DMHAS Region 2
Regional Priority Report
June 27, 2019

Alliance for Prevention & Wellness
A program of BHcare

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Alliance for Prevention & Wellness
June 2019

Contributors

Sarah Ali	CT High Intensity Drug Trafficking
Anna Gasinski	Prevention Specialist – APW
Robert Lawlor	CT High Intensity Drug Trafficking
Lorrie McFarland	Program Coordinator – APW
Pamela Mautte	Director – APW
Prevention Committee	APW
Regional Behavioral Health Priority Setting Workgroup	RBHPSW
Taylor Quijano	AmeriCorps Prevention Corp Member -APW

Abbreviations

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

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

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Executive Summary

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

The overall profile offers the communities of the APW service area, information regarding substance use and misuse, both illegal and legal; mental health concerns, suicide and gambling. The information is gathered from many sources and separated into individual profiles of ten areas of concern: alcohol, tobacco, prescription drugs, marijuana, heroin, illicit opioids, cocaine, problem gambling, mental health problems such as anxiety and depression, and suicide. The information is gathered from federal and state data and is then compared to local data when available.

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

The BHPSW focus groups were held in the following communities: Ansonia, Branford, Old Saybrook, and Middletown. These communities are all located in the DMHAS Region 2 service area. In addition to focus groups, community members and key leaders participated via phone interviews, and a survey monkey link. A First Responders focus group was held with 7 law enforcement and fire department members. Additionally, information was discussed with the APW Prevention Committee Members.

The 32 BHPSW participants reviewed data compiled by APW from the data sets, focus group answers, community readiness data, as well as participant anecdotal information and feedback. Members utilized this information to determine rankings for the ten priority areas.

Based on data analysis, surveys, focus groups, and interviews, these are the top priorities identified by the BHPSW workgroups.

1. Mental Health Issues
2. Suicide
3. Prescription Drug Misuse
4. Alcohol
5. Heroin
6. Electronic Nicotine Delivery Systems (ENDS), vaping, juuling
7. Marijuana
8. Cocaine
9. Problem Gambling
10. Tobacco

The first three priorities were very closely ranked in magnitude and impact. Mental health issues along with suicide were tied with the same rating, but mental health issues had a slightly higher magnitude. Anxiety along with mental health conditions were discussed at great length along with mental health conditions that co-occur with substance use disorders. The 2018 Community Readiness for Substance Abuse Prevention & Mental Health Promotion Assessment illustrated that APW's region mean stage of readiness is 5.25 which is comparable to the State's average of 5.26. The key leaders interviewed illustrated that the data collected is mostly used for strategic planning /program planning, leveraging grants and resources. While it is good news that we are using data for planning and funding, it is of great concern that we report problems in funding to collect data and the negative stigma data can bring to a community. The Priority Report ranked mental health and suicide as the top priorities which also correlated with findings in the Community Readiness report. APW hopes to work with the identified system strengths and community partners to break down barriers and assist local coalitions and partners in implementing initiatives that fill identified needs and gaps in services. The changeability rankings along with capacity / readiness matched in the top five priorities. It is

important to note that, as with any survey responses and BHPSW meetings, the selection of key stakeholders they represent can influence the outcome of this report. The limitation of the BHPSW included not having a more diverse representation from each of the towns in our sub-region.

Region 2 is very diverse in terms of communities and populations within each of those communities. The top three identified priorities of mental health, suicide, and prescription drug abuse is an issue across all income levels and communities. Discussions included that the prescription drug problem is more of an issue than opioids and focus should also be placed on benzodiazepines and stimulants. While every community in the region has been affected by opioids and opioid related overdoses, it is overshadowing other issues.

Issues of concern as related to the top three identified priorities included the need for more coordination and collaboration among providers, community- based organizations, and first responders so they can help the people in most need. Many felt that services are still fragmented and operating in silos. Children's services are also hard to access for mental health and substance use and, the services are not readily available in the community. Additional concerns included the need for enhanced communication, education, awareness, and cultural competence. The lack of cultural competence was discussed for various sub-populations such as people who are abusing substances, those with mental health challenges, and the LGBTQI community. It was recommended that enhanced education and training be provided to the hospitals and specifically emergency room professionals, so they would have more compassion for those with behavioral health disorders. It was found that there is a culture among medical professionals of engaging in stigmatizing language deprived of empathy. Lastly, the distribution of resources and services varies across the region. Many of the smaller communities feel overshadowed by their larger neighboring towns.

RBHPSW (Workgroup) Priority Ranking Matrix

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	3.8	3.6	2.6	2.4	3.4	15.8	3.1
Tobacco	1.8	1.9	2.0	2.0	2.2	9.9	1.9
Electronic Nicotine Delivery Systems (ENDS), vaping, juuling	3.0	2.8	2.8	2.7	3.2	14.5	2.9
Marijuana	3.3	2.8	2.2	2.1	3.0	13.4	2.6
Prescription Drug Misuse	3.9	3.7	3.2	3.0	4.2	18	3.6
Heroin	3.3	3.2	2.4	2.7	3.5	15.1	3.0
Cocaine	2.3	2.4	2.1	2.6	3.0	12.4	2.4
Problem Gambling	1.9	2.0	2.7	2.4	2.2	11.2	2.2
Mental Health Issues (specify as applicable)	4.3	3.5	3.2	3.2	4.2	18.4	3.6
Suicide	3.6	3.7	3.5	3.4	4.2	18.4	3.6

Introduction

The Regional Priority Report supports the CT Department of Mental Health & Addiction Services (DMHAS) Substance Abuse Prevention and Treatment (SABG) and Mental Health Block Grant (MHBG) requirements. In 2004, DMHAS adopted the Substance Abuse and Mental Health Services Administration (SAMHSA) Strategic Prevention Framework (SPF) at the State, sub-regional and community levels. The SPF is a five- step data driven process known to promote youth development and prevent risky behaviors across the life span. APW completed similar reports in 2010 and 2012. This Priority Report is a new report which combines the former Regional Mental Health Board Priority Planning Process Report and the former Regional Action Council's Sub-Regional Epidemiological Profile. APW has written this Priority Report with assistance from community members in support of the SPF process. This report is an analysis of the magnitude, impact and capacity within DMHAS Region 2 of the following areas of concern for CT: alcohol, tobacco, prescription drugs, marijuana, heroin, illicit opioids, cocaine, problem gambling, mental health problems such as anxiety and depression, and suicide. It includes the following cities and towns which comprise DMHAS Service Region 2: Ansonia, Bethany, Branford, Chester, Clinton, Cromwell, Deep River, Derby, Durham, East Haddam, East Hampton, East Haven, Essex, Guilford, Haddam, Hamden, Killingworth, Lyme, Madison, Meriden, Middlefield, Middletown, Milford, New Haven, North Branford, North Haven, Old Lyme, Old Saybrook, Orange, Portland, Seymour, Shelton, Wallingford, Westbrook, West Haven, Woodbridge.

Purpose

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

on the identified priorities among the identified populations, increase awareness of substance use and other behavioral health problems, inform strategic plans, support leveraging of funds, and enhance membership in local prevention councils, advisory groups, task forces / work groups, coalitions.

Data Sources

Most of the data utilized in the report was obtained from the CT SEOW Data Portal. The portal is an interactive repository for behavioral health and related data that supports a comprehensive public health approach to substance abuse prevention and health promotion. Local community student surveys on the core measures which include: past 30-day use, perception of harm, peer disapproval and parental disapproval of substances. Additional data was drawn from the following sources:

APW Community Readiness Results

APW Narcan Data

Centers for Disease Control

CT High Intensity Drug Trafficking Reports

CT Open Data

CT Youth Tobacco Survey 2017

DMHAS annual statistical report SFY 2018

DPH Neonatal Abstinence Syndrome in CT May 2016

EMPS 2-1-1 Crisis Calls

Focus Groups

Local Police Data

National Gambling data

Office of Chief Medical Examiner

Problem Gambling Helpline Call data through the CT Council on Gambling

Survey Monkey Survey to Key Informants

Treatment Episode Data Statistics SAMHSA – CT Specific

Uniform Crime Reports

Strengths and limitations of the report

The strengths of this profile include a comprehensive overview of Region 2. Other strengths include the qualitative data collected through focus groups who participated in the process. Some limitations of the report include the lack of data obtained from young adults ages 18-25, varying socio-economics of residents residing in the span of urban, suburban and rural communities located in region two. Lastly, averaging available youth survey data does not give an accurate data story of youth use and perception of harm.

Data Limitations

This report was designed to provide a comprehensive assessment of areas of concern in CT, specifically in DMHAS Region 2 for the following: alcohol, tobacco, prescription drugs, marijuana, heroin, illicit opioids, cocaine, problem gambling, mental health problems such as anxiety and depression, and suicide. We recognize that it cannot accurately measure all possible aspects of the areas. This assessment incorporates a significant amount of quantitative data that was collected from a variety of sources. The data is believed to be reliable, valid and relevant. However, it is **not** practical to include all available data. Since this information was sometimes limited as to the level of geographic detail or demographic identifier, availability for all health indicators, and by the timeliness of the information' s reporting period.

Qualitatively, many community individuals were involved in the development of this report, however, given that input was not provided by all community members, there may be instances where specific concerns are not adequately represented.

Methods

Development of this profile was a multi-step process. Available data on the state's ten priority areas was compiled, reviewed, tabulated and summarized. APW conducted several focus groups, attended various meetings and distributed a survey monkey survey seeking input from diverse community members on the identified areas of concern. APW then convened several Community Needs Assessment Workgroup (CNAW) to review the profiles for each of the priority areas. At the conclusion of the meetings, workgroup members provided input on the

profiles and ranked the priority areas in magnitude, impact, consequences, and changeability of the priority. APW staff summarized the rankings to create the regional report.

Description of the Region

Region 2 is in the South-Central region of CT, consisting of most of New Haven and Middlesex counties. These two counties include a 36- town region with a total population of 850,717 and median household incomes ranging from $43,386 to $136,786 (source: CT Open Data, 2015 & ctdata.org 2016 median incomes). The South-Central Region of Connecticut is an economically diverse area spanning from the Lower Naugatuck Valley through the Shoreline and into central CT. The areas range from the small rural communities of 2,556 to the second largest city in the state, New Haven, which has a population of 135,175, with many other rural, suburban, and urban communities falling in between the ranges. Poverty rates across the region also vary and range from the lowest of 2.4% to some of the highest in the state at 25.6% with 173, 671 people are currently recipients of Medicaid insurance. Most communities in region two are comprised of residents identifying as white non-Hispanic (60%+) except for the City of New Haven which reports 30% of their residents identify as white non-Hispanic.

Sub-populations that emerged as part of this report include the elderly, young adults (18-25), LGBTQI, ALICE (Asset Limited Income Constrained Employed), those living in poverty, post jail transition and those currently incarcerated.

Alcohol continues to be the most commonly used substance nationally, statewide and locally. Alcohol is a central nervous system depressant and is metabolized in the liver. A standard drink is 12 ounces of beer (5% alcohol content), 8 ounces of malt liquor (7%), 5 ounces of wine (12%), or 1.5 ounces of distilled spirit or liquor (40%). For youth ages 12-20, *binge drinking* is defined as have 5 or more drinks in a two week time span. For adults, 21 and older, *binge drinking* is defined as having 4 or more (for women) or 5 or more (for men) drinks during a single occasion.

Screening and Brief Intervention for alcohol use is proven to be an effective clinical prevention strategy to reduce excessive alcohol use. In the state of CT and in the Region, many youth serving organizations have trained staff to conduct a motivational interviewing screening called Adolescent Screening and Brief Intervention Referral to Treatment (A-SBIRT) to ask youth about their current alcohol use, providing individuals with feedback about their use, and advising those who are drinking excessively to change their behavior and/or referring the individual to more specialized treatment.

Magnitude

In 2016, NSDUH data revealed that past 30-day use of alcohol rates have decreased nationally in youth, young adults and adults aged 26 and older since 2002. However, rates of past 30-day use among all ages is significantly higher statewide in CT and in Region 2 than national rates.

% Averages	**NSDUH (national, 2016)**	**CT**	Region 2
Past Month Use for Ages 12-17	9.2	11.4	27
Past Month Use for Ages 18-25	57.1	66.3	
Past Month Use for Ages 26 +	54.6	64.5	

Binge drinking within the past two weeks for Region 2 youth data shows about 18%, which exceeds the national average of 4.9%. For youth, ages 12-20. In 2013, legislation passed in CT, easing access to alcohol, allowing off premise permittees extended hours of operations, ability to sell on Sundays and on holidays.

Impact

The consequences and impact of alcohol use, abuse and dependence include negative short and long term legal, academic and health effects on the individual and a community at-large. According to the Centers for Disease Control and Prevention (CDC):

- Excessive drinking is responsible for more than 4,300 deaths among underage youth each year.
- In 2013, there were approximately 119,000 emergency rooms visits by

persons aged 12 to 21 for injuries and other conditions linked to alcohol.

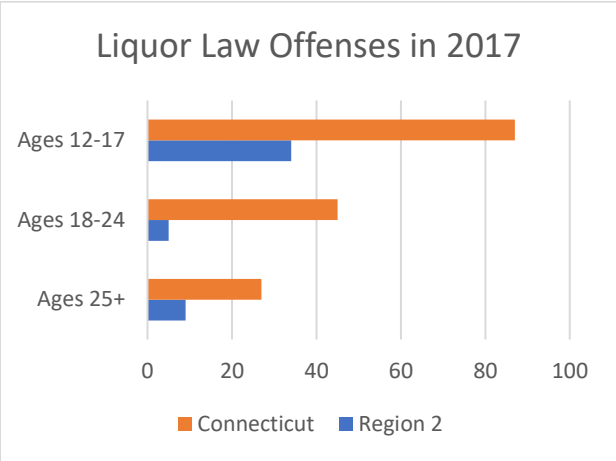
- Total cost of excessive alcohol consumption in Connecticut is $3.29 billion, which results in $2.04 cost per drink and $847 cost per capita.

In 2017, the total number of Driving Under the Influence (DUI) arrests in the State of Connecticut was 8,332. Specifically in Region 2, the total number of DUI arrests were 2,740. DUI among youth ages (12-17) was low and majority of DUI arrests were among the ages of 21-35 in 2017.

# DUI arrests (2017)	CT	Region 2
Ages 12-17	29	9
Ages 18-24	1,408	407
Ages 25 +	6,895	2,324

In Connecticut, in 2017 there were a total of 159 liquor law offences; in Region 2, there were 48 liquor law offenses. New Haven County had a total of 41 liquor law offenses and Middlesex County had a total of 7 liquor law offenses.

Liquor Law Offenses (2017)	CT	Region 2
Ages 12-17	27	9
Ages 18-24	45	5
Ages 25 +	87	34



In 2018 in Connecticut, there were a total of 18,616 admissions to a Department of Mental Health and Addiction Services (DMHAS) treatment facility for either substance abuse treatment or mental health treatment, where alcohol was the primary drug of use. Those who reported alcohol as the primary drug at admission, alcohol was more frequent in admission to a mental health program (45%) than a substance abuse program (30%). (DMHAS, Statistical Analyst Report 2018)

According to the 2018 Treatment Episode Data Set (TEDS) by the Substance Abuse Mental Health Service Administration (SAMHSA), in Connecticut:

- Males sought treatment for alcohol use only and alcohol with a secondary drug (70%) at a much higher rate than females (30%) and over 60% of admissions were White.
- 12% of admissions were Hispanic or Latino and 11% were Black or African American.

Capacity

According to the Center for Prevention Evaluation and Statistics, in their 2018

Connecticut Community Readiness Survey, Key Informants would somewhat agree that most community residents are concerned about preventing alcohol abuse, but more strongly believe that attention should be paid to preventing prescription drug misuse. Also, Key Informants in the study, somewhat agreed that most community residents believe that enforcement of liquor laws should be a priority. Specifically in Region 2, Key Informants somewhat agree (3.02) that most community residents are concerned about preventing alcohol abuse. Key Informants somewhat agree (3.06) that community residents believe that enforcement of liquor laws should be a priority.

In region 2, Key Informants somewhat disagree that community residents believe that youth should be able to drink at parties with parental supervision (2.00), that it is okay for teens to drink if they don't drive (2.00), and that it is okay for youth to drink alcohol occasionally (2.29). However, Key Informants were between somewhat disagree and somewhat agree when it pertained to adult alcohol use. They believe that most community residents believe it is okay for adults to get drunk occasionally (2.61), and that it is okay for adults to drive after having one or two alcoholic drinks (2.67).

Based on Region 2 focus groups and interviews, alcohol and underage drinking remains to be a medium (3) priority on the ranking scale. In Region 2 focus groups, alcohol was not discussed in as much detail as other drugs and behavioral health issues, such as marijuana and suicide.

