Amplify

2023 Regional Priority Report, Region 4

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Executive Summary

Purpose

Every two years, the Department of Mental Health, and Addiction Services (DMHAS) Planning Division is required to conduct a needs assessment and priority planning process to capture needs on the local, regional, and state level. DMHAS contracts with the Regional Behavioral Health Action Organizations to conduct these assessments. Amplify conducts this process for Region 4 by gathering local data and perspectives. Information gleaned from this process is used to inform the DMHAS Mental Health Block Grant and DMHAS biennial budgeting process as well as the planning and priority setting process for Amplify.

Process

The priority planning process involved various forms of qualitative and quantitative data collection mechanisms including data review, a regional stakeholder survey, key informant interviews, and focus groups. Between December and March of 2023, Amplify, in partnership with DMHAS and its Center for Prevention Evaluation and Statistics (CPES), collected and reviewed data including epidemiological profiles and summary reports that capture regional, state, and national trends. During this time, Amplify also administered a regional online survey, conducted focus groups, and key informant interviews. Upon completion of the data collection and review, a Regional Behavioral Health Priority Setting Workgroup (RBHPSW) was established with key community representatives from the across the continuum of prevention, treatment, and recovery support systems. Summary data were presented, discussed, and analyzed using a prioritization matrix required to determine the 2023 priority needs for Region 4**.**

Regional Priorities and Recommendations

The priority concerns and recommendations by Region 4 in 2023 emphasize a broad array of needs, both emerging and intensified, within a post-pandemic system characterized as "in recovery" itself with increased demand on an already constricted and drained workforce. Connecticut is rich in innovation and support for best practices, as evidenced by recent advancements in service delivery, prevention infrastructure, and recovery supports; however, without the workforce to implement proven practices, the promise of Connecticut's systems improvement efforts will be futile.

Identified mental health priorities for Region 4 are **anxiety, suicide, and depression** and top substances of concern are **heroin/fentanyl, alcohol, and vaping/ENDS**.

The full list of priorities was ranked as follows:

1. Heroin/Fentanyl
2. Anxiety
3. Suicide
4. Depression, Alcohol, and Vaping
5. Marijuana
6. Prescription Drug Use
7. Serious Mental Illness – Children
8. Cocaine
9. Trauma/PTSD
10. Serious Mental Illness – Adult and Tobacco
11. Problem Gambling

Region 4 believes that lived experiences should inform all aspects of systems improvement efforts across the full range of initiatives that aim to educate, evaluate, and advocate.

This includes parents and caregivers, especially of youth and older adults experiencing anxiety and depression, people in recovery, behavioral health providers, suicide attempt and overdose and suicide loss survivors. There is a desire to support regional and statewide education and promotion regarding crisis system enhancements and to consider improvements in data tracking platforms to provide more actionable real-time data to identity and inform community and system stakeholders earlier and more often. Last, there is a fervent desire to support innovative and aggressive strategies that aim to address behavioral health workforce shortages.

Region 4 believes collaboration improves outcomes.

Regional and local coalitions work hard to increase community awareness about prevention efforts, substance use treatment options, and recovery supports. The legalization of adult-use marijuana, online gambling and sports betting have invoked the need for a reciprocal and comparable response to combat the increased risks caused by these legislative actions. Concentrated efforts must continue to build capacity and readiness among our identified subpopulations including youth, young adults, older adults, and veterans. Underserved and overrepresented groups in Region 4 would benefit from targeted outreach, especially in the areas of suicide prevention, overdose awareness, and problem gambling.

In all areas, increased access to end-user-friendly data including dashboards and syndromic surveillance would better equip RBHAOs, local and regional coalitions, to offer technical assistance and support earlier and more often.

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Image generated from Region 4 focus group response data.

Many people offered their lived experiences to inform this report. For those named and anonymous, we thank you for your trust and for joining us in service to our region.

Abbreviations:

AAPI	Asian American and Pacific Islander
ADPC	Alcohol and Drug Policy Council
AFSP	American Foundation for Suicide Prevention
CAC	Catchment Area Council
CCBHC	Certified Community Behavioral Health Center
CHDI	Child Health Development Institute
CPES	Center for Prevention Evaluation and Statistics at UConn Health
CRS	Community Readiness Survey
CTSAB	Connecticut Suicide Advisory Board
DFC	Drug-Free Communities grant
DMHAS	Department of Mental Health and Addiction Services
ED	Emergency Department
ENDS	Electronic Nicotine Delivery Systems (vape devices)
LMHA	Local Mental Health Authority
LPC	Local Prevention Council
MCRLC	Mobile Crisis Response Learning Collaborative
NMUPD	Non-medical use of prescription drugs
PFS	Partnership for Success grant
PSA	Public Service Announcement
RBHAO	Regional Behavioral Action Organization
RBHPSW	Regional Behavioral Health Priority Setting Workgroup
REL	Race, Ethnicity, Language
RGAT	Regional Gambling Awareness Team
RSAB	Regional Suicide Advisory Board
SAMHSA	Substance Abuse and Mental Health Services Administration
SOR	State Opioid Response grant
SEOW	State Epidemiological Outcomes Workgroup
THC	Tetrahydrocannabinol
UCC	Urgent Care Center
YSB	Youth Service Bureau
ZSLC	Zero Suicide Learning Collaborative

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Introduction

Background

As the Regional Behavioral Health Action Organization (RBHAO) for Region 4, Amplify supports best practices that promote mental health and aim to prevent suicide, substance misuse, and problem gambling. With support from the Department of Mental Health and Addiction Services, Amplifys serves 37 towns in greater Hartford and Tolland counties including: *Andover, Avon, Berlin, Bloomfield, Bolton, Bristol, Burlington, Canton, East Granby, East Hartford, East Windsor, Ellington, Enfield, Farmington, Glastonbury, Granby, Hartford, Hebron, Manchester, Marlborough, New Britain, Newington, Plainville, Plymouth, Rocky Hill, Simsbury, Somers, South Windsor, Southington, Stafford, Suffield, Tolland, Vernon, West Hartford, Wethersfield, Windsor, and Windsor Locks.* Amplify partners with family members, people in recovery, providers, schools, law enforcement, elected officials, and other community leaders from across the region. This report was completed with support, collaboration, and assistance from multiple key informants, survey respondents, and community members from prevention, treatment, and recovery support systems.

Data Sources

The priority planning process included several forms of qualitative and quantitative data collection, synthesis, and analysis that took place between December 2022 and March 2023. Local, regional, state, and national data sources include:

- Region 4 Priority Planning survey
- Region 4 Student Survey data (Youth Counts)
- National Survey on Drug Use and Health (NSDUH),
- Centers for Disease Control and Prevention (CDC) State Unintentional Drug Overdose Reporting System (SUDORS),
- Epidemiological profiles, DMHAS Center for Prevention Evaluation and Statistics (CPES),
- Connecticut Council on Problem Gambling Help Line Statistics
- DMHAS Treatment data
- Connecticut HEDIS data (Carelon/CTBHP)
- CT Data Collaborative data dashboards
- CT Open Data Portal

- **Online surveys (n=97)**: Online survey was administered to parents, families, people in recovery, local prevention and catchment area councils, coalitions, providers, and other community members across the region. (See Appendix)

- **Focus groups:** During the winter of 2023, local perspectives about Region 4 were gathered through a series of focus groups. Five (5) focus groups were held with **Catchment Areas Councils** (CACs) representing people in recovery, family members, community referral organizations, **Local Prevention Council coordinators** and members, the North Central **Regional Suicide Advisory Board**, and the **North**

Central Network of Care. Focus groups included in-person or virtual discussion with standard questions and incorporated live polling software. (See Appendix)

- **Region 4 Student Health Survey data (n=14,592)**: Middle and High School youth perspectives from 2019-2023. Data include 30-day use for alcohol, tobacco, vape/ENDS, NMUPD, marijuana, binge drinking, depression, suicide, gambling. Substances and gambling are available by risk factor of perception of parental disapproval, perception of risk/harm, perception of peer approval.

- **Region 4 data, SEOW Data Portal and statistical reports from state agencies**. Data for 11 Epidemiological Profiles on problem substances and mental health conditions was obtained from the DMHAS Center for Prevention Evaluation and Statistics (CPES). These included statistical reports from the Office of the Chief Medical Examiner, Department of Public Health, Department of Mental Health and Addiction Services, and the Child Health, and Development Institute (CHDI).

- **2022 CT Community Readiness Survey, Region 4 (n=216):** Key stakeholders and coalition members were asked to complete a Community Readiness Survey to help the RBHAO and DMHAS determine the level of readiness for prevention in local communities and help them secure additional funding for prevention initiatives. The 2022 CRS for Region 4 garnered participation from every town (100%) in Region 4. The report reflects community attitudes, perceived strengths, barriers and support for prevention initiatives, availability and perceived effectiveness of strategies, and an overall rating of community readiness for addressing substance misuse and mental health promotion.

- **Region 4 Behavioral Health Priority Setting Workgroup:** Volunteer Workgroup established with eight (8) key stakeholders representing mental health and substance use across the continuum of prevention, treatment, and recovery support systems. Summary data were discussed and analyzed with the RBHPSW using a Prioritization Matrix that ranked magnitude, impact, capacity/readiness, and consequences of inaction for mental health, suicide, substance use and gambling.

- **Key informant Interviews:** Discussions with people who have first-hand knowledge about a topic of interest about prevention, treatment, and recovery support including DMHAS State Tobacco Enforcement, Problem Gambling Services, behavioral health providers, public health analysts, faith leadership, families, loss survivors, and community members. Amplify leads multiple regional coalitions and meets routinely with partner agencies, community leaders, state, and local committees. Feedback was collected and minutes were reviewed for the purposes of this report.

- **CT Council on Problem Gambling and DMHAS Problem Gambling Services** data regarding crisis calls and treatment admissions.

- **Youth Anxiety Review, Amplify 2020:** Youth anxiety was identified as an emerging issue and key area of concern in Amplify's 2019 and 2021 Priority Needs reports. As a result of the 2019 report, Amplify formed a workgroup and conducted a review of youth anxiety in Region 4 including surveys, focus groups, key stakeholder interviews.

- Review of data from the **Mobile Crisis Intervention Services 2020 PIC Report** regarding crisis calls for children.

General Limitations of the Report:

The 2021 CT School Health Survey data is not comparable to prior years, due to the timing of the survey (fall versus spring semester) and likely reflects lower prevalence than is the case for risk behaviors. Data have shown that student surveys conducted in the fall semester often have lower prevalence rates. That said, data on current mental health and some other data could be utilized, except to note that Covid has impacted behavioral health across age groups.

The National Survey of Drug Use and Health (NSDUH) experienced a methodological change, involving a shift from in person to online administration due to Covid. The SAMHSA rescinded the 2018-2020 substate (DMHAS regional) estimates resulting in the 2016-2018 data serving as the most current usable substate data. Thus, the focus on the substate NSDUH data is limited.

For the NSDUH state-level estimates, the National Survey of Drug Use and Health (NSDUH) experienced a methodological change, involving a shift from in person to online administration due to Covid. The SAMHSA rescinded the 2019-20 state estimates resulting in the 2018-2019 data serving as the most current usable state trend data. 2021 NSDUH state estimates represent a return to the original data collection methodology, so are reliable as single year data, but should not be compared to prior years. Caution should be taken when interpreting comparisons by year (trend) beyond 2018/19.

This report and its outcomes are limited by the types of data available at the Region 4 level. In some cases, there is more substance use related data for certain subpopulations, i.e., youth. It was difficult to consider risk factors in the collection and interpretation of data since some risk-factor-related data are not yet available at the regional level.

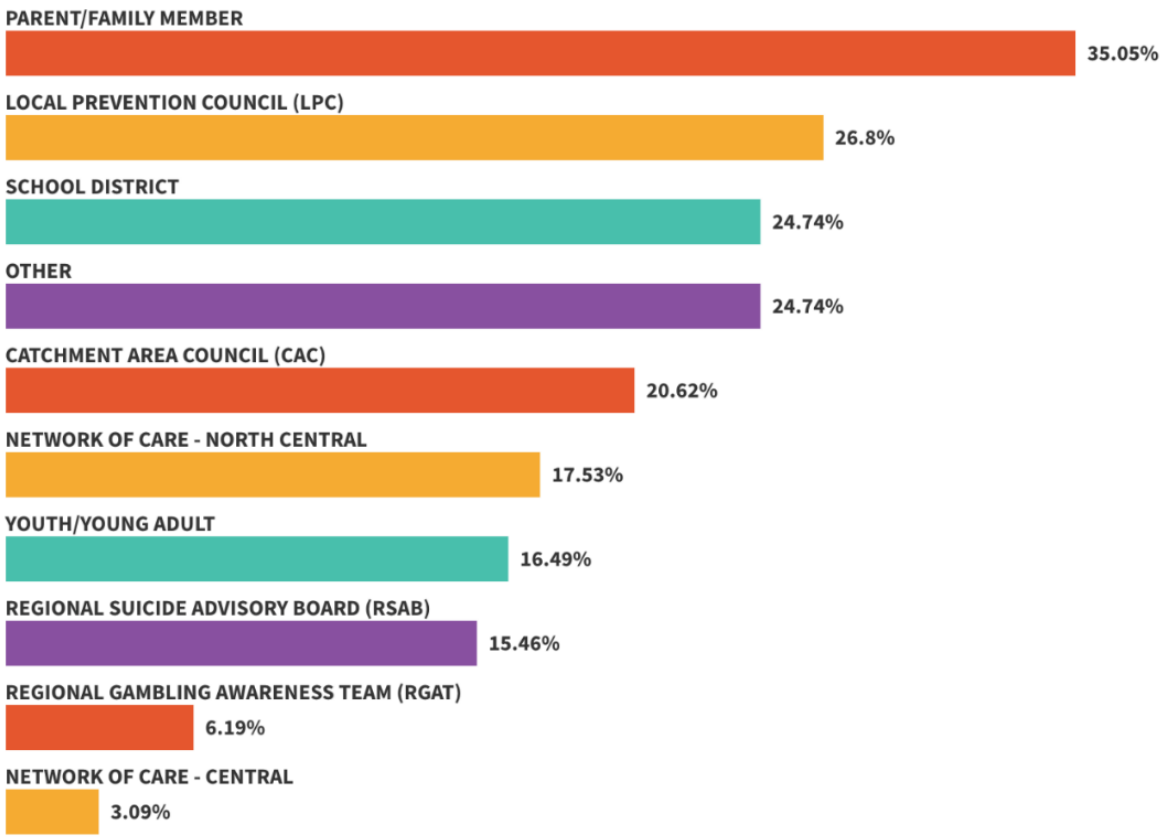
Development of the Report:

This report was developed by Amplify staff. Tasks were divided among staff based on knowledge, experience, and relationships within the region. This included knowledge of data collection, synthesis of data, data visualization, group facilitation, and report generation. Staff held meetings specific to the Priority Process, at minimum monthly, with numerous emails and zoom sessions and phone calls. The DMHAS Center for Prevention Evaluation and Statistics (CPES) provided Epidemiological profiles augmented with local data. Data from the profiles was culled into a PowerPoint for review by the Regional Behavioral Health Priority Services Workgroup (RBHPSW). An online survey was created and administered in accordance with the "Guidelines for Developing Regional Priority

Reports" document. Ninety-seven (97) individuals responded to the survey in the Winter of 2023 with the greatest number of responses coming from *parent/family members, local prevention and catchment area councils, schools and "other"* (See Figure 1). Most "other" respondents included the Office of the Chief Medical Examiner's Office (OCME), specialty providers (i.e., gambling), law enforcement, and public health representatives including the Connecticut Department of Public Health (DPH) and local health departments.

In April 2023, the RBHPSW was convened to review planning progress to date, discuss data and summary fundings, and to determine the 2023 priority needs for Region 4. Amplify team members presented summary findings from the online survey and focus groups in addition to other relevant data and subpopulation information about substance use, suicide, problem gambling, and mental health across the lifespan. Participants were encouraged to react and question the data throughout the presentation. After the discussion, participants were educated about the prioritization method and asked to complete the Prioritization Matrix. Scores were compiled into a master chart with the final mean score for each topic within the matrix (See Appendix).

Figure 1. Region 4 Survey Respondents



Priority needs identified by Region 4:

Identified mental health priorities are ***anxiety, suicide, and depression***. Top substances of concern are ***heroin/fentanyl, alcohol, and vaping/ENDS***.

The complete list of concerns is ranked as follows:

1. Heroin/Fentanyl
2. Anxiety
3. Suicide
4. Depression, Alcohol, and Vaping
5. Marijuana
6. Prescription Drug Use
7. Serious Mental Illness – Children
8. Cocaine
9. Trauma/PTSD
10. Serious Mental Illness – Adult and Tobacco

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

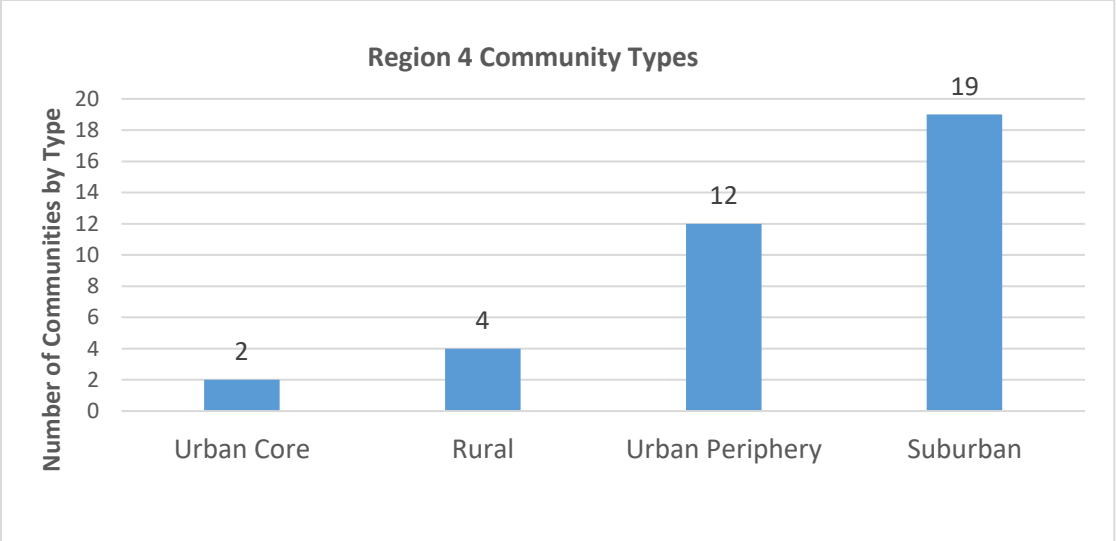
Mental Health Concern	Mean Ranking Score
Anxiety	4.1
Suicide	4.0
Depression	3.9

Substance of Concern	Mean Ranking Score
Heroin & Fentanyl	4.4
ENDS/Vaping	3.9
Alcohol	3.9
Marijuana	3.7

Description of the Region:

Region 4 has a population of 1,008,086 people who live among thirty-seven towns. The southern-most areas include suburban towns such as Rocky Hill, Marlborough, and Southington, and the center of the region is our state's capitol city of Hartford. The northern boundary consists of five rural/suburban towns along the Massachusetts border. Figure 2 illustrates Region 4 towns and cities within CT Data's categories by community type.

Figure 2. Community Types



Most Region 4 towns are classified as suburban followed by urban periphery and rural.

