



# 2024-25 Regional Priority Report: Region 2

Developed by Alliance for Prevention & Wellness

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## Executive Summary

The 2024–25 Regional Priority Report for Region 2 presents a comprehensive assessment of behavioral health trends, emerging issues, service gaps, and regional strengths across the 34-town area encompassing much of New Haven and Middlesex Counties. Developed by the Alliance for Prevention and Wellness (APW), this report synthesizes extensive quantitative and qualitative data to inform regional goals and state-level recommendations in behavioral health prevention, treatment, and recovery.

The report aims to identify the most pressing behavioral health needs in region 2, the populations most affected, and the systemic factors contributing to these needs. Using a mixed-method, community-informed process, APW engaged over 100 regional partners and community partners community leaders through surveys, focus groups, and key informant interviews. In addition, RPW conducted a secondary data analysis c between September 2024 and April 2025. These efforts informed a three-phase prioritization process grounded in data and equity-focused community input.

The report and accompanying data will be used as a building block for state and community-level processes including capacity and readiness building, strategic planning, and the implementation of evidence-based programs and strategies. It will also assess the needs, strengths, and critical gaps in the service delivery systems and identifies target populations and priorities for these populations. The report includes priority recommendations for prevention, treatment, and recovery systems. The Regional Priority Reports have many users. APW will take every opportunity to publicize the availability of the regional data, engage other organizations such as planning groups, policy makers, service providers, coalitions, foundations, and applicants for funding. APW will encourage these groups to work on the identified priorities among the identified populations, increase awareness of substance use and other behavioral

health problems, inform strategic plans, support leveraging of funds, and enhance membership in local prevention councils, advisory groups, task forces / work groups, coalitions, and others.

Key findings of the report are outlined below:

**Substance Use Prevention and Mental Health Promotion:**

Youth substance use continues to be an emerging concern, specifically around cannabis and nicotine use. Data reflects that youth are using these substances in isolation and not with peers. The normalization of use of cannabis continues to be the top risk factor for use. In review of region 2's crash repository data it is noted that we have had a reduction in impaired driving. Simultaneously, promising declines in impaired-driving crashes and overdose rates were noted. However, limited LPC capacity, prevention funding flexibility, and lack of youth-specific data—especially for ages 18–24—remain critical gaps.

**Suicide Prevention:** LGBT and Hispanic/Latino high school students exhibit disproportionately high rates of suicidal ideation, depression, and attempts. Waitlists and a shortage of culturally competent services outside urban areas, particularly New Haven, limit access to care. Post-crisis care coordination is limited and disjointed.

**Problem Gambling:** Youth as young as six are engaging in gambling behaviors, largely via digital platforms. Prevention education is severely lacking in schools, and community readiness remains low.

**Behavioral Health Treatment:** Access to treatment is the priority concern. While services are available, provider capacity remains limited, particularly outside the New Haven area. Key barriers include long waitlists, staffing shortages, lack of affordable care, housing insecurity, transportation challenges, and fragmented care coordination. While services are available, provider capacity remains limited, particularly outside the New Haven area. Key barriers include long waitlists, staffing shortages, lack of affordable

care, housing insecurity, transportation challenges, and fragmented care coordination. It is recommended to prioritize the waitlists and improve the behavioral health continuation of care protocols.

**Behavioral Health Recovery:** Barriers to finding and sustaining recovery are related to social determinants of health such as housing insecurity, reliable transportation, and needing more community-centered and peer-led recovery community supports.

Recommendations include more community-centered and peer-led recovery community supports, sober-community events, and increase peer support services beyond emergency departments.

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## Abbreviations and Acronyms

APW	Alliance for Prevention and Wellness
CCAR	CT Community Addictions Recovery
CDC	Centers for Disease Control
CPES	Center for Prevention Education and Statistics
CCPG	Connecticut Center for Problem Gambling
CT	Connecticut
CT BRFSS	Connecticut Behavioral Risk Factor Surveillance System
CT SUDORS	CT State Unintentional Drug Overdose Reporting System
CT YRBS	CT Youth Risk Behavior Survey
DCWS	Data Haven Community Wellbeing Survey
HIDTA	High Intensity Drug Trafficking Area
LPC	Local Prevention Council
NAMI	National Alliance on Mental Illness
OCME	Connecticut Office of the Chief Medical Examiner
RBHAO	Regional Behavioral Health Action Organization
RGAT	Regional Gambling Awareness Team
RPR	Regional Priority Report Team
RPW	Regional Priority Workgroup
RSAB	Regional Suicide Advisory Board
YVCS	Youth Voices Count Survey

## Introduction

The Priority Report is an in-depth assessment of the behavioral health emerging and ongoing trends, service gaps and needs, and strengths of region 2. The report includes an overview of region 2, data collected from reputable secondary sources on national, state, and local levels, and uses that data to create actionable recommendations and goals for the behavioral health industry. Data collection for this report spanned September 2024 through April 2025. The data collected ranged from recent 2025 reports, to the latest of 2020.

This report begins with an overview of the priority report process and the procedures of this behavioral health needs assessment and prioritization process. An in-depth regional profile, including demographics and subpopulations are described, followed by this report's findings. The results are organized by (1) Emerging Issues (2) Regional Strengths, Resources and Assets (3) Regional Resource Gaps and Needs and (4) Other Needs Assessments and Funding

The findings are organized by topic area, the framework in which the RBHAO approached this report. The topic areas are as follows: *Substance Use Prevention and Mental Health Promotion, Suicide Prevention, Problem Gambling, and Behavioral Health Treatment and Recovery*. *The RBHAO's focus is on primary prevention efforts within Substance Use Prevention and Mental Health Promotion, Suicide Prevention, and Problem Gambling*. Regional trends, gaps, and strengths are compiled into RBHAO priority areas and goals. The final topic area of *Behavioral Health Treatment and Recovery* also includes an in-depth analysis of trends, gaps, strengths and priority

areas, but does not include a goal for the RBHAO. Actionable recommendations for the behavioral health treatment and recovery services are provided.

## Background

The Regional Priority Report supports the CT Department of Mental Health & Addiction Services (DMHAS) Substance Abuse Prevention and Treatment (SABG) and Mental Health Block Grant (MHBG) requirements. In 2004, DMHAS adopted the Substance Abuse and Mental Health Services Administration (SAMHSA) Strategic Prevention Framework (SPF) at the State, sub-regional and community levels. SPF is a five- step data driven process known to promote youth development and prevent risky behaviors across life span. This Priority Report has been compiled with the assistance of various community members who have participated in listening sessions, as well as members of the regional behavioral health priority setting workgroup (RBHPSW) who understand and support the SPF process.

This report is an analysis of the magnitude, impact and capacity within DMHAS Region 2 of the following areas of concern for CT: alcohol, cocaine, heroin and other illicit opioids, marijuana, mental health, prescription drug abuse, problem gambling, suicide, tobacco / electronic nicotine devices (ENDS) / vaping.

It includes the following 34 cities and towns which comprise DMHAS Service Region 2: Ansonia, Bethany, Branford, Chester, Clinton, Cromwell, Deep River, Derby, Durham, East Haddam, East Hampton, East Haven, Essex, Guilford, Haddam, Hamden, Killingworth, , Madison, Meriden, Middlefield, Middletown, Milford, New Haven, North Branford, North Haven, , Old Saybrook, Orange, Portland, Seymour, Shelton, Wallingford, Westbrook, West Haven, Woodbridge.

This priority report process has been historically used as a bi-annual indicator of emerging issues and service gaps. This was done through an in-depth analysis of national, state, and regional trends by substance use and mental health topics (i.e., epidemiological profiles) that concluded with recommendations for the Department of Mental Health and Addiction Services (DMHAS) as well as service providers. This 2025 reiteration of the report is more focused on viewing the behavioral health system as a whole, and organizing the findings into:

- Substance Use Prevention
- Substance Use Treatment and Recovery
- Mental Health Promotion
- Mental Health Treatment and Recovery
- Problem Gambling Prevention
- Suicide Prevention

Findings within these 6 topic areas will be organized into:

- Emerging Issues (trends)
- Resource Gaps and Needs
- Regional Strengths, Resources, and Assets
- Priorities
- Goal and Recommendations

The intention of this report is to be used as a used as a building block for community level processes including capacity and readiness building, strategic planning, and implementation of evidence -based programs & strategies.

## Data Sources

In general terms, describe the sources of data for the report, value or uses (what it addresses) and the overall strengths and limitations of those sources. A discussion of the completeness of the data, whether they are representative and timely, and whether they can be generalized, may be included. Include both **quantitative** and **qualitative** data sources in this section (including the Stakeholder Survey, focus groups and other key informant input).

Data was collected from multiple sources to gather insight into the Region 2's behavioral health needs. Data was sourced from previous priority reports, and from CPES's "epidemiological slide deck" that comprised of regional and statewide behavioral health trend data. Additionally, subject matter experts within the behavioral health field in region 2 assisted by identifying key data sources to include in our analysis. Secondary data sources included in this report include:

- Data Haven Community Well-Being survey
- Medicaid insurance (Husky) behavioral health utilization data (Carelton Behavioral Health)
- DMHAS treatment admissions
- Local Region 2 student surveys on behavioral health risks
- CT crash depository
- Mobile crisis data
- 2-1-1 Counts data
- Emergency department data
- Region 2 health department data from community needs assessments
- CT DPH overdose data
- Region 2 needs assessment data

**Figure 1. Data Sources and Uses**

<b>Data Source</b>	<b>Strengths (and/or Purpose/Value)</b>	<b>Limitations (and What/Who is Missing)</b>
Epidemiological data	Quantitative overview of statewide and regional trends	Limited to data available to CPES and the RBHAO.
Stakeholder Survey Data	To gather community stakeholder input on priority areas, gaps, and recommendations	Small sample size. Not generalizable to the entire region. Limited to existing partnerships; missing large community perspective.
Focus group data	To gather contextual information on the emerging issues, gaps, and recommendations to address the gaps from key community partners	Limited to existing partnerships; missing large community perspective.
Key informant interviews	To gather stories from key community partners on the Region 2 behavioral health trends, gaps, strengths, and recommendations	Limited to existing partnerships; missing large community perspective

## Description of Prioritization Process

The Region 2, 2025 Priority Report process followed a multi-phase, mixed-method approach conducted over seven months (September 2024–April 2025). The process aims to identify behavioral health trends, gaps, strengths, and key priorities through community-informed strategies. Input was gathered from multiple community partners, including APW staff, behavioral health experts, Local Prevention Councils (LPCs), health departments, community collaboratives, and a 19-member Regional Priority Workgroup (RPW) representing diverse behavioral health sectors across region 2.