Consequences/Impact

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ps://wwwdasis.samhsa.gov/webt/newmapv1.htm#

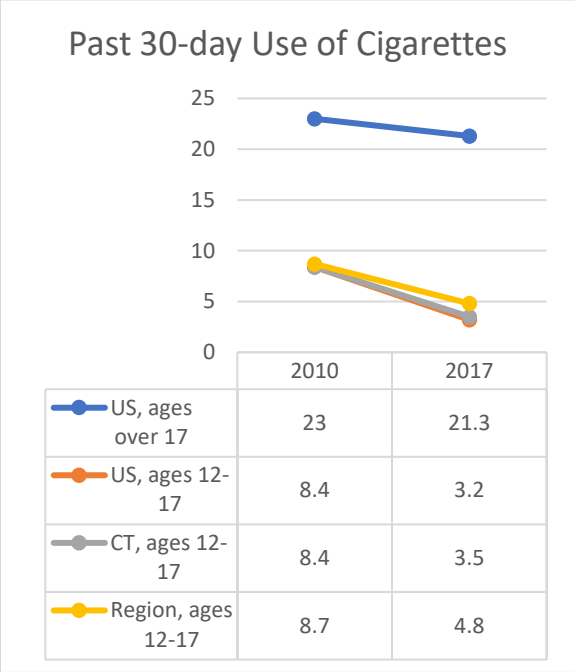
AGE	All substances	Alcohol only	Alcohol with secondary drug	Heroin
12-17 years	0.0	0.0	0.0	0.0
18-20 years	2.8	0.6	2.2	1.4
21-25 years	10.5	5.0	9.4	10.2
26-30 years	17.8	9.6	15.1	22.6
31-35 years	17.1	12.6	15.4	20.4
36-40 years	14.0	13.1	14.6	14.3
41-45 years	9.5	11.4	10.6	8.9
46-50 years	9.9	13.2	11.1	9.5
51-55 years	9.4	16.3	11.5	6.8
56-60 years	5.7	10.8	7.0	3.9
61-65 years	2.2	4.9	2.4	1.4
66 years and over	1.0	2.5	0.7	0.5
Unknown	0.0	0.0	0.0	0.0
Total	100.0	100.0	100.0	100.0

RACE	All substances	Alcohol only	Alcohol with secondary drug	Heroin
White	62.2	67.8	63.3	68.9
Black or African-American	16.0	11.6	19.5	8.5
American Indian or Alaska Native	0.4	0.3	0.7	0.3
Asian or Native Hawaiian or Other Pacific Islander	1.0	0.9	0.7	1.0
Other	16.4	15.6	10.7	19.7
Unknown	4.0	3.8	5.1	1.7
Total	100.0	100.0	100.0	100.0

ETHNICITY	All substances	Alcohol only	Alcohol with secondary drug	Heroin
Hispanic or Latino	18.3	12.1	15.9	20.4
Not Hispanic or Latino	73.6	79.7	74.6	76.0
Unknown	8.1	8.2	9.5	3.6
Total	100.0	100.0	100.0	100.0

SOURCE: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration,

According to SAMHSA, approximately 48.7 million (ages 12 or older) were current cigarette smokers in 2017. According to the National Survey of Drug Use and Health (NSDUH), the percentage of Americans aged 12 or older reporting recent cigarette use declined from 26.0% in 2002 to 23.0% in 2010 and 21.3% in 2017. Since 2002, CT has seen the rates of cigarette use decline as well among those ages 12 and older.



	2010	2017
US, ages over 17	23	21.3
US, ages 12-17	8.4	3.2
CT, ages 12-17	8.4	3.5
Region, ages 12-17	8.7	4.8

Although there is a decline in cigarette use among youth, there has been an increase in use of e-cigarettes and electronic nicotine delivery (ENDs) devices. According to the 2017 DPH CT Youth Tobacco Survey (YTS) results show that 27.3% of youth (ages 12-17) reported using an e-cigarette in the past 30-days. In region 2, it is reported that 14.7% of youth reported past 30-day use. The use of e-cigarettes and other ENDs has become an emerging trend for youth, therefore, the data collected for past 30-day use and perception of harm of vaping/e-cigarette use is limited.

The 2017 YTS reported that 54.6% of youth believe that e-cigarettes are less harmful compared to cigarettes and 57.7% of youth reported using a flavored tobacco products in the past 30-days. In recent focus group discussions, the long-term health consequences associated with e-cigarette are unknown and youth are receiving mixed messages. In CT, the perception of risk of tobacco and cigarette use among youth (12-17) is 69%, and in region 2 among youth the perception of risk is 89%.

Consequence

In the state of Connecticut, the age to legally purchase any tobacco products is 18. Tobacco compliance operations are performed on a regular basis by CT Department of Mental Health and Addiction Services, as well as the Federal Food and Drug Administration (FDA). The 2017 DPH CT Youth Tobacco Survey (YTS) results indicate that among youth (under 18 years old) surveyed, 1.6% reported that they were refused sale of tobacco products in the past 30 days, while 19.4% were not refused sale. The retail violation rates for tobacco retailors has declined in CT from 14.8% in 2013 to 10.7% in 2016. In 2015, CT had the lowest retailor violation rate at 8.97%.

According to the US Surgeon General, of every three young smokers, one will quit and one will die of tobacco related causes. Nearly all tobacco use begins in childhood and adolescence. In fact, 80% of adult cigarette smokers who smoke daily, report that they started smoking by the age of 18.

The US Centers for Disease Control report the following:

- Over 16 million Americans have at least one disease caused by smoking.
- $170 billion in direct medical costs could be saved every year if we prevent youth from starting to smoke and help every person who smokes quit.
- Each year in the United States, adverse health effects from cigarette smoking account for an estimated 480,000 deaths.
- More deaths are caused each year by tobacco use than by HIV, illegal drug use, alcohol use, motor vehicle injuries, and fire-arm-related incidents.
- Smoking causes and estimated 90% of all lung cancer deaths and 80% of all deaths from COPD
- Compared to nonsmokers, smokers are at increased risk of coronary heart disease, stroke, lung cancer and COPD.

In 2016 the US Surgeon General released a report on 'E-Cigarette Use Among Youth and Young Adults,' which was the first report published by a federal agency that comprehensively reviews the public health concerns and impact of e-cigarette use. According to this report, the adverse health effects for youth who use e-cigarette could include:

- Nicotine addiction
- Developmental effects on the brain from nicotine exposure, which may have implications for cognition, attention, and mood
- Effects on psychosocial health, particularly among youth with one or more comorbid mental health disorders
- Initiating the use of other tobacco products, such as cigarettes, and illicit drug uses
- Battery explosion and accidental overdose of nicotine

Prescription Medication

Prescription drug abuse is the use of a prescription medication in a way not intended by the prescribing doctor. Prescription drug abuse or problematic use includes everything from taking a friend's prescription painkiller for your backache to snorting or injecting ground-up pills to get high. Most prescription drugs are dispensed orally in tablets, but abusers sometimes crush the tablets and snort or inject the powder. When a person takes a prescription drug for a nonmedical reason, it can quickly lead to addiction and the need for drug treatment. In fact, 25 percent of people who misused prescription drugs by age 13 ended up with an addiction at some point in their life.

Magnitude

The National Institute on Drug Abuse in 2016 estimated 54 million people over the age of 12 had used prescription drugs for nonmedical reasons in their lifetime. More people report using controlled prescription drugs than cocaine, heroin and methamphetamine combined. That puts prescription drugs second behind marijuana when it comes to illicit drug use. Most abused prescription drugs fall under four categories, based on the number of people who misuse the drug: Painkillers – 3.3 million users, Tranquilizers – 2 million users, Stimulants – 1.7 million users, and, Sedatives – 0.5 million users. The number of adults filling a benzodiazepine prescription increased 67 percent (from 8.1 million to 13.5 million) between 1996 and 2013, while the total quantity filled more than tripled. During this same time, the overdose death rate for benzodiazepines more than quadrupled.

Risk Factor & Subpopulations At-Risk

All populations are at risk for prescription pill abuse. Many times, prescription pill abuse begins in late adolescents with benzodiazepines and later with opioid based medication. Ages 18+ are also at risk based on prescriptions prescribed to them. In several shoreline communities, it was demonstrated based on hospital admissions that many elderly are over medicating and abusing prescription pain relievers.

According to the 2016-2017 National Survey on Drug Use and Health, past year use of pain relievers (Misuse of prescription psychotherapeutics is defined as use in any way not directed by a doctor, including use without a prescription of one's own; use in greater amounts, more often, or longer than told; or use in any other way not directed by a doctor) were higher for Connecticut than nationally and the Northeast region for ages 18-25.

Figure 2.1

	Past Year Use of Pain Relievers Ages 18-25	**Identified as having Pain Reliever Use Disorder Ages 18-25**
United States	**7.13%**	**.91%**
Connecticut	**7.52%**	**.95%**
Northeast Region	**6.62%**	**.86%**

Student survey data collected from funded coalitions, Youth Service Bureau's, Regional Behavioral Health Action Organization's, and school districts in Region 2 has been compiled for a snapshot of youth use and perception of harm in 2015 and 2017 in Figure 2.2. While perception of harm remains high for misuse of prescription medication in general, rates of use have not changed. There's been a significant decline in the misuse of prescription opioids among teens over the past 15 years. For example, Vicodin use among high school seniors dropped from 10.5 percent in 2003 to 2 percent in 2017. National Institute on Drug Abuse, December 2017)

Figure 2.2

CT Region 2 Grades 9-12	2015 Survey Data	2017 Survey Data
Past month Prescription drug use	**4.7%**	**4%**
Perception of harm of misuse of prescription drugs	**88%**	**89%**

Burden

There are many factors that can lead to the increased use of opioids. One factor is the increase in prescribing opioids. In the late 1990s, pharmaceutical companies reassured the medical community that patients would not become addicted to prescription opioid pain relievers, and health care providers began to prescribe them at greater rates. This subsequently led to widespread diversion and misuse of these medications before it became clear that these medications could indeed be highly addictive. Because of its cheaper price, heroin has become the drug of choice for many who are addicted to opioid pain relievers. Approximately three out of four new heroin users misused prescription opioids prior to using heroin.
According to Dr. Daniel Tobin, assistant professor of medicine at Yale University, 80% of opioid prescribers are primary care physicians, not pain specialists. Additionally, interstate 95 is an especially convenient roadway for drug traffickers. It connects New York City to Boston and also provides access to the US-Canadian border. Communities along the I-95 border, New Haven, Stamford, Bridgeport, and New London are vulnerable to drug trafficking operations. Interstate 91 runs north through New Haven into Massachusetts and Vermont into Canada. These two interstates make up what law enforcement officials refer to as the New England Pipeline

More than half of the 4.2 million Americans who misused prescription opioids between 2012 and 2014 also engaged in binge drinking, according to a new study released by the Centers for Disease Control and Prevention (CDC). CDC's analysis shows that people who binge drank were nearly twice as likely to misuse prescription opioids as non-drinkers. While young people who binge drank had higher rates of prescription opioid misuse, 2 in 3 people who binge drank and misused prescription opioids were age 26 years and older.

Capacity & Service System Strengths

According to the 2018 Connecticut Community Readiness Assessment for

Prescription Medication

Substance Abuse Prevention & Behavioral Health, in Region 2, 49.6% of respondents felt that prescription drug use was the substance of greatest concern among those ages 66 and older. The respondents also felt that their community's readiness to "raise awareness about substance abuse" was 3.16 on a scale of 1 through 4. The priority ranking for magnitude and impact of prescription drug use scored "low" by Region 2's workgroup.

There are 16 medication drop boxes located in police departments across Region 2 and that have reported collecting in excess of 2,000 pounds of expired or unused medication in the past year.

Connecticut is part of the New England HIDTA, encompassing Fairfield, New Haven, and Hartford Counties. The New England HIDTA is committed to dismantling drug trafficking efforts that mar the area by connecting a series of task forces throughout the region.

Connecticut has adopted a national framework ("Epidemic: Responding to America's Prescription Drug Crisis") to reduce prescription drug abuse and its adverse consequences. It has a four-point emphasis to: provide education for providers and patients; responsibly dispose of unneeded and extra medications; create Prescription Drug Monitoring Programs (PDMPs); and increase enforcement efforts. Connecticut, however, is one of only nine states that mandate the use of a PDMP. Under Connecticut law, all transactions involving Schedule II-IV drugs must be recorded in its system.

Marijuana

Marijuana is the most commonly use illicit drug nationally and statewide. Marijuana is a mixture of dried flowers of *Cannabis sativa*, and can be inhaled (smoked in joints, pipes or water pipes), ingested (edible or drink form), or vaporized. Vaporized (vaping) marijuana has increasingly grown as the preferred way to consume marijuana. The main psychoactive chemical in marijuana that producing mind-altering and intoxicating effects is tetrahydrocannabinol (THC). Vaping marijuana concentrated wax is becoming a new trend among young people, called dabbing or waxing, which is when concentrated resins containing THC are consumed.

Magnitude

The current political climate in our nation and state continues to be a contributing factor in the increase in marijuana use among youth. In 2011, marijuana became decriminalized in the State of Connecticut. Soon after in 2012, medical marijuana was passed and in 2016-2019, the legalization of recreational marijuana has been proposed. Many prevention, treatment providers, youth serving and faith based organizations in the State of CT have increased their efforts to educate legislators on the harmful effects that marijuana use has on youth, and how a decreased perception of harm has a direct correlation to youth having access and using marijuana underage. The perceived risk of marijuana use (12 years or older) is 26% nationally, 24% in CT and 51% in Region 2. Since decriminalization of marijuana in CT, legalization of medical marijuana in CT and other states legalizing marijuana for recreational use, we have seen a decrease in perception of risk/harm of marijuana use among youth. Youth report an unclear difference between decriminalization of marijuana and legalization. Many youth believe that by decriminalizing marijuana, it is now legal to use marijuana.

The following chart shows the past 30-day use of marijuana rates in the State of CT and in Region 2:

% Averages	CT	Region 2
Past Month Use for Ages 12-17	20.4	16
Past Month Use for Ages 18-25	66.3	
Past Month Use for Ages 26 and older	64.5	

Nationally, the total number of treatment admissions for marijuana use was over 240,000 as the primary drug at admission, 13.6% of all admissions for all substances. According to 2016 TEDS data, among adolescent admissions in Connecticut, marijuana and other stimulants were the most prevalent substances of abuse. In Connecticut, the total number of admissions for marijuana treatment was 7,826. Of the total admissions for marijuana treatment, 72.5 percent (5,674) were males and 37.2 percent (2,152) were females. Individuals that sought treatment for marijuana use in 2016, 38% were White, 37% were Black, and 16% other races; 29% were Hispanic or Latino. Marijuana was the primary drug at admission for youth ages 12-17 at 21.5%, as opposed to alcohol at .8% in 2016. Nationally, the total number of treatment admissions for marijuana use was over 240,000 as the primary drug at admission, 13.6% of all admissions for all substances. In Connecticut, among youth 12-17 that sought treatment reported marijuana as the primary drug upon admission, as opposed to alcohol at 0%. Individuals that sought treatment for marijuana use in 2016, 38% white, 37% black, and 16% other race. Also, 29% were Hispanic or Latino.

In recent interviews with Key Informants, it was discussed that 'they are witnessing patients in search of a diagnosis that will qualify them for a medical marijuana card.' In addition, many youth and young adults are self-reporting that they are using marijuana to self-medicate for an underlying issue, such as anxiety, stress or other behavioral health issues. Meanwhile, in focus groups the discussions included the concern around legalization of marijuana for recreation use, and the impact it will have on our youth in Region 2.

Capacity

According to the 2018 Community Readiness Survey by CPES, Key Informants believe that most community residents somewhat agree (2.59) that occasional use of marijuana is not harmful and somewhat disagree (2.46) that most community residents would support legalization of marijuana. Specifically in Region 2, Key Informants are between somewhat disagree and somewhat agree (2.31) that most community residents would support legalization of marijuana and (2.49) believe that community residents think that the occasional use of marijuana is not harmful.

