

2020 REGIONAL PRIORITY REPORT

FOR SOUTHWESTERN CONNECTICUT (REGION 1)

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THE HUB: BEHAVIORAL HEALTH ACTION ORGANIZATION FOR SOUTHWESTERN CT



Download report at www.thehubct.org/data

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ABBREVIATIONS

AFSP	American Foundation for Suicide Prevention
ASIST	Applied Suicide Intervention Skills Training
ATOD	Alcohol, Tobacco & Other Drugs
BH	Behavioral Health
CAC	Catchment Area Councils
CADCA	Community Anti-Drug Coalitions of America
CAP	Community Awareness Program
CBD	Cannabidiol
CCAR	CT Community for Addiction Recovery
CCPG	Connecticut Council on Problem Gambling
CCT	Community Care Team
CDC	Centers for Disease Control and Prevention
CHIP	Community Health Improvement Project
CHNA	Community Health Needs Assessment
CIT	Crisis Intervention Trained
COD	Co-Occurring Disorders
COLI	Cost of Living Increase
CPN	CT Prevention Network
CPMRS	CT Prescription Monitoring and Reporting System
CRS	Community Readiness Survey
CSP	Community Support Program
CT	Connecticut
CVH	Connecticut Valley Hospital
DBSA	Depression and Bipolar Support Alliance
DCF	Department of Children and Families
DMHAS	Department of Mental Health and Addiction Services
DMV	Department of Motor Vehicles
DOC	Department of Corrections
DPH	Department of Public Health
DUI	Driving Under the Influence
ESS	Effective School Solutions
FDA	Federal Drug Administration
IOP	Intensive Outpatient Program
LPC	Local Prevention Council
LGBTQ	Lesbian, Gay, Bisexual, Transgender and Questioning
LIST	Local Interagency Service Team
MADD	Mothers Against Drunk Driving
MAT	Medication-Assisted Treatment
MH	Mental Health
NAMI	National Alliance for Mental Illness
NCHS	National Center for Health Statistics
NCPG	National Council on Problem Gambling
NIDA	National Institute on Drug Abuse
NORA	Naloxone + Overdose Response App
NSDUH	National Survey on Drug Use and Health
OCME	Office of the Chief Medical Examiner
ODFC	Opening Doors Fairfield County
PSA	Public Service Announcement
QPR	Question, Persuade & Refer
RAB	Regional Advisory Board
RBHAO	Regional Behavioral Health Action Organization
RSAB	Regional Suicide Advisory Board



RSS	Recovery Support Specialist
RYASAP	Regional Youth Adult Social Action Partnership
SEOW	State Epidemiological Outcomes Workgroup
SADD	Students Against Destructive Decisions
SAMHSA	Substance Abuse and Mental Health Services Administration
SBIRT	Screening, Brief Intervention and Referral to Treatment
SDE	State Department of Education
SMI	Serious Mental Illness
SUD	Substance Use Disorders
SW CT	Southwest Connecticut
TEDS	Treatment Episode Data Set
THC	Tetrahydrocannabinol
TRS	Telephone Recovery Support
US	United States
USDEA	U.S. Drug Enforcement Agency
YRBS	Youth Risk Behavior Survey



EXECUTIVE SUMMARY

As the Regional Behavioral Health Action Organization (RBHAO) for Southwestern Connecticut, The Hub—a division of RYASAP was tasked by the Connecticut Department of Mental Health and Addiction Services (DMHAS) providing a data-driven analysis of the magnitude, impact and capacity within DMHAS Region 1. The report wouldn't be possible if it weren't for our key community members.

The profile and data will be used to:

- To set priorities among populations who need behavioral health prevention, treatment and recovery services;
- To provide a basis for determining emerging needs, projecting future needs, and identifying health disparities;
- To inform a comprehensive strategic plan;
- To increase general community awareness of substance use and other behavioral health problems;
- To support leveraging of funding;
- To respond to public data needs (e.g., providers, educators, funding agencies, media, policymakers);
- To enhance membership of planning or advisory groups to be more demographically representative and/or more responsive to priority needs of the region

The report's primary purpose is to inform DMHAS of the behavioral health needs of children, adolescents, and adults in Southwest CT (Region 1), providing data and priority recommendations for prevention, treatment, and recovery services.

The report offers the communities in Southwest CT, information regarding substance use and misuse, both illegal and legal; mental health concerns; suicide; and gambling. The information is gathered from many sources and separated into 9 regional epidemiological profiles: alcohol, tobacco & ENDS, prescription drugs, marijuana, heroin & illicit opioids, cocaine, problem gambling, mental health problems such as anxiety and depression, and suicide. The information is gathered from federal and state data and is then compared to local data when available. Each profile identifies the prevalence and magnitude of the issue, lists risk factors and at-risk populations, and summarizes the region's capacity and resources to address that problem. Our data workgroup offered their insights and perceptions regarding their communities which was also reflected in each of the profiles. These profiles can be used individually or together to provide a snapshot of behavioral health in the region. We have additionally used the data from the profiles to develop infographics for use in community education throughout the region. The profiles will be able to assist communities in Southwest CT in developing strategies to address their own issues.

The Hub conducted several virtual focus groups; which many towns were represented. In addition to focus groups, community members and key leaders participated via phone interviews, and a google form link. The Hub also targeted focus groups with their Community Care Teams (CCT), Community Health Improvement Projects (CHIPS) and with people in Recovery.

The identified data workgroup consisted of 15 participants who ranked the region's priority after reviewing the profiles, focus group responses, 2020 Community Readiness Survey and data sets. During a meeting, members discussed and ranked the priority areas in magnitude, impact, consequences, and changeability. The Hub staff summarized and calculated the rankings to complete the priority ranking matrix. It was concluded that the top priorities of the region are, in descending order, 1. mental health, 2. suicide, 3. alcohol, 4. marijuana, 5. Tobacco/ENDS 6. prescription drug use, 7. Heroin/Illicit drugs, 8. gambling and 9. cocaine. The number one priority, mental health, had an overall ranking of 4.6 whereas the second and third, suicide and alcohol had a closer over all ranking of 3.9 and



3.7. Mental health had unanimous 5's for both magnitude and impact. Mental health was discussed at great length with a large concern for the impact for the COVID-19 pandemic. The concern for mental health and youth in particular was also discussed and reflected in the 2020 Community Readiness Survey (CRS) results for SW CT. There is a concern from the CRS survey participants as well as the priority report data workgroup around teens' mental health, especially anxiety. The priority report ranked suicide second with a regional concern of 13 out of 14 towns in SW CT having had a suicide. The data workgroup rated the consequence of suicide the highest followed by the impact. Alcohol ranked third with the highest ranking in magnitude. There is a large concern of an uptick in alcohol consumption during the COVID-19 pandemic. SW CT had a 4.86 mean stage of readiness for suicide and mental promotion, and a 5.14 mean stage of readiness for alcohol(substance) misuse prevention. 5.14 was a decrease from 5.9 in 2018. All 3 mean stages of readiness's are below the states. The Hub plans to work with community partners and coalitions to identify the reasoning and barriers to implement initiatives to change the readiness of SW CT. It is important to note that the selection of the data workgroup and key stakeholders/informants and the COVID-19 pandemic can influence the outcome of this report.



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INTRODUCTION

BACKGROUND

Every two years, the Connecticut Department of Mental Health and Addiction Services (DMHAS) planning unit conducts a priority setting process meant to develop plans for mental health and addiction services at the local, regional, and state levels and supports the federal block grants allocated by the United States Substance Abuse and Mental Health Service Administration (SAMHSA). The SAMHSA Substance Abuse Prevention, Treatment Block Grant and Mental Health Block Grant funding requires DMHAS to annually:

- Assess needs, strengths, and critical gaps in their service delivery systems;
- Identify target populations and priorities for those populations.

As strategic community partners, Regional Behavioral Health Action Organizations (RBHAOs) assist with this charge by:

- assessing the needs for children, adolescents, and adults across the regions and
- developing Regional Strategic Plans to include epidemiological profiles and priority recommendations for prevention, treatment, and recovery services.

The RBHAO Regional Priority Report is designed to¹:

- provide a thorough description of substance use, problem gambling, and mental health problems, including suicide, among the various populations (overall and subpopulations) in a region;
- describe the current status of instances of the substance use problems, problem gambling, and mental health issues, including suicide, in the region and examine trends over time where possible;
- identify characteristics of the general population and of populations who are living with, or at high risk for, substance use and mental health problems, suicide, and problem gambling in the regions and who need primary and secondary prevention or health promotion services;
- provide information required to conduct prevention needs assessments and gap analyses for substance use and mental health problems, suicide, and problem gambling;
- Define regional priorities, resources, assets, and subpopulations at increased risk for behavioral health issues, and make recommendations on addressing regional gaps and needs, as well as health disparities.

In Southwest CT (SW CT), The Hub, a program of the Regional Youth Adult Social Action Partnership (RYASAP), is the Regional Behavioral Health Action Organization (RBHAO) charged with conducting this process in order to assess the behavioral health needs of children, adolescents, and adults regarding substance misuse, mental health, and problem gambling. This process also informs and is informed by SAMHSA's Strategic Prevention Framework (SPF) model, which is a five-step, data-driven process known to promote youth development and prevent problem behaviors across the lifespan.

PURPOSE

The present report is the result of the 2020 priorities process in Southwest CT, designated by DMHAS as "Region 1." In completing the report, The Hub developed a regional plan that includes epidemiological profiles and priority recommendations for prevention, treatment, and recovery services. The findings will be used by DMHAS to generate identify initiatives and funding priorities for the federal block grants, to develop recommendations and priorities within the Prevention Division, and to compare findings across regions. The

¹ [_Priority Report & Infographs 2019\RBHAO Priority Setting Process and Results_SEOW_final_rev091819.pdf](#)



report will also be disseminated to partners within the region, including municipal health and social services departments, treatment agencies, prevention councils, consumer groups, legislators, and funding agencies, to inform regional and local initiatives. This will help the partners support state and community-level data driven processes, including readiness assessment and capacity building, strategic planning, implementation of evidence-based programs and strategies, and evaluation of those programs and strategies.

DATA SOURCES

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

Local Youth Surveys: Conducted by local prevention coalitions and school districts to ascertain prevalence, attitudes, behaviors, and perceptions among youth and families with regard to substance use, mental health, and related behaviors.

Regional Surveys: Including the 2018 surveys of adults over 18 in the Bridgeport, Norwalk, Stamford, and Greenwich sub-regions, conducted by DataHaven as part of the Community Health Needs Assessments, focus groups, Survey to Key Informants, and the 2020 Community Readiness Survey conducted by The Hub.

State Data: Including EMPS 211 call data, the Connecticut School Health Survey, CT Behavioral Risk Factor Surveillance Survey, accidental overdose deaths, and suicides from the Office of the Chief Medical Examiner, treatment admissions, and other statistics compiled by the CT Data Collaborative from state and federal sources and available through the State Epidemiological Outcomes Workgroup website (SEOW).

National Data: Including National Survey of Drug Use and Health, Youth Risky Behavior Surveillance System, and various journal articles.

Qualitative Data: Including focus groups with Catchment Area Councils (CACs), Regional Suicide Advisory Boards (RSABs), Regional Advisory Board (RAB), CT Community for Addiction Recovery (CCAR), and Community Care Teams; key informant interviews with behavioral health consumers and providers; discussions at Local Prevention Council (LPC) meetings; and identification of needs and gaps at subregional meetings and coalitions, including the Greenwich Community Health Improvement Project, the Bridgeport Health Improvement Alliance, Region 1 Gambling Awareness team, and other meetings throughout the year.

STRENGTHS AND LIMITATIONS

This report is a comprehensive overview of behavioral health prevention, treatment, and recovery needs and recommendations for Southwest CT. Although we believe the information presented is reliable and valid, it is neither practical nor possible to cover such a wide spectrum in a single report.

The main strength of this report is that it is based as much as possible on state, regional and local data, as well as input from a broad range of behavioral health stakeholders with a deep understanding of the region. Additionally, there were opportunities for local prevention as well as community members to share their experiences and be involved in the gathering of information during their participation through key informant interviews. The epidemiological profiles present regional information in comparison to national and state data, with regional and local specific data where possible and applicable. The recommendations are consistent with past needs and community suggestions and also work to build upon past findings while recognizing new and emerging trends in recovery, prevention, and treatment.



The report is limited by inconsistencies in the data sources available as well as limitations due to Covid-19. While all data presented are the most current available, they are not all from the same year. Some indicators are available only at the state level but not the regional or local. Key informant interviews were throughout 2020 & 2021 and reflect general sentiments of the community in relation to substance use and behavioral health in the region. Youth surveys were conducted in some, but not all, towns in the region from 2019 up to this current year, 2021. It could have been not a survey year or municipalities chose not to survey because schools were learning remotely due to Covid-19. Data from both key informant interviews as well as youth surveys are present throughout the report in its entirety.

This report is also based on available data. There are still many statistics and figures from 2020 that are still being finalized and not published yet. Therefore, all data that was available and relevant at the time of compiling this report is included. The report will be updated as new findings come to light. As the RBHAO of the region, The Hub felt compelled to include all data that was relevant. However, some data is conflicting as it is sourced from different communities, sub-populations, and retrieved at different times.

PROCESS FOR DEVELOPING REPORT

There is a multi-step process in developing the profile.¹

1. Identify Regional Data Workgroup;
2. Review and update process and content for focus groups and surveys;
3. Administer provider/stakeholder surveys and implement focus groups;
4. Review and analyze data;
5. Prepare epidemiological profiles by priority problem;
6. Identify strengths, services and resources, gaps, and needs;
7. Understand and utilize criteria for selecting priorities;
8. Convene the data workgroup and select priorities;
9. Prepare comprehensive report, utilizing specified report template;
10. Submit and disseminate report. Submission deadline: June 30, 2021

Hub staff invited members of Local Prevention Councils (LPCs), Catchment Area Councils (CACs), and the Regional Advisory Board (RAB) to participate in a Regional Data Workgroup. Volunteers included a cross section of consumers, family members, and providers with experience with substance use and mental health. The Hub conducted several focus groups, attended various meetings and distributed a Google Forms survey seeking input from diverse community members on the identified areas of concern. CPES and Hub staff compiled focus group and survey results and researched available data and produced draft epidemiological profiles on 9 required topics, which were shared with workgroup members. Members provided feedback on drafts via email. Hub staff incorporated the feedback and produced revised epidemiological profiles, which were shared with workgroup members.

In early June, the stakeholders met to review the compiled information, share anecdotal information and feedback about the issues from their local perspectives, and participate in a consensus-building discussion to rank the priority areas in magnitude, impact, consequences, and changeability of the priority (see matrix in appendix). Staff then produced a draft summary of regional feedback (included in appendix) which was reviewed and all feedback was incorporated in the present document.



BEHAVIORAL HEALTH IN SOUTHWEST CT

DESCRIPTION OF THE REGION

DMHAS's Region 1 is comprised of the 14 towns and cities in Southwest Connecticut: Bridgeport, Darien, Easton, Fairfield, Greenwich, Monroe, New Canaan, Norwalk, Stamford, Stratford, Trumbull, Weston, Wilton, and Westport. It is a region of contrasts, containing three of the largest urban areas in the state as well as many small suburbs. It includes both CT's "Gold Coast"—the wealthy coastal towns from Greenwich to Fairfield—and one of CT's poorest cities.

DEMOGRAPHICS

Region 1 has a total population of 702,385. (Source: SEOW prevention data portal 2018-2019) 23.3% are youth aged 0-17. 14.8% are aged 65 and older.

Region 1 is predominantly White non-Hispanic. Among the 14 municipalities, Bridgeport stands out as the only place where Caucasians are a minority ethnic group, at 20.3%.

- The municipalities with a significant Black non-Hispanic population are Bridgeport (32.9%), Stratford (15.8%), Norwalk (13.5%) and Stamford (12.6%). Bridgeport's Black non-Hispanic population is more than twice as high as the next-largest in the region.
- Municipalities with significant Latino populations include, in descending order, Bridgeport (40%), Norwalk (27.9%), Stamford (26.1%), Stratford (16.5%), and Greenwich (13.8%).
- While Asians make up only 5.5% of region 1's population overall, five municipalities in region 1 have Asian populations greater than this average: Stamford (9%), Wilton (9%), Greenwich (8%), Westport (7%), and Trumbull (6%).

Southwest CT proportion of youth aged 0-17 is 23.3%. 14.8% are the elderly aged 65+.

- Municipalities with significant youth populations include, in descending order, Darien (32.8%), Weston (30.3%), New Canaan (29.4%), and Wilton (28.5%).
- The highest proportion of the elderly aged 65+ include municipalities, in descending order, Stratford (19.4%), Trumbull (18.8%), Easton (18%), and Greenwich (16.8%).

The median household income in region 1 varies significantly from \$45,441 in Bridgeport to \$219,083 in Weston. 2 out of the 14 municipalities in region have a median household income lower than Connecticut's median (\$76,106). Some of the richest municipalities include, in descending order, Darien (\$210,511), New Canaan (\$192,428), Westport (\$187,988), and Wilton (\$187,903). Towns with the lowest median household income include, as mentioned before, Bridgeport (\$45,441), Stratford (\$75,845), and Norwalk (\$82,474).

Chronic absenteeism and disengaged youth are school based factors that are associated with substance use in youth. Chronically absent students are defined as those who miss 10% or more of the total number of days in the school year. In region 1, Bridgeport School District had the highest chronically absent White non-Hispanic youth at 16.3% followed by Stratford School District at 9.9%. The school districts in the region with the highest chronically absent Hispanic and Latino youth are Bridgeport (20.7%), Stratford (13.9%), and Stamford (12.7%). Black non-Hispanic youth are chronically absent most in Weston (20.9%) and Bridgeport (18.5%) school districts. (Source: CT Department of Education, 2018–2019)

In Region 1 there are 4.2% of female youth and 5.6% of male youth who are disengaged; youth who are not enrolled in school and are not employed. The municipalities with the highest proportion of disengaged youth are:

- Bridgeport – 10% male and 7% female
- Stamford – 5% male and 6% female



- Norwalk – 10% male and 5% female
- Greenwich – 6% male and 3% female
- Fairfield – 4% male and 1% female
- Stratford - 5% male and 1% female

ECONOMIC PROFILE, INCLUDING HOUSING AND TRAVEL

The most striking difference in the region is economic. Based on American Community Survey 2019 data, the median household income ranges from a low of \$46,662 in Bridgeport (one-half the median income for the county, which is \$95,645) to a high of \$222,535 in Weston (2.5 times the county median). In Bridgeport, 21.8% of individuals live in poverty compared with 2.7% in Trumbull.

The Cost-of-Living Index (COLI)² is a way of comparing the cost of living in a particular community to the median cost of living for the U.S., which is represented by an average score of 100. In Fairfield County, the COLI is 126.7, or 26.7% higher than the U.S. as a whole. This is also much higher than the state COLI of 107.8.

Housing and Transportation are particularly expensive within the region, as shown by the COLIs below. This creates critical challenges for behavioral health clients, staff, and programs:

The Housing COLI for the county is 144.4, compared with 103.6 for the state. The housing index ranges from 74.9 in Bridgeport (lower than the state and US) to **577.6** in Darien. Behavioral health agencies that are located in the region’s urban areas have to contend with much higher housing costs than agencies located in other cities in the state: 171.1 in Norwalk and 125.9 in Stamford. (The Norwalk housing COLI has surpassed Stamford’s in the past few years.)

The Transportation COLI for the county is 129.7, compared with 112.4 for the state. It is even higher in Bridgeport, at 131.6.

Transportation in the region is a special challenge. Although towns/cities are geographically close together and traversed by 3 main routes (I-95, Route 1 and the Merritt Parkway), the region has very heavy traffic. Travel time between nearby cities such as Norwalk and Stamford (10 miles apart) can often take an hour or more+. Agencies recommend only scheduling meetings between 10am and 2pm to try to reduce the likelihood of commuter traffic. For behavioral health agency staff from Greenwich to attend a state meeting in Middletown (a distance of 72 miles), it is necessary to plan for 2 hours of travel each way on top of the meeting time.

Other transportation services such as MTA and CT transit have similar experiences with increased ticket fares, reduced operating schedules, and unreliable arrival/departure times.

REGIONAL EPIDEMIOLOGICAL PROFILES

The following pages provide an analysis of the magnitude, impact and capacity, and a brief discussion of resources that address the issue within DMHAS Region 1 of the following areas of concern for CT: alcohol, tobacco, prescription drugs, marijuana, heroin/illicit opioids, cocaine, problem gambling, mental health problems such as anxiety and depression, and suicide. It includes the following cities and towns which comprise DMHAS Service Region 1: Bridgeport, Darien, Easton, Fairfield, Greenwich, Monroe, New Canaan, Norwalk, Stamford, Stratford, Trumbull, Weston, Westport, and Wilton. In the following section we discuss the findings, trends, and recommendations. (Note some possible redundancies in the information provided, as these profiles are expected to also serve as independent handouts.)

² https://www.bestplaces.net/cost_of_living/county/connecticut/fairfield



2020 Region 1 Epidemiological Profile: Alcohol

Problem Statement

Alcohol is the most commonly used substance nationally and in Connecticut. According to the 2018-2019 National Household Survey of Drug Use and Health (NSDUH), Connecticut has the 5th highest prevalence of current alcohol use (60.0%) compared to other states in the U.S., higher than the national prevalence (50.9%)¹. The current data provided pre-dates the COVID-19 pandemic and, therefore, trends outlined in this profile may be subject to change.

