).
- Hallucinogens were used in the past month by 1.3 million persons (0.5 percent) aged 12 or older in 2009, including 760,000 (0.3 percent) who had used Ecstasy. The number and percentage of Ecstasy users increased between 2008 (555,000 or 0.2 percent) and 2009.
- In 2009, there were 7.0 million (2.8 percent) persons aged 12 or older who used prescription-type psychotherapeutic drugs nonmedically in the past month. These estimates were higher than in 2008 (6.2 million or 2.5 percent), but similar to estimates in 2007 (6.9 million or 2.8 percent).
- The number of past month methamphetamine users decreased between 2006 and 2008, but then increased in 2009. The numbers were 731,000 (0.3 percent) in 2006, 529,000 (0.2 percent) in 2007, 314,000 (0.1 percent) in 2008, and 502,000 (0.2 percent) in 2009.
- Among youths aged 12 to 17, the current illicit drug use rate increased from 2008 (9.3 percent) to 2009 (10.0 percent). Between 2002 and 2008, the rate declined from 11.6 to 9.3 percent.
- The rate of current marijuana use among youths aged 12 to 17 decreased from 8.2 percent in 2002 to 6.7 percent in 2006, remained unchanged at 6.7 percent in 2007 and 2008, then increased to 7.3 percent in 2009.
- Among youths aged 12 to 17, the rate of nonmedical use of prescription-type drugs declined from 4.0 percent in 2002 to 2.9 percent in 2008, then held steady at 3.1 percent in 2009.
- The rate of current Ecstasy use among youths aged 12 to 17 declined from 0.5 percent in 2002 to 0.3 percent in 2004, remained at that level through 2007, then increased to 0.5 percent in 2009.

- Between 2008 and 2009, the rate of current use of illicit drugs among young adults aged 18 to 25 increased from 19.6 to 21.2 percent, driven largely by an increase in marijuana use (from 16.5 to 18.1 percent).
- From 2002 to 2009, there was an increase among young adults aged 18 to 25 in the rate of current nonmedical use of prescription-type drugs (from 5.5 to 6.3 percent), driven primarily by an increase in pain reliever misuse (from 4.1 to 4.8 percent). There were decreases in the use of cocaine (from 2.0 to 1.4 percent) and methamphetamine (from 0.6 to 0.2 percent).
- Among those aged 50 to 59, the rate of past month illicit drug use increased from 2.7 percent in 2002 to 6.2 percent in 2009. This trend partially reflects the aging into this age group of the baby boom cohort, whose lifetime rate of illicit drug use is higher than those of older cohorts.
- Among persons aged 12 or older in 2008-2009 who used pain relievers nonmedically in the past 12 months, 55.3 percent got the drug they most recently used from a friend or relative for free. Another 17.6 percent reported they got the drug from one doctor. Only 4.8 percent got pain relievers from a drug dealer or other stranger, and 0.4 percent bought them on the Internet. Among those who reported getting the pain reliever from a friend or relative for free, 80.0 percent reported in a follow-up question that the friend or relative had obtained the drugs from just one doctor.
- Among unemployed adults aged 18 or older in 2009, 17.0 percent were current illicit drug users, which was higher than the 8.0 percent of those employed full time and 11.5 percent of those employed part time. However, most illicit drug users were employed. Of the 19.3 million current illicit drug users aged 18 or older in 2009, 12.9 million (66.6 percent) were employed either full or part time. The number of unemployed illicit drug users increased from 1.3 million in 2007 to 1.8 million in 2008 and 2.5 million in 2009, primarily because of an overall increase in the number of unemployed persons.
- In 2009, 10.5 million persons aged 12 or older reported driving under the influence of illicit drugs during the past year. This corresponds to 4.2 percent of the population aged 12 or older, which is similar to the rate in 2008 (4.0 percent) and the rate in 2002 (4.7 percent). In 2009, the rate was highest among young adults aged 18 to 25 (12.8 percent).

Alcohol Use

- Slightly more than half of Americans aged 12 or older reported being current drinkers of alcohol in the 2009 survey (51.9 percent). This translates to an estimated 130.6 million people, which is similar to the 2008 estimate of 129.0 million people (51.6 percent).
- In 2009, nearly one quarter (23.7 percent) of persons aged 12 or older participated in binge drinking. This translates to about 59.6 million people. The rate in 2009 is similar to the estimate in 2008. Binge drinking is defined as having five or more drinks on the same occasion on at least 1 day in the 30 days prior to the survey.
- In 2009, heavy drinking was reported by 6.8 percent of the population aged 12 or older, or 17.1 million people. This rate was similar to the rate of heavy drinking in 2008. Heavy drinking is defined as binge drinking on at least 5 days in the past 30 days.
- Among young adults aged 18 to 25 in 2009, the rate of binge drinking was 41.7 percent, and the rate of heavy drinking was 13.7 percent. These rates were similar to the rates in 2008.
- The rate of current alcohol use among youths aged 12 to 17 was 14.7 percent in 2009, which is similar to the 2008 rate (14.6 percent). Youth binge and heavy drinking rates in 2009 (8.8 and 2.1 percent) were also similar to rates in 2008 (8.8 and 2.0 percent).
- Past month and binge drinking rates among underage persons (aged 12 to 20) declined between 2002 and 2008, but then remained unchanged between 2008 (26.4 and 17.4 percent) and 2009 (27.2 and 18.1 percent).
- Among persons aged 12 to 20, past month alcohol use rates in 2009 were 16.1 percent among Asians, 20.4 percent among blacks, 22.0 percent among American Indians or Alaska Natives, 25.1 percent among Hispanics, 27.5 percent among those reporting two or more races, and 30.4 percent among whites.

- In 2009, 55.9 percent of current drinkers aged 12 to 20 reported that their last use of alcohol in the past month occurred in someone else's home, and 29.2 percent reported that it had occurred in their own home. About one third (30.3 percent) paid for the alcohol the last time they drank, including 9.0 percent who purchased the alcohol themselves and 21.3 percent who gave money to someone else to purchase it. Among those who did not pay for the alcohol they last drank, 37.1 percent got it from an unrelated person aged 21 or older, 19.9 percent from another person younger than 21 years old, and 20.6 percent from a parent, guardian, or other adult family member.
- In 2009, an estimated 12.0 percent of persons aged 12 or older drove under the influence of alcohol at least once in the past year. This percentage has dropped since 2002, when it was 14.2 percent. The rate of driving under the influence of alcohol was highest among persons aged 21 to 25 (24.8 percent).

Tobacco Use

- In 2009, an estimated 69.7 million Americans aged 12 or older were current (past month) users of a tobacco product. This represents 27.7 percent of the population in that age range. In addition, 58.7 million persons (23.3 percent of the population) were current cigarette smokers; 13.3 million (5.3 percent) smoked cigars; 8.6 million (3.4 percent) used smokeless tobacco; and 2.1 million (0.8 percent) smoked tobacco in pipes.
- Between 2002 and 2009, past month use of any tobacco product decreased from 30.4 to 27.7 percent, and past month cigarette use declined from 26.0 to 23.3 percent. Rates of past month use of cigars, smokeless tobacco, and pipe tobacco in 2009 were similar to corresponding rates in 2002.
- The rate of past month tobacco use among 12 to 17 year olds remained steady from 2008 to 2009 (11.4 and 11.6 percent, respectively). The rate of past month cigarette use among 12 to 17 year olds also remained steady between 2008 and 2009 (9.1 and 8.9 percent, respectively) but declined since 2002 when the rate was 13.0 percent. However, past month smokeless tobacco use among youths increased from 2.0 percent in 2002 to 2.3 percent in 2009.

Initiation of Substance Use (Incidence, or First-Time Use) within the Past 12 Months

- In 2009, an estimated 3.1 million persons aged 12 or older used an illicit drug for the first time within the past 12 months. This averages to about 8,500 initiates per day and is similar to the estimate for 2008 (2.9 million). A majority of these past year illicit drug initiates reported that their first drug was marijuana (59.1 percent). Nearly one third initiated with psychotherapeutics (28.6 percent, including 17.1 percent with pain relievers, 8.6 percent with tranquilizers, 2.0 percent with stimulants, and 1.0 percent with sedatives). A sizable proportion reported inhalants (9.8 percent) as their first illicit drug, and a small proportion used hallucinogens as their first drug (2.1 percent).
- In 2009, the illicit drug categories with the largest number of past year initiates among persons aged 12 or older were marijuana use (2.4 million) and nonmedical use of pain relievers (2.2 million). These estimates were not significantly different from the numbers in 2008. However, the number of marijuana initiates increased between 2007 (2.1 million) and 2009 (2.4 million).
- In 2009, the average age of marijuana initiates among persons aged 12 to 49 was 17.0 years, significantly lower than the average age of marijuana initiates in 2008 (17.8 years), but similar to that in 2002 (17.0 years).
- The number of past year initiates of methamphetamine among persons aged 12 or older was 154,000 in 2009. This estimate was significantly higher than the estimate in 2008 (95,000), but lower than the estimate in 2002 (299,000).
- There was a significant increase in the number of past year initiates of Ecstasy between 2008 and 2009, from 894,000 to 1.1 million. The estimate was 1.2 million in 2002, declined to 642,000 in 2003, and nearly doubled between 2005 (615,000) and 2009.
- The number of past year cocaine initiates declined from 1.0 million in 2002 to 617,000 in 2009. The number of initiates of crack cocaine declined during this period from 337,000 to 94,000.

- In 2009, there were 180,000 persons who used heroin for the first time within the past year, significantly more than the average annual number from 2002 to 2008. Estimates during those years ranged from 91,000 to 118,000 per year.
- Most (85.5 percent) of the 4.6 million past year alcohol initiates were younger than 21 at the time of initiation.
- The number of persons aged 12 or older who smoked cigarettes for the first time within the past 12 months was 2.5 million in 2009, similar to the estimate in 2008 (2.4 million), but significantly higher than the estimate for 2002 (1.9 million). Most new smokers in 2009 were younger than 18 when they first smoked cigarettes (58.8 percent or 1.5 million).
- The number of persons aged 12 and older who used smokeless tobacco for the first time within the past year increased from 951,000 in 2002 to 1.5 million in 2009.

Youth Prevention-Related Measures

- Perceived risk is measured by NSDUH as the percentage reporting that there is great risk in the substance use behavior. The percentage of youths aged 12 to 17 perceiving great risk in smoking marijuana once or twice a week increased from 51.5 percent in 2002 to 55.0 percent in 2005, but dropped to 49.3 percent in 2009. Between 2002 and 2008, the percentages who reported great risk in smoking one or more packs of cigarettes per day increased from 63.1 to 69.7 percent, but in 2009 the percentage dropped to 65.8 percent.
- Almost half (49.9 percent) of youths aged 12 to 17 reported in 2009 that it would be "fairly easy" or "very easy" for them to obtain marijuana if they wanted some. Approximately one in five reported it would be easy to get cocaine (20.9 percent). About one in seven (13.5 percent) indicated that LSD would be "fairly" or "very" easily available, and 12.9 percent reported easy availability for heroin. Between 2002 and 2009, there were declines in the perceived availability for all four drugs.
- A majority of youths aged 12 to 17 (90.5 percent) in 2009 reported that their parents would strongly disapprove of their trying marijuana or hashish once or twice. Current marijuana use was much less prevalent among youths who perceived strong parental disapproval for trying marijuana or hashish once or twice than for those who did not (4.8 vs. 31.3 percent).
- In 2009, almost four fifths (77.0 percent) reported having seen or heard drug or alcohol prevention messages from sources outside of school, lower than in 2002 (83.2 percent). The percentage of school-enrolled youths reporting that they had seen or heard prevention messages at school also declined during this period, from 78.8 to 74.9 percent.

Substance Dependence, Abuse, and Treatment

- In 2009, an estimated 22.5 million persons (8.9 percent of the population aged 12 or older) were classified with substance dependence or abuse in the past year based on criteria specified in the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition (DSM-IV). Of these, 3.2 million were classified with dependence on or abuse of both alcohol and illicit drugs, 3.9 million were dependent on or abused illicit drugs but not alcohol, and 15.4 million were dependent on or abused alcohol but not illicit drugs.
- Between 2002 and 2009, the number of persons with substance dependence or abuse was stable (22.0 million in 2002 and 22.5 million in 2009).
- The specific illicit drugs that had the highest levels of past year dependence or abuse in 2009 were marijuana (4.3 million), pain relievers (1.9 million), and cocaine (1.1 million). The number of persons with marijuana dependence or abuse has not changed since 2002, but the number with pain reliever dependence or abuse has increased (from 1.5 million to 1.9 million) and the number with cocaine dependence or abuse has declined (from 1.5 million to 1.1 million).
- In 2009, adults aged 21 or older who had first used alcohol at age 14 or younger were more than 6 times as likely to be classified with alcohol dependence or abuse than adults who had their first drink at age 21 or older (16.5 vs. 2.5 percent).

- The rate of substance dependence or abuse for males aged 12 or older in 2009 was nearly twice as high as the rate for females (11.9 vs. 6.1 percent). Among youths aged 12 to 17, however, the rate of substance dependence or abuse among males (6.7 percent) was similar to the rate among females (7.4 percent).
- Between 2002 and 2009, the percentage of youths aged 12 to 17 with substance dependence or abuse declined from 8.9 to 7.0 percent.
- Treatment need is defined as having a substance use disorder or receiving treatment at a specialty facility (hospital inpatient, drug or alcohol rehabilitation, or mental health centers) within the past 12 months. In 2009, 23.5 million persons aged 12 or older needed treatment for an illicit drug or alcohol use problem (9.3 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, 20.9 million persons (8.3 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 substance abuse facility in the past year.
- Of the 20.9 million persons aged 12 or older in 2009 who were classified as needing substance use treatment but did not receive treatment at a specialty facility in the past year, 1.1 million persons (5.1 percent) reported that they felt they needed treatment for their illicit drug or alcohol use problem. Of these 1.1 million persons who felt they needed treatment, 371,000 (34.9 percent) reported that they made an effort to get treatment, and 693,000 (65.1 percent) reported making no effort to get treatment.

1. Introduction

This report presents a first look at results from the 2009 National Survey on Drug Use and Health (NSDUH), an annual survey of the civilian, noninstitutionalized population of the United States aged 12 years old or older. The report presents national estimates of rates of use, numbers of users, and other measures related to illicit drugs, alcohol, and tobacco products. The report focuses on trends between 2008 and 2009 and from 2002 to 2009, as well as differences across population subgroups in 2009. Estimates from NSDUH for States and areas within States will be presented in separate reports. NSDUH estimates related to mental health, which have been included in national findings reports in prior years, are not included in this 2009 report. A separate report focusing on 2009 mental health data, including co-occurring mental and substance use disorders, will be published later in 2010.

1.1. Summary of NSDUH

NSDUH is the primary source of statistical information on the use of illegal drugs, alcohol, and tobacco by the U.S. civilian, noninstitutionalized population aged 12 or older. Conducted by the Federal Government since 1971, the survey collects data by administering questionnaires to a representative sample of the population through face-to-face interviews at the respondent's place of residence. The survey is sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services, and is planned and managed by SAMHSA's Office of Applied Studies (OAS). Data collection and analysis are conducted under contract with RTI International, Research Triangle Park, North Carolina.[1] This section briefly describes the survey methodology; a more complete description is provided in Appendix A.

NSDUH collects information from residents of households and noninstitutional group quarters (e.g., shelters, rooming houses, dormitories) and from civilians living on military bases. The survey excludes homeless persons who do not use shelters, military personnel on active duty, and residents of institutional group quarters, such as jails and hospitals. Appendix D describes surveys that cover populations outside the NSDUH target population.

From 1971 through 1998, the survey employed paper and pencil data collection. Since 1999, the NSDUH interview has been carried out using computer-assisted interviewing (CAI). Most of the questions are

Attachment F

Web Posting: "Blumenthal Holds Forum on Prescription Drug Abuse"

Blumenthal Holds Forum on Prescription Drug Abuse

The goal of the roundtable was to educate the public on the dangers of prescription drugs.

Rocky Hill Patch, October 29, 2011

By Joseph Wenzel IV

The goal of the roundtable was to educate the public on the dangers of prescription drugs.

U.S. Sen. Richard Blumenthal led a panel discussion on prescription drug abuse Friday morning at the Connecticut Department of Veterans Affairs.

"This working roundtable was very important to take the next steps for stopping prescription drug abuse, which is one of the epidemic scourges in public health," Blumenthal said. "People need to understand that their medicine cabinet can be a ticking time bomb. The best way to prevent a tragedy is to get rid of drugs no longer being used."

In 2007, 28,000 people in the United States died from unintentional drug overdoses, mostly due to prescription drug abuse, according to Blumenthal.

One of those in attendance was the director of the Office of National Drug Control Policy, Gil Kerlikowske, who discussed the importance of getting rid of expired and unnecessary drugs.

"We learn an awful lot going around the country and from a result of listening to what people have done and seen. It gives us a chance to talk about what the administration's position is on prescription drugs."

The event was held at the State Veterans Home because officials wanted to raise awareness about the rise in veterans' prescription drug abuse. Blumenthal said prescription drug abuse by veterans more than doubled from 2005 to 2008, shooting from from 5% to 12%.

"So it is definitely affecting veterans."

Dr. Linda Schwartz, commissioner of the Connecticut Department of Veterans' Affairs, said the department just finished a needs assessment of 650 veterans in Connecticut and found that prescription drug abuse in the state is in line with the national average.

Officials were shocked to learn that many of the soldiers returning from Iraq and Afghanistan are using steroids.

"I think it is a new issue," Schwartz said.

Schwartz, however, was not surprised and said that many of them do it to keep with the “macho image.”

Some of the veterans who really need pain medicine are forced to quit "cold turkey" because of financial restraints.

Blumenthal added that prescription drugs are the second most commonly abused drugs, behind only marijuana.

“Prescription drug abuse is horrendously prevalent and pernicious.”

Kerlikowske said there are two problems involving young people and prescription drugs. One is that young people do not recognize that prescription drugs are dangerous and second that they are so “widely available.”

The key to stopping prescription drug abuse is education, Schwartz said.

“I think that it (education) is listed as the first pillar of the administration’s prescription drug control strategy," Kerlikowske said. "And it is not just education for the patients and physicians, but also the young people."

Schwartz said the people who prescribe drugs need to make sure their patients understand what they are taking and the side effects.

People should also be aware of the dangers of mixing prescription drugs with alcohol, Schwartz said.

"I think it is one of the things that we see here, people take something for pain and if it doesn’t work they will have a couple of drinks. And they feel no pain.”

National Drug Take Back day is Saturday. Check with your local police department or town hall on the location of your town’s drop off. About 100,000 pounds of prescription drugs are expected to be collected nationally, Kerlikowske said.

Attachment G

DMHAS: "Collection and Evaluation of Data Related to Substance Use, Abuse and Prevention Programs, June 2011"

COLLECTION AND EVALUATION OF DATA RELATED TO SUBSTANCE USE, ABUSE, AND ADDICTION PROGRAMS

2010 BIENNIAL REPORT

For Submittal to

Members of the
Connecticut General Assembly,
Office of Policy and Management, and the
Connecticut Alcohol and Drug Policy Council

Prepared by the
Department of Mental Health
and Addiction Services

Patricia A. Rehmer
Commissioner

June 2011

ACKNOWLEDGEMENTS

We wish to acknowledge the following persons for their support in the development of this report.

Department of Mental Health and Addiction Services	Patricia A. Rehmer Commissioner	Paul J. Di Leo
Office of Policy and Management	Benjamin Barnes Secretary	Anne Foley Undersecretary
Judicial Branch	Judge Barbara M. Quinn Chief Court Administrator	William Carbone
Department of Children and Families	Joette Katz Commissioner	Peter Panzarella
Department of Correction	Leo C. Arnone Commissioner	Deborah Henault
Department of Education	George A. Coleman Acting Commissioner	Scott Newgass
Department of Motor Vehicles	Melody A. Currey Commissioner	Marilyn Lukie
Department of Public Health	Jewel Mullen Commissioner	Meg A. Hooper
Department of Public Safety	Reuben F. Bradford Commissioner	Gene Labonte Lieutenant Colonel
Department of Social Services	Roderick L. Bremby Commissioner	Mark Schaefer
Department of Transportation	James P. Redeker Acting Commissioner	Stephen Livingston
Department of Veterans' Affairs	Linda Schwartz Commissioner	Felice Guberman
Board of Pardons & Parole	Erika Tindill Chairman	John Lahda

ACKNOWLEDGEMENTS

For their cooperation and effort in the preparation of this report, we acknowledge the following persons.

Department of Mental Health and Addiction Services	Alfred Bidorini Linda Frisman Hsiu-Ju Lin Carol Meredith Janet Storey
Office of Policy and Management	Barbara Parks Wolf
Judicial Branch	Brian Hill Susan Glass Bryan Sperry
Department of Children and Families	Tere Foley Robert Plant Arnie Pritchard Melissa Sienna
Department of Consumer Protection	John Gadea Xaviel Soto
Department of Correction	Mary Lansing
Department of Public Health	Charles Nathan
Department of Public Safety	Lois Desmarais
Department of Transportation	Joseph Cristalli
Department of Veterans' Affairs	Shumei Chu
Board of Pardons & Paroles	John Lahda

We also wish to acknowledge the assistance of all other agency staff for their contributions.

Table of Contents

I. Background

Enacted in 1999, Connecticut General Statutes (CGS) Section 17a-451(o) requires the Department of Mental Health and Addiction Services (DMHAS) to establish uniform policies and procedures for collecting, standardizing, managing, and evaluating data related to substance use, abuse, and addiction programs administered by state agencies, state-funded community-based programs, and the Judicial Branch.

Furthermore, it is DMHAS' responsibility to establish and maintain a central data repository of substance abuse services and submit a report to the General Assembly, the Office of Policy and Management (OPM), and the Connecticut Alcohol and Drug Policy Council (ADPC). This report shall include: a) client and patient demographic information; b) trends and risk factors associated with alcohol and drug use, abuse, and addiction; c) effectiveness of services based on outcome measures; and d) a statewide cost analysis. In 2002, CGS Section 17a-451(o) was amended, changing the submission of the report from annual to biennial.

Since the enactment of CGS 17a-451(o), the number of collaborating state agencies and scope of data sharing has grown immensely. Today eleven state departments, the Office of Policy and Management, and the Judicial Branch work together to share data and report the findings presented in the *2010 Biennial Report on the Collection and Evaluation of Data Related to Substance Use, Abuse, and Addiction Programs* (2010 Biennial Report). This broad-based interagency collaboration has resulted in the submission of seven previous reports (February 2000, July 2001, February 2002, December 2003, May 2004, June 2007 and December 2009).

Progress made over the past eleven years towards achieving the legislative directive has included:

- continued assessment of uniform procedures and the data interoperability of substance abuse treatment and prevention information systems across state agencies;
- sharing data across state agencies to determine the interrelated service needs of those receiving substance abuse treatment; and
- enhancing the level of interagency collaboration leading to more effective and efficient use of scarce resources.

In 2004, the first of a series of treatment outcome and effectiveness studies was initiated. Collaborating with the Department of Labor, DMHAS' Research Division and Yale University, conducted a study of earnings two years before and after receiving treatment. The *Treatment Effects on Wages Study* was the first in Connecticut to directly link employment wage data with substance abuse treatment records. This study of treatment effectiveness was followed by a study of treatment and its effects on recidivism as measured by re-arrest and re-incarceration. Findings from the joint DMHAS and Department of Correction (DOC) *Treatment Effects on Criminal Justice Involvement Study* were presented in the 2006 Biennial Report. In the 2008 Biennial Report, the most ambitious yet data linkage study was completed–*Young Adults Receiving Substance Abuse Treatment with Prior Child Welfare or Judicial Court Involvement* - an analysis linking child welfare, juvenile justice, adult substance abuse treatment, adult arrests and mortality records. For the 2010 Biennial Report, DMHAS collaborated with the Department of Consumer Protection to link patients in Connecticut's Prescription Monitoring Program with substance abuse data. The *Nonmedical Use of Narcotic Prescriptions and Its Affect on Connecticut's Substance Abuse Treatment System* focuses on those abusing opiate prescription drugs, particularly young adults, the rate of transitioning to heroin, the rate of treatment access, and the use of Medication Assisted Therapies (e.g., Suboxone).

In 2010, work continued on population overlaps as part of the Data Sharing Project. The Probabilistic Population Estimation or PPE model used in previous years was replaced with a direct linking model. As criminal justice data (i.e., arrests, incarcerations and probationers) has been routinely linked with behavioral health (substance abuse and mental health) records, this was thought to be a good starting point to pilot the new method of analysis. More comprehensive analyses may soon be performed to better understand the characteristics of those who are criminally involved and receiving care for their behavioral health needs. As confidentiality requirements are addressed, other state agency populations will be included in the population overlap model. This would include child welfare neglect and abuse cases, social services recipients (e.g. Medicaid, Temporary Family Assistance, etc.) and others.

The cross-agency data repository initiative begun in September 2002, known as the *Interagency Substance Abuse Treatment Information System* (I-SATIS), met with challenges over the years due to confidentiality concerns brought about by the Health Insurance Portability and Accountability Act (HIPAA). Even more stringent HIPAA security and privacy regulations were recently enacted. Also, technological changes in data transfer and sharing require reexamination of how a data repository is conceptualized. Due to these and other factors, work continues as how best to bring together the various state-funded and -operated addiction service data systems.

Another area of data sharing is the State Epidemiological Outcomes Workgroup (SEOW), first convened in 2005 as part of DMHAS' Strategic Prevention Framework State Incentive Grant funded by the federal Center for Substance Abuse Prevention (CSAP). The primary mission of the SEOW is to contribute to the collection, analysis, and interpretation of state- and community-level epidemiological data, track data trends over time, and produce information to prioritize, focus, and strengthen prevention efforts. For DMHAS, the SEOW provides a broader perspective of trends in substance use and consequences, taps into other state agency areas of expertise and knowledge, works towards more universally accessible information for all stakeholders, and offers the possibility to collaborate on studies of common concern. In 2007, the SEOW was expanded to incorporate some of the reporting objectives under the Biennial Report.

The SEOW has collected and reviewed state level consumption and consequence data from a variety of state and federal sources. These data were used to develop a state epidemiological profile which identified the top six problem substances in the state based on their impact, burden and susceptibility to change. This profile formed the basis of the Comprehensive Strategic Prevention Plan available at http://www.ct.gov/dmhas/lib/dmhas/prevention/ctspf/SEWprofiles09.pdf. Through the SEOW, data is reviewed and updated biennially, and secondary data sources are made available to regions and municipalities to develop community profiles which are used to plan effective prevention strategies.

The SEOW, managed by the DMHAS Prevention and Health Promotion Unit, is working with the Connecticut Data Quality and Access Consortium to pilot a web-based interactive social indicator data repository. The website will contain approximately 50 indicators, as well as census data and student survey data collected locally. It will allow users to create tables, charts, and maps, displaying data values (numbers, percentages, or rates) for towns, Uniform Service Regions (USR), or statewide, and by population group. The site is expected to be up and running by summer 2011.

Another important stakeholder body is the state Child Poverty and Prevention Council (CPPC). The Council continues to meet to formulate strategies for action on its priority recommendations. To advance its efforts in reducing poverty among children in Connecticut by 50% over ten years, the Council's work has focused on a process that: selected target populations; built consensus around priority recommendations using national experts, documented research and proven practices; utilized a Results Based Accountability approach to focus resources and strategies; created an economic model to assess which policies will likely reduce child poverty by 50%; developed a community model where selected municipalities will work to decrease child poverty; and promoted interagency collaborations among state agencies to meet the child poverty and prevention goals.

Additionally, the Council will examine strategies to lessen the impact of the recession on Connecticut's children. The Council will work with other agencies to develop and promote policies, practices and procedures, to mitigate the long-term impact of economic recessions on children; provide appropriate assistance and resources to families to minimize the number of children who enter poverty as a result of the recession; and reduce the human and fiscal costs of recessions, including foreclosures, child hunger, family violence, school failure, youth runaways, homelessness, and child abuse and neglect. Child Poverty and Prevention Council Plans and Reports are available at the Office of Policy and Management web site at http://www.ct.gov/opm/cwp/view.asp?a=2997&q=383356 .

II. Executive Summary

The 2010 Biennial Report, as in previous reports, looks across the spectrum of state agency services for the prevention, intervention, and treatment of substance use, misuse, and abuse. A range of information is reported using various methods (trend analyses, data sharing and linkage, etc.) to provide the best overview of the current situation. Barriers to implementing a consolidated substance abuse services information system persist but advances in data sharing technology afford an opportunity for expanded collaborations.

The 2010 Biennial Report contains the culmination of years of work on some very important cross-agency projects. Among them are:

1. Adolescent Treatment Service Data

In the last decade, the Department of Children and Families (DCF) has focused on integrating services for substance use and mental health disorders, including co-occurring disorders. At the same time, the department has led the country in implementing evidence-based approaches to treating adolescent substance use. This has included funding services with proven success such as MultiSystemic Therapy (MST) and Multi-Dimensional Family Therapy (MDFT). In order to assess the effectiveness of services DCF has implemented the Global Appraisal of Individual Needs (GAIN) standardized assessment tool. Also the department revamped its behavioral health services information system in 2009, now known as Programs and Services Data Collection Reporting System or PSDCRS.

Together, these data provide rich detail about those served by DCF's substance abuse treatment providers, and document the success of these services in improving the health and well-being of youth and families. DCF's entire report can be found at:

http://www.ct.gov/dcf/lib/dcf/substance_abuse_services_report_2011.pdf

Major findings include:

- Utilization of adolescent substance abuse treatment services has more than doubled since 2004. While the volume of clients served in outpatient and intensive in-home community-based programs has risen, residential treatment has remained unchanged.
- Ninety-eight percent of adolescents in residential treatment and 81% of adolescents in outpatient treatment report a 50% or greater reduction in problems related to substance use from intake to discharge.
- At discharge from Family Based Recovery , 75% of children were living at home with their biological parent(s).
- The MST-Building Stronger Families pilot study shows that children of families receiving these services were less likely to be placed out-of-home.
- Intensive, in-home services result in reduced marijuana and alcohol use; getting into trouble at home, school or with friends; or missed school days.

2. Adult Treatment Service Data

Using data collected through DMHAS' substance abuse treatment information systems a trend analysis was conducted for SFYs 2006, 2008, and 2010. This comprehensive data repository contains admission and discharge information from all community-based substance abuse treatment programs licensed by the Department of Public Health (DPH). Additionally, some non-licensed, state-operated programs report to DMHAS as well, including DMHAS operated hospitals and Department of Correction prison-based services. Client-level data are routinely submitted and contain information on each admitted or discharged client.

As in past reports, trends in admissions are analyzed for the primary drug reported at admission, age of first use, demographics, service utilization and other areas of interest.

Major findings in the SFY 2006 to 2010 analysis include:

- The percent of primary heroin admissions continued to drop after years of steady increases giving rise to alcohol to become, once again, the most frequently reported substance at admission.
- Treatment admissions due to other (prescription) opiates (e.g.,OxyContin®, Vicodin®) had the greatest percentage increase, continuing a seven-year trend.
- The average age at admission for those with a primary heroin problem decreased from SFY 2008 to 2010 by one year (34.8 to 33.1) and by 4.5 years for those reporting other opiates.

3. Caseload Overlaps

Since 2000, the Data Sharing Project has drawn upon data from seven state agencies and the Judicial Branch. This project has been highly successful in generating statistical information in the past including trends in measuring the overlap of state agency populations receiving treatment.

While PPE was useful to examine general rates of treatment access, it was very limited in its capacity to provide insight as to the sequencing of treatment services (e.g., before or after incarceration) or client outcomes. For this reason it was decided to move to linking individual records directly across systems. As DMHAS and the state's criminal justice agencies have established consistent and valid methods for linking large administrative databases, this seemed a logical starting point.

At the June 2010 meeting of the Criminal Justice Policy Advisory Commission, a recommendation was offered that would allow for the routine linking of behavioral health and criminal justice data. During SFY 2011, DMHAS and the criminal justice partners formed a steering committee responsible for:

- Determining the scope of data sharing.
- Overseeing the creation of essential data documentation.
- Recommending a linking method that meets state and federal confidentiality laws and regulations.
- Suggesting standard reports and developing criteria for ad hoc or special reports.
- Assisting in the interpretation of findings.
- Developing and facilitating the execution of confidentiality agreements and approvals across all participating parties.

It is anticipated that data documentation and the Memorandum of Understanding regarding governance, publication and other pertinent matters will be completed by late summer 2011. At that time, five years of criminal justice (arrests, incarceration and probation) and behavioral health data will be linked for the purpose of services research, evaluation, and outcomes analysis.

4. Nonmedical Use of Prescription Narcotic Pain Relievers and Treatment

Today, Connecticut's rate of non-medical use of pain relievers is estimated to be 3.8% of the adult population according to the most recent National Survey on Drug Use and Health findings. For young adults (18-25), the rate continues to be about two and a half times the general adult population at 10.5%. There is evidence that many persons who become addicted to prescription pain relievers move to heroin as a cheaper and more readily available alternative.

Recent analyses of DMHAS substance abuse treatment data indicate that the rate of primary heroin admissions is declining. On the other hand, persons entering treatment reporting a primary substance problem for "other synthetic opiates" (e.g., Vicodin®) continues to rise. Over the past decade, treatment options for opiate dependent persons have expanded, particularly with the introduction of buprenorphine (e.g., Subutex, Suboxone). Use of buprenorphine for both detoxification and long-term replacement therapy has been proven to be effective and DMHAS has encouraged the expansion of this treatment approach for opiate dependent persons.

For the purpose of this study, data from the Department of Consumer Protection's (DCP) Connecticut Prescription Monitoring Program (CPMP), a central database containing prescription drug data for Schedule II-V controlled medications, was linked to DMHAS substance abuse treatment service records. Other data included in the linked analytic database were adult arrests, incarceration, adult probation and deaths.

Preliminary analyses conducted include the following results:

- Many young adults (18-24) prescribed buprenorphine were found to have a history of criminal justice involvement (arrested - 48%) but at a rate lower than those the same age treated in licensed or operated programs (arrested - 72%).
- Access to buprenorphine treatment for young adults as been steadily increasing over the last two years (SFYs 2009 and 2010) providing an important alternative to Methadone Maintenance for the treatment of opiate addiction.
- Identifying cases in which questionable activity such as "doctor shopping" or abuse of prescription pain relievers requires more careful consideration due to "false positives".

As this study was exploratory in nature, analyses will continue in the coming year.

5. Prevention Services

Prevention Data

Over the recent past, the DMHAS Prevention and Health Unit, in collaboration with other state agencies, has leveraged federal funding to enhance its capacity for obtaining, using, and disseminating interagency data. Since 2005, through funding from the federal Center for Substance Abuse Prevention (CSAP), DMHAS has supported the efforts of the State Epidemiological Outcomes Workgroup (SEOW) to promote the use of substance abuse prevention and mental health promotion data to select effective programs and strategies. The SEOW provides a framework to expand interagency collaboration, promote sharing of state agency expertise to access, interpret, and analyze data, and explore opportunities to collaborate on issues of common concern.

Since 2006, the SEOW has been tracking epidemiological data on six substances (alcohol, tobacco, marijuana, heroin, prescription drugs, and cocaine). SEOW data were used to update profiles for each substance, as well as suicide and problem gambling. These profiles can be found at: http://www.ct.gov/dmhas/lib/dmhas/prevention/ctspf/SEWprofiles09.pdf

In SFY 2010, the SEOW began the process of replacing its web-based data repository with a state-of-the-art, interactive site which will enable any registered user to access substance abuse prevention and mental health promotion indicators, analyze the data, and produce high-quality visualizations (maps, graphs, etc.). These reports may be used to construct community profiles, assess service needs, prepare funding applications, and measure the impact and effectiveness of programs. The new site is expected to be up and running by summer 2011.

6. Statewide Cost Analysis

Overall funding for substance abuse services has grown from SFY 1999 to SFY 2009. Some of the growth, especially in SFYs 1999 to 2002, reflects improved expenditure reporting. Particularly, the increase in total expenditures between SFYs 2000 and 2001 is partially due to the identification and inclusion of additional state agencies not previously reporting (e.g., Department of Social Services–Medicaid).

Overall funding for substance abuse services has experienced a steady growth from SFY 1999 to SFY 2007 but saw a 1.2% decrease (not adjusted for inflation) from SFY 2007 to 2009. Looking at SFY 2009 expenditure categories, the greatest reduction (40.9%) from SFY 2007 was seen in prevention services. The major contributor to this reduction was a $13.6 million dollar loss in State Department of Education discretionary federal grants. Treatment expenditures saw a slight increase (6.7%) due primarily to DSS Medicaid expenditures while deterrence dropped by 19% in SFY 2009 when compared to SFY 2007.

III. Adolescent Substance Abuse Treatment

In the last decade, the Department of Children and Families (DCF) has focused on integrating services for substance use and mental health disorders, including co-occurring disorders. At the same time, DCF has led the country in implementing evidence-based approaches to treating adolescent substance use by focusing its funding on services with proven success including MultiSystemic Therapy (MST) and Multi-Dimensional Family Therapy (MDFT), and implementing data collection systems to evaluate the effectiveness of these treatment services. In addition, DCF is leading the nation with approaches to caregiver substance abuse treatment and child maltreatment, including participating in a National Institute of Drug Abuse (NIDA) clinical trial for MST-Building Stronger Families.

The data that follow are excerpts from a comprehensive service system report prepared by DCF. The comprehensive report includes data from many of the sources the agency uses to monitor and evaluate its services including the Global Appraisal of Individual Needs (GAIN) standardized assessment tool, the Programs and Services Data Collection Reporting System (PSDCRS), and model-specific quality assurance data. Together, these data provide rich details about those served by DCF's substance abuse treatment providers, and document the success of these services in improving the health and well-being of youth and families. DCF's entire report can be found at: http://www.ct.gov/dcf/lib/dcf/substance_abuse_services_report_2011.pdf

Outcomes from DCF's substance abuse programs include:

- All of DCF's substance abuse programs average lengths of stay that meet or exceed NIDA's recommendation of 90 days or more to obtain a therapeutic effect from treatment. (Table 1)

- Ninety-eight percent of adolescents in residential treatment and 81% of adolescents in outpatient treatment report a 50% or greater reduction in problems related to substance use from intake to discharge from treatment. (Graph 2)

- At discharge, adolescents receiving intensive in-home services (MDFT and MST) report reductions in: marijuana and alcohol use; getting into trouble at home, school or with friends; missed school days; and days bothered by mental health problems. (Graph 3)

- Among the 278 caregivers discharged from Family Based Recovery (FBR), there were statistically significant improvements in parental depression, stress and postpartum bonding with their child(ren) (Table 2). At discharge from FBR, 75% of children were living at home with their biological parent(s). (Table 3)

- The MST-Building Stronger Families pilot study shows that children of families receiving these services were less likely to be placed out-of-home and had significantly fewer reports of child maltreatment when compared to services as usual. (Graph 4)

- Project SAFE, a DCF and DMHAS interagency program, provides screening and treatment referrals to families involved in child protective services. The rate at which those referred to treatment actually enter treatment has increased dramatically in recent years. (Graph 5)

Table 1. Adolescent Substance Abuse Outpatient & Residential Treatment Individuals Served: SFY 2010

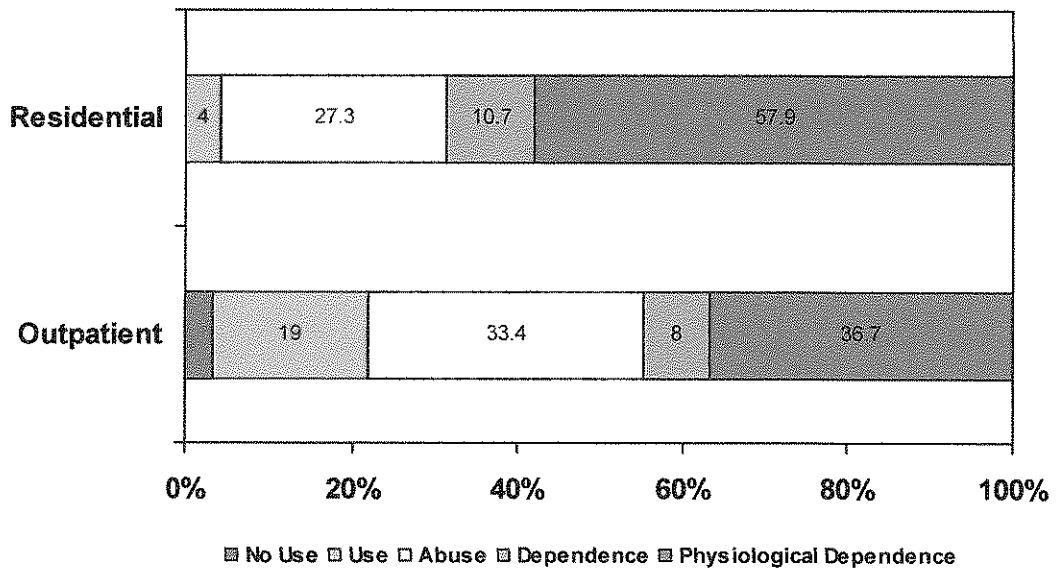
OUTPATIENT		RESIDENTIAL	
Total Served	804	Total Served	102
Male	71.4 %	Male	71.2 %
Age of Youth Served		Age of Youth Served	
11-12	0.7 %	11-12	0.0 %
13-14	13.3 %	13-14	15.3 %
15-16	50.6 %	15-16	67.8 %
17-18	34.9 %	17-18	16.9 %
>18	0.5 %	>18	0.0 %
Average Length of Treatment	94 Days	Average Length of Treatment	191 Days

Adequate Length of Treatment = Good Outcomes

NIDA recommends <u>at least 90</u> days for positive outcomes.

