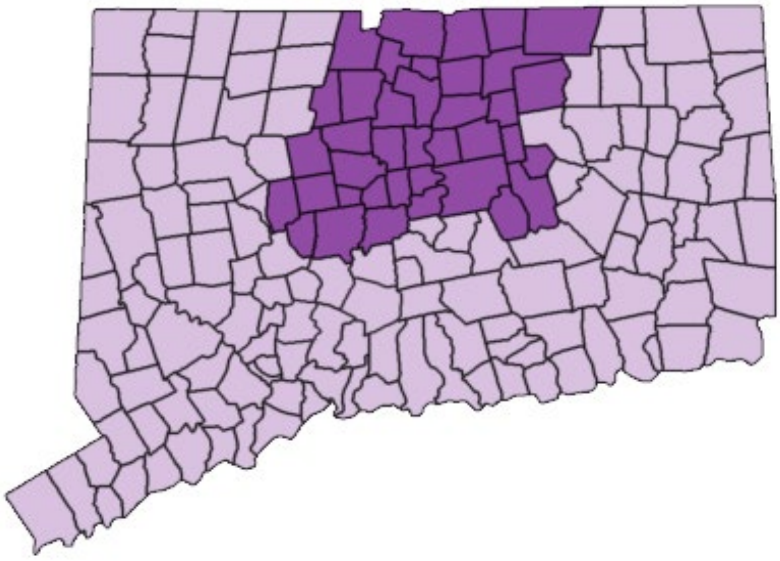
2021 North Central Region (Region 4) Priority Report



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

Amplify
A Trusted Voice for Healthy Communities

June 2021

TABLE OF CONTENTS AND FIGURES

I. Contributors

We would like to thank the following parties who were the main contributors to this report:

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The Priority Planning process included several forms of data collection which took place in the fall of 2020 through the spring of 2021. These included review and analysis of population profile and region-specific data, on-line surveys, focus groups, and feedback received from key stakeholders and coalition members. A Regional Behavioral Health Priority Setting Workgroup (RBHPSW) was established with key stakeholders representing perspectives across the region, the lifespan, and the continuum of prevention treatment and recovery for behavioral health concerns. Qualitative and quantitative data was shared with and analyzed by the RBHPSW using a Prioritization Matrix required by DMHAS.

Regional Behavioral Health Priority Setting Workgroup Participants:

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II. Abbreviations

The following is a list of abbreviations for terms and organizations that appear in the report:

AAPI: Asian American and Pacific Islander

ADPC: Alcohol and Drug Policy Council (Governor's Council)

CAC: Catchment Area Council

CHDI PIC: Child Health Development Institute Mobile Crisis Intervention Center Performance Improvement Center

CPES: Center for Prevention Evaluation and Statistics at UConn Health

CRS: Community Readiness Survey

CTSAB: Connecticut Suicide Advisory Board

DFC: Drug-Free Communities (A federal grant program for promoting drug-free communities)

DigIn: Disordered Gambling Integration Project

DMHAS: Department of Mental Health and Addiction Services

ED: Emergency Department

ENDS: Electronic Nicotine Delivery Systems (also called vape devices)

LMHA: Local Mental Health Authority (DMHAS funded behavioral health provider for a specific catchment area)

LPC: Local Prevention Council

MCRLC: Mobile Crisis Response Learning Collaborative

NMUPD: Non-medical use of prescription drugs

PFS: Partnership for Success (A federal grant program for substance misuse prevention)

PSA: Public Service Announcement

RBHAO: Regional Behavioral Action Organization

RBHPSW: Regional Behavioral Health Priority Setting Workgroup

RGAT: Regional Gambling Awareness Team

RSAB: Regional Suicide Advisory Board

SAMHSA: Substance Abuse and Mental Health Services Administration

SERAC: Supporting and Engaging Resources for Action and Change (RBHAO for Eastern CT)

SOR: State Opioid Response (Federal grant to support initiative that address the Opioid epidemic

YSB: Youth Service Bureau

SEOW: State Epidemiological Outcomes Workgroup – a collaborative group of State agency representatives and key stakeholders committed to the use of data to improve behavioral health in general.

ZSLC: Zero Suicide Learning Collaborative

III. Executive Summary

Every two years, the Department of Mental Health and Addiction Services (DMHAS) Planning Division is required to carry out a statewide need's assessment and priority planning process to capture needs and trends on the local, regional, and statewide basis. DMHAS contracts with Regional Behavioral Health Action Organizations to conduct these assessments. In the North Central Region (Region 4), Amplify, Inc., carries out this process by gathering local and regional data and perspectives. Information gleaned from this process is used to inform the DMHAS Mental Health Block Grant and DMHAS biennial budgeting process as well as the planning and priority setting process for Amplify.

Region 4 is comprised of 37 towns surrounding Hartford: Andover, Avon, Berlin, Bloomfield, Bolton, Bristol, Burlington, Canton, East Granby, East Hartford, East Windsor, Ellington, Enfield, Farmington, Glastonbury, Granby, Hartford, Hebron, Manchester, Marlborough, New Britain, Newington, Plainville, Plymouth, Rocky Hill, Simsbury, Somers, South Windsor, Southington, Stafford, Suffield, Tolland, Vernon, West Hartford, Wethersfield, Windsor, and Windsor Locks.

The priority planning process included several forms of qualitative and quantitative data collection, synthesis, and analysis. These included an on-line survey, focus groups, and anecdotal information from stakeholder groups, Region 4 Student Substance Use and Mental Health Survey data, and population profile information from the UConn Center for Prevention Evaluation and Statistics (CPES), CT Council on Problem Gambling, and DMHAS Problem Gambling Unit. Epidemiologic profiles were developed for a set of problem substances, mental health, and problem gambling issues (see page 1 for a complete list of profiles).

A Regional Behavioral Health Priority Setting Workgroup (RBHPSW) was established with key stakeholders representing perspectives across the region, the lifespan, and the continuum of prevention treatment and recovery for behavioral health concerns. Qualitative and quantitative data was shared with and analyzed by the RBHPSW using a Prioritization Matrix required by DMHAS**. The top priority substances of concern to the RBHPSW were alcohol, heroin and other illicit opioids, and prescription drug misuse. The top mental health issues of concern were depression, anxiety (especially among youth), and suicide.**

A majority of Region 4 stakeholders who responded to our stakeholder survey rated services as "adequate or somewhat adequate" vs. "less than or not at all adequate" (see responses to questions in the Appendix, Q3-6), however, the majority of people who rated problem gambling service gave them a neutral or "I don't know" rating.

Top priorities for treatment and recovery support were:

- Mental Health: **Emergency or crisis response, integration of primary and behavioral health care, and inpatient, partial hospitalization and intensive outpatient levels of**

care, **Case management/community support services, care coordination for children and families, and supported employment**.

- Substance Use: **Inpatient rehabilitation (including detox), emergency or crisis response, and integration of primary and behavioral health care, Case management/Community Support Services, and housing**
- Suicide Prevention: **Peer support, primary and inpatient care, crisis response, community supports, and family/loved one support.**
- Problem gambling: **Peer support, and emergency or crisis response and Community Support Services.**

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

Emerging issues requiring attention include public health problems that have dramatically increased since the onset of Co-VID: increase in alcohol use, mental health and addiction issues (both in number and acuity); inadequate workforce; overdose deaths involving multiple substances including stimulants, synthetic opioids, and counterfeit prescription medications; suicide and overdose rates for Black men and youth; and lack of awareness and associated risk of harm regarding problem gambling and recreational use of marijuana in the wake of legislation that will expand access to both.

The following are our recommendations based on emerging issues, regional strengths and assets, and resources gaps and needs identified:

<u>Substance Use Prevention:</u>

Regional:

- Continue efforts to reduce overdose deaths with focus on Amplify's equity goals to better focus SOR funding on subpopulations at greatest risk for overdose and suicide.
- Work with the other RBHAOs and the Connecticut Prevention Network to launch an awareness campaign about counterfeit prescription medication misuse.
- Work with LPCs and school districts to address increased use of cannabis and decreased perception of harm by young people (including use in vape devices)

State:

- Monitor and provide REL data re: alcohol, stimulants, and multiple substance overdose rates.
- Address issue of availability of NARCAN via prescription vs. over-the counter

Substance Use Treatment:

Regional:

- Promote ongoing dialogue between grassroots outreach efforts and behavioral health providers to address barriers for accessing treatment.
- Represent regional perspectives in the ADPC treatment and recovery subcommittee recommendations for substance use system improvements.

State: Promote ADPC treatment subcommittee initiative to further harm reduction approaches

Substance Use Recovery:

Regional: Support the establishment of "Recovery Friendly Communities" and Recovery Friendly Workplace initiatives

State: Expand family support options

Mental Health Promotion:

Regional: Enhance reach of suicide prevention/mental health gatekeeper trainings

State: Expand opportunities for local/regional needs assessments to inform state-funded local/regional priority prevention programs

Mental Health Treatment:

Regional:

- Promote Universal screening among primary care and health/behavioral providers.
- Continue to explore options for mobile and tele-health options for people with limited income or living in rural communities.
- Continue to work in partnership with the Mobile Crisis Response Learning Collaborative (MCRSLC) to monitor and enhance mobile crisis response.

State:

- Ensure that youth, regardless of insurance, can access a comprehensive system of care.
- Invest in efforts that strengthen the behavioral workforce including those that support employee/workplace wellness and diversity.
- Promote emerging treatment models such as peer respite and walk-in urgent care for mental health, resulting in improved outcomes.

Mental Health Recovery:

Regional:

- Increase leadership development opportunities for CAC members.
- Work with Partnership for Strong Communities workgroups to ensure the supportive housing needs of individuals with behavioral health challenges are addressed in their efforts to make homelessness a rare, brief, and one-time issue.

State: Support groups that advance opportunities for people in recovery and family/community members and inform systems improvement efforts, including the statewide network of Catchment Area Council (CAC)s

Problem Gambling Prevention:

Regional:

- Address the overlap between computer gaming, sports better and gambling.
- Include computer gaming as a topic in all Problem Gambling training
- Continue partnership with the AAPI Ambassador program to include topics of trauma, mental health, and addiction in presentations to AAPI communities.

State: Provide support for expansion of training programs offered by AAPI Ambassadors (translation and training for Ambassadors)

Problem Gambling Treatment:

Regional: Ensure Bettor choice treatment providers have capacity to address the needs of veterans and teens regarding new online sports betting and gaming issues

State: Expand Disordered Gambling Integration Project (DigIn) and Helpline in areas where Gambling has expanded in North Central CT

Problem Gambling Recovery:

Regional: Engage leaders of Gamblers Anonymous for expansion of Gamblers Anonymous meetings in those areas where gambling has expanded

State: Promote inclusion of problem gambling/gaming in recovery coach and recovery support specialist training.

Further detail about each of these recommendations can be found on page 52 of this report.

IV. Introduction

Background:

The Region 4, Regional Behavioral Health Action Organization (RBHAO), is a public-private partnership comprised of people in recovery, families, providers, community leaders, and other key stakeholders across the region. Via community partnerships, the RBHAO assesses the behavioral health needs of children, adolescents and adults across the regions and develops Regional Strategic Plans to include priority recommendations for prevention, treatment, and recovery services. To support development of these plans and to make recommendations to the Department of Mental Health and Addiction Services a priority planning process occurs every two years.

Data Sources Utilized:

The priority planning process included several forms of qualitative and quantitative data collection, synthesis, and analysis. All took place from the fall of 2020 through June 2021. These are summarized below.

- **Online surveys (104)**, using were conducted with people in recovery, families, providers, and other key stakeholders across the region. (See the Appendix for questions asked and a summary of their responses).
- **Focus groups (12)**, Throughout the Spring 2021, local perspectives from all the towns in Region 4 were gathered by through a series of focus groups. (see the Appendix for questions asked and a summary of their responses). Twelve focus groups were held, one in each of Amplify's **Catchment Areas Councils** (CACs) representing people in recovery, family members, community referral organizations, Local Prevention Council coordinators and members, and MH/SA providers (37 participants). one with **Local Prevention Council Coordinators** (22 participants representing 22 or our 37 Region 4 communities), one with members of the **Region 4 Problem Gambling Awareness** Team (10 participants) representing prevention and treatment perspectives), one with the **Region 4 Suicide Advisory Board** (10 participants). one with members of the **North Central Network of Care** (72 participants), one with youth and families from the **Hartford Local Interagency Agency Service Team** (15 participants), and one with the **CT Young Adult Leaders Partnership** (4 participants).
- **Region 4 Student Substance Use and Mental Health Survey data** (2019-2020) n=10,418. Data on 30-day use for alcohol, tobacco, vape/ENDS, NMUPD, marijuana, binge drinking, depression, suicide, gambling. Substances and gambling are available by risk factor of perception of parental disapproval, perception of risk/harm, perception of peer approval. Data are from combination of comparable data for schools (n=7 towns) surveyed in Region 4 using the Amplify or SERAC survey tool.

- **Region 4 specific data from the SEOW Data Portal and statistical reports from CT State Agencies**. Data for 11 Epidemiological Profiles on problem substances and mental health conditions was obtained from the DMHAS Center for Prevention Evaluation and Statistics (CPES) at UConn Health. These included statistical reports from the Office of the Chief Medical Examiner, Department of Public Health, Department of Mental Health and Addiction Services, the Child Health and Development Institute (CHDI)of Connecticut.
- **2020 CT Community Readiness Survey results for Region 4.** Key stakeholders and coalition members (n=247) were asked to complete a Community Readiness Survey to help the Department of Mental Health and Addiction Services determine the level of readiness for prevention in local communities and help them acquire and distribute additional funding for prevention initiatives. The report measures community attitudes, perceived strengths, barriers and support for prevention initiatives, availability and perceived effectiveness of strategies, and an overall rating of community readiness for addressing substance misuse and mental health promotion.
- **Regional Behavioral Health Priority Setting.** A Regional Behavioral Health Priority Setting Workgroup (RBHPSW) was established with 15 key stakeholders representing mental health or substance misuse treatment or prevention in rural, suburban, and urban communities across the region, the lifespan, and the continuum of prevention treatment and recovery for behavioral health concerns. Qualitative and quantitative data was shared with and analyzed by the RBHPSW using a Prioritization Matrix ranking magnitude, impact, capacity/readiness, and consequences of inaction for substance use, gambling, and mental health problems.
- **Anecdotal information solicited from key informants** from both within and outside of the DMHAS services system (RBHAO Catchment Area Council [CAC] and Program Advisory Council, staff from town social services, shelters, health departments, local colleges and universities, and parents and individuals in recovery who are new to the system or from the private sector). Amplify meets regularly with partner agencies and coalitions representing state, regional and local concerns. Feedback is collected and minutes generated and consulted for the purposes of this review.
- **Data collected via Amplify review on Youth Anxiety.** Youth anxiety was identified as an emerging issue and key area of concern in Amplify's 2019 Priority Needs Assessment. Our team was interested in learning more about youth anxiety in the region, what might be causing it, and what might help to decrease it. To achieve this, we conducted surveys, focus groups, key stakeholder interviews and formed a workgroup to information collected and make recommendations for addressing the issue. A report can be found on the Amplify website: https://amplifyct.org/publications
- Review of **data from CT Council on Problem Gambling and DMHAS Problem Gambling Services** regarding crisis calls and treatment admissions.
- Review of **data from the Mobile Crisis Intervention Services 2020 PIC Report** regarding crisis calls for children.
- Review of 211 Counts Data

General Limitations of the Report:

This report and its outcomes are limited by the types of data available at the Region 4 level. In many cases there is more substance abuse-specific data for certain subpopulations, i.e., youth. It was difficult to consider risk factors in the collection and interpretation of data since many risks factor-related data are not yet available at the regional level. Data at the sub-population level are limited as well because most of the current information on sub-populations is derived from key informant observations.

Development of the Report:

This report was developed by Amplify staff. Tasks were divided among staff based on knowledge, experience, and relationships within the region. This included knowledge of data collection, synthesis of data, data visualization, group facilitation, and report generation. Staff held meetings specific to the Priority Process, at minimum monthly, with many e-mails and phone calls in-between. Epidemiological profiles were obtained from the DMHAS Center for Prevention Evaluation and Statistics (CPES) at UConn Health and augmented with local data. Data from the profiles was culled into a PowerPoint for review by the Regional Behavioral Health Priority Services Workgroup (RBHPSW).

On June 3, 2021, we convened the RBHPSW. We shared a PowerPoint presentation and encouraged participants to react to the data throughout the presentation. Participants felt the data represented their understanding of current Region 4 substance use, gambling, and mental health problems across the lifespan with some limitations on racial/ethnic and other at-risk populations. After the data were presented and discussed, participants were asked to complete the Prioritization Matrix. Finally, their prioritizations were compiled into a graph that shows the final mean score for each topic within the matrix (See Figure 1 below).

Figure 1. Average Group Scores for Regional Priority Setting Process with RBHPSW

PROBLEM	MAGNITUDE	Group Score	IMPACT	Group Score	CHANGEABILITY	Group Score	CAPACITY/ READINESS	Group Score	CONSEQUENCE OF INACTION	Group Score	TOTAL	MEAN RANKING SCORE
Anxiety	36	**4.5**	34	4.3	30	**3.8**	27	**3.4**	34	4.3	20.1	**4.0**
Depression	36	**4.5**	36	**4.5**	32	**4.0**	27	**3.4**	36	**4.5**	20.9	**4.2**
PTSD	29	3.6	35	4.4	28	3.5	21	2.6	31	3.9	18.0	3.6
Trauma	35	4.4	35	**4.4**	25	3.1	24	3.0	34	4.3	19.1	3.8
Serious Emotional Disturbance (youth)	31	3.9	35	4.4	29	3.6	26	**3.3**	36	**4.5**	19.6	3.9
Early Serious Mental Illness (late youth to young adult-First Episode Psychosis	29	3.6	35	4.4	27	3.4	21	2.6	33	4.1	18.1	3.6
Serious Mental Illness (adult)	25	3.1	33	4.1	25	3.1	21	2.6	32	4.0	17.0	3.4
Suicide	29	3.6	37	**4.6**	30	**3.8**	27	**3.4**	38	**4.8**	20.1	**4.0**

PROBLEM	MAGNITUDE	Group Score	IMPACT	Group Score	CHANGEABILITY	Group Score	CAPACITY/ READINESS	Group Score	CONSEQUENCE OF INACTION	Group Score	TOTAL	MEAN RANKING SCORE
Alcohol	35	**4.4**	33	**4.1**	27	3.4	27	**3.4**	31	3.9	19.1	**3.8**
Tobacco	29	3.6	29	3.6	25	3.1	22	2.8	26	3.3	16.4	3.3
ENDS/ Vaping	31	3.9	27	3.4	29	**3.6**	21	2.6	26	3.3	16.8	3.4
Marijuana	36	**4.5**	31	3.9	25	3.1	23	2.9	34	**4.3**	18.6	3.7
Rx Drug Use	29	3.6	29	3.6	29	**3.6**	24	3.0	31	3.9	17.8	3.6
Heroin and Fentanyl	26	3.3	37	**4.6**	27	3.4	25	**3.1**	38	**4.8**	19.1	**3.8**
Cocaine	22	2.8	30	3.8	24	3.0	23	2.9	33	4.1	16.5	3.3
Problem Gambling	20	2.5	26	3.3	23	2.9	17	2.1	31	3.9	14.6	2.9

Like 2019, Alcohol was the substance given highest priority by the group although heroin and fentanyl edged above prescription drug misuse and marijuana as a concern. Depression, anxiety, and suicide remain top priority mental health concerns with suicide edging over trauma and PTSD. These line up well with feedback from Region 4 survey and focus groups.

