Regional Behavioral Health Action Organization

DMHAS Region 2

Priority Report

April 2023

Alliance for Prevention & Wellness

A program of BHcare

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Abbreviations

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

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

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 are 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 thirty-four communities of the BHcare, Alliance for Prevention & Wellness (APW) service area, information regarding substance use, mental health, problem gambling and suicide. The information is gathered from many cited sources and separated into individual profiles of eight areas of concern: alcohol, cocaine, heroin and other illicit opioids, marijuana, mental health, prescription drug misuse, problem gambling, and suicide. The information from federal and state data is then compared to local data when available.

Our priority ranking working group offered their individual insights regarding their communities and their perception of their communities as key stakeholders in region 2, comprised of behavioral health leaders, first responders, people with lived and living experience, and prevention professionals. 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.

Focus groups were utilized to capture the behavioral health trends, gaps, needs, and strengths of our region as a qualitative measure to inform this report. Focus groups within the Region 2 community targeted the recovery community, youth-serving providers, and school representatives. Key informant interviews, as well as administering focus group questions through a quantitative instrument via Survey Monkey was also utilized. With these

additional efforts, were able to further capture the perceptions of prevention professionals and first responders in our regional area, as well as key informant interviews with prevention professionals, health departments, and first responders.

Based on data analysis, surveys, and focus groups the priority ranking working group ranked the following top priorities.

The substance use top five priorities mean rankings included:

1. Heroin & Fentanyl (4.4)
2. Prescription Drug Misuse (3.9)
3. Electronic Nicotine Delivery Systems (ENDS) (3.8)
4. Marijuana (3.7)
5. Alcohol/Cocaine (3.6)

The mean scores for the ranking matrix increased from the 2021 report, as well as with the following findings:

- Marijuana scored above Alcohol in the 2023 matrix compared to the previous year.
- Cocaine also increased in its priority ranking as now scoring tied with Alcohol.
- In the matrix, Alcohol, ENDS, Marijuana, Heroin & Fentanyl all scored highest at a 5 for “magnitude.”
- Alcohol and Heroin & Fentanyl both scored highest for “impact” and “consequence of inaction.
- ” Cocaine and ENDS were highest for “changeability”
- Prescription Drug Misuse and Heroin & Fentanyl were highest for “capacity/readiness.”
- It was noted that the ENDS was ranked high as many people are utilizing vapor devices for THC products.
- Additionally, Cocaine ranked high in the matrix overall partly related to the increase in magnitude of the substance, but also because there has been a general increase in stimulant use across our region. It is recommended that future ranking matrixes include options for stimulants and THC products to ensure validity.

The mental health issues top five priorities mean rankings included:

1. Anxiety (4.4)
2. Serious Mental Illness – Children (4)
3. Depression/Trauma Early Serious (4.2)
4. Suicide (3.9)
5. Serious Mental Illness - Adults (3.8)

The mental health portion of the priority ranking matrix slightly decreased in overall mean scores compared to the 2021 report.

- Anxiety remained the number one priority and held the highest score of 5 for all ranking topics excluding “capacity/readiness.”
- Children with Serious Mental Illness (SMI) moved up the priority ranking matrix compared to 2021, and held highest ranking scores for “magnitude,” “impact,” and “consequence of inaction.”
- Children with SMI’s shared the lowest score of a 1 with Adults with SMI’s and Trauma.
- Depression and Trauma both scored highest for “magnitude,” “impact,” and “consequences of inaction.” Their differences were with “changeability,” where Depression scored lower at a 4, signifying a slightly less ability in region 2 to make changes regarding this mental health condition.
- Trauma /PTSD ranked the lowest, whereas Depression scored a 2, for “capacity/readiness.”
- It was discussed that while in our region we have some towns implementing the “Handle with Care” trauma-informed protocols in schools, this is not widespread, and we have much work to do in our region in addressing trauma within our communities.
- Suicide remained the 4th priority mental health concern, and adults with serious mental illness remained the 5$^{th\ as}$ compared to the previous report.

The 2022 Community Readiness Survey (CRS) for Substance Abuse and Mental Health Promotion Assessment illustrated that APW’s mean stage of readiness for substance misuse prevention is a 5.36 compared to the State’s average of 5.31.

The Community Readiness Survey illustrated that APW’s mean stage of readiness for mental

health promotion is a 5.11 compared to the State's average of 4.98. There are some noted discrepancies between the CRS results and the data collected from our community within the regional profile.

One of the notable differences is between cocaine usage and age of concern for cocaine use. It was found within the SUDORS platform (SUDORS, New Haven County, 2022) that most cocaine-involved fatalities were between 45-54, and then the primary age group of concern for cocaine use in the CRS was 12–17-year-olds (Community Readiness Survey, 2022). This signifies a major gap noted in our regional data collection process that often data collected does show matching trends which can lead to confusion within the community prevention sector on what is the most valid source of information, and how to best determine the priority response.

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

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

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

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

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

PROBLEM	MAGNITUDE	IMPACT	CHANGEABILITY	CAPACITY/ READINESS	CONSEQUENCE OF INACTION	TOTAL	Mean Ranking Score:
Alcohol	5	5	2	1	5	18	3.6 5
Tobacco	3	2	2	1	2	10	2 6
Electronic Nicotine Delivery Systems (ENDS), vaping, juuling	5	3	4	3	4	19	3.8 3
Marijuana	5	4.5	2	2	5	18.5	3.7 4
Prescription Drug Misuse	4	4	3	4	4.5	19.5	3.9 2
Heroin and Fentanyl	5	5	3	4	5	22	4.4 1
Cocaine	5	3.5	4	1	4.5	18	3.6 5

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

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

PROBLEM	MAGNITUDE	IMPACT	CHANGEABILITY	CAPACITY/ READINESS	CONSEQUENCE OF INACTION	TOTAL	Mean Ranking Score:
Anxiety	5	5	5	2	5	22	4.4 1
Depression	5	5	4	2	5	21	4.2 3
Trauma/PTSD	5	5	5	1	5	21	4.2 3
Serious Mental Illness - Children	5	5	4	1	5	20	4 2
Serious Mental illness - Adults	4	5	4	1	5	19	3.8 5
Suicide	4	4	4	2.5	5	19.5	3.9 4

RBHPSW (Workgroup) Priority Ranking Matrix: Problem Gambling

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

PROBLEM	MAGNITUDE	IMPACT	CHANGEABILITY	CAPACITY/ READINESS	CONSEQUENCE OF INACTION	TOTAL	Mean Ranking Score:
Problem Gambling	5	2.5	4	1	4.5	17	3.5

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Introduction

This report was designed to provide a comprehensive assessment of areas of concern in CT, specifically in DMHAS Region 2 for the following: alcohol, cocaine, heroin and other illicit opioids, marijuana, mental health, prescription drug abuse, problem gambling, suicide, tobacco / electronic nicotine devices (ENDS) / vaping.

Methods

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

Data Limitations

We recognize that it cannot accurately measure all possible aspects of the aforementioned areas. This assessment incorporates a significant amount of quantitative data that was collected from a variety of sources. The data is believed to be reliable, valid, and relevant. However, it is **not** practical to include all available data and this information was sometimes limited as to the level of geographic detail or demographic identifier, availability for all health indicators, and by the timeliness of the information' s reporting period.

Qualitatively, many community individuals were involved in the development of this report, however, given that input was not provided by all community members, there may be instances where specific concerns are not adequately represented. These information gaps could potentially limit this report's ability to assess all the aforementioned areas of concern in Region 2.

Description of the Region

Region 2 is in the South-Central region of CT, consisting of most of New Haven and Middlesex counties. These two counties include a 34- town region with a total population of 834,293 (DMHAS Regional Data Stories, 2023), and median county household incomes ranging from $48,973 to $171,652 (DMHAS Regional Data

Stories, 2023. 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 4,213 (Ctdata.org; Chester, 2023) to the second largest city in the state, New Haven, which has a population of 130,250 (ctdata.org, 2023), with many other rural, suburban, and urban communities falling in between the ranges.

Most communities in region two are comprised of residents identifying as white non-Hispanic, except for the City of New Haven and West Haven where the white non-Hispanic population falls below the 50% percentile (DMHAS Regional Data Stories, 2023).

Sub-populations

Sub-populations that continued to become noted as communities to focus on as part of this report include middle / high school youth, young adults (18-25), Women, LGBTQI+ youth, and communities of color.

Regional Epidemiological Profiles

Alcohol
Cannabis
Cocaine
Heroin and Other Illicit Opioids
Mental Health
Prescription Drug Misuse
Problem Gambling
Suicide
Tobacco/ENDS

2022 Region 2 Epidemiological Profile: Alcohol

Problem Statement

Alcohol is the most commonly used substance nationally and in Connecticut, although the prevalence of alcohol use is higher in the state compared to the national average. According to the 2019-2020 National Household Survey of Drug Use and Health (NSDUH), Connecticut has the 9th highest prevalence of current alcohol use (56.6%) compared to other states in the U.S., higher than the national prevalence (50.4%)[1].

Region 2 has had a decrease regarding alcohol use/abuse between 2021-2022. Binge drinking and alcohol use in general has increased approximately 5% amongst teens and young adults within Region 2.

Magnitude (prevalence)

According to the National Survey of Drug Use and Health (NSDUH) the prevalence of past 30 day use of alcohol among individuals 12 and older is 56.3% in 2021, higher than the US prevalence of 47.5% for the same age group. Connecticut ranks fourth highest in the country for alcohol use. However, consistent with national underage drinking trends, use among Connecticut's 12 to 17 year olds has decreased over time, from 17.8% in 2009-2010 to 7% in 2021.

Adults 26 and older in Connecticut in 2021 have the highest prevalence of reported past month alcohol use (61.4%), followed by young adults 18-25 (58.5%).

The prevalence of binge drinking**, or heavy episodic drinking, in Connecticut has remained relatively stable since 2010, but in 2021 has dipped below the US in prevalence (CT 19.9% vs. US 21.5%). Binge drinking is highest among young adults (41.1%), followed by adults ages 26 or older (24.3%), and youth ages 12-17 (5.1%).[1]

2021 Connecticut School Health Survey (CT YRBS): 17.5% of high school students reported using alcohol in the past month and 7% reported binge drinking** in the past month[2].

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

A sample of 4 student surveys conducted in DMHAS Region 2 communities between 2021 and 2022 found that alcohol was the most commonly used substance among high school students. Lifetime rates for alcohol use among high school were higher than for any other substance. Rates of consumption for high school students were higher for 11th and 12th grade as compared to 9th and 10th grade.

Among the students reporting alcohol use, consumption in their home or the home of others was the most mentioned site. Many youth reported that because their parents were drinking more at home, alcohol was more readily accessible to them, with or without their parent's permission. Youth commented that they were drinking, not as they did pre-COVID as "partying", but at home, often alone out of "boredom".[23]

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

	2016-2018	2018-2019	2021
CT	6.1	6.2	10.3

Among individuals 12 years and older, those reporting alcohol use disorder (AUD) in the past year was relatively stable from 2016 to 2019, at about 6%. However, the 2021 NSDUH data indicates that reported AUD rates for this age group have increased almost two-fold (11.4%).[1]

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

	2016-2018	2018-2019	2021
CT	5.7	5.6	10.4

Risk Factors and Subpopulations at Risk

- Young people who drink are more likely than adults to report being binge drinkers.[3]
- Men are more likely than women to be heavy drinkers.[4]
- Women are more likely than men to develop alcoholic hepatitis and cirrhosis and are at increased risk for damage to the heart muscle and brain with excessive alcohol use.[5]
- Individuals with mental health disorders are about four times more likely to be heavy alcohol users.[6]
-

2022 Region 2 Epidemiological Profile: Alcohol

- Native Americans are at especially high risk of alcohol-related traffic accidents, DUI and premature deaths associated with alcohol misuse.[7]

- While Hispanics have higher rates of abstinence from alcohol, those who do drink often have higher rates of binge drinking.[8]

Among youth, risk factors include:

- Academic and/or other behavioral health problems in school;
- Alcohol-using peers;
- Lack of parental supervision;
- Poor parent-child communication;
- Parental modeling of alcohol use;
- Anxiety or depression;
- Child abuse or neglect;
- Poverty;
- Norms that encourage or tolerate underage drinking.[10]

Throughout the state, increased access to alcohol at home during the COVID pandemic has been reported as a problem, including home delivery services of alcohol in some areas increasing home access. Anxiety and post-COVID mental health issues may also have impacted both youth and adult alcohol use as a coping mechanism.[23]

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

	CT	Region 1	**Region 2**	Region 3	Region 4	Region 5
2016-2018	43.8	44.6	**42.6**	39.8	45.3	45.2

NSDUH 2016-18 substate estimates, the most recent substate data currently available from SAMHSA, showed 42.6% of respondents 12 and older in Region 2 reporting perception of great risk of harm from having 5+ drinks of an alcoholic beverage once or twice a week. Region 2 was slightly lower than the state (43.8%) in perception of risk, and second lowest of the five regions, higher than only Region 3.[1]

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

Burden (consequences)

Alcohol use carries with it a variety of consequences or adverse impacts on the personal, familial, and community levels. Some of these impacts include the following:

- Immediate adverse effects of alcohol can include: impaired judgment, reduced reaction time, slurred speech, and loss of balance and motor skills.[3]
- When consumed rapidly and in large amounts, alcohol can also result in coma and death.
- Alcohol use can increase risk of death when used with other substances, i.e. prescription medication like benzodiazepines and opioids.[11]
- In 2021, alcohol was listed as a contributing cause of death in 4017 (27.8%) of the 1464 unintentional drug-involved fatalities (overdose deaths) which occurred in Connecticut.[12]

1 NSDUH (2021)

2 DPH, 2021 Connecticut School Health Survey

3 CDC (2022), Alcohol and Public Health

4 CDC (2022), Excessive Alcohol Use is a Risk to Men's Health

5 CDC (2022), Excessive Alcohol Use is a Risk to Women's Health

6 NIDA (2014), Severe Mental Illness Tied to Higher Rates of Substance Use

7 NIAAA (2014), Focus On: Ethnicity & the Social and Health Harms from Drinking

8 NIAAA (2021), Alcohol and the Hispanic Community

2022 Region 2 Epidemiological Profile: Alcohol

- Approximately 95,000 deaths each year in the U.S. are attributed to alcohol-related causes.[13]
- In 2019, Connecticut ranked as the fourth highest state in the country for the percent of alcohol-impaired driving fatalities compared to total driving fatalities (38%), versus the United States overall (28%).[14]
- Excessive drinking has numerous chronic and acute health effects, including: liver cirrhosis, pancreatitis, various cancers, cardiomyopathy, stroke, high blood pressure, and psychological disorders as well as increased risks for lower respiratory infections such as tuberculosis.[15]
- Excessive drinking has been associated with increased risk of motor vehicle injuries, falls, and interpersonal violence.[3]
- Drinking during pregnancy can lead to a variety of developmental, cognitive, and behavioral problems in the child (Fetal Alcohol Spectrum Disorders).[15]
- Older adults aged 65+ who drink are at increased risk of health problems associated with lower tolerance for alcohol, existence of chronic health problems (i.e., diabetes, high blood pressure, congestive heart failure, and liver problems) and interactions with medications (e.g., aspirin, acetaminophen, cough syrup, sleeping pills, pain medication, and medication for anxiety or depression).[16]
- Initiation of alcohol use at young ages has been linked to increased likelihood of AUD later in life. [17]
- Of all FY2022 Connecticut treatment admissions, 52.8% identified alcohol as the primary drug at admission.[9]