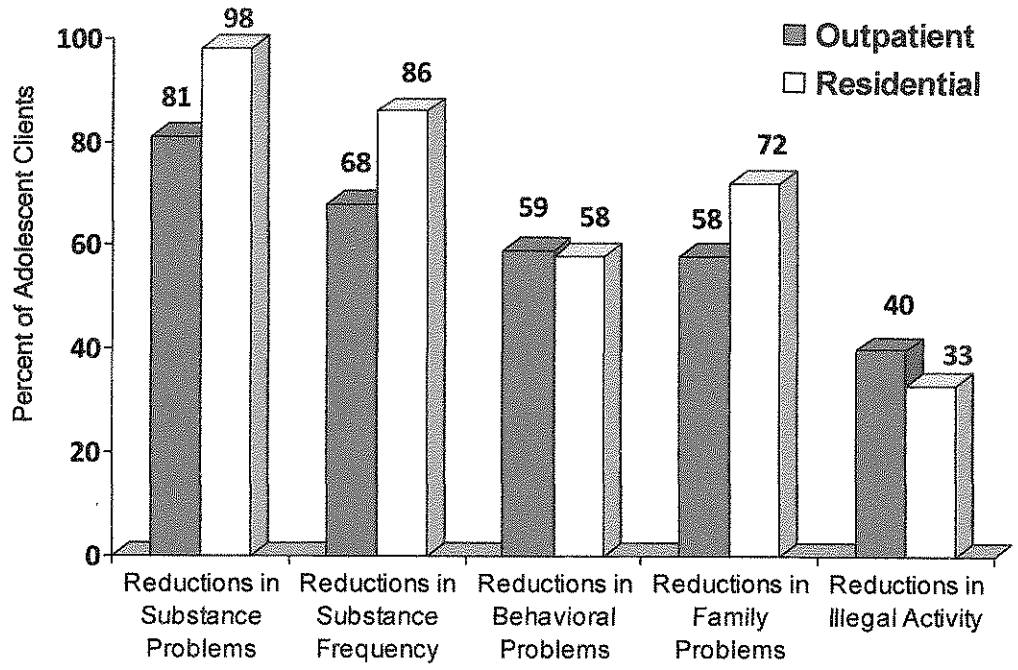
Source: Intake Data for SFY 2010 from PSDCRS, the Behavioral Health Partnership and the GAIN

Graph 1. Lifetime Substance Use Severity Reported by Adolescents at Intake



Ninety-six percent of adolescents in residential treatment and nearly 80% of adolescents in outpatient treatment self report having problems that indicate a substance use diagnosis.

Graph 2. Percent of Adolescent Treatment Clients With Reduced Problems* at Discharge



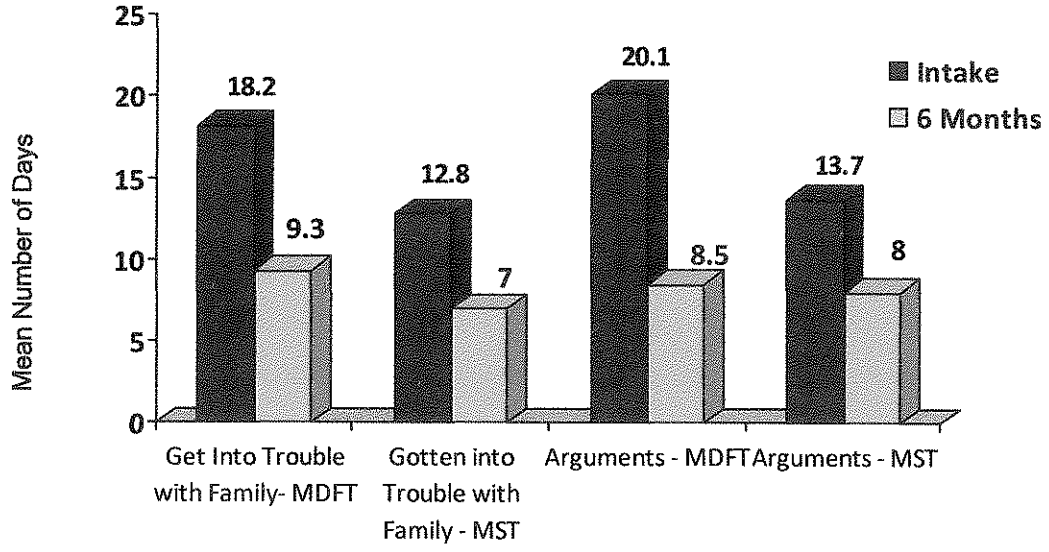
Treatment works:

At discharge, adolescents report significant reductions in problems related to substance use, frequency of use and associated problems.

* Having a 50% or better reduction in substance related problems from intake to discharge.

In-Home Adolescent Treatment

Graph 3. Mean Days of Family or Peer Problems Reported



Over time, adolescents in MDFT and MST report fewer days of getting into trouble with family and having fewer arguments.

Family Based Recovery (FBR) Programs

Using an evidenced-based and preferred practice model, Family Based Recovery (FBR) Programs provide intensive home-based services that integrate parental substance abuse treatment with family treatment designed to enhance parenting and parent-child attachment. The target population is infants (birth to 24 months) who have been exposed to parental substance abuse in-utero and/or environmentally from their parent(s) and their siblings; who are involved with DCF for child abuse / neglect issues; and who are at risk of removal from their homes.

Table 2. Changes Over Time in Parental Depression, Stress and Postpartum Bonding in FBR

Measures	Baseline	Discharge	T-Value and Significance
Edinburgh Depression Scale (N= 174)			
Total Score	7.24	5.01	5.20 **
Parenting Stress Index-Short Form (N=163)			
Total Score	68.03	61.55	5.42 **
Postpartum Bonding Questionnaire (N=149)			
Total Score	5.79	4.37	3.35**

Note: *p<05
**p<01

Significant improvement in depression, parental stress and bonding were seen in Family Based Program participants from baseline to discharge.

Table 3. Family Based Recovery - Child Placement at Discharge

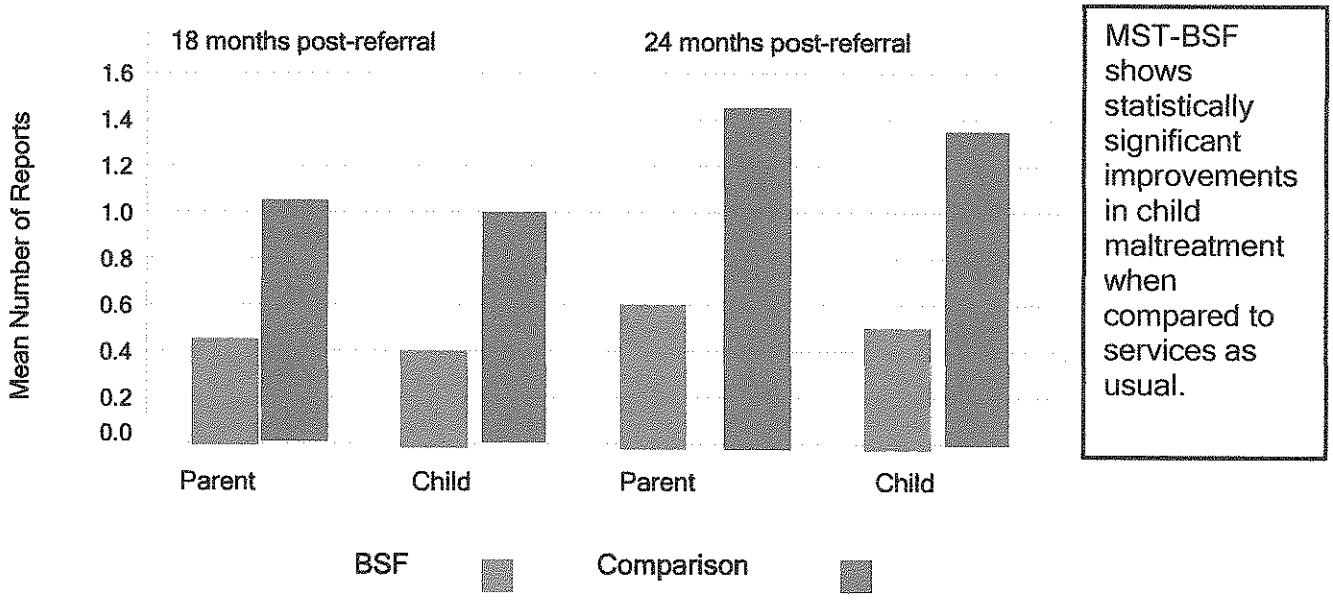
Total Served in SFY10	164
Child Placement at Discharge	
Home with Biological Parent	75%
Relative's Home	13%
Foster Care	10%
Other	2%
Mean Length of Stay	8.7 Months

Three out of four children receiving family-based services were placed in the home with their biological parent at time of discharge.

MultiSystemic Therapy - Building Stronger Families (MST-BSF)

MST-BSF provides intensive in-home and community-based treatment for DCF families with physical abuse and/or neglect of a child due to parental substance abuse. The target population is children, age 6 - 17 years, who have had maltreatment reports within the past 180 days and are at risk of removal from the home.

Graph 4. Maltreatment Reports After Initial Referral To MST-BSF Therapy



Recovery Services Voluntary Program (RSVP)

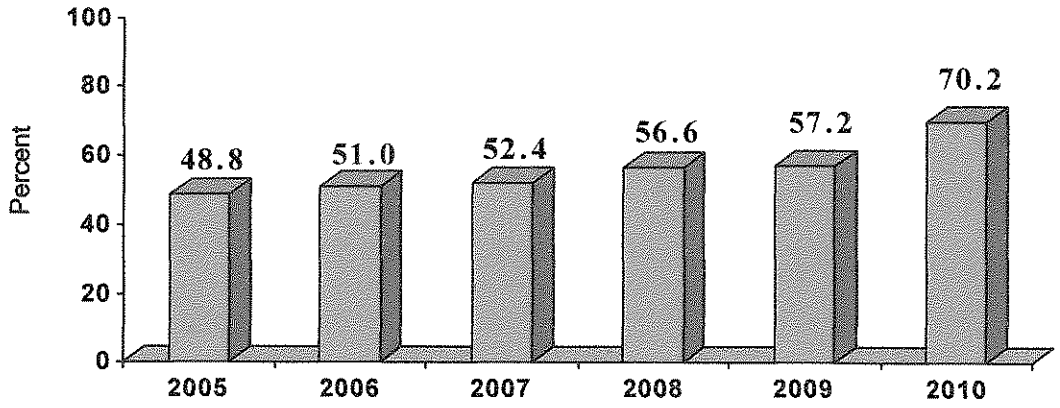
RSVP is a voluntary program within Project SAFE (Substance Abuse Family Evaluation) for parents/ caregivers who have had a child removed by an Order of Temporary Custody (OTC) and need support for recovery from problematic use of alcohol and/or drugs. The program is the result of a joint collaboration between DCF, the Judicial Branch, and DMHAS in three pilot sites: Bridgeport/ Norwalk, New Britain, and Willimantic DCF Area Offices. RSVP helps the parent/caregiver engage in substance abuse treatment, conducts random alcohol/drug screens, supports parents in increasing their recovery capital (e.g. housing, employment), and provides timely documentation to the courts and DCF on the parents' efforts and progress. As of December 2010, RSVP has served 113 families in the three pilot locations.

When parents with substance use problems who are involved with the child welfare system have their children removed from their homes, the children tend to have significantly longer out-of-home placements than parents who do not have substance-related problems. The goal of RSVP is to improve permanency by quickly engaging and retaining parents in substance abuse treatment and support services. Early data from the court indicates more timely permanency plans for children of parents who agree to participate in RSVP.

Project SAFE

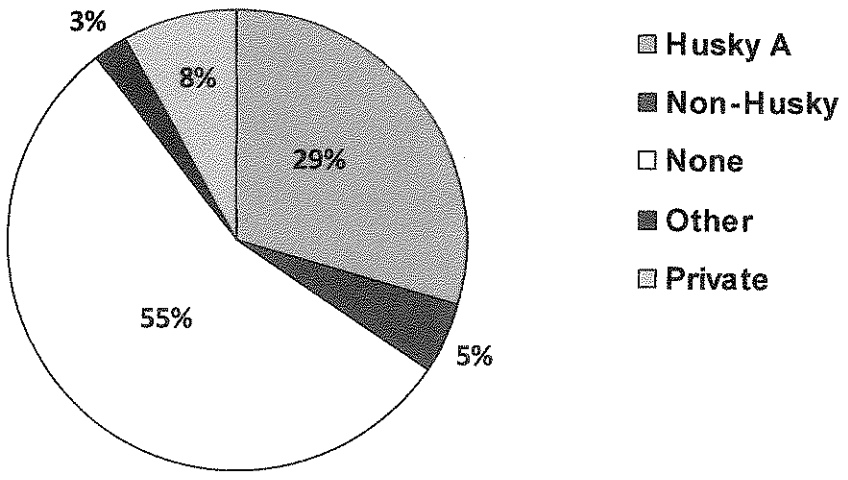
Project SAFE (Substance Abuse Family Evaluation) is an interagency collaboration between DMHAS and DCF that funds evaluations and direct care services for families identified with substance abuse treatment needs. Advanced Behavioral Health, the Administrative Services Organization, manages all referrals to Project SAFE, collects screening information, and manages utilization of treatment services. Over the past several years, DCF has implemented a standardized screening tool, the GAIN Short Screener (GAIN-SS), to improve identification of substance use among caregivers.

Graph 5. Project SAFE Referrals to Treatment Percent Receiving Services: SFY 2005 - 2010



The "show rate" of individuals evaluated and recommended for treatment through Project SAFE rose 18% between 2009 and 2010.

Graph 6. Health Insurance Status at Intake to Project SAFE: SFY 2010



Most Project SAFE clients have no insurance (55%) while the remainder have mostly public entitlement coverage.

IV. Adult Substance Abuse Treatment

Substance Abuse Treatment Information for Adults
Trend Analysis of Admissions for State Fiscal Years (SFY) 2006 - 2010

Most Connecticut substance abuse treatment programs report client information, for persons 18 and older, to DMHAS through its data collection system. Data are electronically submitted to DMHAS monthly and contain information on each admitted or discharged client. The range of client information collected at admission includes: demographics, employment status, education level, type of drug use, frequency of drug use, living arrangements, arrests, and other pertinent data.

All substance abuse treatment programs licensed by the Department of Public Health (DPH) are required, by state statute, to report to DMHAS. Additionally, some non-licensed, state-operated programs report as well, including DMHAS state hospitals and DOC prison-based services. This mandatory reporting system ensures that all publicly supported clients, i.e., those whose treatment is paid out of public entitlement programs such as Medicaid or have no insurance, are included in the department's database. Excluded from the DMHAS information system are those persons who receive services through the Veterans' Administration, general hospitals or private practitioners.

DMHAS routinely checks the data for quality, completeness and internal consistency. On-line reports are available to treatment providers and DMHAS monitoring, evaluation and planning staff. The department is in the process of finalizing "report cards" to evaluate individual service providers as well as overall system performance. Specific trends over the three-year period include:

Client Demographics

- Whites comprised about two-thirds of all admissions while blacks accounted for almost one in five admissions, and Hispanics about one in four.
- Males represented the vast majority of admissions (73%).
- The average age at admission dropped slightly between SFY 2008 and 2010 (36.7 vs. 35.9).
- Rates of admissions grew slightly for those age 25 to 34 and 45 to 64 while those age 25 to 34 dropped over the five-year period. (Graph 7)

Patterns and Trends of Primary Problem Substance

- The percent of primary heroin admissions dropped after years of steady increases giving rise to alcohol to become, once again, the most frequently reported substance at admission. (Graph 8).

- Treatment admissions due to other (prescription) opiates (e.g., OxyContin®, Vicodin®) continued to have the greatest percentage increase continuing a seven-year trend. (Graph 8)

- The average age at admission for those with a primary heroin problem decreased from SFY 2008 to SFY 2010 by 1.7 years (34.8 to 33.1) and by 4.5 years for those reporting other opiates. (Table 4)

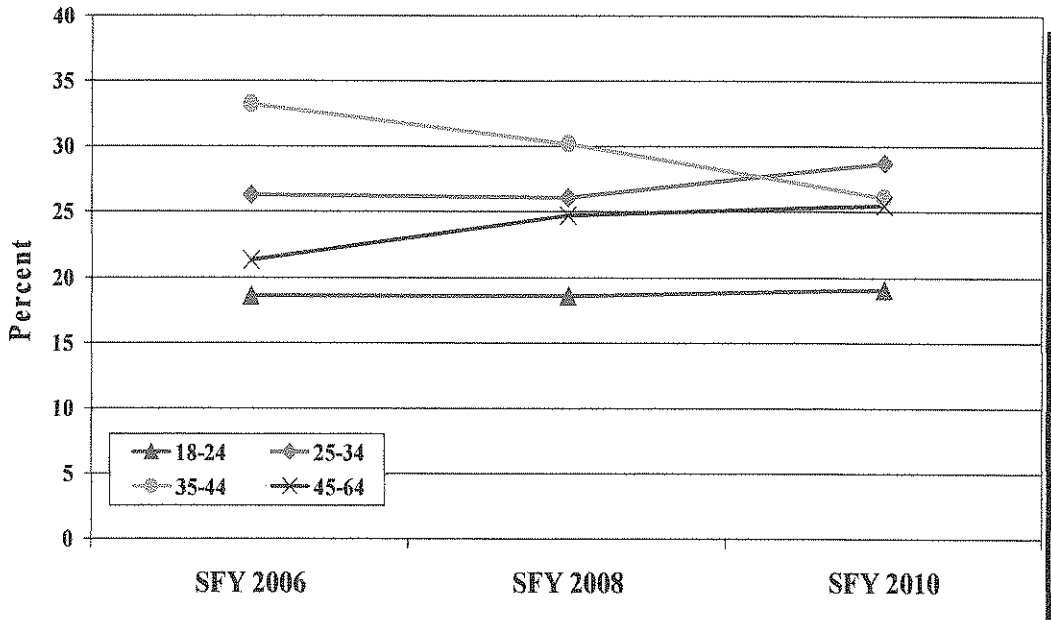
- The pattern of primary substances reported by race or ethnicity remained similar to those in past years. Whites most frequently present for treatment of other opiates and alcohol followed by cocaine and then heroin. Blacks reported primarily marijuana followed by cocaine. Latinos reported marijuana followed by heroin as their primary problem substance. (Table 4)

- Injection drug use in SFY 2010 remained similar to past years with about one out of every five persons admitted to treatment having injected drugs.

- Type of care received by primary problem substance followed past patterns with alcohol admissions using outpatient and detoxification; heroin - detoxification and methadone maintenance; cocaine - outpatient followed by residential care; and marijuana predominately outpatient. Overall, utilization of detoxification services dropped while and outpatient increased, and residential rehabilitation and methadone maintenance remained unchanged. (Table 5).

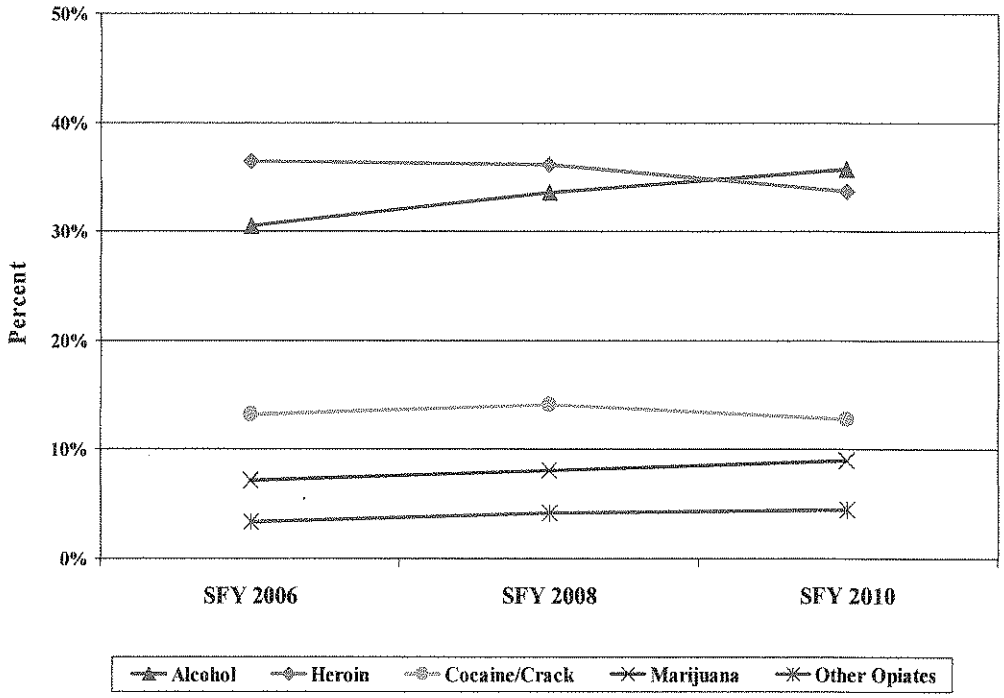
- Variation in age of first use for primary problem substances reported at admission showed little change and only minor differences between males and females. The greatest variance was seen with clients reporting age of first use for other opiates. In SFYs 2006 and 2008, the average age of first use was about 25.5 years old. In SFY 2010, the average age dropped to 23.5.

Graph 7. Admissions to Substance Abuse Treatment at Time of Admission: SFYs 2006 - 2010



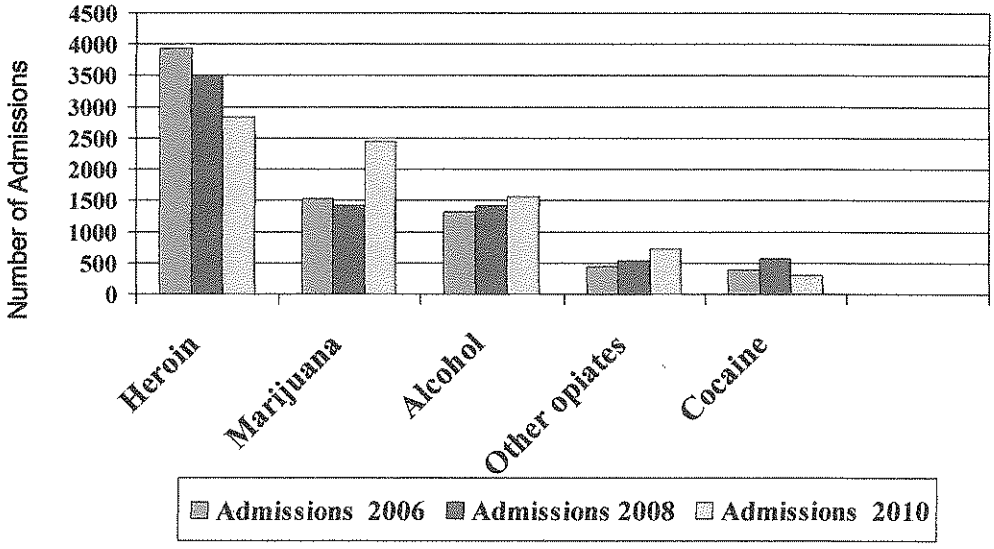
While the average age (35.9) at admission has stayed fairly constant, the percent of admissions by those 25 to 34 and 45 to 64 has increased. Admissions for persons age 35 to 44 experienced a drop over the five year period while young adult admissions (18-24) remained fairly constant.

Graph 8. Primary Problem Substance Reported at Time of Admission: SFYs 2006 - 2010



The percent of clients reporting heroin as their primary drug at admission began to drop in SFY 2006 and by SFY 2009 was replaced by alcohol admissions as the most reported abused substance. Cocaine continued a slow but steady decrease while marijuana had a noticeable increase from SFY 2008 to SFY 2010. Admissions for other opiates (e.g., Vicodin®) continued a steady upward climb.

Graph 9. Admissions of Young Adults (18 - 24) by Primary Drug Reported at Admission: SFY 2006 - SFY 2010



Admissions by young adults between SFYs 2006 and 2010 indicate that the spike in heroin admissions seen in SFY 2006 has declined steadily while marijuana had a rapid rise in SFY 2010. Those presenting for treatment with prescription opiate abuse increased by 60%. Alcohol admissions increased while cocaine admissions had a slight increase in SFY 2008 before dropping back in SFY 2010.

Table 4. Characteristics of Substance Abuse Treatment Clients by Primary Problem Substance at Admission - SFY 2010

	Alcohol	Heroin	Other Opiates	Cocaine	Marijuana
% Female	24.7	27.9	35.1	36.2	20.3
Mean age (years)	42.9	33.1	29.3	39.8	26.3
Race					
% White	71.5	68.1	90.7	50.4	37.9
% Black	17.8	9.7	2.3	33.2	38.7
% Other	10.0	21.4	6.3	15.5	22.2
Ethnicity					
% Hispanic	16.4	25.7	9.9	20.9	32.0
%Non-Hispanic	83.6	74.3	90.1	79.1	68.0

Types of primary substances reported at admission differ by gender, age, race, and ethnicity. Those who enter treatment for marijuana are generally younger and male. The rate of admission for a heroin problem continued to drop for Hispanics from a previous high of 4 out of 10 to 1 out of 4 in SFY 2010. On the other hand, almost all admissions for other opiates, like OxyContin® , continue to be white non-Hispanics. Of note, the median age at admission for heroin and other opiates dropped between SFYs 2008 and 2010 (34.8 to 33.1 and 33.8 to 29.3), respectively.

Table 5. Level of Service by Primary Substance Among Substance Abuse Treatment Admissions - SFY 2010

	Alcohol	Heroin & Other Opiates	Cocaine	Marijuana
% Hospital & Residential Detoxification	29.4	31.6	3.9	0.0
% Residential Rehabilitation	20.9	20.2	33.2	11.6
% Outpatient Services	49.7	14.1	62.8	88.4
% Methadone Services	0.0	30.9	0.0	0.0
% Ambulatory Detoxification	0.0	3.2	0.0	0.0

Treatment varies by type of substance and severity. Persons reporting heroin and other opiates as their primary problem substance mainly use detoxification services followed by methadone. In recent years emphasis has been placed on connecting opiate detox clients to residential and methadone services. This has resulted in a significant decrease in the use of costly detox services. Persons seeking treatment for cocaine addiction continued to use mostly outpatient services followed by residential rehabilitation. The vast majority of those reporting marijuana as their primary problem substance received outpatient services.

V. Substance Abuse Treatment and Caseload Overlaps

The Data Sharing Project, initiated in December 2000, originally drew upon data from seven state agencies and the Judicial Branch. The project had been highly successful in generating statistical information including trends over the years regarding shared caseloads. Analyses conducted using a statistical model called Probabilistic Population Estimation or PPE was instrumental in measuring the "population or caseload overlap" of Connecticut's substance abuse treatment system with criminal justice, and health and human service systems. Over that 10-year period, a series of reports were produced which included an unduplicated count of persons in each state agency population, the percent and number of overlap (i.e., those receiving treatment who were also arrested, incarcerated, on probation, receiving welfare benefits, involved in child protective services, etc.) and demographics such as age, race and gender.

While PPE was useful in examining general rates of treatment access, it was very limited in its capacity to provide insight as to the sequencing of treatment services (e.g., before or after incarceration) or client outcomes. For this reason it was decided to move to linking individual records directly across systems. As DMHAS and the state's criminal justice agencies had established consistent and valid methods for linking large administrative databases, this seemed a logical starting point. At the June 2010 meeting of the Criminal Justice Policy Advisory Commission, a recommendation was offered that would allow for the routine linking of behavioral health and criminal justice data. Essentially, the concept was to match individual records across separate databases using person identifiers such as first/last name, Social Security number, date of birth and gender. Once linked, all person identifiers would be removed although a random identifier for each person would be assigned so that analyses could be conducted at the person level. This random unique identifier would not be tied to any person identifiers and therefore would pose no risk for redisclosure. This linking method has been exhaustively scrutinized by a number of state agency review boards and academic human subject committees, and has been validated as complying with state and federal confidentiality laws and regulations.

During SFY 2011, DMHAS and the criminal justice partners (DOC, DPS and JB-CSSD) formed a steering committee responsible for the following components of the data linking project:

- Determining the scope of data sharing (i.e., which data elements to be included, frequency of updates, etc.).
- Overseeing the creation of data dictionaries and other essential documentation.
- Recommending a linking method that meets state and federal confidentiality laws and regulations.
- Suggesting standard reports and developing criteria for ad hoc or special reports.
- Assisting in the interpretation of findings.
- Developing and facilitating the execution of confidentiality agreements and approvals across all participating parties.

It is anticipated that data documentation and the Memorandum of Understanding regarding governance, publication and other pertinent matters will be completed by late summer 2011. At that time, five years of criminal justice (arrests, incarceration and probationer) and behavioral health data will be linked for the purpose of services research, evaluation and outcomes analysis.

VI. Data Linkage Study

Nonmedical Use of Narcotic Prescriptions and Its Affect on Connecticut's Substance Abuse Treatment System

Today, Connecticut's rate of non-medical use of pain relievers is estimated to be 3.8% of the adult population, according to the most recent National Survey on Drug Use and Health findings. For young adults (18-25), the rate continues to be about two and a half times the general adult population at 10.5%. There is evidence that many persons who become addicted to prescription pain relievers move to heroin as a cheaper and more readily available alternative. An analysis conducted by the Department of Mental Health and Addiction Services (DMHAS) for the 2006 Biennial Report highlighted this trend. Treatment admission data for SFY 2003 through SFY 2006 indicted that the number of young adults (18-24) entering treatment for a primary heroin and other opiate (e.g., Vicodin® , Oxycontin) addiction grew significantly. In fact, heroin admissions increased by 18% over the four-year period for young adults.

More recent analyses (see Graph 9) of DMHAS substance abuse treatment data indicate that the rate of primary heroin admissions is declining. On the other hand, persons entering treatment reporting a primary substance problem for "other synthetic opiates" (e.g., Vicodin®) continues to rise. Over the past decade, treatment options for opiate dependent persons have expanded particularly with the introduction of buprenorphine (e.g., Subutex, Suboxone). Use of buprenorphine for both detoxification and long-term replacement therapy has been proven to be effective and DMHAS has encouraged the expansion of this treatment approach for opiate dependent persons.

For the purpose of this study, data from the Department of Consumer Protection's (DCP) Connecticut Prescription Monitoring Program (CPMP), a central database containing prescription drug data for Schedule II-V controlled medications, was linked to DMHAS substance abuse treatment service records. Two years of prescription records (SFYs 2009 and 2010) and three years (SFYs 2008, 2009 and 2010) of DMHAS substance abuse treatment were included. Additionally data sets for SFYs 2008-2010 included:

- Department of Correction (DOC) inmate files,
- Department of Public Safety arrest records,
- Judicial Branch-Court Support Services Division adult probation data, and
- Department of Public Health death records.

Study objectives included:

- Understanding the scope of nonmedical use of opiate prescription drugs;
- Assessing the association between abuse of narcotic prescription drugs and initiation of heroin for those individuals seeking treatment;
- Determining whether there has been a change in Medication Assisted Therapies (e.g., methadone maintenance and/or buprenorphine) in response to opiate abuse; and
- Analyzing outcomes such as successful treatment completion, criminal justice involvement (i.e., arrest or incarceration) or death.

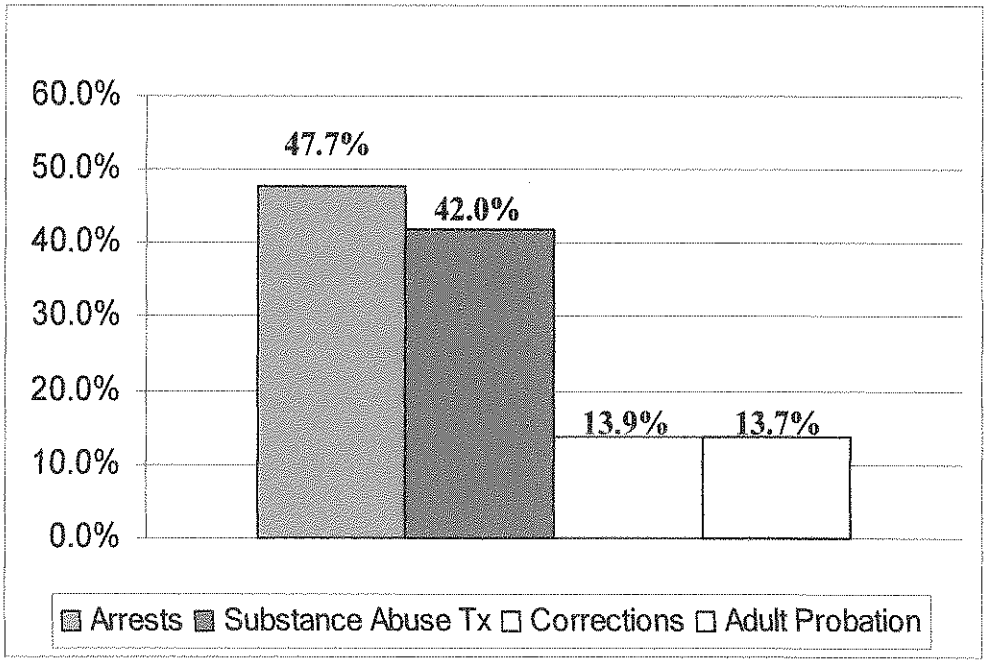
Access to Alternative Treatment for Opiate Addiction

National data, such as the Drug Abuse Warning Network or DAWN which captures emergency department (ED) visits, show that the nonmedical use of narcotic pain relievers to be a growing problem. In a June 2010 DAWN report, trends ED visits for 2004 to 2008 found the two most frequently mentioned prescription pain relievers to be oxycodone and hydrocodone. The rate of reported ED visits for these two narcotic pain relievers grew by 152% and 123%, respectively.

DMHAS has supported expanded access to buprenorphine as a way of addressing opiate dependence, whether from heroin or nonmedical use of prescription pain relievers. This has been especially important for increasing the likelihood of young adults to seek treatment. The CPMP linkage study affords an opportunity to examine how physician-based buprenorphine treatment has assisted in expanding access. There were limitations in the CPMP data set as there were fewer person identifiers upon which to link records. This in turn lowered the possible number of valid matches and as such the following analyses are more than likely an underreporting.

Graph 10 shows the overlap of young adults prescribed buprenorphine and their rate of involvement with the criminal justice system or treatment. Compared with all young adults treated for substance abuse in licensed facilities, those receiving buprenorphine were less likely to have been arrested (48% vs. 72%), on probation (14% vs. 40%) or incarcerated (14% vs. 42%).

Graph 10. Young Adults (18-24) Prescribed Buprenorphine Rate of Involved with the Criminal Justice System or Receiving Substance Abuse Treatment SFYs 2009 - 2010



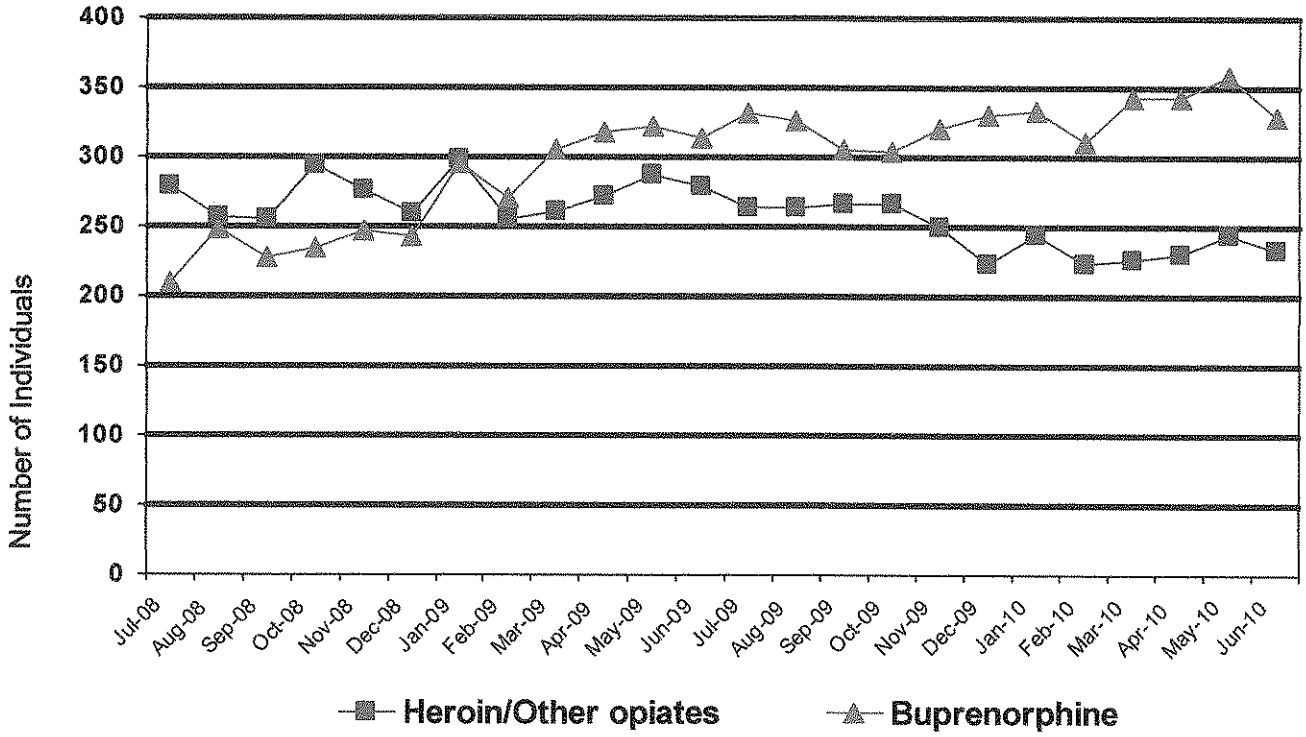
Many (44%) young adults, age 18-24 at the time of filling a prescription for buprenorphine, had a history of arrest. Close to fourteen percent had been incarcerated and/or were or had been on adult probation. Over 42% had received some form of substance abuse treatment in the past year or two.

Access to Alternative Treatment for Opiate Addiction

One of the aims of the prescription drug linkage study was to determine whether there has been a change in response to treating individuals with an opiate dependence. Graph 11 displays, by month, the rate of young adults prescribed buprenorphine (i.e., Suboxone or Subutex) compared to the rate of admission of young adults reporting a primary heroin or other opiate substance problem at time of admission to a licensed or state operated treatment facility. As can be seen from the graph, the number individuals admitted to all treatment facilities with a primary opiate addiction has declined slightly over the 24-month period while the rate of those prescribed buprenorphine has continued to increase.

This appears to be a promising sign that access to an alternative treatment approach (i.e., buprenorphine) to opiate addiction is growing in recognition and access.

