# 2024-25 Regional Priority Report: Region 1(Southwestern CT)

## Developed by RBHAO: Catalyst CT | The Hub

# Table of Contents

**Executive Summary** ..... 3
**Contributors** ..... 7
**Abbreviations and Acronyms** ..... 10
**Introduction** ..... 13
- **Background** ..... 14
- **Data Sources** ..... 15
- **Description of Prioritization Process** ..... 18
- **Strengths and Limitations of This Report** ..... 21

**Regional Profile** ..... 24
- **Description of the Region** ..... 24
- **Subpopulations in Region 1** ..... 28
- **Emerging Issues** ..... 34
- **Regional Strengths, Resources, and Assets** ..... 39
- **Regional Resource Gaps and Needs** ..... 45
- **Other Needs Assessments and Funding** ..... 51

**Priorities and Recommendations** ..... 55
- **Regional Priorities** ..... 61
- **Recommendations** ..... 64
- **Regional Goals** ..... 67

**Conclusion** ..... 71
**Appendices** ..... 73

# Executive Summary

As the Regional Behavioral Health Action Organization (RBHAO) for Southwestern Connecticut, Catalyst CT | The Hub is tasked every two years by the Connecticut Department of Mental Health and Addiction Services (DMHAS) Prevention & Health Promotion Division to carry out a regional needs 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 Catalyst CT | 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 partners.

The profile and data will be used as 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/misuse and other behavioral health problems.

• To support leveraging 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.

This report serves as a foundational tool for DMHAS, state and municipal partners, coalitions, funders, and providers to understand and respond to behavioral health needs across Region 1. The 14 towns of this region—Bridgeport, Darien, Easton, Fairfield, Greenwich, Monroe, New Canaan, Norwalk, Stamford, Stratford, Trumbull, Weston, Westport, and Wilton—represent a diverse cross-section of Connecticut, spanning urban, suburban, and wealthy enclaves. The overall profile offers the 14 communities of Catalyst CT | 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. The 2024–25 Regional Priority Report fulfills multiple purposes:

- Establishes behavioral health priorities across substance use, mental health, suicide, and gambling.
- Highlights disparities affecting subpopulations including BIPOC, LGBTQIA+, youth, older adults, and individuals with co-occurring disorders.
- Provides evidence-based recommendations rooted in a SMARTIE (Strategic, Measurable, Ambitious, Realistic, Time-bound, Inclusive, Equitable) framework.
- Guides community-level planning, systems coordination, funding strategies, and legislative advocacy.

The assessment process drew from diverse data sources including statewide epidemiological profiles, local youth surveys, key informant interviews, stakeholder and community surveys, and 2025 regional focus groups. The Catalyst CT team facilitated a structured prioritization process through its Regional Priority Workgroup (RPW), incorporating voices from prevention, treatment, and recovery sectors.

Both qualitative and quantitative findings were organized into topic-specific profiles and assessed using weighted prioritization criteria: magnitude, severity and impact,

changeability, capacity/readiness, and consequence. This ensured a data-informed, equity-driven approach to selecting regional priorities.

**Key Findings**

Region 1 continues to face significant behavioral health challenges:

- **Mental health needs,** especially among youth, young adults, and LGBTQIA+ populations—have escalated, with rising rates of anxiety, depression, suicidal ideation, and isolation.
- **Substance misuse** remains pervasive. Cannabis and alcohol are highly normalized among youth and adults, while stimulant-related and polysubstance overdose deaths have surged.
- **Adult alcohol use and gambling** are under-acknowledged despite mounting evidence of harm, particularly among men aged 18–34.
- **Systemic gaps,** including workforce shortages, inadequate crisis response, poor care coordination, and lack of culturally competent services—create barriers across all levels of care.

Focus groups underscored that residents who are low-income, undocumented, uninsured, or housing-insecure are disproportionately affected by structural barriers and often excluded from timely care.

**Emerging Trends**

Several cross-cutting issues were identified as emerging and urgent:

- Rapid increases in stimulant-related overdose deaths and intentional poly substance use.
- Escalating loneliness and digital dependency, particularly among youth and older adults.
- Gaps in gambling prevention, screening, and treatment—especially for youth and college-aged individuals.

- Burnout among providers and critical staffing shortages, particularly among bilingual and BIPOC clinicians.
- Widespread concern about the sustainability of prevention and outreach efforts as federal pandemic-related funding declines.

**Strengths and Assets**

Region 1 is home to a wide range of prevention, treatment, and recovery resources, including over 30 behavioral health providers, peer recovery networks, mobile outreach units, and integrated school-based mental health initiatives. Cross-sector collaboration remains a regional strength, exemplified by active regional Local Prevention Councils (LPCs), Suicide Advisory Boards (RSAB), Gambling Awareness Teams (RGAT), Cannabis Awareness Team (RCAT) and Recovery Friendly Workplace initiative.

Local efforts, including youth-led coalitions, Question, Persuade, & Refer (QPR) suicide prevention training, and cannabis compliance enforcement, reflect a high degree of community readiness and innovation. These assets form a strong foundation for implementing the recommendations outlined in the report.

**Regional Priorities and Recommendations**

The 2025 Regional Priority Report identifies ten core priority areas, including:

- Youth mental health and suicide prevention
- Adult alcohol misuse
- Stimulant use and polysubstance overdose
- Culturally competent and linguistically accessible care
- Gambling prevention and intervention
- Crisis response and care coordination
- Social determinants of health—particularly housing, transportation, and affordability

Accompanying each priority is a set of SMARTIE-aligned goals and action steps for prevention, treatment, and recovery. These are tailored to underserved groups and aligned with both regional strengths and current system gaps.

It was concluded that the top priorities of the region are, in descending order, 1. Mental Health 2. Suicide 3. Heron & Other Illicit Opioids 4. Alcohol 5. Vaping & ENDS 6. Prescription Drugs 7. Problem Gambling 8. Cannabis 9. Tobacco 10. Cocaine & Other Stimulants. The number one priority, Mental Health, had a total ranking score of 64.25, whereas the second and third were close with Suicide 55.85 and Heroin & Other Illicit Opioids 54.8. The Regional Priority Workgroup (RPW) 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. Alcohol was ranked fourth by the RPW due to under-acknowledged despite mounting evidence of harm. The Hub plans to work with community partners and coalitions to address Mental Health and Suicide and to continue to address the opioid crisis.

Behavioral health in Region 1 is shaped by structural inequities, extreme economic pressures and disparities, shifting cultural norms, and evolving public health challenges. This report reflects the voices and experiences of thousands of community members, providers, and partners across the region. It is both a planning tool and a call to action: to prioritize equity, reduce stigma, and build resilient, connected systems of care for every resident of Southwestern Connecticut.

## Contributors

We sincerely thank everyone in our region for your ongoing support, dedication, and the valuable insights you have shared with us throughout the year. Whether through meetings, focus groups, key informant interviews, work groups, committees, training, or events, your involvement has been essential in helping us identify the region’s strengths, needs, concerns, and service gaps. Your feedback has directly informed us of the recommendations included in this report.

We also extend our heartfelt appreciation to B. Weyland Consulting LLC for their vital partnership in completing the various needs assessments for Region 1. Their expertise, professionalism, and attention to detail were instrumental in ensuring a comprehensive and high-quality assessment process. We are grateful for their collaboration in helping shape the priorities reflected here.

Over the past several months, Catalyst CT's The Hub team has worked diligently to collect, analyze, and synthesize data into a strategic plan focused on the behavioral health needs of our region. This includes areas such as substance misuse, problem gambling, mental health, and suicide prevention. We hope this report will serve as a valuable tool to guide prevention, treatment, and recovery efforts across Region 1.

The Catalyst CT staff members who played a key role in the development of this report include:

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We would especially like to extend our gratitude to the members of our Local Prevention Councils (LPCs), Gambling Awareness Team, Regional Cannabis Awareness Team, Regional Suicide Advisory Board (RSAB), Recovery Friendly organizations, and the Regional Priority Workgroup for their invaluable support throughout this process.

Many of our partners participated in focus groups and/or completed the statewide priority survey, both of which played a significant role in shaping the insights shared in this report.

We are particularly thankful to the following individuals from these groups who helped review the prioritized needs and provided thoughtful feedback on the recommendations:

Rachel Vogt, CADC, Liberation Programs

Brian Morris, Recovery Network of Programs

Daniella Arias, MPH, Liberation Programs

# Abbreviations and Acronyms

| | |
|---|---|
| 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 |
| CTSD | Connecticut State Department |
| 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 |

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|---|---|
| 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 |
| GBTA | Greater Bridgeport Transit Authority |
| 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 |
| LGBTQIA | Lesbian, Gay, Bisexual, Transgender, Questioning, Intersex, and Asexual |
| 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 | Post Traumatic Stress Disorder |
| QPR | Question, Persuade & Refer |
| RBHAO | Regional Behavioral Health Action Organization |
| RCAT | Regional Cannabis Awareness Team |
| RGAT | Regional Gambling Awareness Team |
| RSAB | Regional Suicide Advisory Board |
| RSS | Recovery Support Specialist |
| RFW | Recovery Friendly Workplace |

| | |
|---|---|
| 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 |
| SMARTIE | Strategic, Measurable, Ambitious, Realistic, Time-bound, Inclusive, and Equitable |
| 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 |

# Introduction

The purpose of this Regional Priority Report is to identify and communicate the most pressing behavioral health needs across Southwestern CT (SW CT). Developed by Catalyst CT | The Hub, the designated Regional Behavioral Health Action Organization (RBHAO), this report serves as a tool to inform statewide planning, guide local prevention efforts, and support data-driven decision-making. By incorporating input from a wide range of community partners—including Local Prevention Councils (LPCs), service providers, advocacy groups, and individuals with lived experience—we aim to reflect a comprehensive understanding of the region's behavioral health landscape.

This report is organized into several key sections:

1. **Overview of the Assessment Process** – Describes the methods used to gather data, including surveys, focus groups, and stakeholder engagement.
2. **Regional Data Snapshot** – Provides demographic and behavioral health data that set the context for identifying local needs.
3. **Prioritized Regional Needs** – Highlights the top behavioral health priorities identified through data analysis and community input.
4. **Recommendations** – Offers strategic recommendations for addressing the prioritized needs through prevention, intervention, and systems-level collaboration.
5. **Acknowledgments** – Recognizes the partners and contributors who supported this process.

This report is intended to be a living document used by state agencies, local coalitions, planning groups, policy makers, service providers, foundations, all community partners and applicants for funding—to align efforts, strengthen collaboration, and promote equitable access to behavioral health services across the region.

Regional reports serve several important purposes, including:

- **Establishing priorities** for populations in need of behavioral health prevention, treatment, and recovery services.

- **Identifying emerging trends, projecting future needs**, and highlighting existing health disparities.
- **Guiding the development** of comprehensive strategic plans.
- **Raising public awareness** about substance use and other behavioral health issues within the community.
- **Supporting efforts to secure funding** by providing data-driven justification for resource allocation.
- **Fulfilling data requests** from stakeholders such as providers, educators, funders, media, and policymakers.
- **Improving the diversity and responsiveness** of planning and advisory groups by encouraging more representative membership aligned with regional priorities.

## Background

Every two years, the Connecticut Department of Mental Health and Addiction Services (DMHAS) 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 prioritize recommendations for prevention, treatment, and recovery services.

The RBHAO Regional Priority Report is designed to:

- 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 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 elevated risk for, substance use and mental health problems, suicide, and problem gambling in the regions and who need primary and secondary prevention, treatment, recovery, 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 that are underserved or at increased risk for behavioral health issues, and make recommendations on addressing regional gaps and needs, as well as health disparities.

## Data Sources

This Regional Priority Report draws from a diverse range of quantitative and qualitative data sources to provide a comprehensive understanding of behavioral health needs across the region. The use of multiple data types enhances the depth and reliability of the findings, offering both measurable trends and rich community perspectives.

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 Data Haven as part of the Community Health Needs Assessments, focus groups, key informant surveys, and the 2022 Community Readiness Survey conducted by Catalyst CT | The Hub.

**State-Level Data:** This report draws on a variety of Connecticut-based data sources, including Mobile Crisis Intervention Services (MCIS), 2-1-1 call data, the Connecticut School Health Survey (CSHS), the Behavioral Risk Factor Surveillance Survey (BRFSS), accidental overdose death data from the Department of Public Health, mortality data from the Office of the Chief Medical Examiner (OCME), and treatment admission data from DMHAS. The statewide stakeholder survey represents a hybrid approach, offering both quantitative ratings with some open-ended questions. It provides a broad view of perceived community needs from a range of partners and is particularly helpful for ranking priorities and identifying themes.

**National Data:** 2024 U.S. Census Bureau

**Qualitative Data:** A range of qualitative information enriches the report with community-based perspectives and lived experience knowledge. These include:

Focus groups conducted with community members and partners:

- Regional Suicide Advisory Boards (RSABs),
- Local Prevention Councils (LPCs),
- Regional Cannabis Awareness Team (RCAT),
- Regional Gambling Awareness Team (RGAT),
- Recovery Friendly Workplace (RFW) certified agencies, and
- Key informant interviews with behavioral health consumers and providers,
- Partner discussions during LPC meetings and subregional gatherings.

These data sources offer essential insights into emerging needs, community priorities, service gaps, and barriers to care particularly for populations that may be underrepresented in traditional quantitative datasets. Their strengths lie in their

timeliness, depth of context, and inclusivity. However, they may be limited by small sample sizes, varied data collection methods, and the potential for subjective interpretation.

Additionally, these sources shed light on patterns of service utilization, health behaviors, and rates of morbidity and mortality related to behavioral health. Their value stems from their consistency, comprehensive scope, and ability to track trends over time. Nonetheless, limitations such as delayed data release, inconsistencies in reporting, and underreporting, especially among individuals less likely to access formal services, should be acknowledged.

**Figure 1. Data Sources and Uses**

| Data Source | Strengths *(and/or Purpose/Value)* | Limitations *(and What/Who is Missing)* |
|---|---|---|
| Latest Data and Research of Region 1, CT (Census Bureau; CT State Department (CTSD) data; survey data) | Provides a broad overview of regional behavioral health trends, integrating state and local findings. | Our regional data can lack granularity for subpopulations and rapidly evolving issues. |
| Locally Accessed Data (Suicide Advisory Boards, Gambling Awareness Teams, surveys, etc.) | Reflects real-time, community-based perspectives; can identify gaps not visible in state-level data. | There is some inconsistency in data collection across towns, and there are no standardized reporting methods across the board. |
| Epidemiological Slide Deck Data | Offers standardized, quantitative indicators useful for trend analysis and regional comparisons. | Primarily quantitative; does not capture community context or lived experiences. |
| 2023-24 LPC Youth Survey Results | Captures youth voice directly; includes local school data on substance use and mental health. | Limited to youth populations; excludes adult, elderly, and out-of-school youth perspectives. |
| Center for Prevention Evaluation and Statistics (CPES) Stakeholder Survey Results | Reflects system-level insights from providers and stakeholders across sectors. | These perceptions are subjective and may underrepresent non-participating groups or smaller providers. |
| Key Informant Input | Provides expert insights and qualitative depth; surfaces nuanced local concerns. | Anecdotal and potentially biased toward specific stakeholders or issues. |

| | | |
|---|---|---|
| Community Qualitative Focus Group Results | Rich, narrative data capturing lived experience and localized needs. | The volume of groups is not statistically representative; there is also limited scale and generalizability. |

## Description of Prioritization Process

The development of the Regional Priority Report is a collaborative, multi-step effort led by the Regional Behavioral Health Action Organizations (RBHAOs) in partnership with key community partners. This process is designed to be thoughtful and systematic, considering regional context including strengths, challenges, political and social dynamics, organizational conditions, and existing health disparities. The prioritization process is intended to reflect diverse perspectives and skill sets.

**Key Steps in the Process:**

- Identify members of the Regional Priority Workgroup (RPW),
- Collect and analyze data from various sources,
- Identify data gaps,
- Incorporate local data to supplement statewide findings,
- Conduct a regional needs assessment and prioritization,
- Identify gaps in services, available resources, and priority populations,
- Develop the Regional Priority Report,

Submit and disseminate the finalized report. Submission deadline April 30, 2025.

Catalyst CT | The Hub invited community partners from LPCs, RSAB, RCAT, and the RGAT to participate in the RPW. This volunteer group represented a diverse cross-section of consumers, family members, and providers with lived experience and professional expertise in behavioral health.

The workgroup engaged in multiple activities, including conducting focus groups, attending various partner meetings, and distributing a statewide priority survey to gather input from a broad range of community members regarding key areas of concern.

In April 2025, the workgroup convened to review the compiled data, share local insights and anecdotal experiences, and engage in a consensus-building discussion. Using a prioritization matrix (see Appendix), members assessed each identified issue based on its magnitude, impact, consequences, and changeability.

Both qualitative and quantitative data were systematically organized and synthesized into **topic-specific profiles** to support the prioritization and planning process. These profiles served as comprehensive snapshots, combining statistical data, community input, and key insights into clearly defined behavioral health focus areas (e.g., substance use, mental health, suicide prevention, etc.).

The topic profiles were developed in advance of the RPW's prioritization meeting and were shared with workgroup members to provide a **data-informed foundation** for discussion. Each profile highlighted relevant findings, emerging trends, health disparities, and known gaps in services, drawing from a range of state, national, and community-based sources.

This synthesis process ensured that stakeholders entered the prioritization phase with a **shared understanding of the issues**, enabling more effective consensus-building and informed decision-making.

The profiles also directly informed the development of **SMARTIE goals** (Specific, Measurable, Achievable, Relevant, Time-bound, Inclusive, and Equitable) and **recommendations**, ensuring continuity between the data analysis and the strategic planning phases of the report.

To guide the identification of regional behavioral health priorities, the RPW used a **Weighted Prioritization Matrix** to evaluate ten key topic areas:

- Mental Health
- Suicide
- Heroin & Other Illicit Opioids
- Alcohol
- Vaping
- Cannabis

- Prescription Drugs
- Problem Gambling
- Tobacco
- Cocaine

Each workgroup member independently scored all ten topics on a scale of **1 to 5**, with **1 representing the lowest priority** and **5 the highest (critical) priority**. These scores were applied across five evaluation categories:

1. **Magnitude** (.25 weight)
    a. The burden and scope of the problem.
    b. Considerations: How many individuals are affected? How widespread is the issue?
2. **Severity & Impact** (.25 weight)
    a. The seriousness of the problem and its potential consequences.
    b. Considerations: What are the implications for health, safety, and quality of life?
3. **Changeability** (.15 weight)
    a. The potential for improvement or resolution within a realistic timeframe.
    b. Considerations: Are evidence-based strategies available? How feasible is implementation?
4. **Capacity & Readiness** (.15 weight)
    a. The current ability to address the issue, including available resources, workforce, community infrastructure, and willingness to take action.
5. **Consequence** (.20 weight)
    a. The short- and long-term outcomes if the issue is not addressed.
    b. Considerations: What will happen if action is not taken?

Each category was **weighted based on its relative importance**, and scores were aggregated to produce a **composite prioritization score** for each topic. This structured, data-informed approach enabled the workgroup to rank behavioral health concerns in a consistent and transparent manner, guiding the subsequent development of SMARTIE goals and regional recommendations.

Following the prioritization process, the RPW reviewed a **preliminary list of recommendations** that had been compiled based on available data, focus group input, and early stakeholder feedback. This initial list served as a foundation for further discussion.

Workgroup members then engaged in a collaborative review process, during which they:

- **Validated existing recommendations** based on alignment with data and community needs,
- **Identified gaps or missing areas** informed by their professional expertise and lived experience,
- **Suggested additional strategies** that reflect regional strengths, challenges, and emerging trends.

This approach ensured the final set of recommendations was **comprehensive**, **regionally relevant**, and **grounded in both data and practical experience**. Recommendations were ultimately refined and aligned with the **SMARTIE** framework to promote specificity, equity, and actionable outcomes.

## Strengths and Limitations of This Report

This Regional Priority Report is designed to offer a comprehensive overview of the behavioral health landscape in Southwestern Connecticut (DMHAS Region 1), with an emphasis on identifying priority needs, highlighting service gaps, and informing actionable strategies across prevention, treatment, and recovery domains. The information included here was developed through a structured, multi-step process that combined quantitative data, community engagement, and expert input. It is intended to be used by state and local agencies, policy makers, service providers, funders, coalitions, and other stakeholders to guide strategic planning, resource allocation, and advocacy efforts over the next two years (2025-2027).

