2020 Regional Profile

June 30th, 2021

www.wctcoalition.org

Executive Summary

The *2021 Region 5 Regional Priority Report* provides an updated overview and thorough description of substance misuse, suicide, problem gambling, and mental health issues of our region's diverse population. It includes a brief demographic description of CT DMHAS Region 5; in-depth regional profiles of substance misuse, suicide, problem gambling, and mental health issues in our service area; a discussion on emerging issues and trends; descriptions of resources, community norms and conditions, strengths and assets, and service gaps and resource needs; and recommendations that are realistic and reflective of the region's challenges and available resources.

Western CT Coalition worked within the framework of our Regional Priority Setting Workgroup (RBHPSW), comprised of Coalition members, community volunteers, partners, and stakeholders. The Western CT Coalition staff conducted regional focus groups and key informant interviews to rank alcohol, marijuana, tobacco, electronic nicotine delivery systems, cocaine, heroin, prescription drug misuse, suicide, problem gambling, and mental health concerns. We also accessed several local, regional, and national data sources to help develop individual profiles and inform recommendations.

Through surveys and data analyses, the RBHPSW identified specific areas of concern and emerging issues and trends. These include:

- Continued widespread use of alcohol as the most widely used of all substances, with negative consequences of alcohol and underage drinking being of primary concern.
- Rapid rise of vaping and use of e-cigarettes among teens and young adults. Region 5 closely follows both statewide and national outbreaks.
- Widespread and growing use of marijuana among youth and adults, with low perception of harm.
- Availability of cocaine, though without a significant increase of use over the last several years.
- Decrease in the use of heroin, though complicated by fentanyl a dangerous mixing agent.
- Pervasive often fatal use of other illicit opioids, the most prevalent being fentanyl.
- Persistent misuse of prescription drugs, especially benzodiazepines and amphetamines among youth and adults. Over the last three years, approximately one third of all overdose fatalities in Western CT were related to misuse of prescription medications.
- An increase in the prevalence of mental health issues among youth and adults. Stress and anxiety are the most reported mental health disorders, affecting youth, teens, and adults of all ages and from all socioeconomic strata and ethno-racial groups.
- The linkage between mental health issues and substance use disorders and the associated risks of addiction and compounding behavioral health risks.
- Suicide rates in Region 5 continue to increase slightly, following statewide and national trends. Most recent DPH statistics show that over the latest 4-year reporting period (2015-2019), 337 people in our region died by suicide. *(CT Violent Death Reporting System. Suicides: The CT Landscape 2015-2019)*
- Problem gambling, gambling disorder, gambling addiction, or problems related to gambling affect youth, young adults, and adults of all ages and is tagged as a high-risk behavior.

Demographics in Region 5 are highly disparate town by town. This region comprises 43 communities in the western part of Connecticut, including all of Litchfield County, and northern Fairfield and New Haven Counties. It includes three urban centers (Danbury, Torrington, and Waterbury-an urban core), 15 suburban communities, 24 rural towns, and 1 unique small city (Winsted) within a town (Winchester).

All socioeconomic strata are represented within this region, from among the highest to lowest median annual household incomes in the state. Racial diversity ranges from less than 3% in Norfolk to more than 60% in Waterbury. Linguistic diversity and immigrant populations are among the highest (Danbury) and lowest (Northwest corner) in the entire state. Disparate demographics within our region make this priority setting report a limited snapshot of the overall regional picture.

The *2021 Region 5 Regional Priority Report* identifies risk factors, burdens, and sub-populations at risk and explores how and why they are at-risk for substance misuse, suicide, problem gambling, and mental health issues. At-risk groups include youth, adolescents, those facing homelessness, LGBTQ community, those living at or below the poverty level, new immigrants, and those in chronic pain and/or using prescription pain relievers. There are specific at-risk groups within each category, described in detail. For example, people dependent on alcohol are *at risk* for heroin addiction. This report addresses health disparities throughout the region and how these correlate to subpopulations at risk. There are disparities by race, ethnicity, age, gender, sexual orientation, sexual identity, and educational attainment in the prevalence of mental health issues, alcohol dependence, substance use disorders, and problem gambling.

The report acknowledges persistent resource gaps and needs in this region. These focus on access to and affordability of preventive care and treatment options, lack of transportation for mental health and addiction services and supports, shortage of service providers in certain communities particularly for youth, reactive/crisis intervention over prevention, and stigma around mental health and addiction issues. There is need for better coordination and collaboration among agencies, departments, and law enforcement. There is definitive need for more pro-active resources and supports that might intercept the need for crisis intervention, especially among youth. While there is representation from local officials and area legislators on local Prevention Councils and Opioid Workgroups, there is need for a deeper level of engagement from this sector. Although mental health promotion and substance misuse prevention are mainstays in the region, we recognize the need for continued outreach and engagement, especially among youth and families.

We identify many community resources, strengths, and assets. These vary widely from town to town and include innovative treatment options and emerging trends in customized therapies. Supportive resources include initiatives such as TRED (Transportation Reaching Every Direction) that provides free car service for eligible DMHAS clients in the northwestern region as well as free transportation from area hospital emergency departments to a designated in-patient drug treatment facility. No-cost mental health awareness, crisis intervention, and suicide prevention training workshops are more widely available and address stigma in an effort to encourage people to seek treatment. Supportive resources for youth and families in rural communities include the YMCA, Boys and Girls Clubs, and Youth Service Bureaus. All school districts provide education and awareness around substance abuse, mental health, and positive youth development and family structures. Across the region, faith-based organizations – from small neighborhood churches to large non-denominational congregations – are recognized in the region as a community resource where people can go for guidance and assistance during challenging times. Several congregations offer opioid awareness and Narcan trainings, QPR (Suicide Prevention), CAP (Congregational Awareness Program), and Mental Health First Aid throughout Region 5. Their efforts have resulted in a reduction of stigma related to mental health and substance use disorders. Another asset is our ongoing positive communication with various Councils of Government (COG), represented by WESTCOG (*Western CT*), NWCOG (*Northwestern CT*) and NVCOG (*Naugatuck Valley*).

Positive community norms and conditions are abundant in Region 5. Most people do not misuse substances or present with problem gambling. Most enjoy good mental health, maintain positive relationships with others, cite strong support systems when facing challenges, and remain resilient to adversity.

Western CT Coalition, the RBHPSW, and community partners and collaborators acknowledge cultural humility in each phase of the development of the *2021 Region 5 Regional Priority Report*. Within the lens of equity and inclusion, our intention is to present a fair and just representation of data. We purposefully sought to include diverse voices on committees and in surveys, focus groups, and interviews. We strived to maintain awareness of implicit bias when interpreting and analyzing data. This report seeks to be transparent about inequalities within and across communities, including unequal access to prevention, treatment, and other resources.

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Abbreviations

APEX-formerly Aids Project of Greater Danbury

ATOD: Alcohol, Tobacco, and Other Drugs

AUD: Alcohol Use Disorder

BRFSS: Behavioral Risk Factor Surveillance System

CACs: Catchment Area Councils

CAGs: Catchment Area Groups

CADCA: Community Anti-Drug Coalitions of America

CCAR: Connecticut Community for Addiction Recovery

CCATS: Center for Child and Adolescent Treatment Services

CCPG: Connecticut Council on Problem Gambling

CCT: Community Care Team (CCT)

CGAC: Connecticut Gambling Awareness Community

CHOICES: **C**ultivating **H**ealthy **O**pportunities **I**n **C**ollege **E**nvironments Office

CIFC: Connecticut Institute for Communities

CME: Chief Medical Examiner, Office of

COG: Councils of Government

CORE: College Population Surveys

CORI: Connecticut Opioid Response Initiative

CNAW: Community Needs Assessment Workgroup

DEA: Drug Enforcement Agency

DEA DTA: DEA Drug Threat Assessment

DCP: Department of City Planning

DFS: Drug Free Schools Committee

DMHAS: Department of Mental Health and Addiction Services

DCF: Department of Children and Families

DCP: Department of Consumer Protection

DESPP: Department of Emergency Services and Public Protection

DOC: Department of Corrections

DPH: Department of Public Health

DSM: Diagnostic and Statistical Manual of Mental Disorders

DSS: Department of Social Services

DVA: Department of Veteran Affairs

DUI: Driving Under the Influence

ECC: Enhanced Care Clinic

ED: Emergency Department

ENDS: Electronic Nicotine Delivery System

FDA: Food and Drug Administration

FPL: Federal Poverty Level

HIDTA: High Intensity Drug Trafficking Area

HVCASA: Housatonic Valley Coalition Against Substance Abuse

IICAPS: Intensive In-home Child and Adolescent Psychiatric Services

IMF: Fentanyl

LGBTQIA: Lesbian, Gay, Bisexual, Transgender, Questioning, Intersexual and Asexual

LMHAs: Local Mental Health Authorities

LPCs: Local Prevention Councils

LOUD: Live Life Without Opioid Use Disorder

MAT: Medication Assisted Treatment

MCCA: Midwestern Connecticut Council on Addiction

MDFT: Multidimensional Family Therapy

MH: Mental Health

MHFA: Mental Health First Aid

MTF: Monitoring the Future Survey

NAMI: National Alliance for Mental Illness

NCPG: National Council on Problem Gambling

NIAAA: National Institute on Alcohol Abuse and Alcoholism

NORA: Naloxone Overdose Response Application

NSDUHL: National Survey on Drug Use and Health

NHCOG: Northwest Hills Council of Governments

NVCOG: Naugatuck Valley Council of Governments

OD: Overdose

OTC: Over the Counter

PDMP: Prescription Drug Monitoring Program

PGAT: Problem Gambling Action Team

PSN: Project Safe Neighborhood

PTSD: Post-traumatic Stress Disorder

QPR: Question, Persuade, Refer

RBHAO: Regional Behavioral Health Action Organization

SA: Substance Abuse

SAMHSA: Substance Abuse Mental Health Service Administration

SAPT: Substance Abuse, Prevention, and Treatment

SEOW: State Epidemiological Outcomes Workgroup

SMI: Severe Mental Illness

SOR: State Opioid Response

SRO: School Resource Officer

SSPs: Syringe Service Programs

STR: State Targeted Response

SUD: Substance Use Disorder

SWORD: State Wide Opioid Reporting Directive

THC: Tetrahydrocannabinol

WCHN: Nuvance, formerly Western Connecticut Health Network

WCSU: Western Connecticut State University

YRBSS: Youth Risk Behavior (Connecticut School Surveys

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REGION 5 RBHAO 2020 REGIONAL PROFILE

Introduction

Background:

Western CT Coalition has worked on different iterations of the Regional Priority Setting Report with partners from DMHAS Region 5 for several years. The report has been used in conjunction with epidemiological profiles specific to sub-regions of the five main DMHAS service regions. The 2019 report combined previously studied elements to better represent the climate of behavioral health. It intentionally integrated substance misuse with mental health issues and information that would be useful to planning groups, policy makers, and other coalitions and stakeholders.

Purpose:

The purpose of this report is to provide a thorough description and representation of substance misuse, suicide, problem gambling, and mental health issues among the populations that we serve. We examine trends and attempt to identify specific sub-populations who are at heightened risk and may be in need of services. We organize data into profiles to help with needs assessments and gap analyses for substance misuse, suicide, problem gambling, and mental health issues. We define regional priorities and resources, so that we can make informed recommendations to address these needs. The report also identifies health disparities in order to address these inequities.

Data Sources:

The assessment incorporates a significant amount of quantitative data collected from a variety of sources. The national data used in this report came primarily from the National Survey of Drug Use and Health (NSDUH), Monitoring the Future, and the Youth Risk Behavior Surveillance System. Statistics from CT Department of Public Health, CT Office of Chief Medical Examiner, 2-1-1 Infoline, the CT State Epidemiological Outcomes Workgroup (SEOW) data portal, and CT Datahaven provided statewide and some regional information. Regional demographic data was taken from the most recent CERC Town Profiles. Local quantitative data came from area treatment providers, Community Health Needs Assessments, law enforcement, Western CT Coalition's Community Readiness Survey, and youth surveys. CT is very generous with qualifications for Medicaid. Approximately one out of four people in CT are enrolled in Medicaid (3,608,288 total). Region 5 comprises about 23% of those enrolled statewide (838,673 individuals). Beacon Health Options, which manages the Medicaid program for CT, was helpful in providing some Region 5 behavioral health data for this report. As with all survey instruments, there are strengths and limitations to each of these data sources.

Specific to our needs, national surveys are most useful for comparisons. Interpreting and applying data from these sources require some caution because of the large geographic area and wide range of demographics in Region 5. For instance, it was important to consider the differences between youth surveys in rural areas and those of urban centers. Aggregate data from youth surveys across an area of 43 disparate communities becomes diluted and therefore lacks significance. Region 5 covers forty-three distinct communities, including three core cities: Danbury, Torrington, and Waterbury. We tried to separate the urban or greater metro area data from that of rural communities in the northwestern corner of

the state where populations can be less than 2,000 full-time residents. When using the local data, we recommend that communities make observations without waging comparisons to neighboring communities. Priorities are more accurately identified when local conditions, resources and strengths are considered in tandem with areas of concern.

In addition to the quantitative data sources listed above, qualitative input was used to describe behavioral health conditions. Focus groups and key informant interviews were conducted between January and May of 2021. Focus groups included local school nurses, school resource officers, suicide prevention groups, among others, Green TEAR Initiative (Torrington), Naugatuck Youth Services, Problem Gambling Awareness Team (PGAT), and others. Key informant interviews were conducted with school principals, youth, parents, treatment providers, and local officials.

Qualitative input also included information gathered through our daily work and community involvement as an active coalition. The committees at Western CT Coalition involved in this report include the Drug-Free Schools Committee, Prevention Committee, Consumer Action Group, Opioid/Recovery Committee, Regional Suicide Advisory Board, and the Catchment Area Councils. These groups provided both quantitative and qualitative data throughout the year, as they use local level data to identify needs and address emerging issues for their own purposes. These long-standing committees brought great relevance to the data gathering process. They are engaged in a wide array of community sectors and are invaluable to our work.

How the Report was Developed:

The bulk of the priority setting process transpired between January and June 2021. In collaboration with others, Western CT Coalition staff developed the epidemiological profiles. Western CT Coalition staff recruited members of standing committees and community partners to participate on the RBHPSW. We intentionally included new people from diverse backgrounds to provide fresh perspectives and new insights. Members of the RBHPSW met regularly, consulted with other community partners and volunteers, reviewed the profiles, and completed priority ranking matrices. Coalition staff tabulated results and incorporated these into the report.

Beginning in January 2021, Western CT Coalition staff, members, volunteers, and community partners facilitated focus groups. For consistency and accuracy, the facilitator posed identical questions to each focus group and a scribe completed the required form for each focus group. In addition to data collected from focus groups, we gathered local, state, and national data to help develop the individual profiles. Written results of the focus groups were included in the data shared with the RBHPSW.

This group analyzed the profile data, community readiness data, and focus group responses. They used anecdotal and timely information to support the quantitative data provided in the profiles. They also discussed availability of resources and changes in perceptions around substance use disorders and other behavioral health issues. The RBHPSW used a Priority Ranking Matrix to score Magnitude, Impact, Changeability, Capacity/Readiness and Consequence of Inaction. The results of individual RBHPSW rankings are combined to determine similar recommendations, which can be actionable.

Strengths and Limitations of the Report:

The overarching strength of this report is its comprehensive assessment of the region's behavioral health. The profiles are detailed and thorough. We recognize that the report cannot accurately measure all possible aspects of behavioral health within its forty-three communities. Information was at times limited as to the level of geographic detail, availability of certain indicators, and timeliness of reporting periods. Overall, we were able to find ample local information and resources pertinent to the development of the profiles and to generate recommendations and priorities at the regional level.

Body

Demographic Characteristics:

DMHAS Region 5 covers the 43 communities in the western part of Connecticut. It includes all of Litchfield County, and extends into northern Fairfield and New Haven Counties. It includes Falls, Bethel, Bethlehem, Bridgewater, Brookfield, Canaan, Cheshire, Colebrook, Cornwall, Danbury, Goshen, Hartland, Harwinton, Kent, Litchfield, Middlebury, Morris, Naugatuck, New Fairfield, New Hartford, New Milford, Newtown, Norfolk, North Canaan, Oxford, Prospect, Redding, Ridgefield, Roxbury, Salisbury, Sharon, Sherman, Southbury, Thomaston, Torrington, Warren, Washington, Waterbury, Watertown, Winchester/Winsted, Wolcott, and Woodbury.

According to the most recent data (*https://dmhasregions.ctdata.org/region/5*), the total population of DMHAS Region 5 is 616,399, which accounts for just over 17% of the total population of CT, which is 3,565,287 (*census.gov, 2019*). From a different perspective, due to its many small rural and suburban communities, the Western CT Coalition service area comprises a full quarter, or 25%, of all municipalities in CT.

The Western CT Coalition service area has among the most divergent income levels in the state. The three urban centers of Danbury, Torrington, and Waterbury, as well as several rural and suburban towns, have *lower than state average* per capita income of $45,359. However, Brookfield, Ridgefield, Roxbury, and Washington are among the *wealthiest towns* in CT. The poverty rate in Waterbury is 23.4%, while Ridgefield's poverty rate is 1.3% (*census.gov 2019*).

Racial and ethnic demographics in Region 5 are equally divergent. While rural Northwestern CT has the lowest ethno-racial diversity in the state, two cities in our region (Waterbury and Danbury) have among the highest ethno-racial diversity, ranking 5th and 7th respectively.