The **2021 Monitoring The Future** data tables highlights the reported declines in youth substance use nationally:

Past year Alcohol	2020	2021
8th grade	20.5%	17.2%
10th grade	40.7%	28.5%
12th grade	55.3%	46.5%

Monitoring The Future investigators studied the difference in location between survey respondents as a limitation of the survey. Investigators did see a slight drop in response rate across all age groups, indicating that a small segment of typical respondents may have been absent during the year. This difference in location between survey respondents is a limitation of the survey, as students who took the survey at home may not have had the same privacy or may not have felt as comfortable truthfully reporting substance use as they would at school, when they are away from their parents. In addition, students with less engagement in school – a known risk factor for drug use – may have been less likely to participate in the survey, whether in-person or online. [20]

Local health department data shows that the Griffin Hospital (Region 2) had more admissions for acute care interactions for alcohol than Yale New Haven Hospital, Hartford Healthcare locations, and Waterbury Hospital.[21]

Valley Residents Hospitalized for Suspected Alcohol Intoxication 7/1/21-12/31/21

Town	Acute Care ED Visits
Ansonia	121
Beacon Falls	8
Derby	93
Seymour	87
Shelton	148

[9] CT DMHAS FY 2021 2022 Treatment Admissions
[10] SAMHSA (2019), Risk and Protective Factors
[11] CDC (2022), Alcohol and Other Substance Use
[12] CT Department of Public Health Drug Overdose Monthly Report, 2021
[13] NIAAA (2022), Alcohol Facts and Statistics
[14] NHTSA (2019), Alcohol-impaired Driving
[15] WHO (2018), Global Status Report on Alcohol and Health
[16] NIAAA (2017), Older Adults
[17] NIAAA (2006), Alcohol Alert No. 67 Underage Drinking
[18] Community Readiness Survey State Report, 2022
[19] Community Readiness Survey Region 2 Report, 2022
[20] Monitoring the Future, 2021

2022 Region 2 Epidemiological Profile: Alcohol

Treatment Admissions where Alcohol is the Primary Drug at Admission[7]:

	CT	Region 1	Region 2	Region 3	Region 4	Region 5
FY2021	14,985	1,816	3,385	2,861	3,780	3,144
FY2022	14,096	1,089	3,384	2,680	5,253	1,689

Region 2 treatment admissions in FY2021 and FY2022 where alcohol was the primary drug at admission were the second highest among the regions with 3,385 in FY2021 and 3,384 in FY2022. These admissions accounted for 20-25% of the state's admissions where alcohol was the primary drug. In Region 2, treatment admissions where alcohol was primary drug accounted for over 1 in 3 (37.2%) treatment admissions in the region in FY2021 and over 50% of alcohol admissions in FY2022. Admissions for the two fiscal years remained comparable in region 2 despite fluctuations (increases and decreases) in other regions.

The CT Department of Consumer Protection published data on sales of "nips" between April 1, 2022, through September 30, 2022, in Connecticut. In that year, there were 24 cities and towns that sold over a million of the miniature bottles, led by New Haven, where more than 3.8 million were sold, netting the Elm City $190,617. Region 2 had the most sales of nips in its larger towns compared to other regions similarly.22

CT Town	Region	Number of Nips Sold, 2022
Bridgeport	1	1,181,374
Fairfield	1	309,778
Norwalk	1	639,480
Middletown	2	558,728
Milford	2	600,082
New Haven	2	1,573,810
Groton	3	673,578
New London	3	553,938
Stonington	3	275,652
East Hartford	4	667,832
Hartford	4	1,272,672
Manchester	4	1,000,610
Danbury	5	830,790
Naugatuck	5	435,142
Waterbury	5	1,172,876

An added five cent surcharge per nip allows for distribution of funds to each town for litter control associated with recycling and cleanup of nip waste.

Capacity and Service System Strengths

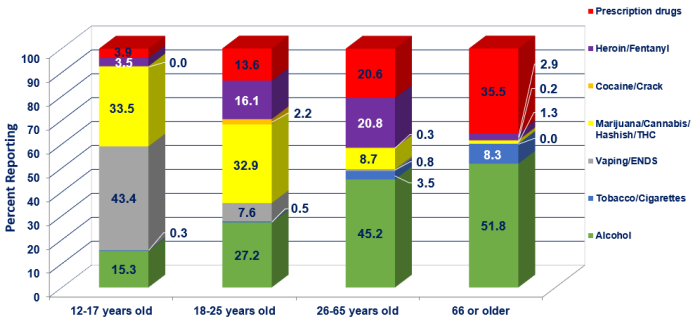
Community Readiness Survey 2022 key informants in Region 2 rated the readiness of communities in the region to implement substance misuse prevention activities at 5.36 on a 1-9 readiness scale, indicating slightly higher than moderate readiness, comparable with readiness statewide.

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

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

The 2022 Community Readiness Survey results for Region 2 also indicated that key informants identified alcohol as the substance of greatest community concern for those between the ages of 26 and 65 (45.2%) and 66 and older (51.8%).

Problem Substances of Greatest Concern for Age Groups, According to Key Informants: APW CRS, 2022[18]



Key informants statewide *disagreed* that it is okay for youth to drink alcohol at parties with parental supervision.[19]

According to the Region 2's 2023 Priority Ranking Matrix of substances (in this report), alcohol ranked as the 4th priority substance after heroin/fentanyl, prescription drugs, and use of ENDS. The mean score for capacity and readiness to address alcohol was low.[19]

[21]Naugatuck Valley Health District, Suspected Alcohol Intoxication Acute Care Interactions / ED Visits, 2022
[22]Connecticut Department of Consumer Protection, By the Numbers: Nickel Per Nip Municipal Payments, 2022
[23]DMHAS Youth and Parent Focus Group Initiative (2020)

2022 Region 2 Epidemiological Profile: Cannabis

Problem Statement

Cannabis, also called marijuana, is a term widely used to encompass all products made with marijuana in any form or stage of growth. The Connecticut Legislature legalized cannabis use on July 1st, 2021. An individual 21 years of age or older can now possess and consume up to 1.5 ounces of cannabis. Retail sales in the state will begin as of January 10th, 2023.[1] Cannabis remains illegal under federal law.[2]

Marijuana use is widespread among young adults and adolescents in Connecticut. The 2021 National Survey on Drug Use and Health (NSDUH) showed that for Connecticut individual ages 18 and over, past year marijuana use in CT was slightly higher (20.87%) than the national average (19.59%).[3]

Community norms and perception of harm among youth and adults during the pandemic impacted the rates of use of across the region. Parents and adults were more generally accepting of young adults using marijuana over alcohol or other substances.

Magnitude (prevalence)

The 2021 Connecticut School Health Survey shows about 11.1% of Connecticut high school students report currently using marijuana.[4]

NSDUH Substate Estimates:

Percent Reporting Past Month Marijuana Use, ages 12+ for 2016-2018[5]

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

A student survey conducted in 2022 in Region 2 found that out of 505 High School students, 9% reported past 30- day use of marijuana (DMLWC). Across multiple student surveys in Region 2, as the student age range increase so did the likelihood that they used marijuana within the last month (Hamden, APW, DMLWC).

In Region 2 between 2016 and 2019, the number of hospital admissions for marijuana related diagnosis increased by 39% for those under the age of 18. Additionally, those admitted with comorbidity (psychotic disorder with misuse/dependence of marijuana) increased by 308%.

Among young adults in Region 2 receiving substance use treatment services through Department of Mental Health & Addiction Services in 2022, 64.1% reported had used marijuana use in their lifetime, which was the highest of all of the substances.[7] Among all cases admitted to substance use treatment, 25.9% reported marijuana use, which came in second to alcohol (45.5%).

A CT Young Adults Statewide Survey in 2020 showed that of young adults who used a vape device, 51% used THC or marijuana oil.[7] A recent trend in the region as reported by key informant stakeholder interviews is that the purchase and use of CBD and THC based products by youth for use in vapor devices.

Beacon Health Options reported that for youth 17 and under with Husky insurance, the most prevalent substance use diagnosis was Cannabis-Use Disorder.[8]

It was reported by EMS within a Region 2 focus group that cannabis gummies are used frequently by youth, as well as using cannabis with alcohol, and driving under the influence of cannabis gummies.

It was also reported during a Region 2 focus group with youth-serving providers and school staff that youth are vaping marijuana, and there is a low perception of harm around cannabis use. Additionally, it is reported that some parents give their youth CBD gummies and that is being viewed as a low-risk behavior by some Region 2 parents.

Risk Factors and Subpopulations at Risk

Risk factors include:

- Availability of marijuana
- Family history of marijuana use
- Favorable parental attitudes towards marijuana
- Low academic achievement and low bonding to school environment
- Peers who use marijuana
- Low peer disapproval of marijuana use
- Prior use of alcohol/tobacco
- Sensation seeking behavior/impulsivity
- Childhood abuse/trauma[9]

The 2021 Connecticut School Health Survey shows higher current marijuana use in girls (14.1%) compared to boys (8.2%).[4] Reported current use increases by grade from 4.7% of 9th graders to 16.0% of 12th graders.[4] More Black students reported

current use (14.7%) than White students (9.9%) and Hispanic students (13.9%).[4]

Subpopulations at risk:

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

Burden (consequences)

Short-term consequences include:[10]

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

Long-term consequences include:[10]

- Impaired learning and coordination
- Sleep problems
- Potential for addiction to marijuana, as well as other drug and alcohol use disorders
- Potential loss of IQ (particularly in those who used heavily during adolescence)
- Decreased immunity
- Increased risk of bronchitis and chronic cough
- Marijuana potency has increased over the past few decades: in the 90s, the average THC content in confiscated samples was less than 4%, and in 2018 it was over 15%.[9]

- Marijuana use during pregnancy also increases the risk of child development problems including low birth weight, and brain development. Additionally, children exposed to marijuana in-utero have increased risk for problems with attention span and problem solving.[9]

- Several studies have linked marijuana use to increased risk for psychiatric disorders and substance use disorders. The amount used, age at first use, and genetic vulnerability are thought to influence this relationship.[9]

- Because marijuana use impairs motor coordination and reaction time, many studies have shown a relationship between blood THC concentration and impaired driving.[10]

- A recent national outbreak of e-cigarette, or vaping product use-associated lung injury (EVALI) was linked to vaping THC, possibly due to the presence of Vitamin E acetate which is used as a diluent in THC-containing products.[11]

In 2021, Connecticut had the first known positive lab test for traces of fentanyl in marijuana.[12] Individuals who were revived by naloxone claimed that they only used marijuana. Further lab reports indicated that the marijuana tested was cross contaminated by traces of fentanyl, not laced with the opioid.

Capacity and Service System Strengths

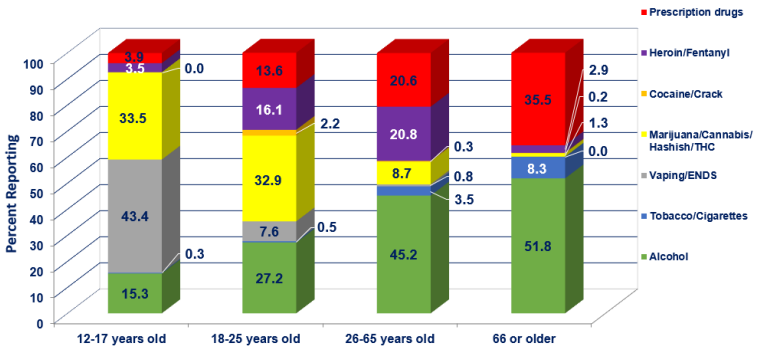
Key informants in region 2 wo responded via the 2022 Community Readiness Survey rated their region's readiness to implement substance misuse prevention on average at 5.36 on a 1-9 scale, which is in line with the average key informant readiness rating statewide.[9]

Community Readiness Survey: Mean Stage of Readiness for Substance Use Prevention[9]

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

Via the same survey, community concern about cannabis according to key informants was highest for 12-17 year olds at 33.5%, with 18-25 year olds at a close second at 32.9%.[13]

Problem Substances of Greatest Concern for Age Groups, According to Key Informants: APW CRS, 2022[9]



Of the Region 2 stakeholders, the majority reported that they "somewhat disagree" that they are concerned about the effects of CT legalization of adult cannabis use on youth cannabis use. There was a

slight increase where the average amount of participants voted in between "somewhat disagree" to "somewhat agree" that occasional use of marijuana is not harmful for youth. Thus, signifying a low perception of harm for youth cannabis use amongst Region 2 adults.

According to Region 2's Priority Ranking Matrix of substances, marijuana ranked 4th overall on the priority substances for the region. However, marijuana ranked highest for magnitude and consequence of inaction.

From 2021 to 2023, some of the Region 2's prevention coalitions have worked with their local municipalities to advocate for prevention-based decisions with towns' marijuana ordinances regarding the sale of adult-use cannabis. Some coalitions directly advocated within their town's Planning & Zoning committees and provided testimony that led to the decision to vote against opening retail shops (east haven). Other Region 2 towns are working with their local legislatures to use the 3% sales tax towards prevention efforts.

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[1] "Be In The Know," DMHAS Cannabis Prevention Campaign, 2023
[2]Department of Justice/Drug Enforcement Administration, 2020 Marijuana/Cannabis Drug Fact Sheet
[3]NSDUH, 2021
[4]Connecticut School Health Survey, 2021 (YRBS)
[5]NSDUH, 2016-2018
[6]CT DMHAS, 2022 Treatment Admissions
[7]CT Young Adults Statewide Survey (CT YASS), 2020
[8]Beacon Health Options, 2021
[11]CDC, "Outbreak of Lung Injury Associated with the Use of E-Cigarette, or Vaping, Products," 2020
[12]New England Hight Intensity Drug Trafficking Areas, Connecticut Overdose Response Strategy (CT-ORS): Marijuana Fentanyl Awareness. November 19, 2021
[13]Connecticut Community Readiness Survey, 2020, 2022

2022 Region 2 Epidemiological Profile: Cocaine

Problem Statement

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

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

Magnitude (prevalence)

According to data from the 2021 Connecticut School Health Survey (CT YRBSS), 1.2% of Connecticut high school students reported using some form of cocaine in their lifetime.[1] This is consistent with a decreasing trend since 2007, when the prevalence was 8.3%.

The 2021 the National Survey on Drug Use and Health (NSDUH) reported that 1.69 % of Connecticut respondents reported past year use of cocaine.[2] This is highest among young adults ages 18-25 (3.34%).