A great deal of discussion focused on lack of treatment options for individuals with opioid use disorder. People working at the grassroots level indicate they meet with people looking for treatment, but there is a small window of interest that requires a prompt response. There is also a small window of time (between 7 a.m. and 8 a.m.) to call for a detox bed. For many people detox is the entry point for treatment, but detox options are lacking. Given lack of options, people and their advocates spend much of their time and energy jumping through the hoops, dealing with insurance barriers, and making the person seeking treatment to be considered a priority. People who are desperate may go to a hospital Emergency Department just to get off the street, attempt to self-detox, or develop their own harm reduction strategies. During the workgroup discussion providers from the Root Center, Hartford Healthcare and the Village described their services and offered to work more closely with advocates to address the barriers they were experiencing. Several had same or next day intake options and can offer Medicated Assisted Treatment on an outpatient basis even while someone is waiting for a residential treatment option.

Another issue of grave concern to the workgroup were the risks faced by Black males for both addiction and suicide. For Black youth ages 10 to 19 years, suicide is the second leading cause of death; their suicide death rate has nearly doubled over the past ten years and is increasing faster than any other racial/ethnic group.[1] We reviewed CT drug overdose mortality rates by race and ethnicity and noted that drug overdose mortality rates increased substantially from 2019 (340) to 2020 (520) and were the highest mortality rates among race or ethnic groups.[2] This is a shift from prior reports about CT overdose deaths that focused on white males aged 21-45. It is important that we continue to track and address mortality rates across race and ethnicity groups and that we develop strategies to address the mortality rates for Black youth and men.

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

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

Concern regarding the misuse of prescription drugs focused on overdose deaths that have occurred with substances with counterfeit prescription medications, obtained other than through a pharmacy that have been contaminated with toxic and illicit substances. The Department of Drug Enforcement has recently issued warnings regarding the increase in sale and use of counterfeit pills and advises the public to obtain prescription drugs only from state-licensed pharmacies.[3] Another concern regarding prescription medications is for older adults who have difficulty following a complicated medication regime or may be taking medication in combination with alcohol. Stakeholders who responded to the 2020 Community Readiness Survey identified prescription drugs along with alcohol as problem substances of great concern for the 66 years and older age group.[4]

The workgroup thanked Amplify staff for involving them in this work and encouraged us to continue listening to the people most affected by these issues and their communities. One workgroup member commented, "You see a house that has broken windows and you keep driving by and wondering why the people who live there aren't taking care of their home. Take the time to knock on the door and find out what is happening to cause their windows to be broken time and again." Listen; utilize peers, neighborhood churches and community groups to learn more about the populations we are concerned about and develop better policies and prevention and treatment strategies that work for them. We also must think outside the box. A lot of evidence-based programs were created and used for certain populations. Prevention is not one size fits all. What can be done to better support the voice and involvement of local programs and community members in the work and to be given credit (and funding) for the roles they can or are already playing.

In June 2021, Amplify staff had collected the requisite information and data to create the priority report. The report was drafted under the leadership of Marcia DuFore, Amplify Executive Director.

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

[4] 2020 Community Readiness Survey

V. Region 4 Priorities

Description of the Region:

Geography/Demographics:

Region IV has a population of 1,002,592 people who live within 37 towns. The southern-most areas include suburban towns such as Rocky Hill, Marlborough, and Southington, and the center of the region is our state's Capitol City of Hartford. The northern boundary consists of five rural/suburban towns along the Massachusetts border. Figure 2 illustrates how Region 4 towns and cities fit within Data Haven's categories for community type.

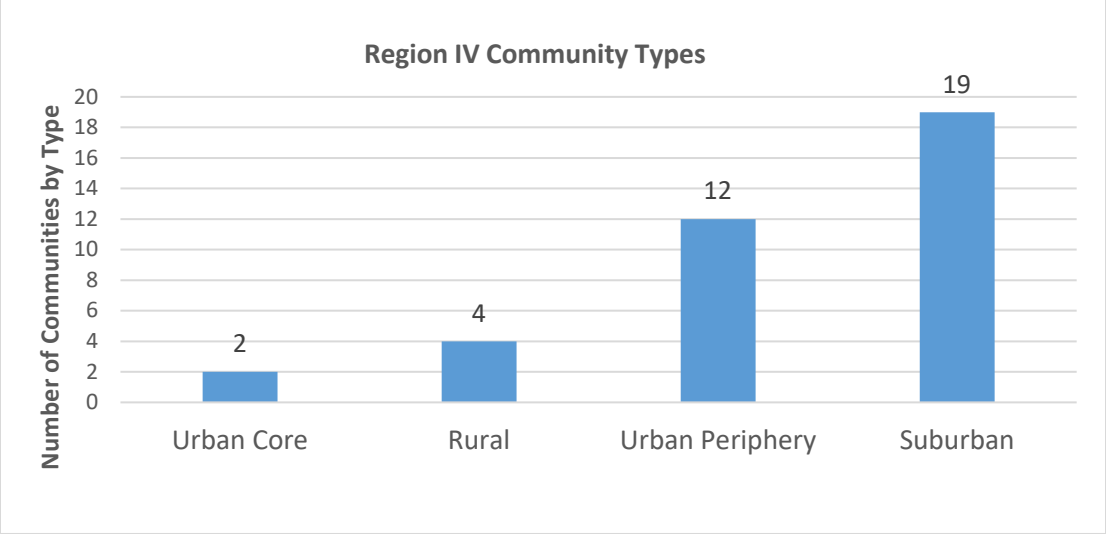


Figure 2. The majority of Region 4 towns are classified as suburban followed by urban periphery. There are no towns or cities classified as "Wealthy."

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

Notable features that directly and indirectly impact behavioral health in Region IV are as follows:

- 6 correctional facilities
- 1 international airport
- Most of the towns are within 50 miles of MGM Casino in Springfield, MA
- 9 Hospitals of which one is CT Children's Medical Center, the state's only pediatric specialty hospital.
- 34 of 37 towns are served by a Youth Service Bureau
- 12 health departments/districts serve Region IV towns/cities

- High Education-UConn our states largest university abuts Region 4, there are 3 public community colleges, and 5 private colleges/universities in the region.

Existing/Emerging Subpopulations:

The following is a breakdown of racial ethnic populations for Region 4 based on 2010-2017 census information:[5] 76.9% Caucasian, 17.8% Hispanic, 13.3% Black, 4.9% Asian or Pacific Islander, .5% American Indian, .5% Alaskan Native.

Subpopulations of greatest concern to survey focus group participants included young adults, youth, veterans, LGBTQ youth and adults, persons of color (including Latino, Black and Asian American). When we asked what Amplify and the service system can do differently to promote health equity or address health disparities for these groups, we heard the following (for greater detail please see the Appendix, Q17-20).

<u>Amplify</u>

Advocate for more flexibility in the use of funds at the agency and community level
Do more with these groups. Appeal to them directly. Diversify staffing and all aspects of Amplify work and workgroups.
Collaborate with community leaders and grassroots organizations that have established relationships and trust with these groups.
Continue educating legislators about priority issues.
Involve members of these groups in designing and implementing surveys and focus groups.
Support grassroots initiatives that are out the doing the work
Do not view each racial/ethnic group as a block. People who are Black, Latino, and Asian descent are not all the same, do not have the same cultural background, or even speak the same language. Hold listening sessions with various subgroups.

<u>Service System</u>

Offer safe and reliable transportation for youth to participate in activities.
Improve coordination for teens moving into young adult services.
Train ED staff on communicating with young adults. Too many young people with depression and suicidal ideation are just sent home after horrible experiences and hours in an ED.
Increase parenting education and support to help impoverished families deal with crisis situations and institutional pressures.
Provide mainstream family support programs for families that are not mandated to take them – before they develop high levels of need.
Target outreach

- to reduce stigma around mental health in communities of color,

[5] 2010-2017 American Community Survey Racial/Ethnic Data for Hartford County from U.S. census bureau: state and county quick facts

- substance use and suicide prevention outreach and treatment for LGBTQ youth
- problem gambling efforts focused on sports/drafting/fantasy football, etc.

Provide more training regarding how certain populations can be at increased risk and impacted by stigma. Train on implicit bias
Create peer support positions across all the subgroups.
Engage more with towns and communities as they are front line workers as well.
Expand insurance to cover all kinds of support and services for mental health and addiction.

Epidemiological Profiles:

Epidemiologic profiles are documents that describe the burden of a particular health issue or problem on a population or subpopulations. The profiles that follow provide information about magnitude (prevalence and trends), burden (impact across populations and towns), risk factors (including subpopulations at greatest risk), and strengths and capacity in our Region to address each problem. The following profiles are included in the pages that follow:

Alcohol
Tobacco and Electronic Nicotine Devices (ENDS)
Prescription Drugs, Not for Medical Use
Marijuana
Cocaine
Heroine and Illicit Opioids
Problem Gambling
Mental Health
Suicide

2020 North Central Region (Region 4) Epidemiological Profile: Alcohol

Problem Statement

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

Magnitude (prevalence)

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

Young adults in Connecticut 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:
2019 Connecticut School Health Survey (YRBS):
25.9% of high school students reported using alcohol in the past month and almost half of them (12.9%) reported binge drinking** in the past month[2].
**Four or more drinks of alcohol in a row for females, five for males

2019-2020 aggregated student survey data from Region 4 communities reflects a 2.1% increase in past month alcohol use in individuals 12+ years old. The data in Region 4 also reflects that past month binge drinking in ages 12+ was 27.8% in comparison to the state average of 28.6%.

Risk Factors and Subpopulations at Risk

- Young people who drink are more likely than adults to report being binge drinkers.[3]
- Men are more likely than women to be heavy drinkers.[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]
- 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]

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]

[1] NSDUH (2017-2018)
[2] DPH, 2019 Connecticut School Health Survey
[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
[7] CT DMHAS 2019 Treatment Admissions
[8] National Research Council and Institute of Medicine

Burden (consequences)

According to 2019-2020 aggregated student survey data from Region 4 communities, 45.3% of respondents age 12+ perceived great risk from having 5+ drinks of an alcoholic beverage once or twice a week, which is higher than the state (43.9%) and all other CT regions. This data also reflects that the perception of risk of alcohol use was around 66-75% with an outlier reporting 82.5%.

- Immediate adverse effects of alcohol can include impaired judgment, reduced reaction time, slurred speech, and loss of balance and motor skills.[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]

Capacity and Service System Strengths

DMHAS data for the funding year 2019-2020, shows 4800 alcohol treatment admissions occurred in Region 4 (24%) of treatment admissions across the state.[7] This is a reduction from 6546 in 2019.

The percent (ages12+) reporting symptoms meeting the criteria for alcohol use disorder also dropped in Region 4 from 2014/16 to 2018. However, region 4 remains higher than all other regions and the state. (see chart below).[1] However, the percent (ages 12+) needing, but not receiving treatment for alcohol use in the past year is lower than the state average and lower than all other regions in CT.[1]

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

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

Key stakeholders who completed the 2020 Community Readiness Survey also ranked their communities' stage of readiness to address these areas of concern substance misuse as 5.59 out of a scale of 9, an increase in perceived readiness from 2018 (5.19). This was comparable to other regions in the state and to the state average.[14]

[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
[14] 2020 CT Community Readiness Survey

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

Noted areas of strength are:

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

2020 North Central Region (Region 4) Epidemiological Profile: Cocaine

Problem Statement

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

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

Magnitude (prevalence)

According to data from the 2019 Connecticut School Health Survey (CT YRBSS), 2.6% of Connecticut high school students reported using some form of cocaine in their lifetime.[1] This is consistent with a decreasing trend since 2007, when the prevalence was 8.3%.

The 2018-2019 National Survey on Drug Use and Health (NSDUH) data show 1.99% of Connecticut respondents reported past year use of cocaine.[2] This is highest among young adults 18-25 (6.21%), compared to youth 12-17 (.37%) and adults 26+ (1.50%).

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

- Ages 18-25: past year use in 2016 was 8.9%, decreased to 6.31% in 2018.
- Ages 26 and Older: past year use in 2016 was 2.06%, decreased to 1.85% in 2018.[2]

In Region 4 there was a decrease in the 12+ population between 2016 and 2018. In 2016, this region had higher reported use than the state and all other regions but has since decreased and in 2018 was in line with statewide reported past year use (*see chart below).

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

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

Risk Factors and Subpopulations at Risk

Risk factors include:

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

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

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

- Young adults ages 18 to 25 have a higher rate of current use than any other age group.[2]
- Males are more likely to use cocaine than females.
- Those with current or previous misuse of other illicit substances, such as marijuana and heroin/fentanyl
- Individuals with mental health challenges[3]

According to data from the 2019 Connecticut School Health Survey (CT YRBSS), males reported higher rates (3.6%) than females (2.5%). The prevalence of lifetime cocaine use was highest among 12th graders (2.9%). Black students reported higher rates (4.8%) than

[1] Connecticut School Health Survey, 2019 (CT YRBSS)
[2] NSDUH 2018-2019
[3] NIDA

Hispanic (2.7%) or White (2.1%) students, though the difference was not statistically significant.

Burden (consequences)

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

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

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

- Tolerance, requiring higher and more frequent doses.
- Sensitization, where less cocaine is needed to produce anxiety, convulsions, or other toxic effects (increasing risk of overdose)
- Loss of appetite leading to malnourishment.
- Increased risk of stroke and inflammation of the heart muscle
- Movement disorders such as Parkinson's disease
- Impairment of cognitive function
- Cocaine users are also at risk for contracting blood-borne diseases such as HIV and hepatitis C via needle sharing and other risky behavior.3
- Users are at risk of accidental overdose, especially in the presence of alcohol or other drugs.3
- In 2019, cocaine was the primary drug in 7.7% of all Connecticut substance use treatment admissions. This represents 5,904 admissions. [4]

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

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

Cocaine-Involved Fatal Overdoses in 2019[3]

	CT	Region 1	Region 2	Region 3	Region 4	Region 5
N	399	39	73	50	149	88
Rate	11.19	5.56	8.82	11.84	14.87	14.37

*Rate per 100,000 population

In 2020, Region 4 had the second highest treatment admissions for cocaine (N 4,877) and in 2019 had the highest cocaine involved fatal overdoes (N 149).

Capacity and Service System Strengths

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

	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

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

[4] Connecticut Department of Mental Health and Addiction Services, (2019)
[5] CT Office of the Chief Medical Examiner, 2019
[6] Tomassoni AJ. MMWR 2017;66:107-111.
[7] 2020 CT Community Readiness Survey

Noted key areas of strength were:

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

2020 North Central Region (Region 4) Epidemiological Profile: Heroin and Other Illicit Opioids

Problem Statement

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

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

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

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

According to the CT Office of the Medical Examiner, Region 4 had 360 overdose deaths (29% of the CT total). 305 of the 360 involved fentanyl. 297 involved more than one substance. [3]

Magnitude (prevalence)

According to NSDUH Substate estimates, .72% of individuals ages 12+ reported past year heroin use. Between 2014 and 2016. This was slightly reduced to .67% by 2018, but still the highest reported use among all the regions and higher than the state average. [1]

Risk Factors and Subpopulations at Risk

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

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

The 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.

[1] NSDUH
[2] Connecticut School Health Survey, 2019 (YRBS)
[3] CT OCME
[4] US DOJ- DEA, 2018 National Drug Threat Assessment (October 2018)
[5] CDC. Overdose: Heroin. https://www.cdc.gov/drugoverdose/opioids/heroin.html

2020 North Central Region (Region 4) Epidemiological Profile: Heroin and Other Illicit Opioids

Burden (consequences)

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

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

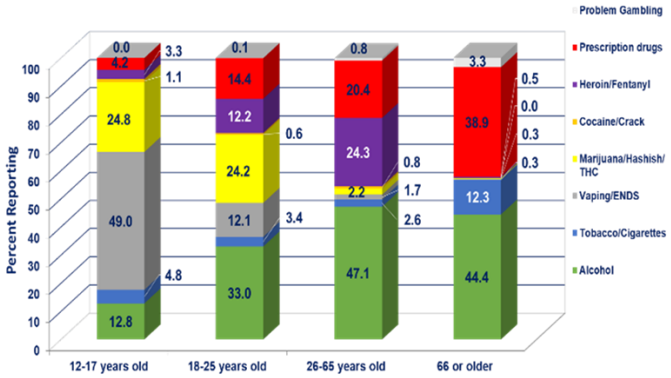
Opioid-Involved Non-Fatal Overdoses (DPH)

In 2020 there were 15,226 treatment admissions statewide where heroin was the primary substance. Of those, 3667 were from Region IV. Region IV admissions were the second highest in the state, second only to Region 2.

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

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

Problem Substances of Greatest Concern for Age Groups, According to Key Informants: Amplify CRS, 2020



Capacity and Service System Strengths

Key Stakeholders who completed the Community Readiness survey also ranked their communities' readiness to address these areas of concern 5.59 out of a scale of 9. This was slightly higher than all but one of region in the state and higher than the state average (See chart below)

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

Areas of strength are:

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

Fortunately, both Bristol and New Britain have committed to become *"Recovery Friendly Communities"* to overcome substance misuse in their communities. This is a community that is committed to making it easier

[6] 2020 CT Community Readiness Survey

for people in recovery from drug or alcohol addiction to maintain their sobriety. Some examples of this commitment are good access to treatment; drug and alcohol-free entertainment; discouraging stigma; and drug courts.

Hartford, Bristol, and New Britain (communities with the highest overdose rates in our region) have all established Opioid Task Forces to combat Opioid addiction and overdose. Hartford and New Britain have recently received *"Overdose Data to Action"* grants from the Department of Public Health to help in this endeavor. The Central CT Health District has also established an Opioid Task Force and has a "How Can We Help" grant from DMHAS to support families and individuals who have experienced an overdose.

