PRIORITY REPORT 2022-2023

Biennial Priority Report Region 3: Eastern CT

CT Department of Mental Health and Addiction Services
Prevention and Health Promotion Division
Regional Behavioral Health Action Organizations

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Executive Summary: SERAC Region 3 Priority Report 2021-2022

Goal

The goal of the biennial priority process is to provide a thorough description of substance use, problem gambling, and mental health issues, including suicide, among the various populations and subpopulations in the region. This report provides data and information on the current prevalence rates and trends over time, where possible. The goal of this information is to assist in prevention needs assessments and gap analyses. This report defines the DMHAS Region 3 priorities, resources, assets, gaps, and subpopulations at increased risk for behavioral health issues as well recommendations on addressing these regional gaps, needs, and health disparities.

Process

During the first half of 2023, SERAC (in partnership with DMHAS and CPES) collected and reviewed regional and state data sources to create epidemiological profiles and data summary reports for community stakeholders. Qualitative interviews with key stakeholders were also conducted. Key stakeholders were identified through voluntary processes and active involvement in both regional and local initiatives across prevention, treatment, and recovery in behavioral health. In total, 12 focus groups and 15 stakeholder interviews were conducted in tandem with an online key stakeholder survey, which yielded a total of 13 responses. Overall, over 132 individuals participated in the priority report process, with individuals representing all 12 sectors included (youth, parents, business, media, religious/fraternal organizations, schools, youth serving organizations, law enforcement, healthcare professionals, state/local/tribal government, substance abuse organizations, civic/volunteer organizations) as well as at least 50% of the 41 towns SERAC serves. The data was synthesized and presented to the Regional Behavioral Health Priority Setting Workgroup (RBHPSW) to aid in their assessment of the priority issues of the region.

Regional Priorities & Key Findings

The 2023 regional priority report demonstrates the clear need to prioritize co-occurring mental health and substance use issues for future regional and local planning purposes in conjunction with a strong need to address availability and capacity of services as well as barriers to accessing care such as housing and food insecurity, transportation, childcare, and economic issues. Findings indicate that prevention, treatment, and recovery services are all suffering from a staffing and resource crisis that undermines their ability to address the demand for care within the region. In Region 3, services that lapsed or were terminated during the pandemic need to be reinstated and strategic partnerships across public service departments, such as law enforcement and behavioral health workers, need to be utilized to increase the efficacy of care. Priorities were ranked as follows:

1. Suicide
2. Heroin & Fentanyl
3. Depression
4. Alcohol; Trauma/PTSD
5. Prescription Drug Misuse
6. Serious Mental Illness Adult & Child
7. Anxiety
8. Electronic Nicotine Delivery Systems (ENDS)
9. Cannabis
10. Cocaine
11. Tobacco
12. Problem Gambling

Top recommendations in Substance Use/Misuse include:

- Prevention: Develop a regional curriculum to educate parents and community about underage cannabis and alcohol use in order to increase the perception of harm and compliance with social hosting laws.
- Treatment: Review the state policies and guidelines for patients to qualify for in-home treatment that may be too restrictive, especially for parents suffering from substance use disorders.
- Recovery: Expand options for recovery support services that provide statewide cash assistance post-treatment (90 days) for basic needs in order to stabilize individuals as they transition from treatment.

Top recommendations in Mental Health include:

- Prevention: Focus regional prevention efforts on common underlying causes of the top priority issues (suicide and fentanyl/heroin), such as depression, trauma/PTSD, and alcohol use, to have a greater impact on reducing mortality rates.
- Treatment: To address the staffing crisis, review statewide certification program requirements for mental health, addiction, and suicide prevention through the CCB to expedite the process so that more individuals enter the workforce sooner.
- Recovery: Create a statewide infrastructure to support collaboration between law enforcement and behavioral health to provide early intervention and diversionary planning for individuals at risk of overdose and suicide.

Top recommendations for Problem Gambling include:

- Prevention: Conduct a regional needs assessment to understand the prevalence of gambling/gaming problems and behaviors as well as the risk and protective factors surrounding the issue.
- Treatment: Provide youth gambling treatment services (individual and group) to address the gap in service.
- Recovery: Develop more resources for those in gambling recovery, such as putting a stop to financial collection calls for 30 days for those diagnosed with a gambling disorder.

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Regional Gambling Awareness Team
Regional Prevention/LPC Team
Regional Suicide Advisory Board
Southeastern Catchment Area Council
Three Rivers Community College
Windham PRIDE Coalition
Windham PRIDE Sociological Interns

Abbreviations:

2SLGBTQ+	Two-Spirit, Lesbian, Gay, Bisexual, Transgender, Queer or Questioning, and additional sexual orientations and gender identities
ALICE	Asset Limited Income Constrained Employed
ACEs	Adverse Childhood Experiences
CBD	Cannabidiol
CDC	Centers for Disease Control
CPES	Center for Prevention Evaluation and Statistics
CT	Connecticut
CTSHS	Connecticut School Health Survey
CRS	Community Readiness Survey
DCF	Department of Children and Families
DHHS	Department of Health and Human Services
DMHAS	Department of Mental Health and Addiction Services
DOJ	Department of Justice
DOL	Department of Labor
DPH	Department of Public Health
DPS	Department of Public Safety
DUI	Driving Under the Influence
ENDS	Electronic Nicotine Delivery System
HIV	Human Immunodeficiency Virus
LPC	Local Prevention Council
MVA	Motor Vehicle Accident
NHTSA	National Highway Transportation Safety Administration
NIDA	National Institute on Drug Abuse
NSDUH	National Survey of Drug Use and Health
PSA	Public Service Announcement
RBHAO	Regional Behavioral Health Action Organization
RBHPSW	Regional Behavioral Health Priority Setting Workgroup
SAMHSA	Substance Abuse and Mental Health Service Administration
SERAC	Southeastern Regional Action Council
SDE	State Department of Education
SEOW	State Epidemiologic and Outcomes Workgroup
SPF	Strategic Prevention Framework
THC	Tetrahydrocannabinol
US	United States
YRBSS	Youth Risk Behavior Surveillance System

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Introduction

Background:

SERAC is one of five Regional Behavioral Health Action Organizations (RBHAO) that work toward the promotion of mental health and the prevention of suicide, substance use and problem gambling in Connecticut. SERAC serves CT DMHAS Region 3 which includes the following 41 communities located in Eastern Connecticut: Ashford, Bozrah, Brooklyn, Canterbury, Chaplin, Colchester, Columbia, Coventry, East Lyme, Eastford, Franklin, Griswold, Groton, Hampton, Killingly, Lebanon, Ledyard, Lisbon, Lyme, Mansfield, Montville, New London, North Stonington, Norwich, Old Lyme, Plainfield, Pomfret, Preston, Putnam, Salem, Scotland, Sprague, Sterling, Stonington, Thompson, Union, Voluntown, Waterford, Willington, Windham and Woodstock.

Since 2004, DMHAS has utilized the United States Substance Abuse and Mental Health Service Administration's (SAMHSA) Strategic Prevention Framework (SPF) at the state, regional, and community levels. The SPF is a five-step, data-driven process known to promote youth development and prevent problem behaviors across the life span. SERAC has completed this Priority Report with assistance from community members in support of the DMHAS SPF process to facilitate a data driven analysis of the magnitude, impact, changeability, capacity, and consequence of inaction of several priority issues of concern in Connecticut and in Region 3. The core issues related to substance use are identified by DMHAS as alcohol, tobacco, electronic nicotine delivery system (ENDS), prescription drug misuse, cannabis, heroin and fentanyl, and cocaine. Gambling disorders are also a key area of focus identified by DMHAS in partnership with CT Problem Gambling Services. The issues related to mental health are identified as anxiety, depression, trauma/posttraumatic stress disorder, serious mental illness in children, serious mental illness in adults. Suicide prevention and postvention are also identified by DMHAS in partnership with Department of Children and Families, under the scope of Regional Suicide Advisory Boards and the CT State Advisory Board.

Data Sources:

The data used to compile this report have been drawn from a variety of sources including the following:

- CT SEOW Prevention Data Portal
- DMHAS Community Readiness Survey 2022
- OCME Data
- CT Violent Death Reporting System
- DataHaven Community Wellbeing Survey
- SERAC Regional Youth Summary 2021-2022
- SERAC Community Survey 2022
- SERAC Key Stakeholder Survey 2023
- National & State Surveys, including: National Survey of Drug Use and Health (NSDUH)

- Youth Risk Behavior Surveillance System (YRBSS)
- Connecticut School Health Survey (CTSHS)
- DMHAS Treatment and Admission Reports
- United Way ALICE Report 2020
- Regional focus groups

Strengths and Limitations of Data:

This report attempts to summarize data collected at the national, state, and regional level. Although the data herein is as comprehensive as possible, it is not feasible to include all available data across so many complex issues. A particular strength of this report is the use of both quantitative and qualitative data to get a complete understanding of the region. Likewise, the availability of local data, such as the Regional Youth Survey and Community Survey implemented by SERAC under federal grant awards, is a unique regional strength. Although this report includes information about clinical populations, youth, parents, and other adults, there remains a gap in assessing subclinical populations regarding these issues. Local data is also very limited in the northeast corner of Region 3 because of the lack of resources and infrastructure across the continuum of care in rural communities.

Due to methodological issues related to the COVID-19 pandemic, the data included in these epidemiological profiles provide a snapshot of what is currently occurring and should not be extrapolated upon or compared to pre-pandemic data. The pandemic has introduced a historical threat to validity in that we cannot be certain how much any observed changes are due to the impact of COVID-19 rather than typical risk and protective factors. In cases when data sources were 5 or more years old, they were omitted for ranking. Approximately 19 individuals participated in the prioritization ranking process and it should be noted that they are not exclusively representative of all the populations and residents in Region 3.

Ranking Process and Report Development:

The development of this report was a multi-step process. First, the available data relevant to the statewide priorities were compiled, tabulated, and summarized in partnership with DMHAS Center for Prevention Evaluation and Statistics (CPES). Additional local data was also compiled and analyzed to give more context to Region 3, specifically. Next, a Regional Behavioral Health Priority Setting Workgroup (RBHPSW) was convened with the purpose of reviewing data for each of the statewide priorities and for ranking their importance within the region. Members for the RBHPSW were self-selected through voluntary attendance at scheduled meetings and specifically invited to participate to ensure balanced and diverse points of views. RBHPSW members were asked to review the relevant qualitative and quantitative data to prepare to rank the priority issues in Region 3.

Overall, 12 focus groups and 15 key stakeholder interviews were conducted. Focus group participants included members from local prevention councils and coalitions, catchment area councils, regional meetings, among others. Key sector community representatives ranged from business, law enforcement, school, treatment providers, youth serving organizations,

parents, and individuals with lived experience. Stakeholder and focus group questions were designed to obtain further information on risk factors, at risk sub-populations, strengths and assets, gaps and needs, and recommendations for the region or state. Additionally, a key stakeholder survey was conducted via survey monkey to reach individuals who may not have had the availability to attend a focus group. The key stakeholder survey and summary report are included as appendices in addition to the focus group question list. Results from both the survey and focus groups are included in this report. Overall, more than 132 individuals across the region participated in the priority report process through surveys, focus groups, and key stakeholder interviews.

In developing their rankings, RBHPSW members were asked to consider not only the sheer magnitude of individual issues but also the impact, changeability, community readiness, and consequences of inaction associated with each issue. All responses were collected, and mean rank scores were compiled for all the issues across substance use, problem gambling, mental health, and suicide. The final report was compiled by SERAC's Epidemiologist, Jennika Jenkins, and the Executive Director, Angela Duhaime.

Region 3 Priority Report

Description of the Region

According to the American Community Survey (Census Bureau, 2021) 5-year estimate the total population in the towns served by SERAC is approximately 426,026 residents. In Region 3, 77% of the population self-identify as White non-Hispanic, 4% as Black non-Hispanic, 4% as Asian non-Hispanic, and 11% self-identify as Hispanic or Latino of any race. Towns with the highest proportion of Hispanic population are Windham (40.5%), New London (33.8%), Norwich (18.8%), Groton (13.1%), and Chaplin (9.5%). The proportion of Black non-Hispanic population is highest in New London (13.1%), Norwich (10.2%), Montville (7.1%), and Groton (5.9%); Asian non- Hispanic— in Mansfield (11.4%), East Lyme (7.7%), Willington (7.1%), and Groton (7%).

Approximately 19% of the population are youth aged 0–17 and 17% are elderly (aged 65+). Towns with the highest proportion of young people are Ledyard (25.8%), Sterling (25.4%), Lisbon (24.4%), and Franklin (23.6%). In Region 3, North Stonington (24.7%), East Lyme (23.8%), and Union (23%) have the highest proportion of the elderly (65+) population.

Median household income in Region 3 varies from $45,388 in Mansfield to $113,983 in Columbia. Some of richest towns are Salem ($108,953), Colchester ($104,527), East Lyme ($98,987) and Eastford ($98,000). Towns with the lowest median household income are Mansfield ($45,388), Windham ($49,528) and New London ($50,819). According to the most recent ALICE Report (2020) six communities are experiencing a 30%-54% population struggle to afford basic needs in northeastern CT. In southeastern CT, four communities are experiencing a 35%- 57% rate. The ALICE Threshold assesses the percentage of households that earn more than the Federal Poverty Level but less than the basic cost of living. In southeastern CT, 67% of households are above the ALICE threshold and 65% within the northeast subregion.

According to the CT Office of Rural Health (2014) 25 towns out of 39 are considered rural. Resources vary across the region and are often shared among small towns. The southern subregion has more resources available for behavioral health including treatment providers, law enforcement, and youth serving organizations. The current infrastructure across the region varies from fully organized local prevention councils and coalitions that have been in existence for 10 or more years to newly organizing and developing advisory groups. There are also regional efforts to address substance use and mental health issues coordinated by local hospitals and health districts.

2022 Region 3 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 2021 National Household Survey of Drug Use and Health (NSDUH), Connecticut has the 5th highest prevalence of current alcohol use (56.3%) compared to other states in the U.S., higher than the national prevalence (47.6%)[1].

Magnitude (prevalence)

Overall, 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 59.4% in 2009-2010 and 56.3% in 2021. However, consistent with the national trend, underage drinking in Connecticut among 12 to 17-year-olds decreased significantly, from 17.8% in 2009-2010 to 7.0% in 2021.

In 2021, young adults in Connecticut ages 18-25 have the second highest rate of reported past month alcohol use (58.5%), preceded by those aged 26 or older (61.4%). In Region 3, 28.83% of those under 21 report having used alcohol in the past month (2016-2018).