The region is bisected north to south, by the Connecticut River and Interstate Highway 91. Interstate Highway 84 divides the region from the Massachusetts boarder in Stafford Springs eastward through Hartford to Southington. Just over the border is MGM Springfield, a casino that opened in 2018.

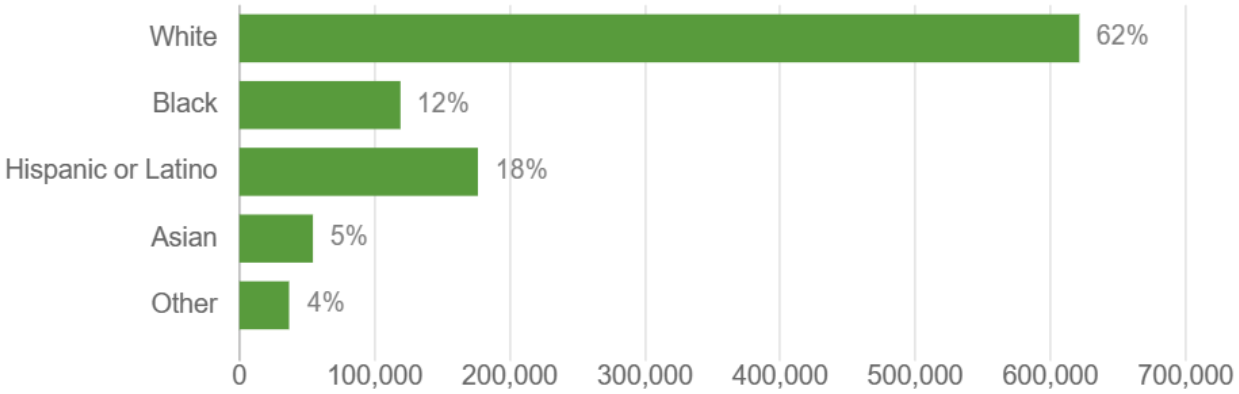
Features that directly and indirectly impact behavioral health in Region 4 include:

- 9 Hospitals including CT Children's Medical Center, a Level I Pediatric Trauma Center and the state's only pediatric specialty hospital; Hartford Healthcare that includes the regions only Level 1 Trauma Center with the state's first air ambulance system, LIFE STAR, and the Hartford Behavioral Health Network that includes the Institute of Living, one of the first mental health centers in the United States, and the first hospital of any kind in Connecticut.
- Six correctional facilities with one reintegration center. Two additional facilities closed in 2021 and 2023 due to a reduction of inmate population.
- One international airport
- All Region 4 towns are within fifty miles of a casino.
- 34 of 37 towns are served by a Youth Service Bureau
- Twelve health departments/districts

- Rich in higher education including the University of Connecticut, multiple Colleges within the State Colleges and University System including Central Connecticut State University, Asnuntuck, Capitol, Manchester, and Tunxis Community Colleges plus five private colleges/universities including Goodwin University, the University of Hartford, Lincoln College, University of Saint Joseph, and Trinity College.

Existing/Emerging Subpopulations:

The following is a breakdown of racial ethnic populations for Region 4 based on the 2021 American Community Survey, 5-year estimates.[1]



62% Caucasian, 18% Hispanic or Latino, 12% Black, 5% Asian or Pacific Islander, and 4 % Other (includes American Indian/Alaska Native, and those identifying as Other Race Alone or Two or More Races).

Since our last report in 2020, the population of Region 4 has decreased by approximately 15% with the decline mostly attributed to Caucasian followed by a decrease in the Black population. There was a slight increase in population of Hispanic or Latino and Asian and Pacific Islanders.

Towns with the highest proportion of Hispanic population are Hartford (45.5%), New Britain (42.7%), East Hartford (36.7%), Bristol (17.4%), and Manchester (15.7%).

The share of Black non-Hispanic population is highest in Bloomfield (56), Windsor (36.3), Hartford (34.1), and East Hartford (24.4); and the towns with greatest percent of Asian non-Hispanic are Rocky Hill (18%), South Windsor (17.2%), Farmington (16.4%), and Avon (14.2%).[2]

Epidemiological Profiles:

Epidemiologic profiles are documents that describe the burden of a particular health issue or problem in a population or subpopulations. The profiles that follow provide information

[1] 2021 American Community Survey, 5-year estimates

[2] CT Data

about *magnitude* (prevalence and trends), *burden* (impact across populations and towns), *risk factors* (including subpopulations at greatest risk), and *strengths* and *capacity* in the region to address each problem. Epidemiologic profiles were developed for a set of problem substances, mental health, suicide, and problem gambling issues including:

- Alcohol
- Cannabis
- Cocaine
- Heroin and other Illicit Opioids
- Mental Health
- Prescription Drugs, Not for Medical Use
- Problem Gambling
- Suicide
- Tobacco and ENDS

2022 North Central Region (Region 4) 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 9th highest prevalence of current alcohol use (56.6%) compared to other states in the U.S., higher than the national prevalence (50.4%).[1]

Magnitude

Overall, NSDUH shows that alcohol use in Connecticut has remained relatively stable; the prevalence of current alcohol use in individuals 12+ was 56.3% in 2021. However, consistent with the national trend, underage drinking in Connecticut among 12 to 17-year-olds decreased significantly, from 11.2% in 2018-2019 to 7% in 2021. Adults 26 or older in CT have the highest rate of reported past month alcohol use (61.4%). Young adults in Connecticut ages 18-25 have the second highest rate of reported past month alcohol use (58.5%), which is higher than this age group nationwide (50.1%).[1]

Binge drinking in Connecticut is highest among young adults (29.2%), followed by adults ages 26 or older (20.32%), 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

Percent Reporting Past Month Binge Drinking, ages 12+

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

2021 Connecticut School Health Survey (CT YRBS) data show that **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

NSDUH data from 2016-18 for region 4 showed that past month binge drinking in ages 12-17 was **5.7%.** More recent (2021-22) aggregated student survey data from Region 4 communities show past month alcohol use in middle school youth as .**9% and high school youth at 4.9%.**

Risk Factors and Subpopulations at Risk

- Young people who drink are more likely than adults to report being binge drinkers.[3]
- Men are more likely than women to be heavy drinkers.[4]
- 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.[5]
- Individuals with mental health disorders are about four times more likely to be heavy alcohol users.[6]
- Native Americans are at especially high risk of alcohol-related traffic accidents, DUI and premature deaths associated with alcohol misuse.[7]
- While Hispanics have higher rates of abstinence from alcohol, those who do drink often have higher rates of binge drinking.[8]
- In 2022, 68.2% of alcohol admissions were male, and 59.6% were non-Hispanic White.[9]
- Among youth, risk factors include[10]:
  - 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;

[1] NSDUH (2021)
[2] DPH, 2021 Connecticut School Health Survey
[3] CDC (2022), Alcohol and Public Health
[4] CDC (2022), Excessive Alcohol Use is a Risks to Men's Health
[5] CDC (2022), Excessive Alcohol Use is a Risks to Women's Health
[6] NIDA (2014), Severe Mental Illness is Tied to Higher Rates of Substance Use
[7] NIAAA (2014), Focus On: Ethnicity and the Social and Health Harms from Drinking
[8] NIAAA (2021), Alcohol and the Hispanic Community
[9] CT DMHAS FY2022 Treatment Admissions, DMHAS EQMI
[10] SAMHSA (2019), Risk and Protective Factors

  - Poverty;
- Social norms that encourage or tolerate underage drinking.

The 2021 Connecticut School Health Survey shows high school females were more likely than males to report past month drinking (29.2% and 14.2%, respectively) and binge drinking (8.5% vs 5.6%). Non-Hispanic whites had the highest prevalence of past month drinking (22.4%) and binge drinking (10.3%). Reports of Hispanics and Blacks past month drinking (13.7% and 12.1% respectively) and binge drinking (4.0% and 3.5%, respectively) were similar between the two groups.[2]

Burden (consequences)

According to 2020-2021 aggregated student survey data from Region 4 communities, 77.2% of respondents age 12+ perceived great risk from having 5+ drinks of an alcoholic beverage once or twice a week. These data also reflect that the perception of moderate to great risk of alcohol use was around 66-75% with an outlier reporting 82.5%.

- Immediate adverse effects of alcohol can include impaired judgment, reduced reaction time, slurred speech, and loss of balance and motor skills.[3]
- When consumed rapidly and in large amounts, alcohol can also result in coma and death.[3]
- Alcohol use can increase risk of death when used with other substances, i.e. prescription medication like benzodiazepines and opioids.[11]
- 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.[12]
- Approximately 95,000 deaths each year in the U.S. are attributed to alcohol-related causes.[13]
- 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%).[14]
- 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.[15]
- Excessive drinking has been associated with increased risk of motor vehicle injuries, falls, and interpersonal violence.[3]
- Drinking during pregnancy can lead to a variety of developmental, cognitive and behavioral problems in the child (Fetal Alcohol Spectrum Disorders).[15]
- 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).[16]
- Initiation of alcohol use at young ages has been linked to increased likelihood of AUD later in life.[17]
- Of all FY 2022 treatment admissions in region 4, 51.4% identified alcohol as the primary drug at admission.[9]
- DMHAS treatment data for the funding year 2021-22 shows 5253 alcohol treatment admissions occurred in Region 4 (a reduction from 6546 in 2019), accounting for 37.3% of treatment admissions across the state.[9]

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 indicates that reported AUD rates for this age group have increased almost two-fold (10.3%).[1]

[11] CDC (2022) Alcohol and Other Substance Use
[12] CT Department of Public Health Drug Overdose Monthly Report, 2021
[13] NIAAA (2022), Alcohol Facts and Statistics
[14] NHTSA (2019), Alcohol-Impaired Driving
[15] WHO (2018), Global Status Report on Alcohol and Health
[16] NIAAA (2017), Older Adults
[17] NIAAA (2006), Alcohol Alert, No.67 Underage Drinking

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

	2018-2019	2021
CT	6.2	10.3

Capacity and Service System Strengths

Community Readiness Survey: Mean Stage of Readiness for Substance Misuse Prevention[18 & 19]

	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

Key stakeholders who completed the 2022 Community Readiness Survey also ranked their communities' stage of readiness to address these areas of concern relating to substance misuse as 5.25 out of a scale of 9, a decrease in perceived readiness from 2020 (5.59). This was comparable to other regions in the state and to the state average.[18]

Noted areas of Strength:

- Planning for substance misuse prevention and focusing on practical details including seeking funds for prevention efforts.
- Creating policies and more than one substance misuse prevention program is running with financial support and trained staff.

[18] Community Readiness Survey State Report, 2022

[19] Community Readiness Survey Region 4 Report, 2022

2022 North Central Region (Region 4) Epidemiological Profile: Cannabis

Problem Statement

Cannabis, also called marijuana, is a term widely used to encompass all products made with marijuana 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 are expected to begin in late 2022 (ct.gov). Cannabis remains illegal under federal law (dea.gov).

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

Adults and adolescents increasingly view marijuana as harmless. Potential problems include harms from prenatal exposure and unintentional childhood; decline in educational or occupational functioning after early adolescent use and in adulthood; and increase in impaired driving and vehicle crashes.

Magnitude

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

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

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

In Region 4, past 30-day use for ages 26 and older in 2016 was 7.0% and 9.2% in 2018 (NSDUH).[1]

According to 2019-2020 aggregated student survey data from Region 4 communities, among students in grades 7- 12, 8.75% reported using marijuana in the past month, this being the second highest substance of use, with only alcohol past month use being higher. School survey data was limited due to the number of school closures as result of the pandemic; therefore, there is limited information about the impact of COVID or the presence of cannabis in vape devices. Both have been described during our focus groups and growing problems. In fact, key stakeholder responses to the 2022 Community Readiness Survey showed marijuana as the substance of greatest community concern for 12-17 and 18-25 year old age groups (33.4% and 35.8% respectively).[7]

Risk Factors and Subpopulations at Risk

Risk factors include:

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

According to NSDUH Substate estimates, perception of great risk from smoking Marijuana once a month (ages 12+) is just over 21%. This is the 2nd highest perception of the risk and slightly higher than the state average) (see chart below).[1]

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

	CT	Region 1	Region 2	Region 3	Region 4	Region 5
2016-2018	21.2	23.0	20.3	19.6	21.7	20.6

According to 2019-2020 aggregated student survey

[1] NSDUH 2021
[2] Connecticut School Health Survey, 2021 (YRBS)
[3] SAMHSA, CAPT Northeast Regional Marijuana Webinar

Series: Strategies/Interventions for Reducing Marijuana Use

data from Region communities, Region 4 youth grades 7-12, only 57% perceive using marijuana is risky. This is much higher than the general population (12+), but also the lowest perception of risk among all substances and only slightly higher than perceived risk for gambling.

The 2021 Connecticut School Health Survey shows slightly higher current marijuana 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.[2]

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 marijuana, as well as other drug and alcohol use disorders,
- Potential loss of IQ (particularly in those who used heavily during adolescence),
- Decreased immunity,
- Increased risk of bronchitis and chronic cough.

Marijuana potency has increased over the past few decades: in the 90s, the average THC content in confiscated samples was less than 4%, and in 2018 it was over 15%.[4]

Marijuana use during pregnancy also increases the risk of child development problems including low birth weight, and brain development. Additionally, children exposed to marijuana in-utero have increased risk for problems with attention span and problem solving.[4] Several studies have linked marijuana use to increased risk for psychiatric disorders and substance use disorders. The amount used, age at first use, and genetic vulnerability are thought to influence this relationship.[4] In 2019, marijuana was identified as the primary drug in approximately 12% of treatment admissions in Connecticut.[5] Of these, approximately 67.3% were male. About 30% where White, non-Hispanic, 28% Black, non- Hispanic, and about 26.4% Hispanic.[4]

Because marijuana use impairs motor coordination and reaction time, many studies have shown a relationship between blood THC concentration and impaired driving.[4]

A recent national outbreak of e-cigarette, or vaping product use-associated lung injury (EVALI) was linked to vaping THC, possibly due to the presence of Vitamin E acetate which is used as a diluent in THC-containing products.[5]

In addition, CT DMHAS data on adult (18+) substance use treatment admissions showed that marijuana was the primary substance at admission in Region 4 for 16.9% of admissions in FY 2021 (vs. 12.8% in CT), and 9.8% of admissions in FY 2022 (vs. 7.8% in CT).[6]

Capacity and Service System Strengths

Key stakeholders who completed the Community Readiness Survey also ranked their communities' stage of readiness to address these areas of concern 5.59 out of a scale of 9. This was comparable to other regions in the state and to the state average (see chart below).[7]

Community Readiness Survey: Mean Stage of Readiness for Substance Misuse Prevention[7]

	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

[4] NIDA, Marijuana

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

[6] CT DMHAS, FY 2021 and FY2022 Treatment Admissions

[7] 2022 CT Community readiness Survey

Based on this rating, areas of strength in region 4 are in:

- Planning for substance misuse prevention and focus on practical details including seeking funds for prevention efforts.
- Enough information to be able to justify a substance misuse prevention program and great enthusiasm for the initiative as it begins.

Region 4 communities have been funded through their Local Prevention Councils to address concerns regarding teen vaping. Given their concern about the presence of cannabis in confiscated vape devices, it will be important to continue to use continued funding for this purpose. Electronic Nicotine Devices (ENDS) are just the device of concern. As important is to address the nicotine and cannabis being used in the devices. It is anticipated, with the re-opening of our schools, Local Prevention Councils will have greater opportunity to address the risks associated with cannabis use with the student population.

2022 North Central Region (Region 4) 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

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 1.7% of Connecticut respondents reported past year use of cocaine.[2] This is highest among young adults 18-25 (3.3%), compared to adults 26+ (1.6%).

Region 4 past year use of cocaine also decreased in both age groups (2016-2018) were slightly higher than the state averages.

For CT:

- Ages 18-25: past year use in 2016-2018 was 6.3%, decreased from 8.7% in 2014-2016.
- Ages 26 and Older: past year use in 2018 was 1.9%, decreased from 2.1% in 2014-2016.[2]

In Region 4 there was a decrease in past year cocaine use among those 12 and older between 2014-2016 and 2016-2018, the most recent substate data available. In 2014-2016, this region had higher reported use than the state and all other regions but, had decreased somewhat by 2018 (*see chart below).

NSDUH Substate Estimates:
Percent Reporting Past Year Cocaine Use, ages 18+

	CT	Region 1	Region 2	Region 3	Region 4	Region 5
2014 - 2016	2.6	2.3	2.4	2.6	3.0	2.4
2016 - 2018	2.5	2.3	2.7	2.6	2.5	2.3

NSDUH Substate Estimates:
Percent Reporting Perception of Great Risk from Using Cocaine Once a Month, ages 18+

	CT	Region 1	Region 2	Region 3	Region 4	Region 5
2016-2018	69.7	68.3	70.1	69.0	70.2	70.6

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)
- 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 marijuana and heroin/fentanyl

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

[2] NSDUH 2021

- 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.

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 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 FY 2021, cocaine was the primary drug in 7.7% of all Connecticut treatment admissions. This represents 4,432 admissions.[4]

Treatment Admissions: Cocaine[2]

	CT	Region 1	Region 2	Region 3	Region 4	Region 5
FY2020	4,432	573	1,086	574	1,461	738

- Overdose deaths involving cocaine increased about 34% in Connecticut, from 345 in 2018 to 684 in 2022.[5]
- More than 7 in 10 (72%) overdose deaths involving cocaine in 2019 occurred in urban core or urban periphery communities.
- Cocaine-involved deaths have been linked to fentanyl-contaminated cocaine in Connecticut.[6] In 2019, almost 9 in 10 (85%) cocaine-involved deaths in Connecticut (n=463) also involved fentanyl.
- Cocaine's co-incidence with fentanyl increases the burden/consequence of cocaine use, especially as the incidence of fentanyl continues to climb.
- In Region 4 there were 149 overdose deaths involving cocaine (over 35% of cocaine-involved overdose fatalities in CT). 91 of those also involved fentanyl (see chart below).
- Given these statistics, of concern is that key stakeholders from the 2020 Community Readiness Survey regarded cocaine as the substance of least concern (second to problem gambling). The highest percent of concern being reported for those 12-17 at 1.1% followed by .8 % for those 26-65 and .6% 18-25 and 0% 66 and older.[7]

Cocaine-Involved Fatal Overdoses in 2019[3]

	CT	Region 1	Region 2	Region 3	Region 4	Region 5
N	632	39	73	50	149	88
Rate	11.19	5.56	8.82	11.84	14.87	14.37

*Rate per 100,000 population

In FY2021, Region 4 had the highest treatment admissions for cocaine (N= 1,461) and in 2019 had the highest cocaine involved fatal overdoes (N= 149).

Capacity and Service System Strengths

Community Readiness Survey: Mean Stage of Readiness for Substance Misuse Prevention[7]

	CT	Region 1	Region 2	Region 3	Region 4	Region 5
2020	5.37	5.14	5.55	5.21	5.59	5.25

[3] NIDA

[4] Connecticut Department of Mental Health and Addiction Services, FY 2021

[5] CT Office of the Chief Medical Examiner, 2022

[6] Tomassoni AJ. MMWR 2017;66:107-111.