Magnitude (prevalence)

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

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

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

NSDUH Substate Estimates:

Percent Reporting Past Month Binge Drinking, ages 12+

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

2019 Connecticut School Health Survey (YRBS):

25.9% of high school students reported using alcohol in the past month and almost half of them (12.9%) reported binge drinking** in the past month².

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

The 2014-2018 NSDUH data for the Southwest Connecticut region indicates the rate of past month alcohol usage for ages 12 and older has also remained stable, at 62 percent, which is higher than most regions and the state.

Binge drinking was reported by 3% of Stamford-area adults, 5% of Bridgeport-area adults, 6% of Norwalk-area adults, and 11% of Greenwich-area adults (2018 DataHaven surveys). According to 2016-2018 NSDUH data, 31% of SW CT residents ages 12 and older reported binge drinking, which is higher than the state (29%) and all other regions.

Adults: In 2018, alcohol use rates within SW CT ranged from 24% in Greater Bridgeport to 28% in Greater Stamford and Norwalk to 31% in Greater Greenwich, according to DataHaven surveys. 8% to 10% of adults within the region reported feeling a need to cut down on drinking/drugs in the past 12 months.

Youth: A review of local youth surveys conducted in SW CT during 2018-19 found that between 21% and 50% of high school students reported past 30-day alcohol consumption, with rates increasing by grade. Where racial data was available, Whites reported drinking more than Hispanics or Blacks.

In 2018-19 local school surveys reported:

- One town reported that 14% of middle school students had used alcohol in the past 30 days.
- In one local suburb, the alcohol use rate had declined from a high of 41% several years earlier to 21%.
- A suburb town reported 13% of high school students binge drinking in one youth survey.

¹ NSDUH (2017-2018)

² DPH, 2019 Connecticut School Health Survey



2020 Region 1 Epidemiological Profile: Alcohol

- Students in a local city reported the most common place to drink alcohol is at their home (67%), or their friend's home (62%).

Perception of Harm:

- High school students' perception of harm from alcohol ranged from 74%-82% according to local surveys. Perception of harm from binge drinking, however, was lower (38% according to one local youth survey).
- Adult perception that young people will abuse drugs or alcohol varies significantly: Greenwich area, 18%; Norwalk area, 20%; Stamford area, 22%; and Bridgeport area, 41%.⁹
- Key informants in the 2020 Community Readiness Survey (CRS) for SW CT identified alcohol as the problem substance of greatest community concern for young adults ages 18 to 25 and adults 26 and older.
- A national study by Kaiser Foundation published in Feb 2021 reported that 13% of adults said they had started or increased their use of substances during the pandemic.
- In focus groups in SW CT in Nov/Dec 2020, some adults report drinking more heavily and more frequently during the pandemic.
- Focus groups with youth during fall 2020 found that they report drinking on Zoom with friends as a way of socializing.

- Individuals with mental health disorders are about four times more likely to be heavy alcohol users.⁵
- Native Americans are at especially high risk of alcohol-related traffic accidents, DUI and premature deaths associated with alcohol misuse.⁶
- While Hispanics or Blacks have higher rates of abstinence from alcohol, those who do drink often have higher rates of binge drinking.⁷
- In 2019, 68.2% of alcohol admissions were male, and 59.6% were non-Hispanic White.⁷
- Among youth, risk factors include:
 - Academic and/or other behavioral health problems in school;
 - Alcohol-using peers;
 - Lack of parental supervision;
 - Poor parent-child communication;
 - Parental modeling of alcohol use;
 - Anxiety or depression;
 - Child abuse or neglect;
 - Poverty;
 - Social norms that encourage or tolerate underage drinking.⁸

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

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

The 2019 Connecticut School Health Survey shows high school females were more likely than males to report drinking (29.2% and 22.8%, respectively) and binge drinking (14.4% vs 11.5%). Non-Hispanic white and Hispanic students had the highest prevalence of past month drinking (29.6% and 26.0%, respectively) and binge drinking (15.8% and 12.8%, respectively).²

•

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.³
- 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.⁴

³ CDC (2016), Excessive alcohol use and risks to men's health

⁴ CDC (2016), Alcohol and public health

⁵ NIDA (2014), Severe mental illness tied to higher rates of substance use

⁶ NIAAA, Minority Health and Health Disparities

⁷CT DMHAS 2019 Treatment Admissions

⁸ National Research Council and Institute of Medicine

⁹DataHaven Surveys, 2018



2020 Region 1 Epidemiological Profile: Alcohol

Burden (consequences)

- Immediate adverse effects of alcohol can include: impaired judgment, reduced reaction time, slurred speech, and loss of balance and motor skills.⁴
- When consumed rapidly and in large amounts, alcohol can also result in coma and death.⁴
- Alcohol use can increase risk of death when used with other substances, i.e., prescription medication like benzodiazepines and opioids. In 2019, alcohol was listed as a contributing cause of death for almost 3 in 10 (29%) of 1200 fatal overdoses which occurred in Connecticut.
- Approximately 88,000 deaths each year in the U.S. are attributed to alcohol misuse.⁹
- In 2017, Connecticut ranked as the highest state in the country for the percent of alcohol-impaired driving fatalities compared to total driving fatalities (43%), versus the United States overall (29%).¹⁰
- 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.¹¹
- Excessive drinking has been associated with increased risk of motor vehicle injuries, falls, and interpersonal violence.⁴
- Drinking during pregnancy can lead to a variety of developmental, cognitive and behavioral problems in the child (Fetal Alcohol Spectrum Disorders).¹¹
- Older adults aged 65+ who drink are at increased risk of health problems associated with lower tolerance for alcohol, existence of chronic health problems (i.e., diabetes, high blood pressure, congestive heart failure, and liver problems) and interactions with medications (e.g., aspirin, acetaminophen, cough syrup, sleeping pills, pain medication, and medication for anxiety or depression).¹²
- Initiation of alcohol use at young ages has been linked to increased likelihood of AUD later in life.¹³
- Of all 2019 Connecticut treatment admissions, 38.2% identified alcohol as the primary drug at admission.⁸

- In 2019 there were 249 alcohol impaired driving fatalities in CT; which is a 21.7% decrease from 2018.
- In 2019, Connecticut saw a decrease in alcohol usage for youths. However, emerging 2020 data which takes the COVID pandemic into consideration may reveal a change in this trend.

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

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

Community Wellbeing Survey: Percent Reporting Past Month Binge Drinking

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

Capacity and Service System Strengths

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

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

The Southwest region of Connecticut reported high rates of readiness in 2018, 5.90, which is higher than the state or any other region. This rate corresponds with stage 5 “planning for substance misuse prevention and focus on practical details, including seeking prevention funds” and closely approaching stage 6, “has enough information to justify substance misuse prevention”. Additionally, key informants’ assessment of readiness dropped to 5.14 in 2020, possibly due to a higher standard for readiness, based on increased prevention knowledge.

⁹ NIAAA, Alcohol Facts and Statistics

¹⁰ NHTSA (2018), [Alcohol-Impaired Driving](#)

¹¹ WHO (2018), Global status report on alcohol and health—2018

¹² NIAAA (2008), Older Adults

¹³ NIAAA (2006), Alcohol Alert No. 67, Underage drinking



2020 Region 1 Epidemiological Profile: Alcohol

Prevention:

- Local Prevention Councils (LPC) provide education about alcohol to youth and parents, often in collaboration with groups such as MADD and SADD. Several LPCs have created alcohol awareness campaigns. Darien, which has significantly higher rates of teen drinking compared with the country, is in their 5th year of a high-profile “06820” campaign to educate parents about the impact of alcohol on the teen brain, the importance of parent-child dialogue, social hosting laws that hold adults legally responsible for drinking that occurs under their roof, etc. LPCs and other community partners sponsor post-prom events and encourage the use of Uber, Lyft, and Safe Rides to prevent driving under the influence.
- Fairfield, who received the CT Strategic Prevention Framework (CSC) grant 6 years ago has been able to change perception of harm and decrease use within their town specific initiatives.
- Throughout SW CT, pediatricians, clinicians, family physicians, and counselors are trained in Screening, Brief Intervention and Referral to Treatment (SBIRT) and also Adolescent SBIRT. Colleges, hospitals, and social services agencies also use an integrated Mental Wellness Screening tool for “check-up from the neck up” screenings during Wellness Month and beyond.
- Older adults and others at risk are educated about the dangers of mixing alcohol and medications through the state’s Change the Script campaign.
- Due to Covid-19 several LPCs came together and created the Let’s #mentionprevention campaign which is a campaign to assist retailers and guardians to keep alcohol out of the hands of minors.

Recovery Center at Greenwich Hospital, and Silver Hill Hospital.

Recovery: There are several sober homes in the region, although costs can be prohibitive and they are not regulated. There are many 12-step meetings (AA, AlAnon) including some in Spanish, for teens, and for medical practitioners that are now also being offered virtually due to COVID-19. There are also a variety of support options such as the CT Community for Addiction Recovery (CCAR) in Bridgeport, which offers a free weekly Telephone Recovery Support program; LifeRing; SMART Recovery; LIFTT Confidential; Refuge Recovery; and Women for Sobriety.

Enforcement: Alcohol compliance checks are intended to be conducted every six months; however, some town departments report a lack of capacity to train and deploy youth for sting operations. Police departments continue to educate officers on how to strategically disperse parties. Since the pandemic, checks have not been conducted due to closures and social distancing.

Treatment: Treatment for alcohol and other addiction disorders is available through local provider agencies and hospitals, including specialized programs such as Mountainside Treatment Center, the Addiction



2020 Region 1 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 2019 data, 2.6% 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%.

According to 2018 – 2019 data, 1.99% of Connecticut respondents reported past year use of cocaine.² This is highest among young adults 18-25 (6.21%), compared to youth 12-17 (.37%) and adults 26+ (1.50%).

Cocaine use in the past year in ages 12+ in Region 1 of Southwest Connecticut (SW CT), remained consistent from 2014 – 2018 at 2.1%. This is slightly lower than other regions and the state (2.4%).² Cocaine did not arise as a substance of community concern for any age

group except for 18–25-year-olds, where it was ranked 5th as a substance of concern out of 8 substances.⁴

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 harm (youth, adults),
- Perception of cocaine risk is high state-wide and throughout all regions. In CT, 68.5% of individuals, ages 12 and older, perceived a great risk of using cocaine. All regions follow with similar high percentages of risk,
- Childhood trauma (youth and adults),
- Young adults ages 18 to 25 have a higher rate of current use than any other age group,²
- Men are more likely to use cocaine than women,
- Those with current or previous misuse of other illicit substances, such as marijuana and heroin/fentanyl,
- Individuals with mental health challenges³

According to data from a 2019 school health survey, men reported higher rates of use (3.6%) than women (2.5%). The prevalence of lifetime cocaine use was highest among 12th graders (2.9%). Black students reported higher rates (4.8%) than Hispanic (2.7%) or White (2.1%) students, though the difference was not statistically significant.¹

Within SW CT, local youth surveys do not ask specific questions about cocaine. According to The Hub’s key informant focus group, community members and providers in the region indicate an increase in cocaine usage in the past several years. According to feedback gathered from The Hub’s key informant focus group, a treatment provider and local Community Care Team

¹ Connecticut School Health Survey: Youth Risk Behavior Survey (2019)

² National Survey on Drug Use and Health (NSDUH) (2018 – 2019)

³ National Institute on Drug Abuse (NIDA)

⁴ CT Community Readiness Survey (CRS) (2020)



2020 Region 1 Epidemiological Profile: Cocaine

outreach worker from our region disclosed that they have seen an increase in cocaine use in adults.

Burden (consequences)

Physical short-term consequences of cocaine use include³:

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

Long-term physical consequences of cocaine use include³:

- Tolerance, requiring higher and more frequent doses,
- Sensitization, where less cocaine is needed to produce anxiety, convulsions, or other toxic effects (increasing risk of overdose),
- Loss of appetite leading to malnourishment,
- Increased risk of stroke and inflammation of the heart muscle,
- Movement disorders such as Parkinson’s disease,
- Impairment of cognitive function,
- Cocaine users are also at risk for contracting blood-borne diseases such as HIV and hepatitis C via needle sharing and other risky behavior,³
- Users are at risk of accidental overdose, especially in the presence of alcohol or other drugs³

Treatment Admissions: Cocaine ²

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

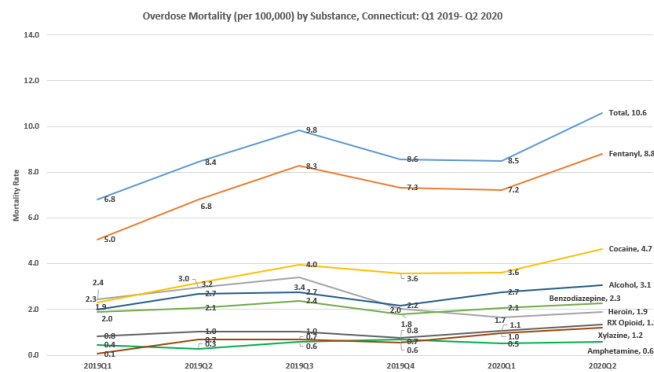
- In 2019, cocaine was the primary drug in 7.7% of all Connecticut substance use treatment admissions. This represents 5,904 admissions ³,
- Overdose deaths involving cocaine increased about 34% in Connecticut, from 345 in 2018 to 463 in 2019,⁶
- In 2020, overdose deaths involving cocaine increased to 529,⁶

- More than 7 in 10 (72%) overdose deaths involving cocaine in 2019 occurred in urban core or urban periphery communities.
- Cocaine-involved deaths have been linked to fentanyl-contaminated cocaine in Connecticut.⁴ In 2019, almost 9 in 10 (85%) cocaine-involved deaths in Connecticut (n=463) also involved fentanyl.
- In 2020, OCME reported 427 cases involved cocaine and fentanyl and 100 cases involved heroin and cocaine in CT.⁶

In 2019, percentage of cocaine-involved fatal overdoses was quite a bit lower in SW CT (5.56%) than the state (11.9%) and all other regions.

Per the accidental drug intoxication death report by the OCME, it shows Connecticut has seen an increase in the number of cocaine-involved overdoses since 2015. Additional to the upward trends of cocaine use, individuals are also accessing poly-substances, a mix of drugs such as cocaine with fentanyl. Also, some fentanyl users may utilize cocaine to balance effects as needed.

Region 1 Overdose Mortality (per 100,000), Q1 2019- Q2 2020



Source: OCME 2019-2020 ⁶

Capacity and Service System Strengths

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

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



2020 Region 1 Epidemiological Profile: Cocaine

Southwest CT has seen a decrease in the perception of community readiness in regard to substance misuse and prevention efforts. This could potentially be due to the fact that the perception of harm has decreased.⁴

In the SW CT, there are over 30 public and nonprofit addiction treatment facilities, private substance use treatment facilities (Mountainside, Clearpoint, Newport Academy), and specialty hospital programs such as the Addiction Recovery Program at Greenwich Hospital and Silver Hill Hospital, which specializes in behavioral health treatment. Treatment options include inpatient, outpatient, and Intensive Outpatient (IOP) programs. Most provider agencies provide support to clients with co-occurring mental health and substance use disorders. Specialized treatment supports include the Families in Recovery Program (Norwalk), separate IOPs for women and men, and programs in Spanish particularly at CASA in Bridgeport. Child and Family Guidance of Greater Bridgeport runs a teen substance use program in Bridgeport and Norwalk.

Education about cocaine is provided in school health classes as part of information about illicit drugs, often taught by the School Resource Officers. Presentations on illicit drugs and emerging drug trends are available through The Hub and other partners.



2020 Region 1 Epidemiological Profile: Heroin & Other Illicit Opioids

Problem Statement

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

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

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

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

In CT there were 1,374 confirmed drug overdoses deaths for 2020, with an increase of 14.6%

compared to 2019 (OCME). The average percentage of fentanyl-involved deaths was at 85% for 2020 with an increase of 3% from the previous year, 2019. Of the total number of overdose deaths, 262 deaths involved heroin, and 243 deaths involved a mix of heroin and fentanyl. According to the Department of Public Health, Southwest CT (SW CT) experienced 202 drug overdose deaths in 2020; an increase since 2019 with 171 deaths.⁶ Within SW CT, Norwalk and Stratford experienced 17 overdose deaths and Stamford experienced 19 overdose deaths. Bridgeport overdose fatalities continue at a high rate, compared to other cities in the region, with 65 deaths in 2020.

According to key informant focus groups conducted by The Hub, fentanyl continues to be a serious concern. Oftentimes, individuals are accessing poly-substances, a mix of drugs including fentanyl. Therefore, many individuals are under the impression that they are obtaining a specific drug, not realizing that their drugs are typically a mix of dangerous substances.

The COVID-19 pandemic had a significant impact on individuals' use of and access to substances. Some factors to consider include a combination of stressors and isolation. At the height of the pandemic, barriers were present in Naloxone access. Throughout 2020, there were less upticks in overdose deaths, possibly due to the decrease in accessibility to substances and less opportunity for transportation due to the pandemic. According to key informant focus groups conducted by The Hub, methadone clinics are consistently seeing high numbers of participants because of opioid addictions. These numbers have not wavered during the pandemic, and have only remained high.

¹ NSDUH

² Connecticut School Health Survey, 2019 (YRBS)

³ CT OCME

⁴ US DOJ- DEA, 2018 National Drug Threat Assessment (October 2018)



2020 Region 1 Epidemiological Profile: Heroin & Other Illicit Opioids

Magnitude (prevalence)

NSDUH Substate Estimates:

Percent Reporting Past Year Heroin Use, ages 12+

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

Fentanyl- and Heroin- Involved Deaths in Connecticut, 2012-2019

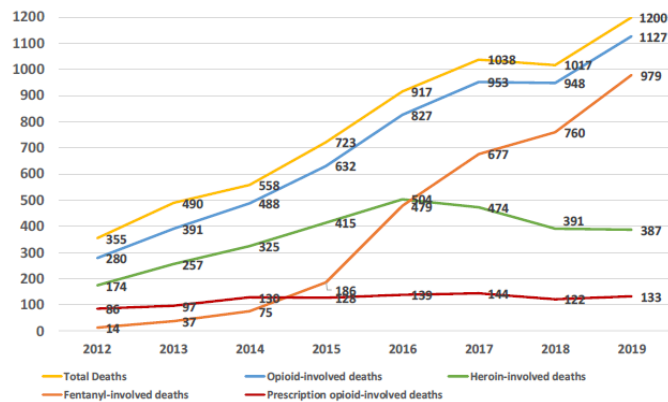
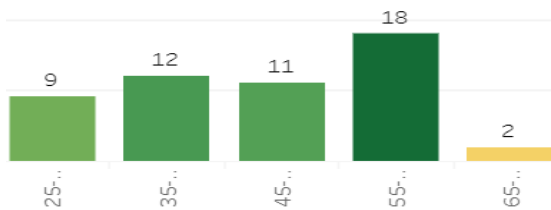


Figure #: Data Source: SAMHSA

According to CT's Department of Public Health reports, a total of 52 people have died in SW CT in 2020 from a heroin overdose alone.⁶ This is a slight decrease from the 57 reported in 2019.⁶ Bridgeport had the highest in SW CT with 18 deaths reported in 2020 compared to Norwalk's 7 and Stamford's 5.⁶

Number of Heroin by Age Group Deaths in SW CT

Number of Deaths by Age Group

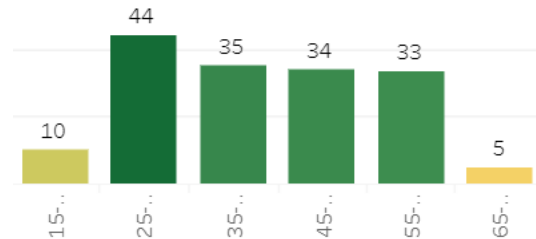


Data Source: 2020 CT DPH Drug Overdose Deaths

In SW CT, individuals in the 55-year-old age group experienced the highest numbers of heroin deaths with 18 deaths followed by the 35-year-old age group with 12 deaths.

Number of Fentanyl or Fentanyl Analog deaths by Age Group in SW CT

Number of Deaths by Age Group



Data Source: 2020 CT DPH Drug Overdose Deaths

In SW CT, individuals in the 25-year-old age group experienced the highest numbers of fentanyl or fentanyl analog deaths with 44 deaths followed by the 35-year-old age group with 35 deaths, 45-year-old age group with 34 deaths, and the 55-year-old age group with 33 deaths.

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 risk factors include previous overdose; personal or family history of substance misuse, history of depression or anxiety;
- Other groups at risk include³:
 - Non-Hispanic whites;
 - Males;
 - Young adults (18 to 25);

⁵ CDC. Overdose: Heroin.

<https://www.cdc.gov/drugoverdose/opioids/heroin.html>

⁶ DPH Drug Overdose Deaths in CT FROM 2015-2021

https://public.tableau.com/profile/heather.clinton#!/vizhome/SUDORS_Dashboard_final2/OverdoseDashboard

⁷ CT DMHAS, 2019 Treatment Admissions

⁸ CRS 2020 Regional Report



2020 Region 1 Epidemiological Profile: Heroin & Other Illicit Opioids

- Adults (25 to 44);
- People without insurance or enrolled in Medicaid;
- Seniors prescribed multiple medications;
- Women (due to biological factors and an increased likelihood of being prescribed opioids and being given longer term and higher dose prescriptions);
- People living in urban communities.

NSDUH Substate Estimates:

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

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

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

Burden (consequences)

According to the Department of Public Health, suicide deaths in CT have declined 20% from 2015 – 2019; however, unintentional drug overdose deaths have increased 20% in 2020 compared to 2019 data. There were 1,200 unintentional drug overdose deaths in 2019. In 4% of these cases, non-Hispanic, White males between the ages of 25 – 44, showed higher rates of suicide ideation history and suicide attempts compared to females across other age groups and other Races and Ethnicity. In 2019, 82% of cases with previous suicide ideation and previous suicide attempts involved opiates.

