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## I. Contributors

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

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- Sarah Sanborn, Research Analyst, ERASE

The Priority Planning process included several forms of data collection which took place in the fall of 2018 through the spring of 2019. These are summarized below.

### ***Focus Group Participants:***

Throughout the Spring 2019, local perspectives from all the towns in Region IV were gathered by North Central Regional Mental Health Board (NCRMHB) and East of the River Action for Substance Abuse Elimination (ERASE) through a series of focus groups. Participants were asked to respond to the following questions via a written survey and focus group discussion (see Appendix A for questions asked and a summary of their responses).

Seven focus groups were held, one in each of NCRMHB's six Catchment Areas (CACs), one with Local Prevention Council Coordinators (22 participants representing 20 towns), and one with members of the Region IV Problem Gambling Awareness Team (8 participants representing prevention and treatment perspectives). CAC participants included interested community members from the towns in each of the Catchment Areas (88 participants), people in recovery (11), family members (6), community referral organizations (6), local prevention council coordinators and members, and MH/SA providers (2).

### ***Regional Behavioral Health Priority Setting Workgroup Participants:***

Lisa Palazzo, Beacon Health Options; Lori Stanczyc, Town of Rocky Hill, Youth Services; Judy Gardner, Stafford Family Services; Cooper Davis, Advocacy Unlimited; Mui Mui McCormick, Hartford Healthcare; Aisha Brown, CHR; Kelly Waterhouse, Town of East Hartford Youth Services; Kaitlin Carafa, Vernon Youth Services

## II. Abbreviations

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

CAC: Catchment Area Council

CPES: Center for Prevention Evaluation and Statistics at UConn Health

DFC: Drug-Free Communities Grant

DigIn: Disordered Gambling Integration Project

ENDS: Electronic Nicotine Delivery Systems

ERASE: East of the River Action for Substance Abuse Elimination

LPC: Local Prevention Council

NCRMHB: North Central Regional Mental Health Board

NCRBHAO: North Central Regional Behavioral Health Action Organization – ERASE and North Central Regional Mental Health Board are in the process of a merger to become one organization and act as the Regional Behavioral Health Action Organization for Region IV

NMUPD: Non-medical use of prescription drugs

PFS: Partnership for Success, 2015 grantees

RBHAO: Regional Behavioral Action Organization

RBHPSW: Regional Behavioral Health Priority Setting Workgroup

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

### **III. Executive Summary**

Every two years, the Department of Mental Health and Addiction Services (DMHAS) Planning Division is required to carry out a statewide needs 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 Region IV the North Central Regional Mental Health Board, Inc. (NCRMHB) and the East of the River Action for Substance Abuse Elimination, Inc. (ERASE) carry 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 NCRMHB and ERASE.

Region IV 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 using a set of stakeholder questions required by DMHAS, focus groups and Community Conversations and anecdotal information from key stakeholder groups, Region IV Student Substance Use and Mental Health Survey data, and population profile information from Beacon Health Options, the UConn Center for Prevention Evaluation and Statistics, the Hartford Healthcare Community Needs Assessment, 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 14 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 issues identified by the RBHPSW were alcohol, anxiety (especially among youth), depression, trauma/PTSD, and prescription drug misuse.

Region IV stakeholders who responded to our stakeholder survey rated prevention and treatment services mental health issues to be barely adequate (rated 3.1 of 5) but recovery support less than adequate (2.95 of 5).

Top priorities for treatment across mental health, substance use and problem gambling include outpatient treatment (individual, intensive, and assertive community therapy), navigation

assistance and a warm hand-off between levels of care, inpatient rehabilitation (including longer lengths of stay and especially for adolescents), and integrated medical and behavioral healthcare. Also identified were the need for more prescribers and crisis response.

Many barriers to accessing treatment for problem substance use, especially for detoxification and rehabilitation were identified. Lack of insurance coverage, high co-pays and deductibles are significant barriers, especially for some commercial plans, some Medicaid plans and Medicare.

In the area of recovery support, focus group participants cited the need for more case management/community support services, housing, respite, crisis response, transportation, family and peer support and marketing of peer support options.

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, and expansion of medication assisted treatment.

Emerging issues requiring attention include skyrocketing use of vaping products by youth, high rates of anxiety among school youth, growing number of options for gambling (casino, on-line and sports betting) with an accompanying lack of understanding among the general public about the risk and treatment options for problem gambling, and concern among members of Catchment Area Councils about the potential loss of support from the new Regional Behavioral Health Action Organization (RBHAO) for consumer engagement and service monitoring functions.

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

#### Substance Use

- Identify effective strategies for outreach and education about the dangers of nicotine and vaping
- Continue efforts to reduce opioid-related deaths through the promotion of prevention, treatment, and recovery activities for opioid use disorder with a focus on highest-risk communities (including mobile and tele-health options)
- Continue to develop and advertise other effective approaches for providing substance abuse treatment
- Support the establishment of “Recovery Friendly Communities” in Region IV

#### Mental Health

- Adjust school surveys to include a measure for anxiety as one of the mental health indicators

- Address the gaps in the continuum of care for supportive, supported, and residential housing for individuals with mental health and addiction challenges in order to prevent rehospitalizations
- Provide Strategic Prevention Framework training to community members so they can address the lack of affordable housing for individuals with mental health and/or addiction challenges
- Support the role of Catchment Area Councils (CACs) as vital mechanisms for consumer engagement and service monitoring

### Problem Gambling

- Adjust school surveys to measure perceived risk and use rates for problem gambling and address the overlap between computer gaming, sports betting, and gambling
- Continue conversations with key community informants about prevalence and strategies being implemented to address anxiety, vaping, and problem gambling
- Include computer gaming as a topic in all Problem Gambling training
- Expand Disordered Gambling Integration Project (Digin) and increase Helplines in areas with new casinos
- Engage leaders of Gamblers Anonymous to expand meetings in areas with new casinos; promote inclusion of problem gambling in recovery coach and recovery support specialist training

### Other Recommendations

- Elicit feedback from Hartford Foundation Community Fund Advisory Committees as key grassroots stakeholders to see what rises to the top as priority needs in our communities.

*Further detail about each of these recommendations can be found on page 47 of this report. An Infographic providing a brief summary of emerging issues; resources, strengths, assets; resource gaps and needs; and recommendations can be found on page 60 of this report.*

## IV. Introduction

### Background:

The Region IV, Regional Behavioral Health Action Organization (RBHAO), is a public-private partnership comprised of community leaders. 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. This 2018-2019 process is the first for the RBHAO, as in previous years this has occurred through two separate entities, known as Regional Action Councils and Regional Mental Health Boards. In March of 2018, these two entities came one under contract with DMHAS and the merger process of the two independent nonprofits began.

### 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 2018 through April 2019. These are summarized below.

- **Online survey**, integrating the Required Stakeholder Questions for Regional Priority Reports, was created and disseminated to community stakeholders through CAC and LPC distribution lists (see the Appendix for questions asked and a summary of their responses. Strengths - allowed for quantification of the required questions. Limitations – tool did not allow for an in-depth review of sub-group level perceptions of community concerns.
- **Focus groups**, allowing for in-depth review of the outcomes of the Required Question Survey, were conducted by the RBHAO with key stakeholder groups in each Catchment Area Council (CAC) and the Prevention Committee for a total of 6 groups. The Region IV Gambling Awareness Team addressed the gambling-specific, required questions. Strengths - allowed for an in-depth review of outcomes from the online survey mentioned above, some mention of sub-populations at-risk. Limitations - groups had difficulty separating the required focus areas, often would provide answers that were more holistic.
- The results of 30 **Community Conversations** conducted with youth and family members involved with the Connecticut Network of Care were obtained from FAVOR and incorporated into the anecdotal responses obtained from focus group participants. The Community Conversations were facilitated by Family Systems Managers from Favor and were designed to gather input from consumers about the CT's service system for youth and their families. Participants were asked:



1. What are the strengths of Connecticut's service system for children and families?
2. What are the major areas of concern within Connecticut's service system for children and families?
3. How should we fix these problems? What are your suggestions to improve our system of care?

- **2017 Population Profile data** for CT Medicaid recipients made available by Beacon Health Options. Strengths - provided data on service utilization and information about some of the mental health issues missing from other available sources broken out by age, gender, race, and ethnicity. Limitations - data was statewide and limited to Medicaid recipients.
- **Region IV Student Substance Use and Mental Health Survey data** (2016-2018) n=12,000. 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. All data are presented by grade groups of 6-8 and 9-12. Data are from combination of comparable data for schools (n=11 towns) surveyed in Region IV using the ERASE or SERAC survey tool. Strengths - sample size is large over a short amount of time. Limitations - data are unweighted, no trend is available, and there may be variation in survey administration mode since two survey tools were used over 2 years.
- **Region IV specific data from the SEOW Data Portal.** Strengths - data are reliable and vetted by CPES and are available for the first time at the regional level. Limitations - many indicators available at the town level that would have better described risk factors were not aggregated to the regional level.
- Review of data made available through the **Behavioral Health Partnership Quality Access Committees.** Strengths - presentations are interactive with data filtered by a variety of variables like age, gender, race in response to questions and concerns. Limitations - data requests require several levels of permission and therefore are not readily available.
- **Regional Behavioral Health Priority Setting Workgroup** ("RBHPSW") - nine strategically selected participants—representing mental health treatment or substance use prevention in rural, suburban, and urban communities within Region IV—reviewed data provided by the RBHAO. Then they completed the prioritization matrix, ranking magnitude, impact, capacity/readiness of the required substance use, gambling and mental health problems. The quantitative outcomes of the process were tabulated and presented to the group to discuss whether outcomes matched expectations and reasoning behind individual rankings. Strengths - the group was well-rounded in mental health and substance use background and asked thoughtful questions regarding data presented. Limitations - given the breadth of the priority process, it was impossible to present all data collected in this process and expect meaningful interpretation in that time period, data presented was a sub-set of all data and was chosen based on reliability, region specific indicators, and age groups, ensuring that data to represent the life span was included. The group had difficulty considering each issue individually. Ultimately, depression and anxiety were the two priority issues identified as the risk factors for all other substances and behaviors ranked that day. Participants struggled to consider a

score for “capacity/readiness” as a group, some chose to score these individually. This was accounted for when tabulating outcomes.

- **Anecdotal information solicited from key informants** from both within and outside of the DMHAS services system (RBHAO Catchment Area Council [CAC] and Review and Evaluation Committee [R & E] members, 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).
- **Anecdotal Information solicited via RBHAO provider evaluations** with Region IV Supportive Housing settings and an informational forum with housing and homelessness public officials and coalition leaders. Strengths - consumer and provider perspectives were captured across the region. Limitations - only 5 supportive housing settings were visited.
- 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 2018 PIC Report. Strengths - provided information about some of the mental health issues missing from other available sources. Limitations - not all of the data was disaggregated by region.
- Review of **Hartford Healthcare Community Needs Assessment**. Strengths - included an assessment of social determinants of health, good mental health indicators, areas of greatest service shortages and matched the Region IV service area. Limitations - looked at behavioral health in general without disaggregation by diagnostic categories.
- Review of 211 Counts Data

## **General Limitations of the Report:**

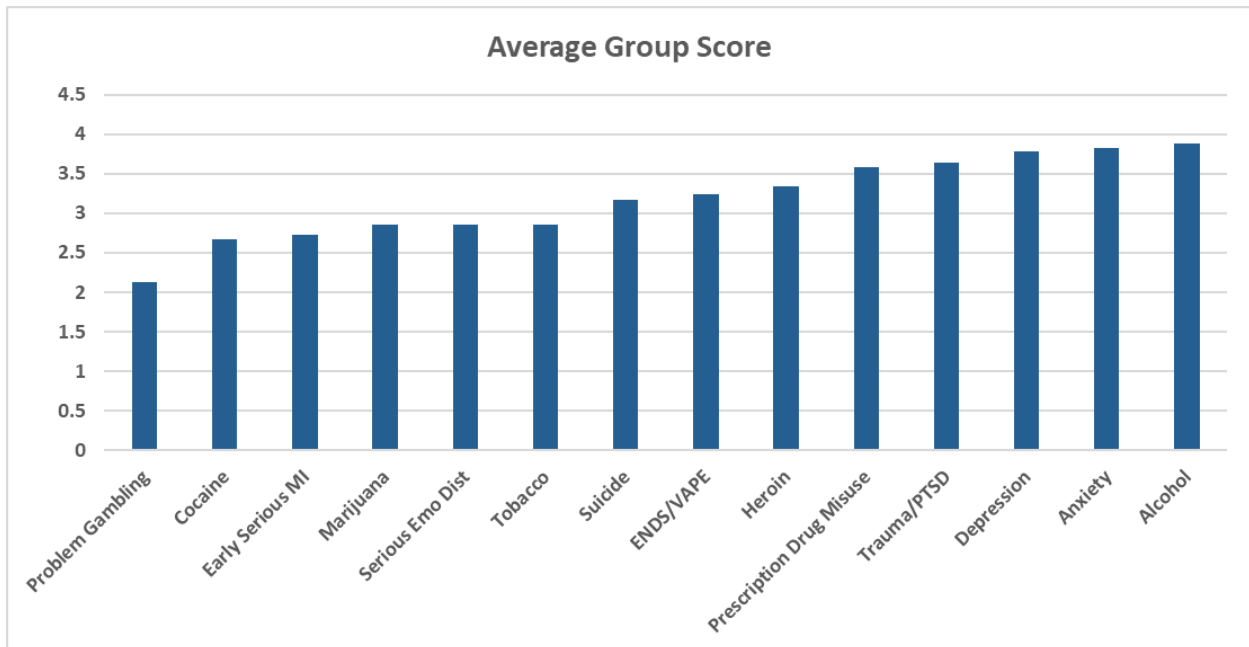
This report and its outcomes are limited by the types of data available at the Region IV level. In many cases there is more substance abuse-specific data, particularly for youth. It was difficult to consider risk factors in the collection and interpretation of data, since many risk factor-related data 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 staff from North Central Regional Mental Health Board and ERASE, two non-profits that will merge in July 2019 to become Amplify, Inc. To create this report, staff from both agencies divided tasks in the fall of 2018, based on their strengths, 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 established between January 2019 and April 2019. During this time, data from the profiles was culled into a PowerPoint for review by the RBHPSW.

On April 25, 2019, we convened the RBHPSW. We shared a PowerPoint presentation and encouraged participants to react to the data throughout the presentation. With the exception of a representative of a rural treatment organization, most participants felt the data represented their understanding of current Region IV 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 and encouraged to discuss their thoughts with the group during their individual scoring process. We asked participants to explain their top priorities in terms of age and other demographics on the back of the matrix. Finally, their prioritizations were compiled into a graph that shows the final mean score for each topic within the matrix, and the group discussed their reactions to these scores. (See Figure 1 below).

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



In May 2019, staff had collected the requisite information and data to create the priority report. From May to June, the report was drafted under the leadership of Marcia DuFore and Melisa Luginbuhl.

## V. Region IV 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 IV towns and cities fit within Data Haven's categories for community type.

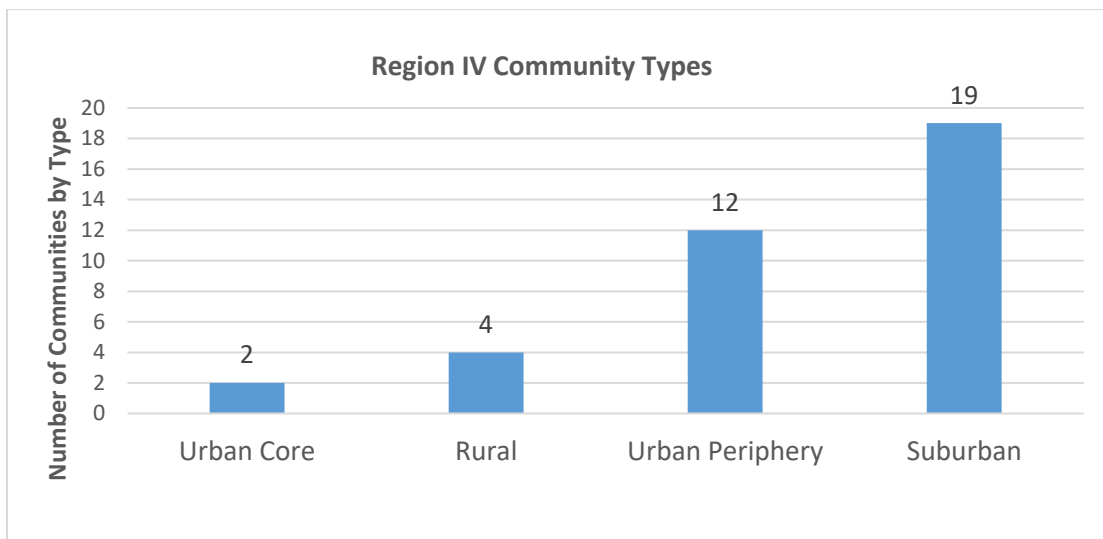


Figure 2. The majority of Region IV towns are classified as suburban followed by urban periphery. There are no towns or cities classified as "Wealthy."