For New Haven County, there was 5.03% increase in cocaine-involved overdose deaths from 2021 (199 deaths) to 2022 (209 deaths).[6] There was also a decline in the age of individuals impacted. In 2021 the primary age group affected by cocaine-involved overdose deaths were 45-54 year old's, accounting for a total of 33.66% of those total cocaine involved deaths.

In 2022 that number declined to 28.22% (n=59), and the 34-44 year old's became new majority at 28.71% (n=60) of those deaths involving cocaine.

NSDUH Substate Estimates:[3]
Percent Reporting Past Year Cocaine Use, ages 12+

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

Within a collection of 5 student surveys conducted in Region 2 between 2021 and 2022, only 3 surveys asked about cocaine use, and the 30 day use rates ranged from 0% to around 2% at the highest.

However, it was noted within the 2022 DMHAS treatment admission data for Region 2 that cocaine was higher (36.1%) than marijuana (29.5%) as reported drugs used throughout the lifespan out of all admitted cases.[4] Cocaine was also comparable to marijuana as the primary drug for treatment in 2022. It was reported that 354 individuals across the lifespan entered treatment for cocaine use, and 367 entered treatment for marijuana use. Cocaine was noted to be the lowest substance of primary use by young adults ages 18-25 within Region 2 (1.6%), and moderately low for reported drugs used in lifetime for youth (19%).

Within the Naugatuck valley area of Region 2, it was reported for 2021 there were 17 hospital admissions for a suspected stimulant overdose, although the specific type of stimulant was not identified.[5]

Treatment Admissions: Cocaine[8,4]

	CT	Region 1	Region 2	Region 3	Region 4	Region 5
FY2021	4,432	573	1,086	574	1,461	738
FY2022	1,137	127	354	176	288	192

It was also reported by the New England High Intensity Drug Trafficking Authority (HIDTA), that "cocaine is flooding in Connecticut," and is affecting primarily college campuses."

[1] Connecticut School Health Survey, 2021 (CT YRBSS)
[2] National Survey of Drug Use and Health (NSDUH), 2021
[3] NSDUH Substate Estimates, 2016-18
[4] DMHAS Fiscal Year (FY) 2022 Treatment Admission Data

2022 Region 2 Epidemiological Profile: Cocaine

Risk Factors and Subpopulations at Risk

Risk factors include:

- Family history of substance use (youth and adults)
- Lack of parental supervision (youth)
- Substance-using peers (youth and adults)
- Lack of school connectedness and low academic achievement (youth)
- Low perception of risk/harm (youth, adults)
- Childhood trauma (youth and adults)
- Co-occurring mental health concerns
- Current or previous misuse of other illicit substances, such as marijuana and heroin/fentanyl

NSDUH Substate Estimates:[3]
Percent Reporting Perception of Great Risk from Using Cocaine Once a Month, ages 12+

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

In 2021, NSDUH reported state-specific perceptions of great risk from using cocaine once a month among people aged 12 or older.[2] In Connecticut, youth 12-17 reported the lowest prevalence of perception of great risk of cocaine use at 46.3%. The second lowest prevalence of perception of great risk was for young adults (18-25), at 60%. The age group that had the highest perception of great risk was adults 26 and older, at 72.9%.

According to data from the 2021 Connecticut School Health Survey (CT YRBSS), boys reported higher rates (1.7%) than girls (0.6%).[1] The prevalence of lifetime cocaine use was highest among 9th and 11th graders (1.5% each). Hispanic students reported higher rates (1.4%) than Black (0.4%) or White (1.2%) students.

Additionally, the CT overdose data portal SUDORS shows within New Haven County that most cocaine involved fatal overdoses (n=209) in 2022 were predominantly Male (74.2%) and White/Caucasian (54.5%).[6]

[5]Naugatuck Valley Health District, 2021

Burden (consequences)

Physical short-term consequences of cocaine use include:[7]

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

Long-term physical consequences of cocaine use include:[7]

- Tolerance, requiring higher and more frequent doses;
- Sensitization, where less cocaine is needed to produce anxiety, convulsions, or other toxic effects (increasing risk of overdose);
- Loss of appetite leading to malnourishment;
- Increased risk of stroke and inflammation of the heart muscle;
- Movement disorders such as Parkinson's disease;
- Impairment of cognitive function;
- Cocaine users are also at risk for contracting blood-borne diseases such as HIV and hepatitis C via needle sharing and other risky behavior.
- Users are at risk of accidental overdose, especially in the presence of alcohol or other drugs.

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

For New Haven County, there was 5% increase in cocaine-involved overdose deaths from 2021 (199 deaths) to 2022 (209 deaths). There was also a decline in age groups primarily impacted. In 2021 the primary age group affected by cocaine-involved overdose deaths were 45-54 year old's, accounting for a total of 33.66% of those total cocaine involved deaths. In 2022 that number declined to 28.22% (n=59), and the younger age group of 34-44 year old's became new majority at 28.71% (n=60) of those deaths involving cocaine.

[6] CT State Unintentional Drug Overdose Reporting System (SUDORS) via the Drug Overdose Deaths in Connecticut Data Dashboard, CT DPH
[7] NIDA
[8]DMHAS Fiscal Year (FY) 2021 Treatment Admission Dat

2022 Region 2 Epidemiological Profile: Cocaine

Capacity and Service System Strengths

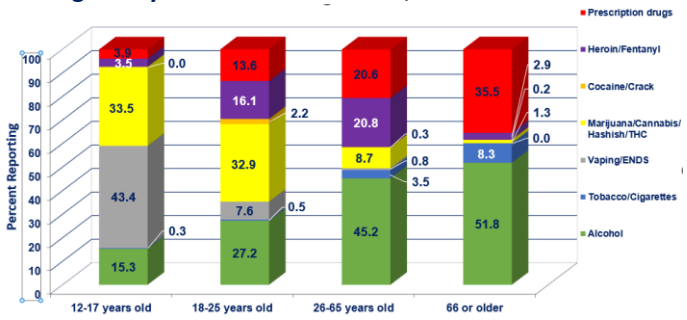
Community Readiness Survey: Mean Stage of Readiness for Substance Use Prevention[9]

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

Key informants who responded to the Community Readiness Survey rated Region 2's community readiness to implement substance use prevention activities as 5.36 on a scale of 1-9, placing it in range, if slightly higher, versus perceived readiness for the state (5.31). [9]

According to the 2022 Community Readiness Survey, Region 2 adults reported that their primary age of concern for cocaine/stimulants use are youth 12–17 (33.5%) and young adults 18-25 (32.9%).[9] CT SUDORS data on overdose fatalities data indicate that of the 209 cocaine-involved overdose fatalities in New Haven County, most involved adults 26 and older[6], making that this concern is largely prevention-focused.

Problem Substances of Greatest Concern for Age Groups, According to Key Informants: APW CRS, 2022[9]



Within the Region 2 Priority Ranking Matrix collected for 2022-2023, Cocaine resulted as a tie with Alcohol at #5 on the priority list. Cocaine shared the highest ranking for magnitude on the matrix, and had a higher rate of changeability, signifying that there were more opportunities to address cocaine use in our region. Cocaine scored lower than Alcohol on impact, capacity and readiness, and consequence of inaction.

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[9]Community Readiness Survey, Region 2, 2020, 2022

2022 Region 2 Epidemiological Profile: Heroin and Illicit Opioids

Problem Statement

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

According to the 2021 National Survey on Drug Use and Health (NSDUH), an estimated less than one percent (0.32%) of Connecticut residents 18 or older have used heroin in the past year, a rate slightly lower than the estimated national average (0.43%).[1] The highest prevalence is by adults aged 26 or older (estimated 0.17%), followed by young adults aged 18-25 years old (estimated 0.17%). Adolescents did not report any heroin use for this time period.[1] According to the 2021 Connecticut School Health Survey (CT's Youth Risk Behavior Surveillance survey), an estimated 0.6% of high school students in Connecticut reported ever used heroin.[2]

In 2021, 11% of unintentional overdose deaths that occurred in Connecticut involved heroin.[3] While the number of overdose deaths in Connecticut involving heroin has declined since 2016, these numbers are misleading due to the concomitant rise of fentanyl, the increasing number of opioid deaths in Connecticut involving fentanyl and/or heroin, and the intertwined nature of heroin and fentanyl in the illicit opioid supply. Across New England, fentanyl availability is high, may be available either mixed with white powder heroin, or alone, and may be sold in powder form as heroin or as fentanyl.[4]
Fentanyl is often sold under the same or similar "brand" names as heroin, creating confusion and uncertainty among buyers. The fentanyl deaths that involved heroin in 2021 (153) has dropped since 2019 (339).[3] Since 2017, deaths involving fentanyl have outnumbered deaths involving heroin, suggesting that much of the heroin consumed in Connecticut may contain fentanyl. In 2021, nearly 9 in 10 unintentional overdose deaths (86%) in Connecticut involved fentanyl.[1] Thus, all individuals who use heroin are at risk of fentanyl exposure.

[1] NSDUH, 2021 CT, 2016-18 substate estimates
[2] Connecticut School Health Survey, 2021 (CT YRBS)
[3] CT OCME
[4] US DOJ- DEA, 2018 National Drug Threat Assessment (October 2018)

Heroin and Opioid usage continue to be an issue within region 2, but overall, there has been a considerable decline of overdoes within the region. In 2021, Opioid overdoes (1413) have taken a spike over Heroin overdoses (165).

Magnitude (prevalence)

NSDUH Substate Estimates:
Percent Reporting Past Year Heroin Use, ages 12+[1]

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

NSDUH substate estimates for 2016-18, the most recent estimates available from SAMHSA, indicate that Region 2 had the 2nd lowest prevalence of past year heroin use among those 12 and older compared to other regions.

Unintentional Heroin Overdoses 2021 by County[6]

New Haven	48
Middlesex	2
New London	2
Tolland	3
Hartford	18
Litchfield	8
Fairfield	26

Unintentional fatalities involving heroin in Connecticut during 2021 was 117, with 48 of those deaths (41%) being in New Haven. The age group with the highest mortality rate was 55-64 (37), accounting for 31.6% of all heroin-involved deaths .[6]

3 Month Rolling Average of ED Visits for "Suspected Heroin Overdose" Syndrome ending December 2021 by County	Rate per 100,000	Number of visits
Connecticut	2.66	96
New Haven	4.86	42
Middlesex	*	3
Fairfield	1.99	19
Litchfield	*	7
Hartford	1.78	16
Tolland	*	1
Windham	*	3
New London	*	4
*Rates were not calculated for counties with fewer than 20 total visits over the 3-month period due to the instability of the rates		

2022 Region 2 Epidemiological Profile: Heroin and Illicit Opioids

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

The five most frequently occurring opioids and stimulants, alone or in combination, accounted for 78.2% of overdose deaths. The specific breakdown is represented below.[8]

Percentages of overdose deaths involving the most common opioids and stimulants alone or in combination in 2021, *Connecticut* [8]

Illicitly Manufactured Fentanyl with no other opioids or stimulants	35%
Illicitly Manufactured Fentanyl and Cocaine	25.5%
Illicitly Manufactured Fentanyl and Prescription Opioids	8.1%
Illicitly Manufactured Fentanyl and Heroin	5.2%
Cocaine with no other stimulants or opioids	4.5%

Risk Factors and Subpopulations at Risk

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

NSDUH Substate Estimates:
Percent Reporting Perception of Great Risk from Trying Heroin Once or Twice, ages 12+[1]

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

The NSDUH 2016-18 substate estimates showed perception of great risk from even trying heroin to be high, in line with perception of great risk statewide. [1]

The 2021 Connecticut School Health Survey shows that Hispanics reported the highest overall rate (1.1%), which is higher than the prevalence for Black non-Hispanic and White non-Hispanics (0.4% each). One percent of male students and .2% of female students reported ever using heroin.[2]

Burden (consequences)

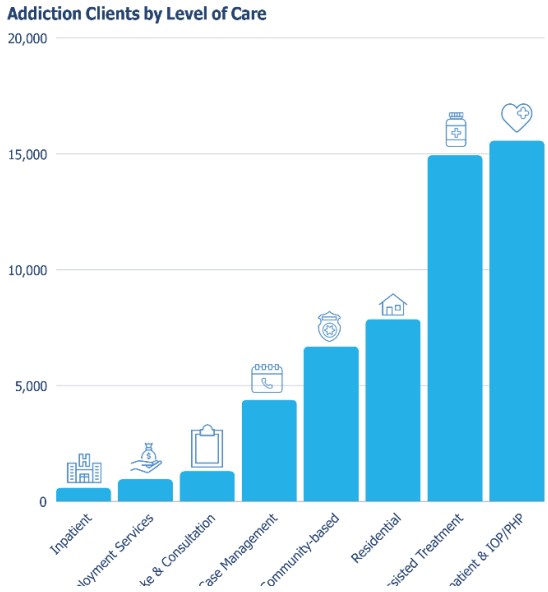
Opioids such as fentanyl and heroin are highly addictive, and their misuse has multiple medical and social consequences including increased risk for HIV/AIDS, property and violent crime, arrest and incarceration, unemployment, disruptions in family environments, and homelessness.

Chronic opioid misuse may lead to serious medical consequences such as fatal overdose, scarred and/or collapsed veins, bacterial infections of the blood vessels and heart valves, abscesses and other soft-tissue infections, and liver or kidney disease. Poor health conditions and depressed respiration from heroin use can cause lung complications, including various types of pneumonia and tuberculosis.

Opioid misuse during pregnancy can result in a miscarriage or premature delivery, as well as neonatal abstinence syndrome (NAS), and exposure in utero can increase a newborns' risk of sudden infant death syndrome (SIDS).

According to Connecticut's Office of the Chief Medical Examiner (OCME), in 2021, heroin was involved in 165 overdose deaths, and fentanyl was involved in 1,312 deaths.[3]

2022 Region 2 Epidemiological Profile: Heroin and Illicit Opioids



Capacity and Service System Strengths

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

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

According to the 2022 Community Readiness Survey, heroin and fentanyl are substances of concern among those aged 18-25 (12.0%) and those aged 26-65 (13.8%). However, alcohol is ranked higher as a substance of concern within these age groups.

Region 2's Priority Ranking Matrix of substances showed heroin and fentanyl as the overall priority substances of concern. Alcohol was ranked second and prescription misuse was ranked third as priority substances of concern. Heroin and fentanyl also ranked highest in magnitude, impact and consequence of inaction.

The Alliance for Prevention and Wellness (APW), Region 2's RBHAO, trained over 1,000 people in Opioid Overdose and Narcan Administration, and distributed 1,081 Narcan Kits to the community within 2022. The APW provided Narcan trainings were hosted both virtually and in person.

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

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

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

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

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

In2021 heroin was second in the state when it came to primary drug at admission in FY2021 (8,600 substance abuse & 507 mental health). Alcohol was first (9,662 SA & 2,673 MH) with the state having over 32,000 in SFY2021.[7] Treatment admissions with heroin as the primary drug were the highest in both 2019 and 2020 as compared to the other 4 regions.