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

- Chronic opioid misuse may lead to serious medical consequences such as fatal overdose, scarred and/or collapsed veins, bacterial infections of the blood vessels and heart valves, abscesses, and other soft-tissue infections, and liver or kidney disease. Poor health conditions and depressed respiration from heroin use can cause lung complications, including various types of pneumonia and tuberculosis.
- Opioid misuse during pregnancy can result in a miscarriage or premature delivery, as well as neonatal abstinence syndrome (NAS), and exposure in utero can increase a newborns' risk of sudden infant death syndrome (SIDS).
- According to Connecticut's Office of the Chief Medical Examiner (OCME), in 2019, heroin was involved in 387 overdose deaths, and fentanyl was involved in 979 deaths.³
- Heroin-involved mortality rates have dropped from a high of 14.1 to 10.8 per 100,000 population between 2016 and 2019. However, since 2012 there has been a sharp increase in fentanyl-involved deaths, reaching the highest rate in 2019 with a death rate of 27.4 per 100,000 population.³

Opioid-Involved Non-Fatal Overdoses (DPH)

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

*Numbers are approximate due to suppression

Heroin-Involved Fatal Overdoses in 2019³

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

*Rate per 100,000 population

Opioid-Involved Fatal Overdoses in 2019³

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

*Rate per 100,000 population



2020 Region 1 Epidemiological Profile: Heroin & Other Illicit Opioids

Fentanyl-Involved Fatal Overdoses in 2019³

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

*Rate per 100,000 population

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

Treatment Admissions: Heroin* as the Primary Drug

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

*This includes heroin and non-prescriptive methadone

Heroin was the primary substance in 30.4% of all Connecticut treatment admissions in 2019. Of these, 68% were male, and 62.5% were White, non-Hispanic.⁷

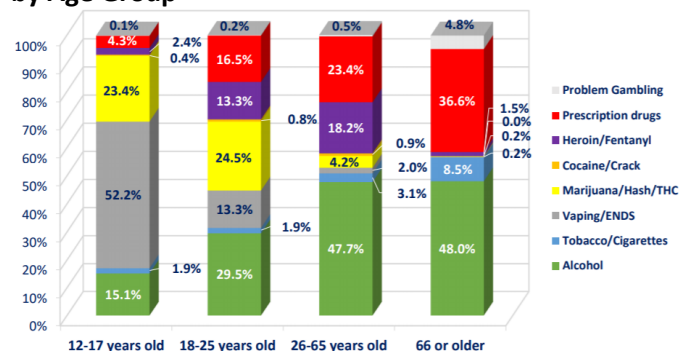
Capacity and Service System Strengths

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

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

According to the 2020 Community Readiness Survey, 18.2% of 26 - 65-year-olds are and 13.3% of 18 - 25-year-olds are concerned about heroine and fentanyl.⁸

Problem Substances of Greatest Community Concern by Age Group



Data Source: 2020 CT Community Readiness Survey (CRS)

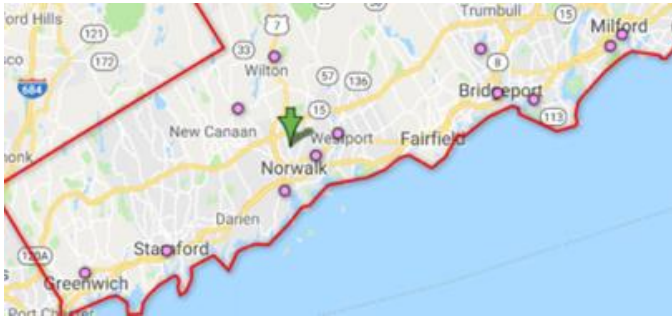
Prevention & Education: Southwest CT continues to provide awareness about the harmful effects and high potential for addiction to the community at large. Local Prevention Councils (LPCs) have conducted community education on heroin and other opioids for families and prescribers and supports training on the use of Narcan to reverse an overdose. The Hub supports these efforts through information, opioid education, and distribution of Narcan kits, in conjunction with LPCs and through an AmeriCorps PreventionCorps grant. Narcan training within SW CT continues to provide education and resources such as the Naloxone + Overdose Response App (“NORA”) app (available at www.norasaves.com) as well as on the LiveLOUD campaign.

The NarcanNOW app and the state’s newly developed Naloxone + Overdose Response App (“NORA,” available at www.norasaves.com) are both useful resources providing information on how to recognize the symptoms of a suspected opioid overdose, administer Narcan, dispose of medications, and find treatment and recovery resources. NORA also has an anonymous feature to report on kits used in a revival.

Treatment: Medication Assisted Treatment (MAT) is available via 12 publicly funded nonprofits, 2 private for profits, and individual providers throughout the region (see map below).



2020 Region 1 Epidemiological Profile: Heroin & Other Illicit Opioids



MAT in Southwest CT

Source: SAMHSA

There are detoxification facilities in the region. The state Access Line provides transportation to detoxes when needed.

Recovery: Southwest CT hospitals have hired Recovery Coaches as an effective way to use people with lived experience to respond to overdoses that come into the Emergency Department, connecting people to treatment and recovery support. Other recovery supports in the region include the CT Community for Addiction Recovery (for individuals with a substance use disorder) and The CARES Group, Courage to Speak, SMART Recovery Family & Friends for family support.

2020 Region 1 Epidemiological Profile: Marijuana

Problem Statement

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

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

The 2019 CT School Health Survey identified differences in marijuana use among youth based on racial, gender, and sexual identities:

- Gay, lesbian & bisexual youth (33%)²
- Hispanic youth (24%)²
- White youth (22%)²
- Black youth (15.5%)²
- Boys (22%), Girls (20%)²

Southwest CT has seen an increased level of marijuana usage among younger individuals. Rates of usage among those 12 and older are higher when compared to previous findings. Marijuana concentrates are also widely used by youth and young adults who vape them.¹

Magnitude (prevalence)

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

NSDUH Substate Estimates:

Percent Reporting Past Month Marijuana Use, ages 12+

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

Current statistics date from 2018, and therefore do not reflect changes in patterns that have emerged since the start of the COVID 19 pandemic. Connecticut legislation has also recently proposed a bill that would allow for marijuana to become legal.

The Regional Behavioral Health Priority Setting Workgroup found that the overall perception of harm in relation to Marijuana has decreased. It was suggested that this stems from a lack of education and understanding. The medicalization of marijuana is also thought to be a contributing factor when it comes to the perceived risk of this substance. 12th graders admitted that they would be more likely to try or increase their current use of marijuana if it were legalized.⁸ Legalization of marijuana in other states may have resulted in a decrease in perception of harm for individuals of all ages.

According to Connecticut State's Department of Consumer Protection, as of May 16, 2021 there are 53,605 residents registered with medical marijuana certificates. There are 11,995 residents registered in Southwest CT. There are 18 medical marijuana dispensaries in the state with 2 of them being located in Southwest CT (Stamford and Westport).

A sample of four youth surveys conducted within SW CT during 2017-2019 shows that:

- Past-month marijuana use among local high school students varied from 9% to 20% (for all 4 grades combined). Broken down by grade, usage is seen to increase each year, up to almost half of seniors.
- Between 9% and 12% of local high schoolers reported vaping marijuana in the past month.

¹ NSDUH

² Connecticut School Health Survey, 2019 (YRBS)



2020 Region 1 Epidemiological Profile: Marijuana

According to feedback gathered from The Hub's key informant focus groups, SW CT indicates extremely low perception of harm among youth, low perception of peer and parent disapproval, and that the majority of vapers are vaping marijuana--which means ingesting extremely high potency THC.

Risk Factors and Subpopulations at Risk

Risk factors include:

- Availability of marijuana;
- Early initiation;
- Frequency of usage;
- 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;
- Anxiety, depression, PTSD or other mental health issues;
- Childhood abuse/trauma;³
- Individuals with schizophrenia (whose symptoms worsen with marijuana consumption);
- Individuals with specific AKT1 and COMT gene variants (who are more likely to develop schizophrenia).

NSDUH Substate Estimates:

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

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

Compared to their statewide peers, Southwest CT young adults report the highest perception of great risk from smoking marijuana once a month. Among adolescents (ages 12 through 17) the perceived risk of harm from smoking marijuana weekly is steadily

declining. In the state of Connecticut, this decrease is prominent and reflected in our statistics. We also see that as age increases, so too does the percentage of those who see a risk in using marijuana.

The 2019 Connecticut School Health Survey shows slightly higher current marijuana use in females (22.9%) compared to males (20.5%).² Reported current use increases significantly by grade from 12.1% of 9th graders to 31.0% of 12th graders.² More Hispanic students reported current use (24.3%) than White students (22.4%) and Black students (15.5%).² Overall, the percentage of Connecticut high school students reporting current use has remained relatively stable since 2005. Current use nationally also appears to be relatively stable.

Burden (consequences)

Short-term consequences include⁴

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

Long-term consequences include⁴:

- Impaired learning and coordination;
- Sleep problems;
- Potential for addiction to marijuana, as well as other drug and alcohol use disorders;
- Youth who are heavy users are 3 times more likely to become addicted to heroin;
- Potential loss of IQ points (particularly in those who used heavily during adolescence);
- Decreased immunity;
- Increased risk of bronchitis and chronic cough;
- Marijuana potency has increased over the past few decades: in the 90s, the average THC content in confiscated samples was less than 4%, and in 2018 it was over 15%;⁴
- Marijuana use during pregnancy also increases the risk of child development problems including low birth weight, and brain

³ SAMHSA, CAPT Northeast Regional Marijuana Webinar Series: Strategies/Interventions for Reducing Marijuana Use

⁴ NIDA, Marijuana



2020 Region 1 Epidemiological Profile: Marijuana

development. Additionally, children exposed to marijuana in-utero have increased risk for problems with attention span and problem solving;⁴

- Several studies have linked marijuana use to increased risk for psychiatric disorders and substance use disorders. The amount used, age at first use, and genetic vulnerability are thought to influence this relationship;⁴
- In 2019, marijuana was identified as the primary drug in approximately 12% of treatment admissions in Connecticut.⁵ Of these, approximately 67.3% were male. About 30% were White, non-Hispanic, 28% Black, non-Hispanic, and about 26.4% Hispanic;⁴
- Traffic accidents, emergency room visits, and fatalities increase in states that legalize retail marijuana;⁷
- Emergency room visits for marijuana-induced psychosis, marijuana overdose and overdose in children who consume marijuana edibles that look like candy are rising;⁷
- Regular heavy marijuana use by teens can lead to an IQ drop of up to 8 points;⁸

of Vitamin E acetate which is used as a diluent in THC-containing products.⁶

Marijuana concentrate is being seen at higher rates in recent history. These concentrates have extremely high levels of THC, ranging anywhere from 40 through 80 percent of THC. This form of marijuana can be up to four times stronger in THC levels than traditional marijuana. The longer lasting impacts of marijuana concentrates are not fully known due to the lack of research on long term usage. Known effects of marijuana plant usage include paranoia, anxiety, panic attacks, and hallucinations. There are short term harms such as marijuana-related hospitalization and overdoses as well as longer term harms such as THC addiction, psychosis, depression, and anxiety.⁹

The legalization of marijuana has also had a significant impact on youth. In the past year the use of marijuana in those ages 12 through 17 in states which have legalized marijuana has increased around 3.5%, each from 2016-2017 to 2017-2018.¹ Additionally, another study was able to conclude that Cannabis Use Disorder in young people in states which marijuana is legalized, has increased 25% following the legalization.¹¹

Recent studies have also shown a strong correlation between usage of marijuana and opioids. The American Journal of Psychiatry found cannabis use, even among adults with moderate to severe pain, was associated with a substantially increased risk of non-medical prescription opioid use in conjunction with marijuana.¹⁰

Treatment Admissions: Marijuana⁵

	CT	Region 1	Region 2	Region 3	Region 4	Region 5
FY2019	13945	1238	2678	3254	4486	2289
FY2020	7126	1138	1343	855	2360	1430

- The southwest region of Connecticut reported one of the lowest rates of treatment admissions in connection to Marijuana. Overall, these rates have generally declined from 2019 to 2020;
- Because marijuana use impairs motor coordination and reaction time, many studies have shown a relationship between blood THC concentration and impaired driving;⁴
- A recent national outbreak of e-cigarette, or vaping product use-associated lung injury (EVALI) was linked to vaping THC, possibly due to the presence

Capacity and Service System Strengths

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

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

⁵ CT DMHAS, 2019 Treatment Admissions

⁶ CDC (2020), Outbreak of Lung Injury Associated with the Use of E-Cigarette, or Vaping, Products

⁷ USDEA: [Marijuana Edibles](#)

⁸ MTF Survey <https://www.drugabuse.gov/drug-topics/trends-statistics/monitoring-future>

⁹ JTT: "The Facts About Marijuana Concentrate"

<https://learnaboutsam.org/toolkit/>

¹⁰ SAM: "Marijuana and Other Drugs: A Link We Can't Ignore"

¹¹ SAM "Youth Use"



2020 Region 1 Epidemiological Profile: Marijuana

Prevention: Since legislation decriminalizing marijuana and approving it for health-related purposes has reduced the perception of harm, many Local Prevention Councils (LPCs) continue to focus on marijuana as a priority in their towns. LPCs have addressed the perception of low-risk use of marijuana by utilizing the following prevention strategies:

- Dissemination of myths and facts about marijuana with a primary focus on the health-related risks.
- Several LPCs coordinated efforts in providing common prevention language using a social media campaign on Instagram and Facebook around health effects and brain development.
- Coalitions created blog posts and used coalition meetings to educate stakeholders how Marijuana can affect the adolescent brain development.
- Educating community members on regulations for medical marijuana use.
- Educate parents / professionals about signs and symptoms of marijuana use.
- Support school policies related to marijuana and other illicit drugs.
- Local LPC's have started marijuana subcommittee with both focusing efforts on education and awareness by disseminating information and holding webinars and trainings for the region.

A group of advocates virtually met often for months including representation from Fairfield County, had coordinated educational webinars, provided information and developed educational campaigns. They provided advocacy efforts which were coordinated by a New Canaan parent / leader.

Individual prevention advocates have been involved with legislation and the proposed bill of legalizing recreational marijuana. The efforts have been around funding for prevention, treatment and recovery not only for marijuana but for the mental health impacts.

Even with the region's prevention strategies and advocacy efforts there still is not enough community readiness or capacity to support the efforts of marijuana prevention needed in our area.

Treatment and Recovery: The state Department of Mental Health and Addiction Services (DMHAS) reported 10,284 treatment admissions statewide for marijuana in 2019 (13% of all admissions). Marijuana was responsible for 4,849 (8.8%) of substance abuse admissions and 5,435 (21.9%) mental health admissions.



2020 Region 1 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 2018-2019 National Survey on Drug Use and Health (NSDUH), 7.1% of Connecticut respondents reported a major depressive episode in the past year.³

Serious Mental Illness

Serious mental illness (SMI) refers to mental, behavioral, or emotional disorders resulting in serious functional impairment, interfering with major life activities.¹ Examples of serious mental illnesses include schizophrenia, bipolar disorder, and major depression⁴. The 2018-2019 NSDUH shows 4.5% of adults in Connecticut reported serious mental illness in the past year.³

Key informant interviews conducted in 2021 by The Hub identified a major concern regarding SMI for Southwest CT (SW CT) is the effect of the COVID-19 pandemic on individuals, especially youth and young adults.

The long-term effects of the pandemic are still unknown, however there has been a significant increase in mental health concerns. A recent national report showed that 41% of adults report anxiety or depression; this is more than double the percentage reported pre-pandemic at 11%, 13% of adults report new or increased substance use and 11% of adults report suicidal ideation in the past month. The *highest-risk groups* include young adults (26% experience suicidal ideation), lower income/ job loss, women & minorities, and essential workers (22% experience suicidal ideation). This is possibly due to isolation and the unknowns of the virus. Many fear for the post pandemic anxiety, stress, and trauma.

The American Psychiatric Association found that 82 percent of survey respondents reported using telehealth services and another 43 percent of the respondents reported wanting to continue using telehealth services following the end of the pandemic.⁵

¹ NIMH

² CDC, Depression and Anxiety

³ NSDUH 2018-2019

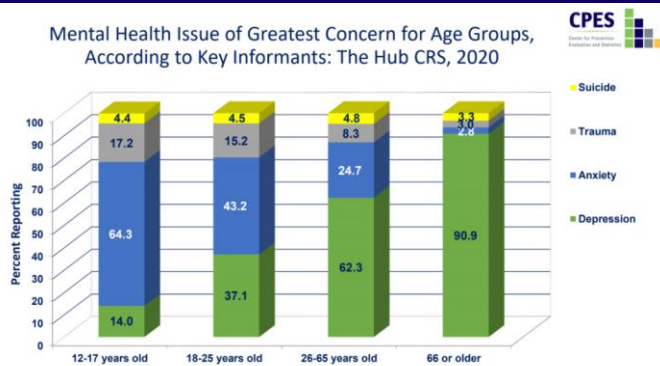
⁴ Connecticut School Health Survey 2019

⁵ Medscape 2021



2020 Region 1 Epidemiological Profile: Mental Health

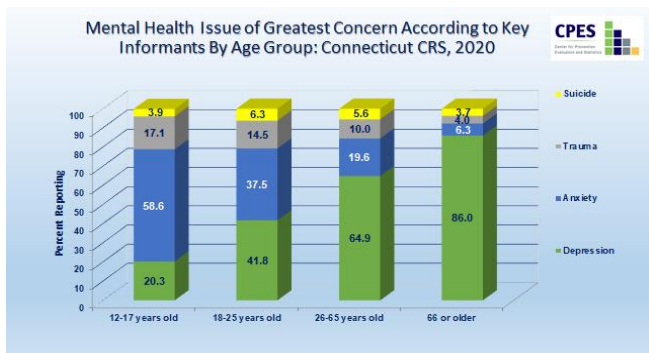
Magnitude (prevalence)



Data Source: 2020 Community Readiness Survey (CRS)

Anxiety

The 2018 Connecticut BRFSS showed 11.2% of adults reported feeling nervous, anxious, or on edge for more than half the days or nearly every day in the past 2 weeks.⁶



Data Source: 2020 Community Readiness Survey (CRS)

Depression

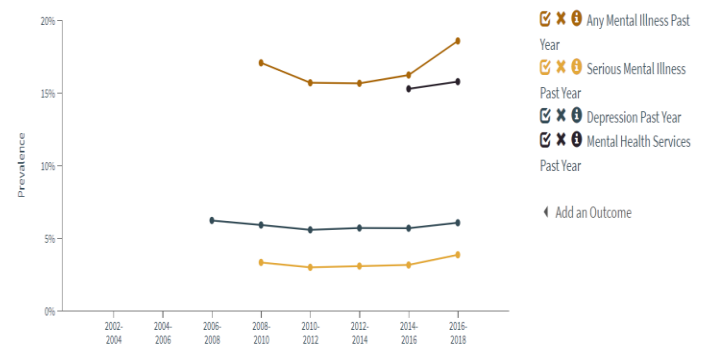
The percentage reporting past year major depressive episode was highest among young adults 18-25 (15.3%) compared to youth 12-17 (14.4%), and adults 26+ (5.8%).⁴ According to the 2018 Connecticut BRFSS, 15.5% of adults reported being told by a doctor that they had a depressive disorder.³ Similar to the NSDUH, the BRFSS showed a higher percentage among younger adults 18-24 (19.1%), compared to those 35-54 (15.0%) and those 55+ (13.8%). NSDUH reports 6.05% of SW CT reported a past year major depressive episode, ages 18+ from 2016-2018; while the state reported 6.84%. This is an increase for SW CT reporting 5.67% from 2014-2016.

Serious Mental Illness

In the 2018-2019 NSDUH, young adults 18-25 had a higher percentage reporting serious mental illness (8.54%) than those 26+ (3.86%).³ In 2016-2018 SW CT reported 3.84% of past year serious mental illness ages 18+ which was an increase from 3.14% in 2014-2016.

The 2019 Connecticut School Health Survey reported that almost 70% of high school students said their past 30 day mental health was not good (including depression, stress, emotional problems).⁴ This was higher among females (82%) and LGBT students (88%). The percentage of high school students reporting feeling sad or hopeless almost every day for two weeks or more in the past year, so that they stopped doing usual activities, was 30.6%. This was higher among females (40.5%) than males (21%), and was higher among Hispanic students (36.8%) than non-Hispanic Black (30.3%) or non-Hispanic White students (28.7%).⁶

Prevalence among Adults Aged 18 or Older in Connecticut Southwest, by Outcome



Data Source: NSDUH

The NSDUH prevalence chart above shows that in SW CT there has been an increase in reported mental health issues for adults 18 or older.³ Specifically:

- Any mental illness in the past year (2016-2018) 18.57% increased from 16.22% (2014-2016)
- Serious mental illness in the past year (2016-2018) 3.84% increased from 2.14% (2014-2016)
- Depression in the past year (2016-2018) 6.05% increased from 5.67% (2014-2016)

⁶ CT BRFSS 2018

⁷ NAMI



2020 Region 1 Epidemiological Profile: Mental Health

- Use of mental health services in the past year (2016-2018) 15.76% increased from 15.27% (2014-2016)

According to feedback gathered from The Hub’s key informant focus groups and emerging resources, TeenTalk crisis counselors and other providers who work with youth and young adults have seen an increase in need and in severity of symptoms. Providers who work with adults also reported an uptick in the number of individuals suffering from depression and anxiety.