**What the Reader Will Find in This Report:**

- A summary of key behavioral health indicators—covering substance use, mental health, suicide, and problem gambling—supported by regional, state, and national data.
- Rich qualitative insights from focus groups, key informants, and stakeholder surveys that illuminate community experiences, service gaps, and emerging issues.
- A profile of the Region 1 population, including subpopulations at higher risk or with unmet needs.
- Clearly articulated regional priorities, SMARTIE-aligned goals, and practical recommendations for system-level and local action.
- A record of existing strengths, services, and assets that can be leveraged to support future work.

**Key Strengths of This Report:**

- The use of a diverse range of data sources—including quantitative datasets (e.g., CT School Health Survey, 2-1-1, treatment admissions, overdose data) and qualitative input (focus groups, key informant interviews, regional surveys)—ensures that the report reflects both statistical trends and community voice.
- The prioritization process was conducted using a collaborative and equity-informed approach, involving individuals with professional expertise and lived experience from across Region 1.
- The inclusion of subpopulation analysis and social determinants of health (e.g., housing, transportation, access to culturally competent care) enhances the relevance and specificity of recommendations.

**Limitations and Considerations:**

- This report reflects the most current data available at the time of writing; some sources may lag in reporting, and emerging trends may not yet be captured in official statistics.
- Disparities in data availability across communities and populations—particularly smaller towns or underserved groups—may limit the precision of local comparisons or generalizations.
- Some data points (e.g., focus group narratives or key informant quotes) are qualitative and should be interpreted as thematic insights rather than statistically representative findings.
- There is variability in data collection methods across sources (e.g., youth surveys vs. statewide hospitalization data) which may result in differences in how behavioral health issues appear across datasets. Additionally, surveys and focus groups were not collected or interviewed at a statistically significant volume to represent all of Region 1.
- While the report draws on epidemiological methods and synthesizes findings across sectors, the Regional Priority report (RPR) process was developed by a regional planning team with a prevention-focused lens rather than specialized epidemiological training. Center for Prevention Evaluation and Statistics (CPES) and the Department of Mental Health and Addiction Services' (DMHAS) Prevention & Health Promotion Division guidance helped support data interpretation throughout.

**Living Document Note:** As conditions evolve and new data become available, this report is intended to be a dynamic resource. Stakeholders are encouraged to revisit, build upon, and adapt the report to inform ongoing planning and decision-making.

# Regional Profile

## Description of the Region

DMHAS' Region 1 is comprised of the fourteen towns and cities in Southwestern CT (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 most socioeconomically-disadvantaged cities, Bridgeport.

SW CT, home to over 900,000 residents, reflects vast demographic diversity and complex behavioral health needs. The region includes 14 municipalities—ranging from urban centers like Bridgeport and Stamford to suburban and rural towns like Weston and Easton. Updated data from the U.S. Census Bureau (2022 ACS 5-Year Estimates), the Connecticut State Department of Education (2025), and other verified sources provide a detailed picture of the population.

**Youth and Elderly Distribution:**

- Region 1's youth population under 18 represents 22.6% of total residents, while the elderly population aged 65 and over accounts for 16.1%.
- Municipalities with the highest youth proportions include Darien (31.7%), New Canaan (28.2%), Weston (27.9%), and Wilton (27.4%).
- The highest elderly population concentrations are in Stratford (20.1%), Easton (19.2%), Trumbull (18.3%), and Westport (17.5%).

**Racial and Ethnic Composition:**

- Region 1 is predominantly White non-Hispanic. Bridgeport is the only municipality where White residents are a minority (17.4%).
- Municipalities with significant Black or African American populations include Bridgeport (32.7%), Stratford (20.3%), Stamford (12.8%), and Norwalk (12.2%).
- Latino populations are largest in Bridgeport (33.1%), Norwalk (29.7%), Stamford (28.5%), Stratford (20.6%), and Greenwich (13.5%).

- Asian populations are most concentrated in Stamford (9.2%), Wilton (8.7%), Greenwich (7.5%), and Trumbull (6.9%).

**Income Disparities:**

- The median household income varies widely—from $52,113 in Bridgeport to $250,001 in Darien.
- Municipalities below Connecticut's median household income ($84,530) include Bridgeport and Stratford ($87,342).
- High-income municipalities include Westport ($241,355), New Canaan ($219,041), Wilton ($212,789), and Weston ($208,314).
- Bridgeport maintains the highest poverty rate at 23.4%, followed by Norwalk (9.9%), Stamford (9.6%), and Stratford (7.5%).

**Disengaged Youth:**

- 3.5% of female youth and 6.2% of male youth in region 1 are disengaged (not in school and not working).
- Towns with the highest rates of disengaged youth include Bridgeport, Stamford, Norwalk, Greenwich, Stratford, and Fairfield.

**Economic Profile and Cost of Living:**

- The regional Cost of Living Index (COLI) in Fairfield County ranges from 38% to 61% higher than the national average. Housing COLI: Fairfield County average is 176.5. Darien's housing COLI is now 537.6, while Bridgeport remains low at 93.1.
- Utilities in this region are 34% higher than the national average.
- According to the Economic Policy Institute's Family Budget Calculator, Connecticut ranks 6th among all states for the highest cost of food.
- Fairfield County sits in one of most expensive states to live in the U.S.

**Transportation Access:**

Region 1 has access to Metro North which stops at all cities/towns along the coast with its final stop in New York City. SW CT is often considered a bedroom community of New York City. Interstate 95 runs along the coast of Fairfield County and brings with it a high degree of traffic congestion making travel by car difficult at times. Along with Metro North there is the Greater Bridgeport Transit Authority (GBTA) which provides a bus service to Bridgeport, Stratford, Trumbull, Fairfield, Westport, Norwalk and Monroe; however, most

residents find this service extremely limited and somewhat unreliable. GBTA did suspend bus fares in 2022, with fare-free services extending through 2023. As of April 2024, fares have resumed for CT Transit and paratransit riders, impacting low-income and disabled residents.

**Housing and Homelessness:**

- In October 2024, Fairfield County's Coordinated Access Network, (part of the statewide housing collective), had a total of 94 men, 40 women and 23 families experiencing homelessness and on the shelter waitlist. Within the families there were thirty-six children under the age of 18 and 25% of those on their shelter wait list were over 62.
- Fairfield County has seen a 19% increase in homelessness during the 2023-2024 according to the Coordinated Access Network.
- More than half of Fairfield County's homeless population is in the greater Bridgeport area, and the county is lacking about 25,000 affordable homes.
- Rent in Fairfield County has increased 20-30% over the last 6 years, making affordability out of reach for many residents.

## Figure 2. Region 1 Town Characteristics

| Town/ City | Total Population [1] | Community Type[2] | Median Income[1] | % Poverty Rate[1] | % White[1] | % Black/ African American [1] | % Hispanic / Latinx[1] | % Asian[1] | % Native American [3] | % Other[1] |
|---|---|---|---|---|---|---|---|---|---|---|
| Bridgeport | 148,470 | Urban Core | $54,440 | 23.0 | 32.0 | 20.0 | 36.0 | 7.0 | | 5.0 |
| Darien | 21,571 | Wealthy | $250,001 | 5.0 | 81.0 | 1.0 | 6.0 | 7.0 | | 5.0 |
| Easton | 7,630 | Wealthy | $181,934 | 7.0 | 90.0 | 1.0 | 2.0 | 2.0 | | 5.0 |
| Greenwich | 63,498 | Wealthy | $185,850 | 5.0 | 70.0 | 4.0 | 14.0 | 7.0 | | 5.0 |
| Fairfield | 62,072 | Suburban | $165,316 | 5.0 | 88.0 | < 1.0 | 4.0 | 4.0 | | 2.0 |
| Monroe | 18,851 | Suburban | $145,714 | 3.0 | 88.0 | 1.0 | 4.0 | 4.0 | | 2.0 |
| New Canaan | 20,639 | Wealthy | $250,001 | 2.0 | 85.0 | 2.0 | 4.0 | 6.0 | | 4.0 |
| Norwalk | 91,050 | Urban Periphery | $97,879 | 11.0 | 45.0 | 17.0 | 31.0 | 4.0 | | 3.0 |
| Stamford | 135,413 | Urban Periphery | $100,718 | 10.0 | 42.0 | 18.0 | 30.0 | 7.0 | | 3.0 |
| Stratford | 52,436 | Urban Periphery | $91,025 | 6.0 | 73.0 | 9.0 | 14.0 | 1.0 | | 3.0 |
| Trumbull | 36,922 | Suburban | $153,846 | 5.0 | 79.0 | 2.0 | 5.0 | 9.0 | | 5.0 |
| Wilton | 18,473 | Wealthy | $230,545 | 2.0 | 78.0 | 2.0 | 6.0 | 6.0 | | 8.0 |
| Weston | 10,336 | Wealthy | $220,754 | 2.0 | 77.0 | 4.0 | 7.0 | 5.0 | | 6.0 |
| Westport | 27,332 | Wealthy | $242,868 | 5.0 | 80.0 | 2.0 | 9.0 | 5.0 | | 5.0 |
| **Connecticut** | **3,611,317** | **NA** | **$90,213** | **10.1** | **65.9** | **12.2** | **16.9** | **5.0** | **NA** | **8.5** |

[1]Connecticut Town Profile, 2024 (American Community Survey, 2018-2022).
[2]Levy, Don: Five Connecticuts 2010 Update. (2015).
[3]CT Data combined Native American w/ Other; 'Other' includes American Indian, Alaska Native, Native Hawaiian, Pacific Islander, two or more races. Please explore detailed census here.

## Subpopulations in Region 1

Southwestern Connecticut, home to more than 900,000 residents, is marked by both cultural richness and entrenched behavioral health disparities. Within Region 1, these disparities play out across age, race, income, geography, and identity, disproportionately affecting access, outcomes, and equity in behavioral health care.

Youth and adolescents are navigating an intensifying behavioral health landscape. Schools and prevention partners across Region 1 have reported surges in emotional distress and self-regulation challenges. Behaviors like food restriction and early substance use often appear as coping mechanisms, especially where youth lack consistent access to school-based support or trusted adults. Stakeholders consistently name cannabis and vaping as prominent issues for this group, with accessibility through smoke shops exacerbating the problem in suburban towns. For **LGBTQIA+ youth**, the need for affirming environments is paramount; when such support is missing, risks escalate quickly. One community leader put it plainly: “Trusted adults and affirming spaces are the difference between prevention and crisis for queer youth.” **Young adults** face their own complex matrix of challenges, such as navigating early careers, financial instability, and the long tail of pandemic trauma. Many who belong to these groups turn to cannabis, vaping/ENDS, alcohol, and even online gambling to manage stress and anxiety. Across the region, providers point to a sharp uptick in digital gambling and delayed mental health treatment among young adults, fueled by both cost barriers and inconsistent insurance coverage. While highly connected through digital spaces, many report feeling deeply isolated or unable to maintain meaningful mental health routines. For **older adults**, behavioral health needs are frequently hidden or dismissed. Stakeholders in Bridgeport and Stratford emphasized that seniors often go unseen in outreach and prevention planning. Living on fixed incomes, facing mobility barriers, and experiencing profound isolation, many seniors do not receive geriatric-informed mental health care. This invisibility has significant consequences, particularly when symptoms of depression or grief go undetected or untreated.

**BIPOC residents** continue to face systemic barriers in accessing behavioral health services. Stakeholders describe cultural mismatch, stigma, and language gaps as

persistent hurdles. One Norwalk-based informant shared, “The region and state as a whole are not good about developing culturally relevant messaging for populations who don't speak English.” These gaps compound the effects of long-standing structural racism, leaving many residents of color to rely on emergency care rather than preventive or outpatient supports. Additionally, behavioral health risks can intersect powerfully with **low-income and working-class families**, especially within urban centers like Bridgeport. The cost of living in Fairfield County places immense strain on these households. When facing stress, families without private insurance are often forced to delay or forego care. Scheduling limitations, childcare needs, and transportation hurdles add to the burden, further deepening health disparities.

For individuals managing **co-occurring disorders**, the care system can feel more like an obstacle than a lifeline. From emergency departments to shelters, the cycle of discharge without coordinated follow-up remains a central concern. This group includes not only those with both substance use and mental illness, but also **neurodivergent individuals**, particularly those with autism spectrum disorder or intellectual/developmental disabilities, whose behavioral health needs are frequently misunderstood or unsupported.

Though they are often underrepresented in data, **veterans and first responders** emerged as a population of concern in focus group discussions. Providers named the unique behavioral health risks they face—post-traumatic stress, substance use, and suicide—compounded by stigma and a lack of culturally competent care. Many respondents called for more providers with lived experience or specialized training to meet their needs.

**Figure 3. Subpopulations in Region 1 and Areas of Concern**

| Subpopulation/Group | Area(s) of Concern | Rationale/Evidence |
|---|---|---|
| Youth and Adolescents | Mental health crises, suicide risk, substance use disorder | 16% of high schoolers considered suicide (2021); LGBTQIA+ youth at 34.2%. 21-42% report persistent anxiety. Darien: 33% reported disordered eating. Cannabis/vaping linked to self-medication. |

| | | |
|---|---|---|
| Young Adults (18-34) | Cannabis, vaping/ENDS, alcohol use disorder, digital gambling, trauma | 27.9% past-month cannabis use; 37.1% of alcohol-related admissions. 12.8% gamble weekly. Common stressors: financial instability, housing, trauma. |
| Older Adults (65+) | Suicide risk, isolation, underdiagnosed mental illness | Suicide mortality: 16.8 per 100,000. High isolation, mobility/access issues. Often excluded from planning. |
| BIPOC Residents | Disparities in ED visits, access to culturally competent care | ED visits for cannabis/alcohol nearly 2x higher than White peers. Hispanic adults: 183.6 per 10,000 alcohol ED visits. Language/culture barriers reported. |
| LGBTQIA+ Youth and Adults | Suicidal ideation, substance use disorder, lack of affirming care | 34.2% of LGBTQIA+ teens considered suicide. Disproportionate use of vaping, cannabis, and reports of anxiety. Protective factors: trusted adults, safe spaces. |
| Low-Income and Working-Class Families | Access to care, affordability, insurance gaps | Bridgeport poverty: 23%. Affordability/scheduling top barriers. High cost of living prevents access to private care. |
| Individuals with Co-Occurring Disorders | Fragmented care, under-supported neurodivergence | Fragmented systems; frequent ED/shelter discharge without follow-up. Especially acute for ASD/I/DD individuals. |
| Veterans and First Responders | PTSD, substance use, suicide, stigma in accessing care | Identified by providers as high-risk but underrepresented in data. Reported barriers: stigma, |

| | | |
|---|---|---|
| | | lack of trauma-informed providers. |

## Findings

Behavioral health in Southwest Connecticut (SW CT) is not a singular narrative—it is a layered and complex story of trauma, resilience, systemic gaps, and shifting norms. Our data tells a story of behavioral health systems strained at every level—of prevention efforts overwhelmed by rising normalization, of treatment systems unable to retain staff, and of individuals falling through cracks that grow wider with each passing year. Yet they also tell a story of resilience: of peer support stepping in, of youth coalitions taking action, and of communities committed to building safer, healthier spaces. The region's behavioral health landscape in 2024–2025 reflects not just individual struggles with mental health and substance use, but structural inequalities that continue to place the most vulnerable at the greatest risk. These patterns emerged from Catalyst CT/The Hub's Priority Report data, including youth and stakeholder surveys, hospital data, community focus groups, and state epidemiological reports.

Mental health needs have escalated dramatically, particularly among youth, young adults, and underserved groups. Anxiety, depression, and trauma are now common experiences for youth in Region 1. In Stamford, 21.2% of students said they felt hopeless for two or more weeks (Stamford Youth Survey, 2024). In Trumbull, 34% of high schoolers reported persistent anxiety. LGBTQIA+ youth report the highest mental health burdens, with up to 1 in 3 reporting suicidal ideation or past attempts (TPAUD Youth Survey, 2023). In Darien, 1 in 3 high schoolers reported restricting food intake to lose weight, especially among Hispanic girls and LGBTQIA+ students (Darien Youth Survey, 2023).

While youth feel these stressors acutely, adults are also deeply impacted. In Bridgeport, 31% of adults reported depression symptoms in 2022 — well above the state average (CHNA, Yale, 2022). Black (17%) and Hispanic (20%) adults were more likely than white adults (10%) to experience frequent anxiety (CHNA, Yale, 2022). Despite expanded awareness and the rise of school-based supports, the region is not equipped to manage this demand. Provider shortages, long waitlists, cultural mismatches between clients and

providers, and cost remain persistent barriers. One parent noted: "Even when you find a provider, the waitlist is too long. Parents are at a loss."

Substance use issues compound these mental health concerns. Cannabis use among youth is normalized. In one youth survey, 50% of 12th graders in Darien reported past-month alcohol use. Emergency room visits for cannabis-related issues in Norwalk jumped from 128 in 2021 to 179 in 2022. Among school discipline cases, marijuana incidents exploded from 35 in 2021–22 to over 800 in 2022–23 statewide. Yet adult substance misuse receives less attention. Binge drinking among Fairfield County adults was 17%, with males aged 18–34 reporting the highest rates (22.2%) (SW DMHAS Equity Profile, 2023). Alcohol was involved in 42 accidental deaths statewide in 2023—76% of them at home (SW DMHAS Equity Profile, 2023). Prevention coalitions note: "We're not talking about adult alcohol misuse... and binge drinking is huge."

Stimulant use, particularly cocaine, has emerged as a silent crisis. In 2023, Region 1 recorded ninety-three deaths involving cocaine—a 32% increase from 2022. Bridgeport alone accounted for more than half of those (CT HHS Data, 2023). In Stamford, stimulant-involved deaths rose 50%, and Stratford saw an 83% spike (CT HHS Data, 2023). Polydrug use involving fentanyl, cocaine, and methadone is now the norm. Opioid use, while better known, continues to take lives. In 2024, 118 opioid-related deaths occurred in Region 1 (CT HHS Data, 2023). Bridgeport led with 68 deaths, followed by Stamford (11) and Stratford (14). Fentanyl was present in over 75% of all cases. Xylazine and other synthetics compound lethality (CT HHS Data, 2023).

Suicide is another persistent threat. Region 1’s suicidal ideation rate rose to 179.4 per 10,000 visits in 2024, with suicide attempts at 27.2 per 10,000. LGBTQIA+ youth reported dramatically higher suicide risk—34% had considered suicide, compared to just 8.4% of their heterosexual peers (Hub Assessment of Suicide Across the Lifespan, 2024). Yet support remains fragmented. "We’ve moved from reactive to prevention, but we need more people trained," one suicide prevention facilitator said (KII participant, 2025).

Vaping remains the second most common substance used by youth, behind alcohol (Youth Voices Count, 2024-25). Among Region 1 youth, 9.7% of high schoolers reported

vaping in the past 30 days. The average age of first use is 13.3. Bridgeport has 3 ENDS retailers per square mile. In Norwalk, 72.5% of youth who vape got their products from peers (Youth Voices Count, 2024-25).

Finally, problem gambling has skyrocketed, particularly through sports betting and gaming features like loot boxes. In Norwalk, 2% of high school youth reported gambling monthly (Norwalk Youth Survey, 2023). Among adults, 6.7% gamble weekly. Yet 83% of adults said no provider had ever asked them about gambling—a massive screening gap (Gambling Community Survey, 2023-24).

At the systems level, barriers include long 211 wait times, inadequate discharge follow-up, housing instability, and burnt-out providers. One treatment provider caseworker noted: "Referrals are becoming more of a barrier than a help."

Considering these findings, Catalyst CT | The Hub, in collaboration with community partners, moved into the next phase of our regional assessment: translating key data points and community insights into strategic priorities. Recognizing that behavioral health challenges in Region 1 are deeply interwoven - shaped by social determinants, workforce shortages, and systemic inequities, we began organizing the themes into a matrix of core issues. This matrix served as a bridge between data collection and action planning, allowing us to systematically identify the gaps, populations most affected, and corresponding resource needs.

Each matrix item reflects not only statistical trends, but also the lived experience shared in focus groups, key informant interviews, and partner surveys. Whether it was a parent struggling to find mental health care for their teen, a provider reporting high rates of discharge without follow-up, or a youth coalition leader describing peer normalization of vaping and cannabis use, these stories became the qualitative spine of our priorities. By centering both numbers and narratives, we ensured that our regional strategy would be rooted in the community, informed by diverse voices, and responsive to real-world needs.

Through this process, we identified and defined ten regional gaps and corresponding needs ranging from crisis response to culturally responsive care, gambling prevention, and workforce sustainability. The matrix helped us frame these needs holistically, cross-

referencing them with affected populations and geographic disparities, and pairing them with actionable recommendations that advance equity, accessibility, and readiness for change. Please see Appendix A for a copy of our matrix and results.