In 2019-20 14 region 4 communities were awarded mini grants to provide education about the dangers of Opioid misuse and use of NARCAN to reverse an overdose.

2020 North Central Region (Region 4) Epidemiological Profile: Marijuana

Problem Statement

Marijuana remains the most 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]

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

Magnitude (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

In Region 4, past 30-day use for ages 26 and older in 2016 was 7.03% and 9.17% in 2018 (NSDUH).[1]

According to 2019-2020 aggregated student survey data from Region communities, among students in grades 7-12, 8.75% had used marijuana in the past month. This being the second highest substance of use. Only alcohol past month use was higher. School survey data was limited due to the number of school closures because of the pandemic; therefore, we have limited information about the impact of CoVID or the presence of cannabis in vape devices. Both have been described during our focus groups and growing problems. In fact, key stakeholders from the 2020 Community Readiness Survey regarded marijuana as the second highest problem substance of greatest concern for all substances only second to vaping/ENDS among 12-17 years old.[7]

Risk Factors and Subpopulations at Risk

Risk factors include:

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

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

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

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

According to 2019-2020 aggregated student survey data from Region communities, Region 4 youth grades 7-12, only 57% perceive using marijuana is risky. This is much higher than the general population (12+), but also the lowest perception of risk among all substances and only slightly higher than perceived risk for gambling.

The 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

[1] NSDUH
[2] Connecticut School Health Survey, 2019 (YRBS)
[3] SAMHSA, CAPT Northeast Regional Marijuana Webinar Series: Strategies/Interventions for Reducing Marijuana Use

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.[2]

Burden (consequences)

Short-term consequences include[4]

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

Long-term consequences include[4] :

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

Marijuana potency has increased over the past few decades: in the 90s, the average THC content in confiscated samples was less than 4%, and in 2018 it was over 15%.[4]
Marijuana use during pregnancy also increases the risk of child development problems including low birth weight, and brain development. Additionally, children exposed to marijuana in-utero have increased risk for problems with attention span and problem solving.[4]
Several studies have linked marijuana use to increased risk for psychiatric disorders and substance use disorders. The amount used, age at first use, and genetic vulnerability are thought to influence this relationship.[4]
In 2019, marijuana was identified as the primary drug in approximately 12% of treatment admissions in Connecticut.[5] Of these, approximately 67.3% were male. About 30% where White, non-Hispanic, 28% Black, non-Hispanic, and about 26.4% Hispanic.[4]

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

- A recent national outbreak of e-cigarette, or vaping product use-associated lung injury (EVALI) was linked to vaping THC, possibly due to the presence of Vitamin E acetate which is used as a diluent in THC-containing products.[6]

CT DMHAS data on adult (18+) substance abuse treatment admissions showed that marijuana was the primary substance at admission for 11.4% of admissions in 2018, 8.9% in 2019, and 9.7% in 2020.[5]

Capacity and Service System Strengths

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

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

	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

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

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

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

[4] NIDA, Marijuana
[5] CT DMHAS, 2019 Treatment Admissions
[6] CDC (2020), Outbreak of Lung Injury Associated with the Use of E-Cigarette, or Vaping, Products
[7] 2020 CT Community readiness Survey

2020 North Central Region (Region 4) 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 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.[4]

Serious Mental Illness

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

Magnitude (prevalence)

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

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

Anxiety

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

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.[6] Similar to the NSDUH, the BRFSS showed a higher percentage among younger adults 18-

[1] NIMH
[2] CDC, Depression and Anxiety
[3] SAMHSA, Adults with SMI
[4] NSDUH 2018-2019
[5] Mobile Crisis Intervention Services PIC Quarterly Report FY2021: Q2
[6] CT BRFSS 2018

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

Serious Mental Illness

In the 2018-2019 NSDUH, young adults 18-25 had a higher percentage reporting serious mental illness (8.54%) than those 26+ (3.86%). Adults 18+ reporting a major depressive episode (7.54%) was higher than the other regions and the state average (6.84%). Adults 18+ reporting past year serious mental illness was also higher than the state average (4.15%). [4)]

The 2019 Connecticut School Health Survey reported that almost 70% of high school students said their past 30-day mental health was not good (including depression, stress, emotional problems).[7] 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% (compared to 3 local school surveys ranging from 14.5% to % to 22.3%). 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]

Risk Factors and Subpopulations at Risk

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

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

- Academics
- Post high school planning
- Schedules

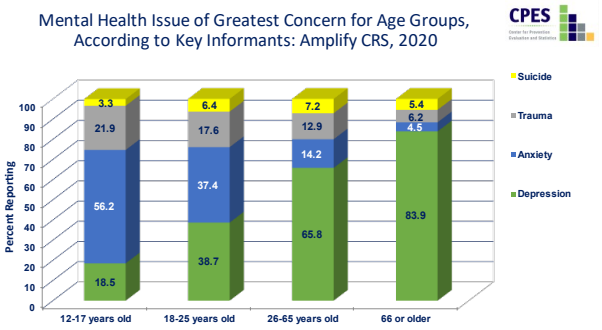
Interestingly social media was not considered by students as a strong contributor to their anxiety. [8]

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

Burden (consequences)

- Mental illness (including depression, anxiety, bipolar disorder, among others) is a risk for suicide.
- Depression is the leading cause of disability in the world,[7]
- Mental illness costs Americans $193.2 billion in lost earnings per year;[7]
- 1 in 8 emergency department visits involves a mental health or substance use condition.[7]
- Mental health treatment admissions (19,895) were higher than the other regions and the state average (12,670).[10]
- A Community readiness survey conducted in 2020 among key stakeholders in our area identified key areas of concern per age group for residents of Region IV (see graph on next page). Anxiety was reported as the main concern for youth. Depression was reported as the primary concern as people age.[11]

Mental Health Issue of Greatest Concern for Age Groups, According to Key Informants: Amplify CRS, 2020



[7] Connecticut School Health Survey 2019
[8] Amplify Youth Anxiety Review 2020
[9] NAMI
[10] DMHAS treatment Admissions FY20
[11] Community Readiness Survey 2020

Capacity and Service System Strengths

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

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

Problem Statement

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

Magnitude (prevalence)

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

According to 2018 NSDUH data, Region 4 is higher than all other regions and the state in reported past year Rx pain reliever use (see chart in the next column).[2] Region 4 is also higher than all other regions in the state in the percentage meeting criteria for past year pain reliever use disorder (.65 compared with the CT average of .58%.[2] Fortunately, Region 4 had the lowest number of prescription drug-involved fatal overdoses than all of the other regions in 2019. Although the rate of prescription-involved fatal overdoses rose slightly in 2020, it came back down by the end of 2020 to a rate comparable to 2019 and to the CT average.

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

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

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

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

Risk Factors and Subpopulations at Risk

- Persons at risk of misusing prescription drugs include[4] :
  - Those with past year use of other substances, including alcohol, heroin, marijuana, inhalants, cocaine, and methamphetamine.
  - People who take high daily dosages of opioid pain relievers.
  - Persons with mental illness.
  - People who use multiple controlled prescription medications, often prescribed by multiple providers.
  - Individuals with disabilities are at increased risk of prescription opioid misuse and use disorders.[5]
- Among all fatal overdoses involving prescription opioids in Connecticut in 2019, the majority occurred among non-Hispanic whites, with male deaths occurring 1.3-2.8 times more frequently than females in each racial/ethnic group[6]
- The elderly population may be at risk of consequences of prescription drug misuse, as they use prescription medications more frequently

[1] NIDA, Misuse of Prescription Drugs Research Report
[2] NSDUH (2017-2018)
[3] Connecticut School Health Survey, 2019 (CT YRBSS)
[4] Bali V. Research in Social and Administrative Pharmacy 2013; 9(3): 276–287.
[5] Lauer EA et al. Disability and Health Journal 2019;12(3):519-522
[6] Connecticut Office of the Chief Medical Examiner, 2019

compared to the general population and may be at higher risk of medication errors[7]
- According to the 2019 Connecticut School Health Survey, Hispanic students had the highest rates of taking prescription drugs without a doctor's prescription (14.2%), significantly higher than White non-Hispanic students (8.0%). The rates among Black students (12.8%) were also significantly higher than White non-Hispanics. The NMUPD rates were slightly higher among females (11.3%) than males (9.1%).[3]

Region 4 youth in grades 7-12, 80% perceive misusing prescription drugs is risky. This is the highest perception of risk among all substances. However, key stakeholders from the 2020 Community Readiness Survey reported prescription drugs as the substance or second highest of concern for ages 66 or older (39%).

Burden (consequences)

- Prescription opioid misuse is a risk factor for heroin and other illicit opioid misuse, including illicitly manufactured fentanyl. While the estimated proportion of individuals who transition to heroin following prescription opioid misuse is low (<5%), a majority of those who use heroin initiated opioid use with non-medical use of prescription drugs (NMUPD).[8,9]
- According to reports from the Office of the Chief Medical Examiner (OCME), Connecticut experienced 1,127 opioid-involved fatalities in 2019, including 131 that involved a prescription opioid; 92 involved oxycodone, 20 oxymorphone, 14 hydrocodone, 15 tramadol, and 14 hydromorphone.[6]
- Approximately 12% of all opioid overdose fatalities involved a prescription opioid, but only 15% of those overdoses involved only the prescription opioid. The majority involved multiple substances; 54% also involved fentanyl, 38% involved benzodiazepines, and 20% involved heroin.[6]

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

Capacity and Service System Strengths

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

	CT	Region 1	Region 2	Region 3	Region 4	Region 5
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

Key stakeholders who completed the Community Readiness Survey ranked their communities' stage of readiness to address these areas of concern 5.59 out of a scale of 1-9. This was comparable to other regions in the state and to the state average.

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

[7] Perez-Jover V et al. Int J of Environmental Research and Public Health 2018; 15:310.
[8] Jones CM. Drug Alcohol Depend 2013; 132:95-100
[9] Muhuri PK et al. CBHSD Data Review, 2013.
[10] DOJ/DEA Drug Fact Sheet http://www.dea.gov/

2020 Region 4 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]

Magnitude (prevalence)

In the United States, about 2 million adults meet criteria for severe gambling problems in a given year, and another 4-6 million (1-3%) would have mild or moderate gambling problems.[1]

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

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

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

- The Connecticut School Health Survey shows that 34.6% of high school males reported gambling, compared to 16.2% of females. The prevalence among 12th graders was significantly higher (31.7%) than any other grade (22.1%-24.3%). Differences among race/ethnicity were not statistically significant.[3]

Risk Factors and Subpopulations at Risk

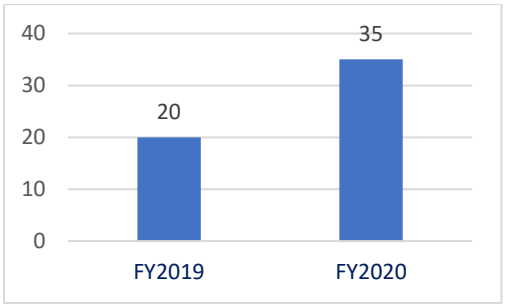
- Problem gambling rates double for individuals living within 50 miles of a casino.
- Among Region 4 youth in grades 7-12, risk factors for gambling include:
  - 22% of youth feel their friends think gambling is “not at all wrong/slightly wrong.”
  - 23% of youth perceive that gambling has “no risk/slight risk.”
  - 12% report no clear family rules about gambling
  - 9% of youth believe their parents think that youth gambling is “not at all wrong/slightly wrong.”
  - Being male, more males have gambled in the past month (2.61%) and for all noted risk factors above, males were more likely to experience them than females.

[1] National Council on Problem Gambling
[2] American Psychiatric Association, Gambling Disorder
[3] Connecticut School Health Survey, 2019

[4] Youth Voices Count Survey, (N=3,686, Nov 2019-March 2021) representing DataHaven Community Types; Urban Periphery, Suburban and Rural
[5] Risk Factors for Developing a Gambling Problem, Centre for Addiction and Mental Health (CAMH)

Burden (consequences)

Region 4 Gambling Treatment Admission Estimates[6]:



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

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

Capacity and Service System Strengths

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

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

Region 4 has the second lowest perceived ability to raise awareness of problem gambling/gaming addiction, of all DMHAS regions, as well as the state. Only 28.6% of region 4 respondents said that community ability to raise awareness was medium/high, compared to 33.8% of respondents statewide.

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

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

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

The PAWs Program, in which teens are helping each other notice the warning signs of gambling and learn that it is not just a risk-free game.

The Congregation/Community Assistance (CAP) Program, which is specifically designed for faith communities and civic groups.

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

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

[6] Better Choice Gambling Treatment, Wheeler Clinic (unduplicated, new EMR system may underrepresent)

[7] 2020 Community Readiness Survey Results, Region 4, Amplify, Inc., August 2020

[8] 2021 Regional Priority Needs Assessment, Amplify

2020 North Central Region (Region 4) 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]

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

Magnitude (prevalence)

Data from the 2018-2019 National Survey on Drug Use and Health (NSDUH) showed 4.5% of adult respondents (18+) in Connecticut reported having serious thoughts of suicide in the past year.[5] This percentage is higher among those 18-25 years old (12.4%) compared to those 26+ (3.2%).[5] Additionally, .4% of Connecticut adult 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
2014-16	3.62	3.45	3.65	4.42	3.35	3.65
2016- 18	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.[6] In 2019, 6.7% of high school students reported attempting suicide one or more times during the past year.[6]

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

Region 4 experienced an increase in the percent of people 18+ old reporting serious thoughts of suicide from 2014-16 to 2016-18. This increase is consistent with the statewide increase for the same time period.[5]

For youth, school survey data reveal that upwards of 10% of Region 4 youth reported having considered suicide in the past year. This is lower than the statewide average. However, regional youth anxiety focus group and survey data indicate that this may be on the rise. [8]

Risk Factors and Subpopulations at Risk

- On average, men account for 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 factor for suicide, including depression, anxiety, bipolar disorder, and general depressed mood.[3]
- For those over 45 years old, other risks include physical illness, such as terminal illness and chronic pain, as well as intimate partner problems.[3]

[1] CDC (2019). Suicide Prevention
[2] NIMH (2019). Suicide
[3] CT DPH (2018). CTVDRS, Violent Deaths: CT Data 2015 to 2018
[4] CT OCME (2019). Annual Statistics: Suicides
[5] NSDUH 2018-2019
[6] Connecticut School Health Survey, 2019 (CT YRBSS)
[7] Connecticut BRFSS 2018
[8] Amplify Youth Anxiety Review, 2020

Other risk factors include[1]:

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

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

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

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

Burden (consequences)

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

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

Capacity and Service System Strengths

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

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

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

As the Regional Behavioral Health Action Organization for North Central CT, Amplify leads a Regional Suicide Advisory Board that meets monthly to plan and implement programs to increase awareness and assist local communities to develop postvention response plans. A series of training programs have been offered by the RSAB and/or in the region including: QPR Train the Trainer, QPR Gatekeeper and NARCAN training, Talk Saves Lives, and Postvention Response trainings including the CONNECT NAMI New Hampshire 2-day training.

In addition, numerous health systems and providers participate in the CT Suicide Advisory Board Zero Suicide Learning Community (ZSLC). Multiple hospitals and

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

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

community-based care providers are implementing the Zero Suicide framework within their care delivery system. Examples include Hartford Healthcare (ZSLC co-chair), Connecticut Children's, Bristol Hospital, and Community Health Resources.

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

2020 North Central Region (Region 4) Epidemiological Profile: Tobacco and ENDS

Problem Statement

According to the National Survey of Drug Use and Health (NSDUH) and the Youth Risk Behavior Surveillance Survey (YRBSS), tobacco use has decreased for all age groups over the past decade. NSDUH data show that past month tobacco product use among Connecticut residents 12+ declined significantly from 25.3% in 2008-2009 to 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 (prevalence)

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

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 (Region 4 is made up of primarily suburban and urban periphery communities), and lower in wealthy communities (14%).[4]

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

Risk Factors and Subpopulations at Risk

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

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

Populations most at-risk for using ENDS are:

- Youth (12-17)[6]
- Young adults (18-34)[1]
- Males[1]
- Hispanics[1]
- Current smokers
- Those living in urban communities[4]
- Adults from households earning less than $35,000[2]
- Adults with disabilities[2]
- Those with a high school diploma or less[2]
- Adults without health insurance[2]

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

2020 North Central Region (Region 4) Epidemiological Profile: Tobacco and ENDS

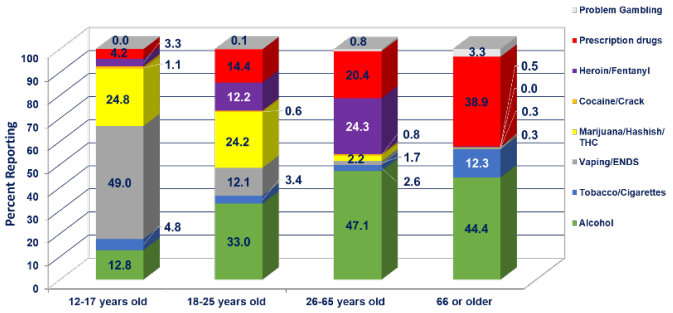
NSDUH substate estimates (2019) show that in region 4, 73% of respondents age 12+ perceived great risk from smoking one or more packs of cigarettes per day, in comparison to the 75% in the state.

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.

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

Problem Substances of Greatest Concern for Age Groups, According to Key Informants: Amplify CRS, 2020



Burden (consequences)

- Evidence shows that young people who use e-cigarettes may be more likely to smoke cigarettes in the future.[6]
- A recent CDC study found that 99% of e-cigarettes sold in the US contained nicotine, which can cause harm to parts of the adolescent brain that control attention, learning, mood, and impulse control.[6]
- E-cigarette aerosol can contain several potentially harmful substances, including diacetyl (in flavorings), which is a chemical linked to serious lung disease. It can also contain volatile organic compounds, cancer causing chemicals, and heavy metals such as nickel and lead.[6]
- Some ENDS devices, including those that are particularly popular among youth, have been modified to allow for higher doses of nicotine to be delivered. They also facilitate the use of THC, and in higher potency. This is especially problematic in youth use, because of the increased risk of tobacco and cannabis use disorders later in life.[7]
- As of January 7, 2020, a total of 2,602 cases of e-cigarette or vaping product use-associated lung injury (EVALI) had been reported to the CDC across all 50 states, the District of Columbia, Puerto Rico and the U.S. Virgin Islands. Of these, 57 resulted in deaths. The median age of these patients was 24 years old, and 62% were between 18 and 34 years old. EVALI appears to be primarily driven by the use THC-containing vaping products, possibly due to substances, such as vitamin E acetate, added to the formulations. [7]
- Qualitative feedback from Region 4 stakeholders indicates a critical lack of youth nicotine cessation programs within the state.