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 (29.3%), followed by adults ages 26 or older (20.3%), and youth ages 12-17 (3.6%).[1]

NSDUH Substate Estimates:

Percent Reporting Past Month Use, ages 12+

	CT	Region 1	Region 2	Region 3	Region 4	Region 5
2016-2018	60.6	61.5	59.4	58.3	63.0	59.0

Note. Substate estimates are not available for 2021 due to methodological differences as a result of the COVID-19 pandemic

[1] NSDUH *2021 data should not be compared with previous years data due to methodological differences as a result of the COVID-19 pandemic

Percent Reporting Past Month Binge Drinking, ages 12+

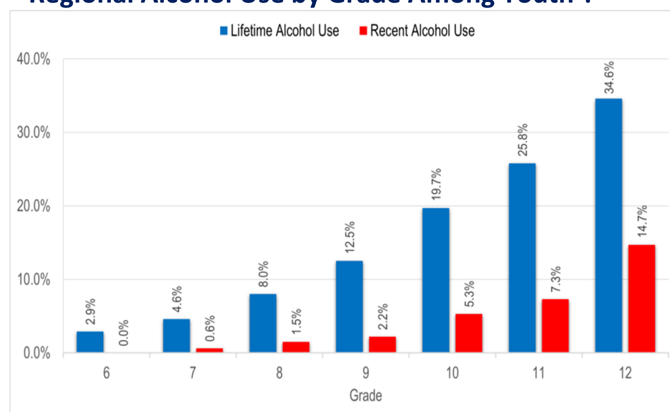
	CT	Region 1	Region 2	Region 3	Region 4	Region 5
2016-2018	26.8	28.0	26.8	27.5	26.1	26.0

2021 Connecticut School Health Survey (YRBS): 17.5% of high school students reported using alcohol in the past month and 7.0% reported binge drinking** in the past month[2].

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

SERAC Youth Survey Regional Summary 2021-2022 Estimates:

Regional Alcohol Use by Grade Among Youth[3]:



Alcohol Use Rates 2021-2022[3]

- Lifetime Use
  - 16.6% of youth report ever having used alcohol in their lifetime.
- Recent Use
  - 4.8% of youth report having used alcohol in the past 30 days.

While alcohol trends have shown a decrease over the past 15 years and cannabis has shown a slight increase in recent years, this dataset is largely limited to the southeast region (67% of responses). Data is extremely limited in the northeast corner. The pandemic-related barriers to data collection in 2020 create a gap year where it is difficult to determine trend over point in time data.

2022 Region 3 Epidemiological Profile: Alcohol

Risk Factors and Subpopulations at Risk

- Young people who drink are more likely than adults to report being binge drinkers.[4]
- Men are more likely than women to be heavy drinkers.[5]
- 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.[6]
- Individuals with mental health disorders are about four times more likely to be heavy alcohol users.[7]
- Native Americans are at especially high risk of alcohol-related traffic accidents, DUI and premature deaths associated with alcohol misuse.[8]
- While Hispanics have higher rates of abstinence from alcohol, those who do drink often have higher rates of binge drinking.[9]
- 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;
  - Social norms that encourage or tolerate underage drinking[11]

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
2018-2020	44.8	46.2	45.5	42.0	44.4	45.0

The 2021 Connecticut School Health Survey shows high school females were more likely than males to report past month drinking (21.2% and 14.2%, respectively) and binge drinking (8.5% vs 5.6%). Non-Hispanic whites had the highest prevalence of past month drinking (22.4%) and binge drinking (10.3%).[2] Reports of Hispanics and Blacks past month drinking (13.7% and 12.1% respectively) were similar between the two groups.[2]

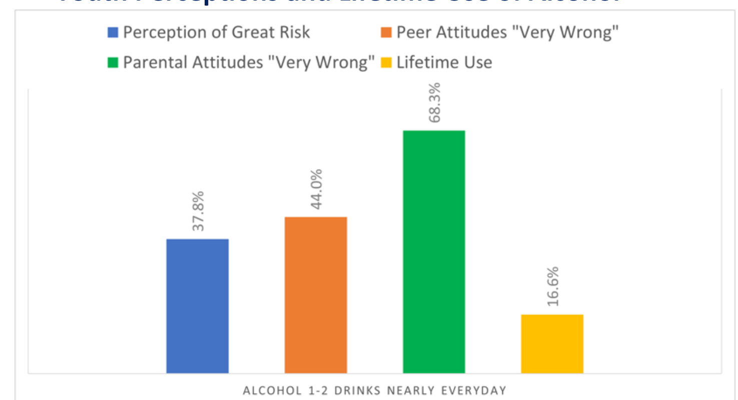
SERAC Youth Survey Regional Summary 2021-2022[3]

- About 38% of youth report that it is a **great risk** to drink one or two drinks of alcohol nearly every day.
- About 56% of youth report that it is **definitely true** that their family has clear rules discouraging their use of alcohol.
- Only about 44% of youth feel that their friends think it would be **very wrong** for them to drink alcohol nearly every day.
- 18% of youth **neither approve nor disapprove** of someone their age having one or two drinks of an alcoholic beverage nearly every day.

Among youth who do report having used alcohol in their lifetime[3]:

- The most common source of alcohol is from **parents, with permission**, followed by from **friends**.
- 46% report **ever** having consumed 4 or more drinks in a single occasion in their **lifetime**.
- 14.7% report having had 4 or more drinks in a single occasion in the **past 30 days**.

Youth Perceptions and Lifetime Use of Alcohol[3]



[2] DPH, 2021 Connecticut School Health Survey
[3] SERAC Youth Regional Summary Survey, 2021-2022
[4] CDC (2022), Alcohol and public health
[5] CDC (2022), Excessive Alcohol Use is a Risk to Men's Health
[6] CDC (2022), Excessive Alcohol Use is a Risk to Women's Health
[7] NIDA (2014), Severe Mental Illness Tied to Higher Rates of Substance Misuse

2022 Region 3 Epidemiological Profile: Alcohol

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.[12]
- 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.[13]
- Approximately 95,000 deaths each year in the U.S. are attributed to alcohol-related causes.[14]
- In 2019, Connecticut ranked as the fourth highest state in the country for the percent of alcohol-impaired driving fatalities compared to total driving fatalities (38%), versus the United States overall (28%).[15]
- Excessive drinking has numerous chronic and acute health effects, including: liver cirrhosis, pancreatitis, various cancers, cardiomyopathy, stroke, high blood pressure, and psychological disorders as well as increased risks for lower respiratory infections such as tuberculosis.[16]
- Excessive drinking has been associated with increased risk of motor vehicle injuries, falls, and interpersonal violence.[4]
- Drinking during pregnancy can lead to a variety of developmental, cognitive and behavioral problems in the child (Fetal Alcohol Spectrum Disorders).[16]
- 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).[17]
- Initiation of alcohol use at young ages has been linked to increased likelihood of AUD later in life.[18]
- Of all 2022 Connecticut treatment admissions, 52.8% identified alcohol as the primary drug at admission.[10]
- Of all accidental drug-related deaths occurring in Region 3 in 2021, 26.4% included alcohol.[23]

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

	2016-2018	2018-2019	2021
CT	6.1	6.2	10.3%

Among individuals 12 years and older, those reporting alcohol use disorder (AUD) in the past year was relatively stable from 2016 to 2019, at about 6%. However, the 2021 NSDUH data indicate that reported AUD rates for this age group have increased to 1 in 10.[1]

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

	2016-2018	2018-2019	2021
CT	5.7	5.6	10.4%

Among individuals 12 years and older, those reporting needing but not receiving treatment at a specialty facility for alcohol use in the past year followed a similar trend to those reporting alcohol use disorder in the past year with relative stability between 2016 to 2019 (~6%) and then nearly doubling in 2021 to 10.4%.[1]

Treatment Admissions where Alcohol is the primary drug at admission[10]

	CT	Region 1	Region 2	Region 3	Region 4	Region 5
FY2021	14,985	1,816	3,384	2,861	3,780	3,144
FY2022	14,096	1,089	3,385	2,680	5,253	1,685

[8] NIAAA (2014), Focus On: Ethnicity and the Social and Health Harms from Drinking
[9] NIAAA (2021), Alcohol and the Hispanic Community
[10] CT DMHAS 2021 Treatment Admissions
[11] SAMHSA (2019), Risk and Protective Factors
[12] CDC (2022), Alcohol and Other Substance Use
[13] CT Department of Public Health Drug Overdose Monthly Report, 2021

2022 Region 3 Epidemiological Profile: Alcohol

Community Wellbeing Survey: Percent Reporting Past Month Binge Drinking[19]

	CT	Wealthy	Suburban	Rural	Urban Periphery	Urban Core
2021	219	20	18	19	20	17

SERAC Community Survey 2022 Estimates[20]

- More than 70% of parents reported that someone in the household uses alcohol (household with youth in grade school).
- Approximately 78% of nonparents reported that an adult in the household uses alcohol.
- Approximately 50% of parents reported that alcohol is not secure in their homes.
- Approximately 8% of parents report that it is **mostly true** or **definitely true** that youth should be allowed to drink, so they learn how to drink responsibly.
- About 8% of parents report that there has been a party at their home within the past year where alcohol was consumed.

Capacity and Service System Strengths

Community Readiness Survey: Mean Stage of Readiness for Substance Misuse Prevention[21 & 22]

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

According to the Region 3 Community Readiness Survey (CRS) report, key informants identified alcohol as the substance of greatest concern for individuals aged 66 and older followed by 26-65 years of age then 18-25 years of age. Results on community attitudes show that the majority of respondents disapprove of underage drinking. Approximately 60% of respondents felt that financial resources to address substance misuse in the community was a great barrier in the region followed low community buy-in and low willingness to volunteer as well as lack of knowledge regarding effective strategies to address substance misuse problems.[22]

[14] NIAAA (2022), Alcohol Facts and Statistics
[15] NHTSA (2019), Alcohol-Impaired Driving
[16] WHO (2018), Global Status Report on Alcohol and Health
[17] NIAAA (2017), Older Adults
[18] NIAAA (2006), Alcohol Alert No. 67 Underage drinking

[19] DataHaven Community Wellbeing Survey, 2021
[20] SERAC Community Survey, 2022
[21] Community Readiness Survey State Report, 2022
[22] Community Readiness Survey Region 3 Report, 2022
[23] CT Office of the Chief Medical Examiner, 2021

2022 Region 3 Epidemiological Profile: Cannabis

Problem Statement

Cannabis, also called cannabis, is a term widely used to encompass all products made with cannabis in any form or stage of growth. The Connecticut Legislature legalized cannabis use on July 1st, 2021. An individual 21 years of age or older can now possess and consume up to 1.5 ounces of cannabis. Retail sales began in January 2023. Cannabis still remains illegal under federal law (dea.gov).

Cannabis use is widespread among young adults and adolescents in Connecticut. The 2021National Survey on Drug Use and Health (NSDUH) showed that, for 18 to 25 year olds, past year cannabis use was higher than the national average (36.0% in CT vs. 35.4% nationally).[1] Among youth ages 12-17 in Connecticut, 10.1% had used within the past year, and 4.7% had used within the past month.[1]

Magnitude (prevalence)

The 2021 Connecticut School Health Survey shows about 11.1% of Connecticut high school students report currently using cannabis.[2]

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

	CT	Region 1	Region 2	Region 3	Region 4	Region 5
2016-2018	10.9	9.6	11.0	11.4	11.8	10.4

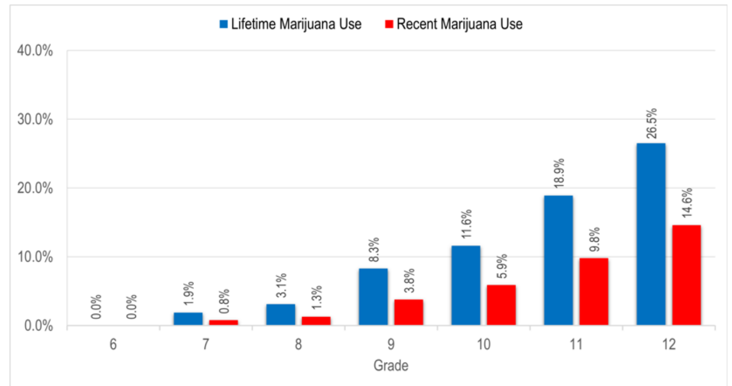
SERAC Youth Survey Regional Summary Report 2021-2022:

Cannabis Use:

- Lifetime Use
  - 11% of youth report ever having used cannabis in their lifetime.
  - 26.5% of 12th graders report ever having used cannabis in their lifetime
- Recent Use
  - 11% of youth report having used cannabis in the past 30 days.
  - 14.6% of 12th graders report using cannabis in the past 30 days

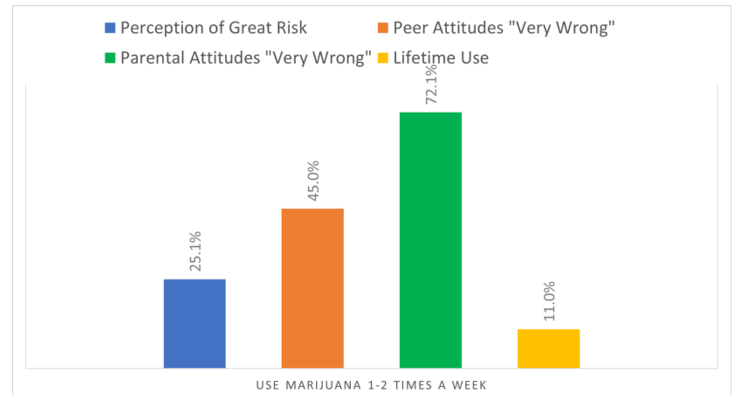
[1] NSDUH
[2] Connecticut School Health Survey, 2021 (YRBS)

Regional Cannabis Use by Grade Among Youth (2021-2022)



Youth Perceptions and Lifetime Use of Cannabis

Cannabis use has shown a slight increase in recent years among youth in the region and have marginally risen above alcohol use as a potential top substance of use. In the 2021-2022 Regional Youth Survey, cannabis had the highest



recent use rate (past 30 days) of any substance. However, this is indicated by preliminary data in recent school surveys and more data is needed to determine if this is accurate across all of the region.

2022 Region 3 Epidemiological Profile: Cannabis

Risk Factors and Subpopulations at Risk

Risk factors include:

- Availability of cannabis
- Family history of cannabis use
- Favorable parental attitudes towards cannabis
- Low academic achievement and low bonding to school environment
- Peers who use cannabis
- Low peer disapproval of cannabis use
- Prior use of alcohol/tobacco
- Sensation seeking behavior/impulsivity
- Childhood abuse/trauma[3]

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

	CT	Region 1	Region 2	Region 3	Region 4	Region 5
2018-2020	18.93	22.19	18.07	17.07	18.66	18.17

SERAC Youth Survey Regional Summary 2021-2022 Estimates:

Perceived Harm

- Only 25% of youth report that there is a **great risk** in using cannabis 1 or 2 times a week and it is the substance with the highest reported **no risk** across the region (14%).
- Perception of risk fluctuates given the method of cannabis ingestion. The perception of great risk for using cannabis edibles (28%) or cannabis concentrates like dab, wax, oils (30%) is slightly higher than using cannabis 1 or 2 times a week (25%).
- Between 19-27% of youth report that they do not know the risk associated with using the various forms of cannabis.

Peer Disapproval

- 45% of youth report that their peers would think it was very wrong for them to smoke cannabis. Slightly fewer believe their peers would find it very wrong for them to use cannabis edibles (41%) or cannabis concentrates (43%).

[3] SAMHSA, CAPT Northeast Regional Cannabis Webinar Series:

SERAC Regional Community Survey 2022:

Adult Use

- 22.3% of parents and 26.2% of nonparents report that adults in their household use cannabis.
- 17.9% of parents and 8.7% of nonparents report that it is **definitely true** or **mostly true** that cannabis is secured in their home.

Perceived Harm

- 35.5% of parents and 24.6% of nonparents perceive there is **no risk** or **slight risk** associated with youth using cannabis 1-2 times a week.
- 6.7% of all parents and 12.7% of high school youth parents think that it is **mostly true** that youth should be allowed to use cannabis, so they learn how to use cannabis responsibly.