Graph 11. Young Adults (18-24) Prescribed Buprenorphine[1] vs. Heroin and Other Opiate Admissions by Monthly Volume: SFY 2009 and 2010



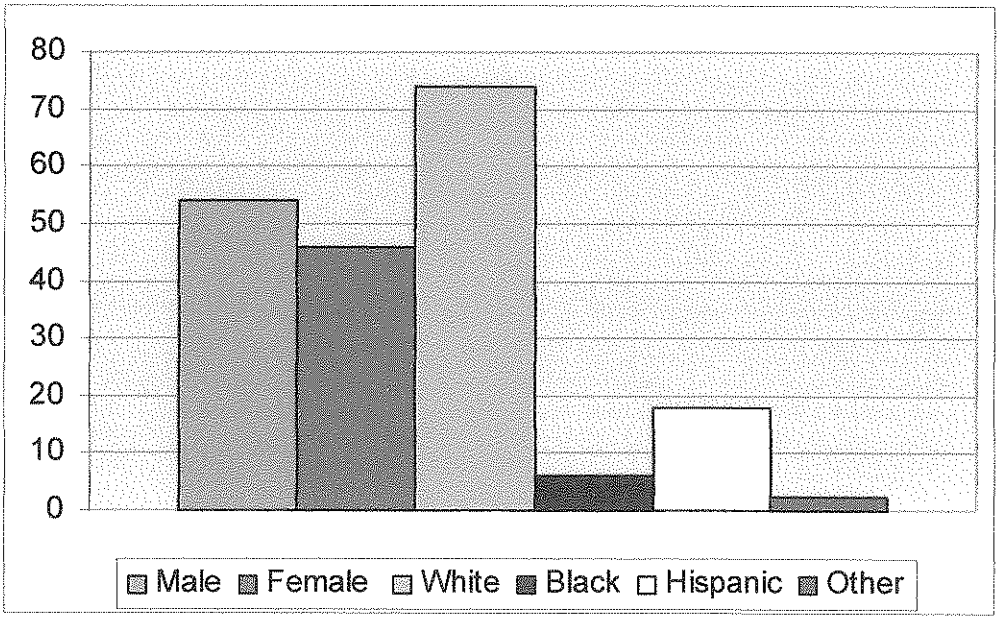
[1] The monthly number of persons prescribed buprenorphine adjusted based upon the one year prevalence rate (NSDUH) of persons age 18-24 estimated to be using narcotic pain relievers for nonmedical purposes.

Another objective of the prescription drug linkage study was to assess the association between the abuse of narcotic prescription drugs and initiation of heroin for those individual seeking treatment. There has been much anecdotal evidence that individuals who become addicted to narcotic pain relievers often seek out heroin as an inexpensive and readily available substitute.

As part of that analysis, it had been of interest to identify those cases in which there was questionable activity such as "doctor shopping" or abuse of prescription pain relievers. This type of analysis proved difficult as identifying multiple prescribers or pharmacies, overlapping prescriptions or increased dosage can produce "false positives". DMHAS and DCP will continue to explore other methods to identify those cases in the linked data set which might be recognized as nonmedical users of prescription drugs.

In an attempt to begun to understand the scope on this phenomenon, persons treated for an opiate addiction (either heroin or other opiate) in a state operated or licensed addictions treatment program in SFY 2010 and having been prescribed a narcotic pain reliever were analyzed. Of all (11,670) persons admitted to treatment in SFY 2010 who reported a primary opiate problem, 47.7% (5,565) had a history of narcotic prescription use prior to admission. About 35% (1,934) of the 5,565 might be identified as having questionable use of narcotic pain relievers. This is based upon criteria used in a 2009 study of Massachusetts' prescription drug monitoring system (Pharmacoepidemiology and Drug Safety: 2010: 19: 115-123) . In that study, a cut-point for identifying individuals having questionable nonmedical use of narcotic pain relievers was - having 4 or more prescribers and 4 or more pharmacies. Graph 12 shows the distribution by gender, race and ethnicity of those thought to have been engaged in questionable use of prescription pain relievers and admitted to treatment.

Graph 12. SFY 2010 Treatment Admissions Reporting Heroin Or Other Opiates as a Primary Substance Who Had a History of Prescribed Narcotic Pain Relievers and Identified as Having Questionable Nonmedical Use



Of those admitted to treatment for opiate abuse or dependence and having a "questionable" history of narcotic pain reliever use, there was little difference in gender. Regarding race and ethnicity most were white, with Hispanics the next highest.

VII. Prevention Data

Over the past two years, the DMHAS Prevention and Health Unit, in collaboration with other state agencies, has leveraged federal funding to enhance its capacity for obtaining, using, and disseminating interagency data. Since 2005, through funding from the federal Center for Substance Abuse Prevention (CSAP), DMHAS has supported the efforts of the State Epidemiological Outcomes Workgroup (SEOW) to promote the use of substance abuse prevention and mental health promotion data to select effective programs and strategies. The SEOW provides a framework to expand interagency collaboration, promote sharing of state agency expertise to access, interpret, and use data, and explore opportunities to collaborate on issues of common concern.

In SFY 2010, the SEOW began the process of replacing its web-based data repository with a state-of-the-art, interactive site which will enable any registered user to access substance abuse prevention and mental health promotion indicators, analyze the data, and produce high-quality visualizations (maps, graphs, etc.). These reports may be used to construct community profiles, assess service needs, prepare funding applications, and measure the impact and effectiveness of programs. The new site is expected to be up and running by summer 2011.

Partnerships for Success Initiative

In September 2009, DMHAS was awarded a Partnerships For Success grant from CSAP. The goal of this grant program is to achieve a quantifiable decline in statewide substance abuse rates, incorporating an incentive award to grantees that have reached or exceeded their prevention performance targets. The statewide prevention priority to be addressed is underage drinking. The performance target approved by CSAP was a reduction in the incidence of past month drinking among 12 to 20 years olds as measured by the 2006-2007 National Survey on Drug Use and Health, from 19.6% to 14.9% - a 4.7 percentage point reduction from the baseline rate.

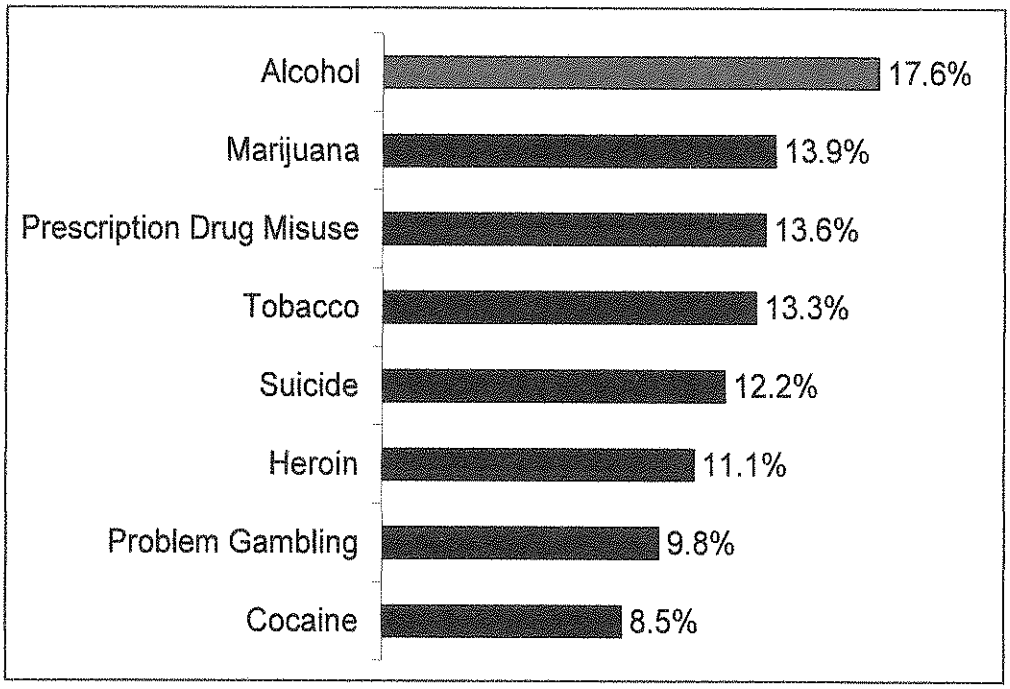
State Epidemiologic Profile

Since 2006, the SEOW has been tracking epidemiological data on six substances (alcohol, tobacco, marijuana, heroin, prescription drugs, and cocaine). SEOW data were used to update profiles for each substance, as well as suicide and problem gambling. These profiles can be found at: http://www.ct.gov/dmhas/lib/dmhas/prevention/ctspf/SEWprofiles09.pdf

Trends in Alcohol and Other Drug Use in Connecticut

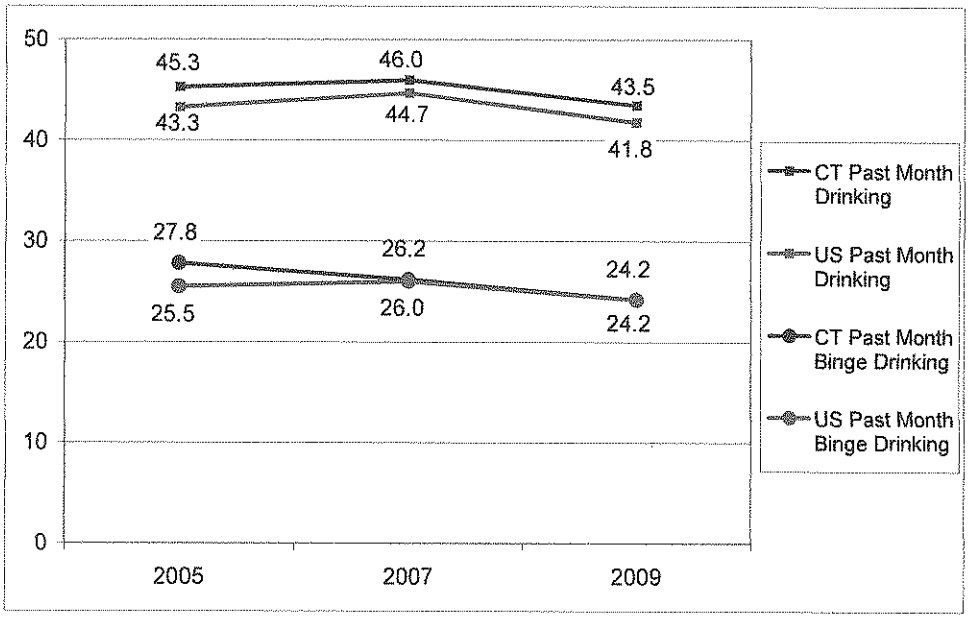
In 2010, Regional Action Councils reconvened subregional Community Needs Assessment Workgroups, for a third time since 2006, to assist in development of community profiles with regard to alcohol and other substances. The Community Workgroups were charged with examining the use and consequences of alcohol, tobacco, marijuana, nonmedical use of prescription drugs, heroin, and cocaine in their geographic areas. After analyzing the data, each substance was scored on a scale of one to five (low to high) for magnitude (burden/breadth of problem); impact (depth of problem across dimensions); and changeability (amenable to change through evidence-based strategies). Also suicide and problem gambling data were incorporated for the first time in SFY 2010. Overall, alcohol use especially underage drinking was ranked as the highest priority Nonmedical use of prescription drugs rose to be ranked third in SFY 2010. (Graph 13).

Graph 13. 2010 Community Needs Assessment Workgroups Priority Problem Ranking



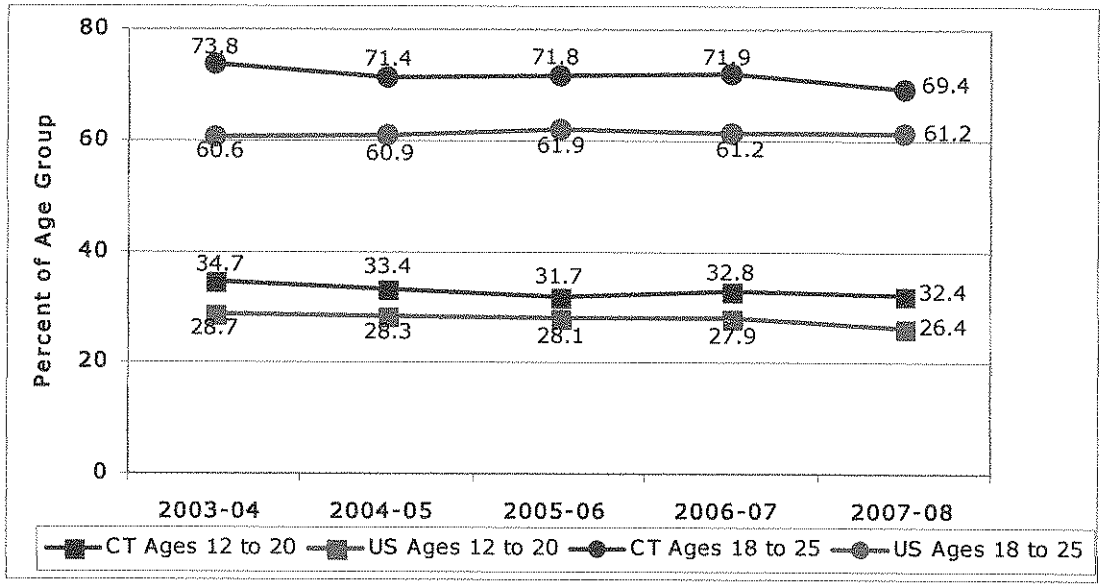
In the 2010 community assessment of alcohol and other drugs, alcohol and marijuana continued to be in the top ranking for use and consequences. Of particular notice is the ranking of prescription drug misuse in the top three substances. As was noted in earlier in this report, nonmedical use of prescription drugs is a growing concern requiring coordinated efforts at public awareness, prevention and treatment.

Graph 14. Trends in Past 30 Day Alcohol Use and Binge Drinking High School Students Connecticut vs. US



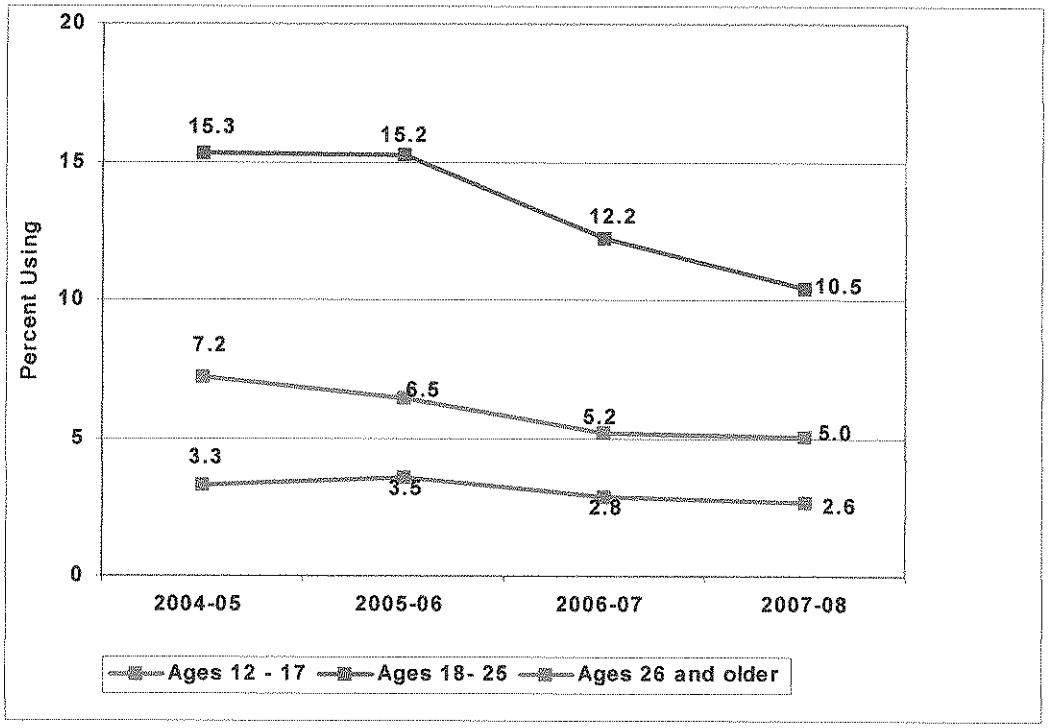
Findings from the Connecticut School Health Surveys show a decline in past month alcohol use and binge drinking among high school students. Although Connecticut's prevalence of binge drinking was above the national average in 2005, it declined in 2007 and now (2009) equals the national average.

Graph 15. Past 30 Day Alcohol Use Among Age Groups Connecticut vs. US: NSDUH 2003-2008



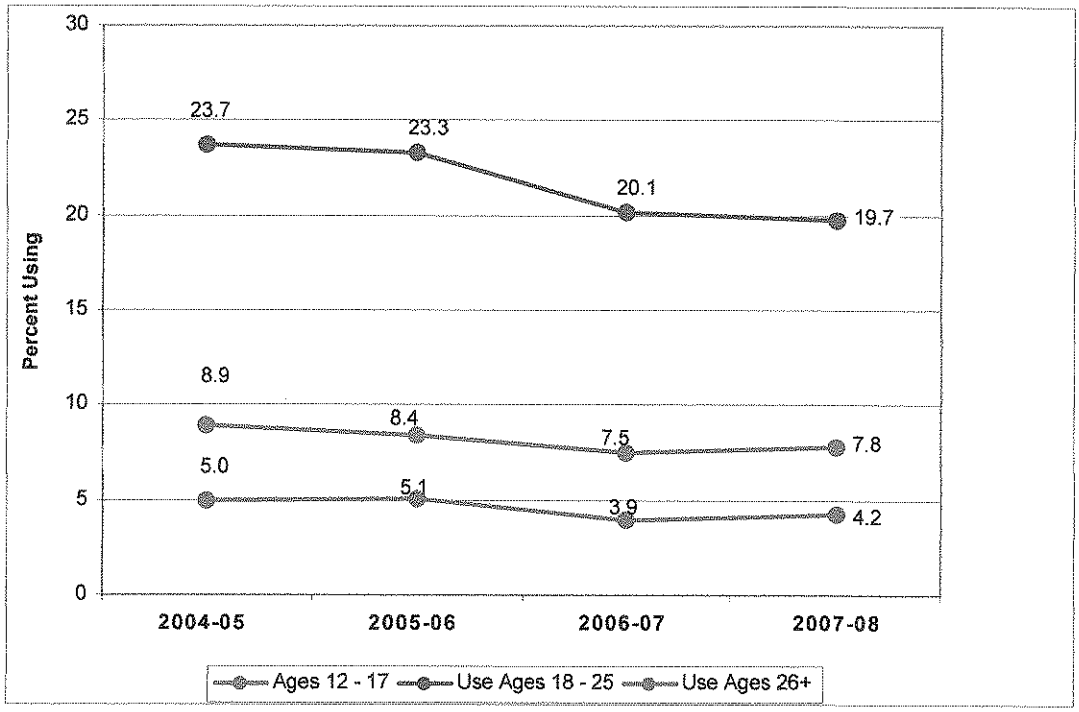
From 2003 to 2008, past month alcohol use in Connecticut has declined. This is especially true among 18 to 25 year olds. Under-age (12-20) drinking declined, but only slightly, indicating that efforts are still needed to delay early use.

Graph 16. Past Year Non-Medical Use of Pain Relievers Among Age Groups - Connecticut vs. US: NSDUH 2004 - 2008



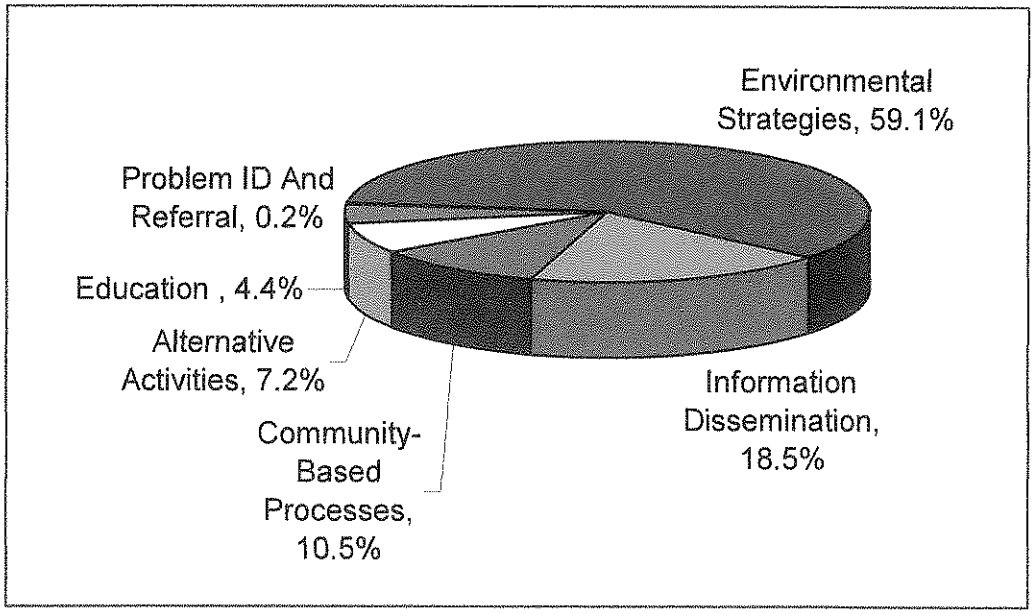
From 2004 to 2008, past year nonmedical use of narcotic pain relievers has decreased for all age groups. Most striking is the decline in use by young adults (18-25 years old) experiencing a 31% drop in the four year period. This is promising as nonmedical use of narcotic pain relievers has sometimes been associated with subsequent use of heroin.

Graph 17. Past 30-Day Use of Marijuana Among Age Groups - Connecticut vs. US NSDUH 2004 - 2008



Current (past 30 days) use of marijuana has declined since 2004/2005 but the decrease has varied by age group. Certainly the most impressive drop has been with young adults (18-25) having a 17% reduction. While those 26 and older showed a general decline, the rate in 2007/2008 has begun to reverse and is on the rise.

Graph 18. Programs and Strategies DMHAS Funded Prevention Programs SFYs 2008 - 2010



Reflecting a shift in federal priorities toward changing the community environment, DMHAS refocused its prevention services to information dissemination (public education/media campaigns) and environmental strategies (alcohol compliance checks, sobriety checkpoints, and enforcement of the social host liability law).

Community Readiness Assessment

For the third time in four years, a key informant survey was administered to a broad range of community key informants, including youth 18 or under, parents, business community, media, school, youth-serving organization, law enforcement agencies, religious or fraternal organizations, civic and volunteer groups, healthcare professionals, State, local, or tribal governmental agencies with expertise in the field of substance abuse (if applicable, the State authority with primary authority for substance abuse), and other organizations involved in substance abuse prevention and mental health promotion. Beyond identifying the drug that most concerned them, which across all age groups was alcohol, they provided their perspective on the importance of data in planning, budgeting, resource development and other critical functions.

Survey results indicated that key informants believed that data relevant for substance abuse prevention were most likely to be used for strategic planning and evaluation purposes. There was an overall spike in uses of data from 2006 to 2008 when community grantees had just completed their needs assessments and were implementing their strategic plans.

Overall, there were fewer barriers to data collection reported from 2006 to 2010 (Table 6). The greatest reductions in barriers to data collection were the following: community not seeing the need for data, people to collect data, and funds for a community needs assessment. Although not asked in 2006, uncertainty about what data to collect, lack of cooperation among stakeholders, and concerns about negative publicity were less likely to be reported between 2010 than in 2008.

Table 6. Barriers to Data Collection in the Community DMHAS Community Readiness Assessment 2006, 2008, and 2010

Barrier to Data Collection	2006 (%)	2008 (%)	2010 (%)
Community does not see need to collect data	29	26	21
Lack of understanding of how to collect data	17	26	18
Lack of understanding of how to use data	19	30	24
Lack of trained volunteers/personnel to facilitate data collection	41	39	31
Lack of trained volunteers/personnel to interpret data	31	34	30
Lack of community leadership support to collect data	29	34	25
Unable to gain permission to collect data from students, local government personnel	23	30	23
Lack of funds to facilitate a comprehensive community needs assessment process	58	57	48
Uncertainty about which data to collect	N/A	29	19
Lack of cooperation among stakeholders	N/A	24	19
Concerns about negative publicity	N/A	43	36

VIII. Statewide Cost Analysis

Information regarding the funding, directly or indirectly, of substance abuse services was gathered from ten state agencies and the Judicial Branch, the Office of Policy Management (OPM) and the Board of Pardons and Paroles. Expenditures reported include all funding sources - state, federal, or other. Clearly, the most easily defined service is substance abuse treatment. Treatment dollars, for the most part, are readily identified and reported. Less clearly defined are intervention activities, as the range of services in this category often overlap into prevention services. Therefore, intervention funds are included within prevention expenditures. While CGS Section 17a-451(o) speaks about prevention and education services separately, for purposes of expenditure reporting, these two activities have been combined, as education is one segment of the prevention continuum. The category "deterrence", also a component of prevention services, was added in the *2001 Annual Report* but is reported separately as law enforcement activities. A summary of statewide service expenditures by state fiscal years is shown in Table 7, while substance abuse service expenditures by agency for SFY 2009 are included in Table 8.

Overall funding for substance abuse services has experienced a steady growth from SFY 1999 to SFY 2007 but saw a 1.2% decrease (not adjusted for inflation) from SFY 2007 to 2009. Some of the growth over the decade, especially in SFYs 1999 to 2002, reflects improved expenditure reporting, for instance the inclusion of Medicaid expenditures. Also, improvements in reporting methodologies has made trend analysis of expenditures difficult. Looking at SFY 2009 expenditure categories, the greatest reduction (40.9%) from SFY 2007 was seen in prevention services. The major contributor to this reduction was a $13.6 million dollar loss in State Department of Education discretionary federal grants. Treatment expenditures saw a slight increase (6.7%) due primarily to DSS Medicaid expenditures while deterrence dropped by 18.7% in SFY 2009 when compared to SFY 2007.

Table 7. Substance Abuse Service Expenditures By State Fiscal Years (Dollars in Millions)

Services	Prevention*	Deterrence	Treatment	Total
SFY 1999**	$53.70	NA	$136.80	$190.50
SFY 2000***	$54.80	$6.80	$152.40	$214.00
SFY 2001	$55.90	$8.50	$153.20	$217.60
SFY 2002****	$53.60	$7.60	$175.00	$236.20
SFY 2003	$47.25	$8.93	$182.94	$239.12
SFY 2005	$59.21	$5.76	$202.04	$267.01
SFY 2007	$43.05	$7.49	$233.12	$283.66
SFY 2009	$25.45	6.09	$248.69	$280.23

* Includes substance abuse education, prevention, and intervention expenditures.
** Expenditures for SFY 1999 updated to include Board of Pardons and Paroles and Department of Veteran Affairs, but missing Department of Public Health.
*** Expenditures for SFY 2000 updated to include Department of Veteran Affairs' treatment expenditures.
**** Department of Social Services treatment expenditures, omitted in previous SFYs, reported for SFY 2002 forward.

Table 8. Substance Abuse Service Expenditures By Agency State - Fiscal Year 2009

Agency	Prevention	Deterrence	Treatment	Total
DMHAS[1]	$11,657,735	$0	$155,717,125	$167,374,860
JUDICIAL-CSSD[2]	$6,515,788	$0	$9,006,298	$15,522,086
DCF[3]	$1,587,518	$0	$19,068,456	$20,655,974
DMV[4]	$0	$0	$0	$0
DOC[5]	$0	$0	$13,363,604	$13,363,604
DOT[6]	$1,281,195	$2,602,950	$0	$3,884,145
DPH[7]	$1,589,305	$0	$0	$1,589,305
DPS	$80,932	$3,484,107	$0	$3,565,039
DSS[8]	$0	$0	$51,135,498	$51,135,498
DVA	$0	$0	$396,337	$396,337
OPM[9]	$419,260	$0	$0	$419,260
PAROLE[10]	$0	$0	$0	$0
SDE[11]	$2,322,177	$0	$0	$2,322,177
TOTAL	$25,453,910	$6,087,057	$248,687,318	$280,228,285

[1]Note that expenditures do not include administration dollars.
[2]Expenditures for SFY 2007 and later reflect improved reporting and includes only those services that are directly related to substance abuse prevention and treatment. Since 2005 accounting and data collection has improved and CSSD is now able to identify expenditures devoted to either treatment or prevention.
[3]Decreases in expenditures for SFY 2009 are due to a shift in funding priorities from residential to evidenced based and promising practices of In-home Family treatment.
[4]Clients pay directly for retraining, education and required substance abuse treatment programs.
[5]Department of Correction expenditures include Parole and Community Services outpatient and residential drug treatment expenditures.
[6]All figures are based upon a Federal Fiscal Year (i.e., October 1 through September 30). Prevention costs from the Transportation Safety Section include staff salaries, public information and education initiatives and media. Deterrence costs reflect law enforcement initiatives.
[7]SFY 2009 expenditures reflect adjustments in existing and new programs involved in tobacco cessation.
[8]Increase in SFY 2009 expenditures were due to enhanced Medicaid fee and caseload growth. Expenditures include claims paid for Inpatient and Outpatient substance abuse treatment. Excludes pharmacy, transportation and crossover claims.
[9]SFY 2009 expenditures are lower than in past reporting as several programs previously included no longer address substance abuse.
[10]Treatment expenditures include services provided to offenders in Parole and Community Services, see DOC expenditures.
[11]Decrease in FY 2009 expenditures due to the loss of federal competitive grant funding.

IX. Update on DMHAS Three-Year Strategic Substance Abuse Treatment Plan

Background

On June 29, 2009 the Connecticut state legislature passed, and the governor signed, Public Act 09-149 which required DMHAS, to address in its three-year strategic substance abuse treatment plan, a number of specific elements for consideration, such as data management, continuum of care and use of evidence based practices. This was offered as part of observations and recommendations provided by the Program Review and Investigation Committee's report entitled *State Substance Abuse Treatment for Adults* published in December 2008.

The DMHAS strategic report was issued in September 2010 based upon focus groups held with key stakeholders, consultation with advisory bodies such as the Alcohol and Drug Policy Council and the Criminal Justice Policy Advisory Commission, and the department's biennial priority setting process. Below is an update on the status of strategies and activities as developed in the DMHAS three-year substance abuse treatment plan.

Strategy #1

Assure the availability of adequate residential and case management supports to eligible individuals in the network of Supported Recovery Housing Services.

Supported Recovery Housing Services provide safe, sober housing and case management to support residents in securing treatment and other community based recovery supports. There are currently 11 providers in 21 locations providing 158 beds with supports. This includes a recent acquisition in March 2010 of two new providers and 18 additional beds. DMHAS is currently assessing gaps in need for a potential re-procurement, pending resource availability.

Strategy #2

Analyze the impact, opportunities, and potential challenges of the Patient Protection and Affordable Care Act (i.e., health reform).

DMHAS, in partnership with Department of Social Services (DSS), converted the State Administered General Assistance program to the Medicaid Low Income Adult population, taking advantage of provisions within the health reform act that afford broader coverage. An Alternative Benefit Package, an option under the act, is being explored to both assure quality and manage costs.

The DMHAS Commissioner was an active participant on the Health Reform Cabinet chaired by the Department of Public Health's Deputy Commissioner.

Health reform is a standing agenda item in the Commissioner's Executive Group where a number of demonstration projects were considered. As a result, a workgroup which includes Department of Social Services staff is exploring the advantages of the Medicaid state plan option - 1915(i) Home and Community Based Services - that was significantly modified under the Affordable Care Act.

Strategy #3

Examine the ability to expand provision of case management, life coaching, employment, education, community affiliation and wellness supports, including the provision of these services by peer providers (continuum of care), by capitalizing on opportunities created by federal reforms to address desires of the recovery community and service providers.

These services are available throughout the state funded by the federal Center on Substance Abuse Treatment grant program known as, Access to Recovery III. The ability to expand provision of these services will be addressed by the Commissioner's Executive Group described

in Strategy #2. Shifting resources in support of these efforts may be a consideration as greater numbers of the population obtain coverage for clinical services through the Patient Protection and Affordable Care Act.

Strategy #4

Promote the provision of comprehensive assessments.

DMHAS is in the process of completing the Assessment Guidance document and will complete that by July 2011, as scheduled. The plan is to disseminate this document to state-operated and DMHAS-funded agencies via their CEOs and to the various Learning Communities DMHAS regularly convenes; these learning communities or collaboratives include program managers and directors. Agencies will be asked to review their biopsychosocial assessment documents and compare them to the DMHAS Assessment Guidance document. Changes to assessment forms may be needed so that they are more consistent with DMHAS' assessment expectations.

Strategy #5

Promote the adoption of evidence based and best practices and models

DMHAS recently created an Evidence-Based and Best Practices Governance Committee, chaired by the DMHAS Commissioner. This committee met for the first time in January 2011 and continues to meet on a quarterly basis. The Governance Group consists of 17 members in addition to the Commissioner and includes other executive staff and Office of the Commissioner Division Directors. Over the past year DMHAS also designated a new position in the Office of the Commissioner's Community Services Division: Manager of Evidence-Based and Best Practices Implementation. This manager provides staff support to the Governance Group as described above along with other functions that promote the adoption of evidence based practices. A behavioral health specialist has been reassigned to work for this manager, further enhancing the infrastructure necessary to complete the multiple and varied goals involving evidence-based and best practices in the DMHAS system.

The first product from the Governance Committee is the DMHAS Catalog of Evidence-Based & Best Practices. This catalog includes twenty practices that are currently being implemented in various ways through the DMHAS system of care, across six Divisions. The catalog describes each practice, the number of programs involved, the implementation process being used, training and technical assistance currently available, a summary of fidelity measurement being used, and a summary of how client outcomes are being measured. A version of this catalog will be disseminated to providers in 2011. A project plan for next steps to more fully implement several of these practices is being developed with completion anticipated by June 30, 2011.

Strategy #6

Improve access to treatment for young adults, criminal justice populations, and other adults

6.1 Young Adults

DMHAS is exploring expansion of buprenorphine (i.e., Suboxone or Subutex) services through its recently awarded federal grant - Access to Recovery (ATR) III. The goals of the federal grant include: 1) facilitating individual choice and promoting multiple pathways to recovery; 2) expanding access to a comprehensive array of clinical substance use treatment and recovery support services; and (3) ensuring each client receives an assessment for the appropriate level of services. All services are designed to assist recipients remain engaged in their recovery while promoting independence, employment, self-sufficiency, and stability.

When fully operational, ATR III will support the administration or prescription of buprenorphine for persons having an opioid

addiction. Clinical supports will include an assessment of needs, recovery planning, individual and group therapy, and relapse prevention strategies.

Suboxone has been suggested as an alternative to methadone for individuals uncomfortable with or unable to attend a licensed Chemical Maintenance Treatment Facility (i.e., a methadone clinic) for daily dispensing and receipt of the methadone. In order to allow for great access to Suboxone, DMHAS collaborated with the Department of Public Health (DPH) to enact changes in Connecticut's licensing regulations. Currently, DPH regulations prohibit dispensing of Suboxone in substance abuse outpatient clinics not licensed as Chemical Maintenance Treatment Facilities. DPH has submitted a bill which would allow for the prescribing of Suboxone in licensed substance abuse outpatient clinics (other than Chemical Maintenance Treatment Facilities) while final licensing regulations are codified. This change would greatly increase access to Suboxone providing an alternative treatment option to methadone. Individuals having an opiate dependence, whether to heroin or narcotic painkillers, would be able to receive treatment within their own communities. This is especially true of young adults who are struggling with a short-term addiction to heroin or painkillers who would be able to access care through an outpatient program instead of a methadone clinic.

6.2 Criminal Justice Populations

By July 1, 2011, a preliminary pilot implementation report will be drafted that will: 1) determine the scope of the pilot; 2) roles of each party in the pilot program; 3) costs associated with the pilot; and a recommendation as to the number and location of pilot sites situated in Geographical Area Courts.

The first Proposed Outcome for Goal 6.2 indicates that "DMHAS, CSSD, and the Office of the Public Defender will meet to discuss the possibility of developing a pilot program modeled after DMHAS' Jail Diversion Program" for "unsentenced inmates who have an unplanned release from custody by the courts." Such a pilot program would include an increase in services and service capacity, requiring additional resources. Due to uncertainty of the State Fiscal Year 2012 state budget, DMHAS is delaying plan development for this pilot until available resources are determined. Until then, existing collaborations to address Goal 6.2 will continue as follows:

- The DMHAS Jail Diversion program, in collaboration with CSSD and the Office of the Public Defender, is present in every arraignment court and currently serves a significant number of individuals with substance use disorders.
- A significant portion of individuals currently served by DMHAS have open cases in criminal court.
- As described in the 2011 Criminal Justice Policy Advisory Commission (CJPAC) Reentry and Risk Assessment Strategy, DMHAS and CSSD will continue to operate programs that connect unsentenced inmates to community treatment upon planned release from custody by the court.

Criminal Justice and Behavioral Health Data Linkage Initiative

At the June 6, 2010 meeting of the CJPAC, members endorsed a proposal to link individual records across the criminal justice (arrests, incarcerations, adult probation and parole) and behavioral health populations. In December 2011 a Steering Committee with representation from the Judicial Branch (CSSD), Department of Correction, Department of Public Safety, Department of Mental Health and Addiction Services, Board of Pardons and Paroles, and Office of Policy

and Management was formed. The University of Connecticut Health Center's Correctional Managed Health Care division was later added.

The current plan is for each party to contribute five years of data (e.g., SFY 2006 - SFY 2010) which will be linked and de-identified. Currently, work continues on drafting a Memorandum of Understanding that will include the data sharing protocol, confidentiality and governance, and documentation of data sets (e.g. data dictionaries). Intensive work is underway on data documentation and conventions (e.g., race/ethnicity values). It is anticipated that all work will be concluded by summer 2011 at which time the data linkage will be completed.

6.3 Treatment Availability for Public Information

Upon further review of the Connecticut Clearinghouse's Behavioral Health Service Directory, DMHAS decided that improvements could be implemented on the department's website that would result in a more consumer- and public- friendly application for locating treatment resources.

As a result of some of these changes already being implemented, a consumer or member of the public can now be linked directly to a specific provider website, once the geographic preference has been indicated. By accessing the provider's web site through a hyperlink, an interested individual will be able to develop his/her own impression of the treatment provider and perhaps be motivated to make that first contact to enter treatment. DMHAS website users are given the opportunity to offer feedback about the use of the website though the "Contact Us" link: *"Do you have questions, inquiries or feedback regarding the DMHAS Website?"* Please contact: DMHAS Webmaster@po.state.ct.us"

Some individuals may be interested in more than just provider website information and seek out actual "performance" information. As previously described, DMHAS has been developing provider performance reports intended for use by consumers, providers and other interested parties for assessing treatment effectiveness as well as customer satisfaction. Although customer satisfaction reports are currently available, provider performance reports are still under development. DMHAS will make performance reports available on its provider locator website once available.

Finally, DMHAS is in the process of developing a "Facebook" page for users of this form of social media. The intent is not to replicate what already exists on the DMHAS website but rather to help individuals know when and how to access the website for treatment service resources, as well as other relevant information pertaining to behavioral health.

6.4 Demand for Services

DMHAS will track individuals admitted to treatment regarding the wait time between first contact and first treatment service. Also, DMHAS will continue to monitor its annual client satisfaction survey as to access to services to evaluate the responsiveness of the treatment system to admit persons demanding treatment.

See Strategy 8.1

Strategy #7

Implement provisions of the Criminal Justice Policy Advisory Committee Community Re-entry Strategy

The Preliminary Action Steps of Goal 7 indicates that "DMHAS will convene an interagency workgroup to develop a detailed Action Plan to establish a comprehensive substance abuse service system for reentry." Such an Action Plan would include an increase in services and service

capacity, and would require additional resources. Due to uncertainty of the State Fiscal Year 2012 state budget, DMHAS is delaying development of an Action Plan until available resources are determined. Until then, existing collaborations to address Goal 7 will continue as follows.

- DMHAS, DOC, CSSD, and BOPP have constant formal and informal communications to manage referral of discharging inmates to the community service system.
- DMHAS, DOC, and CSSD will continue to operate reentry programs as discussed earlier.
- State agencies and the Judicial Branch will continue to develop and implement the reentry strategy as discussed in the 2011 CJPAC Reentry and Risk Assessment Strategy.

Strategy #8

Address data management and policy provisions of P.A. 09-149

DMHAS implemented two new data systems in SFY 2010. The Avatar system collects client level data from state-operated facilities. This system was implemented in mid-May 2010. The DMHAS Data Performance system (DDaP) captures client level data from private not-for-profit providers. DDaP was implemented in mid-July 2010. Since these systems were implemented, DMHAS has been designing and developing a data warehouse that standardizes and stores the data form both of information systems. The data warehouse became fully operational in March 2011 and the department is now aggressively working to enhance its reporting capacities. These new data systems have greatly enhanced the department's ability to collect and report on client outcomes. Providers have been required to report outcome data on an episodic basis (every 6 months) and early efforts post-implementation have focused on reporting compliance and data quality. The sections that follow highlight the status of certain measures.

8.1 Access to services prior to and following admission.

Establish baseline data of actual system performance reflecting time from request to service to service initiation, January 1, 2012.

DMHAS' new data systems now capture the date a person requested service from a substance abuse agency. DMHAS is using this data element to track how long it takes before a client receives their first service at that agency. Providers are now entering this data on all new admissions. Providers are required to report the services they provide so DMHAS is able to determine the time it takes to receive treatment. Now that all data has been consolidated in the data warehouse, a report is being developed that will measure the "time to treatment". DMHAS will be able to report a full year's data in the next (2012) Biennial Report.