Consequences

- Smoking marijuana frequently has been associated with increased reporting of health problems and more days of missed employment than nonsmokers.
- In the short-term marijuana use may cause adverse physical, mental, emotional, and behavioral changes such as problems with memory and learning, distorted perception,
- existing mental health concerns. difficulty in thinking and problem solving, loss of coordination, and increased heart rate.
- Longer term adverse health effects include respiratory illnesses, memory impairment, and weakening of the immune system. Long-term marijuana use causes changes in the brain similar to those seen after long-term use of other major drugs of abuse.
- Marijuana has been shown to compromise the ability to learn and remember information, often leading to deficits in accumulating intellectual, job or social skills.
- Initiation of marijuana use at younger ages has been linked to higher and more severe patterns of use of marijuana and other substances in adolescence and adulthood.
- Youth report using marijuana concentrated wax, which is a highly concentrated for of THC (50-99% THC).
- There have been reports of youth overdosing and being transported to the emergency rooms after adverse effect of vaping dab in Region 2.
- Depression, anxiety, and personality disturbances have been associated with marijuana use.
- Instant caused of dabbing can include, but not limited to: high anxiety, hallucinations, panic attacks, paranoia, psychotic break, increased heart rate and blood pressure, and overdose. These symptoms can be intensified or conditions worsen with persons with

Heroin is an illegal, highly addictive drug processed from morphine, a naturally occurring substance extracted from the seed pod of certain varieties of poppy plants.
Pure heroin is a white powder with a bitter taste that predominantly originates in South America and, to a lesser extent, from Southeast Asia, and dominates U.S. markets east of the Mississippi River. Highly pure heroin can be snorted or smoked and may be more appealing to new users because it eliminates the stigma associated with injection drug use.

Magnitude

According to the 2016-2017 National Survey on Drug Use and Health, .64% of people between the ages of 18-25 in the U.S. had used heroin in the past year, while in Connecticut, the rate for the age group was 1.31%. This age group had the highest rate of heroin use in state.
Heroin use of once or twice a week had the greatest perceived risk than any other substance among people aged 12 or older in the United States. (SAMHSA 2017).

In 2017, the Department of Health and Human Services (DHHS) declared a nationwide public health emergency with regard to the opioid crisis. On average, 130 Americans die every day from an opioid overdose. Approximately 68% of the more than 70, 200 drug overdose deaths in 2017 involved an opioid. There has been an increase in overdose deaths
and emergency department visits for overdoses nationally, with each increasing by approximately 30% from July 2016 through September 2017. In 2017, accidental drug overdoses in Connecticut resulted in 1038 deaths, up from 357 in 2012. More people died in Connecticut due to drug overdoses than car accidents or gunshot wounds combined. The
drug overdose death rate increased 12.8% from 2016 – 2017.6 In 2016, Connecticut ranked eleventh among all states in the highest rate of overdoses, with 27.4 deaths per 100 000 people.

The prominence of specific drugs has varied over time, but the current epidemic took root on the soil of prior epidemics. Among the more than 70,237 drug overdose deaths in the U.S. in 2017, the sharpest increase occurred among deaths related to synthetic opioids other than methadone, including fentanyl and fentanyl analogs, and tramadol; deaths from these drugs increased 45 percent from 2016 to 2017. This increase, combined with a higher suicide rate, has lowered life expectancy in the U.S. for the second year in a row. (NCHS Data Brief, No. 329. National Center for Health Statistics)

Connecticut's accidental intoxication deaths peaked in 2017 with 1,038 deaths due to opioids. Fentanyl was implicated in more than half of those deaths.
DMHAS Region 2 accidental intoxication deaths also peaked in 2017 with 242 deaths attributed to opioids.

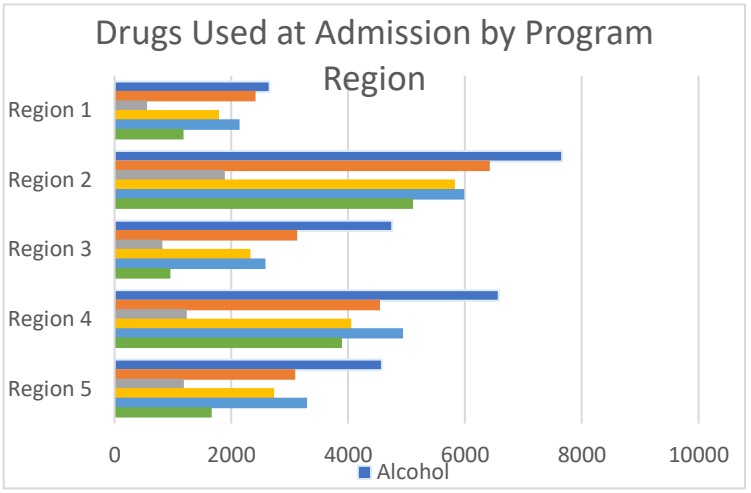
By the end of 2018, New Haven and Middlesex County had a combined 1,455 Emergency Department visits for suspected opioid overdose. During this same year, the total number of visits to an Emergency Department in CT was 4,554 Both regionally and statewide, the months of the year when these visits peak in May through July. Among DMHAS funded treatment admissions to Substance Abuse programs in 2018, heroin was the most frequently

reported drug. Among Substance Abuse Out Patient programs, 13,000 people were engaged in Medication Assisted Treatment (DMHAS 2018) A total of 4,425 people engaged in some form of Opioid Treatment in 2018 in DMHAS Region 2 – with 1,425 from New Haven alone.

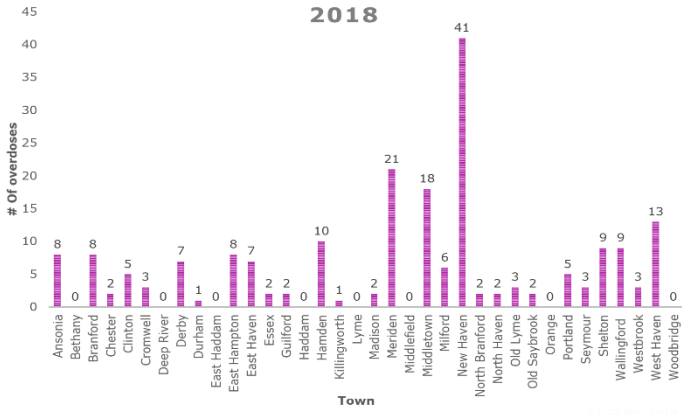
The following table illustrates primary substance at admission for young adults (18-25) for 2018:

	Program region					Total
	Region 1	Region 2	Region 3	Region 4	Region 5	
Alcohol	2655 45.9%	7665 49.9%	4754 56.2%	6576 53.1%	4577 52.2%	26227
Heroin, Non-prescription Methadone	1959 33.9%	4708 30.6%	2322 27.5%	3350 27.1%	2304 26.3%	14643
Other Opiates	208 3.6%	662 4.3%	298 3.5%	343 2.8%	318 3.6%	1829
Crack, Cocaine	229 4.0%	712 4.6%	391 4.6%	522 4.2%	394 4.5%	2248
Marijuana, Hashish, THC	576 10.0%	1061 6.9%	555 6.6%	1315 10.6%	735 8.4%	4242
Other	155 2.7%	557 3.6%	135 1.6%	272 2.2%	437 5.0%	1556
Total	5782	15365	8455	12378	8765	50745

In 2018, Region 2 had more admissions for heroin than the other regions (DMHAS 2018):



The number of overdoses in Region 2 towns are depicted with the highest rates noted in the cities of New Haven and Meriden:



Burden

The rising prevalence of opioid use disorder (OUD) in pregnancy has led to a sharp increase in neonatal abstinence syndrome (NAS), a constellation of physiologic and neurobehavioral signs exhibited by newborns exposed to addictive prescription or illicit drugs in utero. Between the years 2004 to 2013, the incidence of neonatal

abstinence syndrome tripled in the United States. The annual number of NAS hospitalizations in Connecticut has more than doubled in the past decade. (CT Medicine 2019)
Within DMHAS Region 2, the Middlesex County region had the second highest rate of neonatal abstinence syndrome between 2015-2017 at 2.80 (per 10,000). Connecticut's rate of NAS per 10,000 women in 2017 was 6.54. (DPH office of Injury Prevention 11/28/2019).

According to The Ripple Effect: The Impact of the Opioid Epidemic on Children and Families, March 2019, states that four overarching problem areas that need to be addressed:

• Pervasive stigma, misunderstanding, and fear about SUD and treatment;
• Failure to make the ripple effect a public and political priority, which exacerbates a shortage of family-centered treatment options and inadequate funding for programs that work;
• Silos in government and service organizations that lead to lack of communication, coordination, and collaboration, particularly regarding risk assessment of children and reporting requirements;
- Missed opportunities to identify children at risk and provide them and families with essential support.

Government policymakers, health care providers, and community agencies are working to identify individuals misusing opioids and enroll them in appropriate treatment programs. Concurrently, law enforcement agencies are focused on controlling the supply of drugs fueling the epidemic—not just prescription opioids but, increasingly, street drugs like heroin and fentanyl.

Capacity & Service System Strengths
Connecticut has utilized federal funding (State Targeted Response) to implement community-based initiatives that include: opioid overdose awareness, Narcan administration training, Screening, Brief Intervention and Referral to Treatment screening programs, statewide media campaign, and, expansion of Medication Assisted Treatment programs.

DMHAS Region 2 has distributed 813 Narcan kits and educated more than 600 people in 2018 on opioid overdose prevention in its' communities.

According to the 2018 Connecticut Community Readiness Assessment for Substance Abuse Prevention & Behavioral Health, in Region 2, 20.8% of respondents felt that heroin was a substance of concern in our communities for those ages 18-25. Alcohol and Prescription drugs were more of a concern for all age groups. According to Region 2's Priority Ranking Matrix for Heroin, the *impact* of this substance on our communities rated low at 2.75.

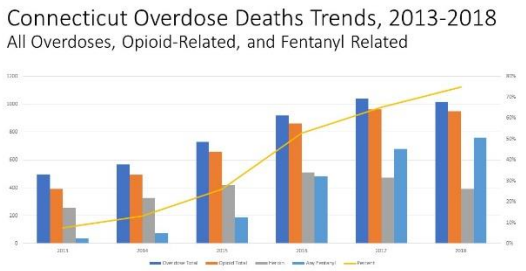
Opioids are a class of drugs that include the illegal drug heroin, synthetic *opioids* such as fentanyl (50 to 100 times more potent than morphine), and pain relievers available legally by prescription, such as oxycodone (OxyContin®), hydrocodone (Vicodin®), codeine, morphine, and many others.

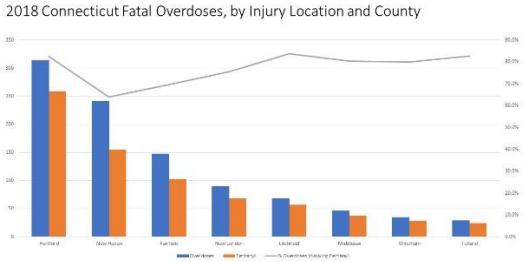
Magnitude

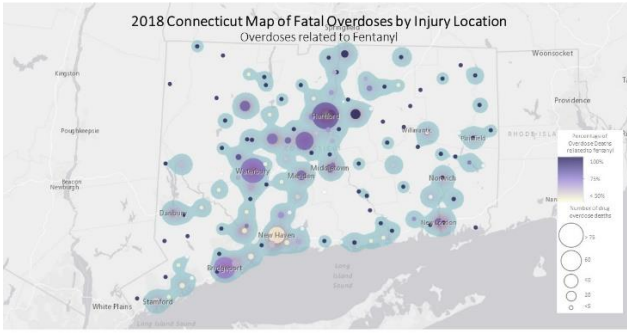
More than 130 people die a day in the United States from overdosing on opioids. Reports across the US and here in CT indicate an increase in fentanyl-related overdose deaths. Over the past two years fentanyl has been outpacing heroin in overdose deaths in CT. According to 2017 CT OCME data, 677 decedents were attributed to fentanyl, this is more than half of the overdose deaths in CT. Many of these deaths are due to the cheaply made illicitly manufactured fentanyl analogs. Synthetic opioids like fentanyl are now the most common drugs involved in overdose deaths in the United States, according to the National Institute on Drug Abuse. A study conducted by the National Institutes of Health utilizing the national opioid abuse surveillance system from 2012-2016 indicates a sharp increase in fentanyl. Findings included: "Total past-month fentanyl-use rose modestly from 2012 to 2016. While use of known fentanyl products remained relatively stable (mean=10.9%; P=0.25), endorsements of 'unknown' fentanyl products nearly doubled from 9% in 2013 to 15.1% by 2016 (P<0.001). Data show no discernable indication that this increase is diminishing or stabilizing." The increase in the illicit synthetic opioids is due to several factors: lower cost to manufacture, higher profit, higher potency, not reliant on cultivation of plants, can be cut or sold into other drugs, pressed into counterfeit prescription pills, and sold through the dark web.

The below graphics were created from the Overdose Response Strategy by: Robert Lawlor Jr., Drug Intelligence Officer, Sarah Ali, Public Health Analyst - New England High Intensity Drug Trafficking Area (HIDTA)

County	City	Overdose	Fentanyl	Percentage
Fairfield	Shelton	9	6	66.7%
Middlesex	Chester	1	1	100.0%
Middlesex	Clinton	6	6	100.0%
Middlesex	Cromwell	2	2	100.0%
Middlesex	East Hampton	2	2	100.0%
Middlesex	Middletown	18	15	83.3%
Middlesex	Old Saybrook	4	2	50.0%
Middlesex	Portland	5	4	80.0%
Middlesex	Westbrook	3	1	33.3%
New Haven	Ansonia	5	4	80.0%
New Haven	Branford	9	6	66.7%
New Haven	Derby	8	4	50.0%
New Haven	East Haven	8	2	25.0%
New Haven	Guilford	2	2	100.0%
New Haven	Hamden	11	8	72.7%
New Haven	Madison	1		0.0%
New Haven	Meriden	22	18	81.8%
New Haven	Milford	10	5	50.0%
New Haven	New Haven	43	20	46.5%
New Haven	North Branford	1		0.0%
New Haven	North Haven	1		0.0%
New Haven	Orange	1	1	100.0%
New Haven	Seymour	4	2	50.0%
New Haven	Wallingford	7	4	57.1%
New Haven	West Haven	13	8	61.5%







Risk Factors and Subpopulations At-Risk

All populations who use illicit drugs are at risk of overdosing from a synthetic opioid. These illicit opioids are being mixed in with other drugs and many times users are unaware they are using a drug with a synthetic opioid mixed in. According to the CT OCME data, the highest risk population are white males aged 36-45. However, deaths among African – Americans and Hispanics are beginning to increase.

Burden

Illicit opioids continue to be a national epidemic and significant public health issue. It is costing communities millions in social and economic welfare which include healthcare costs, employment costs, addiction treatment, social service costs, and criminal justice costs. The devasting consequences are significant and include increases in fatal overdoses as well as increases in children being raised by grandparents or involved with the DCF. In addition, rates of babies being born with neonatal abstinence syndrome are increasing. Within DMHAS Region 2, the Middlesex County region had the second highest rate of neonatal abstinence syndrome between 2015-2017 at 2.80 (per 10,000).

Capacity & Service System Strength

Connecticut has utilized federal funding (State Targeted Response) to implement community-based initiatives that include: expansion of opioid treatment, law enforcement partnerships to engage at risk populations into treatment, opioid overdose awareness, Narcan administration training, Screening, Brief Intervention and Referral to Treatment screening programs, statewide media campaign, and, expansion of Medication Assisted Treatment programs.

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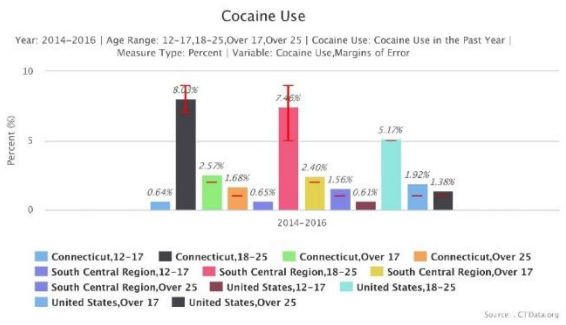
Connecticut is part of the New England HIDTA, encompassing Fairfield, New Haven, and Hartford Counties. The New England HIDTA is committed to dismantling drug trafficking efforts that mar the area by connecting a series of task forces throughout the region. They continue to partner with public health and local law enforcement to provide education on this emerging threat and work in partnership to combat the threat.

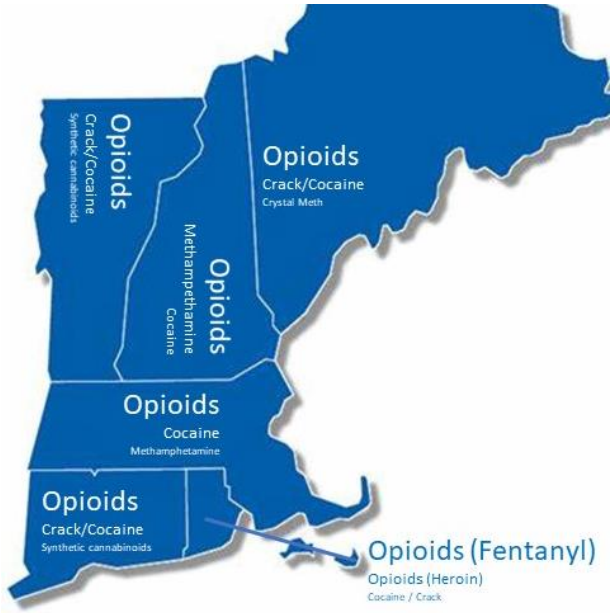
Cocaine, also known as coke, is a strong stimulant mostly used as a recreational drug. It is commonly snorted, inhaled as smoke, or dissolved and injected into a vein. The rock/crystalline form known as crack. Along with its pain reduction effects, cocaine also speeds up heart and breathing rates. The brain will also release dopamine, a neurotransmitter associated with pleasurable feelings and general positivity. Street dealers may also mix it with other drugs such as the stimulant amphetamine, or synthetic opioids, including fentanyl. Increasing numbers of overdose deaths among cocaine users might be related to tampered / cross contaminated cocaine.