## Emerging Issues

The landscape of behavioral health in Region 1 continues to shift and reveal new and intensifying challenges that demand timely attention. This section outlines the most urgent emerging trends, many of which cut across age, geography, and service domains that have been identified through stakeholder input, local data, and focus groups. From the normalization of cannabis and vape use among youth to the rise in stimulant-related deaths, mounting loneliness, workforce fatigue, and housing instability, these issues signal the need for adaptable, and community-informed responses. Readers will find both data-driven insights and direct quotes from local experts, residents, and stakeholders that illustrate how these trends are experienced 'on the ground' and where gaps in prevention, treatment, recovery and policy persist.

### Normalization and Illicit Access to Cannabis and Vapes Among Youth

Youth in Region 1 are increasingly normalizing cannabis use. In Darien, 50% of 12th graders used alcohol in the past 30 days, and 30.7% statewide reported past-year cannabis use (Darien Youth Survey, 2023). Vaping is prevalent among high schoolers, with over 10% reporting past-month use (CSHS, 2023). Smoke shops sell high-potency THC and synthetic psychedelics, often unchecked. One youth advocate shared, "Middle schoolers are walking in and out of smoke shops" (LPC Focus Group Participant, 2025). Emergency visits for cannabis increased in Norwalk from 128 in 2021 to 179 in 2022 (CT Epidemiological Profile, 2025). Compliance checks found 17.4% of vape retailers in Region 1 sold to underage buyers (CT Epidemiological Profile, 2025).

### Surge in Loneliness and Mental Health Decline Across Ages

Partners repeatedly cited loneliness as an emerging public health crisis. A focus group participant noted (2025), "It started with depression, then anxiety… now it's loneliness." In Norwalk, 26% of low-income adults reported regular anxiety, and among Region 1 youth, 21–42% experienced persistent sadness (Norwalk CHNA, 2022). Social isolation

is fueling substance use and mental distress in youth, seniors, and working adults. Telehealth helped bridge access, but many still lack services due to technology gaps.

**Increase in Polydrug Use and Stimulant-Related Deaths**

Bridgeport saw stimulant-involved deaths rise 32% from 2022 to 2023 (40 to 53 deaths) (CT HHS Data, 2023). Statewide, 620 deaths in 2023 involved both cocaine and fentanyl (CT HHS Data, 2023). Methamphetamine deaths doubled in Stamford and Norwalk. Polysubstance use is now intentional, not just contamination. A Norwalk provider reported, “We’re seeing people mix pills on purpose to try to control the high” (LPC Focus Group, 2025). Bromazolam, methadone, and phenacetin are among substances found in Region 1 overdose toxicology reports.

**Provider Burnout and Systemic Fatigue**

Staff at a local treatment provider described the system where “referrals are more of a barrier than a help” (LPC Focus Group, 2025) Waitlists, high 211 call times (up to 4 hours), and discharges without care coordination plague the system. Providers report using their own income to help clients meet basic needs. Burnout is rampant. One Stratford worker stated, “We are losing people because the systems are too slow” (LPC Focus Group, 2025)

**Under-Addressed Adult Alcohol Use and Related Harms**

While youth vaping garners prevention funds, adult alcohol misuse is under-addressed. Binge drinking affected 17% of adults in Fairfield County, with higher rates among young adult males (22.2%) (SW DMHAS Equity Profile, 2023). Alcohol was involved in 42 unintentional deaths in 2023 (SW DMHAS Equity Profile, 2023). A Darien respondent noted, “Adults get it when it comes to DUI or kids drinking. They don’t see their own use as a problem” (Focus Group, 2025). In Bridgeport, alcohol-related ED visits hit 153.1 per 10,000—the highest in the region (CT Epidemiological Profile, 2025).

Alcohol-related emergency department (ED) visits paint a concerning picture: Bridgeport had the highest rate in Region 1 at 153.1 visits per 10,000 people, followed by Stamford (123.9) and Norwalk (121.0) (CT Community Readiness Survey, 2022). Hispanic residents in Region 1 experienced the highest alcohol-related ED visit rate (183.6 per

10,000), and Black residents were nearly twice as likely to visit the ED for alcohol-related issues as white residents (1,498 vs. 735 per 100,000) (CT CRS, 2022). Hospital systems, such as Norwalk Hospital, have implemented screening, brief interventions, and referral to treatment (SBIRT), and Community Care Teams (CCTs) have coordinated efforts to connect individuals experiencing alcohol-related emergencies to needed care (Norwalk CHNA, 2022). However, barriers persist, including high rates of uninsured or underinsured residents, lack of culturally responsive care, and stigma. Only 14.6% of Black residents and 10.5% of Hispanic residents in need received treatment for alcohol use (CT CRS, 2022).

**Other emerging issues of concerns related to Alcohol use are Nips and Wrong Way driving.**

According to the Wine and Spirit Wholesalers of CT there were approximately 49 million nips sold in 2024 in CT. In Region 1 approximately 5.5 million nips were sold or 16,000 nips per day. Bridgeport has the third highest in sales with Stamford, Norwalk and Stratford in the top 20 for sales. The highest sales per 1000 people occur in Stratford, Bridgeport and Monroe. The region receives approximately 273,000 dollars per year to address environmental clean-up; revenue distribution is based on the number of nips sold per town. There is some movement in the State Legislature to ban nips altogether to address the environmental and alcohol use concerns.

Wrong Way driving continues to be a concern throughout CT. According to CT DOT 86% of wrong way driving accidents from 2019-2023 involved drivers with a BAC rate above .08. In May of 2024 4 people died in a wrong way driver accident on the Merritt Parkway in Stratford.

Governor Lamont signed into law P.A. 23-51 in 2023, calling for wrong-way technology at 120 high-risk ramps by 2025, the DOT surpassed this goal by installing these devices on more than 130 high-risk ramps in 2024, with plans to install 200 more systems at additional high-risk locations. High risk locations are identified as those restaurants, bars and night clubs close to entrance/exit ramps.

**Youth Gambling and Digital Dependency**

Youth surveys in Norwalk found that 8.7% of students gambled almost daily, often through video games or sports betting. Males were most at risk, yet few prevention programs address gambling. In the Problem Gambling Severity Index (PGSI) survey, only 16.3% of respondents had ever been asked about gambling by a health provider. A New Canaan parent said, “Social media addiction should be in the mental health bucket like gambling” (2025).

### Housing Instability and Inadequate System Navigation

Many residents face eviction, displacement, or couch-surfing, yet are deemed “housed” by state systems, blocking services. Clients discharged from shelters or hospitals often return to crisis. A recovery specialist shared, “Some would rather go back to jail for food and warmth.” Transportation, digital access, and language remain structural barriers.

### Suicide Risk and Inadequate Response

Suicide deaths in Region 1 rose to 57 in 2022. Youth aged 10–17 had a suicidal ideation ED visit rate of 435.5 per 10,000. LGBTQIA+ students remain at highest risk, with one partner saying, “Parents are desperate for tools and have nowhere to go.” While Question-Persuade-Refer (QPR) and Mental Health First Aid (MHFA) training have expanded, cultural awareness and postvention gaps remain. Darien’s Wellness center is a positive step, but many communities lack similar investment.

### Concern Over Dwindling Federal and State Funding

American Rescue Plan Act (ARPA) dollars and other federal funds are drying up, threatening prevention, housing, and workforce development programs. One partner remarked, “We’ve made progress. If funding disappears, so will the solutions” (Suicide Focus Group, 2025). Nonprofits are especially vulnerable, with many depending on unstable grants to sustain core services.

**Figure 4. Emerging Issues in Region 1**

| Emerging Issue | For Whom/What Group | Rationale/Evidence |
|---|---|---|
| Normalization and Illicit Access to Cannabis and Vapes/ENDS Among Youth | Middle and High School Students in Region 1 | 50% of 12th graders in Darien used alcohol in past 30 days; 30.7% of CT youth reported past-year cannabis |

| | | |
|---|---|---|
| | | use. Vaping exceeds 10% past-month use among high schoolers. Cannabis-related ED visits rose in Norwalk (128 in 2021 to 179 in 2022). 17.4% of vape retailers failed compliance checks. Quote: “Middle schoolers are walking in and out of smoke shops” |
| Surge in Loneliness and Mental Health Decline Across Ages | Youth, Seniors, and Working Adults | 21-42% of Region 1 youth reported persistent sadness or anxiety. 26% of low-income Norwalk adults reported regular anxiety. Quote: “It started with depression, then anxiety, now it’s loneliness” |
| Increase in Polydrug Use and Stimulant-Related Deaths | Adults in Bridgeport, Stamford, Norwalk | Bridgeport stimulant-involved deaths rose 32% (40 in 2022 to 53 in 2023). 620 CT deaths in 2023 involved cocaine and fentanyl. Methamphetamine deaths doubled in Stamford and Norwalk. Quote: “We’re seeing people mix pills on purpose to try to control the high.” |
| Provider Burnout and Systemic Fatigue | Behavioral Health Providers and Case Workers | Wait times for 211 up to 4 hours; providers use personal funds for clients. Quote: “Referrals are more of a barrier than a help.” Quote: “We are losing people because the systems are too slow.” |
| Under-Addressed Adult Alcohol Use Disorder | Adult Males (18-34), Bridgeport Residents | Binge drinking affects 17% of Fairfield adults, 22.2% among young adult males. 42 accidental deaths involved alcohol in 2023. |

| | | |
|---|---|---|
| | | ED visit rate in Bridgeport: 153.1 per 10,000. Quote: “They don’t see their own use as a problem.” |
| Youth Gambling and Digital Dependency | Youth in Norwalk, Male Students | 8.7% of Norwalk students gamble almost daily. Only 16.3% were asked about gambling by providers. Quote: “Social media addiction should be in the mental health bucket like gambling.” |
| Housing Instability and Inadequate System Navigation | Individuals in Crisis or Homeless, Unhoused Youth and Adults | Clients denied services if 'couch-surfing'; system navigation barriers include digital/phone/language. Quote: “Some would rather go back to jail for food and warmth.” |
| Suicide Risk and Inadequate Response | Youth (10-17), LGBTQIA+ Students | Region 1 suicide deaths reached 57 in 2022. Youth suicidal ideation ED visit rate: 435.5 per 10,000. Quote: “Parents are desperate for tools and have nowhere to go.” |
| Concern Over Dwindling Federal and State Funding | Nonprofits and Public Health Programs | ARPA and federal prevention funds are drying up. Quote: “We’ve made progress. If funding disappears, so will the solutions.” |

## Regional Strengths, Resources, and Assets

Southwestern Connecticut (SW CT) is a diverse and resource-abundant region encompassing urban, suburban, and rural communities, including cities such as Stamford, Norwalk, Bridgeport, and Greenwich. The region is well-positioned to support behavioral health, community well-being, and resilience through a wide range of strengths, resources, and assets.

Key assets include a comprehensive continuum of care, robust recovery support, certified peer support specialists, and mobile outreach vans that extend services directly into communities. The region's capacity is further strengthened by dynamic cross-sector partnerships among behavioral health providers, hospitals, social services, housing organizations, public health departments, advocacy groups, prevention professionals, educators, first responders, and other community stakeholders.

These partnerships are formalized through over 90+ active committees, coalitions, and workgroups operating at local, subregional, and regional levels. These groups collaborate on initiatives that enhance access to care, reduce stigma, and address barriers related to substance use, mental health, housing, and juvenile justice.

## Regional Strengths

SW CT is uniquely positioned to address behavioral health challenges due to its strong culture of collaboration, deep-rooted community engagement, and well-established systems infrastructure. The region benefits from a broad and diverse network of stakeholders; including behavioral health providers, healthcare systems, social services, prevention coalitions, schools, advocacy groups, and municipalities—who work together to coordinate care, share resources, and advance public health goals.

A hallmark of the region's strength is its political and institutional support for behavioral health initiatives. Local and state leaders are actively engaged in efforts to reduce stigma, improve access to care, and promote mental wellness. This strength is reinforced by a network of over 90 coalitions, committees, and task forces that operate across local, subregional, and regional levels, allowing for responsive and data-informed strategies tailored to community needs.

Region 1 also demonstrates a strong prevention and recovery-oriented culture, supported by a wide continuum of care and innovative practices such as mobile outreach vans, peer recovery services, and integrated care models. With a history of adapting to emerging trends—such as cannabis legalization, fentanyl-related risks, and youth gambling—the

region maintains a proactive stance, leveraging both public and private resources to enhance service delivery.

This collaborative and resource-rich environment enhances the RBHAO's ability to implement and sustain comprehensive, community-driven strategies that support prevention, intervention, treatment, and recovery across the behavioral health spectrum.

## Regional Resources and Assets

Region 1 is supported by a strong network of programs and partnerships focused on behavioral health, substance use prevention, and recovery. Key efforts include:

- **Prevention campaigns** targeting youth vaping, underage drinking, opioid misuse, gambling, and suicide.
- **Community coalitions and grants** supporting local action and public education across all 14 towns.
- **Partnerships** with over 30 behavioral health providers, schools, and organizations for treatment, training, and outreach.
- **Support services** include recovery programs, mental health care, nicotine cessation, and crisis response teams.

These coordinated efforts work together to address regional needs and promote personal well-being across all age groups.

**Figure 5: Summary of Resources and Assets in Region 1**

| Funding/Initiatives | | |
|---|---|---|
| **Resource/Asset** | **Focus Area** | **Catchment Area/Reach** |
| RBHAO | LPC support and training Cannabis, opioids, gambling, alcohol, suicide, Drug Endangered Children, Recovery Friendly Workplace, vaping/ tobacco | 14 towns, Region 1, all ages |

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| Cannabis Community Coalition | Prevent underage youth use | 8 towns: Westport, Wilton, Weston, Norwalk, New Canaan, Trumbull, Easton and Monroe |
| Regional Suicide Advisory Board RSAB | Suicide Prevention/Postvention | 14 towns, Region 1, all ages; |
| Drug Free Communities Grants | Preventing youth substance use through community mobilization. | Greenwich, Darien, Fairfield, Stamford, Westport |
| Prescription Drug/Opioid Overdose | Reduce fatal opioid poisonings<br>Provide Opioid Overdose Rescue Kits | First Responders, 14 towns, Region 1 |
| Drug Endangered Children Grant | Raise awareness of drug-endangered/substance-exposed children | 14 towns, Region 1, all ages |
| JUUL Initiative | Support the abatement, mitigation, cessation, reduction, or prevention of e-cigarette use | 14 towns, Region 1, Under 21 |
| Regional Gambling Awareness Team (RGAT) | Responsible Gambling | 14 towns, Region 1, all ages |
| Local Prevention Council (LPC) | Reduce vaping use rates by 5% by 2025 among 12–18-year-olds by targeting related risk and protective factors/<br>Increase public awareness of vaping risks and prevention | 14 towns: Bridgeport, Darien, Easton, Fairfield, Greenwich, Monroe, New Canaan, Norwalk, Stamford, Stratford, Trumbull, Westport, Wilton, Weston |
| You Think You Know CT Campaign | Reduce fatalities from counterfeit medications | Statewide |
| State Campaigns (i.e. Change the Script, Be In the Know, LiveLOUD, Prevent suicide CT | Reduce impact of substance use and support recovery | Statewide |
| OK to Talk About It Campaign | Reduce stigma, encourage conversations surrounding mental health | Region 1 |
| CT Partnership for Hope and Healing (PH2) | Suicide Prevention | Darien Public School District |
| Catalyst CT \| Prevention Corps | Workforce development in Prevention | Statewide |
| Partnership for Success (PFS) | Underage drinking | Stamford Youth |

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| Recovery Friendly Workplaces (RFWs) | Behavioral Health (Substance Use/Mental Health) | 20 certified workplaces in Region 1 |
| Legislative Grant | Alcohol use/misuse and co-occurring disorders – specific to depression and anxiety special focus on those within the Hispanic community | Bridgeport & Stratford focused, Adult Males |
| Prevention Corps | Prevention Workforce Development | RBHAOs |
| **Partnerships** | | |
| **Resource/Asset** | **Focus Area** | **Catchment Area/Reach** |
| Treatment and Recovery Services | Substance misuse, Mental Health and Gambling Services | Region 1 has over 30 public, private, and nonprofit behavioral health providers. Many are in partnership with the RBHAO. |
| Silver Hill Hospital | Training-MH | Regional |
| CCAR Recovery Center | Gambling Treatment Substance Use Recovery & Treatment | Regional |
| Department of Children and Families (DCF) | Behavioral Health (BH) | Bridgeport, Norwalk, Stamford offices servicing region |
| Postvention Teams | Suicide Postvention | Greenwich, Stamford, Darien, Trumbull, Westport, Norwalk |
| CT Clearinghouse | BH | Statewide |
| Department of Public Health | BH | Statewide |
| MATCH Coalition | Substance Use/Legislation | Statewide |
| True 2 You Coalition | Substance Use | Statewide |
| Tobacco Merchant and Community Education Steering Committee | Substance Use / Retailor | Statewide |
| Mothers Against Drunk Driving (MADD) | Substance Use | Statewide |
| Greater Bridgeport Health Improvement Alliance (HIA) Community Health Improvement Plan | BH | Great Bridgeport |
| Bridgeport Public Schools | Social Emotional Learning, vaping and cannabis education | Bridgeport |

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| CT Smart Approaches to Marijuana | Prevention, Education, Advocacy | Statewide |
| CT Substance Exposed Children (SEC) overseen by DCF | Prevention, Education | Statewide |
| Greenwich Department of Human Services | Prevention, Education, Training | Greenwich, all ages |
| CT Prevention Network (CPN) | RBHAO collaborative | Statewide |
| Norwalk Health Department | Suicide prevention, postvention | Norwalk |
| Community Care Teams (CCTs) | Provider meetings | Bridgeport, Norwalk, Stamford |
| Fairfield Public Schools | Social Emotional Learning AmeriCorps Program | Fairfield Public School District |
| Community Response Initiative (CRI) Law Enforcement and BH Collaborative | Address MH and SUD in the community | Stratford, Bridgeport, Fairfield, Norwalk, Stamford |
| **Services** | | |
| **Resource/Asset** | **Focus Area** | **Catchment Area/Reach** |
| Treatment and Recovery Services | Substance misuse, Mental Health and Gambling services | Region 1 has over 30 public, private and nonprofit behavioral health providers |
| Tobacco Control Program | Nicotine prevention, treatment, recovery resources | Statewide |
| DCP / Commit to Quit | Nicotine cessation for 18 and over | Statewide |
| vaprefreeCT | Nicotine cessation for youth | Statewide |
| CATCH My Breath | School Supports | Statewide |
| Stanford Medicine \| REACH Lab | School Supports | Statewide |
| Triangle Community Center | LGBTQIA+ | Regional |
| Warmlines / Hotlines | BH | Statewide |

# Regional Resource Gaps and Needs

The behavioral health challenges across Region 1 demand bold, equitable, and sustained investments. The following gaps and needs are drawn from regional data, focus groups, surveys and the lived experience of providers and residents:

**Systemic Service Gaps**

**1. Workforce Shortages & Burnout**

Across nearly every focus group, the shortage of behavioral health professionals, especially psychiatrists, bilingual clinicians, and culturally competent providers, was identified as a major barrier. Waitlists for mental health care, especially for children and Spanish-speaking families, remain unacceptably long. Professionals are overextended and undercompensated, leading to burnout and staff attrition. Nonprofit providers struggle to offer competitive wages, and many report that staff are working a second job or paying for client needs out of their own pocket.

While in a focus group, a treatment provider “There’s not enough money, not enough people, overwhelming needs everywhere you turn.”

“Even when you find a provider, the waitlist is too long. Parents are at a loss.” — Mental Health Focus Group

**2. Inadequate Crisis and Follow-Up Care**

Partners consistently highlighted the lack of timely and responsive crisis services for both youth and adults. Adolescents in crisis often must travel for hours for urgent psychiatric care, with few localized acute resources in lower Fairfield County. Adults, especially males, face stigma and limited after-hours crisis options. Hospitals frequently discharge individuals without follow-up or wraparound services.

“We’re losing people because the systems are too slow.” — RNP Focus Group, 2025

“Youth-specific crisis services are lacking, and adult males are less likely to seek help due to stigma.” — Suicide Prevention Focus Group. 2025

**3. Care Coordination & Navigation Barriers**

Many individuals and families are left without clear pathways to care. Navigating insurance, provider referrals, and eligibility systems can feel like an endless maze, particularly for those with limited literacy, internet access, or stable housing.