The Regional Priority Workgroup played a central role in interpreting data, identifying regional strengths and gaps, and determining recommendations. It met four times between December and March. Meetings included goal setting, trend and gap analysis, strength identification, and prioritization. Small groups were formed by topic areas (e.g.,

substance use, mental health) to analyze data using the jigsaw method (Utah State University, n.d.). These groups reviewed primary and secondary data sources organized in Excel and summarized them through presentation materials.

This report was formulated within three phases. **Phase 1 (Secondary Data)** drew from sources such as Data Haven, CPES slide decks, DMHAS, Carelon Behavioral Health, 2-1-1 Counts, school surveys, and emergency/crisis system reports. **Phase 2 (Primary Data)** included a regionally distributed community survey (140 responses across all communities) and five focus groups on prevention, behavioral health treatment and recovery, suicide, and gambling. Informal key informant input occurred through RBHAO community partnerships.

In **Phase 3 (Prioritization)**, RPW members individually ranked trends and gaps based on prevalence, severity, and changeability using a weighted matrix. Prevalence and severity were weighted at 0.25, and changeability at 0.50. Each member selected their top three issues. Small groups then calculated average scores and selected a shared priority area for their assigned topic. Final recommendations reflected these aggregated group rankings, ensuring that priorities were actionable and grounded in both community insight and data-driven analysis.

## Strengths and Limitations of This Report

We recognize that this report cannot accurately measure all possible aspects of the Region 2 behavioral health trends, service gaps, strengths, and community-wide input to address the gaps. This assessment incorporates a significant amount of data that was collected from a variety of primary and secondary sources. The data is believed to be reliable, valid, and relevant. However, it is not feasible to include all available data. The data may be limited as to the level of geographic detail or demographic identifier,

availability for all health indicators, and by the timeliness of the information's reporting period.

Qualitatively, many community individuals were involved in the development of this report. However, given that input was not provided by all community members, there may be instances where specific concerns are not adequately represented. These information gaps could potentially limit this report's ability to assess all the aforementioned areas of concern in region 2.

## Regional Profile

### Description of the Region

Region 2 is in the South-Central region of CT, consisting of most of New Haven and Middlesex Counties. These two counties include a 34-town region with a total population of 834,293 and a median county household income ranging from \$48,973 to \$171,652 (CT Data). The South-Central region of CT is an economically diverse area spanning from the lower Naugatuck Valley through the shoreline area and into central CT. The areas range from the small rural communities of 3,740 (Chester) to the second largest city in the state, New Haven, with a population of 135,736 (CT Data, 2024).

Within the Five Connecticut's (5CT) model of viewing town level characteristics (Levy & Data Haven, 2015), most of the Region 2 communities are Suburban (57.1%), followed by Urban Periphery. Region 2 has one Urban Core community (New Haven), and one Wealthy (Woodbridge). Region 2 is unique from other regions in that it has all five types within the 5CTs.

Most communities in region 2 are comprised of residents identifying as White, Non-Hispanic. The exception is within the City of New Haven and West Haven where the White, non-Hispanic population falls below the 50% percentile (CT Data, n.d.).

## Region 2 Town Characteristics

Town/ City	Total Population <sup>1</sup>	Community Type <sup>2</sup>	Median Income <sup>1</sup>	% Poverty Rate <sup>1</sup>	% White <sup>1</sup>	% Black/ African American <sup>1</sup>	% Hispanic/ Latinx <sup>1</sup>	% Asian <sup>1</sup>	% Native American <sup>3</sup>	% Other <sup>1</sup>
Ansonia	18,954	Urban Periphery	\$67,474	11.0	52.0	11.0	31.0	3.0		3.0
Bethany	5,295	Suburban	\$141,000	1.0	92.0	2.0	1.0	2.0		2.0
Branford	28,177	Urban Periphery	\$94,750	7.0	85.0	2.0	6.0	4.0		2.0
Chester	3,740	Suburban	\$90,929	10.0	88.0	1.0	5.0	< 1.0		5.0
Clinton	13,284	Suburban	\$110,556	5.0	88.0	< 1.0	5.0	3.0		3.0
Cromwell	14,250	Suburban	\$101,424	6.0	76.0	5.0	9.0	6.0		6.0
Deep River	4,445	Rural	\$85,859	5.0	91.0	2.0	5.0	< 1.0		2.0
Derby	12,373	Urban Periphery	\$69,835	13.0	56.0	11.0	23.0	2.0		7.0
Durham	7,197	Suburban	\$148,095	4.0	89.0	< 1.0	3.0	2.0		6.0
East Haddam	8,921	Rural	\$107,096	5.0	94.0	< 1.0	3.0	< 1.0		3.0
East Hampton	12,798	Suburban	\$116,163	4.0	87.0	< 1.0	7.0	3.0		3.0
East Haven	27,871	Urban Periphery	\$83,489	7.0	74.0	4.0	17.0	2.0		2.0
Essex	6,754	Suburban	\$96,734	5.0	90.0	2.0	2.0	3.0		2.0
Guilford	22,046	Suburban	\$124,793	3.0	86.0	2.0	6.0	3.0		3.0
Haddam	8,492	Suburban	\$119,252	3.0	87.0	< 1.0	4.0	5.0		3.0
Hamden	61,069	Urban Periphery	\$90,484	9.0	56.0	23.0	14.0	4.0		4.0
Killingworth	6,216	Suburban	\$124,620	3.0	90.0	< 1.0	2.0	2.0		6.0
Lyme	2,390	Suburban	\$119,352	2.0	90.0	3.0	1.0	< 1.0		5.0
Madison	17,658	Suburban	\$156,171	2.0	90.0	< 1.0	2.0	3.0		4.0
Meriden	60,556	Urban Periphery	\$63,671	16.0	50.0	7.0	37.0	2.0		3.0
Middlefield	4,240	Suburban	\$102,083	6.0	90.0	< 1.0	2.0	6.0		2.0

Middletown	48,152	Urban Periphery	\$75,120	12.0	66.0	13.0	11.0	5.0		5.0
Milford	52,283	Urban Periphery	\$104,441	4.0	83.0	2.0	8.0	5.0		3.0
New Haven	135,736	Urban Core	\$54,305	25.0	32.0	28.0	31.0	5.0		4.0
North Branford	13,560	Suburban	\$114,167	4.0	92.0	< 1.0	3.0	3.0		3.0
North Haven	24,179	Suburban	\$121,250	6.0	82.0	3.0	7.0	6.0		2.0
Old Lyme	7,648	Suburban	\$122,116	4.0	86.0	< 1.0	8.0	3.0		3.0
Old Saybrook	10,492	Suburban	\$99,825	4.0	92.0	< 1.0	6.0	< 1.0		1.0
Orange	14,231	Suburban	\$138,514	3.0	82.0	4.0	3.0	9.0		2.0
Portland	9,409	Rural	\$116,098	4.0	89.0	< 1.0	4.0	4.0		2.0
Seymour	16,766	Rural	\$96,747	6.0	76.0	4.0	14.0	2.0		4.0
Shelton	41,206	Suburban	\$112,366	6.0	71.0	4.0	12.0	9.0		4.0
Wallingford	44,251	Suburban	\$98,465	6.0	80.0	1.0	12.0	4.0		2.0
Westbrook	6,816	Suburban	\$76,779	4.0	76.0	1.0	13.0	2.0		7.0
West Haven	55,336	Urban Periphery	\$72,827	11.0	50.0	16.0	27.0	4.0		4.0
Woodbridge	9,050	Wealthy	\$190,536	1.0	79.0	2.0	6.0	10.0		3.0
<b>Connecticut</b>	<b>3,611,317</b>	<b>NA</b>	<b>\$90,213</b>	<b>10.1</b>	<b>65.9</b>	<b>12.2</b>	<b>16.9</b>	<b>5.0</b>	<b>NA</b>	<b>8.5</b>

<sup>1</sup>[Connecticut Town Profile, 2024](#) (American Community Survey, 2018-2022).

<sup>2</sup>Levy, Don: Five Connecticut's 2010 Update. (2015).

<sup>3</sup>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 2

**Figure 3. Subpopulations in Region 2 and Areas of Concern**

Subpopulation/Group	Area(s) of Concern	Rationale/Evidence
LGBT	Higher rates of depression, suicide ideation and attempts	RSAB focus group, Region 2 Student survey data 2023, 2024
Hispanic / Latino(a) across all ages	Higher rates of sadness, hopelessness, and suicide ideation	RSAB focus group
Youth	Increased cannabis use, nicotine pouch use	Region 2 Student Survey data 2023. 2024, Substance Use Focus Group
Young Adults	Increased cannabis use treatment admissions,	Substance Use focus group
Women	Treatment for co-morbidity	Recovery Focus Group,

# Findings

## Emerging Issues

### ***Substance Use/Misuse Prevention & Mental Health Promotion***

#### **Youth and Young Adults (Ages 25 and under).**

Alcohol use remains the most reported substance among youth, with 21.2% of middle and high school students indicating 30-day use (CT YRBS, 2023). However, the work to target youth alcohol prevention specifically is limited and needs to be standardized and expanded throughout the entire region.

The growing popularity of nicotine pouches (e.g., Zyn) is a rising concern for young people under the age of 21, particularly among student athletes. While vaping remains common, participants in regional focus groups noted a shift toward cannabis being the primary substance used in vape devices. This aligns with findings from the APW Cannabis Needs Assessment (2024), which identified a low perception of harm associated with cannabis use and its normalization among middle and high school youth—64.5% of students rated moderate to great risk associated with cannabis use.