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. Along the I-91 corridor, a new casino is being developed with a tentative opening date of 2021. Just to the north, a brand-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; 5 private colleges/universities in the region

***Existing/Emerging Subpopulations:***

Subpopulations of concern to focus group participants included veterans, persons of color (including Black, Hispanic, and Asian American), youth, young adults, older adults, LGBTQ youth and adults, and people coming out of incarceration.

## **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

Prescription Drugs, Not for Medical Use

Marijuana

Cocaine

Heroin

Fentanyl

Anxiety

Depression

Serious Mental Illness

Early Serious Mental Illness

Suicide

## Alcohol-Region IV RBHAO Epidemiological Profile

**PROBLEM STATEMENT:** Alcohol is an addictive drug for some people, especially those that initiate use at a young age or have risk factors for developing alcohol abuse. “Alcohol use, including underage drinking and binge drinking can lead to increased risk of health problems such as injuries, violence, liver diseases, and cancer.”<sup>1</sup>

### Magnitude:

Alcohol use nationally, in CT has declined steadily among youth ages 12-17 from 2004-2016,<sup>2</sup> Region 4 youth data mirror this with town past 30-day use rates of alcohol in 2014 and 2015 ranging from 17% to 30% for grades 9-12. Across the Region today the past 30-day use rate is 13.4% (2018).<sup>3</sup> Of youth who report recent (30-day) alcohol use 7% report binge drinking.<sup>4</sup> This is down from the 2014-2015 range of past 30-day binge drinking rates of 8.3% to 17%.

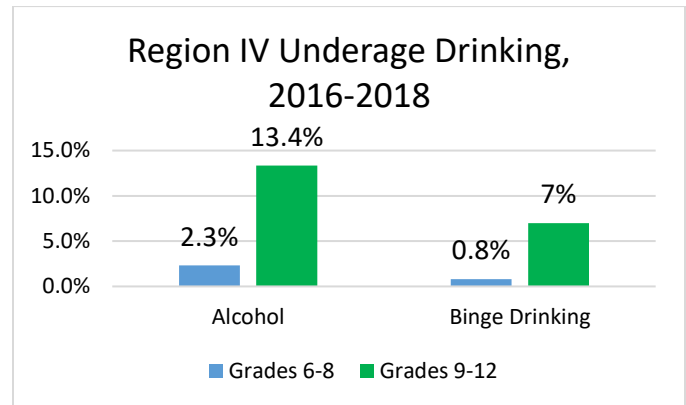
Youth ages 12-17 alcohol dependence and abuse has declined at the state and regional level with the regional level declining by 50.2% from 5% (2008) to 2.49% (2016).

Alcohol use by adults over age 17 in CT and Region IV has remained relatively consistent from 2008-2016 ranging from 63.2% to 70%.

Adult past year alcohol dependence and abuse in Connecticut has averaged 7.8%. The regional rate has also remained consistent over this time period with the most recent rate being 7.6%.<sup>5</sup>

Data Haven’s Community Wellbeing data show similar adult binge drinking rates to those of youth, with 6% of CT adults reporting they had four to five or more drinks on a single occasion at least six days this month.<sup>6</sup>

Figure 1.



### Risk Factors and Sub Population At-Risk:

Region IV youth survey data for grades 9-12 show that risk factors for youth use, perceived risk (72.1%), perceived parental disapproval (85.3%) and perceived peer disapproval (60%) are relatively high as compared to ENDS, Marijuana and gambling. For CT adults in treatment for alcohol abuse as the primary drug, the majority were ages 41-55 (45.4%) male (70.9%) white (68%), black (12.4%) or non-Hispanic or Latino (85%).<sup>7</sup>

### Burden:

In 2018, 12,040 adults or 18.6% of those entering treatment in CT reported alcohol as the primary substance. 16.1% or 10,779 reported using alcohol with a secondary drug.<sup>8</sup>

Alcohol overdose deaths, estimated unintentional injury, estimates of violent crime, estimates of alcohol dependence, DUI deaths, DUI injuries are all indicators that can provide an understanding of the impact alcohol use has in Region IV in the future as data are available.

<sup>1</sup> Centers for Disease Control and Prevention, Alcohol and Public Health, <https://www.cdc.gov/alcohol/index.htm>.

<sup>2</sup> NSDUH via SEOW Portal 2004-2016, CT and NC Region, ages 12-17.

<sup>3</sup> SERAC and ERASE student Use Survey data, compiled January 2019, grades 9-12.

<sup>4</sup> SERAC and ERASE student Use Survey data, compiled January 2019, grades 9-12.

<sup>5</sup> NSDUH SEOW Portal 2008-2016 ages 17+.

<sup>6</sup> DataHaven, 25<sup>th</sup> Anniversary and Statewide Data Release Preliminary Results – November 19, 2018, <http://www.ctdatahaven.org/sites/ctdatahaven/files/25th%20Anniversary%20and%20Statewide%20Data%20Release%20Summary.pdf>.

<sup>7</sup> TEDS 2018.

<sup>8</sup> TEDS 2018

## Alcohol-Region IV RBHAO Epidemiological Profile

### **Capacity and Service System Strengths:**

- Alcohol was prioritized as the number one substance use and mental health issue in Region IV.
- Two Region IV towns are PFS 2015 grantees and both address underage drinking.
- Both DFC grantees in Region IV (covering 4 towns) address underage drinking.
- Most towns in Region IV address underage alcohol consumption annually by hosting a variety of alcohol and substance free family and community recreational events.
- A majority of Region IV towns host overnight alcohol and substance free events in their high schools on prom and graduation night as a safe alternative to celebrations that could otherwise encourage risky behaviors.
- A range of events/presenters are offered throughout the region for parents that address underage drinking and social hosting.



## Tobacco-Region IV RBHAO Epidemiological Profile

**PROBLEM STATEMENT:** Tobacco use is the largest preventable cause of death and disease in the United States. Each year, approximately 480,000 Americans die from tobacco-related illnesses. Further, more than 16 million Americans suffer from at least one disease caused by smoking. Smoking-related illness in the United States costs more than \$300 billion each year, including nearly \$170 billion for direct medical care for adults and more than \$156 billion in lost productivity.<sup>1</sup>

### Magnitude:

Since 2004 tobacco use among all ages groups has been declining at the state and within Region IV. Tobacco use rates for young adults, ages 18-25, are the highest compared to those under 18 and over 25.

Data Haven Community Wellbeing Survey shows similar trends. Rates of CT adults who smoke cigarettes have declined from 15% in 2015 to 13.7% in 2018. About 37% of young adults have tried e-cigarettes, which is up from 31% in 2015.<sup>2</sup>

Figure 1.

Connecticut and Region IV Use Rates, by Age

Age Group	CT 30-day Use Rates NSDUH (2014-2016)	Region IV 30-Day Use Rates NSDUH (2014-2016)
12-17	3.56%	3.06%
18-25	28.4%	31.67%
25 and older	17.58%	17.08%

Region IV youth survey data for grades 9-12 for 2016-2018 demonstrate that while past month cigarettes use is down to 0.6%, Electronic Nicotine Delivery System (ENDS) Use has emerged to 2.3% in the past 30-days. The majority of youth surveys indicate that after “E-flavored liquids” “tobacco/nicotine products” are the most common substance used in ENDS.

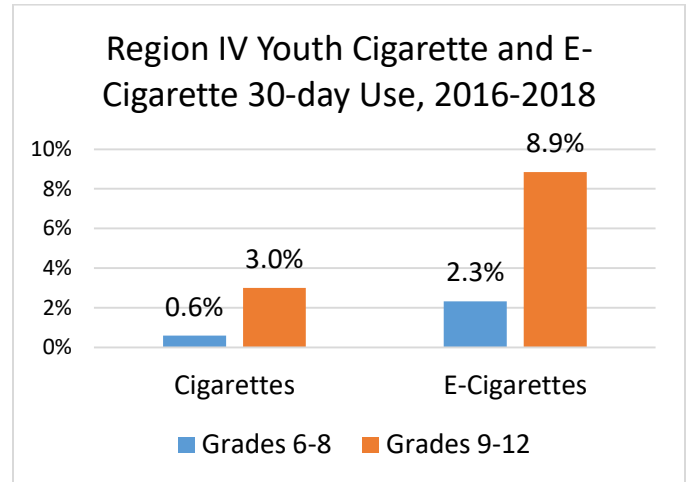
<sup>1</sup> Healthy People, *Tobacco Use*,

<https://www.healthypeople.gov/2020/topics-objectives/topic/tobacco-use#4>

<sup>2</sup> CT Data Haven, 25<sup>th</sup> Anniversary and Statewide Data Release Preliminary Results – November 19, 2018,

<http://www.ctdatahaven.org/sites/ctdatahaven/files/25th%20Anniversary%20and%20Statewide%20Data%20Release%20Summary.pdf>.

Figure 2.



### Risk Factors and Sub Population At-Risk:

Residents of CT communities identified as “Urban Core” have current smoking rates of 21% as compared to other community types which range from 6% “wealthy” to 15% “urban periphery”.<sup>3</sup> Similar trends are seen with ENDS by community type with the “Urban Periphery” and “Urban Core” resident reporting highest use rates of 21% and 25% respectively for lifetime use.

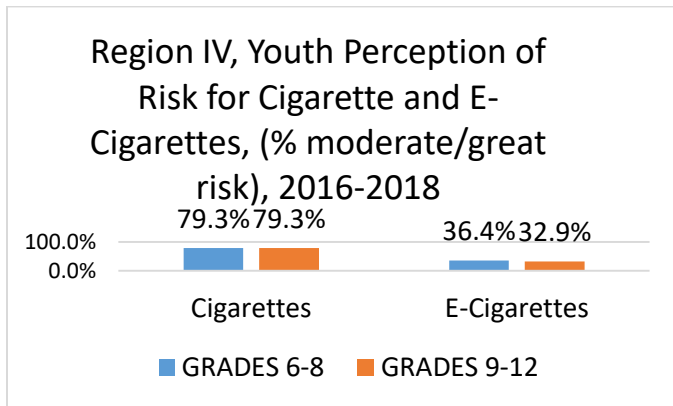
Region IV, perceived risk or harm for grades 9-12 group is 79% for cigarettes and 32% for ENDS, the lowest perceived risk rate among all “core substances and gambling (see Figure 3).” Perceived parental disapproval for cigarettes is 90.4% and 49.7% for ENDS, meaning more than 50% of youth grades 9-12 think their parents think youth use of ENDS is acceptable. Peer disapproval of cigarettes is 73.2% and for ENDS it is 31%.<sup>4</sup>

<sup>3</sup> Data Haven 2018

<sup>4</sup> SERAC ERASE Combined youth survey data 2016-2018, grades 9-12.

## Tobacco-Region IV RBHAO Epidemiological Profile

Figure 3.



Other risk factors include race/ethnicity, age, education, and socioeconomic status. Significant disparities in tobacco use exist geographically; such disparities typically result from differences among states in smoke-free protections, tobacco prices, and program funding for tobacco control.

### Burden:

Cigarette smokers generate higher medical care costs and have more inpatient and outpatient visits than those who do not smoke. Among patients admitted to the hospital, smokers have longer lengths of stay and incur greater expenses per admission than nonsmokers. Smokers are significantly more likely to have greater workplace absenteeism. The likelihood of workplace absence increases with the number of cigarettes smoked per day.

In 2010 the four leading causes of death in the United States were heart disease (597,700 deaths), cancer (574,700 deaths), chronic lower respiratory diseases (138,100 deaths), and stroke and cerebrovascular disease (129,500). Cigarette smoking is a major cause of all four of these diseases. Furthermore, smoking is also a cause of the seventh (diabetes, 69,000 deaths) and eighth (influenza/pneumonia, 50,100 deaths) leading causes of death.<sup>5</sup>

### Capacity and Service System Strengths:

Hartford was the first city in the state to pass “Hartford 21” an ordinance to increase required age of sale from 18 to 21 years.

In June 2019, the CT State Legislature voted to support Tobacco 21, this bill covers all forms of tobacco, including e-cigarettes, vaping products and chewing tobacco. Concern over vape/ENDS has increased community engagement on the topic of nicotine and tobacco prevention, legislation and ordinances.

Many Region IV school systems have policies in place so that students who are found with nicotine or tobacco products are provided with cessation program opportunities.

<sup>5</sup> HHS, The health consequences of smoking: A report of the Surgeon General, Centers for Disease Control and Prevention, Office on Smoking and Health; 2004.

## Prescription Drugs, Not for Medical Use-Region IV RBHAO Epidemiological Profile

**PROBLEM STATEMENT:** Misuse of prescription drugs means taking a medication in a manner or dose other than prescribed; taking someone else’s prescription, even if for a legitimate medical complaint such as pain; or taking a medication to feel euphoria (i.e., to get high).

The term “non-medical use” of prescription drugs also refers to these categories of misuse. The three classes of medication most commonly misused are:

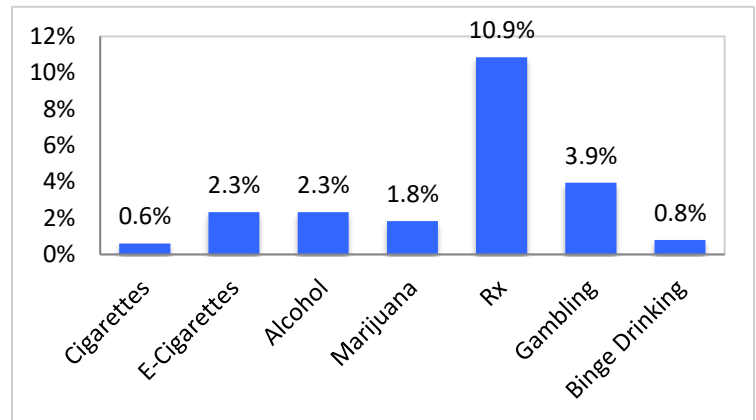
- opioids—usually prescribed to treat pain
- central nervous system [CNS] depressants (this category includes tranquilizers, sedatives, and hypnotics)—used to treat anxiety and sleep disorders
- stimulants—most often prescribed to treat attention-deficit hyperactivity disorder (ADHD).<sup>1</sup>

Prescription drug misuse can have serious consequences including overdose, overdose death, increased emergency room utilization and addiction.

### Magnitude:

From 2012-2017 CT has seen a 220% increase in overdose death from any opioid drug. However, state level data and Region IV data show an overall decline in misuse of prescription drugs from 2004-2014 across all age groups. The adults ages 18-25 is the age group with the highest report use which has declined in Region IV from 13.6% (2004) to 8.52% (2014).<sup>2</sup> Youth ages 12-17, had a past year use rate of 2.74% in 2014.<sup>3</sup> In 2016-2018, 9.1% of youth grades 9-12 had reported misuse of prescription drugs in the past 30-days. For grades 6-8, the most commonly used substance in the past 30-days was NMUPD (See Figure 1). Town level data from individual towns in 2014-2015 range from past 30-day use rated from 3.2% to 9.7%.

Figure 1.



### Risk Factors and Sub Populations At-Risk:

Region IV, perceived risk or harm for grades 9-12 is 78.2%, the second highest perceived risk rate among all “core substances and gambling.” Perceived parental disapproval for NMUPD 91.7%. Peer disapproval of marijuana use 77.5% meaning more than 20% of youth think their friends approve of peers using prescription drugs non-medically.

Persons at risk of misusing prescription drugs include:

- Those with past year use of other substances, including alcohol, heroin, marijuana, inhalants, cocaine and methamphetamines;
- Individuals with family incomes less than \$20,000 and \$40,000-\$74,999;
- People who take high daily dosages of opioid pain relievers;
- Persons with mental illness;
- People who obtain multiple controlled substance prescriptions (especially the combination of opioid analgesics and benzodiazepines) from multiple providers;
- Between 2012-2015, the majority of opioid overdoses in Connecticut occurred among non-Hispanic whites, with male deaths occurring 2-3

<sup>1</sup> National Institute on Drug Abuse, *Misuse of Prescription Drugs*, <https://www.drugabuse.gov/publications/misuse-prescription-drugs/overview>.

<sup>2</sup> SEOW Portal NSDUH 2004-2014 Prescription Drug Misuse.

<sup>3</sup> Id.

## Prescription Drugs, Not for Medical Use-Region IV RBHAO Epidemiological Profile

times more frequently than females in each racial/ethnic group;

- Among those in treatment for non-heroin opiate use disorder, males and non-Hispanic whites are overrepresented.

Misuse of prescription drugs may be the most common form of drug abuse among the elderly who use prescription medications approximately three times as frequently as the general population and have been found to have the poorest rates of compliance with directions for taking a medication.

