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

☒ (**New**). A completed supplemental application specific to the proposal type can be found on OHCA's website at "OHCA Forms." A list of supplemental forms can be found on page 2.

☒ 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.

☒ Attached is evidence demonstrating that public notice has been published in a suitable newspaper that relates to the location of the proposal, 3 days in a row, at least 20 days prior to the submission of the CON application to OHCA. (*OHCA requests that the Applicant fax a courtesy copy to OHCA (860) 418-7053, at the time of the publication)*

☒ Attached is a completed Financial Attachment

☒ Submission includes one (1) original hardcopy in a 3-ring binder and a USB flash drive containing:

1. A scanned copy of each submission in its entirety, including all attachments in Adobe (.pdf) format.
2. An electronic copy of the applicant's responses in MS Word (the applications) and MS Excel (the financial attachment).

For OHCA Use Only:

Docket No.: ______________ **Check No.:** 2349

OHCA Verified by: [signature] **Date:** 4/19/17

Checklist

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For OHCA Use Only:

Docket No.: ______________ **Check No.: ________**
OHCA Verified by:__________ **Date: ____________**

State of Connecticut
Department of Public Health
Office of Health Care Access

Certificate of Need Application
Main Form
Required for all CON applications

Contents:

- Checklist
- List of Supplemental Forms
- Proposal Information
- Affidavit
- Executive Summary
- Project Description
- Public Need and Access to Health Care
- Financial Information
- Utilization

Supplemental Forms

In addition to completing this **Main Form** and **Financial Worksheet (A, B or C)**, the applicant(s) must complete the appropriate **Supplemental Form** listed below. Check the box of the **Supplemental Form** to be submitted with the application, below. If unsure which form to select, please call the OHCA main number (860-418-7001) for assistance. All CON forms can be found on OHCA's website at OHCA Forms.

Check form included	Conn. Gen. Stat. Section 19a-638(a)	Supplemental Form
☒	(1)	**Establishment of a new health care facility (mental health and/or substance abuse)** - *see note below**
☐	(2)	**Transfer of ownership of a health care facility** (excludes transfer of ownership/sale of hospital – see "Other" below)
☐	(3)	**Transfer of ownership of a group practice**
☐	(4)	**Establishment of a freestanding emergency department**
☐	(5) (7) (8) (15)	**Termination of a service:** - inpatient or outpatient services offered by a hospital - surgical services by an outpatient surgical facility** - emergency department by a short-term acute care general hospital - inpatient or outpatient services offered by a hospital or other facility or institution operated by the state that provides services that are eligible for reimbursement under Title XVIII or XIX of the federal Social Security Act, 42 USC 301, as amended
☐	(6)	**Establishment of an outpatient surgical facility**
☐	(9)	**Establishment of cardiac services**
☐	(10) (11)	**Acquisition of equipment:** - acquisition of computed tomography scanners, magnetic resonance imaging scanners, positron emission tomography scanners or positron emission tomography-computed tomography scanners - acquisition of nonhospital based linear accelerators
☐	(12)	**Increase in licensed bed capacity** of a health care facility
☐	(13)	**Acquisition of equipment utilizing [new] technology** that has not previously been used in the state
☐	(14)	**Increase of two or more operating rooms** within any three-year period by an outpatient surgical facility or short-term acute care general hospital
☐	Other	**Transfer of Ownership / Sale of Hospital**

*This supplemental form should be included with all applications requesting authorization for the establishment of a **mental health and/or substance abuse treatment facility**. For the establishment of other "health care facilities," as defined by Conn. Gen. Stat § 19a-630(11) - hospitals licensed by DPH under chapter 386v, specialty hospitals, or a central service facility - complete *the Main Form* only.

**If termination is due to insufficient patient volume, or it is a subspecialty being terminated, a CON is not required.

Proposal Information

Select the appropriate proposal type from the dropdown below. If unsure which item to select, please call the OHCA main number (860-418-7001) for assistance.

Proposal Type (select from dropdown)	Establishment of a new health care facility
Brief Description	Counseling Center of Waterbury, LLC, d/b/a Connecticut Counseling & Wellness, proposes to establish an intensive outpatient program for the care and treatment of substance abusive or dependent adults at its existing location in Wolcott, Connecticut.
Proposal Address	1776 Meriden Road, Wolcott, CT
Capital Expenditure	$ 0

Is this Application the result of a Determination indicating a CON application must be filed?

☐ No

☐ Yes, Docket Number: Click here to enter text.

Applicant(s) Information

	Applicant One	**Applicant Two*** (if applicable)
Applicant Name & Address	Counseling Center of Waterbury, LLC, d/b/a Connecticut Counseling & Wellness	
Parent Corporation Name & Address (if applicable)		
Contact Person Name	Amy St. Pierre	
Title	Clinical Supervisor	
Email Address	amy@ccwellness.org	
Phone	203-596-7870	
Fax Number		
Tax Status (check one box)	☒ For Profit ☐ Not-for-Profit	☐ For Profit ☐ Not-for-Profit

**For more than two Applicants, attach a separate sheet with the above information*

FOR OFFICE USE ONLY

Docket #:	Staff Assigned :
Date Received:	

Affidavit

Applicant: Counseling Center of Waterbury, LLC

Project Title: Establishment of Intensive Outpatient Program for the Care or Treatment of Substance Abusive or Dependent Persons in Wolcott, CT

I, Gerard Marcil, Jr. , CEO
(Name) (Position – CEO or CFO)

of Counseling Center of Waterbury being duly sworn, depose and state that the (Facility Name) said facility complies with the appropriate and applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 and/or 4-181 of the Connecticut General Statutes.

Signature Date: April 12, 2017

Subscribed and sworn to before me on April 12, 2017

Notary Public/~~Commissioner of Superior Court~~

Phyllis A. DiLeo
NOTARY PUBLIC
STATE OF Connecticut
My Commission Expires August 31, 2018

My commission expires: __________

Executive Summary

The purpose of the Executive Summary is to give the reviewer a conceptual understanding of the proposal. In the space below, provide a succinct overview of your proposal (this may be done in bullet format). Summarize the key elements of the proposed project. Details should be provided in the appropriate sections of the application that follow.

The Applicant, Counseling Center of Waterbury, LLC, d/b/a Connecticut Counseling & Wellness, ("CCW") proposes to establish an intensive outpatient program ("IOP") for the care and treatment of substance abusive or dependent adults at its existing location in Wolcott, Connecticut.

CCW has been providing services to adults with substance use disorders ("SUDs") for residents of Waterbury and its surrounding suburbs for over 20 years. CCW currently provides individual substance abuse counseling, group substance abuse counseling, counseling services for family members of addicted persons, as well as counseling regarding conditions associated with addiction, including anger management and domestic violence counseling. CCW does not currently hold a DPH license.

The growing opioid epidemic in Connecticut as well as the number of adults confronting other substance abuse disorders has created a clear public need for IOP services in the Greater Waterbury area. In its first year of operation, CCW anticipates serving approximately 5 IOP clients per week, with each client's individualized recovery plan involving visits at least 3 days per week, for 3-4 hours at a time. A typical patient will likely maintain this level of involvement for 4-6 weeks. After completion of IOP treatment, clients will be transitioned to an appropriate level of care through CCW.

This proposal will meet the need for additional addiction treatment in Connecticut and help address what the Department of Mental Health and Addiction Services recently described as potentially the single largest health crisis in the State. In addition, it will improve quality, accessibility and cost-effectiveness of health care in the region, expand patient choice and improve outcomes for one of the state's most vulnerable patient populations.

Pursuant to Section 19a-639 of the Connecticut General Statutes, the Office of Health Care Access is required to consider specific criteria and principles when reviewing a Certificate of Need application. Text marked with a "§" indicates it is actual text from the statute and may be helpful when responding to prompts.

Project Description

1. Provide a detailed narrative describing the proposal. Explain how the Applicant(s) determined the necessity for the proposal and discuss the benefits for each Applicant separately (if multiple Applicants). Include all key elements, including the parties involved, what the proposal will entail, the equipment/service location(s), the geographic area the proposal will serve, the implementation timeline and why the proposal is needed in the community.

   Counseling Center of Waterbury, LLC, d/b/a Connecticut Counseling & Wellness ("CCW"), is located at 1776 Meriden Road in Wolcott, Connecticut and currently provides outpatient substance abuse counseling to adults in the area. CCW proposed to expand its services to include the establishment of an IOP for the care or treatment of substance abusive or dependent adults, both male and female, at its existing location. CCW professionals possess over 60 years of counseling experience collectively and its lead clinician, Jerry Marcil, has been a fixture of the community for more than two decades. CCW currently provides outpatient substance abuse treatment services, including individual substance abuse counseling, group substance abuse counseling, services for family members of addicted persons, recovery and relapse prevention groups, and counseling regarding conditions associated with addiction, including anger management and domestic violence. CCW provides services to clients throughout the greater Waterbury area, with the majority of its clients residing in Waterbury, Wolcott, Naugatuck, Watertown, Southbury, Branford, Cheshire, New Britain, and Wallingford (the "Service Area"). In providing these services, CCW has become aware of the need for additional IOP availability in the Service Area, particularly in an exurban setting.

   Currently the need for the treatment of substance abuse disorder ("SUDs") in the Service Area, as well as nationally, far exceeds capacity. According to the 2016 Surgeon General's Report on Alcohol, Drugs, and Health, "In 2014 there were 47,055 drug overdose deaths including 28,646 people who died from a drug overdose involving some type of opioid, including prescription pain relievers and heroin – more than in any previous year on record." Connecticut in particular is currently facing an opioid epidemic. During his tenure, Governor Malloy has prioritized battling the opioid epidemic in the state of Connecticut, and his first legislative proposal of the 2017 Session focuses efforts on reducing the potential for people to become addicted.[1] In 2016, DMHAS issued a *Triennial State Substance Abuse Plan* which explains that "Connecticut has been in the grips of an opioid epidemic that has resulted in increasing numbers of overdose deaths across the state. . . . This issue has now become perhaps the single most important health concern we as a state are facing." [2]

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[1] Governor Dannel Malloy, Press Release: Gov. Malloy proposes legislative package to further the state's efforts combating opioid addiction and overdoses (Jan. 26, 2017), available at http://portal.ct.gov/Office-of-the-Governor/Press-Room/Press-Releases/2017/01-2017/Gov-Malloy-Proposes-Legislative-Package-to-Further-the-States-Efforts-Combating-Opioid-Addiction.

[2] Miriam Delphin-Rittmon, Commissioner, & Nancy Navarretta, Deputy Commissioner, DMHAS, *Triennial State Substance Abuse Plan*, available at http://www.ct.gov/dmhas/lib/dmhas/publications/triennialreport2016.pdf.

The Community Health Needs Assessment ("CHNA") process in Connecticut has also identified substance abuse as a problem in all communities and made SUD treatment a priority.[3] The 2014 Statewide Health Care Facilities and Services Plan ("Statewide Plan") acknowledges that "improving access to treatment for . . . substance abuse is a priority for the State as a whole and each of the communities in Connecticut." Additionally, the Statewide Plan explains that Community Health Needs Assessments "show the need to increase availability and access to . . . substance abuse . . . care . . . ." At a local level, the Greater Waterbury Health Improvement Partnership (a collaboration among Saint Mary's Hospital, Waterbury Hospital, the Waterbury Department of Public Health, the City of Waterbury, and other community partners) published a CHNA in 2013 which identified substance abuse as a health priority.[4] The CHNA identified increasing access to substance abuse treatment services as one of the ways to address this issue.[5] A 2016 CHNA published by Saint Mary's Hospital in collaboration with the Greater Waterbury Health Improvement Partnership also identified substance abuse as a priority and stated that "as one of the top five conditions for [their] Emergency Department non-admission rates, substance use and abuse remains a problem in particular with prescription and opioid based medications."[6]

While some IOPs currently operate in the Service Area, CCW has become aware of the need for additional substance abuse treatment services. Over the past few years, CCW has experienced a steady rise in the number of individuals seeking substance abuse treatment generally. Additionally, existing clients and referral sources have communicated to CCW that the availability of IOPs in the area is limited, requiring that some individuals travel to a facility outside of their community in order to receive treatment immediately. Providing accessibility to comprehensive services when an individual is in crisis is a key to the successful treatment of substance abuse.

In addition to increasing the availability of intensive outpatient treatment, CCW's IOP will provide individuals with an option that is distinguishable from existing programs in the Service Area for the following reasons:

- Unique Practice Setting: CCW is a small private practice located in a discrete, rural setting and will offer an alternative to the larger treatment facilities in the City of Waterbury.
- Continuity of Care: Through treating clients who have recently completed IOPs, CCW has experienced first-hand the difficulties with clients transferring from one provider to another and understands that continuity of care would benefit these clients. After a client completes IOP treatment at CCW, he or she can continue to receive treatment at CCW through various step-down programs. CCW understands that recovery is a life-long process and intends to continue to provide these clients

[3] State of Connecticut Department of Public Health, *Statewide Facilities and Services Plan 2014 Supplement*, p. 77, available at http://www.ct.gov/dph/lib/dph/ohca/publications/2014/final_2014__facilities_plan_-_2_24_15.pdf.
[4] Greater Waterbury Health Improvement, Community Health Needs Assessment, p. 9 (2013), available at http://www.ct.gov/dph/lib/dph/ohca/community_needs_assessment/chna/2014/waterbury_hospital.pdf.
[5] Greater Waterbury Health Improvement, Community Health Needs Assessment, p. 45 (2013), available at http://www.ct.gov/dph/lib/dph/ohca/community_needs_assessment/chna/2014/waterbury_hospital.pdf.
[6] Saint Mary's Hospital, Community Health Needs Assessment, p. 16 (2016), available at http://www.stmh.org/app/files/public/1583/SMHCHNA16.pdf.

with services appropriate for their needs at each stage of recovery. Even after an individual is no longer a regular client of CCW, he or she will still have a person that they can contact, at any time of day, in times of need. This continuity of care will allow CCW to establish meaningful relationships with clients and provide clients with high quality care.

- Personalized Program: The IOP offered by CCW will be highly personalized to each client's unique needs. In order to provide the best care possible, CCW intends to begin by working with only 5 IOP clients at any given time and will only gradually increase this number based on resource availability and other appropriate measures.
- Strong Family Component: CCW understands that the family can play a very important role in recovery and intends to establish a program with a strong family component. Not only will CCW offer group sessions for family members of clients, but CCW will also make available individual sessions to further collaborate with the client and his or her family to achieve a personalized treatment program.
- Community Knowledge: CCW has been providing substance use services in the area for over 20 years. CCW understands the community and has established referral relationships with other community-based organizations to transition patients and improve outcomes.

CCW does not require additional space as its planning activities resulted in CCW moving to a larger location two years ago where it has capacity for an IOP and the equipment and staffing necessary to begin operations. Accordingly, CCW intends to begin accepting clients into the IOP immediately upon CON approval and issuance of a license by DPH.

2. Provide the history and timeline of the proposal (i.e., When did discussions begin internally or between Applicant(s)? What have the Applicant(s) accomplished so far?).

   CCW began considering establishing an IOP approximately one year ago, after the need for additional IOPs in the Service Area had become increasingly apparent. The IOP will begin operation as soon as it receives CON approval and DPH licensure as a private freestanding facility for the care or treatment of substance abusive or dependent persons.

3. Provide the following information:

   a. utilizing **OHCA Table 1**, list all services to be added, terminated or modified, their physical location (street address, town and zip code), the population to be served and the existing/proposed days/hours of operation;

   b. identify in **OHCA Table 2** the service area towns and the reason for their inclusion (e.g., provider availability, increased/decreased patient demand for service, market share);

4. List the health care facility license(s) that will be needed to implement the proposal;

   In order to implement this proposal, CCW will need to obtain a license from the Department of Public Health as a Private Freestanding Facility for the Care or Treatment of Substance Abusive or Dependent Persons.

5. Submit the following information as attachments to the application:

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

Not applicable

b. a list of all key professional, administrative, clinical and direct service personnel related to the proposal and attach a copy of their Curriculum Vitae;

The following key individuals are engaged to implement the proposed services. Copies of the Curriculum Vitae appear in Attachment I.

- Gerard Marcil, LADC, Director
- Amy St. Pierre, LADC, Clinical Supervisor

c. copies of any scholarly articles, studies or reports that support the need to establish the proposed service, along with a brief explanation regarding the relevance of the selected articles;

See Attachment II for the following articles:

Substance Abuse Intensive Outpatient Programs: Assessing the Evidence: This article provides a review of evidence supporting the effectiveness of IOP services.

Department of Mental Health and Addiction Services Annual Statistical Report (2016) : This article provides statistics regarding the individuals served by DMHAS programs.

Drugs, Death, and Despair in New England: This article provides insight into the opioid crisis in New England in particular.

National Survey on Drug Use and Health (Excerpts): This report provides statistics regarding the prevalence of SUDs nationally.

Behavioral Health Barometer: Connecticut (Excerpts): This report provides the statistics regarding the prevalence of SUDs in the state of Connecticut.

Substance Abuse: Clinical Intensive Outpatient Treatment: SAMHSA Treatment Improvement Protocol (TIP) 47, Quick Guide for Clinicians (Excerpts): This treatment improvement protocol provides consensus-based, field-reviewed guidelines on IOP.

d. letters of support for the proposal;

See Attachment III.

e. the protocols or 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 the protocols or guidelines.

See Attachment IV.

f. copies of agreements (e.g., memorandum of understanding, transfer agreement, operating agreement) related to the proposal. If a final signed version is not available, provide a draft with an estimated date by which the final agreement will be available.

Not applicable.

Public Need and Access to Care

> § *"Whether the proposed project is consistent with any applicable policies and standards adopted in regulations by the Department of Public Health;" (Conn. Gen. Stat. § 19a-639(a)(1))*

6. Describe how the proposed project is consistent with any applicable policies and standards in regulations adopted by the Connecticut Department of Public Health.

   CCW will be applying for licensure as a private freestanding facility for the care or the treatment of substance abusive or dependent persons, and will therefore implement the proposed project in a manner consistent with the requirements set forth in R.C.S.A. §19a-495-570 (*Licensure of private freestanding facilities for the care or the treatment of substance abusive or dependent persons*). Additionally, clinical professional staff members and any consultants who will be providing services at CCW as part of the IOP will be required to be appropriately licensed to practice in the state of Connecticut, and to maintain their licenses in accordance with Title XX of the Public Health Code (which includes the license requirements for alcohol and drug counselors).

> § *"The relationship of the proposed project to the statewide health care facilities and services plan;" (Conn. Gen. Stat. § 19a-639(a)(2))*

7. Describe how the proposed project aligns with the Connecticut Department of Public Health Statewide Health Care Facilities and Services Plan, available on OHCA's website.

   The 2014 Statewide Plan states that "improving access to treatment for . . . substance abuse is a priority for the State as a whole and each of the communities in Connecticut." Additionally, the Statewide Plan explains that CHNAs "show the need to increase availability and access to . . . substance abuse . . . care . . . ." This proposal would improve access to intensive outpatient treatment of SUDs and is therefore aligned with the Statewide Plan.

> § *"Whether there is a clear public need for the health care facility or services proposed by the applicant;" (Conn. Gen. Stat. § 19a-639(a)(3))*

8. With respect to the proposal, provide evidence and documentation to support clear public need:

   a. identify the target patient population to be served;

      The target population to be served is adults (18 years of age and above), both male and female, with diagnosable SUDs who reside in the Service Area. These clients will reach CCW from a variety of sources, including referrals from Trade Union 478, with which CCW has an existing relationship. Other clients will be referred by providers and community organizations such as Wolcott Crossroads and Family + Children's Aid. In addition, in keeping with CCW's current referral patterns, a significant portion will be referred by former CCW clients.

b. discuss how the target patient population is currently being served;

The target population will be existing and future clients of CCW in need of IOP services. Current clients who completed an IOP prior to receiving treatment through CCW did not have the option of receiving IOP treatment in Wolcott. It is difficult to say definitively how other individuals in the Service Area receiving IOP therapy are being served, as this information is not publicly available. It is CCW's understanding that existing IOPs in the area often operate at capacity, requiring potential clients to be placed on a wait list or to travel out of their local community for treatment. Additionally, the trade union with which CCW has had a longstanding relationship currently sends some potential clients to out of state IOPs. CCW's proposed IOP program will bring these services back to the state of Connecticut, allowing clients to be closer to their families and continue to work (full or part-time) during IOP participation.

c. document the need for the equipment and/or service in the community;

Need for Treatment Nationally:

The general population segment within which the target population rests includes adults (ages 18 years and above), both male and female, with diagnosable SUDs who reside in the Service Area.

Most current national data from the Substance Abuse and Mental Health Services Administration ("SAMHSA"), an operating division of the US. Department of Health and Human Services, is from 2015. Based upon results from the National Survey on Drug Use and Health ("NSDUH"), the prevalence of SUDs (including alcohol and illicit drugs) among adults in the United States was at 5.9% of the population (ages twelve and over) in 2015.[7]

Need for Treatment in Connecticut:

The most compelling evidence demonstrating the need for SUD treatment in Connecticut comes from the *Behavioral Health Barometer – Connecticut 2015*, a publication by SAMHSA which shows a rate of SUD prevalence above national benchmarks.[8] For 2013-14, SAMHSA estimated that in Connecticut approximately 6.8% of individuals aged 12 or older (approximately 206,000 individuals) were dependent on or abused alcohol within the year prior to being surveyed. This is higher than the national average of 6.5%. With respect to Connecticut residents twelve years of age and above with alcohol dependence or abuse, data from 2010 to 2014 shows that only 7.1% received treatment, and 92.9% did not receive treatment. Similarly, for Connecticut residents twelve years of age and above, in 2013-14 2.9% were dependent on or abused illicit drugs (approximately 88,000 individuals), a number higher than the national average of 2.6%. Data from 2010 to 2014 shows that only 20.1% received treatment, and 79.9% did not receive treatment. Based upon this evidence, there remains significant unmet need for alcohol and drug treatment in Connecticut. Additionally, DMHAS' *Triennial State*

[7] Results from the 2015 National Survey on Drug Use and Health: Detailed Tables, Table 5.1B, available at https://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabs-2015/NSDUH-DetTabs-2015/NSDUH-DetTabs-2015.htm.

[8] SAMHSA, *Behavioral Health Barometer – Connecticut 2015*, available at https://www.samhsa.gov/data/sites/default/files/2015_Connecticut_BHBarometer.pdf.

Substance Abuse Plan makes clear that "Connecticut has been in the grips of an opioid epidemic that has resulted in increasing numbers of overdose deaths across the state. . . . This issue has now become perhaps the single most important health concern we as a state are facing." [9] The plan goes on to explain that the opioid epidemic has led to "escalating overdose deaths related to opioids, especially over the past three years." Finally, according to Chief Medical Examiner's Office, in 2016 there were 917 accidental opioid overdose deaths reported in the state. The number of accidental opioid overdose deaths has risen substantially every year since 2012 (the earliest year publicly available).[10]

Need for Treatment in Service Area:

The above-referenced statistics from the Office of the Chief Medical Examiner's regarding accidental intoxication overdose deaths establish that of the 917 accidental overdose deaths that occurred in 2016, over 100 were from the Service Area.[11] In recent years, CCW has seen a steady increase in the demand for outpatient SUD treatment, including the need for a higher level of care (intensive outpatient treatment). This firsthand experience, coupled with the statistics reported in this application, makes it abundantly clear that the need for additional SUD treatment services in Connecticut is substantial and will likely continue to grow in the coming years.

d. explain why the location of the facility or service was chosen;

The location of the facility was chosen for a number of reasons. The facility is conveniently located off of I-84 and I-91 and is easily accessible for those in surrounding towns. Additionally, as discussed previously, the location in Wolcott offers a rural, exurban alternative for those who prefer not to travel to downtown Waterbury for treatment. The actual building was selected for its discrete location in respect of client privacy concerns.

e. provide incidence, prevalence or other demographic data that demonstrates community need

As discussed in response to Question 8.d., at a national level, NSDUH estimates that the prevalence of SUDs (including only alcohol and illicit drugs) in the United States was at 5.9% of the population (for persons ages twelve and over) in 2015.[12] In Connecticut, SAMHSA's *Behavioral Health Barometer – Connecticut 2015*[13], demonstrates that for 2013-14, 6.8% of Connecticut residents aged 12 or older were dependent on or abused alcohol within the year prior to being surveyed, which is higher than the national average

[9] Miriam Delphin-Rittmon, Commissioner, & Nancy Navarretta, Deputy Commissioner, DMHAS, *Triennial State Substance Abuse Plan*, available at http://www.ct.gov/dmhas/lib/dmhas/publications/triennialreport2016.pdf.
[10] Office of the Chief Medical Examiner, Connecticut Accidental Drug Intoxication Deaths, available at http://www.ct.gov/ocme/lib/ocme/AccidentalDrugIntoxication2012-2016.pdf.
[11] Office of the Chief Medical Examiner, Accidental Drug Intoxication in Excel by town/city (2015-16), available at http://www.ct.gov/ocme/cwp/view.asp?a=2165&Q=295128&ocmeNav=|
[12] Results from the 2015 National Survey on Drug Use and Health: Detailed Tables, Table 5.1B, available at https://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabs-2015/NSDUH-DetTabs-2015/NSDUH-DetTabs-2015.htm
[13] SAMHSA, *Behavioral Health Barometer – Connecticut 2015*, available at https://www.samhsa.gov/data/sites/default/files/2015_Connecticut_BHBarometer.pdf

of 6.5%. With respect to Connecticut residents twelve years of age and above with alcohol dependence or abuse, data from 2010 to 2014 shows that only 7.1% received treatment, and 92.9% did not receive treatment. Similarly, for Connecticut residents twelve years of age and above, in 2013-14 2.9% were dependent on or abused illicit drugs (approximately 88,000 individuals), a number higher than the national average of 2.6%. Additionally, from 2010 to 2014 only 20.1% received treatment, and 79.9% did not receive treatment. [14]

In 2016, there were 917 accidental intoxication overdose deaths reported in the state and 116 of these were from the Service Area.[15] The number of accidental opioid overdose deaths has risen substantially in recent years, as shown in the chart below.

Connecticut Accidental Drug Intoxication Deaths
Office of the Chief Medical Examiner

	2012	2013	2014	2015	2016
Accidental Intoxication Deaths*	357	495	568	729	**917**
-Heroin, Morphine, and/or Codeine detected	195	286	349	445	**541**
-Heroin in any death	174	258	327	416	**504**
-Heroin + Fentanyl	1	9	37	108	**276**
-Heroin + Cocaine	50	69	73	106	**152**
-Morphine/Opioid/Codeine NOS	21	28	22	29	**37**
-Cocaine in any death	105	147	126	177	**273**
-Oxycodone in any death	71	75	107	95	**110**
-Methadone in any death	33	48	51	71	**84**
-Hydrocodone in any death	15	19	15	20	**20**
-Fentanyl in any death	14	37	75	188	**479**
-Fentanyl + Cocaine	2	16	14	43	**142**
-Fentanyl + Prescription Opioid	4	7	14	23	**72**
-Fentanyl + Heroin	1	9	37	108	**276**
-Any Opioid + Benzodiazepine	41	60	140	221	**232**
-Hydromorphone	1	0	12	17	**22**
-Amphetamine/Methamphetamine	7	5	11	20	**19**
-MDMA	0	0	2	1	**1**

*Some deaths had combinations of drugs; pure ethanol intoxications are not included.
NOS, not otherwise specified
Source: Office of the Chief Medical Examiner (data updated 2/24/17).

f. discuss how low income persons, racial and ethnic minorities, disabled persons and other underserved groups will benefit from this proposal;

In 2016, 43% of CCW's clients were Medicaid recipients. CCW will accept Medicaid patients into the proposed IOP as well. Additionally, in accordance with their Pro Bono

[14] SAMHSA, *Behavioral Health Barometer – Connecticut 2015*, available at https://www.samhsa.gov/data/sites/default/files/2015_Connecticut_BHBarometer.pdf
[15] Office of the Chief Medical Examiner, 2015 to 2016 *town/city) Accidental Drug Intoxication in Excel, available at http://www.ct.gov/ocme/cwp/view.asp?a=2165&Q=295128&ocmeNav=|

Policy and Fee Scale and Fee Agreement, CCW will work with clients who have limited resources on a case by case basis to determine how to best meet their needs.

g. list any changes to the clinical services offered by the Applicant(s) and explain why the change was necessary;

   Applicant currently offers outpatient substance abuse treatment services. Approval of this application will allow CCW to offer intensive outpatient substance abuse treatment services. Please see responses to questions 1 and 4 for reasons why this change is necessary.

h. explain how access to care will be affected; and

   As discussed in response to Questions 1 and 8, there is a need for IOP services in the Service Area as evidenced by: i) SAMHSA's national and state-level statistics; ii) the Greater Waterbury CHNAs; and iii) the Office of the Chief Medical Examiner's publication. Accordingly, establishing a new IOP in the Service Area will improve access to needed care.

i. discuss any alternative proposals that were considered.

   No alternative proposals needed to be considered.

> *§ "Whether the applicant has satisfactorily demonstrated how the proposal will improve quality, accessibility and cost effectiveness of health care delivery in the region, including, but not limited to, (A) provision of or any change in the access to services for Medicaid recipients and indigent persons; (Conn. Gen. Stat. § 19a-639(a)(5))*

9. Describe how the proposal will:

   a. improve the quality of health care in the region;

      The proposal would improve the quality of health care in the region by adding a new, high quality IOP. CCW has been in operation for over 20 years and employs a staff with substantial SUD treatment experience. CCW has a long-term, family-centered approach to SUD treatment. It is widely understood in the addictions field that the longer one remains engaged in treatment, the better the odds are for achieving sustained recovery. After a client has successfully completed the IOP, he or she will be transitioned to a lower level of care at CCW as appropriate. CCW will provide educational and regular group therapy sessions. This cohesive clinical approach will encourage continuing of care and better outcomes, improving quality of care in the region.

   b. improve accessibility of health care in the region; and

      See response to question 8.

   c. improve the cost effectiveness of health care delivery in the region.

      There are a number of ways that the proposal will improve the cost effectiveness of

health care delivery in the region. First, it is well established that investment in substance abuse treatment saves the health care system money. According to a 2012 Office of National Drug Control Policy report, every dollar spent on substance abuse treatment saves $4 in healthcare costs.[16] Second, some clients will be able to receive intensive outpatient treatment in a more convenient location, allowing them to continue to work during IOP treatment. Third, CCW's SUD treatment experience, in combination with its family-centered and long-term approach to treatment, will lead to better outcomes and will thereby reduce the costs associated with client relapse.

10. How will the Applicant(s) ensure that future health care services provided will adhere to the National Standards on culturally and Linguistically Appropriate Services (CLAS) to advance health equity, improve quality and help eliminate health care disparities in the projected service area. (More details on CLAS standards can be found at http://minorityhealth.hhs.gov/).

    Applicant will adhere to the National Standards on Culturally and Linguistically Appropriate Services ("CLAS"). CCW will accomplish this by maintaining up to date on the CLAS standards and the State of Connecticut Department of Public Health's policies and statements related to the equitable provision of public health services and the CLAS standards.

11. How will this proposal help improve the coordination of patient care (explain in detail regardless of whether your answer is in the negative or affirmative)?

    This proposal will help improve the coordination of patient care by allowing CCW clients who receive treatment through the proposed IOP to gradually transition to a lower level of care with CCW. The ability to develop a long-term relationship with CCW is expected to improve client outcomes.

    Additionally, CCW intends to develop relationships with other SUD providers in the area who offer inpatient treatment services and would like their discharged patients to step down to an IOP. This coordination will facilitate a smooth transition from inpatient to intensive outpatient treatment.

12. Describe how this proposal will impact access to care for Medicaid recipients and indigent persons.

    In 2016, 43% of CCW's clients were Medicaid recipients. The Medicaid population will continue to be served as CCW will accept Medicaid recipients into its proposed IOP as well.

    Additionally, pursuant to its Pro Bono Policy and the sliding fee scale described in its Fee Scale and Fee Agreement, CCW will work with clients on a case by case basis to determine how to best meet each individual's needs.

13. Provide a copy of the Applicant's charity care policy and sliding fee scale applicable to the proposal.

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[16] Office of National Drug Control Policy, Executive Office of the President, *Cost Benefits of Investing Early in Substance Abuse Treatment* (May 2012), available at https://obamawhitehouse.archives.gov/sites/default/files/ondcp/Fact_Sheets/investing_in_treatment_5-23-12.pdf.

See Pro Bono Policy and the sliding fee scale described in the Fee Scale and Fee Agreement at Attachment V.

> *§ "Whether an applicant, who has failed to provide or reduced access to services by Medicaid recipients or indigent persons, has demonstrated good cause for doing so, which shall not be demonstrated solely on the basis of differences in reimbursement rates between Medicaid and other health care payers;" (Conn. Gen. Stat. § 19a-639(a)(10))*

14. If the proposal fails to provide or reduces access to services by Medicaid recipients or indigent persons, provide explanation of good cause for doing so.

Not applicable.

> *§ "Whether the applicant has satisfactorily demonstrated that any consolidation resulting from the proposal will not adversely affect health care costs or accessibility to care." (Conn. Gen. Stat. § 19a-639(a)(12))*

15. Will the proposal adversely affect patient health care costs in any way? Quantify and provide the rationale for any changes in price structure that will result from this proposal, including, but not limited to, the addition of any imposed facility fees.

The proposal will not adversely affect patient health care costs in any way. In fact, by increasing access to IOP services, the proposal should help facilitate more SUD care being provided in the less costly outpatient setting.

Financial Information

> *§ "Whether the applicant has satisfactorily demonstrated how the proposal will impact the financial strength of the health care system in the state or that the proposal is financially feasible for the applicant;" (Conn. Gen. Stat. § 19a-639(a)(4))*

16. Provide the Applicant's fiscal year: start date (mm/dd) and end date (mm/dd).

    01/01 to 12/31.

17. Describe the impact of this proposal on the financial strength of the state's health care system or demonstrate that the proposal is financially feasible for the applicant.

    The proposal will improve the financial strength of the state's health care system as it will improve access to much needed services and will enable more residents, including a sizeable number of Medicaid recipients, to enroll in a local program close to where they live and work.

    As discussed previously, the proposal will also improve continuity of care, leading to better patient outcomes and decreased health care costs overall.

    The proposal is financially feasible to the Applicant. The proposal does not require the expenditure of additional funds or expansion of existing facilities, and as is established in Attachment VII (Financial Worksheet B), will produce incremental net gains from the start of operations, with continued increases throughout the three-year projection period.

18. Provide a final version of all capital expenditure/costs for the proposal using **OHCA Table 3.**

19. 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.

    As established in Table 3, the proposal does not require any additional capital expenditure and therefore does not require any additional funding sources.

20. Include as an attachment:

    a. audited financial statements for the most recently completed fiscal year. If audited financial statements do not exist, provide other financial documentation (e.g., unaudited balance sheet, statement of operations, tax return, or other set of books). Connecticut hospitals required to submit annual audited financial statements may reference that filing, if current;

       Unaudited balance sheets, statements of operations, and tax returns are provided in Attachment VI.

    b. completed **Financial Worksheet A (non-profit entity), B (for-profit entity) or C (§19a-486a sale)**, available on OHCA's website under OHCA Forms, providing a summary of revenue, expense, and volume statistics, "without the CON project," "incremental to the

CON project," and "with the CON project." **Note: the actual results reported in the Financial Worksheet must match the audited financial statement that was submitted or referenced.**

A completed Financial Worksheet B for CCW appears in Attachment VII.

21. Complete **OHCA Table 4** utilizing the information reported in the attached Financial Worksheet.

22. Explain all assumptions used in developing the financial projections reported in the Financial Worksheet.

CCW assumes a July 1, 2017 start date for the proposed IOP.

Rates are projected to increase at 3.5% per year.

The percentage of revenue from government, non-government, and self-pay clients is expected to remain the same.

Units of service are three-hour intensive outpatient treatment sessions, provided 3 times per week per client.

Projections regarding revenues *with the CON* assume the following: in 2017, the IOP will serve an average of 5 clients per week (15 visits total per week); in 2018, the IOP will serve an average of 6 clients per week (18 visits total per week); in 2019, the IOP will serve an average of 7 clients per week (21 visits total per week); and in 2020, the IOP will serve an average of 8 clients per week (24 visits total per week). CCW anticipates a steady increase in the number of clients served each year, consistent with the increase in the number of clients receiving outpatient treatment services through CCW, as evidenced in Table 5.

Bad debt is projected at .3%.

For operating expenses, CCW assumes a projected increase of 1.5% per year.

Additionally, if the CON is approved CCW anticipates employing or contracting with an additional health care professional beginning in 2018. We have estimated the additional salaries and wages for this individual at $40,000, although we are unsure what the additional need will be or the type of professional that will be hired or contracted.

23. Explain any projected incremental losses from operations resulting from the implementation of the CON proposal.

Not applicable.

24. Indicate the minimum number of units required to show an incremental gain from operations for each projected fiscal year.

As there are no costs associated with establishing the proposed IOP, any number of units will show an incremental gain from operations for each projected fiscal year.

Utilization

> *§ "The applicant's past and proposed provision of health care services to relevant patient populations and payer mix, including, but not limited to, access to services by Medicaid recipients and indigent persons;" (Conn. Gen. Stat. § 19a-639(a)(6))*

25. Complete **OHCA Table 5** and **OHCA Table 6** for the past three fiscal years ("FY"), current fiscal year ("CFY") and first three projected FYs of the proposal, for each of the Applicant's existing and/or proposed services. Report the units by service, service type or service level.

26. Provide a detailed explanation of all assumptions used in the derivation/ calculation of the projected service volume; explain any increases and/or decreases in volume reported in OHCA Table 5 and 6.

    Table 5:
    No assumptions were required with respect to Table 5. Because FY 2017 is less than 6 months (January 1, 2017 through March 31, 2017), the actual volume for this time frame was reported.

    Table 6:
    With respect to Table 6, the Outpatient Substance Abuse Treatment was predicted using a 3.5% increase per year, as from 2014 to 2015, the increase was 3.44%, and from 2015 to 2017, the increase was 6.6% over a two year period (we excluded 2016 from our analysis as there was a great increase in visits due to the number of providers increasing for this year only). Overall, the 3.5% increase accurately reflects the increase predicted going forward.

    With respect to Table 6, the Intensive Outpatient Substance Abuse Treatment numbers predict 5 patients being seen per week in the first year, with each patient making 3 visits per week. The number of patients per week is predicted to increase to 6 in 2018, 7 in 2019, and 8 in 2020.

    For Table 6, FY 2017 for the Intensive Outpatient Substance Abuse Treatment visits only take into account 6 months, as it is anticipated that CCW will begin providing these services on July 1, 2017.

27. Provide the current and projected patient population mix (number and percentage of patients by payer) for the proposal using **OHCA Table 7** and provide all assumptions. **Note: payer mix should be calculated from patient volumes, not patient revenues.**

> *§ "Whether the applicant has satisfactorily identified the population to be served by the proposed project and satisfactorily demonstrated that the identified population has a need for the proposed services;" (Conn. Gen. Stat. § 19a-639(a)(7))*

28. Describe the population (as identified in question 8(a)) by gender, age groups or persons with a specific condition or disorder and provide evidence (i.e., incidence, prevalence or other demographic data) that demonstrates a need for the proposed service or proposal. **Please note: if population estimates or other demographic data are submitted,**

provide only publicly available and verifiable information (e.g., U.S. Census Bureau, Department of Public Health, CT State Data Center) and document the source.

The population to be served by the proposed IOP will be adults (ages 18 and over), both male and female, with SUD.

29. Using **OHCA Table 8**, provide a breakdown of utilization by town for the most recently completed fiscal year. Utilization may be reported as number of persons, visits, scans or other unit appropriate for the information being reported.

> § *"The utilization of existing health care facilities and health care services in the service area of the applicant;" (Conn. Gen. Stat. § 19a-639(a)(8))*

30. Using **OHCA Table 9**, identify all existing providers in the service area and, as available, list the services provided, population served, facility ID (see table footnote), address, hours/days of operation and current utilization of the facility. Include providers in the towns served or proposed to be served by the Applicant, as well as providers in towns contiguous to the service area.

31. Describe the effect of the proposal on these existing providers.

There is little or no anticipated impact on existing providers as these providers typically operate at or near capacity and CCW will be serving clientele that favor receiving care in a more rural, exurban setting. Also, it is believed that a number of CCW's IOP clients will be individuals who are currently receiving care outside of the state.

32. Describe the existing referral patterns in the area served by the proposal.

As this information is not publicly available, it is not possible for CCW to definitively state what the existing referral patterns are in the Service Area. With respect to Trade Union 478, CCW understands that it currently refers to patients in need of IOP to facilities outside of the state.

33. Explain how current referral patterns will be affected by the proposal.

As discussed above, CCW does not know what the current referral patterns in the general Service Area are, but it is anticipated that the approval of this CON application will have little to no impact on these referral patterns. CCW's IOP will be a relatively small operation, serving an anticipated 5 clients per week. Additionally, CCW believes that a substantial number of its IOP clients will be referred by Trade Union 478, which does not currently refer clients to other programs in the area.

> § *"Whether the applicant has satisfactorily demonstrated that the proposed project shall not result in an unnecessary duplication of existing or approved health care services or facilities;" (Conn. Gen. Stat. § 19a-639(a)(9))*

34. If applicable, explain why approval of the proposal will not result in an unnecessary duplication of services.

The approval will not result in an unnecessary duplication of services as there is currently a need for additional access to IOPs in the Service Area. See response to Question 8.

> *§ "Whether the applicant has satisfactorily demonstrated that the proposal will not negatively impact the diversity of health care providers and patient choice in the geographic region;" (Conn. Gen. Stat. § 19a-639(a)(11))*

35. Explain in detail how the proposal will impact (i.e., positive, negative or no impact) the diversity of health care providers and patient choice in the geographic region.

There are a number of ways that the proposal will positively impact the diversity of health care providers and patient choice in the geographic region beyond simply providing an additional IOP where individuals may choose to receive treatment. CCW provides a unique setting for care, as it is located in a private setting in the rural town of Wolcott, providing clients with an alternative to the larger and more urban IOPs in the area. CCW also provides a family-centered focus, providing support to a client's family members and also working with the family and the client together. Additionally, CCW has a long-term perspective on recovery, and will continually assess each individual client's needs and the level of care that is appropriate, as the client's treatment regimen evolves.

Tables

TABLE 1
APPLICANT'S SERVICES AND SERVICE LOCATIONS

Service	Street Address, Town	Population Served	Days/Hours of Operation	New Service or Proposed Termination
Outpatient Substance Abuse Treatment, including IOP	1776 Meriden Road, Wolcott, CT 06716	Adults (over the age of 18), male and female	Monday-Friday, 9am-9pm	New service

[back to question]

TABLE 2
SERVICE AREA TOWNS

List the official name of town* and provide the reason for inclusion.

Town*	Reason for Inclusion
Waterbury	These towns represent Applicant's traditional service area.
Wolcott	
Naugatuck	
Watertown	
Southbury	
Branford	
Cheshire	
New Britain	
Wallingford	

* Village or place names are not acceptable.

[back to question]

TABLE 3
TOTAL PROPOSAL CAPITAL EXPENDITURE

Purchase/Lease	**Cost**
Equipment (Medical, Non-medical, Imaging)	$0
Land/Building Purchase*	$0
Construction/Renovation**	$0
Other (specify)	$0
Total Capital Expenditure (TCE)	**$0**
Lease (Medical, Non-medical, Imaging)***	**$0**
Total Lease Cost (TLC)	**$0**
Total Project Cost (TCE+TLC)	**$0**

* 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.

[back to question]

TABLE 4
PROJECTED INCREMENTAL REVENUES AND EXPENSES

	FY 2017*+	**FY 2018***	**FY 2019***	**FY 2020**
Revenue from Operations	$97,208	$233,298	$272,181	$311,064
Total Operating Expenses	$40,000	$40,600	$41,209	$41,827
Gain/Loss from Operations	**$57,208**	**$192,698**	**$230,972**	**$269,237**

* Fill in years using those reported in the Financial Worksheet attached.

+For 2017, the projected incremental revenue from operations contemplates only 6 months of services, from 07/17 to 12/17.

[back to question]

TABLE 5
HISTORICAL UTILIZATION BY SERVICE

Service**	Actual Volume+ (Last 3 Completed FYs)			CFY Volume*
	FY 2014***	FY 2015***	FY 2016***	FY 2017***
Outpatient Substance Abuse Treatment	2,895	3,000	5,899++	800+++
Total	2,895	3,000	5,899	800

*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 6 months, report actual volume and identify the period covered.
**Identify each service type and level adding lines as necessary. Provide the number of visits or discharges as appropriate for each service type and level listed.
***Fill in years. If the time period reported is not *identical* to the fiscal year reported in Table 4 of the application, provide the date range using the mm/dd format as a footnote to the table.

+The volume is measured by number of patient visits.
++For FY 2016, CCW had additional staff, and was therefore able to see additional clients. The number of staff went back down in 2017.
+++For FY 2017, the volume accounts for January 1, 2017 through March 31, 2017.

[back to question]

TABLE 6
PROJECTED UTILIZATION BY SERVICE

Service*	Projected Volume+			
	FY 2017**	FY 2018**	FY 2019**	FY 2020
Outpatient Substance Abuse Treatment++	3,200	3,312	3,428	3,548
Intensive Outpatient Substance Abuse Treatment++++	390+++	936	1,092	1,248
Total	3,590	4,248	4,520	4,796

*Identify each service type by location and add lines as necessary. Provide the number of visits/discharges as appropriate for each service listed.
**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. If the time period reported is not *identical* to the fiscal year reported in Table 4 of the application, provide the date range using the mm/dd format as a footnote to the table.

+The volume is measured by number of patient visits.
++The estimates for Outpatient Substance Abuse Treatment visits assume a 3.5% increase each year.
+++The estimate for 2017 is for six months only, as the anticipated date of operation is July 1, 2017.
++++The estimates for IOP visits assume 15 visits per week in 2017 (5 clients at any given time, with each making 3 visits per week), 18 visits per week in 2018 (6 clients at any given time, with each making 3 visits per week), 21 visits per week in 2019 (8 clients at any given time, with each making 3 visits per week), and 24 visits per week in 2020 (9 clients at any given time, with each making 3 visits per week).

[back to question]

TABLE 7
APPLICANT'S CURRENT & PROJECTED PAYER MIX

Payer	Current FY 2017**++		Projected					
			FY 2018**		FY 2019**		FY 2020**	
	Discharges+	%	Discharges	%	Discharges	%	Discharges	%
Medicare*	0	0%	0	0%	0	0%	0	0%
Medicaid*	1544	43%	1827	43%	1943	43%	2062	43%
CHAMPUS & TriCare	0	0%	0	0%	0	0%	0	0%
Total Government	**1544**	**43%**	**1827**	**43%**	**1943**	**43%**	**2062**	**43%**
Commercial Insurers+++	1687	47%	1997	47%	2124	47%	2254	47%
Uninsured	359	10%	425	10%	452	10%	480	10%
Workers Compensation	0	0%	0	0%	0	0%	0	0%
Total Non-Government	**2046**	**57%**	**2421**	**57%**	**2576**	**57%**	**2734**	**57%**
Total Payer Mix	**3590**		**4248**		**4520**		**4796**	

*Includes managed care activity.
**Fill in years. Ensure the period covered by this table corresponds to the period covered in the projections provided. New programs may leave the "current" column blank.

The estimates for Outpatient Substance Abuse Treatment visits assume a 3.5% increase each year.
The estimate for IOP visits assume 15 visits per week in 2017 (5 clients at any given time, with each making 3 visits per week), 18 visits per week in 2018 (6 clients at any given time, with each making 3 visits per week), 21 visits per week in 2019 (8 clients at any given time, with each making 3 visits per week), and 24 visits per week in 2020 (9 clients at any given time, with each making 3 visits per week).
+"Discharges" are visits, as CCW provides only outpatient services, and after CON approval will continue to provide only outpatient services.
++The column titled "Current FY 2017" provides estimates based on 2016 payer composition. The estimates for 2017 assume that the proposed IOP is in operation for 6 months of 2017, as the anticipated date of operation is July 1, 2017.

[back to question]

TABLE 8
UTILIZATION BY TOWN

Town	Utilization FY 2016**
Waterbury	31
Wolcott	19
Naugatuck	7
Watertown	5
Southbury	4
Branford	3
Cheshire	3
New Britain	3
Wallingford	3
Other	32

*List inpatient/outpatient/ED volumes separately, if applicable
**Fill in most recently completed fiscal year.

[back to question]

TABLE 9
SERVICES AND SERVICE LOCATIONS OF EXISTING PROVIDERS

Service or Program Name	Population Served	Facility ID*	Facility's Provider Name, Street Address and Town	Hours/Days of Operation	Current Utilization
Intensive Outpatient Program	NPA	1598764474	Family Intervention Center, Inc., 22 Chase River Road, Waterbury	NPA	NPA
Intensive Outpatient Program NPA	NPA	1154415354	Catholic Charities Inc. – Archdiocese of Hartford, 56 Church Street, Waterbury	NPA	NPA
Intensive Outpatient Program	NPA	129580787	Catholic Charities Inc. – Archdiocese of Hartford, 13 Wolcott Street, Waterbury	NPA	NPA
Intensive Outpatient Program	NPA	1477999340	Staywell Health Care, Inc., 1309 Main Street, Waterbury	NPA	NPA
Intensive Outpatient Program	NPA	1083022230	Staywell Health Care, Inc., 402 East Main Street, Waterbury	NPA	NPA
Intensive Outpatient Program	NPA	1962760561	Wellmore, Inc., 402 East Main Street, Waterbury	NPA	NPA
Intensive Outpatient Program	NPA	1336407915	Wellmore, Inc., 142 Griggs Street, Waterbury	NPA	NPA
Intensive Outpatient Program	NPA	187161676	Connecticut Counseling Centers, Inc., 4 Midland Road, Waterbury	NPA	NPA
Intensive Outpatient Program	NPA	1760426969	St. Mary's Health System, 56 Franklin Street, Waterbury	NPA	NPA
Intensive Outpatient Program	NPA	1184615114	Waterbury Hospital, 64 Robbins Street, Waterbury	NPA	NPA

Intensive Outpatient Program	NPA	156853 2810	The Hospital of Central Connecticut, 73 Cedar Street, New Britain	NPA	NPA
Intensive Outpatient Program	NPA	194239 3814	Community Mental Health Affiliates, Inc., 55 Winthrop Street, New Britain	NPA	NPA
Intensive Outpatient Program	NPA	171018 6911	Farrell Treatment Center, Inc., 586 Main Street, New Britain	NPA	NPA
Intensive Outpatient Program	NPA	179018 3515	Rushford (Hartford Healthcare), 680 South Main Street, Suite 204, Cheshire	NPA	NPA

* Provide the Medicare, Connecticut Department of Social Services (DSS), or National Provider Identifier (NPI) facility identifier and label column with the identifier used.

"NPA" means not publicly available

[back to question]

Supplemental CON Application Form

Establishment of a New Health Care Facility (Mental Health and/or Substance Abuse Treatment)*

Conn. Gen. Stat. § 19a-638(1)

Applicant: Counseling Center of Waterbury, LLC

Project Name: Establishment of Intensive Outpatient Program for the Care or Treatment of Substance Abusive or Dependent Persons in Wolcott, CT

*This supplemental form should be included with all applications requesting authorization for the establishment of a **mental health and/or substance abuse treatment facility**. For the establishment of other "health care facilities," as defined by Conn. Gen. Stat § 19a-630(11) - hospitals licensed by DPH under chapter 386v, specialty hospitals, or a central service facility - complete *the Main Form* only.

Affidavit

Applicant: Counseling Center of Waterbury, LLC

Project Title: Establishment of Intensive Outpatient Program for the Care or Treatment of Substance Abusive or Dependent Persons in Wolcott, CT

I, Gerard Marcil, Jr., CEO
(Name) (Position – CEO or CFO)

of Counseling Center of Waterbury being duly sworn, depose and state that the (Facility Name) said facility complies with the appropriate and applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 and/or 4-181 of the Connecticut General Statutes.

[signature] April 12, 2017
Signature Date

Subscribed and sworn to before me on April 12, 2017

Phyllis A. DiLeo

Notary Public/~~Commissioner of Superior Court~~

Phyllis A. DiLeo
NOTARY PUBLIC
STATE OF Connecticut
My Commission Expires August 31, 2018

My commission expires: ____________

1. **Project Description: New Facility (Mental Health and/or Substance Abuse)**

   a. Describe any unique services (i.e., not readily available in the service area) that may be included in the proposal.

   The IOP services Connecticut Counseling & Wellness ("CCW") has proposed will be distinguishable from other programs in the following ways:

- Unique Practice Setting: CCW is a small private practice located in a discrete, rural setting and will offer an alternative to the larger treatment facilities in the City of Waterbury.
- Continuity of Care: Through treating clients who have recently completed IOPs, CCW has experienced first-hand the difficulties with clients transferring from one provider to another and understands that continuity of care would benefit these clients. After a client completes IOP treatment at CCW, he or she will continue to receive treatment at CCW. CCW understands that recovery is a life-long process and intends to continue to provide these clients with services appropriate for their needs at each stage of recovery. Even after an individual is no longer a regular client of CCW, he or she will still have a person that they can contact, at any time of day, in times of need. This continuity of care will allow CCW to establish meaningful relationships with clients and to provide clients with high quality care.
- Personalized Program: The IOP offered by CCW will be highly personalized to each client's unique needs. In order to provide the best care possible, CCW intends to begin by working with only 5 IOP clients at any given time and will only gradually increase this number based on resource availability and other appropriate measures.
- Strong Family Component: CCW understands that the family can play a very important role in recovery and intends to establish a program with a strong family component. Not only will CCW offer group sessions for family members of clients, but CCW will also make available individual sessions to further collaborate with the client and his or her family to achieve a personalized treatment program.
- Community Knowledge: CCW has been providing substance use services in the area for over 20 years. CCW understands the community and has established referral relationships with other community-based organizations to transition patients and improve outcome.

   b. List the type and number of DPH-licensed health care professionals that will be required to initiate the proposal.

- At the outset of the IOP, CCW will utilize the services of a Clinical Supervisor, with a minimum of a master's degree in a behavioral health services field and at least three years of full-time work experience in substance use disorders treatment. This individual will be licensed by the state of Connecticut or certified, as appropriate in his or her respective discipline in conformance with R.C.S.A. §17a-453a-12(7)(A)(ii).
- The IOP will initially be staffed by two Licensed Alcohol and Drug Counselors (one of which will serve as the Clinical Supervisor).

CCW's IOP patients will continue to receive services from CCW after completion of intensive outpatient treatment. As CCW's non-intensive outpatient practice grows, CCW will hire additional Licensed Alcohol and Drug Counselors, Licensed Clinical Social Workers, and/or Licensed Professional Counselors on an as needed basis. However, this proposal does not anticipate the addition of any new employees or contractors for the first year of the project.

2. Projected Volume

a. For each of the specific population groups to be served, report the following by service level (include all assumptions):

(i) An estimate of the number of persons within the population group by town that need the proposed service; and

(ii) The number of persons in need of the service that will be served by the proposal (estimated patient volume).

Town	Population	In Need	To be Served (first 12 month period)	% of need Served
Waterbury	108,802	6,419	16	.25%
Wolcott	16,673	984	10	1%
Naugatuck	31,538	1,861	3	.16%
Watertown	21,911	1,352	3	.22%
Southbury	19,675	1,155	2	.17%
Branford	28,145	1,661	2	.12%
Cheshire	29,262	1,726	2	.12%
New Britain	72,808	4,296	2	.05%
Wallingford	44,893	2,649	2	.06%

Data presented in the figure above are based on the following assumptions:

- Population numbers are 2015 calculations provided by the Connecticut Department of Public Health in their Report titled "Estimated Populations in Connecticut as of July 1, 2015, available at http://www.ct.gov/dph/lib/dph/hisr/hcqsar/population/pdf/pop_towns2015.pdf.
- The estimates of individuals "in need" of SUD treatment are calculated by applying the 5.9% estimated average for the United States population provided by SAMHSA (see Attachment II).
- The estimated number of individuals to be served (client volume) is based on an estimated 57 patients being treated in the first 12 months (for the first 6 months, 5 patients will be seen per week, it is estimated that approximately 26 clients seen total in the first 6 months; for the second 6 months, 6 patients will be seen per week, with an estimated 31 clients being seen in this time period).The chart shows the total number of clients to be served in the first 12 months as 42

because the additional 15 clients served will be from a number of other towns in the surrounding area.

- The percentages reported are the percentage of estimated individuals to be served of the estimated number of persons in need of treatment.
- We understand that part of the challenge is motivating individuals to seek treatment, and therefore the demand for treatment is not equivalent to the number of individuals with SUD.

b. Provide statistical information from the Substance Abuse and Mental Health Administration ("SAMSHA"), or a similar organization demonstrating that the target population has a need for the proposed services.

General Population – Incidence and Prevalence:

The general population segment within which the target population rests includes adults (ages 18 years and above), both male and female, with diagnosable substance use disorders (SUDs) who reside in the Service Area.

The most current national data are available are from 2015 from the Substance Abuse and Mental Health Services Administration ("SAMHSA") and are based on results from the National Survey on Drug Use and Health ("NSDUH").[1] The NSDUH estimates that the prevalence of SUD (including alcohol and illicit drugs) among adults in the United States was at 5.9% of the population (ages twelve and over) in 2015.

Need for Treatment in Service Area:

The *Behavioral Health Barometer – Connecticut 2015*, a publication by SAMSHA presents compelling evidence demonstrating the need for substance use treatment.[2] For 2013-14, SAMHSA estimated that in Connecticut about 6.8% of individuals aged 12 or older (206,000 individuals) were dependent on or abused alcohol within the year prior to being surveyed, which is higher than the national average of 6.5%. With respect to Connecticut residents twelve years of age and above with alcohol dependence or abuse, data from 2010 to 2014 shows that only 7.1% received treatment, and 92.9% did not receive treatment. Similarly, for Connecticut residents twelve years of age and above with illicit drug dependence or abuse, data from 2010 to 2014 shows that only 20.1% received treatment, and 79.9% did not receive treatment. (Note that this statistic only takes into account illicit drugs. It can be assumed that when prescription drugs are also taken into account, this number would be significantly higher.). Based upon this evidence, a conclusion that there is a very high unmet need for alcohol and drug treatment is reasonable (although we understand that part of the challenge is motivating individuals to seek treatment, and therefore the demand for treatment is not equivalent to the number of individuals with SUD).

[1] Results from the 2015 National Survey on Drug Use and Health: Detailed Tables, Table 5.1B, available at https://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabs-2015/NSDUH-DetTabs-2015/NSDUH-DetTabs-2015.htm

[2] SAMHSA, *Behavioral Health Barometer – Connecticut 2015*, available at https://www.samhsa.gov/data/sites/default/files/2015_Connecticut_BHBarometer.pdf

OHCA 000034

Additionally, the state of Connecticut's Department of Mental Health and Addiction Services ("DMHAS") issued a *Triennial State Substance Abuse Plan* in 2016.[3] The plan explains that "Connecticut has been in the grips of an opioid epidemic that has resulted in increasing numbers of overdose deaths across the state. . . . This issue has now become perhaps the single most important health concern we as a state are facing." The plan goes on to explain that the opioid epidemic has led to "escalating overdose deaths related to opioids, especially over the past three years." The Office of the Chief Medical Examiner reported that in 2016, there were 917 accidental intoxication overdose deaths reported in the state, 116 of which were from the Service Area (as defined in Table 8).[4]

Connecticut Accidental Drug Intoxication Deaths
Office of the Chief Medical Examiner

	2012	2013	2014	2015	2016
Accidental Intoxication Deaths*	357	495	568	729	**917**
-Heroin, Morphine, and/or Codeine	195	286	349	445	**541**
-Heroin in any death	174	258	327	416	**504**
-Heroin + Fentanyl	1	9	37	108	**276**
-Heroin + Cocaine	50	69	73	106	**152**
-Morphine/Opioid/Codeine NOS	21	28	22	29	**37**
-Cocaine in any death	105	147	126	177	**273**
-Oxycodone in any death	71	75	107	95	**110**
-Methadone in any death	33	48	51	71	**84**
-Hydrocodone in any death	15	19	15	20	**20**
-Fentanyl in any death	14	37	75	188	**479**
-Fentanyl + Cocaine	2	16	14	43	**142**
-Fentanyl + Prescription Opioid	4	7	14	23	**72**
-Fentanyl + Heroin	1	9	37	108	**276**
-Any Opioid + Benzodiazepine	41	60	140	221	**232**
-Hydromorphone	1	0	12	17	**22**
-Amphetamine/Methamphetamine	7	5	11	20	**19**
-MDMA	0	0	2	1	**1**

*Some deaths had combinations of drugs; pure ethanol intoxications are not included.
NOS, not otherwise specified
Updated 2/24/17

The number of accidental opioid overdose deaths has risen substantially every year since 2012 (the first year reported), indicating that the need for SUD treatment will only continue to rise.[5]

Please note: provide only publicly available and verifiable information and document the source.

[3] Miriam Delphin-Rittmon, Commissioner, & Nancy Navarretta, Deputy Commissioner, DMHAS, *Triennial State Substance Abuse Plan*, available at http://www.ct.gov/dmhas/lib/dmhas/publications/triennialreport2016.pdf.
[4] Office of the Chief Medical Examiner, Accidental Drug Intoxication by Town/City in Excel (2015-16), available at http://www.ct.gov/ocme/cwp/view.asp?a=2165&Q=295128&ocmeNav=|
[5] Office of the Chief Medical Examiner, Connecticut Accidental Drug Intoxication Deaths, available at http://www.ct.gov/ocme/lib/ocme/AccidentalDrugIntoxication2012-2016.pdf.

COUNSELING CENTER OF WATERBURY
1776 MERIDEN RD
REAR UNIT B
WOLCOTT, CT 06716

2349

51-7010/2111
7

DATE 4/13/17

PAY TO THE ORDER OF Treasurer State of Ct. $ 500.00

Five hundred and 00/xx DOLLARS

Security Features Details on Back.

Webster Bank
WebsterOnline.com

FOR CON Application

MP

⑈002349⑈ ⑆211170101⑆10 0010764602⑈

Ad #: RA0754822

AFFIDAVIT OF PUBLICATION

STATE OF CONNECTICUT
County of New Haven Waterbury March 20th 20 17

The subcriber, being duly sworn, deposes and says that he (she) is the bookkeeper of the **Republican-American** and that the foregoing notice for

PULLMAN & COMLEY, LLC

was published in said **Republican-American** in **1** edition of said newspaper issued between **03/16/17** and **03/16/17**

NOTICE
Notice is hereby given that, pursuant to Connecticut General Statutes Section 19a-638, Counseling Center of Waterbury, LLC (d/b/a Connecticut Counseling & Wellness) intends to file a Certificate of Need application with the State of Connecticut to establish an intensive outpatient program for the treatment of substance abusive or dependent adults at 1776 Meriden Road, Wolcott, Connecticut 06716. There is no capital expenditure associated with this application.
R-A March 16, 17 & 18/2017

SUBSCRIBED AND SWORN BEFORE ME THIS THE 20th

day of March 20 17

Notary Public

My Commission Expires: 8/31/17

LINDA M. PLOSKI NOTARY PUBLIC CONNECTICUT

OHCA 000037

Ad #: RA0754822

AFFIDAVIT OF PUBLICATION

STATE OF CONNECTICUT
County of New Haven

Waterbury

March 20th 2017

The subcriber, being duly sworn, deposes and says that he (she) is the bookkeeper
of the **Republican-American** and that the foregoing notice for

PULLMAN & COMLEY, LLC

was published in said **Republican-American** in **2** editions of said newspaper issued between **03/17/17** and **03/18/17**

NOTICE
Notice is hereby given that, pursuant to Connecticut General Statutes Section 19a-638, Counseling Center of Waterbury, LLC (d/b/a Connecticut Counseling & Wellness) intends to file a Certificate of Need application with the State of Connecticut Office of Health Care Access to establish an intensive outpatient program for the treatment of substance abusive or dependent adults at 1776 Meriden Road, Wolcott, Connecticut 06716. There is no capital expenditure associated with this application.
R-A March 16, 17 & 18/2017

SUBSCRIBED AND SWORN BEFORE ME THIS THE 20th

day of March 2017

Notary Public

My Commission Expires: 8/31/17

OHCA 000038

Tag/estate sales

THOMASTON 160 Main St. St. Peter's-Trinity Church. Fri March 17, 8am-8pm & Sat March 18, 8am-2pm

Wanted to buy

ACCORDIANS ACOUSTIC GUITARS amp drums, musical instrument. Cash paid any cond 508-688-5138.

ACCORDIANS, all antiques, audio, amps, guitars, musical instr, old toys, watches, jewelry, Military, art, radios, HAM EQ 860-757-9350

MACHINIST TOOLS AND TOOLING. MECHANIC TOOLS. SMALL LATHES 860-985-5798

WANTED Diabetic Test Strips. Cash paid. Will pick up. Call Don 203-732-8134

Real Estate For Rent

Apartments
Condos
Garages
Houses
Mobile homes
Motels & hotels
Out-of-town
Rental services
Roommates
Rooms
Storage
Suburban
Vacation
Wanted to rent

Apartments for rent

NAUGATUCK 3 BR's, priv. prkg. Sect 8 OK. $900+sec/cr ck. 203-994-7918 or 203-775-3808

NAUGATUCK Immac 2 BR, 1st flr duplex, bright w/ HW frs, fridge, stove, D/W, full bsmt, nice yard, shed space, prkg, no pets. $1000/mo + util, sec, lease & cr. chk. Call 203-723-4733 leave msg.

NAUGATUCK SAFE & QUIET 1 BDRM $900; 2 BDRM $1000; incl heat, cooking gas & storage 203-723-5991; 1-914-384-8740

NAUGATUCK SAFE & QUIET 1 BDRM $900; 2 BR $1000; includes heat, cooking gas & storage 203-723-5991; 1-914-384-8740

NORTHFIELD/LITCHFIELD Country setting 2BR, appls incl. $875/mo plus sec. 203-592-5821

SEYMOUR- AGE 55+ NEW 1 & 2-BDRM APTS. $842-$1,650 +UTIL. NOW ACCEPTING APPLICATIONS. 36COLUMBUS.COM 203-881-0863

WATERBURY 1, 2, 3 & 4 BR apts. available. Property Management Center (203) 755-6649.

WATERBURY 1, 2, 3, 4 BR Apts & Houses available NEWLY RENOVATED Agent 203-565-9620

WATERBURY 1, 2 & 3 rm apts clean, appl, util secure bldg indry $465/up. Sect 8 OK. 203-753-3226

WATERBURY 1, 2 & 3 rms, nice, heat & appl, secure building, prkg, $450 & up (203) 206-4051

WATERBURY 109 Rose St. 3BR, 1st fl. Newly renovated. Section 8 Accepted. 203-802-0619

WATERBURY 1259 North Main St. 2 BR, twnhse style, $950+util. Avail. now. Call John 914-420-3962

WATERBURY 174 Willow St. studios, 1br start @ $450 H/HW incl Sect 8 ok 203-510-6177

WATERBURY 1BR, 2BR, 3BR available starting @ $550. Section 8 accepted. 203-510-6177

Waterbury 2 bdr, 2 ba, heat/HW incl. $950/mo. 88 Wakelee Rd. No pets. 203-419-5852

WATERBURY 2 BR apt or room for rent, off street parking, utilities not included $850. 203-922-2976

WATERBURY 2 BR's 2nd floor, 50 Springbrook Rd. Apt. D, private area, $775/mo. 347-277-6449

WATERBURY 3 & 4 BR apts. Chestnut Ave. big rooms no pets. Sect. 8 ok. $875/up. 203-558-5142

WATERBURY BUNKER HILL renov 2 & 2BR 3rd fr, nice location, $725 & $800 plus sec. 203-528-4004

WATERBURY BUNKER HILL renov 2 & 2BR 3rd fr, nice location, $725 & $800 plus sec. 203-528-4004

WATERBURY Charles St., 2.5 BR, 2nd floor, no pets, Sect. 8 OK, $800 + security 203-893-3053

WATERBURY DOWNTOWN Beautiful renov. apts. in modern 10 story fireproof Elev. Bldg. w/great views; 1 BR $650; Low rentals incl: 1 Parking Space, Carpet/HW Flr., Security / Lndry Rm. No Pets. Habla Espanol. Mgmt: 203-756-1999; 203-837-7428

WATERBURY East End 2 BR, appls, non-smoke/no pets, parking, $800 Sec. & cr. chk. 203-278-6212

WATERBURY
EASTGATE APTS.
Applications being accepted for spacious Studio $655; 1BR $825; 2BR $950. Includes elect, heat, H/W range, fridge, carpet, on-site laundry rm, security cameras. Sect. 8 welcome. Applications may be picked up at 34 Prospect St., Wtby, Mon.-Fri. 9am.-12:00pm. ONLY. No phone calls.

WATERBURY nice 2 BR, full kit, bath, LR & pantry, no utils or pets $625. Owner 516-225-3125

WATERBURY
RIDGEGATE APTS
2 story T/H 2-3 BR H/HW included, appl. prkg. W/D hookup HW Flr start $875 Sect. 8 OK 203-575-1680 ext. 106

WATERBURY Spacious Studio & 1BR & 2BR. $625, $750 & $850. Call for details 203-898-0857

WATERBURY tired of viewing dirty, neglected apts, ours are clean & updated. 2 & 3BR Hopeville $725 & $825. 2BR Town Plot $850. 203-729-2269, 203-805-1680.

WATERBURY Town Plot renov. 2br, $990 3rd flr, 2br, 1st flr $1100. No pets. WD hkup 203-942-9829

Waterbury- Two 2bdrm, 1.5 ba apts for rent. $675 and $695/mo. 203-560-3854 or email: brksdcoopertive@aol.com

WATERBURY two apts. both 2 BR, 1 bath, kit, LR, all appls. & utils. incl. No W/D. 203-213-7771

Waterbury/Wolcott Line
Mod. elev. bldgs convenient well maintained HILLTOP MANOR Studios $640; 1 BR from $890. LIBERTY COURT heat, HW, elect. incl.; studios $685; 1 BR $800; Both incl. prkg., carpet/HW flrs, sec. & laundry. No pets. Mgmt: 203-755-0623; 203-470-5800

Condos for rent

WATERBURY 1BR clean, quiet, off st prkg. $850 no pets, garages avail. Wayne 860-368-1256

WATERBURY 2BR twnhses & 3 BR house, fully appl kit, 1.5 bath, HW flr & tile, AC, gas heat, gar, EZ 84/8 start @ $1100. 203-756-7068

WATERBURY 2br updated fully appl. 1 bth, clean, 2 car drwy. Avail now $850. 917-952-0746

WATERBURY Twnhse 2BR remodeled. WD hkup. $1000 mo. 1st & sec, or check 203-704-7128

Houses for rent

NAUGATUCK 3BR, 1 bath Ranch, full bsmt, 2 car det gar, no utils. $1500. 1st/last sec 203-400-2295

OAKVILLE 4 BR cape, big kit/LR, sunroom, 2 car gar, no pets, $1500 2 mo. dep. 203-982-4389

WATERBURY 3 Bdr, 2.5 bath, Accepting applications. Section 8 ok. 203-982-4489

WATERBURY Charming 2br w/gar $1100, renov. 4br w/gar. $1350. 203-729-2269, 203-805-1680.