Youth Use & Access

- 3.6% of parents (6.8% of high school parents) report that a party has been hosted in their home in the past year where cannabis was consumed by youth.
- 56.5% of parents and 56.2% of nonparents believe that the legalization of cannabis will increase access to underage youth.
- Approximately 37% of parents and 92.3% of nonparents think that it would be **sort of easy** or **very easy** for youth to access cannabis.
- 13% of parents of high school aged youth believe their child has used cannabis in the past 30 days.

The 2021 Connecticut School Health Survey shows higher current cannabis use in girls (14.1%) compared to boys (8.2%).[2] Reported current use increases significantly by grade from 4.7% of 9th graders to 16.0% of 12th graders.[2] More Black students reported current use (14.7%) than White students (9.9%) and Hispanic students (13.9%).[2] Overall, the percentage of Connecticut high school students reporting current use has remained relatively stable since 2005. Current use nationally also appears to be relatively stable.

There has been a decline in the perception of harm of cannabis use during the past 15 years. This risk factor has been difficult to address with recent legalization attempts and the promotion of cannabis use.

2022 Region 3 Epidemiological Profile: Cannabis

Burden (consequences)

Short-term consequences include[4]

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

Long-term consequences include[4] :

- Impaired learning and coordination
- Sleep problems
- Potential for addiction to cannabis, as well as other drug and alcohol use disorders
- Potential loss of IQ (particularly in those who used heavily during adolescence)
- Decreased immunity
- Cannabinoid hyperemesis syndrome
- Increased risk of bronchitis and chronic cough
- Cannabis potency has increased over the past few decades: in the 90s, the average THC content in confiscated samples was less than 4%, and in 2021 it was over 15%.[4]
- Of all of the medical cannabis products registered for sale with the state of Connecticut, the average THC content is about 18%.[8]
- Cannabis use during pregnancy also increases the risk of child development problems including low birth weight, and brain development. Additionally, children exposed to cannabis in-utero have increased risk for problems with attention span and problem solving.4
- Several studies have linked cannabis use to increased risk for psychiatric disorders and substance use disorders. The amount used, age at first use, and genetic vulnerability are thought to influence this relationship.[4]
- In 2021, cannabis was identified as the primary drug in 12.8% of clients admitted to treatment. Among 18-25 year olds, 36.8% reported cannabis as their primary drug while 70% of youth reported using cannabis at all. [5]

DMHAS 2022 Treatment Admissions[5]

	CT	Region 1	Region 2	Region 3	Region 4	Region 5
All clients	*	30.9%	29.5%	30.1%	40.3%	32.3%
Primary	7.8%	6.8%	6.3%	6.6%	9.8%	7.2%

- Because cannabis 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]

Regional Estimates:

- Cannabis is reported 61.8% as a drug of use in individuals receiving treatment ages 18-25.
- 26.4% of individuals age 18-25 report cannabis as the primary drug of use.

Capacity and Service System Strengths

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

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

The Region 3 Community Readiness Survey indicates that respondents feel cannabis is the greatest concern among ages 18-25 and 12-17 years old. The concern for cannabis use among adults was much less of a concern in the region. Key informants also reported that most residents in the region are not very concerned about the legalization of cannabis, but that legalization poses risks for the decrease in perception of harm associated with cannabis use, especially among youth. The greatest barriers that were identified in the prevention of substance misuse were lack of financial resources, trained staff to serve specific populations, community buy-in and willingness to volunteer.[7]

[4] NIDA, Cannabis
[5] CT DMHAS, 2021-22 Treatment Admissions
[6] CDC (2020), Outbreak of Lung Injury Associated with the Use of E- Cigarette, or Vaping, Products
[7] 2022 CRS
[8] Department of Consumer Protection, Health and Human Services, Medical Cannabis Brand Registry

2022 Region 3 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 2021 Connecticut School Health Survey (CT YRBSS), 1.2% 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 2021 National Survey on Drug Use and Health (NSDUH) data show 1.69% of Connecticut respondents reported past year use of cocaine.[2] This is highest among young adults 18-25 (3.34%), compared adults 26+ (1.62%). Data on past year cocaine use is unavailable for 12 to 17-year-olds.

NSDUH Substate Estimates:

Percent Reporting Past Year Cocaine Use, ages 12+

	CT	Region 1	Region 2	Region 3	Region 4	Region 5
2016 - 2018	2.3	2.1	2.5	2.5	2.3	2.1

[1] Connecticut School Health Survey, 2021 (CT YRBSS)

[2] NSDUH 2021

SERAC Youth Survey Regional Summary 2021-2022 Estimates:

Approximately 0.9% of 12th graders report that they have used cocaine in their lifetime.

99.5% of all youth report that they have never used cocaine in their lifetime.

6.1% of youth report that it would be ***easy or sort of easy*** to get an illicit drug if they wanted to.

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	Region 1	Region 2	Region 3	Region 4	Region 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 group[2]

Males are more likely to use cocaine than females.

Those with current or previous misuse of other illicit substances, such as cannabis and heroin/fentanyl

Individuals with mental health challenges[3]

According to data from the 2021 Connecticut School Health Survey (CT YRBSS), boys reported higher rates (1.7%) than girls (0.6%). The prevalence of lifetime cocaine use was highest among 9th and 11th graders (1.5% each). Hispanic students reported higher rates (1.4%) than Black (0.4%) or White (1.2%) students.

2022 Region 3 Epidemiological Profile: Cocaine

Burden (consequences)

- Physical short-term consequences of cocaine use include[3]:
- 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 include[3]:

- 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 behavior[3]
- Users are at risk of accidental overdose, especially in the presence of alcohol or other drugs.[3]
- In 2022, cocaine was the primary drug in 9% of all Connecticut substance use treatment admissions. [4]

Treatment Admissions: Cocaine

	CT	Region 1	Region 2	Region 3	Region 4	Region 5
FY2022	9,270	1,094	2,120	1,604	3,068	1,384

35.4% of all clients in Region 3 report crack/cocaine as a drug of use for admissions in 2022, an increase from 26.7% in 2021.
3.9% of all clients admitted in 2022 report crack/cocaine as their primary drug
2.5% report crack/cocaine as the primary drug among 18-25 year old adults.

Cocaine-Involved Fatal Overdoses in 2019[3]
***Rate per 100,000 population**

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

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.
Crack/Cocaine is reported as a drug of use in all cases in Region 3 at 35.4%
Of all accidental drug-related deaths occurring in Region 3 in 2021, 45.6% included cocaine.[8] 91.3% of deaths included multiple substances.

Capacity and Service System Strengths

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

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

According to the Region 3 CRS report, the highest age groups of concern for crack/cocaine use are adults age 18-25 years of age. Results on community attitudes show that the majority of respondents believe the community are concerned about preventing substance misuse and that it is a good investment in the community. Approximately 30% of respondents felt that financial resources to address substance abuse prevention was a great barrier in the region followed by a lack of trained staff to serve appropriate populations, as well as low community buy-in and low willingness to volunteer

[3] NIDA
[4] Connecticut Department of Mental Health and Addiction Services
[5] CT Office of the Chief Medical Examiner, 2019
[6] Tomassoni AJ. MMWR 2017;66:107-111.
[7] CRS 2022
[8] CT Office of the Chief Medical Examiner
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2022 Region 3 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 2021 National Survey on Drug Use and Health (NSDUH), less than one percent (0.32%) of Connecticut residents 18 or older have used heroin in the past year, a rate slightly lower than the national average (0.43%).[1] The highest prevalence is among young adults aged 26 or older(0.34%), followed by adults aged 18-25 (0.17%). Adolescents did not report any heroin use for this time period.[1]

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, it 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. In 2021, nearly 9 in 10 unintentional overdose deaths (86%) in Connecticut involved fentanyl.[1] Thus, all individuals who use heroin are at risk of fentanyl exposure.

Magnitude (prevalence)

In 2021, 30 of the 41 towns that Region 3 serves experienced an accidental death related to heroin use.[3] Of all accidental drug-related deaths, 91.3% of them included polysubstance use.

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

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

Note. Substate estimates are not available for 2019/2020 or 2020/2021 due to methodological differences as a result of the COVID-19 pandemic

Risk Factors and Subpopulations at Risk

- People who are addicted to other substances are more likely to meet criteria for heroin use disorder. Compared to people without an addiction, those who are addicted to alcohol are 2 times more likely to become addicted to heroin. Those addicted to cannabis are 3 times more likely, while those addicted to cocaine are 15 times more likely, and those addicted to prescription pain medications are 40 times more likely to become addicted to heroin.[5]
- Other groups at risinclude3:
  - 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	Region 1	Region 2	Region 3	Region 4	Region 5
2018-2020	86.17	84.74	86.01	85.56	85.64	86.17

[1] NSDUH
[2] Connecticut School Health Survey, 2021 (YRBS)
[3] CT OCME
[4] US DOJ- DEA, 2018 National Drug Threat Assessment (October 2018)
[5] CDC. Overdose: Heroin.https://www.cdc.gov/drugoverdose/opioids/heroin.html

2022 Region 3 Epidemiological Profile: Heroin & Other Illicit Opioids

SERAC Youth Survey Regional Summary Report 2021- 2022 Estimates:

- 99.7% of all youth (grades 6- 12) report that they have never used heroin in their lifetime
- 0.5% of 11th graders report that they have used heroin in their lifetime.
- 6.1% of youth report that it would be ***easy or sort of easy*** to get an illicit drug if they wanted to.

The 2021 Connecticut School Health Survey shows that Hispanics reported the highest overall rate (3.1%), which is higher than the prevalence for Black non-Hispanics and White non-Hispanics (0.4% each). One percent of boys and (.2%) of girls reported ever used 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 2021, heroin was involved in 166 overdose deaths, and fentanyl was involved in over 1300 deaths.[3]
- Of all accidental drug-related deaths occurring in Region 3 in 2021, 86% included fentanyl, 93.3% included any opioid, and 8.8% included prescription opioids.[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]

Opioid-Involved Non-Fatal Overdoses (DPH)

	CT	Region 1	Region 2	Region 3	Region 4	Region 5
2018	4492	584*	1050*	475*	1632*	654*
2019	5022	585*	1168*	465*	1808*	860*

***Numbers are approximate due to suppression**

Heroin-Involved Fatal Overdoses in 2019[3]

	CT	Region 1	Region 2	Region 3	Region 4	Region 5
N	346	46	87	24	70	119
Rate	9.70	6.56	10.52	5.68	6.99	19.43

***Rate per 100,000 population**

Opioid-Involved Fatal Overdoses in 2019[3]

	CT	Region 1	Region 2	Region 3	Region 4	Region 5
N	1005	111	217	138	323	216
Rate	28.19	15.83	26.23	32.67	32.24	35.26

***Rate per 100,000 population**

Fentanyl-Involved Fatal Overdoses in 2019[3]

	CT	Region 1	Region 2	Region 3	Region 4	Region 5
N	865	81	164	125	298	197
Rate	24.26	11.55	19.83	29.60	29.74	32.16

***Rate per 100,000 population**

In FY 2021 there were 9,085 treatment admissions where heroin was the primary substance. For that time period, Region 3 accounted for 15% of substance use treatment admissions where the primary substance was heroin (CT DMHAS 2021).

Treatment Admissions: Heroin* as the Primary Drug

	CT	Region 1	Region 2	Region 3	Region 4	Region 5
FY2021	9,085	1,278	2,656	1,348	2,411	1,392
FY2022	5,907	1,060	1,141	677	2,057	972

*This includes heroin and non-prescriptive methadone

The rate of opioid involved deaths (32.67 per 100,00) in Region 3 is the second highest region in the state. There were approximately 1,223 non-fatal suspected overdoses in the region (CT DPH 2019-2022). The communities that have seen an increase in non-fatal suspected overdoses are rural communities. Of the 6 communities that have seen an increase, 5 of them are located in the northeast area of the region.

Overall, the treatment data has not significantly changed in the past 4 years. Efforts to expand naloxone and medicated assisted treatment programs in the region have a primary goal for the past 4 years. The region also has many safe disposal sites at local police departments and many local prevention councils participated in Drug Take Back Events. In October 2022, a total of 1068.5 drugs were taken back among several towns in Region 3. Qualitative information from focus groups indicated that the impact of heroin and illicit opioid use is a high concern alongside the consequences of inaction. Anecdotal information suggests that most deaths occur alone and in a residence location. Issues related to the access of treatment and recovery support, particularly due to a lack of respite housing, safe use centers, and barriers related to meeting basic needs are top issues related to heroin and illicit opioid use. This is largely due to gaps of service providers in the northeast region, loss of income, lack of health insurance coverage, housing and food insecurity, and transportation.

Capacity and Service System Strengths

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

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

According to the Region 3 CRS 2022 report, the highest age groups of concern for heroin use are adults age 26-65 followed by ages 18-25. Results on community attitudes show that the majority of respondents believe the community are concerned about preventing substance misuse and that it is a good investment in the community. Approximately 59.2% of respondents felt that financial resources to address substance abuse prevention was a great barrier in the region followed by a lack of trained staff to serve appropriate populations, as well as low community buy-in and low willingness to volunteer.

