THE NEXT RIGHT THING

The Next Right Thing, LLC
345 North Main Street, Suite 306
West Hartford, CT 06117

February 6, 2013

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

Dear Ms. Davis,

The following is The Next Right Thing, LLC's application for a certificate of need (CON). If you have any questions or require additional information, feel free to phone me at 860-236-1499 or email me at Jenifer@NextRightThing.net.

Thank you for your consideration.

Best regards,

Jenifer C. Simson

Jenifer C. Simson
Co-Founder and Executive Director
The Next Right Thing, LLC

CHEMICAL ADDICTIONS TREATMENT SERVICES (CATS)
Website: www.johnforlenza-baileyladc.com
Phone: (860) 796-7974
1268 Main Street Suite 107
Newington, CT 06111

July 3, 2013

Deputy Commissioner Lisa Davis
State of Connecticut, Department of Public Health
410 Capital Avenue, MS # 13HCA
PO Box 340308
Hartford, CT 06134

RE: reference to 13-31822-CON-The Next Right Thing

Dear Deputy Commissioner Lisa Davis:

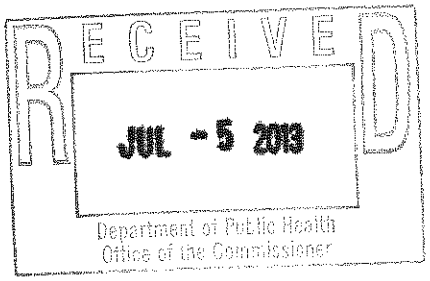
I am writing you to address a dire IOP need in the Greater Hartford Area in towns such as West Hartford, Newington, Avon, Simsbury, and Farmington.

I am supporting the Intensive Outpatient Program (IOP) level of care for the teens with a primary substance abuse and dual diagnoses in our area. As a clinician and alcohol and drug counselor who has practiced in the West Hartford Area for the last 25 years, I have witnessed a lack of resources especially for IOP level of care needs for teenagers (14 to 19) with co-occurring disorders (psychiatrically diagnosed teenagers with chemical dependency issues). This level of care is needed for intervention and stabilization. This need has been clearly lacking for the last 25 years and the dual diagnosed population for teenagers is growing at its fastest rate ever. High risk substance abuse use such as opioid and cocaine abuse (more dangerous and highly addictive drugs) are being used by more teens and at younger ages regarding first time usage reports. IOP with extended aftercare for the adolescents and parents will insure a greater level of care than just outpatient services have historically provided in the past. Our youth warrant IOP services.

Thank you for your attention to this matter.

John Forlenza-Bailey, LADC

John Forlenza-Bailey, LADC



The Next Right Thing, LLC's Application for a Certificate of Need (CON)

For a community-based Intensive Outpatient Program that offers substance abuse and mental health treatment for adolescents (ages 16-23) and their families.

The community-based treatment will:

- Provide rapid access to assessment and treatment of at-risk, dually diagnosed teens
- Provide individualized treatment services not offered in other community-based settings for mid to late adolescents (ages 16 – 23) suffering from substance abuse (sa) and mental health (mh) issues
- Reduce need for more intensive services for this at-risk population
- Incorporate parents with more intensive involvement in their children's treatment to enhance long-term stabilization of substance abuse and mental health problems
- Coordinate services with local school systems to ensure success in advancing academic achievement
- Coordinate services with the judicial system to decrease anti-social behaviors associated with drug abuse

Research studies, newspaper articles, and local emergency rooms report the epidemic nature of drug abuse, especially opiate addiction, for this population. The lack of specialized care focused on 16-23 year olds has added to this escalating trend. The morbidity and mortality rates clearly indicate that treatment needs for this population are not being adequately addressed.

The Next Right Thing's clinical staff brings an extensive history and expertise in treating substance abuse and mental health issues. The treatment program incorporates best practices using CBT, relapse prevention, and 12-step program concepts. The Next Right Thing desires to expand services; obtaining DPH licensure approval will allow third-party insurance payers to contract with The Next Right Thing which in-turn will create improved access and availability to patients and families seeking care.

THE NEXT RIGHT THING

Table of Contents

THE NEXT RIGHT THING

Application Checklist

Instructions:

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

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

For OHCA Use Only:

Docket No.: 13-31822 **Check No.:** 0001050345
OHCA Verified by: [illegible] **Date:** 2-13-13

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

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

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

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

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

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

X☐ **The following have been submitted on a CD/Thumbdrive**

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

CON Application filing fee


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

WebsterBank® OFFICIAL CHECK 0001050345

145 Bank St.
Waterbury, CT 06702 00119 102543 02/06/2013

61-7010
2111

********$500.00

PAY TO THE ORDER OF **500 DOLLARS AND 00 CENTS**

TREASURER STATE OF CONNECTICUT

REMITTER CON APP.

AUTHORIZED SIGNATURE MP

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

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THE NEXT RIGHT THING

The Hartford Courant.
A TRIBUNE PUBLISHING COMPANY

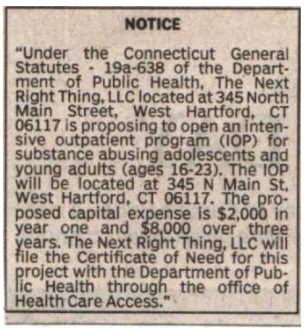
Affidavit of Publication

State of Connecticut

Thursday, November 15, 2012

County of Hartford

I, Rena Matus, do solemnly swear that 1 am Financial Operations Assistant of the Hartford Courant, printed and published daily, in the state of Connecticut and that from my own personal knowledge and reference to the files of said publication the advertisement of Public Notice was inserted in the regular edition.



NOTICE

"Under the Connecticut General Statutes - 19a-638 of the Department of Public Health, The Next Right Thing, LLC located at 345 North Main Street, West Hartford, CT 06117 is proposing to open an intensive outpatient program (IOP) for substance abusing adolescents and young adults (ages 16-23). The IOP will be located at 345 N Main St, West Hartford, CT 06117. The proposed capital expense is $2,000 in year one and $8,000 over three years. The Next Right Thing, LLC will file the Certificate of Need for this project with the Department of Public Health through the office of Health Care Access."

On dates as follows:

11/13/2012	$46.18
11/14/2012	$41.18
11/15/2012	$41.18

In the amount of $128.54
THE NEXT RIGHT THING, LLC
20258911
ZONE 6

Financial Operations Assistant
Rena Matus

Subscribed and sworn to before me on November 15, 2012

William McDonald **Notary Public**

THE NEXT RIGHT THING

AFFIDAVIT

Applicant: The Next Right Thing, LLC

Project Title: Community Based Relapse Prevention IOP for Substance Abusing Adolescents and Young Adults

I, Jenifer C. Simson, CEO
(Individual's Name) (Position Title – CEO or CFO)

of The Next Right Thing, LLC being duly sworn, depose and state that
(Hospital or Facility Name)

The Next Right Thing, LLC's information submitted in this Certificate of
(Hospital or Facility Name)

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

Jenifer C. Simson 2/8/2013
Signature Date

Subscribed and sworn to before me on Feb. 8th 2013

Notary Public/Commissioner of Superior Court

WHITNEY D. HAUGHTON
NOTARY PUBLIC
MY COMMISSION EXPIRES JAN. 31, 2018

My commission expires:

WHITNEY D. HAUGHTON NOTARY PUBLIC CONNECTICUT

THE NEXT RIGHT THING

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

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

Docket Number:

Applicant: THE NEXT RIGHT THING, LLC

Contact Person: Jenifer C. Simson

Contact Person's Title: Executive Director and Co-Founder

Contact Person's Address: 246 Steele Rd., West Hartford, CT 06117

Contact Person's Phone Number: 860-236-1499

Contact Person's Fax Number: 860-236-1414

Contact Person's Email Address: Jenifer@NextRightThing.net

Project Town: West Hartford, CT

Project Name: Community Based Relapse Prevention IOP

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

Estimated Total Capital Expenditure: $8,000 over three years ($2,000 the first year)

Project Description

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

a. Please provide a narrative detailing the proposal.

The Next Right Thing, LLC was established in October of 2011 as a private office- based substance abuse treatment center designed to meet the complex needs of dually diagnosed mid-late adolescents between the ages of 16-23. The majority of clients receiving services are poly substance abusing (multiple drug usage including heroin) with a co-morbid psychiatric diagnosis. The program currently provides: comprehensive evaluation, individual, family, and group services, crisis intervention, ongoing medication management services, intensive outpatient programming, coordination of treatment with schools and the judicial system, and ongoing after-care services.

Since the inception of The Next Right Thing, we have provided a variety of treatment services to 23 families. These services are 100% funded by the families on a self-pay basis payable to The Next Right Thing. We provide service statements to submit to third party payer for out-of-network reimbursement, when covered.

The purpose of this application is to obtain intensive outpatient program (IOP) licensure so that TNRT can be recognized by third party payers and a contractual relationship for reimbursement can be established. Insurance companies require DPH licensure in order to reimburse clients for this level of care. Insurance companies will not reimburse clients for more than one service per day in outpatient settings.

Structure of the IOP

The Next Right Thing's IOP program complies with federal, state, and third-party payer regulations. The program is structured for minimally three times a week with an approximate length of stay of six-eight weeks, followed by long-term long term aftercare for the adolescent and his/her parents.

Program components include:

- Comprehensive assessment with the patient and their family that incorporates the Stages of Change Model to provide the guidelines for determining when a client is ready for less intensive treatment.
- During the initial treatment assessment, The Next Right Thing will develop a treatment plan that includes both IOP and after-care goals. These treatment plans will be reviewed weekly during the IOP phase of treatment.
- Other treatment includes individual, family, a variety of group based services, parent support, and on-going medical supervision and medication titration.
- We provide an alternative medically supervised ambulatory detox for opiate addicts (as opposed to a Suboxone detox). Our detox occurs in a highly structured and supervised program because in our experience 1) Suboxone detoxes are often misused and frequently unsuccessful and 2) by using a non-opioid detox protocol we can move patients more rapidly to an opiate blocker (Naltrexone).

The Next Right Thing – Admission Criteria

An IOP level of care for an adolescent client is necessitated by the following factors:

1) A client's age/and or lack of cognitive and behavior skills to cope with simultaneous substance abuse and mental health issues.
2) The client demonstrates little or no insight into how continued substance abuse poses risks in all domains of functioning (social, emotional, moral, and intellectual) or minimizes severity of both substance abuse and mental health problems. Functional impairment in meeting age appropriate expectations is already evident and can be documented.
3) Attempts at outpatient treatment are unlikely to be productive or have failed.
4) The client's parents demonstrate adequate understanding of substance abuse and mental health risk factors and can provide appropriate support and structure to facilitate the client achieving the goals of treatment in an IOP setting.

5) The parents also consent to involvement in treatment as an essential factor in their adolescent achieving treatment objectives and goals.
6) The IOP level of care is appropriate level for a client's transition from more intensive treatment or as a level of treatment to avoid more intensive partial hospital or inpatient care.
7) The adolescent demonstrates symptomatology consistent with the American Psychiatric Association's (Diagnostic and Statistical Manual) DSM-IV-TR (Axis 1-5) diagnosis or diagnoses, which require and can reasonably be expected to respond to therapeutic intervention at this level of care.
8) Admission to the IOP is consistent with the American Society of Addiction Medicine's ASAM PC-2R adolescent placement criteria for *both* clinical appropriateness *and* medical necessity of treatment.
9) There are reasonable expectations that the adolescent will show significant progress toward achievement of treatment goals within the specified time frames dictated by an individual treatment plan.

Customized Services

The Next Right Thing, LLC offers rapid access to appropriate services, from stabilization to continuity of care. The following are the specific services offered along with the rationale for them:

To address the fragmented way addiction and mental health care is currently delivered for this population:

- Provide a more accurate assessment of a client's diagnosis, treatment and medication needs; the 1-6 months duration of the IOP and aftercare provides time and opportunity to assess and stabilize patients.
- Access: same day or within 24 hour assessment offered.
- Individualized care.
- Mobile crisis capacity.
- Long term aftercare for the adolescents and parents. The long term aftercare reduces the need for higher levels of care.

To address major domains in late adolescent development (social, emotional, moral, intellectual/academic) that have been sabotaged by continued drug abuse and addiction:

- Stabilization and continuity of care.
- Relapse prevention skill development for both substance abuse and mental health problems. Relapse prevention skills are developed within a setting of both ongoing peer and parental support & guidance. Lack of a positive, drug-free peer group is one of the leading causes of relapse.

To address the need for community support:

- Parent involvement: HIPPA regulations in other settings often preclude active involvement by parents when an adolescent reaches 18 years of age. In this program, parents are actively involved and critical for treatment success. They are informed about the results of toxicology screens and are encouraged to impose consequences if their adolescent's screen is positive. We combine both a positive peer experience and appropriate parental support to help dually diagnosed teens recover from set-backs in social/emotional development secondary to drug abuse.
- Coordination with local high schools and colleges to address students meeting academic goals. Students may require classroom accommodations that need to be adjusted as the clinical picture changes. In turn feedback from schools is critical in shaping clinical interventions. *Coordinating a safety net that includes the treatment program, school, and family enhances odds of preventing relapse and stabilizing other mental health problems.*
- Coordination with the judicial system: Not infrequently drug abusing teens and their parents benefit from external legal supports. We are working closely with the judicial system to assure that the client successfully meets the terms or conditions for probation or court order supervision

Why Parental Involvement is Key

Two factors need to be in place in order to move through the initial pre-contemplation stage of change (I don't a have problem) to accepting responsibility for the entire gamut

of drug related behaviors. These two factors are: (1) Parents who are more comfortable in the role of authority *and* who can understand the implications of drug use on adolescent thinking and doing and not shame and blame their child, and (2) A clinical program that understands and supports both the parents need to *parent* and teen's need to trust and be honest about their behavior. If both are in place, clear parent/child obligations, and honesty and trusting adolescent behaviors, then—and then only—can moral aspects of character development get back on track. As behavior skill sets become more positive or adaptive, the adolescent can cope more successfully with other psychological or psychiatric problems.

Social, emotional, and moral development are inseparable processes occurring between the ages of 16 and 23. Treatment goals for teens and parents require a longer, comprehensive program, combining and extending the resources that are already available in the community.

The Next Right Thing Fills a Gap in Care

The Next Right Thing is the missing link in coordinating and providing care between existing services for late adolescents with substance abuse and mental health problems.

This is a specialized program that targets 16-23 year-old substance abusers with significant mental health issues. As a private practice model, the current program offers intensive treatment services in community based setting.

Part of the unique nature of our program is 1) we offer individualized care with a varying levels of therapy not available in either facility or private practice settings, and 2) the in-community, normal setting (office suite in a professional office building) helps minimize adolescents' and parents' negative perceptions and fears often associated with hospital based programs.

As an existing intensive treatment program we are already serving as a link between more intensive programs (residential treatment and hospital based programs) and routine outpatient services. For example, the program has:

1) Accepted referrals from local hospital psychiatric inpatient and partial programs (such as Institute of Living and Rushford Center) as well as taking referrals from hospitals outside of our area in New Haven and New Canaan. We also cross-refer.
2) Worked with a residential program for teens in Durham CT, sending and receiving referrals.
3) Coordinated services with private practitioners, school counselors, and probation officers in the community where additional, more intensive services are required while the adolescent remains in individual or family therapy with existing clinicians.

Summary of Need

In summary, The Next Right Thing, LLC Is applying to the Department of Public Health for a license to provide intensive outpatient treatment for dually diagnosed late adolescents. The morbidity and mortality rates with this group are escalating at an unprecedented rate, which points to the need for more specialized services.

Our treatment approach has evolved in employing the best practice guidelines for treating the developmental problems associated with adolescence. We are already working closely with the local Capital Area Substance Abuse Council (CASAC) community substance abuse prevention committee, private practitioners, schools, pediatricians, probation officers, hospitals and other service providers to extend treatment options and tighten the safety net.

Licensure will help families with adolescents in need to use insurance to cover the range of services we offer, from intensive outpatient programs through long term aftercare.

2. Clear Public Need

The national and local press report stories and statistics that flesh out a widely recognized epidemic of opiate and alcohol addiction among adolescents and young adults. A sampling is included in this application and in its bibliography (Appendix A).

CT DPH Drug overdose death rates have never been higher, rising steadily since 1970. According to testimony given by Patricia Rehmer, MSN, CT Commissioner Department of Mental Health and Addiction Services before the Public Health Committee on 3/7/2012, CT averaged one opiate death a day among 18-25 year olds – the leading rate of death for this age group in 2009.

In April 2011's National Public Health Week Fact Sheet, the CT Department of Public Health stated that:

1. Overdose death rates in the United States have increased fivefold since 1990.
2. According to the CDC, the increase in drug overdose is largely due to the use of prescription opioids painkillers.
3. Accidental drug-related poisoning has surpassed motor vehicle crashes as a leading cause of death in CT.
4. From 2005-2007 there were 2,578 hospitalizations and 7,140 poisoning-related emergency department visits to the state. In addition, there were 106 suicide deaths due to drug and alcohol poisonings; and over 3, 000 hospitalizations and over 3,000 emergency department visits related to suicide attempt drug poisoning.

In contrast to other treatment programs that address alcohol and marijuana abuse only, The Next Right Thing is responding to the nationally recognized opiate epidemic (Heroin and prescription pain killers). In addition, most other programs separate this 16-23 year old age-group into treatment programs treating 16 and 17 year olds with patients as young as 12 year-olds and 18 through 23 year olds with much older adults. The Next

Right Thing is designed to address this age group's unique developmental and neurological challenges.

Location Rationale

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

The Next Right Thing, LLC is located at a major intersection in West Hartford at the corner of North Main Street and Albany Avenue or Route 44. The office is within a 20 mile radius that includes public high schools in West Hartford, Avon, Simsbury, Bloomfield, and Canton. Within the same geographic area are a number of private boarding and day schools, parochial schools and several colleges and universities. We are also 20 minutes from Interstate 84 and therefore a reasonable driving distance from surrounding communities from Glastonbury to Southington.

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

We chose this location utilizing 4 criteria:

1) What is the population with an unmet need
2) Where is there a high density of a population in need
3) What location (setting) would have the best chance of engaging parents and families
4) What precise location would promote ease of access – i.e., parking, main roads

In summary, we chose the greater West Hartford area because the demographics are consistent with documented need for services and a lack of treatment options.

The primary market area is dense with 16-23 year olds. This becomes obvious when we look at the density of private and public high schools and colleges. There are more than 15 of these institutions within a 5 mile radius. At the college level West Hartford alone

has St. Joseph's and UConn extension campus and is within 5 miles there are U of Hartford, Trinity, Tunxis Community, Greater Hartford Capital, Rensselaer Hartford Graduate Center, Harford School of Music, Hartford Seminary, and Lincoln College of New England, as well as technical and trade programs.

We selected the professional office building private practice suite in order to reduce patient anxiety around treatment. There's a mix of retail, professional, and healthcare providers within the building – our patients and their families could be going anywhere and can feel comfortable that their concerns that bring them to the building will remain private and confidential.

The specific office location in Bishop's Corner West Hartford was selected because it is 1) on a major intersection of two well-traveled commuter roads (Rt. 44 links Avon to Hartford and North Main Street links Newington to Bloomfield), 2) ample and well-lit parking with plenty of handicap parking, 3) high quality, handicap accessible building, and 4) 24-hour security.

The population in most need for this specific treatment resides in West Hartford and the surrounding communities. The current location was picked in order to be convenient to patients and their families – close to where many parents work and where our patients live and go to school.

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

The service area is centered in West Hartford and includes Avon, Canton, Farmington, and Simsbury. These towns are included in our service area because of 1) service needs of their adolescents and 2) ease of access to our office. The practice has drawn families from Glastonbury and as far away as Orange.

Per US census data, the 4 suburbs – surrounding Hartford to the west of the river - have approximately 130,000 residents and 16,600 16-23 year olds. The youth numbers are significantly higher when you include private high school and college students. Our assessment is that the number of targeted population is sufficient to support this program.

Overwhelming evidence both nationwide (e.g., Monitoring the Future studies) and local (e.g. 2011 Biannual West Hartford Drug and Alcohol Survey) shows that these relatively affluent communities are at particular risk in the current drug epidemic due to the high risk nature of the patterns of drug abuse that these towns' teens indulge in. Compounding factors that influence their high risk of using (and overdosing) include:

- Adolescents and young adults continue to use even as their understanding of the perceived risks increase. This trend is documented in in the 2011 Biannual West Hartford High School Drug and Alcohol study. In the study, over a fifth of the teens reported having taken pills without knowing what they were. In The Next Right Thing's practice, we're seeing unprecedented willingness to "try" heroin despite its reputation as a dirty drug.
- Access to money, credit cards, expensive jewelry, electronics, etc. in the relatively affluent suburbs is being used to pay for costly prescription drugs sold on the streets and marijuana.
- Parents' tendency to minimize the severity of their children's substance abuse problems (they assume it's at the level of their own use 20-30 years ago) or their lack of knowledge and skill in recognizing signs and symptoms of substance abuse.

- High relapse rates after residential care. In our experience of the population we have already treated, 30% of those receiving care started with The Next Right Thing after having relapsed post residential treatment. The Next Right Thing also provides after-care and reconnects substance abusing youth to their community in healthy ways.
- Affluent parents' willingness to pay for attorneys rather than allow their children to face the natural consequences of their children's drug and alcohol behavior.

Evidence of Need

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

Per US census data The 4 suburbs – surrounding Hartford to the west of the river - have approximately 130,000 residents and 16,600 16-23 year olds. The national prevalence data shows that at any given time an estimated 20% of 16-23 year olds are engaging in risky drug and alcohol behaviors.

If this estimate is true, at any given time over 3,000 youths between the ages of 16-23 in our target market are engaged in illicit drug use including binge drinking. The Next Right Thing, LLC estimates that it can serve about .5% or 15 youths and their families at any one time, an estimated 60 patients and families over the course of a year. This represents 2% of the population in need.

So let's review a sampling of published evidence relating to suburban teens and young adults in communities just like this one.

1. Abundant research regarding risk: SAMHSA, Center for Behavioral Health Statistics and Quality's National Survey on Drug Use and Health in 2008 and 2009 showed that in Connecticut adolescents between 12-17 years of age percentages of illicit drug use

is 10% and binge drinking is 13% among the highest in the nation. For young adults 18-25, illicit drug use within the last month was just under 25% and binge drinking close to 47%.

2. In West Hartford, CT, where The Next Right Thing, LLC is located, the 2011 Biannual West Hartford High School Drug and Alcohol Survey reports:
    - 40% of teens get prescription drugs from friends
    - 21.3 % of teens reported having taken pills without knowing what they were
    - 19.6% of youth reported having mixed drinking and prescription/over the counter drugs
    - In the past 30 days, 6.2% reported using pain relievers or opioids, and 3.3% reported using stimulants
3. Treatment Episode Data Set (TED) Dec 2009: In 2007 1,600 adolescent treatment admissions for heroin. On average adolescent heroin admissions were 14.8 years old when they first used heroin and 16.3 at their first admissions. More than half of adolescent heroin admissions had at least one prior treatment episode. More male than female. 75% Caucasian. Greatest percentage came through criminal justice system. 56% abused marijuana. 32% cocaine. Recovery services need to be age appropriate.
4. 2010 National Survey on Drug Use and Health (NSDUH): Summary of National Finding. Marijuana most commonly used illicit drug. Narcotics second. **The rate of current use of illicit drugs among young adults 18 to 25 increased from 19.6 percent in 2008 to21.2 percent in 2009 and 21.5 percent in 2010.** Primarily driven by marijuana.
5. Patricia Rehmer, MSN and CT Commissioner Department of Mental Health and Addiction Services before the Public Health Committee on 3/7/2012. She spoke in favor of act HB 5063 that would allow Narcan, "which is used to counteract drug overdoses" to be prescribed more broadly. Patricia Rehmer quoted a CT 2009 study that showed that "drug overdose was the leading cause of death among 18-25 year olds" in the state.

6. The Monitoring the Future (MTF) project (see abstract summary in Appendix A or http://www.monitoringthefuture.org) shows that daily marijuana use increased among 8th, 10th and 12th grades from 2009 to 2010 paralleling softening attitudes of risk. Among 12th graders nonmedical use of Vicodin decreased but nonmedical use of Oxycontin remained unchanged and increased among 10th graders over the past 5 years. Nonmedical use of Adderall increased among 12th graders.
7. Partnership atDrugfree.org and Met Life foundation (April 6 2011) "…indicates that teen drug and alcohol use is headed in the wrong direction, with marked increase in use of marijuana and Ecstasy over the past three years. The 22 annual Partnership Attitude Tracking Study (PATS) affirms a disturbing trend that has emerged among American teens since 2008 and highlights that as underage drinking becomes more normalized among adolescents, parents feel unable to respond to the negative shifts in teen drug and alcohol use… Among teens who reported drinking alcohol, the average age of first alcohol use was 14… **Teens see little risk in heavy drinking. Parents feel they can't stop risky behavior**… It is important to note that teens that begin drinking before the age of 15 are much more likely to develop problems with alcohol as adults." According to the PATS survey teen abuse of prescription continues to be an area of major concern. The data found that 25% of teens have taken a prescription drug not prescribed by a doctor at least once in their lives. This PATS data is from the 22nd annual study of 2,544 teens in grades 9-12 and 831 parents.
8. The Ridgefield Patch June 25, 2012 reported "The Center for Disease Control and Prevention (CDC) released a rather alarming statistic this week regarding teen deaths. The incidents of teen fatalities related to poisonings among 15 to 19 year olds increased more than 90% between 2000 and 2009. The CDC's report states that this is a result of our country's epidemic of prescription drug abuse. Although many teens might otherwise shy away from illegal street drugs, more and more teens are turning to prescription drugs and over the counter medicines to get high. These drugs include pain killers that might be prescribed after a person undergoes surgery, depressants that are taken for sleep aid, depression or anxiety or stimulants such as those used for ADHD. The over the counter medicines include cough medicine and cold remedies. Narcotic pain killers like Vicodin, Oxycontin, Percocet or Lortab, including the

generics such as methadone and hydrocodone are highly addictive and are very dangerous. **Sadly, each day 2,500 students from 12 to 17 abuse a pain relieving drug for the first time. In fact, prescription medicine is the second most abused drug other than marijuana. Most teenagers obtain these prescription meds by stealing them from their parent's medicine cabinets and even share them with friends or sell them at school.**

9. Daily News, June 20, 2012 reads "**Heroin use among suburban teens skyrockets; Experts say prescription pills are the new gateway drug.** "Twenty years ago half of the heroin addicts in treatment lived in two states-New York and California," according to Dr. Joe Gay director of health Recovery Services in Ohio, "Now we are seeing it spread out of the cities, into the suburbs and rural areas." …National data from the Substance Abuse And mental Health Services Administration (SAMHSA) shows that the number of teens dying form heroin use has skyrocketed. In 1999, 198 people between the ages of 15 and 19 died of a heroin overdose, compared to 510 in 2009, the latest year data was taken. More teens are seeking treatment for heroin use, too—the figure jumped from 4,414 to more that 21,000 (about 80%) between 1999 and 2009. Ninety percent of teen heroin addicts are white, according to the data."

10. Excerpted from Adolescent Substance Abuse Knowledge Base 2009© (www.Adolescent-Substance-Abuse.com) article titled "The New Faces of Heroin Addiction: Teen Use on the Rise"

Causes of the Trend

With the recent proliferation of prescription opioid painkillers, opiate use has become far more domesticated and widespread than ever before. Because of drugs like Oxycontin and Vicodin, more people are familiar with the effects of opioid medications, which, by extension, makes heroin seem less scary and not so exotic. Many people, including teenagers, no longer associate heroin with the horror stories of overdose and crippling addiction. Instead, they associate it more and more with those relatively safe and familiar prescription drugs. The result is

that, for young people especially, prescription opioids can act as gateway drugs to heroin.

Compounding this problem is the fact that heroin is often far cheaper than its prescription counterparts. A single pill of Vicodin or Oxycontin can be anywhere from $40 to $75, while a small bag of heroin may cost less than a six pack of beer and achieve the same high. So, for anyone already addicted to prescription opioids, cheap, accessible heroin may seem like a much better deal.

While people in their late 20s, 30s or older may remember alcohol and marijuana as being the drugs of choice for teenagers, things have changed. Heroin is no longer thought of as some inaccessible drug mostly used by grown-up junkies in big cities. These days, people in their teens and early 20s are being targeted as the next big market for a drug that has long been in decline among adult populations. In some places, teens report that heroin is even more accessible than marijuana, ecstasy and alcohol.

Dangers of Teen Heroin Use

Adding to the problem is the fact that today's heroin is as much as 15 times as potent as the heroin of decades past. When you combine this factor with the low price and increased accessibility of the drug, teens are in grave danger. Even when it wasn't so potent, heroin was already one of the most dangerous and addictive illicit drugs on the market.

Lack of education and misinformation is a problem. Among kids who use heroin, there are likely to be myths and false rumors about use of the drug. For example, some experts say that the rash of teenage heroin overdoses over the past few years is a result of a mistaken belief that snorting heroin is less dangerous and less addictive than injecting. Bad information about hard drugs like heroin can lead people to put their lives in danger without even knowing it.

Teenagers also tend to be more reckless with their safety than adults, which makes all of the dangers of heroin use that much more acute. Teenagers are more likely to overdose, to allow themselves to become addicted, or to mix heroin with other drugs. Also, among individuals who do inject the drug, teenagers are

less likely to take precautions to prevent blood borne illnesses like HIV and Hepatitis.

Finally, teenagers are less likely to seek heroin treatment, as they may be worried that they'll get in trouble if they tell their parents. Thus, parents often do not find out about the addiction until the child overdoses, begins failing in school or gets in trouble with the law. *((Added by applicant) The growing body of research shows that Suboxone used to detox patients from opiates is a problem in the suburb. Teens are using the opiate agonist to get high to detox themselves so their parents won't know they're addicted.)*

Heroin Use among Suburban and Privileged Youth

A major component of the increase in teenage heroin use is a marked upswing among kids in suburban areas. For instance, in places like Suffolk County, N.Y., a suburban area outside of New York City, the number of deaths associated with heroin use has more than doubled in just the past couple of years. In nearby Nassau County, the number of people between the ages of 19 and 25 entering heroin rehab has increased nearly fivefold in the past eight years — from 59 in 2000 to 458 in 2008. *There are many possible ways to explain this trend. For one thing, suburban youth from middle-class backgrounds are much more likely to have access to gateway prescription painkillers. And while those prescription drugs tend to run out, heroin is always available for those who know where to find it. Suburban teenagers also have more money to spend, and many of them have cars, which gives them a greater amount of freedom and mobility. Suburban ennui and academic pressure may also play a role, with heroin giving teenagers an outlet for their frustrations and a temporary escape from their problems.* (Emphasis added)

11. Courant.com June 25, 2012. "Teen Pot Use at 30-Year Peak—Are We Too Lax?" Excerpts read: "Marijuana is not as innocent as it is being perceived," said Yiraf Kaminer, a professor of psychiatry and pediatrics at the University of Connecticut Health Center and who directs the Adolescent Treatment of Marijuana Study…A

researcher who has been studying addiction and marijuana for decades, Kaminer treats hundreds of teenagers from throughout the Hartford area who are part of his study. These kids are chronic smokers of marijuana suffering from--"cannabis use disorder"—who come on their own or who are referred to his program by the courts." [Siting the Monitoring the Future out of the University of Michigan study of over 50,000 8th, 10th, and 12th graders, Kaminer says that "the daily use of pot is at a 30 year peak among teenagers. About 1 in every 15 high school seniors report smoking at least daily… Kaminer warns about the effect of pot on the still-developing teenage brain, about the danger of driving under the influence of pot being as risky as driving drunk, and the link between drug use and psychiatric disorders in young people… "We've seen more cases of early onset schizophrenia. Marijuana increases the chance for early onset by 10%."

12. Numerous references in the literature prove that the psychoactive ingredient in marijuana *tetrahydrocannabinol* may cause transient anxiety and panic episodes—even with regular users. Roger Myer, M.D., previous chairman of the Department of Psychiatry at University of Connecticut found that marijuana users could have idiosyncratic experiences he described as both "acute" leading to various intensities of anxiety, and "toxic" episodes resulting in psychosis. In my practice over the past 40 years I have seen both types. Of particular concern to me has been adolescents with a family history of Bipolar disorders who used marijuana on a regular basis present for treatment with manic or hypomanic symptoms. It's not worth discussing the probabilities whether or not these symptoms would have surfaced on their own at some point. The facts are that heavy use was present at the onset of symptoms—and if they returned to smoking, even when on mood stabilizing medication, manic symptoms returned. But as the documented perceived risks associated with acceptance of "Medical Marijuana" diminished for teens, the potency or concentration of TCH increased 10 fold in the years since 1972 when the substance was listed as a Class 2. As the potency increased so have the harmful sequelae of use. For a fuller understanding of the mechanisms involved in metabolizing marijuana, refer to "Foundations in Behavioral Pharmacology" Third Edition. How this Population is Being Under Served

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

There are no intensive outpatient programs that primarily target substance abusing adolescents (16-23) in the area. For this population, many are going untreated. This becomes clear when one looks at the demographic numbers, emergency room visits, and overdose statistics. (Per research cited in the prior sections)

Some of the 16-23 year olds who are abusing are currently served by The Next Right Thing but not at an IOP level due to financial constraints by insurers and by the patient families.

Others patients are served at programs not designed for this population. Most, if not all IOP programs that treat 18-23 year olds, treat them in the same program along with both much older adults and those with a wide variety of mental health issues. This is also true for those IOP providers who treat adolescents – 16-17 year olds are treated in the same program with much younger adolescents and adolescents with a variety of psychiatric issues.

The remainder of those who do get treatment are often treated out of state in residential or wilderness programs.

The justification for this program is based on evidence that this patient population is not being adequately served for the reasons already cited and we provide the missing piece in the safety net. The IOP program will offer:

- Specialized diagnostic and treatment services dedicated to this age group
- Local and accessible within 24 hours
- Treats the whole family not just the substance abusing patient
- Connected to the community through close working relationships with school counselors, parole officers, mental health professionals, and parents.

Existing Providers

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

We've done significant research to identify treatment resources in the greater West Hartford area that specialize in providing "substance abuse & relapse prevention" services to older adolescents and young adults. We have not been able to find specific providers who target our intended population. However, the following offer mental health services to either children/adolescents and/or adults:

Private Clinicians

There are a variety of private practice clinicians within the service area. The majority of those providers provide individual therapy based services to address patients' mental health needs. Substance abuse, for most of these clinicians, is a secondary diagnostic category. These clinicians do offer some group based treatments but not IOP programs.

Hospitals

In the greater Hartford area, the following hospitals offer IOP and partial hospital services:

ADRC or Alcohol and Drug Recovery Centers, Inc. 500 Blue Hills Ave. Hartford, CT 06112.

– Adult treatment services only, mostly alcohol

Hartford Hospital 80 Seymour St., Hartford, CT 06102;

– Child & Adolescent IOP combines all types of mental health issues and ages of children & adolescents into one program;

– Young Adult Services (ages 17-26) IOP/PHP addresses all sorts of behavioral problems and mental health issues (not specific to substance abuse) under one roof;

– Adult Day Treatment for substance abuse and addiction mixes ages 18 on up.

U Conn Medical Center 263 Farmington Avenue, Farmington, CT 06030

– Dual Diagnosis IOP for ages 18+ who have completed a detox program. Again, young adults (18-23) will be in the same program as much older men and women at very

different stages of development and experiences.

St. Francis Hospital 114 Woodland Street, Hartford, Connecticut 06105

– No IOP. St. Francis Hospital offers complementary services by offering in-patient opiate detox and Methadone treatment and offers outpatient services.

Government Run facilities

Capital Region Mental Health Center 500 Vine St., Hartford CT. 06112

– Outpatient services for adults only (18+) with serious psychiatric disorders or dual-diagnosed: HOPE (Homeless Outreach & Positive Engagement) and Co-Occurring Disorders Team

Please note that The Next Right Thing is currently receiving referrals from Hartford Hospital and private clinicians due to 1) The Next Right Thing's clinical expertise (i.e., regionally acknowledged staff treating this age group and these types of disorders), 2) the lack of availability of treatment that targets adolescents/young adults and, 3) specific treatment expertise regarding opiate addiction.

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

Given the large volume of prospective patients who go under or untreated, the addition of The Next Right Thing's IOP is not anticipated to have a negative impact on other providers within the community.

Conversely, we believe that the licensure of The Next Right Thing's IOP will allow patients and families the ability to access their third party insurance to support the patient's treatment at an IOP level of care. This will enhance the delivery system in total and significantly streamline the referral process for patients and providers who want to access The Next Right Thing's services. In addition, for patients who require more or ongoing care we expect that our referrals back to community providers (including hospital programs) will continue.

In short, The Next Right Thing, LLC will be referring to private practitioners in the community when 1) our patients no longer need intensive level of services, or 2) when we identify family members who need treatment that we don't provide. We will refer to inpatient and PHP providers if during intake or during the course of treatment we identify a patient who needs more intensive levels of care.

3. Projected Volume

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

Table 1: Projected Volume

	Projected Volume (First 3 Full Operational FYs)**			
	Actual FY 2012	FY 2013	FY 2014	FY 2015
Service type: IOP level of Care (S9480)	**NA**	**31**	**38**	**52**
Service type: Current IOP-type services (number of patients who would qualify for IOP level of care)	20	NA	NA	NA
Total	**20**	**31**	**38**	**52**

** If the first year of the proposal is only a partial year, provide the first partial year and then the first three full FYs**. The Next Right Thing, LLC operates in Calendar Years, i.e., Jan 1- Dec 31.**

Volume Assumptions

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

The Next Right Thing served 20 patients during 2012 to whom we provided multiple services to and who would have qualified for an IOP. We've seen at least 4 more in January 2013 as the program has gotten established in the community and our referral rate grows.

Once The Next Right Thing, LLC is licensed to offer an IOP, we project that 31 in 2013 will be easily attained. This represents an increase of only 11 new families over 2012. As we bring on additional part-time and full time clinicians, we will have the ability to say yes to referrals from towns, parole officers, hospitals, and residential programs. We've assumed an additional 7 patients in 2014 and another 14 in 2015 – conservative growth given the extremely high number of adolescents/young adults who are currently struggling with substance abuse issue.

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

The Next Right Thing, LLC started taking patients in October 2011. Since inception of the NRT, we have provided intensive outpatient services to 20 patient families. We have offered treatment services to approximately 15 other patients and families who chose to not accept care due their need to accept care from their insurance companies' in-network provider.

Fiscal Year	Number of Families Served who qualified for IOP level of care
3 months 2011 (Oct-Dec)	5
2012	20

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

Please refer to Appendix A for a list of reference material used throughout this application.

4. Quality Measures

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

Bios for key clinical staff

Julian N. Hartt Jr., ACSW, LCSW

Clinical Director and Founder

Julian Hartt Jr. brings 40 years of clinical experience working with adolescents with substance abuse and psychiatric problems and their families. He has extensive experience in a variety of settings: hospital, college and high school campuses, and private practice. He worked for 13 years at a private inpatient psychiatric hospital with adolescents, including 4 years as Unit Chief. Julian designed and implemented the first partial hospital program for adolescents in Connecticut. He has worked for 20 years with Atlantic Health Services (New Haven/Hamden), 8 years as their Clinical Director. Julian also consulted for Quinnipiac University, Choate-Rosemary Hall, several public schools, and community-based drug and alcohol programs.

At The Next Right Thing, Julian Hartt is responsible for intake evaluations, treatment program design, and therapy.

Dr. Ann L. Price, MD

Chief Medical Consultant

Ann Price, MD has over 34 years of psychiatric experience serving adolescents and adults. She maintains a private practice for children and adults, is a Clinical Assistant Professor, Department of Psychiatry with the University of Connecticut Medical School, and is a Faculty Member and Supervising Analyst, Division of Psychoanalytic Medicine

at New York Medical College. She has been the Chief Medical Officer for Intercommunity Mental Health Group in East Hartford since 2004.
Ann's career shows a deep commitment to adolescents; she has been the psychiatric consultant to school programs in Connecticut and Massachusetts, was the Chief of Psychiatric Consultation consulting on complex treatment cases for the Office of the Commissioner, Department of Mental Health (1989-91) and, was the Director of Adolescent Services (1983-1987) for The Institute of Living.
At The Next Right Thing, Dr. Price is responsible for medical evaluations and the opiate detox program.

Please See Appendix C for Curriculum Vitae
Key Personnel – clinical and administrative
Dr. Anne Price – Medical Director
Julian Hartt, Jr., LCSW – Clinical Director & Co-Founder
Jenifer C. Simson – Executive Director & Co-Founder

Improving Healthcare Delivery

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

This proposal contributes to the quality of delivery system in the greater Hartford region by:

1) answering the demand for substance abuse treatment for adolescents and young adults that is developmentally appropriate,
2) filling the gap for intensive treatment that falls between the level of PHP and weekly psychiatric visits,
3) building parent & peer community,
4) coordinating services with parole officers and school counselors, and
5) negotiating case rates with insurers to make theses intensive services affordable to more families.

Creating Consistency, Continuity of Care

Treatment for many at -risk substance abusing adolescents is fragmented between brief hospitalizations for acute crises, brief partial hospitalizations, and conventional outpatient therapies. To utilize insurance patients must meet criteria for medical necessity as defined by acute need for care-not remedial care or services. Moreover, the number of adolescent inpatient beds has declined dramatically in the past 15 years in Connecticut, leaving many teens sitting in emergency departments waiting for services. Because of the corrosive effects of the primary drugs currently being abused on the major domains of adolescent adjustment, marijuana and opiates—as well as binge drinking, longer term treatment is necessary, as ASAM indicates. **The Next Right Thing, LLC's IOP will add an option for consistent, continuity of care that is needed for substance abusing adolescents.**

Insurance may cover 7 to 10 days of residential care, if at all, depending on benefit structure. Because of the limits on insurance coverage for treatment at the inpatient or partial hospital levels of care, there is now a trend for parents to refer their children to expensive, self-pay residential and "wilderness" programs—*especially in the communities The Next Right Thing targets.* There are no objective outcome studies that these programs reduce rates of relapse. Aftercare is still necessary—especially with family involvement. Families need to rely on insurance covered treatment. **Once licensed, insurers will negotiate case rates with The Next Right Thing, resulting in lower costs to patient families.**

Improving Medication Management

The Next Right Thing started admitting patients in October 2011. It has been our experience that many of the adolescents and young adults referred to our program were already on psychotropic medication even though they were abusing drugs. It is difficult, at best, to determine what medication is appropriate if drugs are still affecting brain activity in adolescents. For example, a disproportionate number of adolescents have been referred for treatment already diagnosed and medicated for ADHD while they continued to use

marijuana, a drug which affects motivation, concentration, and memory: the primary symptoms of ADHD.

With a program expectation that all clients will be drug free, monitored by weekly drug - screens, we have found that clients require less medication for the full spectrum of DSM disorders. Or, because a diagnosis was made at other levels of care while the adolescent was abusing drugs or had recently discontinued use, the diagnosis wasn't accurate and the medication wasn't appropriate. *Abstinence from illicit drugs as well as less medication is certainly preferable for a developing adolescent's brain.* **Our treatment practices are and will continue to result in safer, more efficacious medication management for this high-risk group.**

Standard of Practice Guidelines

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

The Next Right Thing is Dual Diagnosis Capable (DDC) Complying with NIDA and NAMI Recommendations

1) The IOP is structured and staffed to address in policy, procedures, assessments, treatment planning, and program content adolescent co-occurring substance abuse and mental health issues.
2) The NRT acknowledges biopsychosocial factors in etiology, expression, and treatment.
3) An onsite psychiatrist will provide psychopharmalogical assessments, administration and monitoring of medication supported by ongoing psychosocial assessments and treatment. A psychiatrist is available 10 hours a week for a maximum of 16 clients.
4) A licensed mental health professional coordinates care for each group of 8 clients.
5) Crisis intervention services are provided 9 to 5 during the week with mobile capability to homes or schools.
6) 24/7 emergency services.

The Next Right Thing has adapted the ASAM guidelines within the practice of its acceptance and treatment of this population. (See Appendix D to view ASAM criteria incorporated into treatment plan). The ASAM criteria have become nationally recognized guidelines and accepted by most insurers and practicing clinicians to determine the patients' severity of illness and level of care requirements.

A Brief Overview of the Standard of Practice Guidelines Follows:

Placement Criteria Guidelines

The Next Right Thing, LLC follows the American Society of Addiction Medicine's patient placement criteria (ASAM PPC-2R).

The ASAM PPC-2R Preface to Adolescent Criteria: "The goal of the adolescent criteria is to facilitate the process of matching patients in need of treatment with treatment services and settings in order to maximize treatment accessibility, effectiveness, and efficiency. The principle on which the criteria are based is that of *clinical appropriateness.* In considering appropriateness, quality and efficiency are emphasized over cost. The concept of "clinical appropriateness" contrasts with the more familiar "medical necessity," which has become a term associated with the restrictions on utilization and thus has become defined narrowly, often related only to the first three ASAM assessment dimensions. In fact all six dimensions on the ASAM PPC-2R are needed to accurately assess the severity of the adolescent's problem, his or level of functioning, and the clinically appropriate placement.

The ASAM criteria are intended to evolve in response to ongoing advances in the field of adolescent addiction medicine. At present, the ASAM criteria are based predominately on consensus best practices." (Found on page 179 of The ASAM PC-2R)

The ASAM criteria considers multiple dimensions of assessment, clinically-determined treatment, variable length of stay and a better definition of a continuum of care. The PPC-2 defined six areas or dimensions of assessment:

- **Dimension 1** - Acute Intoxication and/or Withdrawal
- **Dimension 2** - Biomedical Conditions and Complications
- **Dimension 3** - Emotional/Behavioral Conditions and Complications
- **Dimension 4** - Treatment Acceptance/Resistance
- **Dimension 5** - Relapse / Continued Use Potential
- **Dimension 6** - Recovery Environment

ASAM Criteria are based on "bio psychosocial" vulnerabilities with middle to late adolescents summarized:

1) Primary importance is the stage of emotional, cognitive, physical, social and moral development.
2) Although most adolescents do not evidence dependence or physical withdrawal symptoms or physiological deterioration secondary to alcohol use, never the less they are vulnerable to the full range of emotional, behavioral, cognitive, and familial manifestations of addiction.
3) Adolescents typically demonstrate a higher degree of co-occurring psychopathology, which may not remit with abstinence. These limitations severely inhibit the ability of adolescents to arrest their addictions and address essential developmental tasks without external assistance and support.
4) Adolescents' use of alcohol {*and/ or other drugs}* impairs their emotional and intellectual growth, preventing completion of maturational tasks. The substance abusing adolescent's psychological and social development are compromised and therefore the formation of a strong positive self- identity.
5) These and other developmental issues make adolescents particularly vulnerable. In general, for a given degree of severity or functional impairment, adolescents require more intensive treatment than adults.
6) The difference is reflected in clinical practice—and in the criteria for placement--by a tendency to place adolescents in more intensive levels of care."