WATERBURY single family E.End, Overlook, Bunker Hill, South End Starting @ $1200 203-510-6177

Motels & hotels

PLYMOUTH MOTOR LODGE Daily, weekly, phone, refrig, whirlpool, free internet 860-582-6331 24hrs

Roommates

WATERBURY FURNISHED West End house to share w/male adult, 2BR, 2 ba., $500 or $400 if handy. 203-756-0013 lv msg

Rooms

WATERBURY 236 Hillside Ave. all utilities, laundry $500/month + security. Call 203-266-1011

WATERBURY Overlook, shared ba. & bdrd rooms. [illegible] Offst. prkg. [illegible]

Real Estate For Sale

Agents & brokers

Real Estate Agents needed for 2 local offices. Will Train. Call Steve 203-509-3194

Lots for sale

NAUGATUCK 4+acre wooded land in Union City on May St. $199K. [illegible]

Mobile home

NAUGATUCK 4 units to choose from starting at $29,900 incl. pool & clubhouse 203-729-8277

NAUGATUCK Asking $42,900 2 BR, 2 bath, new carpet & linoleum. 860-747-6881 860-940-1304

PROSPECT Owner wants quick sale! 2 bedroom, 1 bath, shed $87,000. LIBERTY 860-747-6881

Remodel It Right!
Find Help In The
At Your Service Directory
Every Day In The
Republican-American Classifieds!

Commercial

Business for sale
Commercial for sale, lease, rent

Commercial for sale, lease, rent

MIDDLEBURY Private office suites w/util/ties incl $550, 860, 1,900.00 WATERTOWN Warehouse 1,000sf plus 2 offices $1,000.00 WATERTOWN 1,500sf stand alone industrial $1,500.00 PROSPECT 1,500-5,000sf Retail/Medical 1200 sf Warehouse and 500sf office. Call J-R 860.[illegible]

Announcements

Absolutely free
Lost & found
Special notices

Absolutely free

4 WOODEN PALLETS P/U curb-side. 49 Washington, Middlebury. Call/text 203-528-7099

Lost & found

IMPOUNDED WATERBURY DLH cat, black, grey, & orange, bobtail. To Redeem 203-574-6909

LOST Black computer bag & green backpack, in Wolcott on 3/1. Reward offered. Call Chris 203-558-5817

LOST hearing aides in white Siemens case, 3x2x1. Call 860-868-6667.

Legals/ Public Notices

INVITATION TO BID

Sealed bids addressed to the Regional School District No. 1 for Boiler/Direct Digital Controls System Replacement, Housatonic Valley Regional High School, Falls Village, CT, will be received by Mr. Samuel Herrick, Business Manager, Regional School District No. 1, 246 Warren Turnpike Road, Falls Village, CT 06031-1600, no later than 2:30 PM local time on April 12, 2017. The information for Bidders, Proposal Form, Plans, Specifications and other Contract Documents, as prepared by Salamone & Associates, P.C., 116 North Plains Industrial Road, Wallingford, CT 06492; may be examined at the following location on or after 10:30 AM, Wednesday, March 22, 2017:
Mr. Sam Herrick
Regional School District No. 1,
246 Warren Turnpike Road
Falls Village, CT 06031
Copies may be obtained on or after 10:30 AM, Wednesday, March 22, 2017, at Regional School District No. 1, 246 Warren Turnpike Road Falls Village, CT 06031, upon payment of $25.00 for each set. Make check payable to the Regional School District No. 1. General Contractors may take out two (2) sets. Addenda will be issued to all Bidders registered with the office of the Engineer. As security, each Bid must be accompanied by a Certified Check or Cashiers Check drawn upon either a State Bank and Trust Company or a National Banking Association, to the order of the Regional School District No. 1, or the Bid must be accompanied by a Bid Bond having as surety thereto, such Surety Company or Companies as are authorized to do business in the State of Connecticut, of an amount not less than 10% of the Bid. The successful Bidder shall furnish Performance, Labor and Material Payment Bonds, each for 100% of the Contract Sum. A Mandatory Pre-Bid Conference will be held on March 22 2017, at 10:30 AM, at the Housatonic Valley Regional High School, 246 Warren Turnpike Road, Falls Village, CT.
Samuel J. Herrick
Business Manager
Regional School District No. 1,
Falls Village, Connecticut
RA 3/16/2017

INVITATION TO BID

Sealed bids addressed to the Regional School District No. 1 for Underground Fuel Oil Storage Tank Replacement, Housatonic Valley Regional High School, Falls Village, CT, will be received by Mr. Samuel Herrick, Business Manager, Regional School District No. 1, 246 Warren Turnpike Road, Falls Village, CT 06031-1600, no later than 2:00 PM local time on April 12, 2017 The information for Bidders, Proposal Form, Plans, Specifications and other Contract Documents, as prepared by Salamone & Associates, P.C., 116 North Plains Industrial Road, Wallingford, CT 06492; may be examined at the following location on or after 9:30 AM, Wednesday, March 22, 2017:
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Samuel J. Herrick
Business Manager
Regional School District No. 1,
Falls Village, Connecticut
RA 3/16/2017

LEGAL NOTICE

Bids will be accepted for HVAC Renovations at Sheehan HS until March 29, 2016. Contact J A Rosa Construction LLC at 203-879-3495 for access to online specifications and drawings. DBE, WBE, MBE and Section 3 businesses welcome. AA/EEOE
RA 3/16, 2017

Take Advantage Of The Services You'll Find Advertised In The Classifieds.
Appliance Repair, Roofing, Childcare, Cleaning Services, Masonry, Just to name a few!
Republican American

LEGAL NOTICE
Winchester Planning & Zoning Commission
Notification of Public Hearing

Notice is hereby given that the Winchester Planning & Zoning Commission will hold a Public Hearing on Monday, March 27, 2017 at 7PM in the P. Francis Hicks Room, 2nd Floor, Town Hall, 338 Main Street, Winsted for the following application:
1. PZC #17-03 Special Permit
Applicant: Community Health & Wellness Center of Greater Torrington, Inc.
Owner: Winsted Super Saver Property, LLC
372-376 Main Street and 30 Elm Street
Map 110, Block 001, Lot 2, 2A, 18 and 18A
Proposal: Proposed Relocation and Expansion.
At this Hearing, interested persons may appear and be heard and written communications will be received. Copies of the above application are on file for public inspection in the Planning & Community Development Office.
Dated at Winchester, CT this 15th day of March, 2017
Craig Sanden, Chairman
RA 3/16/2017

North Canaan School Readiness Council is soliciting proposals for North Canaan Early Childhood providers interested in providing School Readiness services to eligible children.

Applicants must meet all statutory requirements http://www.ct.gov/oec/generalpolicies.

Request for Proposal can be obtained by email at dumondeconsulting@gmail.com Completed submissions must be received no later than 4:00 p.m. on Friday, March 31, 2017
R-A March xx, 2017

NOTICE

Notice is hereby given that, pursuant to Connecticut General Statutes Section 19a-638, Counseling Center of Waterbury, LLC (d/b/a Connecticut Counseling & Wellness) intends to file a Certificate of Need application with the State of Connecticut to establish an intensive outpatient program for the treatment of substance abusive or dependent adults at 1776 Meriden Road, Wolcott, Connecticut 06716. There is no capital expenditure associated with this application.
R-A March 16, 17 & 18/2017

NOTICE OF ACTIONS

Public Notice as provided under Connecticut General Statutes is herewith given of the Official Actions and Decisions of the City Plan Commission of the City of Waterbury at a Meeting held on March 8, 2017.
PL 2017-0053 CGS 8-24 Review - Land Swap Transaction for SEDA Landfill - vicinity of State Route 8; Applicant: City of Waterbury/Board of Public Works.
- APPROVED
James A. Sequin, AICP
City Planner
R-A March 16, 2017

ORDER OF NOTICE
STATE OF CONNECTICUT
SUPERIOR COURT
AT WATERBURY
DOCKET #UWY-FA16-5018332-S
JUDICIAL DISTRICT OF WATERBURY
February 17, 2017
RANDOLPH, TERRANCE
VS
PETION, FRANCESCA
NOTICE TO: FRANCESCA PETION

The Applicant in the above entitled action is seeking an order of SOLE CUSTODY for their minor MALE CHILD born on 03/7/2014 and other relief as may appear on file.

A HEARING on the plaintiff's application will be held on Tuesday, MARCH 21, 2017 AT 9 A.M. at the Superior Court, 300 Grand Street, Waterbury, CT, courtroom 4, second floor.

The defendant is ordered to attend the court hearing to explain why the applicant's request should not be granted. Defendant is advised that should she not attend court on March 21, 2017 the court may enter custody orders that affect her.

Automatic Orders have been issued in the case as required by Section 25-5 of the Connecticut Practice book and are a part of the Application on file with the Court.

By the Court, (Ficeto, J.)
Regina M. Gilroy,
Temporary Assistant Clerk
R-A March 16, 2017

REQUEST FOR PROPOSALS

Sealed proposals will be received at the Office of the Purchasing Agent, City Hall, Room 206, 140 Main St., Torrington, CT until April 5, 2017 at 11:00 AM for the following:

RFP #DGM-011-040517
MAINTENANCE OF DOWNTOWN GARDEN BEDS & PLANTERS

Specifications may be downloaded from the City's web site, www.torringtonct.org under Purchasing Department, select "OPEN BIDS". Those without internet access may call (860) 489-2224 to request the bid documents.

The City reserves the right to accept or reject any or all bids, or any portion thereof, to waive technicalities, to award the bid to a bidder other than the lowest bid, and to award the bid as will best serve the public interest.

Pennie Zucco
Purchasing Agent
An Affirmative Action/
Equal Opportunity Employer
R-A March 16, 2017

If you're trying to BUY, SELL or FIND anything...
CLASSIFIED has the solution!
(203) 574-3616.
Republican American

Thomaston Early Childhood Council is soliciting proposals for Thomaston Early Childhood providers interested in providing School Readiness services to eligible children.

Applicants must meet all statutory requirements http://www.ct.gov/oec/generalpolicies.

Request for Proposal can be obtained by email at dumondeconsulting@gmail.com Completed submissions must be received no later than 4:00 p.m. on Friday, March 31, 2017
R-A March 16, 2017

TOWN OF KENT
PLANNING AND ZONING COMMISSION
NOTICE OF FINAL ACTIONS

At its regular meeting held on March 9, 2017 the Kent Planning and Zoning Commission took the following action(s):

Approved: Application #11-17C, 24 South Main Street Kent, LLC, 24 South Main Street, construction of 3-bay garage with storage and a change of use from restaurant/apartment to restaurant/apartment/contractor business, Map 19 Block 13 Lot 44.

Dated this 9th day of March, 2017.
John Johnson, Chairman
RA 3/16/2017

READY FOR A NEW POSITION? Check us out in print and online, you'll soon find there's opportunity in the Classifieds!
Republican American

WATERBURY ZONING COMMISSION
NOTICE OF PUBLIC HEARING

Date: Wednesday, March 22, 2017
Time: 7:00 PM
Place: City Hall, 2nd Floor, Aldermanic Chambers
235 Grand Street,
Waterbury, Connecticut
Notice is hereby given that the following Public Hearings will be held before the Members of the Zoning Commission at the above date, time and place:
1. PL 2017-0007 Special Permit for a Accessory Earth Excavation; Location: 3580 East Main Street; Applicant: JMDH Real Estate of Waterbury, LLC c/o Pullman & Comley LLC.
2. PL 2017-0012 Special Permit for a Surface Parking Lot in RO Zone; Location: 54, 56, 58 Gaffney Place; Applicant: Jonathan Tunsky/TO Design, LLC.
3. PL 2017-0017 Special Permit for a Accessory Earth Excavation; Location: 18.87 acres located on the north side of Chase Parkway, east of the Middlebury town line, south of the terminus of Crest Street and west of Lakeside Blvd West, Wooster Street and the rear property lines of the properties on the northwestern side of Mason Avenue/MLB# 0383-1009-0911; Applicant: Mike Dillon.
4. PL 2017-0019 Special Permit for Vehicle Service Facilities; Location: 99 South Leonard Street; Applicant: Luis Barona.
Applications are on file and available for public inspection in the Office of the City Plan Department, One Jefferson Square, 5th Floor, (185 S. Main Street), Waterbury, Connecticut 06706. Telephone: (203)574-6817.

ATTEST:
James A. Sequin, AICP
City Planner
RA March 9, 16, 2017

WOODRIDGE LAKE SEWER DISTRICT
NOTICE OF AUDIT

Pursuant to the Connecticut General Statutes which govern Municipalities, Notice is hereby given that an Audit of the Books of the Woodridge Lake Sewer District for fiscal year Ending June 30, 2016 has been completed by Carney, Roy and Gerrol, PC and is available for inspection during office hours of the Clerk.

DATED AT GOSHEN, CONNECTICUT THIS THE 15H DAY OF MARCH 2017

Laurie Mosley, Tax Collector & Recording Clerk
WOODRIDGE LAKE SEWER DISTRICT
RA 3/16/17

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DW ELECTRICAL Any size jobs, srvc grounding, upgrades, rem. Free est #182990. 203-982-3562

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PIET SEAMLESS GUTTERS Installs, cleanings, guards, repairs 860-283-2252. #628524

Hauling services

ALL ABOUT SERVICE S&P CARTING trash & cleanups 10-40 yard roll off containers. Same day svc. Ins V/MC 203-755-4808

JOE ROCCO RUBBISH REMOVAL Est. Clean-outs Bsmnts, Attics, Gar., Demolition removal, All unwanted items. Roll off • 30 Yd. Mstrcard/Visa 203-509-3297.

Hauling services

JOE'S JUNK REMOVAL & MORE Furn, appl, shed, attic, basement, Spring Clean up. 20% off. V/MC 203-535-9817, 860-575-8218

Home improvement

Kitchen Bath Remodeling www.FickleyHome.com Mike 203-558-2428 CT Lic#573498

Masonry

JIMMY'S MASONRY Stonewalls, stone siding, patios, all masonry. Free est 860-274-4892. CT#604498

KO MASONRY Free est Stone, brick, block walls. Steps, sidewalk #604534 203-558-4951.

NICK'S MASONRY Driveways stonewalls walkways patios tile bricks roof 3d tie etc #0634606. 860-274-0829 / 203-982-2226

Moving

DON'S * MOVING 203-[illegible]

Painting

ARMEND'S PAINTING LLC Int/ext carpentry low prices! Free est. CT#0631318. 203-597-7179

ASHLEY'S PAINTING LLC Interior & exterior. Call for estimate. 860-331-5308 #0642743

PAUL DEVINO PAINTING CO. LLC Schools, classrooms, college dorms, apartments, condos, stores, factories, shops, plaza, hotels. Low prices. Free est. Lic. #527946. 203-509-4486

ROCCO'S PAINTING Res. Free est & cleanup. CT# 581112. 30+ yrs exp 203-574-1098

Plumbing

CAPINERA PLUMBING & HEATING Gas pipe, boilers, HW heaters, & repairs #202962. 203-575-1551

CHRIS SHEPPARD PLUMBING repair, wtr heater, pipe freeze ups, gas. #283570 203 305-0072

Roofing

AFFORDABLE ROOFING SIDING & GUTTERS. licensed & ins. #0642005. Tom 860-484-1644.

Missing/damaged Shingles? Insurance claim specialist Local/Working owner

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Lema Construction Roofing, Siding, Masonry & Chimney repair, Lic#636870. 203-512-3809

Roofing

S&S Roofing you feeling lucky? You will if you sign up with us by St. Patty's Day!! A-rating w/BBB. Steve 8ff Saunders 860-[illegible] Vet owned. #571633

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ALL SEASONS TREE REMOVAL Bucket & chip. serv. Storm damage, ins'd. 860-945-0001

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BELL TREE SERVICE Tree Removal, Trim trees, bushes, shrubs. (Give us a ring!) 203-217-7311

Old2 TREE SERVICES 87' bucket truck & climbing. 24 hr. service. #0630195. 203-942-6351

LOG DOGS COMPLETE TREE SERVICE Lot clearing, stump grinding. Free est. 203-271-3358. 5% of every job donated to local dog rescue. www.logdogstreeremoval.com

P.F.D. LLC Bucket truck service & climbing, tree remov., chipper, stump grinding. 24 hr serv., Sr. Disc. #618879. Free Est. 860-274-8694

Training

EMT Programs April. $900 Space Limited! Register 203-632-8247 or mededstaff@mededct.com

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for more information, go to REP-AM.COM/APPS

Real Estate For Sale

Houses

WATERBURY-RENT TO OWN! $89,900 43 Warner St., 3BR Cape, lg yard, 1 car gar. Owner will fin. Velazia Realty 203-574-7777

Lots for sale

NAUGATUCK 4+acre wooded land in Union City on May St. $199K. 802-384-4444

Mobile home

NAUGATUCK 4 units to choose from starting at $29,900 incl. pool & clubhouse 203-729-8277

NAUGATUCK No age limit park! 2 BR, 2 bath, c/air & porch $80,000. 860-747-5881 860-940-1204

PROSPECT New 2 BR 2 bath, 36" wide doors, ADA shower, $87,500. LIBERTY 860-747-5881

If you're trying to BUY, SELL or FIND anything... CLASSIFIED has the solution! (203) 574-3616. RepublicanAmerican

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Commercial for sale, lease, rent

Commercial for sale, lease, rent

MIDDLEBURY Private office suites w/utilities incl $550, 650, 1,500.00
WATERTOWN Warehouse 1,000sf plus 2 offices $1,2000.00
WATERTOWN 1,500sf stand alone industrial $1,500.00
PROSPECT 1,500-6,000sf Retail/Medical 1200 sf Warehouse and 500sf office. Call J-R 800.308.0378

Announcements

Absolutely free
Lost & found
Special notices

Absolutely free

4 WOODEN PALLETS P/U curbside. 49 Washington, Middlebury. Call/text 203-528-7099

CAT Male, 2-3 years old. "Rocky" needs a home. Call Donna 860-274-0686

Lost & found

FOUND male cat on Olive St, Naugatuck. Call Tara 617-840-8270

IMPOUNDED WATERBURY DSH cat, female, grey and blk tabby, To Redeem 203-574-6909

IMPOUNDED WATERTOWN Blue & white female pitbull. To redeem or adopt, call 860-945-5217

LOST Black computer bag & green backpack, in Wolcott on 3/1. Reward offered. Call Chris 203-558-5817

LOST hearing aides in white Siemens case, 3x2x1. Call 860-868-6667.

Remodel It Right! Find Help In The At Your Service Directory Every Day In The RepublicanAmerican Classifieds!

Legals/Public Notices

Auction Ad

A-1 Self Storage will sell at Public Auction under Conn. Gen. Statue Chapter 743, section 42-168, on Friday March 31st, 2017 at 2:00 p.m. at 141 S. Main St. Beacon Falls CT. the property described as cartons, furniture, appliances, tools, sporting equipment, toys and other effects belonging to :#5 Joseph Dabrow, #145 Robert Bradley, #197 Paul Johnson Jr, #242 Jay Sweet, #228 Jeff Katz, #154 James Woermer, #202, #214 & #218 Donna Jean Curtis, #415 Michael Lewis, #507 Bobby Simpson, #401 Joann Adams,#160 Josephine Asplund, #109 Valarie Brookins, #152 Scott Cambell, #187 Delphine Charron, #409 Empire Tool L.L.C. #429 Patrick Flick, #404 Pareicia Jarusinsky, #417 Jeffery Jurzynski, #105 Keara Mcnulty, #301 Anthony Micalizzi, #110 Michelle Pace. The landlord reserves the right to bid on any space.
R-A March 10 & 17, 2017

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INVITATION TO BID TOWN OF CORNWALL, CONNECTICUT RECONSTRUCTION OF FLAT ROCKS ROAD BRIDGE OVER THE WEST BRANCH OF THE SHEPAUG RIVER

Sealed bids will be submitted to the Selectman's Office at the Cornwall Town Hall, 24 Pine Street, Cornwall, Connecticut 06753 until 10:00 A.M. on April 3, 2017 after which they will be publicly opened and read aloud.

An optional pre-bid meeting with potential bidders will be held at the Cornwall Town Hall on March 23, 2017 at 10:00 A.M. The project involves the replacement of the existing bridge with a pre-cast concrete arch. The Town of Cornwall will provide a "Con-Tech" arch, footings and wings delivered to the site. The project also includes the installation of pre-cast concrete wingwalls and the installation of new metal beam guiderails and end anchorages. Approximately 200 feet of the road will be reconstructed with a new pavement structure consisting of 10" of subbase, 4" of processed aggregate base, 2" of bituminous concrete class 1 base course, and 1" of bituminous concrete class 2 surface course. The road will be closed to traffic for a maximum duration of 30 consecutive days during construction.

Plans and Specifications for the above project may be examined and/or obtained for a non-refundable fee of $40.00 at the Cornwall Town Hall, 24 Pine Street, Cornwall, Connecticut 06753 after 12:00 noon on March 16, 2017. Checks are to be made payable to the Town of Cornwall and must accompany a request for Bid Documents.

The Town reserves the right to waive any informality or to reject any or all bids should it be in the Town's best interest to do so. The Contractor chosen for the project shall be required to furnish 100% Performance bond and proof or required insurance coverage.

Minimum State Wage Rates are required for this project.

No bid may be withdrawn for a period of 90 days after the actual date of opening. The allowed contract time for work under this projects is 120 days.

Inquiries and additional information, call the Selectman's office 860-672-4959 or send to cwlselectmen@optonline.net

Gordon M. Ridgway
First Selectman
Town of Cornwall
R-A March 17, 2017

LEGAL NOTICE

WATERBURY SCHOOL READINESS (WSR) 30-B CHURCH ST. WATERBURY, CT 06702
LEGAL NOTICE WSR 30-B CHURCH ST. WATERBURY, CT 06702 REQUEST FOR PROPOSALS, SCHOOL READINESS AND EARLY CHILDHOOD PROGRAMS, as the Office of Waterbury School Readiness invites licensed center-based child care programs to submit a Request for Proposal application for the greater Waterbury area School Readiness Grant Program. If you are a licensed center-based program caring for 3 and 4-year-old children residing in the community, then you may be eligible to apply for School Readiness funds. WSR will receive applications from programs at the Office of Early Childhood, 30-B Church St. Waterbury, CT 06702. PLEASE NOTE WSR WILL HOLD A MANDATORY SCHOOL READINESS BIDDERS' MEETING ON Tuesday, March 21st ,2017, at 3:00 P.M. at WSR Office of Early Childhood, 30-B Church St. Waterbury, CT 06702. Request for Proposal applications will be available at that time. Detailed instructions in how to submit an application will be provided at the mandatory session on March 21st, 2017. WSR reserves the right to reject any and all applications submitted after the deadline. Incomplete or late applications will not be accepted. Please contact Shiroon Hickox or Marie Klein at 203-573-6684 with questions. Proposals should be hand delivered to Shiroon Hickox or Marie Klein at the WSR Office of Early Childhood, 30-B Church St. Waterbury, CT 06702
RA March 14-20, 2017

NAUGATUCK ZONING COMMISSION

NOTICE OF PUBLIC HEARING is hereby given by the Zoning Commission that on Wednesday, March 22, 2017 at the Town Hall, the following will transpire: 6:15 PM Public Hearing for proposed revisions to Section 58 of the Naugatuck Zoning Regulations, Applicant: Kevin T. Nixon, Sr, Trustee. Maps and plans are available for review at the Land Use Office, Town Hall, M-F, 8:30 To 4:00 P.M.
R-A March 10 & 17, 2017

HIDDEN TREASURES! Can't Find What You're Looking For? Check Out The Classifieds For Those Hard To Find Items! Republican American

NOTICE TO CREDITORS ESTATE OF Anne L. Cepelak (17-00080)

The Hon. Thomas P. Brunnock, Judge of the Court of Probate, District of Waterbury Probate Court, by decree dated March 15, 2017, 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.

Thomas P. Brunnock, Judge

The fiduciary is:
Michael R. Cepelak
c/o Atty. Brian Tynan
Tynan & Iannone
250 Wolcott Road
Wolcott, CT 06716
R-A March 17, 2017

NAUGATUCK ZONING BOARD OF APPEALS NOTICE OF PUBLIC HEARING

The Zoning Board of Appeals hereby gives NOTICE that on Tuesday, March 28, 2017 at the Naugatuck Town Hall the following will transpire: 6:00 P.M. PUBLIC HEARING APPEAL #1993 - Applicant: Antonio Pereira, for property located at 62 Hotchkiss Street, will seek a variance of Section 24.1, Schedule B #5.1, #5.2 and #5.3 of the Naugatuck Zoning Regulations for front, rear and side yard setbacks. Maps and Plans are available for review at the Land Use Office, 229 Church St., Naugatuck, CT, M-F 8:30 A.M. to 4:00 P.M.

ATTEST: Charles Marino, Chair
R-A March 17 & 24, 2017

NOTICE

Notice is hereby given that, pursuant to Connecticut General Statutes Section 19a-638, Counseling Center of Waterbury, LLC (d/b/a Connecticut Counseling & Wellness) intends to file a Certificate of Need application with the State of Connecticut Office of Health Care Access to establish an intensive outpatient program for the treatment of substance abusive or dependent adults at 1776 Meriden Road, Wolcott, Connecticut 06716. There is no capital expenditure associated with this application.
R-A March 16, 17 & 18/2017

NOTICE OF HEARING INSOLVENT ESTATE ESTATE OF of Daniel Andrew Guidi, of Beacon Falls, (15-00333)

DATE OF HEARING: March 7, 2017
TIME OF HEARING: 12:15 PM

NOTICE TO RECIPIENT
A hearing has been scheduled on the above petition. This notice is sent to you because your interests in this matter may be affected by the court's decision on the above referenced petition. If you wish to be heard or seek further information, you should appear at the date, time and place set for the hearing.

If you wish to attend this hearing, but are unable to do so because of physical incapacity, please call or write the Probate Court. The address and telephone number of the court are: Naugatuck Probate Court, Town Hall, 229 Church Street, Naugatuck, CT 06770. (203) 720-7046.

You have the right to request a copy of the petition from the petitioner or the fiduciary, if any.

You also have the right to review and obtain data documents in the court file during court hours except as restricted by law. The law requires the court to charge a fee for copies.

By Order of the Court
Patricia Alegi, Chief Clerk

R-A March 17, 2017

PROSPECT ZONING BOARD OF APPEALS NOTICE OF PUBLIC HEARING

The Prospect Zoning Board of Appeals will hold a public hearing on Tuesday, March 28, 2017 at the Prospect Town Hall, 36 Center Street on the following: 7:05 p.m. Application 01-2017 of Joe Testa on behalf of K & L Inc. of CT dba Oliver's Supermarket, 75 Waterbury Road for a 24-foot variance of Zoning Regulations Section 3.4.4 2 to construct a covered platform 1-foot off the left side property line.
The complete file may be reviewed in the Land Use Office in the Prospect Town Hall, 36 Center Street, Prospect.
David Michaud, Chairman
R-A March 17 & 24, 2017

REQUEST FOR PROPOSALS 2017-2018 ADULT EDUCATION PROGRAM ENHANCEMENT PROJECTS

The State Department of Education, Bureau of Health/Nutrition, Family Services and Adult Education announces the 2017-2018 request for proposals (RFP) for improvement of adult education programs. Competitive grants will be awarded for: Workforce Readiness; Family Literacy Services; Transition to Postsecondary Education and/or Training Programs; Corrections Education and Other Institutionalized Individuals or Special Populations; Connecticut Adult Virtual High School; Expansion of the National External Diploma Program; Integrated Basic Education and Skills Training and Integrated English Literacy and Civics Education.

Eligible Applicants must be able to demonstrate effectiveness in providing adult education services to adult learners. Eligible applicants may include a local educational agency; a community-based or faith-based organization; a volunteer literacy organization; an institution of higher education; a public or private nonprofit agency; a library; a public housing authority; other nonprofit institutions that have the ability to provide adult education and literacy activities to eligible individuals; a consortium or coalition of the agencies, organizations, institutions, libraries, or authorities described above; and a partnership between an employer and an entity described above.

Application Due Date:
April 28, 2017

A bidders' conference will be held on Tuesday, March 21, 2017 at 1:00 p.m. at Energize CT, 122 Universal Drive North (Target Shopping Center), North Haven. Individuals with a disability who may need accommodations to attend the bidders' conference are requested to contact the below named individual at least 4 days in advance of this event in order that appropriate accommodations and/or arrangements may be made.

To access and/or download the RFP, go to www.ct.sde.gov after March 16, 2017. To discuss appropriateness of proposed projects or for information on the bidders' conference, please contact Susan Pierson at susan.pierson@ct.gov or 860-807-2121.
R-A March 17, 2017

Waterbury Legal Notice Public Auction

A Public Auction of the following personal property, such as furniture, household goods, and miscellaneous items will be help at Central Connecticut Transportation Inc. 980 Old Colony Road Meriden, CT at 9:00 AM on 3/23/2017 as required under Section 47-a-42 of Connecticut General Statutes. /Each of you is hereby notified that your personal property will be sold unless all moving, storage, and related costs are paid: Corrina Brunson Alan Dumschaft, Robert Civitello, John Jannaccio, Megan Bernad, Laura Swanson. All items will be sold as is.
No warranty is expressed or implied. Buyers assumes all risks. CASH OR CERTIDED CHECKS ONLY.
RA 3/17/17

Notice of Public Hearing Town of Goshen Planning and Zoning Commission

The Town of Goshen Planning and Zoning Commission will hold the following public hearing on Tuesday, March 28, 2017 at 7:30PM in the Conference Room at Goshen Town Hall, 42 North Street, Goshen, CT:

Town of Goshen Planning and Zoning Commission - Zoning Map Amendment/Zone Change from RA-2 to Center Business (CB) Zone for 2 North Street, 6 North Street, 12 North Street, 16 North Street, and 45 Torrington Road.

At this public hearing, interested persons may appear and be heard and written communications received. The proposed amended Zoning Map is available for inspection on the Town website and in both the Town Clerk and Land Use Offices in Goshen Town Hall, 42 North Street, Goshen, CT.

Dated this 16th day of March, 2017
Don Wilkes, Chairman
Planning & Zoning Commission
RA 3/17 & 21, 2017

TOWN OF PLYMOUTH INVITATION TO BID Bridge Replacement

The Town of Plymouth is seeking bids for the replacement of Bridge No. 01670, North Main Street over the Poland River.

Sealed bids be received at the Office of the Mayor, Town Hall, 80 Main Street, Terryville, CT until, 10:30 A.M., April 7, 2017, at which time they will publicly opened, read and recorded.

The contractor who is selected to perform this State project must comply with CONN. GEN. STAT. §§ 4a-60, 4a-60a, 4a-60g, and 46a-68b through 46a-68f, inclusive, as amended by June 2015 Special Session Public Act 15-5.
State law requires a minimum of twenty-five (25%) percent of the state-funded portion of the contract for award to subcontractors holding current certification from the Connecticut Department of Administrative Services ("DAS") under the provisions of CONN. GEN. STAT. § 4a-60g. (25% of the work with DAS certified Small and Minority owned businesses and 25% of that work with DAS certified Minority, Women and/or Disabled owned businesses.) The contractor must demonstrate good faith effort to meet the 25% set-aside goals.
For municipal public works contracts and quasi-public agency projects, the contractor must file a written or electronic non-discrimination certification with the Commission on Human Rights and Opportunities. Forms can be found at: http://www.ct.gov/opm/cwp/view.asp?a=2982&q=390928&opmNav_GID=1806

The project is subject to Federal and State prevailing wage rate requirements.

The project consists of replacement of the existing bridge with prestressed deck units on cast in place concrete spread footings with associated roadway reconstruction.

The Town of Plymouth hereby notify all bidders that it will affirmatively insure that in any contract entered into pursuant to this advertisement, Disadvantaged Business Enterprises will be afforded full opportunity to submit bids in response to this invitation and that they will not be discriminated against on the grounds of race, color, national origin, sex, mental retardation or physical disability including but not limited to blindness, in consideration for an award.

"Bid Proposal Form", Schedule of Prices", "Bid Bond" and "Non Collusion Affidavit" must be completed and returned with the submitted bid. Failure to properly execute and include any one of these four documents in the bid submission will result in the bid not being read and the subsequent rejection of the bid.

Plans and Specifications for the above project are available from Advanced Reprographics, 50 Corporate Avenue, Plainville, CT 06062, (860) 410-1020. Plans and Specifications may be viewed and/or obtained by going to the Advanced Reprographics website www.advancedrepro.net. Prospective bidders should access the "planroom" on the website and go to the "Public Jobs" area, no log in information is necessary. Bidders are responsible for printing and shipping costs, or pick up at the Advance Reprographics office. Plans and specifications may also be ordered by calling the Advanced Reprographics number listed above. Bidders are responsible for obtaining all and the latest addendums from the Advanced Reprographic website.

Form 817 Standard Specifications may be purchased at the ConnDOT Plans Sales Office, 160 Pascone Place, Newington, Connecticut. All Proposals must be on the form furnished by the Town of Plymouth and must be requested for the above named project.

NOTE:Prime contractors must be prequalified with ConnDOT for the work to be performed.
NOTE:A Surety Company Bond, on the form furnished by the Town, for at least 30 percent of the amount of the bid must accompany each proposal. A certified check will not be accepted.

CONTRACTORS that find discrepancies and/or errors in or between plans, specifications, quantities and other matters must immediately notify the Town in writing not less than ten days before the scheduled bid opening.

The Town of Plymouth is an Equal Opportunity Employer. The Town reserves the right to reject all bids if deemed to be in the best interest of the Town.

David V. Merchant
Mayor
R-A March 17, 2017

As a service to our readers, the Republican-American presents Open House Preview

- Check individual ads in our Saturday Home & Real Estate Magazine for more specific information.
- Preview may not represent a complete listing of all area Open Houses by area Realtors.

CITY	ADDRESS	DAY & TIME	BROKER	PHONE
BEACON FALLS	7 PAMANATA MEADOWS	SAT 12:30-3:00	BERKSHIRE HATHAWAY HOME SERVICES	203-264-2880
BRISTOL	22 TRELLI LANE	SUN 12:00-2:00	SHOWCASE REALTY	860-276-2000
MIDDLEBURY	2 STONINGTON CT	SUN 1:00-3:00	WILLIAM RAVEIS REAL ESTATE	203-264-8180
MIDDLEBURY	615 LONG MEADOW RD	SUN 12:00-3:00	WILLIAM RAVEIS REAL ESTATE	203-264-8180
MIDDLEBURY	67 FALCON CREST	SUN 12:00-2:00	BHGRE BANNON & HEBERT	203-758-1300
NAUGATUCK	259 MAY ST.	SUN 1:00-3:00	SHOWCASE REALTY	203-720-0069
OAKVILLE	16 SLADE AVE.	SUN 12:30-2:00	WEST VIEW PROPERTIES	860-274-7838
OXFORD	15 DAVIS RD	SUN 1:00-3:00	WILLIAM RAVEIS REAL ESTATE	203-264-8180
OXFORD	33 FIDDLEHEAD	SUN 1:00-3:00	WILLIAM RAVEIS REAL ESTATE	203-264-8180
PROSPECT	7 BOULDERBROOK CT #71	SUN 2:00-4:00	WILLIAM RAVEIS REAL ESTATE	203-264-8180
SOUTHBURY	323 KUHNE RD	SUN 1:00-3:00	WILLIAM RAVEIS REAL ESTATE	203-264-8180
SOUTHBURY	550 PETER RD	SUN 1:00-3:00	WILLIAM RAVEIS REAL ESTATE	203-264-8180
SOUTHBURY	2 JEFFERSON LANE	SUN 1:00-3:00	WILLIAM RAVEIS REAL ESTATE	203-264-8180
SOUTHBURY	886A HERITAGE VILLAGE	SUN 1:00-3:30	WILLIAM RAVEIS REAL ESTATE	203-264-8180
SOUTHBURY	534B HERITAGE VILLAGE	SUN 12:30-2:30	WILLIAM RAVEIS REAL ESTATE	203-264-8180
SOUTHBURY	32 FAR VIEW COMMONS	SUN 1:00-3:00	WILLIAM RAVEIS REAL ESTATE	203-264-8180
SOUTHBURY	273B HERITAGE VILLAGE	SUN 12:30-2:30	WILLIAM RAVEIS REAL ESTATE	203-264-8180
SOUTHBURY	66 OAKWOOD DRIVE	SAT 12:00-3:00	WILLIAM RAVEIS REAL ESTATE	203-264-8180
SOUTHBURY	20 BOULDER WAY	SUN 1:00-3:00	BERKSHIRE HATHAWAY HOME SERVICES	203-264-2880
SOUTHBURY	7 INDEPENDENCE	SUN 1:00-3:00	BERKSHIRE HATHAWAY HOME SERVICES	203-264-2880
TERRYVILLE	7 LOVELY ST	SAT 1:00-2:00	JENSEN COMMUNITIES	860-793-0281
TERRYVILLE	7 BLUEBERRY LANE	SAT 11:00-12:30	JENSEN COMMUNITIES	860-793-0281
TERRYVILLE	15 LOVELY ST.	SAT 2:15-3:30	JENSEN COMMUNITIES	860-793-0281
THOMASTON	55 HOTCHKISS	SUN 11:00-1:00	TOWN & COUNTRY REAL ESTATE	860-283-0124
WATERBURY	47 EASTRIDGE DR.	SUN 12:00-2:00	SHOWCASE REALTY	203-879-4900
WATERBURY	239 HAUSER STREET	SUN 2:00-4:00	STAR REALTY	203-9980407
WATERBURY	35 HAMPTON RD	SUN 12:00-2:00	WILLIAM RAVEIS REAL ESTATE	203-264-8180
WATERTOWN	76 FARM CIRCLE	SUN 12:30-2:00	WEST VIEW PROPERTIES	860-274-7838
WATERTOWN	33 NEILL DRIVE	SUN 1:00-3:00	WEICHERT REALTORS BRIOTTI GROUP	203-879-2339
WOODBURY	260 COWLES STREET	SUN 12:00-3:00	WILLIAM RAVEIS REAL ESTATE	203-264-8180
WOLCOTT	19 KILMARTIN AVE	SUN 1:00-3:00	WEICHERT REALTORS BRIOTTI GROUP	203-879-2339

TO ADVERTISE IN THE SATURDAY HOMES, CALL (203) 574-3636 BOB EXT 1121 or BARBARA EXT 1123

AT YOUR SERVICE DIRECTORY

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KNL ASPHALT PAVING LLC 203-266-6612 Reg. #579605 www.knlasphalt.com

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SPINO'S PAVING Comm'l and resid'l driveways, parking areas, plow damage repair and curbing replaced. Free estimates. Ct Lic #579761. 203-574-2547 cell 203-537-3151

THEPURPLEPAVERS.COM One call for all your pavement needs! The area's largest residential paving contractor. No money down. We guarantee your satisfaction! Visit us online or call 860-945-0873. CT #612743

Electrical

DW ELECTRICAL Any size jobs, wire, grounding, upgrades, rem. Free est #182996. 203-592-3562

Gutters

PEST SEAMLESS GUTTERS Installs, cleanings, guards, repairs 860-283-2292. #638534

Hauling services

ALL ABOUT SERVICE S&P CARTING trash & cleanup 10-40 yard roll off containers. Same day svc. Ins. V/MC 203-759-4868

JOE ROCCO RUBBISH REMOVAL Est. Clean-outs Bsmnts, Attics, Gar., Demolition removal, All unwanted items. Roll off - 8-30 Yd. Mstrcard/Visa 203-509-3297.

JOE'S JUNK REMOVAL & MORE Furn, appl, shed, attic, basement, Spring Clean up. 20% off, V/MC, 203-535-9817, 860-575-0218

Home improvement

Kitchen Bath Remodeling www.FixMyNewHome.com Mike 203-558-2438 CT Lic#573498

Masonry

JIMMY'S MASONRY Stonewalls, stone siding, patios, all masonry. Free est 860-274-4853. CT#604498

KC MASONRY Free est Stone, brick, block walls. Steps, sidewalk #604814 203-558-4853.

NICK'S MASONRY Driveways stonewalls walkways patios tpic bricks roof old tile etc #636406. 860-274-9829 / 203-982-3226

Moving

DON'S * MOVING 203-888-1400 * 203-272-3052

Painting

ARMEND'S PAINTING LLC Int/ext carpentry low prices! Free est. CT#0631318. 203-597-7179

ASHLEY'S PAINTING LLC Interior & exterior. Call for estimate. 860-331-5308 #0643743

PAUL DEVINO PAINTING CO. LLC Schools, classrooms, college dorms, apartments, condos, stores, factories, shops, plaza, hotels. Low prices. Free est. Lic. #627846. 203-558-4499

ROCCO'S PAINTING Res. Free est & cleanup. CT# 561112. 30+ yrs exp 203-574-3906

Plumbing

CAPINERA PLUMBING & HEATING Gas pipe, boilers, HW heaters, & repairs #282962. 203-575-1561

CHRIS SHEPPARD PLUMBING repair, w/z heater, pipe freeze ups, gas. #283570 203-305-0072

Roofing

S&S Roofing you feeling lucky? You will if you sign up with us by St. Patty's Day!!! Arraiting w/888. Steve Biff Saunders 860-283-9590 Vet owned. #571533

AFFORDABLE ROOFING SIDING & GUTTERS. licensed & ins. #0642005. Tom 860-484-1644.

BURYSIDE ROOFING LLC Missing/Damaged Shingles? Insurance claim specialist Local/Working owner 888 #0638890 Inc. 203.205.6157

DIDONATO ROOFING Remodeling & Siding. Reasonable rates. Sr. discount. #563056. 203-809-2773

Lema Construction Roofing, Siding, Masonry & Chimney repair. Lic#635670. 203-610-3836

ANY ROOF shoveled by professional roofers, most roofs $250; lic. & ins. Tom 860-484-1644.

Snowplowing

Big storm coming. Call now for snowplowing, shoveling, roof shoveling, walkways, driveways. Call 203-910-8274

Tree care

BILL TREE SERVICE Tree Removal, Trim trees, bushes, shrubs. (Give us a ring!) 203-217-7311

OMJ TREE SERVICES 60' bucket truck & climbing, 24 hr. service. #0630188. 203-942-6351

LOG DOGS COMPLETE TREE SERVICE Lot clearing, stump grinding, free est. 203-271-3192. 5% of every job donated to local dog rescue. www.logdogstreeremoval.com

ALL SEASONS TREE REMOVAL Bucket & climb, serv. Storm damage, Ins'd. 860-945-0001

P.F.D. LLC Bucket truck service & climbing, tree remov., chipper, stump grinding, 24 hr. serv., Sr. Disc. #518875. Free Est. 860-274-8884

INCREASE BUSINESS! SAVE DOLLARS!
Run Your Ad for 28 Days & $AVE When You Prepay!
Deadline: 4:00 pm Mon-Thurs for next day insertion
Deadline: 2:00 pm Fri for Sat, Sun, Mon insertions
Call for details 203-574-3616

Help wanted

MECHANIC Exp'd only. Must have tools & driver's license. Top wages. Pay based on exp. Apply QUALITY AUTO, 7 East Aurora St, Wtby. 203-756-7841

PAVING & CONSTRUCTION "LAST CALL" Asphalt Paving co. seeking motivated trustworthy applicants to join our team. Must be reliable! Experience preferred, competitive wages, sick & vacation time, retirement programs, health ins, company functions every quarter! Winter work available. Join the fastest growing pavement maint. company in the state! The following skill sets are encouraged to apply!
- Paver Operator (sign on bonus!!)
- Roller Operator (sign on bonus!!)
- Asphalt Raker
- Project Manager
- Marketing Manager
- Entry Level Laborer
- Commercial sales rep for asphalt paving
- Truck and Equip. Mechanic

Call 203-560-6716 Ext. 1
CT SEALCOATING
27 Siemon Company Drive Suite 228W, Watertown, CT

RESTAURANT Cook/Prep for sm. restaurant, P/T, exp req'd. Apply 33 Union City Rd, Prospect or 203-758-3304

Restaurant Manager
The University of Connecticut, Department of Dining Services, has an immediate opening for a full-time, Area Manager in its new Starbucks location on the Waterbury Campus. This position reports to the Assistant Director of Retail Operations or the appropriate designee, oversees and participates in all aspects of the Starbucks retail operations at the Waterbury campus. This position contributes to Starbuck success by leading a team to create and maintain the Starbucks Experience. For details on the position, qualifications, and application instructions please visit www.job.uconn.edu
The University of Connecticut is an EEO/AA employer.

RESTAURANT Short Order and Saute Cook, Exp. only. Apply Mary's Diner II, 538 Meriden Rd, Wtby. No calls.

Help wanted

SALES RETAIL SALES ASSOCIATE BUYER for museum gift shop in Washington, CT. Part Time including wknds. Customer service and retail sales experience required, online sales experience preferred. Email resume to: general@iaismuseum.org

SERVICE TECH OIL & PROPANE
FT tech to perform all repairs & installations of all Oil & Propane equip. Must have CT occupational lic. Competitive salary, medical insurance & IRA Savings Plans.
Email resume to: ellen@muccofuels.com
Or apply in person: 595 Wolcott Road, Wolcott CT

TEST BORING/DRILL RIG OPERATOR for test boring, H S A; Mud Rotary; Air Rotary. Exp'd with CDL $20-$23/hr+benefits. Send Resume Fax 203-264-3414; alecia@soiltestinginc.net AA/EOE

TREE SERVICE Hiring Ground Worker possible climber/bucket operator. Exp'd must have valid license, CDL preferred. Casadei Tree 860-459-8395

Educational Services

Instruction classes

EMT SPRING COURSE Classes starting SPRING Limited space 475-222-6805

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Furniture
Good things to eat
Household goods
Jewelry
Machinery & tools
Mall & www orders
Medical, surgical
Musical merchandise
Pawn shops
Precious metals, coins
Restaurant equipment
Seeds, plants, flowers
Swapping
Tag & estate sales
Vendors wanted
Wanted to buy
Wearing apparel
Wood & fuel

Articles for sale

BASEBALL BAT "Stealth" $60. Bag & gloves & helmet. Sony IHome $25. 203-879-2155

BATTERY HOLDOWN New never used. Early Chevelle GTO Skylark. $5; 860-274-8192

CANNING JARS with lids-NEW- one dozen quart size. $10 Call 203-528-6039

COMFORTER queen white (Chic & Shabby), excellent condition $45. 203-525-7369

DOG CARRIER for medium sized dog. Call for measurements. $30. 203-525-7369

DOLLS Collectible, Annalee. $15 each. 860-283-5616

ELECTRONICS Vintage amps, stereo equip. Under $99 ea. 860-482-5642, 860-689-2125

EMBROIDERY HAND TOWELS ASSORTED COLORS 17X27 $10 EACH PERFECT GIFTS 203-527-4345

FISHING Fly fishing rods $2 ea. Pkgs of hooks, sinkers, bobbers $1 ea. 203-528-6039

FISHING Rods - Reels & Lures. Tons of tackle- USED refinished $1-$99. 203-574-4928

Articles for sale

FOR SALE EMBROIDERY SEWING MACHINE $195. VIKING HEIRLOOM ALPHABET COLLECTION $35. CABINET AVAILABLE B/O 203-527-4345

LAMP Winnie the Pooh, Home decor $10-$20. 203-879-2155

LAWNMOWER TROYBILT 21" Gas Push Mower. 1 Yr. Old. $100 or best. 475-235-4570

LEAF MULCHER $15. Storm Guard $45. Call 860-355-0304

LIGHT FIXTURE Fluorescent with tube and plug. 17" long. Works fine. $5; 860-274-8192

PHONE AT&T speaker phone with caller ID, other features, new in box $50. 860-489-0089

PURSE Ladies Dooney & Bourke, good condition $40 firm. Call 860-384-1183

PUZZLES 300-1,500 pieces. Perfect condition. $2.50 each. 203-879-5278

SPRING VALLEY FLAXSEED OIL Two 2400mg bottles, 400 soft gels. $29.95. Call Ann 203-910-6783

SWIFFER NEW Wet Sweeper Starter Kit $8. Call Ann 203-910-6783

TABLE WITH LEAF $30; drafting table $15; 2 new 13" snare drums $99. 203-757-6849

TABLETOP 54 x 54 glass w/ 4 chairs, glass & wire baker's rack. $350 OBO. Diane 475-212-9192

TRACTOR MOWER Poulan, 18 H.P., 6 sp., very gd. cond. $350 203-729-6726 or 203-528-6090

USED OIL TANK 275 Gal., $50. Call 203-755-7614

Feed & fertilizer

TOPSOIL SCREENED FILL crushed stone, process, conrete / asphalt disposal, p/u or del 203-596-1354

Furniture

LOVE SEATS (2) Great condition. Local pick up only. $200; Text 203-217-0746 for pics

Tag/estate sales

GOSHEN ESTATE SALE 139 School Hill Rd. 60+yrs New England family's home. Fri. & Sat. March 17 & 18 9-3. Antique/vintage items, bedding, furniture, kitchen & glassware. Many items under $1. Cash sales. Inquiries: loispeters@gmail.com

PROSPECT 87 Clark Hill Rd. Sat. & Sun. 9-4. MOVING- furniture, wall hangings, accessories. MORE!

Prospect Rain or Shine. Sat/Sun March 18/19, 9-4. 13 Apple Hill Dr. Furn, Appl, Hdwre, Clothes, misc

THOMASTON 180 Main St. St. Peter's Trinity Church. Fri March 17, 5pm-8pm & Sat March 18, 9am-2pm

Wanted to buy

ACCORDIANS ACOUSTIC GUITARS amp drums, musical instrument, Cash paid any cond 508-688-5138.

ACCORDIANS, all antiques, audio, amps, guitars, musical instr, old toys, watches, jewelry, Military, art, radios, HAM EQ 860-707-9350

MACHINIST TOOLS AND TOOLING, MECHANIC TOOLS, SMALL LATHES 860-985-3768

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Announcements

Absolutely free
Lost & found
Special notices

Absolutely free

4 WOODEN PALLETS P/U curbside. 49 Washington, Middlebury. Call/text 203-528-7099

CAT Male, 2-3 years old. "Rocky" needs a home. Call Donna 860-274-0686

Lost & found

FOUND male cat on Olive St, Naugatuck. Call Tara 617-840-8270

IMPOUNDED WATERBURY Male Pit Bull mix brown & white to redeem 203-574-6909

LOST Black computer bag & green backpack, in Wolcott on 3/1. Reward offered. Call Chris 203-558-5817

LOST hearing aides in white Siemons case, 3x2x1. Call 860-868-6667.

Legals/ Public Notices

PUBLIC NOTICE
The Naugatuck Valley Health District Public Hearing and Regular Board
Meeting scheduled for March 14, 2017 is cancelled. The Public Hearing will be re-scheduled for a later date and the next Regular Board Meeting is scheduled for 7:00 PM on April 11, 2017.
John Zikaras, Chairman.
R-A March 18, 2017

NOTICE
Notice is hereby given that, pursuant to Connecticut General Statutes Section 19a-638, Counseling Center of Waterbury, LLC (d/b/a Connecticut Counseling & Wellness) intends to file a Certificate of Need application with the State of Connecticut Office of Health Care Access to establish an intensive outpatient program for the treatment of substance abusive or dependent adults at 1776 Meriden Road, Wolcott, Connecticut 06716. There is no capital expenditure associated with this application.
R-A March 16, 17 & 18/2017

LEGAL NOTICE
FORECLOSURE AUCTION SALE
Docket No: LLI-CV15-6013024-S
Case Name: Connecticut Housing Finance Authority vs. Karen A. Morris, et al
Property Address: 183 North Chapel Street, Torrington, CT
Property Type: Residential
Date of Sale: Saturday, March 25, 2017
Committee Name: Gerald R. Reis, Esq.
Committee Phone Number: 860-482-3473
See Foreclosure Sales at www. jud.ct.gov for more detailed information
RA-March 11, 18, 2017

LIQUOR PERMIT
NOTICE OF APPLICATION
This is to give notice that I, Raju A Patel of 350 Buckingham St, Oakville, CT 06779 have filed an application placarded 3/9/2017 with the Department of Consumer Protection for a Package Store Liquor permit for the sale of alcoholic liquor on the premises at: 384 Buckingham St., Oakville, CT 06779
The business will be owned by: New Shreeji LLC
Objections must be filed by 4/19/2017 Raju A Patel
R-A March 11, 18, 2017

Legals/ Public Notices

LEGAL NOTICE
FORECLOSURE AUCTION SALE
Docket No
LLI CV 196013521S
Case Name:
Citimortgage, Inc vs. Shelley L Weaver If Living of If not living her Widower, Heirs, Beneficiaries, Devisees, Representatives
Property Address: 191 Roosevelt Avenue, Torrington CT 06790
Property Type: Residential
Date of Sale: March 25, 2017
Committee Name: Paul R. Griffin
Committee Phone Number: 860-489-6444
See Foreclosure Sales at www.jud.ct.gov for more detailed information
R-A March 11 & 18, 2017

SHARON HISTORIC DISTRICT
LEGAL NOTICE
On Monday, March 27, 2017 at 6:00 PM the Sharon Historic District Commission will hold a public hearing on the following application: Amendment to 22 Upper Main Street. The hearing will be held at Sharon Town Hall, 63 Main Street, Sharon, CT on the second floor.

This application is on file at the Sharon Land Use Office. At this hearing, interested persons may be heard and written communications received.

Dated this 10th day of March 2017.

John Baroody
Chairman
R-A March 18, 2017

LEGAL NOTICE
FORECLOSURE AUCTION SALE

DOCKET NO: CV-15-6012469-S

CASE NAME: Reverse Mortgage Solutions, Inc. v. Ralph R. White, et al

PROPERTY ADDRESS: 154 Norfolk Rd., Litchfield, CT 06759

PROPERTY TYPE: Residential

DATE OF SALE: Saturday, April 1, 2017

COMMITTEE NAME: Steven H. Levy

COMMITTEE PHONE NUMBER: 860-482-4451

See Foreclosure Sales at www.jud.ct.gov for more detailed information
R-A March 18 & 25, 2017

LEGAL NOTICE
WATERBURY SCHOOL READINESS (WSR) 30-B CHURCH ST. WATERBURY, CT 06702
LEGAL NOTICE WSR 30-B CHURCH ST. WATERBURY, CT 06702 REQUEST FOR PROPOSALS, SCHOOL READINESS AND EARLY CHILDHOOD PROGRAMS, as the Office of Waterbury School Readiness invites licensed center-based child care programs to submit a Request for Proposal application for the greater Waterbury area School Readiness Grant Program. If you are a licensed center-based program caring for 3 and 4-year-old children residing in the community, then you may be eligible to apply for School Readiness funds. WSR will receive applications from programs at the Office of Early Childhood, 30-B Church St. Waterbury, CT 06702. PLEASE NOTE WSR WILL HOLD A MANDATORY SCHOOL READINESS BIDDERS' MEETING ON Tuesday, March 21st ,2017, at 3:00 P.M. at WSR Office of Early Childhood, 30-B Church St. Waterbury, CT 06702. Request for Proposal applications will be available at that time. Detailed instructions in how to submit an application will be provided at the mandatory session on March 21st, 2017. WSR reserves the right to reject any and all applications submitted after the deadline. Incomplete or late applications will not be accepted. Please contact Shiroon Hickox or Marie Klein at 203-573-6684 with questions. Proposals should be hand delivered to Shiroon Hickox or Marie Klein at the WSR Office of Early Childhood, 30-B Church St. Waterbury, CT 06702
RA March 14-20, 2017

Legals/ Public Notices

REQUEST FOR QUALIFICATIONS
Bogue Road Bridge
Design-Build Project
Torrington/Harwinton, Connecticut

RFQ BRB-027-040717

The City of Torrington is issuing this Request for Qualifications (RFQ) in order to choose a Design-Build team for the replacement of the Bogue Road Bridge deck located on the southside of Torrington and western edge of Harwinton. The bridge spans over the Naugatuck River between the municipalities. The Design-Build team will be selected based on a two-step Best-Value Procurement Process. The first step includes review of Design Build team qualifications and then short listing of a select number of Design-Build teams. The second step includes reviewing Request for Proposals from the short-listed teams and then selection of a Design-Build team. Note that in the future the City of Torrington may elect to solicit proposals and contract with any of the short-listed teams for other upcoming City bridge replacement projects.

The objective of this locally funded Design-Build project is to streamline the overall process with the goal of replacing the existing Bogue Road bridge deck in a very short time frame with a high quality product with low long-term maintenance needs. This project is not associated with a CT DOT project. It is imperative that vehicular access is maintained to two neighboring major businesses and the Torrington Water Pollution Control Authority (WPCA) wastewater facility during the deck replacement construction period.

Respondents are requested to submit their Statement of Qualifications, which should include product literature, company background information, references, related budget costs, and any other pertinent data. The Respondent's submittal shall include an original and five (5) copies (in addition to the hard copies an electronic copy is optional) and shall be delivered to the Purchasing Agent, 140 Main Street, Room 206, Torrington, CT 06790, during normal office hours by no later than 11:00 a.m. on April 7, 2017. Submittals received after this date and time will be not be accepted. Sealed envelope(s) should be clearly marked: "RFQ BRB-027-040717, Bogue Road Bridge Design-Build Project". In the event of the closure of City Hall, the qualification submittals will be received until 11:00 A.M on the following business day that City Hall is open. Any questions on RFQ must be submitted by March 30, 2017. All questions shall be submitted by email to the Purchasing Agent at pennie_zucco@torringtonct.org. Pertinent questions will be answered and will be posted on the City of Torrington website. Short listed Design-Build teams will be required to submit their RFP proposal as specified in the Information to Bidders.

Interested parties may obtain or examine Contract Documents at the Office of the City Purchasing Agent, Rm 206, City Hall, 140 Main Street, Torrington, Connecticut 06790, during normal office hours (M. - W. 9:00 a.m. - 4:00 p.m., Th. 9:00 a.m. - 6:30 p.m., F. 9:00 a.m. - 12:30 p.m.). Prospective Respondents may purchase documents for a $50.00 non-refundable fee, payable to the City of Torrington.

The information provided by the City is not intended to and shall not bind the City of Torrington to any of the statements or assumptions set forth therein. This RFQ does not commit the City of Torrington to select any Respondent or enter into any contract agreement. The City of Torrington reserves the right to waive any informalities or technicalities and, if it is deemed to be in the public interest, to enter directly into negotiations with one or more Respondents based on responses to the RFQ, to request additional information from some or all Respondents, or to issue a formal Request for Proposals and to award a contract.

Pennie Zucco
Purchasing Agent
An Affirmative Action/ Equal Opportunity Employer
R-A March 18, 2017

AT YOUR SERVICE DIRECTORY

Asphalt paving

KNL ASPHALT PAVING LLC 203-206-6812 Reg. #629605 www.knlasphalt.com

MARINI PAVING 860-274-3078 * Driveways * Repairs * Seal Coating * Drainage #563045. 203-410-5226

SPINO'S PAVING Comm'l and resid'l driveways, parking areas, plow damage repair and curbing replaced. Free estimates. CT Lic #579761. 203-574-2547 cell 203-537-3151

THEPURPLEPAVERS.COM One call for all your pavement needs! The area's largest residential paving contractor. No money down. We guarantee your satisfaction! Visit us online or call 860-945-0873. CT #612743

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JOE'S JUNK REMOVAL & MORE Furn, appl, shed, attic, basement, Spring Clean up. 20% off, V/MC, 203-535-9817, 860-575-8218

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Kitchen Bath Remodeling www.FixMyNewHome.com Mike 203-558-2428 CT Lic#573490

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KC MASONRY Free est Stone, brick, block walls, Steps, sidewalk #604514 203-558-4951.

Masonry

NICK'S MASONRY Driveways stonewalls walkways patios fplc bricks roof sid tile etc #0634606. 860-274-9629 / 203-982-3226

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DON'S * MOVING 203-509-1488 * 203-272-3032

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ASHLEY'S PAINTING LLC Interior & exterior. Call for estimate. 860-331-5308 #0642743

Painting

PAUL DEVINO PAINTING CO. LLC Schools, classrooms, college dorms, apartments, condos, stores, factories, shops, plaza, hotels. Low prices. Free est. Lic. #627846. 203-509-4489

ROCCO's PAINTING Res. Free est & cleanup. CT# 561112. 20+ yrs exp 203-574-1906

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CAPINERA PLUMBING & HEATING Gas pipe, boilers, HW heaters, & repairs #232962. 203-575-1551

CHRIS SHEPPARD PLUMBING repair, wtr heater, pipe freeze ups, gas, #283570 203-305-0072

Roofing

AFFORDABLE ROOFING SIDING & GUTTERS. licensed & ins. #0642005. Tom 860-484-1544.

BUSYBEE ROOFING LLC Missing/damaged Shingles? Insurance claim specialist Local/Working owner BBB #0620990 Ins. 203.206.6157

DIDONATO ROOFING Remodeling & Siding, Reasonable rates. Sr. discount. #563098. 203-509-2773

Lema Construction Roofing, Siding, Masonry & Chimney repair, Lic#636670. 203-510-3830

S&S Roofing you feeling lucky? You will if you sign up with us by St. Patty's Day!!! A+rating w/BBB. Steve Biff Saunders 860-283-8590 Vet owned. #573533

Tree care

ALL SEASONS TREE REMOVAL Bucket & chip. serv. Storm damage, Ins'd. 860-945-0001

BELL TREE SERVICE Tree Removal, Trim trees, bushes, shrubs. (Give us a ring!) 203-217-7311

GMJ TREE SERVICES 60' bucket truck & climbing, 24 hr. service. #0630189. 203-942-6351

LOG DOGS COMPLETE TREE SERVICE Lot clearing, stump grinding. Free est. 203-271-3356. 5% of every job donated to local dog rescue. www.logdogstreeremoval.com

P.F.D. LLC Bucket truck service & climbing, tree remov., chipper, stump grinding, 24 hr serv., Sr. Disc. #618875. Free Est. 860-274-0804

INCREASE BUSINESS! SAVE DOLLARS!

Run Your Ad for 28 Days & $AVE When You Prepay!
Deadline: 4:00 pm Mon-Thurs for next day insertion
Deadline: 2:00 pm Fri for Sat, Sun, Mon insertions
Call for details 203-574-3616

"I want to be a comb. Recycle me."

IWantToBeRecycled.org

OHCA 000041

ATTACHMENTS

I	Resumes
II	Scholarly Articles
III	Letters of Support
IV	Protocols
V	Charity Care Policy and Sliding Fee Scale
VI	Balance Sheets, Statements of Operations, and Tax Returns
VII	Financial Worksheet B

ATTACHMENT I

Resumes

Gerard R. Marcil
332 Central Avenue,
Wolcott CT 06716
(203) 233-7581
Jerry@ccwellness.org

Academic Qualifications	**Capella University, Minneapolis, MN.** / M.S. Human Services. - March/2008
	Post University, Waterbury, CT. / Bachelor of Science. - June/2004

Licenses	**LADC. State of Connecticut #001023**
Certifications	**CEAP, LAP-C, CEAP, SAP Qualified**

Professional Experience

Director/Owner -CCW (2012 to Present)

1776 Meriden Road, Wolcott, CT

CCW is a private counseling practice, focusing on substance use disorders through individual, group, and family education and counseling.

Employee Assistance Program Coordinator (2000 to 2014)

Pratt and Whitney Aircraft

EAP for joint labor management – provided intake, assessment, short-term counseling, referral, and follow-up care for employees referred to EAP by management, union, or self. Trained supervisors, and peer counselors in recognizing and addressing employee performance issues.

Affiliations

NADAAC (2008 – Present)

CT Labor Assistance Professionals (2004 – Present)

CT Employee Assistance Professionals (2002 – 2009)

President of 2008CT Employee Assistance Professionals (2008-2010)

Leadership Awards

Founder of CT Chapter of Labor Assistance Professionals (2003)

LAP Founder Award, Presenter LAP National Conference (2011)

Member of UCONN "Substance Abuse in the Workplace" Research Team

AMY ST. PIERRE

43 Edgemont Avenue, West Hartford, Connecticut 06110 ♦ C: 860-380-0293 ♦ amystp65@yahoo.com

PROFESSIONAL SUMMARY

Empathetic mental health professional with 19 years' experience providing highly skilled services to co-occurring populations

WORK HISTORY

Clinical Supervisor, 2/1/2017 to current, **Connecticut Counseling and Wellness, Wolcott, CT.**

Responsible for individual case load and daily supervision of ancillary and clinical staff.

Senior Crisis Clinician, 03/2016 to Current **Wheeler Clinic Hartford, CT**

Develop disposition, discharge planning and coordinate transfer to higher level of care .Facilitate appropriate referrals and provide education to patient and family regarding diagnosis and discharge services .Kept abreast of new and developing information in the mental health field by regularly attending professional conferences and workshops. Presented case history material to review and discussion with other staff members. Psychiatric assessment of all substance use and mental health patients referred by ED attending M.D.

Senior Clinician, 09/2012 to 03/2016 **Wheeler Clinic Hartford, CT**

Responsible for a men's day substance abuse intensive outpatient program. Ran a weekly co-occurring group and a weekly relapse prevention group .Conducted therapeutic individual sessions .Provided comprehensive case management services, including creating treatment plans and connecting clients and families to appropriate resources. Displayed sensitivity to the cultural and linguistic needs of the clients and families served. Guided clients in effective therapeutic exercises integrated from Cognitive Behavior Therapy and Dialectical Behavior Therapy (DBT).Managed a caseload of 100 patients with substance dependence and co-occurring Axis I and Axis II disorders.

Psychiatric Clinician, per diem, 08/2012 to 10/2014 **Hospital Of Central Connecticut, New Britain CT**

Provided individual and group psychotherapy for adult inpatient. Facilitated family visits and helped to coordinate discharge planning Observed and monitored client behavior and responses to treatment. Facilitated a smooth discharge by encouraging and reassuring clients throughout their transitions.

Outpatient Counselor, 09/2009 to 08/2012 **Connecticut Counseling Centers, Inc , Waterbury CT**

Responsible for individual and group counseling for methadone maintenance and detox patients .Co-facilitated co-occurring IOP, and a weekly co-occurring group Provided case management, developed treatment planning, and coordinated discharge planning and referral for chemically dependent and co-occurring populations.

Vocational Rehabilitation Counselor, 09/2006 to 05/2009 **State Of CT Bureau of Rehabilitation, New Britain CT**

Responsible for intake, assessment, counseling and case management of the physically, psychiatrically or cognitively disabled who qualified for state and federal assistance in an effort to remediate or accommodate their disability and to prepare them for work.

Outpatient Counselor, 01/2004 to 02/2005 **Community Solutions, Behavioral Health Services, Hartford CT**

Responsible for biopsychosocial assessment, diagnostic impression, disposition, individual counseling for predominately criminal justice clients. Provided crisis intervention and case management of court mandated chemically dependent and co-occurring disorder clients.

Outpatient Counselor, 09/1998 to 05/2000 **Community Prevention and Addiction Services, Willimantic, CT**

Responsible for evaluation, diagnostic assessment, individual and group counseling, crisis intervention and case management for Co-occurring population.

EDUCATION

Springfield College, Springfield MA
Master of Education: Counseling Psychology, August 1997
Mental Health Counseling
University of Connecticut, Storrs CT

Bachelor of Arts: Psychology, May 1989
Psychology, Sociology

ADDITIONAL INFORMATION

LICENSED ALCOHOL AND DRUG COUNSELOR since 12/2010

ATTACHMENT II

Scholarly Articles

Substance Abuse Intensive Outpatient Programs: Assessing the Evidence

Dennis McCarty, Ph.D.
Lisa Braude, Ph.D.
D. Russell Lyman, Ph.D.
Richard H. Dougherty, Ph.D.
Allen S. Daniels, Ed.D.
Sushmita Shoma Ghose, Ph.D.
Miriam E. Delphin-Rittmon, Ph.D.

Objective: Substance abuse intensive outpatient programs (IOPs) are direct services for people with substance use disorders or co-occurring mental and substance use disorders who do not require medical detoxification or 24-hour supervision. IOPs are alternatives to inpatient and residential treatment. They are designed to establish psychosocial supports and facilitate relapse management and coping strategies. This review assessed the evidence base for IOPs. _Methods:_ Authors searched major databases: PubMed, PsycINFO, Applied Social Sciences Index and Abstracts, Sociological Abstracts, Social Services Abstracts, Published International Literature on Traumatic Stress, ERIC, and CINAHL. They identified 12 individual studies and one review published between 1995 and 2012. They chose from three levels of research evidence (high, moderate, and low) based on benchmarks for the number of studies and quality of their methodology. They also described evidence of service effectiveness. _Results:_ Based on the quality of trials, diversity of settings, and consistency of outcomes, the level of evidence for IOPs was rated high. Multiple randomized trials and naturalistic analyses that compared IOPs with inpatient or residential care found comparable outcomes. All studies reported reductions in alcohol and drug use. However, substantial variability in the operationalization of IOPs and outcome measures was apparent. _Conclusions:_ IOPs are an important part of the continuum of care for substance use disorders. They are as effective as inpatient treatment for most individuals. Public and commercial health plans should consider IOP services as a covered health benefit. Standardization of the elements included in IOPs may improve their quality and effectiveness. (_Psychiatric Services_ 65:718–726, 2014; doi: 10.1176/appi.ps.201300249)

Dr. McCarty is with the Department of Public Health and Preventive Medicine, Oregon Health and Science University, Portland. Dr. Braude, Dr. Lyman, and Dr. Dougherty are with DMA Health Strategies, Lexington, Massachusetts. Dr. Daniels and Dr. Ghose are with Westat, Rockville, Maryland. Dr. Delphin-Rittmon is with the Office of Policy, Planning, and Innovation, Substance Abuse and Mental Health Services Administration (SAMHSA), Rockville. Send correspondence to Dr. Lyman (e-mail: russl@dmahealth.com). *This article is part of a series of literature reviews being published in* Psychiatric Services. *The reviews were commissioned by SAMHSA through a contract with Truven Health Analytics and were conducted by experts in each topic area, who wrote the reviews along with authors from Truven Health Analytics, Westat, DMA Health Strategies, and SAMHSA. Each article in the series was peer reviewed by a special panel of* Psychiatric Services *reviewers.*

Substance abuse intensive outpatient programs (IOPs) are ambulatory services for individuals with substance use disorders who do not meet diagnostic criteria for residential or inpatient substance abuse treatment as well as for individuals who are discharged from 24-hour care in an inpatient treatment facility and continue to need more support than the weekly or biweekly sessions provided in traditional outpatient care (1). IOP services offer a minimum of nine hours of service per week in three, three-hour sessions; however, some programs provide more sessions per week or longer sessions, and many programs become less intensive over time (1,2). Because services are provided in outpatient settings, the duration may be longer than that required for inpatient services. Individuals in IOPs remain in their homes, reduce the use of expensive inpatient care, and learn to recover in their community (1).

Since 2002, the annual census of specialty addiction treatment facilities in the United States has consistently identified IOPs as second in prevalence only to regular outpatient treatment for alcohol and drug use disorders. In 2011, there were 6,089 treatment programs in the United States that reported offering IOP services (44% of 13,720 addiction treatment programs), and IOPs served 141,964 patients—12% of the 1.2 million patients receiving specialty addiction treatment (3).

This article reports the results of a literature review that was undertaken as part of the Assessing the Evidence Base Series (see box on this page). The purpose of this review was to provide policy makers, treatment providers, and consumers with current information on IOPs so that they can make informed decisions when comparing these programs with alternative treatments. Public and commercial health plan administrators may use this information to assess the need to include IOPs as a covered benefit. Our assessment of IOPs defines the programs as a level of care, reviews available research, and evaluates the quality of the evidence, most notably compared with evidence for the effectiveness of inpatient treatment services.

About the AEB Series

The Assessing the Evidence Base (AEB) Series presents literature reviews for 13 commonly used, recovery-focused mental health and substance use services. Authors evaluated research articles and reviews specific to each service that were published from 1995 through 2012 or 2013. Each AEB Series article presents ratings of the strength of the evidence for the service, descriptions of service effectiveness, and recommendations for future implementation and research. The target audience includes state mental health and substance use program directors and their senior staff, Medicaid staff, other purchasers of health care services (for example, managed care organizations and commercial insurance), leaders in community health organizations, providers, consumers and family members, and others interested in the empirical evidence base for these services. The research was sponsored by the Substance Abuse and Mental Health Services Administration to help inform decisions about which services should be covered in public and commercially funded plans. Details about the research methodology and bases for the conclusions are included in the introduction to the AEB Series (5).