2022 Region 3 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 2021 National Survey on Drug Use and Health (NSDUH), 7.7% of Connecticut adults and 20.4% of Connecticut youths reported a major depressive episode in the past year.[3]

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 depression[4]. The 2021 NSDUH shows 4.3% of adults in Connecticut reported serious mental illness in the past year.[3]

Magnitude (prevalence)

One in 5 adults in the United States experience mental illness each year.[5] According to the National Alliance on Mental Illness, 531,000 adults and 40,000 youth in Connecticut have a mental health condition in 2021. In February 2021. 40.6% of adults in Connecticut reported symptoms of anxiety or depression and 22.3% were unable to get needed counseling or therapy.[5]

Anxiety

The 2019 Connecticut BRFSS showed 11.1% of adults reported feeling nervous, anxious, or on edge for more than half the days or nearly every day in the past 2 weeks.[6] According to the SERAC Community Survey (2022), about 71% of adults reported that they felt more anxious as a result of the COVID-19 pandemic.[7]

Depression

The percentage reporting past year major depressive episode was highest among youth 12-17 (20.4%) compared to young adults 18-25 (18.9%), and adults 26+ (6.0%).[3] According to the 2019 Connecticut BRFSS, 14.4% of adults reported being told by a doctor that they had a depressive disorder.[6] The BRFSS showed a higher percentage among younger adults 18-24 (18.1%), compared to those 35-54 (12.4%) and those 55+ (13.9%). In Eastern Connecticut, an estimated 20.1% of those 18 or older experienced a mental illness in the past year.[3] According to NAMI, 40,000 youth in Connecticut age 12-17 have depression.[5] About 35% of adults reported experiencing depressive symptoms for more than two weeks as a result of the COVID-19 pandemic.[7]

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[1] NIMH
[2] CDC, Depression and Anxiety
[3] SAMHSA, Adults with SMI
[4] NSDUH 2021
[5] CT BRFSS 2019
[6] Connecticut School Health Survey 2021

2022 Region 3 Epidemiological Profile: Mental Health

Serious Mental Illness

In the 2021 NSDUH, young adults 18-25 had a higher percentage reporting serious mental illness (9.97%) than those 26+ (3.43%). In 2018 in Region 3, an estimated 4.2% of those 18 or older experienced a serious mental illness in the past year.[3]

NSDUH Substate Estimates:

Percent Reporting Past Year Major Depressive Episode, ages 18+

	CT	Region 1	Region 2	Region 3	Region 4	Region 5
2016 - 18	6.84	6.05	6.93	7.34	7.34	6.43
2018 - 20	7.66	6.23	7.74	8.08	8.71	7.15

Percent Reporting Past Year Serious Mental Illness, ages 18+

	CT	Region 1	Region 2	Region 3	Region 4	Region 5
2016 - 18	4.15	3.84	4.38	4.36	4.28	3.80
2018 - 20	4.65	3.54	5.11	5.03	4.99	4.45

According to call data from 211, mental health and addiction calls were the second highest need of all the calls in 2022, preceded by housing and shelter needs. One in 4 calls to 211 included requests for mental health and addictions issues (25.9%).[8] Of the calls, 50.5% were specifically related to mental health services.[8]

The 2021 Connecticut School Health Survey reported that almost 28.5% of high school students said their past 30 day mental health was not good (including depression, stress, emotional problems).[9] This was higher among girls (40.5%) and LGBT students (54.1%). 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 35.6%. This was higher among girls (47.6%) than boys (24.2%), and was higher among Hispanic students (42.6%) than non-Hispanic Black (34.9%) or non-Hispanic White students (31.8%).[9]

[7] NAMI
[8] 2022 CRS
[9] 211 data, 2022

SERAC Youth Survey Regional Summary 2021-2022 Mental health Indicators in the Past Year:

- ☑ In the past year, 1 in 4 youth
  - Report having felt so sad or hopeless for 2 weeks or more that it stopped them from doing their usual activities (26%)
  - Report having had thoughts of hurting themselves (24.8%)
- ☑ In the past year, 1 in 6 youth report having hurt themselves on purpose (15.7%)
- ☑ In the past year, 1 in 8 youth report having seriously considered attempting suicide (12.1%)

Risk Factors and Subpopulations at Risk

- Risk factors for depression and anxiety include[1]:
  - Family history of anxiety, or depression, or other mental illness
  - Experiencing traumatic or stressful events
  - Some physical conditions can produce or aggravate anxiety symptoms, and having medical problems such as cancer or chronic pain can lead to depression
  - Substance use such as alcohol or drugs
- Young adults report higher rates of depression and serious mental illness.[3,6]
- The prevalence of major depressive episodes is higher among adult females than males[1], and among adults reporting two or more races[1]
- The prevalence of any anxiety disorder is higher among females than males.[1]
- 2SLGBTQ+ 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.[5]
- 89% of clients in the region access crisis services within the eastern region.
- Only 49.3% of clients access inpatient or residential services in the region.

2022 Region 3 Epidemiological Profile: Mental Health

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 world;[5]
- Mental illness costs Americans $193.2 billion in lost earnings per year;[5]
- 1 in 8 emergency department visits involves a mental health or substance use condition.[5]
- 1 in 4 people with a serious mental illness has been arrested by the police at some point in their lifetime.[5]
- About 2 in 5 adults in jail or prison have a history of mental illness and 7 in 10 youth in the juvenile justice system have a mental health condition.[5]
- 1 in 8 homeless people in Connecticut live with a serious mental illness.[5]

Mental Health Treatment Admissions*

	CT	Region 1	Region 2	Region 3	Region 4	Region 5
FY2021	55,822	7,159	14,414	7,291	18,262	8,696
FY2022	57,786	6,591	14,991	7,516	19,193	9,496

*Includes admissions for MH only as well as MH+SA

CT DMHAS Region 3 Mental Health Services:

- 44.1% of clients received services for mental health alone. This is the third highest percentage of all the regions in the state. Focus group and key informant information indicates this is likely due to a lack of service providers.

Capacity and Service System Strengths

Community Readiness Survey: Mean Stage of Readiness for Mental Health Promotion[10]

	CT	Region 1	Region 2	Region 3	Region 4	Region 5
2022	4.98	5.36	5.11	4.54	4.91	4.79

The readiness for Region 3 is slightly lower than other regions with regard to mental health promotion. According to the CRS Region 3 report, the greatest mental health concern among 12-17 year old youth is anxiety. The greatest concern among all 18 and older populations is depression. The age group with the highest reported concern for depression is 66 or older. The strongest area of support from the community as reported by key informants is the early identification in children and youth. Information also suggests that residents are concerned about mental health in their communities but maybe uncomfortable discussing the issue. It was also mentioned that there are not sufficient mental health supports in educational settings in region 3. The highest barriers to address mental health promotion were limited financial resources followed by the lack of a regional strategic plan to address mental health needs, and trained staff to serve specific at-risk subpopulations.

[10] SERAC Community Survey 2022

2022 Region 3 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), oxymorphone, tramadol, and hydrocodone are examples of opioid pain medications. Opioid painkillers work by mimicking the body's natural pain-relieving chemicals, so the user experiences pain relief. 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]

Magnitude (prevalence)

Among prescription medications, pain relievers are the most frequently used for non-medical purposes in the US. The 2021 National Survey of Drug Use and Health (NSDUH) reported that during the past year, 2.7% of the US population aged 12 and older had used prescription pain relievers non-medically.[2]

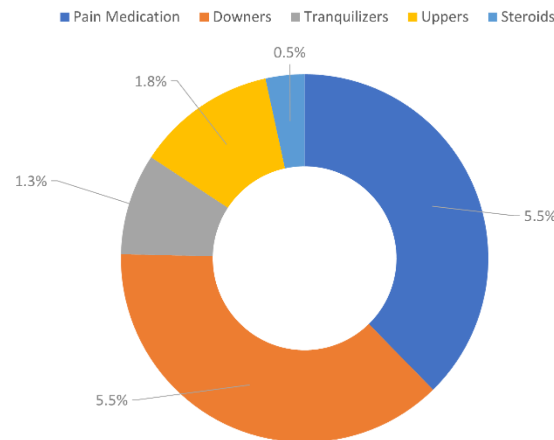
NSDUH Substate Estimates:
Percent Reporting Past Year Pain Reliever Misuse, Ages 12+

	CT	Region 1	Region 2	Region 3	Region 4	Region 5
2018-2020	3.26	3.28	3.37	3.55	3.15	3.09

According to the 2021 Connecticut School Health Survey (CT's Youth Risk Behavior Surveillance survey), 8.5% of high school students reported ever taking prescription drugs without a doctor's prescription.[3]

SERAC Youth Survey Regional Summary 2021-2022:

Rates of Lifetime Use Among Youth:



Lifetime use of pain medication and "downers" are tied as the highest category of lifetime prescription drug misuse among youth in the region, followed by "uppers." Downers have the highest recent use across all grades.

Risk Factors and Subpopulations at Risk

- Persons at risk of misusing prescription drugs include[4] :
  - Those with past year use of other substances, including alcohol, heroin, cannabis, inhalants, cocaine and methamphetamine.
  - People who take high daily dosages of opioid pain relievers.
  - Persons with mental illness.
  - People who use multiple controlled prescription medications, often prescribed by multiple providers.
  - Individuals with disabilities are at increased risk of prescription opioid misuse and use disorders.[5]

[1] NIDA, Misuse of Prescription Drugs Research Report
[2] NSDUH 2021
[3] Connecticut School Health Survey, 2021 (CT YRBSS)

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

2022 Region 3 Epidemiological Profile: Prescription Drug Misuse

- Among all fatal overdoses involving prescription opioids in Region 3 in 2021, the majority occurred among non-Hispanic whites, with male deaths occurring 1.4-3.25 times more frequently than females in each racial/ethnic group[6]
- The elderly population may be at risk of consequences of prescription drug misuse, as they use prescription medications more frequently compared to the general population and may be at higher risk of medication errors[7]
- According to the 2021 Connecticut School Health Survey, Hispanic students had the highest rates of taking prescription drugs without a doctor's prescription (12.5%)[3]

SERAC Community Survey 2022

- More than 17% of parents reported that it is "definitely or mostly not true" that they secure prescription drugs in their home.
- 29% of non-parent respondents reported that they do not secure prescription drugs in their home.

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] In 2021, 8.8% of accidental overdoses included a prescription opioid in Region 3. Of all drug-related accidental deaths, 91.3% included polysubstance use.
- 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

Prescription Drug-Involved Fatal Overdoses in 2019[3]

	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
FY2021	5452	655	1319	1052	1574	852
FY2022	5191	358	1073	1132	2073	555

Region 3 is the 3rd highest region in the state to meet the criteria for past year pain reliever use disorder.[2] It ranks 4th in prescription drug involved fatal overdoes (2019). Other opiates is the 4th most commonly reported drug used among admitted patients in 2022. The region is ranked 1st for treatment admissions related to opiates (25%) across all regions. Focus group information indicated a lack of detox, inpatient, and sober living support services in the northeastern area of the region as well as a need for harm reduction-based support, respite housing, and more case management. Similarly, there is a need to address barriers to treatment, including addressing basic needs such as housing, food, and transportation issues.

[5] Lauer EA et al. Disability and Health Journal 2019;12(3):519-522
[6] Connecticut Office of the Chief Medical Examiner, 2021
[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

2022 Region 3 Epidemiological Profile: Prescription Drug Misuse

Capacity and Service System Strengths

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

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

According the Region 3 CRS (2022) report prescription drug misuse is the highest concern among ages 66 or older (29.6%) followed by ages 26-65 (10.8%). It was the lowest concern among ages 12-17 (3.5%).[11] Results on community attitudes show that the majority of respondents believe the community are concerned about preventing substance misuse and that it is a good investment in the community. Approximately 59.2% of respondents felt that financial resources to address substance abuse prevention was a great barrier in the region followed by a lack of trained staff to serve appropriate populations, as well as low community buy-in and low willingness to volunteer.

[11] 2022 CRS

2022 Region 3 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]

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]

According to the Connecticut School Health Survey in 2021, 18.4% of high school students reported gambling on a sports team, playing cards or dice game, state lottery games, gambling on the internet, or bet on a game of personal skill.[3]

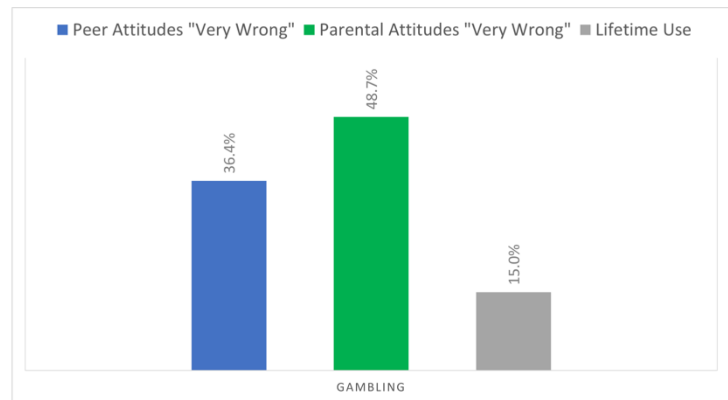
SERAC Youth Survey Regional Summary 2021-2022

- ☑ Overall, about 15% of youth report ever having gambled while 1% of youth report that they gamble on a daily basis.
- ☑ 12.2% of youth report that someone in their family has gambled so much that it created problems at home, at work or with friends.

Perceptions around gambling tend to be more permissive than any other behavior investigated in the Regional Youth Survey. Only 36.4% of youth report that their peers would find it very wrong for them to gamble and 48.7% perceive that their parents would find it very wrong for them to gamble.

[1] National Council on Problem Gambling
[2] American Psychiatric Association, Gambling Disorder
[3] Connecticut School Health Survey, 2021

Perceptions about Gambling Among Youth



Connecticut Council on Problem Gambling (CCPG) Help Line[5]

According to the CCPG, among Region 3 in 2022:

- 65% of callers self-reported a gambling problem while 35% were affected by someone else's gambling problem.
- 63% of callers were male; 35% of callers were female
- 14% of callers were between the ages of 21-25, followed by 12% between the ages of 56-65
- The most commonly reported types of gambling include:
  - Casino 30%
  - Internet 28%
  - Sports 23%

Qualitative data suggest that online gambling is an emerging issue that requires priority attention. Online gambling allows for easier access and therefore greater risk for developing problem behavior. Similarly, youth under the age of 18 may engage with online gambling more easily.

Risk Factors and Subpopulations at Risk

Risk Factors include:[4]

- Having an early big win
- Having easy access to preferred form of gambling
- Holding mistaken beliefs about odds of winning

[4] Risk Factors for Developing a Gambling Problem, Centre for Addiction and Mental Health (CAMH)
[5] Connecticut Council on Problem Gambling Help Line Statistics, 2022

- 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 Connecticut School Health Survey shows that significantly higher high school males (24.7%) reported gambling, compared to females (11.7%). The prevalence among 12th graders was higher (20.9%) than any other grade (16.4%-18.6%). Differences among race/ethnicity were not statistically significant.[3]
- Problem gambling rates double for individuals living within 50 miles of a casino.

Burden (consequences)

Treatment Admissions:

- 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]

CT DMHAS Bettor Choice Program

- 307 individuals were treated for problem gambling (2022) in CT.
- 86 of those individuals were in Region 3.
- Region 3 has the second highest number of individuals receiving treatment from problem gambling (2022).
- Of those seeking treatment in Region 3, 58.1% were female and 41.9% were male. 25.6% were not in the labor force and 14% were disabled, while 48.8% were employed competitively.
- Within Region 3, about 89.4% of those seeking treatment for problem gambling were able to find treatment within their resident region.

CT DMHAS Problem Gambling Treatment Subpopulation Estimates (2022):

- The majority of individuals receiving treatment for problem gambling are white/Caucasian.
- The second highest ethnic population is black/African American individuals at 9.8%.
- About 4.5% of the treatment population are Hispanic individuals.
- Approximately 5.2% are of Asian/Pacific Islander descent.
- Those aged 55-64 (25.7%) make up the majority of those seeking treatment.

Qualitative data suggest that youth under the age of 18, those 21-30, and 65+ are ages of concern for gambling problems. Similarly, the East Asian and those who do not speak English as a first language are subpopulations of risk for gambling problems.

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
2022	37.9	48.9	35.9	39.9	29.2	37.8

According to the Region 3 CRS report (2022) key informants believe that the community is concerned about adults aged 26-65 years of age being vulnerable to gambling problems (60.3%). They also reported that the community likely felt like it was more ***okay*** to give youth under the age of 18 lottery or scratch off tickets than to allow youth to gamble with parental supervision. Approximately 71% of respondents felt it was either ***very or somewhat important*** to prevent problem gambling/gaming addiction in the region. A little more than half of respondents felt that their community had a low ability to raise awareness about the risks of problem gambling/gaming addiction. Only 38% reported that residents in the region are either ***very or somewhat*** aware that gambling activities can be an addiction for some people.

Qualitative data suggest a need for technology-based treatment platforms that interact with the client immediately rather than simply offering referrals.