Treatment Guidelines

The Next Right Thing's current program and proposed IOP is Dual Diagnosis Capable (DDC) and is designed to comply with NIDA and NAMI Recommendations.

NIDA (The National Institute on Drug Abuse - www.drugabuse.gov/) recommends that treatment should be supported by evidence that the treatment modalities are appropriate for the population. In line with NIDA recommendations, The Next Right Thing's IOP incorporates Stage Recovery, Relapse Prevention, Cognitive Behavioral Therapy (CBT),

and 12 step treatment approaches. The Next Right Thing also follows NIDA recommendations to assess and adapt treatment as the patient's needs change-- including plans for aftercare formulated in the initial phases of treatment.

NAMI (National Alliance on Mental Illness - www.nami.org) acknowledges in "Dual Diagnosis in Adolescence" (2012):

> "Adolescents are often referred to treatment for substance abuse but are not referred to a qualified mental health professional for an appropriate diagnosis and treatment of any underlying cause for their drug and alcohol abuse.
>
> However, many teens have symptoms of a mood disorder that may in fact lead to self-medicating with street drugs and alcohol. Families and caregivers know how difficult it is to find treatment for an adolescent who abuses drugs or alcohol but is also diagnosed with a brain disorder (mental illness), i.e., ADHD, depression, or bipolar disorder. Traditionally programs that treat individuals with brain disorders do not treat individuals with active substance abuse problems, and programs for substance abusers are not geared for people with mental illness. Adolescents are caught in the treatment gap. The combination of mental illness and substance abuse is so common that many clinicians now expect to find it. Studies show that *more than half of young persons with a substance abuse diagnosis also have a diagnosable mental illness."*
>
> [Also a disproportionate number of adolescents with learning disabilities present for treatment with both substance abuse and mental health problems. Comment added by Julian Hartt, Jr., LCSW]

5. Organizational and Financial Information

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

LLC-Limited Liability Corporation

b. Does the Applicant have non-profit status? No

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

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

Ann L. Price, MD - CT license number is 01732
Julian N. Hartt Jr., LCSW – CT license number is 001459

d. Financial Statements

i. If the Applicant is a Connecticut hospital: NA

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

Please refer to Appendix C for financial statements

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

Table 2: Proposed Capital Expenditures/Costs

Medical Equipment Purchase	$0
Imaging Equipment Purchase	0
Non-Medical Equipment Purchase	$2,000/year for 2 years (chairs, desk, etc.) and $4,000 in the third year.
Land/Building Purchase *	0
Construction/Renovation **	0
Other Non-Construction (Specify)	0
Total Capital Expenditure (TCE)	**$2,000**
Medical Equipment Lease (Fair Market Value) ***	$0
Imaging Equipment Lease (Fair Market Value) ***	0
Non-Medical Equipment Lease (Fair Market Value) ***	0
Fair Market Value of Space ***	$0 for next two years expected to increase in year by $16,000
Total Capital Cost (TCC)	**$0**
Total Project Cost (TCE + TCC)	**$2,000**
Capitalized Financing Costs (Informational Purpose Only)	0
Total Capital Expenditure with Cap. Fin. Costs	**$2,000**

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

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

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

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

None – The Next Right Thing, LLC is financing this program out of existing operations and resources.

Patient Population Mix

6. Patient Population Mix: Current and Projected

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

Table 3: Patient Population Mix

	Current FY *****	**Year 1 FY *****	**Year 2 FY *****	**Year 3 FY *****
Medicare*	0	0	0	0
Medicaid*	0	0	0	0
CHAMPUS & TriCare	0	0	0	0
Total Government	**0**	**0**	**0**	**0**
Commercial Insurers*	100%	100%	100%	100%
Uninsured	0	0	0	0
Workers Compensation	0	0	0	0
Total Non-Government	100%	100%	100%	100%
Total Payer Mix	100%	100%	100%	100%

* Includes managed care activity.

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

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

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

All of our current IOP patients are "self-pay" due to The Next Right Thing, LLC's absence of licensure and contractual relationships with insurance payers. Once licensed, we expect our patient mix to continue to be primarily covered by commercial insurance.

Financial Worksheets & Assumptions

7. Financial Attachments I & II

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

See following page

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

See following pages

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

See following pages

THE NEXT RIGHT THING

Financial Attachment I

(7.a) Please provide one year of actual results and three years of projections of **Total Facility** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

Total Facility: **Description**	12 mo **FY2012 Actual** **Results**	**FY2013 Projected W/out CON**	**FY2013 Projected Incremental**	**FY2013 Projected With CON**	**FY2014 Projected W/out CON**	**FY2014 Projected Incremental**	**FY2014 Projected With CON**	**FY2015 Projected W/out CON**	**FY2015 Projected Incremental**	**FY2015 Projected With CON**
NET PATIENT REVENUE										
Non-Government	$102,122	$112,334	$213,629	$325,963	$123,568	$263,222	$386,790	$135,924	$358,410	$494,334
Medicare	$0			$0			$0			$0
Medicaid and Other	$0			$0			$0			$0
Other Government	$0			$0			$0			$0
Total Net Patient Revenue	$102,122	$112,334	$213,629	$325,963	$123,568	$263,222	$386,790	$135,924	$358,410	$494,334
Other Operating Revenue										
Revenue from Operations	$102,122	$112,334	$213,629	$325,963	$123,568	$263,222	$386,790	$135,924	$358,410	$494,334
OPERATING EXPENSES										
Salaries and Fringe Benefits	$18,509	$36,000	$222,685	$258,685	$50,000	$227,410	$277,410	$75,000	$293,020	$368,020
Professional Services	$21,027	$18,200	$6,000	$24,200	$6,000	$6,000	$12,000	$6,000	$6,000	$12,000
Supplies ~~and Drugs~~	$2,787	$3,000	$9,300	$12,300	$4,000	$11,400	$15,400	$5,000	$15,600	$20,600
Bad Debts	$6,123	$6,740	$9,720	$16,460	$7,414	$11,232	$18,646	$8,155	$16,272	$24,427
Other Operating Expense	$16,792	$18,471	$2,000	$20,471	$20,318	$2,000	$22,318	$22,350	$4,000	$26,350
Subtotal	$65,238	$82,411	$249,705	$332,116	$87,732	$258,042	$345,774	$116,506	$334,892	$451,398
Depreciation/Amortization*							$0			$0
Interest Expense	$732	$634	$0	$634	$0	$0	$0	$0	$0	$0
Lease Expense	$16,450	$16,800	$0	$16,800	$17,400	$0	$17,400	$18,000	$16,000	$34,000
Total Operating Expenses	$82,420	$99,845	$249,705	$349,550	$105,132	$258,042	$363,174	$134,506	$350,892	$485,398
Income (Loss) from Ops.	$19,702	$12,489	($36,076)	($23,587)	$18,435	$5,180	$23,616	$1,419	$7,518	$8,936

Non-Operating Income	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Income before income taxes	$19,702	$12,489	($36,076)	($23,587)	$18,435	$5,180	$23,616	$1,419	$7,518	$8,936
Provision for income taxes	$2,520	$1,438	($1,438)	$0	2,330	$777	$3,107	$0	$905	$905
Net Income	$17,182	$11,051	($34,638)	($23,587)	$16,105	$4,403	$20,508	$1,419	$6,612	$8,031
RE, beginning of year	$13,643	$47,436	$47,436	$47,436	$58,486	$12,798	$23,848	$74,591	$17,201	$44,356
Net Contribution/Withdrawal	$16,611	$0	$0	$0	$0	$0	$0	$0	$0	$0
REs, end of year	$47,436	$58,486	$12,798	$23,848	$74,591	$17,201	$44,356	$76,010	$23,813	$52,387
ASSUMPTIONS:										
Full Time Equivalents		1	1.7	2.7	1	1.7	2.7	1.2	2.3	3.5

Note: Assumptions used to develop both financial attachments follow after Financial Attachment II

- * Depreciation ran almost $5,000 in 2011 and is expected to be low going forward. Final entries for depreciation for 2012 will be made before filing taxes in April 2013.

FINANCIAL ATTACHMENT II (7.b.) Provision of 3 years of projections of incremental revenue, expense, and volume statistics

Fiscal Year 2013 FY Projected Incremental	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
Total Incremental Expenses:	**$239,985**	Rate	Units	Gross Revenue Col. 2 * Col. 3	Allowances/ Deductions	Charity Care	Bad Debt	Net Revenue Col.4 - Col.5 -Col.6 - Col.7	Operating Expenses Col. 1 Total * Col. 4 / Col. 4 Total	Gain/(Loss) from Operations Col. 8 - Col. 9
Total Facility by Payer Category:										
Commercial Insurers		$400	450	$180,000	$2,880		$5,400	$171,720	$193,536	($21,816)
Uninsured		$400	108	$43,200	$691	$6,000	$4,320	$32,189	$46,449	($14,260)
Total NonGovernment		$9,600	558	$223,200	$3,571	$6,000	$9,720	$203,909	$239,985	($36,076)
Total All Payers		$0	558	$223,200	$3,571	$6,000	$9,720	$203,909	$239,985	**($36,076)**

Fiscal Year 2014 FY Projected Incremental	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
Total Incremental Expenses:	**$246,810**	Rate	Units	Gross Revenue Col. 2 * Col. 3	Allowances/ Deductions	Charity Care	Bad Debt	Net Revenue Col.4 - Col.5 -Col.6 - Col.7	Operating Expenses Col. 1 Total * Col. 4 / Col. 4 Total	Gain/(Loss) from Operations Col. 8 - Col. 9
Total Facility by Payer Category:										
Commercial Insurers		$400	576	$230,400	$3,686		$6,912	$219,802	$207,840	$11,962
Uninsured		$400	108	$43,200	$691	$6,000	$4,320	$32,189	$38,970	($6,781)
Total NonGovernment			684	$273,600	$4,378	$6,000	$11,232	$251,990	$246,810	$5,180

Total All Payers		$0	684	$273,600	$4,378	$6,000	$11,232	$251,990	$246,810	**$5,180**

Fiscal Year 2015	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
FY Projected Incremental Total Incremental Expenses:	**$338,620**	Rate	Units	Gross Revenue Col. 2 * Col. 3	Allowances/ Deductions	Charity Care	Bad Debt	Net Revenue Col.4 - Col.5 -Col.6 - Col.7	Operating Expenses Col. 1 Total * Col. 4 / Col. 4 Total	Gain/(Loss) from Operations Col. 8 - Col. 9
Total Facility by Payer Category:										
Commercial Insurers		$400	756	$302,400	$4,838		$9,072	$288,490	$273,501	$14,989
Uninsured		$400	180	$72,000	$1,152	$10,000	$7,200	$53,648	$65,119	($11,471)
Total NonGovernment			936	$374,400	$5,990	$10,000	$16,272	$342,138	$338,620	$3,518
Total All Payers		$0	936	$374,400	$5,990	$10,000	$16,272	$342,138	$338,620	**$3,518**

Note: Assumptions used to develop both financial attachments follow on the next page/

ASSUMPTIONS (7.c.) used in developing both Financial Attachments I and II.

Summary of Assumptions used to develop financial attachments

1. Type of service: S9480-Intensive Outpatient Program which assumes at least 3 consecutive hours/day for 3 days/week (With the IOP would expect additional family, individual, and psychiatric care each week)

2. Type of Unit Description: 1 average Intensive Outpatient Day

3. Number of Months in Operation: 12 months in a year

4. Rate Assumptions: Am assuming insurance reimbursement or direct payments of $400/IOP day for 3 days a week for an average 6 weeks.

5. Allowances/deductions: Assume an average 1.6% deduction for payment card (bank) charges

6. Bad debt: Assumes 3% bad debt related to families with insurance and 10% bad debt/uncollectable for families who self-pay. An additional $6,000 of charity care in 2013 & 2014 and $10,000 in 2015 is added to the bad debt allowance. 2012's experience of 6% bad debt & charity is assumed for the non-IOP portion of the business going forward.

7. Payer Category: We expect our payers to continue to be self-pay or insurance payers.

8. Non-CON related Revenues: Expected to increase slightly to $85,000 in 2013, to $100,000 (up 11.5%) in 2014, and to $125,000 (up 25%) in 2015. The increases primarily reflect an increase in after-care services as patients wind down from IOP level of service.

9. IOP Revenue Increases:

Year	Number of IOP Patients seen in Year	Net change in IOP Patients seen in Year	Projected IOP Net Revenue (net of bad debt	Percent Change in Net Revenue
2013	31	NA	$203,909	NA
2014	38	7	$251,990	+24%
2014	52	14	$342,138	+36%

10. Number of IOP Patients Served: We expect to see roughly twice as many new patients in 2013 than 2012 assuming the CON is approved, The Next Right Thing is licensed by The Connecticut Department of Public Health, and insurers negotiate IOP rates. Given the size of the growing drug and alcohol problem amongst our area's adolescents and young adults coupled with growing awareness in the community of The Next Right Thing, we anticipate adding modestly to the total number of patients served by the IOP in a calendar year by 7 in 2014 and 14 in 2015.

11. Professional & Consulting Expenses

The Next Right Thing, LLC is currently used consulting services in 2013 to set up its back-office supports, initiate rate conversations with insurance payers, purchase book keeping and accounting services, and to explore licensing options – with some deferred payments in 2014. The Next Right Thing expects consulting and professional services to peak in 2014 (with final payments of start-up expenses) then to continue at a lower maintenance rate.

12. Other Operating Expenses: Consist primarily of office and food supplies needed to run IOP groups. Assumed to run about $2000/year through 2014 and to double as The Next Right Thing, LLC expands in 2015 to meet demand for more IOP groups.

13. Salaries & Fringe Benefits: 2012 actual results include 1099 payments to our staff (office administrator, Clinical Director, and Medical Consultant) under Salaries. All other 1099 payments are considered professional & consulting expenses.

Breakdown of yearly **incremental** expenses

2013
IOP to start Jan/Feb of 2013

	$2,000	Other operating expenses
	6,000	Consulting/Contractors
	9,300	Supplies
	52,000	PT Clinician (1 at 20 hours per week)
	20,925	MD (1 part time at approximately 2 hours/week)
	104000	Clinician
	45760	Admin
Total incremental expenses	**$239,985**	
Incremental Salaries	222,$685	(1.7 FTE)

2014

	$2,000	Other operating expenses
	6,000	Consulting/Contractors
	11,400	Supplies
	52,000	PT Clinicians (2 at 20 hours per week)
	25,650	MD (1 part time, averaging about 2.5 hours per week)
	104,000	Clinician (1 full time)
	45,760	Admin
Total incremental expenses	**$246,810**	
Incremental Salaries	$ 227,410	(1.7 FTE)

2015

$4,000	Other operating expenses
6,000	Consulting/Contractors
15,600	Supplies

	20,000	Rent for about 1500 additional square feet
	35,100	MD (1 part time at about 3.5 hours per week)
	208,000	2 FT Clinicians
	49,920	Admin
Total incremental expenses	**$338,620**	
Incremental Salaries	$293,020	(2.3 FTE)

Other Assumptions:

13. **Projections are based on the cash basis** (rather than accrual) which is how The Next Right Thing, LLC operates its books for IRS purposes.

14. **Allowances for taxes** were based on 2012 tax tables found at www.irs.gov

Schedule X—Use if your 2012 filing status is Single

If line 5 is:		The tax is:	
Over—	But not over—		of the amount over—
$0	$8,700	---------- 10%	$0
8,700	35,350	$870.00 + 15%	8,700
35,350	85,650	4,867.50 + 25%	35,350
85,650	178,650	17,442.50 + 28%	85,650
178,650	388,350	43,482.50 + 33%	178,650
388,350	----------	112,683.50 + 35%	388,350

15. **Non IOP revenues** and most non-CON expenses are expected to grow at 10%/year – a conservative assumption.

16. **Non-IOP salaries** for 2012 include 1099 consulting fees for office help, our Chief Medical Consultant, and paraprofessional fees. The Clinical Director worked for free in 2012 while building the practice and the Chief Medical Consultant at a steep discount; future salary costs for the non-IOP part of the projections are expected to increase by $18,000 in 2013, $14,000 in 2014, and $25,000 in 2015.

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

Professional Rate Schedules

Based on preliminary discussions with Anthem Blue Cross and Aetna and local knowledge of rates of reimbursement for other providers offering similar levels of care (Partial Hospital/Intensive Outpatient), The Next Right Thing anticipates that it will be able to charge from $400 to $600 per IOP day.

Intensive Outpatient Services	CPT Code	Fee ($)	Length
Intensive Outpatient Service/day	S9480	400.00	3 consecutive hours
IOP week	S9480	1200.00	3 days/week

A La Carte Services	CPT Code 2012/2013	Fee ($)	Length (minutes)
Family Psychotherapy with patient	90847	200.00	50
Family Psychotherapy without patient	90846	200.00	50
Group Psychotherapy	90853	75.00	50
Individual Psychotherapy	90806/90834	200.00	50
Individual Psychotherapy extended	90808	300.00	90
Medication management	90862	150.00	15-20
Multiple family group Psychotherapy	90849	75.00	50
Psychological Diagnostic interview	90801/90791	250.00	90
Pstyx (with medical evaluation and management)	90805/99214	250.00	20-30
Pstyx (with medical evaluation and management)	90807/99215	300.00	45-50

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

Our breakeven rate for the program is at about 38 patients or 669 units of care/year.

Year	Number of patients to show an incremental gain	Number of units (one IOP day) to show gain
2013	38 patients	669 patient IOP days
2014	38 patients	669 patient IOP days
2015	52 patients (with expansion)	926 patient IOP days

These numbers assume that we also carry 1-2 charity patients amongst 6 uninsured patients in 2013 and 2014 and 10 in 2015, with default/bad debt rates of 10%.

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

We are being relatively conservative in our expectations of revenue and realistic in terms of expenses. We expect to lose money in the first year of the IOP as we are building the program – it will take time for patient volume to grow as well as time to contract with managed care companies. If The Next Right Thing attracts an additional 6-7 patients over its forecast (or 108 billable day units above forecast), the IOP program will breakeven in year 1.

Cost Effectiveness of Proposal

g. Describe how this proposal is cost effective.

The IOP program will be cost effective in two major ways:
Decreased expense for clients immediately once The Next Right Thing, LLC is licensed as an IOP and can participate in-network with providers,
If these adolescents get effective treatment now for substance abuse and co-morbidities, relapse and recidivism will decrease and they will need less treatment later.

Quality of care for this population equates to cost effective care.

Appendix A – References & Bibliography

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http://www.adolescent-substance-abuse.com/substance-abuse/the-new-faces-of-heroin-addiction-teen-use-on-the-rise.htm

American Psychiatric Association. DSM-IV-TR or Diagnostic and Statistical Manual, edition IV transitional (2000). The DSM-IV-TR provides a classification of mental disorders, criteria sets to guide the process of differential diagnosis , and numerical codes for each disorder to facilitate medical record keeping. The stated purpose of the *DSM* is to: 1) provide "a helpful guide to clinical practice"; 2) "to facilitate research and improve communication among clinicians and researchers"; and3) to serve as "an educational tool for teaching psychopathology."

The five diagnostic axes specified by *DSM-IV-TR* are:

- Axis I: Clinical disorders, including anxiety disorders, mood disorders, schizophrenia and other psychotic disorders.
- Axis II: Personality disorders and mental retardation. This axis includes notations about problematic aspects of the patient's personality that fall short of the criteria for a personality disorder.
- Axis III: General medical conditions. These include diseases or disorders that may be related physiologically to the mental disorder; that are sufficiently severe to affect the patient's mood or functioning; or that influence the choice of medications for treating the mental disorder.
- Axis IV: Psychosocial and environmental problems. These include conditions or situations that influence the diagnosis, treatment, or prognosis of the patient's mental disorder. *DSM-IV-TR* lists the following categories of problems: family problems; social environment problems; educational problems; occupational problems; housing problems; economic problems; problems with access to health care; problems with the legal system; and other problems (war, disasters, etc.).
- Axis V: Global assessment of functioning. Rating the patient's general level of functioning is intended to help the doctor draw up a treatment plan and evaluate treatment progress. The primary scale for Axis V is the Global Assessment of Functioning (GAF) Scale, which measures level of functioning on a scale of 1–100. *DSM-IV-TR* includes three specialized global scales in its appendices: the Social and Occupational Functioning Assessment Scale (SOFAS); the Defensive Functioning Scale; and the Global Assessment of Relational Functioning (GARF) Scale. The GARF is a measurement of the maturity and stability of the

relationships within a family or between a couple.

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

Connecticut Department of Public Health. National Public Health Week Fact Sheet: Drug and Alcohol-related Poisoning (April 2011). http://www.ct.gov/dph/cwp/view.asp?q=476708&a=3987

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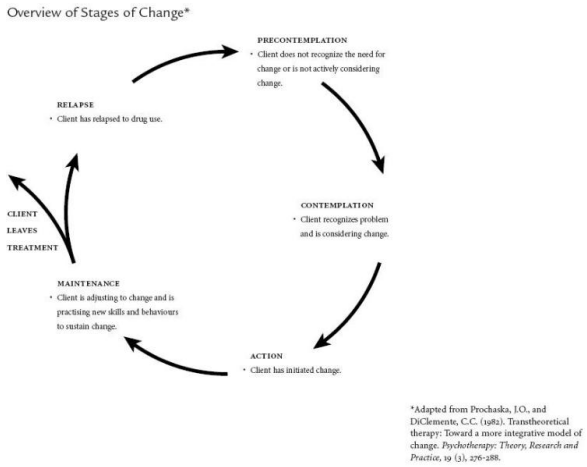

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Murray, Rheana. New York Daily News (June 2012). Heroin use among suburban teens skyrockets; Experts say prescription pills are the new gateway drug. http://www.nydailynews.com/life-style/health/heroin-soars-suburban-teens-talk-heroin-problem-talking-prescription-drug-problem-article-1.1099140.

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PR Newswire-US Newswire (April 6, 2011). National Study Confirms Teen Drug Use Trending in Wrong Direction: Marijuana, Ecstasy Use Up Since 2008, Parents Feel Ill-Equipped to

Respond. http://m.prnewswire.com/news-releases/national-study-confirms-teen-drug-use-trending-in-wrong-direction-marijuana-ecstasy-use-up-since-2008-parents-feel-ill-equipped-to-respond-119302034.html

Rehmer MSN, Patricia. CT Commissioner Department of Mental Health and Addiction Services before the Public Health Committee on 3/7/2012. Speaking in favor of HB 5063 that would allow Narcan to be prescribed more broadly. Narcan or Naloxone "is used to counteract drug overdoses."

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

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West Hartford. 2011 Bi-annual West Hartford High School Drug and Alcohol Survey

Appendix B – Curriculum Vitae

JULIAN N. HARTT, JR. LCSW

345 NORTH MAIN STREET
SUITE 306
WEST HARTFORD, CT 06107
860 233 8803

203 407 8500 (office)

SUMMARY

- Exemplary administrative record of innovative program development and management.
- Extensive experience in providing direct and supervisory services to children, adolescents, and adults with the full spectrum of psychiatric disorders in all clinical modalities, including inpatient, partial hospital programs, intensive out- patient programs, and private practice.
- Extensive experience in treatment, education, and training in the field of addiction.
- Extensive experience working in academic settings providing direct services, training, and education. School based intervention programs.
- Experience working with managed care companies creating out-patient programs for high-risk patients.
- Selected to be an advisor for various managed care companies and mental health organizations.
- Skilled in working collaboratively with state referral agencies and providers in the community.
- Strong analytical skills with the ability to review data and measure results

Experience

The Next Right Thing, LLC

Co-Founder and Clinical Director_____2011-Present

- Created Intensive Outpatient Program for dually diagnosed and substance abusing adolescents. Family oriented after school program focused on long term stability for a high risk population.

Private Practice_____2007-2012

- Individual, family, and group therapy with children, adolescents, and adults with

focus on addictions, dual diagnosis, and mood disorders. Specialty in consulting on difficult to diagnosis late teens and young adults. Created on-line access program for teens and parents confronting the new crisis in opiate addiction.

Working with community based groups to address adolescent opiate addiction. Running a weekly recovery group for 18 to 22 year olds

Rushford Center, Inc **2005-2007**

- Consultant to adolescent male residential program on program development and management. Assisted Director in bringing program into compliance with DPH and DCF requirements

- Manager of Rushford Mobile Crisis Program in Meriden/Wallingford catchment area, which included supervising clinical staff at Midstate Medical Hospital Emergency Department. Supervised staff of 23 crisis and hotline workers, licensed triage clinicians, and community mobile responders.

Quinnipiac University, Hamden, CT **2002 – 2005**
Full-time Consultant/Psychotherapist

- Provided consultation to administration and faculty regarding students with psychological and behavior issues.
- Provided direct services to students in individual and group therapy settings.
- Assessed and developed treatment plans for students referred through the University judicial system due to alcohol and/or drug problems.
- Designed and implemented an on-line triage process for students seeking counseling, which resulted in the delivery of services within a three day period.
- In conjunction with the Associate Dean of Students, designed a student satisfaction survey for the counseling department to measure both student satisfaction with the services they received and improvement with presenting problems.

Atlantic Health Services, PC, Hamden, CT **1990 – 2002**
Clinician

- Designed and implemented a substance abuse relapse prevention programs which served as a model for intensive outpatient programs for several CMO'S.
- Worked with high-risk patients, including those with Borderline Personality Disorders and Post Traumatic Stress Disorders.
- Proficient in the use of Cognitive Behavior Therapy with patients with depression and anxiety disorders.
- Initiated a group program for patients with Bipolar Disorders and their families.
- Developed treatment protocols for children to enhance self-management of behavior.

Atlantic Health Services, PC, Hamden, CT **1995 - 2002**
Clinical Director

- Established procedures with a variety of managed care companies to create intensive outpatient and diversion programs
- Oversaw weekly case management committee for internally managed contracts. Utilization management oversight as well as quality management reporting responsibilities to CMO's.
- Served as a liaison to HMO/CMO's and managed core clinical group contracts.
- Supervised clinical staff as well as the intake and triage department.
- Served as a consultant to Quinnipiac University for alcohol/drug assessments and counseling.

Choate-Rosemary Hall, Wallingford, CT 1989 - 1992
Consultant

- Consultant to faculty and counseling staff for a college preparatory school.
- Evaluated and treated, in group and individual therapy, high-risk students and others who presented with substance-abuse problems.

Windham Hospital, Willimantic, CT 1989-1992
Consultant/EAP Clinician

- Evaluated and treated students with psychological problems for Windham High School Health Center.
- Trained teachers at Windam High School to facilitate student support groups in unique Student Assistance Program.
- Provided EAP service at Windham Hospital for the nursing division.

Middlesex Family Resource Center, Portland, CT 1985-1989
Private Practice, Owner

- Established outpatient programs for adolescents and their families.
- Treated behavior disorders in children and adolescents.
- Employed CBT protocols with patients diagnosed with anxiety disorders and depression

Summer Street Treatment Center, Portland, CT 1989-1991
Clinical Director, 1990-1991; Consultant 1989-1990

- As Director, managed all aspects of the clinical program for psychiatric and substance abuse treatment of adolescents and adults in partial hospital setting.
- Provided consultation and supervised program.

Community Health Center, Middletown, CT 1989-1991

Consultant

- Supervised multi-family therapy leaders in an innovative after-school program for adolescents with substance abuse and psychiatric problems.

Midstate Psychotherapy Associates, Portland CT **1979-1985**
Part-time Psychotherapist

- Provided individual, group, couples and family therapy for adolescents and adults.

Elmcrest Psychiatric Institute, Portland, CT **1972-1985**
Director, Adolescent Partial Hospitalization Program ***1984-1985***

- Designed the first adolescent PHP in Connecticut.
- Developed a comprehensive day treatment program, supervised clinical and nursing staff, and provided direct care.

Senior Clinician/Unit Chief ***1981-1984***

- Monitored the nursing, clinical and education departments on a treatment unit of 25 adolescents.
- Supervised clinical staff and interns on case and unit management.
- Provided evaluation and direct individual, group, and family therapy.

Director, Alcohol and Drug Program for Adolescents ***1979-1984***

- Organized and monitored AA programs and led drug and alcohol groups
- Provided education to staff on dynamics of substance abuse.

Clinical Administrator ***1979-1981***

- Coordinated clinical activities of the interdisciplinary treatment team and managed discharge planning.
- Provided individual and family therapy.

Social Work Intern ***1978-1979***

Supervisory Mental Health Worker ***1972-1978***

ADVISORY COMMITTEES/MEMBERSHIPS

- **Quinnipiac University Task Force on Alcohol** 2000-2002.
- **Yale University**-IPO Credentialing Committee 2001-2002.
- **Value Options**-Provider Advisory Committee for NE Region 2000-2002.
- **Behavioral Health Care** – Advisor/Organizer of CMO on Clinical Group Model. **Human Affairs International** -Providers Credentialing Committee for new contracts -1998.
- **American Society of Addiction Medicine-Managed Care Coalition**

  Substance Abuse Disorders – Bi-monthly meetings on managed care and discussions of ASAM Placement criteria.1996-1999

CERTIFICATION

CONNECTICUT CERTIFICATION NO. 001459
L.C.S.W., 1994
C.I.S.W., 1986
A.C.S.W., 1982

EDUCATION

Masters of Social Work **May 1978**
University of Connecticut, West Hartford, Connecticut
Concentration in Group Work; Minor in case work;
Independent Study on History of Psychoanalytic Thought

Bachelors of Arts in English **May 1971**
Rocky Mountain College, Billings, Montana

PROFESSIONAL PRESENTATIONS

NATIONAL ASSOCIATION OF STUDENT PERSONNEL ADMINISTRATORS **NOVEMBER 2003**
PANEL PRESENTATION ON SUBSTANCE ABUSE AND UNIVERSITY POLICY

NATIONAL ASSOCIATION OF STUDENT PERSONNEL ADMINISTRATORS **NOVEMBER 2001**
PANEL PRESENTATION ON ASPERGER'S STUDENTS IN A COLLEGE SETTING

DANBURY HOSPITAL GRAND ROUNDS, DANBURY, CT **2000**
THERAPEUTIC STRATEGIES FOR ADOLESCENTS AT HIGH RISK FOR VIOLENCE

YALE UNIVERSITY, NEW HAVEN, CT **1995**
TREATING DUALLY DIAGNOSED ADOLESCENTS: A DEVELOPMENTAL APPROACH

NEWINGTON'S CHILDREN'S HOSPITAL, NEWINGTON, CT **1992**
INTERVENTION APPROACHES WITH OLDER ADOLESCENTS WITH ATTENTION DEFICIT

HYPERACTIVE DISORDER

ELMCREST PSYCHIATRIC INSTITUTE, PORTLAND, CT **1998**
RUSHFORD CENTER, MIDDLETOWN, CT **1998**
SUBSTANCE ABUSE AND THE ADOLESCENT WITH LEARNING DEFICITS

CARRIER FOUNDATION, BELLE MEAD, NJ **1984**
STRUCTURING ALCOHOL AND DRUG PROGRAMS FOR ADOLESCENTS AT AN INPATIENT PSYCHIATRIC FACILITY

MOUNT SINAI HOSPITAL, HARTFORD, CT **1982**
TREATING ADOLESCENT CHEMICAL DEPENDENCY IN A PSYCHIATRIC FACILITY

AMERICAN ASSOCIATION OF PSYCHIATRIC SERVICES FOR CHILDREN, SAN FRANCISCO **1981**
FAMILY TREATMENT OF CHEMICALLY DEPENDENT ADOLESCENTS IN A RESIDENTIAL PSYCHIATRIC FACILITY

ELMCREST PSYCHIATRIC INSTITUTE, PORTLAND, CT **1981**
MARIJUANA REVISITED

PUBLICATIONS

Barnard, C.A. and Hartt, J.N. (Copyrighted 2004). University Counseling Intake Form.

Barnard, C.A. and Hartt, J.N. (Copyrighted 2004). University Counseling Satisfaction Form.

Ann L. Price, M.D.

155 Ayrshire Lane
Avon, CT 06001
E-mail: annprice5@aol.com

Home: (860) 677-484 Office: 646-733-7816

- Certified: American Board of Psychiatry and Neurology (Psychiatry) -
- Licensed: Connecticut 1983; Massachusetts 1992 -

EDUCATION

Tulane Medical School, New Orleans, LA
M.D., 1976

Tulane Medical Center
Resident in Psychiatry, 1976 – 1978; Fellow in Child Psychiatry, 1978

Tulane Psychoanalytic Medicine Program
Candidate, 1977 – 1982; Certified, 1982

Bennington College, Bennington, VT
B.A., Biology, 1971

EXPERIENCE

As an Administrator and Clinician. . .

Chief Medical Officer, 2004 to Present
INTERCOMMUNITY MENTAL HEALTH GROUP, INC., East Hartford, CT

Private Psychiatric Practice for Children and Adults, 1981 to Present
ANN L. PRICE, M.D.

Chief Medical Consultant, 2011 to present
THE NEXT RIGHT THING, LLC

Psychiatric Consultant, 2002 to 2004
CCMC SCHOOL, Wethersfield, CT

Medical Director, 1991 to 1994
COMMUNITY MENTAL HEALTH AFFILIATES, INC., New Britain, CT
Developed and staffed a clinic for the economically disadvantaged, at-risk children and their families. Worked closely with Department of Children and Families (DCF) and served as expert witness for DCF in termination of parental rights cases.

Acting Medical Director: Psychiatric Consultant, 1991 to 1993
KOLBURNE SCHOOL, Sandisfield, MA
Provided direct treatment for seriously disturbed children and adolescents (ages 6 – 18) in this residential school, and helped develop school's overall program.

Chief of Psychiatric Consultation, 1989 to I991
OFFICE OF THE COMMISSIONER, DEPT OF MENTAL HEALTH, Hartford, CT
Responsible for consultation on complex treatment cases at three facilities: Fairfield Hills, Connecticut Valley Hospital and Cedarcrest Hospital. Developed treatment plans for adolescents (ages 16 – 18) who were "aging out" of the DCF system and transitioning into adult services.

Director, Adolescent Services, 1983 to 1987
THE INSTITUTE OF LIVING, Hartford, CT
Supervised Physicians and social workers as well as therapeutic aspects of an inpatient school serving 120 adolescents residing at the Institute.

Attending Psychiatrist, Adolescent Intensive Treatment Unit, 1982 to 1983
RIVER OAKS HOSPITAL, New Orleans, LA

Supervising Analyst, I982 to 1983
TULANE PSYCHOANALYTIC MEDICINE PROGRAM, New Orleans, LA

Director, Pediatric Liaison – Consultation Service, 1980 to 1983
CHARITY HOSPITAL, New Orleans, LA
Worked closely with Child Protective Services of the State of Louisiana to identify and assess children at risk for neglect and abuse.

Consultant, Surgical Oncology Service, 1977 to 1983
TULANE MEDICAL CENTER, New Orleans, LA

Psychiatric Consultant, Substance Abuse Clinic, 1977 to 1981
Psychiatric Consultant, Title XIX Program, Board of Education, 1980 to 1983
JEFFERSON PARISH, LA

EXPERIENCE
As an instructor. . .

Clinical Assistant Professor, Department of Psychiatry, 1983 to Present
UNIVERSITY OF CONNECTICUT MEDICAL SCHOOL, Farmington, CT

Faculty Member and Supervising Analyst,
Division of Psychoanalytic Medicine, 1983 to Present
NEW YORK MEDICAL COLLEGE, New York, NY

Clinical Assistant Professor of Adult and Child Psychiatry, 1980 to 1983
Clinical Assistant Professor of Pediatrics, 1980 to 1983
Training Director, Child Psychology Fellows, 1981 to 1983
TULANE MEDICAL CENTER, New Orleans, LA

PRESENTATIONS

American Academy of Psychoanalysis, "The Impact of Alzheimer's Disease on the Family," 1997
American Academy of Psychoanalysis, "Gender Disturbance in Young Children," 1991
American Psychiatric Association, Symposium Leader, "Diagnostic and Statistical Manual IV Child Psychiatric Diagnosis," 1988
American Psychiatric Association, Symposium Leader, "Pregnancy, Intrapsychic and Institutional Issues,"1985
American Academy of Psychoanalysis, Chair, Winter Meeting, 1985
American Academy of Psychoanalysis, Presenter at Special Conference on the Emerging Identity of Women, "The Cinderella Complex: Masochism Masquerading as Liberation," 1985
American Academy of Psychoanalysis, "Discipline: Psychoanalytic and Developmental," 1984
American Association of Directors of Psychiatric Residency Training, "Part Time and Interrupted Training: A National Survey," 1984
American Association of Directors of Psychiatric Residency Training, "Developing a Curriculum in Adolescent Psychiatry," 1984

PUBLICATIONS

Price, A. et al, Psychotropic Medication and Family Therapy: A Systems Approach, [in press].

Price, A. "A Model for the Classification and Diagnosis of Relational Disorders," Psychiatric Services, Sept. 1995, Vol. 46, No. 9.

Simmons, Price, Ozeerkis. "The Immunologic Problem of Pregnancy," American Journal of Obstetrics and Gynecology, Vol. 50.

Price, Self Help Groups: "Trouble on the Frontier," Current Concepts in Psychiatry, Vol. 4.

Winstead, Price. "Chronic Illness Behavior in Psychiatric Patients," Psychosomatic Medicine, Volume 42, No. 2.

Nadelson, C. and Price, A. "Part Time and Interrupted Training: A National Survey," AADPRT Journal, Jan. 1985

Price, A. and Gunter, D. Medical Grand Rounds. "Psychiatric Management of the Adolescent Diabetic,"

MEMBERSHIPS

American Academy of Psychoanalysis
Chinese American Psychoanalytic Association
Group for the Advancement of Psychiatry
American Academy of Child Psychiatry [former]
American Association of Directors of Psychiatric Residency Training [former]
American Psychiatric Association [former]

***

ADDITIONAL DATA

Qualified Expert Witness: Connecticut and Louisiana
Cases included custody, legal malpractice, and termination of parental rights

Russian Language - Proficient

246 Steele Rd. West Hartford, CT 06117-2742
PH: 860-236-1499
Jenifer@NextRightThing.net

Jenifer C. Simson

Experience

2011-Present **The Next Right Thing, LLC** W. Hartford, CT

Co-Founder & Executive Director

Responsible for starting up The Next Right Thing, LLC, a community based substance abuse and mental health intensive outpatient program for adolescents (ages 16-23). Oversees administration and finances. Co-facilitates parent support group.

2011-Present **Hartt and Mind Market Research** W. Hartford, CT

Principal

- Responsible for managing & executing qualitative market research projects including:
  - Online, in-person, telephone, mobile, and hybrid research
  - B2B and consumer
- Coordinate competitive intelligence, quantitative and secondary research studies.

Work with a broad spectrum of clients in the following industries: payment cards, insurance, banking, brokerage, pharmaceuticals, healthcare, state government, marketing & advertising, publishing, telecommunications, and consumer packaged goods.

2009-Present **Feature Editor, VIEWS magazine**

Develops articles with writers and edits 3-4 articles a quarter for the award winning VIEWS magazine for qualitative market researchers.

2003-2010 **Quantum Insights, LLC** West Hartford, CT

Managing Partner, Qualitative

- Responsible for managing & executing all qualitative research (e.g., Focus Groups, In-depth Interviews).
- Design and coordinate major research studies including concept testing & development, motivation & behavior, advertising, and message development studies.
- Served a wide range of industries: advertising, food, pharmaceutical, healthcare, financial services, packaged goods, etc.

2001-2002 **Simson Market Research, LLC** W. Hartford, CT

President

Moderated focus groups, designed & wrote screeners, discussion guides, and reports for qualitative research studies (corporate and government).

1998-2002 West Hartford, CT

Consultant

Sample projects included:

- Drafted consumer focus group formats, analyzed group results, and wrote final reports for a marketing research company.
- Worked with team to develop strategy and market plans for an internet start-up in the energy field.
- Designed equity sales and trust account review processes for an Investment Firm.

1994 -1997 **CIGNA Global Portfolio Strategies, Inc.** Bloomfield, CT

Vice-President – Manager, Investment Research and Services

- Managed investment-consulting staff providing asset allocation services to over 300 clients, primarily DB and DC pension plans.
- Designed consultative process for use with clients.
- Directed capital market research and modeling, asset/liability analyses, and article publication.

1990-1994 West Hartford/Avon CT

Partner, Private Investment Partnership

Focused on research, analysis, and trading of futures and options for client funds.

1988-1990 **The Travelers Insurance Companies** Hartford, CT

Portfolio Manager, Securities Department

- Managed 5 total return portfolios totaling $5 billion of bonds, real estate, and equity securities.
- Worked closely with Casualty & Property and Life departments to manage interest, liquidity, and credit risk.
- Developed and implemented investment policies, hedging strategies, and new investment strategies.
- Aggregate portfolio equaled or exceeded target return each year.

1987-1988 **The Travelers Insurance Companies** Hartford, CT

Assistant Portfolio Manager, Securities Department

Assisted in the analysis and implementation of hedging and restructuring strategies for the GIC, Commercial Lines, and Life Annuity portfolios.

1983-1987 **The Travelers Insurance Companies** Hartford, CT

Private Placement Analyst

- Analyzed, negotiated, structured and recommended for investment privately placed debt and equity-kicker deals.
- Monitored $400 million credit portfolio.

1981-1983 **Deloitte, Haskins & Sells** New Haven & Houston

Consultant and Accountant

- Designed and programmed comprehensive forecasting and M&A programs.
- Assisted in designing compensation and operating policies.

Education

1981 **Cornell University** Ithaca, NY

- M.B.A.., Finance and Accounting concentration.
- Johnson School of Management

1979 **University of Washington** Seattle, WA

- B.A.., Economics
- Honors Program

Appendix C - Financial Statements

Bookkeeping & Admin Services
171 Market Square, Suite 111 | Newington | CT 06111
www.MovingMountains.BIZ
860-757-3440 | 866-703-6577 (fax)

Next Right Thing
Profit and Loss
January 2012 to December 2012

	Jan - Dec 12
Ordinary Income/Expense	
Income	
Therapy Income	101,963.93
Other Services	158.08
Total Income	102,122.01
Gross Profit	102,122.01
Expense	
Advertising and Promotion	363.51
Bad Debt	2,885.80
Bank Service Charges	76.55
Computer Expenses	242.40
Credit Card Fees	1,118.47
Discounts & Comp. Visits	3,037.92
Education	5.00
Insurance Expense	9,229.69
Interest Expense	732.06
IT Expenses	191.43
License Fees	728.54
Meals and Entertainment	198.71
No Show write off	200.00
Office Supplies	
Group & Event Supplies	1,230.16
Office Supplies - Other	1,556.52
Total Office Supplies	2,786.68
Paraprofessional Fees	5,516.88
Postage and Delivery	61.54
Professional Fees	34,019.11
Reference Materials	472.04

Bookkeeping & Admin Services
171 Market Square, Suite 111 | Newington | CT 06111
www.MovingMountains.BIZ
860-757-3440 | 866-703-6577 (fax)

Rent Expense	16,450.00
Repairs and Maintenance	426.76
Taxes	312.40
Telephone and Internet Expenses	3,058.90
Town Tax	60.00
Travel Expense	245.16
Total Expense	82,419.55
Net Ordinary Income	19,702.46
Net Income	**19,702.46**

Disclaimer: This was prepared by Moving Mountains, a bookkeeping company. We are not an accountant nor do we practice GAA principles. We use the QuickBooks method of reporting.

MOVING MOUNTAINS LLC
We will move mountains for you...
Bookkeeping & Admin Services
www.MovingMountains.BIZ
860-922-0028 | 866-703-6577 (fax)

Next Right Thing
Balance Sheet
As of December 31, 2012

	Dec 31, 12
ASSETS	
Current Assets	
Checking/Savings	
Webster Bank - 7407	70,690.99
Total Checking/Savings	70,690.99
Accounts Receivable	
Accounts Receivable	-326.00
Total Accounts Receivable	-326.00
Total Current Assets	70,364.99
Fixed Assets	
Accumulated Depreciation	4,995.53
Furniture and Equipment	6,224.86
Total Fixed Assets	11,220.39
Other Assets	
Security Deposits Asset	1,350.00
Total Other Assets	1,350.00
TOTAL ASSETS	**82,935.38**
LIABILITIES & EQUITY	
Liabilities	
Accounts Payable	-631.00
Loan	33,609.77
Total Current Liabilities	32,978.77

Bookkeeping & Admin Services
www.MovingMountains.BIZ
860-922-0028 | 866-703-6577 (fax)

Total Liabilities	32,978.77
Equity	
Retained Earnings	13,643.17
Owner's Contribution	43,610.98
Owner's Draw	-27,000.00
Total Owner's Equity	16,610.98
Net Income	19,702.46
Total Equity	49,956.61
TOTAL LIABILITIES & EQUITY	82,935.38

Disclaimer: This was prepared by Moving Mountains, a bookkeeping company. We are not an accountant nor do we practice GAAP principles. We use the QuickBooks method of reporting.

Appendix D – Intake Assessment & Treatment Plan

345 N. Main St., Suite 306
West Hartford, CT 06117
860-233-8803

Patient Name: _____ Date: _____

Insurance Identification #: _____

Clinician Intake

Clinician Therapist: _____
MD/APRN _____
Medication: _____
Fee/Copay: _____
Insurance Company: _____
Need for Review: _____
Referred by: _____
Primary MD: _____
Primary Therapist: _____
_____
_____
_____
_____
_____
_____

IDENTIFYING INFORMATION and Referral:

_____
_____
_____

CHIEF ISSUES:

_____

_____
_____

HISTORY OF Problems: (Include Functional Impairment) _____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Patient Name: _____ ID#: _____ Date:_____

DRUG and Alcohol HISTORY: Describe lifetime use: when begun, type, amount, duration, and any IV use.