Description of the service

IOPs treat individuals with substance use disorders or co-occurring mental and substance use disorders who do not require medical detoxification or 24-hour supervision. IOPs provide a specified number of hours per week of structured individual, group, or family therapy as well as psychoeducation about mental and substance use disorders.

The American Society of Addiction Medicine (ASAM) defines five levels of care to guide practitioners in selecting the appropriate intensity for treating alcohol and drug use disorders: Level .5 (early intervention services), Level I (outpatient services), Level II (intensive outpatient services), Level III (residential and inpatient services), and Level IV (medically managed intensive inpatient services) (2). Thus IOPs represent a higher level of care than usual outpatient services and a lower level of care than residential and inpatient services. (A separate article in this series addresses residential treatment for individuals with substance use disorders [4].)

The Substance Abuse and Mental Health Services Administration defines a set of core services for inclusion in IOPs, such as a specified number of hours of structured programming per week; individual, group, or family therapy; and psychoeducation about substance use disorders and mental disorders (1). Table 1 provides a description of the service.

IOP goals are to help the individual learn early-stage relapse management and coping strategies, to ensure that the person has psychosocial support, and to address individual symptoms and needs. However, broad variation across programs in terms of service delivery (for example, mechanisms for screening and assessment), treatment planning and provision, crisis management, discharge planning, and the intensity and duration of care limit attempts to assess the quality and effectiveness of care across IOPs. Moreover, IOP services vary by setting: hospitals, community behavioral health centers, and day treatment programs. The ASAM criteria note that the duration of treatment varies with the severity of the person's illness and his or her response to the treatment intervention. Therefore, progress in a particular level of care, rather than a predetermined length of stay, determines an individual's movement through the treatment continuum.

In the clinical and research literature, IOPs may also include partial

Table 1

Summary of substance abuse intensive outpatient programs

Feature	Description
Service definition	Substance abuse intensive outpatient programs (IOPs) are direct services for people with substance use disorders or co-occurring mental and substance use disorders who do not require medical detoxification or 24-hour supervision. The programs provide treatment for symptoms or disabilities associated with these disorders. Core services generally include a specified number of hours of structured programming per week; individual, group, or family therapy; and psychoeducation about substance use and mental disorders.
Service goals	Learn early-stage relapse management; develop coping strategies; establish or re-establish psychosocial supports; address problems related to social, psychological, and emotional well-being
Populations	Adults with substance use disorders (both alcohol and drug diagnoses)
Settings for service delivery	Hospital-based inpatient and day treatment in community hospitals and Veterans Affairs hospitals; social model residential programs; community-based public and private substance abuse treatment centers

OHCA 000049

hospitalization and day treatment (ASAM Level II.5), both of which are used to treat people who have serious mental illness or substance use problems. For the purposes of this review, partial hospitalization and day treatment for individuals with substance use are included in the definition of an IOP. Day treatment models operate full-day schedules five to seven days per week and may treat patients with co-occurring serious mental illness.

Methods

Search strategy

We identified and reviewed research from 1995 through 2012. We conducted a survey of major databases: PubMed (U.S. National Library of Medicine and National Institutes of Health), PsycINFO (American Psychological Association), Applied Social Sciences Index and Abstracts, Sociological Abstracts, Social Services Abstracts, Published International Literature on Traumatic Stress, the Educational Resources Information Center, and the Cumulative Index to Nursing and Allied Health Literature. We also examined bibliographies of major reviews and meta-analyses. We used combinations of the following search terms: intensive outpatient treatment, substance abuse treatment, addiction treatment, drug rehabilitation, and alcohol treatment.

Inclusion and exclusion criteria

This review was limited to U.S. and international studies in English and included the following types of articles: randomized controlled trials (RCTs), quasi-experimental studies, naturalistic assessments, and qualitative reviews. Studies were included if they compared levels of care (that is, inpatient or residential treatment versus IOP or day treatment) for adult study participants seeking treatment for alcohol or illicit drug use. The ASAM *Patient Placement Criteria for the Treatment of Substance-Related Disorders* (2) and the Treatment Improvement Protocol on intensive outpatient programs from the Center for Substance Abuse Treatment (1) were also examined. Studies were excluded that examined residential treatment only, ambulatory treatment only, aftercare only, treatment for mental disorders only, developmental disability programs, hospital-based inpatient treatment programs without comparisons to less intensive services, and treatment services for adolescents.

Strength of the evidence

The methodology used to rate the strength of the evidence is described in detail in the introduction to this series (5). The research designs of the identified studies were examined. Three levels of evidence (high, moderate, and low) were used to indicate the overall research quality of the collection of studies. Ratings were based on predefined benchmarks that considered the number and quality of the studies. If ratings were dissimilar, a consensus opinion was reached.

In general, high ratings indicate confidence in the reported outcomes and are based on three or more RCTs with adequate designs or two RCTs plus two quasi-experimental studies with adequate designs. Moderate ratings indicate that there is some adequate research to judge the service, although it is possible that future research could influence reported results. Moderate ratings are based on the following three options: two or more quasi-experimental studies with adequate design; one quasi-experimental study plus one RCT with adequate design; or at least two RCTs with some methodological weaknesses or at least three quasi-experimental studies with some methodological weaknesses. Low ratings indicate that research for this service is not adequate to draw evidence-based conclusions. Low ratings indicate that studies have nonexperimental designs, there are no RCTs, or there is no more than one adequately designed quasi-experimental study.

We accounted for other design factors that could increase or decrease the evidence rating, such as how the service, populations, and interventions were defined; use of statistical methods to account for baseline differences between experimental and comparison groups; identification of moderating or confounding variables with appropriate statistical controls; examination of attrition and follow-up; use of psychometrically sound measures; and indications of potential research bias.

Effectiveness of the service

We described the effectiveness of the service—that is, how well the outcomes of the studies met the service goals. We compiled the findings for separate outcome measures and study populations, summarized the results, and noted differences across investigations. We evaluated the quality of the research design in our conclusions about the strength of the evidence and the effectiveness of the service.

Results

Level of evidence

The level of evidence for IOPs was rated as high. Multiple RCTs and quasi-experimental studies have been conducted of IOPs that were designed for individuals with substance use disorders. We identified five reports based on four RCTs that compared IOP services or day treatment services with inpatient or residential treatment (6–10) and two studies of inpatient treatment versus IOPs that included participants who had been randomly assigned to a treatment group and those who refused randomization (11,12). Our search also found six naturalistic analyses of patients treated in inpatient and IOP settings (13–18) and one qualitative review of research published after 1995 (19). Table 2 summarizes the studies included in this review.

Most of the RCTs had good internal validity and used the Addiction Severity Index (ASI), a well-validated treatment outcome measure. However, samples were sometimes small to modest, and insufficient statistical power may have contributed to a lack of strong findings. Conversely, the naturalistic studies reported large samples but had more variability in outcome measures. Nonetheless, findings from the RCTs and naturalistic analyses appeared to complement each other.

Patient populations and service settings

In studies of IOP services, alcohol dependence (9,10,15,19) and cocaine dependence (6,16) were the primary

OHCA 000050

Table 2

Studies of intensive outpatient programs (IOPs) included in the review[a]

Study	Design, participants, setting	IOP treatment	Comparison treatment	Primary outcome measures	Summary of findings
RCT					
Schneider et al., 1996 (6)	Day treatment (N=32) versus inpatient (N=42). Individuals seeking treatment for cocaine dependence from a large health maintenance organization in metropolitan Boston	Day treatment: 2 weeks, Monday through Friday, 5 hours of services per day; weekly aftercare for ≤6 months (47% completed 14 days of IOP services)	Inpatient care: 14 days in a nonhospital facility with 6 hours of services per day; referral to halfway house, aftercare, or a mental health provider (95% completed 14 days of inpatient care)	ASI scores at baseline and telephone interviews at 3 months (completed by 91%) and 6 months (completed by 85%) after treatment; self-report of abstinence	ASI problem severity declined for both groups at 3 and 6 months and did not differ between groups. At 3 months, inpatients were more likely to report abstinence (63%) than the day treatment group (38%); no significant difference at 6 months (46% versus 35%, respectively).
Guydish et al., 1998 (7) and 1999 (8)	Day treatment (N=114) versus residential treatment (N=147) in a therapeutic community drug treatment program	Day treatment: 8 hours of treatment per day, 7 days per week for 6 to 8 months	Residential therapeutic community with 1-month orientation; 3 to 6 months active treatment; 3 to 6 months reentry	ASI scores at baseline and 6-, 12-, and 18-month follow-ups; treatment retention; days of treatment	ASI problem severity scores declined significantly from baseline; improvements were maintained at 6, 12, and 18 months. Residential patients had more improvement on social and psychiatric problems; remaining outcomes did not differ.
Rychtarik et al., 2000 (9)	Individuals seeking treatment for alcohol dependence randomly assigned to IOP (N=63) versus inpatient and outpatient (N=58) versus outpatient (N=61)	IOP: 5 days per week for 28 days; 3 months of weekly aftercare	Inpatient and outpatient: 28 days plus 8 sessions of outpatient plus weekly aftercare; or outpatient: 8 sessions in 28 days	Percentage of days abstinent	Days abstinent increased from pretreatment for all groups, and groups did not differ at 18-month follow-up: inpatient, 37% to 81%; IOP, 50% to 75%; outpatient, 41% to 76%. Patients with high alcohol involvement had better outcomes when treated in inpatient care.
Weithmann and Hoffmann, 2005 (10)	Day hospital (N=56) versus inpatient (N=54) care in a German psychiatric hospital	Day hospital: same services and staff as inpatient	Inpatient: same services and staff as day hospital	Percentage of days abstinent, assessed quarterly	Days abstinent increased for both groups. There were no differences between levels of care.
RCT included those who refused randomization					
McKay et al., 1995 (11)	Day hospital versus inpatient care; patients randomly assigned (N=48) and patients who refused randomization and self-selected their level of care (N=96)	Day hospital: 27 hours per week for 4 weeks	Inpatient: 48 hours per week of group and individual counseling plus psychoeducation	ASI scores at baseline and at 3-, 6-, and 9-month follow-ups after treatment	ASI problem severity declined in both groups at all measurement intervals. There were no differences between levels of care. Randomly assigned and self-selected participants had similar outcomes.
Witbrodt et al., 2007 (12)	Day hospital versus residential care; patients randomly assigned (N=293; day hospital=154, residential care=139) and patients who refused randomization and self-selected their level of care (N=403; day hospital=321, residential care=82)	Day hospital	Social model residential care	ASI scores at baseline and at follow-up interviews at 6 and 12 months	ASI problem severity declined in both groups at both measurement intervals. There were no differences between levels of care.

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OHCA 000051

Table 2

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Study	Design, participants, setting	IOP treatment	Comparison treatment	Primary outcome measures	Summary of findings
Natural cohort analysis					
McLellan et al., 1997 (13)	Adults (N=918) from 10 outpatient programs (N=338) and 6 IOPs (N=580)	IOP: ≥3 hours per day, ≥3 days per week	Outpatient: ≤2 hours per session, ≤2 days per week	ASI scores at baseline and 7 months after baseline	ASI problem severity declined in both groups. There were no differences between levels of care. IOP patients had more severe problems at admission.
Harrison and Asche, 1999 (14)	Inpatient (N=1,156) versus outpatient programs (including IOPs) (N=3,007)	Outpatient: 145 programs in Minnesota providing intensive levels of care (median of 9 hours of care per week)	Inpatient: 38 programs in Minnesota (minimum of 30 hours of service per week)	ASI scores at intake and 6 months after intake	ASI problem severity declined in both groups. There were no differences between levels of care. Patients with recent suicidal ideation had better outcomes in inpatient care.
Pettinati et al., 1999 (15)	Alcohol-dependent patients admitted to inpatient (N=93) or outpatient (N=80) care in a psychiatric hospital	IOP: 8 weeks of 12-step program plus individual, group, and family therapy	Inpatient: 4 weeks of 12-step program plus individual, group, and family therapy	SCL-90R scores; number of drinking days; return to significant drinking (days of drinking ≥3 drinks) or return to inpatient care	Survival analysis suggested that IOP patients returned to significant drinking more quickly (50% at 2 months) than inpatients (25% at 2 months). Six months after discharge, the percentage of patients with heavy drinking stabilized at about 50% in both groups.
Simpson et al., 1999 (16)	Secondary analysis of data from DATOS assessing cocaine-dependent patients in 3 levels of care: outpatient drug free (including IOP) (N=458), long-term residential (N=542), short-term inpatient (N=605)	Outpatient drug free: 24 programs	Residential: 19 long-term programs; inpatient: 12 short-term programs	Weekly cocaine use 1 year after discharge	Weekly cocaine use declined from 73% before treatment to 23% at follow-up and did not differ across groups. A significant interaction between level of care, problem severity, and retention in care suggested that patients with more severe problems were less likely to report weekly cocaine use after long-term residential care (23%) versus short-term residential care (37%).
McKay et al., 2002 (17)	Patients in Washington state receiving inpatient plus outpatient care (N=167) versus IOP services only (N=96)	IOP: 2 programs	Inpatient: a 28-day inpatient program	ASI scores at baseline and 3 and 9 months after baseline	ASI problem severity declined in both groups at 3 and 9 months. Participants in inpatient plus outpatient programs improved more because their symptoms were more severe at baseline.
Tiet et al., 2007 (18)	Veterans Affairs clients receiving outpatient (N=410) or IOP services (N=601) versus inpatient and residential care (N=1,520)	IOP or outpatient	Inpatient and residential: inpatient (N=224), residential (N=390), and domiciliary (N=906) settings	ASI scores at baseline and 6 months after baseline	ASI problem severity declined in both groups after baseline. There were no differences between levels of care except for the most severe cases.

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OHCA 000052

Table 2

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Study	Design, participants, setting	IOP treatment	Comparison treatment	Primary outcome measures	Summary of findings
Review of 1995 or earlier studies					
Finney et al., 1996 (19)	Qualitative review of 14 studies of inpatient versus outpatient programs	Settings where patients do not stay over night	Residential, 24-hour settings	Varied, as reported in the publications	Treatment intensity was related to better outcomes. Inpatient outcomes were superior in 5 studies (2 based on naturalistic cohorts). Day hospital outcomes were superior in 2 studies. There were no differences in 7 randomized studies.

[a] Studies are listed in chronological order under type of research design. Abbreviations: ASI, Addiction Severity Index; DATOS, Drug Abuse Treatment Outcome Study; RCT, randomized controlled trial; SCL-90R, Symptom Checklist 90–Revised

diagnoses of participants. Two RCTs (7,20) and four naturalistic analyses (13,14,17,18) included people with alcohol and drug (undefined) diagnoses. There was demographic variation across study populations, including individuals who were uninsured and homeless in inner cities (13,14), employed men and women with commercial health plans (6,12,15), patients in the Veterans Affairs (VA) health system (11,18), and men and women treated in public systems of care (7,11,14,16,17). One study compared a one-year day treatment program with a one-year residential program (7,8). African Americans were the primary racial-ethnic minority group studied, and most study populations had good racial-ethnic mixes. No studies compared the effects of IOPs across racial or ethnic groups.

Service settings for these studies included hospital-based inpatient and day treatment in VA hospitals (11,18) and community hospitals (6,9,10,15), residential programs (7,8,12), community-based public (7,8,11,14,16,17) and private (6,12,14,15) substance use treatment centers, and one drug treatment program based on therapeutic community principles (7,8). The services varied in intensity (that is, hours per week), duration, content of the sessions, and therapeutic approaches. Follow-up periods ranged from three months to 18 months. The dependent variables used to assess patient outcomes also varied, but abstinence (6,9,10) and changes in ASI scores (6,7,11–14,17,18) were most common (Table 2).

Effectiveness of the service

Variation in the operationalization of IOPs across studies and differences in outcome measures slightly tempered our assessment of the equivalent effectiveness of inpatient and IOP services. In most studies, the inpatient and IOP services differed on many dimensions (for example, setting, duration, and intensity), although one investigation used the same staff, facility, and therapeutic process between experimental and control groups and altered only the setting (inpatient versus outpatient) (9). The primary commonality was treatment in an IOP setting versus an overnight stay in a more controlled residential or inpatient setting (6–18), but variation in the operationalization of IOP services and outcome measures limited direct comparisons.

The RCTs and quasi-experimental studies consistently reported significant reductions in measures of problem severity and increases in days abstinent at follow-up interviews (between three and 18 months after baseline assessment) for study participants receiving IOP services or day treatment services and for individuals in inpatient or residential care (Table 2). One trial with small samples found higher rates of abstinence three months after treatment among individuals who received inpatient care compared with those who received day treatment (63% versus 38%), but this effect was not observed at six months after treatment (6). In addition, all RCTs reported similar reductions in ASI measures when inpatient and IOP settings were compared (7,8,11,12). Finally, the studies that included participants who were randomly assigned to treatment condition and those who self-selected levels of care reported a similar lack of overall differences in study outcomes when levels of care were compared (11,12). Indeed, a study based in the VA reported that two-thirds of the participants refused randomization, but outcomes were similar for study participants whether or not they were randomly assigned (11).

Although analyses of natural cohorts generally assume that patients treated in residential settings have more severe substance use problems than those treated in outpatient treatment settings, differential effectiveness based on problem severity was elusive in the articles we reviewed. Only two of six naturalistic analyses reported main effects for treatment setting. One was an analysis of Washington State treatment programs (17). Results showed that patients treated in an inpatient setting who stepped down to treatment in an IOP improved more than those treated only in IOP settings, because problem severity was greater at baseline among those admitted to inpatient care. Another analysis of a cohort of patients

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Evidence for the effectiveness of substance abuse intensive outpatient programs (IOPs): high

Despite some variations in programming and design, substance abuse IOPs compared with control conditions demonstrate consistent evidence for the following outcomes:

- Reduced drug or alcohol use from baseline to follow-up
- Few differences between IOPs and inpatient programs

treated in a psychiatric hospital reported that patients who were alcohol dependent and treated in an IOP returned to "significant" drinking more quickly than those treated in inpatient care (15). The other four analyses did not find main effects for treatment setting (13,14,16,18).

There is some evidence that disorder severity may influence the effectiveness of IOPs compared with inpatient or residential treatment. In Minnesota treatment programs, patients with recent suicidal ideation had better outcomes after residential care than patients who participated in an IOP (14). A secondary analysis of data from clients in treatment for cocaine dependence noted that patients with more severe drug problems were more likely to benefit from long-term residential care than from less intensive levels of care (16). Finally, an analysis of patients in a VA program also suggested that those with more severe alcohol or drug problems had better response when treated in residential settings than in IOPs (18). Although there is still some debate about the equivalence of inpatient treatment and treatment in an IOP for patients with the most severe levels of dependence, there appears to be general consensus that for most patients the levels of care are equivalent.

It is noteworthy that the current assessment of IOP services echoes findings from similar reviews conducted since the 1960s (20–30). Despite changing research methods and study populations, results are consistent—patient outcomes from inpatient, residential, and intensive outpatient services are positive and more similar than different. This consistency over time enhances confidence in the stability of the findings and the value of IOP services.

Discussion

Overall, the current literature suggests that a wide range of service intensities can be effective for individuals with substance use disorders. There is a high level of evidence—with the caveats we have noted—that IOPs are as effective as inpatient and residential treatments when studies compare these approaches directly (see box on this page). IOPs have emerged as a critical facet of 21st century addiction treatment for people who need a more intensive level of service than usual outpatient treatment. IOPs allow participants to avoid or step down successfully from inpatient services. This is an important consideration for policy makers, providers, and individuals engaged in substance abuse treatment services when deciding which level of care is most appropriate for specific clinical situations.

Taken together, RCTs and quasi-experimental studies consistently reported equivalent reductions in measures of problem severity and increases in days abstinent at follow-up for participants who received IOP services or day treatment services compared with those in inpatient or residential care. We found no studies comparing IOP participants with wait-list or no-treatment control groups. Reviews of the literature point out many design and treatment differences that may affect conclusions about the effectiveness of inpatient versus outpatient services. A chapter in an ASAM-sponsored text (31) reiterated the debate on inpatient versus outpatient settings and concluded that engagement in longer, less-intensive services may have greater benefit than brief, intensive interventions without ongoing support, especially among individuals with a more severe history of addiction. The important feature appears to be continuity of care over a long duration, and this perspective is consistent with emerging models of recovery-oriented systems of care. However, the interaction between severity of alcohol and drug problems and setting of care has been elusive, and the effect (when present) appears to be small. Overall, studies have found that 50%–70% of participants reported abstinence at follow-up, and most studies found that this outcome did not differ for inpatient versus outpatient settings of care. This makes cost, treatment duration, and living in the community the major points of comparison between inpatient and IOP services for individuals with substance use disorders.

It is difficult to say which aspects of IOPs are most likely to be effective with specific populations. Naturalistic studies using large samples found subtle improvements among people with the most serious substance use problems, suggesting that this level of inpatient or residential care may be helpful or necessary for a subset of people. However, a primary ongoing research need is to identify individuals with severe alcohol and drug use for whom inpatient or residential care is of greatest value. One complication is the variation in how residential care and IOP services are defined. This is an important distinction that needs clarification as provider systems move into an increasingly risk-based financing environment. Payers and providers should collaborate to define IOP services more consistently, so that effects are replicable across settings and patient populations. Likewise, there is a need for more research on the most effective length of IOP treatment. IOP models should clearly identify the type, duration, and intensity of IOP services. Researchers also need to determine the optimal type and level of stabilization services following discharge from an IOP that will sustain the gains made during the IOP treatment episode.

Although African Americans were the dominant racial-ethnic minority group in many of the investigations comparing residential and inpatient services with intensive outpatient

services, race-ethnicity varied substantially across the studies. The finding that IOP services and residential or inpatient care lead to equivalent outcomes appears to generalize across racial and ethnic groups; however, we cannot make specific recommendations for IOP services related to race-ethnicity on the basis of the current literature. Future studies may systematically vary components of IOPs to determine the more critical features for efficient and effective care.

Surprisingly, none of the studies examined in this review included the use of pharmacotherapy, which improves treatment outcomes when used in conjunction with therapeutic interventions. We believe that 21st century systems of addiction treatment should provide ongoing pharmacological and behavioral therapies within a continuing care model that increasingly relies on IOP settings rather than on residential and inpatient care. Recent RCTs also document the value of enhancing IOP services with contingency management during treatment in an IOP (32) and during aftercare (33).

Without increased standardization, patients, payers, and policy makers will continue to have difficulty comparing IOP services with other levels of substance abuse treatment services. Requirements to adhere to the National Quality Forum consensus standards, for example, could help ensure that IOPs provide consistent and effective pharmacological and behavioral addiction treatments (34). Accordingly, this calls for improved assessment of the specific needs of each person requiring intensive services in order to determine the appropriate level of care. Policy makers, payers, and consumers should consider demanding these assessments, and providers across all levels of care should receive the necessary training to complete them properly.

Conclusions

This review found that studies of inpatient treatment and IOP services have yielded results that are consistent and similar: outcome measures of alcohol and drug use at follow-up show reductions in substance use and increases in abstinence, and outcomes do not differ significantly between inpatient and IOP settings. Although a few studies suggest that patients with greater impairment may have better outcomes if treated in inpatient settings than in IOPs, such differential effectiveness appears elusive and may apply only to the most severely impaired individuals. Compared with inpatient care, IOP services have at least two advantages: increased duration of treatment, which varies with the severity of the patient's illness and his or her response, and the opportunity to engage and treat consumers while they remain in their home environments, which affords consumers the opportunity to practice newly learned behaviors. IOPs are an important service for inclusion as a covered benefit for people with substance use disorders. The diversity of settings and range of outcomes assessed, combined with the consistency of improvement over time, suggest that the effectiveness reflects the intensity and duration of treatment rather than a specific setting or patient population.

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References

1. Substance Abuse: Clinical Issues in Intensive Outpatient Treatment. Treatment Improvement Protocol (TIP) Series, no 47. Rockville, Md, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment, 2006
2. ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders (ASAM PPC-2R). Chevy Chase, Md, American Society of Addiction Medicine, 2001
3. National Survey of Substance Abuse Treatment Services (N-SSATS): 2011. Data on Substance Abuse Treatment Facilities. BHSIS Series S-64, HHS pub no SMA-12-4730. Rockville, Md, Substance Abuse and Mental Health Services Administration, 2012
4. Reif S, George P, Braude L, et al: Residential treatment for individuals with substance use disorders: assessing the evidence. Psychiatric Services, 2014; doi 10.1176/appi.ps.201300242
5. Dougherty RH, Lyman DR, George P, et al: Assessing the evidence base for behavioral health services: introduction to the series. Psychiatric Services, 2013; doi 10.1176/appi.ps.201300214
6. Schneider R, Mittelmeier C, Gadish D: Day versus inpatient treatment for cocaine dependence: an experimental comparison. Journal of Mental Health Administration 23:234–245, 1996
7. Guydish J, Werdegar D, Sorensen JL, et al: Drug abuse day treatment: a randomized clinical trial comparing day and residential treatment programs. Journal of Consulting and Clinical Psychology 66:280–289, 1998
8. Guydish J, Sorensen JL, Chan M, et al: A randomized trial comparing day and residential drug abuse treatment: 18-month outcomes. Journal of Consulting and Clinical Psychology 67:428–434, 1999
9. Rychtarik RG, Connors GJ, Whitney RB, et al: Treatment settings for persons with alcoholism: evidence for matching clients to inpatient versus outpatient care. Journal of Consulting and Clinical Psychology 68:277–289, 2000
10. Weithmann G, Hoffmann M: A randomised clinical trial of in-patient versus combined day hospital treatment of alcoholism: primary and secondary outcome measures. European Addiction Research 11:197–203, 2005
11. McKay JR, Alterman AI, McLellan AT, et al: Effect of random versus nonrandom assignment in a comparison of inpatient and day hospital rehabilitation for male alcoholics. Journal of Consulting and Clinical Psychology 63:70–78, 1995
12. Witbrodt J, Bond J, Kaskutas LA, et al: Day hospital and residential addiction treatment: randomized and nonrandomized managed care clients. Journal of Consulting and Clinical Psychology 75:947–959, 2007
13. McLellan AT, Hagan TA, Meyers K, et al: "Intensive" outpatient substance abuse treatment: comparisons with "traditional" outpatient treatment. Journal of Addictive Diseases 16:57–84, 1997
14. Harrison PA, Asche SE: Comparison of substance abuse treatment outcomes for inpatients and outpatients. Journal of Substance Abuse Treatment 17:207–220, 1999
15. Pettinati HM, Meyers K, Evans BD, et al: Inpatient alcohol treatment in a private healthcare setting: which patients benefit and at what cost? American Journal on Addictions 8:220–233, 1999

OHCA000055

16. Simpson DD, Joe GW, Fletcher BW, et al: A national evaluation of treatment outcomes for cocaine dependence. Archives of General Psychiatry 56:507–514, 1999

17. McKay JR, Donovan DM, McLellan T, et al: Evaluation of full vs partial continuum of care in the treatment of publicly funded substance abusers in Washington State. American Journal of Drug and Alcohol Abuse 28:307–338, 2002

18. Tiet QQ, Ilgen MA, Byrnes HF, et al: Treatment setting and baseline substance use severity interact to predict patients' outcomes. Addiction 102:432–440, 2007

19. Finney JW, Hahn AC, Moos RH: The effectiveness of inpatient and outpatient treatment for alcohol abuse: the need to focus on mediators and moderators of setting effects. Addiction 91:1773–1796, 1996

20. Cole SC, Lehman WE, Cole EA, et al: Inpatient vs outpatient treatment of alcohol and drug abusers. American Journal of Drug and Alcohol Abuse 8:329–345, 1981

21. Armor DJ, Polich JM, Stambul HB: Alcoholism and Treatment. New York, Wiley, 1978

22. Diesenhaus H: Current trends in treatment programming for problem drinkers and alcoholics; in Prevention, Intervention and Treatment: Concerns and Models. Alcohol and Health Monograph no 3. DHHS pub no ADM-82-1192. Rockville, Md, National Institute on Alcohol Abuse and Alcoholism, 1982

23. Edwards G, Guthrie S: A controlled trial of inpatient and outpatient treatment of alcohol dependency. Lancet 1:555–559, 1967

24. Institute of Medicine: Prevention and Treatment of Alcohol Problems: Research Opportunities. Washington, DC, National Academy Press, 1989

25. Emrick CD: A review of psychologically oriented treatment of alcoholism, II: the relative effectiveness of different treatment approaches and the effectiveness of treatment versus no treatment. Journal of Studies on Alcohol 36:88–108, 1975

26. Polich JM, Armor DJ, Braiker HB: The Course of Alcoholism: Four Years After Treatment. New York, Wiley, 1981

27. Institute of Medicine: Broadening the Base of Treatment for Alcohol Problems. Washington, DC, National Academy Press, 1990

28. Saxe L, Dougherty D, Esty K, et al: The Effectiveness and Costs of Alcoholism Treatment. Washington, DC, Office of Technology Assessment, 1983

29. Sells SB, Simpson DD: The case for drug abuse treatment effectiveness, based on the DARP research program. British Journal of Addiction 75:117–131, 1980

30. Sells SB, Simpson DD: Studies of the Effectiveness of Treatments for Drug Abuse, vol 5: Evaluation of Treatment Outcomes for 1972–1973, DARP Admission Cohort. Cambridge, Mass, Ballinger, 1976

31. Finney JW, Moos RH, Wilbourne PL: Effects of treatment setting, duration, and amount on patient outcomes; in Principles of Addiction Medicine, 4th ed. Edited by Ries RK, Fiellin DA, Miller SC, et al. Philadelphia, Wolters Kluwer/Lippincott Williams & Wilkins, 2009

32. Petry NM, Alessi SM, Hanson T: Contingency management improves abstinence and quality of life in cocaine abusers. Journal of Consulting and Clinical Psychology 75:307–315, 2007

33. McKay JR, Lynch KG, Coviello D, et al: Randomized trial of continuing care enhancements for cocaine-dependent patients following initial engagement. Journal of Consulting and Clinical Psychology 78:111–120, 2010

34. National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices. Washington, DC, National Quality Forum, 2007

Coming in July

- ♦ **Mental illness prevalence in U.S. state prisons: a review**
- ♦ **Effectiveness of peer recovery services for substance use disorders**
- ♦ **CBT for medication-resistant psychosis: a meta-analytic review**
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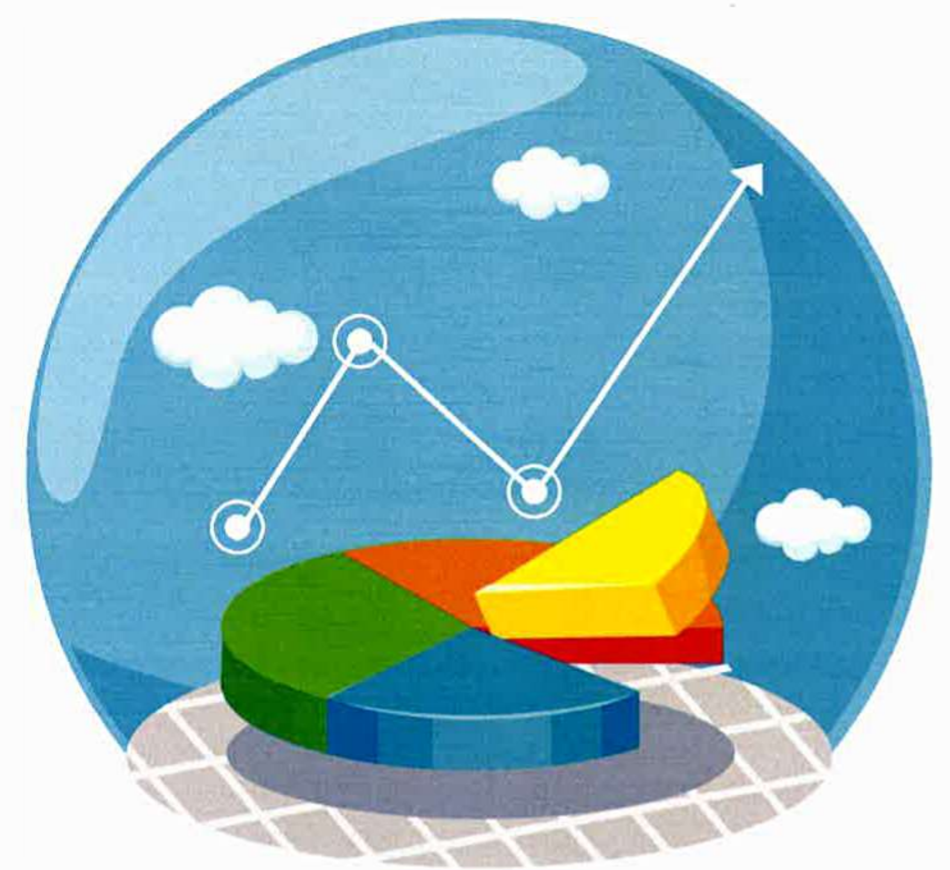
OHCA 000056

DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES ANNUAL STATISTICAL REPORT

SFY2015



Produced by the Evaluation, Quality Management and Improvement Division

January 2016

Table of Contents

Introduction 3
Background........ 4
DMHAS SFY2015 Annual Statistical Data - Quick Facts 6
Data Summaries........ 7
DEMOGRAPHICS OF CLIENTS SERVED 9
LEVEL OF CARE (LOC) DATA........ 11
BED CAPACITY AND UTILIZATION 16
PRIMARY DRUG USE........ 17
DIAGNOSIS........ 19
YOUNG ADULT SERVICES 21
APPENDIX A. SFY15 LOC data by Region........ 22
APPENDIX B. SFY15 Bed Capacity and Utilization by Region........ 26

Tables

Table 1: SFY15 Episode Counts 8
Table 2: Unduplicated Clients........ 8
Table 3: PNP vs. State Operated – Episode Counts........ 8
Table 4: PNP vs. State Operated - Unduplicated Clients........ 8
Table 5: Gender........ 9
Table 6: Race........ 9
Table 7: Ethnicity 10
Table 8: Age 10
Table 9: MH Inpatient/Residential LOCs 11
Table 10: Mental Health Outpatient LOCs 12
Table 11: Substance Abuse Inpatient/Residential LOCs 14
Table 12: Substance Abuse Outpatient LOCs........ 15
Table 13: Bed Capacity and Utilization 16
Table 14: Primary Drug at Admission – All Active Clients 17
Table 15: Primary Drug at Admission - New Admissions Only 18
Table 16: Top 20 Most Frequent Primary Diagnoses 19
Table 17: Major Diagnosis Categories........ 20
Table 18: Young Adult Clients 21

Figures

Figure 1: Levels of Analysis 4
Figure 2: Discharge Data for 239 YAS Discharges in SFY2015........ 21

OHCA 000058

Introduction

The Evaluation, Quality Management and Improvement (EQMI) Division at the Department of Mental Health and Addiction Services (DMHAS) is pleased to publish its second Annual Statistical Report. The report provides information about the services the Department provides and the individuals served by our mental health and substance abuse system.

To develop this report, we used data taken from DMHAS' Enterprise Data Warehouse on August 16, 2015.

EQMI receives multiple requests for data from DMHAS staff, providers, legislative groups, researchers and the media. This report makes key information more accessible to departmental stakeholders; it includes data on clients served, demographic characteristics, types of services provided, residential and inpatient utilization, substance use trends. This year, we have added information on Young Adult Services and Bed Capacity and Utilization by Region.

Special thanks to all of the EQMI staff and University of Connecticut School of Social Work contractors who assisted with this report. Karin Haberlin coordinated the development of the report, while Kristen Miller, Hsiuju Lin, Jeff Johnson, Hiroki Toi, and Josh Pierce compiled, tested, and analyzed the data. Abel Rommer provided the bed capacity and utilization analyses. Kristen Miller was responsible for writing the report.

Jim Siemianowski
Director EQMI

OHCA 000059

Background

In this report, we summarize clients served and services provided by the Department of Mental Health and Addiction Services (DMHAS) during state fiscal year 2015. These data include clients served in DMHAS funded or DMHAS operated programs. The clients and the services are diverse, and the data is complex.

This report will, at different times, report numbers that refer to different subgroups or events that are based on *specific filtering of the data*. For instance, we frequently filter out programs that are not required to report treatment data when we present information from the Level of Care perspective.

We also distinguish between clients and episodes. This distinction is important:

- **Client counts** are unduplicated counts in which each client is counted **once**.
- **Episode counts** represent an *episode of care* to a client – entailing admission, all services received, and discharge. All occur within the context of an episode of care for a client at a particular program.
- Each client may have multiple episodes of care that occur within the fiscal year; thus, the client may be counted **multiple times** – once for each episode, if applicable.
- Thus, **Admissions and Discharges** are reported as **episode counts,** as many clients have multiple episodes.
- In addition, a client may be admitted to/enrolled several programs simultaneously; therefore, *each* admission will be included in the overall Admission count below.

Figure 1 provides a visual representation of the different levels of analysis used in this report.

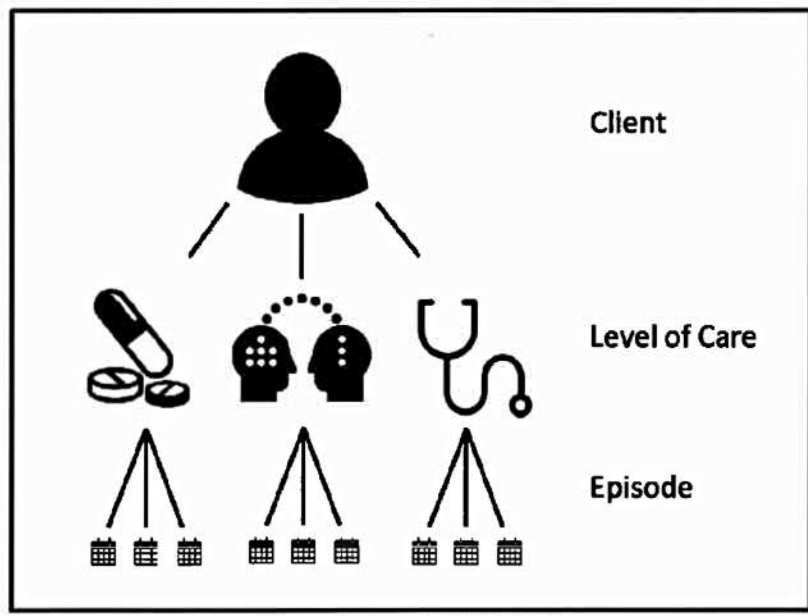


Figure 1: Levels of Analysis

OHCA 000060

In each section of the report, there is a brief description of what the counts represent.

The data contained in this report were taken from DMHAS' Enterprise Data Warehouse (EDW) on August 16, 2015. The data warehouse is a dynamic system, so reports or other analyses performed on different dates may produce slightly different results. **The numbers contained in this report are the official DMHAS data for SFY2015.**

OHCA 000061

DMHAS SFY2015 Annual Statistical Data - Quick Facts

Program Type	N
Mental Health Programs	57,451
Substance Abuse Programs	59,203
Total Unduplicated Count	109,444

Race/Ethnicity	N	%
White/Caucasian	70,489	64%
Black/African American	17,212	16%
Other	15,326	14%
Latino/Hispanic Identity	22,090	20%

Gender	N	%
Male	63,930	58%
Female	44,968	41%
Transgender	5	0%

Level of Care	Unduplicated Client Count
MH Inpatient	1,542
MH Residential	2,843
MH Outpatient	56,575
SA Inpatient (Detox)	2,691
SA Residential Rehab	11,694
SA Outpatient	52,509

Primary Drug at Admission – All SFY15 Active	N	%
Alcohol	31,458	36%
Heroin	28,838	33%
Marijuana/Hashish/THC	10,943	13%

Primary Drug at Admission – SFY15 All Admissions	N	%
Heroin/Other Opiates	20,019	51%
Alcohol	19,258	30%

Major Diagnosis Categories	N	%
Serious Mental Illness (SMI)	39,687	51%
SA diagnosis	52,455	65%
Dual diagnosis (SMI + SA)	20,455	25%

Most Common Primary Diagnosis	N	%
Opioid use disorder, severe	32,377	23%
Other and unspecified alcohol use disorder	12,724	9%
Schizoaffective disorder	6,976	5%
Major depressive disorder, recurrent	5,627	4%
Post-traumatic stress disorder	4,552	3%

Most Common MH Diagnosis Category	N	%
Major mood disorder	23,793	29%
Major depressive disorder	15,762	20%
Bipolar disorder	9,324	12%

Data Summaries

Clients

- During State Fiscal Year 2015 (July 1, 2014 – June 30, 2015), the Department of Mental Health and Addiction Services served **109,444** people.

- **59,203** clients were treated in **Substance Abuse (SA)** programs (51,993 in only SA programs, plus 7,210 who received SA and MH services).

- **57,451** clients were served in **Mental Health (MH)** programs. (50,241 MH only, plus 7,210 MH and SA)

- A smaller group of clients (**7,210**) received services from **both MH and SA** programs during SFY15.[1]

Admissions

- There were **99,468 admissions** (each client may have a single or multiple admissions) to DMHAS operated or DMHAS funded programs.

- **68%** of clients had a **single MH program admission** during SFY2015.

- **75%** of clients had a **single SA program admission** during SFY2015.

- There were **19,904** more admissions to Substance Abuse programs than to Mental Health programs.

Discharges

During this same timeframe,

- There were **95,088** discharges from DMHAS operated or DMHAS funded programs. This does not necessarily mean that clients were discharged from the DMHAS system completely, but simply that an episode of treatment within a program was ended.

- There were **15,532** more discharges from SA programs than from MH programs.

Open Episodes

Finally, there were **51,185** episodes of care (covering **42,731** clients) that were **open for the entire fiscal year** (admitted prior to SFY15 and not yet discharged by the end of SFY15).

[1] Note that receiving services from both program types does not imply that these clients have a dual diagnosis.

OHCA 000063

Table 1: SFY15 Episode Counts

	SA	MH	Total
Admission	59,686	39,782	99,468
Discharge	55,310	39,778	95,088
Open*	15,798	35,387	51,185
Total	89,126	92,245	181,371

* Open-episode --started prior to FY15, but not yet discharged by 6/30/15

Table 2: Unduplicated Clients

	SA	MH	Both	Total
Admissions	33,374	22,533	3,810	59,717
Discharges	31,519	24,331	3,404	59,254
Open	14,779	27,243	709	42,731
Unduplicated Clients	51,993	50,241	7,210	109,444

The tables below provide the same basic information as above, but have differentiated the data by Private Non-Profit (PNP) providers and State Operated facilities.

Table 3: PNP vs. State Operated – Episode Counts

	Funding source	SA	MH	Total
Admission	DMHAS Human Services Agreements	55,340	25,701	81,041
	DMHAS-operated	4,346	14,081	18,427
Discharge	DMHAS Human Services Agreements	50,973	25,299	76,272
	DMHAS-operated	4,337	14,479	18,816
Open	DMHAS Human Services Agreements	15,754	27,676	43,430
	DMHAS-operated	44	7,711	7,755

Table 4: PNP vs. State Operated - Unduplicated Clients

	Funding source	SA	MH	Both	Total
Admissions	DMHAS Human Services Agreements	30,943	15,528	2,161	48,632
	DMHAS-operated	1,004	5,705	194	6,903
	Both	1,427	1,300	1,455	4,182
	Total	33,374	22,533	3,810	59,717
Discharge	DMHAS Human Services Agreements	28,960	16,274	1,867	47,101
	DMHAS-operated	1,144	6,721	188	8,053
	Both	1,415	1,336	1,349	4,100
	Total	31,519	24,331	3,404	59,254
Open	DMHAS Human Services Agreements	14,743	21,035	605	36,383
	DMHAS-operated	36	4,720	5	4,761
	Both	0	1,488	99	1,587
	Total	27,243	14,779	709	42,731
Total	DMHAS Human Services Agreements	49,527	37,202	4,701	91,430
	DMHAS-operated	975	9,035	191	10,201
	Both	1,491	4,004	2,318	7,813
	Total	51,993	50,241	7,210	109,444

OHCA 000064

DEMOGRAPHICS OF CLIENTS SERVED

The data presented in the Demographics section includes all clients served by DMHAS. The values represent unduplicated client counts (each client counted once) within program type (SA only, MH only or both SA & MH). The statewide total is a fully unduplicated client count. The narrative will generally discuss the results in terms of SA and MH programs; the counts under the "Both" category are added into the SA and MH counts to include everyone who received SA services or MH services.

Table 5: Gender

	SA		MH		Both		Statewide Total	
	N	%	N	%	N	%	N	%
Female	15,711	30.2%	26,309	52.4%	2,948	40.9%	44,968	41.1%
Male	35,750	68.8%	23,920	47.6%	4,260	59.1%	63,930	58.4%
Transgender	2	0.0%	3	0.0%	0	0.0%	5	0.0%
Unknown	530	1.0%	9	0.0%	2	0.0%	541	0.5%
Total	51,993	100.0%	50241	100.0%	7,210	100.0%	109,444	100.0%

Statewide, more males received DMHAS services than females. Within MH specific programs, slightly more women than men received treatment (26,309 (52%) and 23,920 (48%) respectively). In SA specific programs, however, there were more than twice as many male clients than female clients (35,750 (69%) and 15,711 (30%) respectively). Additionally, clients who received both MH and SA services were more likely to be male (59% vs. 41% female). These patterns across program type have been observed since SFY12.

Table 6: Race

	SA		MH		Both		Statewide Total	
	N	%	N	%	N	%	N	%
American Indian/ Native Alaskan	244	0.5%	278	0.6%	48	0.7%	570	0.5%
Asian	323	0.6%	483	1.0%	27	0.4%	833	0.8%
Black/African American	7,423	14.3%	8,407	16.7%	1,382	19.2%	17,212	15.7%
Native Hawaiian/ Other Pacific Islander	89	0.2%	121	0.2%	8	0.1%	218	0.2%
White/Caucasian	34,014	65.4%	31,920	63.5%	4,555	63,2%	70,489	64.4%
Multi-race	511	1.0%	167	0.3%	41	0.6%	719	0.7%
Missing/unknown	1,914	3.7%	2,030	4.0%	133	1.8%	4,077	3.7%
Other	7,475	14.4%	6,835	13.6%	1,016	14.1%	15,326	14.0%
Total	51,993	100.0%	50,241	100.0%	7,210	100.0%	109,444	100.0%

Of the total number of statewide clients served in FY 2015, 64% were White/Caucasian. With the addition of the next two largest groups, Black/African Americans and Other (often selected by clients of Hispanic ethnicity who view their race as neither Caucasian nor African American), at 16% and 14% respectively, this accounted for 94% of clients served. The distribution of clients by race was very consistent across SA and MH treatment programs. White/Caucasian clients were the most represented in treatment followed by Black/African American and Other at nearly equivalent levels. These patterns have been observed for the past three years.

OHCA 000065

Table 7: Ethnicity

	SA		MH		Both		Statewide Total	
	N	%	N	%	N	%	N	%
Cuban	165	0.3%	90	0.2%	18	0.2%	273	0.2%
Mexican	419	0.8%	246	0.5%	18	0.2%	683	0.6%
Hispanic-Other	4,005	7.7%	3,701	7.4%	519	7.2%	8,225	7.5%
Puerto Rican	6,419	12.3%	5,576	11.1%	914	12.7%	12,909	11.8%
Non-Hispanic	37,006	71.2%	37,509	74.7%	5,409	75.0%	79,924	73.0%
Unknown	3,979	7.7%	3,119	6.2%	332	4.6%	7,430	6.8%
Total	51,993	100.0%	50,241	100.0%	7,210	100.0%	109,444	100.0%

Of the total number of clients served by DMHAS, 20% were of Hispanic/Latino ethnicity. The largest group of Hispanic/Latino consumers was of Puerto Rican origin (12%). Statewide, 73% of clients receiving DMHAS services were not of Hispanic/Latino ethnicity. The distribution of ethnic origin across SA/MH programs was generally balanced, with slightly more consumers in Substance Abuse programs (+1%) being of Hispanic/Latino origin. Non-Hispanic clients represented a slightly larger proportion (+3.5%) of mental health clients than substance abuse clients. These patterns have been observed for the past three years.

Table 8: Age

	SA		MH		Both		Statewide Total	
	N	%	N	%	N	%	N	%
18-25	9,468	18.2%	6,143	12.2%	808	11.2%	16,419	15.0%
26-34	14,965	28.8%	8,259	16.4%	1,721	23.9%	24,945	22.8%
35-44	10,642	20.5%	8,438	16.8%	1,615	22.4%	20,695	18.9%
45-54	9,951	19.1%	12,113	24.1%	2,026	28.1%	24,090	22.0%
55-64	5,100	9.8%	10,516	20.9%	930	12.9%	16,546	15.1%
65+	1,057	2.0%	4,401	8.8%	108	1.5%	5,566	5.1%
Missing/unknown	810	1.6%	371	0.7%	2	0.0%	1,183	1.1%
Total	51,993	100.0%	50,241	100.0%	7,210	100.0%	109,444	100.0%

- Average age of DMHAS clients is 41.4 years (±14.13)
- Average age of clients receiving MH services is 45.1 years (±14.96)
- Average age of clients receiving SA services is 37.9 years (±12.58)
- Average age of clients receiving **both** MH and SA services is 41.0 Years (±11.95)

Examining the data by age group, it appears that younger clients (up to age 44) were more likely to receive Substance Abuse services while older clients (45 and over) were more likely to receive Mental Health services. Among clients receiving mental health services, the largest age group was 45 to 54 years, while most frequent age group for Substance Abuse clients was the 26 to 34 age range. Of clients receiving treatment, few were 65 years or older with the majority of them in Mental Health services. These patterns have been observed over the past three years.

OHCA 000066

LEVEL OF CARE (LOC) DATA

The data presented in the Level of Care section include clients served by DMHAS funded programs that are required to submit treatment data to DMHAS.

- The client counts represent unique (unduplicated) clients.
- The admission and discharge counts are based on episodes of care and represent duplicated client counts – each admission or discharge is counted once, but a client may have multiple admissions and/or discharges.
- To reduce the chance of confusion between unduplicated client count and admission/discharge counts (they all are counts based on clients), the number of clients admitted or discharged are referred to as 'admissions' or 'discharges' (versus 'clients admitted').

Mental Health Inpatient and Residential

Four thousand seventy-six (4,076) clients were served in mental health inpatient and residential programs, with 5,008 admissions and 2,390 discharges during SFY15. The majority (70%) of these clients were in residential LOCs.   Please see Appendix A for regional totals.

Table 9: MH Inpatient/Residential LOCs

9a. Active Clients		Total
Forensic MH	Inpatient Services	483
	Residential Services	56
Mental Health	Inpatient Services	1,060
	Residential Services	2,787
Total		4,076

9b. Admissions		Total
Forensic MH	Inpatient Services	575
	Residential Services	60
Mental Health	Inpatient Services	1,233
	Residential Services	3,140
Total		5,008

9c. Discharges		Total
Forensic MH	Inpatient Services	351
	Residential Services	49
Mental Health	Inpatient Services	863
	Residential Services	1,127
Total		2,390

OHCA 000067

Mental Health Outpatient

- For each LOC listed, we provide the unduplicated client count as well as the (fully unduplicated) total client count for all listed LOCs.
- Clients who received services from more than one LOC are counted in each relevant LOC.

Fifty-six thousand five hundred seventy-five (56,575) clients received services in outpatient levels of care. The majority of clients (69%) were served in a Standard Outpatient MH program, followed by Crisis (11%), Social Rehabilitation (11%), and Case Management (10%).

There were 37,392 admissions to MH Outpatient LOCs during the Fiscal Year. The majority of the admissions (57% total) were to standard outpatient (34%) and crisis services (23%). There were also 37,388 discharges during SFY15. Standard Outpatient and Crisis Services had the most discharges (57% total) of all the service types.

Table 10: Mental Health Outpatient LOCs

10a. Active Clients		Total
Forensic MH	Case Management	138
	Crisis Services	41
	Forensics Community-based	4,887
	Outpatient	372
Mental Health	ACT	1,032
	Case Management	5,897
	Community Support	5,514
	Consultation	522
	Crisis Services	6,486
	Education Support	262
	Employment Services	4,001
	Forensics Community-based	24
	Housing Services	476
	Intake	2,981
	IOP	587
	Prevention	396
	Social Rehabilitation	6,277
	Standard Outpatient	39,215
Total		56,575

OHCA 000068

Table 10 – Mental Health Outpatient LOCs - continued

10b. Admissions		Total
Forensic MH	Case Management	77
	Crisis Services	37
	Forensics Community-based	4,221
	Standard Outpatient	163
Mental Health	ACT	482
	Case Management	2,314
	Community Support	1,694
	Crisis Services	8,544
	Education Support	127
	Employment Services	1,890
	Forensics Community-based	28
	Housing Services	71
	Intake	2,599
	IOP	586
	Standard Outpatient	12,746
	Prevention	69
	Social Rehabilitation	1,744
Total		37,392

10c. Discharges		Total
Forensic MH	Case Management	81
	Crisis Services	34
	Forensics Community-based	4,015
	Standard Outpatient	207
Mental Health	ACT	313
	Case Management	1,934
	Community Support	1,939
	Crisis Services	8,489
	Education Support	119
	Employment Services	2,000
	Forensics Community-based	23
	Housing Services	105
	Intake	3,039
	IOP	555
	Standard Outpatient	12,960
	Prevention	62
	Social Rehabilitation	1,513
Total		37,388

OHCA 000069

Substance Abuse Inpatient and Residential

Thirteen thousand four hundred three (13,403) clients received Substance Abuse Inpatient and Residential services. Most (89%) of these clients were in the residential LOC. There were 22,503 admissions to SA inpatient or residential programs and 22,497 discharges during this timeframe.

Table 11: Substance Abuse Inpatient/Residential LOCs

11a. Active Clients		Total
Substance Abuse	Inpatient Services	2,691
	Residential Services	11,964
Total		13,403

11b. Admissions		Total
Substance Abuse	Inpatient Services	3,664
	Residential Services	18,839
Total		22,503

11c. Discharges		Total
Substance Abuse	Inpatient Services	3,667
	Residential Services	18,830
Total		22,497

Substance Abuse Outpatient

- For each LOC listed, we provide the unduplicated client count as well as the (fully unduplicated) total client count for all listed LOCs.
- Clients who received services from more than one LOC are counted in each relevant LOC.

Fifty-two thousand five hundred nine (52,509) clients received SA Outpatient services in SFY15. Over a third of clients (35%) were served in an outpatient SA program, followed by Forensic SA community based (consisting of almost exclusively of Pre-Trial Intervention, which was its own labeled category last year) (32%), and Medication Assisted Treatment (28%).

There were 37,183 admissions to SA Outpatient LOCs during the Fiscal Year. Almost 80% of the admissions were to the three LOCs noted above: Standard Outpatient (35%), Forensic SA community based (Pre-Trial Intervention) services (26%), and Medication Assisted Treatment (17%).

There were also 32,813 discharges during SFY15. Standard Outpatient (36%) and Pre-Trial Intervention services (24%) again had the most discharges (60% total) of all the service types.

OHCA 000070

Table 12: Substance Abuse Outpatient LOCs

12a. Active Clients		Total
Substance Abuse	Case Management	3,490
	Employment Services	566
	Forensics Community-based	305
	IOP	3,519
	Medication Assisted Treatment	14,904
	Standard Outpatient	18,266
	PHP	670
Forensic SA	Case Management	439
	Forensics Community-based	17,059
Total		52,509

12b. Admissions		Total
Substance Abuse	Case Management	2,629
	Employment Services	452
	Forensics Community-based	246
	IOP	3,494
	Medication Assisted Treatment	6,222
	Standard Outpatient	13,197
	PHP	663
Forensic SA	Case Management	477
	Forensics Community-based	9,803
Total		37,183

12c. Discharges		Total
Substance Abuse	Case Management	2,500
	Employment Services	452
	Forensics Community-based	157
	IOP	3,272
	Medication Assisted Treatment	5,646
	Standard Outpatient	11,760
	PHP	626
Forensic SA	Case Management	425
	Forensics Community-based	7,975
Total		32,813

OHCA 000071

BED CAPACITY AND UTILIZATION

Data for this section comes from the EQMI Outlier Report database (as of September 17, 2015). Bed capacity represents the total number of beds available within a Level of Care.

- DMHAS defines utilization as the number of days each bed is in use during the SFY.
- State average utilization represents the total number of days each bed is used (# beds * # days used) divided by the total number of bed days (in this case total # beds * 365 days in FY).
- For Group Homes, there are 172 beds available, and they were in use by a client 90% of the time.
- Bed Utilization by Region data are located in Appendix B.

Table 13: Bed Capacity and Utilization

13a. MH Inpatient	Bed Capacity	State Avg. Utilization
Acute Psychiatric	331	100%
Acute Psychiatric – Intermediate	10	68%
Non-Certified Sub-Acute	16	97%
Forensic MH Acute Psychiatric	232	99%

13b. MH Residential	Bed Capacity	State Avg. Utilization
Group Home	172	90%
Intensive Residential	100	81%
Supervised Apartments	659	90%
Transitional	51	90%

13c. SA Inpatient	Bed Capacity	State Avg. Utilization
SA Intensive Res Rehabilitation 3.8	111	93%
Medically Managed Detox 4.2	41	86%

13d. SA Residential	Bed Capacity	State Avg. Utilization
Intermediate/Long Term Res Tx 3.5	711	95%
Long Term Care 3.3	50	88%
Medically Monitored Detox 3.7D	128	89%
SA Intensive Res Rehabilitation 3.7	177	86%
SA Intensive Residential - Enhanced	43	95%
Transitional/Halfway House 3.1	102	92%

OHCA 000072

PRIMARY DRUG USE

The data in these tables represent the primary drug reported at admission to treatment related programs. These counts do not represent unduplicated clients, as each client may have multiple admissions during the SFY.

- The admission totals in these tables are different from those in the previous section, because these data include *all LOCs* and the previous section pertained only to selected LOCs.
- Note that there are two tables presented for each fiscal year. The first includes active clients – anyone who was treated during the fiscal year regardless of when they were admitted. The second includes only those clients who had an admission during the fiscal year.

Across all active clients in DMHAS funded treatment related programs, **alcohol was the most frequently reported primary drug** (36%) at admission. The second most frequently reported primary drug was **heroin** (33%). **Marijuana/hashish/THC** was the third most frequently reported drug at 13%; all other drugs were reported as primary at less than 10% of all admissions.

Among admissions to SA programs, **heroin** (44%) was the most frequently reported primary drug. **Alcohol** was reported as the primary drug at 30% of admissions. **Heroin or other opiate drugs account for the primary drug reported at 51% of all SA admissions.**

During admission to MH programs, **alcohol** was reported as the primary drug for over half of the admissions (53%). The second most frequently reported drug during admission to MH programs was **marijuana/hashish/THC** (19%).

Table 14: Primary Drug at Admission – All Active Clients

	SA		MH		Total	
	# Admissions	%	# Admissions	%	# Admissions	%
Alcohol	18,110	29.5%	13,348	53.0%	31,458	36.3%
Heroin	27,221	44.3%	1,617	6.4%	28,838	33.3%
Marijuana, Hashish, THC	6,060	9.9%	4,883	19.4%	10,943	12.6%
Cocaine	3,411	5.6%	2,385	9.4%	5,796	6.7%
None	138	0.2%	725	2.9%	863	1.0%
Other Opiates and Synthetics	4,063	6.6%	736	2.9%	4,799	5.5%
Other Substances*	2,137	3.5%	877	3.5%	3,014	3.5%
Unknown	287	0.4%	617	2.5%	904	1.1%
Total	61,427	100%	25,188	100%	86,615	100%

*This category includes benzodiazepines, PCP, amphetamines, hallucinogens, non-prescription methadone, other sedatives or hypnotics, barbiturates, inhalants, methamphetamines, other stimulants, over the counter, tobacco, and tranquilizers.

Table 15: Primary Drug at Admission - New Admissions Only

	SA		MH		Total	
	# Admissions	%	# Admissions	%	# Admissions	%
Alcohol	14,886	34.9%	4,372	48.6%	19,258	37.3%
Heroin	16,975	39.8%	782	8.7%	17,757	34.4%
Marijuana, Hashish, THC	4,427	10.4%	2,049	22.8%	6,476	12.5%
Cocaine	2,568	6.1%	839	9.4%	3,407	6.6%
None	48	0.1%	265	2.9%	313	0.6%
Other Opiates and Synthetics	1,972	4.6%	290	3.2%	2,262	4.4%
Other Substances *	1,661	3.7%	273	3.0%	1,934	3.7%
Unknown	70	0.2%	101	1.1%	171	0.3%
Total	42,626	100.0%	9,001	100.0%	51,627	100.0%

*This category includes benzodiazepines, PCP, amphetamines, hallucinogens, non-prescription methadone, other sedatives or hypnotics, barbiturates, inhalants, methamphetamines, other stimulants, over the counter, tobacco, and tranquilizers.

Overall, alcohol is still the most frequently reported drug at admission (37%). When looking specifically at admissions during SFY15 (Table 15 above), the most frequent primary drug reported by clients admitted to SA programs is now **heroin** (40%). **Alcohol** is the second most frequently reported drug (35%). *This is the first year in which heroin has been reported more frequently than alcohol.*

Comparing the percentages for heroin and other opiates when looking at all active clients in SA programs in SFY15 versus clients admitted to SA programs in SFY15, there are more active clients reporting heroin and other opiates (51%) than there are new admissions (SFY15 only) (44%). This increase is due to the number of clients who stay in long term methadone maintenance programs.

OHCA 000074

DIAGNOSIS

Diagnosis data come from treatment related programs, and reflect the *most recent primary diagnosis* during the *most recent episode of care* that was open during the fiscal year.

- These values represent *an unduplicated client count* within each diagnostic category; however, as each client may actually have multiple primary diagnoses on file, the overall percentages do not add up to 100%.

Table 16: Top 20 Most Frequent Primary Diagnoses

Rank	Diagnosis	N	%
1	Opioid use disorder, Severe	32,377	22.9
2	Other And Unspecified Alcohol Dependence, Unspecified	12,724	9.0
3	Schizoaffective Disorder, Unspecified	6,976	4.9
4	Major Depressive Affective Disorder Recurrent	5,627	4.0
5	Posttraumatic Stress Disorder	4,552	3.2
6	Schizophrenia, Paranoid Type	4,254	3.0
7	Major depressive disorder, Recurrent episode, Severe	4,173	2.9
8	Schizophrenia, Undifferentiated Type	3,328	2.4
9	Cannabis Dependence, Unspecified Use	3,182	2.2
10	Mood Disorder NOS	2,889	2.0
11	Depressive Disorder NOS	2,872	2.0
12	Alcohol use disorder, Mild	2,710	1.9
13	Cocaine Dependence	2,546	1.8
14	Major Depression, Recurrent, With Psychotic Features	2,457	1.7
15	Bipolar Disorder NOS	2,319	1.6
16	Other And Unspecified Bipolar Disorders Other	2,054	1.5
17	Generalized Anxiety Disorder	1,976	1.4
18	Diagnosis Deferred On This Axis	1,920	1.4
19	Anxiety Disorder NOS	1,851	1.3
20	Psychotic Disorder NOS	1,702	1.2

Note: clients may have more than one primary diagnosis

The most frequent primary diagnosis was **severe opioid use** (previously called opioid dependence) (23%). Five of the top 20 diagnoses are substance use related and 14 are mental health related.

OHCA 000075

Table 17: Major Diagnosis Categories

17a. Based on Primary Diagnosis Only	N	%
Bipolar disorder	9,324	11.5
Major depression	15,762	19.5
Major mood disorder	23,793	29.4
Schizophrenic disorder	9,750	12.0
Alcohol dis/abuse	11,368	14.0
Drug dis/abuse	29,602	36.6
17b. Based on Primary and Non-Primary Diagnosis		
SMI (Serious Mental Illness)	41,224	50.9
SA disorder	52,455	64.8
Dual dx (SMI+SA)	20,455	25.3

Total N=80,934 clients receiving treatment related services

- In clients who received treatment services, **drug disorders** (36%) comprise the most frequently diagnosed condition type.
- Over one fourth (29%) of clients have a diagnosis of **major mood disorder**; while close to 20% have a diagnosis of major depression.
- When looking at primary and non-primary diagnoses, **just over half of the clients qualify for an SMI (serious mental illness) diagnosis**, which involves having any (or multiple), of the following diagnoses: Schizophrenia (including related disorders), Bipolar Disorder, or Major Depression.
- About 50% of clients have a **substance use/abuse disorder**.
- One quarter (25%) of clients qualify for a **dual diagnosis**, meaning that they have both an SMI diagnosis and a substance abuse diagnosis.

OHCA 000076

YOUNG ADULT SERVICES

Within the DMHAS system, Young Adult Services (YAS) serves clients who are ages 18-25 and have a history of DCF involvement. They must also have a history of a major mental health problem. These data represent unduplicated client counts. Clients are counted as YAS clients as long as they receive any YAS services. They may also receive non-YAS DMHAS services.

In SFY15, **YAS** programs served **1,184 clients**. This is a 6% increase from SFY14.

- To provide context, we present client numbers in different DMHAS subgroups below.
- Client counts are unduplicated within each subgroup, but not across subgroups.

Table 18: Young Adult Clients

ALL 18-25	SA 18-25	MH 18-25	Young Adult Services
16,512	10,269	7,029	1,184 (7.2% of total 18-25 population)

Since FY13, YAS has been collecting information from YAS clients who have been discharged during the fiscal year. In FY15, over 62% of discharged clients were living stably in the community, an increase of over 5% from FY14. Additionally, over 50% of clients were able to live independently after discharge. Almost a third of discharged YAS clients had obtained a high school diploma or GED and a quarter were employed. Over 5% were considered to be responsible parents and/or had obtained a driver's license. This data comes from the YAS Evaluation Form, which is managed by the School of Social Work at UCONN.

