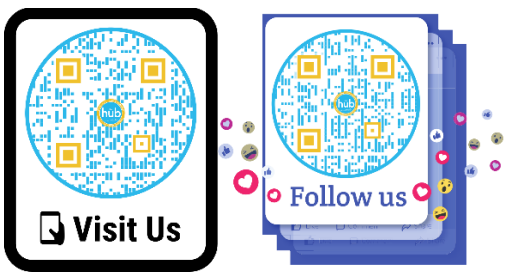
2022-2023 REGIONAL PRIORITY REPORT

FOR SOUTHWESTERN CONNECTICUT (REGION 1)

APRIL 2023

PREPARED BY:



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EXECUTIVE SUMMARY

As the Regional Behavioral Health Action Organization (RBHAO) for Southwestern Connecticut, The Hub—a division of RYASAP is tasked every two years by the Connecticut Department of Mental Health and Addiction Services (DMHAS) to carry out a regional need's assessment and priority planning process to capture the needs and trends at the local and regional level. The report is a data–driven analysis and community perspectives of the magnitude, impact and capacity within DMHAS Region 1. This process is used to inform the DMHAS Mental Health Block Grant and DMHAS biennial budgeting process as well as the planning and priority setting process for The Hub. The report's primary purpose is to inform DMHAS of the behavioral health needs of children, adolescents, and adults in Southwestern CT (SW CT) also known as Region 1, providing data and priority recommendations for prevention, treatment, and recovery services. The report wouldn't be possible if it weren't for our key community members.

The profile and data will be a building block for community level processes including:

- To set priorities among populations who need behavioral health prevention, treatment and recovery services;
- To provide a basis for determining emerging needs, projecting future needs, and identifying health disparities;
- To inform a comprehensive strategic plan;
- To increase general community awareness of substance use and other behavioral health problems;
- To support leveraging of funding;
- To respond to public data needs (e.g., providers, educators, funding agencies, media, policymakers);
- To enhance membership of planning or advisory groups to be more demographically representative and/or more responsive to priority needs of the region.

The overall profile offers the 14 communities (Stratford, Trumbull, Monroe, Easton, Bridgeport, Fairfield, Westport, Weston, Wilton, Norwalk, New Canaan, Darien, Stamford & Greenwich) of The Hub's service area information regarding substance use and misuse, both illegal and legal; mental health concerns; suicide; and gambling. The information was gathered from many cited sources (qualitative & quantitative) that we collected, synthesized and analyzed. This included an online survey, many focus groups, Key informant interviews (KII), and anecdotal information from stakeholder groups. It's separated into 9 epidemiological profiles: alcohol, tobacco, electronic nicotine delivery systems (ENDS), prescription drugs, cannabis, heroin & other illicit opioids (fentanyl), cocaine, problem gambling, mental health, and suicide. The information is gathered from federal and state data and is then compared to local data when available. Each profile identifies the prevalence and magnitude of the issue, lists risk factors and at-risk populations, and summarizes the region's capacity and resources to address that problem.

Unlike previous reports. 2021 data should not be compared with prior years' data due to methodological differences (mode of data collection) as result of the COVID-19 pandemic. Because of this, we relied more on our quantitative sources, which made it more difficult to analyze and compare results from previous sources and priority reports.

Our data workgroup offered their insights and perceptions regarding their communities which were also reflected in each of the profiles. These profiles can be used individually or together to provide a snapshot of behavioral health in the region. We have additionally used the data from the profiles to develop infographics for use in community education throughout the region. The profiles will be able to assist communities in SW CT in developing strategies to address their own issues.

The identified data workgroup consisted of participants who ranked the region's priority after reviewing the profiles, focus group responses, 2022 Community Readiness Survey and data sets. During a meeting, members discussed and ranked the priority areas in magnitude, impact, consequences, and changeability. The Hub summarized and calculated the rankings to complete the priority ranking matrix.

It was concluded that the top priorities of the region are, in descending order, 1. Depression 2. Anxiety 3. Suicide 4. Electronic Nicotine Delivery Systems (ENDS), vaping, juuling 4. Heroin and Fentanyl 5. Alcohol 6. Trauma/PTSD 7. Tobacco 8. Marijuana 8. Rx Drug Use 9. Serious Mental Illness - Children 10. Serious Mental Illness – Adults 11. Problem Gambling and 12. Cocaine. The number one priority, depression, had an overall ranking of 4.04, whereas the second and third were remarkably close with anxiety 3.94 and suicide 3.92. Both depression and anxiety had magnitudes of 4.7 and suicide had the highest consequence of inaction at 4.8. This year's priority matrix was broken down into mental health disorders, where in previous reports, there was only one category, mental health issues. This allowed for a deeper look into mental health and what disorders are affecting the region most. The data workgroup identified mental health overall being a large concern among all ages across the lifespan, as many struggled moving into the post COVID-19 pandemic life. Electronic Nicotine Delivery Systems (ENDS, vaping, juuling) was ranked fourth by the data workgroup. ENDs usage was seen to decrease in the last report due to the pandemic but now with individuals, especially youth, back to being able to access products, there has been an increase in use and ranked a magnitude of 4.1. The data workgroup is concerned for youth after reviewing multiple school surveys in the region as results are showing there is a significant number of youths who are addicted and a need for cessation programs. Heroin and Fentanyl also ranked fourth. This matrix combined heroin and fentanyl whereas previous ones only had heroin. After reviewing data and surveys, the data workgroup ranked the impact and consequence of inaction 4.5. The hub plans to work with community stakeholders and coalitions to address these specific mental health disorders and ENDS epidemic, as well as continue to address the opioid crisis. It is important to note that the selection of the data workgroup, key stakeholders/KII and the COVID-19 pandemic can influence the outcome of this report.

CONTRIBUTORS

We would like to **THANK** our region for the support, commitment, and insights they have shared with us in various meetings, focus groups, KIIs, workgroups, committees, trainings, and events throughout the year at which strengths, needs, concerns and gaps are discussed. The feedback is essential to our understanding of the region which drives the recommendations included in this report.

Over the course of numerous months, staff members at The Hub worked to compile, assess and formulate a strategic plan to best address regional needs in relation to substance misuse, problem gambling, mental health and suicide. Ultimately, it is our hope that this information will help assist the region across the spectrum of prevention, treatment and recovery for behavioral health needs. Hub staff who were the main contributors to this report:

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We would particularly like to thank the members of our Catchment Area Councils (CACs), Local Prevention Councils (LPCs), Gambling Awareness Team, Regional Suicide Advisory Board (RSAB), Recovery Friendly organizations and Data Workgroup who supported us through this process. Special gratitude to the following members of these groups who helped review the epidemiological profiles, prioritized needs, and provided feedback on the recommendations:

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ABBREVIATIONS

AA	Alcoholics Anonymous
AFSP	American Foundation for Suicide Prevention
ASIST	Applied Suicide Intervention Skills Training
ATOD	Alcohol, Tobacco & Other Drugs
BENZO	Benzodiazepine
BH	Behavioral Health
BRFSS	Behavioral Risk Factor Surveillance System
CAC	Catchment Area Councils
CADCA	Community Anti-Drug Coalitions of America
CAP	Community Awareness Program
CBHAC	The Children's Behavioral Health Advisory Committee
CBD	Cannabidiol
CCAR	CT Community for Addiction Recovery
CCPG	Connecticut Council on Problem Gambling
CCT	Community Care Team
CDC	Centers for Disease Control and Prevention
CHIP	Community Health Improvement Project
CHNA	Community Health Needs Assessment
CIT	Crisis Intervention Trained
CoC	Continuums of Care
COD	Co-Occurring Disorders
COLI	Cost of Living Increase
CPES	Center for Prevention Evaluation and Statistics
CPN	CT Prevention Network
CPMRS	CT Prescription Monitoring and Reporting System
CRS	Community Readiness Survey
CSP	Community Support Program
CSHS	Connecticut School Health Survey
CT	Connecticut
CT SAB	Connecticut Suicide Advisory Board
CVH	Connecticut Valley Hospital
DAWN	Drug Abuse Warning Network
DBSA	Depression and Bipolar Support Alliance
DCF	Department of Children and Families
DEA	Drug Enforcement Agency
DFC	Drug Free Communities
DMHAS	Department of Mental Health and Addiction Services
DMV	Department of Motor Vehicles
DOE	Department of Education
DOC	Department of Corrections
DOT	Department of Transportation
DPH	Department of Public Health
DSM	Diagnostic and Statistical Manual of Mental Disorders
DUI	Driving Under the Influence
ESS	Effective School Solutions
EVALI	E-cigarette or Vaping Product Use Associated Lung Injury
ENDS	Electronic Nicotine Delivery System
FDA	Federal Drug Administration
FTS	Fentanyl Testing Strip
GA	Gambling Awareness
HUD	U.S. Department of Housing and Urban Development
IOP	Intensive Outpatient Program

IQ	Intelligence quotient
KII	Key Informant Interview
LPC	Local Prevention Council
LGBTQ	Lesbian, Gay, Bisexual, Transgender and Questioning
LIST	Local Interagency Service Team
MADD	Mothers Against Drunk Driving
MCIS	Mobile Crisis Intervention Services
MOUD	Medication for Opioid Use Disorder (formerly MAT)
MH	Mental Health
MHFA	Mental Health First Aid
NAMI	National Alliance for Mental Illness
NAS	Neonatal Abstinence Syndrome
NCHS	National Center for Health Statistics
NCPG	National Council on Problem Gambling
NIDA	National Institute on Drug Abuse
NIH	National Institute of Health
NORA	Naloxone + Overdose Response App
NSDUH	National Survey on Drug Use and Health
OCME	Office of the Chief Medical Examiner
OD	Overdose
ODFC	Opening Doors Fairfield County
PCP	Phencyclidine
PGAM	Problem Gambling Awareness Month
PGS	Problem Gambling Services
PIT	Point-in-Time
PSA	Public Service Announcement
PTSD	Posttraumatic Stress Disorder
QPR	Question, Persuade & Refer
RBHAO	Regional Behavioral Health Action Organization
RSAB	Regional Suicide Advisory Board
RSS	Recovery Support Specialist
RFW	Recovery Friendly Workplace
RYASAP	Regional Youth Adult Social Action Partnership
SEOW	State Epidemiological Outcomes Workgroup
SADD	Students Against Destructive Decisions
SAM	Smart Approaches to Marijuana
SAMHSA	Substance Abuse and Mental Health Services Administration
SBIRT	Screening, Brief Intervention and Referral to Treatment
SDE	State Department of Education
SIDS	Sudden Infant Death Syndrome
SMART	Specific, Measurable, Achievable, Relevant, Time-Bound
SMART Recov.	Self-Management and Recovery Training
SMI	Serious Mental Illness
SOR	State Opioid Response
SPF	Strategic Prevention Framework
SUD	Substance Use Disorders
SW CT	Southwestern Connecticut
TEDS	Treatment Episode Data Set
THC	Tetrahydrocannabinol
TOT	Training of Trainers
TRS	Telephone Recovery Support
US	United States
USDEA	U.S. Drug Enforcement Agency
YRBS	Youth Risk Behavior Survey
YTYK	You Think You Know Campaign

CONTENTS

INTRODUCTION

BACKGROUND

Every two years, the Connecticut Department of Mental Health and Addiction Services planning unit conducts a priority setting process meant to develop plans for mental health and addiction services at the local, regional, and state levels and supports the federal block grants allocated by the United States Substance Abuse and Mental Health Service Administration (SAMHSA). The SAMHSA Substance Abuse Prevention, Treatment Block Grant and Mental Health Block Grant funding requires DMHAS to annually:

- Assess needs, strengths, and critical gaps in their service delivery systems,
- Identify target populations and priorities for those populations.

As strategic community partners, Regional Behavioral Health Action Organizations (RBHAOs) assist with this charge by:

- assessing the needs for children, adolescents, and adults across the regions and
- developing Regional Strategic Plans to include epidemiological profiles and priority recommendations for prevention, treatment, and recovery services.

The RBHAO Regional Priority Report is designed to[1]:

- provide a thorough description of substance use, problem gambling, and mental health problems, including suicide, among the various populations (overall and subpopulations) in a region,
- describe the current status of instances of the substance use problems, problem gambling, and mental health issues, including suicide, in the region and examine trends over time where possible,
- identify characteristics of the general population and of populations who are living with, or at high risk for, substance use and mental health problems, suicide, and problem gambling in the regions and who need primary and secondary prevention or health promotion services,
- provide information required to conduct prevention needs assessments and gap analyses for substance use and mental health problems, suicide, and problem gambling,
- define regional priorities, resources, assets, and subpopulations at increased risk for behavioral health issues, and make recommendations on addressing regional gaps and needs, as well as health disparities.

In SW CT, The Hub, a program of the Regional Youth Adult Social Action Partnership (RYASAP), is the RBHAO charged with conducting this process in order to assess the behavioral health needs of children, adolescents, and adults regarding substance misuse, mental health, suicide and problem gambling. This process also informs and is informed by SAMHSA's Strategic Prevention Framework

[1] PowerPoint Presentation (ct.gov)

(SPF) model, which is a five-step, data-driven process known to promote youth development and prevent problem behaviors across the lifespan.

PURPOSE

This report is the result of the 2021/2022 priorities process in SW CT, designated by DMHAS. In completing the report, The Hub developed a regional plan that includes epidemiological profiles and priority recommendations for prevention, treatment, and recovery services. The findings will be used by DMHAS to identify initiatives and funding priorities for the federal block grants, to develop recommendations and priorities within the Prevention Division, and to compare findings across regions. The report will also be disseminated to partners within the region, including municipal, health, and social services departments, treatment agencies, prevention councils, consumer groups, legislators, funding agencies, and to inform regional and local initiatives. This will help partners support state and community-level data driven processes including readiness assessment, capacity building, strategic planning, implementation of evidence-based programs and strategies, and evaluation of those programs and strategies.

DATA SOURCES

The data used to compile this report has been drawn from a variety of national, state, regional and local quantitative and qualitative sources, including the following:

Local Youth Surveys: Conducted by Local Prevention Councils (LPCs) and school districts to ascertain prevalence, attitudes, behaviors, and perceptions among youth and families regarding behavioral health across the continuum of prevention, treatment and recovery.

Regional Surveys: Including the surveys of adults over 18 in the Bridgeport, Norwalk, Stamford, and Greenwich sub-regions, conducted by DataHaven as part of the Community Health Needs Assessments, focus groups, key informant surveys, and the 2022 Community Readiness Survey conducted by The Hub.

State Data: Including Mobile Crisis Intervention Services (MCIS), 211 call data, the Connecticut School Health Survey, Connecticut Behavioral Risk Factor Surveillance Survey, accidental overdose deaths from the Department of Public Health, and deaths from the Office of the Chief Medical Examiner, DMHAS treatment admissions, and other statistics compiled by the Connecticut Data Collaborative from state and federal sources and available through the State Epidemiological Outcomes Workgroup website (SEOW).

National Data: Including National Survey of Drug Use and Health, Youth Risk Behavior Surveillance System, National Institutes of Health and various journal articles.

Qualitative Data: Including focus groups with Catchment Area Councils (CACs), Regional Suicide Advisory Boards (RSABs), Local Prevention Councils (LPCs), Recovery Friendly Workplace (RFW) certified agencies, and Community Care Teams (CCT); key informant interviews with behavioral health consumers and providers; discussions at LPC meetings; and identification of needs and gaps at subregional meetings and coalitions, including the Greenwich Community Health Improvement

Project, the Bridgeport Health Improvement Alliance, Region 1 Gambling Awareness team, and other meetings throughout the year.

STRENGTHS AND LIMITATIONS

This report is a comprehensive overview of behavioral health prevention, treatment, and recovery needs and recommendations for SW CT. Although we believe the information presented is reliable and valid, it is neither practical nor possible to cover such a wide spectrum in a single report. Due to Covid-19 pandemic, it's important to note that 2021 data should not be compared with prior years' data due to methodological differences (mode and data collection).

One of the report's key strengths is that it has, to the best of our ability, included all recent and relevant data on state, regional and local levels in relation to behavioral health topics identified. Through utilization of key informant interviews (KIIs)and focus groups, this report can offer unique perspectives from those offering direct and indirect services as well as lived experience family and friends. The epidemiological profiles present regional information in comparison to national and state data, with regional and local specific data where possible and applicable. The recommendations are consistent with past needs and community suggestions and work to build upon past findings while recognizing new and emerging trends in recovery, prevention, and treatment.

The report is limited by inconsistencies in the data sources available as well as limitations in data collection due to Covid-19. While all data presented are the most current available, they are not all from the same year. Comparisons among data sets are limited as some indicators are available only at the state level but not the regional or local. Center for Prevention Evaluation and Statistics (CPES) also advised us not to compare 2021 data due to the methodological differences. KIIs were conducted throughout 2022 and early 2023 and reflect general sentiments of the community in relation to substance use and behavioral health in the region. Youth surveys were conducted in some, but not all, towns in the region from 2019 up to 2022. Data from both KIIs, focus groups as well as youth surveys are present throughout the report in its entirety.

This report is also based on available data. There are still many statistics and figures from 2022 that are still being finalized and not published yet. Therefore, all data that was available and relevant at the time of compiling this report is included. The report will be updated as new findings come to light. As the RBHAO for SW CT, The Hub felt compelled to include all data that was relevant. However, some data is conflicting as it is sourced from different communities, sub-populations, and retrieved at different times. Additionally, this report was constructed by The Hub team members who are skilled prevention specialists with no evaluation or epidemiologist background; utilizing learned skills and strengths in data gathering, data interpretation and focus group facilitation.

PROCESS FOR DEVELOPING REPORT

There is a multi-step process in developing the report.[1]

1. Identify Regional Data Workgroup,
2. Review and update process and content for focus groups and surveys,
3. Administer provider/stakeholder surveys and implement focus groups,
4. Review and analyze data,
5. Customize epidemiological profiles by priority problem,
6. Identify strengths, services and resources, gaps, and needs,

7. Understand and utilize criteria for selecting priorities,
8. Convene the data workgroup and select priorities,
10. Prepare comprehensive reports, utilizing specified report template,
11. Submit and disseminate report. Submission deadline: April 28, 2023.

Hub staff invited members of LPCs, CACs, RSAB and Gambling Awareness Team to participate in the Regional Data Workgroup. Volunteers included a cross section of consumers, family members, and providers with experience with behavioral health topics. The Hub conducted several focus groups, attended various meetings, and distributed a Google Forms survey seeking input from diverse community members on the identified areas of concern. CPES and Hub staff compiled focus group and survey results and researched available data and produced draft epidemiological profiles on 9 required topics, which were shared with the data workgroup and CPES. The data workgroup members and CPES reviewed all profiles and provided their feedback. Hub staff incorporated the feedback and produced revised epidemiological profiles, which were shared with all parties.

In March 2023, the workgroup met to review the compiled information, share anecdotal information and feedback about the issues from their local perspectives, and participate in a consensus-building discussion to rank the priority areas in magnitude, impact, consequences, and changeability of the priority (see matrix in appendix). Staff then produced a draft summary of regional feedback (included in appendix) which was reviewed, and all feedback was incorporated in the present document.

BEHAVIORAL HEALTH IN SOUTHWESTERN CT

DESCRIPTION OF THE REGION

DMHAS' Region 1 is comprised of the fourteen towns and cities in SW CT: Bridgeport, Darien, Easton, Fairfield, Greenwich, Monroe, New Canaan, Norwalk, Stamford, Stratford, Trumbull, Weston, Wilton, and Westport. It is a region of contrasts, containing three of the largest urban areas in the state as well as many small suburbs. It includes both CT's "Gold Coast''—the wealthy coastal towns from Greenwich to Fairfield—and one of CT's poorest cities.

DEMOGRAPHICS

Since the onset of Covid-19 pandemic this region has seen an increase in change of address. Much of the impact of the pandemic made Americans question where they would live since SW CT borders the State of New York, many cities/towns saw an influx in neighbors. According to USA Facts, between 2010 and 2021, Fairfield County had the largest growth with 40,397 more residents. The largest racial or ethnic group in Connecticut was the white (non-Hispanic) group, which had a population of 2.3 million. Between 2010 and 2021, the Hispanic/Latino population had the most growth increasing by 154,711 from 482,401 in 2010 to 637,112 in 2021.[2] As of 2021 it's reported that SW CT has a total population of 713,133.[3]

SW CT's proportion of youth under 18 is 22.9% and 15.3% are of the elderly aged 65+.

- Municipalities with significant youth populations include, in descending order, Darien (32%), New Canaan (28.5%), Weston (28.2%), and Wilton (27.5%).

[2] Connecticut population by year, county, race, & more | USAFacts
[3] Southwest CT - DMHAS Regional Data Stories (ctdata.org)

- The highest proportion of the elderly aged 65+ include municipalities, in descending order, Stratford (19.7%), Easton (18.7%), Trumbull (17.7%), and Westport (16.9%).

Region 1 is predominantly White non-Hispanic. Among the 14 municipalities, Bridgeport stands out as the only place where Caucasians are a minority ethnic group, at 18%.

- The municipalities with a significant Black non-Hispanic population are Bridgeport (32.1%), Stratford (19.7%), Stamford (12.4%) and Norwalk (11.9%). Compared to the other regions, Bridgeport's Black non-Hispanic population is more than twice as high.
- Municipalities with significant Latino populations include, in descending order, Bridgeport (32.1%), Norwalk (28.9%), Stamford (27.8%), Stratford (20.1%), and Greenwich (13.1%).
- While Asians make up only 5.6% of Region 1's population overall, four municipalities in Region 1 have Asian populations greater than this average: Stamford (8.5%), Wilton (8.1%), Greenwich (7.1%), and Trumbull (6.7%).

The median household income in Region 1 varies significantly from $50,597 in Bridgeport to $250,001 in Darien. 1 out of the 14 municipalities in the region have a median household income lower than Connecticut's median ($83,572). Some of the richest municipalities include, in descending order, Westport ($236,892), New Canaan ($214,977), Wilton ($209,635), and Weston ($204,792). Towns with the lowest median household income include, as mentioned before, Bridgeport ($50,597), Stratford ($86,113), and Norwalk ($91,434).

Chronic absenteeism and disengaged youth are school based factors that are associated with substance use in youth. Chronically absent students are defined as those who miss 10% or more of the total number of days in the school year. In Region 1, Bridgeport School District had the highest chronically absent White non-Hispanic youth at 24.7% followed by Stratford School District at 23.2%. The school districts in the region with the highest chronically absent Hispanic and Latino youth are Norwalk (29.5%), Stratford (29.1%), and Bridgeport (28.8%). Black non-Hispanic youth are chronically absent most in Stamford (32.6%) and Norwalk (31.1%) school districts.

In Region 1 there are 3.4% of female youth and 6.1% of male youth who are disengaged; youth who are not enrolled in school and are not employed. The towns with the highest proportion of disengaged youth, in descending order, are Bridgeport, Stamford, Norwalk, Greenwich, Stratford, and Fairfield. The towns of Bridgeport and Stamford have the highest percentage of disengaged youth males.

ECONOMIC PROFILE, INCLUDING HOUSING AND TRAVEL

The most striking difference in the region is economic. Based on American Community Survey 2021 data, the Connecticut median household income in the past 12 months is $83,572. The same survey reported Fairfield County's median household income is $101,194.[4] According to Census, Region 1's median household income ranges from a low of $50,597 in Bridgeport to a high of $250,001 in Darien. In Connecticut, 10.1% of individuals live in poverty compared to 9.1% in Fairfield County. The percentage of individuals that live in poverty ranges from 2.1% in Wilton to 23.2% in Bridgeport. Municipalities in this region with significant percentages of individuals that live in poverty include, in descending order, Bridgeport (23.2%), Norwalk (9.7%), Stamford (9.4%), and Stratford (7.2%).[5]

[4] Connecticut Demographics - Get Current Census Data for Connecticut (connecticut-demographics.com)
[5] U.S. Census Bureau QuickFacts: Fairfield County, Connecticut; Connecticut

The Cost-of-Living Index (COLI)[6] is a way of comparing the cost of living in a particular community to the median cost of living for the U.S., which is represented by an average score of 100. In Fairfield County, the COLI is 138.6, or 38.6% higher than the U.S. This is also much higher than the state COLI of 111.8.

Housing and Transportation are particularly expensive within the region, as shown by the COLIs below. This creates critical challenges for behavioral health clients, staff, and programs:

The Housing COLI for the county is 174.3, compared with 109.2 for the state. The housing index ranges from 92.4 in Bridgeport (lower than the state and US) to **532.3** in Darien. Behavioral health agencies that are in the region's urban areas have to contend with much higher housing costs than agencies located in other cities in the state: 190.6 in Stamford and 148.4 in Monroe.

As of 2021, the Transportation COLI for the county is 129.7, compared with 112.4 for the state. It is even higher in Bridgeport at 131.6.

Transportation in the region is a special challenge. Although towns/cities are geographically close together and traversed by 3 main routes (I-95, Route 1 and the Merritt Parkway), the region has very heavy traffic. Travel time between nearby cities such as Norwalk and Stamford (10 miles apart) can often take an hour or more. Agencies recommend only scheduling meetings between 10am and 2pm to try to reduce the likelihood of commuter traffic.

One of many positives that came out of the pandemic was the suspension of bus fares statewide. Recently, the State Department of Transportation (DOT) announced, CT transit and paratransit services for passengers with disabilities will resume effective April 1, 2023. CT commuters have not paid for fares since April 1, 2022.[7] The fare-free bus program helped low-income individuals and provided people with more access to receive services.

Continuums of Care (CoCs) are mandated by the U.S. Department of Housing and Urban Development (HUD) to conduct an annual count of people who are experiencing homelessness, both sheltered and unsheltered. In January 2022, the State of Connecticut carried out its yearly Point-in-Time (PIT) Count of individuals who are homeless across the whole state. It's reported that 2,930 people were recognized as homeless in that year. According to the research, the overall rate of homelessness increased by 13% between 2021 and 2022. However, between 2021 and 2022, there was a noticeable 30% drop in chronic homelessness across the state.[8]

For the 2022-23 school year, the Connecticut Department of Education (DOE) anticipates a 25% increase in the number of homeless kids, which might be the highest number of students without stable housing since 2017. Homelessness is defined by DOE as "children and youth who lack a fixed, regular and adequate nighttime residence," which includes students who are "doubled-up" and living with friends or family, in a shelter, in a motel/hotel, or in a car, park or other unsheltered location. DOE reported that 3,979 students were reported to have experienced homelessness throughout the 2021-22 school year.[9]

[6] Cost of Living in Fairfield County, Connecticut (bestplaces.net)
[7] CT Transit bus fares to return on April 1 after yearlong suspension (stamfordadvocate.com)
[8] HIC PIT 2022 (aids-ct.org)
[9] CT students experiencing homelessness could increase, data show | Education | journalinquirer.com

REGIONAL EPIDEMIOLOGICAL PROFILES

The following pages provide an analysis of the magnitude, impact and capacity, and a brief discussion of resources that address the issue within DMHAS Region 1 of the following areas of concern for CT: alcohol, tobacco, Electronic Nicotine Delivery Systems (ENDS), vaping, juuling, prescription drugs, marijuana, heroin & fentanyl, cocaine, problem gambling, mental health such as anxiety and depression, and suicide. It includes the following cities and towns which comprise DMHAS Service Region 1: Bridgeport, Darien, Easton, Fairfield, Greenwich, Monroe, New Canaan, Norwalk, Stamford, Stratford, Trumbull, Weston, Westport, and Wilton. In the following section we discuss the findings, trends, and recommendations. (Note some possible redundancies in the information provided, as these profiles are expected to also serve as independent handouts.)

2022 Region 1 Epidemiological Profile: Alcohol

Problem Statement

Alcohol continues to be the most used substance nationally and in Connecticut. Alcohol use prevalence in CT has in fact remained higher than the nation since 2010, and CT has been among the ten states with highest prevalence most/all these years. According to the 2021 National Survey on Drug Use and Health (NSDUH), over half of respondents 12 and older (56.3%) report using alcohol in the past 30 days, making CT the fourth highest state in the US in reported prevalence of alcohol use.[1]

Magnitude (prevalence)

Overall, NSDUH shows that the prevalence of alcohol use in Connecticut among the general population has remained relatively stable; the prevalence of past 30-day alcohol use in individuals 12 and older was 59.3% in 2008-2009 and 56.2% in 2021. The prevalence of heavy episodic drinking in Connecticut has also remained stable since 2010, and it has remained consistently higher than the national average.[1]

Young adults aged 26 or older in Connecticut have the highest reported prevalence of past 30-day alcohol use (61.4%), followed closely by those age 18-25 (58.5%). Binge alcohol use is highest among adults aged 18-25 (29.3%), followed by young adults aged 26 or older (20.3%).[1]

According to the 2021 Data Haven Community Wellbeing Survey, 79% of CT residents report no alcohol use in the past 30 days. However, 14% of CT residents reported having 1-5 alcoholic drinks in the past 30 days, 3% had 6-10 drinks, and 2% had more than ten drinks. 18% of residents surveyed reported a definite increase in alcohol use in 2020. Within this group, 43% reported that use has increased in themselves and another adult, and 34% reported that use has increased in themselves alone.[2]

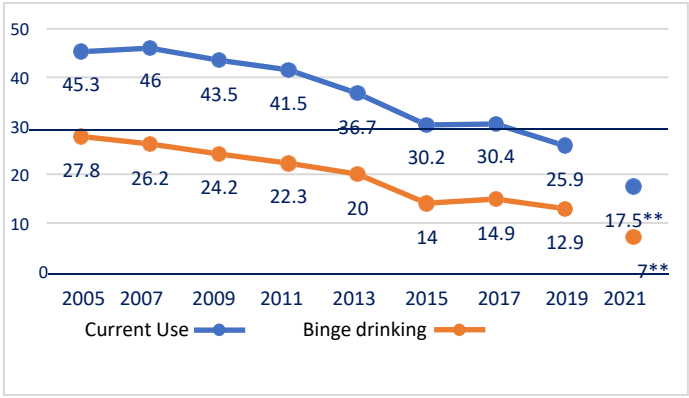
One survey in the Community Health Needs Assessment reported Trumbull residents had a higher percentage of alcohol use in the past 30 days compared to other local towns, with 21% of residents reporting having 1-5 drinks in the past 30 days. This is followed by Stratford (15%), Fairfield (14%), Bridgeport (12%), Greenwich (12%) and Monroe (0%). Most towns that reported past 30-day use, male residents had more alcoholic drinks than female residents. Greenwich was an exception, with female residents (15%) reported having more alcoholic drinks than male (8%) residents. It was also reported that in Stratford, 9% of residents had 6-10 drinks in the past 30 days and in Trumbull, 8% of residents reported 6-10 drinks in the past 30 days.[3]

Even though the NSDUH shows that alcohol use in the general population of CT has remained consistent, underage drinking in Connecticut among 12 to 17-year-olds decreased significantly, from 18.6% in 2008-2009 to 7.0% in 2021.[1]

The 2021 Connecticut School Health Survey (CSHS) also reported lower prevalence of past 30-day alcohol use in Connecticut's high school students compared to their national counterparts (18% vs 23%).[4]

The CSHS, CT's Youth Risk Behavior Survey, also shows that the reported prevalence of past month alcohol use and binge drinking among Connecticut high school students has steadily declined since 2005 (Figure 1). In the 2021 CSHS, 17.5% % of high school students reported using alcohol in the past month. Of these students, 7.0% of them reported binge drinking* in the past month. However, caution should be taken when comparing the 2021 data to that of previous years because the 2021 CSHS was collected during a different semester than in previous years (Fall vs Spring).[4]

Figure 1. **Percent of High School Students Reporting Past Month Alcohol Use and Binge Drinking*: 2005-2019**



* The definition for binge drinking was five or more drinks in a row, until 2017 when it became 5 or more for males or 4 or more for females
**Caution should be taken when comparing 2021 data to that of previous years due to differences in methodology in survey collection.

