

Regional Behavioral Health Action Organization
DMHAS Region 2
Priority Report June 2021



Contributors

Anna Gasinski	CT High Intensity Drug Trafficking Area
Robert Lawlor	CT High Intensity Drug Trafficking
Nicole Mason	Prevention Specialist - APW
Lorrie McFarland	Prevention Coordinator – APW
Pamela Mautte	Director – APW
Local Prevention Councils	APW
Regional Behavioral Health Priority Setting Workgroup	RBHPSW
Stefanie Goins	APW / CT National Guard Counterdrug

Abbreviations

APW	Alliance for Prevention & Wellness
BIPOC	Black, Indigenous, and People of Color
CDC	Centers for Disease Control
CCAR	CT Community Addictions Recovery
CT	Connecticut
DAWN	Drug Abuse Warning Network
DESPP	Department of Emergency Services and Public Protection
DHHS	Department of Health & Human Services
DMHAS	Department of Mental Health & Addiction Services
DPH	Department of Public Health
DPS	Department of Public Safety
DUI	Driving Under the Influence
HIDTA	High Intensity Drug Trafficking Area
LPC	Local Prevention Council
MTF	Monitoring the Future
MVA	Motor Vehicle Accident
NHTSA	National Highway Transportation Safety Administration
NIDA	National Institute on Drug Abuse
ONDCP	Office of National Drug Control and Policy
OCME	Office of Chief Medical Examiner
RBHAO	Regional Behavioral Health Action Organization
RBHPSW	Regional Behavioral Health Priority Setting Workgroup
SAMHSA	Substance Abuse and Mental Health Services Administration
SDE	State Department of Education

SEOW	State Epidemiological & Outcomes Workgroup
SPF	Strategic Prevention Framework
TEDS	Treatment Episode Data Set
US	United States
YPLL	Years of Potential Life Loss
YRBSS	Youth Risk Behavior Surveillance System

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Executive Summary

The Priority Report is an analysis of the magnitude, impact, and capacity within DMHAS Region 2. It is based on data –driven analysis of issues in the region, with assistance from key community members. The profile and data will be used as a building block for community level processes including capacity and readiness building, strategic planning, and implementation of evidence -based programs & strategies.

The overall profile offers the 34 communities of the APW service area, information regarding substance misuse, mental health, problem gambling and suicide. The information is gathered from many cited sources and separated into individual profiles of eight areas of concern: alcohol, cocaine, heroin and other illicit opioids, marijuana, mental health, prescription drug misuse, problem gambling, and suicide. The information is gathered from federal and state data and is then compared to local data when available.

Our BHPSW group offered their individual insights regarding their communities and their perception of their communities. This information is included in each of the profiles. The individual profiles give a picture of the magnitude of the issue, populations at risk, burden, capacity, and service system strengths. Charts are incorporated into the profiles for visual understanding of some numerical and/or percentage figures. Each community has a different make-up; therefore, the information is more general than specific for some of the problem areas. The profiles, however, will be used by all communities as a basis for each community to develop strategies to address their own issues.

The BHPSW focus groups were held in the following communities:

- Group 1: Bethany, Milford, Orange, West Haven, and Woodbridge
- Group 2: Local Prevention Council service areas of – Derby, Clinton, Meriden, Middletown, Essex, Chester, Deep River, Guilford, and Clinton
- Group 3: New Haven CT Communities Addiction Recovery
- Group 4: First Responders – Lower Naugatuck Valley

These communities are all located in the DMHAS Region 2 service area. In addition to virtual focus groups, community members and key leaders participated via survey monkey link.

The 21 BHPSW participants reviewed data compiled by APW from the data sets, focus group answers, survey monkey responses, community readiness data, as well as participant anecdotal information and feedback. Members utilized this information to determine rankings for the eight priority areas.

Based on data analysis, surveys, and focus groups the BHPSW ranked the following top priorities were identified.

The substance use, misuse, and addiction the top five priorities mean rankings included:

1. Heroin & Fentanyl (4.2)
2. Prescription Drug Misuse (3.7)
3. Electronic Nicotine Delivery Systems (ENDS) (3.5)
4. Alcohol (3.4)
5. Marijuana (3.2)

In the matrix rankings of magnitude and impact the ratings were slightly different and included: Heroin & Fentanyl the high magnitude and impact followed by marijuana, and alcohol. It was noted that the ENDS was ranked high as many people are utilizing vapor devices for marijuana with a high magnitude rating and medium impact rating.

The mental health issues top five priorities mean rankings included:

1. Anxiety (4.6)
2. Depression (4.4)
3. Early Serious Mental Illness (4.3)
4. Suicide (4.3)
5. Serious Emotional Disturbances (4.2)

The top five mental health issues were all ranked the same with highest ratings in both magnitude and impact.

The 2020 Community Readiness for Substance Abuse and Mental Health Promotion Assessment (CRS) illustrated that APW's mean stage of readiness for substance misuse prevention is a 5.55 compared to the State's average of 5.37. The CRS illustrated that APW's

mean stage of readiness for mental health promotion is a 5.0 compared to the State's average of 4.88. The RBHPSW was surprised with the priority rankings not being in alignment with the findings reported in the community readiness report. Regarding substance misuse the CRS ranked alcohol as the substance of greatest concern and depression for mental health challenges. Members discussed some of the differences and felt that the global pandemic has played a large role in the findings. The RBHPSW stated that the reports are very useful in leveraging grant funding and conducting planning. However, many were concerned that the tools would not be utilized appropriately to plan for post pandemic responses needed for substance misuse and mental health promotion. Members felt that many key leaders would rather utilize the report for quick fixes that don't result in long term changes and sustainability.

APW will continue to work with our Local Prevention Councils and other community partners to strengthen community partnerships and engagement and break down barriers and concerns to addressing the identified priorities and critical issues.

It is important to note that, as with any survey responses and RBHPSW meetings, the selection of key stakeholders they represent can influence the outcome of this report. The limitation of the RBHPSW included not having a more diverse representation from each of the towns we serve and less verbal participation through the on-line platforms. The RBHPSW and APW team did notate more hesitancy from participants in the on-line platforms compared to in-person sessions.

Region 2 is very diverse in terms of communities and populations within each of those communities. The identified priority issues affect all populations throughout our region. The RBHPSW felt the six priority recommendations can be accomplished overtime through creative innovations, evidence -based programs and strong collaborative efforts.

RBHPSW (Workgroup) Priority Ranking Matrix: Substance Use/Misuse/Addiction

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

PROBLEM	MAGNITUDE	IMPACT	CHANGEABILITY	CAPACITY/ READINESS	CONSEQUENCE OF INACTION	TOTAL	Mean Ranking Score:
Alcohol	4	4	3	2	4	17	3.4
Tobacco	2	3	2.5	2	4	13.5	2.7
Electronic Nicotine Delivery Systems (ENDS), vaping, juuling	4	3	3	3.5	4	17.5	3.5
Marijuana	4	4	2	2	4	16	3.2
Prescription Drug Misuse	3	4	3.5	4	4	18.5	3.7
Heroin and Fentanyl	5	5	3	3	5	21	4.2
Cocaine	3	3	2	2	3	13	2.6
Problem Gambling	3	2	2	2	4	13	2.6

RBHPSW (Workgroup) Priority Ranking Matrix: Mental Health and Suicide

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

PROBLEM	MAGNITUDE	IMPACT	CHANGEABILITY	CAPACITY/READINESS	CONSEQUENCE OF INACTION	TOTAL	Mean Ranking Score:
Anxiety	5	5	5	3	5	23	4.6
Depression	5	5	4	3	5	22	4.4
PTSD	4	5	3	3	5	20	4
Trauma	4	5	3	3	5	20	4
Serious Emotional Disturbance	5	5	3	3	5	21	4.2
Early Serious Mental Illness	4	5	4	3.5	5	21.5	4.3
Serious Mental Illness	5	5	3	3	5	21	4.2
Suicide	5	5	3	3.5	5	21.5	4.3

Introduction

Background & History

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. The SPF is a five-step data driven process known to promote youth development and prevent risky behaviors across the 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, Lyme, Madison, Meriden, Middlefield, Middletown, Milford, New Haven, North Branford, North Haven, Old Lyme, Old Saybrook, Orange, Portland, Seymour, Shelton, Wallingford, Westbrook, West Haven, Woodbridge.

Purpose

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 identify target populations and priorities for community populations. The report includes priority recommendations for prevention, treatment, and recovery system. 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.

Data Sources

Most of the data utilized in the report was obtained from The DMHAS Center for Prevention Evaluation and Statistics (CPES) at UConn Health and the CT SEOW Data Portal. The portal is an interactive repository for behavioral health and related data that

supports a comprehensive public health approach to substance abuse prevention and health promotion. Local community student surveys on the core measures which include past 30-day use, perception of harm, peer disapproval and parental disapproval of substances. Additional data was drawn from the following sources:

- Alliance for Prevention & Wellness (APW) Narcan training and distribution reports
- CT Council on Problem Gambling
- CT Suicide Advisory Board
- CT Department of Children and Families
- CT Department of Mental Health & Addiction Services Annual Statistical Report, SFY 2020
- CT Department of Mental Health & Addiction Services Region 2 Community Readiness Report
- CT Department of Public Health
- Focus Groups
- Local Police Data
- National Gambling Data
- Overdose Detection Mapping Application System (ODMAP)
- Substance Abuse & Mental Health Services Administration (SAMHSA)
- Survey Monkey
- Uniform Crime Reports
- United Way of CT (2-1-1)

The Regional Behavioral Health Priority Setting Workgroup (RBHPSW) participants reviewed data compiled by APW from the data sets as well as participant anecdotal information, surveys, and other feedback. Members subsequently provided a ranking input on the mental health and substance misuse priority matrix.

Strengths and limitations of the report

The strengths of this profile include a comprehensive overview of DMHAS Region 2. Other strengths include the qualitative data collected through focus groups of diverse groups who participated in the process. Some limitations of the report include the lack of data obtained from youth surveys and lower participation in focus groups and listening sessions. This is attributed to working virtually with our community partners throughout the pandemic.

Data Limitations

This report was designed to provide a comprehensive assessment of areas of concern in CT, specifically in DMHAS Region 2 for the following: alcohol, cocaine, heroin and other illicit opioids, marijuana, mental health, prescription drug abuse, problem gambling, suicide, tobacco / electronic nicotine devices (ENDS) / vaping. We recognize that it cannot accurately measure all possible aspects of the aforementioned areas. This assessment incorporates a significant amount of quantitative data that was collected from a variety of sources. The data is believed to be reliable, valid, and relevant. However, it is **not** practical to include all available data and this information was sometimes 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.

Methods

Development of this profile was a multi-step process. Available data on the state's eight priority areas was compiled, reviewed, tabulated, and summarized. APW conducted several focus groups, attended various meetings, and distributed a survey monkey survey seeking input from diverse community members on the identified areas of concern. APW then convened the Regional Behavioral Health Priority Setting Workgroup RBHPSW to review the profiles for each of the priority areas. At the conclusion of the meetings, workgroup members provided input on the profiles and ranked the priority areas in magnitude, impact, consequences, and changeability of the priority. APW staff then summarized all the rankings to create the regional report.

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 1,017,293, and median county household incomes ranging from \$67,845-84,761 (source: ctdata.org 2019 median incomes). The South-Central Region of Connecticut is an economically diverse area spanning from the Lower Naugatuck Valley through the Shoreline and into central CT. The areas range from the small rural communities of 2,556 to the second largest city in the state, New Haven, which has a population of 130,764, with many other rural, suburban, and urban communities falling in between the ranges. Poverty rates across the region also vary and range from the lowest of 2.4% to some of the highest in the state at 25.6% with 194,751 residents' recipients of Medicaid insurance.

Most communities in region two are comprised of residents identifying as white non-Hispanic (60%+) except for the City of New Haven which reports 30% of their residents identify as white non-Hispanic.

Sub-populations

Sub-populations that emerged as part of this report include the middle / high school youth, young adults (18-25), Women, LGBTQI, and BIPOC.

2021 Region 2 Epidemiological Profile: Alcohol

Problem Statement

Alcohol is the most commonly used substance nationally and in Connecticut, although the prevalence of alcohol use is higher in the state compared to the national average. According to the 2018-2019 National Household Survey of Drug Use and Health (NSDUH), Connecticut has the 5th highest prevalence of current alcohol use (60.0%) compared to other states in the U.S., higher than the national prevalence (50.9%)¹.

Region 2 has had an increase regarding alcohol use/abuse between 2017-2020. Binge drinking and alcohol use in general has increased approximately 5% amongst teens and young adults within Region 2.

Alcohol emerged as the most widely used substance among youth, young adults, and adults in Region 2 during the pandemic. Acceptance of youth consuming alcohol with their parents as a means of coping with pandemic stress is an emerging theme.

Magnitude (prevalence)

Overall, the NSDUH shows that the rate of alcohol use in Connecticut has remained relatively stable; the prevalence of current alcohol use in individuals 12 and older was 59.3% in 2008-2009 and 60.0% in 2018-2019. However, consistent with the national trend, underage drinking in Connecticut among 12- to 17-year-olds decreased significantly, from 18.6% in 2008-2009 to 11.2% in 2018-2019.

Young adults in Connecticut ages 18-25 have the highest rate of reported past month alcohol use (65.6%), followed closely by those aged 26 or older (64.6%).

The prevalence of binge drinking in Connecticut has remained relatively stable since 2010, and it has remained consistently higher than the national average. Binge drinking is highest among young adults (47.6%), followed by adults ages 26 or older (27.5%), and youth ages 12-17 (5.4%).¹

2019 Connecticut School Health Survey (YRBS):

25.9% of high school students reported using alcohol in the past month and almost half of them (12.9%) reported binge drinking** in the past month².

**Four or more drinks of alcohol in a row for females, five for males

A sample of 6 surveys conducted in Region 2 between 2019 and 2021 found that 24.2% of high school students had consumed alcohol in the past 30 days. Rates of consumption for high school students were higher for 11th and 12th grade as compared to 9th and 10th grade. The range was as high as 47% in one shoreline town - to 14% in a suburban town. Many youth reported that because their parents were drinking more at home, alcohol was more readily accessible to them, with or without their parent's permission. Youth commented that they were drinking, not as they did pre-COVID for "partying", but at home, often alone out of "boredom". (CPES Focus Group Report, 2021)

NSDUH Substate Estimates:

Percent Reporting Past Month Use, ages 12+

	CT	Region 1	Region 2	Region 3	Region 4	Region 5
2014-2016	59.9	61.8	60.7	58.1	60.9	57.5
2016-2018	60.6	61.5	59.4	58.3	63.0	59.0

Percent Reporting Past Month Binge Drinking, ages 12+

	CT	Region 1	Region 2	Region 3	Region 4	Region 5
2016-2018	28.6	30.6	28.6	29.1	27.8	27.6

According to the NSDUH binge drinking table, Region 2 was in line with the state, but only lower than regions 1 and 3. Reported binge drinking for 12+ in Region 2 was in line with CT, but slightly lower than contiguous regions (NSDUH, 2016-2018).

¹ NSDUH (2017-2018)

² DPH, 2019 Connecticut School Health Survey

2021 Region 2 Epidemiological Profile: Alcohol

Risk Factors and Subpopulations at Risk

- Young people who drink are more likely than adults to report being binge drinkers.³
- Men are more likely than women to be heavy drinkers.³
- Women are more likely than men to develop alcoholic hepatitis and cirrhosis and are at increased risk for damage to the heart muscle and brain with excessive alcohol use.⁴
- Individuals with mental health disorders are about four times more likely to be heavy alcohol users.⁵
- Native Americans are at especially high risk of alcohol-related traffic accidents, DUI and premature deaths associated with alcohol misuse.⁶
- While Hispanics or Blacks have higher rates of abstinence from alcohol, those who do drink often have higher rates of binge drinking.⁷
- In 2019, 68.2% of alcohol admissions were male, and 59.6% were non-Hispanic White.⁷

Among youth, risk factors include:

- Academic and/or other behavioral health problems in school
- Alcohol-using peers
- Lack of parental supervision
- Poor parent-child communication
- Parental modeling of alcohol use
- Anxiety or depression
- Child abuse or neglect
- Poverty
- Norms that encourage or tolerate underage drinking⁸

Throughout the state, increased access to alcohol at home during the COVID pandemic has been reported as a problem, including home delivery services of alcohol in some areas. (CPES Focus Group Report, 2021)

Percent Reporting Perception of Great Risk from Having 5+ Drinks of an Alcoholic Beverage Once or Twice a Week, ages 12+¹

	CT	Region 1	Region 2	Region 3	Region 4	Region 5
2016-2018	43.9	44.6	42.6	39.8	45.3	27.6

Region 2 show that those reporting great risk of harm from having 5+ drinks of an alcoholic beverage once or twice a week for those over the age of 12 is 42.6%, slightly higher than the state and higher than Region 3 and 5.

The 2019 Connecticut School Health Survey shows high school females were more likely than males to report drinking (29.2% and 22.8%, respectively) and binge drinking (14.4% vs 11.5%). Non-Hispanic white and Hispanic students had the highest prevalence of past month drinking (29.6% and 26.0%, respectively) and binge drinking (15.8% and 12.8%, respectively).²

Region 2 has a risk factor of individuals between the ages of 12-18 to use/abuse, and/or binge on alcohol from parental influence. In the towns of Derby, Ansonia, and Shelton; 50.4% of the youth consumed alcohol under parental supervision. When parents are a contributing factor to the access of alcohol to minors, their risk of dependence to alcohol may be greater in the future.

Burden (consequences)

- Immediate adverse effects of alcohol can include: impaired judgment, reduced reaction time, slurred speech, and loss of balance and motor skills.⁴
- When consumed rapidly and in large amounts, alcohol can also result in coma and death.⁴
- Alcohol use can increase risk of death when used with other substances, i.e. prescription medication like benzodiazepines and opioids. In 2019, alcohol was listed as a contributing cause of death for almost 3 in 10 (29%) of 1200 fatal overdoses which occurred in Connecticut.

³ CDC (2016), Excessive alcohol use and risks to men's health

⁴ CDC (2016), Alcohol and public health

⁵ NIDA (2014), Severe mental illness tied to higher rates of substance use

⁶ NIAAA, Minority Health and Health Disparities

⁷CT DMHAS 2019 Treatment Admissions

⁸ National Research Council and Institute of Medicine

2021 Region 2 Epidemiological Profile: Alcohol

- Approximately 88,000 deaths each year in the U.S. are attributed to alcohol misuse.⁹
- In 2017, Connecticut ranked as the highest state in the country for the percent of alcohol-impaired driving fatalities compared to total driving fatalities (43%), versus the United States overall (29%).¹⁰
- Excessive drinking has numerous chronic and acute health effects, including: liver cirrhosis, pancreatitis, various cancers, cardiomyopathy, stroke, high blood pressure, and psychological disorders as well as increased risks for lower respiratory infections such as tuberculosis.¹¹
- Excessive drinking has been associated with increased risk of motor vehicle injuries, falls, and interpersonal violence.⁴
- Drinking during pregnancy can lead to a variety of developmental, cognitive, and behavioral problems in the child (Fetal Alcohol Spectrum Disorders).¹¹
- Older adults aged 65+ who drink are at increased risk of health problems associated with lower tolerance for alcohol, existence of chronic health problems (i.e., diabetes, high blood pressure, congestive heart failure, and liver problems) and interactions with medications (e.g., aspirin, acetaminophen, cough syrup, sleeping pills, pain medication, and medication for anxiety or depression).¹²
- Initiation of alcohol use at young ages has been linked to increased likelihood of AUD later in life.¹³
- Of all 2019 Connecticut treatment admissions, 38.2% identified alcohol as the primary drug at admission.⁸

Percent Reporting Alcohol Use Disorder in the Past Year, ages 12+¹

	CT	Region 1	Region 2	Region 3	Region 4	Region 5
2014-2016	6.7	6.2	7.2	6.6	7.1	6.2
2016-2018	6.1	6.1	5.9	6.1	6.3	5.8

Those reporting alcohol use disorder in the past year in Region 2 saw a decrease of 1.3% between 2016 and 2018. The state and other regions saw slight decreases as well for the same reporting period.

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

	CT	Region 1	Region 2	Region 3	Region 4	Region 5
2016-2018	5.7	5.9	5.7	6.2	5.5	5.5

The percentage of those needing but not receiving treatment for alcohol use in the past year for those over the age of 12 was consistent with both the state and other regions.

Treatment Admissions where Alcohol is the primary drug at admission⁷:

	CT	Region 1	Region 2	Region 3	Region 4	Region 5
FY2019	24,985	2,698	5,450	5,464	6,546	4,827
FY2020	19,916	2,128	5,014	4,403	4,801	3,570

*Excluding 741 admissions where residence was unknown

Treatment admissions where alcohol was the primary drug at admission in Region 2 was the highest than for the other regions. Region 2 saw a decrease in admissions from 2019 to 2020. Similarly, the state as well as the other regions had decreases in admissions for the same reporting period.

Capacity and Service System Strengths

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

	CT	Region 1	Region 2	Region 3	Region 4	Region 5
2018	5.26	5.90	5.25	4.35	5.19	4.94
2020	5.37	5.14	5.55	5.21	5.59	5.25

The 2020 Community Readiness Survey for suburban Connecticut indicated that 53.4% agreed that alcohol was the substance of greatest concern for those between the ages of 26 and 65. Nearly 41% of respondents *somewhat agree* that it is okay for youth to drink alcohol at parties with parental supervision.