Region 1 is the only area in the state without access to an Urgent Crisis Center (UCC) for families and youth under 18 experiencing a behavioral health crisis. As a result, families are often forced to choose between visiting an emergency room or traveling over 30 minutes to Danbury or Waterbury for support. Additionally, there is a lack of clarity around how youth should be safely transported to a UCC during a crisis.

“Referrals are becoming more of a barrier than help.” — RNP Focus Group, 2025

“People who want to get better are stopped by every system they interact with.” — Suicide Focus Group, 2025

**4. Structural Determinants of Health**

Housing instability, food insecurity, transportation, and economic hardship significantly impact behavioral health in Region 1. Individuals experiencing homelessness, unemployment, or undocumented status face disproportionate barriers to treatment. Behavioral health providers noted that clients often forgo care due to these competing priorities.

“Some would rather go back to jail for food and warmth.” — RNP Focus Group, 2025

“When someone is struggling with housing, they most likely won’t have a mental health provider.” — Behavioral Health Focus Group, 2025

**Behavioral Health Service Gaps by Topic**

**Mental Health:**

- Long wait times for therapy and psychiatry, especially for youth and non-English speakers.
- Lack of culturally and linguistically appropriate care.
- Need for adolescent IOP/PHP programs and school-based services.
- Inadequate suicide prevention infrastructure, especially for adult males and LGBTQIA+ youth.

**Substance Use:**

- Gaps in adult prevention funding, particularly for alcohol misuse and polysubstance use.
- Limited recovery support and harm reduction services for people post-discharge.
- High need for long-term residential and intensive outpatient care, with disparities by race/ethnicity and insurance status.
- Smoke shops are a persistent problem, with illegal sales to youth and unregulated cannabis/ENDS products.

**Suicide Prevention:**

- Stigma and limited awareness persist among older adults and working-aged men.
- Communities lack visible prevention signage and coordinated postvention responses.
- Funding instability threatens the sustainability of prevention initiatives post-ARPA.

**Prescription Drug Misuse:**

- Gabapentin and benzodiazepines remain frequently implicated in overdose deaths.
- Limited data on distinctions between prescribed vs. illicit use.
- Inadequate safe disposal awareness and uneven access to drop boxes.

**Problem Gambling:**

- Minimal integration into youth prevention efforts.
- High rates of sports betting among high school and college-aged individuals.
- Providers are often unaware or ill equipped to screen for gambling issues.
- No stable or flexible funding stream to support prevention or treatment.

**Gaps Within Underserved Populations**

Partners and providers identified multiple groups consistently falling through the cracks:

- Uninsured/underinsured individuals, including undocumented immigrants and low-income families.
- Working adults and caregivers, especially those unable to access services during standard business hours.
- Youth and young adults, particularly LGBTQIA+ youth, high-achieving students, and those self-medicating with cannabis or ENDS.
- Older adults, facing loneliness, untreated mental illness, and high suicide risk.
- People experiencing homelessness, who are often excluded from long-term care planning due to shelter limitations or documentation requirements.
- Men struggling with depression or suicidality, who are less likely to seek help and more likely to face stigma.

**Cross-Cutting Emerging Issues**

1. **Stigma & Discrimination in Care**

   Many focus groups spoke to the lived experience of being treated poorly or denied compassionate care because of one's appearance, housing status, insurance, or co-occurring conditions.

   "Discriminatory care—if you look healthier or have better insurance, you're treated better." — RNP Focus Group, 2025

2. **Loneliness and Social Disconnection**

   Across communities and age groups, social isolation was cited as a major driver of behavioral health challenges, especially in the post-COVID era.

   "This loneliness is the fallout of COVID. At first, it was depression & suicide. Then, it was anxiety. Now, it is loneliness." — LPC Prevention Focus Group, 2025

3. **Disconnected and Underfunded Prevention Systems**

   Prevention providers report significant challenges due to siloed funding, substance-specific grant restrictions, and an overwhelming volume of responsibilities. There is no community prevention funding dedicated to suicide or gambling, and adult-focused efforts are severely under-resourced.

"Youth substance use gets prevention money. Gambling gets silence." — Gambling Focus Group, 2025

"There is very little funding for adult alcohol misuse, suicide prevention, or adult cannabis use." — LPC Prevention Focus Group, 2025

**Figure 6: Summary of Resource Gaps and Needs in Region 1**

| Gap/Need | For Whom/What Group | Rationale/Evidence |
|---|---|---|
| No urgent crisis centers for youth; limited postvention resources following suicide attempts. | Youth and families in crisis; LGBTQIA+, BIPOC populations | Region 1 lacks child-specific crisis stabilization centers. Youth aged 10–17 had a suicide ideation rate of 435.5 per 10,000. Focus groups highlighted post-crisis gaps. QPR training is underutilized. |
| Fragmented referral systems, long 2-1-1 wait times, and inconsistent care coordination. | Individuals navigating behavioral health services | Stakeholders cited delayed access due to fragmented referrals and 2-1-1 inefficiencies. 35.2% identified care coordination as a top mental health service need. |

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| Inconsistent behavioral health supports across school districts. | Youth and school staff | Youth surveys show disparities in support access: only 35% of Trumbull students know where to get help. Stakeholders cited school avoidance and unmet mental health needs. |
| High staff turnover and burnout; shortage of bilingual, culturally competent providers. | Behavioral health workforce and clients needing culturally aligned care; BIPOC populations | Focus groups and surveys highlighted staff burnout. There is a shortage of Spanish-speaking providers and peer roles. Equity profiles show service disparities. |
| Prevention efforts are overconcentrated on youth vaping/ENDS. | Adults, seniors, and underserved populations | Prevention funds favor youth ENDS use. Community input notes rising alcohol, gambling, and stimulant use among adults are ignored. Stakeholders emphasized lack of adult-focused campaigns. |
| Homeless and unstably housed individuals lack access to care. | Unhoused and at-risk residents | Bridgeport respondents emphasized re-use post-discharge due to lack of wraparound care. |
| Problem gambling prevention and treatment. | Youth, Young Adults, Older Adults, BIPOC populations | Gambling behavior is increasing among youth and young adults, especially through online sports betting and gaming-related microtransactions. Region 1 lacks dedicated prevention infrastructure—no LPCs include gambling, and prevention is rarely included in school curricula. Only 16.3% of Region 1 residents have been asked about gambling by a provider. Stakeholders emphasized concern about financial instability, low awareness, |

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| | | and a lack of screening and referral services. |

## Other Needs Assessments and Funding

As part of the regional prioritization process, existing data and findings from **issue-specific needs assessments and strategic plans** were reviewed to ensure alignment and avoid duplication of efforts. These existing efforts provided valuable insight into **established behavioral health priorities** and **populations of concern** across the region.

**Figure 7** presents a summary of **previously identified needs and priorities** derived from regional assessments and initiatives, including targeted assessments on cannabis, suicide, vaping, alcohol, and mental health. These reports reflect deep community engagement and underscore disparities across subpopulations, including youth, LGBTQIA+ individuals, Black and Latine communities, veterans, and older adults. Many of the priorities align with the regional findings presented in this report.

At the same time, **Figure 8** outlines **current RBHAO funded initiatives** addressing key behavioral health priorities. These initiatives are supported by a range of public funding sources, including the Connecticut Department of Mental Health and Addiction Services (DMHAS), the Department of Children and Families (DCF), and the United Way. The funded projects span a variety of focus areas, such as opioid overdose prevention, suicide prevention, youth vaping and cannabis use, and community-based mental health efforts. Importantly, these initiatives also reflect the use of **evidence-based strategies** and **cross-sector partnerships** to address health disparities.

Together, these tables provide a snapshot of **where the region has already committed resources** and where additional efforts may be needed to fill remaining gaps, align initiatives, or reinforce strategies targeting **underserved populations**.

**Figure 7: Summary of Needs Assessment Priorities in Region 1**

| Needs Assessment Initiative/Project | Focus Area of Initiative/Project | Identified Priority (Issue and Population of Focus) |
|---|---|---|

| | | |
|---|---|---|
| Regional Cannabis Needs Assessment | Regional Cannabis Use | Less perception of risk/harm in youth.<br>Illicit cannabis sales from noncompliant merchants.<br>Youth vaping high-THC oils, especially girls, LGBTQIA+, Black & Latine.<br>Lack of education for parents. |
| The Hub Assessment of Suicide Across the Lifespan | Suicide Across the Lifespan | LGBTQIA+ youth experience increased suicidal ideation and behavior compared to peers. Men. Older adults (75-84 and 85+) increased suicide deaths. |
| Assessment of Vaping Nicotine | Regional e-cigarette prevention and cessation | Increase youth perception of risk/harm in Urban Core and Urban Periphery community types, assist schools in Restorative Practices including education and cessation resources and services, increase perception of harm from vaping among parents/caregivers, increase low enforcement of minimum age to purchase and fair proportion of youth report<br>purchasing vape products from stores, support and provide resources to ENDS retailers including education on<br>checking IDs and generally the benefits of preventing underage sales |
| Addressing Priority Concerns Established in the Deeper Dive of 2023 Priority Reports | Regional Alcohol Use | Alcohol use in adults has increased and continues to be a priority area of concern, specifically for |

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| | | Black and Latine communities. |
| Addressing Priority Concerns Established in the Deeper Dive of 2023 Priority Reports | Regional Mental Health | Co-occurring disorders in adults.<br>Stigma, lack of access and lack of providers available in multiple languages in adults.<br>Lack of resources for veterans, LGBTQIA+, and other marginalized groups. |

**Figure 8: Summary of Current Funded Priorities in Region 1**

| Initiative/Project Name | Funding Source | Time Period | Priority Issue and Population of Focus |
|---|---|---|---|
| Prescription Drug Opioid Contract | DMHAS | 6/1/2024-8/30/2028 | Building capacity within First Responder role (i.e. EMS) to educate and provide Naloxone kits to people in a dwelling that witnessed/experienced an overdose |
| Regional Suicide Advisory Board Grant | DMHAS | 3/1/2023-8/31/2025 | Promote, facilitate, build capacity and readiness related to suicide prevention, postvention and grief support across the continuum of care |
| State Opioid Response / Recovery Friendly Workplace Grant | DMHAS | 9/30/2024-9/29/2027 | Prioritizes preventing opioid use disorder by targeting non-prescription use and the shift from prescription opioids to heroin through multi-faceted strategies. Efforts focus on education, early intervention, and outreach to high-risk |

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| | | | populations across the region. |
| Regional Behavioral Health Action Organization Grant | DMHAS | 7/1/2024-6/30/2027 | The operation of the RBHAO and managing Local Prevention Councils |
| JUUL (Vape) Contract | DMHAS | 5/1/2024-9/30/2025 | Support the abatement, mitigation, cessation, reduction, or prevention of e-cigarette use by Connecticut residents under 21 years of age. |
| Legislative Grant | DMHAS | 12/1/2023-6/30/25 | Implement the Strategic Prevention Framework (SPF) to address adult alcohol use and co-occurring mental health conditions across the lifespan in the communities of Bridgeport and Stratford. |
| Cannabis Grant | DMHAS | 3/1/2024-6/30/2026 | Youth cannabis prevention efforts and promote responsible adult use cannabis |
| Suicide Prevention Grant | DCF | 1/1/2024-9/30/2026 | Perform training, coaching, and competency development in prevention, intervention and Postvention od suicide for children, adolescents and emerging adults |
| CT Alliance of Substance Exposed Children | DCF | 10/1/2024-9/30/2027 | Train and coordinate Drug Endangered Children curriculum to our community at large |
| CT Partnership for Hope and Healing (PH2) | United Way of CT | 9/30/2023-9/29/2028 | Build the capacity of informed, coordinated and sustainable key partnerships across |

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| | | | multiple sectors and settings, including schools to reduce suicide risk and death among youth age 24 and under within the selected PH2 community |
| Community Partnership Grant | Greenwich Department of Human Services | 7/1/2024-6/30/2025 | Enhance our work within the Greenwich Community operating as a RBHAO |

## Priorities and Recommendations

The following summary reflects a synthesis of epidemiological data, stakeholder surveys, youth surveys, and extensive input from local focus groups conducted across DMHAS Region 1 in early 2025. It addresses the core questions guiding the regional behavioral health priority-setting process.

**What are the most pressing [behavioral health] needs in your region?**

Partners overwhelmingly pointed to the shortage of mental health and substance use treatment providers as one of the most urgent challenges. Despite increased awareness and demand, access to care remains limited, particularly for youth, those without insurance, individuals experiencing homelessness, and non-English speakers. As one treatment center staff member shared, “People who want to get better are stopped by every system they interact with.” Parents in the region echoed this frustration, noting that even when a provider is identified, “there are long waitlists,” especially for children’s psychiatric care.

Another dominant theme was the widespread impact of loneliness, isolation, and social fragmentation—what several focus group participants described as the “fallout of COVID.” As one LPC prevention leader reflected, “At first, it was depression and suicide. Then, it was anxiety. Now, it is loneliness.” This disconnection is not only affecting youth but also seniors, caregivers, and working adults. Local prevention leaders noted a drop in

community engagement and club participation, while seniors remain “shut in” and “haven’t come out of this since COVID.”

Substance misuse remains a top concern—particularly the normalization of alcohol and cannabis use among adults and youth. Vaping, cannabis, and alcohol were frequently cited as the most used and most concerning substances, with youth and young adults facing high exposure through peers, parents, and retail environments. Several communities highlighted unregulated smoke shops and the illegal sale of cannabis and vape products to minors. As one prevention specialist put it, “This is a storefront drug dealing operation,” with middle schoolers observed entering and exiting shops freely.

Mental health concerns, particularly anxiety, depression, and suicidality—continue to affect youth and young adults at alarming levels. Stakeholders described a surge of psychiatric calls, especially for teens and college-aged individuals, alongside a shortage of culturally competent care and wraparound services. One college health professional reflected, “Many stories of people attempting [suicide] are not being documented,” and the need for suicide awareness and follow-up support remains pressing.

**Which groups are most at-risk or burdened by these issues (a.k.a. for whom/which groups)?**

Region 1 partners identified several populations as being particularly at risk or under-resourced:

- Youth and young adults, especially those navigating post-COVID social development, academic pressure, and substance use normalization.
- Adults aged 30–50, who are often overlooked in prevention messaging despite high rates of alcohol use and stress-related coping.
- LGBTQIA+ individuals, especially youth and young adults, who report higher rates of anxiety, depression, and substance use.
- Unhoused individuals, undocumented residents, and those with limited English proficiency, who face significant barriers to care and discrimination.

- Middle-income individuals and working professionals, who are often “too rich” for subsidized care but “too poor” for private services.
- Behavioral health staff themselves, many of whom are “burnt out, underpaid, and struggling with basic needs,” as noted by multiple treatment provider participants.

**What are the contributors to these conditions?**

The drivers of behavioral health conditions in Region 1 are both structural and cultural. The housing crisis, cost of living, and lack of transportation were repeatedly cited as barriers to treatment and recovery. Behavioral health professionals described watching clients “get discharged with no support” and “return to the streets where the nearest liquor store is open, but the warming center isn’t.”

Additionally, stigma and discrimination within healthcare systems persist. Clients have reported feeling dismissed or shamed, especially those with visible poverty, co-occurring disorders, or complex needs. As one counselor put it, “It’s always who has it worse,” suggesting a triage culture that leaves the most vulnerable behind.

Prevention leaders also emphasized shifting cultural norms around substances, with cannabis and gambling being widely accepted—and even promoted—through advertising, social media, and adult modeling. As one prevention specialist noted, “We smell weed in every smoke shop parking lot… no one’s talking about adult alcohol misuse, and binge drinking is huge.”

**What [behavioral health] need(s) are not being adequately addressed in your region?**

Several needs remain critically underserved despite high urgency:

- Crisis care and emergency mental health infrastructure: waitlists are long, discharge plans are inadequate, and follow-up care is inconsistent.
- Access to care for uninsured, underinsured, or undocumented residents: especially those who fall into gaps due to age, citizenship status, or insurance changes (e.g., age 62–65).

- Adult prevention efforts: funding is overwhelmingly focused on youth, with little support for adult behavioral health education, alcohol misuse, or gambling.
- Problem gambling prevention and treatment: communities are unprepared for the cultural shift in gambling norms and lack both resources and screening protocols.
- Behavioral health supports for those experiencing homelessness: warming centers, shelters, and outpatient treatment services are insufficient or poorly coordinated.
- Multilingual, culturally competent care: a major gap in behavioral health access for immigrant populations and non-English speakers.
- Workforce recruitment and retention: the region is losing experienced providers to burn out and financial stress, exacerbating provider shortages.

**For whom/what groups?**

Across behavioral health domains, Region 1's most affected populations include:

- Youth: (especially high school students and College Freshman, LGBTQIA+, and girls): for anxiety, depression, vaping, cannabis use, and suicide ideation.
- Young Adults (18–34): for cannabis, alcohol, gambling, and stimulant misuse; lack of services for post-high school youth was frequently noted.
- Adults aged 35–64: for alcohol misuse, stimulant use, and mental health concerns, especially in urban centers and among those navigating financial stress.
- BIPOC and Hispanic communities: for higher rates of ED visits, lower treatment access, and increased cannabis/alcohol/stimulant involvement in overdoses.
- Uninsured and undocumented individuals: who face systemic barriers to care, including lack of providers who accept Medicaid or sliding scale options.
- People experiencing homelessness or housing insecurity: who are often discharged from care without follow-up, transportation, or a plan.
- Men: are underrepresented in help-seeking and disproportionately affected by substance-related deaths and suicide.
- Providers themselves: who face burnout, low pay, and high turnover while navigating a system that often fails to meet the needs of their clients.

**What actions and/or services do you recommend to better address these needs?**

Region 1 is focused on expanding harm reduction strategies, improving merchant compliance, and increasing access to peer recovery supports and housing. Key efforts include:

**Substance Use/Misuse Prevention and Treatment:**

- Merchant education and compliance trainings to reduce youth access to alcohol, cannabis, and tobacco/vape products.
- Advocacy for stricter retail enforcement and greater access to reliable drug testing tools.
- Expansion of harm reduction education and insurance coverage for peer recovery coaches.
- Emphasis on affordable housing as a critical recovery support.

**Mental Health Promotion, Treatment, and Recovery:**

To address ongoing stigma, service gaps, and infrastructure needs, the region is prioritizing:

- Community conversations focused on reducing isolation among seniors.
- Youth mental health assessment through focus groups and surveys.
- Opening a mental health urgent care center in Southwest CT.
- Expanding crisis response and de-escalation training for first responders.

**Suicide Prevention:**

The region aims to strengthen suicide prevention by:

- Standardizing notification processes for adult sudden deaths.
- Increasing public understanding of the 988-crisis line.
- Conducting focus groups to identify service gaps for the LGBTQIA+ population, a group with elevated suicide risk.

**Problem Gambling:**

Efforts will focus on early identification and education through:

- Integration of gambling screenings in primary and behavioral healthcare.
- Provider education sessions to highlight changing laws, risk factors, and available resources, with a focus on high-risk males.

**System-Level Recommendations:**

To strengthen planning and service delivery, Region 1 recommends:

- Supporting RBHAOs with robust local data dashboards.
- Improving prioritization, funding, and planning using more detailed and accessible data.

Region 1's RPR Team engaged in a comprehensive data review and partner engagement process to identify and prioritize the region's most pressing behavioral health needs. This included analyzing local and statewide quantitative data, conducting key informant interviews and focus groups, and synthesizing input from providers, community leaders, and individuals with lived experience.

The most critical needs identified across the region include rising rates of youth substance use, limited access to mental health crisis services, persistent stigma—particularly among men and seniors—and emerging behavioral health challenges such as problem gambling and gaming. Data also revealed underserved populations such as LGBTQIA+ individuals, isolated seniors, and underage youth who face heightened risks without adequate access to supports.

Concurrently, significant resource gaps were identified. These include a lack of regional mental health crisis infrastructure (e.g., no Urgent Crisis Center for youth and families), underutilization of peer support professionals, limited education around harm reduction and problem gambling, and barriers to care such as affordability, insurance limitations, and transportation.

To address these issues, the RPR Team developed specific, actionable regional goals across each focus area—substance use prevention and recovery, mental health, suicide prevention, and problem gambling. Each goal is grounded in SMARTIE principles and supported by current data and stakeholder insights. Additionally, a state/system-level recommendation was developed to support data-driven planning, funding equity, and service improvement.

Together, these goals and recommendations reflect a shared commitment to building a more responsive, inclusive, and equitable behavioral health system in Region 1.

## Regional Priorities

Based on the prioritization process conducted by the Region 1 Priority Workgroup (RPW), this section summarizes the most pressing behavioral health priorities across the domains of substance use, mental health, suicide, and problem gambling. The RPW engaged in a structured and collaborative review of quantitative epidemiological data, stakeholder survey results, and qualitative insights from key informant focus groups representing prevention, treatment, recovery, and special populations. This process centered equity by identifying populations most at risk and historically underserved, and emphasized changeability, regional capacity, and alignment with local needs.