Determine correlation between performance measures and National Outcome Measure System (NOMS) on a sample of individuals served.

DMHAS issued provider Quality Reports throughout SFY 2010 to all DMHAS providers. These "report cards" compared how providers were performing in relation to DMHAS benchmarks and statewide averages for key indicators such as abstinence, arrests, stable living, employment, use of 12 step programs, and treatment completions. The reports also show utilization rates and the degree to which consumers are satisfied with their services. Report cards were issued on a quarterly basis during SFY 2010.

Currently these Quality Reports are being redesigned to be more consumer-friendly. DMHAS expects to pilot a new version of the report cards in summer 2011 and to begin posting report cards to the web in fall 2011. Since the report cards were implemented, data quality has significantly improved as

providers have focused more attention on data reporting and data quality. The report cards will be available to consumers and will help inform them as they make decisions regarding where to access treatment. These reports are also being used to target monitoring and corrective actions by identifying providers with poor performance.

8.2 Percentage of clients who should receive a treatment episode of ninety days or greater

Establish a baseline for the percentage of clients exposed to ninety-day (or greater) care episodes from July 1, 2010 to July 1, 2011.

The data warehouse now provides DMHAS with the ability to monitor the length of time that a consumer is exposed to substance abuse treatment. Substance abuse literature suggests that patients with treatment exposures in excess of 90 days have improved outcomes. DMHAS is now developing a report that shows the number and percentage of DMHAS clients that have continuous treatment episodes of 90 days or more. The report definitions and specifications are being developed and DMHAS will be able to report on a full year's worth of data in the next Biennial Report.

8.3 Department policies and guidelines concerning recovery oriented treatment

Substance Use Monitoring

It is in the best interest of DMHAS to wait for a decision from DPH regarding their position on oral swabs for drug testing before the department proceeds with a policy or position. This issue will be covered under DPH's licensing of substance abuse treatment agencies. It will be addressed as an adjustment to DPH's technical bill authorizing this testing and then in DPH proposed regulation revisions that are being developed. DMHAS will revisit this issue in a timeframe that will ensure consistency between the state agencies.

Attachment H

SAMHSA Reports

- States in Brief: Substance Abuse and Mental Health Issues At a Glance: Connecticut
- Connecticut State Profile and Underage Drinking Facts

CONNECTICUT

States In Brief

Substance Abuse and Mental Health Issues At-A-Glance

A Short Report from the Office of Applied Studies

Prevalence of Illicit Substance[1] and Alcohol Use

The National Survey on Drug Use and Health (NSDUH) generates state-level estimates for 23 measures of substance use and mental health problems for four age groups: the entire state population over the age of 12 (12+); individuals age 12 to 17; individuals age 18 to 25; and individuals age 26 and older (26+). Since state estimates of substance use and abuse were first generated using the combined 2002–2003 NSDUHs and continuing until the most recent state estimates based on the combined 2005–2006 surveys, Connecticut has been among the 10 States with the *highest*[2] rates on the following measures (Table 1).

Table 1: Connecticut is among those States with the highest rates of the following:

Measure	Age Groups
Past Month Illicit Drug Use	18-25
Past Month Marijuana Use	18-25
Past Year Marijuana Use	18-25
Past Month Alcohol Use	12+, 18-25, 26+

It is worth noting that on the three measures of drug use in Table 1, the rates of use for all age groups have been above the national averages for all survey years.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
www.samhsa.gov

This is one in a series of brief state-based reports intended to give the reader a quick overview of substance abuse and mental health issues within a single state. The data derive principally from national surveys conducted by the Office of Applied Studies, a component of the Substance Abuse and Mental Health Services Administration (SAMHSA). Sources for all data used in this report appear at the end.

Abuse and Dependence

Questions in NSDUH are used to classify persons as being dependent on or abusing specific substances based on criteria specified in the *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV)* (American Psychiatric Association, 1994).

On the global measure of any abuse of or dependence on illicit drugs or alcohol, Connecticut's rates have generally been at or above the national rates. In 2004–2005 and again in 2005–2006, the rates for those individuals age 18 to 25 were among the highest in the country. It is also worth noting that over the same time period, the rates of alcohol dependence or abuse and illicit drug dependence or abuse were among the highest in the country for this age group (Charts 1 and 2).

Chart 1 **Past Year Alcohol Dependence or Abuse Among Individuals Age 18 to 25 - Connecticut**

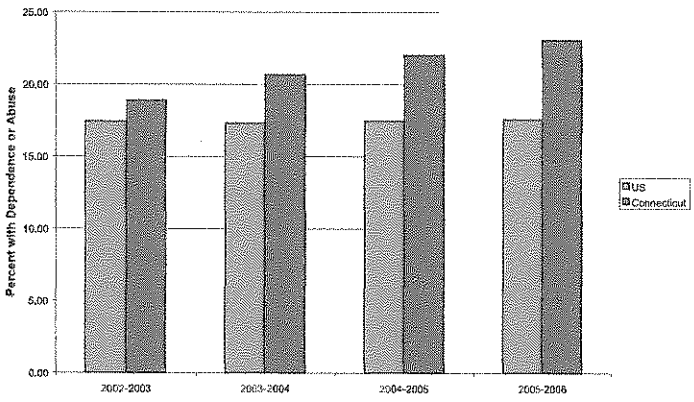
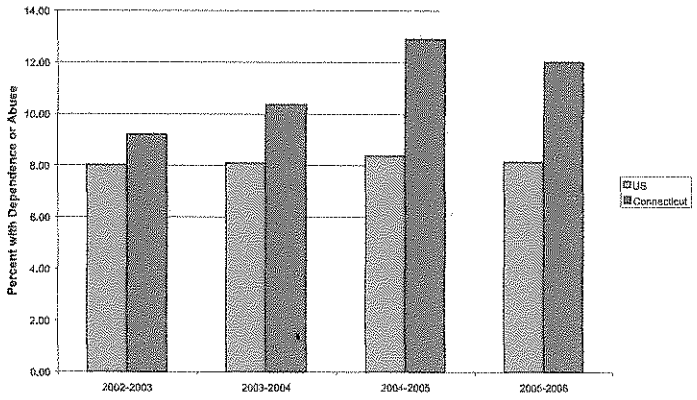


Chart 2 **Past Year Dependence on or Abuse of Illicit Drugs Among Individuals Age 18 to 25 - Connecticut**



Substance Abuse Treatment Facilities

According to the National Survey of Substance Abuse Treatment Services (N-SSATS)[3] annual surveys, the number of treatment facilities in Connecticut has declined from 247 in 2002, to 209 facilities in 2006. In 2006, the majority of facilities (179 of 209, or 86%) were private nonprofit. An additional 12 facilities were private for-profit. One facility in Connecticut is owned/operated by a Tribal government. The decrease in facilities between 2002 and 2006 is primarily accounted for by the loss of 32 private for-profit facilities and 10 private nonprofit facilities.

Although facilities may offer more than one modality of care, 152 facilities (73%) offer some form of outpatient care. An additional 66 facilities offer some form of residential care, and 41 facilities offer an opioid treatment program. In addition, 171 physicians and 46 treatment programs are certified to provide buprenorphine treatment.

In 2006, 73 percent of all facilities (153) received some form of Federal, State, county, or local government funds, and 142 facilities had agreements or contracts with managed care organizations for the provision of substance abuse treatment services.

Treatment

State treatment data for substance use disorders are derived from two primary sources—an annual one-day census in N-SSATS and annual treatment admissions from the Treatment Episode Data Set (TEDS).[4] In the 2006 N-SSATS survey, Connecticut showed a one-day total of 22,809 clients in treatment, the majority of whom (20,896 or 92 %) were in outpatient treatment. Of the total number of clients in treatment on this date, 645 (3%) were under the age of 18.

Since 1992, there has been a steady increase in the annual number of admissions to treatment; from 39,000 in 1992, to 46,000 in 2006 (the most recent year for which data are available). Chart 3 shows the percent of admissions mentioning particular drugs or alcohol at the time of admission.[5] Across the last 15 years, there has been a steady decline in the number of admissions mentioning alcohol as a substance of abuse; from 78 percent of all admissions in 1992, to 50 percent in 2006. At the same time, the number of admissions mentioning heroin has nearly doubled; from 22 percent in 1992, to 41 percent in 2006.

Across the years for which TEDS data are available, Connecticut has seen a substantial shift in the constellation of problems present at treatment admission. Alcohol-only admissions have declined from over 36 percent of all admissions in 1992, to just over 16 percent in 2006. Concomitantly, drug-only admissions have increased from 22 percent in 1992, to 45 percent in 2006 (Chart 4).

Chart 3 **Drug Mentions at Treatment Admission - Connecticut**

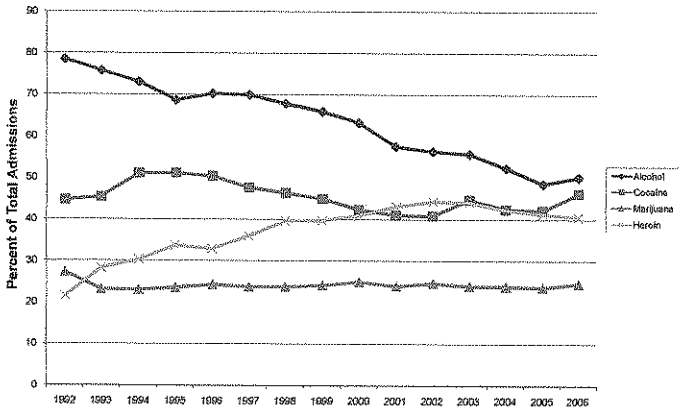
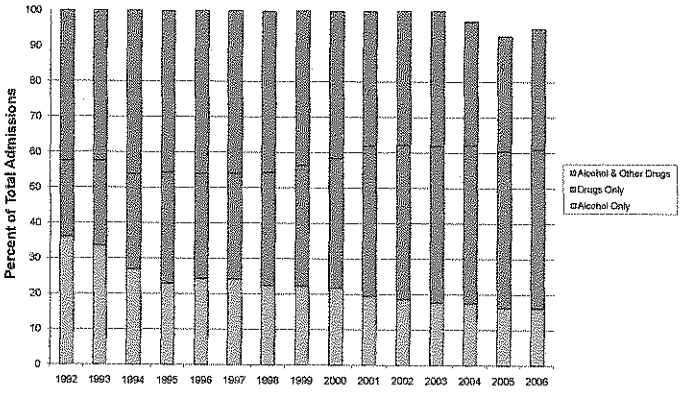


Chart 4 **Alcohol and Drug Combinations at Treatment Admission Connecticut**



Unmet Need for Treatment

NSDUH defines unmet treatment as an individual who meets the criteria for abuse of or dependence on illicit drugs or alcohol according to the *DSM-IV,* but who has not received specialty treatment for that problem in the past year. Connecticut's rates of unmet need for drug treatment have generally remained at or above the national average. In 2005–2006, the rates of this unmet need for individuals age 12 to 17 and for those age 18 to 25 were among the highest in the Nation (Chart 5).

Similarly, rates of unmet treatment need for alcohol use have generally remained at or above the national rates for all age groups, but especially for those individuals age 18 to 25 (Chart 6).

Chart 5 **Needing and Not Receiving Treatment for Drug Use 2005-2006 Connecticut**

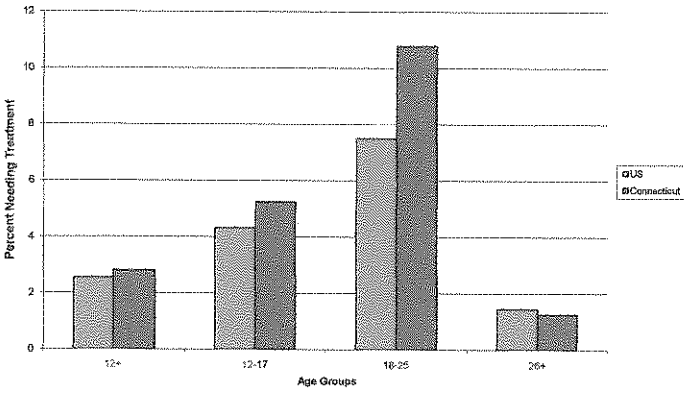
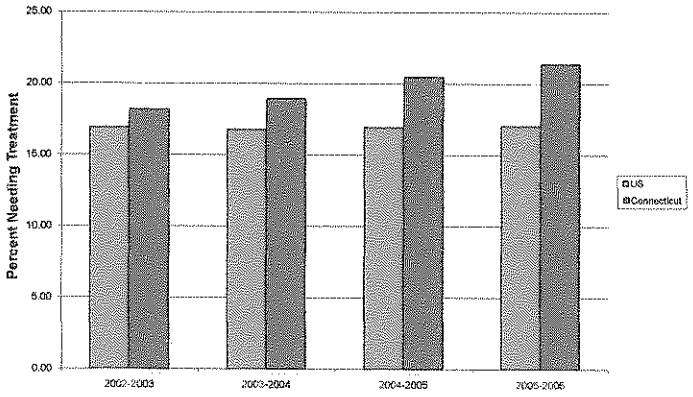


Chart 6 **Needing and Not Receiving Treatment for Alcohol Use Among Individuals Age 18 to 25 - Connecticut**

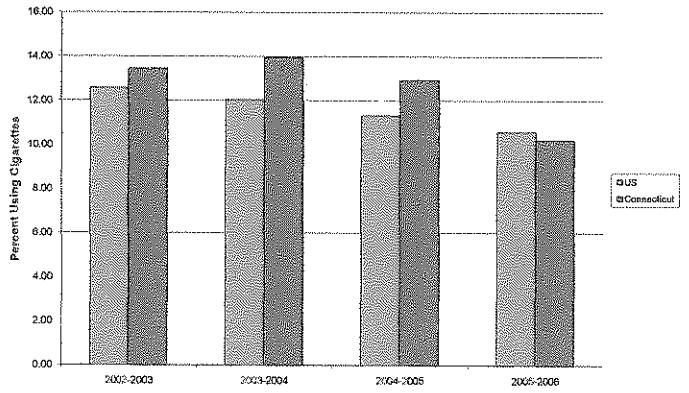


Tobacco Use and Synar Compliance

Connecticut's rates for past month cigarette use and tobacco products use for the State population age 12 and older for all survey years have been among the lowest in the country. However, the rates for underage smokers have generally been at or above the national rate (Chart 7).

SAMHSA monitors the rate of retailer violation of tobacco sales through the Agency's responsibilities under the Synar Amendment. Retailer violation rates represent the percentage of inspected retail outlets that sold tobacco products to a customer under the age of 18. Connecticut's rates of noncompliance with the Synar Amendment have been consistently below the target rate since 1998 (Chart 8).

Chart 7 **Past Month Cigarette Use Among Individuals Age 12 to 17 Connecticut**



Mental Health Indicators

For individuals age 18 and older, the National Survey on Drug Use and Health measures past year serious psychological distress (SPD), an overall indicator of nonspecific psychological distress. Since 2004–2005, the survey also measures past year major depressive episodes (MDE) for the same age group and for individuals age 12 to 17. MDE is defined as a period of 2 weeks or longer during which there is either depressed mood or loss of interest or pleasure, and at least four other symptoms that reflect a change in functioning such as problems with sleep, eating, energy, concentration, and self-image.

In the 2005–2006 analyses, Connecticut's rates on both of these measures for the State population age 18 and older were among the lowest in the country (Charts 9 and 10).

Chart 8 **Rate of Retailer Violation Rates Under the Synar Amendment - Connecticut**

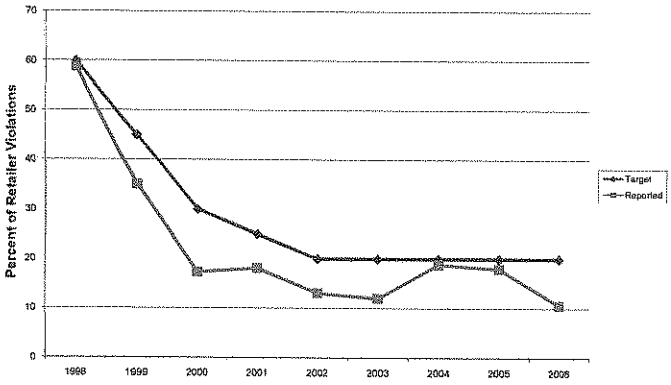
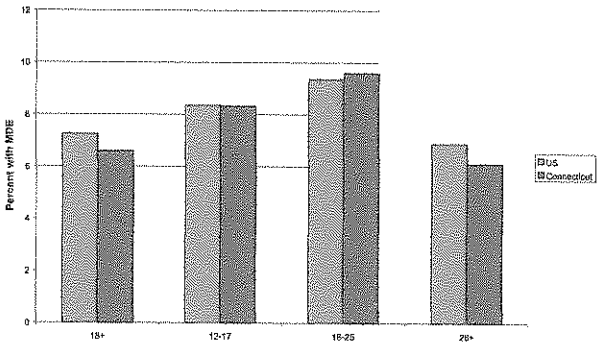


Chart 9 **Past Year Serious Psychological Distress Connecticut**

Chart 10 **Past Year Major Depressive Episode 2005-2006 Connecticut**



SAMHSA Funding

SAMHSA funds two basic types of grants—block and formula grants allocated to states and territories by formula, and discretionary grants which are awarded competitively (Chart 11). Each of the three SAMHSA Centers (Center for Substance Abuse Treatment [CSAT], the Center for Substance Abuse Prevention [CSAP] and the Center for Mental Health Services [CMHS]) has a unique discretionary portfolio.

2004–2005:	
$16.9 million	Substance Abuse Prevention and Treatment Block Grant
$5.5 million	Mental Health Block and Formula Grants
$22.8 million	SAMHSA Discretionary Program Funds
$45.2 million	Total SAMHSA Funding

CMHS: State Mental health Data Infrastructure Grant; Children's Services; Youth Violence Prevention; Jail Diversion; Emergency Response (mental health); Statewide Family Networks; AIDS Targeted Capacity Expansion—Service Capacity Building in Minority Communities; Past-Traumatic Stress Disorder in Children.

CSAP: Drug-Free Communities (20 grants); Drug-Free Communities—Mentoring; HIV/AIDS Services; Strategic Prevention Framework State Incentive Grant; State Incentive Cooperative Agreement; Ecstasy and Other Club Drug Prevention.

CSAT: Targeted Capacity Expansion—HIV/AIDS; Targeted Capacity Expansion—Innovative Treatment; Strengthening Communities—Youth; Access to Recovery; Recovery Community Support—Recovery; State Data Infrastructure; Effective Adolescent Treatment; and SAMHSA Dissertation Grants.

2005–2006:	
$16.7 million	Substance Abuse Prevention and Treatment Block Grant
$5.5 million	Mental Health Block and Formula Grants
$28.8 million	SAMHSA Discretionary Program Funds
$51.0 million	Total SAMHSA Funding

CMHS: Children's Services; Child Mental Health Initiative; Mental Health Transformation State Incentive Grant; Co-Occurring State Incentive Grant; State Mental health Data Infrastructure Grant; Jail Diversion; Statewide Family Networks; AIDS Targeted Capacity Expansion—Service Capacity Building in Minority Communities; Community Treatment and Service Centers of the National Child Traumatic Stress Initiative; National Child Traumatic Stress Initiative—Treatment and Service Adaptation Centers.

CSAP: Drug-Free Communities (18 grants); Drug-Free Communities—Mentoring; Strategic Prevention Framework State Incentive Grant; State Incentive Cooperative Agreement; HIV Strategic Prevention Framework; Ecstasy and Other Club Drug Prevention.

CSAT: Targeted Capacity Expansion—HIV/AIDS; Targeted Capacity Expansion—Innovative Treatment; Strengthening Communities—Youth; Access to Recovery; SAMHSA Conference Grant; State Adolescent Substance Abuse Treatment; Targeted Capacity Expansion—Campus Screening/ Colleges and Universities; Recovery Community Support—Recovery; Homeless Addictions Treatment; and Effective Adolescent Treatment.

2006–2007:	
$16.7 million	Substance Abuse Prevention and Treatment Block Grant
$5.5 million	Mental Health Block and Formula Grants
$28.8 million	SAMHSA Discretionary Program Funds
$51.0 million	Total SAMHSA Funding

CMHS: Child Mental Health Initiative; Mental Health Transformation State Incentive Grant; Co-Occurring State Incentive Grant; State Mental health Data Infrastructure Grant; Youth Suicide Prevention and Early Intervention; Children's Services; Jail Diversion; Statewide Family Network; Campus Suicide; Community Treatment and Service Centers of the National Child Traumatic Stress Initiative; National Child Traumatic Stress Initiative—Treatment and Service Adaptation Centers.

CSAP: Drug-Free Communities (15 grants); Drug-Free Communities—Mentoring; Strategic Prevention Framework State Incentive Grant; State Incentive Cooperative Agreement; HIV Strategic Prevention Framework.

CSAT: Targeted Capacity Expansion—HIV/AIDS; Targeted Capacity Expansion—Innovative Treatment; Strengthening Communities—Youth; Access to Recovery; SAMHSA Conference Grant; State Adolescent Substance Abuse Treatment; Targeted Capacity Expansion—Campus Screening/ Colleges and Universities; Recovery Community Support—Recovery; Homeless Addictions Treatment; and Effective Adolescent Treatment.

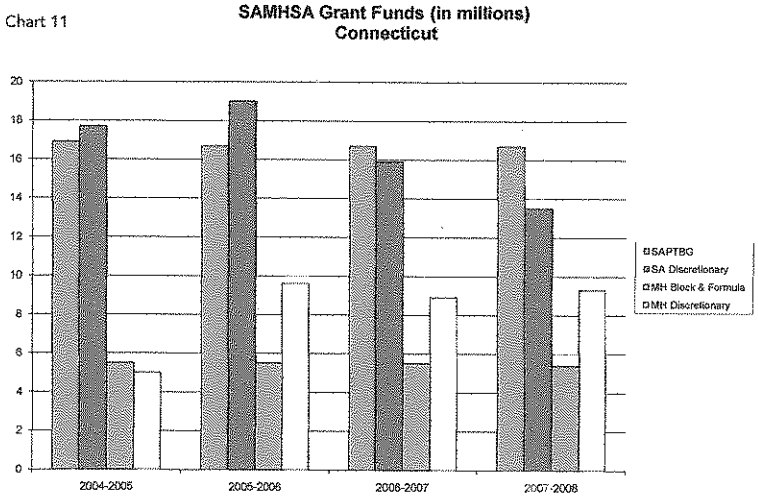
2007–2008:	
$16.7 million	Substance Abuse Prevention and Treatment Block Grant
$5.5 million	Mental Health Block and Formula Grants
$28.8 million	SAMHSA Discretionary Program Funds
$51.0 million	Total SAMHSA Funding

CMHS: Child Mental Health Initiative; State Mental health Data Infrastructure Grant; Seclusion and Restraint; Mental Health Transformation State Incentive Grant; Statewide Consumer Network; Co-Occurring State Incentive Grant; Youth Suicide Prevention and Early Intervention; Jail Diversion; Statewide Family Networks; Community Treatment and Service Centers of the National Child Traumatic Stress Initiative; National Child Traumatic Stress Initiative—Treatment and Service Adaptation Centers.

CSAP: Drug-Free Communities (17 grants); Drug-Free Communities—Mentoring; Strategic Prevention Framework State Incentive Grant.

CSAT: State Adolescent Substance Abuse Treatment; Access to Recovery; Targeted Capacity Expansion—HIV/AIDS; Targeted Capacity Expansion—Campus Screening/ Colleges and Universities; and Homeless Addictions Treatment.

Chart 11



For Further Information

A comprehensive listing of all NSDUH measures for every state is available at: **http://oas.samhsa.gov/statesList.cfm.**

Also, information about variations in incidence and prevalence of the NSDUH substance abuse and mental health measures within each state is available at: **http://oas.samhsa.gov/metro.htm.**

Data Sources

Grant Awards: **http://www.samhsa.gov/statesummaries/index.aspx.**

Facility Data: National Survey of Substance Abuse Treatment Services (N-SSATS)—2006 available at: **http://www.dasis.samhsa.gov.**

Treatment Data: Treatment Episode Data Set—Concatenated File—available from the Substance Abuse and Mental Health Data Archive: **http://www.icpsr.umich.edu/SDA/SAMHDA.**

[1] NSDUH defines illicit drugs to include marijuana/hashish, cocaine (including crack), inhalants, hallucinogens, heroin, or prescription-type drugs used nonmedically. Nonmedical use is defined as use not prescribed for the respondent by a physician or used only for the experience or feeling the drug(s) caused. Nonmedical use of any prescription-type pain reliever, sedative, stimulant, or tranquilizer does not include over-the-counter drugs. Nonmedical use of stimulants includes methamphetamine use.

[2] States are assigned to one of five groups according to their ranking (quintiles). Because there are 51 areas to be ranked for each measure, the middle quintile was assigned 11 areas and the remaining groups 10 each. Throughout this document "highest" refers to the 10 states in the first quintile and "lowest" to those in the fifth quintile.

[3] N-SSATS is designed to collect information from all facilities in the United States, both public and private, that provide substance abuse treatment. N-SSATS does not collect information from the following three types of facilities: non-treatment halfway houses; jails, prisons, or other organizations that treat incarcerated clients exclusively; and solo practitioners.

[4] TEDS is an admissions-based system, and TEDS admissions do not represent individuals. For example, an individual admitted to treatment twice within a calendar year would be counted as two admissions.

[5] TEDS collects information on up to three substances of abuse that lead to the treatment episode. These are not necessarily a complete enumeration of all drugs used at the time of admission.

Prevalence Data

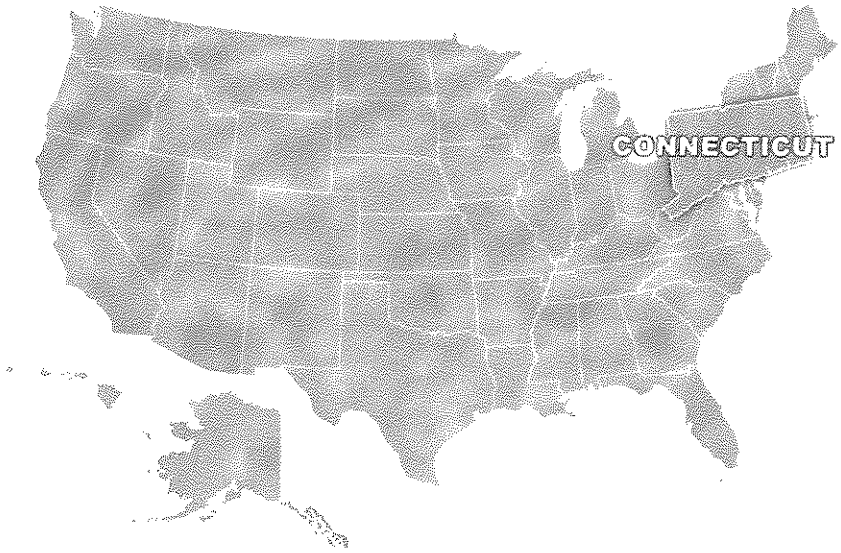
Wright, D. & Sathe, N. (2005) *State Estimates of Substance Use from the 2002-2003 National Surveys* on Drug Use and Health (DHHS Publication No. SMA-05-3989, NSDUH Series H-26) Rockville, MD: Substance Abuse and Mental Health Services Administration, Office of Applied Studies.

Wright, D. & Sathe, N. (2006) *State Estimates of Substance Use from the 2003-2004 National Surveys on Drug Use and Health* (DHHS Publication No. SMA-06-4142, NSDUH Series H-29) Rockville, MD: Substance Abuse and Mental Health Services Administration, Office of Applied Studies.

Wright, D., Sathe, N. & Spagnola, K. (2007) *State Estimates of Substance Use from the 2004-2005 National Surveys on Drug Use and Health* (DHHS Publication No. SMA-07-4235, NSDUH Series H-31) Rockville, MD: Substance Abuse and Mental Health Services Administration, Office of Applied Studies.

Hughes, A. & Sathe, N. (2008) *State Estimates of Substance Use from the 2005-2006 National Surveys on Drug Use and Health* (DHHS Publication No. SMA-08-4311, NSDUH Series H-33) Rockville, MD: Substance Abuse and Mental Health Services Administration, Office of Applied Studies.

A Life in the Community for Everyone
SAMHSA
Substance Abuse and Mental Health Services Administration
U.S. Department of Health and Human Services



CONNECTICUT

State Profile and Underage Drinking Facts[39]

State Population	3,501,252	
Population-Ages 12-20	425,000	
	Percentage	**Number**
Ages 12-20		
Past-Month Alcohol Use	32.3	137,000
Past-Month Binge Alcohol Use	23.5	100,000
Ages 12-14		
Past-Month Alcohol Use	5.9	8,000
Past-Month Binge Alcohol Use	2.8	4,000
Ages 15-17		
Past-Month Alcohol Use	32.3	51,000
Past-Month Binge Alcohol Use	22.5	35,000
Ages 18-20		
Past-Month Alcohol Use	60.7	78,000
Past-Month Binge Alcohol Use	47.1	61,000

[39] Overall population information is taken from 2008 population estimates based on 2000 Census data. Data about the portion of each State's population comprised of 12- to 20-year-olds is averaged from 2005, 2006, 2007, and 2008 NSDUHs (SAMHSA, CBHSQ, NSDUH, special data analysis, 2009), as are facts about past-month alcohol use and binge use. Additional references for data in this section can be found in Appendix C.

Alcohol-Attributable Deaths (under 21)		34
Years of Potential Life Lost (under 21)		1,976
Traffic Fatalities, 15- to 20-Year-Old Drivers With BAC >.01	22.0	8

Laws Addressing Minors in Possession of Alcohol

Underage Possession of Alcohol

Possession is prohibited WITH THE FOLLOWING EXCEPTION(S):

- Private location OR
- Parent/guardian presence and consent OR
- Spouse

Underage Consumption of Alcohol

Consumption is not explicitly prohibited.

Internal Possession by Minors

Internal possession is not explicitly prohibited.

Underage Purchase of Alcohol

Purchase is prohibited, but youth may purchase for law enforcement purposes.

False Identification for Obtaining Alcohol

Provision(s) targeting minors

- Use of a false ID to obtain alcohol is a criminal offense
- Penalty may include driver's license suspension through a judicial procedure

Provisions targeting retailers

- State provides incentives to retailers who use electronic scanners that read birth dates and other information digitally encoded on valid identification cards
- Licenses for drivers under age 21 are easily distinguishable from those for drivers age 21 and older
- Specific affirmative defense: the retailer inspected the false ID and came to a reasonable conclusion based on its appearance that it was valid

Laws Targeting Underage Drinking and Driving

BAC Limits: Youth (Underage Operators of Noncommercial Motor Vehicles)

- BAC limit: 0.02
  - BAC at or above the limit is *per se* (conclusive) evidence of a violation
  - Applies to drivers under age 21

Loss of Driving Privileges for Alcohol Violations by Minors ("Use/Lose Laws")

Use/lose penalties apply to minors under age 21.

Type(s) of violation leading to driver's license suspension, revocation, or denial:

- Underage possession

Authority to impose driver's license sanction:

- Mandatory

Length of suspension/revocation:

- 30 days

Graduated Driver's License

Learner stage

- Minimum entry age: 16
- Minimum learner stage period:
  - 4 months —with driver education
  - 6 months—without driver education
- Minimum supervised driving requirement: 40 hours

Intermediate stage

- Minimum age: 16 years, 4 months
- Unsupervised night driving:
  - Prohibited after 11 p.m.
  - Primary enforcement of the night driving rule
- Passenger restrictions exist:
  - First 6 months—limited to one parent, instructor, or licensed adult who is at least 20 years old
  - Second 6 months—expands to include immediate family
  - Primary enforcement of the passenger restriction rule

License stage

- Minimum age to lift restrictions: 18
- Passenger restrictions expire 12 months after issuance of intermediate license
- Unsupervised night driving restrictions remain until age 18

Notes: A parent or guardian of any applicant less than 18 to whom a learner's permit is issued on or after August 1, 2008 shall attend two hours of safe driving instruction with such applicant.

Laws Targeting Alcohol Suppliers

Furnishing of Alcohol to Minors

Furnishing is prohibited WITH THE FOLLOWING EXCEPTION(S):

- Parent/guardian OR
- Spouse

Responsible Beverage Service

No beverage service training requirement.

Minimum Ages for Off-Premises Sellers

- Beer 15
- Wine 18
- Spirits 18

Minimum Ages for On-Premises Sellers

- Beer 18 for both servers and bartenders
- Wine 18 for both servers and bartenders
- Spirits 18 for both servers and bartenders

Dram Shop Liability

Statutory liability exists subject to the following conditions:

- Limitations on damages: $250,000.
- Limitations on elements/standards of proof: Minor must be intoxicated at time of service.
- The courts recognize common law dram shop liability

Notes: A common law cause of action is not precluded by the dram shop statute. Under common law, the limitations on damages may be avoided.

Social Host Liability

There is no statutory liability. The courts recognize common law social host liability.

Host Party Laws

Social host law is not specifically limited to underage drinking parties:

- Action by underage guest that triggers violation: possession
- Property type(s) covered by liability law: residence, outdoor, other
- Standard for hosts' knowledge or action regarding the party: KNOWLEDGE—host must have actual knowledge of the occurrence
- Preventive action by the host negates the violation (see note)
- Exception(s): family

Notes: The "preventive action" provision in Connecticut requires the prosecution to prove that the host failed to take preventive action.

Direct Sales/Shipments From Producers to Consumers

Direct sales/shipments from producers to consumers are permitted for wine with the following restrictions:

Age verification requirements

- Producer must verify age of purchaser: ID check is required at some point prior to delivery.
- Common carrier must verify age of recipient: ID check required at some point prior to delivery.

State approval/permit requirements

- Producer/shipper must obtain State permit
- State must approve common carrier

Reporting requirements

- Producer must record/report purchaser's name
- Common carrier must record/report purchaser's name

Shipping label statement

- Contains alcohol
- Recipient must be 21

Keg Registration

Keg definition: 6 gallons or more.

Prohibited

- Possessing an unregistered, unlabeled keg—max. fine/jail: $500 or 3 months

Purchaser information collected

- Purchaser's name and address: verified by a government-issued ID
- Warning information to purchaser: passive—no purchaser action required
- Deposit: not required
- Provisions do not specifically address disposable kegs

Attachment I

Additional Publications in Support of Proposal

- New England High Intensity Drug Trafficking Area: Drug Market Analysis 2010
- Article: "Prescription Drug Abuse in Danbury Area is Stealing Lives"

U.S. Department of Justice
National Drug Intelligence Center

New England High Intensity Drug Trafficking Area

Drug Market Analysis 2010

U.S. Department of Justice
National Drug Intelligence Center

2010-R0813-018

June 2010

New England High Intensity Drug Trafficking Area

Drug Market Analysis 2010

This assessment is an outgrowth of a partnership between the NDIC and HIDTA Program for preparation of annual assessments depicting drug trafficking trends and developments in HIDTA Program areas. The report has been coordinated with the HIDTA, is limited in scope to HIDTA jurisdictional boundaries, and draws upon a wide variety of sources within those boundaries.

Table of Contents

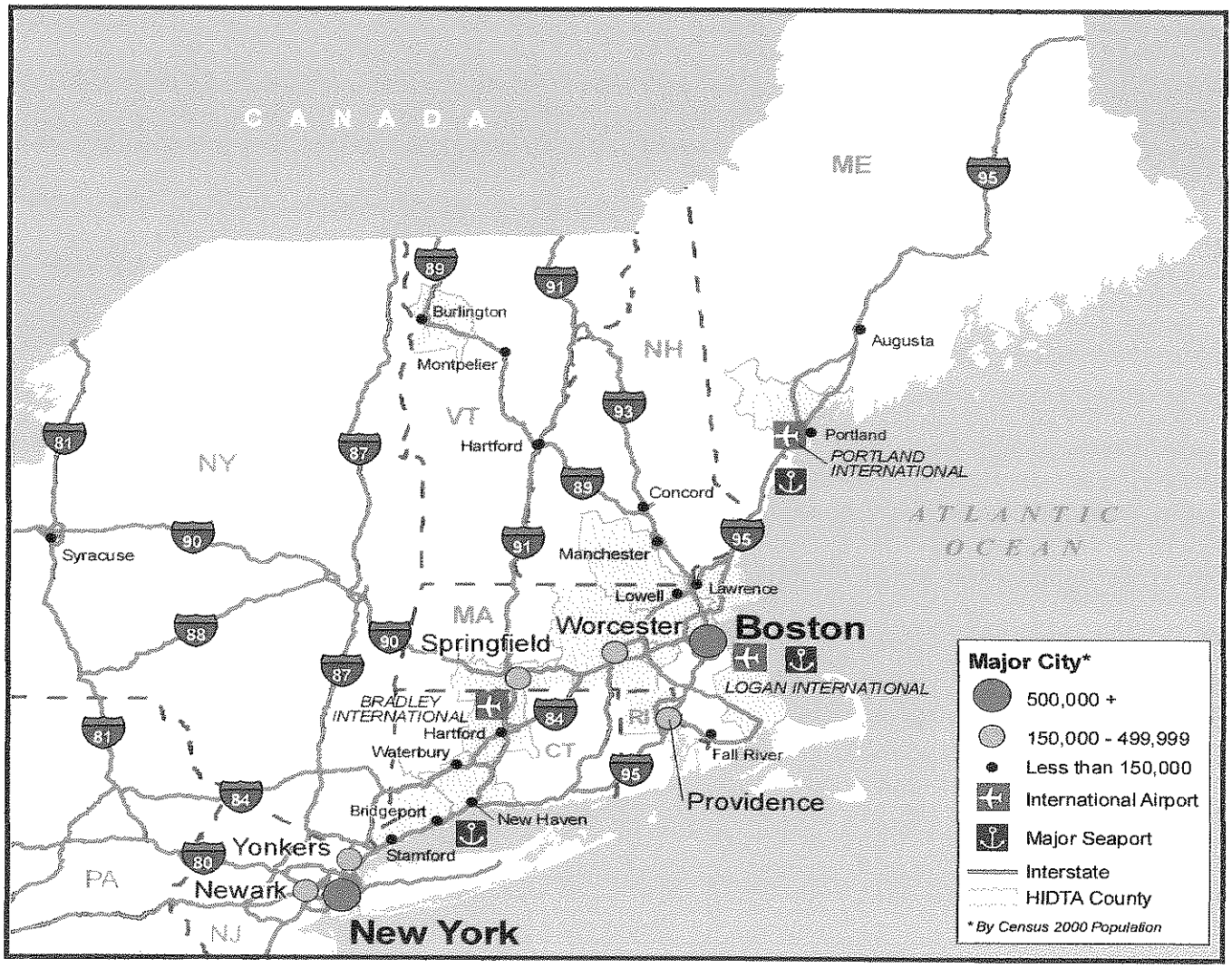
Strategic Drug Threat Developments

Opioid abuse (particularly the abuse of South American (SA) heroin and diverted controlled prescription opioids) is the primary drug concern in the New England High Intensity Drug Trafficking Area (NE HIDTA) region. Opioid abuse is associated with high levels of violent crime and property crime and accounts for 70 percent of all illicit drug-related treatment admissions and the majority of poison center hotline calls, hospital visits, and drug-related deaths in the region.

The following are significant strategic drug threat developments in the NE HIDTA region:

- Mexican drug trafficking organizations (DTOs) have increased their operations in the NE HIDTA region and are now significant wholesale suppliers of SA heroin, cocaine, and marijuana, which they transport directly from their sources of supply in Atlanta, Georgia; Houston and Dallas, Texas; and the Southwest Border area to New England.
- Cocaine is readily available in the region; wholesale prices in most areas are elevated compared with those reported prior to cocaine shortages that occurred in New England in 2007.
- Violence among street gangs is increasing in the NE HIDTA region, particularly violence associated with disputes over drug territories. Street gangs are expanding their drug distribution operations into rural and suburban areas.
- Illicit drug abusers in the NE HIDTA region are unwittingly being exposed to illicit substances that they do not intend to ingest, primarily through their use of synthetic drug tablets/capsules (often represented as MDMA (3,4-methylenedioxymethamphetamine, also known as ecstasy)), which are increasingly available in the region. The harmful adulterant levamisole has also been identified in cocaine samples from the region.