[7] 2020, 2022 CT Community Readiness Survey

2022	5.31	5.72	5.36	4.89	5.25	5.12

Key stakeholders who completed the Community Readiness Survey also ranked their communities' stage of readiness to address these areas of concern 5.25 out of a scale of 9. This was comparable to other regions in the state and to the state average. Perceived community readiness according to key informants dropped slightly from 2020 (5.59) to 2022 (5.25) and dipped below perceived community readiness at the state level (5.31).[7]

Noted key areas of strength in Region 4 are:

- Planning for substance misuse prevention and focus on practical details including seeking funds for prevention efforts.
- Enough information to be able to justify a substance misuse prevention program and great enthusiasm for the initiative as it begins.[7]

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.

State estimates for 2019-2020 are no longer available due to methodological concerns with combining 2019 and 2020 day.[1] However, according to the 2021 Connecticut School Health Survey (CT's Youth Risk Behavior Surveillance survey), an estimated 0.6% of high school students in Connecticut reported ever used heroin.[2]

In 2021, 93% of unintentional overdose deaths that occurred in Connecticut involved an opioid (e.g., fentanyl, heroin, or a prescription opioid pain reliever).[3] While the number of overdose deaths in Connecticut involving heroin declined from 2020 to 2021, these numbers are misleading due to the concomitant rise of fentanyl, the increasing number of opioid deaths in Connecticut involving fentanyl and/or heroin, and the intertwined nature of heroin and fentanyl in the illicit opioid supply. Across New England, fentanyl availability is high, may be available either mixed with white powder heroin or alone, and may be sold in powder form as heroin or as fentanyl.[4]

Fentanyl is often sold under the same or similar "brand" names as heroin, creating confusion and uncertainty among buyers. More than 1 in 3 (35%) fentanyl deaths in Connecticut in 2019 also involved heroin.[4] Since 2017, deaths involving fentanyl have outnumbered deaths involving heroin, suggesting that much of the heroin consumed in Connecticut may contain fentanyl. In 2020, 31% of deaths involved illicitly manufactured fentanyl with no other opioids or stimulants. 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. Region 4 had 404 overdose deaths in 2021 (11.4% of the CT total). [3]

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

Magnitude (prevalence)

According to 2016-18 NSDUH substate estimates for Region 4, less than 1% of individuals ages 12+ reported past year heroin use. [1]

Risk Factors and Subpopulations at Risk

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

According to NSDUH substate estimates for region 4, 87% of individuals ages 12+ reported perception of great risk from trying heroin one or twice. Based on 2016- 2018 data, this is comparable to other CT regions and to the state average (also 87%)

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

[4] US DOJ- DEA, 2018 National Drug Threat Assessment (October 2018)
[5] CDC. Overdose: Heroin. https://www.cdc.gov/drugoverdose/opioids/heroin.html

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 involved in 387 overdose deaths, and fentanyl was involved in 979 deaths.[3] Heroin-involved mortality rates have dropped from a high of 14.1 to 10.8 per 100,000 population between 2016 and 2019. However, since 2012 there has been a sharp increase in fentanyl-involved deaths, reaching the highest rate in 2019 with a death rate of 27.4 per 100,000 population.[3]

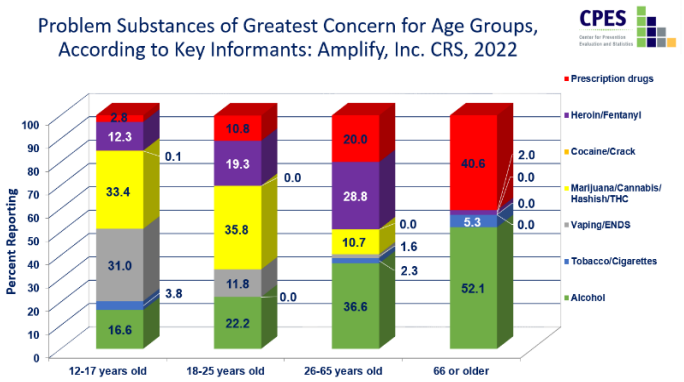
Region 4 had 70 heroin involved fatal overdoses in 2019, second only to region 5. As suggested above, there was a sharp increase in region 4 opioid-involved overdoses in 2019 (323). This was higher than all the other regions. The number of fentanyl related overdoses was also the highest in the state (298).[3]

Opioid-Involved Non-Fatal Overdoses (DPH)
In 2020 there were 15,226 treatment admissions statewide where heroin was the primary substance. Of those, 3667 were from Region IV. Region IV admissions were the second highest in the state, second only to Region 2.

The highest number of deaths in 2020 came from our more urban centers: Hartford (89), New Britain (44), and Bristol (32).

Despite these statistics, the chart below reflects key areas of concern by substance for key stakeholders from Region 4. Heroin and Fentanyl shown in purple rise in concern for the 26-65 age group but are still less of a concern than prescription drug misuse. [6]

Key Stakeholders who completed the Community Readiness survey also ranked their communities' readiness to address these areas of concern 5.25 out of a scale of 9. This was slightly higher than all but one of region in the state and higher than the state average (See chart below)



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

Areas of strength are:
Planning for substance misuse prevention and focus on practical details including seeking funds for prevention efforts.
Enough information to be able to justify a substance misuse prevention program and great enthusiasm for the initiative as it begins.
Southington's development of 3C's prevention curriculum.

Fortunately, both Bristol and New Britain have committed to become *"Recovery Friendly Communities"* to overcome substance misuse in their communities.

[6] 2022 CT Community Readiness Survey

This is a community that is committed to making it easier for people in recovery from drug or alcohol addiction to maintain their sobriety. Some examples of this commitment are good access to treatment; drug and alcohol-free entertainment; discouraging stigma; and drug courts.

Hartford, Bristol, and New Britain (communities with the highest overdose rates in our region) have all established Opioid Task Forces to combat Opioid addiction and overdose.

Hartford and New Britain have recently received “Overdose Data to Action” grants from the Department of Public Health to help in this endeavor.

The Central CT Health District has also established an Opioid Task Force and has a “How Can We Help” grant from DMHAS to support families and individuals who have experienced an overdose. Enfield has a North Central Opioid Addiction Taskforce as well.

In 2021-22, 13 region 4 communities were awarded mini grants to provide education about the dangers of Opioid misuse and use of NARCAN to reverse an overdose.

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 reported mental health issues, while SMI has serious consequences for the lives, livelihood, and wellbeing of individuals and families experiencing it. According to the 2021 Behavioral Risk Surveillance System (BRFSS) survey, 12.7% of adults (18+) report poor mental health.

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] 2021 Behavioral Health Risk Surveillance System (BRFSS Survey) data showed CT adults reporting depression at 18%.[6] 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

One measure of magnitude is the number of occasions that require an emergency crisis response for a behavioral health issue. During the last quarter of 2020, the Greater Hartford region had the highest number of youth mobile crisis episodes in the state. In addition, behavioral health providers report who participated in our surveys and focus groups reported a concerning increase in the acuity of mental health issues they were seeing for both youth and adults.[5]

Another measure of magnitude is the number of calls to 2-1-1 info line for mental health and/or addition resources. Two Region 4 communities were among the top 10 communities in CT seeking resources. Hartford County had the highest number of requests in the state. 14.4% of Hartford County calls to 2-1-1 were for mental health or addiction resources compared to 11.3% statewide.

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] About 12% of recent calls to the CT Emergency Mobile Psychiatric Response system (for youth) were for issues related to anxiety disorder.[5] This is the first-year measures of anxiety were reported in local school surveys. Over 20% of youth in three region IV schools surveyed reported almost always or always feeling anxious or nervous in the past year.

[1] NIMH
[2] CDC, Depression and Anxiety
[3] NSDUH 2021, 2016-18
[4] SAMHSA, Adults with SMI
[5] Mobile Crisis Intervention Services PIC Quarterly Report FY2021: Q2
[6] CT BRFSS 2019, 2021

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 2021 Connecticut BRFSS, 18.0% of adults reported being told by a doctor that they had a depressive disorder.[6] Similar to the NSDUH, 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%).[6]

Serious Mental Illness

In the 2021 NSDUH, young adults 18-25 had a higher percentage reporting serious mental illness (10.0%) than those 26+ (3.4%). 2016-18 NSDUH substate (regional) estimates, the most recent regional data available, showed that for past year mental illness (19.4%) and past year SMI (4.28%), region 4 was second highest of the 5 regions, and higher than the state prevalence.[3]

The 2021 Connecticut School Health Survey reported that 28.5% of high school students reported that their past 30-day mental health was not good (including depression, stress, emotional problems).[7] 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% (compared to 3 local school surveys ranging from 14.5% to % to 22.3%). 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%).[7]

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 that can produce or aggravate anxiety symptoms and having medical problems such as cancer or chronic pain that can lead to depression;
- Substance use such as alcohol or drugs;

Region IV students who participated in school surveys or responded to Amplify surveys and focus groups identified the following factors as strongest contributors to heighten anxiety:

- Academics
- Post high school planning
- Schedules

Interestingly social media was not considered by students as a strong contributor to their anxiety.[8]

- Young adults report higher rates of depression and serious mental illness.[4,5]
- The prevalence of major depressive episodes is higher among adult females than males[1], and among adults reporting two or more races.[1]
- The prevalence of any anxiety disorder is higher among females than males.[1]
- LGBTQ individuals are more likely than heterosexual individuals to experience a mental health condition. Individuals who are transgender are four times more likely to experience a mental health condition.[9]

Burden (consequences)

- Mental illness (including depression, anxiety, bipolar disorder, among others) is a risk factor for suicide.
- Depression is the leading cause of disability in the world.[7]
- Mental illness costs Americans $193.2 billion in lost earnings per year.[7]
- 1 in 8 emergency department visits involves a mental health or substance use condition.[7]
- Mental health treatment admissions (19,895) were higher than the other regions and the state average (12,670).[10]
- A Community readiness survey conducted in 2022 among key stakeholders in our area identified key areas of concern per age group for residents of Region 4 (see graph on next

[7] Connecticut School Health Survey 2021

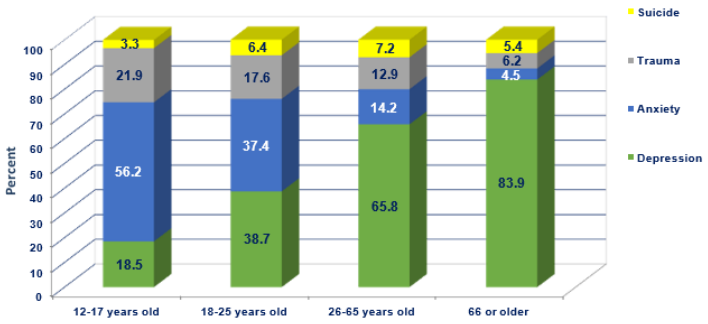
[8] Amplify Youth Anxiety Review 2020

[9] NAMI

[10] DMHAS treatment Admissions FY20

page). Anxiety was reported as the main concern for youth. Depression was reported as the primary concern as people age.[11]

Mental Health Issue of Greatest Concern for Age Groups, According to Key Informants: Amplify CRS, 2022



Capacity and Service System Strengths

Key Stakeholders who completed the Community Readiness survey also ranked their communities' readiness to address these areas of concern noting the following strengths: communities recognize community mental health concerns, have identified community leaders, and have done some planning for programs including seeking funds for awareness efforts. Region IV's ranking of community readiness was comparable to other regions in the state and to the state average.

As the Regional Behavioral Health Action Organization for North Central CT, Amplify led a workgroup of interested stakeholders to conduct a review of youth anxiety given rising concerns about the impact of COVID. Youth mental health and suicide were confirmed as areas of need. More research was recommended to identify root causes and effective strategies. The resulting report and recommendations can be found on the Amplify website, www.amplifyct.org. Members of the workgroup committed and have already begun working at the local level to address many of the recommendations.

[11] Community Readiness Survey 2022

Problem Statement

Non-medical use of prescription drugs is a problem that continues to be a concern in the U.S., including within Connecticut. The types of prescription drugs that are most misused include painkillers (opioids), central nervous system depressants (tranquilizers, sedatives, benzodiazepines) and stimulants.[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, Halcion 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, 3.1% of the US population aged 12 and older (an estimated 10.3 million) had misused prescription pain relievers, 1.7% used sedatives and tranquilizers(4.9 million), 1.4% reported misusing benzodiazepines(3.9 million) and 1.3% used stimulants (3.7 million).[2]

According to 2018 NSDUH data, Region 4 is higher than all other regions and the state in reported past year Rx pain reliever use (see chart in the next column).[2] Region 4 is also higher than all other regions in the state in the percentage meeting criteria for past year pain reliever use disorder (.65% compared with the CT average of .58%).[2]

Fortunately, Region 4 had the lowest number of prescription drug-involved fatal overdoses than all the other regions in 2019. Although the rate of prescription-involved fatal overdoses rose slightly in 2020, it came back down by the end of 2020 to a rate comparable to 2019 and to the CT average.

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

	CT	Region 1	Region 2	Region 3	Region 4	Region 5
2016-2018	0.58	0.50	0.55	0.59	0.65	0.61

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]

According to 2020 aggregated student survey data from Region 4 communities, 2.13% of grade 7-12 students reported having misused prescription drugs in the past month. This was the second lowest substance of use, with only past month use of cigarettes being was lower.

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, marijuana, 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]
- Among all fatal overdoses involving prescription opioids in Connecticut in 2019, the majority occurred among non-Hispanic whites, with male deaths occurring 1.3-2.8 times more frequently than females in each racial/ethnic group[6]

[1] NIDA, Misuse of Prescription Drugs Research Report
[2] NSDUH
[3] Connecticut School Health Survey, 2019 (CT YRBSS)
[4] Bali V. Research in Social and Administrative Pharmacy 2013; 9(3): 276–287.
[5] Lauer EA et al. Disability and Health Journal 2019;12(3):519-522 [6] Connecticut Office of the Chief Medical Examiner, 2019

- The elderly population may be at risk of consequence 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]

Region 4 youth in grades 7-12, 80% perceive misusing prescription drugs is risky. This is the highest perception of risk among all substances. However, key stakeholders from the 2022 Community Readiness Survey reported prescription drugs as the substance or second highest of concern for ages 66 or older (40.6%).

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]

- Xylazine, a non-opioid veterinary tranquilizer not approved for human use, has been linked to an increasing number of overdose deaths nationwide in the evolving drug addiction and overdose crisis.[12]
- According to reports from the Office of the Chief Medical Examiner (OCME), Connecticut experienced 1531 opioid-involved fatalities in 2021.
- The majority involved multiple substances; 86% involved fentanyl, 18% involved benzodiazepines, and 11% involved heroin.[6]

The Department of Drug Enforcement has recently issued warnings regarding the increase in sale and use of counterfeit pills and advises the public to obtain prescription drugs only from state-licensed pharmacies.[10] This along with evidence that most recent overdose deaths involved multiple substances gives rise to concern that individuals may believe they are taking a prescription medication, but if obtained other than through a licensed pharmacy, may contain toxic or illicit ingredients such as fentanyl.

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

Key stakeholders who completed the Community Readiness Survey ranked their communities' stage of readiness to address these areas of concern 5.25 out of a scale of 1-9. This was comparable to other regions in the state and to the state average.[11]

Based on this rating, areas of strength are:

- Planning for substance misuse prevention and focus on practical details including seeking funds for prevention efforts.
- Enough information to be able to justify a substance misuse prevention program and great enthusiasm for the initiative as it begins.
- Amplify has joined with other RBHAOs to launch a statewide campaign to educate the public about the risk of counterfeit pills. This will be shared with all Region 4 communities.

[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] DOJ/DEA Drug Fact Sheet http://www.dea.gov/

[11] 2022 CRS

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 (1-3%) would have mild or moderate gambling problems.[1]

According to the Connecticut School Health Survey in 2021, 18.4% of high school students, including nearly 25% of males and 12% of females, 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, which included .[3]

According to 2019-21 aggregated student survey data in Region 4, among students in grades 7-12, 1.7% had gambled in the past month and 6% reported having gambled before in their lifetime. Past month gambling increases to 3.6% by 12th grade. Ten percent of youth reported someone in their family has a gambling problem.[4]

Risk Factors and Subpopulations at Risk

- Risk Factors include:[5]
  - Having an early big win;
  - Having easy access to preferred form of gambling;
  - Holding mistaken beliefs about odds of winning;
  - Having a recent loss or change, such as divorce, job loss, retirement, death of a loved one;
  - Financial problems;
  - A history of risk-taking or impulsive behavior;
  - Depression and anxiety;
  - Having a problem with alcohol or other drugs;
  - A family history of problem gambling.

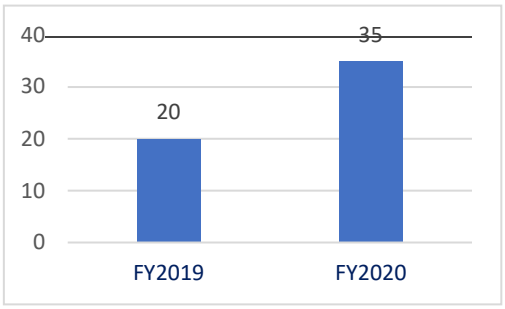
The 2021 Connecticut School Health Survey shows that 24.7% of high school males reported gambling in the past year, a significantly higher percentage than the 11.7% of females who reported past year gambling. The prevalence difference between grades and racial/ethnic groups were not statistically significant.[3]

- Problem gambling rates double for individuals living within 50 miles of a casino.
- Among Region 4 youth in grades 7-12, risk factors for gambling include:
  - 28% of youth perceive that gambling something of value has “no risk/slight risk.”
  - 28.3% of youth spent most school days not video gaming at all. 32.2% spent 2 to 5 hours most schools days and 7.6% more than 5 hours.
  - Being male, 44.1% of males have video gamed at twice the rate of females at 21.1% for 2 to 5 hours on most days of the week. All noted risk factors above, males were more likely to experience them than females.
  - In October 2021, online sports betting and casino gambling were legalized in the State of Connecticut.

[1] National Council on Problem Gambling
[2] American Psychiatric Association, Gambling Disorder
[3] Connecticut School Health Survey, 2021
[4] Youth Voices Count Survey, (N=3,686, Nov 2019-March 2021) representing DataHaven Community Types; Urban Periphery, Suburban and Rural
[5] Risk Factors for Developing a Gambling Problem, Centre for

Burden (consequences)

Region 4 Gambling Treatment Admission Estimates[6]:



Gambling treatment admissions in Region 4, increased by 75% from 20 in 2019 to 35 in 2020.

The number of calls to the Connecticut Council on Problem Gambling (CCPG) Help Line increased in Region 4 in 2022 for ages under 21 by .6%. There were no calls made to the Help Line in 2021 for ages under 21. The highest increase in Help Line calls during this two-year span was for ages 21-25 from 3% in 2021, to 21% in 2022. The highest percentage of gambling calls were for internet gambling at 45%, followed by sports betting at 36%.

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

Capacity and Service System Strengths

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

	CT	Region 1	Region 2	Region 3	Region 4	Region 5
2020	33.8	36.6	39.9	44.4	28.6	24.1
2022	37.9	48.9	35.9	39.9	29.2	37.8

Region 4 has the second lowest perceived ability to raise awareness of problem gambling/gaming addiction, of all DMHAS regions, as well as the state. In 2022, only 29.2% of region 4 key informants said that community ability to raise awareness was medium/high, compared to nearly 38% of key informant respondents statewide.