The national 2015 NSDUH data showed that past year users of other substances (alcohol, heroin, cocaine, marijuana, inhalants, methamphetamines) were more likely than others to have misused prescription drugs, as were adults 18 and over with mental illness.

Over half of other opiate treatment admissions in 2016 were between the ages of 21 and 35 years old, 80% were white, and 60% were male.<sup>4</sup>

### **Burden:**

The Centers for Disease Control and Prevention estimates that the total "economic burden" of prescription opioid misuse alone in the United States is \$78.5 billion a year, including the costs of healthcare, lost productivity, addiction treatment, and criminal justice involvement.<sup>5</sup>

### **Capacity and Service System Strengths:**

Over 2 years 25 opioid mini grants awarded.

In past year, 572 Narcan kits distributed.

At least 4 opioid workgroups are established in Bristol, New Britain, towns in North Central CT and towns within the Central CT Health District area.

In Region IV, there 27 prescription drug drop boxes and 25 communities doing annual prescription drug take back events.

The DFC funded communities address NMUPD as part of their action plans.

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<sup>4</sup> CPES Epi Profile: <https://s3.amazonaws.com/cpes-ctdata/reports/Prescription+Drugs+Profile.pdf>.

<sup>5</sup> National Institute on Drug Abuse, *Opioid Overdose Crisis*, <https://www.drugabuse.gov/drugs-abuse/opioids/opioid-overdose-crisis>.

## Marijuana-Region IV RBHAO Epidemiological Profile

**PROBLEM STATEMENT:** Adults and adolescents increasingly view cannabis as harmless. However, potential problems include harms from prenatal exposure and unintentional childhood exposure; decline in educational or occupational functioning after early adolescent use, and in adulthood, impaired driving and vehicle crashes; cannabis use disorders (CUD), cannabis withdrawal, and psychiatric comorbidity.<sup>1</sup>

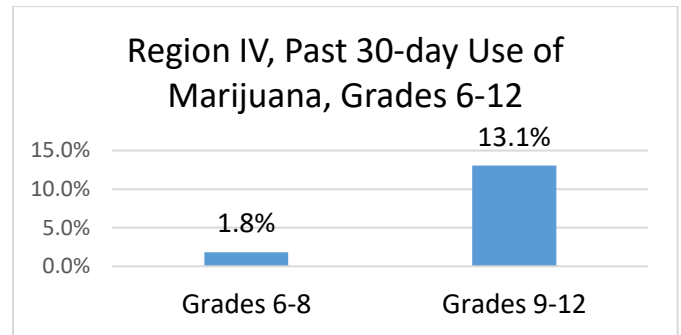
### Magnitude:

Cannabis-use disorder is estimated to affect 1-2% of adults in the past year and 4-8% of adults during their lifetime.<sup>2</sup>

Past month marijuana use among Connecticut and Region IV adults has remained steady from 2008-2016. Use rates at the state and regional level are similar across age groups. In Region IV (2016) 25% of adults ages 18-25 and 7% of those age 26 and older used marijuana in the past 30-days. Data Haven notes that in CT 7% of adults used marijuana or cannabis at least six days in the past month, with 27% of these adults reporting that use was only for medical reasons.<sup>3</sup>

Past month use of marijuana among 12-17 year olds at the state level has remained consistent from 2004-2016, with a 2016 use rate of 7.78%. Region IV youth data, grades 9-12, show that marijuana is the second most commonly used substance at 13.1% in the past 30-days. Individual town data from 2014-2015 have 30-day use rates ranging from 10.5% to 20.5%.

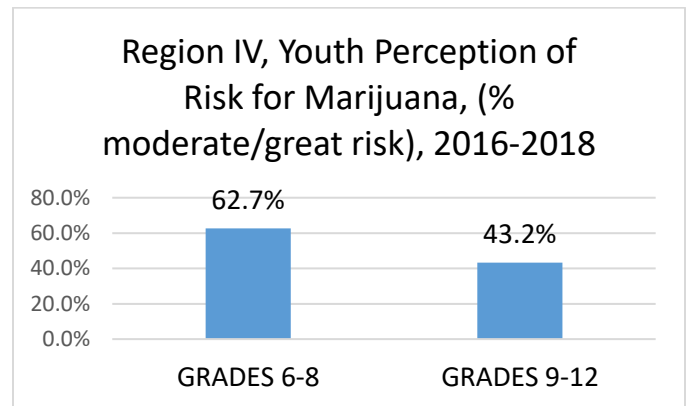
Figure 1.



### Risk Factors and Sub Populations At-Risk:

Region IV, perceived risk or harm for grades 9-12 is 43.2% the second lowest perceived risk rate among all “core substances and gambling”. Perception of risk for marijuana use, drops by over 30% between middle and high school in Region 4 (See Figure 2). Perceived parental disapproval for marijuana is 79.9%. Peer disapproval of marijuana use 44.8% meaning more than 50% of youth think their friends approve of peers using marijuana.<sup>4</sup>

Figure 2.



<sup>1</sup> Hasin D. S. (2017). US Epidemiology of Cannabis Use and Associated Problems. *Neuropsychopharmacology official publication of the American College of Neuropsychopharmacology*, 43(1), 195-212.

<sup>2</sup> Hall WD, Pacula RL (2010). Cannabis use and dependence: public health and public policy, (reissue of first edition 2003). Cambridge: Cambridge University Press. From: Chapter 3: [https://www.who.int/substance\\_abuse/publications/cannabis\\_report/en/index12.html](https://www.who.int/substance_abuse/publications/cannabis_report/en/index12.html).

<sup>3</sup> CT Data Haven, 25<sup>th</sup> Anniversary and Statewide Data Release Preliminary Results – November 19, 2018, <http://www.ctdatahaven.org/sites/ctdatahaven/files/25th%20Anniversary%20and%20Statewide%20Data%20Release%20Summary.pdf>.

<sup>4</sup> SERAC and ERASE Youth Survey Regional outcomes 2016-2018.

## Marijuana-Region IV RBHAO Epidemiological Profile

Other risk factors for marijuana use include tobacco smoking; Poor academic performance; Having friends that smoke marijuana; Social media influences; Easy availability; and Co-occurring anxiety, depression, PTSD, or other mental health issues.<sup>5</sup>

Males have higher cannabis dependence prevalence rates (23%) than females (14%). Women exhibit an accelerated progression to cannabis-use disorder after first use, and show more adverse clinical problems than men do. Prevalence peaks in between ages 20-24.<sup>6</sup>

### **Burden:**

In Connecticut (2018) 11.7% of all adult treatment admission are for marijuana use as the primary substance.<sup>7</sup> Of those 7,062 people, 76.2% were female; 66.2% were ages 21-35 with the majority being black (39.8), white (37.4%) and non-Hispanic/Latino (68.3%).

Driving while under the influence of cannabis is associated with 20 to 30 percent higher odds of a motor vehicle crash.<sup>8</sup>

### **Capacity and Service System Strengths:**

Active partners (LPCs, YSBs, law enforcement) in legislative advocacy related to legalization of marijuana.

Increased community understanding of marijuana as an additive substance with elevated risks for youth.

ERASE Youth Survey Data has collected information on marijuana use, including use of vape or ENDS as mechanism for use for over 3 years, allowing for data to drive community conversations around the use of vape/ENDS.

Both DFC funded communities address youth marijuana use as part of their action plans.

Youth sent to the Juvenile Review Board in their community with infractions of marijuana possession/use in Region IV receive marijuana education services and if they meet criteria, are referred to a program at UCONN Health.

A host of events (i.e., parent cafes, presentations, PTO meetings, etc.) are offered throughout the region for parents to address perceptions of MJ use among youth and teen brain biology.

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<sup>5</sup> CPES Profile, <https://s3.amazonaws.com/cpes-ctdata/reports/Marijuana+Profile.pdf>.

<sup>6</sup> Cooper ZD, Haney M (2014). Investigation of sex-dependent effects of cannabis in daily cannabis smokers. *Drug Alcohol Depend.* 136:85–91.; Degenhardt L, Hall WD (2012). Extent of illicit drug use and dependence, and their contribution to the global burden of disease. *Lancet.* 379(9810):55–70From: Chapter 3: [https://www.who.int/substance\\_abuse/publications/cannabis\\_report/en/index12.html](https://www.who.int/substance_abuse/publications/cannabis_report/en/index12.html).

<sup>7</sup> TEDS 2018

<sup>8</sup> National Academies of Sciences, Health Effects of Cannabis and Cannabinoids: The Current State of Evidence and Recommendations for Research. Washington (DC): National Academies Press (US); 2017 Jan 12. 9, Injury and Death. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK425742/>.

## Cocaine-Region IV RBHAO Epidemiological Profile

**PROBLEM STATEMENT:** Cocaine is a powerfully addictive stimulant drug. Health care providers use it for valid medical purposes however, recreational cocaine use is illegal. As a street drug, cocaine looks like a fine, white, crystal powder. It is often mixed with cornstarch, talcum powder, or flour. It may also be mixed with other drugs such as the amphetamine, or synthetic opioids, including fentanyl. Adding synthetic opioids to cocaine is especially risky when people using cocaine don't realize it contains this dangerous additive. Increasing numbers of overdose deaths among cocaine users might be related to this tampered cocaine.

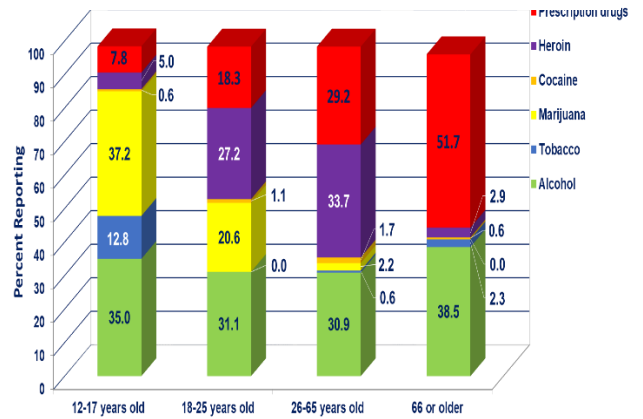
People snort cocaine powder through the nose, or they rub it into their gums. Others dissolve the powder and inject it into the bloodstream. Those who inject cocaine are at risk of Hepatitis and HIV. Studies have shown that cocaine use speeds up HIV infection. Some of the most frequent and severe health consequences of overdose are irregular heart rhythm, heart attacks, seizures, and strokes. Other symptoms of cocaine overdose include difficulty breathing, high blood pressure, high body temperature, hallucinations, and extreme agitation or anxiety.<sup>1</sup>

### Magnitude:

In Connecticut cocaine was involved in 36% of heroin and 33% of Fentanyl overdose deaths in 2017. From 2009-2017 cocaine use among those 18-25 years has increased from 5.1% to 8.4% with youth ages 12-17 seeing a decrease from 1% to 0.6%. Those ages 26 and older had a slight increase from 1.2% to 2.08%.<sup>2</sup> In Region IV Community Readiness Data, cocaine was noted as the least concern for all substances by key informants with the highest percent of concern being reported for those 26-65 years at 1.7%, followed by 1.1% for those 18-25 years<sup>3</sup>, see Figure 1.

Figure 1.

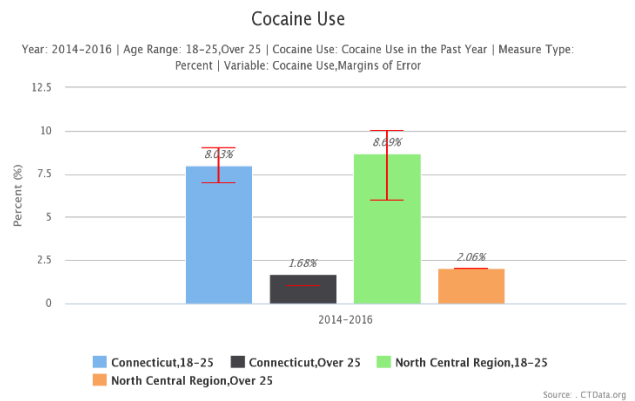
Problem Substances of Greatest Concern, By Age Group: Region IV CRS, 2018



### Risk Factors and Sub populations at-risk:

Young adults ages 18-25 and heroin users, see Figure 2.

Figure 2.



### Strengths:

Cocaine use is recently on the RBHAO radar due to data indicating an increase in use.

<sup>1</sup> NIDA Drug Facts Cocaine.

<sup>2</sup> CPES ADPC Presentation Dec 2018, citing NSDUH 2009-2017.

<sup>3</sup> Region IV Community Readiness Survey Report 2018.

## Heroin-Region IV RBHAO Epidemiological Profile

**PROBLEM STATEMENT:** Heroin is an illegal, highly addictive opioid drug. Heroin is typically injected but is also smoked and snorted. When people inject heroin, they are at risk of serious, long-term viral infections such as HIV, Hepatitis C, and Hepatitis B, as well as bacterial infections of the skin, bloodstream, and heart.<sup>1</sup> People often use heroin along with other drugs or alcohol. This practice is especially dangerous because it increases the risk of overdose.<sup>2</sup>

### Magnitude:

Nationally heroin-related overdose death has increased almost 400% between 2010-2017.<sup>3</sup> In the US, persons 18-25 have highest reported rates of heroin use at 0.64% for CT this rate is 1.31%.<sup>4</sup> Youth in grades 9-12 nationally have use rates of 1.7% compared to 2.2% in CT.<sup>5</sup> In 2018 opioid deaths in Hartford accounted for 13.3% of opioid deaths statewide.<sup>6</sup> Eleven Region IV towns in 2018 had increases in accidental opioid-related overdoses between 2017 and 2018. Ten towns in Region IV had 80% of the deaths between 2012-2018.

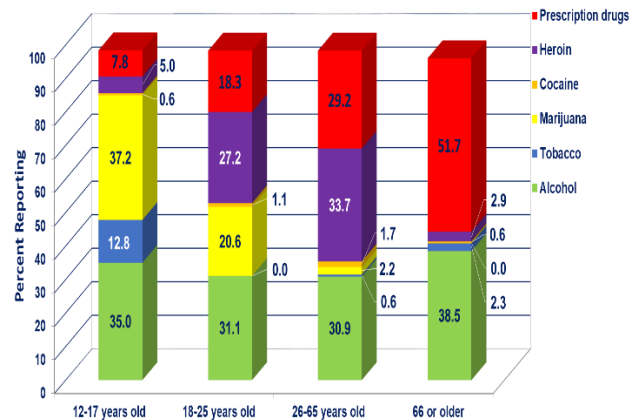
### Risk Factors and Sub Populations At-Risk:

In Region IV, White, Male, Not-Hispanic age 21 to 45 years old experienced the most overdose deaths. Followed by person ages 46 to 60.<sup>7</sup> Urban Core, Urban Periphery and Rural community types have the highest rates of overdose death with mortality rates (per 100,000 pop) of 36.1%, 29% and 23.3% respectively for 2017.<sup>8</sup> Poly substance users and intentional an unintentional users of Fentanyl are at the highest risk of overdose death. Community Readiness Data (2018) indicate that key leaders are most concerned regarding heroin use for those ages 26-65 (33.7%) followed persons 18-25 years (37.2%). See Figure 1.

Figure 1.

Problem Substances of Greatest Concern, By Age Group: Region IV CRS, 2018

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### Strengths:

Over 2 years 25 opioid mini grants awarded.

In past year, 572 Narcan kits distributed.

At least 4 opioid workgroups are established in Bristol, New Britain, towns in North Central CT and towns within the Central CT Health District area.

In Region IV, there 27 prescription drug drop boxes and 25 communities doing annual prescription drug take back events.

The DFC funded communities address NMUPD as part of their action plans.

<sup>1</sup> Substance Abuse and Mental Health Services Administration. Alcohol, Tobacco, and Other Drugs: Opioids, <http://www.samhsa.gov/atod/opioids>.

<sup>2</sup> US Department of Health and Human Services. HHS takes strong steps to address opioid-drug related overdose, death and dependence. Press Release: March 26, 2015, <http://www.hhs.gov/news/press/2015pres/03/20150326a.html>.

<sup>3</sup> Hedegaard H, Miniño AM, Warner M. [Drug overdose deaths in the United States, 1999–2017](#). NCHS Data Brief, no 329. Hyattsville, MD: National Center for Health Statistics. 2018.

<sup>4</sup> NSDUH Past year heroin 2016-2017.

<sup>5</sup> YRBS CT vs. US 2017

<sup>6</sup> Region IV Accidental Opioid Related Deaths Report May 2019.

<sup>7</sup> Region IV Accidental Opioid Related Deaths Report May 2019.