Magnitude

Cocaine continues to rise in CT and in region two. Data from the 2014-2016 National Survey on Drug Use and Health (NSDUH) illustrates that 12% of residents aged 12 and older used cocaine in the southcentral region of CT, which is comparable to CT's rate of approximately 12% compared to the US average of 9%. The trend in CT has seen an increase in the past several years. According to the 2017 Youth Risk Behavior Surveillance Survey (YRBSS) data, 3.9% of high school students in Connecticut reported using some form of cocaine in their lifetime. Youth survey data for region two also had very low rates consistent with the YRBSS data.



The chart below from New England High Intensity Drug Trafficking depicts- Trends across New England: Increasing Synthetics, Stimulants and Changing Drug Delivery Systems



Risk Factors & Subpopulations At-Risk

Cocaine is reported to be increasing among young adults according to a longitudinal (1975-2015) study conducted by *Monitoring the Future national survey results on drug use.* The study found that past year use of cocaine among those aged 19-28 increased from 3.9 percent in 2013 to 5.0 percent in 2014 and 5.7 percent in 2015. The NSDUH data also illustrates that cocaine use among adults 18-25 has increased and 7 out of every 10 new cocaine users are aged 12 or older. Treatment data illustrates primary substance at admission for young adults (18-25) for 2018 in Region two for crack /cocaine is 4.6% or 712 individuals.

Burden

In 2017, cocaine was involved in 350 overdoses in CT, of those deaths 65 were in region two. Cocaine is readily available in CT especially in the form of crack. The cost for a gram of cocaine in the region is about $60-$85. Cocaine use over time leads to addiction which impacts communities throughout the State. The impact cocaine abuse causes can be classified into two categories: criminal justice and health consequences. Many times, people addicted to cocaine can spend more than $200 a week to fuel their addiction which leads them to committing property crimes in search of funding their addiction. This leads to increase use of the juvenile justice system and incarceration costs. Health consequences are also broad and far reaching. Health consequences include disability, increased costs for hospital / emergency room visits, as well as specialized treatment. Other health consequences include: cardiovascular disease, including hypertension, arrhythmia, cardiomyopathy, myocarditis, myocardial ischemia, myocardial infarction, erosion of dental enamel, rhinitis, perforation of nasal septum, seizures, lung damage, pneumonia, chronic cough, acute renal failure, sexual dysfunction, spontaneous abortion in pregnant women, and infections (HIV, hepatitis B or C, tetanus) from sharing needles. In addition to physical health consequences, psychological consequences include: anxiety, depression, suicidal feelings and behaviors, insomnia, emotional instability, irritability, aggressive behavior, and psychotic symptoms. Symptoms of psychiatric disorders such as schizophrenia, panic disorder, depression, or mania can be triggered or exacerbated by cocaine use or withdrawal.

Capacity & Service System Strength

While the opioid epidemic is overshadowing other drugs, both treatment providers and law enforcement are aware of the continued use and increase in cocaine in region two. Unlike alcohol and opioids, cocaine there is not medication assisted treatment for cocaine. Many cocaine user's preference is to use crack and most of them are poly substance users. Treatment providers understand the complexity of substance use disorders and implement the best practices for the disorder which is usually a combination of treating the primary substance along with any other co-occurring mental health disorders. In the 2018 Community Readiness profile for region two, cocaine was of very little concern for key informants. Connecticut is part of the New England HIDTA, encompassing Fairfield, New Haven, and Hartford Counties. The New England HIDTA is committed to dismantling drug trafficking

efforts that mar the area by connecting a series of task forces throughout the region.

Gambling Disorder is the term used by the American Psychiatric Association in the 5th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) to describe the most severe form of the disorder (American Psychiatric Association, 2013). According to the DSM-5, gambling disorder is indicated by four (or more) of the following: preoccupied with gambling, unable to cut back or control, irritable or restless when attempting to cut down or stop gambling, risks more money to reach desired level of excitement, gambles to escape problems or depressed mood, chases losses, lies to family and others about gambling risks or loses relationships or job because of gambling, or, relies on others for financial needs caused by gambling.

The many labels used to describe gambling problems are a source of confusion for the public and frustration for researchers. Commonly used terms include “problem”, “at risk”, “compulsive”, “disordered”, and “pathological” gambling. These various terms reflect the efforts of researchers to describe the different levels of severity observed among people with gambling problems.

Magnitude

According to some estimates, gambling is a $137 billion-dollar industry in the United States. Two million U.S. adults meet the criteria for pathological gambling (the most severe level of gambling addiction), and another four to six million are considered problem gamblers. And the earlier a person is introduced to gambling, the more likely they are to become problem gamblers as adults – or even earlier.

According to the National Survey on Gambling Attitudes and Gambling Experience (NGAGE) report in 2019, 83% of adults in Connecticut participated in some form of gambling during 2018. The top three gambling activities that CT adults participated in where: any lottery game (74%), raffle ticket (55%), and casino activity (48%).

Of U.S. residents ages 14-21, approximately 2.1 percent struggle with problem gambling. Another 6.5 percent are at-risk. Gambling problems relate to accessibility. Rates of problem gambling are twice as high among persons who live within 50 miles of a casino relative to those who do not. The development of a new casino in East Windsor in the near future, will mean every resident in the state will live within 40 miles of a casino. Persons with substance use disorders, and even those with family histories of substance use problems, are at increased risk of developing gambling problems. Persons with psychiatric conditions suffer from gambling problems at extraordinarily high rates, and up to one-third of persons with gambling disorder attempt suicide. (Clinical Journal of Psychology, 2005)

Data collected from student surveys in Region 2 for all forms of gambling show that:

Region 2 CT Youth Data (grades 9 through 12)	**2016-2017**
Gambled in the past year	17%

Burden

The National Council on Problem Gambling notes the annual cost associated with gambling (crime, addiction, and bankruptcy) is $17 billion. The burden of problem gambling is not limited to the gambler. For every problem gambler, it is estimated that six or more other individuals are affected financially, socially and psychologically. Although many people participate in lotteries, and go to casinos, the largest share of total money spent comes from a small minority of heavy gamblers.

Increases in gambling problems will require greater need for social services in CT, including:
police assistance with gambling-related crimes and violence, economic support for those experiencing gambling-related divorce, job loss, and bankruptcy, and treatment for medical and psychiatric problems associated with gambling problems.

In 2018, the World Health Organization (WHO) classified gaming disorder in their *International Classification of Diseases* (*ICD-11*). The *ICD-11* is a list of diseases and medical conditions that health professionals use to make diagnoses and treatment plans. Gambling at the ages of 10 or 11 can seem innocent and harmless, but studies have shown that children who are introduced to and begin gambling by age 12 are four times more likely to become problem gamblers. That early introduction can be critical in the development of a gambling addiction. We must educate our kids about the potential dangers of gambling in an effort to prevent future gambling addiction.

Capacity & Service System Strengths

There is good evidence for many methods of effective prevention, including restrictions on availability and access, regulating game features, and management of risk behavior.

Region 2 has trained a cadre of facilitators in DMHAS Problem Gambling Services' *Community Awareness Program* which raises awareness of gambling as a risky behavior and mental health disorder. Additional community efforts include student education for middle and high school aged youth on risks of gaming and gambling, and student led public service announcements.

According to the 2018 Connecticut Community Readiness Assessment for Substance Abuse Prevention & Behavioral Health, in Region 2, 36% of respondents felt that the issue of problem gambling was "a little important" in their community, while 26% felt that it had no importance in their community.

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

Behavioral health describes the connection between behaviors and the health and well-being of the body, mind and spirit. This would include how behaviors like eating habits, drinking or exercising impact physical or mental health.
Behavioral health also includes both mental health and substance use, encompassing a continuum of prevention, intervention, treatment and recovery support services.

Magnitude

According to the 2016-2017 National Survey on Drug Use and Health, the rate of "any mental illness" for people ages 18-25 in the U.S. was 23.93% and comparable to CT for the age same group at 25.56%. This same age group had the highest rates for "major depressive episode" both in the U.S at 11.95% and CT at 13.10%. One in six Connecticut adults in 2016 had ever been diagnosed with depression (15.9%). The prevalence for having depression among adults in CT was greater for those identifying as women, disabled adults, household earnings less than $35,000, Hispanic adults, and Black adults. Those receiving mental health services in the past year in the U.S (in-patient, out-patient, use of prescription medication, not to include substance abuse treatment) were greatest for ages 18-25 at 13.9%. This rate was higher for CT with 18.42% receiving mental health services for the same age population.

Risk Factors & Subpopulations At-Risk

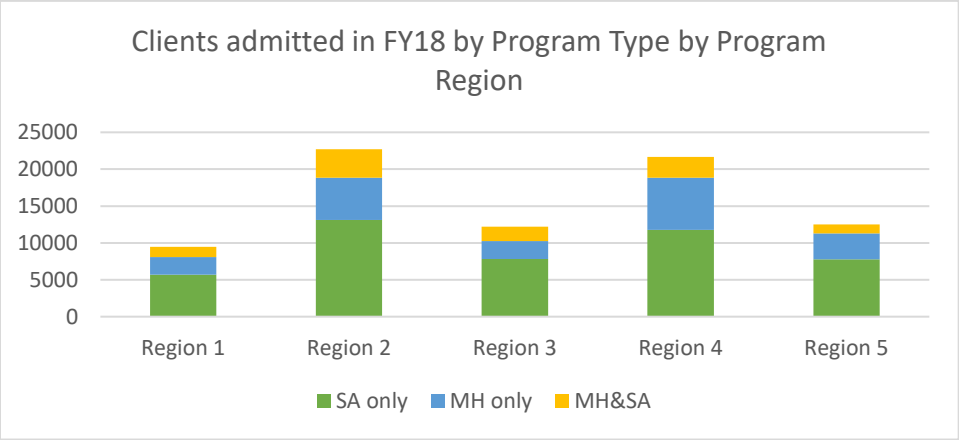
The Connecticut Department of Public Health in December 2018 showed that three out of five adults in CT reported having experienced at least one "adverse childhood experience" (ACE), and 21.2% reported three or more. In CT, emotional abuse (27.2%) and parents that are separated or divorced (26.2%) are the most prevalent ACE events. ACEs are stressful or traumatic events, including abuse or neglect, and household dysfunction. Adverse Childhood Experiences are also associated with increased risk of mental health and substance use disorders in adulthood.
Participant' in each regional focus group categorized social media and screen time as a major contributing factor to adolescent mental health in our Region 2 communities. A recent study published in the Journal of Clinical Psychological Science finds that "increased time spent with popular electronic devices — whether a computer, cell phone or tablet — might be contributing to an uptick in symptoms of depression and suicidal thoughts."
The rise of anxiety and depression disorders among students in elementary school is evidenced by the increase use of Emergency Mobile Psychiatric Service calls. Clifford Beers in New Haven provides EMPS to a catchment area covering 17 towns. Table 2.1 illustrates the call volume from the Lower Naugatuck Valley in Region 2 during two consecutive years.

Table 2.1

Town	Number of calls from July 1, 2017-June 30, 2018	Number of calls from July 1, 2018-May 2019
Ansonia	61	94
Derby	59	87
Seymour	60	48
Shelton	77	73

Region 2 data in Table 2.2 illustrates the number of people utilizing mental health treatment services was more than any of the other state's regions.

Table 2.2



Substance	Number of Admissions	Percent of Admissions
Heroin	3,851	34.7%
Alcohol	3,516	31.7%
Marijuana, Hashish, THC	1,502	13.5%
Other Opiates and Synthetics	638	5.8%
Cocaine	485	4.4%
Crack	388	3.5%
PCP	275	2.5%
Benzodiazepines	257	2.3%
Other	175	1.6%

Source: CT DMHAS accessed via ctdata.org

Substance Abuse Treatment Admissions by Drug Type (FY 2016)

Burden

Heath conditions, including mental health conditions, impact not only the person who is living with the health condition but also their family and the greater community, especially if health conditions restrict the person's ability to engage in community life and contribute to the nation's economic output. Serious mental illness is associated with an annual loss of earnings totaling over $193 billion. The economic impact of mental health conditions is compounded by the high unemployment rate for these individuals. Most people who live with mental health conditions prefer paid employment and independence to relying on government for income support and medical benefits (as cited in NAMI report 'Road to Recovery: Employment and Mental Illness).

Behavioral health services account for less than 8% of all health spending, with great opportunities for cost savings. People with behavioral health issues are at higher risk for physical illness and disability. As the leading cause of disability worldwide, 300 million people live with depression. Close to 40 percent of the population are affected by an anxiety disorder in their lifetime; Nearly 70 million people worldwide struggle with eating disorders, and one person around the world dies by suicide every 40 seconds.

Capacity & Service System Strengths

The Medicaid expansion under ACA means that more Connecticut residents are covered by insurance and therefore eligible for mental health and substance abuse services. While the increased coverage is good for Connecticut citizens, this may place increased pressure on providers within the state as mental health and substance abuse services become more accessible. It is important to recognize that the recent election may destabilize the mental health and substance abuse system. While some aspects of the ACA may remain, the elimination of ACA has the potential to increase the number of uninsured in the state making increased numbers more dependent on the state's safety net at a time when Connecticut's economy is incapable of paying for service needs that were previously covered by Medicaid.
Connecticut is one of the few states that has maintained or increased funding for mental health services and supports over the past few years. Yet, people with these health conditions are still dealing with wait lists for crucial supports including supportive housing and employment services. The Department of Mental Health and Addiction Services (DMHAS) has made employment services a central part of its recovery-oriented system of care and supports several employment programs across the state.
Currently, Connecticut has 56 full-time equivalent behavioral health care professionals in designated shortage areas and facilities with behavioral health care professional shortages. In order to address the shortage issue, 89 more full-time professionals are needed in these areas, 31 of whom in correctional facilities. *Source: Health Professional Shortage Areas (HPSA), HRSA Data Warehouse, 03/16/2018*

According to the 2018 Connecticut Community Readiness Assessment for Substance Abuse Prevention & Behavioral Health, in Region 2, the majority of respondents "somewhat agree" that the community would support measures to early identify mental health problems in children and youth. Respondents reported also they that "somewhat agree" that there is concern for adults needing access to mental health services.

According to Region 2's Priority Ranking Matrix, mental health ranked as the issue of greatest concern and, having the most *impact* within our communities. Mental health also ranked as having the highest consequence of inaction.

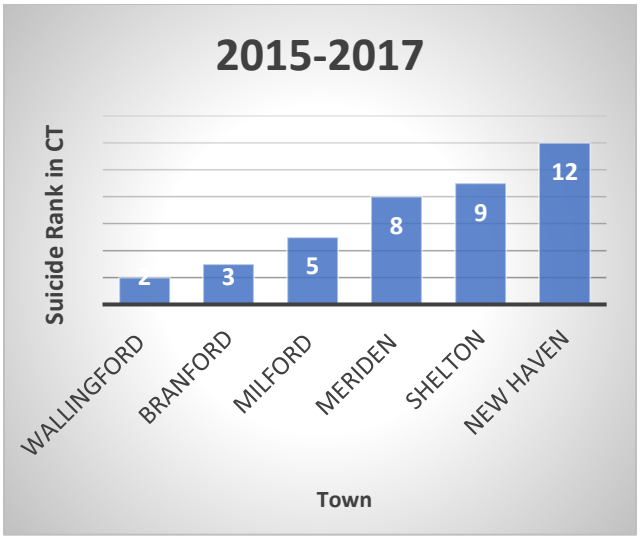
Suicide is a complex issue involving numerous factors and should not be attributed to any one single cause. Not all people who die by suicide have been diagnosed with a mental illness and not all people with a mental illness attempt to end their lives by suicide. Suicide is not about a moral weakness or a character flaw. People considering suicide feel as though their pain will never end and that suicide is the only way to stop the suffering.

Magnitude

Suicide was declared a public health crisis in the United States as long ago as 1999 by the Surgeon General. According to the National Center for Health Statistics, it remains the 10th leading cause of death in the United States. Suicide was the 12th leading cause of death for all ages in CT in 2017(afsp.org 2017.)