Below is a table that clearly demonstrates these demographic disparities town by town in Region 5, as well as how each town compares to statewide averages:

Town/City	Total Population	% White	% Black/ African American	% Hispanic/ Latinx	% Asian	% Native American	% Other/ Multi-Racial	Median Household Income	% Poverty Rate
Barkhamsted	3,779	94	0	1	2	0	1	$111,198	2.4
Beacon Falls	6,420	85	2	7	1	0	1	$88,355	3.6
Bethel	17,618	93	2	8	6	0	2	$97,289	2.9
Bethlehem	3,595	93	1	1	0	0	2	$91,7126	6
Bridgewater	1,506	91	4	2	1	0	2	$102,250	3.3
Brookfield	15,780	93	1	6	5	0	2	$113,009	3.8
Canaan	1,212	76.8	9.4	12.5	0	0	1.5	$77,417	4.0
Cheshire	29,261	84.2	4.7	0	5	0	1.2	$114,932	2
Colebrook	1,386	97	0.3	1.1	0.6	0	0.8	$84,583	4.6
Cornwall	1,266	95.6	0.1	2.4	0.6	0.7	1.1	$76,563	5.7
Danbury	84,694	51,4	10.6	29.2	6.1	0	2.0	$72,226	10.7
Goshen	3,095	95.5	0.3	2.3	1.2	0.1	0.5	$96,026	9.6
Hartland	2,035	96.7	0.4	0.6	0.8	0.3	1.1	$94,569	3.0
Harwinton	5,526	96.7	0.2	1.4	0.9	0.1	0.6	$104,205	4.7
Kent	2,843	91.9	1.1	3.2	1.6	0.6	1.3	$64,464	9.2
Litchfield	8,197	92.0	2.4	2.5	0.6	0	0.7	$78,375	7.3
Middlebury	8,233	91.4	0.9	2.7	3.8	0.5	1.1	$105,036	5.1
Morris	2,341	95.5	0.5	2.1	0.8	0	1.1	$89,107	2.8
Naugatuck	32,210	70.6	9.3	13.1	2.8	0	3.6	$63,452	10.0
New Fairfield	11,825	91.4	1.0	4.4	1.7	0.1	1.0	$104,402	3.4
New Hartford	7,625	95.9	0.3	1.8	1.1	0	0.8	$96,291	3.0
New Milford	27,718	77.7	2.1	11.2	4.3	0.2	3.9	$83,676	5.3
Newtown	27,788	89.9	0.9	2.7	4.5	0	0.4	$115,137	4.1
Norfolk	1,629	95.8	0.7	1.8	0.6	0.1	0.9	$74,844	3.6
North Canaan	3,145	91.8	1.2	5.9	0.2	.09	0.8	$72,411	5.9
Oxford	14,924	92.6	1.1	3.7	1.5	0.1	1.0	$104,316	2.0
Prospect	9,222	92.9	1.9	3.3	0.8	0.1	1.0	$102,617	3.2
Redding	9,133	92.8	0.7	2.6	2.1	0	1.7	$129,763	3.2
Ridgefield	23,172	86.4	1.2	6.8	3.5	0	0.9	151,399	2.3
Roxbury	2,251	95.0	0.6	2.1	0.8	0.1	1.3	$119,167	2.5
Salisbury	3,368	93.0	1.4	2.9	1.1	0	1.6	$82,217	5.3
Sharon	2,395	94.6	1.6	2.0	0.7	0	1.0	$81,442	12.5
Sherman	2,981	95.4	0.3	2.1	0.9	0	1.2	$113,636	0.3
Southbury	19,357	92.8	0.8	2.6	2.7	0.8	1.0	$90,324	7.7
Thomaston	7,836	95.2	0.3	2.6	0.7	0.2	0.8	$67,639	5.9
Torrington	30,044	79.9	2.9	12.8	3.4	.06	5.0	$64,191	10.3
Warren	1,582	95.4	0.5	2.1	1.4	0	0.5	$98,750	5.6
Washington	3,347	93.5	0.6	4.0	0.7	.08	0.1	$93,375	6.2
Waterbury	107,568	39.6	17.9	37.4	1.9	0	2.5	$42,754	26.8
Watertown	22,011	92.0	1.3	3.7	1.7	0.2	1.0	$77,946	3.8
Winchester	11,356	91.0	1.2	5.2	0.9	0.1	1.5	$57,468	17.1
Wolcott	16,921	92.1	1.6	3.7	1.2	0.1	1.3	$87,045	5.2
Woodbury	9,835	93.9	0.6	2.5	1.7	0.2	1.1	$82,923	5.4
STATE*	3,565,287	65.9	12.2	16.9	5.0	.6	8.54	$73,781	10.1

*(CERC Town Profiles 2019 and * U.S. Census Bureau 2019)*

Demographic data extends beyond racial, ethnic, and economic diversity to include factors such as age, educational attainment, gender, English language proficiency, sexual orientation, and gender identity. There are many differences in behavior, attitude, culture, resources, and community norms. If it is to be

effective and sustained, efforts towards community level change must consider equity, inclusion, and diversity in the broadest sense.

The region's LGBTQ community has recently gained voice, albeit based on community. There is increasing awareness of the need for more support for this community. However, while there are significant resources in larger cities such as Hartford and New Haven, as well as in lower Fairfield County, these resources are lacking throughout Region 5. Plans are in place to bring LGBTQ healthcare to the region, but at present there are no significant LGBTQ practices in this region and people must travel to other parts of the state for this healthcare. There are local pockets of mental health practices supportive of the LGBTQ community, such as in Naugatuck and Waterbury. QUEST – Queer Unity Empowerment Support Team – is present in Waterbury and hopes to expand to the greater region. There are a few Pride organizations in the region as well as the Pride in the Hills Fund that supports, inspires, and celebrates LGBTQ people in Greater Waterbury and the Litchfield Hills. LGBTQ community is identified as a subpopulation at higher risk for substance use disorder, mental health issues, and suicide ideation.

Hispanic and Latinx communities are a relevant group in terms of their behavioral health needs. In Danbury and Waterbury, people of Hispanic and Latinx descent comprise 30-31% of the population. This does not include the undocumented members of our communities. Language and cultural barriers need to be considered as we make recommendations that will improve access and outcomes for these folks.

Those of us who work in the realm of prevention, treatment and recovery remain sensitive to the impact of the recent pandemic on everyone's overall behavioral health. We acknowledge that caregivers and providers are a group that has been under unusual strain since March of 2020. We know that our emergency departments continue to exceed capacity and mental health professionals are booked out for many weeks. Young people will continue to be a sub-population of focus. They are seeking treatment for depression, self-harm and suicidal thoughts at higher rates. Some of the bruises that people have sustained have yet to be uncovered. It seems likely that youth mental health will be one of our highest priorities once again.

Various Populations of Concern Identified by Region 5 RBHPSW and Focus Groups

1. Undocumented immigrants.
2. Homeless individuals with acute behavioral health needs.
3. People for whom English is not their spoken language.
4. Veterans.
5. Young Adults who are not enrolled in-school or employed.
6. Older Adults- isolation, loneliness, sedentary lifestyle, medication mismanagement, dementia, compromised physical health.
7. People coming out of incarceration- disconnected and higher risk of OD.
8. People coming out of in-patient treatment-heightened risk of OD.
9. Caregivers and Providers- exhaustion, trauma, lack of self-care practices.
10. Individuals discharged from ED after a suicide attempt.

2020 Region 5 Epidemiological Profile: Alcohol

Problem Statement

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

Magnitude (prevalence)

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

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

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

According to 2014-2018 NSDUH data, Region 5 reports slightly lower rates of past month alcohol use and past month binge drinking than all other regions and the Connecticut average. Region 5 was one of three regions in Connecticut to report a slight increase in past month use from 2016-2018.[1]

NSDUH Substate Estimates:

Percent Reporting Past Month Use, ages 12+

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

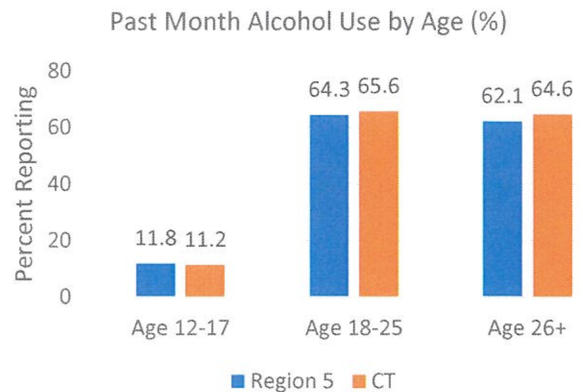
Percent Reporting Past Month Binge Drinking, ages 12+

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

2019 Connecticut School Health Survey (YRBS): 25.9% of high school students reported using alcohol in the past month and almost half of them (12.9%) reported binge drinking** in the past month[2].

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

According to 2018 NSDUH data, 62.4% of the Region 5 population 18 and older used alcohol in the past month. When broken down further by age, 11.8% of 12-17 year olds, 64.3% of 18-25 year olds, and 62.1% of those 26 and older used alcohol in the last month. These reported numbers for Region 5 align closely with the reported numbers for the state of Connecticut as shown in the chart below.[1]



Seven schools in Region 5 conducted Search Institute Attitudes and Behaviors surveys in 2019. On average, 21.4% of students reported using alcohol once or more in the last 30 days. Males and females reported similar numbers and the number of students reporting drinking in the past 30 days steadily increased from grade 7 to grade 12.[3]

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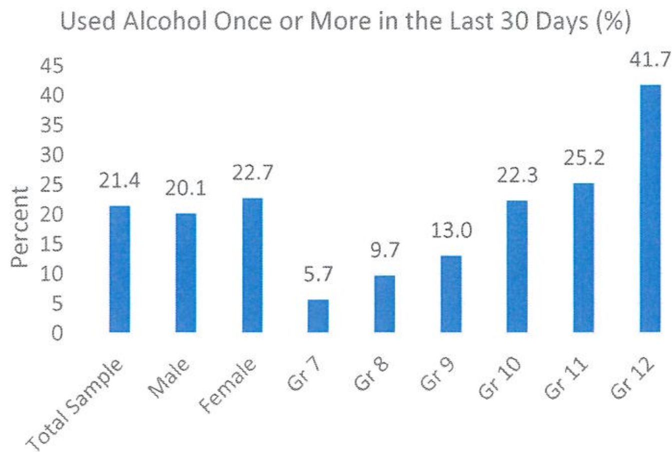
[1] NSDUH (2017-2018)

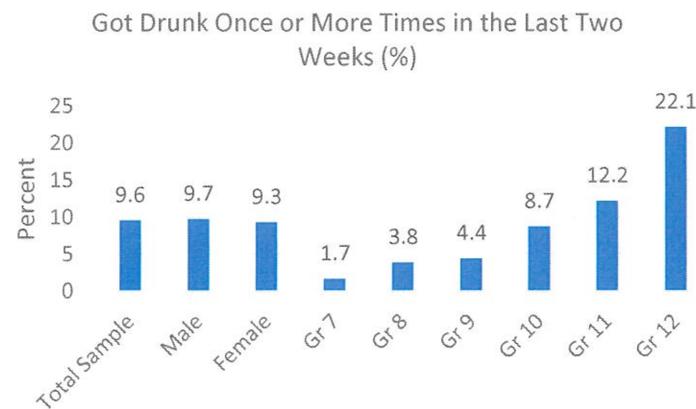
[2] DPH, 2019 Connecticut School Health Survey

[3] Search Institute, Attitudes and Behaviors Survey, 2019

2020 Region 5 Epidemiological Profile: Alcohol

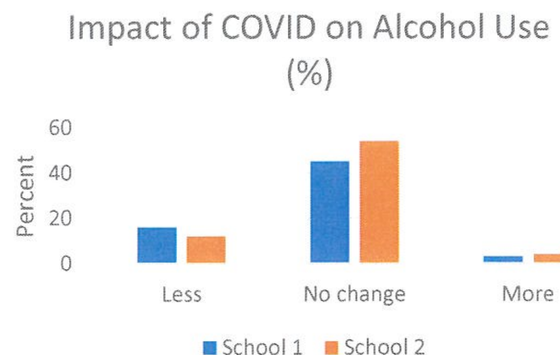


The percentages of students reporting being drunk once or more in the last two weeks follow a similar trend to past 30 day use with similar rates between males and females and an increase from grade 7 to grade 12.[3]



COVID-19 and its accompanying year-long quarantine impacted alcohol use across the lifespan throughout Connecticut and particularly in Region 5. According to parent focus groups conducted by UConn Health as part of the PFS 2015 initiative, many adults who had previously considered themselves social drinkers reported drinking more alcohol more often in their homes. While they suggest their children are aware of their drinking, they rarely reporting feeling it was affecting them.[4]

Two school systems in Region 5 conducted surveys in 2020 including specific questions regarding COVID-19 and its impact on substance use. In both surveyed schools, about half of the surveyed students reported that there was no change in their alcohol use due to COVID 19. The chart below shows that more students reported drinking less alcohol due to COVID than drinking more alcohol. Limited access to alcohol from peers due to quarantine may have impacted these numbers.[5]

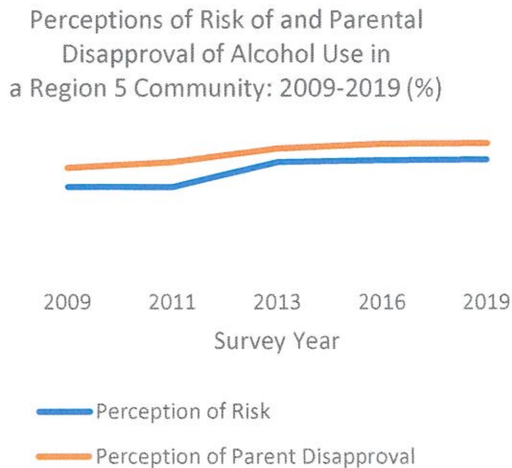


Perception of harm and perception of parent disapproval are two important factors that impact youth alcohol use. When looking at one Region 5 high school over 10 years, both perception of harm and perception of parental disapproval increased (displayed in the chart below). Increased perception of risk around alcohol is a trend seen in other Region 5 schools as well. [3]

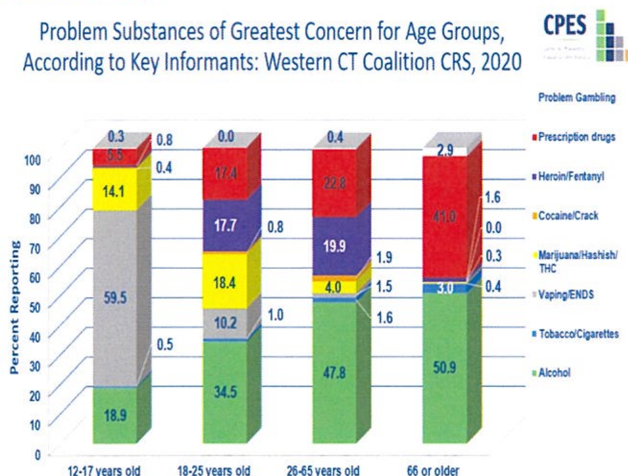
[4] Connecticut's Partnerships for Success (PFS) 2015 No Cost Extension Final Evaluation Report, 2020

[5] Core Measures Survey, Youth Voices Count Survey, 2020

2020 Region 5 Epidemiological Profile: Alcohol



Data from the 2020 Community Readiness Survey specific to Region 5 indicates that key informants view alcohol (represented in green in the graph below) as the problem substance of greatest concern for individuals 18 and older.[6]



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.[7]
- 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.[8]
- Individuals with mental health disorders are about four times more likely to be heavy alcohol users.[9]
- Native Americans are at especially high risk of alcohol-related traffic accidents, DUI and premature deaths associated with alcohol misuse.[10]
- While Hispanics or Blacks have higher rates of abstinence from alcohol, those who do drink often have higher rates of binge drinking.[7]
- In 2019, 68.2% of alcohol admissions were male, and 59.6% were non-Hispanic White.[11]
- Among youth, risk factors include:
  - Academic and/or other behavioral health problems in school;
  - Alcohol-using peers;
  - Lack of parental supervision;
  - Poor parent-child communication;
  - Parental modeling of alcohol use;
  - Anxiety or depression;
  - Child abuse or neglect;
  - Poverty;
  - Social norms that encourage or tolerate underage drinking[12]

As previously mentioned, perception of risk is known to impact alcohol consumption and other behaviors related to alcohol use. 2018-2018 NSDUH data (included below) suggests that Region 5 residents, ages 12 and older, report significantly lower perception of great risk from heavy drinking once or twice than all other regions and the Connecticut average.

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

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

The 2019 Connecticut School Health Survey shows high school females were more likely than males to report

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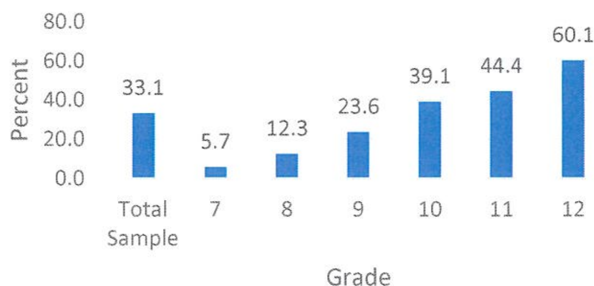
[6] Community Readiness Survey, 2020
[7] CDC (2016), Excessive alcohol use and risks to men's health
[8] CDC (2016), Alcohol and public health
[9] NIDA (2014), Severe mental illness tied to higher rates of substance use

[10] NIAAA, Minority Health and Health Disparities
[11] CT DMHAS 2019 Treatment Admissions
[12] National Research Council and Institute of Medicine

drinking (29.2% and 22.8%, respectively) and binge drinking (14.4% vs 11.5%). Non-Hispanic white and Hispanic students had the highest prevalence of past month drinking (29.6% and 26.0%, respectively) and binge drinking (15.8% and 12.8%, respectively).[2]

Previously mentioned risk factors for youth including alcohol-using peers and social norms that encourage and tolerate underage drinking are risk factors of high concern for Region 5. By their freshman year, almost 1 in 4 students have been to a party where people their age are drinking. This number rises to 60% by their senior year of high school.[3]



Burden (consequences)

- Immediate adverse effects of alcohol can include: impaired judgment, reduced reaction time, slurred speech, and loss of balance and motor skills.[4]
- When consumed rapidly and in large amounts, alcohol can also result in coma and death.[4]
- Alcohol use can increase risk of death when used with other substances, i.e. prescription medication like benzodiazepines and opioids. In 2019, alcohol was listed as a contributing cause of death for almost 3 in 10 (29%) of 1200 fatal overdoses which occurred in Connecticut.
- Approximately 88,000 deaths each year in the U.S. are attributed to alcohol misuse.[13]
- In 2017, Connecticut ranked as the highest state in the country for the percent of alcohol-impaired driving fatalities compared to total driving fatalities (43%), versus the United States overall (29%).[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.[4]
- Drinking during pregnancy can lead to a variety of developmental, cognitive and behavioral problems in the child (Fetal Alcohol Spectrum Disorders).[11]
- Older adults aged 65+ who drink are at increased risk of health problems associated with lower tolerance for alcohol, existence of chronic health problems (i.e., diabetes, high blood pressure, congestive heart failure, and liver problems) and interactions with medications (e.g., aspirin, acetaminophen, cough syrup, sleeping pills, pain medication, and medication for anxiety or depression).[16]
- Initiation of alcohol use at young ages has been linked to increased likelihood of AUD later in life. [17]
- Of all 2019 Connecticut treatment admissions, 38.2% identified alcohol as the primary drug at admission.[8]

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

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

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

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

[13] NIAAA, Alcohol Facts and Statistics
[14] NHTSA (2018), Alcohol-Impaired Driving
[15] WHO (2018), Global status report on alcohol and health—2018
[16] NIAAA (2008), Older Adults
[17] NIAAA (2006), Alcohol Alert No. 67, Underage drinking

2020 Region 5 Epidemiological Profile: Alcohol

Treatment Admissions where Alcohol is the primary drug at admission[7]:

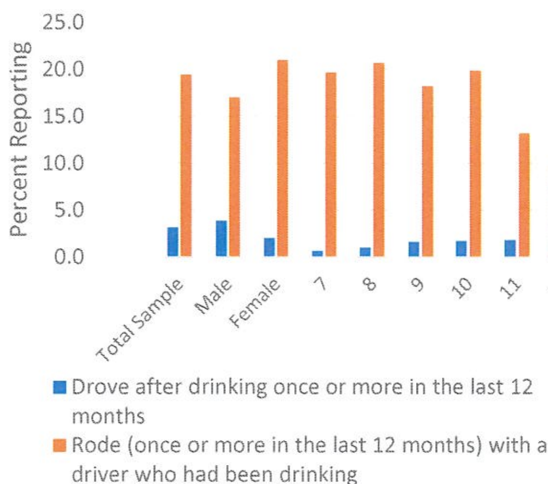
	CT	Region 1	Region 2	Region 3	Region 4	Region 5
FY2019	24,985	2,698	5,450	5,464	6,546	4,827
FY2020	19,916	2,128	5,014	4,403	4,801	3,570

*Excluding 741 admissions where residence was unknown

Community Wellbeing Survey: Percent Reporting Past Month Binge Drinking

	CT	Wealthy	Suburban	Rural	Urban Periphery	Urban Core
2018	28	28	27	27	29	27

Limited availability of rideshare apps like Uber and Lyft in many of the rural areas of Region 5 may impact the number of individuals who drive after drinking alcohol. Driving or riding in a car with someone who is under the influence of alcohol are high risk behaviors that are reported by young people in Region 5. The Attitudes and Behaviors survey does not differentiate between riding with a peer who has been drinking or an adult who has been drinking but on average, 19.4% of surveyed students in Region 5 have been in the car with a driver who had been drinking. The rates of driving while under the influence in Region 5 are significantly lower than riding with a driver who has been drinking.[3]

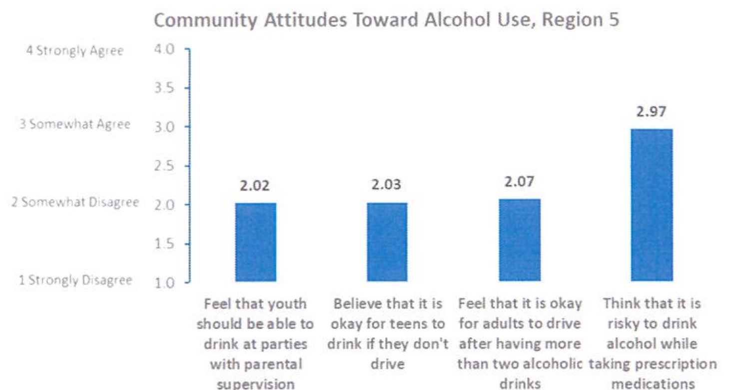


Community Readiness Survey: Mean Stage of Readiness for Substance Misuse Prevention

	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

While the chart above reports an increase in Region 5's readiness for substance misuse prevention from 2018 to 2020, the numbers are still slightly lower than the Connecticut average.[6]

As previously mentioned, alcohol is viewed as the problem substance of greatest concern for individuals 18 and older. Community awareness of an issue is one of the first steps in building capacity to create change. While there is community awareness, the attitudes of key informants reflect a need for increased education around alcohol use and misuse. The chart below displays attitudes around some alcohol related behaviors.[6]



Capacity and Service System Strengths

2020 Region 5 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.

In Region 5, there has been a significant increase in accidental drug overdose deaths involving cocaine. In 2019, 103 people died of an accidental OD involving cocaine (39%). Of those, all but 7 involved cocaine and fentanyl. Comparatively, between 2012 and 2015, the region experienced 20 total deaths involving cocaine (17%), with only 1 involving fentanyl.[1]

Magnitude (prevalence)

According to data from the 2019 Connecticut School Health Survey (CT YRBSS), 2.6% of Connecticut high school students reported using some form of cocaine in their lifetime.[2] This is consistent with a decreasing trend since 2007, when the prevalence was 8.3%.

Survey data from 2019 for 7 school districts in region 5 show that 1% or less of students on average reported using cocaine in their lifetime.[3]

The 2018-2019 National Survey on Drug Use and Health (NSDUH) data show 1.99% of Connecticut respondents reported past year use of cocaine.[4] This is highest among young adults 18-25 (6.21%), compared to youth 12-17 (.37%) and adults 26+ (1.50%).

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

	CT	Region 1	Region 2	Region 3	Region 4	Region 5
2014-2016	2.4	2.1	2.3	2.5	2.7	2.3
2016-2018	2.3	2.1	2.5	2.5	2.3	2.1

Detective Mark Williams of the Danbury Police Department reports that cocaine prevalence in region 5 "remains constant and has for years." Recent arrests more frequently involve hard or crack cocaine, but they are also seizing "substantial quantities" in powder form. When tested, they are finding that the cocaine is mixed with fentanyl. He believes individuals who are buying cocaine are "unaware" of the existence of fentanyl in the product they are purchasing. The result has been an increase in overdose deaths involving cocaine mixed with fentanyl.

Risk Factors and Subpopulations at Risk

Risk factors include:

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

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

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

[1] OCME Data
[2] Connecticut School Health Survey, 2019 (CT YRBSS)
[3] Search Institute Attitudes and Behaviors and SERAC surveys
[4] NSDUH 2018-2019

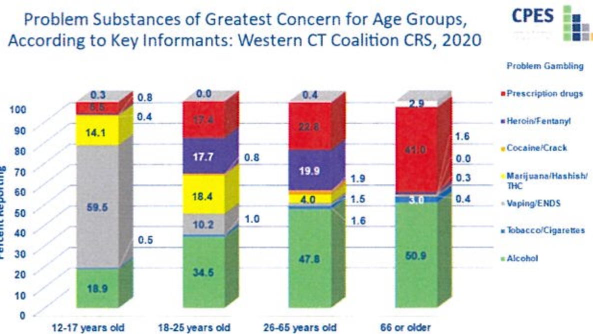
2020 Region 5 Epidemiological Profile: Cocaine

- 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
- Individuals with mental health challenges[5]

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

Some high school seniors in the region are using at higher rates: 15% of 12th graders in one high school and 8% in another reported using 1 or more times in their lifetime.[6]

Cocaine ranks low when compared to other substance or issues of concern in region 5 according to the CRS 2020 results:



Burden (consequences)

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

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

Long-term physical consequences of cocaine use include[3]:

- Tolerance, requiring higher and more frequent doses
- Sensitization, where less cocaine is needed to produce anxiety, convulsions, or other toxic effects (increasing risk of overdose)
- Loss of appetite leading to malnourishment
- Increased risk of stroke and inflammation of the heart muscle
- Movement disorders such as Parkinson's disease
- Impairment of cognitive function

- Cocaine users are also at risk for contracting blood-borne diseases such as HIV and hepatitis C via needle sharing and other risky behavior[3]
- Users are at risk of accidental overdose, especially in the presence of alcohol or other drugs.[3]
- In 2019, cocaine was the primary drug in 7.7% of all Connecticut substance use treatment admissions. This represents 5,904 admissions.[7]

Treatment Admissions: Cocaine[2]

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

- Overdose deaths involving cocaine increased about 34% in Connecticut, from 345 in 2018 to 463 in 2019.[8]
- 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.[9] In 2019, almost 9 in 10 (85%) cocaine-involved deaths in Connecticut (n=463) also involved fentanyl.

In Region 5, overdose death rates involving cocaine slightly rose from 39% (n= 103) in 2019 to 42% (n= 107)

[5] NIDA
[6] Search Institute Attitudes and Behaviors survey, 2019
[7] Connecticut Department of Mental Health and Addiction Services, (2019)

[8] CT Office of the Chief Medical Examiner, 2019
[9] Tomassoni AJ. MMWR 2017;66:107-111.

in 2020. The percentage of those deaths where fentanyl was also involved decreased slightly from 93% (n= 96) in 2019 to 84% (n= 90) in 2020. Deaths involving cocaine remain a concern in the region, especially with the risk of fentanyl contaminated cocaine.

Capacity and Service System Strengths

Prevention efforts in the region aimed at harm reduction and overdose prevention related to cocaine include:

- The Regional Opioid and Other Drug Policy Workgroup raises awareness of cocaine and fentanyl within the treatment and recovery community
- Newsletter articles focused on cocaine and fentanyl
- We have increased our capacity to conduct Narcan trainings as a webinar during 2020-2021 where we address the involvement of cocaine in accidental overdoses and the dangers of fentanyl contaminated cocaine

Treatment is available.

2020 Region 5 Epidemiological Profile: Heroin & Other Illicit Opioids

Problem Statement

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

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

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

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

In Region 5, there are two major factors to be addressed. One, the illicit supply is not regulated, so there is no guarantee that a substance is what someone believes it is. With fentanyl being so much stronger and used as a filler with heroin, there is no way to tell the dosage being received. The second is polysubstance use within Region 5. Both anecdotally, and with data from accidental overdoses from the OCME, the overwhelming majority of substance misuse is polysubstance. One notable rising substance misused is Xylazine. Xylazine is a veterinary drug, not an opioid, but is found in many fatal overdoses where opioids are also present. In 2019 there were 16 accidental overdose deaths which involved Xylazine in Region 5. In 2020 the OCME data shows there were 25 deaths; a 43.75% increase[3].

Magnitude (prevalence)

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

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

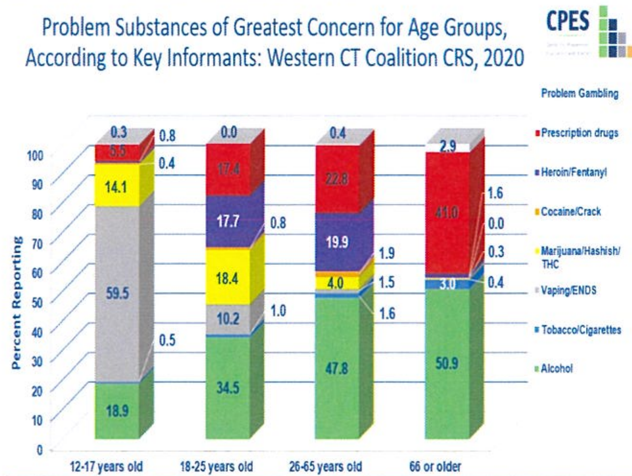
Within Region 5 there was no statistical change in reported past year heroin use between 2014-2016 and 2016- 2018. However, there is a difference to be noted between national and state NSDUH data for 2018-2019 and Region 5. National data has 12+ usage at 0.28%, Connecticut at 0.33% with Region 5 at 0.61%. Region 5 is almost double the national and state percentages. In Region 5, of the 219 accidental overdoses in 2020-2021, 91.8% contained any opioid, 184 (91.5%) contained Fentanyl, and 58 (26.5%) contained heroin.

Of 201 accidental overdoses involving any opioid, 87.1% were male and 87.6% were non-Hispanic, 28 (13.9%) were Black and 171 (85.1%) were white. 13 (6.5%) accidental overdoses deaths were individuals age 19-24, 48 (23.9%) were 25-24, 105 (52.2%) were 35-54, and 35 (17.4%) were over 55. Region 5 overdoses were primarily 25-54 year old (76.1%) white, non-Hispanic, males.

[1] NSDUH
[2] Connecticut School Health Survey, 2019 (YRBS)
[3] CT OCME
[4] US DOJ- DEA, 2018 National Drug Threat Assessment (October 2018)

2020 Region 5 Epidemiological Profile: Heroin & Other Illicit Opioids

Data from the 2020 Community Readiness Survey specific to Region 5 indicates that key informants view heroin/fentanyl (represented in purple in the graph below) as the problem substance of third greatest concern for individuals 18-65.[5]



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.[6]
- 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.

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

	CT	Region 1	Region 2	Region 3	Region 4	Region 5
2016-2018	87.1	86.5	87.4	86.0	87.4	87.9

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

The Waterbury Department of Public Health (DPH) has a particular concern for homeless individuals that have co-morbid, untreated behavioral health disorders that have difficultly connecting to services and may display aggressive behaviors.

Burden (consequences)

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

[5] Community Readiness Survey, 2020

[6] CDC. Overdose: Heroin. https://www.cdc.gov/drugoverdose/opioids/heroin.html

deaths, reaching the highest rate in 2019 with a death rate of 27.4 per 100,000 population.[3]

Opioid-Involved Non-Fatal Overdoses (DPH)

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

***Numbers are approximate due to suppression**

Heroin-Involved Fatal Overdoses in 2019[3]

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

***Rate per 100,000 population**

Opioid-Involved Fatal Overdoses in 2019[3]

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

***Rate per 100,000 population**

Fentanyl-Involved Fatal Overdoses in 2019[3]

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

***Rate per 100,000 population**

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

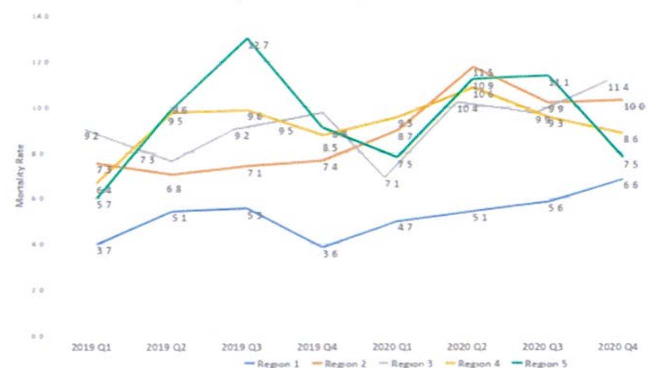
Treatment Admissions: Heroin* as the Primary Drug

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

*This includes heroin and non-prescriptive methadone

The data shows that in Region 5 rates for heroin, opioid and fentanyl overdoses are higher per 100,000 residents than all other regions. Region 5 is represented by the green line in the chart below.

Overdose Mortality (per 100,000) by RBHAO
Q1 2019-Q2 2020



During COVID-19 local treatment providers did see an increase in overdoses and overdose deaths in Region 5 outpatient facilities.
Waterbury DPH, CIFC, and MCCA are increasingly concerned about the appearance of co-occurring substance misuse and mental health issues. One diagnosis may be treated independently of the other and the client will then not get the necessary treatment. Also, with the rise of mental health cases presenting, this can cause screening, funding, treatment bed, staffing, and logistical problems for those treatment providers.

Capacity and Service System Strengths

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

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

According to MCCA there are not enough treatment beds required to treat all those in need. The insurance (usually Medicaid) does not cover the level of care required for many persons with a substance use disorder (SUD). Local short-term inpatient treatment facilities have operated with a 98% occupancy rate. This did not change during COVID-19. Treatment providers continue to see more referrals than availability and operate with a waiting list.
With COVID-19 there has been an uptick in dual diagnoses of psychiatric with SUD.[7]
In addition to prevention, treatment, and recovery tools, the SWORD data and Overdose Spike Response

[7] Key Informant Interviews

Framework are invaluable tools at not only the regional level, but the town level as well. With this real time data, overdose response teams are able deploy immediately to address the threat with multiple tools and cross-agency collaboration.

Western CT Coalition has hosted Opioid Education/Overdose Prevention trainings throughout Region 5, both in person and then virtually during COVID-19 quarantine. The presentations pair data and education about the opioid epidemic and prescription drugs with training on how to recognize an opioid overdose and use naloxone. From June 3, 2020 through December 21, 2020, 295 individuals were trained in Opioid Education and Narcan Administration. From January 1, 2021 through June 9, 2021 an additional 150 individuals have been trained. Increased efforts around harm reduction like Narcan, syringe exchange programs and fentanyl testing strips speak to Region 5's capacity. Local Prevention Councils in Region 5 apply for SOR mini-grants that permit them to raise awareness about prescription and illicit opioids, overdose prevention and community involvement in opioid prevention initiatives.

One of the main strengths in Region 5 is the inter-agency, inter-department, and inter-workgroup collaboration. There are 3 Opioid Workgroups in the Greater Danbury, Greater Waterbury, and Greater Torrington areas, each with its own unique way of addressing the opioid crisis within its area. Through the Litchfield County Opioid Taskforce there are 5 Rovers which carry harm reduction tools like nasal and injectable naloxone, wound care supplies, safe sex supplies, and now COVID safety materials like face masks. They also supply referral to treatment and other community resources. Within Waterbury there are Overdose Response Technicians who supply all overdoses with Narcan and information New Milford has a Community Care Coordinator, which over the two years of being in existence, has seen a 50% reduction in overdoses. These specialized programs are reaching the population where they are at and should be common and widespread.

2020 Region 5 Epidemiological Profile: Marijuana

Problem Statement

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

Marijuana use is widespread among young adults and adolescents in Connecticut. The 2018-2019 National Survey on Drug Use and Health (NSDUH) showed that for 18 to 25 year-olds, past year marijuana use was higher than the national average (43.9% in CT vs. 35.1% nationally). Similarly, young adults' past month use was also higher (27.2% in CT vs. 22.5% nationally)[1]. Among youth ages 12-17 in Connecticut, 14.1% had used within the past year, and 7.5% had used within the past month, also higher than their national peers.[1]

According to the 2020 CRS in Region 5, key informants report that their communities are concerned about youth and young adult use of marijuana. Respondents fell in the category of "somewhat agree" (2.8 out of 4) for "are concerned about the legalization of marijuana.

Magnitude (prevalence)

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

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

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

According to 2019 Search Institute Attitudes and Behaviors Survey results from 7 school districts in region 5, on average 2% of middle and 15.8% of high school youth reported past 30 day use of marijuana. A comparison of past 30 day use rates showed a drop between 2016 and 2019 in region 5. In one school the 12th grade rate dropped from 27.7% to 25.5%.