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

Key stakeholders who completed the Community Readiness Survey ranked their communities' readiness to address these areas of concern 5.59 out of a scale of 9. This was comparable to other regions in the state and to the state average.

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

Based on these rankings, areas of strength are:

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

As the Regional Behavioral Action Organization for North Central CT, Amplify offered DMHAS funded mini grants to each of our local communities to develop and implement programs to inform their residents about the risks of using vape devices. A barrier to implementation of these programs were the many Co-VID related school closures that limited access to students. As well, local energy and resources had to be redirected to programs that addressed the basic needs of residents facing illness and loss of income during the pandemic. In spite of these obstacles several communities have developed strong educational programs to help their students quit vaping. Mini-grant funding will continue into 2021-2022.

Emerging Issues:

Alcohol use in the U.S. is a public health problem that appears to have worsened since the onset of COVID-19. Although we do not have studies for alcohol sales specifically for Region 4, recent news reports indicate a surge in alcohol sales at the regional as well as nationally. Nielsen reports alcohol sales in stores were up 54% in late March compared to that time last year, while online sales were up nearly 500% in late April.[6] One survey was conducted by Pollard and colleagues using data from the RAND Corporation American Life Panel, a nationally representative probability-sampled panel of adults.[7] "Our study shows that people drank more frequently, and for women in particular, more heavily, and with more negative consequences, during the initial stages of COVID-19 compared to their own behaviors from a year earlier," Pollard said. He added that alcohol consumption is associated with a variety of negative physical health outcomes including high BP, heart disease, liver disease, lung disease and acute respiratory distress syndrome, and mental health outcomes such as depression and anxiety. **"Health care providers, the public and their families should all be mindful of changes in alcohol use during this stressful time and aware of the risks they involve."**

Survey and focus group participants expressed concern about the impact of CoVid on the mental health of our communities. Town and school personnel from Region 4 communities report the need to shift priorities, time, and resources in response to residents struggling with meeting basic needs, coping with school closures, social isolation, grief, trauma, and loss. Behavioral health providers and school staff report that children and youth are presenting with higher levels of acuity as a result of the pandemic. Emergency departments and inpatient levels of care cannot decompress without the availability of community-based care options. Of concern is the number of providers of substance use and mental health services who are struggling because of Co-VID office closures, the adjustment to offering assistance via telehealth, the volume and high acuity of people coming for treatment, and the stress of not being able to meet the needs of their patients due to high caseloads and staff turnover. Several providers indicated that their seasoned workers left to open their own private practices, leaving new and less experienced staff to work with people with serious and complex needs. **The need for behavioral health services has increased, but the workforce has been able to expand in response to the need.** With the rise in acuity and demand for support, the strain on the system further highlights the need for all youth, regardless of insurance, to have access to a comprehensive system of care and investment in our workforce including workplace wellness programs for those providing care.

In spite of the social isolation imposed by CoVid19, some improvements have been identified in outpatient treatment due to relaxed rules and available funding for telehealth services.

[6] Nielsen CGA: COVID-19: Measuring the On Premise Impact

[7] Changes in Adult Alcohol Use and Consequences During the COVID-19 Pandemic in the US
Michael S. Pollard, PhD et al., September 2020

Providers report a decrease in no-show appointments and a new ability to view the individuals in their home environment. Individuals in recovery report less frustration over transportation barriers. Individuals seeking Methadone treatment are less dissuaded by having to stand in line daily at a facility. Both individuals and providers alike indicate they hope some of the positive experiences by a forced reliance on telehealth are not sacrificed if and when things return to "normal. Many Amplify members rely on audio-only telephone access for telehealth services. They are covered by Medicaid and qualify for free phones through the Lifeline Assistance program. Most do not have computers or access to Wi-Fi in their homes. They tend to rely on Recovery Clubhouses managed by their behavioral health providers or local libraries to access Wi-Fi. During much of the pandemic both options were closed and cut off to them. Even when they became available, they did not offer needed privacy for participation in healthcare appointments. For a brief time, people using Lifeline Assistance program phones also had unlimited data and minutes, so they readily used their phones for telehealth and did not have to worry about running out of minutes during their therapy session. Once that disappeared, those unlimited data and minute features ended, leaving many of our members struggling to figure out whether to pay for their medication, food, rent, or for additional minutes for therapy and psychiatry appointments. The FCC has recently established a Broadband Benefit Program that provides a temporary discount for broadband services and equipment. Programs such as this must continue and expand to **address the digital divide experienced by people living on limited income.**

After a brief decline in 2018 overdose rates from illicit substance use have continue to rise, reaching a record high in 2020 (CT: 1372; (Region 4: 360). As well, we are beginning to see significant changes in drug use during to CoVid 19 pandemic.[8] Per Dr. Joseph Stanton's report, overdose deaths from Heroin and Prescription Opioids across the nation have decreased, however deaths from methamphetamines, cocaine, and synthetic Opioids (primarily fentanyl) have all increased. **Illicit fentanyl contributes to the majority of deaths, but stimulant-involved deaths are also increasing.** Given that there is no antidote like NARCAN for a methamphetamine overdose and no FDA-approved medications indicated for methamphetamine use disorder, the increase in methamphetamine use is even more alarming. In Region 4 there were 16 overdose deaths involving methamphetamines with 15 of those involving multiple substances.[8] Although not an increase from 2019, this still a trend to be watched. **Of concern is the number of overdose deaths involving multiple substances.** According to the CT Office of the Medical Examiner, Region 4 had 360 overdose deaths in 2020 (29% of the CT total). 305 of the 360 involved fentanyl. 297 involved more than one substance.[9] Of equal concern is the misuse of prescription drugs and overdose deaths that have occurred with counterfeit prescription medications, obtained other than through a pharmacy that have been contaminated with toxic and illicit substances. The Department of Drug Enforcement has recently issued warnings regarding the **increase in sale**

[8] Evaluation of National, Regional, and State Drug Use Trends Utilizing Near-Real Time Urine Drug test Results, Joseph D Stanton, PhD, April, 2021`

[9] CT OCME, 2020

and use of counterfeit pills and advises the public to obtain prescription drugs only from state-licensed pharmacies.[10] **Amplify, along with the other 4 RBHAOs is current working a consultant on a campaign (to be launched in the fall of 2021) to create awareness about dangers of counterfeit medications.**

Of positive note is a decrease in deaths by suicide in 2020 across the nation (6%) and particularly in CT (17%). Dr. Christine Yu Moutier, Chief Medical Officer for the American Foundation for Suicide Prevention (AFSP), the nation's largest suicide prevention organization, released the following statement regarding the CDC's provisional data: "The reported decrease in deaths by suicide makes us hopeful that protective mental health measures are having a positive impact amid a time of collective distress." This decrease in the total number of suicide deaths may not be a decrease in suicide deaths for all groups- as the pandemic has had a disproportionate effect on particular populations. We do not yet have the data to consider suicide in specific populations based on demographic factors such as age, gender and racial/ethnic background or social determinants such as income, access to health care and stressors that minoritized communities may experience**. As noted in our RBHPSW discussion on page 12, for Black youth ages 10 to 19 years, suicide is the second leading cause of death; their suicide death rate has nearly doubled over the past ten years and is increasing faster than any other racial/ethnic group.**[11]

The Co-VID public health crisis highlighted something we already knew— the experience of homelessness is unacceptable. When people have access to safe and stable housing, their health outcomes (Including behavioral health outcomes) improve. Among those of greatest risk when the CoVID pandemic hit, were people experiencing homelessness. In immediate response to the public health emergency declaration, regional homeless service provider organizations worked with the state Department of Housing to decompress shelter capacity and reduce the risk of spread. The state secured hotel contracts across Connecticut and moved over 830 households from shelter to safer temporary living conditions. Once significant numbers of households were moved from streets and shelters to safe, temporary accommodations, the focus broadened from prevention of acute COVID-19 spread to the goal that no one returns to homelessness. In Region 4 these efforts were led by housing coalitions all working under the leadership of the Partnership for Strong Communities. Their efforts continue to be challenged by the lack of affordable housing in CT. The Partnership's Reaching Home Campaign has as its mission to make homelessness in Connecticut rare, brief, and one-time by 2023. Amplify is represented on the Partnership's working group to **ensure the supportive housing needs of people with behavioral health concerns are addressed.**

With the passage of legislation that legalizes online gaming and sports wagering, online casino games and wagering on sporting events will soon be available in the state. Although, for some, this will create new recreational opportunities, it will make life harder for people with

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

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

gambling addictions. Of concern is the lack of awareness about problem gambling and treatment resources among Region 4 residents. In response to our survey and focus group question "How appropriate and available problem gambling services to meet the need in the areas of prevention, treatment, and recovery supports," the majority of respondents said, "I don't know." On the 2020 Community Readiness Survey, Region 4 key stakeholders gave a low rating to their communities' ability to raise awareness of problem gambling. Only 28.6% of respondents said that community ability to raise awareness was medium/high, compared to 33.8% of respondents statewide**. Clearly there is much work to be done by our Regional Gambling Awareness Team.** Subpopulations of greatest concern to Region 4's survey and focus group participants were Veterans, Blacks, and young adults. Members of the Regional Gambling Awareness team recommended targeted outreach to these groups as well as a targeted focus on the crossover between gaming and gambling.

With the passage of legislation that legalizes recreational use of marijuana, concerns on the part of the prevention and service delivery systems focus on increased use and decreased perception of harm by young people. According to 2019-2020 aggregated student survey data from Region 4 communities, among students in grades 7-12, 8.75% had used marijuana in the past month. This was the second highest substance of use, second only to alcohol use. School survey data was limited due to the number of school closures as a result of the pandemic; therefore, we have limited information about the impact of CoVID or the presence of marijuana in vape devices. Both have been described during our focus groups and growing problems. In fact, key stakeholders from the 2020 Community Readiness Survey regarded marijuana as the second highest problem substance of greatest concern for all substances only second to vaping/ENDS among 12-17 years old. Region 4 Communities have been funded through their Local Prevention Councils to address concerns regarding teen vaping. Given their concern about the presence of cannabis in confiscated vape devices, it will be important to continue to use continued funding to better understand and address these issues. It is anticipated, with the re-opening of our schools, Local Prevention Councils will have greater opportunity to address the risks associated with cannabis use with the student population.

Resources, Strengths, Assets:

Having the option of telehealth has made it easier to access behavioral health services, especially if transportation was a barrier. (See further discussion on page 41 in the Emerging Issues section)

The Connecticut Department of Social Services (DSS) is ready to file for **1115 Demonstration Waiver for SUD inpatient and residential treatment** for adults and children under fee-for-service (FFS). This will allow CT to receive federal funding for large SUD residential and hospital treatment facilities that were historically only State funded. It will require CT to improve access to and delivery of all SUD treatment. It is expected to improve coordination of care, especially for transitions between levels of care. Peer support services are funded as part of the service array. These will be positive developments as peer support services and coordination of care were priority issues identified in the Region 4 Priority Needs Assessment survey and focus groups.

It is also hoped that additional federal funding will allow for more flexibility regarding length of stay and expansion of services where needed (i.e., detox programs and residential programs for adolescent girls).

With the passage of the Police Accountability bill this session, there is **hope for improved coordination between Mobile Crisis Services and Law Enforcement.** DMHAS has established a Mobile Crisis Response Learning Collaborative (MCRLC) is working to enhance DMHAS funded mobile crisis services (to include peer support staff and better collaboration with faith and other community resources). A central call number and system has been created through United Way 2-1-1. The MCRLC is working with a SAMHSA Technical Assistance team to develop further enhancements. There has been a significant investment on the part of CT to train CT law enforcement officers in crisis intervention and an approach to crisis intervention that requires collaboration between law enforcement and behavioral health providers. This Crisis Intervention Team (CIT) training, provided by CABLE, funded by DMHAS, and offered to both law enforcement and mobile response teams, provides excellent support for this collaboration. Amplify staff were surprised to learn that many of our community members were not aware of this program or the availability of CIT trained personnel. Region 4 has the good fortune of having two collaborative arrangements between law enforcement and DMHAS-funded mobile crisis teams that serve four of its towns. These are grants that are meant to be short term and require plans to sustain the funding and collaboration. Recently the City of Hartford issued a Request for Proposals for a response to crisis calls stemming from emotional distress, but not needing the level of intervention required by mobile crisis staff. It is a good effort on the part of the city to reduce the involvement of law enforcement (and its inherent risks) for responding to people in emotional crisis.

With the passage of Senate Bill 1, racism has been declared a public health crisis in Connecticut, The legislation creates a cross-sector Commission on Racial Equity in Public Health, tasks this Commission with creating a strategic plan for addressing health equity, and standardizes the way the state collects race, ethnicity, and language (REL) among other important provisions. The collection of REL data is critical to understanding how different subgroups identified in our report could be better served. Amplify has had to the good fortune to have **worked in close partnership with Health Equity Solutions, the UConn Health Disparities Institute, and the Ministry Health Fellowship,** all who have worked tirelessly on these issues.

The Governor's Alcohol and Drug Policy Council (ADPC) and its subcommittees are very active, and their initiatives have led to many service system improvements for prevention, treatment, and recovery. Examples include promotion of Recovery Friendly Communities (2 in Region 4), a new initiative to promote Recovery Friendly Workplaces, training, and increased commitment by providers to embrace and implement harm reduction principles, and opportunities for medication assisted treatment induction in emergency departments, mobile outreach vans, jails, and prisons. Region 4 has benefited from Amplify's role on the council as Senator Kissel's designee and has representation on the treatment and recovery subcommittees.

Region 4 has the good fortune of the presence of 4 behavioral health providers who were awarded CCBHC Expansion Grants to enhance their enhance its existing services for children, families, and adults with mental illness, and substance use disorders. The grants provide for expanded and open access service hours, community outreach, better integration of behavioral and physical health and co-occurring mental health and addiction issues, wellness programs and peer support. Several focus specifically on veterans and their families, people who were formally incarcerated, and children with serious emotional challenges. All the towns and cities in Region 4 are covered by these expanded services. A representative of each came to our May 2021 Catchment Area Council meetings to describe their services and outcomes after one year of working under the grants.

DMHAS and DMHAS-funded providers have demonstrated a strong commitment to developing and maintaining recovery support services. Peer support programs like CCAR's telephone recovery support, community center support groups and recovery coach training, Advocacy Unlimited's TOIVO, Peer Bridger, Recovery University, and Hearing Voices Network are highly regarded. There are four Hearing Voices support groups in the region and several Region IV providers host Warm Lines staffed by individuals in recovery. CCAR Recovery Coaches are available in five Region 4 hospital emergency rooms. Other strengths noted by focus group participants were jail diversion programs offered by local mental health providers and the re-entry collaboratives in New Britain and Hartford that support people coming out of incarceration. Also noted were an increase in intensive outpatient and in-home services for teens. Region 4 Clubhouses have always been noted as a service system strength; however, Co-VID forced their closure this past year. Several hosted outdoor and on-line events whenever possible.

All the Region 4 Local Mental Health Authorities (LMHA) offer medication assisted treatment ("MAT"). In addition, MAT is offered in seven hospitals, five-Wheeler clinics, four Root Centers (formerly known as the Hartford Dispensary), three Community Health Centers, and a variety of other private and non-profit settings. Locations and types of treatment available are listed on the Beacon Health Options Medication Assisted Treatment Locator Map. Three Supported Recovery Houses and 4 Certified Sober Homes are listed on the DMHAS bed availability list. The region has at least four active Opioid work groups addressing prevention, treatment, and recovery issues in their communities. There are many recovery support groups in the region including 9 "SMART" recovery programs specifically for youth. To date over 70 NARCAN trainings have been hosted in Region IV communities with over 2000 NARCAN kits distributed. A growing number of towns in the region have initiated Hope or Hope-like initiatives to divert individuals struggling with addiction to treatment instead of incarceration. Twenty-seven communities have prescription drug drop boxes, and 25 communities conduct annual prescription drug take back events.

2019-2020 aggregated student survey data from Region 4 communities reflects a 2.1% increase in past month alcohol use in individuals 12+ years old. The data in Region 4 also reflects that past month binge drinking in ages 12+ was 27.8% in comparison to the state average of 28.6%.

Region IV has a strong Bettor Choice provider for treatment of problem gambling and a Gambling Awareness Team with ten professionals certified in Problem Gambling, Amplify hosts an annual youth-led gambling awareness conference, which includes a presentation of youth-developed PSAs on problem gambling and gaming. Problem gambling is also addressed in student youth surveys. Amplify hosts Community and Congregational Awareness Programs to increase awareness about problem gambling. Region 4 also supports a successful ambassador program designed to address problem gambling concerns specific to the Asian American and Pacific Islander community. AAPI Ambassadors offer outreach, training, and resources for Asian American communities – all in the primary language of the recipients.

GIZMO's Pawesome Guide to Mental Health Curriculum is highly regarded as an education campaign to help youth, their trusted adults, and the settings in which they live to support their mental health and create a greater sense of individual and community connectedness. The program strengthens mental wellness and reduces the risk of many negative health outcomes, most importantly poor mental health, and suicide. An increasing number of Region 4 schools are utilizing the curriculum. Connecticut's www.preventsuicidect.org provides a wealth of resources on its website for prevention, crisis response, and toolkits for the aftermath of a suicide. As the Regional Behavioral Health Action Organization for North Central CT, Amplify leads a Regional Suicide Advisory Board that meets monthly to plan and implement programs to increase awareness and assist local communities to develop postvention response plans. A series of training programs have been offered: Trainer of Trainers in a combination of QPR and NARCAN, Talk Saves Lives, and Postvention after a Suicide. In addition, numerous health systems and providers participate in the CT Suicide Advisory Board Zero Suicide Learning Community (ZSLC). Multiple hospitals and community-based care providers are implementing the Zero Suicide framework within their care delivery system. Examples include Hartford Healthcare (ZSLC co-chair), Connecticut Children's, Bristol Hospital, and Community Health Resources. Last, Amplify is an active member on the CTSAB Legislative Advocacy Working Group that aims to increase legislative support for suicide prevention efforts in Region 4.

Region IV has the good fortune of having a First Episode Psychosis program through Hartford Health Care's Institute of Living that accepts referrals for these needed services. This is a specialty program designed for people who are experiencing the early stages of a psychotic illness. The program includes individual and group psychotherapy, medication management, family education and support services and cognitive remediation.