Among individuals 12 years and older, those reporting alcohol use disorder (AUD) in the past year were stable from 2016 to 2019, at about 6%. However, the 2020 NSDUH data indicates a nearly two- fold increase in reported AUD for this age group (11.4%).

[1] National Survey on Drug Use and Health (NSDUH), 2021
[2] Data Haven Community Wellbeing Survey, 2021
[3] Community Health Needs Assessment, 2022
[4] DPH, 2021 Connecticut School Health Survey (CSHS/YRBS)

2022 Region 1 Epidemiological Profile: Alcohol

A review of 2020-21 local youth surveys revealed the following:

- Between 10% and 41% of middle and high school students reported past 30-day alcohol consumption, with rates increasing by grade.
- 25% of high schoolers had used alcohol in the past month. In another local youth survey, 10% of high school students reported drinking 4 or more drinks in less than 2 hours in the past 30 days.
- One town reported that 60% of their 12th grade students had used alcohol in the past 30 days.
- In one suburban town, the alcohol use rate had increased from 3% in 2017 to 10% in 2021.
- In one suburban town, 27.61% of high school students reported binge drinking 5 or more times in the past 30 days.
- Students in a local city reported the most access to alcohol is at home (60%) or at their friends' home (57%).

Perception of Harm:

- High school students' perception of harm from alcohol ranged from 76%-88% according to local surveys. In one town, 36% of high schoolers reported usually having 3 alcoholic drinks when they drink.[5]
- One local town reported 15% of high schoolers drinking alcohol in the past 30 days. 93% of the students reported that their parents feel that alcohol use is wrong. This shows a strong correlation between youth alcohol use and parental disapproval.[5]
- Key informants in the 2022 Community Readiness Survey (CRS) for SW CT identified alcohol as the problem substance of greatest community concern for adults ages 26 and older.[6]
- According to key informant interviews, there was a higher utilization of alcohol delivery services during and after the pandemic. There have been reports of youth obtaining alcohol through these deliveries due to differences or lack in ID'ing. There has been an increase in parent/caregivers hosting parties and serving alcoholic beverages to underage youth. In some local towns, parents/caregivers are consuming alcohol on school property during youth school and athletic activities, normalizing the behavior.

Risk Factors and Subpopulations at Risk

- Young people who drink are more likely than adults to report being binge drinkers.[7]
- Misuse of alcohol at an early age can develop into later alcohol dependency.[7]
- Men are more likely than women to be heavy drinkers.[8]
- Women are more likely than men to develop alcoholic hepatitis and cirrhosis and are at increased risk for damage to the heart muscle and brain with excessive alcohol use.[9]
- Individuals with mental health disorders are about four times more likely to be heavy alcohol users.[10] One SW CT urban city found that out of students who reported feeling sad or hopeless almost every day for the past 12 months, 18.1% reported using alcohol in the past 30 days. These findings reflect the high correlation between substance misuse and mental health symptoms.[5]
- Native Americans are at especially high risk of alcohol-related traffic accidents, DUI and premature deaths associated with alcohol misuse.[11]
- While Hispanics have higher rates of abstinence from alcohol, those who do drink often have higher rates of binge drinking.[12]
- In many local youth surveys, White individuals reported higher rates of drinking than Hispanic or Black individuals.[5]
- Through key informant focus groups, a strong correlation between alcohol misuse and problem gambling was seen.
- In Southwest Connecticut (SW CT), adults, ages 18-34, were most likely to have 1-5 alcoholic drinks in the past 30 days. This is followed by individuals who are between the ages of 35-49.
- Among youth, risk factors include:
    - Academic and/or other behavioral health problems in school;
    - Alcohol-using peers;
    - Lack of parental supervision;
    - Poor parent-child communication;
    - Parental modeling of alcohol use;

[5] SW CT Local Youth Surveys

[6] Community Readiness Survey Report, 2022

[7] CDC (2022), Alcohol and Public Health

[8] CDC (2022), Excessive Alcohol Use is a Risk to Men's Health

[9] CDC (2022), Excessive Alcohol Use is a Risk to Women's Health

[10] NIDA (2014), Severe Mental Illness Tied to Higher Rates of Substance Use

- Anxiety or depression;
- Child abuse or neglect;
- Poverty;
- Social norms that encourage or tolerate underage drinking.[13]

- The 2021 CSHS also shows that high school females were more likely than males to report past month drinking (29.2% and 14.2%, respectively) and binge drinking (8.5% vs 5.6%). Non-Hispanic whites had the highest prevalence of past month drinking (22.4%) and binge drinking (10.3%). Hispanic and Black students' reported prevalence of past month (13.7% and 12.1% respectively) and binge drinking (4.0% and 3.5%, respectively) were similar between the two groups.[4]
- Young adults in CT ages 18-25 have the highest rate of reported past month alcohol use (60.5%), followed closely by those aged 26 or older (60.98%).[1]

Burden (consequences)

- Immediate adverse effects of alcohol can include: impaired judgment, reduced reaction time, slurred speech, and loss of balance and motor skills.[7]
- When consumed rapidly and in large amounts, alcohol can also result in coma and death.[7]
- Alcohol use can increase risk of death when used with other substances, i.e., prescription medication like benzodiazepines and opioids.[14]
- In CT, the number of unintentional drug overdose deaths involving alcohol increased in 2021 to 5078 deaths compared to 474 in 2020 and 404 deaths in 2019. [15]
- Excessive drinking has numerous chronic and acute health effects, including: liver cirrhosis, pancreatitis, various cancers, cardiomyopathy, stroke, high blood pressure, and psychological disorders as well as increased risks for lower respiratory infections such as tuberculosis.[16]
- Excessive drinking has been associated with increased risk of motor vehicle injuries, falls, and interpersonal violence.[7]
- Drinking during pregnancy can lead to a variety of developmental, cognitive, and behavioral problems in the child (Fetal Alcohol Spectrum Disorders).[16]
- Older adults, 65+, who drink are at increased risk of health problems associated with lower tolerance for alcohol, existence of chronic health problems and interactions with medications.[17]
- In 2021, 50.1% of adult DMHAS treatment admissions in SW CT reported alcohol use. This decreased in 2022 to 40.5%. For young adults, 40.8% of treatment admissions reported alcohol use. This increased in 2020 to 42.2%. [18]

- In SW CT during 2021 and 2022 alcohol remains the primary drug of use for adults in DMHAS treatment admissions. For young adults, alcohol was the second primary drug of use in 2021 (32%) but then became the primary drug of use in 2022 (42.2%).[18]

Percent Reporting Needing but Not Receiving Treatment at a Specialty Facility for Alcohol Use in the Past Year, ages 12+ [1]

	2021
CT	10.4

2021 Data Haven Community DataHaven Community Wellbeing Survey: Percent Reporting Past Month Binge Drinking [2]

CT	Wealthy	Suburban	Rural	Urban Periphery	Urban Core
19	20	18	19	20	17

Community Readiness Survey: Mean Stage of Readiness for Substance Misuse Prevention[6]

	CT	**Region 1**	R2	R3	R4	R5
2020	5.37	**5.14**	5.55	5.21	5.59	5.25
2022	5.31	**5.72**	5.36	4.89	5.25	5.12

[11] NIAAA (2014), Focus On: Ethnicity & the Social and Health Harms from Drinking
[12] NIAAA (2021), Alcohol and the Hispanic Community
[13] SAMHSA (2019), Risk and Protective Factors
[14] CDC (2022), Alcohol and Other Substance Use
[15] CT Department of Public Health
[16] WHO (2018), Global Status Report on Alcohol and Health
[17] NIAAA (2017), Older Adults

2022 Region 1 Epidemiological Profile: Alcohol

SW CT shows higher rates of readiness in 2022 compared to all regions and the state average.[6] This shows an increase in readiness from 2020, due to a high recognition of substance misuse problems and planning for prevention.

Prevention:

- Local Prevention Councils (LPC) and federally funded community coalitions provide education about alcohol to youth and adults, often in collaboration with groups such as Mothers Against Drunk Driving (MADD) and Students Against Destructive Decisions (SADD). These prevention and intervention efforts include awareness campaigns, retailer educations, compliance checks, social hosting law education and post-prom events; encouraging the use of Uber, Lyft, and Safe Rides to prevent driving under the influence.
- Many LPCs have supplied and encouraged local alcohol retailers to provide liquor stickers, a prevention method for underage use.
- Many local coalitions have partnered with local law enforcement to conduct compliance checks for retailers and continue to do so.
- Throughout SW CT, pediatricians, clinicians, family physicians, and counselors are trained in Screening, Brief Intervention and Referral to Treatment (SBIRT) and Adolescent SBIRT. Colleges, hospitals, and social services agencies also use an integrated Mental Wellness Screening tool for "check-up from the neck up" screenings during Wellness Month and beyond.
- Older adults and others at risk are educated about the dangers of mixing alcohol and medications through the state's Change the Script campaign.
- Due to Covid-19 several LPCs came together and created the Let's #mentionprevention campaign which is a campaign to assist retailers and guardians to keep alcohol out of the hands of minors.

Treatment:

- Treatment for alcohol and other addiction disorders is available through local provider agencies andhospitals, including specialized programs such as Mountainside Treatment Center, the Addiction Recovery Center at Greenwich Hospital, and Silver Hill Hospital.

Recovery: There are several sober homes in the region. There are many 12-step meetings (AA, AlAnon) including some in Spanish, for teens, and for medical practitioners. There are also a variety of support options such as the CT Community for Addiction Recovery (CCAR) in Bridgeport, which offers a free weekly Telephone Recovery Support program; LifeRing; SMART Recovery; LIFTT Confidential; Refuge Recovery; and Women for Sobriety. There are a wide array of free support groups available to SW CT.

[18] CT DMHAS Treatment Admissions

2022 Region 1 Epidemiological Profile: Cannabis

Problem Statement

Cannabis is a term widely used to encompass all products derived from the cannabis sativa plant. Cannabinoids refer to the group of substances found in the cannabis plant, including tetrahydrocannabinol (THC) and cannabidiol (CBD). Marijuana refers to parts of or some products from the cannabis sativa plant and often contains substantial levels of THC, the major psychoactive component recognized in cannabis.[1]

Federally, cannabis is still illegal. However, the Connecticut Legislature legalized cannabis use on July 1st, 2021. As a result, individuals 21 years of age or older can now possess and consume up to 1.5 ounces of cannabis. Retail sales began on January 10th, 2023. As of February 2023, there are 18 medical marijuana dispensaries and 10 retail cannabis stores throughout Connecticut (CT).[2]

Marijuana concentrates are popular and can have extremely high levels of THC, ranging anywhere from 40% - 80%[1] or higher. These forms of cannabis can be many times stronger in THC potency than plant forms or edibles. THC may also refer to the delta-9 isomer or the delta-8. There are a wide array of cannabis and THC products on the marketplace, including vapes, hemp, distillates, tinctures, gummies, infused food and beverages and more.[3] Today's THC potency in cannabis products has increased in the most recent years and is significantly stronger and more addictive than cannabis products from decades ago.[4]

Cannabis is the most commonly used federally illegal substance in the nation, and especially with states with legal regulated use, overall use is going up. With this, the perception of how harmful cannabis can be is declining. Additionally, approximately 1 in 10 people who use cannabis will become addicted. If an individual were to use cannabis before the age of 18, the rate of cannabis dependency addiction rises to 1 in 6. These rates can only be expected to rise with the increased use of illegal and legal use of cannabis.[5]

According to the 2021 National Survey on Drug Use and Health, the percentage of people who used marijuana in the past month was highest in young adults, ages 18-25 (24.1%) followed by those aged 26 and older (12.2%) and adolescents (5.8%). In CT, past 30-day marijuana use for the state population, individuals over the age of 12 (13.5%), was slightly higher than the national percentage (13%). In young adults, ages 18-25 (22.9%), use was lower than the national percentage (24.1%). Similarly, in adolescents, ages 12-17 (4.7%), use was lower than the national percentage (5.8%).[6]

[1] National Institutes of Health (NIH), 2021
[2] Connecticut State Department of Consumer Protection, 2023
[3] Center for Disease Control and Prevention (CDC)
[4] Substance Abuse and Mental Health Services Administration (SAMHSA)
[5] Substance Abuse and Mental Health Services Administration (SAMHSA) - https://www.samhsa.gov/marijuana
[6] National Survey on Drug Use and Health (NSDUH), 2019, 2021

Magnitude (prevalence)

As of February 12, 2023, CT has 48,818 registered patients for medical marijuana. There are 11,651 patients registered in Fairfield County. These numbers have decreased since 2021. As of February 2023, there are 3 medical marijuana dispensaries in SW CT, 2 in Stamford and 1 in Westport; and 3 retail cannabis stores, and 2 in Stamford.[2] In environmental scans of smoke shops in SW CT, conducted by Local Prevention Councils, many vape shops, gas stations and in one case, a wellness studio, were selling THC products. In some cases, these retail establishments did not realize they were breaking the law. Most of these locations sold THC products to minors.

Since 2019, the overall number of unintentional drug overdose deaths with the presence of cannabis in CT has increased. In 2019, there were 304 overdose fatalities with cannabis present, 412 in 2020 and 428 in 2021.[7]

Cannabis use in 2021 reported by young adults, ages 19 – 30, has increased significantly compared to previous years. For young adults, 43% report past-year cannabis use and 29% report past-month use. Daily use has also increased in young adults to 11%. According to the National Institute of Health (NIH), these are the highest levels of cannabis use since trends were first monitored in 1988.[1] In 2021, 5.8% (16.3 million) of people 12 years and older had a cannabis use disorder in the past year.[8]

The 2020 Monitoring the Future survey assessed cannabis use among college students across the United States and found use to be at a 35 year high among college aged adults, while remaining constant among young adults not in college.[8] Data from the 2022 Monitoring the Future survey of middle and high school students showed a decline in youth cannabis use from 2019 to 2022, which could be largely attributed to the COVID-19 restriction where youth don't have access to their usual sources to get cannabis.[9]

Nationwide, the prevalence of adolescent cannabis use decreased during and immediately after the COVID-19 pandemic from 2020- 2021 compared to pre-pandemic years. This is likely due to the inability of adolescents to access substances from others or to become socially influenced to use as well as the decreased likelihood to use substances outside of parental supervision. However, in recent studies, the use of cannabis in youth are beginning to return to pre-pandemic levels and are expected to continue to rise.[8]

In the summer of 2020, in the midst of COVID-19, Monitoring

[7] Department of Public Health (DPH)
[8] National Institute on Drug Abuse (NIDA)
[9] Gali, K, et al. (2021).

the Future conducted a survey of 12th grade students across the United States. Data indicated a 46-year record high drop in students' perceptions of cannabis availability. Despite this significant change in perception, data did not show a significant decline in past 30-day cannabis use among 12th graders, suggesting that perceived inaccessibility did not reduce use.[8]

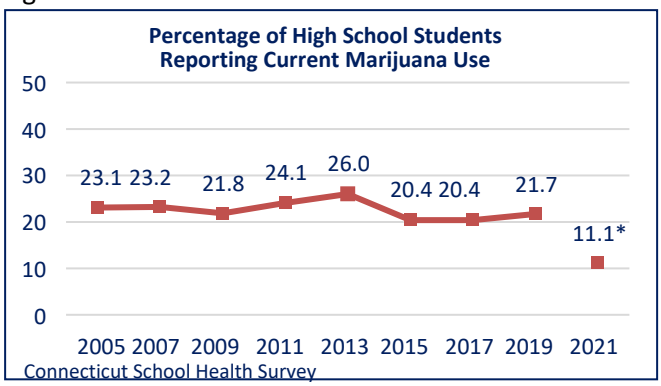
According to one study, the percentage of youth who reported lifetime and past year marijuana use remained the same or edged slightly upward in 2021, and prevalence in 2022 remained closer to 2021 than 2020 levels. Reported prevalence of lifetime marijuana use in 2022 was 11% among 8th grade students, 24% among 10th graders, and 38% among 12th grade students.[4] The reported cannabis use in the past year was 8.3% among 8th grade students, 19.5% among 10th graders, and 30.7% among 12th grade students.[6]

Cannabis use is widespread among young adults and adolescents in CT. The 2021 NSDUH showed that, for 18 to 25 year-olds, past year cannabis use was higher than the national average (36% in CT vs. 35.4% nationally).[6] Among youth ages 12-17 in Connecticut, 10.1% had used within the past year, and 4.7% had used within the past month.[10] Among CT adults aged 26 and older, reported past year use (18.5%) and past month (13%) marijuana use were both higher than the US.

Compared to their national peers, CT youth, young adults, and adults all report a lower perception of great risk from smoking cannabis once a month than their national peers.[6] Perception of risk has generally been decreasing among all age groups, and was lowest among CT's 18-25 year-old young adults in 2021 (12.2%), followed by adults age 26 and older (18.2%) and 12-17 year-old youth (21.9%).[6] The legalization of medical cannabis in CT and its neighboring states, as well as the decriminalization of low-level possession of cannabis in CT may contribute to the lessened perception of risk seen in the survey results. A study in California, which was conducted post-legalization of cannabis, indicated an increase in self-reported cannabis use and lessened perceptions of negative health impacts due to cannabis consumption.[9]

Moreover, the 2021 Connecticut School Health Survey (CSHS) shows that about 11.1% % of Connecticut high school students report currently using cannabis.[11] Overall, the percentage of CT high school students reporting current use has remained relatively stable since 2005 (Figure1). Current use nationally also appears to be relatively stable.[12] However, caution should be taken when comparing the 2021 data to that of previous years because the 2021 CSHS was collected using during a different semester than in previous years.

Figure 1.



**Caution should be taken when comparing CSHS 2021 data to that of previous years due to differences in methodology in survey collection.*

Vaping

As the use of e-cigarettes and other electronic vaping devices has increased, the use of THC oil in vaping devices has also increased. THC oil is more potent, with the average extract containing 50-80% THC.[8]

Analyses of 2022 Monitoring the Future data showed that adolescent cannabis vaping has relatively held steady from 2019 to 2020, and a small increase in reported use among 10th graders, though reported use among 10th graders in 2022 is still significantly below pre- pandemic levels.[9]

SW CT has seen an increased level of marijuana usage among younger individuals. Rates of usage among those 12 and older are higher when compared to previous findings. Cannabis concentrates are also widely used by youth and young adults who vape them.[6]

According to local youth surveys within SW CT in 2021:[13]

- In some towns, youth as early as 8th grade are trying marijuana.
- In some towns, marijuana use in the past 30 days in high school students has increased compared to previous years, especially in 11th and 12th grade students.
- In some towns, students in 12th grade are most likely to use marijuana and report higher rates of use in the past 30 days than previous years.
- In some towns, marijuana use rates increase, and perception of risk decreases with increasing grade level.
- In some towns, more than half of 11th and 12th graders believe that it is safe to use marijuana once or twice a week.
- There is a low perception of risk of marijuana use, low perception of peer disapproval and low perception of parent disapproval, compared to alcohol, tobacco, and other drugs (ATOD).

[10] CT.gov

[11] Connecticut School Health Survey (CSHS), 2021

[12] SAMHSA, CAPT Northeast Regional Marijuana Webinar Series: Strategies/Interventions for Reducing Marijuana Use

[13] Local Youth Survey Data, 2021

- Marijuana is the 2nd most likely use substance in high school students, the first being alcohol.
- Youth who are using marijuana are more likely to use in the homes of other people or public places.
- Many youth believe that marijuana is an easy substance to obtain.

In one suburban town, more youth were using marijuana than vaping products. In one urban town, nearly half of youth who reported that they vape, were vaping THC.

Based on data from The Hub's focus groups, key informants in SW CT report extremely low perception of harm from cannabis among youth, low perception of peer and parent disapproval, and that the majority of those who vape, are vaping cannabis--which means ingesting extremely high potency THC. There are serious concerns about young people obtaining cannabis in illegal ways, especially through social media. High potency THC is causing youth to have panic attacks or become hospitalized. There are more children mistaking cannabis edibles for candy or snacks and getting sick. Many advocates are concerned about the many gaps in the state's cannabis law, including the late onset of prevention funding, lack of monitoring of cannabis advertisements, exemptions to the caps on THC potency for products popular with youth and lack of consequences for underage possession or illegal sales to underage youth.[14]

According to a community survey in one urban city, adults reported increasing their use of marijuana in 2021 for the purpose of getting high or to feel good. Within this town, 16% of residents believe that marijuana is a normal part of growing up and 25% believe it is okay to use.[13]

Risk Factors and Subpopulations at Risk

Risk factors include:

- Availability of cannabis;
- Early initiation;
- Frequency of usage;
- Family history of cannabis use;
- Favorable parental attitudes towards cannabis;
- Potency levels;
- Low academic achievement and low bonding to school environment;
- Peers who use cannabis and low peer disapproval of cannabis use;
- Low perception of harm/risk;
- Prior use of alcohol/tobacco;
- Sensation seeking behavior/impulsivity;
- Anxiety, depression, PTSD or other mental health issues;
- Childhood abuse/trauma;[4]
- Individuals with schizophrenia (whose symptoms worsen with cannabis consumption);
- Several studies have linked cannabis use to increased risk for psychiatric disorders and substance use disorders. The amount used, age at first use, and genetic vulnerability are thought to influence this relationship;[8]
- Individuals with active suicide ideation are at an increased risk of a suicide attempt with cannabis use.[1] LGBTQ+ students were more likely than their peers to engage in risky behaviors including cannabis use.[11]
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According to the 2021 Community Wellbeing Survey, past 30-day cannabis use was more widely reported among male adults ages 18- 34, Hispanic population, those with some college education, and those with higher income.[1] There was little difference in past 30 day use by community type.[15]

Similarly, use of cannabis was more often reported by males, adults ages 18-34, White and Hispanic respondents, high school students, and those with higher income. Rural communities had slightly lower reported recreational cannabis use than the other community types.[8]

The 2021 CSHS shows higher past 30-day marijuana use among girls (14.1%) compared to boys (8.2%).[11] Reported past 30 day use increases by grade from 4.7% of 9th graders to 16.0% of 12th graders. More Black students reported current use (14.7%) than White students (9.9%) and Hispanic students (13.9%).

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[14] The Hub Stakeholder Focus Group, 2022

[15] DataHaven (2021) Community Wellbeing Survey

Burden (consequences)

Short-term consequences include:[11] decreased memory and concentration; impaired attention and judgement; impaired coordination and balance; increased heart rate; and anxiety, paranoia, and sometimes psychosis

Long-term consequences include: impaired learning and coordination; sleep problems; potential for dependence to cannabis, as well as other substance and alcohol use disorders; potential loss of IQ points (particularly in those who used heavily during adolescence which can lead to an IQ drop of up to 8 points)[10]; decreased immunity; and increased risk of bronchitis and chronic cough. Youth who are heavy users are 3 times more likely to become dependent on heroin.[11]

Cannabis use during pregnancy also increases the risk of child development problems including low birth weight, and brain development. Additionally, children exposed to cannabis in-utero have increased risk for problems with attention span and problem solving.[8]

In SW CT, 42.9% (2,049) of all FY 2021 treatment admissions reported marijuana use and 14.1% (672) reported marijuana as the primary drug of use. In all young adult (18 – 25 years old) admissions, 79.4% (377) reported marijuana use and 40.8% (194) reported marijuana as the primary drug of use. In 2022, treatment admissions involving marijuana use has decreased to 30.9% (829) in adult cases and 67.7% (151) in young adult cases. Marijuana reported as the primary drug of use has also decreased for all.[16]

Typically, traffic accidents, emergency room visits, and fatalities increase in states that legalize retail cannabis;[17] and because THC use impairs motor coordination and reaction time, many studies have shown a relationship between blood THC concentration and impaired driving.[8]

In CT, hospital admissions for cannabis intoxication in adults and young adults have increased.[3] Emergency room visits for cannabis-induced psychosis, cannabis overdose and overdose in children who consume cannabis edibles that look like candy are rising.[17]

In 2021, there was an increase in calls to CT Poison Control about small children ingesting marijuana edibles. Overall, there were a total of 3,125 cases involving marijuana.[18] There has been one confirmed case in which a supply of marijuana was laced with fentanyl, leading to an overdose. It was deemed likely to have been an unintentional cross-contamination of substances and is an isolated incident.[19]

According to the 2022 Community Readiness Survey (CRS), marijuana/cannabis was ranked as the greatest substance of concern for individuals between the ages of 12-25.[20]

Recent studies have also shown a strong correlation between usage of marijuana and opioids. Marijuana use, even among adults with moderate to severe pain, was associated with a substantially increased risk of non-medical prescription opioid use in conjunction with cannabis.[21]

A recent national outbreak of e-cigarette, or vaping product use- associated lung injury (EVALI) was linked to vaping THC, possibly due to the presence of Vitamin E acetate which is used as a diluent in THC-containing products.[22]

According to The Hub's key informant focus groups, some local tobacco retailers have been repeatedly cited for out of compliance sales of vapes and cannabis products to minors. Additionally, there is a need for more cannabis cessation programs, especially for youth.[14]

Capacity and Service System Strengths

Community Readiness Survey (CRS): Mean Stage of Readiness for Substance Misuse Prevention[20]

	CT	Region 1	Region 2	Region 3	Region 4	Region 5
2020	5.37	5.14	5.55	5.21	5.59	5.25
2022	5.31	5.72	5.36	4.89	5.25	5.12

According to the 2022 CRS, there is a statewide decrease of readiness for substance misuse prevention from 2020 to 2022 but an increase of readiness in SW CT. SW CT had the highest perceived substance use/misuse prevention readiness (5.72) of any region, and higher than the state as a whole (5.31). This indicates that SW CT has increased in the ability to be open to prevention education and strategies.[20]

Since legislation decriminalizing cannabis and approving it for health- related purposes has reduced the perception of harm, many Local Prevention Councils (LPCs) and federally funded coalitions continue to focus on cannabis prevention, especially

[16] Department of Mental Health and Addictions Services (DMHAS) Treatment Admissions, 2022
[17] Connecticut Drug Enforcement Administration (DEA)
[18] Connecticut Poison Control Center, 2021
[19] Connecticut Overdose Response Strategy, 2022
[20] Community Readiness Survey (CRS), 2022
[21] Smart Approaches to Marijuana (SAM)
[22] Center for Disease Control and Prevention (CDC), Outbreak of Lung Injury Associated with the use of E-Cigarette, or Vaping, Products, 2020

for youth, in their towns. LPCs have made efforts to raise awareness about the risks to young people. However, lack of funding and the state's direction to focus prevention efforts on vaping means that only communities with federal funding through the Drug-free Communities grant have been able to focus on cannabis prevention.

Coalitions have addressed the perception of low-risk use of marijuana by utilizing prevention strategies including education to community members and stakeholders, dissemination of information, increased awareness of campaigns and utilizing local subcommittees in providing common prevention language, creating social media and blog posts, and engaging with parents/professionals about the signs and symptoms of cannabis use. Many groups have also collaborated with local law enforcement for different initiatives, including environmental scans, and partnered with schools to provide resources, education and support for policies related to cannabis use and other substances.

Some education and awareness campaigns used within the region, are You Think You Know (YTYK), DrugfreeCT.org, and **BeIntheKnow**, a new DMHAS state campaign that includes resources, education, common prevention templates, and more. There is also the CT Government's Cannabis Awareness and Education Program. In Norwalk and Westport, many teens were trained as Johnny's Ambassadors to become cannabis education for their fellow peers. Many towns partnering or planning to partner with their local law enforcement for cannabis compliance checks.