Age first used: ____ Age of regular use: ____ Frequency _____ Quantity_____ Last used____*(fill in space provided below)

Do you have cravings to use? Never____ Sometimes__ Most of the time_____ Has drug/alcohol use caused problems at home, school, or with friends? N____S_____M_____ Does the expectation of getting high equal the actual experience of using? Or is the high not as good as it used to be? Yes___ Sometimes____ Seldom_____ Do you expect negative things to happen and still use? Yes__ No__ Have you used drugs to avoid withdrawal or getting sick?_____ Have you combined using different drugs or alcohol at the same time?_____

*_____
_____
_____
_____
_____
_____
_____
_____
_____

Check all that apply: □MJ □LSD □ Ecstasy, K, Synthetics □Cocaine □Amphetamines

□Narcotics(prescription pain killers or heroin) □Benzodiazepines □OTC's

LEGAL ISSUES: Yes □ No □ If Yes, explain: _____

PAST PYSCHIATRIC AND SUBSTANCE ABUSE TREATMENT HISTORY: Names and dates, Clinicians, Hospitals: _____
_____
_____
_____
_____
_____
_____
_____

Patient Name: _____ ID#: _____ Date: _____

Family Psychiatric History: _____
_____
_____
_____
_____
_____

MEDICAL & SURGICAL HISTORY: Include dates & providers
_____
_____
_____
_____
_____

Smoker: Yes □ No □ Tobacco amount_____ Caffeine amount _____ Seizures: Yes □ No □

Allergies: _____ Adverse reaction to meds: _____

Immunization up-to-date: Yes □ No □ Head Trauma _____

Last physical Exam: _____

CURRENT MEDICATIONS: _____
_____
_____
_____
_____
_____

Patient Name: _____ **ID#:** _____ **Date:** _____

MENTAL STATUS:

APPEARANCE: Well-Groomed ◯ Disheveled ◯ Bizarre ◯ Inappropriate ◯
ATTITUDE: Cooperative ◯ Guarded ◯ Suspicious ◯ Uncooperative ◯ Belligerent ◯
MOTOR ACTIVITY: Calm ◯ Hyperactive ◯ Agitated ◯ Tremors/Tics ◯ Muscle Spasms◯
AFFECT: Appropriate ◯ Labile ◯ Expansive ◯ Constricted ◯ Blunted ◯ Flat ◯
MOOD: Euthymic ◯ Depressed ◯ Anxious ◯ Euphoric ◯ Irritable ◯
SPEECH: Normal ◯ Delayed ◯ Soft ◯ Loud ◯ Slurred ◯ Excessive ◯
Pressured ◯ Perseverating ◯ Incoherent ◯ Racing Thoughts ◯

THOUGHT PROCESS: Intact ◯ Circumstantial ◯ Loosening of Association ◯ Tangential ◯
Flight of Ideas ◯ Grandiose ◯

HALLUCINATIONS: Not Present ◯ Auditory ◯ Visual ◯ Olfactory ◯
DELUSIONS: Not Present ◯ Persecutory ◯ Being Controlled ◯ Grandiose ◯
Thought Insertion/Deletion ◯ Bizarre ◯

SELF-PERCEPTION: No Impairment ◯ Depersonalization ◯ De-realization ◯
ORIENTATION: Fully Oriented ◯
DISORIENTED: Always ◯ Sometimes ◯ Time ◯ Place ◯ Person ◯
MEMORY: Intact ◯ Impaired: Immediate ◯ Recent ◯ Remote ◯
CONCENTRATION: Intact ◯ Impaired: Minimal ◯ Moderate ◯ Severe ◯
ATTENTION: Intact ◯ Impaired: Minimal ◯ Moderate ◯ Severe ◯
ABSTRACTION: Intact ◯ Impaired: Concrete ◯ Idiosyncratic ◯
JUDGEMENT: Intact ◯ Impaired: Minimal ◯ Moderate ◯ Severe ◯
INSIGHT: Intact ◯ Impaired: Minimal ◯ Moderate ◯ Severe ◯

(Use Mini-Mental State if significant cognitive deficits)

NEUROVEGETATIVE:

SLEEP: No Change ◯ DFA ◯ MNA _____ EMA ◯ Hours of sleep _____

APPETITE: No Change ◯ Decrease ◯ Increase ◯ Lbs. lost ____ Current Weight ____

LIBIDO: No Change ◯ Decrease ◯ Increase ◯
MOTIVATION: No Change ◯ Decrease ◯
CONCENTRATION: No Change ◯ Decrease ◯
ENERGY: No Change ◯ Decrease ◯ Increase ◯
INTEREST: No Change ◯ Decrease ◯ Increase ◯
OTHER SYMPTOMS:
AnxietySx: _____
Phobias: _____
PanicSx: _____
Obsessive Thoughts: _____
Compulsive Rituals: _____
Sx of ADD – ADHD: _____
BipolarSx: racing thoughts ◯ increase in activity level ◯ increase in energy ◯
rapid mood shifts ◯ _____
Difficulty with Impulse Control: Yes ◯ No ◯ Explain: _____

Patient Name: _____ **ID#:** _____ **Date:** _____

SUICIDE RISK EVALUATION:

Thoughts about death/escape:

Wishing for death/escape:

Plan:

Intent:

Past Attempt:

VIOLENCE/HOMICIDE RISK EVALUATION:

Thoughts of harming anyone else:

Plan:

Intent:

History of harming others:

If there is a risk, include and describe plan to ensure safety of patient and/or others: _____
_____
_____

FAMILY, SOCIAL AND DEVELOPMENTAL HISTORY: Include history of sexual &/or physical abuse or other trauma. For children - Include developmental history including prenatal and perinatal events.

_____
_____
_____
_____
_____
_____
_____
_____
_____

FORMULATION:

_____
_____
_____
_____
_____

Strengths:	Limitations:

Patient Name: _____ ID#: _____ Date: _____

DSM –IV DIAGNOSIS

Axis I _____ Axis II _____ Axis III _____

Axis IV …… a. Family ◯ b. Social ◯ c. Educational ◯
d. Occupational ◯ e. Housing ◯ f. Economic ◯
g. Health Care ◯ h. Legal ◯ i. Other ◯

Axis V…… Current _____ Highest in the past year _____

91-100 Superior function, 81-90 Minimal symptoms, 71-80 Mild/transient symptoms, 61-70 Mild symptoms,

51-60 Moderate symptoms, 31-40 Impaired Reality testing, 21-30 Inability to function, 11-20 Some danger,

1-10 Serious danger of hurting self or others.

PLAN: Include areas in need of further assessment _____
Records requested _____
Treatment Interventions planned _____
Treatment Plan Complete _____
Information sent to Primary Care Provider: Yes ◯ No ◯
Release of information to and from PCP: Yes ◯ No ◯
Coordination with other institutions and providers: Yes ◯ No ◯

TO BE COMPLETED MY MDs AND APRNs

Medications Prescribed: Include date, dose, Rx # and refills _____
_____
_____
_____
_____

Aims Score (if on Antipsychotics): _____

Discussed diagnosis, risks and benefits of medication including: alternative treatment options, side effects, and medication interactions: Yes ◯ No ◯

Convey findings to clinician/therapist: Yes ◯ No ◯

If patient is receiving antipsychotic medication, metabolic side effects, weight gain, the risk of movement disorders, and /or Tardive Dyskinesia was discussed: Yes ◯ No ◯

If the patient is a woman of reproductive age, she has been advised not to get pregnant on medication prescribed: Yes ◯ No ◯

Follow-up appointment date and time: _____

_____ _____

SIGNATURE OF CLINICIAN **DATE**

THE NEXT RIGHT THING

THE NEXT RIGHT THING

345 North Main Street
West Hartford, CT 06107

MASTER TREATMENT PLAN

Admission Date: _____ **Date TP Completed:** _____ **Date of Review:** _____ **Date to start After Care:**_____

Patient Name: _____ **D.O.B:**_____

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V: **Current GAF:**_____ **Past Year GAF:**_____

Rationale for Treatment: _____

Strengths/natural supports that may be incorporated into the treatment plan: _____

Barriers that may obstruct the treatment plan: (*if left blank, it is not applicable. If completed, the barrier must be incorporated into the treatment plan*).

Cognitive/Learning Impairments: _____ **Developmental Disabilities:** _____

Social/Environmental/Spiritual Factors: _____ **Legal/DCF:** _____

Physical Disabilities: _____

Other: _____

Goals/Criteria for Discharge to Aftercare: (Include target dates)
1:

2:

3:

4:

THE NEXT RIGHT THING

345 North Main Street
West Hartford, CT 06107

MASTER TREATMENT PLAN

Date: _____ **Patient Name:** _____ **MR #:** _____

ASAM- Functional Area (FA):	1.Level of risk-harm to self/others	3.Psychological	5.Self Maintenance/ADL's	7.Family
	2. Medical	4.Substance Abuse	6.Interpersonal/Social	8.Occupational/Educational
Treatment Modality (TM):	1.Group Psychotherapy 2.Psychoeducation (specific)	3. Individual Psychotherapy	5.Family Psychotherapy	6.Pharmacotherapy
Stage of Recovery stated in Problem: as evidenced by				

Problem # (progress note reference)	**FA**	**TM**	**PROBLEM** (Must be clearly defined)	**SHORT TERM** (State what patient is going to accomplish)	**INTERVENTION** (State intervention and frequency of intervention)	**LONG TERM GOAL** (Identify Goal # from 1st page)	**Date Goal Completed**

This treatment plan has been agreed upon by the following members of treatment team. (Signature must be legible with appropriate titles)

Clinician Signature/Date

Patient Signature/Date

Medical Director Signature/Date

Greer, Leslie

From:	Greci, Laurie
Sent:	Friday, March 08, 2013 10:54 AM
To:	Greer, Leslie
Subject:	FW: The Next Right Thing, LLC CON Application for Intensive Outpatient Program in West Hartford (13-31822-CON)
Attachments:	13-31822-CON Completeness Letter.docx; 31822 Completeness Letter.pdf

From: Greci, Laurie
Sent: Thursday, March 07, 2013 3:27 PM
To: 'jenifer@NextRightThing.net'
Subject: The Next Right Thing, LLC CON Application for Intensive Outpatient Program in West Hartford (13-31822-CON)

Dear Ms. Simson,

The Certificate of Need application filed with the Department of Public Health, Office of Health Care Access on February 13, 2013, for the establishment of an intensive outpatient behavioral health treatment program in West Hartford has been reviewed. Attached is the completeness letter for your response. The official letter is in .pdf format; for your convenience, I have also attached the MS Word file.

Please feel free to call or email me with any questions.

Regards,

Laurie Greci

Laurie K. Greci
Associate Research Analyst
Department of Public Health
Health Care Access
laurie.greci@ct.gov
860 418-7032
860 418-7053

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

March 7, 2013

Via Electronic Mail Only

Jenifer C. Simson
Executive Director
The Next Right thing, LLC
246 Steele Rd.
West Hartford, CT 06117

RE: Certificate of Need Application; Docket Number: 13-31822-CON
Establishment of an Intensive Outpatient Behavioral Health Treatment Program
CON Completeness Letter

Dear Ms. Simson:

On February 13, 2013, the Department of Public Health ("DPH), Office of Health Care Access ("OHCA") received your initial Certificate of Need ("CON") application filing on behalf of The Next Right Thing, LLC ("Applicant") proposing to establish an intensive outpatient behavioral health treatment program in West Hartford ("Program").

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

1) Please provide population information by age group and by town for the service area identified as West Hartford, Avon, Canton, Farmington and Simsbury.

2) Utilizing the information and statistics provided in the initial CON application and in the documentation provided, determine the number of persons, by group, that will benefit from the proposal. Use the format given in the following table to quantify the number of persons needing the proposal. The first row of the table demonstrates how to quantify the potential number of persons from a single group for a single town. (Note: the numbers are meant to demonstrate the method only). Delete the first row and develop a similar calculation for each group of persons by the towns listed in Question 1. Add additional rows as needed to quantify the total number of persons from the various groups and towns that may benefit from the proposal.

Table 1: Number of Persons in Service Area with Unmet Need

Description of Population	Town	Number of Persons	% Needing Services (but not receiving treatment)*	Number of Persons Needing Services	% of Persons Proposed to be Served by the Applicant	Number of persons that may benefit from proposal
Children in foster care	Hartford	2,500	2%	50 (2,500 * .02)	30%	15 (2,500 * .02 *.60)
Total number of persons that may benefit from proposal:						

*Include documentation that support the percentages used.

3) Please provide Curriculum Vitaes for the officers and directors of The Next Right Thing, LLC that may not have been included with the initial CON application.

4) In the following table, check the corresponding license(s) needed to establish the services listed as part of the proposal that is/are not currently held by the Applicant. Information concerning DPH licensure may be obtained by contacting Sandra Bauer, DPH Facility Licensing, at (860) 509- 8023 or Sandra.Bauer@ct.gov. Licenses to provide behavioral health care to children are under the statutory authority of the Department of Children and Families ("DCF"). Information on DCF licenses may be obtained by contacting Jim McPherson, Program Manager for DCF Licensing Unit, at (860) 550-6532 or Jim.Mcpherson@ct.gov.

Table 2: Licenses Needed by the Applicant for the Proposal

Agency	License	Needed for Proposal (✓)
DPH	Psychiatric Outpatient Clinic for Adults	
	Facility for the Care or the Treatment of Substance Abusive or Dependent Persons (Outpatient)	
	Mental Health Day Treatment Facility	
DCF	Outpatient Psychiatric Clinic for Children	
	Extended Day Treatment	

5) Provide a copy of the articles, studies, or reports that have been cited to support the statements made in this application. If the article or report is excessive in length provide a copy of each relevant section.

6) Concerning the patient payer mix reported on page 43, it states that the program will be 100% covered by reimbursements from commercial insurers. On page 49, however, it states that the payer categories will continue to be self-pay or insurance payers. In addition, there is discussion on charity care on pages 49 and 54. Please revise the payer mix percentages reported on page 43 to agree with the statements made in the initial CON application on pages 43 and 49.

In responding to the questions contained in this letter, please repeat each question before providing your response. Information filed after the initial CON application submission (e.g., completeness response letter, prefile testimony, late file submissions and the like) must be numbered sequentially from the Applicant's document preceding it. **Paginate and date** your response (e.g., each page in its entirety) beginning with Page Number 83. Please reference "Docket Number: 13-31822-CON." Submit one (1) original and four (4) hard copies of your response. Each copy must be fully paginated. In addition, please submit a scanned copy of your response paginated and including all attachments on CD in an Adobe format (.pdf) and in an MS Word format.

Pursuant to Section 19a-639a(c) you must submit your response to this request for additional information not later than sixty days after the date that this request was transmitted. Therefore, please provide your written responses to OHCA no later than May 5, 2013. If you have any questions concerning this letter, please feel free to contact me at (860) 418-7032.

Sincerely,

Laurie K. Greci

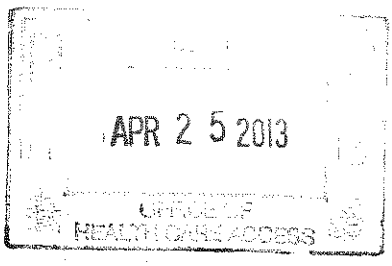
Laurie K. Greci
Associate Research Analyst

Copy of PDF file: Kim Martone, Director of Operations, DPH OHCA
Kevin Hansted, DPH Staff Attorney
Kaila Riggott, CON Supervisor, DPH OHCA

THE NEXT RIGHT THING

The Next Right Thing, LLC
345 North Main Street, Suite 306
West Hartford, CT 06117

April 25, 2013



Ms. Laurie K. Greci
Associate Research Analyst
State of Connecticut
Department of Public Health
Facility Licensing & Investigations Section
410 Capitol Avenue
Hartford, CT 06134-0308

RE: Certificate of Need Application; Docket Number: 13-31822-CON
Establishment of an Intensive Outpatient Behavioral Health Treatment Program
CON Completeness Letter

Dear Ms. Greci:

Thank you for reviewing our CON application and for your request for additional information. The following document is our response to your Completeness Letter dated March 7, 2013.

The attached USB drive includes both WORD and PDF versions of our response and copies of the original CON application.

If you require additional clarification or information, feel free to phone me at 860-236-1499 or email me at Jenifer@NextRightThing.net.

Thank you for your consideration.

Best regards,

Jenifer C. Simson
Co-Founder and Executive Director
The Next Right Thing, LLC

Appendix E – Response to Completeness Letter dated March 7, 2013

RE: Certificate of Need Application; Docket Number: 13-31822-CON
Establishment of an Intensive Outpatient Behavioral Health Treatment Program
CON Completeness Letter

The questions are numbered per Completeness Letter dated March 7, 2013. The questions from the original letter are included.

1) **Please provide population information by age group and by town for the service area identified as West Hartford, Avon, Canton, Farmington and Simsbury.**

Table 1: Population by Age for Towns in the Service Area

Town	Total population	15-19 year olds (2010 US Census)	20-24 year olds (2010 US Census)	Total 2010 Census for 15-24 Year-olds	Estimated 16-23 Year Olds (based on US Census)
Avon	18,098	1,257	459	1,716	1,373
Canton	10,292	628	372	1,000	800
Farmington	25,340	1,572	1,162	2,734	2,187
Simsbury	23,511	1,840	705	2,545	2,036
West Hartford	23,268	4,376	3,009	7,385	5,908
Totals	**140,509**	**9,673**	**5,707**	**15,380**	**12,304**

*The calculation for 16-23year olds is as follows: Total 2010 census for 15-24 year olds times 80%. We multiplied by 80% to take out two years (out of the ten shown) – the 15 year-olds and 24 year-olds.

Please note that the actual number of 15-23 year-olds in the service area is HIGHER than what shows by census due to the large number of private high schools and public/private colleges in the area. On page 20 of our application, we used census from current town websites, CERC, and 2000 census data to estimate 15-24 year-olds. The numbers above are therefore conservative in that they do not include out-or-town high-school and college students nor do they reflect town growth since the last census.

Note – Population numbers are from the US Census Bureau's American FactFinder web-pages: http://factfinder2.census.gov/faces/nav/jsf/pages/community_facts.xhtml#none

Geography: Avon town, Hartford County, Connecticut

Subject	Number	Percent
SEX AND AGE		
Total population	18,098	100.0
15 to 19 years	1,257	6.9
20 to 24 years	459	2.5

Geography: Canton town, Hartford County, Connecticut

Subject	Number	Percent
SEX AND AGE		
Total population	10,292	100.0
15 to 19 years	628	6.1
20 to 24 years	372	3.6

Geography: Farmington town, Hartford County, Connecticut

Subject	Number	Percent
SEX AND AGE		
Total population	25,340	100.0
15 to 19 years	1,572	6.2
20 to 24 years	1,162	4.6

Geography: Simsbury town, Hartford County, Connecticut

Subject	Number	Percent
SEX AND AGE		
Total population	23,511	100.0
15 to 19 years	1,840	7.8
20 to 24 years	705	3.0

Geography: West Hartford town, Hartford County, Connecticut

Subject	Number	Percent
SEX AND AGE		
Total population	63,268	100.0
15 to 19 years	4,376	6.9
20 to 24 years	3,009	4.8

2) **Utilizing the information and statistics provided in the initial CON application and in the documentation provided, determine the number of persons, by group, that will benefit from the proposal. Use the format given in the following table to quantify the number of persons needing the proposal. Develop a similar calculation for each group of persons by the towns listed in Question 1. Add additional rows as needed to quantify the total number of persons from the various groups and towns that may benefit from the proposal.**

Table 1: Number of Persons in Service Area with Unmet Need

Description of population	Town	Number of Persons with substance abuse issues	% Needing Services (but not receiving treatment)*	Number of Persons Needing Services	% of Persons Proposed to be Served by the Applicant	# of persons to benefit from proposal
16-23 year-old residents	Avon	1,373	16.54%	227 (1,370*.1654)	2.95%	7 (227*.0295)
16-23 year-old residents	Canton	800	16.54%	132	2.95%	4
16-23 year-old residents	Farmington	2,187	16.54%	362	2.95%	10
16-23 year-old residents	Simsbury	2,036	16.54%	337	2.95%	10
16-23 year-old residents	West Hartford	5,908	16.54%	977	2.95%	29
	Total Service Area	**12,304**		**2,035**		**60**

*The percent of adolescents needing services but not receiving treatment is taken from (Substance Abuse and Mental Health Services Administration) SAMSA's 2010-2011 National Surveys on Drug Use and Health (NSDUH). The NSDUH is an ongoing survey of the civilian, non-institutionalized population of the United States aged 12 years or older. All estimates are based on a small area estimation (SAE) methodology in which State-level NSDUH data are combined with county and census block group/tract-level data from the State. Two excerpts from relevant tables are included below.

For 18-25 year-olds (the age category that best overlaps our target population) the prevalence in CT for those who need treatment for alcohol in the past year but did not receive it is estimated at 16.54% and for illicit drug use at 6.96%. The degree to which these two prevalence percentages are additive is not clear. We've taken a conservative approach by using 16.54% rather than the total of 23.5%.

Table 22. *Needing But Not Receiving Treatment for Alcohol Use in the Past Year*, by Age Group and State: Percentages, Annual Averages Based on 2010 and 2011 NSDUHs

NOTE: Needing But Not Receiving Treatment refers to respondents classified as needing treatment for alcohol, but not receiving treatment for an alcohol problem at a specialty facility (i.e., drug and alcohol rehabilitation facilities [inpatient or outpatient], hospitals [inpatient only], and mental health centers).

NOTE: State and census region estimates, along with the 95 percent Bayesian confidence (credible) intervals, are based on a survey-weighted hierarchical Bayes estimation approach and generated by Markov Chain Monte Carlo techniques. For the "Total U.S." row, design-based (direct) estimates and corresponding 95 percent confidence intervals are given.

NOTE: The column labeled "Order" can be used to sort the data to the original sort order.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2010 and 2011 (2010 Data - Revised March 2012).

Order	State	12 or Older Estimate	12 or Older 95% CI (Lower)	12 or Older 95% CI (Upper)	12-17 Estimate	12-17 95% CI (Lower)	12-17 95% CI (Upper)	18-25 Estimate	18-25 95% CI (Lower)	18-25 95% CI (Upper)	26 or Older Estimate	26 or Older 95% CI (Lower)	26 or Older 95% CI (Upper)
1	Total U.S.	6.45%	6.24%	6.66%	4.03%	3.78%	4.30%	14.46%	13.98%	14.96%	5.36%	5.10%	5.62%
2	Northeast	6.71%	6.28%	7.17%	4.08%	3.71%	4.50%	15.13%	14.32%	15.98%	5.61%	5.10%	6.16%
3	Midwest	6.64%	6.29%	7.01%	3.87%	3.56%	4.20%	15.20%	14.54%	15.90%	5.50%	5.08%	5.95%
4	South	5.74%	5.43%	6.07%	3.66%	3.36%	3.99%	12.89%	12.29%	13.51%	4.77%	4.40%	5.17%
5	West	7.18%	6.69%	7.71%	4.72%	4.22%	5.27%	15.71%	14.74%	16.72%	5.96%	5.38%	6.61%
6	Alabama	5.05%	4.04%	6.28%	3.35%	2.55%	4.38%	11.31%	9.41%	13.55%	4.16%	3.08%	5.61%
7	Alaska	7.44%	6.05%	9.13%	4.21%	3.24%	5.46%	15.13%	12.63%	18.02%	6.40%	4.83%	8.43%
8	Arizona	7.68%	6.18%	9.50%	4.48%	3.43%	5.83%	16.02%	13.49%	18.91%	6.67%	5.01%	8.85%
9	Arkansas	4.94%	3.93%	6.19%	3.77%	2.86%	4.94%	11.03%	9.17%	13.20%	4.06%	2.97%	5.53%
10	California	7.11%	6.36%	7.94%	5.08%	4.29%	6.02%	15.62%	14.13%	17.23%	5.80%	4.92%	6.82%
11	Colorado	8.09%	6.72%	9.70%	4.47%	3.43%	5.82%	18.75%	16.20%	21.61%	6.67%	5.15%	8.60%
12	Connecticut	6.97%	5.63%	8.59%	4.06%	3.10%	5.29%	16.54%	13.99%	19.45%	5.78%	4.33%	7.68%
13	Delaware	5.89%	4.73%	7.32%	3.55%	2.70%	4.65%	13.82%	11.57%	16.44%	4.84%	3.59%	6.51%

Table 21. *Needing But Not Receiving Treatment for Illicit Drug Use in the Past Year*, by Age Group and State: Percentages, Annual Averages Based on 2010 and 2011 NSDUHs

NOTE: Needing But Not Receiving Treatment refers to respondents classified as needing treatment for illicit drugs, but not receiving treatment for an illicit drug problem at a specialty facility (i.e., drug and alcohol rehabilitation facilities [inpatient or outpatient], hospitals [inpatient only], and mental health centers). Illicit Drugs include marijuana/hashish, cocaine (including crack), inhalants, hallucinogens, heroin, or prescription-type psychotherapeutics used nonmedically, including data from original methamphetamine questions but not including new methamphetamine items added in 2005 and 2006. See Section B.4.8 in Appendix B of the *Results from the 2008 National Survey on Drug Use and Health: National Findings*.

NOTE: State and census region estimates, along with the 95 percent Bayesian confidence (credible) intervals, are based on a survey-weighted hierarchical Bayes estimation approach and generated by Markov Chain Monte Carlo techniques. For the "Total U.S." row, design-based (direct) estimates and corresponding 95 percent confidence intervals are given.

NOTE: The column labeled "Order" can be used to sort the data to the original sort order.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2010 and 2011 (2010 Data - Revised March 2012).

Order	State	12 or Older Estimate	12 or Older 95% CI (Lower)	12 or Older 95% CI (Upper)	12-17 Estimate	12-17 95% CI (Lower)	12-17 95% CI (Upper)	18-25 Estimate	18-25 95% CI (Lower)	18-25 95% CI (Upper)	26 or Older Estimate	26 or Older 95% CI (Lower)	26 or Older 95% CI (Upper)
1	Total U.S.	2.40%	2.28%	2.51%	4.34%	4.10%	4.59%	7.05%	6.73%	7.38%	1.34%	1.22%	1.48%
2	Northeast	2.37%	2.20%	2.57%	4.22%	3.81%	4.68%	7.33%	6.72%	8.00%	1.33%	1.14%	1.55%
3	Midwest	2.24%	2.10%	2.39%	4.02%	3.69%	4.38%	6.64%	6.20%	7.11%	1.25%	1.09%	1.43%
4	South	2.31%	2.17%	2.47%	4.06%	3.73%	4.42%	6.54%	6.09%	7.03%	1.36%	1.20%	1.55%
5	West	2.69%	2.46%	2.94%	5.14%	4.56%	5.77%	7.98%	7.25%	8.79%	1.42%	1.18%	1.70%
6	Alabama	2.14%	1.74%	2.62%	3.74%	2.76%	5.06%	6.34%	4.84%	8.26%	1.20%	0.84%	1.72%
7	Alaska	2.78%	2.22%	3.46%	5.22%	3.88%	6.98%	6.62%	4.95%	8.80%	1.69%	1.13%	2.50%
8	Arizona	2.78%	2.21%	3.50%	5.70%	4.15%	7.80%	7.50%	5.69%	9.84%	1.60%	1.08%	2.35%
9	Arkansas	2.21%	1.80%	2.71%	4.02%	2.99%	5.39%	6.47%	5.03%	8.30%	1.27%	0.89%	1.81%
10	California	2.79%	2.46%	3.18%	5.31%	4.46%	6.30%	8.34%	7.20%	9.65%	1.42%	1.08%	1.87%
11	Colorado	2.58%	2.15%	3.10%	5.05%	3.71%	6.83%	9.26%	7.33%	11.63%	1.13%	0.78%	1.64%
12	Connecticut	2.28%	1.84%	2.82%	3.98%	2.94%	5.36%	6.96%	5.31%	9.07%	1.31%	0.91%	1.89%
13	Delaware	2.34%	1.90%	2.87%	3.84%	2.81%	5.21%	7.04%	5.39%	9.14%	1.38%	0.94%	2.01%

3) **Please provide Curriculum Vitaes for the officers and directors of The Next Right Thing, LLC that may not have been included with the initial CON application.**

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

SUMMARY

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

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

EXPERIENCE

GBM HealthCare Management Resources, LLC 2000-Present

Principal

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

- **Behavioral Health management consultant to The Next Right Thing, LLC** (2011-present)
- Within 6 months of operations created a healthcare management consultation company and contracted with 6 Facility based providers, 1 Integrated Health System, 1 Managed care vendor, and 4 Community Based providers.
- Developed capacity to deliver comprehensive "Operational Analysis" of organizations clinical, financial and Utilization Management processes.
- Established provider accounts receivable systems/process and collected 3.2 million dollars in provider reimbursement.
- Re-contracted for services and rates with 6 HMO Behavioral Health Vendors for 10 facilities and 4 community-based providers.
- Created a State-wide Medicaid network of providers including: Acute-care and Residential Facility providers, community -based Child Guidance Clinics, Family Service Associations, Local Mental Health Clinics, and Federally Qualified Health Clinics.
- Current Client portfolio includes: 10 Facility based providers, 1 Integrated Health System, 3 Managed care vendors, 1 Outsource Billing Company, and 5 Community Based providers.

New England HealthCare Management Services, LLC 1999-2000
Director of Consultation Services

Developed / created consulting company providing managed care contracting, clinical operations, accounts

receivable/management services

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

Behavioral Health Connecticut, LLC, Hartford, CT 1997 - 1999
Network Management & Provider Relations

A State-wide Provider Sponsored Behavioral Health Managed Care/Utilization Management company of the Hartford Health Care Corporation

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

Psych Options East, Inc., Mansfield Center, CT 1995 - 1999
Executive Director

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

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

Natchaug Hospital, Mansfield Center, CT 1989 - 1999
Director of Network Development (1993-1999)

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

- Established the organizational capacity to effectively respond to significant changes in the managed-care, public and governmental payers implementing systems to evaluate market share, target payers, and implement marketing strategies. Since 1993, successfully negotiated 39 contracts for services, covering 98% of the lives in the defined service area.
- Developed the internal information systems and processes to proactively manage contract performance,

monitor payer satisfaction, utilization of services, and reimbursement. Since 1993, have increased third party market share, maintained inpatient census/payer mix, and improved partial hospital census/payer mix during a period of significant state and national reductions in behavioral health expenditures.

Director of Adult Services (1991-1995)

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

Director of Adult Partial Hospital Programs (1989-1991)

·Successfully redesigned the Partial Hospital Social Rehabilitation Model" to acute service providers, incorporating chemi by area providers and payers, 80% growth in admissions and gross revenues increased to $1.5 million.

Aetna Life and Casualty, Middletown, CT **1987 - 1989**
Psychiatric Review Specialist

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

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

Elmcrest Psychiatric Institute, Portland, CT **1980 - 1987**
Director of Outpatient/EAP Services (1986-1987)

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

- Proposed and secured first EAP contract for a local municipality including 11 union contracts, successfully negotiating management and labor issues and obtaining first year 7.2% penetration/utilization rate for employees.

- Designed, developed, and implemented business office and clinical processes, becoming operational in 90 days, and by year-end was providing services to 80 clients weekly (33% above plan).

EDUCATION

MSW, Group Work/Administration 1983
University of Connecticut School of Social Work, West Hartford, CT

B.A., Clinical Psychology 1981
University of Hartford, West Hartford, CT

THE NEXT RIGHT THING

175 Union Street, Rockville, CT 06066•(860)573-6907•kcolt1211@gmail.com

Karen M. Colt, MEd, LADC

Experience

3/13- Present **The Next Right Thing, LLC** West Hartford, CT

Clinician, 3/13-present: Responsible for treatment and discharge planning for adolescents in a community-based substance abuse and mental health program. Leads and co-leads adolescent, parent, and family groups and treats adolescent patients and their families.

5/07-3/13 New Hope Manor, Inc. Manchester, CT

Chief of Clinical Operations, 6/09-present: Responsible for developing, implementing and maintaining clinical programs in non-profit agency with full range of services for adolescent and adult clients, including: supervision of master's level clinical staff; crisis management; quality assurance; training of clinical and milieu staff in treatment models; management of census in all programs; collaborate with DCF at management level; provide clinical input for grant proposals.

Residential Director, 6/08-6/09: Responsible for managing clinical and direct care staff in 20-bed residential for girls ages 12-18 with co-occurring disorders; duties included clinical supervision, collaboration with DCF, program development and management, assessment and intake of residents.

Group Home Director, 5/07-6/08: Responsible for managing clinical and direct care staff in 5-bed therapeutic group home for girls ages 13-21 with mental health and/or substance abuse disorders..

11/96-5/07 Eastern Connecticut Health Network Manchester, CT

Inpatient Social Worker, 6/02-5/07: Responsible for assessment, treatment and discharge planning for adult and adolescent inpatient psychiatric clients; worked within multidisciplinary treatment team; collaborated with DMHAS and DCF funded agencies; participated in Probate Court processes; referred clients to appropriate level of care and community supports at discharge.

Mental Health Counselor, 9/99-6/02: Responsible for direct care to patients on adult psychiatric unit. Developed and ran substance abuse groups for appropriate clients.

Pharmacy Technician: 11/96-9/99: Responsible for filling hospital pharmacy orders.

6/01-6/02 ECHN Manchester, CT

Intern

Inpatient Psychiatric Unit, 2/02-6/02
Partial Hospital Program, 6/01-6/02

Education

6/01-6/02 Cambridge College Cambridge, MA

Master of Education, Counseling Psychology

Additional courses in Addiction Counseling

9/97-5/99 Manchester Community College Manchester, CT

Associate of Science

Drug and Alcohol Rehabilitation Counseling (DARC)

9/74-5/77 University of Connecticut Storrs, CT

Major in Animal Science

Additional Training

Seven Challenges
Initial Training – 2007
Leader Training – 2008

Dialectical Behavior Therapy (DBT)
10 Day Intensive (Behavioral Tech) – 2008

Global Assessment of Individual Needs (GAIN)
Administration Training – 2008
Local Trainer Certification – 2008
Clinical Interpretation Certification – 2011

Multidimensional Family Therapy (MDFT)
Initial Training (ABH) - 2009

Clinical Supervision of Substance Abuse Counselors
Connecticut Certification Board -- 2011

Trauma Focused Cognitive Behavior Therapy (TF-CBT)
2 Day Training - 2012

4) **In the following table, check the corresponding license(s) needed to establish the services listed as part of the proposal that is/are not currently held by the Applicant.**

Table 2: Licenses Needed by the Applicant for the Proposal

Agency	License	Needed for Proposal (✓)
DPH	Psychiatric Outpatient Clinic for Adults	✓
	Facility for the Care or the Treatment of Substance Abusive or Dependent Persons (Outpatient)	✓
	Mental Health Day Treatment Facility	✓
DCF	Outpatient Psychiatric Clinic for Children	✓
	Extended Day Treatment	NO

5) **Provide a copy of the articles, studies, or reports that have been cited to support the statements made in this application. If the article or report is excessive in length provide a copy of each relevant section.**

Copies of Articles and Studies Cited Through-out the Application

The following sources are from Appendix A – References and Bibliography. After each listing (data source), we've referenced the applicable page number and bullet in the original CON application where we have used data or quoted information. A copy of the relevant portion of a study or article along with a web-address follows. When the relevant data is buried in text or data tables, we circled it.

American Psychiatric Association. DSM-IV-TR or Diagnostic and Statistical Manual, edition IV transitional (2000). The DSM-IV-TR provides a classification of mental disorders, criteria sets to guide the process of differential diagnosis, and numerical codes for each disorder to facilitate medical record keeping. The stated purpose of the *DSM* is to: 1) provide "a helpful guide to clinical practice"; 2) "to facilitate research and improve communication among clinicians and researchers"; and3) to serve as "an educational tool for teaching psychopathology." *Referenced on p. 12 bullet number 7 of this CON application*

The five diagnostic axes specified by *DSM-IV-TR* are:

- Axis I: Clinical disorders, including anxiety disorders, mood disorders, schizophrenia and other psychotic disorders.
- Axis II: Personality disorders and mental retardation. This axis includes notations about problematic aspects of the patient's personality that fall short of the criteria for a personality disorder.
- Axis III: General medical conditions. These include diseases or disorders that may be related physiologically to the mental disorder; that are sufficiently severe to affect the patient's mood or functioning; or that influence the choice of medications for treating the mental disorder.
- Axis IV: Psychosocial and environmental problems. These include conditions or situations that influence the diagnosis, treatment, or prognosis of the patient's mental disorder. *DSM-IV-TR* lists the following categories of problems: family problems; social environment problems; educational problems; occupational problems; housing problems; economic problems; problems with access to health care; problems with the legal system; and other problems (war, disasters, etc.).
- Axis V: Global assessment of functioning. Rating the patient's general level of functioning is intended to help the doctor draw up a treatment plan and evaluate treatment progress. The primary scale for Axis V is the Global Assessment of Functioning (GAF) Scale, which measures level of functioning on a scale of 1–100. *DSM-IV-TR* includes three specialized global scales in its appendices: the Social and Occupational Functioning Assessment Scale (SOFAS); the Defensive Functioning Scale; and the Global Assessment of Relational Functioning (GARF) Scale. The GARF is a measurement of the maturity and stability of the relationships within a family or between a couple.

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

Referenced on p.12 bullet number 8 of this CON application

The ASAM Criteria

The ASAM Criteria, also known as the ASAM Patient Placement Criteria, are the result of a collaboration that began in the 1980s to define one national set of criteria for providing outcome-orientated and results based care in the treatment of addiction. Today the criteria have become the most widely used and comprehensive set of guidelines for placement, continued stay and discharge of patients with addictive disorders and the ASAM Criteria are required in over 30 states.

The ASAM Criteria is an indispensable resource that addiction medicine professionals rely on to provide a nomenclature for describing the continuum of addiction services.

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

http://www.ct.gov/dph/cwp/view.asp?q=476708&a=3987 *Referenced on p. 16*

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

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

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

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

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

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

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

DiClemente, Carlo and James Prochaska. Stages of Change Model. Developed in the late 1970's and early 1980's, the Stages of Change Model is applied to a broad range of behaviors including weight loss, injury prevention, overcoming alcohol, and drug problems. For more on The Stages of Change model, see: http://www.addictioninfo.org/articles/11/1/Stages-of-Change-Model/Page1.html. *The model is referenced on p. 11 first bullet* Excerpt from article:

Stages of Change Model

Stages of Change Theory

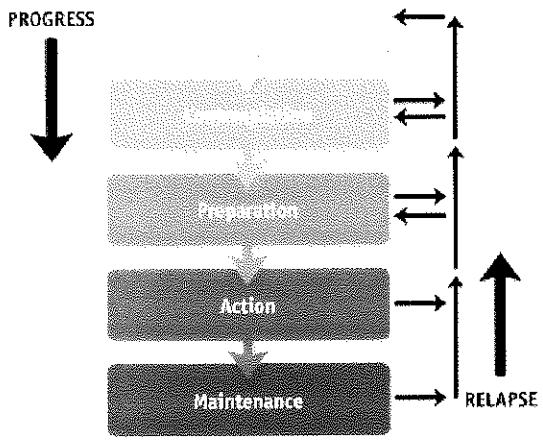
The Stages of Change Model was originally developed in the late 1970's and early 1980's by James Prochaska and Carlo DiClemente at the University of Rhode Island when they were studying how smokers were able to give up their habits or **addiction**.

Addiction: The negative end state of a syndrome (of neurobiological and psychosocial causes) resulting in continued or increasing repetitive involvement despite consequences and conscious efforts to discontinue the behavior. Addiction to any particular substance or behavior is seen mainly as a matter of personal vulnerability, exposure and access, and the capacity to produce a desirable shift in mental state.

This definition was originally formulated by Howard J. Shaffer, Ph.D., C.A.S. Harvard Medical School, Division on Addictions.

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

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



The Stages of Change

The stages of change are:

Precontemplation (Not yet acknowledging that there is a problem behavior that needs to be changed)

Contemplation (Acknowledging that there is a problem but not yet ready or sure of wanting to make a change)

Preparation/Determination (Getting ready to change)

Action/Willpower (Changing behavior)

Maintenance (Maintaining the behavior change) and

Relapse (Returning to older behaviors and abandoning the new changes)

Drake, Robert MD. NAMI National Alliance on Mental Illness. (September 2003). Dual Diagnosis and Integrated Treatment of Mental Illness and Substance Abuse Disorder. http://www.nami.org/Template.cfm?Section=By_Illness&Template=/TaggedPage/TaggedPageDisplay.cfm&TPLID=54&ContentID=23049. *References the need for The Next Right Thing to be dual diagnosis capable on p. 37 of this CON application*

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

What are dual diagnosis services?

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

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

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

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

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

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

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

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

The ECA Survey found that individuals with severe mental disorders were at significant risk for developing a substance use disorder during their lifetime. Specifically:

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

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

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

For the consumer, the consequences are numerous and harsh. Persons with a co-occurring disorder have a statistically greater propensity for violence, medication noncompliance, and failure to respond to treatment than consumers with just substance abuse or a mental illness. These problems also extend out to these consumers' families, friends and co-workers.

Purely health wise, having a simultaneous mental illness and a substance abuse disorder frequently leads to overall poorer functioning and a greater chance of relapse. These consumers are in and out of hospitals and treatment programs without lasting success. People with dual diagnoses also tend to have tardive dyskinesia (TD) and physical illnesses more often than those with a single disorder, and they experience more episodes of psychosis. In addition, physicians often don't recognize the presence of substance abuse disorders and mental disorders, especially in older adults.

Socially, people with mental illnesses often are susceptible to co-occurring disorders due to "downward drift." In other words, as a consequence of their mental illness they may find themselves living in marginal neighborhoods where drug use prevails. Having great difficulty developing social relationships, some people find themselves more easily accepted by groups whose social activity is based on drug use. Some may believe that an identity based on drug addiction is more acceptable than one based on mental illness.

Consumers with co-occurring disorders are also much more likely to be homeless or jailed. An estimated 50 percent of homeless adults with serious mental illnesses have a co-occurring substance abuse disorder. Meanwhile, 16% of jail and prison inmates are estimated to have severe mental and substance abuse disorders. Among detainees with mental disorders, 72 percent also have a co-occurring substance abuse disorder.

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

Green, Rick. Courant.com. Teen Pot Use at 30-Year Peak – Are We Too Lax? June 25, 2012.

http://articles.courant.com/2012-06-25/health/hc-green-marijuana-0626-20120625_1_medical-marijuana-marijuana-study-pot *Referenced on pp.25-26 bullet #11*

Rick Green: Teen Pot Use at 30-Year Peak - Are We Too Lax?

June 25, 2012|Rick Green

Decriminalizing pot and opening the door to medical marijuana seems like the right thing. We've wasted millions of taxpayer dollars in a futile effort to block use of something that seems less harmful than alcohol.

I'm sure of it, just like I can't think of anything more pointless than a small-time pot arrest.

And yet.

Is there some threshold we are crossing here, particularly for those of us who grew up in the largely benign marijuana haze of the 1970s and 1980s, who now have teenage children living in a far different illicit drug world?

"Marijuana is not as innocent as it is being perceived," said Yifrah Kaminer, a professor of psychiatry and pediatrics at the University of Connecticut Health Center and who directs something called the Adolescent Treatment of Marijuana Study. Kaminer spends a good deal of his time trying to help area kids who can't kick their marijuana addiction. Often, they come from communities where folks don't want to talk about a surge in marijuana use.

"The law has never been so lax," Kaminer said. "The messages are so confusing."

In the last few weeks, we've heard about state officials drawing a plan for dispensing medical marijuana in response to a new law approved by the General Assembly this year. Last week, a man showed up in downtown Hartford with a prototype vending machine for pot. A teacher and lacrosse coach at Northwest Catholic High School was arrested for allegedly running a homegrown marijuana operation out of his Bloomfield home. President Obama's youthful dalliance with weed has been meticulously detailed in a new biography by David Maraniss.

"It's all over the place. These kids tell us marijuana is fine," Kaminer said, noting that's not quite the case: the concentration of pot's active ingredient has spiked, making today's weed far more potent than those joints at the Dead shows back in '79. "This is going to become a bigger problem."

I stopped by Kaminer's office because he's been telling me for months that society's increasingly casual attitudes toward weed may be leading us down a disastrous path, at least when it comes to creating a fresh crop of teenage pot addicts. I'm troubled but not convinced, since it seems like decades of screwed-up drug laws have pretty effectively created generations of addicts and needlessly ruined lives for relatively petty offenses.

But I have a hard time dismissing Kaminer.

We've seen more cases of early onset schizophrenia. [Marijuana] increases the chance for early onset schizophrenia by 10 percent," Kaminer said. "This is one of the issues that are a major concern for us."

Kaminer warns about the effect of pot on the still-developing teenage brain, about the danger of driving under the influence of pot being as risky as driving drunk and the link between drug use and psychiatric disorders in young people.

A researcher who has been studying addiction and marijuana for decades, Kaminer treats hundreds of teenagers from throughout the Hartford area who are part of his study. These kids can be chronic smokers of marijuana – suffering from "cannabis use disorder" – who come on their own or who are referred to his program by the courts.

Kaminer's worry is buttressed by a long-running study of adolescent behavior at the University of Michigan that shows a steady rise in marijuana use by teenagers across the land during the last decade. The "Monitoring the Future" study reports that daily pot use is at a 30-year peak among teenagers – about 1 in every 15 high school seniors report toking up at least daily.

More significantly, the survey of nearly 50,000 students in 8th,10th and 12th grade also shows that fewer teenagers see what scientists call "perceived risk" from using marijuana. Disapproval rates have also dropped, suggesting usage will continue to rise. Students in the U.S. trail only those in France and Monaco in use of marijuana or hashish during the last 30 days, the Michigan researchers recently reported.

The issue isn't whether adults use pot. That's their business, Kaminer said. What's missing from the discussion is what's happening to our teenagers.

"When we make decisions such as approving medical marijuana and reducing fines, the message we send to adolescents is 'No big deal'," Kaminer said. "How can we then ask them not to use it?"

Hastings, Richard. Ridgefield Patch. Teen Deaths Related to Prescription Drug Abuse Skyrocket, April 20, 2012.

http://ridgefield.patch.com/articles/teen-death-s-related-to-prescription-drug-abuse-skyrocket.