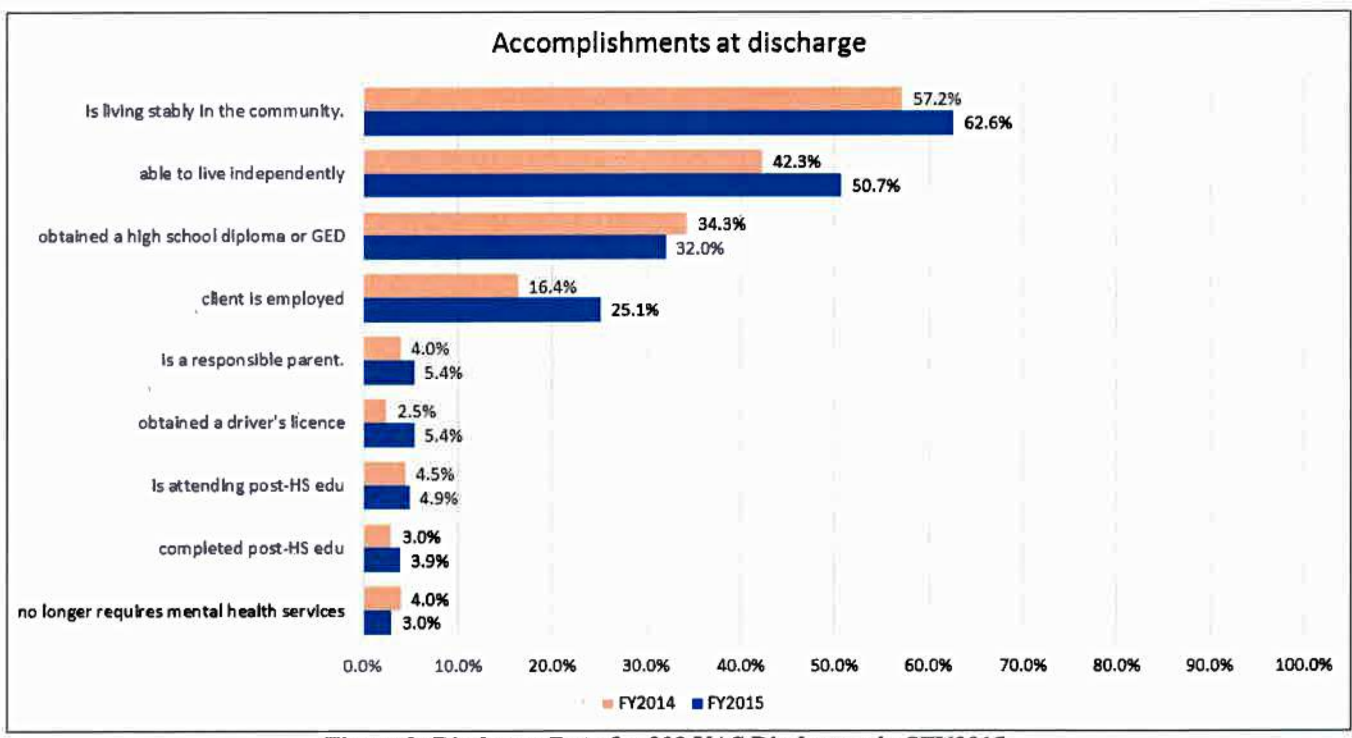


Figure 2: Discharge Data for 239 YAS Discharges in SFY2015

OHCA 000077

APPENDIX A. SFY15 LOC data by Region

MH IP/Res LOCs Active Clients		Region 1	Region 2	Region 3	Region 4	Region 5	Total
Forensic MH	Inpatient Services	0	483	0	0	0	483
	Residential Services	0	56	0	0	0	56
Mental Health	Inpatient Services	278	566	29	213	0	1,060
	Residential Services	508	663	544	566	525	2,787
Total MH		766	1636	568	764	525	4,076

MH IP/Res LOCs Admissions		Region 1	Region 2	Region 3	Region 4	Region 5	Total
Forensic MH	Inpatient Services	0	575	0	0	0	575
	Residential Services	0	60	0	0	0	60
Mental Health	Inpatient Services	320	657	33	223	0	1,233
	Residential Services	539	741	686	605	569	3,140
Total MH		859	2033	719	828	569	5,008

MH IP/Res LOCs Discharges		Region 1	Region 2	Region 3	Region 4	Region 5	Total
Forensic MH	Inpatient Services	0	351	0	0	0	351
	Residential Services	0	49	0	0	0	49
Mental Health	Inpatient Services	252	418	32	161	0	863
	Residential Services	136	265	380	207	139	1,127
Total MH		388	1,083	412	368	139	2,390

OHCA 000078

MH OP LOCs Active Clients		Region 1	Region 2	Region 3	Region 4	Region 5	Total
Forensic MH	Case Management	0	103	0	37	0	138
	Crisis Services	9	16	0	0	16	41
	Forensics Community-based	773	1,808	554	1,755	226	4,887
	Outpatient	0	0	0	372	0	372
Mental Health	ACT	62	148	252	518	56	1,032
	Case Management	1,668	1,469	680	1,243	895	5,897
	Community Support	696	1,531	1,068	1,509	721	5,514
	Consultation	47	106	158	168	53	522
	Crisis Services	990	1,473	627	1,216	2,244	6,486
	Education Support	67	52	56	50	37	262
	Employment Services	505	1,230	630	1,030	616	4,001
	Forensics Community-based	2	2	2	20	0	24
	Housing Services	177	209	15	74	2	476
	Intake	717	1,393	353	249	296	2,981
	IOP	0	0	0	382	205	587
	Outpatient	3,836	10,288	5,850	14,486	4,944	39,215
	Prevention	0	396	0	0	0	396
	Social Rehabilitation	1,377	1,294	719	1,651	1,263	6,277
Total MH		8,130	14,543	7,791	18,483	8,941	56,575

MH OP LOCs Admissions		Region 1	Region 2	Region 3	Region 4	Region 5	Total
Forensic MH	Case Management	0	65	0	12	0	77
	Crisis Services	8	18	0	0	11	37
	Forensics Community-based	777	1,344	513	1,387	200	4,221
	Outpatient	0	0	0	163	0	163
Mental Health	ACT	41	40	100	261	40	482
	Case Management	671	691	243	560	149	2,314
	Community Support	146	448	316	576	208	1,694
	Crisis Services	1,195	2,360	661	1,483	2,845	8,544
	Education Support	36	11	27	29	24	127
	Employment Services	240	537	315	515	283	1,890
	Forensics Community-based	3	2	2	21	0	28
	Housing Services	1	68	2	0	0	71
	Intake	516	1,358	355	169	201	2,599
	IOP	0	0	0	390	196	586
	Outpatient	646	3,791	2,107	4,992	1210	12,746
	Prevention	0	69	0	0	0	69
	Social Rehabilitation	420	409	268	322	325	1744
Total MH		47.00	11,211	4,909	10,880	5,692	37,392

OHCA 000079

MH OP LOCs Discharges		Region 1	Region 2	Region 3	Region 4	Region 5	Total
Forensic MH	Case Management	0	63	0	18	0	81
	Crisis Services	6	17	0	0	11	34
	Forensics Community-based	759	1,304	511	1,284	157	4,015
	Outpatient	0	0	0	207	0	207
Mental Health	ACT	8	29	93	178	5	313
	Case Management	541	676	241	333	143	1,934
	Community Support	306	409	349	666	209	1,939
	Crisis Services	1,188	2,330	687	1,452	2,832	8,489
	Education Support	29	17	33	17	23	119
	Forensics Community-based	273	542	316	579	290	2,000
	Employment Services	3	2	2	16	0	23
	Housing Services	0	102	3	0	0	105
	Intake	721	1,429	349	213	327	3,039
	IOP	0	0	0	373	182	555
	Outpatient	910	3,899	2,314	4,691	1,146	12,960
	Prevention	0	62	0	0	0	62
	Social Rehabilitation	262	331	283	381	256	1,513
Total MH		5,006	11,212	5,181	10,408	5,581	37,388

SA IP/Res LOCs Active Clients		Region 1	Region 2	Region 3	Region 4	Region 5	Total
Addiction	Inpatient Services	0	2,691	0	0	0	2691
	Residential Services	2,708	3,868	1,784	3,306	2,679	11,964
Total SA		2,708	6,203	1,784	3,306	2,679	13,403

SA IP/Res LOCs Admissions		Region 1	Region 2	Region 3	Region 4	Region 5	Total
Addiction	Inpatient Services	0	3664	0	0	0	3664
	Residential Services	3431	4823	2404	4829	3352	18,839
Total SA		3,431	8,487	2,404	4,829	3,352	22,503

SA IP/Res LOCs Discharges		Region 1	Region 2	Region 3	Region 4	Region 5	Total
Addiction	Inpatient Services	0	3,667	0	0	0	3,667
	Residential Services	3,352	4,885	2,397	4,877	3,319	18,830
Total SA		3,352	8,552	2,397	4,877	3,319	22,497

SA OP LOCs Active Clients		Region 1	Region 2	Region 3	Region 4	Region 5	Total
Addiction	Case Management	76	2,220	159	591	559	3,490
	Employment Services	88	160	99	220	0	566
	Forensics Community-based	0	97	0	208	0	305
	IOP	892	47	583	1,169	859	3,519
	Medication Assisted Tx	3,666	4,141	1,171	4,610	1,885	14,904
	Outpatient	1,622	4,191	2,685	7,249	2642	18,266
	PHP	60	394	0	218	0	670
Forensic SA	Case Management	0	0	97	230	113	439
	Forensics Community-based	2,476	4,384	1,575	6,070	2,668	17,059
Total SA		8,047	14,798	5,739	18,544	7,878	52,509

SA OP LOCs Admissions		Region 1	Region 2	Region 3	Region 4	Region 5	Total
Addiction	Case Management	44	1,814	132	334	305	2,629
	Employment Services	74	121	78	179	0	452
	Forensics Community-based	0	82	0	164	0	246
	IOP	863	47	603	1,109	872	3,494
	Medication Assisted Tx	1,630	1,687	458	1,685	762	6,222
	Outpatient	1,256	2,543	2,229	4,974	2,195	13,197
	PHP	57	405	0	201	0	663
Forensic SA	Case Management	0	0	107	252	118	477
	Forensics Community-based	1,505	2,840	1,014	2,924	1,520	9,803
Total SA		5,429	9,539	4,621	11,822	5,772	37,183

SA OP LOCs Discharges		Region 1	Region 2	Region 3	Region 4	Region 5	Total
Addiction	Case Management	21	1,797	93	299	290	2,500
	Employment Services	57	115	88	192	0	452
	Forensics Community-based	0	56	0	101	0	157
	IOP	870	49	600	963	790	3,272
	Medication Assisted Tx	1,382	1,795	406	1,575	488	5,646
	Outpatient	1,169	2,235	2,054	4313	1989	11,760
	PHP	62	399	0	165	0	626
Forensic SA	Case Management	0	0	89	238	98	425
	Forensics Community-based	1,418	1,317	1,125	2,747	1,368	7,975
Total SA		4,979	7,763	4,455	10,593	5,023	32,813

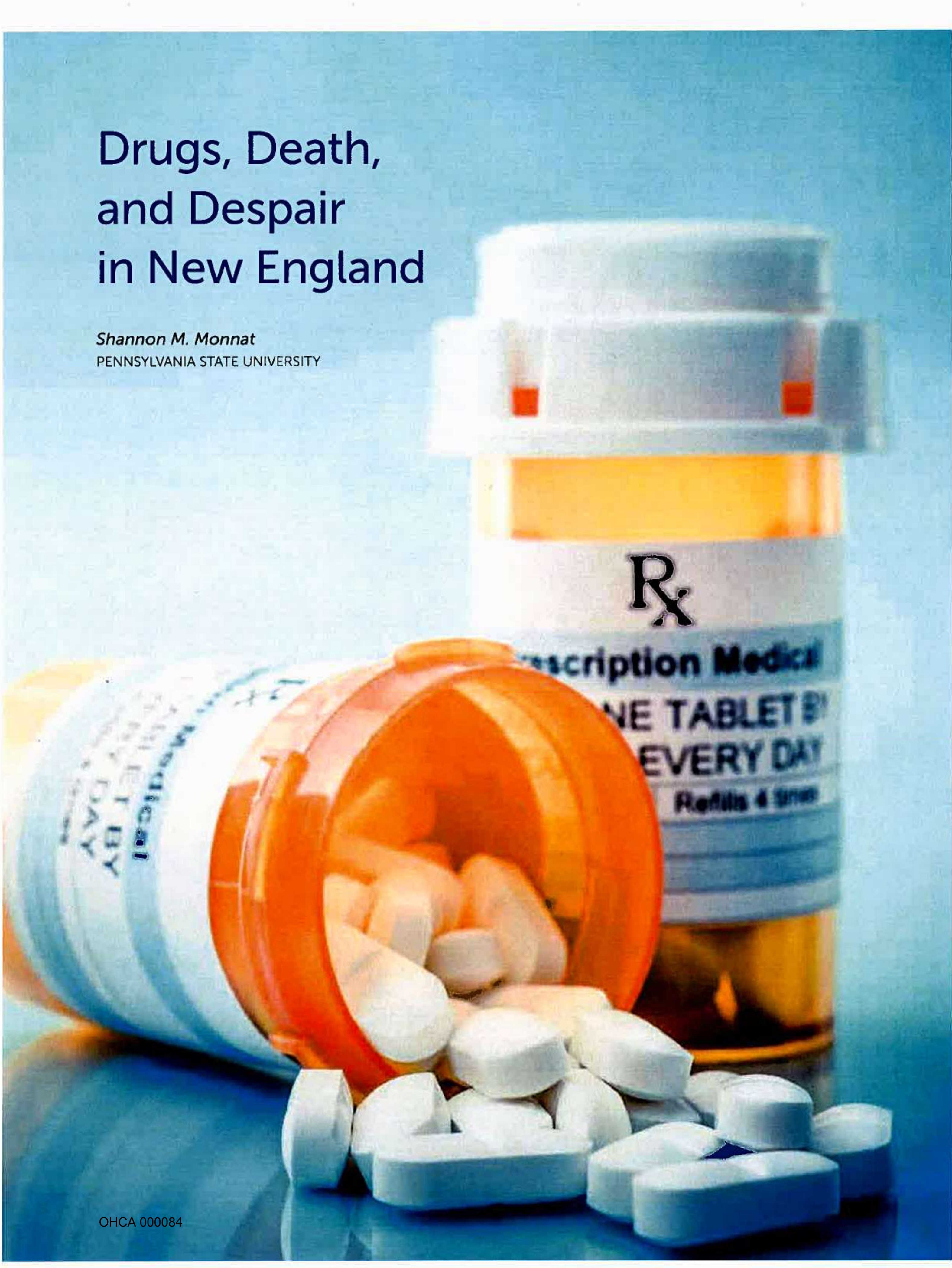
OHCA 000081

APPENDIX B. SFY15 Bed Capacity and Utilization by Region

Program Type	LOC Type	LOC Mode	Data Type	Region 1	Region 2	Region 3	Region 4	Region 5	Grand Total or State Avg	Goal
Addiction	Inpatient Services	Intensive Res. Rehabilitation 3.8	Bed Capacity		111				111	
			Utilization Rate		93%				93%	90%
		Medically Managed Detox 4.2	Bed Capacity		41				42	
			Utilization Rate		86%				86%	90%
	Residential Services	AIDS Residential	Bed Capacity	25	16		9		50	
			Utilization Rate	99%	91%		90%		95%	90%
		Intermediate/Long Term Res.Tx 3.5	Bed Capacity	179	202	146	70	114	711	
			Utilization Rate	119%	81%	94%	89%	118%	100%	90%
		Long Term Care 3.3	Bed Capacity					50	50	
			Utilization Rate					112%	112%	90%
		Medically Monitored Detox 3.7D	Bed Capacity	19	42	20	35	12	128	
			Utilization Rate	123%	76%	80%	83%	95%	88%	90%
		SA Intensive Res. Rehabilitation 3.7	Bed Capacity	25	42	16	52	42	177	
			Utilization Rate	89%	68%	76%	93%	92%	85%	90%
		SA Intensive Residential - Enhanced	Bed Capacity	23				20	43	
			Utilization Rate	93%				96%	94%	90%
		Transitional/Halfway House 3.1	Bed Capacity	6	14	34	35	14	103	
			Utilization Rate	125%	87%	89%	89%	98%	92%	90%
Forensic MH	Crisis Services	Respite Bed	Bed Capacity	3	3			2	8	
			Utilization Rate	69%	81%			191%	104%	90%
	Inpatient Services	Acute Psychiatric	Bed Capacity		232				232	
			Utilization Rate		100%				100%	90%
	Residential Services	MH Intensive Res. Rehabilitation	Bed Capacity		6				6	
			Utilization Rate		28%				28%	90%

(See next page for Mental Health)

Program Type	LOC Type	LOC Mode	Data Type	Region 1	Region 2	Region 3	Region 4	Region 5	Grand Total or State Avg	Goal
Mental Health	Case Management	Outreach & Engagement	Bed Capacity		34				34	
			Utilization Rate		62%				62%	90%
	Crisis Services	Respite Bed	Bed Capacity	10	29		18	2	59	
			Utilization Rate	75%	106%		91%	420%	107%	90%
	Inpatient Services	Acute Psychiatric	Bed Capacity	66	254	4	5	2	331	
			Utilization Rate	97%	94%	133%	942%	6%	108%	90%
		Acute Psychiatric - Intermediate	Bed Capacity	10					10	
			Utilization Rate	68%					68%	90%
		Non-Certified Subacute	Bed Capacity				16		16	
			Utilization Rate				97%		97%	90%
	Residential Services	Group Home	Bed Capacity	36	55	14	44	23	172	
			Utilization Rate	93%	101%	93%	94%	97%	96%	90%
		MH Intensive Res. Rehabilitation	Bed Capacity		25		60	15	100	
			Utilization Rate		92%		86%	65%	86%	90%
		Sub-Acute	Bed Capacity			15			15	
			Utilization Rate			77%			77%	90%
		Supervised Apartments	Bed Capacity	83	164	127	155	130	659	
			Utilization Rate	96%	93%	90%	89%	95%	92%	90%
		Transitional	Bed Capacity	5	1	5		40	51	
			Utilization Rate	95%	84%	101%		89%	91%	90%



Drugs, Death, and Despair in New England

Shannon M. Monnat
PENNSYLVANIA STATE UNIVERSITY

OHCA 000084

The opioid crisis has been called a national epidemic. In New England it blights urban, suburban, and rural communities, fueled by prescription pain killers and cheap and plentiful heroin.

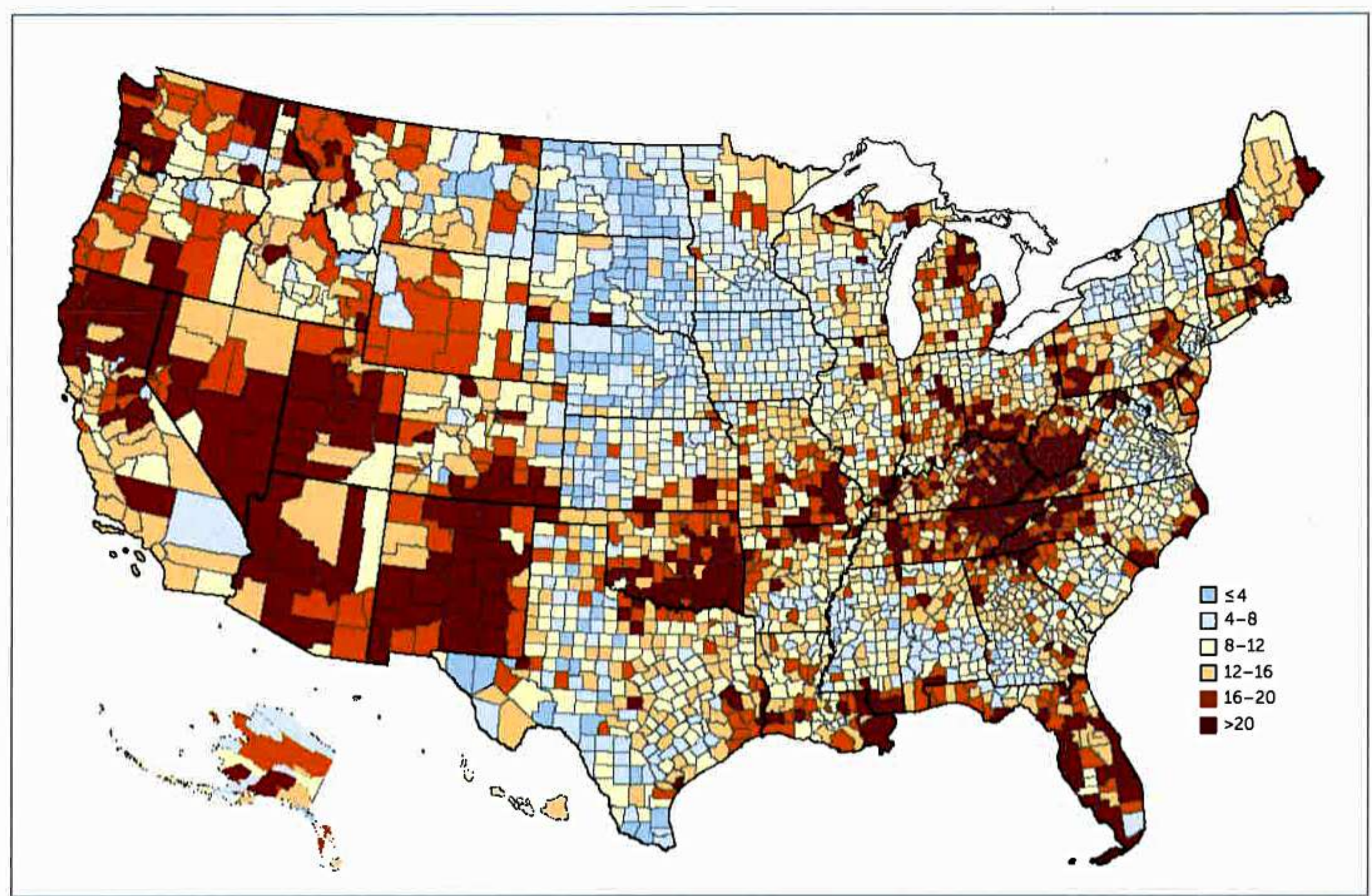
To say that the United States is in the midst of an opioid epidemic seems almost cliché at this point. Over the past two years, thousands of articles have been written about the crisis; nearly all US states and counties have held public hearings, town halls, and symposia; Congress passed the Comprehensive Addiction and Recovery Act of 2016; and President Obama pledged funding and action to address the crisis.

Most media commentary has characterized the crisis as a national epidemic. That portrayal is accurate. The US overdose death rate reached 15 per 100,000 in 2014 and is climbing at a much faster rate than other causes of death, due primarily to opioids (prescription pain relievers and heroin).[1] Opioids now kill more Americans than do motor vehicle accidents. In 2014, 28,647 (61 percent) of drug overdose deaths involved an opioid, and nearly all counties in the United States experienced increases in drug overdose mortality over the past decade. (See "County Drug Overdose Deaths per 100,000 in 2014.")

High overdose mortality rates were once mostly restricted to large cities and Appalachia. Now, however, places considered buffered from widespread drug problems as recently as a decade ago, including New England, face surging drug overdose mortality rates. Between 2002 and 2014, drug overdose mortality rates more than doubled in every New England county. Washington County, Maine; Barnstable, Bristol, and Suffolk counties in Massachusetts; Coös County, New Hampshire; and Kent and Providence counties in Rhode Island now have drug overdose mortality rates above 20. (See "Overdose Deaths per 100,000 for New England Counties in 2002 and 2014.")

The highest overdose mortality rates in New England span the rural-urban continuum, including places as urban as New Haven County, Connecticut, and places as sparsely populated as Essex County, Vermont—the least populated county in New England. Still, the 20 New England counties that had overdose mortality rates above 16 in 2014 have several characteristics in common, including poverty, disability, unemployment rates that exceed New England averages, and above-average declines in manufacturing and manual-labor occupations since 1970.

County Drug Overdose Deaths per 100,000 in 2014



Source: Centers for Disease Control and Prevention, National Vital Statistics System, Age-Adjusted Death Rates for Drug Poisoning, 2014.

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Adolescent Drug Abuse and Overdose

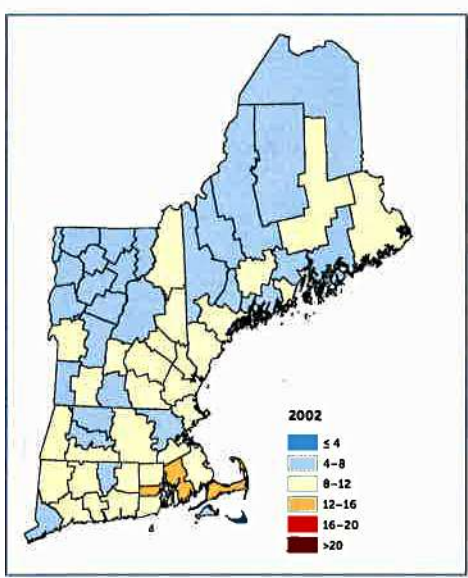
Nationally, overdose rates are highest among individuals aged 25 to 54, but adolescents and young adults also abuse and overdose. In 2014, the overdose death rate among individuals aged 15 to 24 was 8.6, with the highest rate among non-Hispanic white males (17.4), followed by non-Hispanic white females (7.0), Hispanic males (6.0), black males (4.0), Hispanic females (2.5), and black females (2.3).[2]

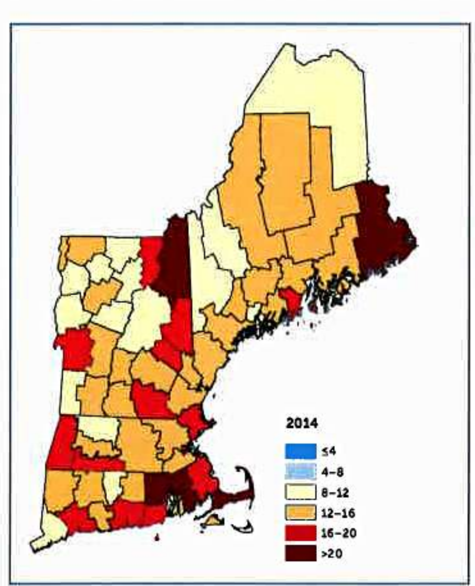
As noted earlier, the surge in overdose mortality has been driven by prescription pain relievers (e.g., oxycodone, hydrocodone) and heroin. Although rates of abuse are much higher among young adults (18–25), over 1.1 million adolescents (4.7 percent of youth aged 12–17) abused prescription pain relievers in 2014.[3] Among both teens and adults, only marijuana is more frequently abused than prescription pain relievers.[4] See "Reported Drug Use by State, 2013–2014, Individuals 12–17" and "Reported Drug Use by State, 2013–2014, Individuals 18–25." Adolescent drug use is particularly worrisome because this is the period when most substance abuse and addiction disorders begin, and abuse during these formative years increases the likelihood of future economic precariousness, relationship instability, poor health, and criminal-justice involvement.

Rates of current (past-month) illicit-drug use among adolescents and young adults are higher in all New England states than in the United States overall.[5] However, overall illicit-drug use rates are driven mostly by marijuana. Although there are short- and long-term adverse effects associated with marijuana use, there have been no reported overdose deaths from marijuana. Nonmedical use of prescription opioids, while much less prevalent, is unequivocally much more deadly. Adolescent abuse of prescription pain relievers in New England is comparable to the overall US rate. However, among young adults (aged 18–25), rates of nonmedical use of prescription opioids are higher in Connecticut and New Hampshire than in the United States overall.

Using data from the National Survey on Drug Use and Health, my colleague and I found that the most salient contributors to opioid abuse among adolescents and young adults are poor mental health, peer substance use, the perception that substance use is not risky, and having access to drugs.[6] Adolescents who smoke daily and consume alcohol to excess are more likely than their nonsmoking and nondrinking peers to use illicit drugs and to abuse prescription opioids. Importantly, use of emergency departments, where opioids are more commonly prescribed, also increases adolescents' risk of abusing opioids.

Drug Overdose Deaths per 100,000 in 2002 & 2014





How Did We Get Here?

US overdose deaths involving prescription opioids have quadrupled since 1999. Not coincidentally, so have sales of prescription opioids. Annual sales of OxyContin (a brand name for the drug oxycodone)—the most widely prescribed, abused, and profitable prescription narcotic in history—alone skyrocketed from $45 million in 1996 (when it entered the market) to $3.1 billion by 2010. In *Dreamland: The True Tale of America's Opiate Epidemic*, Sam Quinones notes that Purdue Pharma, the company that makes OxyContin, aggressively marketed its blockbuster drug for chronic noncancer pain, particularly in areas with relatively high shares of blue-collar laborers who were at risk of work-related back pain and other injuries.[7] In 2007, Purdue Pharma and three of the company's executives pleaded guilty in federal court to criminal charges that they misled regulators, physicians, and patients about OxyContin's addiction and abuse potential. However, by then, 5.2 million Americans were already misusing prescription opioids,[8] and annual prescription opioid–related overdose deaths exceeded 14,000.[9]

Over the past decade, public-health and government efforts have focused on combating the prescription opioid epidemic by cracking down on "pill mills" (medical establishments that prescribe pills inappropriately), creating statewide prescription-drug monitoring programs, and educating physicians on safe prescribing practices. These efforts have been largely successful; there have been recent declines in prescription opioid abuse and overdose deaths among both adolescents and adults.[10] However, there has been an unintended consequence. As the supply of prescription opioids has dwindled, heroin, which produces the same high and is just as addictive, has filled the gap. About 80 percent of people who are currently using heroin report misusing prescription opioids first.[11] Increased mixing of heroin with the synthetic pain reliever fentanyl (which is up to 50 times more powerful than heroin) has made New England's opiate problem much more deadly.

Moreover, despite widespread awareness of prescription opioid

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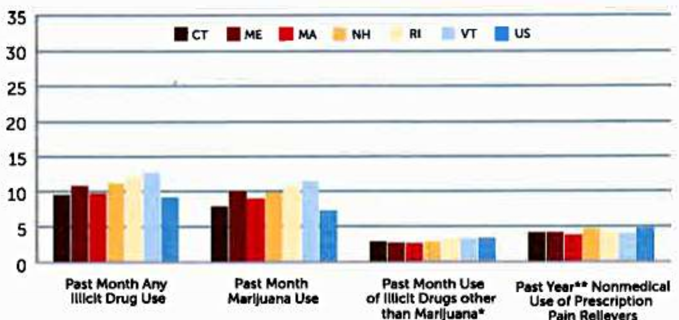
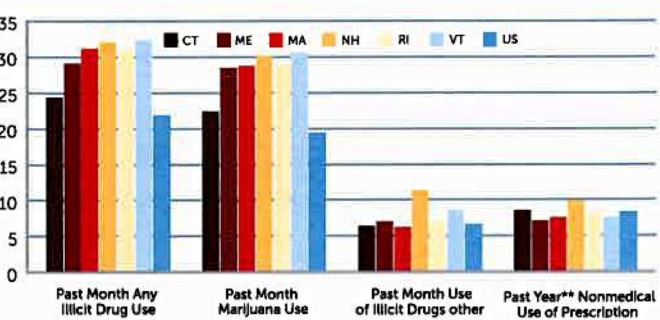
Reported Drug Use by State, 2013–2014, Individuals 12–17



Reported Drug Use by State, 2013–2014, Individuals 18–25



Source: US Substance Abuse and Mental Health Services Administration, 2013–2014 NSDUH State-Specific Tables *Illicit drugs other than marijuana include cocaine (including crack), heroin, hallucinogens, inhalants, and prescription-type psychotherapeutics used nonmedically. **Estimates of past-month use are not available by state for prescription pain relievers.

abuse, high rates of opioid prescribing continue, though they vary by state.[12] Maine currently ranks first and New Hampshire ranks third in the nation in prescribing rates for long-acting/extended-release opioids, which have an especially high overdose risk because abusers can crush them and instantly achieve the full dose (possible even with so-called abuse-deterrent formulations). Massachusetts (8th), Connecticut (13th), Rhode Island (14th), and Vermont (16th) are also ranked in the top 20 states for long-acting/extended-release prescribing. All six New England states also have above-average rates of high-dose opioid prescribing, and all but Vermont have above-average prescribing rates for benzodiazepines—psychoactive sedatives commonly abused along with opiates, drastically increasing overdose risk.

Saving Lives and Communities

Although physicians are aware of the highly addictive nature of opioids and are cognizant of the overdose risk, they also know that if they cut patients off from these highly addictive narcotics, some are likely to turn to heroin, which, thanks to increased distribution from Mexico, has become easily accessible and incredibly cheap: heroin is now cheaper than a pack of cigarettes or a six-pack of beer in most parts of the United States.[13]

Although increasing first-responder and community access to naloxone (a drug that counteracts the effects of an opioid overdose) has potential to reduce overdoses, and increased use of medication-assisted treatments like buprenorphine holds potential for treating opioid dependence, preventing initiation is the key to turning the tide on the opiate abuse and overdose epidemic. About 60 percent of current heroin users report first using heroin between the ages of 17 and 25,[14] suggesting that those are the years to target. Different strategies will work better in different communities, but general prevention strategies include more comprehensive physician training in pain management and addiction, moving physicians toward safer prescribing practices, and better parent and youth education on the risks of opioid use for minor injuries. Finally, given high rates of abuse and overdose in communities that have long suffered from employment restructuring and economic decline, comprehensive job-growth strategies that emphasize secure employment with livable wages for individuals all along the educational gradient are likely to have the most significant long-term and sustainable impacts in New England and elsewhere.

Shannon M. Monnat *is an assistant professor of rural sociology, demography, and sociology at Pennsylvania State University. Contact her at smm67@psu.edu.*

Endnotes

1 "Multiple Cause of Death Data," Centers for Disease Control and Prevention, 2016, http://wonder.cdc.gov/mcd.html.
2 Ibid.
3 Shannon Monnat and Khary K. Rigg, "Rural Adolescents Are More Likely Than Their Urban Peers to Abuse Prescription Painkillers" (Carsey Research National Fact Sheet No. 32, Carsey School of Public Policy, University of New Hampshire, 2015).
4 Shannon Monnat and Khary K. Rigg, "Examining Rural/Urban Differences in Prescription Opioid Misuse Among US Adolescents," *Journal of Rural Health* 32, no. 2 (2016):204–18.
5 "National Survey on Drug Use and Health (NSDUH) Series," Substance Abuse and Mental Health Services Administration, http://www.samhsa.gov/data/population-data-nsduh.
6 Monnat and Rigg, "Rural Adolescents Are More Likely Than Their Urban Peers to Abuse Prescription Painkillers."
7 Sam Quinones, *Dreamland: The True Tale of America's Opiate Epidemic* (London and New York: Bloomsbury, 2015).
8 "Trends in Nonmedical Use of Prescription Pain Relievers: 2002 to 2007" (report, National Survey on Drug Use and Health, Rockville, MD, 2009), http://media.samhsa.gov/data/2k9/painRelievers/nonmedicalTrends.htm.
9 "Multiple Cause of Death Data."
10 Ibid.
11 "National Survey on Drug Use and Health (NSDUH) Series."
12 L.J. Paulozzi, K.A. Mack, and J.M. Hockenberry, "Vital Signs: Variation Among States in Prescribing of Opioid Pain Relievers and Benzodiazepines – United States, 2012," *Morbidity and Mortality Weekly Report* 63, no. 26 (2014):563–68.
13 L. Bernstein, "Why a Bag of Heroin Costs Less Than a Pack of Cigarettes," *Washington Post*, August 27, 2015.
14 "National Survey on Drug Use and Health (NSDUH) Series."

Key Substance Use and Mental Health Indicators in the United States:

Results from the 2015 National Survey on Drug Use and Health

OHCA 000088

Key Substance Use and Mental Health Indicators in the United States: Results from the 2015 National Survey on Drug Use and Health

SAMHSA Authors

Jonaki Bose
Sarra L. Hedden
Rachel N. Lipari
Eunice Park-Lee

RTI Authors

Jeremy D. Porter
Michael R. Pemberton

SAMHSA Project Officer

Peter Tice

RTI Project Director

David Hunter

For questions about this report,
please e-mail Peter.Tice@samhsa.hhs.gov.

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Originating Office

Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, 5600 Fishers Lane, Room 15-E09D, Rockville, MD 20857.

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Table of Contents

Summary 1

Introduction 5

Survey Background 5

Notable 2015 NSDUH Questionnaire Changes 5

Data Presentation and Interpretation 6

Illicit Drug Use 6
- Any Illicit Drug Use 7
- Marijuana Use 7
- Misuse of Psychotherapeutic Drugs 8
- Pain Reliever Misuse 8
- Tranquilizer Misuse 9
- Stimulant Misuse 9
- Sedative Misuse 9
- Cocaine Use 9
- Heroin Use 10
- Hallucinogen Use 12
- Inhalant Use 12
- Methamphetamine Use 12

Tobacco Use 13
- Cigarette Use 14
- Daily Cigarette Use 15
- Cigar and Pipe Tobacco Use 16
- Smokeless Tobacco Use 17

Alcohol Use 18
- Current Alcohol Use 18
- Binge Alcohol Use 19
- Heavy Alcohol Use 19
- Underage Alcohol Use 19

Substance Use Disorders in the Past Year 20
- Substance Use Disorder 21
- Alcohol Use Disorder 22
- Illicit Drug Use Disorder 22
- Marijuana Use Disorder 23
- Cocaine Use Disorder 23
- Heroin Use Disorder 24
- Methamphetamine Use Disorder 25
- Pain Reliever Use Disorder 25
- Tranquilizer Use Disorder 25
- Stimulant Use Disorder 25

Need for Substance Use Treatment 25

Receipt of Substance Use Treatment 26

Mental Health Issues and Mental Health Service Use 27
- Mental Illness among Adults 27
- Mental Health Service Use among Adults 29

Co-Occurring Mental Health Issues and Substance Use Disorders among Adults 31
- Mental Illness and Substance Use Disorders among Adults with a Disorder 31
- Co-Occurring Mental Illness and Substance Use Disorders among Adults in the General Population 32

Receipt of Services among Adults with Co-Occurring Mental Illness and a Substance Use Disorder 33

Major Depressive Episode (MDE) and MDE with Severe Impairment among Adults 34
- Treatment for Depression among Adults 36

Mental Health Service Use among Adolescents 37
- Mental Health Service Use among All Adolescents 37

MDE and MDE with Severe Impairment among Adolescents 38
- Treatment for Depression among Adolescents 39

Co-Occurring MDE and Substance Use among Adolescents 39
- Substance Use and Substance Use Disorders among Adolescents with MDE 39
- MDE among Adolescents with a Substance Use Disorder 40
- Co-Occurring MDE and Substance Use Disorder among Adolescents in the General Population 40

Receipt of Services among Adolescents with Co-Occurring MDE and a Substance Use Disorder 40

Endnotes 41

Appendix A: Supplemental Tables of Estimates for Key Substance Use and Mental Health Indicators in the United States A-1

Appendix B: List of Contributors B-1

Report Revision Note:

In this revised report, Figure 37 and its associated text were removed to be consistent with the Office of National Drug Control Policy's National Drug Control Strategy.

Summary

This national report summarizes key findings from the 2015 National Survey on Drug Use and Health (NSDUH) for indicators of substance use and mental health among people aged 12 years old or older in the civilian, noninstitutionalized population of the United States. Results are provided for the overall category of individuals aged 12 or older as well as by age subgroups. The NSDUH questionnaire underwent a partial redesign in 2015 to improve the quality of the NSDUH data and to address the changing needs of policymakers and researchers with regard to substance use and mental health issues. Trends continue to be presented for estimates that are assumed to have remained comparable with those in earlier years (e.g., marijuana and heroin use trends for 2002 to 2015 and mental health trends typically for 2008 to 2015).

Illicit Drug Use

Changes in measurement for 7 of the 10 illicit drug categories—hallucinogens, inhalants, methamphetamine, and the misuse of prescription pain relievers, tranquilizers, stimulants, and sedatives—may have affected the comparability of the measurement of these illicit drugs.[1] Therefore, only 2015 estimates are presented for these seven illicit drug categories and for the use of any illicit drug. In 2015, 27.1 million people aged 12 or older used an illicit drug in the past 30 days, which corresponds to about 1 in 10 Americans (10.1 percent). The illicit drug use estimate for 2015 continues to be driven primarily by marijuana use and the misuse of prescription pain relievers, with 22.2 million current marijuana users aged 12 or older (i.e., users in the past 30 days) and 3.8 million people aged 12 or older who reported current misuse of prescription pain relievers. The 2015 estimate of current marijuana users was similar to the estimate in 2014, but it was higher than the estimates from 2002 to 2013. This increase in marijuana use among people aged 12 or older reflects the increase in marijuana use by adults aged 26 or older and, to a lesser extent, the increase in marijuana use among young adults aged 18 to 25.

In 2015, NSDUH adopted a revised definition of prescription drug misuse, which defined misuse as use in any way not directed by a doctor, including use without a prescription of one's own; use in greater amounts, more often, or longer than told to take a drug; or use in any other way not directed by a doctor. The estimated 3.8 million people aged 12 or older who were current misusers of pain relievers represent 1.4 percent of the population aged 12 or older.

The estimate of current heroin use in 2015 among people aged 12 or older was higher than the estimates in most years between 2002 and 2009, but it was similar to the estimates between 2010 and 2014. Current cocaine use in 2015 was similar to the estimates in most years between 2007 and 2013, but it was higher than the estimate in 2014. The 2015 estimate of crack use was similar to the estimates in most years from 2008 to 2014. There were new baselines in 2015 for hallucinogen, inhalant, and methamphetamine use (0.5, 0.2, and 0.3 percent, respectively, for current use among people aged 12 or older).

Tobacco Use

In 2015, an estimated 52.0 million people aged 12 or older were current cigarette smokers. Although about 1 in 5 people aged 12 or older were current cigarette smokers, cigarette use generally declined between 2002 and 2015 across all age groups. Among the 52.0 million current cigarette smokers in 2015, 30.2 million were daily cigarette smokers, including 12.4 million daily smokers who smoked approximately a pack or more of cigarettes per day.

Alcohol Use

NSDUH collects information on past month alcohol use, binge alcohol use, and heavy alcohol use. For men, binge alcohol use is defined in NSDUH as drinking five or more drinks on the same occasion on at least 1 day in the past 30 days. For women, binge drinking is defined as drinking four or more drinks on the same occasion on at least 1 day in the past 30 days. Heavy alcohol use is defined as binge drinking on 5 or more days in the past 30 days. In 2015, there were 138.3 million Americans aged 12 or older who reported current use of alcohol, including 66.7 million who reported binge alcohol use in the past month and 17.3 million who reported heavy alcohol use in the past month. Past month binge drinkers and heavy alcohol users represented 24.9 and 6.5 percent of people aged 12 or older, respectively.

[1] NSDUH obtains information on the following 10 categories of drugs: marijuana, cocaine (including crack), heroin, hallucinogens, inhalants, and methamphetamine, as well as the misuse of prescription pain relievers, tranquilizers, stimulants, and sedatives. Estimates of "illicit drug use" reported from NSDUH reflect the use of drugs in any of these 10 categories.

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Underage alcohol use (i.e., among people aged 12 to 20) and binge and heavy use among young adults aged 18 to 25 are a concern. In 2015, about 7.7 million people aged 12 to 20 reported drinking alcohol in the past month, including 5.1 million who reported binge alcohol use and 1.3 million who reported heavy alcohol use. Among all people aged 12 to 20 in 2015, 13.4 percent were binge drinkers, and 3.3 percent were heavy drinkers. About 2 out of 5 young adults aged 18 to 25 were current binge alcohol users, and 1 out of every 10 young adults were heavy alcohol users.

Substance Use Disorders

In 2015, approximately 20.8 million people aged 12 or older had a substance use disorder (SUD) related to their use of alcohol or illicit drugs in the past year,[2] including 15.7 million people who had an alcohol use disorder and 7.7 million people who had an illicit drug use disorder. The percentage of people aged 12 or older with an alcohol use disorder (5.9 percent) in 2015 was lower than the percentages in 2002 to 2014. Due to revisions to the NSDUH illicit drug questions, estimates in 2015 for any illicit drug use disorder are not compared with estimates from previous years.

Substance Use Treatment

In 2015, an estimated 21.7 million people aged 12 or older needed substance use treatment (i.e., treatment for problems related to the use of alcohol or illicit drugs), or about 1 in 12 people (8.1 percent). For NSDUH, people are defined as needing substance use treatment if they had an SUD in the past year or if they received substance use treatment at a specialty facility in the past year.[3]

In 2015, 10.8 percent of people aged 12 or older (2.3 million people) who needed substance use treatment received treatment at a specialty facility in the past year.

Mental Health Issues among Adults

In 2015, an estimated 43.4 million adults aged 18 or older (17.9 percent) had any mental illness (AMI) in the past year. An estimated 9.8 million adults in the nation had a serious mental illness (SMI) in the past year, representing 4.0 percent of all U.S. adults in 2015.[4] The percentage of adults with AMI and the percentage of adults with SMI remained stable from 2008 to 2015. In 2015, 6.7 percent of adults aged 18 or older (16.1 million adults) had at least one major depressive episode (MDE) in the past year, and 4.3 percent (10.3 million adults) had an MDE with severe impairment in the past year.[5] The percentage of adults who had a past year MDE remained stable between 2005 and 2015.

Mental Health Service Use among Adults

In 2015, an estimated 34.2 million adults (14.2 percent of adults) received mental health care during the past 12 months. Among the 43.4 million adults with AMI, 18.6 million (43.1 percent) received mental health services in the past year. About 6.4 million of the 9.8 million adults with past year SMI (65.3 percent) received mental health services in the past year. The percentage of adults with AMI who received mental health care in 2015 was similar to the percentages in most years from 2008 to 2014. Use of mental health services among adults with SMI remained relatively steady across years between 2008 and 2015.

---

[2] People who met the criteria for dependence or abuse for alcohol or illicit drugs in the past 12 months based on criteria specified in the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition (DSM-IV), were defined as having an SUD. See the following reference: American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (DSM-IV) (4th ed.). Washington, DC: Author.

[3] Specialty treatment refers to substance use treatment at a hospital (only as an inpatient), a drug or alcohol rehabilitation facility (as an inpatient or outpatient), or a mental health center.

[4] Adults with AMI were defined as having any mental, behavioral, or emotional disorder in the past year that met DSM-IV criteria (excluding developmental disorders and SUDs). Adults with AMI were defined as having SMI if they had any mental, behavioral, or emotional disorder that substantially interfered with or limited one or more major life activities. See footnote 2 for the reference for the DSM-IV criteria.

[5] Based on DSM-IV criteria, adults and youths were defined as having an MDE if they had a period of 2 weeks or longer in the past 12 months when they experienced a depressed mood or loss of interest or pleasure in daily activities, and they had at least some additional symptoms, such as problems with sleep, eating, energy, concentration, and self-worth. Some wordings to the questions for adolescents were designed to make them more developmentally appropriate for youths. Adults and youths were defined as having an MDE with severe impairment if their depression caused severe problems in carrying out life activities in four developmentally appropriate role domains. For adults, these domains were the ability to manage at home, manage well at work, have relationships with others, or have a social life. For youths, these domains were the ability to do chores at home, do well at work or school, get along with their family, or have a social life. See footnote 2 for the reference for the DSM-IV criteria.

OHCA 000093

Co-Occurring Mental Illness and Substance Use Disorders among Adults

An estimated 8.1 million adults (3.3 percent of all adults) had both AMI and SUDs in the past year, and 2.3 million adults (1.0 percent of all adults) had co-occurring SMI and SUDs in the past year. Among the 8.1 million adults with co-occurring AMI and an SUD in the past year, 48.0 percent received either substance use treatment at a specialty facility or mental health care in the past year. Among the 2.3 million adults who had co-occurring SMI and an SUD in the past year, 62.6 percent received either substance use treatment at a specialty facility or mental health care in the past year.

Mental Health Issues among Adolescents

In 2015, 12.5 percent of adolescents aged 12 to 17 (3.0 million adolescents) had an MDE during the past year, and 8.8 percent of adolescents (2.1 million adolescents) had a past year MDE with severe impairment.[5] The percentage of adolescents in 2015 who had a past year MDE was higher than the percentages in 2004 to 2014. Among the 3.0 million adolescents in 2015 who had a past year MDE, 1.2 million (39.3 percent) received treatment for depression. This 2015 percentage was similar to the percentages in most years from 2004 to 2014.

Co-Occurring MDE and Substance Use among Adolescents

In 2015, the percentage of adolescents who used illicit drugs in the past year was higher among those with a past year MDE than it was among those without a past year MDE (31.5 vs. 15.3 percent). An estimated 350,000 adolescents in 2015 had an SUD and an MDE in the past year. This number represents 1.4 percent of all adolescents in the United States. Among adolescents who had a co-occurring MDE and an SUD in the past year, 63.1 percent received either substance use treatment at a specialty facility or mental health services in the past year.

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Introduction

Substance use and mental health issues affect millions of adolescents and adults in the United States and contribute heavily to the burden of disease.[1,2,3] The National Survey on Drug Use and Health (NSDUH) is the primary source for statistical information on illicit drug use, alcohol use, substance use disorders (SUDs), and mental health issues for the civilian, noninstitutionalized population of the United States. Information on mental health and substance use allows the Substance Abuse and Mental Health Services Administration (SAMHSA) and other policymakers to gauge progress toward improving the health of the nation.

The benefit of using NSDUH data to assess trends across time has to be balanced with the periodic need to revise NSDUH content to address changes in society and emerging issues. Although minor changes may sometimes be made annually, the 2015 NSDUH included a wide array of changes that affected the reporting of trends for many NSDUH estimates.

This report contains one of the first sets of findings from the 2015 NSDUH for key substance use and mental health indicators in the United States. Comprehensive 2015 NSDUH detailed tables that show additional substance use and mental health-related outcomes, including data for various subpopulations covered in NSDUH, are available separately at http://www.samhsa.gov/data/.[4]

Survey Background

NSDUH is an annual survey of the civilian, noninstitutionalized population of the United States aged 12 years old or older.[5] The survey is sponsored by SAMHSA within the U.S. Department of Health and Human Services (HHS). The survey covers residents of households and individuals in noninstitutional group quarters (e.g., shelters, boarding houses, college dormitories, migratory workers' camps, halfway houses). The survey excludes people with no fixed address (e.g., homeless people not in shelters), military personnel on active duty, and residents of institutional group quarters, such as jails, nursing homes, mental institutions, and long-term care hospitals.

NSDUH employs a stratified multistage area probability sample that is designed to be representative of both the nation as a whole and for each of the 50 states and the District of Columbia. The 2015 NSDUH annual target sample size of 67,500 interviews was distributed across three age groups, with 25 percent allocated to adolescents aged 12 to 17, 25 percent allocated to young adults aged 18 to 25, and 50 percent allocated to adults aged 26 or older. From 2002 through 2013, the NSDUH sample was allocated equally across these three age groups. Although the sample design changed in 2014, NSDUH had the same total target sample size per year of 67,500 interviews between 2002 and 2015.[6]

NSDUH is a face-to-face household interview survey that is conducted in two phases: the screening phase and the interview phase. The interviewer conducts a screening of the eligible household with an adult resident (aged 18 or older) in order to determine whether zero, one, or two residents aged 12 or older should be selected for the interview.[7] NSDUH collects data using audio computer-assisted self-interviewing (ACASI) in which respondents read or listen to the questions on headphones, then enter their answers directly into a NSDUH laptop computer. ACASI is designed for accurate reporting of information by providing respondents with a highly private and confidential mode for responding to questions about illicit drug use, mental health, and other sensitive behaviors. NSDUH also uses computer-assisted personal interviewing (CAPI) in which interviewers read less sensitive questions to respondents and enter the respondents' answers into a NSDUH laptop computer.

In 2015, screening was completed at 132,210 addresses, and 68,073 completed interviews were obtained, including 16,955 interviews from adolescents aged 12 to 17 and 51,118 interviews from adults aged 18 or older. Weighted response rates for household screening and for interviewing were 79.7 and 69.3 percent, respectively, for an overall response rate of 55.2 percent for people aged 12 or older. The weighted interview response rates were 77.7 percent for adolescents and 68.4 percent for adults.[8] Further details about the 2015 NSDUH design and methods can be found on the web at http://www.samhsa.gov/data/.[9]

Notable 2015 NSDUH Questionnaire Changes

The NSDUH questionnaire underwent a partial redesign in 2015 to improve the quality of the NSDUH data and to address the changing needs of policymakers and researchers with regard to substance use and mental health issues. The prescription drug questions were redesigned to shift the focus from lifetime misuse to past year misuse. Additionally, questions were added about any past year prescription drug use rather than just misuse. New methamphetamine questions were added, replacing the methamphetamine questions that were previously asked within the context of

prescription stimulants. Substantial changes were also made to questions about smokeless tobacco, binge alcohol use, inhalants, and hallucinogens. These changes led to potential breaks in the comparability of 2015 estimates with estimates from prior years. Consequently, these changes potentially affected overall summary measures, such as illicit drug use, and other measures, such as initiation, SUD, and substance use treatment. Additionally, certain demographic items were changed as part of the partial redesign. Education questions were updated, and new questions were added on disability, English-language proficiency, sexual orientation of adults, and military families.

Due to these changes, only 2015 data are presented for certain estimates until comparability with prior years can be established. Trends will continue to be presented for items that are assumed to have remained comparable with earlier years. Details on the 2015 NSDUH questionnaire changes, reasons for the changes, and implications of the changes for NSDUH data users are included in a brief report on these questionnaire changes, in a report on the design changes for the 2014 and 2015 NSDUHs, and in the methodological summary and definitions report for 2015.[10,11,12]

Data Presentation and Interpretation

This report focuses on substance use and mental health in the United States based on NSDUH data from 2015 and earlier years.[13] Estimates of substance use and substance use treatment are presented for individuals aged 12 or older, adolescents, and adults.[14] However, estimates of mental health issues and mental health service use are not presented jointly for individuals aged 12 or older. Rather, these estimates are presented separately for adolescents aged 12 to 17 and adults aged 18 or older because adolescents and adults completed different sets of questions regarding mental health and mental health service utilization.

All estimates (e.g., percentages and numbers) presented in the report are derived from NSDUH survey data that are subject to sampling errors. The estimates have met the criteria for statistical precision. Estimates that do not meet these criteria have been suppressed and are not shown.[15] Trend analyses in this report focus on percentages because the percentages take into account any change in the size of the total population and facilitate the comparison of estimates across years.[16] This report focuses on long-term trends by comparing percentages in 2015 with percentages in each of the years from 2002 to 2014. Statistical tests also have been conducted for comparisons that appear in the text of the report. Statistically significant differences are described using terms such as "higher," "lower," "increased," or "decreased." Statements use terms such as "similar," "remained steady," or "stable" when a difference is not statistically significant. Analyses of long-term trends in this report summarize whether the 2015 estimates are different from or similar to estimates in most or all previous years,[17] while minimizing discussion of anomalous differences between any 2 years that can occur due to these estimates being based on samples.[18] Graphics and tables contain estimates that support the statements in this report, and supplementary tables of estimates (including standard errors) are included in Appendix A. Also, Appendix B provides a list of contributors, reviewers, and report production staff who worked on this report.

Illicit Drug Use

NSDUH obtains information on 10 categories of illicit drugs: marijuana, cocaine (including crack), heroin, hallucinogens, inhalants, and methamphetamine, as well as the misuse of prescription pain relievers, tranquilizers, stimulants, and sedatives; see the section on the misuse of psychotherapeutic drugs for the definition of misuse. Estimates of "illicit drug use" reported from NSDUH reflect the data from these 10 drug categories. Changes in measurement for 7 of the 10 illicit drug categories—hallucinogens, inhalants, methamphetamine, and the misuse of prescription pain relievers, tranquilizers, stimulants, and sedatives—may have affected the comparability of the measurement of these illicit drugs between 2015 and prior years. Therefore, only 2015 estimates are presented for these seven illicit drug categories. Also, only 2015 estimates are presented for the use of any illicit drug.

In 2015, an estimated 27.1 million Americans aged 12 or older were current (past month) illicit drug users, meaning that they had used an illicit drug during the month prior to the survey interview (Figure 1). The most commonly used illicit drug in the past month was marijuana, which was used by 22.2 million people aged 12 or older. An estimated 6.4 million people reported misusing psychotherapeutic drugs in the past month, including 3.8 million people who were misusers of prescription pain relievers. Thus, the number of current misusers of pain relievers was second to marijuana among specific illicit drugs. Smaller numbers of people in 2015 were current users of the other illicit drugs shown in Figure 1.[19]

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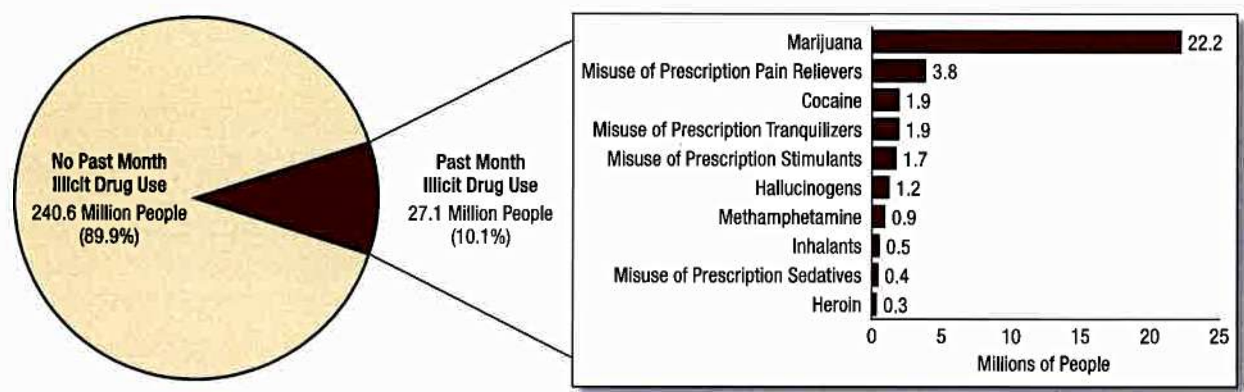
Figure 1. Numbers of Past Month Illicit Drug Users among People Aged 12 or Older: 2015



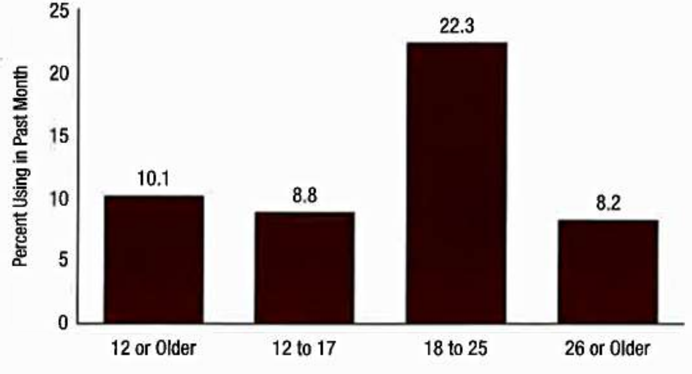
Note: Estimated numbers of people refer to people aged 12 or older in the civilian, noninstitutionalized population in the United States. The numbers do not sum to the total population of the United States because the population for NSDUH does not include people aged 11 years old or younger, people with no fixed household address (e.g., homeless or transient people not in shelters), active-duty military personnel, and residents of institutional group quarters, such as correctional facilities, nursing homes, mental institutions, and long-term care hospitals.

Note: The estimated numbers of current users of different illicit drugs are not mutually exclusive because people could have used more than one type of illicit drug in the past month.

Any Illicit Drug Use

The estimated 27.1 million people aged 12 or older who were current illicit drug users in 2015 (Figure 1) represent 10.1 percent of the population aged 12 or older (Figure 2). Stated another way, 1 in 10 individuals aged 12 or older in the United States used illicit drugs in the past month. Approximately 2.2 million adolescents aged 12 to 17 in 2015 were current users of illicit drugs, which represents 8.8 percent of adolescents. Approximately 1 in 5 young adults aged 18 to 25 (22.3 percent) were current users of illicit drugs in 2015. This percentage corresponds to about 7.8 million young adults in 2015 who were current users of illicit drugs. In 2015, 8.2 percent of adults aged 26 or older were current users of illicit drugs, or about 17.1 million adults in this age group.

Figure 2. Past Month Illicit Drug Use among People Aged 12 or Older, by Age Group: Percentages, 2015



Marijuana Use

As noted in the illicit drug use section, an estimated 22.2 million Americans aged 12 or older in 2015 were current users of marijuana (Figure 1). This number of past month marijuana users corresponds to 8.3 percent of the population aged 12 or older (Figure 3). The percentage of people aged 12 or older who were current marijuana users in 2015 was similar to the percentage in 2014, but it was higher than the percentages from 2002 to 2013. This increase in marijuana use among people aged 12 or older reflects the increase in marijuana use by adults aged 26 or older and, to a lesser extent, increases in marijuana use among young adults aged 18 to 25.

Aged 12 to 17

In 2015, 7.0 percent of adolescents aged 12 to 17 were current users of marijuana (Figure 3). This means that approximately 1.8 million adolescents used marijuana in the past month. The percentage of adolescents in 2015 who were current marijuana users was similar to the percentages in most years between 2004 and 2014.

Aged 18 to 25

In 2015, about 1 in 5 young adults aged 18 to 25 (19.8 percent) were current users of marijuana (Figure 3). This means that 6.9 million young adults used marijuana in the past month. The percentage of young adults who were current marijuana users in 2015 was stable compared with the percentages between 2011 and 2014. However, the 2015 estimate was higher than the estimates in 2002 through 2010.

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Aged 26 or Older

In 2015, 6.5 percent of adults aged 26 or older were current users of marijuana (Figure 3), which represents about 13.6 million adults in this age group. The percentage of adults aged 26 or older who were current marijuana users in 2015 was similar to the percentage in 2014, but it was higher than the percentages in 2002 to 2013.

Misuse of Psychotherapeutic Drugs

Because of the changes that were made to the prescription drug questions in 2015, a new baseline started in 2015 for all prescription drug measures. The four categories of prescription drugs (pain relievers, tranquilizers, stimulants, and sedatives) cover numerous medications that currently are or have been available by prescription. NSDUH respondents are asked to report misuse of these drugs, defined as use in any way not directed by a doctor, including use without a prescription of one's own; use in greater amounts, more often, or longer than told to take a drug; or use in any other way not directed by a doctor. Misuse of over-the-counter drugs is not included. NSDUH reports combine the four prescription drug groups into a category referred to as "psychotherapeutics." Additional information on the revisions to the NSDUH prescription drug questions are documented in a separate 2015 NSDUH report on prescription drugs.[20] The report for prescription drugs also includes new content, such as estimates of any use of prescription drugs (i.e., not just misuse), and motivations for misusing prescription drugs.

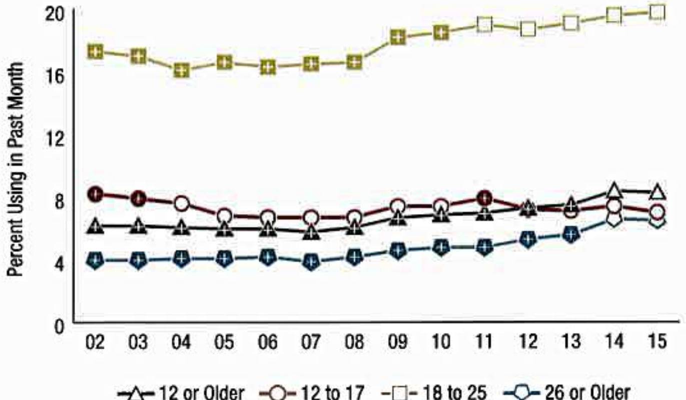
In this section, a summary of current misuse of any prescription psychotherapeutic drug is presented first, followed by sections on the current misuse of pain relievers, tranquilizers, stimulants, and sedatives. In 2015, an estimated 6.4 million Americans aged 12 or older were current misusers of psychotherapeutic drugs, which represent 2.4 percent of the population aged 12 or older (Figure 4). An estimated 492,000 adolescents aged 12 to 17 misused psychotherapeutic drugs in the past month. Stated another way, about 1 in 50 adolescents (2.0 percent) were current misusers of psychotherapeutic drugs. An estimated 1.8 million young adults aged 18 to 25 were current misusers of psychotherapeutic drugs, which corresponds to 5.1 percent of young adults. There were 4.1 million adults aged 26 or older who were current misusers of psychotherapeutic drugs, or 2.0 percent of adults in this age group.

Pain Reliever Misuse

Overall estimates of current prescription psychotherapeutic drug misuse in 2015 among the population aged 12 or older that were described previously were largely driven by the misuse of prescription pain relievers. In 2015, about three fifths of the current misusers of psychotherapeutic drugs who were aged 12 or older reported misusing pain relievers in the past month (Figure 5).

An estimated 3.8 million people aged 12 or older in 2015 were current misusers of pain relievers, which represents 1.4 percent of the population aged 12 or older (Figures 5

Figure 3. Past Month Marijuana Use among People Aged 12 or Older, by Age Group: Percentages, 2002-2015



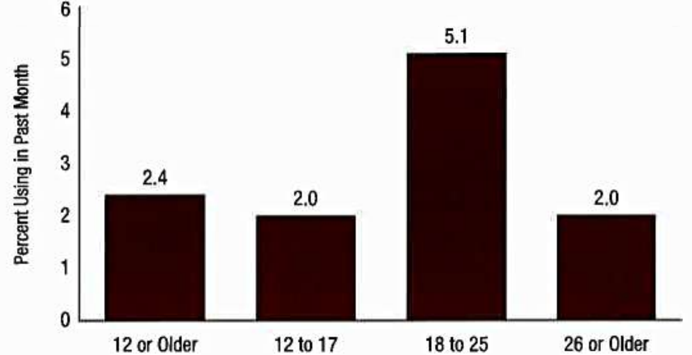
+ Difference between this estimate and the 2015 estimate is statistically significant at the .05 level.

Figure 3 Table. Past Month Marijuana Use among People Aged 12 or Older, by Age Group: Percentages, 2002-2015

Age	02	03	04	05	06	07	08	09	10	11	12	13	14	15
≥12	6.2+	6.2+	6.1+	6.0+	6.0+	5.8+	6.1+	6.7+	6.9+	7.0+	7.3+	7.5+	8.4	8.3
12-17	8.2+	7.9+	7.6	6.8	6.7	6.7	6.7	7.4	7.4	7.9+	7.2	7.1	7.4	7.0
18-25	17.3+	17.0+	16.1+	16.6+	16.3+	16.5+	16.6+	18.2+	18.5+	19.0	18.7	19.1	19.6	19.8
≥26	4.0+	4.0+	4.1+	4.1+	4.2+	3.9+	4.2+	4.6+	4.8+	4.8+	5.3+	5.6+	6.6	6.5

+ Difference between this estimate and the 2015 estimate is statistically significant at the .05 level.

Figure 4. Past Month Misuse of Prescription Psychotherapeutics among People Aged 12 or Older, by Age Group: Percentages, 2015



and 6). In 2015, an estimated 276,000 adolescents aged 12 to 17 were current misusers of pain relievers, which corresponds to 1.1 percent of adolescents (Figure 6). An estimated 829,000 young adults aged 18 to 25 misused pain relievers in the past month, which represents 2.4 percent of young adults. An estimated 2.7 million adults aged 26 or older were current misusers of pain relievers, which corresponds to 1.3 percent of adults aged 26 or older.

Tranquilizer Misuse

An estimated 1.9 million people aged 12 or older in 2015 were current misusers of tranquilizers, which represents 0.7 percent of people aged 12 or older (Figures 1 and 6). In 2015, an estimated 162,000 adolescents aged 12 to 17 were current misusers of tranquilizers, which represents 0.7 percent of adolescents (Figure 6). An estimated 582,000 young adults aged 18 to 25 misused tranquilizers in the past month, which represents 1.7 percent of young adults. In 2015, an estimated 1.1 million adults aged 26 or older were current misusers of tranquilizers, which corresponds to 0.5 percent of adults in this age group.

Stimulant Misuse

In 2015, an estimated 1.7 million people aged 12 or older, or 0.6 percent of this population, were current misusers of stimulants (Figures 1 and 6). About 117,000 adolescents aged 12 to 17 were current misusers of stimulants in 2015, corresponding to about 0.5 percent of adolescents (Figure 6). There were about 757,000 young adults aged 18 to 25 in 2015 who misused stimulants in the past month, which corresponds to about 2.2 percent of young adults in 2015. In 2015, an estimated 779,000 adults aged 26 or older were current misusers of stimulants, which represents 0.4 percent of this age group.

Sedative Misuse

An estimated 446,000 people aged 12 or older were current misusers of sedatives in 2015, which rounds to the 0.4 million people shown in Figure 1. This number represents 0.2 percent of the population aged 12 or older (Figure 6). There were an estimated 21,000 adolescents in 2015 who were current misusers of sedatives (0.1 percent of adolescents). In 2015, an estimated 86,000 young adults aged 18 to 25 misused sedatives in the past month (0.2 percent of young adults). An estimated 340,000 adults aged 26 or older were current misusers of sedatives in 2015 (0.2 percent of adults aged 26 or older).

Cocaine Use

In this report, estimates of the use of cocaine include use of crack cocaine. Estimates also are presented separately for crack use. In 2015, the estimate of about 1.9 million people aged 12 or older who were current users of cocaine (Figure 1) included about 394,000 current users of crack. These numbers correspond to about 0.7 percent of the population aged 12 or older who were current users of cocaine (Figure 7) and 0.1 percent who were current users of crack (Table A.1B in Appendix A). The 2015 estimate for current cocaine use was similar to the estimates in most years between 2007 and 2013, but it was higher than the estimate in 2014. The 2015 estimate of crack use was similar to the estimates in most years from 2008 to 2014. The 2015 estimates of both cocaine and crack use were lower than most of the estimates between 2002 and 2006.

Figure 5. Misuse of Prescription Pain Relievers and Other Prescription Psychotherapeutics among People Aged 12 or Older Who Were Current Misusers of Any Prescription Psychotherapeutics: 2015

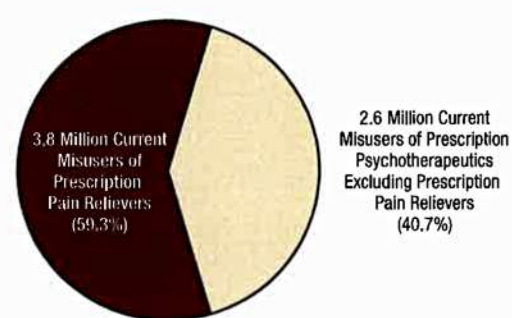
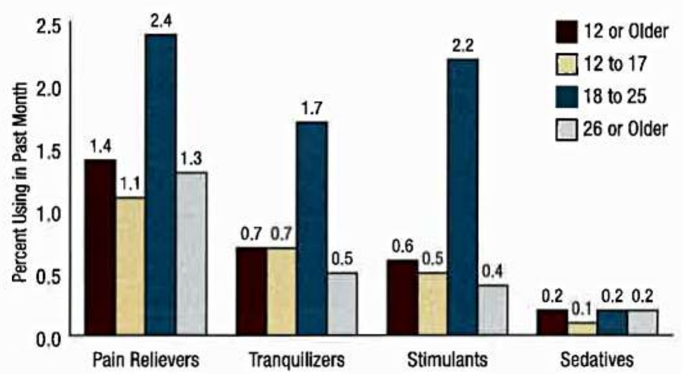


Figure 6. Past Month Misuse of Prescription Pain Relievers, Tranquilizers, Stimulants, and Sedatives among People Aged 12 or Older, by Age Group: Percentages, 2015



Aged 12 to 17

There were 53,000 adolescents aged 12 to 17 who were current users of cocaine in 2015. This number who used cocaine represents 0.2 percent of adolescents (Figure 7). The 2015 estimate for current cocaine use among adolescents was similar to the estimates between 2009 and 2014, but the 2015 estimate was lower than the estimates in the years from 2002 to 2008. Where estimates had sufficient precision to be reported, estimates of crack use among adolescents in 2002 to 2015 ranged from less than 0.1 percent to 0.1 percent (Table A.2B in Appendix A).

Aged 18 to 25

An estimated 1.7 percent of young adults aged 18 to 25 were current users of cocaine in 2015 (Figure 7), and 0.1 percent used crack in the past month (Table A.3B in Appendix A). These percentages represent 580,000 young adults who used cocaine, including 39,000 who used crack. The 2015 percentage of young adults who were current cocaine users was lower than the percentages in 2002 through 2006, and it was similar to the percentages in most years between 2007 and 2014. The estimate of current crack use among young adults in 2015 was similar to estimates between 2007 and 2014.

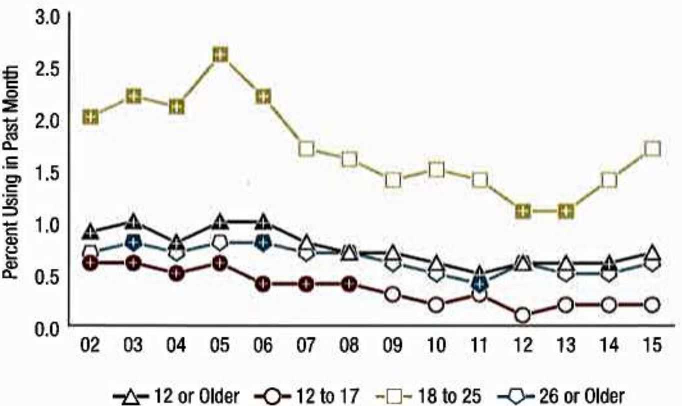
Aged 26 or Older

In 2014, 0.6 percent of adults aged 26 or older were current users of cocaine (Figure 7), and 0.2 percent used crack in the past month (Table A.4B in Appendix A). These percentages represent 1.2 million adults aged 26 or older who currently used cocaine, including 354,000 who currently used crack. The 2015 estimate of current cocaine use among adults aged 26 or older was similar to the estimates from most years between 2002 and 2014. Current use of crack was stable between 2008 and 2015, but the 2015 estimate was lower than the estimates in most years from 2002 to 2007.

Heroin Use

Heroin is a highly addictive opioid that is illegal and has no accepted medical use in the United States. About 329,000 people aged 12 or older were current heroin users in 2015, which rounds to the 0.3 million people shown in Figure 1. This number corresponds to about 0.1 percent of the population aged 12 or older (Figure 8). Because heroin use is not as common as the use of other illicit drugs, monitoring both past month and past year heroin use provides additional context for interpreting the trends. For past year

Figure 7. Past Month Cocaine Use among People Aged 12 or Older, by Age Group: Percentages, 2002-2015



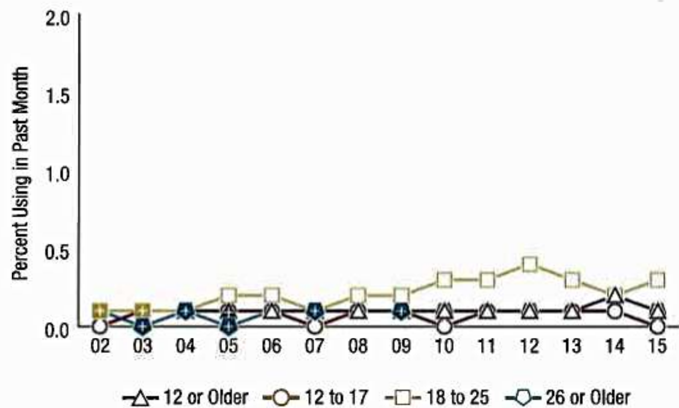
+ Difference between this estimate and the 2015 estimate is statistically significant at the .05 level.

Figure 7 Table. Past Month Cocaine Use among People Aged 12 or Older, by Age Group: Percentages, 2002-2015

Age	02	03	04	05	06	07	08	09	10	11	12	13	14	15
≥12	0.9+	1.0+	0.8+	1.0+	1.0+	0.8	0.7	0.7	0.6	0.5+	0.6	0.6	0.6+	0.7
12-17	0.6+	0.6+	0.5+	0.6+	0.4+	0.4+	0.4+	0.3	0.2	0.3	0.1	0.2	0.2	0.2
18-25	2.0+	2.2+	2.1+	2.6+	2.2+	1.7	1.6	1.4	1.5	1.4	1.1+	1.1+	1.4	1.7
≥26	0.7	0.8+	0.7	0.8	0.8+	0.7	0.7	0.6	0.5	0.4+	0.6	0.5	0.5	0.6

+ Difference between this estimate and the 2015 estimate is statistically significant at the .05 level.

Figure 8. Past Month Heroin Use among People Aged 12 or Older, by Age Group: Percentages, 2002-2015



+ Difference between this estimate and the 2015 estimate is statistically significant at the .05 level.

Figure 8 Table. Past Month Heroin Use among People Aged 12 or Older, by Age Group: Percentages, 2002-2015

Age	02	03	04	05	06	07	08	09	10	11	12	13	14	15
≥12	0.1+	0.1+	0.1+	0.1+	0.1	0.1+	0.1	0.1+	0.1	0.1	0.1	0.1	0.2	0.1
12-17	0.0	0.1	0.1	0.1	0.1	0.0	0.1	0.1	0.0	0.1	*	0.1	0.1	0.0
18-25	0.1+	0.1+	0.1	0.2	0.2	0.1	0.2	0.2	0.3	0.3	0.4	0.3	0.2	0.3
≥26	0.1	0.0+	0.1+	0.0+	0.1	0.1+	0.1	0.1+	0.1	0.1	0.1	0.1	0.2	0.1

+ Difference between this estimate and the 2015 estimate is statistically significant at the .05 level.