Figure 1. New England High Intensity Drug Trafficking Area



HIDTA Overview

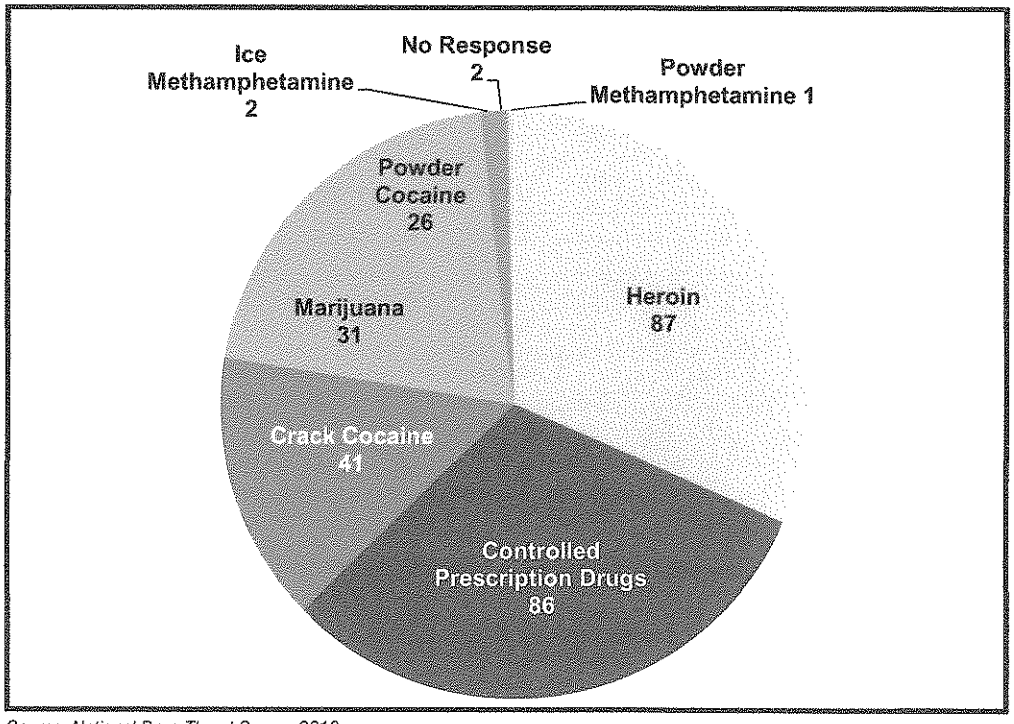
The NE HIDTA region comprises 13 counties in six states, including six counties in Massachusetts, three in Connecticut, and one each in Maine, New Hampshire, Rhode Island, and Vermont. Approximately 8.8 million residents, 61 percent of the New England population, reside in the HIDTA region. Drug distribution within the NE HIDTA region is centered in two primary hubs located in the Hartford, Connecticut/Springfield, Massachusetts, and Lowell/Lawrence, Massachusetts, areas. The Providence, Rhode Island/Fall River, Massachusetts, area is a secondary distribution center that supplies Cape Cod. Boston, Massachusetts, New England's largest city, is predominantly a consumer market supplied primarily by distributors operating from Lawrence, Lowell, and the New York City metropolitan area. The approximate wholesale value of drugs seized under NE HIDTA initiatives in 2009 was $42.1 million.

New England is a global financial center that is linked electronically to world markets as well as to numerous domestic and foreign markets in drug source and transit zones. High per capita income levels make New England an attractive area for drug traffickers. During 2009, per capita income among New England states was among the highest in the nation. Connecticut ranked first, Massachusetts ranked third, and New Hampshire ranked eighth nationally in this category.

Drug Threat Overview

Opioids—including heroin (primarily SA heroin) and diverted controlled prescription drugs (CPDs) such as OxyContin and Percocet (both oxycodone) and Vicodin (hydrocodone)—collectively pose the greatest drug threat to the NE HIDTA region. According to National Drug Intelligence Center (NDIC) National Drug Threat Survey (NDTS)[a] 2010 data, 173 of the 276 state and local law enforcement agency respondents in the NE HIDTA region identify either heroin or CPDs as the greatest drug threat in their jurisdictions. Law enforcement officials seized 21.7 kilograms of heroin, 13,200 dosage units of OxyContin, 4,502 dosage units of Percocet, and 1,316 dosage units of oxycodone in conjunction with NE HIDTA initiatives in 2009. (See Table 1 on page 5.)

Figure 2. Greatest Drug Threat to the New England HIDTA Region as Reported by State and Local Law Enforcement Agencies, by Number of Respondents



Source: National Drug Threat Survey 2010.

a. NDTS data for 2010 cited in this report are as of March 1, 2010. NDTS data cited are raw, unweighted responses from federal, state, and local law enforcement agencies solicited through either NDIC or the Office of National Drug Control Policy (ONDCP) HIDTA program. Data cited may include responses from agencies that are part of the NDTS 2010 national sample and/or agencies that are part of HIDTA solicitation lists.

Controlled prescription opioid abusers are fueling the heroin abuse problem in the region: an increasing number of these abusers are switching to heroin because of its higher potency and greater affordability. Heroin prices at the street level decreased substantially in some primary drug distribution centers in 2009 and remain low. Heroin abuse now encompasses a broad cross section of society, including chronic abusers in urban areas, residents of suburban and rural communities, and young adults and teenagers who switched to heroin after initially abusing CPDs.

Cocaine, particularly crack, is commonly abused in some parts of the region, mainly inner-city neighborhoods in Boston, Springfield, and Providence, and in Bridgeport, Hartford, and New Haven, Connecticut. Crack availability has also expanded in many northern New England cities, such as Burlington, Manchester, and Portland, largely because African American and Hispanic criminal groups and street gangs from southern New England states and New York City have increased distribution in those areas.

Marijuana abuse is pervasive throughout the NE HIDTA region, with commercial-grade Mexican marijuana and high-potency marijuana from regional domestic and Canadian suppliers readily available. New England law enforcement officials believe that marijuana seizure amounts will decline as local production increases in the near future, mainly as a result of the Massachusetts law passed in November 2008 that decriminalized the possession of small amounts of marijuana, and state-enacted medical marijuana programs in Maine, Rhode Island, and Vermont.

MDMA is widely available, and distribution and abuse are increasing in some areas of the region. Some synthetic drug tablets available in the NE HIDTA region are represented as MDMA but actually contain methamphetamine—or methamphetamine and MDMA in combination, as well as other drug combinations.[b] Public health officials report that MDMA and methamphetamine combinations may produce greater adverse neurochemical and behavioral effects than either drug alone, thus placing abusers at greater risk.

Drug Trafficking Organizations

New York City-based Colombian DTOs are the primary wholesale suppliers of SA heroin and cocaine in the NE HIDTA region. They typically transport drugs to the region to supply midlevel and retail-level distributors. Colombian DTOs sometimes contract with Dominican, Guatemalan, Honduran, Jamaican, Mexican, Puerto Rican, and other Central America- and Caribbean-based groups to smuggle heroin and cocaine directly into the region for distribution. Increased law enforcement pressure along the Southwest Border has led some DTOs to use smuggling routes through Venezuela, Central America, and the Caribbean.

Mexican DTOs have increased their operations in the NE HIDTA Region and are now significant wholesale suppliers of SA heroin, cocaine, and marijuana, which they transport directly from their sources of supply in Atlanta, Georgia; Houston and Dallas, Texas; and the Southwest Border area to New England. Mexican DTOs also supply limited amounts of ice methamphetamine to the region.

Dominican DTOs are significant transporters and distributors of retail-level quantities of cocaine, commercial-grade marijuana, SA heroin, and CPDs in the region. Some New England-based Dominican traffickers travel to New York City to obtain drug supplies from Colombian and Dominican DTOs; conversely, some Colombian and Dominican distributors from New York City travel to New England to supply illicit drugs to Dominican traffickers.

b. Synthetic drug tablets, capsules, or powder seized in New England often contain multiple ingredients in various combinations, including substances such as MDMA, MDA (3,4-methylenedioxyamphetamine), methamphetamine, amphetamine, 4-Methylmethcathinone (4-MMC, Mephedrone), BZP (1-benzylpiperazine), caffeine, ephedrine, ketamine, LSD (lysergic acid diethylamide), OMPP (ortho-methoxyphenylpiperazine), PCP (phencyclidine), procaine, pseudoephedrine, and TFMPP (1-(3-trifluoromethylphenyl)piperazine). Some laboratory operators who produce synthetic drugs custom-blend drug tablets and capsules to provide abusers with a specific physiological effect, and they use information about that effect as a marketing tool. Moreover, methamphetamine, which is less costly to produce, has been used as an adulterant/additive to MDMA tablets for several years. MDMA producers sometimes add methamphetamine during MDMA manufacturing to stretch their supplies and increase their profit margins. Methamphetamine is often more readily available to laboratory operators and less expensive than pure MDMA. Because the chemical structure of MDMA is similar to that of methamphetamine and the two drugs produce similar stimulant effects, producers can sell combination MDMA/methamphetamine tablets to an unsuspecting MDMA user population.

Table 1. Drug Seizures in the New England HIDTA Region, 2009

Drug	Amount Seized	Wholesale Value
Cocaine HCL (in kilograms)	183.5	$ 6,350,951
Crack Cocaine (in kilograms)	11.8	$ 493,017
Heroin (in kilograms)	21.7	$ 1,918,044
Marijuana (in kilograms)	8,821.4	$ 29,704,942
Marijuana, hydroponic (in kilograms)	23.2	$ 150,233
Methamphetamine (in kilograms)	36.7	$ 212,955
Hydrocodone (in dosage units)	194	$ 2,188
LSD (in dosage units)	45	$ 225
MDMA (in dosage units)	108,667	$ 2,708,580
Methadone (in dosage units)	155	$ 4,590
Morphine (in dosage units)	1,265	$ 35,420
Oxycodone (in dosage units)	1,316	$ 15,752
OxyContin (in dosage units)	13,200	$ 325,927
Percocet (in dosage units)	4,502	$ 44,876
Ritalin (in dosage units)	220	$ 1,100
Suboxone (in dosage units)	234.2	$ 2,394
Valium (in dosage units)	7,462	$ 37,208
Vicodin (in dosage units)	777	$ 6,156
Xanax (in dosage units)	6,146	$ 30,701

Source: New England High Intensity Drug Trafficking Area.

La Familia Michoacana Drug Cartel Linked to Massachusetts

In October 2009, the Attorney General of the United States announced the arrests of individuals in 19 states, including Massachusetts, during Project Coronado, a significant international law enforcement effort directed against the La Familia Michoacana Cartel. This violent Mexican DTO based in the southwestern state of Michoacán had been operating multiple cocaine, marijuana, and methamphetamine drug distribution cells in the United States. The DTO had smuggled large quantities of illicit drugs from Mexico to the United States and laundered millions of dollars in drug proceeds. The DTO had also acquired military-grade weapons and arranged to smuggle them into Mexico for use by La Familia. Law enforcement officials report that Project Coronado resulted in the arrests of 1,186 individuals and the seizure of approximately $33 million in U.S. currency, 1,999 kilograms of cocaine, 2,730 pounds of methamphetamine, 29 pounds of heroin, 16,390 pounds of marijuana, 389 weapons, 269 vehicles, and 2 clandestine drug laboratories.

Source: U.S. Department of Justice.

Asian polydrug trafficking organizations operating between New England and Canada are the primary producers, transporters, and distributors of Canadian high-potency hydroponic marijuana, MDMA, and synthetic drug combinations containing such substances as methamphetamine, MDMA, and MDA. They smuggle drug shipments from Canada for distribution in New England and elsewhere in the United States.

Guatemalan, East and West African, and Native American organizations are also active in the NE HIDTA region. Guatemalan DTOs transport SA heroin to the region and distribute retail quantities of heroin and cocaine. East African DTOs transport khat to the region for distribution to Somali communities in the Boston and Lewiston areas, while West African DTOs transport small quantities of Southwest Asian (SWA) heroin to the region for distribution. Native American traffickers smuggle high-potency Canadian marijuana to the region for further distribution in New England and other regions of the United States.

Street gangs such as 18th Street, Asian Boyz, Bloods, Crips, La Familia, Latin Gangster Disciples, Latin Kings, Mara Salvatrucha (MS 13), Ñeta, Sureños (Sur 13), Tiny Rascal Gangsters, and Vatos Locos distribute cocaine, marijuana, heroin, and CPDs in the NE HIDTA region. Most street gangs operating in New England can be classified as one of four main racial/ethnic groups—African American, Asian, Caucasian, or Hispanic. New York City and southern New England-based African American and Hispanic street gangs travel to areas throughout the NE HIDTA region to distribute powder cocaine, crack cocaine, and heroin at higher prices than they command in their home areas. They also obtain weapons in the NE HIDTA region, which, along with drug proceeds, are typically returned to the gangs' urban bases of operation.

Members of international outlaw motorcycle gangs (OMGs), such as Hells Angels and Outlaws and their associates, distribute cocaine, marijuana, MDMA, powder methamphetamine, and CPDs in New England. Some OMG members also engage in various financial crimes, firearms offenses, and violent crimes, including assault and armed carjacking. Violence among OMGs is increasing in the region as the gangs and their associates compete for territory.

Production

Most of the illicit drugs distributed in the NE HIDTA region are produced at locations outside the region; however, marijuana production occurs at indoor and outdoor grow sites throughout New England. Data from the Drug Enforcement Administration (DEA) Domestic Cannabis Eradication/Suppression Program (DCE/SP) reveal that the number of cannabis plants eradicated from indoor and outdoor grow sites in the region trended upward in 2009, reaching the second-highest total since 2005. (See Table 2.) Production levels are rising in some areas of New England where young adults are increasingly renting properties in rural locations and establishing indoor grow sites. An increasing number of weapons are also being encountered at grow sites in the region.

Table 2. Cannabis Plants Eradicated at Indoor and Outdoor Cultivation Sites in the New England HIDTA Region, 2005–2009

	2005	2006	2007	2008	2009
Indoor cultivation sites	2,712	15,337	5,277	5,671	10,047
Outdoor cultivation sites	11,054	13,622	14,486	7,430	10,636
Total	**13,766**	**28,959**	**19,763**	**13,101**	**20,683**

Source: Domestic Cannabis Eradication/Suppression Program.

Transportation

Drug traffickers exploit the NE HIDTA's proximity to New York City and the eastern provinces of Canada as well as the region's vast transportation network, which provides links to drug sources in other regions of the United States and internationally. Numerous land ports of entry (POEs) and the mostly remote, 759-mile land boundary along the U.S.–Canada border provide traffickers with various avenues to transport drug shipments from foreign locations to the NE HIDTA region. International airports and maritime ports further facilitate illicit drug smuggling into and through the region. In 2008, Boston Logan International Airport, New England's largest air transportation center, ranked 28th in the world for passenger traffic. Major airports are also located in Hartford; Providence; Burlington, Vermont; Manchester, New Hampshire; and Portland and Bangor, Maine. Major commercial seaports are located in Bridgeport, Groton, New London, and New Haven, Connecticut; Boston and Fall River, Massachusetts; Portsmouth, New Hampshire; and Eastport, Portland, Sandy Point, and Searsport, Maine. Six major interstate highways, three intraregional interstates, and a network of secondary and tertiary roadways link New England to major population centers throughout the country. Additionally, Interstates 89, 90, 91, 93, and 95 offer direct routes through New England to locations at or near the U.S.–Canada border.

Traffickers in the region frequently use transportation brokers and couriers who specialize in smuggling contraband, primarily overland. These specialists employ a variety of sophisticated concealment methods, use countersurveillance measures, alter methods of communication, and frequently change routes and methods of conveyance to thwart law enforcement interdiction efforts. Traffickers also send drugs and drug proceeds through the mail and parcel delivery services.

Drug-Related Crime

Law enforcement officials throughout the NE HIDTA region report a distinct relationship between drug trafficking and crime—both violent and property crime. They indicate that most robberies, thefts, shootings, murders, and cases of domestic violence have a drug nexus. Illicit drug abusers in the HIDTA region have robbed pharmacies to obtain CPDs for personal use and for resale to other addicts. Additionally, most of the bank robberies in the HIDTA region have been linked to drug abusers. According to NDTS 2010 data, 94 of the 276 state and local law enforcement agency respondents in the NE HIDTA region identify crack cocaine as the drug that most contributes to violent crime in their areas; 118 respondents identify heroin as the drug that most contributes to property crime.

Violent, armed street gang members who engage in midlevel and retail drug distribution, particularly of powder cocaine, crack cocaine, and heroin, frequently commit violent crimes (such as assaults on police officers and civilians, home invasion robberies, shootings and assaults with dangerous weapons, and robberies) and property crimes (burglaries and thefts) to protect and expand drug operations and to collect drug debts. Additionally, some drug traffickers in the region use threats of violence to intimidate witnesses in trials against them. The propensity for violence is significant, particularly among gang members who joined the military, received training in weapons and tactics, and returned to gang life following discharge.

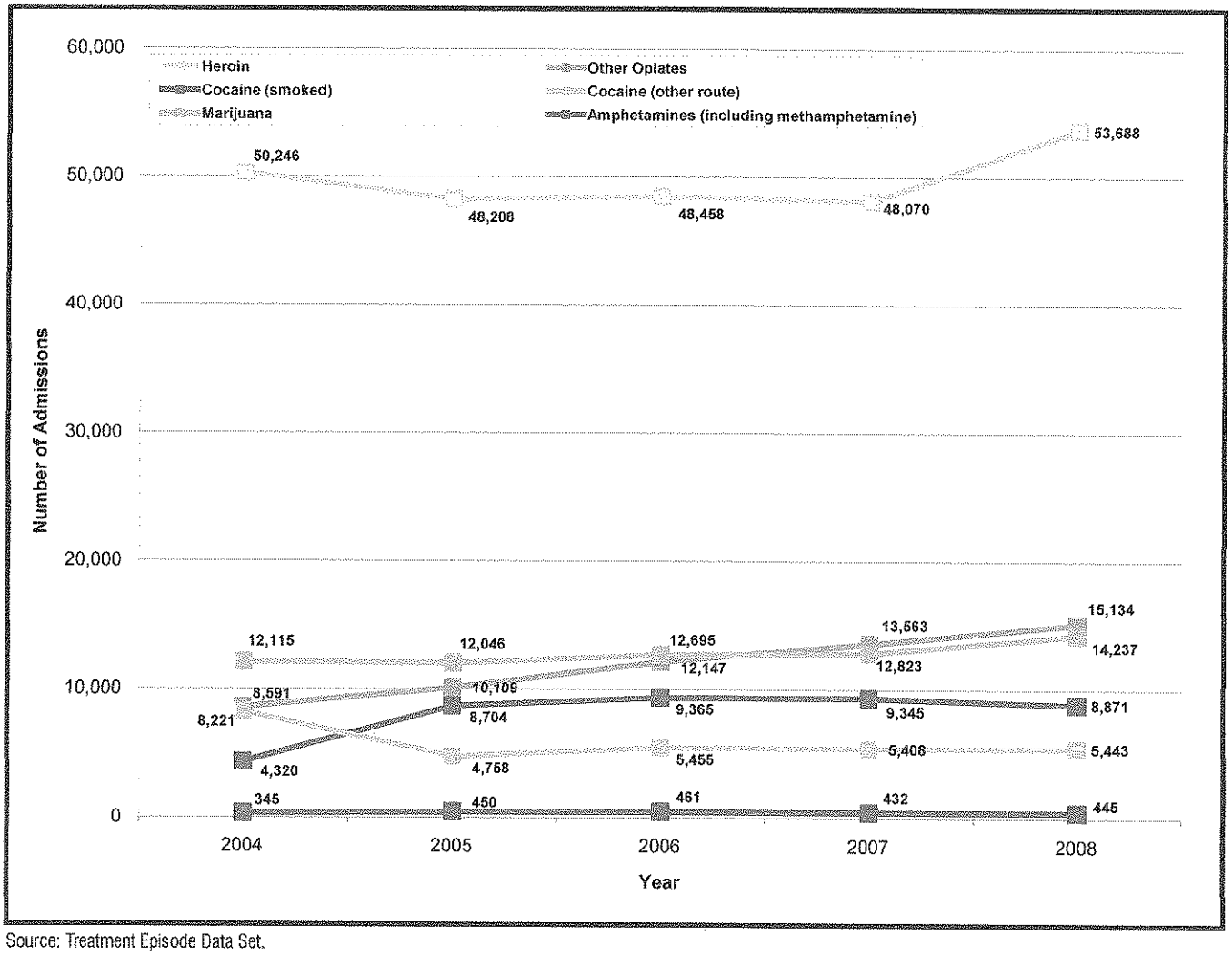
The acquisition and use of firearms by street gang members poses an increasing threat in the NE HIDTA region. Gang members generally obtain firearms through either direct or intermediary purchases, by theft, or in exchange for drugs. Many suburban and rural communities in New England are experiencing increasing gang-related crime and violence because of expanding gang influence, particularly incidents related to disputes over drug territories. Most street gangs that operate in New England engage in violence in conjunction with various crimes, including retail-level drug distribution.

Abuse

Opioid abuse, particularly abuse of SA heroin and diverted controlled prescription opioids, is the most significant drug concern in the HIDTA region, according to various drug abuse indicators. Opioid-related inquiries accounted for the highest percentage of substance abuse-related, nonemergency information calls from healthcare professionals and the general public to the Northern New England Poison Center (NNEPC) hotline from 2005 through 2009. Most of the opioid-related calls to the hotline, which serves Maine, New Hampshire, and Vermont, involved oxycodone; hydrocodone products accounted for the second-highest number of calls.

Treatment Episode Data Set (TEDS) reporting indicates that the number of heroin-related treatment admissions to publicly funded facilities in New England exceeded admissions related to all other illicit substances combined from 2003 through 2008, the latest year for which such data are available. Heroin and other opiate-related treatment admissions increased during that time frame, peaking in 2008, when they accounted for approximately 70 percent of all illicit drug-related treatment admissions. Other opiate-related treatment admissions increased by more than 76 percent from 2004 (8,591) through 2008 (15,134), and heroin-related admissions rose from 50,246 to 53,688, or nearly 7 percent. (See Figure 3.)

Figure 3. Drug-Related Treatment Admissions to Publicly Funded Facilities in New England, 2004–2008



Source: Treatment Episode Data Set.

Opioids are mentioned in the majority of the drug-related deaths reported in New England, and most of these deaths occurred in HIDTA counties. (See Table 3 on page 9; see Appendix A.) There is also a distinct relationship between the abuse of heroin and controlled prescription opioids and addiction treatment drugs such as methadone and buprenorphine in New England. According to substance abuse treatment providers in the region, in addition to controlled prescription opioid abusers switching to heroin use, former heroin abusers are abusing the synthetic opioids methadone and buprenorphine, which are addiction treatment drugs. Some heroin abusers self-medicate with drugs such as Suboxone to avoid the withdrawal symptoms commonly associated with heroin abuse. These individuals are then able to resume using heroin more quickly than heroin addicts who did not use Suboxone. In 2009, methadone was mentioned in approximately 25

Table 3. Drug-Related Deaths in New England States

State	Year (Most Current Available Data)	Total Number of Drug-Related Deaths	Total Number of Opioid Mentions (Heroin and/or Controlled Prescription Opioids)	Top Illicit Drug Mentions and Number (Excludes Alcohol)
Connecticut	2009	515	192	Heroin (98), multiple drugs (88), cocaine (48), methadone (31), opiate (25), oxycodone (21), fentanyl (11)
Maine	2008	168	Not available	Not available
Massachusetts	2007	906	633	Not available
New Hampshire	2009	164	124	Methadone (41), oxycodone (29), cocaine (25), heroin (22), citalopram (11), fentanyl (16), morphine (15), alprazolam (14), diazepam (13), clonazepam (11), opiate (9)
Rhode Island	2009	537*	Not available	Not available
Vermont	2009	93	52	Methadone (18), oxycodone (13), hydrocodone (10), morphine (10)

Source: State Medical Examiner Offices.

*Data provided by DAWN *Live!*

percent of all drug-related deaths in New Hampshire, 6 percent in Connecticut,[c] and 19 percent in Vermont. The number of opioid-related deaths that occurred in New England is likely underreported, since not all decedents are autopsied and specific drugs are not always identified in deaths involving multiple drug mentions. Moreover, a significant number of potentially fatal opioid overdoses were reversed because first responders administered Narcan.[d]

Heroin was mentioned in an increasing percentage of drug-related deaths in Connecticut from 2006 through 2009—approximately 22 percent of drug-related deaths in 2006, 23 percent in 2007, 29 percent in 2008, and 38 percent in 2009, according to the Connecticut Medical Examiner's Office.[e] The ages of the heroin-related overdose decedents ranged from 19 to 65 during 2009.

Many heroin abusers in the region are "functional abusers"—they hold jobs, have families, attend school, and participate in community events. Moreover, many abusers from the northern New England states are commonly viewed by law enforcement and public health officials as "day trippers" because they drive to the Lowell/Lawrence and Hartford/Springfield areas to purchase heroin on a daily basis. They often ingest or inject a portion of the heroin while driving back to their home state and typically sell a portion of their purchase to other abusers to defray costs associated with their addiction. Canadian law enforcement officials have reported that SWA heroin has replaced Southeast Asian heroin as the primary heroin type available in Canada. Other types of heroin may become more available in New England if the demand for heroin remains high.

Some cocaine abusers in the region have been unwittingly exposed to illicit substances, such as levamisole, used by distributors as cutting agents to stretch cocaine supplies and increase profits. (See text box on page 10.)

c. Multiple unidentified drugs were mentioned as having contributed to approximately 17 percent of the drug-related deaths reported in Connecticut during 2009.

d. Narcan (naloxone), also marketed as Nalone and Narcanti, is an injectable narcotic antagonist that immediately reverses respiratory arrest caused by a heroin or other opiate overdose.

e. The mortality percentages listed may be understated because they include only incidents in which heroin was mentioned as contributing to a drug-related death; the percentages may exclude incidents in which heroin was involved and the pathologist listed the cause of death as multiple drug toxicity.

Potential Health Risks Associated With the Abuse of Cocaine Cut With Levamisole

Public health officials in New England, some other regions of the United States, and some foreign countries are investigating the potential health consequences to patients who abused cocaine that had been cut with the diluent levamisole and were subsequently diagnosed as having agranulocytosis—a condition that destroys bone marrow, makes it difficult for a patient to fight off infections, and can be fatal because it compromises the human immune system. Levamisole, a drug initially developed to treat worm infestations in humans and animals, has been encountered as a cutting agent in some bulk and user quantities of cocaine. The New Hampshire State Police Forensic Laboratory reports that it encounters levamisole in 30 to 40 percent of the cocaine exhibits submitted for analysis. Levamisole-contaminated cocaine has also been encountered in other New England states.

Source: Bureau of Alcohol, Tobacco, Firearms and Explosives; Drug Enforcement Administration; New Hampshire State Police Forensic Laboratory; New Mexico Department of Health.

Illicit Finance

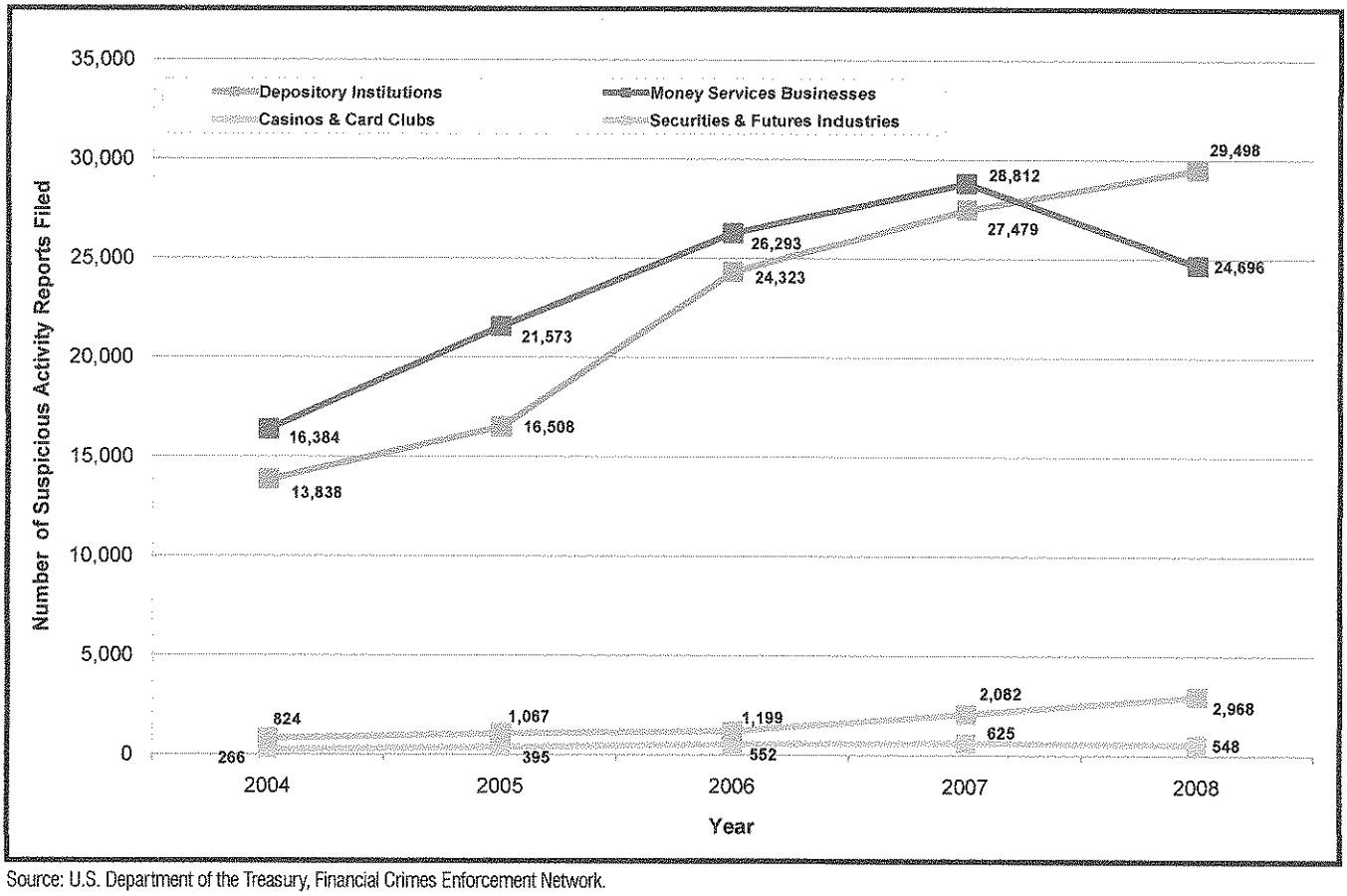
Tens of millions of dollars in illicit drug proceeds are generated in the NE HIDTA region each year. New England HIDTA initiatives seized more than $61.8 million in drugs and drug assets in 2009, including drugs valued at more than $42.1 million and more than $19.6 million in cash and other assets. Illicit drug proceeds generated in the NE HIDTA region are typically transported by traffickers through bulk cash and monetary instrument smuggling or laundered through money services businesses (MSBs), depository institutions, front companies, casinos, securities and futures instruments, and the purchase of real property and expensive consumer goods. Wholesale-level traffickers transport drug proceeds in bulk, either in the form of cash (U.S. and foreign currency) or monetary instruments, to New York City, Canada, the Dominican Republic, Mexico, and other source areas for eventual repatriation; they generally transport the proceeds in private vehicles and tractor-trailers and aboard commercial aircraft. They also ship drug proceeds through the U.S. mail and via package delivery services.

Wholesale-level traffickers operating in the HIDTA region use personal and business accounts to launder drug proceeds through depository institutions, a segment of the New England financial industry that ranked first in the number of Suspicious Activity Reports filed in the region in 2008 (the latest available data) after ranking second annually from 2004 through 2007. (See Figure 4 on page 11.)

Wholesale-level traffickers also launder drug proceeds through MSBs, typically by electronic wire transfers of funds to associates outside the HIDTA region or to domestic and international bank accounts owned by the trafficker or money brokers. Law enforcement officials seized approximately $2.4 million in U.S. currency in 46 incidents linked to New England during 2009, according to National Seizure System data. U.S. postal inspectors seized 71 parcels and nearly $1.8 million in cash that had been mailed from New England to various locations from 2007 through 2009; most of the seized currency parcels were destined for California and Puerto Rico.

Midlevel and retail traffickers operating in the region often launder proceeds by commingling them with legitimate funds generated from cash-intensive area businesses such as clothing, music, and convenience stores; restaurants; tanning and nail salons; travel agencies; and used car dealerships. Retail distributors also use drug proceeds to purchase real estate and high-value personal items such as expensive clothing, jewelry, consumer electronics products, and automobiles. In addition, drug traffickers use prepaid cards—often referred to as stored value cards—to anonymously move monies associated with all types of illicit activity. Some traffickers use unscrupulous members of the financial and legal professions to launder drug proceeds in the New England region.

Figure 4. Number of Suspicious Activity Reports Filed in New England, by Type, 2004–2008



Source: U.S. Department of the Treasury, Financial Crimes Enforcement Network.

Outlook

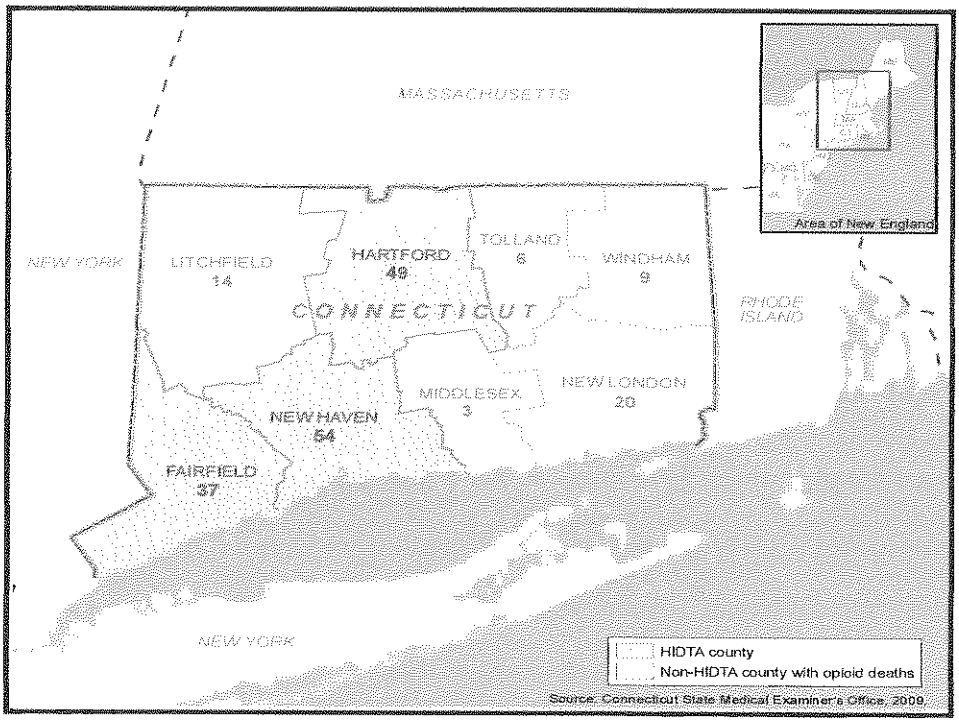
Opioid abuse will remain the primary drug threat in the NE HIDTA region over the next year. SA heroin will continue to be widely available and abused and will present a greater threat if street-level prices continue to decline. Additionally, the availability of SWA heroin in the region may increase if heroin demand escalates. The rate at which controlled prescription opioid abusers switch to heroin use will increase as more of these abusers are attracted by the lower cost and higher potency of heroin. The abuse of CPDs that are used to treat opioid addiction is expected to increase if abuse of heroin and CPDs continues to rise in New England; this situation will result in greater demand for drug treatment and other health-related services.

NDIC analysts expect that Dominican DTOs will take a more prominent role in drug trafficking in the NE HIDTA region as increased law enforcement efforts along the Southwest Border cause Colombian and Dominican DTOs to use the Caribbean corridor and the Dominican Republic as transshipment points to transport cocaine and heroin to the eastern United States.

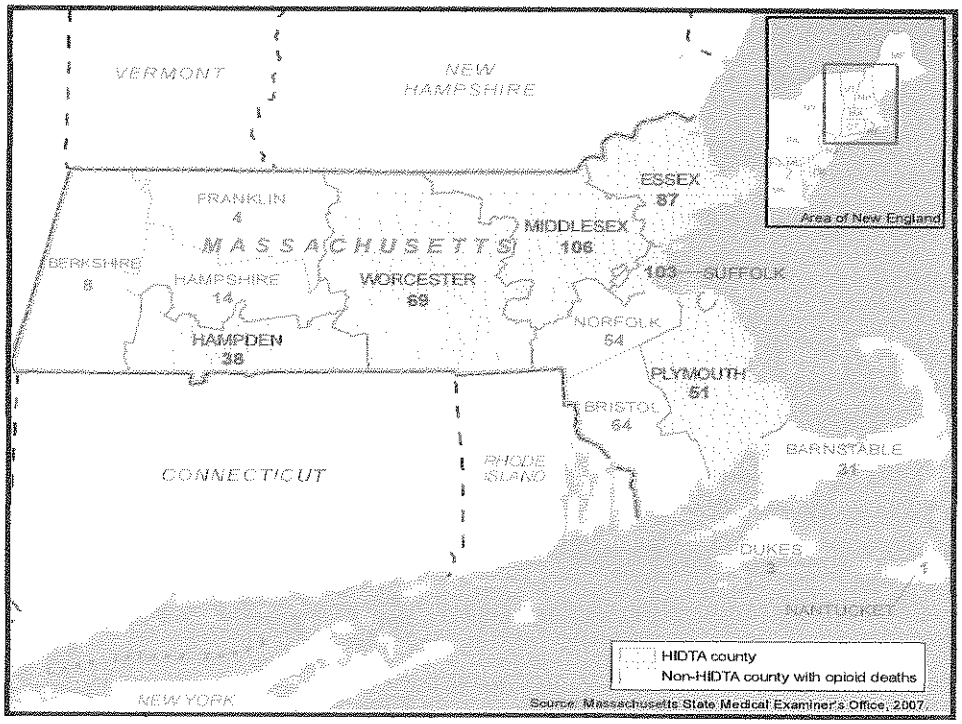
The level of violence occurring among street gangs competing for drug distribution territory in New England will escalate as gangs expand their areas of operation to suburban and rural locations. Canada-based Asian DTOs will pose a serious threat as they expand their high-potency marijuana and synthetic drug distribution networks. They will use their well-established marijuana distribution networks to introduce larger quantities of synthetic drugs, primarily MDMA and methamphetamine, into the region.