Burden (consequences)

- Depression is the leading cause of disability in the world;⁷
- Mental illness costs Americans \$193.2 billion in lost earnings per year;⁷
- Economic burden of \$400 million per year to the state for serious mental illness in adults, with over half due to lost productivity: unemployment, lost compensation for caregivers, or early death;⁸
- Increased risk of school suspensions and expulsions;⁹
- 1 in 8 emergency department visits involves a mental health or substance use condition.⁷

Risk Factors and Subpopulations at Risk

Risk factors for depression and anxiety include¹:

- 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;
- Life stressors such as financial hardship or personal loss;
- Mental illness (including depression, anxiety, and bipolar disorder, among others) is a risk for suicide;
- Co-occurring substance use disorder;⁹
- Young adults report higher rates of depression and serious mental illness.^{4,5}
- The prevalence of major depressive episodes is higher among adult females than males¹, and among adults reporting two or more races¹
- The prevalence of any anxiety disorder is higher among females than males.¹
- LGBTQIA+ individuals are more likely than heterosexual individuals to experience a mental health condition. Individuals who are transgender are four times more likely to experience a mental health condition.⁴

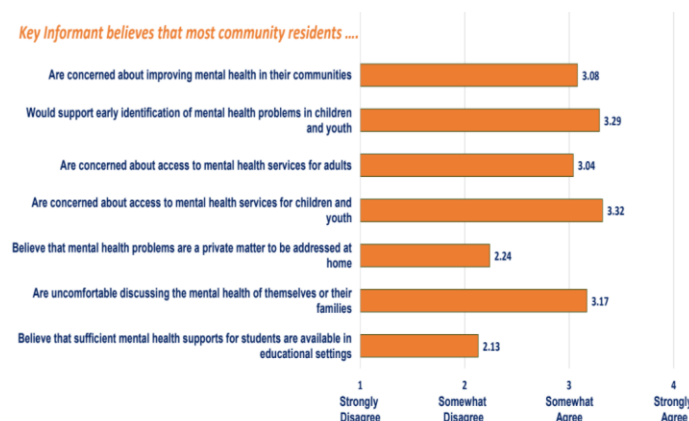
According to DMHAS, 70% of patients had a mental health disorder upon admission to a treatment facility in Connecticut during FY 2019.⁸

Capacity and Service System Strengths

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

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

In 2020 SW CT has the lowest mean stage of readiness for mental health promotion in the state.



Data Source: 2020 Community Readiness Survey (CRS)

⁸ CT DMHAS, 2019 Treatment Admissions

⁹May 20, 2019 CT Mirror: Almost one-third of students with emotional disturbances are suspended or expelled, far more than students with any other disability.



2020 Region 1 Epidemiological Profile: Mental Health

SW CT is served by: 6 hospitals offering mental health services (including Silver Hill Hospital, a psychiatric hospital); the Department of Mental Health and Addiction Services (DMHAS), which operates facilities in Bridgeport and Stamford to serve low-income individuals with serious mental illness and also contracts with local nonprofit agencies; some 30 nonprofit offices serving adults with mental illness and another 30 serving youth; several private for-profit agencies specializing in eating disorders, anxiety or addiction; and many individual therapists and private practices. In addition, in most towns the municipal social or human services department can provide limited counseling and referral to care. There is a need for respite care and for a first-episode psychosis program.

The state's Infoline is a resource for the region and handled **11,414 calls** for mental health and addiction referrals from SW CT residents in the past year. 11,510 calls were made to the 2-1-1 crisis intervention & suicide program, which connects youth under age 18 to mobile crisis services in 2020. So far from January 1, 2021 to May 1, 2021, 3,644 calls have been made to 2-1-1 from SW CT. Many calls are from schools, which are the front line for adolescent mental health. Some school districts (Stamford & Norwalk) are redesigning their school counselor program. Several contract with Kids in Crisis to embed Teen Talk counselors (3 local middle schools and 6 high schools). Some of our local school districts have contracted with Effective School Solutions for in-school support. The Fitch Academy, Spire School, and Newport Academy provide therapeutic alternative school programs for those with behavioral health disorders. Most school systems are building social-emotional programming into their curriculum, including teaching mindfulness and DBT skills and using educational programs GoZen, GoHackify, Wingman, 2nd Steps and others.

Dozens of free peer support groups are available throughout the region, including Depression Bipolar Support Alliance (DBSA), National Alliance for Mental Illness (NAMI), SMART Recovery, The C.A.R.E.S. Group,

and more, providing support to individuals and families for mental health, substance use, gambling, suicide loss, bereavement, and other issues. During the pandemic, RIPPLE, a Norwalk-based peer-led nonprofit, launched late-night online support groups which now meet 3 times a week from 10pm to midnight, filling an important gap. All of these were offered virtually throughout the pandemic. There are also trained Recovery Support Specialists and Recovery Coaches in the region.

The Community Health Improvement Projects (CHIPs) of the local hospitals all include behavioral health goals, and there are ~90 committees, task forces and coalitions in the 14-town region that work on behavioral health issues.

Each year community partners including Local Prevention Councils and Catchment Area Councils work together with coordination from The Hub to support community awareness through:

- Mental Health Awareness Month, with 30+ events every May (pre-covid);
- Wellness Month, offering ~20 free behavioral health screening events in communities every October (pre-covid);
- National Prevention Week each May;
- Mental Health First Aid, suicide prevention trainings, and other programs throughout each year.

Many efforts and collaborations have been made throughout SW CT and the state to continue community awareness throughout the pandemic by becoming available virtually.



2020 Region 1 Epidemiological Profile: Prescription Drug Misuse

Problem Statement

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

There were 1,374 accidental intoxication deaths throughout the state of CT. In this total, 286 deaths involved a mix of any opioid and a benzodiazepine, 120 deaths involved methadone, 95 deaths involved oxycodone, 95 deaths involved amphetamine/methamphetamine, and 51 deaths involved buprenorphine alone.² Region 1 Southwest CT (SW CT) experienced 202 drug overdose deaths in 2020; an increase since 2019 with 171 deaths.³ Within Region 1, Norwalk and Stratford experienced 17 overdose deaths and Stamford experienced 19 overdose deaths. Bridgeport overdose deaths continue to experience high numbers compared to other cities in SW CT, with 65 deaths in 2020.

There were 377 fatal suspected overdoses reported by EMS from all counties.⁴ Hartford County reported the

highest numbers with 150 suspected overdoses. Fairfield County had the third highest number of suspected overdoses with 59.

Prescription drugs, particularly oxycodone and Percocet, were present in 11% of total suspected overdose deaths for the state. These numbers include counterfeit, diverted, and prescribed medications. Bridgeport rated highest in suspected overdose deaths in Fairfield County with 338 deaths, followed by Danbury with 130 deaths. The total prescription count for Southwest CT was 490,155. The most common controlled substances dispensed include benzodiazepines and opiate agonists, followed by anxiolytics, sedatives, hypnotics, and amphetamine derivatives. These include alprazolam, lorazepam, oxycodone, and hydrocodone.⁵

According to key informant focus groups conducted by The Hub, counterfeit drugs or pills are becoming increasingly more concerning. The use of counterfeit prescription drugs is more of a concern in SW CT and is a higher priority in young adults compared to youth and children.

Magnitude (prevalence)

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

According to the 2019 CT YRBS, 10.1% of high school students reported ever taking prescription drugs without a doctor's prescription.⁶ Young adults, ages 18 to 25, show 6% use of over the counter, non-medical prescription drugs. 77% of young adults reported engaging in substances to have a good time. 78% of young adults reported limiting substance use due to physical or health concerns. 30% of high school students

¹ NIDA, Misuse of Prescription Drugs Research Report

² OCME, Office of the Chief Medical Examiner (2020)

³ CT DPH, Department of Public Health (2020)

⁴ SWORD Statewide Reporting (2019 – 2020)

⁵ CT Prescription Monitoring and Reporting System, CPMRA (2020)

⁶ Connecticut School Health Survey: Youth Risk Behavior Survey (2019)



2020 Region 1 Epidemiological Profile: Prescription Drug Misuse

obtained prescription pain medication without a prescription by someone giving it to them or taking it from their home or someone else's home. 4.4% of high school students have taken over-the-counter drugs to get high.³ According to the Young Adults Statewide Survey, of 1,257 young adults ages 18-25, 14% had engaged in prescription drugs in the past month and 6% in their lifetime.

According to key informant focus groups conducted by The Hub, use of prescription drugs are a higher priority for young adults compared to youth. It is a low priority in youth and children. With young adults, stimulants, counterfeit drugs, and Adderall are particularly misused.

Risk Factors and Subpopulations at Risk

Persons at risk of misusing prescription drugs include⁷:

- Those with past year use of other substances, including alcohol, heroin, marijuana, inhalants, cocaine, and methamphetamine;
- People who take high daily doses of opioid pain relievers;
- Persons with mental illness;
- People who use multiple controlled prescription medications, often prescribed by multiple providers;
- Individuals with disabilities are at increased risk of prescription opioid misuse and use disorders;⁸
- Overall data on the typical overdose victim shows a Non-Hispanic White male between the ages of 35 - 44 in 2020. However, the typical overdose victim in some towns with higher numbers of overdose deaths, particularly Bridgeport, are Hispanic males or Non-Hispanic Black Males between the ages of 35 - 44;
- Undocumented individuals are least likely to receive accessible care due to fear of arrest or deportation;
- According to key informant focus groups conducted by The Hub, Electronic Sport Gamers or "E-Gamers" are increasingly using Adderall to stay awake longer for gaming;

- Among all fatal overdoses involving prescription opioids in Connecticut in 2019, male deaths occurred 1.3-2.8 times more frequently than female deaths in each racial/ethnic group;³
- The elderly population may be at risk of consequences of prescription drug misuse, as they use prescription medications more frequently compared to the general population and may be at higher risk of medication errors;⁹
- Hispanic students had the highest rates of taking prescription drugs without a doctor's prescription (14.2%), significantly higher than White non-Hispanic students (8.0%). The rates among Black students (12.8%) were also significantly higher than White non-Hispanics. The NMUPD rates were slightly higher among females (11.3%) than males (9.1%);⁶
- According to key informant focus groups conducted by The Hub, treatment providers state that many individuals face language barriers in accessing care. In particular, there is a lack in Spanish, Creole, and Polish speaking providers;
- According to key informant focus groups conducted by The Hub, treatment providers frequently see individuals facing barriers in accessing care due to insurance. Many are uninsured or under-insured.

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).^{10, 11}
- Connecticut experienced 1,127 opioid-involved fatalities in 2019, including 131 that involved a prescription opioid; 92 involved oxycodone, 20 oxymorphone, 14 hydrocodone, 15 tramadol, and 14 hydromorphone. The rate for SW CT prescription

⁷ Bali V. Research in Social and Administrative Pharmacy 2013; 9(3): 276-287.

⁸ Lauer EA et al. Disability and Health Journal 2019;12(3):519-522

⁹ Perez-Jover V et al. Int J of Environmental Research and Public Health 2018; 15:310.



2020 Region 1 Epidemiological Profile: Prescription Drug Misuse

drug-involved fatal overdoses in 2019 was higher than most other regions and the state (3.53) at a rate of 3.57 and has increased in 2020.³

- 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.²
- There were 1,062 non-fatal stimulant overdoses in 2018, and 2,372 in 2019.⁴

Treatment admissions for opiates and synthetics have increased from 2018 to 2020. In the state, there were 1,829 admissions in 2018 and an increase to 3,260 admissions in 2020. In SW CT, admissions increased from 2018 (208) to 2020 (394), and numbers overall are less compared to other regions.³

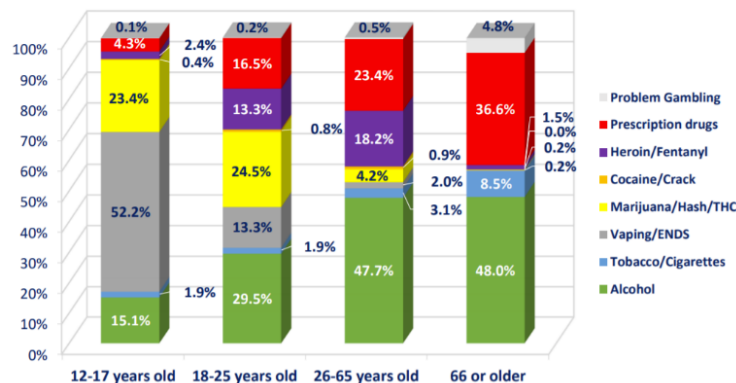
There is an increase in opioid-involved fatalities in Connecticut from 2019 with 1,127 to 1,273 deaths in 2020. In 2020, 286 deaths involved a mix of any opioid and benzodiazepine, 120 deaths involved methadone, 95 deaths involved oxycodone, 95 deaths involved amphetamine/methamphetamine, and 51 deaths involved buprenorphine alone. Overall, there has been around a 15.7% increase of drug overdose deaths from 2019 to 2020. A lethal combination of xylazine, an animal tranquilizer and fentanyl were identified in 141 overdose deaths in 2020. An emerging and deadly substance, Flualprazolam, is a designer benzodiazepine combined with fentanyl, and has resulted in 11 overdose deaths in 2020. Eutylone, a synthetic stimulant, had resulted in 3 overdose deaths.³

Capacity and Service System Strengths

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

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

PROBLEM SUBSTANCES OF GREATEST COMMUNITY CONCERN BY AGE GROUP



Data Source: 2020 CT Community Readiness Survey (CRS)

Overall, there is an increase of community readiness statewide from 2018 to 2020. Southwest CT is at a slight decrease of community readiness in 2020 as compared to 2018. Prescription drug concerns account for 4.3% in ages 12 to 17, 16.5% in ages 18 to 25, 23.4% in ages 26 to 65, and 36.6% in ages 65 and older.¹²

Prevention: Local communities are working to reduce demand for prescription drugs by educating about health risks, increasing perception of risk, and disseminating information about prescription drug misuse through multiple channels to different community sectors. Key informant focus group data indicate the strengths of SW CT is the resilience and dedication of the network of professionals. Through the state's Change the Script campaign, communities have been able to educate prescribers about the CPMRS and parents about safe storage of prescription drugs.

¹⁰ Jones CM. Drug Alcohol Depend 2013; 132:95-100

¹¹ Muhuri PK et al. CBHSD Data Review, 2013.

¹² CT Community Readiness Survey (CRS) (2020)

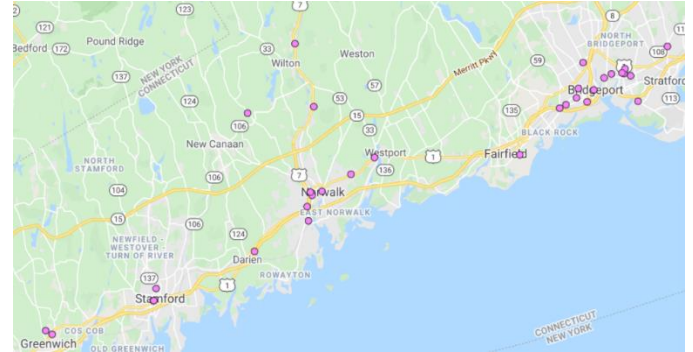


2020 Region 1 Epidemiological Profile: Prescription Drug Misuse

Reducing access: Prescription drop boxes at 13 police departments in SW CT are successful in reducing access to unused prescription drugs. Statewide, 43,728 lbs. of returned prescriptions were burned in 2018, up from 37,541 in 2017, according to the Department of Consumer Protection. As of 2020, drop boxes will be available in 3 big box store pharmacies throughout the state. Many towns in SW CT also participate in biannual Drug Take Back Days, and Local Prevention Councils (LPCs) have used state opioid response grants to purchase and distribute medication lock boxes. According to key informant focus groups conducted by The Hub, medication drop-off boxes at local police stations are frequently utilized and emptied on a weekly, sometimes twice a week basis, showing excellent results of effectiveness.

Treatment & Recovery: For individuals ready to seek help, there are state and private treatment providers throughout the region to treat prescription drug abuse. (See map.) Local hospitals in Southwest CT have begun hiring Recovery Coaches to respond to overdoses and connect people to recovery services. Through new grants, 2 providers are now operating mobile vans to do outreach to opioid users and initiate life-saving Medication Assisted Treatment (methadone, suboxone). Support groups for individuals in recovery and for affected family and friends include CCAR, The CARES Group, Courage to Speak, and SMART Recovery Family and Friends. The state's new LiveLOUD website provides excellent resources.

Substance Use Treatment Facilities and Buprenorphine Physicians in SW CT



Data Source: SAMHSA Treatment Locator Map

Through several state opioid response grants, all local communities have sponsored educational sessions on opioids and have trained people to administer Narcan, distributing 800 free Narcan kits in 2020.

The NarcanNOW app and the state's newly developed Naloxone + Overdose Response App ("NORA," available at www.norasaves.com) are both useful resources providing information on how to recognize the symptoms of a suspected opioid overdose, administer Narcan, dispose of medications, and find treatment and recovery resources. NORA also has an anonymous feature to report on kits used in a revival.



2020 Region 1 Epidemiological Profile: Prescription Drug Misuse

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2020 Region 1 Epidemiological Profile: Problem Gambling

Problem Statement

Problem gambling, sometimes referred to as gambling addiction, includes gambling behaviors which disrupt or damage personal, family, or vocational pursuits.¹

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

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

In key informant interviews and focus groups (including teens, clinicians, and persons in recovery) conducted in 2021 in Southwest CT (SW CT), participants indicated that there was a general lack of awareness regarding problem gambling, including prevalence, risk factors, and potential consequences.

One focus group member did indicate that gambling "...is absolutely a problem in Fairfield. I would say particularly for teen boys it is an issue. They do a lot of gambling and sometimes spend a lot of money. I have heard of high schoolers who even go as far as selling all of their family's old iPhones and iPads."

The increasing availability of online gambling opportunities has increased ease of access and thereby represents a potential major contributor to problem gambling. Legislation is currently underway in Connecticut to legalize sports betting and online wagers.³

Although raising awareness regarding the risks of gambling behaviors may be particularly effective when included in early education in schools, that remains a challenge due to competing priorities for school-aged

youth. Gambling disorders typically have an age of onset ranging from mid-20s to late 30s⁴ whereas substance use disorders may begin much earlier. In the 2019 Connecticut School Health Survey, only 25.4% of all students reported ever having gambled compared with 49.8% had ever had alcohol and 35.9% who had ever used marijuana.

Many online video games include "loot boxes", in which random rewards can be purchased, and so this may constitute a form of gambling. Video game addiction is relatively new and is not yet recognized in the US as a diagnosable disease. Thus, there is no data regarding the magnitude.

Magnitude (prevalence)

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

In 2018 national survey data, the rate of past-year gambling activity in Connecticut was higher than the national average (83% vs 73%, respectively).^{1a} In 2019, the Connecticut Council on Problem Gambling reported that about 70,000 Connecticut residents met the clinical criteria for disordered gambling and another 280,000 residents were at risk of developing a gambling problem in their lifetime.⁵

According to data from Bettor Choice and Problem Gambling Services, among 291 persons admitted to treatment for gambling disorder in FY2019, most were white (80%), more than half were between ages 45 – 64 (51%), and there were approximately equal proportions of females and males (47% and 53%, respectively).

There is limited quantitative data regarding the prevalence of problem gambling in SW CT. Focus groups were conducted in 2021, it was noted that teens are now frequently engaging in gambling activities (e.g., poker, e-sports betting). In youth surveys performed in

¹ National Council on Problem Gambling

² American Psychiatric Association, Gambling Disorder

³ Singer S. 2021. Expanded gambling in Connecticut closer to reality as sports betting and online wagers approved by General Assembly committee; Bridgeport casino also included. *Hartford Courant*, Mar 24

⁴ Black DW et al. *Compr Psychiatry*. 2015;60:40-46

National Council on Problem Gambling

⁵ Connecticut Council on Problem Gambling Annual Report 2019



2020 Region 1 Epidemiological Profile: Problem Gambling

2 communities in SW CT during 2018, between one third and one half of respondents indicated that they had engaged in betting on sports.⁶ However, the prevalence of problem gambling among youth or any other age group in the region is currently unknown. Furthermore, there are wide differences in demographics and socioeconomic factors between wealthy and urban core communities in the region, and so there might exist differences in the prevalence between subregions. In addition, factors such as the increase in online gambling sites and the 2020 COVID-19 pandemic are likely to have had an impact on the current prevalence.

According to the Connecticut School Health Survey in 2019, 25.4% of high school students reported gambling on a sports team, playing cards or dice game, state lottery games, gambling on the internet, or bet on a game of personal skill.⁷ The survey also showed that 34.6% of high school males reported gambling, compared to 16.2% of females. The prevalence among 12th graders was significantly higher (31.7%) than any other grade (22.1%-24.3%). Differences among race/ethnicity were not statistically significant.

Risk Factors and Subpopulations at Risk

- Risk Factors include:⁸
 - Having an early big win
 - Having easy access to preferred form of gambling
 - Holding mistaken beliefs about odds of winning
 - Having a recent loss or change, such as divorce, job loss, retirement, death of a loved one
 - Financial problems
 - A history of risk-taking or impulsive behavior
 - Depression and anxiety
 - Having a problem with alcohol or other drugs
 - A family history of problem gambling
- Problem gambling rates double for individuals living within 50 miles of a casino.

- Although there is presently not a casino in SW CT, there is ongoing legislation that includes construction of a new casino in Bridgeport.¹

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 others.¹

Treatment Admissions:

	CT	Region 1	Region 2	Region 3	Region 4	Region 5
FY2019	291	28	87	93	27	56

In data from Bettor Choice and Problem Gambling Services for Regions 1–5, treatment admissions for gambling disorder in region 1 during FY2019 were among the lowest in the state. However, those data are unlikely to represent a comprehensive assessment of treatment burden in any of these regions. For example, gambling disorder often exists as a comorbidity with substance use disorder but may not be assessed in institutions and agencies treating patients for those disorders. Furthermore, persons from wealthy communities might seek treatment in private facilities and therefore would not be counted.