A survey of WCSU students , 38% reported past 30-day use of marijuana Of those who reported past 30 day use, 20% indicated they used 10 or more times per month.[3]

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[5]
- Medical marijuana dispensaries are located in Bethel, Waterbury, and Torrington. The Bethel dispensary is looking to expand into Danbury with a potential drive-thru service option in 2021. This contributes to a low perception of harm in those communities.
- Perception of harm is lower among people who are unaware of the following adverse health impacts of marijuana use[6]
  - Serious mental health problems like psychosis, paranoia, anxiety and depression
  - Impaired cognitive development in adolescents
  - Altered brain development in children whose mothers used while pregnant

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

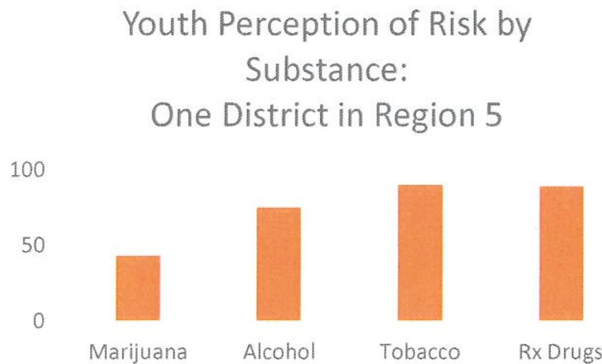
	CT	Region 1	Region 2	Region 3	Region 4	Region 5
2016-2018	21.2	23.0	20.3	19.6	21.7	20.6

[1] NSDUH
[2] Connecticut School Health Survey, 2019 (YRBS)
[3] Core Institute Survey, 2017

[5] SAMHSA, CAPT Northeast Regional Marijuana Webinar Series: Strategies/Interventions for Reducing Marijuana Use
[6] Statement of Concern: Marijuana Policy in Massachusetts

2020 Region 5 Epidemiological Profile: Marijuana

In region 5, youth perception of risk is lowest for marijuana when compared to alcohol, tobacco and prescription drugs. This chart represents one school, but the data is similar in all 7 districts who conducted the survey in 2019.



Perception of parental disapproval remains high (89.1%) but perception of peer disapproval is much lower (61.8%). [7]

With the possibility of the legalization of retail sale of marijuana comes the social acceptance of its use. In focus groups, youth report it is accessible and sold through social media platforms like Snapchat. [8]

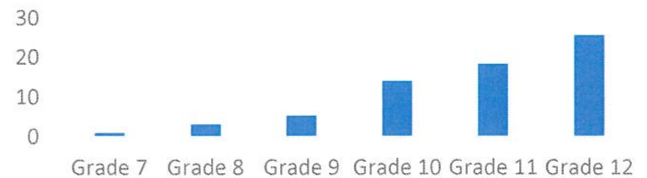
Local law enforcement partners have shared that they anticipate the black market will thrive even with legalization. It is a profitable business, considered a "staple" in the illicit drug world and often found while executing a search warrant for other drugs. (Det. Mark Williams, Danbury PD)

The 2019 Connecticut School Health Survey shows slightly higher current marijuana use in females (22.9%) compared to males (20.5%).[2] Reported current use increases significantly by grade from 12.1% of 9th graders to 31.0% of 12th graders.[2] More Hispanic students reported current use (24.3%) than White students (22.4%) and Black students (15.5%).[2] 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.

Region 5 data indicates that rates increase as youth get older.

Average Reported Past 30 Day Use of Marijuana by Grade

(7 school districs in Region 5)



Males and females are equally at risk, reporting similar rates of use.[9]

Vaping devices provide an opportunity for youth use of marijuana- in the form of THC oils or "dabs."

In a sample of three region 5 schools using the SEARCH survey supplemental items, 50% of the youth who indicated past 30 day use of an e-cig reported the substance they vaped was marijuana.[10]

In focus groups, youth indicate the relief of stress and anxiety as a reason to use marijuana.[11]

CT SAM (Smart Approaches to Marijuana) sees youth as the population most at risk. They support a minimum age of 25 to purchase if sales are legalized. They have collected data that indicate that adolescents who use marijuana may be at increased risk for depression and suicide.[12]

Burden (consequences)

Short-term consequences include[13]

- Decreased memory and concentration,
- Impaired attention and judgement,
- Impaired coordination and balance,
- Increased heart rate,

[7] 2019 Search Institute Attitudes and Behaviors Survey results from 7 school districts

[8] PFS 2015 NCE final report, 2021

[9] 2019 Search Institute Attitudes and Behaviors Survey results from 7 school districts

[10] Supplemental question on vaping within the Search Institute Attitudes and Behaviors survey

[11] PFS 2015 NCE final report, 2021

[12] Statement of Concern: Marijuana Policy in Massachusetts

[13] NIDA, Marijuana

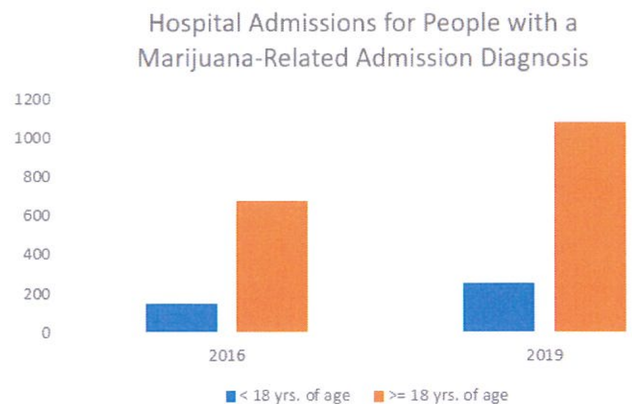
- Anxiety, paranoia, and sometimes psychosis.

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.[14] Of these, approximately 67.3% were male. About 30% where White, non-Hispanic, 28% Black, non-Hispanic, and about 26.4% Hispanic.[4]
- MCCA reported that 21.5% of their outpatient clients in region 5 were being treated primarily for marijuana in 2019-2020. (MCCA "Primary Drug Used" Report). CT Counseling Centers reported a similar figure, at 20%. They also indicated that many patients being treated for opioids will continue to self-medicate using marijuana/THC ; the patients view it has harm reduction because it is not as deadly as using opioids., as (Stacy Benson, Program Director)
- 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.[15]
- From 2017-2020, enforcement actions for marijuana in the largest high school in our region have been climbing (by 42%). The Crisis Counselor is seeing referrals for students across all demographics due to being caught "under the influence" or possessing marijuana, and due to poor school performance and legal issues related to use.[16]

As indicated in the below chart, the number of hospital admissions for people with marijuana-related admissions diagnosis increased between 2016 and 2019 (by 69% for those under the age of 18 and by 60% for those 18 and over).



The number of hospital admissions for people with comorbidity of Psychotic Disorders, including Schizophrenia as admission diagnosis with combination of marijuana use, misuse or dependence plus intoxication rose by 195% between 2016 and 2019.[17]

[14] CT DMHAS, 2019 Treatment Admissions
[15] CDC (2020), Outbreak of Lung Injury Associated with the Use of E-Cigarette, or Vaping, Products
[16] Key informant interview
[17] CHIME Data (Connecticut Hospital Association's ED/Admission visits)

2020 Region 5 Epidemiological Profile: Marijuana

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**

As indicated by the above chart, the mean stage for readiness for substance misuse prevention has increased in our region. However, in 2020 our readiness is lower than the state (5.25 vs. 5.37)

Service System strengths:

- Treatment providers in the region offer programs for marijuana addiction.
- Recovery Coaches in region 5 hospitals
- The Community Care Teams in Waterbury and Danbury are helping to connect populations at risk to various levels of treatment- including 12-step programs and family supports that are available in our area.
- A byproduct of the work our LPCs are doing with vaping prevention is an increased focus on marijuana and THC as well. Local data collected indicated risk of youth use of THC with vapes. They are utilizing the vaping and marijuana toolkit provided by CT Clearinghouse this year.

2020 Region 5 Epidemiological Profile: Mental Health

Problem Statement

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

Mental health was ranked the highest priority during the 2019 Priority Setting process in Region 5.

Anxiety

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

Depression

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

Serious Mental Illness

Serious mental illness (SMI) refers to mental, behavioral, or emotional disorders resulting in serious functional impairment, interfering with major life activities.[1] Examples of serious mental illnesses include schizophrenia, bipolar disorder, and major depression[3]. The 2018-2019 NSDUH shows 4.5% of adults in Connecticut reported serious mental illness in the past year.[4]

Although we experienced a minor increase in Serious Mental Illness reported among individuals 18+, Region 5 continues to have the lowest percentage (under 4%) in the state. In general, Serious Mental Illness is rare and resources are appropriate and remain stable. More evident in Region 5 is the effect of the recent pandemic which has served to further challenge people with existing anxiety and depression. In addition, those who were at lower risk, or previously not experiencing these symptoms at all, have been negatively impacted. The comment that "we are all victims of COVID-19" has resonated here. Older adults have been more isolated, families have had to adjust their customary routines and roles, and youth have been living with a host of uncertainties. An on-going gap in Region 5 is the lack of inpatient psychiatric treatment for youth and adolescents.

Magnitude (prevalence)

Anxiety

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

Depression

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

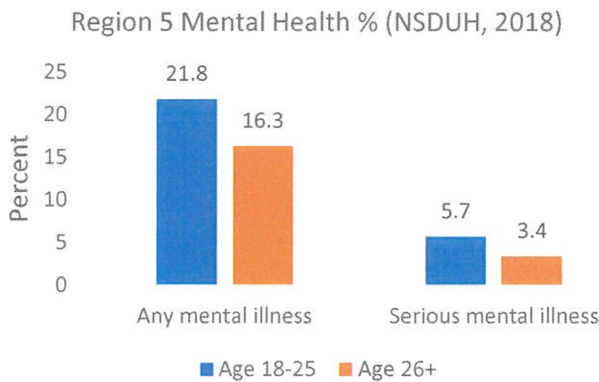
[1] NIMH
[2] CDC, Depression and Anxiety
[3] SAMHSA, Adults with SMI
[4] NSDUH 2018-2019
[5] CT BRFSS 2018

adults 18-24 (19.1%), compared to those 35-54 (15.0%) and those 55+ (13.8%).

Serious Mental Illness

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

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

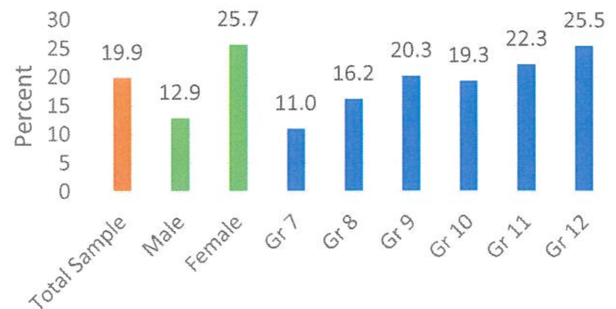


Residents of Region 5 utilize 211 as a resource to access needed mental health services and facilities. The chart below summarizes the mental health-related requests from Region 5.[7]

Region 5 211 Requests

	Percent of all Region 5 211 requests that were for mental health & addictions	Percent of mental health & addictions requests that were for mental health services	Percent of mental health & addictions requests that were for mental health facilities
FY 2020	19.2%	48.5%	<1%
Fy 2021 (through April 1)	11.4%	55.0%	<1%

Seven schools in Region 5 conducted the Search Institute Attitudes and Behaviors surveys in 2019. When asked if they felt sad or depressed most or all of the time in the last month, female students reported higher rates than male students, and 12th grade students reported the highest rates of feeling sad or depressed.[8]



COVID-19 and its accompanying year-long quarantine impacted the mental health of Region 5 residents across the lifespan. When surveyed, students from two Region 5 schools reported that their mental health has been negatively impacted by COVID.[9]

COVID Related Youth Depression (2020)

	Total # of youth surveyed	Feeling **a little** more down, sad or depressed due to COVID	Feeling **a lot** more down, sad or depressed due to COVID
School 1	481	32%	28%
School 2	843	29%	24%

[6] Connecticut School Health Survey 2019
[7] ct.211counts.org
[8] Search Institute, Attitudes and Behaviors Survey, 2019
[9] Core Measures Survey, Youth Voices Count Survey, 2020

2020 Region 5 Epidemiological Profile: Mental Health

Youth Depression (2+ weeks) (2020)
Felt so sad or hopeless almost every day for 2+weeks that they stopped doing some usual activities

	Total # of youth surveyed	7-8 grade	9-12 grade
School 1	481	39%	36%
School 2	843	22%	31%

The CT DMHAS Annual Statistical Report SFY 2019 summarizes all mental health admissions in Region 5 (chart below). The most common admissions include crisis services, outpatient and case management.[11]

State Fiscal Year 2019 DMHAS MH Admissions	
	Region 5
Assertive community treatment	79
Case management	306
Community support	107
Consultation	41
Crisis services	1737
Education support	17
Employment services	281
Forensics community-based	
Housing services	
Intake	197
IOP	27
Outpatient	1318
Prevention	
Social Rehabilitation	139

Risk Factors and Subpopulations at Risk

- Risk factors for depression and anxiety include[1]:
    - Family history of anxiety, or depression, or other mental illness
    - Experiencing traumatic or stressful events
    - Some physical conditions can produce or aggravate anxiety symptoms, and having medical problems such as cancer or chronic pain can lead to depression
    - Substance use such as alcohol or drugs
- Young adults report higher rates of depression and serious mental illness.[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.[10]

Burden (consequences)

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

Capacity and Service System Strengths

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

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

The CT DMHAS Annual Statistical Report SFY 2019 summarizes the clients and services provided by DMHAS funded or DMHAS operated programs. When looking at the capacity of DMHAS services in Region 5, most available mental health services are highly utilized.[11]

SFY19 Bed Capacity and Utilization by Region			
Level of Care Type	Level of Care Mode	Data Type	Region 5
	Respite bed	Bed capacity	26
Crisis services		Utilization rate	29%
Residential services	Group home	Bed capacity	30
		Utilization rate	95%
	MH Intensive res. rehab	Bed capacity	17
		Utilization rate	34%
	Sub-acute	Bed capacity	
		Utilization rate	
	Supervised apartments	Bed capacity	134
		Utilization rate	94%
	Transitional	Bed capacity	14
		Utilization rate	85%

[10] NAMI
[11] CT DMHAS Annual Statistical Report SFY 2019

2020 Region 5 Epidemiological Profile: Mental Health

The 2020 Community Readiness Survey results for Region 5 suggest that some assets of the region include political support for mental health promotion, the availability of leadership, trained staff that are appropriate for the populations they serve and community members with the time or willingness to volunteer. The community perceives barriers in Region 5 when it comes to financial resources to address mental health in the community, community buy-in that mental health is an important issue, and the data to determine/support the extent or magnitude of the issue. In addition, respondents to the Community Readiness Survey indicate a score of 3.17 (somewhat knowledgeable) when it comes to level of knowledge of mental health issues in their community.[12]

Mental health promotion and support for those experiencing mental illness is integrated into much of the prevention work done in Region 5.
There are three Catchment Area Councils (CACs) that provide education and raise awareness about important issues impacting those living with mental illness including homelessness, police accountability and retail marijuana legalization.

A Consumer Action Group that formed more than 30 years ago by the Regional Mental Health Board is also active and recently provided recommendations for Emergency Departments and Psychiatric Hospitals on how they could improve treatment for individuals – especially those experiencing a mental health crisis.

The Green TEAR (Teach, Empower, Advocate, Recovery) Initiative is a volunteer, grassroots nonprofit out of the Greater Torrington area that aims to increase awareness and understanding about mental health and addiction. This group has hosted multiple online panels touching on topics including minority inclusivity, fair housing and recognizing emotional and behavioral challenges. In October 2020 Western CT Coalition partnered with Green TEAR for QPR suicide prevention and Narcan overdose prevention trainings in recognition of World Mental Health Day.

In addition to their work around substance use prevention, many local treatment providers and Local Prevention Councils in Region 5 host webinars and share materials regarding mental health promotion and resources for those seeking mental health treatment for themselves or a friend or family member.

[12] 2020 Community Readiness Survey

2020 Region 5 Epidemiological Profile: Prescription Drug Misuse

Problem Statement

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

Polysubstance use, the mixing and misuse of several prescription drugs leads to overdose deaths in Region 5.

Magnitude (prevalence)

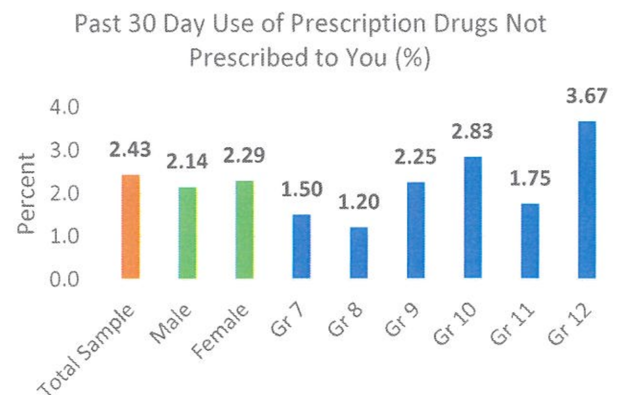
Among prescription medications, pain relievers are the most frequently used for non-medical purposes in the US. In Connecticut, the 2018-2019 NSDUH found that 3.3% of individuals aged 12 or older reported nonmedical use of pain relievers during the past year. The highest rate of pain reliever misuse was reported by 18-25 year olds (4.9%), followed by those 26 or older (3.2%), and youth ages 12-17 (2.1%).[2]

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

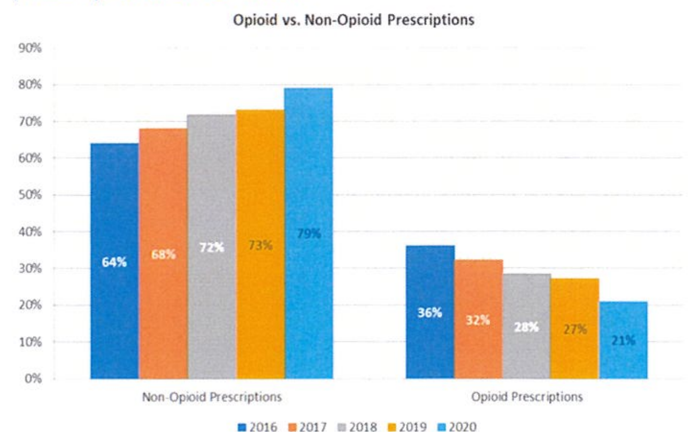
	CT	Region 1	Region 2	Region 3	Region 4	Region 5
2016-2018	3.98	3.57	3.73	4.09	4.40	4.02

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

Seven schools in Region 5 conducted Search Institute Attitudes and Behaviors surveys in 2019. Reported rates of past 30-day use of prescription drugs not prescribed to them was lowest in middle school (grades 7 and 8) and slightly lower in males compared to females.[4]



While prescription pain medication misuse continues it is important to be aware of the increase of non-opioid medications drugs that are being misused. In CT, there has been a decrease in the number of opioid prescriptions but an increase in non-opioid prescriptions since 2016.[5]



Of the top five prescribed controlled substances in CT in 2020, three of the five were benzodiazepines.[5]

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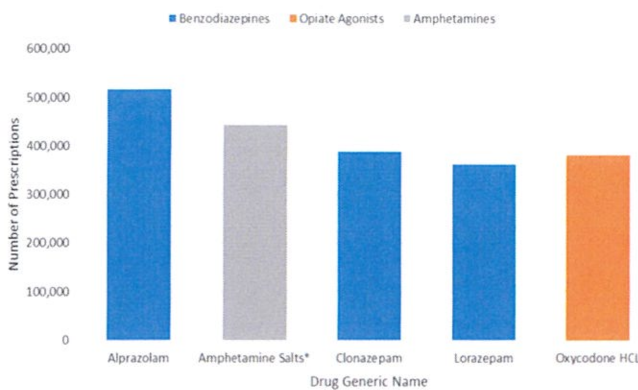
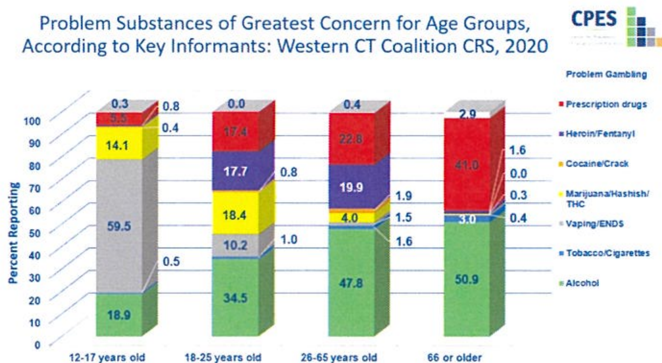
[1] NIDA, Misuse of Prescription Drugs Research Report
[2] NSDUH (2017-2018)
[3] Connecticut School Health Survey, 2019 (CT YRBSS)
[4] Search Institute Attitudes and Behaviors Survey, 2019
[5] Connecticut Department of Consumer Protection, PMP Statistics

2020 Region 5 Epidemiological Profile: Prescription Drug Misuse



Data from the 2020 Community Readiness Survey specific to Region 5 indicates that key informants view prescription drugs (represented in red in the graph below) as the problem substance of second greatest concern for adults 26 and older, topped only by alcohol.[6]



Risk Factors and Subpopulations at Risk

- Persons at risk of misusing prescription drugs include[7] :
  - 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.[8]
- 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[9]
- The elderly population may be at risk of consequences of prescription drug misuse, as they use prescription medications more frequently compared to the general population and may be at higher risk of medication errors[10]
- According to the 2019 Connecticut School Health Survey, Hispanic students had the highest rates of taking prescription drugs without a doctor's prescription (14.2%), significantly higher than White non-Hispanic students (8.0%). The rates among Black students (12.8%) were also significantly higher than White non-Hispanics. The NMUPD rates were slightly higher among females (11.3%) than males (9.1%).[3]

Perception of both parental and peer disapproval impacts youth use of non-prescribed prescription drugs. Higher rates of peer and parental disapproval may lead to lower rates of use in youth.
In the seven schools surveyed in Region 5 during 2019, youth reported high rates of parental disapproval, all above 95%. Youth reporting that their parents would feel it's wrong or very wrong to misuse prescription drugs stayed consistent across sex and grade Peer disapproval of prescription drug misuse was lower and it decreased as students got older.[4]
The following chart describes these attributes.