2022 Region 3 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 10-14 years old, third leading cause of death among people 15-24, and fourth among people 35-44 years old.[1]

In the United States, the age-adjusted suicide rate increased 35.2% from 2000 to 2018, from 10.4 to 14.2 per 100,000. This rate is higher in males (22 per 100,000) than females (5.5 per 100,000).[2]

In Connecticut, the crude suicide rate in 2021 was 10.9 deaths per 100,000 population.[3] This rate is highest among those ages 65+, with a rate of 16.8 deaths per 100,000 population.[3] The number of suicide deaths per year in Connecticut has risen each year since 2008, but shows decrease in 2020 and 2021, according to the Office of the Chief Medical Examiner. [4]

Magnitude (prevalence)

Data from the 2021 National Survey on Drug Use and Health (NSDUH) showed 4.0% 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 (11.5%) compared to those 26+ (2.8%).[5] Additionally, .4% of Connecticut adults respondents reported attempting suicide in the past year. This is also higher among the young adults age 18-25 (2.26%) than those 26+ (.1%).[5]

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

	CT	Region 1	Region 2	Region 3	Region 4	Region 5
2016-2018	4.17	4.30	4.23	4.63	3.94	4.00

[1] CDC (2019). Suicide Prevention
[2] NIMH (2020). Suicide
[3] CT DPH (2021). CTVDRS, Violent Deaths: Connecticut Data 2015 to 2021
[4] CT OCME (2019). Annual Statistics: Suicides

According to data from the 2021 Connecticut School Health Survey (CT YRBSS), 14.1% of high school students reported seriously considering attempting suicide in the past year.[6] In 2021, 5.9% 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 CTVDRS, Region 3 has experienced 347 suicide deaths between 2015-2021. Twenty four of the 41 towns in Region 3 have experienced an adult suicide loss in 2022.

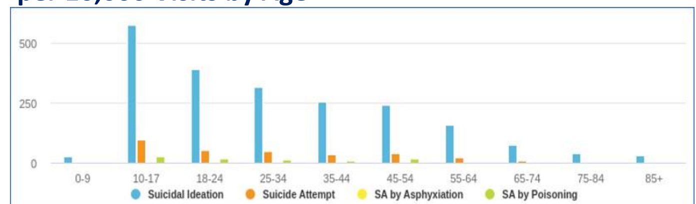
SERAC Youth Survey Regional Summary Report 2021-2022 Estimates:

In the past year, approximately 1 in 10 youth report having seriously considered attempting suicide (12.1%). Approximately 1 in 4 youth report having had thoughts about hurting themselves (25%) and 1 in 7 report having actually hurt themselves on purpose (15.7%) in the past year.

Region 3 has shown an increased in the number of individuals reporting that they have had serious thoughts of suicide in the past year. Currently, the region has the highest rate in the state of CT.

CT Suicidal Ideation and Self Harm Emergency Department Visit Report 2022[9]:

Rates of Suicidal Ideation and Self Harm ED Visits in Region 3 per 10,000 Visits by Age



- Suicidal ideation rates are highest among youth aged 10-17, with a rate of 576 per 10,000 visits in 2022. The rates decrease linearly as age increases.

[5] NSDUH 2021
[6] Connecticut School Health Survey, 2021 (CT YRBSS)
[7] Connecticut BRFSS Summary Tables 2018

- Those aged 10-17 also have the highest rate of attempted suicide, comprising 95.9 visits out of 10,000.
- Overall, more males than females visit the emergency department for suicidal ideation, while more females than males visit for suicide attempt.
- For cases of suicidal ideation, the majority race was White followed by Asian. For suicide attempts, Black or African American individuals had the highest rate per 10,000 visits, followed by Asian.
- Overall, females are more likely to attempt suicide by poisoning rather than asphyxiation. Males were the opposite.

Risk Factors and Subpopulations at Risk

- On average, men account for 88% of suicides in CT.[3]
- White non-Hispanic males account for 91% 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 include[1]:

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

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

Data from the SERAC Youth Survey Regional Summary Report (2021-2022) showed that approximately 11.5% of youth in the eastern region of CT think it would be ***very easy or sort of easy*** to access a gun if they wanted to.[8] About 15% of youth report that it would ***very easy or sort easy*** to access a prescription drug without a prescription.

About 26% of youth report having felt so sad or hopeless almost every day for 2 weeks or more that it stopped them from doing their usual activities in the past year.

[8] SERAC Youth Survey Regional Summary Report 2021-2022
[9] CT DPH, CT Suicidal Ideation and Self Harm Emergency Department Visit Report, 2022

2022 Region 3 Epidemiological Profile: Suicide

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]

The long-term effects of suicide deaths result in post-traumatic stress and depression for survivors. SERAC has provided intermediate assistance in posttraumatic stress management. However, there have been several requests to provide more postventions services and follow up planning session after a suicide death has occurred. In several communities in the region there have been multiple suicide deaths compounding the burden on current residents and institutions that serve the public. Key stakeholder and focus group data suggest that we need a way to enforce legislation surrounding suicide prevention efforts, to ensure that prevention programs are being properly implemented when and where appropriate to maximize our efforts.

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
2022	4.98	5.36	5.11	4.54	4.91	4.79

Almost 72.2% of respondents from the CRS in the region indicated that there was ***a lot or some support*** to implement suicide prevention efforts in eastern CT. The majority of respondents felt that the ability was either medium or high to implement activities. Some of the areas that were noted for more capacity building included support groups, regular on-going training, postvention intervention and the assistance to develop local postvention community plans.

Region 3 is currently in Readiness Stage 5: Preparation. The is a clear recognition of the issue and local stakeholder are in agreement that action needs to occur to address suicide deaths in the region. There are several active leaders in the region that provide support and guidance in statewide and regional planning activities.[10]

[10] 2022 CRS

2022 Region 3 Epidemiological Profile: Tobacco & ENDS

Problem Statement

According to the National Survey of Drug Use and Health (NSDUH) and the Youth Risk Behavior Surveillance Survey (YRBSS), tobacco use has decreased for all age groups over the past decade. NSDUH data show that past month tobacco product use among Connecticut residents 12+ declined significantly from 25.3% in 2008-2009 to 16.4% in 2021.[1] Tobacco product use includes cigarettes, smokeless tobacco (i.e., chewing tobacco or snuff), cigars, or pipe tobacco. According to the 2021 NSDUH, Connecticut young adults 26 or older had the highest rates of cigarette use of any age group (18.2%).[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 BRFSS), the prevalence of ever using e-cigarettes has increased each year since 2012. The 2018 CT BRFSS results showed that 19.6% of adults in Connecticut reported having tried e-cigarettes in their lifetime.[2]

Magnitude (prevalence)

The 2021 Connecticut School Health Survey shows current use of cigarettes among high school students is 1.3%, down significantly from 17.8% in 2009.[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 2021 Connecticut School Health Survey found current use of electronic vapor products to be 10.6% among high school students, with 14.2% of 12th graders reporting using vaping products.[3]

DataHaven’s 2021 Community Wellbeing Survey showed 23% of all respondents reported using vape pens or e-cigarettes.[4] This percentage is higher in wealthy communities (27%) as compared to urban core (24%) and urban periphery (21%) communities.[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

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

Percent Reporting Past Month Cigarette Use, ages 12+

	CT	Region 1	Region 2	Region 3	Region 4	Region 5
2014-2016	17.6	15.5	17.6	21.3	17.6	17.5
2016-2018	16.6	13.7	16.1	17.2	17.3	18.6

Percent Reporting Past Month Cigarette Use, ages 12+

	CT	Region 1	Region 2	Region 3	Region 4	Region 5
2014-2016	17.6	15.5	17.6	21.3	17.6	17.5
2016-2018	16.6	13.7	16.1	17.2	17.3	18.6

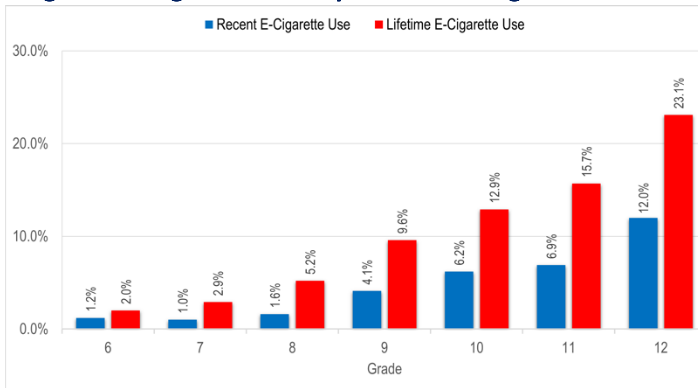
[1] NSDUH 2021
[2] Zheng X. (2018) CT BRFSS.
[3] Connecticut School Health Survey, 2021 (YRBS)
[4] DataHaven and Siena College Research Institute (2021). 2021 DataHaven Community Wellbeing Survey.

2022 Region 3 Epidemiological Profile: Tobacco & ENDS

SERAC Youth Survey Regional Summary Estimates:

According to the 2021-2022 SERAC Regional Youth Survey, 11% of youth in grades 6-12 report ever having used e-cigarettes in their lifetime, while 23.1% of 12th graders have reported ever having used e-cigarettes. E-cigarettes have the second highest recent use rate of any substance, with 5% of youth reporting use within the past 30 days, coming second to cannabis.

Regional E-Cigarette Use by Grade Among Youth[5]



Overall, cigarettes and tobacco use have shown a decline in the region in the past decade. Electronic nicotine delivery devices have seen an increase since becoming an emerging trend in 2012.

In the spring of 2022, SERAC conducted an online community survey of adults in the region (parents and nonparents). Between 9.9-11% of all adults reported that someone in their household smokes cigarettes and 6.5-7.6% use electronic cigarettes.[6] About 23% percent of youth report that it is ***definitely not true or mostly not true*** that their family has clear rules regarding smoking cigarettes, other tobacco use, or the use of ENDS. Less than 5% of parents and nonparents reported that it is ***definitely or mostly*** not true that they have clear rules.

Risk Factors and Subpopulations at Risk

Populations at-risk for smoking cigarettes are[6]:

- American Indians/Alaska Natives
- Certain Hispanic adult subpopulations in the US, including Puerto Rican adults
- LGBT 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)[7]
- Young adults (18-34)[1]
- Males[1]
- Hispanics[1]
- Current smokers
- Those living in urban communities[4]
- Adults with disabilities[2]
- Those with a high school diploma or less[2]
- Adults without health insurance[2]

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

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

The 2021 Connecticut School Health Survey shows the prevalence of current cigarette smoking among high school students to be occurring mostly among males and those in the 12th grade.[3] Additionally, students identifying as gay, lesbian, or bisexual reported higher prevalence (9.2%) than their heterosexual peers (2.3%).[3] The 2021 survey also found higher rates of current use of electronic vapor products in females (14.5%) than males (6.9%). Use was relatively consistent among race, with Hispanic students (12.4%) reporting current use more frequently than White (10.7%) or Black students (10.9%).

[5] SERAC Regional Youth Survey 2021-2022
[6] SERAC Community Survey 2022
[7] CDC (2020), Current Cigarette Smoking Among Specific Populations- United States

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

2022 Region 3 Epidemiological Profile: Tobacco & ENDS

SERAC Youth Survey Regional Summary Estimates: Perception of Harm and Access:

Approximately 78% of youth (age 12-17) in the region report that they feel there is a ***great or moderate risk*** associated with smoking cigarettes (1 or more packs a day). Only a little more than 70% of youth report that there is a ***great or moderate risk*** associated with electronic cigarettes. Approximately 29% of youth report that is would be ***very easy or sort of easy*** to get electronic cigarettes if they wanted to, compared to roughly 33% for cigarettes.

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.[7]
- 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.[9]
- 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 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 THC-containing vaping products, possibly due to substances, such as vitamin E acetate, added to the formulations. [8]

SERAC Environmental Scan Results in 2019:

- In 2019 SERAC conducted environmental scans through 5 school districts to collect informal information on the amount of confiscated ENDS/vaping devices for THC residue. Approximately 18% of devices showed some level of THC residue.

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**

In Region 3, about 55% of key informants reported that electronic nicotine delivery devices/vaping were the top concern among youth ages 12-17 whereas only 1.7% reported the same for tobacco/cigarettes.[10] Focus group respondents reported that the concern to ENDS/vaping is possibly linked to cannabis use among youth.

Several school systems have done THC testing on confiscated ENDS. The capacity and readiness to address ENDS/vaping has increased due to increase in public education and awareness activities through the work of local prevention councils and school systems. Key stakeholder and focus group data suggest that legislation address loopholes that are being exploited in vape advertisement, such as renaming flavors as colors after being flavored vapes were banned by the FDA.

[9] King BA, Jones, CM, Baldwin GT, & Briss PA. (2020). The EVALI and Youth Vaping Epidemics—Implications for Public Health
[10] 2022 CRS

Priorities

Ranking	Priority Issue	Mean Rank Score
1	Suicide	4.11
2	Heroin/Fentanyl	3.96
3	Depression	3.94
4	Alcohol	3.77
4	Trauma/PTSD	3.77
5	Prescription Drugs	3.67
6	Serious Mental Illness – Child	3.66
6	Serious Mental Illness – Adult	3.66
7	Anxiety	3.49
8	Electronic Nicotine Delivery (ENDS)	3.48
9	Cannabis	3.27
10	Cocaine	3.25
11	Tobacco	3.24
12	Problem Gambling	3.20

Ranking	Mental Health Priority Issue	Mean Rank Score
1	Suicide	4.11
2	Depression	3.94
3	Trauma/PTSD	3.77
4	Serious Mental Illness – Child	3.66
5	Serious Mental Illness – Adult	3.66
6	Anxiety	3.49
Ranking	**Substance Use Priority Issue**	**Mean Rank Score**
1	Heroin/Fentanyl	3.96
2	Alcohol	3.77
3	Prescription Drugs	3.67
4	Electronic Nicotine Delivery (ENDS)	3.48
5	Cannabis	3.27
6	Cocaine	3.25
7	Tobacco	3.24
8	Problem Gambling	3.20

Key Findings

Priority Issue: Suicide

Suicide was ranked as the top priority of Region 3. The impact of suicide and the consequences of inaction were tied as the top indicators for prioritization. In 2020, suicide was listed as the second leading cause of death in the US for ages 1-44 (CDC Injury Prevention & Control). Twenty-four of the 41 towns in Region 3 experienced an adult suicide loss in 2022 and approximately 1 in 10 youth report having seriously considered suicide in the past year (SERAC Regional Youth Survey, 2021-2022). According to the Department of Public Health's Emergency Department Visit Report for 2022, youth aged 10-17 had the highest rate per 10,000 visits for both suicidal ideation and suicide attempts in Region 3.

Capacity/readiness was the lowest ranked indicator, likely due to issues surrounding access to care, including the lack of available care given the age of the client and the intensity of their need, waitlists and response times that make it difficult to respond to emergent issues effectively, and the shortage of qualified staff to address needs. There remains a great deal of stigma related to suicidal ideation, attempts, and loss. A low efficacy of providers to address suicidal ideation and attempts appear present at times due to gaps in training across professional disciplines.

Priority Issue: Heroin & Fentanyl

Heroin and fentanyl were ranked as the second highest priority of Region 3, with the consequences of inaction ranked the highest indicator for prioritization, followed by impact. These indicators were likely ranked so high due to the fatal consequences associated with heroin and fentanyl. Within the overdose epidemic affecting the US, fentanyl has consistently risen in use to overshadow both heroin and other opioid use and continues to be a factor that contributes to accidental overdoses and deaths. Connecticut was ranked the 8th state to have the highest illicitly manufactured fentanyl overdose deaths in 2021 (SUDORS, CDC). Fentanyl was involved in over 1300 deaths while heroin was involved in 166 accidental overdose deaths in Connecticut. In Region 3, 86% of accidental overdoses included fentanyl (OCME, 2021).