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

6 CT DPH https://portal.ct.gov/DPH/Health-Education-Management--Surveillance/The-Office-of-Injury-Prevention/Opioid-and-Drug-Overdose-Statistics

[7] DHMAS Treatment admissions

8 https://www.cdc.gov/drugoverdose/fatal/dashboard/index.html

Heroin-involved deaths dropped 7.1% in 2021

compared to data from 2020. Just over 60% of unintentional overdoses in the state of Connecticut occurred at a residence with males having a higher mortality rate than females (62.7 vs 22 per 100,000 population).[6]

2022 South Central Region 2 Epidemiological Profile: Mental Health

Problem Statement

Mental health refers to emotional, psychological, and social well-being. Mental health has a critical impact on thoughts, feelings and actions. It also determines how individuals handle stress, relate to others, and make life choices. Mental health is important at every stage of life, from childhood and adolescence through adulthood. Many factors contribute to mental health problems, including: biological factors, such as genes or brain chemistry; life experiences, such as trauma or abuse; family history of mental health problems.

Types of mental health disorders include but are not limited to: depression; anxiety; post-traumatic stress disorder (PTSD); obsessive compulsive disorder; mood and personality disorders; eating disorders; and serious mental illness (SMI).

Anxiety and depression are the most commonly reported mental health issues, while SMI has serious consequences for the lives, livelihood, and wellbeing of individuals and families experiencing it.

Anxiety

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

Depression

Depression is a relatively common but serious mood disorder. It interferes with everyday functioning, and includes symptoms like feeling sad all the time, loss of interest in activities previously enjoyed, sleeping too much or too little, having trouble concentrating, and thinking about suicide or hurting oneself.[2] About 1 in 6 adults will have depression at some point in their life.[2] According to the 2021 National Survey on Drug Use and Health (NSDUH), 7.7% of Connecticut adults 18 and over, and 20.4% of Connecticut youths ages 12-17 reported a major depressive episode in the past year.[3]

Serious Mental Illness

Serious mental illness (SMI) refers to mental, behavioral, or emotional disorders resulting in serious functional impairment, interfering with major life activities.[4] Examples of serious mental illnesses include schizophrenia, bipolar disorder, and major depression[5]. The 2021 NSDUH reports that 4.3% of Connecticut adults that are 18 years old and over reported serious mental illness in the past year.[3]

Due to the COVID-19 pandemic, the numbers regarding mental health deaths are skewed. As many studies and graphs show, the numbers for mental health issues and deaths have declined in CT, yet they have also risen during the lockdown of 2020. More than half of Americans report that COVID-19 has had a negative impact on their mental health.[24] These complications from the pandemic have also impacted data collection methodology. Major surveys, like the Youth Risk Behavior Survey (YRBSS), Connecticut School Health Survey (CT's YRBS), and the National Survey of Drug Use and Health (NSDUH) have been impacted, making data collected by these surveys during COVID unusable for trend analysis, and to be interpreted with caution.

Magnitude (prevalence)

Anxiety

The 2019 Connecticut BRFSS showed 11.1% of adults reported feeling nervous, anxious, or on edge for more than half the days or nearly every day in the past 2 weeks.[6]

Beacon Health Options, which monitors the behavioral health claims for Husky insurance holders, reports that in the New Haven County area, at 17.1%, anxiety was the most common diagnosis among individuals 18 and older who

received treatment for mental health conditions.[7] CT PDMP data show that Benzodiazepines, which are the psychotropic medication used to treat anxiety were the second most prescribed behavioral health medication at 12.2%.

Depression

The 2021 NSDUH results showed that more CT young adults 18-25 (20.2%) reported experiencing a major depressive episode in the last year than any other age group (18+: 7.7%, 12-17: 20.2%). More CT young adults also reported illicit drug use across categories and time periods than other ae groups..[3] According to the 2021 Connecticut BRFSS, nearly 1 in 5 adults (18%) reported being told by a doctor that they had a depressive disorder, which was an increase from previous years.[8] For New Haven County, depression was the second most common diagnosis being treated for those 18 and older with state insurance (14%). Anti-depressants were the most prescribed medication for behavioral health treatment (18.2%).[7]

Mobile Crisis Response Episodes by Provider in Region 2[9,10,11,12]

Mobile Crisis Episodes by Provider *(Region 2)	2019	2020	2021	2022
CHR/Midd Hosp EMPS	515	538	488	620
Wheeler Meriden EMPS	528	454	364	525
Clifford Beers EMPS	2005	1442	1204	1763

Region 2 mobile crisis service providers saw an increase in calls from the year 2021 to 2022.[11,12] In the New Haven County mobile crisis service area the primary mental health disorder identified upon intake were depressive disorders (26.2%) followed closely by adjustment disorders (24.6%) which is a trauma and stress-related diagnoses.[12]

Serious Mental Illness

In 2021 the NSDUH data show that young adults 18-25 had a higher percentage reporting serious mental illness (9.97%) than those 26+ (3.34%).[3]

The 2021 Connecticut School Health Survey reported that almost 28.5% of high school students said their past 30-day mental health was not good (including depression, stress, emotional problems).[13] This was higher among girls (40.5%) and LGBT students (54.1%). The percentage of high school students reporting feeling sad or hopeless almost every day for two weeks or more in the past year, so that they stopped doing usual activities, was 35.6%. This was higher among girls (47.6%) than boys (24.2%), and was higher among Hispanic students (42.6%) than non-Hispanic Black (34.9%) or non-Hispanic White students (31.8%).[13]

In 2022, the national survey conducted by the Trevor Project found that 69% of LGBTQ youth in Connecticut experience symptoms of anxiety, and is even higher for transgender youth (74%). Rates were slightly lower for LGBTQ youth experiencing symptoms of depression (53%), but was also more pervasive among transgender youth (61%).[14]

Risk Factors and Subpopulations at Risk

Risk factors for depression and anxiety include[1,2,15]:

- Family history of anxiety, or depression, or other mental illness;
- Experiencing traumatic or stressful events;
- Some physical conditions can produce or aggravate anxiety symptoms, and having medical problems such as cancer or chronic pain can lead to depression;
- Substance use such as alcohol or drugs;
- Young adults report higher rates of depression and serious mental illness.[17,18]
- The prevalence of major depressive episodes is higher among adult females than males, and among adults reporting two or more races.[15]
- The prevalence of any anxiety disorder is higher among females than males.[1]
- LGBTQ individuals are more likely than

heterosexual individuals to experience a mental health condition.[14]
- Individuals who are transgender are four times more likely to experience a mental health condition.[16]
- 1 in 4 people with a serious mental illness has been arrested by the police at some point in their lifetime – leading to over 2 million jail bookings of people with serious mental illness each year.
- About 2 in 5 adults in jail or prison have a history of mental illness. 2,905 people in Connecticut are homeless and 1 in 8 live with a serious mental illness. [24]

Burden (consequences)

Mental health impacts individuals and communities in a variety of ways, including impacting quality of life, the economy, and service systems in the state. Some consequences of mental illness include:

- Mental illness (including depression, anxiety, bipolar disorder, among others) is a risk factor for suicide.[2] [16]
- Depression is the leading cause of disability in the world.[16]
- Mental illness costs Americans $193.2 billion in lost earnings per year.[16]
- 1 in 8 emergency department visits involves a mental health or substance use condition.[16]

From 2021-2022 there was a 46.1% increase in mental health treatment admissions in Region 2, and a decrease in total number of admissions from 2021 (n=3,330) to 2022 (n=2,556) with co-occurring substance use and mental health disorders.[19,20]

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

DMHAS Mental Health Treatment Admissions 2022[9]
(unduplicated clients)

Type of Admission	Region 1	Region 2	Region 3	Region 4	Region 5
Substance Use Only	6,535	8,066	6,587	20,958	7,291
Mental Health Only	5,639	12,434	6,216	15,618	8,338
Mental Health & Substance Abuse	952	2,556	1,300	3,575	1,158

Capacity and Service System Strengths

Over half of Americans nationwide that have a mental health condition are not receiving treatment, and the Mental Health America (MHA) 2022 national trend analysis found Connecticut to rank 26th in adults who have untreated mental health conditions.[21] Connecticut also ranked as 19th out of 50 in adults reporting their mental health needs have been unmet. MHA reports that these findings are not directly correlated to whether an individual holds insurance, but rather is a culmination of multiple systemic barriers that leave some adult CT residents feeling that they are unable to access quality care. For youth specifically, Connecticut rated among the lowest for youth with major depressive disorders accessing (40th) and receiving consistent treatment (35th).

It was also reported by NAMI Connecticut that In February 2021, 40.6% of adults in Connecticut reported symptoms of anxiety or depression, and of those, 22.3% were unable to get needed counseling or therapy. People in Connecticut struggle to get the help they need. Of the 160,000 adults in Connecticut who did not receive needed mental health care, 32% did not because of cost. 1,122,563 people in Connecticut live in a community that does not have enough mental health professionals. [24]

2022 South Central Region 2 Epidemiological Profile: Mental Health

People in Connecticut are over 11x more likely to be forced out-of-network for mental health care than for primary health care — making it more difficult to find care and less affordable due to higher out-of-pocket costs. It is more important than ever to build a stronger mental health system that provides the care, support and services needed to help people build better lives. 531,000 adults in Connecticut have a mental health condition. That's more than 4x the population of New Haven. 1 in 5 U.S. adults experience mental illness each year. 40,000 youth in Connecticut age 12–17 have depression. [24]

An inadequate mental health system affects individuals, families, and communities. High school students with depression are more than 2x more likely to drop out than their peers. 49% of youth in Connecticut age 12–17 who have depression did not receive any care in 2020. [24]

LGBTQ+ youth also continue to struggle with having access to culturally appropriate services, despite the above noted high prevalence of mental health concerns.[14] In 2021, 52% of LGBTQ youth in Connecticut wanted mental health services but were not able to get it. The Trevor Project reported the primary barriers found in CT for LGBTQ youth in accessing mental health services were "I was afraid to talk about my mental health concerns with someone else" (50%) and youth "experienced discrimination based on sexual orientation or gender identity (73%).

In a focus group within the recovery community in Region 2 it was reported that access to psychiatric and serious mental illness services is lacking, and not many community members know what co-occurring mental health and substance use disorders are. One person reported, "I didn't know I had a behavioral health issue." Also noted within our focus group to first responders is that there are continued barriers in finding mental health treatment providers and medication prescribers.

Another theme found within the region-wide focus group data collection for the 2022 Priority Report were that Region 2 community members in the social services sector reported continued wrap-around services are needed that address mental health holistically, including co-occurring disorders, trauma, family and home wellness, and increase collaboration across community service providers in our areas.

Community Readiness Survey: Mean Stage of Readiness for Mental Health Promotion[22]

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

While the mean stage of readiness for mental health promotion in CT is 5.[11] overall, Region 2's was higher than both the state.[22]

The Community Readiness survey showed a drastic rise in the primary perceived barrier to addressing mental health in the Region 2 community went from 31.6% in 2020 to 66.5% in 2022.[22,23] Additionally, it was reported in the 2022 CRS that most Region 2 key informants were concerned about access to mental health services for children (3.39%) compared to 3.19% in 2020.[22,23]

According to Region 2's 2022 Priority Ranking Matrix of behavioral health issues, anxiety continues to be the priority mental health issue (4.4), followed by a tie for depression (4.2) and trauma (4.2). The magnitude and impact of anxiety, trauma, and depression all have the highest rank, as does childhood serious mental illness.

Additionally, within the 2022 Connecticut Readiness Survey, 82.% of Region 2 key informants reported that depression among individuals 65 and over was the primary concern in their communities. Perceived community concern for depression trended down as age groups of focus became younger, with its

lowest reported age of concern at 12-17 year olds (28.6). Anxiety however trended down as the age group increased, with its highest age group of concern being 12-17 year olds (55%) and lowest for 65+ (8.6).

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[1]NIMH, "Anxiety Disorders."
[2]CDC, "Mental Health Conditions: Depression and Anxiety," 2022
[3]NSDUH, 2021
[4]NIMH, "Mental Illness."
[5]SAMHSA, "Living Well with Serious Mental Illness", 2022
[6]CT BRFSS 2019
[7]Beacon Health Options, 2021
[8]CT BRFSS 2021
[9]CHIDI, Mobile Crisis Intervention Services Performance Improvement Center Annual Report, FY2019
[10]CHIDI, Mobile Crisis Intervention Services Performance Improvement Center Annual Report, FY2020
[11]CHIDI, Mobile Crisis Intervention Services Performance Improvement Center Annual Report, FY2021
[12]CHIDI, Mobile Crisis Intervention Services Performance Improvement Center Annual Report, FY2022
[13]Connecticut School Health Survey 2021
[14]Trevor Project National Survey on LGBTQ Youth Mental Health by State, 2022
[15]NIMH, "Depression"
[16]NAMI, "Mental Health By The Numbers" 2020-2022
[17]NSDUH 2019-2020
[18]CT BRFSS 2019
[19]CT DMHAS, Treatment Admissions 2021
[20]CT DMHAS, Treatment Admissions 2022
[21]Mental Health America, "The State of Mental Health in America," 2022
[22]Community Readiness Survey, 2022
[23]Community Readiness Survey, 2020
[24]NAMI, “Connecticut State Fact Sheet”, 2021

2022 Region 2 Regional Epidemiological Profile: Prescription Drug Misuse

Problem Statement

Non-medical use of prescription drugs is a problem that continues to be a concern in the U.S., including within Connecticut. The types of prescription drugs that are most commonly misused include painkillers (opioids), central nervous system depressants (tranquilizers, sedatives, benzodiazepines) and stimulants.[1]

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

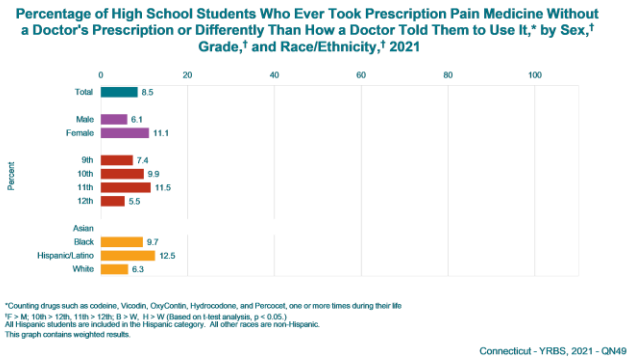
Experimentation with stimulants and anti-anxiety medications among college and high school students is an issue of concern in Region 2 in light of counterfeit pill seizures that have occurred in the last year.

Oxycodone (OxyContin), oxymorphone, tramadol, and hydrocodone are examples of opioid pain medications. Opioid painkillers work by mimicking the body's natural pain-relieving chemicals, so the user experiences pain relief. Opioids can also induce a feeling of euphoria by affecting the parts of the brain that are involved with feeling pleasure.