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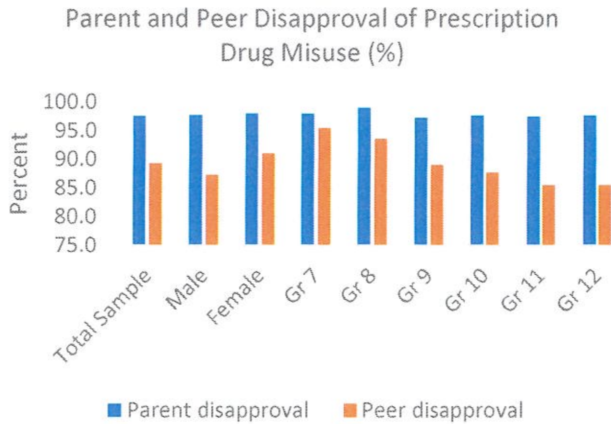
[6] 2020 Community Readiness Survey
[7] Bali V. Research in Social and Administrative Pharmacy 2013; 9(3): 276–287.
[8] Lauer EA et al. Disability and Health Journal 2019;12(3):519-522
[9] Connecticut Office of the Chief Medical Examiner, 2019
[10] Perez-Jover V et al. Int J of Environmental Research and Public Health 2018; 15:310.



In addition, youth perception of risk, especially if it is low, is another risk factor for misuse of prescription drugs. In our school surveys, students reported high rates of perceived risk which were relatively consistent across sex and grade.[4]

Youth Who Think There is Moderate or Great Risk in Using Prescription Drugs That are Not Prescribed to Them (%)									
	Total	M	F	Gr 7	Gr 8	Gr 9	Gr 10	Gr 11	Gr 12
Avg (%)	90.0	89.0	91.4	90.0	93.6	90.0	90.3	92.5	89.2

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).[11,12]
- According to reports from the Office of the Chief Medical Examiner (OCME), Connecticut experienced 1,127 opioid-involved fatalities in 2019, including 131 that involved a prescription opioid; 92 involved oxycodone, 20 oxymorphone, 14 hydrocodone, 15 tramadol, and 14 hydromorphone.[6]
- Approximately 12% of all opioid overdose fatalities involved a prescription opioid, but only 15% of those overdoses involved only the prescription opioid. The majority involved multiple substances; 54% also involved fentanyl, 38% involved benzodiazepines, and 20% involved heroin.[6]
- There were 1062 non-fatal stimulant overdoses in 2018, and 2372 in 2019.[13]

NSDUH Substate Estimates: Percent Meeting Criteria Past Year Pain Reliever Use Disorder, ages 12+

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

Prescription Drug-Involved Fatal Overdoses in 2019[3]

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

***Rate per 100,000 population**

Treatment Admissions: Other Opiates and Synthetics

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

Capacity and Service System Strengths

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

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

According to our Regional Readiness Survey, prescription drugs are viewed as the problem substance of second greatest concern for individuals 26 and older. Community awareness of an issue is one of the first steps in building capacity to create change.[6] Continuing to raise this awareness of

[11] Jones CM. Drug Alcohol Depend 2013; 132:95-100
[12] Muhuri PK et al. CBHSD Data Review, 2013.

[13] CT DPH, EpiCenter

prescription drugs, the risks of misuse and education around overdose prevention, specifically related to opioids is a priority in Region 5.

Western CT Coalition has hosted Opioid Education/Overdose Prevention trainings throughout Region 5, both in person and then virtually during COVID-19 quarantine. The presentations pair data and education about the opioid epidemic and prescription drugs with training on how to recognize an opioid overdose and use naloxone. From June 3, 2020 through December 21, 2020, 295 individuals were trained in Opioid Education and Narcan Administration. From January 1, 2021 through June 9, 2021 an additional 150 individuals have been trained. Print materials, billboards, PSAs and more featuring the Change the Script campaign are used by Western CT Coalition and Local Prevention Councils to raise awareness of prescription drug safe storage and safe disposal, to encourage community members to talk with their doctors about the drugs they are prescribed and to highlight the lifesaving effects of naloxone.
Region 5 has a total of 19 medication drop boxes, mostly located in local police departments. Many Region 5 communities participate in National Drug Take Back Days each April and October.
Local Prevention Councils in Region 5 apply for SOR mini-grants that permit them to raise awareness about prescription drugs, overdose prevention and community involvement in prescription drug safety initiatives.

2020 Region 5 Epidemiological Profile: Problem Gambling

Problem Statement

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

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

Region 5 is seeing day-trading as a troubling emerging trend among all age groups. The legalization of sports betting and internet gambling could potentially increase risk for young adults. Both could potentially normalize gambling and make it more accessible.

Magnitude (prevalence)

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

According to the Connecticut School Health Survey in 2019, 25.4% of high school students reported gambling on a sports team, playing cards or dice game, state lottery games, gambling on the internet, or bet on a game of personal skill.[3]

According to 2019 Search Institute Attitudes and Behaviors Survey results from 6 districts in region 5, 17.2% of middle and high school students gambled 1 or more times in the last 12 months and 5.2% gambled 3 or more times in the last 12 months (the question defines gambling as "bought lottery tickets or tabs, bet money on sports").

[1] National Council on Problem Gambling
[2] American Psychiatric Association, Gambling Disorder

2019 Data across 6 School Districts

"Has gambled one or more times in the last 12 months": (by %)

Total Sample	Male	Female	7	8	9	10	11	12
17.2%	23.8%	10.5%	15.0%	14.6%	13.3%	17.2%	15%	21.3%

"Has gambled three or more times in the last 12 months": (by %)

Total Sample	Male	Female	7	8	9	10	11	12
5.2%	7.5%	2.7%	4%	4%	3.3%	5.8%	4.8%	8%

Anecdotally, youth reported an understanding of what gambling activities are, and that there is a risk involved such as losing money or potential addiction. However, they do not see gambling as big of an issue among their peers when compared to drinking, using drugs, or engaging in other risky behaviors like speeding. Focus group conversations revealed the types of activities youth are commonly engaged in:

- Betting on sports
- Poker, Crazy 8's, and other cards games
- Dice
- Raffles at school functions are common

Stakes are typically low and may not even be monetary (bags of chips, etc.) and consequences are defined as "losing my money" or "I get angry." According to youth, it can disrupt relationships and cause fights.

When asked about their parent's attitudes, focus group participants say their parents understand the risks as well, and gamble only socially and as a form of entertainment. Parental disapproval is high.[4]

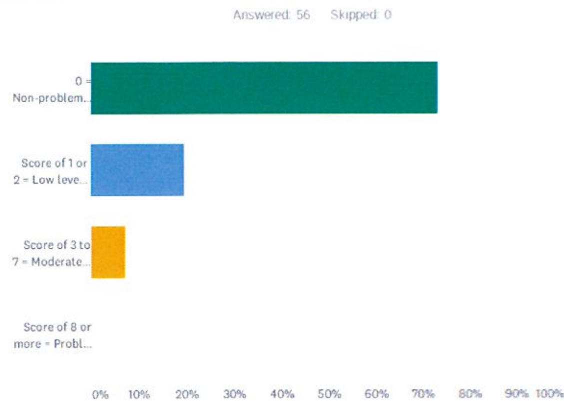
Key informants at WCSU report that college students believe gambling is a low-risk behavior. It is done socially with the most prevalent activities being poker, fantasy sports, and day-trading (emerging as a trend). Gambling is seen as less of a problem than substance misuse or mental health issues on campus.
(Key informant interview with Sharon Guck and Travis Tanuis, WCSU CHOICES office)

Problem Gambling Severity Index Screening Days were held at 2 college campuses in March of 2020. Of 56 participants at Western CT State University (WCSU), 15 (27%) scored in the low to moderate category for

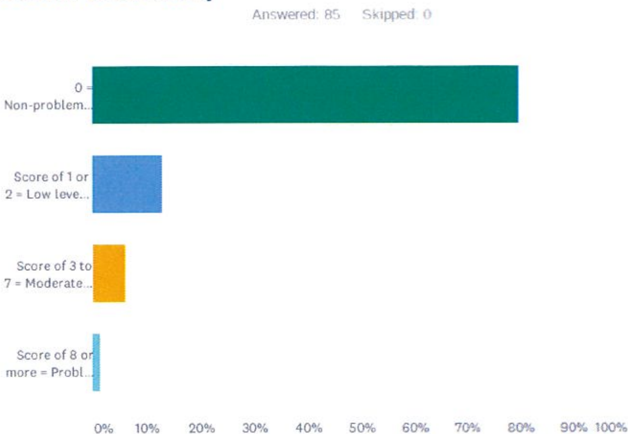
[3] Connecticut School Health Survey, 2019
[4] New Milford YA and Naugatuck YS Focus Groups, 2021

problem gambling. Of 85 students screened at UConn Waterbury campus, 17 (20%) scored in the low to moderate category with 1 student falling into the "problem gambling with a negative consequence category.

WCSU



UConn Waterbury



Western CT Coalition hosted an adult focus group 5/3/21 which revealed the following adult attitudes about gambling:

- Gambling is common
- It is entertaining; there is a social aspect
- There is risk involved
- Using apps like Robinhood is viewed as gambling
- Disordered gambling is viewed similarly to other addictions and can cause mental health problems like depression

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 Connecticut School Health Survey shows that 34.6% of high school males reported gambling, compared to 16.2% of females. The prevalence among 12th graders was significantly higher (31.7%) than any other grade (22.1%-24.3%). Differences among race/ethnicity were not statistically significant.[3]
- Problem gambling rates double for individuals living within 50 miles of a casino.
- 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]
- Among youth in Region 5, males gamble at a much higher rate than females. Rates do climb from grade 9 (13.3%) to grade 12 (21.3 %). Higher rates were reported among middle school (14.8%) when compared to 9th grade (13.3%). Other risk factors for youth who gamble:
  - higher rates of substance use
  - higher rates of depression and attempted suicide
  - deficits in other assets like family communication and school achievement[6]

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

[6] Search Institute A and B Survey Data results and analysis, 2019

2020 Region 5 Epidemiological Profile: Problem Gambling

Burden (consequences)

In a key informant interview with MCCA, The Bettor Choice provider in Region 5, the informant reported they currently have their largest census to date:70 clients. (05/3/21). Other comments:

- They are starting to see younger clients struggling with sports betting and gaming.
- They believe a program for those 18 and under will become a necessity.
- They are also servicing parents of those who are struggling.
- More than half their clients also suffer from a co-occurring mental health or substance use disorder.

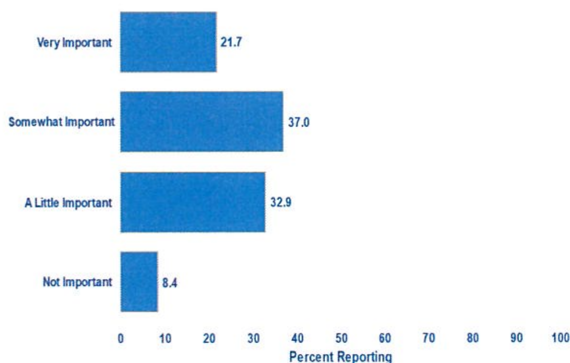
Region 5 data from the CT Council on Problem Gambling helpline from 2020 and 2021 show the following:

- 16 total calls in 2020, and10 calls in 2021 as of 4/15/21;
- Majority of callers are male (75% in 2020, 80% in 2021);
- All but 1 in 2021 were referred to either a Peer Counselor or to MCCA for treatment[7]

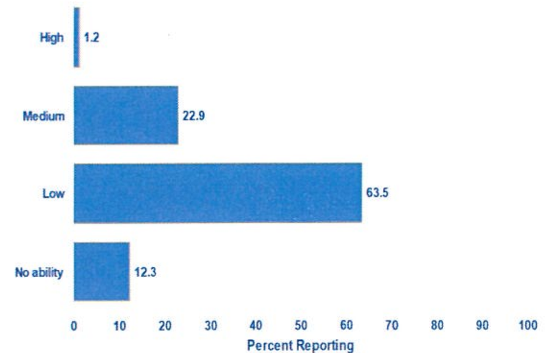
The National Council on Problem Gambling estimates the national societal cost of problem gambling to be about $7 billion, including gambling-related criminal justice and healthcare spending, job loss, and bankruptcy among others.

Capacity and Service System Strengths

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



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



According to Community Readiness Survey 2020 results, 24.1% of participants rate our ability to raise awareness about the risks of problem gambling and gaming addiction as medium/high. This is lowest rating within the state. (See table and chart 1 below)
Problem gambling ranks lowest as an issue of concern with all age groups except 65 and older. (chart 2 below)
59% of participants believe it is important (somewhat or very) to prevent problem gambling/gaming addiction in their community. (chart 3 below)

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

Service System Strengths in Region 5:

- The Problem Gambling Awareness team efforts:
  - Quarterly meetings with state-wide partners (PGS and CCPG) and community stakeholders
  - Yearly Problem Gambling Awareness Month event and initiatives
  - Radio PSAs promoting the Helpline
  - Capacity Building with team members achieving a Certificate of Competency in Problem Gambling (5 members in FY 21)
  - Hosting webinars

  - Youth Gambling Awareness Project coordinated with a regional partner
- Newsletters and info-briefs
- Problem Gambling Awareness Toolkit
- Coordinating with the local prevention councils to infuse gambling awareness within the work they do in their communities

2020 Region 5 Epidemiological Profile: Suicide

Problem Statement

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

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

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

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

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

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

The Connecticut Violent Death Reporting System reported on all 2,022 suicide deaths from 2015-2019 in Connecticut. Of the total suicide deaths, 337 of the deceased were residents of Region 5 and the region's suicide rate was 11.1 per 100,000. Waterbury, an urban center in Region 5 reported the highest number of suicide deaths during this time period at 65 deaths. When examining city and town suicide rates, both Torrington (15.0 per 100,000) and Waterbury (12.0 per 100,000) ranked in the top 20.[8]

Residents of Region 5 utilize 211 to access crisis intervention and suicide resources, including seeking direct help or help finding programs and hotlines providing emergency support, assistance, referrals and information. In FY2020, 43.2% of all mental health and addiction requests to 211 were related to crisis intervention and suicide. For FY2021 (through April 1) 36.1% of all mental health and addiction requests to 211 were for crisis intervention and suicide.[9]

Seven schools in Region 5 conducted Search Institute Attitudes and Behaviors surveys in 2019. According to the results, on average, 11.6% of youth surveyed reported having attempted suicide one or more times. On average, 24.3% of youth reported being frequently depressed and/or having attempted suicide. Reports of frequent depression and suicide attempts increased from grade 7 to grade 12 across all schools surveyed.[10]

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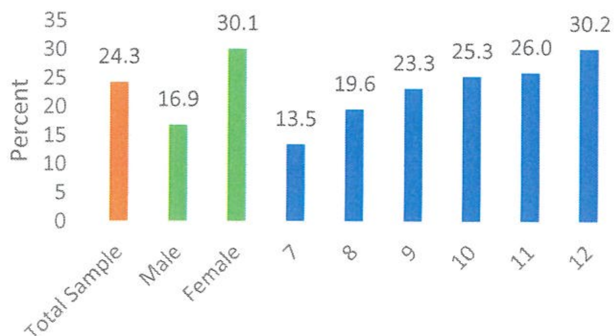
1 CDC (2019). Suicide Prevention
2 NIMH (2019). Suicide
3 CT DPH (2018). CTVDRS, Violent Deaths: Connecticut Data 2015 to 2018
4 CT OCME (2019). Annual Statistics: Suicides
5 NSDUH 2018-2019
6 Connecticut School Health Survey, 2019 (CT YRBSS)
7 Connecticut BRFSS 2018
8 CT DPH Violent Death Reporting System, 2019
9 ct.211counts.org/
10 Search Institute, Attitudes and Behaviors Survey, 2019