Youth report frequently vaping at home alone (Nicotine 43.7%; Cannabis 40.8%) rather than in social settings. Despite prevention efforts, 2.9% of youth in 7 student survey reports in region 2 districts report past month vape use, with lifetime use at 7.9%. Nearly half of these users have attempted to quit. Expanded access to nicotine and cannabis partially contributes to growing rates of use. The proliferation of smoke shop store fronts and recreational cannabis dispensaries in the region, combined with vape devices & other tobacco products that are becoming more technologically advanced, more discreet to use, paired with social media channels simplifying purchasing, is an increasing concern.

**General Population.** There are promising trends in substance use prevention.

Impaired-driver crashes involving individuals aged 22–34 declined by 22% from 661 in 2022 to 518 in 2024. Males accounted for 72% of these incidents (CT Crash

Depository). Drug overdose rates in region 2 also declined from 58.6 per 10,000 in 2022 to 48.0 per 10,000 in 2023 (OCME). However, stimulants were present in 55.7% of CT overdose deaths in 2023, compared to 44.6% in 2022, reflecting just under a 10% increase in stimulant involved deaths in the twelve-month time frame (CDC SUDORS).

A persistent challenge is limited community engagement in prevention work. Local Prevention Councils (LPC) shared ongoing difficulties in mobilizing schools and community members. One LPC member noted, “no one finds substance use prevention exciting,” highlighting the need for innovative, community-driven approaches to sustaining prevention efforts over time.

**Figure 4.1: Substance Use Prevention Emerging Issues in Region 2**

<b>SUBSTANCE USE/MISUSE PREVENTION &amp; MENTAL HEALTH PROMOTION</b>		
<i>Youth and Young Adults (ages 25 and under)</i>		
<b>Emerging/Ongoing Issue</b>	<b>For Whom/What Group</b>	<b>Rationale/Evidence</b>
Alcohol has the highest 30-day use rate (21.2%) among middle school and high school students in region 2	Middle and high school students in region 2	CT YRBS, 2023
Cannabis use is normalized and is related to a low perception of harm  Middle and High School students in region 2 report moderate to great risk for cannabis use 64.5%	Middle and High School students within region 2	Substance use prevention and mental health promotion focus group; YVCS (2022-2024); APW Cannabis Needs Assessment, 2024
Underage youth are using substances home alone instead of primarily in social gatherings  Home alone vaping nicotine 43.7% & Cannabis 40.8%	Youth under the age of 21 in region 2	Substance use prevention and mental health promotion focus group; APW Vaping Needs Assessment, 2024; APW Cannabis Needs Assessment, 2024

Middle school and High school youth continue to use vape devices (ongoing).  7 school districts in region 2: 2.9% past month use, 7.9% lifetime use. 49% of current users have tried to quit.  Cannabis is more frequently used in vape devices	Youth under the age of 21 in region 2	Substance use prevention and mental health promotion focus group; APW Vaping Needs Assessment, 2024; CT YRBS and BRFSS, 2023
Nicotine pouches (Zyn's, etc.) are growing in popularity among underage youth	Youth under the age of 21 in region 2; Athletes among sub populations increasing use of products.	Substance use prevention and mental health promotion focus group; Environmental scans with tobacco retailers
Decrease in impaired-driver related crashes from 661 in 2022 to 518 in 2024	Region 2 individuals between the ages of 22 & 34 had the highest concentration of crashes  Males account for 72% of crashes	CT Crash Depository – Person Summary Dashboard – Region 2 from 1/1/2022 to 12/31/2024
<b>General population</b>		
<b>Emerging/Ongoing Issue</b>	<b>For Whom/What group</b>	<b>Emerging Issue</b>
Drug overdoses in South Central CT have declined from 58.6 per 10,000 in 2022 to 48.0 per 10,000 in 2023	Region 2 individuals (age not defined)	Office of the Chief Medical Examiner (OCME) 2020-2023  CDC SUDORS 2023
Lack of consistent community involvement in coalition activities contributes to difficulty in sustaining prevention efforts over time.	Local Prevention Councils in Region 2	Substance use prevention and Behavioral health focus group

**Behavioral Health Treatment and Recovery**

**Youth and Young Adults (Ages 25 and under).** Cannabis remains the most reported substance upon treatment admission for young adults (ages 18–25), surpassing alcohol (DMHAS EQMI). Additionally, younger women are increasingly seeking recovery supports that address co-occurring mental health and interpersonal violence concerns.

**Adults.** Among Region 2 adults, the top barriers to behavioral health treatment include cost (41% cite affordability as a barrier), time constraints, and rising rates of alcohol and crack/cocaine treatment admissions (Data Haven 2024; DMHAS EQMI). These challenges reinforce the need for low-barrier, accessible services.

**General Population.** Structural barriers to accessing behavioral health treatment and recovery services emerged as the priority issue across Region 2. Specifically structural barriers such as housing insecurity, transportation, and long waitlists for inpatient and outpatient care, especially following a crisis, were indicated as the priority issue across collected secondary and primary data.

Housing was one of the primary concerns across region 2 community members and key community partners. Individuals experiencing housing instability or relying on emergency shelters often encounter providers unequipped to meet behavioral health needs. Hospitals are frequently used as default crisis responders, though they are not ideally suited for behavioral health care. Police departments report being the primary responders to mental health emergencies, highlighting gaps in the region’s crisis response infrastructure. Limited insurance coverage for in-home services, especially for children post-crisis, and a shortage of providers trained in neurodevelopmental disorders further restrict access to appropriate care.

Focus group participants and community partners expressed growing fear around the sustainability of behavioral health services in light of federal funding uncertainty. These concerns are especially heightened among immigrant populations, LGB residents, and organizations supporting individuals in recovery.

Medication-Assisted Treatment (MAT) misuse was raised as a concern in recovery focus groups, along with the ongoing contamination of substances (e.g., fentanyl in “molly,” xylazine in opioids). These trends underscore the urgent need for coordinated, trauma-informed, and community-led treatment and recovery efforts.

**Figure 4.2: Behavioral Health Treatment and Recovery Emerging Issues in Region 2**

<b>BEHAVIORAL HEALTH TREATMENT/RECOVERY</b>		
<i>Youth and Young Adults (ages 25 and under)</i>		
<b>Emerging/Ongoing Issues</b>	<b>For Whom/What Group</b>	<b>Rationale/Evidence</b>
Among young adults (ages 18-25), cannabis has a higher rate of substance use upon treatment admission than alcohol	Young adults (ages 18-25) in region 2	DMHAS EQMI Treatment Admissions – young adults ages 18-25 (CPES slide deck data)
Younger women are seeking substance use recovery and mental health supports	Young women in region 2	Recovery focus group
<b>Adults</b>		
<b>Emerging/Ongoing Issue</b>	<b>For Whom/What Groups</b>	<b>Rationale/Evidence</b>
Adults report that “not having time” is the primary reason for not seeking care in region 2, and is the highest rate across the state	Adults in Region 2	Data Haven Community Wellbeing Survey (DCWS), 2024 (CPES slide deck)
Increase in adult alcohol and crack/cocaine treatment admissions	Adults in Region 2	DMHAS EQMI Treatment Admissions – all clients (ages) (CPES slide deck data)
Region 2 adults 18 and over, not being able to afford the cost was the primary reason for not seeking care (41%)	Adults 18 and over in region 2	Data Haven Community Wellbeing Survey (DCWS), 2024 (CPES slide deck)
<b>General Population</b>		
<b>Emerging/Ongoing Issue</b>	<b>For Whom/What groups</b>	<b>Rationale/Evidence</b>
Waitlist for services (post-crisis referrals, inpatient and outpatient levels of care)	Individuals with behavioral health concerns in region 2; Children and adolescents with mental health concerns in region 2	Treatment & Recovery focus group

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Fentanyl continues to contaminate illicit substances (“molly” among youth; xylazine)	Individuals currently using or experimenting with substances in region 2	Recovery focus group
Fentanyl is readily available, easy to find, an inexpensive	Individuals currently using or experimenting with substances in region 2	Recovery focus group
Medications used for MAT are misused, rather than taken as prescribed	Individuals currently struggling with opioid dependence in region 2; Individuals currently receiving MAT for opioid dependence in region 2	Recovery focus group
Increased anxiety and fear among the recovery community 2025 federal administration budget cuts and political climate	Recovery service providers and clients in region 2; LGBTQ+ and Hispanic/Latino community members, and Immigrants/asylum seekers in region 2	Recovery focus group; Key informant interviews; Regional Priority Workgroup
Housing instability is a barrier for people accessing and sustaining within behavioral health treatment	Individuals who are unhoused and have behavioral health concerns in region 2	Treatment and Recovery focus group
Transportation continues to be a barrier in accessing treatment (ongoing)	Individuals who have behavioral health concerns in region 2	Treatment and Recovery focus group
Lack of understanding of behavioral health needs by emergency housing shelters and low capacity to address appropriately.	Individuals who are unhoused and have behavioral health concerns in region 2	Treatment and Recovery focus groups
Individuals are avoiding behavioral health clinics due to fear of legal concerns	Hispanic/Latino populations and individuals with behavioral health concerns in region 2	Treatment and Recovery focus group; Key informant interview
Treating hospitals as a catch-all for behavioral health needs (ongoing)	For individuals suffering from behavioral health concerns across the lifespan in region 2	Treatment and Recovery focus group

Police are acting as first-responders to behavioral health crises (ongoing)	Police officers in region 2	Treatment and Recovery focus group; Suicide focus group 2025
A higher rate of individuals needing mental health treatment but did not get it in region 2 (16%) than in CT (15%)	Individuals in Region 2 (age not specified)	Data Haven Community Wellbeing Survey (DCWS), 2024 (CPES slide deck)
Insurance is a barrier for accessing in-home services for children and families	Children and families post mental health crises in region 2	Treatment & Recovery focus group
Shortage of treatment staff that specialize in addressing neurodevelopmental disorders	Individuals in Region 2	Key informant from behavioral health insurance

### **Problem Gambling**

Problem gambling is an emerging behavioral health concern in region 2, with early onset increasingly common. Youth as young as 6 to 12 years old are engaging in gambling activities through sports betting, video games with gambling mechanics, card games, and scratch-off tickets. The rise in digital and online gambling platforms has made these activities more accessible, contributing to the normalization of gambling behavior at a young age. Among adults, those aged 50 to 64 show the highest prevalence of gambling compared to other age groups statewide. Lottery products continue to be the most frequently consumed gambling option among both youth and adults. These trends point to the need for more targeted prevention strategies that address both early exposure and high-use age groups.