Community Readiness Survey[7] data indicate that in Region 4, gambling expansion is not perceived as "good for the community," however, there is some agreement that "most community residents think it is okay to give youth lottery or scratch off tickets."

Region 4's own survey of stakeholders[8] indicate that veterans, young adults, and African Americans are subpopulations that are not adequately being supported by the "problem gambling system." Knowledge about problem gambling support services is a significant gap in gambling awareness, as the most common response to the stakeholder survey was "I don't know."

Thanks to funding from the Department of Mental Health and Addiction Services Problem Gambling Unit, Amplify provides leadership for a team of consumers and professionals to raise awareness about problem gambling and connect them with resources that can help. Amplify Ambassadors lead training workshops for organizations, tailored to meet their unique needs, including:

The Youth Gambling Awareness Project (YGAT), in which teams of youth are assigned to promote problem gambling awareness and resources among peers. Four of the ten youth groups represented for this initiative are from diverse communities in Region 4 and will be addressing charitable gaming, online gambling, off-track betting, and available resources through various media platforms.

The Congregation/Community Assistance (CAP) Program, which is specifically designed for faith communities and civic groups. The program has piqued interest from groups not previously identified such as a grandparents raising grandchildren group to address gambling and gaming behaviors among youth, and gambling among older adult peers. The forementioned group presentation generated a local television spot featuring gambling among the older adult population.

Veterans were identified as an underserved population in the region 4 2021 priority needs report. This continues to be a population identified in need of additional awareness and resources. Region 4 held a Problem Gambling Among U.S. Veterans Event presented by the New York Council on Problem

Gambling in recognition of Problem Gambling Awareness Month. The well-attended event advanced education and awareness of needs within this population.

The Asian American Pacific Islander Ambassadors (AAPIA) Program, where Asian Ambassadors hold community conversations designed specifically for Asian Americans and for other minority groups. In response to the pandemic, ambassadors are converting all their sessions to on-line forums with presentations translated into Chinese Mandarin, Chinese Cantonese, and Laotian.

In addition, gambling-specific treatment is offered by Wheeler Clinic in its Bettor Choice Programs. These are offered in Hartford, Bristol and New Britain and include individual and group counseling, peer recovery support, medication, and budget counseling for both problem gamblers and those affected.

[6] Better Choice Gambling Treatment, Wheeler Clinic (unduplicated, new EMR system may underrepresent)
[7] 2020 Community Readiness Survey Results, Region 4, Amplify, Inc., August 2020
[8] 2021 Regional Priority Needs Assessment, Amplify

Problem Statement

Suicide is defined as death caused by injuring oneself with intent to die.[1] Suicide is a growing public health problem and is the now the 12th 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 ages 10-14 and 25-34 years old, the third leading cause of death among individuals between the ages of 15-24, and the fourth leading cause of death among individuals between the ages of 35-44.[2]

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] There were 383 deaths by suicide in CT in 2022, which was slightly down from 2021. [3]

Compared with other regions, Region 4 has the highest number of suicide deaths from 2015-2019. Moreover, more than a quarter (27%) of Region 4 towns experienced 20 or more suicides in 2020.[3]

Magnitude (prevalence)

Data from the 2021 National Survey on Drug Use and Health (NSDUH) showed 3.9% of adult respondents (18+) in Connecticut reported having serious thoughts of suicide in the past year.[5] This percentage is highest among those 18-25 years old (11.5%) compared to those 26 and over (2.8%).[5] Additionally, while less than 1% of Connecticut adult respondents reported attempting suicide in the past year, reported past year suicide attempts are highest among the young adult population, 18-25 (2.3%).[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

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]

Region 4 experienced an increase in the percent of people 18+ old reporting serious thoughts of suicide from 2016-18 to 2018-20. This increase is consistent with the statewide increase for the same time period.[5]

For youth, aggregate school survey data reveal that nearly 12% of Region 4 youth reported having considered suicide in the past year. This is lower than the statewide average. However, regional youth anxiety focus group and survey data indicate that this may be on the rise. [8]

Risk Factors and Subpopulations at Risk

- On average, men account for 71% of suicides in CT.[4]
- 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]

[1] CDC (2022). Suicide Prevention
[2] NIMH (2022). Suicide
[3] CT DPH (2021). CTVDRS, Violent Deaths: CT Data 2015 to 2021
[4] CT OCME (2021). Annual Statistics: Suicides
[5] NSDUH
[6] Connecticut School Health Survey, 2019 (CT YRBSS)
[7] Connecticut BRFSS 2019
[8] Amplify Youth Anxiety Review, 2020

- Sexual minority youth experience increased suicidal ideation and behavior compared to their peers.[1]
- Mental illness is a risk factor for suicide, including depression, anxiety, bipolar disorder, and general depressed mood.[3]
- For those over 45 years old, 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/loved ones history of suicide;
- Current or prior adverse childhood experiences;
- Previous suicide attempts;
- Substance use;
- Stress of acculturation;
- Unsafe media portrayal of suicide;
- Isolation;
- Lack of access to healthcare
- Loss (financial, relational, social, work); and
- Easy access to lethal means.

Region 4 school survey data reveal that there is a statistically significant association between seriously considering suicide and past 30-day substance use.

Data from the 2021 Connecticut School Health Survey shows the percentage of female high school students who seriously considered attempting suicide was higher (19.8%) than males (8.7%).[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%).

An issue of concern to the workgroup is the risks faced by black males for both addiction and suicide. In youth ages 10 to 19 years, suicide is the second leading cause of death. The suicide death rate for Black youth has nearly doubled and is increasing faster than any other racial/ethnic group.[9] We reviewed CT drug overdose mortality rates by race and ethnicity and noted that drug overdose mortality rates increased substantially from 2019 (340) to 2020 (520) and were the highest mortality rates among race or ethnic groups.[10]

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

Qualitative feedback from a focus group with the Region 4 Suicide Advisory Board indicates loss to suicide is having an impact on the region at the local level, particularly for those communities with multiple losses, smaller towns, and those that lack a postvention response plan.

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

Key Stakeholders who completed the Community Readiness survey noted the following strengths: communities recognize community mental health concerns, have identified community leaders, and have done some planning for programs including seeking funds for awareness efforts. Region IV's ranking of community readiness was comparable to other regions in the state and to the state average.[11]

As the Regional Behavioral Health Action Organization for North Central CT, Amplify leads a Regional Suicide Advisory Board that meets quarterly to plan and implement programs to increase awareness and assist local communities to develop postvention response plans. A series of training programs have been offered by the RSAB and/or in the region including: QPR Train the Trainer, QPR Gatekeeper, NARCAN training, Talk Saves Lives, ASIST (Applied Suicide Intervention Skills Training) and Postvention Response trainings including the CONNECT NAMI New Hampshire 2-day training. Also, Amplify increases awareness by proving information at tabling opportunities in the region such as health fairs, Veterans Stand Down, and other community events within the region.

[9] Ring the Alarm, the Crisis of Black Youth in America, A Report to Congress from The Congressional Black Caucus Emergency Task Force on Black Youth Suicide and Mental Health, 2019

[10] CT DPH Drug Overdose Monthly Report, Jan 2021

[11] 2022 CRS

In addition, numerous health systems and providers participate in the CT Suicide Advisory Board Zero Suicide Learning Community (ZSLC). Multiple hospitals and community-based care providers are implementing the Zero Suicide framework within their care delivery system. Examples include Hartford Healthcare (ZSLC tri- chair), Connecticut Children's(tri-chair), Bristol Hospital, and Community Health Resources.

Last, Amplify is an active member on both the CTSAB Legislative Advocacy Working Group that aims to increase legislative support for suicide prevention efforts in Region 4 and Lethal Means Workgroup.

2022 North Central Region (Region 4) Epidemiological Profile: Tobacco and 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 16.42% 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 18-25 continue to have the highest rates of cigarette use of any age group.[1] Despite significant decreases, smoking remains a health concern due to serious adverse physical effects of tobacco use.

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

Vaping is an emerging problem nationally and in Connecticut, as rates continue to rise at a steady pace. According to Connecticut's Behavioral Risk Factor Surveillance Survey (CT BRFSS), the prevalence of ever using e-cigarettes has increased each year since 2012. The 2019 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 10.3% in 2015.[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.[3]

DataHaven's 2022 Community Wellbeing Survey showed 10% of all respondents reported using vape pens or e-cigarettes.[4] This percentage consistent across most region 4 community types (Region 4 is made up of primarily suburban and urban periphery communities), but lower in wealthy communities (5%).[4]

According to 2020 aggregated student survey data from Region 4 communities, there has been no significant decline in Region 4 past tobacco use in individuals 12+, in comparison to other regions. This same school survey data reflects past month tobacco use in schools have been 1 – 2% with an outlier reporting 9.5%.

Risk Factors and Subpopulations at Risk

Populations at-risk for smoking cigarettes are[5]:

- 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)[6]
- Young adults (18-34)[1]
- Males[1]
- Hispanics[1]
- Current smokers
- Those living in urban communities[4]
- Adults from households earning less than $35,000[2]
- Adults with disabilities[2]
- Those with a high school diploma or less[2]
- Adults without health insurance[2]

[1] NSDUH 2018-2019
[2] Zheng X. (2019) CT BRFSS.
[3] Connecticut School Health Survey, 2021 (YRBS)
[4] DataHaven and Siena College Research Institute (2022). 2022 DataHaven Community Wellbeing Survey.
[5] CDC (2020), Current Cigarette Smoking Among Specific Populations-United States
[6] Centers for Disease Control and Prevention. (2019). Quick Facts on the Risks of E-cigarettes for Kids, Teens, and Young Adults. Retrieved from https://www.cdc.gov/tobacco/basic_information/e-cigarettes/

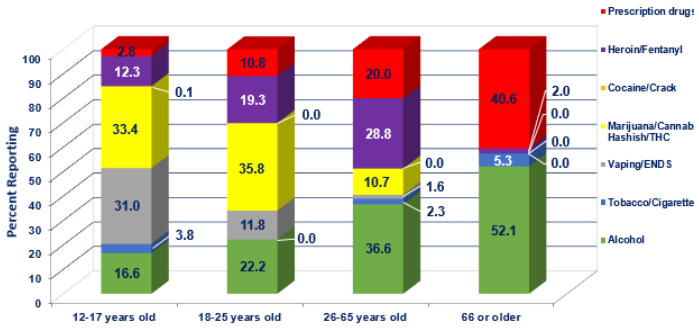
2022 North Central Region (Region 4) Epidemiological Profile: Tobacco and ENDS

NSDUH 2016-18 substate estimates show that in region 4, 73% of respondents age 12+ perceived great risk from smoking one or more packs of cigarettes per day, in comparison to the 75% in the state.

Results from the 2021 Connecticut School Health Survey (CT's YRBS) showed significantly higher prevalence of current use of electronic vapor products in females (14.5%) versus males (6.9%). There were no significant differences between racial/ethnic groups, but 11th (13.9%) and 12th grade (14.25%) student reports of current use were significantly higher than that of 9th grade students (6.5%) .

According to 2020 aggregated student survey data from Region 4 communities, past month e-cigarette use in grade 9-12 varies from 3% -13.3% with one outlier reporting 18.35 %. Despite these statistics, the chart below, reflecting key areas of concern by substance for key stakeholders from Region 4, shows significant concern regarding use of E-cigarettes for individuals ages 12-17 (49%)

Problem Substances of Greatest Concern for Age Groups, According to Key Informants: Amplify CRS, 2022



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]
- It can also contain volatile organic compounds, cancer causing chemicals, and heavy metals such as nickel and lead.[6]
- Some ENDS devices, including those that are particularly popular among youth, have been modified to allow for higher doses of nicotine to be delivered. They also facilitate the use of THC, and in higher potency. This is especially problematic in youth use, because of the increased risk of tobacco and cannabis use disorders later in life.[7]
- As of January 7, 2020, a total of 2,602 cases of e-cigarette or vaping product use-associated lung injury (EVALI) had been reported to the CDC across all 50 states, the District of 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. [7]
- Qualitative feedback from Region 4 stakeholders indicates that there remains a critical lack of youth nicotine cessation programs within the state.
- The Department of Mental Health and Addiction Services (DMHAS) and the DMHAS Tobacco Prevention and Enforcement Program (TPEP) reported a 41.1% retailer violation rate (RVR) of not checking photo ID and selling to minors in the 2022 Annual Synar Report.

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
2022	5.31	5.72	5.36	4.89	5.25	5.12

Key stakeholders who completed the Community Readiness Survey ranked their communities' readiness to address these areas of concern as 5.25 on a readiness scale of 1 to 9. This was in range with other some regions in the state and comparable to the state average.

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

Based on these rankings, areas of strength are:

- Planning for substance misuse prevention and focus on practical details including seeking funds for prevention efforts.
- Enough information to be able to justify a substance misuse prevention program and great enthusiasm for the initiative as it begins.
- As of July 1, 2022, Public Act 22-118 requires retailers to request photo ID from anyone asking to purchase tobacco products.

As the Regional Behavioral Action Organization for North Central CT, Amplify offered DMHAS funded mini grants to each of our local communities to develop and implement programs to inform their residents about the risks of using vape devices. A barrier to implementation of these programs were the many COVID related school closures that limited access to students. As well, local energy and resources had to be redirected to programs that addressed the basic needs of residents facing illness and loss of income during the pandemic. Despite these obstacles several communities have developed strong educational programs, and print/media campaigns to help their students identify problem vaping behaviors and resources to quit vaping. Mini-grant funding continued into 2022-2023.

Key Findings

Heroin/Fentanyl

The CT Overdose Response Strategy (CT-ORS) team reports the extreme volatility of the illicit drug market in Connecticut, along with poly drug use continues to drive fatal and nonfatal overdoses in Region 4 and throughout the state. From January to December 2022, there were 1,462 confirmed fatal overdoses in Connecticut, with 85.4% (1,248) of cases involving fentanyl. What's more, at least 343 (23%) of overdoses occurred in Region 4.

Region 4 community members identified heroin/fentanyl as the top problem substance category of concern due to their fears about fentanyl. The 2022 Community Readiness Survey results reflect heroin/fentanyl as one of the greatest concerns of problem substance use among adults aged 26 to 65 (28%) followed by young adults aged 18-25 (19%). Most CRS respondents agreed "somewhat" that preventing substance misuse is a concern and that alcohol and drug prevention is a worthwhile investment for the community**. In Connecticut, residents are more likely to die from unintentional drug overdose than a motor vehicle accident.**[3] Most of these deaths are linked to overdose of prescription opioid painkillers and illicit opioids. According to the CDC, the 2020 Connecticut age-adjusted rate for drug-induced mortality was 39.1 per 100,000 population compared to the 2020 national rate of 28.3.

CT Opioid Settlement dollars amounting in $13.5 million will be paid to Connecticut with $300 million arriving over the next 18 years to be used exclusively for opioid remediation, including explaining access to opioid use disorder prevention, intervention, treatment, and recovery.[3] Region 4 is expected to receive $470,618.33 of these funds, with towns receiving a portion of the funds ranging from $855.67 (Andover) to $88,813 (Hartford.) Access to Naloxone, a medication used to treat opioid overdose, has become more readily available and was recently approved by the FDA for over the counter. Amplify provides Naloxone training and distribution to the community to promote awareness and assist in the effort to save lives in CT and Region 4.

Alcohol

According to the 2022 Community Readiness Survey, alcohol is of greatest concern for older adults aged 66 and up (52.1%), followed by adults aged 26 to 65 years old, and is ranked second for concern following marijuana for young adults ages 18 to 25. Community attitudes toward alcohol and other drug prevention reflect that those surveyed agree that programming for prevention is a sound investment and effective. Among the 133.1 million current alcohol users aged twelve or older in 2021, 45% (60.0 million people) were past month binge drinkers. The percentage of people who were past month binge drinkers was highest among young adults aged 18 to 25 (29.2% or 9.8 million people), followed by adults aged twenty-six or older (22.4% or 49.3 million people), then by adolescents aged 12 to 17 (3.8% or 995,000 people). Among people aged 12 to 20 in 2021, 15.1% (or 5.9

[3] CT DPH, Opioid and Drug Overdose Statistics

million people) were past month alcohol users. Estimates of binge alcohol use and heavy alcohol use in the past month among underage people were 8.3% (or 3.2 million people) and 1.6% (or 613,000 people), respectively.[4]

Youth Voices Count survey results for Region 4, reveal that past month alcohol use for students grades 6-12 between Fall 2019 and January 2023, was 4.9%, lower than the national average, with a lifetime use at 10.3%. Towns in Region 4 are utilizing resources to conduct compliance checks for alcohol distributors to educate business owners and combat underage alcohol sales.

Cannabis

Recreational cannabis sales began on Jan. 10 in Connecticut. Within 3 weeks, there was $5.1 million in recreational cannabis sales, not including medical cannabis which account for an additional $8.2 million dollars in sales in the same time period.[5] With the passage of legislation that legalized recreational use of marijuana in 2021 and dispensaries opening in 2023, concerns on the part of the prevention and service delivery systems are focusing on increased use, decreased perception of harm by young people, and poison control.

In Region 4, student survey data reveal that 4.9% youth in middle and high school (grades 6 through 12) used marijuana in the past month, matching alcohol use. Data indicated use was more prevalent in high school students and slightly higher in females.

Region 4 community members report marijuana as the substance of greatest concern for youth and young adults aged 12 to 25 years old and as the second highest problem substance of concern for all substances, second only to vaping/ENDS among 12-17 years old. Anecdotal information suggests that many community members in Region 4 believe using marijuana once or twice a week is not at all harmful or only slightly harmful. This level of perception of harm considers approximately 1 in 10 people who use marijuana will become addicted, with the rate of addiction rising when use starts before age 18. Marijuana can cause permanent IQ loss of as much as eight points when people start using at an early age and IQ points are not restored after quitting marijuana.[6]

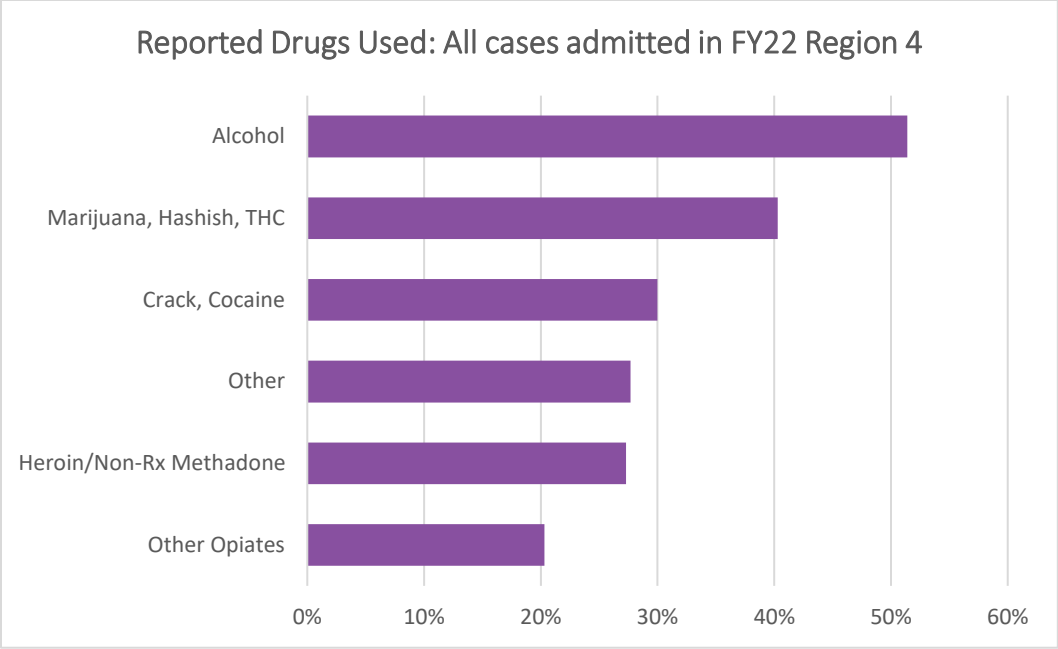
Marijuana edibles and the presence of THC in vape devices are growing problems described by our key stakeholders. See more about vaping below.