⁹ NIAAA, Alcohol Facts and Statistics

¹⁰ NHTSA (2018), [Alcohol-Impaired Driving](#)

¹¹ WHO (2018), Global status report on alcohol and health—2018

¹² NIAAA (2008), Older Adults

¹³ NIAAA (2006), Alcohol Alert No. 67, Underage drinking

2021 Region 2 Epidemiological Profile: Alcohol

According to Region 2's Priority Ranking Matrix of substances, alcohol ranked as the 4th priority substance after heroin / fentanyl, prescription drugs, and, use of ENDS. The mean score for capacity and readiness to address alcohol was low.

Connecticut's Region 2 includes a number of federally funded community coalitions in the shoreline area addressing alcohol misuse and abuse among youth and adults through environmental strategies. These prevention and intervention efforts include media campaigns, retailer education, and parent education on social hosting laws.

Many of these communities have shown improved outcomes in the rates of underage alcohol use evidenced by their bi-annual student survey reports.

2021 Region 2 Epidemiological Profile: Cocaine

Problem Statement

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

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

Magnitude (prevalence)

According to data from the 2019 Connecticut School Health Survey (CT YRBSS), 2.6% of Connecticut high school students reported using some form of cocaine in their lifetime.¹ This is consistent with a decreasing trend since 2007, when the prevalence was 8.3%.

The 2018-2019 National Survey on Drug Use and Health (NSDUH) data show 1.99% of Connecticut respondents reported past year use of cocaine.² This is highest among young adults 18-25 (6.21%), compared to youth 12-17 (.37%) and adults 26+ (1.50%).

NSDUH Substate Estimates: Percent Reporting Past Year Cocaine Use, ages 12+

	CT	Regio n 1	Regio n 2	Regio n 3	Regio n 4	Regio n 5

2014 - 2016	2.4	2.1	2.3	2.5	2.7	2.3
2016 - 2018	2.3	2.1	2.5	2.5	2.3	2.1

A sample of 6 student surveys conducted in Region 2 between 2019 and 2021 showed that only one school district asked about the use of cocaine. The rate for cocaine use in this one district was .1% for lifetime use and 0% for past 30-day use. Comparing this to the 2019 CT YRBSS, it would appear that Region 2 maintains lower rates of lifetime use than the state overall.

Risk Factors and Subpopulations at Risk

Risk factors include:

- Family history of substance use (youth and adults)
- Lack of parental supervision (youth)
- Substance-using peers (youth and adults)
- Lack of school connectedness and low academic achievement (youth)
- Low perception of risk/harm (youth, adults)
- Childhood trauma (youth and adults)

NSDUH Substate Estimates: Percent Reporting Perception of Great Risk from Using Cocaine Once a Month, ages 12+

	CT	Regio n 1	Regio n 2	Regio n 3	Regio n 4	Regio n 5
2016 - 2018	68.5	67.2	69.0	68.1	68.8	69.1

- Young adults ages 18 to 25 have a higher rate of current use than any other age group²
- Males are more likely to use cocaine than females.
- Those with current or previous misuse of other illicit substances, such as marijuana and heroin/fentanyl
- Individuals with mental health challenges³
- Caucasian, young adult males were found to be more at risk than females in Region 2, and, more likely to be engaged in outpatient treatment for cocaine use

¹ Connecticut School Health Survey, 2019 (CT YRBSS)

² NSDUH 2018-2019

³ NIDA

2021 Region 2 Epidemiological Profile: Cocaine

- Poly- substance use was identified as a risk factor for cocaine use in urban periphery area in Region 2

According to data from the 2019 Connecticut School Health Survey (CT YRBSS), males reported higher rates (3.6%) than females (2.5%). The prevalence of lifetime cocaine use was highest among 12th graders (2.9%). Black students reported higher rates (4.8%) than Hispanic (2.7%) or White (2.1%) students, though the difference was not statistically significant.

Burden (consequences)

Physical short-term consequences of cocaine use include³:

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

Long-term physical consequences of cocaine use include³:

- Tolerance, requiring higher and more frequent doses.
- Sensitization, where less cocaine is needed to produce anxiety, convulsions, or other toxic effects (increasing risk of overdose)
- Loss of appetite leading to malnourishment.
- Increased risk of stroke and inflammation of the heart muscle
- Movement disorders such as Parkinson's disease
- Impairment of cognitive function
- Cocaine users are also at risk for contracting blood-borne diseases such as HIV and hepatitis C via needle sharing and other risky behavior³
- Users are at risk of accidental overdose, especially in the presence of alcohol or other drugs.³
- In 2019, cocaine was the primary drug in 7.7% of all Connecticut substance use treatment admissions. This represents 5,904 admissions.⁴

When someone uses cocaine for a long time, this can lead to lung damage, heart muscle inflammation, psychosis, etc. Cocaine abuse also comes with a risk of overdosing.

Treatment Admissions: Cocaine²

	CT	Regio n 1	Regio n 2	Regio n 3	Regio n 4	Regio n 5
FY2019						
FY2020	19,074	2,703	5,584	2,640	4,877	3,287

The number of admissions to treatment for cocaine in Connecticut Region 2 in 2020 was highest compared to the other 4 regions.

- Overdose deaths involving cocaine increased about 34% in Connecticut, from 345 in 2018 to 463 in 2019.⁵
- More than 7 in 10 (72%) overdose deaths involving cocaine in 2019 occurred in urban core or urban periphery communities.
- Cocaine-involved deaths have been linked to fentanyl-contaminated cocaine in Connecticut.⁶ In 2019, almost 9 in 10 (85%) cocaine-involved deaths in Connecticut (n=463) also involved fentanyl.

Cocaine-Involved Fatal Overdoses in 2019³

	CT	Regio n 1	Regio n 2	Regio n 3	Regio n 4	Regio n 5
N	399	39	73	50	149	88
Rate	11.19	5.56	8.82	11.84	14.87	14.37

*Rate per 100,000 population

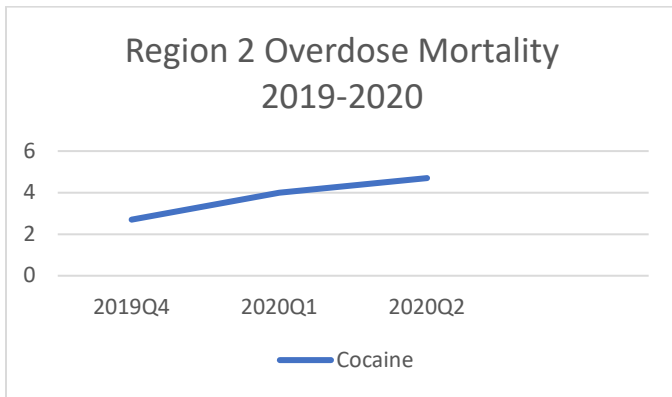
Connecticut Region 2 experienced a gradual increase in cocaine involved overdose mortality throughout 2019 and into 2020. However, the mortality rates are higher in Regions 3 and 4 at 11.84 and 14.87 respectively.

⁴ Connecticut Department of Mental Health and Addiction Services, (2019)

⁵ CT Office of the Chief Medical Examiner, 2019

⁶ Tomassoni AJ. MMWR 2017;66:107-111.

2021 Region 2 Epidemiological Profile: Cocaine



Capacity and Service System Strengths

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

	CT	Region 1	Region 2	Region 3	Region 4	Region 5
2018	5.26	5.90	5.25	4.35	5.19	4.94
2020	5.37	5.14	5.55	5.21	5.59	5.25

According to the 2020 Community Readiness Survey within the suburban population, .02% agreed that cocaine was a substance of concern among those between the ages of 18- and 25. Among ages 26- to 65, .08% of respondents agreed that cocaine was a substance of concern.

According to Region 2's Priority Ranking Matrix of substances, cocaine ranked lowest overall as a substance of concern. Cocaine's magnitude and impact on communities is ranked *medium*, with low changeability and readiness.

CT Region 2 has a concentration of detox and rehabilitation treatment centers offering treatment for substance use disorder within the Greater New Haven area. Several are gender specific to address needs of men, woman, and young adults. There is one treatment provider – Teen Challenge, that does not accept insurance, but is funded through private donors.

2021 Region 2 Epidemiological Profile: Heroin & Other Illicit Opioids

Problem Statement

Heroin is an illicit opioid. In Connecticut, the use of heroin now often involves the use of fentanyl, either intentionally or not. This profile, where appropriate, describes the concurrent and overlapping use of fentanyl and heroin.

According to the 2018-2019 National Survey on Drug Use and Health (NSDUH), less than one percent (0.33%) of Connecticut residents 12 or older have used heroin in the past year, a rate slightly higher than the national average (0.28%).¹ The highest prevalence is among young adults aged 18-25 years old (0.38%), followed by adults aged 26 or older (0.36%), and then adolescents (0.01%). According to the 2019 Connecticut School Health Survey (CT's Youth Risk Behavior Surveillance survey), an estimated 1.8% of high school students in Connecticut reported heroin use in their lifetime.²

In 2019, about 1 in 3 (32%) unintentional overdose deaths that occurred in Connecticut involved heroin.³ While the number of overdose deaths in Connecticut involving heroin has declined since 2016, these numbers are misleading due to the concomitant rise of fentanyl, the increasing number of opioid deaths in Connecticut involving fentanyl and/or heroin, and the intertwined nature of heroin and fentanyl in the illicit opioid supply. Across New England, fentanyl availability is high, may be available either mixed with white powder heroin or alone, and may be sold in powder form as heroin or as fentanyl.⁴

Fentanyl is often sold under the same or similar "brand" names as heroin, creating confusion and uncertainty among buyers. More than 1 in 3 (35%) fentanyl deaths in Connecticut in 2019 also involved heroin.⁴ Since 2017, deaths involving fentanyl have outnumbered deaths involving heroin, suggesting that much of the heroin consumed in Connecticut may contain fentanyl. Thus, all individuals who use heroin are at risk of fentanyl exposure.

Heroin and Opioid usage continue to be an issue within region 2, but overall, we have seen a significant decline of overdoses within the region. In 2020, Opioid overdoses have taken a spike over Heroin.

Magnitude (prevalence)

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

	CT	Region 1	Region 2	Region 3	Region 4	Region 5
2014 - 2016	.67	.52	.74	.77	.72	.62
2016 - 2018	.60	.47	.59	.64	.67	.61

NSDUH substate estimates indicate that Region 2 had the 2nd lowest rate of past year heroin use among those 12 and older compared to other regions.

Overdose Mortality Rate 2019 – 2020

*CT DPH

CT Region	Rate Per 100,000
Region 1	5.0
Region 2	11.5
Region 3	10.4
Region 4	10.6
Region 5	10.9

The overdose mortality rate in 2020 in Region 2 was the highest than any other CT region. Between 2015 and 2018, the Lower Naugatuck Valley region averaged 30.1 drug overdose deaths per 100,000 residents per year, compared to a statewide rate of 24.2.

3 Month Rolling Average of ED Visits for "Suspected Heroin Overdose" Syndrome ending May 2021 by County	Rate per 100,000	Number of visits
Connecticut	3.76	134
New Haven	6.79	58
Middlesex		2
Fairfield	3.50	33

¹ NSDUH

² Connecticut School Health Survey, 2019 (YRBS)

³ CT OCME

⁴ US DOJ- DEA, 2018 National Drug Threat Assessment (October 2018)

2021 Region 2 Epidemiological Profile: Heroin & Other Illicit Opioids

Litchfield	3.88	7
Hartford	2.24	20
Tolland		2
Windham		6
New London	2.64	7

New Haven County, located within Region 2, had the highest average rate of those seen at an ED with suspected heroin overdose by the end of May 2021.

Risk Factors and Subpopulations at Risk

- People who are addicted to other substances are more likely to meet criteria for heroin use disorder. Compared to people without an addiction, those who are addicted to alcohol are 2 times more likely to become addicted to heroin. Those addicted to marijuana are 3 times more likely, while those addicted to cocaine are 15 times more likely, and those addicted to prescription pain medications are 40 times more likely to become addicted to heroin.⁵
- Other groups at risk include³:
 - Non-Hispanic whites;
 - Males;
 - Young adults (18 to 25);
 - People without insurance or enrolled in Medicaid;
 - People living in urban communities.

NSDUH Substate Estimates: Percent Reporting Perception of Great Risk from Trying Heroin Once or Twice, ages 12+

	CT	Regio n 1	Regio n 2	Regio n 3	Regio n 4	Regio n 5
2016 - 2018	87. 1	86.5	87.4	86.0	87.4	87.9

The 2019 Connecticut School Health Survey shows that Black non-Hispanics and Hispanics reported the highest overall rate (3.0% each), which is higher than the prevalence for White non-Hispanics (1.1%). Almost three percent of males (2.7%) and .9% of females reported ever use of heroin.² Use among high school students in general is of

particular concern, as youth use is often linked to continued use and substance use disorder in the future.

Burden (consequences)

- Opioids such as fentanyl and heroin are highly addictive, and their misuse has multiple medical and social consequences including increased risk for HIV/AIDS, property and violent crime, arrest and incarceration, unemployment, disruptions in family environments, and homelessness.
- Chronic opioid misuse may lead to serious medical consequences such as fatal overdose, scarred and/or collapsed veins, bacterial infections of the blood vessels and heart valves, abscesses and other soft-tissue infections, and liver or kidney disease. Poor health conditions and depressed respiration from heroin use can cause lung complications, including various types of pneumonia and tuberculosis.
- Opioid misuse during pregnancy can result in a miscarriage or premature delivery, as well as neonatal abstinence syndrome (NAS), and exposure in utero can increase a newborns' risk of sudden infant death syndrome (SIDS).
- According to Connecticut's Office of the Chief Medical Examiner (OCME), in 2019, heroin was involved in 387 overdose deaths, and fentanyl was involved in 979 deaths.³
- Heroin-involved mortality rates have dropped from a high of 14.1 to 10.8 per 100,000 population between 2016 and 2019. However, since 2012 there has been a sharp increase in fentanyl-involved deaths, reaching the highest rate in 2019 with a death rate of 27.4 per 100,000 population.³

In 2019 there were 22,274 treatment admissions where heroin was the primary substance. This accounts for 32.58% of all substance use treatment admissions.

Treatment Admissions: Heroin* as the Primary Drug

⁵ CDC. Overdose: Heroin.

<https://www.cdc.gov/drugoverdose/opioids/heroin.html>

2021 Region 2 Epidemiological Profile: Heroin & Other Illicit Opioids

	CT	Regio n 1	Regio n 2	Regio n 3	Regio n 4	Regio n 5
FY2018	14,643	1,959	4,708	2,322	3,350	2,304
FY2020	15,226	2,378	4,379	2,302	3,667	2,500

*This includes heroin and non-prescriptive methadone

The treatment admissions with heroin as the primary drug were the highest in both 2019 and 2020 as compared to the other 4 regions.

Capacity and Service System Strengths

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

	CT	Regio n 1	Regio n 2	Regio n 3	Regio n 4	Regio n 5
2018	5.26	5.90	5.25	4.35	5.19	4.94
2020	5.37	5.14	5.55	5.21	5.59	5.25

According to the 2020 Community Readiness Survey within the suburban population, heroin and fentanyl are substances of concern among those aged 18-25 (13.1%) and those aged 26-65 (13.4%). However, alcohol is ranked higher as a substance of concern within these age groups.

According to Region 2's Priority Ranking Matrix of substances, heroin and fentanyl ranked as the overall priority substances of concern. Heroin and fentanyl also ranked highest in magnitude, impact and consequence of inaction.

Region 2's prevention and intervention efforts during the year 2020 saw 830 people trained in Narcan administration with 15 people receiving training as trainers. More than 750 Narcan kits have been distributed. Almost all of this training was conducted virtually during the height of the pandemic.

With respect to Region 2's urban community response, the City of New Haven and collaborative partners implemented *New Haven Innovative Community Engagement (NICE)* to:

- Identify high risk individuals
- Increase awareness of treatment options
- Improve the landscape to become more recovery friendly

- Evaluate these efforts and communicate to the larger community

Connecticut's Region 2 has utilized federal funding (State Opioid Response) to implement community-based initiatives including Screening, Brief Intervention and Referral to Treatment screening programs, statewide media campaign, and, expansion of Medication Assisted Treatment programs.

There are presently 18 funded hospital sites in Connecticut where Recovery Coaches / Peer Support staff are available in Emergency Departments to connect individuals in a substance crisis to appropriate treatment.

Connecticut Region 2 sites include Mid State Medical Center in Meriden, and Middlesex Hospital in Middletown. Griffin Hospital in Derby was added as a site in October 2020.

2020 Region 2 Epidemiological Profile: Marijuana

Problem Statement

Marijuana remains the most commonly used drug, after alcohol, both in Connecticut and nationally. In Connecticut, the rates for marijuana usage have been consistently higher than the national average over the last couple decades.¹

Marijuana use is widespread among young adults and adolescents in Connecticut. The 2018-2019 National Survey on Drug Use and Health (NSDUH) showed that for 18- to 25-year-olds, past year marijuana use was higher than the national average (43.9% in CT vs. 35.1% nationally). Similarly, young adults' past month use was also higher (27.2% in CT vs. 22.5% nationally)¹. Among youth ages 12-17 in Connecticut, 14.1% had used within the past year, and 7.5% had used within the past month, also higher than their national peers.¹ Community norms and perception of harm among youth and adults during the pandemic impacted the rates of use of across the region. Parents and adults were more generally accepting of young adults using marijuana over alcohol or other substances.

Magnitude (prevalence)

The 2019 Connecticut School Health Survey shows about 21.7% of Connecticut high school students report currently using marijuana.²

NSDUH Substate Estimates:

Percent Reporting Past Month Marijuana Use, ages 12+

	CT	Region 1	Region 2	Region 3	Region 4	Region 5
2014-2016	9.3	8.5	9.7	10.6	9.3	8.6
2016-2018	10.9	9.6	11.0	11.4	11.8	10.4

NSDUH indicates those reporting past month use of marijuana increased in Region 2 between 2014 and 2018, and, was higher than the overall rate for CT.

A sample of student surveys conducted in 2019 in Region 2 found that between 10% and 36% reported past 30- day use of marijuana. The average reported for all grades was 24.2% for past 30-day use of marijuana.

In Region 2 between 2016 and 2019, the number of hospital admissions for marijuana related diagnosis increased by 39% for those under the age of 18.

Additionally, those admitted with comorbidity (psychotic disorder with misuse/dependence of marijuana) increased by 308%.

Among young adults in Region 2 receiving substance use treatment services through Department of Mental Health & Addiction Services in 2020, 61.5% reported marijuana use. Among all cases admitted to substance use treatment, 28.7% reported marijuana use.

A CT Young Adults Statewide Survey in 2020 showed that of young adults who used a vape device, 51% used THC or marijuana oil.

A recent trend in the region includes the purchase and use of CBD based products by youth for use in vapor devices.

Treatment Admissions Young Adults: Marijuana⁵

	CT	Region 1	Region 2	Region 3	Region 4	Region 5
FY2020	7126	1138	1343	855	2360	1430

*Primary drug by program

Risk Factors and Subpopulations at Risk

Risk factors include:

- Availability of marijuana
- Family history of marijuana use
- Favorable parental attitudes towards marijuana
- Low academic achievement and low bonding to school environment
- Peers who use marijuana
- Low peer disapproval of marijuana use
- Prior use of alcohol/tobacco
- Sensation seeking behavior/impulsivity
- Childhood abuse/trauma³

The 2019 Connecticut School Health Survey shows slightly higher current marijuana use in females (22.9%) compared to males (20.5%).² Reported current use increases significantly by grade from 12.1% of 9th

¹ NSDUH

² Connecticut School Health Survey, 2019 (YRBS)

³ SAMHSA, CAPT Northeast Regional Marijuana Webinar Series: Strategies/Interventions for Reducing Marijuana Use

2020 Region 2 Epidemiological Profile: Marijuana

graders to 31.0% of 12th graders.² More Hispanic students reported current use (24.3%) than White students (22.4%) and Black students (15.5%).²

Subpopulations at risk:

- Adolescents
- Young Adults
- Those in substance use treatment
- Those in recovery

Burden (consequences)

Short-term consequences include⁴

- Decreased memory and concentration
- Impaired attention and judgement
- Impaired coordination and balance
- Increased heart rate
- Anxiety, paranoia, and sometimes psychosis

Long-term consequences include⁴ :

- Impaired learning and coordination
- Sleep problems
- Potential for addiction to marijuana, as well as other drug and alcohol use disorders
- Potential loss of IQ (particularly in those who used heavily during adolescence)
- Decreased immunity
- Increased risk of bronchitis and chronic cough
- Marijuana potency has increased over the past few decades: in the 90s, the average THC content in confiscated samples was less than 4%, and in 2018 it was over 15%.⁴
- Marijuana use during pregnancy also increases the risk of child development problems including low birth weight, and brain development. Additionally, children exposed to marijuana in-utero have increased risk for problems with attention span and problem solving.⁴
- Several studies have linked marijuana use to increased risk for psychiatric disorders and substance use disorders. The amount used, age at first use, and genetic vulnerability are thought to influence this relationship.⁴

- In 2019, marijuana was identified as the primary drug in approximately 12% of treatment admissions in Connecticut.⁵ Of these, approximately 67.3% were male. About 30% were White, non-Hispanic, 28% Black, non-Hispanic, and about 26.4% Hispanic.⁴
- Because marijuana use impairs motor coordination and reaction time, many studies have shown a relationship between blood THC concentration and impaired driving.⁴
- A recent national outbreak of e-cigarette, or vaping product use-associated lung injury (EVALI) was linked to vaping THC, possibly due to the presence of Vitamin E acetate which is used as a diluent in THC-containing products.⁶

Capacity and Service System Strengths

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

	CT	Region 1	Region 2	Region 3	Region 4	Region 5
2018	5.26	5.90	5.25	4.35	5.19	4.94
2020	5.37	5.14	5.55	5.21	5.59	5.25

The 2020 Community Readiness Survey measured community attitudes toward substance use in a suburban population – 39.1% of respondents somewhat agree that the occasional use of marijuana is not harmful for youth. Moreover, a majority of respondents somewhat agree that their communities are concerned about the legalization of recreational marijuana. A majority of people (56.1%) somewhat, or strongly agree that they are aware of their community’s efforts in preventing substance misuse.