Through this process, CPES and DMHAS identified six primary focus areas:

**(1)** Substance Use/Misuse Prevention;

**(2)** Substance Use/Misuse Treatment/Recovery;

**(3)** Mental Health Promotion;

**(4)** Mental Health Treatment/Recovery;

**(5)** Suicide prevention; and

**(6)** Problem Gambling.

One additional statewide systems-level priority, data infrastructure improvement, was also identified to support all areas of behavioral health work.

Each identified priority includes a population of focus and was selected based on both the scale of the issue and the feasibility of addressing it with existing or enhanced resources. For example, youth vaping and cannabis use remain prevalent and normalized, prompting calls for merchant education and access control. Mental health concerns among seniors and youth alike, especially anxiety, loneliness, and isolation—emerged as persistent but under-addressed issues. Meanwhile, crisis care infrastructure gaps and increasing suicide risk among LGBTQIA+ youth and adults highlighted the need for more responsive and inclusive service models. Cross-cutting issues such as workforce burnout, housing instability, and insufficient access to culturally and linguistically appropriate care further shaped the region's priorities.

Figure 9 (following) outlines each focus area, the rationale for its selection, and the populations of focus. These priorities will guide regional goals and actions over the 2025–2027 implementation period and serve as a foundation for collaboration, funding strategies, and systems improvement efforts.

**Figure 9: Summary of Identified Priorities in Region 1**

| Focus Area | Rationale/Considerations | Population of Focus |
|---|---|---|
| 1. Mental Health | Rising rates of anxiety, depression, and loneliness across age groups; limited access to culturally competent, affordable, and bilingual care; long waitlists; provider burnout; school systems overwhelmed; older adults often excluded from mental health outreach and planning. | Youth (especially girls and LGBTQIA+), older adults, working-age adults, BIPOC residents, non-English speakers. |
| 2. Suicide | Suicide rates are increasing, particularly among LGBTQIA+ youth, men, and older adults; emergency room data shows high suicidal ideation among youth; systems lack consistent postvention infrastructure and culturally responsive suicide prevention. | LGBTQIA+ youth and adults, men, and older adults. |

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| 3. Heroin & Other Illicit Opioids | High rates of opioid-related deaths in Bridgeport, Stamford, and Stratford; fentanyl present in over 75% of cases; ongoing concerns about xylazine and polydrug use; lack of wraparound care after overdose or detox; treatment access uneven by geography and insurance. | Adults 25–64, especially in urban centers and those experiencing homelessness or co-occurring disorders. |
| 4. Alcohol | Alcohol misuse is normalized and under-addressed, especially among adult men; binge drinking rates are high (22.2% in males 18–34); alcohol-related ED visits are highest in Bridgeport and among Hispanic residents; few adult-focused prevention efforts exist. | Adult males (18–34), Hispanic and Black adults, working-class families, older adults. |
| 5. Vaping & ENDS | Vaping is the second most commonly used substance among youth; average age of first use is 13.3; 17.4% of vape retailers failed compliance checks; normalization through peer networks and retail access is rampant. | Middle and high school students; youth of all genders and backgrounds; LGBTQIA+ youth; suburban youth. |
| 6. Prescription Drugs | Increases in misuse of gabapentin and benzodiazepines; high rates of co-prescription with opioids; lack of disposal awareness and proper tracking; polypharmacy risks not well managed among older adults or those with chronic conditions. | Adults with chronic pain, older adults, individuals with co-occurring conditions. |
| 7. Problem Gambling | Surge in online and sports betting among youth and young adults; 83% of residents were never screened by providers; males most affected; providers lack training on gambling risks and interventions; gambling intertwined with gaming, financial stress, and mental health. | Youth and young adults, especially males; BIPOC adults; older adults; individuals with co-occurring disorders. |
| 8. Cannabis | Cannabis use is increasingly normalized; youth use linked to self-medication and emotional distress; sharp increase in school-related incidents and ER visits; illegal high-THC sales from smoke shops; little adult education. | Youth and young adults (especially LGBTQIA+ and suburban youth); adults using for stress relief or co-occurring conditions. |

| | | |
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| 9. Tobacco | While vaping dominates headlines, cigarette use persists, especially in low-income areas; tobacco is often co-used with cannabis and alcohol; youth prevention remains a focus, but adult cessation resources are underutilized. | Youth (12–18); low-income adults; individuals in recovery from other substance use. |
| 10. Cocaine & Other Stimulants | Stimulant-related deaths are rising sharply— 93 in Region 1 in 2023; often involved in polydrug use with fentanyl; Bridgeport and Stamford have the highest rates; lack of treatment infrastructure and public awareness of stimulant risks. | Adults 25–64; especially in Bridgeport, Stamford, Stratford; individuals with co-occurring disorders or housing instability. |

## Recommendations

The Regional Priority Workgroup (RPW) reviewed existing data, identified service gaps, and considered emerging behavioral health issues to develop targeted, actionable recommendations. These reflect input from diverse stakeholders and address six key areas: **substance use prevention**, **treatment and recovery**, **mental health promotion**, **mental health treatment and recovery**, **suicide prevention**, and **problem gambling**. One system-level recommendation was also included. Common themes across all areas include the need for improved access to care, workforce support, community education, and affordable housing.

**Figure 10: Summary of Regional Recommendations: Region 1**

| Area/ System of Focus | Recommendation | Rationale | Involved Parties |
|---|---|---|---|
| **Substance Use/Misuse Prevention*** | Increase accessibility to reliable drug testing tools<br><br>Stricter policies and enforcement of retailers | Harm reduction<br>No reliable testing<br>Access is too easy for underage individuals<br><br>These will reduce overdose, and underage use | DMHAS, DPH, LPCs<br>Legislators |

| | | | |
|---|---|---|---|
| **Substance Use/Misuse Treatment/Recovery*** | Increase harm reduction education and practices<br><br>Insurance coverage for peer support/recovery people<br><br>Affordable housing | Need multiple ways to recovery - abstinence only can be a deterrent for entering treatment<br><br>Peers are trained but not being fully utilized and are an important part of recovery<br>Significant lack of affordable housing in Fairfield County Safe and affordable housing is an important part of recovery | DMHAS. Treatment providers Legislators and local municipalities |
| **Mental Health Promotion*** | Stigma reduction campaigns<br><br>Comprehensive look at youth anxiety including a statewide survey | There continues to be stigma regarding mental health treatment – especially among males – males are at high risk of overdose, alcoholism and suicide<br><br>Anxiety among youth continues to be a concern raised in focus groups and in surveys – 34% of Trumbull youth reported persistent anxiety | DMHAS, RBHAOs, LPCs |
| **Mental Health Treatment/Recovery*** | Open an urgent care center is Southwest CT<br><br>Increase de-escalation and mental health | SW CT is the only region that does not have an urgent crisis center – families must find | DCF, DMHAS. Local and State police departments, |

| | | | |
|---|---|---|---|
| | crisis training for first responders | transportation to New Haven or Waterbury<br><br>First responders need support and training when working with the public to reduce the number of people with significant mental health issues in prison | Legislators, RBHAOs, LPCs |
| **Suicide Prevention*** | Create notification process regarding adult sudden deaths<br><br>Increase education regarding 988 | Lacking a consistent notification process for adult sudden death<br><br>Lack of community understanding of the difference between 911, 988 and 211, 988 texting etc. | DCF, DPH RBHAOs LPCs DMHAS |
| **Problem Gambling*** | Incorporate gambling into behavioral health screenings at primary care offices<br><br>Education of pediatricians and primary care doctors regarding gambling due to the increase in access | Gambling misuse is connected to all behavioral health issues- most individuals with a gambling problem are never asked this question.<br><br>Drs need a better understanding of the connection to other health concerns | DMHAS. DPH, RBHAOs, LPCs Legislators |

**Figure 11: Summary of State/System Recommendations: Region 1**

| Area/ System of Focus | Recommendation | Rationale | Involved Parties |
|---|---|---|---|
| **Statewide Data Collection Improvement** | No later than January 1, 2027, implement a comprehensive data tracking platform capable of illustrating local data to support the efforts of the Regional Behavioral Health Action Organizations (RBHAOs). The platform will inform the identification and prioritization of needs across prevention, treatment, and recovery-support systems, with the resulting data used to develop regional (RBHAO) dashboards that deliver timely, actionable insights for ongoing monitoring, strategic planning, and system-level improvements. | Improving the availability of regional and local data will enhance coordination across systems, strengthen prevention and treatment efforts, and ultimately lead to better outcomes for individuals and communities throughout Connecticut. The issue of inadequate data or no data was an issue for each category. The lack of data inhibits everyone's ability to improve services, tell the right story, allocate funding appropriately, etc. | RBHAOs, DMHAS/ other state agencies, CPES |

## Regional Goals

The RPW identified four SMARTIE-aligned goals for 2025–2027, addressing key behavioral health areas: **substance use/misuse prevention**, **mental health promotion**, **problem gambling**, and **suicide prevention**. Each goal is data-informed, region-specific, and centered on the needs of high-risk and underserved populations. The goals aim to promote equity, increase awareness, improve provider capacity, and reduce behavioral health risks across our communities.

### Substance Use/Misuse Prevention

**Figure 12: Region 1 Substance Use/Misuse Prevention Goal**

| **Regional Goal** |
|---|
| Within two years, develop a merchant education, and compliance training, in collaboration with the Statewide Tobacco Merchant and Community Education Steering Committee. The training will address alcohol, cannabis and tobacco/vaping product to reduce access to under-aged individuals. 4 trainings will be conducted by the end of year 2 with 8-10 participants per training session. |
| **Rationale** |
| TPEP data covering 2023 and 2024 showed compliance rates in Region 1 80.1% and non-compliance rates at 19.9%. Among non-compliant results, ENDS were involved 33.6% of the time, tied with cigars and followed by cigarettes. |
| **Focus Population(s)** |
| Merchants and underage youth |

### Mental Health Promotion

**Figure 13: Region 1 Mental Health Promotion Goal**

| **Regional Goal One** |
|---|
| Within two years, 4 community conversation sessions focused on loneliness and isolation among seniors will be conducted. Conversations will be held at senior centers in Region 1. The Conversations will focus on how to better engage and reach seniors, and what kind of resources can be created specifically for seniors in order in increase connectedness. Minimum of 4 conversations with 5-10 participants per conversation. |
| **Rationale** |
| According to key informant focus groups and interviews, community isolation is often a challenge that is not captured by data but continues to persist in a post-COVID. Stakeholders in Bridgeport and Stratford emphasized that seniors often go unseen in |

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| outreach and prevention planning. Living on fixed incomes, facing mobility barriers, and experiencing profound isolation, many seniors do not receive geriatric-informed mental health care. This invisibility has significant consequences, particularly when symptoms of depression or grief go undetected or untreated. |
| **Focus Population(s)** |
| Seniors in Region 1 |
| **Focus Population(s)** |
| Seniors in Region 1 |

### Mental Health Promotion

**Figure 14: Region 1 Mental Health Promotion Goal**

| **Regional Goal One** |
|---|
| Over two years a comprehensive collection of data regarding the severity of anxiety among youth ages 12-18. Find and implement in collaboration with other RBHAOs a youth survey and focus groups that specifically ask questions about youth mental health, depression and anxiety. |
| **Rationale** |
| Anxiety among youth continues to be a concern raised in focus groups and in surveys – 34% of Trumbull youth reported persistent anxiety. |
| **Focus Population(s)** |
| |
| Youth 12-18 |
| |

### Suicide Prevention

**Figure 15: Region 1 Suicide Prevention Goal**

| **Regional Goal** |
|---|
| In 2 years, conduct a minimum of 4 focus groups to better identify gaps in services needed to address the high suicide rate among LQBTQIA+ community - 2 focus groups per year. - 2 groups that include LGBTQIA+ individuals, 1 group of parents of |

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| LGBTQIA+ children and 1 group of LGBTQIA+ serving organizations. 5-8 individuals in each focus group.<br>The goal of the focus groups will be to identify gaps in services and how to more effectively reach this population with resources, education and support, resulting in a more informed region. |
| **Rationale** |
| The LGBTQIA+ community has the highest rate of suicide - 34% of LGBTQIA+ youth have contemplated suicide.<br>This community is also seen as one of the most underserved and underreported. |
| **Focus Population(s)** |
| LGBTQIA+ |

### Problem Gambling

**Figure 16: Region 1 Problem Gambling Goal**

| **Regional Goal** |
|---|
| Within 2 years educate providers (pediatricians, treatment providers on problem gambling and gaming behaviors in youth/adults through direct education. Education will include the changes in gambling laws and trends, the dangers and warning signs and how to identify risk factors. Training will include CT based resources, optional screening tools, and gambling helpline number.<br>A minimum of 4 education sessions will be held – 2 treatment providers and 2 school based or community-based health centers. |

| **Rationale** |
| --- |
| Doctors and treatment providers lack understanding of problem gambling or gaming and its connection to other behavioral health concerns.<br>Individuals are not asked about their gambling or gaming behavior during doctor visits or when they enter treatment. 83.7% of individuals reported never being asked about their gambling behaviors, which is higher than last year at 83% - Gambling Community Survey 2023-2024<br>Problem Gambling continues to emerge as a significant behavioral health challenge in CT. |
| **Focus Population(s)** |
| The focus is educating providers in school-based health center and community-based health centers with an emphasis on male patients - being at much higher risk than females - 81% males, 19% females in calls to the help line from Region 1. |

## Conclusion

The 2024–2025 Regional Priority Report for Region 1 reflects a comprehensive and community-informed process to identify the most pressing behavioral health needs across Southwestern Connecticut. Grounded in both qualitative and quantitative data including epidemiological indicators, focus groups, stakeholder surveys, and youth feedback, this report presents a multifaceted view of the behavioral health challenges and opportunities within the region.

Throughout the process, several core issues emerged: provider shortages and burnout, disparities in care access for BIPOC and LGBTQIA+ populations, unmet mental health needs among youth and older adults, the normalization of substance use among young people, and a lack of prevention infrastructure for under-addressed areas such as

gambling and adult alcohol use. These challenges are compounded by structural determinants such as housing instability, transportation inequities, economic pressures, and persistent stigma.

Despite these barriers, Region 1 is also home to significant strengths, including a robust network of prevention coalitions, treatment and recovery providers, community champions, and cross-sector partnerships. The region has shown a strong capacity for innovation—through initiatives like Recovery Friendly Workplaces, youth-led prevention campaigns, culturally tailored programming, and interagency collaboration. The priorities and recommendations outlined in this report are designed not only to respond to today's challenges but to anticipate future needs.

Moving forward, Catalyst CT | The Hub and our partners will use these findings too:

- Inform local and statewide strategic planning,
- Target resources to underserved populations and unmet needs,
- Guide the allocation of DMHAS funding and other public investments,
- And support equitable, data-driven prevention, treatment, and recovery services across Region 1.

As a living document, this report will continue to evolve. We invite ongoing engagement from stakeholders across systems and communities to ensure that our efforts remain responsive, inclusive, and aligned with the behavioral health realities of the diverse populations we serve.

# Appendices

## Appendix A: Regional Priority Workgroup Matrix – Final ranking results

| PROBLEM | Magnitude (Average) | Severity & Impact (Average) | Changeability (Average) | Capacity & Readiness (Average) | Consequence of Inaction (Average) | Total Ranking Score | Total Average Score | Rank |
|---|---|---|---|---|---|---|---|---|
| Alcohol | 1.05 | 1.04 | .49 | .47 | .84 | 54.55 | 3.90 | 4 |
| Cannabis | 1.09 | .78 | .49 | .48 | .73 | 46.95 | 3.35 | 8 |
| Cocaine & Other Stimulants | .71 | .80 | .46 | .39 | .74 | 43.5 | 3.11 | 10 |
| Problem Gambling | .88 | .82 | .49 | .47 | .67 | 47.3 | 3.38 | 7 |
| Heroin & Other Illicit Opioids | .98 | 1.04 | .55 | .47 | .89 | 54.8 | 3.91 | 3 |
| Mental Health | 1.25 | 1.25 | .57 | .58 | .94 | 64.25 | 4.59 | 1 |
| Prescription Drugs | .82 | .88 | .49 | .49 | .74 | 47.95 | 3.43 | 6 |
| Suicide | .91 | 1.11 | .54 | .55 | .89 | 55.85 | 3.99 | 2 |
| Tobacco | .82 | .77 | .55 | .54 | .66 | 44.6 | 3.19 | 9 |
| Vaping & ENDS | 1 | .98 | .57 | .51 | .8 | 54.1 | 3.86 | 5 |

**Final Ranking**

1. Mental Health
2. Suicide
3. Heroin & Other Illicit Opioids
4. Alcohol
5. Vaping & ENDs
6. Prescription Drugs
7. Problem Gambling
8. Cannabis
9. Tobacco
10. Cocaine & Other Stimulants

## Appendix B – Data Profiles for Prioritization Team

Region 1, Data Profiles, 2025

Alcohol

Use in Connecticut:

Alcohol remains the most commonly used substance across all age groups in Connecticut. According to the 2022 Connecticut Community Readiness Survey, 61.2% of adults aged 26 and older reported past-month alcohol use, the highest among all substances across age groups. Binge drinking — defined as five or more drinks on one occasion for men or four for women — was reported by 17.0% of Fairfield County adults in 2022, close to the state average (17.3%) and slightly lower than the national average (17.9%).

In Southwest Connecticut (Region 1), alcohol was identified as the top primary substance of concern among adults 26-65 (60.5%) and adults aged 66+ (61.9%). Among high school youth, past-30-day alcohol use ranged from 5.3% in Stamford to 25.9% statewide, with higher usage rates in upper grades—Darien reported 50% of 12th graders consumed alcohol in the past month.

Magnitude, Impact, and Severity

Alcohol-related health impacts are visible through emergency department (ED) data and mortality reports. Southwest Connecticut (Region 1) had the second-highest rate of alcohol-related ED visits in the state (90.39 per 10,000), with Bridgeport (153.1), Stamford (123.9), and Norwalk (121.0) which had the highest rates within the region. Alcohol was involved in 42 accidental deaths in Connecticut in 2023, with 76% of these deaths occurring at home. Of those who died, the majority were male (76%) and White (69%).

Substance-related emergency visits have risen, particularly for younger adults aged 20–44. Alcohol accounted for 68% of hospital referrals to recovery coaches from 2017–2023, and only 14.6% of Black individuals and 10.5% of Hispanic individuals in need of treatment received it, indicating disparities in access.

Emerging Issues and Needs

Alcohol misuse increased during the COVID-19 pandemic, with 20% of Connecticut adults reporting greater consumption due to heightened depression, anxiety, job loss, and food insecurity. Youth access to alcohol remains high. In New Canaan, 95% of respondents believe youth can access alcohol from home, and 49% consider underage drinking a

"normal part of growing up." Darien youth report obtaining alcohol from friends (56%), parents with permission (33%), and parents without permission (29%).

Barriers to treatment include affordability, lack of insurance, stigma, and limited availability of culturally and linguistically appropriate services. In Norwalk, multi-agency teams now intervene through Emergency Departments to provide SBIRT (Screening, Brief Intervention, and Referral to Treatment), and the city continues to enforce DUI laws and support zoning limitations near schools to reduce alcohol outlet density.

Data Gaps

Though data on binge drinking and alcohol-related hospital encounters are robust, there are gaps in tracking underage drinking behaviors across communities, as well as in measuring long-term treatment outcomes. Additionally, more comprehensive local-level data on alcohol-related violence and DUI incidents would strengthen the picture of alcohol's community impact.

Populations of Focus

- Youth: Young adults (ages 21-34) accounted for 37.1% of alcohol-related treatment admissions in Connecticut in 2022. Among youth, older high school students are most likely to report alcohol use, with rates as high as 50% in 12th grade.
- Race/Ethnicity: Hispanic individuals had the highest rates of alcohol-related ED visits (183.6 per 10,000) and binge drinking (23.3%), followed by Black individuals, who had nearly twice the rate of alcohol-related ED visits as White individuals.
- Geography: Urban centers such as Bridgeport, Stamford, and Norwalk bear the highest burden of alcohol-related harm, reflected in both ED visits and sales data (for example, Stratford had the highest per capita nip sales).
- Gender: Males comprised 71% of alcohol-related hospital referrals and had the highest rate of binge drinking (22.2%) among adults aged 18-34.