Risk Factors & Subpopulations At-Risk

Connecticut's Department of Public Health reported that Connecticut had 388 suicides in 2016 with the average age of the decedent to be 50 years old .
Suicide was the 2nd leading cause of death for ages 15-34 in CT in 2017, and second for young adults in college in the ten- year span of 1999-2009. According to data provided by University of CT Health Center (UCHC) and OCME the CT averages 308 suicides per year with more men then female completing suicide. The 36 towns in Region 2 which comprise part of New Haven County and Middlesex County reported 411 suicides between 2010 -2014.
Between 2015 -2017 the overall suicide rank in Connecticut for towns in Region 2:



Medication overdose suicide attempts have more than doubled in the U.S. since 2000, and more than tripled for girls. According to The Journal of Pediatrics, researchers at Nationwide Children's Hospital in Ohio, reported that from 2000 through November of 2018 found more than 1.6 million suspected suicide attempts by self-poisoning in children and young adults, ages 10 to 24. The research is the latest in a string of evidence in recent years showing suicide is on an upward trend, including last year's report from the Centers' for Disease control that showed that suicide was a leading cause of death across the U.S., with increasing rates in nearly every state.

According to *Crisis Text Line,* from 2015 to present, 18.6% of the texts received from Connecticut were related to suicide. Suicide was the top third reason that texters accessed this service. Crisis Text Line is a free 24 hour a day, 365 days a year support for those in crisis accessible from all 50 states.

CT and Region 2 youth appear to have comparable problems with other US youth when reviewing the data from the 2017

Youth Risk Behavior Survey (YRBS). Overall in CT, 26.7% of students in grades 9-12 reported feeling sad or hopeless for two weeks in a row during the past 12 months before the survey. CT Region 2 survey data shows that 19% of youth reported feeling depressed most or all of the time in the last 30 days during the 2017-2018 year. Additionally, 11% of students in CT Region 2 had attempted suicide in the past 12 months in 2017.

Burden

Suicide has no single cause or group of causes that can give a complete explanation to it and affects the health of various communities in which the suicide occurred. Overall mortality, particularly in the middle years, is increasing as a result of the so-called deaths of despair due to suicide, alcohol, opioids and liver disease. (May 2019, Christine Moutier, AFSP)

In the United States, as attitudes evolve regarding mental health and suicide prevention, the national rate of suicide has risen 33% over the past two decades with a price tag of $70 billion annually. Suicide cost CT an average of $1,163,740 per suicide death in combined lifetime medical and work loss. Although 94% of American adults believe mental health is equally important as physical health, most do not know how to identify changes in mental health that signal serious risk, nor what to do in response. In addition, those people contemplating suicide or previously attempted end up disabled due to injuries sustained from attempting such as brain injury or other mental health problems.

Capacity & Service System Strengths

Greater understanding and awareness of mental health and suicide prevention throughout communities are proven to reduce the rates of suicide in those communities. Prevention for psychiatric illness can start early, suicide prevention can be built into every school and pediatric clinic, and children and adults can be taught strategies that protect and enhance cortical brain development. (May 2019, Christine Moutier, AFSP)

The CT Suicide Advisory Board (CTSAB) has functioned as the single state-level suicide advisory board in CT that addresses suicide prevention and response across the lifespan. It is cooperatively co-chaired by the CT Departments of Mental Health and Addiction Services and Children and Families (DCF), and is legislatively mandated under DCF.

The Statewide Suicide Network of Care has been working to increase capacity across the state. Recipients of a two-year CT NCSP funding in Region 2 included Clinton Schools, Derby Public Schools, Guilford Schools and Durham-Middlefield School districts. Implementation of suicide awareness and prevention through curriculum- based instruction, was implemented for hundreds of students and educators in elementary, middle and high school grades in 2019.A number of health care providers have also adopted the “Zero Suicide” initiative. This approach aims to improve care and outcomes for individuals at risk of suicide in health care systems. While this approach involves revising practices and policy, it is voluntary. Currently in Region 2, Hartford Healthcare affiliates in Middletown and Meriden, as well as BHcare sites have adopted the Zero Suicide initiative. We are fortunate to have Question, Persuade, and Respond (QPR) trainers and CONNECT (suicide prevention) trainers in our region. These trainers have

been working to promote the ONE WORD, ONE VOICE, ONE LIFE campaign throughout the region. The addition of QPR training to community-based Narcan instruction in Region 2 engaged more community residents in overall suicide prevention efforts by highlighting the connection of Opioid Use Disorder to suicide.

According to the 2018 Connecticut Community Readiness Assessment for Substance Abuse Prevention & Behavioral Health, in Region 2, 94.0% of respondents agree that "suicide prevention efforts (such as educational programs, training, policies, and identification and referral of individuals at risk of suicide) are needed in the community." However, the assessment shows that there is only "some support" in the region for suicide prevention efforts.

Discussion of resources, strengths, assets in the region

Many resources, strengths and assets were identified in Region 2. The region boasts a variety of behavioral health providers that provide comprehensive services across the continuum of care. Participants stated all levels of care are present even though some may be more limited than others in the region. Increased access to services is being reported in areas of the region through expansion of satellite service office locations, medication assisted treatment (MAT), intensive outpatient groups, and open access appointments. The CTaddictions.com and 1-800 number with up to date information is helpful for providers and community residents in learning about bed availability and reducing frustration with cold calling agencies. In addition, ancillary services such as expansion of recovery coaches in outpatient centers and emergency rooms along with a growing number of family support groups.

First responders reported having improved communication and connection with behavioral health providers. They also reported that a culture shift continues within their field, which is assisting in reducing stigma and improving interactions with vulnerable populations. The first responders also reported that many departments are encouraging employees to attend trainings such as Mental Health First Aid Trainings (MHFA) and Crisis Intervention Trainings (CIT), and learn about new innovative programs in CT and the nation.

Another strength is the attention and funding addressing the opioid epidemic has increased discussions about mental health issues and suicide. This is helping to reduce stigma and shame for both mental health and substance use disorders, and increasing readiness to address concerns in many communities. It has also assisted in communities and providers applying for and accessing grant funding for behavioral health issues. New programs / resources mentioned in the area include but are not limited to: Meriden Opioid Referral for Recovery (MORR) program, Bridges Mobile Addiction Treatment Unit, Middletown's Ministry Support Program, New Haven Innovative Community Engagement (NHICE), the Children's Center Recovery Outreach Program, Parent Child Resource Center's Today's Choices Program, and a new suicide prevention foundation. Additionally, the State Targeted Response and State Opioid Response mini grants along with suicide prevention grants have assisted communities in providing prevention programs in their schools and communities. The Ever-fi curriculum, a free resource

for schools has also been an enhancement not just for prescription drug education, but also for financial literacy and other substances of abuse.

Discussion resource gaps and needs in the region.

While significant progress has been made in Region 2 over the past several years, many gaps and needs in the region continue to be present need to be addressed. Top concerns in the region include the areas of treatment, prevention, and integration.

Treatment concerns continue to focus on the lack of one stop shop for behavioral health needs. This includes the segregation of adult and youth, as well as family. It also includes the lack of comprehensive services for mental health and substance abuse combined and offered by one service provider. Services for older adults is challenging in both the area of mental health and substance abuse. The greatest challenge discussed for this sub-population included that Medicare insurance creates several barriers for alcohol treatment, as well as therapists not covered for mental health care. This barrier is creating lack of detox and in-patient care for older adult substance abuse treatment. An additional mental health barrier is older adults that have worked with a therapist and when their insurance changed to Medicare, their therapist is not accepted by Medicare or does not meet the Medicare requirements.

The sub-population of people with current substance use and mental health disorders has some challenges in receiving care. Again, the eligibility requirements to access the service are not met or the client has been “kicked out” of the program and when brought back they are not accepted.

The sub-population of adolescents with a behavioral health condition has many barriers. The first barrier is not having a specific detox for adolescents besides the ambulatory emergency department. Regarding mental health care for adolescents and children, there is no place to take them other than an Emergency Department of a local hospital. It was repeated in all focus groups that hospital sites have substantial grid lock and youth are admitted and discharged over several days until they were admitted for the level of care needed. Concerns were also discussed about the stress of waiting for hours in an Emergency Department, being released

and feeling helpless in managing their children's condition. When children are discharged or referred after using the crisis services, parents are faced with long wait times to access children's services.

The LGBTQI sub-population access to care is an issue across the lifespan. This sub-population has increased rates of methamphetamine which is now a concern for some police departments in the region. Law enforcement has described it as well hidden, and the drugs are being delivered to people's homes in the suburban communities via the postal service.

Medication Assisted Treatment (MAT) was discussed as having several barriers to services. These barriers include: providers having staff trained but uncomfortable with MAT, and providers having a hard time hiring qualified staff. It was mentioned that many private for-profit providers or private physicians who offer MAT services only accept cash payments and do not offer the behavioral health services along with the MAT. Access to methadone is a quality of life issue. The available methadone services are all located in New Haven. This creates several barriers which include travel, employment, and child care. These barriers exist because of the strong regulations in place of methadone and the need to access it daily.

Two other areas identified included the disabled population's access to services if they are home bound, and the insurance barriers in which age requirements do not match with commercial insurance ages. It was also stated that group therapy, if utilized should be more targeted as some clients do not feel the group is the right fit (i.e. mixing of various substances used in one group) or the age ranges of group members is too broad.

Housing remains a concern for behavioral health clients. The lack of safe and affordable housing creates challenges for individuals especially those recently in recovery. Sober homes and half way houses vary across the region and state. While many of these homes support recovery efforts, others are not safe because of illicit substance use occurring in some homes.

The opioid epidemic has overshadowed the alcohol issues that continue to remain a concern for many people and communities. First responders stated that the residents they encounter under the influence of alcohol are released within a few hours from the hospital and they are

back responding to the same individual. Community members and family members experience the same frustration. The frustration is that the person is not fully detoxed and placed in a program or connected to services at the point of contact. In most cases the person is assessed, stabilized, and released. The concern is why we are not addressing alcohol like we are with opioids and offering immediate treatment.

Regarding police initiatives that address substance and mental health related arrests, there are only two in the region. Neither the HOPE initiative or the Meriden MORR with only a few months of operation seems to be working. The New Haven LEAD program is the other program and program information is not readily shared or communicated with community partners. First responders in the area stated they would like to have clinicians and recovery coaches available to respond to calls. In addition, they would like an alternative location other than the

Emergency Department to transport people who do not necessarily need ED services but a higher level of care from mobile crisis. It was stated that on certain days or times the mobile crisis wait is up to five hours.

Prevention needs, and gaps were discussed in the region. One of the most pressing needs throughout the region focused on vaping and vaping products. Specifically, the need for vaping to be treated as a substance use disorder and primary prevention services for vaping of not just nicotine but of marijuana among young people. Reduced, sporadic, outdated, non-evidence based, or non-existent health curriculum in middle and high school classes is also a concern in the region. Along with this concern arose the lack of gambling/ problem gambling prevention in high schools. It was stated that many young adults in recovery are engaging in on-line gambling and it is a concern among recovery oriented young adult services. The gaming, social media and screen time effects highlighted the need for education on brain health and the impact of media. The discussions regarding media and gaming also prompted the concern that young adults are lacking life skills. This was a concerning trend shared among providers assisting young adults with behavioral health issues, impeding recovery and employment for the young adults.

The loss of primary prevention focused on substance abuse and mental health was a top concern in the region. This concern arose from recent regionalization of programs and feeling

disconcerted that new funding opportunities are solely focused on single substances. Participants voiced the concern that we need to focus on the roots of prevention and community-based efforts addressing all substances while promoting behavioral health. The lack of attention and effort to reach young students and teach them about mental wellness needs to be addressed. It was mentioned that we need to seek an expansion component to the Gizmo suicide prevention curriculum. This is more than attempting to get schools to integrate the Signs of Suicide (SOS) curriculum into the high schools. Advocating for mental wellness curriculum and discussion should be integrated in pre- k through 12th grades.

Recommendations

The following seven recommendations have been compiled for Region 2 based on the CNAW and interested other feedback:

1. To have a better coordinated system of all behavioral health issues in elementary, middle and high school levels.
2. Expansion of Certified Prevention Specialist (CPS) staffing at the RBHAO's to further enhance primary prevention consisting of all behavioral health issues and other

prevention concerns such as gaming and social media along with the ability to provide localized training and workshops.

3. Expansion of recovery coaches to community- based settings and police / fire departments.

4. First responders to have clinicians available to respond with them to assess if the person truly needs to go to the emergency room, as well as a triage center in which people can be helped with avoiding the emergency department and the revolving door.

5. Treatment should be comprehensive and one stop shop addressing the entire family and not segregation of adult and children's services, as family issues and supports are needed.

6. Develop universal trauma screenings for K-12 population students to address trauma through trauma informed schools.

7. Develop a comprehensive plan to address the potential of legalized marijuana. This issue is complicated and affects providers, educational systems, and communities. Providers are struggling with the co-use of marijuana among clients and clients who are arriving under the influence for appointments and groups. It is also an issue in sober living situations. Law enforcement are concerned as they do not have the means to conduct road side sobriety for marijuana. Lack of funding and expansion of the Drug Recognition Expert (DRE) officers is expensive and an intense and lengthy training for officers. Drug Endangered Children training should be expanded to local police departments with the emerging threat of legalized marijuana. Educational systems are experiencing the issue of marijuana use through vaping devices and the need to test confiscated vaping devices for marijuana. Currently, not all communities have the resources available to test confiscated devices or to enforce current school policies regarding substance use. This also led to the need for consistent restorative justice

practices for students who may have a substance use disorder from vaping nicotine or marijuana.

Appendices

Focus Group Questions

Focus Group Summary Chart

Notes

BHPSW Participants

APW Community Readiness Report

Required Stakeholder Questions for Regional Priority Reports

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

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

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

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

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

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

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

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

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

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

Answer Summary Grid for DMHAS Required Stakeholder Questions

1. How appropriate are available services to meet the needs of:								
Of Substance Use?			**Of Mental Health?**			**Of Problem Gambling?**		
Prevention	**Treatment**	**Recovery**	**Prevention**	**Treatment**	**Recovery**	**Prevention**	**Treatment**	**Recovery**
There are many, and varying prevention services available, however most communities are not aware of these resources. YSB's, funded coalitions and the RBHAO should provide a data base of the various services. Participants agreed that most prevention is youth focused. Collaborations have been formed since the RBHAO acquired additional towns. Not all are on board with partnering to increase efficiency.	***Availability of treatment services varies by town and city. Abundance of services in Greater New Haven and Middlesex area, however, shoreline communities and Lower Naugatuck Valley residents must travel to larger city to get SA inpatient, methadone, and detox treatment. Adolescent SA inpatient and detox beds continue to be discussed as a need. MAT resources were mentioned as part of out-patient treatment resources.***	***Participants are largely not aware of the recovery services available in their area of the region. Community based self-help support groups like AA and NA were most often mentioned. Knowledge of family support services and their availability was minimal.***	**Early education in trauma and developing trauma informed systems in the schools**	***It was echoed by participants in each focus group that major hospital's in the region (Yale, Middlesex) are sending people home from Emergency Departments with no follow up and no referral for appropriate services. Law enforcement continues to be burdened with repeat calls for the same BH or SA issue not being addressed.***	***There is one CCAR Young Adult and Family Program service center located in Derby. A handful of participants were aware of its existence in the region. SMART Recovery groups are available only in the larger cities :New Haven, Milford, Meriden, and West Haven. There is room for more recovery support.***	***Prevention of problem gambling resources are limited by location and primarily focused on youth.***	**Expand to target other ethnicities as most helpline callers are white males 18-35**	***Participants were not aware of recovery support resources in their local regions.***

2. What Prevention Program, strategy, or policy would you like most to see accomplished:		
Related to Substance Use?	**Related to Mental Health?**	**Related to Problem Gambling?**
Consistent School District Policy addressing vaping Legalization of recreational marijuana legislation should not move forward	**Provide enhanced education and training be provided to the hospitals and specifically emergency room professionals, so they would have more compassion for those with behavioral health disorders**	**Guidelines to enforce age restrictions for sports betting and on-line gaming in CT. More prevention at the high school level**
3. What treatment levels of care do you feel are unavailable or inadequately provided related to:		
Related to Substance Use?	**Related to Mental Health?**	**Related to Problem Gambling?**
Higher levels of care for the older adult population with alcohol use disorder. Current MAT services just deal with OUD – should address alcohol as well. ***Lack of detox for adolescents***	**Grid lock of adolescent in the emergency room and police need to keep responding until the adolescents receive higher levels of care.** **Not enough residential care**	**Low awareness of problem gambling treatment resources**
4. What adjunct services/support services/recovery supports are most needed to assist persons:		
With substance use issues?	**With mental health issues?**	**With problem gambling issues?**
Recovery coaches in the community to work with people being discharged from the emergency room with alcohol use disorder to connect them with services	***Recovery homes / sober living homes could be an asset, but insurance needs to cover these services.***	**Young adults in recovery are gaming and participating in on-line gambling and more peer support outreach is needed.**