According to Region 2’s Priority Ranking Matrix of substances, marijuana ranked high for both the magnitude and impact on our communities. Overall, marijuana ranked 5th as a priority substance.

The region’s capacity to address the anticipated legalization of recreational marijuana was influenced by inclusion as a chapter of the national organization- *Smart Approaches to Marijuana* (SAM). Coalitions

⁴ NIDA, Marijuana

⁵ CT DMHAS, 2019 Treatment Admissions

⁶ CDC (2020), Outbreak of Lung Injury Associated with the Use of E-Cigarette, or Vaping, Products

2020 Region 2 Epidemiological Profile: Marijuana

within Region 2 initiated collaborative work groups to share data and science to their municipalities.

2021 Region 2 Epidemiological Profile: Mental Health

Problem Statement

Mental health refers to emotional, psychological, and social well-being. Mental health has a critical impact on thoughts, feelings and actions. It also determines how individuals handle stress, relate to others, and make life choices. Mental health is important at every stage of life, from childhood and adolescence through adulthood. Many factors contribute to mental health problems, including: biological factors, such as genes or brain chemistry; life experiences, such as trauma or abuse; family history of mental health problems. Types of mental health disorders include, but are not limited to: depression; anxiety; post-traumatic stress disorder (PTSD); obsessive compulsive disorder; mood and personality disorders; eating disorders; and serious mental illness (SMI). Anxiety and depression are the most commonly reported mental health issues, while SMI has serious consequences for the lives, livelihood, and wellbeing of individuals and families experiencing it.

Anxiety

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

Depression

Depression is a relatively common but serious mood disorder. It interferes with everyday functioning, and includes symptoms like feeling sad all the time, loss of interest in activities previously enjoyed, sleeping too much or too little, having trouble concentrating, and thinking about suicide or hurting oneself.² About 1 in 6 adults will have depression at some point in their life.² According to the 2018-2019 National Survey on Drug Use and Health (NSDUH), 7.1% of Connecticut respondents reported a major depressive episode in the past year.⁴

Serious Mental Illness

Serious mental illness (SMI) refers to mental, behavioral, or emotional disorders resulting in serious functional impairment, interfering with major life activities.¹ Examples of serious mental illnesses include schizophrenia, bipolar disorder, and major depression³.

The 2018-2019 NSDUH shows 4.5% of adults in Connecticut reported serious mental illness in the past year.⁴

Due to the COVID-19 pandemic, the numbers regarding mental health deaths are skewed. As many studies and graphs show, the numbers for mental health issues and deaths have declined in CT, yet they have also risen during the lockdown of 2020.

Magnitude (prevalence)

Anxiety

The 2018 Connecticut BRFSS showed 11.2% of adults reported feeling nervous, anxious, or on edge for more than half the days or nearly every day in the past 2 weeks.⁵

Depression

The percentage reporting past year major depressive episode was highest among young adults 18-25 (15.3%) compared to youth 12-17 (14.4%), and adults 26+ (5.8%).⁴ According to the 2018 Connecticut BRFSS, 15.5% of adults reported being told by a doctor that they had a depressive disorder.⁵ Similar to the NSDUH, the BRFSS showed a higher percentage among younger adults 18-24 (19.1%), compared to those 35-54 (15.0%) and those 55+ (13.8%).

Mobile Crisis Episodes by Provider *(Region 2)	2018	2019	2020	2021
CHR/Midd Hosp EMPS	506	515	538	138
Wheeler Meriden EMPS	534	528	454	96
Clifford Beers EMPS	1883	2005	1442	363

¹ NIMH

² CDC, Depression and Anxiety

³ SAMHSA, Adults with SMI

⁴ NSDUH 2018-2019

⁵ CT BRFSS 2018

2021 Region 2 Epidemiological Profile: Mental Health

Region 2 mobile crisis service providers saw a decrease in calls from the year 2020 to 2021. From 2018 through 2021, the age group experiencing the most mobile crisis visits is 13- to 15 years old. During the same time period, the top primary diagnosis at time of intake is Depressive Disorder.

Serious Mental Illness

In the 2018-2019 NSDUH, young adults 18-25 had a higher percentage reporting serious mental illness (8.54%) than those 26+ (3.86%).⁴

NSDUH Substate Estimates:

Percent Reporting Past Year Major Depressive Episode, ages 18+

	CT	Region 1	Region 2	Region 3	Region 4	Region 5
2014 - 16	6.64	5.67	7.16	7.42	6.54	6.59
2016 - 18	6.84	6.05	6.93	7.34	7.34	6.43

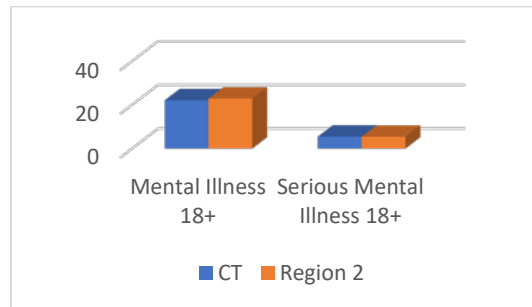
Percent Reporting Past Year Serious Mental Illness, ages 18+

	CT	Region 1	Region 2	Region 3	Region 4	Region 5
2014 - 16	3.60	3.14	3.59	4.20	3.62	3.67
2016 - 18	4.15	3.84	4.38	4.36	4.28	3.80

The 2019 Connecticut School Health Survey reported that almost 70% of high school students said their past 30-day mental health was not good (including depression, stress, emotional problems).⁶ This was higher among females (82%) and LGBT students (88%). The percentage of high school students reporting feeling sad or hopeless almost every day for two weeks or more in the past year, so that they stopped doing usual activities, was 30.6%. This was higher among females (40.5%) than males (21%), and was higher among Hispanic students (36.8%) than non-Hispanic Black (30.3%) or non-Hispanic White students (28.7%).⁶ The rate of serious mental illness across all Connecticut regions during 2016-2018 among those 18 and older was highest in Region 2 at 4.38%

Serious Mental Illness past year 2016 -2018 (Ages 18 and older)	Rate
CT Region 1	3.84%
CT Region 2	4.38%

CT Region 3	4.36%
CT Region 4	4.28%
CT Region 5	3.80%



Risk Factors and Subpopulations at Risk

Risk factors for depression and anxiety include¹:

- Family history of anxiety, or depression, or other mental illness
- Experiencing traumatic or stressful events
- Some physical conditions can produce or aggravate anxiety symptoms, and having medical problems such as cancer or chronic pain can lead to depression
- Substance use such as alcohol or drugs
- Young adults report higher rates of depression and serious mental illness.^{4,5}
- The prevalence of major depressive episodes is higher among adult females than males¹, and among adults reporting two or more races¹
- The prevalence of any anxiety disorder is higher among females than males.¹
- LGBTQ individuals are more likely than heterosexual individuals to experience a mental health condition. Individuals who are transgender are four times more likely to experience a mental health condition.⁷

Burden (consequences)

- Mental illness (including depression, anxiety, bipolar disorder, among others) is a risk for suicide
- Depression is the leading cause of disability in the world⁷

⁶ Connecticut School Health Survey 2019

⁷ NAMI

2021 Region 2 Epidemiological Profile: Mental Health

- Mental illness costs Americans \$193.2 billion in lost earnings per year⁷
- 1 in 8 emergency department visits involves a mental health or substance use condition.⁷

DMHAS Mental Health Treatment Admissions 2020

(unduplicated clients)

Type of Admission	Region 1	Region 2	Region 3	Region 4	Region 5
Substance Use Only	9,586	20,340	9,923	22,208	12,526
Mental Health Only	5,834	11,743	5,344	14,911	6,635
Mental Health & Substance Abuse	1,587	4,227	2,051	4,326	1,693

highest of all the mental health issues having greatest concern within communities. The Medicaid expansion under ACA means that more Connecticut residents are covered by insurance and therefore eligible for mental health and substance abuse services. The availability of telehealth during the pandemic increased access to individuals who were already receiving services, and those seeking services.

Region 2 experienced some of the highest rates of treatment admissions for both substance use and mental health in 2020, second to Region 4 which encompasses Hartford County.

Capacity and Service System Strengths

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

	CT	Region 1	Region 2	Region 3	Region 4	Region 5
2020	4.88	4.86	5.00	4.71	4.89	4.88

While the mean stage of readiness for mental health promotion in CT is 4.88 overall, Region 2's was higher than both the state and the other 4 Connecticut regions.

The Community Readiness survey showed one of the perceived barriers in addressing mental health in suburban communities was financial resources.

According to Region 2's Priority Ranking Matrix of behavioral health issues, anxiety was the priority mental health issue (4.6), followed by depression (4.4) and early serious mental illness (4.3)

The magnitude and impact of anxiety, depression and serious mental illness all equally ranked

2021 Region 2 Epidemiological Profile: Prescription Drug Misuse

Problem Statement

Non-medical use of prescription drugs is a problem that continues to be a concern in the U.S., including within Connecticut. The types of prescription drugs that are most commonly misused include painkillers (opioids), central nervous system depressants (tranquilizers, sedatives, benzodiazepines) and stimulants.¹ Oxycodone (OxyContin), oxycodone, tramadol, and hydrocodone are examples of opioid pain medications. Opioid painkillers work by mimicking the body's natural pain-relieving chemicals, so the user experiences pain relief. Opioids can also induce a feeling of euphoria by affecting the parts of the brain that are involved with feeling pleasure. Tranquilizers, sedatives and benzodiazepines are central nervous system depressants often prescribed for anxiety, panic attacks and sleep disorders. Examples include Xanax, Valium, Klonopin, Ativan and Librium. These drugs can also slow normal brain function. Stimulants increase alertness, attention and energy by enhancing the effects of norepinephrine and dopamine in the brain. They can produce a sense of euphoria and are prescribed for attention-deficit/ hyperactivity disorder (ADHD), narcolepsy and depression.¹

Prescription drugs continues to be a leading issue amongst all ages. The elderly (ages 66 and older) is at most risk of misuse prescription drugs due to the potential of mental illnesses. Connecticut's overdose death rate has risen during 2020.

Experimentation with stimulants and anti-anxiety medications among college and high school students is an issue of concern in Region 2 in light of counterfeit pill seizures that have occurred in the last year year.

Magnitude (prevalence)

Among prescription medications, pain relievers are the most frequently used for non-medical purposes in the US. In Connecticut, the 2018-2019 NSDUH found that 3.3% of individuals aged 12 or older reported nonmedical use of pain relievers during the past year. The highest rate of pain reliever misuse was reported by

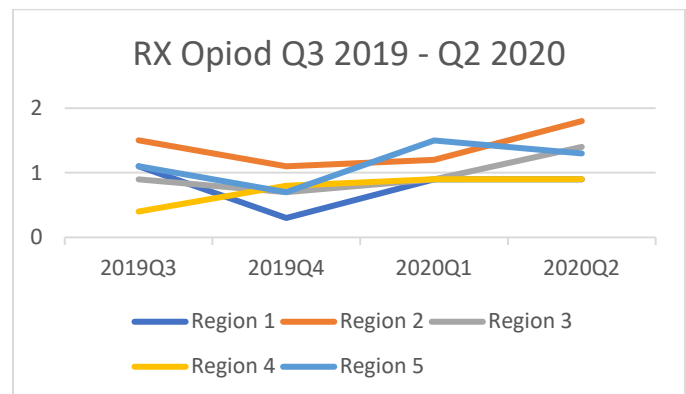
18–25-year-olds (4.9%), followed by those 26 or older (3.2%), and youth ages 12-17 (2.1%).²

NSDUH Substate Estimates:

Percent Reporting Past Year Pain Reliever Misuse, Ages 12+

	CT	Region 1	Region 2	Region 3	Region 4	Region 5
2016-2018	3.98	3.57	3.73	4.09	4.40	4.02

According to the 2019 Connecticut School Health Survey (CT's Youth Risk Behavior Surveillance survey), 10.1% of high school students reported ever taking prescription drugs without a doctor's prescription.³



According to the 2019-June 2020 Analysis of Substance-Involved Overdose Fatalities (per 100,000)

A sample of student surveys conducted in 2019 in Region 2 found that between 1% and 4% reported past 30- day use of a prescription drug. The average reported for all grades was 2.7% for past 30-day use of a prescription drug.

Risk Factors and Subpopulations at Risk

Persons at risk of misusing prescription drugs include⁴ :

- Those with past year use of other substances, including alcohol, heroin, marijuana, inhalants, cocaine and methamphetamine
- People who take high daily dosages of opioid pain relievers
- Persons with mental illness

¹ NIDA, Misuse of Prescription Drugs Research Report

² NSDUH (2017-2018)

³ Connecticut School Health Survey, 2019 (CT YRBSS)

⁴ Bali V. Research in Social and Administrative Pharmacy 2013; 9(3): 276–287.

2021 Region 2 Epidemiological Profile: Prescription Drug Misuse

- People who use multiple controlled prescription medications, often prescribed by multiple providers
- Those who purchase counterfeit pills

Individuals with disabilities are at increased risk of prescription opioid misuse and use disorders⁵ Among all fatal overdoses involving prescription opioids in Connecticut in 2019, the majority occurred among non-Hispanic whites, with male deaths occurring 1.3-2.8 times more frequently than females in each racial/ethnic group⁶

- The elderly population may be at risk of consequences of prescription drug misuse, as they use prescription medications more frequently compared to the general population and may be at higher risk of medication errors⁷
- According to the 2019 Connecticut School Health Survey, Hispanic students had the highest rates of taking prescription drugs without a doctor's prescription (14.2%), significantly higher than White non-Hispanic students (8.0%). The rates among Black students (12.8%) were also significantly higher than White non-Hispanics. The NMUPD rates were slightly higher among females (11.3%) than males (9.1%).³

Burden (consequences)

- Prescription opioid misuse is a risk factor for heroin and other illicit opioid misuse, including illicitly manufactured fentanyl. While the estimated proportion of individuals who transition to heroin following prescription opioid misuse is low (<5%), a majority of those who use heroin initiated opioid use with non-medical use of prescription drugs (NMUPD).^{8,9}
- According to reports from the Office of the Chief Medical Examiner (OCME), Connecticut experienced 1,127 opioid-involved fatalities in 2019, including 131 that involved a prescription opioid; 92 involved oxycodone, 20 oxymorphone, 14 hydrocodone, 15 tramadol, and 14 hydromorphone.⁶

- Approximately 12% of all opioid overdose fatalities involved a prescription opioid, but only 15% of those overdoses involved only the prescription opioid. The majority involved multiple substances; 54% also involved fentanyl, 38% involved benzodiazepines, and 20% involved heroin.⁶
- There were 1062 non-fatal stimulant overdoses in 2018, and 2372 in 2019.¹⁰

NSDUH Substate Estimates:

Percent Meeting Criteria Past Year Pain Reliever Use Disorder, ages 12+

	CT	Region 1	Region 2	Region 3	Region 4	Region 5
2016-2018	.58	.50	.55	.59	.65	.61
2020	3.7					

DMHAS Center for Prevention Evaluation and Statistics at UConn Health

Prescription Drug-Involved Fatal Overdoses in 2019³

	CT	Region 1	Region 2	Region 3	Region 4	Region 5
N	126	25	42	13	26	20
Rate	3.53	3.57	5.08	3.08	2.59	3.27

*Rate per 100,000 population

Treatment Admissions: Other Opiates and Synthetics

	CT	Region 1	Region 2	Region 3	Region 4	Region 5
FY2018	1829	208	662	298	343	318
FY2020	3260	394	904	555	908	499

According to Partnership for Safe Medicines, counterfeit drugs that are manufactured in pill press operations, have resulted in law enforcement seizures of deadly substances. CT Region 2 had one such counterfeit drug seizure in Shelton in 2019.

Platforms such as *Snapchat* have made it easier for drug dealers to access youth and sell counterfeit pills.

Capacity and Service System Strengths

⁵ Lauer EA et al. Disability and Health Journal 2019;12(3):519-522

⁶ Connecticut Office of the Chief Medical Examiner, 2019

⁷ Perez-Jover V et al. Int J of Environmental Research and Public Health 2018; 15:310.

⁸ Jones CM. Drug Alcohol Depend 2013; 132:95-100

⁹ Muhuri PK et al. CBHSD Data Review, 2013.

¹⁰ CT DPH, EpiCenter

2021 Region 2 Epidemiological Profile: Prescription Drug Misuse

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

	CT	Region 1	Region 2	Region 3	Region 4	Region 5
2018	5.26	5.90	5.25	4.35	5.19	4.94
2020	5.37	5.14	5.55	5.21	5.59	5.25

According to the 2020 Community Readiness Survey within the suburban population, 37.5% of respondents agreed that prescription drugs were of great concern among those 66 and older. After alcohol, this was the substance of greatest concern within the suburban population for this age group. Additionally, 25.4% of respondents agreed that prescription drugs are a substance of great concern for ages 26- to 65. According to Region 2's Priority Ranking Matrix of substances, prescription drugs ranked as the second substance of concern (3.7) after heroin and fentanyl. Prescription drug's magnitude ranked medium, with a ranking of high impact in our communities.

Connecticut's Region 2 Regional Behavioral Health Action Organization in coordination with funded State Opioid Response (SOR) recipients to implement community-based initiatives to address the misuse and abuse of prescription drugs including:

- Education for prescribers encouraging use of the state's *Prescription Monitoring Program*.
- Education for parents, educators, and other adults on youth prescription drug misuse and addiction
- Promotion of DMHAS's *Change the Script* statewide media campaign throughout the region

2021 Region 2 Epidemiological Profile: Problem Gambling

Problem Statement

Problem gambling, sometimes referred to as gambling addiction, includes gambling behaviors which disrupt or damage personal, family, or vocational pursuits.¹ Symptoms include: increasing preoccupation with gambling, needing to bet more money more frequently, irritability when attempting to stop, and continuation of the gambling behavior despite serious negative consequences.¹

According to the American Psychiatric Association, for some people gambling becomes an addiction and individuals may crave gambling the way someone craves alcohol or other substances.² Aside from financial consequences, problems with relationships and work, or potential legal issues, problem gamblers are at increased risk of suicide.²

The National Survey on Gambling Attitudes conducted in 2019 showed that three out four adults reported gambling in the past year. Only 12% claim to have never gambled.

Connecticut became the third state in New England to legalize sports betting in the Spring of 2021. The bill puts Connecticut among a half-dozen states with online casino gambling, effectively giving any adult physically in the state the means to gamble 24/7 on a smartphone, tablet or computer. (CT Mirror, May 2021)

While responsible gambling / gaming safeguards will be included in online betting platforms, electronic access will increase the number of people engaged in gambling activity.

Magnitude (prevalence)

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

The following illustrates that trends for various forms of gambling activity are higher than national rates of the same activities.

In 2018, the World Health Organization (WHO) classified gaming disorder in their *International Classification of Diseases (ICD-11)*. The *ICD-11* is

a list of diseases and medical conditions that health professionals use to make diagnoses and treatment plans.

2019 Gambling Trends	CT	Nationally
Any Past Year Gambling Activity	83%	73%
Buying Any Lottery Game	74%	66%
Buying any Raffle Ticket	55%	41%
Spending money on any Casino Activity	48%	37%
Spending money on any gaming machine	37%	32%

Student Survey Questions on Gambling Behavior	CT Region 2 2018 Student Survey Data N=1105	All other CT Regions N=9928
Past Year Gambling	17%	14%
Ever tried cutting back (% replied yes)	19%	31%
Missed school, work, or important activities (% replied Yes)	5.6%	9%
Do you think you have a gambling problem?	6.6%	12%

A sample of student survey data collected in 2018, shows that students in Region 2 showed higher rates of past year gambling activity than the other CT regions. Additionally, students in all other regions reported more problem gambling behavior than in Region 2.

According to the Connecticut School Health Survey in 2019, 25.4% of high school students reported gambling on a sports team, playing cards or dice

¹ National Council on Problem Gambling

² American Psychiatric Association, Gambling Disorder

2021 Region 2 Epidemiological Profile: Problem Gambling

game, state lottery games, gambling on the internet, or bet on a game of personal skill.³

Risk Factors and Subpopulations at Risk

The National Council on Problem Gambling indicates young adults and those who engage in sports betting are at higher risk for problem gambling.

Sports bettors are three or more times likely to report frequent risky behavior than non-sports bettors.

Risk Factors include:⁴

- Having an early big win
- Having easy access to preferred form of gambling
- Holding mistaken beliefs about odds of winning
- Having a recent loss or change, such as divorce, job loss, retirement, death of a loved one
- Financial problems
- A history of risk-taking or impulsive behavior
- Depression and anxiety
- Having a problem with alcohol or other drugs
- A family history of problem gambling

The National Council on Problem Gambling indicates young adults and those who engage in sports betting are at higher risk for problem gambling.

Sports bettors are three or more times likely to report frequent risky behavior than non-sports bettors.