* Low precision; no estimate reported.

Note: Estimates of 0.0 percent round to less than 0.1 percent when shown to the nearest tenth of a percent.

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use, 0.3 percent of people aged 12 or older in 2015 had used heroin (Figure 9), which represents about 828,000 people.

Despite the dangers associated with heroin use, its use has increased in recent years. The estimate of current heroin use in 2015 among people aged 12 or older was higher than the estimates in most years between 2002 and 2009, but it was similar to the estimates between 2010 and 2014 (Figure 8). However, even when there was a statistically significant difference between the 2015 estimate and prior years, the percentages were approximately the same, except for the estimate in 2014 (0.2 percent). For example, all of these estimates for current heroin use rounded to 0.1 percent. In 2014, the estimate of current heroin use was higher than in all previous years; however, the 2015 estimate does not provide strong support that the increase in 2014 signaled the start of a change in the trend. Future survey years will be useful for monitoring this trend.

The estimate of past year heroin use in 2015 (0.3 percent) was also higher than the estimates for most years between 2002 and 2008, but it was similar to the estimates between 2009 and 2014 (Figure 9). This shift in heroin use among people aged 12 or older reflects changes in heroin use by adults aged 26 or older and, to a lesser extent, smaller increases in heroin use among young adults aged 18 to 25.

Aged 12 to 17

In 2015, less than 0.1 percent of adolescents aged 12 to 17 were current heroin users (Figure 8), and 0.1 percent were past year users (Figure 9). These percentages represent 21,000 adolescents who used heroin in the past year, including 5,000 adolescents who were current users of heroin. The percentage of adolescents in 2015 who were current heroin users was similar to available estimates for heroin use in 2002 to 2014. The percentage of adolescents in 2015 who were past year heroin users was similar to the percentages in most years from 2005 through 2014.

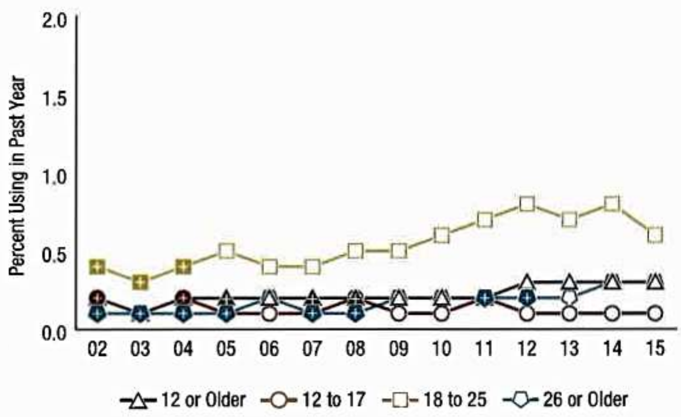
Aged 18 to 25

Among young adults aged 18 to 25 in 2015, 0.3 percent were current heroin users (Figure 8), and 0.6 percent were past year users (Figure 9). These percentages represent 217,000 young adults who used heroin in the past year, including 88,000 who were current users of heroin. The percentage of young adults in 2015 who were current heroin users (0.3 percent) was higher than the percentages in 2002 and 2003, and it was similar to the percentages in 2004 through 2014. The percentages of young adults who were past year heroin users were similar between 2005 and 2015 (ranging from 0.4 to 0.8 percent), but the percentage in 2015 (0.6 percent) was higher than the percentages from 2002 through 2004 (ranging from 0.3 to 0.4 percent).

Aged 26 or Older

In 2015, 0.1 percent of adults aged 26 or older were current heroin users (Figure 8), and 0.3 percent were past year users (Figure 9). These percentages represent 591,000 adults aged 26 or older who used heroin in the past year, including 236,000 who were current users of heroin. The percentage of adults aged 26 or older in 2015 who were current heroin users (0.1 percent) was similar to the percentages for most years between 2008 and 2014, but it was higher than the percentages for most years between 2002 and 2007 (ranging from less than 0.1 to 0.1 percent). The percentage of adults aged 26 or older in 2015 who were past year heroin users (0.3 percent) was similar to the percentages for most years between 2009 and 2014, but it was higher than the percentages in most years from 2002 to 2008.

Figure 9. Past Year Heroin Use among People Aged 12 or Older, by Age Group: Percentages, 2002-2015



+Difference between this estimate and the 2015 estimate is statistically significant at the .05 level.

Figure 9 Table. Past Year Heroin Use among People Aged 12 or Older, by Age Group: Percentages, 2002-2015

Age	02	03	04	05	06	07	08	09	10	11	12	13	14	15
≥12	0.2+	0.1+	0.2+	0.2+	0.2	0.2+	0.2+	0.2	0.2	0.2	0.3	0.3	0.3	0.3
12-17	0.2+	0.1	0.2+	0.1	0.1	0.1	0.2	0.1	0.1	0.2+	0.1	0.1	0.1	0.1
18-25	0.4+	0.3+	0.4+	0.5	0.4	0.4	0.5	0.5	0.6	0.7	0.8	0.7	0.8	0.6
≥26	0.1+	0.1+	0.1+	0.1+	0.2	0.1+	0.1+	0.2	0.2	0.2+	0.2+	0.2	0.3	0.3

+ Difference between this estimate and the 2015 estimate is statistically significant at the .05 level.

Hallucinogen Use

Several drugs are grouped under the category of hallucinogens, including LSD, PCP, peyote, mescaline, psilocybin mushrooms, "Ecstasy" (MDMA or "Molly"), ketamine, DMT/AMT/"Foxy," and *Salvia divinorum*.[21] The 2015 estimates for hallucinogen use are presented in this section. In 2015, the NSDUH estimate of any hallucinogen use was expanded to include the use of ketamine, DMT/AMT/"Foxy," and *Salvia divinorum*. Because of this change, estimates of hallucinogen use in 2015 are not compared with estimates in prior years.

In 2015, an estimated 1.2 million people aged 12 or older were current users of hallucinogens (Figure 1), representing 0.5 percent of the population aged 12 or older (Figure 10). An estimated 121,000 adolescents aged 12 to 17 were current users of hallucinogens in 2015, or 0.5 percent of adolescents. In 2015, 1.8 percent of young adults aged 18 to 25 were current users of hallucinogens, which represents 636,000 young adults who used hallucinogens. An estimated 0.2 percent of adults aged 26 or older were current users of hallucinogens in 2015, which represents 482,000 individuals in this age group who were using hallucinogens.

Inhalant Use

Inhalants include a variety of substances, such as nitrous oxide, amyl nitrite, cleaning fluids, gasoline, spray paint, computer keyboard cleaner, other aerosol sprays, felt-tip pens, and glue. Respondents are asked to report the use of inhalants to get high, but not to include accidental inhalation of a substance. In 2015, the NSDUH estimate of inhalant use was expanded to include the use of felt-tip pens or computer keyboard cleaner to get high. Because of this change, estimates of inhalant use in 2015 are not compared with estimates in prior years.

In 2015, approximately 527,000 people aged 12 or older were current users of inhalants, which rounds to the estimate of 0.5 million people shown in Figure 1. This number represents 0.2 percent of the population aged 12 or older (Figure 11). Current use of inhalants in 2015 was more common among adolescents aged 12 to 17 than among people in other age groups. Percentages of people in different age groups who were current users of inhalants in 2015 were 0.7 percent of adolescents, 0.4 percent of young adults aged 18 to 25, and 0.1 percent of adults aged 26 or older (Figure 11). About 175,000 adolescents, 126,000 young adults, and 226,000 adults aged 26 or older were current users of inhalants in 2015.

Methamphetamine Use

Prior to 2015, questions about methamphetamine use were asked in the context of questions about the misuse of prescription stimulants because methamphetamine is legally available by prescription (Desoxyn®). However, most methamphetamine that is now used in the United States is produced and distributed illicitly rather than through the pharmaceutical industry. Therefore, for 2015, a new set of questions specific to methamphetamine was created and administered separately from the questions about the misuse of prescription stimulants. Because of these changes, estimates of methamphetamine use in 2015 are not compared with estimates from prior years.

In 2015, approximately 897,000 people aged 12 or older were current users of methamphetamine, which rounds to the estimate of 0.9 million people shown in Figure 1. This number represents 0.3 percent of the population aged 12 or older (Figure 12). About 13,000 adolescents aged 12 to 17 were current methamphetamine users in 2015. This number corresponds to about 0.1 percent of adolescents in 2015

Figure 10. Past Month Hallucinogen Use among People Aged 12 or Older, by Age Group: Percentages, 2015

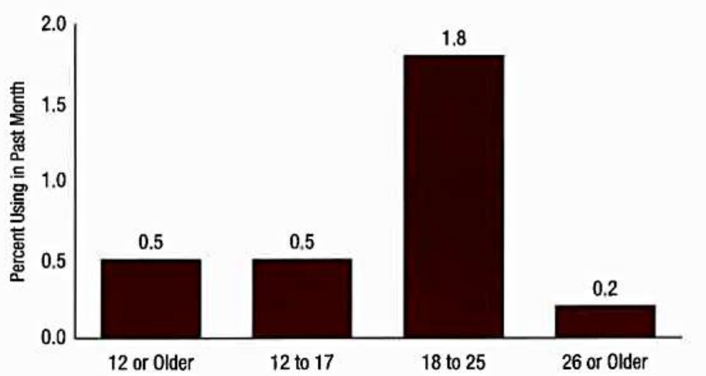
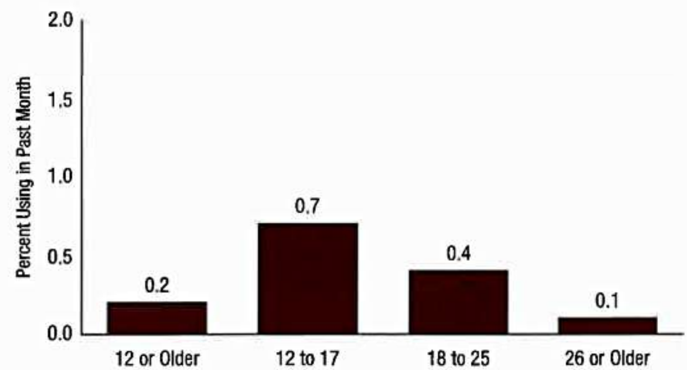


Figure 11. Past Month Inhalant Use among People Aged 12 or Older, by Age Group: Percentages, 2015



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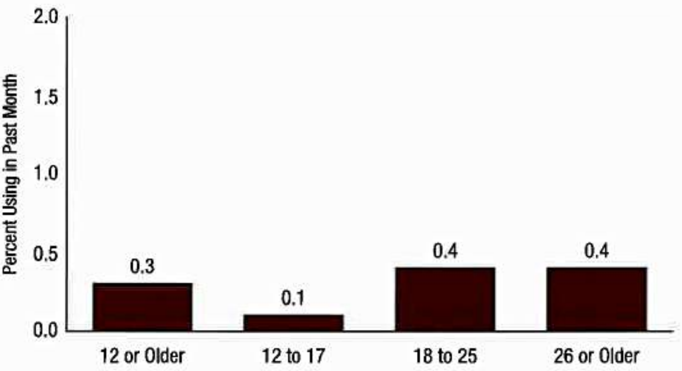
being current methamphetamine users. There were about 128,000 young adults aged 18 to 25 in 2015 who used methamphetamine in the past month, which corresponds to about 0.4 percent of young adults (Figure 12). In 2015, an estimated 757,000 adults aged 26 or older used methamphetamine, which represents 0.4 percent of this age group.

Figure 12. Past Month Methamphetamine Use among People Aged 12 or Older, by Age Group: Percentages, 2015



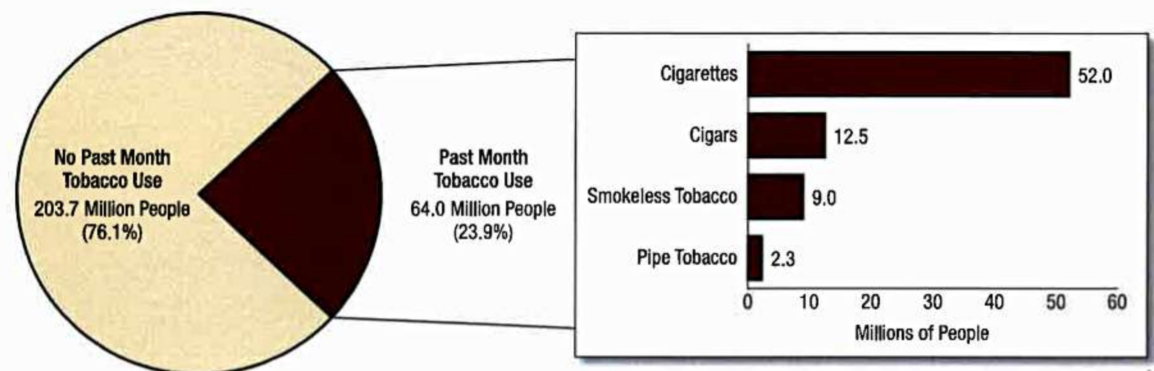
Tobacco Use

Tobacco use continues to be the leading cause of preventable death in the United States. Tobacco use, particularly cigarette smoking, imposes substantial health and financial costs on our nation.[22,23] NSDUH data can be used to estimate the percentage of individuals who used tobacco products and, in turn, can be used to monitor changes in use over time. NSDUH asks respondents aged 12 or older about their tobacco use in the 30 days before the interview. Tobacco products include cigarettes, smokeless tobacco (such as snuff, dip, chewing tobacco, or "snus"), cigars, and pipe tobacco. Cigarette use is defined as smoking "part or all of a cigarette." A discussion of the estimates for daily cigarette smoking follows a presentation of the estimates for any current cigarette smoking. Finally, this section presents estimates for current use of cigars, pipe tobacco, and smokeless tobacco.

In 2015, respondents were asked about their use of any smokeless tobacco product (i.e., instead of being asked separately about their use of snuff and chewing tobacco) because data from prior years indicated that respondents had difficulty distinguishing between these types of smokeless tobacco. Due to these changes, estimates of smokeless tobacco use in 2015 are not compared with estimates in prior years.

The majority of current (i.e., past month) tobacco users in 2015 were current cigarette smokers (Figure 13), as has been the case historically.[24] Among current users of any tobacco product aged 12 or older in 2015, 66.3 percent smoked cigarettes but did not use other tobacco products, 15.0 percent smoked cigarettes and used some other type of tobacco product, and 18.8 percent used only tobacco products other than cigarettes (Figure 14). This same pattern was observed across the three age groups in 2015 (adolescents aged 12 to 17, young adults aged 18 to 25, and adults aged 26 or older), with most current tobacco use consisting only of cigarette smoking, followed by the use of tobacco products other than cigarettes or the use of both cigarettes and other tobacco products. Among young adults and adults aged 26 or older who were current users of tobacco products, about 20 percent did not smoke cigarettes (19.0 and 18.4 percent, respectively). In contrast, among adolescents who were current tobacco users,

Figure 13. Past Month Tobacco Use among People Aged 12 or Older: 2015



Note: The estimated numbers of current users of different tobacco products are not mutually exclusive because people could have used more than one type of tobacco product in the past month.

OHCA 000104

30.3 percent used tobacco products other than cigarettes but did not smoke cigarettes. In addition, about one fourth of adolescents and young adults who were current tobacco users smoked cigarettes and used other tobacco products (26.0 and 23.6 percent, respectively). Among adults aged 26 or older who were current tobacco users, about 1 in 8 (12.7 percent) were current cigarette smokers and current users of other tobacco products.

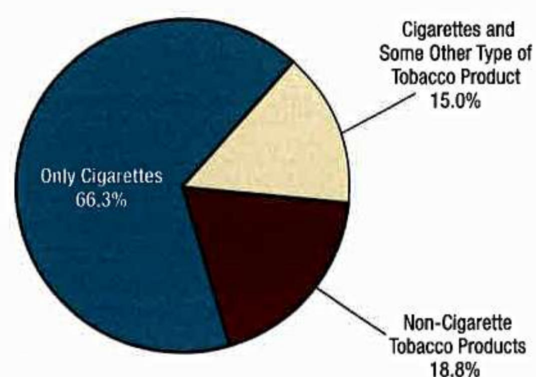
Cigarette Use

In 2015, an estimated 52.0 million people aged 12 or older were current cigarette smokers (Figure 13). This number corresponds to 19.4 percent of the population being current cigarette smokers (Figure 15). Past month cigarette use among the population aged 12 or older was lower in 2015 than in 2002 to 2014. Stated another way, about 1 in 5 people aged 12 or older in 2015 were current cigarette smokers. In comparison, about 1 in 4 people aged 12 or older were current cigarette smokers in 2002 to 2008 (ranging from 24.0 to 26.0 percent). Although cigarette smoking has declined, some of this decline may reflect the use of electronic vaporizing devices for delivering nicotine, such as e-cigarettes. For example, recent research indicates that more than a quarter million middle school and high school students in 2013 (263,000) never smoked a conventional cigarette but used e-cigarettes.[25] Future research on both cigarette use and e-cigarette use is needed to continue monitoring these developments; however, NSDUH does not currently ask direct questions about e-cigarette use.

Aged 12 to 17

Among adolescents aged 12 to 17 in 2015, 1.0 million smoked cigarettes in the past month. This number represents 4.2 percent adolescents who were current cigarette smokers (Figure 15). The percentage of adolescents who were past month cigarette smokers declined from 13.0 percent in 2002 (or about 1 in 8 adolescents) to 4.2 percent in 2015 (or fewer than 1 in 20). The percentage of adolescents who were current cigarette smokers in 2015 also was lower than the percentages in each year from 2002 to 2014.

Figure 14. Type of Past Month Tobacco Use among Current Tobacco Users Aged 12 or Older: Percentages, 2015



Note: The percentages do not add to 100 percent due to rounding.

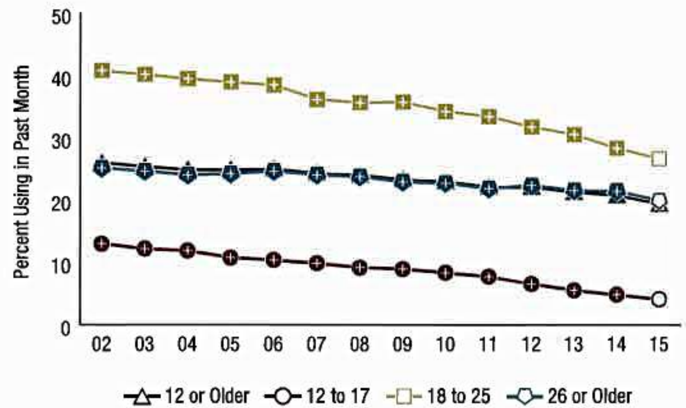
Aged 18 to 25

Among young adults aged 18 to 25 in 2015, 9.3 million smoked cigarettes in the past month. This number of young adults who were current cigarette smokers represents about one quarter of young adults (26.7 percent) (Figure 15). The percentage of young adults who were current cigarette smokers in 2015 was lower than the percentages in 2002 to 2014.

Aged 26 or Older

In 2015, 41.6 million adults aged 26 or older smoked cigarettes in the past month. Stated another way, 1 out of 5 adults aged 26 or older (20.0 percent) were current cigarette smokers in 2015 (Figure 15). The 2015 estimate for current cigarette smoking among adults in this age group was lower than the estimates from 2002 to 2014.

Figure 15. Past Month Cigarette Use among People Aged 12 or Older, by Age Group: Percentages, 2002-2015



+ Difference between this estimate and the 2015 estimate is statistically significant at the .05 level.

Figure 15 Table. Past Month Cigarette Use among People Aged 12 or Older, by Age Group: Percentages, 2002-2015

Age	02	03	04	05	06	07	08	09	10	11	12	13	14	15
≥12	26.0+	25.4+	24.9+	24.9+	25.0+	24.3+	24.0+	23.3+	23.0+	22.1+	22.1+	21.3+	20.8+	19.4
12-17	13.0+	12.2+	11.9+	10.8+	10.4+	9.9+	9.2+	9.0+	8.4+	7.8+	6.6+	5.6+	4.9+	4.2
18-25	40.8+	40.2+	39.5+	39.0+	38.5+	36.2+	35.7+	35.8+	34.3+	33.5+	31.8+	30.6+	28.4+	26.7
≥26	25.2+	24.7+	24.1+	24.3+	24.7+	24.1+	23.8+	23.0+	22.8+	21.9+	22.4+	21.6+	21.5+	20.0

+ Difference between this estimate and the 2015 estimate is statistically significant at the .05 level.

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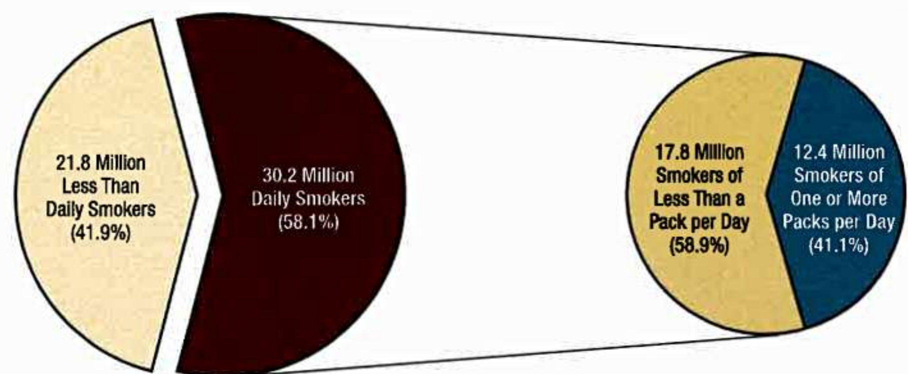
Figure 16. Daily Cigarette Use among Past Month Cigarette Smokers Aged 12 or Older and Smoking of One or More Packs of Cigarettes per Day among Current Daily Smokers: Percentages, 2015



Note: Current daily smokers with unknown data about the number of cigarettes smoked per day were excluded from the pie graph on the right.

Daily Cigarette Use

Among the 52.0 million current cigarette smokers aged 12 or older in 2015, 30.2 million were daily cigarette smokers. The 30.2 million daily smokers represent 58.1 percent of current cigarette smokers (Figure 16). Thus, about three fifths of current cigarette smokers in 2015 smoked cigarettes daily. The percentage of current smokers aged 12 or older in 2015 who smoked cigarettes daily was lower than the percentages in most years from 2002 to 2012, but it was similar to the percentages in 2013 and 2014 (Table 1).

Among the 30.2 million daily smokers aged 12 or older in 2015, 12.4 million reported smoking 16 or more cigarettes per day (i.e., approximately one pack or more per day). Stated another way, about 2 out of 5 daily smokers (41.1 percent) reported smoking a pack or more of cigarettes per day (Figures 16 and 17). The percentage of daily smokers aged 12 or older who smoked one or more packs of cigarettes per day was lower in 2015 than the percentages in 2002 to 2011.

Aged 12 to 17

In 2015, about 208,000 adolescents aged 12 to 17 smoked cigarettes every day in the past month, which represents about one fifth (20.0 percent) of adolescents who were current smokers (Table 1). The 2015 percentage was lower than the percentages in 2002 and 2007, but it was similar to the percentages in 2008 to 2014. The percentage of adolescent daily smokers who smoked one or more packs of cigarettes per day was lower in 2015 (7.8 percent) than in 2002 to 2011 (Figure 17).

Aged 18 to 25

About 3.9 million young adults aged 18 to 25 in 2015 were daily cigarette smokers in the past month, or 42.0 percent of young adults who were current cigarette smokers (Table 1). Thus, about 2 in 5 young adults in 2015 who were current cigarette users smoked cigarettes daily. The percentage of young adult current smokers who smoked cigarettes daily in 2015 was lower than the percentages in years from 2002

Table 1. Daily Cigarette Use among Past Month Cigarette Smokers Aged 12 or Older, by Age Group: Percentages, 2002-2015

Age Group	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
12 or Older	63.4+	62.9+	62.3+	63.0+	62.3+	61.3+	61.5+	61.0+	59.5	60.7+	60.7+	59.6	58.8	58.1
12 to 17	31.8+	29.7+	27.6+	25.8+	26.5+	26.4+	22.3	23.0	22.5	22.7	22.0	19.4	24.1	20.0
18 to 25	51.8+	52.7+	51.6+	50.1+	48.8+	49.2+	47.8+	45.3+	45.8+	45.3+	45.1+	43.1	43.0	42.0
26 or Older	68.8+	68.0+	67.8+	68.9+	67.9+	66.3+	67.0+	67.2+	64.8	66.5+	66.0+	64.9	63.3	62.7

+ Difference between this estimate and the 2015 estimate is statistically significant at the .05 level.

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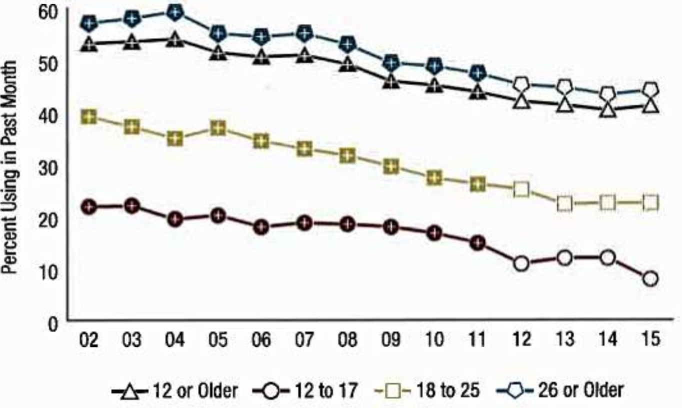
to 2012, and it was similar to the percentages in 2013 and 2014. The percentage of young adult daily smokers who smoked one or more packs of cigarettes per day was lower in 2015 (22.5 percent) than in 2002 to 2011 (Figure 17).

Aged 26 or Older

In 2015, about 26.1 million adults aged 26 or older smoked cigarettes every day in the past month, which represents 62.7 percent of the adults aged 26 or older who were current smokers (Table 1). The percentage of current smokers aged 26 or older in 2015 who smoked cigarettes every day was lower than the percentages in most years from 2002 to 2012, but it was similar to the percentages in 2013 and 2014. Despite the decline since 2002, when nearly 70 percent of current smokers aged 26 or older were daily smokers, more than three fifths of current smokers in this age group in 2015 were daily smokers. Among daily smokers aged 26 or older, the percentage who smoked one or more packs of cigarettes per day was lower in 2015 (44.1 percent) than in 2002 to 2011, but the percentage was stable between 2012 and 2015 (Figure 17).

Figure 17. Smokers of One or More Packs of Cigarettes per Day among Past Month Daily Cigarette Smokers Aged 12 or Older, by Age Group: Percentages, 2002-2015



+Difference between this estimate and the 2015 estimate is statistically significant at the .05 level.

Figure 17 Table. Smokers of One or More Packs of Cigarettes per Day among Past Month Daily Cigarette Smokers Aged 12 or Older, by Age Group: Percentages, 2002-2015

Age	02	03	04	05	06	07	08	09	10	11	12	13	14	15
≥12	53.1+	53.5+	54.0+	51.4+	50.6+	50.9+	49.2+	45.9+	45.1+	43.8+	42.0	41.3	40.3	41.1
12-17	21.8+	22.0+	19.4+	20.1+	17.9+	18.7+	18.4+	17.9+	16.7+	14.8+	10.8	11.9	11.9	7.8
18-25	39.1+	37.1+	34.9+	36.9+	34.4+	32.9+	31.6+	29.5+	27.3+	26.1+	25.1	22.3	22.5	22.5
≥26	57.1+	58.0+	59.2+	55.1+	54.5+	55.1+	53.0+	49.4+	48.8+	47.4+	45.2	44.7	43.3	44.1

+ Difference between this estimate and the 2015 estimate is statistically significant at the .05 level.

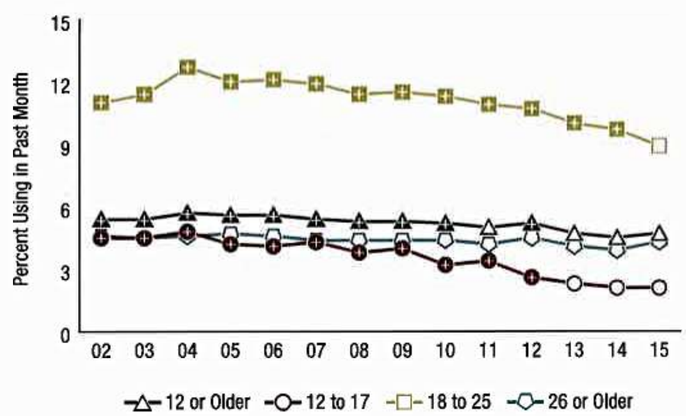
Cigar and Pipe Tobacco Use

An estimated 12.5 million people aged 12 or older in 2015 were current cigar smokers, and 2.3 million were current pipe tobacco smokers (Figure 13). These numbers correspond to 4.7 percent of the population aged 12 or older who were current cigar smokers (Figure 18) and 0.8 percent who were current pipe tobacco smokers (Figure 19). Among people aged 12 or older, the percentage who were current cigar smokers was lower in 2015 than in most years between 2002 and 2012, but it was similar to the percentages in 2013 and 2014. The percentage of people who were current pipe tobacco smokers in 2015 was similar to the percentages in most years between 2002 and 2014.

Aged 12 to 17

Among adolescents aged 12 to 17 in 2015, 517,000 smoked cigars, and 84,000 smoked pipe tobacco in the past month. These numbers indicate that 2.1 percent of adolescents were current cigar smokers (Figure 18) and 0.3 percent were current pipe tobacco smokers in 2015 (Figure 19). A lower percentage of adolescents in 2015 were current cigar smokers

Figure 18. Past Month Cigar Use among People Aged 12 or Older, by Age Group: Percentages, 2002-2015



+Difference between this estimate and the 2015 estimate is statistically significant at the .05 level.

Figure 18 Table. Past Month Cigar Use among People Aged 12 or Older, by Age Group: Percentages, 2002-2015

Age	02	03	04	05	06	07	08	09	10	11	12	13	14	15
≥12	5.4+	5.4+	5.7+	5.6+	5.6+	5.4+	5.3+	5.3+	5.2+	5.0	5.2+	4.7	4.5	4.7
12-17	4.5+	4.5+	4.8+	4.2+	4.1+	4.3+	3.8+	4.0+	3.2+	3.4+	2.6+	2.3	2.1	2.1
18-25	11.0+	11.4+	12.7+	12.0+	12.1+	11.9+	11.4+	11.5+	11.3+	10.9+	10.7+	10.0+	9.7+	8.9
≥26	4.6	4.5	4.6	4.7	4.6	4.4	4.4	4.4	4.4	4.2	4.5	4.1	3.9	4.3

+ Difference between this estimate and the 2015 estimate is statistically significant at the .05 level.

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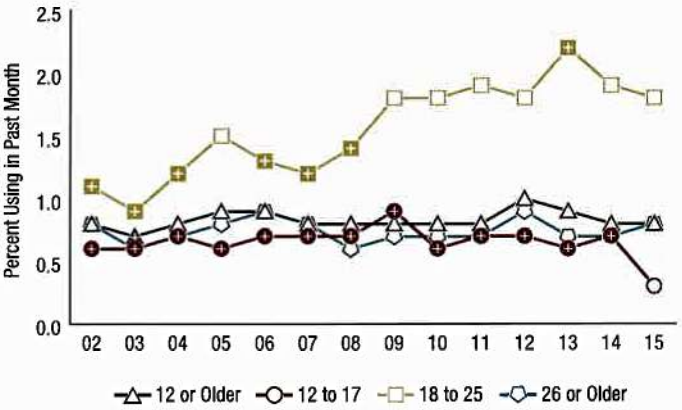
than in 2002 to 2012, although the 2015 estimate was similar to the estimates in 2013 and 2014. The estimate for current pipe tobacco smoking among adolescents in 2015 was lower than the estimates in 2002 to 2014.

Aged 18 to 25

In 2015, 3.1 million young adults aged 18 to 25 smoked cigars, and 0.6 million smoked pipe tobacco. These numbers indicate that 8.9 percent of young adults were current cigar smokers (Figure 18) and 1.8 percent were current pipe tobacco smokers in 2015 (Figure 19). The percentage of young adults in 2015 who were current cigar smokers was lower than in 2002 to 2014. The percentage of young adults in 2015 who were current pipe tobacco smokers was greater than the percentages in most years from 2002 to 2008, but the 2015 estimate was similar to the estimates in most years from 2009 to 2014. Although the percentage of young adults who were current pipe tobacco smokers increased relative to the percentages in 2002 to 2008 and was fairly stable after 2008, current smoking of pipe tobacco among young adults in 2015 was less common than the use of other types of tobacco.

Figure 19. Past Month Pipe Tobacco Use among People Aged 12 or Older, by Age Group: Percentages, 2002-2015



+Difference between this estimate and the 2015 estimate is statistically significant at the .05 level.

Figure 19 Table. Past Month Pipe Tobacco Use among People Aged 12 or Older, by Age Group: Percentages, 2002-2015

Age	02	03	04	05	06	07	08	09	10	11	12	13	14	15
≥12	0.8	0.7+	0.8	0.9	0.9	0.8	0.8	0.8	0.8	0.8	1.0	0.9	0.8	0.8
12-17	0.6+	0.6+	0.7+	0.6+	0.7+	0.7+	0.7+	0.9+	0.6+	0.7+	0.7+	0.6+	0.7+	0.3
18-25	1.1+	0.9+	1.2+	1.5	1.3+	1.2+	1.4+	1.8	1.8	1.9	1.8	2.2+	1.9	1.8
≥26	0.8	0.6	0.7	0.8	0.9	0.8	0.6	0.7	0.7	0.7	0.9	0.7	0.7	0.8

+Difference between this estimate and the 2015 estimate is statistically significant at the .05 level.

Aged 26 or Older

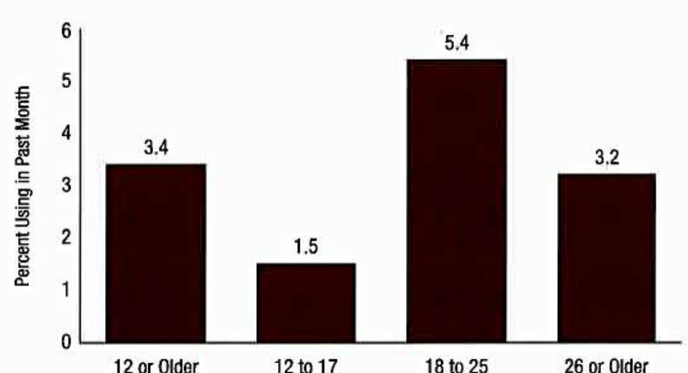
About 8.9 million adults aged 26 or older in 2015 smoked cigars, and 1.6 million smoked pipe tobacco. These numbers correspond to current cigar smoking by 4.3 percent of adults aged 26 or older (Figure 18) and current pipe tobacco smoking by 0.8 percent of adults in this age group (Figure 19). The 2015 estimates for current cigar use and current pipe tobacco smoking among adults aged 26 or older were similar to estimates between 2002 and 2014.

Smokeless Tobacco Use

As noted previously, questions on snuff and chewing tobacco were combined into a single set of questions about smokeless tobacco in 2015, and a moist tobacco powder referred to as snus was added as an example of smokeless tobacco. This change resulted in a new baseline being established in 2015 for measuring trends in smokeless tobacco use. Consequently, comparisons are not made between estimates of smokeless tobacco use in 2015 and those in prior years.

An estimated 9.0 million people aged 12 or older in 2015 were current smokeless tobacco users (Figure 13). This number of current smokeless tobacco users corresponds to 3.4 percent of the population aged 12 or older (Figure 20). In 2015, about 367,000 adolescents aged 12 to 17 used smokeless tobacco in the past month, or 1.5 percent of adolescents. An estimated 1.9 million young adults aged 18 to 25 used smokeless tobacco in the past month, or 5.4 percent of young adults. About 6.7 million adults aged 26 or older in 2015 used smokeless tobacco in the past month, which represents 3.2 percent of adults in this age group.

Figure 20. Past Month Smokeless Tobacco Use among People Aged 12 or Older, by Age Group: Percentages, 2015

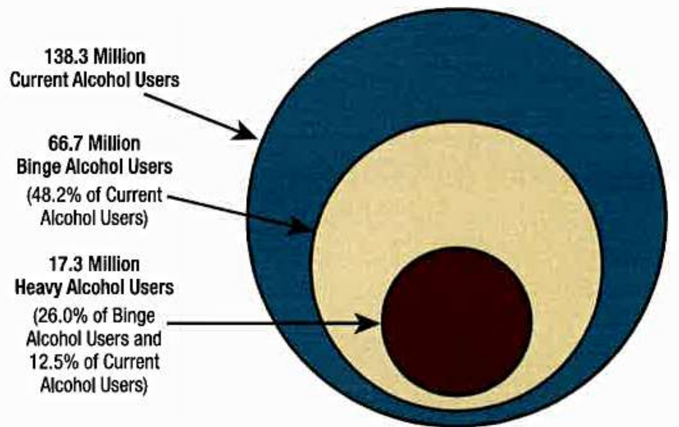


Alcohol Use

NSDUH asks respondents aged 12 or older about their alcohol use in the 30 days before the interview. Current alcohol use is defined as any use of alcohol in the past 30 days. In addition to asking about any alcohol use, NSDUH collects information on binge alcohol use and heavy alcohol use.[26] Consistent with federal definitions[27] and other federal data collections, the NSDUH definition for binge alcohol use varies for males and females. Binge drinking for males is defined as drinking five or more drinks on the same occasion on at least 1 day in the past 30 days, which is the same as the definition of binge alcohol use that was applied to males in prior years. For females, binge alcohol use is defined in 2015 as drinking four or more drinks on the same occasion on at least 1 day in the past 30 days. The threshold of four or more drinks for females differs from the threshold of five or more drinks that was used in prior years. Heavy alcohol use is defined as binge drinking on 5 or more days in the past 30 days based on the thresholds that were described previously for males and females. Any alcohol use, binge drinking, and heavy drinking are not mutually exclusive categories of use; heavy use is included in estimates of binge and current use, and binge use is included in estimates of current use (Figure 21). Because of these changes to the definition of binge alcohol use in NSDUH, estimates of binge and heavy alcohol use in 2015 are presented in this report, but these 2015 estimates are not compared with estimates from prior years.[28]

In 2015, 138.3 million Americans aged 12 or older reported current use of alcohol, 66.7 million reported binge alcohol use in the past month, and 17.3 million reported heavy alcohol use in the past month (Figure 21). Thus, nearly half of current alcohol users reported binge alcohol use (48.2 percent), and about 1 in 8 current alcohol users reported heavy alcohol use (12.5 percent). Among binge alcohol users, about 1 in 4 (26.0 percent) were heavy users.

Figure 21. Current, Binge, and Heavy Alcohol Use among People Aged 12 or Older: 2015

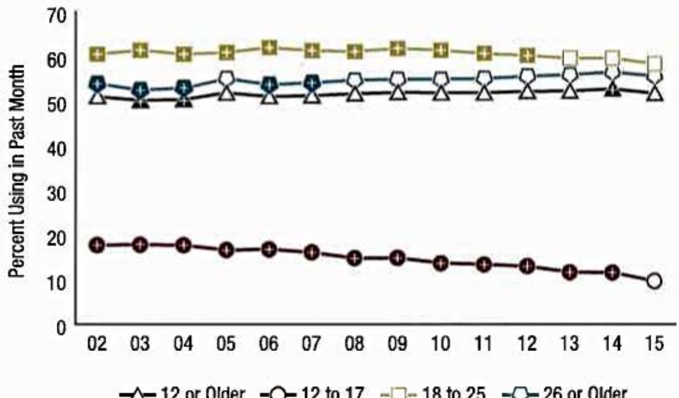


Note: In 2015, the threshold for determining binge alcohol use for females changed from five or more drinks on an occasion to four or more drinks on an occasion.

Current Alcohol Use

The estimate of 138.3 million current alcohol users aged 12 or older in 2015 (Figure 21) corresponds to alcohol use in the past month by slightly more than half (51.7 percent) of people aged 12 or older (Figure 22). The 2015 estimate of past month alcohol use was similar to the estimate in 2005 to 2013, but it was lower than the 2014 estimate.

Figure 22. Past Month Alcohol Use among People Aged 12 or Older, by Age Group: Percentages, 2002-2015



+Difference between this estimate and the 2015 estimate is statistically significant at the .05 level.

Figure 22 Table. Past Month Alcohol Use among People Aged 12 or Older, by Age Group: Percentages, 2002-2015

Age	02	03	04	05	06	07	08	09	10	11	12	13	14	15
≥12	51.0	50.1+	50.3+	51.8	51.0	51.2	51.6	51.9	51.8	51.8	52.1	52.2	52.7+	51.7
12-17	17.6+	17.7+	17.6+	16.5+	16.7+	16.0+	14.7+	14.8+	13.6+	13.3+	12.9+	11.6+	11.5+	9.6
18-25	60.5+	61.4+	60.5+	60.9+	62.0+	61.3+	61.1+	61.8+	61.4+	60.7+	60.2+	59.6	59.6	58.3
≥26	53.9+	52.5+	53.0+	55.1	53.7+	54.1+	54.7	54.9	54.9	55.1	55.6	55.9	56.5	55.6

+Difference between this estimate and the 2015 estimate is statistically significant at the .05 level.

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Aged 12 to 17

The percentage of adolescents aged 12 to 17 who were current alcohol users was 9.6 percent in 2015 (Figure 22), which corresponds to 2.4 million adolescents in 2015 who drank alcohol in the past month. The percentage of adolescents who were current alcohol users in 2015 was lower than the percentages in 2002 through 2014. Although the estimate of current alcohol use among adolescents decreased between 2002 and 2015, about 1 in 10 adolescents aged 12 to 17 were current alcohol users in 2015.

Aged 18 to 25

In 2015, 58.3 percent of young adults aged 18 to 25 were current alcohol users (Figure 22), which corresponds to about 20.4 million young adults. The percentage of young adults in 2015 who drank alcohol in the past month was similar to the percentages in 2013 and 2014. Although the 2015 estimate was lower than the estimates in 2002 through 2012, about three fifths of young adults were current alcohol users in each year between 2002 and 2015 (ranging from 58.3 to 62.0 percent).

Aged 26 or Older

More than half (55.6 percent) of adults aged 26 or older in 2015 were current alcohol users (Figure 22). This percentage corresponds to about 115.6 million adults in this age group who drank alcohol in the past month. The percentage of adults aged 26 or older in 2015 who were current alcohol users was higher than the percentages in most years from 2002 to 2007, but it was similar to the percentages in 2008 to 2014. In each year between 2002 and 2015, however, more than half of adults aged 26 or older were current alcohol users (ranging from 52.5 to 56.5 percent).

Binge Alcohol Use

In 2015, an estimated 66.7 million people aged 12 or older were binge alcohol users in the past 30 days (Figure 21). This number of people who were current binge drinkers corresponds to about 1 in 4 people aged 12 or older (24.9 percent) (Figure 23). About 1.4 million adolescents aged 12 to 17 in 2015 were past month binge alcohol users, which corresponds to 5.8 percent of adolescents. Thus, about 1 in 17 adolescents aged 12 to 17 in 2015 were current binge drinkers. An estimated 39.0 percent of young adults aged 18 to 25 in 2015 were binge alcohol users in the past month, which corresponds to about 13.6 million young adults. Stated another way, about 2 out of 5 young adults in 2015 were current binge alcohol users. About a quarter (24.8 percent) of adults aged 26 or older in 2015 were current binge alcohol users. This percentage corresponds to about 51.6 million adults in this age group who were binge drinkers.

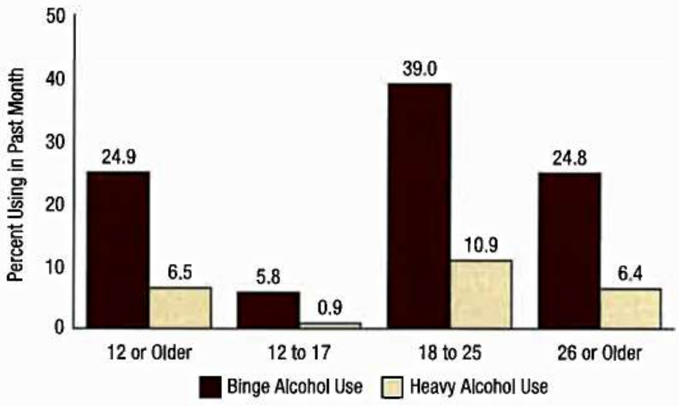
Heavy Alcohol Use

The estimate of 17.3 million people aged 12 or older in 2015 who were heavy alcohol users in the past month (Figure 21) represents 6.5 percent of the population aged 12 or older (Figure 23). In 2015, 221,000 adolescents aged 12 to 17 were current heavy alcohol users. Stated another way, about 1 out of 100 adolescents (0.9 percent) engaged in binge drinking on 5 or more days in the past 30 days. About 1 out of every 10 young adults aged 18 to 25 (10.9 percent) were heavy alcohol users in the past month, which corresponds to 3.8 million young adults. An estimated 6.4 percent of adults aged 26 or older in 2015 were current heavy alcohol users. This percentage corresponds to about 13.3 million adults aged 26 or older who were heavy alcohol users in the past month.

Underage Alcohol Use

All 50 states and the District of Columbia currently prohibit possession of alcoholic beverages by individuals younger than 21, and most prohibit underage consumption (i.e., consumption of alcoholic beverages prior to the age of 21).[29] In 2015, about 7.7 million people aged 12 to 20 reported drinking alcohol in the past month, including 5.1 million who reported binge alcohol use and 1.3 million who reported heavy alcohol use (Figure 24). Thus, about

Figure 23. Past Month Binge and Heavy Alcohol Use among People Aged 12 or Older, by Age Group: Percentages, 2015

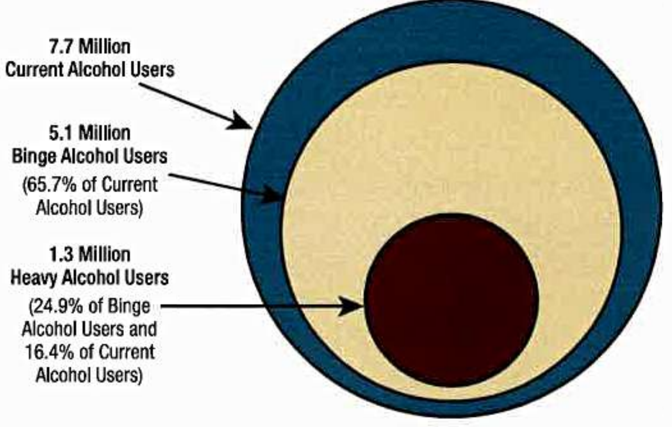


Note: In 2015, the threshold for determining binge alcohol use for females changed from five or more drinks on an occasion to four or more drinks on an occasion.

two thirds of underage current drinkers (65.7 percent) were binge alcohol users, and about 1 in 6 were heavy alcohol users (16.4 percent). About one fourth of underage binge alcohol users (24.9 percent) were heavy drinkers.

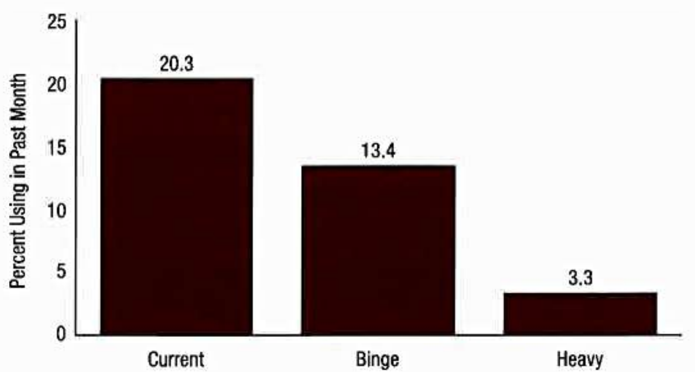
The estimate of 7.7 million underage people in 2015 who reported current alcohol use represents 20.3 percent of 12 to 20 year olds (Figure 25). Among all people aged 12 to 20 in 2015, 13.4 percent were binge drinkers, and 3.3 percent were heavy drinkers. The percentage of underage individuals who reported current alcohol use in 2015 was lower than the percentages in 2002 through 2014 (Figure 26). Despite these declines over time, about 1 in 5 individuals aged 12 to 20 in 2015 drank alcohol in the past month.

Figure 24. Current, Binge, and Heavy Alcohol Use among People Aged 12 to 20: 2015



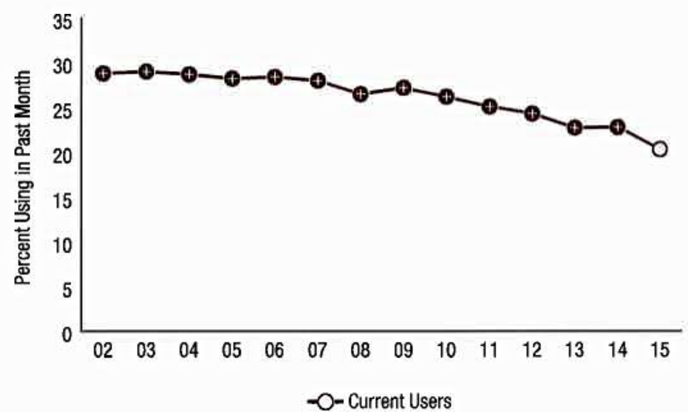
Note: In 2015, the threshold for determining binge alcohol use for females changed from five or more drinks on an occasion to four or more drinks on an occasion.

Figure 25. Current, Binge, and Heavy Alcohol Use among People Aged 12 to 20: Percentages, 2015



Note: In 2015, the threshold for determining binge alcohol use for females changed from five or more drinks on an occasion to four or more drinks on an occasion.

Figure 26. Current Alcohol Use among People Aged 12 to 20: Percentages, 2002-2015



+ Difference between this estimate and the 2015 estimate is statistically significant at the .05 level.

Figure 26 Table. Current Alcohol Use among People Aged 12 to 20: Percentages, 2002-2015

Use	02	03	04	05	06	07	08	09	10	11	12	13	14	15
Current	28.8+	29.0+	28.7+	28.2+	28.4+	28.0+	26.5+	27.2+	26.2+	25.1+	24.3+	22.7+	22.8+	20.3

+ Difference between this estimate and the 2015 estimate is statistically significant at the .05 level.

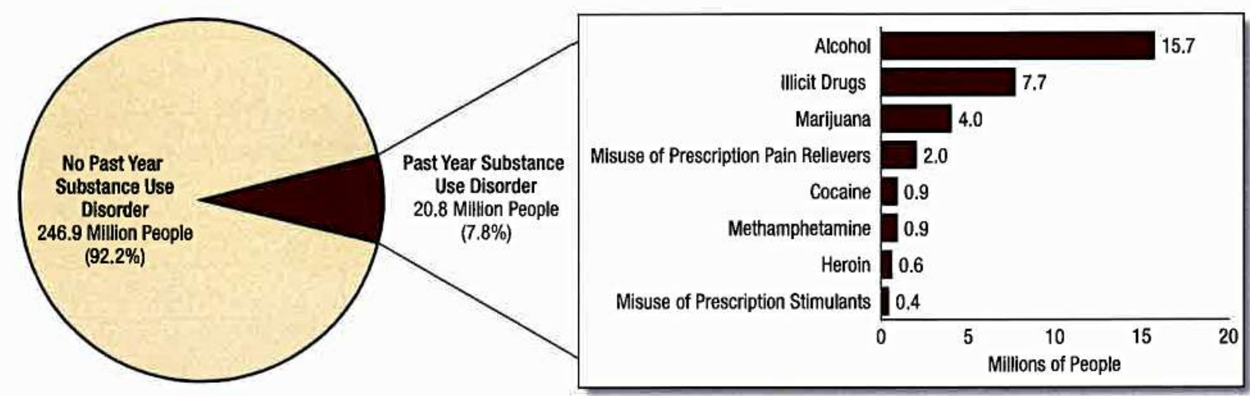
Substance Use Disorders in the Past Year

Substance use disorders (SUDs) represent clinically significant impairment caused by the recurrent use of alcohol or other drugs (or both), including health problems, disability, and failure to meet major responsibilities at work, school, or home. NSDUH includes a series of questions to estimate the percentage of the population aged 12 or older who had SUDs in the past 12 months. Respondents were asked questions about SUDs if they previously reported use in the past 12 months of alcohol or illicit drugs. Illicit drugs include marijuana, cocaine, heroin, hallucinogens, inhalants, methamphetamine, and the misuse of prescription psychotherapeutic drugs (i.e., pain relievers, tranquilizers, stimulants, and sedatives). These SUD questions classify people as having an SUD in the past 12 months and are based on criteria specified in the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition (DSM-IV).[30,31]

Because of changes that were described previously to the questions for the use of hallucinogens, inhalants, and methamphetamine and the misuse of prescription drugs, the sets of respondents who were asked the SUD questions for those drugs in 2015 could have differed from the corresponding sets of respondents who were asked these SUD questions in prior years. Consequently, the 2015 SUD estimates for those drugs are not comparable with

OHCA 000111

Figure 27. Numbers of People Aged 12 or Older with a Past Year Substance Use Disorder: 2015



Note: Estimated numbers of people refer to people aged 12 or older in the civilian, noninstitutionalized population in the United States. The numbers do not sum to the total population of the United States because the population for NSDUH does not include people aged 11 years old or younger, people with no fixed household address (e.g., homeless or transient people not in shelters), active-duty military personnel, and residents of institutional group quarters, such as correctional facilities, nursing homes, mental institutions, and long-term care hospitals.

Note: The estimated numbers of people with substance use disorders are not mutually exclusive because people could have use disorders for more than one substance.

the estimates from prior years. Also, questions were added in 2015 about SUD symptoms that respondents attributed specifically to their use of methamphetamine; prior to 2015, past year methamphetamine users were asked about SUD symptoms for the misuse of prescription stimulants. In addition, these changes are assumed to have affected the comparability of the overall SUD measures in 2015 with those prior to 2015 for illicit drugs and for any substance (i.e., illicit drugs or alcohol). Thus for these measures, the 2015 estimates are not compared with estimates from prior years. Because the questions did not change for alcohol, marijuana, cocaine, and heroin, estimates of SUDs for these substances in 2015 are assumed to have remained comparable with estimates from earlier years.

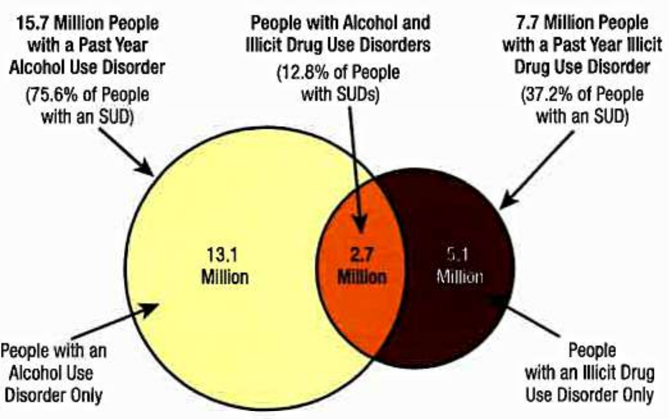
This section presents estimates for the most common SUDs among the population aged 12 or older. Estimates of less common SUDs are not discussed in this report (e.g., inhalant use disorder) but are available in Table A.12B in Appendix A.

Substance Use Disorder

In 2015, approximately 20.8 million people aged 12 or older had an SUD in the past year, including 15.7 million people who had an alcohol use disorder and 7.7 million people who had an illicit drug use disorder (Figure 27). An estimated 2.7 million people aged 12 or older had both an alcohol use disorder and an illicit drug use disorder in the past year (Figure 28). Thus, among people aged 12 or older in 2015 who had an SUD in the past year, nearly 3 out of 4 had an alcohol use disorder, and about 1 out of 3 had an illicit drug use disorder. About 1 in 8 people aged 12 or older who had SUDs in the past year had both an alcohol use disorder and an illicit drug use disorder.

Of the 7.7 million people aged 12 or older who had a past year SUD related to their use of illicit drugs, 4.0 million had a past year disorder related to their use of marijuana, and 2.0 million people had a disorder related to their misuse of prescription pain relievers (Figure 27). Smaller numbers of people in 2015 had disorders in the past year related to their use of cocaine or heroin.

Figure 28. Alcohol Use Disorder and Illicit Drug Use Disorder in the Past Year among People Aged 12 or Older with a Past Year Substance Use Disorder (SUD): 2015



20.8 Million People Aged 12 or Older with Past Year SUDs

The 20.8 million people who had SUDs in 2015 (Figure 27) represent 7.8 percent of people aged 12 or older (Figure 29). This percentage of people in 2015 who had SUDs corresponds to about 1 in 13 people aged 12 or older. An estimated 1.2 million adolescents aged 12 to 17 had SUDs in 2015, which represents 5.0 percent of adolescents, or about 1 in 20 adolescents. In 2015, 5.3 million young adults aged 18 to 25 had SUDs; this number of young adults with SUDs represents 15.3 percent of young adults, or about 1 in 7 young adults. An estimated 14.2 million adults aged 26 or older in 2015 had SUDs, which represents 6.9 percent of adults aged 26 or older, or about 1 in 15 adults in this age group.

Alcohol Use Disorder

The 15.7 million people aged 12 or older who had an alcohol use disorder in 2015 (Figures 27 and 28) represent 5.9 percent of people aged 12 or older (Figure 30), or about 1 in 17 people aged 12 or older. The percentage of people aged 12 or older with an alcohol use disorder in 2015 was lower than the percentages in 2002 to 2014.

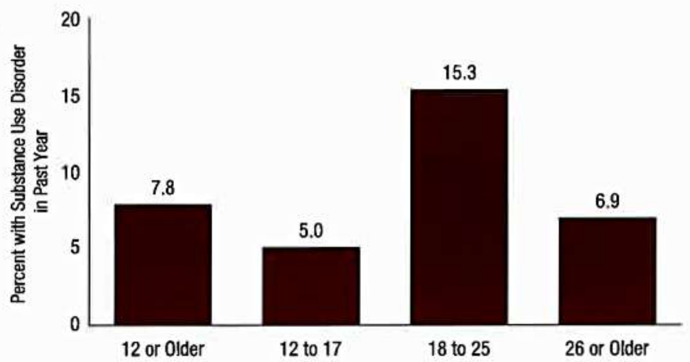
Aged 12 to 17

There were 623,000 adolescents aged 12 to 17 in 2015 with a past year alcohol use disorder, or 2.5 percent of adolescents (Figure 30). The percentage of adolescents with an alcohol use disorder in 2015 was lower than the percentages in 2002 to 2012, but it was similar to the percentages in 2013 and 2014. In particular, the percentage of adolescents in 2015 with an alcohol use disorder was roughly half the percentages in 2002 to 2008 (ranging from 4.9 to 6.0 percent).

Aged 18 to 25

Approximately 3.8 million young adults aged 18 to 25 in 2015 had an alcohol use disorder in the past year.

Figure 29. Substance Use Disorder in the Past Year among People Aged 12 or Older, by Age Group: Percentages, 2015



This number of young adults with an alcohol use disorder represents 10.9 percent of young adults (Figure 30). The percentage of young adults with an alcohol use disorder in 2015 was lower than the percentages in 2002 to 2014. Nevertheless, about 1 in 9 young adults in 2015 had an alcohol use disorder.

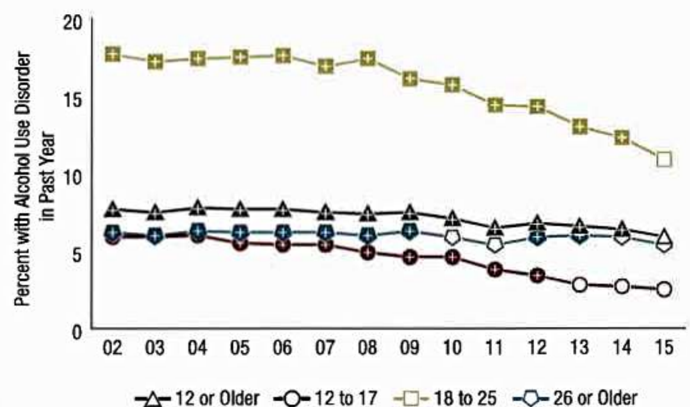
Aged 26 or Older

In 2015, approximately 11.3 million adults aged 26 or older had an alcohol use disorder in the past year, which represents 5.4 percent of the adults in this age group (Figure 30). The percentage of adults aged 26 or older with an alcohol use disorder in 2015 was lower than the percentages in most years from 2002 to 2013, but it was similar to the percentage in 2014.

Illicit Drug Use Disorder

The 7.7 million people aged 12 or older who had an illicit drug use disorder in 2015 (Figures 27 and 28) represent 2.9 percent of people aged 12 or older (Figure 31). An estimated 3.4 percent of adolescents aged 12 to 17 had an illicit drug use disorder in 2015, or about 855,000 adolescents. Approximately 2.5 million young adults aged

Figure 30. Alcohol Use Disorder in the Past Year among People Aged 12 or Older, by Age Group: Percentages, 2002-2015



+Difference between this estimate and the 2015 estimate is statistically significant at the .05 level.

Figure 30 Table. Alcohol Use Disorder in the Past Year among People Aged 12 or Older, by Age Group: Percentages, 2002-2015

Age	02	03	04	05	06	07	08	09	10	11	12	13	14	15
≥12	7.7+	7.5+	7.8+	7.7+	7.7+	7.5+	7.4+	7.5+	7.1+	6.5+	6.8+	6.6+	6.4+	5.9
12-17	5.9+	5.9+	6.0+	5.5+	5.4+	5.4+	4.9+	4.6+	4.6+	3.8+	3.4+	2.8	2.7	2.5
18-25	17.7+	17.2+	17.4+	17.5+	17.6+	16.9+	17.4+	16.1+	15.7+	14.4+	14.3+	13.0+	12.3+	10.9
≥26	6.2+	6.0+	6.3+	6.2+	6.2+	6.2+	6.0+	6.3+	5.9	5.4	5.9+	6.0+	5.9	5.4

+Difference between this estimate and the 2015 estimate is statistically significant at the .05 level.

OHCA 000113

18 to 25 in 2015 had an illicit drug use disorder in the past year, which represents 7.2 percent of young adults. In 2015, approximately 4.4 million adults aged 26 or older had an illicit drug use disorder in the past year, which represents 2.1 percent of adults aged 26 or older.

Marijuana Use Disorder

The approximately 4.0 million people aged 12 or older in 2015 who had a marijuana use disorder in the past year (Figure 27) represent 1.5 percent of people aged 12 or older (Figure 32). The 2015 percentage of the population aged 12 or older with a marijuana use disorder was lower than the percentages in most years between 2002 and 2010 and was similar to the percentages in 2011 to 2014.

Aged 12 to 17

In 2015, 2.6 percent of adolescents aged 12 to 17 had a marijuana use disorder in the past year (Figure 32), or about 651,000 adolescents. The percentage of adolescents with a marijuana use disorder in 2015 was lower than the percentages in 2002 to 2012, but it was similar to the percentages in 2013 and 2014.

Aged 18 to 25

Approximately 1.8 million young adults aged 18 to 25 in 2015 had a marijuana use disorder in the past year, or 5.1 percent of young adults (Figure 32). The percentage of young adults with a marijuana use disorder in 2015 was lower than the percentages in 2002 through 2005, but it was similar to the percentages in 2006 to 2014.

Aged 26 or Older

In 2015, approximately 1.6 million adults aged 26 or older had a marijuana use disorder in the past year, or 0.8 percent of adults in this age group (Figure 32). The 2015 percentage of adults aged 26 or older with a marijuana use disorder was similar to the percentages in all years between 2002 and 2014.

Cocaine Use Disorder

About 896,000 people aged 12 or older in 2015 had a cocaine use disorder in the past year, which rounds to the 0.9 million people shown in Figure 27. This number of people with a cocaine use disorder represents 0.3 percent of the population aged 12 or older (Figure 33). The percentage of the population aged 12 or older with a cocaine use disorder remained stable between 2010 and 2015. However, the percentage in 2015 was lower than the percentages in 2002 to 2009.

Aged 12 to 17

An estimated 0.1 percent of adolescents aged 12 to 17 in 2015 had a cocaine use disorder in the past year (Figure 33), or about 31,000 adolescents. The percentage of adolescents with a cocaine use disorder in 2015 was lower than the percentages in 2002 to 2008, but it was similar to the percentages in 2009 to 2014.

Figure 31. Illicit Drug Use Disorder in the Past Year among People Aged 12 or Older, by Age Group: Percentages, 2015

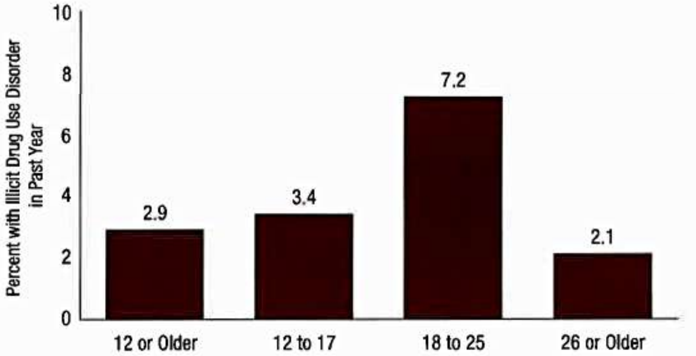
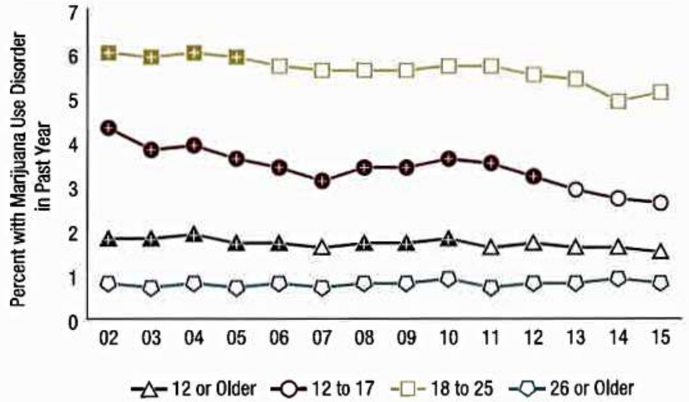


Figure 32. Marijuana Use Disorder in the Past Year among People Aged 12 or Older, by Age Group: Percentages, 2002-2015



+Difference between this estimate and the 2015 estimate is statistically significant at the .05 level.

Figure 32 Table. Marijuana Use Disorder in the Past Year among People Aged 12 or Older, by Age Group: Percentages, 2002-2015

Age	02	03	04	05	06	07	08	09	10	11	12	13	14	15
≥12	1.8+	1.8+	1.9+	1.7+	1.7+	1.6	1.7+	1.7+	1.8+	1.6	1.7	1.6	1.6	1.5
12-17	4.3+	3.8+	3.9+	3.6+	3.4+	3.1+	3.4+	3.4+	3.6+	3.5+	3.2+	2.9	2.7	2.6
18-25	6.0+	5.9+	6.0+	5.9+	5.7	5.6	5.6	5.6	5.7	5.7	5.5	5.4	4.9	5.1
≥26	0.8	0.7	0.8	0.7	0.8	0.7	0.8	0.8	0.9	0.7	0.8	0.8	0.9	0.8

+ Difference between this estimate and the 2015 estimate is statistically significant at the .05 level.

OHCA 000114

Aged 18 to 25

Approximately 229,000 young adults aged 18 to 25 in 2015 had a cocaine use disorder in the past year. This number represents 0.7 percent of young adults (Figure 33). Similar to the pattern for adolescents aged 12 to 17, the percentage of young adults with a cocaine use disorder in 2015 was lower than the percentages in 2002 to 2009, but it was similar to the percentages in 2010 to 2014.

Aged 26 or Older

In 2015, approximately 637,000 adults aged 26 or older had a cocaine use disorder in the past year, which represents 0.3 percent of adults in this age group (Figure 33). The percentage of adults aged 26 or older with a cocaine use disorder in 2015 was lower than the percentages in 2002 to 2008, but it remained steady when compared with the percentages between 2009 and 2014.

Heroin Use Disorder

About 591,000 people aged 12 or older in 2015 had a heroin use disorder, which rounds to the 0.6 million people shown in Figure 27. This number of people with a heroin use disorder represents 0.2 percent of people aged 12 or older (Figure 34). The percentage of people aged 12 or older with a heroin use disorder in 2015 was higher than the percentages in 2002 to 2010 (0.1 percent), but it was similar to the percentages in 2011 to 2014.

Aged 12 to 17

Less than 0.1 percent of adolescents aged 12 to 17 in 2015 had a heroin use disorder in the past year (Figure 34), which corresponds to about 6,000 adolescents. The percentage of adolescents with a heroin use disorder remained stable from 2002 to 2015.

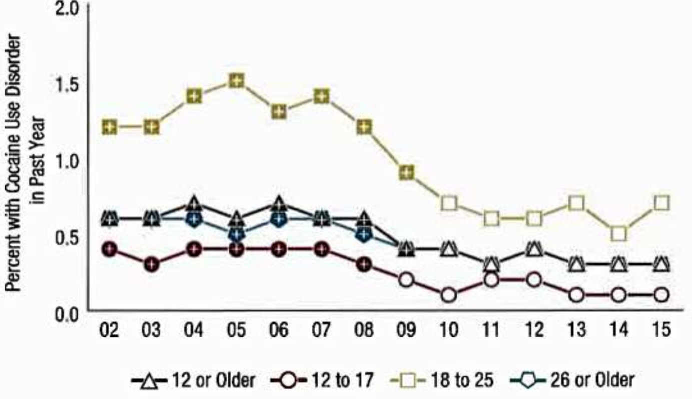
Aged 18 to 25

Approximately 155,000 young adults aged 18 to 25 in 2015 had a heroin use disorder in the past year, which represents 0.4 percent of young adults (Figure 34). The percentage of young adults with a heroin use disorder in 2015 was greater than the percentages in 2002 to 2007, but it was similar to the percentages in 2008 to 2014.

Aged 26 or Older

In 2015, approximately 430,000 adults aged 26 or older had a heroin use disorder in the past year, which represents 0.2 percent of adults in this age group (Figure 34).

Figure 33. Cocaine Use Disorder in the Past Year among People Aged 12 or Older, by Age Group: Percentages, 2002-2015



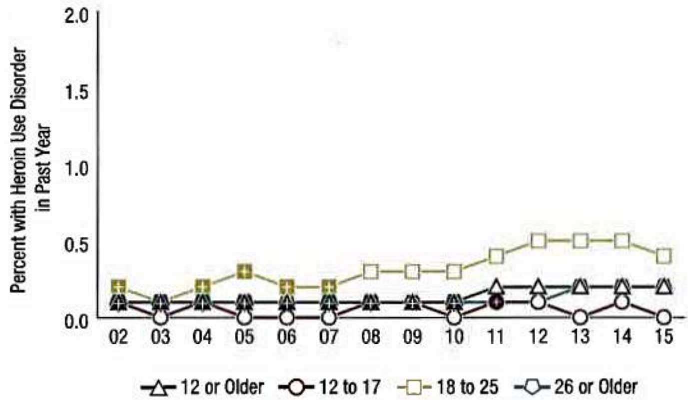
+ Difference between this estimate and the 2015 estimate is statistically significant at the .05 level.