There is no regional data regarding the burden associated with gambling-related issues such as criminal justice and healthcare spending, job loss, bankruptcy, etc.

Capacity and Service System Strengths

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

	CT	Region 1	Region 2	Region 3	Region 4	Region 5
2020	33.8	36.6	39.9	44.4	28.6	24.1

⁶ Key informant interview. 2021. Region 1 Gambling Awareness Team member

⁷ Connecticut School Health Survey, 2019

⁸ Risk Factors for Developing a Gambling Problem, Centre for Addiction and Mental Health (CAMH)



2020 Region 1 Epidemiological Profile: Problem Gambling

In the 2020 CT Community Readiness Survey, more than one third of respondents indicated the ability to raise awareness about the risks of problem gambling/gaming addiction as medium/high.

Community Readiness Survey: % Rating Community Importance of Preventing Gambling/Gaming Addiction as Somewhat/Very Important and Ability to Raise Awareness of Risks of Problem Gambling/Gaming Addiction as Medium/High

Community Type	Importance of Prevention	Ability to Raise Awareness
CT	62.1	33.8
Wealthy CT	56.7	48.7
Urban Core CT	67.2	29.3
Urban Periphery CT	63.3	37.7
Suburban CT	57.3	28.3

- CT-wide results from the 2020 CT Community Readiness Survey with respect to prevention and ability to raise awareness of problem gambling/gaming addiction were compared with those of communities best representing SW CT (Wealthy CT, Urban Core CT, Urban Periphery, Suburban CT).
- Overall, more than half of respondents in CT and in each community rated the importance of prevention as somewhat/very important, although less than half rated the ability to raise awareness as medium/high.
- Compared with overall results in CT, a higher percentage of respondents from Urban Core CT and Urban Periphery CT rated prevention as somewhat/very important, whereas lower percentages from Wealthy CT and Suburban CT responded similarly.
- A higher percentage of respondents from Wealthy CT and Urban Periphery CT indicated ability to raise awareness as medium/high, whereas a lower percentage from Urban Core CT and Suburban CT responded similarly.
- In SW CT, focus groups conducted in 2021, participants expressed recognition of a growing problem among youth, potential problems associated with increased advertising, and the lack of resources allocated to addressing problem gambling.
- Taken together, the recognition of the importance of prevention by respondents in the survey and the recognition of problems and associated factors by the focus groups suggests that the level of community readiness might be higher than realized by survey respondents.
- In SW CT, CT Renaissance is the grantee of the “Better Choice” program funded by the state to provide treatment for problem gambling at little to no cost.
- In October 2018, the Brief Biosocial Gambling Screen (BBGS) was integrated into the Mental Wellness screening tool used throughout the region during Wellness Month, as well as by several towns, colleges and providers throughout the year. Use of this tool allows for assessment of potential problem gambling at any screening event for mental health and substance use.
- Within SW CT there are two primary teams focused on strengthening gambling awareness. They are the Regional Gambling Awareness Team, whose members presently represent 20 different organizations, and the Caribe Gambling Awareness Youth Team, whose members range in age from 14-18 years. Both teams annually plan and implement a number of initiatives to increase awareness, including infusing gambling awareness into existing opportunities (e.g. integrating gambling screening and discussions with mental health), developing social media (e.g. youth PSA), planning and coordinating events during PGAM (Problem Gambling Awareness Month), hosting opportunities to educate elected officials, and organizing forums on “emerging trends” such as sports betting and using interactive activities to demonstrate key messages about gambling.
- Congregation Assistance Program/Community Awareness Program (CAP), which is a community-based training program available to interested faith communities or other groups through The Hub. A CAP training provides awareness not only about problem gambling but also substance misuse, suicide, and mental health.



2020 Region 1 Epidemiological Profile: Suicide

Problem Statement

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

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

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

Magnitude (prevalence)

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

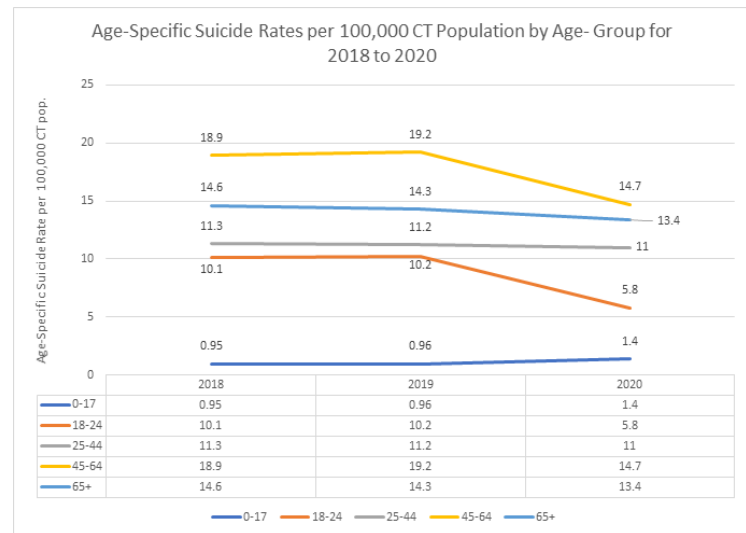
NSDUH Substate Estimates: Percent Reporting Past Year Serious Thoughts of Suicide, ages 18+

	CT	Region 1	Region 2	Region 3	Region 4	Region 5
2014-2016	3.62	3.45	3.65	4.42	3.35	3.65
2016-2018	4.17	4.30	4.23	4.63	3.94	4.00

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

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

The next two charts show suicide decreases occurred by age group in CT. 18–24-year-old had the greatest decrease and all races were impacted similarly.



Data Source: CT DPH

¹ CDC (2019). Suicide Prevention

² NIMH (2019). Suicide

³ CT DPH (2018). CTVDRS, Violent Deaths: Connecticut Data 2015 to 2018

⁴ CT OCME (2019). Annual Statistics: Suicides

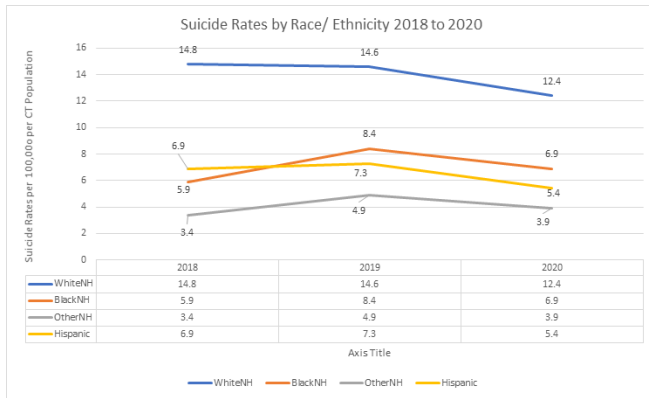
⁵ NSDUH 2018-2019

⁶ Connecticut School Health Survey, 2019 (CT YRBSS)

⁷ Connecticut BRFSS 2018



2020 Region 1 Epidemiological Profile: Suicide



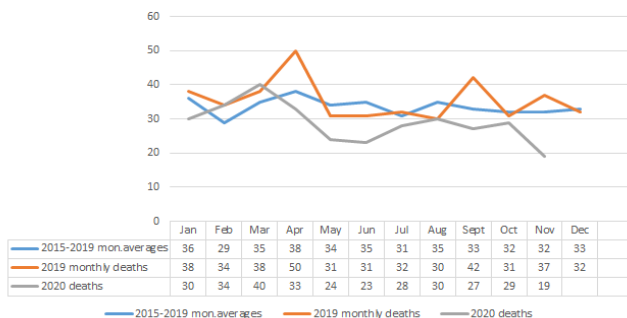
Data Source: CT DPH

From 2015-2019 SW CT averaged 48 deaths by suicides per year and totaled 239 suicides during that time period. Every town in SW CT reported at least one suicide during that period. Among SW CT cities; Stamford reported 50 suicides, Norwalk 27, and Bridgeport 49.³

Even though CT DPH reports a decrease in suicides, from March – May 2020 all but one of the 14 towns had at least one suicide. The highest population cities reported the most suicide deaths in this time period were Stamford with 12, Norwalk with 8, and Bridgeport with 5.

The region saw the highest rates of suicide among ages 25 and older with a total of 42 suicides, followed by ages 18 through 24 with 3 suicides and 2 suicides completed in those ages 17 and younger.

Comparison of Suicide Deaths: Monthly Averages 2015-2019 to 2019 Deaths by Month to 2020 Data as Nov 30th



Data Source: CT Violent Death Reporting System

The NVDRS data from CT Department of Public Health for 2019 and preliminary data for 2020 showed the following:

- From 2015 to 2019 (Jan - November 30th), CT averaged 370 suicide deaths during that time period;
- From January – November 30, 2020, there were 317 suicides;
- Based on preliminary data for 2020, CT has experienced a 17% decline in suicide deaths when compared to the 5-year average (2015 to 2019).
- These data were compiled to assess the impacts of Covid-19 in CT.

A recent national study found that 11% of adults reported an increase in suicidal ideation in the past month (more than double the pre-pandemic rate), and that the highest risk demographics are young adults 18-25 (26%) and essential workers (22%) due to the Covid-19.⁸

Risk Factors and Subpopulations at Risk

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

Other risk factors include¹:

- Family history of suicide;
- Childhood abuse/trauma;

⁸Kaiser Family Foundation, "Implications of COVID-19 for Mental Health and Substance Use," Feb. 2021



2020 Region 1 Epidemiological Profile: Suicide

- Previous suicide attempts;
- History of substance misuse;
- Cultural and religious beliefs;
- Local epidemics of suicide;
- Isolation;
- Barriers to treatment;
- Co-Occurring Disorders;
- Loss (financial, relational, social, work);
- Easy access to lethal means.

While suicide rate among pre-teens remains lower than the rate among adolescents, it has been rising. Suicide is the second leading cause of death for ages 10-14 nationally. A longitudinal study completed by CRS from 2018 to 2020 found that the rate of suicide completions for ages 0 to 17 increased from 0.95 to 1.4. The group consisting of ages 0 to 17 was the only category which saw an increase in the rate of suicides. All others saw a significant decrease in rates.

Data from the 2019 Connecticut School Health Survey shows the percentage of female high school students who seriously considered attempting suicide was significantly higher (15.9%) than males (9.3%).⁷ Additionally, the percentage of students identifying as gay, lesbian, or bisexual reporting considering attempting suicide is higher than their heterosexual peers (36.7% vs. 8.2%).⁶ A greater percentage of female students reported attempting suicide (8.3%) compared to male students (5.2%). Additionally, Hispanic reported this at a greater rate (10.1%) than Black non-Hispanic students (5.8%) or White non-Hispanic students (5.7%).

As mentioned above, one population that is at significant risk when it comes to suicidal ideation is youth. While we see statewide this is a growing trend, in Region One there is also growing concern surrounding younger populations and mental health. Themes from key informant focus groups held in SW CT reflected how during the pandemic younger age groups struggled with their mental health and consequently suicidal ideation as a result of increased isolation as well as in conjunction with higher rates of alcohol and drugs use.

Burden (consequences)

- Suicide impacts the health of the community and those around the individual. Family and friends experience many emotions including shock, guilt, and depression.¹
- People who attempt suicide and survive can sometimes experience serious injuries which can have long term health effects.¹
- The impacts of a suicide on the community at large are far reaching. In SW CT we see that suicide leads to higher medical costs⁹
- Children who lost a parent to suicide have a 4 times higher risk of dying by suicide, according to the QPR Institute.
- Experts in the field also suggest that anywhere from 20-40 % of overdose deaths are actually suicides.¹⁰
- The majority of key informants reported agreeing with the fact that prevention efforts, specifically surrounding suicides are needed in the community.
- Data compiled from CRS highlights that while the Caucasian population of Connecticut experiences suicide completions at the highest rates, across all races and ethnicities, suicides are decreasing in frequency.¹¹

Capacity and Service System Strengths

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

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

During the key informant interview focus groups that The Hub conducted over half of participants stated that they would support measures to identify mental health warning signs, risks, and problems as seen in children and youth.

While there are many mental health prevention, treatment and recovery programs across the southwestern region of Connecticut, the overall perception of readiness in Region 1 is lower compared to some other regions.

⁹ "America's Health Ranking" 2021

¹⁰ Maloney et al. "Are non-fatal opioid overdoses misclassified as suicide attempts? Comparing the associated correlates" (2009)

¹¹ CRS 2020



2020 Region 1 Epidemiological Profile: Suicide

Hotlines: The national Suicide Prevention Lifeline, 1-800-273-TALK (soon to be 988), routes callers to the local mobile crisis line. The national Crisis Text Line, accessed by texting 741741, is more likely to be used by youth or young adults than telephone crisis services, therefore all youth-serving organizations are encouraged to raise awareness of this resource. SW CT also benefits from the Greenwich-based Kids in Crisis, which has a 24/7 hotline for youth as well as emergency shelter beds for ages 0-18. Warmlines include a statewide Young Adult service that operates daily from 12-9pm and the regional Soundview Warmline, staffed by people in recovery from 5-10pm nightly, Magellan Health Crisis Hotline a free crisis supports for first responders & healthcare workers responding to COVID-19, ActionLine, and CT BH Partnership warmline that has multiple translators and open M-F 9am to 5pm.

Mobile Crisis: In Connecticut, the adult mobile crisis is distinct from children's mobile crisis. Children's mobile crisis is available 24/7. In the past year, 2-1-1 received 4,385 calls for Crisis Intervention and Suicide from SW CT, representing 50.1% of all behavioral health-related calls.¹⁰ Police departments are often called instead of or by mobile crisis. The increase in Crisis Intervention Trained (CIT) officers is cited by families as invaluable.

School Services: Several school districts in the region (Greenwich and Weston) are contracted with Effective School Solutions (ESS). ESS provides wraparound services within the school and also supports the family. In addition, 3 middle schools in Greenwich and 5 high schools in Greenwich, Stamford, New Canaan, Wilton, Norwalk and Westport have embedded "Teen Talk" counselors from Kids In Crisis to provide crisis intervention, counseling, and connections to local clinical supports.

Support Groups: There are 4 support groups in the region for people who have lost someone to suicide: one each in Darien, Greenwich, Trumbull and Westport. The state now has a Survivors of Suicide Attempts (SOSA) Group. All groups are currently online for all CT residents. Additionally, AFSP holds an annual Survivors of Suicide event each November in Fairfield or Westport; in 2020 it was held virtually. Currently Recovery Innovations for Pursuing Peer Leadership and Empowerment (RIPPLE) host a late-night support group Tuesdays, Thursdays and Sundays from 10 pm to midnight, offering an alternative to suicide for people

who are personally experiencing recurrent suicidal ideation.

Awareness / Prevention: Prevention efforts in the region include community mental health screenings during "Wellness Month," providing gatekeeper prevention training (e.g., Question-Persuade-Refer in English and Spanish, safeTALK, or Talk Saves Lives) as well as ASIST suicide intervention training, raising awareness about local resources, teaching coping skills, and removing barriers to behavioral health treatment. AFSP's annual Out of the Darkness Walk in Westport raises significant funds and awareness and offers support for suicide loss survivors.



2020 Region 1 Epidemiological Profile: Tobacco & ENDS

Problem Statement

According to the National Survey of Drug Use and Health (NSDUH) and the Youth Risk Behavior Surveillance Survey (YRBSS), tobacco use has decreased for all age groups over the past decade. NSDUH data show that past month tobacco product use among Connecticut residents 12+ declined significantly from 25.3% in 2008-2009 to 18.8% in 2018-2019.¹ Tobacco product use includes cigarettes, smokeless tobacco (i.e., chewing tobacco or snuff), cigars, or pipe tobacco. According to the 2018-2019 NSDUH, Connecticut young adults 18-25 continue to have the highest rates of cigarette use of any age group.¹ Despite significant decreases, smoking remains a health concern due to serious adverse physical effects of tobacco use.

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

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

Magnitude

The 2019 Connecticut School Health Survey shows current use of cigarettes among high school students is 3.7%, down significantly from 17.8% in 2009.³ While cigarette use among this age group has declined, e-

cigarette smoking or vaping has increased, suggesting e-cigarettes are replacing tobacco smoking as the main mechanism for nicotine delivery. The 2019 Connecticut School Health Survey found current use of electronic vapor products to be 27.0% among high school students.³

DataHaven’s 2018 Community Wellbeing Survey showed 19% of all respondents reported using vape pens or e-cigarettes.⁴ This percentage is higher in urban core (25%) and urban periphery (21%) communities, and lower in wealthy communities (14%).⁴ In Southwest CT (SW CT), the survey also showed the prevalence of tobacco use among adults ranges from 7% in the Greenwich (wealthy) area to 21% in Greater Bridgeport (urban community).

According to the NSDUH, SW CT reported prevalence of past month tobacco use dropped from 18.4% based on 2014-2016 data, to 17.4% in 2016-2018. For both time periods, the region was lower than the state (22.2% in 2014-16 and 21.3% in 2016-18) and all other CT regions.

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

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

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

The Covid-19 pandemic has had an effect on the use of tobacco and ENDS. According to a local urban community survey, 9.8% of participants reported using nicotine (cigarettes or vapes) less frequently due to the pandemic, and 8.0% reported using more frequently.

In regional focus groups held during October through December 2020, youth reported that they thought their peers were vaping less, and that those who were still vaping were the ones who were addicted. Youth surveys during spring 2021 in some suburban towns in

¹ NSDUH 2018-2019

² Zheng X. (2018) CT BRFSS.

³ Connecticut School Health Survey, 2019 (YRBS)

⁴ DataHaven and Siena College Research Institute (2018). 2018 DataHaven Community Wellbeing Survey.



2020 Region 1 Epidemiological Profile: Tobacco & ENDS

SWCT found lower 7th-12th grade vaping rates than prior to the pandemic. However, up to a quarter of seniors were still vaping. Among students who vaped, up to 2/3 reported vaping marijuana.

Risk Factors and Subpopulations at Risk

Populations at-risk for smoking cigarettes are⁵:

- American Indians/Alaska Natives
- Certain Hispanic adult subpopulations in the US, including Puerto Rican adults
- LGBT individuals
- Military service members and veterans
- Adults living with HIV
- Adults with experiencing mental illness

Populations most at-risk for using ENDS are:

- Youth (12-17)⁶
- Young adults (18-34)¹
- Males¹
- Hispanics¹
- Current smokers
- Those living in urban communities⁴
- Adults from households earning less than \$35,000²
- Adults with disabilities²
- Those with a high school diploma or less²
- Adults without health insurance²

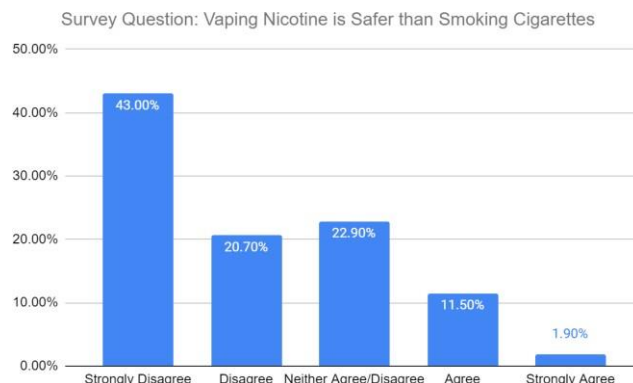
NSDUH Substate Estimates:

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

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

According to key informant focus groups held in a local wealthy community in December 2020, participating youth feel they better understand the risks of vaping now as high schoolers than when they were in middle school. An urban community in SW CT conducted a community survey and reported strong disagreement

that vaping nicotine is safer than smoking cigarettes (see below).



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

Burden (consequences)

- Evidence shows that young people who use e-cigarettes may be more likely to smoke cigarettes in the future.⁶
- A recent CDC study found that 99% of e-cigarettes sold in the US contained nicotine, which can cause harm to parts of the adolescent brain that control attention, learning, mood, and impulse control.⁶
- E-cigarette aerosol can contain several potentially harmful substances, including diacetyl (in flavorings), which is a chemical linked to serious lung disease. It can also contain volatile organic

⁵ CDC (2020), Current Cigarette Smoking Among Specific Populations - United States

⁶ Centers for Disease Control and Prevention. (2019). Quick Facts on the Risks of E-cigarettes for Kids, Teens, and Young Adults. Retrieved from https://www.cdc.gov/tobacco/basic_information/e-cigarettes/



2020 Region 1 Epidemiological Profile: Tobacco & ENDS

compounds, cancer causing chemicals, and heavy metals such as nickel and lead.⁶

- Some ENDS devices, including those that are particularly popular among youth, have been modified to allow for higher doses of nicotine to be delivered. They also facilitate the use of THC and in higher potency. This is especially problematic in youth use, because of the increased risk of tobacco and cannabis use disorders later in life.⁷
- As of January 7, 2020, a total of 2,602 cases of e-cigarette or vaping product use-associated lung injury (EVALI) had been reported to the CDC across all 50 states, the District of Columbia, Puerto Rico and the U.S. Virgin Islands. Of these, 57 resulted in deaths. The median age of these patients was 24 years old, and 62% were between 18 and 34 years old. EVALI appears to be primarily driven by the use of THC-containing vaping products, possibly due to substances, such as vitamin E acetate, added to the formulations.⁷

Capacity and Service System Strengths

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

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

Prevention: Tobacco control efforts are largely conducted through local Prevention Councils (LPCs), municipal health departments, and school systems, with unequal levels of investment that depend on local community resources and grants. Local communities are all addressing vaping as a growing epidemic; for example, all 14 towns have the same goal: to reduce vaping amongst youth ages 12–18-year-old.