Other Considerations

High Morbidity: Alcohol is a carcinogen linked to at least seven types of cancer, including liver, breast, and colorectal cancers. Despite broad awareness campaigns, many individuals still do not fully understand the long-term risks. Community perception also reflects normalization of underage drinking, especially among older teens, and highlights a need for enhanced education and prevention efforts.

Cannabis

The legalization of cannabis in Connecticut has led to an evolving landscape in both recreational and medical use. This analysis examines cannabis use trends, emerging concerns, magnitude and severity, populations at risk, risk factors, and policy considerations, with a specific focus on Southwest Connecticut (Region 1).

Use in Connecticut:

Cannabis consumption in Connecticut has steadily increased, with 16% of adults reporting past-month use in 2022, up from 12.1% in 2021.

Among young adults aged 18-34, the prevalence is even higher, reaching 27.9%. Among high school students, lifetime cannabis use was reported by 11% of 8th graders, 24% of 10th graders, and 38% of 12th graders in 2022. While youth cannabis use remains lower than state and national averages, it is still a point of concern.

In Southwest Connecticut (Region 1), past 30-day cannabis use rates in high schools were lower than state and national averages. Among those who reported cannabis use, most obtained it from friends or peers and used it at friends' houses, parties, or public parks. Populations identified as being at higher risk for cannabis use in the region include girls, LGBTQIA+ youth—especially transgender and non-binary individuals—and Black and Latine youth (Various Local Youth Surveys, 2024).

Magnitude, Impact, and Severity

In 2022, 8.0% of adults reported daily or near-daily cannabis use, with higher rates among young adults. The increasing prevalence of cannabis use has raised concerns regarding its impact on public health and safety. Emergency department visits related to marijuana/THC use have risen significantly, particularly among young males aged 10-29 and disproportionately affecting Black and Hispanic populations. Data from Norwalk indicates that cannabis-related emergency department visits increased from 128 in 2021 to 179 in 2022. Additionally, cannabis-related school incidents have surged dramatically, with marijuana possession cases in Connecticut public schools increasing from 35 in the 2021-2022 school year to 823 in 2022-2023, and use-related incidents doubling from 226 to 456.

A regional survey of 38 school districts in Southwest Connecticut (Region 1) found that 74% of respondents agreed that their district understands youth cannabis use can result in addiction or dependence. However, 28.3% of respondents stated that their district does not consider the relationship between vaping and addiction or mental health when addressing vaping cases (B. Weyland Smith Cannabis Needs Assessment). In Southwest Connecticut (Region 1), emergency department visits related to marijuana/THC have also increased from 2021 to 2022. One specific town reported that marijuana/THC is one of the

primary substances associated with emergency cases for individuals aged 10-29 (Report on School Discipline in CT Public Schools).

The perception of risk associated with cannabis use has declined, particularly among youth. Surveys show that among 12th graders, cannabis has the lowest perception of harm compared to other substances, a trend that aligns with increased usage rates among this age group. The normalizing of cannabis use, combined with the availability of high-potency THC products, raises concerns about both short- and long-term health impacts.

Emerging Issues and Needs

One of the most pressing issues in Connecticut is the increased accessibility of cannabis through both legal and illicit markets. The legalization of adult-use cannabis in 2021, its open dispensaries starting in 2023, expanded retail availability, and unlicensed sales remain a staunch concern, with several reports of illicit THC products being sold at vape shops and convenience stores.

Currently, Southwest Connecticut (Region 1) has 6 hybrid retailers, 4 adult-use cannabis retailers, and 1 medical marijuana facility. However, illicit sales continue to be a problem. From 2023-2024, there have been multiple compliance inspection failures, resulting in arrests and citations for illicit cannabis sales. A recent law enforcement operation led to the seizure of 4,826 unlawful and unregulated products from eight different vape shops, with one smoke shop found to be selling fentanyl-laced cannabis (Regional Compliance Reports, 2024).

According to key stakeholders in Southwest Connecticut (Region 1), cannabis use remains a high-priority concern. Since the legalization of adult-use marijuana, community leaders have observed an increase in cannabis use, particularly among youth who are turning to vaping. Many report that the perception of harm associated with cannabis use has decreased. Additionally, illicit cannabis sales from vape and smoke shops, as well as gas stations and convenience stores, have contributed to greater accessibility. A growing concern in the region is the increase in high-potency THC products and their impact, including impaired driving risks and mental health consequences (Regional Focus Groups, 2024).

Data Gaps

Despite the available data, there are significant gaps in Connecticut's cannabis research, particularly at the regional level. There is limited comprehensive data on cannabis use patterns in Southwest Connecticut (Region 1), especially concerning underreported demographics such as LGBTQIA+ individuals, veterans, pregnant women, and homeless populations. Furthermore, data on cannabis-impaired driving incidents remains

insufficient, making it difficult to fully assess the risks associated with cannabis use and road safety.

Populations of Focus

Cannabis use varies significantly by age, with young adults (18-34) displaying the highest usage rates. Among adolescents, 30.7% of 12th graders reported past-year cannabis use, with the majority obtaining cannabis from friends. Use among older adults (55+) is increasing, reflecting shifting cultural attitudes and evolving product availability.

- Youth (12-17 years): In 2022, 8.3% of 8th graders, 19.5% of 10th graders, and 30.7% of 12th graders reported past-year cannabis use.
- Young Adults (18-34 years): This group has the highest prevalence of use, with 27.9% reporting past-month use in 2022.
- Adults (35-54 years): Reported a 15.7% past-month use in 2022.
- Older Adults (55+ years): Reported a 9.6% past-month use in 2022, showing the largest increase since 2017.

Sociodemographic Groups:

Disparities in cannabis use are evident across demographic groups. Males report higher use rates (15.4%) than females (9.1%). Non-Hispanic Black individuals report higher past-month cannabis use (15.5%) compared to White (12.4%) and Hispanic (10.9%) individuals. Additionally, individuals with lower income (<$25,000 annually) report significantly higher cannabis use rates (17.1%).

LGBTQIA+ youth, particularly transgender and non-binary individuals, are identified as a high-risk population, with significantly higher cannabis use rates compared to their peers. Surveys from Darien, Fairfield, and Greenwich consistently indicate that LGBTQIA+ youth and females have elevated cannabis use rates and are more likely to perceive the substance as less harmful.

Gender: Males reported higher usage (15.4%) compared to females (9.1%) in 2021.

Race/Ethnicity: Non-Hispanic Black individuals reported a 15.5% past-month use, higher than Non-Hispanic Whites (12.4%) and Hispanics (10.9%) in 2021.

Income: Individuals with an annual income below $25,000 reported higher usage (17.1%) compared to those earning more (12.4%) in 2021.

Sexual and Gender Identity: LGBTQIA+: Individuals identifying as LGBT+ reported higher usage (26.1%) compared to straight individuals (11.1%) in 2021.

Other Considerations

Perception of risk/harm: Declining perception of harm is associated with increased use, particularly among youth and young adults. The implementation of Connecticut's cannabis program has elicited mixed reactions from communities. While some view legalization as a progressive step toward rectifying past injustices, others express concerns about the effectiveness and transparency of social equity initiatives. Notably, the Social Equity Council (SEC), established to oversee equitable distribution of resources, has faced scrutiny over its operations. An audit revealed issues such as a lack of transparency and absence of formal procedures, leading to a pause in certain funding distributions.

Existing Funding: for social equity programs in Connecticut's cannabis industry is derived from various sources, including cannabis sales tax revenue and license fees. The SEC has been responsible for allocating these funds to communities disproportionately affected by previous drug policies. The SEC collaborates with various community organizations and stakeholders to implement social equity initiatives. These partnerships are crucial for promoting economic opportunities and addressing disparities resulting from historical drug enforcement policies. Despite these efforts, challenges persist in ensuring that resources effectively reach the intended communities, as evidenced by controversies surrounding grant distributions and the need for improved procedural frameworks. In 2023, the SEC distributed $6 million to third-party organizations as part of a community reinvestment pilot program. However, concerns regarding the distribution process and organizational practices led to a suspension of further funding pending an audit.

Cocaine & Other Illicit Stimulants

Stimulant use, particularly cocaine, was involved in 4.4% of all suicide deaths in Connecticut between 2015 and 2022 (CTVDRS, 2023). In Southwest Connecticut (Region 1), greater Bridgeport experienced a rate of 40.0 per 100,000 of drug overdose deaths in 2023. Despite its growing role in the overdose crisis, community concern about cocaine remains low across all age groups, particularly among youth and adults over age 66. Community education and public awareness campaigns will be critical to increasing recognition of stimulant-related harms.

Use in Connecticut:

Cocaine use in Connecticut, while not among the most commonly reported substances, remains a significant concern due to its growing involvement in overdose fatalities. According to the National Survey on Drug Use and Health (NSDUH), 2.1% of Connecticut adults reported past-year cocaine use in 2021-2022. Young adults aged 18-25 had the

highest rate (3.9%), compared to 2.0% among adults aged 26 and older, and just 0.2% among youth aged 12-17.

Statewide, cocaine is the third most reported drug of choice at DMHAS-funded substance use treatment centers, following alcohol and opioids. It is also the third most common drug of choice among individuals receiving mental health treatment (DMHAS Annual Statistics Report, 2023).

In Southwest Connecticut (Region 1) (Southwest CT), there were 93 accidental deaths involving cocaine in 2023, up from 71 in 2022—a 32% increase. Bridgeport accounted for more than half of those deaths, with 53 in 2023, up from 40 the year prior. Stamford and Stratford also saw significant increases (up 50% and 83%, respectively). Norwalk, Fairfield, and other towns reported consistent if lower numbers (CT OCME, 2023).

Magnitude, Impact, and Severity

In 2024, there were 532 confirmed cocaine-involved overdose fatalities in Connecticut, with the proportion of overall overdose deaths involving cocaine projected to rise to 58% from 55% in 2023. Cocaine, particularly when used in combination with fentanyl, remains a leading contributor to overdose mortality. In 2023, 620 deaths involved both fentanyl and cocaine—a 3.5% increase from 2022. Cocaine and crack continue to be among the top illicit substances seized by law enforcement, and Connecticut has become a key supply hub for cocaine in the region (CT DPH Monthly Report, 2024).

Cocaine-involved overdose deaths disproportionately impact men. In 2024, 70% of such deaths involved males (370 of 532), compared to 162 female deaths. Adults aged 35-64 represent the age groups most affected, accounting for nearly 70% of cocaine-involved deaths (CT DPH Dashboard, 2024).

Amphetamines and methamphetamines are also emerging concerns. While total deaths are much lower than those for cocaine, amphetamine-involved deaths rose sharply from 5 in 2022 to 12 in 2023 in Southwest Connecticut (Region 1) (a 140% increase), with Stamford and Norwalk reporting the most significant upticks (CT OCME, 2023).

Emerging Issues and Needs

Polydrug use is a dominant pattern in stimulant-related deaths. Most cocaine-involved overdose deaths also involved fentanyl, and increasingly, other substances such as bromazepam (a designer benzodiazepine), methadone, and phenacetin. Unlike contamination, this is frequently a result of intentional polydrug use aimed at modulating the effects of multiple substances.

Methamphetamine is appearing more frequently in non-traditional forms, including powders and pills that resemble legitimate prescriptions like Adderall® or ecstasy (MDMA). The presence of methamphetamine in counterfeit pills presents new risks, particularly for young people who may unknowingly consume these substances.

The growing stimulant-involved death rate demands increased attention to harm reduction strategies tailored to stimulant use. Unlike opioids, there are currently no FDA-approved medications for stimulant use disorder, making behavioral interventions, peer support, and early identification particularly crucial.

Data Gaps

There is limited data specific to nonfatal stimulant-involved overdoses. Additionally, regional and demographic differences in stimulant use are underreported, particularly among LGBTQIA+ individuals, veterans, and unhoused populations.

Populations of Focus

- Age and Gender: Adults aged 35-64 account for the majority of stimulant-related deaths. Males are significantly more affected than females, with nearly three times as many deaths in 2023 and 2024. Young adults aged 18-25 report the highest rates of past-year cocaine use statewide (3.9%), although they are less likely to die from stimulant-involved overdose.

- Race and Ethnicity: Non-Hispanic White individuals accounted for 68 of the 93 stimulant-related deaths in Southwest Connecticut (Region 1) in 2023, up from 42 in 2022 (a 62% increase). Hispanic/Latino individuals saw a 61% increase in cocaine-involved deaths between 2022 and 2023, rising from 18 to 29 (CT OCME, 2023).

- Geography: Bridgeport remains the epicenter of stimulant-related fatalities in Southwest Connecticut (Region 1), with 53 deaths in 2023. Stamford, Stratford, and Norwalk also report elevated stimulant-involved deaths.

Other Considerations

Risk Factors: Stimulant-involved overdoses often stem from concurrent use with opioids, mental health conditions, or attempts to self-medicate symptoms such as fatigue, anxiety, or depression. The increasing presence of stimulants in counterfeit pills poses a unique risk for youth and individuals who are unaware of what they are consuming.

Heroin & Other Illicit Opioids

Use in Connecticut:

Heroin use in Connecticut has declined over time, yet it continues to pose a significant public health concern, largely due to its intersection with fentanyl. In 2021, 0.3% of Connecticut residents aged 18 or older reported using heroin, slightly below the national average of 0.4%. Among high school students, 0.6% reported using heroin (CT School Health Survey, 2021). By 2024, the state recorded 862 opioid-related overdose deaths, with 77.6% (n=720) involving fentanyl (CT DPH Monthly Report, 2024). The average age of decedents was 48.5 years.

Southwest Connecticut (Region 1) (Southwest CT) accounted for 118 of those deaths (13.7%), with the largest number occurring in Bridgeport (68), followed by Stamford (11), Stratford (14), and Norwalk (10). The vast majority of opioid-involved deaths occurred at private residences (OCME, 2023).

Heroin remains the second most common substance reported upon admission to DMHAS-funded treatment centers in Connecticut, following alcohol (DMHAS Annual Statistics Report, 2023). In Southwest Connecticut (Region 1), heroin use is prevalent, especially in Bridgeport, which continues to see high overdose fatalities year after year. The DMHAS report notes that 38.3% of substance use treatment admissions in Southwest Connecticut (Region 1) in 2021 were for heroin or non-prescription methadone.

While heroin use has declined, it remains intrinsically linked to fentanyl and other synthetic opioids, making it a persistent driver of overdose fatalities. Southwest Connecticut (Region 1) continues to experience a substantial share of opioid-related deaths, particularly in Bridgeport and other urban centers. The growing presence of xylazine, carfentanil, and nitazenes has escalated the urgency for integrated and adaptive public health responses.

Investment in early intervention, harm reduction, and equitable access to treatment remains essential. Community-based naloxone distribution, peer support services, and culturally informed outreach must be expanded to meet the changing face of the opioid crisis. With targeted prevention, treatment, and response strategies, Connecticut can continue to make progress in reducing opioid-related harms and supporting recovery statewide.

Magnitude, Impact, and Severity

Although heroin-involved deaths have declined since 2015, the substance remains deeply embedded in the overdose crisis. In 2023, 1,329 accidental drug deaths occurred in Connecticut, with 1,217 involving any opioid and 1,124 involving fentanyl (OCME, 2023). Only 21 deaths were attributed to heroin alone, highlighting the fact that most heroin-related deaths now involve fentanyl, either as a contaminant or a substitute.

Xylazine and synthetic opioids such as nitazenes and carfentanil are increasingly being detected in opioid-related fatalities. In 2024, xylazine was found to be in 35.1% of opioid overdose deaths. Carfentanil, a fentanyl analog with extreme potency, contributed to 9 deaths in 2024 (CT DPH Monthly Report, 2024). These additions to the illicit drug supply have increased the complexity and lethality of overdose events, making reversal efforts more difficult.

Emerging Issues and Needs

The overdose landscape in Connecticut has evolved into a poly-substance environment, where heroin is frequently used in combination with other substances or substituted with fentanyl. Polysubstance use presents heightened risk, as it involves substances like heroin, benzodiazepines, alcohol, and synthetic opioids that collectively exacerbate respiratory depression.

Emerging threats include the increasing presence of xylazine, designer benzodiazepines (for example, bromazolam), and synthetic opioids like nitazenes. These compounds were each involved in growing number of deaths from 2023 to 2024. Additionally, fake pills mimicking legitimate pharmaceuticals (for example, oxycodone, Xanax®) often contain fentanyl or other unexpected drugs, contributing to increased accidental overdose risk.

Data Gaps

While heroin and opioid overdose trends are well-documented, regional differences in treatment access, harm reduction use, and social determinants of health are less consistently tracked. There is insufficient statewide data on heroin use among high-risk populations such as veterans, LGBTQIA+ individuals, and those experiencing homelessness. Improved data infrastructure is needed to understand nonfatal overdose trends in order to develop better targeted intervention strategies.

Populations of Focus

- Age and Gender: Opioid overdose deaths are most prevalent among individuals aged 45-64. In 2024, 228 deaths were reported among those aged 55-64, followed by 222 in those aged 35-44. Males accounted for 596 of the 862 opioid-related deaths statewide (CT DPH Dashboard, 2024).

- Race and Ethnicity: Non-Hispanic White individuals made up the majority of opioid overdose deaths in Southwest Connecticut (Region 1) (131 of 175 in 2023), followed by Black/African American individuals (40). Hispanic/Latino individuals accounted for 50 deaths in Southwest Connecticut (Region 1) in 2023, up from 41 in 2022.

- Geography: Bridgeport, Stamford, Norwalk, and Stratford continue to represent the bulk of opioid-related deaths in Southwest Connecticut (Region 1). Smaller towns such as Fairfield and Trumbull also report consistent though lower numbers.

Other Considerations

Risk Factors: Individuals with a history of polysubstance use, previous overdose, or underlying mental health conditions such as depression or anxiety are at higher risk for developing heroin use disorder. Family history of substance misuse also contributes to vulnerability. National and local data confirm that young adults and middle-aged non-Hispanic white males are disproportionately affected.

Co-Occurring Morbidity: From 2015 to 2022, opioids were found in 15.7% of suicide deaths in Connecticut. Intentional poisoning remains a major method of suicide among both males (14%) and females (44%). In Southwest Connecticut (Region 1), 11 suicides in 2024 were due to intentional self-poisoning involving unspecified substances (CTVDRS, 2023).

Naloxone Use & Access: Naloxone continues to be a critical tool in opioid overdose response. The Hub has led extensive regional efforts, training 1,158 individuals in opioid emergency response and distributing 1,586 naloxone kits in 2024 alone. Despite these efforts, a JAMA study found that nearly 40% of overdose deaths had bystanders present, underscoring the importance of expanding awareness and use of naloxone.

Policy and Prevention: Connecticut's Good Samaritan Laws are designed to protect those who assist during overdose emergencies, but their impact is hampered by public mistrust and lack of awareness. Strengthening community education, expanding harm reduction services, and promoting culturally competent outreach are critical steps moving forward.

Mental Health

Mental health remains one of the most pressing behavioral health concerns in Southwest Connecticut (Region 1). While awareness and identification of mental health needs have improved, barriers to care continue to disproportionately impact youth, low-income populations, people of color, and LGBTQ+ individuals. Addressing these challenges requires a multi-sector approach: expanding school-based supports, diversifying the workforce, reducing cost barriers, and increasing culturally competent, trauma-informed care across all levels of service delivery.

Use in Connecticut:

Mental health concerns have grown significantly in Connecticut and Southwest Connecticut (Region 1) (Southwest CT), particularly since the COVID-19 pandemic. According to the National Survey on Drug Use and Health (NSDUH), in 2022, 41% of U.S.

adults reported anxiety or depression, up from 11% pre-pandemic. Connecticut ranked among the top ten states for both mental health admissions and discharges in 2022 (SAMHSA, TEDS Report, 2022).

In Southwest Connecticut (Region 1), 43% of all DMHAS treatment admissions in 2022 were for mental health care. Depression and anxiety remain the most reported concerns across all age groups. Emergency department data from 2024 show youth ages 10-17 had a suicide ideation rate of 435.5 per 10,000, while young adults 18-24 had a rate of 311.9 per 10,000 (CT Suicidal Ideation and Self-Harm Report, 2024). Southwest Connecticut (Region 1) consistently reported lower suicide ideation rates than the other 4 regions in CT, rates remain troublingly high.

In local youth surveys, 72% of Darien youth and 75% of Fairfield youth said they knew where to go for mental health help. However, access awareness remains a challenge in communities like Trumbull, where only 35% of high schoolers reported knowing where to go in-school for support (TPAUD Survey, 2023).

Magnitude, Impact, and Severity

Mental health-related calls made up the second highest category of 2-1-1 requests statewide in 2022. Among these, 32.1% were related to risk of self-harm, 23.7% to disruptive behavior, and 15% to depression. Youth self-referrals to helplines like Kids in Crisis increased by 71% from 2020 to 2021.