**Figure 4.5: Problem Gambling Emerging Issues in Region 2**

<b>PROBLEM GAMBLING</b>		
<b>Emerging Issue</b>	<b>For Whom/What Group</b>	<b>Rationale/Evidence</b>
Age of first gambling behavior between ages of 6 – 12 years old. Primarily gambling through sports betting, video	Middle and elementary school youth in region 2	Qualitative data collected from gambling awareness in high schools in region 2

games, card games, and scratch offs		
Adults aged 50-64 have higher use of gambling compared to other adults	Adults aged 50-64 (state-wide)	Impacts of legalized gambling in Connecticut, Gemini Research, Inc. 2024 (CPES data slide deck)

### Suicide Prevention

When examining suicide prevention trends and emerging issues in Region 2 of Connecticut, significant disparities are evident among specific subpopulations. Young adults aged 18 to 24 experience notably high rates of suicide across the region. Among high school students, LGBT and Hispanic/Latino youth report disproportionately high levels of sadness, hopelessness, poor mental health, suicidal ideation, and suicide attempts. Additionally, access to timely care remains a challenge, with many individuals in region 2 identifying time constraints—particularly the lack of services outside traditional business hours—as a primary barrier to seeking mental health support.

**Figure 4.6: Suicide Prevention Emerging Issues in Region 2**

SUICIDE PREVENTION		
Emerging Issue	For Whom/What Group	Rationale/Evidence
High rates of suicide in region 2 among young adults	Age 18-24 in region 2	Connecticut Suicidal Ideation and Self Harm Emergency Department Visit Report, 2024 (CPES data slide deck); Suicide focus group 2025
Individuals for whom time limitations are a barrier to care	Adults 18+ in region 2	Data Haven Community Wellbeing Survey (DCWS), 2024 (CPES data slide deck)
LGBTQIA+ students disproportionately report high rates of feeling sad/hopeless and poor, mental health, 4x higher suicide attempt rate than heterosexuals	LGBTQ+ high school students (state-wide)	CSHS (CT YRBS), 2023 (CPES data slide deck)
Hispanic/Latino students reporting highest prevalence of sadness/hopelessness,	Hispanic/Latino high school students (state-wide)	CSHS (CT YRBS), 2023 (CPES data slide deck)

suicidal ideation, and suicide attempts across the board		
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## Regional Strengths, Resources, and Assets

Region 2 is comprised of a diverse range of strengths to address substance use, mental health, problem gambling and suicide. One of the most notable strengths within our focus groups was the increase in peer-support services and community-based outreach programs. New Haven boasts the strongest area of behavioral health treatment options compared to the rest of the region. Additionally, funding to support primary prevention initiatives has expanded since the 2023 report. This has allowed the APW to expand partnerships and grow regional capacity to expand the reach of prevention initiatives across the region.

## Regional Resources and Assets

**Figure 5: Summary of Resources and Assets in Region 2**

Funding/Initiatives		
Resource/Asset	Focus Area	Catchment Area/Reach
<b>Expanded RBHAO model</b>	<b>Behavioral Health</b>	<b>South Central CT</b>
Bridges MATT Van (Mobile Addiction Treatment Team)	Harm Reduction Supplies, Narcan, Prescription/Dosing information same day MAT services, peer recovery support New Haven, West Haven, Milford	Reg.2
Yale Community Healthcare Van	Wound Care, Drop-in Center, Fentanyl test strips, Naloxone distribution, Hepatitis and HIV education and testing, LGBTQ services, overdose education, testing of drug supply, STI testing and treatment New Haven and Fair Haven	Reg.2
CT Harm Reduction Alliance	River Valley area and New Haven – Mobile Van Middletown, Durham, Chester, East Hampton SWAN (Sex Workers and Allies Network) Mobile Outreach – Greater New Haven area	Reg.2

Overdose Response Coordinator – Sarah Blodgett	Post Overdose Services	Reg.2
APT Foundation BHcare Bridges Columbus House Connection, Inc. Cornell Scott-Hill Health Center  Hartford Healthcare– Rushford Waterstone Counseling Center	New Haven Valley Shoreline Milford New Haven Middletown New Haven Ansonia Meriden Madison	Reg.2
Yale Community Healthcare Van – 270 Congress Ave	New Haven	Reg.2
Swan – Program of CTHRA – 269 Peck Street	New Haven	Reg.2
Cornell Scott-Hill Health (SCRC) Retreat Behavioral Health CVH – Merritt Hall Rushford	New Haven New Haven Middletown Middletown	Reg.2
Connecticut Clearing House	Information on substance use, mental health disorders, prevention and health topics	Statewide
Connecticut Community for Addiction Recovery (CCAR)	Help navigate the recovery community by connecting you with others in recovery and provides access to area support services	Statewide
DrugFreeCT.org	Helping Connecticut understand, prevent, and recover from substance use disorders	Statewide
Harm Reduction	Nationwide advocate and ally for people who use substances	Statewide
Live LOUD	Life with Opiate Use Disorder education, information, treatment  <b>24/7 Access Line</b>	Statewide
NORA Saves Naloxone and Overdose Response App		
Never Use Alone	If you are using by yourself, call this hotline; you will be asked for your first name, location, and the number you are calling from. The operator will stay on the line while you use, if you stop responding the operator will notify emergency services of an “unresponsive person” at	<b>Catchment Area/Reach</b>

	your location	
Rocking Recovery	Organizations, services and programs for people living with mental health challenges and substance use disorders	School-based services in partnership with behavioral health service provider
SAMHSA	Substance Abuse and Mental Health Services Administration  National Help Line	Hamden area
SMART Recovery	Self-Management and Recovery Training with online and hybrid recovery meetings	Region 2
Suicide and Crisis Lifeline	<b>24/7 Access Crisis Line</b>	Region 2
TriCircle	Resources to overcome substance use by creating real, long-term solutions	New Haven
Youth Recovery	Recovery assistance, peer support, and hope for teens and young adults	Region 2 (statewide resource)
Responsible Play, the CT Way Resource Van	Problem Gambling Prevention	Region 2 (statewide resource)
CT Clearinghouse	Statewide Library / Resource center	CT
Governors Prevention Partnership	Youth mentoring and substance use prevention	CT
Regional Gambling Team	Problem gambling prevention	Region 2
Regional Suicide Advisory Board	Suicide prevention	Region 2
Local Prevention Councils		Region 2
988 lifeline / 211, call, text, chat	helpline	CT
Regional Cannabis / Vaping work group	Cannabis / vaping prevention	Region 2
National Problem Gambling Hotline	Helpline	CT
CT Problem Gambling Hotline	Helpline	CT
Responsible Play Van	Community resource	CT
<b>Services</b>		
<b>Resource/Asset</b>	<b>Focus Area</b>	<b>Catchment Area/Reach</b>
Behavioral Health Treatment Services (BHcare, Fair Haven)	Substance Use Treatment and Recovery; Suicide Prevention; Mental Health Treatment and Recovery	Region 2

Health Center, Cornell Scott Hill Health Centers, Bridges Healthcare, Yale Community Health Care, River Valley Services, CT Mental Health Center, Waterstone Counseling, Clifford Beers, STOP program)		
Harm Reduction Services (SWAN, CT Harm Reduction Alliance, COMPASS New Haven, Yale Syringe Service Program)	Substance Use Treatment and Recovery; Suicide Prevention; Mental Health Treatment and Recovery	New Haven area
Local Health Departments that provide Mental Health First Aid, Psychological First Aid, Emergency Preparedness	Mental Health Promotion	New Haven County, Lower Naugatuck Valley, Shoreline
Youth Service Bureaus providing behavioral health services	Mental Health Promotion	Region 2
Recovery support Specialists, Peer Navigators and Recovery Coaching at community based out-patient treatment, Hospital Emergency Departments, Local health departments, Recovery Centers	Mental Health Promotion	Region 2
Telehealth behavioral health services	Mental Health Treatment and Recovery	Region 2
Yale Street Psychiatry	Mental Health Treatment and Recovery	Region 2
Crisis response (Clifford Beers, Connecticut Mental Health Center, Continuum, Wheeler Clinic, Yale New Haven Hospital, Middlesex Hospital)	Suicide Prevention	Region 2

Columbus House post-crisis response (drop-in center)	Suicide Prevention	New Haven area
Support Groups (Alternatives to Suicide, Wildflower Alliance in Middletown, Out of the Abyss, NAMI New Haven)	Suicide Prevention	Region 2
AFSP Healing Conversations	Suicide Prevention	Region 2
Veteran’s Hospital suicide prevention	Suicide Prevention	Region 2
Umbrella Center/HOPE	Suicide Prevention	Region 2
DigIn Program	Problem Gambling	New Haven area
Bettor Choice Treatment Programs at Communicare	Problem Gambling	New Haven and Middletown area
Latino Outreach Program (DMHAS-funded program)	Mental Health Treatment and Recovery; Substance Use Treatment and Recovery	Region 2 (statewide initiative)
Latino Behavioral Health Services (LBHS) Program (DMHAS-funded program)	Mental Health Treatment and Recovery; Substance Use Treatment and Recovery	Region 2 (statewide initiative)

## Regional Resource Gaps and Needs

### *Substance Use/Misuse Prevention & Mental Health Promotion*

A key theme emerging from region 2’s prevention landscape is the need for more flexible and sustainable funding. The Regional Priority Workgroup emphasized the need to expand alcohol misuse prevention efforts with funding models similar to those supporting cannabis prevention.

Local Prevention Councils (LPCs) highlighted gaps in capacity and funding flexibility. Though the LPC grant provides baseline support, it often falls short of meeting community-specific needs. LPC’s reported the low staffing capacity as a significant barrier, calling for sustainable funding to recruit and retain skilled prevention staff. Many

in Region 2 are volunteer run, or a small allocation of personnel dedicated to prevention work. LPC’s expressed the need for more targeted prevention programming and improved data collection to better understand and address the unique needs of this age group.