Stamford created a vaping task force and Trumbull has conducted a vaping education campaign. LPCs also pooled their funds together and created Let's #mentionprevention campaign: How to talk about vaping. The Hub received a mini grant from Tobacco Free Kids to promote their Flavors Hooks Tobacco campaign as well as bring awareness to SW CT. Lastly, Norwalk-based Courage to Speak Foundation has incorporated vaping education in their 2019 school health curriculum.

Treatment and Recovery: Some behavioral health providers have focused on reducing smoking and increasing healthy behaviors. Several years ago, Bridge House in Bridgeport was the first psychosocial program in the state to go smoke-free. The local hospitals in Bridgeport, Greenwich, Norwalk, and Stamford offer smoking cessation programs. In Bridgeport, St. Vincent's Medical Center runs a vaping cessation program for teens, and in Norwalk, the local SMART Recovery teen group addresses vaping on a regular basis, including encouraging alternatives. Insight Counseling out of Ridgefield, CT also created a program called VapeStoppers. The program is targeted for teens that have been disciplined for violating a school policy or caught by caregivers abusing substances. Smoke Free Teen and Truth Initiative also have text-based quitting services.

Legislation and Enforcement: As of January 2021, Fairfield County has had 19 cases of patients hospitalized with vaping-associated lung injuries, as compared to 51 total state-wide. State law now prohibits the sale of tobacco products to individuals under the age of 21. State Bill 326 has been introduced in the 2021 legislative season. If passed, it will prohibit the sale of flavored tobacco products in Connecticut.

Additionally, House Bill 6110 aims to reduce youth vaping by requiring identification that matches the name on the method of payment for online sales of electronic nicotine delivery systems.

SW CT police departments conducted 189 inspections resulting in 22 violations and 15 cases in which cigarettes were sold to a minor.

FDA Compliance Check Inspections of Tobacco Product Retailers 1/1/2020-2/28/2021

Town	Checks	Violations	Sales to Minors
Region 1	189	22	15
Bridgeport	32	10	5
Darien	10	0	0
Easton	0	0	0
Fairfield	2	0	0
Greenwich	0	0	0
Monroe	17	0	0
New Canaan	0	0	0
Norwalk	40	6	4
Stamford	9	1	1
Stratford	51	2	2
Trumbull	7	1	1
Weston	1	1	1
Westport	12	0	0
Wilton	8	1	1

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



EMERGING ISSUES

Data—both quantitative and anecdotal—show several trends (also discussed below under Recommendations) that have been emerging over the past several years and require greater attention. These issues are not limited to SW CT but are also found at the state and national levels. They include:

1. Before 2020, vaping was increasing dramatically each year, particularly among teens and young adults. During the COVID-19 pandemic, vaping use has seemed to decrease. However, data and treatment providers indicate that while there may be a decrease in vaping use overall, there is a significant increase in vaping in some subpopulations of youth and young adults. This suggests that many youths and young adults have stopped vaping but the individuals who increased their vaping may be the ones who have become addicted.
2. Vaping marijuana is common, although not captured in all surveys, which often ask about vaping and marijuana separately. Anecdotal reports from some clinicians indicate that vaped marijuana is the most commonly used substance by teens. The use of “dabs ” in vaping can deliver extremely high concentrations of marijuana that are associated with neurological risks.
3. The perception of harm from marijuana continues to decrease as more conditions are added to the list approved for medical marijuana and possible legalizing marijuana in CT. Meanwhile, providers indicate that there is an increase in marijuana-induced psychosis. Youth reports indicate that perception of harm from other substances are decreasing as well, including cocaine, prescription drugs, and vaping.
4. Mental health disorders are increasing dramatically among teens and young adults. Although CT DPH reported a decrease in suicides from March - May 2020 during the height of the COVID-19 pandemic, all but one of the 14 towns in SW CT had at least one suicide. Attention to suicidal ideation even in young children is essential. Surveys conducted throughout the COVID-19 pandemic show higher numbers of individuals experiencing mental health challenges, especially depression and anxiety, and an increase in crisis hotline calls and services.
5. The use of psychiatric medications continues to increase, with benzodiazepines (benzos) and antidepressants commonly prescribed. Among providers and consumers concern has been expressed that dependence on benzos requires attention and may be seen as the next epidemic after opioids.
6. Many young adults and youth are accessing prescription drugs not otherwise directly prescribed to them, although not captured in all surveys. Treatment providers indicate an increase in use of prescription drugs in youth and young adults, and an emerging trend of electronic sport gamers utilizing Adderall to stay awake longer for gaming. Counterfeit drugs and pills are becoming increasingly more concerning and is a high priority in young adults, ages 18 - 25, compared to youth and children.
7. A lethal combination of xylazine, an animal tranquilizer, and fentanyl were identified in 141 overdose deaths in 2020. An emerging and deadly substance, Flualprazolem, is a designer benzodiazepine combined with fentanyl, and has resulted in 11 overdose deaths in 2020. Eutylone, a synthetic stimulant, had resulted in 3 overdose deaths.
8. Oftentimes, individuals are accessing poly-substances, a mix of drugs, including fentanyl. Therefore, many individuals are under the impression they are obtaining a specific drug, not realizing that their drugs are typically a mix of dangerous substances.
9. During the pandemic, younger age groups struggled with their mental health and consequently suicidal ideation as a result of increased isolation as well as in conjunction with higher rates of alcohol and drug use.



RESOURCES, STRENGTHS, ASSETS

The region has many strengths and assets to draw upon, including partnerships among many community stakeholders; a wide treatment continuum; many varied recovery supports; peer support specialists; and vans to provide mobile outreach and resources in the community. Much of prevention capacity/strengths are stated within the epidemiological profiles.

Southwest CT benefits from **strong partnerships** among a large number of behavioral health, hospital, social services, housing, and other community groups who meet regularly throughout the region to coordinate and work on initiatives such as increasing access to care, raising awareness, and decreasing barriers. There is 90+ of these committees, coalitions and workgroups in the region working at different levels (local, subregional, regional) and tackling issues from substance use to mental health to housing to juvenile justice. These include the following:

- the hospital-led Community Health Improvement Projects (CHIPs) in the Bridgeport, Norwalk, Stamford, and Greenwich areas, which survey community health needs every three years and develop and implement plans to meet the priority needs;
- the Community Care Teams (CCTs) in Stamford, Greenwich, Norwalk, and Bridgeport, which meet weekly to coordinate care across sectors for a limited number of high-need clients;
- the Catchment Area Councils (CACs), which meet regionally four times per year, with behavioral health consumers, family/friends, and providers at the table, to identify concerns and make recommendations about treatment and recovery services;
- the Local Prevention Councils (LPCs), which meet most months at the municipal level to plan and implement prevention strategies in their community; several of which have Drug-Free Community grants, CT Strategic Prevention Framework Coalition, and Partnership for Success grants that have allowed them to use staff and resources to create impressive campaigns and services;
- the Liberation Programs, who has created a Stamford Youth Vaping Task Force to empower youth prevention initiatives;
- the Local Interagency Service Teams (LISTs), which meet sub-regionally on a monthly basis to address juvenile justice concerns.

For those seeking behavioral health care, **treatment providers** are located throughout the region, making geographic access to services possible, even though transportation is often a challenge. Individuals who are eligible or have insurance or private pay capability can make use of a continuum of care, from outpatient through hospitalization, including residential programs and Medication Assisted Treatment programs. Treatment services in the region include the following⁵⁵:

- 6 hospitals (including Silver Hill Hospital, which is explicitly for behavioral health)
- Some 30 nonprofit behavioral health agencies serving adults;
- Another 30 nonprofit behavioral health agencies serving youth, including the Child Guidance system and Kids in Crisis;
- DMHAS-operated programs in Bridgeport and Stamford;
- Municipal social services in many towns that offer counseling free of charge to their residents;
- Supportive housing, supported education, and supported employment programs as well as Community Support Programs serving individuals with mental health and substance use challenges;
- Federally Qualified Health Centers that offer behavioral health treatment;
- For-profit specialty services for issues such as addiction, eating disorders, anxiety, failure to launch, and in-home recovery;
- Circle Care, Triangle Community Center, as well as additional LGBTQ youth programs;

⁵⁵ To download a complete list of public and nonprofit crisis, treatment, and supportive services in the region, visit www.thehubct.org/treatment



- The Latino Outreach Program who provides outreach and referral resources to the Latino community for substance misuse and mental health;
- A vast number of private therapists and clinical practices;
- Warm lines and hotlines for mental health and substance use disorder were utilized at higher rates in recent history. These heightened rates could be due to the isolation resulting from the pandemic or increased awareness of their existence;
- The COVID-19 pandemic created unprecedented limitations in regards to substance use and behavioral health services, giving many patients and providers no choice but to transfer to online delivery of care. While telehealth did act as a barrier for individuals without access to WIFI or technology, those who faced transportation barriers as outlined in the travel segment of this report, were able to see their providers on virtual platforms without the worry of transportation and added costs that accompany it.

The region offers many **recovery supports**, including support services identified above and a variety of free peer support options, such as those listed below:

- 2 very active NAMI affiliates operate a large number of monthly support groups as well as offering free speaker meetings and book clubs.⁵⁶
- The CT Community for Addiction Recovery (CCAR) operates the Bridgeport Recovery Community Center, which offers a wide range of daily meetings as well as the Telephone Recovery Support (TRS) program.
- Support groups exist for a number of specific issues, from brain injury to hoarding, bereavement to sex addiction, and co-occurring mental health and substance use. Individuals can seek support through multiple pathways, since there are groups available that use a variety of models: SMART Recovery, LifeRing, Women in Sobriety, Refuge Recovery, Double Trouble in Recovery, Depression and Bipolar Support Alliance, The C.A.R.E.S. Group, Courage to Speak, etc. The COVID-19 pandemic forced many of these supports to transfer their programs to online, virtual settings.⁵⁷
- Family and friends can also access a large number of free support groups and training programs.⁴
- The problem gambling hotline and the 12 step “Gambler’s Anonymous” program were cited as strengths for those struggling with problem gambling in the region;

Key informant interviews consistently highlighted the strong network of providers such as recovery support specialists within the SW CT region of the state as being one of the best assets. The relationships among providers allows for a strong collaboration of care seen in the prevention, treatment, as well as recovery areas.

Peer support specialists—Recovery Support Specialists (RSS’s) and Recovery Coaches are trained and available throughout the region, although they are significantly underutilized and many are seeking employment. Currently a number of DMHAS-funded providers and one CCT are employing peers, and the local hospitals are hiring Recovery Coaches to meet with patients in the emergency departments to address opioid overdoses. Some Recovery Coaches are able to work with patients privately.

New resources in 2020/2021 include several vans, which will complement existing mobile outreach efforts (such as the medical bus run in Norwalk by the Community Health Center. The new grant-funded vans are the following:

⁵⁶ Find a complete list of various trainings and trainers in Southwest CT, <N:\Hub Admin\BH Training\BH Training Inventory table for SW Region Jan 2021.docx>

⁵⁷ To download a complete list of all behavioral health support groups in the region, visit <https://www.thehubct.org/recovery>



- The “Vehicle for Change” purchased by Supportive Housing Works, which does outreach to homeless and at-risk youth in the Bridgeport region.
- A van run by Recovery Network of Programs, operating from Bridgeport to Norwalk to engage opioid users and do suboxone induction.
- A van run by Liberation Programs in the Stamford area to engage opioid users and connect them to services including methadone.
- CT Clearinghouse Change the Script van who visits towns statewide and provides resources at events.
-

New resources specific to **prevention** also include the creation and implementation of a variety of awareness campaigns. Many statewide LPCs including our region pooled their grant dollars together to create these campaigns. These include but are not limited to:

- Let’s #MentionPrevention Alcohol - a campaign designed to assist retail and dining locations to do their part in keeping alcohol out of the hands of minors.
- Let’s #MentionPrevention Vaping- a campaign designed to assist and guide parents in talking to their children about vaping.
- CT Clearinghouse launched a free, statewide Let’s #MentionPrevention Alcohol Campaign
- CT Prevention Network (CPN) and other LPCs are working together to create a counterfeit drug campaign; launching August 2021.
-

RESOURCE GAPS AND NEEDS

Resource gaps and needs that emerged during this process are listed below, grouped by prevention, treatment, and recovery. These summarize a variety of issues raised by stakeholders, which are detailed in the appendix. Specific recommendations related to these needs appear in the following section of this report.

PREVENTION

To create and sustain a robust prevention infrastructure capable of effectively promoting mental health and preventing substance misuse, problem gambling, and suicide, much more funding is necessary. A dollar invested in prevention has an estimated return on investment of \$10.⁵⁸

The state’s infrastructure for implementing community-level prevention efforts consists of 5 RBHAOs supporting Local Prevention Councils (LPCs) around the state. The role of the LPCs is to build coalitions and develop local capacity to plan and implement prevention strategies in their individual communities to the extent possible given their funding. However, the following factors are significant limitations:

- The state funding to LPCs is generally in the \$5000-\$10,000 range per year, with additional \$5000 mini-grants currently available for opioid response. With that level of funding, many LPCs depend on volunteers to disseminate flyers, organize small-scale presentations, and do very limited awareness raising. The LPCs that are able to effect change in social norms, policies or environment in their community are those that are able to receive other grants (e.g., Drug Free Community grants).
- As of 2019, the regional infrastructure was replaced by 5 RBHAOs, with less total staff per region yet an enlarged mission of supporting the state’s 169 communities across prevention, treatment, and recovery in the areas of mental health, substance use, and problem gambling.
- The regional coordination of suicide efforts has been added to the RBHAO work without any attached financial support. Regional partners are willing to address this issue, but without resources to support plans, impact may not be sufficient. Key informant interviews also showed that suicide and self-harm rates among youth increased during the pandemic and echoed the sentiment that

⁵⁸ Community Prevention Initiative: Power of Prevention



additional funding is required. The Southwestern region of Connecticut covers 14 towns. Of these towns, all but one suffered loss of life through suicide.

- Throughout the focus groups that the hub facilitated; stakeholders highlighted how isolation during COVID-19 pandemic was compounded with heightened rates of overdoses and subsequent overdose deaths. This is due to the fact that individuals were using substances alone, a known risk factor for overdose. Additionally, warm lines and hotlines were utilized at much higher rates during the months of the heightened pandemic.
- There is no regional data regarding the burden associated with gambling-related issues such as criminal justice and healthcare spending, job loss, bankruptcy, etc.
- There is limited quantitative data regarding the prevalence of problem gambling in SW CT.
- The lack of gambling/problem gambling prevention in high schools.
- The loss of primary prevention focused on substance abuse and mental health was a concern due to funding opportunities focused on single substances. Participants voiced the concern that we need to focus on the roots of prevention and community-based efforts addressing all substances while promoting behavioral health.
- Lack of behavioral health curriculum and discussion integrated in Pre-K through 12th grades.
- Lack of partnership with the faith-based community
- Focus groups that were conducted highlighted significant prevention barriers in relation to problem gambling. There was an overall sentiment that there is a lack of education, training opportunities, and resources allocated to this population. Problem gambling is often overlooked and misunderstood by the general population.
- Key informant interviews discussed the confusion between “gaming” and “gambling” and a need for resources specific to youth to aid in understanding how “games” can lead to addiction. These same informants saw a linkage between gambling and the pandemic due to increased isolation. People were able to gamble virtually at higher rates and do so in isolation so as to not alarm friends or family.
- As community members have pointed out, campaigns by Big Tobacco, Big Pharma Marijuana dispensaries, and other lobbying groups are extremely well funded and able to make their products and messages constantly visible to their target audiences. With increased resources, prevention in CT can provide alternative messaging to better educate the public and seek to change social norms.

TREATMENT

The primary needs of behavioral health clients that are identified both by clients and by social services providers continue to be for *supportive services*, rather than treatment. Specifically:

- **Supportive and affordable housing** is cited as a critical factor to achieving or maintaining recovery and has been a top priority in the region for years. The lack of safe and affordable housing creates challenges for individuals, especially those recently in recovery. Sober homes and halfway houses vary across the region and state. While many of these homes support recovery efforts, others are not safe because of illicit substance use occurring in some homes.
- **Case management** is essential for individuals with complex and interconnected challenges to be able to navigate the variety of services and benefits that are possible, as well as for insured families seeking care for a loved one whose needs go beyond a therapist and/or psychiatrist. Virtual case management worked for some consumers but not for all as individuals had more responsibility in completing their own goals/case plans.

In terms of *resource gaps*, the number one challenge continues to be accessing prescribers (psychiatrists and/or APRNs) for medication.⁵⁹ Currently, as a result of the lack of psychiatrists (not to mention the lack of

⁵⁹ This is a challenge nationwide; a newly established state task force (created as a result of CAC work in region 1) will make recommendations in 2020 to address this critical workforce shortage.



bilingual psychiatrists and psychiatrists who take insurance), Informants reported that HUSKY-D was virtually the only insurance that offered viable options in regards to treatment providers.

- The isolation was detrimental to many due to Covid-19. People either experienced a recurrence or increased substance use due to lack of connection. Individuals weren't (and still aren't) able to connect to virtual platforms due to lack of internet access and/or tablet/smart device. Another CT city; Bristol, was able to provide free Wi-Fi for the entire city. The city of Norwalk has a free Wi-Fi initiative for 1,000 families, excluding the single population. By creating these initiatives, areas such as Norwalk began to break down barriers in accessing resources and treatment options which have become increasingly virtual due to the pandemic.

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

Another key gap that was identified during key informant interviews was specific to the COVID-19 pandemic. During the pandemic, many providers relied heavily, if not solely, on delivery through telehealth. Many individuals in the region have limited to no access to the internet, little knowledge of Zoom or other virtual platforms and limited availability of technology. All of these factors acted as barriers for individuals to seek treatment. It is projected that many providers will continue to use telehealth platforms for the foreseeable future. Rectifying access to technology is imperative in order to close that gap for those seeking treatment.

Many individuals are treated for a crisis through emergency rooms due to lack of awareness of community resources and services or waiting a significantly long time to be connected to services. After being discharged from emergency rooms, individuals are often not prepared for treatment or recovery on their own, potentially leading to another crisis. Many treatment providers have expressed that there needs to be more implementation of awareness of crisis services, such as hotlines, and a more time efficient process of connecting individuals with resources. There should be improvements to discharge planning by providing individuals a handoff process. This should include treatment and recovery plans, community resources, housing and support services, and case management and peer support services. Additionally, agencies should implement following up with client referrals to improve connecting clients to care.

Key Informants also discussed an overall lack of suicide prevention and treatment. Additionally, there was discussion surrounding the need for support prior to an individual reaching a point of crisis and needing to be hospitalized. This can be seen through offering more MHFA & QPR trainings.

There is a strong agreement across treatment providers for increased support and funding for treating co-occurring disorders by removing elicibility barriers (both in DMHAS-funded programs and at CVH). There should be more recognition and implementation of more integrated services of care for both substance use disorders and mental health disorders to break down silos of care.

The following treatment gaps have also been identified:

- no First Episode Psychosis program in the region;
- no respite beds or peer respite for those with suicidal ideation or experiencing psychosis, which results in expensive hospitalization and rehospitalization;
- no equivalent to DMHAS Young Adult Services for young people who are not DMHAS eligible;
- not enough longer-term treatment beds for addiction;
- Not enough follow-up with individuals after being discharged from emergency rooms or being referred to services;



- Probate referrals take about 3+ months and by then the person either isn't top utilizer anymore, or unfortunately lost their battle with addiction;
- Managed Medicare not covering any BH inpatient stays is a huge problem in the senior population. Can switch to regular Medicare if you haven't already used your 180 lifetime BH inpatient days;
- Not enough recognition and funding for treatment of co-occurring disorders;
- Proper equipment to hold teletherapy;
- DMHAS provider not having the resources to conduct virtual sessions for consumers;
- Lack of or no resources for undocumented population;
- lack of providers offering bus passes;
- Lack of bi-lingual or multi-lingual staff and/or providers;
- lack of options for those who are uninsured or under-insured;
- Lack of connection among providers to better aid in the dual diagnosis process;
- No safety planning before a psychiatric crisis point is reached and emergency services are utilized.

RECOVERY

In the area of recovery, a number of gaps in support services have been identified and are listed below:

- support for postpartum depression
- support for those with suicidal ideation (e.g., Alternatives to Suicide support group, respite beds)
- SMART Recovery groups for adults over 25, since existing groups are aimed at teens, young adults of family and friends
- more supports for those with co-occurring disorders
- help in training and sustaining support group facilitators
- job opportunities for certified peer specialists and funding for providers to hire them
- support for families and loved ones of those struggling with substance use disorder, mental health and/or problem gambling
- concept of the "7-day window" - need more of an emphasis of aftercare and check-in's following an individual's discharge from a treatment/recovery facility
- Veyo isn't always reliable and community providers don't offer monthly or daily bus passes any longer

UNDERSERVED POPULATIONS

The following is a list of underserved populations identified by stakeholders. In addition, continued attention should be paid to the elderly (at risk for alcohol and opioid misuse) and middle-aged populations who represent the largest population at risk of suicide and opioid abuse.