Changeability was the lowest ranked indicator for heroin and fentanyl, which may speak to the difficulty in combating addiction in general. In 2022, half of the 211 calls related to substance use and addictions in Region 3 were classified as unmet. According to qualitative data, a harm reduction approach is crucial to addressing this issue. Additionally, more resources are needed, such as the availability of beds, intensive outpatient therapy, the lack of resources in the northern region, issues around information dissemination so people know where to go, safe use sites. There is a need for more recovery coaches and case managers, 24/7 supervised apartments and respite housing, and harm reduction services.

Priority Issue: Depression

Overall, depression was ranked the third highest priority of Region 3, but the top mental

health concern. The consequences of inaction was the highest indicator, followed by the magnitude. According to NAMI, 7.7% of Connecticut adults and 20.4% of youths reported a major depressive episode in the past year. The number of adults reporting experiencing a major depressive episode has increased since 2018. In 2022, 45.5% of those seeking treatment in Region 3 were seeking treatment for a mental health disorder exclusively, as compared to 40.2% in 2021 (DMHAS Treatment Admission, 2021-2022). About 35% of adults in Region 3 reported depressive feelings for more than 2 weeks as a result of the COVID-19 pandemic while 55% reported feeling down, sad, or depressed (SERAC Community Survey, 2022). Depression is a mood disorder that is pervasive, affecting many aspects of life and overall functioning. Left untreated, it may escalate into suicidal ideation or suicidal attempts. The indicator of capacity/readiness was ranked the lowest, likely due to the inability of our current services to meet the need, in terms of understaffing, waitlists, and lack of appropriate services.

Priority Issue: Alcohol

Alcohol was tied with Trauma/ PTSD for the 4th highest ranked priority issue. Magnitude was the highest ranked priority indicator with alcohol, followed by the consequences of inaction. Alcohol is the most commonly used substance nationally and in Connecticut. More than 70% of parents surveyed in 2022 reported that someone in their household uses alcohol and about 8% of parents reported that it was true that youth should be allowed to drink so that they learn how to drink responsibly. Since the pandemic in 2020, individuals aged 12+ reporting alcohol use disorder has increased almost twofold from pre-pandemic estimates (NSDUH). In 2021, 47.9% of individuals seeking treatment in Region 3 were seeking treatment for alcohol as their primary substance; this increased to 59.1% in 2022 (DMHAS Treatment, 2021-2022). According to the OCME, 26.4% of accidental overdoses included the use of alcohol in Region 3 in 2021. Alcohol ranked 3rd across all areas of substance use for impact. The social impact of alcohol use across the lifespan affects several state departments such as Department of Transportation, Department of Labor, and Department of Justice (including but not limited to motor vehicle accidents, alcohol-related crime, and unemployment). Changeability was higher for alcohol than heroin/fentanyl, prescription drug misuse, cocaine, and cannabis. Capacity/readiness for alcohol also ranked 3rd among substances followed by ENDS, prescription drug misuse, cocaine, and cannabis. This suggests that Region 3 is more amenable to addressing prevention, treatment, and recovery for alcohol use than other substances.

Priority Issue: Trauma/PTSD

Trauma/PTSD was tied with Alcohol for the 4th highest ranked priority issue. The consequences of inaction was ranked the highest priority indicator, followed by magnitude. Trauma/PTSD was ranked the 2nd highest magnitude across mental health issues. This suggests that more individuals are reporting experiences of trauma. The connection between Adverse Childhood Experiences (ACEs) and chronic health problems, such as mental health and substance use issues in adulthood, has led to the discussion of trauma/PTSD as an underlying

issue to target for prevention. Toxic stress from ACEs can affect brain development and alter the way the body responses to stress in general. These potentially traumatic experiences in childhood can influence the way that we cope well into our adulthood, therefore the consequences of inaction are dire. In terms of magnitude, the ACEs initiative has demonstrated how pervasive traumatic experiences are in our society. Changeability for Trauma/PTSD ranked higher than other mental health issues such as serious mental illness (adults) and anxiety. Capacity/readiness was ranked as the 2nd highest across all mental health issues. This suggests that Region 3 may have more ability to increase readiness in the area Trauma/PTSD to move from stage 4 (pre-planning) to stage 5 (preparation). Key leaders in education and treatment sectors could benefit from training on evidence-based practices and program in trauma informed care across the lifespan.

Priority Issue: Prescription Drugs

The issue of prescription drug misuse was ranked the 5th priority issue in Region 3. Impact and consequences of inaction were tied as the top priority indicators for this issue. Due to the fact that prescription opioid use is contributing to the opioid epidemic and subsequent loss of life due to drug overdoses, it is obvious that both the social cost and the consequences of inaction are important to address. In 2021, 8.8% of all accidental overdose deaths in Region 3 included prescription opioids (OCME, 2021). Changeability was fairly low for prescription drug misuse falling slightly above cocaine and cannabis. Capacity/readiness is moderate ranking in the middle of all substances. Region 3 has engaged sectors in educational outreach programs that highlight prevalence and trends and overview prevention strategies to school leaders, parents, youth, and healthcare professionals. Outreach and education could be expanded to target underrepresented sectors for more community wide awareness to increase readiness. Collaborations with primary care have waned since the COVID-19 pandemic and present an opportunity for re-engagement to increase brief screening, intervention, and referral to treatment.

Priority Issue: Serious Mental Illness – Child & Adult

Serious mental illness for both children and adults were tied for 6th priority issue overall. For both children and adults, the consequences of inaction was the highest ranked indicator. Consequence of inaction for serious mental illness (adults) was ranked 2nd among all mental health issues and 3rd for serious mental illness (children). In terms of magnitude, serious mental illness (children) ranked higher than adults. One in eight homeless individuals in the state of CT live with a serious mental illness (NAMI, 2021). Although changeability for both populations ranked moderately, capacity/readiness indicators were lower. This suggests that education and awareness regarding serious mental illness is inconsistent at the regional and local levels. Several respondents report little to no self-efficacy in developing prevention and promotion strategies to address due to lack of training. There is also a lack of resources for intervention and treatment facilities in the region to support children and adolescents.

Priority Issue: Anxiety

Anxiety was ranked the 7th priority concern for Region 3. Magnitude was the highest ranked indicator, followed by impact. Anxiety has become more prevalent post-pandemic, with 71% of adults reporting that they feel more anxious as a result of the COVID-19 pandemic (SERAC Community Survey, 2022). Issues related to anxiety that were noted among key stakeholders were issues related to basic needs (such as housing and food insecurity), financial issues post-pandemic (including inflation and rent spikes), and lack of resources that lead to opportunity costs (e.g., continuing college or tending to mental health). Anxiety ranked last among mental health issues and second to last for capacity/readiness. It should be noted that consequence of inaction also ranked lowest among all mental health issues. This report shows that anxiety ranked lower of a priority for Region 3 than it did two years ago. Anxiety and depression are often co-occurring issues and further information is needed in the area of anxiety to determine the decrease in priority post-pandemic. Current regional surveys (SERAC Youth Survey and Community Survey) have a gap in data collection with regard to anxiety. More indicators related to depression are collected at the local level and may yield a more comprehensive understanding of the issue among stakeholders who participated in the priority report process.

Priority Issue: Electronic Nicotine Delivery (ENDS)

ENDS was ranked the 8th priority concern for Region 3. Impact was the highest ranked indicator, followed by a tie between magnitude and the consequences of inaction. Qualitative data shows a rise in use of ENDS, particularly among youth, which among youth serving sectors may imply higher levels of impact and magnitude. Concerns regarding targeted marketing at youth populations are a concern in eastern CT. ENDS are constantly changing to aid in camouflaging as other objects. For example, there is a device that is camouflaged as an inhaler, which makes it increasingly difficult for school personnel to effectively detect and discourage use among youth. Among key stakeholders, the emerging issue of vaping and juuls was of particular concern among youth, specifically regarding the marketing targeted towards children. The need for increased compliance checks regarding age restrictions is needed in the region. Education for licensed merchants of nicotine on checking ID's and preventing underage sales is needed. Changeability for ENDS is high among all substance and moderate for capacity/readiness. Issues related to youth and prevention appear to have more readiness than cessation and treatment programs for adults.

Priority Issue: Cannabis

Cannabis was ranked the 9th priority concern for Region 3. Magnitude and impact were tied as the top indicators for cannabis. Cannabis use is prevalent among youth and adults in CT. According to SERAC's Regional Youth Survey (2021-2022), more youth report past 30 day cannabis use than any other substance. Key stakeholder interviews revealed that the legalization of cannabis, on some level, communicates that cannabis use is acceptable, which

encourages use. Similarly, about 36% of parents reported that there was little to no risk associated with youth using cannabis 1-2 times a week. Cannabis legalization has led to a decrease in perception of harm. Consequence of inaction for cannabis falls low only ranking above tobacco among all substances. It is clear that youth and adults across the region have inadequate understanding regarding the associated harms and consequences of cannabis use. More education and awareness are needed in the region regarding the physiological, social, and mental effects of cannabis use. Changeability and capacity/readiness is the lowest for cannabis among all substances as well. To increase readiness from vague awareness to pre-planning, cultivating and developing more regional leadership to address this issue is required.

Priority Issue: Cocaine

Cocaine was ranked the 10th priority concern for Region 3. The consequences of inaction was the highest ranked indicator, followed by impact. Cocaine seems to be a drug commonly used in polysubstance use. Of all accidental drug-related deaths in Region 3 in 2021, 45.6% included cocaine and 91.3% included multiple substances. Prolonged use of cocaine has toxic effects on the heart and cardiovascular system, which can contribute to accidental drug-related death due to the weakened state (NIDA, 2021). In CT, 17 per 100,000 people die of cocaine use (SUDORS). The highest use of cocaine is among 18-25 year olds in CT (NSDUH). RBHPSW members ranked cocaine with the second to lowest magnitude across all substances. Focus group data implied that there was a lack of accurate quantitative data with regard to cocaine use for populations 18 years and older. More local data from the law enforcement and healthcare sectors would help to increase readiness and understanding of the issue across the lifespan within the community. The lowest ranked indicator was a tie between changeability and capacity and readiness. Addressing polysubstance use is important, yet researchers still tend to view substances individually. Education and prevention related to stimulant use (cocaine and nicotine) appear to be a gap in eastern CT.

Priority Issue: Tobacco

Tobacco was ranked the 11th priority concern for Region 3. The highest ranked indicator was a three-way tie between impact, capacity/readiness, and consequences of inaction. Tobacco use, in terms of smoking cigarettes and pipes, has fallen in popularity given smoke-free policies and taxes. Arguably, the use of ENDS has replaced traditional tobacco use, hence why magnitude was the lowest ranked indicator for this priority issue. Changeability and capacity/readiness is highest for tobacco among all other substances. This suggests that prevention and education strategies implemented over the past 20 years alongside public policy changes have made an affected magnitude and social impacts. It should be noted however that nicotine education and awareness as a collective whole across both tobacco products and ENDS is needed across the region.

Priority Issue: Problem Gambling

Problem gambling was ranked the 12th priority concern for Region 3. The highest ranked indicator for problem gambling was impact, followed by a tie between magnitude and consequences of inaction. Impact is likely ranked as the highest indicator because the financial costs associated with gambling use disorder can be debilitating and may be a risk factor for suicide. Key stakeholder interviews suggested that online gambling is a risk factor for developing a gambling use disorder. Increased access and availability of legalized gambling venues in eastern CT is an opportunity for prevention planning. Social norms and views of acceptability presented through local conditions in the region reduce the perception of harm and consequence of inaction. Through technology advancements, the field of gambling is evolving, and service providers need to grow with the ever-changing landscape. The lowest ranked indicator was a tie between changeability and capacity and readiness. RBHPSW members indicated the need for more education and awareness regarding local alternative activities and prosocial events.

Emerging Issues

Mental Health

Emerging issues in mental health include the necessity of implementing trauma-informed practices within mental health services. Prevention related to intergenerational trauma and culturally inclusive programming is an emerging prevention issue important to stakeholders. Similarly, there is a call for school-based health centers for secondary schools and colleges so that early identification of mental health issues can be made and addressed.

Suicide

Suicide ideation continues to be an issue of concern among youth aged 10-17 in Region 3. According to emergency department visit data in 2022, suicidal ideation and suicide attempt rates are highest among those 10-17. Approximately 1 in 10 youth reported that they have seriously considered attempting suicide (SERAC Youth Survey, 2021-2022). The effects of the COVID-19 pandemic have yet to fully unfold, but the concern about financial stress, isolation, mental health struggles, and limited access to health care services leading to increased suicides remains prevalent.

Substance Use

In addition to issues around access to care, stakeholders were concerned about youth use of cannabis post legalization, e-cigarette and vape use, fentanyl use and the lacing of fentanyl in other drugs, the emerging use of xylazine and stimulant use, and the need for science-based alternative recovery programs to the faith-based 12 step program.

Although cannabis use did not emerge as a top concern for the region, qualitative data suggests that youth use is a top concern. The 2021-2022 Regional Youth Survey shows that

cannabis is the most commonly used substance within the past 30 days among youth in grades 6-12, eclipsing both alcohol and e-cigarettes. Youth are commonly using vape products to vape THC as well. About 25-30% of youth report that they believe there is a great risk associated with using cannabis and 18-27% report that they don't know how to assess the risk associated with using cannabis. In the SERAC 2022 Community Survey, 12.7% of high school parents reported that they thought it was mostly true that youth should be allowed to use cannabis, so they learn how to use it responsibly and about 7% of high school parents reported that there has been a party at their home in which cannabis was consumed by youth in the past year. Altogether, this suggests a more permissive view of cannabis use within the eastern region that may culminate in increased use among youth in future.

According to the OCME, 86% of all accidental drug deaths in Region 3 involved fentanyl in 2021; about 34% included xylazine and 46% included cocaine use. Key stakeholders suggested that there is not adequate information regarding the prevention of fentanyl exposure as well as guidance for fentanyl clean up and how to reduce the risks to others in the same environment. Similarly, the increase in use of xylazine is leading to serious skin issues and amputations in patients.

Problem Gambling

Emerging issues in problem gambling mostly surround the new methods of gambling available. Sports betting became legal in Connecticut in October of 2021, allowing individuals to gamble via online sport betting apps such as DraftKings. Key stakeholders maintain that online gambling makes it easier for underage youth to participate in gambling and that the expansion of gambling online has quickly increased the need for prevention, education, and new methods to treat gambling problems. Similarly, online gaming has been linked to gambling behaviors and so youth online gaming behaviors, particularly around loot boxes, may be an indicator of future gambling issues.

Consequences of the COVID-19 Pandemic.

Key stakeholders often referenced the changes in our society due to the COVID-19 pandemic, both positive and negative. On the positive side, stakeholders advocate for the continuation of telehealth care, arguing that it allows individuals greater access to care and addresses some barriers like transportation issues and childcare. Ideally, telehealth would receive legislative support so that it remains available to clients. Additionally, it was commonly referenced that the stigma around mental health has substantially lessened due to the pandemic and the heightened attention that mental health concerns received while the population was quarantined.

On the other hand, it seems as if a lot of mental health and substance use patient care professionals chose to leave the field during the pandemic, causing an issue of understaffing and lack of qualified individuals to hire to address the gap. Further, certain protections were provided during the pandemic that have been phased out and unreplaced, such rent

protections and stimulus checks. The subsequent economic inflation and rent increases post-COVID are causing a lot of housing and food insecurities and making it more difficult for individuals to meet their basic needs. Before addressing mental health or substance use issues, individuals need to provide for their basic needs, making this an emerging barrier that needs to be addressed imminently.