Figure 33 Table. Cocaine Use Disorder in the Past Year among People Aged 12 or Older, by Age Group: Percentages, 2002-2015

Age	02	03	04	05	06	07	08	09	10	11	12	13	14	15
≥12	0.6+	0.6+	0.7+	0.6+	0.7+	0.6+	0.6+	0.4+	0.4	0.3	0.4	0.3	0.3	0.3
12-17	0.4+	0.3+	0.4+	0.4+	0.4+	0.4+	0.3+	0.2	0.1	0.2	0.2	0.1	0.1	0.1
18-25	1.2+	1.2+	1.4+	1.5+	1.3+	1.4+	1.2+	0.9+	0.7	0.6	0.6	0.7	0.5	0.7
≥26	0.6+	0.6+	0.6+	0.5+	0.6+	0.6+	0.5+	0.4	0.4	0.3	0.4	0.3	0.3	0.3

+ Difference between this estimate and the 2015 estimate is statistically significant at the .05 level.

Figure 34. Heroin Use Disorder in the Past Year among People Aged 12 or Older, by Age Group: Percentages, 2002-2015



+ Difference between this estimate and the 2015 estimate is statistically significant at the .05 level.

Figure 34 Table. Heroin Use Disorder in the Past Year among People Aged 12 or Older, by Age Group: Percentages, 2002-2015

Age	02	03	04	05	06	07	08	09	10	11	12	13	14	15
≥12	0.1+	0.1+	0.1+	0.1+	0.1+	0.1+	0.1+	0.1+	0.1+	0.2	0.2	0.2	0.2	0.2
12-17	0.1	0.0	0.1	0.0	0.0	0.0	0.1	0.1	0.0	0.1+	0.1	0.0	0.1	0.0
18-25	0.2+	0.1+	0.2+	0.3+	0.2+	0.2+	0.3	0.3	0.3	0.4	0.5	0.5	0.5	0.4
≥26	0.1+	0.1+	0.1+	0.1+	0.1	0.1+	0.1+	0.1	0.1+	0.1	0.1	0.2	0.2	0.2

+ Difference between this estimate and the 2015 estimate is statistically significant at the .05 level.
Note: Estimates of 0.0 percent round to less than 0.1 percent when shown to the nearest tenth of a percent.

OHCA 000115

Between 2002 and 2015, 0.1 to 0.2 percent of adults aged 26 or older had a heroin use disorder in the past year. The 2015 estimate was higher than the estimates in most years between 2002 and 2010, but it remained steady when compared with the percentages between 2011 and 2014.

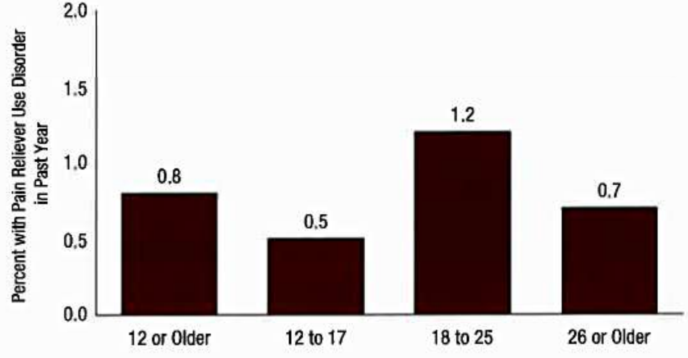
Methamphetamine Use Disorder

Questions were added in 2015 about SUD symptoms that respondents attributed specifically to their use of methamphetamine. Prior to 2015, past year methamphetamine users were asked about SUD symptoms for the misuse of prescription stimulants. An estimated 872,000 people aged 12 or older had a methamphetamine use disorder in 2015.[32] This number represents about 0.3 percent of people aged 12 or older (Table A.12B in Appendix A). An estimated 0.1 percent of adolescents aged 12 to 17 in 2015 had a methamphetamine use disorder in the past year (Table A.13B), which represents about 22,000 adolescents. Approximately 156,000 young adults aged 18 to 25 and 694,000 adults aged 26 or older in 2015 had a methamphetamine use disorder in the past year. Adults with a methamphetamine use disorder correspond to 0.4 percent of young adults aged 18 to 25 (Table A.14B) and 0.3 percent of adults aged 26 or older (Table A.15B).

Pain Reliever Use Disorder

The estimated 2.0 million people aged 12 or older in 2015 who had a pain reliever use disorder (Figure 27) represents 0.8 percent of people aged 12 or older (Figure 35). An estimated 0.5 percent of adolescents aged 12 to 17 in 2015 had a pain reliever use disorder in the past year, which represents about 122,000 adolescents. Approximately 427,000 young adults aged 18 to 25 and 1.5 million adults aged 26 or older in 2015 had a pain reliever use disorder in the past year. These numbers of adults with a pain reliever use disorder correspond to 1.2 percent of young adults and 0.7 percent of adults aged 26 or older.

Figure 35. Pain Reliever Use Disorder in the Past Year among People Aged 12 or Older, by Age Group: Percentages, 2015



Tranquilizer Use Disorder

In 2015, an estimated 688,000 people aged 12 or older had a tranquilizer use disorder. This number represents 0.3 percent of people aged 12 or older (Table A.12B in Appendix A). An estimated 0.3 percent of adolescents aged 12 to 17 in 2015 had a tranquilizer use disorder in the past year (Table A.13B), which represents about 77,000 adolescents. Approximately 234,000 young adults aged 18 to 25 and 376,000 adults aged 26 or older in 2015 had a tranquilizer use disorder in the past year. These numbers correspond to 0.7 percent of young adults (Table A.14B) and 0.2 percent of adults aged 26 or older (Table A.15B).

Stimulant Use Disorder

An estimated 426,000 people aged 12 or older had a stimulant use disorder in 2015, which rounds to the estimate of 0.4 million people in Figure 27.[32] This number of people with a stimulant use disorder represents 0.2 percent of people aged 12 or older (Table A.12B in Appendix A). An estimated 0.2 percent of adolescents aged 12 to 17 in 2015 had a stimulant use disorder in the past year (Table A.13B in Appendix A), which represents about 38,000 adolescents. Approximately 159,000 young adults aged 18 to 25 and 229,000 adults aged 26 or older in 2015 had a stimulant use disorder in the past year. These numbers correspond to 0.5 percent of young adults (Table A.14B) and 0.1 percent of adults aged 26 or older (Table A.15B).

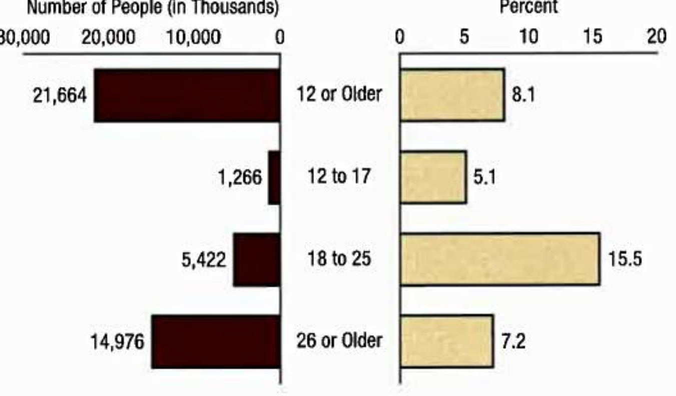
Need for Substance Use Treatment

NSDUH includes questions that are used to identify people who needed substance use treatment (i.e., treatment for problems related to the use of alcohol or illicit drugs) in the past year. For NSDUH, people are defined as needing substance use treatment if they had an SUD in the past year or if they received substance use treatment at a specialty facility[33] in the past year.[34,35] Because of the previously described effects of the questionnaire changes on the comparability of SUD estimates between 2015 and prior years, the 2015 estimates of the need for substance use treatment are not compared with estimates from prior years.

OHCA 000116

In 2015, an estimated 21.7 million people aged 12 or older needed substance use treatment, which means that about 1 in 12 people (8.1 percent) needed substance use treatment (Figure 36).[35] About 1.3 million adolescents aged 12 to 17 in 2015 needed treatment for a substance use problem in the past year, representing 5.1 percent of adolescents. About 5.4 million young adults aged 18 to 25 in 2015 needed treatment for a substance use problem in the past year, representing 15.5 percent of young adults. Stated another way, about 1 in 6 young adults needed substance use treatment. In 2015, about 15.0 million adults aged 26 or older needed substance use treatment in the past year. This number represents 7.2 percent of adults in this age group.

Figure 36. Need for Substance Use Treatment in the Past Year among People Aged 12 or Older, by Age Group: 2015



Receipt of Substance Use Treatment

NSDUH respondents who used alcohol or illicit drugs in their lifetime are asked whether they ever received substance use treatment, and those who received substance use treatment in their lifetime are asked whether they received treatment in the 12 months prior to the survey interview (i.e., the past year). Substance use treatment refers to treatment or counseling received for illicit drug or alcohol use or for medical problems associated with the use of illicit drugs or alcohol. NSDUH collects information on the receipt of substance use treatment at a specialty facility. Receipt of substance use treatment at a specialty facility is defined as substance use treatment a respondent received at a hospital (only as an inpatient), a drug or alcohol rehabilitation facility (as an inpatient or outpatient), or a mental health center. People could report receiving treatment at more than one location.

As previously described, the changes to the questions for the use of hallucinogens, inhalants, and methamphetamine and the misuse of prescription drugs also had the potential to affect the group of respondents in 2015 who answered questions about their receipt of substance use treatment. Investigations with future years of NSDUH data will help to assess whether these changes ultimately affected the comparability of NSDUH estimates for the receipt of substance use treatment between 2015 and prior years. For this report, however, the 2015 estimates of the receipt of substance use treatment are not compared with estimates from prior years.

Report Revision Note:

In this revised report, Figure 37 and its associated text were removed to be consistent with the Office of National Drug Control Policy's National Drug Control Strategy.

OHCA 000117

Behavioral Health Barometer

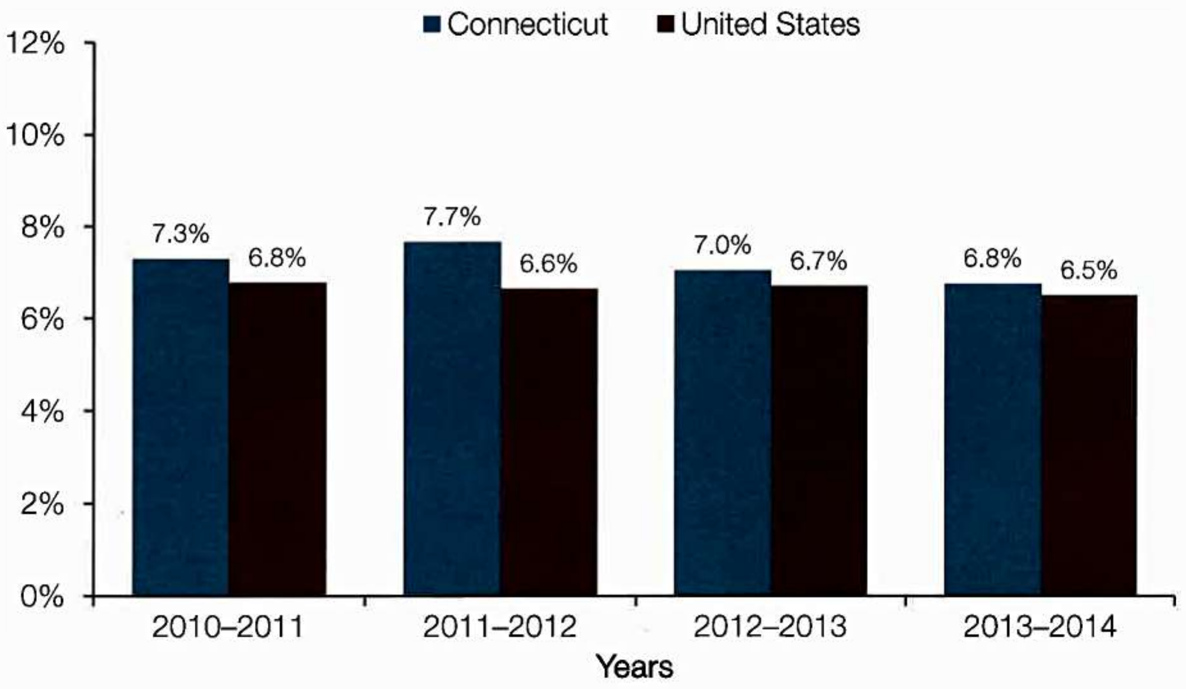
Connecticut, 2015

OHCA 000118

SUBSTANCE USE
ALCOHOL DEPENDENCE OR ABUSE

Past Year Alcohol Dependence or Abuse Among Individuals Aged 12 or Older in Connecticut and the United States (2010–2011 to 2013–2014)[1]

Connecticut's percentage of alcohol dependence or abuse among individuals aged 12 or older was similar to the national percentage in 2013–2014.



In Connecticut, about 206,000 individuals aged 12 or older (6.8% of all individuals in this age group) per year in 2013–2014 were dependent on or abused alcohol within the year prior to being surveyed. The percentage did not change significantly from 2010–2011 to 2013–2014.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health, 2010–2011 to 2013–2014.

Statistical tests (t-tests) have been conducted for all statements appearing in the text on this page of the report that compare estimates between years or between the state and the nation as a whole. Unless explicitly stated that a difference is not statistically significant, all statements that describe differences are significant at the .05 level.

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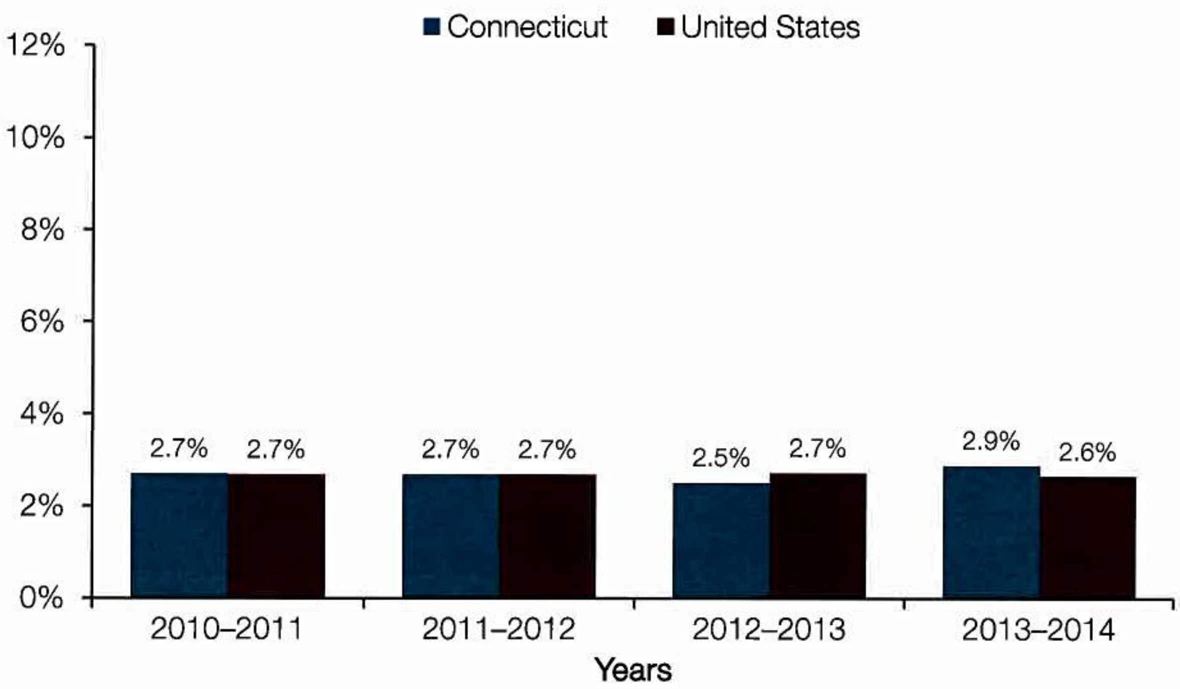
Past Year Illicit Drug Dependence or Abuse Among Individuals Aged 12 or Older in Connecticut and the United States (2010–2011 to 2013–2014)[1]

Connecticut's percentage of illicit drug dependence or abuse among individuals aged 12 or older was similar to the national percentage in 2013–2014.



In Connecticut, about 88,000 individuals aged 12 or older (2.9% of all individuals in this age group) per year in 2013–2014 were dependent on or abused illicit drugs within the year prior to being surveyed. The percentage did not change significantly from 2010–2011 to 2013–2014.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health, 2010–2011 to 2013–2014.

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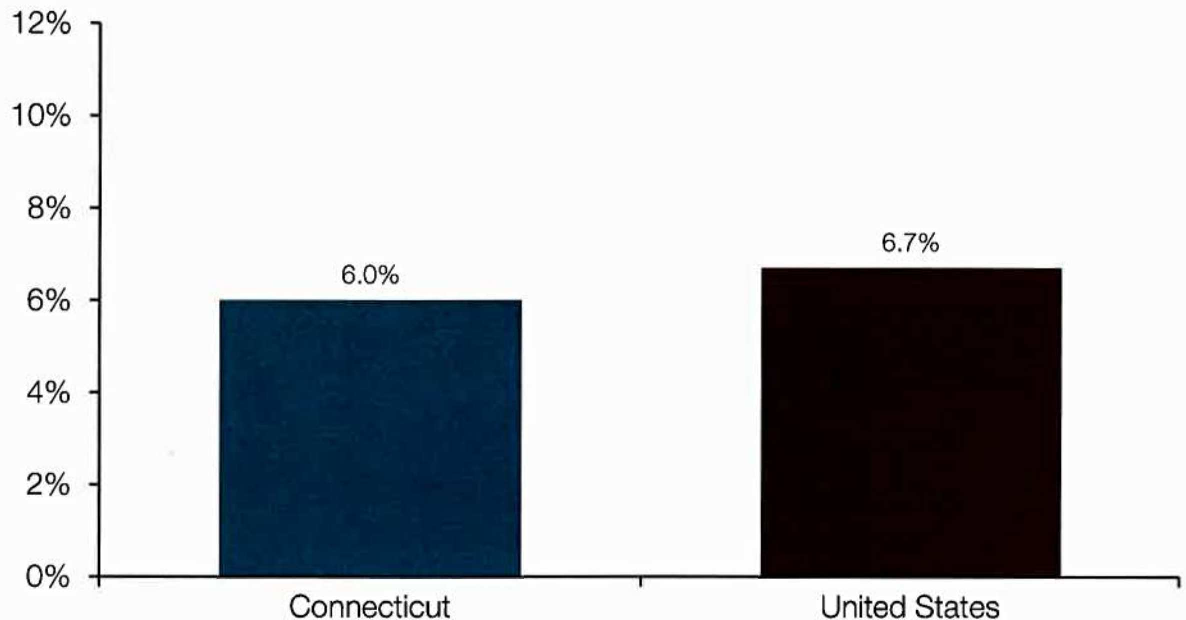
Past Month Heavy Alcohol Use Among Adults Aged 21 or Older in Connecticut and the United States (Annual Averages, 2010–2014)[2]

Connecticut's annual average of heavy alcohol use among adults aged 21 or older was similar to the annual average for the nation from 2010 to 2014.



In Connecticut, about 154,000 adults aged 21 or older (6.0% of all adults in this age group) per year from 2010 to 2014 reported heavy alcohol use within the month prior to being surveyed.

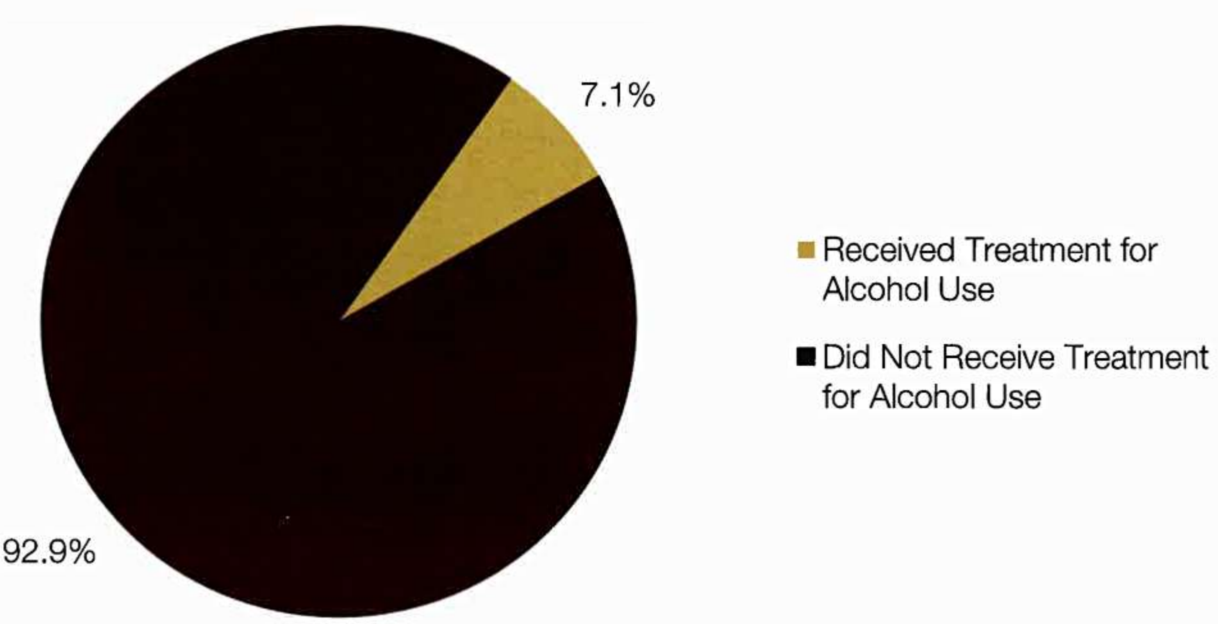
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health, 2010–2014.

OHCA 000121

SUBSTANCE USE TREATMENT
ALCOHOL

Past Year Treatment for Alcohol Use Among Individuals Aged 12 or Older with Alcohol Dependence or Abuse in Connecticut (Annual Average, 2010–2014)[2]

Connecticut's annual average of treatment for alcohol use among individuals aged 12 or older with alcohol dependence or abuse was similar to the annual average for the nation (7.3%) from 2010 to 2014.



In Connecticut, among individuals aged 12 or older with alcohol dependence or abuse, about 16,000 individuals (7.1%) per year from 2010 to 2014 received treatment for their alcohol use within the year prior to being surveyed.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health, 2010–2014.

Statistical tests (t-tests) have been conducted for all statements appearing in the text on this page of the report that compare estimates between years or between the state and the nation as a whole. Unless explicitly stated that a difference is not statistically significant, all statements that describe differences are significant at the .05 level.

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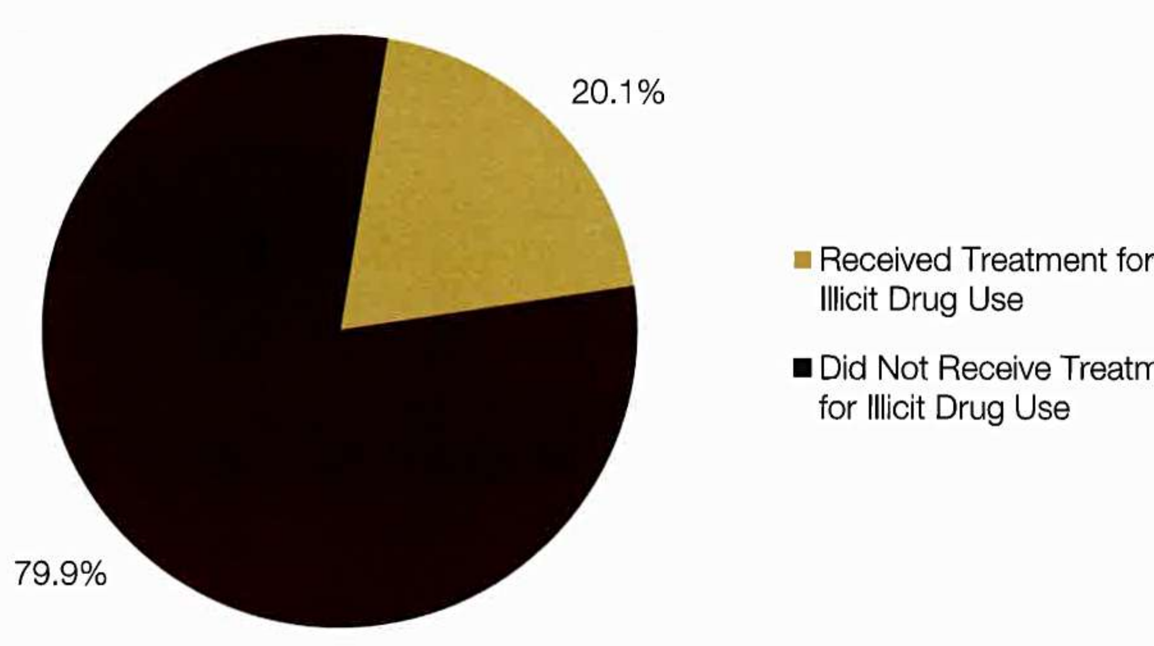
SUBSTANCE USE TREATMENT

ILLICIT DRUGS

Past Year Treatment for Illicit Drug Use Among Individuals Aged 12 or Older with Illicit Drug Dependence or Abuse in Connecticut (Annual Average, 2007–2014)[2]

Connecticut's annual average of treatment for illicit drug use among individuals aged 12 or older with drug dependence or abuse was similar to the annual average for the nation (13.9%) from 2007 to 2014.



In Connecticut, among individuals aged 12 or older with illicit drug dependence or abuse, about 18,000 individuals (20.1%) per year from 2007 to 2014 received treatment for their illicit drug use within the year prior to being surveyed.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health, 2007–2014.

Statistical tests (t-tests) have been conducted for all statements appearing in the text on this page of the report that compare estimates between years or between the state and the nation as a whole. Unless explicitly stated that a difference is not statistically significant, all statements that describe differences are significant at the .05 level.

OHCA 000123

FIGURE NOTES

[1] State estimates are based on a small area estimation procedure in which state-level National Survey on Drug Use and Health (NSDUH) data from 2 consecutive survey years are combined with local-area county and census block group/tract-level data from the state. This model-based methodology provides more precise estimates at the state level than those based solely on the sample, particularly for states with smaller sample sizes.

[2] Estimates are annual averages based on combined 2010–2014 NSDUH data or combined 2007–2014 NSDUH data where indicated. These estimates are based solely on the sample, unlike estimates based on the small area estimation procedure as stated above.

[3] Risk perceptions were measured by asking respondents to assess the extent to which people risk harming themselves physically and in other ways when they use various illicit drugs, alcohol, and cigarettes, with various levels of frequency. Response options were (1) no risk, (2) slight risk, (3) moderate risk, and (4) great risk. Respondents with unknown risk perception data were excluded.

[4] Respondents with unknown past year major depressive episode (MDE) data were excluded.

[5] Respondents with unknown past year MDE or unknown treatment data were excluded.

[6] Estimates were based only on responses to suicide items in the NSDUH Mental Health module. Respondents with unknown suicide information were excluded.

[7] Estimates of serious mental illness (SMI) and any mental illness (AMI) presented in this publication may differ from estimates in other publications as a result of revisions made to the NSDUH mental illness estimation models in 2012. Other NSDUH mental health measures presented were not affected. The 2013 and 2014 Barometer reports include the revised SMI and AMI estimates. For further information, see *Revised Estimates of Mental Illness from the National Survey on Drug Use and Health*, which is available on the SAMHSA Web site at http://www.samhsa.gov/data/sites/default/files/NSDUH148/NSDUH148/sr148-mental-illness-estimates.pdf.

[8] Respondents were not to include treatment for drug or alcohol use. Respondents with unknown treatment/counseling information were excluded. Estimates were based only on responses to items in the NSDUH Adult Mental Health Service Utilization module.

Any mental illness (AMI) among adults aged 18 or older is defined as currently or at any time in the past year having had a diagnosable mental, behavioral, or emotional disorder (excluding developmental and substance use disorders) of sufficient duration to meet diagnostic criteria specified within the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV). Adults who had a diagnosable mental, behavioral, or emotional disorder in the past year, regardless of their level of functional impairment, were defined as having AMI.

Binge alcohol use is defined as drinking five or more drinks on the same occasion (i.e., at the same time or within a couple of hours of each other) on at least 1 day in the past 30 days.

Dependence on or abuse of alcohol or illicit drugs is defined using DSM-IV criteria.

Heavy alcohol use is defined as drinking five or more drinks on the same occasion on each of 5 or more days in the past 30 days.

Illicit drugs is defined as marijuana/hashish, cocaine (including crack), inhalants, hallucinogens, heroin, or prescription-type drugs used nonmedically, based on data from original National Survey on Drug Use and Health (NSDUH) questions, not including methamphetamine use items added in 2005 and 2006.

Illicit drug use treatment and ***alcohol use treatment*** refer to treatment received in order to reduce or stop illicit drug or alcohol use, or for medical problems associated with illicit drug or alcohol use. They include treatment received at any location, such as a hospital (inpatient), rehabilitation facility (inpatient or outpatient), mental health center, emergency room, private doctor's office, self-help group, or prison/jail.

Major depressive episode (MDE) is defined as in the DSM-IV, which specifies a period of at least 2 weeks in the past year when an individual experienced a depressed mood or loss of interest or pleasure in daily activities and had a majority of specified depression symptoms.

Mental health treatment/counseling is defined as having received inpatient or outpatient care or having used prescription medication for problems with emotions, nerves, or mental health.

Nonmedical use of psychotherapeutics includes the nonmedical use of pain relievers, tranquilizers, stimulants, or sedatives and does not include over-the-counter drugs.

Serious mental illness (SMI) is defined by SAMHSA as adults aged 18 or older who currently or at any time in the past year have had a diagnosable mental, behavioral, or emotional disorder (excluding developmental and substance use disorders) of sufficient duration to meet diagnostic criteria specified within the DSM-IV that has resulted in serious functional impairment, which substantially interferes with or limits one or more major life activities.

Treatment for depression is defined as seeing or talking to a medical doctor or other professional or using prescription medication for depression in the past year.

OHCA 000125

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (DSM-IV) (4th ed.). Washington, DC: Author.

Center for Mental Health Services. (2015). *2014 CMHS Uniform Reporting System Output Tables.* Rockville, MD: Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services. Retrieved from http://www.samhsa.gov/data/us_map

The National Survey on Drug Use and Health (NSDUH) is 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, and also includes mental health issues and mental health service utilization for adolescents aged 12 to 17 and adults aged 18 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 their place of residence. The data used in this report are based on information obtained from approximately 67,500 individuals aged 12 or older per year in the United States. Additional information about NSDUH is available at http://www.samhsa.gov/data/population-data-nsduh.

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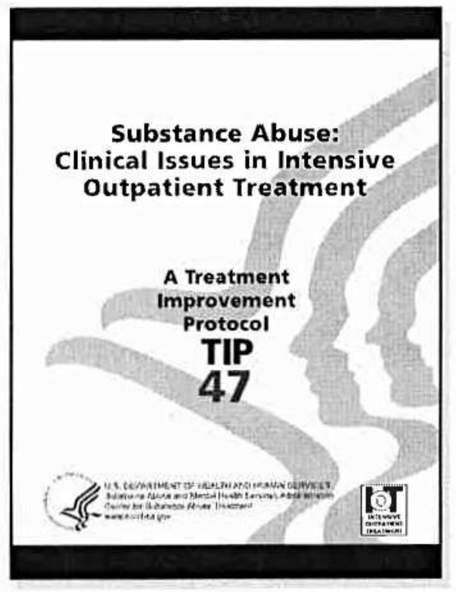
Center for Behavioral Health Statistics and Quality
www.samhsa.gov

OHCA 000127

Quick Guide

For Clinicians

Based on TIP 47
Substance Abuse: Clinical Issues in Intensive Outpatient Treatment



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment
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OHCA 0001

Contents

Why a Quick Guide? 2

What Is a TIP? 3

Introduction 5

14 Principles of IOT 7

Intensive Outpatient Treatment and Continuing Care. 9

Services in IOT Programs 16

Treatment Entry and Engagement. 18

Family-Based Services 21

Clinical Issues, Challenges, and Strategies. . 24

Intensive Outpatient Treatment Approaches. . 35

Adapting Intensive Outpatient Treatment for Specific Populations 43

Addressing Diverse Populations 56

OHCA 000129

Quick Guide

For Clinicians

Based on TIP 47

Substance Abuse: Clinical Issues in Intensive Outpatient Treatment

This Quick Guide is based entirely on information contained in TIP 47, published in 2006. No additional research has been conducted to update this topic since publication of TIP 47.

OHCA 000130

WHY A QUICK GUIDE?

This Quick Guide was developed to accompany *Substance Abuse: Clinical Issues in Intensive Outpatient Treatment,* Number 47 in the Treatment Improvement Protocol (TIP) Series published by the Center for Substance Abuse Treatment (CSAT), Substance Abuse and Mental Health Services Administration (SAMHSA). This Quick Guide is based entirely on TIP 47 and is designed to meet the needs of the busy clinician for concise, easily accessed how-to information.

The Quick Guide is divided into 12 sections (see *Contents*) to help readers quickly locate relevant material. It will help clinicians make informed decisions when treating clients in outpatient settings.

For more information on the topics in this Quick Guide, readers are referred to TIP 47.

OHCA 000131

WHAT IS A TIP?

The TIP series has been in production since 1991. The series provides the substance abuse treatment and related fields with consensus-based, field-reviewed guidelines on substance abuse treatment topics of vital current interest.

TIP 47, *Substance Abuse: Clinical Issues in Intensive Outpatient Treatment*—

- Addresses the expansion of intensive outpatient treatment (IOT) represented by the development and adoption of new approaches to treat a wide range of clients
- Describes the core services every IOT program should offer, the enhanced services that should be available on site or through links with community-based services, and the processes of assessment, placement, and treatment planning that help counselors address each client's needs
- Discusses major clinical challenges of IOT and surveys the most common treatment approaches used in IOT programs
- Presents treatment strategies for specific groups including women; adolescents; criminal justice system clients; individuals with HIV/AIDS, co-occurring disorders, or physical or cognitive disabilities; racial and ethnic minorities; rural populations; people who are homeless; and older adults

OHCA 000132

- Examines the complex issues facing IOT providers and offers analytical discussions and incisive opinions.

See the inside back cover for information on how to order TIPs and other related products.

OHCA 000133

INTRODUCTION

IOT is a multidimensional treatment modality that serves a variety of clients. It recognizes substance abuse as a chronic disorder requiring case management and the involvement of families, communities, and mutual-help groups in ongoing care. The blending of evidence-based interventions with community-based services has helped clinicians, clients, and family members understand that substance use disorders have complex biological, social, psychological, and spiritual dimensions. IOT has the following features:

- 6–30 contact hours per week;
- Step-up and stepdown levels of care that vary in intensity and duration;
- A minimum duration of 90 days followed by outpatient continuing care;
- Core services including—
  - Comprehensive biopsychosocial assessment
  - Group, individual, and family counseling
  - Psychoeducational programming
  - Integration into support groups
  - Relapse prevention training
  - Substance use screening and monitoring
  - Vocational and educational services; and
- Enhanced services including—
  - Ambulatory detoxification

OHCA 000134

- Child care
- Outreach.

For more detailed information, see TIP 47, pp. 1–6.

14 PRINCIPLES OF IOT

The TIP consensus panel identified 14 principles integral to IOT:

1. Make treatment available to a wide spectrum of clients;
2. Make treatment access straightforward and welcoming;
3. Build on existing motivation by using strategies that enhance client motivation;
4. Enhance the therapeutic alliance by building trust between the counselor and client;
5. Make client retention a priority;
6. Assess the client's treatment needs and match services to the individual;
7. Provide ongoing care through a chronic care model that adjusts to the client's needs;
8. Monitor abstinence by recognizing the client's achieving and maintaining abstinence;
9. Help clients integrate into support groups;
10. If indicated, use medications to manage co-occurring substance use and mental disorders;
11. Educate clients and family members about substance use disorders and recovery skills;
12. Include families, employers, and significant others in the treatment process;

OHCA 000136

13. Seek out and use evidence-based training and materials; and
14. Improve program administration.

For more detailed information, see TIP 47, pp. 7–16.

ATTACHMENT III

Letters of Support

International Union of Operating Engineers

LOCAL UNIONS 478, 478A, 478C, 478D, 478E

AFFILIATED WITH THE AFL-CIO

1965 DIXWELL AVENUE
HAMDEN, CONNECTICUT 06514-2475

TELEPHONE (203) 288-9261
FAX (203) 281-3749

Dear Jerry,

I would like to thank you for your support with the International Union of Operating Engineers Local 478 members. I know that every time I reach out to you, you are always there to provide me with the best solution to any issues that come about. Countless times, Counseling Center of Waterbury has demonstrated their ability to go above and beyond with any situation presented to them and have treated our members and their families with nothing but remarkable service and respect. The Intensive Outpatient Program you are proposing will provide the service area with much needed assistance and will undoubtedly be utilized by the Operating Engineers 478 members.

I look forward to many more years of outstanding service.

Sincerely,

Kyle Zimmer
IUOE Local 478 Health & Safety Director

Irvin R. Jennings, MD
Executive and Medical Director

November 18, 2015

To Whom it May Concern:

Counseling Center of Waterbury has been a great resource for the community for substance abuse treatment. The Family and Children's Aid IICAPS (Intensive In-home Child and Adolescent Psychiatric Services) program works with many families to try to stabilize the identified child in the home while helping the family make use of more traditional services. In many cases, we have families struggling with substance abuse diagnoses and the Counseling Center of Waterbury has been great to work with. We have referred adults along with adolescents in order to work collaboratively to stabilize the home situation. We have also utilized the services from Counseling Center of Waterbury as a discharge plan for some of our families that are struggling with addiction. Counseling Center of Waterbury has been accommodating, opens cases quickly and always keeps in communication when needed. Please feel free to contact me with any questions.

Respectfully,

LCSW

Hanna Profeta, LCSW
Site Coordinator – Waterbury IICAPS
Family and Children's Aid
203-241-8988
hanna.profeta@fcaweb.org

Mailing address: PO Box 6001 Wolcott, Ct 06716
Phone: Joe Dunn 203-560-1665 Laurie Dunn 203-206-9038
www.wolcottcrossroadsinc.com

Wolcott Crossroads, Inc. is a community based, non-profit group, that works to help individuals and families find the proper resources that will assist them with the healing process of addiction. From our formation six years ago, we have collaborated with Connecticut Counseling and Wellness. Jerry is sincere and genuine, and he is committed to seeing that the individual suffering from the disease of addiction, and their families, have their lives restored. "Jerry is in it to win it," and we have witnessed first-hand the positive results of his caring approach and will continue to offer this wonderful resource to anyone, or any family that is in need of counseling. Wolcott Crossroads, Inc. is very excited, encouraged, and in full support of the idea of having an Intensive Outpatient Program available for the community of Wolcott.

We look forward to our continual work with such wonderful people, people who have that special personal quality that puts them above the rest.

Sincerely,

Joe Dunn (co-founder)

Laurie Dunn (co-founder)

ATTACHMENT IV

Protocols

The Matrix Model of Intensive Outpatient Treatment

A guideline developed for the Behavioral Health Recovery Management project

Richard A. Rawson
UCLA Integrated Substance Abuse Programs
Los Angeles, California

Michael J. McCann
The Matrix Institute on Addictions
Los Angeles, California

Richard A. Rawson, Ph.D., Richard Rawson is the Associate Director of the UCLA Integrated Substance Abuse Programs (ISAP) in the Department of Psychiatry and Biobehavioral Science, UCLA School of Medicine. He received a Ph.D. in experimental psychology from the University of Vermont in 1974. Dr. Rawson has been a member of the UCLA Department of Psychiatry for over 25 years and is a Professor-in Residence. In his role at ISAP, Dr. Rawson coordinates and contributes to a portfolio of addiction research ranging from brain imaging studies to numerous clinical trials on pharmacological and psychosocial addiction treatments, to the study of how new treatments are applied in the treatment system. During the past decade, he has worked with NIDA, SAMHSA, the US State Department, the World Heath Organization and the United Nations Office of Drugs and Crime on international substance abuse research and training projects, exporting US technology and addiction science throughout the world. He directs the capacity building and training component of the UNODC International Network of Drug Treatment and Rehabilitation Resource Centres. He is currently principal investigator of the Pacific Southwest Addiction Technology Transfer Center, and the NIDA Methamphetamine Clinical Trials Group. Dr. Rawson has published 2 books, 20 book chapters and over 175 professional papers and annually conducts over 50 workshops, paper presentations and training sessions.

Michael McCann, M.A., Associate Director of the Matrix Institute is one of the founders and creators of the Matrix Model. He has over 30 years experience in substance abuse treatment and research and has authored or co-authored over 40 articles and books in the area. He was the principal investigator for one of the sites in the CSAT-funded Matrix Model Methamphetamine Treatment Project, and also for the NIDA-funded Methamphetamine Clinical Trials Group projects. He is also the Project Director for a CSAT-funded TCE/HIV grant which is expanding treatment services for opioid dependence and providing evidence-based enhancements to standard services. Mr. McCann has developed and overseen the operation of Matrix clinics as well as the integration of many research projects within these sites. He has trained and lectured on evidence-based behavioral interventions, pharmacologic treatments, methamphetamine dependence, and on the implementation of research findings into clinical practice.

The Behavioral Health Recovery Management project is an initiative of Fayette Companies, Peoria, IL; Chestnut Health Systems, Bloomington, IL; and the University of Chicago Center for Psychiatric Rehabilitation

OHCA 000143

Table of contents

Background....3

Evaluations....6

Clinical Guidelines....13

- Program Components....13
  - Individual counseling....13
  - Early Recovery Skills Groups....14
  - Relapse Prevention Groups....14
  - Family Education Groups....15
  - 12-Step meetings....16
  - Urine/breath tests....16
  - Relapse Analysis....16
  - Social Support....16

- Guiding Principles....17
  - Positive and collaborative relationship....17
  - Structure and expectations....18
  - Psychoeducation....21
  - Cognitive behavior skills....24
  - Positive reinforcement....26
  - Family education....29
  - Self-help groups....30
  - Urine and breath alcohol testing....31

References....33

Resources....36

- Treatment Materials....36

- Training....37

OHCA 000144

The Matrix Model of Intensive Outpatient Treatment.

The Matrix Model is a multi-element package of therapeutic strategies that complement each other and combine to produce an integrated outpatient treatment experience. It is a set of evidence-based practices delivered in a clinically coordinated manner as a "program." The research reports which have described the compilation of clinical experience with the model, plus the results of a multi-site trial have all provided information on the application of the entire package of techniques. However, many of the treatment strategies within the Model are derived from clinical research literature, including cognitive behavioral therapy, research on relapse prevention, motivational interviewing strategies, psycho-educational information and 12-Sstep program involvement.

Background

The Matrix Model of outpatient treatment was developed at the height of the cocaine epidemic in Southern California in the 1980's. In the urban areas of Los Angeles, cocaine and crack were the major drugs to effect communities, and 50 miles to the East of downtown Los Angeles, in San Bernardino County, large numbers of methamphetamine users began to present at the Matrix clinic for assistance. At the time, there was no established approach for structuring outpatient services to attempt to meet the needs of these two groups of psychostimulant users.

The development of the Matrix model was influenced by an ongoing interaction between clinicians working with clients and researchers collecting related information. As clinical

experience with stimulant dependent individuals was amassed, clinical impressions frequently generated questions that were answered by using relevant research findings.

Treatment materials had to be developed that were sophisticated enough to capture the essence of the proven efficacious therapies, yet simple enough to be readily used and easily monitored in widely diverse clinical situations by patients and the clinical staff. Materials were written to guide clinical staff in how to work collaboratively with patients and effectively teach cognitive/behavioral strategies and basic brain research to patients and their families. With funding from NIDA, the authors of the Matrix approach attempted to integrate existing knowledge and empirically supported techniques into a single, multi-element manual that could serve as an outpatient "protocol" for the treatment of cocaine and methamphetamine users (Rawson, Obert, McCann, Smith & Scheffey, 1989; Rawson, Obert & McCann, 1995). These manuals were written for patients that contained handouts for each session. Each topic was introduced by a simple exercise in which scientific information was explained in patient-friendly terms and questions directed participants to apply the information specifically to their immediate situation. The groups were focused on discussing patients' written and oral responses to the questions.

Treatment is delivered in a 16-week intensive outpatient program primarily in structured group sessions targeting the skills needed in early recovery and for relapse prevention. A primary therapist conducts both the individual and group sessions for a particular patient and is responsible for coordinating the whole treatment experience. There is also a 12-week family and patient education group series and induction into an ongoing weekly social support group for continuing care. Weekly urine testing is another program component and participants are

OHCA 000146

encouraged to attend 12-step meetings as an important supplement to intensive treatment and a continuing source of positive emotional and social support.

The Matrix Model has been delivered to a broad spectrum of people. In the Matrix clinics in Southern California the race/ethnicity representation is approximately 17% African-American, 18% Hispanic, 62% Caucasian, and 3% other. Females comprise about 1/3 of the patient population. In the CSAT multi-site comparison of the Matrix Model and Treatment-as-Usual (described below) the sample consisted of 55% females and 45% males; 60% Caucasian, 18% Hispanic, and 17% Asian/Pacific Islander.

The Matrix Model treatment manuals have been published by Hazelden Publishing Company (Rawson et al., 2005). Hazelden has also published a Spanish translation of the treatment materials. A version of the Matrix Manual for Native Americans has been published (Matrix Institute, 2006). There are also translations in Thai and Slovakian. The Matrix Model for stimulant use disorders has been published by the Center of Substance Abuse Treatment (SAMHSA, 2006) and is in the public domain. The Model was adapted for gay and bisexual methamphetamine using men (see Shoptaw, S., C. J. Reback, et al., 2005).

OHCA 000147

Evaluations

Several evaluations of the Matrix Model have been conducted over the past 20 years. These range from open trials with few controls to controlled clinical trials. The earliest of these was a pilot study conducted in 1985 which documented the clinical progress of 83 cocaine abusers at 8 months following treatment admission (Rawson et al., 1986). During an evaluation session, patients self-selected either: no formal treatment (voluntary involvement in AA, CA, or NA); 28-day inpatient treatment; or the Matrix Model outpatient treatment. An independent research assistant was hired to conduct telephone follow-up interviews inquiring into drug and alcohol use and participation in aftercare and self-help.

There were no demographic or drug use differences among the patients prior to beginning treatment. The hospital patients received 26.5 of 28 days of treatment and the Matrix patients received 21.6 of 26 weeks. By contrast, only 20% of the no formal treatment patients ever attended more than one self-help meeting. The most noteworthy finding of this pilot study were reports of significantly less cocaine use by the Matrix patients at 8 months after treatment admission. The number of patients reporting a return to monthly or more cocaine use in the Matrix group was 4 of 30, compared to 10 of 23 in the inpatient group, and 14 of 30 in the no formal treatment group. Although the quasi-experimental nature of this evaluation, and the small numbers of subjects per cell limit the degree to which strong conclusions may be drawn, the findings did provide some support for the Matrix Model and also were a basis for altering treatment materials to prescribe total abstinence as a necessary tactic for preventing relapse to cocaine.

OHCA 000148

Through the Small Business Innovative Research Program the protocol for the Matrix Model was formalized into a 300 page treatment manual. After completion of the manual, a controlled trial of the model was conducted over a two-year period (Rawson et al., 1995). In this study 100 cocaine dependent subjects were randomly assigned to six-month Matrix treatment condition or they were referred to "other available community resources." Subjects assigned to the community resource group were given detailed information on treatment alternatives in the area and were given a referral and an appointment time to receive an evaluation at a community treatment location. Subjects in both conditions were scheduled for 3, 6, and 12-month follow-up evaluations.

Racial/ethnic representation was: African –American (27%), Hispanic (23%), and the remainder were Caucasian. At 3 and 6-month follow-ups, 40% of the community resource subjects reported involvement in some formal treatment ranging from outpatient to hospital treatment. There was a strong positive relationship between the amount of treatment received and the percent of cocaine negative urine results for the Matrix subjects but not for the community resources subjects. Similarly, greater amounts of treatment participation for the Matrix subjects were associated with improvement on the ASI employment and family scales, and on a depression scale. These analyses supported the clinical impression of the counseling staff of an orderly dose-response association between amount of treatment and outcome status. This study supported the Model's clinical utility but the results did not provide definitive empirical confirmation of its efficacy. The variability of community resource subjects' treatments made differential treatment outcomes undetectable. In addition, failure to employ a pre-randomization "lead-in" period to screen out applicants resulted in high rates of attrition in both

OHCA 000149

treatment groups. This reduced the number of subjects receiving a meaningful dose of treatment and further impaired the identification of differential treatment outcomes.

A convenience sample of 114 patients out of the 500 referred to in the Rawson et al. (2002) report was followed at 2-5 years after treatment. In this study funded by CSAT, 437 potential study candidates were telephoned by research assistants and asked to come to the clinic for a follow-up interview. When necessary the interview was performed at a neutral offsite location and as a last resort it was done by phone. Of the total pool of 437, 183 (42%) were located, contacted and asked to participate. Of the 183, 114 agreed to participate in the follow-up interview. The participants were similar to the non-participants on demographics, however they remained in treatment almost twice as long and gave more methamphetamine-free urine samples during the course of treatment.

There was a significant change in self-reported methamphetamine use in the 30 days prior to treatment (86% reporting use), and 30 days prior to follow-up (17.5% reporting use). The only predictor of non-use at follow-up was marital status with married patients more likely to be methamphetamine non-users at follow-up. Urine samples were collected on 46 individuals and only 3 (6.5%) were positive for methamphetamine. Of the 54 who had reported daily use at baseline, 39 (72.2%) were abstinent at follow-up.

At treatment admission 26% of the follow-up sample were employed compared to 62% employed at follow-up. There was significant reduction in the percentages of participants

OHCA 000150

reporting paranoia, however there was not a reduction in complaints of depression (more than 60%) and headaches (38.9% at baseline and 44.1% at follow-up).

The limitations of the study methodology preclude conclusions about the specific impact of the Matrix treatment, and the 114 patients who were followed were not representative of the entire initial sample of 437. However, despite these limitations, it was demonstrated that many methamphetamine users are able to discontinue methamphetamine use following treatment with the Matrix Model.

In 1998, the Center for Substance Abuse Treatment selected the Matrix Model approach for a randomized, controlled evaluation with other methamphetamine treatment methods available in the community, called Treatment-As-Usual (TAU). The study was conducted as an 8-site, outpatient trial, coordinated by UCLA. The sites were located in Northern and Southern California, Hawaii, and Montana. Over an 18-month period, between 1999 and 2001, 978 treatment-seeking MA-dependent individuals were recruited by the eight sites. At each site half of the participants were randomly assigned to receive the Matrix Model of treatment, whereas the other half received TAU as delivered at that site. Several important points should be noted in the design and results of this study.

The design involved a comparison of the Matrix approach with 8 different forms of treatment as usual (TAU). This was not an optimal efficacy design, but was necessitated by CSAT's desire to provide as much treatment as possible within an evaluation study. In this study, many of the TAU protocols were very similar to the materials in Matrix model and in some cases, the "dose"

of treatment delivered in the TAU conditions was designed to be more intensive than the Matrix condition. The variability of the comparison conditions was tremendous (not an optimal circumstance for finding statistically significant differences between study groups). In addition, in no sense were these TAU conditions designed to be "minimal treatment control conditions." In fact, since the TAU protocols were designed by the clinical staff of the 8 programs, they were viewed at the beginning of the study as being quite effective treatment interventions.

The sample consisted of 55% females and 45% males; 60% Caucasian, 18% Hispanic, and 17% Asian/Pacific Islander. Other characteristics of those seeking treatment included: age: 32.8 years on average; education: 12.2 years on average; employment: 69%; and married and not separated: 16%. Participants were recruited through media advertisements, referrals from community agencies, and word-of-mouth. During the study their primary drug used was MA. The participants had on average 7.54 years of lifetime MA use and 11.53 days of MA use in the past 30 days. The preferred route of administration of MA was smoking (65%), followed by injecting (24%), and snorting (11%).

Retention was higher for the Matrix participants at all sites except the drug court site, and at five of the sites, retention rates for Matrix participants were significantly higher than for TAU participants. Comparisons at two of the other sites were marginally significant, with the Matrix condition having increased retention relative to the TAU condition. At the drug court site, both the Matrix and the TAU programs were more stringent, and as a result, there was no difference in retention between the two conditions at this site.

OHCA 000152

Completion of the program was defined as a participant having attended at least one treatment session in his/her last scheduled week of treatment. Comparison across all sites indicates that the completion rate for Matrix participants was significantly higher (40.9%) than for TAU participants (34.2%).

All participants were required to provide one urine sample each week, which was sent to an outside laboratory and tested for drug metabolites. At all sites, except the drug court site, Matrix participants provided more methamphetamine-free urine samples than did TAU participants.

For all sites, urine samples that were submitted at the discharge interview, were methamphetamine-free for 66% of the Matrix participants, and 69% of the TAU participants.(this difference is not significant). For urine samples at the six-month follow-up time-point, the rates were the same for both conditions (69%). At the 12-month follow-up, the differences between Matrix and TAU were again not significant, and they were 70% and 73% respectively.

Overall self-reported MA use dropped dramatically during treatment. At enrollment participants reported approximately 11 days of use in the last 30 days, whereas at discharge the number was reduced to approximately four days of use in the last 30 days. At the six-month follow-up time-point the number was still approximately four days and it decreased even more at the 12-month follow-up time-point (approximately three days). This reduction from enrollment to the different time-points was consistent across sites and conditions.

This study was conducted in "real-world" treatment programs, using the diverse collection of treatment methods normally used in these communities, therefore the study was not a conventional multi-site study comparing identical approaches at all sites. Despite these study limitations, during the application of the Matrix model, the participant performance in 7 of the 8 sites was clearly superior in the Matrix condition to the TAU condition (the lone exception was within a drug court, mandated program, where there was no difference). The retention was superior, the urinalysis data were superior and the ability to produce a sustained period of abstinence was superior.

OHCA 000154

Clinical Guidelines

The elements of the treatment approach are a collection of group sessions (early recovery skills, relapse prevention, family education and social support) and 3 to 10 individual sessions delivered over a 16-week intensive treatment period. Patients are scheduled three times per week to attend two Relapse Preventions groups (Monday and Friday) and one Family/education group (Wednesdays). During the first four weeks patients also attend two Early Recovery Skills groups per week (these groups occur on the same days as the Relapse Prevention groups just prior to them). After 12 weeks they attend a Social Support group on Wednesdays instead of the Family/education group.

Sample Schedule

Monday	**Wednesday**	**Friday**
Early Recovery Skills Weeks1-4	Family/education Weeks 1-12	Early Recovery Skills Weeks1-4
Relapse Prevention Weeks 1-16	Social Support Weeks 13-16 Continues past week 16	Relapse Prevention Weeks 1-16

Urine tests once per week

Program Components

Individual counseling. These sessions are critical to the development of the crucial relationship between the patient and the therapist. The content of the individual sessions is primarily concerned with setting and checking on the progress of the patient's individual goals. These

sessions can be combined with conjoint sessions, including significant others in the treatment planning. Extra sessions are sometimes necessary during times of crisis to change the treatment plan. These individual sessions are the glue that ensures the continuity of the primary treatment dyad and, thereby, retention of the patient in the treatment process.

Early Recovery Skills Groups. The eight Early Recovery Skills Groups are designed for patients in the first month of treatment or those who need extra tutoring in how to stop using drugs and alcohol. The purpose of the group is to teach patients: 1) how to use cognitive tools to reduce craving, 2) the nature of classically-conditioned cravings, 3) how to schedule their time, 4) about the need to discontinue use of secondary substances and 5) to connect patients with community support services necessary for a successful recovery. The reduced size of the groups allows the therapist to spend more individual time with each patient of these critical early skills and tasks. Patients who destabilize during treatment are often encouraged to return to the Early Recovery group until they re-stabilize.

Relapse Prevention Groups. The Relapse Prevention groups occur at the beginning and end of each week from the beginning of treatment through Week 16. They are the central component of the Matrix Model treatment package. They are open groups run with a very specific format for a very specific purpose. Most patients who have attempted recovery will agree that stopping using is not that difficult; it is *staying stopped* that makes the difference. These groups are the means by which patients are taught how to stay in sobriety.

The purpose of the Relapse Prevention groups is to provide a setting where information about relapse can be learned and shared. The 32 relapse prevention topics are focused on behavior change, changing the patient's cognitive/affective orientation, and connecting patients with 12-

step support systems. Each group is structured with a consistent format during which: 1) Patients are introduced if there are new members, 2) Patients give an up to the moment report on their progress in recovery, 3) Patients read the topic of the day and relate it to their own experience, 4) Patients share their schedules, plans, and commitment to recovery from the end of group until the group meets again. Input and encouragement from other group members is solicited but the group leader does not relinquish control of the group or promote directionless cross talk about how each member feels about what the others have said. The therapist maintains control and keeps the groups topic centered and positive with a strong educational element. Care is taken not to allow group members to share graphic stories of their drug and alcohol use. Therapists specifically avoid allowing the groups to become confrontational or extremely emotional. Whenever possible the use of a co-leader who has at least 6 months of recovery is employed. The co-leader serves as a peer support person who can share his or her own recovery experiences.

Family Education Groups. The 12-week series is presented to patients and their families in a group setting using slide presentations, videotapes, panels, and group discussions. The educational component includes such program topics as: (a) the biology of addiction, describing concepts such as neurotransmitters, brain structure and function and drug tolerance; (b) conditioning and addiction, including concepts such as conditioned cues, extinction, and conditioned abstinence; (c) medical effects of drugs and alcohol on the heart, lungs, reproductive system, and brain; and (d) addiction and the family, describing how relationships are affected during addiction and recovery. Successfully engaging families in this component of treatment can significantly improve the probability of retaining the primary patient in treatment for the entire 16 weeks.

OHCA 000157

12-Step Meetings. The optimal arrangement is to have a 12-Step meeting on site at the treatment center one night each week. This meeting does not have to be an official meeting. Rather, the patients presently in treatment and graduated members can conduct an "Introduction to 12-Step Meeting" using the same format as an outside meeting with the purpose of orienting patients unfamiliar to the meetings in a safe setting with people they already know. Attending these meetings often makes going to an outside meeting for the first time much easier and less anxiety provoking. These meetings, along with outside 12-step meetings chosen by patients and the Social Support Group provide strong continuing support for graduated group members.

Urine/Breath Tests. Urine testing is done randomly on a weekly basis. Positive urine tests revealing previously undisclosed drug use serve as points of discussion rather than incrimination. Patients struggling with secondary drug or alcohol use should also be tested for those substances.

Relapse Analysis A specific exercise is used when a patient relapses unexpectedly or repeatedly and does not seem to understand the causes of the relapses. The optional exercise and forms are designed to help the therapist and the patient understand the issues and events that occurred preceding the relapse(s) in order to help prevent future relapses. This exercise is typically conducted during an individual session with the patient and, possibly, a significant other.

Social Support. Designed to help patients establish new nondrug-related friends and activities, these groups are less structured and topic-focused than the Relapse Prevention Groups. Patients begin the groups during the last month in treatment at the end of the family education series, in order to ensure that they feel connected before they graduate from the Relapse Prevention Groups. The content of the groups is determined by the needs of those members attending. If patients have relapsed, relapse prevention work may be in order, unstable patients are given

OHCA 000158

direction to help stabilize them and patients moving successfully through the stages of recovery are aided and encouraged to continue with the lifestyle changes that they are making.

Guiding Principles

The Matrix has a number of central therapeutic constructs. These include:

1) Establishing a positive and collaborative relationship with the client
2) Creating explicit structure and expectations
3) Teaching psycho-educational information (including information on brain chemistry and other research derived clinically relevant knowledge).
4) Introducing and applying of cognitive-behavioral concepts
5) Positively reinforcing desired behavioral change
6) Educating family members regarding the expected course of recovery
7) Introducing and encouraging self-help participation
8) Monitoring drug use through the use of urinalyses

1) Positive and collaborative relationship

The context of the Matrix Model is characterized by a positive and collaborative relationship between the patient and therapist. Within this model, the therapist is required to be directive but to maintain a client-centered therapeutic stance. As cited in much psychotherapy research, it is essential to deliver accurate empathy, positive regard, warmth, and genuineness. It means treating patients with dignity, respect, and listening attentively and reflectively to their unique experience without imposing judgment.

OHCA 000159

A collaborative relationship will develop when you actively listen to patient's concerns and opinions and attempt to see the world from his/her perspective. This allows the creation of a spirit of cooperation and mutual effort. Conversely, use of a confrontational and therapist imposition of treatment goals and demands will create and adversarial relationship which can frequently contribute to premature treatment termination. Setting mutually agreed upon goals engages your client as an active participant. In addition, it validates and acknowledges his expertise and experiences, thereby reinforcing the therapeutic alliance. This collaborative climate increases the client's readiness to learn new skills and practice more adaptive coping strategies and establishes an environment where the successes and failures of using these new strategies can be shared.

The Motivational Interviewing techniques developed by Miller and Rollnick (1991; 2002) are all extremely valuable in building a successful therapeutic relationship with patients in outpatient treatment. The clinical skills incorporated within this approach are of tremendous value throughout treatment and especially during the early weeks of treatment.

2) Structure and Expectations

Structure is a critical element in any effective outpatient program. In outpatient settings structure is created by defining for patients the activities that are required parts of their treatment involvement. These activities include attendance at the individual and group sessions of the program, participation in community self-help groups, and the scheduled daily activities that minimize contact with drugs and other high risk situations. The structure provided by treatment helps to define for the patient exactly what is expected of him/her in treatment and provides a "roadmap" for recovery. This information can be useful in reducing the anxiety that is

OHCA 000160

commonly experienced by substance dependent individuals upon treatment initiation. Functioning within a structure can decreases stress and provide consistency and predictability which are all incompatible an addict's spontaneous, unplanned, chaotic lifestyle.

The primary component of structure during outpatient treatment is the daily, hour by hour schedule of his/her activities. The purpose of this exercise is not to create a list of one activity after another. Rather, the intent is to impart the concept of proactive planning of work activities, treatment and recovery activities, family and recreational activities, and relaxation activities. Within the context of this scheduling exercise it is possible to teach the identification and avoidance of high risk settings and people, and to promote engagement in new, non-drug related alternative behaviors. Creating a 24-hour schedule with the patient can help operationalize how to stay abstinent "one day at a time". This exercise can reduce feelings of being over whelmed in early recovery and/or of neglecting oneself in an attempt to immediately resolve problems created by the addiction.

The patient should keep the schedule and refer to it during day to day activities. It is important that the counselor keep a copy of the schedule and review it at the beginning of the next session. During early stages of treatment many patients forget to follow the schedule or decide to ignore the schedule. Frequently lapses will occur and these lapses can reinforce the use of the schedule procedure. Patients should realize that they can change their plan when essential but they should take the time to actually change the written schedule and write in the new activity. This process allows the patient time to think through the feasibility and advisability of the schedule change.

OHCA 000161

Some challenges and solutions:

1) Patients (and therapists) may forget to schedule in leisure activities, time to rest, or time to relax. The schedule can become a marathon of productive activities. This type of unrealistic scheduling will lead to noncompliance with the schedule and quickly will make the scheduling activity pointless. One helpful way to make sure that the schedule is realistic is to review the events of typical drug-free days and see what a normal routine is for that person. If the schedule created is too different from normal habits, it will be difficult for the client to incorporate it into his/her routine.
2) Many patients have difficulty making an hour-by-hour schedule. If this is the case, it is necessary to simplify the process. One way to do that is to simply use a small, pocket-sized card with the day divided into four sections; morning, midday, afternoon and evening. Beginning scheduling is easier if the patient can just plan activities for those four times of day. At first, some have trouble learning this skill. If this is the case, it can be helpful to have them describe what they did for the past 24 hours and then guess at what they are likely to do in the next 24 hours. You can write their schedule as they talk about it.
3) Some families want to help "plan" (dictate) a patient's schedule. Spouses and parents, especially, have lots of ideas for things that have been neglected or things that the patient should do. Since many patients are trying to win back the support of their families, they can be easily convinced that they should do whatever family members want rather than what they need to do sustain a plan for their recovery. If someone else's wishes and desires are the basis for the schedule regularly, sooner or later the recovering person will get resentful and will not find the scheduling useful or helpful. It will be viewed as a

OHCA 000162

"sentence" imposed by the family member and the therapist will be viewed as a colluding compatriot.

It is important for the patient to be the person who is responsible for constructing the schedule with input from the therapist.

3) Psychoeducation

A key component of the Matrix Model is information regarding conditioning and neurobiology to. Accurate, understandable information helps patients understand what has been happening in the past and also what predictable changes that will occur in their thinking, mood, and relationships over the course of several months. This education process identifies and normalizes symptoms, thereby empowering them to draw upon resources and techniques to help manage the symptoms.

The use of patient education as a treatment component is a not a new treatment concept, unique to the Matrix Model. However, teaching patients and their families about how the chronic use of drugs or alcohol produces changes in brain functioning in a manner that has direct application to patients' behavior is a relatively new strategy. Much of the information about drug-induced changes in the brain is highly technical and requires extensive scientific knowledge to comprehend the concepts fully. Without scientific training, it is not intuitive to substance abusing individuals or to their families to understand that the behavior associated with drug use may, in part, be explained by modifications in brain chemistry.

OHCA 000163

Two very basic "brain chemistry made simple" lectures were developed to be delivered in the treatment setting by a senior clinical staff person to patients and their families. (These lectures are also available in commercially produced video and DVDs through Hazelden Publishing.) New therapists are coached in explaining the essence of this brain chemistry change process along with the concept of classical conditioning as it relates to craving. Classically conditioned craving occurs independently of rational choice or renewed resolve to stop drug use. This fact provides a reassuring explanation of past behavior and an uncompromising context for recovery. From this premise follows many of the treatment handouts and exercises such as time scheduling (to avoid depending on in-the-moment, addiction-compromised thought processes) thought-stopping (to prevent initiation of the craving sequence), and avoidance of triggers (which also trigger release of neurotransmitters and simulate a desire to use). Without any more sophisticated knowledge than seeing the red areas of the brain light up with repeated cocaine dosing, clinical staff could refer to the "addicted brain" with science on their side and work collaboratively with patients to overcome the effects of this now very obvious physical alteration in the working brain.

The second basic lecture involves continuing changes in brain chemistry as the healing brain attempts to regain normal functioning. New scientific information continues to provide supportive evidence for the stages of recovery that patients have reported over the last 16 years. Studies are consistently showing that the recovery process often results in some brain functions getting worse before they get better, the brain needing a drug free environment for the healing to occur, and the entire recovery taking a much longer time to return to normal than we ever imagined. Even without a technical understanding of how and why these issues are occurring,

OHCA 000164

counselors can now say that they are occurring with certainty and can provide pictures to support their claims. This knowledge sets the stage for the continued teaching of the relapse prevention activities and supports vigilant treatment participation far beyond the initial withdrawal phase. Patients are comforted by the existence of a roadmap delineating the process of recovery and are more secure in the knowledge that activities they are asked to do relate directly to their recovery from a very physical disease state.

In the Matrix model the science-made-simple lectures are delivered midweek during the family education group for patients and their families. They are part of a series of 16 educational groups that the senior clinical person in each clinic conducts. New counselors are required to sit in on the education groups and to complete a formal training process that includes reading scientific articles and publications, becoming familiar with professional guidelines, viewing educational videotapes and observing a required number of groups, individual sessions and hotline phone calls.

Some challenges and solutions:

1. The presentation of psycho-educational information based on science can be dull and tedious for patients and families if presented improperly. The material from the research literature has to be "translated" into non-technical language and presented at an 8-10th grade level. Visual aids, including clear and understandable pictures and videos can be very useful to convey this information. It is important that the material be presented in a context of clinical issues so that patients and their family members understand the relevance of the information and how it applies to their addiction recovery.

OHCA 000165

2. The individual who presents this material as part of the Matrix program has to be well versed in the neurobiological concepts and other research information. For the material to be understood and used by patients, the presenter must have credibility, be able to expand on the material, and make the material relevant to patients' clinical challenges.

4) Cognitive Behavioral Skills

Knowledge and skills that have been developed within the field of cognitive behavioral therapy (CBT) play a large role in the Matrix Model. The work of Marlatt and Gordon (1985), Carroll and colleagues (Carroll et al., 1994; Carroll and Onken, 2005), and others have contributed greatly to the content of the group treatment activities at Matrix. This approach teaches patients that drug use and relapse are not random events, and that they can learn skills that can be applied in daily life to promote abstinence and prevent relapse. One of these skills is self-monitoring to bring into awareness any dysphoric or uncomfortable symptoms, thoughts, warning signs, high-risk situations, and subtle precipitating events. Patients learn skills to identify triggers, develop coping skills, and manage immediate problems. They are encouraged to practice and experiment with new behaviors outside the clinic setting. In the group, patients report back on what worked and what didn't work, what obstacles were encountered, and what changes need to be made to make the interventions successful in the future. In this process patients become the experts on their own individual recovery processes.

Each of the Matrix groups is anchored with a specific CBT topic for each session. The topic is introduced by the therapist and a brief explanation is given about how this topic is related to the achievement of a successful recovery. There is a review of a handout/worksheet that explains

the concept and includes questions that are used to personalize the concept and make it relevant to each person. Each patient in the group discusses how the topic is a factor in his/her life and how the skills being introduced could help with specific challenges each faces in recovery. The discussion is never confrontational and while the primary exchange is typically between the patient and the therapist/group leader, frequently other patients can make observations about similarities and differences between their experiences and those of other patients. Frequently the therapist will suggest to one or more of the group members to apply the skill in the following days as a homework assignment.

Some challenges and solutions:

1. A cognitive-behavioral orientation can be very engaging, and a nonjudgmental stance communicates positive regard for the patient. However, if the topic is not accompanied with useful real world examples of how the topic can actually relate to patient challenges and benefits, the sessions can feel excessively didactic and academic, in short, boring. An important part of therapist training in the Matrix Model is the art of CBT delivery to keep the topic interesting and relevant and find ways to apply it to patients in the group.

2. Another challenges is maintaining a stimulating pace, staying on topic and managing the time of the group. At times, group members may be disruptive and interrupt the group with cross talk or impulsive behaviors. Speaking calmly and redirecting clients is an effective way to keep the group focused and on task. (With methamphetamine use there maybe some cognitive impairment, which should not be confused with "resistance" or "noncompliance.")

3. Some patients (particularly those who are mandated) may be at a stage of readiness where they are not receptive to total abstinence, lifestyle change, or even any modification in

their current drug or alcohol use. Often the cohesiveness and positive momentum of the group can also move them towards change. A skilled therapist will need to limit negative, counterproductive input from such a patient and at the same time be accepting, positive, and not be judgmental.

4. On occasion an intoxicated patient may show up for group. If another counselor is available on site, he or she can work with the patient to ensure safe transportation home. Any discussion on the matter regarding the drug or alcohol use should be avoided until the next appointment. If possible, an individual session should be scheduled to address the particular issues surrounding the relapse. The effect of such an event on other group members should not be ignored. They may need to discuss their reactions, and possible triggering, resulting from being in such close proximity to a relapsing colleague.

5) **Positive reinforcement**

There is a large amount of research supporting the efficacy of the systematic use of reinforcement for meeting specific behavioral criteria in the treatment of addictions (Higgins et al., 1994, 2000; Iguchi et al. 1997; Petry et al., 2000; Rawson et.al., 2002, 2006). Contingency management research with substance abuse problems usually has targeted drug-free urine results, attendance at treatment sessions, or achieving treatment goals as the basis for receiving incentives. Participants in research studies usually receive certificates that are redeemable for items with monetary values ranging from as little as one dollar to as much as one hundred dollars. Coupled with social recognition, relatively inexpensive items can have a strong effect on behavior. This approach has long been a part of both the educational system and of parenting skills training.