Appendix A. Maps

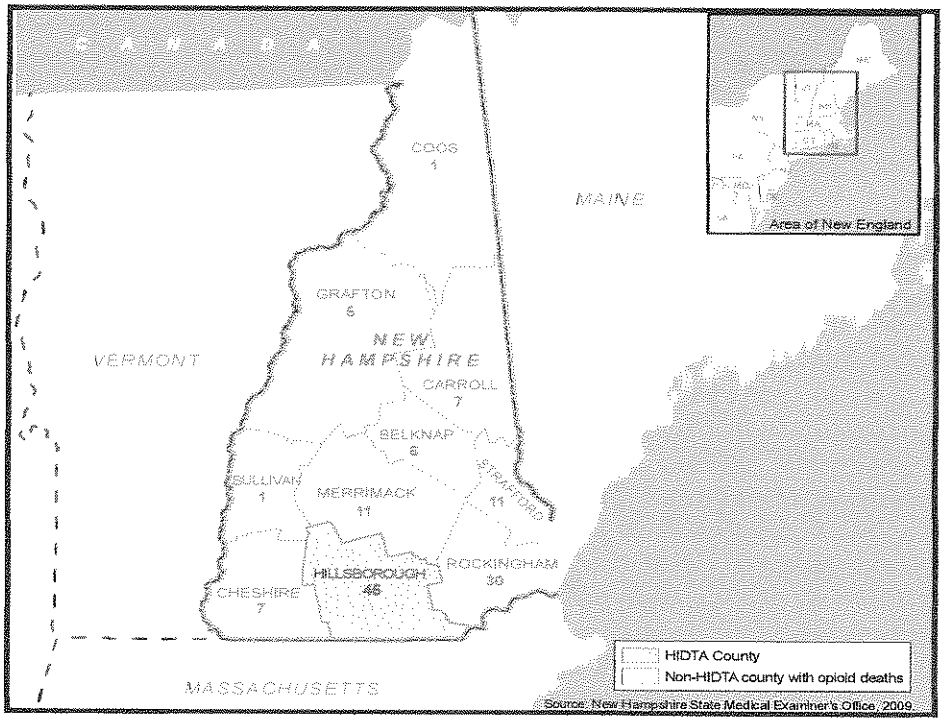
Map A1. Opioid Deaths in Connecticut, by County, 2009



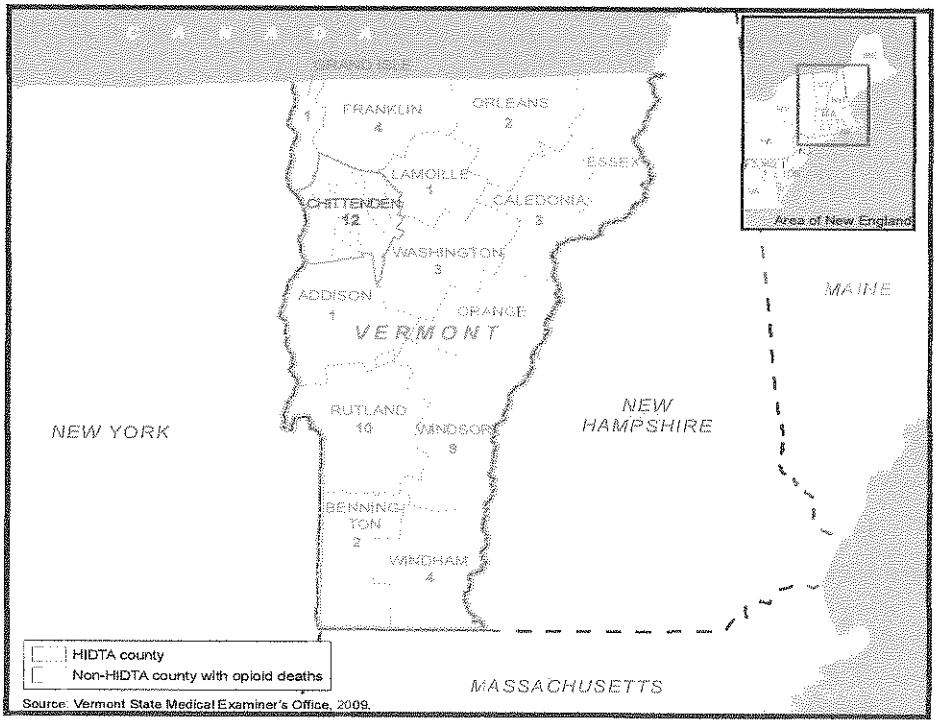
Map A2. Opioid Deaths in Massachusetts, by County, 2007



Map A3. Opioid Deaths in New Hampshire, by County, 2009



Map A4. Opioid Deaths in Vermont, by County, 2009



Sources

Local, State, and Regional

Connecticut

Bridgeport Police Department
Bristol Police Department
Connecticut Intelligence Center
East Haven Police Department
Hartford Police Department
New Britain Police Department
New Haven Police Department
Norwalk Police Department
Stamford Police Department
State of Connecticut
  Connecticut National Guard
  Connecticut State Medical Examiner
  Department of Public Safety
    Connecticut State Police
West Haven Police Department

Maine

Portland Police Department
South Portland Police Department
State of Maine
  Maine Drug Enforcement Agency
  Maine Office of Substance Abuse
  Maine State Medical Examiner
  Maine State Police
  Office of the Attorney General
  Office of the State Medical Examiner

Massachusetts

Auburn Police Department
Brockton Police Department
Chelsea Police Department
City of Boston
  Centers for Youth and Families
  Police Department
    Drug Control Unit
  Public Health Commission
Commonwealth of Massachusetts
  Department of Banking
  Department of Corrections
  Department of Public Health
    Bureau of Substance Abuse Statistics
      Office of Statistics and Evaluations
    State Medical Examiner
  Massachusetts National Guard
  Office of the Attorney General
  State Police
    Division of Investigative Services
Essex County Sheriff's Department
Fitchburg Police Department
Framingham Police Department
Holyoke Police Department
Lawrence Police Department
Lowell Police Department
Lynn Police Department
Methuen Police Department
Milford Police Department
North Andover Police Department
Southbridge Police Department
Springfield Police Department
Webster Police Department
Worcester Police Department

New Hampshire

Manchester Police Department
Nashua Police Department
State of New Hampshire
  New Hampshire Attorney General's Drug Task Force
  New Hampshire National Guard
  New Hampshire State Medical Examiner
  New Hampshire State Police

New Mexico

Department of Health

Rhode Island

Cranston Police Department
Hopkinton Police Department
Pawtucket Police Department
Providence Police Department
State of Rhode Island
  Rhode Island National Guard
  Rhode Island State Medical Examiner
  Rhode Island State Police
Warwick Police Department
Westerly Police Department
Woonsocket Police Department

Vermont

Colchester Police Department
Hartford Police Department
South Burlington Police Department
State of Vermont
  Office of the Chief Medical Examiner
  Vermont National Guard
  Vermont State Police

Regional

New England State Police Information Network
Northern New England Poison Center

Federal

Executive Office of the President
- Office of National Drug Control Policy
  - High Intensity Drug Trafficking Area
    - New England
      - Financial Task Force

U.S. Department of Commerce
- Bureau of Economic Analysis
- U.S. Census Bureau
  - American Community Survey

U.S. Department of Health and Human Services
- National Institutes of Health
  - National Institute on Drug Abuse
    - Community Epidemiology Work Group
- Substance Abuse and Mental Health Services Administration
  - Office of Applied Studies
    - Drug Abuse Warning Network
    - Treatment Episode Data Set

U.S. Department of Homeland Security
- U.S. Customs and Border Protection
  - U.S. Border Patrol
- U.S. Immigration and Customs Enforcement

U.S. Department of Justice
- Bureau of Alcohol, Tobacco, Firearms and Explosives
  - Violent Crime Impact Teams
- Drug Enforcement Administration
  - Domestic Cannabis Eradication/Suppression Program
  - Domestic Monitor Program
  - El Paso Intelligence Center
    - National Seizure System
  - New England Field Division
- Federal Bureau of Investigation
- U.S. Attorneys Offices
  - District of Connecticut
  - District of Maine
  - District of Massachusetts
  - District of New Hampshire
  - District of Rhode Island
  - District of Vermont

U.S. Department of State
U.S. Department of the Treasury
- Financial Crimes Enforcement Network

U.S. Postal Service
- U.S. Postal Inspection Service

Other

The Boston Globe
Community Substance Abuse Centers
- Director of Operations

Hartford Courant
International Law Enforcement Association
National Association of Drug Diversion Investigators
Project North Star

Questions and comments may be directed to
New England/New York/New Jersey Unit, Regional Threat Analysis Branch

National Drug Intelligence Center

319 Washington Street 5th Floor, Johnstown, PA 15901-1622 • (814) 532-4601
NDIC publications are available on the following web sites:
INTERNET www.justice.gov/ndic ADNET http://ndicosa.adnet.sgov.gov RISS ndic.riss.net
LEO https://www.leo.gov/http://leowcs.leopriv.gov/lesig/ndic/index.htm

062510

Prescription drug abuse in Danbury area is stealing lives

Danbury News Times, Published 02:03 p.m., Monday, August 16, 2010

By Nanci G. Hutson, Staff Writer

Ridgefield substance abuse therapist Liz Jorgensen is shocked that no one has hit the panic button yet over the latest drug abuse trends.

Statistics indicate prescription drug overdoses are killing nice kids from nice families in well-to-do communities all over the country.

Prescription drug use in Connecticut now kills more people under the age of 34 than car crashes, Jorgensen said, quoting a national study of figures from 2006 released this year.

Nationwide, 45,000 are killed in car crashes; 39,000 die from prescription drug overdoses, according to the study.

"Why isn't everybody freaking out?" asked Jorgensen, who owns Insight Counseling and leads educational seminars and workshops on substance abuse. "It's terrifying."

Jorgensen's professional network and private practice indicate an increasing number of teens are dying from the scourge of prescription drugs, particularly opiates that mimic heroin. She said kids do not perceive the addictive danger of these drugs.

Jorgensen said some teens get hooked on heroin when the price of narcotic painkillers gets too high.

In recent months, Jorgensen said she has sent 30 of her patients under age 22 to in-patient treatment for opiate abuse. They all started using strong painkillers and then moved toward heroin as a cheaper alternative.

One OxyContin pill -- a trademark version of the narcotic painkiller oxycodone -- costs about $80; a gram of cocaine is $50, and heroin is even cheaper at about $10 a bag, area experts said.

Jorgensen and other substance abuse specialists said opiates -- many found in bathroom cabinets and family medicine drawers -- are quite prevalent and accessible. Not only are they addictive, too often they can prove deadly when combined with other medications or alcohol.

The much-publicized death of a 17-year-old Newtown High School student, Danielle Jacobsen, just before her graduation ignited renewed concern about these troubling trends, according to area substance abuse specialists.

The investigation determined Jacobsen ingested a relatively unknown drug at a party in a Monroe condominium complex and early the next morning was found dead in a nearby pond.

Soon after news broke about Jacobsen's death, rumors started to circulate about teens who attend "pharm" parties, where unknown brands of prescription drugs are offered to guests.

Local substance abuse officials and police said they think that is relatively rare. Rather, they said, teens tend to sell or barter prescription drugs raided from family stashes, with some even stealing the drugs or altering medications they are able to buy over the counter.

"I don't think this `bowl thing' is exactly what it looks like," said Allison Fulton, executive director of the Housatonic Valley Coalition Against Substance Abuse. "But prescription drugs are out there.

Students don't just abuse narcotic painkillers, Fulton said.

She said she regularly hears of teens and young adults abusing attention deficit disorder and anti-anxiety drugs, as well as taking over-the-counter cough medications in higher doses than advised.

Cocaine is making a resurgence in some of the wealthier towns, and heroin use is clearly on the rise and readily available, she said.

Fulton also is highly concerned about underage drinking and marijuana use. She and others said that often is the beginning of drug exploration by teens and young adults. If not stopped early it can fuel addictions that lead them crave other drugs.

"It's pretty scary," Fulton said.

Newtown Parent Connection co-founder Dorrie Carolan said the availability of prescription drugs is cause for concern. In recent months, she has received calls about overdosing teens who ended up in emergency rooms and some in relapse after a period of sobriety.

Teens most vulnerable to these drugs tend to be those with lower self-esteem who are yearning for peer acceptance or approval, Carolan said.

"When they are high, they feel good," she said.

As for the cult or rare, drugs, Carolan said she doesn't hear much about that. Rather, it is opiates, prescription narcotics and heroin. She also hears from teens about marijuana experimentation, and the pot teens smoke today is far more potent than what their parents might have tried years ago.

Most disturbing, though, is teens mixing drugs and alcohol, she said.

"They all think they are invincible, nothing's going to happen," Carolan said, noting she has attended far too many funerals of teenagers whose friends' final goodbye is a night of drinking and drugging. "When there's a death, it raises awareness, but two weeks later everyone goes back to their day-to-day routines."

Some overdose deaths go unreported as such, deemed accidental or linked to some other health ailment, local specialists said. Families fear the stigma, so they stay silent.

But Carolan, a mother who helped create the coalition in 1999 as a response to the prescription drug overdose of her 28-year-old son, Brian, chooses to fight back by educating all those who can make a difference: parents, teachers, doctors, social service providers and their peers.

The coalition wants to ensure that addicted teens and their families find the right treatment the first time or for a relapse; embrace the success of a recently sober teen; and educate the entire community on prevention techniques and why this problem can affect everyone.

Carolan said teen drug abuse hurts senior citizens when they cross paths with an impaired driver; it hurts the unsuspecting student who shares the locker next to someone dealing drugs or the neighbor whose house is burglarized by someone looking for prescription medications.

"When we started Parent Connection, we figured it would be worth it if we saved one life. And we have seen many, many kids stay clean for years, and some of those kids have given a lot back to their community," Carolan said.

But the effort to halt drug abuse requires constant community vigilance, Carolan and others said.

Parents, schools, law enforcement, the medical profession, civic leaders, and the media need to be banging the drum about the realities so the danger is clear and easy access diminishes, the local experts said.

"What needs to happen is a whole culture shift," Fulton said, citing the success of the decades-long anti-smoking campaign that taught the public its health risks.

"We can't be Pollyanna about it. We have to create real awareness about what is going on ... and get kids to be more informed," Fulton said.

Attachment J

Admissions by Town of Client Origin, 2010

Mountainside Treatment Center
2011 Admissions by Connecticut Town

CT	Town	Admission
	Andover	1
	Avon	5
	Bantam	2
	Bethany	2
	Bethel	4
	Bethlehem	1
	Bloomfield	3
	Bozrah	1
	Branford	3
	Bridgeport	7
	Bristol	5
	Brookfield	4
	Canaan	6
	Canton	3
	Canton Center	1
	Cheshire	11
	Colbalt	1
	Colchester	2
	Colebrook	2
	Cos Cobb	3
	Cromwell	3
	Danbury	11
	Darien	6
	Deep River	1
	Durham	1
	E. Hartford	5
	E. Windsor	1
	East Granby	1
	Enfield	8
	Fairfield	10
	Farmington	5
	Gales Ferry	1
	Glastonbury	4
	Granby	1
	Greenwich	7
	Griswold	1
	Guilford	5
	Haddam	3
	Hamden	2
	Hartford	6
	Harwinton	3
	Hebron	1
	Ivoryton	1

CT	Town	Admission
	Ledyard	2
	Litchfield	6
	Madison	3
	Manchester	5
	Marlborough	2
	Middletown	6
	Milford	6
	Monroe	4
	Mystic	3
	Naugatuck	3
	New Britain	2
	New Canaan	5
	New Hartford	2
	New Haven	9
	New London	4
	New Milford	4
	Newington	3
	Newtown	1
	Niantic	3
	Norfolk	3
	North Branford	1
	Northfield	1
	Norwalk	7
	Norwich	3
	Oakville	1
	Old Lyme	2
	Old saybrook	4
	Oxford	3
	Plantsville	1
	Portland	4
	Prospect	2
	Ridgefield	4
	Rocky Hill	2
	Salisbury	2
	Sandy Hook	2
	Sharon	3
	Shelton	6
	Somers	2
	South Glastonburry	1
	South Windsor	1
	Southbury	3
	Southington	4
	Storrs	2
	Stratford	3
	Suffield	1
	Terryville	2

CT

Town	Admission
Thomaston	2
Tolland	1
Torrington	9
Trumbull	1
Uncasville	2
Wallingford	3
Waterbury	6
Waterford	1
Weathersfield	2
west Granby	1
West Hartford	5
Westbrook	2
Weston	3
Westport	3
Wethersfield	3
Wilton	3
Winsted	5
Wolcott	3
Woodbury	4
	356

Attachment K

Curriculum Vitae

MOUNTAINSIDE

TERENCE R. DOUGHERTY
President and CEO
Mountainside Treatment Center
Canaan, CT 06018
terence.dougherty@mountainside.com

Mr. Dougherty has some fifteen years of experience in the addiction treatment field, having been a co-founder of Mountainside Treatment Center, where he holds the positions of President and Chief Executive Officer.

In 1995, Mr. Dougherty formed a Connecticut corporation to start a new alcohol and drug treatment center in Canaan, Connecticut. The founders took title to the former Parkside Lodge in 1997, and the center was licensed and opened in February 1988. Mountainside had a change of ownership in October 2009, and Mr. Dougherty was retained as President and CEO. In its almost fourteen years of operating, more than 6,000 people have come through its doors for treatment.

It was the goal of Mountainside's founders that the center provide innovative and individualized treatment. It has incorporated many new treatment modalities to support its evidence based program; its holistic program is viewed as one of the most innovative and effective holistic programs in the treatment field. Mountainside's treatment program wins widespread acclaim throughout the treatment field.

Mr. Dougherty is regularly invited to speak at treatment industry conferences and forums in this country and overseas about Mountainside's unique and innovative treatment program.

He is a member of the National Association of Addiction Treatment Providers and serves on the Drugs and the Law Committee of The Association of the Bar of the City of New York. He is a member of the Board of Directors of the National Council on Alcohol and Drug Addiction in Westchester County, New York.

Prior to starting Mountainside, he held various positions with companies in New York City. He holds a BA from St. John's University.

Martin Fedor
Chief Operating Officer
Mountainside Treatment Center
Canaan, CT 06018

Mr. Fedor has significant industry experience (+10 years) and has held other executive roles including Chief Financial Officer. Apart from managing the growth and operations at Mountainside, Martin is a Managing Director at Artemis Partners.

Martin received his BS from Fordham University where he majored in Economics and graduated with high honors. Afterward Martin received his Master in Business with a concentration in Finance from Columbia School of Business where he graduated with high honors and is a member of the Hermes Society and Beta Gamma Sigma honors society.

MOUNTAINSIDE

NANCY TREVOR, MS, APRN
Nurse Practitioner
Mountainside Treatment Center
Canaan, CT 06018
nancy.trevor@mountainside.com

Ms. Trevor is a Certified Adult Psychiatric Nurse Practitioner, Certified Clinical Nurse Specialist in Adult Psychiatry and Certified Addictions Nurse-Advanced Practice.

Ms. Trevor has worked as a charge nurse at The University of Connecticut inpatient psychiatry unit, as an outpatient clinician in the Latino Program at MidState Medical Center and as Manager of the inpatient psychiatric unit at MidState Hospital in Meriden, CT. She was Director of Nursing at Alliance Treatment Center in Avon, CT for both Detox and Residential Services. She also provided psychiatric medication management for the IOP Program at Alliance Treatment Center.

Ms. Trevor has been at Mountainside Treatment Center for five years as an Advanced Practice Psychiatric Nurse. Her responsibilities include monitoring for detox needs of newly admitted clients, medication management, referrals to outside providers when necessary and supervising staff members involved in nursing needs and medication management.

Ms. Trevor received her BA in Psychology from Mount Holyoke College and her MS in Nursing at Vanderbilt University where she was inducted as a member of Sigma Theta Tau, the international honor society of nursing. She is currently a member of Sigma Theta Tau, The American Psychiatric Nurses Association and The International Nurses' Society of Addictions.

Fred Keane, LCSW
Clinical Director
Mountainside Treatment Center
Canaan, CT 06018
fred.keane@mountainside.com

Fred Keane, LCSW, is primarily responsible for management and oversight of the Clinical Counseling Team, as well as the integration of Family Wellness, Continuing Care, MBS, and ABC into individualized Client Treatment Plans. He is also engaged in program development initiatives, trainings, in-services, medical records maintenance and compliance related issues. He has overall responsibility for Mountainside's evidence based treatment program and incorporating into our program other treatment components such as our Holistic Program.

Mr. Keane is currently engaged in the planning of the addition to Mountainside's services of Residential Detoxification and Evaluation.

Prior to joining Mountainside, Mr. Keane worked in a variety of clinical case management and supervisory capacities in the field of substance abuse. He served as Program Director of the 31 bed Detox Unit at Arms Acres Treatment Center in Carmel, NY. While there he worked in close collaboration with the Nursing and Medical staff to provide truly collaborative care and assure that all standards and practices of care were met.

Among his achievements, he integrated elements of trauma informed care and dual diagnosis into treatment planning and program development as well as other relative evidence based practices. He has presented at several conferences on these topics.

Mr. Keane is a graduate of Colgate University and Fordham University Graduate School of Social Services. He has been an Adjunct Professor and faculty advisor at Fordham Graduate School of Social Services since 2009 where he has taught the elective course on Practice with Substance Abuse.

Attachment L

Department of Public Health License

STATE OF CONNECTICUT

Department of Public Health

License No. 0388

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

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

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

Mountainside Treatment Center is located at 187 South Canaan Rd., Rte 7, Canaan, CT 06018 with:

Timothy J. Walsh as Executive Director

The maximum number of beds shall not exceed at any time:

62 Intermediate and Long Term Treatment and Rehabilitation Beds

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

Intermediate and Long Term Treatment and Rehabilitation
Day and Evening Treatment
Outpatient Treatment

This license expires **September 30, 2013** and may be revoked for cause at any time.

Dated at Hartford, Connecticut, October 1, 2011. RENEWAL.

Jewel Mullen, MD, MPH, MPA
Commissioner

Attachment M

Audited Financial Statements

MCI HEALTHCARE, LLC.

FINANCIAL STATEMENTS
FOR THE YEAR ENDED
DECEMBER 31, 2010
AND INDEPENDENT AUDITORS' REPORT

MC1 HEALTHCARE, LLC

TABLE OF CONTENTS

December 31, 2010

Carl J. Bagge, CPA
Joseph N. Cennamo, CPA
Kenneth P. Pascoe, CPA

BAGGE, CENNAMO & PASCOE LLP
Certified Public Accountants and Consultants

66 Maple Avenue
Windsor, CT 06095
860-298-9815 telephone
860-298-9498 fax
advisors@bcp-cpas.com email

INDEPENDENT AUDITORS' REPORT

The Member
MC1 Healthcare, LLC
Route 7, Box 717
Canaan, CT 06018

We have audited the accompanying balance sheet of MC1 Healthcare, LLC as of December 31, 2010 and the related statements of income, changes in member's equity, and cash flows for the year then ended. These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these financial statements based on our audit.

We conducted our audit in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audit provides a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of MC1 Healthcare, LLC as of December 31, 2010, and the results of its operations and its cash flows for the year then ended in conformity with accounting principles generally accepted in the United States of America.

Bagge, Cennamo & Pascoe, LLP

BAGGE, CENNAMO & PASCOE LLP
Certified Public Accountants

November 18, 2011

MC1 HEALTHCARE, LLC

BALANCE SHEET
DECEMBER 31, 2010

ASSETS

Current Assets:	
Cash and Cash Equivalents	$ 46,907
Accounts Receivable - net	228,133
Employee Advances	5,974
Inventory	27,500
Due from Limestone, LLC	51,329
Prepaid Expenses and Other Assets	5,753
Total Current Assets	365,596
Property and Equipment:	
Leasehold Improvements	17,534
Vehicles	40,268
Equipment and Furniture	519,905
Less: Accumulated Depreciation	(79,853)
Net Property and Equipment	497,854
Other Assets:	
Start up Costs, Net of Amortization	5,370
Total Other Assets	5,370
TOTAL ASSETS	$ 868,820

LIABILITIES AND MEMBER'S EQUITY

Current Liabilities:	
Accounts Payable	$ 34,656
Advance Payments	91,683
Line of Credit Payable	168,000
Vehicle Notes Payable - Current Portion	11,727
Due to Related Parties	216,000
Total Current Liabilities	522,066
Long-Term Liabilities	
Vehicle Notes Payable	22,992
Less Current portion	(11,727)
Total Long-Term Liabilities	11,265
Member's Equity	335,489
TOTAL LIABILITIES AND MEMBER'S EQUITY	$ 868,820

See notes to financial statements

MC1 HEALTHCARE, LLC

STATEMENT OF INCOME
AND CHANGES IN MEMBER'S EQUITY
FOR THE YEAR ENDED DECEMBER 31, 2010

Revenue		
Resident Revenue	$	6,503,162
Total Revenue		6,503,162
Operating Expenses		
Salaries		2,578,583
Payroll Taxes		223,538
Workers Compensation Insurance		48,536
Health Insurance		298,458
Staff Expenses		6,037
Payroll Service		27,380
Food		198,518
Contract Labor		112,665
Bank Fees		118,158
Professional Fees		84,657
Rent Expense		480,000
Utilities, Telephone & Cable		172,298
General Insurance		88,037
Maintenance		223,681
Leased Equipment and Laundry		42,312
Dues, Subscriptions and Miscellaneous		23,446
Auto Expense		54,224
Donations		13,895
Program Expense		165,072
Security		72,485
Office Expenses		142,844
Events		10,877
Marketing		175,710
Travel and Entertainment		3,792
Management Fee		576,000
Depreciation Expense		58,668
Amortization Expense		390
Interest Expense		3,095
Total Operating Expenses		6,003,356
Net Income		499,806
Members Equity (Deficit) -Beginning of Year		(164,317)
Members Equity - End of Year	$	335,489

See notes to financial statements

MC1 HEALTHCARE, LLC

STATEMENT OF CASH FLOWS

FOR THE YEAR ENDED DECEMBER 31, 2010

Cash Flows From Operating Activities:		
Net Income	$	499,806
Adjustments To Reconcile Change In Net Assets		
To Net Cash Provided By Operating Activities:		
Depreciation		58,668
Amortization		390
(Increase) Decrease in Accounts Receivable		(205,933)
(Increase) Decrease in Employee Advances		1,352
(Increase) Decrease in Prepaid Expenses		(5,753)
Increase (Decrease) in Advanced Payments		91,683
Increase (Decrease) in Deferred Revenue		(124,200)
Increase (Decrease) in Accounts Payable		1,424
Increase in Due to Related Parties		84,500
Net Cash Provided By Operating Activities		401,937
Cash Flows From Investing Activities:		
Purchase of Equipment and Improvements		(286,774)
Net Cash Used in Investing Activities		(286,774)
Cash Flows From Financing Activities:		
Proceeds From Line of Credit		193,000
Repayments on Line of Credit		(265,000)
Principal Payments on Notes Payable		(12,650)
Net Cash Used By Financing Activities		(84,650)
Net Increase in Cash and Cash Equivalents		30,513
Cash and Cash Equivalents at Beginning of Year		16,394
Cash and Cash Equivalents at End of Year	$	46,907
Supplemental Information:		
Cash Paid for Interest	$	3,095
Cash Paid for Taxes		-

See notes to financial statements

MC1 HEALTHCARE, LLC
Notes to Financial Statements
For The Year Ended December 31, 2010

1. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Nature of Business

MC1 Healthcare, LLC. (The Company) is a leading provider of substance abuse treatment services in the United States. The Company is organized as a limited liability company (LLC) in the state of Connecticut.

Basis of Accounting

The accompanying financial statements have been prepared on the accrual basis of accounting.

Inventory

Inventory is recorded at cost, determined on a first-in, first-out (FIFO) basis and consists of food and supplies used for resident dining facilities.

Estimates

The preparation of financial statements in conformity with Generally Accepted Accounting Principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and reporting period. Accordingly, actual results could differ from those estimates.

Property and Equipment

Property and equipment of the Company is stated at cost. Expenditures for major renewals and betterments, which extend the useful lives of property and equipment, are capitalized; expenditures for maintenance and repairs are charged to expense as incurred. Upon the sale of depreciable property and equipment, the costs and the related accumulated depreciation are removed from the accounts; any gain or loss on disposition is reflected in net income in the year of realization.

Depreciation expense for the year was $58,668. Depreciation is computed using the straight-line method for assets over their estimated useful lives as follows:

Furniture & Fixtures	5-10 years
Building improvements	10 years
Computer equipment and software	3-5 years
Motor vehicles	5 years

1. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Continued)

Recognition of Revenue

The Company uses the accrual basis of accounting. The accrual basis of accounting provides for the recognition of revenue when earned, and expenses when incurred rather than when collected or paid.

Accounts Receivable

The Company carries its accounts receivable at cost less an allowance for doubtful accounts. On a periodic basis, the Company evaluates its accounts receivable and establishes an allowance for doubtful accounts, when deemed necessary, based on its history of past write-offs and collections and current credit conditions. At December 31, 2010, the allowance for doubtful accounts totaled $31,950.

Advertising Costs

Advertising costs are expensed as incurred. Advertising expense for the year ended December 31, 2010 was $102,617.

Income Taxes

The Company is an LLC which is a non-taxable entity. In lieu of income taxes, the owners of an LLC are taxed on the Company's taxable income. Therefore, no provision or liability for federal and state income taxes has been included in these financial statements.

The Company files income tax returns in the U.S. federal jurisdiction and the state of Connecticut. The 2010 and 2009 income tax returns are subject to U.S. federal and state income tax examinations by tax authorities.

Statement of Cash Flows

For purposes of the statement of cash flows, the Company considers all highly liquid securities purchased with a three month or less to be cash equivalents.

Concentration of Credit Risk

The Company maintains its cash and cash equivalents in bank deposit accounts that, at times, may exceed federally insured depository limits. The Company has not experienced any losses in such accounts and believes it is not exposed to any significant credit risk.

2. RELATED PARTY TRANSACTIONS AND BALANCES

The Company leases real property from Limestone Partners, LLC, a related entity by virtue of common ownership. The lease, dated October 1, 2009 expires on September 30, 2014, and stipulates monthly rental amounts of $40,000 with periodic increases. Rental expense amounted to $480,000 for the year ended December 31, 2010. The lease agreement allows for three extensions at five years each, and was increased to $50,000 per month effective January 1, 2011 and to $150,000 effective August 1, 2011.

Future obligations relating to the above lease are:

2011.....	$ 1,100,000
2012.....	1,800,000
2013.....	1,800,000
2014.....	1,350,000
Total.....	$ 6,050,000

The Company also paid a monthly management fee of $48,000 during 2010 to Artemis Partners, LLC, the sole member of the Company. Management fees totaled $576,000 for the year.

The Company had the following balances due from and to related parties as of December 31, 2010:

Due From Limestone Partners, LLC	$	51,329
Due To Artemis Partners, LLC	$	216,000

There are no formal repayment terms for these amounts and no interest associated with this balance. These amounts have been repaid during 2011.

3. PENSION PLANS

The Company has instituted a 401(k) profit sharing plan which covers all employees who are 18 years of age with 1,000 hours of service, and who are not covered by collective bargaining agreements. The plan has no provision for Company matching contributions.

4. NOTES PAYABLE AND LONG-TERM DEBT

Notes payable and long-term debt consists of the following:

The Company has a revolving line of credit with a bank which is secured by real and personal property of Limestone Partners, LLC and guaranteed by Artemis Partners, LLC. The line had a limit of $250,000 as of December 31, 2010 which was increase to $350,000 on January 31, 2011 upon renewal. The line is payable upon demand and monthly interest payments are due at the banks prime rate plus 1.75% with a floor of 5%. The line has a provision which requires that the outstanding principal balance be paid down to a maximum of $100 for 30 consecutive days annually...	$	168,000
Installment notes due in amounts of $551 and $426 including interest of 0% and 1.9% through May 2013, secured by vehicles		22,992
Total		190,992
Less: Current portion		179,727
Long-term debt	$	11,265

Maturities on long-term debt are as follows:

2012	$	8,508
2013		2,757
Long-term debt	$	11,265

5. CLAIMS AND CONTINGENCIES.

The Company, from time to time, has miscellaneous claims and lawsuits arising from the ordinary course of business. Management believes that such proceedings in the aggregate are within the limits of the Company's liability insurance policies, and therefore, will not have a materially adverse effect on the Company's financial position. No other known contingencies exist which, in the opinion of management, will have a materially adverse effect upon the Company's financial position or operating results.

6. SUBSEQUENT EVENTS

The Company has evaluated subsequent events through November 18, 2011, the date which the financial statements were available to be issued.

Attachment N

Bank of America Letter

Bank of America

November 15, 2011

Mr. Martin Fedor
MC1 Healthcare d/b/a Mountainside Treatment Center
187 South Canaan Road
Canaan, CT 06018

RE: APPLICATION TO OFFICE OF HEALTH CARE ACCESS FOR CERTIFICATE OF NEED
MC1 HEALTHCARE LLC d/b/a MOUNTAINSIDE TREATMENT CENTER

Dear Mr. Fedor,

This letter is offered to be shared with the State of Connecticut Office of Health Care Access with respect to the application of MC1 Healthcare d/b/a Mountainside Treatment Center for approval of its Certificate of Need.

Bank of America is pleased to have provided conditional approval for financing to construct a 34,000 square foot detoxification program facility at approximating a total expense of $10 million. We look forward to supporting the programs and operations of Mountainside Treatment Center and its affiliates.

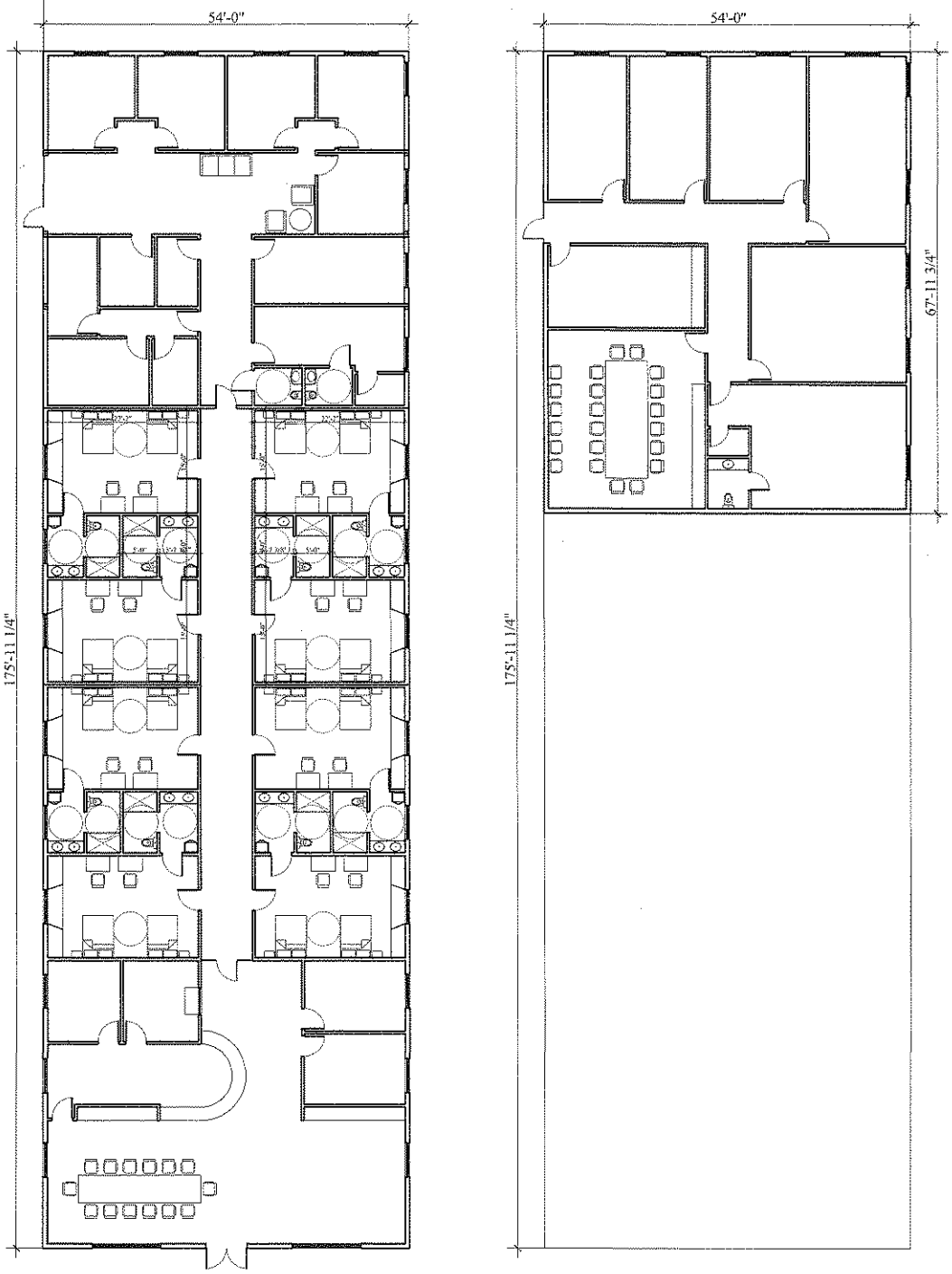
Please contact me with any questions.

Sincerely,

Jonathan B. Dayton
Senior Vice President

Attachment O

Proposed Floor Plan



FIRST FLOOR

SECOND FLOOR

Drawn by: Bernard Toni

Scott Koniecko, A.I.A.
80 Eighth Avenue, Suite 1600
New York, NY 10011

Mountainside
North Canaan - Connecticut
Detox Wing

June 30, 2011
Scale: 1/16" = 1'-0"
Job No. 1105

SKA-16

Attachment P

Financial Attachment I & Assumptions

Mountainside Treatment Center: Increase in Bed Capacity of 16 Beds (Residential Detoxification)

13. B i. Please provide one year of actual results and three years of projections of **Total Facility** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

Total Facility: Description	FY Actual Results	FY 2012 Projected W/out CON	FY 2012 Projected Incremental	FY 2012 Projected With CON	FY 2013 Projected W/out CON	FY 2013 Projected Incremental	FY 2013 Projected With CON	FY 2014 Projected W/out CON	FY 2014 Projected Incremental	FY 2014 Projected With CON
NET PATIENT REVENUE										
Non-Government	$10,250,000	$10,813,750	$1,728,000	$12,541,750	$11,354,438	$3,785,940	$15,140,378	$11,922,159	$4,089,750	$16,011,909
Medicare										
Medicaid and Other Medical Assistance										
Other Government										
Total Net Patient Patient Revenue	$10,250,000	$10,813,750	$1,728,000	$12,541,750	$11,354,438	$3,785,940	$15,140,378	$11,922,159	$4,089,750	$16,011,909
Other Operating Revenue										
Revenue from Operations	$10,250,000	$10,813,750	$1,728,000	$12,541,750	$11,354,438	$3,785,940	$15,140,378	$11,922,159	$4,089,750	$16,011,909
OPERATING EXPENSES										
Salaries and Fringe Benefits	$4,515,000	$4,831,050	$645,000	$5,476,050	$5,072,603	$977,274	$6,049,876	$5,427,685	$1,026,137	$6,453,822
Professional / Contracted Services	$223,497	$223,497	$85,000	$308,497	$234,672	$89,250	$323,922	$246,405	$93,713	$340,118
Supplies and Drugs	$150,000	$154,500	$125,000	$279,500	$162,225	$165,000	$327,225	$170,336	$165,000	$335,336
Bad Debts	$75,000	$77,250	$25,000	$102,250	$81,113	$50,000	$131,113	$85,168	$80,000	$165,168
Other Operating Expense	$955,449	$984,112	$265,000	$1,249,112	$1,033,318	$325,000	$1,358,318	$1,084,984	$345,000	$1,429,984
Subtotal	$5,918,946	$6,270,409	$1,145,000	$7,415,409	$6,583,929	$1,606,524	$8,190,453	$6,913,126	$1,709,850	$8,622,976
Depreciation/Amortization	$750,000	$750,000	$108,974	$858,974	$787,500	$217,948	$1,005,448	$826,875	$217,948	$1,044,823
Interest Expense	$114,408	$114,408	$297,591	$411,999	$120,128	$495,276	$615,404	$126,135	$480,830	$606,965
Lease Expense	$3,000,000	$3,300,000	$300,000	$3,600,000	$3,465,000	$1,500,000	$4,965,000	$3,638,250	$1,500,000	$5,138,250
Total Operating Expenses	$9,783,354	$10,434,817	$1,851,565	$12,286,382	$10,956,558	$3,819,748	$14,776,306	$11,504,386	$3,908,628	$15,413,014
Income (Loss) from Operations	$466,646	$378,933	($123,565)	$255,368	$397,880	($33,808)	$364,072	$417,774	$181,122	$598,896
Non-Operating Income										
Income before provision for income taxes	$466,646	$378,933	($123,565)	$255,368	$397,880	($33,808)	$364,072	$417,774	$181,122	$598,896
Provision for income taxes	$186,659	$151,573		$102,147	$159,152	($13,523)	$145,629	$167,109	$72,449	$239,558
Net Income	$279,988	$227,360	($123,565)	$153,221	$238,728	($20,285)	$218,443	$250,664	$108,673	$359,337
Retained earnings, beginning of year		$279,988			$507,348	($123,565)	$433,209	$746,075	($143,850)	$651,652
Retained earnings, end of year	$279,988	$507,348	($123,565)	$433,209	$746,075	($143,850)	$651,652	$996,740	($35,176)	$961,563
FTEs	60	62	12	74	62	13	75	62	13	75

ASSUMPTIONS:

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.