Referenced on p.22 bullet #8 of this CON application

Teen Deaths Related to Prescription Drug Abuse Skyrocket

How You Can Help to Prevent a Leading Cause of Teen Accidents and Deaths

By Richard Hastings April 20, 2012

The Center for Disease Control and Prevention (CDC) released a rather alarming statistic this week regarding teen deaths. The incidents of teen fatalities related to poisonings among 15 to 19 year olds increased more than 90% between 2000 and 2009. The CDC's report states that this is a result of our country's epidemic of prescription drug abuse.

Although many teens might otherwise shy away from illegal street drugs, more and more teens are turning to prescription drugs and over the counter medicines to get high. These drugs include pain killers that might be prescribed after a person undergoes surgery, depressants that are taken for sleep aid, depression or anxiety or stimulants such as those used for ADHD. The over the counter medicines include cough medicine and cold remedies. Narcotic pain killers like Vicodin, OxyContin, Percocet or Lortab, including the generics such as methadone and hydrocodone are highly addictive and are very dangerous.

Sadly, each day 2,500 students from 12 to 17 abuse a pain relieving drug for the first time. In fact, prescription medicine is the second most abused drug other than marijuana. Most teenagers obtain these prescription meds by stealing them from their parent's medicine cabinets and even share them with friends or sell them at school. So one easy way that parents can help reduce incidents of prescription medication abuse is to make sure that all old, unused prescription medication, especially the pain medication we receive after surgery is properly disposed of so they are not available to children who might otherwise experiment with them.

Next Saturday, April 28, 2012 from 10am to 2pm, The Drug Enforcement Administration (DEA) has scheduled its fourth National Prescription Drug Take-Back Day. This provides all of us with an opportunity [for those] who have accumulated unwanted prescription medicines to safely dispose of those drugs. The last DEA sponsored event collected almost 200 tons of unwanted or expired medications. The total collected in the three prior events amounted to almost 500 tons of medicines.

DEA Administrator Michele Leonhart stated "The amount of prescription drugs turned in by the American public during the past three Take-Back Day events speaks volumes about the need to develop a convenient way to rid homes of unwanted or expired prescription drugs." To find out the nearest law enforcement office taking part in the program, please visit the Collection Site Locator.

This very important, and obviously much needed service, could give new meaning to Spring Cleaning and could help to prevent a serious injury or death. Please take the time to participate in this very worthwhile event as our greatest responsibility as parents is to help ensure our children's safety.

Richard P. Hastings is a Connecticut personal injury lawyer at Hastings, Cohan & Walsh, LLP, with offices throughout the state. A graduate of Fordham Law School, he has been named a New England Super Lawyer and is the author of the books: "The Crash Course on Child Injury Claims"; "The Crash Course on Personal Injury Claims in Connecticut" and "The Crash Course on Motorcycle Accidents." He has also co-authored the bestselling book "Wolf in Sheep's Clothing- What Your Insurance Company Doesn't Want You to Know and Won't Tell You Until It's Too Late!" He can be reached at 1(888) CTLAW-00 or by visiting www.hcwlaw.com.

Johnston, L. D., O'Malley, P. M., Bachman, J. G., & Schulenberg, J. E. (2012). Monitoring the Future: national survey results on drug use, 1975–2011: Volume I, Secondary school students. Ann Arbor: Institute for Social Research, The University of Michigan. http://www.monitoringthefuture.org/pubs/monographs/mtf-overview2010.pdf (See p. 5 of overview) *Referenced on p. 22 bullet #6*

Summary of Key Findings

<...>The most important findings to emerge from the 2010 survey were the following: ***Marijuana*** use, which had been rising among teens for the past two years, continued to rise in 2010 in all prevalence periods for all three grades. This stands in stark contrast to the long, gradual decline that had been occurring over the preceding decade. Of relevance, perceived risk for marijuana has been falling in recent years. Of particular relevance, ***daily marijuana use*** increased significantly in all three grades in 2010; and stands at 1.2%, 3.3%, and 6.1% in grades 8, 10, and 12. In other words, nearly one in sixteen high school seniors today is a current daily, or near-daily, marijuana user.

<...>

Cocaine and ***powder cocaine*** use continued gradual declines in all grades in 2010, though the one-year change did not reach statistical significance. ***Sedative*** use and use of ***narcotics other than heroin***, which are reported only for 12th graders, similarly continued their slow, non-significant declines in 2010. ***Vicodin*** use decreased significantly only among 12th graders in 2010, with annual prevalence falling from 9.7% in 2009 to 8.0% in 2010. Even at 8%, it remains one of the most widely used illicit drugs.

The use of quite a number of drugs held fairly steady in 2010. These included an index of the use of ***any illicit drug other than marijuana***, ***LSD***, ***hallucinogens other than LSD*** taken as a class, ***PCP***, ***crack cocaine***, ***heroin*** without using a needle, ***OxyContin***, ***amphetamines*** (***Ritalin*** and ***Adderall*** specifically), ***methamphetamine***, ***crystal methamphetamine***, ***tranquilizers***, ***cough and cold medicines*** taken to get high, several so-called "club drugs" (***Rohypnol***, ***GHB***, and ***ketamine)***, and ***anabolic steroids***. Use of most of these drugs is at or below peak levels, in particular methamphetamine and crystal methamphetamine. In fact, annual use of methamphetamine is down in all three grades by between 60% and 80% since 1999, when its use was first measured. The drugs that are not down much from peak levels are the ***narcotics other than heroin***; their continued high rate of use is among the more disturbing findings from the 2010 survey.

Murray, Rheana. New York Daily News (June 2012). Heroin use among suburban teens skyrockets; Experts say prescription pills are the new gateway drug. http://www.nydailynews.com/life-style/health/heroin-soars-suburban-teens-talk-heroin-problem-talking-prescription-drug-problem-article-1.1099140. *Referenced on p. 23 bullet #9*

Heroin use among suburban teens skyrockets; Experts say prescription pills are the new gateway drug

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

Heroin use among teenagers is increasing at an alarming rate as experts say the drug, long considered to be prevalent only in urban areas, is infiltrating the suburbs. All across suburban America, young people are getting hooked on a drug parents never suspected they needed to fear.

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

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

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

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

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

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

"It's hard to talk about the heroin problem without talking about the prescription drug problem," Rafael Lemaitre, of the White House Office of National Drug Control Policy told NBC News.
Death from prescription drugs tripled between 2000 and 2008, according to national data from the Centers for Disease Control and Prevention.

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

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

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

National Survey on Drug Use and Health (NSDUH) (2010). Results from the 2010 National Survey on Drug Use and Health: Summary of National Findings.

http://www.samhsa.gov/data/NSDUH/2k10NSDUH/2k10Results.pdf

http://www.samhsa.gov/newsroom/advisories/1109075503.aspx *Referenced on pp. 20-21 bullet #1 of this CON application*

SAMHSA News Release

Date: 9/8/2011 9:30 AM
Media Contact: SAMHSA Press Office
Telephone: 240-276-2130

National survey shows a rise in illicit drug use from 2008 to 2010
Increased rates of marijuana use drive increase, especially among young adults

The use of illicit drugs among Americans increased between 2008 and 2010 according to a national survey conducted by the Substance Abuse and Mental Health Services Administration (SAMHSA). The National Survey on Drug Use and Health (NSDUH) shows that 22.6 million Americans 12 or older (8.9-percent of the population) were current illicit drug users. The rate of use in 2010 was similar to the rate in 2009 (8.7-percent), but remained above

the 2008 rate (8- percent).
An increased rate in the current use of marijuana seems to be one of the prime factors in the overall rise in illicit drug use. In 2010, 17.4 million Americans were current users of marijuana - compared to 14.4 million in 2007. This represents an increase in the rate of current marijuana use in the population 12 and older from 5.8-percent in 2007 to 6.9-percent in 2010.
Another disturbing trend is the continuing rise in the rate of current illicit drug use among young adults aged 18 to 25 -- from 19.6-percent in 2008 to 21.2-percent in 2009 and 21.5-percent in 2010. This increase was also driven in large part by a rise in the rate of current marijuana use among this population.

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

Referenced on pp. 39-40 regarding NIDA guidelines. Excerpt below:

Principles of Effective Treatment

1. **Addiction is a complex but treatable disease that affects brain function and behavior.** Drugs of abuse alter the brain's structure and function, resulting in changes that persist long after drug use has ceased. This may explain why drug abusers are at risk for relapse even after long periods of abstinence and despite the potentially devastating consequences.
2. **No single treatment is appropriate for everyone.** Treatment varies depending on the type of drug and the characteristics of the patients. Matching treatment settings, interventions, and services to an individual's particular problems and needs is critical to his or her ultimate success in returning to productive functioning in the family, workplace, and society. <...>

PR Newswire-US Newswire (April 6, 2011). National Study Confirms Teen Drug Use Trending in Wrong Direction: Marijuana, Ecstasy Use Up Since 2008, Parents Feel Ill-Equipped to Respond. http://m.prnewswire.com/news-releases/national-study-confirms-teen-drug-use-trending-in-wrong-direction-marijuana-ecstasy-use-up-since-2008-parents-feel-ill-equipped-to-respond-119302034.html *Referenced on p.22 bullet #7*

National Study Confirms Teen Drug Use Trending in Wrong Direction: Marijuana, Ecstasy Use Up Since 2008, Parents Feel Ill-Equipped to Respond

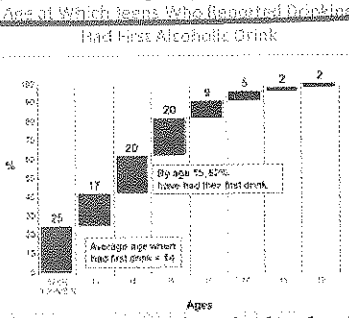
62 Percent of Teens Who Reported Alcohol Use Had First Drink by Age 15

NEW YORK, April 6, 2011 /PRNewswire-US Newswire/ -- Following a decade of steady declines, a new national study released today by The Partnership at Drugfree.org and MetLife Foundation indicates that teen drug and alcohol use is headed in the wrong direction, with marked increases in teen use of marijuana and Ecstasy over the past three years. The 22nd annual Partnership Attitude Tracking Study (PATS), sponsored by MetLife Foundation, affirms a disturbing trend that has emerged among American teens since 2008 and highlights that as underage drinking becomes more normalized among adolescents, parents feel unable to respond to the negative shifts in teen drug and alcohol use.

According to the three-year trend confirmed in this year's 2010 PATS data, there was a significant 67 percent increase in the number of teens who reported using Ecstasy in the past year (from 6 percent in 2008 to 10 percent in 2010). Similarly, past-year marijuana use among teens increased by a disturbing 22 percent (from 32 percent in 2008 to 39 percent in 2010).

Youth Drinking More Normalized: Majority of Teens Surveyed Report First Alcohol Drink by Age 15
The new data underscore alarming patterns in early adolescent alcohol use and found that teens view drinking alcohol – even heavy drinking – as less risky than using other substances.

- Of those teens who reported alcohol use, a majority (62 percent) said they had their first full alcoholic drink by age 15, not including sipping or tasting alcohol.
- Of those teens who reported alcohol use, one in four (25 percent) said they drank a full alcoholic drink for the first time by age 12 or younger.
- Among teens who reported drinking alcohol, the average age of first alcohol use was 14.



"As teen drug and alcohol use take a turn for the worse, a heavier burden is placed squarely on the shoulders of parents – who need to take an active role in preventing substance abuse in their families, take action if they suspect their child is using and get immediate help for a child who has developed a problem with drugs or drinking," said Steve Pasierb, President and CEO of The Partnership at Drugfree.org. "We are troubled, but not completely surprised, by these numbers because, in schools and communities across the country, support for drug education and prevention programs has been cut drastically due to budgetary pressures."

Teens See Little Risk in Heavy Drinking; Parents Feel They Can't Stop Risky Behavior

Weak perceptions of risk and a perceived "normalization" of underage drinking underlie the PATS survey data on adolescent alcohol use.

- Almost half of teens (45 percent) reported they do not see a "great risk" in heavy daily drinking.
- Only 31 percent of teens strongly disapprove of teens and peers their age getting drunk.
- A majority of teens, seven out of 10 (73 percent), report having friends who drink alcohol at least once a week.

While the number one reason teens reported using alcohol is that they think "it's fun to drink" (60 percent), a significant number of teens reported using alcohol to deal with stress.

- One in three (32 percent) teens said they drank "to forget their troubles."
- Almost one in four (24 percent) said they used alcohol to help them "deal with problems at home."
- One in five (20 percent) teens reported they drank to "deal with the pressures and stress of school."

It's important to note that teens who begin drinking before the age of 15 are much more likely than other teens to develop problems with alcohol as adults(1).

The PATS survey also found that parents feel unprepared to respond to underage drinking by their children. Almost a third of parents (28 percent) feel "there is very little parents can do to prevent their kids from trying alcohol." One in three teens (32 percent) thinks their parents would be ok if they drank beer once in a while; yet only one in ten parents agrees with teens drinking beer at a party.

"These findings should serve as a call to action for parents," said Dennis White, President and CEO of MetLife Foundation. "We encourage parents and caregivers to pay attention to the warning signs of teen drinking and other drug use, in order to intervene early and effectively. If you suspect a problem, do not wait to get help for a child who is struggling with substance abuse or addiction."

Time To Get Help: Resource to Help Parents Intervene and Get Treatment for Addiction in Their Families

For parents who suspect or know their child is using drugs or alcohol, The Partnership at Drugfree.org created Time To Get Help, a first-of-its-kind website and online community to provide parents of teens and young adults with lifesaving information when families are in crisis and facing a child's addiction.

With teen drug and alcohol use on the rise, the likelihood that more young people will need treatment increases. Of the nine million American teens and young adults needing treatment, two million are between the ages of 12-17, and ninety percent of those are not getting the help they need(2).

Time To Get Help offers parents and caregivers comprehensive insight into adolescent alcohol and drug abuse, dependence and addiction; support from top experts and other parents who have been there; and treatment options for their child and family.

No Improvement in Teen Abuse of Rx/OTC Drugs, Inhalants, Cigarettes, Meth, Cocaine/Crack, Heroin

According to the PATS survey, teen abuse of prescription (Rx) medicines continues to be an area of major concern, with abuse rates holding steady and at levels that should be worrisome to parents. The data found one in four teens (25 percent) reported taking a prescription drug not prescribed to them by a doctor at least once in their lives, and more than one in five teens (23 percent) used a prescription pain reliever not prescribed to them by a doctor. Teen past-year use of over-the-counter (OTC) cough medicine has remained at roughly one in ten (11 percent).

Past-year teen inhalant abuse remains at 10 percent, yet only 60 percent of teens strongly agree that "sniffing or huffing things to get high can kill you," significantly less than the 70 percent of teens who said the same in 2008. Inhalant abuse merits careful monitoring – as teen attitudes towards inhalant abuse weaken, abuse is more likely to increase.

Teen smoking rates have remained stable with 27 percent of teens reporting smoking cigarettes in the past month. Among teens, past-year methamphetamine use is holding at 5 percent and cocaine/crack is at 9 percent. Teen use of heroin use remains low at 4 percent for lifetime use.

For more information, or to view the full PATS report, please visit drugfree.org.

Rehmer MSN, Patricia. CT Commissioner Department of Mental Health and Addiction Services before the Public Health Committee on 3/7/2012. Speaking in favor of HB 5063 that would allow Narcan to be prescribed more broadly. Narcan or Naloxone "is used to counteract drug overdoses." http://www.ct.gov/dmhas/lib/dmhas/legislative/lt3.7.12.pdf *referenced on page 21 bullet # 5*

Testimony by Patricia Rehmer, MSN, Commissioner
Department of Mental Health and Addiction Services
Before the Public Health Committee
March 7, 2012

Good morning Sen. Gerratana, Rep. Ritter, and distinguished members of the Public Health Committee. I am Commissioner Patricia Rehmer of the Department of Mental Health and Addiction Services, and I am here this morning to speak in favor of, **HB 5063 AN ACT CONCERNING TREATMENT FOR A DRUG OVERDOSE** and **HB 5064 AN ACT CONCERNING THE DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES' REPORTING REQUIREMENTS**. I want to thank the Committee for your assistance in raising these proposals.

HB 5063 would allow a broader group of individuals to be prescribed a drug called Narcan or Naloxone which is used to counteract drug overdoses. The current statute allows the drug to be prescribed to individuals suffering from addiction. However, an individual who has overdosed becomes unable to self- administer. This proposal would allow family members, significant others, roommates and the like to have Narcan on hand should the situation warrant it.

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

SAMHSA (Substance Abuse and Mental Health Services Administration), Center for Behavioral Health Statistics and Quality (formerly the Office of Applied Studies) (2007 and 2009). Treatment Episode Data Set. National Admissions to Substance Abuse Treatment Services. http://www.samhsa.gov/data/2k9/201/201AdHeroinTx2k9.htm *Referenced on p. 21 bullet #3 and bullet #4.* Excerpt below:

Treatment Episode Data Set

The TEDS Report

December 3, 2009

Characteristics of Adolescent Heroin Admissions

- In 2007, there were just over 1,600 adolescent substance abuse treatment admissions for heroin abuse
- On average, adolescent heroin admissions were 14.8 years old when they first used heroin and 16.3 years old at admission to treatment, indicating approximately 18 months of use before entering treatment
- More than half (56 percent) of adolescent heroin admissions had at least one prior treatment episode

Heroin is a highly addictive opiate with a large potential for abuse. It poses a considerable danger for adolescents, potentially resulting in serious psychological, social, educational, and legal consequences. Heroin use can also result in significant health problems including overdose and death, and, if sharing needles or other injection equipment, exposure to HIV, hepatitis C, and other diseases.

Using data from the 2007 Treatment Episode Data Set (TEDS), this report examines the characteristics of substance abuse treatment admissions aged 12 to 17 reporting heroin abuse. TEDS collects information on up to three substances of abuse at the time of admission. Of the approximately 132,000 adolescent substance abuse treatment admissions in 2007, slightly more than 1,600 reported heroin as a primary, secondary, or tertiary substance of abuse. Understanding the characteristics of adolescent admissions reporting heroin abuse may help treatment providers offer age-appropriate services, including behavioral support and pharmacotherapy, to help reduce heroin use and associated negative consequences in this population.

SAMHSA, Center for Behavioral Health Statistics and Quality (formerly the Office of Applied Studies), National Survey on Drug Use and Health. (2008 and 2009) http://www.samhsa.gov/data/2k9State/WebOnlyTables/CT.pdf (CT data) *Referenced on pp. 20-21bullet #1*

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CONNECTICUT

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

Measure	12+	12-17	18-25	26+	18+
ILLICIT DRUGS					
Past Month Illicit Drug Use[1]	281	30	91	141	231
Past Year Marijuana Use	368	46	134	188	322
Past Month Marijuana Use	212	24	82	106	188
Past Month Use of Illicit Drugs Other Than Marijuana[1]	100	13	31	56	88
Past Year Cocaine Use	61	4	23	35	57
Past Year Nonmedical Pain Reliever Use	111	14	38	59	97
Perception of Great Risk of Smoking Marijuana Once a Month	969	82	65	822	887
Average Annual Number of Marijuana Initiates[2]	34	17	15	2	17
ALCOHOL					
Past Month Alcohol Use	1,736	54	246	1,436	1,683
Past Month Binge Alcohol Use[3]	792	38	170	583	754
Perception of Great Risk of Drinking Five or More Drinks Once or Twice a Week	1,195	117	117	961	1,078
Past Month Alcohol Use (Persons Aged 12 to 20)[4]	129[5]	--	--	--	--
Past Month Binge Alcohol Use (Persons Aged 12 to 20)[3]	99[5]	--	--	--	--
TOBACCO PRODUCTS					
Past Month Tobacco Product Use[6]	744	31	151	561	712
Past Month Cigarette Use	629	25	133	472	605
Perception of Great Risk of Smoking One or More Packs of Cigarettes Per Day	2,175	203	251	1,721	1,972
PAST YEAR DEPENDENCE, ABUSE, AND TREATMENT[7]					
Illicit Drug Dependence[8]	55	7	21	27	48
Illicit Drug Dependence or Abuse[8]	86	13	33	40	73
Alcohol Dependence	102	6	26	70	96
Alcohol Dependence or Abuse	253	17	73	165	236
Alcohol or Illicit Drug Dependence or Abuse[8]	287	23	86	179	265
Needing But Not Receiving Treatment for Illicit Drug Use[8,9]	75	12	29	35	63
Needing But Not Receiving Treatment for Alcohol Use[9]	244	17	71	156	227
PAST YEAR MENTAL HEALTH					
Had at Least One Major Depressive Episode[10]	--	23	29	127	156
Serious Mental Illness[9,11]	--	--	30	86	116
Any Mental Illness[9,11]	--	--	121	399	521
Had Serious Thoughts of Suicide	--	--	24	80	104

-- Not available.

NOTE: Estimates are based on a survey-weighted hierarchical Bayes estimation approach.

[1] Illicit Drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically. Illicit Drugs Other Than Marijuana include cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically. These estimates are based on data from original questions, excluding those on the use of over-the-counter drugs or new methamphetamine items that were added in 2005 and 2006. See Section B.4.8 in Appendix B of the *Results from the 2008 National Survey on Drug Use and Health: National Findings*.

[2] *Average annual number of marijuana initiates* = $\bar{x}_i$, where $\bar{x}_i$ is the number of marijuana initiates in past 24 months.

[3] 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.

[4] Underage drinking is defined for persons aged 12 to 20; therefore, the "Total" estimate reflects that age group and not persons aged 12 or older.

[5] Tobacco Products include cigarettes, smokeless tobacco (i.e., chewing tobacco or snuff), cigars, or pipe tobacco.

[6] Dependence or abuse is based on definitions found in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV).

[7] Needing But Not Receiving Treatment refers to respondents classified as needing treatment for illicit drugs (or alcohol), but not receiving treatment for an illicit drug (or alcohol) problem at a specialty facility (i.e., drug and alcohol rehabilitation facilities [inpatient or outpatient] hospitals [inpatient only], and mental health centers).

[8] Major depressive episode is defined as in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV), which specifies a period of at least 2 weeks when a person experienced a depressed mood or loss of interest or pleasure in daily activities and had a majority of specified depression symptoms. There are minor wording differences in the questions in the adult and adolescent major depressive episode modules. Therefore, data from youths aged 12 to 17 were not combined with data from persons aged 18 or older to get an overall estimate (12 or older).

[9] For more details, see Section A.11 in Appendix A of the report on *State Estimates of Substance Use and Mental Disorders from the 2008-2009 NSDUHs*.

[10] Serious mental illness is defined as having a diagnosable mental, behavioral, or emotional disorder, other than a substance use disorder, that met the criteria found in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) and resulted in serious functional impairment.

[11] Any mental illness is defined as having a diagnosable mental, behavioral, or emotional disorder, other than a substance use disorder, that met the criteria found in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV).

Source: SAMHSA, Center for Behavioral Health Statistics and Quality (formerly the Office of Applied Studies), National Survey on Drug Use and Health, 2008 and 2009.

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CONNECTICUT

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

Measure	12+	12-17	18-25	26+	18+
ILLICIT DRUGS					
Past Month Illicit Drug Use[1]	8.90	10.27	24.91	6.19	8.75
Past Year Marijuana Use	12.53	16.89	29.60	8.24	12.17
Past Month Marijuana Use	7.24	8.37	22.52	4.68	7.12
Past Month Use of Illicit Drugs Other Than Marijuana[1]	3.42	4.43	8.60	2.48	3.31
Past Year Cocaine Use	2.07	1.25	6.19	1.52	2.16
Past Year Nonmedical Pain Reliever Use	3.79	4.96	10.50	2.59	3.67
Perception of Great Risk of Smoking Marijuana Once a Month	33.12	28.63	17.81	36.10	33.60
Average Annual Rate of First Use of Marijuana[2]	2.15	7.10	9.06	0.13	1.24
ALCOHOL					
Past Month Alcohol Use	59.32	18.05	67.76	63.07	63.72
Past Month Binge Alcohol Use[3]	27.03	13.31	46.83	25.62	28.52
Perception of Great Risk of Drinking Five or More Drinks Once or Twice a Week	40.83	40.68	32.27	42.11	40.85
Past Month Alcohol Use (Persons Aged 12 to 20)	31.08[4]	--	--	--	--
Past Month Binge Alcohol Use (Persons Aged 12 to 20)[3]	23.70[4]	--	--	--	--
TOBACCO PRODUCTS					
Past Month Tobacco Product Use[5]	25.40	10.92	41.56	24.65	26.96
Past Month Cigarette Use	21.49	8.64	36.30	20.72	22.88
Perception of Great Risk of Smoking One or More Packs of Cigarettes Per Day	74.28	70.44	69.10	75.58	74.70
PAST YEAR DEPENDENCE, ABUSE, AND TREATMENT[6]					
Illicit Drug Dependence[7]	1.89	2.52	5.90	1.17	1.82
Illicit Drug Dependence or Abuse[7]	2.92	4.38	9.11	1.76	2.76
Alcohol Dependence	3.48	2.08	7.24	3.06	3.53
Alcohol Dependence or Abuse	4.63	5.95	20.68	3.16	4.92
Alcohol or Illicit Drug Dependence or Abuse[7]	6.80	7.82	23.67	4.85	6.01
Needing But Not Receiving Treatment for Illicit Drug Use[8,9]	2.55	4.06	7.86	1.53	2.39
Needing But Not Receiving Treatment for Alcohol Use[9]	8.31	5.75	19.49	6.86	8.59
PAST YEAR MENTAL HEALTH					
Had at Least One Major Depressive Episode[10]	--	7.96	8.00	5.57	5.90
Serious Mental Illness[9,10]	--	--	8.13	3.79	4.39
Any Mental Illness[9,11]	--	--	33.41	17.53	19.70
Had Serious Thoughts of Suicide	--	--	6.61	3.52	3.94

-- Not available.

NOTE: Estimates are based on a survey-weighted hierarchical Bayes estimation approach.

[1] Illicit Drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically. Illicit Drugs Other Than Marijuana include cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically. These estimates are based on data from original questions, excluding those on the use of over-the-counter drugs or new methamphetamine items that were added in 2005 and 2006. See Section B4.8 in Appendix B of the *Results from the 2008 National Survey on Drug Use and Health: National Findings*.

[2] *Average annual marijuana initiation rate* = $100 * \{[X_1 - (0.5 * X_1 + X_2)] \div 2\}$, where X_1 is the number of marijuana initiates in the past 24 months and X_2 is the number of persons who never used marijuana. Both of the computation components, X_1 and X_2, are based on survey-weighted hierarchical Bayes estimation approach. Note that the age group is based on a respondent's age at the time of the interview, not his or her age at first use.

[3] 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.

[4] Underage drinking is defined for persons aged 12 to 20; therefore, the "Total" estimate reflects that age group and not persons aged 12 or older.

[5] Tobacco Products include cigarettes, smokeless tobacco (i.e., chewing tobacco or snuff), cigars, or pipe tobacco.

[6] Dependence or abuse is based on definitions found in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV).

[7] Needing But Not Receiving Treatment refers to respondents classified as needing treatment for illicit drugs (or alcohol), but not receiving treatment for an illicit drug (or alcohol) problem at a specialty facility (i.e., drug and alcohol rehabilitation facilities [inpatient or outpatient], hospitals [inpatient only], and mental health centers).

[8] Major depressive episode is defined as in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV), which specifies a period of at least 2 weeks when a person experienced a depressed mood or loss of interest or pleasure in daily activities and had a majority of specified depression symptoms. There are minor wording differences in the questions in the adult and adolescent major depressive episode modules. Therefore, data from youths aged 12 to 17 were not combined with data from persons aged 18 or older to get an overall estimate (12 or older).

[9] For more details, see Section A.11 in Appendix A of the report on *State Estimates of Substance Use and Mental Disorders from the 2008-2009 NSDUHs*.

[10] Serious mental illness is defined as having a diagnosable mental, behavioral, or emotional disorder, other than a substance use disorder, that met the criteria found in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) and resulted in serious functional impairment.

[11] Any mental illness is defined as having a diagnosable mental, behavioral, or emotional disorder, other than a substance use disorder, that met the criteria found in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV).

Source: SAMHSA, Center for Behavioral Health Statistics and Quality (formerly the Office of Applied Studies), National Survey on Drug Use and Health, [illegible]

Stanford, Mark. Foundations in Behavioral Pharmacology: An Introduction To The Neuroscience Of Drug Addiction And Mental Disorders, Third Edition (2008)

The above reference book explains the mechanisms involved in metabolizing marijuana. Below are two of the many references in the literature that show concerns about how marijuana may be related to the onset of bipolar disorders in adolescents and may cause anxiety and panic even in regular users. *Referring to p. 26 bullet #12*

Loga S, Loga-Zec S, Spremo M. Psychiatria Danubina. 2010 Jun;22(2):296-7. **Cannabis and psychiatric disorders.** http://www.ncbi.nlm.nih.gov/pubmed/20562767

Source

Academy of Sciences and Arts of Bosnia and Herzegovina, Sarajevo, Bosnia and Herzegovina. sloga@bih.net.ba

Abstract

There are connection between use of cannabis and many psychiatric disturbances in adolescents, especially "cannabis psychosis", depression, panic attacks and suicide. Negative effects could occur either as a result of a specific pharmacological effect of cannabis, or as the result of stressful experiences during the intoxication of cannabis in young people. Potentially is very dangerous high frequency suicidal ideation among cannabis users.

Duffy A, Horrocks J, Milin R, Doucette S, Persson G, Grof P. Journal of Affective Disorders. 2012 Dec 15;142(1-3):57-64. doi: 10.1016/j.jad.2012.04.010. Epub 2012 Sep 7. **Adolescent substance use disorder during the early stages of bipolar disorder: a prospective high-risk study.** http://www.ncbi.nlm.nih.gov/pubmed/22959686

Source

Department of Psychiatry, University of Calgary, Calgary, Alberta, Canada. acduffy@ucalgary.ca

Abstract

BACKGROUND:

There is a paucity of longitudinal data characterizing the relationship between substance use disorder (SUD) and the early clinical course of bipolar disorder (BD). We studied this relationship in a prospectively assessed cohort of high-risk offspring.

METHODS:

Eligible families had one parent with confirmed BD based on SADS-L interviews and best estimate diagnostic procedure. Offspring completed KSADS-PL interviews at baseline and were reassessed prospectively. DSM-IV diagnoses were made on blind consensus review using all available information. This analysis included 211 offspring ≥12 years, and used GEE and linear mixed models to determine clinical characteristics differentiating those with compared to those without SUD, and CPH models to assess the relationship between SUD and the early stages of BD.

RESULTS:

Lifetime SUD was diagnosed in 24% of offspring; cannabis use being most common. The peak hazard of SUD was between 14 and 20 years of age. Male sex (HR 3.285; p=.0007), a prior mood disorder (HR 2.437; p=.0091) and parental history of SUD (HR 2.999; p=.0027) contributed to the risk of SUD in the offspring, while SUD predicted an increased risk of psychosis (HR 3.225; p=.0074). The estimated hazard of a major mood disorder in those offspring with compared to those without a prior SUD was almost 3-fold (HR 2.990 ($p \leq 0.01$).

LIMITATIONS:

The novel clinical staging model requires independent replication.

CONCLUSIONS:

SUD is a common comorbidity arising during the early course of BD, even before the first activated episode. Further research is needed to understand causative factors and to develop effective early intervention and prevention strategies.

Watkins, Anne. Adolescent substance Abuse Knowledge Base (2209). The New Faces of Heroin Addiction: Teen Use on the Rise. http://www.adolescent-substance-abuse.com/substance-abuse/the-new-faces-of-heroin-addiction-teen-use-on-the-rise.htm. *Quoted on p.23-25 bullet #10*

Adolescent Substance Abuse Articles

The New Faces of Heroin Addiction: Teen Use on the Rise

By Anne Watkins

Over the past few years, experts and law enforcement officials have noticed a disturbing trend: While heroin use in general has leveled off or even declined in most areas, there has been a dramatic spike in teenage heroin use.

There are many causes for this trend, which has been seen in New York, Illinois, Alabama and Oregon, but experts agree that it's closely associated with the easy accessibility of prescription opioid painkillers as well as the decline in the adult heroin market.

For teenagers who are addicted to heroin, there are many heroin treatment options available, including methadone or suboxone detox and rehab programs. Because heroin users gain tolerance to the drug so rapidly, it's important to recognize the problem and seek heroin treatment as early as possible. This presents unique difficulties for teenage heroin users, who may be afraid to be honest with their parents about their problem until it's too late.

Causes of the Trend

With the recent proliferation of prescription opioid painkillers, opiate use has become far more domesticated and widespread than ever before. Because of drugs like Oxycontin and Vicodin, more people are familiar with the effects of opioid medications, which, by extension, makes heroin seem less scary and not so exotic.

Many people, including teenagers, no longer associate heroin with the horror stories of overdose and crippling addiction. Instead, they associate it more and more with those relatively safe and familiar prescription drugs. The result is that, for young people especially, prescription opioids can act as gateway drugs to heroin.

Compounding this problem is the fact that heroin is often far cheaper than its prescription counterparts. A single pill of Vicodin or Oxycontin can be anywhere from $40 to $75, while a small bag of heroin may cost less than a six pack of beer and achieve the same high. So, for anyone already addicted to prescription opioids, cheap, accessible heroin may seem like a much better deal.

While people in their late 20s, 30s or older may remember alcohol and marijuana as being the drugs of choice for teenagers, things have changed. Heroin is no longer thought of as some inaccessible drug mostly used by grown-up junkies in big cities. These days, people in their teens and early 20s are being targeted as the next big market for a drug that has long been in decline among adult populations. In some places, teens report that heroin is even more accessible than marijuana, ecstasy and alcohol.

The causes for this market shift are still being researched. However, some experts believe that the widespread effectiveness of anti-heroin measures for adults may be a large factor. While adult heroin use has dramatically declined since the 1970s, law enforcement has not been able to stop the drug from coming into the country. In fact, global heroin production has only increased in recent years. Since fewer adults are using heroin, sellers are targeting teenagers, who are less likely to have negative associations with the drug.

Dangers of Teen Heroin Use

Adding to the problem is the fact that today's heroin is as much as 15 times as potent as the heroin of decades past. When you combine this factor with the low price and increased accessibility of the drug, teens are in grave danger. Even when it wasn't so potent, heroin was already one of the most dangerous and addictive illicit drugs on the market.

Lack of education and misinformation is a problem. Among kids who use heroin, there are likely to be myths and false rumors about use of the drug. For example, some experts say that the rash of teenage heroin overdoses over the past few years is a result of a mistaken belief that snorting heroin is less dangerous and less addictive than injecting. Bad information about hard drugs like heroin can lead people to put their lives in danger without even knowing it.

Teenagers also tend to be more reckless with their safety than adults, which makes all of the dangers of heroin use that much more acute. Teenagers are more likely to overdose, to allow themselves to become addicted or to mix heroin with other drugs. Also, among individuals who do inject the drug, teenagers are less likely to take precautions to prevent blood borne illnesses like HIV and Hepatitis.

Finally, teenagers are less likely to seek heroin treatment, as they may be worried that they'll get in trouble if they tell their parents. Thus, parents often do not find out about the addiction until the child overdoses, begins failing in school or gets in trouble with the law.

Heroin Use Among Suburban and Privileged Youth

A major component of the increase in teenage heroin use is a marked upswing among kids in suburban areas. For instance, in places like Suffolk County, N.Y., a suburban area outside of New York City, the number of deaths associated with heroin use have more than doubled in just the past couple of years. In nearby Nassau County, the number of people between the ages of 19 and 25 entering heroin rehab has increased nearly fivefold in the past eight years — from 59 in 2000 to 458 in 2008.

There are many possible ways to explain this trend. For one thing, suburban youth from middle-class backgrounds are much more likely to have access to gateway prescription painkillers. And while those prescription drugs tend to run out, heroin is always available for those who know where to find it. Suburban teenagers also have more money to spend, and many of them have cars, which gives them a greater amount of freedom and mobility. Suburban ennui and academic pressure may also play a role, with heroin giving teenagers an outlet for their frustrations and a temporary escape from their problems.

Whatever the cause of teenage heroin use, it is a serious problem that requires immediate attention and available heroin treatment.

West Hartford. 2011 Bi-annual West Hartford High School Drug and Alcohol Survey

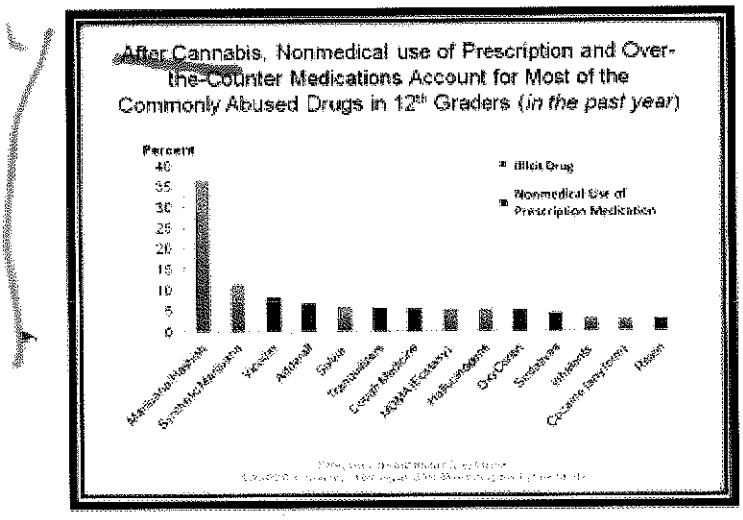
Scanned hand-out to West Hartford's Substance Abuse Prevention Commission (The Next Right Thing's Clinical Director is a member). *Referenced on p.19 first bullet and p.21 bullet #2*

Prescription Druge Misuse: "Bending the Trend" in West Hartford

LOCAL STATISTICS: (2011 Biannual WH High School Drug and Alcohol Survey)

- **21.3%** of teens reported having taken pills without knowing what they were.
- **19.6%** of youth reported having mixed drinking and prescription/over the counter drugs.
- In the past 30 days, **6.2%** of youth reported using pain relievers or opioids, **3.3%** reported using stimulants.
- **40%** of teens say that prescription drugs are easy to obtain.
- **40%** of teens get prescription drugs from friends.
- **20%** of teens mix alcohol with prescription drugs.

NATIONAL STATISTICS: (National Institute on Drug Abuse, Monitoring the Future 2011)



- "Nearly **1** in **12** high school seniors reported nonmedical use of Vicodin; **1** in **20** reported abuse of OxyContin." (www.drugabuse.gov)
- "When asked how prescription narcotics were obtained for nonmedical use, **70%** of 12th graders said they were given to them by a friend or relative (MTF 2011)." (www.drugabuse.gov)
- "Nonmedical use of prescription and over-the-counter medicines remains a significant part of the teen drug problem. In 2011, 15.2 percent of high-school seniors used a prescription drug nonmedically in the past year. Data for specific drugs show that the most commonly abused prescription drugs by teens are the pain reliever **Vicodin and the stimulant Adderall.**" (www.drugabuse.gov)

PLUS:

- The 2011 Town Hall Meeting on underage drinking was a success!
- The "Teen RxeAction" group of W.H. teens have already done research on prescription drug abuse in West Hartford and created two short videos informed by their research; the videos depict two composite scenarios involving multi-drug use (including prescription drugs, marijuana and alcohol) and the negative consequences associated with prescription drug abuse and misuse.

6) **Concerning the patient payer mix reported on page 43, it states that the program will be 100% covered by reimbursements from commercial insurers. On page 49, however, it states that the payer categories will continue to be self-pay or insurance payers. In addition, there is discussion on charity care on pages 49 and 54. Please revise the payer mix percentages reported on page 43 to agree with the statements made in the initial CON application on pages 43 and 49.**

The chart from page 43 is revised below. Revisions are highlighted. An additional chart breaks out charity patients.

Patient Population Mix

1. **Patient Population Mix: Current and Projected**
   a. **Provide the current and projected patient population mix (based on the number of patients, not based on revenue) with the CON proposal for the proposed program.**

Table 3: Patient Population Mix

	Current** FY 2012	Year 1 FY2013	Year 2 FY2014	Year 3 FY 2015
Medicare*	0	0	0	0
Medicaid*	0	0	0	0
CHAMPUS & TriCare	0	0	0	0
Total Government	**0**	**0**	**0**	**0**
Commercial Insurers*	0	81%	84%	81%
Uninsured/Self-pay/charity	0	19%	16%	19%
Workers Compensation	0	0	0	0
Total Non-Government	100%	100%	100%	100%
Total Payer Mix	100%	100%	100%	100%

* Includes managed care activity.

** New programs may leave the "current" column blank. In 2012, most patients had some form of commercial insurance.

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

Note: Uninsured is equivalent to self-pay. Charity is included in self-pay. The breakdown of self-pay (or uninsured) and charity is projected as follows:

	Year 1 FY2013	Year 2 FY2014	Year 3 FY 2015
Commercial Insurers	81%	84%	81%
Uninsured or self-pay	16%	14%	16%
Charity	3%	2%	3%

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

May 8, 2013

VIA FACISIMILE ONLY

Jenifer C. Simson
Executive Director
The Next Right Thing, LLC
246 Steele Rd.
West Hartford, CT 06117

RE: Certificate of Need Application; Docket Number: 13-31822-CON
The Next Right Thing, LLC
Establishment of an Intensive Outpatient Behavioral Health Treatment Program
CON Application Deemed Complete

Dear Ms. Simson:

This letter is to inform you that, pursuant to Section 19a-639a (d) of the Connecticut General Statutes, the Office of Health Care Access has deemed the above-referenced application complete as of May 6, 2013. This revises the date reported to you in the letter that was faxed to you on May 3, 2013.

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

Sincerely,

Laurie K. Greci

Laurie K. Greci
Associate Research Analyst

****
*** TX REPORT ***
****

TRANSMISSION OK

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STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: Jennifer Ellison

FAX: 860 236 1414

AGENCY: Next Right Thing, LLC

FROM: Lynne K Brech

DATE: 5/8/2013 **TIME:** 10:30 AM

NUMBER OF PAGES: 2
(including transmittal sheet

Comments: Re: CON Application 13-31822-CON

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

Phone: (860) 418-7001 ***Fax: (860) 418-7053***

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Jewel Mullen, M.D., M.P.H., M.P.A.
Commissioner

Dannel P. Malloy
Governor
Nancy Wyman
Lt. Governor

TO: Kevin Hansted, Hearing Officer

FROM: Jewel Mullen, M.D., M.P.H., M.P.A., Commissioner

DATE: May 13, 2013

RE: Certificate of Need Application; Docket Number: 13-31822-CON
The Next Right Thing
Community Based Relapse Prevention Intensive Outpatient Program

---

I hereby designate you to sit as a hearing officer in the above-captioned matter to rule on all motions and recommend findings of fact and conclusions of law upon completion of the hearing.

Connecticut Department of Public Health

Phone: (860) 509-8000 • Fax: (860) 509-7184 • VP: (860) 899-1611
410 Capitol Avenue, P.O. Box 34038
Hartford, Connecticut 06134-0308
www.ct.gov/dph

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

May 13, 2013

Jenifer C. Simson
Executive Director
The Next Right Thing, LLC
246 Steele Road
West Hartford, CT 06117

RE: Certificate of Need Application, Docket Number 13-31822-CON
The Next Right Thing, LLC
Establishment of an Intensive Outpatient Behavioral Health Treatment Program

Dear Ms. Simson,

With the receipt of the completed Certificate of Need ("CON") application information submitted by The Next Right Thing, LLC ("Applicant") on May 6, 2013, the Office of Health Care Access ("OHCA") has initiated its review of the CON application identified above.

Pursuant to General Statutes § 19a-639a (f), OHCA may hold a hearing with respect to any Certificate of Need application.

This hearing notice is being issued pursuant to General Statutes § 19a-639a (f)

Applicant:	The Next Right Thing, LLC
Docket Number:	13-31822-CON
Proposal:	Establishment of an Intensive Outpatient Behavioral Health Treatment Program in West Hartford, with an associated capital expenditure of $8,000 (over three years)

Notice is hereby given of a public hearing to be held in this matter to commence on:

Date: June 19, 2013

Time: 10:00 a.m.

Place: Department of Public Health, Office of Health Care Access
410 Capitol Avenue, Third Floor Hearing Room
Hartford, CT 06134

The Applicant is designated as party in this proceeding. Enclosed for your information is a copy of each hearing notice for the public hearing that will be published in the *Hartford Courant* pursuant to General Statutes § 19a-639a (f).

Sincerely,

Kimberly R. Martone
Director of Operations

Enclosure

cc: Henry Salton, Esq., Office of the Attorney General
Marianne Horn, Department of Public Health
Kevin Hansted, Department of Public Health
Wendy Furniss, Department of Public Health
Marielle Daniels, Connecticut Hospital Association

KRM: LKG:lmg

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH
Office of Health Care Access

May 13, 2013 Requisition # 42164

Hartford Courant
285 Broad Street
Hartford, CT 06115

Gentlemen/Ladies:

Please make an insertion of the attached copy, in a single column space, set solid under legal notices, in the issue of your newspaper by no later than **Wednesday, May 15, 2013.** Please provide the following **within 30 days** of publication:

- Proof of publication (copy of legal ad. acceptable) showing published date along with the invoice.

If there are any questions regarding this legal notice, please contact Kaila Riggott at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Director of Operations

Attachment

cc: Danielle Pare, DPH
Marielle Daniels, Connecticut Hospital Association

KRM:LKG:lmg

Hartford Courant **May 13, 2013**
Notice of Public Hearing, Docket Number 13-31822-CON

PLEASE INSERT THE FOLLOWING:

Office of Health Care Access Public Hearing

Statute Reference:	19a-638
Applicant:	The Next Right Thing, LLC
Town:	West Hartford
Docket Number:	13-31822-CON
Proposal:	Establishment of an Intensive Outpatient Behavioral Health Treatment Program in West Hartford, with a total capital expenditure of $8,000 (over three years)
Date:	June 19, 2013
Time:	10:00 a.m.
Place:	Department of Public Health, Office of Health Care Access 410 Capitol Avenue, Third Floor Hearing Room Hartford, CT 06134

Any person who wishes to request status in the above listed public hearing may file a written petition no later than June 14, 2013 (5 calendar days before the date of the hearing) pursuant to the Regulations of Connecticut State Agencies §§ 19a-9-26 and 19a-9-27. If the request for status is granted, such person shall be designated as a Party, an Intervenor or an Informal Participant in the above proceeding. Please check OHCA's website at **www.ct.gov/ohca** for more information or call OHCA directly at (860) 418-7001. If you require aid or accommodation to participate fully and fairly in this hearing, please phone (860) 418-7001.