2020 Region 5 Epidemiological Profile: Suicide



Risk Factors and Subpopulations at Risk

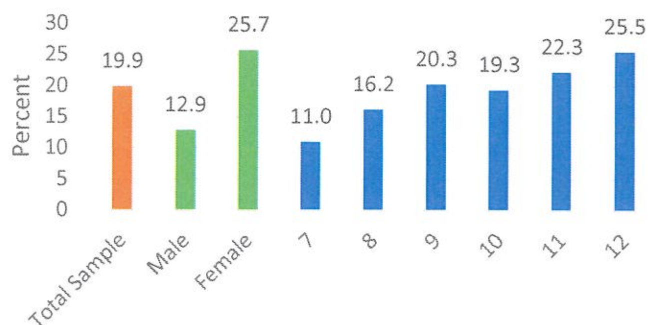
- On average, men account for 88% of suicides in CT.[3]
- White non-Hispanic males account for 78% of suicides in CT.[3]
- Nationally, non-Hispanic American Indian/Alaska Natives experience high rates of suicide.[1]
- Other disproportionately impacted populations include Veterans and military personnel and certain occupational groups such as construction and sports.[1]
- Sexual minority youth experience increased suicidal ideation and behavior compared to their peers.[1]
- Mental illness is a risk for suicide, including depression, anxiety, bipolar disorder, and general depressed mood.[3]
- For those over 45, other risks include physical illness, such as terminal illness and chronic pain, as well as intimate partner problems.[3]

Other risk factors include[1]:

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

Mental illnesses, particularly depression, are prominent risk factors for suicide in Connecticut. Data from the Crisis Text Line reports that of all CT texts that involved talk of suicide, 46% also included issues of sadness and depression in the same conversation (crisistrends.org). According to the CT Violent Death Reporting system, from 2015-2019, for those whose circumstances were known, having a mental health problem and having a depressed mood were the top two circumstances related to suicides for young people age 10-24.[8]

According to the survey results of seven Region 5 schools, 19.9% on average report feeling sad or depressed most or all of the time in the last month.[9]



Most recently, surveys and focus groups conducted report increased levels of depression and mental health concerns related to the stresses of the COVID-19 pandemic. Data collected through Connecticut's Partnerships for Success (PFS) 2015 No Cost Extension Focus Group initiative found that 76.4% of parent respondents reported an increase in depressive symptoms and 68% of youth respondents felt a little or a lot more sad or depressed due to COVID restrictions altering their lives. [11]

Two school systems in Region 5 conducted surveys in 2020 including specific questions regarding COVID-19 and emotional health. In both surveyed schools, on average, over 30% of 9-12 graders reported they felt so

[11] CT PFS No Cost Extension Final Evaluation Report, 2020

sad or hopeless almost every day for 2+weeks that they stopped doing some usual activities.[12]

COVID Related Youth Depression (2020)

	Total # of youth surveyed	Feeling a little more down, sad or depressed due to COVID	Feeling a lot more down, sad or depressed due to COVID
School 1	481	32%	28%
School 2	843	29%	24%

The National Institute on Drug Abuse (NIDA) reports that experts suggest around 30% of opioid overdoses may actually be intentional suicides.[13] With the increasing number of individuals with opioid use disorder and who experience opioid overdoses, there is concern that this would mean an increased number of overdoses that are really suicides. Based on this estimation, with over 200 overdose deaths in Region 5 in 2020, it is possible that near 60 of the overdoses may have been intentional suicides.

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

Of the 2,022 individuals who died by suicide in CT from 2015-2019, 74% were male and 26% were female. Based on VDRS data, males use more lethal means and die by suicide more than females who use less lethal means but attempt more often.[8]

Most Common Methods – Death by Suicide:

Males
1) Firearm (34%)
2) Hanging/asphyxiation (29%)
3) Drug overdose (10%)

Females
1) Hanging/asphyxiation (37%);
2) Drug overdose (32%);
3) Firearm (11%)

Data Source: CT Violent Death Reporting System

The statewide concern around the subpopulation of female high school students at risk is also a concern in Region 5. Females reported higher rates of suicide attempts in all seven schools surveyed in Region 5 in 2019.

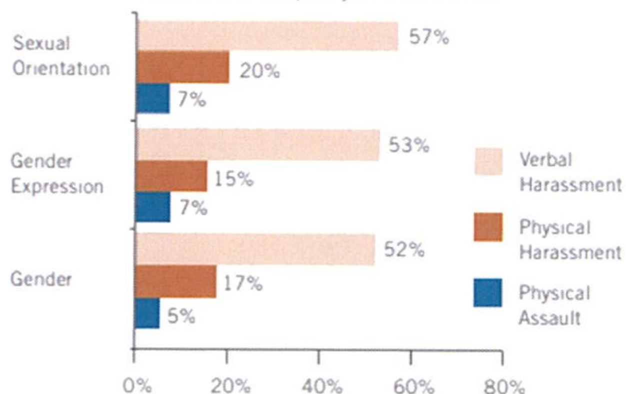
	Has attempted suicide one or more times (%)		Is frequently depressed and/or has attempted suicide (%)	
School	Male	**Female**	Male	**Female**
A	6	**14**	18	**36**
B	9	**14**	18	**29**
C	7	**10**	14	**24**
D	9	**14**	20	**29**
E	7	**13**	14	**31**
F	9	**17**	16	**30**
G	11	**15**	18	**32**
Average	8.3	**13.9**	16.9	**30.1**

The LGBTQ+ population, in particular LGBTQ+ youth, are a subpopulation of concern for our region. The GLSEN 2019 National School Climate Survey results suggest that most LGBTQ+ students in Connecticut high schools experience anti-LGBTQ+ victimization. 59% of these students never report an incident to school staff and when incidents are reported, only 35% of LGBTQ+ students say staff intervened effectively. 91% of surveyed students reported heard "gay" used in a negative way and 11% reported regularly hearing school staff make homophobic remarks. We know that experiencing harassment, lack of supportive trusted adults and isolation from peers are all risk factors that

[12] Core Measures Survey, Youth Voices Count Survey, 2020

[13] National Institute on Drug Abuse, 2019

put this group at a particular risk for mental health and thoughts of suicide.[14]



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]

According to research done by Cerel et al., (2016), 115 people are exposed to a single suicide death and one in five report devastating impact or major-life disruption caused by the suicide death. If Region 5 lost 337 individuals to suicide from 2015-2019, that means that in that time period almost 39,000 individuals have been exposed to a suicide and over 3,700 people had devastating effects on their lives. [15]

Capacity and Service System Strengths

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

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

[14] GLESN 2019 State Snapshot, 2019

Region 5 engages in suicide prevention education and capacity building consistently throughout the year. The Region 5 Suicide Advisory Board meets quarterly to provide educational opportunities and network building for clinical providers, school social workers, prevention professionals, and others.

In an effort to address and reduce the burden previously mentioned, the Regional Suicide Advisory Board has made suicide postvention training and support a top priority. A postvention training was held in 2021 with 13 communities from the region represented and monthly follow up meetings continue to provide support to communities as they build their postvention teams and plans. In addition to postvention work, the Region 5 Suicide Advisory Board supports CTSAB lethal means initiatives including letters sent to two Region 5 communities (Cornwall and Harwinton) about the installation of signage at locations were individuals may attempt.

Eight schools/communities throughout Region 5 received the CT Networks of Care of Suicide Prevention grants from the Department of Mental Health and Addiction Services. Participating in the Networks of Care involved gatekeeper training for staff and mental health promotion and help seeking training for students that increased awareness of mental health and suicide within the region. Some of these communities continue to do suicide prevention and mental health promotion work after the grant dollars have finished.

The *Gizmo's Pawesome Guide to Mental Health* book and accompanying curriculum have a strong presence in Region 5. Multiple communities have the book in their local libraries and schools and online read-alongs during COVID included the book. This book is an important mental health promotion resource for all ages.
The Connecticut Chapter of the American Foundation for Suicide Prevention has a strong presence in Region 5 including multiple Talk Saves Lives trainings held in Newtown and Out of the Darkness walks in Danbury and Brookfield.

[15] Exposure to Suicide in the Community: Prevalence and Correlates in One U.S. State, Cerel et al., 2016

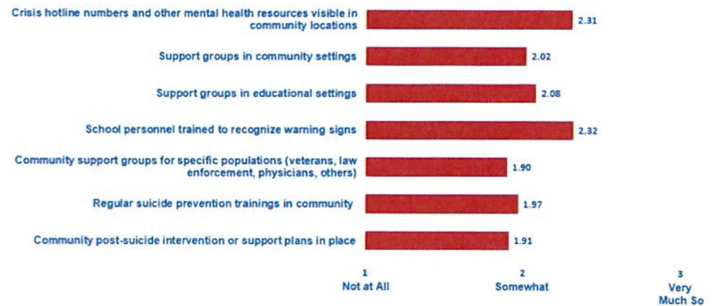
2020 Region 5 Epidemiological Profile: Suicide

In response to the challenges of COVID-19, Western CT Coalition began hosting regular Question, Persuade, Refer Suicide Prevention Gatekeeper Trainings online. From April 2020-April 2021, over 500 individuals from Region 5 and beyond have been trained to recognize the signs that someone may need help and access appropriate resources. Beyond Western CT Coalition, Tom Steen of Steen Consulting shared that there are over 60 registered QPR trainers in Region 5.

For those seeking help for crisis intervention and suicide in Region 5, most requests made through 211 are being met.[9]

Suicide Prevention Supports in Place in the Community [Q24]: Western CT Coalition CRS, 2020

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



Region 5 211 Requests

	Total mental health and addiction requests	Requests for crisis intervention & suicide	Percent of requests gone unmet
FY 2020	10,485	4,529	2%
FY 2021 (through April 1)	8,061	2,904	3%

The Community Readiness Survey 2020 results report that 65.2% of key informants in Region 5 think there is some or a lot of support for suicide prevention efforts. When asked specifically about ability to implement suicide prevention efforts, 57.5% of respondents in Region 5 feel their community has medium or high ability.[16]

[16] Community Readiness Survey, 2020

Problem Statement

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

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

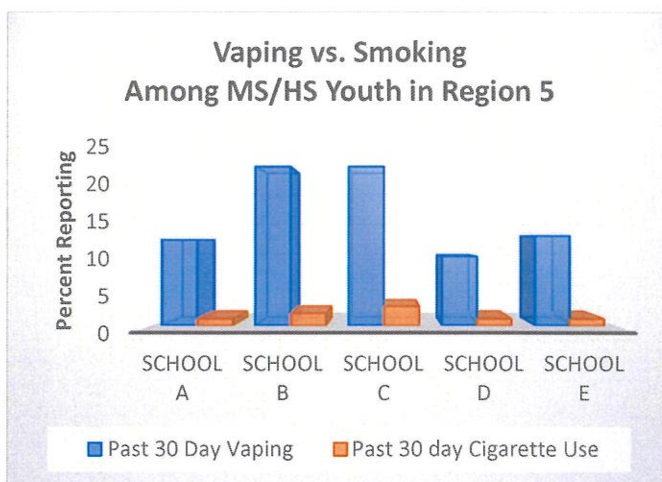
Vaping is an emerging problem nationally and in Connecticut, as rates continue to rise at a steady pace. According to Connecticut's Behavioral Risk Factor Surveillance Survey (CT BRFSS), the prevalence of ever using e-cigarettes has increased each year since 2012. The 2018 CT BRFSS results showed that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

While vaping rates may be lower than other substance use rates (like alcohol and marijuana) among youth in our region, vaping prevention is a priority. Reduced rates of traditional cigarette use among youth are a prevention success. ENDS, specifically the Juul and other disposable flavored vape products, introduced a new generation to smoking and to nicotine. These devices provide another way for young people to use marijuana as well. We would like to see the youth vaping rates as low as the cigarette smoking rates or even lower.

Magnitude (prevalence)

The 2019 Connecticut School Health Survey shows current use of cigarettes among high school students is 3.7%, down significantly from 17.8% in 2009.[3] While cigarette use among this age group has declined, e-cigarette smoking or vaping has increased, suggesting e-cigarettes are replacing tobacco smoking as the main mechanism for nicotine delivery. The 2019 Connecticut School Health Survey found current use of electronic vapor products to be 27.0% among high school students.[3]

In Region 5, less than 2% of middle and high school youth reported past 30 day use of cigarettes[4]. Within a combined sample of 4,154 youth (MS and HS) where districts collected vaping data, 16.3% of students reported past 30 day "vaping or juuling". [5] . The chart below compares vaping vs. smoking in these 5 districts.



In 2 high schools, reported past 30 day use of vaping devices was as high as 23%.

DataHaven's 2018 Community Wellbeing Survey showed 19% of all respondents reported using vape

[1] NSDUH 2018-2019

[2] Zheng X. (2018) CT BRFSS.

[3] Connecticut School Health Survey, 2019 (YRBS)

[4] 2019 Search Institute Attitudes and Behaviors Survey results from 7 school districts

[5] Supplemental question on vaping within the Search Institute Attitudes and Behaviors survey

pens or e-cigarettes.[6] This percentage is higher in urban core (25%) and urban periphery (21%) communities, and lower in wealthy communities (14%). Waterbury is an urban core community; Danbury, Naugatuck, and Torrington urban core periphery. This indicates there may be higher prevalence of vaping in these communities and further interventions may be necessary. The below NSDUH data indicates that all tobacco use rates in region 5 have risen slightly from 2016-2018. It is important for us to continue our prevention efforts focusing on ENDS and all tobacco and cigarettes.

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

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

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

Percent Reporting Past Month Cigarette Use, ages 12+

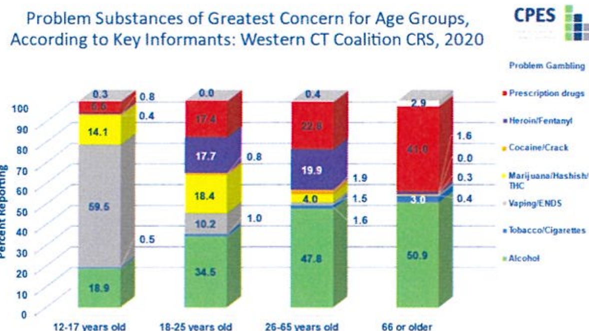
	CT	Region 1	Region 2	Region 3	Region 4	Region 5
2014-2016	17.6	15.5	17.6	21.3	17.6	17.5
2016-2018	16.6	13.7	16.1	17.2	17.3	18.6

In 2018 12.2% of adults in CT smoked cigarettes; 5.6% used e-cigarettes and 1.8% used smokeless tobacco.[7]

Within Region 5 Data Report 2020[8], rates of adults who reported "ever vaping" ranged from 2% to 17%; one community reported a rate of 27% among those age 19-25.

As indicated in the chart below, youth and young adult vaping is by far the substance of greatest community concern reported in the Region 5 CRS:

[6] DataHaven and Siena College Research Institute (2018). 2018 DataHaven Community Wellbeing Survey.
[7] The Truth Initiative
[8] Data collected from 18 of our local prevention councils



Risk Factors and Subpopulations at Risk

Populations at-risk for smoking cigarettes are[9]:

- 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)[10]
- 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]

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

	CT	Region 1	Region 2	Region 3	Region 4	Region 5

[9] CDC (2020), Current Cigarette Smoking Among Specific Populations- United States
[10] 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/

2016-2018	74.5	77.1	75.3	72.2	73.2	74.4

Perception of great risk from smoking one or more packs of cigarettes per day as reported among region 5 youth surveys[11] is similar to the above NSDUH data (73.9% on average). When perception of great risk and moderate risk are combined, it is 90% on average. .

When asked "how much do youth risk harming themselves when they vape" 64% reported moderate to high risk.[12] Among adults surveyed[13] perception of harm was high ranging from 72-91%.

Retailers who sell to minors are a potential problem. Compliance checks since the onset of tobacco 21 laws have been limited, mainly due to COVID. A Danbury PD undercover investigation of 6 vape shops in February 2021 resulted in 1 arrest for selling to minors. The PD had received multiple complaints about this establishment prior to the arrest (Det. Mark Williams). According to data collected in early 2020[14], some retailers selling ENDS in 4 region 5 communities were not registered with CT Department of Consumer Protection. (7 out of 25 retailers in Newtown and 9 out of 14 in New Milford). Registration certificates are required by DCP to be on display; most did not display their registration visibly in the store.

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

In region 5, 12th graders report higher rates of past 30 day use, doubling that of underclassmen. One school's rate for 12th grade was 7.5% compared to 3.8 for 10th grade). [15]

Burden (consequences)

- Evidence shows that young people who use e-cigarettes may be more likely to smoke cigarettes in the future.[6]
- A recent CDC study found that 99% of e-cigarettes sold in the US contained nicotine, which can cause harm to parts of the adolescent brain that control attention, learning, mood, and impulse control.[6]
- E-cigarette aerosol can contain several potentially harmful substances, including diacetyl (in flavorings), which is a chemical linked to serious lung disease. It can also contain volatile organic compounds, cancer causing chemicals, and heavy metals such as nickel and lead.[6]
- Some ENDS devices, including those that are particularly popular among youth, have been modified to allow for higher doses of nicotine to be delivered. They also facilitate the use of THC, and in higher potency. This is especially problematic in youth use, because of the increased risk of tobacco and cannabis use disorders later in life.[16]
- 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]
- According to the CDC, 4,900 adults die each year in CT from smoking related illness and smoking related healthcare costs in our state are $2.03 billion annually. It is also the leading cause of preventable death in our country. CDC research suggests that

[11] 2019 Search Institute Attitudes and Behaviors Survey results from 7 school districts
[12] Supplemental question on vaping within the Search Institute Attitudes and Behaviors survey from 5 school districts
[13] Data collected from 18 of our local prevention councils
[14] Data collected from 18 of our local prevention councils
[15] 2019 Search Institute Attitudes and Behaviors Survey results from 7 school districts
[16] King BA, Jones, CM, Baldwin GT, & Briss PA. (2020). The EVALI and Youth Vaping Epidemics—Implications for Public Health.

for every $1 spend on tobacco prevention, CT can reduce tobacco related healthcare expenditures and hospitalizations up to $55.

- Calls to the CT State Quitline increased by 35% during the CDC "Tips" campaign in 2020 (3/23-10/8/2020).
- Waste from ENDS and other tobacco products causes environmental contamination[17]. Based on anecdotal conversations with school administration in the region, we have concerns that these FDA guidelines for proper disposal of e-cigs are not being followed in most communities, but rather this waste is simply thrown into the trash.
- NIH reports that cigarette butts and other tobacco product waste are the most common items found in urban and beach cleanups worldwide. This waste contains toxins, microplastics, nicotine, and carcinogens and can potentially negatively affect the environment.
- Through their "This is Quitting" program, The Truth Initiative surveyed 2,000 users aged 13-24 and asked why they wanted to quit. 51% cited health concerns, 22% cost, and 16% indicated they wanted to be free from addiction.