In 2023, approximately 29% of Connecticut high schoolers reported their mental health was "not good" during the past 30 days. In Southwest Connecticut (Region 1) surveys, between 21% and 42% of youth reported symptoms of depression and persistent anxiety. Notably, 25.4% of Stratford youth and 34% of Trumbull youth reported feeling anxious frequently, while 21.2% of Stamford students felt sad or hopeless for two weeks or more.

Adults in the region also experience growing mental health challenges. The Greater Bridgeport CHNA in 2022 reported 31% of Bridgeport adults had symptoms of depression, compared to 25% statewide. Anxiety was reported more frequently among Black (17%) and Latino (20%) residents than among White (10%) residents (SW DMHAS Equity Profile, 2023).

Emerging Issues and Needs

The shortage of mental health providers, especially those from diverse backgrounds, is a significant barrier across Southwest Connecticut (Region 1). Wait times for care, lack of culturally competent providers, and language barriers were highlighted in focus groups and the RNP Bridgeport study (2025).

Adolescents continue to cite academics, future expectations, and post-high school planning as top sources of stress. According to surveys, these stressors frequently outweigh family conflict, friendships, or social media. These dynamics underscore a need for school-based mental health services, trusted adult connections, and peer support.

Barriers to care include cost, lack of time, and difficulties getting appointments. In New Canaan, 7.2% of respondents reported an unmet need for mental health care, and nearly 30% experienced at least one barrier. The most common obstacles were cost (16.1%), insurance coverage (12.0%), and appointment availability (9.8%).

Data Gaps

Despite strong survey participation, regional data lacks nuance in understanding disparities in mental health among LGBTQ+ individuals, people with disabilities, and undocumented residents. There's also a shortage of disaggregated data on co-occurring disorders (for example, substance use and mental illness), mental health outcomes by insurance status, and long-term impacts of unmet needs.

Populations of Focus

- Youth and Young Adults: Mental health concerns are especially high among young people. Across Southwest Connecticut (Region 1), 1 in 4 youth report persistent anxiety or depression. Girls, LGBTQ+ youth, and students identifying as non-binary report the highest rates. In Darien, 1 in 3 high school students reported restricting food to lose weight, with highest rates among Hispanic girls and LGBTQ+ students.

- Adults 18–44: This group experiences the highest rates of anxiety and depression in the region. Financial instability, job loss, caregiving burdens, and housing cost stress are significant contributing factors. Mental health-related hospital visits were also highest among adults aged 20-44 (Norwalk CHNA, 2022).

- Racial and Ethnic Disparities: In Greenwich and Norwalk, mental health conditions are reported at higher rates among non-White populations. For example, 26% of low-income Norwalk residents reported regular anxiety, compared to just 13% overall.

Stakeholder Quoted Needs for Risk and Protective Factors:

Risk Factors:

- Academic and post-graduation pressure (youth)
- Financial hardship, especially post-pandemic (adults)
- Family history of mental illness

- Social isolation
- Discrimination and language barriers

Protective Factors:

- Feeling safe at school or in the community
- Having a trusted adult to talk to
- Peer and community connections
- Culturally competent providers and early intervention services

Other Considerations

Co-Occurring Morbidity: Mental health is closely tied to suicide, substance use, and physical health conditions. In Southwest Connecticut (Region 1), suicide ideation rates among youth and young adults remain significant, though lower than in other regions. In the New Canaan BH Alliance Survey, 54% of residents were "very concerned" about youth social media use and 41.8% about youth anxiety.

Technology: Telehealth has expanded access for many, but barriers persist for those without technology access, stable housing, or English proficiency. The expansion of telehealth and school-based mental health programs has been a regional strength, but ongoing support for these systems is critical.

Prescription Drug Misuse

The misuse of prescription medications, including opioids, benzodiazepines, stimulants, and gabapentin, remains a critical and evolving concern in Connecticut, especially in Southwest Connecticut (Region 1). While prescription medications are essential for many individuals' health and well-being, their misuse can lead to addiction, overdose, and other serious health outcomes. This section explores recent trends, the impact of misuse, and regional efforts to promote safe use and disposal.

Use in Connecticut:

The use and misuse of prescription drugs remain a pressing public health concern in Connecticut and Southwest Connecticut (Region 1). According to the Connecticut Department of Consumer Protection’s Prescription Monitoring Program, 2023 saw 7.96 million prescriptions for controlled substances dispensed statewide, increasing from 6.9 million in 2022. By contrast, the number of non-controlled prescriptions declined to 2.3 million in 2023, compared to 3.8 million in 2022. However, 2024 reflects a notable shift:

only 5.4 million controlled prescriptions were dispensed, while non-controlled prescriptions surged to 7.9 million (CT Prescription Monitoring Program, 2024).

Southwest Connecticut (Region 1) continues to experience significant rates of prescription drug-involved fatalities. In 2022, Southwest Connecticut (Region 1) recorded 181 drug poisoning deaths, 243 of which statewide involved benzodiazepines. In 2023, drug poisoning deaths in Southwest Connecticut (Region 1) rose to 194 (14.5% of all statewide deaths). Of the 1,338 statewide deaths in 2023, 201 involved benzodiazepines, with 39 occurring in Southwest Connecticut (Region 1). By 2024, the number of drug poisoning deaths in Southwest Connecticut (Region 1) was 118 of 862 statewide deaths. Benzodiazepines were implicated in 147 of these statewide deaths, including 18 in Southwest Connecticut (Region 1) (CT DPH, Drug Overdose Deaths Dashboard, 2024).

Prescription stimulant misuse is another area of concern. Southwest Connecticut (Region 1) recorded 5 amphetamine-related deaths in 2022, 12 in 2023, and 8 in 2024. Meanwhile, gabapentin-involved deaths statewide fell from 166 in 2022 to 73 in 2024. Southwest Connecticut (Region 1) accounted for 19 such deaths in 2022, 15 in 2023, and 7 in 2024.

Magnitude, Impact, and Severity

The impact of prescription drug misuse remains significant across Connecticut. Benzodiazepines, gabapentin, and amphetamines are commonly found in toxicology reports of overdose deaths, especially when combined with other central nervous system depressants such as opioids and alcohol. In 2023 alone, 243 deaths statewide involved benzodiazepines. These substances—though often legitimately prescribed for anxiety, pain, or attention disorders—can become dangerous when misused or combined with other drugs.

Bridgeport, as the largest city in Southwest Connecticut (Region 1), continues to be disproportionately impacted. In 2023, the city accounted for over half (100) of the region's 194 drug poisoning deaths, including 15 deaths involving benzodiazepines. Stamford, Norwalk, Stratford, and Trumbull also experienced persistent overdose fatalities involving prescription drugs.

Emerging Issues and Needs

While overall prescription monitoring and safe disposal efforts have improved in Connecticut, key challenges remain. The presence of prescription drugs in overdose deaths suggests ongoing diversion, misuse, or unsafe use practices. Increases in amphetamine- and gabapentin-involved deaths point to rising nonmedical use or co-ingestion with opioids. These trends call for heightened awareness among prescribers, patients, and the community.

Equally important is the accessibility and visibility of safe disposal resources. Southwest Connecticut (Region 1) currently has 14 prescription drug drop boxes located in towns including Bridgeport, Darien, Fairfield, Greenwich, and Stratford. Take Back Day events continue to see strong participation—over 10,000 pounds of medications were collected in 2024 across Connecticut (DEA National Drug Take Back Day, 2024).

Data Gaps

There remains limited data distinguishing between medically prescribed versus illicitly obtained prescription drugs in overdose deaths. Moreover, granular demographic data on misuse patterns—especially by age, race/ethnicity, and sexual orientation—is lacking. Better integration of prescription monitoring data with public health surveillance could enhance timely interventions.

Populations of Focus

- Older adults: are at elevated risk for prescription drug misuse due to polypharmacy and chronic health conditions. Youth and young adults, particularly those misusing amphetamines, also represent a vulnerable population.

- Gender: In Southwest Connecticut (Region 1), the majority of benzodiazepine-involved deaths occurred in urban centers and disproportionately affected males. From 2022 to 2024, Bridgeport consistently reported the highest number of deaths involving prescription drugs. There is also a need to monitor disparities across racial and ethnic groups, as Black and Hispanic residents often face systemic barriers to treatment and safe disposal access.

Other Considerations

Strengths and Protective Factors: Safe disposal practices are a key strength in Connecticut's prevention efforts. Naloxone training programs across Southwest Connecticut (Region 1) include components on safe disposal and medication safety. From July 2023 to December 2024, The Hub trained 1,158 individuals in opioid emergency response and best practices around disposal (Birdseye Reports, 2024).

Community education, school-based prevention efforts, and proper storage of medications in the home remain essential to reducing prescription drug misuse. Integration of these efforts into broader mental health and substance use disorder strategies will help address the underlying drivers of misuse and prevent overdose deaths.

Problem Gambling

The rise of legalized gambling in Connecticut, particularly through online platforms and sports betting, has reshaped the behavioral health landscape of Region One. This analysis focuses on recent trends, emerging concerns, population-level impact, and service needs related to gambling and gaming in Southwest Connecticut (Region 1) of Southwest Connecticut.

Use in Connecticut:

Gambling is widely accessible in Connecticut through online sports betting, casinos, lotteries, and charitable gambling. In 2024, 69.2% of Connecticut adults aged 18 and older reported gambling in the past year (Gemini Research, 2024). Weekly lotteries were the most common form of gambling, followed by sports betting and video gaming involving purchases such as loot boxes or skins.

In Southwest Connecticut (Region 1), 309 individuals completed the Gambling Community Survey, with responses offered in English and Spanish. Nearly all Spanish-language responses (4 of 4) came from Southwest Connecticut (Region 1), underscoring its linguistic diversity and need for bilingual outreach.

Adolescents and young adults are increasingly engaged in gambling activities. Among Connecticut high school students, the prevalence of someone ever gambling rose from 3.45% in grade 7 to 9.57% in grade 12 (CSHS, 2023). Males were nearly three times more likely to report gambling compared to females. Youth under 18 most frequently reported gambling via video games with in-game purchases and sports betting.

In Southwest Connecticut (Region 1), local youth surveys reflect similar patterns. In Norwalk, 2.02% of high school youth reported past-month gambling, with males more likely to gamble than females. Greenwich and Trumbull data highlight concerns about gaming and gambling overlaps, with more than 1 in 4 students reporting that gaming interfered with sleep or schoolwork, and 16–18% of males acknowledging excessive spending on gaming features like loot boxes (Trumbull & Greenwich Youth Surveys, 2023).

Among adults, gambling is most prevalent among individuals aged 50–64 (76.6%), followed by those 35–49 (74.1%). However, young adults (18–34) are also at high risk, particularly with online sports betting, esports wagering, and gamified digital platforms.

Magnitude, Impact, and Severity

Although comprehensive gambling data in Connecticut is limited compared to other behavioral health domains, the available evidence points to increasing impact. In youth surveys, gambling is perceived as a low-risk activity—often with less peer disapproval than alcohol, vaping, or tobacco use.

In Southwest Connecticut (Region 1)'s 2024 survey, 25.7% of participants reported gambling monthly or more frequently, and 6.7% reported gambling weekly. Those aged 25–34 reported the highest frequency of weekly gambling at 12.8%, while 8.7% of youth under 18 reported gambling almost daily.

Gambling-related harm is more commonly underrecognized and underreported. Data from the Connecticut Council on Problem Gambling (2024) show that 62% of helpline callers were seeking help related to internet gambling, and 34% related to sports betting. Among these callers, 81% were male, and 90% were referred to state-sponsored treatment programs.

The Problem Gambling Severity Index (PGSI) findings from Southwest Connecticut (Region 1) show that individuals aged 25–34 and 35–54 had the highest average risk scores, while males scored significantly higher than females, indicating greater severity and need for targeted support.

Importantly, youth who gambled in the past month were more likely to report past-month substance use than their non-gambling peers, suggesting co-occurring risk patterns. Those reporting the most severe gambling issues also expressed the strongest desire to reduce or stop gambling altogether (CT College Gambling Report, 2024).

Emerging Issues and Needs

Increased Accessibility: The legalization of online and mobile sports betting has dramatically expanded access, particularly for young adults and adolescents. With sports gambling now embedded in entertainment and culture, frequent ads from sports betting apps and influencers further normalize gambling behaviors.

Perception of Harm: Public understanding of gambling risks remains low. In Southwest Connecticut (Region 1), only 16.3% of respondents reported that a healthcare provider had ever asked them about gambling, a missed opportunity for early intervention. Perceived risk of gambling seemed to be lower among Hispanic/Latino adults where 18.1% reported that the benefits of gambling outweigh the harms—nearly triple the rate of White adults (6.4%).

Financial Consequences: Stakeholders report growing concern about young adults facing financial instability due to excessive gambling, particularly through sports betting. Bankruptcy risk and impulsive financial decisions are increasingly associated with gambling-related harm.

Data Gaps

Gambling remains underreported and under-surveyed across Connecticut. Stakeholders in Southwest Connecticut (Region 1) cited a lack of reliable, granular data on gambling behaviors, treatment access, and health system screening. Unlike substances like cannabis or alcohol, gambling is rarely discussed in youth prevention programming or routinely screened in primary care or mental health settings.

Additionally, regional data disaggregation—by town, gender identity, and sexual orientation—remains limited. These gaps hinder the development of targeted interventions for vulnerable populations.

Risk of Gambling based on Sociodemographic Characteristics

- Age Youth (<18): Most likely to gamble through video gaming with microtransactions (for example, loot boxes) and informal betting with friends. 8.7% reported gambling almost daily.
- Young Adults (18–34): High-risk group for online sports betting and video game-related gambling. 6.2% reported gambling weekly.
- Adults 35–49: Most likely to perceive benefits of gambling as equal to or outweighing harms.
- Adults 50–64 and 65+: Highest overall gambling participation but also the highest perception of gambling-related harm.

Gender: Males are significantly more likely to engage in gambling and seek help (81% of helpline callers). In Southwest Connecticut (Region 1), they also reported more frequent gambling and higher PGSI risk scores. Women were more likely to participate in lotteries.

Race/Ethnicity: Hispanic/Latino individuals had the highest belief that gambling benefits outweigh harms. White individuals showed the highest rates of gambling overall (71.7%), while Asian adults reported the lowest (60.2%) but had the highest perception that gambling causes harm (74.2%).

Other Considerations

Perception of risk/harm: Stakeholders in Southwest Connecticut (Region 1) expressed concern about the lack of prevention messaging and education around gambling. Unlike cannabis or alcohol, gambling is not typically addressed in school-based prevention curricula, and many caregivers lack awareness of digital forms of gambling such as in-app purchases or fantasy sports betting.

System Gaps: Healthcare system gaps are also evident: over 83% of adults reported that no provider had ever asked them about gambling behavior, representing a major missed opportunity for screening and early intervention.

Existing Funding: Funding for prevention, treatment, and recovery supports related to gambling is still emerging and less robust compared to substance use and mental health resources.

Suicide

Suicide remains a leading public health issue in Connecticut, particularly in Southwest Connecticut (Region 1) among youth and marginalized populations. While the state has seen slight increases in suicide rates since 2020, consistent rates in Southwest Connecticut (Region 1) indicate an opportunity to intervene. Young people, especially LGBTQIA youth and students of color, remain at elevated risk. Expanded screening, timely access to mental health care, stigma reduction, culturally competent interventions, and school-community partnerships are critical next steps in suicide prevention.

Use in Connecticut:

Suicide continues to be a critical public health concern in Connecticut. In 2021, there were 392 deaths by suicide statewide, reflecting an increase from 359 in 2020 (CT DPH). The crude suicide rate also rose, from 9.9 per 100,000 in 2020 to 10.9 per 100,000 in 2021. Suicide rates are highest among adults aged 65 and older (16.8 per 100,000), followed by those aged 45-64 (13.6 per 100,000). Preliminary 2022 data indicates that 97% of suicides across the state occurred among individuals aged 19 or older.

In Southwest Connecticut (Region 1) (Southwest Connecticut), suicide death counts have slightly increased in recent years. There were 53 suicide deaths in 2020 (5.5 per 100,000), 54 in 2021 (5.6 per 100,000), and 57 in 2022 (6.0 per 100,000). Despite the consistent number of reported suicide cases in Southwest Connecticut (Region 1), the number of emergency department visits for suicidal ideation was very low in 2022 (0.6%), suggesting need for further intervention to ensure those who need medical attention have access before the incidences occur. In 2024, Southwest Connecticut (Region 1)'s suicidal ideation rate was 179.4 per 10,000 visits, and the suicide attempt rate was 27.2 per 10,000 (The Hub, 2024).

Youth suicide remains a key concern. In Darien, 10% of youths in 2023 reported self-harming without suicidal intent, down from 18% in 2021 (Darien Youth Survey, 2023).

Magnitude, Impact, and Severity

The impact of suicide spans emotional, social, and economic domains. Suicide is consistently among the top 10 leading causes of death nationwide and among the top three for adolescents and young adults. In Connecticut, youth suicide attempts, and ideation remain prevalent, especially among vulnerable populations.

According to the 2021 Connecticut School Health Survey, 29% of high school students reported poor mental health in the previous 30 days. Nearly 16% seriously considered suicide, and 7.7% reported attempting suicide. Girls were more likely to report suicidal ideation (19.8%) and attempts (8.8%) than boys (8.7% and 3.3%, respectively). LGBTQ+ youth were also disproportionately affected, with 34.2% considering suicide compared to 8.4% of heterosexual peers.

Older adults (65+) experience the highest suicide mortality rates, often tied to chronic illness, isolation, and underdiagnosed mental health conditions. Regionally, Fairfield County has seen fluctuations in suicide rates, with Bridgeport and Stamford reporting the highest local suicide death counts.

Emerging Issues and Needs

One emerging dynamic is the increased risk of suicide among individuals exposed to suicide in their family or peer networks. This phenomenon, known as suicide contagion, is particularly concerning for adolescents and young adults.

Mental illness continues to be the strongest predictor of suicide risk. Conditions such as depression, bipolar disorder, PTSD, and substance use disorder are common among individuals who die by suicide. Other drivers include adverse childhood experiences, trauma, discrimination, and lack of access to care.

Adults over 45 also face suicide risks associated with physical illness, financial strain, and intimate partner problems. Suicidal ideation is increasingly presenting in emergency departments, yet many individuals fall through the cracks due to lack of follow-up care or insufficient community-based mental health infrastructure.

Regionally, Bridgeport and surrounding communities continue to report challenges such as provider shortages, long waitlists, stigma, and lack of culturally competent care.

Data Gaps

Although Connecticut has made progress in suicide surveillance, key gaps remain. Suicide attempt data is largely underreported, particularly for nonfatal cases managed outside of hospital settings. There is also insufficient tracking of suicide risk factors by race, ethnicity, and gender identity. For Southwest Connecticut (Region 1), there is limited real-time data available on suicide attempts, emergency interventions, and follow-up outcomes.

Additionally, cross-sector data integration between schools, hospitals, and community agencies is limited, making it difficult to establish timely intervention systems.

Populations of Focus

- Youth and Adolescents: Youth aged 10–17 have the highest rates of suicidal ideation, followed by young adults 18–24. Students identifying as LGBTQ+, particularly transgender and nonbinary individuals, are at elevated risk. Hispanic and female students also report higher-than-average rates of depression and suicide attempts.

- Older Adults: Individuals aged 65+ consistently have the highest suicide mortality rates. Physical health decline, social isolation, and untreated mental health issues are primary risk factors.

- Racial/Ethnic Minorities: Although White individuals account for the highest number of suicide deaths in Southwest Connecticut (Region 1), rates of suicidal ideation among Black, Asian, and Hispanic individuals are comparably high (The Hub, 2024).

Other Considerations

Community and Contextual-Level Factors: Exposure to suicide whether through family, peers, or media increases risk of self-harm.

Strengths and Protective Factors: Southwest Connecticut (Region 1) has invested in suicide prevention through public education, gatekeeper training, and crisis intervention. From July 2023 to June 2024, Catalyst CT | The Hub trained 283 individuals across 25 QPR (Question, Persuade, Refer) suicide prevention workshops. Youth surveys show an increase in awareness about where to seek help for mental health concerns. Protective factors include having trusted adults, feeling safe at school, and connectedness to peers and community.