****
*** TX REPORT ***
****

TRANSMISSION OK

TX/RX NO	3478
RECIPIENT ADDRESS	98602361414
DESTINATION ID	
ST. TIME	05/14 10:38
TIME USE	02'09
PAGES SENT	5
RESULT	OK

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: JENIFER C. SIMSON

FAX: (860) 236-1414

AGENCY: THE NEXT RIGHT THING, LLC

FROM: OHCA

DATE: 5/14/13 **TIME:**

NUMBER OF PAGES: 5
(including transmittal sheet

Comments: DN: 13-31822-CON Hearing Notice

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

Phone: (860) 418-7001 ***Fax: (860) 418-7053***

Greer, Leslie

From: ADS <ADS@graystoneadv.com>
Sent: Monday, May 13, 2013 3:44 PM
To: Greer, Leslie
Subject: Re: Hearing Notice 13-31822-CON

Good day!

Thanks so much for your ad submission.
We will be in touch shortly and look forward to serving you.

If you have any questions or concerns, please don't hesitate to contact us at the number below.

We sincerely appreciate your business.

PLEASE NOTE: New Department of Labor guidelines allow web base advertising when hiring foreign nationals. To provide required documentation Graystone will retrieve & archive verification for the 1st and 30th days of posting for $115.00/web site. If required, notify Graystone when ad placement is approved.

Thank you,
Graystone Group Advertising

2710 North Avenue
Bridgeport, CT 06604
Phone: 800-544-0005
Fax: 203-549-0061

E-mail new ad requests to: ads@graystoneadv.com
http://www.graystoneadv.com/

From: <Greer>, Leslie <Leslie.Greer@ct.gov>
Date: Monday, May 13, 2013 3:02 PM
To: ads <ads@graystoneadv.com>
Subject: Hearing Notice 13-31822-CON

Please run the attached hearing notice in the Hartford Courant by 5/15/13. For billing, refer to requisition 42164. In addition, please submit to me a "proof of publication" when available.

Thank you,

Leslie M. Greer
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS#13HCA
Hartford, CT 06134
Phone: (860) 418-7013
Fax: (860) 418-7053
Website: www.ct.gov/ohca

Greer, Leslie

From: Laurie <Laurie@graystoneadv.com>
Sent: Tuesday, May 14, 2013 2:44 PM
To: Greer, Leslie
Subject: FW: Hearing Notice 13-31822-CON
Attachments: 13-31822np Hartford Courant.doc

Your legal notice is all set to run as follows:

Hartford Courant, 5/15 issue - $302.72

Thanks,
Laurie Miller

2710 North Ave., Ste 200, Bridgeport, CT 06604
Ph: 203-549-0060, ext 319, Fax: 203-549-0061,Toll free: 800-544-0005
email: laurie@graystoneadv.com
www.graystoneadv.com

From: <Greer>, Leslie <Leslie.Greer@ct.gov>
Date: Monday, May 13, 2013 3:02 PM
To: ads <ads@graystoneadv.com>
Subject: Hearing Notice 13-31822-CON

Please run the attached hearing notice in the Hartford Courant by 5/15/13. For billing, refer to requisition 42164. In addition, please submit to me a "proof of publication" when available.

Thank you,

Leslie M. Greer
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS#13HCA
Hartford, CT 06134
Phone: (860) 418-7013
Fax: (860) 418-7053
Website: www.ct.gov/ohca
Please consider the environment before printing this message

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

May 24, 2013

Jenifer C. Simson
Executive Director
The Next Right Thing, LLC
246 Steele Road
West Hartford, CT 06117

RE: Certificate of Need Application, Docket Number 13-31822-CON
The Next Right Thing, LLC
Establishment of an Intensive Outpatient Behavioral Health Treatment Program

Dear Ms. Simson,

With the receipt of the completed Certificate of Need ("CON") application information submitted by The Next Right Thing, LLC ("Applicant") on May 6, 2013, the Office of Health Care Access ("OHCA") has initiated its review of the CON application identified above.

Pursuant to General Statutes § 19a-639a (f), OHCA may hold a hearing with respect to any Certificate of Need application.

This hearing notice is being issued pursuant to General Statutes § 19a-639a (f)

Applicant:	The Next Right Thing, LLC
Docket Number:	13-31822-CON
Proposal:	Establishment of an Intensive Outpatient Behavioral Health Treatment Program in West Hartford, with an associated capital expenditure of $8,000 (over three years)

Notice is hereby given of a public hearing to be held in this matter to commence on:

Date: June 20, 2013

Time: 9:00 a.m.

Place: Department of Public Health, Office of Health Care Access
410 Capitol Avenue, Third Floor Hearing Room
Hartford, CT 06134

The Applicant is designated as party in this proceeding. Enclosed for your information is a copy of each hearing notice for the public hearing that will be published in the *Hartford Courant* pursuant to General Statutes § 19a-639a (f).

Sincerely,

Kimberly R. Martone
Director of Operations

Enclosure

cc: Henry Salton, Esq., Office of the Attorney General
Marianne Horn, Department of Public Health
Kevin Hansted, Department of Public Health
Wendy Furniss, Department of Public Health
Marielle Daniels, Connecticut Hospital Association

KRM: LKG:lmg

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH
Office of Health Care Access

May 24, 2013 Requisition # 42319

Hartford Courant
285 Broad Street
Hartford, CT 06115

Gentlemen/Ladies:

Please make an insertion of the attached copy, in a single column space, set solid under legal notices, in the issue of your newspaper by no later than **Saturday, May 25, 2013.** Please provide the following **within 30 days** of publication:

- Proof of publication (copy of legal ad. acceptable) showing published date along with the invoice.

If there are any questions regarding this legal notice, please contact Kaila Riggott at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Director of Operations

Attachment

cc: Danielle Pare, DPH
Marielle Daniels, Connecticut Hospital Association

KRM:LKG:lmg

Hartford Courant **May 24, 2013**
Notice of Public Hearing, Docket Number 13-31822-CON

PLEASE INSERT THE FOLLOWING:

Office of Health Care Access Public Hearing

Statute Reference:	19a-638
Applicant:	The Next Right Thing, LLC
Town:	West Hartford
Docket Number:	13-31822-CON
Proposal:	Establishment of an Intensive Outpatient Behavioral Health Treatment Program in West Hartford, with a total capital expenditure of $8,000 (over three years)
Date:	June 20, 2013
Time:	9:00 a.m.
Place:	Department of Public Health, Office of Health Care Access 410 Capitol Avenue, Third Floor Hearing Room Hartford, CT 06134

Any person who wishes to request status in the above listed public hearing may file a written petition no later than June 14, 2013 (5 calendar days before the date of the hearing) pursuant to the Regulations of Connecticut State Agencies §§ 19a-9-26 and 19a-9-27. If the request for status is granted, such person shall be designated as a Party, an Intervenor or an Informal Participant in the above proceeding. Please check OHCA's website at **www.ct.gov/ohca** for more information or call OHCA directly at (860) 418-7001. If you require aid or accommodation to participate fully and fairly in this hearing, please phone (860) 418-7001.

****
*** TX REPORT ***
****

TRANSMISSION OK

TX/RX NO	3499
RECIPIENT ADDRESS	98602361414
DESTINATION ID	
ST. TIME	05/24 11:24
TIME USE	02'09
PAGES SENT	5
RESULT	OK

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: JENIFER SIMSON

FAX: (860) 236-1414

AGENCY: THE NEXT RIGHT THING, LLC

FROM: LAURIE GRECI

DATE: 5/24/13 **TIME:**

NUMBER OF PAGES:
(including transmittal sheet

Comments: DN: 13-31822-CON Rescheduled Public Hearing Notice

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

Phone: (860) 418-7001 ***Fax: (860) 418-7053***

Greer, Leslie

From: ADS <ADS@graystoneadv.com>
Sent: Friday, May 24, 2013 10:41 AM
To: Greer, Leslie
Subject: Re: Hearing Notices 12-31798-CON & 13-31822-CON

Good day!

Thanks so much for your ad submission.
We will be in touch shortly and look forward to serving you.

If you have any questions or concerns, please don't hesitate to contact us at the number below.

We sincerely appreciate your business.

PLEASE NOTE: New Department of Labor guidelines allow web base advertising when hiring foreign nationals. To provide required documentation Graystone will retrieve & archive verification for the 1st and 30th days of posting for $115.00/web site. If required, notify Graystone when ad placement is approved.

Thank you,
Graystone Group Advertising

2710 North Avenue
Bridgeport, CT 06604
Phone: 800-544-0005
Fax: 203-549-0061

E-mail new ad requests to: ads@graystoneadv.com
http://www.graystoneadv.com/

From: <Greer>, Leslie <Leslie.Greer@ct.gov>
Date: Friday, May 24, 2013 10:15 AM
To: ads <ads@graystoneadv.com>
Subject: Hearing Notices 12-31798-CON & 13-31822-CON

Please run the attached public hearing notices in the Hartford Courant by May 25, 2013. For billing, refer to requisition 42319. . In addition, please submit to me a "proof of publication" when available.

Thank you,

Leslie M. Greer
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS#13HCA
Hartford, CT 06134
Phone: (860) 418-7013
Fax: (860) 418-7053
Website: www.ct.gov/ohca

Greer, Leslie

From: Laurie <Laurie@graystoneadv.com>
Sent: Friday, May 24, 2013 1:58 PM
To: Greer, Leslie
Subject: FW: Hearing Notices 12-31798-CON & 13-31822-CON
Attachments: 12-31798 Hartford Courant.doc; 13-31822np Hartford Courant Rescheduled.doc

Your legal notice is all set to run as follows:

12-31798-CON – Hartford Courant, 5/25 issue - $302.72
13-31822-CON – Hartford Courant, 5/25 issue - $302.72

Thanks,
Laurie Miller

Graystone Group Advertising
2710 North Ave., Ste 200, Bridgeport, CT 06604
Ph: 203-549-0060, ext 319, Fax: 203-549-0061,Toll free: 800-544-0005
email: laurie@graystoneadv.com
www.graystoneadv.com

From: <Greer>, Leslie <Leslie.Greer@ct.gov>
Date: Friday, May 24, 2013 10:15 AM
To: ads <ads@graystoneadv.com>
Subject: Hearing Notices 12-31798-CON & 13-31822-CON

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Thank you,

Leslie M. Greer
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS#13HCA
Hartford, CT 06134
Phone: (860) 418-7013
Fax: (860) 418-7053
Website: www.ct.gov/ohca

13-31822 CON

Rentals

E. HARTFORD 1BR @ OCTOBER HILLS $ 1ST MONTH FREE RENT/HT & HW $ 860-282-7454 860-424-6961

Ellington - Meadowbrook Apartments Lovely country setting, 1 BR. with view, Private entry, walk-in closets, some with fireplaces! $660, & up. 860-875-0500

www.Harvest-Properties.com

ELLINGTON - Autumn Chase Brand new 1 & 2BR Luxury Apartments with garage. Close to I84, I91 and Bradley Airport. **Please call 860-872-1000**

FARMINGTON - FOREST PARK APTS. 2 BRs, 1½ bth Twnhses & Ranches. New kits. Starting at $1410 + utils. No pets. 860-678-6600 cwenterprises.com

Farmington
Village at Yorkshire & Hunters Ridge 1 & 2BR available. Ranch style, private entrance, patio, washer/dryer in every unit. Must be 62+ and meet income restrictions. **Call Sandy 860-269-0116**

Farmington
Heritage Glen, spacious 1 bd, 1 ba & 2 bd, 1 1/2 ba units, fully appl'd, W/D patio, prv. entrance. $842 - $967 PLUS UTILS's, income restrictions apply. No pets.
Westwoods 2 bd, 1 ba units, coin operated laundry on site. $939 plus util's. Income restrictions apply. No pets.
Call Rachel 860-269-0546.

HARTFORD - Studio $550, 1BR $600, 2BR $850, Well-kept, elev building. ht/hw included, parking available. No Pets. **860-549-3181**

HARTFORD
Sigourney
Studio: $405
Westland Place
3 BD - $825
All apartments include HT & HW
JRH Asset Mgmt 860-246-0013

HARTFORD SW Newly Decorated 1 & 2 BR APTS, $525-$750, Parking, **SML 249-1396, 978-3725, 550-0178.**

HARTFORD/W. HARTFORD LINE- 408 Prospect. Large 1 BR, appliances, oversized closets, heat & hot cooking gas, oak floors, exercise & game room, laundry, (parking available). **Res Super 860-570-4870. Mgmt 860-549-3330**

MIDDLETOWN - Highview Apts Huge 1&2 BR. Fully appl.eat in kitchen, Large livingrm w/ balcony, Laundry, prkg! **Free H&HW. $675/$805 800-704-0102.**

NEW BRITAIN Spac 2 bd, lg kitch, w/w, appl, clean, on-site lndry, lg closets, off st prkg. On bus line. No dogs. **Free Heat/HW. $675. 223-8866 EOH**

NEW BRITAIN 860-223-8866
Evergreen Townhouse Apartments Remodeled 2 & 3 Bedroom Town-homes in quiet area. Private entry, hardwood floors. Laundry. On bus line. Heat & Hot Water included. $750 & up for two beds.

www.Harvest-Properties.com

NEWINGTON Salem & Gloucester Vlg 1BR & 2BR Twnhses, H/HW & cooking gas included **Call 860-667-2233**

ROCKVILLE Well Maint, 1,2 & 3 BR. Quiet bldg, wall/wall, appls, laundry. **Heat & HW Incl.** Short term leases. **$725, $825 & $925 860-875-9500 EOH**

Simsbury 1 & 2BR apts, Twnhses, Bsts, some w/garages. **Call 860-677-1381.**

VERNON LEE & LAMONT REALTY
1 & 2 BR, 24 hour maintenance.
www.leelamont.com
860-872-4090 EHO

WEST HARTFORD Clean, sunny, mined. 1 & 2 bd, quiet area, Appls, w/w, lndry. on busline, great schools, community rm FREE HT/HW $695/mo. 053-8030 EOH

www.Harvest-Properties.com

WETHERSFIELD Sunny 1 bd, w/w, appls, quiet bldg, no pets. **Secure Entr. Lrg closets, FREE HT/HW** laund, elevator, on busline. $850 and up. 860-721-1033 EOH

WINDSOR LOCKS - Beautiful Spacious 1 & 2 bd, quiet building, W/W, appls, on-site laundry, c/air, elevator, busline. **Free Heat/HW. $750-$850 and up 860-876-9500 EOHH**

www.Harvest-Properties.com

Real Estate Services

www.coldwellbankermoves.com

Office Space / Retail

FARMINGTON 500-7,500 sf. Off I84, Immediate occupancy, Park-like setting. RWR 651-3531 Owner/Mgr. rwrenterprises.com

PUBLIC NOTICES

Connecticut

Legal Notice - Request for Proposals

The Connecticut Department of Labor (CTDOL), Office of Workforce Competitiveness (OWC) is soliciting applications for consulting services to support planning and workforce policy development for OWC and the Connecticut Employment & Training Commission (CETC).

For more info, visit the Department of Administrative Services website, www.das.state.ct.us or you can obtain copies of the Solicitation for Proposals including a copy of the regulations which are available for download from the Connecticut Department of Labor, OWC website at: http://www.ctdol.state.ct.us/OWC/index.htm
Or Contact Lee Ryan at (860) 263-6518 or Lee.Ryan@ct.gov

LEGAL NOTICE

SOUTH WINDSOR PUBLIC SCHOOLS INVITATION TO BID FOR STRATEGIC PLANNING STUDY OF SOUTH WINDSOR ELEMENTARY SCHOOLS 2013 BID # 1213-016

Bid documents for strategic planning study services for South Windsor elementary schools 2013, BID #1213-016, may be obtained at the Business Office of the Director of Finance & Operations, South Windsor Public Schools, 1737 Main Street, Room 203, South Windsor, CT or online at www.southwindsorschools.org on or after 9:00 a.m., May 15, 2013.

Sealed bids will be received at the address listed above until 12:45 p.m., Eastern Standard Time, on June 6, 2013. Thereafter, bids will be publicly opened and read aloud.

The Board reserves the rights to: amend or terminate this Invitation to Bid; accept all or any part of a bid; reject any or all bids; waive any informalities or non-material deficiencies in a bid; and award the bid to the bidder that, in its judgment, will be in the Board's best interests.

NOTICE OF PETITION FOR TERMINATION OF PARENTAL RIGHTS, G.L. c. 210 3 COMMONWEALTH OF MASSACHUSETTS THE TRIAL COURT PROBATE AND FAMILY COURT

Middlesex Probate and Family Court
208 Cambridge Street
Cambridge, MA 02141
(617) 768-5800

Docket No.: MI13A

In the matter of: Baby Girl Megarry

To: Megan Ann Megarry of Whitinsville, MA, Jesse James DeRosier of Whitinsville, MA, Don Maddingly of CT, and any unknown or unnamed father, parent(s) of the above named child.

A putative father will not have standing as a party to this case without a voluntary acknowledgment of parentage or an adjudication of paternity.

A petition has been presented to said court by Bright Futures Adoption Center, Acton, MA 01720 representing that the parent(s) of the child lack(s) current ability, capacity, fitness and readiness to assume parental responsibility for the child; that the petitioner's plan for the child will serve the child's best interests; and, requesting that this Honorable Court enter a decree under the provisions of the General Laws of Massachusetts, Chapter 210, Section 3, that shall have the effect of terminating the rights of the person(s) named herein to receive notice of or to consent to any legal proceeding affecting the custody, guardianship, adoption, or other disposition of the child named herein.

IF YOU DESIRE TO OBJECT THERETO, YOU OR YOUR ATTORNEY MUST FILE A WRITTEN APPEARANCE IN SAID COURT AT CAMBRIDGE ON OR BEFORE TEN O'CLOCK IN THE MORNING (10:00 AM) ON 06/26/2013.

YOU ARE ENTITLED TO THE APPOINTMENT OF AN ATTORNEY IF YOU ARE AN INDIGENT PERSON. An indigent person is defined by SJC RULE 3:10. The definition includes but is not limited to persons receiving AFDC, EAEDC, poverty related veteran's benefits, food stamps, refugee resettlement benefits, medicaid and SSI. The Court will determine if you are indigent. Contact an Assistant Judicial Case Manager/Adoptions Clerk of the Court on or before the date listed above to obtain the necessary items.

Witness: Hon. Peter C. DiGangi
First Justice of this Court
Tara E. DeCristofaro
Register of Probate
Date: April 30, 2013

Glastonbury

TOWN OF GLASTONBURY INVITATION TO BID REVISED

BID # GL-2013-33

ITEM 5 Elementary Schools Electrical Distribution Improvements

DATE & TIME REQUIRED May 30, 2013 @ 11:00 a.m.

The Town of Glastonbury is seeking bids for the replacement of electrical panels and the installation of additional outlets in all classrooms 5 Elementary Schools.

Bid packages may be obtained at The Print House LLC, 22 Krieger Lane, Unit 6, Glastonbury, CT 06033 for a nonrefundable cost of $30. Bidders are advised to call at least 30 minutes prior to pick up.

A mandatory pre-bid meeting and site walk through will be held starting at the Hebron Ave Elementary School, 1363 Hebron Ave, Glastonbury, CT 06033 on May 22th at 1:00 p.m. All bidders must attend in order for their bid to be considered. Contractors shall comply with State Statutes concerning Employment, and Labor Practices, if applicable, and Section 31-53 of the Connecticut General Statutes as amended (Prevailing wages), including annual adjustments in Prevailing Wages. Certified payrolls will be required biweekly. Sealed bids must be accompanied with Bid Security. Bid Security shall be issued payable to the "Town of Glastonbury" in the form of a certified check or Bid Bond in an amount not less than 10% of the total amount of the base bid. The Bid Bond must be issued by a surety company licensed in the State of Connecticut. Cashier's checks will not be accepted.

The Town reserves the right to waive informalities or reject any part of, or the entire bid, when said action is deemed to be in the best interest of the Town. All Sealed Bids must be submitted to the Office of the Purchasing Agent no later than the time and date indicated. All bids will be publicly opened and read.

The Town of Glastonbury is an Affirmative Action/Equal Opportunity Employer. Minority / Women / Disadvantaged Business Enterprises are encouraged to bid.

Mary F. Visone
Purchasing Agent

Connecticut

PUBLIC NOTICE
Office of Health Care Access Public Hearing

Statute Reference: 19a-638
Applicant: The Next Right Thing, LLC
Town: West Hartford
Docket Number: 13-31822-CON
Proposal: Establishment of an Intensive Outpatient Behavioral Health Treatment Program in West Hartford, with a total capital expenditure of $8,000 (over three years)
Date: June 19, 2013
Time: 10:00 a.m.
Place: Department of Public Health, Office of Health Care Access 410 Capitol Avenue, Third Floor Hearing Room Hartford, CT 06134

Any person who wishes to request status in the above listed public hearing may file a written petition no later than June 14, 2013 (5 calendar days before the date of the hearing) pursuant to the Regulations of Connecticut State Agencies §§ 19a-9-26 and 19a-9-27. If the request for status is granted, such person shall be designated as a Party, an Intervenor or an Informal Participant in the above proceeding. Please check OHCA's website at www.ct.gov/ohca for more information or call OHCA directly at (860) 418-7001. If you require aid or accommodation to participate fully and fairly in this hearing, please phone (860) 418-7001.

JEEP

Model	Yr	Miles	WebID	Price	Dealer	Phone #
Wrangler Unlimited	'12	11,123	136802	$36,333	Papa's Chrysler Dodge Jeep	(866) 809-8544
Wrangler Unlimited	'11	15,290	599329	$32,443	Papa's Chrysler Dodge Jeep	(866) 809-8544
Wrangler Unlimited	'11	11,860	591408	Call	Crowley Chrysler Jeep Dodge	(877) 705-2866

KIA

Model	Yr	Miles	WebID	Price	Dealer	Phone #
Forte	'10	60,145	168009	$12,300	Crowley Kia	(877) 401-6311
Optima	'13	5,187	009281	$32,000	Crowley Kia	(877) 401-6311
Optima	'13	20,479	097772	$22,750	Crowley Kia	(877) 401-6311
Sedona	'03	140,774	435190	$8,500	Crowley Kia	(877) 401-6311
Sorento	'13	24,396	330914	$25,325	Crowley Kia	(877) 401-6311
Sorento	'13	11,200	340158	$23,224	Crowley Kia	(877) 401-6311
Sorento	'12	11,818	304630	$25,000	Crowley Kia	(877) 401-6311
Sorento	'11	31,172	152655	$23,000	Crowley Kia	(877) 401-6311
Sorento	'11	34,696	090741	$23,000	Crowley Kia	(877) 401-6311
Sorento	'11	65,105	019450	$15,895	J & M Automotive	(877) 272-1487
Spectra	'09	69,130	661770	$7,995	J & M Automotive	(877) 272-1487

LEXUS

Model	Yr	Miles	WebID	Price	Dealer	Phone #
ES 350	'09	59,255	289288	$19,977	Middletown Toyota/Scion	(888) 420-6780
IS 250	'07	75,471	010671	$19,995	The Highline Car Connection	(877) 276-0786
RX 300	'01	124,311	211798	$9,750	Bristol Motor Works	(866) 813-9152

LINCOLN

Model	Yr	Miles	WebID	Price	Dealer	Phone #
MKS	'11	20,655	610169	$32,920	Crowley Ford	(877) 516-3516
MKX	'07	96,228	J04204	$16,000	Crowley Kia	(877) 401-6311

MAZDA

Model	Yr	Miles	WebID	Price	Dealer	Phone #
Mazda3	'12	20,927	590924	$19,900	Crowley Ford	(877) 516-3516
Mazda3	'10	51,328	288634	$12,621	Crowley Kia	(877) 401-6311
Mazda3	'08	60,962	165514	Call	Crowley Nissan	(877) 401-9749
MazdaSpeed3	'07	75,100	661098	$10,995	A Better Way Wholesale	(888) 751-2842
RX-8	'07	52,696	208212	$14,500	Crowley Chrysler Jeep Dodge	(877) 705-2866
RX-8	'05	65,868	150594	$12,375	Schaller Honda	(877) 212-6722

MERCEDES-BENZ

Model	Yr	Miles	WebID	Price	Dealer	Phone #
C-Class	'10	47,025	090342	$24,944	Crowley Ford	(877) 516-3516
E-Class	'98	98,645	634807	$8,994	Papa's Auto House	(877) 505-8768

MERCURY

Model	Yr	Miles	WebID	Price	Dealer	Phone #
Milan	'10	34,474	614371	$15,744	Crowley Ford	(877) 516-3516

NISSAN

Model	Yr	Miles	WebID	Price	Dealer	Phone #
Altima	'12	7,037	572056	Call	Crowley Nissan	(877) 401-9749
Altima	'10	32,517	497130	Call	Crowley Nissan	(877) 401-9749
Altima	'10	29,810	494478	Call	Crowley Nissan	(877) 401-9749
Altima	'10	32,657	472422	Call	Crowley Nissan	(877) 401-9749
Altima	'08	32,107	425219	$16,994	Hartford Toyota Superstore	(888) 256-5152
Altima	'09	60,305	124275	$15,995	The Highline Car Connection	(877) 276-0780
Altima	'09	43,444	553192	Call	Crowley Nissan	(877) 401-9749
Altima	'08	41,798	106778	$16,994	Papa's Auto House	(877) 505-8760
Altima	'08	102,570	254620	Call	Crowley Nissan	(877) 401-9749
Altima	'06	101,987	370276	$8,375	Jim Juliani Motor Cars	(866) 731-3460
Altima	'06	100,208	217988	Call	Crowley Nissan	(877) 401-9749
Maxima	'10	36,920	039359	$22,794	Crowley Kia	(877) 401-6311
Maxima	'10	53,292	858029	$20,944	Crowley Ford	(877) 516-3516
Maxima	'10	21,896	866000	Call	Crowley Nissan	(877) 401-9749
Maxima	'03	114,000	404201	$8,985	Car Corner	(866) 624-4317
Maxima	'01	177,379	826446	Call	Crowley Kia	(877) 401-6311
Murano	'11	19,901	158241	Call	Crowley Nissan	(877) 401-9749
Murano	'10	32,379	108316	Call	Crowley Nissan	(877) 401-9749
Murano	'07	102,020	661816	Call	Crowley Nissan	(877) 401-9749
Murano	'04	70,430	327488	Call	Crowley Nissan	(877) 401-9749
Pathfinder	'02	105,524	715721	$6,899	Bristol Motor Works	(866) 813-9152
Rogue	'12	20,255	352100	Call	Crowley Nissan	(877) 401-9749
Rogue	'10	36,455	600610	$17,500	Crowley Kia	(877) 401-6311
Rogue	'10	47,791	603831	Call	Crowley Nissan	(877) 401-9749
Rogue	'09	52,051	180432	Call	Crowley Nissan	(877) 401-9749
Rogue	'08	71,376	101894	$14,412	Schaller Honda	(877) 212-6722
Sentra	'10	30,615	660980	Call	Crowley Nissan	(877) 401-9749
Sentra	'10	24,556	067215	Call	Crowley Nissan	(877) 401-9749
Xterra	'07	95,000	537724	$11,995	Car Corner	(866) 624-4317

PONTIAC

Model	Yr	Miles	WebID	Price	Dealer	Phone #
Grand Am	'00	94,513	864226	Call	Crowley Kia	(877) 401-6311
Grand Am	'99	173,357	768038	Call	Schaller Honda	(877) 212-6722

SATURN

Model	Yr	Miles	WebID	Price	Dealer	Phone #
SC	'99	101,000	243567	$2,950	The Car Place	(860) 414-1932
SL	'02	81,000	143747	$3,950	The Car Place	(860) 414-1932

SCION

Model	Yr	Miles	WebID	Price	Dealer	Phone #
xB	'08	55,596	048027	$13,995	Middletown Toyota/Scion	(888) 420-6780
tC	'10	33,363	313397	$17,995	Middletown Toyota/Scion	(888) 420-6780

SUBARU

Model	Yr	Miles	WebID	Price	Dealer	Phone #
Impreza	'12	8,926	021102	$19,932	Schaller Honda	(877) 212-6722
Outback	'12	Call	242861	$26,478	Schaller Honda	(877) 212-6722
Outback	'10	96,691	372237	$16,999	Schaller Honda	(877) 212-6722

SUZUKI

Model	Yr	Miles	WebID	Price	Dealer	Phone #
Gr Vitara	'07	65,240	204932	$11,995	The Highline Car Connection	(877) 276-0786

TOYOTA

Model	Yr	Miles	WebID	Price	Dealer	Phone #
4Runner	'05	92,240	058321	$11,950	J & M Automotive	(877) 272-1487
4Runner	'00	125,000	298435	$7,785	Car Corner	(866) 624-4317
Avalon	'12	34,087	451958	$25,991	Hartford Toyota Superstore	(888) 256-5152
Camry	'12	4,172	232343	$24,991	Hartford Toyota Superstore	(888) 256-5152
Camry	'12	14,103	164265	$21,995	Middletown Toyota/Scion	(888) 420-6780
Camry	'11	32,198	145078	$20,977	Middletown Toyota/Scion	(888) 420-6780
Camry	'11	21,040	504472	$18,493	Hartford Toyota Superstore	(888) 256-5152
Camry	'11	38,801	593780	$17,001	Hartford Toyota Superstore	(888) 256-5152
Camry	'10	36,249	086712	$17,901	Hartford Toyota Superstore	(888) 256-5152
Camry Hy	'09	79,995	080685	$16,994	Hartford Toyota Superstore	(888) 256-5152
Cmry Solara	'05	116,707	042813	Call	Crowley Nissan	(877) 401-9749
Cmry Solara	'04	138,683	023017	$7,742	Crowley Chrysler Jeep Dodge	(877) 705-2866
Corolla	'12	18,223	843560	$17,491	Hartford Toyota Superstore	(860) 256-5152
Corolla	'12	14,548	800081	$15,777	Middletown Toyota/Scion	(888) 420-6780
Corolla	'10	12,947	406106	$15,477	Middletown Toyota/Scion	(888) 420-6780
Corolla	'09	54,344	032503	$12,995	Car Corner	(866) 624-4317
Corolla	'09	54,442	100907	$12,780	Crowley Ford	(877) 516-3516
Corolla	'00	109,600	297313	$4,950	The Car Place	(860) 414-1932
FJ Cruiser	'07	78,638	063038	$21,992	Hartford Toyota Superstore	(888) 256-5152
Highlander	'10	35,053	023531	$25,977	Middletown Toyota/Scion	(888) 420-6780
Highlander	'10	35,019	033685	$26,477	Middletown Toyota/Scion	(888) 420-6780
Highlander	'10	58,980	154486	$26,377	Middletown Toyota/Scion	(888) 420-6780
H'lander Hy	'08	50,350	020820	$29,895	Middletown Toyota/Scion	(888) 420-6780
RAV4	'11	9,768	175251	$24,092	Hartford Toyota Superstore	(888) 256-5152
Sienna	'12	15,023	042691	$26,977	Middletown Toyota/Scion	(888) 420-6780
Sienna	'11	41,462	041043	$23,991	Hartford Toyota Superstore	(888) 256-5152
Sienna	'08	103,286	184402	Call	Crowley Nissan	(877) 401-9749
Sienna	'05	111,209	053382	$10,894	Papa's Auto House	(877) 505-8758
Tacoma	'11	28,742	006499	$21,992	Hartford Toyota Superstore	(888) 256-5152
Tacoma	'10	55,886	043916	$25,995	Middletown Toyota/Scion	(888) 420-6780
Tacoma	'07	66,975	382628	$16,995	Middletown Toyota/Scion	(888) 420-6780
Tacoma	'08	111,059	318940	$11,742	Crowley Chrysler Jeep Dodge	(877) 705-2866
Tundra	'08	35,078	462375	Call	Hartford Toyota Superstore	(888) 256-5152
Yaris	'12	33,498	518078	$16,991	Hartford Toyota Superstore	(888) 256-5152
Yaris	'09	96,228	014064	$8,995	J & M Automotive	(877) 272-1487

VOLKSWAGEN

Model	Yr	Miles	WebID	Price	Dealer	Phone #
Eos	'11	21,346	002093	$26,986	Acura of Berlin	(860) 205-1754
GTI	'08	69,793	117383	$16,985	The Highline Car Connection	(877) 276-0786
Jetta	'10	36,941	016649	$15,000	Crowley Kia	(877) 401-6311

VOLVO

Model	Yr	Miles	WebID	Price	Dealer	Phone #
V40	'03	104,815	986243	$6,995	Jim Juliani Motor Cars	(866) 731-3400

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

June 5, 2013

Via Fax Only

Jenifer C. Simson
Executive Director
The Next Right Thing, LLC
246 Steele Rd.
West Hartford, CT 06117

RE: Certificate of Need Application; Docket Number: 13-31822-CON
The Next Right Thing, LLC
Establishment of an Intensive Outpatient Behavioral Health Treatment Program
Request for Prefile Testimony and Issues

Dear Ms. Simson:

The Office of Health Care Access ("OHCA") will hold a public hearing on the above docket number on June 20, 2013. The hearing is at 9:00 a.m. in the Department of Public Health's third floor hearing room, 410 Capitol Avenue, Hartford. Pursuant to the Regulations of Connecticut State Agencies § 19a-9-29 (e), any party or other participant is required to prefile in written form all substantive, technical, or expert testimony that it proposes to offer at the hearing. OHCA requests that The Next Right Thing, LLC ("Applicant") submit prefiled testimony by 12:00 p.m. on June 14, 2013.

All persons providing prefiled testimony must be present at the public hearing to adopt their written testimony under oath and must be available for cross-examination for the entire duration of the hearing. If you are unable to meet the specified time for filing the prefiled testimony you must request a time extension in writing, detailing the reasons for not being able to meet the specified deadline.

Additionally, please find attached OHCA's Issues outlining the topics that will be discussed at the hearing.

Please contact Laurie Greci at (860) 418-7032, if you have any questions concerning this request.

Sincerely,

Kevin Hansted
Hearing Officer

Attachment

Issues

Certificate of Need Application, Docket Number: 13-31822-CON

The Next Right Thing, LLC
Establishment of an Intensive Outpatient Behavioral Health Treatment Program in West Hartford

Applicant should prepare to argue and present supporting evidence on the following issues to support the proposal identified above:

1. Clear public need, including the patient populations to be served and service area demographics.

2. Need for the proposal based on incidence and/or prevalence in the service area.

3. The levels of treatment to be provided under the proposal and the licenses needed to provide those levels of treatment.

****
*** TX REPORT ***
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TRANSMISSION OK

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STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: Jenifer Simsm

FAX: 860 236 1414

AGENCY: The Next Right Thing, LLC

FROM: Lisa Gray

DATE: 6/5/2013 TIME: 10:10 am

NUMBER OF PAGES: 3
(including transmittal sheet

Comments: Re: 13-31822-CON

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

From: Jenifer Hartt [mailto:Jenifer@NextRightThing.net]
Sent: Friday, June 14, 2013 11:49 AM
To: User, OHCA
Subject: Attention Laurie Greci

Dear Laurie, attached is our statement for next Thursday's hearing. Would you like me to fax it as well?

Thank you for your guidance through this process. All of us at The Next Right Thing, LLC are looking forward to meeting you in person.

Best regards,

Jenifer Simson

The Next Right Thing, llc
Relapse Prevention for Adolescents with Substance Abuse and Mental Health Problems
345 N. Main Street, Suite 306
West Hartford, CT 06117
Main Office: 860-233-8803
Direct line:860-236-1499
www.NextRightThing.net

THE NEXT RIGHT THING

June 14, 2013

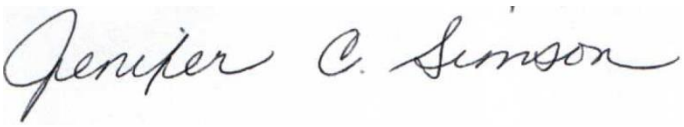
Ms. Lisa A. Davis
OHCA Commissioner
State of Connecticut
Office of Health Care Access (OHCA)
Department of Public Health
410 Capitol Avenue
Hartford, CT 06134

Dear Ms. Davis,

The following is The Next Right Thing, LLC's statement for our CON hearing on June 20th. If you have any questions or require additional information, feel free to phone me at 860-236-1499 or email me at Jenifer@NextRightThing.net.

Thank you,

Best regards,



Jenifer C. Simson
Co-Founder and Executive Director
The Next Right Thing, LLC

The Next Right Thing, LLC's CON Public Hearing Statement

Certificate of Need Application, Docket Number: 13-31822-CON

The Next Right Thing, LLC
Establishment of an Intensive Outpatient Behavioral Health Treatment Program in West Hartford

SUMMARY STATEMENT

The CON application is for a community-based Intensive Outpatient Program that offers substance abuse and mental health treatment for adolescents (ages 16-23) and their families.

The community-based treatment will:

- Provide rapid access to assessment and treatment of at-risk, dually diagnosed teens
- Provide individualized treatment services not offered in other community-based settings for mid to late adolescents (ages 16 – 23) suffering from substance abuse (sa) and mental health (mh) issues
- Reduce need for more intensive services for this at-risk population
- Incorporate parents with more intensive involvement in their children's treatment to enhance long-term stabilization of substance abuse and mental health problems
- Coordinate services with local school systems to ensure success in advancing academic achievement
- Coordinate services with the judicial system to decrease anti-social behaviors associated with drug abuse

Research studies, newspaper articles, and local emergency rooms report the epidemic nature of drug abuse, especially opiate addiction, for this population. The lack of specialized care focused on 16-23 year olds has added to this escalating trend. The morbidity and mortality rates clearly indicate that treatment needs for this population are not being adequately addressed.

The Next Right Thing's clinical staff brings an extensive history and expertise in treating substance abuse and mental health issues. The treatment program incorporates best practices using CBT, relapse prevention, and 12-step program concepts. The Next Right Thing desires to expand services; obtaining DPH licensure approval will allow third-party insurance payers to contract with The Next Right Thing which in-turn will create improved access and availability to patients and families seeking care.

1)
CLEAR PUBLIC NEED

The national and local press report stories and statistics that flesh out a widely recognized epidemic of opiate and alcohol addiction among adolescents and young adults.

CT DPH Drug overdose death rates have never been higher, rising steadily since 1970. According to testimony given by Patricia Rehmer, MSN, CT Commissioner Department of Mental Health and Addiction Services before the Public Health Committee on 3/7/2012, CT averaged one opiate death a day among 18-25 year olds – the leading rate of death for this age group in 2009.

In April 2011's National Public Health Week Fact Sheet, the CT Department of Public Health stated that:

1. Overdose death rates in the United States have increased fivefold since 1990.
2. According to the CDC, the increase in drug overdose is largely due to the use of prescription opioids painkillers.
3. Accidental drug-related poisoning has surpassed motor vehicle crashes as a leading cause of death in CT.
4. From 2005-2007 there were 2,578 hospitalizations and 7,140 poisoning-related emergency department visits to the state. In addition, there were 106 suicide deaths due to drug and alcohol poisonings; and over 3, 000 hospitalizations and over 3,000 emergency department visits related to suicide attempt drug poisoning.

In contrast to other treatment programs that address alcohol and marijuana abuse only, The Next Right Thing is responding to the nationally recognized opiate epidemic (Heroin and prescription pain killers). In addition, most other programs separate this 16-23 year old age-group into treatment programs treating 16 and 17 year olds with patients as young as 12 year-olds and 18 through 23 year olds with much older adults. The Next Right Thing is designed to address this age group's unique developmental and neurological challenges.

NEED BASED ON LOCAL PREVALENCE DATA

Calculating the Size of the Need

To calculate the need for our services, we start by identifying the number of people within our target age. This data is based on the US Census data – the details immediately follow this chart. Please note that the actual number of 15-23 year-olds in the service area is HIGHER than what shows by census due to the large number of private high schools and public/private colleges in the area.

Table 1: Population by Age for Towns in the Service Area

Town	Total population	15-19 year olds (2010 US Census)	20-24 year olds (2010 US Census)	Total 2010 Census for 15-24 Year-olds	Estimated 16-23 Year Olds (based on US Census)
Avon	18,098	1,257	459	1,716	1,373
Canton	10,292	628	372	1,000	800
Farmington	25,340	1,572	1,162	2,734	2,187
Simsbury	23,511	1,840	705	2,545	2,036
West Hartford	23,268	4,376	3,009	7,385	5,908
Totals	**140,509**	**9,673**	**5,707**	**15,380**	**12,304**

*The calculation for 16-23year olds is as follows: Total 2010 census for 15-24 year olds times 80%. We multiplied by 80% to take out two years (out of the ten shown) – the 15 year-olds and 24 year-olds.

Note – Population numbers are from the US Census Bureau's American FactFinder web-pages: http://factfinder2.census.gov/faces/nav/jsf/pages/community_facts.xhtml#none

US Census Bureau data found on American FactFinder's web pages

Geography: Avon town, Hartford County, Connecticut

Subject	Number	Percent
SEX AND AGE		
Total population	18,098	100.0
15 to 19 years	1,257	6.9
20 to 24 years	459	2.5

Geography: Canton town, Hartford County, Connecticut

Subject	Number	Percent
SEX AND AGE		
Total population	10,292	100.0
15 to 19 years	628	6.1
20 to 24 years	372	3.6

Geography: Farmington town, Hartford County, Connecticut

Subject	Number	Percent
SEX AND AGE		
Total population	25,340	100.0
15 to 19 years	1,572	6.2
20 to 24 years	1,162	4.6

Geography: Simsbury town, Hartford County, Connecticut

Subject	Number	Percent
SEX AND AGE		
Total population	23,511	100.0
15 to 19 years	1,840	7.8
20 to 24 years	705	3.0

Geography: West Hartford town, Hartford County, Connecticut

Subject	Number	Percent
SEX AND AGE		
Total population	63,268	100.0
15 to 19 years	4,376	6.9
20 to 24 years	3,009	4.8

The following table starts with the number of 16-23 year old adolescents in each of the service area towns. The number of adolescents in each of these towns is multiplied by the percentage of those needing but not getting treatment for substance abuse issues. Out of the resulting number of persons who need substance abuse treatment, The Next Right Thing's IOP program proposes to serve just under 3%.

Number of Persons in Service Area with Unmet Need

Description of population	Town	Number of Persons (16-23)	% Needing Services (but not receiving treatment)*	Number of Persons Needing Services	% of Persons Proposed to be Served by the Applicant	# of persons to benefit from proposal
16-23 year-old residents	Avon	1,373	16.54%	227 (1,370*.1654)	2.95%	7 (227*.0295)
16-23 year-old residents	Canton	800	16.54%	132	2.95%	4
16-23 year-old residents	Farmington	2,187	16.54%	362	2.95%	10
16-23 year-old residents	Simsbury	2,036	16.54%	337	2.95%	10
16-23 year-old residents	West Hartford	5,908	16.54%	977	2.95%	29
	Total Service Area	**12,304**		**2,035**		**60**

*The percent of adolescents needing services but not receiving treatment is taken from (Substance Abuse and Mental Health Services Administration) SAMSA's 2010-2011 National Surveys on Drug Use and Health (NSDUH). The NSDUH is an ongoing survey of the civilian, non-institutionalized population of the United States aged 12 years or older. All estimates are based on a small area estimation (SAE) methodology in which State-level NSDUH data are

combined with county and census block group/tract-level data from the State. Two excerpts from relevant tables are included below.

For 18-25 year-olds (the age category that best overlaps our target population) the prevalence in CT for those who need treatment for alcohol in the past year but did not receive it is estimated at 16.54% and for illicit drug use at 6.96%. The degree to which these two prevalence percentages are additive is not clear. We've taken a conservative approach by using 16.54% rather than the total of 23.5%.

Table 22. *Needing But Not Receiving Treatment for Alcohol Use in the Past Year*, by Age Group and State: Percentages, Annual Averages Based on 2010 and 2011 NSDUHs

NOTE: Needing But Not Receiving Treatment refers to respondents classified as needing treatment for alcohol, but not receiving treatment for an alcohol problem at a specialty facility (i.e., drug and alcohol rehabilitation facilities [inpatient or outpatient], hospitals [inpatient only], and mental health centers).

NOTE: State and census region estimates, along with the 95 percent Bayesian confidence (credible) intervals, are based on a survey-weighted hierarchical Bayes estimation approach and generated by Markov Chain Monte Carlo techniques. For the "Total U.S." row, design-based (direct) estimates and corresponding 95 percent confidence intervals are given.

NOTE: The column labeled "Order" can be used to sort the data to the original sort order.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2010 and 2011 (2010 Data - Revised March 2012).