In terms of advocacy, local coalition members have collaborated with statewide advocates, including CT SAM to raise awareness of the effects of cannabis use, especially in youth, for the community and policymakers. Within the region, many legislative events were dedicated to discussing cannabis. The efforts included funding for prevention, treatment and recovery not only for marijuana but for the mental health impacts. However, even with the region's prevention strategies and advocacy efforts there still is not enough community readiness or capacity to support the efforts of marijuana prevention needed in our area. According to the cannabis law, 25% of sales tax based on THC potency levels will be allocated to the Cannabis Prevention and Recovery Services Fund. However, these funds will not start until FYs 24-26. These funds are not yet detailed in how dollars will be allocated. There is currently no line item for Local Prevention Councils or law enforcement.

There are numerous behavioral health resources available within and to SW CT including CT SAM (Smart Approaches to Marijuana), a national organization providing resources and education, that many coalitions collaboratively work with to share data and science to their municipalities.

For individuals and family members seeking support to recover from cannabis dependence, there are options such as CCAR, SMART Recovery and SMART Family & Friends programs, and treatment facilities. However, there is a lack of cannabis-focused cessation programs. See the Resources & Strengths portion of this Priority Report for more.

2022 Region 1 Epidemiological Profile: Cocaine

Problem Statement

Cocaine is a powerful and addictive nervous system stimulant that comes in several forms including powder, crack, or freebase. In the United States, cocaine is a Schedule II drug, meaning that it has a high potential for abuse and dependence, but there is some acceptable medical use.

Cocaine binds to dopamine transporters, leading to an accumulation of dopamine, causing a euphoric feeling. Cocaine is primarily used intranasally, intravenously, orally, or by inhalation, and is often used with other licit and illicit substances. Cocaine may be intentionally combined with fentanyl and/or heroin and injected ("speedball"). Alternately, an individual may purchase cocaine that has fentanyl and/or heroin added without their knowledge, with increased risk of overdose, especially among non-opioid tolerant individuals. Some individuals use cocaine concurrently with alcohol, resulting in the production of cocaethylene, which tends to have a longer duration of action and more intense feelings than cocaine alone. The formation of cocaethylene is of particular concern because it may potentiate the cardiotoxic effects of cocaine or alcohol.

Nationwide, 4.8 million individuals aged 12 and older reported engaging in cocaine use in 2021. Use was the highest (3.3%) among ages 18 to 25.[1] The COVID pandemic placed individuals across the lifespan at higher risk for engaging in substance use. Nationally, about one third of people who misused central nervous system stimulants in the past year used only cocaine. However, national perception of harm in relation to cocaine remains low and therefore can be said to contribute to the growing number of people who use and misuse this substance.

According to 2021 Connecticut School Health Survey (CSHS) data, 1.2% of Connecticut (CT) students reported using some form of cocaine in their lifetime. This is consistent with a decreasing trend since 2007, when the prevalence was 8.3%.[2]

Magnitude (prevalence)

Across the state of CT from 2015-2021, cocaine was the 6th most common substance and 4.4% of those fatalities had cocaine in the bloodstream at the time of their death.[3] CT continues to see a steady rise in use. In 2015, there were 105 accidental drug intoxication deaths compared to 2021, 656 deaths. Two deaths in 2015 were a combination of fentanyl and cocaine whereas 561 deaths in 2021 involved the same combination.[3] While these findings are consistent with the overall increase in the number of overdose fatalities in CT, it is important to understand the prevalence and potency of cocaine when illicitly mixed with other substances such as fentanyl.

In Southwest (SW) CT from 2015 to 2022 (as of 1/17/23) 450 overdoses involved cocaine.[3] While 2022 deaths are being finalized by the office of the Chief Medical Examiner, it is important to note that thus far, 2022 data is reflecting an increase in the number of cocaine involved overdose fatalities. In 2021, there were 70 cocaine involved overdose deaths whereas 2022 data thus far reflects 91 cocaine involved overdose deaths.[3]

The most common stimulant involved in overdose deaths in 2021 was cocaine (39.7%) statewide. Across the state, opioids and stimulants, in combination or alone, were responsible for 78.2% of fatal overdoses. 25.5% of those were a lethal combination of cocaine and fentanyl. Another 4.5% of fatal overdoses were cocaine with *no* other stimulants or opioids.[3]

The 2022 Community Readiness Survey revealed that within SW CT, cocaine was not identified by key informants as a top substance of community concern for any age group.[4]

[1]NSDUH 2021
[2]CT School Health Survey 2021
[3]CT OCME Report Statistics 2015-2022
[4]2022 CRS

2022 Region 1 Epidemiological Profile: Cocaine

Risk Factors and Subpopulations at Risk

Risk factors include:

- Family history of substance use (youth and adults)[5],
- Lack of parental supervision (youth)5,
- Substance-using peers (youth and adults)[5],
- Lack of school connectedness and low academic achievement (youth)[5],
- Low perception of harm (youth, adults)[5],
- Perception of cocaine risk is high state-wide and throughout all regions. All regions follow with similar high percentages of risk[5],
- Childhood trauma (youth and adults)[5],
- Young adults ages 18 to 25 have a higher rate of current use than any other age group,[1]
- Men are more likely to use cocaine than women[5],
- Those with current or previous misuse of other illicit substances, such as marijuana and heroin/fentanyl[5],
- Individuals with mental health challenges.[5]
- 12.6% of suicides in the state of CT from 2015-2021 involved cocaine reflecting a high correlation between substance use and suicide.[3]
- The presence of cocaine in an individual who had a positive drug result for cocaine at the time of a homicide across CT increased from 10.1% (2015-2019) to 15.1% (2020-2021).[3]

In 2021, cocaine use in the past year among people aged 12 or older did not differ among racial or ethnic groups. According to data from the 2021 CT School Health Survey, boys reported higher rates of use (1.7%) than girls (0.6%). The prevalence of lifetime cocaine use was highest among 9th and 11th graders (1.5% each).[2] Hispanic students reported higher rates (1.4%) than Black (0.4%) or White (1.2%) students.[2] Within SW CT, local youth surveys do not ask specific questions about cocaine.

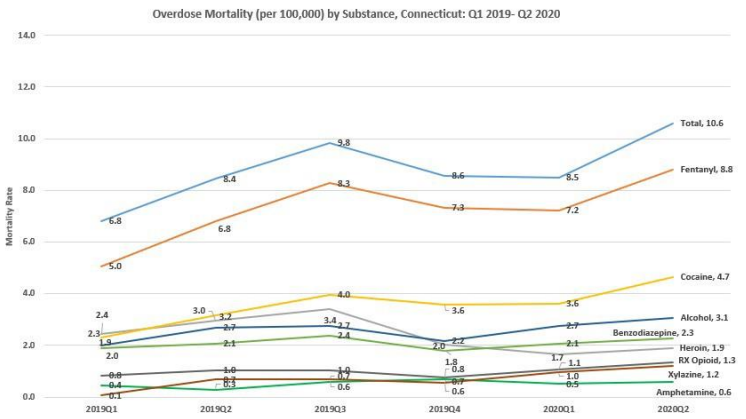
According to The Hub's key informant focus group, community members and providers in the region indicate an increase in cocaine usage in the past several years. A treatment provider and local Community Care Team outreach worker who participated in this focus group both disclosed that they have seen an increase in cocaine use amongst adults.

Burden (consequences)

Physical short-term consequences of cocaine use include

- Increased heart rate and blood pressure,
- Restlessness, irritability, and anxiety,
- Tremors and vertigo,
- Hypersensitivity to sight, sound, and touch,
- Large amounts can result in bizarre, unpredictable, and violent behavior.

Region 1 Overdose Mortality (per 100,000), Q1 2019- Q2 2020



[5]National Institute on Drug abuse (NIDA)
[6]CT DMHAS Treatment Admissions

2022 Region 1 Epidemiological Profile: Cocaine

Long-term physical consequences of cocaine use include:

- Sensitization, where less cocaine is needed to produce anxiety, convulsions, or other toxic effects (increasing risk of overdose),
- Loss of appetite leading to malnourishment,
- Increased risk of stroke and inflammation of the heart muscle,
- Movement disorders such as Parkinson's disease,
- Impairment of cognitive function,
- Cocaine users are also at risk for contracting blood-borne diseases such as HIV and hepatitis C via needle sharing and other risky behavior,[3]
- Users are at risk of accidental overdose, especially in the presence of alcohol or other drugs[3]
- In 2022, there were 26,710 total treatment admission for cocaine. Region One made up for only 11.5% of these cases (see chart below).

6

Treatment Admissions: Primary Drug – Crack, Cocaine [10]

	CT	Region 1	Region 2	Region 3	Region 4	Region 5
FY2020	4,646	536	1,431	793	939	947
FY2021	4,432	573	1,086	574	1,461	738
FY2022	1,137	127	354	176	288	192

- In FY 21, there were 2187 cases in which cocaine was identified as the primary drug of choice at the time of admission.[6]
- In 2021, overdose deaths involving cocaine increased to 70 in SW CT,[3]
- In 2021, OCME reported 579 overdose deaths involving cocaine across the state of Connecticut.[3]

Data reflect that the likelihood of an individual overdosing from cocaine alone is rare; the rate of overdoses which involve cocaine and fentanyl is becoming increasingly responsible for fatalities. Additionally, upward trends in cocaine usage may also lead to increased overall overdose rates due to the illicit and potent combinations of cocaine and fentanyl. [3]

Per the accidental drug intoxication death report by the OCME, Connecticut has seen an increase in the number of cocaine-involved overdoses since 2015.[3] Additional to the upward trends of cocaine use, individuals are also accessing poly-substances, a mix of drugs such as cocaine with fentanyl. Also, some fentanyl users may utilize cocaine to balance effects as needed.

Capacity and Service System Strengths

Community Readiness Survey: Mean Stage of Readiness for Substance Misuse Prevention

	CT	Region 1	Region 2	Region 3	Region 4	Region 5
2020	5.37	5.14	5.55	5.21	5.59	5.25
2022	5.31	5.72	5.36	4.89	5.25	5.12

According to the 2022 Community Readiness Survey within SW CT, key informants reported increased community readiness for substance misuse prevention (5.72 on a 9 point readiness scale) compared to 2020 (5.14), which would include prevention of cocaine use. In 2022 Region 1 had higher perceived readiness than any other region, and the state (5.31).[4]

Although region 1 has seen a decrease in the perception of harm in regard to cocaine consumption, in SW CT there are over 30 public and nonprofit addiction treatment facilities, private substance use treatment facilities (Mountainside, Clearpoint, Newport Academy, TurnBridge), and specialty hospital programs such as the Addiction Recovery Program at Greenwich Hospital and Silver Hill Hospital, which specializes in behavioral health treatment. Treatment options include inpatient, outpatient, and Intensive Outpatient (IOP) programs. Several programs are catered to address the specific needs of women, men and young adults.

Most provider agencies provide support to clients with co-occurring mental health and substance use disorders. Specialized treatment supports include the Families in Recovery Program (Norwalk), separate IOPs for women and men, and programs in Spanish particularly at CASA in Bridgeport. Child and Family Guidance of Greater Bridgeport runs a teen substance use program in Bridgeport and Norwalk.

2022 Region 1 Epidemiological Profile: Cocaine

Education about cocaine is provided in school health classes as part of information about illicit drugs, often taught by the School Resource Officers. Presentations on illicit drugs and emerging drug trends are available through The Hub and other partners. While the number of overdoses involving cocaine has steadily increased, there have been numerous efforts to increase awareness and availability of harm reduction measures such a Naloxone Nasal Spray and Fentanyl Testing Strips.

2022 Region 1 Epidemiological Profile: Heroin & Other Illicit Opioids

Problem Statement

In Connecticut (CT), the use of heroin often involves the use of fentanyl, either intentionally or unknowingly. We continue to see a rise in the use of fentanyl. This profile will attempt to, where appropriate, describe the concurrent and overlapping use of fentanyl and heroin.

Less than one percent (0.3%) of CT residents 18 or older have used heroin in the past year, a rate slightly lower than the national average (0.4%). The highest prevalence is among young adults aged 26 or older (0.3%), followed by adults 18-25 years old(0.2%). Adolescents did not report any heroin use for this time period.[1]

According to the 2021 Connecticut School Health Survey (CSHS) (CT's Youth Risk Behavior Surveillance survey), an estimated 0.6% of high school students in Connecticut reported to have used heroin.[1]

Since 2017, fentanyl-related deaths have progressively outnumbered heroin-involved deaths in CT, while the number of drug-related deaths continues to rise (11% increase from 2020-21, 28% increase since 2019). Of deaths involving heroin, 93% also involved fentanyl.[2] With 9 out of 10 heroin-involved deaths including fentanyl, and just over 1 in 10 (12%) fentanyl-involved deaths including heroin[3], most of the heroin consumed in CT contains fentanyl. This puts all individuals who use heroin at risk of fentanyl exposure.[3]

According to the Drug Abuse Warning Network (DAWN), in 2021, fentanyl was responsible for 62.62% of all drug- related emergency department visits in CT; most of these visits from individuals between the ages of 26-44. Heroin was responsible for 57.33% of all drug-related emergency department visits in CT; most of these visits were from individuals between the ages of 26-44. Most of these individuals were mostly Non-Hispanic White males.[4]

According to the 2021 National Survey on Drug Use and Health (NSDUH), among people aged 12 or older in 2021, 2.9% misused opioids (heroin or prescription pain relievers) in the past year.[1]

While the number of overdose deaths in CT involving heroin has declined since 2016, these numbers are misleading due to the associated rise of fentanyl. The increasing number of opioid deaths in CT involving fentanyl and/or heroin relate to the intertwined nature of heroin and fentanyl in the illicit opioid supply. Across New England, fentanyl availability is high, and may be available either mixed with white powder heroin or alone and may be sold in powder form as heroin or as fentanyl.[5] Fentanyl is often sold under the same or similar "brand" names as heroin, creating confusion and uncertainty among buyers.

The COVID-19 pandemic had a significant impact on individuals' use of and access to substances. Some factors to consider include a combination of stressors and isolation. At the height of the pandemic, barriers were present in Naloxone access. People living with a substance use disorder may also be more vulnerable to health complications related to COVID-19 because of compromised respiratory and pulmonary health. For individuals who are in recovery, the pandemic may have presented many mental health challenges, including isolation, that may have led to individuals relapsing in their recovery or even experiencing or dying from an overdose.[6]

Magnitude (prevalence)

The opioid epidemic does not discriminate and affects all individuals. Overdose deaths are now common across all genders, races, and ethnicities. Opioid overdose deaths more commonly involve illicit drug use and have increased with the presence of fentanyl in such supplies. However, there is a statistically significant decrease in overdose deaths involving heroin in CT from 2019-2020. Decreases in heroin overdoses have corresponded with increases in fentanyl overdoses. Fentanyl almost entirely

[1] Connecticut School Health Survey (CSHS), 2021
[2] Connecticut Office of Chief Medical Examiner (OCME), 2021
[3] Center for Disease Control (CDC)
[4] Drug Abuse Warning Network (DAWN), 2021
[5] DataHaven, 2020
[6] National Institute of Health (NIH), 2022

supplanted heroin in CT's illicit drug supply. This continues into 2022.[6]

The number of individuals diagnosed with Heroin Use Disorder has decreased since 2015. The overall rate of use has declined. This includes individuals between the ages of 18-25 who are most likely to use heroin in CT.[1]

NSDUH Substate Estimates:
Percent Reporting Past Year Heroin Use, ages 12+[1]

	CT	Region 1	Region 2	Region 3	Region 4	Region 5
2016-2018	.60	.47	.59	.64	.67	.61

According to Office of the Chief Medical Examiner (OCME), there were 1,524 accidental intoxication deaths in CT in 2021. Of these deaths, 1,312 involved fentanyl and 165 involved heroin. Compared to 2020, the number of fentanyl involved deaths (1,159) has increased and the number of heroin involved deaths (262) has decreased.[3] From 2019 to 2021, there has been a 4% increase in fentanyl involved drug overdose deaths and a 19% decrease in heroin involved overdose deaths.[7]

According to Department of Public Health (DPH), Southwestern CT (SW CT) experienced 150 drug overdose deaths in 2021: an increase since 2020 with 136 deaths. In 2022, there were at least 82 deaths from January to September.[8]

The towns with the largest numbers of overdose deaths in 2021 are as follows: Bridgeport (89), Stamford (23), Norwalk (19) and Fairfield (9). More than half of these overdose deaths happened at a residence.[8]

In 2021, 26 people died in SW CT from a heroin overdose alone. This is a large decrease from the 55 reported in 2020. Bridgeport had the highest in SW CT with 10 deaths reported in 2021 compared to Norwalk's 4 and Stamford's 4.[8]

In SW CT, individuals between the ages of 45 to 64 saw a total of 31 heroin overdose deaths in 2020. In 2021, this number dropped to 14 deaths in this age range. There was a similar drop in heroin overdose deaths for 55-year-olds (7 deaths in 2021) and 35-year-olds (5 deaths in 2021).[8] These numbers indicate that state-wide, young adults are most at risk for a heroin overdose but in SW CT, older adults are most at risk instead.

According to DPH, there is a new and emerging trend in polysubstance use. The presence of xylazine, an animal tranquilizer, in fentanyl-involved deaths was first seen in 2019 and has risen steadily since then. [8]

According to key informant focus groups conducted by The Hub, fentanyl continues to be a serious concern.

Oftentimes, individuals are accessing poly-substances, a mix of drugs (cannabis, alcohol, cocaine, xylazine, etc.) including fentanyl. Therefore, many individuals are under the impression that they are obtaining a specific drug, not realizing that their drugs are typically a mix of dangerous substances.[8]

In SW CT, 49.8% of Department of Mental Health and Addiction Services (DMHAS) treatment admissions were for Substance Abuse care. In 2021, 38.3% of reported drugs used in DMHAS treatment cases were for Heroin & Non-Rx Methadone. This number is higher than other DMHAS regions in CT and has increased in 2022 to 48.1%. These numbers are similar for young adults (18-25) admitted to DMHAS treatment.[9]

According to The Hub's key informant focus groups, individuals who are either seeking treatment for substance use disorder or are currently in recovery from substance use disorder are rarely engaging in heroin alone. If someone is using heroin, it is typically with a mix of other substances, including fentanyl. On the other hand, fentanyl is everywhere, and it is increasing. More individuals are using fentanyl, whether intentionally seeking fentanyl, or unknowingly because fentanyl is mixed with other substances.

[7] Department of Public Health (DPH), 2021

[8] The Hub's Key Informant Focus Groups, 2022

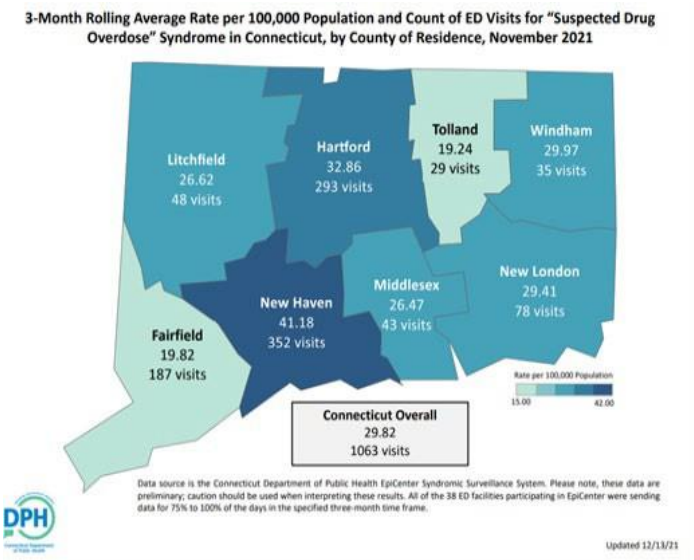
[9] Department of Mental Health and Addiction Services (DMHAS) Treatment Admissions, FY 2021, 2022

There are variations of fentanyl analogs that are incredibly potent and on the rise. Many stakeholders encourage a harm-reduction approach when providing prevention, treatment, and recovery services. The rise in fentanyl use is creating some challenges in treatment admissions as many agencies need to test individuals for fentanyl before admitting individuals to detox. Often, this fentanyl testing can take up to two days to process, causing a barrier for individuals seeking timely treatment.[9]

According to local youth surveys, most middle-school and high-school aged students feel that it is difficult to obtain illicit substances such as heroin, cocaine, methamphetamine, phencyclidine (PCP), etc. Nearly all youth are aware of the risk of misusing illicit drugs. However, the small group of students who have tried illicit substances were mostly 12 years or younger.[10] According to key informants who were interviewed, youth who are seeking substances often do so over social media and unknowingly obtain counterfeit drugs that are laced with fentanyl.[9]

Risk Factors and Subpopulations at Risk

- People who are addicted to other substances are more likely to meet criteria for heroin use disorder. Compared to people without an addiction, those who are addicted to alcohol are 2 times more likely to become addicted to heroin. Those addicted to cannabis are 3 times more likely, while those addicted to cocaine are 15 times more likely, and those addicted to prescription pain medications are 40 times more likely to become addicted to heroin;[6]
- Other risk factors include previous overdose, personal or family history of substance misuse, history of depression or anxiety.
- Other groups at risk include[8];
  - Non-Hispanic whites;
  - Males;
  - Young adults (18 to 25);
  - Adults (25 to 44).
  - People without insurance or enrolled in Medicaid.
  - Seniors prescribed multiple medications.
  - Women (due to biological factors and an increased likelihood of being prescribed opioids and being given longer term and higher dose prescriptions).
  - People living in urban communities.
  - There is a strong correlation between substance misuse and suicide. A new National Institute of Health (NIH) 2022 study found that nationwide, the number of intentional overdose deaths, or suicides, have declined in recent years but have increased among ages 15-24, 75-84 and
  - non-Hispanic Black women. This same study reports that about 5-7 percent of reported overdose deaths are intentional (ie. suicides).[7]



The 2021 CSHS shows that Hispanics reported the highest overall rate (1.1%), which is higher than the prevalence for Black non-Hispanics and White non- Hispanics (0.4% each). One percent of boys and .2% of girls reported ever use of heroin.[2] Use among high school students in general is of particular concern, as youth use is often linked to continued use and substance use disorder in the future.

[10] Local Youth Survey Data, 2021

2022 Region 1 Epidemiological Profile: Heroin & Other Illicit Opioids

Burden (consequences)

- Opioids such as fentanyl and heroin are highly addictive, and their misuse has multiple medical and social consequences including increased risk for HIV/AIDS, property and violent crime, arrest and incarceration, unemployment, disruptions in family environments, and homelessness.
- Chronic opioid misuse may also lead to serious medical consequences such as fatal overdose, scarred and/or collapsed veins, bacterial infections of the blood vessels and heart valves, abscesses, and other soft-tissue infections, and liver or kidney disease. Poor health conditions and depressed respiration from heroin use can cause lung complications, including various types of pneumonia and tuberculosis.
- Opioid misuse during pregnancy can result in a miscarriage or premature delivery, as well as neonatal abstinence syndrome (NAS), and exposure in utero can increase a newborns' risk of sudden infant death syndrome (SIDS).

Data Source: DPH, 2021

Opioid-Involved Non-Fatal Overdoses (DPH)[7]

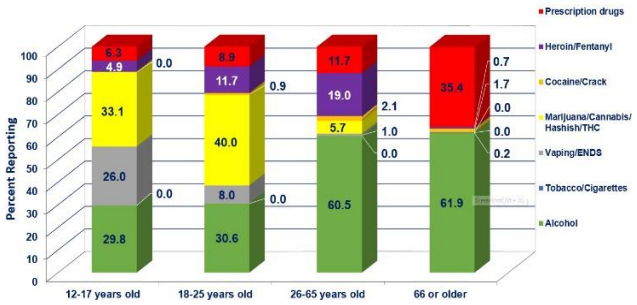
	CT	Region 1	Region 2	Region 3	Region 4	Region 5
2020	5,842	680	1636	626	1822	1086
2021	5,420	666	1714	520	1552	977

***Numbers are approximate due to suppression**

In one urban core town in SW CT, roughly 1 in 3 adults personally know someone who is struggling with an opioid addiction.[11] According to the Community Wisdom Survey (2021), 51% of respondents reported that the community is struggling with drugs and alcohol.[12] In the Community Wellbeing Survey (2021), 15% of residents reported that the likelihood of youth in the area to abuse drugs or alcohol is "almost certain.[13]

According to the 2022 Community Readiness Survey, 19.0% of 26 – 65-year-olds and 11.7% of 18 – 25- year-olds are concerned about heroin and fentanyl.[13]

Problem Substances of Greatest Community Concern by Age Group, According to Key Informants: The Hub[13]



Capacity and Service System Strengths

Mean Stage of Readiness for Substance Misuse Prevention by Region[13]

	CT	Region 1	Region 2	Region 3	Region 4	Region 5
2020	5.37	5.14	5.55	5.21	5.59	5.25
2022	5.31	5.72	5.36	4.89	5.25	5.12

According to the 2022 CRS, Region 1 SW CT had the highest mean stage of substance use prevention readiness in CT and has since increased in perceived readiness since 2020.[14]

Prevention & Education: SW CT continues to provide awareness about the harmful effects and high potential for substance use disorders to the community at large. We have educated our communities in life-saving interventions, such as Naloxone, and have been able to distribute Naloxone kits. This has likely contributed to the reversal of many fatal overdose experiences.

[11] Community Health Needs Assessment (CHNA), 2021
[12] Community Wisdom Survey, 2021
[13] Community Readiness Survey, 2022

2022 Region 1 Epidemiological Profile: Heroin & Other Illicit Opioids

In 2022, The Hub has trained 295 individuals and multiple stakeholder groups throughout the region in Naloxone administration and gave out nearly 1,862 Naloxone kits. The Hub hosted two Naloxone TOT's, increasing our training capacity to include new Spanish-speaking trainers. Local Prevention Councils (LPCs) have also conducted community education on opioids and overdose reversal and provided Naloxone kits for families, providers and more. The Hub supports these efforts through information, opioid education, and distribution of Naloxone kits, in conjunction with LPCs and through an AmeriCorps Prevention Corps grant. Many LPCs are also supported with the State Opioid Response (SOR) grant and opioid settlement dollars are being distributed to municipalities. Fentanyl-testing strips, safe needle exchanges and other harm reduction programs are also available.

SW CT's Naloxone training includes resources such as Naloxone + Overdose Response (NORA) app, the Live LOUD campaign and You ThinkYouKnow. The Narcan NOW app and the state's newly developed Naloxone + Overdose Response App ("NORA," available at www.norasaves.com) are both useful resources providing information on how to recognize the symptoms of a suspected opioid overdose, administer Naloxone, dispose of medications, and find treatment and recovery resources. NORA also has an anonymous feature to report on kits used in a revival.

Treatment: Medications for Opioid Use Disorder (MOUD), such as buprenorphine, methadone and naltrexone are available at 12 publicly funded nonprofits, 2 private for profits, and individual providers throughout the region. There are detoxification facilities in the region. The state Access Line provides transportation to detoxes when needed.

Recovery: SW CT has many peer support specialists, including Recovery Coaches available. Recovery Coaches are an effective way to use people with lived experience to respond to overdoses that are common in Emergency Departments, connecting people to treatment and recovery support. Other recovery supports include the CT Community for Addiction Recovery (CCAR), the CARES Group, Courage to Speak, SMART Recovery for individuals and Family & Friends support. Many virtual and in-person support groups are available throughout the region and state. Additional resources include Turningpointct.org, a program developed by young people who are in recovery from behavioral health issues, and YouThinkYouKnow, an educational campaign on the dangers of counterfeit drugs causing overdoses.

The Recovery Friendly Workplace initiative empowers agencies with resources, training, and support to promote employee health and success within the work environment in relation to substance use disorder and recovery. With the support from The Hub, there currently are 6 SW CT agencies that have completed certification and have been declared state certified by Governor Lamont.

2022 Region 1 Epidemiological Profile: Mental Health

Problem Statement

Mental health refers to emotional, psychological, and social well-being. Mental health has a critical impact on thoughts, feelings, and actions. Mental health is important throughout the lifespan. Many factors contribute to mental health problems, including: biological factors, such as genes or brain chemistry; life experiences, such as trauma or abuse; & family history of mental health problems. Types of mental health disorders include but are not limited to: depression; anxiety; post-traumatic stress disorder (PTSD); obsessive compulsive disorder; mood and personality disorders; eating disorders; and serious mental illness (SMI).[1]

Depression

Depression is a relatively common but serious mood disorder. It interferes with everyday functioning, and includes symptoms like feeling sad all the time, loss of interest in activities previously enjoyed, sleeping too much or too little, having trouble concentrating, and thinking about suicide or hurting oneself.[2] Depression is also associated with suicide.

Serious Mental Illness

SMI refers to mental, behavioral, or emotional disorders resulting in serious functional impairment, interfering with major life activities. Examples of SMI include schizophrenia, bipolar disorder, borderline, and major depression.[1] In 2021, 14.2 million adults (5.6%), nationwide had a SMI in the past year.[3]

A recent national report showed that 41% of adults report anxiety or depression; this is more than double the percentage reported pre- pandemic at 11%.[4]

Magnitude

According to The State of Mental Health in America (2022), Connecticut (CT) was ranked #4, indicating lower prevalence of mental illness and higher rates of access to care, compared to all other states.[5] The prevalence of adult mental illness is 18.85% and the prevalence of untreated adults with mental illness is 54%. 42,000 youth experienced at least one major depressive episode in the past year (a prevalence of 15.46%), among whom 42.9% reported not receiving mental health treatment.[5]

In terms of calls to 211 (mobile crisis), following a statewide decrease in call for mental health services in 2020, calls began to increase again in 2021 (13,762 calls) and in 2022, (83,611 calls). 17,591 of the 2022 calls were requests for crisis intervention. The most common

Anxiety and depression are the most reported mental health challenges, while SMI has serious consequences for the lives, livelihood, and wellbeing of individuals and families experiencing it.