Although supported by a large amount of research, contingency management has not made significant inroads into treatment mainly because of cost and complexity. The Matrix Model includes many different uses of contingency management that are simple and inexpensive. The specific behavior targets and reinforcers may vary from program to program depending on the clinical needs and the program resources, but some general features should be common to all. These include:

a) Specific, clear criteria. The requirement for earning an incentive should be described in writing and in detail. For example, if attendance at group meetings earns a voucher, attendance would need to be clearly defined (e.g., attending at least 60 minutes of a 90-minute group; arriving within 5 minutes of the scheduled start time).

b) Verifiable behavior. If urine results are incentivized, it is critical that they are valid and testing procedures should be in place. If achieving treatment planned goals are rewarded, there should be some way of verifying these (e.g., ticket stubs from a museum, job application, or 12-step meeting attendance cards.)

c) Consistency in application of contingencies. If the rules are bent they quickly become ineffective.

d) Use of social reinforcement along with other rewards as much as possible. Acknowledging accomplishments in groups magnifies the effects tremendously.

Some examples of contingency management used in the Matrix programs include:

- Abstinence: At the beginning of each group session patients are asked to place colored stickers "dots" on a calendar for each drug free day. The session opens with

each patient reviewing number of days of abstinence. This public recording of data provides an excellent opportunity to explicitly reinforce the achievement of gaining drug free days.

- Urine results: Everyone who provides a drug-free urine each week participates in a pizza party at the end of the week
- Attendance: Participants who attend all treatment sessions over the course of a month earn a gift card which is presented in group. Those who attend 80% of treatment session earn a gift card of lesser value.
- Promptness: Cookies and chocolates are put out 5 minutes prior to the start of group and are left out until 5 minutes after. Only those who are present within this 10-minute period have access to the treats.
- Behavior in group: Counselors give stickers during group to clients who say something reflective of a positive change in attitude or recovery behavior, something supportive of other group members, or for abiding by group rules for the entire group. The stickers are typically put on the outside of treatment binders and the quickly achieve value in groups.

The cost of these incentives is very small and can be offset by better attendance where fee-for-service billings are the basis for program income. Local merchants may also donate gift cars or merchandise to reduce costs of contingency management.

OHCA 000170

6) Family Education

The Matrix model involves family members in the treatment program. "Family" includes all those people who are part of their everyday existence and are close to them. This includes biological family as well as partners, close friends, associates and people who are part of their extended family. Providing the family with education such as information on classically conditioned craving helps make the patient's behavior prior entering treatment understandable and it helps to demystify treatment and recovery. It is also important for significant others to be better prepared for the range of events such as lapses that may happen during the recovery process.

In the initial stages of treatment, family members will need to decide whether they are willing to be part of the recovery process. It is often necessary for therapists using the Matrix Model to schedule a session with family member to explain the manners in which they can be helpful in participating in the treatment process and strongly encouraging them to attend scheduled sessions. Addiction is presented to the family as a chronic condition which they can be helpful in remediating by providing support for the patient. By presenting their role as providing supportive and positive assistance, as opposed to entering "therapy" for their family systems pathology, family members are often more willing to help support the recovery process and attend treatment.

Not all family members will want to be a part of the recovery process, despite the urging by the therapist or patient. There are many reasons for this. One may be that the family members feel they have been through tremendous stress and disappointment and that they cannot put

OHCA 000171

themselves through any more of the emotional turmoil. These people usually still care very deeply for their affected family member but cannot stand to keep watching them destroy their life. Usually they have been involved in previous treatment attempts and are exhausted, emotionally and financially, from multiple unsuccessful attempts at recovery. Another reason for family members being unwilling to participate may be that that they are very angry. They may be tired of all the family resources being expended fruitlessly on battling the addiction. Other family members say they are just tired of all the deception and turmoil that is part of the addiction and they are not willing to invest more energy into helping the patient recover. These family members might say something like "This is your problem not mine. Go get fixed and when you are all better we can continue leading our lives together." In these circumstances, if the patient initiates treatment and demonstrates some positive progress, family members can then be approached again and invited to participate.

7) Self-Help Groups

AA/NA meetings are widely available, are free of charge, and provide a place where recovering people can meet others who are dealing with many of the same issues. Recently there have been some well designed studies that have demonstrated empirically the usefulness of participation in 12-Step programs. It makes sense for patients to use the meetings as an ongoing resource if they find them beneficial, and the Matrix Model includes topics designed to familiarize patients with this resource.

Not everyone responds favorably to the concepts of the 12-Steps or to the groups themselves. Many patients are not willing to attend 12-Step meetings, or they sample one or two meetings

and find them unhelpful/aversive. Much of the resistance to the 12-Step program concerns the "spiritual" dimension of AA/NA. This resistance can be reduced by urging patients to focus on other benefits of the program which they can find useful. For example, one basic principle of the Matrix approach is the creation of structure and development of non-drug related activities. The 12-Step groups can be presented as a means to construct a schedule with drug-free activities during high-risk time periods. Often motivational interviewing strategies can be helpful in addressing resistance to participation in 12-Step program involvement.

8) Urine and Breath Alcohol Testing

The Matrix approach requires accurate information on the drug use status of patients as they progress through treatment. The most accurate means of monitoring clients for drug and alcohol use during treatment is through the use of urine and breath alcohol testing. The variety of testing options available today makes it much easier for programs to regularly administer the tests than in the past. Tests can be analyzed on site or sent out to laboratories. Specimens can be monitored with temperature strips, they can be observed or unobserved. Regardless of the specific procedure used, the objective is the same: to monitor drug use and to provide feedback to the patient. Some patients may resist the necessity of urine testing. They may view the procedure as coercive or indicative of mistrust by the treatment program staff. It is possible to mitigate this resistance by describing the purpose of the testing as offering objective evidence of the patient's abstinence, if situations occur when family members or others make accusations of drug use. Patients will often say things like, "You don't need to test me. Why would I come in here and lie about using? I will tell you if I use." It's important to let new patients know that the testing

OHCA 000173

procedure is a standard part of the program, and that urine testing is not a way of "catching" misbehavior.

One important point to take into consideration is that urine testing should not be presented primarily as a monitoring measure. Instead of being used as a policing device, testing should be seen as a way to help a person not use drugs. Urine and breath alcohol testing done in a clinical setting for clinical purposes is quite different from urine testing that is done for legal monitoring.

Summary

The Matrix Model provides an integrated treatment experience for drug and alcohol users through a cognitive/behavioral approach, imbued with a motivational interviewing style, and supplemented with contingency management. The program as outlined here is typical and ideal. It has also been delivered within the context of medication-assisted treatment, with criminal justice patients (including a drug court), and as a track of residential treatment. In addition, as a result of the vagaries of funding (particularly managed care), or other requirements (our drug court is an 18-month program) treatment durations have not always been the 16-weeks described here. Our experience is that some variation on the ideal does not sacrifice effectiveness as long as there is adherence to the cognitive/behavioral elements of the Model.

In the future, we plan to augment this treatment approach with additional evidence-based interventions in order to sustain and increase effectiveness, and to expand the focus of treatment. For example, we hope to more successfully extend patient care beyond the initial intensive phase

OHCA 000174

through applications of contingencies targeting attendance in continuing care groups, or through scheduled telephone follow-up calls.

References

Carroll, K. M., B. J. Rounsaville, et al. (1994). "One-year follow-up of psychotherapy and pharmacotherapy for cocaine dependence. Delayed emergence of psychotherapy effects." Arch Gen Psychiatry **51**(12): 989-97.

Carroll, K. M. and L. S. Onken (2005). "Behavioral therapies for drug abuse." Am J Psychiatry **162**(8): 1452-60.

Higgins, S. T., A. J. Budney, et al. (1994). "Incentives improve outcome in outpatient behavioral treatment of cocaine dependence." Arch Gen Psychiatry **51**(7): 568-76.

Higgins, S. T., C. J. Wong, et al. (2000). "Contingent reinforcement increases cocaine abstinence during outpatient treatment and 1 year of follow-up." J Consult Clin Psychol **68**(1): 64-72.

Huber, A., Ling, W., Shoptaw, S.J., Gulati, V., Brethen, P., & Rawson, R.A. 1997. Integrating Treatments for Methamphetamine Abuse: A Psychosocial Perspective. *Journal of Addictive Diseases,* 16: 41-50.

OHCA 000175

Iguchi, M. Y., M. A. Belding, et al. (1997). "Reinforcing operants other than abstinence in drug abuse treatment: an effective alternative for reducing drug use." J Consult Clin Psychol **65**(3): 421-8.

Marlatt, B.A., and Gordon, J.R. 1985. *Relapse Prevention*. New York: Guilford Press.

Petry, N. M., B. Martin, et al. (2000). "Give them prizes, and they will come: contingency management for treatment of alcohol dependence." J Consult Clin Psychol **68**(2): 250-7.

Rawson, R. A., A. Huber, et al. (2002). "A comparison of contingency management and cognitive-behavioral approaches during methadone maintenance treatment for cocaine dependence." Arch Gen Psychiatry **59**(9): 817-24.

Rawson, R., Huber, A., Brethen, P., Obert, J. L., Gulati, V., Shoptaw, S., & Ling, W. (2002). Status of methamphetamine users 2-5 years after outpatient treatment. *Journal of Addictive Diseases, 21,* 107-119

Rawson, R.A., P. Marinelli-Casey, M.D. Anglin, A. Dickow, Y. Frazier, C. Gallagher, G.P. Galloway, J. Herrell, A. Huber, M.J. McCann, J. Obert, S. Pennell, C. Reiber, D. Vandersloot, J. Zweben, and The Methamphetamine Treatment Project Corporate Authors. 2004. A Multi-Site Comparison of Psychosocial Approaches for the Treatment of Methamphetamine Dependence. *Addiction*, 99, 708-717.

OHCA 000176

Rawson, R. A., M. J. McCann, et al. (2006). "A comparison of contingency management and cognitive-behavioral approaches for stimulant-dependent individuals." Addiction **101**(2): 267-74.

Rawson, R.A., Obert, J.L., McCann, M.J., & Ling W. 1991. Psychological approaches to the treatment of cocaine dependency. *Journal of Addictive Diseases*, 11: 97-120.

Rawson, R.A.; Obert, J.L.; McCann, M.J.; and Mann, A.J. Cocaine treatment outcome: Cocaine use following inpatient, outpatient, and no treatment. 1986. In Harris, L.S., ed. *Problems of Drug Dependence: Proceedings of the 47th Annual Scientific Meeting, the Committee on Problems of Drug Dependence.* NIDA Research Monograph Series, Number 67. DHHS Pub. No. (ADM) 86-1448. Rockville, MD: National Institute on Drug Abuse, 271-277.

Rawson, R.A., Shoptaw, S.J., Obert, J.L., McCann, M.J. Hassson, A.L., Marinelli-Casey, P.J. Brethen, P.R. & Ling, W. 1995. An intensive outpatient approach for cocaine abuse treatment: The Matrix model. *Journal of Substance Abuse Treatment*, 12: 117-127.

Shoptaw, S., Reback, C.J. et al. (2005). "Behavioral treatment approaches for methamphetamine dependence and HIV-related sexual risk behaviors among urban gay and bisexual men." *Drug and Alcohol Dependendence* **78**(2): 125-34.

OHCA 000177

Resources

Treatment Materials:

Matrix Institute (2006). *Matrix Model; Culturally Designed Client Handouts for American Indians/Alaskan Natives*. Los Angeles: Matrix Institute.

Rawson, R.A., McCann, M.J., Obert, J.L. (2005). *The Matrix Model Handouts and Worksheets. The Family Unit Spanish CD-Rom.* Center City, Minnesota: Hazelden.

Rawson, R.A., McCann, M.J., Obert, J.L. (2005). *The Matrix Model Handouts and Worksheets. Spanish CD-Rom.* Center City, Minnesota: Hazelden.

Rawson, R.A., Obert, J.L., McCann, M.J., Ling, W. (2005). *The Matrix Model Intensive Outpatient Alcohol and Drug Treatment Program: a 16-week Individualized Program.* Center City, Minnesota: Hazelden.

SAMHSA (2006). *Matrix Intensive Outpatient Treatment for People with Stimulant Use Disorders.* Rockville, MD: U.S. Department of Health and Human Services.

OHCA 000178

Training

The Matrix Model has been extensively disseminated over the past several years. There is a standard training curriculum. Training procedures include an initial 2-day training in the Matrix Model with follow-up intensive training in order to better achieve a reliable and faithful translation of training into a Matrix Model treatment program. All agencies who receive Matrix Model training identify a "Key Supervisor" who receives additional training at the Matrix Institute clinics and ongoing guidance in clinical supervision and maintenance of fidelity. This person will be a contact person for Matrix and will be the individual who assumes responsibility for assisting the program in getting the Model in place and maintaining a standard of practice with regard to fidelity. During their visits to Matrix in Los Angeles and following, the Key Supervisors are trained to supervise clinicians in the Matrix Model of treatment, to work with administrators to adapt the Model to their settings, and to administer the fidelity instruments. They have access to consultations with experienced Matrix clinicians, they are listed on the Matrix website as Key Supervisors, and they participate in a national listserve designed to connect all the Key Supervisors in the country and engage them in devising and developing ways to best disseminate the Matrix Model. Matrix uses this network of Key Supervisors to communicate changes and updates to the program.

Information regarding training is available at www.matrixinstitute.org

ATTACHMENT V

Charity Care Policy and Sliding Fee Scale

PRO BONO POLICY

Connecticut Counseling and Wellness has been servicing the residents of the greater Waterbury area for over 20 years. We offer clinical services to those affected by the disease of addiction, including but not limited to the identified client and their family. We recognize that there are residents of our community who do not have the resources or support to battle their disease, as such, we accept several Pro Bono clients per year.

Connecticut Counseling and Wellness determines Pro Bono status on a case by case basis; typically we discuss the need for Pro Bono services with referral source, verify client's inability to pay and determine those who demonstrate a need that can be best met by our clinical area of expertise.

"Because of our kinship with the suffering, our channels to contact have always been charged with the language of the heart"

-- Bill W.

Fee Scale and Fee Agreement

SERVICES FEE :
Intake - $150.00
Individual 60 minute session: $100.00
Group session: $75.00

FEE AGREEMENT If you have Medical Assistance or private insurance we will bill your insurance company for services at the established rate. You are responsible for any co-payments and deductibles. If your insurance does not pay in full, you will be responsible for the amount not paid by your insurance company. The Fee agreement does not apply to co-pays and deductibles since those rates are set by your insurance company or Medicaid. This Fee agreement only applies if you do not have insurance or if your insurance does not cover behavioral health services. CCW will help verify coverage, but financial obligations are still the responsibility of the client. Should your coverage change or be denied by the insurance company you are responsible for paying for the services you or your child receives. Fees are subject to change at the beginning of each calendar year. You may request a copy of the fee schedule at any time. If you do not have insurance, or if your insurance benefits have been exhausted, you will be responsible for paying the rate established on this fee agreement. You are also responsible for continued payment at the agreed upon rate once your maximum insurance benefits have been used. If you cannot afford the fees listed, you may request a sliding or reduced fee. This sliding fee will be taken from a sliding fee scale that is based on income and number of dependents. Proof of income is required to set the sliding fee amount below the full rates listed above. If you do not provide proof of income you will be charged the full amount. This agreement is re-negotiable with loss of insurance or change in income or family size. It will be agreed upon at your first session.

SLIDING (REDUCED) FEE SCALE: Connecticut Counseling and wellness services are offered for a reduced fee for those who may not be able to afford the full price. These lower fees are based on income and family size.

Sliding fee scale for Intake may be reduced to $75.00 from the standard $150.00
Individual sessions may be reduced to $50.00 per one hour session, from the standard $100.00
Group sessions may be available at $25.00 per session , down from the standard $75.00

I attest that the information provided above is true and agree to pay the established fee as listed in the table above. I also authorize the agency to release any information necessary to process my insurance claims. I further acknowledge that this information has been reviewed with me and that I have received a copy.

Client or Parent/Guardian's Signature: ____________________ Date: ____________

Therapist's Signature: ________________________ Date: __________________

ATTACHMENT VI

Balance Sheets, Statements of Operations, and Tax Returns

1776 Meriden Road * Wolcott CT * 06716

PROFIT AND LOSS

January - December 2016

	TOTAL
INCOME	
cash, checks, copays	-90.00
Edward Edgar	75.00
Gerry Marcil	9,985.00
Insurance compensation / Ed	-5.37
Sales	258,975.43
Steve Smolka	17,615.00
Uncategorized Income	35.00
Total Income	**$286,590.06**
GROSS PROFIT	**$286,590.06**
EXPENSES	
Bank fee	519.30
Bookkeeping	1,210.00
Credit Card Fees	732.13
donation	600.00
Expense Reimbursement	684.60
Health Insurance	1,448.40
insurance	398.00
Licenses & Permits	380.00
Office Expense	3,772.86
Payroll Expenses	13,531.44
Professional expense	8,605.24
rent	12,000.00
Subcontractors	165,728.73
supplies	2,326.21
Tax Collector, Waterbury	117.02
Uncategorized Expense	890.89
Utility (Oil)	1,007.20
Utility (Telecom)	985.79
voided	0.00
Total Expenses	**$214,937.81**
NET OPERATING INCOME	**$71,652.25**
OTHER EXPENSES	
Bad Debt	781.63
fee difference	55,365.30
write off	4,149.29
Total Other Expenses	**$60,296.22**
NET OTHER INCOME	**$ -60,296.22**
NET INCOME	**$11,356.03**

1776 Meriden Road * Wolcott CT * 06716

BALANCE SHEET

As of December 31, 2016

	TOTAL
ASSETS	
Current Assets	
Bank Accounts	
Checking	6,472.53
Total Bank Accounts	**$6,472.53**
Accounts Receivable	
Accounts Receivable	53,649.91
Total Accounts Receivable	**$53,649.91**
Other Current Assets	
Accounts Receivable - Adj	2,214.78
Accounts Receivable - Tax Adj	0.00
Prepaid expense	1,500.00
Security Deposit	1,500.00
Undeposited Funds	-2,116.29
Total Other Current Assets	**$3,098.49**
Total Current Assets	**$63,220.93**
Fixed Assets	
Accumulated Depreciation	-9,387.00
Bldg and Other Assets	9,387.00
Total Fixed Assets	**$0.00**
Other Assets	
Goodwill	9,613.00
Goodwill - Accum Amortization	-1,816.00
Section 754 Accum Depreciation	-368.20
Section 754 Adjustment	5,156.20
voided check	0.00
Total Other Assets	**$12,585.00**
TOTAL ASSETS	**$75,805.93**
LIABILITIES AND EQUITY	
Liabilities	
Current Liabilities	
Credit Cards	
First Data	-2.72
Total Credit Cards	**$ -2.72**
Other Current Liabilities	
due to J Marcil	10,900.00
Total Other Current Liabilities	**$10,900.00**
Total Current Liabilities	**$10,897.28**
Total Liabilities	**$10,897.28**
Equity	
Member Equity - Jerry	72,979.56
Draw- Marcil, Jerry	-18,925.00

	TOTAL
Investmnt- Marcil, Jerry	0.00
Total Member Equity - Jerry	**54,054.56**
Member Equity- Steve	0.00
Draw- Smolka, Steve	0.00
Investmnt- Smolka, Steve	0.00
Total Member Equity- Steve	**0.00**
Retained Earnings	-501.94
Net Income	11,356.03
Total Equity	**$64,908.65**
TOTAL LIABILITIES AND EQUITY	**$75,805.93**

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01/26/16

Accrual Basis

Counseling Center of Waterbury
Profit & Loss
January through December 2015

	Jan - Dec 15
Ordinary Income/Expense	
Income	291,926.95
Gross Profit	291,926.95
Expense	
Amortization	641.00
Bank fee	297.85
Credit Card Fees	782.15
Office Expense	16,509.62
Prior Period Adjustments	13,205.38
Professional expense	5,279.95
refund	148.00
rent	13,944.00
state business tax	250.00
Subcontractors	87,566.25
supplies	1,647.33
Tax Collector, Waterbury	117.02
Utility (Electric)	2,210.34
Utility (Gas)	1,461.60
Utility (Oil)	464.36
Utility (Telecom)	2,273.93
Total Expense	146,798.78
Net Ordinary Income	145,128.17
Other Income/Expense	
Other Expense	
Bad Debt	19,968.56
Total Other Expense	19,968.56
Net Other Income	-19,968.56
Net Income	**125,159.61**

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01/26/16

Accrual Basis

Counseling Center of Waterbury
Balance Sheet
As of December 31, 2015

		Dec 31, 15
ASSETS		
Current Assets		
Checking/Savings		
Checking		1,837.62
Total Checking/Savings		1,837.62
Accounts Receivable		
Accounts Receivable		56,216.94
Total Accounts Receivable		56,216.94
Other Current Assets		
Security Deposit		1,100.00
Undeposited Funds		-660.00
Total Other Current Assets		440.00
Total Current Assets		58,494.56
Fixed Assets		
Accumulated Depreciation		-9,387.00
Bldg and Other Assets		9,387.00
Total Fixed Assets		0.00
Other Assets		
Goodwill		
Accumulated Amortization	-1,816.00	
Goodwill - Other	9,613.00	
Total Goodwill		7,797.00
Section 754 Adjustment		5,156.20
Total Other Assets		12,953.20
TOTAL ASSETS		71,447.76
LIABILITIES & EQUITY		
Equity		
Member Equity- Steve		
Draw- Smolka, Steve	-56,100.00	
Member Equity- Steve - Other	56,100.00	
Total Member Equity- Steve		0.00
Member Equity - Jerry		
Draw- Marcil, Jerry	-56,750.00	
Member Equity - Jerry - Other	128,197.76	
Total Member Equity - Jerry		71,447.76
Retained Earnings		-125,159.61
Net Income		125,159.61
Total Equity		71,447.76
TOTAL LIABILITIES & EQUITY		71,447.76

OHCA 000189

Form **1065** Department of the Treasury Internal Revenue Service

U.S. Return of Partnership Income

For calendar year 2015, or tax year beginning ________, ____, ending ________, ____

OMB No. 1545-0123

2015

A Principal business activity: COUNSELING	Name of partnership: COUNSELING CENTER OF WATERBURY, LLC	D Employer identification number: 46-1590675
B Principal product or service: COUNSELING	Type or Print — Number, street, and room or suite no. If a P.O. box, see the instructions: 525 WOLCOTT STREET	E Date business started: 01/01/2013
C Business code number: 621420	City or town, state or province, country, and ZIP or foreign postal code: WATERBURY CT 06705	F Total assets: $ 72,980.

G Check applicable boxes: (1) [ ] Initial return (2) [X] Final return (3) [ ] Name change (4) [ ] Address change (5) [ ] Amended return (6) [ ] Technical termination - also check (1) or (2)

H Check accounting method: (1) [ ] Cash (2) [X] Accrual (3) [ ] Other (specify) ▶

I Number of Schedules K-1. Attach one for each person who was a partner at any time during the tax year ▶ 2

J Check if Schedules C and M-3 are attached [ ]

Caution. *Include only trade or business income and expenses on lines 1a through 22 below. See the instructions for more information.*

	Line	Description				Amount
Income	1a	Gross receipts or sales	1a	339,195.		
	b	Returns and allowances	1b	60,473.		
	c	Balance. Subtract line 1b from line 1a			1c	278,722.
	2	Cost of goods sold (attach Form 1125-A)			2	
	3	Gross profit. Subtract line 2 from line 1c			3	278,722.
	4	Ordinary income (loss) from other partnerships, estates, and trusts (attach statement)			4	
	5	Net farm profit (loss) (attach Schedule F (Form 1040))			5	
	6	Net gain (loss) from Form 4797, Part II, line 17 (attach Form 4797)			6	
	7	Other income (loss) (attach statement)			7	
	8	**Total income (loss).** Combine lines 3 through 7			8	278,722.
Deductions (see the instructions for limitations)	9	Salaries and wages (other than to partners) (less employment credits)			9	
	10	Guaranteed payments to partners			10	
	11	Repairs and maintenance			11	
	12	Bad debts			12	19,969.
	13	Rent			13	12,044.
	14	Taxes and licenses			14	367.
	15	Interest			15	
	16a	Depreciation (if required, attach Form 4562)	16a			
	b	Less depreciation reported on Form 1125-A and elsewhere on return	16b		16c	
	17	Depletion (**Do not deduct oil and gas depletion.**)			17	
	18	Retirement plans, etc.			18	
	19	Employee benefit programs			19	
	20	Other deductions (attach statement) SEE STATEMENT 1			20	119,282.
	21	**Total deductions.** Add the amounts shown in the far right column for lines 9 through 20			21	151,662.
	22	**Ordinary business income (loss).** Subtract line 21 from line 8			22	127,060.

Sign Here — Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete. Declaration of preparer (other than general partner or limited liability company member manager) is based on all information of which preparer has any knowledge.

▶ Signature of general partner or limited liability company member manager ▶ Date

May the IRS discuss this return with the preparer shown below (see instr.)? [X] Yes [ ] No

Paid Preparer Use Only

Print/Type preparer's name	Preparer's signature	Date	Check [ ] if self-employed	PTIN
JOHN J. MOONEY, CPA, CFE				P00167755

Firm's name ▶ BAILEY MOORE GLAZER SCHAEFER PROTO LLP — Firm's EIN ▶ 06-0674931

Firm's address ▶ 16 LUNAR DRIVE WOODBRIDGE, CT 06525-9941 — Phone no. (203)397-7700

LHA For Paperwork Reduction Act Notice, see separate instructions. Form **1065** (2015)

511001 12-23-15

Schedule B Other Information

		Yes	No
1	What type of entity is filing this return? Check the applicable box: a [X] Domestic general partnership b [ ] Domestic limited partnership c [ ] Domestic limited liability company d [ ] Domestic limited liability partnership e [ ] Foreign partnership f [ ] Other ▶		
2	At any time during the tax year, was any partner in the partnership a disregarded entity, a partnership (including an entity treated as a partnership), a trust, an S corporation, an estate (other than an estate of a deceased partner), or a nominee or similar person?		X
3	At the end of the tax year:		
a	Did any foreign or domestic corporation, partnership (including any entity treated as a partnership), trust, or tax-exempt organization, or any foreign government own, directly or indirectly, an interest of 50% or more in the profit, loss, or capital of the partnership? For rules of constructive ownership, see instructions. If "Yes," attach Schedule B-1, Information on Partners Owning 50% or More of the Partnership		X
b	Did any individual or estate own, directly or indirectly, an interest of 50% or more in the profit, loss, or capital of the partnership? For rules of constructive ownership, see instructions. If "Yes," attach Schedule B-1, Information on Partners Owning 50% or More of the Partnership	X	
4	At the end of the tax year, did the partnership:		
a	Own directly 20% or more, or own, directly or indirectly, 50% or more of the total voting power of all classes of stock entitled to vote of any foreign or domestic corporation? For rules of constructive ownership, see instructions. If "Yes," complete (i) through (iv) below		X

(i) Name of Corporation	(ii) Employer Identification Number (if any)	(iii) Country of Incorporation	(iv) Percentage Owned in Voting Stock

		Yes	No
b	Own directly an interest of 20% or more, or own, directly or indirectly, an interest of 50% or more in the profit, loss, or capital in any foreign or domestic partnership (including an entity treated as a partnership) or in the beneficial interest of a trust? For rules of constructive ownership, see instructions. If "Yes," complete (i) through (v) below		X

(i) Name of Entity	(ii) Employer Identification Number (if any)	(iii) Type of Entity	(iv) Country of Organization	(v) Maximum Percentage Owned in Profit, Loss, or Capital

		Yes	No
5	Did the partnership file Form 8893, Election of Partnership Level Tax Treatment, or an election statement under section 6231(a)(1)(B)(ii) for partnership-level tax treatment, that is in effect for this tax year? See Form 8893 for more details		X
6	Does the partnership satisfy all four of the following conditions?		
a	The partnership's total receipts for the tax year were less than $250,000.		
b	The partnership's total assets at the end of the tax year were less than $ 1 million.		
c	Schedules K-1 are filed with the return and furnished to the partners on or before the due date (including extensions) for the partnership return.		
d	The partnership is not filing and is not required to file Schedule M-3		X
	If "Yes," the partnership is not required to complete Schedules L, M-1, and M-2; Item F on page 1 of Form 1065; or Item L on Schedule K-1.		
7	Is this partnership a publicly traded partnership as defined in section 469(k)(2)?		X
8	During the tax year, did the partnership have any debt that was cancelled, was forgiven, or had the terms modified so as to reduce the principal amount of the debt?		X
9	Has this partnership filed, or is it required to file, Form 8918, Material Advisor Disclosure Statement, to provide information on any reportable transaction?		X
10	At any time during calendar year 2015, did the partnership have an interest in or a signature or other authority over a financial account in a foreign country (such as a bank account, securities account, or other financial account)? See the instructions for exceptions and filing requirements for FinCEN Form 114, Report of Foreign Bank and Financial Accounts (FBAR). If "Yes," enter the name of the foreign country. ▶		X

Form 1065 (2015)

Schedule B **Other Information *(continued)***

		Yes	No
11	At any time during the tax year, did the partnership receive a distribution from, or was it the grantor of, or transferor to, a foreign trust? If "Yes," the partnership may have to file Form 3520, Annual Return To Report Transactions With Foreign Trusts and Receipt of Certain Foreign Gifts. See instructions		X
12a	Is the partnership making, or had it previously made (and not revoked), a section 754 election? See instructions for details regarding a section 754 election.	X	
b	Did the partnership make for this tax year an optional basis adjustment under section 743(b) or 734(b)? If "Yes," attach a statement showing the computation and allocation of the basis adjustment. See instructions STATEMENT 2	X	
c	Is the partnership required to adjust the basis of partnership assets under section 743(b) or 734(b) because of a substantial built-in loss (as defined under section 743(d)) or substantial basis reduction (as defined under section 734(d))? If "Yes," attach a statement showing the computation and allocation of the basis adjustment. See instructions		X
13	Check this box if, during the current or prior tax year, the partnership distributed any property received in a like-kind exchange or contributed such property to another entity (other than disregarded entities wholly owned by the partnership throughout the tax year) ▶ ☐		
14	At any time during the tax year, did the partnership distribute to any partner a tenancy-in-common or other undivided interest in partnership property?		X
15	If the partnership is required to file Form 8858, Information Return of U.S. Persons With Respect To Foreign Disregarded Entities, enter the number of Forms 8858 attached. See instructions ▶		
16	Does the partnership have any foreign partners? If "Yes," enter the number of Forms 8805, Foreign Partner's Information Statement of Section 1446 Withholding Tax, filed for this partnership. ▶		X
17	Enter the number of Forms 8865, Return of U.S. Persons With Respect to Certain Foreign Partnerships, attached to this return. ▶		
18a	Did you make any payments in 2015 that would require you to file Form(s) 1099? See instructions	X	
b	If "Yes," did you or will you file required Form(s) 1099?	X	
19	Enter the number of Form(s) 5471, Information Return of U.S. Persons With Respect To Certain Foreign Corporations, attached to this return. ▶		
20	Enter the number of partners that are foreign governments under section 892. ▶		

Designation of Tax Matters Partner (see instructions)

Enter below the general partner or member-manager designated as the tax matters partner (TMP) for the tax year of this return:

Name of designated TMP ▶	GERARD MARCIL	Identifying number of TMP ▶	***-**-2629
If the TMP is an entity, name of TMP representative ▶		Phone number of TMP ▶	
Address of designated TMP ▶	175 PEACH ORCHARD ROAD WATERBURY, CT 06706		

Form **1065** (2015)

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OHCA 000192

Schedule K Partners' Distributive Share Items

Section	Line	Description	Sub-box	Line no.	Total amount
Income (Loss)	1	Ordinary business income (loss) (page 1, line 22)		1	127,060.
	2	Net rental real estate income (loss) (attach Form 8825)		2	
	3 a	Other gross rental income (loss)	3a		
	b	Expenses from other rental activities (attach statement)	3b		
	c	Other net rental income (loss). Subtract line 3b from line 3a		3c	
	4	Guaranteed payments		4	
	5	Interest income		5	
	6	Dividends: a Ordinary dividends		6a	
		b Qualified dividends	6b		
	7	Royalties		7	
	8	Net short-term capital gain (loss) (attach Schedule D (Form 1065))		8	
	9 a	Net long-term capital gain (loss) (attach Schedule D (Form 1065))		9a	
	b	Collectibles (28%) gain (loss)	9b		
	c	Unrecaptured section 1250 gain (attach statement)	9c		
	10	Net section 1231 gain (loss) (attach Form 4797)		10	
	11	Other income (loss) (see instructions) Type ▶		11	
Deductions	12	Section 179 deduction (attach Form 4562)		12	
	13 a	Contributions		13a	
	b	Investment interest expense		13b	
	c	Section 59(e)(2) expenditures: (1) Type ▶ (2) Amount ▶		13c(2)	
	d	Other deductions (see instructions) Type ▶ SECTION 754 DEPRECIATION		13d	368.
Self-Employment	14 a	Net earnings (loss) from self-employment		14a	127,060.
	b	Gross farming or fishing income		14b	
	c	Gross nonfarm income		14c	278,722.
Credits	15 a	Low-income housing credit (section 42(j)(5))		15a	
	b	Low-income housing credit (other)		15b	
	c	Qualified rehabilitation expenditures (rental real estate) (attach Form 3468, if applicable)		15c	
	d	Other rental real estate credits (see instructions) Type ▶		15d	
	e	Other rental credits (see instructions) Type ▶		15e	
	f	Other credits (see instructions) Type ▶		15f	
Foreign Transactions	16 a	Name of country or U.S. possession ▶			
	b	Gross income from all sources		16b	
	c	Gross income sourced at partner level		16c	
		Foreign gross income sourced at partnership level			
	d	Passive category ▶ e General category ▶ f Other ▶		16f	
		Deductions allocated and apportioned at partner level			
	g	Interest expense ▶ h Other ▶		16h	
		Deductions allocated and apportioned at partnership level to foreign source income			
	i	Passive category ▶ j General category ▶ k Other ▶		16k	
	l	Total foreign taxes (check one): ▶ Paid ☐ Accrued ☐		16l	
	m	Reduction in taxes available for credit (attach statement)		16m	
	n	Other foreign tax information (attach statement)			
Alternative Minimum Tax (AMT) Items	17 a	Post-1986 depreciation adjustment		17a	
	b	Adjusted gain or loss		17b	
	c	Depletion (other than oil and gas)		17c	
	d	Oil, gas, and geothermal properties - gross income		17d	
	e	Oil, gas, and geothermal properties - deductions		17e	
	f	Other AMT items (attach statement)		17f	
Other Information	18 a	Tax-exempt interest income		18a	
	b	Other tax-exempt income		18b	
	c	Nondeductible expenses		18c	
	19 a	Distributions of cash and marketable securities		19a	132,694.
	b	Distributions of other property		19b	
	20 a	Investment income		20a	
	b	Investment expenses		20b	
	c	Other items and amounts (attach statement)			

Analysis of Net Income (Loss)

1 Net income (loss). Combine Schedule K, lines 1 through 11. From the result, subtract the sum of Schedule K, lines 12 through 13d, and 16l					1	126,692.
2 Analysis by partner type:	(i) Corporate	(ii) Individual (active)	(iii) Individual (passive)	(iv) Partnership	(v) Exempt Organization	(vi) Nominee/Other
a General partners		126,692.				
b Limited partners						

Schedule L | Balance Sheets per Books

Assets	Beginning of tax year (a)	(b)	End of tax year (c)	(d)
1 Cash		4,454.		1,838.
2a Trade notes and accounts receivable	43,627.		56,217.	
b Less allowance for bad debts		43,627.		56,217.
3 Inventories				
4 U.S. government obligations				
5 Tax-exempt securities				
6 Other current assets (attach statement)	STATEMENT 3	1,100.		2,340.
7a Loans to partners (or persons related to partners)				
b Mortgage and real estate loans				
8 Other investments (attach statement)				
9a Buildings and other depreciable assets	9,387.		14,543.	
b Less accumulated depreciation	9,387.		9,755.	4,788.
10a Depletable assets				
b Less accumulated depletion				
11 Land (net of any amortization)				
12a Intangible assets (amortizable only)	9,613.		9,613.	
b Less accumulated amortization	1,175.	8,438.	1,816.	7,797.
13 Other assets (attach statement)				
14 Total assets		57,619.		72,980.
Liabilities and Capital				
15 Accounts payable				
16 Mortgages, notes, bonds payable in less than 1 year				
17 Other current liabilities (attach statement)	STATEMENT 4	3,637.		
18 All nonrecourse loans				
19a Loans from partners (or persons related to partners)				
b Mortgages, notes, bonds payable in 1 year or more				
20 Other liabilities (attach statement)				
21 Partners' capital accounts		53,982.		72,980.
22 Total liabilities and capital		57,619.		72,980.

Schedule M-1 | Reconciliation of Income (Loss) per Books With Income (Loss) per Return

Note. The partnership may be required to file Schedule M-3 (see instructions).

1 Net income (loss) per books	126,692.	6 Income recorded on books this year not included on Schedule K, lines 1 through 11 (itemize): a Tax-exempt interest $	
2 Income included on Schedule K, lines 1, 2, 3c, 5, 6a, 7, 8, 9a, 10, and 11, not recorded on books this year (itemize):			
3 Guaranteed payments (other than health insurance)		7 Deductions included on Schedule K, lines 1 through 13d, and 16l, not charged against book income this year (itemize): a Depreciation $	
4 Expenses recorded on books this year not included on Schedule K, lines 1 through 13d, and 16l (itemize): a Depreciation $ b Travel and entertainment $		8 Add lines 6 and 7	
5 Add lines 1 through 4	126,692.	9 Income (loss) (Analysis of Net Income (Loss), line 1). Subtract line 8 from line 5	126,692.

Schedule M-2 | Analysis of Partners' Capital Accounts

1 Balance at beginning of year	53,982.	6 Distributions: a Cash	132,694.
2 Capital contributed: a Cash	25,000.	b Property	
b Property		7 Other decreases (itemize):	
3 Net income (loss) per books	126,692.		
4 Other increases (itemize):		8 Add lines 6 and 7	132,694.
5 Add lines 1 through 4	205,674.	9 Balance at end of year. Subtract line 8 from line 5	72,980.

SCHEDULE B-1 (Form 1065)
(Rev. December 2011)
Department of the Treasury Internal Revenue Service

Information on Partners Owning 50% or More of the Partnership

▶ Attach to Form 1065. See Instructions.

OMB No. 1545-0099

Name of partnership: COUNSELING CENTER OF WATERBURY, LLC

Employer identification number: 46-1590675

Part I Entities Owning 50% or More of the Partnership (Form 1065, Schedule B, Question 3a)

Complete columns (i) through (v) below for any foreign or domestic corporation, partnership (including any entity treated as a partnership), trust, tax-exempt organization, or any foreign government that owns, directly or indirectly, an interest of 50% or more in the profit, loss, or capital of the partnership (see instructions).

(i) Name of Entity	(ii) Employer Identification Number (if any)	(iii) Type of Entity	(iv) Country of Organization	(v) Maximum Percentage Owned in Profit, Loss, or Capital

Part II Individuals or Estates Owning 50% or More of the Partnership (Form 1065, Schedule B, Question 3b)

Complete columns (i) through (iv) below for any individual or estate that owns, directly or indirectly, an interest of 50% or more in the profit, loss, or capital of the partnership (see instructions).

(i) Name of Individual or Estate	(ii) Identifying Number (if any)	(iii) Country of Citizenship (see instructions)	(iv) Maximum Percentage Owned in Profit, Loss, or Capital
GERARD MARCIL	***-**-2629	UNITED STATES	100.00

LHA For Paperwork Reduction Act Notice, see the Instructions for Form 1065.

Schedule B-1 (Form 1065) (Rev. 12-2011)

524551
04-01-15

Form **4562** | **Depreciation and Amortization** (Including Information on Listed Property) OTHER 1 | OMB No. 1545-0172 **2015** Attachment Sequence No. 179

Department of the Treasury Internal Revenue Service (99)

▶ Attach to your tax return.

▶ Information about Form 4562 and its separate instructions is at www.irs.gov/form4562.

Name(s) shown on return	Business or activity to which this form relates	Identifying number
COUNSELING CENTER OF WATERBURY, LLC		46-1590675

Part I Election To Expense Certain Property Under Section 179 **Note:** If you have any listed property, complete Part V before you complete Part I.

1	Maximum amount (see instructions)	1	
2	Total cost of section 179 property placed in service (see instructions)	2	
3	Threshold cost of section 179 property before reduction in limitation	3	
4	Reduction in limitation. Subtract line 3 from line 2. If zero or less, enter -0-	4	
5	Dollar limitation for tax year. Subtract line 4 from line 1. If zero or less, enter -0-. If married filing separately, see instructions	5	

6 (a) Description of property	(b) Cost (business use only)	(c) Elected cost

7	Listed property. Enter the amount from line 29	7	
8	Total elected cost of section 179 property. Add amounts in column (c), lines 6 and 7	8	
9	Tentative deduction. Enter the **smaller** of line 5 or line 8	9	
10	Carryover of disallowed deduction from line 13 of your 2014 Form 4562	10	
11	Business income limitation. Enter the smaller of business income (not less than zero) or line 5	11	
12	Section 179 expense deduction. Add lines 9 and 10, but do not enter more than line 11	12	
13	Carryover of disallowed deduction to 2016. Add lines 9 and 10, less line 12 ▶	13	

Note: Do not use Part II or Part III below for listed property. Instead, use Part V.

Part II **Special Depreciation Allowance and Other Depreciation (Do not include listed property.)**

14	Special depreciation allowance for qualified property (other than listed property) placed in service during the tax year	14	
15	Property subject to section 168(f)(1) election	15	
16	Other depreciation (including ACRS)	16	

Part III **MACRS Depreciation (Do not include listed property.) (See instructions.)**

Section A

17	MACRS deductions for assets placed in service in tax years beginning before 2015	17	
18	If you are electing to group any assets placed in service during the tax year into one or more general asset accounts, check here ▶ ☐		

Section B - Assets Placed in Service During 2015 Tax Year Using the General Depreciation System

(a) Classification of property	(b) Month and year placed in service	(c) Basis for depreciation (business/investment use only - see instructions)	(d) Recovery period	(e) Convention	(f) Method	(g) Depreciation deduction
19a 3-year property						
b 5-year property						
c 7-year property						
d 10-year property						
e 15-year property						
f 20-year property						
g 25-year property			25 yrs.		S/L	
h Residential rental property	/		27.5 yrs.	MM	S/L	
	/		27.5 yrs.	MM	S/L	
i Nonresidential real property	/		39 yrs.	MM	S/L	
	/			MM	S/L	

Section C - Assets Placed in Service During 2015 Tax Year Using the Alternative Depreciation System

(a)	(b)	(c)	(d)	(e)	(f)	(g)
20a Class life					S/L	
b 12-year			12 yrs.		S/L	
c 40-year	/		40 yrs.	MM	S/L	

Part IV Summary (See instructions.)

21	Listed property. Enter amount from line 28	21	
22	**Total.** Add amounts from line 12, lines 14 through 17, lines 19 and 20 in column (g), and line 21. Enter here and on the appropriate lines of your return. Partnerships and S corporations - see instr.	22	
23	For assets shown above and placed in service during the current year, enter the portion of the basis attributable to section 263A costs	23	

516251 12-28-15 LHA **For Paperwork Reduction Act Notice, see separate instructions.** Form **4562** (2015)

Part V **Listed Property** (Include automobiles, certain other vehicles, certain aircraft, certain computers, and property used for entertainment, recreation, or amusement.)

Note: For any vehicle for which you are using the standard mileage rate or deducting lease expense, complete **only** 24a, 24b, columns (a) through (c) of Section A, all of Section B, and Section C if applicable.

Section A - Depreciation and Other Information (Caution: See the instructions for limits for passenger automobiles.)

24a Do you have evidence to support the business/investment use claimed? ☐ Yes ☐ No **24b** If "Yes," is the evidence written? ☐ Yes ☐ No

(a) Type of property (list vehicles first)	(b) Date placed in service	(c) Business/ investment use percentage	(d) Cost or other basis	(e) Basis for depreciation (business/investment use only)	(f) Recovery period	(g) Method/ Convention	(h) Depreciation deduction	(i) Elected section 179 cost
25 Special depreciation allowance for qualified listed property placed in service during the tax year and used more than 50% in a qualified business use						25		
26 Property used more than 50% in a qualified business use:								
		%						
		%						
		%						
27 Property used 50% or less in a qualified business use:								
		%				S/L -		
		%				S/L -		
		%				S/L -		
28 Add amounts in column (h), lines 25 through 27. Enter here and on line 21, page 1						28		
29 Add amounts in column (i), line 26. Enter here and on line 7, page 1							29	

Section B - Information on Use of Vehicles

Complete this section for vehicles used by a sole proprietor, partner, or other "more than 5% owner," or related person. If you provided vehicles to your employees, first answer the questions in Section C to see if you meet an exception to completing this section for those vehicles.

	(a) Vehicle		(b) Vehicle		(c) Vehicle		(d) Vehicle		(e) Vehicle		(f) Vehicle	
30 Total business/investment miles driven during the year (**do not** include commuting miles)												
31 Total commuting miles driven during the year												
32 Total other personal (noncommuting) miles driven												
33 Total miles driven during the year. Add lines 30 through 32												
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
34 Was the vehicle available for personal use during off-duty hours?												
35 Was the vehicle used primarily by a more than 5% owner or related person?												
36 Is another vehicle available for personal use?												

Section C - Questions for Employers Who Provide Vehicles for Use by Their Employees

Answer these questions to determine if you meet an exception to completing Section B for vehicles used by employees who **are not** more than 5% owners or related persons.

	Yes	No
37 Do you maintain a written policy statement that prohibits all personal use of vehicles, including commuting, by your employees?		
38 Do you maintain a written policy statement that prohibits personal use of vehicles, except commuting, by your employees? See the instructions for vehicles used by corporate officers, directors, or 1% or more owners		
39 Do you treat all use of vehicles by employees as personal use?		
40 Do you provide more than five vehicles to your employees, obtain information from your employees about the use of the vehicles, and retain the information received?		
41 Do you meet the requirements concerning qualified automobile demonstration use?		

Note: If your answer to 37, 38, 39, 40, or 41 is "Yes," do not complete Section B for the covered vehicles.

Part VI **Amortization**

(a) Description of costs	(b) Date amortization begins	(c) Amortizable amount	(d) Code section	(e) Amortization period or percentage	(f) Amortization for this year
42 Amortization of costs that begins during your 2015 tax year:					
43 Amortization of costs that began before your 2015 tax year				43	
44 **Total.** Add amounts in column (f). See the instructions for where to report				44	

516252 12-28-15 Form **4562** (2015)

10110307 747646 4026 2015.03001 COUNSELING CENTER OF WATERB 4026___1

OHCA 000197

2015 DEPRECIATION AND AMORTIZATION REPORT

OTHER 1

Asset No.	Description	Date Acquired	Method	Life	C o n v	Line No.	Unadjusted Cost Or Basis	Bus % Excl	Section 179 Expense	* Reduction In Basis	Basis For Depreciation	Beginning Accumulated Depreciation	Current Sec 179 Expense	Current Year Deduction	Ending Accumulated Depreciation
1	WAITING ROOM FURNITURE	01/01/13	200DB	5.00	HY	17	630.		630.					0.	
2	DOCTORS OFFICE FURNITURE	01/01/13	200DB	5.00	HY	17	1,410.		1,410.					0.	
3	GROUP ROOM FURNITURE	01/01/13	200DB	5.00	HY	17	860.		860.					0.	
4	GROUP ROOM EDP	01/01/13	200DB	5.00	HY	17	200.		200.					0.	
5	OFFICE FURNITURE	01/01/13	200DB	5.00	HY	17	790.		790.					0.	
6	OFFICE EDP	01/01/13	200DB	5.00	HY	17	150.		150.					0.	
7	BUSINESS OFFICE FURNITURE	01/01/13	200DB	5.00	HY	17	630.		630.					0.	
8	BUSINESS OFFICE EDP	01/01/13	200DB	5.00	HY	17	550.		550.					0.	
9	CENTRAL AREA FURNITURE	01/01/13	200DB	5.00	HY	17	60.		60.					0.	
10	BACK OFFICE FURNITURE	01/01/13	200DB	5.00	HY	17	700.		700.					0.	
11	ARTWORK	01/01/13	200DB	5.00	HY	17	200.		200.					0.	
12	FIXTURES	01/01/13	200DB	5.00	HY	17	175.		175.					0.	
13	FIXTURES	01/01/13	200DB	5.00	HY	17	1,200.		1,200.					0.	
14	FIXTURES	01/01/13	200DB	5.00	HY	17	828.		828.					0.	
15	FIXTURES	01/01/13	200DB	5.00	HY	17	226.		226.					0.	
16	FIXTURES	01/01/13	200DB	5.00	HY	17	778.		778.					0.	
	* TOTAL OTHER DEPRECIATION						9,387.		9,387.		0.	0.		0.	0.

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04-01-15

(D) - Asset disposed

* ITC, Salvage, Bonus, Commercial Revitalization Deduction, GO Zone

Worksheet for Figuring Net Earnings (Loss) From Self-Employment

Name of partnership				Employer identification number
COUNSELING CENTER OF WATERBURY, LLC				46-1590675
1 a Ordinary income (loss) (Schedule K, line 1)	1a	127,060.		
b Net income (loss) from **CERTAIN** rental real estate activities	1b			
c Net income (loss) from other rental activities (Schedule K, line 3c)	1c			
d Net loss from Form 4797, Part II, line 17, included on line 1a above. Enter as a positive amount	1d			
e Other additions	1e			
f Combine lines 1a through 1e	1f	127,060.		
2 a Net gain from Form 4797, Part II, line 17, included on line 1a above	2a			
b Other subtractions	2b			
c Add lines 2a and 2b	2c			
3 a Subtract line 2c from line 1f. If line 1f is a loss, increase the loss on line 1f by the amount on line 2c	3a	127,060.		
b Part of line 3a allocated to limited partners, estates, trusts, corporations, exempt organizations, and IRAs	3b			
c Subtract line 3b from line 3a			3c	127,060.
4 a Guaranteed payments to partners (Schedule K, line 4) derived from a trade or business as defined in section 1402(c)	4a			
b Part of line 4a allocated to individual limited partners for **other than** services and to estates, trusts, corporations, exempt organizations, and IRAs	4b			
c Subtract line 4b from line 4a			4c	
5 Net earnings (loss) from self-employment. Combine lines 3c and 4c. Enter here and on Schedule K, line 14a			5	127,060.

FORM 1065 | OTHER DEDUCTIONS | STATEMENT 1

DESCRIPTION	AMOUNT
AMORTIZATION EXPENSE	641.
BANK CHARGES	298.
CREDIT AND COLLECTION COSTS	782.
EXPENSE REIMBURSEMENTS	148.
OFFICE EXPENSE	16,510.
OUTSIDE SERVICES	87,566.
PROFESSIONAL EXPENSE	5,280.
SUPPLIES	1,647.
TELEPHONE	2,274.
UTILITIES	4,136.
TOTAL TO FORM 1065, LINE 20	119,282.

SCHEDULE B | OPTIONAL BASIS SECTION 743(B) ADJUSTMENT | STATEMENT 2

DESCRIPTION	IDENTIFICATION NUMBER	AMOUNT
SECTION 754 ADJUSTMENT-FURNITURE		5,156.

SCHEDULE L | OTHER CURRENT ASSETS | STATEMENT 3

DESCRIPTION	BEGINNING OF TAX YEAR	END OF TAX YEAR
DEPOSITS	1,100.	1,500.
PREPAID EXPENSE		840.
TOTAL TO SCHEDULE L, LINE 6	1,100.	2,340.

SCHEDULE L | OTHER CURRENT LIABILITIES | STATEMENT 4

DESCRIPTION	BEGINNING OF TAX YEAR	END OF TAX YEAR
CREDITORS	3,637.	
TOTAL TO SCHEDULE L, LINE 17	3,637.	

OHCA 000200

ATTACHMENT VII

Financial Worksheet B

FOR-PROFIT

Applicant Name: Connecticut Counseling & Wellness

Financial Worksheet (B)

Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

LINE	Total Entity: Description	(1) FY2016 Actual Results	(2) FY2017 Projected W/out CON	(3) FY2017 Projected Incremental	(4) FY2017 Projected With CON	(5) FY2018 Projected W/out CON	(6) FY2018 Projected Incremental	(7) FY2018 Projected With CON	(8) FY2019 Projected W/out CON	(9) FY2019 Projected Incremental	(10) FY2019 Projected With CON	(11) FY2020 Projected W/out CON	(12) FY2020 Projected Incremental	(13) FY2020 Projected With CON
A.	**OPERATING REVENUE**													
1	Total Gross Patient Revenue	$286,591	$296,622	$97,500	$394,122	$307,004	$234,000	$541,004	$317,750	$273,000	$590,750	$328,871	$312,000	$640,871
2	Less: Allowances	$0	$0	$0	$0			$0			$0			$0
3	Less: Charity Care	$0	$0	$0	$0			$0			$0			$0
4	Less: Other Deductions	$0	$0	$0	$0			$0			$0			$0
	Net Patient Service Revenue	**$286,591**	**$296,622**	**$97,500**	**$394,122**	**$307,004**	**$234,000**	**$541,004**	**$317,750**	**$273,000**	**$590,750**	**$328,871**	**$312,000**	**$640,871**
5	Medicare	$0	$0	$0	$0			$0			$0			$0
6	Medicaid	$93,000	$96,255	$31,590	$127,845	$99,624	$75,816	$175,440	$103,111	$88,452	$191,563	$106,720	$101,088	$207,808
7	CHAMPUS & TriCare	$0	$0	$0	$0			$0			$0			$0
8	Other	$700	$725	$195	$920	$750	$468	$1,218	$776	$546	$1,322	$803	$624	$1,427
	Total Government	**$93,700**	**$96,980**	**$31,785**	**$128,765**	**$100,374**	**$76,284**	**$176,658**	**$103,887**	**$88,998**	**$192,885**	**$107,523**	**$101,712**	**$209,235**
9	Commercial Insurers	$65,300	$67,586	$22,327	$89,913	$69,952	$53,586	$123,538	$72,400	$62,517	$134,917	$74,934	$71,448	$146,382
10	Uninsured	$0	$0	$0	$0			$0			$0			$0
11	Self Pay	$127,591	$132,056	$0	$132,056	$136,678	$104,130	$240,808	$141,463	$121,485	$262,948	$146,414	$138,840	$285,254
12	Workers Compensation	$0	$0	$0	$0			$0			$0			$0
13	Other	$0	$0	$43,388	$43,388			$0			$0			$0
	Total Non-Government	**$192,891**	**$199,642**	**$65,715**	**$265,357**	**$206,630**	**$157,716**	**$364,346**	**$213,863**	**$184,002**	**$397,865**	**$221,348**	**$210,288**	**$431,636**
	Net Patient Service Revenue[a] (Government+Non-Government)	**$286,591**	**$296,622**	**$97,500**	**$394,122**	**$307,004**	**$234,000**	**$541,004**	**$317,750**	**$273,000**	**$590,750**	**$328,871**	**$312,000**	**$640,871**
14	Less: Provision for Bad Debts	$782	$889	$292	$1,181	$921	$702	$1,623	$953	$819	$1,772	$987	$936	$1,923
	Net Patient Service Revenue less provision for bad debts	**$285,809**	**$295,733**	**$97,208**	**$392,941**	**$306,083**	**$233,298**	**$539,381**	**$316,797**	**$272,181**	**$588,978**	**$327,884**	**$311,064**	**$638,948**
15	Other Operating Revenue	$0	$0	$0	$0			$0			$0			$0
17	Net Assets Released from Restrictions	$0	$0	$0	$0			$0			$0			$0
	TOTAL OPERATING REVENUE	**$285,809**	**$295,733**	**$97,208**	**$392,941**	**$306,083**	**$233,298**	**$539,381**	**$316,797**	**$272,181**	**$588,978**	**$327,884**	**$311,064**	**$638,948**
B.	**OPERATING EXPENSES**													
1	Salaries and Wages	$165,729	$168,214	$40,000	$208,214	$170,737	$40,600	$211,337	$173,298	$41,209	$214,507	$175,897	$41,827	$217,724
2	Fringe Benefits	$1,448	$1,470		$1,470	$1,492		$1,492	$1,514		$1,514	$1,537		$1,537
3	Physicians Fees	$0	$0	$0	$0			$0			$0			$0
4	Supplies and Drugs	$2,326	$2,361	$0	$2,361	$2,396		$2,396	$2,432		$2,432	$2,468		$2,468
5	Depreciation and Amortization	$0	$0	$0	$0			$0			$0			$0
6	Provision for Bad Debts-Other[b]	$0	$0	$0	$0			$0			$0			$0
7	Interest Expense	$0	$0	$0	$0			$0			$0			$0
8	Malpractice Insurance Cost	$398	$404	$0	$404	$410		$410	$416		$416	$422		$422
9	Lease Expense	$12,000	$12,180	$0	$12,180	$12,363		$12,363	$12,548		$12,548	$12,736		$12,736
10	Other Operating Expenses	$33,037	$33,533	$0	$33,533	$34,036		$34,036	$34,546		$34,546	$35,064		$35,064
	TOTAL OPERATING EXPENSES	**$214,938**	**$218,162**	**$40,000**	**$258,162**	**$221,434**	**$40,600**	**$262,034**	**$224,754**	**$41,209**	**$265,963**	**$228,124**	**$41,827**	**$269,951**
	INCOME/(LOSS) FROM OPERATIONS	**$70,871**	**$77,571**	**$57,208**	**$134,779**	**$84,649**	**$192,698**	**$277,347**	**$92,043**	**$230,972**	**$323,015**	**$99,760**	**$269,237**	**$368,997**
	NON-OPERATING INCOME	**$0**	**$0**	**$0**	**$0**			**$0**			**$0**			**$0**
	Income before provision for income taxes	**$70,871**	**$77,571**	**$57,208**	**$134,779**	**$84,649**	**$192,698**	**$277,347**	**$92,043**	**$230,972**	**$323,015**	**$99,760**	**$269,237**	**$368,997**
	Provision for income taxes[c]	**$0**	$0	$0	**$0**			**$0**			**$0**			**$0**
	NET INCOME	**$70,871**	**$77,571**	**$57,208**	**$134,779**	**$84,649**	**$192,698**	**$277,347**	**$92,043**	**$230,972**	**$323,015**	**$99,760**	**$269,237**	**$368,997**
C.	**Retained Earnings, beginning of year**	**$0**	**$0**	**$0**	**$0**			**$0**			**$0**			**$0**
	Retained Earnings, end of year	**$0**	**$0**	**$0**	**$0**			**$0**			**$0**			**$0**
	Principal Payments	$0	**$0**	$0	**$0**			**$0**			**$0**			**$0**
D.	**PROFITABILITY SUMMARY**													
1	Hospital Operating Margin	24.8%	26.2%	58.9%	34.3%	27.7%	82.6%	51.4%	29.1%	84.9%	54.8%	30.4%	86.6%	57.8%
2	Hospital Non Operating Margin	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
3	Hospital Total Margin	24.8%	26.2%	58.9%	34.3%	27.7%	82.6%	51.4%	29.1%	84.9%	54.8%	30.4%	86.6%	57.8%
E.	**FTEs**	4	4	1	5	4	1	5	4	1	5	4	1	5
F.	**VOLUME STATISTICS[d]**													

FOR-PROFIT

Applicant Name: Connecticut Counseling & Wellness

Financial Worksheet (B)

Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

LINE	Total Entity:	(1) FY2016 Actual Results	(2) FY2017 Projected W/out CON	(3) FY2017 Projected Incremental	(4) FY2017 Projected With CON	(5) FY2018 Projected W/out CON	(6) FY2018 Projected Incremental	(7) FY2018 Projected With CON	(8) FY2019 Projected W/out CON	(9) FY2019 Projected Incremental	(10) FY2019 Projected With CON	(11) FY2020 Projected W/out CON	(12) FY2020 Projected Incremental	(13) FY2020 Projected With CON
	Description													
1	Inpatient Discharges	0	0	0	0			0			0			0
2	Outpatient Visits	5,899	3,200	390	3,590	3,312	936	4,248	3,428	1,092	4,520	3,548	1,248	4,796
	TOTAL VOLUME	5,899	3,200	390	3,590	3,312	936	4,248	3,428	1,092	4,520	3,548	1,248	4,796

[a]Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.

[b]Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No.2011-07, July 2011.

[c]Provide the amount of income taxes as defined by the Internal Revenue Services for for-profit entities.

[d]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.

FOR-PROFIT

Applicant Name: Connecticut Counseling & Wellness

Financial Worksheet (B)

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A.	**OPERATING REVENUE**													
1	Total Gross Patient Revenue	$286,591	$296,622	$97,500	$394,122	$307,004	$234,000	$541,004	$317,750	$273,000	$590,750	$328,871	$312,000	$640,871
2	Less: Allowances	$0	$0	$0	$0			$0			$0			$0
3	Less: Charity Care	$0	$0	$0	$0			$0			$0			$0
4	Less: Other Deductions	$0	$0	$0	$0			$0			$0			$0
	Net Patient Service Revenue	**$286,591**	**$296,622**	**$97,500**	**$394,122**	**$307,004**	**$234,000**	**$541,004**	**$317,750**	**$273,000**	**$590,750**	**$328,871**	**$312,000**	**$640,871**
5	Medicare	$0	$0	$0	$0			$0			$0			$0
6	Medicaid	$93,000	$96,255	$31,590	$127,845	$99,624	$75,816	$175,440	$103,111	$88,452	$191,563	$106,720	$101,088	$207,808
7	CHAMPUS & TriCare	$0	$0	$0	$0			$0			$0			$0
8	Other	$700	$725	$195	$920	$750	$468	$1,218	$776	$546	$1,322	$803	$624	$1,427
	Total Government	**$93,700**	**$96,980**	**$31,785**	**$128,765**	**$100,374**	**$76,284**	**$176,658**	**$103,887**	**$88,998**	**$192,885**	**$107,523**	**$101,712**	**$209,235**
9	Commercial Insurers	$65,300	$67,586	$22,327	$89,913	$69,952	$53,586	$123,538	$72,400	$62,517	$134,917	$74,934	$71,448	$146,382
10	Uninsured	$0	$0	$0	$0			$0			$0			$0
11	Self Pay	$127,591	$132,056	$0	$132,056	$136,678	$104,130	$240,808	$141,463	$121,485	$262,948	$146,414	$138,840	$285,254
12	Workers Compensation	$0	$0	$0	$0			$0			$0			$0
13	Other	$0	$0	$43,388	$43,388			$0			$0			$0
	Total Non-Government	**$192,891**	**$199,642**	**$65,715**	**$265,357**	**$206,630**	**$157,716**	**$364,346**	**$213,863**	**$184,002**	**$397,865**	**$221,348**	**$210,288**	**$431,636**
	Net Patient Service Revenue[a] (Government+Non-Government)	**$286,591**	**$296,622**	**$97,500**	**$394,122**	**$307,004**	**$234,000**	**$541,004**	**$317,750**	**$273,000**	**$590,750**	**$328,871**	**$312,000**	**$640,871**
14	Less: Provision for Bad Debts	$782	$889	$292	**$1,181**	$921	$702	**$1,623**	$953	$819	**$1,772**	$987	$936	**$1,923**
	Net Patient Service Revenue less provision for bad debts	**$285,809**	**$295,733**	**$97,208**	**$392,941**	**$306,083**	**$233,298**	**$539,381**	**$316,797**	**$272,181**	**$588,978**	**$327,884**	**$311,064**	**$638,948**
15	Other Operating Revenue	$0	$0	$0	**$0**			**$0**			**$0**			**$0**
17	Net Assets Released from Restrictions	$0	$0	$0	**$0**			**$0**			**$0**			**$0**
	TOTAL OPERATING REVENUE	**$285,809**	**$295,733**	**$97,208**	**$392,941**	**$306,083**	**$233,298**	**$539,381**	**$316,797**	**$272,181**	**$588,978**	**$327,884**	**$311,064**	**$638,948**
B.	**OPERATING EXPENSES**													
1	Salaries and Wages	$165,729	$168,214	$40,000	$208,214	$170,737	$40,600	$211,337	$173,298	$41,209	$214,507	$175,897	$41,827	$217,724
2	Fringe Benefits	$1,448	$1,470		$1,470	$1,492		$1,492	$1,514		$1,514	$1,537		$1,537
3	Physicians Fees	$0	$0	$0	$0			$0			$0			$0
4	Supplies and Drugs	$2,326	$2,361	$0	$2,361	$2,396		$2,396	$2,432		$2,432	$2,468		$2,468
5	Depreciation and Amortization	$0	$0	$0	$0			$0			$0			$0
6	Provision for Bad Debts-Other[b]	$0	$0	$0	$0			$0			$0			$0
7	Interest Expense	$0	$0	$0	$0			$0			$0			$0
8	Malpractice Insurance Cost	$398	$404	$0	$404	$410		$410	$416		$416	$422		$422
9	Lease Expense	$12,000	$12,180	$0	$12,180	$12,363		$12,363	$12,548		$12,548	$12,736		$12,736
10	Other Operating Expenses	$33,037	$33,533	$0	$33,533	$34,036		$34,036	$34,546		$34,546	$35,064		$35,064
	TOTAL OPERATING EXPENSES	**$214,938**	**$218,162**	**$40,000**	**$258,162**	**$221,434**	**$40,600**	**$262,034**	**$224,754**	**$41,209**	**$265,963**	**$228,124**	**$41,827**	**$269,951**
	INCOME/(LOSS) FROM OPERATIONS	**$70,871**	**$77,571**	**$57,208**	**$134,779**	**$84,649**	**$192,698**	**$277,347**	**$92,043**	**$230,972**	**$323,015**	**$99,760**	**$269,237**	**$368,997**
	NON-OPERATING INCOME	**$0**	**$0**	**$0**	**$0**			**$0**			**$0**			**$0**
	Income before provision for income taxes	**$70,871**	**$77,571**	**$57,208**	**$134,779**	**$84,649**	**$192,698**	**$277,347**	**$92,043**	**$230,972**	**$323,015**	**$99,760**	**$269,237**	**$368,997**
	Provision for income taxes[c]	**$0**	$0	$0	**$0**			**$0**			**$0**			**$0**
	OHCA 000204													
	NET INCOME	**$70,871**	**$77,571**	**$57,208**	**$134,779**	**$84,649**	**$192,698**	**$277,347**	**$92,043**	**$230,972**	**$323,015**	**$99,760**	**$269,237**	**$368,997**

FOR-PROFIT

Applicant Name: Connecticut Counseling & Wellness

Financial Worksheet (B)

Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

LINE	Total Entity:	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
		FY2016	FY2017	FY2017	FY2017	FY2018	FY2018	FY2018	FY2019	FY2019	FY2019	FY2020	FY2020	FY2020
		Actual	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected
	Description	Results	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON
C.	Retained Earnings, beginning of year	$0	$0	$0	$0			$0			$0			$0
	Retained Earnings, end of year	$0	$0	$0	$0			$0			$0			$0
	Principal Payments	$0	$0	$0	$0			$0			$0			$0
D.	**PROFITABILITY SUMMARY**													
1	Hospital Operating Margin	24.8%	26.2%	58.9%	34.3%	27.7%	82.6%	51.4%	29.1%	84.9%	54.8%	30.4%	86.6%	57.8%
2	Hospital Non Operating Margin	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
3	Hospital Total Margin	24.8%	26.2%	58.9%	34.3%	27.7%	82.6%	51.4%	29.1%	84.9%	54.8%	30.4%	86.6%	57.8%
E.	**FTEs**	4	4	1	5	4	1	5	4	1	5	4	1	5
F.	**VOLUME STATISTICS[d]**													
1	Inpatient Discharges	0	0	0	0			0			0			0
2	Outpatient Visits	5,899	3,200	390	3,590	3,312	936	4,248	3,428	1,092	4,520	3,548	1,248	4,796
	TOTAL VOLUME	5,899	3,200	390	3,590	3,312	936	4,248	3,428	1,092	4,520	3,548	1,248	4,796

[a]Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.

[b]Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No.2011-07, July 2011.

[c]Provide the amount of income taxes as defined by the Internal Revenue Services for for-profit entities.

[d]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.

User, OHCA

From:	Walker, Shauna
Sent:	Thursday, May 18, 2017 7:21 AM
To:	amy@ccwellness.org
Cc:	User, OHCA; Riggott, Kaila; Mitchell, Micheala
Subject:	Completeness Questions on CON Application # 17-32163
Attachments:	32163 Counseling Center of Waterbury LLC.pdf

Dear Ms. St. Pierre:

Attached is a request for additional information regarding CON application 17-32163 – Establishment of a Facility for the Care or Treatment of Substance Abusive or Dependent Persons for Adults in Wolcott, CT. Responses are due by **Monday July 17, 2017 at 4:30 p.m.**

Please confirm receipt of this email.

Much Regards,

Shauna L. Walker
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue
Hartford, CT 06134
Phone: (860) 418-7069
Email: Shauna.Walker@ct.gov

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor

Nancy Wyman
Lt. Governor

Office of Health Care Access

May 18, 2017 Via Email Only

Amy St. Pierre
Counseling Center of Waterbury, LLC
Clinical Supervisor
1776 Meriden Road
Wolcott, CT 06716
amy@ccwellness.org

RE: Certificate of Need Application: Docket Number: 17-32163-CON
Establishment of a Facility for the Care or Treatment of Substance Abusive or Dependent Persons for Adults in Wolcott, CT
Certificate of Need Completeness Letter

Dear Ms. St. Pierre:

On April 18, 2017, OHCA received the Certificate of Need application from Counseling Center of Waterbury, LLC, d/b/a Connecticut Counseling & Wellness ("CCW" or "Applicant"), seeking authorization to establish a facility for the care or treatment of substance abusive or dependent persons for adults in Wolcott. OHCA requests additional information pursuant to Connecticut General Statutes §19a-639a(c). *Please "reply all" to electronically confirm receipt of this email as soon as you receive it.* Provide responses to the questions below in both a Word document and PDF format as an attachment to a responding email. ***Please email your responses to both of the following email addresses: OHCA@ct.gov and Kaila.Riggott@ct.gov.***

Paginate and date your response (i.e., each page in its entirety). Repeat each OHCA question before providing your response. Information filed after the initial CON application submission (e.g., completeness response letter, prefiled testimony, late file submissions, etc.) must be numbered sequentially from the Applicant's preceding document. Begin your submission using **Page 206** and reference "**Docket Number: 17-32163-CON**."

Pursuant to Section 19a-639a(c) of the Connecticut General Statutes, you must submit your response to this request for additional information no later than sixty days after the date this request was transmitted. Therefore, please provide your written responses to OHCA no later than **July 17, 2017, by 4:30 p.m.**, otherwise your application will be automatically considered withdrawn.

1. Provide copies of the State of Connecticut, Department of Public Health practitioner licenses for Gerard Marcil and Amy St. Pierre.

2. Explain the existing relationship that CCW has with Trade Union 478, as stated on page 12 of the application.

3. Will CCW have a transfer agreement with other facilities in the event of a crisis or emergency? If so, please provide a draft transfer agreement with an estimated date by which the final will be available.

4. Provide the names of the inpatient service providers that CCW intends to develop relationships with, as stated on page 17 of the application.

5. Update the projected volume on page 33 of the application as follows:

   a. provide a population estimate for the proposed service area towns based on the target population (adults ages 18 years and older) only;
   b. utilizing supporting scholarly articles, apply a prevalence estimate that is specific to the target population (adults ages 18 years and older) to calculate the number of persons within the population group by town that will need the proposed service; and
   c. list all data sources used in calculating the population and prevalence estimates.