Order	State	12 or Older Estimate	12 or Older 95% CI (Lower)	12 or Older 95% CI (Upper)	12-17 Estimate	12-17 95% CI (Lower)	12-17 95% CI (Upper)	18-25 Estimate	18-25 95% CI (Lower)	18-25 95% CI (Upper)	26 or Older Estimate	26 or Older 95% CI (Lower)	26 or Older 95% CI (Upper)
1	Total U.S.	6.45%	6.24%	6.66%	4.03%	3.78%	4.30%	14.46%	13.98%	14.96%	5.36%	5.10%	5.62%
2	Northeast	6.71%	6.28%	7.17%	4.08%	3.71%	4.50%	15.13%	14.32%	15.98%	5.61%	5.10%	6.16%
3	Midwest	6.64%	6.29%	7.01%	3.87%	3.56%	4.20%	15.20%	14.54%	15.90%	5.50%	5.08%	5.95%
4	South	5.74%	5.43%	6.07%	3.66%	3.36%	3.99%	12.89%	12.29%	13.51%	4.77%	4.40%	5.17%
5	West	7.18%	6.69%	7.71%	4.72%	4.22%	5.27%	15.71%	14.74%	16.72%	5.96%	5.38%	6.61%
6	Alabama	5.05%	4.04%	6.28%	3.35%	2.55%	4.38%	11.31%	9.41%	13.55%	4.16%	3.08%	5.61%
7	Alaska	7.44%	6.05%	9.13%	4.21%	3.24%	5.46%	15.13%	12.63%	18.02%	6.40%	4.83%	8.43%
8	Arizona	7.68%	6.18%	9.50%	4.48%	3.43%	5.83%	16.02%	13.49%	18.91%	6.67%	5.01%	8.85%
9	Arkansas	4.94%	3.93%	6.19%	3.77%	2.86%	4.94%	11.03%	9.17%	13.20%	4.06%	2.97%	5.53%
10	California	7.11%	6.36%	7.94%	5.08%	4.29%	6.02%	15.62%	14.13%	17.23%	5.80%	4.92%	6.82%
11	Colorado	8.09%	6.72%	9.70%	4.47%	3.43%	5.82%	18.75%	16.20%	21.61%	6.67%	5.15%	8.60%
12	Connecticut	6.97%	5.63%	8.59%	4.06%	3.10%	5.29%	16.54%	13.99%	19.45%	5.78%	4.33%	7.68%
13	Delaware	5.89%	4.73%	7.32%	3.55%	2.70%	4.65%	13.82%	11.57%	16.44%	4.84%	3.59%	6.51%

Table 21. *Needing But Not Receiving Treatment for Illicit Drug Use in the Past Year*, by Age Group and State: Percentages, Annual Averages Based on 2010 and 2011 NSDUHs

NOTE: Needing But Not Receiving Treatment refers to respondents classified as needing treatment for illicit drugs, but not receiving treatment for an illicit drug problem at a specialty facility (i.e., drug and alcohol rehabilitation facilities [inpatient or outpatient], hospitals [inpatient only], and mental health centers). Illicit Drugs include marijuana/hashish, cocaine (including crack), inhalants, hallucinogens, heroin, or prescription-type psychotherapeutics used nonmedically, including data from original methamphetamine questions but not including new methamphetamine items added in 2005 and 2006. See Section B.4.8 in Appendix B of the *Results from the 2008 National Survey on Drug Use and Health: National Findings.*

NOTE: State and census region estimates, along with the 95 percent Bayesian confidence (credible) intervals, are based on a survey-weighted hierarchical Bayes estimation approach and generated by Markov Chain Monte Carlo techniques. For the "Total U.S." row, design-based (direct) estimates and corresponding 95 percent confidence intervals are given.

NOTE: The column labeled "Order" can be used to sort the data to the original sort order.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2010 and 2011 (2010 Data - Revised March 2012).

Order	State	12 or Older Estimate	12 or Older 95% CI (Lower)	12 or Older 95% CI (Upper)	12-17 Estimate	12-17 95% CI (Lower)	12-17 95% CI (Upper)	18-25 Estimate	18-25 95% CI (Lower)	18-25 95% CI (Upper)	26 or Older Estimate	26 or Older 95% CI (Lower)	26 or Older 95% CI (Upper)
1	Total U.S.	2.40%	2.28%	2.51%	4.34%	4.10%	4.59%	7.05%	6.73%	7.38%	1.34%	1.22%	1.48%
2	Northeast	2.37%	2.20%	2.57%	4.22%	3.81%	4.68%	7.33%	6.72%	8.00%	1.33%	1.14%	1.55%
3	Midwest	2.24%	2.10%	2.39%	4.02%	3.69%	4.38%	6.64%	6.20%	7.11%	1.25%	1.09%	1.43%
4	South	2.31%	2.17%	2.47%	4.06%	3.73%	4.42%	6.54%	6.09%	7.03%	1.36%	1.20%	1.55%
5	West	2.69%	2.46%	2.94%	5.14%	4.56%	5.77%	7.98%	7.25%	8.79%	1.42%	1.18%	1.70%
6	Alabama	2.14%	1.74%	2.62%	3.74%	2.76%	5.06%	6.34%	4.84%	8.26%	1.20%	0.84%	1.72%
7	Alaska	2.78%	2.22%	3.46%	5.22%	3.88%	6.98%	6.62%	4.95%	8.80%	1.69%	1.13%	2.50%
8	Arizona	2.78%	2.21%	3.50%	5.70%	4.15%	7.80%	7.50%	5.69%	9.84%	1.60%	1.08%	2.35%
9	Arkansas	2.21%	1.80%	2.71%	4.02%	2.99%	5.39%	6.47%	5.03%	8.30%	1.27%	0.89%	1.81%
10	California	2.79%	2.46%	3.18%	5.31%	4.46%	6.30%	8.34%	7.20%	9.65%	1.42%	1.08%	1.87%
11	Colorado	2.58%	2.15%	3.10%	5.05%	3.71%	6.83%	9.26%	7.33%	11.63%	1.13%	0.78%	1.64%
12	Connecticut	2.28%	1.84%	2.82%	3.98%	2.94%	5.36%	6.96%	5.31%	9.07%	1.31%	0.91%	1.89%
13	Delaware	2.34%	1.90%	2.87%	3.84%	2.81%	5.21%	7.04%	5.39%	9.14%	1.38%	0.94%	2.01%

LEVEL OF TREATMENT AND REQUIRED LICENSES

The Next Right Thing, LLC was established in October of 2011 as a private office- based substance abuse treatment center designed to meet the complex needs of dually diagnosed mid-late adolescents between the ages of 16-23. The majority of clients receiving services are poly substance abusing (multiple drug usage including heroin) with a co-morbid psychiatric diagnosis. The program currently provides: comprehensive evaluation, individual, family, and group services, crisis intervention, ongoing medication management services, intensive outpatient programming, coordination of treatment with schools and the judicial system, and ongoing after-care services.

Since the inception of The Next Right Thing, we have provided a variety of treatment services to 23 families. These services are 100% funded by the families on a self-pay basis payable to The Next Right Thing. We provide service statements to submit to third party payer for out-of-network reimbursement, when covered.

IOP Level of Treatment to be Provided

The purpose of this application is to obtain intensive outpatient program (IOP) licensure so that TNRT can be recognized by third party payers and a contractual relationship for reimbursement can be established. Insurance companies require DPH licensure in order to reimburse clients for this level of care. Insurance companies will not reimburse clients for more than one service per day in outpatient settings.

Structure of the IOP

The Next Right Thing's IOP program complies with federal, state, and third-party payer regulations. The program is structured for minimally three times a week, three consecutive hours a day with an approximate length of stay of six-eight weeks, followed by long-term long term aftercare for the adolescent and his/her parents.

Program components to include:

- Comprehensive assessment with the patient and their family that incorporates the Stages of Change Model to provide the guidelines for determining when a client is ready for less intensive treatment.

- During the initial treatment assessment, The Next Right Thing will develop a treatment plan that includes both IOP and after-care goals. These treatment plans will be reviewed weekly during the IOP phase of treatment.
- Other treatment includes individual, family, a variety of group based services, parent support, and on-going medical supervision and medication titration.
- We provide an alternative medically supervised ambulatory detox for opiate addicts (as opposed to a Suboxone detox). Our detox occurs in a highly structured and supervised program because in our experience 1) Suboxone detoxes are often misused and frequently unsuccessful and 2) by using a non-opioid detox protocol we can move patients more rapidly to an opiate blocker (Naltrexone).

The Next Right Thing – Admission Criteria

An IOP level of care for an adolescent client is necessitated by the following factors:

1) A client's age/and or lack of cognitive and behavior skills to cope with simultaneous substance abuse and mental health issues.
2) The client demonstrates little or no insight into how continued substance abuse poses risks in all domains of functioning (social, emotional, moral, and intellectual) or minimizes severity of both substance abuse and mental health problems. Functional impairment in meeting age appropriate expectations is already evident and can be documented.
3) Attempts at outpatient treatment are unlikely to be productive or have failed.
4) The client's parents demonstrate adequate understanding of substance abuse and mental health risk factors and can provide appropriate support and structure to facilitate the client achieving the goals of treatment in an IOP setting.
5) The parents also consent to involvement in treatment as an essential factor in their adolescent achieving treatment objectives and goals.
6) The IOP level of care is appropriate level for a client's transition from more intensive treatment or as a level of treatment to avoid more intensive partial hospital or inpatient care.
7) The adolescent demonstrates symptomatology consistent with the American Psychiatric Association's (Diagnostic and Statistical Manual) DSM-IV-TR (Axis 1-5)

diagnosis or diagnoses, which require and can reasonably be expected to respond to therapeutic intervention at this level of care.

8) Admission to the IOP is consistent with the American Society of Addiction Medicine's ASAM PC-2R adolescent placement criteria for *both* clinical appropriateness *and* medical necessity of treatment.
9) There are reasonable expectations that the adolescent will show significant progress toward achievement of treatment goals within the specified time frames dictated by an individual treatment plan.

Licenses Needed by the Applicant for the Proposal

Agency	**License**	**Needed for Proposal (✓)**
DPH	Psychiatric Outpatient Clinic for Adults	✓
	Facility for the Care or the Treatment of Substance Abusive or Dependent Persons (Outpatient)	✓
	Mental Health Day Treatment Facility	✓
DCF	Outpatient Psychiatric Clinic for Children	✓
	Extended Day Treatment	NO

SUMMARY OF NEED

In summary, The Next Right Thing, LLC Is applying to the Department of Public Health for a license to provide intensive outpatient treatment for dually diagnosed late adolescents. The morbidity and mortality rates with this group are escalating at an unprecedented rate, which points to the need for more specialized services.

Our treatment approach has evolved in employing the best practice guidelines for treating the developmental problems associated with adolescence. We are already working closely with the local Capital Area Substance Abuse Council (CASAC) community substance abuse prevention committee, private practitioners, schools, pediatricians, probation officers, hospitals and other service providers to extend treatment options and tighten the safety net.

Licensure will help families with adolescents in need to use insurance to cover the range of services we offer, from intensive outpatient programs through long term aftercare.

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

AGENDA

PUBLIC HEARING

Docket Number: 13-31822-CON

The Next Right Thing, LLC

Establishment of an Intensive Outpatient Behavioral Health Treatment Program

June 20, 2013, at 9:00 a.m.

I. **Convening of the Public Hearing**

II. **Applicant's Direct Testimony (10 minutes)**

III. **OHCA's Questions**

IV. **Closing Remarks**

V. **Public Hearing Adjourned**

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

TABLE OF THE RECORD

APPLICANT: **The Next Right Thing, LLC**

DOCKET NUMBER: **13-31822-CON**

PUBLIC HEARING: **June 20, 2013 at 9:00 a.m.**

PLACE: **410 Capitol Avenue, Third Floor Hearing Room**
Hartford, Connecticut

EXHIBIT	DESCRIPTION
A	Letter from The Next Right thing, LLC (Applicant) dated February 6, 2013, enclosing the CON application under Docket Number 13-31822, received by OHCA on February 13, 2013. (82 Pages)
B	OHCA's letter to the Applicant dated March 7, 2013, requesting additional information and/or clarification in the matter of the CON application under Docket Number 13-31822. (4 Pages)
C	Applicant's responses to OHCA's letter of March 7, 2013, dated April 25, 2013, in the matter of the CON application under Docket Number 13-31822, received by OHCA on April 25, 2013. (30 Pages)
D	OHCA's letter to the Applicant dated May 8, 2013 deeming the application complete as of May 6, 2013 in the matter of the CON application under Docket Number 13-31822. (1 page)
E	Designation letter dated May 13, 2013 of the hearing officer in the matter of the CON application under Docket Number 13-31822. (1 page)
F	OHCA's request for legal notification in the *Hartford Courant* and OHCA's Notice to the Applicant of the public hearing scheduled for June 19, 2013, in the matter of the CON application under Docket Number 13-31822, dated May 13, 2013. (4 Pages)
G	OHCA's request for legal notification in the *Hartford Courant* and OHCA's Notice to the Applicant of the rescheduling of the public hearing scheduled for June 20, 2013, in the matter of the CON application under Docket Number 13-31822, dated May 24, 2013. (4 Pages)
H	OHCA's letter to the Applicant dated June 5, 2013, requesting prefile testimony and enclosing issues to be discussed at the hearing in the matter of the CON application under Docket Number 13-31822. (2 Pages)
I	E-mail Letter from the Applicant attaching Prefile Testimony dated June 14, 2013, in the matter of the CON application under Docket Number 13-31822, received by OHCA on June 14, 2013. (11 Pages)

Administration Meeting data available from DMHAS.

OHCA HEARINGS - EXHIBIT AND LATE FILE FORM

Applicants: The Next Right Thing, LLC

DN: 13-31822-CON

Hearing Date: June 20, 2013

Time: 9:00 a.m.

Proposal: Establishment of an Intensive Outpatient Behavioral Health Treatment Program

OHCA Exhibit #	Description
1	
2	
3	
4	
5	

Applicant Late File #	Description	Due Date	Rec'd
1	Letters as Requested	30 days	
2	# Referrals by Provider and Nos. of Referrals	30 days	
3			
4			
5			
6			

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

TENTATIVE AGENDA

PUBLIC HEARING

Docket Number: 13-31822-CON

The Next Right Thing, LLC

Establishment of an Intensive Outpatient Behavioral Health Treatment Program

June 20, 2013, at 9:00 a.m.

I. **Convening of the Public Hearing**

II. **Applicant's Direct Testimony (10 minutes)**

III. **OHCA's Questions**

IV. **Closing Remarks**

V. **Public Hearing Adjourned**

PUBLIC HEARING
INFORMAL PARTICIPANT
SIGN UP SHEET

June 20, 2013
9:00 a.m.

Docket Number: 13-31822-CON
The Next Right Thing, LLC
Establishment of an Intensive Outpatient Behavioral Health Treatment Program

PRINT NAME	Phone	Fax	Representing Organization
Jenifer Simpson	236-1499	-1414	The Next Right Thing, LLC
Ann L Price MD	646-733-7816	∅	The Next Right Thing LLC
Julian Hartt Sr	860.810.8574	860.233.8807	The Next Right Thing LLC
Karen Colt	860 573-6907	∅	The Next Right Thing LLC
[signature]	860-209-0798	∅	"

Greer, Leslie

From: Greci, Laurie
Sent: Friday, June 21, 2013 8:20 AM
To: jenifer@NextRightThing.net
Cc: Hansted, Kevin; Riggott, Kaila; Greer, Leslie
Subject: 13-31822-CON, The Next Right Thing, LLC

Dear Jenifer,

At the hearing held on Thursday, June 20, 2013, concerning the above Certificate of Need application, the Hearing Officer, Att. Kevin Hansted, requested that The Next Right Thing, LLC provide OHCA with two late files:

Late File 1: Letters that support the need for the Applicant's proposed Intensive Outpatient Program. Letters are to be addressed to:

Deputy Commissioner Lisa Davis
State of Connecticut, Department of Public Health
410 Capitol Avenue, MS #13HCA
P. O. Box 340308
Hartford, CT 06134

Late File 2: The number of referrals made to the Applicant from other providers by year and provider name requesting the Intensive Outpatient level of service.

The two late files must be submitted to the Office of Health Access by 4:30 p.m. on July 22, 2013. If you need additional time, please submit a request in writing to OHCA by July 19. If you have any questions, please do not hesitate to contact me.

Sincerely,

Laurie

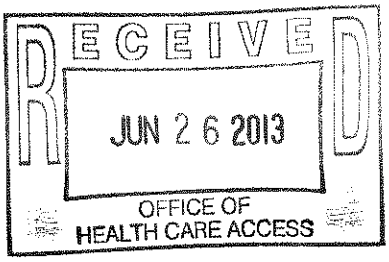
Laurie K. Greci
Associate Research Analyst
Department of Public Health
Health Care Access
laurie.greci@ct.gov
860 418-7032
860 418-7053

ORIGINAL

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

OFFICE OF HEALTH CARE ACCESS



THE NEXT RIGHT THING, LLC

ESTABLISHMENT OF AN INTENSIVE OUTPATIENT
BEHAVIORAL HEALTH TREATMENT PROGRAM

DOCKET NO. 13-31822-CON

JUNE 20, 2013

9:00 A.M.

410 CAPITOL AVENUE
HARTFORD, CONNECTICUT

POST REPORTING SERVICE
HAMDEN, CT (800) 262-4102

. . .Verbatim proceedings of a hearing before the State of Connecticut, Department of Public Health, Office of Health Care Access, in the matter of The Next Right Thing, LLC, Establishment of an Intensive Outpatient Behavioral Health Treatment Program, held at 410 Capitol Avenue, Hartford, Connecticut, on June 20, 2013 at 9:00 a.m. . . .

HEARING OFFICER KEVIN HANSTED: Good morning, everyone.

ALL: Good morning.

HEARING OFFICER HANSTED: This public hearing before the Office of Health Care Access, identified by Docket No. 13-31822-CON, is being held on June 20, 2013 to consider the Next Right Thing, LLC's application to establish an intensive outpatient behavioral health treatment program.

This public hearing is being held pursuant to Connecticut General Statutes, Section 19a-639a, and will be conducted as a contested case, in accordance with the provisions of Chapter 54 of the Connecticut General Statutes.

My name is Kevin Hansted, and I've been designated by Commissioner Jewel Mullen of the Department of Public Health to serve as the Hearing Officer for this matter.

The staff members assigned to assist me in this case today are Kaila Riggott and Laurie Greci. The hearing is being recorded by Post Reporting Services.

In making its decision, OHCA will consider and make written findings concerning the principles and guidelines set forth in Section 19a-639 of the Connecticut General Statutes.

The Applicant, The Next Right Thing, LLC, has been designated as a party in this proceeding.

At this time, I will ask staff to read into the record those documents already appearing in OHCA's Table of the Record in this case. All documents have been identified in the Table of the Record for reference purposes. Ms. Greci?

MS. LAURIE GRECI: Thank you. Laurie Greci, OHCA staff. I'd like to read in the Table of the Record those exhibits listed as A through I.

HEARING OFFICER HANSTED: And are there any additional exhibits?

MS. GRECI: Not at this time.

HEARING OFFICER HANSTED: And does the Applicant have any objections to the exhibits?

MR. JULIAN HARTT: No.

HEARING OFFICER HANSTED: Thank you. And, at this time, I'm just going to take administrative notice of the data that is within the Department of Mental and Addiction Services.

And would any, actually, all of the individuals, who are going to testify here today, would you please stand, raise your right hand, and be sworn in?

(Whereupon, the parties were sworn.)

HEARING OFFICER HANSTED: Thank you. And I would just remind you, the first time you speak today, please state your full name for the record. At this time, The Next Right Thing may proceed with their testimony.

MR. HARTT: Good morning. My name is Julian Hartt, Jr., a Licensed Clinical Social Worker, and I am the Clinical Director of The Next Right Thing.

HEARING OFFICER HANSTED: Good morning.

MR. HARTT: Good morning. Thank you for the opportunity to present our case, our program to the Department of Public Health.

I conceived this program approximately two

years ago, when I saw the rampant increase in the morbidity and mortality rates of adolescent substance abuse in the suburbs.

The adolescents in the suburbs were presenting with greater risk than some of the adolescents in the urban centers.

A particular concern of mine was not just polysubstance abuse. The linear path from ostensibly soft drugs to hard drugs was no more. According to the APA findings in 2006 American Psychiatric Association, the stepping stones were gone.

Adolescents were starting with drugs of abuse that had high abuse liability, and a particular concern to me was in '02 to '04. Across the country, again, with this particular demographic, there was a growing number of adolescents, who were becoming addicted and dependent to prescription pain_meds.

This addiction started in the home. It didn't start on the streets, and there weren't adequate resources to treat them, and families were sending their kids to out-of-state, sometimes in-state, but expensive residential self-pay programs for detox and treatment.

The opiate addiction, again, this was a national phenomenon by '06, '08, was moving rampantly to

heroin. When the supply at home became depleted, adolescents would turn to heroin, and, again, the morbidity and especially the mortality rates began to climb, and those statistics were noted in our application.

So as the severity of the problems with adolescent substance abuse increased, the availability of services offered by insurance companies decreased. There were brief stays for inpatient stays, some partial hospital stays for dual diagnosis kids. There was nothing for primary substance abuse.

And, then, step down to the least intensive of care, which was outpatient, you know, once-a-week individual family, perhaps a group there, so there was, you know -- I noted there was a huge gap in services that we could provide with intensive outpatient services of an indeterminate nature, then stepping down into after-care, noting that the kids would need a longer term recovery process, and insurance companies would no longer -- well, two years ago, were hesitant to admit adolescents to inpatient detox facilities, because opiates are essentially medically not life threatening.

The detox isn't, so they could be detoxed on an ambulatory basis, and, fortunately, suboxone was

available at the time, so it defaulted to detoxes. My experience was that suboxone, in time, would become abused, also, and the literature is there to support that.

Dr. Price joined me in this endeavor. We've been detoxing adolescents from heroin approximately -- we've been in operation for about a year and a half, and 25 percent of the population, about 40 families, have required detox, and we've been using Clonidine detox, Dr. Price can speak to the medical issues with that, then moving the kids directly to Naltrexone, which is a complete opiate blocker, to keep kids alive.

The first group we admitted, the first seven we admitted, five of them are heroin addicts. One of them was to die, because of non-compliance with Naltrexone, and two of them overdosed, so a high risk, a high-risk population.

And I knew, from having been in practice for 40 years working with the adolescent population, that the entire family had to be treated. It wasn't just a matter of sending a kid to residential placement.

If there's going to be a sustained chance of recovery, the whole family had to be treated and treated intensively, with individual family therapy,

parent, group and multi-family therapy, and that certainly proved to be the case. Without the family being a major part of treatment, the adolescent didn't have a chance.

So as this is an intensive level of care, according to the criteria, that the chances would be that these adolescents would not make it in a lesser intensive setting as an individual therapy or group therapy, and they didn't require a hospitalization, but, again, there isn't hospitalization or residential care insurance companies just don't cover residential treatment, by and large, or they may cover the first 10 days.

So this was designed to be an after-school program for long-term recovery of a primary Axis I diagnosis of substance abuse. I think, without exception, all of our adolescents have carried another Axis II diagnosis that is a medical diagnosis of a major psychiatric disorder.

So these are adolescents demonstrating significant psychopathology, and, in order to get the right medication, we've changed virtually every single adolescent meds that came into the program, because the adolescents were diagnosed while they were still using drugs or that have just stopped, and it takes months to

see what the actual psychiatric presentation is going to be, so I think we've changed every single adolescent's diagnosis and medication that's entered into our program, so it's the dual diagnosis program, it's critical.

As SAMHSA notes in the ASAM P2R criteria for IOP placement, the psychopathology sets in quicker without signs of physical dependency with this population, so long-term recovery is going to be the issue, in part, to keep kids out of more intensive levels of care, to keep kids out of emergency rooms, and this piece has been missing.

There isn't any program that's offering intensive outpatient services in Connecticut for primary substance abuse kids. We've had families come from as far away as Orange, although our program is designed to treat kids in the immediate proximity to West Hartford, Avon, Simsbury, Farmington. Follow the money, sad to say, but extremely high-risk population.

As indicated by the House Bill that was passed last summer, I think it was House Bill 1053, that now families, who have an adolescent, who is abusing opiates, can be prescribed Narcan, which was only prescribed at one time in the emergency rooms.

By 2009, the statistics were that opiate

overdose between 18 and 22 is the leading cause of accidental deaths in Connecticut, so just merely recognition of that's how rampant the problem has become.

The IOP was to offer a level of care that is just not available, again, for primary diagnosis of substance abuse. And when we went to the insurance companies originally last summer, they required us to have a license, because we're going to offer more than one service a day. An IOP is three hours of consecutive treatment three days a week, and they would not reimburse more than one service unit a day.

So I'm here before you today to say there's a great public health need. The numbers are there. There's a great public health need to treat primary substance abuse. Services weren't being offered, and the insurance companies asked us to have this level of licensure, so, in short, that's why we're here.

HEARING OFFICER HANSTED: Okay, thank you. Is there anyone else that wants to give a statement here today?

DR. ANN PRICE: Just briefly.

HEARING OFFICER HANSTED: Sure.

DR. PRICE: I'm Dr. Ann Price.

HEARING OFFICER HANSTED: Good morning.

DR. PRICE: I'm Chief Medical Consultant for The Next Right Thing. I just want to underline some of the things that Julian has said, and, from my standpoint, over the past two years, I've just been truly appalled at the lack of appropriate clinical services for this population.

As Julian said, we're finding that, when you look at these adolescents over time, they present very differently from what they do when they're just in withdrawal or just post-withdrawal, and that really impacts the way you're going to treat them with psychotropic medications, so we have a whole population of adolescents and young adults out there, who I believe are not getting appropriate care.

HEARING OFFICER HANSTED: Okay. Thank you, Doctor. Is there anyone else, who would like to give a statement? Okay. We have some questions. Laurie?

MS. GRECI: Okay. Laurie Greci. Currently, what services are you providing under your professional licenses?

MR. HARTT: We're providing individual therapy --

HEARING OFFICER HANSTED: Hold on one

second. Go ahead.

MR. HARTT: Julian Hartt. We're providing individual therapy, as this is highly individualized treatment, so there's individual therapy, family therapy, group therapy, multi-family therapy, and parent group.

MS. GRECI: Provided under your social work license?

MR. HARTT: Under my license and -- excuse me. I should add to that, also, administration of medication.

MS. GRECI: Under Dr. Price?

MR. HARTT: Correct.

MS. GRECI: Okay.

MR. HARTT: Under my license, all the other therapies are being conducted.

DR. PRICE: I just want to make one correction to that. It's not administration of medication. We have no medications at the facility. It's prescriptions, because I know that can be a real concern.

HEARING OFFICER HANSTED: Thank you.

DR. PRICE: Um-hum.

MS. GRECI: And once you're licensed, would you have any?

DR. PRICE: No.

MS. GRECI: Or you'd still do it the same way?

DR. PRICE: It's really my belief that once you have a substance abuse program, the last thing you want --

MS. GRECI: Are meds on site.

DR. PRICE: Yeah, because it's an attractive nuisance, basically.

MS. GRECI: Okay.

DR. PRICE: And I'm on call 24/7, so if someone needs something, they all have my number, and I feel much better about caring for people that way.

MS. GRECI: Okay. And, then, once you -- say you obtain the licenses, you will be billing all these services under that license?

MR. HARTT: Correct.

MS. GRECI: Correct, okay. Just trying to get the lay of the land. You do ambulatory detox. Now could you describe that program and how you do that?

DR. PRICE: Of course.

MS. GRECI: What volume of people you treat, and how long it takes?

DR. PRICE: Of course. First of all, this

is a tried and true program that was started at the University of Texas Medical Center. What you do is you use a medication, called Clonidine, which is actually a blood pressure medication, but it basically calms the agitated response that a lot of people get in withdrawal.

We do monitor them closely, blood pressure-wise. We send a cuff home with the parents, and it's an automatic cuff, so it's easy to do, and we give them parameters. If it's this low, please call us immediately and stop the medication.

What we add to that is aspirin and hydration, and what happens with most of these patients is they get a flu-like syndrome for a couple of days, they're uncomfortable, but they're not miserable.

If they follow our instructions, it's about a three to five-day detox. Unfortunately, some of them use while they're allegedly detoxing, and we have to start it again, because if you start the Naltrexone when they've been using, they do get really sick.

It's not life-threatening at all, but they get uncomfortable, and that, of course, makes it difficult for us to get their trust.

The Naltrexone -- oh, let me just finish up. I'm sorry. So it's a three to five-day detox. I

think we've done like 10 or 15 kids. I don't have the exact number, but that's ballpark, and, certainly, the number of patients, who come in needing detox, because they're on heroin, is clearly increasing, and these are nice kids from the suburbs, who you would never suspect.

So once they're detoxed, they're started on Naltrexone, and we have a very strict rule that the Naltrexone is powdered, it's crushed, put in either pudding or apple sauce, and administered by the parent, because we've really found that's the only way to guarantee it's being taken, and we found that, when that's not being done, there are very frequent lapses.

Suboxone in some ways is a little more elegant, but even the drug company that manufactures it says 20 to 40 percent is diverted to the streets, so we're not going to give kids something that will be street currency for other drugs.

MS. GRECI: So there's really no limit to the number of children or adolescents that you could detox on time, because they're doing it at home. A limit would be parental participation?

DR. PRICE: That's one thing, and we certainly, at least at this point, have not gotten to the point where I'm not comfortable monitoring what we have.

If we get there, that will be another discussion, but we've got a ways to go.

MS. GRECI: Okay.

MR. HARTT: Excuse me. Julian Hartt. If I may add, I've been working with adolescents for 40 years, Dr. Price for 35. I've never seen such a needy population, so the cell phone I hear from them and Dr. Price does.

DR. PRICE: Texts constantly.

MR. HARTT: So during the detox, we'll hear from them two or three times a day. Is this okay? Is that okay? A relapse is not unusual while they're detoxing, because they don't have the ability to handle the distress, the physical distress, and they want to feel better right now, and it's very easy to hide.

A bag of heroin is the size of a stamp, essentially, so it's very easy to hide this. And I have kids skipping over pills right now, because all the prescribed narcotics are really expensive, so, unfortunately, kids are moving right to heroin, and there's no FDA stamp on this.

Is this 80 percent? Is this 20 percent? So, last week -- and they're moving very quickly from nasal use to IV use. The last young woman, who is in

detox right now, well she's on Naltrexone right now, she has track marks on her arms. Now she's a beautiful 18-year-old, but there was no pills.

So, in my experiences working with addictions, once a drug is on the table, it stays on the table, so this is the new generation. This is not primarily an inner city problem. This is a suburb problem, but, also, incredible polysubstance abuse.

These kids are not risk aversive, for a variety of reasons, not to make this a sociological discussion, but the quality of polysubstance abuse, of using substances and drinking over the top of it and being absolutely mindless of risk is huge.

HEARING OFFICER HANSTED: Doctor, I just have one question for you.

DR. PRICE: Of course.

HEARING OFFICER HANSTED: You had mentioned earlier that the Naltrexone --

DR. PRICE: Naltrexone?

HEARING OFFICER HANSTED: Naltrexone, sorry, is crushed up and put into pudding. Does the patient know they're taking the medication?

DR. PRICE: Absolutely.

HEARING OFFICER HANSTED: Okay.

DR. PRICE: Absolutely. We would never do that. A lot of this program is based on building a relationship and trust.

HEARING OFFICER HANSTED: Okay, thank you.

DR. PRICE: Yeah, we really keep on top of them when they're detoxing.

HEARING OFFICER HANSTED: Okay, thank you.

MS. GRECI: In your application, you state that your main purpose is to provide this intensive outpatient program for dually-diagnosed adolescents and young adults. What programs or services are you planning perhaps in the future to provide under the various licenses that you'll be getting in order to do the current one that you're proposing? Do you have any future business plan to add different services?

MR. HARTT: No. This will allow us to expand our practice and allows insurance to get into the -- Blair Maclachlan, who is sitting behind us, is our business consultant and works directly with the insurance companies.

They are not reluctant to do this, so we can offer more intensive services. We can offer a truly structured. The parents have balked at the cost of this, and understandably so, so we discount, we put payments

down. We have to turn kids away, because we are out-of-network. There's huge deductibles. I want to make this available to people, who have commercial insurance, so I don't want anything more fancier than offering quality treatment, a true IOP to kids, who have insurance. I want to do more.

I'd like to see us have, at maximum, maybe 15 kids, because of the level of care that they need, so I don't see us -- the license that was available was a facility license. I don't have a COBRA plan to build a residential program. I just would like to do what we're doing and get the insurance world. I mean that's really our agenda, to get them involved in this.

And we've shown them what we were doing. They'd say this really makes sense to us. It will reduce the need for higher utilization of higher services, such as the emergency room.

MS. GRECI: Right.

MR. HARTT: I had one boy develop sepsis when I was in practice in New Haven, because of the rituals engaged in heroin use. He didn't have heroin, so he shot water with a dirty needle, and he ended up in the ICU for three weeks. I mean he almost didn't make it. That's this generation of kids. And his cost, can you

imagine? Three weeks in the ICU.

HEARING OFFICER HANSTED: So this is a continuum of care issue, correct?

MR. HARTT: Correct.

HEARING OFFICER HANSTED: Okay.

MR. BLAIR MACLACHLAN: If I could just --

HEARING OFFICER HANSTED: Sure. Why don't you come up to a microphone and just state your name?

MR. MACLACHLAN: Yeah. I'm Blair Maclachlan. I'm a social worker. I've known Julian for way longer than we want to admit to each other or anybody else.

I'm a social worker, been working in psychiatry for 35 years as an independent consultant. I've worked for the majority of the psychiatric departments at most of the hospitals in Connecticut, worked for lead mental health authority and child guidance clinics. I've worked for an insurance company, doing utilization review.

I think this is an issue that providers and insurance companies struggle with. Substance abuse here in the State of Connecticut, the rates of utilization, relapse rates don't seem to be changing, but only growing.

The current system of care for substance abuse in the State is very fragmented for this particular population. There are lots of hospitals, who run adult programs with some substance abuse, but the age range is from 18 to 65.

They're mostly hospital-based, which means they're mostly urban-centered. There are hospitals, who run partial hospital and IOP programs for adolescents.

Under the age of 18, most of the population is under the age of 16, without a primary substance abuse diagnosis, and, so, this adolescent population, 16 to 23, with a primary substance abuse diagnosis, mostly opiate-addicted, is not a place that you're going to find that provides that specific services.

And the ones that come close are ones that are located in urban centers, with mostly governmentally-insured patients, and, so, that patient population that live in the suburbs that have working families going to those locations sets up an additional barrier, and, so, continuing in treatment and following care over the long-term is really impacted by that.

When we've talked to insurance companies, most of them have said we are pleased as punch that

you're going to try to do this. We can't contract with you, unless you have a license, because of the insurance companies' own NCQA accreditation, which is another story all together, so that each insurance company that we've talked to have said we're happy to contract with you, we know we have this problem with this population, we know we're getting calls from parents and their kids are in the Midwest or in the Southeast in these residential programs, and when they come home, they have nothing, and they relapse.

HEARING OFFICER HANSTED: Let me just interrupt for one minute.

MR. MACLACHLAN: Please.

HEARING OFFICER HANSTED: You had mentioned that the insurance companies are happy that you're going to consider this program and that there's a need for this. Is it possible for you to get me letters from the insurance companies, evidencing that need?

MR. MACLACHLAN: I don't know the answer to that, to be honest with you. I know that we've talked about them, with them repeatedly over the last 12 to 18 months. Actually, before we actually started the program.

They have agreed that they would like to

contract with the entity and are willing to do some single-case agreements currently, so the insurance companies are reimbursing either the families directly as an out-of-network benefit, or working with The Next Right Thing around single-case agreements, so I don't know if they would be willing to do that.

I know, historically, insurance companies have been conservative in their formal recognition or recommendation for a certain provider type or particular level of care, so I don't know the answer to that.

HEARING OFFICER HANSTED: Okay.

MR. MACLACHLAN: I know that we've had multiple conversations with the clinical directors of the two major, three major insurance carriers here in the State, and all of them understand the need and have actually given suggestions, in terms of program design, consistent with what The Next Right Thing is doing.

I think the other thing that I would mention and underscore is the individual nature of the treatment that The Next Right Thing is offering, which is, from a payer perspective, attractive, and the real focus on the family involvement, that the multi-family group education, individual family sessions, that component of their program is what, in my mind, separates

this from many of the current programs offering similar kinds of services.

Not many programs across the state operate under the assumption that you have to do family therapy, you have to be in family therapy, multi-family support group, and you have to be in multi-family group therapy as being part of this service.

Part of it is many of those programs are treating patients that don't have intact family units, whereas The Next Right Thing, the majority, if not all of them, have intact family units, plus the recognition of the clinical efficacy of, you know, not only including, but requiring family involvement.

And, so, I think that that not only supports the ongoing monitoring success, that this is a family issue, not just an individual issue, but I think most insurance companies understand that the family support system for these 16, 17, 18 to 23 year olds really is the safety net that kind of holds them together and are very supportive of that.

To answer your question shortly, I don't know the answer to that, but I know ambulatory detox and intensive outpatient services focused on this population is not just a problem that families are experiencing and

providers are experiencing, but insurance companies are experiencing, too.

HEARING OFFICER HANSTED: Okay. Just to elaborate on that, you know, one of the things we look at in making our determination is the actual need for a program like this, and I appreciate what you've provided in your application and testimony you're providing here today.

What I'm trying to get is additional evidence, documentary evidence, showing that there's truly a need out there in the specific area you're proposing.

Do you know of any resources you can tap to get that documentary evidence, that, you know, maybe reach out to the insurance companies, hospitals, doctors, to provide letters of evidencing the need, you know, namely, we've seen this amount of patients, there's a need for a program, such as yours, just like you've been stating the insurance companies have been saying? Is that a possibility?

MR. HARTT: I think that was in the Certificate of Need, the numbers, and I think we, in terms of prevalence and the number of, according to statistics, the number of kids that are going untreated.

HEARING OFFICER HANSTED: Right, and we do have those statistics. What I'm looking for is something beyond statistics, narrowing it down more to a more precise piece of evidence.

MR. HARTT: I'm just not sure how you would go about. I mean I'm here, because the insurance companies asked me to be here, so they're saying there is a need, and we've spoken with them face-to-face, saying that your services are needed. We're not going to reimburse them until you get a license.

HEARING OFFICER HANSTED: Right. Unfortunately, you telling me what the insurance companies have told you is hearsay that I can't consider.

MR. HARTT: They write a letter. Would they write a letter, saying there's a level -- not The Next Right Thing is needed. They couldn't advocate for us.

HEARING OFFICER HANSTED: No, no, and I appreciate that. What I'm looking for is something that states to the effect that this level of care is needed, and it doesn't necessarily have to be an insurance company; a hospital, doctors, etcetera.

MR. MACLACHLAN: I think we can ask them.

HEARING OFFICER HANSTED: Okay.

MR. MACLACHLAN: I mean I think that's reasonable. I think, you know, Julian and Dr. Price have been involved in local, in some of the local substance abuse council activity, and, you know, that would be another place.

There's certainly a variety of providers that they're working with, accept referrals from and refer back to. I assume that those people and organizations could be asked, as well.

HEARING OFFICER HANSTED: That's fine. Yeah, that's fine. And what I'll do is order that as Late File No. 1, and, typically, I would give an Applicant 30 days to get those letters in. Is that reasonable? I'm willing to give you as much time as you think you need.

MR. HARTT: Well, no, I think we can ask.

HEARING OFFICER HANSTED: And, certainly, just to clarify, if you can't get it, then that's fine. Just let us know that you've reached out, and you're unable to procure the letters.

MR. HARTT: I think the number of hospital admits for overdose, which, again, was behind the House Bill passing so quickly last summer, the number of overdoses, the number of deaths in Connecticut in this

population because of heroin speaks to the need for treatment, and speaks to the need for treatment that isn't being provided. I don't know if that's by you. By inference, the Narcan -- if your daughter is allergic to bee stings, you're going to carry an EpiPen. If you think your kid is doing opiates, you can carry a Narcan pen, so I think that speaks to the need.

HEARING OFFICER HANSTED: No, and I agree with you. It does speak to the need. I'm just looking for something more specific in your area.

MR. HARTT: It probably goes under-reported, because --

HEARING OFFICER HANSTED: It may very well.

MR. HARTT: We've seen that. Not my daughter. Not my daughter.

HEARING OFFICER HANSTED: Right. The reason why we ask for this additional evidence is because I believe it does go unreported or underreported, so we don't have access to the information to verify what you're saying, in terms of the specific need for the specific population you want to treat, so that's why we ask just for you to reach out and get a little bit more additional information for us to consider.

MR. HARTT: Okay.

HEARING OFFICER HANSTED: And is 30 days enough time for you to do that? Okay.

MR. MACLACHLAN: Barring anybody's vacation.

HEARING OFFICER HANSTED: That's fine.

MR. MACLACHLAN: It's that time of the year, July holiday kind of thing.

HEARING OFFICER HANSTED: And if you need additional time, just reach out to us, and I'm happy to give you additional time, but, for now, we'll say 30 days.

MR. MACLACHLAN: I just think about the timing of it.

HEARING OFFICER HANSTED: It is summertime. People are on vacation.

MR. MACLACHLAN: Right, but, in the flip side, if we can, you know, if you're looking for one letter versus two letters versus five letters versus 10 letters, I mean, I guess what I'm asking is, you know, what's the nature of the volume of the support that you need to be able to make a final judgment?

HEARING OFFICER HANSTED: One or more letters. I'll leave the extent up to you.

MR. MACLACHLAN: All right. And, so, I'm sure we can get that relatively quickly. Yeah. I assume that 30 days would be more than adequate.

HEARING OFFICER HANSTED: Okay, so, I'll order that 30 days from today's date, and if that date falls on a weekend, we'll bump it to the next Monday.

MR. MACLACHLAN: I assume you're not going to need an elaborate five-page document?

HEARING OFFICER HANSTED: No.

MR. MACLACHLAN: All right, thank you.

HEARING OFFICER HANSTED: You're welcome.

MS. GRECI: Ave you applied for the DCF license for the outpatient clinic, psychiatric clinic for children?

MS. JENNIFER SIMPSON: This is Jennifer Simpson.

HEARING OFFICER HANSTED: Can you come up more? Can you hear her?

MS. SIMPSON: We did an official thing to the DPH. Now I want to say it's probably been close to a year, because we had thought we would not need a full-blown Certificate of Need, so it's already in there.

What I don't know is whether we'll need to do some updates for that.

MS. GRECI: To DCF?

MS. SIMPSON: Well it's to the -- they said it would go from one department to another, so it hasn't reached DCF, and it hasn't been fully reviewed there for the -- somewhere in DPH until the Certificate of Need gets attached to it or is approved. Does that make sense?

We needed to have either approval or that we didn't need it, so the paperwork is there, but it hasn't gone through. This step has to be met first.

HEARING OFFICER HANSTED: So you need your CON before you can get your license?

MS. SIMPSON: Before everything else is completed.

MS. GRECI: Okay, but it's in the works?

MR. MACLACHLAN: Yes.

MS. SIMPSON: Yes.

MS. GRECI: Okay. How long will clients be in your after-care program?

MR. HARTT: Forever. I've been doing this a long time, and this generation, the millennials, are presenting with incredible need, so I can see, if we do an IOP, four to six weeks of intensive outpatient services to get them going.

Now I'm using ASAM's criteria for admission and discharge, which is the -- ASAM bases its criteria on stages of change model, that they've moved from pre-contemplation, I don't have a problem, you think I do, they move from pre-contemplation into contemplation into the action phases of recovery, and that's their benchmark.

Four to six weeks, you can document that they are moving with goals of treatment being reviewed monthly, the master treatment plan being reviewed monthly, individual family therapy that they should be in beyond maybe I do have a problem, and I do have a problem, and I'm on the road to recovery, as measured by I'm back in school, I've got a job.

The juvenile justice is heavily involved with our program. I presented last Thursday afternoon to every single juvenile probation officer in Connecticut.

They wanted a workshop on heroin in the suburbs. They asked me if I do it. I was flattered, but the juvenile justice system is heavily -- they don't know what to do with these kids, so the kids, who have probation officers, usually do well, so they have to be in school.

We do random drug screens. We have a very

sophisticated laboratory arrangement with Quest laboratories. The day the kids go in, we get the results to my e-mail and to the computer the same day, so we want the kids clean for that period of time, and, then, after four to six weeks of intensive outpatient, to step down to two after-care meetings a week.

I think the parents have to be involved with this, going through this. We have sort stepped around some of the problems of the other programs. Our families are more involved.

An 18-year-old doesn't have the option to say, well, I don't want my parents to know what's going on, and I think, for effective substance abuse, the parents have to know.

There's some information said in individual therapy that parents will never know about, but they're going to know about the drug screens, and the parent is going to have consequences in place, meaningful, if the child turns up with positive urines, and, in the case that that's happened, I haven't discharged an adolescent.

I've asked them to give me a discharge date, and what date do you think? What date are you going to discharge yourself, because you and your parents

can't get you to clean, but, again, is this a dual diagnosis program? We have no idea what meds they need, and we've had an inordinate amount of bipolar diagnoses that was completely missed all together.

We need that extended period of time to pick up. I don't know if we've seen an adolescent that hasn't carried another Axis I diagnosis. In many cases, I know, when I started working with this population 10 years ago, that the drugs teased out latent biological disorders, that marijuana is probably the principal offender.

As perceived risk of marijuana has approached zero, the actual risk, because cannabis, marijuana now is 10 times to 15 times more potent than what Bill Clinton didn't inhale in 1972, so we're working with very potent psychoactive substances.

We've seen kids with marijuana-induced psychosis. Who is treating these kids? Actually, we had one come to us and was given a diagnosis of major depression with psychotic features wasn't the case at all, but that's because inpatient allowed for five days of treatment, and you're going to get a lousy diagnosis with five days of treatment, and you're going to get lousy medication, because if you're inpatient, we've got

to give you something.

MR. MACLACHLAN: I think, typically, from an after-care perspective, a good answer is as long as needed, but within some parameters. I think that the program is based for a population of this age group, so having somebody receiving after-care services into their fifties or their forties is probably not going to happen.

I think, given the nature of the family dynamics and the nature of this illness, that patients in this program will have the ability to use a higher or lower intensity of after-care services, based on their need, so that there's a structure setup of after-care groups, there's a structure of after-care family work, there's a structure of individual and group-based services, so that after the intensive program is no longer needed, that, based on patient need, they'll be able to make use of whatever they, or their families, or their group, or their treaters feel is the next level of need to kind of keep them on that road.

So one could go once a week, or once every other week, or once a month, and then run into something and say, oops, I think I need a little bit of a touchup, and then increase it to, you know, once a week or twice a week and do some family work.

And, so, the after-care thing I think is going to be more fluid than some of the canned programs. Well it's once a week on Tuesdays from 6:00 until 7:30, and all the other times you're kind of on your own. That's not the basis of their after-care program, or structure, or the nature of their service.

And, so, I would anticipate, you know, 10 years from now, if we look back on the data to say the after-care services run, on average, you know, 14 months, but, you know, I mean, but I think --

DR. PRICE: I think there's also another very important neurobiological piece to this. These are kids, whose brains are still developing. We now know that it's only in your early 20s that your brain is literally fully developed, and the last area to develop is the judgment area, the frontal lobe.

So, here, you have a population that's really bathed their brains in goodness knows what, so the guess is, and I think it's more than a guess, is it's going to take much longer for them to reach a mature adult brain, so I think there are going to be real blips.

COURT REPORTER I'm sorry.