Anxiety

Anxiety can be a normal part of life for many people, but anxiety disorders involve more than temporary worry or fear.[1] These symptoms can interfere with the individual's daily life and can impact work, school, and relationships. Anxiety disorders can include panic disorder, phobia- related disorders, social anxiety and generalized anxiety disorder.

presenting problems are Harm/Risk of Harm to Self (32.1%), Disruptive Behavior (23.7%), Depression (15%) and Anxiety (8%).[6] Within SW CT, mental health and addiction services were the second or third most common 211 call.[7] Calls peaked in January- March of 2022 with over 600 calls in this quarter alone.

There has been a similar increase in crisis calls to the Kids in Crisis Helpline. Calls increased 19% in 2021 and more youth contacted the helpline on their own. Self-referrals have increased 71% in 2021 compared to the previous year. The most common calls pertain to family conflict followed by mental health. More problems in schools are being reported.[8] For 211 calls, most children were referred by schools (44.2%), followed by self or family member (39.1%) then emergency departments (8.4%). School referral calls were on a decline in 2020 but have since increased.[9]

In the public section in 2022, 43% of DMHAS treatment admissions were for mental health care in SW CT. This has increased from 2021, when it was 36%. Most individuals receiving treatment were between the ages 35 - 44 (23.4%) followed by those between the ages of 25-34 (22.6%). Less than half of individuals admitted for treatment actually completed treatment in 2021-2022.[10]

The 2021 Connecticut School Health Survey reported that 29% of high school students said their past 30-day mental health was "not good". This was higher among girls (40.5%) and LGBTQ+ students (54.1%). 36% of high school students reporting feeling sad or hopeless almost every day for 2 weeks or more in the past year.[11]

In SW CT (Region 1), concern about depression has increased among all age groups. The 2022 Community

[1] National Institute on Mental Health, 2022

[2] Center for Disease Control and Prevention, Depression and Anxiety, 2022

[3] National Survey on Drug Use and Health (NSDUH), 2021

[4] American Psychological Association (APA), 2022

[5] The State of Mental Health in America, 2022

[6] 211 Count Tracker, 2022

[7] Community Health Needs Assessment, 2022

[8] Kids in Crisis, 2022

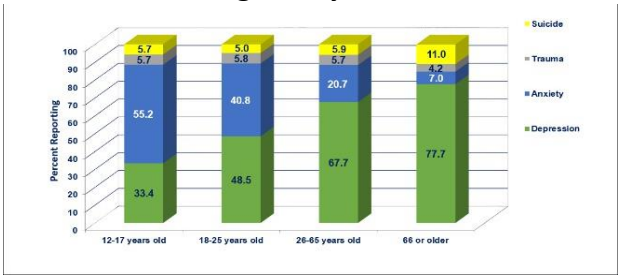
[9] Child Health in Development Institute (CHDI) Mobile Crisis Reports, 2021

[10] DMHAS Treatment Admissions, 2022

[11] Connecticut School Health Survey, 2021

Readiness Survey (CRS) found that last year depression was highest in ages 66+ (77.7%), followed by ages 26-65 (67.7%) in SW CT.[12]

Mental Health Issue of Greatest Community Concern According to Key Informants: The Hub[12]



According to the 2021 Connecticut BRFSS, 1 in 6 adults in CT reported experiencing depression. Additionally, depression among young adults 18-34 (19.5%) was higher compared to those 35-54 (12.6%) and 55+ (8.8%).[13]

A 2021 community survey in one lower Fairfield county town, using the PHQ4 screener, found that 34% of adults scored positive for anxiety and 30% scored positive for depression.[14]

In 2022, 34% of Greater Bridgeport, 31% of Fairfield, and 28% of Greenwich residents self-reported depression. In Greenwich, 88% of residents reported that they do not receive the emotional and social support that they need.[7]

In 2022 in lower Fairfield County, mental health was consistently the primary or secondary diagnosis in hospital admissions for individuals ages 75+. These numbers were significantly higher than other age groups.[7]

In the Community Wisdom Survey, 50% of Greater Bridgeport respondents reported that the community is struggling with mental health challenges.[15] According to local youth surveys, there are more middle and high- school aged students reporting increased feelings of depression, anxiety and isolation. Most youth are feeling high levels of stress, mainly due to school pressure and high expectations of caregivers. Most youth reported that COVID-19 had a significant impact in their emotional wellbeing. In some towns, girls were reporting feeling more stressed than boys. In some towns, students who were Black, Mixed Race or Hispanic reported higher rates of depression. In all towns that incorporated LGBTQ+ questions, LGBTQ+ students reported significantly more depression and other risk factors compared to non-LGBTQ+ students.[14] In one local Survey, 70% of LGBTQ youth reported depression in 2021.[14]

According to local youth surveys, 7-12 graders are bouncing back from the pandemic. Depression rates in these students dropped from 39% in 2021 to 23% in 2022, although local clinicians report that students who are still struggling with depression are experiencing more acute symptoms. [14] In the 2022, the same local youth survey reported that 27% of 7th-12th graders experienced very high levels of anxiety and 35% reported irregular eating behaviors.[11]

Risk Factors and Subpopulations at Risk

Risk factors for depression and anxiety include[1]:

- Family history of anxiety, or depression, or other mental illness;
- Experiencing traumatic or stressful events;
- Some physical conditions can produce or aggravate anxiety symptoms, and having medical problems such as cancer or chronic pain can lead to depression;
- Substance use such as alcohol or drugs;
- Life stressors such as financial hardship or personal loss;
- Mental illness (including depression, anxiety, and bipolar disorder, among others) is a risk for suicide;
- Co-occurring substance use disorder and/or problem gambling;

Populations at higher risk include:

- Young adults, who report higher rates of depression and serious mental illness.[11]
- The prevalence of major depressive episodes is higher among adult females than males, and among adults reporting two or more races[10]
- The prevalence of any anxiety disorder is higher among females than males.
- LGBTQ+ individuals are more likely than heterosexual individuals to experience a mental health condition. Individuals who are transgender are four times more likely to experience a mental health condition.[11]
- Most individuals receiving treatment for a mental health condition are Non-Hispanic White Males and a significant amount do not finish treatment.[10]
- Rates of depression are higher in marginalized communities; and in Black, Mixed-Race, and Hispanic youth.[14]

[12] Community Readiness Survey, 2022

[13] CDC, Behavioral Risk Factor Surveillance System, 2022

[14] Local Youth Survey Data, 2020-2021

[15] Community Wisdom Survey, 2021

Burden (Consequences)

- Depression is the leading cause of disability in the world;[1]
- NAMI estimates that untreated mental illness costs about $300 billion annually due to loss of productivity, costs due to absenteeism, employee turnover, and increases in mental and disability expenses;[16]
- Across the state, 86% of DMHAS funded and operated mental health beds went to acute psychiatric cases.[17]
- 1 in 8 emergency department visits involves a mental health or substance use condition.[16]
- Emotional neglect was the second most common DCF call in September - October, 2021. Most reports came from schools, police and mental health professionals.[18]
- There has been an increase in children emergency department visits for active suicidal ideation and eating disorders. It has been reported that there is limited psychiatric bed capacity and long waitlists for referrals to inpatient or community-based care.[19]
- In Greenwich, most mental health visits are due to anxiety (11.9%) and depressive disorders (9.2%). In Greater Norwalk, mental disorders were the most prevalent behavioral health condition for all age groups. [7]
- Most mobile crisis episodes of care were female (53%). Most children served were between the ages of 13 - 15 (36.7%) and 9 - 12(29.8%).[9]

According to The Hub's key informant focus groups, the COVID-19 pandemic has had a significant impact in exacerbating mental health symptoms. There are more reports of depression, anxiety, attention-deficit hyperactive disorder, eating disorders and hoarding disorders in SW CT.[20]

Capacity and System Strengths

Mean Stage of Readiness for Mental Health Promotion by Region[12]

	CT	Region 1	Region 2	Region 3	Region 4	Region 5
2020	4.88	4.86	5.00	4.71	4.89	4.88
2022	4.98	5.36	5.11	4.54	4.91	4.79

The 2022 CRS found that SW CT (Region 1) had the highest mean average of community readiness in mental health promotion (5.36) compared to other regions as well as the state average.[12]

For emergency and inpatient services, SW CT is served by six hospitals offering mental health services (including Silver Hill Hospital, a psychiatric hospital); DMHAS, which operates facilities in Bridgeport and Stamford to serve low- income individuals with SMI and contracts with local nonprofit agencies.

In terms of outpatient services, SW CT has an abundance of nonprofit offices serving adults and youth with mental illness; several private for-profit agencies specializing in eating disorders, anxiety or addiction; and many individual therapists and private practices. In addition, in most towns the municipal social or human services department can provide limited counseling and referral to care. To expand services to teens, three providers opened new adolescent IOPs during 2022 and into 2023.

Several school districts have contracted with Kids in Crisis to embed Teen Talk counselors (6 high schools and 4 middle schools in SW CT, as well as an office at the Stamford Boys & Girls Club). Kids in Crisis' SafeHaven is a co-ed shelter for ages 18 and under in Fairfield County. The amount of individuals served has significantly increased in 2022 compared to previous years.[19] Numerous schools districts within SW CT have implemented strategies such as Social Emotional Learning curriculum, in-school support and alternative programming to support students with behavioral health needs. In SW CT Newport Academy and Turnbridge provide therapeutic alternative school programs for those with behavioral health disorders.

The Lighthouse Program serves the LGBTQ+ community and provides peer-to-peer social support groups for LGBTQ+ identifying youth and allies. In 2021-22, Kids in Crisis assisted 1,160 students in receiving individual counseling across all schools and clubs via Teen and Kid Talk. 291 students received group counseling and 132 Risk Assessments were provided.[8]

Recovery Network of Programs continues to expand the community response initiative by embedding social workers in police departments in Stamford, Norwalk and Stratford. As a result, there has been an overall reduction of mental health calls coming into 911 dispatch by approximately 30% in the first two years.

[16] NAMI, 2022

[17] DMHAS Statistical Report, 2021

[18] Department of Children and Families Bridgeport LIST, 2021

[19] CT Mirror, 2021

[20] The Hub's Stakeholder Focus Group, 2022

There are many free behavioral health support groups available throughout the region. Two new Alternatives to Suicide support groups opened in the region in 2022, one online and one in-person. A comprehensive list of free peer support groups within SW CT can be found on The Hub's website.

According to The Hub's key informant focus groups, Peer- support specialists are a strength in the region for prevention, treatment, and recovery services, and are an integral part in assisting individuals to navigating the mental health system. According to many local youth surveys, most youth feel they can speak to an adult, especially their parents and parents report caring deeply about the wellbeing of their children.[20]

Other efforts such as collaborations with Community Health Improvement Plans, Local Prevention Councils, and Catchment Area Councils assist with increased regional community awareness of mental health. Ongoing trainings such as Mental Health First Aid and Question, Persuade, Refer as well as participation in events for awareness months and National Prevention Week have assisted in the visibility and promotion of resources available.

2022 Region 1 Epidemiological Profile: Prescription Drug Misuse

Problem Statement

Non-medical use of prescription drugs is a problem that continues to be a concern in the U.S., including within Connecticut. The types of prescription drugs that are most misused include painkillers (opioids), central nervous system depressants (tranquilizers, sedatives, benzodiazepines), and stimulants. Oxycodone (OxyContin), oxymorphone, tramadol, and hydrocodone are examples of opioid pain medications. Opioid painkillers work by mimicking the body's natural pain- relieving chemicals so the user experiences pain relief. [1]

Magnitude (prevalence)

According to the Office of the Chief Medical Examiner (OCME) there were 1,527 unintentional intoxication deaths throughout the state of CT in 2021. In this, 18% total deaths involved a mix of any opioid and benzodiazepine, 128 deaths involved methadone, 83 deaths involved oxycodone, 87 deaths involved amphetamine/methamphetamine, and 34 deaths involved buprenorphine alone.[2] Department of Public Health (DPH) reports as of 2021, 93% of overdose deaths involved an opioid (e.g., fentanyl, heroin, or a prescription opioid pain reliever).[3]

First reported in 2019, xylazine, an animal tranquilizer, and fentanyl combinations were involved in 71 drug overdoses, and the same lethal combination continued to be a problem in 2020 with 141 overdoses followed by in 2021 with 295.This continues to be a problem into 2022.[3]

According to DPH, gabapentin was involved in 11.87% of drug overdose deaths in 2021. CT also saw the introduction of Gabapentin. This drug is used to treat nerve pain and epilepsy and is prescribed for a host of other issues, including some mental health issues.[3]

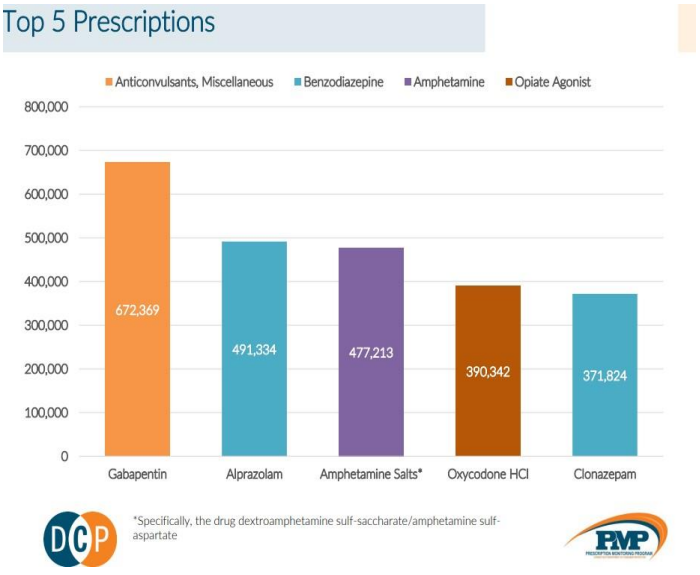
According to data from Connecticut Department of Consumer Protection (DCP), the total schedule II* prescriptions dispensed in SW CT was 2,349,120 in 2021 compared to 6,309,422 prescribed statewide. The most common controlled substances dispensed include medical marijuana, benzodiazepines, and opiate agonists, followed by opiate partial agonist and stimulants.[4]

* Schedule II drugs are defined as, substances, or chemicals, drugs with a high potential for abuse, with use potentially leading to severe psychological or physical dependence.

Opioids can also induce a feeling of euphoria by affecting the parts of the brain that are involved with feeling pleasure. Tranquilizers, sedatives, and benzodiazepines are central nervous system depressants often prescribed for anxiety, panic attacks and sleep disorders. Examples include Xanax, Valium, Klonopin, Ativan, and Librium. These drugs can also slow normal brain function. Stimulants increase alertness, attention, and energy by enhancing the effects of norepinephrine and dopamine in the brain. They can produce a sense of euphoria and are prescribed for attention-deficit/ hyperactivity disorder (ADHD), narcolepsy, and depression.

In Southwestern Connecticut (SW CT), there were 239 drug overdose deaths in 2021. Of these deaths, 25% (60) were a result of Benzodiazepines. The number of Benzodiazepine deaths have increased from 2020 (54).

Bridgeport, Stamford, Norwalk, and Stratford continue to experience high numbers of prescription drug overdose deaths into 2021. Of the 96 total overdose deaths, in Bridgeport (13) or 13.5% were a result of Benzodiazepines with Stamford (27) or 33.33%, Norwalk (20) or 25% and Stratford (17) with 23%. [3]



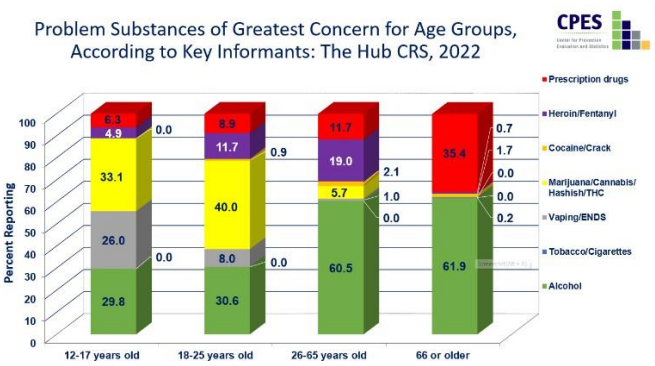
[1] NIDA, Misuse of Prescription Drugs Research Report

[2] OCME, Office of the Chief Medical Examiner (2021)

[3] CT DPH, Department of Public Health (2021)

[4] CT Department of Consumer Protection (DCP)

2022 Region 1 Epidemiological Profile: Prescription Drug Misuse



Although the state has had a long history with heroin, recent data reflects a palpable shift from prescription use to heroin and now fentanyl as the primary substance involved in 85% of deaths in 2021.[3]

Among prescription medications, pain relievers are the most frequently used for non-medical purposes in the US. According to the 2021 Survey of Drug Use and Health (NSDUH), 2.7% of CT respondents 12 and older reported past year use of prescription pain relievers, generally in line with the northeast and the US.[5]

Approximately 1.4% of CT respondents 12 and older met criteria for pain reliever disorder, vs 1.7% in the northeast, and 1.8% in the US.[5]

According to the 2021 CT YRBS, 8.5% of high school students reported ever taking prescription drugs without a doctor's prescription.[6]

According to the Young Adults Statewide Survey, of 1,257 young adults ages 18-25, 14% had engaged in prescription drugs in the past month and 6% in their lifetime.[7] Young adults, ages 18 to 25, show 6% use of over the counter, non-medical prescription drugs. 77% of young adults reported engaging in substances to have a "good time". 78% of young adults reported limiting substance use due to physical or health concerns.

Analysis of local youth surveys revealed that high school aged youth in the region reported limiting substance use due to potential physical or health concerns.[8] 30% of high school students obtained prescription pain medication without a prescription by someone giving it to them or taking it from their home or someone else's home. 4.4% of high school students have taken over-the-counter drugs to get high.[8]

According to key informant focus groups conducted by The Hub, use of prescription drugs is a higher priority for young adults compared to youth. It is a low priority for youth and children. With young adults, stimulants, counterfeit drugs, and Adderall are particularly misused.[9] The use of counterfeit prescription drugs is more of a concern in SW CT and is a more of an issue among young adults compared to youth and children.[9]

Risk Factors and Subpopulations at Risk

Persons at risk of misusing prescription drugs include:

- Those with past year use of other substances, including alcohol, heroin, marijuana, inhalants, cocaine, and methamphetamine.
- People who take high daily doses of opioid pain relievers.
- There is a strong correlation between prescription drug misuse and problem gambling; often referred to as a dual diagnosis.
- Veterans.
- People who are prescribed multiple controlled prescription medications, often by different providers.
- Individuals with disabilities or mental illness are at increased risk of prescription opioid misuse and use disorders.
- Undocumented individuals are less likely to receive accessible care due to fear of arrest or deportation.
- According to key informant focus groups conducted by The Hub, Electronic Sport Gamers or "E-Gamers" are increasingly using Adderall to stay awake longer for gaming.
- The elderly population may be at risk of consequences of prescription drug misuse, as they use prescription medications more frequently compared to the general population and may be at higher risk of medication errors.
- CT Hispanic students had the highest rates of taking prescription drugs without a doctor's prescription (12.5%)

[5] NSDUH (2021)
[6] Connecticut School Health Survey (2021)
[7] Young Adults Statewide Survey (YASS)
[8] Local Youth Survey Data, 2020-2021
[9] The Hub's Key Informant Focus Groups, (2022)

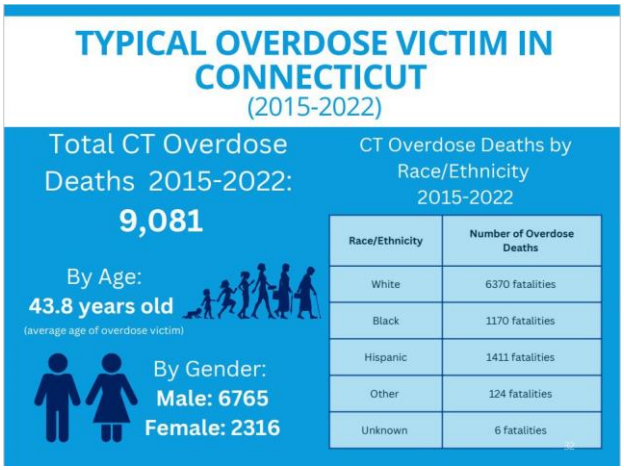
2022 Region 1 Epidemiological Profile: Prescription Drug Misuse

According to key informant focus groups conducted by The Hub, treatment providers state that many individuals face language barriers in accessing care. There is a lack of Spanish, Creole, and Polish speaking providers.

According to key informant focus groups conducted by The Hub, treatment providers frequently see individuals facing barriers in accessing care due to insurance, as many are uninsured or underinsured.[9]

- Prescription opioid misuse is a risk factor for heroin and other illicit opioid misuse, including illicitly manufactured fentanyl.

Data on the typical overdose victim in CT indicates Non-Hispanic White male between the ages of 35 – 64 was most likely to overdose. However, drug overdose deaths have risen across several race/ethnicity groups. In some towns with higher numbers of overdose deaths, particularly Bridgeport and Norwalk, Non-Hispanic Black Males are increasingly overdosing more so than non- Hispanic white males.



Source: Naloxone Training Slides, The Hub

Burden (consequences)

There was an increase in opioid-involved fatalities in Connecticut from 2020 (1,273) to (1,413) 2021.[2]

- 275 deaths involved a mix of any opioid and benzodiazepine,
- 128 deaths involvedmethadone,
- 83 deaths involved oxycodone,
- 87 deaths involved amphetamine/ methamphetamine, and
- 34 deaths involved buprenorphine alone.
- An emerging substance, Para-fluorophenyl, a fentanyl analog, was present in 13 overdose deaths in 2020,94 overdose deaths in 2021, and 33 overdose deaths in 2022 as of the first week of December.3

According to the 2021 CT Community Wellbeing Survey, 31% of CT residents personally know someone struggling with addiction to heroin or other opiates, such as prescription painkillers 44% of whom state that the person is a family member.[10]

Within SW CT, rates of residents knowing someone who is currently struggling with addiction to heroin or other opiates are similar to state rates. In most towns, residents who know someone who is struggling are most likely to be a family member and are most likely to be the individual who residents identify as struggling. However, in Greenwich, it is more likely for residents to identify a close friend. In Trumbull, it is more likely for residents to identify an acquaintance.

Treatment admissions in the SW region for opiates and synthetics have increased from 2018 through 2021. In SW, there were 1,829 admissions in 2018, 3,260 admissions in 2020 and 4,772 admissions in 2021.[3]

Capacity and Service System Strengths

2022 Community Readiness Survey (CRS): Mean Stage of Readiness for Substance Misuse Prevention[11]

	CT	Region 1	Region 2	Region 3	Region 4	Region 5
2020	5.37	5.14	5.55	5.21	5.59	5.25
2022	5.31	5.72	5.36	4.89	5.25	5.12

[10] Data Haven (2021)

[11] Community Readiness Survey (CRS) (2022)

2022 Region 1 Epidemiological Profile: Prescription Drug Misuse

There is a decrease in community readiness statewide from 2020 to 2022. However, SW CT shows an increase in community readiness from 2020 to 2022.

Prevention & Education:
Connecticut's Region 1 Behavioral Health Action Organization is funded by DMHAS to provide community support through mini grants. With the coordination communities can:

- Educate prescribers on the CT Prescribing Monitoring response system (CPMRS)
- Promote awareness campaigns such as:
    - You Think You Know (YTYK)
    - Change the Script
    - LiveLOUD
    - Naloxone + Overdose Response App (NORA)

In the 2022 calendar year, The Hub/Region 1 RBHAO hosted 44 trainings, trained 295 people and distributed 1862 Naloxone kits. We have increased the number of regional Naloxone trainers, which includes newly trained Spanish speaking leads. According to DPH between 12/1/21-11/30/22 it was aggregated that naloxone was given to 3,693 patients.

Treatment & Recovery: Medications for Opioid Use Disorder (MOUD), such as buprenorphine, methadone and naltrexone are available throughout the region. There are detoxification facilities in the region. The state Access Line provides transportation to detoxes when needed. SW CT has many peer support specialists, including Recovery Coaches available.

Recovery Coaches are an effective way to use people with lived experience to respond to overdoses that are common in Emergency Departments, connecting people to treatment and recovery support. Other recovery supports include the CT Community for Addiction Recovery (CCAR), the CARES Group, Courage to Speak, SMART Recovery for individuals and Family & Friends support. Many virtual and in-person support groups are available throughout the region and state. Additional resources include Turningpointct.org, a program developed by young people who are in recovery from behavioral health issues, and YTYK, an educational campaign on the dangers of counterfeit drugs causing overdoses.

The Recovery Friendly Workplace initiative empowers agencies with resources, training, and support to promote employee health and success within the work environment in relation to substance use disorder and recovery. With the support from The Hub, there currently are 7 SW CT agencies that have completed certification and have been declared state certified by Governor Lamont.

2022 Region 1 Epidemiological Profile: Problem Gambling

Problem Statement

Problem gambling, sometimes referred to as gambling addiction, includes gambling behaviors which disrupt or damage personal, family, or vocational pursuits. Symptoms include: increasing preoccupation with gambling, needing to bet more money more frequently, irritability when attempting to stop, and continuation of the gambling behavior despite serious negative consequences. [1]Problem gambling is also strongly associated with mental health disorders and substance use disorders.[2]

According to the American Psychiatric Association, for some people gambling becomes an addiction and individuals may crave gambling the way someone craves alcohol or other substances[3]. Aside from financial consequences, problems with relationships and work, or potential legal issues, problem gamblers are at increased risk of suicide. An earlier age of onset of gambling behavior is associated with greater risk of developing gambling problems and an increased severity of those problems.[4]

In a focus group conducted in January 2023 (including clinicians, advocates, prevention specialists and persons in recovery), participants indicated that services related to prevention, treatment and recovery were, at best, "somewhat sufficient." Screening for gambling problems was felt to be inadequate and gambling-specific treatment was insufficient. Participants identified underserved populations that included ethnic/racial minorities, LGBTQ community members, and college students.

The legalization of sports betting and online gambling in Connecticut (CT) in 2021 has led to increases in gambling addiction and the number of people seeking help in CT. As of October 2022, the numbers of calls and chats to the CT problem-gambling hotline were up by 134%.[5] Legalization has also been accompanied by an increase in advertisements for gambling, which is associated with a greater risk of development of problem gambling behaviors, especially in children, young people, and vulnerable adults.[6]

Although raising awareness regarding the risks of gambling behaviors may be particularly effective when included in early education in schools, that remains a challenge due to competing priorities for school-aged youth. Gambling disorders typically have an age of onset ranging from mid-20s to late 30s whereas substance use disorders may begin much earlier.[7]However, the legalization of online and retail sports betting may be changing the typical demographics. For example, the National Council on Problem Gambling indicated in 2022 that between 60% and 80% of high school students report having gambled for money and between 4% and 6% were considered addicted to gambling.[8]

Many online video games include "loot boxes", in which random rewards can be purchased, and so this may constitute a form of gambling. Video game addiction is relatively new and is not yet recognized in the US as a diagnosable disease. One community has included questions related to gaming behavior in a survey of middle school and high school students but there is no data regarding the magnitude of video game addiction.

Magnitude (prevalence)

In the United States, about 2 million adults meet criteria for severe gambling problems each year, and another 4-6 million would have mild or moderate gambling problems.[1]

In 2018 national survey data, the rate of past-year gambling activity in Connecticut was higher than the national average (83% vs 73%, respectively).[1] In 2019, the Connecticut Council on Problem Gambling (CCPG) reported that about 70,000 Connecticut residents met the clinical criteria for disordered gambling and another 280,000 residents were at risk of developing a gambling problem in their lifetime.[9]

[1] National Council on Problem Gambling
[2] Ford M et al. PLoS One. 2020; 15(1): e0227644.
[3] American Psychiatric Association, Gambling Disorder
[4] Rahman AS et al. J Psychiatr Res. 2012;46:675-83
[5] CT Insider, Oct 24, 2023

[6] McGrane E et al. Public Health. 2023;215:124-30 [7] Black DW et al. Compr Psychiatry. 2015;60:40A6 [8] PewTrusts.org, July 12, 2022
[9] Risk Factors for Developing a Gambling Problem, Centre for Addiction and Mental Health (CAMH)

There is limited quantitative data regarding the prevalence of problem gambling in Southwest Connecticut (SW CT). Nevertheless, according to data from CT Problem Gambling Services, the demographics of adults admitted to treatment for gambling disorder in this region may be changing in recent years. For example, the proportion of those between the ages of 18 and 25 years increased from just under 9% in 2021 to 20% in 2022. This might reflect an increasing prevalence of gambling behavior in younger age groups. It is well established that males are more prone than females to gambling addiction, and it is notable that the proportion of males increased from 61% in 2021 to 70% in 2022.

Data from the CCPG Helpline for SW CT suggests that the types of gambling might also be changing in recent years. For example, increases between 2021 and 2022 were found for contacts (chats or calls) related to sports (30% to 34%), casino (general; 9% to 20%) and internet gambling (15% to 39%). Although the increase in casino gambling contacts might be related to easing of pandemic restrictions, the increase in internet gambling contacts is more likely to be a result of the changed legal status in Connecticut.

In preliminary data from several towns in SW CT (part of the Datahaven Community Wellbeing Survey in 2021), between 27% and 41% of participants in each town acknowledged having gambled within the past year. However, the proportion of those who reported having bet more than they could afford to lose was almost twice as high for those in one more affluent town compared with those in a more economically challenged subregion (7% vs 3-4%).

Recovery Network of Programs Inc (Disordered Gambling Integration [DiGIn] Program site in SW CT), includes screening for problem gambling for all their clients. Their data have identified yearly increases from 2020 to 2022 in the percentage of clients who have a gambling disorder (table below). More than one third of clients with a gambling problem also have an alcohol use disorder, and more than 90% have a substance use disorder.