The Connecticut School Health Survey shows that 34.6% of high school males reported gambling, compared to 16.2% of females. The prevalence among 12th graders was significantly higher (31.7%) than any other grade (22.1%-24.3%). Differences among race/ethnicity were not statistically significant³

- Problem gambling rates double for individuals living within 50 miles of a casino.

- Gambling in youth can lead to substance use
- Region 2's largest at-risk audience are white males, 45 years of age and older

Burden (consequences)

Treatment Admissions:

The number of individuals receiving services from Connecticut's *Bettor Choice* for problem gambling program in 2020 was 291. Region 2 provided services to 110 individuals in 2019 through its' *Bettor Choice* sites.

The National Council on Problem Gambling estimates the national societal cost of problem gambling to be about \$7 billion, including gambling-related criminal justice and healthcare spending.

- job loss, and bankruptcy, among others.¹

Capacity and Service System Strengths

Community Readiness Survey: % Rating Community Ability to Raise Awareness About the Risks of Problem Gambling/Gaming Addiction as Medium/High

	CT	Region 1	Region 2	Region 3	Region 4	Region 5
2020	33.8	36.6	39.9	44.4	28.6	24.1

The 2020 Community Readiness Survey ranked the ability to raise awareness about the risks of problem gambling / gaming as low. Additionally, 48.9% of respondents reported having little awareness that gambling can lead to addiction.

According to Region 2's Priority Ranking Matrix of behavioral health issues, problem gambling had the lowest ranking for both magnitude and impact on communities.

Cross-regional collaboration through "Gambling Awareness" Teams in each region supports efforts to enhance awareness of gambling prevention, treatment, and recovery throughout the state.

³ Connecticut School Health Survey, 2019

⁴ Risk Factors for Developing a Gambling Problem, Centre for Addiction and Mental Health (CAMH)

2021 Region 2 Epidemiological Profile: Problem Gambling

While Region 2 provides both Better Choice treatment sites (Ansonia, Milford), as well as Disordered Gambling Integration (DiGI) at participating treatment organizations, adequate staffing is a barrier. There is little awareness among the behavioral health workforce about problem gambling as a disorder that has a treatment modality that can be included in clinical practice.

Additionally, Region 2 does not have a Better Choice site with certified staff to address problem gaming.

2021 Region 2 Epidemiological Profile: Suicide

Problem Statement

Suicide is defined as death caused by self-directed violence with an intent to die.¹ Suicide is a growing public health problem and is now the tenth leading cause of death in the United States.¹ Suicide is a problem across the lifespan; however, it is the second leading cause of death among people 10-34 years old, and fourth among people 35-54 years old.¹

In the United States, the age-adjusted suicide rate increased 31% from 2001 to 2017, from 10.7 to 14.0 per 100,000. This rate is higher in males (22.4 per 100,000) than females (6.1 per 100,000).²

In Connecticut, the age adjusted suicide rate in 2017 was 10.4 deaths per 100,000 population.³ This rate is highest among those ages 45 to 64, with a rate of 17.3 deaths per 100,000 population.³ The number of suicide deaths per year in Connecticut has risen each year since 2008, and most recently in 2019, it rose to 424 deaths according to the Office of the Chief Medical Examiner.⁴

211 Mobile Crisis Episodes	2018	2019	2020	2021
Statewide	19,965	20,515	16,548	3851
New Haven	1,883	2,005	1,442	363
Hartford	3,731	3,932	3,114	803
Central	2,145	2,243	1,859	490
Eastern	1,802	1,770	1,330	280
Southwestern	1,978	1,933	1,605	338
Western	2,307	2,696	2,106	496

The Child Health and Development Institute of Connecticut (CHDI, 2021) released in their recent report data on the 2021 usage of Emergency Mobile Crises Services utilized in comparison to previous years. So far in 2021, there were 363 youth “211 mobile crises episode” in New Haven county, which is significantly less than the approximate 1400 calls in 2020.

The most commonly reported presenting problem was Harm / Risk of Harm to self.

Magnitude (prevalence)

Data from the 2018-2019 National Survey on Drug Use and Health (NSDUH) showed 4.5% of adult respondents (18+) in Connecticut reported having serious thoughts of suicide in the past year.⁵ This percentage is higher among those 18-25 years old (12.4%) compared to those 26+ (3.2%).⁵ Additionally, .4% of Connecticut adults respondents reported attempting suicide in the past year. This is also higher among the young adult population (1.5%) than those 26+ (.2%).⁵

DMHAS Region	Suicide Rate per 1000,00 from 2015-2019	Number of suicides in region	Region's population from 2015-2019
Region 1	7.0	249	3,540,506
Region 2	11.9	499	4,159,953
Region 3	13.9	287	2,085,989
Region 4	10.9	546	5,011,450
Region 5	11.1	337	3,029,715

According to the Connecticut Department of Public Health, 11.9% of suicides have taken place in Region 2. The suicide rate for Region 2 is based on data from 2015 to 2019.

Comparing the region's rates of suicide during 2015-2019 time period, Region 2 had the second highest rate per 100,000. The cities of New Haven, Meriden, Milford and Wallingford were the areas that had the most suicide death during the time period 2015 -2019.

The state of Connecticut overall in 2020 has experienced a 17% decline in suicide deaths when compared to the 5-year average (2015 to 2019).

¹ CDC (2019). Suicide Prevention

² NIMH (2019). Suicide

³ CT DPH (2018). CTVDRS, Violent Deaths: Connecticut Data 2015 to 2018

⁴ CT OCME (2019). Annual Statistics: Suicides

⁵ NSDUH 2018-2019

2021 Region 2 Epidemiological Profile: Suicide

NSDUH Substate Estimates: Percent Reporting Past Year Serious Thoughts of Suicide, ages 18+

	CT	Region 1	Region 2	Region 3	Region 4	Region 5
2014 - 2016	3.62	3.45	3.65	4.42	3.35	3.65
2016 - 2018	4.17	4.30	4.23	4.63	3.94	4.00

According to data from the 2019 Connecticut School Health Survey (CT YRBSS), 12.7% of high school students reported seriously considering attempting suicide in the past year.⁶ In 2019, 6.7% of high school students reported attempting suicide one or more times during the past year.⁶

The 2018 Connecticut Behavioral Risk Factor Surveillance System (BRFSS) showed that among adults over 18, 12.4% reported ever thinking of taking their own life.⁷ Among those who thought of suicide, 30.5% had attempted suicide.⁷

According to the Connecticut Department of Public Health, 11.9% of suicides have taken place in Region 2. The suicide rate for Region 2 is based on data from 2015 to 2019.

Risk Factors and Subpopulations at Risk

- On average, men account for 88% of suicides in CT.³
- White non-Hispanic males account for 78% of suicides in CT.³
- Nationally, non-Hispanic American Indian/Alaska Natives experience high rates of suicide.¹

- Other disproportionately impacted populations include Veterans and military personnel and certain occupational groups such as construction and sports.¹
- Sexual minority youth experience increased suicidal ideation and behavior compared to their peers.¹
- Mental illness is a risk for suicide, including depression, anxiety, bipolar disorder, and general depressed mood.³
- For those over 45, other risks include physical illness, such as terminal illness and chronic pain, as well as intimate partner problems.³

Other risk factors include¹:

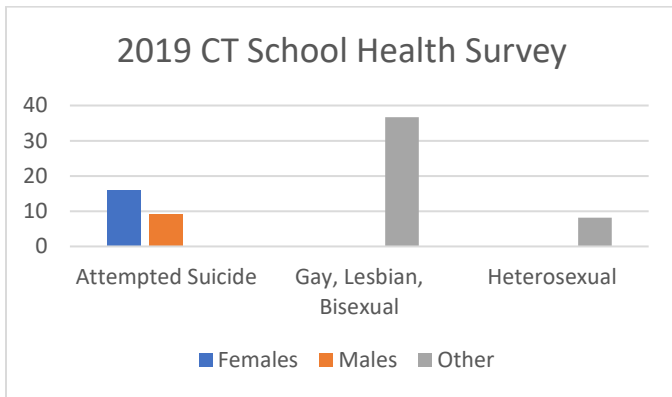
- Family history of suicide
- Childhood abuse/trauma
- Previous suicide attempts
- History of substance misuse
- Cultural and religious beliefs
- Local epidemics of suicide
- Isolation
- Barriers to treatment
- Loss (financial, relational, social, work)
- Easy access to lethal means
- Isolation

Data from the 2019 Connecticut School Health Survey shows the percentage of female high school students who seriously considered attempting suicide was significantly higher (15.9%) than males (9.3%).⁶ Additionally, the percentage of students identifying as gay, lesbian, or bisexual reporting considering attempting suicide is higher than their heterosexual peers (36.7% vs. 8.2%).⁶ A greater percentage of female students reported attempting suicide (8.3%) compared to male students (5.2%). Additionally, Hispanic students reported this at a greater rate (10.1%) than Black non-Hispanic students (5.8%) or White non-Hispanic students (5.7%).

⁶ Connecticut School Health Survey, 2019 (CT YRBSS)

⁷ Connecticut BRFSS 2018

2021 Region 2 Epidemiological Profile: Suicide



According to Region 2's Priority Ranking Matrix of behavioral health issues, suicide ranked third as a priority behavioral health issue after anxiety and depression, respectively. Suicide, however, ranked highest for magnitude, impact and consequence of inaction with regard to our communities.

Cross-regional collaboration through "Suicide Advisory Board" teams in each region supports efforts to enhance awareness of suicide prevention, enhanced training, and resources throughout the state.

Burden (consequences)

- Suicide impacts the health of the community and those around the individual. Family and friends experience many emotions including shock, guilt, and depression.¹
- People who attempt suicide and survive can sometimes experience serious injuries which can have long term health effects.¹

Capacity and Service System Strengths

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

	CT	Regio n 1	Regio n 2	Regio n 3	Regio n 4	Regio n 5
2020	4.88	4.86	5.00	4.71	4.89	4.88

The 2020 Community Readiness Survey for suburban Connecticut indicated that 45.2% agreed that there was *some support* for suicide prevention efforts, while 25.1% felt there was *a lot of support*.

Prevention efforts in Region 2 included Question, Persuade, Refer (suicide prevention training) for 345 people over 15 virtual workshops from 2020 through 2021. A cadre of trained facilitators in *Talk Saves Lives*, *Alternatives to Suicide*, and *Question, Persuade, Refer*, offer many opportunities for citizen participation in suicide prevention.

The *Zero Suicide* initiative has engaged many behavioral health organizations to commit to prevention of suicide within their respective agency.

2021 Region 2 Epidemiological Profile: Tobacco & ENDS

Problem Statement

According to the National Survey of Drug Use and Health (NSDUH) and the Youth Risk Behavior Surveillance Survey (YRBSS), tobacco use has decreased for all age groups over the past decade. NSDUH data show that past month tobacco product use among Connecticut residents 12+ declined significantly from 25.3% in 2008-2009 to 18.8% in 2018-2019.¹ Tobacco product use includes cigarettes, smokeless tobacco (i.e., chewing tobacco or snuff), cigars, or pipe tobacco. According to the 2018-2019 NSDUH, Connecticut young adults 18-25 continue to have the highest rates of cigarette use of any age group.¹ Despite significant decreases, smoking remains a health concern due to serious adverse physical effects of tobacco use.

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

Vaping is an emerging problem nationally and in Connecticut, as rates continue to rise at a steady pace. According to Connecticut’s Behavioral Risk Factor Surveillance Survey (CT BRFS), the prevalence of ever using e-cigarettes has increased each year since 2012. The 2018 CT BRFS results showed that 19.6% of adults in Connecticut reported having tried e-cigarettes in their lifetime.²

Magnitude (prevalence)

The 2019 Connecticut School Health Survey shows current use of cigarettes among high school students is 3.7%, down significantly from 17.8% in 2009.³ While cigarette use among this age group has declined, e-cigarette smoking or vaping has increased, suggesting e-cigarettes are replacing

tobacco smoking as the main mechanism for nicotine delivery. The 2019 Connecticut School Health Survey found current use of electronic vapor products to be 27.0% among high school students.³

A sample of 6 student surveys conducted in Region 2 between 2019 and 2021 found that 2.24% of high school students had used tobacco in the past 30 days. Rates for past 30-day use of tobacco for high school students ranged between 1% to 6%.

Data Haven’s 2018 Community Wellbeing Survey showed 19% of all respondents reported using vape pens or e-cigarettes.⁴ This percentage is higher in urban core (25%) and urban periphery (21%) communities, and lower in wealthy communities (14%).⁴

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

	CT	Region 1	Region 2	Region 3	Region 4	Region 5
2014 - 2016	22.2	18.4	22.8	27.0	22.4	21.9
2016 - 2018	21.3	17.4	21.6	22.5	22.0	23.1
2020		33.6				

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

CT High School Students Reporting Past Month Use of ENDS (YRBS)

Year	Percentage
2011	2.4%
2013	5.3%
2015	7.2%
2017	14.7%
2019	27%

Connecticut has seen significant increases in the use of ENDS between 2011 and 2019. A sample of 6 student surveys collected in Region 2 between 2019 and 2021, found that 13.5% of high school students had used an ENDS in the past 30 days. The rates ranged from 9.4% in one

¹ NSDUH 2018-2019

² Zheng X. (2018) CT BRFS.

³ Connecticut School Health Survey, 2019 (YRBS)

⁴ DataHaven and Siena College Research Institute (2018). 2018 DataHaven Community Wellbeing Survey.

2021 Region 2 Epidemiological Profile: Tobacco & ENDS

shoreline community, to 35% in a suburban community.

Risk Factors and Subpopulations at Risk

Populations at-risk for smoking cigarettes are⁵:

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

Populations most at-risk for using ENDS are:

- Youth (12-17)⁶
- Young adults (18-34)¹
- Males¹
- Hispanics¹
- Current smokers
- Those living in urban communities⁴
- Adults from households earning less than \$35,000²
- Adults with disabilities²
- Those with a high school diploma or less²
- Adults without health insurance²
- Unsupervised youth

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

	CT	Regio n 1	Regio n 2	Regio n 3	Regio n 4	Regio n 5
2016 - 2018	74. 5	77.1	75.3	72.2	73.2	74.4

One New Haven public high school conducted a survey of high school youth. Out of 1,043 youth, 45% of youth have used substances in their lifetime, and 11% currently use some form of tobacco products.

*2018 survey

The 2019 Connecticut School Health Survey shows the prevalence of current cigarette smoking among high school students to be similar across gender and race, however prevalence increases with grade (2.0% of 9th graders compared to 6.6% of 12th graders).³ Additionally, students identifying as gay, lesbian, or bisexual reported higher prevalence (9.2%) than their heterosexual peers (2.3%).³ The 2019 survey also found higher rates of current use of electronic vapor products in females (30.0%) than males (24.1%). White students reported significantly higher use (30.0%) than Black students (19.4%). Current use among Hispanic students (26.0%) is also significantly higher than Black students.

Burden (consequences)

- Evidence shows that young people who use e-cigarettes may be more likely to smoke cigarettes in the future.⁶
- A recent CDC study found that 99% of e-cigarettes sold in the US contained nicotine, which can cause harm to parts of the adolescent brain that control attention, learning, mood, and impulse control.⁶
- E-cigarette aerosol can contain several potentially harmful substances, including diacetyl (in flavorings), which is a chemical linked to serious lung disease. It can also contain volatile organic compounds, cancer causing chemicals, and heavy metals such as nickel and lead.⁶
- Some ENDS devices, including those that are particularly popular among youth, have been modified to allow for higher doses of nicotine to be delivered. They also facilitate the use of THC, and in higher potency. This is especially problematic in youth use, because of the increased risk of tobacco and cannabis use disorders later in life.⁷
- As of January 7, 2020, a total of 2,602 cases of e-cigarette or vaping product use-associated lung injury (EVALI) had been reported to the CDC across all 50 states, the District of

⁵ CDC (2020), Current Cigarette Smoking Among Specific Populations- United States

⁶ Centers for Disease Control and Prevention. (2019). Quick Facts on the Risks of E-cigarettes for Kids, Teens, and Young Adults. Retrieved from https://www.cdc.gov/tobacco/basic_information/e-cigarettes/

⁷ King BA, Jones, CM, Baldwin GT, & Briss PA. (2020). The EVALI and Youth Vaping Epidemics—Implications for Public Health.

2021 Region 2 Epidemiological Profile: Tobacco & ENDS

Columbia, Puerto Rico and the U.S. Virgin Islands. Of these, 57 resulted in deaths. The median age of these patients was 24 years old, and 62% were between 18 and 34 years old. EVALI appears to be primarily driven by the use of THC-containing vaping products, possibly due to substances, such as vitamin E acetate, added to the formulations.⁷

Capacity and Service System Strengths

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

	CT	Region 1	Region 2	Region 3	Region 4	Region 5
2018	5.26	5.90	5.25	4.35	5.19	4.94
2020	5.37	5.14	5.55	5.21	5.59	5.25

The 2020 Community Readiness Survey for suburban Connecticut indicated that 7.2 % agree that tobacco was the substance concern for those ages 66 and older. Another 1.3% agree it is a substance of concern for those between the ages of 12- to 17.

According to Region 2's Priority Ranking Matrix of priority substances, ENDS (Electronic Nicotine Delivery System) was ranked as the third highest priority after heroin and prescription drug use. The magnitude with regard to use of ENDS ranked high and impact was ranked as medium.

Tobacco ranked low as a priority substance of concern. Tobacco was also ranked low in magnitude, impact, and readiness to address the substance. However, tobacco ranked high with regard to consequence of inaction. Tobacco ranked higher overall as a priority substance (2.7) before cocaine (2.6).

The passing of Connecticut Public Act number 19-13 prohibiting the sale, delivery and possession of tobacco products, ENDS, and vapor products to anyone under the age of 21. Subsequently, prevention education for tobacco retailers began a short time later to encourage compliance to the new law.

Collaborative efforts between the Regional Behavioral Health Action Organization, Local Prevention Councils, and federally funded coalitions have utilized prevention and intervention efforts over the last two years to increase awareness about the harm caused by use of ENDS.

These efforts include:

- Innovative media campaigns to discourage use of ENDS while increasing perception of harm among youth and young adults
- Use of social media platforms to publicize youth survey results on vaping behavior
- Virtual parent education sessions by local experts
- Use of THC testing strips by school personnel on confiscated vapor devices
- On-going community surveys to monitor trends

Discussion of resources, strengths, assets in the region

Many resources, strengths and assets were identified in Region 2. The region boasts a variety of behavioral health providers that provide comprehensive services across the continuum of care. Telehealth increased access to both behavioral health and substance abuse treatment services during the pandemic. Participants stated all levels of care are present even though some may be more limited than others in the region. Increased access to services is being reported in areas of the region through expansion of satellite service office locations, medication assisted treatment (MAT), intensive outpatient groups, and open access appointments. The CTaddictions.com and 1-800 number with up-to-date information is helpful for providers and community residents in learning about bed availability. Recovery Coaching / Peer Support staff have become available in three Region 2 specific hospitals, including Midstate Medical Center, Middlesex Hospital, and Griffin Hospital, which were created as initiatives in response to key priorities previously defined. Additionally, substance use outpatient services in the area have expanded to include methadone treatment and Recovery Coach / Peer Support staff.

Community members also reported strengths within the region regarding key priority issues. Development of initiatives that support, and advocate for environmental strategies occurred across the region. These strategies included the “*You Think You Know*” initiative to address prescription medication misuse by youth, as well as promotion of “*Tobacco 21*” legislation. A unique messaging campaign was created through the efforts of several Region 2 coalitions aptly titled: “*Mention Prevention*”. This media campaign used social media platforms, billboards, and radio announcements to reach youth and adults. It was reported that most locales within Region 2 are aware of the on-going substance use prevention efforts in their town. The continued State Opioid Response initiatives supports local community environmental prevention strategies as well as community Narcan distribution.

Within the Region, a strength reported is access and availability to community suicide prevention training that has increased its reach to community members due to virtual platforms. APW is comprised of trainers for Question, Persuade, and Refer suicide prevention trainings that are easily available to community members through video conference software. Another strength reported in priority data collection was strong suicide prevention coalitions, like Region 2 town-specific Suicide Advisory Boards. Additionally, within these coalitions, communities have begun to come together with stakeholders to develop and implement post-vention suicide response initiatives.

Additional noted existing community strengths and assets regarding mental health is the promotion of available treatment options through various platforms including social media. It was also noted that Region 2 does well hosting and promoting Mental Health First Aid and the Community Assistance Program training’s to diverse populations. These trainings are provided by various community partners including APW and attendance has increased due to the ability to provide workshops virtually. Many community partners have also embraced the language matters movement and promote the messaging through various platforms. New treatment resources developed for those

affected by early serious mental illnesses like first *episode psychosis* as an early intervention program promoting recovery. Such treatment is provided in New Haven for affected young adults.

First responders have reported observed and experienced strengths in their community related to behavioral health prevention, treatment, and recovery. During data collected from the Region 2 focus group interviews, first responders reported having improved communication and connection with behavioral health providers. They also reported that a culture shift continues within their field which is assisting in reducing stigma and improving interactions with vulnerable populations. The first responders also stated that many of their departments are working on developing collaborations with other service providers to assist with behavioral health calls.

For problem gambling, some strengths highlighted in community member data responses were the community's awareness of problem gambling resources. Initiatives like the Connecticut Council of Problem Gambling that promote problem gambling initiatives have been made easily accessible to community members. Additionally, another strength mentioned in the Region 2 quantitative data collection was the "specialized treatment services" available in the local area for problem gambling.

Discussion resource gaps and needs in the region.

While significant progress has been made in region two over the past several years, many gaps and needs in the region continue to be present need to be addressed. Top concerns in the region include the areas of treatment, prevention, recovery.