<sup>8</sup> CPES ADPC Presentation Dec 2018 (OCME)



## Fentanyl-Region IV RBHAO Epidemiological Profile

**PROBLEM STATEMENT:** Pharmaceutical fentanyl is a synthetic opioid pain reliever, approved for treating severe pain, typically advanced cancer pain. It is 50 to 100 times more potent than morphine. It is prescribed in the form of transdermal patches or lozenges and can be diverted for misuse and abuse in the United States. Most cases of fentanyl-related harm, overdose, and death in the U.S. are linked to illegally made fentanyl. It is sold through illegal drug markets for its heroin-like effect. It is often mixed with heroin and/or cocaine as a combination product—with or without the user’s knowledge—to increase its euphoric effects.<sup>1</sup>

**Magnitude:**

Nationally overdose deaths involving synthetic opioids other than methadone, which includes fentanyl, increased almost 47% from 2016 to 2017.<sup>2</sup> Roughly 28,400 people died from overdoses involving synthetic opioids other than methadone in 2017.<sup>3</sup> In Region IV, from 2012-2017 there was a 1,212% increase in deaths involving fentanyl,<sup>4</sup> see Table1. In 2017 Region IV Fentanyl deaths accounted for 37% of all Fentanyl deaths statewide. Oxycodone deaths in Region IV have decreased by 74% in the same time period.

Table 1. Region IV Fentanyl Deaths

	2012	2013	2014	2015	2016	2017
Fentanyl Deaths	5	4	25	77	186	249
Any Opioid Deaths	87	123	166	214	288	330
<b>% Fentanyl Deaths</b>	<b>6%</b>	<b>3%</b>	<b>15%</b>	<b>36%</b>	<b>65%</b>	<b>76%</b>

**Risk Factors and Sub populations at-risk:**

In Region IV, White, Male, Not-Hispanic age 21 to 45 years old experienced the most opioid overdose deaths, followed by person ages 46 to 60. Urban Core, Urban Periphery and Rural community types have the highest

rates of overdose death with mortality rates (per 100,000 pop) of 36.1%, 29% and 23.3% respectively for 2017. Poly substance users and intentional and unintentional users of Fentanyl are at the highest risk of overdose death. Community Readiness Data (2018) indicate that key leaders are most concerned regarding heroin use for those ages 26-65 (33.7%) followed persons 18-25 years (37.2%).

**Strengths:**

Over 2 years 25 opioid mini grants awarded.

In past year, 572 Narcan kits distributed.

At least 4 opioid workgroups are established in Bristol, New Britain, towns in North Central CT and towns within the Central CT Health District area.

In Region IV, there 27 prescription drug drop boxes and 25 communities doing annual prescription drug take back events.

The DFC funded communities address NMUPD as part of their action plans.

<sup>1</sup> Department of Justice, Drug Enforcement Administration, DEA Investigative Reporting, January 2015.

<sup>2</sup> Wide-ranging online data for epidemiologic research (WONDER). Atlanta, GA: CDC, National Center for Health Statistics; 2018. Available at <http://wonder.cdc.gov>.

<sup>3</sup> Scholl L, Seth P, Kariisa M, Wilson N, Baldwin G. [Drug and Opioid-Involved Overdose Deaths – United States, 2013-2017](#). Morb Mortal Wkly Rep. ePub: 21 December 2018.

<sup>4</sup> Region IV-Accidental Opioid-Related Deaths in CT Mental Health Region IV (2012-2018 Data), May 2019.

## Anxiety-Region IV RBHAO Epidemiological Profile

### PROBLEM STATEMENT: ANXIETY

Anxiety disorders involve more than temporary worry or fear. For a person with an anxiety disorder, the anxiety does not go away and can get worse over time.<sup>1</sup>

Anxiety disorders differ by the objects or situations that induce anxiety and range from specific phobias to generalized anxiety or post-traumatic stress. All share features of excessive worry and related behavioral disturbances. All can interfere with daily activities such as job performance, school work, and relationships.

About half of people diagnosed with depression are also diagnosed with an anxiety disorder.<sup>2</sup>

### Magnitude:

Based on diagnostic interview data from the National Comorbidity Study Replication (NCS-R)<sup>3</sup>, over 19% of adults and (NCS-A)<sup>4</sup> over 31% of children experienced an anxiety disorder in the past year.

According to 2017 Population Profile data for CT Medicaid recipients, almost 16% of adults and 6% of children were treated for anxiety disorder in the past year.<sup>5</sup> About 10.5% of calls to the CT Emergency Mobile Psychiatric Response system (for youth) in FY 2018 were for issues related to an anxiety disorder (11.9% were for anxiety as a secondary diagnosis<sup>6</sup>).

### Risk Factors and Sub Populations At-Risk:

The chart to the right reflects the demographic breakdown of CT Medicaid recipients treated for anxiety disorder in 2017.<sup>7</sup>

According to a 2015 Data Brief completed by Beacon Health Options for the CT Behavioral Health Partnership:

Blacks, Asians, and Hispanics were disproportionately underrepresented in populations who utilize behavioral health service, as well as those that utilize the Emergency Department and inpatient services. Blacks were disproportionately overrepresented in state psychiatric hospital bed use. Nationally and in Connecticut, women had higher prevalence rates for anxiety and tended to be higher users of behavioral health services. Adults aged 45 to 54 tended to be overrepresented in behavioral health service utilization, while those in the 18 to 25 age range were underrepresented.

Demographic	Anxiety Disorders	
	N	% within Demographic with Disorder
<b>Gender</b>		
Female	65,135	14.89%
Male	36,840	9.62%
<b>Age Group</b>		
Youth (3-17)	17,005	5.89%
Adult (18+)	84,970	15.98%
<b>Race/Ethnicity</b>		
White	47,341	18.03%
Unknown	23,779	10.95%
Hispanic	19,051	10.67%
Black	8,605	7.15%
Asian	1,052	4.56%
Others	2,147	11.48%
<b>Emerging Adult</b>		
Yes	23,004	11.82%
No	78,971	12.62%

Anxiety can occur with other mental health conditions can have an impact on overall health. Anxiety can often worsen related conditions, such as substance misuse, eating disorders, and suicide ideation. A variety of life

<sup>1</sup> National Institute of Mental Health, Anxiety Disorders Overview, 2018, [www.nimh.nih.gov/health/topics/anxiety-disorders/index.shtml](http://www.nimh.nih.gov/health/topics/anxiety-disorders/index.shtml)

<sup>2</sup> Anxiety and Depression Association of America, Facts and Statistics, <http://adaa.org/about-adaa/press-room/facts-statistics>

<sup>3</sup> Harvard Medical School, 2007. National Comorbidity Survey (NCS), August 21, 2017, retrieved from: <https://www.hcp.med.harvard.edu/ncs/index.php>. See also Data Table 2: 12-month prevalence DSM-IV/WMH-CIDI disorders by sex and cohort.

<sup>4</sup> Merikangas KR, He JP, Burstein M, Swanson SA, Avenevoli S, Cui L, Benjet C, Georgiades K, Swendsen J. *Lifetime prevalence of mental disorders in U.S. adolescents: results from the National Comorbidity Survey Replication--Adolescent Supplement* (NCS-A). *J Am Acad Child Adolesc Psychiatry*. 2010 Oct;49(10):980-9. PMID: 20855043

<sup>5</sup> Ad hoc request for Population Profile CY 2017, CT Beacon Health Options

<sup>6</sup> Mobile Crisis Intervention Services PIC report FY 2018

<sup>7</sup> Ad hoc request for Population Profile CY 2017, CT Beacon Health Options

## Anxiety-Region IV RBHAO Epidemiological Profile

experiences and social determinants such as social inequality, bullying, trauma, and economic or housing insecurity may also impact incidences of anxiety disorder. Mental health is also influenced by the social, economic, and physical environments in which people live. According to the 2017 Youth Risk Behavior Survey,<sup>8</sup> safety concerns such as bullying (including electronic bullying) experienced by CT high school students were increased slightly between 2105 and 2017.

According to the 2018 Hartford Healthcare Community Needs Assessment,<sup>9</sup> prevalence of good mental health indicators is below the state average in Hartford, Bristol, and New Britain. These are also the towns with the highest rates of requests for mental health and addiction information from 2-1-1,<sup>10</sup> and the areas of greatest shortage for medical and health professionals.

Social determinants that impact health in the Greater Hartford area include: 1) a higher poverty rate, especially among Hispanic residents; 2) a higher percentage of children living in poverty and single parent households; 3) a higher percentage of minority unemployment rates; 4) lower level of educational attainment; and 5) higher crime rates. On a positive note, Greater Hartford residents have lower rates of uninsured residents and better primary, dental, and mental health provider ratios.

### **Burden:**

People with an anxiety disorder are three to five times more likely to go to the doctor and six times more likely to be hospitalized for psychiatric disorders than those who do not suffer from anxiety disorders. Anxiety disorders develop from a complex set of risk factors, including genetics, brain chemistry, personality, and life events. Research shows that untreated children with anxiety disorders are at higher risk to perform poorly in school, miss out on important social experiences, and engage in substance abuse.

### **Capacity and Service System Strengths:**

According to the 2018 Hartford Healthcare Community Needs Assessment,<sup>11</sup> the following contribute to continuing challenges with mental health in the Greater Hartford service area: 1) a shortage of mental health providers and counselors; 2) the difficulty of recruiting additional providers; and 3) a lack of effective mental health screening at all levels. This was also reflected in responses from our surveys and focus groups with residents and providers in Region IV Communities. Other factors that impact community health include: 1) housing and safety concerns related to a lack of safe affordable housing, neighborhood safety, and housing conditions; 2) a lack of coordination among providers and community-based organization that limits the overall effectiveness of the programs and funding that serve the populations most in need; and 3) lack of availability of transportation, insurance cost (high deductibles and co-pays), lack of availability of providers who take all insurance types, and limited hours of operation at community health centers.<sup>12</sup>

An important step in the priority setting process was the convening of a priority setting workgroup to review data, survey, and focus group results and agree on a ranked order of issues to be addressed in Region IV. Anxiety, especially among youth, was identified as the top behavioral health issue to be addressed – second only to alcohol use among all the issues to be considered.

School and Local Prevention Council (LPC) personnel noted high rates of anxiety among school youth. Several LPCs have hosted events using the film “Angst” for education and discussion with parents.

One strength noted in our focus groups and surveys was an increase in the availability of wrap around and in-home services for children.

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<sup>8</sup> 2017 Youth Risk Behavior Survey, Component of the CT School Health Survey, CT Department of Health in collaboration with the CT Department of Education

<sup>9</sup> Hartford HealthCare Community Health Needs Assessment, June 2018, Percival Health Advisors

<sup>10</sup> 211 Counts Connecticut, <https://ct.211counts.org/>

<sup>11</sup> Hartford HealthCare Community Health Needs Assessment, June 2018, Percival Health Advisors

<sup>12</sup> Id.

## Depression-Region IV RBHAO Epidemiological Profile

### PROBLEM STATEMENT: DEPRESSION

Depression is one of the most common mental health disorders for children and adults. Symptoms may be mild, moderate, or major. Major depression is a period of two weeks or longer during which there is either a depressed mood or loss of interest or pleasure, and other symptoms that impede one’s ability to function, such as problems with sleep, eating, energy, concentration, self-image, or recurrent thoughts of death or suicide. About half the people diagnosed with depression are also diagnosed with an anxiety disorder.<sup>1</sup>

### Magnitude:

Based on prevalence data from the 2016 National Survey on Drug Use and Health,<sup>2</sup> over 6% of all CT adults (17+) have experienced at least one major depressive episode in the past year.

Region IV youth survey data from 2016-2018 indicates that 13% of region IV students in grades 6-8 and 16.7% of students grade 9-12 reported they had, “during the 12 months felt so sad or hopeless every day for 2 or more weeks such they that stopped during usual activities.”

According to 2017 Population Profile data for CT Medicaid recipients, almost 16% of adults and 6% of children were treated for depression in the past year.<sup>3</sup> About 31.7% of calls to the CT Emergency Mobile Psychiatric Response system (for youth) in FY 2018 were for issues related to depression (10.6% were for depression as a secondary diagnosis).<sup>4</sup>

### Risk Factors and Sub Populations At-Risk:

The chart to the right reflects the breakdown of CT Medicaid recipients treated for depression in 2017.<sup>5</sup>

Depressive Disorders		
Demographic	N	% within Demographic with Disorder
<b>Gender</b>		
Female	60525	13.84%
Male	36705	9.59%
<b>Age Group</b>		
Youth (3-17)	15418	5.34%
Adult (18+)	81812	15.39%
<b>Race/Ethnicity</b>		
White	40280	15.34%
Unknown	22815	10.51%
Hispanic	20348	11.40%
Black	10858	9.03%
Asian	916	3.97%
Others	2013	10.77%
<b>Emerging Adult</b>		
Yes	22696	11.67%
No	74534	11.91%

According to a 2015 Data Brief completed by the Beacon Health Options for the CT Behavioral Health Partnership,<sup>6</sup> Blacks, Asians, and Hispanics are disproportionality underrepresented in populations who utilize behavioral health services. Blacks were disproportionality overrepresented in state psychiatric hospital bed use. Nationally and in Connecticut, women tended to be higher users of behavioral health services. Adults aged 45 to 54 tended to be overrepresented in behavioral health service utilization while those in the 18 to 25 age range were underrepresented.

According to the 2018 Hartford Healthcare Community Needs Assessment,<sup>7</sup> prevalence of good mental health indicators is below the state average in Hartford, Bristol, and New Britain. Prevalence of depression indicators is higher than the state average in Hartford, Manchester, Bristol, and New Britain. These are also the areas of greatest shortage for medical and health professionals.

Among the social determinants that impact health in the Greater Hartford area include: 1) a higher poverty rate, especially among Hispanic residents; 2) a higher

<sup>1</sup> Anxiety and Depression Association of America, Facts and Statistics, <http://adaa.org/about-adaa/press-room/facts-statistics>

<sup>2</sup> 2016 National Survey on Drug Use and Health, Substance Abuse and Mental Health Services Administration

<sup>3</sup> Ad hoc request for Population Profile CY 2017, CT Beacon Health Options

<sup>4</sup> Mobile Crisis Intervention Services PIC report FY 2018

<sup>5</sup> Ad hoc request for Population Profile CY 2017, CT Beacon Health Options

<sup>6</sup> Health Equity and Inequity Within the Connecticut Medicaid Behavioral Health Service System, 2016

<sup>7</sup> Hartford HealthCare Community Health Needs Assessment, June 2018, Percival Health Advisors

## Depression-Region IV RBHAO Epidemiological Profile

percentage of children living in poverty and singly parent households; 3) higher percentage of minority unemployment rates; 4) a lower level of educational attainment; and 5) higher crime rates. On a positive note, Greater Hartford residents have lower rates of uninsured residents and better primary, dental, and mental health provider ratios.

Depression can occur with other mental health conditions, can have an impact on overall health, and can often worsen related conditions, such as substance misuse, eating disorders, and suicide ideation. A variety of life experiences and social determinants may also impact incidence of depressive disorder, such as experiences of social inequality, bullying, trauma and safety concerns such as economic or housing insecurity. Mental health is also influenced by the social, economic, and physical environments in which people live.<sup>8</sup> According to the 2017 Youth Risk Behavior Survey,<sup>9</sup> safety concerns such as bullying (including electronic bullying) experienced by CT high school students increased slightly between 2105 and 2017. Reported incidences of depression remained relatively constant (26.9%).

According to the 2018 Center for Disease Control and Prevention Morbidity and Mortality Report,<sup>10</sup> 18.9 % of CT youth reported being bullied on school property, 15.8% had been electronically bullied, 6.9% did not go to school because of safety concerns on the way to and from or in school, and 26.9% felt so sad or hopeless

almost every day for 2 or more weeks in a row that they stopped doing usual activities.

### **Burden:**

Depression is associated with significant impairment across numerous areas of functioning<sup>11</sup> such as the need for medical care, hospitalizations, and employment.<sup>12</sup> Depression is also associated with higher mortality associated with cardiovascular disease,<sup>13</sup> stroke,<sup>14</sup> and suicide.<sup>15</sup> Depression also has significant social and economic consequences. In 2000, the annual cost of major depression was estimated at \$83.1 billion.<sup>16</sup>

### **Capacity and Service System Strengths:**

According to the Hartford Healthcare Community Needs Assessment,<sup>17</sup> continuing challenges with mental health in the Greater Hartford service area were impacted by: 1) a shortage of mental health providers and counselors; 2) the difficulty of recruiting additional providers; and 3) a lack of effective mental health screening at all levels. Other factors that impact community health include: 1) housing and safety concerns related to a lack of safe and affordable housing, neighborhood safety, and housing conditions; 2) a lack of coordination among providers and community-based organizations limits effectiveness of the programs and funding that serve the populations most in need; and 3) other factors that impact access to care, including availability of transportation, insurance cost, availability of providers who accept all insurance types, lack of employment opportunities, and community health centers' hours of operation.