Strengthening community partnerships was also a common theme. LPCs expressed a need for more support in building relationships with schools, universities, and local communities.

Finally, participants identified data and programming gaps for young adults (ages 18–24). There is limited data on this population's substance use and mental health indicators.

**Figure 6.1: Summary of Substance Use Prevention Resource Gaps and Needs in Region 2**

<b>SUBSTANCE USE/MISUSE PREVENTION &amp; MENTAL HEALTH PROMOTION</b>		
<i>General Population</i>		
<b>Gap/Need</b>	<b>For Whom/What Group</b>	<b>Rationale/Evidence</b>
Need region-wide funding to address underage alcohol use and adult misuse	Region 2 individuals across the lifespan; RBHAOs	Regional Priority Workgroup
Need data on prevalence of stimulant use, and stimulant-use specific prevention efforts	Individuals across the lifespan who use stimulants in region 2	Regional Priority Workgroup
To increase capacity and strengthen outreach, Local Prevention Councils need funding to recruit and retain skilled prevention staff.	Local Prevention Councils in Region 2	Substance use prevention and mental health promotion focus group
Need data on substance use and mental health indicators for college aged young adult population	Individuals aged 18-24 in region 2	Substance use prevention and mental health promotion focus group
Need to increase capacity for Local Prevention Councils to	Local Prevention Councils in Region 2	Substance use prevention and mental health promotion focus group

build partnerships with schools and community		
Need cannabis cessation support services for all age groups, with a focused effort on youth.	Region 2 (and statewide)	Substance use prevention and mental health promotion focus group, qualitative data from key Region 2 community partners

***Behavioral Health Treatment and Recovery***

**Gaps for youth and young adults (ages 25 and under)**

Behavioral health needs for youth and young adults in region 2 reflect critical gaps in early intervention and supportive services. There is a call for improved data tracking on buprenorphine use among young adults aged 18–25 to better understand opioid treatment trends. Destigmatizing mental health support remains a key concern—particularly for parents seeking services for youth under 18 and young adults—which continues to be a barrier to accessing timely and effective care. These needs highlight the importance of cultural sensitivity and normalization of behavioral health support within families.

Additionally, expanding in-home services for children and families has been identified to increase access and provide holistic, family-centered care. These findings emphasize the need for supports that address stigma, increase treatment visibility, and tailor services to the unique developmental and social needs of younger populations

**Gaps for adults and the general population.**

For adults and specific demographic groups like women and unhoused individuals, gaps were focused on accessibility, and supportive housing. Adults over 18 need more affordable mental health services, especially as financial barriers limit preventive and ongoing care. Unhoused populations are particularly underserved and need expanded behavioral health supports that consider housing instability as a major factor in treatment access and recovery outcomes.

Women in Region 2 face overlapping vulnerabilities and require trauma-informed services such as sober housing, domestic violence support integrated with recovery,

and safe houses for those navigating recovery. Additionally, individuals with developmental concerns across the lifespan lack adequate services, and people in recovery report a shortage of sober-friendly social spaces. These gaps show a need for inclusive, and socially integrated services that recognize co-morbidity, and diverse life circumstances impacting behavioral health recovery.

**Systems level gaps.** Many individuals face challenges accessing appropriate levels of care due to private insurance and other limitations. The workforce is experiencing attrition, affecting care quality and consistency. Transportation barriers remain a significant challenge across the behavioral health system, with many individuals lacking consistent, affordable, and timely options to reach services. Transportation systems, like Veyo, are unreliable for Husky recipients, further limiting service access.

Several system-level improvements were identified to strengthen behavioral health care delivery, including expanding access to community-based clinical treatment and creating behavioral health respite care as a viable alternative to hospitalization. A critical barrier for private nonprofit providers remains the lack of funding to upgrade and integrate their electronic health record (EHR) systems. These clinics often operate with limited administrative infrastructure and outdated technology, making it difficult to fully participate in data-sharing initiatives and coordinate care with larger health systems. Without dedicated investment, these providers risk being left out of broader health IT advancements, hindering both care quality and outcome tracking.

It was also suggested within the Treatment and Recovery focus groups to establish more wraparound services across behavioral health to make treatment delivery, coordination of care, and client referrals more accessible, streamlined, and easy to navigate. This is supported by the Stakeholder Survey results which indicate that additional services related to case management (n=53; 37.9%) and care coordination (n=38; 27.1%) are needed.

Further system enhancements also include sustainable funding for recovery organizations like CCAR, peer coach development, and outreach for non-emergency

support. A critical need remains in tracking stimulant use trends and strengthening evaluation mechanisms.

**Figure 6.2: Summary of Behavioral Health Treatment and Recovery Resource Gaps and Needs in Region 2**

<b>BEHAVIORAL HEALTH TREATMENT AND RECOVERY</b>		
<i>Youth and Young Adults (ages 25 and under)</i>		
<b>Gap/Need</b>	<b>For Whom/What Group</b>	<b>Rationale/Evidence</b>
Need data reported on buprenorphine used by young adults for opioid use treatment	Young adults ages 18–25 in region 2	DMHAS EQMI Treatment Admissions – young adults ages 18–25 (CPES slide deck data)
Destigmatize parents pursuing mental health services for young adults and youth 18 and under	Young adults 18–25; Youth 18 and under in region 2	Behavioral Health workgroup
Need to expand in-home services for children and families	Children and families in region 2	Treatment and Recovery focus groups
<i>Adults and General Population</i>		
<b>Gap/Need</b>	<b>For Whom/What Group</b>	<b>Rationale/Evidence</b>
Need more women-specific sober housing options	Women in Region 2	Recovery focus group
Need to increase domestic violence services with co-occurring mental health and recovery support	Women in Region 2	Recovery focus group
Need more safe houses for women who have experienced domestic violence and are in recovery	Women in Region 2	Recovery focus group
Need more services for individuals with developmental disorders	Individuals across the lifespan with developmental concerns in region 2	Treatment and Recovery focus group
Need more sober-friendly social events during evenings and weekends within the community (i.e., sober bars)	Individuals in recovery or substance-free in region 2	Recovery focus group
	<b>Systems Level</b>	

Gap/Need	For Whom/What Groups	Rationale/Evidence
Need to address barriers to appropriate levels of care from private insurances	Individuals seeking behavioral health care in region 2 (statewide)	Treatment and Recovery focus group
Need to address behavioral health workforce attrition	Behavioral health workforce in region 2 (statewide) and individuals suffering from behavioral health concerns	Treatment and Recovery and Recovery focus groups
Need to improve access to transportation system	Individuals seeking access to behavioral health services with Husky insurance in region 2	Treatment and Recovery focus group
Need funding for behavioral health clinics to address EHR systems	Behavioral health clinics in region 2	Treatment and Recovery focus group
Need more funding to expand community-based clinical treatment	Individuals seeking behavioral health clinical and psychiatric treatment in region 2	Treatment and Recovery focus group
Need behavioral health respite services as an alternative to hospitalization that has wraparound medical care	Individuals with behavioral health concerns in region 2	Treatment and Recovery focus group
Need to expand Connection to Recovery through Intervention, Support, and Initiating Services (CRISIS) program funding stream	Region 2 communities that lack mental health crisis resources	Regional Priority Workgroup; Prevention Professional key informant
Need data on prevalence of stimulant use, and stimulant-use specific treatment and recovery options	Individuals across the lifespan who use stimulants	Regional Priority Workgroup – Prevention Professional key informant
More sustainable funding for CCAR with opportunities to expand services	Individuals in substance use recovery in region 2	Regional Priority Workgroup – Prevention Professional key informant; Recovery focus group
Need for a livable wage for peer support and recovery coaches	Individuals in substance use recovery in region 2	Recovery focus group
Need to increase promotional efforts of local recovery and treatment supports (i.e., CCAR)	Individuals in recovery in region 2	Recovery focus group
Need to expand stigma-reduction campaigns	Individuals in active use or recovery in region 2	Recovery focus group
Need more peer outreach staff for non-emergency situations	Individuals with co-occurring economic or housing-related crises and behavioral health concerns	Treatment and Recovery focus groups
Need to increase inpatient bed availability	Individuals in Region 2	Key informant from behavioral health insurance

**Problem Gambling**

Despite the rise in gambling behaviors across age groups, there are critical gaps in education and community readiness to address problem gambling. Prevention education is lacking in elementary, middle, and high schools, and there is currently no mandate for gambling-related content in health curricula. As a result, many youth receive little to no information on the risks associated with gambling or how to recognize early warning signs. Among adults, the perception of harm associated with gambling remains low, and problem gambling behaviors often go unnoticed. To reduce risk and support early intervention, Region 2 community partners identified a need for expanded prevention education that increases public understanding of gambling risks and equips communities to recognize and respond to problematic behaviors.

**Figure 6.3: Summary of Problem Gambling Resource Gaps and Needs in Region 2**

PROBLEM GAMBLING		
Gap/Need	For Whom/What Group	Rationale/Evidence
Prevention education around gambling and risk factors	Middle and elementary school youth in region 2	Qualitative data collected from gambling awareness in high schools in region 2
Increase perception of harm by providing education, including warning signs of problem gambling behaviors.	Adults aged 50-64 (state-wide)	Impacts of legalized gambling in Connecticut, Gemini Research, Inc. 2024 (CPES data slide deck)

### ***Suicide Prevention***

When considering suicide prevention gaps for Region 2, emerging needs include additional clinical services by licensed clinicians beyond regular business hours (outside of the 8:00 AM – 4:00pm/9:00am – 5:00pm, with availability on the weekends, etc.) for those who are seeking treatment that would fit into their personal/professional schedule. Additionally, high school aged students in the LGB community and Hispanic/Latino populations are in need of more culturally appropriate services/providers. As noted in the strengths below, Region 2 includes a variety of support groups, treatment services, crisis response care, and drop-in centers but the majority are located within New Haven which results in high referrals and high wait times. There is limited capacity among

providers due to a shortage of clinical staffing and increasing referrals. //The funding and support for adult suicide postvention needs to be strengthened to replicate youth postvention response.