The overarching behavioral health (substance use and mental health) challenges and gaps include the lack of culturally responsive treatment options was a theme most mentioned by those in recovery. After-care resources for both behavioral health and substance use are greatly inadequate. Additional sites for "recovery centers" are needed in suburban areas for greater accessibility. Services for senior citizens remain a challenge in both the area of mental health and substance abuse. Additional barriers for this population include the co-payments and out of pocket expenses for care.

Additional treatment resources discussed included psycho education for families, step down from hospitalization treatment options, sobering centers, and increased access to existing services. Providers, people with lived experience and first responders reported the lack of alternate hospitalization treatment options such as emergency shelters.

During the pandemic, the sub-population with inadequate behavioral health treatment was adolescents. Mental health providers were not providing in-home care through IICAPS, nor were there providers seeing adolescents in person. Mobile crisis calls during the last year for youth were primarily attributed to harm to self, and depressive symptoms. Concerns were also discussed about the stress associated with being released from the Emergency Department following a suicide crisis. When children are discharged or referred after using the crisis services, parents are faced with long wait times to access children's services.

Culturally responsive behavioral health treatment for persons of color, women and those who identify as LGBTQ+ is not sufficient in Region 2. Participants in the Recovery

Community focus group reported that the LGBTQ+ population as well as persons of color are greatly affected by behavioral health concerns, and our community needs to build capacity within this sector to increase community outreach, break down stigma, and increase awareness of co-occurring substance use and mental health concerns for these vulnerable populations.

A gap in region 2 is to have stronger collaboration among first responders and mental health providers to decrease repeat emergency responses and for the approach to be comprehensive for all behavioral health needs. A challenge for the first responders included that they many times have more options for opioids but not alcohol or other drug use. First responders reported that protocol is not consistent within their own departments. The model programs for policing vary town by town and most focus exclusively on substance abuse. First responders reported feeling frustrated with the challenge of CT not having mandated treatment. There in no mechanism to mandate treatment for those involved in repeat behavioral health crisis and transports.

Community members reported there has been an increase in criminal activity especially among juveniles because of behavioral health conditions. First Responders stated that their communities demonstrate dedication and commitment to this issue, however, more needs to be done to address the concern.

Prevention needs, and gaps were also discussed in the region. One of the most pressing needs throughout the region focused on alcohol and marijuana use and the need for enhanced prevention and early intervention. The pandemic has increased use of these substances on a more individual level and not through a group and party usage. Additionally, social media platforms increased access to youth to obtain these substances as well as through their parents' supply.

While a reported strength by the Region 2 community members is the awareness of gambling prevention and treatment resources, members also reported challenges due to the recent legislation in Connecticut that has legalized online gambling. Attention to problem gambling and gaming efforts needs to be more inclusive of young adults and youth. Participants in one focus group described the need for a skilled workforce on the treatment side of problem gambling. Region 2 does not have certified staff to treat gaming disorder. Community members also reported that there needs to be an increase in treatment accessibility and outreach, as specifically reported by "street outreach is needed" within the quantitative data collected. Community members reported that given the increase in online gambling and video game related gambling behaviors of youth, treatment options need to be accessible and tailored to younger populations. Adult community members and local providers reported concerns regarding youth engaging in online gambling platforms with little awareness of the risk, and a need for increased parental psychoeducation resources was suggested. Furthermore, it was also reported an increase in gambling recovery resources for individuals across the lifespan is needed within local area.

A challenge in recovery is the lack of awareness of available resources by providers. A theme stated by providers and first responders was the lack of synchronicity among treatment delivery systems. Engagement in recovery supports has been difficult during

the pandemic with one of the challenges being the loss of in home and in person services. This disjointedness, in conjunction with the previous reported individual challenges leads to a high level of provider burnout.

Building capacity to move the Local Prevention Structure to more of a coalition framework has been challenging this year in Region 2. Lack of financial and human resources in these grassroots councils prevent the community from developing leadership around prevention issues and embracing the Strategic Prevention Framework (SPF) model.

Recommendations and conclusion

The following six recommendations have been compiled for region 2 based on the RBHPSW and data collected.

- 1) To have 24/7 behavioral health crisis centers for SUD, mental health, and suicide response as alternates to hospitalization. These centers can be utilized by first responders and mental health providers as a referral to support stabilization of community members while in a crisis other than using the local hospital's emergency department. It was also reported as a recommendation by community members that this alternative to hospitalization emphasize accessibility to manage the crises, and providing the opportunity to community members to transition to extended treatment options directly from this service to ensure the window of readiness is captured by the service provider. Community members exemplified that timing and accessibility of recovery treatment options is paramount to the success of these harm reduction and recovery focused initiatives.
- 2) A post- pandemic response regarding prevention is re-focusing efforts on substances of abuse by promoting statewide collaboration for *Mention Prevention* and *You Think You Know* and other developing statewide campaigns. Early intervention and peer to peer education programs that focus on increasing perception of harm among youth and adults for marijuana and alcohol use should be reinforced in current initiatives.
- 3) Increase the number of behavioral health and substance use treatment providers that serve the LGBTQI+ population, Women related issues, as well as Black, Indigenous, and People of Color (BIPOC) in the suburban areas within Region 2.
- 4) Collaboration among treatment service providers and first responders to implement regional or statewide behavioral health strategies. Collaboration will also reinforce efficacy of interventions.
- 5) Increased support and concern for the wellbeing of those working in the behavioral health field to prevent burnout.
- 6) Mental health promotion and prevention should be included in any post pandemic planning within the municipalities in our region.

In conclusion, the RBHPSW members will work with the APW team to advocate that community partners utilize this report to enhance collaborative efforts that work to address the identified challenges. The RBHPSW feels that Region 2 has many service

strengths and strong collaborations that can be key components in breaking down barriers and enhancing services and building programs that create healthier communities.

Appendices

Focus Group Questions

Priority Recommendation Matrix

Focus Group Summary

Chart Notes

BHPSW Participants

APW Community Readiness

Report

Required Stakeholder Questions for Regional Priority Reports

Instructions: *RBHAOs must obtain feedback from a broad array of stakeholders about the needs and strengths of, and opportunities for, the DMHAS funded and operated substance use, mental health and problem gambling systems. Following are the questions that must be asked, analyzed and incorporated in the Regional Priority Report. RBHAOs are free to determine the best format for obtaining the feedback.*

A summary of the answers to these questions must be included in the Appendices to the RBHAO Regional Priority Report. An answer grid, which follows this list of questions, has been developed to aid in this process.

- 1. How appropriate are available services to meet the needs of:**
 - substance use prevention, treatment and recovery?
 - mental health promotion, treatment and recovery?
 - problem gambling prevention, treatment and recovery?

- 2. What prevention program, strategy or policy would you like to most see accomplished related to:**
 - substance use?
 - mental health?
 - problem gambling?

- 3. What treatment levels of care do you feel are unavailable or inadequately provided:**
 - related to substance use?
 - related to mental health?
 - related to problem gambling?

- 4. What adjunct services/support services/recovery supports are most needed to assist persons with:**
 - substance use issues?
 - mental health issues?
 - problem gambling?

- 5. What would you say is the greatest strength/asset of the:**
 - substance use prevention, treatment and recovery service system?
 - mental health promotion, treatment and recovery service system?
 - problem gambling prevention, treatment and recovery service system?

- 6. Are there particular subpopulations (for example, veterans, LGBTQ, Latinos, etc.) that aren't being adequately served by the:**
 - substance use service system?
 - mental health service system?
 - problem gambling service system?

- 7. What are the emerging prevention, treatment or recovery issues that you are seeing or hearing about:**
 - substance use issues?
 - mental health issues?
 - problem gambling?

- 8. Are there opportunities for the DMHAS service system that aren't being taken advantage of (technology, integration, partnerships, etc.)?**

Priority Recommendation Worksheet

Assess each identified substance or behavior based on your prioritization (magnitude, impact, changeability, and readiness/capacity for change).

Document who is being directly and indirectly impacted or harmed, and where (subpopulations), based on an assessment of why (risk factors).

Consider what resources and assets are available (i.e. public education; staff training; evidence-based /environmental approaches to prevention, treatment, and recovery; and data availability), and what local strengths exist (what is being done well).

PRIORITY PROBLEM	Risk Factor(s)	Subpopulation(s) of Increased Risk	Community Strengths, Resources and Assets	Challenges, Gaps, and Needs		
				Prevention	Treatment	Recovery/Maintenance
	Substance Misuse/Abuse					
Alcohol	Ease of access, parental acceptance of youth consuming alcohol during pandemic, access to alcohol delivery services, lack of adult supervision	Youth, Young adults, Older adults,	Community based prevention programs targeting underage alcohol use, Existing media campaigns highlighting social hosting laws,	Increase peer to peer education strategies, need collaborative data sharing of youth survey results	Increase emergency response treatment options, increase inpatient TX options & bed availability, Women-focused TX options, lack of treatment options for those who are black or brown	Need for more recovery support sites, Support for provider burnout, lack of follow up care after detox
Tobacco	Normalization of use, increased availability in urban areas, stress,	Those in recovery from substance use, young adults, those with serious mental illness, African American adults	Promotion of Tobacco 21 legislation, wide array of tobacco prevention and education resources, compliance checks	Increase peer to peer education strategies,	Few tobacco cessation programs	Peer recovery specialists

Electronic Nicotine Delivery Systems (ENDS), vaping, juuling	Low perception of harm, lack of adult supervision, trend factor, availability of flavors	Those using tobacco cigarettes, youth, young adults	Targeted prevention and education programs by Local Prevention Coalitions, promotion of Tobacco 21, social media campaigns	increase parent psychoeducation, Increase peer to peer education strategies	Few cessation programs for youth to quit,	Support for provider burnout, community surveys to monitor trends
Marijuana	Low perception of harm, normalization of use, lack of awareness of addiction risk,	Those in recovery from OUD, youth, young adults, those prescribed medical marijuana	Community resources available, Community based prevention & education,	Increase access/knowledge of resources to community members/providers, increase community members awareness of issue, early interventions in schools, parent psychoeducation	Increase individual motivation, co-occurring D/O, parent psychoeducation	Provider/emergency responders partnerships, support for provider burnout
Prescription Drug Misuse	Those taking prescription opioids,those using prescription stimulants non-medically, disordered eating, lack of awareness of addiction risk	High school youth, college population, young adults	Increased access to community training on misuse, Prescriber support for use of PMP, increased harm reduction initiatives in urban area	Increase peer to peer support, increase parent psychoeducation	Increase treatment options, alternatives to hospitalization, reduce financial barriers to treatment	In-home recovery support
Heroin/Fentanyl	co-occurring D/O, those taking prescribed opioids	Young adult caucasian males, Adult males	Provider support and collaboration, Increased access to community training and naloxone distribution across the region, Increased harm reduction initiatives in urban area	Increase access/knowledge to resources to community members/providers, increase community awareness of issue, early interventions in schools, Increased education for Peer Support/Recovery Coaching, needle exchange initiatives	Increase individual motivation, co-occurring D/O, parent psychoeducation, increase inpatient TX options, lack of mandated TX options, Women-focused TX options, increase emergency shelter options	lack of follow up to providers/first responders upon ED admission, Increase provider/emergency responder partnerships, Support for provider burnout, Lack of after- care following treatment
Cocaine	Poly-substance users, low perception of harm, childhood	Young adult white males, those with cannabis dependence	Some cocaine specific treatment options available, harm reduction initiatives in urban areas	Early intervention psychoeducation with youth, increase peer to peer support and	Increase availability and access to treatment options	In-home recovery support

	trauma, family HX of SUD, peer influences, lack of parental and school supervision			education		
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PRIORITY	Risk Factor(s)	Subpopulation(s) of Increased Risk	Community Strengths, Resources and Assets	Challenges, Gaps, and Needs		
Problem Gambling and Mental Health Issues				Prevention	Treatment	Recovery/Maintenance
Problem Gambling	Exposure to video gaming, Increased access to electronic gaming, parental lack of awareness of gaming' connection to gambling, low perception harm, legalization of sports betting	Youth, Young adults, Young adult males, those with substance use disorder	Availability of gambling awareness training and education resources within the region,	Increase parent psychoeducation, increase community awareness initiatives	Lack of awareness of treatment providers, lack of treatment options for youth	Lack of awareness of available recovery resources
Anxiety, Depression, PTSD, Trauma, etc.	Isolation during pandemic, increased time spent on electronic devices & social media, past trauma, family history of mental health issues, financial hardships and stress	Youth, young adults, adults, older adults	Availability of web resources for referral to care, stigma reduction initiatives	Lack of peer to peer education programs, teen mental health first aid	Financial barriers to treatment, Increase inpatient TX options, increase women-focused tx options, lack of treatment options for those who are black or brown	Support for provider burnout,
Serious Emotional Disturbance	Isolation during pandemic, increased time spent on electronic devices & social media, past trauma, financial hardships and stress, family history of mental	Youth	Stigma reduction initiatives, access to Mental Health awareness trainings	Availability of web resources for referral to care, teen mental health first aid	Increase inpatient options, increase inpatient TX options, Collaboration among emergency responders and mental health providers to	Support for provider burnout, Peer outreach and engagement, step-down treatment options from residential

	health issues				decrease repeat emergency response use and increase a sense of efficacy	
Early Serious Mental Illness	Trauma, financial hardships and stress, family history of mental health issues	Youth, young adults with trauma history	Stigma reduction initiatives, promotion of first episode psychosis treatment in urban region	Availability of web resources for referral to care, teen mental health first aid	Financial barriers to treatment, Collaboration among emergency responders and mental health providers to decrease repeat emergency response use and increase a sense of efficacy	Peer outreach and engagement, step-down treatment options from residential
Serious Mental Illness	Co-occurring D/O, financial hardships and stress, family history of mental health issues	Adults	Stigma reduction initiatives, promotion of in-patient and out-patient care resources in region via social media	Increase resource awareness, increase initiatives to resource accessibility	Financial barriers to treatment, Collaboration among emergency responders and mental health providers to decrease repeat emergency response use and increase a sense of efficacy, Increase emergency shelter options, increase inpatient TX options, increase women-focused TX options	Support for provider burnout, step-down treatment options from residential
Suicide	Use of heroin and prescribed opioids, increased anxiety & depression at younger ages, financial hardships and stress, family history of mental	Elderly, youth, young adults, LGBTQ+, Veterans	Established community support and training in suicide prevention, increased access to staff training for educators and support staff, implementing post-vention planning within some communities	Increase local suicide advisory boards, Elderly awareness & prevention, mandated community psychoeducational resources, more training needed to address the LGBTQ+ community	Increase inpatient TX options, increase women-focused TX options, stigmatizing language about suicide, need alternatives to hospitalization	Support for provider burnout, step-down treatment options from residential

	health issues					
Other Priorities and Emerging Issues (Specify below)						

BHPSW Members 2021

Jodi Brazal	Town of East Hampton
Divinna Schmitt	Town of Old Saybrook
Melissa Ferrara	resident
Kelly Edwards	Clinton YFS
Alfred D'Arena	resident
Heather McNeil	Old Saybrook YFS
Krystle Blake	Rushford
Erika Skoutas	Hartford Healthcare
Bob Lisi	Ansonia Youth Services
Silvia Rodriguez	Shelton Youth Services
Nancy Phund	Woodbridge Youth and
John Saccu	Derby Youth and Family
Cathy Kellitt	Griffin Health Services
Lt. David Emmerman	East Haven Police Dept.
Joe Lucella	Shelton EMS
Robert Lawlor	HIDTA
Erin Marino	Hill Health
Rayna Salemne	Parish Nurse
Julia Marakarian	Parent
Jeremey Brewer	Hamden Police
Tony Corniello	BHcare
Patricia Tarasovic	APW member
Kara Spevulda	QVHD
Carissa Casserta	NHVD

2020 Connecticut Community Readiness Survey Results: Region 2 South Central Alliance for Prevention and Wellness

Developed by the Department of Mental Health and Addiction Services
Center for Prevention Evaluation and Statistics at UConn Health
August, 2020



**CONNECTICUT
Clearinghouse**
a program of the Connecticut Center
for Prevention, Wellness and Recovery



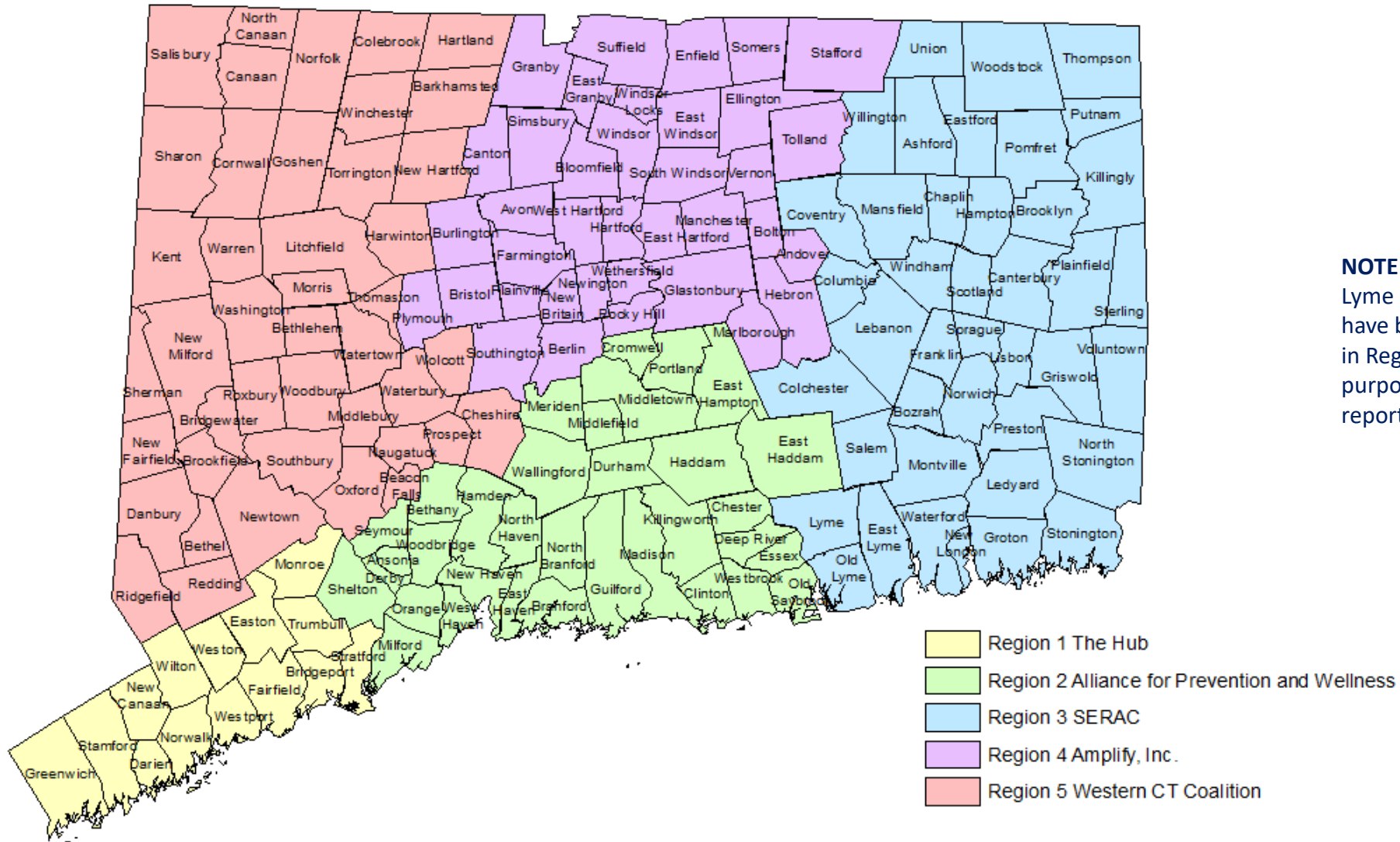
Connecticut Community Readiness Survey (CRS) Objectives

- Assess perceived substance use problems at the local level;
- Measure community readiness for substance abuse prevention:
 - Community attitudes about alcohol and drug use, mental health promotion, and suicide and problem gambling prevention;
 - Community support for prevention;
 - Availability and perceived effectiveness of prevention strategies;
 - Perceived barriers to substance abuse prevention;
 - Use of data for substance abuse prevention;
 - Rating of community readiness;
- Develop a tool and methodology that DMHAS can use for ongoing needs assessment;
- Inform substance abuse prevention planning and mental health promotion at state and regional levels;
- Identify needs for training and technical assistance;
- Provide data to evaluate the impact of SPF-based initiatives.