- The undocumented who fear risk of deportation or legal pursuit due to immigration status;
- Those with cultural/language differences;
- Middle-class individuals and families continue to face cost barriers in accessing services since they may be neither poor enough to qualify for state funded programs nor rich enough to pay out of pocket. (For example, psychiatrists may charge a rate of \$500/hour; co-pays for therapy can add up to \$200+ in a month.)
- Individuals with autism or disabilities are often overlooked in the behavioral health system and assumed to be under the care of a developmental disabilities provider; however, many may have co-occurring mental health issues, and there are very few services available for adults on the spectrum.
- EMS and other first responders are at heightened risk for developing mental health conditions or substance use disorder due to the trauma they endure by being the first people on call for psychiatric and emergency 9-1-1 calls
- Essential workers have reported elevated mental health challenges, specifically depression and anxiety due to the distress of working during a pandemic.
-



RECOMMENDATIONS

The process of gathering quantitative and qualitative data throughout the year, producing epidemiological profiles, and generating priorities has resulted in the findings and recommendations presented in this section of the report. Below we identify the key findings and priorities and make recommendations for both the region and the state.

KEY FINDINGS

It's very clear throughout this process how interrelated mental health and substance use are despite siloes that often occur in agencies, policies, and programs. While the majority of the required epidemiological profiles presented in this report focus on individual drugs, in virtually all cases, individuals who misuse one drug also misuse others; the risk factors for misuse of any given drug include mental illness and use of other drugs; and the risk factors for mental illness include misuse of drugs. *Prevention work* therefore requires an understanding that mental health issues such as depression and anxiety underlie much, if not most, addiction. *Treatment and recovery from addiction* require attention to the individual's mental, social, and emotional health and coping skills. Similarly, *treatment and recovery from mental illness* are jeopardized when substance misuse or other addictive behaviors are used as coping skills.

TOP PRIORITIES FOR THE REGION

1. - Mental Health
2. - Suicide
3. - Alcohol
4. - Marijuana
5. - Tobacco (nicotine)/Vaping
6. - Prescription Drug Use
7. - Heroin
8. - Problem Gambling
9. - Cocaine

With this understanding, our regional data workgroup identified again (also first in 2019 Priority Report) **Mental Health** as the top priority for the region. It emerged as the most important area to address for multiple reasons: mental illness affects the most people, it creates a significant burden, it is associated with all the issues the behavioral health community is trying to prevent (suicide, drug misuse, problem gambling), and it is getting worse, with anxiety and depression increasing dramatically among young people as well as increasing among adults. Mental health is also the number one concern as people in the region, state, and country were largely affected by the COVID-19 pandemic. The COVID-19 pandemic has impacted the mental health of individuals of all ages, making it the most important focus. Addressing people's mental health struggles improves their health and reduces their need for unhealthy coping skills such as use of ATOD's.

Suicide was identified as the second priority for the region, with importance of addressing the effects of COVID-19 on everyone in the region. Although CT DPH reported a decrease in suicides from March - May 2020 during the height of the COVID-19 pandemic, all but one of the 14 towns in SW CT had at least one suicide. In the region there is a growing concern surrounding younger populations. Their mental health has been greatly affected by the pandemic which has resulted in an increase in suicidal ideation. Suicide is an important area to address due to the impact it has on the health of the community as well as those around the individual. Addressing suicide can contribute to mental health as well as the use of drugs and substances.



Alcohol was identified as the third priority for the region, due to its widespread use at all ages. Among underage youth, alcohol is commonly used, particularly in dangerous situations such as binge drinking and drunk driving. The regional data workgroup identified alcohol as the number one problem substance for young adults. In addition, the region has seen an uptick in alcohol usage during the COVID-19 pandemic.

OTHER PRIORITIES AND CONCERNS

The other priorities identified in our regional process included:

Marijuana use overall is increasing, which is risky since the potency of vaped marijuana is very high and can lead to serious side effects including hospitalizations. The possibility of marijuana being legalized for retail purposes is a particular concern since it has led to decreased perception of harm and increased access to youth and young adults, who are at higher risk since their brains are still developing.

Tobacco & ENDS has been rapidly emerging in the region and nationally. Use of tobacco products overall has decreased among all age groups, however use of vaping products has increased in youth and young adults. Perception of harm for vaping is low due to tobacco companies targeting youth. However, studies show that vaping is still a dangerous form of nicotine use as well as other substances, such as marijuana. Although the effects of the COVID-19 pandemic and vaping are not all known yet, there is still a large concern as smoking and vaping is shown to compromise the respiratory system. This is one of the high-risk factors in contracting COVID-19. While surveys show a general decrease in vaping during COVID, there's significant increase in smaller populations in youth/young adults, possibly indicating addiction.

Prescription drugs have been a contributor to overdose deaths and intentional suicides in the region. This area is important because reducing the prescription and misuse of legal opioids helps reduce the number of people who turn to illicit opioids such as heroin. There is an emerging concern around youth and the use of counterfeit prescription drugs (i.e., Xanax, Adderall).

The **opioid** epidemic requires ongoing attention to heroin and fentanyl as well as prescription opioids.

RECOMMENDATIONS FROM PRIORITIES PROCESS

Below we present recommendations for behavioral health work in the region in the coming two years, as well as a separate set of recommendations to the state. Each set of recommendations is presented in the form of a table, to align with DMHAS requirements and permit comparison across regions. These tables show recommendations for prevention, treatment and recovery in the areas of substance misuse, mental health, and problem gambling. Because of the interrelated nature of these issues, we have added a fourth row to each table, providing recommendations that cross all these areas of behavioral health.



TABLE 2. RECOMMENDATIONS FOR SOUTHWEST CT (REGION 1)

Problem/Issue	Prevention	Treatment	Recovery
<p>Substance Abuse/Misuse</p>	<p>Adapt and share locally developed campaigns throughout the region to address common priorities (e.g., alcohol, prescription drugs, counterfeit drugs, vaping etc.).</p> <p>Priorities include raising awareness among families about the social hosting law and working to reduce binge drinking in young adults and across the lifespan.</p> <p>Support development of a regional pool of youth trained to conduct alcohol compliance checks.</p> <p>Provide education about the impact of marijuana on the developing brain and safer alternatives for coping with stress. Monitor consequences associated with use of marijuana (including vaping) and CBD oil. Implement awareness and prevention campaigns for marijuana use.</p> <p>Convene prevention specialists and providers to discuss expanding their SUD screening program to incorporate MH, suicide, tobacco, vaping, and problem gambling using the regionally developed screening tool.</p> <p>Support community-level prevention around Alcohol, Tobacco / Vaping & Other Drugs (ATOD) based on CADCA's 7 strategies for change.</p> <p>Raise awareness to community at large with pharmacies that can provide compliance packaging or "blister packs."</p>	<p>Work with key stakeholders (e.g., CHIPs, Community Care Teams, housing providers) to problem solve around alcohol use disorder, particularly among people who are not ready for treatment.</p> <p>Educate physicians and community members about the value of Medication Assisted Treatment and other evidence-based practices and resources, as well as on non-medication alternatives for treatment (e.g., yoga, reiki, massage therapy, acupuncture, etc.).</p> <p>Create a work group of stakeholders and legislators to discuss improvements to medical/possible legalized marijuana program including reviewing operations of regional dispensaries and giving feedback.</p> <p>Encourage providers to expand treatment for children/teens. Continue to promote teen vaping cessation supports.</p> <p>Raise awareness about use and risks associated with benzodiazepine medications, including support for those wishing to discontinue their use and alternatives for coping with anxiety.</p> <p>Expand and offer services and resources, such as bed availability and crisis mobile lines, during late night hours and weekends.</p> <p>Focus on the continuum of care for individualized care options and approaches.</p>	<p>Encourage sober houses to meet national standards for recovery residences and be listed on the CT Addiction Services website.</p> <p>Raise public awareness about the CT Addiction Services website.</p> <p>Continue to provide Naloxone trainings throughout the region and distribute Narcan kits.</p> <p>Expand access to peer supports such as Recovery Coaches and SMART Recovery groups in both community and provider settings.</p> <p>Implement support beyond the crisis by providing individuals with plans, tools, and connections to resources after being discharged from an emergency room.</p> <p>Improve updates on bed availability websites to be more accurate.</p> <p>Maintaining use of Telehealth as it has proved to be helpful in connecting with individuals and providing more options for individuals whose first language isn't English, and individuals with technological difficulties.</p>



Continue to promote medication drop-off boxes at local police stations and select pharmacies throughout the year and especially during DEA's drug take back days.

Increase in funding for the implementation of prevention and treatment strategies, especially to raise awareness and education on perception of harm of substance misuse.

More simplified and unified process of connecting individuals to services.

Raising awareness of available resources and services to communities.

Hire more bi-lingual or multi-lingual providers for Spanish, Creole, and Polish speaking individuals.



Problem/Issue	Prevention	Treatment	Recovery
Mental Health (suicide and mental illness)	<p>Coordinate and expand regional suicide Advisory Boards (RSAB) to address pre- and postvention, including exploring creation of an Alternatives to Suicide support group.</p> <p>Train new QPR trainers, including Spanish, Creole, and Polish speakers, to increase regional capacity to provide suicide prevention training.</p> <p>Advocate for social-emotional initiatives, such as Free Play, coping skills curricula (e.g., 4 What's Next), and anti-bullying programs, starting in elementary school. Promote social-emotional supports and coping skills to the general public through media campaigns, community outreach, and expansion of support groups.</p> <p>Ensure that all schools (K-12) and colleges in the region publicize the Crisis Text Line.</p> <p>Coordinate & promote Mental Health First Aid, QPR, SafeTALK, ASIST, and other educational programs.</p> <p>Encourage towns to create a postvention planning team</p> <p>Coordinate and implement more awareness campaigns, focusing on stigma reduction and conversations around suicide.</p> <p>Provide more mental health and QPR trainings for educators, and more mental health first aid trainings to the community at large.</p>	<p>Support regional efforts to address timely access to treatment, including access to medication (e.g., open access models, telehealth, cooperative agreements among providers, evening/weekend hours, co-locating clinics at shelters).</p> <p>Improve discharge planning and community connections from hospitals by providing client feedback about the handoff process, reviewing facility protocols about informing clients, and educating inpatient BH providers about community resources for treatment, housing, supportive services, case management, and peer support services. Consider incentives to agencies for following up on client referrals and successfully connecting clients to care.</p> <p>Support education for primary care providers and shelter/housing providers to better understand and serve mental health and trauma.</p> <p>Explore options to create a First Episode Psychosis program for the region.</p> <p>Expand and offer services and resources, such as bed availability and crisis mobile lines, during late night hours and weekends.</p> <p>Coordinate and implement more follow-up check-ins with individuals one week following discharge.</p> <p>Hire more bi-lingual or multi-lingual providers, particularly for Spanish, Creole, and Polish speaking individuals.</p>	<p>Identify mechanisms to create sustainable sources of facilitators and facilitator training for MH and SUD support groups such as NAMI, SMART, etc.</p> <p>Coordinate efforts to create postpartum depression support in the region.</p> <p>Expand use of Certified Peer Recovery Specialists, including exploring using RSSs for a mobile MH outreach program (similar to / following on Homeless outreach Team model).</p> <p>Continue to advocate for a peer respite in the region to divert people from hospital stays.</p> <p>Form more community partnerships, specifically with faith communities.</p> <p>Create more efforts towards subgroups and underserved populations in awareness, treatment and education.</p> <p>Maintaining use of Telehealth as it has proved helpful in connecting with individuals and providing more options for individuals who English is not their first language, and individuals with technological difficulties.</p>



	<p>Creation and awareness of more COD programs and resources.</p> <p>Prevention efforts should be more all-encompassing and inclusive of co-occurring disorders.</p>	<p>Provide more mental health and suicide services of support in emergency rooms.</p>	
Problem Gambling	<p>Promote public awareness of CT Problem Gambling hotline.</p> <p>Build capacity in the region to prevent problem gambling. Improve outreach to those at high risk and to a broader range of cultural groups.</p> <p>Instill gambling awareness into BH activities throughout the region, including disseminating the gambling PSA that was created by Caribe Youth in Bridgeport.</p> <p>Provide awareness and education about gaming addiction for parents and youth.</p> <p>Create and provide more widespread and available trainings on problem gambling.</p> <p>Coordinate and implement more awareness campaigns on gaming addiction.</p>	<p>Educate providers about gambling and gaming.</p> <p>Encourage screening for problem gambling using the Brief Bio-Social Gambling Screening tool (which is incorporated in the regional integrated screening tool).</p> <p>Create more efforts to address the physical withdrawal symptoms, especially suicidality.</p> <p>Provide more resources and services as well as dedicated groups to this population. Especially housing, and digital detox services.</p>	<p>Explore expanding gambling support groups.</p> <p>Create more peer support services to pair clients with peers through their recovery.</p>
Problem/Issue	Prevention	Treatment	Recovery
Systems: Integration across Behavioral Health	<p>Coordinate region-wide educational efforts--including videos and digital toolkits--that integrate messaging around MH, SUD and PG.</p> <p>Invest in social media buys to reach a bigger audience on Instagram, YouTube, & Facebook.</p> <p>Encourage use of integrated BH screening tool.</p>	<p>Ensure info about language support (e.g., Language Line) is posted visibly in multiple languages and with graphics in hospitals and provider agencies.</p> <p>Disseminate "Get Help" poster throughout region.</p> <p>Advocate for increased dissemination and explanation of client rights information at provider facilities.</p>	<p>Encourage and plan for increased use of peers and Community Health Workers to provide community outreach and supports around BH.</p> <p>Advocate for legislation to make certified peer support a reimbursable service.</p> <p>Create SMART Recovery group for adults.</p>



	<p>Continue outreach to various BH providers and invite them to CAC meetings to minimize silos.</p> <p>Make recommendations for improved and/or integrated data collection around MH, SUD and PG, to include hospital / emergency room data, self-injury data, information on non-fatal overdoses, etc...</p>	<p>Provide information and education to pharmacists about behavioral health resources in the region.</p> <p>Explore with treatment providers the resources for and needs of pregnant and parenting clients.</p>	<p>Explore creating new support groups for those with COD, such as Double Trouble in Recovery.</p> <p>Work with interested towns or cities to become Recovery-Friendly Communities.</p>
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TABLE 3. RECOMMENDATIONS FOR THE STATE

Problem/Issue	Prevention	Treatment	Recovery
<p>Substance Abuse/Misuse</p>	<p>Provide training and support for youth compliance inspections in the region, including point-of-sale ID checks, to prevent youth under age 21 from purchasing tobacco products and alcohol.</p> <p>Require all liquor retailers to be TIPS trained.</p> <p>Support legislation to require blister packaging to prevent diversion of medications (initiated by Communities 4 Action).</p> <p>Increase in funding for the implementation of prevention and treatment strategies, especially to raise awareness and education on perception of harm of substance misuse.</p> <p>Recognition and implementation of more integrated services of care for both SUD and MH to break down the silos of care.</p> <p>Increase the utilization of stigma reducing language in publications surrounding substance use disorder.</p>	<p>Increase available resources, especially longer-term programs, detox beds, drug and alcohol counselors.</p> <p>Ensure that treatment providers are fully capable of addressing co-occurring mental illness.</p> <p>Increase in-network MAT providers.</p> <p>Provide more treatment options for uninsured or under-insured individuals.</p> <p>Expand and offer services and resources, such as bed availability and crisis mobile lines, during late night hours and weekends.</p>	<p>Support efforts to ensure safe and affordable sober homes throughout the state.</p> <p>Review functioning of Access Line and make recommendations to improve its service.</p> <p>Maintaining use of Telehealth as it has proved helpful in connecting with individuals and providing more options for individuals who English is not their first language, and individuals with technological difficulties.</p>



Mental Health (suicide and mental illness)

Assist in compiling local data about the nature and extent of suicidal attempts and self-injury.

Support legislation to ensure social-emotional curriculum and positive school climate K-12.

Advertise available resources, services and trainings, and make the process of getting connected with information easier and more efficient. Assist with communication and collaboration among resources.

Recognition and implementation of more integrated services of care for both SUD and MH to break down the silos of care.

Create partnerships with local communities such as faith organizations and educators to offer mental health and suicide trainings.

Ensure that treatment providers are fully capable of addressing co-occurring substance misuse.

Support the recommendations of the task force on the psychiatric workforce (to begin meeting in FY20) to address shortages of providers and provider caseloads.

Consider converting one of the region's Community Support Program (CSP) teams into an ACT team.

Address the lack of state-funded youth beds in the region.

Develop a First Episode Psychosis program in the region.

Improve discharge planning and community connections from hospitals by providing client feedback about the handoff process, reviewing facility protocols about informing clients, and educating inpatient BH providers about community resources for treatment, housing, supportive services, case management, and peer supports. Consider incentives to agencies for following up on client referrals and successfully connecting clients to care.

Offer more resources, services and trainings in more languages, especially Spanish.

Expand and offer services and resources, such as bed availability and crisis mobile lines, during late night hours and weekends to decrease emergency department usage.

Develop peer respite programs throughout the state to reduce hospitalizations.

Implement more peer support services.

Offer more long-term case management after crises happen.

Implement after care plans and/or follow up calls upon patients discharge from a psychiatric facility.



Problem/Issue	Prevention	Treatment	Recovery
Problem Gambling	<p>Continue to offer training programs for community prevention specialists.</p> <p>Advertise available resources, services, and trainings.</p> <p>Implement more awareness campaigns, particularly with more children and youth involved.</p>	<p>Continue research to measure changes in prevalence and to better understand the impact of problem gambling on CT's communities.</p>	<p>Ensure that problem gambling supports are available in multiple languages.</p> <p>Implement more peer support services.</p>



Systems: Integration across Behavioral Health

Integrate messaging about MH, SUD, and PG to fight stigma, raise awareness of the interrelatedness of these issues, and promote wellness.

Develop videos, webinars and digital tool kits that can be disseminated statewide.

Invest in social media buys to reach a bigger audience statewide on YouTube & Facebook.

Revisit SBIRT screening program to integrate MH, Suicide, Tobacco, Vaping and Problem Gambling; consider using integrated Mental Wellness screening tool developed in region 1.

Increase support for Co-Occurring Disorders treatment by removing eligibility barriers (both in DMHAS-funded programs and at CVH) where individuals are told their MH needs are too severe for a SUD program and vice versa. Also expand capacity to treat individuals with BH disorders and physical co-morbidities.

Create incentive programs or other meaningful policy changes to increase the number of bilingual / multilingual providers as well as staff cultural competence.

Conduct statewide campaign to raise awareness of available treatment resources and physician understanding of MAT.

Improve Veyo or find another transportation service. Explore ways to incentivize providers to accept private insurance and Medicaid.

Maintain Telehealth services post-pandemic for individuals to maximize opportunities for care and services. Offer telehealth services in multiple languages and provide technological support for those with limited technological access or knowledge.

Expand and offer services and resources, such as bed availability

Increase supportive housing services for the BH population. Current housing policies and programs aimed at ending homelessness do not always best serve individuals with a mental illness or addiction.

Expand case management resources across programs, including making existing programs less restrictive (e.g., open CSP to those with an SUD primary diagnosis).

Revisit benefits policies and job programs to reduce barriers to employment.

Conduct an external evaluation of existing peer support training programs by Advocacy Unlimited, the CT Coalition for Addiction Recovery, and Mental Health America to cross-walk the content areas and develop a best-practices training.

Support legislation to make peer support a reimbursable service.



Problem/Issue	Prevention	Treatment	Recovery
		<p>and crisis mobile lines, during late night hours and weekends.</p>	
	<p>Remove siloes and integrate programs and structures, for example:</p> <ul style="list-style-type: none"> • Ensure that all relevant state agencies are represented on the Behavioral Health Planning Councils and involved in cross-agency planning. • Work creatively with housing providers to address the need for affordable, supportive housing. • Expand the Alcohol and Drug Policy Council (ADPC) to include and address mental health and problem gambling. • Coordinate suicide and opioid response across DCF, DMHAS and DPH. • Use DPH training materials about the NORA app and the CPMRS rather than develop separate training modules. <p>Work with DOC and DMV to develop legitimate alternative form of identification in order to remove barriers to care for the undocumented.</p> <p>Explore creating slots for case management from the General Funds (as is done in Maryland), to be allocated for individuals with very high need regardless of ability to pay. Such funds could be used to support individuals with multiple comorbidities or young adults presenting with complex issues but ineligible for DMHAS's Young Adult Services program due to their insurance or family status.</p> <p>Ensure information and websites are available in multiple languages.</p> <p>Continue to utilize Microsoft Teams as a meeting platform to reduce travel time and save programs on mileage reimbursement.</p> <p>Regionalize conferences and trainings to maximize participation across the state.</p>		



APPENDICES

PRIORITY RANKING MATRIX FOR REGION 1

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

PROBLEM	Magnitude	Impact	Change-Ability	Capacity/Readiness	Consequence of Inaction	Mean Ranking Score:	RANK
Alcohol	4.5	4.3	3.1	2.9	3.9	3.7	#3
Tobacco (Nicotine) / Vaping	2.7	3.4	3.5	3.5	3.9	3.4	#5
Marijuana	3.7	3.7	3.3	2.5	4.3	3.5	#4
Rx Drug Misuse	2.7	3	3	3.1	3.5	3.1	#6
Heroin	1.7	3	3	3.5	3.5	2.9	#7
Cocaine	1.5	2	2.3	2.2	2.5	2.1	#9
Problem Gambling	2.7	2.7	2.5	2.4	2.8	2.6	#8
Mental Health Issues	5.0	5.0	4.1	3.8	4.9	4.6	#1
Suicide	3.3	4.7	3.4	3.3	4.8	3.9	#2



REQUIRED STAKEHOLDER QUESTIONS

HOW APPROPRIATE ARE AVAILABLE SERVICES TO MEET THE NEEDS OF MENTAL HEALTH, SUBSTANCE USE, AND PROBLEM GAMBLING?