Tranquilizers, sedatives and benzodiazepines are central nervous system depressants often prescribed for anxiety, panic attacks and sleep disorders. Examples include Xanax, Valium, Klonopin, Ativan and Librium. These drugs can also slow normal brain function. Stimulants increase alertness, attention and energy by enhancing the effects of norepinephrine and dopamine in the brain. They can produce a sense of euphoria and are prescribed for attention-deficit/ hyperactivity disorder (ADHD), narcolepsy and depression.[1]

Magnitude (prevalence)

In 2021 pain relievers were most frequently used for non-medical purposes in the US. According to the 2021 National Survey of Drug Use and Health (NSDUH) reported that 8.7 million (3.1%) of the US population aged 12 or older had misused pain relievers. Hydrocodone (46.9%) was most frequently misused followed by oxycodone (30.4%). People aged 12 or older who misused prescription pain relievers also misused fentanyl prescription products at an estimated 6.2% (539,000) of the population.[2]



Percentage of adults who reported using prescription opioids non-medically[14]

United States	7.7%
CT	5.6%

Percentage of adults who reported using prescription drugs other than opioids and cannabis non-medically[14]

United States	7.6%
CT	6.6%

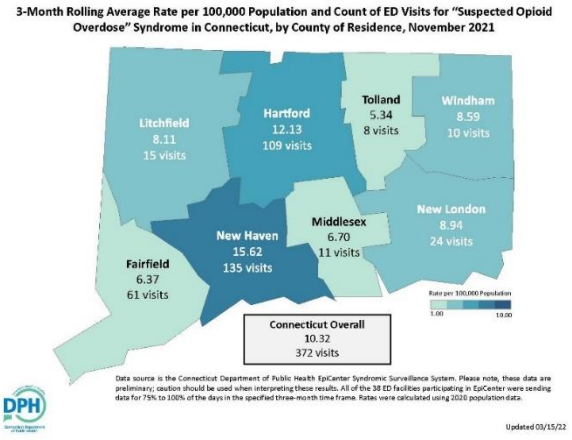
During 2021, 87 unintentional overdoses were caused by amphetamines and 298 unintentional overdoses were caused by benzodiazepines. Both benzodiazepines and amphetamines, the ages 35-44 had the highest fatality rate among any age group in CT. [5]

[1] NIDA, Misuse of Prescription Drugs Research Report

2022 Region 2 Regional Epidemiological Profile: Prescription Drug Misuse

Burden (consequences)

Prescription opioid misuse is a risk factor for heroin and other illicit opioid misuse, including illicitly manufactured fentanyl. While the estimated proportion of individuals who transition to heroin following prescription opioid misuse is low (<5%), a majority of those who use heroin initiated opioid use with non-medical use of prescription drugs (NMUPD).[8,9]



According to reports from the Office of the Chief Medical Examiner (OCME), Connecticut experienced 1,413 opioid-involved fatalities in 2021, including 83 involved oxycodone, 20 oxymorphone, 10 hydrocodone, 14 hydromorphone.[6] According to the Connecticut Department of health tramadol accounted for 49 unintentional overdoses in 2021.[12]

Approximately 12% of all opioid overdose fatalities involved a prescription opioid, but only 15% of those overdoses involved only the prescription opioid. The majority involved multiple substances; 54% also involved fentanyl, 38% involved benzodiazepines, and 20% involved heroin.[6]

There were 1062 non-fatal stimulant overdoses in 2018, and 2372 in 2019.[10]

NSDUH Substate Est mates:
Percent Meeting Criteria Past Year Pain Reliever Use Disorder, ages 12+[2]

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

According to Partnership for Safe Medicines, counterfeit drugs that are manufactured in pill press operations, have resulted in law enforcement seizures of deadly substances. CT Region 2 had one such counterfeit drug seizure in Shelton in 2019. In 2022 the DEA Laboratory found that 6 out of 10 counterfeit pills can contain a lethal amount of fentanyl which is an increase from 4 out of 10 in 2021.[13]

Platforms such as *Snapchat, Tik Tok, Instagram* have made it easier for drug dealers to access youth and sell counterfeit pills.[15]

Risk Factors and Subpopulations at Risk

Persons at risk of misusing prescription drugs include[4] :

- Those with past year use of other substances, including alcohol, heroin, marijuana, inhalants, cocaine and methamphetamine;
- People who take high daily dosages of opioid pain relievers;
- Persons with mental illness;
- People who use multiple controlled prescription medications, often prescribed by multiple providers;
- Those who purchase counterfeit pills
- Individuals with disabilities are at increased risk of prescription opioid misuse and use disorders.[5]
- Among all fatal overdoses involving prescription opioids in Connecticut in 2019, the majority occurred among non-Hispanic

whites, with male deaths occurring 1.3-2.8 times more frequently than females in each racial/ethnic group.[6]

Older adults (65+) may be at risk of consequences of prescription drug misuse, as they use prescription medications more frequently compared to the general population and may be at higher risk of medication errors.[7]

According to the 2021 Connecticut School Health Survey, Hispanic students had the highest rates of taking prescription drugs without a doctor's prescription (12.5%).[3]

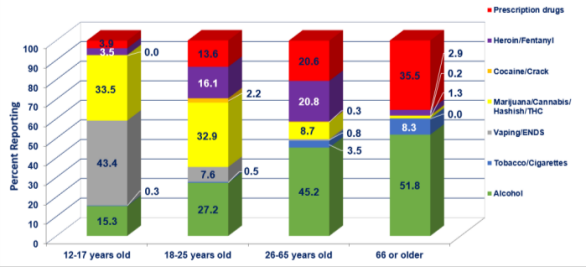
Capacity and Service System Strengths

Community Readiness Survey: Mean Stage of Readiness

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

According to the 2022 Community Readiness Survey, 32.5% of respondents agreed that prescription drugs were of great concern among those 66 and older. After alcohol, this was the substance of greatest community concern for older adults, not surprising given the concern about the interaction between alcohol and prescription medications, especially for older adults.[11]

Problem Substances of Greatest Concern for Age Groups, According to Key Informants: APW CRS, 2022[11]



According to Region 2's Priority Ranking Matrix of substances, prescription drugs ranked as the second substance of concern (3.7) after heroin and fentanyl. Prescription drug's magnitude ranked medium, with a ranking of high impact in our communities.

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

- Education for prescribers encouraging use of the state's Prescription Monitoring Program;
- Education for parents, educators, and other adults on youth prescription drug misuse and addiction;
- Promotion of DMHAS's Change the Script statewide media campaign throughout the region;
- YouThinkYouKnow campaign that raises awareness about the counterfeit pills and the dangers of counterfeit pills.

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[2] NSDUH, 2021 CT, 2016-18 substate estimates
[3] Connecticut School Health Survey, 2021 (CT YRBSS)
[4] Bali V. Research in Social and Administrative Pharmacy 2013; 9(3): 276–287.
[5] Lauer EA et al. Disability and Health Journal 2019;12(3):519-522
[6] Connecticut Office of the Chief Medical Examiner, 2021
[7] Perez-Jover V et al. Int J of Environmental Research and Public Health 2018; 15:310.
[8] Centers for Disease Control and Prevention. (2022). Quick Facts on the Risks of E-cigarettes for Kids, Teens, and Young Adults
[9] Krishnasamy, VP, Hallowell, BD, Ko, JY, et al. (2020)
[10] U.S. Department of Health and Human Services. (2014) 11CDC, National Center for Health Statistics, 2022
[11] Connecticut Community Readiness Survey, 2020, 2022
[12] Tobacco 21 Act, Pub. Act 19-13, 2019

[13]https://www.dea.gov/alert/dea-laboratory-testing-reveals-6-out-10-fentanyl-laced-fake-prescription-pills-now-contain
[14]https://www.americashealthrankings.org/explore/annual/measure/drug_use/population/drug_use_presc_other/state/CT
[15] https://www.justice.gov/opa/pr/department-justice-announces-results-enforcement-surge-reduce-fentanyl-supply-across-united

2022 South Central Region 2 Epidemiological Profile: Problem Gambling

Problem Statement

Problem gambling and Gambling Disorder include gambling behaviors that disrupt, compromise or damage personal, family, or vocational pursuits.[1] Gambling behaviors include online and in-person casinos, sports betting, private wagering, charitable gaming (i.e., bingo, raffles, etc.), lottery, and pari-mutuel (i.e., greyhound racing, off-track betting, etc.). In Connecticut, buying a lottery ticket is the most common form of gambling and football is the most popular sport that sports bettors bet on.[2]

Symptoms of problem gambling include increasing preoccupation with gambling, needing to bet more money more frequently, irritability when attempting to stop, and continuation of the gambling behavior despite serious negative consequences.[1]

According to the American Psychiatric Association, for some people gambling becomes an addiction and individuals may crave gambling the way someone craves alcohol or other substances, thus the move from being classified as an impulse-control disorder in the DSM-III and IV to substance-related and addictive disorders in the DSM-V.[3]

Magnitude (Prevalence)

The National Survey on Gambling Attitudes conducted in 2018 showed that three out four adults reported gambling in the past year. Only 12% claim to have never gambled. [2]

Every year in the United States, 2 million people are expected to have severe gambling problems and 4-6 million are expected to have mild or moderate gambling problems.[1]

According to data from Bettor Choice and Problem Gambling Services, among 306 persons admitted to treatment for gambling disorder in FY2022. Region 2 provided services to 18 individuals in 2022 through its' Bettor Choice sites.

Moreover, the Connecticut's 2020 Young Adults Statewide Survey results showed that 35.2% of young adults ages 18-25 reported gambling in the past year.[4] Of these, about 9% felt the need to bet more and more money, and 3% lied about how much they gamble, indicators of problem gambling.

According to the 2021 Connecticut School Health Survey (CT YRBS) results, 18.4% of high school students reported gambling on a sports team, playing cards or dice games, state lottery games, gambling on the internet, or betting on a game of personal skill.[5]

The 2021 Connecticut School Health Survey also showed that 24.7% of high school males reported gambling, compared with 11.7% of females.[5]

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

2018 Gambling Trends[2]	CT	Nationally
Any Past Year Gambling Activity	83%	73%
Buying Any Lottery Game	74%	66%
Buying any Raffle Ticket	55%	41%
Spending money on any Casino Activity	48%	37%
Spending money on any gaming machine	37%	32%

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

[1] National Council on Problem Gambling, 2022
[2] National Survey of Gambling Attitudes and Gambling Experiences (NGAGE), 2018
[3] American Psychiatric Association, What is Gambling Disorder, 2021
[4] American Psychiatric Association, What is Gambling Disorder, 2021
[5] Young Adults Statewide Survey, 2020
[6] Connecticut School Health Survey, 2021

2022 South Central Region 2 Epidemiological Profile: Problem Gambling

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

Covid-19 Data:

- Studies show that gambling generally decreased or remained the same during the beginning of the COVID-19 epidemic.[6] Furthermore, the amount of money wagered by European sports bettors also decreased during this period, and these sport betters did not transition to playing games in online casinos during this time.[7]
- In Massachusetts, 44.6% of gamblers reported saving money and 66.4% reported spending more time with friends and family during the COVID-19 epidemic period when casinos were closed. [8]

Risk Factors and At-Risk Populations

Studies show that at-risk and problem gambling is unstable, meaning that people typically move into and out of at-risk or problem gambling status over time.[9]

The prevalence of at-risk gambling and problem gambling is significantly higher among:[10]

- Men compared with women
- People who are Black compared with people who are White
- People with high school educations or less compared with college degrees or higher
- People with an annual household income under $15,000

Risk factors for at-risk gambling and problem gambling include:[11]

- Having an early big win
- Having easy access to preferred form of gambling
- Holding mistaken beliefs about odds of winning
- Having a recent loss or change, such as divorce, job loss, retirement, death of a loved one
- Having financial problems
- Having a history of risk-taking or impulsive behavior
- Having depression and anxiety
- Having a problem with alcohol or other drugs
- Having a family history of problem gambling
- Living within 50 miles of a casino
- Gambling on games with fast speeds of play[12]

The National Council on Problem Gambling indicates young adults and those who engage in sports betting are at higher risk for problem gambling. Sports bettors are three or more times likely to report frequent risky behavior than non-sports bettors.

Region 2's largest at-risk population is white males, 45 years of age and older.

Video Games and Gambling:

Playing video games may also be a risk factor for gambling as problem gambling has been found to have a statistically significant association with loot box spending.[13] Loot boxes are features in video games that contain a randomized prize and can be bought using real-life money. Moreover, 60.3% of video gamers reported that they endorse spending money on loot boxes. [14] In addition to loot boxes, betting on E-sports and token wagering are other forms of video-game-related gambling or gambling-like behaviors.

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.

Burden (Consequences)

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

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[7] Auer, M., Malischnig, D., & Griffiths, M. D. (2020)
[8] Wood and Tabri (2020)
[9] A Six-Year Longitudinal Study of Gambling and Problem Gambling in Massachusetts, 2021
[10] Gambling and Problem Gambling in Massachusetts: Results of a Baseline Population Survey, 2017
[11] Risk Factors for Developing a Gambling Problem, Centre for Addiction and Mental Health (CAMH)
[12] Harris, & Griffiths, M. D. (2017)
[13] Zendle, & Cairns, P. (2018)

[14] Brooks, & Clark, L. (2019)

- 439 phone calls were made to the Connecticut Council on Problem Gambling Help Line in 2021.
- Male and female individuals who experience problems with gambling are two times more likely to have a psychiatric condition in their lifetime than those who do not experience problems with gambling.[15]
- Of gamblers with histories of psychiatric conditions, female gamblers tend to start problem gambling after the onset of their psychiatric condition. Meanwhile, their male counterparts are more likely to have the onset of their psychiatric conditions (depression and suicidal events) emerge after they began participating in problem gambling.[16]
- Individuals experiencing problems with gambling are also at increased risk for suicidal ideation and suicide attempts. This risk is especially high for individuals who have a co-occurring psychiatric disorder or/and a substance use disorder.[16]
- Individuals experiencing problems with gambling are 4 to 7 times more likely to have alcohol and other drug problems (including nicotine dependence) than individuals who do not gamble or who gamble recreationally.[17]
- Individuals who participate in high-risk gambling report significantly lower levels of life satisfaction than individuals who do not participate in problem gambling.[18]
- Qualitative interviews show that Individuals who experience problems with gambling commonly report that their problem gambling contributes to some form of negative financial and relationship consequences.[19] For example, individuals who participate in high-risk problem gambling report having overdue household bills 3 times more frequently than individuals who do not participate in problem gambling. [18]
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Readiness

According to the 2022 Connecticut Community Readiness Survey (CRS) results, 36.9% of key informants reported that Connecticut residents believed that preventing problem gambling/gaming addiction in their community is very important.

- There were differences in this perception by community type. For example, 26.4% of key informants in rural communities reported that residents believed that preventing problem gambling/gaming addiction in their community is very important, versus 41.8% in urban core communities.[20]

CRS results also showed that 68.2% of key informants reported that community residents are not at all or only little aware that gambling activities can become an addiction for some people. [20] This points to the need for awareness building about gambling risk.

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

	CT	Region 1	Region 2	Region 3	Region 4	Region 5
2022	37.9	48.9	35.9	39.9	29.2	37.8

The 2022 Community Readiness Survey ranked the ability to raise awareness about the risks of problem gambling / gaming as low.