Region IV is fortunate to have two hospitals offering Geriatric Behavioral Health services, one at the Institute of Living in Hartford and one at the Eastern CT Health Network in Manchester.

Resource Gaps and Needs:

Region 4 survey and focus group participants were asked how appropriate and available they found services to be in the areas of mental health, substance use, problem gambling and suicide prevention. In all cases they rated the services to be more appropriate and available than not. (For further detail see the Appendix, Q3-6).

Prevention

Region 4 survey and focus group participants were asked to identify what following prevention programs, strategies, or policies they would like to see accomplished related to mental health, substance misuse, suicide, and problem gambling. The following areas of need were identified: **funding, universal screening, family support and education, youth programs, substance misuse, and suicide prevention awareness and education programs**.

There was overall agreement that **more funding should be dedicated to prevention** and that funding should be **flexible and responsive to local needs**.

Participants want DMHAS to help push out **universal screening** using SBIRT and Adolescent SBIRT screening tools. Emphasis should be on physician's office, hospitals, and school health educators. All youth should be screened for anxiety, depression, substance use, trauma, and problem gambling issues. Connections to trusted adults and community treatment resources should be explored and reinforced.

Families need additional support and education. Support should address the impact of substance misuse on the user and the entire family. Education should include information about available community resources in lieu of law enforcement intervention in times of crisis.

Work with youth should focus on developmental assets, resilience training and emotional intelligence strategies starting at early ages. There should be more focus on what makes them feel competent and happy vs. avoiding the things that put them at risk or make them sad. There should be more in-school and after school activities to keep them involved in their community. Support should focus on underlying trauma and care should be trauma informed. Schools should partner with local coalitions to provide additional support and education in health classes.

Substance misuse education should focus on the substance of concern vs. the devices (i.e., ENDS). With the passage of legislation that legalizes recreational use of marijuana, concerns on the part of the prevention and service delivery systems should focus on increased use and decreased perception of harm by young people. Accurate information should be provided to youth and families about the effects of substance on the brain. Tertiary prevention programs for substance use disorder should be provided in school settings that address prevention when students have already begun experimenting with substances.

According to the Office of the Chief Medical Examiner's Office, for the years 2015-2019, there are 28 towns in Connecticut have experiences 20 or more losses to suicide. Nine (9) of these towns are in the North Central Region (32%). There continues to be a need for more awareness and training about suicide prevention and postvention. This should include training for town personnel, school staff and students, more public marketing, billboards, and anti-stigma campaigns. Through the CT Suicide Advisory Board, a good communication system has been established to inform and initiate a postvention response when there has been an untimely death of a young person. There is no similar system in place for adults or for the surviving family

members. Participants were hopeful that there would be more funding and support for Regional Suicide Advisory Board to improve system outcomes including postvention planning in all Region 4 communities.

Mental Health Treatment and Recovery Supports

Region 4 survey and focus group participants were asked to identify treatment levels of care they felt were unavailable or inadequately provided.

- The following were the top 3 areas of need identified for mental health: **Emergency or crisis response, integration of primary and behavioral health care, and inpatient, partial hospitalization, and intensive outpatient levels of care**.
- Region 4 survey and focus group participants were also asked to identify the recovery supports most needed. Those were: **Case management/community support services, care coordination for children and families, and supported employment**.
- Also, of note were the priorities identified by the Regional Behavioral Health Priority Services Workgroup (RBHPSW): These were: **depression, anxiety, and suicide**.

As described in the Resources/Strengths/Assets section on page 44 of this report, DMHAS has been working to improve **mobile crisis response services** for several years. Slow progress has been made and the passage of Police Accountability legislation will help promote better collaboration with law enforcement. However, DMHAS Mobile crisis services have been underfunded for at least the past 10 years. This has resulted in reduced hours of operation and limited availability for arriving to the scene when a collaborative approach to crisis is needed. With the infusion of Federal Co-VID Recovery funds, we hope hours can be increased. **Availability of a 24/7 response is needed.** As well, we need to **increase reliance on other supports** that are available in local communities. For example, most communities have one or more **urgent care center**, many of which are connected to a healthcare provider with behavioral health expertise. How can we ensure behavioral health can be better integrated into these settings as an alternative to going to a hospital emergency department? A gap raised by Mobile Crisis staff is that they are not always knowledgeable about **natural supports** available to people in their communities to prevent crisis or offer follow-up support post crisis. DMHAS has recently arranged for some technical assistance to follow through with an asset mapping process to address this issue.

As described in in the Resources/Strengths/Assets section on page 45 of this report, there has been an infusion of federal funding to promote better coordination and integration of primary and behavioral health care. Issues that survey and focus group members hope will be addressed include the following: **more consistent access to services throughout the continuum (inpatient to community-based care were mentioned), integrated coordinated care, one point of access, appointments within 24 hours, afterschool hours, insurance reimbursement for peer support, peer run respites, and use of alternative/wellness approaches** (i.e., holistic health, meditation, tai-chi, creative writing, massage, acupressure).

As described in the emerging issues section page 41 of this report, the need for behavioral health services has increased, but the **workforce has not been able to expand in response to the need.** DMHAS-funded providers describe a significant increase in volume, acuity, and complexity of need for the people who coming to them for care. Turnover and high caseloads are issues in many programs. Information about services remains difficult for families to utilize and navigate. **Treatment and support are needed for the whole family**, especially in families where the identified patient is resistant to treatment. **Peer support** is an effective engagement and support strategy for individuals and families. Continued investment in training and employing peer support specialists and recovery coaches is needed.

In our focus groups we heard from family members who participate in the North Central Network of Care and struggled with **navigating and accessing services for their children with significant behavioral health needs**. It is hoped that the advent a new program managed by Beacon Health Options, the Voluntary Care Management Program, will make a difference for these families. It is funded by DCF but is designed to work with families who need to be connected to appropriate services and supports without the stigmas of being relying on the children welfare system.

<u>Substance Use Treatment</u>

- The following were the top 3 areas of need identified by our survey and focus group participants for substance use treatment: **Inpatient rehabilitation (including detox), emergency or crisis response, and integration of primary and behavioral health care.**
- Region 4 survey and focus group participants were also asked to identify the recovery supports most needed. Those were: **Case management/Community Support Services, housing, and crisis response.**
- Also, of note were the priorities identified by the Regional Behavioral Health Priority Services Workgroup (RBHPSW): **Alcohol was the substance given highest priority by the group although heroin and fentanyl edged above prescription drug misuse and marijuana as a concern**.

Much discussion with the RBHPSW centered around the need for more inpatient residential options for substance use treatment. (For more detail, please see page 12 of this report. It is hoped that CT will be the recipient of a 1115 Waiver which could lead to more and better options in this area, including coordination of care, integration of primary and behavioral health, and assessment and treatment of co-occurring disorders. (For more detail, please see page 44 of this report).

DMHAS, Amplify, health care providers, the public and their families must all be mindful of the increase in alcohol use in response to the pandemic. (For more detail, please see page 41 in the Emerging Issues section of this report).

Housing concerns are one of the top priority issues that impact their recovery in our region. People with mental health and addiction issues face housing discrimination and encounter many

barriers to accessing stable, permanent housing. According to the Director of Connecticut's Department of Housing (DOH), Steve DiLella, "When we put someone in affordable housing, a lot of things get better." He shared that in a program specifically designed for individuals that cycle between the jail system and the homeless service system, the recidivism is usually 50%, but when placed in housing programs, the rate is only 10% to 13%. Director DiLella asserts, "Housing helps create a stable base for recovery." Nonetheless, people with mental health and addiction issues remain some of the most vulnerable groups in CT and in Region IV.

The **opioid crisis** continues to be a major area of concern. (For further detail, please see page 42 in the emerging issues sections of this report). Given issues with counterfeit medications and the presence of fentanyl in most overdose deaths, it is critical that education and availability of NARCAN needs to reach a wide audience of people who may be at risk of using substances without knowledge of the presence of Fentanyl. For this reason, members of the CT Alcohol and Policy Council have suggested further research into the need for NARCAN to be available only by prescription as opposed to an over-the-counter medication.

<u>Problem Gambling</u>

- The following were the top 3 areas of need identified by our survey and focus group participants for problem gambling services: **I don't know, peer support, and emergency or crisis response.**
- Region 4 survey and focus group participants were also asked to identify the recovery supports most needed. Those were: **I don't know, peer support, and Community Support Services**.

Survey and focus group results reflect a significant lack of awareness about resources and services for problem gambling among Region IV's general public. Discussion about populations of **greatest need focused on veterans and young people**. It was reported that some veterans do not want to talk with someone who is not a veteran. Also, veterans and military service personnel fear seeking treatment from the military Support Program because it might affect their clearances. Regarding teens and young people, the **cross over between gaming and gambling** needs further exploration. For other issues of concern please see page 43 in the Emerging Issues section of this report.

<u>Suicide</u>

The following were the top areas of need identified by our survey and focus group participants: **peer support, primary care, and inpatient**.

Region 4 survey and focus group participants were also asked to identify the recovery supports most needed. Those were: **Crisis response, community supports, and family/loved one support**.

(Please see pages 43 in the Emerging Issues Section, 47 in the resources/Strengths/Assets section, and 48 in the Resource Gaps and Needs section for further detail on our discussions with them)

VI. Recommendations for Region 4

Given the findings of this and similar studies, it is important for states to consider both economic and public health concerns when making decisions on U.S. alcohol policy in order to protect individuals, their families, and their communities from the longer-term impacts of increased alcohol intake.

Substance Use Prevention:

Regional:

- Continue efforts to reduce overdose deaths with focus on Amplify's equity goals; partner with local health districts (hot spots), trusted community leaders and grassroots outreach to highest risk communities. Host listening sessions and make use of data that includes race, ethnicity, and language (REL) to better focus our SOR funding on subpopulations at greatest risk for overdose and suicide.
- Work with the other RBHAOs and the Connecticut Prevention Network to launch an awareness campaign about counterfeit prescription medication misuse.
- Work with Local Prevention Councils and school districts to address increased use of cannabis and decreased perception of harm by young people (including use in vape devices)

State:

- Monitor and provide REL data re: alcohol, stimulants, and multiple substance overdose rates.
- Address issue of availability of NARCAN via prescription vs. over-the counter

Substance Use Treatment:

Regional:

- Promote ongoing dialogue between grassroots outreach efforts and behavioral health providers to address barriers for accessing treatment. In spite of extensive resources that have been available from federal grants for problem substance use treatment, our region and state continue to offer limited options for inpatient or residential rehabilitation

treatment. Continue to develop and advertise other effective approaches for providing treatment on an outpatient basis (in-home, connected to sober housing, mobile, MAT induction in hospitals and correctional settings) so that people are not overdosing while waiting for treatment.

- Represent regional perspectives in the ADPC treatment and recovery subcommittee recommendations for substance use system improvements.

State:

- Promote ADPC treatment subcommittee initiative to further harm reduction approaches and availability of medication assisted treatment in hospital, outpatient, and mobile outreach services. Provide education to treatment providers re: side effects and titration approaches for individuals who wish to reduce or discontinue MAT.

Substance Use Recovery:

Regional:

- Support the establishment of "Recovery Friendly Communities" and "Recovery Friendly Workplaces" using federal State Opioid Response mini-grant funding for Local Prevention Councils and Coalitions

State:

- Expand family support options

Mental Health Promotion:

Regional:

- Enhance reach of suicide prevention/mental health gatekeeper trainings with focus on Amplify's health equity goals and 2020 Youth Anxiety Review recommendations. Review Impact data for demographics/characteristics. Partner with local health and prevention leads (health districts, Local Prevention Councils) to tailor outreach to at-risk communities.

State:

- Expand opportunities for local/regional needs assessments to inform state-funded local/regional priority prevention programs. Ensure flexibility with use of Local Prevention Council mini-grant funding to ensure local prevention programs are responsive to local needs assessments.

Mental Health Treatment:

Regional:

- Promote Universal screening among primary care and health/behavioral providers to support early identification and improved connection to care/supports.
- Continue to explore options for mobile and tele-health options for people with limited income or living in rural communities for whom broadband access, equipment, and how to use are barriers to accessing services or participating in service system improvement initiatives.

- Continue to work in partnership with the Mobile Crisis Response Learning Collaborative (MCRSLC) to monitor and enhance mobile crisis response.

State:

- Ensure that youth, regardless of insurance, can access a comprehensive system of care.
- Invest in efforts that strengthen the behavioral workforce including those that support employee/workplace wellness and diversity.
- Promote emerging treatment models such as peer respite and walk-in urgent care for mental health, resulting in improved outcomes.

Mental Health Recovery:

Regional:

- Continue to increase leadership development opportunities for people in recovery and family/community members to inform systems improvement efforts, specifically with the regional network of six (6) Catchment Area Council Meetings
- Continue work with Partnership for Strong Communities workgroups to ensure the supportive housing needs of individuals with behavioral health challenges are addressed in their efforts to make homelessness a rare, brief, and one-time issue.

State:

- Support groups that advance opportunities for people in recovery and family/community members and inform systems improvement efforts, including the statewide network of Catchment Area Council (CAC)s, resulting in enhanced recovery-centered health policy decisions

Problem Gambling Prevention:

Regional:

- Review school survey questions used to measure perceived risk and use rates for problem gambling to address the overlap between computer gaming, sports betting, and gambling.
- Include computer gaming as a topic in all Problem Gambling training
- Continue partnership with the AAPI Ambassador program to include topics of trauma, mental health, and addiction in presentations to AAPI communities.

State:

- Provide support for expansion of training programs offered by AAPI Ambassadors (translation and training for Ambassadors)

Problem Gambling Treatment:

Regional:

- Work with the Regional Gambling awareness team to ensure Bettor choice treatment providers have capacity to address the needs of veterans and teens regarding new online sports betting and gaming issues.

State:

- Expand Disordered Gambling Integration Project (DigIn) in areas where Gambling has expanded in North central CT in connection with the Springfield Casino and increase promotion of Helpline in those same areas

Problem Gambling Recovery:

Regional:

- Engage leaders of Gamblers Anonymous for expansion of Gamblers Anonymous meetings in those areas where gambling has expanded

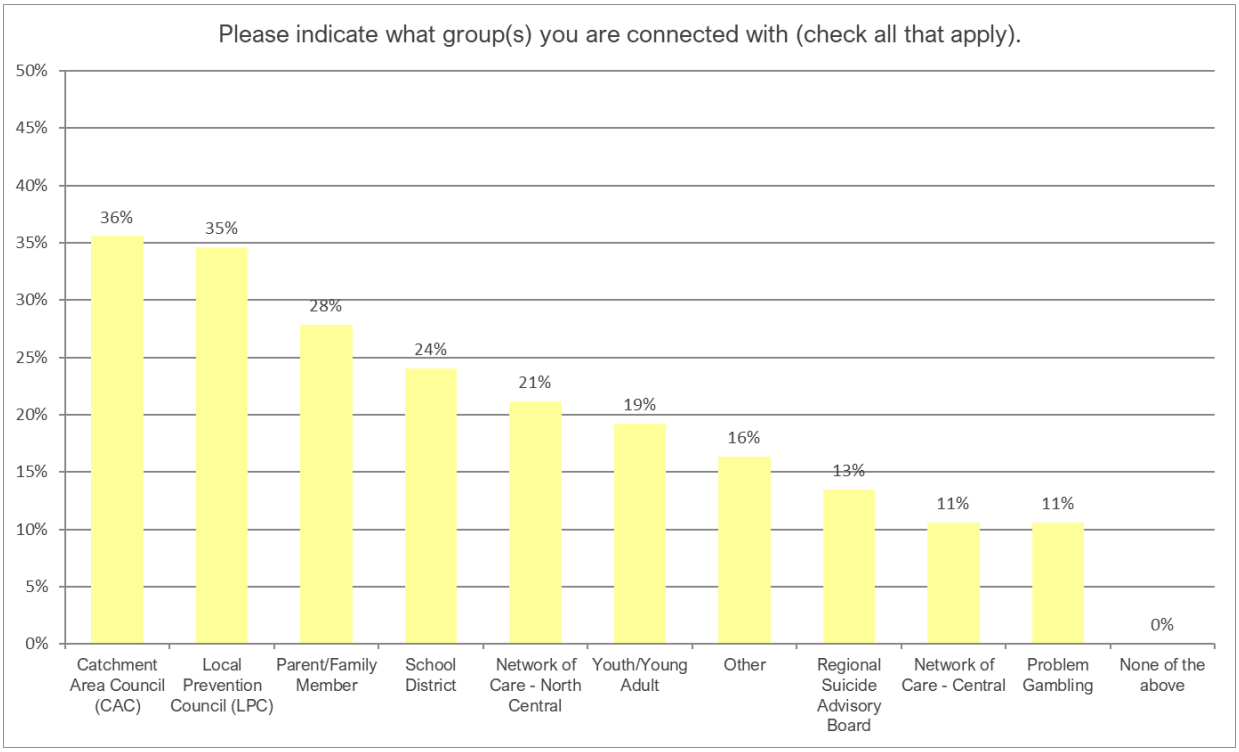
State:

- Promote inclusion of problem gambling/gaming in recovery coach and recovery support specialist training