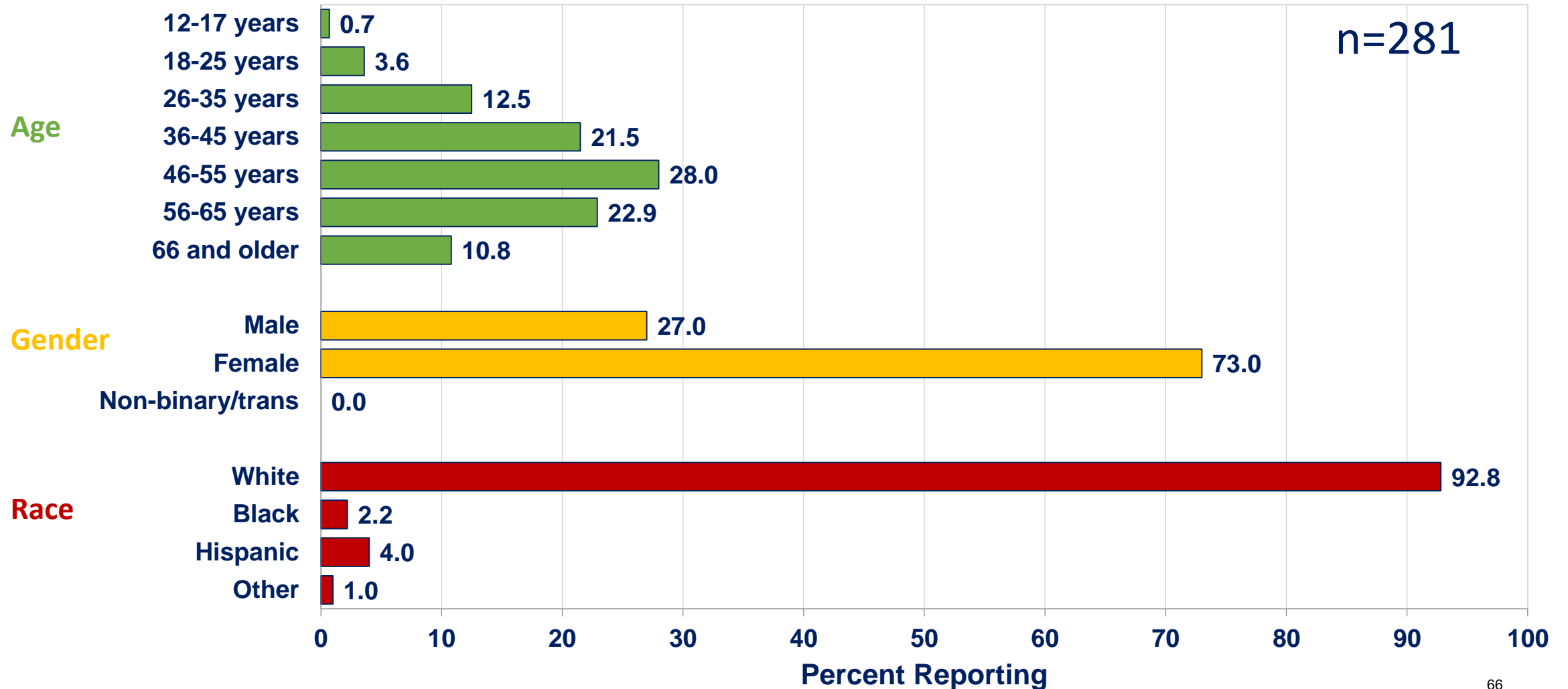
Connecticut Community Readiness Survey (CRS) Approach

- Instrument developed through a consensus process involving DMHAS, its Resource Links, State Advisory Committee and UConn Health;
- Administered biannually statewide since 2006;
- Web-based survey implementation supplemented by paper surveys ;
- CT Clearinghouse coordinates e-mail distribution of the survey;
- Regional Behavioral Health Action Organizations (formerly Regional Action Councils) identify 5-10 key informants per town/city to survey;
- RBHAOs conduct active outreach and follow up with key informants to encourage participation and maximize responses;
- Data analysis by the DMHAS Center for Prevention Evaluation and Statistics at UConn Health;
- State and regional results are disseminated to RBHAOs to support planning;
- This approach resulted in **1236** responses to the 2020 CRS survey statewide, a **60%** response rate based on the established key informant survey sample, with representation in **166** of 169 Connecticut communities.

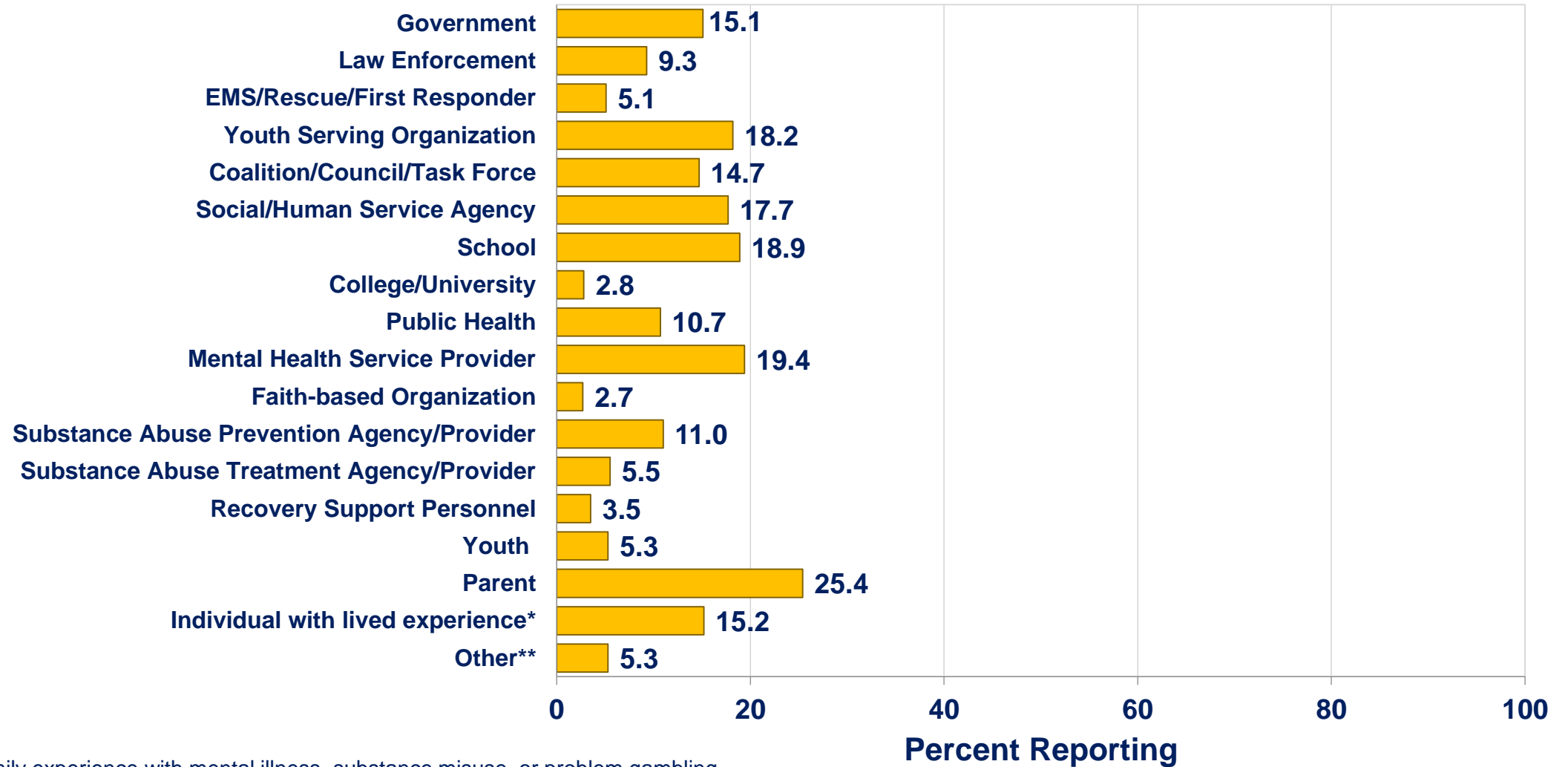
DMHAS Regional Behavioral Health Action Organizations (RBHAOs)



Key Informant Demographic Characteristics: APW CRS, 2020



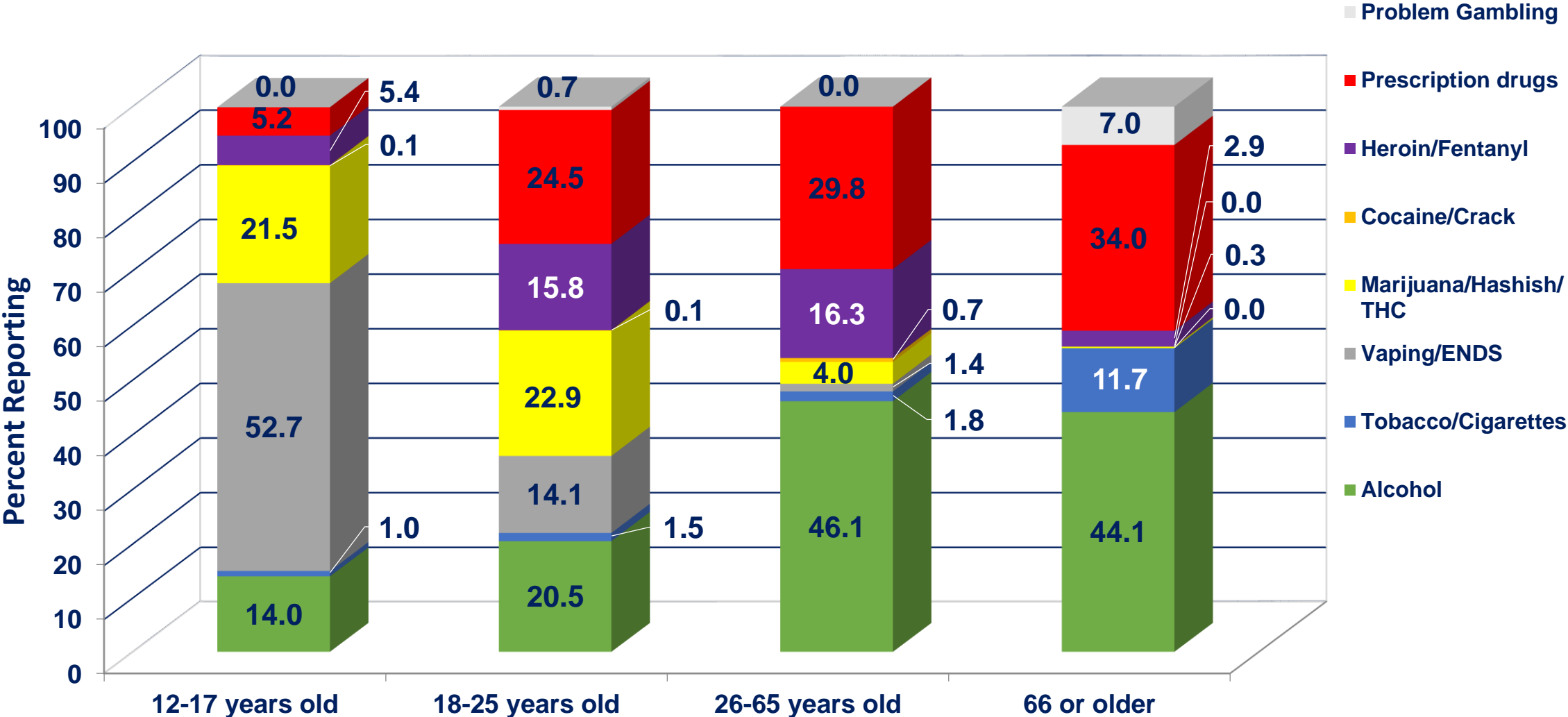
Key Informant Stakeholder Affiliation: APW CRS, 2020



* Personal or family experience with mental illness, substance misuse, or problem gambling

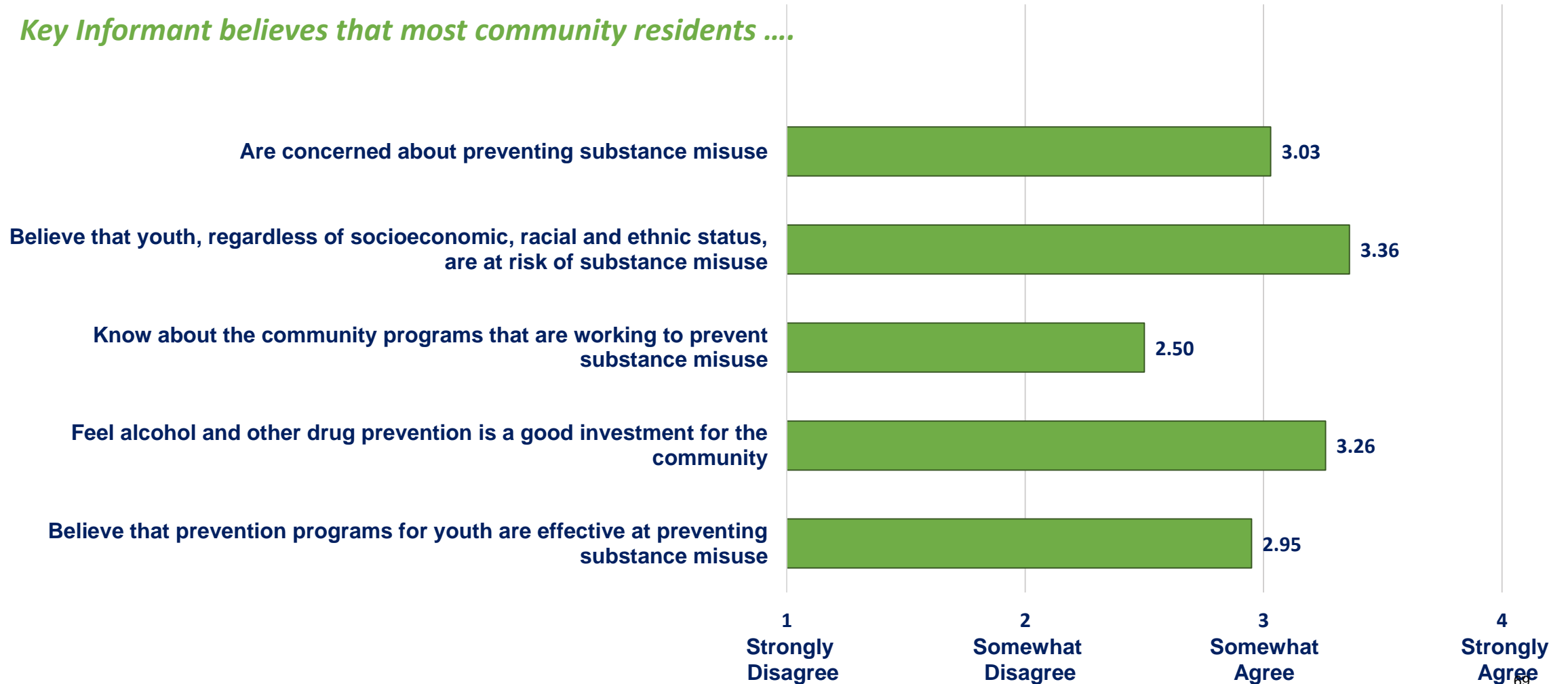
** Includes: advocate, community member, municipality, philanthropic organization, non-profit, business

Problem Substances of Greatest Concern for Age Groups, According to Key Informants: APW CRS, 2020



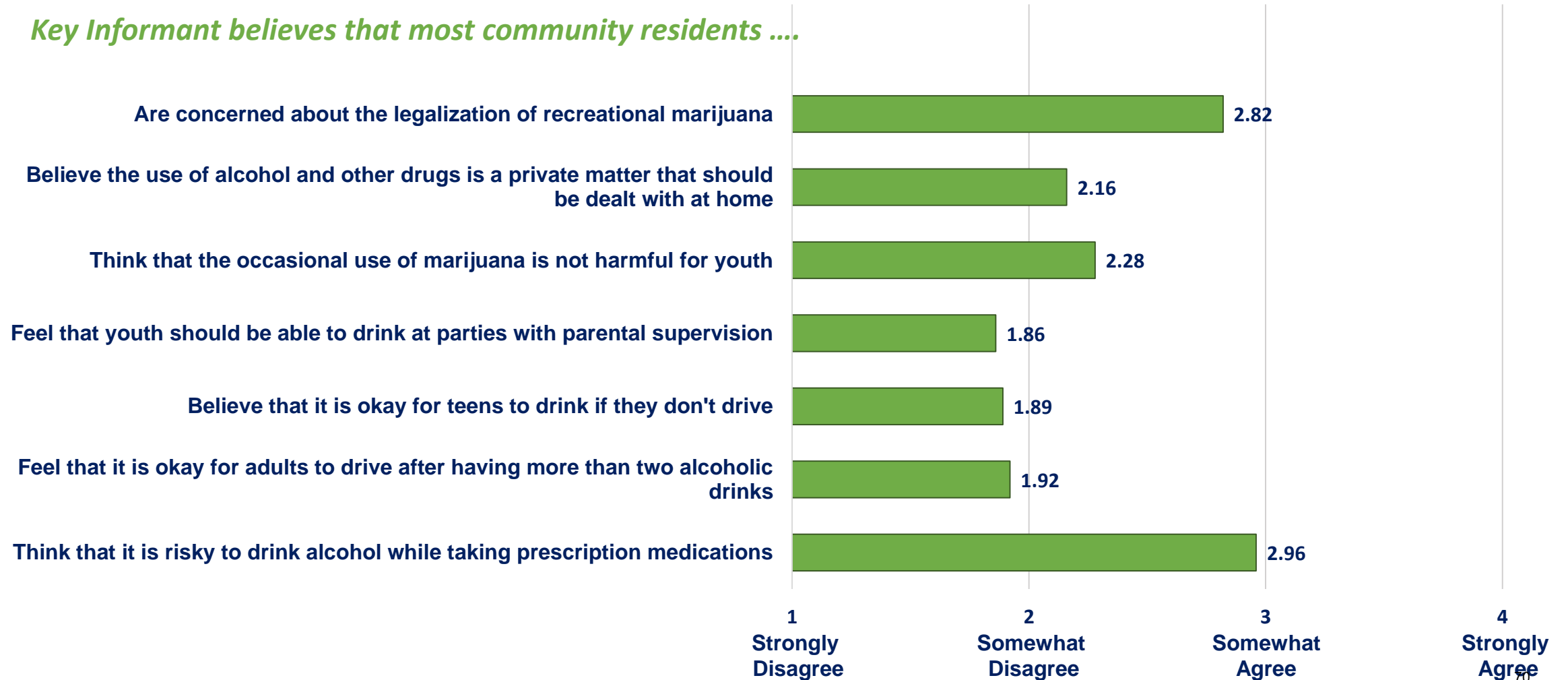
Community Attitudes Toward Substance Misuse Prevention [Q14]: APW CRS, 2020

Key Informant believes that most community residents

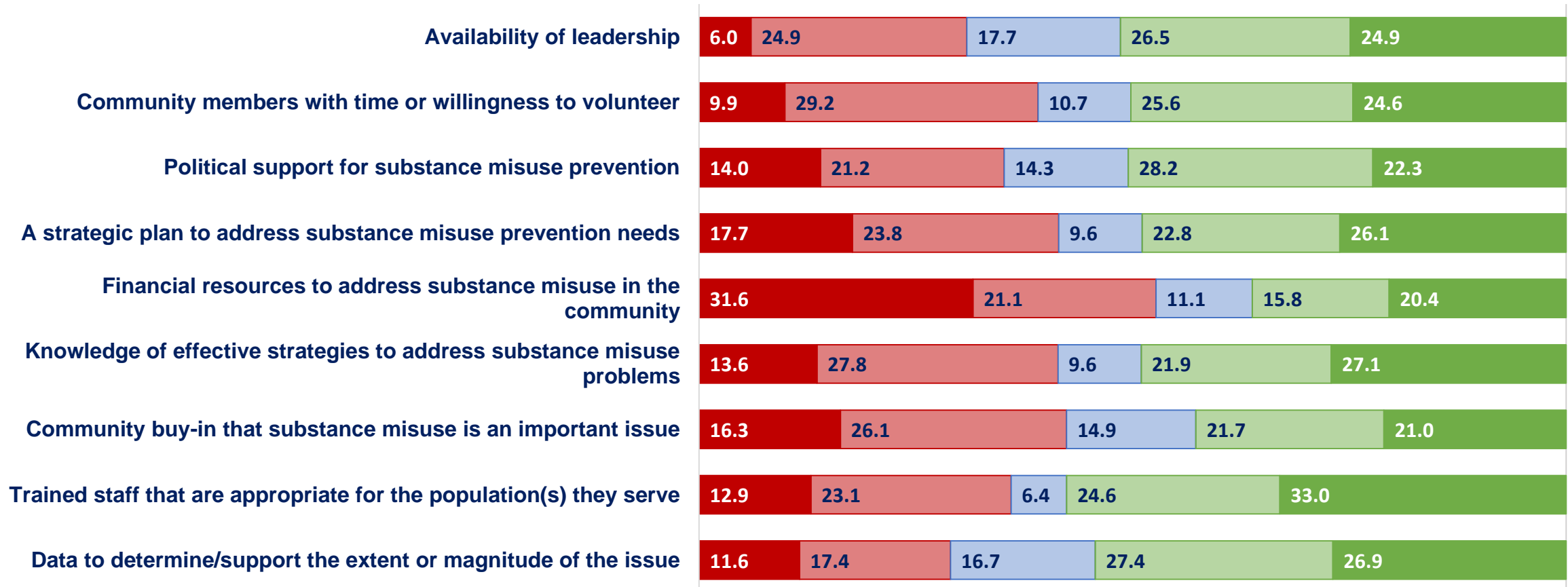


Community Attitudes Toward Substance Use [Q14]: APW CRS, 2020

Key Informant believes that most community residents



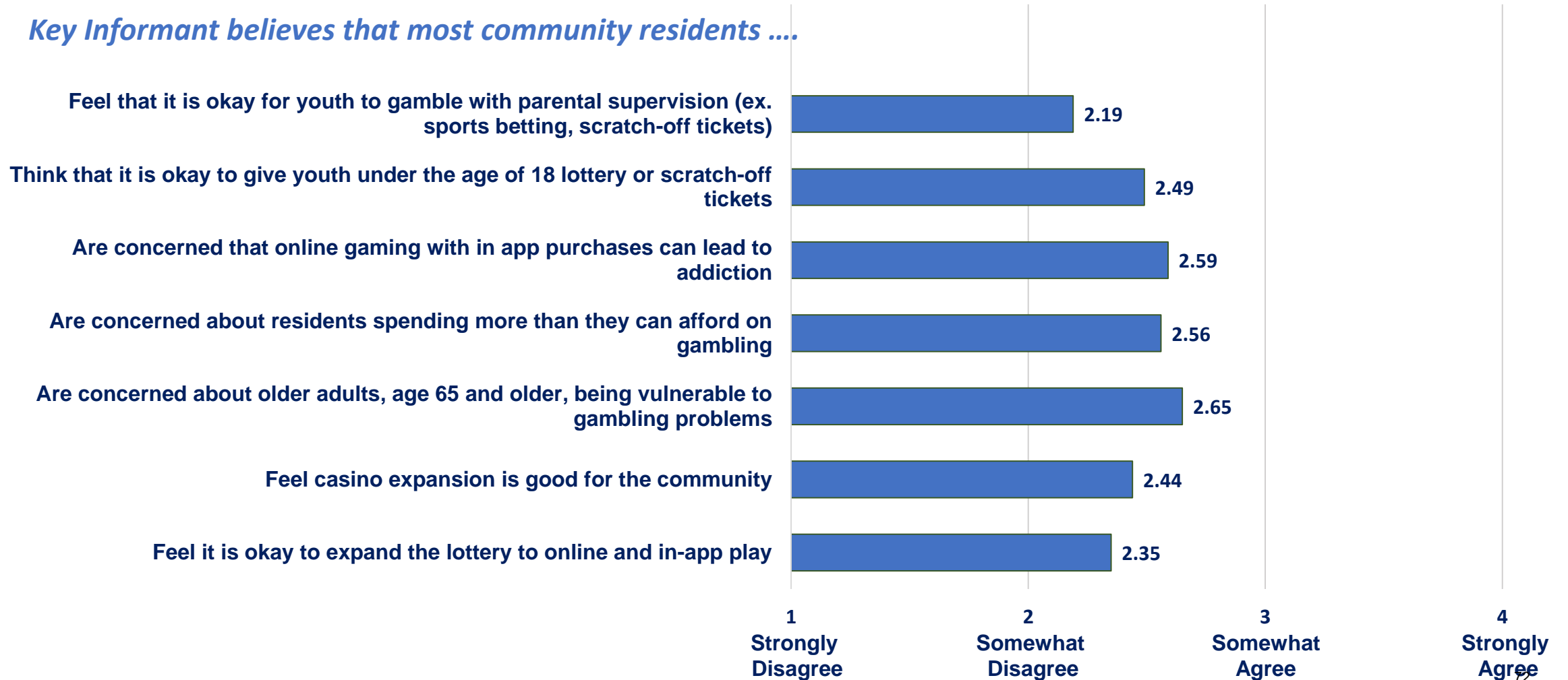
Perceived Barriers/Assets to Substance Misuse Prevention Activities in the Community [Q17]: APW CRS, 2020