**Figure 6.4: Summary of Suicide Prevention Resource Gaps & Needs in Region 2**

SUICIDE PREVENTION		
Gap/Need	For Whom/What Group	Rationale/Evidence
Need more clinical services to address wait times	Adults 18+ in region 2	Suicide focus group 2025; Data Haven Community Wellbeing Survey (DCWS), 2024 (CPES data slide deck)
Need more culturally appropriate services	LGB and Hispanic/Latino high school students (state-wide)	CSHS (CT YRBS), 2023 (CPES data slide deck)
Lack of services outside of New Haven. High levels of referrals in surrounding towns.	Region 2	Suicide focus group 2025; Regional Priority workgroup

### Other Needs Assessments and Funding

**Figure 7: Summary of Needs Assessment Priorities in Region 2**

Needs Assessment Initiative/Project	Focus Area of Initiative/Project	Identified Priority (Issue and Population of Focus)
Adult Alcohol Use Initiative	Specific to communities of Ansonia, Derby, and East Haven	Addresses alcohol use among the adult population (funded by DMHAS)
Underage Alcohol Use Prevention Project	Specific to communities of Ansonia, Derby, and East Haven	Addresses underage alcohol use prevention (funded through DMHAS Project For Success)
Cannabis Misuse Prevention	Region 2 communities and a focus on	Addresses cannabis misuse (funded through DMHAS)
JUUL / ENDS Prevention Initiative	Region 2 communities	Addresses youth vaping prevention (funded through DMHAS)
Problem Gambling Prevention Initiative	Region 2 communities	Addresses prevention of problem gambling among youth, young adults, and adults

		(funded through DMHAS Problem Gambling Services)
Recovery Friendly Workplace Initiative	Region 2 communities	Engages workplaces to support employees in recovery (funded through DMHAS)
Suicide Prevention Initiative	Region 2 communities, and targeted prevention in Wallingford	Addresses suicide prevention among youth, young adults, and adults (funded through DMHAS)
Opioid Overdose Prevention	Specific to communities of Ansonia, Derby, and Shelton	Addresses opioid misuse prevention among youth (funded through Comprehensive Addiction & Recovery Act; Centers for Disease Control)
Opioid Misuse and Overdose Prevention	Region 2 communities	Addresses opioid misuse and overdose prevention among youth, young adults, and adults (Funded through National Guard Drug Demand Reduction)
Promotion of Mental Health Awareness Project	Region 2 communities	Addresses mental health awareness among adults (Funded through Mental Health Awareness Training grant; National Council)
Opioid Misuse and Overdose Prevention Initiative	Region 2 communities	Addresses prevention of misuse and overdose of opioids among youth, young adults, and adults (funded through State Opioid Response; DMHAS)

**Figure 8: Summary of Current Funded Priorities in Region 2**

Initiative/Project Name	Funding Source	Time Period	Priority Issue and Population of Focus
Cannabis Prevention	DMHAS	3/1/24-6/30/26	Prevention of cannabis use in youth and adults
CT Partnership for Hope and Healing (PH2)	DMHAS / SAMHSA	9/1/24-6/30/28	Suicide prevention in region 2 district – Wallingford
General Funds	DMHAS	12/1/23-6/30/25	Prevention of alcohol use (Ansonia, Derby, East Haven)
JUUL/Vaping Prevention	DMHAS	5/1/24-9/30/25	Prevention of nicotine / vaping in youth under 21

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Partnership for Success	DMHAS/ SAMHSA	-9/30/27	Prevention of underage alcohol use in Ansonia, Derby and East Haven
Prescription Drug Overdose (PDO)	DMHAS	7/15/24-8/30/28	Reduction of prescription / opioid overdose related deaths & adverse events for youth and adults
Problem Gambling Services (PGS)	DMHAS	7/1/24-6/30/27	Gambling prevention, education, community awareness for youth and adults
Regional Behavioral Health Action Organization (RBHAO)	DMHAS	7/1/24-6/30/27 7/1/24-6/30/27	Operate the RBHAO in region 2 to do substance use prevention / mental health promotion
Regional Suicide Advisory Board (RSAB) - DMHAS	DMHAS	3/1/23-8/31/25	Prevention and postvention of suicide adult population
Regional Suicide Advisory Board (RSAB) - DCF	DCF	1/1/24-9/30/26	Prevention and postvention of suicide for youth
Statewide Opioid Response (SOR)	DMHAS	9/30/24-9/29/27	Increase awareness of the dangers of opioid use disorders in youth and adults
Substance Exposed Children	DCF	10/1/24-9/30/27	Prevention of substance exposed children
Comprehensive Addiction Recovery Act	CDC	7/1/21-6/30/26	Opioid prevention in Ansonia, Derby and Shelton youth focus
Mental Health Awareness Training Grant (MHAT)	SAMHSA	9/30/21-9/29/26	Mental Health First Aid and De-escalation Training for first responders, educators, families and community members.

# Priorities, Recommendations, and Regional Goals

## Regional Priorities

### ***Substance Use/Misuse Prevention***

Underage substance use prevention continues to be a regional priority, with particular concern around the growing trend of underage youth using substances home alone. This behavior significantly increases the risk of overdose or substance-use related harm without the presence of peers or adults who might intervene. RPW members ranked this area high in both prevalence and severity, as well as high for changeability, as it can be addressed across various RBHAO-led, substance-specific initiatives. While overdose deaths in South Central Connecticut have declined—from 58.6 to 48.0 per 10,000—stimulants remain involved in 58% of those deaths. This may be a potential indicator of the outcome of the prevention efforts in the Region and also highlights the evolving nature of risk. Additionally, there is minimal regional data on substance use patterns among college-aged young adults, which limits the development of targeted interventions. Expanding data collection and tailoring strategies to reflect current use patterns are the next essential steps.

### ***Mental Health Promotion***

Youth mental health promotion, especially for those 18 and under, was identified as a high priority among RPW members based on the collected Region 2 data. Anxiety and depression are highly prevalent in this age group, with RPW members ranking them high in both prevalence and severity. While changeability was considered moderate, there is momentum to expand current regional initiatives to support youth mental health more effectively. Efforts to reduce stigma and improve awareness remain critical, especially as many youth continue to struggle silently. Gaps in access persist, particularly outside urban centers like New Haven, where clinical services are limited, and long wait times are common. Expanding access to diverse supports, including

therapy, support groups, IOPs, and digital support and self-help tools, are key to improving outcomes for youth across region 2.

**Suicide Prevention**

There is an urgent need to address the growing mental health crisis among youth in region 2, particularly among LGBTQIA+ and Hispanic/Latino students who report the highest levels of sadness, hopelessness, and suicide attempts. LGBTQIA+ youth are attempting suicide at four times the rate of their heterosexual peers, and Hispanic/Latino students show the highest prevalence of mental health distress across all indicators. Despite growing demand, the region faces a shortage of clinical services, especially outside of New Haven, where many towns experience long wait times and high referral rates. There's a pressing need to reduce stigma around mental health and suicide prevention within these sub-populations.

**Problem Gambling**

Problem gambling is a growing issue in Region 2, with youth beginning to gamble as early as ages 6 through 12, and primarily accessing gambling through sports betting, video games, card games, and scratch-offs. Despite its early onset and high prevalence, there is a lack of structured prevention education in elementary and middle schools. RPW members rated this issue high in prevalence, severity, and changeability, citing the opportunity to intervene early with age-appropriate education. Expanding awareness of gambling risks and integrating prevention strategies into school-based programs can help reduce long-term harm and promote healthier decision-making among youth.

**Figure 9.1: Summary of Identified RBHAO Priorities in Region 2**

<b>RBHAO Focus Area</b>	<b>Rationale/Considerations</b> Why did your workgroup select this priority?	<b>Population of Focus</b> Is there a specific age group or other subpopulation of focus for this priority? If so, describe.
Opioid and Stimulant Overdose Prevention	High prevalence/severity. Decline in overdose deaths signals prevention success. Stimulants in 58% of overdoses; lack of data on college-age use.	Young adults (ages 18-25); general population.
Preventing underage substance use at home alone	High prevalence/severity. Changeability is high due to broad application across prevention initiatives	Youth underage 21

Youth anxiety and depression	High prevalence/severity. Changeability is high due to broad application across prevention initiatives	Youth 18 and under
Youth mental health crisis and suicide prevention	High prevalence/severity. Changeability is high due to ability to integrate within current mental health promotion and suicide prevention initiatives.	LGBTQIA+ youth; Hispanic/Latino youth; general youth population
Youth gambling prevention	High prevalence/severity. Changeability is high due to ability to integrate within existing gambling and youth behavioral health prevention initiatives.	Elementary and middle school youth

***Behavioral Health Treatment***

In Region 2, the primary need related to behavioral health treatment is to improve access to care. Access to treatment was most often impacted by barriers related to waitlists for services, housing instability, geographic location, cost, and time.

Throughout all primary data collection efforts, waitlists for services were identified as a primary barrier to accessing care. This is exacerbated by care that may not be geographically accessible. Additionally, it was noted by key community partners that referrals and continuation of care continues to be a priority issue. Individuals are challenged to find referral services, and referrals typically do not include warm hand offs to ensure a continuation of care.

Basic needs such as housing were also cited as a primary issue by behavioral health treatment providers as a reason that individuals who have behavioral health needs cannot access care. They also noted that emergency shelters and hospitals were often utilized by the unhoused, and often these institutions have strong stigmas against individuals with behavioral health conditions. Key informants also shared that there are unused buildings in region 2 that are a “missed opportunity” for expanding emergency and permanent sheltering options. Waitlists for Section 8 housing were also noted as a primary issue, especially among the elderly population. Within our Treatment and Recovery focus group, one participant noted “you could die before you get off the wait list” to access supportive housing.

Women who have behavioral health concerns face unique challenges related to substance use and domestic violence. Additionally, there is an increase in young adults

(ages 18-25) cannabis DMHAS treatment admissions, which highlight the need to target college-aged young adults with cannabis-specific treatment options.