(Off the record)

DR. PRICE: I think there are going to be

real blips in the need for after-care. I think there are going to be notable points, like if they go away to college and have a bad time, if they're in a relationship that doesn't work out, so at least I envision that The Next Right Thing will be a place that they can come back to, and we'll know them, and we'll work with them.

MS. GRECI: So, basically, what I'm getting to is you'll be able to handle any of the patients' after-care that go through this IOP?

DR. PRICE: Absolutely.

MS. GRECI: Okay.

MR. HARTT: Julian Hartt. Again, I think one of the critical pieces here, again, having been in services for a long time, is the continuity of care.

If you move from provider-to-provider, you're going to lose something, and I want to offer under one roof the ability to do intensive patient to less-intensive, and there's no reason -- again, I really emphasize individualized care, and I just don't mean that as a slogan.

I mean if you go to a partial hospital program in Connecticut or anywhere, you're going to get cookie cutter services, one size fits all, and you may get, in substance abuse, I know all the programs in

Connecticut for adolescents, you may get one group a week of drug abuse, but it's cookie cutter.

You will do A, B, C in group every day of the week. That doesn't have to be the case, especially individual therapy.

I've had kids and young women, who have come in, and there is a trauma history, there's sexual or physical abuse, so they're going to need some more individual therapy, in order to get them stabilized during the critical initial days of treatment.

It's a continuity of care model that we have the ability to give them a lot upfront, keep them out of hospitals, keep them out of jails.

I don't know how many of our kids have probation officers, so I think, to have this, but once -- you know, if a kid has been clean for a year, he's ready to go, and hopefully get plugged into resources in the community.

There are a growing number of young people in AA meetings. We encourage our kids to go to 12-step meetings. We have taken them to 12-step meetings to get them used to resources in the community that help going forward.

MS. GRECI: Okay, so, basically, your

proposal is to accept duly diagnosed with a primary diagnosis of some kind of opiate addiction, is that correct?

MR. HARTT: No. Substance abuse addiction.

MS. GRECI: Oh, as the primary, but will you also accept duly diagnosed, who only abuse alcohol?

MR. HARTT: I'd like to see one, in all honesty.

MS. GRECI: I understand.

MR. HARTT: The polysubstance abusers. We hadn't admitted a straight alcohol. I haven't seen a straight alcohol kid in a long, long time. It's all polysubstance. We're not doing just heroin.

MS. GRECI: Okay.

MR. HARTT: That should certainly be noted.

MS. GRECI: Okay. In 2015, you wrote in your application that you're going to try to be treating up to 52 patients. What kind of additional resources do you believe you're going to need, in order to handle that population? I mean you'll hire additional staff, obviously.

MS. SIMPSON: This is Jennifer Simpson

again. We're looking at additional space right next to us.

MS. GRECI: Okay.

MR. HARTT: This is Julian. That's 52 patients a year.

MS. GRECI: Correct.

MR. HARTT: Moving through the program. We have hired Casey(phonetic), who is ready to move into full-time, and we'll hire additional Master's-level people as we grow.

MS. GRECI: Okay. How often do you receive a referral to try to get an adolescent into your program?

MR. HARTT: It's regular. I had two this week, and I didn't need to put them into the intensive outpatient program. I thought, if I saw the individual twice a week or saw the family, that I could maintain them at a lower level of care, simply because I know the beast. Don't take that literally.

I have the ability upon intake to judge how much. Probably, a couple a week. Again, right away, I let them know what the insurance coverage is and say check your out-of-network benefits, because I can't do two services a day, and I had people, who come back and

ask me to change the billing. I can't do that.

I want an individual session and a group session a day. Until I get a license, I can't do that. Often, I've had, Laurie, I've had adolescents come in and I've said no. I can work intensively with you and your family and get this done upfront, but give me the option.

MS. GRECI: Right.

MR. HARTT: You know, to do that.

MS. GRECI: Okay.

MR. HARTT: So probably a couple a week, to answer your question.

MS. GRECI: You stated that you do get referrals from local hospitals, like IOL or Rushford Center. Do you keep any records on the referrals that you've received? I mean would you be able to provide some kind of evidence of the number of referrals you've taken in?

MR. HARTT: Sure.

MS. GRECI: Because that would be helpful, too.

HEARING OFFICER HANSTED: All right. I'll order that as Late File No. 2.

MS. SIMPSON: I'm just thinking about HIPAA.

MS. GRECI: Just the numbers. We don't need names.

HEARING OFFICER HANSTED: Yeah.

MS. GRECI: Just the number from each.

MS. SIMPSON: From each facility, okay.

HEARING OFFICER HANSTED: Yeah, certainly, nothing patient-identifiable.

MS. SIMPSON: Okay.

MS. GRECI: With some kind of time frame reported to.

MR. HARTT: Actually, we could -- this is Julian. We could include Yale. We had a referral from Yale and referral from Silver Hill.

MS. GRECI: Okay.

MR. HARTT: So we can do that.

MS. GRECI: Great. That would be great.

MS. SIMPSON: And we don't always take them.

MS. GRECI: No. I'm not asking that. I'm asking the ones that contact you, inquiring about placing someone. Okay.

HEARING OFFICER HANSTED: And that will be due the same date as Late File No. 1.

MS. GRECI: Could you elaborate on the

statement that you say that your structure complies with Federal, State and third party payer regulations? Can you just kind of -- what you're kind of alluding to, expand on it a little bit? It was on page -- oh, I don't have a page, but you say that you already comply, your program already complies with any kind of regulations, and I'm just wondering what those regulation compliance issues were.

MR. MACLACHLAN: I can speak to that broadly, I think, that there are a couple of buckets that I think the world looks at, in terms of IOP.

One is the amount of services provided within a time frame by licensed professionals with area of expertise, so, clearly, you know, how many groups, how many hours a week, that's one bucket by licensed social workers and physicians, who are licensed in the State of Connecticut and have expertise and training in this area, so that's one. One big bucket is the volume.

MS. GRECI: Um-hum.

MR. MACLACHLAN: The second big bucket is around the individual treatment services and the evaluation and planning component.

MS. GRECI: Okay.

MR. MACLACHLAN: So, clearly, the CMS,

Medicaid, and all insurance carriers say, you know, guess what? You have to do an evaluation, and the evaluation has to be done by a licensed person, and it has to include all these various components.

MS. GRECI: Okay.

MR. MACLACHLAN: Which leads to the treatment plan. There's a treatment plan developed that identifies problem areas, and what's the goals of treatment and frequency of review, so on, and so on, and so on.

And, then, lastly is the oversight piece of it, and the oversight piece of it is that most regulations, Federal, State and insurance company regulations, require a physician and a multi-disciplinary team to provide a comprehensive evaluation, treatment planning, execution of treatment interventions, and reviewing of the outcome of those.

Dr. Price and Julian and The Next Right Thing, when you look at those kinds of buckets, they're providing the volume of visits that need to be provided to meet the standard.

Those services that are provided are consistent with community standards related to this population. The evaluation piece, which develops the

treatment plan, is consistent with ASAM criteria, State of Connecticut, and every insurance company, this is what you have to kind of think about when you're providing care, and the review of the outcome of care and the medical record documentation of all of it is consistent with both insurance and Federal and State regulation.

MS. GRECI: Perfect. Thank you.

MR. MACLACHLAN: I think that's the answer.

MS. GRECI: Yeah. I just want to have some idea what they were talking about.

MR. MACLACHLAN: You've got to look at it more concisely, yeah. There's buckets. Medical records, quality, assessment, documentation and clinical structure, all of which is in place currently.

MS. GRECI: Good. Thank you. I just have one last question on page 112 of the application. You have a variability in your percentages. It's not a lot, but it does vary, like, year one, you say you'll do uninsured or self-pay for 16 percent, and then it drops to 14 in year two, and then goes back up to 16 in year three.

MS. SIMPSON: You know, when I worked out the numbers, because we're talking fairly small numbers

and had to round up and actually have a certain number of patients, that's really where that comes from.

MS. GRECI: Okay.

MS. SIMPSON: It's not like I was going in the projection they were thinking it should go 14, 15, 16, or 14, whatever the thing was.

MS. GRECI: It's just how the math worked out?

MS. SIMPSON: Exactly.

MS. GRECI: Okay. All right, thank you. I'm all done.

HEARING OFFICER HANSTED: Kaila, do you have any questions? Okay. I don't have any further questions. Just for the record, are there any members of the public here today that would like to give a statement on this proposal?

Hearing none, let the record reflect there were none, and, with that, I will adjourn this hearing. Thank you, everyone.

MR. HARTT: Thank you.

DR. PRICE: Thank you.

(Whereupon, the hearing adjourned at 10:05 a.m.)

HEARING RE: THE NEXT RIGHT THING, LLC
JUNE 20, 2013

AGENDA

CERTIFICATE

I, Paul Landman, a Notary Public in and for the State of Connecticut, and President of Post Reporting Service, Inc., do hereby certify that, to the best of my knowledge, the foregoing record is a correct and verbatim transcription of the audio recording made of the proceeding hereinbefore set forth.

I further certify that neither the audio operator nor I are attorney or counsel for, nor directly related to or employed by any of the parties to the action and/or proceeding in which this action is taken; and further, that neither the audio operator nor I are a relative or employee of any attorney or counsel employed by the parties, thereto, or financially interested in any way in the outcome of this action or proceeding.

In witness whereof I have hereunto set my hand and do so attest to the above, this 21st day of June, 2013.

Paul Landman
President

Post Reporting Service
1-800-262-4102

CHEMICAL ADDICTIONS TREATMENT SERVICES (CATS)
Website: www.johnforlenza-baileyladc.com
Phone: (860) 796-7974
1268 Main Street Suite 107
Newington, CT 06111

July 3, 2013

Deputy Commissioner Lisa Davis
State of Connecticut, Department of Public Health
410 Capital Avenue, MS # 13HCA
PO Box 340308
Hartford, CT 06134

RE: reference to 13-31822-CON-The Next Right Thing

Dear Deputy Commissioner Lisa Davis:

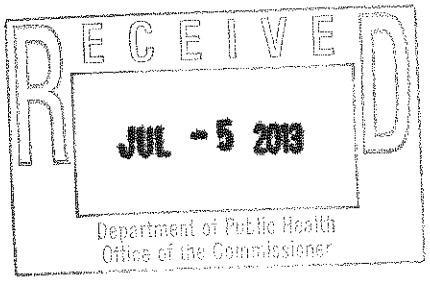
I am writing you to address a dire IOP need in the Greater Hartford Area in towns such as West Hartford, Newington, Avon, Simsbury, and Farmington.

I am supporting the Intensive Outpatient Program (IOP) level of care for the teens with a primary substance abuse and dual diagnoses in our area. As a clinician and alcohol and drug counselor who has practiced in the West Hartford Area for the last 25 years, I have witnessed a lack of resources especially for IOP level of care needs for teenagers (14 to 19) with co-occurring disorders (psychiatrically diagnosed teenagers with chemical dependency issues). This level of care is needed for intervention and stabilization. This need has been clearly lacking for the last 25 years and the dual diagnosed population for teenagers is growing at its fastest rate ever. High risk substance abuse use such as opioid and cocaine abuse (more dangerous and highly addictive drugs) are being used by more teens and at younger ages regarding first time usage reports. IOP with extended aftercare for the adolescents and parents will insure a greater level of care than just outpatient services have historically provided in the past. Our youth warrant IOP services.

Thank you for your attention to this matter.

John Forlenza-Bailey, LADC

John Forlenza-Bailey, LADC

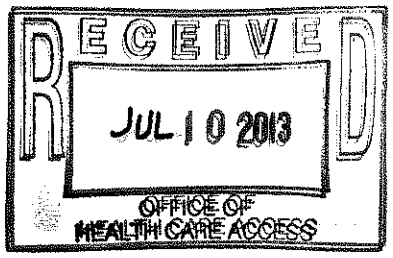


THE NEXT RIGHT THING

The Next Right Thing, LLC
345 North Main Street, Suite 306
West Hartford, CT 06117

July 5, 2013

Ms. Laurie K. Greci
Associate Research Analyst
State of Connecticut, Department of Public Health
Health Care Access
410 Capitol Avenue
P. O. Box 340308
Hartford, CT 06134



Re: 13-31822-CON The Next Right Thing, LLC

Dear Laurie,

Enclosed is our Late File 2 – which includes all the referral sources for patients that were seen at The Next Right Thing, LLC. This does not include those referred who did not participate in the program for any reason. It is the same document that I emailed to you on Friday.

Best regards,

Jenifer Simson

Jenifer Simson
Executive Director
The Next Right Thing, LLC

Late File 2: The number of referrals made to the Applicant from other providers by year and provider name requesting the Intensive Outpatient level of service.

The following refers to those patients who were accepted into The Next Right Thing's program. The first list is sorted by Referral Source and the second list by Referral Date. We do not have referral information from sources for patients who did not participate in the program.

Referral Source – List 1 (by referral source)

REFERRER	APPROXIMATE REFERRAL DATE
Adam Chaffee, psychologist	May-12
Connard High School (social worker)	Mar-12
Connard High School (social worker)	Oct-12
Dr. Doug Berv (psychiatrist - New Haven)	Aug-12
Dr. Doug Berv (psychiatrist - New Haven)	Jan-13
Friend of family	Dec-11
Friend of family (previous patient)	Jan-12
Hall High School (social worker)	Jul-12
Hall High School (social worker)	Apr-13
Hall High School (social worker)	May-13
Insitute of Living (PHP social worker)	Feb-13
Institute of Living (Dr. Nammerow-psychiatrist)	Mar-12
Janet Schraeger/local clinician	Nov-11
Jeff Genser/local clinician	Sep-11
Jeff Genser/local clinician	Oct-11
Jeff Genser/local clinician	Aug-12
Jeff Genser/local clinician	Sep-12
Jeff Genser/local clinician	Apr-13
Juvenile Justice	Mar-12
Juvenile Justice	Mar-12

REFERRER	APPROXIMATE REFERRAL DATE
Juvenile Justice	May-12
Juvenile Justice	Aug-12
Juvenile Justice	Nov-12
Juvenile Justice	Dec-12
Juvenile Justice	Jan-13
Mary Hemelstein/Educational Consultant	Dec-11
NRT patient family	Jan-12
Physician (local)	Feb-13
Psychological Associates	Mar-12
Psychological Associates	Mar-12
Psychologist /local	May-13
Simsbury High School (psychologist)	Sep-12
Simsbury High School (psychologist)	Oct-12
Simsbury High School (social worker)	Apr-12
Simsbury High School (social worker)	Jan-13
Therapist - local	May-13
Therapist - Windsor	Dec-12
Unknown	Mar-12
Walk-by office	Dec-12
Watkinson School (social worker)	Apr-12
Website	Nov-12

Referral Source - List 2 (sorted by date)

REFERRER	APPROXIMATE REFERRAL DATE
	2011
Jeff Genser/local clinician	Sep-11
Jeff Genser/local clinician	Oct-11
Janet Schraeger/local clinician	Nov-11
Friend of family	Dec-11
Mary Hemelstein/Educational Consultant	Dec-11
	2012
Friend of family (previous patient)	Jan-12
NRT patient family	Jan-12
Psychological Associates	Mar-12
Juvenile Justice	Mar-12
Connard High School (social worker)	Mar-12
Juvenile Justice	Mar-12
Unknown	Mar-12
Psychological Associates	Mar-12
Institute of Living (Dr. Nammerow-psychiatrist)	Mar-12
Watkinson School (social worker)	Apr-12
Simsbury High School (social worker)	Apr-12
Juvenile Justice	May-12
Adam Chaffee, psychologist	May-12
Hall High School (social worker)	Jul-12
Juvenile Justice	Aug-12
Jeff Genser/local clinician	Aug-12
Dr. Doug Berv (psychiatrist - New Haven)	Aug-12

13-31822 CON Referrer list for Accepted Patients at The Next Right Thing, LLC

REFERRER	APPROXIMATE REFERRAL DATE
Jeff Genser/local clinician	Sep-12
Simsbury High School (psychologist)	Sep-12
Simsbury High School (psychologist)	Oct-12
Connard High School (social worker)	Oct-12
Website	Nov-12
Juvenile Justice	Nov-12
Therapist - Windsor	Dec-12
Juvenile Justice	Dec-12
Walk-by office	Dec-12
	2013 (partial year)
Simsbury High School (social worker)	Jan-13
Dr. Doug Berv (psychiatrist - New Haven)	Jan-13
Juvenile Justice	Jan-13
Insitute of Living (PHP social worker)	Feb-13
Physician (local)	Feb-13
Hall High School (social worker)	Apr-13
Jeff Genser/local clinician	Apr-13
Therapist - local	May-13
Hall High School (social worker)	May-13
Psychologist /local	May-13

University of Connecticut Health Center
The HomeCare Program

Department of Psychiatry
School of Medicine

July 8, 2013

Deputy Commissioner Lisa davis
DPH-CT

RE: The Next Right Thing LLC

Dear Ms Davis

This is a letter of support for the plan of the NRT to operate an IOP for Youth substance use disorders (SUD) in CT.

As an expert with 25 years of experience in the field of youth SUD (20 of them with UConn Health Ctr), I recognize the lack of such level of care in the chain of levels of continuity of care (see ASAM PPC table 2).

The NRT initiative would provide needed care for adolescents and young adults suffering from severe SUD and consequences. This subpopulation includes youth with or without concurrent mental health disorders and problems (e.g., depression, ADHD, learning disabilities) who have very few options of care in CT.

To emphasize the importance of this initiative, please see the accompanying most recent paper that Dr. Fishman and I wrote about Placement Criteria for Youth SUD. Another more elaborate chapter covering this matter was published by Dr. Fishman in a book I edited in 2011 (Clinical Manual of Adolescent Substance Abuse Treatment-APPI.

I would be happy to provide any further information that you may require.

WBR

Yifrah Kaminer MD
Professor of Psychiatry and Pediatrics
Alcohol Research Center
UConn Health Ctr

kaminer@uchc.edu

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Open Access Review Article

Journal of
Addiction & Prevention

The Case for Placement Criteria for Adolescent Substance Use Disorders

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[2]*Professor of Psychiatry and Pediatrics, Alcohol Research Center, at the University of Connecticut Health Center, Farmington, CT 06030-2103*

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Submission: 08 April 2013
Accepted: 12 April 2013
Published: 13 April 2013

Introduction

Adolescent substance use (MTF, 2012) and substance use disorders (SUD) continue to be major public health concerns. However, SUD has unfortunately received only little resources compared to other high prevalence mental disorders in youth. Lifetime diagnoses of alcohol and drug abuse among adolescents in different states in the US range from 3–10%. Seven percent of youth ages 12–17 years were classified as needing treatment for substance use disorders (SAMHSA, 2011). Due to lack of motivation, limited resources, insufficient age-appropriate quality programs, and lack of a broad consensus on preferred treatment strategies, only 10–15% of adolescents in need of treatment end up receiving service (Kaminer, 2013). In fact, youth account for a substantially disproportionate amount of the unmet national treatment need. For those who do receive any treatment, there are no good estimates of the suitability or adequacy of the type, intensity, quality or duration of those services (Fishman, 2007). Since the early 1990s there has been increased activity in the development of adolescent-specific treatment approaches (Dennis and Kaminer, 2006) as well as confirmation of short-term psychosocial treatment effectiveness of a variety of modalities with similar effectiveness [3,16]. Studies of therapy process, mediators, moderators and proximal outcomes in the treatment of addictive disorders have been developing as the new frontier in our efforts to understand mechanisms of behavior change [1,7,13]. In addition, the increasing consensus on the importance of diagnosing and treating comorbid psychiatric disorders has led to progress in research examining dual diagnosis in youth [6].

Unfortunately, the system and settings in which treatment for adolescents with SUD need to be provided remain difficult to access, navigate, step-up or down leading to confusion and frustration among families of adolescents in need for treatment, referral sources and providers. One of the great challenges in the field of adolescent substance abuse treatment is the attempt to assess the individual needs of drug-involved adolescents and to match them to the most appropriate treatment services, modalities and levels of care and aftercare [4,7].

The objectives of this paper are to review relevant patient treatment matching and placement criteria for adolescents with SUD. A case study will illustrate how to address these issues in the field.

Matching Effects

Recognition of the heterogeneity of individuals with SUD led to increasing interest in the issue of patient-treatment "matching", or the identification of variables that predict differential response to various interventions. The search for matching effects in the addiction field has amounted to the quest of the 'Holy Grail" in terms of the magnitude, intensity, and frequency of research efforts. The largest study to date was PROJECT MATCH [10]. This was a large multi-center study on the treatment of adult alcoholics that employed different treatment modalities such as cognitive behavioral therapy (CBT), Motivational Interview (MI), and 12-step treatment strategy. However, no evidence for matching was found in PROJECT MATCH.

Treatment matching variables that have been investigated in adults and youth include psychiatric comorbidity, motivation (i.e., timing and magnitude of readiness to change), capacity to form therapeutic alliance, differences in number, quality, and magnitude of coping-skills deficits, level of vulnerability and opportunity for exposure to different situations posing high-risk for relapse, self efficacy, negative moods, and treatment expectancies [17]. No conclusive evidence has been found to support matching hypotheses.

General Principles for a Successful Treatment Placement

A different focus on establishing a matching effect between individuals and clinical settings is the development of the American Society of Addiction Medicine-Placement Criteria (ASAM-PPC) for adults and adolescents. The purpose of these criteria is to enhance objective matching decisions for different severity levels to various settings of care. We aspire to a treatment system in which patients can move fluidly and flexibly up and down levels of care as needed. Often episodes of treatment at higher levels of care are (or should be) followed by longer episodes of step-down continuing care or "aftercare" [5]. Often, ongoing treatment at lower levels of care should be punctuated by periodic briefer episodes of treatment at higher levels of care in response to exacerbations known also as stepped care [15]. Repeated episodes of treatment are not necessarily an indicator of treatment failure as much as a marker of severity. Longitudinal care, rather than discrete episodes of time limited care, should be the appropriate model for a relapsing and remitting disorder such as substance abuse. Continuing care, extended monitoring phases, repeated booster doses, and in some cases indefinite maintenance treatment, should be the rule not the exception.

Substance-involved adolescents generally need an array of services broader than just "pure" substance abuse counseling alone for the multi dimensional problems they face (e.g., psychiatric, legal, family education). The debate over the chronology of SUD and comorbid psychiatric disorders is usually not as important as the need for coordination and continuity of services which even when

available tend to be fragmented [8]. Other frequently needed linkages include, medical, family, special education, school support, juvenile justice, social welfare, etc. Generally, the higher the severity, the greater the need for multiple "adjunctive" services.

Another general principle of matching and placement is that increased severity and impairment requires increased intensity of services. This usually translates into an increased level of care, because lower levels of care may not be as effective [2].

Many adolescent substance abuse referral and treatment originates within the juvenile justice system. Disruptive behavior and delinquency is a very common presentation. While the common overlap with conduct disorder is a poor prognostic marker of severity [8] neither that descriptor nor associated low internal motivation or even poor cooperation, should be seen as an exclusion to treatment suitability. Rather, strategies to enhance engagement should become explicit components of treatment and placement plans.

American Society of Addiction Medicine Patient Placement Criteria (ASAM PPC)

The development, refinement and implementation of standardized treatment matching guidelines have been one of the productive trends in moving the field forward. The American Society of Addiction Medicine Patient Placement Criteria 2nd Edition-Revised (ASAM PPC-2R) [11] is the guideline that has become the standard in the field, having been adopted in some form by 32 states, several managed care companies, and the military medical system. It has separate sections with distinct criteria for adults and adolescents. Its overall approach is to guide the clinician by organizing clinical data into 6 broad categories of assessment categories referred to as "Dimensions" that serve to focus the assessment on key practical domains with central treatment implications. In addition to its function as an algorithm for LOC placement, it is also a guideline for treatment matching and treatment planning in general.

The six ASAM PPC assessment Dimensions are listed in Table 1. Dimension 1 relates to the potential for acute and sub-acute withdrawal and intoxication and ensuing treatment needs. Dimension 2 relates to medical symptoms and co-morbidity – pre-existing, substance induced and substance exacerbated conditions, and ensuing treatment needs. Dimension 3 relates to psychiatric symptoms and co-morbidity pre-existing, substance induced and substance exacerbated conditions, and ensuing treatment needs. Dimension 4 relates to treatment engagement, motivation, resistance and stages of change. Dimension 5 relates to the likelihood of relapse, continuation of substance use and associated problems, along with potential consequences and ensuing treatment needs. Dimension 6 relates to the family, peers, living situation, and home setting.

The ASAM PPC also catalogs the various common levels of care (LOCs) utilized in the treatment of adolescent substance use disorders (SUDs) as a consensus picture of the adolescent service delivery model. In its outline of various LOCs, as well as its descriptions of the broad range of service components that are expected in each of these individual LOCs, the PPC is a prescription for the adolescent continuum of care. The PPC LOCs are listed in Table 2. They are: early intervention, outpatient, residential, and hospital, with sub-levels within the major categories. Of course, such a prescription should not be construed rigidly, as flexibility and innovation should be encouraged to match the unique circumstances of local circumstances and even individual adolescents. Unfortunately, not all services or levels of care are available in all communities. This is particularly true of rural communities. And there are usually considerable constraints on the availability and accessibility of services in every community (for example, not enough providers, inadequate reimbursement, and too few treatment slots).

Table 1: ASAM PPC Assessment Dimensions.

Dimension 1.	Intoxication and Withdrawal Potential
Dimension 2.	Biomedical Conditions and Complications
Dimension 3.	Emotional, Behavioral and Cognitive Conditions and Complications
Dimension 4.	Readiness to Change
Dimension 5.	Relapse, Continued Use Potential
Dimension 6.	Recovery Environment

Table 2: ASAM PPC Levels of Care.

Level 0.5:	Early Intervention
Level I:	Outpatient
Level II:	Intensive Outpatient and Partial Hospital
II.1:	Intensive Outpatient (IOP)
II.5:	Partial Hospital / Day Program
Level III:	Residential / Inpatient
III.1:	Clinically Managed Low Intensity Residential
III.5:	Clinically Managed Medium Intensity Residential
III.7:	Medically Monitored High Intensity
Level IV:	Hospital

The treatment and placement matching function of the PPC operates by specifying criteria whereby increasing severity in each assessment dimension correlates to increasing service needs and thereby increasing LOC intensity for placement. In a logical sequence, severity in each assessment dimension leads to a corresponding intensity of service needs, which is in turn available in a corresponding placement. The PPC articulates the criteria that link assessment to treatment, by aggregating the array of severity in each individual assessment dimension through decision rules to produce a consolidated LOC placement recommendation.

While we work towards an expansion of the under-developed continuum, we also have to adapt realistically to the resources at hand. Often, when a given level of care is not practically available, a more intensive level of care that is available may be the best alternative. An example of this approach is the common practice in many communities of using inpatient psychiatric hospitalization (Level IV) as a setting for stabilization of substance-related crises when there is no medically monitored high intensity residential program (Level III.7) available. Another example is the use of brief residential placement (Level III.5) for daily support and monitoring when there is no partial/day program (PHP - Level II.5) available. Another adaptation to limited resources that is sometimes successful is to creatively weave together a multi-dimensional array of services from a variety of sources that approximates the intensity of the unavailable level of care. An example of this "patchwork" approach is substituting increased frequency of Level I outpatient sessions (say, 2-3 per week) for an unavailable Level II.1 intensive outpatient (IOP). Another example might be combining a Level II.5 partial hospitalization (PHP) plus an alternative, temporary living situation that is less problematic than the home environment (say, with a relative).

Case History

TA is a 16 girl referred from detention for evaluation. Her substance use history is notable for onset of marijuana at age 12, progressing to daily use by age 15. Alcohol onset at age 13, with weekend binges to severe intoxication. Sporadic experimentation with nasal cocaine, hallucinogens, and prescription opioids. Abstinence by confinement while in detention for the past 3 weeks. Had a few sessions of substance abuse counseling several months ago, but mostly no show because family couldn't "make her" attend.

She lives with her grandmother. Father is incarcerated and she was removed by the protective services agency from the care of Mother, who has a history of substance abuse and a "breakdown." Allegation of molestation by neighbor age 9. Sexually active since 13, 8 lifetime partners, current unprotected sex with older boys, often while intoxicated. Poor school performance, repeated 3rd grade, told she was a "slow learner," no special education services, multiple suspensions for disruptive behavior, assigned to 10th grade but truant most of year. Most friends are involved with drugs and delinquent behaviors.

Medical history notable for asthma and chronic stomach aches. Legal history notable for an arrest for possession of controlled dangerous substances on school grounds age 14, charges dropped. Received probation at age 14 for assault. House arrest age 15 for intent to distribute drugs. Most recently detained with violation of probation for theft and unauthorized use of a vehicle.

Psychiatric history notable for inattention and hyperactivity since childhood, without treatment. She has had chronic emotional lability and dysphoric mood, tantrums, explosive temper, much worse since onset of substance use past few years. Progressively oppositional and ungovernable at home. Stays away from home habitually until late and ran away overnight once. Chronic nighttime insomnia and sleeping late, with sleep-wake cycle disruption. Says marijuana helps her "chill" and avoid fights with peers. Several attempts at family and school counseling, but never sustained. No formal psych evaluation. Insomnia and irritability worse since discontinuation of marijuana use 3 weeks ago.

Dimensional Assessment, Treatment Service And Placement Considerations

Dimension 1. (Intoxocation/Withdrawal)

Assessment. Abstinent for 3 weeks, some mild "subacute" persistent abstinence effects of insomnia and irritability. *Treatment Service Needs.* Needs education re sleep hygiene and insomnia as potential relapse trigger. Consider mild temporary sleep aid (e.g. diphenhydramine or low-dose trazodone). *Placement.* Dimensional service needs met by Level I placement (and could be addressed in any level of care).

Dimension 2. (Medical)

Assessment: No acute problems.

Treatment Service Needs: Needs general health maintenance. Needs sexually transmitted disease (STD) screening, contraception services and sexual risk behavior counseling. At risk for exacerbation of reactive airways disease from heavy marijuana use.

Placement: Dimensional service needs met by Level I placement (and could be addressed in any level of care).

Dimension 3 (Emotional/Behavioral).

Assessment: Significant symptoms of affective disturbance but without evaluation or treatment. No imminent dangerousness. Social functioning significantly impaired in the school, legal and family domains. Emotional/behavioral symptoms have caused severe interference with addiction recovery efforts through lack of cooperation with treatment, deviant peer group affiliation, and self-professed psychological benefits of substance use. Impaired ability for self care characterized by ongoing sexual risk behaviors.

Treatment Service Needs: Needs psychiatric evaluation, including consideration of treatment for affective disorder. Needs programmatic treatment setting for implementation and close monitoring of psychiatric treatment (pharmacological and/or psychotherapeutic). Needs at least moderately high intensity daily structure and assessment of behavioral response.

Placement: Dimensional service needs probably met by Level II.5 placement with psychiatric treatment either built into the substance abuse program or provided through coordinated psychiatric services. (Consideration might reasonably be given to a Level III.5 placement, especially if additional details of assessment or lack of progress at Level II.5 suggest the need for higher intensity including 24 hr structure and boundaries unavailable in the home environment to prevent further deterioration or social functioning.)

Dimension 4 (Treatment readiness).

Assessment: Currently in pre-contemplative stage of change. Sees herself as having a probation officer problem but not a substance problem.

Treatment Service Needs: Needs significant treatment frequency, intensity and a programmatic milieu to support motivation and progression through the stages of change. Needs motivational enhancement therapy (MET) techniques including functional analysis of pros and cons of substance use, as well as juvenile justice leverage (such as probationary mandate) to improve treatment engagement.

Placement: Dimensional service needs met by Level II.5 placement.

Dimension 5 (Relapse/ Continued Use Potential).

Assessment: Despite brief abstinence by confinement has had no appreciable acquisition of recovery skills and remains at very high risk of immediate continued use/relapse and functional deterioration. Has not been amenable to previous Level I treatment because would not attend.

Treatment Service Needs: Needs near-daily monitoring and structure to overcome pattern of habitual use, impulsive behaviors and susceptibility to relapse triggers. Needs relapse prevention interventions including relapse trigger identification and refusal skills rehearsal, guidance in support of alternative prosocial leisure activities and peer group. *Placement:* Dimensional service needs met by Level II.5 placement.

Dimension 6. (Recovery Environment)

Assessment: Grandmother is supportive but lacks the personal resources to effectively sustain treatment. Peer group is predominantly substance using.

Treatment Service Needs: Needs family intervention including

training for GM on monitoring, home behavior negotiation and management, utilization of services and system (juvenile justice) leverage.

Placement: Dimensional service needs met by Level II.1 placement.

Integrated Multi-Dimensional Placement. The PPC contains decision rules that combine the criteria and placement recommendations for each of the individual Dimensions (as above), into an overall LOC recommendation. In this case that recommendation would be for a Level II.5 placement.

Future Directions

Matching a substance-abusing patient with the right type of treatment program is much discussed but elusive goal in the real world. Therefore, McLellan et al. [9] proposed based on a clinical trial that following a comprehensive multidimensional functional-assessment of patient's needs, efforts should be redirected from matching patients with programs to matching patients' problems with targeted services meeting their needs within the program. It has been recognized that a patient may not have the option of referring or switching to a more appropriate treatment program. Chances may be limited by geographical, slot availability, insurance, psychiatric comorbidity, legal status, or other considerations (Fishman 2007). This model could be tailored to be complementary or an alternative to future revised and tested American Society of Addiction Medicine Patient Placement Criteria (ASAM-PPC).

The ASAM-PPC has become the standard in the field, provides a useful guide to clinicians for placement and treatment planning, provides a framework to researchers for developing treatment matching hypotheses, and gives us a roadmap to advocate for greater access to needed treatment services.

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Greer, Leslie

From: Greci, Laurie
Sent: Wednesday, July 17, 2013 10:45 AM
To: Jenifer Hartt
Cc: Greer, Leslie
Subject: Late File 1 - Letters from Providers
Attachments: 31822- CATS.pdf; 31822-UCHC.pdf

Dear Ms. Hartt,

OHCA has received two letters to-date concerning 13-31822-CON, The Next Right Thing LLC. The first was from Chemical Addictions Treatment Services and the second was from UCHC Home Care Program. Each letter is attached.

Laurie

CHEMICAL ADDICTIONS TREATMENT SERVICES (CATS)
Website: www.johnforlenza-baileyladc.com
Phone: (860) 796-7974
1268 Main Street Suite 107
Newington, CT 06111

July 3, 2013

Deputy Commissioner Lisa Davis
State of Connecticut, Department of Public Health
410 Capital Avenue, MS # 13HCA
PO Box 340308
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RE: reference to 13-31822-CON-The Next Right Thing

Dear Deputy Commissioner Lisa Davis:

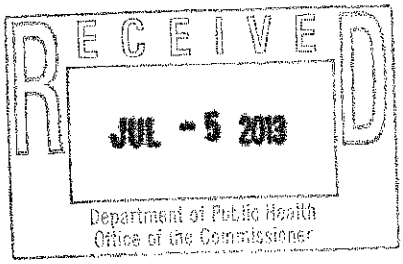
I am writing you to address a dire IOP need in the Greater Hartford Area in towns such as West Hartford, Newington, Avon, Simsbury, and Farmington.

I am supporting the Intensive Outpatient Program (IOP) level of care for the teens with a primary substance abuse and dual diagnoses in our area. As a clinician and alcohol and drug counselor who has practiced in the West Hartford Area for the last 25 years, I have witnessed a lack of resources especially for IOP level of care needs for teenagers (14 to 19) with co-occurring disorders (psychiatrically diagnosed teenagers with chemical dependency issues). This level of care is needed for intervention and stabilization. This need has been clearly lacking for the last 25 years and the dual diagnosed population for teenagers is growing at its fastest rate ever. High risk substance abuse use such as opioid and cocaine abuse (more dangerous and highly addictive drugs) are being used by more teens and at younger ages regarding first time usage reports. IOP with extended aftercare for the adolescents and parents will insure a greater level of care than just outpatient services have historically provided in the past. Our youth warrant IOP services.

Thank you for your attention to this matter.

John Forlenza-Bailey, LADC

John Forlenza-Bailey, LADC



University of Connecticut Health Center
The HomeCare Program

Department of Psychiatry
School of Medicine

July 8, 2013

Deputy Commissioner Lisa davis
DPH-CT

RE: The Next Right Thing LLC

Dear Ms Davis

This is a letter of support for the plan of the NRT to operate an IOP for Youth substance use disorders (SUD) in CT.

As an expert with 25 years of experience in the field of youth SUD (20 of them with UConn Health Ctr), I recognize the lack of such level of care in the chain of levels of continuity of care (see ASAM PPC table 2).

The NRT initiative would provide needed care for adolescents and young adults suffering from severe SUD and consequences. This subpopulation includes youth with or without concurrent mental health disorders and problems (e.g., depression, ADHD, learning disabilities) who have very few options of care in CT.

To emphasize the importance of this initiative, please see the accompanying most recent paper that Dr. Fishman and I wrote about Placement Criteria for Youth SUD. Another more elaborate chapter covering this matter was published by Dr. Fishman in a book I edited in 2011 (Clinical Manual of Adolescent Substance Abuse Treatment-APPI.

I would be happy to provide any further information that you may require.

WBR

Yifrah Kaminer MD
Professor of Psychiatry and Pediatrics
Alcohol Research Center
UConn Health Ctr

kaminer@uchc.edu

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Open Access Review Article

Journal of
Addiction &
Prevention

The Case for Placement Criteria for Adolescent Substance Use Disorders

Fishman M[1] and Kaminer Y[2]*

[1]*Assistant Professor of Psychiatry Johns Hopkins University, Medical Director of Maryland Treatment Centers, 3800 Frederick Avenue, Baltimore MD 21229*

[2]*Professor of Psychiatry and Pediatrics, Alcohol Research Center, at the University of Connecticut Health Center, Farmington, CT 06030-2103*

Address for Correspondence
Dr. Kaminer, Alcohol Research Center, at the University of Connecticut Health Center, Farmington, CT 06030-2103, E-mail: kaminer@uchc.edu

Submission: 08 April 2013
Accepted: 12 April 2013
Published: 13 April 2013

Introduction

Adolescent substance use (MTF, 2012) and substance use disorders (SUD) continue to be major public health concerns. However, SUD has unfortunately received only little resources compared to other high prevalence mental disorders in youth. Lifetime diagnoses of alcohol and drug abuse among adolescents in different states in the US range from 3–10%. Seven percent of youth ages 12–17 years were classified as needing treatment for substance use disorders (SAMHSA, 2011). Due to lack of motivation, limited resources, insufficient age-appropriate quality programs, and lack of a broad consensus on preferred treatment strategies, only 10–15% of adolescents in need of treatment end up receiving service (Kaminer, 2013). In fact, youth account for a substantially disproportionate amount of the unmet national treatment need. For those who do receive any treatment, there are no good estimates of the suitability or adequacy of the type, intensity, quality or duration of those services (Fishman, 2007). Since the early 1990s there has been increased activity in the development of adolescent-specific treatment approaches (Dennis and Kaminer, 2006) as well as confirmation of short-term psychosocial treatment effectiveness of a variety of modalities with similar effectiveness [3,16]. Studies of therapy process, mediators, moderators and proximal outcomes in the treatment of addictive disorders have been developing as the new frontier in our efforts to understand mechanisms of behavior change [1,7,13]. In addition, the increasing consensus on the importance of diagnosing and treating comorbid psychiatric disorders has led to progress in research examining dual diagnosis in youth [6].

Unfortunately, the system and settings in which treatment for adolescents with SUD need to be provided remain difficult to access, navigate, step-up or down leading to confusion and frustration among families of adolescents in need for treatment, referral sources and providers. One of the great challenges in the field of adolescent substance abuse treatment is the attempt to assess the individual needs of drug-involved adolescents and to match them to the most appropriate treatment services, modalities and levels of care and aftercare [4,7].

The objectives of this paper are to review relevant patient treatment matching and placement criteria for adolescents with SUD. A case study will illustrate how to address these issues in the field.

Matching Effects

Recognition of the heterogeneity of individuals with SUD led to increasing interest in the issue of patient-treatment "matching", or the identification of variables that predict differential response to various interventions. The search for matching effects in the addiction field has amounted to the quest of the 'Holy Grail" in terms of the magnitude, intensity, and frequency of research efforts. The largest study to date was PROJECT MATCH [10]. This was a large multi-center study on the treatment of adult alcoholics that employed different treatment modalities such as cognitive behavioral therapy (CBT), Motivational Interview (MI), and 12-step treatment strategy. However, no evidence for matching was found in PROJECT MATCH.

Treatment matching variables that have been investigated in adults and youth include psychiatric comorbidity, motivation (i.e., timing and magnitude of readiness to change), capacity to form therapeutic alliance, differences in number, quality, and magnitude of coping-skills deficits, level of vulnerability and opportunity for exposure to different situations posing high-risk for relapse, self efficacy, negative moods, and treatment expectancies [17]. No conclusive evidence has been found to support matching hypotheses.

General Principles for a Successful Treatment Placement

A different focus on establishing a matching effect between individuals and clinical settings is the development of the American Society of Addiction Medicine-Placement Criteria (ASAM-PPC) for adults and adolescents. The purpose of these criteria is to enhance objective matching decisions for different severity levels to various settings of care. We aspire to a treatment system in which patients can move fluidly and flexibly up and down levels of care as needed. Often episodes of treatment at higher levels of care are (or should be) followed by longer episodes of step-down continuing care or "aftercare" [5]. Often, ongoing treatment at lower levels of care should be punctuated by periodic briefer episodes of treatment at higher levels of care in response to exacerbations known also as stepped care [15]. Repeated episodes of treatment are not necessarily an indicator of treatment failure as much as a marker of severity. Longitudinal care, rather than discrete episodes of time limited care, should be the appropriate model for a relapsing and remitting disorder such as substance abuse. Continuing care, extended monitoring phases, repeated booster doses, and in some cases indefinite maintenance treatment, should be the rule not the exception.

Substance-involved adolescents generally need an array of services broader than just "pure" substance abuse counseling alone for the multi dimensional problems they face (e.g., psychiatric, legal, family education). The debate over the chronology of SUD and comorbid psychiatric disorders is usually not as important as the need for coordination and continuity of services which even when

available tend to be fragmented [8]. Other frequently needed linkages include, medical, family, special education, school support, juvenile justice, social welfare, etc. Generally, the higher the severity, the greater the need for multiple "adjunctive" services.

Another general principle of matching and placement is that increased severity and impairment requires increased intensity of services. This usually translates into an increased level of care, because lower levels of care may not be as effective [2].

Many adolescent substance abuse referral and treatment originates within the juvenile justice system. Disruptive behavior and delinquency is a very common presentation. While the common overlap with conduct disorder is a poor prognostic marker of severity [8] neither that descriptor nor associated low internal motivation or even poor cooperation, should be seen as an exclusion to treatment suitability. Rather, strategies to enhance engagement should become explicit components of treatment and placement plans.

American Society of Addiction Medicine Patient Placement Criteria (ASAM PPC)

The development, refinement and implementation of standardized treatment matching guidelines have been one of the productive trends in moving the field forward. The American Society of Addiction Medicine Patient Placement Criteria 2nd Edition-Revised (ASAM PPC-2R) [11] is the guideline that has become the standard in the field, having been adopted in some form by 32 states, several managed care companies, and the military medical system. It has separate sections with distinct criteria for adults and adolescents. Its overall approach is to guide the clinician by organizing clinical data into 6 broad categories of assessment categories referred to as "Dimensions" that serve to focus the assessment on key practical domains with central treatment implications. In addition to its function as an algorithm for LOC placement, it is also a guideline for treatment matching and treatment planning in general.

The six ASAM PPC assessment Dimensions are listed in Table 1. Dimension 1 relates to the potential for acute and sub-acute withdrawal and intoxication and ensuing treatment needs. Dimension 2 relates to medical symptoms and co-morbidity – pre-existing, substance induced and substance exacerbated conditions, and ensuing treatment needs. Dimension 3 relates to psychiatric symptoms and co-morbidity pre-existing, substance induced and substance exacerbated conditions, and ensuing treatment needs. Dimension 4 relates to treatment engagement, motivation, resistance and stages of change. Dimension 5 relates to the likelihood of relapse, continuation of substance use and associated problems, along with potential consequences and ensuing treatment needs. Dimension 6 relates to the family, peers, living situation, and home setting.

The ASAM PPC also catalogs the various common levels of care (LOCs) utilized in the treatment of adolescent substance use disorders (SUDs) as a consensus picture of the adolescent service delivery model. In its outline of various LOCs, as well as its descriptions of the broad range of service components that are expected in each of these individual LOCs, the PPC is a prescription for the adolescent continuum of care. The PPC LOCs are listed in Table 2. They are: early intervention, outpatient, residential, and hospital, with sub-levels within the major categories. Of course, such a prescription should not be construed rigidly, as flexibility and innovation should be encouraged to match the unique circumstances of local circumstances and even individual adolescents. Unfortunately, not all services or levels of care are available in all communities. This is particularly true of rural communities. And there are usually considerable constraints on the availability and accessibility of services in every community (for example, not enough providers, inadequate reimbursement, and too few treatment slots).

Table 1: ASAM PPC Assessment Dimensions.

Dimension 1.	Intoxication and Withdrawal Potential
Dimension 2.	Biomedical Conditions and Complications
Dimension 3.	Emotional, Behavioral and Cognitive Conditions and Complications
Dimension 4.	Readiness to Change
Dimension 5.	Relapse, Continued Use Potential
Dimension 6.	Recovery Environment

Table 2: ASAM PPC Levels of Care.

Level 0.5:	Early Intervention
Level I:	Outpatient
Level II:	Intensive Outpatient and Partial Hospital
II.1:	Intensive Outpatient (IOP)
II.5:	Partial Hospital / Day Program
Level III:	Residential / Inpatient
III.1:	Clinically Managed Low Intensity Residential
III.5:	Clinically Managed Medium Intensity Residential
III.7:	Medically Monitored High Intensity
Level IV:	Hospital

The treatment and placement matching function of the PPC operates by specifying criteria whereby increasing severity in each assessment dimension correlates to increasing service needs and thereby increasing LOC intensity for placement. In a logical sequence, severity in each assessment dimension leads to a corresponding intensity of service needs, which is in turn available in a corresponding placement. The PPC articulates the criteria that link assessment to treatment, by aggregating the array of severity in each individual assessment dimension through decision rules to produce a consolidated LOC placement recommendation.