DMHAS treatment admissions for fiscal year 2022 show 40% of all admissions in Region 4 reported using marijuana, hashish, or THC. This was particularly high for those ages 18-25; more than two thirds (68%) reported marijuana/THC use and it was the primary drug associated with treatment for 30% in that age group.

[4] 2020 National Survey on Drug Use and Health

[5] Hartford Courant, 2/10/23, https://www.courant.com/2023/02/10/ct-recreational-cannabis-sales-break-5-million-in-january-medical-marijuana-totals-more ;CT Department of Consumer Protection

[6] www.samhsa.gov



Following alcohol, cannabis is the second most frequently used drug in the United States and Connecticut. According to the 2021 National Survey of Drug Use and Health (NSDUH) release, 14% of adults (34,864) aged eighteen or older used marijuana in the past month, with the highest use rates among adults aged 18 to 25. As of 2021, 12% (284,000) of Connecticut adults ages eighteen and older and 11% (17,000) of high school students reported using cannabis in the past 30 days.[7] Like the national trend, use rates were highest among people aged 18 to 25. In Region 4, 43% of people aged 18 to 25 reported using marijuana in the past month, which is much higher than the national trend.[8]

A concerning factor is the increase in popularity of edible cannabis products. Among Connecticut adults, the prevalence of cannabis smoking decreased from 2017 to 2021, while edible product consumption increased during this time, with 17.4% of people reporting that edibles were their primary way to consume cannabis.[9] This is up from 5% in 2017.

A study published in the Journal of Pediatrics analyzed data from the National Poison Data System to determine the trend of pediatric exposures to edible cannabis products from 2017 to 2021. During that time, there were 7,043 total exposures with an alarming increase from 207 cases in 2017 to 3,054 cases in 2021, representing a 1,375% upsurge in exposures and nearly 23% resulting in hospitalization. Furthermore, two and three-year-olds accounted for the largest number of cases (53%) with the majority of the exposures (98%) occurring in a residential setting and 91% in their own home. The study

[7] https://portal.ct.gov/-/media/Departments-and-Agencies/DPH/dph/hems/Cannabis/2022_Cannabis.pdf

[8] https://dmhasregions.ctdata.org/region/4

[9] 2023 Cannabis Health Statistics Report, CT DPH

also found that cases of pediatric exposures to edible cannabis accounted for 42% of all human poison exposures in 2020.[10]

According to the Connecticut Poison Control Center, pediatric cases are on the rise in Connecticut. In 2018, there were no reported edible cannabis exposures for children under the age of five; by 2022, there were thirty-seven reported cases for this age group. It will be important to monitor this data at the regional level.

Packaging that is attractive to children is a growing factor leading to accidental ingestion by children. Although there are regulations in Connecticut to try to prevent marketing and sales to youth, compliance may be challenging to monitor.[11] Adult-use edibles sold in dispensaries must be a square or spherical shape without logos, imprints, or colors and must be entirely white. In addition, edibles must be individually wrapped and dispensed in a child-resistant container that can be resealed. In terms of labeling, only black and white font are allowed with "THC" clearly stamped on the packaging. While these rules apply to legal edibles in Connecticut, that is not preventing illegal, high-potency edible products like "delta-8 THC" flooding the market being sold illegally in gas stations and smoke shops across the state. **Delta-8 THC edibles intentionally imitate common national snack and candy brands, attracting and enticing children to ingest them**. Additionally, some products contain multiple adult servings in one package. For example, the adult serving a "gummy-like candy" edible may be one gummy, however a child will typically eat more than just one "candy," resulting in consuming toxic levels of THC.

The best way to prevent pediatric cannabis exposures is to securely store all cannabis products, keeping them locked and out of reach from children and pets. All cannabis users need to be aware of the dangers of leaving cannabis products unlocked. In addition, young adults have the lowest perception of harm. It is because of these findings that **Region 4 would benefit from increased education about the dangers of consuming high-potency cannabis products, its negative impact on brain development and the importance of safe storage.** Regular and accidental use of cannabis can cause irreversible damage.

The images above are actual examples confiscated in a Region 4 school during the 2022-23 school year.

[10] Tweet MS, Nemanich A, Wahl M. Pediatric Edible Cannabis Exposures and Acute Toxicity: 2017–2021. Pediatrics. 2023;151

[11] What kind of edibles will be available for consumers in the adult-use cannabis market? www.ct.gov

Vaping/ENDS

Region 4 is concerned about the increase in middle and high school referrals to juvenile review boards (JRB) for vaping use, with an alarming number of vapes containing tetrahydrocannabinol (THC) liquid. A Local Interagency Service Team (LIST) which covers sixteen communities in Region 4 conducted a survey of their juvenile review board based on referrals particular to cannabis and vaping THC. Ten of the sixteen (63%) JRB leads reported that 100% of youth referred to them for cannabis use were vaping and "dabbing" THC. Region 4 student survey results reveal 6% of students have used nicotine in a vape or e-cigarette device in their lifetime, with 4% reporting past month use. Use of e-flavored liquids in a vape or e-cigarette device is more prevalent in high school students and slightly higher in females.

According to 2021 NSDUH data, 11% (4.3 million) youth and young adults aged 12 to 20 in the United States used tobacco products or used an e-cigarette or other vaping device to vape nicotine in the past month. Among people in this age group, 8% (or 3.1 million people) vaped nicotine, 5% (or 2.1 million people) used tobacco products, and 3.4% (or 1.3 million people) smoked cigarettes in the past month. Among people aged twelve or older who vaped any substance in the past month, 71% vaped nicotine, 40% vaped marijuana, and 19% vaped flavoring.

According to the 2022 Community Readiness Survey for Region 4, Vaping/ENDS use was identified as a priority problem of concern for youth 12–17-years-old regardless of what the device contained (see Appendix or insert figure). Qualitative feedback from this review also indicates a critical lack of youth nicotine cessation programs within the state for youth under the age of eighteen. This has been an ongoing concern for the Region 4 Local Prevention Councils and their communities as there are scarce resources to refer youth that have been screened and identified as having a nicotine addiction.

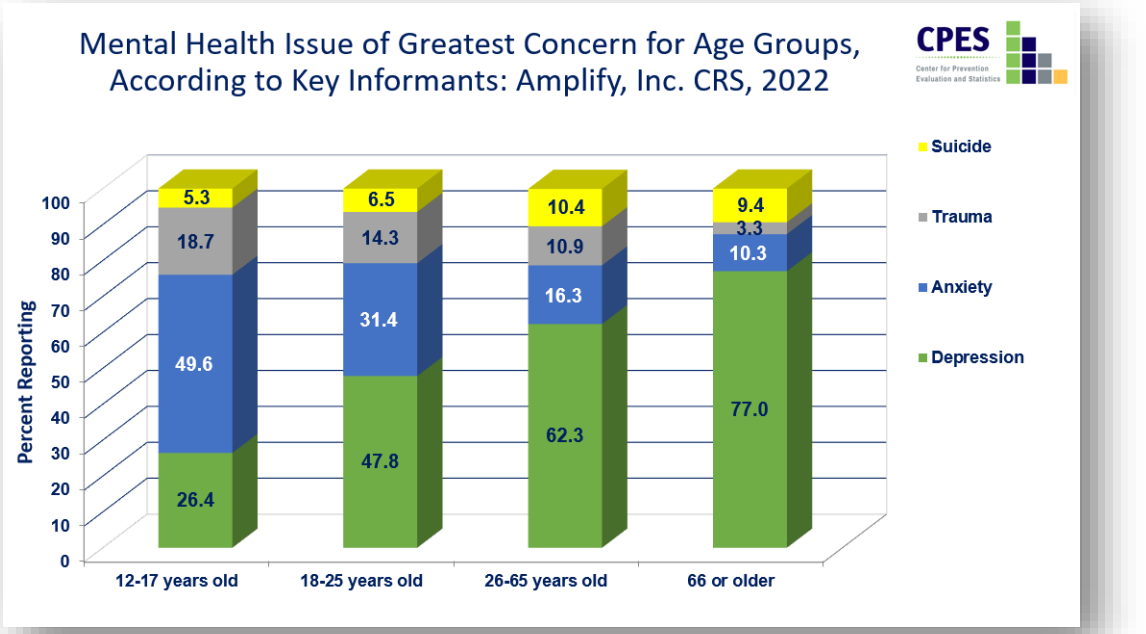
Region 4 has 1400 tobacco/e-cigarette retail stores. According to key informant discussions with the DMHAS Tobacco Prevention Education Program, recent compliance checks revealed that 288 retailers (20%) were non-compliant, cited with licensing issues, and/or selling Delta-8 products. Data from the CT Clearinghouse reveals managers and employees from 315 retail establishments completed the *"Do The Right Things Online Prevention Education Program for Retailers"* online training. Of the 315 retail establishments included in the data set, 87% establishments (274) reported that their store had failed a Tobacco 21 compliance inspection and 13% of establishments (41) reported that their store had passed a Tobacco 21 compliance inspection. 532 managers and employees from the retail establishments completed the training with 414 individuals (77.82%) reporting they worked at tobacco/e-cigarette retail establishments that had failed a Tobacco 21 compliance inspection and 118 individuals (22.18%) reported they worked at tobacco/e-cigarette retail establishments that passed.

Anxiety, Suicide, and Depression

The Region 4 2022 Community Readiness Survey showed anxiety was the mental health issue of greatest concern for those ages 12 to 17 with depression as the greatest concern for all other age groups 18 and older. For older adults, anxiety experienced an increase to

10.3% from 4.5% just 2 years prior. Of greatest concern may be the change in concern about suicide which experienced an increase for every age group compared to the last report in 2020.

Amplify's 2023 regional survey results and focus group discussions align with these findings with anxiety, depression, and suicide identified as the top mental health priorities for Region 4.



DMHAS treatment data for fiscal year 2022 show 45% of admissions were for mental health only, up from 40% in fiscal year 2021. Despite the increase in admissions for mental health treatment, the *"State of Mental Health in America"* report ranks Connecticut at the bottom of the list of states when it comes to adults with any mental illness getting treatment indicating 56% do not receive treatment.[12]

Region 4 middle school and high school students are struggling with depression and anxiety. In grades 6-12, 28% of students report having anxiety "always" or "almost always" in the past year with 23% reporting feeling sad or hopeless for two or more weeks in a row.

[12] Reinert, M, Fritze, D. & Nguyen, T. (October 2022). "The State of Mental Health in America 2023" Mental Health America, Alexandria VA.

Region 4, 2015-20 Suicide Data*

Residence City	Frequency
Andover	2
Avon	12
Berlin	10
Bloomfield	16
Bolton	4
Bristol	59
Burlington	11
East Hartford	16
East Windsor	5
Ellington	14
Enfield	43
Farmington	11
Glastonbury	13
Granby	11
Hartford	46
Hebron	4
Manchester	42
Marlborough	1
New Britain	49
Newington	19
Plainville	23
Plymouth	6
Rocky Hill	11
Simsbury	11
Somers	5
South Windsor	11
Southington	34
Stafford	7
Suffield	13
Tolland	13
Vernon	30
West Hartford	22
Wethersfield	13
Windsor	26
Windsor Locks	9

*preliminary

Suicide is the 11th leading cause of death in Connecticut [13] 388 people died by suicide in 2022 and 392 people in 2021. For both years, more than a quarter (28%) were in Region 4.

According to recent data from the Office of the Chief Medical Examiner's Office, there are thirty towns in Connecticut that have experienced ten or more losses to suicide. A third (10) of these towns are in the North Central Region (33%). In addition, Amplify postvention response efforts reveal that at least three (3) deaths in the last 2 years were young children under the age of twelve.

There continues to be a need for increased capacity-building and training about suicide prevention and postvention response. Efforts include training for town personnel, school staff and students, first responders and community members. Education and advocacy efforts include dissemination of information, signage, billboards, anti-stigma campaigns. Through the CT Suicide Advisory Board (CTSAB), a communication system has been established to inform and initiate a postvention response when there is an untimely death of a young person. There is no similar system in place for adults or for surviving family members. Region 4 participants acknowledge advances in suicide prevention infrastructure including the development of the Regional Suicide Advisory Boards (RSAB), and targeted workgroup efforts that support implementation and spread of best practices including the Zero Suicide Learning Community, of which numerous health and behavioral health systems in Region 4 participate. **Survey participants were hopeful that there would be more funding and support for the Regional Suicide Advisory Boards to improve system outcomes and to promote postvention planning in all communities.**

The 2022 CRS revealed that the opinion regarding "some support" when referencing community support for suicide prevention efforts

[13] Connecticut Suicide Statistics, Rate and Prevention | CAMS-care

increased from 46% in 2020 to 49% in 2022. Focus group discussions highlighted the increased need for warm lines, in-person support, and increased attention to anxiety and depression in youth. The Suicide Prevention program/North Central Regional Suicide Advisory Board at Amplify continues to experience an increase in requests for QPR (Question, Persuade, and Refer) and other suicide-focused trainings since 2021, indicating increased and consistent demand for suicide prevention planning and infrastructure development at the regional level. Subpopulations such as veterans and older adults have been highlighted by the North Central Regional Suicide Advisory Board with speaker presentations at quarterly meetings and during the statewide symposium held in September 2022 in honor of Suicide Prevention Awareness month.

Problem Gambling and Gaming

Between 2021 and 2022, there was an 18% increase in phone calls to the Statewide Gambling Helpline from young adults ages 21-25 years old, with calls for this population remaining highest the first quarter of 2023. Internet and sports betting were the top two types of gambling referenced and callers were predominantly male. Members of the Regional Gambling Awareness Team (RGAT) recommended targeted outreach to these groups and to raise awareness about this trend in the region. Although most survey respondents answered "I don't know" when asked about "appropriate" prevention, treatment, and recovery support services" for Problem Gambling, there was a decline in those reporting "I don't know" suggesting that efforts to increase awareness over the last 2 years had impact.

Emerging Issues

Xylazine, fake pills, and stimulants

The CT Overdose Response Strategy (CT-ORS) team reports that the extreme volatility of the illicit drug market in Connecticut, along with poly drug use continues to drive fatal and nonfatal overdoses in Region 4 and throughout the state. From January to December 2022, in Connecticut there were 1,462 confirmed fatal overdoses, with 85% (N=1,248) of the cases involving fentanyl, and 24.7% (N=353) of the cases involving xylazine. Gabapentin was involved in 11.4% (N=166) of the cases[14].

The CT ORS team has identified the following substances as emerging concerns for Connecticut: illicitly manufactured fentanyl (IMF), Xylazine, fake pills and stimulants.

IMF continues to be the primary contributing factor for fatal and nonfatal overdoses; however, Connecticut continues to see Xylazine in combination with IMF as a major secondary contributing factor. Xylazine is a non-opioid, veterinary sedative. The combination of Xylazine and Fentanyl has severe effects on the respiratory system, resulting in the likelihood of an overdose incident when ingested. Xylazine does not bind to the opioid receptor; therefore, it does not respond to naloxone. As of December 2022,

[14] CT Department of Public Health, 2023

there have been 353 fatal overdoses involving xylazine. Xylazine is a contributing factor in 24.7% of fatal overdoses and has been detected in 24% of law enforcement seizures.

With new and potentially lethal illicit synthetics being pressed into fake prescription pills, this creates a significantly increased risk of overdose. Because of the normalization of medication use, drug trafficking organizations (DTOs) are increasingly selling illicit substances by producing fake pills. Fake pills give a false sense of safety, which reduces perception of harm and stigma associated with drug use. Risks associated with fake pills include individuals wrongly believing they know what they are purchasing when the actual illicit drug they are ingesting is unknown plus the dosages used when creating fake pills are inconsistent. The CT Department of Emergency Services and Public Protection (DESPP), Division of Scientific Services Forensic lab has confirmed the presence of fake pressed oxycodone pills containing Fentanyl and other synthetic opioids, fake pressed benzodiazepines containing designer benzodiazepines, and fake pressed pills containing synthetic cathinones, including methamphetamine. In 2021, the CT HIDTA task forces seized approximately 86,000 fake pills. According to a recent study, Connecticut ranks 12th nationally in the number of fake pills seized by law enforcement.[15]

Cocaine

Connecticut continues to see an increase in stimulant involved overdose deaths, specifically involving cocaine and crack. Cocaine and crack continue to be the top illicit substance seized by law enforcement in Connecticut. Connecticut has become a major source of supply for cocaine for the region. In 2020 and 2021, forensic lab results showed about 10-15% of the cocaine/crack supply was contaminated with IMF, and in 2022, results showed a decrease, to less than 5%. (Source: DESPP, 2023) Through anecdotal data from harm reduction agencies and outreach workers, there have been reports of this trend increasing again in 2023.

Cocaine was involved in 154 overdose deaths in Region 4 in 2022, which accounts for 25% of all cocaine-involved overdose deaths in the state for 2022. Statewide data shows there were 561 unintentional overdose deaths from a combination of fentanyl and cocaine in 2021. This is up 25% from 2020 (N=447) and up 42.7% from 2019 (N=393). Similarly, there were 656 unintentional overdose deaths that involved cocaine in 2021. This is up 24% (N=529) from 2020 and up 41.7% (N=463) from 2019.

Despite these facts, the 2022 Community Readiness Survey shows cocaine is not a substance of concern among any age group in Region 4 and it is of little concern to communities in the state as a whole. Survey, focus group and RBHPW prioritization discussions also revealed cocaine ranked lower among problem substances of concern.

DMHAS treatment admissions for fiscal year 2022 show 30% of admissions in Region 4 reported using cocaine or crack. This remained relatively unchanged from the previous

[15] Trends in seizures of powders and pills containing illicit fentanyl in the United States, 2018 through 2021, Drug and Alcohol Dependence, Volume 234, 2022, 109398, ISSN 0376-8716, https://doi.org/10.1016/j.drugalcdep.2022.109398. (https://www.sciencedirect.com/science/article/pii/S0376871622001351)

year at 31%. Cocaine was the primary drug for just under 3% of admissions in fiscal year 2022, which is down significantly from 13.5% in fiscal year 2021.