Answer Summary Grid for DMHAS Required Stakeholder Questions (continued)

5. What would you say is the greatest strength/asset of:		
Substance use prevention, treatment and recovery service system?	**Mental health promotion, treatment and recovery service system?**	**Problem gambling prevention, treatment and recovery service system?**
Strong local networks of providers across the region **MAT expansion**	**First responders reported having stronger connections and communication with mental health providers**	**We are lacking in this area as nobody answered this question in prevention, treatment and recovery. There is a lack of awareness.**
6. Are there particular subpopulations(for example veterans, LGBTQ, Latinos, etc.) that aren't being adequately served by the:		
Substance use service system?	**Mental health service system?**	**Problem gambling service system?**
Youth LGBTQI **ALICE population** **Older Adults** **Post release from incarceration** **Those living in poverty**	***Children in need of psychiatric services, young adults on the spectrum with BH issues that have left high school.***	**Young adults in recovery** **High school students**
7. What are emerging prevention, treatment or recovery issues that you are seeing or hearing about regarding:		

Substance use issues?	Mental health issues?	Problem gambling issues?
The increased rates of use by students of vaping THC products accompanied by low perception of harm by students and parents. ***Treatment of alcohol use disorders in the older adult population is not adequate to accommodate the referrals.*** ***The legislation to legalize recreational marijuana is of great concern to all participants given the increase need for treatment by adolescents.*** ***The prolific use of medical marijuana among the 18-30 age group who already have behavioral health and substance use disorders.***	***BH and SA within family systems (trauma induced) were discussed at all workgroups.*** ***Severe emotional disturbance and/or psychiatric disorders seen at earlier ages as evidenced by EMPS calls to schools and subsequent hospitalizations.*** ***School districts becoming the "catch all" for students with un-met BH needs.***	**The unaddressed college population who are gaming and gambling**

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

Support for the recovery friendly workplaces and communities.
Support consistent law enforcement initiatives as they vary across the state.
More communication regarding grant opportunities.
Integration of family services (children and adults together)

BHPSW Members 2019

Jodi Brazal	Town of East Hampton
Divinna Schmitt	town of Old Saybrook
Melissa Ferrara	resident
Kelly Edwards	Clinton YFS
Lindsey Lehet	Haddam/Killingworth YFS
Winifred Olsen	CAC 10
James Olsen	East Hampton LPC/Coalition
Alfred D'Arena	resident
Heather McNeil	Old Saybrook YFS
Susan Consoli	Old Saybrook
Krystle Blake	Rushford
Allyson Nadeau	Beacon Health Options
Erika Skoutas	Hartford Healthcare
Noah Morgenstein	Project Courage Works
Megan Goodfield	River Valley Svs.
Bob Lisi	Ansonia Youth Services
Silvia Rodriguez	Shelton Youth Services
Nancy Phund	Woodbridge Youth and Family
John Saccu	Derby Youth and Family
Yolanda Dacey	CCAR
Cathy Kellitt	Griffin Health Services
Shawn Heffernan	Asst. Chief Branford Fire Dept.
Sgt. Brooks	Guilford Police Dept.
Lt. David Emmerman	East Haven Police Dept.
John Masci	Dpty Chief Branford Fire Dept.
Taylor Quijuano	Americorp Member
David Eldridge	Shelton Police Dept.
Carissa Casserta	Nagutuck Valley Health Dept.
Julia Marakarian	parent
Pat Lahaza	Echo Hose Ambulance
Tony Corniello	Bhcare
Patricia Tarasovic	Valley United Way

2018 Connecticut Community Readiness Survey Results:
Region 2 South Central: APW

Developed by the Department of Mental Health and Addiction Services

Center for Prevention Evaluation and Statistics at UConn Health

October 2018

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

dmhas

CPES
Center for Prevention Evaluation and Statistics

Connecticut Community Readiness Survey (CRS) Objectives

CPES
Center for Prevention Evaluation and Statistics

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

Connecticut Community Readiness Survey (CRS) Approach

- Instrument developed through a consensus process involving DMHAS, its Resource Links, State Advisory Committee and UConn Health;
- Administered biannually statewide since 2006;
- Web-based survey implementation supplemented by paper surveys ;
- CT Clearinghouse coordinates e-mail distribution of the survey;
- Regional Behavioral Health Action Organizations (formerly Regional Action Councils) identify 5-10 key informants per town/city to survey;
- RBHAOs conduct active outreach and follow up with key informants to encourage participation and maximize responses;
- Data analysis by the DMHAS Center for Prevention Evaluation and Statistics at UConn Health;
- State and regional results are disseminated to RBHAOs to support planning;
- This approach resulted in **975** responses to the 2018 CRS survey statewide, with representation in **163** of 169 communities.

DMHAS Regional Behavioral Health Action Organizations (RBHAOs)

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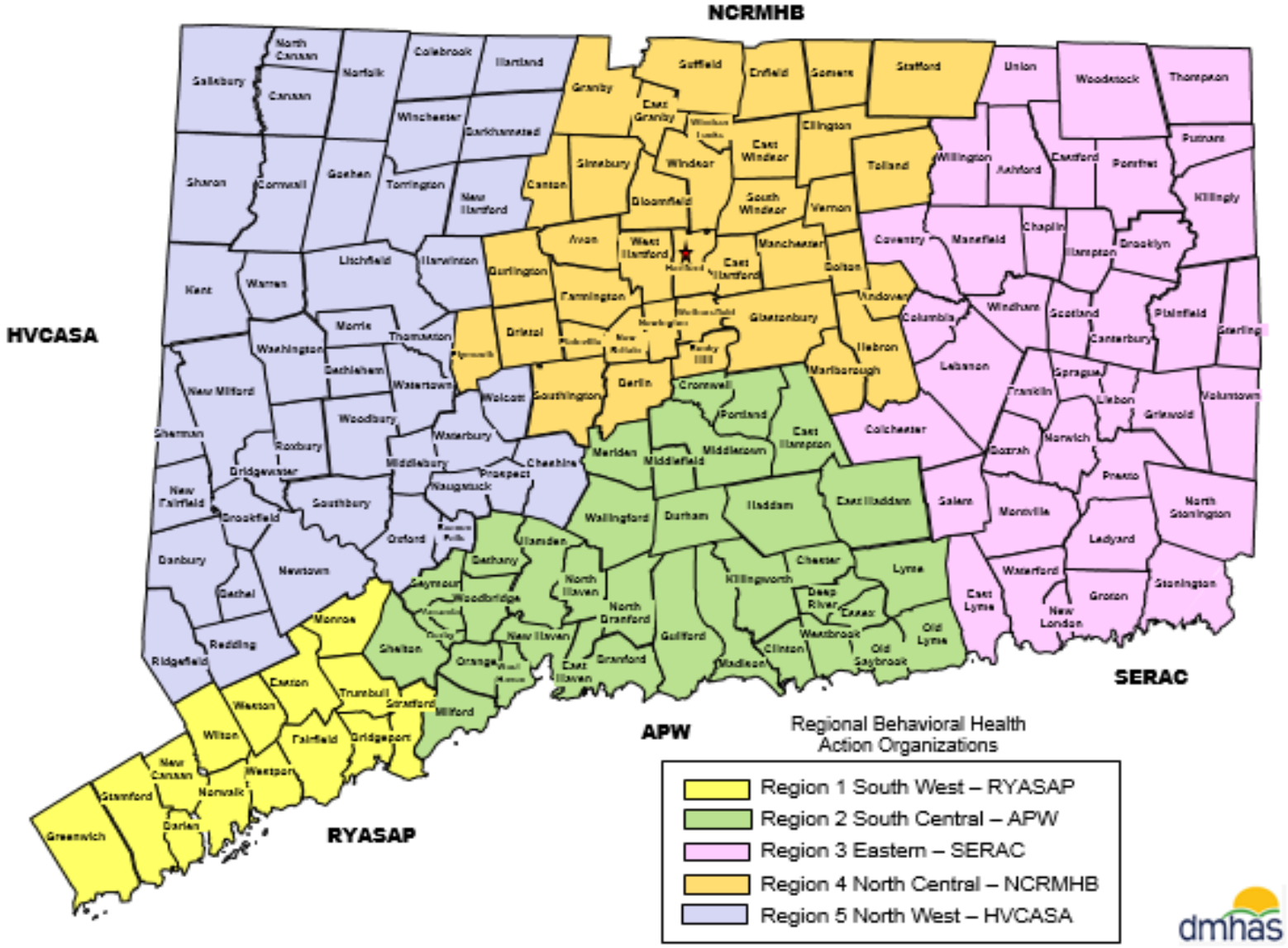

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Key Informant Demographic Characteristics: APW CRS, 2018

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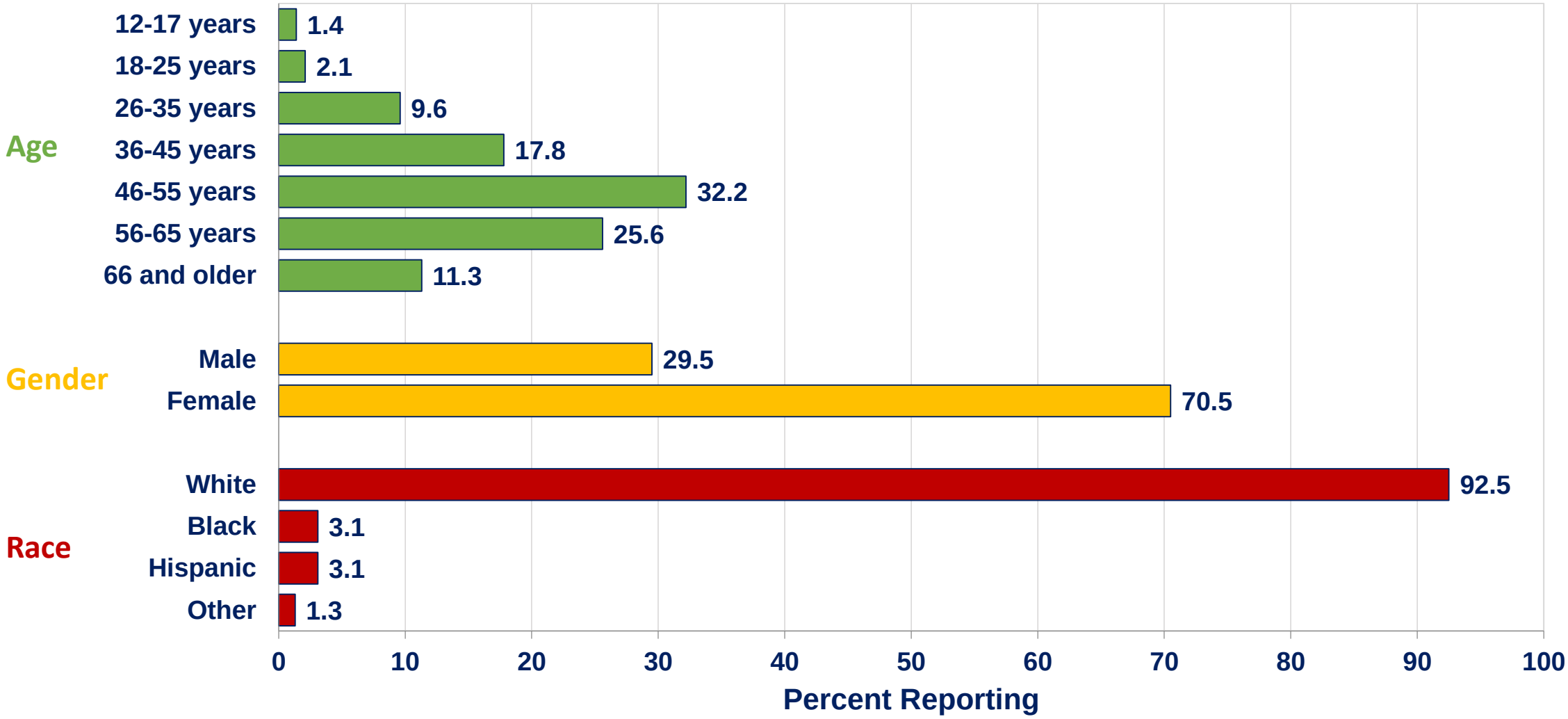
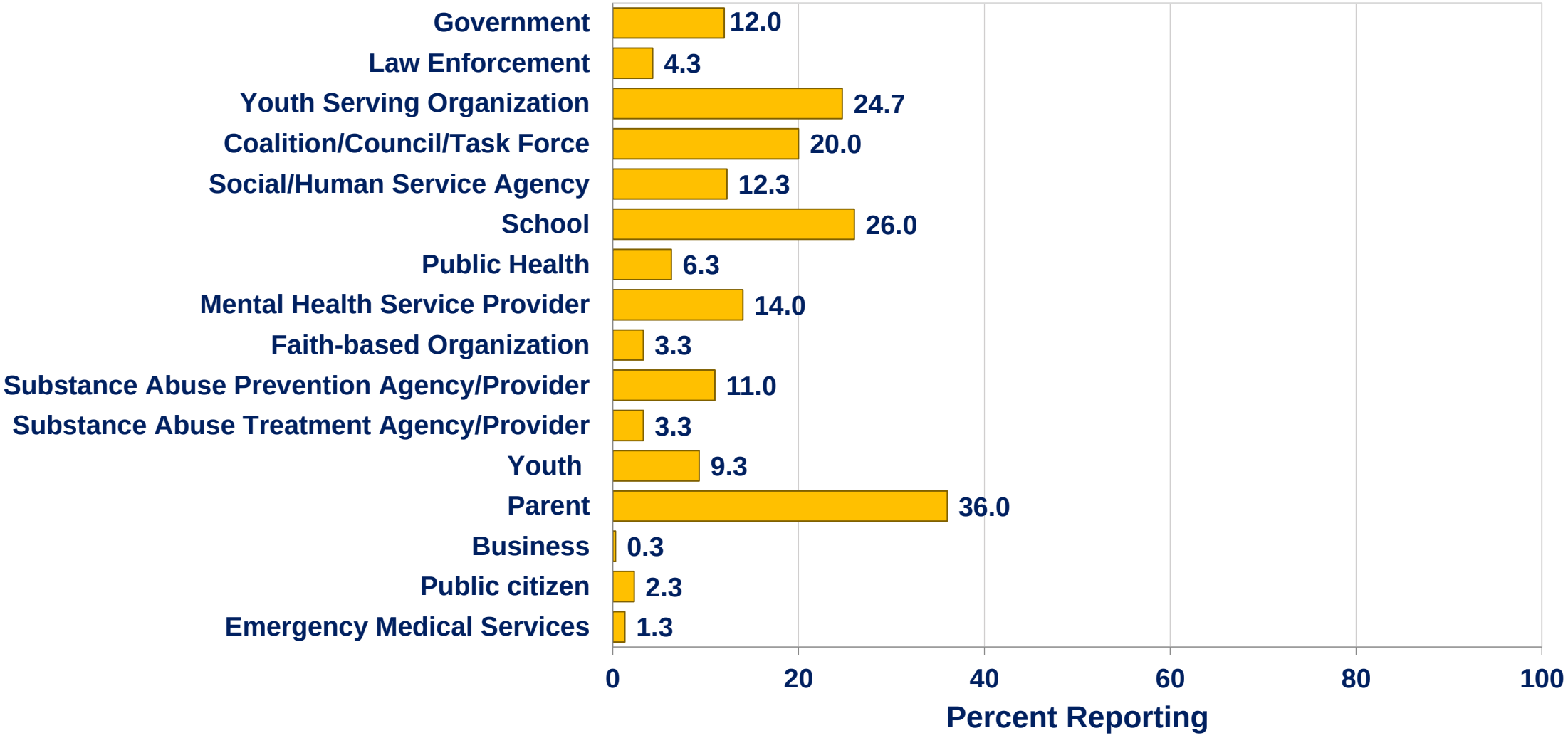


Key Informant Stakeholder Affiliation: APW CRS, 2018



Problem Substances of Greatest Concern According to Key Informants By Age Group: APW CRS, 2018