Another consequence of the COVID-19 pandemic is the issue around truancy among youth. There seems to be an emerging trend where school professionals are finding it difficult to encourage and enforce school attendance. Chronic absenteeism from school and disengagement are risk factors associated with substance use in youth, so this truancy issue may be predictive of future substance use issues within Region 3.

Resources, Strengths, Assets in the Region

Prevention

In Region 3, areas of prevention are strongest in youth substance use, primarily focusing on alcohol, tobacco/ENDS, cannabis, and prescription drug misuse. This is largely due to the support from federally funded grants such as Drug Free Communities and STOP Act Grants. Southeastern CT has more comprehensive local coalitions due to a stronger infrastructure supported by town and regional resources. RBHPSW members note the asset of the Regional Behavioral Health Action Organization (SERAC) in providing mini-grant assistance at the town level (local prevention council grants and state opioid response grants). The sectors engaging the most in prevention efforts across the region are schools and youth serving organizations. Several towns have implemented their own local media campaigns to support community awareness on public policy and perception of harm. Regionally, SERAC has developed and implemented social norming campaigns to target rural communities and address the gaps for the northeastern region through federally funded grant initiatives. Training for professionals, presentations for youth, and information dissemination are among the top resources in the region. Some examples of the specific training that have been noted are naloxone administration, suicide prevention, and vaping prevention. There are several community collaborations at the town and regional level that serve as partners for treatment and recovery in planning. A particular asset in Region 3 is the ability to collect local youth data through partnerships with schools and coalitions. The collection of youth data has assisted many communities to make policy changes at both school and town levels (i.e. advocacy for school based mental health, school naloxone policies, local ordinances on cannabis dispensaries).

Treatment and Recovery

Across substance use, problem gambling, mental health, and suicide, the most mentioned strength among key stakeholders was that of collaboration across providers and the ability to attend meetings where multidisciplinary community members come together to network and discuss the issue at hand. Key stakeholders feel empowered that, although there may be a lack of resources, they can reach out to their network and count on the fact that

other professionals in the field will do whatever they can to coordinate care for a client in need. In addition to these networks, there are local Community Care Teams that consist of community members, such as police officers, social workers, and other professional providers, as well as volunteers, that come together to address local issues. Response hotlines such as 211, 988, and the 1-800 number for gambling were also mentioned as an asset in the region.

Resource Gaps and Needs in the Region

The most common issues among substance use, mental health, and suicide were (1) lack of access to services due to capacity issues around being understaffed, staff turnover, lack of qualified individuals in the field, waitlists that are too long, and lack of appropriate available services in the area; (2) the need to merge substance use and mental health services in order to appropriately meet client needs; (3) the need for an interdisciplinary approach and increased communication between public service providers, such as a partnership between social workers and police, services to refer individuals to once they depart from the hospital, peer services for issues; and (4) issues surrounding meeting basic needs of clientele, including housing, food insecurity, and transportation barriers.

Prevention

Although prevention efforts are often heralded as a strength in Region 3, there remain areas for improvement. Primarily, problem gambling would benefit from a needs assessment and more prevention efforts in the region. It seems as if problem gambling continues to be assessed as a low priority simply due to the fact that key stakeholders report not knowing enough about problem gambling in Region 3. Given the changing landscape of gambling, a regional needs assessment that investigates the interrelations between new facets of gambling, gaming and internet use would allow stakeholders to better understand the scope of the issue.

Regarding mental health and suicide, Connecticut is fortunate in that there are mandates that ensure suicide prevention programming in schools. However, there is no system in place to ensure that these programs and activities are being made available to youth, so there is a question as to whether the mandate is being adhered to. Similarly, there is a call to implement more school-based mental health centers so that mental health issues can be identified and addressed early on and increase access to services among youth. Community colleges and universities would benefit from a similar approach by having counseling services largely available and wellness counselors on every campus. As whole, the region would benefit from a comprehensive plan to implement mental health promotion strategies across all sectors to reach youth and adults across the lifespan.

Substance use issues would benefit from a harm reduction approach in addition to prevention approaches. Current models are too restrictive to appropriately meet needs prior to a crisis or overdose. Harm reduction is an evidence-based practice that promotes client engagement and can be utilized as both a prevention and treatment approach. Key

stakeholders suggested that youth peers be trained as advocates so that they can understand when it is necessary to call for help if their friend is using a substance. Similarly, there is a call for recovery navigators in schools and increased training and education for youth and staff in the school system. A curriculum of parent education about underage use of alcohol, cannabis, and cannabis legalization was also suggested. Due to the increased youth use of ENDS, a prevention program that targets the physical and mental health consequences of the substance of nicotine specifically, rather than focusing on the method of ingestion (ENDS, cigarettes, etc.), is appropriate.

Treatment and Recovery

Although it is acknowledged that there are appropriate services available, those services are limited by their own capacity, which leads to waitlists and an inability to meet the needs in the region. Key stakeholders indicated that it was often necessary to refer an individual to substance use services out of state, simply to get them immediate care, which might undermine the efficacy of care given the client leaving their support network to seek care. Similarly, the Intensive In-Home Child and Adolescent Psychiatric Services (IICAPS) program has ceased to function in Region 3, which leads to a huge gap in resources available for youth. There is a call for more in-home services across the board for both mental health and substance use treatment. Because of scarce resources in the northeastern region of CT, clients are often referred to services in the southeast corner, which leads to bottlenecking issues, especially for emergency departments, who then have the problem of not knowing where to refer patients after discharge for appropriate care.

Often, it was lamented that substance use counselors and mental health counselors required different licensure, which was noted as a significant barrier. To comply with licensure requirements, providers indicated they would need to hire a staff specific to each issue, which was a huge tax on their available resources. Key stakeholders suggested that DMHAS and the DPH collaborate to streamline the licensure so that counselors would be more easily certified to address both mental health and substance use issues.

Barriers to treatment continue to contribute to the prevalence of mental health and substance use issues in Region 3. Specifically, medical insurance presents a huge barrier for treatment as it is difficult to navigate and undermines the ability to receive care. Basic needs were discussed often in terms of housing issues, food scarcity, transportation issues, and childcare. Among stakeholders, there was a call for more case managers to help guide clients to resources and address some of these common barriers.

Underserved Subpopulations

Mental Health. New mothers, 2SLGBTQ+ youth, emerging and young adults, veterans, autistic children, those newly released from prison, first-generation immigrants/refugees, Hispanic/Latinos, and those with English as a second language were identified as underserved by the mental health services in Region 3. Again, those affected by a language barrier were

most noted as being underserved.

Suicide. Youth aged 10-17, 2SLGBTQ+, low-income individuals struggling to meet basic needs, males 18 and older, veterans and military affiliated subpopulations.

Substance Use. Low-income individuals struggling to meet basic needs, homeless individuals, undocumented individuals who might be fearful to access services, those with English as a second language (language issues), members of the 2SLGBTQIA+ community, parents, retail/service workers, elderly, and Hispanic/Latinos were identified as underserved populations. Language barriers and Hispanic/Latinos were most often cited as underserved due to the issues with cultural inclusion and language.

Problem Gambling. East Asian individuals, youth under 18, 21-30 year olds, elderly, undocumented individuals, and Hispanic/Latinos were identified as underserved within Region 3. Commonly, a concern regarding the emerging issue of online gambling affecting youth was expressed, along with concerns regarding language barriers and appropriately engaging with those who do not speak English.

Conclusions & Recommendations

In conclusion, the regional priority report demonstrates the clear need to prioritize co-occurring mental health and substance use issues for future regional and local planning purposes in conjunction with an imminent need to address the capacity crisis that is undermining providers' ability to meet the demand for care.

Recommendations

In effort to supplement clinical care and engage individuals in wellness programs that may meet the demand for subclinical treatment, it is recommended that the region work with the business sector in order to engage workplaces to implement wellness programs. Engaging workplaces post-pandemic will allow access to the general population that usually are not reached by typical methods. These individuals might be suffering from subclinical mental health or substance use issues and would benefit from primary and secondary prevention efforts. Further, accessing individuals via the workplace allows access to all 12 sectors pertinent to community change (i.e., adolescents, young adults, parents, school professionals, law enforcement officials, healthcare provider, media outlets, and faith-based communities).

It is an overall recommendation to increase the capacity of the prevention workforce through developing nontraditional community pathways for residents to receive skills for community development. In order to meet the goals of the RBHAO to increase readiness, to build the capacity, to raise awareness, stable funding and professional development opportunities related to infrastructure are needed. While there are pockets across the region where more support exists, this targeted recommendation would work to reach those communities struggling with capacity, such as small rural towns in eastern CT. RBHAOs should conduct needs assessments across businesses and workplaces in the region as they rebuild from the pandemic, to provide education on the prevention, mental health, problem gambling, and suicide efforts. This will support community engagement and universal information dissemination.

Specific recommendations are displayed below within the Summary of Priority Recommendations Region 3 table.

Summary of Priority Recommendations Region 3

Problem/Issue	Prevention	Treatment	Recovery
Substance Use/Misuse			
Region	• Develop a regional curriculum to educate parents and community about underage cannabis and alcohol use to address the perception of harm and social hosting laws. • Develop a social-norming campaign promoting asset-based messaging to address stigma associated with choosing not to drink alcohol and alcohol-free lifestyles. • Focus ATOD prevention efforts to target emerging adult populations not attending college or university • Aim efforts at collaborating with business sectors to engage workplaces in primary and secondary prevention strategies.	• Increase screening and interventions for polysubstance use and address the lack of awareness regarding substance use disorders related to cocaine and cannabis use. • Develop a regional workforce training opportunities related to fentanyl overdose and how to manage exposure to fentanyl. • Develop and implement a nicotine cessation program targeted at youth. • Increase animal-assisted therapy options for supportive care services.	• Increase non-faith, science-based support groups (other than 12 step programs) for those in recovery and expand faith-based supports to be more culturally inclusive of religions other than traditional Christianity.
State	• Develop a prevention campaign around the ingestion of nicotine itself, rather than focusing on the method of ingestion (ENDS) targeted at both youth and adult populations. • Develop a statewide plan to sustain substance use prevention across the lifespan through collaboration with all state departments: DMHAS, DCF, DPH, DOL, DOJ, and SDE. • Develop a prevention and early intervention plan for addressing alcohol use disorders among adults age 21 and older. • Develop a statewide plan for driving while impaired (polysubstance) to include education to youth, parents, and businesses (seller/servers).	• Educate policy leaders and treatment providers on harm-reduction models for substance use as a whole and implement harm reduction centers across the region. • Review the policies and guidelines for patients to qualify for in-home treatment that may be too restrictive, especially for parents suffering with substance use issues. • Sustain the implementation of telehealth through policy development in order to ameliorate barriers related to transportation, childcare, economics, and employment. • Increase funding to expand treatment providers in the northeast area of the region. • Develop a program to encourage learning Spanish as a second language so as to address the language barrier commonly reported.	• Expand options for recovery support that provide cash assistance post-treatment for 90 days for basic needs in order to stabilize individuals as they transition from treatment providers. • Create the statewide infrastructure to support collaboration between law enforcement and behavioral health to provide early intervention and diversionary planning for individuals at risk of overdose and suicide. • Direct funding to support prosocial activities at the local level to support those in recovery.

Mental Health			
Region	• Develop a plan of action to educate the community on serious mental illness and health promotion. • Focus prevention efforts on underlying causes of the top 2 priority issues (suicide and heroin/fentanyl) in region 3, such as depression, trauma/PTSD, and alcohol use to have a greater impact on reducing mortality rates. • Increase universal screening for early suicidality risk factors in community-based settings. • Conduct a regional data collection/study on risk factors for mental health crisis, challenges, and disorders in the region. • Implement a prevention program with pregnant women and partners to mitigate past traumas, substance use, and mental health disorders in eastern CT. • Aim efforts at collaborating with business sectors to engage workplaces in primary and secondary prevention strategies.	• Increase intensive outpatient mental health services for youth and children in eastern CT. • Increase animal-assisted therapy options for supportive care services. Increase intensive outpatient mental health services for youth and children in eastern CT. • Increase training and presentations regarding trauma/PTSD to treatment providers.	• Increase non-faith, science-based support groups (other than 12 step programs) for those in recovery and expand faith-based supports to be more culturally inclusive of religions other than traditional Christianity. • Pilot more recovery support groups with educational sessions and prosocial supports in eastern CT for residents age 18 and older.
State	• Incentivize school-based health centers for mental health in youth and young adults in public schools and universities. • Standardize the use of universal screening for ACES in school systems and youth serving organizations.	• Increase respite housing across the region. • Develop a concrete plan to integrate trauma-informed practice in mental health and substance use with training protocols and fidelity to implementation. • Increase salary across the treatment workforce so as to increase employee retention and recruit competitive candidates. • To address the staffing crisis, review statewide certificate program requirements for mental health, addiction, suicide prevention through the CCB to expedite the process so that more individuals enter the workforce sooner. • Sustain the implementation of telehealth through policy development to ameliorate barriers related to transportation, childcare, economics, and employment. • Develop a program to encourage learning Spanish as a second language to address the language barrier.	• Create a statewide infrastructure to support collaboration between law enforcement and behavioral health to provide early intervention and diversionary planning for individuals at risk of overdose and suicide. • Direct funding to support prosocial activities at the local level to support those in recovery.

Problem Gambling			
Region	• Regional needs assessment to understand the prevalence of gambling/gaming problems and behaviors as well as risk and protective factors surrounding the issues. • Aim efforts at collaborating with business sectors to engage workplaces in primary and secondary prevention strategies.	• Provide youth gambling treatment to address the gap in service. • Enhance culturally inclusive practices to support subpopulation needs such as age, gender, SES, ethnicity, and geographic location.	• Increase non-faith, science-based support groups (other than 12 step programs) for those in recovery and expand faith-based supports to be more culturally inclusive of religions other than traditional Christianity. • Implement youth support groups and alternative activities for gaming, internet, and gambling addictions.
State	• Develop a state-wide prevention campaign for gambling. • Increase prevention funding across the 5 regions to prioritize gambling issues.	• Sustain the implementation of telehealth through policy development in order to ameliorate barriers related to transportation, childcare, economics, and employment. • Enhance information technology services and integrate artificial intelligence to expand access to care by providing support in more culturally inclusive ways. • Develop a program to encourage learning Spanish as a second language so as to address the language barrier commonly reported.	• Direct funding to support prosocial activities at the local level to support those in recovery. • Develop more resources for those in gambling recovery, such as putting a stop to financial collection calls for 30 days for those diagnosed with a gambling disorder.