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

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

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

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

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[15] Sundqvist, & Rosendahl, I. (2019)
[16] Håkansson, & Karlsson, A. (2020)
[17] Grant, & Chamberlain, S. R. (2020)
[18] Paterson, M., Taylor, M. & Gray, M. (2020)
[19] Langham, E., Thorne, H., Browne, M., Donaldson, P., Rose, J., & Rockloff, M. (2016)
[20] Connecticut Community Readiness Survey, 2022
[21] CT Gen Stat § 17a-713. (Formerly Sec. 19a-4h) (2020)

2022 South Central Region 2 Epidemiological Profile: Problem Gambling

State Context

- In 2021, Governor Ned Lamont signed into law House Bill 6451, legalizing online gaming and sports wagering in Connecticut and increased the annual funding into the Chronic Gamblers Treatment Rehabilitation Account for problem gambling prevention, treatment, and recovery support to 3.3 million dollars.[21]
    - This bill puts Connecticut among a half-dozen states with online casino gambling, effectively giving any adult physically in the state the means to gamble 24/7 on a smartphone, tablet or computer. (CT Mirror, May 2021)
    - While responsible gambling/gaming safeguards will be included in online betting platforms, electronic access will increase the number of people engaged in gambling activity.

- Since 2010, gross sales for lottery, pari-mutuel and charitable gaming have increased by over $187 million.

2022 South Central Region 2 Epidemiological Profile: Suicide

Problem Statement

Suicide is defined as death caused by self-directed violence with an intent to die.[1] Suicide is a growing public health problem and is now the tenth leading cause of death in the United States.[1] Suicide is a problem across the lifespan; however, it is the second leading cause of death among people 10- 14 years old, third leading cause of death among people 15-24, and fourth among people 35-44 years old.[1]

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

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

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

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

[1] CDC (2019). Suicide Prevention
[2] NIMH (2020). Suicide
[3] CT DPH (2021). CTVDRS, Violent Deaths: Region 2 Data 2015-2019, 2015-2021

Magnitude (prevalence)

Data from the 2021 National Survey on Drug Use and Health (NSDUH) showed 4% of adult respondents (18+) in Connecticut reported having serious thoughts of suicide in the past year.[5] This percentage is nearly 3 times that prevalence among young adults 18-25 years old (11.5%) and nearly four times higher than those 26+ (2.8%).[5] Additionally, 2.3% of young adults reported attempting suicide in the past year.[5]

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

According to the Connecticut Department of Public Health, 86 suicides took place in region 2 during 2021, accounting for nearly 22% of CT suicides in that year. Suicides occurred most often in New Haven (11), Meriden (10), Branford (7), Milford (6) and Wallingford (6), although rates were not calculated to account for population.[3]

Comparing the region's rates of suicide during 2015-2019, Region 2 had the second highest rate per 100,000.[3]

The state of Connecticut as a whole has experienced a 15.9% decline in suicide deaths in 2021 compared to the 5-year average (2015 to 2019).[3]

[4] CT OCME (2021). Annual Statistics: Suicides
[5] NSDUH (2021 CT, 2016-18 substate estimates)

2022 South Central Region 2 Epidemiological Profile: Suicide

NSDUH Substate Estimates:
Percent Reporting Past Year Serious Thoughts of Suicide, ages 18+[5]

	CT	Region 1	Region 2	Region 3	Region 4	Region 5
2016-2018	**4.2**	**4.3**	**4.2**	**4.6**	**3.9**	**4.0**

According to data from the 2021 Connecticut School Health Survey (CT YRBSS), 14.1% of high school students reported seriously considering attempting suicide in the past year.[6] In 2021, 5.9% of high school students reported attempting suicide one or more times during the past year.[6]

The 2020 Connecticut Behavioral Risk Factor Surveillance System (BRFSS) showed that among adults over 18, 12.6% reported ever thinking of taking their own life.[7] Among those who thought of suicide, over 1 in 4 had attempted suicide.[7]

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

Risk Factors and Subpopulations at Risk

- Men accounted for 79% (N=68) of suicides from 2015-21 in Region 2.[3]
- White non-Hispanic males account for 66.3% of suicides 2015-21 in Region 2.[3]
- Nationally, non-Hispanic American Indian/Alaska Natives experience high rates of suicide.[1]
- Other disproportionately impacted populations include Veterans and military personnel and certain occupational groups such as construction and sports.[1]
- Sexual minority youth experience increased suicidal ideation and behavior compared to their peers.[1]
- Mental illness is a risk for suicide, including depression, anxiety, bipolar disorder, and general depressed mood.[3]
- For those over 45, other risks include physical illness, such as terminal illness and chronic pain, as well as intimate partner problems.[3]

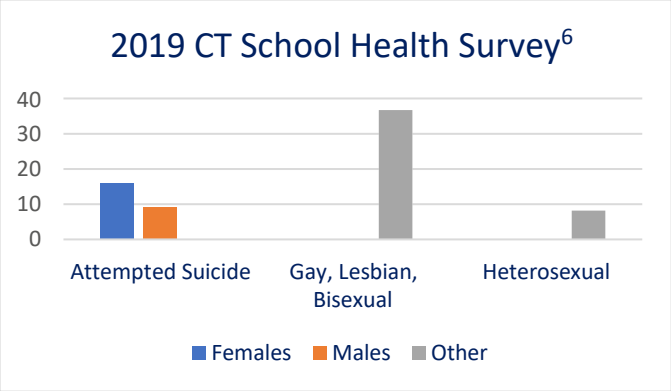
Other risk factors include[1]:

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

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

[6] Connecticut School Health Survey, 2021, 2019 (CT YRBSS)
[7] Connecticut BRFSS 2020
[8] Connecticut Community Readiness Survey, 2022

2022 South Central Region 2 Epidemiological Profile: Suicide



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

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

Burden (consequences)

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

Capacity and Service System Strengths

Community Readiness Survey: Mean Stage of Readiness for Mental Health Promotion[8]

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

The 2022 Community Readiness Survey for suburban Connecticut indicated that 49.4% agreed that there was *some support* for suicide prevention efforts, while 20.9% felt there was *a lot of support*.

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

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

2022 South Central Region 2 Epidemiological Profile: Tobacco and ENDS

Problem Statement

According to the National Survey of Drug Use and Health (NSDUH) and the Youth Risk Behavior Surveillance Survey (YRBSS), tobacco use has decreased for all age groups over the past decade.
Tobacco product use includes cigarettes, smokeless tobacco (i.e., chewing tobacco or snuff), cigars, and pipe tobacco. Young adults aged 18-25 continue to have the highest rates of cigarette use of any age group in Connecticut.[1] Despite significant decreases, smoking remains a health concern due to serious adverse physical effects of tobacco use.

However, tobacco products are only a part of a much larger issue. The use of electronic cigarettes and electronic nicotine delivery systems (ENDS) is an emerging problem nationally and in Connecticut, as rates continue to rise at a steady pace. Vaping refers to the use of e-cigarettes or ENDS which are metal or plastic tube filled with a liquid referred to as "e-juice". This liquid comes in a variety of flavors and nicotine levels. E-cigarettes and ENDS devices aerosolize the liquid via a battery-powered heating element. The resulting aerosol is inhaled by the user and exhaled into the environment The liquid that is utilized in the device is called "e-juice" and is available in a variety of flavors and nicotine levels. There are many types of electronic smoking devices, including: e-hookahs, vape pens, e-cigarettes, and hookah pens.

Magnitude

NSDUH data show that past month tobacco product use among Connecticut residents 12+ declined greatly from 25.1% in 2009-2010 to 16.8% in 2019-2020.[1]

According to NSDUH data, Region 2 reported prevalence of past month tobacco use dropped from 21.6% based on 2016-2018 data, to 18.4% in 2018-2020.

Percent Reporting Past Month Tobacco Product Use, ages 12+

	CT	Region 1	Region 2	Region 3	Region 4	Region 5
2016-2018	**21.3**	17.4	**21.6**	22.5	22.0	23.1

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

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

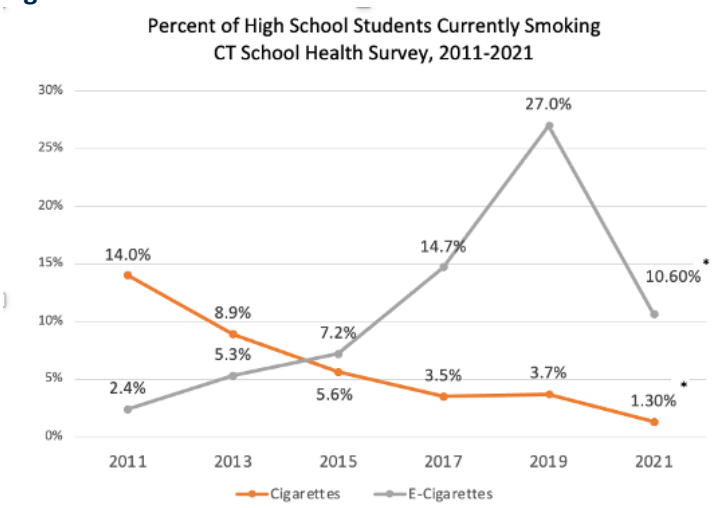
One New Haven public high school conducted a survey of high school youth. Out of 1,043 youth, 45% of youth have used substances in their lifetime, and 11% currently use some form of tobacco products.

Over the past 10 years (Figure 2), trend data shows current cigarette smoking among high school students in Connecticut has declined, while the current use of electronic smoking devices (e-cigarettes) has increased. The 2021 Connecticut School Health Survey (CT YRBS) data show that the current use of cigarettes among high school students is 1.3%, a nearly 13 percentage point decrease since 2011 (Figure 1), While the current use of electronic vapor products among high school students is 10.6%, an 8 percentage point increase since 2011, use has decreased since the 2019 rate of 27.0%. These findings imply that while e-cigarettes had been replacing tobacco smoking as the main mechanism for nicotine delivery, nicotine use in general seems to be decreasing among this age-group. Caution should be taken when comparing the 2021 data to that of previous years because the 2021 Connecticut School Health Survey was collected using a different methodology and during a different semester than done in previous years.[2]

[1] NSDUH, 2021 CT, 2016-18 substate CT estimates
[2] Connecticut School Health Survey, 2021 (and 2011-2021)

2022 South Central Region 2 Epidemiological Profile: Tobacco and ENDS

Figure 1.



*Caution should be taken when comparing the 2021 data to that of previous years since the 2021 Connecticut School Health Survey was collected during the Fall semester instead of during its usual collection period in the Spring due to delays resulting from the COVID-19 pandemic.

Additionally, according to the Connecticut's Behavioral Risk Factor Surveillance Survey (CT BRFSS), the prevalence of adults ever using e-cigarettes has increased each year since 2012. The 2020 CT BRFSS results showed that 20.9% of adults in Connecticut reported having tried e-cigarettes in their lifetime, 8.7% use daily.[3]

DataHaven's 2021 Community Wellbeing Survey reported similar results. According to the survey, ENDS use is most prevalent among 18 to 34 year-olds (45%) with prevalence of use decreasing as age increased. Lifetime use was highest among Suburban (28%) and Urban Core (26%) communities, followed by Urban Periphery (20%), Rural (14%), and Wealthy (8%) communities.[4]

ENDS use is of particular concern among youth, who report significantly higher use rates than adults. Nationally, the 2019 Youth Risk Behavior Survey (YRBS) results showed 50.1% of high school students reported ever using an electronic vapor product, and 32.7% reported use in the past 30 days.[5]

Figure 2. CT High School Students Reporting Past Month Use of ENDS (CSHS)[2]

Year	Percentage
2011	2.4%
2013	5.3%
2015	7.2%
2017	14.7%
2019	27%
2021	10.6%

A sample of 6 student surveys collected in Region 2 between 2019 and 2021, found that 13.5% of high school students had used an ENDS in the past 30 days. The rates ranged from 9.4% in one shoreline community, to 35% in a suburban community.

Risk Factors and Subpopulations at Risk

Populations at-risk for **smoking cigarettes** in CT are:

- Males
- households earning less than $35,000
- Individuals with a disability
- Individuals with no more than a high school education[3]

Additional Populations at-risk include:

- Individuals with poor mental health status
- American Indians/Alaska Natives
- LGBT individuals
- Military service members and veterans[6]

Populations most at-risk for using ENDS are:

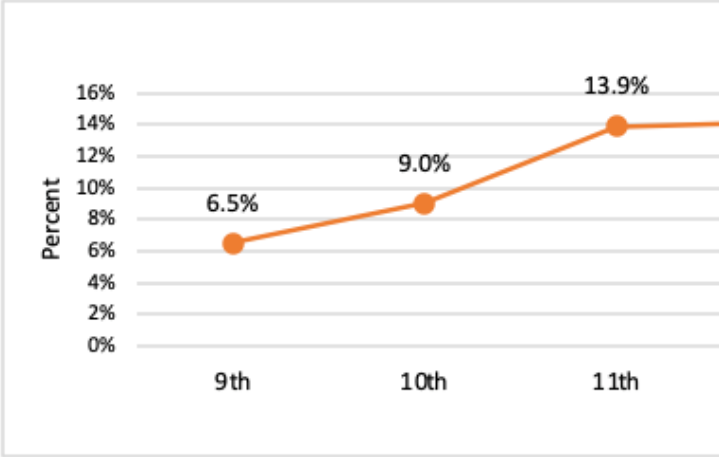
- *Adults* with the following characteristics: male gender; from households earning less than $35,000; with a disability; with less than a high school education; with poor mental health status; or without health insurance[3]
- *Young adults* with the following characteristics: female gender; lesbian, gay or bisexual; white race; Hispanic ethnicity; poor mental health status[2]
- Youth and young adults in general (12-34)[3, 4]
- Current smokers
- Those living in urban and urban and suburban communities[4]

[3] CT BRFSS (2020)
[4] DataHaven and Siena College Research Institute (2021) 2021 DataHaven Community Wellbeing Survey
[5] Creamer MR, Jones SE, Gentzke AS, et al., (2020). YRBS 2019.
[6] CDC (2022) Burden of Cigarette Use in the U.S.