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<sup>8</sup> Health Equity and Inequity Within the Connecticut Medicaid Behavioral Health Service System, 2016

<sup>9</sup> 2017 Youth Risk Behavior Survey, Component of the CT School Health Survey, CT Department of Health in collaboration with the CT Department of Education

<sup>10</sup> Center for Disease Control and Prevention, Morbidity and Mortality Weekly Report, Surveillance Summaries, Vol 67, No. 8, June 15, 2018

<sup>11</sup> The epidemiology of major depressive disorder: results from the National Comorbidity Survey Replication (NCS-R). Kessler RC, Berglund P, Demler O, Jin R, Koretz D, Merikangas KR, Rush AJ, Walters EE, Wang PS, National Comorbidity Survey Replication. JAMA. 2003 Jun 18; 289(23):3095-105.

<sup>12</sup> Impairment in major depression: implications for diagnosis. Mojtabai R Compr Psychiatry. 2001 May-Jun; 42(3):206-12.

<sup>13</sup> Symptoms of depression, acute myocardial infarction, and total mortality in a community sample. Barefoot JC, Schroll M Circulation. 1996 Jun 1; 93(11):1976-80.

<sup>14</sup> Symptoms of depression as a prospective risk factor for stroke. Jonas BS, Mussolino ME Psychosom Med. 2000 Jul-Aug; 62(4):463-71.

<sup>15</sup> Prevalence of and risk factors for lifetime suicide attempts in the National Comorbidity Survey. Kessler RC, Borges G, Walters EE Arch Gen Psychiatry. 1999 Jul; 56(7):617-26.

<sup>16</sup> The economic burden of depression in the United States: how did it change between 1990 and 2000? Greenberg PE, Kessler RC, Birnbaum HG, Leong SA, Lowe SW, Berglund PA, Corey-Lisle PK J Clin Psychiatry. 2003 Dec; 64(12):1465-75.

<sup>17</sup> Hartford HealthCare Community Health Needs Assessment, June 2018, Percival Health Advisors

## Serious Mental Illness-Region IV RBHAO Epidemiological Profile

### Problem Statement: Serious Mental Illness

Serious mental illnesses (SMIs) are a small subset of the 300 mental illnesses that are in Diagnostic and Statistical Manual of Mental Disorders (DSM). They include schizophrenia, bipolar disorder and major depression but also other mental illnesses when those illnesses cause significant functional impairment and substantially limit major life activities.<sup>1</sup>

### Magnitude:

According to the National Institute of Mental Health (NIMH), serious mental illness is relatively rare, affecting less than 5% of the population over 18.<sup>2</sup>

39,316 people were served by DMHAS funded mental health services in 2018. 30% of those individuals live in Region IV. Over 60% of the adults who receive DMHAS funded services qualify for an SMI (serious mental illness) diagnosis, which involves having any (or multiple), of the following diagnoses: Schizophrenia (including related disorders), Bipolar Disorder, Major Depression, or PTSD. One-third (33%) of clients qualify for a dual diagnosis, meaning that they have both an SMI diagnosis and a substance abuse diagnosis.<sup>3</sup>

### Risk Factors and Sub population at-risk:

According to 2017 Population Profile data for CT Medicaid recipients<sup>4</sup>, almost over 4% of adults and less than .5% of children were treated for bipolar disorder in the past year. Almost 3% of adults and less than 1% of youth were treated for schizophrenia and other psychotic disorders. Over 15% of adults and over 5% of youth were treated for depression.

The chart to the right reflects the demographic breakdown of CT Medicaid recipients treated for these disorders in 2017.<sup>5</sup>

Demographic	Bipolar Disorders		Schizophrenia and Other Psychotic		Depressive Disorders	
	N	% within Demographic with Disorder	N	% within Demographic with Disorder	N	% within Demographic with Disorder
<b>Gender</b>						
Female	13717	3.14%	8258.939	1.89%	60525	13.84%
Male	9672	2.53%	10160.85	2.65%	36705	9.59%
<b>Age Group</b>						
Youth (3-17)	1293	0.45%	2727	0.94%	15418	5.34%
Adult (18+)	22096	4.16%	15693	2.95%	81812	15.39%
<b>Race/Ethnicity</b>						
White	10725	4.08%	6202	2.36%	40280	15.34%
Unknown	5292	2.44%	4006	1.85%	22815	10.51%
Hispanic	4180	2.34%	3975	2.23%	20348	11.40%
Black	2604	2.17%	3725	3.10%	10858	9.03%
Asian	128	0.55%	206	0.89%	916	3.97%
Others	460	2.46%	306	1.64%	2013	10.77%
<b>Emerging Adult</b>						
Yes	4766	2.45%	4419	2.27%	22696	11.67%
No	18623	2.98%	14001	2.24%	74534	11.91%

According to the DMHAS 2018 Statistical Report young adults aged 18-25 years had the highest prevalence of SMI (7.43%) compared to adults aged 26+ (3.63%).

Of the total number of statewide clients served in FY 2018, 62% were Caucasian. With the addition of the next two largest groups, Blacks and Other Race (often selected by clients of Hispanic ethnicity who view their race as neither Caucasian nor Black), at 16% and 15% respectively; this accounted for 93% of people served. According to state census data from 2016, Caucasians represent 67.7% of Connecticut residents and are thus underrepresented in the DMHAS population. Blacks represent 11.8% of CT residents and are overrepresented in DMHAS data.

The distribution of clients by race was very consistent across MH treatment programs. Caucasians were the most represented in treatment, followed by Blacks and Others.

Within CT mental health programs in 2018, slightly more women than men received treatment (50.2%) and

<sup>1</sup> "Prevalence of Serious Mental Illness Among U.S. Adults by Age, Sex, and Race in 2008 (NSDUH)" at [http://www.nimh.nih.gov/statistics/SMI\\_AASR.shtml](http://www.nimh.nih.gov/statistics/SMI_AASR.shtml)

<sup>2</sup> Id.

<sup>3</sup> Connecticut Department of Mental Health and Addiction Services, Annual Statistical Report SFY 2018, Produced by the

Evaluation, Quality Management and Improvement Division, November 2017

<sup>4</sup> Ad hoc request for Population Profile CY 2017, CT Beacon Health Options.

<sup>5</sup> Id.

## Serious Mental Illness-Region IV RBHAO Epidemiological Profile

(49.7%) respectively. These patterns across program type have been observed since SFY12.

Of the total number of clients served by DMHAS, 21% were of Hispanic/Latino ethnicity; 15.7% of Connecticut residents are Hispanic or Latino, meaning that they are overrepresented in the DMHAS data.

The largest group of Hispanic/Latino consumers was of Puerto Rican origin (12%).

Statewide, 71% of clients receiving DMHAS services were not of Hispanic/Latino ethnicity. The distribution of ethnic origin across SA/MH programs was generally equivalent, with slightly more consumers in Substance Abuse programs (+1.3%) being of Hispanic/Latino origin.

### **Burden:**

Serious mental illness can disrupt a person's ability to work, care for one's self and health, form and maintain relationships across the lifespan and can lead to premature death.<sup>6</sup> Because the disabling condition may not be visible to others, people are often negatively judged as being weak, lazy, uncooperative, or not ill. This lack of understanding contributes to the stigma and discrimination people experience and is a barrier to seeking treatment and support.

### **Capacity and Service System Strengths**

Region IV DMHAS funded providers offer a full range of services. These include: Assertive Community Treatment, Case Management, Community Support, Crisis Response, Education and Employment Support, Forensics Community-based, Housing Services, Intensive and Outpatient treatment, Prevention, and Social Rehabilitation (Clubhouses)

Responses from our focus groups reveal that Region IV stakeholders rate prevention and treatment services mental health issues to be barely adequate (rated 3.1 of 5) but recovery support less than adequate (2.95 of 5).

In the area of prevention, they cited the need to address bullying, social emotional learning, education

with the general population, youth, and families including information about suicide prevention and school and SBIRT screenings.

In the area of treatment, they cited the need for navigation assistance, better access to treatment, lack of prescribers, use of dialectical therapy, crisis response, inadequate lengths of stay in inpatient treatment, lack of warm handoff to the next level of care, need for more residential treatment beds (especially for adolescents), crisis response, and intensive outpatient options. Treatment levels described as least available were assertive community treatment, intensive outpatient, and individual therapy.

In the area of recovery support, they cited the need for more case management/community support services, respite, housing, transportation, family and peer support and marketing of peer support options.

In the area of system strengths, they cited community education, Gizmo education campaign, crisis response, clubhouses, peer support, warmlines, integrated behavioral and physical health care, and caring agencies and staff (once in the system).

Subpopulations at risk were: younger and older adults, people with commercial insurance, veterans, people who identify as LGBTQ, coming out of incarceration, cultural minority and monolingual groups (especially refugee groups), and youth with complex issues.

Emerging areas of concern included high-deductible insurance plans, e-cigarettes, legalization of marijuana, sports betting, growing older adult population, high levels of anxiety among youth, and people trying to taper off medications.

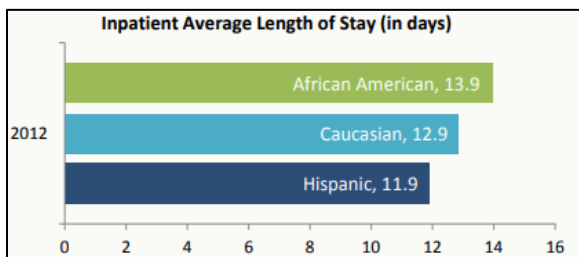
Opportunities suggested were remote patient appointments, better partnerships with local social services staff and faith communities, walk-in centers with holistic and behavioral health support, young adult texting apps, life coaches, and added supportive services to money follows the person program.

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<sup>6</sup> World Health Organization. (2018) Disease incidence, prevalence and disability. In World Health organization (ed.). *The Global Burden of Disease: 2004 Update*.

## Early Serious Mental Illness-Region IV Epidemiological Profile

Another finding of interest was that Spanish-speaking Medicaid youth were less likely to use mental health services, particularly inpatient levels of care, than would be predicted compared to their presence in the Medicaid population. When hospitalized for behavioral health reasons, Hispanic youth stayed on average the fewest days in 2012, while African American youth stayed the longest (see graph below).



### Burden:

Early intervention strategies are important because they reduce the likelihood of long-term disability that people with severe mental illness often experience. The goal is to help these individuals lead fulfilling, independent, and productive lives, reduce the crises that may accompany more advanced mental illness, and ultimately reduce the financial burden on public systems.

### Capacity and Service System Strengths

Early treatment of psychosis, especially during the first episode, leads to the best outcomes.

According to a study conducted by Beacon Health Options, only about 35% of “emerging adults” (ages 15-26) who need behavioral health services receive treatment.<sup>6</sup>

Congress has directed SAMHSA to require that states set aside 10% percent of their Community Mental Health Services Block Grant to address these needs.<sup>7</sup> This requirement aims to support “evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders.”<sup>8</sup>

In CT, this led to the development of a statewide program for Medicaid recipients ages 16-26. Program recipients are identified through claims data or real time referrals to Beacon Health Options. They and their families are offered support by Beacon’s Intensive Care Manager to connect to appropriate levels of care within their communities.

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. Typically, a person would receive two or three services each week. Both individual and group treatment are offered on a weekly basis. Intensive family work is also offered through the outreach program, and through regular family meetings which are convened for planning and support.

In 2017-18 the program served 54 young adults. 32 of those are working part or fulltime, 28 are in school/certificate programs, and 4 are involved in structured volunteer work. During the past year 7 only had hospital re-admissions. In the past year 46 of 52 young people had successfully completed the program. In addition the program offers group social recovery events (~400 participants this year) community education events (~150 participants) and family services (32 families).

As well, DMHAS has a program (YAS) that serves young adults ages 18-25 with a history of DCF involvement and major mental health problems. In SFY18, DMHAS served 13,380 young adults. 45% had a primary diagnosis or mental health disorder. 9% were served by this specialized YAS program.

<sup>6</sup> Id.

<sup>7</sup> NAMI Early Psychosis Project, July 2016

<sup>8</sup> SAMHSA News, Fall 2014, Volume 22, Number 4 » Serious Mental Illness: A New Block Grant Priority



## Suicide-Region IV RBHAO Epidemiological Profile

### PROBLEM STATEMENT: SUICIDE

Suicide is the 10<sup>th</sup> leading cause of death in the United States. It was the second leading cause of death among individuals between the ages of 10 and 34, and the fourth leading cause of death among individuals between the ages of 35 and 54.<sup>1</sup>

Suicides are a major cause of intentional injury death in Connecticut. To better understand the problem in our state, the Office of Injury Prevention actively tracks suicides occurring in CT and among CT residents in/out-of-state and their circumstances using the Connecticut Violent Death Reporting System (CTVDRS).<sup>2</sup>

The top known circumstances for suicide include: depressed mood, having received mental illness or substance abuse treatment, diagnosed mental health problem, currently receiving mental health or substance abuse treatment, history of attempted suicide, and a contributing physical health problem (for ages 64+).<sup>3</sup>

### Magnitude:

According to the CT Office of the Medical Examiner, the statewide number of suicides has steadily increased from 358 in 2010 to 402 in 2017 (7.4% in 2017).<sup>4</sup>

About 8.1% of CT youth have attempted suicide one or more times in the last 12 months, while 13.5% seriously considered suicide. These are comparable averages to national statistics.<sup>5</sup>

Data gathered in Region IV youth surveys throughout 2016-2018 reflects that 6.2% of students grades 6-8 indicated they had thoughts of suicide. About 7.6% of students grades 9-12 had similar thoughts.

According to 2017 Population Profile data for CT Medicaid recipients, almost 2% of adults and 1% of children were treated because of a suicide attempt or self-inflicted injury in the past year.<sup>6</sup>

The chart below reflects the breakdown of CT Medicaid recipients treated for suicide attempt or self-inflicted injury in 2017.<sup>7</sup>

Demographic	Inflicted Injury Diagnoses	
	N	% within Demographic with Disorder
<b>Gender</b>		
Female	6327	1.45%
Male	6454	1.69%
<b>Age Group</b>		
Youth (3-17)	2815	0.98%
Adult (18+)	9966	1.87%
<b>Race/Ethnicity</b>		
White	5268	2.01%
Unknown	3326	1.53%
Hispanic	2322	1.30%
Black	1495	1.24%
Asian	110	0.48%
Others	260	1.39%
<b>Emerging Adult</b>		
Yes	4021	2.07%
No	8760	1.40%

### Burden:

The effects of suicide on family members and loved ones can be severe and far-reaching. Friends and family of those who have died by suicide experience impacts on their own mental health. Parents who lost a child to suicide typically have higher rates of depression, physical problems, and low income (often even before the child's suicide). Anxiety and

<sup>1</sup> National Vital Statistics System, National Center for Health Statistics, CDC 2016

<sup>2</sup> Id.

<sup>3</sup> 2016 CT Violent Death Reporting System Top Five Known Circumstances by Specific Age Categories

<sup>4</sup> Office of the CT Chief Medical Examiner, Annual Statistics,

<https://ct.gov/ocme/cwp/view.asp?a=2165&q=295126&pp=12&n=1>

<sup>5</sup> DPH, 2018 <https://portal.ct.gov/dph/Health-Information-Systems--Reporting/Hisrhome/Connecticut-School-Health-Survey%20>

<sup>6</sup> Ad hoc request for Population Profile CY 2017, CT Beacon Health Options

<sup>7</sup> Id.

## Suicide-Region IV RBHAO Epidemiological Profile

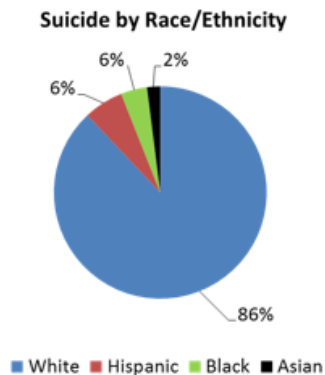
divorce are very common effects on parents after a child's suicide.<sup>8</sup>

When a person dies, society generally offer empathy and compassion, but when a person dies by suicide, there is stigma around that death and people often treat the loved ones of the person who died by suicide differently. Loved ones can be very afraid to talk about the suicide for fear of judgement and condemnation – being blamed for the suicide of their family member or friend. Because of this, one effect of suicide on family and friends can be extreme isolation.

According to one study, children of parents who lost a child to suicide are at a significantly increased risk for dying by suicide themselves. The younger the child at the time of the parent's suicide, the greater the risk of his or her own suicide.<sup>9</sup>

### Risk and Subpopulations:

According to the CT Department of Health,<sup>10</sup> of the 388 suicides that occurred in CT in 2016, 88% were white, 6% Hispanic, 6% Black, and 2% Asian.



Region IV towns with the highest suicide rates in 2015 (in order from highest to lowest) include Vernon, Bristol, Southington, Enfield, Manchester, and Hartford.<sup>11</sup>

<sup>8</sup> HealthyPlace.com, Inc.

<sup>9</sup> Id.