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

Because of the concerns expressed by so many of our prevention partners about youth use of e-cigarettes and vaping behaviors, we have had a high capacity to address the issue. Region 5 ENDS and vaping prevention efforts have included:

- "Educator" Info-briefs distributed in school districts
- Newsletters to all stakeholders
- Education and Awareness and skill-building for parents through presentations in the community
- Education and Awareness for educators through presentations to school staff and administrators
- 18 LPCs in the region worked on a mini-grant focused on vaping in 2019-2020 beginning with an assessment
- Podcast recording on the topic with New Milford Youth Agency
- Testimony shared to support various bills at the state level toward vaping prevention policy

[17] Truth Initiative Report "Tobacco and the Environment"

Emerging Trends:

Many emerging areas of concern in our region are tied to the impact of the recent pandemic on both mental health and substance use. Increased evidence of stress, anxiety, depression, and suicidal thoughts all manifested across age, socio-economic and ethnic groups. Reportedly, alcohol use was up across the state among adults (at one point retail sales increased 55%). We do not have any data indicating an uptick in alcohol use among youth at this point. In fact, alcohol use and vaping decreased in a few communities that conducted student surveys this year in our region.

Adults faced unemployment, or job insecurity, economic hardships, the need to navigate the world of ZOOM and telehealth, and the additional challenge of home-schooling.

Young people were disconnected from school and their peers. Older adults were isolated from family and other social supports. Some people were unable to connect virtually, either because they did not own a computer, or a cell phone, or they simply did not have internet access.

At the very beginning of the pandemic, hospitals were reporting that census was low for in-patient psychiatric care. Similarly, DCF was reporting that they were receiving fewer referrals. We assumed that was a result of people were more fearful of leaving home and interacting with others, especially in a healthcare setting. As time progressed, those situations changed. When COVID-19 restrictions had been in place for awhile, the region experienced more people looking for treatment for severe mental illness. In addition, family needs intensified. A heightened risk of domestic violence, along with anecdotal reports of increases in Obsessive Compulsive Disorder (all ages) and Eating Disorders (among boys and girls) were observed by several of our partners.

Overall, COVID-19 has caused additional stressors. Anxiety, depression, loneliness, are all known risk factors for the misuse of substances. For fifteen months, the entire population of Region 5 was faced with these additional burdens. By all accounts the magnitude and intensity of needs has increased. The regional behavioral health gaps/needs indicated below, and in our profiles, are probably just the beginning. The unusual circumstances that followed the pandemic served to exacerbate these issues. We cannot accurately determine all the potential gaps and soon-to -be emerging trends that will put increased pressure on our behavioral health system.

The legalization of non-medical cannabis is a topic of major concern. The brain is not fully developed until the age of 25 and as of July 1, 2021, cannabis will be legal for people ages 21 and up. Perception of harm among young folks has been dropping over the past 10 years and they also rank marijuana use as having *low parent disapproval*. These are persistent risk factors in our area. Youth Service Bureau staff mentioned that young people were using marijuana to cope with anxiety and stress of the past year..

People also noted that marijuana can be consumed through a “vape”. Any vaping, by youth or adults is a top concern in Region 5. However, it did look like vaping had decreased among youth in our communities during COVID. This may have been the result of reduced access rather than the result of widespread prevention efforts.

The Regional Opioid Workgroup identified Kratom as an emerging trend. It is not currently an illegal substance in Connecticut. Kratom is often easily accessible in convenience stores, gas stations and bodegas. We need to assess the local conditions around the use and availability, consumption and consequences- this is a substance that should be monitored over time for significance.

Region-wide youth surveys from the past two years show little change in youth use of prescription drugs and cocaine. Both have remained low. However, we are monitoring cocaine use among older high school students because they report significantly higher use rates than those in 9-11th grades.

We continue to raise awareness about the misuse of benzodiazepines, risks associated with polysubstance use, and increased incidents of xylazine- involved overdose deaths in Region 5. We will continue to raise awareness about stimulants and track the presence of methamphetamines in toxicology screenings, which has doubled since 2019 in Connecticut.

Another area of concern in Region 5 stems from recent changes in legislation impacting problem gambling. While gambling has historically been a low priority here, we are learning about risky behaviors among youth, such as excess internet/social media/gaming time and access to online gambling. A key informant who works closely with adults in the DMHAS system also noted that clients who have state phones will now have 24-hour access to online gambling.

In our 2019 report, mental health was ranked as the highest priority in Region 5. During state fiscal year 2019, (well before March of 2020) the sub-committees at Western CT Coalition were focused on mental health trends among both youth and adults. This year, the Drug Free Schools committee reported more young people seeking assistance from school social workers, more pupil personnel inquiring about Mental Health First Aid training and referrals to community-based behavioral health resources.

The Region 5 Catchment Area Councils (CACs) identified several on-going concerns around the capacity of our region’s mental health service system. The Region 5 Suicide Advisory Board recognized the need to raise awareness about depression and loneliness across the lifespan.

One recurring recommendation from the focus groups, key informant interviews and committee meetings was the need for increased “wrap-around” services, warm hand-offs and community touchpoints for everyone who is receiving ,or needing, behavioral health services. Coincidentally, most people reported that there is strong collaboration between DMHAS-affiliated providers, 12-step programs, grassroots organizations, municipal leaders and community volunteers.

Resources, Strengths, Assets, Gaps and Needs:

Region 5 has 26 Local Prevention Councils (LPC) that deliver evidence-based prevention strategies to the 43 communities. The LPCs are part of a strong infrastructure of regional prevention partnerships.

Adult Mental Health-

A local Private Non-Profit serving adults with developmental disabilities, autism spectrum disorder, brain injury, and mental illness reported high staff turnover at all levels, including day programs, residential group homes, social workers and psychiatrists. Compensation is a major driver for staff turnover at these programs. Old contracts and insufficient COLAs prohibit many providers from paying staff appropriately. Staff mention that they can make the same or better income with less stress in a private practice setting or in another unrelated field (ie.,retail).

RECOMMENDATION- PNPs need to be able to offer more competitive wages. This workforce is essential to the success of the entire service system. We need to restructure compensation rates to reflect the importance of these workers.

DMHAS Young Adult Services providers noted that there should be better transitional supports for people moving out of group homes into more independent living situations. A full adjustment to new responsibilities takes time, and if people are not provided a warm hand off they can end up "failing" and cycling backwards.

RECOMMENDATION-Assess the current liaisons and transitional supports for people "graduating" from group settings. Engage with additional community partners through regional networks of care.

Another program staff-person mentioned that some of the training requirements for clients who are participating in Employment Services are not adequate. Staff are concerned that clients are not gaining enough useful skills. Arts and Crafts are not sufficient to prepare mental health clients for interacting with the public out in the workforce.

RECOMMENDATION-DMHAS' expectations for skill-building programs and curriculum need to be revised to better prepare consumers for employment.

The Hispanic and Latinx communities make up about 30% of populations of the two largest cities in Region 5. These populations are less likely to have access to mental health services and less likely to seek services. In addition, those who do seek services, are more likely to encounter poor quality services.

Members of our undocumented population lack health insurance. Others have inadequate insurance that does not cover specialists. There continues to be a limited number of bi-lingual, Portuguese or Spanish speaking clinicians. Sometimes secretaries are asked to translate for clients which is also not appropriate.

Cultural stigma is one of the barriers for Hispanic and Latinx community members. Some families think the person is "faking it". Physical symptoms are not apparent, so they must not be sick. Many individuals from this population are indirect communicators, so it is necessary to be patient and

allow them additional time to divulge details impacting their behavioral health.

RECOMMENDATION-Better outreach and more bi-lingual mental health promotion, and substance misuse prevention, treatment and recovery services in Region 5. Possibility of collaboration with LMHAs and CACs to star by assessing the region for existing resources.

In Region 5, Medicaid-enrolled adults with a primary mental health diagnosis comprised about 13.9% of the state total. (Region 5 Medicaid clients with a primary *substance use disorder* diagnosis made up 12.7% of the state total.) As noted in our epidemiological profile, adult mental health treatment tends to be available, and the percentage of people presenting with Serious Mental Illness (SMI) in Region 5 is lower than the rest of the regions in CT.

According to the Waterbury Public Health Department, a population of high concern are the homeless who have co-morbid untreated, sometimes very complex behavioral health disorders. Many are engaged through the various community-level opioid grants which are managed by the Waterbury Health Department. However, these folks remain very difficult to connect to care. The Hospitality Center has a list of "banned" people due to aggressive behavior, active psychosis, etc. There is a clear need for another "place" for those requiring acute mental health treatment. Key informants in the Torrington area also noted the need for additional attention to homeless folks with serious behavior health needs. There were several remarks concerning a lack of empathy and assistance for this population, in general.

RECOMMENDATION- More accessible mental health services and outreach ***specifically focused on the acute/co-morbid/high need homeless population.***

High utilization rates for behavioral health are a factor in the emergency departments in Region 5. During 2020, concerning Medicaid clients alone, 1889 people made 2-5 visits to emergency departments in our region, 213 people made 6-10 visits, 32 people made 11-15 visits, 19 people made between 16-20 visits and 13 people went to the emergency department more than 20 times. STRENGTH-Community Care Teams (CCTs) in Danbury and Waterbury have made great strides in addressing the high utilization rates in their communities.

The Danbury Community Care Team (CCT) worked with the city and its providers to ensure services were available during COVID 19. Once homeless residents were settled into the Super 8 mass shelter, CCT performed daily wellness checks via telephone and helped navigate logistical challenges among the sheltered individuals. This past cold season CCT organized a recurring outreach on the Danbury Green every Tuesday between 10-12pm to reach Latino homeless residents who had previously used the overflow shelter that is no longer in operation. CCT collaborated with Apex Community Care, Greater Danbury Community Health Center and Community Health Center to get individuals into shelter during the cold months in the Greater Danbury area. During the outreaches CCT met a total of 16 homeless Latino individuals and successfully placed 14 of them into the shelter. The CCT also coordinated Covid 19 screenings prior to admission to the sheltering unit.

After the Danbury CCT's *Peer Engagement Specialist* retired in October of 2020, a replacement was hired. The CCT is looking to expand this position to serve more clients in the community who suffer from addiction use disorders. The new Peer Engagement Specialist has a Master's in Addiction Studies.

In Danbury, regular CCT outreach has resulted in reduction of emergency room utilization among CCT clients by at least 40%. The Danbury CCT has served 292 individuals and has been incremental in assisting 109 homeless individuals into housing since inception in 2015. Waterbury CCT is also helping high utilizers of ED by coordinating care among most severe cases- All of the agencies involved in the "network of care" sign releases, so they can report "eyes on" those clients who are already known to many providers around city. Torrington is planning to get a CCT started very soon. These coordinated care services for one of our greatest need populations are a true strength in Region 5.

Connecting people to appropriate levels of care after a hospital visit has been an on-going challenge within both the youth and adult populations. Among Region 5 adults with a primary mental health diagnosis, about one out of three were transitioned to another provider within 7 days of leaving the emergency department. Within 30 days of discharge, about half were connected to other providers. The Changing Pathways initiative has improved this situation at both Rushford and Inter-communities, but at 50% placement within 30 -days, it seems even the best still have a way to go.

RECOMMENDATION- More and better assistance from discharge planners. Warm hand-offs to community providers. Mental Health Recovery Support Services and Recovery Coaches engaged in the Emergency Departments.

Strength- Adult Mobile Crisis was favorably recognized among many of our focus groups and key informants as a high- functioning, "huge help" to the mental health system across Region 5.

The Catchment Area Councils continue to meet and conduct outreach in the three sub-regions. CAC21 held in-depth panel discussions related to police accountability and transparency laws and how they affect people with mental illness. This resulted in the formation of a CIT committee, which has representation from each of the 3 CACs and will conduct a thorough assessment of CIT in Region 5. Our intention is to unite law enforcement, people with lived experience and mental health professionals across the region to improve outcomes.

Strength-Region 5 has a volunteer organization known as the Consumer Action Group (CAG) that was started over 30 years ago by the Regional Mental Health Board. It is comprised of people with lived experience and local providers. During 2018, they began drafting a white paper entitled *"Principles and Action Steps Intended to Improve Psychiatric Emergency Room Services and Hospitalizations".* This document was presented to the State Advisory Board during their January 2021 meeting. This group is an obvious strength in Region 5. Their recommendations included person-centered care plans, education on advance directives, consideration of trauma history, Recovery Support Specialists in hospital, mindfulness, comfortable living environments and other attributes that would lend to a better overall experience and improved outcomes.

Strength- Charlotte Hungerford Hospital, 7th Floor Inpatient Unit currently models some of these recommendations.

Strength-Another organization that has influenced behavioral health in a positive way is the Green TEAR Initiative (GTI). GTI is an active partner with the WCMHN-Torrington and Western CT Coalition among many others in the Torrington area. They are a vital, grassroots organization with broad representation, including many people with lived experience. They organize an Annual Mental Health

Month event that spans several days and involves many different resources and organizations. During the year they run very timely and well-attended roundtables and panels directed at improving behavioral health. Region 5 is fortunate to have this group in our area.

Youth Mental Health-

During 2020, requests for behavioral health screenings among children and adolescents under 18 in our state increased 300% over the previous year. Depression, anxiety, suicidal ideation and somatic symptoms (Gastro-Intestinal, headaches, etc.) were observed by parents and teachers alike.

RECOMMENDATION- Opportunities for Mental Health First Aid, Adolescent-SBIRT, Signs of Suicide, Question Persuade Refer, Social-Emotional Learning, and similar trainings in community settings, and for all school system personnel.

RECOMMENDATION-Youth Mental Health First Aid training provided to High School students grades 10-12. One option would be teams of two instructors who provide the training through existing health classes for entire grade level.

House Bill 6510 required the Behavioral Health Oversight Planning Council (BHOPC) to create a resource document for distribution among emergency departments and schools by December 1, 2021. This document would include information about local resources and other helpful connections like the National Suicide Prevention Lifeline. Resources would also be available online and through the BHOPC and Boards of Education. Obviously, the gap was recognized and has been addressed on the statewide level.

RECOMMENDATION-the resources developed by the BHOPC should be promoted through all community health agencies, the RBHAO, and primary care offices. These resources should be accompanied by more opportunities for providers to attend A-SBIRT trainings. In general, we need to encourage the use of screenings (preferably universal screenings) screenings at schools and primary care settings. There is strong evidence that engaging youth in screening and brief referral in the school and primary care setting begets better outcomes.

In Region 5, the hospital emergency department that saw the most youth was St. Mary's Hospital in Waterbury. During 2020, a total of 414 visits were made by 298 children. Of these visits, 11.7% were seen for behavioral health reasons.

The number of young people with mental health concerns has been steadily climbing even before the onset of COVID-19. In Region 5, of the young people with HUSKY insurance between the ages of 3-19 who came to the various emergency departments in 2018, 10% of those were admitted to the hospital, or to another in-patient facility. In 2019, 12.5% of young people were admitted to in-patient, and in 2020, 13% were admitted. It is worthwhile noting that inpatient admissions (youth ages 3-19) through the emergency departments in our region during April of 2020 reached as high as 22.7%.

In CT, during 2020 there were 32,000 requests for triage (assessments) for depression, anxiety, somatic symptoms, and suicidality, for people under the age 18. The pandemic triggered a variety of behavioral health concerns among youth. One possible reason for youth being at higher risk is that they have not built up the resiliency that older adults have acquired over the years.

In April of 2021, a social worker at one local school reported that the number of students referred to inpatient programs from their school system had doubled during the present school year.

A serious concern in Region 5 is the lack of inpatient treatment for children and adolescents presenting with behavioral health needs. This is a persistent gap and has been reported during our priority setting process previously. Very often, this results in young people being identified as "ED stuck". Families will sometimes be told that their child is "too acute". This is something that needs to change. Among young people with HUSKY insurance, the statewide average length of stay in the emergency department for behavioral health is 4.3 days., at St. Mary's in Waterbury the average is 5-7 days. Currently, there is no child psychiatric staff at the most frequented Emergency Department in Region 5. Discharge delays only intensify these service gaps.

A key informant from Region 5 indicated that her daughter (age 15) was kept in the Emergency Department for 10 days following a suicide attempt before being discharged.

The outcomes are not favorable for young people who are already in in crisis, staying for extended numbers of days, in a hospital unit that is designed for acute care/brief treatments.

Strength- Four Winds Hospital in Katonah, NY is very close to our area. This facility has been one of the few places that we can count on when young people and their families are seeking in-patient behavioral health services. Four Winds' admissions office is open 24 hours a day 7 days a week and they accept insurance including managed Medicaid. Behavioral Health professionals in Region 5 are well aware of the great resources they offer.

Suicide-

Suicide was the 10th leading cause of death in the US during 2019. In 2020, 44,834 died by suicide across the nation. (JAMA 3/31/21). A strength in Region 5 is the Regional Suicide Advisory Board (R5SAB), which meets quarterly. A 2021 Postvention Training attracted 13 local community "teams". These teams are developing their unique community postvention response plans. Another positive factor is the number of QPR Suicide Prevention Gatekeeper covering the 43 towns. In addition, Western CT Coalition has been running QPR online every week for the past year. The RBHAO has trained over 500 people in QPR since the COVID-19 restrictions were established.

The Regional Crisis Team (RCT), which is coordinated through Dr. Gabriel Lomas at Western CT State University is another strength in Region 5. RCT monthly meetings convene School Psychologists, Social Workers, Youth Mobile Crisis, and regional organizations for training and support. The RCT is structured so that any untimely crisis within our school communities can be handled with expedience and best-practices. Teams are "deployed" at the request of the Superintendents, and/or other local officials.

Suicide attempts and suicidal thoughts reportedly increased during the COVID-19 epidemic. Youth surveys from five previous years show that suicide attempts had been trending upward. In Region 5, during the first quarter of 2021, calls to 211 requesting crisis and suicide interventions had already surpassed 64% of the number of calls during the entire previous year. We are concerned about suicide risk among girls 12-17 as the CDC recently reported 50+% increase in suspected suicide attempts during a one-month period in 2021, in comparison to the same time the year prior.

A major challenge that exists regarding suicide prevention relates to the fact that signs and symptoms are not always present. Suicide is hard to predict. *"Although most individuals who attempt suicide have a psychiatric disorder, the* ***majority*** *of people with a psychiatric disorder never attempt suicide."* (Amer. Journal of Psychiatry 2/18/21-Olfson, M. JAMA 2019.2582)

As a result, it is difficult to identify when a person is contemplating suicide. For this reason, population-based screenings might be effective on several levels. Early mental health service delivery in the community and within health-system will also reduce stigma. Environmental strategies will also bear faster results over a larger number of people.

Opioid Use**-**

Coordinated community- based prevention efforts have been directed at opioid use in Region 5 since 2003. Over the past eighteen years, there have been evidence-based strategies employed across virtually every sector. The region has 19 permanent drop-boxes across the 43 communities. Narcan trainings are held every week and several thousand kits have been distributed.