Problem Gambling and Gaming

Sports betting and online gambling/gaming is now legal and operational in Connecticut. In May of 2021, the Connecticut legislature approved amended gaming compacts between the state and its two large gaming tribes, the Mohegan and Mashantucket Pequot, to authorize sports betting, online gambling, and online lottery sales. Other online betting options include online sports betting, horse race betting and daily fantasy sports. Retail sportsbooks at Foxwoods and Mohegan Sun opened in September 2021. Mobile sports betting and online gaming began a month later. In Connecticut, online and in-person sports bettors and gamers must be at least twenty-one years old, located within state lines to participate, and must be eighteen to participate in fantasy contests, purchase a lottery ticket, or play keno. Focus groups respondents report their concern about the lack of awareness about problem gambling prevention and treatment resources, despite widely advertised gambling public service announcements and billboards. When Region 4 survey participants were asked *"How appropriate and available are problem gambling services to meet the need in the areas of prevention, treatment and recovery supports?"* most respondents still said, *"I don't know"* highlighting the need for more aggressive campaigning. In addition, the 2022 Community Readiness Survey for Region 4 key reported a low rating by Region 4 respondents about their communities' ability to raise awareness of problem gambling. Only 29.2% of respondents said that community ability to raise awareness was medium/high, compared to 36.9% of respondents statewide. **Subpopulations of greatest concern to Region 4's survey and focus group participants were youth, young adults, and older adults with numerous references to concerns about youth gaming and online safety.** According to the Statewide Gambling Helpline, there was an 18% increase from 2021 to 2022 in phone calls from young adults ages 21 to 25 years old with internet and sports betting coming as the top forms of gambling referenced. Members of the regional Gambling Awareness Team recommended targeted outreach to these groups and raising awareness of this issue in the region.

Workforce deficiencies

The need for behavioral health services continues to increase, however the workforce has not expanded in response to the need. In the U.S., there are an estimated 350 individuals for every one mental health provider. However, these figures may be an overestimate of active mental health professionals, as it may include providers who are no longer practicing or accepting new patients.[16]

[16] Reinert, M, Fritze, D. & Nguyen, T. (October 2022). "The State of Mental Health in America 2023" Mental Health America, Alexandria VA.

Resources, Strengths, and Assets

Prevention

RBHAO model and Regional Coalitions

There was resounding consensus about the value of the RBHAOs during the priority planning process. Each RBHAO is charged by DMHAS to function as their strategic community partner for planning, education, prevention and promotion of behavioral health, and advocacy to address behavioral health needs and services for children and adults. Although there is concern that the RBHAO funding is not currently adequate to meet the increased demand in each region, DMHAS continues to demonstrate a strong commitment to collaboration and developing and maintaining RBHAO-led programs.

The **North Central Regional Suicide Advisory Board (RSAB)** meets at least quarterly with the goal of building regional capacity and readiness to eliminate suicide in all thirty-seven towns. All Region 4 communities who experience youth loss to suicide are contacted by Amplify and offered resources for postvention response and information about best practices including safe messaging.

The RSAB offers presentations about special populations and programs, including Suicide Among the Veteran Population, Zero Suicide health system updates, the Gizmo curriculum, and routinely shares suicide and overdose data offered by the Chief Medical Examiner's Office. Question, Persuade, Refer trainings are offered monthly, in addition to Talk Saves Lives Applied Suicide Intervention Skills Training (ASIST), a 2-day intensive suicide prevention training offering. Legislation was passed in January 2022 requiring mandatory training for emergency medical technicians (EMT), resulting in increased community requests to the RBHAO and the RSAB members for training and assistance. Region 4 has also experienced an increase in requests from faith-based organizations. In 2023, the American Foundation for Suicide Prevention (AFSP) held their Annual Meeting at Amplify and co-sponsored an ASIST training. In addition, Amplify hosted a Talk Saves Lives training the trainer with AFSP resulting in all five RBHAO RSAB leads becoming Talk Saves Lives trainers.

Amplify currently co-chairs the Education and Advocacy committee (EAC) and the Lethal Means committee of the CT Suicide Advisory Board. The Lethal Means Sub-committee has worked diligently on obtaining bridge signage with suicide prevention messaging at train stations and on bridges, and the EAC supports communications and education efforts that promote the CTSAB and State Plan 2025. Most recently, the committee created a 1-pager that CTSAB members can customize for their advocacy activities. All RBHAO team members promote 211 and 988, various curriculum including Gizmos Pawesome Guide to Mental Health and Signs of Suicide and promote the 1 Word 1 Voice 1 Life campaigns at tabling events including community health fairs and Fresh Check Days.

The **Regional Gambling Awareness Team (RGAT)** consists of prevention, treatment, recovery professionals, and community members who meet quarterly to promote gambling prevention and education initiatives across the region. Historically, gambling was not recognized as an issue of concern, most likely due to stigma and lack

of awareness about gambling addiction. Amplify continues to offer CAP training in the region to faith-based and community groups. With the passing of mobile sports betting and online gaming in October 2021, the RGAT identified an increase in calls to the Gambling Helpline for young adults ages 21 to 25. In response to this, a new College initiative is being implemented throughout the state with three colleges in Region 4 participating. Other initiatives that the Region 4 RGAT supports include youth-focused initiatives such as the high school Youth Gambling Awareness Project. This peer-to-peer initiative involves ten youth groups across the state, with Region 4 sending four youth groups in 2023, and three groups in 2022. The project produced public service announcements and media campaigns for youth peers and the community at large.

Building off the success of the **Asian-American-Pacific-Islander (AAPI)** Ambassador Program in region four, a statewide **Multicultural Program** has been created to address underserved populations. Other programs include the Powered-Up Parent, Player and Professional Training, video gaming awareness training, all offered throughout the region to interested community members. All RGAT members receive professional development, training, and technical assistance such as the six-part training implemented by CADCA. The teams followed the strategic prevention framework (SPF) Model and created a logic model to support an identified problem within their region which served as a springboard to take a deeper dive and identify strategies to address the identified issue. During Problem Gambling Awareness Month in March, the RBHAOs, including Amplify, hosted multiple events to raise awareness and combat stigma related to problem gambling. In the 2021 Priority Needs Report, Veterans were identified as an underserved population. In response to this, Amplify coordinated a special event with the New York Council on Problem Gambling who presented on Problem Gambling Among U.S. Veterans. In 2022, Amplify featured Wheeler Clinic's Bettor Choice Program to present Gambling 101: The Nuts and Bolts with Jordan Wasik.

Region 4 Local Prevention Councils (LPC), with support from the RBHAO and made possible by DMHAS, continue to effectively address the vaping epidemic as a priority. By utilizing the strategic prevention framework process and by targeting related risk and protective factors, the goal is to reduce vaping use rates by 5% by 2025 among 12 to 18-year-olds. Region 4 communities, with the support of their schools and town administrators, are moving forward with the necessary youth school assessments to help identify gaps and needs, as well as assets and strengths. Concerns regarding teen vaping of nicotine products and the presence of cannabis in confiscated vape devices has led to additional and innovative program implementation. For example, Southington has designed a data-driven asset building program called C3 - Community, Creating, Change. The classroom-based prevention curriculum helps build developmental assets and promotes collaboration between sectors. This is presently being piloted by two communities with other communities to follow. LPCs are also working to revitalize merchant compliance checks post-pandemic.

Located in Region 4, serving as a statewide asset is the **CT Clearinghouse.** The Clearinghouse continues to be a valued resource and partner to Amplify and to all our local and regional coalitions. Amplify tried to host one quarterly LPC meeting annually at the Clearinghouse to familiarize our community partners with the many resources they

have to offer. The Clearinghouse van has been present at many regional events and continues to provide our region with countless training and resources.

Treatment and Recovery

Connecticut Medicaid Substance Use Disorder Demonstration Waiver ("1115 Waiver")

As part of the U.S. Department of Health and Human Services' effort to combat the ongoing opioid crisis, the Centers for Medicare & Medicaid Services (CMS) created an opportunity under the authority of section 1115(a) of the Social Security Act for states to demonstrate and test flexibilities to improve the substance use disorder (SUD) service system for beneficiaries17. Historically, longstanding federal policy prohibited coverage of residential and inpatient substance use services in standalone institutes for mental disease (IMDs). The "1115 waiver" waives the criteria for this substance use treatment facilities resulting in increased access to substance use treatment for Medicaid members. CMS approval of the 5-year demonstration waiver started in April 2022 with approval through March 2027.

The goal of the 1115 demonstration is to improve access to a full array of substance use treatments and improve the delivery system for these services. Characteristics of the demonstration include increased provider payment rates and improved provider standards. The program aims to achieve various outcomes including improved access to substance use residential and outpatient services, improved treatment services with higher clinical standards, individualized treatment planning, resulting in reduced utilization of emergency and inpatient care, including readmissions, and improved follow-up and access to medication for addiction treatment. The 1115 waiver has been implemented in state-operated and private Inpatient Treatment settings, free-standing residential treatment facilities, clinic-based intermediate levels of care (IOP/PHP), Enhanced Care Clinics and outpatient drug and alcohol abuse centers. Next steps include implementation in hospital based IOP/PHPs, and other outpatient programs including office based opioid treatment (OBOT), federally qualified health centers (FQHCs) and early intervention programs. Providers in Region 4 report the workforce shortage as a major barrier to implementation. As the Regional Behavioral Health Action Organization, Amplify will continue to monitor this waiver and help ensure community members and providers are aware of its progress.

Family and Loved Ones/Peer and Recovery Supports

"Family and Loved Ones Support" and "Peer and Recovery Supports" emerged as prominent themes in the regional priority planning survey and in focus group discussions. Region 4 benefits from various support groups and initiatives that offer hope and peer connections. Although we cannot include all resources in this report, a few examples are highlighted given recent program growth to support family, loved ones, peer and recovery supports over the last 2 years.

[17] CT DSS, *CT Medicaid Substance Use Waiver*, April 2023, PowerPoint, BHPOC https://www.cga.ct.gov/ph/BHPOC

Advocacy Unlimited, Inc. is a peer run nationally recognized non-profit organization that provides education, advocacy, and support through non-clinical and holistic engagement. AU offers multiple programs that promote personal growth, human rights, and systems transformation through education, advocacy, and support. ***TriCircle, Inc***. has recently expanded in Region 4 offering a Marlborough location for their "Hope and Support" and "Hope After Loss" meetings. Regionally, there are two weekly SMART Recovery Family and Friends' meetings, one in Vernon and 1 Hartford. ***Today I Matter (T.I.M.),*** a local nonprofit created by John Lally after the loss of his son to overdose, offers support to communities and families who have lost loved ones. Today I Matter leads and coordinates a growing poster campaign that includes over six hundred posters of people lost to opioid addiction. The posters are displayed regionally and are part of an annual awareness campaign in Washington, DC. In addition, Today I Matter offers Naloxone administration training courses, in partnership with Amplify. **Connecticut Community For Addiction Recovery, Inc. (CCAR)** has a recovery center and staffs Recovery Coaches in every hospital in Region 4.

In response to the national opioid epidemic, the **Central Connecticut Health District (CCHD)** is offering its Opioid Recovery Program. In partnership with the Department of Mental Health & Addiction Services (DMHAS) and funded by the Connecticut State Opioid Response (SOR) grant, CCHD offers the 'How Can We Help?' initiative. The campaign employs a dual approach, seeking to assist both individuals suffering from an opioid use disorder and family/friends of loved ones suffering from an opioid use disorder.

Telehealth

Access to a telehealth option was indicated as a system need in the 2021 Priority Report and has graduated to become identified as a system asset. The lockdowns that contributed to social isolation during the Covid pandemic catapulted innovation in telehealth to sustain and improve access to care. Advancements in telehealth experienced rapid growth since the last regional report in 2021 with all sectors of outpatient care offering a telehealth option. Providers reported a decrease in no-show appointments and a new ability to view the individuals in their home environment. Individuals in recovery continue to report less frustration over transportation barriers and those in the workforce report that telehealth allows them to maintain a regular appointment schedule without impacting their workday or contributing to sick time away from work. Some members report that they still may not have a reliable device or access to Wi-Fi in their homes, thus they look to Recovery Clubhouses managed by their behavioral health providers or local libraries to help meet this need.

During the public health emergency, the federal requirements under the federal clinic option (42CFR) were waived, meaning a person did not need to be in a clinic for the provider to bill for the service. With the end of the Covid public health emergency in Connecticut, providers and community members were concerned the telehealth option would sunset, potentially negatively impacting access to care. However, per Provider Bulletin 2023-18 (March 2023), the Connecticut Department of Social Services released

new guidance for telehealth services.[18] Effective in May 2023, mental health services billed by freestanding clinics will be categorized and reported to the Centers for Medicare and Medicaid Services as rehabilitation services benefit (already in effect for substance use). In summary, this change will maintain flexibility for the location of service and removes the requirement that either the clinician or patient must be onsite for the provider to bill for the service under Medicaid. Moreover, this allows access to care, especially for specialty providers and during a workforce shortage, with clinicians who may reside out of state and hold Connecticut licensure.

Certified Community Behavioral Health Clinics Expansion

The **Village for Families & Children** secured funding from SAMHSA in 2020 for the Certified Community Behavioral Health Clinics Expansion (CCBHC E) and again in 2022 for the CCBHC Improvement and Advancement (CCBHC IA) grant. These funds support an integrated care model including direct services for behavioral healthcare, targeted case management, and peer led recovery support as well referrals to primary care to increase access and availability of quality care to those in need in the Greater Hartford area. The Village continues work to increase viable connections for those in need by performing frequent street level outreach, engaging in continual quality improvement, and nurturing partnerships with local organizations to widen the scope of available services and address service gaps.

Crisis System Enhancements – 988 and Urgent Care Centers

The Department of Children and Families announced the request for procurement for Urgent Care Centers in the Summer of 2022 resulting in four contract awards statewide. The Village for Families and Children will be the Urgent Care Center provider for the Region. The UCCs will support connect to care resources in each part of the state as a 24-hour clinical outpatient setting that offers full medical and behavioral health assessment for the purposes of helping to identify needs and facilitate resources for youth upon return to home. The UCC program at the Village can serve twenty-four (24) youth per day with primary referral sources including mobile crisis, emergency departments, school systems, first responders, and walk-in care. Recent legislation allows emergency diversion with first responders. Amplify has a memorandum of understanding with the Village for Families and Children in support of their CCBHC program and aims to promote awareness of the crisis service enhancements available to regional youth and their families.

Advancements in Connecticut's crisis system include the opening of Urgent Care Centers (UCC) and the implementation of the 988-call system.

United Way of Connecticut's Contact Center handles crisis calls that come in via multiple crisis lines with "no wrong door," including 211, 988, and the ACTION Line. They provide support over the phone or via text 24 hours, 7 days a week, 365 days a year. 211 provides mental health screening and suicide risk assessment based on national best

[18] New Guidance for Services Rendered via Telehealth under the Connecticut Medical Assistance Program (CMAP), https://www.ctdssmap.com/CTPortal/Information/Get-Download-File?Filename=pb23_18.pdf&URI=Bulletins/pb23_18.pdf

practices, access to home and/or community-based services, and peer support resources, collaborative safety planning, follow-up contacts, a warm transfer to local youth or adult mobile crisis services for in-person services, and coordination with 911 rescue services. This year, youth services are being expanded to include increased short-term stay crisis stabilization beds and community-based 23-hour crisis care sites. The statewide campaigns co-promoted are Gizmo and 1 Word 1 Voice 1 Life campaigns. The Governor's Budget currently includes funding to support the 988 contact center services however, long-term funding is not yet determined at the time this report was written.[19]

Another strength of the that DMHAS and DMHAS-funded providers demonstrate a strong commitment for developing and maintaining treatment and recovery support services, such as peer support, integration of primary care, behavioral health and wellness, specialized programs for young and older adults, telehealth, collaboration with law enforcement for crisis response, and expansion of medication assisted treatment.

Resource Gaps and Needs

Region 4 survey and focus group participants were asked how appropriate and available they found services to be in the areas of mental health, substance use, problem gambling and suicide prevention. In all cases they rated the services to be more appropriate and available than not. (See Appendix).

Prevention

Region 4 survey and focus group participants were asked to identify the prevention programs, strategies, or policies they would like to see most accomplished related to mental health, substance misuse, suicide, and problem gambling. The following themes were reported:

Mental Health and Suicide:

- Promote universal screening in school and primary care.
- The desire for parent/caregiver-focused support and education addressing current topics of concern, and specifically for young children and older adults.
- Parent/caregiver-driven discussions about mental health. *"More parent voice and involvement; mandatory notification to parents/caregivers so they're not in the dark."*
- Parity in support for prevention *"Have prevention viewed as important as treatment and recovery. Prevention IS a part of the care continuum."*
- Sustain the RSABs and CTSAB infrastructure. *"All suicide-related system improvement activities should be connected w/the RSAB & CTSAB."*
- School-based prevention programs.
- Mandated postvention planning and support for all towns.
- Anti-stigma campaigns for youth, their parents/caregivers, and schools.
- Interest in increased education, awareness, and tools that focus on youth anxiety.

[19] Andrea Duarte, (988 CTSAB slide update), CT Suicide Advisory Board, April, 2023

- Promote Gizmo curriculum in all schools; sustain training programs that promote proven practices: *Mental Health First Aid; Question Persuade Refer (QPR); bullying/abuse prevention; Signs of Suicide (SOS).*
- The desire for programs that focus on older adults. *"The needs of older adults need to be recognized and targeted outreach needs to happen to overcome barriers to information, treatment and recovery."*
- Share more user-friendly data through the RSABs/regional coalitions.
- Engage higher education/colleges and universities.
- All workplaces should require QPR or 1-hour suicide prevention training as a part of safety training.
- Expand suicide prevention programs to target older men and veterans.

Substance Use and Problem Gambling/Gaming:

- Training/connections with pediatricians and primary care settings
- Maintain/increase recovery-focused initiatives. *"Maintain SOR mini grants" "More recovery coaches and rehab facilities in the Bristol area."*
- Youth/young-adult focused education about the dangers of marijuana, fentanyl, and fake pills. *"High-potency marijuana is very scary. More education and awareness about MJ and fake pills."*
- Anti-stigma and school-based recovery-focused supports *"In-school options; SMART Recovery groups." "BOEs need to start recognizing issues with substance use earlier."*
- Interest in increased education, awareness, and tools that focus on gaming addition, including specifically for boys.
- Add additional laws concerning marijuana and youth.
- Pass legislation/promote policies that restrict ads that target youth/school-age children; hold social media accountable for targeting youth.
- More data-sharing about youth gaming.
- Less emphasis on raffles at community events; promote community-building activities.
- More education/training about online safety

There was consensus that Region 4 community-members would welcome **additional parent/caregiver-focused prevention programs,** resulting in increased and earlier identification of needs, improved perception of harm about legal and illegal substances, and less stigma. Echoing the previous priority needs report, there remains a request for loosening funding restrictions to **allow more individualized response to local needs**.

Region 4 members recommend **more outreach and collaboration with pediatricians and primary care providers** and support routine screenings for behavioral health concerns including anxiety, depression, substance use, trauma, and problem gambling

issues. **Connections to trusted adults and community treatment resources** should be encouraged and facilitated through the support and technical assistance offered by the RBHAO, local prevention councils, and regional coalitions.

There is little doubt that the impact of legalized medical marijuana and more recently recreational marijuana, and the subsequent proliferation of cannabis establishments in our local communities will impact both youth and adult perceptions of risk and in turn utilization rates. **Tertiary prevention programs for substance use disorders should be provided in school settings** that address prevention when students have already begun experimenting with substances.

The Connecticut state statute now permitting on-line gambling and sports betting and the industry's marketing tactics, will counteract efforts to reduce the incidence of gambling disorders throughout our region.

For suicide prevention services, 42% of survey respondents indicated that prevention needs are at least somewhat adequate followed by treatment (39%) and recovery needs (33%). This suggests that while gains are being made for prevention, there is an opportunity to improve perspectives on accessibility of appropriate services in the areas of treatment and recovery **for suicide-focused care**.