Appendix A: Priority Ranking Matrix Mean Scores

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	4.00	3.79	3.26	2.79	3.63	17.47	3.49
DEPRESSION	4.42	4.32	3.37	3.00	4.58	19.68	3.94
TRAUMA/PTSD	4.21	4.00	3.37	3.00	4.26	18.84	3.77
SERIOUS MENTAL ILLNESS – CHILDREN	4.11	4.00	3.37	2.58	4.26	18.32	3.66
SERIOUS MENTAL ILLNESS – ADULTS	4.00	3.89	3.32	2.79	4.32	18.32	3.66
SUICIDE	4.42	4.58	3.63	3.32	4.58	20.53	4.11

Priority Ranking Matrix Mean Scores

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	4.32	4.16	3.05	3.11	4.21	18.84	3.77
TOBACCO	3.00	3.32	3.26	3.32	3.32	16.21	3.24
ELECTRONIC NICOTINE DELIVERY SYSTEMS (ENDS), VAPING, JUULING, ETC.	3.68	3.79	3.21	3.05	3.68	17.42	3.48
CANNABIS	3.74	3.74	2.74	2.58	3.58	16.37	3.27
PRESCRIPTION DRUG MISUSE	4.05	4.21	2.84	3.05	4.21	18.37	3.67
HEROIN AND FENTANYL	4.32	4.58	3.00	3.16	4.74	19.79	3.96
COCAINE	3.42	3.47	2.79	2.79	3.79	16.26	3.25
PROBLEM GAMBLING	3.32	3.47	2.95	2.95	3.32	16.00	3.20

Appendix B: Key Stakeholder Survey

2023 SERAC Regional Priority Report - Stakeholder Survey

You have been selected as a key stakeholder in the Eastern region of CT to help provide SERAC and the CT Department of Mental Health Addiction Services with important information to guide the future planning for our region.

This survey should take approximately 10 minutes and is extremely important to the residents in our area.

1. Do you consent to participate in our survey?

- ◯ Yes
- ◯ No

2023 SERAC Regional Priority Report - Stakeholder Survey

The following questions pertain to issues in behavioral health across the spectrum (prevention, treatment and recovery) specifically for the Eastern region of CT.

2. Which of the following best describes you? (Please choose only 1)

- ☐ DHMAS-funded mental health treatment provider
- ☐ DHMAS-funded substance abuse treatment provider
- ☐ DHMAS-funded problem gambling treatment provider
- ☐ Private funded mental health treatment provider
- ☐ Private funded substance abuse treatment provider
- ☐ Private funded problem gambling treatment provider
- ☐ Consumer of substance abuse treatment services
- ☐ Consumer of mental health treatment services
- ☐ Consumer of problem gambling treatment services
- ☐ Youth Serving Organization
- ☐ Prevention Coalition
- ☐ Other (please specify)

3. Would you say you primarily work in prevention, treatment, or recovery?

- ◯ Prevention
- ◯ Treatment
- ◯ Recovery
- ◯ N/A - I don't have a job in any of these areas

Available Services

4. How appropriate are the available services to meet the need for:

	Very appropriate	Somewhat appropriate	Appropriate	Somewhat inappropriate	Very inappropriate
Substance Use Prevention	◯	◯	◯	◯	◯
Substance Use Treatment	◯	◯	◯	◯	◯
Substance Use Recovery	◯	◯	◯	◯	◯

5. How appropriate are the available services to meet the need for:

	Very appropriate	Somewhat appropriate	Appropriate	Somewhat inappropriate	Very inappropriate
Mental Health Promotion	◯	◯	◯	◯	◯
Mental Health Treatment	◯	◯	◯	◯	◯
Mental Health Recovery	◯	◯	◯	◯	◯

6. How appropriate are the available services to meet the need for:

	Very appropriate	Somewhat appropriate	Appropriate	Somewhat inappropriate	Very inappropriate
Problem Gambling Prevention	◯	◯	◯	◯	◯
Problem Gambling Treatment	◯	◯	◯	◯	◯
Problem Gambling Recovery	◯	◯	◯	◯	◯

Prevention programs, policies and strategies

7. What prevention program, strategy or policy would you like most to see accomplished related to each of the following?

Substance Use

Mental Health

Problem Gambling

Treatment Levels of Care

8. What treatment levels of care do you feel are unavailable or inadequately provided for each of the following?

Substance Use

Mental Health

Problem Gambling

Adjunct services / Support services / Recovery supports

9. What adjunct services/support services/recovery supports are most needed to assist individuals with each of the following?

Substance Use Issues

Mental Health Issues

Problem Gambling Issues

Strengths/ Assets

10. What would you say is the greatest strength/asset of each of the following?

Substance Use Prevention/Treatment/Recovery Service System

Mental Health Promotion/Treatment/Recovery Service System

Problem Gambling Prevention/Treatment/Recovery Service System

Subpopulations

11. Are there any particular sub-populations that are not being adequately served by the **substance use** service system?

- Youth under age 13
- Youth age 14-17
- Young Adults age 18-25
- Adults age 26-64
- Adults age 65 and older
- Military (active and/or veterans)
- English as a Second Language (ESL)
- Sexual Orientation (LGBQ)
- Transgender Individuals
- Female specific populations
- Male specific populations
- Ethnic or racial populations (specify below)

Other or additional comments

12. Are there any particular sub-populations that are not being adequately served by the **mental health service** system?

- [ ] Youth under age 13
- [ ] Youth age 14-17
- [ ] Young Adults age 18-25
- [ ] Adults age 26-64
- [ ] Adults age 65 and older
- [ ] Military (active and/or veterans)
- [ ] English as a Second Language (ESL)
- [ ] Sexual Orientation (LGBQ)
- [ ] Transgender Individuals
- [ ] Female specific populations
- [ ] Male specific populations
- [ ] Ethnic or racial populations (specify below)

Other or additional comments

13. Are there any particular sub-populations that are not being adequately served by the **problem gambling service** system?

- [ ] Youth under age 13
- [ ] Youth age 14-17
- [ ] Young Adults age 18-25
- [ ] Adults age 26-64
- [ ] Adults age 65 and older
- [ ] Military (active and/or veterans)
- [ ] English as a Second Language (ESL)
- [ ] Sexual Orientation (LGBQ)
- [ ] Transgender Individuals
- [ ] Female specific populations
- [ ] Male specific populations
- [ ] Ethnic or racial populations (specify below)

Other or additional comments

Emerging Issues

14. Are there any emerging prevention, treatment or recovery issues that you are seeing or hearing related to **substance use** issues?

15. Are there any emerging prevention, treatment or recovery issues that you are seeing or hearing related to **mental health** issues?

16. Are there any emerging prevention, treatment or recovery issues that you are seeing or hearing related to **problem gambling**?

Opportunities

17. Are there any opportunities for the DMHAS service system that aren't being taken advantage of such as technology, partnerships, etc?

Appendix C: Key Stakeholder Response Summary (Quantitative Responses Only)

Q2. Which of the following best describes you?

ANSWER CHOICES	RESPONSES	
DHMAS-funded mental health treatment provider	0.00%	0
DHMAS-funded substance abuse treatment provider	0.00%	0
DHMAS-funded problem gambling treatment provider	0.00%	0
Private funded mental health treatment provider	0.00%	0
Private funded substance abuse treatment provider	0.00%	0
Private funded problem gambling treatment provider	7.69%	1
Consumer of substance abuse treatment services	0.00%	0
Consumer of mental health treatment services	0.00%	0
Consumer of problem gambling treatment services	0.00%	0
Youth Serving Organization	7.69%	1
Prevention Coalition	15.38%	2
Other (please specify)	92.31%	12
Total Respondents: 13		

Q3. Would you say you primarily work in prevention, treatment, or recovery?

ANSWER CHOICES	RESPONSES	
Prevention	30.77%	4
Treatment	15.38%	2
Recovery	38.46%	5
N/A – I don't have a job in any of these areas	15.38%	2

TOTAL 13

Q4. How appropriate are the available services to meet the need for:

	VERY APPROPRIATE	SOMEWHAT APPROPRIATE	APPROPRIATE	SOMEWHAT INAPPROPRIATE	VERY INAPPROPRIATE	TOTAL
Substance Use Prevention	8.33% 1	16.67% 2	33.33% 4	33.33% 4	8.33% 1	12
Substance Use Treatment	25.00% 3	8.33% 1	16.67% 2	33.33% 4	16.67% 2	12
Substance Use Recovery	16.67% 2	8.33% 1	33.33% 4	33.33% 4	8.33% 1	12

Q5. How appropriate are the available services to meet the need for:

	VERY APPROPRIATE	SOMEWHAT APPROPRIATE	APPROPRIATE	SOMEWHAT INAPPROPRIATE	VERY INAPPROPRIATE	TOTAL
Mental Health Promotion	16.67% 2	16.67% 2	33.33% 4	25.00% 3	8.33% 1	12
Mental Health Treatment	16.67% 2	16.67% 2	8.33% 1	50.00% 6	8.33% 1	12
Mental Health Recovery	16.67% 2	16.67% 2	25.00% 3	33.33% 4	8.33% 1	12

Q6. How appropriate are the available services to meet the need for:

	VERY APPROPRIATE	SOMEWHAT APPROPRIATE	APPROPRIATE	SOMEWHAT INAPPROPRIATE	VERY INAPPROPRIATE	TOTAL
Problem Gambling Prevention	9.09% 1	36.36% 4	27.27% 3	9.09% 1	18.18% 2	11
Problem Gambling Treatment	9.09% 1	18.18% 2	36.36% 4	18.18% 2	18.18% 2	11
Problem Gambling Recovery	9.09% 1	27.27% 3	27.27% 3	18.18% 2	18.18% 2	11

Q11. Are there any particular sub-populations that are not being adequately served by the substance use service system?

ANSWER CHOICES	RESPONSES	
Youth under age 13	36.36%	4
Youth age 14-17	63.64%	7
Young Adults age 18-25	9.09%	1
Adults age 26-64	0.00%	0
Adults age 65 and older	18.18%	2
Military (active and/or veterans)	27.27%	3
English as a Second Language (ESL)	45.45%	5
Sexual Orientation (LGBQ)	18.18%	2
Transgender Individuals	9.09%	1
Female specific populations	9.09%	1
Male specific populations	9.09%	1
Ethnic or racial populations (specify below)	36.36%	4

Q13. Are there any particular sub-populations that are not being adequately served by the mental health service system?

ANSWER CHOICES	RESPONSES	
Youth under age 13	41.67%	5
Youth age 14-17	50.00%	6
Young Adults age 18-25	16.67%	2
Adults age 26-64	0.00%	0
Adults age 65 and older	25.00%	3
Military (active and/or veterans)	25.00%	3
English as a Second Language (ESL)	33.33%	4
Sexual Orientation (LGBQ)	16.67%	2
Transgender Individuals	16.67%	2
Female specific populations	8.33%	1
Male specific populations	8.33%	1
Ethnic or racial populations (specify below)	33.33%	4
Total Respondents: 12		

Q12. Are there any particular sub-populations that are not being adequately served by the problem gambling service system?

ANSWER CHOICES	RESPONSES	
Youth under age 13	0.00%	0
Youth age 14-17	50.00%	3
Young Adults age 18-25	50.00%	3
Adults age 26-64	0.00%	0
Adults age 65 and older	16.67%	1
Military (active and/or veterans)	16.67%	1
English as a Second Language (ESL)	16.67%	1
Sexual Orientation (LGBQ)	0.00%	0
Transgender Individuals	0.00%	0
Female specific populations	16.67%	1
Male specific populations	0.00%	0
Ethnic or racial populations (specify below)	16.67%	1
Total Respondents: 6		

Appendix D: Focus Group Questions

Stakeholder Focus Group Introduction Script

Introduction

Thank you for taking the time to meet with us today. The purpose of this focus group is to understand important issues around the field of [mental health / problem gambling / suicide / substance use]. This information will help provide SERAC and the CT Department of Mental Health Addiction Services with important information to guide the future planning for our region. The information learned in this focus group will be used to identify priority issues within the eastern Connecticut region.

Here are a couple of things to remember about how a focus group works.

- First, please remember, there are no right or wrong answers to any of the questions that we ask. If you don't feel comfortable answering any question you don't have to.
- Second, we'll ask everyone to please not interrupt so that we make sure everyone gets a chance to talk.
- Third, because we really want to hear what everyone thinks, if it seems like someone is not speaking up, we may ask them what they think.
- Next, we'd like to encourage you all to speak to one another as much as possible. We are here to focus the discussion amongst you.
- Finally, we ask that everyone please agree to keep whatever is said in here private. While it's okay to talk about the focus group generally, we ask that each of you not talk to anyone about what specific people say today.

Because we want to be able to remember everything that people tell us today, we'll be taking some notes about what people say. Sometimes, we can't write fast enough to keep up, so we're also going to digitally record what is being said. This way, we can check later to make sure we get everything right.

I just want to stress once again that everything you say will be confidential. If your name gets recorded, we'll make sure it gets erased from the transcript.

- Our discussion will take just 1 hour. Please feel free to get refreshments or use the bathroom at any time during our discussion.
- Does anyone have any questions about anything I have said?
- Okay, we'd like to start now.

Substance Use

Prevention, Treatment, and Recovery

1. How appropriate are available services to meet the needs of substance use prevention, treatment, and recovery?
2. What prevention program, strategy or policy would you like to most to see accomplished <u>this year</u> related to substance use?
3. What treatment or services do you feel are unavailable or inadequately provided related to substance use?
4. What adjunct services/support services/recovery supports are most needed to assist persons with substance use issues?
5. What would you say is the greatest strength/asset of the substance use prevention, treatment, and recovery services in your region?
6. Are there particular subpopulations (for example, veterans, LGBTQ, Latinos, etc.) that aren't being adequately served by the substance use services in your region?
7. What are the emerging prevention issues that you are seeing or hearing about substance use issues?
   PROMPT: How/where are you seeing/hearing about these emerging issues, or what evidence is there of these (e.g. social media, TV news)?

8. What are the opportunities regarding provision of services that aren't being taken advantage of (technology, integration, partnerships, etc.)?
9. Where are the areas that services can be improved? What can be done differently?

Problem Gambling

Prevention, Treatment, Recovery

1. How appropriate are available services to meet the needs of problem gambling prevention, treatment, and recovery?
2. What prevention program, strategy or policy would you like to most to see accomplished this year related to problem gambling?
3. What treatment or services do you feel are unavailable or inadequately provided related to problem gambling?
4. What adjunct services/support services/recovery supports are most needed to assist persons with problem gambling?
5. What would you say is the greatest strength/asset of the problem gambling prevention, treatment, and recovery services in your region?
6. Are there particular subpopulations (for example, veterans, LGBTQ, Latinos, etc.) that aren't being adequately served by the problem gambling services in your region?
7. What are the emerging prevention issues that you are seeing or hearing about problem gambling issues?
   PROMPT: How/where are you seeing/hearing about these emerging issues, or what evidence is there of these (e.g. social media, TV news)?
8. What are the opportunities regarding provision of services that aren't being taken advantage of (technology, integration, partnerships, etc.)?
9. Where are the areas that services can be improved? What can be done differently?

Mental Health / Suicide

Prevention, Treatment, and Recovery

1. How appropriate are available services to meet the needs of mental health / suicide prevention, treatment, and recovery?
2. What prevention program, strategy or policy would you like to most to see accomplished this year related to mental health / suicide?
3. What treatment or services do you feel are unavailable or inadequately provided related to mental health / suicide?
4. What adjunct services/support services/recovery supports are most needed to assist persons with mental health / suicide issues?
5. What would you say is the greatest strength/asset of the mental health / suicide prevention, treatment, and recovery services in your region?
6. Are there particular subpopulations (for example, veterans, LGBTQ, Latinos, etc.) that aren't being adequately served by the mental health / suicide services in your region?
7. What are the emerging prevention issues that you are seeing or hearing about mental health / suicide issues?
   PROMPT: How/where are you seeing/hearing about these emerging issues, or what evidence is there of these (e.g. social media, TV news)?
8. What are the opportunities regarding provision of services that aren't being taken advantage of (technology, integration, partnerships, etc.)?
9. Where are the areas that services can be improved? What can be done differently?