<sup>10</sup> CT Department of Public Health, Office of Injury Prevention

<sup>11</sup> DPH, CTVDRS, All Ages

Age groups with the highest suicide rates are 45 to 64 years and 65 to 84 years.<sup>12</sup>

Opioid use is associated with a 40%-60% increased likelihood of suicidal thought, and a 75% increased likelihood of suicide attempt. Some studies suggest that opioid and injection drug users are 13 times as likely to die by suicide. An estimated 30% of unintentional opioid overdoses are the result of suicide.<sup>13</sup>

### Strengths and Capacity:

Since January 2012, the CT Suicide Advisory Board (CTSAB) has functioned as the single state-level suicide advisory board in CT that addresses suicide prevention and response across the lifespan. CTSAB is cooperatively co-chaired by the CT Departments of Mental Health and Addiction Services and Children and Families (DCF) and is legislatively mandated under DCF.

The CTSAB is a network of diverse advocates, educators and leaders concerned with addressing the problem of suicide with a focus on prevention, intervention, and health and wellness promotion. Its vision is to eliminate suicide by instilling hope across the lifespan.

The CTSAB leads the state campaign that promotes the National Suicide Prevention Lifeline and the CT Zero Suicide Initiative and advises state agencies on the use of their suicide-related state and federal dollars from the Substance Abuse & Mental Health Services Administration, Centers for Disease Control and Prevention, and Health Resources & Services Administration.

Region IV and the town of Manchester are working under grants to establish networks of care for suicide prevention targeting young people ages 10 to 24 years. In addition, the towns of Ellington, Enfield, Glastonbury, Burlington, and Suffield received grants

<sup>12</sup> Age-Specific Suicide Rates from the CT Violent Death Reporting System 2012-2016

<sup>13</sup> 2016 CT Violent Death Reporting System Top Five Known Circumstances by Specific Age Categories

## Suicide-Region IV RBHAO Epidemiological Profile

for school systems suicide prevention and mental health promotion.

The CTSAB provides a wealth of resources on their website ([preventsuicidect.org](http://preventsuicidect.org)) for communities, schools, families, and religious organizations and more. Resources include suicide prevention training, national lifeline, toolkits for the aftermath of a suicide and more.

## Problem Gambling-Region IV RBHAO Epidemiological Profile

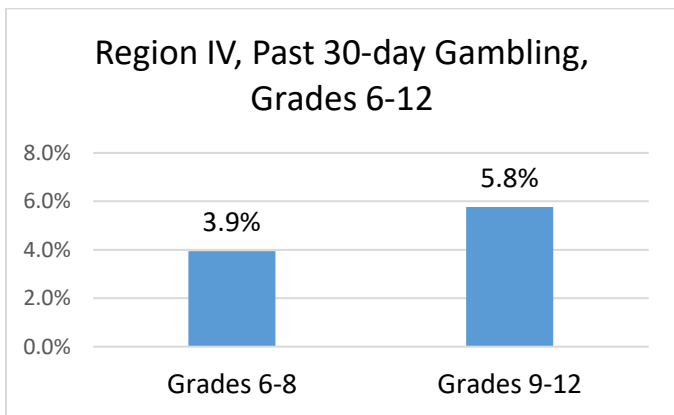
**PROBLEM STATEMENT:** Gambling means that you're willing to risk something you value in the hope of getting something of even greater value. Gambling can stimulate the brain's reward system much like drugs or alcohol can, leading to addiction. People with problem or compulsive gambling may continually chase bets that lead to losses, hide their behavior, deplete savings, accumulate debt, or even resort to theft or fraud to support the addiction.<sup>1</sup>

**Magnitude:**

1.5%-2% of the population will meet the criteria for problem gambling within their lifetime, that is approximately 53,863 of Connecticut residents.

Region IV youth survey data for grades 9-12, indicate that 5.8% had gambled in the past 30-days.

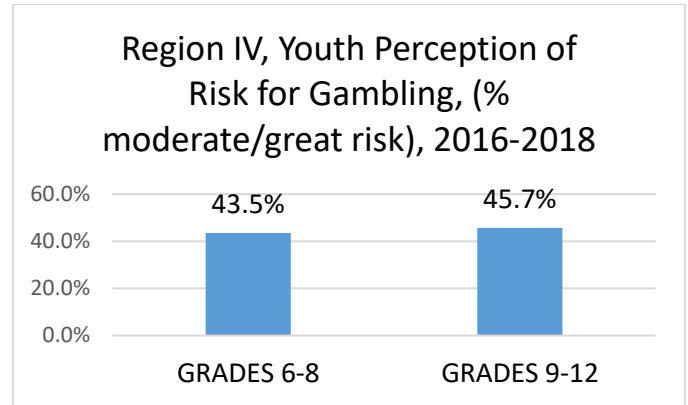
Figure 1.



**Risk Factors and Sub Population At-Risk:**

Region IV youth survey data for grades 9-12 show that risk factors for youth gambling are; perceived risk (45.7%), perceived parental disapproval (77.9%) and perceived peer disapproval (42.7%), meaning 57% of youth approve of their peer gambling.

Figure 2.



People who are described by the following are at-risk: have an early big win; have easy access to their preferred form of gambling; hold mistaken beliefs about the odds of winning; do not take steps to monitor gambling wins and losses; have had a recent loss or change, such as divorce, job loss, retirement or death of a loved one; often feel bored or lonely, or have a history of risk-taking or impulsive behavior; have financial problems; have few interests or hobbies, or feel their lives lack direction; have a history of mental health problems, particularly depression and anxiety; have been abused or traumatized; have a parent who also has (or has had) problems with gambling; have (or have had) problems with alcohol or other drugs, gambling or overspending; tie their self-esteem to gambling wins or losses.<sup>2</sup>

Certain populations are at increased risk including; Males; Individuals with lower educational attainment; Immigrants; Blacks; Older Adults; Those who live or work within 50 miles of a casino.

**Burden:**

Table 1. Region IV Calls to Gambling Helpline, Persons with Problem Gambling and Persons Impacted by Problem Gambler

<sup>1</sup> Mayo Clinic, *Compulsive gambling*, <https://www.mayoclinic.org/diseases-conditions/compulsive-gambling/symptoms-causes/syc-20355178>.

<sup>2</sup> Provincial System Support Program (PSSP), *Gambling, Gaming, and Technology Use*,.

## Problem Gambling-Region IV RBHAO Epidemiological Profile

	<b>Gambler-Caller</b>	<b>Percent of Gambler Callers from Region IV</b>	<b>Persons Impacted by PG</b>
<b>2017</b>	<b>47</b>	<b>23%</b>	<b>12</b>
<b>2018</b>	<b>40</b>	<b>19%</b>	<b>12</b>
<b>2019</b>	<b>28</b>	<b>26%</b>	<b>1</b>

Bettor Choice Treatment Programs in Region IV had 19 Clients in FY 2018, and that amount more than doubled in FY 2019 to 40.

### **Capacity and Service System Strengths:**

Region IV has a strong Bettor Choice Program provider at Wheeler Clinic.

The Region IV Gambling Awareness Team has been in place for over 2 years and is well attended and includes an average of 8 participants per meeting.

There are 10 professionals in Region IV “Certified in Problem Gambling.”

2018 CRS data indicate that 77% of respondents for Region IV think preventing problem gambling in their community is “very important (16%),” “somewhat important (27%)” or “a little important (34%).”

ERASE Student Youth Surveys have included problem gambling for all “core” indicators for over 3 years, allowing for comparison to substance use.

The Region’s PAWS Conference for 154 Middle School Youth was Gambling Awareness themed in March 2019, evaluation outcomes indicated growth in youth knowledge of risks associated with gambling, how online gaming is associated with gambling behaviors and where to get help if someone has a gambling problem.

Two youth leadership groups in the region have completed gambling awareness PSAs in the past 2-years. Evaluations of youth involved in these projects indicate that there was significant growth in knowledge of what is considered gambling, risks associated with gambling, and where to get help if someone has a gambling problem. All youth involved report an interest in learning more about the topic and a need to share information about gambling risks with youth and adults.

## **Emerging Issues:**

The perception, especially among school personnel is that the number of youths using vaping products has skyrocketed. Region IV perceived risk or harm for grades 9-12 was only 32% for ENDS, the lowest perceived risk rate among all “core substances and gambling.” It is expected that use rate (2.3% grades 6-8 and 8.9% grades 9-12) will show an increase in 2019 survey results. The majority of Region IV youth surveyed in 2018 indicated that tobacco/nicotine was the most common substance used in ENDS. This also requires further investigation as school personnel are also finding that marijuana is commonly used.

Although 2018 data shows a slight decline in overdose deaths, the rate of deaths with the presence of Fentanyl continues to climb. Poly-substance users and intentional or unintentional users of Fentanyl are at the highest risk. Hartford rates. Some of the most recent overdose deaths in Hartford were with people using cocaine containing Fentanyl. This raises the need to ensure 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.

School and Local Prevention Council (LPC) personnel noted high rates of anxiety among school youth. This was seconded by the Region IV priority setting workgroup. Anxiety, especially among youth, was identified by the priority setting work group as the top behavioral health issue to be addressed – second only to alcohol use among all the issues to be considered. (see further detail in the next section below).

School and Local Prevention Council (LPC) personnel as well as the Region IV priority workgroup found it important to consider the overlap between computer gaming, sports betting and problem gambling and when they might bleed into internet and phone addiction.

Members of Catchment Area Council expressed concern about the creation of the new RBHAOs. Even though the CAC role continues to be appreciated by community members and protected by state statute, it is not clear how the NCRBHAO will be able to continue to support the role of CACs for consumer engagement and the monitoring of the services that impact CAC members with the dearth of state funding.

## **Resources, Strengths, Assets:**

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 now available in five Region IV hospital emergency rooms. Other strengths noted by focus group

participants included an increase in wrap around and in-home service options for children. Adult participants noted improved quality of mobile teams in response to crisis. Mobile crisis intervention did not always lead to hospitalization but resulted in better support from community resources.

Another strength noted is the integration of behavioral health with overall health and activities that promote wellness. Three out of the four Local Mental Health Authorities (LMHAs) in Region IV have established a medical clinic on site. The fourth has a close working relationship with a nearby hospital for medical care. Two providers are certified as Federally Qualified Health Centers (FQHCs). One provider has clinical staff located in a neighboring outpatient clinic. Several are providing school-based health services in Region IV schools. Region IV clubhouses focus much of their programming on health and wellness. Chrysalis has just added a fully-equipped exercise center to its Recovery Empowerment Center.

The opioid crisis has shined a light on a need for substance use prevention, treatment, and recovery. We also need to continue to reduce stigma, increase access to care, and include as solutions people with lived experience in recovery. All the Region IV Local Mental Health Authorities now 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. Five 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. In the past year, 36 NARCAN trainings have been hosted by Region IV communities with over 500 NARCAN kits distributed. Five towns in the region have initiated Hope or Hope-like initiatives to divert individuals—struggling with addiction—to treatment instead of incarceration.

Eight Region IV towns address underage drinking as objectives in their PFS or DFC grants. Five Region IV communities address NMUPD as objectives in their PFS or DFC grants. Twenty-seven communities have prescription drug drop boxes and 25 communities conduct annual prescription drug take back events. The number of youth (ages 12-17) facing alcohol dependence and abuse has declined at the state and regional level, with the regional level declining by 50% from 2008 to 2016.

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. For the past two years, ERASE has hosted a youth-led gambling awareness conference, which includes a presentation of youth-developed PSAs on problem gambling. Conference evaluations indicate growth in youth knowledge of risks associated with gambling, how online gaming is associated with gambling behaviors, and where to get help if someone has a gambling problem. Problem gambling is also addressed in Student Youth Surveys. Many Community and Congregational Awareness Programs have occurred in Region IV helping to increase awareness about problem gambling. Region IV

also has a successful ambassador pilot program, featured on national and state news (most recently on NPR and WNPR), designed to address problem gambling concerns specific to the Asian American and Pacific Islander community.

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. The program was piloted in 4 Region IV schools. Connecticut's preventsuicidect.org provides a wealth of resources on its website for prevention, crisis response, and toolkits for the aftermath of a suicide.

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:**

Responses from our focus groups reveal that Region IV stakeholders rate prevention and treatment services mental health issues to be barely adequate (rated 3.1 of 5) but recovery support less than adequate (2.95 of 5).

Top priorities across mental health, substance use and problem gambling include outpatient treatment (individual, intensive, and assertive community therapy), navigation assistance and a warm hand-off between levels of care, inpatient rehabilitation (including longer lengths of stay and especially for adolescents), and integrated medical and behavioral healthcare. Also identified were the need for more prescribers and crisis response.

Turnover is an issue 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 the area of recovery support, focus group participants cited the need for more case management/community support services, housing, respite, crisis response, transportation, family and peer support and marketing of peer support options.

Our findings were consistent with the 2018 Hartford Healthcare Community Needs Assessment which identified challenges with mental health in the Greater Hartford service area impacted by:



1) a shortage of mental health providers and counselors; 2) the difficulty of recruiting additional providers; and 3) a lack of effective mental health screening at all levels. Other factors that impact community health include: 1) housing and safety concerns related to a lack of safe and affordable housing, neighborhood safety, and housing conditions; 2) a lack of coordination among providers and community-based organizations limits effectiveness of the programs and funding that serve the populations most in need; and 3) other factors that impact access to care, including availability of transportation, insurance cost, availability of providers who accept all insurance types, lack of employment opportunities, and community health centers' hours of operation.

Lack of housing and residential services continue to be identified as top priority areas of concern. As one focus group participant described the issue, "What used to make sense was if you were in a Partial Hospitalization you would graduate to a supported apartment setting, then to your own apartment with Assertive Community Treatment services, then to that apartment with Community Support Program services. But now there is no graduated level of investment and no flow – no continuum of care." Also, home health care agencies have either discontinued or reduced their behavioral health services due to low reimbursement. This is a significant loss of care that helped people maintain medication adherence and reduce the number of impatient psychiatric admissions.

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.

Transportation is also a significant issue especially in rural and suburban areas with no or limited public transportation. Numerous issues with non-emergency Medicaid transportation have been raised to state departments and legislative committees responsible for oversight of the Medicaid contracts. The provider has been fined several times and a lawsuit has been filed.

The opioid crisis continues to be a major area of concern. Although 2018 data shows a slight decline in overdose deaths, the rate of deaths with the presence of Fentanyl continues to climb. Poly-substance users and intentional or unintentional users of Fentanyl are at the highest risk. Hartford has had the highest number of opioid-related deaths in Region IV each year for the past 6 years. In 2018 Hartford had the most opioid-related overdoses in the city's history, a 23.53% increase from 2017. In 2018, Hartford constituted 13.29% of all opioid-related deaths for the state of Connecticut, the largest percentage it has had since data has been recorded. Some of the most recent overdose deaths in Hartford were with people using cocaine that had Fentanyl

in it. This raises the need to ensure 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.

Many barriers to accessing treatment for problem substance use, especially for detoxification and rehabilitation were identified by focus group participants. Lack of insurance coverage, high co-pays and deductibles are significant barriers, especially for some commercial plans, some Medicaid plans and Medicare. Governor's Alcohol and Drug Policy Council treatment subcommittee is working diligently to address many of these barriers. Other issues involving treatment include the need for smooth transitions to outpatient and recovery supports, treating the whole person including co-occurring mental health issues, and including holistic approaches in addition to medication assisted treatment. Supportive services need to include more step-down options like the InterCommunity Recovery House, good sober homes, and diversion programs like the Hope Initiative in Manchester. Great concern was expressed about the legalization of issues (gambling, marijuana) that can lead to addiction and the impact it has on perception of harm for youth. "Even if part of the revenue is dedicated to prevention and treatment, why would you legalize something you know is going to create more problems?"

Similar concerns as noted above were described about access to treatment for mental health issues, especially in rural areas, youth and adult psychiatry, individual therapy, staffing for adult crisis response, long waits for intensive services, inadequate length of stay for inpatient services, and infrequency of prescriber and outpatient appointments.

School and Local Prevention Council (LPC) personnel noted high rates of anxiety among school youth. Several LPCs have hosted events using the film "Angst" for education and discussion with parents. This was seconded by the Region IV priority setting workgroup. Anxiety, especially among youth, was identified by the priority setting work group as the top behavioral health issue to be addressed – second only to alcohol use among all the issues to be considered. About 10.5% of calls to the CT Emergency Mobile Psychiatric Response system (for youth) in FY 2018 were for issues related to an anxiety disorder (11.9% were for anxiety as a secondary diagnosis). The group recommended more research to look at root causes and effective strategies to combat rising anxiety. More trauma-informed, social/emotional learning programs, mindfulness, resilience and coping strategies must be incorporated into school curriculum for students of all ages with more screening and intervention as younger ages. "We need to pay attention to the impact of social media on youth and educate young people to be savvy consumers. A lot of issues stem from lack of relationships and marketing." After-school programs provide important supports for youth.

Alcohol use was identified by the priority setting work group as the top behavioral health issue to be addressed – followed closely by anxiety, depression, and trauma/PTSD. Region IV survey data for grades 9-12 show that risk factors for underage drinking is relatively high compared to ENDS, marijuana, and gambling.