Appropriateness of services to needs:

- There are public and nonprofit treatment resources and agencies across the region, as well as private practices, all of which offer assistance to those in need throughout the area. These services include 6 hospitals (including Silver Hill Hospital, which is explicitly for behavioral health) and over 20 nonprofit behavioral health agencies serving adults.
- Regional treatment providers are consistently highlighted for their strong network and continuum of care. The quality of care provided coupled with the prevention and mental health community allows for better diagnosis, treatment and overall outcomes.
- Key Informants as well as providers in the region report witnessing an increase of prevention programs and a widening variety of mental health treatment services offered.
- Specialized services for young adults suffering from trauma, mental illness and/or addiction exist for the DMHAS population. However, such services are not available to the majority of the region's population who have private insurance. Relatedly, there is a need for a First Episode Psychosis program for the region.

Mental Health (combined with Suicide):

- There is an overall sentiment that among the SW CT there is a lack of adequate mental health services. Much of that is due to barriers of insurance.
- COVID also presented new barriers in conjunction with telehealth. Many clients did not have access to Wi-Fi or technology, making it impossible for them to attend virtual appointments. Additionally, language barriers made the fundamental understanding of telehealth communication difficult.
- Mental health first aid/Suicide Prevention trainings are needed in a more widespread capacity across the region to better educate and learn the warning signs when someone is in distress.

Substance Use:

- While services offered for those struggling with SUD are present in the region, there is still not enough availability of beds. Client's report utilizing the emergency room for substance use but being discharged shortly thereafter without a long-term care plan. Online resources which report the locations of available beds are also inaccurate, creating barriers to accessing services.
- Community providers report needing assistance to help their clients "beyond the crisis".
- A large percentage of services offered are through private practitioners and therefore a vast majority of the above-mentioned services are inaccessible to the general public without insurance such as Husky D. In addition, there is a large gap in terms of inpatient facilities which accept Medicare.
- Reports from key informants highlight an overall lack of perception of harm in relation to substance use. Some suggestions to combat this include increase funding and implementation of prevention and treatment strategies on both a regional and local level.

Problem Gambling:

- Region wide, there is a substantial gap in awareness on problem gambling. Statistics reporting the percentage of individuals who struggle with problem gambling is largely unavailable.
- There is a need for more in-depth screening questions for problem gambling so providers and patients can become better connected to available services.

Barriers:

- Discharge from hospitals continues to be reported as inadequate. Multiple clients report that they exit without a follow-up therapy appointment or appointment with a prescriber and no info on how to get a script for their refills. Clients are not referred to support groups.
- Clients continue to report issues in accessing timely appointments at provider agencies due to heavy caseloads of staff.
- DMHAS funded agencies still not have proper equipment to virtually see their clients and vice versa consumers not able to get treatment.



Insurance issues:

- When clients switch from Medi-Medi to Medicare only, they lose services and lose access to their existing providers.
- Many clients point to the “slow erosion of the Medicare Savings Program.”
- A lack of inpatient facilities that take Medicare was reported.

WHAT *PREVENTION* PROGRAM, STRATEGY OR POLICY WOULD YOU MOST LIKE TO SEE ACCOMPLISHED RELATED TO:

Mental Health:

- Many informants discussed a need to simplify the process to connect people to services. This is also compounded with the lack of knowledge from the general public about what treatment/recovery/support services are available in the first place. The vast lack of where to begin to seek help from individuals continues to be a barrier and something key informants wish to have rectified.

Suicide Prevention:

- While there is psychiatric crisis (i.e., suicide) treatment options, many informants reported a need for “support beyond the crisis”. It was relayed that many individuals leave inpatient psychiatric facilities with plans, yet are not equipped with the tools and support to implement them.
- There were many reports stating that more suicide (and mental health) tasks forces that are available on off hours including weekends were needed.

Substance Use:

- Drug Corps - one key informant highlighted that consistent effort throughout the CJ system allows for more humane approaches and less stigmatization for those suffering with problematic substance use.
- Heightened support for housing, job training and reintegration into society was also mentioned as a beneficial strategy for people with substance use disorder.
- It was reported that there needs to be a greater perception of harm in the substance use field. This can be combatted through higher funding and implementation of prevention and treatment strategies on both a regional and local level.

Problem Gambling:

- Many informants wished to see heightened promotion of PG prevention and help programs in the region and state.

WHAT *TREATMENT LEVELS OF CARE* DO YOU FEEL ARE UNAVAILABLE OR INADEQUATELY PROVIDED?

Mental Health:

The most reported “unavailable” or “inadequate” services were

- Primary Care
- Emergency/Crisis services
- Outpatient

Suicide:

The most reported “unavailable” or “inadequate” services were

- Telehealth
- Emergency/Crisis services
- Inpatient



The lack of support services in the emergency room for those specifically struggling with suicidality or suicidal ideation was also cited as an area for growth.

Substance Use:

The most reported “unavailable” or “inadequate” services were

- Inpatient’s rehabilitation
- Inpatient services
- Primary Care

Problem Gambling:

- Almost all key informants reported being unaware of any services offered for problem gambling and were therefore unable to properly identify what kinds of services are and are not available. Many in the region report a desire to see more widespread and availability of trainings surrounding problem gambling.

WHAT ADJUNCT SERVICES/SUPPORT SERVICES/RECOVERY SUPPORTS ARE MOST NEEDED TO ASSIST PERSONS WITH:

General Behavioral Health:

- Positives: Certified peer support specialists (Recovery Coaches and Recovery Support Specialists) are available, although there are not enough employment options for them at this time.
- Integration of spirituality as part of holistic treatment was identified as an important recovery support.
- Hard to keep recovery groups going due to people’s schedules and jobs. Need funding to train new facilitators on a regular basis.
- Need training for peers to run support groups. Ideally would have stipends to support peers who run groups.
- SMART Recovery groups have been well received but are focused on teens, young adults, and family and friends. There is interest in SMART Recovery groups for adults over age 25.

Substance Use:

- Need for affordable and responsible sober housing. Some sober homes in region 1 provide very limited services yet cost up to \$8000/month. Most houses cost ~\$1500/month (though Pivot Lighthouse in Bridgeport is \$500.)
- Offering liaisons or simplifying the process to accessing treatment for substance use would eliminate many barriers many people observe when seeking treatment.
- While there are many services in the Southwestern region that are offered for those with substance use disorder, there is a lack of education surrounding what is available. Due to this, many people do not seek treatment because they do not know where to start.

Mental Health:

- Medication issues:
 - Many clients were concerned about having sufficient access to their meds due to new legislation about being given 1 month vs a 3-month supply. However, the danger of having a 90-day supply of meds on hand when suicidal was also cited.
 - Affordability of meds with the cuts to the Medicare Savings Program (MSP) is a real concern as clients may have to choose between paying for their meds or their food.
 - Kids are being given meds very young, heavy reliance on ADHD drugs.
 - Need support for coming off long-term use of benzos.
- Peer support:
 - There is no Alternatives to Suicide support group in the region.
 - Need for postpartum depression support.
 - Need cited for porn/sex addiction support groups. There are 2 sex addiction support groups, but both are in Fairfield.
 - Staying connected to supports like Bridge House after moving away, since they are few and far between. Clients observe that support groups aren’t the same as a psychosocial club.



- It is well known that those struggling with their mental health need heightened support. Key informants report the most needed services are those surrounding community support for these individuals.
- The co-occurrence of a mental health diagnosis and substance misuse is widely seen in the region, however, coordination of care for individuals with dual diagnosis is needed.
- The need for better emergency infrastructure was seen across the region. Due to the lack of inpatient beds, many individuals sought mental health treatment through emergency services and the current infrastructures were not equipped to handle the influx of psychiatric patients.
- Partnerships with faith communities were also cited as a way to increase outreach and create a larger network of resources and community awareness surrounding mental health.
- The majority of work being done in conjunction with suicide surrounds assessing risk. Treatment based models and prevention rather than post-vention resources are needed to as to reduce the number of suicide completions.

Problem Gambling:

- Need more awareness about the state's problem gambling hotline. There are 2 gambling support groups in the region (Darien and Stamford).
- As mentioned above, there is an overall lack of education, promotion and access to services surrounding problem gambling and therefore the community is largely unaware of what is even offered in the region. Therefore, there is an extreme lack of services, support services and recovery supports in general.
- Reports show that there needs to be better coordination between mental health and/or substance use providers and problem gambling providers.
- By educating providers on not only the statistics regarding problem gambling as well as the symptoms, there is a chance that awareness and diagnoses may increase.
- Overall, there is a high report of needing a more intersectional approach to prevention, treatment and recovery. Mental health, substance misuse, problem gambling and suicide are often interlinked with one another and therefore the services offered should be all encompassing. Understanding the prevalence of co-occurring disorders is the first step in creating a community which assists all aspects of a person's struggles.

WHAT WOULD YOU SAY IS THE *GREATEST STRENGTH/ASSET* OF THE PREVENTION, TREATMENT AND RECOVERY SYSTEM?

Prevention:

- Local Prevention Councils develop community coalitions that engage volunteer stakeholders (including treatment providers) in planning, sponsoring and funding events as well as in disseminating information.
- Pass-through federal dollars support local work through mini grants such as STR, SOR, GLS, etc. Some towns have Drug-Free Community grants which enable more in-depth work.
- The treatment system encourages the Multiple Pathways to Recovery approach.
- MAT programs are being expanded to include buprenorphine in addition to methadone, as a way to offer clients choices.
- There is growing use of Recovery Coaches.

Mental Health:

- The individuals who work in the field of mental health are continuously highlighted and reported to be the greatest asset or strength of the prevention, treatment and recovery system.
- Many cite the empathy and quality of care in the region as a strength as well. In addition, the communication, community, and collaboration among mental health providers in the region is beneficial to all who seek services related to mental health.



- Providers use a “no wrong door” approach, helping to connect clients to care.
- There are a variety of hotlines, warmlines, and peer support options at all levels (national, statewide, and within the region).
- The state provides significant support for young adult services.
- Consumer input is valued and sought after through the Catchment Area Councils.

Problem Gambling:

- The state’s 24/7 Problem Gambling hotline is an important resource.
- In Region 1, the Caribe program has developed a gambling-informed youth group and created a culturally appropriate PSA for public use. Disseminate the PSA.
- The Brief Biosocial Gambling Screen has been integrated into the Mental Wellness Screening tool used in Region 1 by several hospitals and providers, municipal social services, and colleges, as well as during The Hub’s annual community screening initiative. This integrated screening tool should be used more widely.

ARE THERE PARTICULAR *SUBPOPULATIONS* THAT AREN'T BEING ADEQUATELY SERVED BY THE SUBSTANCE USE, MENTAL HEALTH AND PROBLEM GAMBLING PREVENTION, TREATMENT AND RECOVERY SERVICE SYSTEM?

- Continued attention to developing cultural competence in working with non-English speakers.
 - Info about Language Line and client rights should be posted in visual format as well as in various languages in all provider agencies and hospitals.
 - Education, treatment, supports in Spanish should be the norm.
- LGBTQ supports, including treatment for the transgender community.
- Youth with Autism Spectrum Disorders or other developmental disabilities, especially when co-occurring with mental health disorders, were identified by providers.
- More services/supports for pregnant and parenting youth were identified by young adults in recovery.
- Substance use issue: The location of liquor stores targets low-income and often predominantly minority neighborhoods.
- Across the region there is a growing concern surrounding youth and gambling. This stems from an overarching lack of delineation between “gaming” and “gambling” and the threshold of “pastime” and “problem”. Because of this, better resources are needed to help children and parents understand how gaming can lead to addiction.

WHAT ARE THE *EMERGING* PREVENTION, TREATMENT OR RECOVERY ISSUES THAT YOU ARE SEEING OR HEARING ABOUT?

Substance Use:

- Increase in crack, PCP.
- Worsening of the Access Line.
- Marijuana:
 - “Huge increase in ER visits” due to marijuana
 - No maximum amount of THC in “medical marijuana”
 - No protocols for dosage at cannabis dispensaries
 - More pregnant woman smoking marijuana in their first trimester (JAMA)
 - Teens vaping marijuana
- Increase in using substances alone due to isolation during the pandemic.

Mental Health:

- individuals are currently wary of inpatient programs because of the potential of quarantine and isolation.
- Continued increase in anxiety, depression, and suicidal ideation in adolescents. Recent death by suicide of a 14-year-old in the region.
- Uptick in children with suicidal ideation with reports of a 5-year-old and 9-year-old that had just been identified at the time of the focus group.



- In 4 sub-regional surveys conducted in 2018, adults in each of the surveyed areas (greater Greenwich, greater Stamford, greater Norwalk and greater Bridgeport) showed a decline in life satisfaction and increase in reported anxiety and depression since 2015.

Problem Gambling:

- Youth surveys in the region indicate an increase in gambling in high schools.
- Gambling treatment providers in the region report more people receiving treatment and more women receiving treatment.
- Gambling treatment providers in the region report an increase in electronic gambling.
- Due to the pandemic and increased isolation, people had much more free time to engage in gambling behaviors by gaming and/or betting on their smart devices.

ARE THERE OPPORTUNITIES FOR THE DMHAS SERVICE SYSTEM THAT AREN'T BEING TAKEN ADVANTAGE OF (TECHNOLOGY, INTEGRATION, PARTNERSHIPS, ETC.)?

Technology:

- Post COVID-19; the need for DMHAS and other state meetings (e.g., ADPC, CT SAB) to continue using video-conferencing technology to reduce time and travel while also maximizing participation.
- It would be useful for DMHAS to develop more webinars and digital toolkits that could be disseminated statewide.

Integration:

- At the RBHAO level, DMHAS encourages the integration of mental health and substance use services, including problem gambling. At the same time, separate programs at the central level continue to foster silos. Co-planning and integration of policies / funds at the central level would be helpful in making these efforts more efficient at all levels. For example:
 - Problem gambling plans, funds and required activities are separate from other regional activities despite the overlap in stakeholders and populations served.
 - ADPC efforts such as the Recovery Friendly Communities model could incorporate mental health along with substance use.
 - Contracts funded through specific grants, such as opioid money, should encourage the integration of general behavioral health efforts while still ensuring that the primary focus is on the targeted subject.
- Screening initiatives such as SBIRT should integrate mental health, substance use, and problem gambling using existing tools.
- The existing peer specialist training curricula used by the CT Community for Addiction Recovery (CCAR) and Advocacy Unlimited (AU) should be evaluated by external stakeholders and integrated so that *all* certified peers are given adequate training related to mental health, substance use, and problem gambling and can competently provide support and referrals as needed. Consideration should be given to use of the national peer certification curriculum developed by Mental Health America.
- Mobile crisis should be integrated across the lifespan. (Recommendations have been made in this regard by CACs in the past.)

Partnerships:

- Coordination across state agencies, such as the Department of Children and Families (DCF) and DMHAS, is critical to reduce duplication of efforts, improve efficiencies, and maximize funding. The CT Suicide Advisory Board is a very successful example. Other opportunities include:
 - The Joint Behavioral Health Planning Council should serve more of a planning function and less of a report-out function. It should ensure that all parties serving individuals with behavioral health needs are represented across state agencies.
 - DCF and DMHAS could seek to integrate their treatment of youth in the 16- to 18-year-old age group.



- The Department of Public Health (DPH) and DMHAS are both working on suicide and opioids. These efforts could be jointly planned and coordinated at the state level, with the plans and resources be disseminated to the regions through the RBHAOs, which would then coordinate with local health departments.
- The NORA app developed by DPH has a training of trainers and handouts that could be used in all the regional Narcan trainings, rather than different regions and communities developing their own.
- CDC is piloted an Academic Detailing program for Health Districts. They will educate prescribers on modules related to CT Prescription Monitoring and Reporting System (CPMRS), Narcan, & Communication (patient, prescriber, dispenser). This education should connect with the work of the RBHAOs and LPCs.
- Materials developed for community use should involve community stakeholders in the planning and review. For example, some Change the Script materials did not provide sufficient space for local resources and phone numbers.

ARE THERE OPPORTUNITIES FOR THE DMHAS SERVICE SYSTEM THAT AREN'T BEING TAKEN ADVANTAGE OF?

Mental Health

- As discussed above, undocumented citizens as well as non-English speakers continue to be largely underserved in regards to mental health. Increasing cultural awareness and overall competence in the DMHAS Service System will allow for gaps of understanding to lessen. Trauma informed care for clients was another suggestion when dealing with these populations. Increasing the number of bi-lingual staff in the DMHAS Service System and in local providers as well.
- School based health centers which highlight the importance of physical and mental wellbeing are needed in order to combat the high rates of mental health among youth populations. Mental health training for both educators and those employed by educational institutions will assist in this as well.
- Peer respite should also be encouraged more as this approach has high success rates. Additionally, peer support assists in bridging the gap between hospitalization and those struggling with suicidality.

Substance Use:

- While in general, it was cited that more long-term case management services are extremely successful when helping those with substance use disorders. That being said, they are scarcely available and it is suggested that the frequency and overall number of long-term case management programs for substance use increase.

Problem Gambling:

- It was found that many people are largely unaware of any services DMHAS offers in relation to Problem Gambling. This can also be used to reflect the general lack of knowledge and understanding surrounding the symptoms and signs of someone who is struggling with problem gambling.

IS THERE ANYTHING THAT YOU FEEL THE SERVICE SYSTEM (INCLUDING DCF AND DMHAS) CAN DO DIFFERENTLY FOR THE SUBGROUPS YOU ARE IDENTIFYING?

- Many identified difficulties in coordinating care with DCF and the miscommunication that often accompanies the process due to the many different employees involved. Key informants highlighted the detrimental impacts on children especially when DCF is involved.
- Some suggestions included offering a “point person” for hospitals and DCF so as to reduce the number of lines of communication and subsequent confusion that accompanies it.



WHAT DO YOU THINK THE HUB NEEDS TO DO TO PROMOTE HEALTH EQUITY AND/OR ADDRESS DISPARITIES IN OUR REGION FOR THE SUBGROUP(S) YOU ARE IDENTIFYING?

- The need for more promotion and hosting of events relating to substance use and mental health was highlighted.
- The idea surrounds lack of knowledge and education on Problem Gambling also reflects a greater need to have programs and resources allocated to this population.
- A need for greater cultural awareness and competency was discussed. This suggestion was expanded upon and has shown success in another region where implementation was achieved.
- Focus groups were said to be a beneficial means to bring people from different backgrounds (experience, ethnicity, service etc.) together. By having people from these spaces come together to share and listen to each other, cultural competency can begin.

WHEN WAS THE LAST TIME YOU CONDUCTED A SCHOOL-BASED YOUTH SURVEY? HAVE YOU EXPERIENCED ANY OF THE FOLLOWING BARRIERS WHEN CONDUCTING/TRYING TO COMPLETE A YOUTH SURVEY (EX. SCHOOL, TOWN, BOE BUY-IN, CAN'T IDENTIFY APPROPRIATE SURVEY INSTRUMENT)

- Overall, it was reported that schools and towns valued these surveys. Suggestions in pairing school-based surveys with parent surveys was commonly seen among focus groups which discussed this topic.
- It is important to note that in many focus groups, school-based surveys were either not discussed in any facet or participants in the focus group had no experience with school-based surveys.

HOW HAS COVID-19 AFFECTED PREVENTION, TREATMENT, OR RECOVERY?

Substance Use:

- Isolation and using substances alone are a known risk factor for overdose and potential fatalities.
- Many individuals who struggle with problematic substance use also face housing insecurity. COVID created many financial and housing challenges and consequently, rates of homelessness rose. Unfortunately, providers were hesitant to work with this population due to fear of increased exposure and the potential to contract the virus. When shelters either reopened or increased their capacity, this fear reduced.

Mental Health:

- Treatment:
 - There are reports of struggles to introduce and effectively utilize telehealth.
 - Many clients are on data-limiting plans for their phones or other technological devices, thus presenting challenges and potential barriers to receive care on virtual platforms when one does not have Wi-Fi.
 - Some clients report not wanting to receive telehealth and instead would prefer to see their providers in person. This is an issue exacerbated by intense social distancing due to COVID-19.
- Recovery:
 - There are fewer beds available for those exclusively experiencing mental health trauma during COVID, this is in part due to numerous facilities cutting their availability in half.
 - Many facilities require a 10-day quarantine on top of their inpatient stay. Many individuals leave or refuse to be admitted to a program because of this.
- Key informants reported that during COVID, many individuals “disappeared” in the sense that they stopped receiving services altogether and could not be located. This represents a scary and unfortunate number of clients who are in need of help but are not receiving it.



Suicide Prevention:

- Many cited that while COVID-19 brought on many health stressors, it also created economic (financial) and relational stressors that either were not as severe or not present prior to the pandemic.
 - These heightened stressors impacted many individuals' mental health and wellbeing. Key informants relayed that some of those who already struggled with mental health also began to face suicidality during COVID-19.
- There is a severe lack of interpersonal connection because of social distancing and isolation during the pandemic. Individuals who are facing suicidality and/or suicide ideation are known to significantly benefit from these kinds of face-to-face interactions.

Problem Gambling:

- Prevention:
 - Many of those struggling with Problem Gambling are able to continue to “gamble” or “game”, heightened isolation and time, allow for more time to be spent engaging in problematic behaviors without raising concern.

Overall points (i.e., correspond to more than one “population”)

Overall, access to regular preventative care was extremely limited in all facets (substance use, mental health, suicide, and problem gambling) as many scrambled to form and adapt to online telehealth. Adaptation to online services occurs at different rates for all individuals. Therefore, the shift to technological platforms must be done in a user-friendly manner for both consumers and providers of services. Overall, all populations saw an increase (MH, SUD, DV specifically mentioned in focus groups) there was a need to meet the level of need.