*Volume Statistics:							
Connecticut	450	450	307	450	623	450	623
Other	175	175	77	175	156	175	156
Admissions	625	625	384	625	779	625	779
Cost per treatment	16,400	17,302	4,500	18,167	4,860	19,075	5,250

Revenue - it is our assumption that the detox will be open for approximately 6 months June through January in 2012
Expenses for FY 2012
Salaries and Fringe Benefits for FY 2012 W/out reflect increase of 2 staff
Salaries and Fringe Benefits for incremental FY 2012 reflect us having to have staff on for ~8 months (.66 of annual) - at it is expected to take ~2 months to train

Supplies and Drugs for FY 2012 incremental - reflect one time load fee for supplies

Lease Expense shows YOY increase for FY 2012 W/out Con - resulting in compressed Net Income

Interest Expense for Incremental 2012 reflects 6 months debt service of ~8.2M at 6% annual - ten year amortized note
Interest Expense for Incremental 2013 reflects 12 months debt service of ~8.2M at 6% annual - ten year amortized note

Provision for Taxes - FY consolidated 2012 - shows the utilization of operating loss carryforward

Term Loan	
Term	10 years
Interest	6%
Amount	8,502,590

Attachment Q

Financial Attachment II

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: Residential Detoxification
Type of Unit Description: Admissions
# of Months in Operation: 6 months

FY 2012	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
FY Projected Incremental		Rate	Units	Gross Revenue Col. 2 * Col. 3	Allowances/ Deductions	Charity Care	Bad Debt	Net Revenue Col.4 - Col.5 -Col.6 - Col.7	Operating Expenses Col. 1 Total * Col. 4 / Col. 4 Total	Gain/(Loss) from Operations Col. 8 - Col. 9
Total Incremental Expenses:	**$1,826,565**									
Total Facility by Payer Category:										
Medicare				$0				$0	$0	$0
Medicaid		$0		$0				$0	$0	$0
CHAMPUS/TriCare		$0		$0				$0	$0	$0
Total Governmental			0	$0	$0	$0	$0	$0	$0	$0
Self Pay		$4,500	307	$1,382,400			$20,000	$1,362,400	$1,461,252	($98,852)
Commercial Insurers		$4,500	77	$345,600			$5,000	$340,600	$365,313	($24,713)
Uninsured		$0		$0				$0	$0	$0
Total NonGovernment		$0	384	1,728,000	$0	$0	25,000	1,703,000	1,826,565	(123,565)
Total All Payers		$0	384	$1,728,000	$0	$0	$25,000	$1,703,000	$1,826,565	($123,565)

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: Residential Detoxification
Type of Unit Description: Admissions
# of Months in Operation: 12 months

FY 2012 **FY Projected Incremental** Total Incremental Expenses: **$3,769,748** **Total Facility by Payer Category:**	(1)	(2) Rate	(3) Units	(4) Gross Revenue Col. 2 * Col. 3	(5) Allowances/ Deductions	(6) Charity Care	(7) Bad Debt	(8) Net Revenue Col.4 - Col.5 -Col.6 - Col.7	(9) Operating Expenses Col. 1 Total * Col. 4 / Col. 4 Total	(10) Gain/(Loss) from Operations Col. 8 - Col. 9
Medicare				$0				$0	$0	$0
Medicaid		$0		$0				$0	$0	$0
CHAMPUS/TriCare		$0		$0				$0	$0	$0
Total Governmental			0	$0	$0	$0	$0	$0	$0	$0
Self Pay		$4,860	623	$3,028,752			$40,000	$2,988,752	$3,015,798	($27,046)
Commercial Insurers		$4,860	156	$757,188			$10,000	$747,188	$753,950	($6,762)
Uninsured		$0		$0				$0	$0	$0
Total NonGovernment		$0	779	3,785,940	$0	$0	50,000	3,735,940	3,769,748	(33,808)
Total All Payers		$0	779	$3,785,940	$0	$0	$50,000	$3,735,940	$3,769,748	($33,808)

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: Residential Detoxification
Type of Unit Description: Admissions
# of Months in Operation: 12 months

FY 2012 FY Projected Incremental Total Incremental Expenses:	(1) **$3,828,628**	(2) Rate	(3) Units	(4) Gross Revenue Col. 2 * Col. 3	(5) Allowances/ Deductions	(6) Charity Care	(7) Bad Debt	(8) Net Revenue Col.4 - Col.5 -Col.6 - Col.7	(9) Operating Expenses Col. 1 Total * Col. 4 / Col. 4 Total	(10) Gain/(Loss) from Operations Col. 8 - Col. 9
Total Facility by Payer Category:										
Medicare				$0				$0	$0	$0
Medicaid		$0		$0				$0	$0	$0
CHAMPUS/TriCare		$0		$0				$0	$0	$0
Total Governmental			0	$0	$0	$0	$0	$0	$0	$0
Self Pay		$5,250	623	$3,271,800			$64,000	$3,207,800	$3,062,902	$144,898
Commercial Insurers		$5,250	156	$817,950			$16,000	$801,950	$765,726	$36,224
Uninsured		$0		$0				$0	$0	$0
Total NonGovernment		$0	779	4,089,750	$0	$0	80,000	4,009,750	3,828,628	181,122
Total All Payers		$0	779	$4,089,750	$0	$0	$80,000	$4,009,750	$3,828,628	$181,122

PAGE INTENTIONALLY LEFT BLANK

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

December 28, 2011

VIA FAX & EMAIL ONLY

Terence Dougherty
President & CEO
MCI Healthcare LLC d/b/a Mountainside Treatment Center
P.O. Box 717
Canaan, CT 06108

RE: Certificate of Need Application; Docket Number: 11-31734-CON
MCI Healthcare LLC d/b/a Mountainside Treatment Center
Increase of 16 Licensed Beds at Mountainside Treatment Center

Dear Mr. Dougherty:

On November 29, 2011, the Office of Health Care Access ("OHCA") received your initial Certificate of Need application filing on behalf of MCI Healthcare LLC d/b/a Mountainside Treatment Center ("Mountainside" or "Applicant"), for increase of 16 licensed beds at the Center to accommodate its new residential detoxification and evaluation service.

OHCA has reviewed the CON application and requests the following additional information pursuant to General Statutes §19a-639a(c):

Page 20 & Attachment C

1. Upon further research by OHCA, it appears that there are other facilities such as Southeastern Connecticut Council on Alcohol and Drug Dependence ("SCADD") in Lebanon, Community Prevention and Addiction Services ("CPAS") in Willimantic, Silver Hill Hospital in New Canaan and Connecticut Valley Hospital (Merritt Hall) in Middletown, that are offering detoxification services in Connecticut. Please explain and discuss why the Applicant did not include the aforementioned facilities.

2. Please address available capacity for similar beds at each of the facilities mentioned above.

Page 19 & Attachment B

3. It appears that majority of the letters of support submitted in this record are from out-of-state providers. Please discuss Mountainside's existing relationship with other substance abuse providers in Connecticut and if the Applicant has referral agreements with any of these in-state providers.

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 (i.e. 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 207 and reference "Docket Number: 11-31734-CON." Submit one (1) original and four (4) 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, feel free to contact me by email or at (860) 418-7069.

Sincerely,

Steven W. Lazarus
Associate Health Care Analyst

****
*** TX REPORT ***
****

TRANSMISSION OK

TX/RX NO	2721
RECIPIENT ADDRESS	918608244021
DESTINATION ID	
ST. TIME	12/28 17:23
TIME USE	00'39
PAGES SENT	3
RESULT	OK

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: Terence Dougherty

FAX: (860) 824-4021

AGENCY:

FROM: Steven Lazarus

DATE: 12/28/11 **TIME:** 4:26

NUMBER OF PAGES: 3
(including transmittal sheet

Comments: Completed Letter Enclosed.

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

31734

Jonathan Spodick, MA, LCSW
NEW ENGLAND MENTAL HEALTH LLC
762 Post Rd
Darien, CT 06820

January 11, 2012

Ms. Kimberly Martone
Director of Operations
Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS#13HCA
P.O. Box 340308
Hartford, CT 06134-0308

Re: CON Application: MC1 HEALTHCARE d/b/a Mountainside Treatment Center

Dear Ms. Martone:

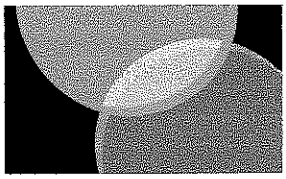
I am writing in full of the above application. I have worked closely and made many referrals to Mountainside over the past two years. Often my patients have required detox in order to start inpatient rehab and have been forced to go long distances in order to receive those services. They have out of state at times. It makes a significant difference, in my professional opinion to have the patient be in one program for their entire treatment. We refer at least five patients a year to Mountainside. There is a clear shortage of detox beds in the region and approval of this application should be expedited to help those suffering from the disease of addiction and cannot find proper care due to a shortage of beds. These 16 beds will make a significant difference to the inadequate detox system that is now in place.

Mountainside offers one of the best programs in the region and certainly use best practice, evidence based treatment. A detox program would enhance the experience not just for the patient but also for the referent.

I am happy to answer any questions, the committee may have but urge acceptance of this application as soon as possible.

Sincerely,

Jonathan Spodick, MA, LCSW
NEW ENGLAND MENTAL HEALTH
(203) 662-3232
762 Post Rd
Darien, CT 06820
jonathan@newenglandmentalhealth.com



kmb consulting, llc
OPTIMIZE YOUR HEALTH CARE PLANNING RESOURCES

January 23, 2012

Ms. Kimberly R. Martone
Director of Operations
Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS#13HCA
P.O. Box 340308
Hartford, CT 06134-0308

RE: Certificate of Need Application; Docket Number: 11-31734-CON MCI Healthcare LLC d/b/a Mountainside Treatment Center Increase of 16 Licensed Beds at Mountainside Treatment Center

Dear Ms. Martone:

Please find responses to the questions requested by the Office of Health Care Access on December 28, 2011. As per your request, an original and four (4) hard copies are provided as well as a scanned copy in an Adobe format (.pdf) on a CD.

Thank you for your time and effort in reviewing this important Certificate of Need application. Please do not hesitate to contact me at (203) 459-1601 or Terence Dougherty at (860) 824-1397 if you have any additional questions.

Sincerely,

Karen M. Banoff
Principal

Attachments

Copy to: Terence Dougherty, Mountainside Treatment Center
Steven Lazarus, OHCA

91 Old Hollow Road • Trumbull, CT 06611 • Phone/Fax: 203-459-1601 • kbanoff@kmbconsult.com

Certificate of Need Application
Docket Number: 11-31734-CON
MCI Healthcare LLC d/b/a Mountainside Treatment Center
Increase of 16 Licensed Beds at Mountainside Treatment Center

Responses to Completeness Questions

Page 20 & Attachment C

1. Upon further research by OHCA, it appears that there are other facilities such as Southeastern Connecticut Council on Alcohol and Drug Dependence ("SCADD") in Lebanon, Community Prevention and Addiction Services ("CPAS") in Willimantic, Silver Hill Hospital in New Canaan and Connecticut Valley Hospital (Merritt Hall) in Middletown, that are offering detoxification services in Connecticut. Please explain and discuss why the Applicant did not include the aforementioned facilities

   Response
   In response to OHCA's CON question requesting information about other residential detoxification providers, a listing was initially requested from DPH's Facility Licensing & Investigations Section to identify residential detoxification facilities in Connecticut. The original listing from DPH is included as Attachment I. DPH was unable to identify substance abuse providers that provided specifically residential detoxification, but indicated that those included on the listing with bed counts should be contacted regarding residential detoxification services. This original listing did not include any of the facilities listed above and therefore they were inadvertently not included in the original CON submission.

   Each of the facilities listed above has been contacted to confirm that they do offer residential detoxification and their present bed availability. The results are noted below.

Facility	Beds	Availability on 1/5/12
CPAS	6	None
CT Valley Hospital (Merritt Hall)	20	None
SCADD Detox	20	2
Silver Hill Hospital	18	None, possibly 1 at night

   It is clear from this information that although these are additional residential detoxification providers, their beds are highly utilized and they have minimal bed availability.

2. Please address available capacity for similar beds at each of the facilities mentioned above.

   Response
   See response to Question 1 above.

Page 19 & Attachment B

3. It appears that majority of the letters of support submitted in this record are from out-of-state providers. Please discuss Mountainside's existing relationship with other substance abuse providers in Connecticut and if the Applicant has referral agreements with any of these in-state providers.

Response

Mountainside has served thousands of Connecticut residents who have struggled with substance abuse and remains committed to meeting the substance abuse treatment needs of Connecticut residents. Mountainside has long standing relationships with many substance abuse providers in Connecticut. There are almost 30 individuals and/or organizations in Connecticut, who routinely refer clients to Mountainside. They are listed below:

- **Bridgeport Hospital**
- **Bristol Hospital**
- **Camille M. Bertram Consultants**
- **Charlotte Hungerford Hospital**
- **Connecticut Therapy Associates**
- **Dwenger, Randall,MD**
- **Fairfield Counseling Services**
- **Fairfield University**
- **Farrell Treatment**
- **First Step**
- **Gallant & Associates**
- **Gary Alger**
- **Gatter, Dori, L PsyD, LPC**
- **Greenwich Hospital**
- **Griffin, Raymond, A. Ph D**
- **HAVEN**
- **Jacobs, Allen MD**
- **Mohegan Indian Tribe**
- **New Direction, The**
- **Newtown Parent Connection**
- **Positive Directions**
- **Regional Network of Programs, Inc.**
- **Sharon Hospital**
- **Silver Hill Hospital**
- **Stonington Institute**
- **Turning Point**
- **Waynik Group, The**
- **Yale-New Haven Psychiatric Hospital**

Mountainside does not have any formal (i.e. written) referral agreements with any other substance abuse providers, just long-standing relationships. Additional letters of support from Connecticut providers have been included in Attachment II or have been mailed to OHCA directly.

Attachment I – Substance Abuse Provider Listing from DPH

July 2011 to November 2011 Substance abuse fac from DPH_2

CT DEPT OF PUBLIC HEALTH LISTING OF SUBSTANCE ABUSE PROVIDERS WITH BEDS							
NAME	PHONE	FAX	ADDR1	TOWN	STATE	ZIP	BEDS
CATHOLIC CHARITIES, INC.	(203)7357481	(203)7355021	205 WAKELEE AVENUE	ANSONIA	CT	06401	0
BIRMINGHAM GROUP HEALTH SERVICES CLINIC	(203)7362601	(203)7368597	435 EAST MAIN STREET	ANSONIA	CT	06401	0
ANSONIA COUNSELING SERVICES	(203)5033577	(203)5033659	121 WAKELEE AVENUE	ANSONIA	CT	06401	0
ANGELUS HOUSE	(203)2668080	(203)2668030	158 FLANDERS ROAD	BETHLEHEM	CT	06751	0
NORTH CENTRAL COUNSELING SERVICES	(860)2436584	(860)2436591	693 BLOOMFIELD AVE	BLOOMFIELD	CT	06002	0
HARBOR HEALTH	(203)4832650	(203)4832644	14 SYCAMORE WAY	BRANFORD	CT	06405	0
FIRST STEP	(203)4161950	(203)4161919	425 GRANT ST	BRIDGEPORT	CT	06610	19
CONNECTICUT RENAISSANCE, INC.	(203)3689755	(203)3689760	115 MIDDLE STREET	BRIDGEPORT	CT	06604	0
NEW PROSPECTS	(203)6106252	(203)6106332	392 PROSPECT ST	BRIDGEPORT	CT	06604	23
SOUTHWEST COMMUNITY HEALTH CENTER, INC.	(203)3306000	(203)3821436	968 FAIRFIELD AVENUE	BRIDGEPORT	CT	06605	0
CONNECTICUT RENAISSANCE, INC.	(203)3311503	(203)3311504	1 LAFAYETTE SQUARE	BRIDGEPORT	CT	06604	0
RECOVERY ADOLESCENT PROGRAM	(203)3334105	(203)3314740	1549 FAIRFIELD AVENUI	BRIDGEPORT	CT	06605	0
LIBERATION METHADONE CLINIC (BRIDGEPORT)	(203)3849301	(203)3364395	399 MILL HILL AVENUE	BRIDGEPORT	CT	06610	0
CONNECTICUT RENAISSANCE, INC.	(203)3677570	(203)3677571	1120 MAIN STREET	BRIDGEPORT	CT	06604	0
NEW ERA REHABILITATION CENTER, INC.	(203)3723333	(203)3747515	3851 MAIN STREET	BRIDGEPORT	CT	06606	0
SOUTHWEST COMMUNITY HEALTH CENTER, INC./OUTPATIENT TREATMENT	(203)3306054	(203)3314716	1046 FAIRFIELD AVENUE	BRIDGEPORT	CT	06604	0
CHILD GUIDANCE CENTER OF GREATER BRIDGEPORT, INC.	(203)3946529	(203)3946534	180 FAIRFIELD AVENUE	BRIDGEPORT	CT	06604	0
CASA EUGENIO MARIA DE HOSTOS	(203)3394112	(203)3394115	690 ARCTIC STREET	BRIDGEPORT	CT	06608	16
HORIZONS	(203)3333518	(203)3825589	1635 FAIRFIELD AVE	BRIDGEPORT	CT	06605	15
KINSELLA TREATMENT CENTER	(203)3352173	(203)3330754	1438 PARK AVENUE	BRIDGEPORT	CT	06604	0
RECOVERY COUNSELING SERVICES	(203)3665817	(203)3946790	480 BOND STREET	BRIDGEPORT	CT	06610	0
PROJECT COURAGE	(203)3394777	(203)3394110	592 KOSSUTH STREET	BRIDGEPORT	CT	06608	0
APT RESIDENTIAL SERVICES	(203)3279943	(203)3379986	425 GRANT STREET	BRIDGEPORT	CT	06608	125
COMMUNITY MENTAL HEALTH AFFILIATES, INC.	(860)5839954	(860)5856811	81 NORTH MAIN STREET	BRISTOL	CT	06010	0
HARTFORD DISPENSARY-BRISTOL CLINIC	(860)5896433	(860)5896442	1098 FARMINGTON AVE	BRISTOL	CT	06010	0
UNITED COMMUNITY AND FAMILY SERVICES	(860)5377676	(860)5377679	212 UPTON ROAD	COLCHESTER	CT	06415	0
UNITED SERVICES, INC.	(860)2284480	(860)2286921	233 ROUTE 6	COLUMBIA	CT	06237	0
TRAVISANO NETWORK	(203)7941975	(203)7941967	24 SHELTER ROCK RD	DANBURY	CT	06810	0
CONNECTICUT COUNSELING CENTERS, INC	(203)7434698	(203)7437393	60 BEAVER BROOK ROA	DANBURY	CT	06810	0
MCCA	(203)7924515	(203)7482604	38 OLD RIDGEBURY RO	DANBURY	CT	06810	30
NORTH CENTRAL COUNSELING SERVICES	(860)2535020	(860)2535030	153 HAZARD AVE	ENFIELD	CT	06082	0
NEW DIRECTIONS, INC. OF NORTH CENTRAL CONNECTICUT	(860)7413001	(860)7418332	113 ELM STREET	ENFIELD	CT	06082	0
CHILD & FAMILY AGENCY OF SOUTHEASTERN CONNECTICUT, INC. CHILD GUIDANCE CLINIC ESSEX	(860)7670147	(860)7670148	190 WESTBROOK ROAD	ESSEX	CT	06426	0
FAIRFIELD COUNSELING SERVICES, INC.	(203)2555777	(203)2599673	125 PENFIELD ROAD	FAIRFIELD	CT	06824	0
CLAYTON HOUSE	(860)6590309	(860)6591864	203 WILLIAMS ST	GLASTONBURY	CT	06033	15
RUSHFORD CENTER, INC.	(860)6578910	(860)6578912	110 NATIONAL DRIVE	GLASTONBURY	CT	06033	0
GREENWICH YOUTH OPTIONS	(203)8691349	(203)6612289	55 OLD FIELD POINT RO	GREENWICH	CT	06830	0
UNITED COMMUNITY & FAMILY SERVICES, INC.	(860)3767040	(860)3767045	70 MAIN ST	JEWETT CITY	CT	06351	0
BEHAVIORAL HEALTH SERVICES AT HAMDEN	(203)2886253	(203)2880948	95 CIRCULAR DRIVE	HAMDEN	CT	06514	0

July 2011 to November 2011 Substance abuse fac from DPH_2

NAME	PHONE	FAX	ADDR1	TOWN	STATE	ZIP	BEDS
CHILDREN'S CENTER OF HAMDEN, INC., THE	(203)2482116	(203)2879815	1400 WHITNEY AVENUE	HAMDEN	CT	06517	0
COMMUNITY RENEWAL TEAM, INC. BEHAVIORAL HEALTH	(860)2490649	(860)8956604	35 CLARK ST	HARTFORD	CT	06120	0
VILLAGE FOR FAMILIES & CHILDREN, INC.	(860)2364511	(860)2318449	105 SPRING ST	HARTFORD	CT	06105	0
COMMUNITY RENEWAL TEAM, INC BEHAVIORAL HEALTH	(860)5605632	(860)5605850	90 RETREAT AVE	HARTFORD	CT	06106	0
SALVATION ARMY ADULT REHABILITATION CENTER, THE	(860)5278106	(860)5245581	333 HOMESTEAD AVE	HARTFORD	CT	06132-0440	110
CATHOLIC CHARITIES, INC.	(860)5228241	(860)5271919	896 ASYLUM AVE	HARTFORD	CT	06105	0
HARTFORD BEHAVIORAL HEALTH	(860)7278703	(860)5482045	ONE MAIN STREET	HARTFORD	CT	06106	0
HARTFORD BEHAVIORAL HEALTH	(860)5480101	(860)5247781	2550 MAIN STREET	HARTFORD	CT	06106	0
INSTITUTE FOR THE HISPANIC FAMILY	(860)5271124	(860)7242539	45 WADSWORTH STREE	HARTFORD	CT	06106	0
HOGAR CREA WOMEN'S CENTER	(860)9517006	(860)2334733	164-166 BARTHOLOMEW	HARTFORD	CT	06106	20
COMMUNITY RENEWAL TEAM, INC. BEHAVIORAL HEALTH SERVICES	(860)7149200	(860)7148516	675 TOWER AVENUE	HARTFORD	CT	06112	0
COMMUNITY RENEWAL TEAM, INC. ASIAN FAMILY SERVICES	(860)9518770	(860)2232796	1921 PARK STREET	HARTFORD	CT	06106	0
HARTFORD DISPENSARY-16-18 WESTON STREET	(860)5275100	(860)2448017	16-18 WESTON STREET	HARTFORD	CT	06120	0
FRESH START	(860)5605805	(860)5273305	17 ESSEX STREET	HARTFORD	CT	06120	21
VILLAGE FOR FAMILIES & CHILDREN, INC.	(860)2364511	(860)2967384	331 WETHERSFIELD AV	HARTFORD	CT	06114	0
DETOXIFICATION CENTER	(860)7143701	(860)7148974	500 BLUE HILLS AVENU	HARTFORD	CT	06112	73
HARTFORD DISPENSARY/DOCTORS CLINIC	(860)5252181	(860)5257332	345 MAIN ST	HARTFORD	CT	06106	0
COMMUNITY HEALTH SERVICES, INC.	(860)2499625	(860)8081540	500 ALBANY AVENUE	HARTFORD	CT	06120	0
VILLAGE FOR FAMILIES & CHILDREN, INC.	(860)2364511	(860)2318449	1680 ALBANY AVENUE	HARTFORD	CT	06105	0
ADRC OUTPATIENT COUNSELING CENTER	(860)7143704	(860)7148974	16 COVENTRY STREET	HARTFORD	CT	06112	0
WHEELER CLINIC, INC., THE	(860)5239788	(860)2325049	645 FARMINGTON AVEN	HARTFORD	CT	06105	0
COMMUNITY SUBSTANCE ABUSE CENTER, INC.	(860)2478300	(860)5487325	55 FISHERY STREET	HARTFORD	CT	06120	0
COVENTRY HOUSE	(860)7143703	(860)7696786	46 COVENTRY STREET	HARTFORD	CT	06112	10
HOGAR CREA	(860)5277440	(860)5278744	33 CENTER STREET	HARTFORD	CT	06106	15
YOUTH CHALLENGE MISSION FOR WOMEN	(860)5272000	(860)5255790	32 ATWOOD STREET	HARTFORD	CT	06105	8
YOUTH CHALLENGE OF CONNECTICUT, INC.- MEN'S RESIDENTIAL CENTER	(860)7285199	(860)5240418	15-17-19 MAY ST	HARTFORD	CT	06105	15
HARTFORD DISPENSARY HENDERSON/JOHNSON CLINIC	(860)5275100	(860)2801080	12 - 14 WESTON ST	HARTFORD	CT	06103	0
HIGH WATCH RECOVERY CENTER	(860)9273772	(860)9271840	62 CARTER RD	KENT	CT	06757	78
UNITED SERVICES, INC.	(860)7742020	(860)7740826	1007 NORTH MAIN STRE	DAYVILLE	CT	06241	0
NEW HOPE BEHAVIORAL HEALTH & SUBSTANCE ABUSE CLINIC	(860)6454901	(860)6472932	935 MAIN STREET, SUIT	MANCHESTER	CT	06040	0
HARTFORD DISPENSARY-MANCHESTER CLINIC	(860)6433210	(860)6433211	335 BROAD STREET	MANCHESTER	CT	06040	0
GENESIS CENTER	(860)6463888	(860)6498576	587 EAST MIDDLE TURN	MANCHESTER	CT	06040	0
COMMUNITY CHILD GUIDANCE CLINIC, INC.	(860)6432101	(860)6451470	317 NORTH MAIN STREE	MANCHESTER	CT	06042	0
COMMUNITY HEALTH CENTER OF WHEREVER YOU ARE SHELTER NOW	(203)2374020	(203)2374020	43 ST. CASIMIR ST	MERIDEN	CT	06450	0
RUSHFORD CENTER INC	(203)6305280	(203)6342799	883 PADDOCK AVENUE	MERIDEN	CT	06450	0
CONNECTION COUNSELING CENTER, THE	(203)6301568	(203)6300698	178 STATE STREET	MERIDEN	CT	06450	0
CHILD GUIDANCE CLINIC FOR CENTRAL CONNECTICUT, INC.	(203)2356767	(203)2382010	384 PRATT ST	MERIDEN	CT	06451	0
WHEREVER YOU ARE EDDY CENTER	(860)3435520	(860)8930801	1 LABELLA CIRCLE	MIDDLETOWN	CT	06457	0
WHEREVER YOU ARE SHEPHERD HOME	(860)3440766	(860)8930801	112 BOW LANE	MIDDLETOWN	CT	06457	0

July 2011 to November 2011 Substance abuse fac from DPH_2

NAME	PHONE	FAX	ADDR1	TOWN	STATE	ZIP	BEDS
HALLIE HOUSE WOMEN AND CHILDREN'S CENTER	(860)3435513	(860)3435508	99 EASTERN DRIVE	MIDDLETOWN	CT	06457	8
RUSHFORD CENTER INC	(860)3460300	(860)3466417	1250 SILVER ST	MIDDLETOWN	CT	06457	58
CONNECTION HOUSE	(860)3435512	(860)3435080	167 LIBERTY ST	MIDDLETOWN	CT	06457	14
CONNECTION COUNSELING CENTER, THE	(860)3435510	(860)3435507	196 COURT STREET	MIDDLETOWN	CT	06457	0
CATHOLIC CHARITIES, INC.	(203)8746270	(203)8743301	203 HIGH STREET	MILFORD	CT	06460	0
BRIDGES...A COMMUNITY SUPPORT SYSTEM	(203)8786365	(203)8773088	949 BRIDGEPORT AVEN	MILFORD	CT	06460	0
COMMUNITY HEALTH CENTER OF WHEREVER YOU ARE PRUDENCE CRANDALL	(860)2255187	(860)6783042	594 BURRITT ST	NEW BRITAIN	CT	06053	0
COMMUNITY HEALTH CENTER OF WHEREVER YOU ARE FRIENDSHIP SERVICES CENTER	(860)2250211	(860)3489040	241-249 ARCH ST	NEW BRITAIN	CT	06050	0
WHEELER CLINIC, INC.	(860)2246360	(860)2297302	75 NORTH MOUNTAIN R	NEW BRITAIN	CT	06053	0
COMMUNITY MENTAL HEALTH AFFILIATES, INC.	(860)2248192	(860)2246968	55 WINTHROP STREET	NEW BRITAIN	CT	06052	0
COMMUNITY MENTAL HEALTH AFFILIATES, INC.	(860)2294850	(860)8273472	5 HART STREET	NEW BRITAIN	CT	06052	0
COMMUNITY MENTAL HEALTH AFFILIATES, INC.	(860)2232778	(860)2233297	26 RUSSELL STREET	NEW BRITAIN	CT	06052	0
ALLIANCE TREATMENT CENTER, INC.	(860)2237707	(860)2237708	33 HIGHLAND STREET	NEW BRITAIN	CT	06052	18
FARRELL TREATMENT CENTER	(860)2254641	(860)2254642	586 MAIN ST	NEW BRITAIN	CT	06051	24
HARTFORD DISPENSARY NEW BRITAIN CLINIC	(860)8273313	(860)8273317	70 WHITING ST	NEW BRITAIN	CT	06050	0
WHEELER CLINIC, INC.	(860)2238885	(860)2239192	36 RUSSELL STREET	NEW BRITAIN	CT	06052	0
HISPANOS UNIDOS, INC.	(203)7810226	(203)7810229	116 SHERMAN AVE	NEW HAVEN	CT	06511	0
PARK STREET INN	(203)8483061	(203)6241801	98 PARK STREET	NEW HAVEN	CT	06511	0
ELM CITY WOMEN AND CHILDREN'S CENTER AND THE CONNECTION COUNSELING CENTER	(203)7529109	(203)7529112	48 HOWE STREET	NEW HAVEN	CT	06511	15
NEW ERA REHABILITATION CENTER, INC.	(203)5622101	(203)5622102	311 EAST STREET	NEW HAVEN	CT	06511	0
STATE STREET COUNSELING SERVICES	(203)5033660	(203)5033562	911-913 STATE STREET	NEW HAVEN	CT	06511	0
OUTPATIENT CLINIC	(203)7872111	(203)7875599	205-209 ORANGE STRE	NEW HAVEN	CT	06511	0
CATHOLIC CHARITIES, INC.	(203)7872207	(203)7733626	501 LOMBARD ST	NEW HAVEN	CT	06513	0
CROSSROADS, INC.	(203)3870094	(203)9074513	44 EAST RAMSDELL ST	NEW HAVEN	CT	06515	0
ADULT PSYCHIATRIC CLINIC/CHILD AND FAMILY GUIDANCE CLINIC	(203)5033055	(203)5033296	400-428 COLUMBUS AVE	NEW HAVEN	CT	06519	0
NORTHSIDE COMMUNITY OUTPATIENT SERVICES/CHILD AND FAMILY GUIDANCE CLINIC	(203)5033472	(203)5033478	226 DIXWELL AVENUE	NEW HAVEN	CT	06511	0
SOUTH CENTRAL REHABILITATION CENTER	(203)5033300	(203)4013362	232 CEDAR STREET	NEW HAVEN	CT	06519	29
CROSSROADS INC	(203)3870094	(203)3872610	54 EAST RAMSDELL ST	NEW HAVEN	CT	06515	174
ACCESS CENTER	(203)7814646	(203)7814624	ONE LONG WHARF	NEW HAVEN	CT	06511	0
GRANT STREET PARTNERSHIP	(203)5033356	(203)5033370	62 GRANT STREET	NEW HAVEN	CT	06519	0
MULTICULTURAL AMBULATORY ADDICTION SERVICES	(203)4957710	(203)4957713	426 EAST STREET	NEW HAVEN	CT	06511	0
ORCHARD HILL TREATMENT SERVICES	(203)7814695	(203)7814700	540 ELLA T. GRASSO BO	NEW HAVEN	CT	06519	0
LEGION AVENUE CLINIC	(203)7814740	(203)7814751	495 CONGRESS AVENU	NEW HAVEN	CT	06511	0
MCCA/NEW MILFORD	(860)3557312	(860)3547023	62 BRIDGE ST	NEW MILFORD	CT	06776	0
NEWTOWN YOUTH AND FAMILY SERVICES, INC.	(203)4268103	(203)2704338	17 CHURCH HILL RD	NEWTOWN	CT	06470	0
NORTH HAVEN COMMUNITY SERVICES	(203)2395321	(203)2343942	5 LINSLEY ST	NORTH HAVEN	CT	06473	0
STONINGTON INSTITUTE	(860)4453008	(860)4453010	75 SWANTOWN HILL RD	NORTH STONING	CT	06359	63
CONNECTICUT RENAISSANCE, INC.	(203)8542915	(203)8556474	17 HIGH ST	NORWALK	CT	06851	0

July 2011 to November 2011 Substance abuse fac from DPH_2

NAME	PHONE	FAX	ADDR1	TOWN	STATE	ZIP	BEDS
FAMILY & CHILDREN'S AGENCY, INC.	(203)8558765	(203)8383325	9 MOTT AVE	NORWALK	CT	06850	0
CONNECTICUT COUNSELING CENTERS, INC.	(203)8386508	(203)8527021	20 NORTH MAIN STREE	NORWALK	CT	06854	0
CONNECTICUT RENAISSANCE, INC.	(203)8662541	(203)8545682	4 BYINGTON PLACE	NORWALK	CT	06852	0
PROJECT REWARD	(203)8316301	(203)8383325	165 FLAX HILL RD	NORWALK	CT	06854	0
ALTRUISM HOUSE FOR MEN	(860)8893414	(860)8893414	313 MAIN STREET	NORWICH	CT	06360	13
CATHOLIC CHARITIES, DIOCESE OF NORWICH, INC.	(860)8898346	(860)8892658	331 MAIN STREET	NORWICH	CT	06360	0
UNITED COMMUNITY & FAMILY SERVICES, INC.	(860)8927042	(860)8233002	47 TOWN STREET	NORWICH	CT	06360	0
HARTFORD DISPENSARY - NORWICH CLINIC	(860)8860446	(860)8867785	772 WEST THAMES STR	NORWICH	CT	06360	0
OUTPATIENT TREATMENT	(860)8893178	(860)8233850	321 MAIN STREET	NORWICH	CT	06360	0
CONNECTION COUNSELING CENTER, THE	(860)3956380	(860)3956382	263 MAIN ST	OLD SAYBROOK	CT	06475	0
ORANGE FAMILY COUNSELING	(203)7956698	(203)8773088	605-A ORANGE CENTER	ORANGE	CT	06477	0
YOUTH CHALLENGE BIBLE TRAINING CENTER	(860)5648400	(860)2300851	111 NORTH STERLING R	MOOSUP	CT	06354	9
UNITED SERVICES, INC.	(860)5646100	(860)5646110	303 PUTNAM ROAD	WAUREGAN	CT	06387	0
WHEELER CLINIC	(860)7933500	(860)7937290	91 NORTHWEST DRIVE	PLAINVILLE	CT	06062	0
CATHOLIC CHARITIES, DIOCESE OF NORWICH, INC.	(860)3420760	(860)3424226	553 PORTLAND-COBALT	PORTLAND	CT	06480	0
RUSHFORD CENTER INC	(860)3423252	(860)3424556	325 MAIN STREET	PORTLAND	CT	06480	26
MILESTONE/NEW LIFE CENTER/PATHWAYS	(860)9281860	(860)9636764	391 POMFRET STREET	PUTNAM	CT	06260	30
MCCA/RIDGEFIELD	(203)4388680	(203)8948386	90 EAST RIDGE ROAD	RIDGEFIELD	CT	06877	0
TRINITY GLEN	(860)6726680	(860)6723021	149 WEST CORNWALL R	SHARON	CT	06069	50
LIBERTY CENTER	(203)9440366	(203)9440159	30 CONTROLS DRIVE	SHELTON	CT	06484	0
STAFFORD FAMILY SERVICES	(860)6844239	(860)6840511	21 HYDE PARK RD	STAFFORD SPRIN	CT	06076	0
INTEGRATED CARE CLINIC	(203)3881551	(203)3881682	780 SUMMER ST	STAMFORD	CT	06902	0
CONNECTICUT RENAISSANCE, INC.	(203)6024441	(203)6027782	141 FRANKLIN ST. FRAN	STAMFORD	CT	06901	0
LIBERATION PROGRAMS, INC. STAMFORD FAMILY AND YOUTH OPTIONS	(203)3561980	(203)6041160	103 WEST BROAD ST	STAMFORD	CT	06902	0
LIBERATION CLINIC	(203)3561980	(203)9679476	125 MAIN STREET	STAMFORD	CT	06901	0
LIBERATION HOUSE	(203)3561980	(203)3530368	119 MAIN STREET	STAMFORD	CT	06901	67
MAIN STREET CLINIC	(203)3561980	(203)3521748	117 MAIN STREET	STAMFORD	CT	06901	0
FAMILIES IN RECOVERY PROGRAM	(203)3521800	(203)3231806	141 FRANKLIN STREET	STAMFORD	CT	06901	10
VIEWPOINT RECOVERY PROGRAM	(203)3561053	(203)3561054	104 RICHMOND HILL AV	STAMFORD	CT	06902	12
FAMILY RESOURCE ASSOCIATES, LLC	(203)3784514	(203)3780443	3300 MAIN STREET	STRATFORD	CT	06614	0
CENTER FOR HUMAN SERVICES	(203)3868802	(203)3868369	2 RESEARCH DRIVE	STRATFORD	CT	06615	0
WATKINS NETWORK	(860)4827242	(860)4827258	257 MAIN ST	TORRINGTON	CT	06790	0
CATHOLIC CHARITIES, INC.	(860)4825558	(860)4892984	132 GROVE STREET	TORRINGTON	CT	06790	0
MCCALL HOUSE	(860)4962105	(860)4962111	127 MIGEON AVE	TORRINGTON	CT	06790	14
MCCALL FOUNDATION	(860)4962100	(860)4962111	58 HIGH ST	TORRINGTON	CT	06790	0
CARNES WEEKS CENTER	(860)4962107	(860)4960109	58B HIGH STREET	TORRINGTON	CT	06790	20
HOCKANUM VALLEY COMMUNITY COUNCIL, INC	(860)8729825	(860)8709384	27 NAEK RD, SUITE 4	VERNON	CT	06066	0
GENESIS CENTER	(860)8718227	(860)8758299	43 WEST MAIN STREET	VERNON	CT	06066	0
COMMUNITY HEALTH CENTER OF WHEREVER YOU ARE MASTER'S MANNA	(203)6783042	(203)6783042	46 NORTH PLAINS INDU	WALLINGFORD	CT	06492	0
MCCA/WATERBURY	(203)5970843	(203)5970834	228 MEADOW STREET	WATERBURY	CT	06702	0
CATHOLIC CHARITIES, INC.	(203)5969359	(203)7579753	13 WOLCOTT STREET	WATERBURY	CT	06705	0
PATRICK F. MCAULIFFE CENTER	(203)3461931	(203)3461936	70 CENTRAL AVENUE	WATERBURY	CT	06702	20
CATHOLIC CHARITIES, INC.	(203)7551196	(203)5759675	56 CHURCH STREET	WATERBURY	CT	06702	0
WOMEN AND CHILDREN'S PROGRAM	(203)5743311	(203)5743315	79 BEACON STREET	WATERBURY	CT	06704	8
FAMILY INTERVENTION CENTER	(203)7532153	(203)7566032	22 CHASE RIVER ROAD	WATERBURY	CT	06704	0
RENAISSANCE WEST	(203)5918010	(203)5918586	466 WEST MAIN STREET	WATERBURY	CT	06702	50
MORRIS FOUNDATION, INC.	(203)5743986	(203)5975459	26-NORTH ELM STREET	WATERBURY	CT	06708	27

July 2011 to November 2011 Substance abuse fac from DPH_2

NAME	PHONE	FAX	ADDR1	TOWN	STATE	ZIP	BEDS
MORRIS FOUNDATION, INC. OUTPATIENT SERVICES	(203)7551143	(203)5743315	402 EAST MAIN STREET	WATERBURY	CT	06702	0
CONNECTICUT JUNIOR REPUBLIC	(203)7579939	(203)7569922	80 PROSPECT STREET	WATERBURY	CT	06702	0
MORRIS FOUNDATION, INC.	(203)5741419	(203)5784180	142 GRIGGS STREET	WATERBURY	CT	06704	0
RENAISSANCE EAST	(203)7532341	(203)7556902	31 WOLCOTT ST	WATERBURY	CT	06702	32
REVEREND EDWARD M. DEMPSEY DRUG SERVICES	(203)7568984	(203)7568984	900 WATERTOWN AVE	WATERBURY	CT	06708	34
CONNECTICUT COUNSELING CENTERS, INC.	(203)7558874	(203)5979570	4 MIDLAND ROAD	WATERBURY	CT	06705	0
BRIDGES...A COMMUNITY SUPPORT SYSTEM, INC.	(203)9375412	(203)9371859	270 CENTER STREET	WEST HAVEN	CT	06516	0
WEST HAVEN HEALTH CENTER COUNSELING SERVICES	(203)5033075	(203)5033414	285 MAIN STREET	WEST HAVEN	CT	06516	0
POSITIVE DIRECTIONS-THE CENTER FOR PREVENTION AND RECOVERY, INC.	(203)2277644	(203)2270037	420 POST ROAD WEST	WESTPORT	CT	06880	0
MCCALL FOUNDATION/WINSTED OFFICE	(860)7381616	(860)4962111	231 NORTH MAIN ST	WINSTED	CT	06098	0
HARTFORD DISPENSARY-WILLIMANTIC CLINIC	(860)4567990	(860)4564342	54-56 BOSTON POST RO	WILLIMANTIC	CT	06226	0
UNITED SERVICES, INC.	(860)4562281	(860)4501357	132 MANSFIELD AVENU	WILLIMANTIC	CT	06226	0
NEW PERCEPTIONS/RIGHT TURN	(860)4500151	(860)4507152	54 NORTH STREET	WILLIMANTIC	CT	06226	0
PERCEPTION HOUSE	(860)4507130	(860)4507151	134 CHURCH ST	WILLIMANTIC	CT	06226	20
TRANSITIONS OUTPATIENT SERVICES/THOMAS MURPHY CENTER	(860)4561769	(860)4233351	1491 WEST MAIN ST	WILLIMANTIC	CT	06226	14
MOUNTAINSIDE TREATMENT CENTER	(860)8241397	(860)8244021	187 SOUTH CANAAN RD	CANAAN	CT	06018	62
DARIEN YOUTH OPTIONS	(203)6558973	(203)6558974	2 RENSHAW ROAD	DARIEN	CT	06820	0
INTERCOMMUNITY INC.	(860)5695900	(860)5694614	287 MAIN ST	EAST HARTFORD	CT	06118	0
INTERCOMMUNITY, INC.	(860)5695900	(860)5695614	281 MAIN ST	EAST HARTFORD	CT	06118	0
PACES COUNSELING ASSOCIATES, INC.	(860)5283238	(860)2182489	991 MAIN STREET	EAST HARTFORD	CT	06108	0
CHILD & FAMILY AGENCY OF SOUTHEASTERN CONNECTICUT, INC. GROTON/MYSTIC CAMPUS	(860)4498217	(860)4498323	591 POQUONNOCK ROA	GROTON	CT	06340	0
STONINGTON INSTITUTE	(860)4490611	(860)4491332	428 LONG HILL ROAD	GROTON	CT	06340	0
STONINGTON INSTITUTE	(860)4453000	(860)4453031	1353 GOLD STAR HIGHW	GROTON	CT	06340	0
MOTHER'S RETREAT AND THE CONNECTION COUNSELING CENTER	(860)4052107	(860)4052102	542 LONG HILL ROAD	GROTON	CT	06340	8
NEW PERCEPTIONS/RIGHT TURN	(860)7795852	(860)7795000	13 WATER ST	DANIELSON	CT	06239	0
TRANSITIONS OUTPATIENT SERVICES	(860)7747179	(860)7796526	37 COMMERCE AVENUE	DANIELSON	CT	06239	0
LEBANON PINES LONG TERM CARE	(860)8891717	(860)8862361	37 CAMP WOOWEEN RD	LEBANON	CT	06249	110
CONNECTICUT JUNIOR REPUBLIC	(860)5679423	(860)5673479	550 GOSHEN ROAD	LITCHFIELD	CT	06759	0
CATHOLIC CHARITIES	(860)4435328	(860)4436013	28 HUNTINGTON ST	NEW LONDON	CT	06320	0
ALTRUISM HOUSE FOR WOMEN	(860)4478021	(860)4478021	1000 BANK ST	NEW LONDON	CT	06320	10
CHILD & FAMILY AGENCY OF SOUTHEASTERN CONNECTICUT, INC. SMITH BENT CHILDREN'S CENTER	(860)4422797	(860)7013776	7 VAUXHALL STREET	NEW LONDON	CT	06320	0
UNITED COMMUNITY & FAMILY SERVICES, INC.	(860)4424319	(860)4372334	400 BAYONET STREET	NEW LONDON	CT	06320	0
SOUND COMMUNITY SERVICES, INC.	(860)4430036	(860)4438940	165 STATE STREET - SU	NEW LONDON	CT	06320	0
ALTRUISM ACUTE CARE & EVALUATION	(860)4471717	(860)4471631	47 COIT ST	NEW LONDON	CT	06320	20
HARTFORD DISPENSARY/NEW LONDON CLINIC	(860)4472233	(860)4472669	931-939 BANK STREET	NEW LONDON	CT	06320	0
ALTRUISM HOUSE FOR WOMEN	(860)4421017	(860)4374424	62-64 COIT STREET	NEW LONDON	CT	06320	11

Attachment II – Additional Letters of Support

Positive Directions
The Center for Prevention & Recovery

January 12, 2012

Ms. Kimberly Martone
Director of Operations
Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS# 13HCA
P.O.Box 340308
Hartford, CT 06134-0308

Re: CON Application: MC1 HEALTHCARE d/b/a Mountainside Treatment Center

Dear Ms. Martone:

Positive Directions is an out-patient facility in Westport, CT for the treatment of substance abuse/addiction and family Interventions. Many people calling our facility are seeking to initiate a program of treatment after a long and intensive period of substance use. Very often these callers/clients require a medically supervised detox and a period of residential treatment. In these cases, our job is to secure a referral for the client for their stage of their recovery.