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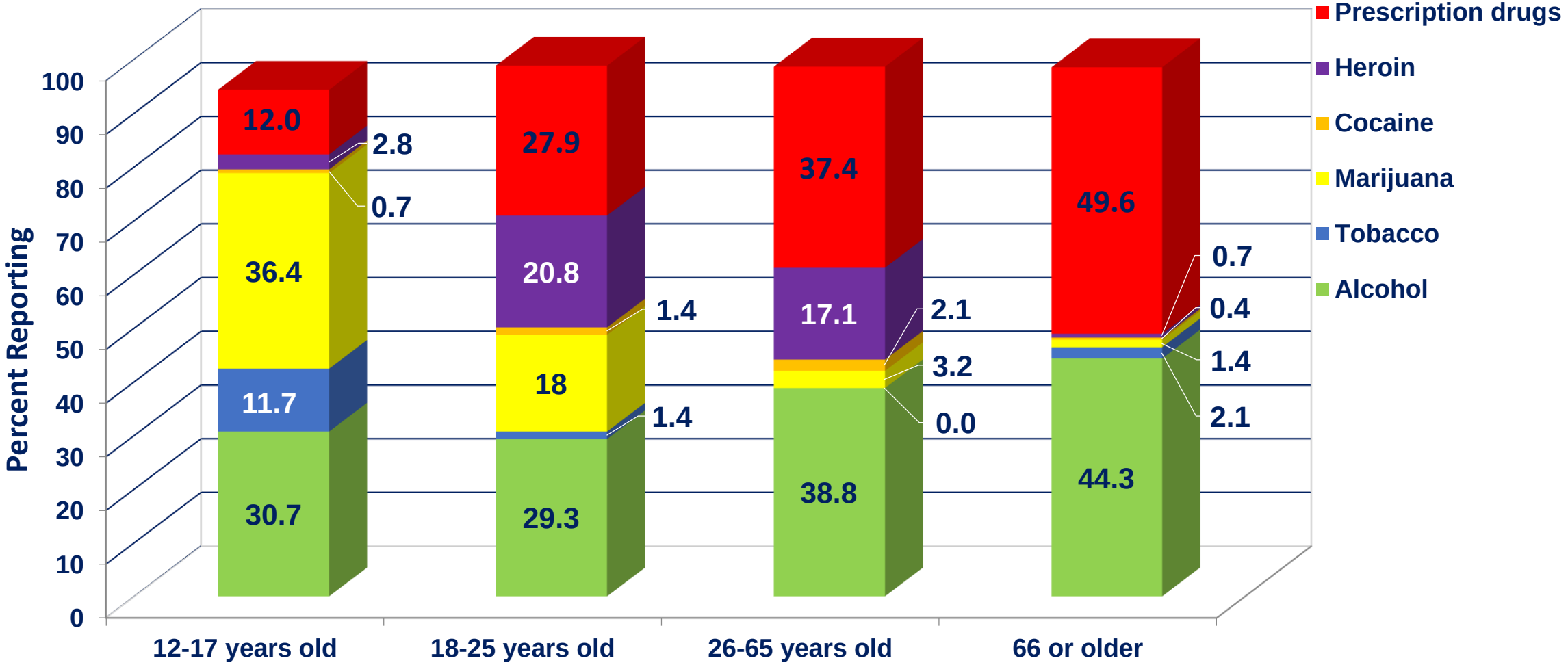

Community Attitudes Toward Substance Abuse Prevention [Q10]: APW CRS, 2018

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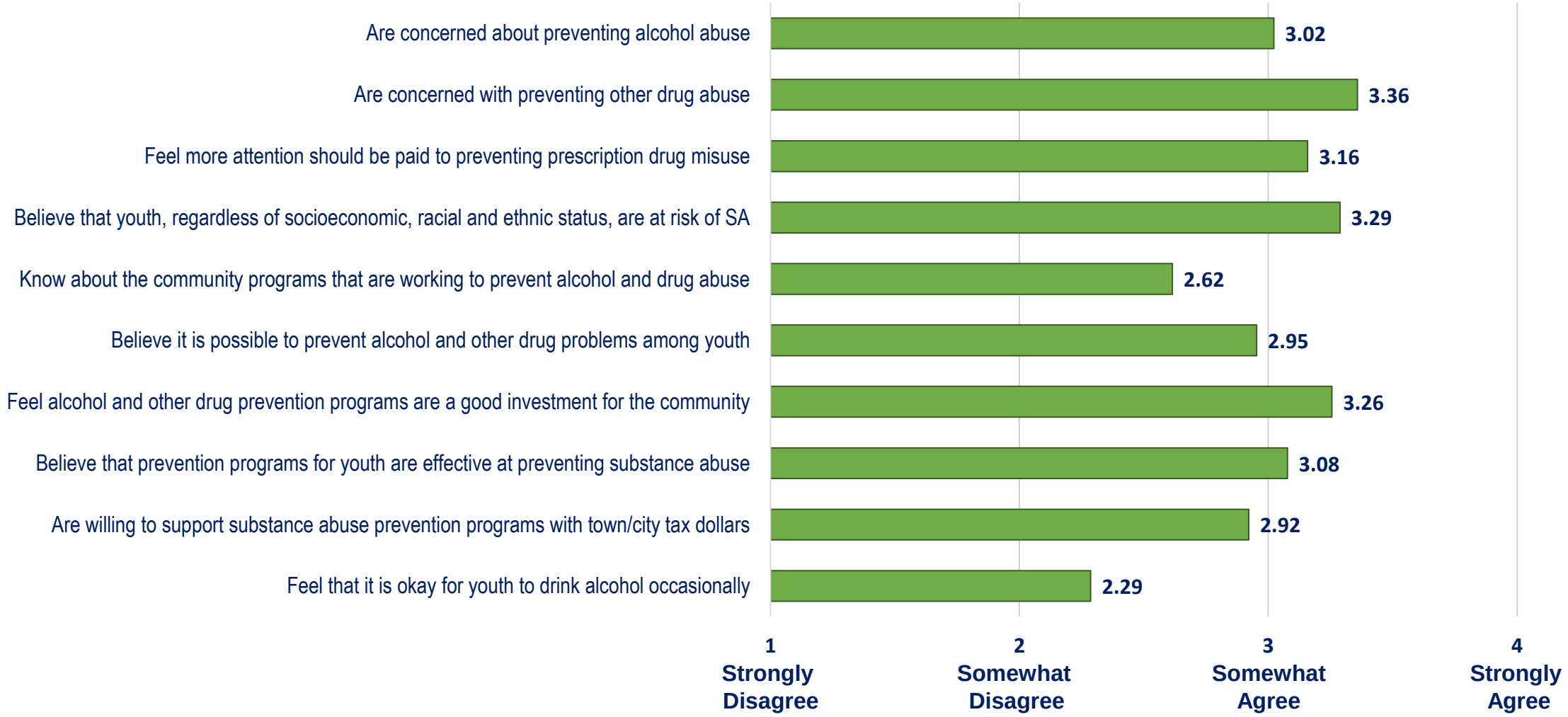
Key Informant believes that most community residents ….



Community Attitudes Toward Substance Abuse Prevention [Q10]: APW CRS, 2018

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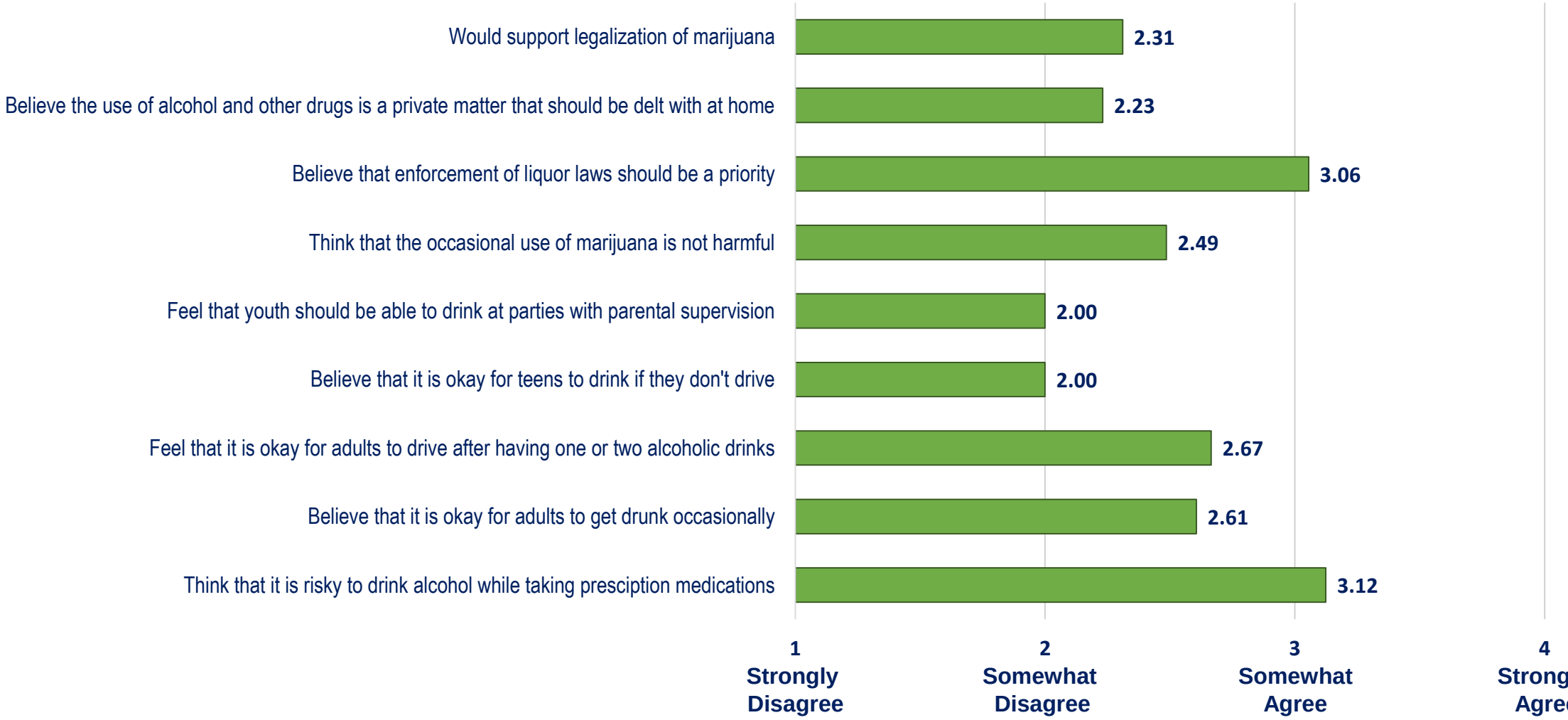

Key Informant Ratings of Substance Abuse Prevention Strategies in the Community [Q11]: APW CRS, 2018

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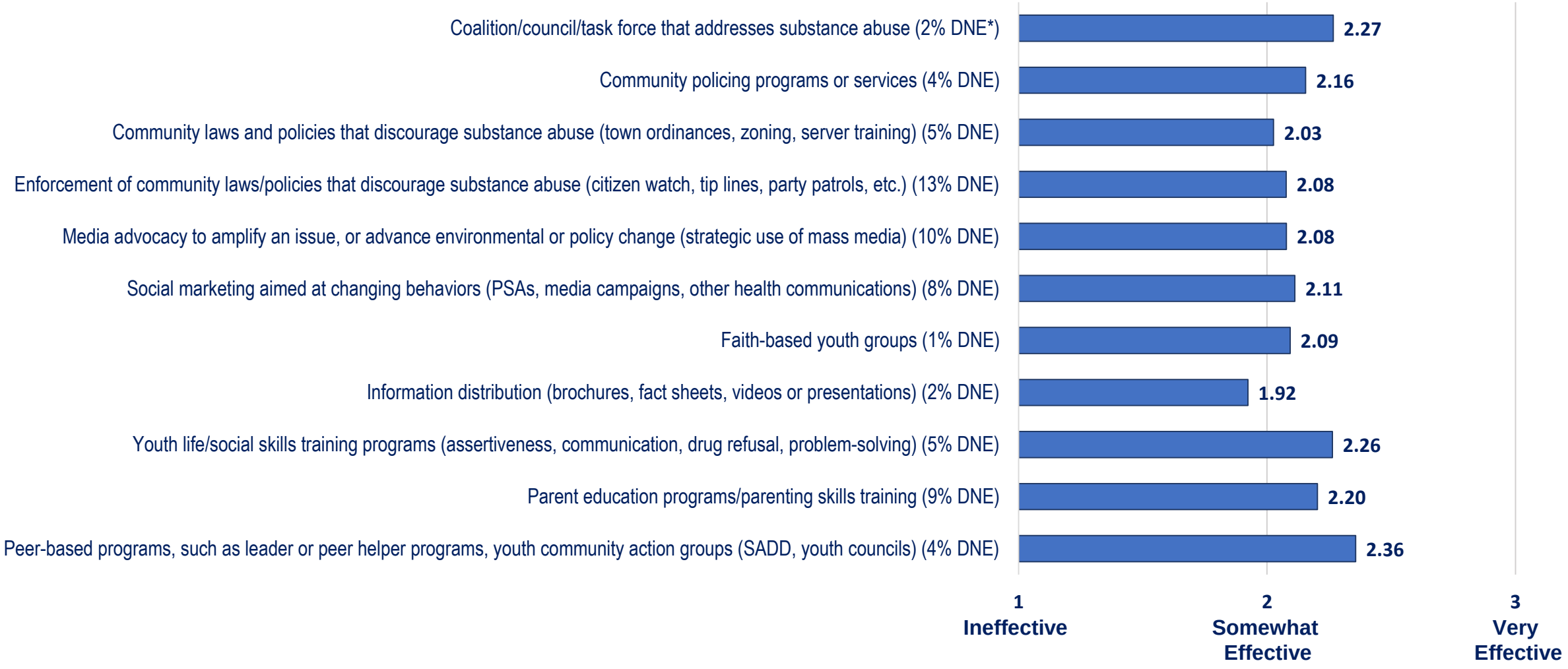
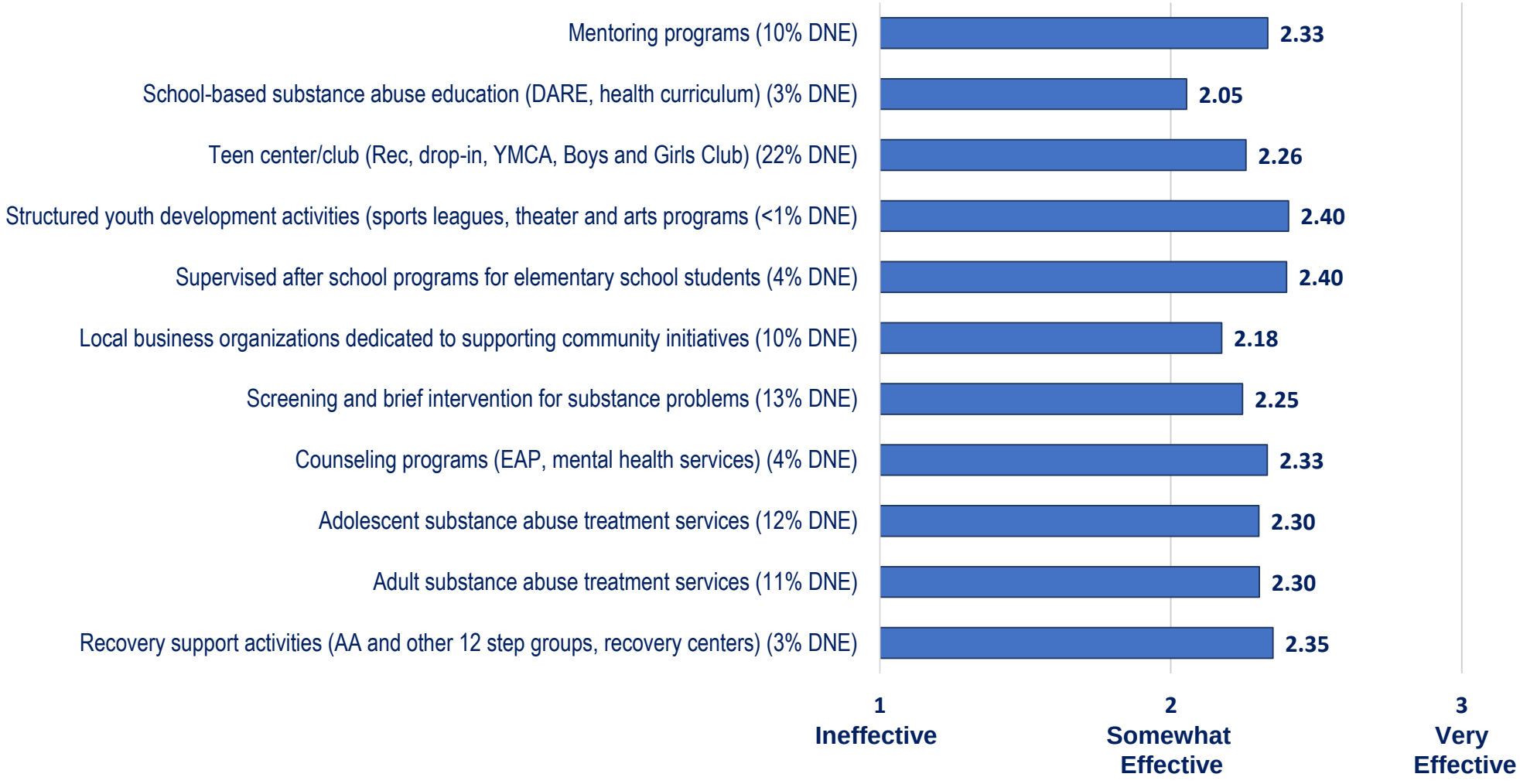