Treatment and Recovery

When asked about treatment levels of care and recovery supports, the availability of adequate treatment and recovery support for mental health and substance use achieved the highest ratings with 41 to 43 percent of respondents indicating services are appropriate. When asked about levels of care that may be lacking, the following treatment levels of care and recovery supports were identified as priorities:

Treatment Levels of Care Lacking Adequacy

Mental health: Outpatient, Primary Care and Peer/Recovery Supports (tied), and Emergency/Crisis and IOP (tied).

Substance Use: Outpatient and Inpatient (tied), Primary Care and Peer/Recovery support.

Suicide: Family/loved one's support, Outpatient, Primary Care, and Emergency/Crisis (tied)

Problem Gambling: Outpatient, peer/recovery support, and family/loved one's support.

Support Services/ Recovery Supports Most Needed

Mental health: Community Support Services, Care Coordination, Housing with Support Services

Substance Use: Community Support Services, Housing with Support Services, and Peer/Recovery Supports

Suicide: Crisis Response, Community Support Services, Family/Loved Ones Support

Problem Gambling: Peer/Recovery Support, Family/Loved Ones Support, (I don't know), Community Support Services

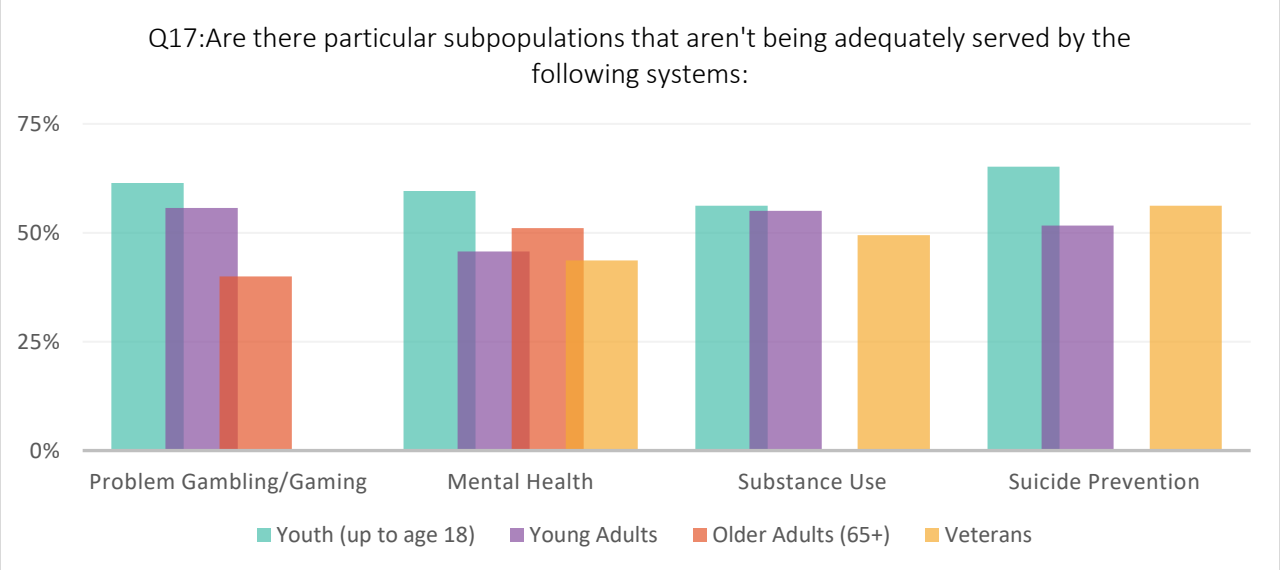
Bed availability is perpetually an issue for inpatient substance use treatment and workforce shortages contribute to long wait times to be seen by a clinician in outpatient care and for those aiming to resume in-person care from telehealth post-pandemic.

The need for behavioral health services continues to increase, but **the workforce has not expanded to meet to the need.** Community support and housing continue to be identified as priority needs.

Outpatient care settings, including primary care, and emergency/crisis services and natural supports emerged as priority areas for Region 4.

System development efforts currently underway in Connecticut that may address these needs include the aforementioned CCBHC's and crisis system enhancements including the roll-out of the 988 and implementation of Urgent Care Centers (UCCs).

Subpopulations



Regional survey and focus group participants indicated **youth, veterans, and young adults** consistently as subpopulations of concern for Problem Gambling, Mental Health, Substance Use, and Suicide. Additional data reveal subgroups at greater risk in these areas as mentioned throughout this report.

There is growing concern for **older adults** in the areas of Problem Gambling and mental health, most notably for anxiety, depression and increasing concerns about suicide.

Veterans are more likely to struggle with substance use when compared to the general population in the U.S. and are more likely to have a co-occurring disorder with more severity than those of the general population. **Veteran**s misuse prescription pain relievers at a rate nearly twice that of the general population in the same age group.

In the United States, the rate of suicide is higher among **males**, the **AI/AN population**, **older adults, Veterans**, and those living in **rural** areas. 2021 rates were highest among **non-Hispanic AI/AN persons** and there was a significant increase among **non-Hispanic Black or African American** persons and for **Hispanic** persons during 2018-2021.

Suicide is the second leading cause of death among young people aged 10 to 24 and

LGBTQ youth are more than four times as likely to attempt suicide than their peers. The Trevor Project estimates that more than 1.8 million LGBTQ youth (13-24) seriously consider suicide each year in the U.S. and at least one youth attempts suicide every 45 seconds.[20]

Region 4 survey respondents also indicate concern about gaming addiction, especially for **young boys**. In Connecticut, HEDIS data reveal that the consistency with which females have better rates on nearly every HEDIS measure compared to males. Males are not typically seen as receiving disparate treatment and although the causes may be complex the clear message is that the service system is not adequately serving them. [21]

When asked *"Is there anything that you feel the service system, including DMHAS and DCF can do differently for the subgroups you identified?"* respondents indicated that support is needed for everyone. ***"Everyone needs help. Mental Health doesn't discriminate. It can happen to anyone."*** Other suggestions included increased collaboration among the RBHAOs and veterans, increased gambling education for the black and Latino communities, support peer respite programs led by people with lived experience, more Spanish-speaking supports, and improve culturally sensitive outreach to all populations.

[20] Johns et al., 2019; Johns et al., 2020)

[21] BHPOC, Carelon/CTBHP, February 2023

Recommendations/Conclusions

The following recommendations are based on emerging issues, strengths, assets, resource gaps, and needs for Region 4:

Substance Use Prevention:

Regional:

- Improve perception of harm of emerging issues (IMF, fake pills, stimulants) and vaping (THC), especially among youth and parents/caregivers
- Increase compliance checks of alcohol and ENDS product sales to minors and acknowledge those who comply/pass, provider resources to merchants

State:

- Promote and implement recommendations of the ADPC Prevention Committee Cannabis workgroup.
- Support comprehensive standardized field sobriety test for cannabis.

Substance Use Treatment:

Regional:

- Engage and educate Region 4 primary care providers about resources and current trends in substance use (cannabis, vaping, IMF/fake pills)
- Identify treatment options for youth addicted to nicotine/vapes.

State:

- Promote campaign educating primary care networks about RBHAO/vaping resources.
- Continue to seek regional perspectives in the ADPC Committee and related subcommittees to identify and inform substance use system improvement opportunities.

Substance Use Recovery:

Regional:

- Engage additional regional partners to join regional "Recovery Friendly" initiatives including Recovery Friendly Workplaces, Campuses, and Communities.
- Increase awareness of housing resources for people with behavioral health needs

State:

- Increase investment in peer-provided education, advocacy, and support, including employing peer support specialists and recovery coaches.

Mental Health Prevention:

Regional:

- Promote and engage additional districts to adopt evidence-based programs (i.e., Gizmo, Signs of Suicide)

- Conduct regional youth anxiety review to capture youth perspectives post-Covid.

State:

- Identify and implement innovative strategies that will grow and sustain a pipeline of prevention professionals to meet the future needs of the state.

Mental Health Treatment:

Regional:

- Educate the community, school and provider partners about crisis system support including 988, mobile crisis, and the Urgent Care Center.

State:

- Invest in innovative and aggressive strategies to address behavioral health workforce shortages.

- Identify and secure sustainable funding source(s) for crisis system enhancements including 988 and urgent care centers.

Mental Health Recovery:

Regional:

- Increase participation of people with lived experiences in all local/regional coalitions

State:

- Advance opportunities for people in recovery and family/community members and inform systems improvement efforts.

Problem Gambling Prevention:

Regional:

- Infuse problem gambling/gaming into existing programs that address substance use and mental health.

- Disseminate awareness campaign about youth/young adult gambling and gaming addiction including online safety.

- Expand AAPI Program to additional sectors (i.e., higher education)

State:

- Build capacity and readiness among underserved populations of youth up to 18, young adults and older adults 65+

- Create campaign message targeting young adult problem gambling/gaming and sports betting.

Problem Gambling Treatment:

Regional:

- Increase community awareness of available treatment options for youth/young adult problem gambling and gaming addiction.

State:

- Expand network of providers for youth/young adult gambling and gaming addiction

Problem Gambling Recovery:

Regional:

- Increase awareness of problem gambling supports and combat stigma at community events (i.e., Play the CT Way mobile van).

State:

- Continue to promote, support, and build upon the 'Responsible Play the CT Way' Campaign with a special focus on youth/young adult population as identified by increased calls to the problem gambling helpline.

Appendices

2023 Regional Priority Needs Report

A trusted voice for healthy communities.

As the Regional Behavioral Health Action Organization (RBHAO), Amplify, Inc. is charged with carrying out the Priority Planning process every 2 years for the towns of:

Andover, Avon, Berlin, Bloomfield, Bolton, Bristol, Burlington, Canton, East Granby, East Hartford, East Windsor, Ellington, Enfield, Farmington, Glastonbury, Granby, Hartford, Hebron, Manchester, Marlborough, New Britain, Newington, Plainville, Plymouth, Rocky Hill, Simsbury, Somers, South Windsor, Southington, Stafford, Suffield, Tolland, Vernon, West Hartford, Wethersfield, Windsor, Windsor Locks.

***Responses will not be associated with any specific individual*.**

Thank You for your participation and we look forward to sharing what we learn.

1. Your Name (optional)

* 2. Please indicate what group(s) you are connected with *(check all that apply).*

- [ ] Catchment Area Council (CAC)
- [ ] Law Enforcement
- [ ] Local Prevention Council (LPC)
- [ ] Network of Care - Central
- [ ] Network of Care - North Central
- [ ] Parent/Family Member
- [ ] Regional Gambling Awareness Team (RGAT)
- [ ] Regional Suicide Advisory Board (RSAB)
- [ ] School District
- [ ] Youth/Young Adult
- [ ] Other

Other (please specify)

* 3. How appropriate *(right fit - accessibility, quality, frequency, duration)* are available **MENTAL HEALTH** services to meet the need in the areas of

	Appropriate	Somewhat appropriate	Neutral	Less than appropriate	Not at all appropriate	I don't know
Prevention	◯	◯	◯	◯	◯	◯
Treatment	◯	◯	◯	◯	◯	◯
Recovery	◯	◯	◯	◯	◯	◯

* 4. How appropriate *(right fit - accessibility, quality, frequency, duration)* are available **SUBSTANCE USE** services to meet the need in the areas of

	Appropriate	Somewhat appropriate	Neutral	Less than appropriate	Not at all appropriate	I don't know.
Prevention	◯	◯	◯	◯	◯	◯
Treatment	◯	◯	◯	◯	◯	◯
Recovery	◯	◯	◯	◯	◯	◯

* 5. How appropriate *(right fit - accessibility, quality, frequency, duration)* are available **SUICIDE PREVENTION** services to meet the need in the areas of

	Appropriate	Somewhat appropriate	Neutral	Less than appropriate	Not at all appropriate	I don't know.
Prevention	◯	◯	◯	◯	◯	◯
Treatment	◯	◯	◯	◯	◯	◯
Recovery	◯	◯	◯	◯	◯	◯

* 6. How appropriate *(right fit - accessibility, quality, frequency, duration)* are available **PROBLEM GAMBLING/GAMING** services to meet the need in the areas of

	Appropriate	Somewhat appropriate	Neutral	Less than appropriate	Not at all appropriate	I don't know.
Prevention	◯	◯	◯	◯	◯	◯
Treatment	◯	◯	◯	◯	◯	◯
Recovery	◯	◯	◯	◯	◯	◯

* 7. What prevention program, strategy or policy would you like to most see accomplished related to:

mental health

substance use

suicide prevention

problem gambling/gaming

* 8. Are there treatment levels of care you feel are unavailable or inadequately provided for MENTAL HEALTH? *(Select up to 3)*

- [ ] Outpatient Therapy
- [ ] IOP-Intensive Outpatient
- [ ] PHP - Partial Hospitalization
- [ ] Primary Care *(incl.integrated medical/behavioral healthcare)*
- [ ] Emergency/Crisis
- [ ] Inpatient
- [ ] Other (please specify)
- [ ] Inpatient Rehabilitation - short/long term
- [ ] Peer/Recovery Supports
- [ ] Family/loved ones support
- [ ] Telehealth
- [ ] I don't know
- [ ] Not applicable

* 9. Are there treatment levels of care you feel are unavailable or inadequately provided for SUBSTANCE USE? *(Select up to 3)*

- [ ] Outpatient Therapy
- [ ] IOP-Intensive Outpatient
- [ ] PHP - Partial Hospitalization
- [ ] Primary Care (incl.integrated medical/behavioral healthcare)
- [ ] Emergency/Crisis
- [ ] Inpatient
- [ ] Other (please specify)
- [ ] Inpatient Rehabilitation - short/long term
- [ ] Peer/Recovery Supports
- [ ] Family/loved ones support
- [ ] Telehealth
- [ ] I don't know
- [ ] Not applicable

* 10. Are there treatment levels of care you feel are unavailable or inadequately provided for SUICIDE/SUICIDALITY? *(Select up to 3)*

- [ ] Outpatient Therapy
- [ ] IOP-Intensive Outpatient
- [ ] PHP - Partial Hospitalization
- [ ] Primary Care (incl.integrated medical/behavioral healthcare)
- [ ] Emergency/Crisis
- [ ] Inpatient
- [ ] Inpatient Rehabilitation - short/long term
- [ ] Peer/Recovery Supports
- [ ] Family/loved ones support
- [ ] Telehealth
- [ ] I don't know
- [ ] Not applicable
- [ ] Other (please specify)

* 11. Are there treatment levels of care you feel are unavailable or inadequately provided for PROBLEM GAMBLING/GAMING? *(Select up to 3)*

- [ ] Outpatient Therapy
- [ ] IOP-Intensive Outpatient
- [ ] PHP - Partial Hospitalization
- [ ] Primary Care (incl.integrated medical/behavioral healthcare)
- [ ] Emergency/Crisis
- [ ] Inpatient
- [ ] Inpatient Rehabilitation - short/long term
- [ ] Peer/Recovery Support
- [ ] Family/loved ones support
- [ ] Telehealth
- [ ] I don't know
- [ ] Not applicable
- [ ] Other (please specify)

* 12. What support services/recovery supports are most needed to assist persons with MENTAL HEALTH issues *(select up to 3):*

- [ ] Community support services (incl. case mgmnt)
- [ ] Care Coordination
- [ ] Supported employment
- [ ] Crisis response
- [ ] Respite
- [ ] Other (please specify)
- [ ] Housing w/ support services (including sober housing)
- [ ] Peer/Recovery Supports
- [ ] Family/loved ones support
- [ ] I don't know

* 13. What support services/recovery supports are most needed to assist persons with SUBSTANCE USE issues *(select up to 3):*

- [ ] Community support services (incl. case mgmnt)
- [ ] Care Coordination
- [ ] Supported employment
- [ ] Crisis response
- [ ] Respite
- [ ] Other (please specify)
- [ ] Housing w/ support services (including sober housing)
- [ ] Peer/Recovery Supports
- [ ] Family/loved ones support
- [ ] I don't know

* 14. What support services/recovery supports are most needed to assist persons with SUICIDE-related challenges *(select up to 3):*

- [ ] Community support services (incl. case mgmnt)
- [ ] Care Coordination
- [ ] Supported employment
- [ ] Crisis response
- [ ] Respite
- [ ] Housing w/ support services (including sober housing)
- [ ] Peer/Recovery Supports
- [ ] Family/loved ones support
- [ ] I don't know
- [ ] Other (please specify)

* 15. What support services/recovery supports are most needed to assist persons with PROBLEM-GAMBLING/GAMING challenges *(select up to 3):*

- [ ] Community support services (incl. case mgmnt)
- [ ] Care Coordination
- [ ] Supported employment
- [ ] Crisis response
- [ ] Respite
- [ ] Housing w/ support services (including sober housing)
- [ ] Peer/Recovery Supports
- [ ] Family/loved ones support
- [ ] I don't know
- [ ] Other (please specify)

* 16. What would you say is the greatest strength/asset of the:

Mental health promotion, treatment and recovery support system

Substance use prevention, treatment, and recovery support system

Suicide prevention, treatment, postvention, and recovery support system

Problem gambling/gaming prevention, treatment, and recovery support system

* 17. Are there particular subpopulations that aren't being adequately served to help with:

	Veterans	Youth (up to age 18)	Young Adults	Older Adults (65+)	Hispanic/Latino	American Indian/Alaska Native	Asian	Black/African American	Native Hawaiian/Pacific Islander	White	LGBTQ+	Other
Mental Health	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Substance Use	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Suicide Prevention	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Problem Gambling/Gaming	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Please comment

* 18. Is there anything that you feel the service system, including DCF and DMHAS, can do differently for the subgroup(s) you identified?

* 19. What are the emerging issues you are seeing or hearing about in the following areas? *(Think of how/where you are seeing them such as social media, TV, news, school, workplace).*

mental health	
substance use	
suicide prevention	
problem gambling/gaming	

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

* 21. One of the best ways to help our youth and get their perspective is to ask them!
If your town/school system has not conducted a school survey in the last 2 years, it is highly recommended that you have one. Would you like to learn more about school-based youth surveys?

- ◯ Yes
- ◯ No

Please share your email or email us at info@amplifyct.org.

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2023 Priority Report Focus Group Questions

- Welcome, gratitude, and introductions
- Overview of RBHAO role, bi-annual priority process, confidentiality

1. **Quality and Access:** (separately) Mental Health, Substance Use, Suicide and Problem Gambling.

    a. <u>Mental Health Services</u>
        i. What works well? (right fit, success stories? Good results/outcomes?)
        ii. Is the service accessible?
        iii. How about quality of the service and/or service system now (PROMPT: think of now as compared with a couple of years ago when we last discussed this. Think of services pre/post-covid)? (reference 2022 CRS charts if needed)

    b. <u>Substance Use Services</u>
        i. what works well?
        ii. Is the service accessible?
        iii. How about quality of the service and/or service system now (PROMPT: think of now as compared with a couple of years ago when we last discussed this. Think of services pre/post-covid)? (reference 2022 CRS charts if needed)

    c. <u>Suicide Prevention</u>
        i. what works well?
        ii. Is the service accessible?
        iii. How about quality of the service and/or service system now (PROMPT: think of now as compared with a couple of years ago when we last discussed this. Think of services pre/post-covid)? (reference 2022 CRS charts if needed)

    d. <u>Problem Gambling, including gaming/ Gambling Awareness:</u>
        i. what works well?
        ii. Is the service accessible?
        iii. How about quality of the service and/or service system now (PROMPT: think of now as compared with a couple of years ago when we last discussed this. Think of services pre/post-covid)? (reference 2022 CRS charts if needed)

2. **Live poll questions with technology:**

    Q1. If you could choose 1 program, practice change or policy, what would it be?