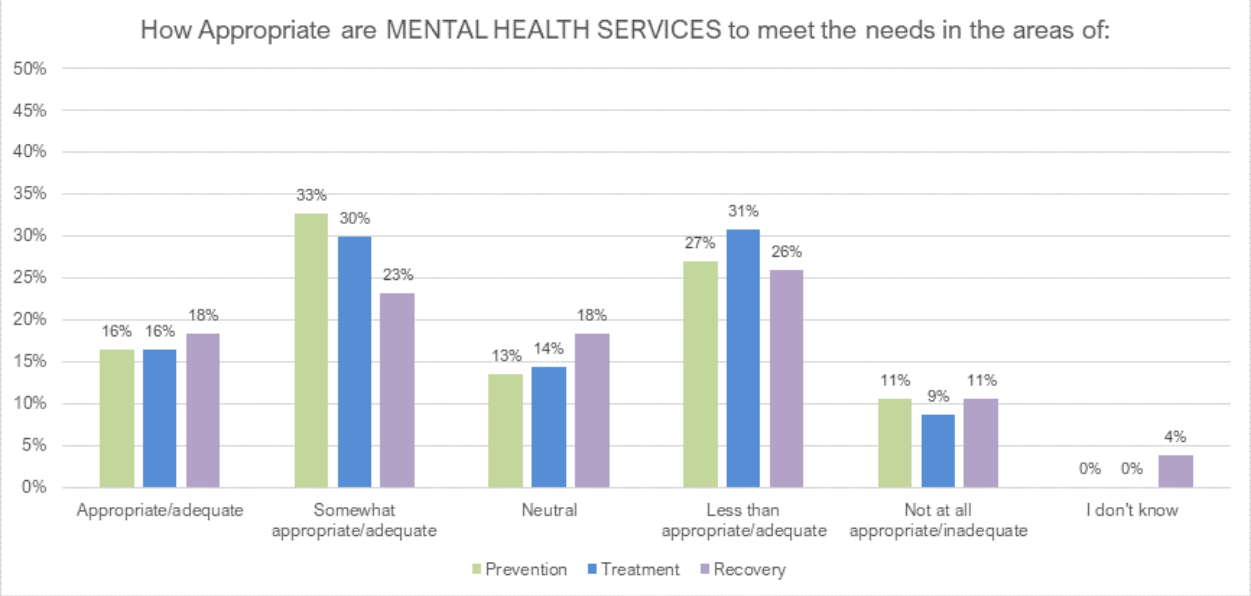
VII. Closing Comments

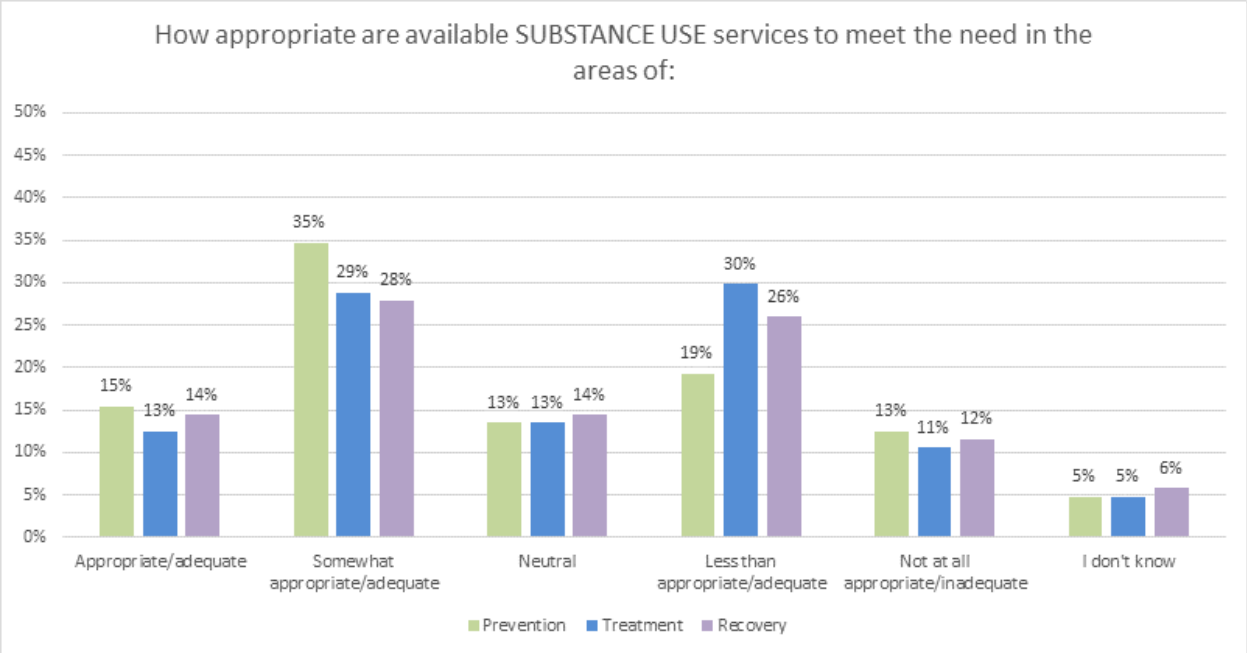
We thank DMHAS for this opportunity to involve recipients of mental health and addiction services, family members, providers, referral organizations and concerned citizens in this priority setting process. There is a strong desire on the part of RBHAOs to ensure that this process provides the needed information to DMHAS that will help set priorities and inform the budget and federal block grant application. There was much time contributed and earnest caring among survey and focus group participants and key informants that their participation would make a difference. We look forward to working with DMHAS to clarify and promote the recommendations in this report.

Appendix: Answer Summary Grid for DMHAS Required Stakeholder Questions



Q3-6: How appropriate (right fit - accessibility, quality, frequency, duration) are available. services to meet the need in the areas of Prevention, Treatment, and Recovery:




How appropriate are available SUBSTANCE USE services to meet the need in the areas of:
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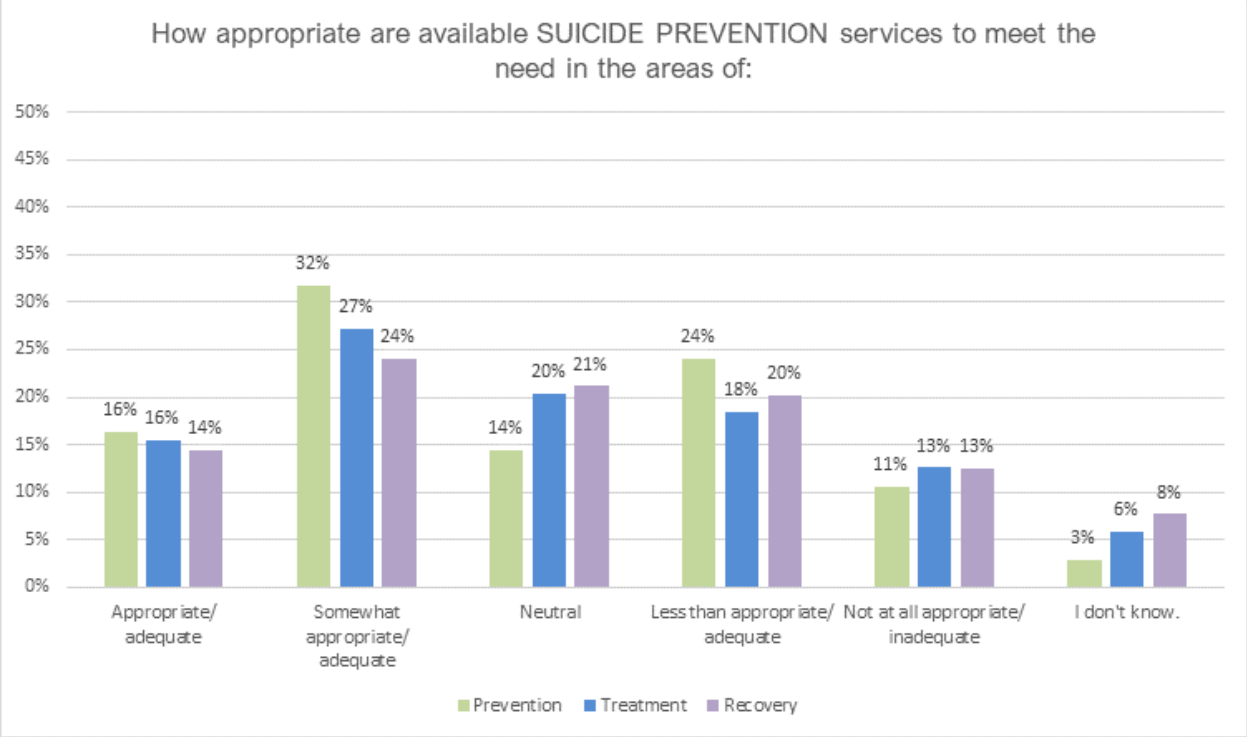
Appropriate/adequate
Somewhat appropriate/adequate
Neutral
Less than appropriate/adequate
Not at all appropriate/inadequate
I don't know
Prevention
Treatment
Recovery


How appropriate are available SUICIDE PREVENTION services to meet the need in the areas of:
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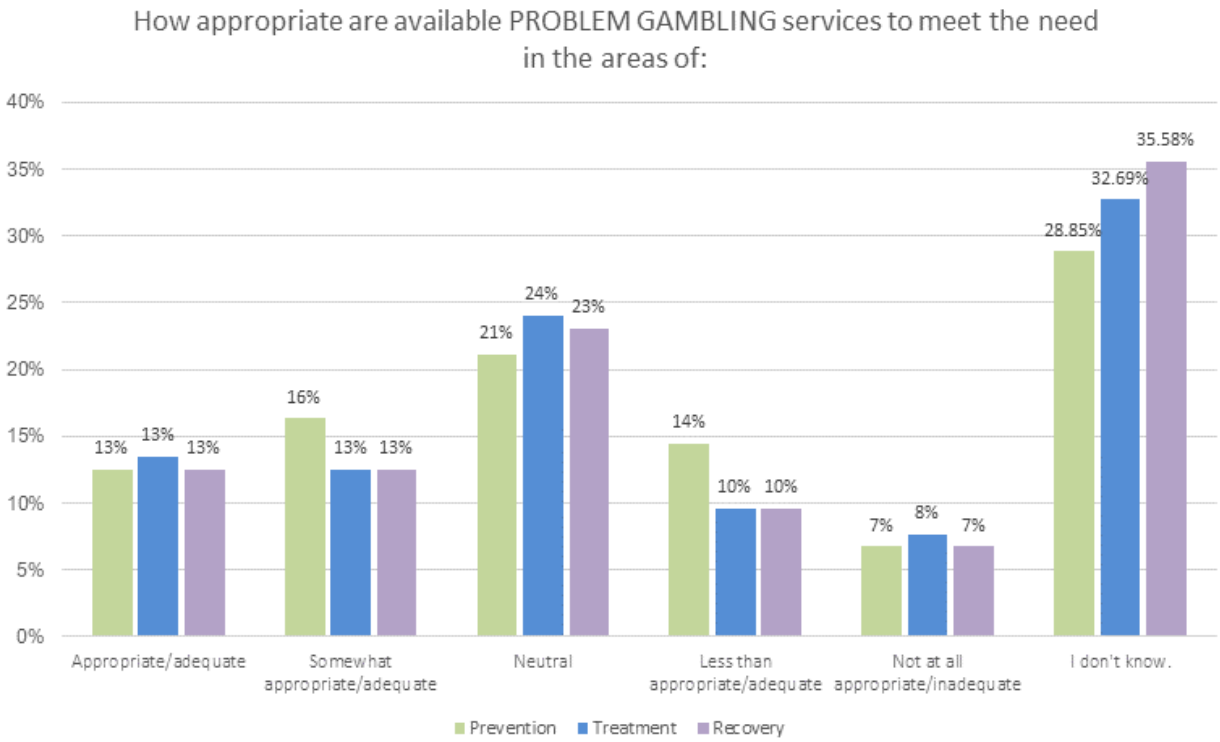
Appropriate/ adequate
Somewhat appropriate/ adequate
Neutral
Less than appropriate/ adequate
Not at all appropriate/ inadequate
I don't know.
Prevention
Treatment
Recovery



Focus Group feedback:

Specific to ***Mental Health*** *and* ***Substance Use:***

- Barriers to communication when the counselor and psychiatrist work for different agencies
- Need more support for kids with bipolar disorder or major mental health diagnosis.
- Need standardization of substance use programs and evidence-based practices.
- Need universal screening, specifically in primary care provider settings.
- Need improved quality and focus on underlying trauma/trauma-informed care.
- Expand insurance coverage.
- Covid impact - need more support, education, and training to identify and combat anxiety.
- Workforce/workplace wellness – *"daily therapeutic needs are not being met because of huge caseloads."*
- Promote client-centered care - *"The client may not know how to evaluate different programs and/or the level of care must suit the needs of the client."*
- Need to move away from the medical model and move it into peer support, insurance reimbursement for peer support.
- Levels of care are prescriptive, and insurance based.
- Need for screening and assessment of youth and families to support appropriate referrals.
- Trust of who is delivering the treatment is an issue and so there needs to be more "gateway" MH supports for youth.
- Inpatient is often carceral and non-therapeutic. Emotional distress is pathologized. Structural systemic change that eases poverty is crucial.
- Improve quality of police involvement in mental health crisis.
- Affordable care for those with Private/Commercial Insurance

- Easier and more consistent access to services throughout the continuum (inpatient to community-based care), integrated coordinated care, one point of access, appointments within 24 hours, afterschool hours, and alternative treatments (i.e., holistic health, meditation, tai-chi, creative writing, massage, acupressure).
- Recommendations are not family centered or flexible based on individual needs.

*Specific to **Suicide:***

- Need more collaboration with social media and advertising about suicide prevention training in addition to increasing access to available trainings.
- Need to learn more about which social groups are most affected by suicide (data).
- Anti-stigma and gatekeeper training - *"People are still uncomfortable going up to a stranger and asking the needed questions to know if they are OK."*
- Increase collaboration with faith-based groups/churches.
- There is fear discussed and hesitancy that people feel when feeling like hurting themselves, but do not want to get the police called on them or end up involuntarily in the hospital.
- Improve and increase follow-up after an attempt or hospital discharge.

*Specific to **Problem Gambling Services:***

- More research on effective strategies to engage people in treatment.

Q7: What Prevention program, strategy or policy would you like to most see accomplished:

General feedback from focus groups, polls, and the survey:

- Concerns about the effect and impact of COVID including isolation, trauma, grief, and loss.
- Funding/financing options - *"It would be helpful to know how we could work as a group to better understand how to braid and blend funding to get to some better impact funding."*
- Policy change "*We will be working with our pediatricians to screen all youth for substances and depression. We also are working with our health teachers to implement QPR and SBIRT into their curriculum."*
- Best practice prevention guidance would be screening all youth for depression, substance use, and trauma.
- DMHAS to help push out screening – work with pediatrics SBIRT screening, health teachers to implement QPR and SBIRT into health classes, connection to trusted adult.
- Funding for prevention
- Improved access to same quality care regardless of insurance including less administrative burden (red tape) and limits on length of treatment for high levels of care.
- Improved collaboration and communication
- Increased access to training including: QPR trainings for the public, Gizmo and SOS program
- Lip service to empowering coalitions, but when setting priorities for funding, become very directive (not just the topic, but also how much to spend on staff, presenters, food, etc.)
- More education for doctors' offices, OBGYN offices
- More public marketing, billboards, increase suicide prevention, anti-stigma campaigns.
- people noted that it is still uncomfortable going up to a stranger and asking the needed questions to know if they are OK. There was also the aspect of fear discussed and hesitancy that people feel

when feeling like hurting themselves, but do not want to get the police called on them or end up involuntarily in the hospital.
- Support and funding to expand mental health clinical services.
- Use of mini grants for what community needs vs. just vaping.
- Increase collaboration with churches.
- Share needs assessment findings broadly to increase access to the data *("here within the town that I work for)."*
- School-based resources – SROs and teachers need training in mental health, early warning signs.
- More focus on youth and what makes them HAPPY versus only focusing on what makes them sad (developmental assets).
- Increase Medicaid Rates and Reimbursement for Peer Recovery Specialists

<u>For Mental Health:</u>

Early Identification & Screening including:
- Universal mental health screening, mental health evaluation through physical exam at pediatrician's office, (in doctor's offices with appropriate referrals, etc.), Mental Health screening to support early identification of mental health diagnosis and generational complexity,
- Early intervention in the schools, private schools,
- Elementary school education and screening for early issues, more resilience training
- emotional intelligence strategies starting at early ages.
- Focus on building resiliency in youth.

Increased Prevention, Education and Outreach including:
- Prevention support and funding
- Increase school workshops for students; Youth Mental Health First Aid, "Gizmo" in Schools
- Youth mental health awareness
- Increase community forums and conversations.
- Anti-stigma and prioritization of importance of mental health and Wellness to increase normalization of emotional distress and coping skills.
- Increase development assets program(s), build resiliency in youth.
- Provide additional education about mental health for teachers, school administrators and parents.
- Mandatory DBT skills training (dialectical behavioral therapy)
- Increase education to families/schools about available community services versus utilizing police.

<u>For Substance Use:</u>

Early Screening and Identification:
- Address mental health issues when screening for substance use.
- Building a strong foundation starting in preschool and building from there.
- mental health evaluation through yearly physical exam
- universal screenings

Increased Prevention, Outreach and Education including:
- Trauma-informed care (ACES, prevention due to SDOH)
- More substance use prevention and education for all levels of care and with families/schools
- Address impact of substance use on the user and families

- Increase awareness, prevention.
- Emergency, non-criminal care
- More family education to families and schools about available community services vs utilizing police interventions.
- more SU education (NOT VAPING)
- Prevention and education for marijuana use because of legal changes happening.
- accurate information about effects of drugs on the bran
- Warnings one cigs, crack down on singles.
- Raise community awareness further and work with other stake holders to communicate across the board that one type of treatment does not work for everyone.

Youth/Young Adults:

- identifying substance abuse in youth
- more IP options for adolescents and insurance coverage
- More organized approach for YA/Youth
- Ongoing prevention work with young adults
- more education towards youth not engaging in substance use.
- more in-school and afterschool activities to keep children involved in their community.
- schools partnering with coalitions to provide education in health classes.
- Tertiary prevention programs for substance use disorder in school settings that address prevention when students have already begun experimenting with substances.
- wrap around services between community and schools.

<u>For Suicide:</u>

Increased Prevention, Outreach and Education including:

- Increase support for the RSABs to improve system outcomes (Regional Suicide Advisory Boards).
- Need more focus on what is making our kids feel confident, secure, HAPPY, rather than only discussing the negative
- Increase age-appropriate suicide prevention efforts and stigma education.
- Increase education, outreach, and awareness, including for families about signs and symptoms.
- Increase use of Gizmo (Gizmos Pawesome Guide to Mental Health)
- Increase education to families and schools about available community services vs utilizing police.
- More targeted to adults *"I see a lot targeted at YA/Youth."*
- Increase normalization of talking about feeling distressed.
- More outreach to young people and seniors of people with Autism Spectrum Differences
- hearing more from survivors or affected family.
- QPR in schools and community
- Increase postvention training in towns and schools.
- Increase awareness, training to recognize root societal causes of suicidal despair.

Early Screening and Identification:

- Increase universal screenings (in primary care, emergency department)
- Start earlier; Build a stronger foundation starting in preschool.
- Increase early intervention and identification of at-risk youth.
- Increase QPR in schools and community, postvention ("postvention is prevention")

Youth/ Young Adults:

- more access to education and identification of at-risk youth
- more emphasis/education of youth in schools with suicide screenings - more social workers/mental health staff to work with kids in school.
- training for all school staff

Incorporate Lived Experience

- Self-empowerment training, sharing of overcoming testimonies.
- hearing more from survivors or affected family members.

<u>For Problem Gambling:</u>

- Walk-in/urgent care model access to assessment/treatment
- Access to mental health counseling
- More culturally responsive treatment. More gender specific/responsive treatment.
- More program within local communities and collaborations with churches
- Casinos and other gambling facilities make it too easy to gain access to money and once in debt throw hands up more accountability.