We have made many referrals to Mountainside Treatment Center to secure residential treatment. Our experience (and the experience of clients reporting back to us) with Mountainside's program has been very positive. The staff and program have exhibited professionalism both clinically and administratively. However, unfortunately the continuum of care for our clients from detox to residential care has not been seamless because they have had to obtain detox elsewhere prior to admission to Mountainside's residential program. Often this two-step (facility) process and the difficulty in finding an available detox bed have delayed and sometimes diminished the client's initial motivation and willingness to enter treatment.

Certainly Mountainside's ability to provide detox would positively change the flow of treatment. I feel confident that the staff at Mountainside will provide equally good treatment for detoxification as they have for continuing treatment.

I support the above application. Mountainside's ability to provide detoxification will benefit the people seeking treatment, the community of treatment providers and the public health of the State of Connecticut.

Respectfully,

Bob Vietro, MS, LADC
Clinical Director

420 Post Road West, Westport, CT 06880
(203) 227-7644 Fax: (203) 227-0037
www.positivedirections.org

THE GREENWICH CENTER

90 Greenwich Hills Drive
Greenwich, CT 06831
203 249-7678 *phone*
914-328 3433 *fax*

5 Waller Avenue
Suite 101
White Plains, NY 10601
914 328 1171 *phone*
914 328 3433 *fax*

FORENSIC EVALUATIONS
HAIR TESTING
DRUG SCREENS
CONSULTATIONS
ADDICTION TREATMENT

January 3, 2012

Ms. Kimberly Martone
Director of Operations
Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS#13HCA
P.O. Box 340308
Hartford, CT 06134-0308

Re: CON Application: MC1 HEALTHCARE d/b/a Mountainside Treatment Center

Dear Ms. Martone:

I am writing in full support of the above application. I have worked closely and made many referrals to Mountainside since they opened. Many times my patients have required detox in order to start inpatient rehab and have been forced to go long distances in order to receive those services. They have gone to facilities such as Arms Acres in NY to Greenwich Hospital and then up to Canaan. It makes a significant difference, in my professional opinion, to have the patient only be in one program for their entire treatment. In fact, it seems to me after thirty three years of practice in this field, that all inpatient rehabs should be required to have a detox unit. I refer at least five to six patients a year to Mountainside, and some of these are after interventions. I have had problems on three cases this past year alone because Greenwich, Arms and three other detoxes I tried, had no detox beds. There is a clear shortage of detox beds in the region and approval of this application should be expedited to help those suffering from the disease of addiction and cannot find proper care due to a shortage of beds. These 16 beds will make a significant difference to the inadequate detox system that is now in place.

Mountainside offers one of the best programs in the region and certainly use best practice, evidence based treatment. A detox program would enhance the experience not just for the patient but also for the referent. I have had to use other facilities, not as good, at times because the patient refused to be admitted to one hospital for detox be discharged and then travel to another facility be admitted there and continue the treatment process.

I am happy to answer any questions, the committee may have but urge acceptance of this application as soon as possible.

Sincerely,

Raymond A. Griffin, Ph.D., CASAC, LADC
Diplomate & Fellow ABMP

237 Taconic Rd.
Greenwich, CT 06831

January 3, 2012

Ms. Kimberly Martone
Director of Operations
Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS#13HCA
P.O. Box 340308
Hartford, CT 06134-0308

Re: CON Application: MC1 HEALTHCARE d/b/a Mountainside Treatment Ctr.

Dear Ms. Martone:

I am writing this letter of support regarding Mountainside's CON application for the addition of a detox unit at their facility. As an Interventionist in Connecticut and the New England area in particular, the absence of a detox unit on their campus has been a factor on occasions in my decision not to send a client there.

Mountainside is a wonderful facility, with an excellent clinical staff. In this geographic area, it provides a unique, well-rounded program that incorporates programs attending to the mind, body, and spirit, while people are in recovery from addiction. I have had many positive experiences with the staff and good clinical outcomes from their work as an acute care treatment facility.

However, Connecticut is lacking in access to detox units. At times, we have to wait and scramble to get a bed just at the moment our client has agreed to go to treatment which can derail the process. This should not be an issue after all the work we put into preparing or persuading a person in distress to get help. There have been occasions when I have sent a person by necessity to a detox far away from the Mountainside campus, and the client then considered the detox their treatment and refused to continue their recovery when it required being transported to another facility (Mountainside). This is not acceptable and it is a liability to the individual's recovery from their substance abuse addiction.

I urge you to approve the 16 additional detox beds at Mountainside in order for them to offer a full continuum of care on campus. I am certain there would be no problem whatsoever in filling these beds. As an interventionist this would definitely factor into the number of referrals I would send them.

Please consider the impact that insufficient detox beds in CT has on the ever-increasing number of persons struggling with the disease of addiction. For so many people, detox is the first step towards a life of sobriety. The provision of additional detox beds will certainly improve the quality of Connecticut's substance abuse services, which will have an impact on families far and wide.

Thank you for your consideration in this matter of urgent importance.

Sincerely,

Paige Stetson, LPC, LMHC
Interventionist
237 Taconic Rd.
Greenwich, CT 06831
203 898-2512

BRIAN G. LE BLANC, CEAP, LAPC, NACAII
UNION ASSISTANCE PROGRAM
COMMUNICATIONS WORKERS OF AMERICA
LOCAL1298

3055 Dixwell Ave.
Hamden Ct 06518
1-800-734-2157

January 16, 2012

Ms. Kimberly Martone
Director of Operations
Department Of Public Health
Office of Health Care Access.
410 Capital Avenue. MS#13HCA
P.O. Box 340308
Hartford, Ct. 06134-0308

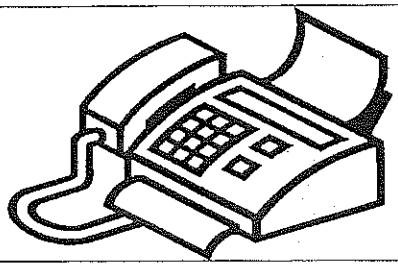
Reference: CON Application: MC 1 HEALTHCARE d/b/a
Mountainside Treatment Center

Dear Ms. Martone;

I am an Employee Assistance Professional with the Communications Workers of America.
Often I receive calls from people seeking help for themselves or a family member with substance abuse/addiction issues. Many times the call presents a case requiring immediate detoxification. The resources in Connecticut for adequate skilled detoxification are limited at best. Often times, the lack of proper resources results in a need to refer my clients to facilities in other states for their necessary care. As a result this can be costly, and dangerous, as well as presenting a barrier for family support. I am pleased that Mountainside is attempting to close the gap in Connecticu detox bed availability and stand proactively in continuity of care for their patients.
I without question or hesitation rely on Mountainside to meet the needs of my clients. I have had a positive relationship with them for several years.
I with the strongest recommendation place my name in support of any endeavor they pursue.

Please feel free to contact me with any further questions

Sincerely,
Brian G. LeBlanc
Brian G. LeBlanc CEAP, LAPC, NACAII



A facsimile from

kmb consulting, llc
OPTIMIZE YOUR HEALTH CARE PLANNING RESOURCES

Karen M. Banoff
(203) 459-1601

To: Steven Lazarus (OHCA)
Fax number: (860) 418-7053

Date: 2/7/2012

Regarding: Docket Number: 11-31734-CON
Mountainside Treatment Center

Comments:

Public Notice copy displaying newspaper name (upper right corner)

Absolutely free

RESCUED KITTENS FREE to good homes. Need spaying/neutering, will deliver call between 6pm-9pm 203-574-4064 btwn 6-9

TURTLE free red-eared slider 203-982-4255 ask for Luke

WARNING! ADS FOR FREE PETS
Your beloved pet deserves a loving caring home. The ad for your free pet may draw responses from individuals who will sell your animal for research, breeding or other purposes. Please screen respondents carefully when giving an animal away. Your pet will thank you!

Lost & found

FOUND Adult Shih-Tzu in Historic Overlook District Waterbury. Please call 270-498-2763

FOUND CAT Baldwin St. vicinity. Lg. orange tiger male 203-597-1236

FOUND CAT Cornwall Bridge advertisement and then only to the extent of a "make good" insertion. Errors which do not lessen the value of the advertisement will not be corrected by "make good" insertions.

ANNOUNCEMENT
For the benefit of reader understanding, this newspaper does not accept abbreviations for any words except English standard and industry standard abbreviations. We will not automatically abbreviate and when requested to do so, will follow only standard abbreviations.

Legals/ Public Notices

FORECLOSURE AUCTION
SUPERIOR COURT
JUDICIAL DISTRICT OF LITCHFIELD

DOCKET NO.:
LLI-CV-1106004474-S

CASE NAME:
DEUTSCHE BANK NATIONAL TRUST CO., AS TRUSTEE
VS.
KATHLEEN E. CAMPANELLA

PREMISES:
70 PARK AVENUE
OAKVILLE, CT 06779

PROPERTY TYPE:
RESIDENTIAL

DATE: SATURDAY, OCTOBER 29, 2011 AT 12:00 NOON

PLACE: ON THE PREMISES

DEPOSIT: Bank or Certified Check $18,000.00
The premises will be available for inspection from 10:00 a .m. to 12:00 noon on the Date of Sale.

For Further Information Contact:
Mark D. Malley, Esq.
Committee for Sale

R-A October 21, 22, & 23, 2011

Legals/ Public Notices

LIQUOR PERMIT
NOTICE OF APPLICATION

This is to give notice that I,
ROBERT VOLPACCHIO
88 BROOKFIELD RD
SEYMOUR, CT 06483-2378
have filed an application placarded 10/12/2011 with the Department of Consumer Protection for the sale of alcoholic liquor on the premises at
313 MAIN STREET
ANSONIA, CT 06401-2301
The Business will be owned by:
TAMALE EXPRESS CORP
Entertainment will consist of:
NONE
Objections must be filed by:
11/22/2011
ROBERT VOLPACCHIO
R-A October 22 & 29, 2011

LIQUOR PERMIT
NOTICE OF APPLICATION

This is to give notice that I,
ROSANNA F GUERRERA
27 KENNEDY DRIVE
THOMASTON, CT 06787 - 1141
have filed an application placarded 10/22/2011 with the Department of Consumer

Naugatuck Housing Authority is accepting applications for Federal Housing located on Osborn Road and Weid Drive. Those wishing to apply must be 62 years of age or older. Applications will be available starting: 10/24/2011 at the following location:

The Naugatuck Housing Authority and shall institute such investigations and periodic monitoring procedures as deemed necessary to determine compliance with labor standard provisions and the Federal requirements of the Statutes as amended.

The Naugatuck Housing Authority
16 Ida Street
Naugatuck Ct, 06770

In addition you may call to have the application mailed. If you have any questions, please call the Naugatuck Housing Authority, (203) 729-8214.

The Town of Watertown reserves the right to take into account the residency of bidders within the Town of Watertown and/or the location of the bidder's business within the Town of Watertown in awarding this bid.

All bids will be considered valid for a period of sixty (60) days.

Carol Z. Roman
Purchasing Agent
Town of Watertown
R-A October 22, 2011

Legals/ Public Notices

TOWN OF WATERTOWN

REQUEST FOR PROPOSAL

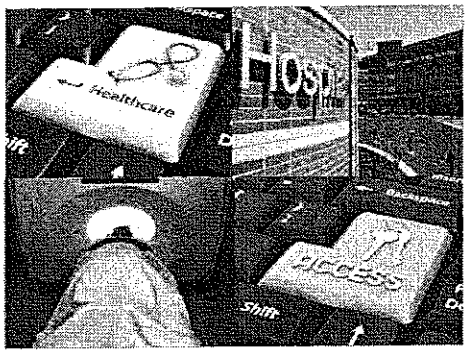
REAPPRAISAL AND REVALUATION OF REAL PROPERTY (TAXABLE AND EXEMPT) AND INSTALLATION OF ASSESSMENT/ COLLECTION ADMINISTRATIVE SOFTWARE

The Town of Watertown requests proposals for the reappraisal and revaluation of all real property (taxable and exempt) located within the corporate limits of the Town of Watertown CT effective October 1, 2013, and installation of software for administering assessment and tax collection. Only proposals from State certified revaluation companies will be considered. Request for Proposal documents may be obtained or examined at the office of the Purchasing Agent, Town Hall Annex, 424 Main Street, Watertown, Connecticut 06795, or by accessing the Town of Watertown's website at http://www.watertownct.org. Sealed proposals must be submitted no later than 4:00 P.M., FRIDAY, NOVEMBER 11, 2011. Any Request for Proposals received after said

PUBLIC NOTICE

Pursuant to Section 19a-638 of Connecticut General Statutes, MC1 Healthcare d/b/a Mountainside Treatment Center, located at 187 South Canaan Road, Route 7, Canaan, CT 06081, will submit a Certificate of Need application to the Office of Health Care Access for the addition of sixteen (16) residential Detoxification and Evaluation beds to its licensed bed capacity at an estimated total capital expenditure of $10 million.
R-A October 21, 22, & 23, 2011

OHCA Main
Certificate of Need
Consumer Assistance Process
Facilities Plan
OHCA Forms
Freedom of Information
Hospital Financial Data
Laws and Regulations
OHCA Publications
Glossary
Contact OHCA
Legal Notices and Status Reports



Welcome to the Office of Health Care Access. Our Mission is to ensure that the citizens of Connecticut have access to a quality health care delivery system.

CT State-Wide Health Care Facilities and Services Plan Advisory Body

Outpatient Data Work Group

News:

- **NEW !!!** On February 17, 2012 OHCA received the CON Application of Community Mental Health Affiliates, Inc. (CMHA) for the transfer of ownership of CMHA from Central Connecticut Health Alliance to CMHA. Filed under Docket No.: 12-31750-CON.
- **NEW !!!** On February 24, 2012, OHCA Deemed Complete the CON application of WBC Connecticut East, LLC to establish a Partial Hospital and Intensive outpatient program for the treatment of adults and adolescents with Eating Disorders in South Windsor, filed under Docket No.: 11-31731-CON.
- **NEW !!!** On February 23, 2012, OHCA deemed Complete the CON Application of MCI Healthcare LLC d/b/a Mountainside Treatment Center for the increase of licensed bed capacity by 16, filed under Docket No.: 11-31734-CON.
- **NEW !!!** On February 9, 2012 OHCA received the CON Application of Yale-New Haven Hospital and Saint Raphael Healthcare System d/b/a Hospital of Saint Raphael, Inc. for Yale-New Haven Hospital to acquire ownership of Saint Raphael Healthcare System, Inc. and certain associated assets. Filed under Docket No.: 12-31747-CON.
- On January 30, 2012, OHCA deemed Complete the CON Application of Eastern Connecticut Health Network for the acquisition of four MRI Scanners located in the towns of Enfield, Glastonbury, Middletown and South Windsor, as filed under Docket Number 11-31737-CON.
- On January 27, 2012 OHCA received the CON Application for Yale-New Haven Hospital's proposal to increase its licensed general hospital bed count by 70, from 896 to 966 licensed beds, at a total capital expenditure of $1,438,919, Docket Number 12-31745-CON.
- On January 17, 2012, OHCA deemed Complete the CON Application of Lawrence & Memorial Hospital for the acquisition of a PET-CT scanner to be located at its L&M Diagnostic Imaging at Crossroads in Waterford, as filed under Docket Number 11-31730-CON.
- On January 6, 2012, OHCA deemed Complete the CON Application of Eastern Connecticut Health Network and Manchester Memorial Hospital for the transfer of ownership of Evergreen Imaging Center to an affiliate of ECHN, as filed under Docket Number 11-31736-CON.
- On December 09, 2011 OHCA received the CON Application of Eastern Connecticut Health Network, Inc. and Mandell & Blau, M.D.s, P.C. for the Acquisition by Eastern Connecticut Health Network, Inc. of the Open MRI scanners currently operated by Mandell & Blau, M.D.'s P.C. under Docket No.: 11-31737-CON.

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

May 11, 2012

IN THE MATTER OF:

An Application for a Certificate of Need filed Pursuant to Section 19a-638, C.G.S. by:	Notice of Final Decision Office of Health Care Access Docket Number: 11-31734-CON
MCI Healthcare, LLC **d/b/a Mountainside Treatment Center**	**Increase in Licensed Bed Capacity**

To: Mr. Terence Dougherty
President & CEO
Mountainside Treatment Center
P.O. Box 717
Canaan, CT 06018

Dear Mr. Dougherty:

This letter will serve as notice of the Final Decision of the Office of Health Care Access in the above matter, as provided by Section 19a-638, C.G.S. On May 11, 2012, the Final Decision was rendered as the finding and order of the Office of Health Care Access. A copy of the Final Decision is attached hereto for your information.

Kimberly R. Martone
Director of Operations

Enclosure
KRM:swl

Department of Public Health
Office of Health Care Access
Certificate of Need Application

Final Decision

Applicant: **MCI Healthcare, LLC d/b/a Mountainside Treatment Center**

Docket Number: **11-31734-CON**

Project Title: **Increase in Licensed Bed Capacity by 16 Beds**

Project Description: MCI Healthcare, LLC d/b/a Mountainside Treatment Center ("Mountainside" or "Applicant") is proposing to increase its licensed bed capacity by 16 beds.

Procedural History: On January 2, 2012, the Office of Health Care Access ("OHCA") received a Certificate of Need ("CON") application from the Applicant for the above-referenced proposal. Mountainside published notice of its intent to file the CON Application in the *Waterbury Republican,* on October 21, 22 and 23, 2011. OHCA received no responses from the public concerning the Applicant's proposal and no hearing requests were received from the public per General Statutes §19a-639a (e).

Findings of Fact

1. Mountainside is located at 187 South Canaan Road, Route 7, Canaan, Connecticut and is licensed as a Facility for the Care or Treatment of Substance Abusive or Dependent Persons by the State of Connecticut, Department of Public Health ("DPH"). Ex. A, p.183.

2. Mountainside opened in 1998 with 50 beds for rehabilitation, intermediate and long-term care as classified by DPH. In 2006, it expanded to 66 beds and in 2010, it reduced its bed complement to 62. The bed reduction was necessary in order to create physical space for critically important support functions (e.g., rooms for group activities). Ex. A, p. 17.

3. The Applicant is currently licensed by DPH to offer 62 Intermediate and Long Term Treatment and Rehabilitation Beds. Ex. A, p.183.

4. Mountainside is a residential drug addiction and alcoholism rehabilitation facility that uses a multi-disciplinary approach to treat individuals suffering from addiction and provides individual addiction treatment and aftercare. Ex. A, p. 17.

5. Mountainside's current treatment methods include, but are not limited to, one-on-one counseling, group counseling, gender-specific groups, family counseling, the 12-Step education, a mind body spirit program, adventure-based initiatives and continuing care planning. The Center also offers day and evening and outpatient treatment as well as aftercare (e.g., Sober House). Ex. A, p. 17.

6. The Applicant's staff include licensed and certified social workers and counselors. Ex. A, pg. 17.

7. Mountainside currently uses all of its 62 licensed beds for rehabilitation care, and occupancy levels reach 100% regularly throughout the year, resulting in waiting lists. Ex. A, p. 18.

8. The proposed increase in bed capacity at Mountainside will increase the total bed complement by 16 beds to a total bed capacity of 78 beds. These additional beds will be utilized to provide residential detoxification and evaluation ("detoxification") services. Ex. A, p. 18-19.

9. The proposed detoxification beds will be housed in a newly constructed wing of the main facility, which will be connected by a glass-enclosed walkway. Ex. A, p. 18.

10. Residential detoxification generally requires five to seven days to complete before an individual is ready to begin substance abuse rehabilitation treatment, which typically continues for 28 days. Ex. A, p. 18.

11. Mountainside will provide level 3.7 residential detoxification services as defined by the American Society of Addiction Medicine's five levels of detoxification care. Ex. A, p. 18.

12. A 3.7 level of care includes providing 24-hour medically supervised evaluation and withdrawal management, a permanent facility with inpatient beds and services that are delivered under a defined set of physician-approved policies and the availability of 24-hour observation, monitoring and treatment. Ex. A, p. 18.

13. Offering detoxification in the same facility where rehabilitation will occur will help to ensure continuity of care throughout the patient's treatment process. Ex. A, p. 18.

14. According to the State of Connecticut, Department of Mental Health and Addiction Services ("DMHAS"), while treatment is available and effective, the majority who need treatment do not obtain it. It is estimated that for every one person who seeks and/or receives behavioral health care for addiction, there are six individuals with similar conditions who will neither gain access to, nor receive, such care. Ex. A, p. 18.

15. Effective treatment must provide a combination of culturally competent therapies and consider other factors including age, race, culture, language, sexual orientation, gender, family roles, housing, employment, etc. Ex. A, p. 18.

16. Mountainside's approach to addiction treatment combines therapeutic and holistic methods to support its evidence-based program. Ex. A, p. 18.

17. Access to detoxification beds in Connecticut is problematic, and there are often waiting lists at the few facilities that offer the service. Ex. A, p. 18.

18. There are currently 44 DPH licensed residential (non-hospital) substance abuse facilities in Connecticut; however, only 10 are known to offer level 3.7 residential detoxification services. Ex. A, p. 19 & Ex. C, p. 207.

19. Mountainside conducted two surveys of Connecticut substance abuse facilities currently providing level 3.7 residential detoxification services to determine same-day detoxification bed availability. The first survey of six providers was conducted prior to submitting the CON application. It found that three of the facilities had between one and three detoxification beds available and three facilities had no detoxification beds available for several days. The second survey, conducted after filing the CON application, found that three of the facilities had no detoxification beds available (with one bed possibly available at night) and one facility had two beds available. Additionally, four out-of-state facilities were surveyed and only one of those four had available detoxification beds. Ex. A, p. 19 & 207.

20. The following is a list of the ten (10) substance abuse facilities in Connecticut that are currently providing level 3.7 residential detoxification services:

Facility Name	Town	Total Beds	Available Detox Beds
*First Step	Bridgeport	19	19
*MCCA	Danbury	30	10
*Detoxification Center (Blue Hills & ADRC)	Hartford	73	35
*Rushford Center	Middletown	58	16
*South Central Rehabilitation Center	New Haven	29	29
*Stonington Institute	North Stonington	63	13
**Community Prevention and Addiction Services (CPAS)	Willimantic	Unavailable	6
**CT Valley Hospital (Merritt Hall)	Middletown	Unavailable	20
**Southeastern Connecticut Council on Alcohol and Drug Dependence (SCADD)	Lebanon	Unavailable	20
**Silver Hill Hospital (Silver Hill)	New Canaan	Unavailable	18
Total Detox Beds			***186***

Notes: *First Survey **Second Survey
Ex. A, p. 79, & Ex. C, p. 207.

21. Mountainside receives requests for residential detoxification care from existing referral sources. These referral sources include physicians, acute care hospitals, family members, interventionists, therapists and other mental health facilities. Ex. A, p. 21.

22. Over the past 21 months, Mountainside has referred approximately 170 individuals to facilities outside of Connecticut (New York, New Jersey and Massachusetts) primarily due to limited or lack of (level 3.7) bed availability. Ex. A, p. 20.

23. Mountainside submitted letters of support from a variety of referral sources from within Connecticut and the neighboring states indicating need for access to additional detoxification beds in Connecticut. Ex. C, p. 214-218.

24. By increasing access to detoxification care through the addition of detoxification beds at Mountainside, continuity of care will be greatly enhanced and will ensure the successful completion of rehabilitation care. Ex. A, p. 21.

25. According to a Substance Abuse and Mental Health Services Administration ("SAMHSA") report (the "Report") issued in 2009, an estimated 8.7% of the population

aged 12 or older were illicit drug users, 23.7% of persons aged 12 and older participated in binge drinking and 6.8% reported being a heavy drinker. Ex. A, p. 22.

26. The Report states that while drug and alcohol abuse are major problems, they are not being adequately treated; of the people who needed treatment at a specialty facility for an illicit drug or alcohol use problem in the past year, only 11.2% of this population received treatment. Ex. A, p. 22.

27. SAMHSA's 2010 census data indicates that there are 2,757,082 Connecticut residents 18 years of age and over, which is approximately 77% of the total population. According to SAMHSA's States in Brief report for Connecticut ("State Report"), the global measures for abuse or dependence on illicit drugs or alcohol are at or above national rates. Ex. A, p. 24.

28. The State Report further states that Connecticut has been among the 10 states with the highest rates for past month illicit drug marijuana use and past year marijuana use for the 18-25 age group as well as past month alcohol use for several age groups including 12+, 18-25 and 26+. This has been a steady trend in Connecticut survey data collected between 2002-2003 and 2005-2006. Ex. A, p. 24.

29. According to SAMHSA's State Profile and Underage Drinking Facts, 137,000 (32.3%) of 12-to-20 year-olds consumed alcohol in the past month and 100,000 individuals (23.5%) binged on alcohol. Mountainside currently treats many young adults with alcohol abuse and dependence and a large percentage of these clients began drinking before they were of legal drinking age. Ex. A, p. 24.

30. Mountainside contends the proposed population either a) may not be receiving detoxification services at all because of the difficulty in obtaining access to detoxification beds, b) may be accessing out-of-state detoxification services, or c) may be able to access one of the limited number of available detoxification beds in Connecticut. Ex. A, p. 24.

31. Due to the limited number of detoxification beds and the fact that the existing providers are generally at or near capacity, the proposed addition of 16 detoxification beds at Mountainside is expected to have little or no impact on any existing providers. Additionally, Mountainside has an established referral base due to its other existing behavioral health services. Ex. A, p. 25.

32. Mountainside developed the following volume projections for the proposed 16 bed increase:

    a. Monthly admissions are estimated to be 65 per month. This is based on Mountainside's recent historical admissions per month which have ranged between 65 and 80. Each admission is expected to utilize the detoxification beds. Some clients will only require 24 hours of observation but most will

require up to seven days of detoxification. Therefore, the projected detoxification admissions for a full year are estimated to be 780.

b. The projected patient days have been calculated using an average length of stay of 6 days. Therefore, for a full year, 4,680 patient days are projected. Ex. A, p. 26.

33. The following are the historical occupancy and average daily census rates for Mountainside:

Table A: Historical Occupancy Rate

	FY 2008	FY 2009	FY 2010	FY 2011
Occupancy Rate	72%	70%	74%	87%

Table B: Historical Average Daily Census

	FY 2008	FY 2009	FY 2010	FY 2011
Avg. Daily Census	48	46	46	53

Table C: Historical Variability in Census (high vs. low)

	FY 2008	FY 2009	FY 2010	FY 2011
Census High	66	66	62	61
Census Low	36	36	34	33

Table D: Historical Patient Days

	FY 2008	FY 2009	FY 2010	FY 2011
Patient Days	17,342	16,762	16,820	17,429

Ex. A, p. 27.

34. Mountainside's historical and actual service admissions (for all services) was as follows:

Table E: Historical and Actual Service Admissions

	FY 2008	FY 2009	FY 2010	FY 2011
Admissions	598	578	580	601

Ex. A, p. 28.

35. In 2008, Mountainside was a not-for-profit facility but due to recent economic challenges, it was unable to obtain the necessary funding for needed renovations and improvements to the physical plant. The facility converted to a for-profit in 2009 in order to obtain the necessary funding for physical plant improvements. As a result of these facility improvements, admissions and census have increased, approaching 90% occupancy this current fiscal year. Ex. A, p. 28.

36. Utilizing projected admissions and patient days, Mountainside expects the proposed 16 detoxification beds to operate at 80% occupancy. This occupancy rate would allow Mountainside to respond to many same-day requests for bed access. Ex. A, p. 26.

37. Mountainside's projected detoxification admissions are as follows:

Table F: Projected Residential Detoxification Admissions

	FY 2012*	FY 2013	FY 2014
Detox Admissions	768	780	780

*Annualized

38. Mountainside estimates that the age distribution for the proposed detoxification beds will be similar to their existing population, which is primarily young adults between 18 and 30 years of age, with a smaller percentage being between 30 and 65 years of age. Ex. A, p. 25.

39. The addition of the proposed 16 detoxification beds will improve timely access to residential detoxification care, improved continuity of care due to the provision of detoxification and rehabilitation care at the same location and the ability to retain Connecticut residents who currently leave the state for residential detoxification care. Ex. A, p. 26.

40. Mountainside's proposal will have a direct and positive impact on the quality of health care delivery. Availability of residential detoxification services in the same facility as the residential rehabilitation care will help ensure more drug-addicted and alcoholic individuals complete their treatment. Additionally, it will improve continuity of care and by improving access to detoxification care, will help to ensure that more individuals are entering the first phase of critical services at the same facility in which they will continue their rehabilitation to help them manage their addiction. Ex. A, p. 29.

41. The total capital expenditure associated with this proposal is $9,672,513, which includes $8,055,000 related directly to land/building construction costs and the remaining $995,000 is related to non-medical equipment purchase. Ex. A, p. 30-31.

42. The project will be funded through a combination of an equity contribution and a commercial bank loan. The equity contribution is for a total of $1,169,923 and the bank loan will be for a term of 10 years at 6% for a total loan amount of $8,502,590. Ex. A, p. 31 & 201.

43. The following table illustrates the projected net income based on the *incremental* operational revenue and expenses for the proposed 16-bed increase:

Table G: Mountainside's incremental net income

	FY 2012	FY 2013	FY 2014
Total Revenue from Operations:	**$1,728,000**	**$3,785,940**	**$4,089,750**
Total Expenses from Operations	**$1,851,565**	**$3,819,748**	**$3,908,628**
Net Income (Before Taxes)	**$(123,565)**	**$(33,808)**	**$181,122**

Ex. A, p. 200.

44. Although Mountainside is projecting small incremental losses for the first two years of the proposal attributed directly to depreciation expenses, it is projecting an incremental gain in net income by year three of the proposal. Additionally, Mountainside is projecting gains from net income for each of the first three years of the proposal for the overall facility. Ex. A, p. 200.

45. The following table illustrates the projected net income based on the operational revenue and expenses *with the proposal*:

Table G: Mountainside overall net income with proposal

	FY 2012	FY 2013	FY 2014
Total Revenue from Operations:	**$12,541,750**	**$15,140,378**	**$16,011,909**
Total Expenses from Operations:	**$12,286,382**	**$14,776,306**	**$15,413,014**
Net Income (Before Taxes)	**$255,368**	**$364,072**	**$598,896**

Ex. A, p. 200.

46. Mountainside's current patient population mix of 80% Commercial and 20% Self-Pay is not expected to change as a result of this proposal. Ex. A, p. 32.

Discussion

CON applications are decided on a case by case basis and do not lend themselves to general applicability due to the uniqueness of the facts in each case. In rendering its decision, OHCA considers the factors set forth in General Statutes § 19a-639(a) and the Applicant bears the burden of proof in this matter by a preponderance of the evidence. *Goldstar Medical Services, Inc., et al. v. Department of Social Services,* 288 Conn. 790 (2008); *Swiller v. Commissioner of Public Health*, No. CV 95-0705601 (Sup. Court, J.D. Hartford/New Britain at Hartford, October 10, 1995); *Bridgeport Ambulance Serv. v. Connecticut Dept. of Health Serv.*, No. CV 88-0349673-S (Sup. Court, J.D. Hartford/New Britain at Hartford, July 6, 1989); *Steadman v. SEC*, 450 U.S. 91, 101 S.Ct. 999, *reh'g den.*, 451 U.S. 933 (1981); *Bender v. Clark*, 744 F.2d 1424 (10th Cir. 1984); *Sea Island Broadcasting Corp. v. FCC*, 627 F.2d 240, 243 (D.C. Cir. 1980).

Mountainside is licensed as a Facility for the Care and Treatment of Substance Abusive or Dependent Persons in Canaan, Connecticut. FF1. The Applicant is proposing to increase its licensed bed capacity by adding 16 residential detoxification beds, which will bring its total complement of substance abuse beds to 78. FF10. Mountainside currently operates 62 Intermediate and Long-Term Treatment and Rehabilitation beds. FF3. Although Mountainside treats adults of all ages, it treats many young adults with alcohol abuse and dependence and a large percentage of these clients began drinking before they were of legal drinking age. FF29.

Mountainside, is a residential drug and alcoholism rehabilitation facility, uses a multi-disciplinary approach to help individuals suffering from addiction and provides individual addiction treatment and comprehensive aftercare. FF4. Current treatment methods include, but are not limited to, one-on-one and group counseling, day, evening and outpatient treatments as well as aftercare. FF5. Mountainside currently uses all of its 62 licensed beds for rehabilitation care, and occupancy levels reach 100% regularly throughout the year, resulting in waiting lists. FF7.

The proposed additional beds will be utilized to provide level 3.7 residential detoxification services: providing 24-hour medically supervised evaluation and withdrawal management, a permanent facility with inpatient beds and services that are delivered under a defined set of physician-approved policies and the availability of 24-hour observation, monitoring and treatment. FF10&14. Residential detoxification generally requires five to seven days to complete before an individual is ready to begin substance abuse rehabilitation treatment, which typically continues for 28 days. FF10. Additionally, the monthly admissions are estimated to be 65 per month, which is based on Mountainside's historical admissions, which have ranged between 65 and 80 per month FF32. Offering detoxification in the same facility where rehabilitation will occur will help to ensure continuity of care throughout the patient's treatment process. FF13.

Although there are 10 facilities in Connecticut that offer level 3.7 residential detoxification service, with a total of 186 detoxification beds, these beds are not readily available for same-day service for patients requiring this level of care. FF20-22. Over the past 21 months, Mountainside has referred approximately 170 individuals to facilities outside of Connecticut (New York, New Jersey and Massachusetts) primarily due to limited or lack of (level 3.7) bed

availability. FF24. Mountainside receives requests for residential detoxification care from existing referral sources. These include physicians, acute care hospitals, family members, interventionists, therapists and other mental health facilities. FF23. As evidence, the Applicant submitted letters of support from a variety of referral sources from within Connecticut and neighboring states indicating the need for access to additional detoxification beds in Connecticut. FF24. Additionally, SAMHSA data indicates the prevalence of the significant use of drug and alcohol by the population age 12 and older at the national level; moreover, the data also indicates that Connecticut has been among the 10 states with the highest rates for illicit drug and alcohol use. According to SAMHSA data, this has been a steady trend since 2002. FF26-29. By increasing access to detoxification care through the addition of detoxification beds at Mountainside, continuity of care will be greatly enhanced and will ensure the successful completion of rehabilitation care. FF24.

It appears to OHCA there is a need for 16 additional detoxification beds, based on the Applicant's demonstration of limited access to level 3.7 detoxification service beds in Connecticut and referrals of their existing patient population to other providers in order to accommodate needed detoxification services. In addition, supporting national and state-level data provided further indicate a need. The addition of level 3.7 detoxification service beds will not only have a positive impact on the quality of health care delivery in Connecticut but will provide Mountainside an opportunity to offer a full complement of substance abuse services to their existing patients, thereby improving continuity of care.

The total capital expenditure associated with the proposal is $9,672,513, including $8,055,000 associated with construction related to land and building. FF43. Although the Applicant is projecting a net income loss incremental to the proposal, attributed directly to the non-cash depreciation expense related to the construction for the first two years of the proposal, the Applicant is projecting a gain in net income incremental to the proposal by the third year of the proposal and additionally, the net income for the total facility for the first three years of the proposal is projecting a gain. FF45-46.

Order

Based upon the foregoing Findings and Discussion, the Certificate of Need application of MCI Healthcare LLC d/b/a Mountainside Treatment Center to increase its total licensed beds by 16, from 62 total licensed beds to 78 total licensed beds at its treatment center located 187 South Canaan Road, Route 7 in Canaan, Connecticut, at an associated total capital expenditure of $9,672,513 is hereby **approved**.

All of the foregoing constitutes the final order of the Office of Health Care Access in this matter.

By Order of the
Department of Public Health
Office of Health Care Access

5/11/2012
Date

Lisa A. Davis, MBA, BSN, RN
Deputy Commissioner

LAD:swl

****
*** TX REPORT ***
****

TRANSMISSION OK

TX/RX NO	2918
RECIPIENT ADDRESS	918608244021
DESTINATION ID	
ST. TIME	05/15 16:23
TIME USE	01'49
PAGES SENT	13
RESULT	OK

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: Terence Doughtery

FAX: (860) 824-4021

AGENCY:

FROM: Steven Lazar

DATE: 5/14/12 **TIME:** 8 4:15

NUMBER OF PAGES:
(including transmittal sheet

Comments: Final Decision, DN. 11-31734 - Con Cleland

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.