Furthermore, within the Data Haven Community Wellbeing survey results for region 2 (2024), 41% of adults identified affordability as the primary reason for not accessing care, while lack of time was the top barrier overall (Data Haven Community Wellbeing Survey, 2024). Suburban and rural areas outside New Haven experience significant service shortages, especially in in-home care for children and families and specialized support for developmental disorders.

It should also be noted that across all primary data collection efforts, behavioral health service provider attrition is a significant issue. Reports included excessive paperwork, high caseloads, and stress related to the behavioral health system of care. Provider shortages were also suggested to be related to stigma and subpar care quality, which in turn impacts treatment outcomes.

### ***Behavioral Health Recovery***

Barriers to recovery services in region 2 are rooted in a lack of supportive infrastructure, peer-led services, and culturally relevant programs tailored to specific populations. Housing instability, stigma, and transportation limitations remain systemic obstacles. Women in recovery in particular face a shortage of gender-responsive resources, including sober housing, trauma-informed domestic violence supports, and safe houses for those in recovery. The recovery community has called for more peer recovery coaches, especially those trained as clinicians, and sober-friendly events that provide social connection during evenings and weekends. Instead of asking persons in recovery to find support, like CCAR, stated one focus group member, instead we need to “go to them” by having more support in the community. It was also suggested that more peer-led services need to be integrated within professional career spaces, like the medical career field, to reduce stigma, increase recovery visibility, and make recovery supports more accessible.

This peer-led model, as reported by the recovery community focus group, is a key component to helping individuals find and sustain their recovery. Sustainable funding for

peer-led organizations like CCAR, expanding non-emergency peer-outreach roles, and greater community promotion of recovery supports are essential to build inclusive, long-term recovery systems in region 2.

**Figure 9.2: Summary of Behavioral Health Treatment and Recovery in Region 2**

<b>Behavioral Health Treatment and Recovery Focus Area</b>	<b>Rationale/Considerations</b> Why did your workgroup select this priority?	<b>Population of Focus</b> Is there a specific age group or other subpopulation of focus for this priority? If so, describe.
Access to treatment across levels of care	Ranked high in prevalence and severity due to long waitlists and service shortages, especially outside New Haven. Housing is one of the primary barriers. Timely care is limited and disjointed across inpatient, outpatient, and crisis services.	All populations, with emphasis on youth, families, and rural residents
Behavioral health treatment for youth, families, young adults and adults	High rates of cannabis use among young adults, and increased alcohol/crack cocaine treatment admissions among adults. Cannabis now exceeds alcohol at point of treatment entry for young adults. Limited supports and services barriers for neurodivergent youth and their families, as well as neurodivergent adults.	Young adults (18–25), adults with substance use concerns
Reducing systemic barriers and stigma in accessing care	Many avoid treatment due to fear of legal issues, stigma, transportation, cost, and lack of culturally competent care.	Hispanic/Latino, LGB, unhoused individuals with behavioral health concerns
Barriers to recovery and peer-led supports	Recovery limited by housing, stigma, and lack of culturally relevant, peer-led services. Women need gender-responsive supports (sober housing, DV services, safe houses). Recovery community calls for more peer coaches, sober social events, and sustainable funding for community-centered recovery programs.	Women in recovery; unhoused individuals in recovery; general population in recovery

## Recommendations

### ***Behavioral Health Treatment***

Within the behavioral health treatment system, barriers to accessing care were the primary issue. This includes housing insecurity, waitlists for services, disjointed care coordination and referrals, as well as transportation. To address this concern, focus group participants recommended that all state-funded mental health clinics implement a mandatory warm hand-off protocol for client referrals. A warm hand-off is defined as a structured process whereby a direct referral connection is established between the

current and receiving provider, thereby ensuring that the responsibility for coordinating the transition does not rest solely with the client.

Related to barriers, housing, historically, has been noted as another primary concern. It was recommended by region 2 community partners for the State to do a thorough examination of unused housing opportunities within region 2, and through that assessment, identify additional opportunities for emergency and permanent sheltering options. Housing is a significant barrier to accessing and retention in behavioral health treatment services and must be addressed.

Finally, waitlists were a primary concern across the behavioral health field at large in region 2. To address this, it is recommended to do an in-depth assessment of the behavioral health system of care effectiveness and efficiency. It could also be determined the length of time the paperwork takes to complete, and if these are feasible requirements for clinicians with high caseloads.

### ***Behavioral Health Recovery***

Within the Region 2 recovery community, the primary concern was also related to accessibility of care. Transportation was also listed as a primary barrier to accessing recovery services. To remedy this, the recovery community recommended to increase peer-outreach available in community hot spots and expand this within rural communities. It was noted to focus less on asking individuals to seek out the recovery support but instead for recovery service providers to go out in the community to meet individuals where they are at.

It was also discussed that we need to expand recovery services beyond overdose hot spot areas to embed into the workforce. Within the focus group, it was shared how individuals in professional within traditional careers (medical, construction, etc.), often struggle with finding and maintaining their recovery. It was suggested to expand opportunities for peer-outreach within these professional workspaces. Additionally, it was discussed how more women-focused recovery supports are needed to address the nuanced complexities related to women in recovery.

### ***Substance use/Misuse Prevention***

The Region 2 LPCs primary needs and related recommendations were related to funding opportunities and increased opportunity for cross-coalition collaboration. Funding was the primary concern amongst our LPCs, and it was recommended to increase funding available for coalitions that is sustainable, and significant enough that it can pay multiple full-time staff at a competitive wage. LPCs often reported that they only have enough funding to pay for one full-time staff member, if at all, which results in a strained capacity for the coalition. One coalition leader stated within our focus group that, “what we need is people and money to pay them.” It was also reported to make funding flexible based on communities’ needs. Often funding that becomes available to smaller coalitions, like the LPC grant, is focused on a state-wide issue and is not always relevant to the specific community’s needs. Another coalition member stated on this issue, “I would like a grant that says, ‘use as you see fit’ so I can use it [funds] for multiple things and tailor it to my community.” It was noted that these funding streams need to be more equitably distributed to lower-capacity and rural-focused areas communities.

LPCs also requested more opportunities for connections and shared prevention efforts across region 2. One recommendation was to do region-wide campaigns, like the #MentionPrevention campaign that originated from a combined multi-town effort in region 2. It was also suggested to have more opportunities for networking and connection across the Region 2 coalitions.

Finally, it was recommended to increase cessation programs and continue prevention initiatives that address youth nicotine and cannabis use. While cessation programs are not within the primary prevention scope of RBHAO practice, LPC leaders report community members are often looking for youth and young-adult focused nicotine and cannabis cessation programs, and the LPCs want to meet their community needs. Alternatively, the LPCs can focus some of their environmental-level prevention initiatives on cannabis and nicotine use prevention (including the use of nicotine pouches likes Zyn’s) for underage youth and young adults.

### ***Mental Health Promotion***

A primary concern related to promoting mental health in region 2 is the barrier of accessing treatment resources. While services are available, waitlists persist, and individuals and providers in region 2 struggle to navigate what services are currently available. Additionally, it was recommended to promote alternatives to traditional therapies, like online intensive outpatient (IOP) levels of care, support groups, and self-help mental health apps.

Anxiety and depression are the priority mental health concerns among youth in region 2. It was recommended that Region 2 focus its efforts on promoting awareness of mental health risks, along with the resources above, throughout all prevention initiatives.

### ***Suicide Prevention***

Within the RSAB focus group, as well as the suicide prevention focused Regional Priority Workgroup, recommendations centered around increasing access to care, improving care effectiveness, and promoting suicide recovery. To strengthen access to care and support individuals experiencing suicidal ideation or behavioral health challenges, it is recommended that behavioral health providers in region 2 actively promote peer-led Alternatives to Suicide groups and expand partnerships with organizations such as NAMI to offer additional peer-led support services. These community-based, peer-driven models provide critical alternatives to traditional clinical care and help address gaps in access, particularly for individuals who face barriers related to stigma, cost, or availability of services. Peer-led groups should be made virtual. If support is only available in-person, efforts should be made to ensure that barriers to attendance like childcare and transportation are considered.

It was also reported by these key community leaders, similar to behavioral health treatment and recovery group, that improving post-crisis follow up options and care coordination continues to be a pervasive need. Community leaders advocated for alternatives to hospitalization, as well as suicide survivor respite and follow-up. This could be modeled after the overdose response and outreach efforts that are growing throughout the state.

By acknowledging that surviving from a suicide is an ongoing process, adopting this recovery language can reduce stigma and increase the recognition for ongoing post-crisis support.

Suicide prevention efforts should be inclusive of firearm safety initiatives across the region. While awareness of lethal means is currently incorporated into some suicide prevention and awareness training, there remains a critical need to place greater emphasis on firearm safety as an essential component of these efforts. Given that firearms are among the most common and lethal means of suicide, integrating targeted firearm safety education, such as safe storage practices, temporary transfer options, and counseling on access to lethal means—can significantly enhance the effectiveness of suicide prevention strategies.

### ***Problem Gambling***

As gambling awareness continues to grow in our Region, it was recommended by RGAT members, as well as gambling prevention-focused Regional Priority Group members to address increasing access to gambling awareness education among youth. A strategy for this is to require gambling awareness education to be embedded within health education curriculum in grades K-12 throughout the state. This will ensure that gambling awareness education is not just prioritized by communities that already have a high degree awareness of the problem but can be equally prioritized throughout the Region.

Gambling prevention experts within region 2 also suggested that we need to improve gambling awareness campaigns to make them more up to date, visible, and frequent. It was noted within the RGAT focus group that gambling risk awareness campaigns are often too subtle compared to the loud pro-gambling messaging. It was also suggested to prioritize on-demand and online gambling treatment options, as well as expanding gambling treatment services to include families. Furthermore, it was advocated that there needs to be an increase in gambling treatment training opportunities to have a great network of providers from a diverse set of backgrounds and language proficiencies.