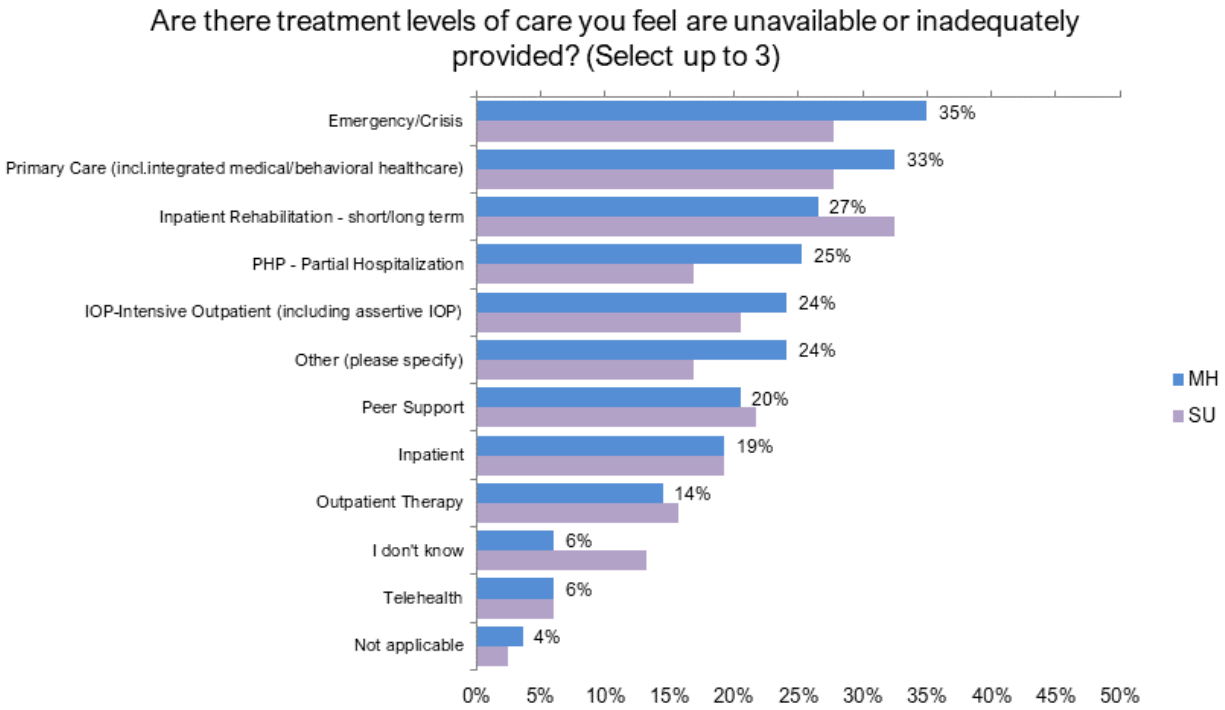
Increased Prevention, Outreach and Education including:

- Need increased education and awareness that PG is a problem, including gaming (awareness campaigns)
- Decrease stigma.
- Less State Lottery advertising
- PREVENTION PROGRAMMING IN HIGHSCHOOLS
- raise community awareness- I think this subject is often overlooked but it is a very important one.
- youth education/prevention in health classes

Earlier Identification:

- Universal screening - mental health evaluation through yearly physical exam, screen for problem gambling
- identify the problem in middles school and teens.
- increased early education and intervention. Earlier intervention and education.
- Increased Education, Outreach and Awareness

Q8-11: Are there treatment levels of care you feel are unavailable or inadequately provided?



General feedback from focus groups, polls, and the survey:

- Walk-in/urgent care model for mental Health services
- Intensive in home and home-based visitation (particularly with private insurances)
- Peer-run respite
- Emergency care
- Hard to find culturally appropriate treatment in suburban communities.
- Cessation programs needed for tobacco/vaping.
- Psychiatric/ medication management
- Peer Support
- Peer run respite program(s)

For Mental Health:

- walk-in/urgent care access to assessment/treatment
- wrap around services between community and schools, to support the family system.
- Lack of hospital beds
- Child psychiatry
- Psych/neuropsychological evaluations for a child with a serious mental illness – not enough practitioners for kids with high levels of need
- Emergency, non-criminal care
- More culturally responsive treatment and gender specific/responsive treatment
- More local/community-based care needed.
- providing more resources to older adults on Medicare

- need for more geriatric psychiatrists as evidenced by a reported increase in referrals from PCPs to psychiatrists for elderly patients.
- psychotherapy for schizophrenics

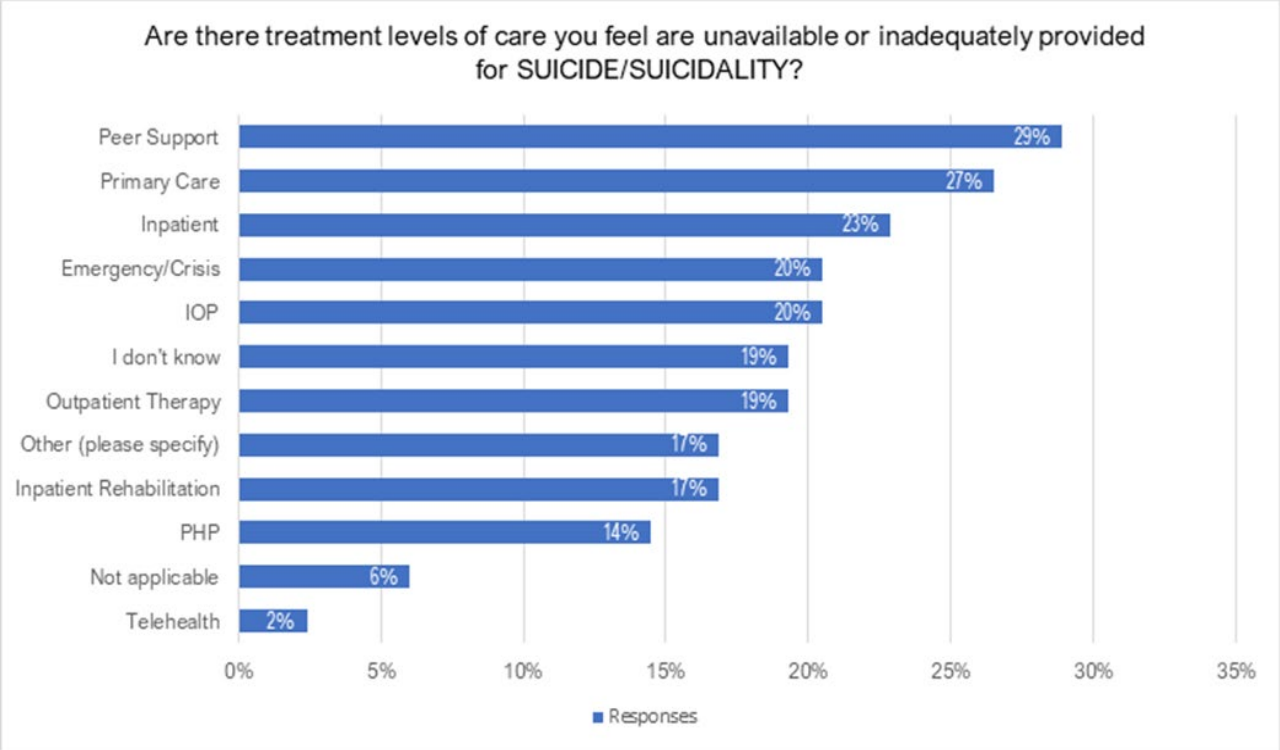
Youth/Adolescent Services including:

- More children's recreation and socialization programming
- Teen mental health - need targeted to adolescents: adolescent depression and suicide prevention.
- School-based resources – SROs and teachers need training in mental health, early warning signs.
- Need a higher level of treatment (not once a week counseling or PHP) but wraparound services. *"All kids being seen are more acute, more severe than before and things are getting missed. No face-to-face contact and things are rising to the next level."*
- Psychiatric/ medication management
- Peer support is necessary although all descriptors (consumer, advocate, peer) stigmatize people.
- Child psychiatry
- Waiting lists for IICAPS services for youth

For Substance Abuse

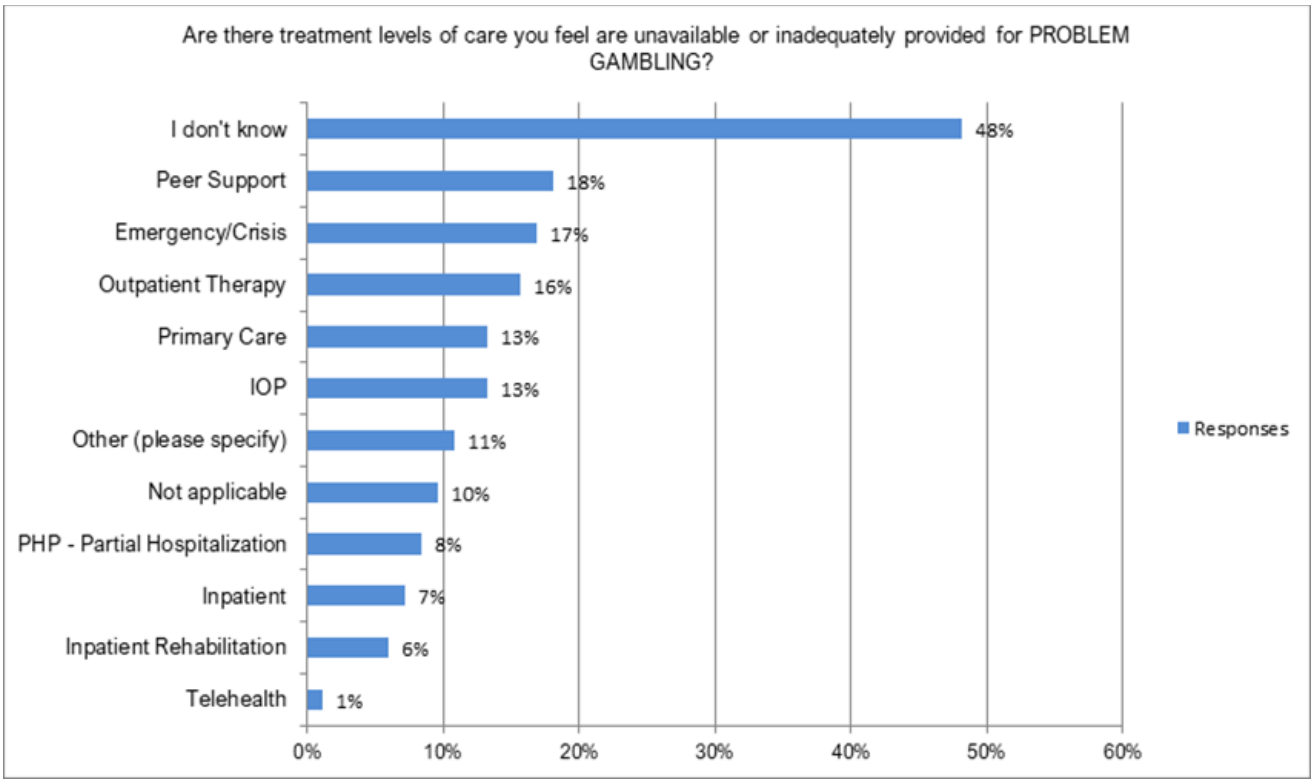
Improved Quality, Coordination and Access to Care including:

- walk-in/urgent care access to assessment/treatment
- Workforce development - "*There are enough services but not enough workers to provide them."*
- Need increased capacity with less limits on LOS (i.e., 30+ days rehab)
- Beds need to meet demand only the most determined "win" a bed.
- Continue growing the network of peer supports available (capacity and workforce development)
- Consistent access to treatment; more comprehensive prevention programs
- INCREAST TREATMENT OPTIONS- OFFER OPTIONS FOR RECOVERY- NOT JUST SMART RECOVERUY-
- Mandatory DBT skills training, access to naturopathic detox methodologies and self-empowerment training
- Medicare coverage to be broadened.
- More culturally responsive treatment. More gender specific/responsive treatment.
- Community supports including housing.
- More recovery coaches, better handoffs from detox to treatment to recovery and aftercare
- more treatment beds available
- peer support services
- programs that target 25 to 45 users
- Recovery support Specialist on call
- wrap around services between community and schools.
- adolescent detox
- MAT - IOP
- Late teen and young adult detox programs with warm handoff to next level of treatment
- Inpatient for adolescent females
- Need more family support.
- teen services / groups

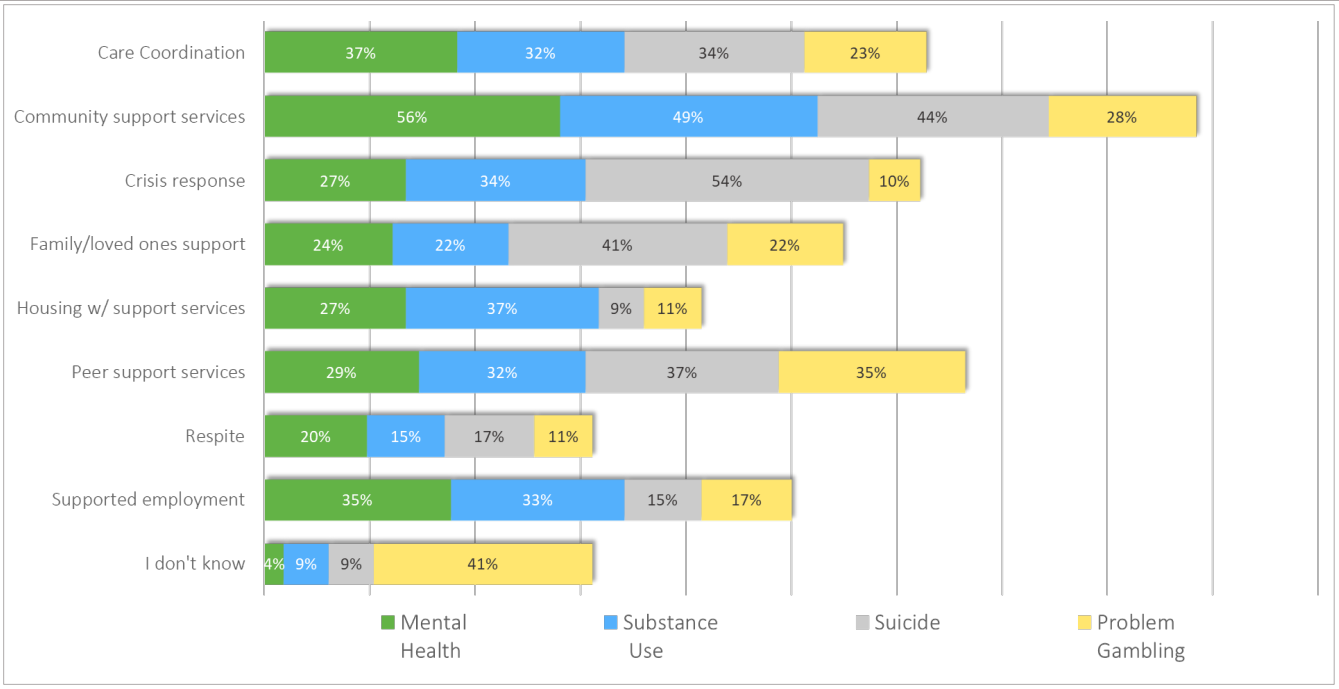


For Suicide:

- Need for a walk-in/urgent care model for assessment/access to treatment.
- Need wraparound services between community and schools.
- Emergency/Crisis ("non-criminal care")
- Culturally responsive treatment, gender specific/responsive treatment, LGBTQ services
- Peer Education/Peer Support services (including 24-hour support)
- CIT trained law enforcement that includes peer staff on the CIT teams.
- Positive mental health promotion - parent supports.
- Psychiatric/medication management
- Loss-survivor supports and services



Q12-15: What support services/recovery supports are most needed to assist persons:



Top 3 results for each:

Mental Health: Community Supports, Care Coordination, Supported Employment
Substance Use: Community Support Services, Housing, Crisis Response
Suicide: Crisis Response, Community Supports, Family/Loved one's support
Problem Gambling: I don't know, Peer Support, Community Support Services

"Other" Responses included:

Mental Health:

- Self-motivation self-empowerment training
- Service directly in communities
- public awareness

Substance Use:

- Interpersonal Effectiveness Skills and Self-Empowerment Skills
- alternative treatment models such as intensive in-home treatment that works with the person holistically- family, work, school, peers, community - instead of removing the person treating and returning to the same environment. Work with the entire ecology

Suicide

- DBT Building Mastery Skills, Self-Empowerment and testimonials of people overcoming trials, trauma, and abuse.
- Inpatient and psychiatry
- improve ED assessment process- outcomes. Educate schools and community on culture needed to identify and support suicide related issues. Support program/ protections through employers for job protections when treatment is sought. Support program/ protections through employers for job protections when treatment is sought.

Problem Gambling

- Financial management, and safe wealth building strategies
- Outpatient treatment options
- increased education in community and schools. Support program/ protections through employers for job protections when treatment is sought.
- behavioral health/mental health treatment

Feedback from focus groups and polls:

- Handoff to treatment and aftercare
- Youth need strong caring relationships, access to protective factors, connection to positive youth development resources, getting them out and connected in the world.
- Need recovery supports for vaping – intervention groups.
- We need more supportive programs that are delivered with trained supports that could include some recovery, but more importantly for front line staff for youth development programs of ALL kinds.
- What is it they think we can do with this money – put toward resources – healthy risk-taking behaviors, positive programming, risk and resiliency protective factors, adventure programming, character development, after school and weekend programs, relationship building?

- Activities on grids we can choose from are primarily messaging. Best done at the state level. Waste of resources to have local communities focus on that. We have the relationship piece.
- To narrow down positive character development is applicable to many problem behaviors.
- Housing with support services,
- Care coordination,
- Supported employment,
- Peer support services,
- Family/loved one's support.
- increased residential housing.
- Supported housing.

Q16: What are the greatest strengths/assets of our mental health, substance use, and suicide prevention, treatment, and support systems?