Data From the DiGIn Program in Region 1: Co-Occurrence of Gambling Problems with Alcohol and Substance Use Disorders, 2020 to 2022

Year	% of clients who indicated problem gambling	% of clients with a gambling problem who have AUD	% of clients with a gambling problem who have SUD
2020	1.2	39.2	90.2
2021	2.5	39.1	91.1
2022	3.4	36.4	90.7

There is very limited recent data regarding gambling behaviors and attitudes among adolescents in this region. Nevertheless, one town conducted a survey of middle school and high school students in 2022 that included gambling data. The incidence of self-reported gambling in their lifetime increased incrementally by grade from 3.45% in Grade 7 to 9.57% in Grade 12, and males were almost 3 times more likely than females to report gambling. Across all grades, fewer respondents perceived moderate or great risk of gambling compared with smoking, vaping nicotine, alcohol use, or use of prescription drugs without a prescription. Those who reported any substance use in their lifetime were more likely to perceive less risk of gambling and less peer disapproval for gambling. Importantly, the average "Age of First Use" was 11.2 years, younger than for use of over the counter or prescription drugs, alcohol, vaping nicotine, cigarettes, or marijuana.

Risk Factors and Subpopulations at Risk

Risk factors for development of gambling problems are shown in the table below.[10] [11]

Risk Factor for Development of Adult and Underage Gambling Problems

Adults	Underage - Specific
•Having an early big win •Having easy access to preferred form of gambling •Holding mistaken beliefs about odds of winning •Having a recent loss or change, such as divorce, job loss, retirement, death of a loved one •Financial problems	•Community norms promoting gambling •Availability and access to gambling •Parental involvement and attitudes favorable toward gambling •Favorable youth attitudes toward gambling

[10] CADCA

[11] CADCA 2022 CT Gambling Boot Camp

•A history of risk-taking or impulsive behavior •Depression and anxiety •Having a problem with alcohol or other drugs •A family history of problem gambling •Problem gambling rates double for individuals living within 50 miles of a casino	•Promotion of gambling opportunities •Peer networks engage in gambling activities •Sensation seeking/poor impulse control

Using elements of CADCA training (provided by CT PGS), a regional working group identified low perception of risk and community norms as priority risk factors to address underage gambling in Region 1.

Burden (consequences)

The National Council on Problem Gambling estimates the national societal cost of problem gambling to be about $7 billion, including gambling-related criminal justice and healthcare spending, job loss, and bankruptcy among others.[1]

Treatment Admissions:

	CT	Region 1	Region 2	Region 3	Region 4	Region 5
FY2022	321	31	18	94	70	108

In data from Bettor Choice and Problem Gambling Services for Regions 1–5, treatment admissions for gambling disorder in region 1 during FY2022 were among the lowest in the state. However, those data are unlikely to represent a comprehensive assessment of treatment burden in any of these regions. For example, gambling disorder often exists as a comorbidity with substance use disorder but may not be assessed in institutions and agencies treating patients for those disorders. Furthermore, persons from wealthy communities might seek treatment in private facilities and therefore would not be counted.

There is no regional data regarding the burden associated with gambling-related issues such as criminal justice and healthcare spending, job loss, bankruptcy, etc.

Capacity and Service System Strengths

In Region 1 data from the CT Community Readiness Survey, there was a marked increase in the percent of key informants between 2020 and 2022 who indicated that prevention of gambling/gaming addiction in the community was very important (table below).

Community Readiness Survey: % Rating Importance of Preventing Gambling/Gaming Addiction in the Community, 2020 vs 2022

	2020	2022
Very important	18.8	34.5
Somewhat important	44.2	37.7
A little important	28.3	24.1
Not important	8.8	3.6

Almost half of key informants indicated the ability to raise awareness about the risks of problem gambling/gaming addiction as medium or high, representing a substantial increase from 2020 data (table below).

Community Readiness Survey: % Rating Ability to Raise Awareness About the Risks of Problem Gambling/Gaming Addiction, 2020 vs 2022

	2020	2022
High	8.3	10.9
Medium	28.3	38.0
Low	57.3	51.1
No ability	6.1	0

There were also substantial increases in the percentages of key informants who indicated the awareness of community residents that gambling activities can become an addiction (table below).

Community Readiness Survey: % Rating Awareness That Gambling Activities Can Become an Addiction, 2020 vs 2022

	2020	2022
Very aware	2.3	6.3
Somewhat aware	24.6	29.2
A little aware	48.0	49.3
Not aware	24.5	15.2

Overall, key informants indicated readiness of their community as moderate to high for the following activities:

- Collecting data on the nature of local behavioral health problems
- Identifying community members as resources to address behavioral health problems
- Securing support from local policy makers for behavioral health
- Developing culturally appropriate programs and strategies
- Raising community awareness of priority problems or issues (substance misuse, gambling, mental health, suicide)
- Collaborating with organizations concerned with preventing other types of problems (e.g., HIV, violence)
- Developing policies related to or to specifically address behavioral health problems in the community

2022 Region 1 Epidemiological Profile: Suicide

Problem Statement

Suicide is death caused by injuring oneself with the intent to die.[1] Suicide is a growing public health problem and is now the 12th leading cause of death in the United States. Suicide affects individuals across the lifespan; however, it is the second leading cause of death among people 10-14 years old & 25-34 years old.[2] In 2020, suicide deaths were among the top 9 leading causes of death for ages 10-64.[2]

As of June 2022, the National Institute on Mental Health (NIMH) reported that the age adjusted suicide rate was 13.5 per 100,000 in 2020.[2] This is a decline from previous 2018 findings, which reported the rate was 14.2. Among females, the suicide rate was highest for those aged 45-64 (7.9 per 100,000), highest for those aged 75 and older (40.5 per 100,000) for males in 2020.[2]

According to the 2021 National Survey on Drug Use and Health (NSDUH) among adults ages 18+, 12.3 million individuals had serious thoughts of suicide in the past year.[3] From 2021, there was a 7.5% increase in the number of adults reporting serious thoughts of suicide. Among this same group, 3.5 million (1.4%) made suicide plans, & 1.7 (0.7%) million people nationally attempted suicide in the past year. [3]

Magnitude (prevalence)

Compared to national averages, Connecticut (CT) suicide data is lower. Yet, according to the Office of the Chief Medical Examiner (OCME), while the number of suicide deaths per year in Connecticut decreased in 2020 (359 suicide deaths) from 2019 it has risen yet again in 2021 (392 suicide deaths).[4] In 2021, the crude suicide rates per 100,000 population across CT was 10.9. The previous year was 9.9. This rate is highest among ages 65+ with a rate of 16.8 deaths per 100,000.[4] The second highest age group was ages 45-64 with a rate of 13.6 deaths per 100,000 population. This age range (45-64) had the highest crude suicide rate from 2015 through 2019.[4]

Preliminary 2022 data from the Connecticut Department of Public Health (CT DPH) reveals that 97% of suicides across the state of Connecticut occurred in individuals ages 19 or older.[5]

Ages 19+ had a crude statewide rate of 13.3 per 100,000. Ages 0-18 had a crude rate of 1.2 per 100,000. [5] 2022 numbers thus far reveal that Southwestern Connecticut (SW CT) had a total of 57 deaths, 9% of which occurred in ages 0-18, 81% of which occurred in ages 19 and older. [5]

From 2020-2022, the number of suicide deaths, that occurred in DMHAS Region One, remained steady. 2020 had 53 deaths by suicide (5.5 crude rate per 100,000), 2021 had 54 deaths by suicide (5.6 crude rate per 100,000). Preliminary data for 2022 reveals 57 deaths by suicide (crude rate of 6.0 per 100,000).[5]

The 2022 CT DPH Self Harm Emergency Department Visit Report found that the age adjusted rate per 10,000 for suicidal ideation was highest among ages 10-17 (5.8%) followed by ages 18-24 (3.5%) & then ages 25-34 (2.6%).[6] Generally, suicidal ideation is higher among young adults. In 2022, SW CT had the lowest rate (0.6%) emergency department visits for suicide ideation across the state.[6]

Prevalence Among Youth:
According to data from the 2021 Connecticut School Health Survey (CT YRBSS), 1 in 7, 14.1% high school students reported seriously considering attempting suicide in the past year.[7] In 2021, 1 in 17 high school students reported attempting suicide one or more times in the past 12 months. In one urban area of the Region, there were reports that 11.4% of adults' experienced suicidal ideation in 2020.[7]
Data from CT OCME from 2020 -2022 found that rural areas of SW CT reported higher crude suicide rates at 9.76% whereas urban towns in SW CT had a crude rate of 5.83%.[4]

Risk Factors and Subpopulations at Risk

- Nationally, from November 1st, 2021-October 31st, 2022 preliminary findings showed that 52.8% of suicidal ideations were male across the lifespan.[3]

[1] CDC, Suicide Prevention, 2022
[2] NIMH, Suicide, 2022
[3] National Survey on Drug Use and Health (NSDUH), 2021
[4] Connecticut Office of the Chief Medical Examiner (OCME), 2021
[5] CT Department of Public Health (DPH), 2022
[6] CT DPH, Suicidal Ideation and Self Harm Emergency Department Visit Report, 2022
[7] CT Youth Risk Behavior Surveillance System (YRBSS), 2021

2022 Region 1 Epidemiological Profile: Suicide

- In SW CT the rate of suicidal ideation was highest among White individuals (2.2%), followed closely by Black individuals (2.0%) & then Asian individuals (1.7%).[5]
- Nationally, suicide rates among non-Hispanic American Native/Alaska Native individuals increased nearly 20% from 2015 (20.0 per 100,000) to 2020 (23.9) compared to a less than 1% increase among the overall US population (13.3 to 13.5).[8]
- Region 1 findings show that those who identified as "Not Hispanic" had higher rates of suicidal ideation (201.2 per 10,000 visits) then those who identified as Hispanic or Latino (153.1 per 10,000 visits).[6]
- There is a high correlation between problem gambling, mental health & suicidality.
- Exposure to a death by suicide leads to an increased risk of suicide attempt or completion for those closely impacted; often referred to as suicide contagion.
- LGBTQIA+ youth experience increased suicidal ideation and behavior compared to their peers.[1]
- Mental illness is a risk for suicide, including depression, anxiety, bipolar disorder, and general depressed mood.[3]
- For those over 45, other risks include physical illness, such as terminal illness and chronic pain, as well as intimate partner problems.[3]

Other risk factors include[1]:

- Family history of suicide;
- Childhood abuse/trauma;
- Previous suicide attempts;
- History of substance misuse;
- Cultural and religious beliefs;
- Local epidemics of suicide;
- Isolation;
- Barriers to treatment;
- Loss (financial, relational, social, work); and
- Easy access to lethal means.

According to CDC, the 2020 CT age-adjusted rate for drug-induced mortality was 39.1 per 100,000 compared to the 2020 national rate 28.3.[9] There is a high prevalence of co-occurring disorders (ie. presence of mental health diagnosis and substance use disorder) & may be a large contributing factor to the rates of overdose deaths in the state as well as within SW CT.[10]

While suicide rate among pre-teens remains lower than the rate among adolescents, it has been rising. Suicide is the second leading cause of death for ages 10-14 nationally. A longitudinal study completed by CRS from 2018 to 2020 found that the rate of suicide completions for ages 0 to 17 increased from 0.95 to 1.4. Ages 0 to 17 was the only category, which saw an increase in the rate of suicides. All others saw a significant decrease in rates.[11]

Data from the 2021 Connecticut School Health Survey shows the percentage of female high school students who seriously considered attempting suicide was higher (19.8%) than males (8.7%).[7] Additionally, the percentage of students identifying as gay, lesbian, or bisexual reporting considering attempting suicide is significantly higher than their heterosexual peers (34.2% vs. 8.4%).[6] A significantly greater percentage of female students reported attempting suicide (8.8%) compared to male students (3.3%). Additionally, Hispanic students reported this at a higher rate (7.6%) than Black non- Hispanic students (7.5%) or White non-Hispanic students (4.0%).[6]

In CT in 2021, ages 4 -64 had the highest frequency of suicide deaths (135 deaths) followed by ages 65+ (106 deaths). These findings are reflective of national 2021 data showing these two age brackets also ranked 1st and 2nd for the highest suicide death rates [5]. As focus group findings that The Hub conducted show, ages 65+, has seen an increase in suicidal ideation, suicide attempts & suicide completions in recent years, especially since the onset of the COVID-19 pandemic.[11] There are multiple theories, which suggest this can be a result of increased isolation & lack of connectedness to others & resources. This could also be due to difficulty in accessibility & utilization of technology.[11]

[8] CDC, Suicides Among American Indian & Alaska Native Persons, 2022
[9] CDC, Drug Overdose Mortality by State, 2022
[10] The Hub Stakeholder Focus Group, 2022
[11] Community Readiness Survey (CRS), 2021

2022 Region 1 Epidemiological Profile: Suicide

Burden (consequences)

- Suicide impacts the health of the community and those around the individual. Family & friends experience many emotions including shock, guilt, & depression.[1]
- People who attempt suicide & survive can sometimes experience serious injuries which can have long term health effects.[1]
- The impacts and implications of a suicide on the community at large are far reaching. Aspects of contagion, lack of connection to resources, stigma & fear surrounding suicide are reported in SW CT. [11]
- Local organization, Kids in Crisis, reported that in the 2021-2022 school year, 291 students received group counseling and 132 risk assessments were provided. Among these assessments, the primary presenting problem was suicidal ideation.[12]
- In fiscal year (FY) 2020, 17,254 children were screened in CT. 16% were flagged for thoughts of suicide. This number reached 22% in FY 2021.[13]
- Regional providers report increased need for immediate intervention services. Reports of delays in psychiatric bed availability & connection to appropriate care is often mentioned.[10] Providers report the lack in standardization of screening as a gap in early identification of mental health & suicidal symptoms, especially among youth.[10]
- Focus group findings show an increased need for mental health & suicide related services offered to undocumented individuals, those on public insurance, non-English speaking residents, homeless, elderly, pregnant women & new parents.[10]
- One hospital in Region 1 is in the process of closing their psychiatric unit, which will present heighted barriers and stress in accessibility.

Capacity and Service System Strengths

Statewide entities such as the Connecticut Suicide Advisory Board (CT SAB) have positioned themselves to focus on legislation, which advocates for funding, longevity & sustainability of suicide specific programming. Funding for Regional Suicide Advisory Boards through DMHAS & DCF have allowed for the infrastructure within the CT SAB to be disseminated across the state in partnership with Regional Behavioral Heath Action Organizations.

One resource to come from the suicide prevention field in recent months has been the rollout of 988; The National Suicide and Crisis Lifeline which became effective on July 16, 2022. This system is aimed at aligning crisis services in the hopes of de-escalating situations and decreasing Emergency Room admissions for psychiatric calls. From April 2022 to October 2022,

CT received 15,645 988 calls. The average speed of answer in seconds was 4.86. An additional 25,922 calls were made to 211 for crisis or suicide intervention in 2021.[14] Mobile Crisis will also be transitioning into 24 hour services, which will assist in bridging current gaps in timely connection to services.

Community Readiness Survey: Mean Stage of Readiness for Mental Health Promotion

	CT	Region 1	Region 2	Region 3	Region 4	Region 5
2020	4.88	4.86	5.00	4.71	4.89	4.88
2022	4.98	5.36	5.11	4.54	4.91	4.79

The 2022 Community Readiness Survey showed an increase in overall perception regional readiness for mental health promotion. While data suggests that suicidal ideation & related symptoms persists, SW CT has a strong network of nonprofit partners, clinical & general heightened collaboration of stakeholders.[13]

SW CT groups including peer-led *Alternatives to Suicide Group,* and peer support through, PIPPLE, SOSA & others. Trumbull, Darien, Greenwich & Westport host suicide bereavement groups. SW CT has increased awareness & visibility in relation to suicide prevention through involvement in the American Foundation for Suicide Prevention's regional walk & fundraiser as well as a 3-month digital campaign promoting the new roll out of 988 & other resources.

[12] Kids in Crisis, 2022

[13] CT Mirror, *Children with Psychiatric Needs are Overwhelming Hospital Emergency Departments in CT,* 2021

[14] DCF/DMHAS/United Way 988 Power Point, 2022

2022 Region 1 Epidemiological Profile: Suicide

In the 2022 calendar year, The Hub offered 47 Question, Persuade, Refer (QPR) Suicide Gatekeeper Trainings within the community in which 1,337 individuals were QPR certified. Many other community partners outside of The Hub also continue to offer QPR trainings within the region as well. Embedded social workers and crisis intervention trained officers reflect an overall increase in mental health awareness. School based health centers, which focus on mental health, connected students to appropriate resources.

2022 Region 1 Epidemiological Profile: Tobacco &ENDS

Problem Statement

According to the National Survey of Drug Use and Health (NSDUH) and the Youth Risk Behavior Surveillance Survey (YRBSS), tobacco use has decreased for all age groups over the past decade. *NSDUH data show that past month tobacco product use among Connecticut residents 12+ declined significantly from 25.3% in 2008-2009 to 16.4% in 2021*[1] *Tobacco product use includes cigarettes, smokeless tobacco (i.e., chewing tobacco or snuff), cigars, or pipe tobacco. According to the 2021 NSDUH, Connecticut young adults aged 26 or older have the highest rates of cigarette use of any age group.*[1] Despite significant decreases, smoking remains a health concern due to serious adverse physical effects of tobacco use.

Vaping refers to the use of electronic cigarettes or electronic nicotine delivery systems (ENDS), which are metal or plastic tubes that aerosolize liquids, usually with nicotine, via a battery-powered heating element. The resulting aerosol is inhaled by the user and exhaled into the environment. There are many types of electronic smoking devices, including: e-hookahs, vape pens, e-cigarettes, and hookah pens. The liquid that is utilized in the device is called "e-juice" and is available in a variety of flavors and nicotine levels.

Vaping is an emerging problem nationally and in Connecticut, as rates continue to rise at a steady pace. According to the 2022 National Youth Tobacco Survey (NYTS), over 2.5 million U.S. kids used e-cigarettes in 2022.[2] Although youth e-cigarette use has declined since 2019, from 2017 to 2019, e-cigarette use among high school students more than doubled to 27.5% resulting in the U.S. Surgeon General and public health authorities to declare it an "epidemic".[2] According to Connecticut's Behavioral Risk Factor Surveillance Survey (CT BRFSS), the prevalence of ever using e-cigarettes has increased each year since 2012. The 2018 CT BRFSS results showed that 19.6% of adults in Connecticut reported having tried e-cigarettes in their lifetime.[3]

Magnitude

The 2021 Connecticut School Health Survey shows current use of cigarettes among high school students is 1.3%, down significantly from 17.8% in 2009.[4] While cigarette use among this age group has declined, e-cigarette smoking or vaping has increased, suggesting e- cigarettes are replacing tobacco smoking as the main mechanism for nicotine delivery. The 2021 Connecticut School Health Survey found current use of electronic vapor products to be 11% among high school students.[4]

Connecticut's 2021 Community Wellbeing Survey showed 22% of all respondents reported using vape pens or e-cigarettes.[5] Of those, half of them reported using them every day during the past 30 days. Vape and e-cigarette use is higher in suburban (28%) and urban core (26%) communities, and lower in wealthy communities (8%).[5]

According to the NSDUH, Southwestern CT reported prevalence of past month tobacco use dropped from 18.4% based on 2014-2016 data, to 17.4% in 2016-2018.[1] For both time periods, the region was lower than the state (22.2% in 2014-16 and 21.3% in 2016-18) and all other CT regions.[1]

NSDUH Substate Estimates:
Percent Reporting Past Month Tobacco Product Use, ages 12+

	CT	Region 1	Region 2	Region 3	Region 4	Region 5
2014-2016	22.2	18.4	22.8	27.0	22.4	21.9
2016-2018	21.3	17.4	21.6	22.5	22.0	23.1

**Tobacco Products include cigarettes, smokeless tobacco, cigars, or pipe tobacco*

While the Covid-19 pandemic had affected the use of tobacco and ENDS, especially among youth, recent data shows usage has increased since transitioning into post pandemic life. The increase may be a result of youth self-medicating to cope with increased depression, anxiety, and suicidality due to the pandemic.[6]

In regional focus groups held during December 2022 through January 2023, youth reported that they thought their peers were vaping less, and that those who were still vaping were the ones who were dependent. Youth surveys conducted during 2022 in some suburban towns in SW CT found lower 7th-12th grade vaping rates than prior to the pandemic. However, high school seniors report having the highest vaping rates. Among students who vaped, up to the 2/3 reported vaping marijuana. Focus groups also stated there has been an increase in smokeless tobacco use among youth throughout the region that included nicotine pouches, ZYN, being the most popular. Youth feel it is "easier to hide and be discrete" and there are no "odors or smoke".

[1] NSDUH 2021
[2] Tobacco Free Kids 2022
[3] Zheng X. (2018) CT BRFSS.
4 Connecticut School Health Survey, 2021 (YRBS)
[5] DataHaven- and Siena College Research Institute (2021). 2021 DataHaven Community Wellbeing Survey
[6] Play2PREVENT 2022

Risk Factors and Subpopulations at Risk

Populations at-risk for smoking cigarettes are[7]:

- American Indians/Alaska Natives
- Certain Hispanic adult subpopulations in the US, including Puerto Rican adults
- LGBTQ+ individuals
- Military service members and veterans
- Adults living with HIV
- Adults experiencing mental illness

Populations most at-risk for using ENDS are:

- Youth (12-17)[8]
- Young adults (18-34)[1]
- Males[1]
- Hispanics[1]
- Current smokers
- Those living in urban communities[5]
- Adults from households earning less than $35,000[2]
- Adults with disabilities[9]
- Those with a high school diploma or less[9]
- Adults without health insurance[9]
- Youth whose parent use these products.[10]
- Youth experiencing depression, anxiety, and stress[10]
- Youth with low self-image or self-esteem[10]

NSDUH Substate Estimates:
Percent Reporting Perception of Great Risk from Smoking One or More Packs of Cigarettes per day, ages 12+

	CT	Region 1	Region 2	Region 3	Region 4	Region 5
2016-2018	74.5	77.1	75.3	72.2	73.2	74.4

According to the 2021 Community Wellbeing Survey, 37% of CT residents have had at least 100 cigarettes in their lifetime and 22% use every day.[5] Within SW CT, rates of residents having smoked at least 100 cigarettes in their lifetime are similar to the state rate with higher rates in older adults. Rates of residents who smoke every day differ throughout the region. In more urban towns, rate of everyday cigarette use is higher compared to suburban towns. In Fairfield, individuals between the ages of 35- 49 are most likely to smoke every day. In Bridgeport (30%) and Stratford (46%), it is most likely to be 18–34-year-olds. In all towns, males are more likely than females to smoke except for Trumbull.

The 2019 Connecticut School Health Survey shows the prevalence of current cigarette smoking among high school students to be similar across gender and race, however prevalence increases with grade (2.0% of 9th graders compared to 6.6% of 12th graders).[3] Additionally, students identifying as gay, lesbian, or bisexual reported higher prevalence (9.2%) than their heterosexual peers (2.3%).[3]

The 2019 survey also found higher rates of current use of electronic vapor products in females (30.0%) than males (24.1%). White students reported significantly higher use (30.0%) than Black students (19.4%). Current use among Hispanic students (26.0%) is also significantly higher than Black students. According to youth surveys conducted in Region 1 in 2022, youth have overall reported less vaping usage as low as 5%. These same survey's reported increased youth's perception of risk and harm of vapes.

During the hub's focus groups, factors such as access, policy change, increased retailer education, increased parental and youth education may have led to the decrease in youth vaping trends post COVID-19 pandemic. However, public health officials theorize vaping usage may revert to pre-pandemic findings. We have begun to see some of this in SW CT.

Burden (consequences)

- Evidence shows that young people who use e-cigarettes may be more likely to smoke cigarettes in the future.[6]
- A recent CDC study found that 99% of e-cigarettes sold in the US contained nicotine, which can cause harm to parts of the adolescent brain that control attention, learning, mood, and impulse control.[6]
- E-cigarette aerosol can contain several potentially harmful substances, including diacetyl (in flavorings), which is a chemical linked to serious lung disease. It can also contain volatile organic compounds, cancer causing chemicals, and heavy metals such as nickel and lead.[6]

[7] CDC (2020), Current Cigarette Smoking Among Specific Populations United States

[8] Centers for Disease Control and Prevention. (2019). Quick Facts on the Risks of E-cigarettes for Kids, Teens, and Young Adults.Retrieved from https://www.cdc.gov/tobacco basic_information/e-cigarettes/

[9] Zheng X. (2018) CT BRFSS.

[10] Centers for Disease Control and Prevention (2022). Youth and Tobacco Use

2022 Region 1 Epidemiological Profile: Tobacco & ENDS

- Some ENDS devices, including those that are particularly popular among youth, have been modified to allow for higher doses of nicotine to be delivered. They also facilitate the use of THC and in higher potency. This is especially problematic in youth use, because of the increased risk of tobacco and cannabis use disorders later in life.[11]
- New "Health Vapes" or "Wellness Vapes" are being illegally offered for sale with unproven health or wellness claims.[12] Some of these claims include, improving mental clarity, treating tumors or asthma, anemia, ADHD, anxiety, depression and better sleeping habits. Some also claim to be "nicotine free". These claims may prevent or delay appropriate diagnosis and treatment from a health care professional.

Capacity and Service System Strengths

Community Readiness Survey: Mean Stage of Readiness for Substance Misuse Prevention

	CT	Region 1	Region 2	Region 3	Region 4	Region 5
2020	5.37	5.14	5.55	5.21	5.59	5.25
2022	5.31	5.72	5.36	4.89	5.25	5.12

Prevention: Tobacco control efforts are largely conducted through Local Prevention Councils (LPCs), municipal health departments, and school systems, with unequal levels of investment that depend on local community resources and grants. Local communities are all addressing vaping as a growing epidemic; for example, all 14 towns have the same goal: to reduce vaping amongst youth ages 12–18- year-old by 5% by 2025.

Towns have previously created vaping task forces or vaping education campaigns that have continued to grow and be utilized throughout SW CT. Some school districts in Region 1 have also included vaping in their youth's school health curriculum.

Treatment and Recovery: Some behavioral health providers have focused on reducing smoking and increasing healthy behaviors. Some schools in Region 1 now offer alternatives to students who vape and provide referrals to treatment for them.

Legislation and Enforcement: State law prohibits the sale of tobacco products to individuals under the age of 21. State Bill 326 was introduced in the 2021 legislative season which prohibited the sale of flavored tobacco products in Connecticut. It was not passed, leaving Connecticut in the middle of surrounding states who have banned flavors. It has been reintroduced in the 2022 legislative session.
Additionally, House Bill 6488 was introduced in 2023's legislative session to include the ban of flavor sales and prohibit the use of electronic nicotine delivery systems (ENDS) and vapor products in a motor vehicle while a minor is present in such vehicle.

Attorney General William Tong helped lead Connecticut and 34 states and territories in announcing a $438.5 million agreement with JUUL labs that would force JUUL to comply with a series of strict terms limiting their marketing and sales practices.[13] Connecticut will receive a minimum of $16.2 million through the settlement that will be used for cessation, prevention, and mitigation.

Most schools in SW CT have revised their district's student's handbooks to include polices that address tobacco and ENDS specifically. Policies have also been modified to include alternatives to out of school suspension for those students caught vaping or with tobacco/ENDS products. Some schools provide resources or have a vaping education program for these students.

With the support of DMHAS Prevention and Health Promotion Division Tobacco Prevention Enforcement Program (TPEP), SW CT police departments conducted tobacco compliance inspections in all 14 towns in 2022. There were 587 inspections resulting in 129 violations and 125 cases in which tobacco products were sold to a minor.

EMERGING ISSUES

Data—both quantitative and anecdotal—show several trends (also discussed below under Recommendations) that have been emerging over the past several years and require greater attention. These issues are not limited to SW CT but are also found at the state and national levels. They include:

1. Before 2020, vaping was increasing dramatically each year, particularly among teens and young adults. During the COVID-19 pandemic, vaping decreased and was mainly seen among youth and young adults who were using it and thought to be dependent. As the region moved into post pandemic life, an increase in vaping has been seen, especially among high school seniors. There is a need for more cessation programs.

2. Vaping cannabis is common, although not captured in all surveys, which often ask about vaping and cannabis separately. Anecdotal reports from clinicians indicate that vaped cannabis is the most commonly used substance by teens. The use of "dabs'' in vaping can deliver extremely high concentrations of cannabis that are associated with neurological risks. Many KIIs suggested that youth and young adults often vape as a "coping skill." Therefore, many suggest there is a strong correlation between vaping and other underlying issues. Most often cited is anxiety or other mental health conditions. There is also an increase in use of high-potency THC products, causing many youths to feel sick or experience psychosis or panic attacks.

3. The perception of harm from cannabis continues to decrease, recent legalization of cannabis is thought to decrease this even further. Meanwhile, providers indicate that there is an increase in cannabis-induced psychosis. Youth reports indicate that perception of harm from other substances are decreasing as well, including cocaine, prescription drugs, gambling, and vaping.

4. Although the state of Connecticut, along with SW CT, experienced a decrease in suicide fatalities in 2020, preliminary 2022 numbers reflect that suicide rates have jumped back to pre-pandemic findings. Further, local youth surveys conducted throughout Region 1 have found high rates of depression and other mental health symptoms in youth. KIIs reflect the notion that individuals are experiencing mental health challenges at younger and younger ages. This has been reflected in the overall, dramatic, increase in the number of 211/988 calls made for mental health and crisis services across the region.

5. The use of psychiatric medications continues to increase, with benzodiazepines (benzos) and antidepressants commonly prescribed. Among providers and consumers, concern has been expressed that dependence on benzodiazepines requires attention and may be seen as the next epidemic after opioids. According to key informant focus groups conducted by The Hub, counterfeit drugs or pills are becoming increasingly more concerning. The use of counterfeit prescription drugs is more of a concern in SW CT and is a higher priority in young adults compared to youth and children. The most common controlled substances dispensed include medical marijuana, benzodiazepines, and opiate agonists, followed by opiate partial agonists and stimulants.