Local Prevention Council members participate in DEA take-back events, Statewide Opioid Response grantees have educated providers and promoted the Change the Script and Live LOUD media campaigns. Police departments are partnering with CCT and adopting parts of the HOPE Initiative (Manchester model). Prescribers are using the PDMP. Newtown Parent Connection and other parent and peer supports are available. Schools provide presentations and resources, municipal leaders raise awareness and participate in forums. Higher education and faith-based organizations are engaged. The region has three active Opioid Prevention Workgroups, Litchfield County Opioid Task Force, Waterbury Opioid Workgroup and the Greater Danbury Regional Opioid Workgroup all of which meet monthly. Prevention partners in our area are doing everything they can to address the opioid epidemic.

Strength-Region 5 treatment providers have been going the extra mile, as well. The number of providers offering Medication Assisted Treatment continues to increase. The COVID-19 restrictions resulted in adaptations like teletherapy and revised Methadone maintenance programs. In general, providers were flexible and collaborative, so they could best serve their clients. Waterbury Health Department has an *Overdose 2 Action* grant through the Department of Public Health. After an overdose, Opioid Response Technicians assure that everyone leaves with a cellphone contact number in their phone and Narcan in hand.

Danbury Hospital has improved access to resources for people receiving naloxone upon discharge. The RBHAO developed OUD information and resource bags which were delivered to the hospital pharmacy. The pharmacy created a sticker for each box of Narcan that reads "To be dispensed with resource bag". At discharge, nurses explain the contents of the bag and train people in how to administer the Narcan.

Challenge-After an overdose reversal, there is rarely a friend or family members at the hospital bedside and folks generally leave alone, so there is nobody to train in the administration of naloxone. Very often, people living with opioid use disorder have burned all their bridges. Help identifying someone who can get them to a next step in treatment is needed.

Three-quarters of the overdoses in Waterbury are transported to St. Mary's Hospital. Regretfully, there continues to be very little awareness of Recovery Coaches among Emergency Dept. staff at St. Mary's. Turnover can be a barrier to this information/resource. Recovery Coaches are available in emergency departments all over Region 5. They are an immense resource for people who may be considering recovery.

Strength- CT Counseling staff really extend themselves and cut through the red tape to help people get started in their recovery process. For instance, they will assist folks who are in- between insurance coverage by helping to get the process underway. They won't just turn people away until they have their insurance coverage in force, which can delay assessment and intake.

A challenge at CT Counseling-Waterbury is that the 2 locations do not share records adequately with one another- Brookside does not have info on Midland clients, so there ensues a run-around which could be easily avoidable. During 2020, demand was so great, and staff were stretched, so it is understandable that certain administrative changes were delayed.

APEX is also a highly visible and accessible provider. They have expanded their services and their service area since our last report. Charlotte Hungerford Hospital has a Dual Diagnosis IOP and groups. McCall Center recently launched a Family Service call line- the enormous contributions of these PNPs are fundamental to the successful treatment landscape in Region 5.

In 2019, Waterbury had the second highest number of overdose fatalities in the state (91), just behind Hartford (96). There are not enough treatment beds for people diagnosed with opioid use disorder. Also, Waterbury Health Dept., Connecticut Institute for Communities, and MCCA all voiced concerns about people with co-occurring disorders who are not receiving appropriate care because both mental health and substance use treatment are stretched so thin. Professionals tend to diagnose from their area of expertise, which compounds the problem. Providers need to be mindful of contributing to the "silos".

We have encountered evidence of this in the data from Beacon Health Options which indicates that some people leaving in-patient psychiatric units, without an opioid use disorder diagnosis actually had been diagnosed with an OUD during the past 12 months. Lacking that diagnosis upon discharge, they are not referred to MAT or other services. This puts them at a heightened risk of death by overdose.

Litchfield County Opioid Task Force has reported several "overdose spike alerts" over the past year. According to the Office of Chief Medical Examiner, Danbury overdose deaths doubled from the year prior. Heroin and Fentanyl have the most severe impact on our region. Treatment is more accessible than it was in the past, and recovery supports are more abundant. Unfortunately, the number of overdose deaths in CT continues to increase and our region reflects this trend.

Reports from EMS indicate that most people who experience an overdose reversal are willing to be transported to the Emergency Department until they are stabilized.In our area, the number of non-fatal overdoses has continued to rise, due in part to the wide availability of Narcan and access to fentanyl test strips distributed through the five Harm Reduction Rovers. Recently, in Waterbury, non-fatal overdoses increased by about 19% when comparing the first 5 months of 2020 and 2021. During the same period, fatal overdoses have decreased there by 30%.

Other Challenges noted by the RBHPSW and others

Transportation to services is accessible in most of the region. Partly because it is rural, the Northwest corner encounters the most difficulty with transportation. In addition, transportation is sometimes a problem for our Hispanic and Latino populations, even when programs exist. Language barriers can interfere with access. Another reported transportation barrier is that children cannot ride in state vehicles, so people need someone to watch their children when they use the service. Social norms around alcohol result in many who need services not seeking them. Women, older adults among the cohorts of underserved.

211 can be difficult to navigate- we need a training for community-based providers. Recovery Coaches and Peer Supports requested this.

We need **more** Recovery Coaches and RSS for both addiction disorders and mental health.

Detox criteria can be a series of barriers. Need a "cheat sheet" for RSS and Peer Supports so they can determine barriers during intake.

Access line is great for detox and residential, but insurance still matters.

Detox transportation services- if they are state-wide you should not have to go to the closest available facility. Not always the most appropriate place and can be a barrier to engagement.

Increase responsiveness of Mobile Crisis to our shelters.

Mental health and substance use treatment are still in silos.

Community Engagement specialists need training on how to get SS cards/IDs for clients.

Shortages in staff and clinical workforce at PNPs -all private providers are backlogged.

The number of youth who are seeking services in Emergency Departments exceeds capacity.

Additional Strengths noted by the RBHPSW and others

New adolescent APRN in Danbury (we still need more)

New "all ages" APRNs in region.

Lots of choices for 12-step recovery programs.

Laptops and internet assistance provided by schools and social service, DMHAS service system.

Civic organizations engaged in safe medicine disposal projects.

Telehealth/Teletherapy- most providers and consumers hope that it is here to stay. (Some fine- tuning is necessary as there are still folks for whom virtual platforms do not translate well).

Plenty of MAT available among Medicaid providers in Region 5. School-based Health Centers, Community Health Centers and Federally Qualified Health Centers contribute to the overall accessibility of behavioral health services in Region 5.

Enhanced Care Clinics- There are 5 in our region. FCA- serving youth and families Danbury, Waterbury and New Milford. CMHA- youth in Waterbury, CMHA- Torrington youth and adults, CHH -Center for Youth and Families, McCall Center- adults in Torrington and Winsted, Wellmore- youth in Waterbury and Naugatuck. Grassroots support for suicide prevention (Newtown, New Fairfield, NW corner).

Recovery Coaches and Peer Support Specialists- the Recovery network is growing.

CHESS- New in 2021, it is first program in the US to allocate Medicaid funds to BH providers to pay for housing.

HELP, INC., offers "Women for Sobriety" group throughout our region.

Harm reduction services have improved and are more readily available- Naloxone, Safe Syringe Exchange, fentanyl testing strips, are more mainstreamed in the highest need areas of our region. The attitude of meeting people where they are is spreading across the continuum of care. LMHAs are reaching out for training to enhance harm reduction practices.

DMHAS system improvements- Access Line, Screening and Transportation, Real-time Bed Availability.

Conclusions and Recommendations:

Prevention

- Mental health promotion and substance use prevention are more active than our Community Readiness report would indicate.
- Evidence-based mental wellness and substance misuse prevention strategies are present, but it would advance our goals to promote universal screenings in schools and primary care settings, among others.
- Prevention funding should be part of the state budget.
- Prevention efforts in Region 5 should maintain focus on alcohol use and underage drinking because they are most prevalent, vaping because more education and awareness is needed, cannabis because of the recent legalization and heroin and opioids because the epidemic persists and overdose deaths continue to trend upward.
- We should closely monitor youth mental health trends, and the prevalence of methamphetamine and kratom throughout our region.

Treatment

- We need to reduce stigma surrounding naloxone, provide education and distribute is broadly.
- We are in need of more treatment beds for adults with OUD.
- We are in need of treatment beds for youth and adolescents.
- We need better transitions between level of care, warm hand-offs and touchpoints in the communities.
- Expansion of insurance coverage for innovative, non-traditional treatment.
- We need an aggressive plan to attract, retain and develop skilled treatment professionals and stabilize the workforce.

Recovery

- Recovery has been steadily gaining recognition and respect in Region 5 for many years.
- Recovery Coaches are available and making a positive impact.
- Some Emergency Departments need to remind staff about the Recovery Coaches.
- Mental health advocates recommend placing Recovery Support Specialists in the Emergency Departments.
- Stigma is being addressed. Stigma reducing language is integrated into more trainings, meetings and communications.
- Recovery Friendly Communities and Recovery Friendly Workplaces are being promoted in Region 5.

Summary of Priority Recommendations in Region 5

Issue	Prevention	Treatment	Recovery
Substance Misuse			
Region	Coordinate region-wide media campaigns and social media campaigns about cannabis, vaping and problem gambling with the Local Prevention Councils and other funded coalitions (DFC, etc.) Educate Primary Care Providers in Depression Management, Mental Health First Aid, screenings and early interventions. All Providers Need to check the "language" they are using on their websites and in print. "Addict" is still common to vocabulary- Need to update to more recovery friendly terminology. Continue to raise awareness around prescription drugs, the risks of misuse and education around overdose prevention, specifically related to opioids and benzodiazepines.	More available in-patient youth and adolescent treatment. Increase coordination between various providers/levels of care. Foster touchpoints in community Better engagement of Recovery Coaches in some of the Emergency Departments. MAT should be prescribed as you leave the hospital after an overdose, or if you are diagnosed with an opioid use disorder and leaving in-patient medical of psychiatric unit. Treatment providers should check the language they are using on their websites and in print. "Addict" is still common to vocabulary- Need to update this to reduce stigma and reflect recovery friendly terminology.	More and better assistance from discharge planners. Recovery Support Services and Recovery Coaches better engaged in the Emergency Departments. All Providers Need to check the "language" they are using on their websites and in print. "Addict" is still common to vocabulary- We need to update website and other material content to integrate "recovery friendly" language and raise awareness about Recovery Friendly Communities and Workplaces. Recovery Coaches in Courts with people before they are arraigned. Better engagement and communication

	Work with LPCs and communities to build and maintain programs that encourage safe use, safe storage and safe disposal of prescription drugs Naloxone education should include an emphasis on "mainstreaming". Prevention needs to focus on reducing the shame and stigma associated with this drug among the general public.	Assist in the promotion of restorative practices in school settings when a student is caught vaping or in possession of alcohol or paraphernalia. Naloxone should be co-prescribed for people who are on long-term chronic pain management. Better engagement and communication with discharge planners	with discharge planners
State	Prevention should be a line item in the state budget. RBHAOs should receive state funding designated to enhance the prevention infrastructure in each region. The resources developed by the BHOPC (HB6510) should be promoted through all community health agencies, the RBHAOs, and primary care offices. These resources should be accompanied by more opportunities for school staff and treatment providers to attend trainings on screening tools, and A-SBIRT.	With the legalization of recreational marijuana use for people 21+, there will be a need for more treatment- The current workforce is overwhelmed and we are already experiencing 3-5 week lag time on appointments with private providers. We will need more clinicians. Clinicians will need support. Prior authorizations that were necessary at EECs, but suspended during pandemic should stay that way. Develop a "cheat sheet" for RSS and RCs to navigate criteria for intak to detox .	

	Office of Legislative Research should conduct a study on the availability of Kratom in CT		
Mental Health			
Region	Opportunities for MHFA, A-SBIRT, SOS, QPR, SEL, and similar trainings in community settings and for all school system personnel. Youth Mental Health First Aid Training provided to HS students grades 10-12. One option would be teams of two instructors who provide the training through existing health classes for entire grade level. Resource developed by the BHOPC should be promoted through all community health agencies, the RBHAO, and primary care offices. These resources should be accompanied by more opportunities for providers to attend A-SBIRT trainings. Educate Primary Care Providers in Depression	More and better assistance from discharge planners. Warm hand-offs to community providers. Mental Health Recovery Support Services and Recovery Coaches engaged in the Emergency Departments. More available in-patient youth and adolescent treatment. Hiring process needs to be more efficient. Positions need to be filled in a more timely manner- clients are not receiving best care when clinicians and staff are overworked because of employee turnover. Engage community partners to firm up transitions from levels of care. In Hospital Setting- Patients personal and professional supports	More and better assistance from discharge planners. Warm hand-offs to community providers. Mental Health Recovery Support Services and Recovery Coaches engaged in the Emergency Departments. Provide pre-discharge education, follow-up contact and outreach for psychiatric patients when being discharged from ED or hospital after a suicide attempt. Check in with a phone call or a card to people who recently left the hospital after a suicide attempt. (partnership between hospital psych and RBHAO).

	Management, Mental Health First Aid, screenings and early interventions. Outreach and Education- Address prevention needs of youth who are self-medicating their COVID-related anxiety with marijuana. Prevention programs should incorporate the lessons learned from COVID-Youth need to develop resiliency skills- Better outreach and bi-lingual mental health promotion, prevention, treatment and recovery in Region 5- especially Danbury and Waterbury	should be involved in all discharge planning Transparency in treatment options Discussion of how "stability" is defined Staff training in active listening skills Additional services available at discharge Peer run respite center More accessible mental health services and outreach ***specifically focused on the acute/co-morbid/high need homeless population.*** Increase responsiveness of mobile crisis to the shelters	
State	Resources developed by the BHOPC should be promoted through all community health agencies, the RBHAO, and primary care offices. These resources should be accompanied by more opportunities for providers to attend A-SBIRT trainings.	Hiring process needs to be more efficient. Positions need to be filled in a more timely manner- No flashlights in people's eyes for bed checks. Artwork – especially landscapes Bedrooms – peaceful colors	

	We need a statewide campaigns focused on mental health and wellness and a separate one tackling STIGMA(Like Change the Script)	Environment should be sensitive to needs of individual- "at risk/not at risk of harm" Consider the individual's trauma history.	
Problem Gambling			
Region	Involve community Re-entry partners in problem gambling prevention activities. Conduct outreach to groups that serve young Black and Latino men, and middle-aged women Discuss new laws governing online gambling during other prevention forums, COG meetings, etc. Focus on young male population. Integrate problem gambling awareness into "gaming" presentations, to educate parents.	Raise awareness among clinical folks about disordered gambling screening tools and self-assessments. We need more gambling - informed mental health providers. Problem gambling screening tools in the Emergency Dept. Raise awareness about Bettor Choices at MCCA.	Raise awareness about recovery supports that exist in Region 5- Work together with recovery community to breakdown stigma and secretive nature of disordered gambling
State	Rigorous, multi-step age verification for online gambling. Problem Gambling Services should create a statewide media campaign including press releases, graphics and	Continue to allow virtual groups via "tele-therapy" Introduce voluntary self-exclusions from the Casinos Consider funding online assessment	Problem Gambling Services should create a resource that links people in Recovery from a gambling addiction disorder across the state.

	other targeted materials that can be disseminated to the general population - school aged and up.	program, so people can identify urges, cravings and triggers- self-assess and find resources and support.	Expand Recovery Coach Academy training so we have more than one peer support person per DMHAS region.
Systems/Other			
Region		PNPs need to be able to offer more competitive wages. This workforce is essential to the success of the entire service system. We need to restructure compensation rates to reflect their importance. Workplaces should be encouraged to update EAPs and revise as needed to assure people are offered appropriate length of treatment and specialists.	

State	Teletherapy resources need to continue and be made accessible to underserved populations, un-insured, etc. More opportunities for LGBTQ-IA to find statewide and local resources. Develop more resources. Veteran's behavioral health substance use and mental health services need to be integrated- they are still "silos" in Region 5. Make de-identified suicide data easier to access – develop guidance for using the data to identify trends at the sub-state level.	PNPs need to be able to offer more competitive wages. This workforce is essential to the success of the entire service system. We need to restructure compensation rates to reflect the importance of these workers. DMHAS' expectations for Employment Services skill-building programs need to be revised to better prepare consumers for employment. Either funding for or allowable billable service for peer recovery supports and care coordination. More billable integrated holistic treatment modalities such as, auricular acupuncture, Reiki, Emotional Freedom Therapy, Sound Healing, etc. Human Services Advocates are needed in more agencies. Devise a way to have erroneous mental health diagnoses removed from health records.	The Clients Bill of Rights should be amended to include the right to a Peer Advocate- with an option of said advocate being independent of the agency.

		Statewide transportation to treatment should be to a facility best suited for the person - not just what is closest.	

Region 5 RBHPSW (Workgroup) Priority Ranking Matrix: Substance Use/Misuse/Addiction

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

PROBLEM	MAGNITUDE	IMPACT	CHANGEABILITY	CAPACITY/ READINESS	CONSEQUENCE OF INACTION	TOTAL	Mean Ranking Score:
Alcohol	4.85	3.92	3.2	3.0	4.0	18.97	3.79
Tobacco	2.2	3.2	3.1	3.85	3.0	15.35	3.07
Electronic Nicotine Delivery Systems (ENDS), vaping, juuling	3.85	3.71	3.1	3.14	3.71	17.51	3.5
Marijuana	4.14	3.28	2.57	2.71	4.0	16.70	3.34
Prescription Drug Misuse	2.57	3.85	3.0	3.14	4.14	16.70	3.34
Heroin and Fentanyl	3.14	4.7	2.92	3.0	4.57	18.33	3.66
Cocaine	2.28	3.42	2.5	2.42	3.14	13.75	2.75
Problem Gambling	2.0	2.71	3.28	3.0	2.71	13.7	2.74

Region 5 RBHPSW (Workgroup) Priority Ranking Matrix: Mental Health and Suicide

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

PROBLEM	MAGNITUDE	IMPACT	CHANGEABILITY	CAPACITY/ READINESS	CONSEQUENCE OF INACTION	TOTAL	Mean Ranking Score:
Anxiety	4.28	3.0	3.64	3.5	3.71	18.13	3.63
Depression	3.85	3.2	3.5	3.78	3.5	17.83	3.57
PTSD	2.71	3.42	3.28	3.28	3.14	15.83	3.16
Trauma	3.42	3.71	2.71	3.0	3.14	15.93	3.19
Serious Emotional Disturbance	2.42	4.0	2.42	3.0	3.72	15.56	3.11
Early Serious Mental Illness	2.57	4.14	2.57	3.0	4.14	16.42	3.28
Serious Mental Illness	2.28	3.85	2.42	3.0	3.86	15.41	3.08
Suicide	2.43	4.57	3.14	3.57	4.57	18.28	3.66