While we work towards an expansion of the under-developed continuum, we also have to adapt realistically to the resources at hand. Often, when a given level of care is not practically available, a more intensive level of care that is available may be the best alternative. An example of this approach is the common practice in many communities of using inpatient psychiatric hospitalization (Level IV) as a setting for stabilization of substance-related crises when there is no medically monitored high intensity residential program (Level III.7) available. Another example is the use of brief residential placement (Level III.5) for daily support and monitoring when there is no partial/day program (PHP - Level II.5) available. Another adaptation to limited resources that is sometimes successful is to creatively weave together a multi-dimensional array of services from a variety of sources that approximates the intensity of the unavailable level of care. An example of this "patchwork" approach is substituting increased frequency of Level I outpatient sessions (say, 2-3 per week) for an unavailable Level II.1 intensive outpatient (IOP). Another example might be combining a Level II.5 partial hospitalization (PHP) plus an alternative, temporary living situation that is less problematic than the home environment (say, with a relative).

Case History

TA is a 16 girl referred from detention for evaluation. Her substance use history is notable for onset of marijuana at age 12, progressing to daily use by age 15. Alcohol onset at age 13, with weekend binges to severe intoxication. Sporadic experimentation with nasal cocaine, hallucinogens, and prescription opioids. Abstinence by confinement while in detention for the past 3 weeks. Had a few sessions of substance abuse counseling several months ago, but mostly no show because family couldn't "make her" attend.

She lives with her grandmother. Father is incarcerated and she was removed by the protective services agency from the care of Mother, who has a history of substance abuse and a "breakdown." Allegation of molestation by neighbor age 9. Sexually active since 13, 8 lifetime partners, current unprotected sex with older boys, often while intoxicated. Poor school performance, repeated 3rd grade, told she was a "slow learner," no special education services, multiple suspensions for disruptive behavior, assigned to 10th grade but truant most of year. Most friends are involved with drugs and delinquent behaviors.

Medical history notable for asthma and chronic stomach aches. Legal history notable for an arrest for possession of controlled dangerous substances on school grounds age 14, charges dropped. Received probation at age 14 for assault. House arrest age 15 for intent to distribute drugs. Most recently detained with violation of probation for theft and unauthorized use of a vehicle.

Psychiatric history notable for inattention and hyperactivity since childhood, without treatment. She has had chronic emotional lability and dysphoric mood, tantrums, explosive temper, much worse since onset of substance use past few years. Progressively oppositional and ungovernable at home. Stays away from home habitually until late and ran away overnight once. Chronic nighttime insomnia and sleeping late, with sleep-wake cycle disruption. Says marijuana helps her "chill" and avoid fights with peers. Several attempts at family and school counseling, but never sustained. No formal psych evaluation. Insomnia and irritability worse since discontinuation of marijuana use 3 weeks ago.

Dimensional Assessment, Treatment Service And Placement Considerations

Dimension 1. (Intoxocation/Withdrawal)

Assessment. Abstinent for 3 weeks, some mild "subacute" persistent abstinence effects of insomnia and irritability. *Treatment Service Needs.* Needs education re sleep hygiene and insomnia as potential relapse trigger. Consider mild temporary sleep aid (e.g. diphenhydramine or low-dose trazodone). *Placement.* Dimensional service needs met by Level I placement (and could be addressed in any level of care).

Dimension 2. (Medical)

Assessment: No acute problems.

Treatment Service Needs: Needs general health maintenance. Needs sexually transmitted disease (STD) screening, contraception services and sexual risk behavior counseling. At risk for exacerbation of reactive airways disease from heavy marijuana use.

Placement: Dimensional service needs met by Level I placement (and could be addressed in any level of care).

Dimension 3 (Emotional/Behavioral).

Assessment: Significant symptoms of affective disturbance but without evaluation or treatment. No imminent dangerousness. Social functioning significantly impaired in the school, legal and family domains. Emotional/behavioral symptoms have caused severe interference with addiction recovery efforts through lack of cooperation with treatment, deviant peer group affiliation, and self-professed psychological benefits of substance use. Impaired ability for self care characterized by ongoing sexual risk behaviors.

Treatment Service Needs: Needs psychiatric evaluation, including consideration of treatment for affective disorder. Needs programmatic treatment setting for implementation and close monitoring of psychiatric treatment (pharmacological and/or psychotherapeutic). Needs at least moderately high intensity daily structure and assessment of behavioral response.

Placement: Dimensional service needs probably met by Level II.5 placement with psychiatric treatment either built into the substance abuse program or provided through coordinated psychiatric services. (Consideration might reasonably be given to a Level III.5 placement, especially if additional details of assessment or lack of progress at Level II.5 suggest the need for higher intensity including 24 hr structure and boundaries unavailable in the home environment to prevent further deterioration or social functioning.)

Dimension 4 (Treatment readiness).

Assessment: Currently in pre-contemplative stage of change. Sees herself as having a probation officer problem but not a substance problem.

Treatment Service Needs: Needs significant treatment frequency, intensity and a programmatic milieu to support motivation and progression through the stages of change. Needs motivational enhancement therapy (MET) techniques including functional analysis of pros and cons of substance use, as well as juvenile justice leverage (such as probationary mandate) to improve treatment engagement.

Placement: Dimensional service needs met by Level II.5 placement.

Dimension 5 (Relapse/ Continued Use Potential).

Assessment: Despite brief abstinence by confinement has had no appreciable acquisition of recovery skills and remains at very high risk of immediate continued use/relapse and functional deterioration. Has not been amenable to previous Level I treatment because would not attend.

Treatment Service Needs: Needs near-daily monitoring and structure to overcome pattern of habitual use, impulsive behaviors and susceptibility to relapse triggers. Needs relapse prevention interventions including relapse trigger identification and refusal skills rehearsal, guidance in support of alternative prosocial leisure activities and peer group. *Placement:* Dimensional service needs met by Level II.5 placement.

Dimension 6. (Recovery Environment)

Assessment: Grandmother is supportive but lacks the personal resources to effectively sustain treatment. Peer group is predominantly substance using.

Treatment Service Needs: Needs family intervention including

training for GM on monitoring, home behavior negotiation and management, utilization of services and system (juvenile justice) leverage.

Placement: Dimensional service needs met by Level II.1 placement.

Integrated Multi-Dimensional Placement. The PPC contains decision rules that combine the criteria and placement recommendations for each of the individual Dimensions (as above), into an overall LOC recommendation. In this case that recommendation would be for a Level II.5 placement.

Future Directions

Matching a substance-abusing patient with the right type of treatment program is much discussed but elusive goal in the real world. Therefore, McLellan et al. [9] proposed based on a clinical trial that following a comprehensive multidimensional functional-assessment of patient's needs, efforts should be redirected from matching patients with programs to matching patients' problems with targeted services meeting their needs within the program. It has been recognized that a patient may not have the option of referring or switching to a more appropriate treatment program. Chances may be limited by geographical, slot availability, insurance, psychiatric comorbidity, legal status, or other considerations (Fishman 2007). This model could be tailored to be complementary or an alternative to future revised and tested American Society of Addiction Medicine Patient Placement Criteria (ASAM-PPC).

The ASAM-PPC has become the standard in the field, provides a useful guide to clinicians for placement and treatment planning, provides a framework to researchers for developing treatment matching hypotheses, and gives us a roadmap to advocate for greater access to needed treatment services.

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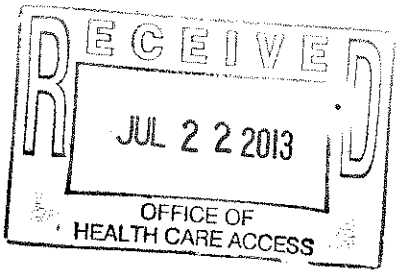
Greer, Leslie

From: Greci, Laurie
Sent: Wednesday, July 17, 2013 10:45 AM
To: Jenifer Hartt
Cc: Greer, Leslie
Subject: Late File 1 - Letters from Providers
Attachments: 31822- CATS.pdf; 31822-UCHC.pdf

Dear Ms. Hartt,

OHCA has received two letters to-date concerning 13-31822-CON, The Next Right Thing LLC. The first was from Chemical Addictions Treatment Services and the second was from UCHC Home Care Program. Each letter is attached.

Laurie



THE NEXT RIGHT THING LLC
345 N. Main Street
West Hartford, CT 06117
860-236-1499
www.NextRightThing.net

Substance Abuse and Mental Health Intensive Outpatient Program

FAX

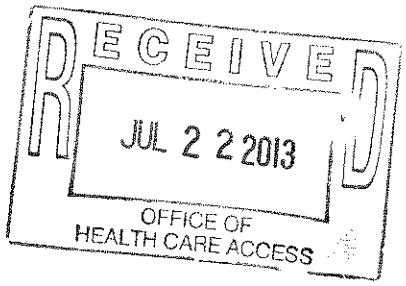
To: Ms. Laurie Greci	From: Jenifer Simson
Fax: (860) 418-7053	Pages: 2
Phone: (860) 418-7032	Date:
Re: **13-31822-CON Late File extension request**	cc: file

Comments: Dear Laurie, Attached is a letter requesting a short extension to finish getting our letters of support in.

Thank you,

Jenifer Simson

THE NEXT RIGHT THING



The Next Right Thing, LLC
345 North Main Street, Suite 306
West Hartford, CT 06117

July 22, 2013

Ms. Laurie K. Greci
Associate Research Analyst
State of Connecticut, Department of Public Health
Health Care Access
410 Capitol Avenue
P. O. Box 340308
Hartford, CT 06134

Re: 13-31822-CON The Next Right Thing, LLC

Dear Laurie,

I respectfully request that the Health Care Access extend our late filing date through the end of this month (July 31st). We anticipate another 3-4 letters of support to make their way to your desk by then.

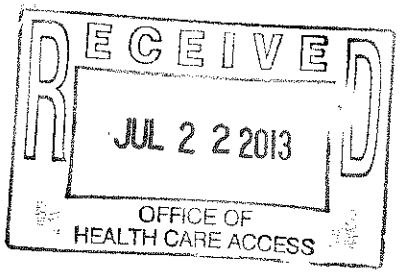
Best regards,

Jenifer Simson

Jenifer Simson
Executive Director
The Next Right Thing, LLC

THE INSTITUTE OF LIVING

HARTFORD HOSPITAL



7/17/2013

Deputy Commissioner
Lisa Davis
State of Connecticut, Department of public Health
410 Capital Avenue, MS#12HCA
PO Box 340308
Hartford, CT 06134

I am writing in support of providing a CON for an IOP through the Next Right Thing, LLC.

I have a busy outpatient practice and clearly see a need for an IOP directed at adolescents struggling with substance use disorders in this area.

Please do not hesitate to contact me at (860) 545-7493.

Sincerely yours,

Lisa B. Namerow

Attending Child and Adolescent Psychiatrist

Cc: Julian Hart, LCSW
345 North Main Street, Suite 306
West Hartford, CT 06117

Greer, Leslie

From: Greci, Laurie
Sent: Tuesday, July 23, 2013 10:16 AM
To: Hansted, Kevin; Riggott, Kaila
Cc: Greer, Leslie
Subject: FW: 13-31822-CON Letter of Support
Attachments: DOC001.PDF

Leslie, would you please add this email to the docket?
Thanks,
Laurie

From: Jenifer Hartt [mailto:Jenifer@NextRightThing.net]
Sent: Tuesday, July 23, 2013 8:55 AM
To: Greci, Laurie
Cc: Julian@NExtRightThing.net
Subject: RE: 13-31822-CON Letter of Support

Dear Laurie,

I have attached a letter of support (pdf copy) from Aetna Insurance Company – the original went in the mail on Monday and you'll probably have it later in the week. One of us will drive down with another letter that was mailed to our office instead of DPH.

Best regards,

Jenifer

The Next Right Thing, llc
Relapse Prevention for Adolescents with Substance Abuse and Mental Health Problems
345 N. Main Street, Suite 306
West Hartford, CT 06117
Main Office: 860-233-8803
Direct line:860-236-1499
www.NextRightThing.net

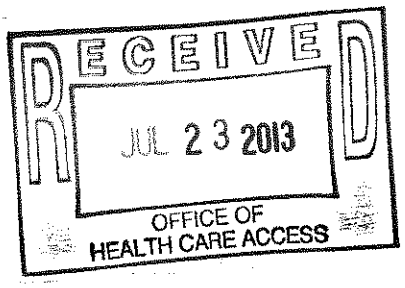
From: RocchinoA@aetna.com
To: julianharttjr@msn.com
Date: Mon, 22 Jul 2013 09:06:30 -0400
Subject: CON

Hi Julian
Here is the letter and it is being mailed as well.
Again I am sorry about my timing – hope it can still be used
Tony

Antonio J Rocchino

Aetna Behavioral Health
Network Market Head
E-Mail - RocchinoA@aetna.com
Phone Number: 215-775-7891

aetna



Aetna
151 Farmington Ave.
Hartford, CT 06105

July 18, 2013

Deputy Commissioner Lisa Davis
State of Connecticut, Department of Public Health
410 Capital Avenue
PO Box 340308
Hartford, CT 06134

RE: Project Number: 13-31822-CON,The Next Right Thing

Dear Ms. Davis:

We are writing today to indicate our support for the Next Right Thing's application for a Certificate of Need for the proposed intensive outpatient program for adolescents with a primary substance abuse diagnosis.

As you may already know, in Hartford, there is a significant increase in adolescent and young adult addictions, especially in relation to painkillers/opiates. Improving access to intensive outpatient substance abuse treatment centers in order to meet this population's needs supports granting the Next Right Thing a Certificate of Need.

The demand for programs geared towards treating adolescents is growing, and the Next Right Thing can further help provide the services needed by the Hartford community. With a growing history of success, the Next Right Thing is an asset to the community and Aetna supports their efforts to provide care to those in need of treatment.

Therefore, Aetna indicates our support for the Next Right Thing's application for a Certificate of Need.

Sincerely,

Antonio J. Rocchino
Network Market Head

Greer, Leslie

From: Greci, Laurie
Sent: Tuesday, July 23, 2013 11:16 AM
To: jenifer@NextRightThing.net
Cc: Hansted, Kevin; Riggott, Kaila; Greer, Leslie
Subject: Response to Request for Additional Time to Submit Late File for The Next Right Thing, LLC
Attachments: 31822 Extension for Receipt of Late File.pdf

Dear Ms. Simson,

I have attached a letter from OHCA extending the submission date for the late file for The Next Right Thing, LLC from July 22, 2013, to August 1, 2013.

If you have any questions, please feel free to contact me.

Regards,
Laurie

Laurie K. Greci
Associate Research Analyst
Department of Public Health
Health Care Access
laurie.greci@ct.gov
860 418-7032
860 418-7053

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

July 23, 2013

VIA Electronic Mail Only

Jenifer Simson
Executive Director
The Next Right Thing, LLC
345 North Main St., Ste. 306
West Hartford, CT 06117

RE: Certificate of Need Application; Docket Number: 13-31822-CON
The Next Right Thing, LLC
Establishment of an Outpatient Mental Health Clinic in West Hartford
Request for Time Extension for Submission of Late File

Dear Ms.Simson:

On July 22, 2013, the Office of Health Care Access received the request from The Next Right Thing to extend the submission date for the late file requested at the hearing held on the above matter on June 20, 2013.

OHCA hereby extends the required submission date of the late file from July 22, 2013, to August 1, 2013.

Please contact Laurie Greci at (860) 418-7032, if you have any questions.

Sincerely,

Kevin Hansted
Hearing Officer

Copy of PDF file: Kim Martone, Director of Operations, DPH OHCA
Kaila Riggott, CON Supervisor, DPH OHCA

aetna

Aetna
151 Farmington Ave.
Hartford, CT 06105

July 18, 2013

Deputy Commissioner Lisa Davis
State of Connecticut, Department of Public Health
410 Capital Avenue
PO Box 340308
Hartford, CT 06134

RE: Project Number: 13-31822-CON,The Next Right Thing

Dear Ms. Davis:

We are writing today to indicate our support for the Next Right Thing's application for a Certificate of Need for the proposed intensive outpatient program for adolescents with a primary substance abuse diagnosis.

As you may already know, in Hartford, there is a significant increase in adolescent and young adult addictions, especially in relation to painkillers/opiates. Improving access to intensive outpatient substance abuse treatment centers in order to meet this population's needs supports granting the Next Right Thing a Certificate of Need.

The demand for programs geared towards treating adolescents is growing, and the Next Right Thing can further help provide the services needed by the Hartford community. With a growing history of success, the Next Right Thing is an asset to the community and Aetna supports their efforts to provide care to those in need of treatment.

Therefore, Aetna indicates our support for the Next Right Thing's application for a Certificate of Need.

Sincerely,

Antonio J. Rocchino
Network Market Head

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

August 7, 2013

Via Fax Only

Jenifer C. Simson
Executive Director
The Next Right Thing, LLC
246 Steele Rd.
West Hartford, CT 06117

RE: Certificate of Need Application; Docket Number: 13-31822-CON
The Next Right Thing, LLC
Establishment of an Intensive Outpatient Behavioral Health Treatment Program
Closure of Public Hearing

Dear Ms. Simson:

On July 25, 2013, the Office of Health Care Access ("OHCA") received the information requested as a late file submission requested by OHCA at the public hearing held in this matter on June 20, 2013. With the receipt of the late file submission, the hearing on the above application is hereby closed.

If you have any questions regarding this matter, please feel free to contact Laurie Greci at (860) 418-7001.

Sincerely,

Kevin Hansted, Esq.
Hearing Officer

KH:lkg

****
*** TX REPORT ***
****

TRANSMISSION OK

TX/RX NO	3625
RECIPIENT ADDRESS	98602361414
DESTINATION ID	
ST. TIME	08/07 11:21
TIME USE	01'00
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RESULT	OK

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: Jenifer Simson

FAX: 860 236 1414

AGENCY: The New Right Thing LLC

FROM: Laurie Greci

DATE: 8/7/2013 **TIME:** 11:10

NUMBER OF PAGES: 2
(including transmittal sheet

Comments: Re: 13-31822-CON

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

Greer, Leslie

From: Greci, Laurie
Sent: Thursday, August 08, 2013 8:23 AM
To: jenifer@nextrightthing.net
Cc: Hansted, Kevin; Riggott, Kaila; Greer, Leslie
Subject: RE: 13-31822-CON Completion Fax

Jenifer,

The documentation was received by OHCA on July 25, 2013. No additional materials were received by OHCA as of the August 1, 2013, the extension date. The letter does not specify a closure date therefore it is the date that the letter was issued, i.e., August 7, 2013. We have the first four letters. I do not see any letter from Jeff Genser and I will double check to see if everything received for your application has been filed.

If you have an other questions, please let me know.

Regards,
Laurie

From: Jenifer Hartt [mailto:Jenifer@NextRightThing.net]
Sent: Wednesday, August 07, 2013 3:55 PM
To: Greci, Laurie
Cc: Julian@NExtRightThing.net
Subject: 13-31822-CON Completion Fax

Dear Laurie,

I received a fax from Kevin Hansted, Esq. that our CON application has been deemed complete as of July 25, 2013. The completion date confuses me slightly as we had received an extension through August 1st and I'm fairly certain that several letters of support were still working their way through the system as of the 25th. Hopefully, you have letters of support from the following in our completed application:

1. John Bailey (local provider)
2. Tony Roccino (Aetna, Behavioral Health)
3. Lisa Namerow (IOL psychiatrist)
4. Yifrah Kaminer (MD researcher, UCONN)
5. Jeff Genser (local provider)

As always, thank you for your help.

Best regards,

Jenifer Simson

The Next Right Thing, llc
Relapse Prevention for Adolescents with Substance Abuse and Mental Health Problems
345 N. Main Street, Suite 306
West Hartford, CT 06117
Main Office: 860-233-8803
Direct line:860-236-1499

Greer, Leslie

From: Greci, Laurie
Sent: Thursday, August 08, 2013 8:49 AM
To: Greer, Leslie
Subject: FW: 13-31822-CON Completion Fax

Leslie, since this may be true, can you call over to the Commissioenr's office and see if they have a letter from Jeff Genser.

Thank you!

From: Jenifer Hartt [mailto:Jenifer@NextRightThing.net]
Sent: Thursday, August 08, 2013 8:47 AM
To: Greci, Laurie
Cc: Julian@NExtRightThing.net
Subject: RE: 13-31822-CON Completion Fax

Dear Laurie,

Thank you Laurie. My suspicion is that Jeff forgot to put the CON number on the letter and it is sitting over in the commissioner's office.

No more questions! Thank you kindly,

Jenifer

From: Greci, Laurie [mailto:Laurie.Greci@ct.gov]
Sent: Thursday, August 08, 2013 8:23 AM
To: jenifer@nextrightthing.net
Cc: Hansted, Kevin; Riggott, Kaila; Greer, Leslie
Subject: RE: 13-31822-CON Completion Fax

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Main Office: 860-233-8803
Direct line:860-236-1499
www.NextRightThing.net

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

October 1, 2013

IN THE MATTER OF:

An Application for a Certificate of Need filed Pursuant to Section 19a-638, C.G.S. by:	Notice of Final Decision Office of Health Care Access Docket Number: 13-31822-CON
The Next Right Thing	**Establishment of an Intensive Outpatient Program for Substance Abusing Adolescents and Young Adults**

To:

Jenifer C. Simson
Executive Director
The Next Right thing, LLC
246 Steele Rd.
West Hartford, CT 06117

Dear Ms. Simson:

This letter will serve as notice of the Final Decision of the Office of Health Care Access in the above matter, as provided by Section 19a-638, C.G.S. On October 1, 2013, the Final Decision was rendered as the finding and order of the Office of Health Care Access. A copy of the Final Decision is attached hereto for your information.

Kimberly R. Martone
Director of Operations

Enclosure
KRM:swl

Department of Public Health
Office of Health Care Access
Certificate of Need Application

Final Decision

Applicant: **The Next Right Thing, LLC**
345 North Main St., West Hartford, CT 06117

Docket Number: **13-31822-CON**

Project Title: **Establishment of an Intensive Outpatient Program for Substance Abusing Adolescents and Young Adults**

Project Description: The Next Right Thing, LLC ("Applicant") seeks authorization to establish an intensive outpatient program for substance abusing adolescents and young adults at 345 North Main Street, West Hartford, Connecticut.

Procedural History: The Applicant published notice of its intent to file the Certificate of Need ("CON") application in the *Hartford Courant* on November 13, 14 and 15, 2012. On February 13, 2013, the Office of Health Care Access ("OHCA") received the CON application from the Applicant for the above-referenced project.

On May 6, 2013, OHCA deemed the CON application complete and a public hearing was scheduled for June 19, 2013. On the request of the Applicant, OHCA rescheduled the hearing. On June 17, 2013, OHCA notified the Applicants of the rescheduled date, time and place of the public hearing. Two notices to the public announcing the hearing were published in the *Hartford Courant* on May 15, 2013, for the initial hearing date and on May 25, 2013, for the rescheduled date and time. Thereafter, pursuant to Connecticut General Statutes ("Conn. Gen. Stat.") § 19a-639a, a public hearing regarding the Certificate of Need application was held on June 20, 2013.

Commissioner Jewel Mullen designated Attorney Kevin T. Hansted as the hearing officer in this matter. The hearing was conducted as a contested case in accordance with the provisions of the Uniform Administrative Procedure Act (Chapter 54 of the General Statutes) and Conn. Gen. Stat. § 19a-639a. The public hearing record was closed on August 7, 2013.

Findings of Fact

1. The Applicant, a for-profit limited liability company established in October of 2011 and located in West Hartford, is a private office-based substance abuse treatment center designed to meet the complex needs of dually-diagnosed adolescents and young adults age 16 to 23. Ex. A, pp. 10, 41

2. The Applicant currently provides intensive outpatient program ("IOP") treatment to clients on a self-pay basis. The IOP level of service is three days per week for three consecutive hours each day. Those clients whose families are unable to pay due to personal financial constraints or whose insurance companies will not reimburse them for the IOP level of care are being served by the Applicant but not at the IOP level. Ex. A, p. 10, 27

3. The Applicant began accepting clients in October 2011 and provided IOP services to 20 clients and their families in 2012. The Applicant also offered treatment services to approximately 15 other clients who instead chose to accept care from their insurance companies' in-network providers. Ex. A, p. 32

4. The majority of clients receiving the Applicant's services are adolescents and young adults that abuse heroin with multiple other drugs and have a co-morbid psychiatric diagnosis. Ex. A, p. 10

5. The Applicant proposes obtaining the licensure required to become a behavioral health outpatient clinic and provide the IOP level of service. By obtaining licensure for this level of care, the Applicant will have the ability to become a recognized provider by third party payers and to establish contractual relationships for reimbursement. Ex. A, p. 10

6. Insurance companies require providers to be licensed by the Department of Public Health (DPH) in order to be reimbursed for the IOP level of care. Ex. A, p. 10, 49

7. The DPH licenses required for this proposal include the Psychiatric Outpatient Clinic for Adults, Mental Health Day Treatment Facility and the Facility for the Care or the Treatment of Substance Abusive or Dependent Persons. The Applicant also proposes obtaining the Outpatient Psychiatric Clinic for Children license from the Department of Children and Families. Ex. C, p. 92

8. The Applicant's service area for the proposal includes Avon, Canton, Farmington, Simsbury and West Hartford. These towns are included in the service area because of the service needs of the adolescents and young adults and the ease of access to the Applicant's office. The practice, however, has drawn families from Glastonbury and as far away as Orange. Ex. A, p. 19

9. According to the 2011 Biannual West Hartford Drug and Alcohol Survey, the relatively affluent communities in the Applicant's proposed service area are at particular risk in the current drug epidemic due to the high risk nature of the patterns of drug abuse in which these towns' teens indulge. The factors that influence the teens' high risk of using drugs include:
   a. Continued drug use even as their understanding of the perceived risks increase and include a willingness to try heroin;
   b. Access to money to pay for drugs;
   c. Access to gateway prescription painkillers, such as Oxycontin and Vicodin;
   d. Tendency of parents to minimize problems; and
   e. Lack of parental knowledge and skill in recognizing signs and symptoms of substance abuse.

   Ex. A, pp. 19, 20, 25

10. The 2011 National Survey on Drug Use and Health ("NSDUH") reported that:
   a. The number of people who were past-year heroin users in 2011 was higher than the number in 2007;
   b. The rate of current illicit drug use varied by age. Among youths aged 12 to 17 in 2010, the rate increased from 4.0 percent at ages 12 or 13 to 9.3 percent at ages 14 or 15 and to 16.6 percent at ages 16 or 17.
   c. The highest rate of current illicit drug use was among18 to 20 year olds (23.1 percent), with the next highest rate among 21 to 25 year olds (20.5 percent).

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

11. There are no IOP providers in the proposed service area that primarily target substance abusing adolescents and young adults (16-23 years of age). The following facilities have intensive outpatient programs for children aged 12 to 18 years and young adults age 18 and over.

Table 1: Intensive Outpatient Programs Serving Residents of the Proposed Service Area

Facility Name	Location	Admission Information
Community Renewal Team	Hartford	Adults 18 yrs. and older
ADRC	Hartford	Adults 18 yrs. and older
Catholic Charities	Hartford	Clients must be referred by the Court System
Hartford Behavioral Health	Hartford	Clients must be referred by the Hartford area Department of Children and Families

Sources: Statewide Health Care Facilities and Services Plan and websites of the listed agencies: http://crtct.org/; http://www.adrc-ct.org/; http://www.ccaoh.org/; and http://www.hbh1.org/

12. Currently, adolescents and young adults may be served by programs not designed for this population. Most, if not all, IOP providers that treat 18 to 23 year olds treat them in the same program along with both much older adults and those with a wide variety of mental health issues. This is also true for IOP providers who treat adolescents and young adults in the same program with patients that are much younger or have a variety of psychiatric issues. Ex. A, p. 27

13. Ann Price, M.D., Chief Medical Consultant, The Next Right Thing, LLC, stated that "these adolescent over time…present very differently from what they do when they're just in withdrawal or just post-withdrawal…we have a whole population of adolescents and young adults out there, who I believe are not getting appropriate care." Transcript of June 20, 2013, Public Hearing ("Tr.") Testimony of Dr. Price, p. 11

14. Current treatment for many at-risk substance abusing adolescents and young adults is fragmented by brief hospitalizations for acute crises, brief partial hospitalizations, and conventional outpatient therapies. Ex. A, p. 35

15. Julian N. Hartt, Jr., L.C.S.W., Co-Founder and Clinical Director of The Next Right Thing, LLC explained:
    a. Inpatient and partial hospital services are available for dually diagnosed adolescents and young adults , but not for those having a substance abuse disorder as the primary diagnosis;
    b. Adolescents and young adults then step down to the least intensive care, outpatient, with once-a-week individual, family, or group session resulting in a gap in services;
    c. Insurance companies have been hesitant to authorize inpatient detox because opiates are essentially medically non-life threatening;
    d. The Applicant can provide intensive outpatient services and after-care, noting that the adolescents and young adults require a longer term recovery process; and
    e. Being in a program during the long-term recovery will keep them out of more intensive levels of care and out of emergency rooms.

    Tr. Testimony of Mr. Hartt, p. 6, 9

16. The Applicant has provided care to adolescents who were referred for treatment from licensed therapists, social workers at area public high schools, and the juvenile justice system. The Applicant receives referrals from Hartford Hospital, private clinicians and others due to its clinical expertise regarding opiate addiction in adolescents and young adults. Table 2 shows the referral sources for clients that were treated or are currently being treated, as provided by the Applicant.

Table 2: Referral Sources of the Applicant's Clients by Calendar Year

Referral Source	2011	2012	2013
	Oct – Dec	Jan – Dec	Jan – May
Licensed Therapists*	6	15	10
Public High School Personnel (social workers)	0	14	6
Other Providers	0	1	2
Juvenile Justice System**	0	12	2
Other***	4	10	0
Total	10****	52****	20

* Includes psychiatrists, psychologists, and other licensed clinicians
** Court Support Services Division of the Department of Justice
*** Includes family and friends, website and others
**** 5 clients in 2011 and 20 clients in 2012 received multiple services and would have qualified for the IOP level of service; the number for 2013 was not provided
Ex. A, pp. 29, 31 and Ex. M (Late File 2)

17. The Applicant's proposed IOP is dual-diagnosis capable and designed to comply with the National Institute on Drug Abuse and the National Alliance on Mental Illness recommendations for treatment. Ex. A, p. 37

18. The Applicant's IOP incorporates best practices using cognitive behavioral therapy, relapse prevention, and 12-step program concepts. Ex. A, p. 2

19. The Applicant's IOP components include:
    a. Comprehensive assessment with the client and their family that incorporates the Stages of Change Model[1] to provide the guidelines for determining when a client is ready for less intensive treatment;
    b. A treatment plan that includes both IOP and after-care goals;
    c. Individual, family, a variety of group based services, parent support, and on-going medical supervision with medication when needed; and

[1] The Stages of Change Theory states people tend to progress through difference stages at different rates on their way to a successful change in behavior. The stages of change are pre-contemplation, contemplation, preparation and determination, action and will power, maintenance, and relapse. Source: http://www.addictioninfo.org. Ex. C, p. 95

d. An alternative medically supervised ambulatory detox for opiate addicts using a non-opioid detox protocol.
Ex. A, p. 11

20. The Applicant's proposed IOP will offer:
a. Specialized diagnostic and treatment services dedicated to 16-23 year olds;
b. Local and accessible treatment within 24 hours;
c. Treatment for the whole family, not just the substance abuser ; and
d. Connections to the community through close working relationships with school counselors, parole officers, mental health professionals and parents.
Ex. A, p. 27

21. Julian N. Hartt, Jr., L.C.S.W., Co-Founder and Clinical Director of The Next Right Thing, LLC, stated that "we've been in operation for a year and a half and 25 percent of the population, about 40 families, have required detox…the first seven we admitted, five of them are heroin addicts. One of them was to die, because of non-compliance with Naltrexone, and two of them overdosed…a high-risk population...If there's going to be a sustained chance of recovery, the whole family had to be treated and treated intensively, with individual, family therapy, parent, group and multi-family therapy." Tr. Testimony of Mr. Julian Hartt, pp. 7-8

22. The Applicant will actively involve the client's parents, high schools and colleges, and the judicial system as critical elements for treatment success. Coordinating a safety net that includes the treatment program, school and family enhances odds of preventing relapse and stabilizing other mental health problems. Ex. A, p. 13

23. Mr. Hartt stated that the proposed IOP "was designed to be an after-school program for long-term recovery of a primary Axis I diagnosis of substance abuse…without exception, all of our adolescent have carried another Axis II diagnosis that is a medical diagnosis of a major psychiatric disorder. So these are adolescents demonstrating significant psychopathology…The IOP [will] offer a level of care that is just not available for primary diagnosis of substance abuse... " Tr. Testimony of Mr. Julian Hartt, p. 8

24. Dr. Price testified that the Applicant provides ambulatory detox using Clonidine, a medication that will calm the agitated response in withdrawal. The clients are closely monitored at home with the help of the family. Once detoxed, Naltrexone[2] is administered by the parent daily. Suboxone[2] is not used by the Applicant as it may be sold to obtain money to buy other drugs. Tr. Testimony of Dr. Price, pp. 13-15

[2] Naltrexone is an opioid receptor antagonist used to help the adolescents and young adults remain drug-free. Suboxone is another drug used to treat opiate addiction. Source: http://www.drug.com

25. The Applicant addresses the behavioral health treatment needs of the proposed population by providing:
    a. Accurate assessment of a client's diagnosis, treatment and medication needs;
    b. Time and opportunity to assess and stabilize clients;
    c. Access, with same day or within 24 hours;
    d. Individualized care;
    e. Mobile crisis capacity; and
    f. Long term aftercare for the clients and parents helping to reduce the need for higher levels of care.

    Ex. A, p. 12

26. The Applicant established its office at 345 North Main Street, West Hartford, as it is at a major intersection of two state routes, has ample and well-lit parking with plenty of handicap parking and a handicap accessible building with 24-hour security. Also, the professional office building private practice suite was chosen to reduce client anxiety around treatment. Ex. A, p. 18

27. According to Census 2010, there are approximately 12,304 16-23 year olds residing in the proposed service area. The population is significantly higher when including students from over 15 private and public high schools and colleges within a 5-mile radius of the proposed location. Ex. A, p.19 and Ex. C, p. 83

28. There are approximately 2,035 16 to 23 year olds within the proposed service area that may utilize the Applicant's proposed services. The Applicant estimates that it can serve about 15 youths and their families at any one time, and approximately 60 youths and families over the course of a year. The following table illustrates these estimates:

Table 3: Estimated Number of 16 to 23 Year Olds in Service Area with Unmet Treatment Need

Town	Population 16 to 23 Years Old*	% Needing Services	Number Needing Services	% Proposed to be Served by Applicant	Number of Persons to Benefit from Proposal
Avon	1,373	16.54%**	227	2.95%***	7
Canton	800		132		4
Farmington	2,187		362		10
Simsbury	2,036		337		10
West Hartford	5,908		977		29
Total	**12,304**		**2,035**		**60**

* Estimates based on Census 2010 counts of 15 to 24 year olds. The Applicant decreased the population count by 20% to remove the counts of the 15 and 24 years old residing in the proposed service area.

** Source: Substance Abuse and Mental Health services Administration's 2010-2011 National Surveys on Drug Use and Health. For Connecticut, the survey reported the percentage by age group for those that needed but did not receive treatment in the past year for substance abuse. The percentages for alcohol use were 4.08% for the 12 to 17 age group and 16.54% for the 18 to 25 age group and the percentages for illicit drug use were 3.99% for the 12 to 17 age group and 6.96% for the 18 to 25 age group. The degree to which these prevalence percentages are additive is not clear, so the Applicant utilized the conservative rate of 16.54%.

*** The Applicant estimates that it can serve approximately 15 youths and their families at any one time and an estimated 60 patients and their families over the course of a year. The yearly percentage is 60/2,035 or 2.95% of the targeted population.

Ex. A, p. 20 and Ex. C, pp. 85, 86

29. In 2012, the Applicant offered treatment services to approximately 15 clients and families who did not accept care due their need to obtain services from their insurance companies' in-network provider. Ex. A, pp. 31, 32

30. The Applicant projects that, once licensed, 31 clients will be served in 2013. With additional part-time and full time clinicians, the Applicant will accept referrals from towns, parole officers, hospitals and residential programs. The Applicant projects providing services to 38 and 52 clients in FYs 2014 and 2015, respectively.

Table 4: Projected Number of Clients by Fiscal Year

Fiscal Year:	2013	2014	2015
Number of Clients:	31	38	52
Change from Previous Year:	-	7	14

Ex. A, p. 31

31. Given the volume of prospective clients who are undertreated or untreated, the Applicant's proposal is not anticipated to have a negative impact on other providers within the community. Ex. A, p. 30

32. Lisa Namerow, M.D., attending child and adolescent psychiatrist at The Institute of Living in Hartford, stated in a letter of support that she "clearly see[s] a need for an IOP directed at adolescents struggling with substance use disorders in this area." Ex. R

33. Yifrah Kaminer, M.D., a professor of psychiatry at the University of Connecticut's Department of Medicine, stated in a letter of support that the "NRT (Next Right Thing) initiative would provide needed care for adolescents and young adults suffering from severe SUD (substance use disorder) and consequences. This subpopulation includes youth with or without concurrent mental health disorders and problems… who have very few options of care in CT." Ex. N

34. John Forlenza-Bailey, a Licensed Alcohol and Drug Counselor at Chemical Addictions Treatment Services in Newington stated in a letter of support that "As a clinician and alcohol and drug counselor who has practiced in the West Hartford area for the last 25 years, I have witnessed a lack of resources especially for IOP level of care needs for teenagers (14 to 19) with co-occurring disorders …High risk substance abuse use such as opioid and cocaine abuse…are being used by more teens and at younger ages regarding first time usage reports. IOP with extended aftercare for the adolescents and parents will insure a greater level of care than just outpatient services have historically provided in the past."
Ex. L

35. The Applicant's proposal contributes to the quality of the health care delivery system in the greater Hartford region by:
    a. Answering the demand for substance abuse treatment for adolescents and young adults that is developmentally appropriate;
    b. Filling the gap for intensive treatment that falls between the level of PHP and weekly psychiatric visits;
    c. Building parent and peer community;
    d. Coordinating services with parole officers and school counselors; and
    e. Negotiating case rates with insurers to make theses intensive services affordable to more families.

    Ex. A, p. 34

36. Based on preliminary discussions with third party payers and local knowledge of rates of reimbursement for other providers offering similar levels of care, the Applicant anticipates charging from $400 to $600 per day per client in the intensive outpatient program. Ex. A, p. 53

37. The Applicant projects an incremental loss of $36,076 with the proposal in the first fiscal year with modest incremental gains in the following two fiscal years.

Table 5: Projected Incremental Revenues and Expenditures by Fiscal Year

Account Description	FY2013	FY2014	FY2015
Net Operating Revenue	$213,963	$263,222	$358,410
Salaries/Benefits	222,685	227,410	291,020
Professional Services	6,000	6,000	6,000
Bad Debts	9,720	11,232	16,272
Other Operating Expense	11,300	13,400	37,600
Total Operating Expense	249,705	258,042	350,892
Income (Loss) from Operations	**($ 36,076)**	**$ 5,180**	**$ 7,518**

Ex. A, p. 45

38. With relatively conservative estimates of revenue and expenses, charity clients and self-pay clients, the Applicant expects the program to break even by serving approximately 38 clients or providing 669 units of care/year in each of the first two years. Ex. A, p. 54

39. The Applicant asserted that the proposal will be cost effective in two ways:
    a. Decreased expense for clients immediately once the Applicant is licensed as an IOP and can participate in-network with providers; and
    b. If these adolescents and young adults get effective treatment for substance abuse and co-morbidities, relapse and recidivism and future treatment will decrease.

    Ex. A, p. 54

40. The current payer mix based on patient population for the Applicant is 100% self-pay due to the absence of licensure and contractual relationships with insurance payers. Once licensed, the Applicant's patient payer mix will be primarily commercial insurance.

Table 6: Payer Mix based on Patient Population by Fiscal Year

Payer	Current	FY 2013	FY 2014	FY 2015
Commercial Insurers	-	81%	84%	81%
Uninsured or Self-pay	100%	16%	14%	16%
Charity/Bad Debt	-	3%	2%	3%
Total	**100%**	**100%**	**100%**	**100%**

Ex. A, p. 44 and Ex. C, p. 112

41. OHCA is currently in the process of establishing its policies and standards as regulations. Therefore, OHCA has not made any findings as to this proposal's relationship to any regulations adopted by OHCA. (Conn .Gen. Stat. § 19a-639(a)(1))

42. This CON application is consistent with the overall goals of the State Health Care Facilities and Services Plan. (Conn. Gen. Stat. § 19a-639(a)(2))

43. The Applicant has established that there is a clear public need for its proposal. (Conn. Gen. Stat. § 19a-639(a)(3))

44. The Applicant has satisfactorily demonstrated that its proposal is financially feasible. (Conn. Gen. Stat. § 19a-639(a)(4))

45. The Applicant has satisfactorily demonstrated that its proposal would improve the accessibility of health care delivery in the region and it has satisfactorily demonstrated a potential improvement in quality and cost effectiveness. (Conn. Gen. Stat. § 19a-639(a)(5))

46. The Applicant has shown that there will be an increase in access to the provision of health care services to the relevant populations and payer mix. (Conn. Gen. Stat. § 19a-639(a)(6))

47. The Applicant has satisfactorily identified the population to be served by its proposal and has satisfactorily demonstrated that this population has a need as proposed. (Conn. Gen. Stat. § 19a-639(a)(7))

48. The Applicant's historical provision of treatment in the service area supports this proposal. (Conn. Gen. Stat. § 19a-639(a)(8))

49. The Applicant has satisfactorily demonstrated that the proposal will not result in an unnecessary duplication of existing services in the area. (Conn. Gen. Stat. § 19a-639(a)(9))

Discussion

CON applications are decided on a case by case basis and do not lend themselves to general applicability due to the uniqueness of the facts in each case. In rendering its decision, OHCA considers the factors set forth in § 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).*

The Applicant is a for-profit limited liability company that currently operates a private office-based substance abuse treatment center in West Hartford that is designed to meet the complex needs of dually-diagnosed adolescents and young adults ages 16 to 23. *FF 1* Since October 2011, the applicant has been providing adolescents and young adults that abuse heroin and have a co-morbid psychiatric diagnosis with intensive outpatient program ("IOP") services on a self-pay basis. *FF 2-4* The Applicant proposes obtaining the licenses needed to establish itself as a behavioral health outpatient clinic. As a licensed facility, the Applicant will be able to establish contractual relationships with third-party payers and thus provide services to more adolescents and young adults. *FF 5*

There are no IOP providers that primarily target substance abusing adolescents and young adults in the proposed service area of Avon, Canton, Farmington, Simsbury and West Hartford. *FF 8, 11* Adolescents and young adults living in the relatively affluent communities of the proposed service area indulge in high risk patterns of drug abuse influenced by continuing drug use; access to money to pay for drugs; access to gateway prescription painkillers; the tendency of parents to minimize problems; and lack of parental knowledge and skill in recognizing the signs and symptoms of substance abuse. *FF 9* Currently, adolescents and young adults may be served at other programs for youth or adults, but these programs are not designed to treat the specific ages proposed to be served by the Applicant. *FF 12, 13* These substance abusing adolescents and young adults are provided inpatient or partial hospitalization for the treatment of their drug addictions and then discharged to receive conventional outpatient therapies. *FF 14* The Applicant's proposal will provide intensive outpatient services, conventional outpatient and after-care for a sustained recovery. *FF 15*

The Applicant has been providing care to adolescents and young adults who were referred to them for treatment from licensed therapists, social workers at area public high schools, juvenile justice and others. *FF 16* Using a treatment program that incorporates best practices, the Applicant proposes to offer a comprehensive assessment of the client, intensive outpatient therapy, after-care, individual, group and family therapy, and an alternative medically supervised ambulatory detox protocol. *FF 18, 19* These high-risk clients need to be treated intensively along with actively involved parents, educators and the judicial system. *FF 21, 22* The proposed IOP has been designed as an after-school program that will provide appropriate care for those with a primary diagnosis of substance abuse. *FF 23* The Applicant also provides an ambulatory detox program that a client receives at home with the support of family. *FF 24* By proposing to provide a continuum of care from detox to after-care for the targeted population, the Applicant's proposal will improve the quality of health care delivery in the West Hartford area. Additionally, clear public need for this proposal is evident as it is providing services that are not readily available to dually-diagnosed adolescents and youth with a primary diagnosis of substance abuse.

available to dually-diagnosed adolescents and youth with a primary diagnosis of substance abuse.

The Applicant is currently treating some, but not all clients, at the intensive outpatient level due to the financial constraints upon the families and restrictions imposed by insurers. *FF 2* Once licensed, the Applicant projects to serve 31, 38 and 52 clients in the first three fiscal years, respectively. *FF 30* The Applicant will be treating a small portion of the potential number of clients needing this level of care each year. *FF 31* The low volume of clients being served will enable the Applicant to meet long-term after-care goals. Therefore, OHCA concludes that there will not be an unnecessary duplication of services in the proposed service area.

Licensure as a facility providing behavioral health services will enable the Applicant to receive reimbursement for its services from third-party payers. Adolescents and young adults who are covered by health insurance but not able to pay out-of-pocket will be able to utilize the Applicant's services. The parents or guardians of these adolescents and young adults will no longer be solely responsible for the costs of the treatment. The proposal will, therefore, improve access to IOP services for the targeted population.

Although the Applicant projects an incremental loss of $36,076 with the proposal in the first fiscal year, it projects modest incremental gains in the next two fiscal years. *FF 37* Consequently, OHCA finds that the proposal is financially feasible.

Order

Based upon the foregoing Findings of Fact and Discussion, the Certificate of Need application of The Next Right Thing, LLC to establish an intensive outpatient program for substance abusing adolescents and young adults to be located at 345 North Main Street, West Hartford, Connecticut, is hereby **APPROVED**.

All of the foregoing constitutes the final order of the Office of Health Care Access in this matter.

By Order of the
Department of Public Health
Office of Health Care Access

9/30/13
Date

Lisa A. Davis, MBA, BSN, RN
Deputy Commissioner

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*** TX REPORT ***
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OFFICE OF HEALTH CARE ACCESS

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