6. Many young adults and youth are accessing prescription drugs which are not directly prescribed to them, although not captured in all surveys. Treatment providers indicate an increase in use of prescription drugs in youth and young adults, and an emerging trend of electronic sport gamers utilizing Adderall to stay awake longer for gaming. Counterfeit

drugs and pills are becoming increasingly more concerning and is a high priority in young adults, ages 18 - 25, compared to youth and children. Many key informants report youth are accessing substances, including cannabis and prescription drugs, on social media platforms. There are also new delivery platforms that deliver alcohol to your home; many of which are lenient with identification.

7. Across the state we have seen Fentanyl-involved drug overdose deaths increase. The average percentage of fentanyl- or fentanyl analog-involved deaths was 85% for 2020 and 2021, compared to 82% in 2019. New and emerging substances: Para-fluorofentanyl, a fentanyl analog, emerged in 2020 and was present in 13 overdose deaths that year, 94 in 2021 and 32 in 2022. There were five overdoses involving Flualprazolam in 2021 and four in 2022. Flualprazolam is a nonregistered drug in the benzodiazepine family and constitutes a new psychoactive substance. There were three overdoses in 2021 and two in 2022 involving Flubromazolam (a benzodiazepine derivative reputed to be highly potent).

8. Xylazine, an animal tranquilizer, identified in drug overdose deaths: For the first time in 2019, xylazine/fentanyl combinations were found to be involved in drug overdoses (N=71). The same lethal combination continued to be a problem in 2020 (N=141), 2021 (N=295) and 2022 (N=347). In 2022, Xylazine was detected in 27 ODs in Region 1. This drug is not an opioid which naloxone will not reverse the overdose state.

9. Oftentimes, individuals are accessing poly-substances, a mix of drugs, including fentanyl. The state has seen a palpable shift from prescription use to heroin and now fentanyl as the primary substance involved in 85% of deaths in 2021. Therefore, many individuals are under the impression they are obtaining a specific drug, not realizing that their drugs are typically a mix of dangerous substances. Utilization of harm reduction methods, such as Fentanyl Testing Strips (FTS), have increased in visibility and accessibility across the region in the attempt to reduce the number of individuals ingesting, and overdosing, from substances laced with fentanyl.

10. Gabapentin (Neurontin) is a “novel anticonvulsant” and is FDA indicated for partial seizures and post-herpetic neuralgia. But the drug has long been heavily marketed to psychiatrists to treat a range of conditions from bipolar disorder to anxiety to alcohol withdrawal. According to DPH, Gabapentin trends have been detected and involved in 11.87% of drug overdose deaths in 2021.

11. During the pandemic, younger age groups struggled with their mental health and consequently suicidal ideation as a result of increased isolation as well as in conjunction with higher rates of alcohol and drug use.

12. Hoarding disorder is being identified in many individuals, especially older adults, struggling with a mental health condition or substance use disorder. Hoarding often affects more than the individual and can cause complicated or dangerous situations for a community.

13. Smokeless tobacco and oral nicotine pouches are new forms of tobacco products that come in various flavors and are being used at an increasing rate among youth in SW CT. These products are also being used at an increased rate for youth who report using them as a cessation method. This is highly concerning as many youths are unaware that these products still contain nicotine. These products are not formally categorized as smokeless tobacco, so they are not regulated by the FDA for cessation. A popular brand being used by

youth is "Zyn" and is referred to as "Zyning". Zyn is a type of smokeless tobacco pouch that does not produce saliva, so it does not require spitting and is easy to conceal and hide.

14. Suicide rates in the elderly and aging populations have increased since the onset of the pandemic. In SW CT in 2021, ages 65 and older had the second highest number of suicide deaths (16 deaths). Many key informants highlighted a greater need for services to be allocated to older individuals to bring awareness and prevention resources to those in need. More detailed information on this topic can be found in the suicide specific epidemiological profile.

15. Increases in gambling addiction and the number of people seeking help in Connecticut and in Region 1 have been observed following the legalization of sports betting and online gambling in Connecticut in 2021. As of October 2022, the numbers of calls and chats to the CT problem-gambling hotline were up by 134%.[10] In Region 1, calls from females increased from 18% in 2021 to 35% in 2022, and there were marked increases overall in reported gambling for "Casino – General," "Internet", and "Lottery – Scratch Tickets."

16. Advertisements for gambling (including live stream gambling events on social media) have also greatly increased as noted in feedback from focus groups and KIIs. Advertising is associated with a greater risk of development of problem gambling behaviors, especially in children, young people, and vulnerable adults.[11]

17. Eating disorders and social media can have a complex relationship. While social media can provide a supportive community and helpful resources for those struggling with eating disorders, it can also exacerbate negative body image and trigger disordered eating behaviors. Many of the stakeholders in our region have inquired about this topic with concern due to seeing an increase in cases with females.

18. Bigorexia, also known as muscle dysmorphia, is a type of body dysmorphic disorder (BDD) in which an individual becomes obsessed with the idea that their body is too small or insufficiently muscular, even when they are already muscular. BDD can have serious consequences for an individual's physical and mental health. Many of the LPCs in our region are inquiring about this and wanting to learn more about the disorder as it's been a topic amongst the coalition members due to seeing an increase in obsession.

RESOURCES, STRENGTHS, ASSETS

The region has many strengths and assets to draw upon, including partnerships among many community stakeholders; a wide treatment continuum; many varied recovery supports; peer support specialists; and vans to provide mobile outreach and resources in the community.

SW CT benefits from **strong partnerships** among many behavioral health, hospital, social services, housing, health departments, advocacy groups, prevention professionals, schools, first responders, and other community groups who meet regularly throughout the region to coordinate and work on initiatives such as increasing access to care, raising awareness, and decreasing barriers. There is 90+ of these committees, coalitions and workgroups in the region working at different levels (local,

[10] CT Insider, Oct 24, 2023
[11] McGrane E et al. Public Health. 2023; 215:124-30

subregional, regional) and tackling issues from substance use to mental health to housing to juvenile justice. These include the following:

- The hospital-led Community Health Improvement Projects (CHIPs) in the Bridgeport, Norwalk, Stamford, and Greenwich areas, which survey community health needs every three years and develop and implement plans to meet the priority needs. The Hub co-chairs the behavioral health task force for the Bridgeport and Greenwich CHIP,
- The Community Care Teams (CCTs) in Stamford, Greenwich, Norwalk, and Bridgeport, which meet weekly to coordinate care across sectors for a limited number of high-need clients,
- The Catchment Area Councils (CACs) managed by The Hub, which meet regionally five times per year, with family/friends, behavioral health providers and lived experience stakeholders at the table, to identify gaps and concerns and make recommendations about prevention, treatment and recovery services,
- The Local Prevention Councils (LPCs), which meet most months at the municipal level to plan and implement prevention strategies in their community; several of which have Drug-Free Community (DFC) grants, CT Strategic Prevention Framework Coalition, and Partnership for Success grants that have allowed them to use staff and resources to create impressive campaigns and services,
- The Regional Suicide Advisory Board (RSAB), managed by The Hub, meets quarterly to convene partners in regional efforts surrounding suicide prevention, awareness, intervention and postvention response. Members include individuals who have attempted suicide or experienced suicide loss, providers, support group leaders, municipal social services and health staff, school personnel, first responders, and others,
- The Local Interagency Service Teams (LISTs), which meet sub-regionally (Bridgeport & Stamford) on a monthly basis to address juvenile justice concerns,
- The Children's Behavioral Health Advisory Committee (CBHAC) is a statewide committee consisting of state appointed agencies who meet monthly to enhance and promote children's behavioral health services across Connecticut,
- The Connecticut Prevention Network (CPN) which is the 5 RBHAOs in the state, work together on a monthly basis to coordinate, collaborate, inform and pool resources together,
- The Southwest Network of Care integrates opportunities for families, youth, schools, community members, behavioral health & primary care providers, to come together and address gaps and barriers in services,
- The Region 1 Gambling Awareness Team, a program of The Hub and subcontracted with Liberation Programs, meets quarterly with representatives from prevention, treatment, and recovery at local, regional, and state levels.
    - Members organize and participate in a wide variety of initiatives, including organizing annual PGAM educational events; presentations to schools, treatment providers, senior networks, LPCs, etc.

The Region 1 Gambling Awareness (GA) Team partners with CCAR to host monthly gambling awareness information sessions; include gambling awareness-related articles in local newsletters; recruited participants for a gaming pilot program.

GA Team representatives from prevention and recovery also completed a new 16-hour CADCA Gambling Awareness Boot camp training hosted by Problem Gambling Services (PGS). The SPF was

applied, resulting in initial development of a logic model with identified risk factors, local conditions and strategies to provide strategic direction to the team.

GA Team members helped to recruit more than 40 parent/teen groups to participate in a pilot for Power Up Parent and Power Up Player Gaming awareness program; an initiative under Connecticut Council on Problem Gambling (CCPG).

Members of the Caribe Youth Leadership Gambling Awareness Team develop annual public service announcements to increase gambling awareness, including an award-winning video in 2022.

Increasing numbers of local coalitions and regional councils infuse gambling awareness into their work (e.g., 4 LPCs, CAC, RSAB).

We now have comparative Help Line data by age, gender, and types of gambling (2021 and 2022).

PGS recently increased funding allowing The Hub and the other 4 RBHAOs to each hire a Full Time Regional Gambling Awareness Coordinator.

Access to the new - free 30-hour Problem Gambling Certification is now offered by PGS, CCPG and CT Women's Consortium. The first cohort runs April-June.

For those seeking behavioral health care, **treatment providers** are located throughout the region, making geographic access to services possible, even though transportation is often a challenge. Individuals who are eligible or have insurance or private pay capability can make use of a continuum of care, from outpatient through hospitalization, including residential programs and Medications for Opioid Use Disorder (MOUD) programs. Treatment services in the region include the following[12]:

- 6 hospitals (including Silver Hill Hospital, which is explicitly for behavioral health),
- Some 30 nonprofit behavioral health agencies serving adults,
- Another 30 nonprofit behavioral health agencies serving youth, including the Child Guidance system and Kids in Crisis,
- DMHAS-operated programs in Bridgeport and Stamford,
- Municipal social services in many towns that offer counseling free of charge to their residents,
- Supportive programs in housing, education, and employment. As well as Community Support Programs serving individuals with mental health and substance use disorders,
- Federally Qualified Health Centers that offer behavioral health treatment,
- For-profit specialty services for issues such as addiction, eating disorders, anxiety, failure to launch, and in-home recovery,
- Triangle Community Center, Lighthouse, local pride chapters, as well as additional LGBTQ+ youth programs,
- Building One Community and Child Family Guidance Center who provides outreach and referral resources to the Latino community for substance misuse and mental health,
- A vast number of private therapists and clinical practices,
- Warm lines and hotlines for mental health and substance use disorder are being utilized at higher rates,

[12] To download a complete list of public and nonprofit crisis, treatment, and supportive services in the region, visit www.thehubct.org/treatment

- Telehealth services increased in response to the COVID-19 pandemic and are still being utilized. Many individuals were able to continue their access to care virtually, and many providers reported higher numbers of client regularity and treatment consistency.

The region offers many **recovery supports**, including support services identified above and a variety of free peer support options, such as those listed below:

- Active NAMI affiliates operate many monthly support groups as well as offering free speaker meetings and book clubs.[13]

- The CT Community for Addiction Recovery (CCAR) operates the Bridgeport Recovery Community Center, which offers a wide range of daily meetings as well as the Telephone Recovery Support (TRS) program.

- Support groups exist for several specific disorders and co-occurring mental health and substance use groups. Individuals can seek support through multiple pathways, since there are groups available that use a variety of models: SMART Recovery, Mountainside Treatment Center, Turnbridge, RIPPLE, Alternatives to Suicide, Depression and Bipolar Support Alliance, The C.A.R.E.S. Group, Courage to Speak, etc. Support groups are offered in person and online post Covid-19.[14]

- Family and friends can also access many free support groups and training programs.

- The problem gambling hotline and the 12 step "Gambler's Anonymous" program were cited as strengths for those struggling with problem gambling in the region.

KIIs consistently highlighted the strong network of providers such as recovery support specialists within the SW CT region of the state as being one of the best assets. The relationships among providers allow for a strong collaboration of care seen in the prevention, treatment, as well as recovery areas.

Social workers, case managers and many peer support specialists help people directly connect and refer to services and support wrap-around care. Many connections to resources happen in social services case conferences within organizations and community meetings.

Peer support specialists—Recovery Support Specialists (RSS's) and Recovery Coaches are trained and available throughout the region, although they are significantly underutilized, and many are seeking employment or reimbursable services through insurance. Some Recovery Coaches can work with patients privately and facilitate support groups.

CCAR's Emergency Department program aims to connect individuals in hospitals with a behavioral health admission to a recovery coach.

The Progressive Institute offers a recovery coaching program which connects individuals to 1:1 coach either virtually or in person to individualize their treatment and recovery plan.

[13] Support Groups - NAMI Southwest CT

[14] To download a complete list of all behavioral health support groups in the region, visit https://www.thehubct.org/recovery

Mobile outreach efforts, with the inclusion of vans, offer behavioral health resources, assessments and interventions throughout the region meeting people where they are at. Examples include:

- The "Vehicle for Change" purchased by Supportive Housing Works, which does outreach to homeless and at-risk youth in the Bridgeport area and is equipped with harm reduction supplies such as FTS.
- A van run by Recovery Network of Programs, operating from Bridgeport to Norwalk to engage opioid users and do suboxone induction. The van has community engagement field workers who have harm reduction supplies equipped with naloxone and FTS including syringe exchange.
- Liberation Programs has a mobile wellness van that provides services to adults 18+ with substance use disorders (SUD). The van travels in Bridgeport, Norwalk, Stamford and Greenwich areas. The van provides treatment referrals, prescriptions for Buprenorphine/Suboxone, Narcan for Overdose Reversal, harm reduction supplies including syringe exchange, educational resources, and access to a Recovery Coach and Prescriber.[15]

- CT Clearinghouse Change the Script van who visits towns statewide that provides substance use prevention and mental health- related pamphlets, posters, factsheets and more resources at events. You can request them to attend your next event![16]

- DMHAS' Problem Gambling Services Department and MCCA launched in March 2023 an outreach van providing resources and minimal services to the community at large promoting the Responsible Play the CT way campaign. You can request the resource van to attend your next event![17]

Resources specific to **prevention** also include the creation and implementation of a variety of awareness campaigns. Many statewide LPCs including our region pooled their grant dollars together to create these campaigns. These include but are not limited to:

- Let's #MentionPrevention Alcohol - a campaign designed to assist retail and dining locations to do their part in keeping alcohol out of the hands of minors.
- Let's #MentionPrevention Vaping- a campaign designed to assist and guide parents in talking to their children about vaping.
- CT Clearinghouse launched a free, statewide Let's #MentionPrevention Alcohol Campaign that addresses the risks associated with alcohol use.
- LiveLOUD is another statewide campaign that provides information to those that are in recovery and their family/friends.
- CT Prevention Network (CPN), LPCs and other partners created youthinkyouknowct.org a counterfeit drug campaign.
- Beintheknowct, a new DMHAS state campaign that includes cannabis resources, education, common prevention templates, and more.
- 21 for a Reason, is a campaign created by one of the five RBHAOs, SERAC, to address physical and mental health risks related to alcohol, vaping and smoking, cannabis and gambling.
- The 988 National Suicide and Crisis Lifeline became effective on July 16th, 2022. This system and resource are aimed at aligning crisis services in the hopes of de-escalating situations and decreasing ER admissions for psychiatric calls. 988 Contact Center services

[15] Medication-Assisted Treatment Wellness Van – Liberation Programs
[16] Substance Use Prevention & Resources Van | DrugFreeCT.org
[17] Request The Resource Van – Responsible Gambling (responsibleplayct.org)

include rapid 24/7 access to trained crisis contact center staff who can help people experiencing suicidal, substance use and other mental health crises, provide referrals to resources, and perform warm transfers to mobile crisis services or emergency services as needed/desired. The state of Connecticut also plans to roll out a campaign regarding 988 in the coming year.

- Mobile Crisis Intervention Services (MCIS) will soon transition into being a 24/7 resource as well, thus being able to intervene during crisis situations regardless of the time or day of the week.

The **Community Response Initiative** (CRI) through Recovery Network of Programs partnered with Stamford Police Department to embed mental health clinicians in the workforce. It has since expanded to Norwalk and Stratford. Other departments are working to adopt the program as well. The program aims to aid individuals outside the realm of law enforcement. The mental health clinicians, alongside Crisis Intervention Trained (CIT) officers, work in tandem to increase capacity and readiness to respond to emotional, psychiatric and general crisis calls. Since inception, at the Stamford Police Department, there has been an overall reduction in mental health related calls coming into 911 dispatch by approximately 30% in the first two years. Norwalk Police Department CRI has assisted in over 120 cases since it began in November 2022.

Similarly, CRI, Bridgeport Social Service and Police Department are collaborating to assist by responding to emergencies that require a trained civilian counselor instead of an armed officer.

In 2021, all five RBHAO's received funding through both DCF and DMHAS in order to implement and promote the state of Connecticut's five-year Suicide Prevention Plan (2020-2025) which aims to reduce suicide rates and promote overall suicide awareness. Much of this work is done through the Regional Suicide Advisory Boards.

RESOURCE GAPS AND NEEDS

Resource gaps and needs that emerged during this process are listed below, grouped by prevention, treatment, and recovery. These summarize a variety of issues raised by stakeholders, which are detailed in the appendix. Specific recommendations related to these needs appear in the following section of this report.

PREVENTION

To create and sustain a robust prevention infrastructure capable of effectively promoting mental health and preventing substance misuse, problem gambling, and suicide, much more funding is necessary. A study from RAND Corporation, among others, indicate that every dollar spent supporting best practices in prevention will save between $17 and $36 in treatment and addressing other negative consequences later on.[18]

The state's infrastructure for implementing community-level prevention efforts consists of 5 RBHAOs supporting Local Prevention Councils (LPCs) around the state. These community-based coalitions build local capacity to plan and implement substance use/misuse prevention strategies to reduce problem behaviors and associated negative outcomes for all ages. In 2019, the statewide priority substance was identified as vaping. As a result, LPCs have two goals they are required to focus on:

[18] The Benefits and Costs of Drug Use Prevention: Clarifying a Cloudy Issue | RAND

- Goal 1: Reduce vaping use rates by 5% by 2025 among 12–18-year-olds by targeting related risk and protective factors.
- Goal 2: Increase public awareness of vaping risks and prevention.

While all 14 towns in Region 1 have an LPC, only some receive enough funding to extensively meet these goals. Some LPCs receive other funding such as a DFC grant which allows them to focus on other behavioral health issues. However, the following factors are significant limitations:

- The state funding to LPCs ranges from $2,265.16 to $10,356.82 per community based on population from the 2013 US Census. An additional $5,000 mini-grants are currently available for opioid response. With that level of funding, many LPCs depend on volunteers to disseminate flyers, organize small-scale presentations, and do extremely limited awareness and fundraising. The LPCs that can affect change in social norms, policies or environment in their community are those that are able to receive other grants (e.g., DFC, Partnership for Success grant). Since the last priority report, this RBHAO has been able to assist in the formulation of Easton's LPC, resulting in all 14 towns within SW CT having their own designated coalition.
- While LPC's current focus is vaping, they are not able to use LPC funds for cannabis related efforts despite the recent legalization of cannabis, the increased use of cannabis in youth, and cannabis ranking as a higher priority in prior matrix rankings. LPC funds for cannabis can only be used if there is data to prove the connection between vaping and cannabis in that town.
- Allocate funding to meet the increased need in prevention related to other ATOD's outside of DMHAS' goal of vaping.
- As of 2019, the regional infrastructure was replaced by 5 RBHAO's, with less total staff per region yet an enlarged mission of supporting the state's 169 communities across prevention, treatment, and recovery in the areas of substance use, problem gambling, suicide prevention with the promotion of mental health across all ages.
- KIIs reflect gaps that persist in relation to postvention implementation, timely connection to care and accessibility of providers. Many report this is due to lack of awareness, capacity, specific funding and stakeholder buy-in.
- KIIs show that while there are resources for suicide intervention available, there are still frequent reports of waitlists and lack of availability of beds, which continues to place emergency departments, clinicians and those offering direct care under significant burden.
- Throughout the focus groups that the hub facilitated; stakeholders highlighted how isolation during COVID-19 pandemic was compounded with heightened rates of overdoses and subsequent overdose deaths. This is due to the fact that individuals were using substances alone, a known risk factor for overdose. Additionally, warm lines and hotlines were utilized at much higher rates during the months of the heightened pandemic.
- There is still limited regional data regarding the burden associated with gambling-related issues such as criminal justice and healthcare spending, job loss, bankruptcy, etc.
- There is limited quantitative data regarding the prevalence of problem gambling in SW CT, including among CT youth.
- There is a lack of gambling/problem gambling prevention programs in schools.
- There is limited quantitative data regarding the prevalence of cannabis in the state and in SW CT. This includes the lack of data collection of cannabis in reported overdose data, treatment admissions, hospital admissions and more.
- The loss of primary prevention focused on substance abuse and mental health was a concern due to funding opportunities focused on single substances. Participants voiced the

concern that we need to focus on the roots of prevention and community-based efforts addressing all substances while promoting behavioral health.
- Lack of behavioral health curriculum and discussion integrated in Pre-K through 12th grades.
- KIIs revealed that across all behavioral health topics, there remains significant barriers in preventative care for those who are non-English speaking, those who are under or uninsured, elderly and those who identify as LBGTQ+.
- Lack of partnership with the faith-based community.
- Focus groups that were conducted highlighted significant prevention barriers with respect to problem gambling. There was an overall sentiment that there is a lack of education, training opportunities, and resources allocated to this population, and a sense that problem gambling is often overlooked and misunderstood by the general population.
- In KIIs, potential confusion between "gaming" and "gambling" was discussed, and a need was identified for resources specific to youth to aid in understanding how gaming can lead to addiction. Informants saw a link between gambling and the pandemic due to increased isolation – people were able to increase gambling activity "virtually" without awareness of their friends or family.
- As community members have pointed out, campaigns by Big Tobacco, Big Pharma, Cannabis dispensaries, and other lobbying groups are extremely well funded and able to make their products and messages constantly visible to their target audiences. With increased resources, prevention in CT can provide alternative messaging to better educate the public and seek to change social norms.
- The need for systemic and capacity changes which would allow for routine compliance checks and retailer accountability would greatly reduce the risk to potential future target audiences of big tobacco.
- Now that Cannabis is legalized, we see a concern of reducing the harm from high-potency products, require products and establishments to display information about health risks, funding to go to cannabis prevention to prevent underage use, provide funding and empower law enforcement to evaluate suspected DUIs and conduct compliance checks.
- A RFW statewide campaign to educate and provide awareness around the initiative.

TREATMENT

The primary needs of behavioral health clients that are identified both by clients and by social services providers continue to be for *supportive services*, rather than treatment. Specifically:

- **Supportive and affordable housing** is cited as a critical factor to achieving or maintaining recovery and has been a top priority in the region for years. The lack of safe and affordable housing creates challenges for individuals, especially those recently in recovery. Sober homes and halfway houses vary across the region and state. While many of these homes support recovery efforts, others are not safe because of illicit substance use occurring in some homes.
- **Case management** is essential for individuals with complex and interconnected challenges to be able to navigate the variety of services and benefits that are possible, as well as for insured families seeking care for a loved one whose needs go beyond a therapist and/or psychiatrist. Virtual case management worked for some consumers but not for all as individuals had more responsibility in completing their own goals/case plans.

- **Wrap Around Services** are highly beneficial to clients in that they provide a more comprehensive, holistic approach to treatment.

- **Timely Access to Services** is essential for individuals actively trying to engage in treatment. Creating and providing a smoother and more efficient process will ultimately capture more clients.

Case Managers, Peer Support Specialists, Referral Coordinators, and Social Workers embedded in hospitals can provide needed wrap-around service to prevent repeated crises for individuals. They can also provide needed attention to decreasing waitlists for individuals seeking treatment; however, there is not enough sustainable funding or appropriate insurance reimbursement for these services.

Many key informants, including providers, health departments, social services and more, report that there is a lack in funding and sustainable structure for the workforce. There is difficulty in maintaining workers because there is very little to no capacity for appropriate compensation or salary wages. There is a competitive hiring market with other organizations offering high sign-on bonuses. There is difficulty in recruiting experienced and licensed clinicians. New graduates often do not have enough experience and require a lot of supervision. More support is needed for new graduates and students still in school so that they may receive more experience and training.

In terms of *resource gaps*, the number one challenge continues to be accessing prescribers (psychiatrists and/or APRNs) for medication. Currently, as a result of the lack of psychiatrists (not to mention the lack of bilingual psychiatrists and psychiatrists who take insurance), Informants reported that HUSKY-D was virtually the only insurance that offered viable options in regard to treatment providers.

Another key gap that was identified during KIIs was specific to the COVID-19 pandemic. During the pandemic, many providers relied heavily, if not solely, on delivery through telehealth. Many individuals in the region have limited to no access to the internet, little knowledge of Zoom or other virtual platforms and limited availability of technology. These factors acted as barriers for individuals to seek treatment. Many providers continue to use telehealth platforms and will do so for the foreseeable future. Rectifying access to technology is imperative in order to close that gap for those seeking treatment.

Treatment concerns continue to focus on the lack of one stop shop for behavioral health needs. It includes the lack of comprehensive services for mental health and substance abuse combined and offered by one service provider. Services for older adults are challenging in both the area of mental health and substance abuse. The greatest challenge discussed for this sub-population included that Medicare insurance creates several barriers for alcohol treatment, as well as therapists not covered for mental health care. This barrier is creating a lack of detox and in-patient care for older adult substance abuse treatment. An additional mental health barrier is older adults that have worked with a therapist and when their insurance changed to Medicare, their therapist is not accepted by Medicare or does not meet the Medicare requirements.

Many individuals are treated for a crisis through emergency rooms due to lack of awareness of community resources and services or waiting a significantly long time to be connected to services. After being discharged from emergency rooms, individuals are often not prepared for treatment or recovery on their own, potentially leading to another crisis. Many treatment providers have expressed that there needs to be more implementation of awareness of crisis services, such as hotlines, and a more time efficient process of connecting individuals with resources. There should be improvements to discharge planning by providing individuals with a handoff process. This should include treatment and recovery plans, community resources, housing and support services,

and case management and peer support services. Additionally, agencies should implement following up with client referrals to improve connecting clients to care.

Key informants also report that there is a lack of psychiatric beds and treatment beds for individuals. There is concern that there will be significant challenges in getting individuals to appropriate care with the anticipated closing of Norwalk Hospital's psychiatric unit. In general, there is trouble getting individuals to available beds in a timely manner. There is also a challenge that if someone is exhibiting severe mental illness or substance use, for example, pervasive psychosis or schizophrenia, then there are no appropriate places for these individuals to go.

Key Informants also discussed an overall lack of suicide prevention and treatment. Additionally, there was discussion surrounding the need for support prior to an individual reaching a point of crisis and needing to be hospitalized. There is a strong agreement between treatment providers for increased support and funding for treating co-occurring disorders by removing elicitability barriers (both in DMHAS-funded programs and at CVH). There should be more recognition and implementation of more integrated services of care for both SUDs and mental health disorders to break down silos of care.

The following treatment gaps have also been identified:

- No standardization of screening - especially for youth,
- Few programs work with parents to educate them on mental health and what to do if their child becomes suicidal,
- No First Episode Psychosis program in the region,
- No respite beds or peer respite for those with suicidal ideation or experiencing psychosis, which results in expensive hospitalization and rehospitalization, potential homelessness, and incarceration,
- No equivalent to DMHAS Young Adult Services for young people who are not DMHAS eligible,
- Not enough longer-term treatment beds for addiction,
- Not enough follow-up with individuals after discharge from emergency rooms or being referred to services,
- Probate referrals take about 3+ months and by then the person either isn't top utilizer anymore, or unfortunately lost their battle with addiction,
- Managed Medicare not covering any BH inpatient stays is a huge problem in the senior population. Can switch to regular Medicare if you haven't already used your 180 lifetime BH inpatient days,
- Not enough recognition and funding for treatment of co-occurring disorders,
- Proper equipment to hold teletherapy,
- Lack of or no resources for undocumented population,
- Transportation barriers to access treatment,
- Lack of understanding and treatment regarding the co-occurrence between homelessness, mental health, and suicidality,
- Lack of bi-lingual or multi-lingual staff and/or providers,
- Lack of treatment providers and options for new and expectant mothers,
- Lack of options for those who are uninsured or under-insured,
- Lack of connection among providers to better aid in the dual diagnosis process,
- No individual safety planning before a psychiatric crisis point is reached and emergency services are utilized. The public relies on 911 for mental health crises and needs to know of other options. More mental health clinicians should be implemented into police departments to handle these crisis calls,

- There is a lack of and/or inconsistent screening amongst treatment providers. Problem gambling can co-occur with SUD, especially AUD. Opportunities to address this may be missed when providers are not screening for problem gambling,
- There is a lack of immediate online support. When people are ready to access support, having an online option can be a viable option for some. For example, this could be an option when people call the 24/7 Help Line,
- In a focus group discussion, the need for gamblers anonymous (GA) virtual meetings was identified. There has been low attendance at one of the GA meetings in our region. Participants indicated that offering a virtual option may help increase participation.
- Long waitlists for individuals seeking treatment. Before the pandemic, individuals would typically wait less than a week to connect to services. However, post-pandemic, some waitlists have individuals waiting for two weeks or even months to connect to services. This leaves individuals without care despite them seeking care for a long time,
- Many non-profit providers, organizations and agencies are reporting being severely short staffed and in need of experienced clinicians as well as psychiatrists.