2022 South Central Region 2 Epidemiological Profile: Tobacco and ENDS

The 2021 Connecticut School Health Survey (CT YRBS) data show that current use of electronic vapor products increased by grade among high school students (Figure 3). 15.5% of female students were current e-cigarette users, compared to 6.9% of males. Non-Hispanic White (10.7%) and Hispanic (12.4%) students were more likely than Black (10.9%) students to be current users. Additionally, students identifying as gay, lesbian, or bisexual reported higher a prevalence (16.7%) than their heterosexual peers (8.9%).[2]

Figure 3. Current Use of Electronic Vapor Products by Grade, CSHS 2021[2]



Burden (consequences)

- Evidence shows that young people who use e-cigarettes may be more likely to smoke cigarettes in the future.[7]
- A recent CDC study found that 99% of e-cigarettes sold in the US contained nicotine, which can cause harm to parts of the adolescent brain that control attention, learning, mood, and impulse control.[7]
- E-cigarette aerosol can contain several potentially harmful substances, including diacetyl (in flavorings), which is a chemical linked to serious lung disease. It can also contain volatile organic compounds, cancer causing chemicals, and heavy metals such as nickel and lead.[7]
- Some ENDS devices, including those that are particularly popular among youth, have been modified to allow for higher doses of nicotine to be delivered. They also facilitate the use of THC and in higher potency. This is especially problematic in youth use, because of the increased risk of tobacco and cannabis use disorders later in life.[7]
- As of January 14, 2020, a total of 2,668 hospitalized cases of e-cigarette or vaping product use-associated lung injury (EVALI) had been reported to the CDC across all 50 states, the District of Columbia, Puerto Rico and the U.S. Virgin Islands.[8] Of these, 57 resulted in deaths. Connecticut accounted for 51 of the cases; 65% were male and 55% were between 18 and 34 years old. The vast majority were from Fairfield (38%) and New Haven (25%) counties.[*9] EVALI appears to be primarily driven by the use THC-containing vaping products, possibly due to substances, such as vitamin E acetate, added to the formulations.[8]
- Because vaping/smoking weakens the lungs and immune system, those who vape are at higher risk of COVID-19 due to compromised immune systems.[9]
- Cigarette smoking is the leading cause of preventable death, disability, and disease in the US.[10] Furthermore, smoking increases the risk of heart disease, cancer, stroke, and chronic lung disease[9]. This is a concern for Connecticut residents because heart disease is the leading cause of death in the US and in Connecticut.[11]

Capacity and Service System Strengths

NSDUH 2016-18 substate estimates, the most recent estimates available, show that 75.3% of Region 2 respondents believed that there is a great risk associated with smoking one or more packs of cigarettes per day. This percentage is greater than the state average of 74.5%. [1]

Figure 4. NSDUH Substate Estimates: Percent Reporting Perception of Great Risk from Smoking One or More Packs of Cigarettes per day, ages 12+[1]

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

2022 South Central Region 2 Epidemiological Profile: Tobacco and ENDS

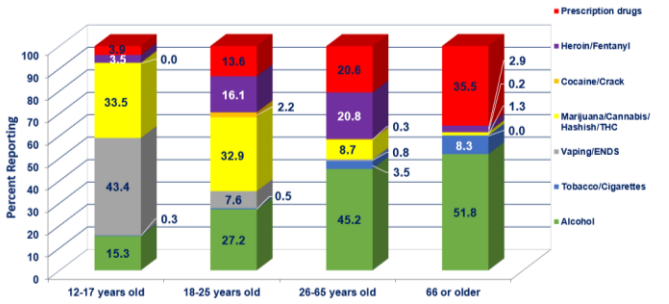
Additionally, key informants who completed the Community Readiness Survey ranked their communities' readiness to address these areas of concern as 5.36 out of a scale of 1- 9. This was the second highest mean stage of readiness for substance use prevention out of all the regions in CT (Figure 5).[12]

Figure 5. Community Readiness Survey: Mean Stage of Readiness for Substance Misuse Prevention

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

The 2022 Community Readiness Survey Region 2 indicated that vaping/ENDS was the substance of greatest community concern for the 12-17 year old age group. (Figure 6).

Figure 6. Problem Substances of Greatest Concern for Age Groups, According to Key Informants: APW CRS, 2022[12]



According to Region 2's Priority Ranking Matrix of priority substances, ENDS (Electronic Nicotine Delivery System) was ranked as the third highest priority after heroin and prescription drug use. The magnitude with regard to use of ENDS ranked high and impact was ranked as medium. Tobacco ranked low as a priority substance of concern. Tobacco was also ranked low in magnitude, impact, and readiness to address the substance. However, tobacco ranked high with regard to consequence of inaction. Tobacco ranked higher overall as a priority substance (2.7) before cocaine (2.6).

Connecticut's Response

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

These efforts include:

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

Effective October 1, 2019, Connecticut prohibited the sale/delivery of ENDS or vapor products to any person under the age of 21 as part of a bill referred to as "Tobacco 21". This bill also expands the Clean Indoor Air Act to prohibit the use of ENDS and vapor products on school properties and day care center facilities or grounds at all times. It also requires the Department of Mental Health and Addiction Services (DMHAS) to conduct compliance checks on e-cigarette dealers and refers those that are noncompliant to the Department of Revenue Services.[13]

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[7] Centers for Disease Control and Prevention. (2022). Quick Facts on the Risks of E-cigarettes for Kids, Teens, and Young Adults
[8] Krishnasamy, VP, Hallowell, BD, Ko, JY, et al. (2020)
[9] Connecticut Department of Public Health (DPH) https://portal.ct.gov/DPH/Health-Education-Management--Surveillance/Tobacco/Vaping
[10] U.S. Department of Health and Human Services. (2014)
[11] CDC, National Center for Health Statistics, 2022
[12] Connecticut Community Readiness Survey, 2020, 2022
[13] Tobacco 21 Act, Pub. Act 19-13, 2019

Discussion of resources, strengths, assets in the region

Many resources, strengths and assets were identified in Region 2. The region boasts a variety of behavioral health providers that provide comprehensive services across the continuum of care. Telehealth increased access to both behavioral health and substance abuse treatment services during the pandemic which helped improved access to 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), and intensive outpatient groups services.

It was reported that the DMHAS action line in particular is seen as efficient and effective for connecting adults to substance use treatment and was reported as having an “80% success rate” during a focus group. The recovery community reported that its effectiveness is most noted in responsiveness on the call-line, the dispatching of emergency response, and the inpatient bed follow-up with the caller. It was reported during a focus group that when no beds are available, the DMHAS action line provider will follow-up with the caller once a bed has been made available. 2-1-1 was also reported as “easy to use” and efficient for mobile crisis response. It was also noted that a strength of our region is in-home addiction treatment options, as well as family-focused addiction services.

Some reports of collaborative efforts between social service providers were mentioned during focus groups as a strength of some of our regional towns. Recovery Coaching / Peer Support continues to be available in three Region 2 specific hospitals. It was also reported that our region’s recovery centers are a major asset to the community. One person during a focus group reported, “People who OD’d across the street walked over to center with a recovery coach and now are employed.” These recovery centers that are peer-led embody a culturally responsive and appropriate framework by meeting the needs of the recovery community by providing access to stigma-free community safe places and increased access to basic needs, like vocational support. The Region is also proud to have a few programs that support individuals' post-incarceration in re-integrating into the community through employment and housing supports.

Community members also reported strengths within the region regarding key priority issues. Development of initiatives that support, and advocate for environmental strategies occurred across the region. Prevention education materials for youth including “Be In The Know,” the new DMHAS educational campaign for cannabis prevention, and the RBHAO’s promotion of external prevention campaigns to local partners was highlighted as a regional strength. It was also noted that within some school systems of our region, there is increased focus on addressing youth mental health through primary prevention strategies and cross collaboration between town social service partners. A unique messaging campaign was created through the efforts of several Region 2 coalitions aptly titled: “*Mention Prevention”*. This media campaign used social media platforms, billboards, and radio announcements to

reach youth and adults. It was reported that most locales within Region 2 are aware of the on-going substance use prevention efforts in their town. The State Opioid Response initiatives continue to support localized prevention strategies, including, community Narcan distribution.

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

Additional noted existing community strengths and assets regarding mental health is the promotion of available treatment options through various platforms including social media. It was also noted that Region 2 does well hosting and promoting Mental Health First Aid and the Community Assistance Program training to diverse populations. APW hosts monthly professional network meetings to increase the capacity of local prevention council leaders and health department members in understanding and adapting the Strategic Prevention Framework in their work.

Many community partners have also embraced the language matters movement and promote the messaging through various platforms. New treatment resources developed for those affected by early serious mental illnesses like first *episode psychosis* as an early intervention program promoting recovery. Such treatment is provided in New Haven for affected young adults.

First responders have reported observed and experienced strengths in their community related to behavioral health prevention, treatment, and recovery. During data collected from the Region 2 focus group interviews, first responders reported a strength is the outreach efforts coming from service providers and making resources easily available within some of our regional towns.

Problem gambling prevention saw gaps in skilled staff for providers of treatment services in region 2. The strengths highlighted were the community's awareness of problem gambling resources. Training initiatives funded by DMHAS' Problem Gambling Services provided problem gambling specific to Strategic Prevention Framework (SPF) training through CADCA. Region 2 had continued presence of both PGS and CCPG in our communities to support training efforts of both youth and adults.

Discussion of resource gaps and needs in the region.

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

The overarching theme across all domains in the behavioral health sector was the continued gap in having culturally responsive prevention, treatment, and recovery options. Culturally responsive options recognize difference between cultural groups and include affirming and appropriate care that addresses the specific needs for diverse racial and ethnic populations, lower socio-economic status communities, and LGBTQ+ individuals. While there were some noted improvements in the treatment field, recovery was still the primary area that was reported to be lacking in culturally appropriate and responsive options.

Participants in the Recovery Community focus group reported that the LGBTQ+ population as well as people of color are greatly affected by behavioral health concerns, and our community needs greater effort towards building capacity in this area to increase culturally responsive outreach efforts. It was also reported that within treatment and recovery, educational materials need to be made available regarding co-occurring disorders. A focus group member reported that, “I didn’t know I had a behavioral health issue.” The siloes between mental health and substance use social service systems creates inappropriate treatment options that do not adequately meet the needs of the community. It is recommended by regional partners that in order to provide culturally attuned and responsive care, it must be led by the communities that are being impacted.

It was also reported that a major need of the substance use treatment options within our Region is to re-evaluate admission criteria and accessibility. It was reported within a focus group that some treatment facilities will not accept individuals that are “too clean,” or not having enough of a substance in their system to have access to treatment. It was also reported that individuals have been denied access to treatment if they “dress well,” and that individuals often experience treatment by providers that is not evidenced-based.

Another gap that was noted this year as it was in 2021 is that after-care and follow-up options for behavioral health treatment and recovery continue to remain greatly inadequate in our Region. It was reported by the recovery community during our focus group that we need to “go to them rather than waiting for them to show up at your door.” It was discussed in the focus group how a barrier to access to treatment and recovery services are that it is not led by peers with shared lived experiences that go to local hot spots to ensure access to resources and to truly meet the community where they are at. It was reported these peer-led outreach efforts should include expanding the awareness of treatment options, as well as treatment follow-up post discharge for both mental health and substance use.

While the region has seen some growth in our “recovery centers” in the New Haven area, Region 2’s River Valley and Shoreline towns are still tremendously under-resourced, especially within the treatment and recovery options. Vocational and housing support were reported to be the most needed by the recovery community. Services for senior citizens remain a challenge in both the area of mental health and substance misuse. Additional barriers for this population include co-payments and out of pocket expenses for care. Additional treatment resources discussed included psychoeducation for families, step down from hospitalization treatment options, sobering centers, and increased access to existing services. Providers, people with lived experience and first responders reported the lack of alternate hospitalization treatment options such as emergency shelters.

During the pandemic, the sub-population with inadequate behavioral health treatment were adolescents, and youth continue to stand out as in need of mental health services in our region, along with communities where English is their second language. It is reported that our region continues to face a provider shortage for mental health and substance use treatment. There continues to be long waitlists, providers not calling back parents or school referrals. The new reduction of telehealth services for Husky insured individuals that will be enacted on May 12th, 2023 under the state’s new policy titled “New Guidance for Services Rendered via Telehealth under the Connecticut Medical Assistance Program (CMAP)” is anticipated to create further barriers to accessing care that was expanded as telehealth services were readily available during the pandemic.

We have also been given reports by community stakeholders that inappropriate levels of care are being utilized due to lack of adolescent services, (ED for behavioral health crises, outpatient clinics instead of higher levels of care, etc). It was reported across multiple focus groups and key informant interviews that anxiety is the most concerning issue among youth, and social service providers struggle to address the anxiety of our region’s young people. Additionally, teachers and social service providers have their own stressors with minimal resources in the region.

Social stigma against behavioral health issues, as well as lack of knowledge concerning available behavioral health resources continues to be a region-wide issue which impacts collaboration opportunities across social institutions and service providers. While efforts for collaboration have increased since the last report, there are still struggles within the emergency response system to collaborate and first responders not knowing what the best resource is for the presenting issue.

Prevention needs, and gaps were also discussed in the region. One of the most pressing needs throughout the region focused on cannabis use and vaping. Early intervention through education at younger ages was a theme heard throughout our communities. It is reported that youth are obtaining cannabis and vape products primarily through social media platforms, as well as from their older siblings and through their parents’ supply.

While a reported strength by the Region 2 community members is the awareness of gambling prevention and treatment resources, members also reported challenges due to the recent legislation in Connecticut that has legalized online gambling. Attention to problem gambling/gaming prevention needs to be more inclusive of young adults and youth. During the one of the Region 2 focus groups, a participant said, “adults gamble, youth game.”

Participants reported that there is not enough youth gambling education readily available in our communities, and most reported they were unsure if the youth in their community were in fact gambling due to lack of their own education on the topic. It was also discussed during the focus groups that the pro-gambling messaging through Draft Kings and FanDuel are much more common than problem gambling prevention messaging. Community members continued to report as they did in 2021 that there is a gap in outreach and promotion of problem gambling resources. While the RBHAO does promote problem gambling material to their local prevention councils, capacity is limited and restricts the ability to promote the material in the community as needed.

Furthermore, it was also reported that an increase in gambling recovery resources for individuals across the lifespan is needed within local area.
Building capacity to move the Local Prevention Structure to more of a coalition framework has been challenging this year in Region 2. Lack of financial and human resources in these grassroots councils prevent the community from developing leadership around prevention issues and embracing the Strategic Prevention Framework (SPF) model.

Recommendations and conclusion

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

1. Improve and expand outreach strategies by using Recovery Coaches to connect with their community to increase access to resources. Outreach efforts are also needed for post-treatment and post-overdose follow-up.
2. Expand recovery centers across the region
3. Availability of 24/7 behavioral health crisis and sobering centers as a holding space for individuals other than emergency departments that are more appropriate for their presenting concerns, while also still meeting their treatment and observation needs.
4. Increase funding for Local Prevention Councils and RBHAO’s to increase capacity for prevention efforts that include innovative environmental and harm-reduction strategies.
5. Increase peer-led prevention social norming campaigns and youth early intervention efforts in schools for students identified being at risk for substance misuse.
6. Increase the behavioral health workforce through more funding and burnout prevention for clinicians and psychiatrists
7. Increase cultural-competence training of behavioral health providers to ensure reduction of biases, mitigation of oppression systems within behavioral health

services, and improve client outcomes. This includes an examination of barriers for individuals across class, racial, and gender-based structures that inhibit access to appropriate and affirming care.

8. Increase funding for culturally-specific behavioral health centers that exist in our region but are under-funded and at minimal capacity.
9. Address housing disparities and transportation barriers to improve access and engagement with resources, as well as improving quality of life of community members as a prevention strategy.
10. Collaboration among treatment service providers and first responders to implement regional or statewide behavioral health strategies. Collaboration will also reinforce efficacy of interventions.
11. Cities and towns should consult with their RBHAO's in regards to opioid settlement funds, as well as other national substance use settlement funds.
12. Implement state-wide ban in alcohol advertisements that target youth drinking, as well as implement drug endangered children's model for all substances.