Concern over vape/ENDS has increased community engagement on the topic of nicotine and tobacco prevention, legislation and ordinances. Region IV perceived risk or harm for grades 9-12 group is 79% for cigarettes and 32% for ENDS, the lowest perceived risk rate among all “core substances and gambling.” NCBHAO has received numerous requests for educational programs about the dangers of vaping. Many Region IV school systems are implementing policies for students who are found with nicotine or tobacco products to be provided with cessation program opportunities rather than discipline. Hartford and Southington passed “Hartford 21” ordinances to increase the age people can purchase tobacco products (including ENDS). Most recently the CT General Assembly has voted to support “Tobacco 21” across the state. The hope is that this legislation—along with community outreach and education—will reduce the number of young people who start smoking or using vaping products.

There is a significant lack of awareness about resources and services for problem gambling among Region IV’s general public. More resources are needed to help elderly individuals and teenagers, especially regarding less-talked about practices such as sports betting. Given that there is only one problem gambling provider in the region, there is a need for trained clinicians who can respond to problem gambling concerns in their practices. From one of the clinicians in our RBHPSW, “This is viewed as a niche treatment versus expanding the approach to reducing problem behaviors.” The Region IV priority workgroup found it important to consider the overlap between gaming and problem gambling and when they might bleed into internet and phone addiction. Discussion focused on gaming groups in schools as a safe space for youth with social anxiety or who don’t fit in other sports or school clubs. Our Region IV youth surveys data reflects youth perception of risk for gambling at 43.5% (grades 6-8) and 45.7% (grades 9-12).

## **VI. Recommendations for Region IV**

### ***Substance Use Prevention:***

Compare perceived risk and use rates for vaping products (including substances other than nicotine) in 2019 and identify effective strategies for outreach and education about the dangers of nicotine and other vaping products for youth.

Continue efforts to reduce opioid overdose related deaths through the promotion of prevention, treatment and recovery activities for opioid use disorder with a focus on highest risk communities.

### ***Substance Use 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. We must 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.

Continue to explore options for offering mobile and tele-health options for people living in rural communities for whom transportation is a significant barrier to accessing services.

### ***Substance Use Recovery:***

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

### ***Mental Health Promotion:***

Region IV school surveys do not include a measure for anxiety as one of the mental health indicators. Our recommendation is that the 2019 surveys should be adjusted to address this issue. More research is needed to look at root causes and effective strategies to combat rising anxiety.

### ***Mental Health Treatment:***

Continue to explore options for offering mobile and tele-health options for people living in rural communities for whom transportation is a significant barrier to accessing services.

Address the gaps in the continuum of care for supportive, supported, and residential housing for individuals with mental health and addiction challenges. This will require DMHAS to look for

revenues within its state allocation for housing supports and services that are not subject to federal requirements targeting only a narrow definition of homelessness. Unless these gaps are addressed, individuals will continue to cycle through hospitalization and Connecticut Valley Hospital at great cost to the system and their personal well-being.

### ***Mental Health Recovery:***

Provide Strategic Prevention Framework training to Region IV Catchment Area Council members for planning and implementing strategies to address the lack of affordable housing in for individuals with mental health and/or addiction challenges.

Support a continued role of CACs due to their necessity for vital consumer engagement and for their critical community monitoring role. Despite the overwhelming statewide community and legislative support for CACs, DMHAS contracts are unclear about the funding that should be allotted to CACs, thus undermining their ability to continue to serve as strategic community partners. In contrast, DMHAS contracts are very clear about the support to be provided to Local Prevention Councils (LPCs) and prevention initiatives. The overemphasis and focus on LPCs rather than an equal focus on LPCs and CACs suggests that mental health prevention and recovery initiatives will also be at risk for being underfunded and neglected, compared to the substance use prevention work.

### ***Problem Gambling Prevention:***

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.

Continue conversations with key community informants about prevalence and strategies being implemented to address anxiety, vaping, and problem gaming especially among youth and young adults.

Include computer gaming as a topic in all Problem Gambling training.

### ***Problem Gambling Treatment:***

Expand Disordered Gambling Integration Project (DigIn) in areas where gambling is expanding (East Windsor, Enfield and Windsor Locks). Increase promotion of Helpline in those same areas.

### ***Problem Gambling Recovery:***

Engage leaders of Gamblers Anonymous for expansion of Gamblers Anonymous meetings in those areas where gambling is expanding (East Windsor, Enfield and Windsor Locks). Promote inclusion of problem gambling in recovery coach and recovery support specialist training.

***Other Recommendations:***

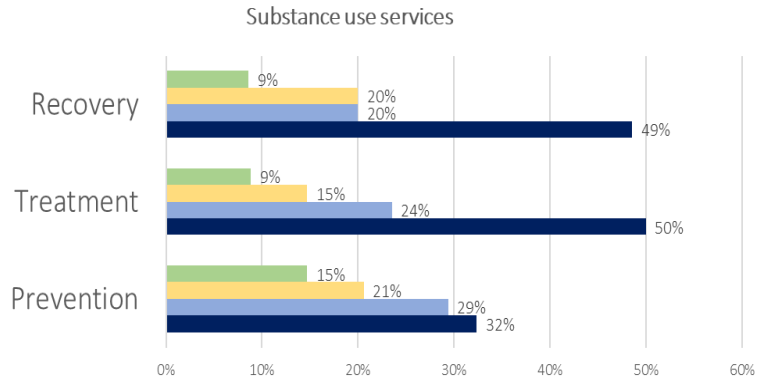
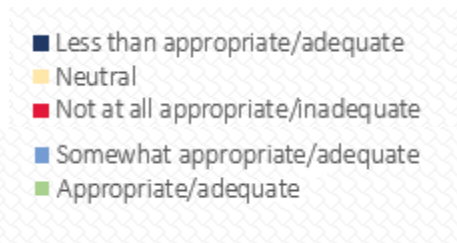
Elicit feedback from Hartford Foundation Community Fund Advisory Committees as key grassroots stakeholders to see what rises to the top as priority needs in our communities. Explanation: The Hartford Foundation for Public Giving has created 29 new funds, one for each of the towns in their region. All of these towns fall with Region IV. The purpose of these funds is to support the community in taking ownership around the needs in their towns, encourage broad and inclusive civic engagement, and anchor the Hartford Foundation in each town. Each community fund will be handled by an advisory committee of town residents that must be inclusive, representative, and reflective of all of the residents of that community. The advisory committees will identify the greatest needs in their communities and design a grantmaking process aimed to ensure that the community funds can have the greatest impact for the benefit of town residents.

**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

### 1. How appropriate are available services to meet the needs of: Substance Use?

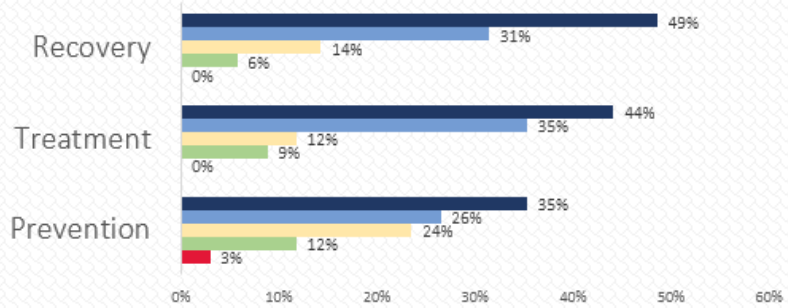


Recovery	Treatment	Prevention
<p>CCAR Recovery Coaches &amp; training are great</p> <p>Some good sober homes – now on bed availability list</p> <p>Bridger program is good</p> <p>More job placement services needed</p>	<p>Lack of beds, specifically for detox and rehab, insurance is also a barrier</p> <p>Need smooth transitions – cannot afford to wait for step down or outpatient services (including prescriber)</p> <p>Not treating the whole person – co-occurring issues</p> <p>Increase in availability of medication assisted treatment is helping but concern also expressed about so much emphasis on medication. Need to promote more holistic options.</p> <p>Make sure DMHAS is providing adequate education to providers about side effects and contra indications of medication assisted treatment</p> <p>Drug testing requirements should be consistent</p>	<p>Concerns re: legalization of things that lead to addiction</p> <p>A lot of education about opioid use disorder is helping</p> <p>Not enough funding for Youth Services Bureaus and RBHAOs</p> <p>Need for more awareness to counteract stigma</p> <p>PSAs and Change the script campaign is reaching people</p> <p>Need more education about vaping</p>

# Mental Health?

- Less than appropriate/adequate
- Neutral
- Not at all appropriate/inadequate
- Somewhat appropriate/adequate
- Appropriate/adequate

Mental Health Services :



Recovery	Treatment	Prevention
<p>Need to teach more practical skills, such as how to speak up for self. System caters to dependency and learned helplessness instead of focusing on skills for discernment and more independence. Need more use of peer mentors and life coaches.</p> <p>There is more focus on whole person, wrap around services</p>	<p>Accessibility - There are not enough doors to enter to access services. Often takes too long to get help. Insurance, high deductibles, and co-pay are barriers to accessing treatment</p> <p>Need less of a push for medication</p> <p>Need more focus on family involvement and understanding</p> <p>If you don't live near the LMHA - there is a problem with getting the care you need.</p> <p>Need smoother transitions from levels of cares</p> <p>Provider assumptions from past issues affects future treatment (some agencies treat you based on your past – they force a certain kind of therapy on you)</p> <p>Understaffed crisis care.</p> <p>Need flexibility to increase level of care for short periods when people are not doing well. Not enough space for people for inpatient services. The opportunity for an appropriate length of stay is limited.</p> <p>Frequency of outpatient psychiatric and counseling services is inadequate</p> <p>Long wait list for intensive services.</p> <p>Need more housing and residential services at higher levels of care than supportive living</p>	<p>GIZMO is an education campaign that helps kids navigate their feelings. Helps name things and navigate hard feelings. Want to see that expanded.</p> <p>Need more screening in schools</p> <p>Need to target some of the DMHAS funding for housing services and supports to prevent homelessness among people served by DMHAS</p>



## Gambling?

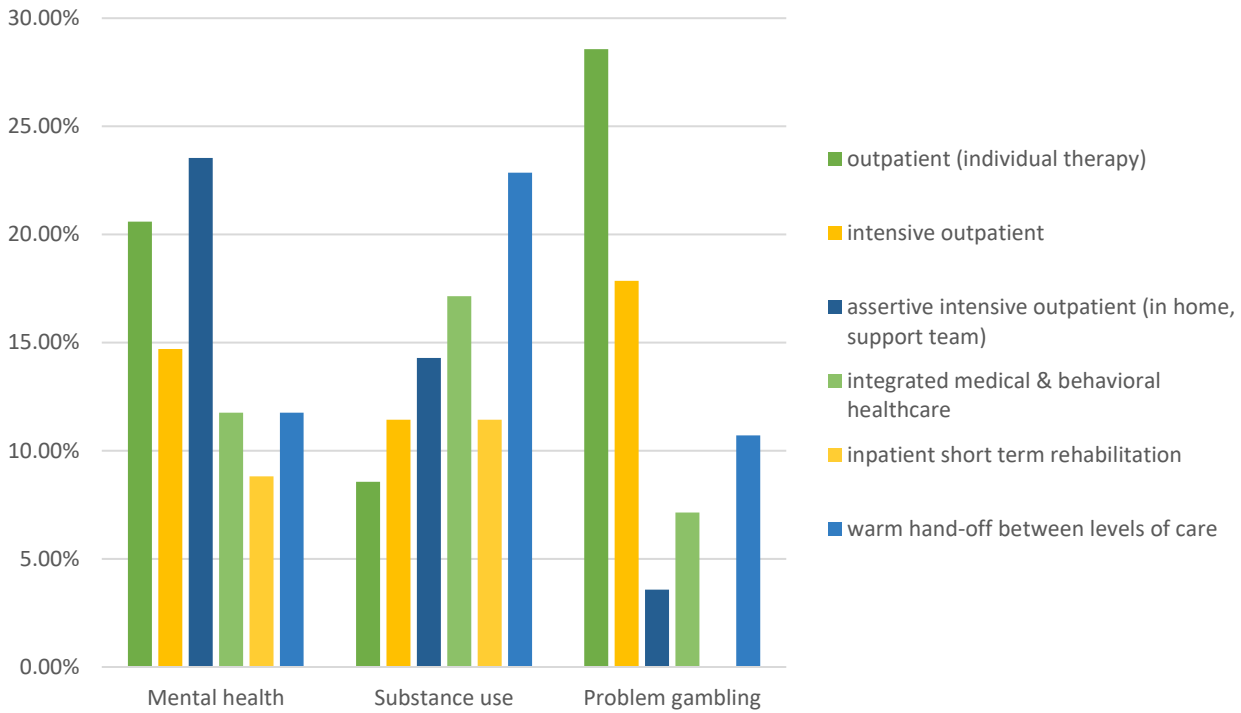
Recovery	Treatment	Prevention
<p>Peer Counseling available at Wheeler; CCAR is DiGNi-Disordered Gambling Integration Initiative; Advocacy Unlimited offers recovery services; GA/Gam-Anon in Hartford, Enfield, and Longmeadow, MA as which is a well-liked meeting; PGS has worked with Dept. of Corrections on treatment and recovery programs and has seen an increase in probation referrals to Bettor Choice Programs since trainings with DOC staff have begun</p>	<p>DiGNi needs expansion it is in Wheeler but not CHR or InterCommunity in Region 4. InterCommunity may have one gambling screening question on their adult assessment.</p>	<p>Strong youth focus with ERASE’s PAWS youth conference which has transitioned to a gambling awareness focus. YSB’s have become more aware as a result of PAWS and efforts to have youth and adult advisors trained at California Conference, specifically in Enfield, Manchester and East Windsor. Asian American Pacific Islander (AAPI) has been implemented primarily in Region 4. PGS leadership sees a marked difference in gambling readiness between the former ERASE Region Towns and other former RAC regions that are within Region 4, former ERASE towns have received more resources regarding gambling awareness, and have better engagement on the topic. Many Community Awareness Programs (CAP) have occurred in Region 4 which contributes to increased community awareness per the program outcomes; ERASE has historically worked with senior centers via LPC contacts during Problem Gambling Awareness Month. College outreach in Region 4 has had limitations. It would be best received if infused into curriculum or considered as an MSW field education project</p>

## 2. What Prevention Program, or policy would you like most to see accomplished related to:

Substance Use	Mental Health	Problem Gambling
<p>More advertising of the peer support non-AA models that exist</p> <p>Marijuana and e-cig prevention for youth</p> <p>Decriminalization/ de-stigmatization of addiction</p> <p>Legalization of marijuana - one of the reps said we will give you money for treatment - but all of us don't believe that. Why would you legalize something that you already know is going to be a problem?</p> <p>Capturing all this so that people can plan to resolve the issue or prevent the issue from coming up in the first place.</p> <p>Many legislators don't know about brain development and marijuana use</p>	<p>More suicide prevention/awareness programs (QPR)</p> <p>Research of social determinants to mental health</p> <p>Need trauma-informed schools (ACES) and "Handle with Care" programs-need for increased communication with community and school with child and family that impacts behaviors at school. Can respond with mental health services and not discipline in these cases.</p> <p>Better coordination with town social services</p> <p>Acceptance and education around the unique strengths those with mental health issues embody and are beneficial for every community.</p> <p>The State Department of Education should implement a system-level approach regarding bullying.</p> <p>Develop structures to engage in peer-to-peer support to enhance their natural supports for youth.</p> <p>Better programs in the school system to teach children about mental health, how to deal with mental health issues, reduce stigma associated with mental health issues, and increase access to safe and inclusive environment</p> <p>Look at causes - it's not what we are providing people but also how we are responding to all the fast changes.</p> <p>A lot of this is about our culture increasingly - there are a lot of compulsive behaviors that are encouraged.</p> <p>Educate young people to be savvy consumers of things.</p> <p>Provide education about what a commercial is designed to do. Teach ways to cope with scary world when kids are young. So that they can avoid compulsive behaviors. A lot of issues stem from lack of relationships and marketing.</p> <p>Pay attention to the impact of social media on youth anxiety</p>	<p>More and better public messaging efforts to educate individuals about gambling</p> <p>Stricter zoning restrictions and more resources to help elderly individuals and teenagers, especially regarding less-talked about practices, such as sport betting.</p> <p>Advertise the hotline</p> <p>Increased awareness of the issues &amp; ways to get help</p> <p>This is viewed as a niche treatment versus expanding the approach to reducing problem behaviors</p> <p>Removal of gambling businesses in low-income areas</p> <p>Education/prevention at high school level</p> <p>Lack of awareness around problem gambling – they're starting to have ads on TV; the ads are cutesy but lack depth.</p>
<p>More local advertising. PSA's, Ads, Educating Physicians, Pharmacists, Vendors and Potential Users of Services</p> <p>Clear Avenues for families to follow to receive help</p> <p>Other options to occupy time</p> <p>General population positive youth development and parent education. Stigma reducing education &amp; parenting programs</p>		