RECOVERY

In the area of recovery, several gaps in support services have been identified and are listed below:

- support for new mothers and those experiencing postpartum depression,
- support for those with suicidal ideation (e.g., Alternatives to Suicide support group, respite beds),
- SMART Recovery groups for adults over twenty-five, since existing groups are aimed at teens, young adults of family and friends,
- Mobile crisis efforts and other psychiatric responses being 24/7,
- more supports for those with co-occurring disorders,
- help in training and sustaining support group facilitators,
- job opportunities for certified peer specialists and funding for providers to hire them,
- support for families and loved ones of those struggling with substance use disorder, mental health and/or problem gambling,
- concept of the "7-day window" - need more of an emphasis of aftercare and check-in's following an individual's discharge from a treatment/recovery facility,
- Veyo is not always reliable and community providers don't offer monthly or daily bus passes any longer,
- More recovery support programs are needed as many clients do not have anywhere to go or have a team of support people when they become discharged from a treatment program.

UNDERSERVED POPULATIONS

The following is a list of underserved populations identified by stakeholders. In addition, continued attention should be paid to the elderly (at risk for alcohol and opioid misuse) and middle-aged populations who represent the largest population at risk of suicide and opioid abuse.

- The undocumented who fear risk of deportation or legal pursuit due to immigration status,
- Those with cultural/language differences,
- Middle-class individuals and families continue to face cost barriers in accessing services since they may be neither poor enough to qualify for state funded programs nor rich enough

to pay out of pocket. (For example, psychiatrists may charge a rate of $500/hour; co-pays for therapy can add up to $200+ in a month.),

- Individuals with autism or disabilities are often overlooked in the behavioral health system and assumed to be under the care of a developmental disabilities provider; however, many may have co-occurring mental health issues, and there are very few services available for adults on the spectrum,
- EMS and other first responders are at heightened risk for developing mental health conditions or SUD due to the trauma they endure by being the first people on call for psychiatric and emergency 911 calls. First responders were identified as an at-risk population during the COVID-19 pandemic.
- Essential workers have reported elevated mental health challenges, specifically depression and anxiety due to the distress of working during a pandemic.
- The underinsured or uninsured. Key informant interviews reflected that for those on HUSKY D, finding providers was difficult. Additionally, many providers have switched to being "Out-Of-Network", thus placing a further financial burden on those seeking treatment or behavioral health services.
- As reflected in the epidemiological profiles, the elderly populations (ages 65+) have reported increasing rates of mental health and suicidality in recent years. Lack of resources specific to the aging population as well as the potential technological barriers in accessing treatment provide added barriers for this population.
- Teenagers and youth were identified as individuals who are not aware of the abundance of resources available to them. There needs to be more outreach for this group and education to train youth on how to recognize mental health challenges in each other, encouraging a peer-to-peer support system, MHFA and QPR training.

RECOMMENDATIONS

The process of gathering quantitative and qualitative data throughout the year, producing epidemiological profiles, and generating priorities has resulted in the findings and recommendations presented in this section of the report. Below we identify the key findings and priorities and make recommendations for both the region and the state.

KEY FINDINGS

It's very clear throughout this process how interrelated mental health and substance use are despite siloes that often occur in agencies, policies, and programs. While most of the required epidemiological profiles presented in this report focus on individual drugs, in virtually all cases, individuals who misuse one drug also misuse others; the risk factors for misuse of any given drug include mental illness and use of other drugs; and the risk factors for mental illness include misuse of drugs. *Prevention work* therefore requires an understanding that mental health issues such as depression and anxiety underlie much, if not most, addiction. *Treatment and recovery from addiction* require attention to the individual's mental, social, and emotional health and coping skills. Similarly, *treatment and recovery from mental illness* are jeopardized when substance misuse or other addictive behaviors are used as coping skills.

TOP PRIORITIES FOR THE REGION

1. – Depression
2. – Anxiety

3. – Suicide
4. – Electronic Nicotine Delivery Systems (ENDS), vaping, juuling & Heroin and Fentanyl (both tied for fourth)
5. – Alcohol
6. – Trauma/PTSD
7. – Tobacco
8. – Marijuana and Prescription Drug Use (both tied for 8th)
9. – Serious Mental Illness – Children
10. – Serious Mental Illness – Adults
11. – Problem Gambling
12. – Cocaine

With this understanding, our regional data workgroup identified **depression** as the top priority for the region. This report included mental health disorders since mental health overall was determined as the number one priority for the region for the last two reports. Mental health emerged as the most important area to address for the last two reports for multiple reasons: mental illness affects the most people, it creates a significant burden, it is associated with all the issues the behavioral health community is trying to prevent (suicide, drug misuse, problem gambling), and it is getting worse. Addressing people's mental health struggles improves their health and reduces their need for unhealthy coping skills such as use of ATOD's. Depression is increasing dramatically among young people as well as increasing among adults. This was a large concern during the COVID-19 pandemic as depression was seen largely in everyone across the lifespan. Depression is one of the most reported mental health disorders and can be very serious as it interferes with everyday functioning, can lead to risky behaviors such as substance use, gambling and thoughts about suicide.

Anxiety was identified as the second priority for the region. Depression and anxiety are co-occurring in many individuals and are often diagnosed together. Anxiety and depression are the most reported mental health disorders. Anxiety is seen in many people's everyday lives, but severe anxiety can interfere with an individual's ability to function and complete daily life tasks. Anxiety diagnoses are being identified in younger children.

Suicide was identified as the third priority for the region, with importance of addressing the effects of COVID-19 on everyone in the region. Although CT DPH reported a decrease in suicides in 2020 during the height of the COVID-19 pandemic, rates have risen again in 2021. There has been a large focus on the youth population, but the rate was highest among the 65+ age group in 2021. Suicide's consequence of inaction for region 1 was ranked a 4.8 which was the highest out of all problems (see priority report matrix in appendices). Suicide is a key area to address due to the impact it has on the health of the community as well as those around the individual. Addressing suicide can contribute to mental health as well as the use of drugs and substances.

OTHER PRIORITIES AND CONCERNS

The other priorities identified in our regional process included:

Electronic Nicotine Delivery Systems (ENDS), vaping, juuling ranked fourth as a regional priority. ENDS use remains a large concern among youth and young adults. School surveys in region 1 conclude that ENDS use and vaping are largely done among youth, especially in high school but are being tried by youth as young as middle school. Connecticut still allows for flavored ENDS and vapes to be sold. Although the legal age to purchase these products is 21, tobacco compliance checks in region 1 have concluded that many are being sold illegally to those under 21. LPCs,

continue to work to reduce vaping rates among youth ages 12 through 18. Perception of harm for vaping is low due to tobacco companies targeting youth. In addition, many youths are unaware of the ingredients, namely nicotine, that are in vapes and can result in dependency. Further, studies show that vaping is still a dangerous form of nicotine use as well as other substances, such as marijuana. While surveys show a general decrease in vaping during COVID, there's a significant increase in smaller populations in youth/young adults, possibly indicating addiction.

Heroin and Fentanyl also ranked fourth in the regional priorities. Current trends and data indicate that people have been moving away from Heroin and into synthetic fentanyl analogs. According to focus groups conducted by The Hub, fentanyl continues to be a serious concern. There are many deadly synthetic forms of fentanyl that are created, including carfentanil. Oftentimes, individuals are accessing poly-substances, a mix of drugs (cannabis, alcohol, Xanax, cocaine, xylazine, etc.) including fentanyl. Fentanyl continues to be mixed or cut in many other substances, sometimes even outside of the knowledge of the individual who may be using said substances. Additionally, fentanyl can be pressed to look like typical prescription pills, contributing to the increase of counterfeit drug overdoses that are rising in our state. Xylazine, a veterinary tranquilizer used for animals, has begun to rise in polysubstance use among individuals in the region and was discussed as a large concern among the regional data committee. According to DPH from January to December 2022, 85.4% of confirmed fatal drug overdose involved fentanyl. Fentanyl is now the leading substance showing up in drug overdoses across the state and in the Southwestern region.

Alcohol was identified as the fifth priority for the region, due to its widespread use at all ages. Among underage youth, alcohol is commonly used, particularly in dangerous situations such as binge drinking and drunk driving. The region had seen an uptick in alcohol usage during the COVID-19 pandemic which resulted in coalitions creating a successful alcohol awareness campaign. Alcohol for youth has remained an easily accessible substance and has a low perception of harm. It has also been reported that parents/caregivers are allowing their youth to drink for many reasons excluding the social host law. Recent findings continue to reflect that Southwestern CT's past month binge drinking is higher than the other DMHAS regions and the states average. According to key informants, in the 2022 Community Readiness Survey (CRS) for SW CT, alcohol was identified as the problem substance of greatest community concern for adults ages 26 and older. Through the Hub's KII's there was concern over the lowering of adult perception of alcohol risk in underage youth resulting in an increase in parents/caregivers hosting parties and serving alcoholic beverages to underage youth. In some local towns, parents/caregivers are consuming alcohol on school property during youth school and athletic activities, normalizing this behavior.

Cannabis and Prescription drugs ranked eighth in our priorities however, these two substances are a big discussion and focus on our region.

Marijuana use overall is increasing, which is risky since the potency of vaped marijuana is very high and can lead to serious side effects including hospitalizations. Since legalization of Cannabis, we are seeing through youth surveys and KIIs the decreased perception of harm and increased access to youth and young adults, who are at higher risk since their brains are still developing. Poison Control has seen an uptick in calls due to accidental ingestion of cannabis products such as gummies and other candies that look appealing to a child.

Prescription drugs have been a contributor to overdose deaths and intentional suicides in the region. This area is important because reducing the prescription and misuse of legal opioids helps reduce the number of people who turn to illicit opioids such as heroin. Recent reports reflect an increase in substances being laced, or cut, with highly potent synthetic opioids such as fentanyl.

Xylazine, a veterinary tranquilizer, has also emerged and is seen in many substances. There is an emerging concern around youth and the use of counterfeit prescription drugs (i.e., Xanax, Adderall). Through KIIs, many college students are experimenting with counterfeit substances and purchasing from social media and black market instead of getting a prescription. Many people in our state have been revived by naloxone or died not knowing that the substance was laced. This past year, DEA put out several press releases warning everyone that there has been an increase in overdoses due to cocaine and fake prescription pills being laced with Fentanyl. Most recently they sent out a warning on xylazine and how it's being laced in all drugs as well.

The **opioid** epidemic requires ongoing attention to heroin and fentanyl as well as prescription opioids.

RECOMMENDATIONS FROM PRIORITIES PROCESS

Below we present recommendations for behavioral health work across the continuum of prevention, treatment, and recovery in the region in the coming two years, as well as a separate set of recommendations to the state. Each set of recommendations is presented in the form of a table, to align with DMHAS requirements and permit comparison across regions. These tables show recommendations for prevention, treatment and recovery in the areas of substance misuse, mental health, and problem gambling. Because of the interrelated nature of these issues, we have added a fourth row to each table, providing recommendations that cross all these areas of behavioral health.

TABLE 2. RECOMMENDATIONS FOR SOUTHWEST CT (REGION 1)

Problem/Issue	Prevention	Treatment	Recovery
Substance Abuse/Misuse	Adapt and share locally developed campaigns throughout the region to address common priorities (e.g., alcohol, prescription drugs, counterfeit drugs, vaping/ENDS). Priorities include raising awareness among families about the social hosting law (Cannabis & Alcohol) and working to reduce binge drinking in young adults and across the lifespan. Support the ongoing development of a regional pool of youth trained to conduct alcohol and tobacco compliance checks. Support LPCs, police and the state's Tobacco Use Prevention and Control Program in conducting environmental scans to identify community retailers that sell illegal products or sell to minors. Support and provide resources to alcohol and tobacco/ENDS/vape retailers in the region. Provide education about the impact of cannabis on the developing brain and safer alternatives for coping with stress. Monitor consequences associated with use of cannabis (including vaping), high potency THC and CBD oil. Implement awareness and educational campaigns for adult use cannabis, safe storage, and illegal underage sales of products to youth. Implement prevention strategies for youth use.	Work with key stakeholders (e.g., CHIPs, CCTs, housing providers) to problem solve around alcohol use disorder, particularly among people who are not ready for treatment. Educate physicians and community members about the value of MOUD and other evidence-based practices and resources, as well as on non-medication alternatives for treatment (e.g., yoga, reiki, massage therapy, acupuncture, etc.). Create a work group of stakeholders and legislators to discuss improvements to medical/possible legalized cannabis programs including reviewing operations of regional dispensaries and giving feedback. Treatment needs to be expanded for children/teens. Raise awareness about use and risks associated with benzodiazepine medications, including support for those wishing to discontinue their use and alternatives for coping with anxiety. Expand and offer services and resources, such as bed availability and crisis mobile lines, during late night hours and weekends. Focus on the continuum of care and wrap around care for individualized options and approaches.	Encourage sober houses to meet national standards for recovery residences and be listed on the CT Addiction Services website. Raise public awareness about the CT Addiction Services website. Continue to provide Naloxone training throughout the region and distribute Narcan kits. Expand access to peer support such as Recovery Coaches and SMART Recovery groups in both community and provider settings. Implement support beyond the crisis by providing individuals with plans, tools, and connections to resources after being discharged from an emergency room. Improve updates on bed availability websites to be more accurate. Maintaining use of Telehealth as it has proved to be helpful in connecting with individuals and providing more options for individuals whose first language isn't English, and individuals with technological difficulties. Continue to outreach and certify within Region 1 the RFW initiative by connecting with local businesses and organizations.

	Convene prevention specialists and providers to discuss expanding their SUD screening program to incorporate MH, suicide, tobacco, vaping, and problem gambling using the regionally developed screening tool.[19] Support community-level prevention around ATOD based on CADCA's 7 strategies for change. Raise awareness to community at large with pharmacies that can provide compliance packaging or "blister packs." Continue to promote medication drop-off boxes at local police stations and select pharmacies throughout the year and especially during DEA's drug take back days. Increase in funding for the implementation of prevention and treatment strategies, especially to raise awareness and education on perception of harm of substance misuse. Assist LPCs in supporting schools to embed behavioral health curriculum in health classes. Continue to provide Naloxone training and Naloxone kits to the community at large. Incorporate and promote harm reduction strategies and trauma-informed care. These include safe injection sites, availability of FTS and access to testing substances. Increasing environmental scans of local retailers as well as compliance checks to be performed on a more consistent basis.	Simplify and unify the process of connecting individuals to services. Raising awareness of available resources and services to communities. Hire more bi-lingual or multi-lingual providers for Spanish, Creole, and Polish speaking individuals. Continue to highlight availability of life saving tools such as Naloxone and FTS. Engage people in recovery in the process. Offering more cessation programs for vaping and cannabis use in teens and young adults which should also address potential underlying mental health symptoms or conditions. Continue to promote the already existing teen vaping cessation support. MOUD should be prescribed as you leave the hospital after an overdose, or if you are diagnosed with an opioid use disorder and leaving in-patient medical of psychiatric unit. "Addict" is still too common in our print vocabulary- We all must update all documents (including written and virtual) to reflect our commitment to anti-stigma language and reflect recovery friendly terminology. Assist in the promotion of restorative practices in school settings when a student is caught vaping or in possession of alcohol or paraphernalia.	Create a Statewide RFW campaign to build awareness and education regarding recovery friendly workplace Supporting RFW certified organizations with regular and updated resources. Encourage communication with employees about the availability of the EAP and related treatment and health and wellness services and options. Educate employers about the appeals process for an employee that had tested positive. Encourage and provide training annually for all employees and supervisors related to RFW certification. Assurances of "exit with dignity" if it becomes necessary for an employee to leave his/her employment. Assist employers in seeking out a liaison or a person in recovery to support other colleagues who may be in recovery or battling addiction. All Providers Need to check the "language" they are using on their websites and in print. "Addict" is still common to vocabulary- Need to update to more recovery friendly terminology. We need to update website and other material content to integrate "recovery friendly" language and raise awareness about Recovery Friendly Communities and Workplaces.

[19] 8dc1cb_e12e5f8e447b47899fa4b9fc84d385e1.pdf (thehubct.org)

	Increase awareness, training and implementation of SBIRT (Screening, Brief Intervention, and Referral to Treatment). Encourage LPCs and other prevention partners to pool funding to build capacity and have a consistent message. Educate Primary Care Providers in Depression Management, Mental Health First Aid, screenings and early interventions. All Providers Need to check the "language" they are using on their websites and in print. "Addict" is still common to vocabulary- Need to update to more recovery friendly terminology. Continue to raise awareness around prescription drugs, the risks of misuse and education around overdose prevention, specifically related to opioids and benzodiazepines. Work with LPCs and communities to build and maintain programs that encourage safe use, safe storage and safe disposal of prescription drugs Naloxone education should include an emphasis on "mainstreaming". Prevention needs to focus on reducing the shame and stigma associated with this drug among the general public. A statewide RFW campaign to educate and provide awareness around the initiative.	Naloxone should be co-prescribed for people who are on long-term chronic pain management. Better engagement and communication with discharge planners	Recovery Coaches in Courts with people before they are arraigned. Better engagement and communication with discharge planners

Problem/Issue	Prevention	Treatment	Recovery
Mental Health (suicide and mental illness)	Continue coordination among all five Regional Suicide Advisory Boards so as to ensure consistency in training, messaging and best practices. Train new QPR trainers, including Spanish, Creole, and Polish speakers, to increase regional capacity to provide suicide prevention training. Advocate for social-emotional initiatives, such as Free Play, coping skills curricula (e.g., 4 What's Next), and anti-bullying programs, starting in elementary school. Promote social-emotional support and coping skills to the general public through media campaigns, community outreach, and expansion of support groups. Ensure that all schools (K-12) and colleges in the region publicize the new Suicide and Crisis Lifeline; 988. Coordinate & promote Mental Health First Aid, QPR, SafeTALK, ASIST, and other educational programs. Promoting and utilizing early behavioral health screening tools, ideally with a universal tool; and standardizing mental health screening to identify symptoms earlier. Encourage and assist regional towns to create a postvention planning team. Coordinate and implement more awareness campaigns, focusing on stigma reduction and conversations around suicide. Provide more mental health and QPR training for educators, first responders and	Support regional efforts to address timely access to treatment, including access to medication (e.g., open access models, telehealth, cooperative agreements among providers, evening/weekend hours, co-locating clinics at shelters). Continue to highlight alternatives to 1:1 treatment as many people cannot get connected to that level of care due to waitlists. Increase awareness of free peer support groups such as Alternatives to Suicide. Encourage open lines of communication, specifically between town postvention teams and school specific postvention teams to collaborate in the event of an untimely death taking place. Improve discharge planning and community connections from hospitals by providing client feedback about the handoff process, reviewing facility protocols about informing clients, and educating inpatient BH providers about community resources for treatment, housing, supportive services, case management, and peer support services. Consider incentives to agencies for following up on client referrals and successfully connecting clients to care. Support education for primary care providers and shelter/housing providers to better understand and serve mental health and trauma. Create a First Episode Psychosis program - in Region 1. Expand and offer services and resources, such as bed availability and crisis mobile	Identify mechanisms to create sustainable sources of facilitators and facilitator training for MH and SUD support groups such as NAMI, SMART, etc. Coordinate efforts to create postpartum depression support in the region. Expanding use of Certified Peer Recovery Specialists, including exploring using RSSs for a mobile MH outreach program (similar to the Homeless outreach Team model). Continue to advocate for a peer respite in the region to divert people from hospital stays. Form more community partnerships, specifically with faith communities. Create more efforts towards subgroups and underserved populations in awareness, treatment and education. Maintaining use of Telehealth as it has proved helpful in connecting with individuals and providing more options for individuals who English is not their first language, and individuals with technological difficulties. Additional peer-to-peer programming. Increase options for psychiatric residential programming. Identify support groups for compulsive disorders.

more mental health first aid training to the community at large.

Creation and awareness of more COD programs and resources.

Prevention efforts should be more all-encompassing and inclusive of co-occurring disorders.

Continued and consistent promotion of warmlines and helplines, specifically 988.

Engagement among stakeholders within "high risk" groups so as to cater services to fit their unique needs.

Require standardized screening tools to be used within all schools so as to ensure consistency and accuracy of findings.

Increase engagement with parents surrounding mental health. Offering training and informational sessions about "warning signs" and "clues" for mental health as well as available resources specific to parents and caregivers.

Continuously disseminating information on mental health crisis resources and postvention best practices.

Continue to imbed social workers into police departments.

Increase efforts to decrease mental health stigma.

Increase awareness around lethal means.

Create a statewide Mental Health anti sigma campaign.

lines, during late night hours and weekends.

Coordinate and implement more follow-up check-ins with individuals one week following discharge.

Hire more bi-lingual or multi-lingual providers, particularly for Spanish, Creole, and Polish speaking individuals.

Provide more mental health and suicide services of support in emergency rooms.

Increase the number of services and awareness of support for young adults and families.

Increase availability and support staff of psychiatric beds as well as inpatient and rehabilitation beds.

Warm hand-offs to community providers.

Mental Health Recovery Support Services and Recovery Coaches engaged in the Emergency Departments.

More available inpatient youth and adolescent treatment.

Identify and promote agencies that have treatment for eating disorders / Bigorexia.

	Youth Mental Health First Aid Training is provided to HS students grades 10- 12. One option would be teams of two instructors who provide the training through existing health classes for entire grade level. Build awareness and educate the community about eating disorders and bigorexia.		
Problem Gambling	Continue to promote public awareness of CT Problem Gambling hotline. Develop and implement a Strategic and Action plan using the results of the Logic Model and Seven Strategies for Community Change completed at the CADCA Gambling Awareness Boot Camp in Feb 2023. Increase awareness of using Play Responsible van for community events (e.g., schools, colleges, health fairs, etc.). Build capacity to reach high risk groups. Increase membership diversity on the Regional Gambling Awareness team. Instill gambling awareness into BH activities throughout the region. Provide awareness and education about gaming addiction for parents and youth. Create and provide more widespread and available training on problem gambling. Develop a 12-month multi-modal communication plan that includes messages related to gambling awareness under prevention, treatment and recovery (include social media, mainstream media, newsletters etc.)	Educate providers about gambling and gaming. Increase number of providers who screen for problem gambling using the Brief bio-social Gambling Screening tool. Use the SPF *process* to develop a logic model, strategic and action plan to address treatment and recovery gaps. Provide more resources and services as well as dedicated groups to this population. Especially housing, and digital detox services. Coordinate a schedule for the Play Responsible van to visit treatment providers in our region. Investigate online gambling treatment support. Identify effective ways to address physical withdrawal, especially suicidality. Develop a 12-month multi-modal communication plan that includes messages related to gambling awareness under prevention, treatment and recovery (include social media, mainstream media, newsletters etc.)	Investigate and identify interest and capacity for an online GA support group in our region. Partner with CCAR and for a regional event during Recovery Month. Develop a 12-month multi-modal communication plan that includes messages related to gambling awareness under prevention, treatment and recovery (include social media, mainstream media, newsletters etc.) Increase awareness and opportunities to support gambling awareness at local and state levels.

	Increase awareness and opportunities to support gambling awareness at local and state levels.	Increase awareness and opportunities to support gambling awareness at local and state levels.	
Problem/Issue	**Prevention**	**Treatment**	**Recovery**
Systems: Integration across Behavioral Health	Coordinate region-wide educational efforts--including videos and digital toolkits--that integrate messaging around MH, SUD and PG. Invest in social media buys to reach a bigger audience on Instagram, YouTube, Tik Tok & Facebook. Encourage use of integrated BH screening tools. Continue outreach to various BH providers and invite them to CAC meetings to minimize silos. Make recommendations for improved and/or integrated data collection around MH, SUD and PG, to include hospital / emergency room data, self-injury data, information on non-fatal overdoses, etc... Encourage providers to take a more holistic approach to treatment, i.e., addressing *both* mental health and substance misuse equally.	Ensure info about language support (e.g., Language Line) is posted visibly in multiple languages and with graphics in hospitals and provider agencies. Disseminate "Get Help" poster and resource flyers throughout region in varying locations to increase visibility. Continued campaigns throughout the region promoting messages of 988, "You Are Not Alone" etc. Highlighting areas where attempts have, or may, take place, such as train platforms. Advocate for increased dissemination and explanation of client rights information at provider facilities. Provide information and education to pharmacists about behavioral health resources in the region. Explore with treatment providers the resources for and needs of pregnant and parenting clients. Implementation of co-occurring disorders treatment, especially for individuals with a substance use disorder and problem gambling disorder. Workplaces should be encouraged to update EAPs and revise as needed to assure people are offered appropriate length of treatment and specialists.	Encourage and plan for increased use of peers and Community Health Workers to provide community outreach and support around BH. Advocate for legislation to make certified peer support a reimbursable service. Create SMART Recovery group for adults. Explore creating new support groups for those with COD, such as Double Trouble in Recovery. Work with interested towns or cities to become Recovery-Friendly Communities and workplaces. Continued legislative advocacy to ensure funding for behavioral health programs is sustained.

TABLE 3. RECOMMENDATIONS FOR THE STATE

Problem/Issue	Prevention	Treatment	Recovery
Substance Abuse/Misuse	Provide training and support for youth compliance inspections in the region, including point-of-sale ID checks, to prevent youth under age 21 from purchasing tobacco/ENDS/vape products and alcohol. Require all liquor retailers to be TIPS trained. Supporting establishments in offering this training. Support legislation to require blister packaging to prevent diversion of medications (initiated by Communities 4 Action). Increase in funding for the implementation of prevention and treatment strategies, especially to raise awareness and education on perception of harm of substance misuse. Recognition and implementation of more integrated services of care for both SUD and MH to break down the silos of care. Increase the utilization of stigma reducing language in publications surrounding substance use disorder. Create and implement statewide protocols and policies to mandate and regulate compliance checks in retailers.	Increase available resources, especially longer-term programs, detox beds, drug, and alcohol counselors. Ensure that treatment providers are fully capable of addressing co-occurring mental illness. Increase in-network MOUD providers. Provide more treatment options for uninsured or under-insured individuals. Expand and offer services and resources, such as bed availability and crisis mobile lines, during late night hours and weekends. Continue to highlight where individuals can obtain harm reduction tools such as fentanyl testing strips and Naloxone Nasal Spray. Providing additional treatment options for those who do not speak English. Increase trauma, grief and PTSD integrated services and treatment. Increase in psychiatric staff and services for medication management. More services and support for groups at a higher risk of developing a mental health condition or substance use disorder including veterans, older adults, teens, LGBTQ+	Develop a certification process to ensure safe and affordable sober homes throughout the state. Review functioning of Access Line and make recommendations to improve its service. Maintaining use of Telehealth as it has proved helpful in connecting with individuals and providing more options for individuals who English is not their first language, and individuals with technological difficulties. Statewide Recovery Friendly Workplace campaign through various streams of communication such as radio, online and billboards. Leveraging tax credits, bonding programs, and partnerships (e.g., with treatment, recovery support, and workforce organizations; problem-solving courts; and other public or private entities) to facilitate the identification and onboarding of people with or in recovery from substance use disorder and/or to meet the needs of current employees affected by addiction to ATODs. Develop and implement innovative approaches for recruiting and creating employment opportunities for people in or seeking recovery, such as second-chance and supported employment models (like Individual Placement and Support) for people with or in recovery from SUD. Implement more recovery support programs as a way to enhance treatment programs to support individuals in adjusting to a fully independent life.

Problem/Issue	Prevention	Treatment	Recovery
	Creation of statewide recognized youth survey with policies and procedures. Expand mobile crisis services and hours. Support and promote statewide campaigns such as the counterfeit drug campaign youthinkyouknowct.org, Mention Prevention, LiveLOUD, beintheknowct etc. Increase access to naloxone as an over the counter non-prescription. To have 24/7 behavioral health crisis centers for SUD, mental health, and suicide response as alternates to hospitalization. These centers can be utilized by first responders and mental health providers as a referral to support stabilization of community members while in a crisis other than using the local hospital's emergency department. Stakeholders feel that timing and accessibility of recovery treatment options is paramount to the success of these harm reduction and recovery focused initiatives. Increase the number of behavioral health and substance use treatment providers that serve the LGBTQI+ population, Women related issues, as well as Black, Indigenous, and People of Color (BIPOC) in the suburban areas. Increased support and concern for the wellbeing of those working in the behavioral health field to prevent burnout. Prevention should be a line item in the state budget. RBHAOs should receive	individuals, undocumented individuals, uninsured individuals, individuals in which English is not their first language, those who are homeless or experience unstable housing, and other marginalized groups. With the legalization of recreational marijuana use for people 21+, there will be a need for more treatment- The current workforce is overwhelmed, and we are already experiencing 3–5-week lag time on appointments with private providers. We will need more clinicians. Clinicians will need support. Develop an incentive program to increase clinical provider pool. - such as student loan forgiveness for both DMHAS/DCF funded but also for private clinicians who are willing to take Medicaid clients Does CT have treatment on demand ???	More affordable recovery houses. Increase utilization of models that support "warm handoffs." Promote and support an increase in school-based health centers.

Problem/Issue	Prevention	Treatment	Recovery
	state funding designated to enhance the prevention infrastructure in each region. Support the effort to require a portion of cannabis tax dollars be allocated to prevention in local communities. Provide cannabis prevention dollars to focus efforts on -reducing the harm from high-potency products, -advocating for required products and establishments to display information about health risks, -funding to go to cannabis prevention to prevent underage use, -support and encourage law enforcement departments to provide appropriate and adequate training so officers can evaluate suspected DUIs and conduct compliance checks.		
Mental Health (suicide and mental illness)	Assist in compiling local data about the nature and extent of suicidal attempts and self-injury. Gaining a better understanding of the extent of regional non-fatal attempts. Promotion of mental health curriculum, specifically Gizmo, in grade schools to begin and normalize discussions surrounding the topic at an early age. Support legislation to ensure social-emotional curriculum and positive school climate K-12.	Ensure that treatment providers are fully capable of addressing co-occurring substance misuse. Consider converting one of the region's Community Support Program (CSP) teams into an ACT team. Continue to disseminate timely and accurate information surrounding mental health to combat misinformation via "pop psychology". Ensure providers are assisting individuals in identifying and highlighting their protective factors, especially in instances of safety planning.	Develop peer respite programs throughout the state to reduce hospitalizations. Implement more peer support services. Offer more long-term case management after crises happen. Implement after care plans and/or follow up calls upon patients discharge from a psychiatric facility.