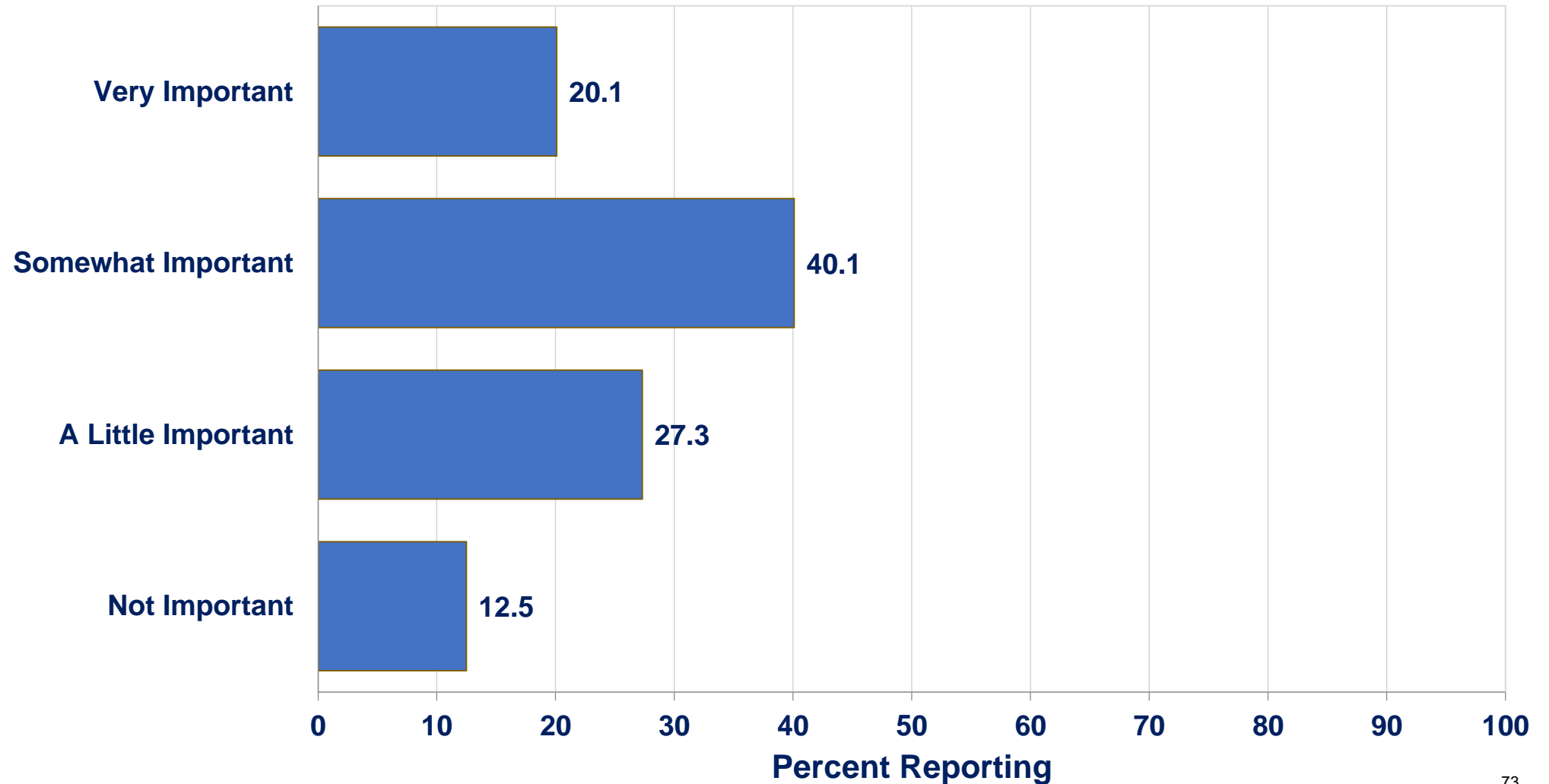
■ A Great Barrier
 ■ A Moderate Barrier
 ■ Neither a Barrier nor an Asset
 ■ A Moderate Asset
 ■ A Great Asset

Community Attitudes Toward Gambling and Gaming [Q16]: APW CRS, 2020

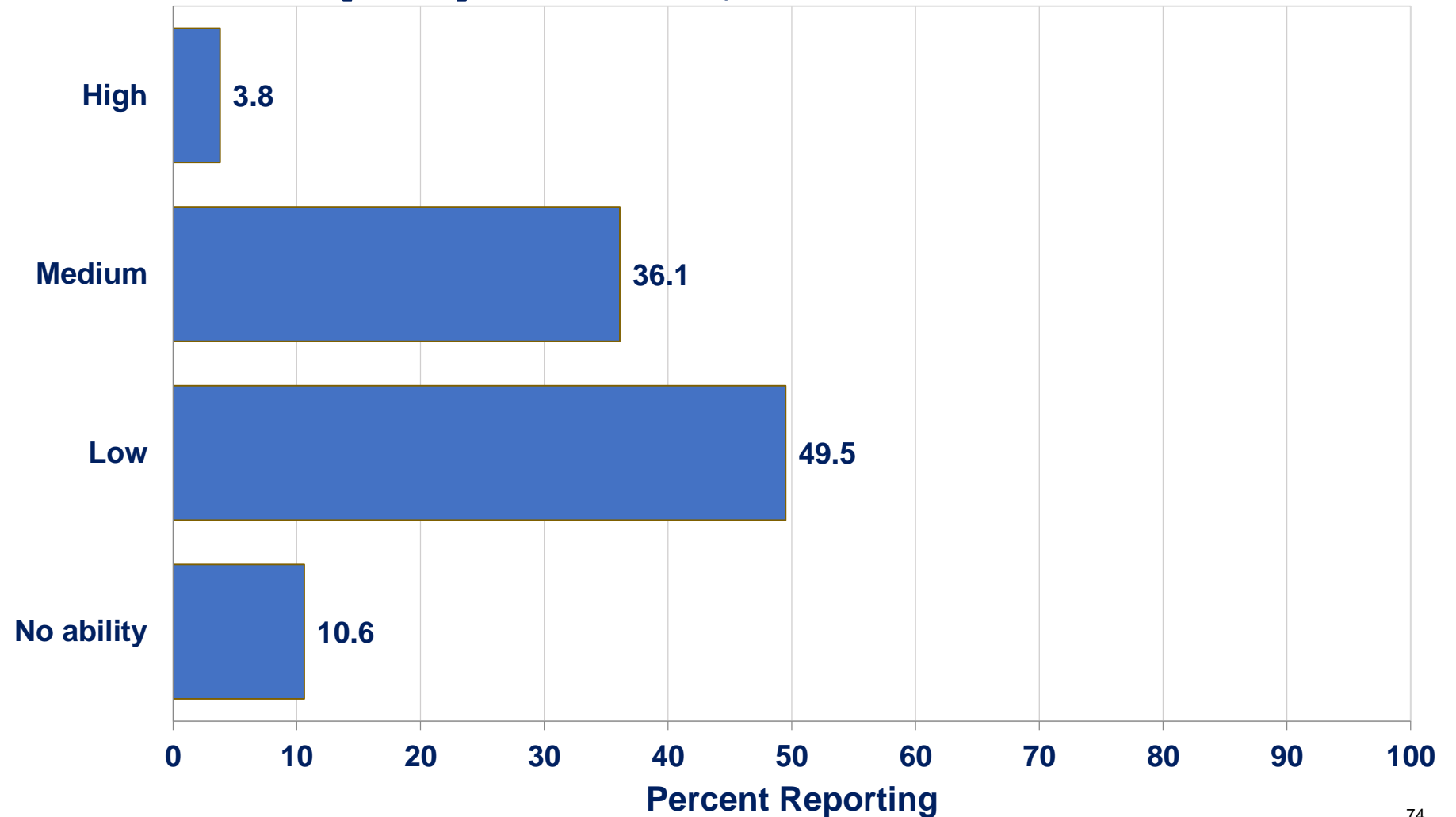
Key Informant believes that most community residents



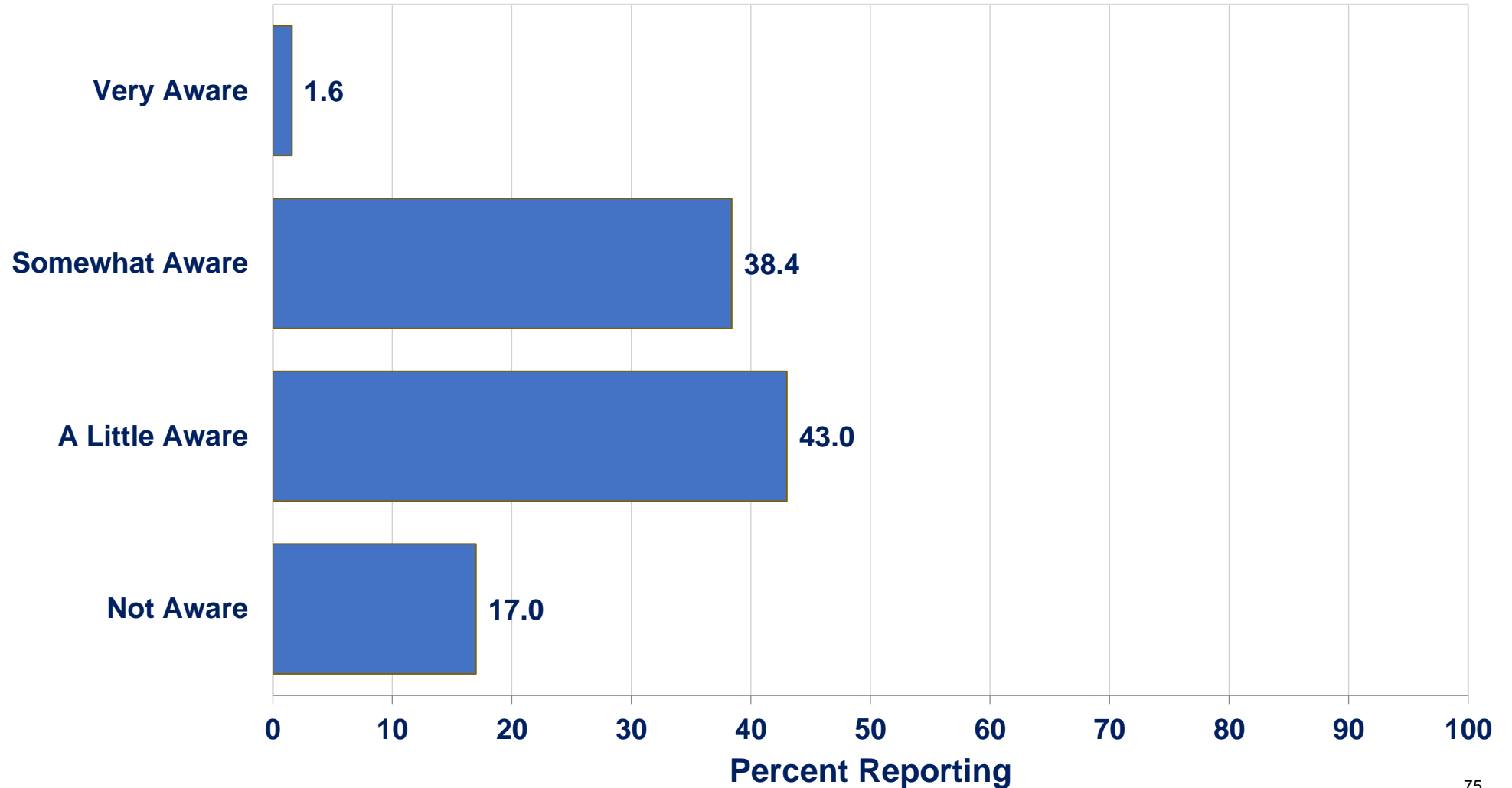
How important is it to prevent problem gambling/gaming addiction in your community? [Q19]: APW CRS, 2020



How would you rate your community's ability to raise awareness about the risks of problem gambling/gaming addiction? [Q20]: APW CRS, 2020

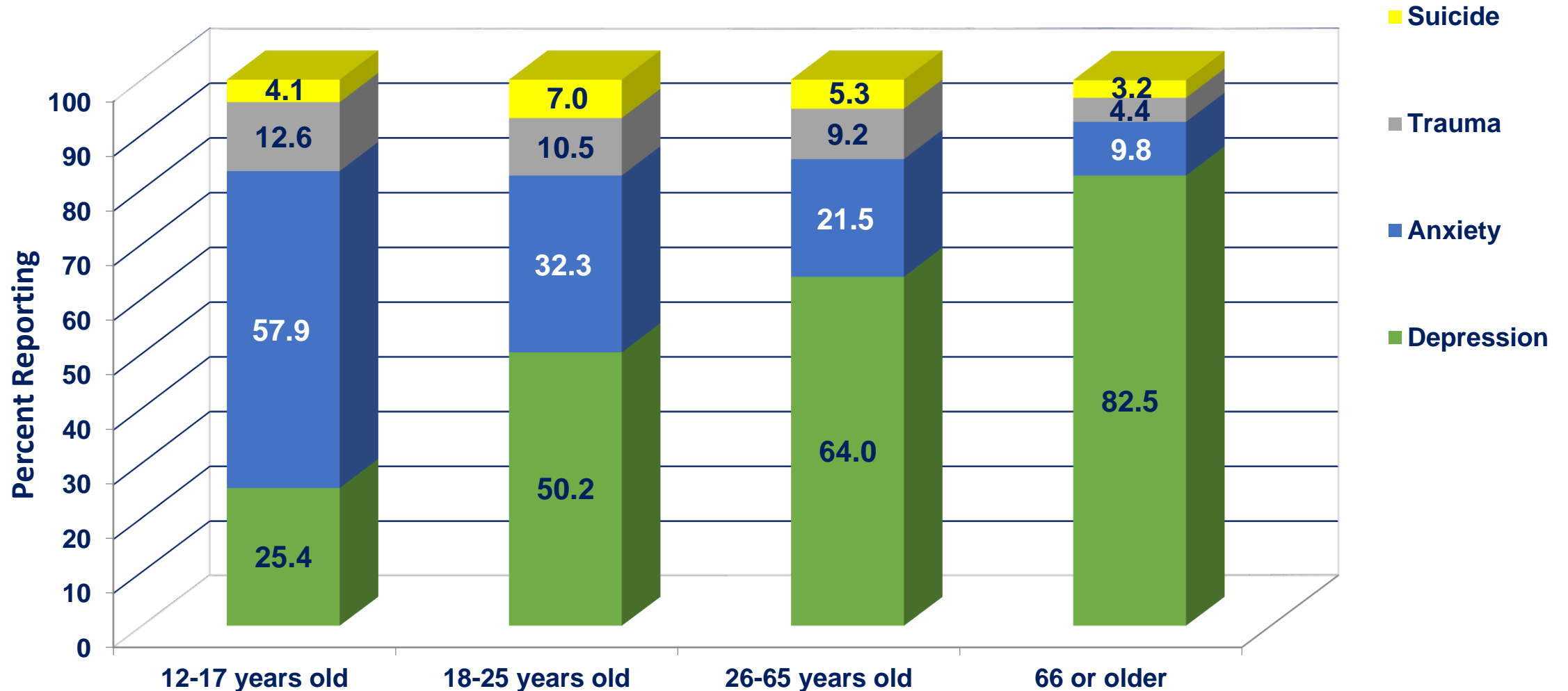


How aware are community residents that gambling activities* can become an addiction for some people? [Q21]: APW CRS, 2020



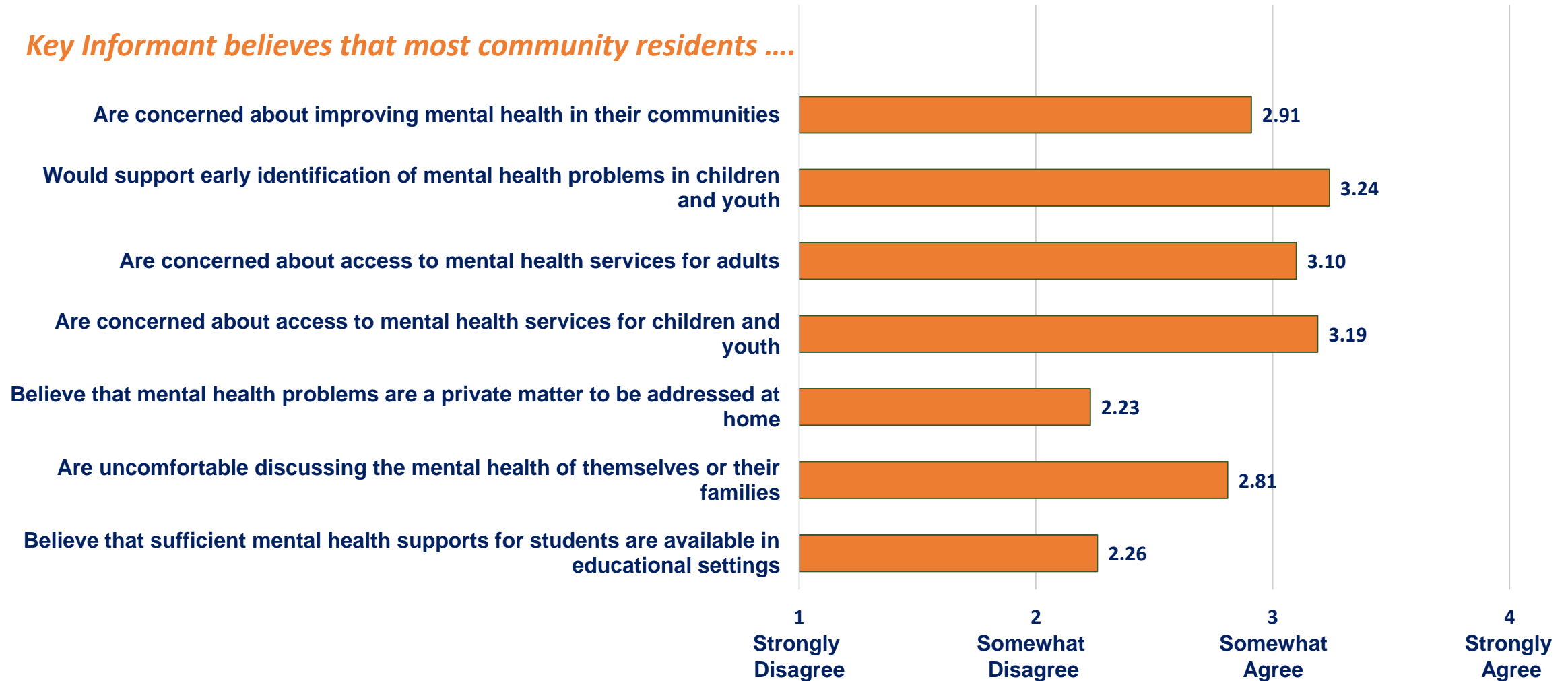
*e.g. scratch-off tickets, sports betting, Keno, casino games, dice, cards, etc.