General feedback from focus groups, polls, and the survey:

- 211 Mobile crisis
- Anti-stigma messaging, campaigns, education, and outreach "More talk about stigma, more openness to talk about mental health because of Covid."
- Availability of resources and treatment options
- Care coordination
- Earlier identification and screening for behavioral health (mental health/suicide and substance use) in primary care setting
- Hotlines and warm lines including text crisis lines.
- Peer and Recovery Support Specialists, including in the Emergency Departments (ED)
- School-focused and school-based supports and interventions (screening/identification, education)
- Several providers locally based in New Britain.
- Support Groups and networks
- There are a lot of agencies, treatment options and network capacity which allows for access to community-based mental healthcare including care coordination, LMHAs, outpatient services, and primary care.
- There is a commitment to helping people and a willingness for agencies/programs to work together.
- When providers/non-profits do not charge fees.
- Specific programs mentioned include Amplify/RBHAO, the clubhouses, CCAR, LMHAs, NAMI
- "What we are offering is connectivity to deal with issues."
- Acknowledgement and advocacy
- Amplify does a great job with having open conversations about important groups and how to support them.
- Catchment Area Councils (CACs)
- Clubhouses and social clubs "Connection through the clubhouse helps the members with their day, every day."
- Community Collaboratives to share ideas!
- Commitment of workers
- Community outreach
- Community supports.
- CVH new social worker and visitation reopened.

- DBT (Dialectical Behavioral Therapy)
- DCF partnerships
- Education and outreach
- Empathetic counselors who care for the patient and work to help them succeed.
- Evidence based programs.
- funding for Vernon Rocks
- Good nurse
- Good therapists
- In-home supports (though many are virtual right now)
- Integrated care is great when available.
- More involved activities
- Network of Care
- Networking between LPCs, partnerships with local towns and pooling of funds
- Not-for-profit provider community
- Parent to parent supports.
- Peer support and recovery support specialists
- People really care and work hard for the program.
- Remote recovery meeting
- Remote support groups
- Some kinds of providers and service are working well together.
- Statewide prevention efforts
- Telehealth
- The increase in peer support, and specifically in the ED and hospitals (CCAR),
- The people like Amplify and other groups working hard to make changes.
- We have a lot of services in CT that other states don't have.
- well checks
- When collaboration happens, significant change is made.
- Youth service bureaus!

Specific to Mental Health:

- Access Mental Health
- *"Having the option of telehealth has made access easier, especially if transportation is an issue."*
- *"Mental Health is something that has been highlighted as a result of the pandemic. We need to capitalize on this and prepare for even more emergent mental health needs as a result of the pandemic."*
- *"The message is very clear at this point that it is alright to ask for help and that there should be no shame in doing so."*
- *"Today there are many people admitting they have a mental health problem and are willing to get help."*
- Awareness that it is an ever growing and evolving problem across age, gender, race, class, etc.
- DMHAS funded programs.
- Holistic healing approaches incorporated into many of the programs.
- Improved identification/awareness of symptoms
- Inpatient
- Jail Diversion Program

- knowledge of resources, skills and tools that work.
- Non-profit agencies that don't ask for fees.
- Providers offering better quality.
- Providers who are non-partisan, this past couple years climate has become incredibly divisive to where people feel afraid and isolated.
- Sharing info throughout the systems

Specific to Substance Use:

- *"Most of us seem to be following the harm reduction model which is allowing those who are in treatment to feel comfortable and know that this community is here to give them the support that they need."*
- A RECENT INCREASE IN IOP AND IN HOME SERVICES FOR TEENS IS HELPFUL
- Access to MAT providers (medication assisted treatment)
- collaboration
- community care/ services
- Community concern for this issue and advocacy efforts
- Detox
- Educating the community
- First Responder Education,
- Identifying patients' needs and support system.
- Improved identification/awareness of symptoms
- information provided.
- Inpatient care with appropriate discharge planning that includes stepdown to PHP or IOP and AA, NA, and outpatient support- *"It's an asset that we follow this model."*
- multi-pronged approach to stopping substance use.
- Narcan training and distribution
- Prevention, education, and outreach are key.
- recovery
- Services are good once accessed.
- Specific programs mentioned as assets include: the LMHAs, ADRC, Amplify, Southington STEPS
- Substance use work is taking a more wholistic approach.
- Support Meetings including 12 Step, NA, and AA
- we have a very good prevention program for people under 20 years old age.
- Youth and parent/guardian education about the dangers of substances.

Specific to Suicide:

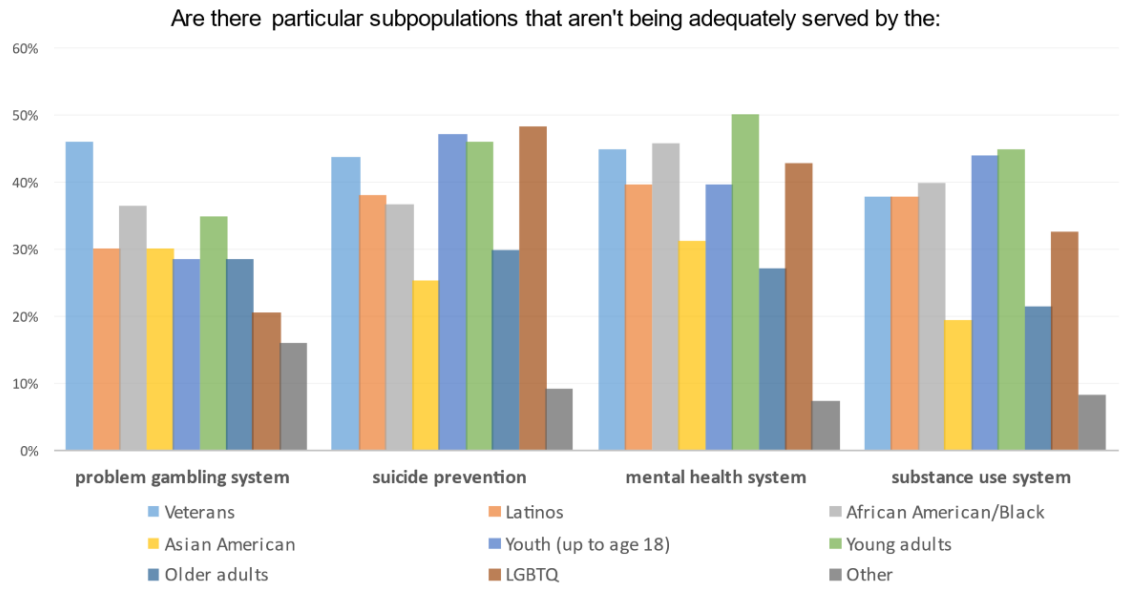
- "This is not an area that I work with closely but based on my observations the resources and the support for suicide prevention over the last few years has been unbelievable. This community has been offering so many support services to families."
- All the work around Gizmo's Pawesome Guide to Mental Health and the curriculum so kids are learning about mental health.
- Availability of services and assessment tools
- Discussed more regularly.
- Early recognition of SI and education for the community about what to do next, so far seems to work.
- Educating the community

- Facility in the community and referral system.
- good services once accessed.
- Improved identification/awareness of symptoms
- Improved, but postvention is crucial!
- Increased awareness about the need for suicide prevention and postvention activities, more recognition of the problem, people recognize it's something that needs to be addressed.
- Increased focus
- information provided, clinical support for follow up, consistent protocols.
- Postvention
- Professionals are always looking for new ways to help sufferers. The prevention holiness is also an asset.
- Question, Persuade, Refer (QPR) training
- Safe Messaging
- School based services
- State of CT Suicide Advisory Board (CTSAB) and the North Central Regional Suicide Advisory Board (NC-RSAB) and the outreach, education, and technical assistance they provide.
- The Purple Pod
- Universal screening in local pediatric emergency department (CT Childrens)
- Youth/young adult programs are active and known in the community.
- Zero suicide providers and the Zero suicide initiative spreading to be implemented in more places.

Specific to Problem Gambling:

- Acknowledging the issue
- Gambling is beginning to be seen as a serious health issue.
- Improved identification/awareness of symptoms
- Less State promotion of gambling
- Specialty Problem Gambling Services
- Systems and communication
- Therapeutic facility in the community
- Time between a client asking for help and receiving services.
- Treatment
- *I have been to many trainings and realized that this community is extremely supportive. They have been advertising resources throughout the state and making us realize that this is a conversation that we should be having across the board with all ages."*

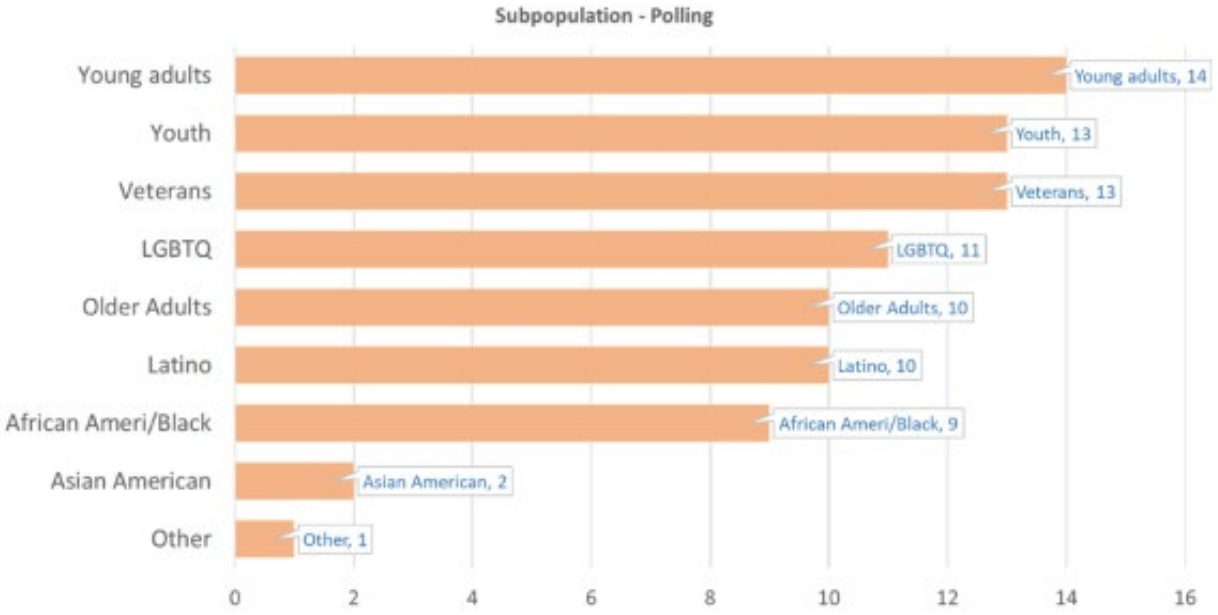
17. Are there particular subpopulations that aren't being adequately served:



Top 3 Survey Results for each:

Mental Health: Young Adults, AA/Black, Veterans
Substance Use: Young Adults, Youth, AA/Black
Suicide: LGBTQ, Youth (closely followed by young adults), and Veterans
Problem Gambling: Veterans, Black/African American, Young Adults

Top 3 per polling (n=approx. 80 polled): Young Adults, Youth, Veterans



Q18: Is there anything that you feel the service system, including DCF and DMHAS, can do differently for the subgroup(s) you are identifying?
· Beacon Voluntary and DCF - It is hard when DCF is active that Beacon Voluntary is on hold. They need to be able to be active at the same time to expedite care. · Become more trauma informed. · Continue/increase efforts to engage and support subgroups especially those that combat stigma and/or racism; provide more training and data to help identify populations at increased risk. · Coordinate with school-based providers more effectively · DCF - Accept cases made by schools and further investigate. · DCF and DMHAS should increase parenting education to help impoverished families deal with crisis and institutional pressures. · DCF can group with other treatment services to get rid of DCF stigma. · DCF can screen more cases "in" instead of referring to community services which is not mandatory, and families do not follow through with community referrals. · DCF full family wraparound care and care coordination professionals need continuous training in Cultural Competencies and grass roots training as well. · DMHAS - help youth and families access services. Train ED staff on communicating with young adults. Too many students with depression and suicidal ideation are just sent home after horrible experiences and hours in an emergency room. · DMHAS - start serving youth earlier, Improve coordination for teens moving into young adults' services, especially with private insurance. · DMHAS needs more inpatient options and options for adolescents and teens. · DMHAS - add more peer support positions including Spanish speaking, black, and Asian peers. · Expand private insurance to cover mental health and addiction services, including MAT. · Explore strategies and supports that combat provider burnout and fatigue. · Get more involvement; people are committing suicide in high numbers; more children are being diagnosed with anxiety we need to get together and make certain adaptations times are very different policies and procedures are expired. · Have services through DMHAS not the VA. · Housing for homeless youth with supports · Increase access to services for mental health and substance use for private insurance clients. · Increase awareness of available resources; provide more services locally in communities. · Increase engagement with towns and communities. · Increase funding to Regional Suicide Advisory Boards (RSABs) · Increase funding to retain more experienced counselors and reduce/eliminate wait lists. *"It's frustrating to wait months for treatment, only to be served by an inexperienced counselor who leaves before treatment is completed."* · Increase primary prevention. · Increase programs in the rural areas. · look at blended funding with other state areas for maximum support services and SDOH supports in addition to mental health supports. · Make services more affordable, specifically for teens. · Make sure the agencies are working to address disproportionality in their own systems. · More grassroots within their communities · More mainstream parenting programs for families that are not mandated to take them. · More outreach to the Senior Center; use printed materials (flyers) for seniors.

- More services geared for transitioning adolescents.
- Offer intense, ongoing, measurable training.
- Partner with community prevention programs for increased proactive interventions
- Promote culturally responsive treatment options - increased specialty treatment tracks for subgroups.
- Provide additional services in crisis management and intensive services. Take down barriers for families with limited resources, income, transportation, and languages.
- Safe & reliable transportation for youth to attend programs on nights and weekends.
- Screening
- *"Stop saying everything is racist and treating so many problems with this idea in mind. It's been incredibly divisive and hurtful for so many people, it's literally causing mental health issues."*
- *"Systems are straight white male centered."* Train on implicit bias and learn to identify how access, treatment, follow up recommendations are connected to personal views, beliefs, and bias. Educate systems about how different cultures experience treatment and ask the groups directly what they need instead of providers assuming they know already. Create treatment plans WITH families/ individuals not FOR them.
- Support workforce development efforts that help to ensure the workforce better represents the community(s) served.
- Use and fund the RBHAOs to help veterans.
- Work together. *"I see that agencies want to, but there are many subgroups/meetings that overlap. I wish there were just one process or group that assisted with agencies working together."*

Q19: Is there anything that you feel Amplify can do to promote health equity or address health disparities for the subgroup(s) you are identifying?

Survey and focus group feedback:

- Allow communities to choose where to focus their grant dollars i.e., there may be a greater need than vaping. Let the community need drive funding. Advocate for more flexibility in the use of funds at the agency/community level. *"Prioritizing use of funds is best done at the local level."*
- Training and awareness of multicultural diversity in our localities; reach people where they are.
- Amplify needs to do more with youth, young adults, veterans, and older adults; for anxiety - do more education/trainings.
- Continue to collaborate with community and grassroots organizations.
- Continue advocacy work and lobbying the legislature.
- Continue to support efforts that address health disparities/social determinants of health; gather/share data, continue focus groups/surveys.
- Continue to develop relationships and raise awareness of the gaps in services.
- Help identify available resources and services - 211 online is not always helpful.
- Increase outreach and support to veterans, youth/young adults, and older adults.
- Increase membership of people with autism, ID, and Downs Syndrome, people of color, and young adults, diversity among coalitions and staff.
- Help expand Zero Suicide to more providers/provider types.
- More emphasis in school/classes, school-based supports
- Outreach to the Sudanese/Somalian community leaders through provider locations.
- Increase programs in rural areas.
- Promote more services for Youth LGBTQ and homeless youth.

- Promote peer support, advocate for more providers/therapists.
- Promote best/evidence-based treatment programs.
- Support workforce development efforts
- Share successes that could be informative to other communities
- Identify support services for youth and young adults to share with families.
- Increase state-level collaboration.
- Work on barriers that exist due to insurance type.

Q20: What are the emerging prevention, treatment, or recovery issues you are seeing or hearing about:

- Great concerns about the impact of Covid including:
  - The anticipated increase in mental health needs this Fall when students return to school.
  - Re-entry anxiety and "pandemic mental health," anxiety and depression among youth/young adults, college students.
  - Post COVID need for anxiety supports for all.
  - Suicide / suicidality
  - Need to combat negative media / news messaging *"the anger/divisiveness is out of control,"* "*Media is a huge problem - fear mongering and no one feels they can even trust what is reported anymore."*
  - Need earlier identification; increase parent/family education about signs, symptoms, and where to find supports.
  - Significant increase in depression across all age groups but especially high school aged youth related to COVID restrictions.
  - Rising rates of youngsters being identified with suicidal ideation. Concerns about the residual and long-term toll of the pandemic on mental health for all ages - stress, reliance on technology and electronic devices, lack of socialization, kids getting behind academically, etc.

- Housing/supported housing.
- Increase in community awareness and availability of telehealth.
- Insurance barriers
- Issues are long-standing, not emerging. Waitlists, inexperienced counselors, staff turnover, also housing, transportation, and employment for patients.
- Lack of access to treatment, in-person services, long wait to access psychiatric appointments.
- Lack of much needed case management; support in the community
- Mandate town/school wide trainings mental health first aid
- Need for coordinated and integrated care.
- Lack of inpatient capacity including CVH.
- Need for more prevention/early intervention.
- Lack of workforce to meet the demand (clinical and non-clinical, peer/recovery support)
- School-based mental health needs, including early childhood, social emotional wellness programs.
- The increase in Fentanyl in all sorts on street drugs and the lack of education about the risks
- fentanyl uptick, opioid use
- Lack of inpatient bed capacity (MH and SU) to meet the increased demand for acute care.
- Increase in vaping, alcohol, and marijuana in response to the pandemic.
- Lack of much needed case management; support in the community
- Legalization and decriminalization of recreational marijuana
- Need for screening and assessment at all levels of care.

- PEER SUPPORT, RECOVERY COACHES- NEED FOR ADOLESCENTS!!!!
- see above, also losing patients at transitions - inpatient-PHP-outpatient-recovery/support, housing, transportation, and employment for patients.
- substance use treatment for the youth and young adults has been extremely difficult to access. parents have been taking their kids for treatment outside of CT because it has been difficult to get them into these residential programs especially for young girls.
- vaping, Narcan administration
- CIT, eCPR, social media ad campaigns, public school campaigns
- Need to combat media / news messaging - the anger/divisiveness is out of control.
- Need for increased school-based training and support.
- Suicide Prevention/Postvention needs –
    - Support more postvention technical assistance.
    - Follow up care for survivors of suicide is poor and/or unavailable.
    - more QPR education
- Need to for PCP training about mental health / substance use.
- use of mobile crisis instead of hospital/peer respite/alternative therapies.
- problem gambling (gaming, sports-betting); CT looking to encourage gambling for tax revenue.
- alternative therapies such as reiki
- Recovery Support Specialist, Community Health Workers