In conclusion, the RBHPSW members will work with the APW team to advocate that community partners utilize this report to enhance collaborative efforts that work to address the identified challenges. The RBHPSW feels that Region 2 has many service strengths and strong collaborations that can be key components in breaking down barriers and enhancing services and building programs that create healthier communities.

Summary of Priority Recommendations: Region 2

Problem/Issue	Prevention	Treatment	Recovery
Substance Abuse/Misuse			
Region	Recovery coaches for resource outreach and harm reduction	Recovery coaches for treatment follow-up	Recovery coaches for recovery follow-up; Expand availability Recovery Centers like CCAR across the region
State	Make youth-led & culturally appropriate parent and youth social norming prevention campaigns that can be easily utilized by coalitions (social media graphics, etc.).; Ban alcohol advertisements that target college youth	Mandated training for all first responders and behavioral health staff on harm reduction and co-occurring disorders; Establish behavioral health crisis and sobering centers; Explore and address provider burnout to increase retention & improve quality care	Expand recovery supports through adding comprehensive vocational supports, and expand recovery supports to make more accessible to the communities
Mental Health			
Region	Recovery coaches for resource outreach	Recovery coaches for treatment follow-up	Recovery coaches for recovery follow-up; Expand availability Recovery Centers like CCAR across the region
State	Make youth-led & culturally-appropriate parent and youth social norming prevention campaigns that can be easily utilized by coalitions (social media graphics, etc.).	Mandated training for all first responders and behavioral health staff on harm reduction and co-occurring disorders; Establish behavioral health crisis and sobering centers; Explore and address provider burnout to increase retention & improve quality care	Expand recovery supports through adding comprehensive vocational supports, and expand recovery supports to make more accessible to the communities
Problem Gambling			
Region	Recovery coaches for resource outreach	Recovery coaches for treatment follow-up	Recovery coaches for recovery follow-up; Expand availability Recovery Centers like CCAR across the region
State	Make youth-led & culturally-appropriate parent and youth social norming prevention campaigns that can be easily utilized by coalitions (social media graphics, etc.); Ban gambling advertisements that college college-youth	Mandated training for all first responders and behavioral health staff on harm reduction and co-occurring disorders; E stablish behavioral health crisis and sobering centers; Explore and address provider burnout to increase retention & improve quality care	Expand recovery supports through adding comprehensive vocational supports, and expand recovery supports to make more accessible to the communities
Systems/Other			
State	Explore and improve transportation and housing barriers; provide more culturally appropriate & affirming community awareness building campaign materials on co-occurring disorders that can be easily utilized by LPCS; Maintain telehealth services for Husky insured individuals to sustain access to treatment		

Substate/ Infrastructure (consider: regional, community, LPCs, RSABs, RGATs, etc.)	Increase RBHAO capacity to address equity and stigma-issues amongst social services in the Region; Increase RBAHO and LPC funding to increase prevention capacity; Develop a synchronized system for RBAHO's to access behavioral health data to provide full insight into local conditions.

APPENDICES

Priority Recommendation Worksheet

PRIORITY PROBLEM	Risk Factor(s)	Subpopulation(s) of Increased Risk	Community Strengths, Resources and Assets	Challenges, Gaps, and Needs		
Substance Misuse/Abuse				**Prevention**	**Treatment**	**Recovery/ Maintenance**
Alcohol	Extended retail sale hours, alcohol home delivery is available, increase in nip sales	Adults, young adults, adolescents	Newly available funding to address underage drinking within our community coalitions	Positive community messaging promoting use, low perception of harm, need more adult prevention efforts	Not enough inpatient beds available for persons needing treatment, Inconsistent and low access to treatment transportation, Need for culturally informed treatment for BIPOC and LGBTQI+, and women-focused treatment options, Waiting lists for outpatient addiction treatment, barriers to accessing treatment due to being insured/high medical costs	Need for more outreach and recovery support, need post-treatment follow-up care, Need for recovery friendly workplaces
Tobacco	Easily accessed, lack of enforcement for underage youth sale, and considered culturally appropriate for adults use especially while drinking, increase risk for vaping use, social clubs promote tobacco use	Adults, Persons with serious mental illness, persons with substance use,	Promotion of tobacco “21 for a reason” legislation educational campaign on social media, Tobacco prevention and educational resources, increased virtual cessation treatment options	Not considered a priority concern, cigar clubs/bars normalized in wedding events,	Need for culturally informed treatment for BIPOC and LGBTQI+, and women-focused treatment options, Waiting lists for outpatient addiction treatment, barriers to accessing treatment due to being insured/high medical costs	Minimal support in maintaining tobacco recovery, Not considered a drug/need to recover from, Need for recovery friendly workplaces

Electronic Nicotine Delivery Systems (ENDS), vaping, juuling	Lack of adult supervision, community low perception of harm, easy accessible, low enforcement at retail outlets of underage sale,	Adults, Adolescents, underage youth	Using SBIRT as a screening tool for students identified as having possession of a vaping device, targeted prevention education programs by local prevention councils, targeted media campaigns within the region to educate on risk	Environmental impact on ENDS cartridge waste, low cost to purchase, no universal bans on flavored ENDS available for retail sale, considered an acceptable risky behavior/social norm	Support for youth looking for cessation, no universal consequences/no longer considered a juvenile offense, Need for culturally informed treatment for BIPOC and LGBTQI+, and women-focused treatment options, Waiting lists for outpatient addiction treatment, barriers to accessing treatment due to being insured/high medical costs	No monitoring of underage vape use
Marijuana	Normalization of use by community, towns allowing marijuana ordinances to be established/increased community access, low perception of harm among adults/parents	Recovery from OUD, young adults, adults/parents	"Be In The Know" state prevention educational campaign, local prevention councils targeting marijuana prevention efforts in their community, Interventions in schools with SBIRT screening with students who are caught in possession, Drug testing to see if fentanyl is present in substance	Legalization of adult-use, increased access to the community, normalized use of marijuana in communities, Increase targeting of parent use, marijuana is not considered addictive, more substance use early intervention programs for youth	Need for culturally informed treatment for BIPOC and LGBTQI+, and women-focused treatment options, Lack of consequences for adults and young adults who are caught with possession of marijuana, poly-substance use, self-medicating mental health conditions, lack of motivation for treatment as not considered addictive, Waiting lists for outpatient addiction treatment, barriers to accessing treatment due to being insured/high medical costs	"California sober" persons in recovery smoke marijuana, low perception of harm/not considered addictive, Need for recovery friendly workplaces
Prescrip tion	Using prescription medications not as prescribed, lack of	College age youth, High school youth	Increase availability of harm-reduction initiatives, Increase	Increase parent educational campaigns and awareness of harmful	Illegally selling prescribed stimulants, Need for culturally	Persons in recovery and/or those utilizing

Drug Misuse	awareness regarding risk of addition		support in starting educational efforts for middle school aged students	outcomes, Increase community members accessing recovery sites (CCAR)	informed treatment for BIPOC and LGBTQI+, and women-focused treatment options, Waiting lists for outpatient addiction treatment, barriers to accessing treatment due to being uninsured/high medical costs	prescription medication denied employment.
Heroin/Fentanyl	Fentanyl present through substance cross contamination/residue causing increase in overdoses, poly-substance use, youth experimenting with substance unaware of fentanyl risk	Adult males, young adults	Increased access to community narcan training, increased harm reduction efforts, more community organizing around reducing opioid overdoses, more prevention education for students on overdose risk, increased outreach efforts, Drug testing to see if fentanyl is present in substance	Fentanyl present in counterfeit pills, Increase community members accessing recovery sites (CCAR), high cost of purchasing narcan from pharmacies for individuals,	Need for culturally informed treatment for BIPOC and LGBTQI+, and women-focused treatment options, Waiting lists for outpatient addiction treatment, barriers to accessing treatment due to being insured/high medical costs, Implement CDC (Centers for Disease Control) Public Health and Safety Teams (PHAST) toolkit in more towns	Illegally selling MAT substances, Persons on MAT denied employment, Need for recovery friendly workplaces, Need for post-treatment follow up care, increase community outreach support,
Cocaine	Persons formally prescribed Adderall, poly-substance users, peer influences, risk of fentanyl contamination,	College age youth, young adults, Black and White men,	Harm reduction initiatives – using fentanyl test strips for cocaine use, Drug testing to see if fentanyl ispresent in substance	Influx in cocaine access, Increase community members accessing recovery sites (CCAR), No cocaine-specific educational efforts,	Need for culturally informed treatment for BIPOC and LGBTQI+, and women-focused treatment options, Waiting lists for outpatient addiction treatment, barriers to accessing treatment due to being insured/high medical costs	Need for more outreach and recovery support, need post-treatment follow-up care

PRIORITY	Risk Factor(s)	Subpopulation(s) of Increased Risk	Community Strengths, Resources and Assets	Challenges, Gaps, and Needs		
Problem Gambling and Mental Health Issues				**Prevention**	**Treatment**	**Recovery/ Maintenance**
Problem Gambling	Increased exposure to media marketing of sports wagering, increased access by youth via technology, low perception of harm by youth	Young adults, youth, adults	Increased education/prevention opportunities through Regional GAT teams, Collaboration among prevention, treatment, and recovery professionals, Development of pilot project to increase educational resources for youth, Increase in virtual options for recovery support	Lack of awareness of risks associated with underage gambling, need for more school-based education on problem gambling/gaming as risky behavior	Lack of adolescent treatment options in DMHAS Region 2, Lack of awareness of adult treatment resources in Region 2	Recovery support for problem gambling not always accessible in Region 2.
Anxiety, Depression, Trauma, PTSD, etc.	Increased exposure to trauma by youth, substance use disorders, post-pandemic stress,	Elementary school youth, adolescents, young adults, adults	A variety of options for out-patient Adult behavioral health resources in Region 2, increased promotion of mental wellness programming for students in middle and high school, funding for community-based training for adults in Mental Health First Aide through several organizations	Community education and awareness building on trauma & ACES; Need to build self-regulation skills for children and families in communities to prevent the use of negative coping skills; Need for outreach workers to connect community members to care	Expand in-home treatment options for Husky insurance recipients that include all ages, Expand psychiatric services/crisis response in shoreline towns; Normalize and expand treatment options; New barriers to accessing telehealth services post-pandemic for individuals with Husky insurance	Post treatment follow-up to ensure sustainable treatment outcomes
Serious Mental Illness -Children	ACES, Trauma from the pandemic, increased time spent on electronic devices & social media, past trauma, financial hardships and stress, family history of mental health issues	Preschool through age 21	Youth mental health first aid training; CT Connecting to care; increased focus on youth mental health post-pandemic; NAMI CT	Loss of ARPA funding; More promotion of CT Connect to care; Early intervention programs; parent education programs	Reduction in telehealth services, loss of ARPA funding, early-intervention programs; more in-home family therapy programs needed that incorporate parent education/coaching	Parental support; Long-term support for children as they age out

Serious Mental Illness -Adults	ACES, Co-occurring disorders, financial hardships and stress, family history of mental health issues	18 – 100+	Social clubs through LMHAs; Street psychiatry	Loss of ARPA funding; co-occurring disorder educational campaigns to build awareness; community stigma against adults with SMI	Loss of ARPA funding, lack of training for staff in best care and outcomes for therapy services for adults with SMI,	Lack of resources (livable income, housing, etc.) to support independence and improved quality of life
Suicide	For youth, co-occurring disorders, cyber-bullying/humiliation, social & relational issues. Experiences of grief, loss, and lack of social belonging across the lifespan. Childhood sexual trafficking. For adults, co-occurring disorders, grief/loss, financial distress, chronic illness, relational issues, custody issues	Lifespan, LGBTQ+, Veterans, Healthcare professionals and first responders, Veterinarians, Teachers & Paraprofessionals, youth ages elementary through young adulthood, youth with disabilities	QPR/SOS/Gizmo trainings throughout the region; RSAB strengthen awareness building of suicide prevention strategies and trainings	Establishing strong and cohesive post-vention team;	Lack of respite for suicide crisis instead of the emergency department	Need suicide survivor groups & attempt survivor groups; Need post-crisis follow-up after treatment
Other Priorities and Emerging Issues (Specify below)						
Methamphetamines (including MDMA)	Poly-substance use, Increase access in New England	College age youth, adults	College students utilizing harm-reduction strategies for safe usage, Drug testing to see if fentanyl is present in substance	College students testing substances with fentanyl test strips, Increase community members accessing recovery sites (CCAR)	Waiting lists for outpatient addiction treatment, barriers to accessing treatment due to being insured/high medical costs	Need for recovery friendly workplaces, Need for more outreach and recovery support, need post-treatment follow-up care
Counterfeit Pills	Lack of awareness of risk for counterfeit pill use/that it can contain fentanyl, people who use prescription medication, youth experimenting with substance unaware of fentanyl risk	College age youth	"you think you know" prevention education campaign, Drug testing to see if fentanyl is present in substance	Increase community members accessing recovery sites (CCAR)	Adderall shortage resulting in individuals seeking out counterfeit as replacement, Waiting lists for outpatient addiction treatment, barriers to accessing treatment due to being insured/high medical costs	Need for recovery friendly workplaces, Need for more outreach and recovery support, need post-treatment follow-up care
Cannabis (THC tinctures, edibles, delta 8)	Low perception of harm, increased access through legalization of	Adults, young adults, underage youth	Drug testing to see if fentanyl is present in substance	Normalized use, low perception of harm in communities,	Waiting lists for outpatient addiction treatment, barriers to accessing treatment due	Need for recovery friendly workplaces, Need

	adult-use of cannabis, Lack of awareness of youth use of concentrated THC			increased access and availability with legalized adult-use, low regulation of gummies & potency, youth using edibles and experiencing mental health concerns, Increase community members accessing recovery sites (CCAR)	to being insured/high medical costs	for more outreach and recovery support, need post-treatment follow-up care
Xylazine	Low awareness of its presence in substances, no awareness of acute and long-term risks & addictive properties	Adults, young adults	Drug testing to see if fentanyl is present in substance, State tracking of xylazine contamination	Increase in access by community, increasing in overdose deaths, Increase community members accessing recovery sites (CCAR), no evidenced-based prevention/harm reduction strategies, minimal adult/parent awareness of trend	Waiting lists for outpatient addiction treatment, barriers to accessing treatment due to being insured/high medical costs, specialized wound treatment for Xylazine use	Need for recovery friendly workplaces, Need for more outreach and recovery support, need post-treatment follow-up care
Zyn/Nicotine Pouch (also have caffeine pouch)	Previous vaping and/or tobacco use, low perception of harm	Young adults		Low cost, caffeine pouches available for online sale and no age limit, minimal restrictions with age verification for online sale, Increase community members accessing recovery sites (CCAR), minimal adult/parent awareness of trend, Ease of access	Waiting lists for outpatient addiction treatment, barriers to accessing treatment due to being insured/high medical costs	Need for recovery friendly workplaces, Need for more outreach and recovery support, need post-treatment follow-up care