Tobacco

Use in Connecticut:

Although overall youth tobacco use has declined in recent years, concern persists over accessibility and early experimentation, especially in Southwest Connecticut (Region 1). According to the 2024 Stamford Youth Survey, only 0.6% of high school students reported past-month cigarette use, lower than both the state (3%) and national (3.8%) rates. Fairfield Public Schools' 2023 survey showed that 50% of students in grades 7–12 believed their friends felt it was “very wrong” to use tobacco products. In Darien, 92% of students reported that their parents have clear rules discouraging tobacco use. However, across

multiple towns, students reported tobacco as being nearly as accessible as alcohol and vaping devices.

Magnitude, Impact, and Severity

Tobacco use remains a disciplinary concern in schools. The 2022–23 Connecticut Report on Student Discipline showed that incidents related to Drugs, Alcohol, and Tobacco increased by 31.4% compared to pre-pandemic levels. While ENDS (Electronic Nicotine Delivery Systems) use dipped after 2019, the possession of both ENDS and traditional tobacco products has nearly returned to pre-pandemic levels. This rebound signals sustained challenges despite prevention efforts.

Emerging Issues and Needs

Stakeholders in Southwest Connecticut (Region 1) continue to express concern over underage access to tobacco products. In the 2024 New Canaan Behavioral Health Alliance Survey, 87% of respondents believed youth could easily access tobacco from their own or friends' homes. Retail compliance remains a key prevention strategy. In Westport, 5 unannounced inspections in 2023 found 100% compliance with Connecticut General Statutes prohibiting sales to individuals under 21. However, broader data from TPEP (2023–2024) show Southwest Connecticut (Region 1) had a 19.9% non-compliance rate among inspected retailers, with ENDS involved in 33.6% of these violations.

Data Gaps

Data on cessation attempts or success rates (especially among youth and BIPOC communities) is limited in Southwest Connecticut (Region 1).

Populations of Focus

- Youth: youth cigarette smoking has declined over time but remains present in some high school populations. Several youth surveys (for example, Stamford YVCS, Stratford Strengths Survey) report that while rates are low, some students still report smoking cigarettes occasionally.
- Gender: Males are more likely than females to report cigarette smoking in statewide datasets, but regional data for this is limited.
- Race/Ethnicity: Black and Hispanic/Latino adults may be disproportionately impacted by cigarette-related health outcomes, as indicated in the DMHAS Equity Profile and Community Health Needs Assessments, though detailed Southwest Connecticut (Region 1) smoking prevalence is limited.

- Socioeconomic status: Low-income individuals and residents in urban centers (such as Bridgeport and Norwalk) face higher tobacco outlet density, reduced access to cessation support, and higher tobacco-related health burdens.

Other Considerations

- The normalization of smoking in certain adult populations (for example, those with co-occurring mental health disorders) was raised as an ongoing issue in community health needs assessments.

- Several local prevention teams and community health organizations expressed interest in reviving anti-smoking campaigns but noted limited funding or focus on the state level.

- There is little awareness of available smoking cessation programs tailored to different cultural or linguistic groups in Southwest Connecticut (Region 1).

Vaping & ENDS

Vaping and ENDS use are a pressing public health concern for Connecticut youth, particularly in Southwest Connecticut (Region 1). While most youth are not using substances, those who do most commonly report alcohol and vaping nicotine. The impact of ENDS is compounded by easy access, mental health coping behaviors, and declining peer disapproval in older teens. Continued monitoring, targeted prevention strategies, and investment in community education are needed to shift the vaping trajectory and protect adolescent well-being.

Use in Connecticut:

Electronic Nicotine Delivery Systems (ENDS), including e-cigarettes and vape pens, remain a prominent concern across Connecticut, particularly among adolescents. According to the 2023 Connecticut School Health Survey, 9.7% of high school students reported current (past 30-day) use of e-cigarettes. Lifetime use of nicotine vaping devices is significantly higher among high school students (11-12.3%) compared to middle schoolers (1-4%), and 3%-11% of high school students reported past 30-day use (The Hub, 2024).

Regionally, ENDS ranked as the top primary substance of concern in The Hub's 2023 Regional Priority Report, reflecting high scores for magnitude and impact. Among Southwest Connecticut (Region 1) youth, vaping nicotine follows alcohol as the second most reported substance of use, ahead of cannabis (2024 Epidemiological Slide Deck). Notably, 74% of Southwest Connecticut (Region 1) school districts reported understanding the relationship between youth cannabis use and addiction, yet only 28.3% reported a

similar awareness regarding the connection between vaping and mental health or addiction (The Hub School Survey, 2024).

Magnitude, Impact, and Severity

The impact of vaping on youth continues to be significant. Vaping-related school discipline cases have sharply increased across Connecticut. According to the 2022-23 State Discipline Report, the Drugs, Alcohol, and Tobacco category increased by 31.4% compared to pre-pandemic levels, with possession and use of ENDS devices doubling since 2015-16. ENDS violations have consistently outpaced traditional tobacco use violations since 2017-18.

Local surveys from Norwalk, Stamford, and Stratford highlight concerning usage patterns: among lifetime users, 4.1% reported using vapes at school or school events, and vaping nicotine is commonly done at friends' homes or alone. In Norwalk, the average age of first vape use was 13.3 years. Nearly three-fourths (72.5%) of youth reported accessing vape products from peers, and 20.8% from stores (Norwalk Survey, 2024).

Retail access remains a systemic contributor. In Southwest Connecticut (Region 1), there are 262 ENDS retailers. Bridgeport has the highest retailer density (3 per square mile), followed by Norwalk (1.9) and Stamford (1.4). Compliance inspections in 2023-24 showed 17.4% of retailers in Southwest Connecticut (Region 1) were non-compliant with sales restrictions (TPEP, 2024).

Emerging Issues and Needs

Mental health and peer influence are key drivers of vaping. Among Southwest Connecticut (Region 1) youth, 47.6% reported using nicotine vapes to cope with anxiety or depression. Nearly half of surveyed students cited low perceived harm or the belief that many of their peers' use vapes. Access and lack of concern about school consequences were also influential (The Hub Assessment, 2024).

Additionally, disparities in perception of risk and disapproval may shape usage. While parental disapproval of vaping remains high (93-99%), peer disapproval is significantly lower, particularly among high schoolers (64%-82%). This perception gap appears to increase with age and may indicate the need for more peer-led education and norming campaigns.

Data Gaps

Although there is growing data on adolescent vaping, more disaggregated information is needed at the local level, particularly regarding LGBTQ+, nonbinary youth, and racial/ethnic disparities in use. There is also a lack of longitudinal data capturing the

transition from vaping to other substances or mental health conditions. Data on non-nicotine vaping (for example, flavored vapor or cannabis concentrates) remains underreported.

Populations of Focus

- Youth (12-18): Vaping rates are highest among high school students, especially 11th and 12th graders. Males have slightly higher use rates than females statewide.
- High-risk populations: LGBTQ+ youth, Hispanic youth, and youth with mental health concerns such as anxiety or depression are at elevated risk.
- Communities with high retailer density: Bridgeport, Norwalk, and Stamford are more vulnerable to increased youth exposure and access.

Other Considerations

Strengths and Protective Factors: Protective factors play a critical role in preventing vaping. Strong parental disapproval, clear family rules, feeling safe at school, and access to trusted adults correlate with lower substance use rates. As noted in the Darien and Fairfield surveys, increased perceptions of risk and disapproval are linked to declining use trends since 2018.

Southwest Connecticut (Region 1)'s Local Prevention Councils (LPCs) have a regional target to reduce vaping among youth aged 12-18 by 5% by 2025. Strengthening peer disapproval messaging, improving retailer compliance, and integrating mental health supports into prevention frameworks are key strategies to meet this goal.

## Appendix C – Region 1 Stakeholder Survey Results (2024-2025)

The DMHAS Center for Prevention Evaluation and Statistics at UConn Health

March 11, 2025

**Community Type Representation**

| Community Type | Count | Percent (%) |
|---|---|---|
| Wealthy | 7 | 50.0 |
| Suburban | 3 | 21.4 |
| Urban Periphery | 3 | 21.4 |
| Urban Core | 1 | 7.1 |

| | | |
|---|---|---|
| Rural | 0 | 0.0 |

**Respondent Representation by Community Type**

| Community Type | Respondent Count | Percent of Respondents (%) |
|---|---|---|
| Wealthy | 55 | 36.9 |
| Urban Periphery | 41 | 27.5 |
| Urban Core | 36 | 24.2 |
| Suburban | 17 | 11.4 |

**Top Communities Represented:**

- Bridgeport: 24.2%
- Stamford: 12.1%
- Norwalk: 8.1%

**Sector Representation**

Respondents could select multiple sectors:

- Parent, guardian, or caregiver: 73.2%
- Community resident: 34.9%
- Individual with lived substance use or mental health experience: 31.5%.
- Youth-serving organization staff: 28.2%
- Prevention provider: 21.5%
- Government: 18.1%

**Substances and Issues of Concern**

Across age groups, anxiety and depression were consistently rated highest. Rankings based on mean scores:

**Infants & Young Children (<11):**

- Anxiety (2.19)
- Depression (3.01)
- Trauma (3.23)

**Youth (12–17):**

- Anxiety (2.67)
- Depression (3.07)
- Alcohol (4.31)

**Young Adults (18–25):**

- Anxiety (3.21)
- Depression (3.37)
- Alcohol (3.70)

**Adults (26–65):**

- Alcohol (2.91)
- Depression (3.45)
- Anxiety (3.80)

**Older Adults (65+):**

- Depression (2.11)
- Alcohol (3.06)
- Anxiety (4.19)

**Problem Gambling and Suicide Prevention**

**Problem Gambling Concern by Age Group:**

- Young adults (18–25): 48%
- Adults (26–65): 28.4%

**Suicide Prevention Concern by Age Group:**

- Youth (12–17): 53.4%
- Young adults (18–25): 31.8%

**Substance Use System Service Gaps and Needs**

**Inadequate Services Identified**

Top gaps included:

- Inpatient Rehabilitation (33.8%)
- IOP (26.9%)
- Emergency/Crisis Services (25.4%)

**Underserved Populations**

- Age group-specific (32.6%)
- Homeless individuals/families (27.1%)
- Non-English-speaking individuals (23.3%)
- LGBTQ2S+ individuals (22.5%)

**Needed Services**

- Community Support Services (48.1%)
- Housing with Support Services (45.0%)
- Care Coordination (35.7%)

**Mental Health System Service Gaps and Needs**

**Inadequate Services Identified**

- Emergency/Crisis Services (33.6%)
- IOP (32.0%)
- Inpatient (29.7%)

**Underserved Populations**

- Age group-specific (36.8%)
- Homeless individuals/families (34.4%)
- LGBTQ2S+ individuals (28.0%)
- Non-English-speaking individuals (25.6%)

**Needed Services**

- Community Support Services (41.6%)
- Care Coordination (35.2%)
- Housing with Support Services (30.4%)

**Suicide Prevention**

**Underserved Populations**

- Age group-specific (35.5%)
- LGBTQ2S+ individuals (29.0%)
- Non-English-speaking individuals (25.0%)

**Community Ability to Implement Suicide Prevention**

- Medium Ability: 58.1%
- High Ability: 15.5%

**Problem Gambling Service Gaps and Needs**

**Adequacy of Services**

- Don't Know: 45.7%
- Somewhat Adequate: 29.1%

**Underserved Populations**

- Don't Know: 61.4%
- Young Adults: 29.9%

**Community Ability to Raise Awareness**

- Low Ability: 36.4%
- Medium Ability: 31.8%

**Comments**

Themes gathered from stakeholder open-ended responses:

- **Access and Affordability:** Mental health and substance use services need expanded hours and affordable access.
- **Housing:** A strong call for affordable housing options and supportive services.
- **Early Intervention:** Stakeholders emphasized the need for earlier interventions targeting childhood mental health and family supports.
- **Culturally Relevant Services:** Spanish-speaking populations and other culturally diverse groups remain underserved.
- **Resource Coordination:** There is a pressing need for better centralized coordination of available behavioral health services.

## Appendix D - CPES Focus Group Template

| | | | |
|---|---|---|---|
| Region: | | Facilitator: | |
| Location: | | Co-Facilitator: | |
| Group Focus: | | Note Taker(s): | |

# of Participants: _____ _____

| Focus Group Question | Follow Up Question/*Prompts* | Key Points | Important Quotes |
|---|---|---|---|
| **Area of Inquiry #1: Regional Needs and Priority Populations** | | | |
| **1. What are the most pressing [behavioral health] needs in your region?** | **1a. On what do you base this?**<br>*Consider:*<br>• *What you are seeing/ hearing/experiencing in your work/region;*<br>• *Data collected within your region, including community assessment data* | | |

| | | | |
|---|---|---|---|
| **2. For whom/which groups?** *Consider demographic groups as well as special needs groups, and groups of individuals at increased risk, need or burden* | **2a. On what do you base this?**<br>*Consider:*<br>• *What you are seeing/hearing/ experiencing in your work/region;*<br>• *Data collected within your region, including community assessment data* | | |
| **Focus Group Question** | **Follow Up Question/ *Prompts*** | **Key Points** | **Important Quotes** |
| **3. Why do you believe this is** | • *What is causing it and what is contributing to it?*<br>• *Are there certain risk factors?* | | |

| | | | |
|---|---|---|---|
| **happening ?** | • *Structural conditions (social determinants of health, etc.)?* | | |

| **Area of Inquiry #2: Regional Gaps and Populations** | | | |
|---|---|---|---|
| **4. What [behavioral health] need(s) are not being adequately addressed in your region?** | **4a. On what do you base this?**<br>*Consider:*<br>• *What you are seeing/hearing/ experiencing in your work/region;*<br>• *Data collected within your region, including community assessment data* | | |
| **5. For whom/which groups?** | **5a. On what do you base this?**<br>*Consider:*<br>• *What you are seeing/hearing/ experiencing in your work/region;*<br>• *Data collected within your region, including community assessment data* | | |
| **Focus Group Question** | **Follow Up Question/*Prompts*** | **Key Points** | **Important Quotes** |
| **6. Why do you believe this is happening?** | • *What is causing it and what is contributing to it?*<br>• *Are there certain risk factors?*<br>• *Structural conditions (social determinants of health, etc.)?* | | |

| **Area of Inquiry #3: Recommendations to Address Regional Needs and Gaps** | | | |
|---|---|---|---|
| **3. What actions and/or services do you** | *What does your community/ region need to address the* | | |

| | | | |
|---|---|---|---|
| **recommend to better address these needs?** | *behavioral health needs in your region?* | | |
| **What actions and/or services do you recommend to better address these needs?**<br><br>*What does your community/region need to address the behavioral health needs in your region?* | *Are there existing partnerships that could be strengthened or new collaborations that should be formed?* | | |
| | *How can we ensure that community voices are heard in the planning and implementation of behavioral health initiatives?* | | |

## Appendix E – Focus Group and KII Questions

**INTRO**

Hello everyone, my name is _____ and I am a _____ at Catalyst CT The Hub.

Catalyst CT The Hub is the state-designated Regional Behavioral Health Action Organization (RBHAO) for Southwestern CT.

Today, we will be conducting a focus group around behavioral health topics in our region for the last two years. To specify, our region includes 14 towns from Greenwich to Stratford. Thank you for participating, we value all voices!

The focus group is an important opportunity for you to provide your expertise based on your work, personal experiences, and knowledge of the region. We encourage you to share your perspectives freely and respectfully, supporting your statements with evidence in the form of quantitative and anecdotal data gained through your work or personal/professional experience. Your perspectives are invaluable as we seek to understand [behavioral health, substance use, problem gambling] needs and gaps and other important issues within the region.

The purpose of the focus groups is to gather insights and perspectives on substance use and mental health, suicide prevention and problem gambling in our region. Data gathered from these groups serve as a foundational element of the biennial regional priority planning process, and a platform for collaboration, allowing us to hear directly from you as experts in the region on behavioral health needs and priorities.

By participating in this focus group, you agree to keep everything that is discuss here confidential. We ask that you do not share information provided by another participant outside of this group. Please refrain from sharing any personally identifiable information. This session is being recorded (specify) and there is a notetaker present so that we may transcribe our data. Once this information has been transcribed, all recordings will be deleted.

What are your questions on the purpose of the focus group and confidentiality?

Now we will establish some ground rules. Firstly, this focus group will be no more than 90 minutes. We will try our best to cover as much feedback as we can but please know that we have additional focus groups happening, specific to certain topics and an online stakeholder survey will be sent out. So, if we do not get to cover a specific area today, there are other opportunities for those stories to be captured.

As we all engage in this process, please know that there are no right or wrong answers. We ask that you share your honest feedback and perspectives as local representatives of your community. For each response you give, you will be asked to provide evidence or a rationale to support your perspective. You do not have to agree with others in this group. We encourage diverse perspectives and thinking. We ask that all participants be respectful of each others' input and viewpoints, fostering a supportive environment for discussion. o We are not here to promote a particular type of thinking. We are here to learn and understand your viewpoints. We ask that you speak one at a time and in turn, and that allow other participants opportunities to speak on the issue. Participants can leave the focus group at any time if they do not feel comfortable.

What are your questions on the process before we begin?

**QUESTIONS**

1. What are the most pressing [behavioral health] needs in your region?

Follow up questions:

- Who is most affected?
- What groups are being impacted the most?
- What do you base this on? Can you give examples or specifics?
- Why do you believe this is happening?
- Can you tell me more about ____?

2. What [behavioral health] need(s) are not being adequately addressed in your region?

Follow up questions:

- Who is most affected?
- What groups are being impacted the most?
- What do you base this on? Can you give examples or specifics?
- Why do you believe this is happening?
- Can you tell me more about ____?

3. What actions and/or services do you recommend to better address these needs?

Follow up questions:

- What does your community need in order to address these needs?
- How can we involve the community in our initiatives and efforts?
- Can you tell me more about ____?

4. (Added Hub Question): What supports do you see that positively impact your community regarding _____?

Follow up questions:

- What positive changes have you seen in the last two years regarding ____ in our region?
- What efforts do you see making the most difference?
- Can you tell me more about ____?

**CLOSING**

Does anyone have any final questions or comments?

Thank you so much for your participation. We want to express our gratitude for your time and contributions. Your insights are valuable and will be incredibly helpful for planning and future initiatives. Please know that we are always here as a support to you and your agency. Feel free to reach out to us at any time. My contact information will be in the chat. If you know of anyone that you think should participate in this process, we have more focus groups happening throughout the month and will be sending out an online stakeholder survey. Feel free to email me for more information.

Thank you for all the work that you do every day for our community. We are so appreciative! Be on the lookout for our published report this year.

Focus Group EMAIL TEMPLATES

*Invitation Email*

Hello,

My name is _____ and I am a _____ at Catalyst CT The Hub.

Catalyst CT The Hub is the state-designated Regional Behavioral Health Action Organization (RBHAO) for Southwestern CT.

We would like to invite you to participate in a focus group to help inform the Regional Priority Planning and Report process conducted biennially by the Regional Behavioral Health Acton Organizations (RBHAO). You have been selected as someone with important knowledge and insight about the needs in your region relevant to behavioral health prevention/health promotion, treatment and recovery, or suicide or problem gambling. The information below explains more about the focus groups and your role in them, as well as any risks, benefits and protections in place.

The purpose of this group is to gather community insights and perspectives on substance use and mental health prevention/health promotion, treatment and recovery, suicide prevention and problem gambling. The insights that are gathered from this focus group will be used to inform data-driven decisions that reflect the needs of the community and will be held confidential.

By participating in this focus group, you are contributing to identifying gaps and needs which will help improve existing services and help us understand what additional services are needed to help support your community/organization. Your participation will help improve the overall well-being of the community and ensure that services are responsive to the actual needs of your community. This is also an opportunity to connect with other community stakeholders who share a commitment to addressing behavioral health needs within the community.

Below are the details for the upcoming focus group. Please respond to this email if you are interested in participating.

Format: Online or In-Person, include address

Date:

Time:

*Reminder Email w/ Questions*

Hello,

Thank you for registering to participate in our upcoming focus group. This is a reminder that our focus group will be meeting (include date, time, online/in-person).

Please see below for the questions that we will be covering during the focus group. We look forward speaking with you!

1. What are the most pressing [behavioral health] needs in your region?
2. What [behavioral health] need(s) are not being adequately addressed in your region?
3. What actions and/or services do you recommend to better address these needs?
4. What supports do you see that positively impact your community regarding _____?

Take care,

The Hub team

*Follow-Up Email*

Hello,

Thank you for participating in our focus group! Your expertise and insight are immensely appreciated. Please feel free to reach out to me at any time with additional questions or comments. Also, Catalyst CT The Hub is here as a partner for you. Please check out our new website to learn more: https://catalystct.org/the-hub/

Additionally, when the report has been published, you can review it on our website.

Thank you and take care,

The Hub team