Finally, it was noted within the RGAT group that gambling prevalence data is limited. While student surveys throughout the Region have begun to incorporate data collection efforts on gambling, it is not an inclusive practice throughout all Region 2 towns. Gambling prevalence data is currently limited to the CCPG helpline calls. Those helpline data calls, while informative, often miss the collection of demographic data. This is due to the primary purpose of the helpline responder is to support the caller, not to collect data, which would not always be a clinically appropriate response. To date, there is no collective gambling prevalence data efforts within the Region that can provide a valid insight into the populations, and subpopulations, at risk for problematic gambling behaviors. Thus, it is recommended that there be effort focused on data collection opportunities regarding prevalence of gambling behaviors, specifically within underrepresented groups.

**Figure 10: Summary of Regional Recommendations: Region 2**

Area/ System of Focus	Recommendation	Rationale	Involved Parties
<i>Considerations</i>	<i>Be as specific as possible</i>	<i>What need/gap issue is this responding to? Why is it needed?</i>  (reference needs, emerging issues, etc.)	<i>Who could/would implement this?</i>  (e.g., DMHAS, ADPC, CPN, LPCs, providers, etc.)
<b>Behavioral Health Treatment*</b>	Require warm hand-offs between behavioral health providers; Expanding emergency and permanent housing options; Evaluation of pilot programs and behavioral health system of care	Continuation of care not always effective; Housing options are scarce; Address behavioral health system effectiveness	DMHAS
<b>Behavioral Health Recovery*</b>	Increase peer-led community outreach in hot spots and employment sites; sober community events; Women-focused recovery services	Recovery services are not easily accessible; Make recovery community more visible and integrated within community social events; Women have specific recovery-needs not being address	DMHAS; CCAR; Behavioral Health Clinics
<b>Substance Use/Misuse Prevention*</b>	Expand funding opportunities for LPCs to be flexible and sustainable; Region-2 wide campaigns; Partner with universities to	LPCs need more funds to hire/retain staff, and address community specific needs; LPCs need more region-wide	DMHAS; RBHAO

	advertise career paths in Prevention; Cessation programs for youth and young-adult cannabis and nicotine use	communication and prevention efforts; Growing concern for youth use of cannabis and nicotine	
<b>Mental Health Promotion*</b>	Promote alternatives to therapy options; integrate mental health promotion with primary substance use prevention initiatives for youth substance use;	Individuals seeking mental health services challenged with waitlists; lack of awareness of alternatives to therapy options; anxiety and depression among youth in region 2 is concerning	RBHAO, Systems of Care Collaboratives; Local Prevention Councils; DMHAS
<b>Suicide Prevention*</b>	Promote peer-led support groups; improve and expand post-crisis follow up care – include social determinants of health and model after post OD outreach and recovery models	Limited options for post-crisis follow up	DMHAS, Behavioral Health Clinics; Mental health emergency response providers
<b>Problem Gambling*</b>	Add gambling education on risk awareness in all required K-12 curriculum; improve campaigns to be more visible and culturally appropriate; increase availability of online gambling treatment options; increase gambling prevalence data collection efforts	Lack of gambling education (Gambling and LPC focus group) – ages of gambling starting as young as 6 years old;	CT Department of Education; DMHAS; CCPG

\*At least one recommendation relevant to each of these areas is required.

## Regional Goals

### Substance Use/Misuse Prevention

**Figure 12: Region 2 Substance Use/Misuse Prevention Goal(s)**

<p><b>Regional Goal:</b></p> <p>By December 2027, increase the capacity of at least 15 Region 2 partner organizations to deliver evidence-based, culturally responsive substance use prevention education targeting youth ages 12–18. This effort will align with RBHAO funding priorities on cannabis, alcohol, and nicotine prevention and will include specific outreach and program adaptation to better engage LGB and Hispanic/Latino youth populations who are disproportionately affected by substance misuse.</p>
<p><b>Rationale:</b></p>

Recent trends indicate that youth in region 2 are increasingly using substances such as cannabis, nicotine, and alcohol in solitary settings, rather than in peer group environments. Data show that 43.7% of youth report vaping nicotine alone at home, and 40.8% report cannabis use
Focus Population:
<ul style="list-style-type: none"> <li>Youth ages 12-18, LGB youth, who report significantly higher rates of substance use and co-occurring mental health challenges.</li> <li>Hispanic/Latino youth, who also show disproportionately high prevalence of substance use, depressive symptoms, and suicidal ideation.</li> </ul>
Regional Goal:
By April 2027, the RBHAO will partner with New England HIDTA to promote a national youth substance use prevention campaign across region 2, reaching at least 12 schools or youth-serving organizations. The campaign will aim to increase awareness of the risks associated with youth substance use—focusing on cannabis, nicotine, and prescription drug misuse—and will include both digital and in-person engagement strategies.
Rationale:
Youth are increasingly using substances (cannabis, alcohol, nicotine) at home, without peers. (Substance Use Prevention Focus group, Regional Priority Workgroup)
Focus Population:
Youth

**Mental Health Promotion**

**Figure 13: Region 2 Mental Health Promotion Goal(s)**

Regional Goal:
By April 2027, expand and promote the Changing Pathways program in collaboration with at least 6 hospitals, emergency departments, and behavioral health provider sites across region 2, including both outpatient (OP) and inpatient (IP) settings.
Rationale:
This effort will ensure that participating sites implement standardized referral pathways connecting individuals with timely behavioral health treatment and recovery services, thus increasing access to appropriate levels of care, and warm hand off protocol. (Behavioral Health Focus Group, Regional Priority Workgroup)
Focus Population:
Youth, Young Adults, and adults seeking behavioral health services

Suicide Prevention

Figure 14: Region 2 Suicide Prevention Goal(s)

Regional Goal:
<p>By April 2027, increase community awareness and practice of safe storage for medications, cannabis, and firearms as a suicide prevention strategy by distributing at least 1,000 firearm safety kits across region 2 and promoting safe storage resources through at least 20 schools, healthcare providers, and community organizations.</p> <p>To ensure inclusion and equity, outreach efforts will prioritize communities with higher suicide risk, including LGBTQIA+, Hispanic/Latino youth, and rural households, and materials will be available in multiple languages (including Spanish)</p>
Rationale:
<p>Lethal means considerations should be an integral part of suicide prevention efforts across the region.</p>
Focus Population:
<p>Region 2 communities</p>

Problem Gambling

Figure 15: Region 2 Problem Gambling Goal(s)

Regional Goal:
<p>By April 2027, implement, age-appropriate gambling prevention education to at least 8 schools, and/or youth serving organizations across region 2, reaching youth ages 6 to 14. This initiative will include training at least 50 school staff and youth-serving professionals on early warning signs of problem gambling and integrating risk education into existing health and wellness curricula.</p>
Rationale:
<p>Early exposure to gambling-related behaviors, including increased access through electronic platforms, has heightened the risk of problem gambling among youth. This growing accessibility—via online sports betting, gaming apps, and virtual casinos—has normalized gambling at a young age and contributed to earlier initiation, increasing the likelihood of long-term harm and addiction.</p> <p>(Region 2 student Survey data 2023, 2024, Gambling Awareness Focus Group)</p>
Focus Population:
<p>Youth</p>

## Statewide/ System Recommendations

Figure 11: Summary of State/System Recommendations: Region 2

Area/ System of Focus	Recommendation	Rationale	Involved Parties
<i>Considerations</i>	<i>Be as specific as possible</i>	<i>What need/gap issue is this responding to?</i> <i>Why is it needed?</i>  (reference needs, emerging issues, etc.)	<i>Who could/would implement this?</i>  (e.g., DMHAS, ADPC, CPN, LPCs, providers, etc.)
<b>Statewide</b>	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 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 results for individuals and communities throughout Connecticut	RBHAOs, DMHAS/ other state agencies, CPES

<p>Statewide</p>	<p>As part of a comprehensive strategy to prevent substance-impaired driving linked to legalized cannabis and alcohol misuse, Connecticut should take the following immediate actions:  <b>Conduct a statewide review and real-time update of impaired driving crash and fatality data</b> in partnership with the Department of Transportation (DOT), Department of Motor Vehicles (DMV), and law enforcement agencies. Special emphasis must be placed on identifying trends involving cannabis and poly-substance use (cannabis and alcohol), to drive data-informed prevention and enforcement responses.  <b>Accelerate investment in next-generation roadside testing technologies and modernize enforcement policies</b> to effectively detect cannabis and poly-substance impairment. By strengthening detection and enforcement capacity, Connecticut can significantly reduce cannabis-related roadway harm, improve public safety, and set a national standard for substance-impaired driving prevention.</p>	<p>Unlike alcohol, there is no validated roadside testing device to detect cannabis intoxication in real time, leaving law enforcement reliant on blood toxicology screenings that can only be conducted after detainment. The lack of Connecticut laws in the context of legalized cannabis is a critical gap.</p>	<p>CT General Assembly, law enforcement, DOT, DMV, RBHAO (Amplify)</p>

## Conclusion

The 2024–25 Regional Priority Report for Region 2 is inclusive of a new and updated process. This report provides a comprehensive assessment of behavioral health trends, emerging issues, service gaps, and regional strengths across the 34-town region of South-Central Connecticut. Through a community-informed process grounded in data this report identifies key behavioral health priorities; youth substance use prevention, youth mental health promotion, suicide prevention, problem gambling awareness, and access to treatment and recovery supports. It provides recommendations and strategies for addressing them.

Despite significant regional strengths, such as strong community partnerships, innovative prevention programming, and expanded harm reduction services, Region 2 continues to face systemic barriers including workforce shortages, underfunded local prevention infrastructure, and inadequate behavioral health services in rural and underserved areas. These challenges are particularly important for subpopulations such as LGBT youth, Hispanic/Latino residents, women in recovery, and individuals experiencing housing insecurity.

Addressing these challenges will require ongoing collaboration, capacity building, leadership and continued dedicated funding at the local, regional and state levels. The recommendations and goals presented in this report are designed to inform future planning, guide resource allocation, and shape policies that prioritize the needs and voices of communities impacted by behavioral health disparities.

Working together by strengthening local coalitions and community partnerships we can strengthen the behavioral health landscape and promote healthier, more resilient communities. BHcare's, Alliance for Prevention and Wellness and the other Regional Behavioral Health Organization will continue to serve as conveners, advocates, and strategic partners to promote these priorities with the goal of improving the behavioral health landscape and creating meaningful and measurable changes.

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