Mandated educational programs in health curriculum. Ways of identifying/screening younger children in school who struggle with MH or SA. School & community awareness & intervention as early as possible. Massive effort at middle school level for prevention

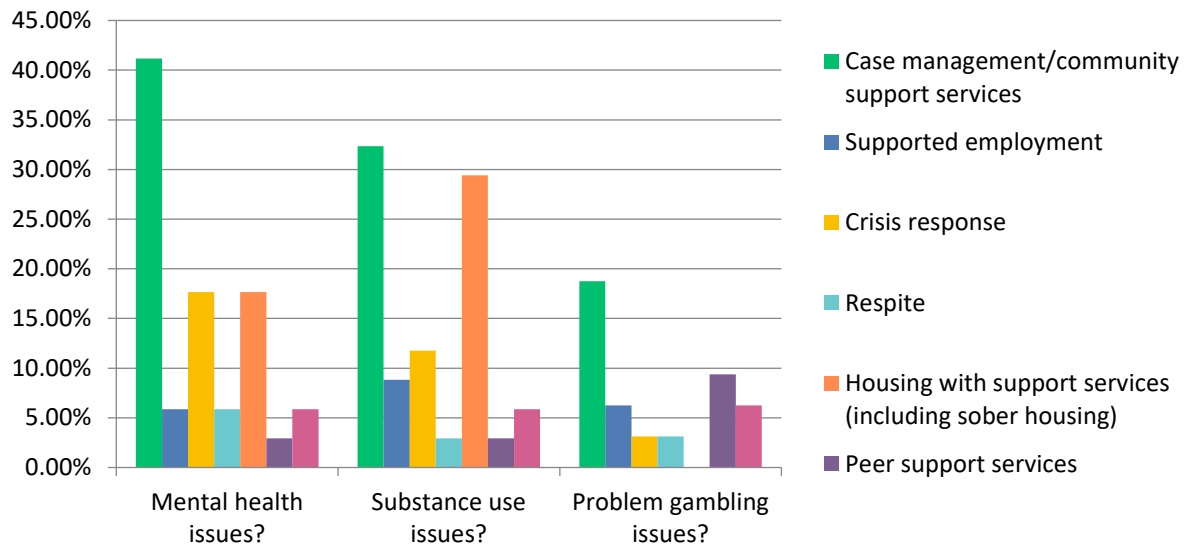
### 3. What treatment levels of care do you feel are unavailable or inadequately provided related to:



Substance use?	Mental Health?	Problem Gambling?
<p>Availability and length of stay for rehab &amp; detox (beds)</p> <p>Work closely with local and state police to identify at risk people and follow-up after the initial call</p> <p>More towns implementing Hope Initiative to divert people from arrest to treatment</p>	<p>Non-medicated treatment plans.</p> <p>Recovery coaches in the ED (and alternatives to the ED) for people psychiatric distress</p> <p>A shortage of intensive services, including resources and staff, including intensive case management. Leads to long waiting list.</p> <p>More options for individual therapy</p> <p>More social/emotional learning programs, Dialectical and cognitive behavioral therapy approaches for teaching coping skills. Mindfulness</p> <p>Partial Hospital Program now is only hospital based -used to be available via community providers</p> <p>Lack of children and adult psychiatry services, unavailable or long wait list and length of time between appointments</p> <p>Home health care agencies either discontinued or reduced their behavioral health services due to low reimbursement. Particularly for the chronically mentally ill population. This is a significant loss of care that helped people maintain medication adherence and reduce the number of inpatient psychiatric admissions.</p> <p>Long waiting lists for individuals who need inpatient care/they often go untreated or undertreated</p> <p>Need better availability of Mental Health Crisis services</p>	<p>Lack of awareness of gambling resources &amp; services</p> <p>Intensive Treatment Options</p> <p>Wheeler is the only problem gambling provider in the region – need trained clinicians who can respond to problem gambling east and west of Hartford</p> <p>Removal of gambling</p>

	Remove policies of serving more clients without adequate funding.	businesses in low-income areas
<p>Access, access, access!</p> <p>More Free Centers. Enhanced insurance coverage and accessibility, High co-pays and deductibles create barriers</p> <p>Turnover is an issue for all programs</p> <p>Information about services remains difficult for families to utilize and navigate.</p> <p>Integrated medical and behavioral healthcare</p> <p>Behavioral health and peer support outreach. More peer support</p> <p>Treatment and support for the whole family</p> <p>Better internal process for connecting with resources. Better pathways to treatment</p> <p>Maintain agency reviews by client advocacy organizations.</p> <p>More case managers, so they can divide their time evenly to give more time.</p> <p>More intervention at younger ages</p>		

#### 4. What adjunct/support services/recovery supports are most needed to assist persons with issues related to:



Substance use?	Mental Health?	Problem Gambling?
<p>Good sober homes, but concern about people with SA living in housing where others are using.</p> <p>More step-down options like InterCommunity Recovery House.</p> <p>Positive response to recovery coaches.</p> <p>Positive response to law enforcement diversion programs like Hope Initiative.</p> <p>Positive response to promotion of “Recovery Friendly Communities”</p>	<p>Safe, affordable housing with support services “Substandard housing and dangerous environments facing people struggling with MH and SA; housing insecurity due to rising rents and concern that rents become too high for Section 8 or vouchers to cover the costs if the landlords change.”</p> <p>Home maker services.</p> <p>Need for respite (peer-run, not hospital based). Respite for parents without penalizing them.</p> <p>" What used to make sense was if you were in Partial Hospitalization, you would graduate to supported apt setting, then graduate to your own apt with ACT, then your own apt with CSP. But not there’s no graduated level of investment and no flow there – no continuum of care.</p> <p>"Case management (as much time as you need) was better than community support specialist programs (limited time, high case load).</p> <p>Residential programs with 24-hour support.</p> <p>See Home health care issues in #3 above.</p> <p>More training in Wellness Recovery Action Planning.</p> <p>What else is there besides clubhouse for people with MH issues? If clubhouse isn’t the model you fit in, what is another model to seek recovery? There are people farther along in their recovery or young people who don’t easily fit into current clubhouse models.</p>	<p>Lack of awareness of gambling resources &amp; services</p> <p>Peer and family support</p>

The biggest issue in the community is lack of access to jobs, have no transportation, all living at home  
 Community Resources such as sports and after-school programs provide important supports for youth.

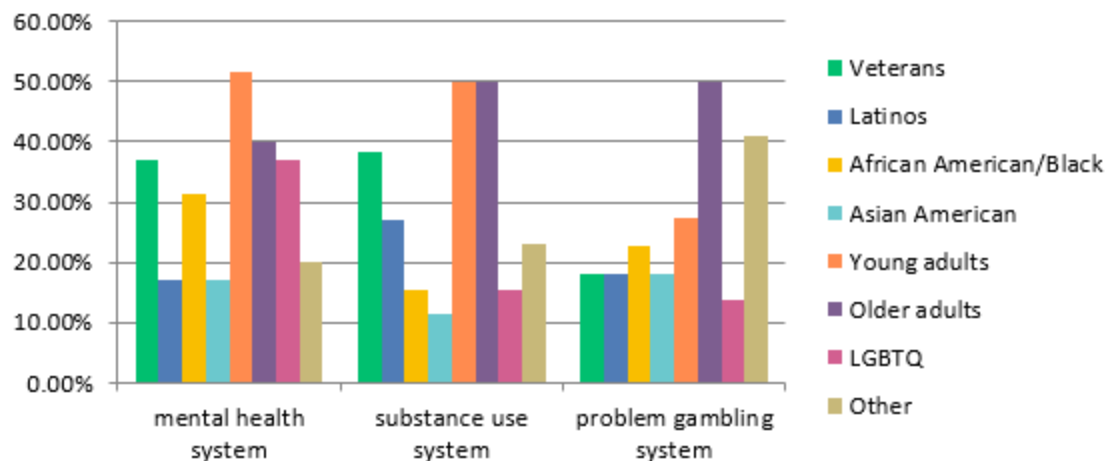
More job placement services needed  
Peer supports, mentoring programs.

5. What would you say is the greatest strength/asset of the prevention/promotion, treatment, and recovery system for:

Substance use?	Mental health?	Problem gambling?
<p>CCAR Recovery Coaches and training are great                      Some great sober homes – now on bed availability list                      Peer Bridger program                      A lot of funding for good work being done and education about opioid use disorder                      The Hope Initiative, if fully implemented &amp; appropriate personnel involved                      Strong Prevention Programs                      public awareness                      Opioid crisis has shined a light on need for substance use prevention, treatment and recovery. Reducing stigma and increasing access to care, including people in recovery                      AA works, it's free, it's widely available.                      CCAR telephone support.                      Methadone clinics                      Staff who understand addiction</p>	<p>GIZMO is an education campaign that helps kids navigate their feelings. Helps name things and navigate hard feelings. Want to see that expanded.                      Bridger program is good                      Crisis response                      Treatment once in the system                      Breaking down barriers/stigma                      Reduction of stigma by high profile folks sharing their stories &amp; increasing awareness among "the public" that MH shouldn't be taboo                      The Clubhouse                      A lot of integrated care is happening with mental health supports on site with primary care                      Peer support                      DBT-Coping skills training</p>	<p>Helpline                      Outreach &amp; PSAs for creating awareness,                      Gamblers anonymous                      increasing access to care, including people in recovery</p>
<p>There is more integration of behavioral and primary healthcare. Abundance of general health &amp; wellness info                      Good and caring service providers                      Whole person wrap-around services.                      Peer support</p>		



## 6. Are there particular subpopulations (for example veterans, LGBTQ, Latinos, etc.) that aren't being adequately served by the:



### Comments

Ex-offenders are also often neglected because programs sometimes have disqualifying criteria for participation which includes background, sex offense conviction, etc.

Women with children

Older adults with elderly parents – losing stable housing, no succession plan, need for caregiver support

Youth - Health curriculum is lacking in some communities, not all grades have this, for example in grades 5 and 6 often is not present

Anxiety is very prevalent among youth and it's not being addressed in a real way. There aren't enough support services. Need to increase mental health services in schools

Ways of identifying younger children in school who struggle with MH or SA; need accurate screening. Things are going undiagnosed for a long time and continue to get worse. Kids can qualify for services, but once they get older, they're not qualified anymore

"More self-help groups targeted at younger people; SMART group at InterCommunity and at Manchester High School (not faith based, not pushy). Another model of a self-help group for people who don't like the spiritual side of AA or NA; they don't look down on MAT

Reality based treatment for youth, CBT versus abstinence or 12-steps, lifetime commitments for youth are "tough to sell." Youth treatment facilitates are lacking in the Northeast, many families have to send youth out of state, if they can afford to.

Adolescents: IOP – Hartford Dispensary has the Root Center for youth.

A lot of homeless adolescents. If they can get into IOP program, maybe they can get Tx

People from Southeast Asian Community and refugee communities in general – have mental health issues, but their understanding of mental health is low.

LGBT – True Colors emphasis on adolescents – but nothing to support older adults

Spanish speaking due to language barriers

Newly diagnosed

All populations are underserved

Stigma, shame, denial, access, inadequate insurance all contribute across the board

Focus seems to be on children and families and with limited budgets all other groups are underserved.

7. What emerging prevention, treatment or recovery issues are you seeing or hearing about regarding:

Substance use?	Mental Health?	Problem Gambling?
<p>Marijuana related psychosis  Vaping is already an epidemic (not just for nicotine)  Impact of legalizing substances on perceived risk rates  Cocaine and methamphetamine are reportedly on the rise</p>	<p>Poor medication management (not enough prescribers to know and follow their patients)  Trying to figure out how to capture impact of phones, since they are a required piece of everyone's lives  Anxiety, especially among youth, was identified as the top mental health issue to be addressed by our priority setting workgroup – second only to alcohol use among all the issues to be considered</p>	<p>Overlap between gaming and gambling can blend into internet and phone addiction  People who designs apps are using the same psychology as slot machines  Sports betting and new casinos  Need for specialized intervention in the state and schools to address problem gaming  There are gaming groups in schools -  There's a social comfort in those groups for youth. because Some students have found a home there  For youth with social anxiety this is a place where they have a safe space, and don't have to deal with people face-to-face</p>
<p>With the loss of funding for Regional Mental Health Boards and creation for the new RBHAOs it is not clear how the new organizations will be able to continue to support the role of Catchment Area Councils for consumer engagement and monitoring of the services and support that impact them in their local communities.</p>		

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

### Technology

Needs to be a clear web based way to help people. 211 just sends people in circles.

Online therapy and consultation

dedicated social service lines/wait times

Information, websites, webinars

Support remote patient appointments which would offset transportation issues.

community awareness through social media

streamlining the workload processes so that human service workers can spend more time with their clients instead of on paperwork

Young adult texting apps

### Integration

Work closely with local and state police to identify at risk people.

Better internal process for connecting with resources

Warm hand-off

Problem gambling is not an area of training or expertise for most clinicians working in behavioral health

With other state agencies serving other family members - DCF, SDE, DSS

### Partnerships

Clear Avenues for families to follow to receive help.

Working together with local social service departments

Work together with homeless and housing coalitions for preventing homelessness for people served by DMHAS

Increased partnerships with local social services and other state agencies serving other family members - DCF, SDE, DSS

We could improve in making partnerships

Self-help groups, clergy, primary care, physicians

Walk in centers

Coordination between police, school and social services for "Handle with Care" after traumatic events

### Other

Mindfulness, stress reduction strategies help with anxiety

"Money follows the person program – problem is some people don't have the capacity to figure out daily medical services, need a case manager or caregiver. This compromises ability of people to live independently – need someone who can coordinate services

There seems to be more talk than effective action.

Funding for the agencies who are combatting these problems to open the door to more.



# 2019 REGION IV PRIORITIES

## EMERGING ISSUES



- Explosion in use of electronic nicotine devices (ENDs)
- Accidental overdose deaths caused by use of substances laced with Fentanyl
- High rates of anxiety among youth
- Overlap between computer gaming, sports betting and problem gambling
- Concern over loss of CAC consumer engagement & monitoring roles in new RBHAO structure

## RESOURCES, STRENGTHS, ASSETS



- CT's commitment to developing and maintaining recovery support services
- Integration of behavioral health and overall health, and promotion of wellness activities
- Increase in offerings of Medication Assisted Treatment ("MAT")
- Decrease in CT youth facing alcohol dependence and abuse by 50% from 2008 to 2016
- Strong problem gambling awareness and treatment programs in Region IV
- GIZMO's Pawesome Guide to Mental Health Curriculum was piloted in 4 Region IV schools
- Geriatric Behavioral Health services offered at two hospitals in Region IV

## RESOURCE GAPS AND NEEDS



- Lack of housing and residential services continue to be top priority areas of concern
- High rates of anxiety among school youth
- Fentanyl-related deaths continue to climb, and Hartford had the highest number of opioid-related deaths
- Treatment priorities: outpatient treatment, navigation assistance, warm hand-off between levels of care, inpatient rehabilitation, integrated medical and behavioral health care, and the need for more prescribers and more crisis response teams
- Treatment barriers: staff turnover, transportation (especially in rural areas), lack of options for detoxification and residential rehabilitation for substance abuse (none for adolescent girls)
- Recovery support priorities: case management and community support services, housing, respite, crisis response, transportation, family and peer support, and marketing of peer support options



## 2019 REGION IV PRIORITIES

# RECOMMENDATIONS

### SUBSTANCE USE



- Identify effective strategies for outreach and education about the dangers of nicotine and vaping
- Continue efforts to reduce opioid-related deaths through the promotion of prevention, treatment, and recovery activities for opioid use disorder with a focus on highest-risk communities (including mobile and tele-health options)
- Continue to develop and advertise other effective approaches for providing substance abuse treatment
- Support the establishment of “Recovery Friendly Communities” in Region IV

### MENTAL HEALTH



- Adjust school surveys to include a measure for anxiety as one of the mental health indicators
- Address the gaps in the continuum of care for supportive, supported, and residential housing for individuals with mental health and addiction challenges in order to prevent rehospitalizations
- Provide Strategic Prevention Framework training to community members so they can address the lack of affordable housing for individuals with mental health and/or addiction challenges
- Support the role of Catchment Area Councils (CACs) as vital mechanisms for consumer engagement and service monitoring.

### PROBLEM GAMBLING



- Adjust school surveys to measure perceived risk and use rates for problem gambling and address the overlap between computer gaming, sports betting, and gambling
- Continue conversations with key community informants about prevalence and strategies being implemented to address anxiety, vaping, and problem gambling
- Include computer gaming as a topic in all Problem Gambling training
- Expand Disordered Gambling Integration Project (DigIn) and increase Helplines in areas with new casinos
- Engage leaders of Gamblers Anonymous to expand meetings in areas with new casinos; promote inclusion of problem gambling in recovery coach and recovery support specialist training