***DNE: % indicating the strategy Does Not Exist**

Key Informant Ratings of Substance Abuse Prevention Strategies in the Community [Q11]: APW CRS, 2018



***DNE: % indicating the strategy Does Not Exist**

Perceived Barriers to Substance Abuse Prevention Activities in the Community [Q12]: APW CRS, 2018

Key Informant Ratings of Community Readiness for Substance Abuse Prevention Planning Activities [Q13]: APW CRS, 2018

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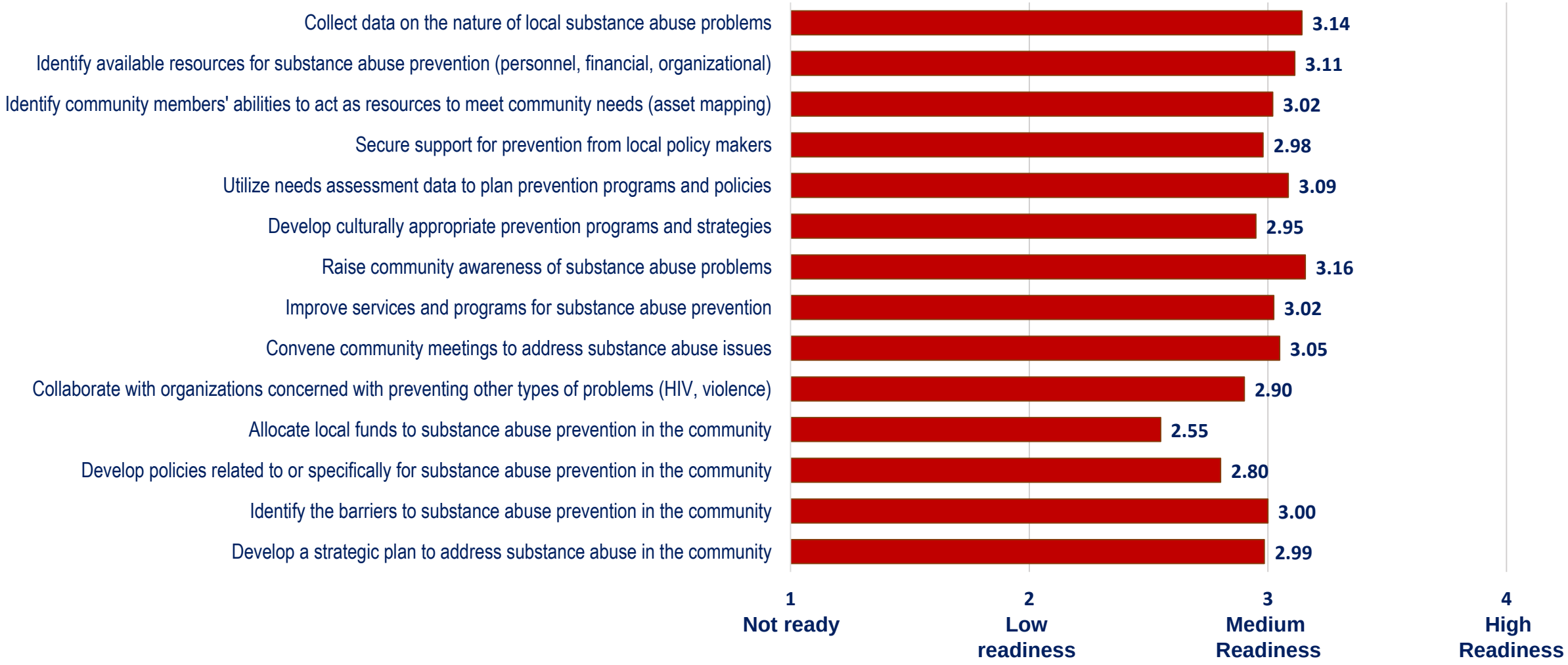

Availability of Substance Abuse Prevention Data [Q14]: APW CRS, 2018

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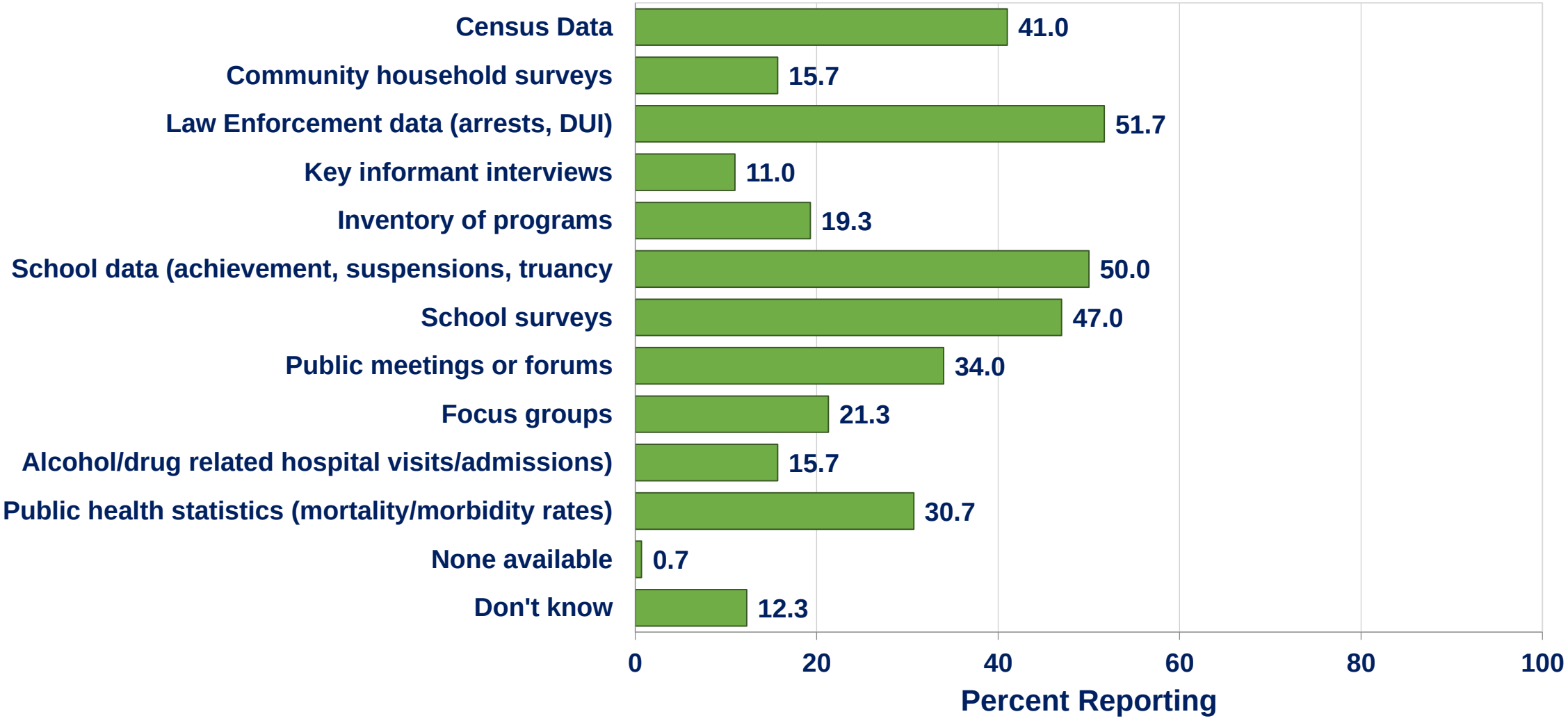

Key Informant Ratings of the Community Stage of Readiness for Substance Abuse Prevention [Q15]: APW CRS, 2018

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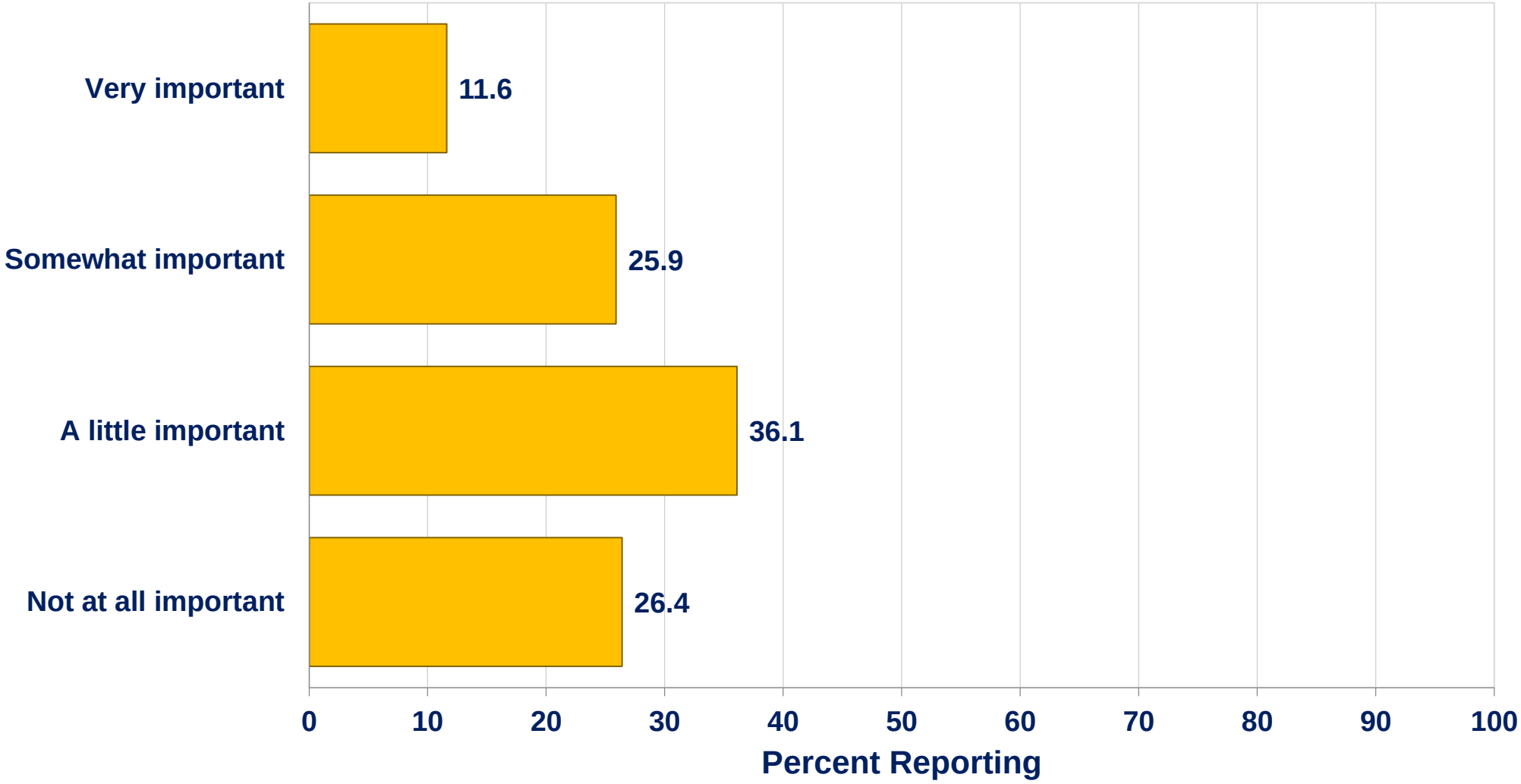
Community Stage of Readiness for Substance Abuse Prevention: APW	Percent
1 - This town/city tolerates or encourages substance abuse.	1.4
2 - This town/city has little or no recognition of the substance abuse problem.	5.2
3 - This town/city believes that there is a substance abuse problem, but awareness of the issue is only linked to one or two incidents involving substance abuse.	10.8
4 - This town/city recognizes the substance abuse problem and leaders on the issue are identifiable, but little planning has been done to address problems and risk factors.	24.5
5 - This town/city is planning for substance abuse prevention and focuses on practical details, including seeking funds for prevention efforts.	17.9
6 - This town/city has enough information to justify a substance abuse prevention program and there is great enthusiasm for the initiative as it begins.	9.9
7 - This town/city has created policies and/or more than one substance abuse prevention program is running with financial support and trained staff.	13.2
8 - This town/city views standard substance abuse programs as valuable, new programs are being developed to reach out to at-risk populations and there is ongoing sophisticated evaluation of current efforts.	12.3
9 - This town/city has detailed and sophisticated knowledge of prevalence, risk factors, and substance abuse program effectiveness and the programming is tailored by trained staff to address risk factors within the community.	4.7
Mean Stage of Readiness for APW (n=212)	**5.25**
Mean Stage of Readiness for Connecticut (n=744)	5.26

How important is it to prevent problem gambling in your community? [Q16]: APW CRS, 2018



Community Ability and Support for Suicide Prevention [Q17-Q19]: APW CRS, 2018

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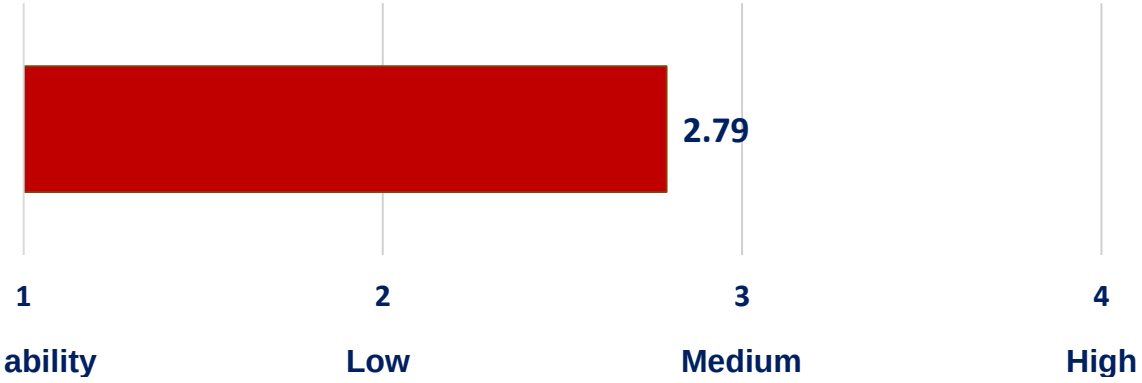
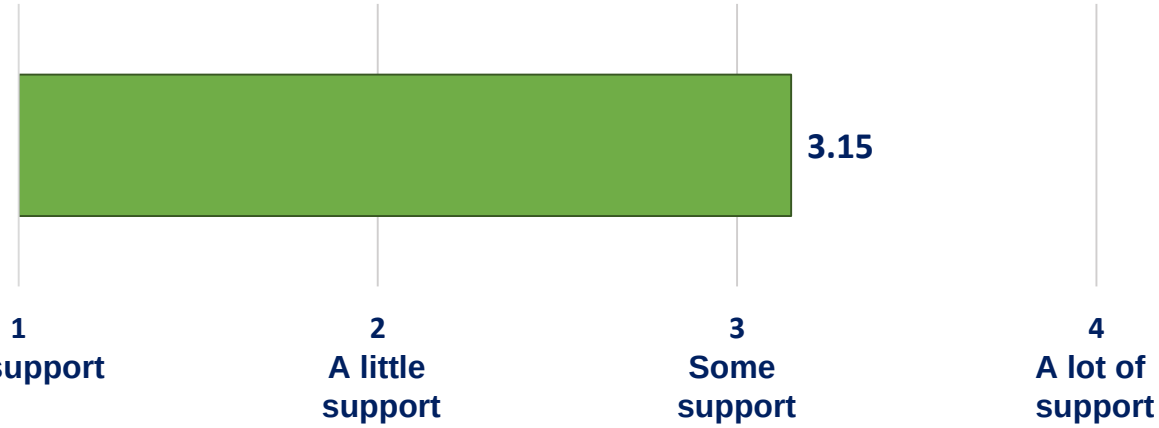
94.0% of respondents agree that "suicide prevention efforts (such as educational programs, training, policies, and identification and referral of individuals at risk of suicide) are needed in the community."

Key informant rating of the community ability to implement suicide prevention efforts



Key informant rating of the community support for suicide prevention efforts



Community Attitudes Toward Mental Health Promotion [Q20]: APW CRS, 2018

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Key Informant agreement that "most" community residents ….