Mental Health Issue of Greatest Concern for Age Groups, According to Key Informants: APW CRS, 2020

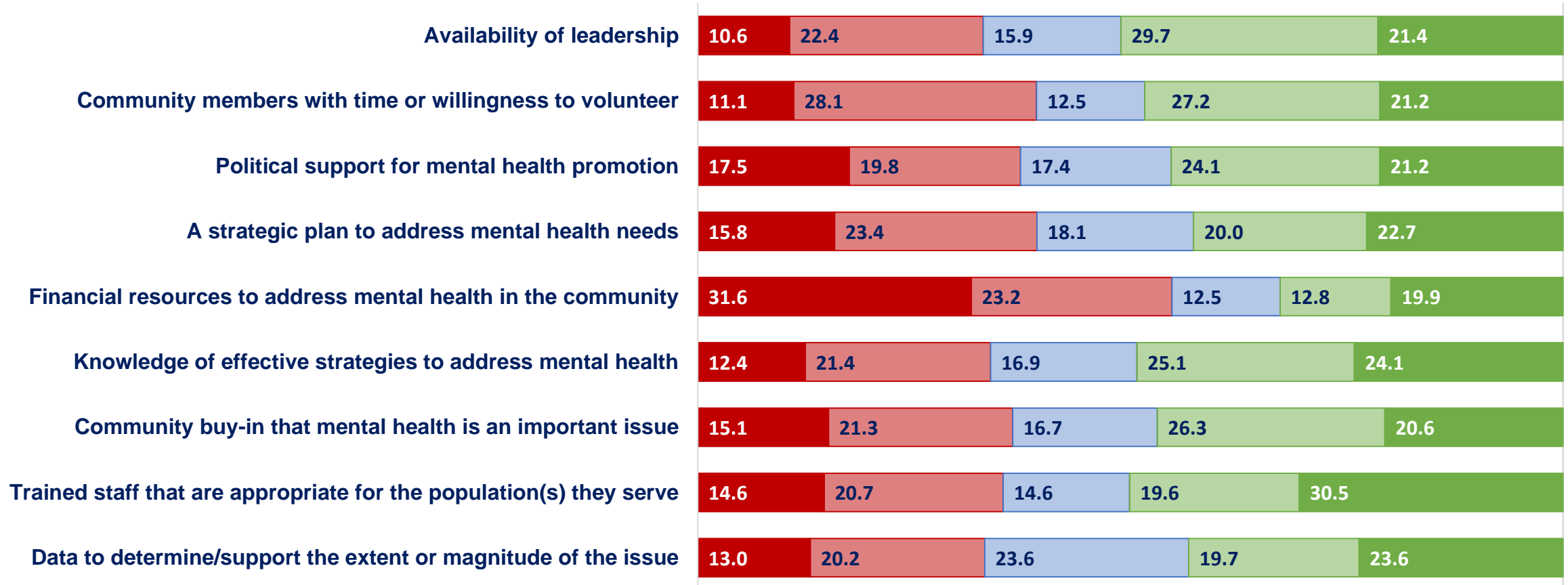


Community Attitudes Toward Mental Health [Q15]: APW CRS, 2020

Key Informant believes that most community residents

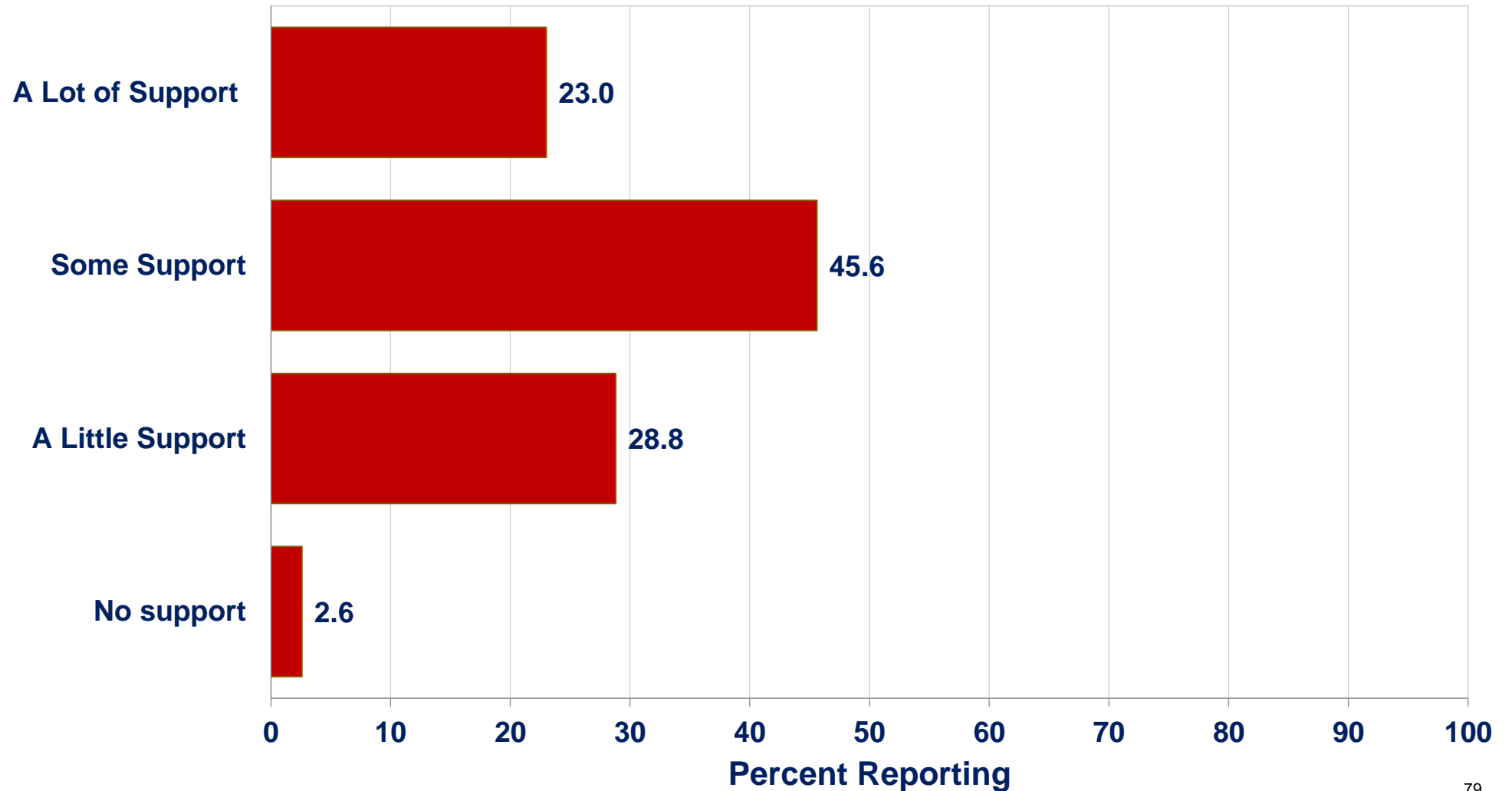


Perceived Barriers/Assets to Mental Health Promotion Activities in the Community [Q18]: APW CRS, 2020

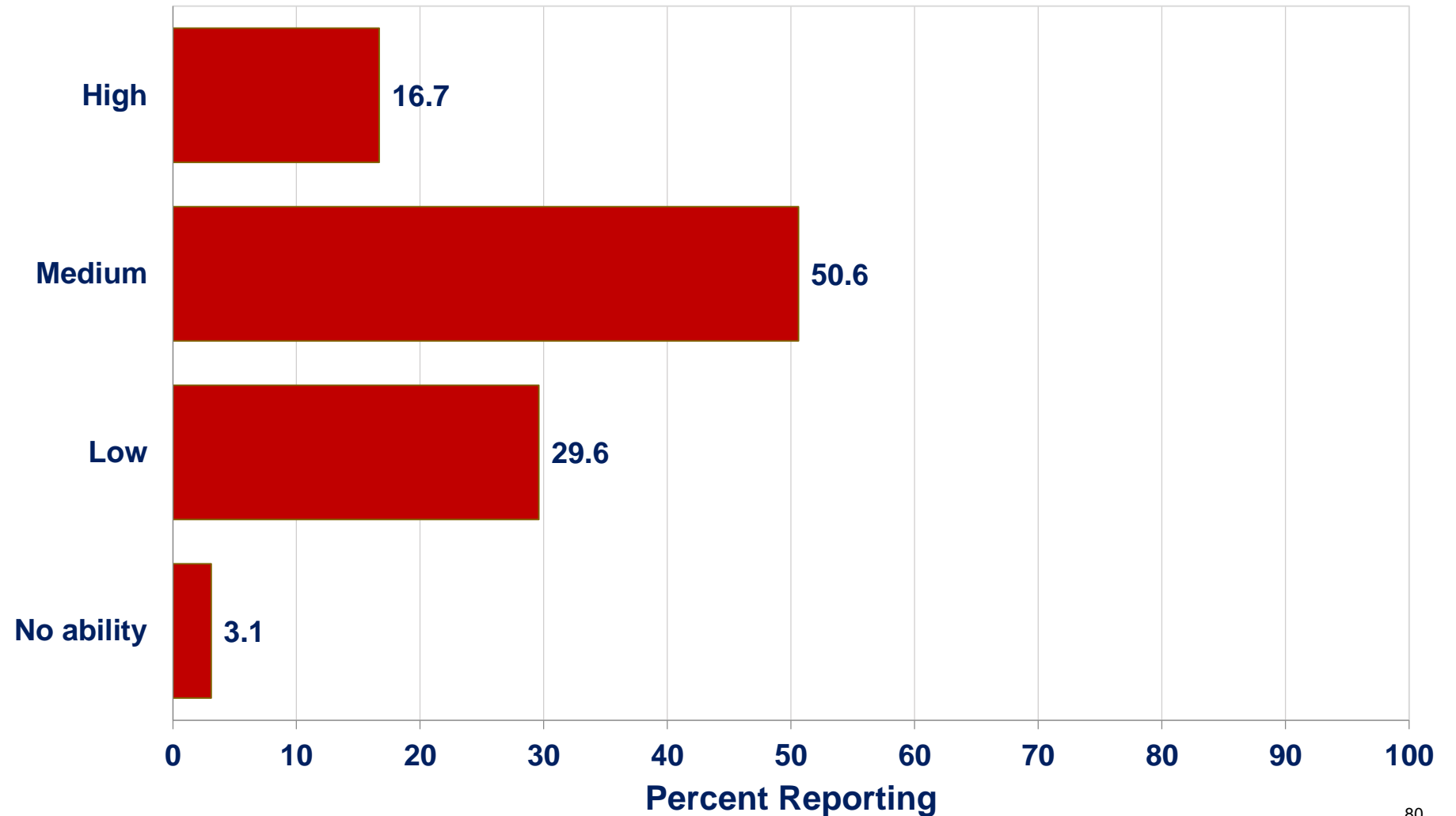


■ A Great Barrier
 ■ A Moderate Barrier
 ■ Neither a Barrier nor an Asset
 ■ A Moderate Asset
 ■ A Great Asset

In your opinion, how much community support is there for suicide prevention efforts? [Q22]: APW CRS, 2020

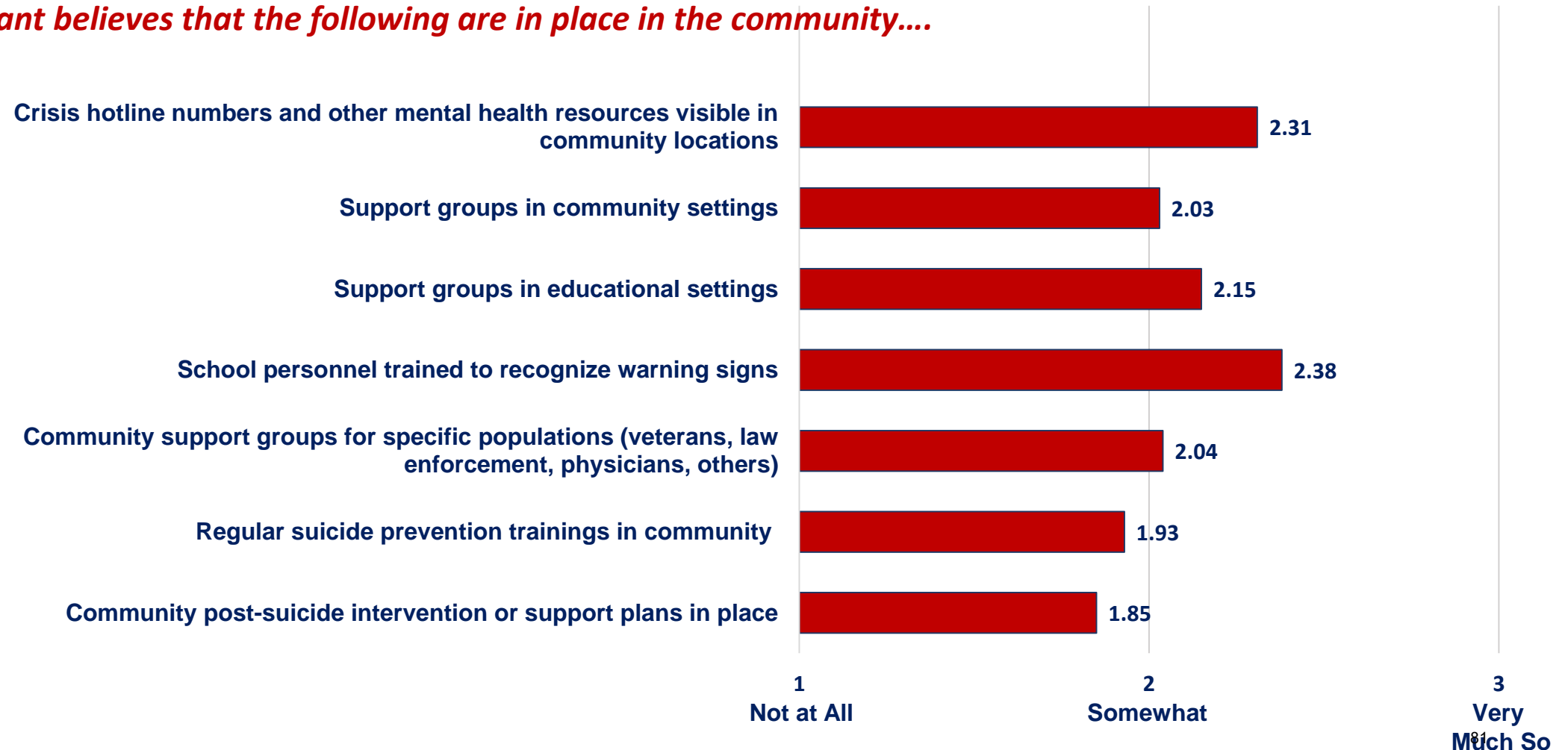


How would you rate your community's ability to implement suicide prevention efforts? [Q23]: APW CRS, 2020



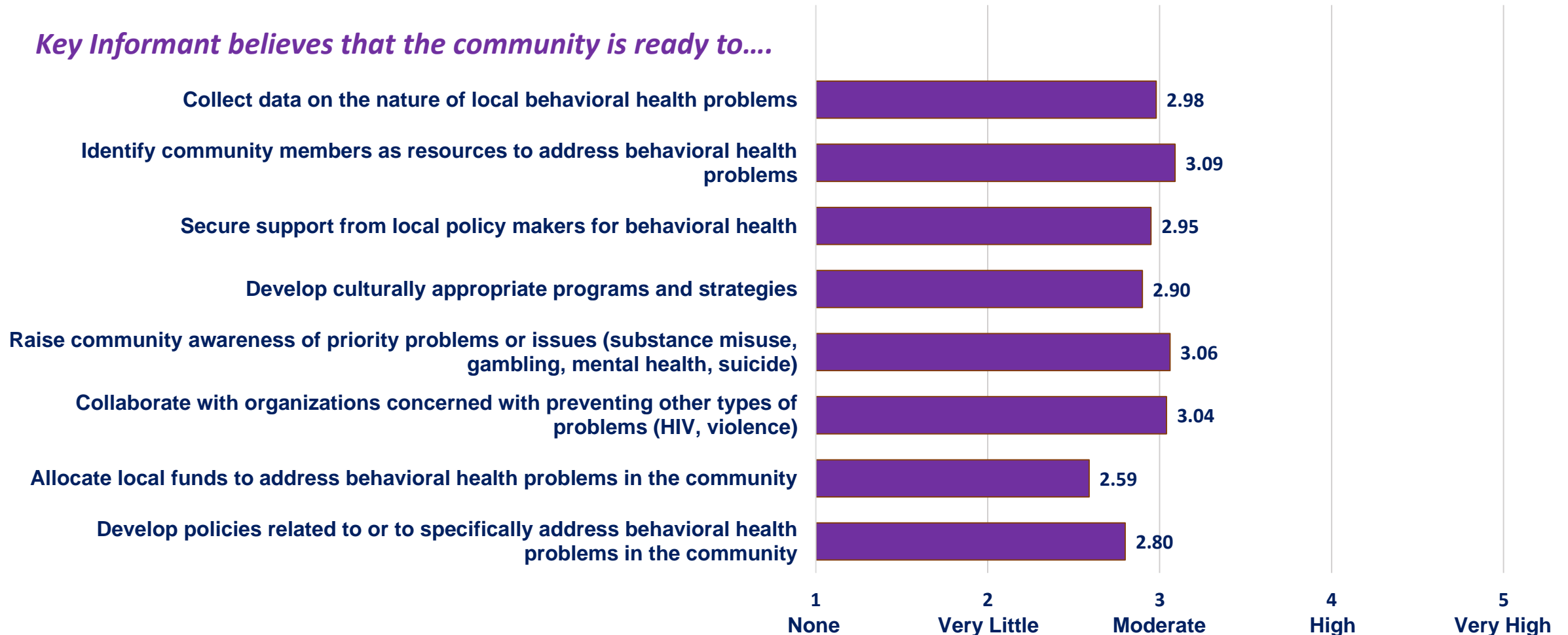
Suicide Prevention Supports in Place in the Community [Q24]: APW CRS, 2020

Key Informant believes that the following are in place in the community....



Community Readiness to Undertake Behavioral Health Promotion Activities* [Q25]: APW CRS, 2020

Key Informant believes that the community is ready to....



*Behavioral Health Promotion Activities includes substance misuse prevention and mental health promotion activities.

Key Informant Ratings of the Community Stage of Readiness for Substance Misuse Prevention [Q26]: APW CRS, 2020

Community Stage of Readiness for Substance Misuse Prevention: APW (n=176)	Percent
1 - This town/city tolerates or encourages substance misuse.	0.0
2 - This town/city has little or no recognition of the substance misuse problem.	6.4
3 - This town/city believes that there is a substance misuse problem, but awareness of the issue is only linked to one or two incidents involving substance misuse.	7.4
4 - This town/city recognizes the substance misuse problem and leaders on the issue are identifiable, but little planning has been done to address problems and risk factors.	24.1
5 - This town/city is planning for substance misuse prevention and focuses on practical details, including seeking funds for prevention efforts.	21.5
6 - This town/city has enough information to justify a substance misuse prevention program and there is great enthusiasm for the initiative as it begins.	3.5
7 - This town/city has created policies and/or more than one substance misuse prevention program is running with financial support and trained staff.	11.3
8 - This town/city views standard substance misuse programs as valuable, new programs are being developed to reach out to at-risk populations and there is ongoing sophisticated evaluation of current efforts.	16.4
9 - This town/city has detailed and sophisticated knowledge of prevalence, risk factors, and substance misuse program effectiveness and the programming is tailored by trained staff to address risk factors within the community.	9.5
Mean Stage of Readiness for APW	5.55
Mean Stage of Readiness for Connecticut	5.37

Key Informant Ratings of the Community Stage of Readiness for Mental Health Promotion [Q27]: APW CRS, 2020

Community Stage of Readiness for Mental Health Promotion: APW (n=178)	Percent
1 - This town/city is unsupportive of those with mental health issues.	0.1
2 - This town/city has little or no recognition of the community's concern about mental health.	9.0
3 - This town/city believes that mental health concerns impact the community, but awareness of the issue is only linked to one or two situations involving mental health.	11.5
4 - This town/city recognizes the mental health concerns of the community and leaders on the issue are identifiable, but little planning has been done to address problems and risk factors.	30.7
5 - This town/city is planning for mental health promotion programs and focuses on practical details, including seeking funds for awareness efforts.	14.8
6 - This town/city has enough information to justify a mental health promotion program and there is great enthusiasm for the initiative as it begins.	9.5
7 - This town/city has created policies and/or more than one mental health promotion program is running with financial support and trained staff.	8.9
8 - This town/city views standard mental health promotion programs as valuable, new programs are being developed to reach out to at-risk populations and there is ongoing sophisticated evaluation of current efforts.	8.2
9 - This town/city has detailed and sophisticated knowledge of prevalence, risk factors, and mental health promotion program effectiveness and the programming is tailored by trained staff to address risk factors within the community.	7.3
Mean Stage of Readiness for APW	5.00
Mean Stage of Readiness for Connecticut	4.88

Key Informant's Level of Knowledge of Behavioral Health Issues in their Community [Q28]: APW CRS, 2020