Problem/Issue	Prevention	Treatment	Recovery
	Advertise available resources, services and training, and make the process of getting connected with information easier and more efficient. Assist with communication and collaboration among resources. Recognition and implementation of more integrated services of care for both SUD and MH to break down the silos of care. Create partnerships with local communities such as faith organizations and educators to offer mental health and suicide training. Continue to bring awareness to "high risk" groups such as elderly individuals, veterans, LGBTQ+, indigenous individuals, new and expecting mothers etc. And identify resources applicable to them. Ensure appropriate and personal first language is highlighted and disseminated in training, flyers, awareness efforts etc. Work to address irresponsible and uninformed portrayals of suicide and mental health on media channels. Implementation of Peer-Run respites. Provide notification when an adult has died untimely or by suicide. Ensure that safe messaging and best practices are adhered to in the event of an untimely death to ensure the safety of loss survivors.	Address the lack of state-funded youth beds in the region. Develop a First Episode Psychosis program in the region. Improve discharge planning and community connections from hospitals by providing client feedback about the handoff process, reviewing facility protocols about informing clients, and educating inpatient BH providers about community resources for treatment, housing, supportive services, case management, and peer supports. Consider incentives to agencies for following up on client referrals and successfully connecting clients to care. Offer more resources, services and trainings in more languages, especially Spanish. Expand and offer services and resources, such as bed availability and crisis mobile lines, during late night hours and weekends to decrease emergency department usage. Develop an incentive program to increase clinical provider pool. - such as student loan forgiveness for both DMHAS/DCF funded but also for private clinicians who are willing to take Medicaid clients	

Problem/Issue	Prevention	Treatment	Recovery
	We need a statewide campaign focused on mental health and wellness and a separate one tackling STIGMA (Like Change the Script)		
Problem Gambling	Continue to offer training programs for community prevention specialists. Advertise available resources, services, and training. Implement more awareness campaigns, particularly with more children and youth involved.	Continue research to measure changes in prevalence and to better understand the impact of problem gambling on CT's communities.	Ensure that problem gambling support is available in multiple languages. Implement more peer support services.
Systems: Integration across Behavioral Health	Integrate messaging about MH, SUD, and PG to fight stigma, raise awareness of the interrelatedness of these issues, and promote wellness. Develop videos, webinars and digital tool kits that can be disseminated statewide. Invest in social media buys to reach a bigger audience statewide on YouTube & Facebook. Revisit SBIRT screening program to integrate MH, Suicide, Tobacco, Vaping and Problem Gambling; consider using integrated Mental Wellness screening tool developed in region 1.	Increase support for Co-Occurring Disorders treatment by removing eligibility barriers (both in DMHAS-funded programs and at CVH) where individuals are told their MH needs are too severe for a SUD program and vice versa. Also expand capacity to treat individuals with BH disorders and physical co-morbidities. Create incentive programs or other meaningful policy changes to increase the number of bilingual / multilingual providers as well as staff cultural competence. Conduct a statewide campaign to raise awareness of available treatment resources and physician understanding of MOUD.	Increase supportive housing services for the BH population. Current housing policies and programs aimed at ending homelessness do not always best serve individuals with a mental illness or addiction. Expand case management resources across programs, including making existing programs less restrictive (e.g., open CSP to those with an SUD primary diagnosis). Revisit benefits policies and job programs to reduce barriers to employment. Conduct an external evaluation of existing peer support training programs by Advocacy Unlimited, the CT Coalition for Addiction Recovery, and Mental Health America to crosswalk the content areas and develop best-practices training. Support legislation to make peer support a reimbursable service.

Problem/Issue	Prevention	Treatment	Recovery
		Improve Veyo or find another transportation service. Explore ways to incentivize providers to accept private insurance and Medicaid. Maintain Telehealth services post-pandemic for individuals to maximize opportunities for care and services. Offer telehealth services in multiple languages and provide technological support for those with limited technological access or knowledge. Expand and offer services and resources, such as bed availability and crisis mobile lines, during late night hours and weekends. More funding and sustainability to the workforce structure. Providing more job opportunities for case managers, social workers, and peer support specialists.	
	Remove siloes and integrate programs and structures, for example: • Ensure that all relevant state agencies are represented on the Behavioral Health Planning Councils and involved in cross-agency planning. • Work creatively with housing providers to address the need for affordable, supportive housing. • Expand the Alcohol and Drug Policy Council (ADPC) to include and address mental health and problem gambling. • Coordinate suicide and opioid response across DCF, DMHAS and DPH. • Use DPH training materials about the NORA app and the CPMRS rather than develop separate training modules. Work with DOC and DMV to develop legitimate alternative form of identification in order to remove barriers to care for the undocumented. Explore creating slots for case management from the General Funds (as is done in Maryland), to be allocated for individuals with very high need regardless of ability to pay. Such funds could be used to support individuals with multiple comorbidities or young adults presenting complex issues but ineligible for DMHAS's Young Adult Services program due to their insurance or family status.		

Problem/Issue	Prevention	Treatment	Recovery
	Ensure information and websites are available in multiple languages. Continue to utilize Microsoft Teams as a meeting platform to reduce travel time and save programs on mileage reimbursement. Regionalize conferences and training to maximize participation across the state.		

APPENDICES

PRIORITY RANKING MATRIX FOR REGION 1

SCALE: 1=Lowest 2=Low 3=Medium 4=High 5=Highest

PROBLEM	Magnitude	Impact	Changeability	Capacity/ Readiness	Consequence of Inaction	Mean Ranking Score:	RANK
Alcohol	**4.8**	**4.4**	**2.8**	**2.8**	**3.5**	**3.66**	**#5**
Tobacco	**3.1**	**3.6**	**3.5**	**3.4**	**3.4**	**3.4**	**#7**
Electronic Nicotine Delivery Systems (ENDS), vaping, juuling	**4.1**	**3.9**	**3.3**	**3.5**	**3.7**	**3.7**	**#4**
Marijuana	**3.7**	**4.0**	**2.9**	**2.6**	**3.6**	**3.36**	**#8**
Rx Drug Misuse	**2.8**	**3.7**	**3.2**	**3.3**	**3.8**	**3,36**	**#8**
Heroin and Fentanyl	**2.9**	**4.5**	**3.2**	**3.4**	**4.5**	**3.7**	**#4**
Cocaine	**2.4**	**3.2**	**2.3**	**2.2**	**3.7**	**2.76**	**#12**
Problem Gambling	**3.2**	**3.7**	**3.1**	**2.1**	**3.6**	**3.14**	**#11**
Suicide	**3.0**	**4.5**	**4.0**	**3.3**	**4.8**	**3.92**	**#3**
Anxiety	**4.7**	**4.0**	**3.9**	**3.1**	**4.0**	**3.94**	**#2**
Depression	**4.7**	**4.4**	**3.7**	**3.0**	**4.4**	**4.04**	**#1**
Trauma/ PTSD	**3.5**	**4.2**	**2.9**	**2.5**	**4.0**	**3.42**	**#6**
Serious Mental Illness Children	**2.7**	**3.8**	**3.0**	**2.7**	**4.2**	**3.28**	**#9**
Serious Mental Illness Adults	**2.7**	**3.8**	**2.8**	**2.4**	**4.2**	**3.18**	**#10**

REQUIRED STAKEHOLDER QUESTIONS

HOW *APPROPRIATE ARE AVAILABLE SERVICES TO MEET THE NEEDS* OF SUBSTANCE USE, MENTAL HEALTH AND PROBLEM GAMBLING IN PREVENTION, TREATMENT AND RECOVERY?

Substance Use:

Prevention

- Appropriate services vary from town to town based on the range of funding available. For some schools, services are not at all appropriate.

Treatment

- Somewhat appropriate to appropriate. The 1115 waiver created many obstacles for individuals seeking substance use treatment services. Clients will have to prove that they have exhausted all other avenues of recovery, including going to the hospital, before going to a detox center. Additionally, only master's level clinicians are able to facilitate this, but many organizations are staffed with bachelor's level clinicians.
- In many cases, individual treatment has been successful. For many in recovery, a recovery group and community has been extremely supportive and helpful.
- Regional reports reflect a shortage in services specific to cessation for vaping.
- Less than appropriate. More services are needed. The services that are available are adequate, but many are stretched thin.

Recovery

- Adequate to appropriate. While there are numerous services available throughout the region, many report that SUD treatments and resources fail to address both SUD and mental health as they traditionally identify a "primary" or "presenting" problem.

Mental Health (combined with Suicide):

Prevention

- Somewhat to less than appropriate. While mental health is now at the forefront of many conversations, there is still not enough mental health education, especially in schools. More mental health training is needed for the community and especially for teens.

Treatment

- Somewhat appropriate. More services in general are needed. The services that we do have are appropriate. Waitlists for individuals to receive treatment are too long and have gotten significantly longer post-pandemic. Individuals can be waiting from two weeks to two months.
- Not at all appropriate. With staffing shortages and barriers to psychiatric services, it is difficult to meet the treatment needs of the community.
- With the potential closing of more psychiatric beds in our region, there will not be enough psychiatric beds available in a timely manner.
- Somewhat appropriate. There are not enough inpatient beds or rehabilitation beds. Some individuals face additional challenges if their conditions are deemed too acute. There are not enough long-term beds or shelter beds.

Recovery

- Somewhat appropriate.
- Some recovery treatment plans are too strict and complex and can present more barriers to an individual.
- Many report a heightened and unaddressed need for intermediate care services. Expansion of mobile crisis hours, engagement between social workers and social service directors and increased 988 awareness are cited as areas for improvement.

Problem Gambling:

Prevention

- In prevention, 42% said that available services are somewhat sufficient, and others said less than sufficient.

Treatment

- In treatment, professionals felt available services were somewhat sufficient.
- There is not enough treatment of co-occurring disorders for individuals with problem gambling and a substance use disorder.
- Many believe there are not enough services in general. More providers and organizations/agencies need training to be able to include services in their programs.

Recovery

- In recovery professionals stated that available services were somewhat sufficient.
- Support groups are far and few in between.

WHAT *PREVENTION* PROGRAM, STRATEGY OR POLICY WOULD YOU LIKE TO MOST SEE ACCOMPLISHED THIS YEAR RELATED TO SUBSTANCE USE, MENTAL HEALTH, AND PROBLEM GAMBLING?

Substance Use:

- More safe injection sites and more access to testing substances. More harm reduction strategies and approaches to the community.
- More cannabis prevention.
- Implementation of Peer-Run Respites.
- Naloxone vending machine.
- Vaping awareness and substance use programming and curriculum taking place during school hours.
- Additional training on social host laws.
- More frequent environmental scans.
- Increased awareness, training, and implementation on SBIRT.

Mental Health & Suicide:

- More mental health training for first responders to better equip them in how to respond to a potential behavioral health crisis.
- More social workers in police departments and hospitals so that individuals can get connected to services directly.
- More support groups or spaces offered to teens and adults.
- Permanency in telehealth services.
- More mental health youth initiatives in schools are needed to increase knowledge and skills in youth. Early screenings are needed.
- We need more of a community-wide strategy and "village" approach to mental health.
- Statewide youth survey for data collection.
- Continued use of harm reduction.
- More efforts to decrease stigma.
- Standardization of mental health screening - *especially for youth and young adults* to identify symptoms earlier.
- Increased awareness surrounding lethal means.
- Additional peer-to-peer programming.
- Increase in financially accessible treatment options.
- More psychiatric residential programming.

Problem Gambling:

- Increased overall funding for problem gambling. This can be done through increased and continued education as well as stronger connections to Gamblers Anonymous.
- There is a reported need for consistency of screening when it comes to problem gambling.
- Many report that there needs to be more equality when discussing problem gambling, mental health, and substance use.
- More awareness and outreach to those providing direct services to the community.
- More data collection.

WHAT *TREATMENT OR SERVICES DO YOU FEEL ARE UNAVAILABLE OR INADEQUATELY PROVIDED RELATED TO SUBSTANCE USE, MENTAL HEALTH AND PROBLEM GAMBLING?*

Substance Use:

- Trauma, grief and PTSD integrated services and treatment. More services are needed for individuals who live with trauma or who are grieving.
- Not enough peer support. We need more integration and sustainability of Peer Support Specialists. A Peer- Run Respite would fill a gap in our services system.
- More support is needed in relation to cessation programming.
- There is a need to educate retailers on substance misuse and sale to minors. This can be done through additional LPC funding or collaboration with local health departments. Additional compliance checks and environmental scans can assist in informing this work.
- Need for teen support services.
- More financially accessible treatment.
- Additional residential services and long-term rehabilitation.
- Increased awareness and accessibility of medication options.

Mental Health & Suicide:

- There is a lack of services overall. The nonprofit workforce is not strong or sustainable enough to meet the behavioral health needs of the community.
- Not enough peer support. We need more integration and sustainability of Peer Support Specialists. A Peer- Run Respite would fill a gap in our services system.
- There are not enough psychiatric and medication management services.
- The crisis service system is not adequate. The public relies on 911 for mental health crises and first responders are not trained, equipped or supported enough to properly respond. The public needs to be aware that there are more options than 911 and police departments need social workers to support them. Many continue to cite waits and shortages for inpatient treatment which can be traumatizing and detrimental to individuals in acute mental health crises.
- There is not enough follow up or wrap around care for individuals as well as appropriate discharge plans.
- Not enough services provided to non-English speakers.
- Lack in awareness surrounding the purposes and goals of postvention planning. Through this education, there must also be an emphasis on partnership and collaboration among stakeholders.

Problem Gambling:

- Currently, many individuals cite a massive gap in the number of services offered to those struggling with problem gambling compared to mental health and substance use.
- Some report that there is a lack of consistency in screening for Problem Gambling.
- A universal screening tool Needs to be developed
- What *adjunct services/support services/recovery supports* are most needed to assist persons with substance use, mental health and problem gambling issues?

Substance Use:

- More Peer Support Specialists, case managers, referral specialists.
- More recovery support programs versus actual treatment programs. Many individuals have nowhere to go after treatment and have a hard time adjusting to life again, especially if they don't have an established support system.
- Allow individuals to engage in multiple services.
- More recovery houses that are affordable.
- More life skills and job training for individuals and their families in recovery.
- More support for families and loved ones of an individual struggling.
- Increased utilization of models which support "warm handoffs."
- Promotion of assets such as school-based health centers.

Mental Health & Suicide:

- Access to psychiatric services. There are not enough psychiatric services in the region and there are too many barriers to access what available; especially for people with Medicaid or Medicare who need medication management.
- More funding and sustainability to the workforce structure is needed. Organizations are having difficulties recruiting and retaining experienced, licensed clinicians to work. More case managers, social workers, and peer support specialists are needed.
- Longer hours for mobile crisis response.

- Support and enhancement of individual protective factors including stable housing, income, accessibility of resources to prevent people from ever reaching a mental health crisis point.

Problem Gambling:

- More postvention and recovery support groups.
- Reported services needed include:
  - Online counseling services
  - Immediate online support
  - Increased number of Gamblers anonymous virtual meetings
  - Education on how gambling affects the physical brain.

WHAT WOULD YOU SAY ARE THE *GREATEST STRENGTHS/ASSETS* OF SUBSTANCE USE, MENTAL HEALTH AND PROBLEM GAMBLING PREVENTION, TREATMENT AND RECOVERY SERVICES IN YOUR REGION?

Substance Use:

Prevention

- There is more recognition of substance use disorder struggles and conversations around prevention. Further, public perception of harm in relation to substance misuse reflects the success of local prevention programs and awareness campaigns.
- Local Prevention Councils are a huge asset to the region. The decrease in the reported rate of vaping region wide reflects the success in their efforts.
- More agencies are open to harm reduction and trauma-informed care.

Treatment

- Strong network of peer providers who collaborate (work)with each other.
- More recognition and treatment of co-occurring disorders. Around half of the agencies in our region provide substance use and mental health services in one location.
- Public entities are working together, including nonprofit and private sectors.
- There remains high community promotion of resources for individuals with substance use disorders, especially among town coalitions and subman services.

Recovery

- The community and camaraderie of peers in recovery help to keep each other engaged.
- The availability and the strength of peer support groups.

Mental Health & Suicide:

Prevention

- Mental health is at the forefront of conversations and there is more awareness and engagement now than ever.
- The hospital CHIPS are incredibly impactful.
- There are many collaborative efforts which take place between towns and across the region which support and promote suicide and mental health awareness.
- The emergence of resources such as 988 open up conversations surrounding mental health and assist in the connection to care.
- There is an abundance of knowledgeable partners within the region surrounding mental health and suicide. Many of these individuals come from diverse personal and professional backgrounds and can offer new perspectives, insight and ideas.

Treatment

- Social workers in hospitals and in police departments help people connect directly to services, providing wrap around care. Clinical partnerships as a whole are cited as regional assets due to their knowledge and passion which drives their work.
- There are more mental health workers in spaces including schools, hospitals, police departments and more.
- There is a strong network of stakeholders in the region, many of whom stay connected to help with referrals and updates of resources.

- Community meetings are incredibly helpful for the exchange of resources and information.
- Programming offered at regional hospitals including Greenwich Hospital and Silver Hill hospital.

Recovery

- Mental health workers are the biggest advocates for their clients throughout treatment and into recovery.
- Many regional towns have, or are in the process, of establishing postvention response teams to as to support suicide loss survivors should an untimely death occur.

Problem Gambling:

Prevention, Treatment, Recovery

- We have the Regional Gambling Awareness team whose members:
  - represent across the spectrum – prevention, treatment, recovery, advocacy,
  - consistently attend and actively participate in meetings,
  - volunteer to help with and/or participate on different initiatives such as: Problem Gambling Awareness; Month Planning, Problem Gambling Services Prevention Initiative-Community Anti-Drug Coalitions of America (CADCA) Gambling Awareness Boot Camp training, and recruiting people for the Connecticut Council Problem Gambling initiative-Power Up Parent and Power Up Player pilot
  - are ambassadors for awareness and where to seek help, as noted by meeting updates,
  - bring in new members,
  - consistently share new resources e.g., research, new presenters, new initiatives,
  - regularly access the expertise of other members and partners on events.
- The state's 24/7 Problem Gambling hotline is an important resource.
- In Region 1, the Caribe program has developed a gambling-informed youth group and created a culturally appropriate PSAs for public use.
- The Brief Biosocial Gambling Screen has been integrated into the Mental Wellness Screening tool used in Region 1 by several hospitals and providers, municipal social services, and colleges, as well as during The Hub's annual community screening initiative. This integrated screening tool should be used more widely.

ARE THERE PARTICULAR *SUBPOPULATIONS (FOR EXAMPLE: VETERANS, LGBTQ, LATINOS, ETC.)* THAT AREN'T BEING ADEQUATELY SERVED BY THE SUBSTANCE USE, MENTAL HEALTH AND PROBLEM GAMBLING SERVICES IN YOUR REGION?

Substance Use:

- Veterans, older adults, LGBTQ+ individuals, teenagers, individuals who are uninsured or underinsured, individuals who are homeless or face housing instability, those with lower income, undocumented individuals, people who do not have access to technology or phone plans and people who do not have the means of transportation.
- Not enough services available in: Spanish, Creole and Portuguese.
- Refugee and immigrant youths.

Mental Health & Suicide:

- Veterans, older adults, LGBTQ+ individuals, teenagers, individuals who are uninsured or underinsured, people who do not have access to technology or phone plans and people who do not have the means of transportation. Not enough services available in: Spanish, Creole, and Portuguese.
- Marginalized communities, especially Black and Brown communities.
- Refugee and immigrant youths
- Pregnant women and/or new parents
- Transitional adult.
- Those who are homeless or have unstable housing.

Problem Gambling:

- Latino individuals
- Black individuals
- Indigenous individuals
- LGBTQ+ individuals
- College students

WHAT ARE THE *EMERGING* PREVENTION, TREATMENT OR RECOVERY ISSUES THAT YOU ARE SEEING OR HEARING ABOUT IN SUBSTANCE USE, MENTAL HEALTH, AND PROBLEM GAMBLING ISSUES?

Substance Use:

- Fentanyl is increasing everywhere and being mixed with so many different substances. Even an individual using may not realize there is fentanyl in their supply.
- Cannabis is everywhere and young people are obtaining it in illegal ways, especially through social media.
- More treatment programs are allowing people to drug test their supply before using their drugs and it is a helpful harm reduction technique.
- There are more high THC cannabis products and some cases of fentanyl laced cannabis. Many kids are having panic attacks, psychosis or getting extremely ill.
- More youth are Zyning.
- Disposable devices with higher nicotine content have gone down in price, thus becoming more appealing to youth.
- Products advertised as "tobacco free" and still contain nicotine.
- Acetate, a CBD derivative, has been reported locally and is known to be highly addictive, contains hallucinogenic property and causes EVALI.
- More people are smoking Hookah as a "social habit" and often dismiss the potential harm.
- Increases in the number of reports of older adults misusing prescription medication.
- Increase use of crack, and PCP.
- Increase in cocaine use.

Mental Health & Suicide:

- nonprofit organizations are struggling with workforce sustainability. Waitlists are incredibly long.
- individuals are just not aware of mental health services in their community.
- We have a housing crisis and people who are homeless are struggling with mental health conditions.
- Some people who have a mental health condition are also struggling with hoarding disorder. This can affect the individual and the community as it may pose complicated and dangerous situations. older adults are struggling with this.
- Huge increase in anxiety and depression.
- stakeholders relay that youth and young adults self-report increases in symptoms a feeling of anxiety, loneliness and suicidal ideation in recent years.
- Reports of pop psychology can, and had, led to the spreading of misinformation and self-diagnosis in relation to mental health.
- Continued mis portrayal of suicide and mental health via media channels. This is detrimental to those struggling themselves as well as suicide loss survivors as it spreads harmful and inaccurate information.

Problem Gambling:

- Many people report seeing an increase in gambling and having advertisements that fail to recognize the dangers. The lack of a gaming commission makes it difficult for regulations to take place.
- Attendance at Gamblers Anonymous meetings is low.
- Overall accessibility of gaming specific treatment is low and there are often few treatment centers that deal with problem gambling; especially when compared to mental health or substance use.

WHAT ARE THE *OPPORTUNITIES REGARDING PROVISION OF SERVICES THAT AREN'T BEING TAKEN ADVANTAGE OF* (TECHNOLOGY, INTEGRATION, PARTNERSHIPS, ETC.)?

Technology:

- It would be useful for DMHAS to develop more webinars and digital toolkits that could be disseminated statewide.
- Continuation of Telehealth.

Integration:

- At the RBHAO level, DMHAS encourages the integration of mental health and substance use services, including problem gambling. At the same time, separate programs at the central level continue to foster silos. Co-planning and integration of policies / funds at the central level would be helpful in making these efforts more efficient at all levels. For example:
  - Problem gambling plans, funds and required activities are separate from other regional activities despite the overlap in stakeholders and populations served.
  - ADPC efforts such as the Recovery Friendly Communities model could incorporate mental health along with substance use.
  - Contracts funded through specific grants, such as opioid money, should encourage the integration of general behavioral health efforts while still ensuring that the primary focus is on the targeted subject.
- Screening initiatives such as SBIRT should integrate mental health, substance use, and problem gambling using existing tools.
- The existing peer specialist training curricula used by the CT Community for Addiction Recovery (CCAR) and Advocacy Unlimited (AU) should be evaluated by an external stakeholder and integrated so that *all* certified peers are given adequate training related to mental health, substance use, and problem gambling and can competently provide support and referrals as needed. Consideration should be given to the use of the national peer certification curriculum developed by Mental Health America.
- Mobile crisis should be integrated across the lifespan. (Recommendations have been made in this regard by CACs in the past.)
- Streamlining the process of connecting to resources so it is accessible and easier to navigate.
- Encouragement of certification through RFW to promote messages of awareness, prevention, treatment and recovery.
- Offering sustainable and long-term funding for mental health so many of the existing efforts can continue.
- Some report that as professionals we are not constantly infusing services. Instead, we are making services seasonal. – what does this mean

Partnerships:

- Coordination across state agencies, such as the Department of Children and Families (DCF) and DMHAS, is critical to reduce duplication of efforts, improve efficiencies, and maximize funding. The CT Suicide Advisory Board is a very successful example. Other opportunities include:
  - The Joint Behavioral Health Planning Council should serve more of a planning function and less of a report-out function. It should ensure that all parties serving individuals with behavioral health needs are represented across state agencies.
  - DCF and DMHAS could seek to integrate their treatment of youth in the 16- to 18-year-old age group.
  - The Department of Public Health (DPH) and DMHAS are both working on suicide and opioids. These efforts could be jointly planned and coordinated at the state level, with the plans and resources be disseminated to the regions through the RBHAOs, which would then coordinate with local health departments.
  - The NORA app developed by DPH has training of trainers and handouts that could be used in all the regional Narcan trainings, rather than different regions and communities developing their own.
  - CDC pilots an Academic Detailing program for Health Districts. They will educate prescribers on modules related to CT Prescription Monitoring and Reporting System (CPMRS), Narcan, & Communication (patient, prescriber, dispenser). This education should be connected to the work of the RBHAOs and LPCs.
- Materials developed for community use should involve community stakeholders in the planning and review. For example, some Change the Script materials did not provide sufficient space for local resources and phone numbers.
- Stronger connections with Gamblers Anonymous are needed.
- Professionals report seeing a need to infuse state community colleges with Problem Gambling agencies now that the community colleges are all united. They suggest increased collaboration as a way to provide resources and information.
- Report that professionals and the President of the state community colleges need to collaborate on a wide range of to work together.
- Mental health support for providers. There is too much burn out in the profession.
- Connection between town entities and Local Prevention Councils.
- Bridging the gap between school systems and LPCs to discuss vaping and other behavioral health topics.
- Reinforcement of cessation programming at a state and national levels as a high priority.

WHERE ARE THE AREAS THAT SERVICES CAN BE IMPROVED? WHAT CAN BE DONE DIFFERENTLY?

Substance Use:

- Increasing consistent compliance checks to retailers
- Creation and implementation of statewide protocols and policies to mandate and regulate compliance checks across CT.
- Provide substance use curriculum and resources to align with existing class content.
- Increase the availability of hybrid services.
- Increase clientele in treatment planning process.
- While in general, it was cited that more long-term case management services are extremely successful when helping those with substance use disorders. That being said, they are scarcely available and it is suggested that the frequency and overall number of long-term case management programs for substance use increase.

Mental Health & Suicide:

- Increased communication among prevention, treatment and recovery providers.
- Offer more mental health services targeting those who are persistently ill.
- Expansion of social workers embedded in police departments to more regional towns
- Support related to process improvement.
- Standardization of screening tools so there is a more uniform approach to diagnosis and treatment.
- undocumented citizens as well as non-English speakers continue to be largely underserved in regard to mental health. Increasing cultural awareness and overall competence in the DMHAS Service System will allow for gaps of understanding to lessen. Trauma-informed care for clients was another suggestion when dealing with these populations. Increasing the number of bilingual staff in the DMHAS Service System and in local providers as well.
- School based health centers which highlight the importance of physical and mental wellbeing are needed in order to combat the high rates of mental health among youth populations. Mental health training for both educators and those employed by educational institutions will assist in this as well.
- Peer respite should also be encouraged more as this approach has high success rates. Additionally, peer support assists in bridging the gap between hospitalization and those struggling with suicidality.

Problem Gambling:

- It was found that many people are largely unaware of any services DMHAS offers in relation to Problem Gambling. This can also be used to reflect the general lack of knowledge and understanding surrounding the symptoms and signs of someone who is struggling with problem gambling.
- Increase the number of Local Prevention Counsels who receive presentation on Gambling 101.
- Increase the number of places where people are exposed to gambling awareness messages.
- Secure more funding for prevention so that there is the manpower to increase, coordinate and implement gambling awareness.
- Increase the social media footprint. Develop social media campaigns throughout the year.
- Develop additional partnerships e.g., partner with community college associations. Partner with them
- Ensure messages are in multi languages.
- Increase the number of Tx providers who infuse gambling screens in their Intake process and where needed, refer to Better Choice.
- Educate providers about the connection between gambling and other SUDs.
- Provide incentives, e.g., training, funding for time limited collection of data (which could be used to get a better picture of prevalence of problem gambling in the region).
- Attendance numbers at Gambling Awareness meetings in our region are low.
- Meet with other support groups such as AA and ask if they will advertise Gamblers Anonymous and Gambling Awareness meetings.
- Meet with Recovery and Sober Housing to share information about Gamblers Anonymous and Gambling Awareness meetings.

OTHER INFORMATION OUTSIDE OF THE REQUIRED STAKEHOLDER QUESTIONS:

Problem Gambling:

According to a teen Gambling Awareness focus group:

- A lot of teens are gambling, talking about gambling/betting, and it has become a new big interest. Specifically, through sports betting. Gambling is being seen as the norm because teens are watching celebrities gamble through Twitch- a streaming service, live stream. Teens are watching celebrities win (The rapper, Drake, was streaming on Twitch)
- Teens report that the best way to reach youth about gambling awareness is through social media, specifically Instagram.
- Teens suggested that the messages sent to youth about gambling awareness should be to only bet what you can, self- control, and to go in with a plan and know your amount. The teens suggested self-control because many youths believe that losing big amounts and finding themselves in doubt would never happen to them. Therefore, they don't recognize the harm.
- It was also reported that football betting has become the easiest type of gamble for youth. Basketball betting is the most consistent type of "family fun".