6. What percentage of the total CT population of adults ages 18 years and older does the population estimate for the proposed service area towns reported in question 5a represent?

7. Clarify whether towns classified as "Other" in Table 8 on page 28 of the application includes residents originating from out of state. Provide the unit of measure reflected in the "Utilization FY 2016" column (e.g. clients, sessions or visits).

8. Is public transportation available from Wolcott to the locations of the existing service area providers listed on pages 28-29 of the application? If so, identify the modes available.

9. Annualized projections should be based on a period greater than six months. Explain the method used to annualize the projected number of outpatient substance abuse treatment visits for FY 2017 in Table 6 on page 26 of the application.

10. Pages 20-21 of the application provide a projected number of clients of 7 in 2019 and 8 in 2020 for the proposed IOP program, whereas the footnote for table 6 on page 26 lists the projected number of clients as 8 in 2019 and 9 in 2020. Confirm the appropriate projected number of clients for 2019 and 2020.

11. Update Table 7 on page 27 of the application based on patient and visit volume. Utilize the table format below. Verify the total number of non-government visits for FY 2018 and the payer mix total visits for FY 2019. Ensure visit totals are consistent with the totals provided in the "Outpatient Visits" row in Financial Worksheet (B) and the total projected volume in Table 6 on page 26 of the application.

CURRENT AND PROJECTED PAYER MIX FOR COUNSELING CENTER OF WATERBURY, LLC, BY NUMBER OF CLIENTS AND VISITS

Payer	Current			Projected								
	FY 2017			FY 2018			FY 2019			FY 2020		
	Patient Vol.	%	Visit Vol.	Patient Vol.	%	Visit Vol.	Patient Vol.	%	Visit Vol.	Patient Vol.	%	Visit Vol.
Medicare*												
Medicaid*		43	1,544		43	1,827		43	1,943		43	2,062
CHAMPUS & TriCare												
Total Government		**43**	**1,544**		**43**	**1,827**		**43**	**1,943**		**43**	**2,062**
Commercial Insurers		47	1,687		47	1,997		47	2,124		47	2,254
Uninsured		10	359		10	425		10	452		10	480
Workers Compensation												
Total Non-Government		**57**	**2,046**		**57**	**2,421**		**57**	**2,576**		**57**	**2,734**
Total Payer Mix		**100**	**3,590**		**100**	**4,248**		**100**	**4,520**		**100**	**4,796**

If you have any questions concerning this letter, please contact Kaila Riggott at (860) 418-7037.

User, OHCA

From: Walker, Shauna
Sent: Tuesday, May 23, 2017 8:36 AM
To: amy@ccwellness.org
Cc: User, OHCA; Riggott, Kaila; Mitchell, Micheala; SCowherd@pullcom.com
Subject: FW: Completeness Questions on CON Application # 17-32163
Attachments: 32163 Counseling Center of Waterbury LLC.pdf

Hello,

Attached is the original e-mail that was sent on May 18, 2017.

Shauna L. Walker
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue
Hartford, CT 06134
Phone: (860) 418-7069
Email: Shauna.Walker@ct.gov

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Cc: User, OHCA <OHCA@ct.gov>; Riggott, Kaila <Kaila.Riggott@ct.gov>; Mitchell, Micheala <Micheala.Mitchell@ct.gov>
Subject: Completeness Questions on CON Application # 17-32163

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STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor

Nancy Wyman
Lt. Governor

Office of Health Care Access

May 18, 2017 Via Email Only

Amy St. Pierre
Counseling Center of Waterbury, LLC
Clinical Supervisor
1776 Meriden Road
Wolcott, CT 06716
amy@ccwellness.org

RE: Certificate of Need Application: Docket Number: 17-32163-CON
Establishment of a Facility for the Care or Treatment of Substance Abusive or Dependent Persons for Adults in Wolcott, CT
Certificate of Need Completeness Letter

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CURRENT AND PROJECTED PAYER MIX FOR
COUNSELING CENTER OF WATERBURY, LLC, BY NUMBER OF CLIENTS AND VISITS

Payer	Current			Projected								
	FY 2017			FY 2018			FY 2019			FY 2020		
	Patient Vol.	%	Visit Vol.	Patient Vol.	%	Visit Vol.	Patient Vol.	%	Visit Vol.	Patient Vol.	%	Visit Vol.
Medicare*												
Medicaid*		43	1,544		43	1,827		43	1,943		43	2,062
CHAMPUS & TriCare												
Total Government		**43**	**1,544**		**43**	**1,827**		**43**	**1,943**		**43**	**2,062**
Commercial Insurers		47	1,687		47	1,997		47	2,124		47	2,254
Uninsured		10	359		10	425		10	452		10	480
Workers Compensation												
Total Non-Government		**57**	**2,046**		**57**	**2,421**		**57**	**2,576**		**57**	**2,734**
Total Payer Mix		**100**	**3,590**		**100**	**4,248**		**100**	**4,520**		**100**	**4,796**

If you have any questions concerning this letter, please contact Kaila Riggott at (860) 418-7037.

User, OHCA

From: Murray, Amy E. <AMurray@pullcom.com>
Sent: Monday, June 12, 2017 4:56 PM
To: User, OHCA; Riggott, Kaila
Subject: 17-32163-CON responses to completeness questions
Attachments: Counseling Center of Waterbury, LLC d_b_a Connecticut Counseling & Wellness Docket Number_ 17-32163-.PDF; Counseling Center of Waterbury LLC 17-32163-CON 6-12-17 Response to Completeness Questions.DOCX

Attached you will find Counseling Center of Waterbury's responses to completeness questions received on May 18, 2017, in both PDF and Word format as requested. (The PDF document includes the three attachments referenced in the responses.) Please let me know if you require any additional information.

Thank you,
Amy

Amy E. Murray
Attorney

PULLMAN
&COMLEY LLC
ATTORNEYS

850 Main Street P.O. Box 7006
Bridgeport, CT 06601-7006
p 203 330 2282 f 203 576 8888
amurray@pullcom.com • www.pullcom.com

V-card • **Bio** • **Directions**

BRIDGEPORT HARTFORD STAMFORD WATERBURY WHITE PLAINS

Please consider the environment before printing this message.
THIS MESSAGE AND ANY OF ITS ATTACHMENTS ARE INTENDED ONLY FOR THE USE OF THE DESIGNATED RECIPIENT, OR THE RECIPIENT'S DESIGNEE, AND MAY CONTAIN INFORMATION THAT IS CONFIDENTIAL OR PRIVILEGED. IF YOU ARE NOT THE INTENDED RECIPIENT, PLEASE (1) IMMEDIATELY NOTIFY PULLMAN & COMLEY ABOUT THE RECEIPT BY TELEPHONING (203) 330-2000; (2) DELETE ALL COPIES OF THE MESSAGE AND ANY ATTACHMENTS; AND (3) DO NOT DISSEMINATE OR MAKE ANY USE OF ANY OF THEIR CONTENTS.

Pursuant to Section 19a-639a(c) of the Connecticut General Statutes, you must submit your response to this request for additional information no later than sixty days after the date this request was transmitted. Therefore, please provide your written responses to OHCA no later than **July 17, 2017, by 4:30 p.m.**, otherwise your application will be automatically considered withdrawn.

1. Provide copies of the State of Connecticut, Department of Public Health practitioner licenses for Gerard Marcil and Amy St. Pierre.

   Response: See Attachment VIII.

2. Explain the existing relationship that CCW has with Trade Union 478, as stated on page 12 of the application.

   Response: CCW Owner Gerard Marcil was the director of the Machinist Union Members Assistance Program (MAP) for 15 years before retiring in 2015 to purchase and operate CCW. During his tenure as director of Pratt and Whitney MAP, he developed a strong professional relationship with Kyle Zimmer who runs the MAP for the International Union of Operating Engineers local 478 (Trade Union 478). When Gerard bought CCW, Trade Union 478 started to refer members to CCW based on how well Gerard understood trade union contracts and policies, including Department of Transportation regulations, his experience with fitness for duty evaluations and his ability to professionally and expediently handle member and or family-member requests for SUD treatment. The working professional relationship between CCW and Trade Union 478 continues to grow and they have been eager for CCW to develop an IOP that can serve the MAP needs.

3. Will CCW have a transfer agreement with other facilities in the event of a crisis or emergency? If so, please provide a draft transfer agreement with an estimated date by which the final will be available.

   Response: Yes, CCW plans to have a transfer agreement with St. Mary's Hospital. You will find a draft agreement at Attachment IX. It is estimated that a final version of the transfer agreement will be available sometime in June or early July.

4. Provide the names of the inpatient service providers that CCW intends to develop relationships with, as stated on page 17 of the application.

   Response: The inpatient service providers that CCW has developed relationships with are Mountainside Treatment Center, High Watch Recovery Center, Connecticut Valley Hospital, HHC Rushford, Stonington Institute and American Addiction Centers.

5. Update the projected volume on page 33 of the application as follows:
   a. provide a population estimate for the proposed service area towns based on the target population (adults ages 18 years and older) only;
   b. utilizing supporting scholarly articles, apply a prevalence estimate that is specific to the target population (adults ages 18 years and older) to calculate the number of persons within the population group by town that will need the proposed service; and
   c. list all data sources used in calculating the population and prevalence estimates.

Town	Population	In Need	To be Served (first 12 month period)	% of need Served
Waterbury	85,954	7,306	16	.22%
Wolcott	13,172	1,120	10	.89%
Naugatuck	24,915	2,118	3	.14%
Watertown	17,310	1,471	3	.20%
Southbury	15,543	1,321	2	.15%
Branford	22,235	1,890	2	.11%
Cheshire	23,117	1,965	2	.10%
New Britain	57,518	4,889	2	.04%
Wallingford	35,465	3,015	2	.07%

Response: Data presented in the figure above are based on the following assumptions:

- Population numbers were calculated based on 2015 numbers published by the Connecticut Department of Public Health in their report titled "Estimated Populations in Connecticut as of July 1, 2015, *available at:*
  http://www.ct.gov/dph/lib/dph/hisr/hcqsar/population/pdf/pop_towns2015.pdf
  As the populations provided in the report account for the entire population, and the proposal would only serve adults, the adult population was estimated at 79% of the total population. (The U.S. Census reported that in 2015, approximately 79% of the Connecticut population was 18 years of age or older. *See* https://www.census.gov/quickfacts/table/AGE295215/09,00.)

- The estimates of individuals "in need" of SUD treatment are 8.5% of the adult population in each town. (In 2013, SAMHSA calculated that 8.5% of adults aged 18 or older had a substance use disorder in the past year, or 20.3 million adults total. *See* https://store.samhsa.gov/shin/content/NSDUH14-0904/NSDUH14-0904.pdf.)

- The estimated number of individuals to be served (client volume) is based on an estimated 57 patients being treated in the first 12 months. (For the first 6 months, it is estimated that approximately 26 clients will be seen - 5 patients will be seen per week, and patients will participate in the IOP for 5 weeks, on average. For the second 6 months, an estimated 31 clients will be seen - 6 patients will be seen per week, and patients will participate in the IOP for 5 weeks, on average). The chart shows the total number of clients to be served in the first 12 months as 42 because the additional 15 clients served will be from a number of other towns in the surrounding area.

- We understand that part of the challenge is motivating individuals to seek treatment, and therefore the demand for treatment is not necessarily equivalent to the number of individuals with SUD.

6. What percentage of the total CT population of adults ages 18 years and older does the population estimate for the proposed service area towns reported in question 5a represent?

   Response: The total population estimate for the towns listed in 5a is 295,229, or 10.4% of the total Connecticut population of adults ages 18 years and older. (To calculate the total Connecticut population of adults (those 18 and above), the population of Connecticut as of July 1, 2016 provided by the U.S. Census, which was 3,576,452, was multiplied by 79%, as the U.S. Census reported in 2015 that approximately 79% of the population was 18 years of age or older, resulting in an adult population in the state of Connecticut of 2,825,397.
   See https://www.census.gov/quickfacts/table/AGE295215/09,00).

7. Clarify whether towns classified as "Other" in Table 8 on page 28 of the application includes residents originating from out of state. Provide the unit of measure reflected in the "Utilization FY 2016" column (e.g. clients, sessions or visits).

   Response: Towns classified as "Other" in Table 8 on page 28 only includes residents of the State of Connecticut.

   The unit of measure reflected in the "Utilization FY 2016" column of Table 8 on page 28 is the number of clients.

8. Is public transportation available from Wolcott to the locations of the existing service area providers listed on pages 28-29 of the application? If so, identify the modes available.

Response: Public transportation is available from Wolcott to all of the existing service providers located in Waterbury, but is not available from Wolcott to the existing service providers located in New Britain or Cheshire.

9. Annualized projections should be based on a period greater than six months. Explain the method used to annualize the projected number of outpatient substance abuse treatment visits for FY 2017 in Table 6 on page 26 of the application.

Response: The annualized projection for outpatient substance abuse treatment visits has been revised to be based on a six month period (December 1, 2016 through May 31, 2017) where the total number of visits was 1,213 (the number of visits each month were as follows: 190 visits in December, 210 visits in January, 200 visits in February, 220 visits in March, 213 visits in April, and 180 visits in May).

TABLE 6
PROJECTED UTILIZATION BY SERVICE

	Projected Volume+			
Service*	**FY 2017****	**FY 2018****	**FY 2019****	**FY 2020**
Outpatient Substance Abuse Treatment++	2,426+++	2,511	2,599	2,690
Intensive Outpatient Substance Abuse Treatment+++++	390++++	936	1,092	1,248
Total	2,816	3,447	3,691	3,938

*Identify each service type by location and add lines as necessary. Provide the number of visits/discharges as appropriate for each service listed.
**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. If the time period reported is not *identical* to the fiscal year reported in Table 4 of the application, provide the date range using the mm/dd format as a footnote to the table.

+The volume is measured by number of patient visits.

++The estimates for Outpatient Substance Abuse Treatment visits assume a 3.5% increase each year.

+++The FY2017 Projected Volume for Outpatient Substance Abuse Treatment is based on the six month period from December 1, 2016 to May 31, 2017, where there were 1,213 patient visits total (190 visits in December, 210 visits in January, 200 visits in February, 220 visits in March, 213 visits in April, and 180 visits in May).

++++The IOP estimate for FY2017 is for six months only, as the anticipated start date for the IOP is July 1, 2017.

+++++The estimates for IOP visits assume 15 visits per week from July 1, 2017 through December 31, 2017 (5 clients on average per week, with each making 3 visits per week), 18 visits per week in 2018 (6 clients on average per week, with each making 3 visits per week), 21 visits per week in 2019 (7 clients on average per week, with each making 3 visits per week), and 24 visits per week in 2020 (8 clients on average per week, with each making 3 visits per week).

Based on the revisions to Table 6, the number of outpatient visits in Section F of Financial Worksheet B have also been revised, which you will find at Attachment X. Table 7 has also been revised to reflect the changes made to Table 6.

10. Pages 20-21 of the application provide a projected number of clients of 7 in 2019 and 8 in 2020 for the proposed IOP program, whereas the footnote for table 6 on page 26 lists the projected number of clients as 8 in 2019 and 9 in 2020. Confirm the appropriate projected number of clients for 2019 and 2020.

    Response: The appropriate projected number of clients for 2019 is 7 and the appropriate projected number of clients for 2020 is 8. The incorrect projected number of clients for 2019 and 2020 included in the footnote to Table 6 were typographical errors, and the projected volume was projected with the appropriate projected numbers of clients. The footnote to Table 6 has been revised, as seen in the response to question 9.

11. Update Table 7 on page 27 of the application based on patient and visit volume. Utilize the table format below. Verify the total number of non-government visits for FY 2018 and the payer mix total visits for FY 2019. Ensure visit totals are consistent with the totals provided in the "Outpatient Visits" row in Financial Worksheet (B) and the total projected volume in Table 6 on page 26 of the application.

    Response:

CURRENT AND PROJECTED PAYER MIX FOR COUNSELING CENTER OF WATERBURY, LLC, BY NUMBER OF CLIENTS AND VISITS

Payer	Current			Projected								
	FY 2017			FY 2018			FY 2019			FY 2020		
	Patient Vol.+	%	Visit Vol.	Patient Vol.	%	Visit Vol.	Patient Vol.	%	Visit Vol.	Patient Vol.	%	Visit Vol.
Medicare*												
Medicaid*	60	43	1,211	78	43	1,482	83	43	1,587	90	43	1,693
CHAMPUS & TriCare												
Total Government	**60**	**43**	**1,211**	**78**	**43**	**1,482**	**83**	**43**	**1,587**	**90**	**43**	**1,693**
Commercial Insurers	66	47	1,323	84	47	1,620	93	47	1,735	98	47	1,851
Uninsured	14	10	282	18	10	345	19	10	369	21	10	394
Workers Compensation												
Total Non-Government	**80**	**57**	**1,605**	**102**	**57**	**1,965**	**112**	**57**	**2,104**	**119**	**57**	**2,245**
Total Payer Mix	**140**	**100**	**2,816**	**180**	**100**	**3,447**	**195**	**100**	**3,691**	**209**	**100**	**3,938**

-Payer composition is based on actual payer composition in 2016, which was 43% government (Medicaid), and 57% non-government (47% commercial insurance, 10% cash payers). This percentage is anticipated to remain the same.

-The Total Payer Mix numbers for Visit Volume are the total Projected Volumes from Table 6 for each fiscal year (taking into account both (a) Outpatient Substance Abuse Treatment visits, which are expected to increase 3.5% each year, and (b) IOP visits, which are expected to increase from 390 in 2017 (assumes 6 months of IOP operation with 15 visits/week, based on 5 clients/week, with each client making 3 visits/week) to 936 in 2018 (assumes 18 visits/week, based on 6 clients/week, with each client making 3 visits/week) to 1,092 in 2019 (assumes 21 visits/week, based on 7 clients/week, with each client making 3 visits/week) to 1,248 in 2020 (assumes 24 clients/week, based on 8 clients/week, with each client making 3 visits/week)).

+For FY2017, the Total Payer Mix numbers for Patient Volume takes into account both (a) Outpatient Substance Abuse Treatment patients, which were calculated based on a 3.5% increase from the number of patients in 2016 (110), and (b) IOP visits for 6 months (July 2017-Dec. 2017), assuming that a total of 26 clients will be seen (5 clients/week, with each client making 3 visits per week and participating in the IOP for an average of 5 weeks).

-For each FY after 2017, Patient Volume takes into account (a) Outpatient Substance Abuse Treatment patients, assuming a 3.5% increase each year (114 in 2017, 118 in 2018, 122 in 2019, and 124 in 2020); and (b) IOP patients, assuming 6 clients per week in 2018, 7 clients per week in 2019, and 8 clients per week in 2020 (meaning a total of 62 clients in 2018, 73 clients in 2019, and 83 clients in 2020). IOP clients will participate in the IOP for 5 weeks, on average.

ATTACHMENT VIII

EMPLOYER'S COPY

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

NAME
GERARD R MARCIL, LADC

VALIDATION NO.	LICENSE NO.	CURRENT THROUGH
03-571328	001023	02/28/18

PROFESSION
LICENSED ALCOHOL AND DRUG COUNSELOR

SIGNATURE COMMISSIONER

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

PURSUANT TO THE PROVISIONS OF THE GENERAL STATUTES OF CONNECTICUT

THE INDIVIDUAL NAMED BELOW IS LICENSED
BY THIS DEPARTMENT AS A

LICENSED ALCOHOL AND DRUG COUNSELOR

LICENSE NO.
000940

AMY M ST PIERRE, LADC

CURRENT THROUGH
11/30/17

VALIDATION NO.
03-553988

SIGNATURE

COMMISSIONER

ATTACHMENT IX

1776 Meriden Road Rear Unit B
Wolcott CT 06716
Phone: 203-596-7870 Fax: 203-527-7683

August 1, 2017

Mr. Chad W. Wable, FACHE
President, St. Mary's Hospital
56 Franklin Street
Waterbury, CT 06706

DRAFT

Dear Mr. Wable:

The following is a transfer agreement between Counseling Center of Waterbury, LLC (d/b/a Connecticut Counseling & Wellness), which is located at 1776 Meriden Road in Wolcott, Connecticut and St. Mary's Hospital.

TRANSFER AGREEMENT

This document represents a written agreement between Counseling Center of Waterbury, LLC (hereafter referred to as CCW) and St. Mary's Hospital. When emergency treatment beyond those services provided by CCW may be necessary for CCW patients, CCW may transfer such patients to St. Mary's Hospital's located at 56 Franklin Street, Waterbury, CT for emergency services treatment. Unless otherwise directed, CCW patients will be directed to the Emergency Services Department (ED) at St. Mary's Hospital. Such transfers will be completed either through St. Mary's Hospital's ambulance resources, or other ambulance service which CCW may contact via 911 emergency responders. CCW will make reasonable attempts to notify St. Mary's Hospital's ED in advance of such transfers. St. Mary's Hospital and CCW will work collaboratively to implement aftercare plans which meet the clinical needs of the patient.

This agreement is effective August 1, 2017, and will remain in effect indefinitely, unless either party desires to modify or discontinue it. This agreement may be modified or discontinued by either party with 60 days' notice. Such notices should be directed to:

For: Counseling Center of Waterbury, LLC
Gerard Marcil
Chief Executive Officer
Counseling Center of Waterbury, LLC

Accepted by:

____

Gerard Marcil

For: St. Mary's Hospital
[Name]
[Title]
St. Mary's Hospital

Accepted by:

____

[Name]

ATTACHMENT X

FOR-PROFIT

Applicant Name: Connecticut Counseling & Wellness

Financial Worksheet (B)

Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

LINE	Total Entity: Description	(1) FY2016 Actual Results	(2) FY2017 Projected W/out CON	(3) FY2017 Projected Incremental	(4) FY2017 Projected With CON	(5) FY2018 Projected W/out CON	(6) FY2018 Projected Incremental	(7) FY2018 Projected With CON	(8) FY2019 Projected W/out CON	(9) FY2019 Projected Incremental	(10) FY2019 Projected With CON	(11) FY2020 Projected W/out CON	(12) FY2020 Projected Incremental	(13) FY2020 Projected With CON
A.	**OPERATING REVENUE**													
1	Total Gross Patient Revenue	$286,591	$296,622	$97,500	$394,122	$307,004	$234,000	$541,004	$317,750	$273,000	$590,750	$328,871	$312,000	$640,871
2	Less: Allowances	$0	$0	$0	$0			$0			$0			$0
3	Less: Charity Care	$0	$0	$0	$0			$0			$0			$0
4	Less: Other Deductions	$0	$0	$0	$0			$0			$0			$0
	Net Patient Service Revenue	$286,591	$296,622	$97,500	$394,122	$307,004	$234,000	$541,004	$317,750	$273,000	$590,750	$328,871	$312,000	$640,871
5	Medicare	$0	$0	$0	$0			$0			$0			$0
6	Medicaid	$93,000	$96,255	$31,590	$127,845	$99,624	$75,816	$175,440	$103,111	$88,452	$191,563	$106,720	$101,088	$207,808
7	CHAMPUS & TriCare	$0	$0	$0	$0			$0			$0			$0
8	Other	$700	$725	$195	$920	$750	$468	$1,218	$776	$546	$1,322	$803	$624	$1,427
	Total Government	$93,700	$96,980	$31,785	$128,765	$100,374	$76,284	$176,658	$103,887	$88,998	$192,885	$107,523	$101,712	$209,235
9	Commercial Insurers	$65,300	$67,586	$22,327	$89,913	$69,952	$53,586	$123,538	$72,400	$62,517	$134,917	$74,934	$71,448	$146,382
10	Uninsured	$0	$0	$0	$0			$0			$0			$0
11	Self Pay	$127,591	$132,056	$0	$132,056	$136,678	$104,130	$240,808	$141,463	$121,485	$262,948	$146,414	$138,840	$285,254
12	Workers Compensation	$0	$0	$0	$0			$0			$0			$0
13	Other	$0	$0	$43,388	$43,388			$0			$0			$0
	Total Non-Government	$192,891	$199,642	$65,715	$265,357	$206,630	$157,716	$364,346	$213,863	$184,002	$397,865	$221,348	$210,288	$431,636
	Net Patient Service Revenue[a] (Government+Non-Government)	$286,591	$296,622	$97,500	$394,122	$307,004	$234,000	$541,004	$317,750	$273,000	$590,750	$328,871	$312,000	$640,871
14	Less: Provision for Bad Debts	$782	$889	$292	$1,181	$921	$702	$1,623	$953	$819	$1,772	$987	$936	$1,923
	Net Patient Service Revenue less provision for bad debts	$285,809	$295,733	$97,208	$392,941	$306,083	$233,298	$539,381	$316,797	$272,181	$588,978	$327,884	$311,064	$638,948
15	Other Operating Revenue	$0	$0	$0	$0			$0			$0			$0
17	Net Assets Released from Restrictions	$0	$0	$0	$0			$0			$0			$0
	TOTAL OPERATING REVENUE	$285,809	$295,733	$97,208	$392,941	$306,083	$233,298	$539,381	$316,797	$272,181	$588,978	$327,884	$311,064	$638,948
B.	**OPERATING EXPENSES**													
1	Salaries and Wages	$165,729	$168,214	$40,000	$208,214	$170,737	$40,600	$211,337	$173,298	$41,209	$214,507	$175,897	$41,827	$217,724
2	Fringe Benefits	$1,448	$1,470		$1,470	$1,492		$1,492	$1,514		$1,514	$1,537		$1,537
3	Physicians Fees	$0	$0	$0	$0			$0			$0			$0
4	Supplies and Drugs	$2,326	$2,361	$0	$2,361	$2,396		$2,396	$2,432		$2,432	$2,468		$2,468
5	Depreciation and Amortization	$0	$0	$0	$0			$0			$0			$0
6	Provision for Bad Debts-Other[b]	$0	$0	$0	$0			$0			$0			$0
7	Interest Expense	$0	$0	$0	$0			$0			$0			$0
8	Malpractice Insurance Cost	$398	$404	$0	$404	$410		$410	$416		$416	$422		$422
9	Lease Expense	$12,000	$12,180	$0	$12,180	$12,363		$12,363	$12,548		$12,548	$12,736		$12,736
10	Other Operating Expenses	$33,037	$33,533	$0	$33,533	$34,036		$34,036	$34,546		$34,546	$35,064		$35,064
	TOTAL OPERATING EXPENSES	$214,938	$218,162	$40,000	$258,162	$221,434	$40,600	$262,034	$224,754	$41,209	$265,963	$228,124	$41,827	$269,951
	INCOME/(LOSS) FROM OPERATIONS	$70,871	$77,571	$57,208	$134,779	$84,649	$192,698	$277,347	$92,043	$230,972	$323,015	$99,760	$269,237	$368,997
	NON-OPERATING INCOME	$0	$0	$0	$0			$0			$0			$0
	Income before provision for income taxes	$70,871	$77,571	$57,208	$134,779	$84,649	$192,698	$277,347	$92,043	$230,972	$323,015	$99,760	$269,237	$368,997
	Provision for income taxes[c]	$0	$0	$0	$0			$0			$0			$0
	NET INCOME	$70,871	$77,571	$57,208	$134,779	$84,649	$192,698	$277,347	$92,043	$230,972	$323,015	$99,760	$269,237	$368,997
C.	**Retained Earnings, beginning of year**	$0	$0	$0	$0			$0			$0			$0
	Retained Earnings, end of year	$0	$0	$0	$0			$0			$0			$0
	Principal Payments	$0	$0	$0	$0			$0			$0			$0
D.	**PROFITABILITY SUMMARY**													
1	Hospital Operating Margin	24.8%	26.2%	58.9%	34.3%	27.7%	82.6%	51.4%	29.1%	84.9%	54.8%	30.4%	86.6%	57.8%
2	Hospital Non Operating Margin	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
3	Hospital Total Margin	24.8%	26.2%	58.9%	34.3%	27.7%	82.6%	51.4%	29.1%	84.9%	54.8%	30.4%	86.6%	57.8%
E.	**FTEs**	4	4	1	5	4	1	5	4	1	5	4	1	5

F. VOLUME STATISTICS[d]

FOR-PROFIT

Applicant Name: Connecticut Counseling & Wellness

Financial Worksheet (B)

Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

LINE	Total Entity:	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
		FY2016	FY2017	FY2017	FY2017	FY2018	FY2018	FY2018	FY2019	FY2019	FY2019	FY2020	FY2020	FY2020
		Actual	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected
	Description	Results	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON
1	Inpatient Discharges	0	0	0	0			0			0			0
2	Outpatient Visits	5,899	2,426	390	2,816	2,511	936	3,447	2,599	1,092	3,691	2,690	1,248	3,938
	TOTAL VOLUME	5,899	2,426	390	2,816	2,511	936	3,447	2,599	1,092	3,691	2,690	1,248	3,938

[a]Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.

[b]Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No.2011-07, July 2011.

[c]Provide the amount of income taxes as defined by the Internal Revenue Services for for-profit entities.

[d]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.

User, OHCA

From: Walker, Shauna
Sent: Tuesday, July 11, 2017 3:23 PM
To: amy@ccwellness.org; AMurray@pullcom.com
Cc: Riggott, Kaila; Mitchell, Micheala; User, OHCA; Walker, Shauna
Subject: 17-32163 CON Second Completeness Correspondence
Attachments: 32163 Counseling Center of Waterbury LLC Second Completeness.pdf

Dear Ms. St. Pierre:

Attached is a second request for additional information regarding CON application 17-32163 – Establishment of a Facility for the Care or Treatment of Substance Abusive or Dependent Persons in Wolcott, CT. Responses are due by Monday, September 11, 2017 at 4:30 p.m.

Please confirm receipt of this email.

Thank you,

Shauna L. Walker
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue
Hartford, CT 06134
Phone: (860) 418-7069
Email: Shauna.Walker@ct.gov

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor
Nancy Wyman
Lt. Governor

Office of Health Care Access

July 11, 2017 Via Email Only

Amy St. Pierre
Counseling Center of Waterbury, LLC
Clinical Supervisor
1776 Meriden Road
Wolcott, CT 06716
amy@ccwellness.org

RE: Certificate of Need Application: Docket Number: 17-32163-CON
Establishment of a Facility for the Care or Treatment of Substance Abusive or Dependent Persons in Wolcott, CT
Certificate of Need Second Completeness Letter

Dear Ms. St. Pierre:

On June 13, 2017, the Department of Public Health ("DPH"), Office of Health Care Access ("OHCA") received completeness responses on behalf of Counseling Center of Waterbury, LLC, d/b/a Connecticut Counseling & Wellness ("CCW") to establish a facility for the care or treatment of substance abusive or dependent persons in Wolcott, Connecticut.

OHCA requests additional information pursuant to Connecticut General Statutes §19a-639a(c). *Please "reply all" to electronically confirm receipt of this email as soon as you receive it.* Provide responses to the questions below in both a Word document and PDF format as an attachment to a responding email. ***Please email your responses to both of the following email addresses: OHCA@ct.gov and Kaila.Riggott@ct.gov.***

Paginate and date your response (i.e., each page in its entirety). Repeat each OHCA question before providing your response. Information filed after the initial CON application submission (e.g., completeness response letter, prefiled testimony, late file submissions, etc.) must be numbered sequentially from the Applicant's preceding document. Begin your submission using **Page 221** and reference "**Docket Number: 17-32163-CON**."

Pursuant to Section 19a-639a(c) of the Connecticut General Statutes, you must submit your response to this request for additional information no later than sixty days after the date this request was transmitted. Therefore, please provide your written responses to OHCA no later than **September 11, 2017 at 4:30 p.m.**, otherwise your application will be automatically considered withdrawn.

1. Page 207 of the application estimates the target population for the service area towns at 79% (based upon the *overall* Connecticut population for adults ages 18 and older). Revise the estimated target population for each service area town utilizing a data source such as the one found at the following link: https://factfinder.census.gov/faces/nav/jsf/pages/searchresults.xhtml?refresh=t&keepList=t.

2. Provide the calculation(s) used to derive 5 clients on average per week for intensive outpatient treatment ("IOP") visits in fiscal year ("FY") 2017, as referenced on page 209 of the application.

3. Update Table 6 on page 209 of the application to provide the projected volume by number of clients. Provide a calculation and rationale for projected year-over-year increases.

4. Explain where existing CCW clients in need of IOP are currently receiving treatment.

If you have any questions concerning this letter, please feel free to contact Kaila Riggott at (860) 418-7037.

User, OHCA

From: Murray, Amy E. <AMurray@pullcom.com>
Sent: Friday, July 14, 2017 3:35 PM
To: User, OHCA; Riggott, Kaila
Subject: CON-17-32163/Counseling Center of Waterbury response to completeness questions
Attachments: Counseling Center of Waterbury LLC 17-32163-CON 9-2017 Response to Completeness Questions.DOCX; Counseling Center of Waterbury 17-32163-CON 7-14-2017 Response to Completeness Questions.PDF

Attached you will find Counseling Center of Waterbury, LLC's response to completeness questions received on July 11, 2017, in both PDF and Word format as requested. Please let me know if you require any additional information.

Thank you,
Amy

Amy E. Murray
Attorney

PULLMAN
&COMLEY LLC
ATTORNEYS

850 Main Street P.O. Box 7006
Bridgeport, CT 06601-7006
p 203 330 2282 f 203 576 8888
amurray@pullcom.com • www.pullcom.com

V-card • **Bio** • **Directions**

BRIDGEPORT HARTFORD STAMFORD WATERBURY WHITE PLAINS

Please consider the environment before printing this message.
THIS MESSAGE AND ANY OF ITS ATTACHMENTS ARE INTENDED ONLY FOR THE USE OF THE DESIGNATED RECIPIENT, OR THE RECIPIENT'S DESIGNEE, AND MAY CONTAIN INFORMATION THAT IS CONFIDENTIAL OR PRIVILEGED. IF YOU ARE NOT THE INTENDED RECIPIENT, PLEASE (1) IMMEDIATELY NOTIFY PULLMAN & COMLEY ABOUT THE RECEIPT BY TELEPHONING (203) 330-2000; (2) DELETE ALL COPIES OF THE MESSAGE AND ANY ATTACHMENTS; AND (3) DO NOT DISSEMINATE OR MAKE ANY USE OF ANY OF THEIR CONTENTS.

Pursuant to Section 19a-639a(c) of the Connecticut General Statutes, you must submit your response to this request for additional information no later than sixty days after the date this request was transmitted. Therefore, please provide your written responses to OHCA no later than **September 11, 2017, at 4:30 p.m.**, otherwise your application will be automatically considered withdrawn.

1. Page 207 of the application estimates the target population for the service area towns at 79% (based upon the overall Connecticut population for adults ages 18 and older). Revise the estimated target population for each services area town utilizing a data source such as the one found at the following link:

   https://factfinder.census.gov/faces/nav/jsf/pages/searchresults.xhtml?refresh=t&keepList=t.

   Response:

Town	Population+	In Need++	To be Served (first 12 month period)+++	% of need Served++++
Waterbury	82,161	6,984	16	.23%
Wolcott	13,093	1,113	10	.90%
Naugatuck	24,585	2,090	3	.14%
Watertown	17,238	1,465	2	.14%
Southbury	15,439	1,312	2	.15%
Branford	23,327	1,983	2	.10%
Cheshire	22,908	1,947	2	.10%
New Britain	55,993	4,759	2	.04%
Wallingford	36,564	3,108	2	.06%

Data presented in the figure above are based on the following assumptions:

+ The populations provided reflect the adult population (ages 18 and above) in each of the listed towns in 2015, as provided by the United States Census Bureau's American Community Survey Demographic and Housing Estimates.
++ The estimates of individuals "in need" of SUD treatment are 8.5% of the adult population in each town. (In 2013, SAMHSA calculated that 8.5% of adults aged 18 or older had a substance use disorder in the past year, or 20.3 million adults total. *See* https://store.samhsa.gov/shin/content/NSDUH14-0904/NSDUH14-0904.pdf.)
+++ The estimated number of individuals to be served (client volume) is based on an estimated 57 patients being treated in the first 12 months. (For the first 6 months, it is estimated that approximately 26 clients will be seen – 5 patients will be seen per week, and each patient will participate in the IOP

for 5 weeks, on average. For the second 6 months, an estimated 31 clients will be seen – 6 patients will be seen per week, and each patient will participate in the IOP for 5 weeks, on average).

The number of clients to be served in each town in the Service Area is anticipated to be substantially the same as the utilization by town in 2016, which was provided in Table 8 of the CON Application. (For example, in 2016 28% of CCW clients were from Waterbury (31 of 110). Accordingly, 28% of the IOP clients served in the first year are anticipated to reside in Waterbury.)

The chart shows the total number of clients to be served in the first 12 months as 41 because, based on utilization by town in 2016 (Table 8 of the CON Application), the additional 16 clients served will be residents of other towns in the surrounding area.

++++ We understand that part of the challenge is motivating individuals to seek treatment, and therefore the demand for treatment is not necessarily equivalent to the number of individuals with SUDs.

2. Provide the calculation(s) used to derive 5 clients on average per week for intensive outpatient treatment ("IOP") visits in fiscal year ("FY") 2017, as referenced on page 209 of the application.

<u>Response</u>: As discussed in response to Questions 1, 8.c. and 8.e. of the CON Application submitted on April 13 2017 and in response to Question 2.b. of the Supplemental CON Application submitted on April 13, 2017, there is a significant need for additional IOPs in the Service Area. Accordingly, CCW believes that the demand for treatment through its IOP will be high. Because the IOP would be a new program for CCW, CCW has made the decision to begin with the proposed IOP serving a relatively small number of clients (5 clients/week), and to gradually increase this number (to 6 clients/week in 2018, 7 clients/week in 2019, and 8 clients/week in 2020).

CCW is prepared for this steady increase in clients. As discussed in response to Question 1 of the CON Application, CCW anticipated this growth when it selected its current location and has capacity for the proposed IOP. Additionally, CCW's existing staff and equipment will be sufficient to operate the proposed IOP through 2020. CCW believes that the structure of the proposed IOP, as discussed in the CON Application as well as this response, will enable CCW to provide high quality, personalized care to each and every client.

3. Update Table 6 on page 209 of the application to provide the projected volume by number of clients. Provide a calculation and rationale for projected year-over-year increases.

Response:

TABLE 6
PROJECTED UTILIZATION BY SERVICE

Service*	Projected Volume			
	FY 2017**	**FY 2018****	**FY 2019****	**FY 2020**
Outpatient Substance Abuse Treatment+	114	118	122	126
Intensive Outpatient Substance Abuse Treatment+++	26++	62	73	83
Total	140	180	195	209

*Identify each service type by location and add lines as necessary. Provide the number of visits/discharges as appropriate for each service listed.
**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. If the time period reported is not *identical* to the fiscal year reported in Table 4 of the application, provide the date range using the mm/dd format as a footnote to the table.

+The estimates for Outpatient Substance Abuse Treatment visits assume a 3.5% increase each year. The FY 2017 projections are based on a 3.5% increase from 2016, where 110 patients received treatment.

++The IOP estimate for FY2017 is for six months only, 07/17 through 12/17. Accordingly, the 2017 Total does not reflect 12 months of IOP operation and leads to a greater increase from 2017 to 2018 than in future years.

+++The estimates for IOP clients for each year assume that each client will receive treatment for an average of 5 weeks. From 07/17 through 12/17 the estimates assume 5 IOP clients are receiving treatment per week, for 2018 the estimates assume 6 IOP clients are receiving treatment per week, for 2019 the estimates assume 7 IOP clients are receiving treatment per week, and for 2020 the estimates assume 8 IOP clients are receiving treatment per week. (As an example of how the number of patients treated each year was calculated, there are 52 weeks in 2018 and 6 patients will be seen each week, therefore there are 312 weeks available for treatment. As each patient will receive 5 weeks of treatment on average, 62 patients will be treated in 2018).

CCW is prepared for this steady increase in clients. As discussed in response to Question 1 of the CON Application, CCW anticipated this growth when it selected its current location and has capacity for the proposed IOP. Additionally, CCW's existing staff and equipment will be sufficient to operate the proposed IOP through 2020. CCW believes that the structure of the proposed IOP, as discussed in the CON Application as well as this response, will enable CCW to provide high quality, personalized care to each and every client.

4. Explain where existing CCW clients in need of IOP are currently receiving treatment.

Response: CCW currently refers CCW clients in need of IOP treatment to Rushford (a Hartford HealthCare partner), Waterbury Hospital, and Family Intervention Center in Waterbury.

User, OHCA

From: Walker, Shauna
Sent: Friday, August 04, 2017 7:37 AM
To: amy@ccwellness.org
Cc: Mitchell, Micheala; User, OHCA; Riggott, Kaila
Subject: Counseling Center of Waterbury, LLC Deemed Complete
Attachments: 32163 Notification of Application Deemed Complete.pdf

Good Morning Ms. St. Pierre,

Attached is a letter deeming the above-referenced application complete. Please confirm receipt of this email and the attachment.

Regards,

Shauna L. Walker
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue
Hartford, CT 06134
Phone: (860) 418-7069
Email: Shauna.Walker@ct.gov

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor

Nancy Wyman
Lt. Governor

Office of Health Care Access

August 4, 2017 Via Email Only

Amy St. Pierre
Counseling Center of Waterbury, LLC
Clinical Supervisor
1776 Meriden Road
Wolcott, CT 06716
amy@ccwellness.org

RE: Certificate of Need Application: Docket Number: 17-32163-CON
Establishment of a Facility for the Care of Treatment of Substance Abusive or Dependent Persons in Wolcott, CT

Dear Ms. St. Pierre:

This letter is to inform you that, pursuant to Section 19a-639a (d) of the Connecticut General Statutes, the Office of Health Care Access has deemed the above-referenced application complete as of August 3, 2017.

If you have any questions concerning this letter, please feel free to contact me at (860) 418-7069.

Sincerely,

Shauna Walker
Digitally signed by Shauna Walker
Date: 2017.08.04 07:28:43 -04'00'

Shauna L. Walker
Associate Research Analyst

Phone: (860) 418-7001 • Fax: (860) 418-7053
410 Capitol Avenue, M.S. #13HCA
P.O. Box 340308
Hartford, Connecticut 06134-0308
www.ct.gov/dph
Affirmative Action/Equal Opportunity Employer

User, OHCA

From: Walker, Shauna
Sent: Wednesday, September 13, 2017 10:28 AM
To: User, OHCA
Subject: FW: Counseling Center of Waterbury, LLC Deemed Complete

From: Amy St. Pierre [mailto:amy@ccwellness.org]
Sent: Tuesday, August 15, 2017 9:01 AM
To: Walker, Shauna <Shauna.Walker@ct.gov>
Subject: Re: Counseling Center of Waterbury, LLC Deemed Complete

Jerry Marcil at jerry@ccwellmess.org. He is now the only licensed clinician in the practice.

On Tuesday, August 15, 2017, Walker, Shauna <Shauna.Walker@ct.gov> wrote:

Hi Amy,

Would you be able to provide us with an alternative contact?

Thank you!

Shauna L. Walker

Office of Health Care Access

Connecticut Department of Public Health

410 Capitol Avenue

Hartford, CT 06134

Phone: (860) 418-7069

Email: Shauna.Walker@ct.gov

From: Amy St. Pierre [mailto:amy@ccwellness.org]
Sent: Monday, August 14, 2017 4:59 PM
To: Walker, Shauna <Shauna.Walker@ct.gov>
Cc: Mitchell, Micheala <Micheala.Mitchell@ct.gov>; User, OHCA <OHCA@ct.gov>; Riggott, Kaila <Kaila.Riggott@ct.gov>; Murray, Amy E. <AMurray@pullcom.com>
Subject: Re: Counseling Center of Waterbury, LLC Deemed Complete

Please be advised that I will no longer be employed by CCW effective 8/28/17. As such, please remove my name from CON application.

Thank you,

Amy St.Pierre, LADC

Clinical Supervisor

Connecticut Counseling and Wellness

1776 Meriden Road

Wolcott, CT 06716

203-596-7870

On Fri, Aug 4, 2017 at 7:37 AM, Walker, Shauna <Shauna.Walker@ct.gov> wrote:

> Good Morning Ms. St. Pierre,

Attached is a letter deeming the above-referenced application complete. Please confirm receipt of this email and the attachment.

Regards,

Shauna L. Walker

Office of Health Care Access

Connecticut Department of Public Health

410 Capitol Avenue

Hartford, CT 06134

Phone: (860) 418-7069

Email: Shauna.Walker@ct.gov

--
Amy St.Pierre, LADC
Clinical Supervisor
Connecticut Counseling and Wellness
1776 Meriden Road
Wolcott, CT 06716
203-596-7870

User, OHCA

From: Riggott, Kaila
Sent: Friday, September 22, 2017 11:58 AM
To: Jerry Marcil
Cc: User, OHCA
Subject: RE: 17-32163-CON Agreed Settlement for your signature

Thank you. We will forward a signed copy after the document is signed by Deputy Commissioner Addo.

Kaila Riggott, MPA
Planning Specialist
State of Connecticut
Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS#13-HCA
Hartford, CT 06134
phone: 860.418.7037
fax: 860.418.7053
http://www/ct.gov/ohca

From: Jerry Marcil [mailto:jerry@ccwellness.org]
Sent: Friday, September 22, 2017 11:51 AM
To: Riggott, Kaila <Kaila.Riggott@ct.gov>
Subject: Fwd: 17-32163-CON Agreed Settlement for your signature

Hi Kaila,
I have reviewed and signed the document.
Jerry Marcil
---------- Forwarded message ----------
From: **Amy St. Pierre** <amy@ccwellness.org>
Date: Fri, Sep 22, 2017 at 9:20 AM
Subject: Fwd: 17-32163-CON Agreed Settlement for your signature
To: Jerry Marcil <jerry@ccwellness.org>

---------- Forwarded message ----------
From: **Riggott, Kaila** <Kaila.Riggott@ct.gov>
Date: Friday, September 22, 2017
Subject: 17-32163-CON Agreed Settlement for your signature
To: "amy@ccwellness.org" <amy@ccwellness.org>

Good Morning Ms. St. Pierre,

Please see the attached Agreed Settlement for Docket No. 17-32163-CON. ***Please confirm receipt of this email*** and then review, electronically sign and return to me by Friday, September 29, 2017 for Deputy Commissioner Addo's signature. Please feel free to call if you have any questions or concerns.

Regards,

Kaila Riggott

CON Supervisor

Kaila Riggott, MPA

Planning Specialist

State of Connecticut

Department of Public Health

Office of Health Care Access

410 Capitol Avenue, MS#13-HCA

Hartford, CT 06134

phone: 860.418.7037

fax: 860.418.7053

http://www/ct.gov/ohca

--
Amy St.Pierre, LADC
Clinical Supervisor
Connecticut Counseling and Wellness
1776 Meriden Road
Wolcott, CT 06716
203-596-7870

--
Jerry Marcil, LADC, CEAP, LAP-c, SAP
Director, CT Counseling and Wellness
(203) 596-7870 Business
(203) 233-7581 Cell

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless the further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CRF Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor
Nancy Wyman
Lt. Governor

Department of Public Health
Office of Health Care Access
Certificate of Need Application

Agreed Settlement

Applicant: **Counseling Center of Waterbury, LLC**
d/b/a Connecticut Counseling & Wellness
1776 Meriden Road
Wolcott, CT 06716

Docket Number: **17-32163-CON**

Project Title: **Establishment of a Psychiatric Outpatient Clinic and Facility for the Care or Treatment of Substance Abuse or Dependence for Adults in Wolcott, Connecticut**

Project Description: Counseling Center of Waterbury, LLC, d/b/a Connecticut Counseling & Wellness ("CCW" or "Applicant") is proposing to establish a psychiatric outpatient clinic and facility for the care or treatment of substance abusive or dependent persons at 1776 Meriden Road, Wolcott, Connecticut.

Procedural History: The Applicant published notice of its intent to file a Certificate of Need ("CON") application in The *Republican-American* (Waterbury) on March 16, 17 and 18, 2017. On April 18, 2017, the Office of Health Care Access ("OHCA") received the CON application from the Applicant for the above-referenced project and deemed the application complete on August 3, 2017. OHCA received no responses from the public concerning the proposal and no hearing requests from the public per Connecticut General Statutes ("Conn. Gen. Stat.") § 19a-639a(e). Deputy Commissioner Addo considered the entire record in this matter.

Phone: (860) 418-7001 • Fax: (860) 418-7053
410 Capitol Avenue, MS#13HCA
Hartford, Connecticut 06134-0308
www.ct.gov/dph
Affirmative Action/Equal Opportunity Employer

Findings of Fact and Conclusions of Law

1. CCW is a for-profit entity that provides outpatient substance abuse treatment services, including individual and group substance abuse counseling and counseling for family members of addicted persons in Wolcott, Connecticut. Ex. A, pp. 7-8.

2. The Applicant has provided counseling services in the Greater Waterbury area for over 20 years with key professionals who collectively possess over 60 years of counseling experience. Ex. A, p. 8.

3. CCW is proposing to establish a psychiatric outpatient clinic and facility for the care or treatment of substance abuse or dependence for adults ages 18 years and older to provide intensive outpatient ("IOP") treatment. Ex. A, pp. 8, 12.

4. The proposed program will primarily treat adults with diagnosable substance use disorders ("SUDs") who reside in the Greater Waterbury area and are in need of treatment at an IOP level of care. Ex. A, pp. 12, 13.

5. The Applicant is proposing to locate the program at its existing 1776 Meriden Road location as it has the necessary space, equipment and staffing to begin operations. Ex. A, pp. 8, 10.

6. There are currently no IOP providers in Wolcott. Furthermore, existing providers in the Applicant's service area often operate at capacity, requiring potential clients to be waitlisted or to seek treatment outside of their local community. Ex. A, p. 13.

7. The Applicant intends to meet the current standards of practice outlined in the Matrix Model of outpatient treatment, which combines multiple therapeutic strategies to produce a clinically coordinated program. Program components include individual counseling, early recovery skills groups, relapse prevention groups, family education groups, 12-step meetings, urine/breath tests, relapse analysis and social support. Guiding principles essential to the model include establishing a positive and collaborative relationship, creating structure and expectations, teaching psychoeducation, cognitive behavioral skills and positive reinforcement. Ex. A, pp. 145-174.

8. Key characteristics of the proposed program will include:
   a. Unique practice setting: CCW is a small private practice located in a discrete, rural setting and will offer an alternative to the larger treatment facilities in the city of Waterbury.
   b. Personalized program: IOP offered by CCW will be personalized to fulfill each client's needs. CCW intends to begin by working with only five IOP clients and will gradually increase this number based on available resources.
   c. Family component: CCW will offer group sessions for family members of clients and individual sessions that will foster collaboration with the client and his or her family.
   d. Continuity of care: after a client completes IOP treatment at CCW, he or she can continue to receive treatment at the facility through various step-down programs. Additionally, after an individual is no longer a client of CCW, he or she will still have a person they can contact at the facility, as needed.
   e. Community knowledge: CCW has established referral relationships with other community-based organizations to assist with client transitions and outcomes.

   Ex. A, pp. 9-10.

9. The proposed IOP will be structured according to each client's individualized recovery plan, consisting of at least three visits per week for 3-4 hours at a time. Clients will receive IOP treatment for 4-6 weeks before they are transitioned to the next appropriate level of care. Ex. A, p. 7.

10. The proposed program will operate from 9:00 a.m. to 9:00 p.m., Monday through Friday. Ex. A, p. 24.

11. In 2016, 72% of CCW's clients were from the proposed service area towns, with the majority originating from Waterbury.

TABLE 1
FISCAL YEAR ("FY") 2016 UTILIZATION BY TOWN OF CLIENT ORIGIN FOR CCW

SERVICE AREA	NO. OF CLIENTS	PERCENT OF TOTAL
Waterbury	31	28%
Wolcott	19	17%
Naugatuck	7	6%
Watertown	5	5%
Southbury	4	4%
Branford	3	3%
Cheshire	3	3%
New Britain	3	3%
Wallingford	3	3%
Other*	32	29%
Total	**165**	**100%****

Ex. A, p. 28; Ex. D, p. 208.
*Includes clients originating from other CT towns.
**Actual total varies due to rounding.

12. Adults within the Applicant's proposed service area represent 10% of Connecticut's population ages 18 years and older. Based on prevalence rates predicated upon national data, nearly 25,000 of these adults may have a diagnosable substance use disorder.

TABLE 2
ESTIMATE OF DIAGNOSABLE SUBSTANCE USE DISORDER IN PROPOSED SERVICE AREA

SUBSTANCE USE DISORDER	POPULATION (18 and older)[1]	PREVALENCE[2]	INCIDENCE
Branford	23,327		1,983
Cheshire	22,908		1,947
Naugatuck	24,585		2,090
New Britain	55,993		4,759
Southbury	15,439		1,312
Wallingford	36,564		3,108
Waterbury	82,161		6,984
Watertown	17,238		1,465
Wolcott	13,093		1,113
Total for proposed service area	291,308	8.5%	24,761
Connecticut	2,808,486	8.5%	238,721
Service area as percent of Connecticut	**10.4%**	**n/a**	**10.4%**

[1]U.S. Census Bureau, 2011-2015 American Community Survey Demographic and Housing 5-Year Estimates (2015 version), available at https://factfinder.census.gov.
[2]Substance Abuse and Mental Health Services Administration. 2014. *The NSDUH Report: Substance Use and Mental Health Estimates from the 2013 National Survey on Drug Use and Health: Overview of Findings*. Rockville, MD. Available at https://store.samhsa.gov/shin/content/NSDUH14-0904/NSDUH14-0904.pdf.
Ex. D, p. 207; Ex. F, p. 221.

13. According to The Department of Mental Health and Addiction Services' ("DMHAS") 2016 Triennial State Substance Abuse Plan, Connecticut is in the midst of an opioid epidemic that has led to an increasing number of overdose deaths across the state. This has resulted in creating one of the most important health concerns currently faced by the state. Ex. A, pp. 13-14.

14. At a local level, the Greater Waterbury Health Improvement Partnership published a Community Health Needs Assessment ("CHNA") in 2013 which identified substance abuse as a health priority. The CHNA identified increasing access as one of the ways to address this issue. Ex. A, p. 9.

15. Additionally, statistics released in February 2017 from the Office of the Chief Medical Examiner ("OCME") reveal that in 2016, there were 917 accidental intoxication overdose deaths in Connecticut, with over 100 occurring in the proposed service area. Ex. A, pp. 14-15.

16. SAMHSA's Behavioral Health Barometer– Connecticut, 2015, estimates that, between 2013 and 2014, 6.8% of Connecticut residents aged 12 years or older were dependent on or abused alcohol within the year prior to being surveyed, which is slightly higher than the national average of 6.5%. Of those Connecticut residents aged 12 years or older with alcohol dependence or abuse, 92.9% did not receive treatment. Ex. A, pp. 14-15.

17. The Applicant projects that a total of 140 clients will participate in all programs in FY 2017. The Applicant further projects a census of over 200 clients by FY 2020.

TABLE 3
COUNSELING CENTER OF WATERBURY, LLC PROJECTED UTILIZATION

SERVICE/PROGRAM	CURRENT CLIENTS	PROJECTED CLIENTS		
	FY 2017	FY 2018	FY 2019	FY 2020
Outpatient Substance Abuse Treatment (Counseling)[1]	114	118	122	126
Intensive Outpatient Treatment Program[2]	26	62	73	83
Total Client Census	140	180	195	209

Fiscal Year is January 1 – December 31
[1]Outpatient Substance Abuse Treatment visits assume a 3.5% increase each year, based on historical growth. It is estimated that 114 clients will receive treatment through 2017, stemming from a 3.5% increase from 2016, where 110 clients received treatment. The 3.5% increase is a conservative estimate, as there was a 3.44% increase from 2014 to 2015 and 6.6% increase over a two year period from 2015 to 2017.
[2]IOP estimated to begin July 1, 2017. Client calculations are as follows:
2017 – 130 weeks (26 weeks x 5 clients/week) / 5 weeks
2018 – 312 weeks (52 weeks x 6 clients/week) / 5 weeks
2019 – 364 weeks (52 weeks x 7 clients/week) / 5 weeks
2020 – 416 weeks (52 weeks x 8 clients/week) / 5 weeks
Initial estimate of five clients receiving IOP treatment per week is based on the demand and need for additional IOPs in the service area. Despite the significant need for additional IOPs in the service area, CCW has made the decision to begin with a relatively small number of clients. Additionally, a steady increase in the number of IOP clients is anticipated each year, based on the increase in the number of clients receiving outpatient substance abuse treatment.
Ex. A, p. 20; Ex. D, pp. 209-210; Ex. F, pp. 222-223.

18. The target population will be derived primarily from existing and future CCW clients. However, the program will also accept referrals from Trade Union 478[1], local providers and community organizations such as Wolcott Crossroads and Family & Children's Aid. Ex. A, p. 12; Ex. D, p. 206.

19. Existing CCW clients currently receive IOP treatment from Rushford (a Hartford HealthCare partner), Waterbury Hospital and Family Intervention Center in Waterbury, all located outside of Wolcott. Potential clients for the proposed program, such as those from Trade Union 478, are at times referred to out of state providers. Ex. A, p. 13; Ex. F, p. 223.

20. The Applicant intends to develop relationships with inpatient SUD treatment providers seeking to discharge their clients to a local IOP program. These providers include Mountainside Treatment Center, High Watch Recovery Center, Connecticut Valley Hospital, Stonington Institute and American Addiction Centers. Ex. A, p. 17; Ex. D, p. 206.

21. CCW plans to develop a transfer agreement with St. Mary's Hospital in Waterbury, Connecticut. Clients will be transferred to St. Mary's Hospital in the event of necessary emergency treatment beyond the scope of services provided by CCW. Ex. D, pp. 206, 216.

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[1]The Machinist Union Members Assistance Program for Trade Union 478 currently refers members to CCW's existing programs.

22. While there are 14 existing IOP providers in the proposed service area, most are operating at or near capacity. Additionally, none are located in Wolcott and/or provide clients with a treatment option in a rural setting. Although public transportation is available from Wolcott to the existing service providers in Waterbury, none is available to the existing service providers in New Britain or Cheshire.

TABLE 4
PROVIDERS OF THE PROPOSED SERVICES IN SERVICE AREA

TOWN	PROVIDER	STREET ADDRESS
Waterbury	Family Intervention Center	22 Chase River Rd.
Waterbury	Catholic Charities Inc. – Archdiocese of Hartford	56 Church St.
Waterbury	Catholic Charities Inc. – Archdiocese of Hartford	13 Wolcott St.
Waterbury	Staywell Health Care, Inc.	1309 Main St.
Waterbury	Staywell Health Care, Inc.	402 East Main St.
Waterbury	Wellmore, Inc.	402 East Main St.
Waterbury	Wellmore, Inc.	142 Griggs St.
Waterbury	Connecticut Counseling Centers, Inc.	4 Midland Rd.
Waterbury	St. Mary's Health System	56 Franklin St.
Waterbury	Waterbury Hospital	64 Robbins St.
New Britain	The Hospital of Central Connecticut	73 Cedar St.
New Britain	Community Mental Health Affiliates, Inc.	55 Winthrop St.
New Britain	Farrell Treatment Center, Inc.	586 Main St.
Cheshire	Rushford (Hartford Healthcare)	680 South Main St., Suite 204

Ex. A, pp. 22, 28-29; Ex. D, p. 209; https://findtreatment.samhsa.gov, accessed June 16, 2017.

23. CCW projects a payer mix of 43% Medicaid, 47% commercially-insured and 10% uninsured (self-pay) clients annually for FYs 2018 through 2020.

TABLE 5
PROJECTED PAYER MIX FOR CCW BY NUMBER OF CLIENTS

Payer	Projected[2]								
	FY 2018			FY 2019			FY 2020		
	Client Volume	%	Visit Volume	Client Volume	%	Visit Volume	Client Volume	%	Visit Volume
Medicare[1]	0		0	0		0	0		0
Medicaid[1]	78	43	1,482	83	43	1,587	90	43	1,693
CHAMPUS & TriCare	0		0	0		0	0		0
Total Government	**78**	**43**	**1,482**	**83**	**43**	**1,587**	**90**	**43**	**1,693**
Commercial Insurers	84	47	1,620	93	47	1,735	98	47	1,851
Uninsured	18	10	345	19	10	369	21	10	394
Workers Compensation	0		0	0		0	0		0
Total Non-Government	**102**	**57**	**1,965**	**112**	**57**	**2,104**	**119**	**57**	**2,245**
Total Payer Mix	**180**	**100**	**3,447**	**195**	**100**	**3,691**	**209**	**100**	**3,938**

[1] Includes managed care activity.
[2]Based on the existing payer mix for the substance abuse treatment services.
Ex. A, pp. 20, 27; Ex. D, pp. 210-211.

24. The proposed program will adopt CCW's pro bono policy, sliding-fee scale and fee agreement. A client's needs and ability to pay will be determined on a case-by-case basis. Ex. A, pp. 15-16, 181-183.

25. The Applicant foresees no associated capital costs with establishing the program as it will operate in an existing facility. CCW currently employs two licensed alcohol and drug counselors that will implement the proposed program, however, it is anticipated that employment or contracting with an additional health care professional will be needed beginning in 2018, at an estimated salary of $40,000. Ex. A, pp. 10, 11, 20.

26. Based on an average of three 3-hour IOP sessions per client per week, a 1.5% annual increase in operating expenses and a steady increase in the number of clients served each year, the Applicant projects incremental gains from the onset of operations.

TABLE 6
PROJECTED INCREMENTAL REVENUES AND EXPENSES

	FY 2017*	FY 2018	FY 2019	FY 2020
Revenue from Operations	$97,208	$233,298	$272,181	$311,064
Total Operating Expenses	$40,000	$40,600	$41,209	$41,827
Gain/Loss from Operations	$57,208	$192,698	$230,972	$269,237

*July 1 – December 31
Ex. A, pp. 20, 25.

27. OHCA is currently in the process of establishing its policies and standards as regulations. Therefore, OHCA has not made any findings as to this proposal's relationship to any regulations not yet adopted by OHCA. (Conn. Gen. Stat. § 19a-639(a)(1)).

28. This CON application is consistent with the Statewide Health Care Facilities and Services Plan. (Conn. Gen. Stat. § 19a-639(a)(2)); Ex. A, p. 12.

29. The Applicant has established that there is a clear public need for the proposal. (Conn. Gen. Stat. § 19a-639(a)(3)); Ex. A, pp. 13-15.

30. The Applicant has demonstrated that the proposal is financially feasible. (Conn. Gen. Stat. § 19a-639(a)(4)); Ex. A, pp. 10, 20.

31. The Applicant has satisfactorily demonstrated that the proposal will improve the accessibility and maintain the quality and cost effectiveness of health care delivery in the region. (Conn. Gen. Stat. § 19a-639(a)(5)); Ex. A, pp. 16-17.

32. The Applicant has shown that there would be no adverse change in the provision of health care services to the relevant populations and payer mix, including access to services by Medicaid recipients and indigent persons. (Conn. Gen. Stat. § 19a-639(a)(6)); Ex. A, pp. 17-18.

33. The Applicant has satisfactorily identified the population to be affected by this proposal. (Conn. Gen. Stat. § 19a-639(a)(7)); Ex. A, pp. 12-13.

34. The Applicant's historical provision of services in the area supports this proposal. (Conn. Gen. Stat. § 19a-639(a)(8)); Ex. A, p. 28; Ex. D, p. 208.

35. The Applicant has satisfactorily demonstrated that this proposal would not result in an unnecessary duplication of existing services in the area. (Conn. Gen. Stat. § 19a-639(a)(9)); Ex. A, p. 22.

36. The Applicant has demonstrated that there will be no reduction in access to services by Medicaid recipients or indigent persons. (Conn. Gen. Stat. § 19a-639(a)(10)); Ex. A, p. 18.

37. The Applicant has demonstrated that the proposal will not negatively impact the diversity of health care providers and client choice in the region. (Conn. Gen. Stat. § 19a-639(a)(11)); Ex. A, p. 23.

38. The Applicant has satisfactorily demonstrated that the proposal will not result in any consolidation that would affect health care costs or accessibility to care. (Conn. Gen. Stat. § 19a-639(a)(12)); Ex. A, p. 18.

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 § 19a-639(a) of the Statutes. The Applicant bears the burden of proof in this matter by a preponderance of the evidence. *Jones v. Connecticut Medical Examining Board, 309 Conn. 727 (2013)*.

CCW is a for-profit entity that provides outpatient substance abuse treatment services, including individual and group substance abuse counseling and counseling for family members of addicted persons in Wolcott, Connecticut. The Applicant is proposing to establish a psychiatric outpatient clinic and facility for the care or treatment of substance abuse or dependence for adults ages 18 years and older to provide IOP treatment. Clients receiving counseling services at CCW endure obstacles in seeking IOP, such as being waitlisted and/or having to travel outside their local community for treatment. Furthermore, recent data released from The Office of the Chief Medical Examiner reveals that in 2016 there were over 100 accidental intoxication overdose deaths in the proposed service area. This emphasizes the need for additional IOP providers and the limited availability of treatment in the Greater Waterbury area. *FF1; FF3; FF6; FF15.*

In addition to operating at or near capacity, none of the existing IOP providers within the proposed service area offer clients the option of receiving treatment in a private, rural setting. The Applicant's program will improve access to treatment because clients will have the option of receiving IOP in their local community rather than traveling to urban areas outside of Wolcott. The proposed program will also accept Medicaid clients and indigent persons in accordance with CCW's existing Pro Bono Policy. *FF22-FF24.*

There are no costs associated with establishing the proposed program as it will operate in an existing facility with excess capacity. The need of an additional health care professional, however, is expected beginning in 2018 at a cost of $40,000. Incremental gains are projected from the onset of operations, surpassing $269,000 by FY 2020. Based on these factors, the Applicant has shown that the proposal is financially feasible. *FF25-FF26.*

The Applicant has satisfactorily demonstrated clear public need for the IOP treatment program in Wolcott and that the proposal will improve client choice in the service area. In order to ensure that access to care will improve for the population currently being served, including the Medicaid population, and that the proposal is consistent with the Statewide Health Care Facilities and Services Plan, OHCA requires that the Applicant agree to take certain actions as stated in the order attached hereto.

Order

NOW, THEREFORE, the Department of Public Health, Office of Health Care Access ("OHCA") and Counseling Center of Waterbury, LLC, d/b/a Connecticut Counseling & Wellness ("CCW" or "Applicant"), through their authorized representatives, hereby stipulate and agree to the following terms of settlement with respect to the Applicant's request to establish a psychiatric outpatient clinic and facility for the care or treatment of substance abusive or dependent persons in Wolcott, CT:

1. CCW shall provide notification to OHCA of the date of commencement of operations and shall provide a copy of the facility license(s) it has obtained. Such notification shall be provided within thirty (30) days of start of operations.

2. Upon execution of this Agreement, the Applicant shall immediately apply to the Connecticut Department of Social Services and be approved as a Medicaid provider and make all efforts to comply with the requirements of participation. The Applicant shall provide documentation to OHCA evidencing approval of its enrollment application. Such documentation shall be filed within thirty (30) days of approval as a Connecticut Medicaid provider.

3. OHCA and CCW agree that this settlement represents a final agreement between OHCA and CCW with respect to OHCA Docket No. 17-32163-CON. The execution of this agreed settlement resolves all objections, claims and disputes, which may have been raised by CCW with regard to OHCA Docket Number 17-32163-CON.

4. OHCA may enforce this settlement under the provisions of Conn. Gen. Stat. §§ 19a-642; 19a-653 and all other remedies available at law, with all fees and costs of such enforcement to be paid by the Applicant.

5. This settlement shall be binding upon CCW and its successors and assigns.

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

September 22, 2017
Date

Yvonne T. Addo, MBA
Deputy Commissioner

September 22, 2017
Date

/Gerard R. Marcil
Duly Authorized Agent for
Counseling Center of Waterbury, LLC

Olejarz, Barbara

From: Olejarz, Barbara
Sent: Monday, September 25, 2017 1:46 PM
To: 'jerry@ccwellness.org'
Cc: 'daniels@chime.org'; Bruno, Anthony M.; McLellan, Rose; Johnson, Colleen M; Bauer, Sandra
Subject: Agreed Settlement
Attachments: 17-32163 Agreed Settlement Final.pdf

Tracking:

Recipient	Delivery	Read
'jerry@ccwellness.org'		
'daniels@chime.org'		
Bruno, Anthony M.	Delivered: 9/25/2017 1:46 PM	
McLellan, Rose	Delivered: 9/25/2017 1:46 PM	
Johnson, Colleen M	Delivered: 9/25/2017 1:46 PM	
Bauer, Sandra	Delivered: 9/25/2017 1:46 PM	
OHCA-DL All OHCA Users		
Foreman, Rebecca		
Jensen, Dana		
Mitchell, Micheala		Read: 9/25/2017 1:46 PM
Ormand.Clarke@ct.gov	Delivered: 9/25/2017 1:46 PM	
Jessica.Rival@ct.gov	Delivered: 9/25/2017 1:46 PM	
David.Fernandes@ct.gov	Delivered: 9/25/2017 1:46 PM	
Yvonne.Addo@ct.gov	Delivered: 9/25/2017 1:46 PM	
Rebecca.Foreman@ct.gov	Delivered: 9/25/2017 1:46 PM	
Dana.Jensen@ct.gov	Delivered: 9/25/2017 1:46 PM	
Micheala.Mitchell@ct.gov	Delivered: 9/25/2017 1:46 PM	
Tillman.Foster@ct.gov	Delivered: 9/25/2017 1:46 PM	
Leslie.Greer@ct.gov	Delivered: 9/25/2017 1:46 PM	
Brian.Carney@ct.gov	Delivered: 9/25/2017 1:46 PM	
Karen.Roberts@ct.gov	Delivered: 9/25/2017 1:46 PM	
Christopher.Wyvill@ct.gov	Delivered: 9/25/2017 1:46 PM	
Kevin.Hansted@ct.gov	Delivered: 9/25/2017 1:46 PM	
Olga.Armah@ct.gov	Delivered: 9/25/2017 1:46 PM	
Steven.Lazarus@ct.gov	Delivered: 9/25/2017 1:46 PM	
Barbara.Olejarz@ct.gov	Delivered: 9/25/2017 1:46 PM	
Jessica.Schaeffer-Helmecki@ct.gov	Delivered: 9/25/2017 1:46 PM	
Kaila.Riggott@ct.gov	Delivered: 9/25/2017 1:46 PM	
Srinivasa.Chalikonda@ct.gov	Delivered: 9/25/2017 1:46 PM	
Alla.Veyberman@ct.gov	Delivered: 9/25/2017 1:46 PM	
Gloria.Sancho@ct.gov	Delivered: 9/25/2017 1:46 PM	
Ronald.Ciesones@ct.gov	Delivered: 9/25/2017 1:46 PM	
Shauna.Walker@ct.gov	Delivered: 9/25/2017 1:46 PM	

Recipient	Delivery	Read
Carmen.Cotto@ct.gov	Delivered: 9/25/2017 1:46 PM	
Kimberly.Martone@ct.gov	Delivered: 9/25/2017 1:46 PM	
Roberts, Karen		Read: 9/25/2017 1:47 PM
Chalikonda, Srinivasa		Read: 9/25/2017 1:48 PM

9/25/17

Gerard R. Marcil,

Please see attached Agreed Settlement for Connecticut Counseling & Wellness, Docket Number: 17-32163-CON

Barbara K. Olejarz
Administrative Assistant to Kimberly Martone
Office of Health Care Access
Department of Public Health
Phone: (860) 418-7005
Email: Barbara.Olejarz@ct.gov

Olejarz, Barbara

From: Microsoft Outlook
To: jerry@ccwellness.org; daniels@chime.org
Sent: Monday, September 25, 2017 1:46 PM
Subject: Relayed: Agreed Settlement

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jerry@ccwellness.org (jerry@ccwellness.org)

daniels@chime.org (daniels@chime.org)

Subject: Agreed Settlement