    Q2. What treatment level of care do you feel is unavailable?

    Q3. What support services/recovery supports do you feel are unavailable?

    Q4. What are the greatest strengths/assets of our mental health, substance use, and suicide prevention, treatment, and support systems?

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Q5. Are there particular sub-populations that aren't being adequately served by the mental health, substance use, or suicide prevention, treatment, and recovery support systems?

3. Announcements (time-allowing):
    a. March is PGAM
    b. May is Amplify our Mental Health Day
    c. Legislative updates and the improved newsletter format coming out soon!

4. Closing gratitude

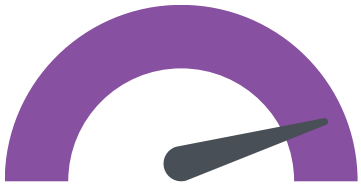
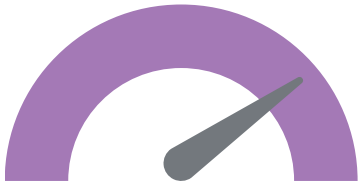
2023 RBHPSW (Workgroup) Priority Ranking Matrix: Mental Health & Suicide

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

Mental Health Concern	Mean Ranking Score
Anxiety	 **4.1**
Suicide	 **4.0**
Depression	 **3.9**

2023 RBHPSW (Workgroup) Priority Ranking Matrix: Substance Use/Misuse/Addiction

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

Substance of Concern	Mean Ranking Score
Heroin & Fentanyl	 4.4
ENDS/Vaping	 3.9
Alcohol	 3.9
Marijuana	 3.7

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Priority Ranking Matrix Mean Scores

Scale: 1 = lowest 2= low 3=medium 4=high 5=highest

Mental Health and Suicide

Problem	Magnitude	Impact	Changeability	Capacity/ Readiness	Consequence of Inaction	MEAN RANKING SCORE
Anxiety	4.7	4.5	3.8	3.3	4.2	4.1
Suicide	3.5	4.2	3.3	4.0	4.8	4.0
Depression	4.3	4.2	3.3	3.2	4.7	3.9
Serious Mental Illness - Children	3.2	3.8	3.0	3.0	4.2	3.4
Trauma/PTSD	3.3	3.5	3.0	3.0	3.3	3.2
Serious Mental Illness - Adult	3.3	3.2	2.5	2.8	3.5	3.1

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Substance Use/Misuse/Addiction

Problem	Magnitude	Impact	Changeability	Capacity/ Readiness	Consequence of Inaction	MEAN RANKING SCORE
Heroin and Fentanyl	3.7	4.3	4.5	4.3	5.0	**4.4**
ENDS/ Vaping	4.5	4.7	3.0	3.5	4.0	**3.9**
Alcohol	4.3	4.0	3.2	4.0	4.2	**3.9**
Marijuana	4.3	4.2	3.0	3.5	3.7	3.7
Rx Drug Use	3.0	3.8	3.3	3.5	4.0	3.5
Cocaine	3.0	2.7	3.7	3.7	3.3	3.3
Tobacco	2.5	2.5	3.7	3.7	3.3	3.1

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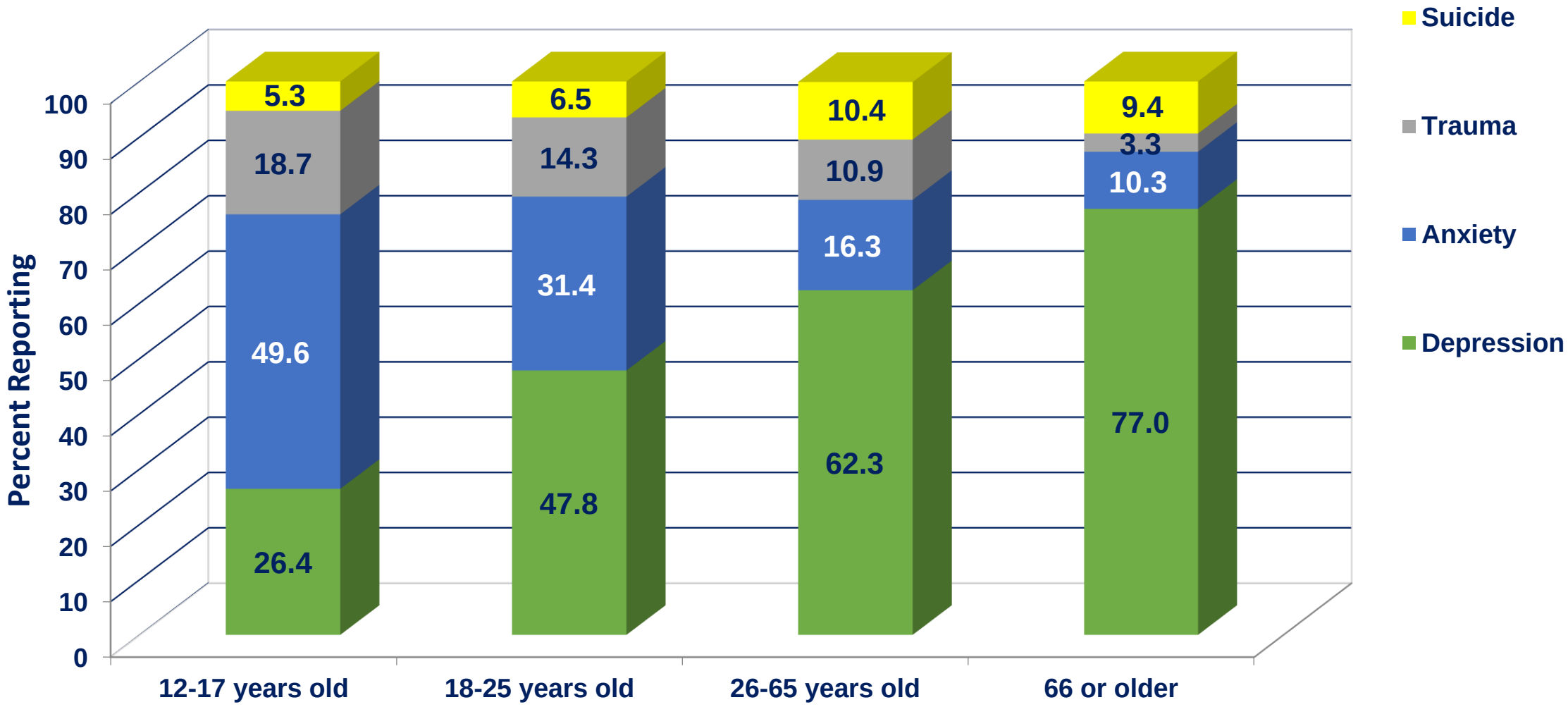
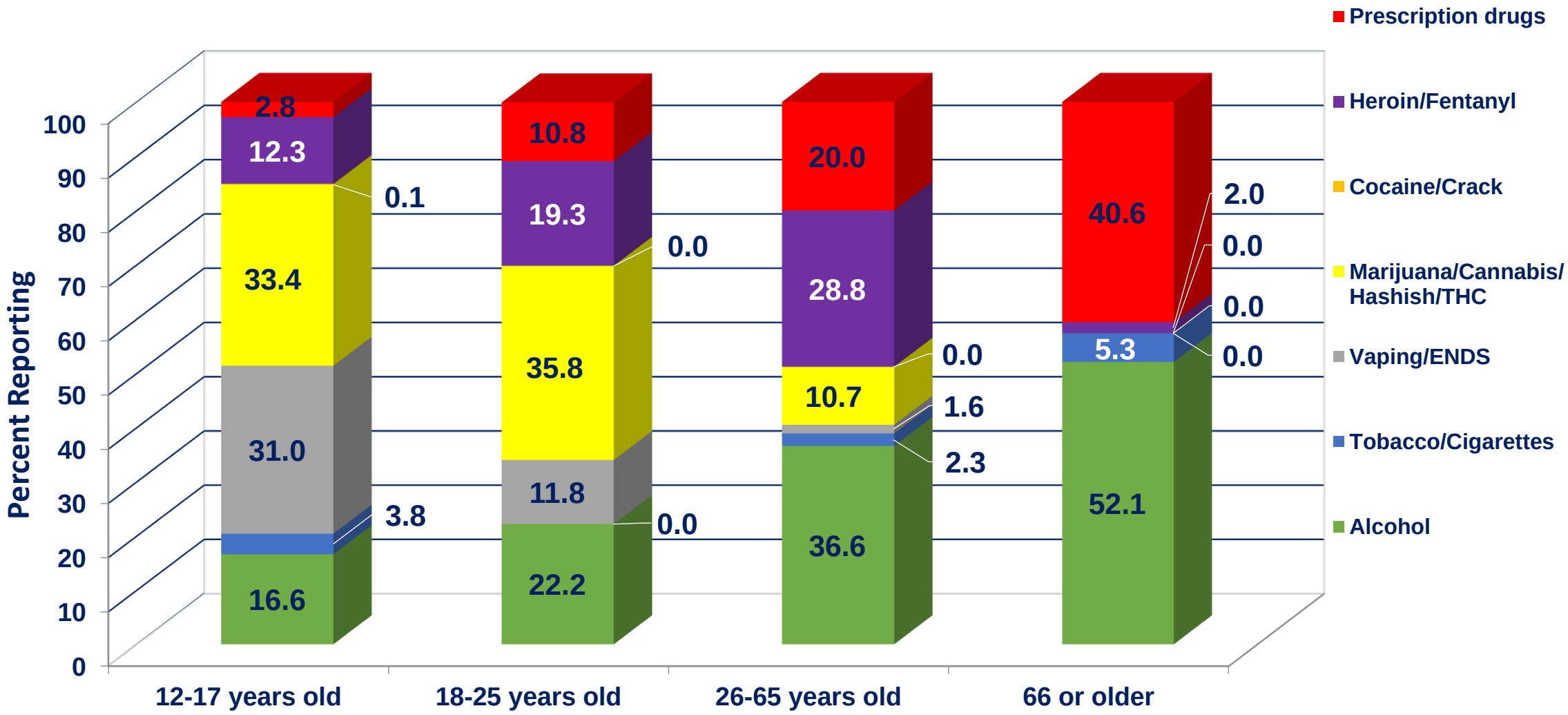
Problem Gambling

Problem	Magnitude	Impact	Changeability	Capacity/ Readiness	Consequence of Inaction	MEAN RANKING SCORE
Problem Gambling	2.7	2.8	2.5	2.7	3.0	2.7

Mental Health Issue of Greatest Concern for Age Groups, According to Key Informants: Amplify, Inc. CRS, 2022



Problem Substances of Greatest Concern for Age Groups, According to Key Informants: Amplify, Inc. CRS, 2022



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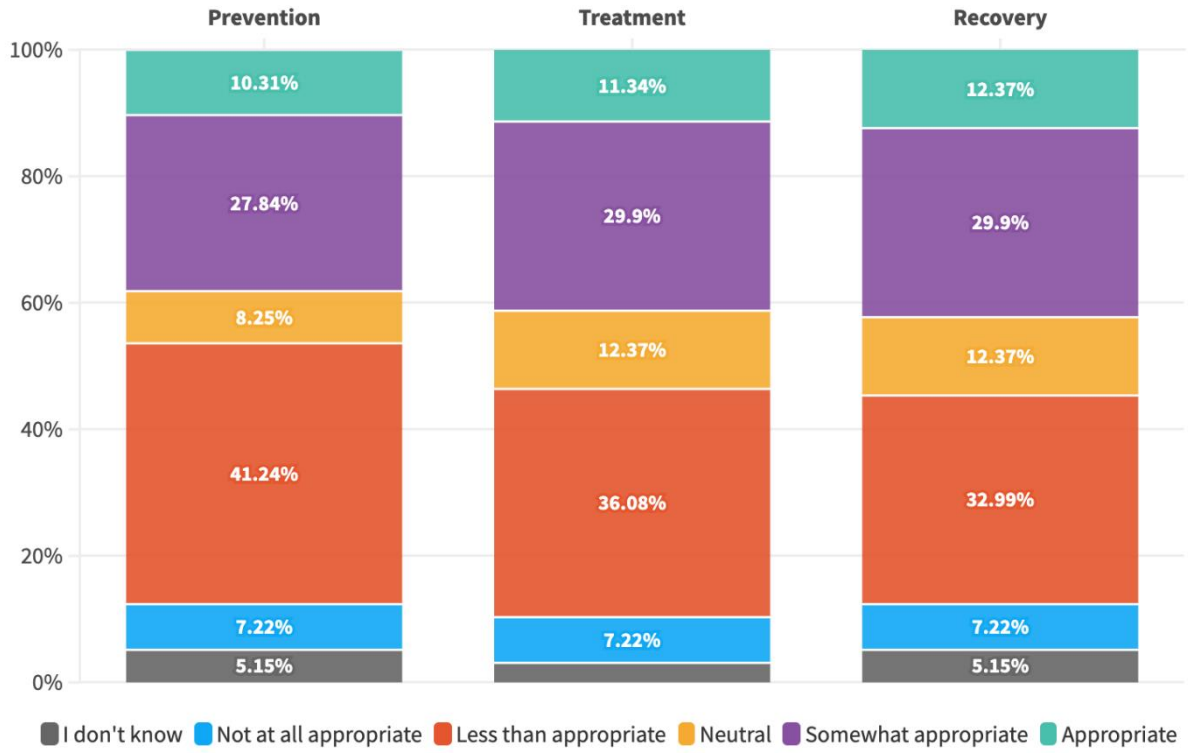
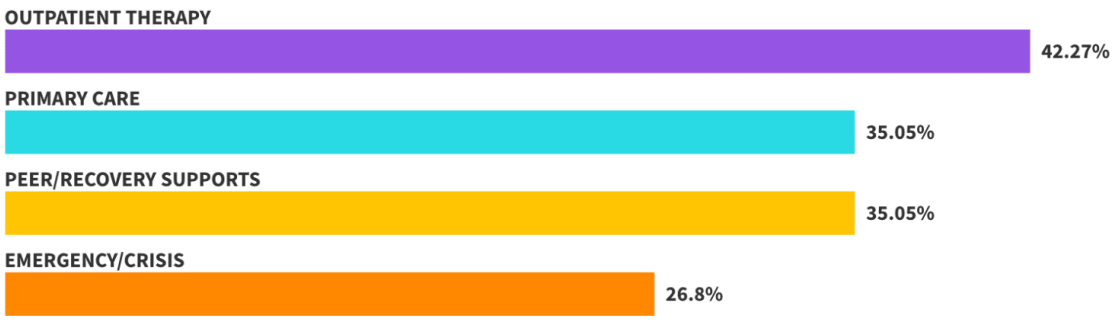
How appropriate (right fit - accessibility, quality, frequency, duration) are available MENTAL HEALTH services to meet the need in the areas of ...



Are there treatment levels of care you feel are unavailable or inadequately provided for MENTAL HEALTH?



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Are there treatment levels of care you feel are unavailable or inadequately provided for:

Mental Health

- Outpatient Therapy — 42%
- Peer/Recovery Supports — 35%
- Primary Care — 35%
- Emergency/Crisis — 27%
- IOP-Intensive Outpatient — 27%

Substance Use

- Inpatient Rehabilitation - short/long term — 33%
- Outpatient Therapy — 33%
- Primary Care — 26%
- Peer/Recovery Supports — 25%
- IOP-Intensive Outpatient — 23%

Suicidal Ideation

- Family/loved ones support — 30%
- Outpatient Therapy — 28%
- Emergency/Crisis — 26%
- Primary Care — 26%
- Peer/Recovery Supports — 25%

Problem Gambling

- I don't know — 48%
- Outpatient Therapy — 27%
- Peer/Recovery Support — 26%
- Family/loved ones support — 22%
- Primary Care — 11%

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Priority Recommendations for Region 4 – North Central

	Prevention	Treatment	Recovery
Substance Abuse/Misuse			
Region	Improve perception of harm of emerging issues (IMF, fake pills, stimulants) and vaping (THC), especially among youth and parents/caregivers Increase compliance checks of alcohol and ENDS product sales to minors and acknowledge those who comply/pass; provider resources to merchants	Engage/educate Region 4 primary care providers about resources and current trends in substance use (cannabis, vaping, IMF/fake pills) Identify treatment option/plans for youth addicted to nicotine/vapes.	Engage additional regional partners to join regional "Recovery Friendly" initiatives including Recovery Friendly Workplaces, Campuses, and Communities. Increase awareness of housing resources for people with behavioral health needs
State	Promote and implement recommendations of the ADPC Prevention Committee Cannabis workgroup. Support comprehensive standardized field sobriety test for cannabis.	Promote campaign educating primary care networks about RBHAO/vaping resources. Continue to seek regional perspectives in the ADPC Committee and related subcommittees to identify and inform substance use system improvement opportunities.	Increase investment in peer-provided education, advocacy, and support, including employing peer support specialists and recovery coaches.
Mental Health			
Region	Engage additional districts to adopt evidence-based programs (i.e., Gizmo, Signs of Suicide) Conduct regional youth anxiety review to capture youth perspectives post-Covid.	Educate community, school, and provider partners about crisis system supports including promoting 988, mobile crisis, and the Urgent Care Center.	Increase participation of people with lived experiences in all local/regional coalitions Increase awareness of housing resources for people with behavioral health needs
State	Identify and implement innovative strategies that will grow and sustain a pipeline of prevention professionals to meet the future needs of the state.	Invest in innovative and aggressive strategies to address behavioral health workforce shortages. Identify and secure sustainable funding source(s) for crisis system enhancements including 988 and urgent care centers.	Advance opportunities for people in recovery and family members to inform systems improvement efforts.

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Priority Recommendations for Region 4 – North Central

Problem Gambling			
Region	Infuse problem gambling/gaming into existing programs that address substances and mental health. Disseminate awareness campaign about youth/young adult gambling and gaming addiction including online safety. Expand AAPI Program to additional sectors (i.e., higher education).	Increase community awareness of available treatment options for youth/young adult problem gambling and gaming addiction.	Increase awareness of problem gambling supports and combat stigma at community events (i.e., Play the CT Way mobile van).
State	Build capacity and readiness among underserved populations of youth up to 18, young adults and older adults 65+. Create campaign message targeting younger adult problem gambling/gaming and sports betting.	Expand network of providers for youth/young adult gambling and gaming addiction.	Continue to promote, support, and build upon the 'Responsible Play the CT Way' Campaign with a special focus on youth/young adult population as identified by increased calls to the problem gambling helpline.
Systems/Other			
State Substate/ Infrastructure	Explore, identify, and implement improved data tracking platforms for state-funded programs resulting in more actionable real-time data that identities and informs community health and system improvement needs earlier and more often.		

What Brings You Joy?

Laughing

Loved ones

Relationships **Family**

My children My daughter

Family time

Coaching kids

Helping others

Helping others in the community

Community

Creating something

Reading Crafting

Creative Endeavors

Hobbies

My pets

My dog Equine therapy

Walking my dog

Work-life Balance

Flexible schedule

Coworkers

Getting groups to work together

Sunshine

Exercise

Me Time

Nature

The beach

Self-Care

Alone Time

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